

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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APPEAL FROM FLORENCE COUNTY  
Court of Common Pleas

William H. Seals, Jr., Circuit Court Judge

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Appellate Case No. 2016-001551

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Christy Byrd, as Next Friend of Julia B., a minor, ..... Appellant,

v.

McLeod Physician Associates II and Dr. John B. Browning, ..... Respondents.

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RECORD ON APPEAL  
VOLUME 2 OF 3

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SC Court of Appeals

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1 (WHEREUPON, the bench conference ended and there was a  
2 pause in the proceedings, after which the proceedings  
3 resumed as follows.)  
4 MS. CRAIG: Your Honor, we're good to go. Thank you.  
5 THE COURT: All right. If you'll go ahead and bring out  
6 the jury?  
7 (WHEREUPON, the jury entered the courtroom at 2:28 p.m.)  
8 THE COURT: All right. If you'll call your next witness?  
9 If the plaintiff will call their next witness?  
10 MR. GRAHAM: Oh, I'm sorry, Your Honor. We rest our  
11 case.  
12 THE COURT: All right. Thank you very much. The  
13 defendant?  
14 MS. CRAIG: Yes.  
15 THE COURT: If you'll call your first witness?  
16 MS. CRAIG: Thank you, Your Honor. The defendants call  
17 Dr. John Browning.  
18 THE CLERK: Place your left hand on the Bible and raise  
19 your right hand. Do you swear or affirm that the testimony  
20 you give in this case will be the truth, the whole truth, and  
21 nothing but the truth, so help you God?  
22 THE DEFENDANT: So help me God.  
23 THE CLERK: Please have a seat and state your name for  
24 the record.  
25 THE DEFENDANT: My name is John Barrett Browning.

1 DR. JOHN BROWNING, being  
2 first duly sworn, testified as follows:

3 DIRECT EXAMINATION

4 BY MS. CRAIG:

5 Q: Good afternoon, Dr. Browning.

6 A: Good morning.

7 Q: I'd like this jury to get to know you. Tell us a little  
8 bit about you and your family, sir?

9 A: I'm married to my wife, Linda. It'll be 40 years this  
10 August. I have three children. I have a 37-year-old daughter  
11 who has two children, a 35-year-old daughter that has two  
12 children, and then I have a 25-year-old son. He's still in  
13 school.

14 Q: Are your children working?

15 A: They are. My oldest daughter is a middle school teacher  
16 for severe disability children and my other daughter is an  
17 obstetrician/gynecologist like I am.

18 Q: How long have you and Mrs. Browning been married?

19 A: Like I said, it'll be 40 years this August.

20 Q: And I've learned a little something about you and Mrs.  
21 Browning through the course of this litigation. What is one  
22 of her hobbies?

23 A: She's a crazy runner.

24 Q: Like, how crazy?

25 A: Very.



**DR. JOHN BROWNING - DIRECT BY MS. CRAIG**

1 Q: Tell us. Tell us about her marathons?

2 A: I think she's done 24 marathons to date. She started  
3 when she was 40.

4 Q: How many grandchildren do you and Ms. Browning have?

5 A: We have four.

6 Q: Do you spend some time with your grandchildren?

7 A: As much as we can. We are in high demand.

8 Q: High babysitting demand?

9 A: Yes. Yes, we are.

10 Q: I understand that. Yes, sir. Tell us where you grew up,  
11 Dr. Browning?

12 A: My father was a career Army officer and I spent from 4  
13 until I was 17 living in Europe, and then came back to our  
14 home in Atlanta and then my schooling was paid for by the Army  
15 and I, after medical school, went out to Seattle for 4 years  
16 and did my training and then went to Europe and then came back  
17 to Fort Jackson as my last Army assignment.

18 Q: So when did you and Mrs. Browning move here to Florence?

19 A: In 1994.

20 Q: All right. Dr. Browning, I'd like to walk through your  
21 education and, if you could, tell us where you went to college  
22 and then medical school?

23 A: I went to college at Georgia State University, which was  
24 a working school, and I went to medical school at Emory  
25 University. And then I did my OB/GYN internship and my

1 residency at -- in Washington.

2 Q: Now, when you were in medical school, did you receive an  
3 award in medical school for being the best obstetric student  
4 your third year?

5 A: I did.

6 Q: And your residency? I believe you were the chief  
7 resident; is that correct?

8 A: Yes, ma'am.

9 Q: You mentioned that you were in the Army. Tell us about  
10 your Army scholarship?

11 A: When you get into medical school, you can apply for  
12 funding from the Army and I was lucky enough to get that.

13 Q: So, Dr. Browning, you've been a doctor for how long?

14 A: Since 1986.

15 Q: So you've been practicing obstetrics for about -- what?  
16 Thirty years?

17 A: Close.

18 Q: Okay. Tell us why you decided to become a doctor?

19 A: I was the sixth of seven children. My mother was able to  
20 take care of it seems every medical problem we had and I took  
21 an interest in that, and she told me I was going to be the  
22 next family doctor.

23 Q: So, Dr. Browning, are you board-certified?

24 A: Yes, ma'am.

25 Q: And we've heard what board certification is. Tell us

**DR. JOHN BROWNING - DIRECT BY MS. CRAIG**

1 what your board certification -- what are you board-certified  
2 in?

3 A: In obstetrics and gynecology.

4 Q: And do you voluntarily recertify?

5 A: Yes, ma'am.

6 Q: I am going to show you what we have marked as Defendant's  
7 Exhibit 2. Can you identify this document?

8 A: Yes. That's my CV.

9 Q: Okay. And does it look to be up-to-date?

10 A: It does.

11 Q: And a CV is what?

12 A: It's a history of what we've done in our profession.

13 Q: Okay. Thank you.

14 MS. CRAIG: Your Honor, at this time, we'd offer Dr.  
15 Browning's CV as Defendant's Exhibit 2.

16 THE COURT: Any objections?

17 MR. GRAHAM: No, Your Honor.

18 THE COURT: All right. Defendant's Number 2 into  
19 evidence without objection.

20 (WHEREUPON, Defendant's Exhibit Number 2, curriculum  
21 vitae of Dr. Browning, was admitted into evidence.)

22 BY MS. CRAIG:

23 Q: Now, back to your board certification. Board  
24 certification -- what type of examinations do you have to take  
25 in order to become a board-certified obstetrician/

1 gynecologist?

2 A: When we finish our residency training, we take a written  
3 exam and, if we pass, the second year out of our residency we  
4 collect cases for a year and then we apply to sit for an oral  
5 exam. And we -- it's an all-day affair where we have a  
6 separate examiner examine us on obstetrics and gynecology and  
7 office practice.

8 Q: All right. Dr. Browning, give us an estimate, if you  
9 can, approximately how many babies have you delivered in your  
10 career?

11 A: I've never counted, but I'm guessing over 5,000.

12 Q: All right. Let's talk about your practice, your practice  
13 here in Florence. Will you describe your practice for us?

14 A: We're a practice of six now. We -- we are -- take care  
15 of everybody. We do all the high-risk transfer obstetric  
16 patients from the Pee Dee. We do a full breadth of  
17 gynecology. We also have our own patients.

18 Q: Do you receive referrals? And when I say referrals, do  
19 you receive patients to see from Dillon?

20 A: We do.

21 Q: Hartsville?

22 A: Yes, ma'am.

23 Q: Johnsonville?

24 A: Of course, yeah.

25 Q: Hemingway?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

- 1 A: Yes.
- 2 Q: Lake City?
- 3 A: Yes.
- 4 Q: Kingstree?
- 5 A: Yes.
- 6 Q: Did I miss any?
- 7 A: No. I mean there are other -- other communities that we
- 8 receive referrals from all over the Pee Dee and we have
- 9 patients out of the Pee Dee that come to us.
- 10 Q: Will you please tell us -- you said you have six
- 11 partners?
- 12 A: Yes, ma'am.
- 13 Q: Who are your partners?
- 14 A: Charles Tatum is the senior partner. I'm the next most
- 15 senior. We have Dr. Gary Emerson, Dr. Cynthia Cole, Dr. John
- 16 Chapman, and Dr. Brad Campbell.
- 17 Q: And who is the managing partner of your practice?
- 18 A: I am.
- 19 Q: And what does that entail?
- 20 A: I make up the schedule. I'm the go-between for
- 21 administration. I organize meetings for our office.
- 22 Q: Do you take call on the weekends and on the weekends
- 23 after office hours?
- 24 A: Yes.
- 25 Q: How does your call schedule -- how does that work?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: We rotate in an equal fashion so that the call is split  
2 evenly amongst all six of us.

3 Q: And let's now move on to your teaching responsibilities.  
4 I'd like to just touch on some of the teaching  
5 responsibilities that you have. Tell us about teaching the OB  
6 residents for McLeod?

7 A: There is a family medicine OB residency at McLeod and we  
8 are the practice that helps them with their training.

9 Q: How about at the University of South Carolina? Are you  
10 involved with any teaching responsibilities?

11 A: Well, as you may have heard, the University of South  
12 Carolina is starting to send medical students for their  
13 clinical years to Florence, and we're the group in town that  
14 agreed to help them with their training.

15 Q: Dr. Browning, do you have any role in teaching nurse  
16 practitioners?

17 A: We do. Nurse practitioners come to our office for  
18 training.

19 Q: And do you actually teach the management of shoulder  
20 dystocia?

21 A: Yes, we talk about it.

22 Q: Have you proctored physician assistants?

23 A: I have.

24 Q: And where do you have hospital privileges, Doctor?

25 A: At McLeod.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 Q: What does it mean to be the chair of the Department of  
2 Obstetrics at McLeod?

3 A: Well, every approximately four years we have a new chair  
4 of our department, and it's, you know, doing a variety of  
5 administrative matters. We hold meetings. We try to upgrade  
6 the clinical capabilities of our practice -- practices in the  
7 hospital.

8 Q: And have you held that position?

9 A: Yes, I have.

10 Q: Are you also a member of the -- of the medical executive  
11 committee?

12 A: I am.

13 Q: And what do you do in that regard?

14 A: It's a -- it's the various chiefs from the different  
15 departments that get together and go over various  
16 administrative and clinical things in the hospital.

17 Q: Moving now to the medical societies and professional  
18 organizations of which you are a member, can you tell us what  
19 societies you're a member of?

20 A: The American College of OB/GYN.

21 Q: Okay. And is that the premier organization for doctors  
22 who deliver babies like you to be a member?

23 A: It is.

24 Q: How about the Florence Medical Society? Are you a member  
25 of that?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Yes, ma'am.

2 Q: And tell us about the volunteer work that you're doing  
3 here in Florence for women who have substance abuse problems?

4 A: We have a committee of physicians that are trying to work  
5 out standards to help these folks.

6 Q: And you participate on that committee?

7 A: Yes, ma'am.

8 MS. CRAIG: Your Honor, at this time, we would offer Dr.  
9 John Browning as an expert witness in the field of obstetrics  
10 and gynecology.

11 THE COURT: Any objections?

12 MR. GRAHAM: Yes, sir, Your Honor. This is a new  
13 opinion.

14 MS. CRAIG: She's offering him as an expert.

15 MR. GRAHAM: Yes, sir. And may we approach, Your Honor?

16 THE COURT: You may.

17 (WHEREUPON, a bench conference was held in the presence  
18 of the jury but out of the hearing of the jury as  
19 follows.)

20 THE COURT: We've already talked about this.

21 MR. GRAHAM: Yes, sir. And we want to preserve and  
22 protect their position on the matter.

23 THE COURT: You're protected. He's been a physician for  
24 umpteen years. There's no doubt about him being an expert.

25 MR. GRAHAM: But one that we weren't allowed to depose as



DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 an expert because of their representation.

2 THE COURT: I understand, but you've already cross-  
3 examined him one time; so you know where it's going and what  
4 he's going to say.

5 MS. CRAIG: Thank you.

6 (WHEREUPON, the bench conference ended and the  
7 proceedings resumed as follows.)

8 MS. CRAIG: Your Honor, could we have Dr. Browning  
9 acknowledged or qualified by the Court as an expert witness --

10 THE COURT: Yes.

11 MS. CRAIG: -- In the fields of obstetrics and  
12 gynecology?

13 THE COURT: The motion is granted.

14 MS. CRAIG: Thank you.

15 BY MS. CRAIG:

16 Q: All right. Dr. Browning, we are going to talk about the  
17 details of this delivery in our time today. My first question  
18 to you is did you comply with the standard of care in the  
19 delivery of Julia B ?

20 MR. GRAHAM: Same objection, Your Honor.

21 BY MS. CRAIG:

22 A: Yes, ma'am.

23 THE COURT: Overruled.

24 BY MS. CRAIG:

25 Q: And did you cause the injuries in this case?

**DR. JOHN BROWNING - DIRECT BY MS. CRAIG**

1 MR. GRAHAM: Same objection, if Your Honor please.

2 THE COURT: I understand.

3 BY MS. CRAIG:

4 A: I don't believe I did.

5 THE COURT: Overruled. Go ahead and answer it.

6 BY MS. CRAIG:

7 Q: Okay, Doctor, and we're going to -- like I said, we're  
8 going to go into great detail. I just wanted that out in the  
9 beginning. Let's talk about your experience with shoulder  
10 dystocia. There's been a lot of testimony about what shoulder  
11 dystocia is. Just very briefly, tell us what it is?

12 A: As you all know by now, it's the shoulders getting stuck  
13 in the pelvis. And when they do and it requires a maneuver to  
14 relieve the obstruction, that meets the definition of a  
15 shoulder dystocia.

16 Q: So explain to us how you received training during your  
17 residency and when you were in medical school about how to  
18 manage shoulder dystocia?

19 A: Well, we learned very early in our residency how to  
20 manage shoulder dystocia. It's not an uncommon complication  
21 of our deliveries.

22 Q: And have you actually participated in shoulder dystocia  
23 drills with simulation equipment at McLeod Hospital?

24 A: I have.

25 Q: Tell us about that?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Well, the initial simulation equipment we had was really  
2 sort of low-tech. It was a doll that came through a pelvic  
3 mannequin and we did drills with the nurses to go over how to  
4 manage shoulder dystocias.

5 Q: We've heard about McRoberts; correct?

6 A: Yes, ma'am.

7 Q: And we've heard about suprapubic pressure?

8 A: Yes, ma'am.

9 Q: There has been testimony about internal maneuvers. Dr.  
10 Browning, do you know how to do internal maneuvers?

11 A: Yes, ma'am.

12 Q: And when were you taught how to do internal maneuvers?

13 A: Very early in my residency.

14 Q: And have you done internal maneuvers when it's necessary  
15 for your patients?

16 A: Many times.

17 Q: And why didn't you do an internal maneuver for this  
18 delivery?

19 A: Because we were able to get the baby delivered with  
20 suprapubic pressure.

21 Q: Now, the word traction. Would you please explain to us  
22 whether or not traction is used only when there's a shoulder  
23 dystocia or is it used during every delivery?

24 A: I think many of you who have seen a childbirth realize  
25 that they're required -- that almost a hundred percent of the

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 time, some traction is required to deliver the babies.

2 Q: All right. So there's also been testimony -- I want to  
3 get some of the stuff just to clear the air. Testimony about  
4 the nurses in this case. Dr. Browning, do you blame the  
5 nurses who assisted with the labor and delivery in this case?

6 A: No, I don't.

7 Q: And are the nurses employees of your practice?

8 A: No, they're not.

9 Q: All right. Dr. Pliskow testified that suprapubic  
10 pressure wasn't done in this case. Do you recall that  
11 testimony?

12 A: I don't.

13 Q: What is your opinion about whether or not suprapubic  
14 pressure was applied in this case?

15 A: It was applied.

16 Q: All right. Let's talk about Plaintiff's Exhibit 6. Have  
17 you seen this picture before?

18 A: Yes, I have.

19 Q: Okay.

20 MS. CRAIG: Can -- Your Honor, could he come down with  
21 that --

22 THE COURT: Yes.

23 MS. CRAIG: -- and show it to our jury?

24 (WHEREUPON, the defendant witness left the witness  
25 stand.)

1 BY MS. CRAIG:

2 Q: I want you to explain the suprapubic pressure that we see  
3 on this still shot. I'll hold it for you.

4 A: Okay.

5 Q: Let's start here and then we'll have to walk it through.

6 A: You can see the nurse's hands here. You know, we teach  
7 suprapubic pressure to apply like that. You can see her  
8 thumbs coming out from the -- from the top portion of the  
9 picture.

10 Q: Where is the rest of the hand?

11 A: Up above. You can tell when you see the thumbs, the  
12 palms, which is really what's exerting the pressure, is well  
13 above where the fingers are.

14 Q: Okay. Let's show it over here. Explain exactly because  
15 we only have this small picture.

16 A: So the hands are placed like this. I mean you can also  
17 use a fist, but we teach this method. And you apply pressure  
18 with the heel. You can see the thumbs here. The heel, of  
19 course, is a good ways back from the thumb. So where the  
20 pressure is applied is actually a good bit above the thumb.

21 Q: So my question is based on this picture, which is  
22 Plaintiff's Exhibit 6, is the nurse pushing down on the pubic  
23 bone?

24 A: I don't think so.

25 Q: Okay. If you'll go back to the stand? That was the last

1 one with that.

2 (WHEREUPON, the witness complied.)

3 BY MS. CRAIG:

4 Q: So, Dr. Browning, when you saw the suprapubic pressure --  
5 and we're going to go through the video step-by-step, but when  
6 you saw the suprapubic pressure, tell us what you did when you  
7 saw that -- what the suprapubic pressure that the nurse was  
8 placing?

9 A: So she applied suprapubic pressure after a brief stopping  
10 of pushing and after some repeat traction to see if that had  
11 relieved the shoulder obstruction. It obviously hadn't. And  
12 when it hadn't, I realized that she was reaching over the  
13 guardrail of the bed to apply it like this, where she was  
14 getting really no leverage. And so what I asked is for  
15 somebody to get a chair, which we do every day, to bring it to  
16 the side of the bed so the nurse could get up and apply  
17 suprapubic pressure where the leverage was from the shoulders  
18 where she would get some good leverage.

19 Q: And why don't we see the nurse going on the stool to get  
20 the leverage that was needed for the suprapubic pressure?

21 MR. GRAHAM: Objection, Your Honor.

22 BY MS. CRAIG:

23 Q: Why --

24 THE COURT: What grounds?

25 MR. GRAHAM: Judge, may we approach?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 THE COURT: You may.

2 (WHEREUPON, a bench conference was held in the presence  
3 of the jury but out of the hearing of the jury as  
4 follows.)

5 MR. GRAHAM: You precluded my expert, Dr. Resnick, from  
6 talking about the video because he hadn't discussed it at his  
7 deposition. What's good for the goose is good for the gander.  
8 This -- this witness had not reviewed the video before he gave  
9 new opinions about the video. This is new opinions when he's  
10 asked to explain things on the video. We would object on the  
11 grounds that you be consistent.

12 THE COURT: This is the defendant in the case.

13 MR. GRAHAM: Yes, sir.

14 THE COURT: Who allegedly did all this stuff. He has a  
15 right to explain what happened.

16 MR. GRAHAM: Well, she's asked -- she's asking him why we  
17 don't see certain things on the video.

18 MS. CRAIG: He was there.

19 THE COURT: Everybody in here has talked about the gap in  
20 the video.

21 MR. GRAHAM: Dr. Resnick wasn't allowed to talk about the  
22 video on the grounds that he didn't do it in the deposition.  
23 This guy hasn't done it in the deposition either.

24 THE COURT: Go ahead.

25 MS. CRAIG: Do I need to -- first of all, he wasn't asked

1 a question about the video.

2 MR. GRAHAM: Neither was Dr. Resnick.

3 MS. CRAIG: I did not ask him --

4 THE COURT: Don't interrupt.

5 MR. GRAHAM: I'm sorry, Your Honor.

6 MS. CRAIG: Dr. Resnick wasn't asked anything about the  
7 video because it wasn't in his report. So this is the named  
8 defendant. He was there. He is the only one who can testify  
9 about what happened.

10 MR. GRAHAM: He also testifies in his deposition that he  
11 doesn't remember any of this.

12 THE COURT: That's how you use a deposition to impeach  
13 him. You can do that.

14 MS. CRAIG: Thank you.

15 (WHEREUPON, the bench conference ended and the  
16 proceedings resumed as follows.)

17 BY MS. CRAIG:

18 Q: Okay. Dr. Browning, I think the question was how do you  
19 know that the stool was moved so that the nurse could stand up  
20 on it and get better leverage? How do you not -- let me ask  
21 it this way. Why is that not on the video?

22 A: It's just not in -- within the -- the view of the -- the  
23 videographer.

24 Q: And how do we know that suprapubic pressure was, in fact,  
25 applied and applied correctly in this case?



DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Because it resulted in the successful delivery.

2 Q: Okay. Thank you, Doctor. Now, I'd like to provide you a  
3 copy of your entire office chart on Ms. Byrd. If you could,  
4 please just confirm that that is a complete copy of your  
5 office chart?

6 A: Yes.

7 Q: And you've been -- you started taking care of Ms. Byrd I  
8 think back in 1999; is that right?

9 A: I believe that's right.

10 Q: Okay. All right. So let's get that marked.

11 MS. CRAIG: Your Honor, we'd offer this as Defendant's  
12 Exhibit 3.

13 THE COURT: Any objections?

14 MR. GRAHAM: I don't see the relevance of it, but no  
15 objection, Your Honor.

16 THE COURT: Defendant's Exhibit Number 3 --

17 MS. CRAIG: Thank you, Your Honor.

18 THE COURT: -- into evidence.

19 (WHEREUPON, Defendant's Exhibit Number 3, medical chart  
20 of Christy Byrd, was admitted in evidence.),

21 MS. CRAIG: All right.

22 BY MS. CRAIG:

23 Q: Doctor, so let us start from the beginning. You said  
24 that there were -- that Ms. Byrd started coming to your  
25 practice in what year?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: I believe it was 1999.

2 Q: Okay. And while she was a patient of your practice, she  
3 had how many children?

4 A: Three.

5 Q: All right. Let's go through the prenatal visits for the  
6 third pregnancy, which was for Julia.

7 MS. CRAIG: Let's make sure everybody can see that.

8 (WHEREUPON, medical records were placed on the screen in  
9 the courtroom.)

10 MS. CRAIG: All right.

11 BY MS. CRAIG:

12 Q: So let's start at the beginning so we get the complete  
13 picture, Doctor.

14 A: Okay.

15 Q: Let's start with the first prenatal visit, which was on  
16 February 24, 2009.

17 A: You don't happen to have a page number, do you, Molly?

18 Q: Yes.

19 A: In this booklet here? It's not in order.

20 Q: McLeod 0135, Doctor.

21 A: Okay.

22 Q: It looks like it's 135 to 139; is that right?

23 A: So it's 0135. I have it now. Yep.

24 Q: Okay. Sure. All right. So let's start with the first  
25 prenatal visit and that is on February 24, 2009; is that

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 right? And you've got to go -- you have to go backwards.

2 A: It looks to me like the first visit was the 9<sup>th</sup> of March.

3 Q: Okay. All right. Let's start there then. Let's start  
4 there and tell us what you see?

5 A: I see that Christy came in and -- I'm sorry. You're  
6 right. It was the 24<sup>th</sup>.

7 Q: Okay. All right.

8 A: I apologize.

9 Q: I was just getting ready to cross that off my thing --

10 A: Yep.

11 Q: -- and fix it. All right. So let's back up and start  
12 with February 2009.

13 A: Okay.

14 Q: Tell us what's going on?

15 A: So Misty [sic.] presented and she had a positive  
16 pregnancy test at home and she was unsure of her last  
17 menstrual period. So she came to the office. She was having  
18 a little bit of nausea and rare vomiting and we did a  
19 transvaginal ultrasound. The earlier we do that, the better  
20 the dating is for the pregnancy.

21 And she had a viable, normal, six-week, three-day, in  
22 utero pregnancy. And we calculated her due date. The earlier  
23 the ultrasound, the better the due date, which was the 17<sup>th</sup> of  
24 October. And we talked about different options of what a  
25 woman over 35 can do to test for chromosomal abnormalities.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 Q: Okay. And were you the one that she saw on February 24<sup>th</sup>,  
2 2009?

3 A: Yes, ma'am.

4 Q: Okay. All right. So let's move on to the next  
5 appointment. It looks like it was the next month, which was  
6 in March 2009. I have on this chart, Doctor, an LER. Can you  
7 tell us what that means?

8 A: An LER?

9 Q: Yeah. If you look at the office note, maybe that will  
10 help.

11 A: Well, basically Christy came in to see our -- we have an  
12 RN in the office who does a complete history taking of medical  
13 issues, previous surgeries, previous deliveries, and gets  
14 obstetric lab work, and that's what all that referred to.

15 Q: Okay. Show it should be RN, not LER; right?

16 A: Right.

17 Q: Okay. Thank you. Let me fix that. All right. If we go  
18 that same month, it looks like she saw you on March 31<sup>st</sup>, 2009;  
19 is that right?

20 A: That's correct.

21 Q: Okay. What happened on that visit?

22 A: She came and we listened to the baby's heartbeat for the  
23 first time with a little hand-held Doppler. So it was normal.  
24 And we talked about options for finding out if the baby had  
25 Down syndrome or other chromosomal abnormalities, and we

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1 talked about her options. And she had decided that what she  
2 wanted to -- what she was thinking about is getting blood work  
3 with an ultrasound to see what her risks were rather than  
4 going to a direct test, like in amniocentesis or a chorionic  
5 villi sample.

6 Q: Okay. So that takes us through the month of March 2009,  
7 and tell us what was going on in April 2009?

8 A: So she came back on the 7<sup>th</sup> of April, saw Dr. Emerson.  
9 She had decided at that point to go ahead with that blood  
10 screening with that ultrasound data, and the baby's heart rate  
11 was listened to again and it was normal. Her vital signs were  
12 normal and she didn't have any complaints.

13 Q: Okay. Who is Dr. Emerson?

14 A: He's one of my partners.

15 Q: So then moving to May, the next month, who is Dr. Cole  
16 and who is Dr. Tatum?

17 A: Like I mentioned before, both of them are partners of  
18 mine.

19 Q: Okay. And tell us -- it looks like she had two visits to  
20 your office in May of 2009. Tell us what was going on?

21 A: She was seen on the 5<sup>th</sup> of May. She didn't have any  
22 complaints, and her vital signs were fine. The baby's heart  
23 rate was fine. The uterus was growing appropriately.

24 Q: All positive?

25 A: All good.

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1 Q: All right. Good. Let's now move into June of 2009. It  
2 looks as though Dr. Shaw saw Mrs. Byrd on 6/8/2009; is that  
3 right?

4 A: That's correct.

5 Q: Okay. Who is Dr. Shaw?

6 A: Dr. Shaw is an ex-partner. He's retired and he saw her  
7 that day. Again, good heart rate. The baby's growth was  
8 good. She didn't have any complaints.

9 Q: Okay. Now, explain how -- when a woman is pregnant and  
10 comes to your practice for prenatal care, explain why she  
11 rotates to see all of the doctors in the practice, like we see  
12 on this timeline?

13 A: Because we practice obstetrics in a group and we want all  
14 of the patients to see all of us. You know, different nights  
15 we're on call and we're going to see different patients.  
16 We're going to be on call delivering different patients and we  
17 want to have seen those patients.

18 Q: Okay. Great. Thank you. All right. Let's now move  
19 into the appointments in July of 2009. It looks like she saw  
20 you on two occasions; correct?

21 A: That's correct.

22 Q: Now, is Ms. Byrd coming to you with more frequency  
23 because she's getting further along in her pregnancy?

24 A: That's correct.

25 Q: Is that typical?

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1 A: That is.

2 Q: All right. So tell us what is going on on July the 6<sup>th</sup>  
3 and July the 22<sup>nd</sup>, Doctor?

4 A: She came in on the 6<sup>th</sup>, had good measurements, good vital  
5 signs, heartbeat sounded fine. She was now feeling the baby  
6 move. We talked about options for birth control after the  
7 delivery and she had what we call a screening glucose test.  
8 Many women know it as the terrible syrupy drink that they have  
9 to drink, and she came in and had that done.

10 Q: Okay. So you are continuing to monitor and perform the  
11 necessary tests for your patient; is that right?

12 A: Yes, ma'am.

13 MR. GRAHAM: Object to the leading at this point, Your  
14 Honor.

15 THE COURT: Sustained.

16 MS. CRAIG: All right.

17 BY MS. CRAIG:

18 Q: Doctor, let's move on then to August of 2009. How many  
19 times did you see your patient then?

20 A: We -- I saw Misty [sic.] three times in August.

21 Q: Okay. And let's just go through each of those.

22 A: So the first time in August, vital signs were fine. She  
23 had failed the initial glucose screen; so we do the more  
24 elaborate three-hour screening to find out if they actually  
25 have diabetes, and she was having that done that day. She has

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1 a negative Rh factor; so we measure to find out if there's  
2 been any sensitization from her baby and give something called  
3 Rhogam to prevent it if she hasn't.

4 Q: What concern did you have about failing the first glucose  
5 test, if any?

6 A: Well, we need to follow up and make sure she didn't have  
7 diabetes, and she didn't.

8 Q: Anything else in 2009?

9 A: No. She was mildly anemic and we got her started on  
10 iron.

11 Q: All right. And then moving forward to September of 2009.  
12 Tell us how your patient is doing now?

13 A: She was progressing and toward the end of September we  
14 were seeing her weekly. She had normal growth. She asked  
15 about possibly being induced later on in the pregnancy. She  
16 was, as most women do at this point in the pregnancy, becoming  
17 miserable. We -- we, on the 29<sup>th</sup> of September, talked about  
18 doing an induction of labor on the 8<sup>th</sup> of October if her cervix  
19 was favorable, which meant it met the criteria for induction.

20 Q: Okay.

21 A: And then --

22 Q: Do you -- do you have any concerns at this time?

23 A: No. Everything was going well.

24 Q: Okay. And I'm sorry. I think I interrupted you. What  
25 did you want to add?



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1 A: I'm sorry. I just was going to say we met the next week.

2 Q: Okay. Thank you. So now we are into October of 2009.

3 When do you see Ms. Byrd this time?

4 A: So on the 6<sup>th</sup> of October.

5 Q: Okay. And what's going on?

6 A: She's doing well. Her cervix is more dilated. The head  
7 has become engaged. The cervix has thinned out and she's met  
8 the criteria to be induced, and we talked about that and  
9 scheduled that.

10 Q: Okay. Is it uncommon to have this many prenatal visits?

11 A: No.

12 Q: With a patient? Explain that, please?

13 A: I mainly -- you know, the earlier we see a patient, the  
14 more time we see them, but there's a routine schedule in an  
15 uncomplicated patient where you see them every four weeks  
16 until the second trimester and then every two weeks after  
17 that, and then every week after 36 weeks.

18 Q: And, Dr. Browning, based on the 15 or so prenatal visits  
19 where Ms. Byrd was receiving care from you and your other  
20 partners, did you have any concerns about the delivery?

21 A: Not at that time.

22 Q: So did Ms. Byrd, in your opinion, have any risk factors  
23 for shoulder dystocia?

24 A: She didn't.

25 Q: And what are the risk factors for shoulder dystocia?

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1 A: Well, the most significant is diabetes. Second would be  
2 maternal obesity. Extensive weight gain. Going a long way  
3 past your due date or having had a prior -- a prior shoulder  
4 dystocia.

5 Q: And do you have an opinion whether or not Ms. Byrd had  
6 any of those risk factors?

7 A: She did not.

8 Q: In this -- in this case, do you have an opinion whether  
9 the shoulder dystocia was predictable?

10 A: It wasn't.

11 Q: And do you have an opinion whether the shoulder dystocia  
12 in this case was preventable?

13 A: It wasn't.

14 Q: Please explain to us what it means for a woman to have a  
15 proven pelvis?

16 A: It means they've had successful vaginal deliveries  
17 before, term successful vaginal deliveries.

18 Q: And how does the term proven pelvis apply to Ms. Byrd?

19 A: Well, she had had two previous vaginal deliveries without  
20 any problems.

21 Q: Okay. Thank you, Doctor. I think we're through with the  
22 prenatal visits.

23 MS. CRAIG: Your Honor, with your permission, could Dr.  
24 Browning come down and use one of the medical exhibits?

25 THE COURT: Yes.

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1 MS. CRAIG: All right.

2 BY MS. CRAIG:

3 Q: Dr. Browning, I'm going to put you right here. You're  
4 soft-spoken; so you've got to speak up for Madam Court  
5 Reporter.

6 THE DEFENDANT: Yes, ma'am.

7 BY MS. CRAIG:

8 Q: I want you to explain to us:--

9 MR. GRAHAM: Your Honor, may I step up here?

10 THE COURT: Sure.

11 BY MS. CRAIG:

12 Q: -- the various stages of labor, please?

13 A: Okay. These are referred to as the cardinal stages of  
14 labor. At --

15 Q: Hold on one second. We can't -- we've got to get  
16 repositioned so everybody can see it.

17 A: Okay. Excuse me.

18 MS. CRAIG: Can everybody see this?

19 BY MS. CRAIG:

20 A: And what happens in Christy's case before we began the  
21 induction is the head became engaged; so the head had settled  
22 into the pelvic inlet. And as labor goes on, there is  
23 obviously descent and the baby's chin has to flex. We call  
24 that flexion.

25 And as the baby gets to the outside or begins to deliver,

1 the head has to rotate. As you can see here, it's in a  
2 lateral position, and it has to rotate from a lateral position  
3 to an anterior and posterior position for that. The head has  
4 to extend and the chin comes out.

5 And then after that, the baby's head goes back to that  
6 lateral position. That's what we call restitution. And then  
7 this is when the anterior shoulder -- we apply some flexion in  
8 this direction, it's delivered, and then after the anterior  
9 shoulder is delivered, we apply flexion in this direction to  
10 deliver the posterior shoulder, and then the baby is  
11 delivered.

12 Q: Okay. I want you to use this illustration and explain to  
13 us the angle -- the angle of -- of how -- what angle -- where  
14 are you when you're delivering the baby and how that angle  
15 looks?

16 A: Well, you can see -- this is a picture here. You can see  
17 this is -- you don't deliver in a horizontal axis. The axis  
18 of delivery, so the axis that's in the axial plane of the  
19 baby's spine is in a downward direction approximately 20 -- 25  
20 degrees.

21 Q: Okay. So just when you say it's not in a horizontal  
22 direction, show us -- show us -- show us what you mean?

23 A: (Gesturing.) Well, you don't sit here and help deliver  
24 the baby. It's got to be in that direction.

25 Q: Okay. Thank you. All right. Thank you. You can go

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 back to the witness stand. Thank you.

2 (WHEREUPON, the witness complied.)

3 BY MS. CRAIG:

4 Q: All right. So, Dr. Browning, I want to talk to you a  
5 little bit about traction. I would like for you to explain to  
6 us how you know what normal traction is?

7 A: Well, I've delivered about -- like I said, over 5,000  
8 babies, and there's a certain amount of force, traction, that  
9 needs to be used to deliver a baby.

10 Q: And tell us what term -- what words do you use to explain  
11 traction or force or what are the -- what's your words?

12 A: The term I've used is controlled traction, and why I use  
13 that is to mean it's in a controlled axial direction along the  
14 -- the axis of the fetal spine.

15 Q: How do you know that you used controlled traction in the  
16 delivery of this child?

17 A: I've been doing this a long time and that's what I do  
18 every time.

19 Q: In the other shoulder dystocias that you have  
20 encountered, what type of traction did you use?

21 A: What I normally use.

22 Q: And what's the name of that? What's the name that you  
23 call it?

24 A: Controlled traction.

25 Q: And let me ask you this. Do some doctors call it other

1 words?

2 A: They do.

3 Q: Okay. Why is it okay for one doctor to say controlled  
4 traction --

5 MR. GRAHAM: Object to the leading, Your Honor.

6 THE COURT: Sustained.

7 MS. CRAIG: May I rephrase?

8 THE COURT: Rephrase it. Sure.

9 BY MS. CRAIG:

10 Q: Why is it okay for doctors to use different words to  
11 describe the same thing?

12 MR. GRAHAM: Objection.

13 THE COURT: Overruled.

14 BY MS. CRAIG:

15 A: Because we use different adjectives. We don't all use  
16 the same adjectives.

17 Q: And how were you trained when you were going through  
18 residency and medical school to describe traction?

19 A: We used controlled traction.

20 Q: How many times have you encountered shoulder dystocia in  
21 your career?

22 A: I would guess over 100 times.

23 Q: And do you consider yourself an expert in managing  
24 shoulder dystocia?

25 A: I'm well trained in the management of shoulder dystocia.

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1 Q: When you did the simulations at McLeod Hospital, how much  
2 traction was registered that you used during that -- those  
3 simulations?

4 A: We've recently had a fancy --

5 MR. GRAHAM: Objection, Your Honor, to the relevancy. If  
6 this is after the delivery --

7 THE COURT: Is this after or before?

8 THE DEFENDANT: It was after.

9 THE COURT: All right. Then what's the relevancy?

10 MS. CRAIG: It's been testified to that he doesn't know  
11 how to -- what his level of traction, and this is directly  
12 answering it.

13 THE COURT: All right. Overruled. Go ahead.

14 MS. CRAIG: So let me see if I can -- if I can restate  
15 the question.

16 BY MS. CRAIG:

17 Q: So when you have done the shoulder dystocia training in  
18 the simulations at McLeod, tell us what was registered in  
19 terms of the amount of traction that you used?

20 A: Well, what I was going to say is there's a very  
21 sophisticated computer pressure gauge mannequin now that's --  
22 that's actually going around South Carolina to different  
23 hospitals to allow us to practice simulations in a more  
24 realistic way, and you can measure the pressure it takes to  
25 resolve a shoulder dystocia.

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1 Q: And approximately how many newtons was that?

2 A: Mine was 50 to 60 roughly.

3 Q: And what is the safe range of newtons? And when I say  
4 newtons, that's measuring the amount of traction. What is the  
5 safe range of newtons?

6 MR. GRAHAM: Objection, Your Honor.

7 THE COURT: Overruled.

8 MR. GRAHAM: New opinion.

9 THE COURT: Overruled. Go ahead.

10 BY MS. CRAIG:

11 A: You know, nobody knows exactly, but most people think  
12 it's somewhere between 100 and 200.

13 Q: And what was the amount of newtons that you were -- you  
14 registered?

15 A: Fifty to 60.

16 Q: Is that an appropriate amount of traction?

17 A: Yes, it is.

18 Q: How do you know that you did not use excessive traction?

19 MR. GRAHAM: Object to the leading, Your Honor.

20 BY MS. CRAIG:

21 Q: How did you --

22 THE COURT: Overruled.

23 MS. CRAIG: Thank you.

24 BY MS. CRAIG:

25 Q: How do you know that you did not use excessive traction?



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1 A: Again, I am an experienced obstetrician and we know what  
2 level of traction is appropriate. And there are other certain  
3 things that we do to -- we don't rock up and down. We don't  
4 shake our hands, those sort of things.

5 Q: Now, do you have an opinion whether or not shoulder  
6 dystocia is a medical emergency?

7 A: It is.

8 Q: Explain why shoulder dystocia is a medical emergency?

9 A: Well, when the baby doesn't deliver right away, the cord  
10 is being compressed against where the cord comes out of the  
11 baby at the abdomen. It's on the floor of the maternal  
12 pelvis. And every minute that goes by, there's increasing  
13 risk to the fetus.

14 You've heard a lot of numbers, but I will tell you that  
15 the numbers are variable and it depends, you know, on many,  
16 many things, but the longer -- the more time it takes to  
17 resolve the shoulder dystocia, the more risk of having gradual  
18 incremental brain injury and then death.

19 Q: And do you have an opinion whether -- when faced with a  
20 shoulder dystocia, whether or not the patient is medically  
21 stable?

22 A: Yes.

23 MR. GRAHAM: Object to the form, Your Honor. Another new  
24 opinion.

25 THE COURT: Overruled.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 BY MS. CRAIG:

2 Q: It --

3 A: It's a medical emergency.

4 Q: And my question is do you have an opinion whether, when  
5 confronted with that medical emergency, is the patient  
6 medically stable?

7 A: No.

8 Q: And there's been a lot a testimony about this, but just  
9 one more time. What can happen to the baby if you can't get  
10 the baby out?

11 A: Babies have died. I mean, you know, I've heard of one  
12 recently. So this is not something that's unheard of.

13 Q: When you are confronted with a shoulder dystocia, when do  
14 you start to worry about the welfare of your patient?

15 A: Well, I'm worried from the get-go.

16 Q: Please explain that, Doctor?

17 A: I mean as soon as there's a shoulder dystocia, we  
18 completely focus on resolving the shoulder dystocia. You're  
19 not watching a clock. You're not listening to other people in  
20 the room. You're -- you're -- you focus on taking care of the  
21 patient and getting the baby delivered.

22 Q: So when does a doctor ever practice medicine or deliver a  
23 baby with the benefit of hindsight?

24 A: Obviously, none.

25 Q: All right. Doctor, I'd like to go through a few medical

1 illustrations.

2 MS. CRAIG: If Your Honor -- if it's okay that he come  
3 down. Thank you.

4 (WHEREUPON, the defendant left the witness stand.)

5 BY MS. CRAIG:

6 Q: And if you could, tell us what we're seeing in some of  
7 these. All right. Let's start with -- let's start with this  
8 one. Tell us what we're seeing? All right. What's going on?

9 A: So this is a baby I think they're depicting in labor and  
10 has a -- the umbilical cord wrapped around the neck.  
11 Obviously, the head hasn't delivered yet.

12 And this delivery -- this is showing the head delivered  
13 with the cord around the neck, and now you see the top  
14 shoulder -- and you've heard the term anterior shoulder -- is  
15 now obstructed by the pubic synthesis, which is that upper  
16 pelvic bone.

17 Q: Okay. And we're going to get to the video in a minute,  
18 but with this delivery, where was the nuchal cord or the  
19 umbilical cord?

20 A: It was around the neck.

21 Q: And what did you do when you realized it was around the  
22 baby's neck?

23 A: I reduced the nuchal cord by bringing the cord around the  
24 head.

25 Q: Okay. Thank you. All right. Let's move on to this

1 illustration. Tell us what we are seeing in this one?

2 A: Okay. So this is a baby that's delivered. The head is  
3 delivered and over here this is a baby that has the cord and  
4 has a -- has a shoulder dystocia.

5 Q: Okay. All right. And then when we have shoulder  
6 dystocia --

7 A: Okay. So --

8 Q: What happens then?

9 A: This is showing, again, an impacted shoulder and this is  
10 showing suprapubic pressure. Of course, what you really don't  
11 see is the shoulder is right up here and how that would -- if  
12 you push down and to the side, you can dislodge that shoulder  
13 from the pubic synthesis.

14 Q: Okay. And tell us about the -- about your hand placement  
15 here, the hand placement. What -- what is that? Why do you  
16 have one on top and one on the bottom?

17 A: So we're cradling the baby's head, and this picture  
18 actually doesn't show it very well, but in the axis of the  
19 spine.

20 Q: Okay. Thank you.

21 A: Uh-huh.

22 Q: And then one more. What are we seeing here?

23 A: So this is a baby whose shoulder dystocia has been  
24 resolved and the anterior shoulder is now free from the pubic  
25 synthesis, coming out, again at that axial angle that we

1 talked about.

2 Q: Does this show that angle that you were talking about?

3 A: It shows it very well.

4 Q: So explain what you mean when you said it's not  
5 horizontal, but it's at an angle?

6 A: So in this picture, you see the woman's legs here. The  
7 hip would be here. The horizontal angle is here and you can  
8 see that this is below the horizontal angle.

9 Q: Okay. Thank you. All right. Since I've got you down  
10 here, I'm going to go through your delivery note, Doctor.

11 A: Okay.

12 Q: And this is MPMC 0122.

13 A: All right.

14 Q: All right. I want you to walk us through your delivery  
15 note.

16 A: It's actually a computer-generated note that we put some  
17 entries, but you see the time of delivery at 5:33 p.m.,  
18 female. The amniotic fluid was clear. The baby presented  
19 head down and I described this as a moderate shoulder  
20 dystocia. And the time between head delivery to complete  
21 delivery was 45 seconds, and controlled traction applied, as  
22 we talked about.

23 And then this talks about the following maneuvers. The  
24 sequence actually is wrong, but suprapubic pressure,  
25 McRoberts, no episiotomy because there was more than adequate

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1 peroneal stretch. And initially, decreased movement of the  
2 right arm. When I went back in, I saw some hand movement,  
3 some arm and shoulder movement, and I think good was an overly  
4 optimistic assessment, and I discussed that with the parents,  
5 the concern with the parents.

6 Q: Okay. Keep going.

7 A: We sent cord blood, as we do in all deliveries. You  
8 know, we measure it to see if kids have PKU or --

9 Q: What does that mean?

10 A: You know, they have a metabolic arrangement, cystic  
11 fibrosis. Those sorts of things are done by law on every baby  
12 in this country. We also sent cord gases and you've heard  
13 about that, and you can see that the baby required some bulb  
14 suction. We delivered the placenta three minutes later and we  
15 examined it and it looked to be normal.

16 Q: Okay.

17 A: Okay.

18 Q: Have we gone through the whole thing?

19 A: We have.

20 Q: All right. So when you encounter shoulder dystocia  
21 during a delivery, do you document that in the medical record?

22 A: We do. This was a computer-generated form that lasted  
23 about a year and the doctors -- none of us liked it; so it's  
24 gone.

25 Q: Okay. Any other -- anything else you want to point out

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1 about your -- about the delivery note?

2 A: No.

3 Q: Okay.

4 A: I think she had an epidural. She didn't tear.

5 Q: When you say a tear, you mean an episiotomy?

6 A: Right.

7 Q: Okay. All right. Great. Thank you, Doctor.

8 A: Okay.

9 Q: Go on back to the witness stand, please.

10 (WHEREUPON, the witness complied.)

11 BY MS. CRAIG:

12 Q: All right. Dr. Browning, in this case, I'd like for you  
13 to tell us what happened when the shoulder dystocia was  
14 recognized, what you did, and then we're going to go through  
15 the video in detail.

16 A: Okay.

17 Q: But why don't you just tell us what you recall and what  
18 you did and why you did it?

19 A: Okay. Well, first of all, I'll just say that we've  
20 watched this videotape a bunch and most of my description of  
21 the -- of the delivery will come from the -- from looking at  
22 the videotape.

23 So we -- the head retracted. So in other words, it was  
24 now side to side along -- just like it was as the baby came  
25 down the birth canal before it had to extend its head. So the

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1 baby's head repositioned and we applied -- I applied some  
2 traction and it was during that application of traction that I  
3 first -- it became evident to me there was a shoulder  
4 dystocia. There was a nuchal cord and that was reduced.

5 At that point in time, I instructed the nurses to do  
6 McRoberts, for Christy to stop pushing briefly, and applied  
7 traction again. And that traction didn't solve it. At that  
8 point, I asked my nurse, Misty, to do suprapubic pressure and  
9 she applied suprapubic pressure and I applied traction again.

10 Every time we do a maneuver, you have to apply traction  
11 to see if it resulted with -- if the shoulders were dislodged.  
12 And it was at that point after that traction that I could see  
13 that she needed a better angle to improve it. I had the chair  
14 come over, got up and did the suprapubic pressure, and the  
15 baby delivered.

16 Q: Okay. Thank you, Dr. Browning.

17 A: Yeah.

18 Q: All right.

19 MS. CRAIG: Let's -- let's tee up the video. And if we  
20 could just go then to the part where the head is delivered for  
21 privacy reasons? We don't need to go through the whole  
22 beginning part.

23 BY MS. CRAIG:

24 Q: And while he's pulling that up, I think you mentioned  
25 this, Dr. Browning. You've reviewed this -- this video a



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1 couple of times did you say?

2 A: More than a couple.

3 Q: Okay.

4 (WHEREUPON, there was a pause in the proceedings and then  
5 Plaintiff's Exhibit Number 5, DVD of birth video, began  
6 playing in open court and the proceedings resumed as  
7 follows.)

8 BY MS. CRAIG:

9 Q: All right. So what we're going to do is we're going to  
10 walk through and then you tell us when to stop so that -- so  
11 that you can tell us exactly what you're doing, Doctor. Okay?

12 A: Okay. So the head is delivering right now.

13 Q: Okay.

14 A: As you can see, it's coming out in that AP plane.

15 Q: Okay.

16 MS. CRAIG: Let's stop.

17 BY MS. CRAIG:

18 A: And then the baby's head --

19 MS. CRAIG: Let's stop here.

20 BY MS. CRAIG:

21 A: Then the baby's head will turn to the --

22 Q: What do you mean by AP plane?

23 A: I'm sorry. That's in the anterior to posterior plane.

24 So as if the baby is looking straight ahead.

25 Q: Okay. Great.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 MS. CRAIG: All right. Let's keep going.

2 BY MS. CRAIG:

3 A: She's still pushing. Pushing. Pushing. And now the  
4 head is -- the -- is now in the -- in the restituted --

5 MS. CRAIG: Okay. Stop right there.

6 BY MS. CRAIG:

7 A: Yeah.

8 Q: Now, what are you doing?

9 A: I'm freeing the umbilical cord from around the neck.

10 Q: Okay.

11 MS. CRAIG: Keep going, please.

12 BY MS. CRAIG:

13 A: And now the nurses have her back in McRoberts and we're  
14 applying traction. You can see that my hands aren't wavering.  
15 They're staying on the same side. My --

16 MS. CRAIG: Let's stop there.

17 THE DEFENDANT: Okay.

18 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth video  
19 stopped playing.)

20 MS. CRAIG: Yeah. Let's stop right there. Can we put  
21 the lights on real quick? Thank you.

22 BY MS. CRAIG:

23 Q: I want you to show this jury what your hands look like.

24 A: Okay. My hands are like this. (Gesturing.)

25 Q: All right.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Okay.

2 Q: And will you come out and will you please show us what  
3 your body positioning is?

4 (WHEREUPON, the witness complied.)

5 BY MS. CRAIG:

6 A: (Gesturing.) So the -- the bed -- I mean the bed comes  
7 to about right here. So I'm like this. Now, at this point in  
8 the video, I'm like this and so we're applying traction in the  
9 axis of the baby's spine.

10 Q: Okay. Having that hand -- I want you to explain that  
11 hand placement.

12 A: The hand is on the top side and the bottom side of the  
13 head and my wrists are neutral. My -- my arms are tucked  
14 across my chest. (Gesturing.) I'm not doing this. I'm not  
15 doing that. You know, I'm just applying careful axial  
16 traction.

17 Q: Dr. Browning, are you at any time doing this?

18 (Gesturing.)

19 A: No, ma'am.

20 Q: Are you doing this? (Gesturing.)

21 A: No.

22 Q: All right. I'd like to show you a picture. If you can,  
23 identify this picture for us?

24 A: Okay. Well, this is just my hands on the top --

25 Q: Let's do it for the record.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: I'm sorry.

2 Q: So is this a still shot from the video?

3 A: It is.

4 Q: Okay. Let me mark this as an exhibit.

5 A: Okay.

6 (WHEREUPON, the photograph was marked as Defendant's  
7 Exhibit Number 4 for identification.)

8 MS. CRAIG: Thank you.

9 BY MS. CRAIG:

10 Q: All right. So if we could, come up here and you could  
11 now orient us to what we're seeing. We're going to have to  
12 start right here, and then we're going to have to do the same  
13 from this side.

14 A: Well, this is the baby. This is -- the head is being  
15 delivered. I have a supporting hand on top and a supporting  
16 hand on the bottom. And you can see that the baby's head is  
17 starting to come out in that axial plane that we talked about.

18 Q: All right. Let's go over here and show this side.

19 A: Same thing that you saw before. Hand above, hand below.  
20 You can see what the axis of the pelvis is and how the baby  
21 comes down the birth canal.

22 Q: Thank you. And why is this placement of the hands, as  
23 shown on Defendant's Exhibit 4 and on the video -- why is that  
24 the appropriate way --

25 MR. GRAHAM: Object to the leading, Your Honor.

1 THE COURT: Overruled.

2 BY MS. CRAIG:

3 A: So you support the head so it stays in that axial plane,  
4 so it stays in that neutral position.

5 Q: Do you have an opinion whether you did that?

6 A: I did do that.

7 Q: Thank you, sir. All right. I'm sorry to interrupt, but  
8 let's keep going through the video. Thank you.

9 (WHEREUPON, the witness returned to the witness stand and  
10 Plaintiff's Exhibit Number 5, the birth video, resumed  
11 playing.)

12 BY MS. CRAIG:

13 Q: All right. Tell us when to stop.

14 A: Okay. So at this point, stop.

15 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
16 video, stopped playing.)

17 BY MS. CRAIG:

18 A: So at this point, we've asked my nurse to apply  
19 suprapubic pressure. You can see her fingers coming out and  
20 the pubic bone is just a little bit above the top -- a little  
21 bit above where you see her fingers -- the end of her fingers,  
22 knowing that her palm, which is where the pressure comes from,  
23 is further back or further up.

24 Q: All right. This is a really good shot actually to show  
25 your point.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 MS. CRAIG: Let's see if I can get over here. Ben, catch  
2 me if I fall.

3 BY MS. CRAIG:

4 Q: Right here is what you're talking about; right?

5 A: That's correct.

6 Q: All right.

7 A: Yeah.

8 Q: So where's the rest of her hand?

9 A: Above that I would guess about an inch and a half to 2  
10 inches.

11 Q: Up in this area?

12 A: Yes, ma'am.

13 Q: Okay.

14 A: I mean just look at your own thumb and look where the  
15 heel of your hand is below that.

16 Q: All right.

17 MS. CRAIG: Let's continue, please.

18 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
19 video, resumed playing.)

20 BY MS. CRAIG:

21 A: So still unable to deliver. Her hands come off.

22 Q: All right.

23 MS. CRAIG: Stop.

24 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
25 video, stopped playing.)

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 BY MS. CRAIG:

2 Q: Now what's going on? The --

3 A: So -- well, at that point, my best guess, because I don't  
4 know for sure, is that whoever went to get the chair to bring  
5 it around to the right side of the bed, which we do all the  
6 time, blocked the video or knocked her up or whatever. And  
7 anyway, at this point, Misty was put up on a chair where she  
8 could give -- you know, you can just see being able to apply  
9 any significant pressure like this versus how -- how I wanted  
10 it done, which was like that. (Gesturing.)

11 Q: Thank you. Could you do that again, Dr. Browning? I'm  
12 sorry. You were in the dark.

13 A: (Gesturing.) So this versus that, and we don't have -- it  
14 just comes from the shoulders. It's a leaning into it.

15 Q: Who is Misty?

16 A: I'm sorry. Misty Barnes, who was the nurse, the  
17 attendant nurse.

18 Q: All right.

19 MS. CRAIG: Let's finish going through.

20 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
21 video, resumed playing.)

22 BY MS. CRAIG:

23 A: And the baby delivers.

24 Q: Okay.

25 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 video, stopped playing.)

2 BY MS. CRAIG:

3 Q: So I next wanted to -- we're going to go through with the  
4 sound and we're going to do this again.

5 A: Okay.

6 Q: With the sound. But I want you to explain to us the  
7 significance of where your elbows are on this video.

8 A: Okay.

9 MS. CRAIG: Yes, sir. Thank you.

10 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
11 video, resumed playing and then stopped.)

12 BY MS. CRAIG:

13 Q: Tell us about -- tell us about your elbow placement?

14 A: Well, I already mentioned it, but basically my elbows are  
15 in, like, here. And I think if you'll -- if you'll do that  
16 yourselves, it restricts you from -- you know, from -- from  
17 just pulling and creating a huge torque or, you know, God  
18 forbid you took your -- your -- your feet and pulled, that  
19 sort of thing.

20 Q: Okay. And how about your wrists? What's the placement  
21 of the wrists?

22 A: The wrists are in a neutral position and stay in a  
23 neutral position.

24 Q: All right. Why is it significant that your wrists aren't  
25 breaking?



DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Well, that shows that we're not doing lateral traction.

2 Q: Okay. So with that being said, let's go through and  
3 let's watch it again and let's listen to the audio this time.

4 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
5 video, resumed playing.)

6 BY MS. CRAIG:

7 Q: Tell us when to stop, Doctor.

8 A: Stop.

9 MS. CRAIG: Stop. Sorry. I wanted you to hear me.

10 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
11 video, stopped playing.)

12 THE DEFENDANT: Yeah.

13 BY MS. CRAIG:

14 Q: All right. Now, tell us what's going on?

15 A: Well, we're back to where the head is delivering.

16 Q: Okay. All right.

17 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
18 video, resumed playing.)

19 BY MS. CRAIG:

20 A: Okay. Restitution.

21 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
22 video, stopped playing.)

23 A: Not yet. I'm sorry.

24 Q: All right.

25 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth

**DR. JOHN BROWNING - DIRECT BY MS. CRAIG**

1 video, resumed playing.)

2 THE DEFENDANT: Stop.

3 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth

4 video, stopped playing.)

5 BY MS. CRAIG:

6 Q: Go ahead.

7 A: Okay. You know, this was at the point where just after

8 that, before we started applying more traction, that we

9 briefly had her stop pushing.

10 Q: Okay. And how do you know that you had her stop pushing?

11 A: Well, that's something that we always do and something I

12 could hear the videotape, but it was very vague.

13 Q: Okay. Let me ask you something. Do you hear everything

14 that you're saying or everything that you said during the

15 delivery on the videotape?

16 A: No. I mean obviously I asked the nurses to do McRoberts

17 maneuver. You didn't hear me say that. Obviously, I asked my

18 nurse to do the suprapubic pressure. I obviously asked

19 somebody to get a chair. I obviously asked her to reposition,

20 and none of that can be heard on the videotape.

21 Q: How do we know that the -- that the patient's legs were

22 in a McRoberts position?

23 A: You can actually see them in this shot right here. You

24 can see that the back of the thighs are back pretty good.

25 Q: And when do we hear on the videotape that you say put the

1 legs in McRoberts?

2 A: I couldn't hear it.

3 Q: How do we know that suprapubic pressure was applied in  
4 this case?

5 A: Because you can see the nurse's hands in the appropriate  
6 position for suprapubic pressure.

7 Q: When do we hear you say apply suprapubic pressure to the  
8 nurses on the video?

9 A: You don't.

10 Q: Did you know this video was being recorded?

11 A: I didn't. It's not something that is often done.

12 Q: What were you focused on?

13 A: I was focused obviously on the patient.

14 Q: All right. So you said that the audio is difficult to  
15 hear. I agree with you. We're going to go back and I want  
16 you -- when the nuchal cord is released, I want you to listen  
17 very carefully and tell me if you hear anything.

18 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
19 video, began playing.)

20 BY MS. CRAIG:

21 Q: That noise right there?

22 A: Yeah, right there.

23 Q: What's that?

24 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
25 video, stopped playing.)

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 BY MS. CRAIG:

2 A: That's where I said don't push.

3 Q: Okay. Let's listen to it again.

4 A: Okay.

5 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
6 video, resumed playing.)

7 MS. CRAIG: Can you turn it up louder, Ben?

8 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
9 video, stopped playing.)

10 BY MS. CRAIG:

11 Q: There's a heartbeat and then is that -- you tell us what  
12 you heard.

13 A: There's a heartbeat and then you can hear don't push, but  
14 it's very -- I mean it's very subtle.

15 Q: What does the heartbeat sound like so we know -- to know  
16 what to recognize?

17 A: Beep.

18 Q: Is it doot doot?

19 A: Yeah. There you go. Thank you.

20 Q: All right. Let's try it. Let's try it again. Back it  
21 up and let's listen for the doot doot and then what comes  
22 after that.

23 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
24 video, resumed playing.)

25 MS. CRAIG: There it is.

**DR. JOHN BROWNING - DIRECT BY MS. CRAIG**

1 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
2 video, stopped playing.)

3 MS. CRAIG: Let's do it again.

4 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
5 video, resumed playing.)

6 THE DEFENDANT: There we go. Right there.

7 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
8 video, stopped playing.)

9 BY MS. CRAIG:

10 Q: All right. Let's do it again. Let's hear it. It's a  
11 heartbeat and then there's something after the heartbeat; is  
12 that right?

13 A: That's correct.

14 Q: Let's do it again.

15 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
16 video, resumed playing, and then stopped.)

17 BY MS. CRAIG:

18 Q: Now, in addition to -- and I -- and the audio is very  
19 poorly recorded. In addition to this, how do we know that you  
20 told Ms. Byrd not to push?

21 A: Because we always do that.

22 Q: And what else? What else is on the video that you can  
23 hear that tells you that she wasn't pushing?

24 A: If you listen, there was a very deep sigh as she's  
25 stopping to push.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

- 1 Q: Okay. So can a woman push a baby when she is sighing?
- 2 A: I don't think so. And -- and you can't push continuously
- 3 either.
- 4 Q: All right. So let's start right there then and will you
- 5 tell us when the sigh happens?
- 6 A: Okay.
- 7 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth
- 8 video, resumed playing.)
- 9 THE DEFENDANT: There.
- 10 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth
- 11 video, stopped playing.)
- 12 BY MS. CRAIG:
- 13 Q: Okay. Tell us the significance of that sigh?
- 14 A: Well, I just think that's an indication that she released
- 15 for a minute and didn't push.
- 16 Q: Okay. All right. So -- and as we listen to --
- 17 A: Not for a minute. For a few seconds. I'm sorry.
- 18 Q: As we listen to the video -- and we've heard it several
- 19 times -- are there other sighs on the video?
- 20 A: There are.
- 21 Q: Doctor, is that normal?
- 22 A: It is.
- 23 Q: Okay. Explain to us when a woman is delivering a baby
- 24 whether or not she can push continuously the whole time?
- 25 A: Well, I'm sure the women in the jury know you can't push

1 the whole time, but if you could think about bearing down, how  
2 long can you bear down, we're -- we -- we try to get the  
3 patients to bear down for 10 seconds at a time and most don't  
4 make it for 10 seconds.

5 Q: All right. So, Doctor, I know that with regard to what's  
6 not on the videotape, tell us just what you recall the best  
7 that you can about assisting the nurse or instructing the  
8 nurse with her hand placement?

9 A: One of the few memories I do have of the delivery was  
10 making sure that Misty brought the chair over to apply  
11 suprapubic pressure and, you know, the hand position was going  
12 to be the same. It was the angle of her shoulders that needed  
13 to improve from this to that. (Gesturing.)

14 Q: And once you made or provided that instruction, what  
15 happened?

16 A: The baby delivered.

17 Q: Okay. In addition to the suprapubic, what else -- what  
18 else -- where were her legs?

19 A: They were still in McRoberts.

20 Q: Okay. And who was holding her legs in McRoberts?

21 A: I couldn't tell you exactly, but you can see they're  
22 back.

23 Q: But you can -- excuse me?

24 A: You can see on the picture that they're back.

25 Q: Okay. There was some testimony yesterday that you

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 obstructed a video -- this video. Dr. Browning, did you  
2 intentionally try to obstruct the video?

3 A: Of course not. My whole focus was on the patient. I  
4 think that's obvious.

5 Q: Let me ask you this --

6 MS. CRAIG: I think that we're -- we're finished with the  
7 -- with the video unless we come back to it. Thank you.

8 BY MS. CRAIG:

9 Q: In Defendant's Exhibit 4 that shows your hand placement,  
10 Doctor, can you tell me what type of traction that is?

11 A: I think it's pretty easy to see that that's axial  
12 direction. The head is supported below and above, that angle  
13 we talked about. It's not down here.

14 Q: At any point on the video, I mean are your hands shaking?

15 A: No, ma'am.

16 Q: At any point on the video or based on your memory, did  
17 you yell at the patient?

18 A: No, ma'am.

19 Q: Why didn't you yell at her?

20 A: When I'm confronted with an emergency, what I like to do  
21 is be extra calm and be very quiet and controlled so that  
22 things are done well. When you get excited, everybody doesn't  
23 -- everybody gets excited and things don't go as well as if  
24 you stay calm.

25 Q: Doctor, did you use downward lateral traction?



DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: No, I did not.

2 Q: And does this still shot from the video show downward  
3 lateral traction?

4 A: No, it does not.

5 Q: In fact, the proper way to deliver a baby is how?

6 A: With axial traction.

7 Q: Now, on the video, who is saying push?

8 A: A bunch of people.

9 Q: Was it you?

10 A: No, ma'am. I mean there were some times I asked her to  
11 push, yes.

12 Q: But once the suprapubic pressure was being applied, who  
13 was telling her to push?

14 A: Probably the nurse and all of her family members.

15 Q: And so how do you know that Ms. Byrd wasn't pushing?

16 A: When she sighed and when I asked her not to push, at that  
17 point she wasn't pushing.

18 Q: So when you're delivering a baby, are you focusing on the  
19 other people in the room or who are you focusing on?

20 A: No. I couldn't have even told you who was in the room,  
21 other than David.

22 Q: Did -- at any time during this delivery, did you use  
23 brute force to deliver?

24 A: I did not.

25 Q: Do you ever use brute force?

1 A: No, I haven't.

2 Q: How did you feel when Dr. Pliskow said that you used  
3 brute force?

4 A: It didn't feel good.

5 Q: Now, during this delivery, based on what you've seen on  
6 the video and what you recall, do you have an opinion whether  
7 the baby's neck ever experienced 50 percent elongation?

8 A: No, ma'am.

9 Q: All right. Let's talk about the fetal monitor strips.  
10 That's already in evidence. The fetal monitor strip is in as  
11 Plaintiff's Exhibit 26 and I don't want to spend a lot of time  
12 on this, but just quickly remind us what a fetal monitor strip  
13 is?

14 A: Well, this is the recording of the baby's heartbeat and  
15 there's another monitor that monitors contractions.

16 Q: Okay.

17 A: So it's an ongoing continuous heartbeat pattern.

18 Q: All right. And if we go through the fetal monitor strip  
19 -- and I am not going to go through all of these pages, but  
20 let's go toward the end of the delivery.

21 A: Okay. Got it.

22 Q: And let's -- let's go to approximately 1704. What time  
23 is that?

24 A: How about a page number?

25 Q: Well, I'm looking for it. What -- what time is 1704?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: 5:04. All right. I've got 5:02. Okay. I have it now.  
2 Q: Will you tell me what page number, please?  
3 A: Okay. It 69. No, I take that back. Okay. So you want  
4 to go to five -- what time did you say again?  
5 Q: Let's go to 1704.  
6 A: Okay. All right.  
7 Q: All right. I can't read this. The type is too small.  
8 Can we read yours?  
9 A: Okay. So 1700 is page 81.  
10 Q: Okay. All right. Do you mind bringing it? Let's go to  
11 the Elmo.  
12 A: To the what?  
13 Q: This Elmo.  
14 A: Okay. All right.  
15 (WHEREUPON, the defendant complied.)  
16 BY MS. CRAIG:  
17 Q: All right. Thank you. All right. Looking at this fetal  
18 monitor strip, let's see if we can -- there we go. That's  
19 better. All right. Just orient us to what we're -- what  
20 we're seeing here?  
21 A: Okay. Well, this is the baby's fetal heart rate track  
22 pattern, and it's normal. I think the baseline is 140.  
23 Q: Okay.  
24 A: And then you see a drop in the baby's heart rate here and  
25 it goes up and it goes down approximately 40 to 50 beats,

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 which is a moderate deceleration. It goes right back up to  
2 140. It goes down to about 100 for a short period of time and  
3 comes back up and then the rest of that. Then you have  
4 another drop of the heartbeat down to 60 that lasts for about  
5 30 seconds and comes right back up.

6 Q: Okay. All right. Let's continue on. What's going on  
7 with the baby's heart rate?

8 A: Here, it didn't recover quite the same. It dropped again  
9 to the 60s, came back up after about 40 seconds, 140s. It  
10 looks like it dropped again and came back down. And then it  
11 has a slow progressive drop from this point on that continues  
12 over onto the next page as well.

13 Q: All right. Why is it medically significant that the  
14 heart rate is dropping?

15 A: Well, in hindsight, I think we can conclude that most of  
16 these sharp up and downs are from cord compression.

17 Q: All right. What's cord compression?

18 A: That's where the umbilical cord gets squeezed and it  
19 causes some changes that lead to a drop in the heartbeat.

20 Q: Is it difficult for the baby to breathe when the -- when  
21 the -- when the cord is compressed?

22 A: Well, it's all about delivery of blood and oxygen because  
23 at this point the baby is not breathing. And if it's  
24 protracted and repetitive, it can be a big problem.

25 Q: Okay. So keep going?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: And so here we're -- it's getting closer to the delivery,  
2 but you can see the drops are more -- more frequent and -- and  
3 they're severe -- what we call severe variable accelerations.

4 Q: So where do you want this line to be? Do you want it  
5 down here or you --

6 A: Well, ideally, we want it here going up and up and then  
7 back to the baseline, up and back to the baseline.

8 Q: Is this a -- is this a strip that you like to see on a  
9 baby during a delivery?

10 A: If this continued for a length of time, we would be very  
11 concerned.

12 Q: Okay. And then what happened?

13 A: And then she delivered.

14 Q: Based on what was going on and documented on the fetal  
15 monitor strip, do you have an opinion whether or not it was  
16 time for this baby to be delivered?

17 A: Absolutely it was time for the baby to be delivered.

18 Q: Thank you.

19 (WHEREUPON, the defendant returned to the witness stand.)

20 BY MS. CRAIG:

21 Q: And what did you say, Doctor, was the most probable cause  
22 of the decelerations with the -- with the difficulty --

23 A: The compression of the umbilical cord.

24 Q: Thank you. So after the delivery, did you speak with Mr.  
25 and Mrs. Byrd?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: So after the baby was delivered, the baby went to the --  
2 to the isolette, the baby warmer, and I delivered the  
3 placenta. I went over and looked at the baby and told them  
4 there was some issues with the arm movement. I went back to  
5 do my paperwork, come back. I thought I saw a little -- I saw  
6 a little bit of hand movement, thought I saw a little arm and  
7 shoulder -- or arm and shoulder movement, and I honestly  
8 thought everything was going to be fine. Most of these are  
9 transient and I think I probably told them that she's  
10 beginning to move a little better and I expected it to be  
11 fine.

12 Q: At any time were you trying to hide that there had been  
13 --

14 A: Absolutely not.

15 Q: -- a shoulder dystocia?

16 A: No.

17 Q: And so when is the timeframe that the brachial plexus  
18 injury -- what's the timeframe for the diagnosis of that?

19 A: Well, I mean you -- the diagnosis of brachial plexus  
20 injury can be made very quickly and then the whole issue is  
21 whether it's going to be permanent or whether it's going to be  
22 transient. And you've heard before from other experts it  
23 takes almost 2 years to get a diagnosis of a permanent  
24 brachial plexus injury.

25 Q: Were you trying to hide that from the Byrds?

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 A: Absolutely not.

2 Q: Now, when did you contact Ms. Byrd after the delivery the  
3 first time?

4 A: I'm guessing it's somewhere between a week and a half and  
5 two weeks.

6 Q: After the delivery?

7 A: That's correct.

8 Q: Okay. And what was the purpose of you contacting Ms.  
9 Byrd on that occasion?

10 A: I called to make sure that her baby was in physical  
11 therapy because we know the sooner that the babies get into  
12 physical therapies with this -- with this brachial plexus  
13 palsy, the better chance that they'll get better.

14 Q: In fact, the next interaction I believe that you had with  
15 Ms. Byrd was when she came back for the six-week postpartum  
16 visit?

17 A: That's correct.

18 Q: Okay. And who -- who was the doctor who took care of her  
19 on that visit?

20 A: I was.

21 Q: And during that visit, how was Ms. Byrd doing?

22 A: She was very concerned. We talked about the brachial  
23 plexus palsy, but from a physical standpoint she was doing  
24 well. She was, you know, very, very concerned, appropriately  
25 so.

DR. JOHN BROWNING - DIRECT BY MS. CRAIG

- 1 Q: And then Ms. Byrd came back again to see you probably  
2 about a year or so for her annual visit; is that right?
- 3 A: That's correct.
- 4 Q: February 2011?
- 5 A: That's correct.
- 6 Q: She came back for an annual visit?
- 7 A: Yes, ma'am.
- 8 Q: Who did she come see at that time?
- 9 A: Me.
- 10 Q: And has Ms. Byrd come back to see you since then?
- 11 A: She has not.
- 12 Q: If she did, would you provide care to her?
- 13 A: I would. I don't think she would come back.
- 14 Q: Do you care about the Byrds?
- 15 A: I do. They're a great couple. Great family.
- 16 Q: Now, Doctor, in the 5,000 -- I know that's an estimate.  
17 In about the 5,000 babies that you have delivered, have you  
18 ever had a delivery that resulted in a permanent brachial  
19 plexus injury?
- 20 A: No, I haven't.
- 21 Q: Is this the only one?
- 22 A: Yes, ma'am.
- 23 Q: Dr. Browning, do you have an opinion whether you used  
24 appropriate controlled traction in this case?
- 25 A: I did.



DR. JOHN BROWNING - DIRECT BY MS. CRAIG

1 Q: And at any time, did you use excessive traction?

2 A: No.

3 Q: The fact that the word traction is continued to be  
4 discussed in this courtroom and is documented in the medical  
5 records, is that of any -- is that worrisome for any reason?

6 A: No. I mentioned before we use traction on almost every  
7 delivery. They don't just pop out.

8 Q: Now, with regard to the video in this case, we know that  
9 the video is a -- is not a professional done video; correct?

10 A: Yes, ma'am.

11 Q: And we wish that there were clearer pictures; correct?

12 A: Of course.

13 Q: And so with regard to the video and you trying to explain  
14 it to us and trying to explain it to this jury, have you done  
15 the best that you can?

16 A: I have.

17 Q: What I want to know is whether or not in this case based  
18 on your recollection, your training, and your experience,  
19 whether you complied with the standard of care?

20 A: I did.

21 Q: Do you have an opinion whether you acted reasonably?

22 A: I -- I did.

23 Q: You did what?

24 A: I did act appropriately and reasonably and did the -- I  
25 did the appropriate delivery.

1 Q: Is controlled traction, which in the axial plane which  
2 you used -- is controlled traction and excessive traction --  
3 is that the same thing?

4 A: It's not.

5 Q: Doctor, did you cause the injuries that Ms. Byrd is  
6 alleging in this case?

7 A: I don't think so.

8 Q: And are all the opinions that you have given today been  
9 to a reasonable degree of medical certainty?

10 A: They have.

11 MS. CRAIG: If you will give me one minute, please?

12 (WHEREUPON, there was a pause in the proceedings, after  
13 which the proceedings resumed as follows.)

14 MS. CRAIG: I've got clearance from Elloree; so those are  
15 all the questions I have. Please answer any questions that  
16 Mr. Graham has.

17 THE WITNESS: Okay.

18 THE COURT: All right. Mr. Graham, do you think we need  
19 a short break before you --

20 MR. GRAHAM: I would appreciate that, Your Honor.

21 THE COURT: All right. Members of the jury, let's take a  
22 10-minute break and we'll come back with cross-examination.

23 (WHEREUPON, the jury exited the courtroom at 3:48 p.m.)

24 THE DEFENDANT: Do you want me to stay here?

25 THE COURT: If you don't mind. If you need to use the

1 restroom, you can.

2 THE DEFENDANT: I'd just like to get some water, if I  
3 could.

4 THE COURT: That's fine, but you can't talk to anybody.

5 THE DEFENDANT: Okay.

6 THE COURT: Nobody. All right.

7 (WHEREUPON, there was a break in the proceedings from  
8 3:48 p.m. until 4:02 p.m.)

9 THE COURT: Go ahead and bring out the jury.

10 MS. CRAIG: Your Honor?

11 THE COURT: Yes?

12 MS. CRAIG: Mr. Graham has just provided us with -- I  
13 guess he put them on my table so I guess he's going to use  
14 those with the doctor -- the letter from our office to Mr.  
15 Graham and Ms. Rodriguez indicating that Dr. Browning will not  
16 be providing expert opinions. I think he brought this up and  
17 showed this to you during Dr. Browning's direct examination.

18 And then regarding the comparative negligence claim, I  
19 think that you've ruled on whether or not this letter is an  
20 appropriate --

21 THE COURT: There's no need for that letter.

22 MS. CRAIG: -- point.

23 MR. GRAHAM: Well, I'd like to make a proffer if Your  
24 Honor please.

25 THE COURT: Go ahead.

1 MS. CRAIG: And then same with regard to the pleadings.

2 THE COURT: Yeah. The defendants' pleadings will not be

3 read into the record. You can read your pleadings into the

4 record pursuant to the rule.

5 MR. GRAHAM: I see.

6 THE COURT: They do not go into evidence, but you can

7 read them.

8 MR. GRAHAM: All right, sir. Well, since you're going to

9 limit me on using that letter representing to us that we would

10 not be allowed to take the deposition of Dr. Browning as an

11 expert because he had been withdrawn as an expert, are you

12 similarly going to preclude me from --

13 THE COURT: Well, I never -- I never prevented you from

14 taking his deposition because I didn't get involved in this

15 case until Monday morning.

16 MR. GRAHAM: Another judge did, Your Honor.

17 THE COURT: All right. Now, he's the defendant in the

18 case and he is a doctor. So it's --

19 MR. GRAHAM: Yes, sir.

20 THE COURT: -- pretty obvious that he can say why he did

21 what he did.

22 MR. GRAHAM: But --

23 THE COURT: I'm not going to let him get into learned

24 treatises and all of that kind of stuff.

25 MR. GRAHAM: Yes, sir.

1 THE COURT: Just as to what he did and what he saw.

2 MR. GRAHAM: Yes, sir. But my question is may I -- I  
3 intend to impeach him with deposition testimony that says I  
4 will not testify that I complied with the standard of care  
5 because I don't know what the standard of care is.

6 THE COURT: Come on. You know he knows what the standard  
7 of care is.

8 MR. GRAHAM: His sworn testimony is to the contrary, Your  
9 Honor, until we got to the courtroom today.

10 THE COURT: What do you say to that?

11 MS. CRAIG: First of all, this whole business about the  
12 deposition, Judge Nettles told him he could take Dr.  
13 Browning's deposition if he wanted to and he refused to do so.  
14 So I mean that issue is -- is over. And not to mention that  
15 that's already been ruled upon by two other judges before Your  
16 Honor.

17 And then with regard to his opinions, when you read his  
18 deposition, it's very clear that he was being asked legal  
19 questions and he did not know the answer to the legal  
20 questions, but when he was asked questions about his care and  
21 treatment, whether it was appropriate and whether it was  
22 reasonable, he would explain exactly why it was. Those are  
23 expert opinions, but he did not define those as, quote,  
24 standard of care, closed quote, opinions.

25 THE COURT: That's the way I see it.

1 MR. GRAHAM: May I just read you the --

2 THE COURT: Go ahead.

3 MR. GRAHAM: -- Q and A?

4 THE COURT: I understand.

5 MR. GRAHAM: All right. This is on page 122 of his  
6 deposition from nine -- from lines 17 to 21.

7 Question: I know we -- I know earlier we discussed the  
8 term standard of care. Do you intend to offer that opinion in  
9 that you complied with the standard of care?

10 Answer: I -- I mentioned before I've heard the term  
11 thrown around and I don't understand it. So no.

12 All I'm asking is that we be allowed in fairness to  
13 impeach him with this deposition testimony. He comes into  
14 court today purporting to say I complied with the standard of  
15 care. We had one chance to take his deposition on that issue  
16 and he said he's not going to do that because he doesn't  
17 understand what it means. I think our ability to prosecute  
18 this case would be altered significantly if we're not allowed  
19 to impeach him. It's such a key point.

20 THE COURT: All right. And how do you respond to that?

21 MS. CRAIG: Your Honor, this is another area where I  
22 anticipate he's going to try to improperly use the deposition.  
23 He just took one piece -- the whole deposition, when you read  
24 it in its totality, it is so blatantly obvious that Dr.  
25 Browning gives expert opinions, but doesn't characterize them

1 in a legal sense. If you look later in his deposition on page  
2 122, line 8, asked specifically later in the deposition:

3 Do you intend to offer an expert opinion regarding your  
4 actions in affecting the delivery?

5 Answer: So I guess I need to understand what you mean by  
6 expert opinion. I'm more than happy to tell you that I'm a  
7 well-trained obstetrician that has managed shoulder dystocias  
8 well throughout my career, and that my management of this  
9 shoulder dystocia was appropriate and I think that was well  
10 done.

11 That's an expert opinion. That's exactly what he's  
12 testified to.

13 THE COURT: I understand what you're saying. The record  
14 is protected, but we're not going there. All right.

15 MR. GRAHAM: All right, sir. And there were multiple  
16 other examples where I'm not qualified to talk about the cause  
17 of this injury, I will not testify at trial about the cause of  
18 this injury. I can recite book and line -- or page and line  
19 as a proffer if Your Honor wants or I can do it during a break  
20 later.

21 THE COURT: All right. Any response to that?

22 MS. CRAIG: Your Honor, we dealt with this in limine.

23 THE COURT: I know.

24 MS. CRAIG: And on day one. This is the third judge and  
25 the third time we've dealt with this. There have been three

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1 rulings that this doctor can testify about what he did, why it  
2 was appropriate, and why it was reasonable. That he didn't  
3 deviate and he didn't cause the injury.

4 THE COURT: And what he observed and what he heard.

5 MS. CRAIG: And otherwise, I guess Mr. Graham expects  
6 that we're going to come in here and admit liability.

7 THE COURT: All right.

8 MR. GRAHAM: Judge, I'm just trying to protect the  
9 record, Your Honor.

10 THE COURT: The record is protected --

11 MR. GRAHAM: Okay.

12 THE COURT: -- but we're not going there. Go ahead and  
13 bring them out.

14 (WHEREUPON, the jury entered the courtroom at 4:07 p.m.)

15 THE COURT: All right. You're recognized for your cross-  
16 examination.

17 MR. GRAHAM: Thank you, Your Honor.

18 THE COURT: Thank you.

19 CROSS-EXAMINATION

20 BY MR. GRAHAM:

21 Q: Dr. Browning, good afternoon.

22 A: Mr. Graham.

23 Q: Dr. Browning, it is never appropriate to use greater than  
24 gentle force on a baby's head; true?

25 A: I use controlled traction. I think we went over that.



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1 Q: I heard you say that, sir, but I'm just asking you this  
2 question. It is never appropriate to use force on a baby's  
3 head greater than gentle force; true?

4 A: I use a controlled traction, and that's -- that's what I  
5 do and that's what I testified to.

6 Q: And we've heard that many times, sir, but please listen  
7 to my question. I'm not asking you if you used controlled  
8 traction and use that phraseology. It is never appropriate  
9 for an obstetrician to use greater than gentle traction or  
10 force on a baby's head; true?

11 A: So I don't use force more than controlled traction that  
12 I've come to know as the amount of force required to deliver a  
13 baby.

14 Q: When in your opinion, Doctor, would it be appropriate for  
15 an obstetrician or a delivery attendant to use greater than  
16 gentle traction?

17 A: Maybe never.

18 Q: So you would agree it's never appropriate --

19 A: I'm sorry. I didn't -- will you rephrase your question  
20 again?

21 Q: Yes, sir. It is never appropriate for an obstetrician or  
22 any delivery attendant to use greater than gentle traction on  
23 a --

24 A: I'm sorry. You're asking the same question.

25 Q: May I finish?

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1 A: Oh, I'm sorry. Go ahead.

2 Q: It is never appropriate for an obstetrician or other  
3 delivery attendant to use greater than gentle traction on a  
4 baby's head; true?

5 A: So what I did -- I'm answering the same question you're  
6 asking -- is I don't use greater than the normal traction that  
7 we need to use to deliver babies and, otherwise, I'm not going  
8 to hypothesize my -- about other cases.

9 MR. GRAHAM: Dave, would you please key up the video  
10 deposition at page 24 -- I'm sorry -- page 47, line 24,  
11 through page 48, line 2.

12 (WHEREUPON, the noted portion of the deposition of Dr.  
13 Browning on video was played in open court, transcribed  
14 as follows.)

15 Q: When, in your opinion, would it be appropriate for  
16 an obstetrician or a delivery attendant to use greater  
17 than gentle traction?

18 A: Never.

19 (WHEREUPON, the video stopped and the proceedings  
20 continued as follows.)

21 MS. CRAIG: Could he continue on under the rule of  
22 completeness?

23 THE COURT: I'll let you redirect him.

24 MS. CRAIG: Yes, sir. Thank you.

25 BY MR. GRAHAM:

**DR. JOHN BROWNING - CROSS BY MR. GRAHAM**

1 Q: Doctor, between the time you gave your deposition in this  
2 case -- do you recall doing that? Do you recall giving a  
3 deposition?

4 A: Yes, I do.

5 Q: Yes, sir. Back on November 13, 2013?

6 A: Okay.

7 Q: At the Turner Padgett office here in Florence?

8 A: I remember giving a deposition.

9 Q: Yes, sir. And you were -- you were sworn just like  
10 today?

11 A: Absolutely.

12 Q: To tell the truth?

13 A: Yes, sir.

14 Q: The whole truth, nothing but the truth?

15 A: Yes, sir.

16 Q: And you had your own attorney there?

17 A: Yes.

18 Q: And an attorney from my office took your deposition?

19 A: That's correct.

20 Q: And asked you to please explain if you didn't understand  
21 any question, please ask for clarification before you answered  
22 it? Do you remember that?

23 A: Yes.

24 Q: Now, since that time, have you had an opportunity to  
25 practice your testimony to be used in this courtroom today?

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1 A: No.

2 Q: Okay. Is it your sworn testimony that you've never been  
3 videotaped by the defense attorneys to help you do a better  
4 job?

5 A: Absolutely not.

6 MS. CRAIG: Your Honor, I'm glad he answered it, but he  
7 knows that is a direct violation of the attorney-client  
8 privilege.

9 THE COURT: It's already been asked and answered. Go  
10 ahead and move on.

11 MR. GRAHAM: Thank you, Your Honor.

12 MS. CRAIG: And, Your Honor, at the appropriate time, I  
13 have a matter of law for the Court.

14 BY MR. GRAHAM:

15 Q: Obstetricians should also avoid lateral traction on a  
16 baby's head; true?

17 A: I don't use lateral traction.

18 Q: All right. I understand what you've testified to, sir,  
19 but I'm asking a simple question. Obstetricians should always  
20 avoid lateral traction on a baby's head; true?

21 A: Obstetricians, like myself, are trained to use axial  
22 traction.

23 Q: When you have a shoulder dystocia and the shoulders are  
24 in an AP plane and you put the mother in McRoberts and have  
25 the nurse perform suprapubic pressure, do you then apply

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1 lateral traction to accomplish delivery?

2 A: I do not.

3 Q: You should not; true?

4 A: I do not.

5 Q: Why should -- why is it important for obstetricians to  
6 avoid lateral traction?

7 A: As we've heard from your previous witness, it increases  
8 the risk of injury.

9 Q: Injury to the brachial plexus nerves?

10 A: That's correct.

11 Q: And if lateral traction is toward the left shoulder, it  
12 creates a risk of brachial plexus injury to the nerves on the  
13 right side of the neck; true?

14 A: Yes, sir.

15 Q: For you to comment on the cause of Julia's nerve damage  
16 would require you to speculate; true?

17 A: Yes.

18 Q: Sir, when a doctor sees that a baby's top shoulder is  
19 stuck behind the mom's pubic bone, the doctor is supposed to  
20 get the mom to stop pushing; true?

21 A: Yes.

22 Q: And I realize what you claim you did in this case based  
23 on your testimony, but the fact is if -- well, let me just ask  
24 a hypothetical question. If a particular doctor were involved  
25 in a delivery in which the baby's top shoulder was stuck

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1 behind the mom's pubic bone and gentle traction failed to  
2 release that stuck shoulder, it would be a violation of  
3 obstetrical standards of care to not get the mom to stop  
4 pushing; true?

5 A: I get the mother to stop pushing.

6 Q: I'm not asking you about what you claim you did here.  
7 I'm asking a hypothetical question.

8 A: So if it was a hypothetical, I would have to see all the  
9 facts in that hypothetical situation to --

10 Q: Yes, sir.

11 A: -- make an assessment.

12 Q: Well, if it's a 45-second shoulder dystocia with the top  
13 right shoulder stuck behind the pubic bone and the doctor sees  
14 that that top shoulder is stuck and won't come with gentle  
15 traction, the standards of care require the doctor to get the  
16 mom to stop pushing; true?

17 A: I would have the mother stop pushing, yes.

18 Q: That's what the standards of care require; true?

19 A: That's good obstetrics, yes.

20 Q: You've known that since when? Since you trained as a  
21 resident?

22 A: Yes, sir.

23 Q: Okay. And that's -- that hasn't changed ever since, has  
24 it?

25 A: No, sir.

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1 Q: In fact, you said something about teaching some folks how  
2 to handle shoulder dystocia. Do you teach folks that they  
3 must get the mom to stop pushing when you realize the shoulder  
4 is stuck?

5 A: Yes.

6 Q: So if a doctor failed to get the mom to stop pushing when  
7 the top shoulder was stuck behind the pubic bone, that would  
8 be a violation of your own training; true?

9 A: So if that sort of thing happened, again, I'd look at the  
10 facts and make an -- make an assessment once I saw the facts.

11 Q: And if you -- and if such a doctor were not to get the  
12 mom to stop pushing, that would violate the training that you  
13 give the other folks that you teach how to manage shoulder  
14 dystocia; true?

15 A: One of the first steps in management of shoulder dystocia  
16 is get the mother to stop pushing, yes.

17 Q: That's an important part of getting the shoulder unstuck  
18 safely; true?

19 A: It's no more important than any of the other maneuvers or  
20 any of the other steps.

21 Q: Well, do you consider it an important --

22 A: Yes, I do.

23 Q: -- step or an unimportant step?

24 A: I consider it important.

25 Q: All right. And that was my question. You do believe

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1 that's an important step in managing a stuck shoulder  
2 situation safely without injury to the baby?

3 A: I do.

4 Q: Good medicine requires it?

5 A: Well-trained obstetricians use that, yes.

6 Q: Careful and prudent medicine requires that you get the  
7 mom to stop pushing?

8 A: We always try to practice careful and prudent medicine,  
9 yes.

10 Q: Reasonable and appropriate medicine requires the doctor  
11 to get the mom to stop pushing; true?

12 A: I think I've answered that, yes.

13 Q: Now, I was a bit confused when I was listening to your  
14 testimony about what you claimed to remember about this  
15 delivery. You don't -- you don't claim to have an independent  
16 recollection of what you did during the delivery, do you?

17 A: I was asked that at my deposition and one of the things I  
18 remember is getting Misty on a chair for the -- for the  
19 suprapubic pressure.

20 Q: Okay.

21 A: But otherwise, no, I didn't remember anything else.

22 Q: All right. Now, you refer to this chair. What kind of  
23 chair are you talking about?

24 A: We have a basic wooden chair in most of the -- the  
25 offices, like a -- you know, a student's desk chair or maybe



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1 even more basic than that.

2 Q: Okay. Does it have a back to it like a chair or is it  
3 more like a stool?

4 A: No. It's got a back. Some places -- the stools are on  
5 rollers. Some places have a stepstool or some of the rooms.

6 Q: All right. And do you claim that this chair was on  
7 Christy's left side of her bed or right side of her bed or  
8 somewhere else?

9 A: I just know it had to be moved to the right side. So I  
10 assume it was not on the right side.

11 Q: And you -- did I understand you correctly to say that  
12 when -- was it a tech behind you that stepped up and bumped  
13 into the camera?

14 A: I have no idea.

15 Q: Okay.

16 A: I don't remember anybody else in the room.

17 Q: Ordinarily during a delivery, would you have a tech  
18 standing near you?

19 A: Yes.

20 Q: All right. So whether it was a tech or somebody else  
21 that stepped over and bumped into the camera, is it -- do I  
22 understand you to say that that person stepped over to grab a  
23 chair and walk it around to the other side of the bed so that  
24 the nurse could stand up on the bed and get a better  
25 suprapubic angle?

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1 A: I have no idea what happened in front of the camera. I  
2 don't even know if the camera was bumped. All I know is what  
3 I remembered was getting a chair so that my nurse could get up  
4 on the chair to apply suprapubic pressure in an effective  
5 angle.

6 Q: Do you claim to remember whether a chair was supposedly  
7 moved after the head delivered or before the head delivered?

8 A: No. It was after the initial attempt at suprapubic  
9 pressure.

10 Q: Apart from your claimed memory about someone moving a  
11 chair, you have no other memories about what happened during  
12 this delivery; true?

13 A: That's correct.

14 Q: Now, Doctor, you've had an opportunity to read Misty --  
15 Nurse Misty's deposition testimony; true?

16 A: Yes, sir.

17 Q: And you know she gave sworn testimony about how she gives  
18 suprapubic pressure; true?

19 A: I did.

20 Q: Okay. And you saw in her testimony that she pushes down  
21 on the pubic bone itself rather than reaching upwards toward  
22 where the shoulder is stuck?

23 A: I doubt she meant that.

24 Q: You doubt she meant that?

25 A: Yep.

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1 Q: You saw her sworn testimony --

2 A: Yes, sir, I did.

3 Q: -- that that is how she believes is the correct way to do  
4 it; true?

5 A: It was in a deposition, true.

6 Q: Have you made any other assumptions about sworn testimony  
7 by McLeod employees being untrue?

8 A: No. Misty is a well-trained nurse that goes through  
9 these various drills that we have and I just -- she knows  
10 better.

11 Q: All right. Well, what about the doctors that she works  
12 with. Do they know better than to just let her do the  
13 suprapubic pressure without paying attention to where she puts  
14 her hands?

15 A: I would --

16 MS. CRAIG: Objection, Your Honor.

17 THE COURT: Sustained.

18 BY MS. CRAIG:

19 Q: Surely you admit it is the doctor's duty to make sure  
20 that an order for suprapubic pressure is carried out  
21 correctly?

22 MS. CRAIG: Same objection.

23 BY MR. GRAHAM:

24 Q: True?

25 THE COURT: Why don't you rephrase it?

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1 BY MR. GRAHAM:

2 Q: Doctor, do you believe that it is a duty of an  
3 obstetrician to -- to make sure that his or her order for  
4 suprapubic pressure is carried out and carried out correctly?

5 MS. CRAIG: Objection. The hospital is not a defendant  
6 in the case.

7 THE COURT: Overruled. Go ahead. You can answer that  
8 question.

9 BY MR. GRAHAM:

10 A: I do and I did.

11 Q: All right. Well, the question is do you believe that and  
12 you do believe that is a duty of the physician?

13 A: I believe -- you know, I'm worried that duty is some  
14 legal term. I'm not a lawyer; so I'm going to tell you that's  
15 part of my practice to make sure that a nurse does the  
16 appropriate maneuver, which I did in this case.

17 Q: In your training, were you trained that when you order  
18 suprapubic pressure, you should watch the nurse to make sure  
19 she does it the correct way?

20 A: You know, we work as a team, Mr. Graham, and we all know  
21 our jobs very well. And so the amount of attention you would  
22 spend to somebody who is in training is completely different  
23 to a seasoned nurse. So we ask supra -- ask for suprapubic  
24 pressure and our nurses, who have done this many times for us  
25 -- we know it's going to be done correctly.

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1 Q: You know it without even looking?

2 A: No. We look as well. We're not blind to what's going on  
3 during the procedure.

4 Q: Well, do you remember my question?

5 A: Maybe not now.

6 Q: All right. The question, sir, is in your training were  
7 you trained that when you give an order for suprapubic  
8 pressure, you should watch the nurse to make sure she's doing  
9 it correctly?

10 A: You know, again, that's not part of implicit training.  
11 It's something as a team we all learned to do and part of our  
12 training is knowing what each one of us are doing. The nurses  
13 know how to do suprapubic pressure.

14 Q: And you say that despite the sworn testimony to the  
15 contrary?

16 A: I told you what I thought about that.

17 Q: Yes, sir. What about -- you told us you teach other  
18 people how to manage shoulder dystocia. Do you teach other  
19 doctors that they should watch a nurse to make sure she  
20 performs suprapubic pressure correctly when it's ordered?

21 A: Same answer. It's -- again, we're a team. The nurses  
22 know how to do suprapubic pressure. If it's a nurse that's  
23 doing it for the first time, by all means we're going to go  
24 over with that nurse how to do suprapubic pressure. You know,  
25 she may be doing it for the first time. Absolutely, we're

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1 going to spend -- we're going to go over that with a nurse in  
2 that situation.

3 Q: And the question is do you train doctors to watch the  
4 nurses to make sure they perform suprapubic pressure  
5 correctly? I think I'm entitled to a yes or no.

6 A: I just think that's a -- it's a vague answer. No, we  
7 don't specifically train doctors to look at the nurses doing  
8 suprapubic pressure.

9 Q: Have you ever been trained specifically to look at the  
10 nurses doing suprapubic pressure?

11 A: It's just something I do. You know, they're in the field  
12 of vision. Just like you've gone over many times, they're  
13 this close away.

14 Q: All right. So is it fair then that when you order  
15 suprapubic pressure with a brand-new rookie nurse, you pay  
16 more careful attention to watch to see if she does suprapubic  
17 pressure correctly than you would with a more seasoned nurse  
18 that you think knows how to do it properly, someone like  
19 Misty?

20 A: Well, in a rookie nurse, I might be telling her exactly  
21 what I want done and watching her and watching everything else  
22 that's going on with every delivery.

23 Q: So with a rookie nurse, you would pay much more careful  
24 attention then to whether she does it correctly than you would  
25 a more seasoned nurse; true?

**DR. JOHN BROWNING - CROSS BY MR. GRAHAM**

1 A: I'll give you that.

2 Q: And you put Misty Barrett, the one who -- who says she  
3 put pressure on the bone -- you put her in the more seasoned  
4 category at McLeod; true?

5 A: Yes, sir.

6 Q: The one that you think is -- has more knowledge than the  
7 other nurses?

8 A: She's not a rookie nurse. That's correct.

9 Q: Do you believe that getting -- well, do you believe that  
10 when a nurse performs suprapubic pressure on the bone itself  
11 instead of correctly that the doctor's duty to correct that  
12 hand positioning is an important part of patient safety?

13 A: If I were to see a nurse putting pressure on the pubic  
14 bone, I think that's important to make sure that that  
15 positioning is changed, yes.

16 Q: Okay. And hypothetically, in a delivery involving any  
17 physician -- I'm not limiting it to the Byrd case, but in any  
18 headfirst vaginal delivery complicated by shoulder dystocia,  
19 if the doctor orders suprapubic pressure, if the nurse puts  
20 pressure on the bone and not the shoulder, and the doctor for  
21 whatever reason doesn't correct her, that's not good medicine,  
22 is it?

23 A: I'd have to see that case and see where the nurse put her  
24 hands, what the doctor did in that situation. So then I would  
25 come up with my --

DR. JOHN BROWNING - CROSS BY MR. GRAHAM

1 Q: Yes, sir. Well --

2 A: -- assessment.

3 Q: I'm asking you to assume that she put her pressure on the  
4 bone, not where it should be. Assuming that to be true, does  
5 good medicine require the doctor to correct the nurse's hand  
6 positioning?

7 A: As a well-trained obstetrician, if I had a nurse that put  
8 the suprapubic pressure on the bone and I could tell that, I  
9 would definitely have them adjust that position. Yes, sir.

10 Q: All right. Do you remember the question, sir? Does good  
11 medicine require an obstetrician to correct the nurse's hand  
12 position if she's pushing on the bone instead of the shoulder?

13 A: I think I answered that. It's good obstetrical practice.  
14 In my hands, if I see somebody putting pressure on a pubic  
15 bone and it's obvious, then they're going to be moved, yes.

16 Q: And do you agree that in a hypothetical situation if  
17 another doctor orders suprapubic in this -- in a shoulder  
18 dystocia situation and the nurse puts pressure on the bone,  
19 the doctor does not for whatever reason correct the hand  
20 positioning, that would be a violation of the obstetrical  
21 standards of care; true?

22 MS. CRAIG: I'm renewing my objection, Your Honor.

23 THE COURT: Overruled. You can go ahead and answer it.

24 BY MR. GRAHAM:

25 A: Again, I think I've answered this about five times now.



DR. JOHN BROWNING - CROSS BY MR. GRAHAM

1 It's good obstetrical practice, if the suprapubic pressure  
2 isn't being done properly, to adjust it so that it is being  
3 done properly.

4 Q: Yes, sir. You didn't answer my question though. If a  
5 doctor doesn't correct the suprapubic pressure, that's a  
6 violation of the doctor's standard of care; true?

7 A: So what I'm doing is good obstetrical practice, which is  
8 the standard of care, and so is to correct that positioning.  
9 So I am answering that question.

10 Q: . Can you give me a yes or no? Do the obstetrical  
11 standards of care --

12 THE COURT: I think it's been answered.

13 MR. GRAHAM: Pardon?

14 THE COURT: You can go ahead and move on to something  
15 else. That's been asked and answered about 15 times. Go  
16 ahead.

17 BY MR. GRAHAM:

18 Q: Apart from your testimony that you think you asked  
19 somebody to move a chair, you don't claim to have any memory  
20 of what happened during the 7 or 8 seconds of no video; true?

21 A: That's correct.

22 Q: After you pulled down on the head that first time and --  
23 and pulled the cord over Julia's head, is it your testimony  
24 that that's when you ordered McRoberts?

25 A: After that, yes, sir.

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1 Q: Is it your testimony that you ordered McRoberts and only  
2 McRoberts at that time?

3 A: Yes.

4 Q: Is it your testimony that when you then pulled down a  
5 second time that after that you ordered suprapubic?

6 A: Yes, sir.

7 Q: And then when you pulled down again that third time, you  
8 pulled the head farther than you did the first two times;  
9 true?

10 A: I applied -- I think the same axial traction was applied.

11 Q: And you pulled the head down at a deeper angle; true?

12 A: No, sir.

13 Q: And you had an opportunity -- instead of pulling harder  
14 and farther down, you had an opportunity to stop pulling,  
15 reach inside the birth canal, and do a Rubin's maneuver; true?

16 A: At that point in time, we tried suprapubic pressure. So  
17 that was the third traction that was applied. And then I was  
18 able to see that it wasn't as effective as it should be  
19 because of the -- the positioning of Misty's shoulders and it  
20 was corrected and then we -- the -- with effective suprapubic  
21 pressure, the baby delivered.

22 Q: Are you claiming that the stool was moved from point A to  
23 point B and the nurse climbed up on the stool while the video  
24 was still running?

25 A: No. I think if you look at the video where there's

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1 suprapubic -- where you see Misty's hands for the suprapubic  
2 pressure, after that traction, then I think the video went up  
3 in the air or whatever it did.

4 Q: The question, sir, is are you claiming that a chair was  
5 moved before or after the video camera was bumped?

6 A: I think it was during that time. You know, pure  
7 guesswork, but I think that might have had something to do  
8 with it getting bumped. But I don't know.

9 Q: And are you claiming that the stool was moved from point  
10 A to point B before or after the camera was turned off?

11 A: I don't -- I have no idea of when the camera was turned  
12 off.

13 Q: Well, you saw the video; right?

14 A: I did see the video. I didn't even see where the camera  
15 was off for --

16 Q: There were four pulls before the camera went off; right?

17 A: I don't think so.

18 Q: You don't count four pulls?

19 A: I think there was three, but I would have to look at it  
20 again.

21 Q: Okay. At any rate, after your first two pulls, whether  
22 you had a total of three or four or some larger number, after  
23 each pull when you released the pulling force and the head  
24 sprung back, you had a point in time when you had to make a  
25 decision whether to keep pulling on that head or reach inside

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1 the birth canal to do an internal maneuver; true?

2 A: Well, my -- the way that we resolve a shoulder dystocia  
3 is with McRoberts and then suprapubic pressure, and we had one  
4 attempt at suprapubic pressure that I was able to see wasn't  
5 effective; so we did effective suprapubic pressure and the  
6 baby delivered. So the next line of maneuvers did not come  
7 up.

8 Q: All right. You called -- I was interested to hear you  
9 describe the Julia B delivery as a successful delivery, a  
10 successful management of shoulder dystocia. You consider all  
11 your deliveries successful, sir, no matter how bad the baby is  
12 injured?

13 A: So we successfully got Julia delivered, yes.

14 Q: Do you consider it a successful resolution of shoulder  
15 dystocia in a 45-second period if the child comes out with  
16 significant partial ruptures of C5, C6, and another partial  
17 rupture at C7? You consider that successful?

18 A: What I said was we were successfully able to deliver the  
19 baby.

20 Q: Her body came out?

21 A: Yes.

22 Q: It would've been more successful, don't you think, if she  
23 had been delivered safely and successfully?

24 A: Clearly, I feel terrible that Julia has an injury and  
25 definitely would not have wished for anything more than that

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1 she didn't have an Erb's palsy.

2 Q: Let me go back to a question that hasn't been answered  
3 yet. After you pulled those first two times, before each  
4 successive pull, you had an opportunity to stop and think let  
5 me stop pulling and reach inside the birth canal; true?

6 A: You know, like I just said, we have our method of  
7 resolving the shoulder dystocia and I told you exactly what I  
8 did.

9 Q: You had plenty of time to do a Rubin's maneuver; true?

10 A: You know, if you want to take it -- I -- there -- sure.  
11 I could've done a Rubin's maneuver.

12 Q: You had plenty of time to do a Wood's corkscrew maneuver;  
13 is that true?

14 A: Yes, sir.

15 Q: You had plenty of time to do a posterior arm delivery  
16 method; true?

17 A: Probably.

18 Q: Those are all non-traction maneuvers; true?

19 A: True.

20 Q: They don't involve pulling on the head?

21 A: Oh, no. Yes, they -- once -- once the -- once the  
22 shoulder dystocia is resolved; you still have to have traction  
23 to get the baby out.

24 Q: You don't have to use more than gentle traction, do you?

25 A: No, you don't. You use the --

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1 Q: With finesse, do you?

2 A: -- typical controlled traction.

3 Q: Okay.

4 A: But every maneuver requires some traction to then deliver

5 the baby.

6 Q: Do you agree that doctors should deliver babies with

7 finesse rather than force?

8 A: I've never heard the term finesse in obstetrics. So

9 that's something you've come up with.

10 Q: Please answer the question, sir. Do you believe that

11 babies should be delivered with finesse rather than force?

12 A: So I'll answer it this way. They require almost all the

13 time appropriate axial traction for delivery.

14 Q: That should be applied with finesse?

15 A: It should be applied appropriately.

16 Q: With finesse and without lateral traction?

17 A: I don't use lateral traction.

18 Q: And without increased pulling force?

19 A: Are you asking me a question?

20 Q: Yes, sir.

21 A: What is the question then?

22 Q: Good practice requires that a doctor refrain from using

23 forceful pulling on the head; true?

24 A: So definitely good obstetric practice avoids excessive

25 traction.

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- 1 Q: Not only did you have time to do Rubin's, but the  
2 standards of care require that you go to an internal maneuver  
3 rather than use greater than gentle traction; true?
- 4 A: Standard of care is what I did with McRoberts, suprapubic  
5 pressure, and if that doesn't -- if the delivery doesn't --  
6 isn't accomplished, then we move on to internal maneuvers.
- 7 Q: All right. Well, let me ask you about another situation.  
8 I don't want to -- I don't want to get personal by asking you  
9 about you in this case.
- 10 Let's just take any hypothetical delivery involving any  
11 doctor, fictitious doctor. If that doctor is managing a  
12 delivery where it's a headfirst vaginal delivery, top shoulder  
13 gets stuck behind the mom's pubic bone, the doctor orders  
14 McRoberts and suprapubic and applies gentle traction and the  
15 top shoulder doesn't deliver, should that doctor move to an  
16 internal maneuver or pull harder?
- 17 A: Internal maneuver.
- 18 Q: And if the doctor pulls harder rather than going to an  
19 internal maneuver, that's not good medicine, is it?
- 20 A: That's not the way I would practice.
- 21 Q: That's not good medicine, is it?
- 22 A: It's not good obstetric practice.
- 23 Q: All right. And in fact, it would violate the standards  
24 of care for obstetricians; fair?
- 25 A: So again, legalized term.

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1 Q: All right. And although it may not matter which  
2 particular internal maneuver the doctor goes to first,  
3 internal maneuvers should be the next resort if gentle  
4 traction doesn't deliver the shoulder; true?

5 A: If -- if McRoberts, suprapubic with axial traction after  
6 each one of those and it isn't effective, then you move on to  
7 internal maneuvers.

8 Q: That's what the standards of care require?

9 A: That's what good obstetric practice requires.

10 Q: Which is the same as the standards of care?

11 A: I would assume that, yes.

12 Q: And more than gentle traction is never proper in the  
13 first five to seven minutes, is it?

14 A: Excessive traction is not proper. That's correct.

15 Q: All right. And certainly not in the first 45 seconds?

16 A: Correct.

17 Q: Nor is lateral traction appropriate in the first five to  
18 seven minutes?

19 A: That's correct.

20 Q: And especially not in the first 45 seconds?

21 A: That's correct.

22 Q: With a baby -- with Julia being delivered in just 45  
23 seconds, you had many minutes of time available to you to take  
24 your time, be careful, and get that shoulder unstuck before  
25 there was any problem with risk of brain damage; true?



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1 A: We try to -- as we told you before, you want to get the  
2 shoulder dystocia resolved as soon as you can. Increasing  
3 time, increasing risk. Increasing time, increasing maneuvers,  
4 increasing risk.

5 Q: This child was never at immediate threat of brain damage  
6 in those 45 seconds, was she?

7 A: No, but you're not -- what you're thinking is to resolve  
8 this right away in a correct fashion.

9 Q: No patient was at risk or at immediate threat of death or  
10 serious permanent -- or serious bodily injury during those 45  
11 seconds; true?

12 A: Well, at the very start of recognizing the shoulder  
13 dystocia, that threat of brain injury, that threat of death is  
14 there. You go through your motions. You're not looking at  
15 the clock to resolve that problem.

16 Q: But there's no immediate threat for at least five to  
17 seven minutes; true?

18 A: Well, I would say that when you start getting over two or  
19 three minutes, there's an increasing risk of problems.

20 Q: But in the first 45 seconds, there's no immediate threat  
21 of any serious harm; true?

22 A: True.

23 Q: Apgars of nine and nine are great; true?

24 A: They're good. Apgars are not very reliable, but they're  
25 good.

DR. JOHN BROWNING - CROSS BY MR. GRAHAM

1 Q: Okay. Nothing about the Apgars suggested any medical  
2 instability, did it?

3 A: No. It showed that the baby was delivered before there  
4 was any medical instability.

5 Q: So at no time in those 45 seconds were the patients  
6 medically unstable?

7 A: In hindsight, no.

8 Q: So you -- you -- I want to make sure I understood. I  
9 think I did. At no time during the 45 seconds --

10 A: Well, I --

11 Q: -- was mother or baby medically unstable?

12 A: No. I don't -- did not agree to that. Like I said  
13 before, when a shoulder dystocia is recognized, it's a medical  
14 emergency, a situation where there can be very serious  
15 sequelae of that.

16 Q: Sure.

17 A: And so at that point in time, that is a medical emergency  
18 and, you know, it's something that if the baby delivered,  
19 that's no -- that's medically stable and no problem. If they  
20 have a shoulder dystocia, that's medically unstable at that --  
21 at that point in time.

22 Q: But as long as -- as long as the shoulder dystocia is  
23 resolved within 45 seconds, you know, as you said before the  
24 two minute mark, there's no immediate risk of any serious --  
25 any serious harm?

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1 A: Right. Generally.

2 Q: The Apgars don't show -- well -- I -- excuse me. I'll  
3 withdraw that. I think I've covered it. The cord gases also  
4 support that this child was doing very well; true?

5 A: They do. There are some minor changes, but they do.  
6 They show that the child was born without deprivation of  
7 oxygen and without acidemia.

8 Q: And you mentioned some variables, even some severe  
9 variables, on the strips, but variables are just consistent  
10 with a cord being compressed?

11 A: They are. There was one that wasn't a variable and  
12 that's a little bit different. The one that was prolonged and  
13 slow, but other than that those were all probably cord  
14 compression.

15 Q: And -- and the worry about cord compression is if it's  
16 serious enough and long enough, then it affects the oxygen to  
17 the brain?

18 A: If it's prolonged, yes, sir.

19 Q: All right. But the cord gases show us that didn't happen  
20 here; true?

21 A: Absolutely, it did not.

22 Q: And even though, as you say, the strips were consistent  
23 with the cord around the neck, I guess that's what the  
24 variables --

25 A: The cord --

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1 Q: -- just reflect the cord; right?

2 A: Probably not around the neck, to be quite honest with  
3 you. It's probably cord compression of the cord insertion  
4 with the baby being in the low portion of the pelvis.

5 Q: Okay. So that happens in just about every vaginal  
6 delivery; true?

7 A: No, not every vaginal delivery, but it happens in some.

8 Q: It's not unusual?

9 A: It's not unusual.

10 Q: And some of the more troubling things that you might see  
11 on a -- on a fetal heart monitor strip would include reduced  
12 variability; right?

13 A: Yes, sir.

14 Q: There was nothing like that here, was there?

15 A: No, sir.

16 Q: Or another troubling sign on a strip might be a late  
17 deceleration, persistent late deceleration?

18 A: Yes.

19 Q: There's nothing like that here, is there?

20 A: No. There's the one prolonged deceleration. I mean we  
21 weren't worried about imminent danger, but we also didn't want  
22 to sit there and not do anything. We wanted Christy to  
23 deliver that baby.

24 Q: In terms of choices, you were the one that chose how hard  
25 to pull on the head and what angle to use; true?

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1 A: Obviously.

2 Q: You were the one that chose continued pulling rather than  
3 an internal safety maneuver; true?

4 A: So I told you what I did. And obviously, how that birth  
5 was accomplished was -- was by me and thought through by me.

6 Q: I'm sorry. What?

7 A: I did the delivery. So I think that's all obvious.

8 Q: All the choices in managing this delivery were --

9 A: Were mine.

10 Q: -- your choices?

11 A: Yes, sir.

12 Q: Now, you've -- you've already acknowledged that -- one  
13 thing you wrote on the delivery note -- okay. On -- on the  
14 delivery note or delivery report rather that you went over a  
15 moment ago and it's -- it's in evidence, the -- you indicated  
16 that you wrote on the official chart initially decreased  
17 movement of right arm, within few minutes good hand, arm, and  
18 shoulder movement. You wrote those words on the chart; true?

19 A: I did. Yes, sir.

20 Q: Were those words true or not?

21 A: In -- I think they were overly optimistic.

22 Q: All right. Were they true or not?

23 A: At the time, I thought it was true, yes.

24 Q: Do you stand by those words today, that Julia had good  
25 movement --

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1 A: No.

2 Q: -- of her hand and arm --

3 A: No, I don't.

4 Q: -- and shoulder within a few minutes after delivery?

5 A: No. I think I saw some movement. Like I told you  
6 before, I know I saw some movement of the hand. I saw a  
7 little movement of the -- of the arm and forearm and, at that  
8 point, I was less concerned until I came back later on that  
9 afternoon.

10 Q: Okay. And in fact, you never changed that note on the  
11 delivery report, did you?

12 A: I didn't.

13 Q: And in fact, that note was untrue and inaccurate?

14 A: It was definitely inaccurate.

15 Q: It was inaccurate, but not untrue?

16 A: You're -- you're mincing words there, splitting words,  
17 whatever.

18 Q: What -- what fault -- what blame do you put on Christy  
19 for Julia's nerve damage?

20 A: Absolutely none.

21 Q: What fault do you put on David for Christy's [sic.] nerve  
22 damage?

23 A: Absolutely none.

24 Q: What fault do you put on Julia for Julia's nerve damage?

25 A: Absolutely zero.

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1 Q: What fault do you put on -- on Christy's uterus  
2 contractions and her pushing efforts with regard to Julia's  
3 nerve damage?

4 A: So as I said in my testimony, I'm not going to give any  
5 expert opinion on the mechanism of injury.

6 Q: Okay. But whatever pushing Christy did, whatever  
7 contractions her uterus went through, those were increased by  
8 drugs you provided; true?

9 A: She was on Pitocin, and Pitocin increases contractions,  
10 yes, sir.

11 Q: Pitocin -- let's talk about Pitocin for a minute. You  
12 ordered Pitocin, as you do for most of your patients I assume;  
13 true?

14 A: No. But for all our inductions, that's how an induction  
15 is accomplished.

16 Q: Sure. And sometimes you prescribe Pitocin just to  
17 augment, not just to induce but to augment?

18 A: That's correct. Yes, sir.

19 Q: And Pitocin has the power not only to increase the force  
20 of the contractions, but also to increase the frequency of the  
21 contractions; true?

22 A: Yes, it does.

23 Q: You were in control of how much Pitocin Christy got?

24 A: There is a protocol that was used and the nurses  
25 administer that protocol.

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1 Q: Okay. But you ordered --

2 A: It's standard for all of us.

3 Q: And you ordered it?

4 A: Yes, I did, after discussing this with Christy.

5 Q: Do you in any way fault the parents for the care that  
6 they have sought and obtained for their daughter?

7 A: No. Instead, I applaud them for all the work that  
8 they've done.

9 Q: When your lawyers were asking some questions earlier, it  
10 sounded as though someone on your side might be critical of  
11 when therapy started for Julia. Are you?

12 A: No. I think the reference was to show that I was  
13 concerned about Christy and Julia.

14 MR. GRAHAM: Your Honor, may we approach?

15 THE COURT: You may.

16 (WHEREUPON, a bench conference was held in the presence  
17 of the jury but out of the hearing of the jury as  
18 follows.)

19 MR. GRAHAM: One thing that Molly did in his direct exam  
20 is to ask about other deliveries. Early on, you told us that  
21 we were going to be limited to this delivery and this case and  
22 these folks unless she opened the door. We believe she opened  
23 the door by talking about other deliveries and other injuries.

24 THE COURT: Where are you going with it?

25 MR. GRAHAM: He was involved in a -- in a significant



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1 brain damage case some years ago.

2 THE COURT: I'm not going there.

3 MR. GRAHAM: Okay.

4 THE COURT: She did it in the context of doctor/patient  
5 relationship, which started in 19 -- whatever. In that  
6 perspective, yeah. Then under the second child. All right.  
7 Let's get to the third child.

8 MR. GRAHAM: That's not what I meant. She asked him how  
9 many times have you dealt with these injuries and with  
10 shoulder dystocia. Have you had any other injuries? She  
11 asked about a hundred other deliveries.

12 MS. CRAIG: The reason why I asked how many times have  
13 you confronted shoulder dystocia was just to show his  
14 experience with shoulder dystocia. That's the whole purpose.  
15 What he's trying to get into is bringing another lawsuit in  
16 the back door.

17 THE COURT: We're not going into any lawsuit. We are  
18 going to try this case and this case only. I ruled on that  
19 pre-trial.

20 MR. GRAHAM: Okay. I just -- that's why I --

21 THE COURT: Thank you for asking. I appreciate it.

22 (WHEREUPON, the bench conference ended and the  
23 proceedings resumed as follows.)

24 BY MR. GRAHAM:

25 Q: When you were talking -- were answering questions

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1 earlier, you said shoulder dystocia is not that uncommon. Do  
2 you -- you agree that even though -- I know it's unpredictable  
3 and you can't always tell when it's going to happen, but  
4 because of that, obstetricians must always be prepared and  
5 anticipate that a shoulder might get stuck in any vaginal  
6 delivery; true?

7 A: True.

8 Q: And doctors should have their checklist of safety  
9 maneuvers to follow to make sure that the baby -- the baby is  
10 delivered safely without too much pulling force; true?

11 A: Those safety maneuvers should be followed; yes.

12 Q: And too much pulling force puts the brachial plexus  
13 nerves at foreseeable risk of damage; true?

14 A: Excess traction is not -- is -- puts that baby at risk,  
15 yes, sir.

16 Q: You've known that nerve damage is a foreseeable risk of  
17 excessive traction for how long?

18 A: Since early in my residency.

19 Q: Okay. Has that changed at all since then?

20 A: No, sir.

21 Q: So at the time you made all of the choices about whether  
22 to pull harder or do an internal maneuver, you were aware of  
23 the risk to the nerves if you pulled harder; true?

24 A: So as a trained obstetrician, I was trying to resolve the  
25 shoulder dystocia, going through the maneuvers that we use,

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1 and that's what I did.

2 Q: The question, sir, is at the time you made the choices,  
3 you were aware that a foreseeable risk of increasing the  
4 pressure, increasing the pulling force put those nerves at  
5 risk; true?

6 A: So through my training, I understand that happens. Yes.

7 Q: Okay. And you also understood -- while you were making  
8 the decisions about how to handle this case, you understood  
9 that lateral traction would also put those nerves at risk of  
10 damage; true?

11 A: Yes, sir.

12 THE COURT: Mr. Graham? Mr. Graham, let me speak to both  
13 of you real quick.

14 (WHEREUPON, a bench conference was held in the presence  
15 of the jury but out of the hearing of the jury as  
16 follows.)

17 THE COURT: Just on an ancillary issue. I forgot about  
18 our juror that --

19 MR. GRAHAM: Oh.

20 THE COURT: -- has to get out of here by 5:15.

21 MR. GRAHAM: What time is it now?

22 THE COURT: Almost 5.

23 MR. GRAHAM: Okay. Do you think you can do it or do I  
24 need to --

25 MS. CRAIG: I would really like to get this over with.

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1 MR. GRAHAM: I'll do my best, but I hate to be --

2 MS. CRAIG: I'd really like to finish.

3 MR. GRAHAM: You know, the other day the attitude was,  
4 you know, let's accommodate the jurors and I'll move on as  
5 quickly as I can, but I don't want to be -- I don't want to be  
6 compromised.

7 MS. CRAIG: Well, I went for --

8 THE COURT: Let's take a break and let me ask her real  
9 quick.

10 MR. GRAHAM: Whatever you want to do.

11 THE COURT: What do you say? I think we need to ask her  
12 because it's getting close.

13 MS. CRAIG: Okay. Sure. The only comment I would -- I  
14 think that my cross was -- excuse me -- my direct is going to  
15 be less than five.

16 (WHEREUPON, the bench conference ended and the  
17 proceedings resumed as follows.)

18 THE COURT: All right. Members of the jury, let's take a  
19 short break. And let me speak with the juror that has to make  
20 arrangements to pick up your child.

21 (WHEREUPON, the jury exited the courtroom at 5:00 p.m.,  
22 with the exception of one juror.)

23 (WHEREUPON, a bench conference was held with a juror as  
24 follows.)

25 THE COURT: We just thought about you and I didn't want

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1 to forget about you.

2 THE JUROR: I have a schoolteacher ear and I heard it.

3 THE COURT: Well, you've already got it done?

4 THE JUROR: No, no, no, no. I heard what you said just  
5 now. I forgot about the juror who had to pick up her  
6 daughter.

7 THE COURT: Okay. Have you made arrangements for  
8 somebody to --

9 THE JUROR: No, sir. I don't have -- my brother is the  
10 only person that helps me and he's out of town this week on a  
11 business trip. I will gladly send that Monday.

12 THE COURT: How old are your children?

13 THE JUROR: I have an 11-year-old and a three-year-old.

14 THE COURT: You don't have any neighbors or somebody that  
15 you can call?

16 THE JUROR: No. My mom has my three-year-old, but she's  
17 80 and she doesn't drive. And obviously I don't have anybody  
18 that can bring Elizabeth. I've called a friend's mom.  
19 Everybody's out of town. It's the end of school.

20 THE COURT: She's at Kings Academy?

21 THE JUROR: Yes, sir. She's at Kings.

22 THE COURT: How far away from Kings Academy do you live?

23 THE JUROR: Another --

24 THE COURT: Twenty minutes? Fifteen minutes?

25 THE JUROR: Another 20 minutes from there.

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1 THE COURT: If we got the sheriff to take your -- take  
2 your child to your mother, would that be okay?

3 THE JUROR: Can I call her and tell her? Because she  
4 will completely wig out if I send the sheriff up there.

5 THE COURT: That's fine.

6 THE JUROR: And my mother will completely wig out if she  
7 shows up with my child. But yeah, I can call the --

8 THE COURT: All right. Let me speak to the deputy over  
9 there and make sure they're okay with that.

10 THE JUROR: I'm sure it would -- it's just an  
11 extraordinary circumstance.

12 THE COURT: I understand.

13 (WHEREUPON, the bench conference ended, the juror exited  
14 the courtroom, and there was a pause in the proceedings,  
15 after which the proceedings resumed as follows.)

16 THE COURT: We are going to get it. She's calling her  
17 daughter to let her know she's not in trouble. The deputy is  
18 going to go get her.

19 MR. GRAHAM: I don't have much left, Judge.

20 THE COURT: Either way. I hate to cut you off if it's --

21 MR. GRAHAM: I'm over here trying to cut.

22 THE COURT: You do what you got to do. We are making  
23 arrangements.

24 (WHEREUPON, there was a pause in the proceedings, after  
25 which the proceedings resumed as follows.)

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1 MR. GRAHAM: Judge, I really think I've got two or three  
2 minutes. I mean depending on the answers, of course. But if  
3 it stretches, it's not going to stretch more than that.

4 THE COURT: Anyway, it's so close in time, let's go ahead  
5 and make arrangements and then you can do what you've got to  
6 do. Once she makes that phone call, we can get started.

7 (WHEREUPON, there was a pause in the proceedings, after  
8 which the proceedings resumed as follows.)

9 THE COURT: All right. If you'll go ahead and bring out  
10 the jury?

11 (WHEREUPON, the jury entered the courtroom at 5:19 p.m.)

12 THE COURT: All right. You may continue.

13 MR. GRAHAM: Thank you, Your Honor.

14 BY MR. GRAHAM:

15 Q: Dr. Browning, I'm going to try to wind this up in the  
16 next few minutes.

17 A: Thank you.

18 Q: You told us that you believe a safe range of newtons is  
19 100 to 200?

20 A: Well, it's debated in the literature. Nobody knows.  
21 Clearly, under 100 is safe.

22 Q: Well, let me ask you this, sir. How do you translate  
23 newtons to pounds?

24 A: It's -- that's a good question. It's either divided by  
25 four or increased by four, and I'd have to look it up.

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1 Q: Okay. So if we divided by four, 100 to 200 newtons would  
2 be roughly 25 to 50 pounds?

3 A: Again, I'd have to look it up.

4 Q: And is it your -- well, if we multiply by four, it would  
5 be 400 to 800?

6 A: Which doesn't sound correct. It must be divided by.

7 Q: Okay. So is it your testimony that 25 to 50 pounds of  
8 force on the baby's head is safe?

9 A: I'm saying that less than 100 newtons appears to be safe.  
10 Now, this is the -- this is the attempt at trying to measure  
11 what happens during deliveries, and I couldn't cite you an  
12 article, but they're out there and you'd have to -- you'd have  
13 to look at those or ask the obstetrical experts if they've  
14 read that literature. I mean I could get you the article if  
15 you want it.

16 Q: Well, you testified earlier I thought -- according to my  
17 notes, you testified that anywhere from 100 to 200 newtons of  
18 force on a baby's head is safe.

19 A: I said --

20 Q: Do you stand by that?

21 A: So it's delivery force. It isn't force on the head.  
22 These are strain gauges within the -- within the pelvis. I'd  
23 have to look at the methodology and see how it was measured.  
24 And when they do use these mannequins, what's cited is less  
25 than 100 there's never a concern, and some people say up to



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1 200 there's not a concern. So I'd have to look at the  
2 methodology and see where the point of measurement is from.

3 Q: Well, just to be clear, I'm asking you about the amount  
4 of force applied to a baby's head after the head delivers and  
5 the top shoulder is stuck.

6 A: I don't know.

7 Q: All right. Do you claim to know how much force can be  
8 safely applied to a baby's head in that situation?

9 A: I don't.

10 Q: And how many times did you have your force measured  
11 before Julia was born?

12 A: Never. This is something just recently.

13 Q: Okay. When did you -- you say recently, but when was it  
14 that you first had your force measured?

15 A: Last year.

16 Q: Nineteen -- I mean 2015?

17 A: Yes, sir.

18 Q: How did you find out that your force was going to get  
19 measured?

20 A: I didn't. I asked did they measure it. I talked with  
21 Scott Sullivan, who is the maternal-fetal medicine doctor who  
22 is taking this truck around to different centers. I asked did  
23 they measure the force. He said yeah. I said, well, could  
24 you look up mine, and he did. It's computerized.

25 Q: When you say can you look up mine, that sounds like

1 you've already had the test.

2 A: Well, it's -- we went through maneuvers and --

3 Q: Okay. Wait a minute. Wait a minute.

4 A: Okay.

5 Q: The pending question is how did you find out that you  
6 would get tested, not how did you find out what the results  
7 were. How did you find out before the test --

8 A: So --

9 Q: -- that you would be tested?

10 A: So I have to explain myself. These are --

11 Q: Go ahead.

12 A: These are -- these are scenarios where we go in with this  
13 particular mannequin and manage shoulder dystocias, manage  
14 hemorrhage, and after it was all said and done, I asked do  
15 they measure the forces, and he said, yeah. I said, well,  
16 what were mine? It wasn't a test.

17 Q: You at some point applied pressure to a dummy's head?

18 A: Yes, sir.

19 Q: Okay. How did you find out that you would be asked to  
20 apply force to a dummy's head?

21 A: What I found out was, after I had completed the  
22 procedure, what the force was.

23 Q: It's a simple question. How did you find out that they  
24 wanted you to go apply force to a dummy's head?

25 A: To resolve a shoulder dystocia.

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1 Q: I'm not asking the purpose. How did you find out to be  
2 there that day and to pull on a dummy?

3 A: Oh, it was advertised for all of us. We actually had  
4 times that we signed up for. All the physicians and all the  
5 nurses. It was literally in a -- in a big van in the parking  
6 lot, and we all took turns going to this van to go through  
7 these scenarios.

8 Q: Okay. So what did the advertisement tell you?

9 A: What did the what?

10 Q: Advertisement about the van being there that day?

11 A: Well, this was something that was routed through our  
12 office to all obstetricians and gynecologists.

13 Q: All right.

14 A: What time would you like to sign up if you want to come  
15 to go do these simulations.

16 Q: Okay. So you did the simulation, knowing that it was the  
17 higher fidelity simulation equipment?

18 A: I didn't know anything until I got there.

19 Q: Okay. But once you got there, you knew it was not the  
20 low fidelity CPR-type dummy?

21 A: Oh, no, no. It's very sophisticated.

22 Q: Okay. You learned when you got there that this is not  
23 the -- and I can't remember what her name was when I was in --

24 A: Annie.

25 Q: -- lifesaving, but Annie? Yeah.

- 1 A: Right.
- 2 Q: This is not one of those low fidelity --
- 3 A: No, sir. It wasn't Annie.
- 4 Q: This is a high-tech, high quality --
- 5 A: Yes, sir, it is.
- 6 Q: -- simulation?
- 7 A: Right.
- 8 Q: And you knew -- before you participated in that
- 9 simulation, you knew that you were going to be observed and
- 10 measured?
- 11 A: No, I didn't. I knew that we were going to have -- we
- 12 were going to go through these simulations. Only after I had
- 13 gone through the simulations, I found out that measurements
- 14 are taken.
- 15 Q: All right. You knew it was some type of invitation for
- 16 Florence-area obstetricians to come work with simulation
- 17 equipment to -- to simulate medical situations that come up
- 18 from time to time, like shoulder dystocia?
- 19 A: Yeah. It was mostly for the nurses, to be quite honest
- 20 with you, and all the physicians that wanted to participate
- 21 did as well.
- 22 Q: Okay. And when you participated in that, you knew that
- 23 you already had a permanent brachial plexus injury from one of
- 24 your shoulder dystocias; true?
- 25 A: Absolutely, yes.

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1 Q: You knew that when you went in there to go through that  
2 measurement?

3 A: No, it was not on my mind when I went in there to do  
4 those simulations.

5 Q: You knew that you had, in fact, had a baby, Julia B ,  
6 born on your watch with significant partial ruptures of two  
7 nerves and another partial rupture on your watch; true?

8 A: Did I know that Julia had an Erb's palsy? Yes, I knew  
9 that. Of course.

10 Q: Let me ask you, sir, you've said that you could look on  
11 the video and see the nurses -- one nurse or more than one --  
12 how many nurses do you see holding Christy's legs up?

13 A: I didn't ever say I saw anybody holding her legs up. I  
14 said you could see that they were up.

15 Q: Okay. Well, do you -- do you claim that a nurse was  
16 holding the legs up or someone else?

17 A: I don't know who was holding the legs up.

18 Q: If, in fact, you ordered McRoberts, are you supposed to  
19 watch to see that is carried out by the nurses?

20 A: Yes. And I would assume Misty did it.

21 Q: All right. And Misty? That's Misty -- Misty, not  
22 Christy? Misty, the nurse?

23 A: That's correct.

24 Q: You assume she did the McRoberts?

25 A: Yeah. I'm guessing, yes. Since she was the nurse in the

1 room.

2 Q: All right. Well, let me ask you this, sir. When a nurse  
3 is in the room, a labor and delivery nurse assisting with a  
4 vaginal headfirst delivery, does she wear anything on her  
5 hands?

6 A: Eventually, yes, she puts gloves on.

7 Q: I'm sorry. What?

8 A: Yeah. They eventually put gloves on.

9 Q: What do you mean they eventually put gloves on?

10 A: Well, you know, during the day I don't think they wear  
11 gloves when they're -- with everything they do. They come in  
12 and adjust the monitors. They -- you know, they, you know,  
13 adjust the IV. I don't think they put a glove on for each one  
14 of those.

15 Q: At what stage of the labor should nurses have their  
16 gloves on by?

17 A: You know, if we asked them to do something that involves  
18 touching a patient that -- where that's an issue, they should  
19 put gloves on then.

20 Q: Okay. So if they're -- if a nurse is holding up one of  
21 Christy's legs, she should have gloves on by then?

22 A: I don't know that.

23 Q: All right.

24 A: It's not something I've noticed.

25 Q: All right. Is it -- is it acceptable for nurses under

DR. JOHN BROWNING - CROSS BY MR. GRAHAM

1 your watch to handle different parts of a patient's body  
2 without gloves on?

3 A: No. I think it would be good practice to have gloves on.

4 MS. CRAIG: Objection, Your Honor.

5 THE COURT: Overruled. He's already answered it.

6 BY MR. GRAHAM:

7 Q: And did the -- did the nurse have gloves on when you say  
8 you saw her doing correct suprapubic?

9 A: Yes.

10 Q: She had gloves on then?

11 A: Yes.

12 Q: So if she had gloves on then, she should've had gloves on  
13 doing the McRoberts; true?

14 A: I would guess.

15 MR. GRAHAM: Thank you. No further questions.

16 THE WITNESS: Okay.

17 THE COURT: All right. Redirect?

18 MS. CRAIG: Thank you, Your Honor. Very briefly.

19 REDIRECT EXAMINATION

20 BY MS. CRAIG:

21 Q: Dr. Browning, I'm going to be brief. It's late in the  
22 day here. Dr. Browning, in this case, not a hypothetical, in  
23 the delivery of Julia B , did you use the appropriate  
24 maneuvers to relieve the shoulder dystocia?

25 A: I did.

DR. JOHN BROWNING - REDIRECT BY MS. CRAIG

1 MR. GRAHAM: Objection, Your Honor. This has already  
2 been covered.

3 THE COURT: Overruled. Keep it -- keep it short.

4 BY MS. CRAIG:

5 Q: And you were asked about the internal maneuvers for this  
6 case. Do you have an opinion whether internal maneuvers were  
7 medically indicated?

8 A: No, because it resolved before internal maneuvers were  
9 needed.

10 Q: And if internal maneuvers were indicated, how does that  
11 affect whether or not traction still needs to be used?

12 A: You still have to do traction after you do the internal  
13 maneuver.

14 Q: All right. Mr. Graham asked you about Pitocin?

15 A: Yes, ma'am.

16 Q: That was the first time we've heard about Pitocin in this  
17 trial?

18 A: Yes, ma'am.

19 Q: How do you know that the appropriate amount of Pitocin  
20 was given?

21 A: Well, we have a protocol that the nurses follow and we  
22 have a monitor strip that records how often they're  
23 contracting and then, of course, we can see a woman's progress  
24 that confirms that their -- that the Pitocin is adequate.

25 Q: Based on the fetal monitor strip -- and we've already



DR. JOHN BROWNING - REDIRECT BY MS. CRAIG

1 gone through it. It's in evidence as Plaintiff's Exhibit 26.

2 Is there any evidence whatsoever that the contractions were  
3 too quick and there was too much Pitocin?

4 A: No, ma'am.

5 Q: Were contractions appropriately timed?

6 A: Yes.

7 Q: All of the questions that Mr. Graham has asked you over  
8 the past hour and half, do any of those questions change your  
9 opinion in this case that you complied with the standard of  
10 care?

11 A: No, ma'am.

12 MS. CRAIG: Thank you, Dr. Browning.

13 MR. GRAHAM: Very quickly.

14 RE CROSS EXAMINATION

15 BY MR. GRAHAM:

16 Q: Doctor, you said that even if you do an internal  
17 maneuver, you still need to use some traction?

18 A: Yes, sir.

19 Q: You don't need to use excessive traction, do you?

20 A: Never a good idea to use excessive traction.

21 Q: Okay. And you -- you told Ms. Craig that you never saw  
22 anything in the -- in the records or in your memory about the  
23 contractions being too quick. Did you ever see anything about  
24 the contractions being too strong?

25 A: You really can't determine how strong the contractions

1 are with the external monitors.

2 Q: Okay. But you have no evidence, do you, sir, of the  
3 contractions being too quick or too strong?

4 A: Yeah. The monitor strip can indicate if the contractions  
5 are too frequent, which is really all we're concerned about.  
6 We're not concerned about them being too strong.

7 Q: Yes, sir. Well, my question is in this case do you have  
8 any evidence that Christy's contractions were ever too quick  
9 or too strong?

10 A: No, sir.

11 MR. GRAHAM: Thank you.

12 THE COURT: Are you done?

13 MS. CRAIG: No further questions.

14 THE COURT: All right. You may step down.

15 THE DEFENDANT: Thank you, sir.

16 THE COURT: Thank you. All right. Ladies and gentlemen  
17 of the jury, we'll see you at 9:30 in the morning. Do not  
18 discuss the case. Do not research the case.

19 (WHEREUPON, the jury exited the courtroom at 5:33 p.m.)

20 THE COURT: All right. We'll see you in the morning at  
21 9:30.

22 MS. CRAIG: Thank you, Your Honor.

23 MS. GANES: Thank you, Your Honor.

24 MS. CRAIG: Your Honor, out of curiosity, did they send  
25 the sheriff to pick up the baby -- the child?

1 deposition about medically stable and immediate threat of  
2 great bodily injury or death. Of course, these are very  
3 significant issues in this case.

4 THE COURT: Uh-huh.

5 MS. GANES: These are proper cross-examination points for  
6 Mr. Graham if he wants, but he said in his deposition that, of  
7 course, when a child is presenting in a shoulder dystocia,  
8 that is not a medically stable environment and there is  
9 immediate threat of great bodily injury or death.

10 THE COURT: All right. I'm not going to argue with you.  
11 I mean you all are saying one thing and you all are saying  
12 another thing. I'm not going to stop right now and read a  
13 400-page deposition. These experts are here for a reason. We  
14 all know why they're here. The plaintiff knows; the defense  
15 knows.

16 Let's bring them out and let's go.

17 MR. GRAHAM: May we get a ruling though that no new  
18 opinions?

19 THE COURT: That's obvious. There's no question about  
20 it. No new opinions.

21 MR. GRAHAM: Thank you.

22 THE COURT: That doesn't mean they're not going to have  
23 an opinion. No new opinions.

24 (WHEREUPON, the jury entered the courtroom at 9:52 a.m.)

25 THE COURT: All right. If you'll call your next witness?

DR. STACY SMITHSON - DIRECT BY MS. GANES

1 MS. GANES: Thank you, Your Honor. The defendants call  
2 Dr. Stacy Smithson.

3 THE CLERK: Please place your left hand on the Bible and  
4 raise your right hand. Do you swear or affirm the testimony  
5 you give in this case will be the truth, the whole truth, and  
6 nothing but the truth, so help you God?

7 THE WITNESS: I do.

8 THE CLERK: Please be seated and then state your name for  
9 the record.

10 THE WITNESS: My name is Dr. Stacy Lee Smithson.

11 DR. STACY SMITHSON, being first  
12 duly sworn, testified as follows:

13 DIRECT EXAMINATION

14 BY MS. GANES:

15 Q: Good morning, Dr. Smithson.

16 A: Good morning.

17 Q: Where do you live?

18 A: I reside in Lexington, South Carolina.

19 Q: And what do you do for a living there in Lexington?

20 A: I am a physician and owner of a practice, a solo practice  
21 named Lake Murray OB/GYN.

22 Q: Do you deliver babies?

23 A: I deliver a lot of babies.

24 Q: Are you a trained obstetrician?

25 A: I am.

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1 Q: Can you tell the jury a little bit about your education,  
2 where you went to college and medical school?

3 A: Certainly. I attended Vanderbilt University as an  
4 undergraduate. I went to the University of Illinois for their  
5 School of Medicine and graduated from there in 1994. Then  
6 came to South Carolina and trained at South Carolina Palmetto  
7 Richland Hospital and left -- and finished that in 1998 and  
8 have been in private practice basically ever since.

9 Q: And how long have you been at your current practice?

10 A: My current practice is 13 years.

11 Q: How many partners do you have there in your practice?

12 A: It's a solo practice, but it's kind of a hybrid practice.  
13 I also am a clinical faculty member with the School of  
14 Medicine and work with the Department of OB/GYN with high-risk  
15 obstetricians and other gynecologists, and I teach the  
16 residents and the medical students in that capacity.

17 Q: Do you teach residents and medical students how to deal  
18 with the medical emergency of shoulder dystocia?

19 A: Yes.

20 Q: Are you board-certified?

21 A: I am.

22 Q: Where do you have hospital privileges?

23 A: The three Palmetto hospitals, which is Palmetto Baptist,  
24 Palmetto Richland, and Palmetto Parkridge.

25 Q: Now, can you tell the jury a little bit about how your

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1 practice is divided or how your time is divided between your  
2 clinical practice, delivering babies and taking care of mamas,  
3 and your teaching responsibilities?

4 A: Certainly. My practice -- I'm basically in the office  
5 Monday through Thursday. Fridays are my days in the hospital  
6 where I work with the residents and the medical students,  
7 where I deliver babies, do C-sections, do gynecological  
8 surgeries, and then I take call with the attendings within  
9 that group as well. So approximately 2 to 3 days a month I'm  
10 on call with the attendings and the residents as well.

11 Q: Now, is it unusual for you to find yourself in a  
12 courtroom as a doctor?

13 A: Quite, yes.

14 Q: How often do you come and provide testimony to juries in  
15 a case like this?

16 A: Maybe once a year.

17 Q: Are you a member of any professional organizations?

18 A: I am a member of the American Congress of OB/GYN, which  
19 is our big representative nonprofit organization that promotes  
20 women's health. And a member of the South Carolina Medical  
21 Association, the AMA, kind of the big ones.

22 Q: Now, the American Congress of Obstetrics and Gynecology,  
23 is that the same as ACOG?

24 A: Yes.

25 Q: Okay. Is that the acronym that that society is known by?

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1 A: Yes.

2 Q: Now, is that the premier professional organization for  
3 obstetrics, obstetricians and gynecologists?

4 A: Yeah. It's the mothership. There's much of other ones  
5 underneath it, you know, American Society of Public Surgeons,  
6 American Society of Maternal-Fetal Medicine, et cetera, et  
7 cetera. So -- but that's the broad reaching one that every  
8 obstetrician is a member of and is board-certified by.

9 Q: As an obstetrician, do you keep up with current medical  
10 literature that applies to your field of practice?

11 A: Yes. I have to because the residents keep me on my toes.

12 Q: Do you have experience delivering babies where the baby's  
13 shoulder gets stuck under the mother's pubic bone like  
14 happened in this case?

15 A: Unfortunately, way too much, yes.

16 Q: Okay. And how many babies have you delivered throughout  
17 your career as an obstetrician?

18 A: Well over 6,000.

19 Q: Do you consider yourself an expert on the practice of  
20 obstetrics and gynecology?

21 A: I do.

22 MS. GANES: Your Honor, at this -- well, let me ask you  
23 one more question.

24 BY MS. GANES:

25 Q: I'm going to hand you a document that is -- or can you

DR. STACY SMITHSON - DIRECT BY MS. GANES

1 tell the jury what this document is, please?

2 MS. GANES: Your Honor, may I approach?

3 THE COURT: You may.

4 MS. GANES: Thank you.

5 BY MS. GANES:

6 A: This is my most recent curriculum vitae.

7 Q: And does it detail your education and personal interests?

8 A: Yes.

9 Q: Can you tell the jury a little bit about your hobbies and  
10 personal interests?

11 A: I'm -- I'm a single father. I raise my two children as  
12 much as my schedule allows. I play golf. I'm really a  
13 musician at heart. So I also am a pianist, and I play in a  
14 band that's in our community called Going Commando. It's me  
15 and two other physicians and a banker and a chemical engineer,  
16 and we just get together and have a good time trying to play  
17 good old-time music.

18 MS. GANES: Your Honor, at this time I would offer into  
19 evidence Dr. Smithson's curriculum vitae or CV.

20 THE COURT: Any objections?

21 MR. GRAHAM: No, Your Honor.

22 THE COURT: All right. Number 4 is into evidence without  
23 objection.

24 THE COURT REPORTER: Number 5.

25 THE COURT: Number 5.. Okay.



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1 (WHEREUPON, Defendant's Exhibit Number 5, curriculum  
2 vitae of Dr. Stacy Smithson, was admitted into evidence.)

3 MS. GANES: Your Honor, at this time I also offer Dr.  
4 Smithson as an expert in the field of obstetrics and  
5 gynecology.

6 THE COURT: Any objections?

7 MR. GRAHAM: No questions at this time, Your Honor.

8 THE COURT: All right. Thank you. Motion is granted.

9 MS. GANES: All right.

10 BY MS. GANES:

11 Q: Dr. Smithson, at my request, did you review the medical  
12 records of Ms. Byrd, as well as the depositions taken in this  
13 case and the birth video of Julia B 's delivery?

14 A: I did.

15 Q: And based on your review of those items, do you have an  
16 opinion as to whether Dr. Browning met the standard of care  
17 with regard to his care and treatment of Ms. Christy Byrd and  
18 the delivery of Julia B ?

19 A: Yes. He very --

20 Q: And what is that opinion?

21 A: My opinion is that he met the standard of care and that  
22 nothing untowards or outside of the realm of standard of care  
23 in the delivery of this infant.

24 Q: Do you have an opinion as to whether Dr. Browning caused  
25 the injuries to Julia B that are at issue in this case?

DR. STACY SMITHSON - DIRECT BY MS. GANES

1 A: Based on the evidence and the video that we have, my  
2 opinion is is that in no way did he contribute to the cause of  
3 this injury.

4 Q: Now, are those your opinions to a reasonable degree of  
5 medical certainty?

6 A: Yes.

7 Q: Now, I want you to talk to the jury a little bit about  
8 how a baby is delivered. Do you use the term traction in your  
9 practice as an obstetrician?

10 A: I tend not to use the term traction because traction to  
11 me reminds me of a tire on pavement. Tension is the word that  
12 I tend to use and, of course, tension directed in the wrong  
13 fashion can always result in injury. And so, therefore, in  
14 the teachings and during deliveries, one of the things that I  
15 always try to teach the residents and medical students about  
16 is the proper delivery and the safest way to deliver a baby.

17 Q: Is it appropriate for physicians in your field to use  
18 different terms to describe the force delivered to -- the  
19 force used to deliver a baby?

20 A: Certainly. And within the standard of care that we  
21 practice, the term gentle axial traction is the accepted  
22 terminology for the guidening -- the guidance force that we  
23 utilize in safely delivering a baby.

24 Q: Does the term that the doctor uses to describe the force  
25 that he used in delivering a baby have any effect on how the

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1 baby was delivered?

2 A: No. I mean we're trained to stay within certain  
3 parameters that are very nebulous to describe and to explain,  
4 but in the process of delivering a baby from very early on we,  
5 of course, are taught to minimize the amount of traction or  
6 force utilized in delivering the baby.

7 Q: Okay. Now, would it assist you to use some of the  
8 demonstratives that the jury has seen throughout this week in  
9 talking to the jury about delivering babies?

10 A: Certainly.

11 Q: Dr. --

12 MS. GANES: Your Honor, may he --

13 THE COURT: Sure.

14 MS. GANES: -- come down?

15 (WHEREUPON, the witness complied.)

16 BY MR. GANES:

17 Q: If you would, just look at the demonstratives and pick  
18 out which one that you think might help. All right. Dr.  
19 Smithson, what I want you to do is help the jury understand  
20 the mechanism of the delivery of a baby and what the  
21 physician's role is --

22 A: So --

23 Q: -- in completing both a normal delivery and a delivery  
24 where shoulder dystocia is present?

25 A: Certainly. And I apologize for my voice. I've got the

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1 allergy thing going on. And I also apologize -- I don't mean  
2 to talk down to anyone who has had a baby because I know that  
3 if you've been through this, you probably know most of this  
4 already.

5 Q: We'll put it up here. I also have a pointer. Let's make  
6 sure that they can see.

7 A: These are basically the progression of steps that happen  
8 at certain times when a baby is in what we call the second  
9 stage of labor, which is after contractions over a number of  
10 minutes or hours has resulted in the woman's cervix being  
11 completely dilated so the head can then pass through the  
12 cervix.

13 But once that occurs, then the baby has to maneuver  
14 through the bones of the pelvis, which are the immovable  
15 things, the things that the baby has to conform to. Many of  
16 --

17 Q: And --

18 A: I'm sorry.

19 Q: I'm sorry. I don't mean to interrupt. Dr. Smithson,  
20 what helps the baby move in that direction during delivery?

21 A: All of the force that is directing the baby during the  
22 first and second stage of the labor from the inside is coming  
23 from the uterus and the contractile force of the uterus. You  
24 know, just like a toothpaste tube trying to squeeze the  
25 toothpaste out of the end, that's what the uterus is trying to

1 do.

2 And so the baby goes through these things we call  
3 cardinal movements, which are positions of the baby as they  
4 come down through the bones of the pelvis. And during this  
5 time, I'm talking about an area that's no more than about 5 to  
6 7 inches probably in most women. But as you see as the baby's  
7 head comes down and passes between the two prominent bony  
8 structures of the pelvis, which is the pubic bone and back  
9 here in back -- it's not depicted very well, but back here in  
10 back you have your sacrum and your tailbone. Okay?

11 Q: So these other demonstratives help depict that a little  
12 better maybe?

13 A: Yes. This right here. And this is what we call the  
14 sacral promontory. This is the narrowest diameter of gap that  
15 you have in the pelvis. So the baby has to be able to fit  
16 through there in order to progress on toward delivery.

17 Q: All right. Dr. Smithson, let me interrupt you right  
18 there. When the baby is coming through that bony prominence,  
19 is it -- is it straight at more of a horizontal angle or -- or  
20 is it at a different angle?

21 A: Well, as you can see, this would be the horizontal zero  
22 and, as you can see, the angle of most women's pelvis is  
23 between 25 and 45 degrees off of horizontal. And so  
24 therefore, once you get to the point where the head is  
25 delivered in a normal delivery, then what happens is is the

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1 baby oftentimes will retribute and, with the help of the  
2 gentle traction that I was speaking of earlier, we help bring  
3 the infant -- instead of this direction, which the anterior  
4 shoulder would be fighting this pubic bone, we're trying to  
5 guide the infant in a non-horizontal fashion so the shoulder  
6 then slips underneath the pubic bone.

7 Q: And were you trained in medical school, Dr. Smithson, on  
8 any placement of your hands in delivering the baby when you  
9 employ that traction?

10 A: Certainly. When the baby's head is delivered, what you  
11 do and what Dr. Browning did, as you saw in the video, is you  
12 let the baby what we call retribute, which means the baby's  
13 head will turn usually one way or another and, you know, the  
14 baby comes out like this, but then once the head is out, turns  
15 like this.

16 And once that happens, then we put the hands on the top  
17 and the bottom of the head and try to maintain the angle of  
18 the neck in a way that we are exhibiting any force whatsoever,  
19 gentle traction as we call it, in a manner that we're going to  
20 affect delivery safely while guiding the baby's shoulders in  
21 front of or underneath the pubic bone.

22 Q: Now, Dr. Smithson, is there any way to measure how much  
23 force is used for a physician when the baby is being guided  
24 out of the pelvis?

25 A: Well, there's been many studies done on it, you know,

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1 using models and such. I guess to kind of help you relate to  
2 the amount of force that we use, most of those studies have  
3 seemed to realize that the amount of force that is being  
4 exhibited by the mother's contractions is much more than the  
5 amount of force that we use on the infant.

6 And, of course, that makes sense because when I'm  
7 training residents and through my training, we realize that  
8 the weak point of the infant is right here at the neck. And  
9 so, therefore, our goal is to basically be the steering wheel  
10 with mom being the engine. That being most of the forces that  
11 are applied are going to be applied by the uterus contracting  
12 and pushing the baby out, and our job is to most effectively  
13 guide that infant in a direction that's the most efficient  
14 manner and in the hopes of causing the least amount of injury  
15 or none at all.

16 And so then what happens is though is in infants that are  
17 -- typically, there's all sorts of risk factors that you can  
18 throw out there, you know, mom being short, mom being heavy,  
19 baby being heavy, diabetes during the pregnancy. There's all  
20 these risk factors, but yet more than 80 percent of dystocias  
21 that we encounter in the real world, these people have no risk  
22 factors whatsoever.

23 Q: And did Mrs. Byrd have any risk factors in this case as  
24 far as shoulder dystocia?

25 A: Not that I recall. It was the third baby. They didn't

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1 think that this infant was any bigger than any of her other  
2 ones. And I don't recall there being any issues with her  
3 sugar tests during the pregnancy. And if I recall too, she  
4 gained an appropriate amount of weight as well.

5 So I think all in all, there was really no signs or  
6 symptoms and her labor went very well as well. There's also  
7 symptoms and signs that happened that we realize during labor  
8 that might make us think, okay, mom is trying to push  
9 something that's not going to happen; so we need to do  
10 something different. We didn't really see any of that. The  
11 labor course itself was very, very normal.

12 And so what happens when you have these babies basically  
13 get stuck is one of two things or usually they work in tandem  
14 together, and that is the anterior shoulder gets stuck behind  
15 the pubic bone. And remember I said this is the narrowest  
16 point, so almost inevitably it makes sense to say that the  
17 other shoulder is probably stuck back here on the sacrum or  
18 what we call the sacral promontory because that's the  
19 narrowest diameter.

20 So, of course, this was first described probably back in  
21 the 17 -- 1800s and since that time, medical knowledge is  
22 gotten better and better. We have, of course, tried to affect  
23 changes in the way that we practice in order to safely and  
24 effectively deliver a baby in the safest manner.

25 Q: Now, Dr. Smithson, when the physician realizes that the



1 shoulder is stuck under the mother's pubic bone, what are the  
2 appropriate maneuvers that -- that -- that you are trained in  
3 and that obstetricians generally are trained in?

4 A: Well, when we characterize it, it seems like it's a  
5 stepwise fashion that we're approaching this, but in all -- in  
6 all reality, it's a matter of we're thinking of all of these  
7 things at the same time trying to figure out the quickest and  
8 safest way to get a baby out that's stuck. It is truly an  
9 emergency. It's like all of a sudden we start holding our  
10 breath when these sort of things happen and we go into kind of  
11 robot mode and say, okay, this is what we've got to do to get  
12 this baby out safely.

13 Q: And can you tell the jury a little bit more about why it  
14 is truly an emergency when a physician realizes that the baby  
15 they are delivering is stuck and not delivering normally?

16 A: Well, this is a fairly good rendition of what happened to  
17 Dr. Browning.

18 Q: I can hold that.

19 A: What?

20 Q: I can hold that for you. I'll hold it right here.

21 A: The baby had a nuchal cord. We see that probably 20  
22 percent of the time in deliveries. It's not that rare. And  
23 then -- but what happens is is the infant is in limbo. It's  
24 kind of like a diver that's, you know, 200 feet underwater and  
25 the air hose is going up to the boat. Well, all of a sudden

1 the air hose is cut off.

2 Q: And is that a medically stable situation?

3 A: Not at all. I mean this is the most risky time during  
4 any birth is from the time the head is delivered until the  
5 time the remainder of the body is being delivered.

6 Q: And is there an immediate threat of great bodily injury  
7 or death --

8 MR. GRAHAM: Objection, Your Honor.

9 Q: -- to the infant at that time?

10 A: Well, yes.

11 THE COURT: What's that?

12 MR. GRAHAM: I objected to the leading.

13 THE COURT: Leading? Sustained.

14 MR. GRAHAM: Thank you.

15 BY MS. GANES:

16 Q: Can you tell the jury a little bit about the effect that  
17 this would have on the baby with regard to its viability or  
18 its general overall well-being?

19 A: Well, essentially what's happening in the situation is  
20 like cutting the air supply off to the diver. The diver is  
21 then holding his breath. And so therefore you have a certain  
22 amount of time to affect something to happen so the baby can  
23 then breathe. Okay?

24 Q: And are there also risks to the mother at that time?

25 A: Of course. There is risk of uterine rupture. There's

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1 risk of tears and bodily injury to the mother. So yes, all of  
2 these things are taken into account during the delivery of an  
3 infant.

4 Q: And, Dr. Smithson, when you are presented with the  
5 shoulder dystocia during delivery, do you have any idea how  
6 long it's going to take to get that baby delivered?

7 A: You have no idea, and that's the scariest part about it.  
8 You don't know what it's going to take, you don't know how  
9 long it's going to take, and you're not sure which maneuver is  
10 going to eventually release the shoulders and allow the baby  
11 to be born. And so, therefore, over time and improvement in  
12 medical literature, we have come up with the maneuvers that  
13 safely help deliver a child in the best possible manner when  
14 you run into these things.

15 Interestingly though, dystocias are going up. The number  
16 of dystocias we see on -- on a monthly basis are going up. We  
17 think that has to do with bigger babies. We think it has to  
18 do with bad nutrition, the way we eat today. And in spite of  
19 our improvement in our delivery methods, the number of  
20 brachial plexus injuries has not changed over the last 30 --  
21 40 years.

22 MR. GRAHAM: May we approach, Your Honor?

23 THE COURT: You may.

24 (WHEREUPON, a bench conference was held in the presence  
25 of the jury but out of the hearing of the jury as

1 follows.)

2 MR. GRAHAM: They're getting into new opinions and he got  
3 it out before I could object, but we would ask that this line  
4 of questioning be stopped.

5 THE COURT: About what?

6 MR. GRAHAM: What he just said. That -- that the rate of  
7 dystocias is not -- I mean the rate of injuries has not gone  
8 down despite better maneuvers.

9 MS. GANES: I think he said exactly that in his  
10 deposition, but I can --

11 THE COURT: Anyway, I'm not sure that's even an opinion  
12 about what this doctor did.

13 MS. GANES: Right.

14 THE COURT: He just stated a fact. I don't see that as  
15 an opinion as to standard of care.

16 MR. GRAHAM: And what we -- we were -- we were precluded  
17 from testimony through Pliskow and especially Resnick about  
18 facts that they saw on the video.

19 THE COURT: The only thing I precluded is new opinions,  
20 not facts.

21 MR. GRAHAM: You didn't let Dr. Resnick talk about  
22 whether lateral traction was depicted on the video.

23 MS. GANES: That's because he was not an obstetrician.  
24 He was a neurologist.

25 MR. GRAHAM: But because he's a neurologist, he knows

1 what lateral traction is.

2 THE COURT: He's a gynecologist and an obstetrician.  
3 He's just stating a fact about it. I don't think it was a new  
4 opinion about anything to do with the standard of care or  
5 breach or anything.

6 MS. GANES: Thank you, Your Honor.

7 (WHEREUPON, the bench conference ended and the  
8 proceedings resumed as follows.)

9 BY MS. GANES:

10 Q: All right. Dr. Smithson, I'm sorry. If you remember  
11 where you were, go ahead, please.

12 A: So unfortunately, when you get into this situation, it is  
13 truly an emergency because it's not like you can all of a  
14 sudden say, okay, I'm going to send you home, come back next  
15 week or I can transfer you to somebody that's better at this  
16 or somebody that's, you know, a level I nursery or whatever.  
17 Something has to be done in a very rapid manner. Okay?

18 And, you know, years ago we used to pull and tug and do  
19 everything else, but as we've gotten better and better with  
20 medical knowledge, we've come to realize that, of course, that  
21 poses harms and neglects to mother and the baby. And so over  
22 the years we've come up with these numerous maneuvers which do  
23 things like -- you've heard the term I'm sure already  
24 McRoberts maneuver.

25 McRoberts maneuver is when you basically take the

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1 mother's legs and really pull them back. And what that does  
2 is it helps separate this smallest diameter that you have  
3 between the bones. Okay? So that in and of itself, realizing  
4 that has -- will resolve probably 60 percent of your  
5 dystocias.

6 So what you do is is you're providing the gentle  
7 traction, you're providing the axial traction in the manner  
8 like I said. It's all horizontal, but going in this  
9 direction. You get mother back to help open the pelvis up,  
10 and you try those things. Okay? You know you've got time so  
11 you want to see if the baby is going to resolve to a position  
12 that will then allow the shoulders to slip through.

13 Then if that doesn't work, the next step is called  
14 suprapubic pressure, and I believe in the video you saw some  
15 evidence of the nurse trying to give suprapubic pressure, all  
16 the while McRoberts is still going on and the gentle traction  
17 is going on and the baby is potentially moving or the shoulder  
18 is moving or whatever. So ultimately we don't know what  
19 ultimately caused the baby to be delivered, but the good news  
20 is is that it happened and it happened fairly quickly, in I  
21 think about 45 seconds.

22 But if those two things don't work -- but they do work  
23 80+ percent of the time together -- then you start looking at  
24 other more extreme measures. You look at going in and doing  
25 what's called a corkscrew or a rotational maneuver where the

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1 obstetrician tries to get their hand in around the head and go  
2 up here and try to see if they can move the shoulder either  
3 way to get it to come out from behind the pubic bone. The  
4 same thing on the backend as well if the shoulder is stuck up  
5 here. Okay?

6 So you try to change the angle of the way the baby is  
7 coming down. Okay? Then if that doesn't work, then you do  
8 something called a posterior arm delivery where you reach in  
9 -- and understand, this is all difficult stuff to do because  
10 you're not working in a very -- you're working in a very tight  
11 space. But you reach in and you kind of try to grab the  
12 baby's hand or forearm and sweep it across the chest and  
13 deliver the posterior arm so the shoulder is like that. That  
14 thereby decreases the diameter of the shoulders.

15 Once you get to that maneuver and it still has not  
16 worked, then you're looking at very extreme measures where  
17 additional force must be applied or we must try to push the  
18 baby's head back in and rush off and do a C-section. These  
19 are -- these are where babies are not going to do very well  
20 and, fortunately in this case, we didn't get near to that  
21 extreme.

22 Q: And, Doctor, is it appropriate to use McRoberts and  
23 suprapubic pressure to deliver a baby before going to the  
24 internal maneuvers?

25 A: Oh, very much so. Again, I mean using these maneuvers,

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1 there's usually not an immediate effect. You know, a lot of  
2 times the nurse may come in and, when they're putting  
3 suprapubic pressure, what they're trying to do is they're  
4 trying to slide off the pubic bone and they're trying to push  
5 this shoulder either one way or the other or even potentially  
6 downward. Okay?

7 Now, that does a number of things. Number one, it can  
8 decrease or it can make the baby's shoulders come in like  
9 this, which decreases the diameter. But number two, you're  
10 also relieving any kind of pinching or any of the stretching  
11 on the brachial plexus itself. And so therefore, that's a  
12 maneuver that we use very early in these situations in order  
13 to try to affect delivery because we know it doesn't do  
14 anything bad to the baby.

15 Q: All right. And, Dr. Smithson, does -- does the  
16 suprapubic pressure applied hurt the brachial plexus in any  
17 way?

18 A: No, no. In fact, it's decreasing the stretch that's on  
19 the brachial plexus and so, therefore, what you're trying to  
20 do is you're trying to get this shoulder underneath or move it  
21 one way or another and many times it takes numerous attempts  
22 to do that, you know. Sometimes we'll try it, but the  
23 physician knows where the shoulder is and can feel kind of  
24 what's happening with the suprapubic pressure, and the  
25 physician may tell the assistant or the nurse or whoever is in



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1 there to try coming in from a little bit of an angle or from  
2 the other angle or something like that because they can feel  
3 the shoulder start to move a little bit.

4 So it's not an exact science by any stretch. You know,  
5 you're kind of trying to see what the baby will let you do.

6 Q: Now, Dr. Smithson, when -- do you order McRoberts in your  
7 practice as an obstetrician?

8 A: Yes, ma'am. Yeah, very much so.

9 Q: And do you order suprapubic pressure in your practice as  
10 a physician?

11 A: I do.

12 Q: Now, when you order it, would it be a nurse who is  
13 helping you with those maneuvers?

14 A: A nurse, resident or medical student.

15 Q: Okay. Now, when you order those maneuvers during a  
16 shoulder dystocia, do you stare at what's being done or stand  
17 there and inspect what's being done?

18 A: No. I'm continuing to try to figure out from my aspect  
19 what the baby is going to give me. The tension, the axial  
20 direction, the baby is not moving. Okay. So let's try the  
21 McRoberts. So then we try the axial traction again in a  
22 gentle fashion to try to see if that's going to help the  
23 shoulders slip underneath the pubic bones.

24 Then we try the suprapubic pressure, all the while still  
25 having mom -- well, you try it sometimes. You try it with

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1 suprapubic pressure when she pushes to see if the additional  
2 force or the main force that's driving the baby out of the  
3 birth canal -- if we can get the shoulder to move while she's  
4 pushing, great, but if that doesn't work, you try to see if  
5 you can do it when the uterus is not contracting or when mom  
6 is not pushing to see if it's relaxed a little bit. That  
7 would then allow the shoulder to slip underneath the pubic  
8 bone.

9       So it's a -- you don't ever know. It's a very individual  
10 thing for each delivery how you figure out what's going to  
11 work to get the baby out.

12 Q: And, Dr. Smithson, is it appropriate and reasonable for  
13 the physician to reposition the resident or the nurse who is  
14 giving the suprapubic pressure if it's not effective the first  
15 time?

16 A: Very much so because, you know -- and sometimes we'll  
17 even reposition the patient. So very much so. It's a matter  
18 of trying to figure out in that particular case how we can get  
19 this baby's shoulders unstuck.

20 Q: Okay. Is there anything else you want to show the jury  
21 on these?

22 A: I don't think so.

23 Q: Okay.

24 MS. GANES: Your Honor, may he return to the witness  
25 stand?

1 THE COURT: Yes.

2 MS. GANES: Thank you.

3 (WHEREUPON, the witness complied.)

4 THE WITNESS: Here's your pointer.

5 MS. GANES: Thank you.

6 BY MS. GANES:

7 Q: All right. Dr. Smithson, did you review the video in  
8 this case of the birth?

9 A: I did.

10 Q: And just to help the jury if they haven't seen a birth of  
11 a baby or been in the delivery room, does the video of the  
12 birth of Julia B depict what a normal delivery of a baby  
13 looks like?

14 A: If I had not known there was a potential issue that  
15 happened with an infant, I would've looked at this video and  
16 to me it looked like almost every other delivery I've ever  
17 been involved in.

18 Q: Would watching the video help you to show the jury some  
19 of the things that happened in this delivery in accordance  
20 with the things that you've shown on the blowup?

21 A: I think I might be able to explain it step-by-step a  
22 little easier, if it's okay with them, to show the axial  
23 traction that was applied was consistent. Let's kind of walk  
24 through it.

25 MS. GANES: Okay.

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1 THE WITNESS: Can everybody see it?

2 THE COURT: See if we can dim the lights.

3 MS. GANES: And you just tell him where to stop if you  
4 want to explain what's being shown on the video.

5 THE WITNESS: Okay.

6 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
7 video, was played in open court.)

8 THE WITNESS: All right. Stop for one moment.

9 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
10 video, was stopped.)

11 BY MS. GANES:

12 A: Now, right here, if you've ever been in delivery or had a  
13 baby yourself, oftentimes when baby -- this is what we call  
14 crowning. And when baby's head is crowning, you know, a lot  
15 of times it can take a little bit of effort on the mom's part  
16 to get the baby's head to come on out.

17 Now, there are numerous variables involved in this. How  
18 well is mother able to push? If she has an epidural,  
19 sometimes that takes some of the sensation away so they're not  
20 able to push as well.

21 So there's a lot of factors that go into this, but  
22 basically what we're looking at here is Dr. Browning's hand is  
23 on the baby's head to help ease the baby's head out because  
24 you don't want it exploding through there and tearing mom up  
25 real bad. So one of the things we do is we put a little bit a

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1 counter pressure against the baby's head to help ease it out  
2 in a gentle fashion. So that's what he's doing right here.

3 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
4 video, resumed playing.)

5 BY MS. GANES:

6 A: And now, there he takes his hands off the baby and you'll  
7 see when the baby's head comes out, the baby's head will what  
8 we call restitute right there. Okay? Now, stop it right  
9 there.

10 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
11 video, stopped playing.)

12 BY MS. GANES:

13 A: Now, what he's doing right there is, again, well within  
14 the standard of care. He's moving the baby's head to check  
15 around the neck to see if there's a nuchal cord there, which  
16 means the cord is wrapped around the neck. The problem with  
17 that is is it further constricts blood flow to the infant and  
18 can cause issues. And on top of that, you don't know how long  
19 the umbilical cord is and so it may be keeping the baby --  
20 holding the baby back if it's real taut.

21 Q: Dr. Smithson, will you stand so they can see the gestures  
22 you're making?

23 A: Sure. (Gesturing.) So you move the baby's head up and  
24 down a little bit, but that's well within the standard of care  
25 as well. And you feel and if there's a nuchal cord there and

1 you're able to, you want to do what we call reduce that. You  
2 want to get rid of that so there's no impingement in the  
3 baby's birth being done because this cord is tangled up with  
4 the baby. Okay? So that's what he's doing right there. All  
5 right.

6 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
7 video, resumed playing.)

8 BY MS. GANES:

9 A: So once that happens -- now, here he's directing the  
10 axial traction or tension in that downward fashion that is  
11 directly on plane with the baby's spine. That's why we call  
12 it axial traction.

13 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
14 video, stopped playing.)

15 BY MS. GANES:

16 Q: Is that appropriate and reasonable?

17 A: That's -- that's exactly what we're trained to do and  
18 that is well within the standard of care because, again, we  
19 are not -- if he was to pull straight out, you're pulling the  
20 shoulder against the pubic bone. Right? And so therefore,  
21 you want to kind of try to guide the forces of the mother  
22 downward and put the gentle traction in a plane where you're  
23 not stretching or pulling on anything inappropriately.

24 You're -- you're -- the mother's forces are being pushed  
25 on the entire baby. You're just trying to do the steering

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1 wheel thing. You're trying to guide those forces in a way  
2 that's appropriate. And this to me looks very appropriate.  
3 All right. Go ahead, Ben.

4 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
5 video, resumed playing.)

6 BY MS. GANES:

7 A: Now, see, the force never changes. I mean -- stop it,  
8 just a minute, Ben.

9 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
10 video, stopped playing.)

11 BY MS. GANES:

12 A: You know, we always talk about this nebulous thing,  
13 gentle traction. Well, how do you describe that? How do we  
14 define that? And all I can tell you is it's like trying to  
15 figure out how you can describe how hard you stand on the  
16 brake pedal to stop your car. Do you have a number in mind?  
17 Do you have any idea? No. You just -- you just know, you  
18 know, and Dr. Browning has delivered probably more babies than  
19 I have. And over the course of your training and experience,  
20 you realize the weak points in the baby and you realize the  
21 amount of traction that you usually need to use in order to  
22 affect the delivery.

23 What he's noticing here is is what his normal traction or  
24 tension is that he puts on a normal delivery is not working.  
25 Okay? Now, that doesn't mean he increases it. It just means,

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1 okay, this is not working; so therefore we've got to do  
2 something extra. Okay.

3 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
4 video, resumed playing.)

5 BY MS. GANES:

6 A: So he stops..

7 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
8 video, stopped playing and then resumed playing.)

9 BY MS. GANES:

10 A: And here I believe they're putting her more into -- okay.  
11 And --

12 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
13 video, stopped playing.)

14 BY MS. GANES:

15 Q: Now, I want to back up just a little bit and I want to  
16 ask you two questions on this. Did you see the nurse's hands  
17 administering the suprapubic pressure in that?

18 A: I did. It went a little faster than I wanted it to, but  
19 yeah.

20 Q: Okay. Now, did you also see the nurse's hands move away  
21 from the suprapubic pressure?

22 MS. GANES: If we back it up real quick?

23 THE WITNESS: Go ahead and play that again, yeah.

24 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
25 video, resumed playing and then stopped.)



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1 BY MS. GANES:

2 A: And see, he doesn't seem to exert any more strength or he  
3 doesn't bow up. He doesn't get down and pull. He doesn't do  
4 anything like that. He is maintaining a steady level of  
5 tension on that baby's head to try to affect the delivery.

6 Now, what is kind of muddled in all that is he's also --  
7 the nurses also have the mother in the McRoberts maneuver to  
8 help open the pelvis up and then the hands that you're seeing  
9 there is the suprapubic pressure.

10 Now, I'm afraid in the nurse's testimony in her  
11 deposition she said that she put it right on the pubic bone,  
12 which, if anything, is going to do minimal because you can't  
13 compress the pelvis. But then I guess she in the second push  
14 or in the fourth push or third push, however you want to  
15 define it, it was redirected and then, as best we can tell in  
16 the video, the baby's shoulder slid underneath the pubic bone  
17 and the -- and the delivery was successful.

18 Q: Now, Dr. Smithson, can any type of suprapubic pressure,  
19 whether you think it was applied correctly or not, cause a  
20 brachial plexus injury?

21 A: No. At worst, it does nothing.

22 Q: Okay.

23 A: You know, if she were to be pressing on the bone, it does  
24 nothing at all, but if she then redirects the forces above the  
25 pubic bone onto the soft tissues, the only thing it's going to

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1 do is either nothing or it's going to move the baby's shoulder  
2 one direction or another or compress it a little bit to where  
3 the shoulder diameter is decreased.

4 Q: And over the course of 45 seconds, would 2 to 3 seconds  
5 of suprapubic pressure before repositioning have any effect on  
6 Julia B 's delivery?

7 A: Not at all.

8 Q: Okay. And when the suprapubic pressure was being applied  
9 on the video, did you see that Ms. Byrd was still in  
10 McRoberts?

11 A: Yes. I mean it looked like her thighs were hyperflexed,  
12 yes.

13 Q: And is that within the standard of care?

14 A: Yes.

15 Q: Is that reasonable and appropriate?

16 A: Very.

17 Q: Did you see anything on the video of Julia B 's  
18 delivery that was not within the standard of care?

19 A: I saw nothing that was below the standard of care in this  
20 delivery. Everything was done by textbook.

21 Q: Okay. Would you have done anything differently if you  
22 had been the physician delivering Julia B ?

23 A: No.

24 Q: Did you see any brute force in that video?

25 A: No. I saw gentle axial traction.

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1 Q: Okay. Did you see anything -- did you see Dr. Browning  
2 do this to Julia? (Gesturing.)

3 A: You didn't see any extension of the neck while he was  
4 doing the axial traction.

5 Q: Okay.

6 A: So no.

7 Q: And did you see Dr. Browning do this to Julia?  
8 (Gesturing.)

9 A: No. The most lateral movement you saw of the baby's head  
10 was the minor deflection to get the nuchal cord off, which was  
11 necessary and proper, but after that the angle never changed.  
12 It was in the plane of the spine, which is what we call axial  
13 traction or tension.

14 Q: Okay. Did you notice Dr. Browning's hands in the video?

15 A: Yes.

16 Q: Did you notice any trembling or shaking of his hands?

17 A: No.

18 Q: Did you notice his elbows in the video?

19 A: His elbows were in and directed in an appropriate  
20 fashion.

21 Q: And why do you keep your elbows in and directed in an  
22 appropriate fashion during a delivery of a baby?

23 A: You want to minimize the vector that you're trying to  
24 direct the force and -- and so, therefore, to do that you want  
25 to make it as unidirectional as possible. You don't want to

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1 have one hand pushing too hard one way and one hand pushing  
2 too hard the other way.

3 Q: Did you see Dr. Browning's wrists move in any way  
4 indicating that he was bending Julia's neck at an  
5 inappropriate angle?

6 A: Not at all.

7 Q: Now, once the shoulder dystocia was recognized in this  
8 case, how long did it take Dr. Browning to deliver Julia  
9 Byrd?

10 A: I believe it was approximately 45 seconds.

11 Q: And was that reasonable and appropriate?

12 A: Certainly, yes. If I may say, when these things begin,  
13 you have no idea how long it's going to take and so,  
14 therefore, it's almost like a stopwatch starts as soon as the  
15 baby's head emerges. And when that happens, you realize,  
16 okay, we've got to get this done at some point in time in the  
17 very near future. It is the most unstable time of the mother  
18 and the baby.

19 Q: Dr. Smithson, I'd like to show you what we put into  
20 evidence yesterday for the jury to see when they go back to  
21 deliberate. It's Defendant's Exhibit 4. Can you tell the  
22 jury what this is?

23 A: It appears that it's Dr. Browning right here and those  
24 are his hands at the anterior and posterior position directing  
25 the axial force, which is by the way much, much less than what

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1 mother's internal forces are contributing to the birth of the  
2 baby, and it's directing it in that off-horizontal fashion  
3 that we talked about to try to maximize the diameter of the  
4 bones.

5 Q: And is the placement of Dr. Browning's hands in this  
6 picture appropriate?

7 A: Very much so.

8 Q: And does the placement of Dr. Browning's hands on the  
9 baby's head in this picture meet the standard of care?

10 A: Yes.

11 Q: All right. Doctor, we talked about the American College  
12 of Obstetricians and Gynecologists or ACOG; correct?

13 A: Correct.

14 Q: Now, this booklet that I'm holding, do you know what this  
15 is?

16 A: I do.

17 Q: And can you tell the jury what this is?

18 MR. GRAHAM: Objection, Your Honor. May we approach?

19 THE COURT: You may.

20 (WHEREUPON, a bench conference was held in the presence  
21 of the jury but out of the hearing of the jury as  
22 follows.)

23 MR. GRAHAM: This is totally new. He's gone into all  
24 kinds of other new stuff, but he did not use this at all. Dr.  
25 Ernest did.

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1 MS. GANES: He talked about this in his deposition. That  
2 this was the only literature that he followed was the American  
3 College and this is my last question.

4 THE COURT: Can you find it real quick?

5 MS. GANES: I'm sorry?

6 THE COURT: Can you find it real quick --

7 MS. GANES: Yes.

8 THE COURT: -- in the deposition?

9 MS. GANES: I beg the Court's indulgence, Your Honor.

10 (WHEREUPON, there was a pause in the bench conference,  
11 after which the bench conference continued as follows.)

12 MS. GANES: Your Honor, in the interest of time --

13 THE COURT: Just wait a minute. All right.

14 MS. GANES: In the interest of time, I'm just going to --  
15 he's already said he's a member and I'm going to move on and  
16 we're going to deal with that with our expert. It is in the  
17 deposition. I'll be happy to provide it to you so you'll know  
18 I'm telling you the truth, but I don't want to waste the  
19 jury's time.

20 THE COURT: All right.

21 (WHEREUPON, the bench conference ended and the  
22 proceedings continued as follows.)

23 MS. GANES: All right.

24 BY MS. GANES:

25 Q: Dr. Smithson, are you a member of the American College of

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1 Obstetrics and Gynecology?

2 A: American Congress now, but, yeah, it used to be American  
3 College.

4 Q: All right. And do they publish literature that you  
5 review?

6 A: Certainly, yeah.

7 Q: All right. Have all of the opinions that you have  
8 provided to this jury been to a reasonable degree of medical  
9 certainty?

10 A: Yes. All my opinions are based on the knowledge, the  
11 literature that's available to us all as  
12 obstetrician/gynecologists, and of course my experience as  
13 well in an effort to -- to safely deliver as many babies as we  
14 can.

15 MS. GANES: Thank you, Dr. Smithson. If you'll answer  
16 any questions that Mr. Graham has.

17 THE COURT: I have one question for you. Are you moving  
18 to have item Number 4 put into evidence?

19 MS. GANES: I think it was already in evidence, Your  
20 Honor.

21 THE COURT: It's not.

22 MS. GANES: Certainly, Your Honor. I would move -- I  
23 would move this into evidence at this time.

24 THE COURT: All right. Any objections?

25 MR. GRAHAM: I'm sorry, Your Honor?

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1 THE COURT: Any objections?

2 MR. GRAHAM: Oh, no, Your Honor.

3 THE COURT: All right. Number 4 is into evidence.

4 (WHEREUPON, Defendant's Exhibit Number 4, a photograph,  
5 was admitted into evidence.)

6 MS. GANES: Thank you.

7 THE COURT: All right. Cross-examination?

8 MR. GRAHAM: Thank you, Your Honor.

9 CROSS-EXAMINATION

10 BY MR. GRAHAM:

11 Q: Good morning, Dr. Smithson.

12 A: Good morning, Mr. Graham.

13 Q: You told us that you have delivered over 6,000 babies?

14 A: Correct.

15 Q: How many times have you encountered shoulder dystocia?

16 A: Well, that depends on the definition of shoulder  
17 dystocia, which I'm sure we'll get into, but I would have to  
18 say well over 100 times.

19 Q: When you manage shoulder dystocia, do you pull on the  
20 baby's head?

21 A: We provide gentle axial traction as your initial maneuver  
22 to deliver any baby.

23 Q: All right.

24 A: And then once the dystocia is recognized, the additional  
25 maneuvers plus the axial traction hopefully will affect the



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1 delivery of the baby.

2 Q: When did you start using the word traction in your  
3 practice?

4 A: It's the common nomenclature that people use. I prefer  
5 to use the word tension or force when I'm discussing it with  
6 residents and medical students.

7 Q: So when you're managing shoulder dystocia, do you take  
8 care to keep the baby's head in the axial plane when you're  
9 providing tension or traction or whatever word you want to  
10 call that pulling activity?

11 A: Yes. That's within standard of care, yeah.

12 Q: All right. You're careful to apply axial traction only?

13 A: Yes. We're aware that lateral traction can cause damage  
14 to the brachial plexus and neck nerves in the infant.

15 Q: Yes, sir.

16 A: As I call it to the residents and medical students, it's  
17 the weak point.

18 Q: Yes, sir. The brachial plexus nerves are the weak point  
19 in every baby?

20 A: Every baby.

21 Q: When you manage a stuck shoulder, do you take care to use  
22 only gentle guidance as opposed to forceful pulling and  
23 stretching of the baby's neck?

24 A: We all have our limits, yes.

25 Q: What --

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1 A: Gentle traction or tension is -- yes, is what we utilize,  
2 yes.

3 Q: All right. And you take care to not use more than that  
4 gentle guidance?

5 A: Because we know any more than that will not do any good.

6 Q: Yes, sir. And any more than that can cause life-changing  
7 injury to the baby; true?

8 A: It potentially could, yes. It doesn't always, but it  
9 potentially could.

10 Q: Yes, sir. And when you manage a stuck shoulder, do you  
11 take care not to stretch the baby's neck?

12 A: That's not what we're talking about. There is natural  
13 stretch in the baby's neck from the cardinal movements of  
14 labor. That's not what we're speaking of. What we're  
15 speaking of is lateral traction that puts additional force and  
16 tension on the brachial plexus. Stretching the baby's neck  
17 does nothing.

18 Q: Do you take care, sir, in your management of a stuck  
19 shoulder to not add extra stretch to a baby's neck by pulling  
20 down?

21 A: In every delivery, we do that. In this delivery, it was  
22 done.

23 Q: All right. I'm asking about your practice, sir, your  
24 practice. Do you take care --

25 A: Of course.

1 Q: -- to avoid adding extra stretch to the neck --

2 A: Now, lateral traction --

3 Q: -- to avoid --

4 A: -- is what we avoid.

5 Q: And you -- you're careful to avoid it?

6 A: Yes.

7 Q: All right.

8 A: Obstetricians are.

9 Q: Given -- given your care in avoiding forceful pulling and  
10 downward traction, it sounds to me like you might be pretty  
11 good at managing a stuck shoulder. How many permanent  
12 injuries have you caused?

13 A: As far as I know, I have had one permanent injury. I  
14 didn't cause it, but I --

15 Q: All right.

16 A: -- have had one permanent injury in a delivery that I've  
17 had.

18 Q: Well, let me -- let me ask you now. I'm talking about a  
19 top shoulder. I'm not talking about some other situation that  
20 doesn't fit with the facts of this case. In terms of a top  
21 shoulder being injured, how many times have you caused a  
22 permanent injury?

23 A: I've never caused any permanent injury.

24 Q: How many times has a baby been born on your watch with  
25 nerve damage in the top part of the neck?

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1 A: There have been I would say 5 to 10 cases of temporary  
2 Erb's palsy in infants that we have delivered, but -- and  
3 unfortunately, I don't have appropriate follow-up with all of  
4 them, but from my -- from what I know, they resolved with  
5 time.

6 Q: The question, sir, to the best of your knowledge, have  
7 you ever delivered a child with a stuck shoulder where the top  
8 part of the neck had permanent nerve damage?

9 A: I do not have knowledge of that ever happening, no.

10 Q: Let's talk about the standards of care. Standards of  
11 care for obstetricians are there for the purposes of patient  
12 safety; true?

13 A: One of the -- one of the caveats, yes.

14 Q: Yes, sir. The obstetrical standards of care absolutely  
15 forbid using more than gentle traction; true? In a shoulder  
16 dystocia situation, stuck shoulder?

17 A: That's not true.

18 Q: Okay. In the first 45 seconds, the standards of care  
19 absolutely forbid more than gentle traction on the head;  
20 true?

21 A: I don't know if there's even a standard of care for that,  
22 but reasonably trained physicians, you know, the normal and  
23 prudent physician in this particular circumstance, in the  
24 first 45 seconds you utilize the first two or three maneuvers  
25 in order to try to affect delivery. So I couldn't see how

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1 excessive traction would be warranted in that case.

2 Q: Of course, it's not warranted. The question, sir, is do  
3 you agree that the standards of care absolutely forbid using  
4 more than gentle traction in the first 45 seconds after the  
5 head comes out?

6 A: I don't think there's any absolutes in any of this, Mr.  
7 Graham.

8 (WHEREUPON, there was a pause in the proceedings.)

9 THE COURT: Mr. Graham, one of the jurors let me know  
10 they need a restroom break.

11 MR. GRAHAM: Yes, sir.

12 THE COURT: Are you okay with taking a --

13 MR. GRAHAM: Absolutely.

14 THE COURT: All right. Members of the jury, if you  
15 would, step in there. And, Mr. Foreman, if you'd just knock  
16 on the door when you're ready, we'll come right back.

17 (WHEREUPON, the jury exited the courtroom at 10:43 a.m.)

18 THE WITNESS: May I take one too, Your Honor? Your  
19 Honor? I'm sorry. May I take a break too?

20 THE COURT: But you cannot talk to anybody. When you get  
21 done, come right back and have a seat.

22 THE WITNESS: Yes, sir.

23 THE COURT: All right.

24 (WHEREUPON, there was a break in the proceedings from  
25 10:43 a.m. until 10:56 a.m., after which the proceedings

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1 resumed as follows.)

2 THE COURT: Let's go ahead and bring out the jury.

3 MR. GRAHAM: Your Honor, may I -- may I mention something  
4 first?

5 THE COURT: Yes.

6 MR. GRAHAM: During -- when I was stumbling around  
7 looking for an original deposition when you called to my  
8 attention that there needed to be a bathroom break, it just --  
9 several things just became clear to me. Our original -- our  
10 file with the witness's original transcript no longer has the  
11 original transcript. It has the original video, but during  
12 the last trial we put in the original transcript.

13 THE COURT: Do y'all have any problem with him using the  
14 copy? The defense? Is that what you're getting to?

15 MS. GANES: Well, I think the originals are here. I mean  
16 we've been in touch with Melissa all week about them. She's  
17 got it.

18 MR. GRAHAM: Yeah.

19 THE COURT: We'll get it for you.

20 MR. GRAHAM: I noticed that Ms. Craig yesterday or  
21 sometime this week shared one with Dr. Pliskow or Dr. Resnick.

22 MS. GANES: I don't have any objection to however he  
23 needs to do it. I'm not going to make an objection on the  
24 seal or anything.

25 THE COURT: As long as you use it for impeachment

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1 purposes the proper way, I have no problem with using -- if  
2 you'll give him that deposition?

3 MR. GRAHAM: Okay.

4 THE COURT: You can do it. Let's go ahead and bring out  
5 the jury in the meantime.

6 MR. GRAHAM: Thank you.

7 (WHEREUPON, the jury entered the courtroom at 10:57 a.m.)

8 BY MR. GRAHAM:

9 Q: Before the interruption, sir, for that last break, I was  
10 just -- just to get us all back to where we were, I was asking  
11 you, sir, focusing right this second on the amount of  
12 traction, do you believe the standard of care requires that in  
13 a shoulder dystocia situation within 45 seconds after delivery  
14 of the head that no more than -- no more traction should be  
15 used than normal gentle traction on the baby's head?

16 A: I agree.

17 Q: More -- do you agree that more than gentle traction is a  
18 standard of care violation?

19 A: In this particular case, based on the evidence, it was  
20 normal gentle axial traction that was applied.

21 Q: Do you -- do you recall my question, sir?

22 A: Please repeat it.

23 Q: I'm not asking you for your interpretation of this case.  
24 I'm asking you about standards of care.

25 A: Within standard of care, gentle axial traction is

1 justified.

2 Q: More than gentle axial traction is a violation of the  
3 standard of care for obstetricians; true?

4 A: It can be, yes.

5 Q: And in -- in the first 45 seconds of a delivery, it would  
6 certainly be a violation?

7 A: In this particular case, there was no violation.

8 Q: I'm asking about the standards of care, sir, not for your  
9 opinions about this case. If within 45 seconds -- in a stuck  
10 shoulder situation, if within 45 seconds after the head  
11 delivers if a doctor in any delivery were to use more than  
12 gentle axial traction, that would violate the standards of  
13 care; true?

14 A: In a hypothetical situation, lateral traction greater  
15 than gentle traction could potentially be a violation of the  
16 standard of care, yes.

17 Q: So if -- if in that 45 seconds lateral traction is used  
18 rather than axial traction, the lateral traction itself would  
19 be a violation of the standard of care; true?

20 A: Inappropriate lateral traction, yes, would probably be a  
21 violation of standard of care.

22 Q: Well, it is a violation of the standard of care; true?

23 A: But in this particular case, there was no lateral  
24 traction; so there was no violation of standard of care. In a  
25 hypothetical situation, yes.



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1 Q: In the 45 seconds after a head delivers, if a doctor uses  
2 lateral traction instead of axial traction, that violates the  
3 standards of care; true?

4 A: Yes.

5 Q: Thank you. If gentle guidance, gentle axial guidance, of  
6 the baby's head does not release the top shoulder behind the  
7 mom's pubic bone, the standard of care requires the  
8 obstetrician to refrain from increasing the pulling force;  
9 true?

10 A: Well, the main force is the maternal forces pushing the  
11 baby. As the guiding force, we can't do anything near to what  
12 the maternal forces can do to expel the baby.

13 Q: Do you -- did you understand my question, sir?

14 A: Yes. I am answering the question, yes.

15 Q: Please try to answer the question. If gentle axial  
16 traction on the baby's head is insufficient to deliver the top  
17 shoulder, the doctor must refrain from increasing the pulling  
18 force and go to an internal maneuver; true?

19 A: No. That's not true. The first thing that you would do  
20 would be McRoberts maneuver and continue with maternal pushing  
21 and with gentle axial traction. If that does not work, then  
22 you proceed to suprapubic pressure.

23 Q: Thank you for that clarification. If -- if McRoberts,  
24 suprapubic pressure, and gentle axial traction are  
25 insufficient to deliver the top shoulder, the standards of

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1 care require the doctor to refrain from increasing the pulling  
2 force and instead use an internal maneuver; true?

3 A: If you get to that point, yes.

4 Q: Failure -- at that point, failure to switch to an  
5 internal maneuver is a standard of care violation; true?

6 A: Not true.

7 Q: Increasing the pulling force at that point rather than an  
8 internal maneuver is a standard of care violation; true?

9 A: What you're asking is -- what you're not asking is the  
10 definition of how long do you let these procedures go to see  
11 if they're going to work. And in this particular case, they  
12 happened to work in 45 seconds. You don't violate standard of  
13 care by waiting longer than that to go to internal maneuvers.

14 Q: Sir, do you remember when I took your deposition in this  
15 case?

16 A: Kind of, yes.

17 Q: Yes, sir. It was at the Williams Hendrix Law Firm in  
18 Lexington, South Carolina?

19 A: I believe. And I believe you were stuck here in  
20 Orangeburg with a flat tire if I recall.

21 Q: And it took place on July 20<sup>th</sup> of 2015?

22 A: Okay.

23 Q: Okay. And you were represented by one of the members of  
24 the Hood Law Firm?

25 A: I believe it was Ms. Ganes was there.

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1 Q: All right. And you were under oath at that time?

2 A: Correct.

3 Q: Just like you're under oath today?

4 A: Correct.

5 Q: Okay.

6 MR. GRAHAM: Your Honor, may I hand up --

7 THE COURT: Sure.

8 MR. GRAHAM: -- the original deposition and the original  
9 video? Dave, would you please queue up at page 103, line 4  
10 through 18?

11 Dr. Smithson, please watch the questions and answers on  
12 the video and then I'll ask you if the video is an accurate  
13 reflection of what you testified to during the deposition.

14 (WHEREUPON, the deposition transcript was marked as  
15 Court's Exhibit Number 11 and the video of the deposition  
16 of Dr. Smithson was marked as Court's Exhibit Number 12.)

17 (WHEREUPON, the indicated deposition portion began  
18 playing in open court, transcribed as follows.)

19 MR. GRAHAM: Assuming a situation where McRoberts,  
20 suprapubic pressure, and normal gentle traction are  
21 insufficient to deliver the anterior shoulder, does the  
22 standard of care require the doctor to go to one of the  
23 internal maneuvers?

24 THE WITNESS: I would say our training and expertise  
25 tells us that, yes.

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1 MR. GRAHAM: All right. And does the standard of care  
2 also require that the doctor refrain from using greater  
3 than normal gentle traction in that situation?

4 THE WITNESS: I would say yes. The standard of care  
5 would expect one to not use excessive tension or traction  
6 at that point in time.

7 MR. GRAHAM: Okay.

8 (WHEREUPON, the video deposition stopped playing.)

9 BY MR. GRAHAM:

10 Q: Dr. Smithson, did that video --

11 MS. GANES: Excuse me, Your Honor. I'm going to object.  
12 That playing of the video was consistent with what this  
13 witness testified to the jury. This is an improper use of the  
14 deposition for impeachment.

15 THE COURT: Overruled. Go ahead.

16 MR. GRAHAM: Thank you, Your Honor.

17 BY MR. GRAHAM:

18 Q: Dr. Smithson, did that video accurately reflect the  
19 question that I posed and the answer that you gave?

20 A: Well, first off, your question wasn't very accurate.  
21 Secondly, that's exactly what I've said up here today and that  
22 is progressing through the maneuvers giving them ample time.  
23 Once you realize that the gentle traction is not going to  
24 further the cause of delivering the baby, then you move on  
25 from that. That's exactly what I said in the video and what

1 I've said today.

2 Q: Doctor, please listen to my question. I don't think it's  
3 a challenging question. Did the video accurately reflect my  
4 question and your answer?

5 A: No. It didn't reflect your question because you're  
6 asking a different question today. Your question today -- and  
7 if I may ask, where in the deposition, what line and page  
8 again?

9 Q: Would you rather read it rather than see it on the video,  
10 sir? Would you like me to read my question and see if you can  
11 answer it --

12 A: It makes no difference.

13 Q: -- the way you answered at the time?

14 A: You're asking --

15 MS. GANES: Your Honor?

16 A: -- a different question today.

17 MS. GANES: I'd ask that you follow the rules related to  
18 the deposition and give the witness the page and line.

19 THE COURT: I think it's already been done.

20 MR. GRAHAM: We've already done it.

21 THE COURT: We've already done it. Go ahead and ask your  
22 next question.

23 BY MR. GRAHAM:

24 Q: Sir, you define -- you've used traction and tension and a  
25 number of words today to describe that pulling force, but

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1 let's talk about how you define the word traction. How is the  
2 term traction properly defined in the obstetrical literature?

3 A: I would say traction would be defined as a force that is  
4 exerted -- in this particular case or in obstetrics, a force  
5 that is exerted by the obstetrician on the infant. Is that  
6 what you're asking for?

7 Q: I'm asking you for your definition of traction in the  
8 shoulder dystocia context.

9 A: Traction to me is force exerted by the obstetrician in  
10 aiding the guidance of the infant out of the birth canal.

11 Q: Do you agree that traction in obstetrics is a pulling  
12 force that stretches an object or elongates an object?

13 A: No.

14 Q: You disagree with that?

15 A: Excessive traction potentially causes deformity, but  
16 gentle axial traction does not cause any appreciable --  
17 appreciable deformity in the infant whatsoever.

18 Q: So you disagree that the obstetrical literature defines  
19 traction as a pulling force that stretches or elongates an  
20 object?

21 A: May I see that ob -- obstetrical definition in -- in  
22 writing?

23 Q: I'm just asking. I'm asking you if you agree or disagree  
24 with that definition, sir.

25 A: I disagree with that definition, but that's not what's in

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1 the medical literature. You're misrepresenting that.

2 Q: I'm misrepresenting that?

3 A: That's not what the medical literature says.

4 Q: Okay. Well, thank you for telling me that I  
5 misrepresented that, sir.

6 A: Well, if you have it in -- I've never seen that  
7 definition in my medical literature.

8 Q: Moving right along, sir, I realize you -- you don't think  
9 traction is pulling that stretches or elongates an object, but  
10 whatever the definition of traction, pulling on the head is a  
11 standard of care breach; true?

12 A: No.

13 Q: No?

14 A: Axial traction or tension is not a breach of standard of  
15 care. It's what we train every obstetrician to utilize in  
16 delivering an infant.

17 Q: All right. Well, in a shoulder dystocia situation, when  
18 a baby's shoulder is stuck, do you believe it would be  
19 inappropriate for an obstetrician to pull on a baby's head?

20 A: Again, the way that you say the question is so nebulous.  
21 No. It is appropriate to apply gentle axial traction in an  
22 effort to deliver an infant. If you encounter a shoulder  
23 dystocia, you do maneuvers in addition to gentle traction  
24 along the axial plane to try to affect delivery of the infant.

25 MR. GRAHAM: Dave, would you please queue up Dr.

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1 Smithson's deposition at page 48, line 25, through page 49,  
2 line 6? Please read along if you care to, sir.

3 (WHEREUPON, the requested portion of the video deposition  
4 was played in open court. Transcribed as follows.)

5 MR. GRAHAM: Do you believe it would be inappropriate for  
6 an obstetrician to pull on a baby's head?

7 THE WITNESS: Again, it depends on what their definition  
8 is, but pulling on a baby's head when your shoulders are  
9 impacted I believe would probably fall between -- below  
10 the standard of care if you're defining it the same way  
11 that I am, yes.

12 (WHEREUPON, the deposition video was stopped.)

13 BY MR. GRAHAM:

14 Q: Sir, did I -- did that video accurately reflect my  
15 question and your answer?

16 A: It reflected the fact that we have two separate and  
17 different definitions of the word traction. Based on my  
18 definition, that does not cause deformity --

19 Q: Yes, sir.

20 A: It is appropriate and within the standard of care.

21 Q: All right. So I -- in that question, my question was  
22 inappropriate because I used traction differently from how you  
23 use traction?

24 A: No. Earlier you tried to get me to define traction in a  
25 way that it is not defined in the medical literature and I'm



1 using the appropriate definition of traction when I answer  
2 your question, which is traction, gentle axial traction that  
3 does not cause deformity.

4 Q: Okay. So you disapprove of my use of the word traction  
5 in that question?

6 A: I think you're trying to imply what you mean upon what I  
7 say and that's not what I said.

8 Q: All right. I'm going to play that question again and I  
9 want you to find the word traction that you claim I used  
10 inappropriately. Okay?

11 A: I didn't say you used the word inappropriately. I said  
12 you have defined it differently than I have.

13 Q: The truth is I didn't use the word traction in that  
14 question at all, did I, Doctor?

15 A: You just asked me that. Pulling was the word --

16 Q: Right.

17 A: -- that you utilized.

18 Q: You disagree with how I used the word pulling?

19 A: If you define it the way that I define it, which is a  
20 non-deforming traction, tension, pulling, then that is within  
21 the standard of care. As I said, if you're defining it the  
22 same way I am.

23 Q: Check your answer and see if I'm reading it accurately.

24 Answer, starting at line 2:

25 Again, it depends on what their definition is, but

1 pulling on a baby's head when your shoulders are impacted

2 I believe would probably fall between -- below the

3 standard of care if you're defining it the same way that

4 I am, yes.

5 So how are you defining pulling when you said it was a

6 violation of the standard of care?

7 A: Let me be clear. If you are doing nothing but pulling  
8 inappropriately on a baby and not utilizing any other means at  
9 your disposal to deliver that baby in a safe and effective  
10 manner, you fall below the standard of care.

11 If, however, you are applying the maneuvers that we are  
12 trained to utilize and then you reapply gentle axial traction  
13 after using those maneuvers, that is well within the standard  
14 of care.

15 Q: All right. And that's not any part of your answer when  
16 you were sworn to give truthful testimony at your deposition,  
17 was it?

18 A: That is expounding on the exact answer that I just gave  
19 in deposition as well as here.

20 Q: Now, you -- you said earlier that sometimes a baby comes  
21 out so fast that the head just explodes through the birth  
22 canal. Do you remember that?

23 A: I have seen that happen, yes.

24 Q: All right. That didn't happen here, did it?

25 A: No. It's not normal for that to happen, but it does

1 happen.

2 Q: But what did happen here was an explosion of a different  
3 type; correct?

4 A: How so?

5 Q: Okay. When Dr. Browning pulled on Julia's head and  
6 ruptured three nerves, two -- two significantly and one to a  
7 less extent, those nerves exploded, didn't they?

8 A: I don't know if we have any proof of that.

9 Q: Well, they ruptured --

10 A: You know there's an injury, but we don't know the extent  
11 --

12 Q: All right.

13 A: -- or cause or damage that was done.

14 Q: Are you denying that those nerves were --

15 MS. GANES: Excuse me, Your Honor. This is a  
16 neurological opinion and I believe this was Mr. Graham's  
17 motion.

18 THE COURT: Why don't you go ahead and move it on just a  
19 little bit?

20 MR. GRAHAM: Yes, sir.

21 BY MR. GRAHAM:

22 Q: How do you define rupture, sir?

23 A: Rupture of?

24 Q: How do you define rupture of a baby's brachial plexus  
25 nerves?

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1 A: Rupture of a string-like object, like a nerve or a muscle  
2 or something along that line, would be, you know, a pulling  
3 where it separates.

4 Q: Okay.

5 MR. GRAHAM: Dave, would you please queue up page 55,  
6 starting at line 21, through page 56, line 3?

7 (WHEREUPON, a portion of the videotaped deposition was  
8 played in open court. Transcribed as follows.)

9 MR. GRAHAM: Yes, sir. And what is a rupture?

10 THE WITNESS: A rupture to me is more of a compression or  
11 explosion of the nerve from whatever mechanism that  
12 occurs. I have seen it used too as a rupture being a  
13 complete detachment or transeverance of the nerve.

14 MR. GRAHAM: But, sir --

15 THE WITNESS: But that's more of a -- I think I -- I  
16 think I would define that as more of a separation of the  
17 nerve.

18 (WHEREUPON, the deposition video was stopped.)

19 BY MR. GRAHAM:

20 Q: Doctor, did I -- did the video accurately read or  
21 accurately play my question and your answer?

22 A: Yes.

23 Q: Let's be clear, sir. You have no opinion about the most  
24 probable cause of this injury, do you?

25 A: Based on the literature, we think that it is a

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1 multifactorial ideology.

2 MR. GRAHAM: Excuse me. Excuse me, Your Honor.

3 BY MR. GRAHAM:

4 Q: Excuse me, Doctor. I'm really looking for a yes/no  
5 answer and I'll give you a follow-up. You have no opinion to  
6 a reasonable degree of medical certainty as to the most  
7 probable cause of this injury, do you? Please, I think I'm  
8 entitled to a yes or no.

9 A: Okay.

10 MS. GANES: Objection, Your Honor.

11 Q: Yes or no?

12 MS. GANES: The witness is allowed to explain his answer.

13 THE COURT: He can. You can answer yes or no and  
14 explain.

15 BY MR. GRAHAM:

16 Q: Yes or no, sir?

17 A: Could you repeat the question, please?

18 Q: Yes, sir. Sir, do you have an opinion to a reasonable  
19 degree of medical certainty as to the most probable cause of  
20 the brachial plexus nerve damage sustained by the Byrd child?

21 A: I would have to say no.

22 Q: Thank you. When you reviewed the fetal heart monitor  
23 strips in this case, did you see anything to suggest that this  
24 child was not medically stable?

25 A: Okay. You can't combine the two things, but the fetal

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1 heart rate monitor strips showed that the infant tolerated  
2 labor very well.

3 Q: All right. The question, sir, is did the strips suggest  
4 at any time that this child was medically unstable?

5 A: Actually, yes. Early on when she got an epidural and  
6 became a bit hypotensive, the baby's fetal heart rate strip  
7 did show some evidence of fetal distress, for lack of a better  
8 term, but with appropriate measures the fetal heart rate strip  
9 improved.

10 MR. GRAHAM: Dave, please queue up page 85, lines 1  
11 through 3..

12 (WHEREUPON, a portion of the deposition testimony was  
13 played in open court. Transcribed as follows.)

14 MR. GRAHAM: Did you see anything on the strips to  
15 suggest that this child was not medically stable?

16 THE WITNESS: No, I did not.

17 (WHEREUPON, the deposition videotape was stopped.)

18 BY MR. GRAHAM:

19 Q: Sir, did that video accurately reflect my question and  
20 your answer?

21 A: Well, earlier on in my deposition where you did not play,  
22 I mentioned this same exact thing.

23 Q: Sir, did the video accurately reflect my question and  
24 your answer?

25 A: That video accurately depicted that moment in time, yes.

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1 Q: In your opinion then, is it your -- is it your opinion  
2 then that this child was medically stable at all times through  
3 the delivery of the body?

4 A: No.

5 MR. GRAHAM: Dave, could you please queue up page 85,  
6 lines 4 through 10?

7 (WHEREUPON, a portion of the deposition testimony was  
8 played in open court. Transcribed as follows.)

9 MR. GRAHAM: Is it your opinion then that this child was  
10 medically stable at all times through delivery of the  
11 body?

12 MS. GANES: Object to form.

13 THE WITNESS: As best I can tell from the medical record,  
14 yes. The baby seemed to be fine.

15 MR. GRAHAM: Okay.

16 (WHEREUPON, the deposition videotape was stopped.)

17 BY MR. GRAHAM:

18 Q: Sir, did that video accurately reflect my question and  
19 your answer?

20 A: It answered your very pointed question, yes. And I still  
21 agree with that statement, as a matter of fact, because  
22 hindsight we know that the baby was medically stable.

23 Q: I'm sorry. With hindsight, we know that the baby was  
24 medically stable?

25 A: As best we could tell, yes.

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1 Q: All right. And you can say that to a reasonable degree  
2 of medical certainty?

3 A: In hindsight. Of course, we can say that the baby's  
4 Apgars were fine. The blood gases revealed some minor  
5 abnormalities, but in hindsight we can say that the baby was  
6 medically stable. In the midst of a delivery, you cannot say  
7 that.

8 It's no different than somebody who lives through  
9 surgery. When they are in surgery, they are not medically  
10 stable. When they're on a respirator, they are not medically  
11 stable. When they get done with the surgery and they survive,  
12 then you can look back and say they're medically stable.

13 Q: With a 45-second head-to-body interval and Apgars of 9  
14 and 9, this child was not at immediate risk of brain damage or  
15 death, was she?

16 A: Again, you're speaking in hindsight. In the middle of  
17 the procedures, in the middle of the delivery, you have no  
18 idea how this book is going to end.

19 Q: Please answer my question, sir.

20 A: I cannot answer.

21 Q: During those 45 seconds, this child was never at  
22 immediate threat or risk of brain damage, was she?

23 A: This baby was at a threat of immediate risk of brain  
24 damage and death the entire time the baby was stuck.

25 MR. GRAHAM: Dave, could you please queue up Dr.



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1 Smithson's testimony on page 84, lines 9 through -- well, if  
2 Your Honor please, there's a nonresponsive question and then I  
3 asked do you remember the question and then we get the answer.  
4 So I would ask you to read the question that ultimately got  
5 answered from line -- well, why don't you -- why don't you  
6 just play the whole thing? Page 84, lines 9 through 25.

7 (WHEREUPON, a portion of the videotaped deposition  
8 testimony was played in open court. Transcribed as  
9 follows.)

10 MR. GRAHAM: So with a 45-second head-to-body interval  
11 and Apgars of 9 and 9, this child was not at immediate  
12 risk of brain damage or death, was she?

13 MS. GANES: Object to form.

14 THE WITNESS: It's my medical opinion here that Dr.  
15 Browning did very little outside of what he normally has  
16 done in thousands of deliveries and yet we had a bad  
17 outcome and we don't know why necessarily.

18 MR. GRAHAM: Doctor, do you remember the question?

19 THE WITNESS: I do. I mean I don't believe that this  
20 baby was at any increased risk at 30 to 45 seconds out of  
21 neonatal asphyxia or any of the other bad outcomes that  
22 can happen from a severe shoulder dystocia.

23 (WHEREUPON, the deposition videotape was stopped.)

24 BY MR. GRAHAM:

25 Q: Did that video accurately portray my question and your

1 answer, sir?

2 A: Yes, it did.

3 Q: Sir, you told us that you teach others how to deal with  
4 shoulder dystocia?

5 A: I do.

6 Q: Do you teach them that the first thing they need to do is  
7 call for help?

8 A: In our institution, yeah, it's part of a protocol that we  
9 have that -- but in our institution we have enough personnel  
10 that are involved in the delivery that we usually have plenty  
11 of help there.

12 Q: All right.

13 A: But given a situation different than ours, yes, I think  
14 that's certainly the first thing that you would want to do.

15 Q: All right. And as soon as a doctor sees that there's a  
16 stuck shoulder, the first thing the doctor should do after  
17 calling for help is to get the mom to stop pushing; true?

18 A: Well, not always because you don't know that it's a stuck  
19 shoulder until she's been pushing for a while.

20 Q: All right. Listen to the question, sir. As soon as the  
21 doctor sees that there is a stuck shoulder, the first thing he  
22 should do -- he or she should do after calling for help is to  
23 get the mom to stop pushing; true?

24 A: On this particular case, you had two reasons for that.  
25 Number one, you had the initial nuchal cord and so you want

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1 her to stop pushing so you can reduce that cord. And then  
2 after another push, he realized that there was a dystocia and  
3 so, therefore, yes, we quit pushing, McRoberts maneuver, you  
4 begin the maneuvers, and then you have her push with those  
5 maneuvers to see if they're going to be effective.

6 Q: Sir, I'm not asking for your interpretation of what  
7 happened in this case. I'm talking about standards of care.  
8 After a doctor sees that there's a nuchal cord -- a loose  
9 nuchal cord that he just lifts over the head, just like a  
10 towel or something, after he takes the loose cord over the  
11 head and he sees that the shoulder is stuck, the first thing  
12 that doctor should do is get the mom to stop pushing; true?

13 A: No. You don't know you have a stuck shoulder until the  
14 normal regular things that you do in any delivery are  
15 attempted and you don't have an effective outcome of  
16 delivering the baby. That's when a dystocia is recognized.

17 Q: At some point, the doctor sees that he's got a stuck  
18 shoulder; true?

19 A: At some point, yes.

20 Q: Okay.

21 A: After mom has pushed and you've done the normal things.

22 Q: And after you see that you've got a stuck shoulder, after  
23 you call for help, the first thing you should do is get the  
24 mom to stop pushing; true?

25 A: That's part of it, yes.

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1 Q: Thank you. And if the nurse is -- is -- is ordered to do  
2 suprapubic pressure to try to move that shoulder inward like  
3 you've demonstrated, if that nurse instead pushes down on the  
4 mom's pubic bone, that's not suprapubic pressure, is it?

5 A: It's an attempt, but it wouldn't do anything.

6 Q: It's not a correct performance of suprapubic pressure;  
7 true?

8 A: It's not a correct performance of suprapubic pressure  
9 because it's pubic pressure, not suprapubic pressure.

10 Q: Right. So when the -- the safety maneuvers for nurses to  
11 do are McRoberts and suprapubic pressure; true?

12 A: Correct. But --

13 Q: And if -- if the nurse pushes on the bone -- assuming  
14 there is McRoberts, if the nurse pushes on the bone instead of  
15 on the shoulder, there's only one safety maneuver being  
16 performed; true?

17 A: But in the time frame that we had, it was still  
18 appropriate I mean.

19 Q: What was appropriate?

20 A: Well, the McRoberts maneuver was being performed. That  
21 can take time for it to work. The suprapubic pressure was  
22 apparently redirected, although the video is kind of vague on  
23 that, but it's not Dr. Browning's, you know, position to  
24 necessarily train the nurses in how to do it. He can redirect  
25 it, but --

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1 Q: Yes, sir. Do you -- tell us, please, sir, do you believe  
2 that when a doctor orders a nurse to push on the shoulder and  
3 a few inches in front of his head, a foot or so, however that  
4 distance is, she pushes on the bone instead of the shoulder,  
5 do you believe the doctor has a duty to correct her hand  
6 position?

7 A: I think his duty is with the mother and the baby first  
8 and foremost and to assure her that she's doing the job  
9 correctly if he sees that is not being done properly.

10 Q: So if the doctor sees that the nurse is doing it  
11 incorrectly, you believe the doctor has a duty to correct the  
12 hand placement?

13 A: He can -- he or she can certainly say something to the  
14 nurse or -- yeah.

15 Q: Well, should the doctor say something to the nurse to fix  
16 the hand position if he sees that she's pushing on the bone?

17 A: I don't know why she did what she did. I can't speak to  
18 that.

19 Q: And I didn't ask you to, did I, sir?

20 A: Actually, you're asking me to, yes. I can't speak to  
21 what she did and what she doesn't do.

22 MS. GANES: Excuse me, Your Honor. I just object on the  
23 same basis of captain of the ship and he's asked the question.

24 THE COURT: Overruled. Go ahead.

25 BY MR. GRAHAM:

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1 Q: Doctor, did you -- I believe you said early on in  
2 response to one of -- one of the first questions that were put  
3 to you by Ms. Ganes, I believe that you testified that you  
4 read all the depositions in this case?

5 A: I did.

6 Q: Does that include the deposition of nurse Misty Barrett?

7 A: Yes.

8 Q: And you saw where she was asked how should a well-trained  
9 competent labor and delivery nurse properly perform suprapubic  
10 pressure?

11 A: Correct.

12 Q: And she said you push on the bone?

13 A: Correct.

14 Q: Down towards the floor, you push on the bone? Are you  
15 saying on the bone? Yes, on the bone. That was her testimony  
16 in essence; true?

17 A: True.

18 Q: That's not the right way to do it, is it?

19 A: No.

20 Q: And if Dr. -- if a doctor saw a nurse pushing on the  
21 bone, do you believe the doctor has a duty to correct the  
22 nurse's hand position?

23 A: His duty is to get the baby out as safely as he can.

24 Now, how that happens can be any number of different ways.

25 The suprapubic pressure may or may not have had any factor in

1 this case whatsoever. Regardless, we know it did at worst  
2 nothing and at best helped propagate the delivery of this  
3 child.

4 Q: Please give me a yes or no answer. Do you believe a  
5 doctor has a duty to correct a nurse's hand position if he  
6 sees the hand on the bone instead of the shoulder?

7 A: A physician has a duty to tell any nurse that he feels  
8 like is doing something wrong or endangering the patient to  
9 correct that, but in this particular case, I can't tell you it  
10 did anything bad or good. We don't know what ultimately  
11 affected the delivery.

12 Q: All right. But what we do know from your testimony is if  
13 the doctor saw hands on bone, he should've fixed it; true?

14 A: And I think after the first push, he did. Did he not say  
15 that in his deposition?

16 Q: Did you see the video, sir? I think you went through it.

17 A: I did.

18 Q: Where on the video did he fix the nurse's hand position?

19 A: I thought during the part that stopped -- when everything  
20 stopped and she had to go get something to change her angle,  
21 then it got corrected. I don't know. That's --

22 Q: You saw that on the video?

23 A: No. We didn't see any of that on the video.

24 Q: So you're just basically regurgitating what you read in  
25 somebody's deposition?

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1 A: That's all the information I have, sir.

2 Q: Yes, sir. And you assume it to be true if it's said by a  
3 member of the healthcare establishment; true?

4 A: Not necessarily, but it makes sense.

5 Q: All right. You have no knowledge as to whether or not  
6 that hand position was ever corrected, do you?

7 A: I just have the sworn testimony of the people that were  
8 there.

9 Q: You have no knowledge as to what happened when the video  
10 camera was bumped and bodies got between the camera and the  
11 birth canal and the camera was turned off? You don't know  
12 what happened during that 7 to 8 seconds, do you?

13 A: All I have is the evidence that's been presented to me.

14 Q: Yes, sir. And what's your understanding about how this  
15 nurse supposedly changed her position? Did she move it away  
16 from the bone or did she just stand -- change where she was  
17 standing?

18 A: I don't know. I don't honestly know.

19 Q: Thank you. Now, you said that the birth canal --  
20 basically, the trip that the baby travels is about 5 or 7  
21 inches?

22 A: No. We're talking about the depth of the pelvis, the  
23 bony pelvis that the baby has to navigate through.

24 Q: Right. The trip that the baby takes through the bony  
25 pelvis, the birth canal, is 5 to 7 inches; true?



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1 A: Roughly. It depends on the size of the women, of course,  
2 but --

3 Q: Okay. And how long did it take Julia to travel through  
4 that 5 to 7 inches?

5 A: I would have to see the medical record again.

6 Q: Yes, sir. It was at a very, very slow rate of progress;  
7 right?

8 A: Again, I'd have to see the medical record. I don't  
9 recall it being abnormal in any way though.

10 Q: Okay. Babies go through the birth canal much slower than  
11 one mile an hour; true?

12 A: One mile an hour? Yeah. I guess so.

13 Q: I mean you're not claiming that babies --

14 A: I would have to convert it to centimeters and inches, but  
15 yeah.

16 Q: You're not claiming that this baby slammed up against  
17 that -- that pubic bone like a -- like a tractor-trailer would  
18 if it lost control and hit the side of an overpass?

19 A: Quite dramatic, but no. What happens is is the maternal  
20 forces are pushing the infant down into the birth canal. If  
21 the infant is too big for the bony parts of the pelvis, then  
22 the shoulders get compressed against the anterior or posterior  
23 aspect of the pelvis.

24 Q: And once -- once the passage of the baby is blocked by  
25 the pubic bone, no matter how hard the uterus continues to

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1 push from behind, that head can't go very far until somebody  
2 starts pulling on it, can it?

3 A: Actually, that's not true at all. The compression  
4 factors compress the infant down along the axial spine, and  
5 it's in that direction of which the forces are directed by the  
6 uterus. You see that obviously in every delivery when you see  
7 the uterus contract and you see the head move forward. It  
8 happens in every delivery.

9 Q: No more than one or two millimeters?

10 A: You can't say that. I've seen it much more than that.

11 Q: Do you have --

12 A: I've seen one contraction deliver a baby.

13 Q: Can you direct me to any medical literature that supports  
14 the proposition that before the doctor starts pulling on the  
15 head that the neck can stretch more than one or two  
16 millimeters?

17 A: I believe that the brachial plexus palsy book explains  
18 that very well.

19 Q: We'll see through your literature expert, but let me ask  
20 you this, sir. You said there were no risk factors in this  
21 case. Many times, when babies have their shoulders stuck,  
22 there is not a risk factor; true?

23 A: Better than 80 percent of the time.

24 Q: That's why doctors have to always be prepared and  
25 anticipate the possibility of a stuck shoulder; true?

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 A: And do what we can, which is what was done in this case.

2 Q: Well, I'm not asking about this case. What I'm asking  
3 about, sir, is the doctor has a duty to be ready for the  
4 possibility of a stuck shoulder in every headfirst vaginal  
5 delivery; true?

6 A: True.

7 Q: And in managing that shoulder -- that stuck shoulder  
8 situation, the doctor is required to follow the safety rules  
9 set forth in the standards of care; true?

10 A: And we have video evidence that was what happened here.

11 Q: I'm not asking you about your interpretation, sir. I'm  
12 asking about the standards of care and the safety rules that  
13 they embody. When -- when a doctor encounters a stuck  
14 shoulder on his watch, his duty is to live up to the safety  
15 rules and the standard of care; true?

16 MS. GANES: Your Honor, I object to the use of the term  
17 safety rules.

18 THE COURT: Sustained.

19 BY MR. GRAHAM:

20 Q: What's the purpose of standards of care, sir? Is it to  
21 promote patient safety? I thought you had already said that.

22 A: That's one of the reasons we have a standard of care.

23 Q: All right. Do you think it's appropriate or  
24 inappropriate to call standards of care safety rules?

25 A: I think it's kind of inappropriate, actually.

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 MS. GANES: Objection, Your Honor.

2 THE COURT: Sustained.

3 BY MR. GRAHAM:

4 A: Because if standard of care means --

5 THE COURT: You don't have to answer.

6 A: -- what would happen --

7 THE COURT: You don't have to answer.

8 THE WITNESS: Thank you.

9 THE COURT: Go on to your next question.

10 BY MR. GRAHAM:

11 Q: Do you believe that doctors should deliver babies with  
12 finesse or force?

13 A: We deliver babies in the appropriate ways that we're  
14 trained.

15 Q: Do you believe that doctors should deliver babies with  
16 finesse or force?

17 A: Well, I can't really answer that question I don't  
18 believe.

19 Q: You can't answer that?

20 A: Can mothers deliver babies without force? No, because  
21 their bodies produce a bunch of force in delivering a baby.

22 Q: Yes, sir. And I don't think I asked you about the mama's  
23 uterus or the pushing that she's asked to do. I believe I  
24 asked you about the doctor. Should the doctor use finesse or  
25 force to deliver a baby?

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 A: The doctor uses the appropriate measures by which to  
2 deliver a baby safely. Guidance of the forces that are  
3 already there.

4 Q: Do you believe it's ever appropriate in the first 45  
5 seconds for the doctor to add force to the baby's progress  
6 through the birth canal?

7 A: In this particular case, it looked quite consistent to  
8 me.

9 Q: I'm not asking you, sir, about your spin on the facts of  
10 this case. I am asking about the rules, the standards of  
11 care. In the first 45 seconds of any headfirst vaginal  
12 delivery, do you believe it is ever appropriate for a doctor  
13 to add to the force applied to a baby's head?

14 A: Outside of gentle axial direction, that's within standard  
15 of care.

16 Q: And there's nothing extreme about internal maneuvers, is  
17 there?

18 A: There's always the risk of fracture of the upper arm,  
19 fracture of the clavicle, fracture of the scapula.

20 Q: Yes, sir.

21 A: Bruising. Yeah, there's always risks.

22 Q: All right.

23 A: Of course.

24 Q: I asked if you consider internal maneuvers an extreme  
25 maneuver.

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 A: No. I would not consider it an extreme dystocia  
2 maneuver.

3 Q: In fact, every competent, well-trained obstetrician  
4 should have the knowledge, skill, and experience of performing  
5 internal maneuvers to get that shoulder unstuck safely  
6 whenever gentle guidance, McRoberts, and suprapubic fail to  
7 get the shoulder delivered; isn't that true?

8 A: I would hope so, yes.

9 Q: You talked about McRoberts. How do you believe is the  
10 proper way for McRoberts to be performed?

11 A: To affect the widening of the pelvis as much as possible,  
12 what I have always been trained or have trained people to do  
13 is to have the legs go out to about a 30 to 45 degree angle  
14 and then hyperflex.

15 Q: Meaning push them up toward the shoulders?

16 A: Push them up. Yeah, knees toward the head.

17 Q: All right. Bend the hips, bend the knees, push the legs  
18 up as close as possible to the mom's shoulders?

19 A: As best you can, yeah.

20 Q: And is the best way to do that to have a nurse on each  
21 side?

22 A: I've seen family members do it. I've seen nurses do it.

23 Q: Okay.

24 A: So I mean usually it's a fairly easy instruction to give.

25 Q: Yes, sir. One of the reasons you're supposed to call for

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 help is to get extra people there to do McRoberts who were  
2 trained in how to do it; right?

3 A: Well, part of the equation, certainly.

4 Q: Yes, sir. And when a mom is in the middle of labor,  
5 having the mom do her own McRoberts is not as efficient or  
6 helpful as having nurses do it, is it?

7 A: Well, I've been in many cases where having the mom pull  
8 back on her legs actually helps her push better. So I can't  
9 say in any or in every case that that's appropriate, but --

10 Q: Yes, sir. Pushing better doesn't get a shoulder unstuck,  
11 does it?

12 A: With McRoberts maneuver and pushing, potentially it  
13 could, yes.

14 Q: All right. The question is -- is -- is a mother's own  
15 efforts to do McRoberts by holding her own legs up as  
16 efficient as having nurses who are trained in McRoberts  
17 position the legs appropriately?

18 A: Again, I don't think you can answer that question. It's  
19 an individual case -- a case-by-case basis.

20 MR. GRAHAM: Your Honor, may we approach?

21 THE COURT: You may.

22 (WHEREUPON, a bench conference was held in the presence  
23 of the jury but out of the hearing of the jury as  
24 follows.)

25 MR. GRAHAM: I believe he opened the door to talk about

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 other deliveries. He was asked by Ms. Ganes over time as  
2 there's been better education about how to do this, what  
3 effect or what -- how the statistics have changed any. He  
4 said we still have the same rate of injury despite  
5 improvements in management. I believe that opens the door for  
6 me to ask him questions about increased risk when doctors  
7 don't follow the training but instead pull harder, which is  
8 why they still have these injuries.

9 THE COURT: That doesn't really have anything to do with  
10 the door that was open. That's just obviously your theme. I  
11 mean you've been asking him about that the whole time.

12 MS. GANES: Right. I don't understand the -- I don't  
13 understand what he's saying about opening the door. And he's  
14 talking about other deliveries by Dr. Smithson. I would  
15 object on relevance.

16 THE COURT: Deliveries by him?

17 MR. GRAHAM: No.

18 MS. CRAIG: Okay. What other deliveries are you asking  
19 about?

20 MR. GRAHAM: The ones that you asked him about. You said  
21 what -- you elicited -- I don't know what your question was,  
22 but you --

23 MS. GANES: I did not.

24 MR. GRAHAM: -- elicited testimony that despite  
25 improvements in training and management, the rate of injury



1 has not gone down.

2 MS. GANES: I didn't ask him that.

3 THE COURT: She didn't ask that.

4 MR. GRAHAM: Well --

5 THE COURT: He answered something about that.

6 MR. GRAHAM: Okay. I just want to touch on it.

7 THE COURT: What do you want to get into?

8 MR. GRAHAM: I want to say when you were talking about  
9 the rate of injury not going down, as long as doctors keep  
10 increasing traction, both gentle traction, you wouldn't expect  
11 the rate of injury to go down, would you?

12 MS. GANES: Your Honor, I would object to that on  
13 relevance and --

14 THE COURT: It sounds like what you've been asking  
15 anyway.

16 MS. GANES: And he's been at it for over an hour.

17 MR. GRAHAM: But it was responsive to his point, which is  
18 a serious point. They're going to come back to it in closing.  
19 I need to touch on it.

20 MS. GANES: Your Honor --

21 THE COURT: Two questions.

22 MR. GRAHAM: Okay.

23 MS. GANES: So -- wait. But, Your Honor --

24 THE COURT: You know what he's going to ask.

25 MS. GANES: Okay. But I just want you to know that this

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 is getting very close to where we ended up on Friday afternoon  
2 of the last trial about, you know, the lobbying and the --

3 THE COURT: I'm sure you told your client not to mention  
4 --

5 MS. GANES: Oh, no, no, no. I mean the mistrial where he  
6 starts that line about doctors doing this and what doctors  
7 need to do.

8 MR. GRAHAM: We can talk about that at the appropriate --

9 THE COURT: We don't want this to be a mistrial.

10 MR. GRAHAM: We can talk about that at the appropriate  
11 time.

12 (WHEREUPON, the bench conference ended and the  
13 proceedings resumed as follows.)

14 BY MR. GRAHAM:

15 Q: Dr. Smithson, you -- you indicated that we have -- in  
16 this country, we have a trend toward bigger moms and bigger  
17 babies?

18 A: Correct.

19 Q: And we still have a problem with too many of these  
20 permanent nerve damages; true?

21 A: There's always a problem with that, yeah. Unfortunately,  
22 nothing has really changed over the last 40 -- 40 to 50 years.

23 Q: All right. If we could get doctors -- if we could get --  
24 if we could get -- if we could eliminate greater than gentle  
25 pulling force on a baby's head, that would reduce the risk of

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 permanent injuries; true?

2 A: It would reduce the part or the fraction of the injuries  
3 that come from excessive traction.

4 Q: Yes, sir. Now, you told us that the --

5 MS. GANES: Excuse me, Your Honor. If he can let the  
6 witness finish his answer?

7 MR. GRAHAM: Oh, I thought he was through.

8 THE COURT: Did you finish your answer?

9 THE WITNESS: I'd like to finish a little bit --

10 THE COURT: Go ahead.

11 THE WITNESS: -- if I could.

12 MR. GRAHAM: I thought you -- I'm sorry.

13 BY MR. GRAHAM:

14 A: You know, there's undoubtedly a fraction of cases,  
15 especially over the years, where excessive traction caused  
16 brachial plexus injuries, neck injuries, scapular injuries, et  
17 cetera. We're not denying that in any way, shape or form.  
18 The whole reason the task force was set up to look at this was  
19 to see the evidence.

20 MR. GRAHAM: Objection, Your Honor. Objection, Your  
21 Honor. May we approach?

22 THE COURT: You may.

23 (WHEREUPON, a bench conference was held in the presence  
24 of the jury but out of the hearing of the jury as  
25 follows.)

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 MR. GRAHAM: He's --

2 THE COURT: Hold on. She isn't here yet.

3 MR. GRAHAM: Oh. He's getting into the literature now.

4 MS. GANES: He asked the question.

5 MR. GRAHAM: I didn't --

6 MS. GANES: And I'm going to tell you I intend to go into

7 it on redirect.

8 MR. GRAHAM: It's not responsive to my question though.

9 MS. GANES: Yes, it is.

10 THE COURT: He's talked about that all the while. It's

11 time to move on.

12 MS. GANES: This isn't the first time he's asked him

13 about literature, and the jury is falling asleep and rolling

14 their eyes.

15 THE COURT: Please don't.

16 MS. GANES: I'm sorry.

17 MR. GRAHAM: I'll be happy to move on.

18 THE COURT: Move on.

19 (WHEREUPON, the bench conference ended and the

20 proceedings resumed as follows.)

21 BY MR. GRAHAM:

22 Q: Doctor, let me move on. You mentioned that ACOG used to

23 be called the American College of Obstetricians and

24 Gynecologists, and now that C has been changed to -- from

25 College to Congress; true?

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 A: Correct.

2 Q: Around the same time that name got changed from College  
3 to Congress, ACOG went from being primarily an educational  
4 institution to more of a lobbying group looking out for the  
5 professional --

6 MS. GANES: Objection, Your Honor.

7 THE COURT: Sustained.

8 MS. GANES: Relevance.

9 THE COURT: Sustained.

10 BY MR. GRAHAM:

11 Q: Among its purposes, the American Congress of  
12 Obstetricians and Gynecologists does conduct lobbying  
13 activities?

14 MS. GANES: Same objection, Your Honor.

15 THE COURT: Sustained.

16 MR. GRAHAM: May we approach, Your Honor?

17 THE COURT: You may.

18 (WHEREUPON, a bench conference was held in the presence  
19 of the jury but out of the hearing of the jury as  
20 follows.)

21 MR. GRAHAM: This -- this would be my last question, but  
22 I don't want to ask it without getting clearance first. In --  
23 in their documents, it's clear that one of their primary  
24 purposes is to protect the professional and financial  
25 interests of obstetricians.

DR. STACY SMITHSON - CROSS BY MR. GRAHAM

1 MS. GANES: This is --

2 THE COURT: We've been going a long time. I'd let you do  
3 it, but --

4 (WHEREUPON, the bench conference ended and the  
5 proceedings resumed as follows.)

6 MR. GRAHAM: Thank you for answering my questions, sir.

7 THE COURT: All right. Redirect?

8 MS. GANES: Yes, sir, Your Honor. Just very briefly.

9 REDIRECT EXAMINATION

10 BY MS. GANES:

11 Q: Dr. Smithson, do you still have your deposition that Mr.  
12 Graham played the video?

13 A: I do.

14 Q: If you will help me by going to page 82 on line 21, I  
15 just want to put into context the portions for the jury that  
16 were played. Do you see where the question says:

17 All right, let me ask you this. You told me earlier that  
18 you believe there comes a time after delivery of the head  
19 in a shoulder dystocia situation where you believe  
20 forceful traction is within the standard of care and you  
21 -- can you tell me how many minutes after head -- after  
22 the head delivers you believe it would be before a baby  
23 is at risk of immediate death or brain damage?

24 And can you start there on line 5 and read your complete  
25 answer to the jury, please?

DR. STACY SMITHSON - REDIRECT BY MS. GANES

1 A: I would say that when you are approaching that time where  
2 you are severely at risk of this infant in question having  
3 some sort of encephalopathy from lack of oxygen. You know,  
4 when a dystocia begins, like I said earlier, you don't have an  
5 end to that book. You don't know how much this -- you don't  
6 know how this movie is going to end. You don't know how much  
7 time is going to happen between the resolution of this  
8 unstable mother and baby, and so you have both patients in  
9 mind and your goal is to have a healthy mom and a healthy baby  
10 at the end of this.

11 Now, if a baby is stuck five -- six -- seven minutes, you  
12 really start to run the risk of there being significant bad  
13 outcomes with that infant. So therefore, I think you get to  
14 that point, anything that you can do to try to have a healthy  
15 baby and a live baby is reasonable. And at that point in  
16 time, things such as breaking of the clavicles, breaking the  
17 humerus in an attempt to deliver the posterior arm, increased  
18 tension on the infant's head, increased tension on the  
19 infant's shoulders, you know.

20 Q: Okay. And that was just before the portion that Mr.  
21 Graham played for the jury; correct?

22 A: Yeah.

23 Q: Is that testimony still truthful today as it was in your  
24 deposition that was taken prior to trial?

25 A: Yes.

1 Q: And is it consistent with the testimony that was played  
2 on video for the jury?

3 A: Yes.

4 Q: Did you change your testimony in any way from your  
5 deposition to your testimony here in trial?

6 A: None at all.

7 Q: Now, just one more place. I want to direct you in your  
8 deposition to page 88, line 17, and the question was:

9 Okay. And at no time was this baby at risk of immediate  
10 -- immediate risk of death or bad neurological damage?

11 And if you'll read on 21 your answer for the jury,  
12 please? On page 21.

13 A: I actually disagree 100 percent with you. Throughout  
14 labor and delivery, the infant is always at risk of immediate  
15 death or injury. So therefore, I have to disagree with your  
16 statement.

17 Q: That wasn't played for the jury on the video, was it?

18 A: It was not.

19 Q: Okay. Is that still truthful testimony today?

20 A: Yes.

21 Q: All right. Now, does an obstetrician ever deliver a baby  
22 with the benefit of hindsight?

23 A: Unfortunately, no.

24 Q: The fetal heart strips and the Apgars and the cord blood  
25 -- are those things that are looked at in hindsight after the



1 moment of the medical emergency is resolved in a shoulder  
2 dystocia?

3 A: Yes. Those things are all given to -- well, the Apgars  
4 are given to show how the baby recovers from the delivery  
5 process and how it adapts to the new environment that it's in,  
6 breathing on its own and all those things.

7 The cord gases are done in order to check to see what the  
8 oxygenation status was at the time of delivery. Once the baby  
9 takes his first breath, then that -- those numbers -- we  
10 basically clamp the cord and then those numbers are kind of  
11 locked in.

12 Q: Okay. In this case, do you have any criticism of Dr.  
13 Browning using the words controlled axial direction?

14 A: No. I think as evidenced on what we see on the video,  
15 that was very appropriate for any vaginal delivery.

16 Q: And is it reasonable and appropriate and within the  
17 standard of care for various obstetricians to use different  
18 terms to describe that force that is used in helping to  
19 deliver a baby?

20 A: Yes.

21 Q: Are you aware -- do you know who Dr. Pliskow is?

22 A: I've heard the name.

23 Q: Okay. Did you know in this case that that was Mr.  
24 Graham's expert?

25 A: Not until today.

DR. STACY SMITHSON - REDIRECT BY MS. GANES

1 Q: Okay. Are you aware that Dr. Pliskow -- well, did you  
2 review his deposition?

3 A: A while back, but I don't recall it very well.

4 Q: Okay. In the deposition, do you recall him having any  
5 criticism of the McRoberts maneuver that was used in this  
6 case?

7 A: Not that I recall.

8 Q: Okay. Now, this neo--- *Neonatal Brachial Plexus Palsy*  
9 *Bulletin* that I asked you about when I did your direct  
10 examination -- are you familiar with this bulletin?

11 A: Yes.

12 Q: And is this published by the American Congress of  
13 Obstetrics and Gynecology?

14 A: Yes.

15 Q: Did Dr. Browning comply with the directives --

16 MR. GRAHAM: Objection, Your Honor.

17 Q: -- in this bulletin?

18 MR. GRAHAM: Leading.

19 THE COURT: Sustained. Rephrase your question.

20 BY MS. GANES:

21 Q: Do you have an opinion as to whether Dr. Browning  
22 complied with the directives in this bulletin?

23 A: Everything that we see in the medical record and the  
24 video that we have available shows that Dr. Browning complied  
25 with or was above the standard of care in delivering this

DR. STACY SMITHSON - REDIRECT BY MS. GANES

1 infant.

2 Q: Is there any doubt in your mind that Dr. Browning was  
3 prepared to manage this medical emergency when it presented?

4 A: Most definitely. After having the experience that he  
5 has, I'm sure he's encountered many dystocias in his career.

6 Q: Okay. Did Dr. Browning do anything or fail to do  
7 anything during this delivery that caused Julia B 's injury?

8 A: Not that I can see.

9 Q: Has anything that you were asked by Mr. Graham changed  
10 your opinion to the jury in this case that Dr. Browning acted  
11 reasonably and appropriately and that he met the standard of  
12 care related to the care and treatment of Christy Byrd and the  
13 delivery of Julia B ?

14 A: It is still my opinion that Dr. Browning operated well  
15 above the standard of care in the delivery of this infant.

16 MS. GANES: Thank you, Dr. Smithson. I have nothing  
17 further.

18 THE COURT: All right. She took five minutes. You've  
19 got five minutes.

20 MR. GRAHAM: Thank you, Your Honor.

21 THE COURT: Starting now.

22 MR. GRAHAM: May I confer with Ms. Ganes just one moment?

23 (WHEREUPON, there was a pause in the proceedings, after  
24 which the proceedings resumed as follows.)

25 MR. GRAHAM: Your Honor, reference was made to the

1 deposition, page 21, I thought and it wasn't there.

2 RECROSS-EXAMINATION

3 BY MR. GRAHAM:

4 Q: Do you remember the page that you were reading from, sir?

5 A: When she asked me what to read?

6 Q: Yeah. When she said to read from page 21, which page  
7 were you reading from?

8 A: I think it was 84.

9 Q: Okay.

10 A: Or 82 -- 82. I think it was page 82. Yeah, actually  
11 page 83, line 5, is where I started reading.

12 Q: Yes, sir. And then there was a second place where you  
13 read from. Do you remember which page that was?

14 A: I don't recall where the page was from that one. I'm  
15 sorry.

16 Q: That's fine. I'll move on, sir. On page 83, you  
17 indicated that if there's a shoulder dystocia where that  
18 shoulder remains stuck for five minutes -- six minutes --  
19 seven minutes, that there begins to be more of a concern about  
20 the baby's brain potentially not having enough oxygen. Fair?

21 A: Yeah. The evidence says that damage can begin as early  
22 as two minutes, irreversible damage, but five -- six -- seven  
23 minutes is when it becomes much, much more likely.

24 Q: Well, if -- if -- if you've got a baby with no reserves  
25 and if there's a complete shutdown of all the blood and the

DR. STACY SMITHSON - RECROSS BY MR. GRAHAM

1 oxygen to the brain, then maybe it doesn't take as long, but  
2 when you've got a healthy baby with good reserves like Julia,  
3 you've got many, many minutes before there's a serious risk of  
4 any brain injury; true?

5 A: Five -- six -- seven minutes. That's --

6 Q: Yes, sir.

7 AL That's in the healthiest babies.

8 Q: So -- so within the first 45 seconds, there would not be  
9 that kind of immediate threat of loss of oxygen and possible  
10 risk of brain damage, would there?

11 A: In the first 45 seconds, you would not expect there to be  
12 any long-term damage, no.

13 MR. GRAHAM: Thank you.

14 THE COURT: All right. Hopefully, that's it.

15 MS. GANES: Thank you, Your Honor.

16 THE COURT: Good.

17 MS. GANES: May Dr. Smithson be excused?

18 THE COURT: Yes.

19 MS. GANES: Thank you.

20 THE COURT: You have a great day.

21 THE WITNESS: Thank you.

22 THE COURT: All right. Call your next witness or does  
23 the jury need a break? You're good? All right. Call your  
24 next witness.

25 MS. CRAIG: Yes, sir, Your Honor. The defense calls Dr.

1 function.

2 THE COURT: All right.

3 MS. CRAIG: I've never heard this before. I don't know  
4 what he's talking about. To the extent that he thinks that  
5 there is -- is something that -- about the author of a  
6 particular article that he disagrees with, it goes to the  
7 weight. If our doctor says it's a reliable source, that's all  
8 we need to prove.

9 MR. GRAHAM: He testified to it at length in his  
10 deposition. Even though it's an engineer --

11 THE COURT: You're going to get a chance to cross-examine  
12 him.

13 MR. GRAHAM: All right. And we would -- again, we would  
14 --

15 THE COURT: Let's get this thing going.

16 MR. GRAHAM: We would ask that he be precluded from  
17 speculating about a low injury threshold in this child.  
18 There's no evidence of that.

19 THE COURT: That would be a perfect time to make an  
20 objection if it gets to that.

21 MS. CRAIG: Thank you.

22 (WHEREUPON, the bench conference ended and the  
23 proceedings resumed as follows.)

24 THE COURT: All right. Ms. Clerk, you can swear him in.

25 THE CLERK: Please place your left hand on the Bible and

DR. JOSEPH "MACK" ERNEST - DIRECT BY MS. CRAIG

1 raise your right hand. Do you swear or affirm the testimony  
2 you give in this case will be the truth, the whole truth, and  
3 nothing but the truth, so help you God?

4 THE WITNESS: Yes.

5 THE CLERK: Please be seated and then state your name for  
6 the record.

7 THE WITNESS: My name is Joseph McDonald Ernest III. I  
8 go by Mack.

9 DR. JOSEPH "MACK" ERNEST III,  
10 being first duly sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MS. CRAIG:

13 Q: Good afternoon, Dr. Ernest. How are you?

14 A: I'm fine. Thank you.

15 Q: All right. Tell us, please, Doctor, where do you live?

16 A: I live now in Oriental, North Carolina, which is on the  
17 coast.

18 Q: Okay. And tell us about your family?

19 A: I have two boys. One is finishing up a PhD in Knoxville,  
20 Tennessee, and is going to be working at the NIH for two  
21 years. The other is an aspiring musician in Atlanta and has a  
22 recording studio and wants to record music.

23 Q: All right. Doctor, will you tell us about your education  
24 leading up to your profession?

25 A: I have a wife also, who is a tennis player by the way.

1 Q: Sir?

2 A: I have a wife also, who is a tennis player. My education  
3 -- I grew up in Mississippi. I went to a small private  
4 Baptist college called William Carey College in Hattiesburg.  
5 I graduated and then went to the University of Mississippi  
6 School of Medicine.

7 I graduated from the school and then came to Charlotte,  
8 North Carolina, where I did my residency in obstetrics and  
9 gynecology. I finished that in 1982 and went to Wake Forest,  
10 which was then called Bowman Gray School of Medicine in  
11 Winston-Salem and did a fellowship in maternal-fetal medicine,  
12 and I stayed on the faculty at Wake Forest for 26 years. I  
13 then moved back to Charlotte, where I was the chairman of the  
14 department at Carolinas Medical Center from 2008 to 2014, and  
15 I retired as the chairman in 2014 and am in the process of  
16 retiring currently.

17 Q: Okay. Great. Thank you. All right. Dr. Ernest, if you  
18 could, please just identify this document?

19 A: This is my current curriculum vitae.

20 Q: Okay. And that's a resume; right?

21 A: Yes.

22 Q: All right. So just a -- and I'm not going to go through  
23 all of this, but on here you've got the education that you've  
24 told us; correct?

25 A: Yes.



1 Q: All right. And then tell us about your academic  
2 appointments?

3 A: My first academic appointment was at Wake Forest. I was  
4 an instructor when I was a fellow. Then I moved up through  
5 the ranks to become a full professor. When I left Wake  
6 Forest, they awarded me the position of professor emeritus,  
7 which means I keep that professor title even though I'm not  
8 working there any longer.

9 I then moved to Charlotte and was professor at Carolinas  
10 Healthcare System and also professor in the University of  
11 North Carolina system while I was working there. I'm  
12 currently still technically a professor at Carolinas, although  
13 I'm not a professor at UNC because I don't teach students  
14 anymore there.

15 Q: And in your teaching responsibilities, did you have the  
16 opportunity to teach medical students and residents how to  
17 deliver babies?

18 A: Yes. We --

19 Q: And --

20 A: We taught medical students, residents, PA students. We  
21 worked with nurses and I also had a chance to talk and teach  
22 private practitioners as well.

23 Q: What are PA students?

24 A: PA students are physician assistant students. They do  
25 similar things to medical students during two years of

1 training to get prepared to do the kind of things that PAs do.

2 Q: Would you train those individuals, the PAs, the  
3 residents, the medical students, how to manage a shoulder  
4 dystocia?

5 A: Yes.

6 Q: Tell us about that?

7 A: Well, there are several ways to teach people. You teach  
8 by lecture and so I gave a number of lectures about shoulder  
9 dystocia to those different groups. We also teach by example.  
10 So when we -- when I took call -- when I take call -- when I  
11 took call, I would observe a student or a resident doing a  
12 delivery or a PA student or I would be doing the delivery and  
13 show the student or resident how to do the delivery and, if  
14 there were a shoulder dystocia, we would go through the steps  
15 and I would make sure they understood the proper steps.

16 Q: Okay.

17 A: We also had drills and we worked with the nurses and  
18 physicians in labor and delivery to practice what to do when  
19 you do have a shoulder dystocia.

20 Q: Thank you. And then what do you -- you're a member of  
21 many professional organizations. The one I want to highlight  
22 is -- I mean are you a member of the American College or the  
23 American Congress of Obstetricians and Gynecologists?

24 A: Yes.

25 Q: Would you agree that this is the premier organization of

1 which doctors like you are a member?

2 A: For obstetrics and gynecology, yes. It's the one that is  
3 our main education and guidance institution, yes.

4 Q: It looks like -- actually, this year you received a life  
5 achievement award at the Association of Professors of  
6 Gynecology and Obstetrics. What is that, Doctor?

7 A: That organization is a group that is the national group.  
8 It's international, but primarily national group that develops  
9 material to teach medical students and some resident material  
10 about women's healthcare. I've worked with that group since  
11 the mid-80s. I was the president of that organization a  
12 number of years ago and have worked on a number of committees,  
13 and this year they awarded me that very nice honor, which was  
14 a lifetime achievement award, which is to recognize the work  
15 I've done with the group over the years.

16 Q: Congratulations.

17 A: Thank you.

18 Q: You've also participated in a number of drug studies it  
19 looks like?

20 A: Yes.

21 Q: How about chapters in books? Have you written any  
22 chapters?

23 A: Yes.

24 Q: In the medical texts?

25 A: Yes.

1 Q: Journal articles. A number of those?

2 A: Yes.

3 Q: A lot of those? How about abstracts? Additional  
4 medicals?

5 A: Yes.

6 Q: Let's see. Awards for teaching and education. It looks  
7 like they start from 1985 up through 2008. Have you received  
8 a number of awards for teaching and medical education?

9 A: Yes.

10 Q: Lectures and presentations. Have you gone and been  
11 invited to do lectures and presentations to other medical  
12 groups?

13 A: Yes.

14 Q: And have you done that around the country?

15 A: Yes.

16 Q: How about in other countries?

17 A: Yes.

18 MS. CRAIG: Your Honor, at this time we would offer Dr.  
19 Ernest's CV into evidence as the next defense exhibit.

20 THE COURT: Any objections?

21 MR. GRAHAM: No, Your Honor.

22 THE COURT: Number 6 is in evidence without objection.

23 (WHEREUPON, Defendant's Exhibit Number 6, curriculum  
24 vitae of Dr. Ernest, was admitted into evidence.)

25 MS. CRAIG: Thank you.

1 BY MS. CRAIG:

2 Q: Dr. Ernest, are you board-certified?

3 A: Yes.

4 Q: In what specialty field of medicine are you board-  
5 certified?

6 A: I'm board-certified in obstetrics and gynecology and  
7 board-certified in maternal-fetal medicine, which is a subset  
8 of obstetrics and gynecology that deals with complicated  
9 pregnancies.

10 Q: And how long have you been a doctor?

11 A: I finished medical school in 1978.

12 Q: And can you give us an estimate about how many babies  
13 you've delivered?

14 A: I didn't keep a count, but somewhere in the 5,000+ range.

15 Q: And do you have experience with handling deliveries when  
16 the medical emergency of shoulder dystocia presents?

17 A: Yes.

18 Q: Do you consider yourself to be an expert on the medical  
19 literature that applies to the management and cause of -- the  
20 management of shoulder dystocia and the cause of brachial  
21 plexus injuries?

22 A: Yes.

23 Q: And, in fact, in order to give your opinions here today,  
24 have you brought numerous articles to show where in the  
25 medical literature your opinions are supported?

1 A: Yes.

2 Q: Okay. I'm going to hand you a folder with numerous  
3 medical articles and, if it any time when I'm asking you  
4 questions you need to reference the actual article, will you  
5 please do so? And if you don't have the article in that  
6 folder for some reason, just let me know and I'll provide you  
7 a copy.

8 A: Okay.

9 Q: Now, with regard to those medical articles -- and did you  
10 do a literature review and a literature search at my request  
11 so that you could give your opinions in this case?

12 A: Yes. One of the things that I've done over the years is  
13 to keep up with the articles that I have reviewed. So I have  
14 an extensive -- it used to be a paper copy on a big folder,  
15 but now that we have electronic copies, I have electronic  
16 copies of articles that I think are pertinent for different  
17 topics.

18 So they're organized in things such as cervical cancer or  
19 diabetes and pregnancy, shoulder dystocia, brachial plexus  
20 injuries. So I have a lot of articles that I have -- with  
21 which I am familiar because I've taught about those things  
22 over the years.

23 But then in addition, when I reviewed the records in this  
24 case and after you asked me to look at this, I looked at those  
25 articles again and then added to that collection.

1 Q: Okay. Thank you. Do you stay current on the medical  
2 literature as it applies to the management of shoulder  
3 dystocia and the cause of brachial plexus injuries?

4 A: Yes.

5 Q: And do you have particular expertise regarding the  
6 medical and the scientific literature that discusses the  
7 various causes for brachial plexus injuries as it relates to  
8 the birthing process?

9 A: Yes.

10 Q: And are the articles, the journals, and the abstracts,  
11 case reports, and texts that you rely on generally relied upon  
12 by other doctors in your field of medicine regarding shoulder  
13 dystocia and brachial plexus injuries?

14 A: Uh-huh. Yes. The articles that are most important I  
15 think and most helpful are ones that are called peer-reviewed.  
16 A peer-reviewed article is an article in which someone writes  
17 a study or a case report or presents some information and then  
18 a series of experts look at those -- look at the article to  
19 decide whether it's worthy of being published.

20 Sometimes the article is sent back to the submitter to  
21 say we like it but you need to change some things or we like  
22 it but you need to add some information or it's not  
23 appropriate or it's wrong and we're not going to accept it.  
24 I've been a reviewer for the *Green Journal*, which is the  
25 OB/GYN journal for ACOG. So I'm familiar with that process

1 both from submitting articles and -- and reviewing them. And  
2 I think that --

3 Q: Can you explain that? How -- how a doctor or an author  
4 will submit a publication for -- to be published and the  
5 review process of which you were a participant?

6 A: Uh-huh. Well, if you -- if you -- the simplest thing  
7 would be if you have an interesting case that you think is  
8 important or different or unusual or helpful for other people,  
9 you can write that case up, give the information, and then  
10 send it to a journal that's appropriate. And the journal then  
11 will decide whether it's never been published before, whether  
12 it's published before but has a different twist or whether it  
13 gives some new insight into medical knowledge. It's reviewed  
14 and then it's either accepted or it's modified or it's  
15 rejected.

16 If you do a study, you do the study. You develop your  
17 results. You discuss the results. So there are different  
18 sections of the article. You put it all together in a format  
19 that is acceptable to that journal and then you send it in.  
20 Again, you submit it. The reviewers look at it and then they  
21 decide modify it and we'll accept it, it's not worthy of being  
22 accepted or we'll take it as is, which is pretty rare.

23 Q: And you're actually a reviewer you said for which  
24 journal?

25 A: For the -- for the journal called *Obstetrics and*



1 Gynecology, which is the journal for ACOG.

2 Q: The ACOG is what we've already been talking about?

3 That's the acronym for the American College or the American

4 Congress --

5 A: Right.

6 Q: -- of Obstetrics and Gynecologists; correct?

7 A: Yes.

8 Q: Okay. And all of the medical articles that you have  
9 reviewed and are prepared to talk about today -- do you  
10 consider those to be reliable?

11 A: Yes.

12 MS. CRAIG: Your Honor, at this time, we would offer Dr.  
13 Ernest as an expert witness to the field of obstetrics and  
14 gynecology and the medical literature as it relates to the  
15 management of shoulder dystocia and the cause of brachial  
16 plexus injuries.

17 THE COURT: Any objections?

18 MR. GRAHAM: We have no questions at this time, Your  
19 Honor.

20 THE COURT: All right. Your motion is granted.

21 MS. CRAIG: Your Honor, I would ask if Mr. Graham has an  
22 objection as opposed to just no questions.

23 THE COURT: Any objections? I took that as a no  
24 objection.

25 MR. GRAHAM: Not -- not at this stage, Your Honor, but I

1 do reserve the right to ask questions later.

2 THE COURT: You can ask questions. Do you have any  
3 objection to him being moved as an expert? Moved in?

4 MR. GRAHAM: Not as to OB/GYN, no, sir.

5 THE COURT: I'm granting your motion.

6 MS. CRAIG: Thank you.

7 BY MS. CRAIG:

8 Q: All right. So, Dr. Ernest, we're going to get to the  
9 medical literature in a minute, but before we go there, did  
10 you review the medical records of Ms. Byrd, as well as the  
11 depositions that were taken in this case?

12 A: Yes.

13 Q: And based upon your review of the depositions and the  
14 medical records, did you also review the video?

15 A: Yes.

16 Q: Okay. And based upon all of that information --

17 MR. GRAHAM: Objection, Your Honor.

18 THE COURT: What grounds?

19 MR. GRAHAM: On the grounds that -- may we approach, Your  
20 Honor?

21 THE COURT: You may.

22 (WHEREUPON, a bench conference was held in the presence  
23 of the jury but out of the hearing of the jury as  
24 follows.)

25 THE COURT: All right. What was your question again?

DR. JOSEPH "MACK" ERNEST - DIRECT BY MS. CRAIG

1 MR. GRAHAM: It has to do with the video. At the  
2 deposition stage, he hadn't looked at it. Any opinions from  
3 the video are new opinions that would be unfair for a variety  
4 of reasons.

5 THE COURT: Are there new opinions?

6 MS. CRAIG: There are no new opinions.

7 THE COURT: No new opinions. That's the rule. I agree  
8 with that.

9 MR. GRAHAM: He can't comment on the video. I mean to  
10 comment on the video would be an opinion as an expert  
11 interpreting the video.

12 THE COURT: As long as it's consistent with his opinion  
13 as he gave it before, it's not a new opinion. Am I wrong?

14 MS. CRAIG: That's exactly right. Yes, sir.

15 (WHEREUPON, the bench conference ended and the  
16 proceedings resumed as follows.)

17 BY MS. CRAIG:

18 Q: All right. Doctor, based upon your review of the medical  
19 records, the deposition testimony, and the video in this case,  
20 do you have an opinion whether Dr. Browning met the standard  
21 of care?

22 A: Yes.

23 Q: And what is that opinion?

24 A: That he met the standard of care in everything he did.

25 Q: And based upon that same information, do you have an

1 opinion whether Dr. Browning caused the injuries in this case?

2 A: Yes, I have an opinion.

3 Q: Please tell us what that is, sir?

4 A: He did not cause the injuries.

5 Q: All right. Now, we have gone through the video quite a  
6 few times, but if at any time during your -- the questions I  
7 ask, if you think that the video would be helpful to show a  
8 point, please let us know and we'll put the video up. Okay?

9 A: Okay.

10 Q: But I don't want to repeat other questions that have  
11 already been asked, but if it would aid in explaining one of  
12 your answers, will you please instruct me to put the video up?

13 A: I will.

14 Q: Okay. Thank you. All right. Doctor, tell us why  
15 traction is used in every delivery?

16 A: Well, traction is a force and you heard Dr. Smithson. I  
17 was here when he was testifying and we -- we understand that  
18 for a baby to deliver, there has to be force from inside the  
19 uterus to push the baby and there has to be in most cases  
20 force from outside to pull on the baby. So there's these two  
21 forces that are affecting the baby's movement through the  
22 birth canal.

23 The traction is generally considered to be the force that  
24 the physician or the person delivering the baby applies.

25 Traction in the obstetrical literature is basically a pulling

1 force and so that's -- that's why in most deliveries women  
2 either request or require some traction to speed up the  
3 delivery process.

4 Q: Doctor, what word choice would you use to describe  
5 traction?

6 A: I would say traction is a force and I think it's the best  
7 word to use because traction implies different things to  
8 different people. It has different definitions or different  
9 meanings. Force I think is more appropriate because you can  
10 understand force as a pushing or a pulling energy, and that's  
11 really what's going on during a delivery.

12 Q: Do you have an opinion whether the standard of care  
13 requires doctors to use a specific word to describe traction?

14 A: No.

15 Q: Why is that?

16 A: Well, there is no standard of care for word usage.  
17 Standard of care is the care you provide, not what you write  
18 in the chart. So as long as we understand what the doctor has  
19 done, we can decide whether they've met the standard of care.  
20 What they write is really not as pertinent as what they did.  
21 So if we know what they did, what they write sort of falls by  
22 the wayside.

23 Q: How does a doctor like you, who has delivered thousands  
24 of babies, how do -- how does a doctor know the appropriate  
25 amount of traction to use when helping to deliver a baby?

1 A: Uh-huh. Well, it comes from several different places.  
2 You first look at the entire picture of the patient, whether  
3 she's had babies before, how quickly and how easily those  
4 deliveries occurred. You estimate what you think the baby's  
5 size will be for this delivery. You get an idea about the  
6 mother's pelvic size, whether you think it's going to be an  
7 easy fit or a tight fit or a difficult delivery or an easy  
8 delivery.

9 And then you watch the progress of labor to see how the  
10 labor is progressing. If the labor is slow, it may concern  
11 you that there may be a fit issue. You then look at the  
12 actual part of labor, called the second stage, while the  
13 mother is pushing to see how quickly the baby descends through  
14 that part of the pelvis.

15 And then when it's time for you to apply traction or the  
16 force of pulling, you use the force that your muscle memory  
17 has been trained to know over the hundreds or thousands of  
18 deliveries that you've done.

19 I think Dr. Smithson's example of a brake is a good one.  
20 If you're in an unfamiliar car, you don't know how much brake  
21 to put -- how much pressure to put -- how much force to put on  
22 the brake pedal the first time or until you do it and you may  
23 put too much or too little. But once you've gotten used to  
24 that car, you know exactly how much to put on the pedal to  
25 slow the car down at the appropriate amount.

1 And that's a little bit -- that's sort of a simple  
2 analogy, but that's a little bit what we do. We do this over  
3 and over and over again until we know what the usual amount of  
4 force is to deliver a baby.

5 Q: Thank you. All right. So that's traction. Now, I'd  
6 like to talk about lateral traction. What is lateral  
7 traction?

8 A: Uh-huh. Well, there are two words there. There's  
9 lateral and there's traction. Traction is the force and  
10 lateral by itself means a change from some plane. So, for  
11 example, if I take the Bible here and I move it this way, it's  
12 going lateral to this platform here.

13 In the context of a shoulder dystocia delivery though, it  
14 really means flexing and we need to think about it not as the  
15 direction of the pull, but whether or not you bend the head.  
16 Now, the baby's head bends itself as it comes through the  
17 birth canal. So there's a lot of bending and flexing that's  
18 normal for the delivery process.

19 At the time of delivery, there's a little bit of flexing  
20 that can happen as we get ready for the actual delivery,  
21 pulling the head over just a bit to get the cord off, which  
22 again we saw in this video.

23 (Gesturing.) What you don't want to do is to apply  
24 excessive lateral bending this way on the head because if you  
25 apply this type of traction, which is the bending which is

1 referred to as lateral traction, it can increase the stretch  
2 on the nerves, which can make them more susceptible to injury.  
3 It doesn't mean they're getting injured. It means they're  
4 more susceptible to injury. So we try to minimize or prevent  
5 as much as possible this (Gesturing) and we want to try to do  
6 as much of this (Gesturing) as we can.

7 Q: Okay. The lateral traction or the bending traction that  
8 you just described -- do you see that on the video?

9 A: No, not at all.

10 Q: Is there any evidence on the video at all that Dr.  
11 Browning used lateral traction?

12 A: No. The only time I saw any movement of the head other  
13 than out was when he moved the head a bit to get the cord off,  
14 and that's appropriate. But you have to move the head a bit  
15 to get your finger around it to get the cord off, but once he  
16 got the cord out -- off from around the neck, the traction I  
17 saw was very appropriately applied with his hands like this  
18 pulling. (Gesturing.)

19 Q: Can you stand up --

20 A: Oh, I'm sorry.

21 Q: -- so we can see that?

22 (WHEREUPON, the witness complied.)

23 BY MS. CRAIG:

24 A: He had his hands around the head to protect the head and  
25 the neck and the nerves, and he was pulling in what people



1 call an axial traction, which again is this way and not this  
2 way. (Gesturing.)

3 Q: Okay. And I do have an exhibit which we've already  
4 marked, thanks to Your Honor, Defendant's Exhibit 4. And can  
5 you tell us if this is the proper hand placement?

6 A: Yeah. I know it's hard to see, but --

7 Q: Why don't you come on down?

8 MS. CRAIG: Your Honor, could he come down?

9 THE COURT: Yes.

10 MS. CRAIG: Thank you.

11 (WHEREUPON, the witness complied.)

12 BY MS. CRAIG:

13 Q: If you'll stand on this side so that the court reporter  
14 can hear you?

15 A: Okay. Can you hold that?

16 Q: Of course, I could.

17 A: The hand -- Dr. Browning's hands are placed on the head  
18 like this. (Gesturing.) If there were bending, the hands  
19 would be like this or they would be like this. That's  
20 bending. That's the lateral traction we want to avoid.

21 What you want to do is to apply traction this way so you  
22 can deliver the baby down and out, but not bending the head.  
23 So again, I think that's perfectly placed to make sure that  
24 the head stays nice and level and on the same plane as the  
25 spine, which then minimizes the stretch on the brachial

1 plexus.

2 Q: Okay. And so I know this is a still shot. It's not a  
3 video, but when you compare the still shot to the video, do  
4 you have an opinion whether or not Dr. Browning is using the  
5 appropriate type of traction to deliver this baby?

6 A: He did. In many cases that I have reviewed, we don't  
7 have the luxury of a video to see exactly what the doctor did,  
8 but we do here. And we can see his hands during this time and  
9 they are appropriately placed. They're protecting the baby's  
10 head and neck and the nerves, and he's applying traction  
11 axially this way and not this way because, again, we would see  
12 his hands doing this or this if he were flexing the neck which  
13 is what we want to avoid. (Gesturing.)

14 Q: Thank you, Doctor. You can go on back to the witness  
15 stand. Thank you.

16 (WHEREUPON, the witness complied.)

17 BY MS. CRAIG:

18 Q: All right. You mentioned the angle about delivering a  
19 baby and I have a picture from a medical text that I'd like to  
20 show you. This is a medical illustration. Does it or would  
21 that help you in explaining the proper angle that a doctor  
22 uses when delivering a baby?

23 A: Uh-huh. Yes.

24 Q: Okay. All right.

25 MS. CRAIG: If it's okay with Your Honor, could I --

1 could he come to the Elmo with me?

2 THE COURT: Yes.

3 MS. CRAIG: Okay. Thanks. This is the Elmo over here.

4 BY MS. CRAIG:

5 Q: Okay. So this is a picture. Let's see if I can zoom in  
6 a little bit. All right. I can't figure out the zoom right  
7 now. All right. It's okay. We don't have to have it.

8 MS. GANES: It's right here.

9 MS. CRAIG: I don't see it.

10 MS. GANES: Up in the corner?

11 MS. CRAIG: Okay. Well --

12 MR. JOYCE: It's a dial on the side.

13 MS. CRAIG: Thank you. Okay. Now you can see it much  
14 better now. All right.

15 BY MS. CRAIG:

16 Q: Now, this is -- this is just out of a medical text, but I  
17 think it's a good one to -- for you to explain to the jury  
18 about the angle at which a baby is delivered. So if you could  
19 explain that to us?

20 A: Uh-huh. Well, when the patient is on the delivery table  
21 -- when the patient is on the delivery table with her legs  
22 ready for delivery, the baby is coming down the birth canal,  
23 not straight out, but at an angle down, and that's why it's so  
24 important to understand what lateral means because lateral is  
25 away from some plane.

1        So the baby is -- is moving laterally down, but that's  
2 not the lateral we care about. That's the type we want to  
3 happen. Lateral from the floor. What we want to happen is  
4 for the head not to be laterally bent or flexed. So think  
5 about it as we want to avoid flexion, but we don't mind and  
6 actually we want to encourage a downward direction, which is  
7 called a vector. We want a downward direction of the baby  
8 because that's the easiest way for the baby to get out.

9        Q:    So show us where is the horizontal plane in this  
10 picture?

11        A:    Okay. The horizontal plane would be -- would be like  
12 this. There's the table below her and you can see the vector  
13 is down. So it's appropriate to pull down on the baby, but  
14 it's not appropriate to bend the head unnecessarily or to flex  
15 the head because that -- that increases the stretch on the  
16 nerves and might increase the risk of injury.

17        Q:    Okay. And based upon your review of the video, did Dr.  
18 Browning use the proper angle to deliver the baby?

19        A:    Yes. You can see that clearly on the video.

20        Q:    Thank you.

21        (WHEREUPON, the witness returned to the witness stand.)

22 BY MS. CRAIG:

23        Q:    Just briefly, I know that you reviewed the entire --  
24 well, let me ask you. Did you review the entire medical  
25 record from Dr. Browning's practice related to Ms. Byrd?

1 A: Yes.

2 Q: Okay. And in reviewing all of those -- and I think there  
3 were 15 or 16 prenatal visits with Dr. Browning. Do you have  
4 an opinion whether the prenatal care that was given to Ms.  
5 Byrd -- was it within the standard of care?

6 A: Uh-huh. Yes, it was.

7 Q: Do you have an opinion whether Dr. Browning probably --  
8 prop -- properly monitored and evaluated his patient  
9 throughout her pregnancy?

10 A: Uh-huh. Yes, he did.

11 Q: Also in your review of those records -- and right now I'm  
12 talking about the prenatal records up until the delivery. Was  
13 there anything in those records that would give Dr. Browning  
14 an indication that the shoulder dystocia would happen in this  
15 case?

16 A: Not at all.

17 Q: So what is your opinion as to whether or not the shoulder  
18 dystocia was predictable and whether it was preventable?

19 A: It was neither, and that's the way we tend to find most  
20 shoulder dystocias. That we don't expect them, nor can we  
21 prevent them, but we need to be prepared to deal with them  
22 when they happen.

23 Q: All right. Talking a little bit more about shoulder  
24 dystocia, please explain to us whether or not it's your  
25 opinion that shoulder dystocia is a medical emergency?

1 A: Well, it is a medical emergency.

2 Q: And we've talked a lot about the various risks to the  
3 mama and to the baby if a shoulder dystocia occurs, but in  
4 your experience tell us what you have seen if you're unable to  
5 dislodge the shoulder?

6 A: Well, I've seen everything from normal outcomes to  
7 significantly injured babies, and I've reviewed cases where  
8 babies have died from an extended period of time before  
9 delivery.

10 So we know that when we see this happen, what we -- what  
11 we know is it's a medical emergency because we don't know how  
12 long it's going to take us to get the baby delivered. It may  
13 take a very short time, as in this situation, or it may take a  
14 very extended time.

15 And when we're -- when we're starting the process, when  
16 we recognize it, we don't know how long it's going to take.  
17 So it is a true medical emergency because you have a limited  
18 amount of time to get the baby out before significant injuries  
19 can and do occur.

20 Q: There has been reference earlier in this trial to the  
21 Zavanelli maneuver. Are you familiar with what that is?

22 A: Yes.

23 Q: Have you had to do that maneuver before?

24 A: Yes.

25 Q: Tell us -- I don't think we got a definition, but what is

1 the Zavanelli maneuver?

2 A: It is a maneuver where we replace the baby's head back up  
3 into the birth canal and then do a C-section. I have done  
4 that once. I did it a week after I had given the lecture on  
5 shoulder dystocia and I had gone through all the maneuvers at  
6 grand rounds at our institution. And it's very easy to give a  
7 lecture and give the maneuvers and say you do this and you do  
8 this and you do this, and you can stand in front and answer  
9 questions and I did and then off you go.

10 And so I experienced this shoulder dystocia and I went  
11 through everything twice and I still could not get the baby  
12 delivered. It took -- I was -- I went through them once, all  
13 the maneuvers I knew. I went through them again and the baby  
14 was not moving at all. Well, I'd never seen nor done a  
15 Zavanelli maneuver, but I'd read about it and I knew how to do  
16 it. I just had never done it.

17 And so it worked. I flexed the head, the head went back  
18 up into the birth canal, and I was as surprised as -- I  
19 remember the anesthesiologist said good job because he had  
20 never seen one either and I thought, well, it was. I don't  
21 know why it was a good job, but it worked and we -- we did a  
22 C-section.

23 So that is a -- that is a maneuver that is rarely done.  
24 Many people practice their whole career and don't do any.  
25 I've done one in the many deliveries I've done. So it's very

1 unusual to do it. It's sort of a last resort.

2 Q: What are other -- what are some of the other extreme  
3 maneuvers that have to be taken in the face of shoulder  
4 dystocia?

5 A: Uh-huh. Well, I guess it depends on what you mean by  
6 extreme. The common maneuvers we do include either maternal  
7 manipulation, such as McRoberts and suprapubic, which is what  
8 most people start with. The fetal maneuvers include turning  
9 the baby sort of in an unscrewing kind of maneuver to get the  
10 baby out in different maneuvers or delivering the posterior  
11 arm to minimize the width between the shoulders. The problem  
12 is the shoulders are too wide for the part of the pelvis  
13 through which they're trying to fit.

14 So you can either collapse the shoulders, you can sort of  
15 unscrew the baby, or you can deliver one of the arms. And if  
16 you can deliver the back arm, the posterior arm, the width  
17 decreases and then you can deliver the baby. So those are  
18 sort of the normal things we think about.

19 Zavanelli would be I guess considered extreme. It's a --  
20 it's a rare -- it's a less common one.

21 Sometimes people have tried to fracture the clavicle, the  
22 collarbone. If you fracture the clavicle, it will heal, and  
23 it also -- that serves to reduce the width of the shoulders so  
24 you can get a baby out sometimes by doing that. Sometimes  
25 that happens spontaneously.



1 I've never seen this or done it, but sometimes people  
2 have actually tried to fracture the -- tried to separate the  
3 pubic bone. There's a -- there's a gap in the pubic bone and  
4 you can separate it with a scalpel, but it's pretty rare.  
5 That's really rare to do.

6 So those are some of the maneuvers that we rarely do, but  
7 I guess would be considered extreme.

8 Q: When you are delivering a baby and you encounter shoulder  
9 dystocia, is that a medically stable or an unstable situation?

10 A: Well, it depends on how you define medically stable, and  
11 I was -- we discussed this in my deposition and I think it's  
12 important. It's an important concept.

13 If you talk about a particular part of the baby, is the  
14 heart rate stable? Well, the baby's heart rate was stable; so  
15 there was a medically stable heart rate. If you talk about  
16 the brain, during the 45 seconds of this delivery, the baby's  
17 brain was medically stable, but if you look at the big  
18 picture, it was a medically unstable condition.

19 And I tried to think about a good example and I think the  
20 best example I can give you is if I stood up and tripped and  
21 cut my forehead and started bleeding from an artery and I'm  
22 sitting on the floor, would you consider that medically stable  
23 or medically unstable? I'm talking to you. I can walk. I  
24 can breathe. My heart rate is okay, but I'm bleeding and it  
25 -- and it's not stopping. At a point, I could die from that

1 bleeding.

2       So I think that's a little bit like the situation with  
3 the shoulder dystocia. If you come over and put pressure on  
4 my forehead and go get me stitches, I'm fine and I didn't hurt  
5 my brain, I didn't hurt my heart, I didn't hurt anything. I  
6 might not have even lost enough blood to be transfused, but it  
7 is a medically unstable condition even though the outcome  
8 hopefully is you're going to come over and put some pressure  
9 on that spot and the bleeding will stop. If you don't do it,  
10 I could die.

11       So that's a little bit like what happens with the  
12 shoulder dystocia. There are medically stable parts of the  
13 baby and, again, we talked about this in my deposition, but  
14 the overall situation is a medically unstable one.

15 Q:   So do you have an opinion whether there is an immediate  
16 risk of harm when presented with the medical emergency of  
17 shoulder dystocia?

18 A:   Definitions are everything; right? And how do we define  
19 immediate? If immediate is if you don't fix it in a few  
20 minutes, there will be brain injury or death, then absolutely,  
21 and that's the situation. So I think most people would  
22 consider if you are at risk of dying unless something is done  
23 in 4 to 5 minutes that was immediate, yeah, I think it's an  
24 immediate risk.

25 Q:   Thank you. All right. Let's talk about the delivery in

1 this case. Once Dr. Browning recognized the shoulder  
2 dystocia, tell us what he did?

3 A: Well, he did two things. Well, he did several things,  
4 actually. He applied the proper amount of traction in that  
5 situation. It takes a while. I keep using my hands because  
6 that's what we do when we deliver a baby. As you recognize a  
7 shoulder dystocia, it can be because of the way the baby's  
8 head comes out through the birth canal. It can be after you  
9 start applying traction. It can be some combination of those,  
10 but once you've recognized it, you then can say, well, I think  
11 there's a shoulder dystocia, but you don't know it for sure at  
12 first.

13 And so the proper thing is to say, well, let me apply  
14 traction and see if I get the normal descent of the baby by  
15 applying the normal traction that I usually do that gets --  
16 that's gotten the other 3,000 babies delivered that I've done.  
17 So you apply traction. You may apply traction once or twice,  
18 not more than you need, not excessive traction, but normal  
19 traction, and the baby doesn't deliver.

20 If you do that, you then start thinking have we started  
21 our maneuvers or do I need to add maneuvers. Many times, the  
22 patient is already in a modified McRoberts position because if  
23 you've ever had a baby or seen a delivery, you know that many  
24 women have their legs up in stirrups and so they're sort of in  
25 a position to have the baby already. So we extend their legs

1 or we flex their legs back rather. That's the technical  
2 McRoberts maneuver, if they're not already back, and then we  
3 can apply traction again.

4 If that doesn't work, we can then go to suprapubic, which  
5 you've heard is pushing on the baby's shoulders just above the  
6 pubic bone. If that doesn't work, we've done our maternal  
7 maneuvers; so now we go to the fetal or the internal  
8 maneuvers.

9 So what he did was he started the delivery, recognized  
10 the nuchal cord. He saw how the skin was going over the  
11 baby's head and thought this may be a problem. Let's see what  
12 happens. He bends the head a bit to get the head -- to get  
13 the cord off the neck. He then applies traction. He does not  
14 get the descent he expects. He recognizes she's in McRoberts.  
15 He applies traction again. He then asks the nurse to apply  
16 suprapubic pressure. And then after the suprapubic pressure  
17 is applied, the baby delivers.

18 Q: Okay. Thank you. There has been an implication that  
19 maybe McRoberts wasn't done in this case. What's your opinion  
20 as to whether or not McRoberts was actually implemented to  
21 help deliver the baby?

22 A: Well, you can see the McRoberts because the legs were  
23 flexed. So it's clear there was McRoberts. And I'm  
24 comfortable that there was suprapubic. There is a gap in the  
25 video during which I think the suprapubic pressure was

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1 modified and I'm comfortable that that -- it happened because  
2 Dr. Browning said it happened, but also because when Ms. Byrd  
3 was describing the delivery to Dr. Resnick when Julia was  
4 having an exam, she described the two parts. She described  
5 the two maneuvers. She said they flexed my legs, which is  
6 McRoberts, and they applied pressure on my abdomen, which is  
7 suprapubic.

8       So I think we've got Dr. Browning's recollection, we've  
9 got the notes in the chart, and we've got Ms. Byrd's  
10 recollection and description that those two maneuvers were  
11 done.

12 Q:    Okay. And Dr. Resnick, who you just referenced, that's  
13 one of the plaintiff's experts down in Miami; right?

14 A:    Yes.

15 Q:    Okay. And that was -- and that's what Ms. Byrd reported  
16 to her expert?

17 A:    She reported that those two maneuvers were done, yes.

18 Q:    All right. So we've talked about McRoberts and then  
19 talking about -- and by the way, on the video, can you hear  
20 Dr. Browning say do McRoberts?

21 A:    No.

22 Q:    Can you hear everything that's going on in that room on  
23 that video?

24 A:    No. It was pretty noisy, as most delivery rooms are.

25 Q:    How about suprapubic pressure? Do you hear Dr. Browning

1 say please start suprapubic pressure on the video?

2 A: I do not.

3 Q: So do you have an opinion whether suprapubic pressure can  
4 cause a brachial plexus injury?

5 A: I do have an opinion and it can't.

6 Q: Can you please explain that to us? There's been a lot of  
7 talk about whether or not there was pushing at the same time  
8 as suprapubic pressure. Would you please explain to us why  
9 that is medically insignificant in terms of --

10 MR. GRAHAM: Objection, Your Honor. New opinion.

11 THE COURT: Come up here.

12 MS. CRAIG: Yes, sir.

13 (WHEREUPON, a bench conference was held in the presence  
14 of the jury but out of the hearing of the jury as  
15 follows.)

16 THE COURT: And how is that a new opinion?

17 MR. GRAHAM: Because it hasn't been disclosed before. It  
18 wasn't expressed during the deposition and they're trying to  
19 get it expressed now for the first time.

20 MS. CRAIG: It's all within the standard of care about  
21 suprapubic pressure, McRoberts, and the cause of the injury.  
22 And suprapubic pressure does not cause this injury. It goes  
23 to that.

24 THE COURT: Did he say that in the deposition? That's  
25 all he's asking.

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1 MS. CRAIG: I don't remember. I don't have a page and  
2 line, Your Honor, where he said that in the deposition, but  
3 the basis of his opinion that -- you want me to --

4 THE COURT: I think it crosses it. I'll tell you what  
5 you do. I'll let you go with the question. If he answers  
6 wrong, then you can hit him up on cross.

7 MS. CRAIG: Thank you.

8 MR. GRAHAM: Well, it's --

9 (WHEREUPON, the bench conference ended and the  
10 proceedings resumed as follows.)

11 THE BAILIFF: Your Honor?

12 THE COURT: You need a break?

13 THE BAILIFF: We have jurors.

14 THE COURT: All right. If you would, take a break and if  
15 the foreman will let me know when you're ready, we'll resume.

16 (WHEREUPON, the jury exited the courtroom at 12:53  
17 p.m.)

18 (WHEREUPON, the bench conference resumed as follows.)

19 THE COURT: How is that different from his opinion  
20 before?

21 MR. GRAHAM: I thought I heard him say that suprapubic  
22 pressure can cause an injury. Is that what you said?

23 THE WITNESS: Today, no.

24 MS. CRAIG: Your Honor, he didn't say that. He said  
25 suprapubic --

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1 THE COURT: I don't remember that either.

2 MS. CRAIG: -- pressure cannot cause a brachial plexus  
3 injury.

4 THE COURT: That's what I remember.

5 MR. GRAHAM: Okay.

6 MS. CRAIG: And actually, this is kind of common sense  
7 actually. I mean --

8 MR. GRAHAM: Well, maybe I misunderstood him. I thought  
9 I heard something outlandish that I had never heard before.

10 THE COURT: All right. I didn't hear that.

11 MR. GRAHAM: Okay.

12 THE COURT: Let's take a break.

13 MS. CRAIG: Okay. Thank you.

14 (WHEREUPON, the bench conference ended and the  
15 proceedings resumed as follows.)

16 THE COURT: We'll come back and we'll resume. You can  
17 take a break, but you can't talk to anybody.

18 THE WITNESS: Okay. Thank you.

19 THE COURT: Just come back and have a seat when you're  
20 done.

21 (WHEREUPON, there was a break in the proceedings from  
22 12:54 p.m. until 1:08 p.m., after which the proceedings  
23 resumed as follows.)

24 THE COURT: Go ahead and bring out the jury.

25 (WHEREUPON, the jury entered the courtroom at 1:08 p.m.)



1 THE COURT: All right. Please continue.

2 MS. CRAIG: Thank you, Your Honor.

3 BY MS. CRAIG:

4 Q: All right. Dr. Ernest, it is -- it's getting to be  
5 lunchtime. My stomach is growling. I'm sure yours probably  
6 is too. So let's see if we can -- we can work through the  
7 remaining questions quickly and efficiently.

8 Before the break, I had asked you this question. Do you  
9 have an opinion whether suprapubic pressure can cause a  
10 brachial plexus injury, and what was your answer?

11 A: No, I don't think it can.

12 Q: So, what -- how about incorrect suprapubic pressure? Do  
13 you have an opinion whether incorrect suprapubic pressure can  
14 cause a brachial plexus injury?

15 A: I do have an opinion and I don't think that could  
16 either.

17 Q: So what does the fact that -- if there was suprapubic  
18 pressure or if there wasn't suprapubic pressure, what does  
19 that have to do with a brachial plexus injury, if anything?

20 A: Well, it's not going to hurt anything just because you're  
21 pushing, for example, on the bone, which is what the nurse  
22 said she did in her deposition. It doesn't help anything  
23 during that time, but it doesn't hurt either.

24 Q: How do we know that suprapubic pressure was appropriately  
25 applied in this case?

1 A: Well, we -- as I said earlier, we have the record in the  
2 chart that says it was applied. We have the deposition of Dr.  
3 Browning that it was applied. And we have Ms. Byrd's  
4 recollection when she described the delivery to one of the  
5 treating physicians for Julia that it was applied.

6 Q: Okay. And now, tell us why internal maneuvers -- and  
7 we've already talked about the various internal maneuvers.  
8 We're not going to go back through that. Why were internal  
9 maneuvers unnecessary in this delivery?

10 A: You do the internal maneuvers if the external maneuvers  
11 don't work, and we've talked about the timeframe within which  
12 to work. The external maneuvers, the maternal maneuvers, the  
13 McRoberts and the suprapubic, worked within 45 seconds. So  
14 with that timeframe, having already manipulated the shoulder  
15 so that it could deliver, you don't need to do the internal  
16 maneuvers.

17 Q: Thank you. All right. Let's talk about the video  
18 briefly. You reviewed the video; correct?

19 A: Yes.

20 Q: All right. And in reviewing of the video, do you have an  
21 opinion whether the traction that you saw in the video -- was  
22 that reasonable and appropriate?

23 A: Yes.

24 Q: Did you see anywhere in the video that Dr. Browning used  
25 excessive traction?

1 A: No.

2 Q: Is there anything about the traction on the video that  
3 concerns you, sir?

4 A: No.

5 Q: And what would you have done differently if you had been  
6 the doctor that was delivering this baby?

7 A: Nothing.

8 Q: There were some questions about Pitocin. What is  
9 Pitocin, just briefly?

10 A: Uh-huh. Pitocin is the medicine we use to either cause  
11 contractions to start or to increase the intensity or the  
12 frequency of them. It's given in labor.

13 Q: Okay. And does Pitocin have anything to do with this  
14 case?

15 A: No.

16 Q: Was the Pitocin appropriate?

17 A: Yes.

18 Q: Doctor, do you have an opinion whether it was reasonable  
19 for Dr. Browning to readjust the nurse's positioning to  
20 perform the suprapubic pressure?

21 A: Uh-huh. Yeah.

22 Q: What would you have done if you had seen that the nurse  
23 in the delivery room needed to have the angle of her -- of her  
24 body changed to help the suprapubic pressure? What would you  
25 do?

1 A: Well, what I would do and what I do is ask the nurse to  
2 get up on some higher -- a chair or a stool, whatever she can  
3 can, get up on the bed sometimes, to apply traction at a  
4 different angle. It's -- it's just a standard way that we can  
5 improve the ability to apply suprapubic pressure.

6 Q: Dr. Ernest, explain how a brachial plexus injury can  
7 occur even when there is no excessive traction?

8 A: Well, the -- there are a number of different ways that  
9 brachial plexus injuries can occur long before the doctor  
10 touches the baby. The -- as you heard earlier, there's a lot  
11 of internal force that the mother's uterus and the pushing,  
12 and even the McRoberts maneuver generates additional force.

13 The numbers that we have come up with have been about 160  
14 newtons and the number is not really critical except to put it  
15 in relation to what the doctor applies. But several years  
16 ago, a study was done that actually measured the pressure in  
17 the uterus --

18 MR. GRAHAM: Objection, Your Honor. Improper use of a  
19 learned treatise. He can read portions, but I don't think  
20 this is proper.

21 MS. CRAIG: Your Honor, he's not referring to a learned  
22 treatise at this point.

23 THE COURT: I agree. Overruled. Go ahead.

24 BY MS. CRAIG:

25 A: You can measure the amount of force that the uterus

1 generates. And when -- when that has been done, it is shown  
2 in humans having normal human babies that the force can be up  
3 to 160 newtons. Now, contrary --

4 Q: I'm sorry. What is -- what is the force that you're  
5 talking about that can be up to 160 newtons?

6 A: This is the -- this is the internal pressure, the  
7 endogenous, the maternal forces before the doctor ever gets  
8 their hands on the baby.

9 Q: Is that when the mama's body is contracting?

10 A: That's the pushing force. We've talked about the pushing  
11 and the pulling. This is the pushing force.

12 Contrast that with other studies that have shown that the  
13 pulling force to overcome a shoulder dystocia is around 100 in  
14 at least one study that -- that used gloves that can measure  
15 the force, and that's been shown in other studies as well.

16 And then we contrast that with physicians who have done  
17 courses, who have practiced, who have actually had their force  
18 measured, who know what their force is and can keep the force  
19 or at least know what a force is below 100. So the internal  
20 force is in -- probably in most cases much more than the  
21 external force. The pushing force is much more than the  
22 internal force.

23 So when that's happening, if a shoulder does not move at  
24 the same rate as the spine, something like this happens. The  
25 baby is one part obviously, but the shoulders, if it gets

1 stuck, can stay put, but the body can keep moving because the  
2 uterus is pushing against the bottom of the baby. And I hope  
3 you can see that.

4 If I'm -- if I'm the baby delivering and I'm upside down  
5 and the uterus is pushing on my bottom end, my head is going  
6 to continue to stretch, but my shoulders are going to stay  
7 put, at least not this one, if this one is the one behind the  
8 pubic bone. So this kind of thing happens and you can see the  
9 stretching that could happen.

10 Now, during that time there's also rotation. There's  
11 flexion that's a normal part of the delivery process. And so  
12 we -- we have a lot of evidence to tell us that during that  
13 time, some babies can be injured. There are different ways to  
14 measure that, different ways to know that. So the internal  
15 forces are a potential problem.

16 Some babies can have either an abnormal rib or they can  
17 have a tumor. They can have an infection. There can be  
18 amniotic membrane abnormalities that put extra pressure.  
19 Sometimes the position of the baby's arm in the uterus can be  
20 abnormal. Sometimes the uterus can have an abnormal shape,  
21 like fibroids. All these things can put additional  
22 compression force on the baby's brachial plexus that can  
23 injure it, again, long before the doctor can participate.

24 Sometimes the babies can be more susceptible to injury.  
25 This has been shown in other studies where babies have a

1 susceptibility that you don't know about.

2 MR. GRAHAM: Objection. That has no relevance to this  
3 case.

4 THE COURT: What was the question again?

5 MS. CRAIG: He is explaining to the jury the other causes  
6 of brachial plexus injuries other than excessive traction.

7 THE COURT: I'm going to overrule it. Go ahead.

8 BY MS. CRAIG:

9 A: Some -- some babies can be more susceptible to an injury;  
10 so that the normal amount of force that the doctor applies can  
11 cause a problem even though it was normal and appropriate. So  
12 some babies have an injury before the doctor participated for  
13 different reasons. Some babies are susceptible and could be  
14 injured during the normal process. So those are -- those are  
15 a general answer to that.

16 Q: So now that we've discussed all of the other causes of a  
17 brachial plexus injury in a general sense, let's talk about  
18 this case. All right? And based upon what you have seen on  
19 the video and all of the documents that you have reviewed, do  
20 you have an opinion whether Dr. Browning caused the child's  
21 brachial plexus injury?

22 A: I do have an opinion.

23 Q: What's that opinion?

24 A: That he did not cause the injury.

25 Q: Is your opinion also supported by the medical and

1 scientific literature?

2 A: Yes.

3 Q: Now, before we run through the scientific and medical  
4 literature, just a couple of quick definitions that we'll hear  
5 in the -- in the literature. What is compression?

6 A: Compression is what you would expect it to be. It's  
7 pressing or a force that flattens or applies a force to, in  
8 this definition, the brachial plexus. And there's always  
9 compression of the shoulder and there's always compression of  
10 the nerves when there's a shoulder dystocia because that's the  
11 whole thing that's happening. There's pressure against the  
12 shoulder and the nerves against the pubic bone.

13 Q: All right. And one more definition. And you referred to  
14 the internal forces just a minute ago, but we'll -- we'll hear  
15 about maternal forces or endogenous forces. What is -- what  
16 is that?

17 A: Well, endo means internal and exo means external. So  
18 endo -- endogenous is the internal forces, the uterus, the  
19 pushing, McRoberts. When a woman's legs are pulled back, not  
20 only does it open up the pelvis a bit, but it also increases  
21 the pressure in the uterus and that helps push the baby out.  
22 So those are all pushing or endogenous forces, endo, inside.

23 The exogenous forces are the ex -- ex -- the outside are  
24 generally the traction force, the pulling force that the  
25 doctor or the nurse applies.



1 Q: Okay. Thank you. All right. We are going to start with  
2 the ACOG Neonatal Brachial Plexus Palsy. Doctor, are you  
3 familiar with this publication?

4 A: Uh-huh. Yes.

5 Q: All right. And is this publication considered reliable  
6 in your field of expertise?

7 A: Yes.

8 Q: Okay. And if you will, tell us are you familiar with the  
9 task force that the ACOG asked to look into the neonatal  
10 brachial plexus palsy and the findings that they found?

11 MR. GRAHAM: Objection, Your Honor. We ask that they use  
12 learned treatises in accordance with the rules. If they want  
13 to read something from the document, that's fine, but all this  
14 editorial comment we object to.

15 MS. CRAIG: Your Honor, I'm establishing it's a learned  
16 treatise.

17 THE COURT: Keep going.

18 MS. CRAIG: Thank you.

19 BY MS. CRAIG:

20 Q: So are you familiar with the task force?

21 A: Yes.

22 Q: Okay. And just tell us briefly your understanding of the  
23 task force so we understand this -- this publication?

24 A: This task force was set up by a former president of the  
25 American College at the time to delve into this problem of

1 brachial plexus palsy because everybody, obstetricians,  
2 pediatricians, surgeons, and most importantly families, wanted  
3 to know what we could do to reduce -- to understand it better  
4 and to reduce or prevent it.

5       So one of the former ACOG presidents developed a task  
6 force that had obstetricians, mechanical engineers,  
7 pediatricians, neurologists, surgeons, people that understood  
8 the different aspects of a delivery, both from a medical and a  
9 mechanical -- and an engineering perspective, and then also  
10 those that cared for the baby to come together as a task force  
11 and put together what we currently know about brachial plexus  
12 palsy. So that's what this -- the result of this was this  
13 129-page document.

14 Q:   Okay. Thank you. And do you have an idea or an estimate  
15 how long it took the authors to obtain this information  
16 included in this monograph or this document?

17 A:   I don't remember specifically, but it was a year or two  
18 or three. It was some period of time because they had  
19 meetings, they had to gather the information, meet about it,  
20 write it. So it was a period of months, if not years.

21 Q:   Okay. And it appears in the document that this -- this  
22 publication has been endorsed by the March of Dimes --

23       MR. GRAHAM: Objection, Your Honor. Objection. This is  
24 -- I mean at this point, Your Honor, I ask that she be  
25 restricted to just reading from the document. She's trying to

1 embellish it and that's -- that's -- what's good for the goose  
2 is good for the gander, Your Honor.

3 THE COURT: Your response to that?

4 MS. CRAIG: Yes, sir. I was just getting ready to ask  
5 him to read all of the groups that have endorsed this  
6 publication.

7 THE COURT: Go ahead.

8 MS. CRAIG: Thank you.

9 BY MS. CRAIG:

10 Q: So on page -- this Roman number XIV, there's a list of  
11 groups that have endorsed this publication. If you could,  
12 just read that list for us?

13 A: The March of Dimes Foundation and the Royal College of  
14 Obstetricians and Gynecologists have offered their full  
15 support of this report. In addition, the following  
16 professional organizations have endorsed this report: The  
17 American Academy of Pediatrics, The American Academy of  
18 Physical Medicine and Rehabilitation, The American College of  
19 Nurse-Midwives, The American Gynecological and Obstetrical  
20 Society, The American Society for Reproductive Medicine, The  
21 Child Neurology Society, The Japan Society for Obstetrics and  
22 Gynecology, The Royal Australian and New Zealand College of  
23 Obstetricians and Gynecologists, The Society for Maternal-  
24 Fetal Medicine, The Society of Obstetricians and Gynecologists  
25 of Canada.

1 Q: Thank you.

2 MS. CRAIG: Your Honor, I think the most efficient way to  
3 go through the medical articles is if the doctor could come  
4 down and I could hand them to him --

5 THE COURT: That's fine.

6 MS. CRAIG: -- and he could publish them.

7 THE COURT: That's fine with me.

8 MS. CRAIG: Would that be all right? Thank you.

9 THE COURT: Go ahead.

10 MS. CRAIG: All right. Doctor, if you'll come down?

11 (WHEREUPON, The witness complied.)

12 BY MS. CRAIG:

13 Q: And in this particular publication, I would like for you  
14 to publish what I have marked, if you would. All you need to  
15 do is just to read the portion marked.

16 MR. GRAHAM: Your Honor, may we please get the reference  
17 to the article and the page and line?

18 THE COURT: That would be fine.

19 MS. CRAIG: Yes, sir. It's the Executive Summary and  
20 it's Roman number XVI and it's under causation and this  
21 document, of course, doesn't have line numbers.

22 THE COURT: All right. Continue.

23 MS. CRAIG: It's the second paragraph.

24 BY MS. CRAIG:

25 A: Neither high quality nor consistent data exists --

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1 THE COURT: She can't -- the court reporter cannot hear  
2 him.

3 MS. CRAIG: You're going to have to speak up. Stand  
4 right here if you can.

5 MR. GRAHAM: May I see where you're reading from, please?

6 MS. CRAIG: I have another copy, Mr. Graham. Would you  
7 like to see it?

8 MR. GRAHAM: Well, the copy you gave me doesn't match the  
9 copy that you've given the witness. That's the problem.

10 MS. CRAIG: Your Honor, I've provided all of the  
11 documentation to counsel prior to trial this morning, and I  
12 was -- counsel said that they had several copies of the ACOG  
13 Journal.

14 THE COURT: I remember that.

15 MS. CRAIG: I do have another set that I'll give to him.

16 MR. GRAHAM: Your Honor, may I show you what she told me  
17 she was going to use?

18 (WHEREUPON, a bench conference was held in the presence  
19 of the jury but out of the hearing of the jury as  
20 follows.)

21 THE COURT: You know, the question is do you have it or  
22 do you not have it?

23 MR. GRAHAM: I don't have it handy because she told me  
24 this is what she would be using and she's using something  
25 different.

1 THE COURT: How is that different?

2 MS. CRAIG: This is the second paragraph. XVI is the  
3 Executive Summary and he's going to publish the highlighted  
4 portion.

5 MR. GRAHAM: No. Your Honor, this is page 902. It's  
6 902. That has letters instead of numbers.

7 MS. CRAIG: This morning --

8 THE COURT: Either way, is it in there? Does it have  
9 that?

10 MS. CRAIG: I don't know. I asked Mr. Ruffin this  
11 morning. I said I'm going to reference this journal and he  
12 said we've got several copies. If Mr. Graham would like to  
13 read along with us --

14 THE COURT: That's fine. Stand up there with them.

15 MS. CRAIG: Then the three of us can stand up there  
16 together.

17 MR. GRAHAM: Well --

18 MS. CRAIG: Sir, it's right here.

19 THE COURT: Stand up there with them.

20 (WHEREUPON, the bench conference ended and the  
21 proceedings resumed as follows.)

22 MS. CRAIG: Stand right next to us. Okay. Mr. Graham,  
23 would you like to come up? Okay.

24 BY MS. CRAIG:

25 Q: If you could stand right here so the court reporter can

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1 hear you and if you can just publish under causation, the  
2 second paragraph?

3 A: Neither high quality nor consistent data exists to  
4 suggest that neonatal brachial plexus palsy can be caused only  
5 by a specific amount of applied force beyond that typically  
6 used by healthcare providers during any delivery. Instead,  
7 available data suggests that the occurrence of neonatal  
8 brachial plexus palsy is a complex event dependent not only on  
9 the forces applied at the moment of delivery, but also on the  
10 constellation of forces. For example, the vector and rate of  
11 application.

12 Q: Okay. Thank you. Now, we will go to --

13 THE COURT: He's going to have to speak up a whole lot  
14 more if she's going to have a record.

15 MS. CRAIG: Yes, sir. Okay.

16 THE COURT: I can tell you that.

17 MS. CRAIG: All right. We will.

18 THE COURT: Would you like for him to read that again?

19 THE COURT REPORTER: I think I caught it.

20 MS. CRAIG: All right.

21 BY MS. CRAIG:

22 Q: Doctor, we're going to move now quickly to page 34 under  
23 Biomechanics of Nerve Injury. If you will, please, read the  
24 highlighted portion?

25 THE COURT: And speak up loud.

1 BY MS. CRAIG:

2 A: Compression alone can result in permanent injury if the  
3 compression is maintained for a sufficient period and is of a  
4 significant magnitude.

5 Q: Thank you.

6 MR. GRAHAM: May we ask for a pause, Your Honor, so I can  
7 go make notes about what they're reading from since it's not  
8 in here?

9 THE COURT: No. We're going to keep going. You can make  
10 notes fast and tell him to speak up now.

11 MS. CRAIG: Yes, sir.

12 THE COURT: She has to hear.

13 MS. CRAIG: Yes, sir.

14 THE COURT: She's the one that's important.

15 MS. CRAIG: You need to speak up loudly. All right.

16 BY MS. CRAIG:

17 Q: Page 37, under Summary, if you could, read the  
18 highlighted portion, sir?

19 A: Neither high quality nor consistent data exists to  
20 suggest that neonatal brachial plexus palsy can be caused only  
21 by a specific amount of applied force beyond that typically  
22 used by healthcare providers and experienced during a delivery  
23 without neonatal brachial plexus palsy. Instead, much of the  
24 data suggests that the occurrence of neonatal brachial plexus  
25 palsy is a complex event dependent not only on the forces



1 applied at the moment of delivery, but also on the  
2 constellation of forces, for example, vector and rate of  
3 application, that have been acting on the fetus during the  
4 labor and delivery process, as well as individual fetal tissue  
5 characteristics, for example, in situ strain and acid-base  
6 balance.

7 Q: Okay. Thank you. The next one. It's on page 47 under  
8 Head-to-Body Delivery Interval.

9 A: During shoulder dystocia deliveries, shoulder impaction  
10 and a prolonged head-to-body delivery interval can lead to  
11 birth asphyxia and subsequent neonatal hypoxic-ischemic  
12 encephalopathy. In 1998, a case-control study of 15 infants  
13 with permanent brain injury after recognized shoulder dystocia  
14 demonstrated that a head-to-body interval of 7 minutes or more  
15 had 67 percent sensitivity in predicting permanent brain  
16 damage. Since then, two larger studies have shown that  
17 permanent neurologic injury can occur as soon as 2 minutes  
18 after shoulder impaction, although the risk of acidosis or  
19 severe hypoxic-ischemic encephalopathy remains low with less  
20 than 5 minutes of impaction.

21 Q: Thank you. And we have one more. No. That's the actual  
22 illustration. So that's it with ACOG. Don't go anywhere.  
23 All right.

24 (WHEREUPON, an article was marked as Court's Exhibit  
25 Number 10.)

1 BY MS. CRAIG:

2 Q: Next, we have what's been pre-marked as Court's Exhibit  
3 10. If you could, identify that document, please, for the  
4 record?

5 A: This is a --

6 MS. CRAIG: Mr. Graham, you do have all of this.

7 MR. GRAHAM: Yes, but you gave mine different numbers,  
8 Ms. Craig. So that's why I'm checking to see what is Exhibit  
9 10. In mine, it's Exhibit 1.

10 MS. CRAIG: Okay.

11 BY MS. CRAIG:

12 Q: If you could, identify the title, please?

13 A: This is an article entitled *Prediction of Brachial Plexus*  
14 *Stretching During Shoulder Dystocia using a Computer*  
15 *Simulation Model.*

16 Q: Okay. And do you consider this to be a reliable  
17 treatise?

18 A: Yes.

19 Q: Okay. All right. Tell us -- if you will, please read  
20 under the Table II. If you could, tell us the -- the  
21 endogenous forces and the exogenous forces, and I'm  
22 specifically looking at the bottom of the table for McRobert's  
23 and the degree of stretching.

24 A: This study was done using a --

25 MR. GRAHAM: No. Objection, Your Honor. He can only

1 read it within the rules.

2 THE COURT: And speak up, please.

3 THE WITNESS: Okay.

4 MS. CRAIG: Yes, sir.

5 THE COURT: He's very soft-spoken.

6 BY MS. CRAIG:

7 A: Endogenous McRoberts, 20 degrees. Brachial plexus  
8 stretching, 14.5 percent. Exogenous McRoberts, 20 degrees.  
9 Axial/fixed, 6.5 percent stretch.

10 Q: All right. And before I ask you about the -- oh, I do  
11 have a follow-up, but what is -- I needed one more definition.  
12 What is exogenous?

13 A: Exogenous is the doctor-generated force.

14 Q: And so in the same article -- and it's Court's Exhibit  
15 10. If you could, just publish that portion.

16 A: Exogenous delivery loads with McRoberts positioning and  
17 axial placement of the fetal head was associated with the  
18 least amount of stretching.

19 (WHEREUPON, an article was marked as Court's Exhibit  
20 Number 9.)

21 MS. CRAIG: Thank you.

22 BY MS. CRAIG:

23 Q: All right. Next is Court's Exhibit 9. If you could,  
24 please give us the identification of the title of that?

25 A: The title is *Use of McRoberts Position During Delivery*

1     *and Increase in Pushing Efficiency.*

2     Q:     Okay.

3     A:     There's a separate second page to this title also.

4     Q:     Okay.

5           THE COURT:   Speak up.

6           MS. CRAIG:   Yes.

7           THE COURT:   Please.

8           MS. CRAIG:   All right.  He just said there's a second  
9     page that --

10          THE COURT:   You may want to move over this way a little  
11     bit.  She's having a hard time hearing --

12          MS. CRAIG:   Yes, sir.

13          THE COURT:   -- everything.  You might even be better --  
14     how about speak into the microphone?

15          MS. CRAIG:   Will that work?  Yes.  That's a great idea.  
16     Let's move this over here.  Here we go.  All right.  So you  
17     talk into the microphone and I'll be over here.  All right.

18     BY MS. CRAIG:

19     Q:     So you said there was two pages?

20          MS. CRAIG:   Your Honor, I'd ask permission to substitute  
21     Court's 9 for one -- this only has one page and it actually  
22     has two.

23          THE WITNESS:  Right.

24          MS. CRAIG:   I'd like to substitute that at the  
25     appropriate time.

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1 MR. GRAHAM: Your Honor, may I get a copy of the article  
2 that they're referencing, it wasn't included in my stack.

3 MS. CRAIG: Your Honor, it was included. He can look on  
4 with us if you'd like to.

5 MR. GRAHAM: It's included? Please show me where.

6 MS. CRAIG: Your Honor --

7 THE COURT: Why don't -- why don't you go ahead and just  
8 look over the shoulder and look at what she's reading -- he's  
9 reading?

10 MS. CRAIG: All right.

11 BY MS. CRAIG:

12 Q: Doctor, so if you could, read the highlighted portion on  
13 Court's Number 9?

14 A: Spontaneous uterine contractions generated a force of  
15 about 82 newtons at the pelvic inlet, .0091 meters square.  
16 Valsalva with the legs in stirrups added 47 newtons, 57  
17 percent, whereas McRoberts maneuver applied 31 newtons, 38  
18 percent, of additional pushing force.

19 Q: Okay. Thank you.

20 MR. GRAHAM: May I see the title to that document,  
21 please? What exhibit did you say this was, please?

22 MS. CRAIG: If you look at the top, it says 9. Your  
23 Honor, may I proceed?

24 THE COURT: You may.

25 MS. CRAIG: Thank you.

1 THE COURT: Please.

2 (WHEREUPON, an article was marked as Court's Exhibit  
3 Number 8.)

4 BY MS. CRAIG:

5 Q: Under now Court's Exhibit 8, we have an article that was  
6 authored by the plaintiff's expert in this case, Dr. Grossman.  
7 If you could, please identify the title of that article?

8 A: The title is *Fetal Deformations: a Risk Factor for*  
9 *Obstetrical Brachial Plexus Palsy*, question mark.

10 Q: Okay. And then on the next page --

11 THE COURT: Hold on. We didn't -- we didn't get that.

12 MS. CRAIG: Okay.

13 THE COURT: I think he needs to come right over here and  
14 stand in the witness box.

15 MS. CRAIG: Yes, sir.

16 (WHEREUPON, the witness complied.)

17 THE COURT: We're not giving you a hard time. You're  
18 just very soft-spoken.

19 THE WITNESS: I'm sorry. Can I sit so that I can --

20 THE COURT: Sure. You do whatever suits you.

21 THE WITNESS: I think that mic works better this way.

22 MR. GRAHAM: May I position myself so I can see what  
23 you're reading?

24 THE COURT: Sure.

25 BY MS. CRAIG:

1 Q: So, this is Court's Exhibit 8, previously produced to  
2 counsel, and as, you know, of course, Dr. Grossman is an  
3 expert for the plaintiff; correct?

4 A: Uh-huh. Yes.

5 Q: If you will, look at this second page and if you'll  
6 publish what Dr. Grossman wrote in his article?

7 A: Forces that stretch and sometimes tear the brachial  
8 plexus during labor are generated by intrauterine  
9 contractions, external manipulation, or both.

10 Q: Thank you. The next document is *Shoulder Dystocia: An*  
11 *Evidence-Based Evaluation of an Obstetric Nightmare*. Do you  
12 recognize this is a reliable publication?

13 A: Yes.

14 Q: Okay. Please, if you will, read the highlighted  
15 portion?

16 A: Although most shoulder dystocias are resolved within a  
17 few minutes, fetal or neonatal death can still result from  
18 this obstetric emergency.

19 Q: Thank you.

20 MS. CRAIG: All right. We'll mark that as -- as Court  
21 Exhibit 11.

22 MR. GRAHAM: May I see please what he's reading from?  
23 (WHEREUPON, the article was marked as Court's Exhibit  
24 Number 13.)

25 MS. CRAIG: Number 13. Your Honor, it's page 357 of the

1 Court's Exhibit 13.

2 MR. GRAHAM: Yes, but which lines, please? Thank you.

3 MS. CRAIG: All right.

4 BY MS. CRAIG:

5 Q: Moving on, Doctor. Keep going. Next one is *Permanent*  
6 *Erb Palsy: A Traction-Related Injury?* If you could, please  
7 tell us whether or not you recognize this as a reliable  
8 learned treatise?

9 A: Yes, it is.

10 Q: Okay. Please publish the highlighted portion?

11 A: We have encountered several cases of permanent Erb palsy  
12 associated with birth that were not attributable to traction  
13 applied at delivery.

14 And the second highlighted area is:

15 We have encountered several cases of permanent Erb palsy  
16 that were not related to manipulations performed at the time  
17 of delivery.

18 Q: Okay. And now moving on --

19 MS. CRAIG: We'll mark that as the next Court's exhibit,  
20 which will be 14. While he's doing that, we'll just keep  
21 going. Thank you.

22 (WHEREUPON, the article was marked as Court's Exhibit  
23 Number 14.)

24 BY MS. CRAIG:

25 Q: *Severe Brachial Plexus Palsy in Women Without Shoulder*



1 Dystocia. Do you recognize this as a reliable publication?

2 A: Yes.

3 Q: And just read that first page, please, the highlighted  
4 portion?

5 A: In this study, we present a series of cases of severe  
6 brachial plexus palsy that occurred without shoulder dystocia.  
7 These results demonstrate that severe brachial plexus palsy  
8 occurs in women without shoulder dystocia and without  
9 identifiable risk factors.

10 Q: Thank you.

11 MR. GRAHAM: Excuse me.

12 MS. CRAIG: We'll mark this as the next exhibit. Thank  
13 you.

14 (WHEREUPON, the article was marked as Court's Exhibit  
15 Number 15.)

16 BY MS. CRAIG:

17 Q: Next, *Shoulder Dystocia* is the name of this and this  
18 appears to be in the Clinics of Perinatology. Doctor, do you  
19 agree that this is a reliable publication?

20 A: Yes.

21 Q: Okay. Let me see if I can quickly get to the page. The  
22 page I'd like for you to publish from is 371.

23 A: The mere existence of a permanent brachial plexus palsy  
24 that was present from birth, no matter its extent or  
25 classification, necessarily bespeaks negligence or misconduct

1 on the part of the delivering clinician.

2 Q: Thank you.

3 MS. CRAIG: We'll mark this is the next Court exhibit.

4 (WHEREUPON, the article was marked as Court's Exhibit  
5 Number 16.)

6 MS. CRAIG: Okay. We're getting there. Let's wrap this  
7 up.

8 BY MS. CRAIG:

9 Q: The next one we have would be from the *Journal of Child*  
10 *Neurology*. Do you recognize that as a reliable publication?

11 A: Yes.

12 Q: Okay. And I'm going to ask that you read from the  
13 discussion portion of this article, which appears to be -- I  
14 don't see page numbers. It's on the second page of the  
15 article.

16 MR. GRAHAM: Can I see the title?

17 BY MS. CRAIG:

18 A: Finally, our study confirms that the obstetrical brachial  
19 plexus palsy can occur following a routine delivery.

20 Therefore, our study clearly demonstrates that the normal  
21 forces of labor and delivery can lead to obstetric brachial  
22 plexus palsy.

23 Q: Thank you.

24 MR. GRAHAM: Hold on just a second. The lead author was  
25 who?

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1 MS. CRAIG: We'll mark that as the next Court exhibit.  
2 (WHEREUPON, the article was marked as Court's Exhibit  
3 Number 17.)

4 MR. GRAHAM: Excuse me, Your Honor. I don't believe I  
5 was furnished that one either. I apologize. It just has a  
6 different exhibit number. Could I see the parts that were  
7 read, please?

8 MS. CRAIG: Your Honor, would you like for me to  
9 continue?

10 THE COURT: Yes.

11 MS. CRAIG: Thank you.

12 BY MS. CRAIG:

13 Q: The next and the last one is from the *Fetal Deformations:*  
14 *A Risk Factor of Obstetrical Brachial Plexus Palsy*. And  
15 again, this is an -- is this the same article that we've  
16 already done from Dr. Grossman?

17 A: Yes.

18 Q: Okay. Thank you. We've already done that one. Those  
19 are all of the articles that I have right now. Thank you.  
20 Thank you for going through all of that medical literature  
21 with us, Doctor.

22 Based on your review of all of this literature and your  
23 training and your experience, do you have an opinion of  
24 whether or not the brachial plexus injury in this case was  
25 caused by Dr. Browning?

1 A: I do have an opinion.

2 Q: And what is that opinion, sir?

3 A: That he did not cause this injury.

4 Q: So how can a brachial plexus injury occur during a  
5 delivery and it's not the doctor's fault?

6 A: Well, we've talked about this and that literature is just  
7 a fraction of what has been published to show us that there  
8 are pushing forces and there are pulling forces. The pushing  
9 forces have been measured in patients. We know the magnitude  
10 of those forces. We have the advantage in this situation of  
11 seeing the pulling forces that Dr. Browning applied, and the  
12 pulling forces clearly don't give any evidence that they were  
13 strong enough or in the wrong direction to hurt the baby.

14 Therefore, if there was no tumor, if there was no  
15 infection, if there was no amniotic band, all the other things  
16 we talked about that are physical things you can see, the  
17 injury had to have occurred before the delivery or before Dr.  
18 Browning started the traction, which means what's left is the  
19 endogenous or the pushing forces.

20 Q: Okay. And when you say the endogenous forces, tell us  
21 exactly what that means?

22 A: Again, endogenous is endo, inside. The contractions and  
23 the mother's pushing and the McRoberts are all forces that are  
24 inside the uterus that increase the pressure and the  
25 compression and the stretching on the nerves before the doctor

1 ever gets his or her hands on the baby.

2 Q: Thank you, Doctor. Do you feel as though -- I know that  
3 you said that there's a lot more medical literature. Do you  
4 feel as though that we have hit on the highlights of the  
5 medical literature that supports your opinion --

6 A: Uh-huh.

7 Q: -- that it was the endogenous forces of labor that most  
8 likely caused the brachial plexus injury?

9 A: I think that that gives a good overview because it comes  
10 from different journals, from different specialties, from  
11 different countries, and the conclusions come up over and over  
12 and over again that this is the case.

13 Q: Thank you. All right. Moving on, I'm almost finished.  
14 Just a couple of questions about hindsight. Do you have an  
15 opinion whether a doctor has the benefit of hindsight when he  
16 or she is delivering a baby?

17 A: Of course not.

18 Q: Based upon the medical literature, the records,  
19 deposition testimony, the video that you have reviewed in  
20 this case, do you have an opinion to a reasonable degree of  
21 medical certainty whether Dr. Browning met the standard of  
22 care?

23 A: Yes, I do.

24 Q: What is that opinion?

25 A: That he very clearly met it.

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1 Q: The same question regarding the medical literature, the  
2 video, the deposition testimony, and all of the medical  
3 records, do you have an opinion whether or not Dr. Browning  
4 caused the injury in this case?

5 A: Yes, I do.

6 Q: And what is that opinion?

7 A: It's very clear that he did not cause the injury.

8 Q: Doctor, are all of the opinions that you have given today  
9 been to a reasonable degree of medical certainty most  
10 probably?

11 A: Yes.

12 MS. CRAIG: Thank you, sir. Those are all the questions  
13 I have.

14 THE WITNESS: You're welcome.

15 THE COURT: All right. Mr. Graham?

16 MR. GRAHAM: Your Honor, is it possible that we can have  
17 a lunch break at this time?

18 THE COURT: I think the jury wanted to go ahead and wrap  
19 it up. When this witness is done, we are finished. Do you  
20 want to stay and continue or do you want a lunch break? I'm  
21 good with either one.

22 A JUROR: Take a lunch.

23 A JUROR: Lunch break.

24 THE COURT: You want to take a lunch break? All right.

25 Why don't you come back at -- can you be back at 2:15? No,

1 no, no. Let's see. It's quarter to. How about 3? Can you  
2 be back at 3? All right. We'll see you at 3.

3 (WHEREUPON, the jury exited the courtroom at 1:44 p.m.)

4 THE COURT: All right. We'll see you at 3 o'clock.

5 MS. CRAIG: Yes, sir.

6 (WHEREUPON, there was a break in the proceedings from  
7 1:45 p.m. until 3:11 p.m.)

8 THE COURT: It's my understanding that Mr. Graham had  
9 promised you would be done in 15 minutes. Is that right? Is  
10 that what I heard? All right. I'll hold you to it.

11 MR. RUFFIN: Your Honor, I have one thing to bring to the  
12 Court's attention.

13 THE COURT: Sure.

14 MR. RUFFIN: When I got on the elevator on the first  
15 floor, I'm not sure if a juror was on there already or if he  
16 got on another floor, but I ended up on the jury -- on the  
17 elevator with a juror and I saw the yellow thing and then he  
18 asked me how old I was, at which point I immediately froze.  
19 And I'm not sure if I answered or not. I think I might have  
20 answered with my age.

21 And I'm bringing it to the Court's attention because I  
22 don't know if he thinks I was rude about kind of turning away  
23 from him and not trying to be responsive. I don't know if  
24 Your Honor had been instructing the jurors to not communicate  
25 with us.

1 THE COURT: I haven't said anything to them. I just told  
2 them not to talk about the case. As long as they're not  
3 talking about the case, I think we're in good shape.

4 MR. RUFFIN: Okay.

5 THE COURT: Any objections from you?

6 MS. CRAIG: If you could just identify who the juror was?

7 THE COURT: Do you know?

8 MR. RUFFIN: I don't. I mean I know race.

9 MS. CRAIG: If you can describe them?

10 MR. RUFFIN: I see no reason why she has an objection to  
11 it.

12 THE COURT: Well, go ahead and just tell us what he looks  
13 like for the record.

14 MR. RUFFIN: African-American male.

15 THE COURT: Old? Young?

16 MR. RUFFIN: Somewhere in the middle. Less than 40.

17 MS. CRAIG: If he could just show us who -- I mean if he  
18 can identify the juror by number when the jurors sit down,  
19 just so that we have that on the record.

20 THE COURT: Okay.

21 MS. CRAIG: And, Your Honor --

22 THE COURT: You can just say back row -- well, I don't  
23 know how -- how you want to do that.

24 THE LAW CLERK: They can come up here.

25 THE COURT: Yeah, come on up here and just tell us. How



1 about that?

2 MS. CRAIG: Yeah. That would be fine.

3 MR. RUFFIN: I mean if she has an objection to the  
4 communication, I'd like to know it now before she identifies  
5 who the juror is for purposes of deciding whether to strike  
6 them.

7 THE COURT: Well, I think just in case something does  
8 come up --

9 MR. RUFFIN: Okay.

10 THE COURT: -- that's inappropriate, we need to know --

11 MR. RUFFIN: Okay.

12 THE COURT: -- exactly who it was.

13 MR. RUFFIN: Fair enough.

14 THE COURT: I don't think it --

15 MS. CRAIG: Thank you. Your Honor, and then also a  
16 housekeeping matter. During the direct examination of Dr.  
17 Ernest, Mr. Graham appeared to act as though he had never seen  
18 these medical articles before. I would like for Your Honor to  
19 know that, first of all, I brought in this morning a stack of  
20 medical articles that I gave to Mr. Ruffin and said that these  
21 are the ones that I intend to use with the witness, the same  
22 medical articles we used the last trial. The same medical  
23 articles we used the other trial.

24 THE COURT: I understand.

25 MS. CRAIG: And I also said I was going to use the ACOG

1 journal and he said we have a couple of copies of those. So I  
2 just want Your Honor to know that that was not a surprise to  
3 plaintiff's counsel. This is stuff that had been produced in  
4 discovery and what I had done is I took the exhibits from Dr.  
5 Ernest's deposition, pulled those off of the actual deposition  
6 that I had, and gave them another copy of those articles.

7 THE COURT: All right.

8 MS. CRAIG: And then, Your Honor, also -- all right. And  
9 so also, during the lunch hour, we made copies of the medical  
10 articles that we have as Court's exhibits and I was going to  
11 -- I was going to ask if I could substitute copies. Because  
12 actually -- to make it go faster, I actually used my copies  
13 out of a notebook. I wanted to see if I could have those back  
14 and substitute copies that we did at the break. And they  
15 would be Court's Exhibit 8, 9, 10, 13 through 16.

16 THE COURT: All right. Any problems with that, Mr.  
17 Ruffin? You're a lot quicker. Let me hear from you. You got  
18 a problem with it or not?

19 MR. RUFFIN: Well, I think that in terms of --

20 THE COURT: We're just substituting.

21 MR. RUFFIN: Right. There's no problem with that. I  
22 mean the representation about how the records were given to us  
23 --

24 THE COURT: Right.

25 MR. RUFFIN: -- isn't accurate.

1 MR. GRAHAM: I would like to put on the record the true  
2 facts about what happened with respect to those documents. It  
3 is true that we have many, many documents, these and far many  
4 more, and it is further true that we had many, many documents  
5 of which we selected three and, at Your Honor's urging, we  
6 gave them to the defense, marked in accordance with how we  
7 presented them for the witness and in order.

8 What they did was give me 22 documents. They refused to  
9 disclose which ones they were planning to use. They had some  
10 of them pre-marked as Court exhibits. They gave them to me  
11 with different exhibit numbers. One article was missing.  
12 Other articles had the page numbers printed differently from  
13 how they presented them to the witness.

14 One can only infer that they didn't want me to be able to  
15 catch up and follow along as they were reading them.  
16 Thankfully, Your Honor allowed me to peer over the shoulder,  
17 but it made it very awkward for me to try to keep up because  
18 they would say Exhibit -- Court's Exhibit 4 or whatever and  
19 I'd have to scramble and find it as number 20 in my list.

20 It was unprofessional. I'd like to make a -- I'd just  
21 like to put on the record my disappointment at how a trickery  
22 in front of the jury caused me to be at a disadvantage in  
23 terms of dealing with one of the most important parts of  
24 evidence of this case.

25 And I think it was intentional from all inferences. The

1 exhibits were pre-marked. They were highlighted for the  
2 witness and for the ease of the witness and the attorney. I  
3 get the ones that have different numberings, no highlighting,  
4 different page numbers, and one of them is missing.

5 THE COURT: Well, the nice thing is you had an hour and  
6 half to go over all that stuff before you actually had to jump  
7 right into your cross.

8 MR. GRAHAM: Thank you, Your Honor.

9 THE COURT: And it's my understanding that all of these  
10 documents were provided to him at the last trial. Correct?

11 MS. CRAIG: Yes, sir.

12 THE COURT: Which went to conclusion before it was  
13 mistried on the very last question on the very last witness of  
14 the whole week of trial. I don't see there how there can be  
15 any surprise.

16 MR. GRAHAM: Well, they're not the same. Some -- well,  
17 there's some in here that were not the same, but maybe they  
18 didn't use them. It's confusing the way they were presented  
19 to us. They didn't match the way they were presented to the  
20 Court and prepared for the use in the court. That's what's  
21 upsetting to me, Your Honor.

22 THE COURT: All right.

23 MR. GRAHAM: But you're right. The lunch break was of  
24 some benefit.

25 THE COURT: It had to be. All right. I'll give you five

1 minutes to reply.

2 MS. CRAIG: My only reply needed to something like that  
3 is that there was no trickery. The way that we gave them the  
4 exhibits -- I mean the medical literature was exactly as they  
5 were attached as an exhibit to Dr. Ernest's deposition that  
6 was taken a couple years ago.

7 These are medical articles that Mr. Graham is very  
8 familiar with. We used them in the first trial. We used them  
9 in another trial back in May of 2015. There is no surprise.  
10 There is no prejudice. There is no trickery. The only issue  
11 is Dr. -- Mr. Graham doesn't like what the medical articles  
12 say.

13 MR. GRAHAM: Right.

14 MS. CRAIG: And so --

15 THE COURT: All right. She's got the last five minutes.  
16 Don't interrupt.

17 MS. CRAIG: And I'm not going to take five minutes. I  
18 think it's really enough on that. I don't appreciate his tone  
19 of voice.

20 THE COURT: I understand.

21 MS. CRAIG: I don't appreciate him saying it's  
22 unprofessional.

23 THE COURT: All right.

24 MS. CRAIG: And I think Your Honor knows what happened in  
25 this case.

1 THE COURT: Good enough. Go ahead and bring in the jury.  
2 And you're done. Is that correct? So we're on cross?  
3 MS. CRAIG: Yes, sir. I am done.  
4 THE COURT: All right.  
5 MS. CRAIG: May I substitute?  
6 THE COURT: Please.  
7 MS. CRAIG: Thank you.  
8 (WHEREUPON, the jury entered the courtroom at 3:19 p.m.)  
9 THE COURT: And if you would, come on up.  
10 (WHEREUPON, a bench conference was held in the presence  
11 of the jury but out of the hearing of the jury as  
12 follows.)  
13 MR. RUFFIN: Your Honor, would it be appropriate just to  
14 let them know that, you know, we're not being rude if we don't  
15 talk to them? It's just, you know, we're just trying to abide  
16 by your rules.  
17 THE COURT: All right. You got any problem with that?  
18 MS. CRAIG: I'm sorry. I didn't hear him. What?  
19 THE COURT: He wanted me to instruct the jury that  
20 they're not supposed to talk to anyone involved in the case or  
21 to anyone about the case. Do you want me to do something in  
22 the charge?  
23 MR. RUFFIN: Okay. That's fine. Yeah, yeah.  
24 MS. CRAIG: I don't think we need to highlight that.  
25 THE COURT: Which one is it?

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1 MR. RUFFIN: Okay. I swear to God I can't remember.

2 Give me a second and I'll come back up here.

3 (WHEREUPON, the bench conference ended and the

4 proceedings resumed as follows.)

5 THE COURT: All right. You may continue, Mr. Graham.

6 MR. GRAHAM: Thank you, Your Honor.

7 CROSS-EXAMINATION

8 BY MR. GRAHAM:

9 Q: Good afternoon, Dr. Ernest.

10 A: Good afternoon.

11 Q: Let's start where you started. When you got a call or a  
12 letter or an email from the Hood Law Firm asking you to defend  
13 the doctor in this case, tell us what you did to put your mind  
14 in the right place where you could be fair to Christy and  
15 David and their daughter, Julia, as well as the side that was  
16 paying you. What did you do to put yourself in an objective,  
17 fair frame of mind, sir?

18 A: I --

19 Q: If anything.

20 A: I looked at the note to ask if I would review the  
21 records. They did not ask if I would defend the doctor, first  
22 of all. I agreed to look at the records and see if I could  
23 make a decision whether the care was appropriate and if we  
24 could determine the cause. I received the records and I  
25 reviewed the records, reviewed depositions, and talked to the

1 attorneys and said that I felt that the care was appropriate  
2 and I did not think that the care caused the injury. I relied  
3 on -- I relied on that --

4 Q: Excuse me, sir. You're telling me what you did.

5 MS. CRAIG: Your Honor, can he finish?

6 THE COURT: Let him finish answering. Go ahead.

7 BY MR. GRAHAM:

8 A: I relied on that and my experience with shoulder  
9 dystocias and my knowledge of the literature to make the best  
10 decision about what happened.

11 Q: My question, sir, was not what you did. My question was  
12 what did you do to prepare yourself for what you did? Did you  
13 do anything to prepare your state of mind to be fair to both  
14 sides or just the doctor?

15 A: I am always prepared to be fair. That's my nature. I  
16 didn't have to do anything particularly to prepare for this  
17 because that's the way I operate.

18 Q: That's the way you operate?

19 A: I'm fair, yes.

20 Q: You're fair to the patient as well as the doctor?

21 A: I'm fair to everyone.

22 Q: All right.

23 A: I was raised that way and that's the way I behave.

24 Q: Well, let me ask you this. Before you find out what the  
25 disputes are about what happened that day, what assumptions,



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1 if any, do you make about who is more worthy of belief, the  
2 parents of an injured child or the doctor on whose watch the  
3 child got injured?

4 A: I think in this case there's no contradiction about what  
5 happened. I think the question is whether the care was  
6 appropriate. I don't see any -- any reason to disbelieve  
7 either group because I think -- from what I can see, everybody  
8 is pretty much saying the same thing.

9 Q: Sir, the question is -- please listen carefully. The  
10 question is did you make any assumptions before you started as  
11 to who was more worthy of belief, the parents of the injured  
12 child or the doctor on whose watch the child sustained a life-  
13 changing injury?

14 A: I assumed that everybody was telling the truth and that  
15 everybody was to be trusted.

16 Q: Every time you get involved as an opinion witness for a  
17 doctor, you assume the doctor is telling the truth, don't  
18 you?

19 A: I assume that everybody is telling the truth unless I  
20 have reason to believe otherwise, yes.

21 Q: You assume the doctor is telling the truth; correct?

22 A: I assume the doctor and everyone involved is telling the  
23 truth unless I see facts to the contrary, yes.

24 Q: And in serving as a defense expert on a brachial plexus  
25 birth injury case, you always assume that the doctor is

1 providing true and accurate information about the amount of  
2 traction they say they used; true?

3 A: Unless I have something else to the contrary to make me  
4 think otherwise, yes.

5 Q: All right. If they say it, you believe it?

6 A: Unless I have some reason to not believe it, yes.

7 Q: And you assume that when Dr. Browning wrote in the chart  
8 that he used controlled traction -- you assumed he used normal  
9 gentle traction; is that fair?

10 A: Yes. That's what he said he did, yes.

11 Q: So in approaching this case and in forming your opinions,  
12 you assumed that Dr. Browning used an appropriate amount of  
13 traction and that it was applied in the axial direction  
14 without any degree of lateral traction component whatsoever;  
15 is that true?

16 A: I assumed that and I saw that on the video to confirm  
17 what I assumed, yes.

18 Q: All right. Now, the Hood Law Firm didn't send you the  
19 video until after your deposition, did they?

20 A: That's correct. The video confirmed my assumptions that  
21 what Dr. Browning said he did was indeed what he did.

22 Q: You had no opportunity when you were forming your  
23 original opinions to look at all the evidence, did you?

24 A: I looked at enough to make a decision and an opinion,  
25 which was confirmed by the video, but I did not see the video

1 at the time I did my deposition.

2 Q: They only -- they only gave you the video after you had  
3 committed to certain opinions under oath; true?

4 A: That's true.

5 Q: And when a maneuver is done -- when a -- when a -- when  
6 you read on the chart or in a deposition that a maneuver was  
7 done, you assume it's done correctly; true?

8 A: Yes.

9 Q: Did you read all the depositions in this case?

10 A: Yes.

11 Q: Did you read that Misty Barrett said that, instead of  
12 pushing on the shoulder when she was ordered to do suprapubic,  
13 she pushed on the pubic bone itself?

14 A: She said -- she did not say how she did this delivery.  
15 She said that her understanding of suprapubic pressure was to  
16 push on the bone, but we have in addition to that the video.

17 Q: And your spin about the video is that she was pushing on  
18 the shoulder, not on the bone, as she thinks is the right way  
19 to do it?

20 A: I think she was pushing on the shoulder at a point before  
21 the delivery, and that's what helped deliver the baby.

22 Q: And I think you told us earlier that -- that you thought  
23 Christy confirmed that there was correct suprapubic pressure  
24 pushing on the child's shoulder. That's what you testified  
25 to, isn't it?

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1 A: No, sir. That's not what I said. I said she said that  
2 she had her legs flexed and there was pressure on the abdomen,  
3 which is different from pressure on the pubic bone. Since  
4 there was no fundal pressure, the only other pressure on the  
5 abdomen would be suprapubic applied properly.

6 Q: Were you aware that Christy had an epidural and could not  
7 feel down in the lower abdomen?

8 A: Yes, I am.

9 Q: Were you aware that her line of vision was blocked at the  
10 time the suprapubic pressure was being done incorrectly?

11 A: I don't know if her line of vision was blocked, but she  
12 said what she said and it confirmed what the chart said and  
13 what I expected had happened. So that's why I'm comfortable  
14 that it was applied.

15 Q: And you referred to the plaintiff's expert, Dr. Resnick.  
16 In his medical history he -- you said that he confirmed  
17 Christy's statement that suprapubic pressure was done  
18 correctly, but, in fact, the words on his report are, quote,  
19 nurse exerted pressure on her abdomen, end quote; true?

20 A: That's correct. I did not say that the report said that  
21 suprapubic pressure was applied. I said that it confirmed  
22 what everybody else said that it was applied.

23 Q: All right. You keep saying what everybody else said.  
24 Does everybody include the nurse who did it?

25 A: No. That includes Dr. Browning, it includes the chart,

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1 and it includes Ms. Byrd.

2 Q: Okay. Everybody except the one who says when I do  
3 suprapubic, I do it the right way. I push on the bone.  
4 Everybody except her you claim says she did it on the  
5 shoulder?

6 A: She said that that's her understanding. She did not say  
7 how she did it in this case. We have a video. We have a  
8 successful delivery and we have the patient's recollections,  
9 and I'm very comfortable that it was applied properly.

10 Q: Yes, sir. And do you think you fairly described Misty's  
11 deposition testimony to the jury?

12 A: Her testimony is that she understands --

13 Q: Sir, the answer is do you believe you have fairly  
14 characterized her testimony to the jury? Yes or no?

15 A: Yes.

16 Q: All right.

17 MR. GRAHAM: Dave, would you please queue up Misty  
18 Barrett's deposition, page 22, line 14, through page 23, line  
19 10?

20 MS. CRAIG: Your Honor, objection. Of course, the  
21 hospital is not a defendant. So we object on that basis and  
22 he can't be impeached with the deposition of somebody else.

23 THE COURT: That is correct.

24 MR. GRAHAM: He claims to be an expert who -- who  
25 reasonably relied on the testimony, the sworn testimony, of

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1 this nurse. We believe in fairness the jury ought to be  
2 allowed to hear what the nurse actually said, not what other  
3 people not paying attention claimed happened.

4 MS. CRAIG: Your Honor, we'd ask that he bring the nurse.  
5 He can bring the nurse to testify.

6 THE COURT: I agree.

7 MS. CRAIG: Thank you.

8 THE COURT: It's not his deposition. Sustained.

9 BY MR. GRAHAM:

10 Q: Well, Doctor, the nurse never indicated that she has ever  
11 done a suprapubic pressure by pushing on the shoulder; true?

12 A: I don't remember if she said ever. I remember she said  
13 that was the way she was -- that she did it, but I don't think  
14 she said how she did it in this delivery. That's the way I  
15 remember that deposition.

16 Q: In fact, she said that she thought the way a competent,  
17 well-trained labor and delivery nurse should do it is by  
18 pushing on the pubic bone straight down to the floor; true?

19 A: That's exactly what I said, yes.

20 Q: Now, in your earlier testimony, you claimed that that did  
21 not cause harm. In fact, the purpose of suprapubic pressure  
22 on the shoulder is to benefit the safe management of shoulder  
23 dystocia; true?

24 A: Yes.

25 Q: And to the extent that this nurse, in fact, pushed on the

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1 bone and not on the shoulder, this delivery did not receive  
2 the benefit of correct suprapubic pressure; true?

3 A: That's true. It was a neutral event. It did not help;  
4 it did not hurt during that time.

5 Q: How many deliveries -- how many shoulder dystocias -- how  
6 many stuck shoulders do you claim can be safely resolved with  
7 McRoberts and gentle traction alone?

8 A: Well over half. The majority can be.

9 Q: How many deliveries do you claim can be safely resolved  
10 with McRoberts, correct suprapubic pressure, and gentle  
11 traction alone?

12 A: Uh-huh. Well, again we'd need to define gentle traction,  
13 but if you mean normal, appropriate traction, probably another  
14 10 or 20 percent.

15 Q: So 50 percent for McRoberts, 60 to 70 percent for  
16 McRoberts, suprapubic, and appropriate traction?

17 A: I would say probably 50 to 60 percent with McRoberts and  
18 maybe 60 to 80 if you add the two, yes.

19 Q: So if you have 60 to 80 deliveries that can be -- or  
20 stuck shoulders that can be successfully managed and safely  
21 managed with McRoberts, correct suprapubic pressure, and  
22 gentle traction, then that leaves 20 to 40 percent of all  
23 headfirst vaginal deliveries with a stuck shoulder where you  
24 should do an internal maneuver; fair?

25 A: That's -- yeah, I think that's correct. Yes.

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1 Q: Okay. And if you don't do correct suprapubic pressure,  
2 then you're back in a situation where you need to do 40 to 60  
3 -- excuse me -- 40 to 50 percent with either an internal  
4 maneuver or correcting of the improper suprapubic; fair?

5 A: Uh-huh. Yes. That's what happened in this case. Yes.

6 Q: Sir, I'm not asking you for your spin on the facts. I'm  
7 asking you about the mathematical relationships.

8 MS. CRAIG: Your Honor, I'm just going to go ahead and  
9 object now to "spin on the facts" and other comments of that  
10 nature.

11 THE COURT: Sustained.

12 BY MR. GRAHAM:

13 Q: Doctor, as you approached the issues in this case, did  
14 you believe it was easy to envision a labor and delivery nurse  
15 pushing on the bone instead of the shoulder?

16 A: I can envision that, yes.

17 Q: That wasn't -- you didn't think it was hard to do  
18 suprapubic pressure incorrectly?

19 A: It's easy to do it correctly and it's easy to do it  
20 incorrectly. It's pressure down on the mother's abdomen.  
21 It's just the place where you apply the pressure --

22 Q: And --

23 A: -- that determines whether it's correct or not.

24 Q: And when -- do you believe that when a doctor sees  
25 suprapubic done incorrectly, the doctor has a duty to correct



1 the hand positioning of the nurse?

2 A: At a point, yes.

3 Q: All right. Do you believe that a doctor has a duty to  
4 look a few inches in front of his face to see if the nurse is  
5 pushing on the bone or on the shoulder?

6 A: At some point, yes.

7 Q: So if Dr. Browning failed to correct hands on the bone,  
8 that violated his duty, whether he saw it or not; true?

9 A: If he never corrected it and he expected it and it was  
10 required, yes, it would be something that he should've done.

11 Q: As we go through evaluating your opinions, are you  
12 willing to concede that the value of your opinions depends in  
13 large part on the value of your assumptions about what  
14 happened in this case?

15 A: The assumptions are valuable. The review of the  
16 videotape is valuable. The understanding of what happens in  
17 most deliveries, the understanding of Dr. Browning's  
18 experience, all of this goes into that, but the assumptions  
19 are important, yes. They help me to understand what happened  
20 and why it was appropriate care.

21 Q: The quality of your opinions -- well, in suggesting  
22 alternative causation instead of the doctor pulling too hard  
23 and suggesting that the uterus did it, you're assuming that  
24 there was no excessive traction and all the traction was  
25 axial, not lateral; true?

1 A: Are you talking about today or at the time of my  
2 deposition?

3 Q: Sir, I'm -- I'm -- I'm talking about your -- have -- have  
4 your opinions changed since your deposition?

5 A: No. My knowledge has increased, but my opinions are the  
6 same.

7 Q: Okay. So in suggesting that this causation was from the  
8 uterus instead of the doctor pulling too hard, you were  
9 assuming there was no excessive traction and there was no  
10 lateral traction; true?

11 A: At the time of the deposition, that's correct. I now  
12 know that there was not because I've seen it. That's why I  
13 say my knowledge is additional now, but my opinions are the  
14 same.

15 Q: All right. The quality of your opinions based on those  
16 assumptions depends on whether or not the assumptions are  
17 valid; true?

18 A: Yes, at the time of the deposition, but I have now the  
19 additional confirmation which confirms those opinions because  
20 I've seen the delivery.

21 Q: The quality of your opinions depends not only on your  
22 assumptions, but also whether or not your interpretation of  
23 the video is correct; fair?

24 A: I think it's an interpretation everybody can see what  
25 happened; so sure. It's what we see, which is very clear

1 there. Yeah, it absolutely helps me.

2 Q: And if your -- if your assumptions are wrong, that  
3 undermines the validity of your opinions based on the  
4 assumptions; fair?

5 A: At the time of my deposition, I would have to say yes to  
6 that, but we have more than assumptions now. I have a  
7 confirmation.

8 Q: And if your interpretation of the video is incorrect,  
9 that undermines the quality of your opinions as well; fair?

10 A: Yes. If my understanding is wrong, then I'm wrong. If  
11 my understanding is correct, then I'm correct.

12 Q: If you were called upon to be an expert witness in a case  
13 where the doctor didn't do any safety maneuver, he just pried  
14 his hard as he could down on the shoulder to try to pry that  
15 shoulder out and caused the child's arm to be injured as bad  
16 as Julia's is, you would come into court and claim that wasn't  
17 even a shoulder dystocia; true?

18 A: I would not come to court because I don't think that's  
19 possible to do what you just said.

20 Q: All right. You -- you define shoulder dystocia as using  
21 one or more of the safety maneuvers; true?

22 A: That's not my definition. I use a standard definition,  
23 which is shoulder dystocia is present when you go to those  
24 additional maneuvers. It is a standard definition, not my  
25 definition. That's the way we decide whether to call

1 something shoulder dystocia.

2 Q: So using that definition, where shoulders can be pried  
3 out by pulling hard down on the head and pulling out down hard  
4 on the head, by using that definition, your colleagues are  
5 able to say that sometimes nerves get injured when there's not  
6 even a stuck shoulder; true?

7 A: The literature is clear that there are injuries when  
8 there is not shoulder dystocia, yes.

9 Q: And you define shoulder dystocia as being when the doctor  
10 manages it correctly?

11 A: That's one of the definitions. The other --

12 Q: If the doctor --

13 A: The other definitions --

14 MS. CRAIG: Your Honor, please --

15 THE COURT: Hold on. Let him finish his answer.

16 MS. CRAIG: Thank you.

17 THE COURT: You may finish it.

18 BY MR. GRAHAM:

19 A: As we discussed in the deposition, other definitions are  
20 difficult deliveries. There's a lot of ways to describe the  
21 complexity of a delivery. And when you do that, you still  
22 find deliveries that have no difficulty, regardless of how you  
23 define it, that still end up with permanent injury.

24 Q: Are you finished?

25 A: Yes, sir.

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1 Q: So, using your definition, if a doctor broke all the  
2 rules, broke all the standards of care and just pulled down as  
3 hard as he could to pry that shoulder out, you would say there  
4 was no shoulder dystocia; fair?

5 A: I would say that he acted inappropriately, that it was  
6 below the standard of care, but if we follow that strict  
7 definition, which would be silly in that case, yeah.

8 Q: No shoulder dystocia? The shoulder wasn't even stuck?

9 A: No, that's not what that would mean. The shoulder was  
10 stuck, but he didn't call it that.

11 Q: Okay. And if the --

12 A: Calling it something --

13 Q: -- doctor doesn't call it that, then that --

14 THE COURT: You've got to let him finish answering.

15 THE WITNESS: I need to finish that answer.

16 BY MR. GRAHAM:

17 A: Calling something a name when that is not what happened  
18 doesn't mean -- doesn't change the reality. The reality is  
19 the doctor in that case acted inappropriately, regardless of  
20 what he called it.

21 Q: Yes, sir. And if -- and the same is true if a doctor  
22 pulls out and down too hard on a baby's head and pulls the  
23 head so much that it springs back when he lets go, that's too  
24 much force, no matter how gentle the doctor later claims it  
25 was; fair?

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1 A: Well, again, I'm not sure that I've seen that happen.

2 Q: Of course not. But assuming hypothetically that that  
3 were to happen, that a doctor might actually say I used gentle  
4 traction, I used controlled traction, when the facts are that  
5 he pulled hard, too hard, bent the head down, and caused  
6 damage to the nerves, writing on the chart controlled traction  
7 or gentle traction doesn't change the underlying facts of what  
8 really happened, does it?

9 A: No, of course not.

10 Q: And yet you would rely on what the doctor wrote on the  
11 chart as being true?

12 A: If I knew he did something inappropriate, I wouldn't rely  
13 on it.

14 Q: But you would start off with the assumption that what the  
15 doctor said on the chart was true?

16 A: If that's the only information I had was what was written  
17 on the chart, that's what I'd have to use. That's correct.  
18 If I had any other information, then I would obviously change  
19 that.

20 Q: Well, let's be clear about what the rules are, what the  
21 standards of care are. In a shoulder dystocia situation  
22 before five, six or seven minutes, there should be no bending  
23 of the neck; true?

24 A: There should be no bending of the neck other than, as we  
25 discussed in the deposition and as I mentioned earlier today,

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1 sometimes we bend the neck to get the cord off. Sometimes  
2 that's part of that axial traction, but you avoid it as much  
3 as possible.

4 Q: And if -- if the nurse maneuvers and gentle traction  
5 don't get that shoulder unstuck, the rules require the doctor  
6 to refrain from increasing the pulling force; true?

7 MS. CRAIG: Objection, Your Honor.

8 THE COURT: What grounds?

9 MS. CRAIG: To the rules. We addressed this previously.

10 THE COURT: Sustained.

11 BY MR. GRAHAM:

12 Q: Doctor, in a situation where shoulder -- there's a stuck  
13 shoulder, McRoberts, an order for suprapubic, and gentle  
14 traction failed to get the shoulder unstuck, the standards of  
15 care require the doctor to refrain from increasing the pulling  
16 force; true?

17 A: No, that's not true.

18 Q: You deny that?

19 A: If you use normal traction -- normal traction, as we  
20 discussed in my deposition, is a range. There's not a single  
21 amount. There's no specific definition of gentle. So the  
22 amount of traction you apply is the attraction you've applied  
23 before that has safely delivered babies. And then once you  
24 get to the level that you think should have worked, then you  
25 stop and you go through your maneuvers.

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1 Q: Doctor, why don't you tell us how hard a doctor has to  
2 pull for you to call it too hard?

3 A: I think that if you have pulled more than you need to  
4 pull, you've pulled too hard. There is a range. We know the  
5 range because we've done many, many deliveries. We have that  
6 in our muscle memory. We can see the effects of our pulling  
7 on the mother and on the baby's neck, and we refrain from  
8 getting above that. So it's -- it sounds complicated, but  
9 it's quite easy when we're doing it because we know what is  
10 appropriate and we know what is harder than we normally pull.

11 Q: And if a doctor uses a normal amount of traction, an  
12 appropriate amount of traction, with McRoberts and suprapubic  
13 being ordered, but that top shoulder doesn't get unstuck, it's  
14 not necessary to pull harder, is it? The doctor can do a safe  
15 maneuver internally; true?

16 A: If he just used normal traction, he shouldn't do anything  
17 other than start with the maneuvers. That's correct.

18 Q: And if he pulls harder rather than going to an internal  
19 maneuver, that violates the obstetrical standards of care;  
20 true?

21 A: Yes. If he applies abnormal traction, he has violated  
22 the standard of care. That's correct.

23 Q: And if he bends the neck, that violates the standards of  
24 care; true?

25 A: If he bends it more than is normal, then that does --



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1 that does violate. We minimize the lateral flexion of the  
2 neck. That's correct. But as I said, there are some times  
3 when we bend it just to get the cord off, just in the process  
4 of getting our hands on the baby, but we should avoid lateral  
5 flexion, yes.

6 Q: Now, you can't tell us how much stretch it takes to  
7 injure a human baby, can you?

8 A: I can tell you what cadaver studies have done. I can  
9 tell you what percent stretch occurs, but in a live human, I  
10 don't know that that's known.

11 Q: Okay. You don't know how much force it takes to injure  
12 brachial plexus nerves in a live human baby?

13 A: The actual quantity because it varies from baby to baby.  
14 We can't say in a specific delivery how much force will injure  
15 because there are variations from baby to baby.

16 Q: And I heard you say something along those lines earlier.  
17 Let's get clear. You have zero evidence that Julia's nerves  
18 were weaker or more vulnerable to injury than anybody else's  
19 baby's nerves; true?

20 A: I have no evidence of that, although that's a -- that's a  
21 reasonable explanation for what happened here. But I have no  
22 evidence that that's the case.

23 Q: Zero evidence; true?

24 A: No evidence is zero evidence. That's correct.

25 Q: Yes, it is. Thank you, sir. And I heard you say

1 something about when the uterus is pushing, the baby's head  
2 stretches. You can't say how much the baby's head is capable  
3 -- I mean the baby's neck is capable of stretching before the  
4 doctor starts pulling, can you?

5 A: We can. We can -- we can get some numbers there if you'd  
6 like.

7 Q: All right. In fact, you can't tell us if it's even as  
8 much as one or two millimeters; true?

9 A: Yes, I can.

10 Q: All right. That's a new opinion since your deposition;  
11 fair?

12 A: No, sir. That's a new fact. The opinion is that it  
13 stretched. There's a -- I have more facts now, but I have the  
14 same opinions.

15 Q: Your opinion at the time of the deposition is that you  
16 didn't know if a baby's neck could stretch even one or two  
17 millimeters; true?

18 A: That was a factual thing that I did not know. I don't  
19 think that was an opinion. My opinion was that the neck is  
20 stretched. The fact was I did not know how much, but since  
21 then I have looked into that and I can give you an answer if  
22 you'd like.

23 Q: I'm not interested in new opinions, sir. The judge has  
24 ruled that those cannot be considered, which is why we  
25 occasionally have to object because we're trying to follow His

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1 Honor's --

2 THE COURT: Go ahead and ask a question.

3 MS. CRAIG: Your Honor, I move to strike.

4 THE COURT: You don't need to quote what I say.

5 BY MR. GRAHAM:

6 Q: The -- assuming that Dr. Browning, in fact, used more  
7 than normal gentle traction, that's the most probable cause of  
8 this child's injury; true?

9 A: Not in this case, no.

10 Q: All right.

11 MR. GRAHAM: Dave, would you please queue up page 160 --  
12 well, let me get the definition. I'm sorry.

13 BY MR. GRAHAM:

14 Q: Dr. Ernest, do you recall that you gave a deposition in  
15 this case on June 8<sup>th</sup>, 2015, at the Hood Law Firm in  
16 Charleston?

17 A: Yes.

18 Q: And you were there represented by a member of the Hood  
19 Law Firm?

20 A: They were not representing me. I was there to explain  
21 what I thought happened and to give causation, but they were  
22 not representing me.

23 Q: And you were put under oath?

24 A: Yes.

25 Q: Sworn to tell the truth?

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1 A: Yes.

2 Q: All right. I'm going to hand you your deposition.

3 MR. GRAHAM: And, Dave, if you would, please go ahead and  
4 play page 169, lines 5 through 8.

5 (WHEREUPON, the video deposition portion was played in  
6 open court as follows. Transcribed as follows.)

7 MR. GRAHAM: If Dr. Browning used more traction than he  
8 should have used, he breached the standard of care?

9 THE WITNESS: That's correct.

10 (WHEREUPON, the video was stopped.)

11 MS. CRAIG: Your Honor, if he could continue with the  
12 next sentence --

13 THE COURT: You will. You'll have your chance in just a  
14 little bit.

15 MS. CRAIG: Thank you, Your Honor.

16 BY MR. GRAHAM:

17 Q: And if Dr. Browning used more than normal gentle  
18 traction, he increased the risk of damage to Julia's nerves;  
19 true?

20 A: If he used more than normal gentle traction, he may not  
21 have increased the risk. If he used more than he should have,  
22 that was the question. If Dr. Browning used more traction  
23 than he should have used, he breached the standard of care  
24 and, of course, that's correct. He should only use what he  
25 should use.

1 Q: And if he --

2 A: You just -- you just asked me to assume that he used more  
3 and I said, no, he didn't. You asked me in the deposition if  
4 he used more, then would that be that breach and I said, of  
5 course, it would. If he used more than he needed, that's --  
6 that's easy to answer.

7 Q: Okay.

8 A: That's a breach of the standard of care.

9 Q: Okay. It's easy to answer. Not only is using more than  
10 he should have used easy to see as a breach of the standard of  
11 care, it's also easy to see as the most probable cause of the  
12 injury; true?

13 A: If he used more than he should have, of course, but  
14 that's not the questions that we were getting to here and, if  
15 it were, I'm sorry I misunderstood your questions. If he used  
16 inappropriate traction, that is a cause of injury. He did  
17 not, but if we assume he did, then that could be a cause of  
18 the injury, yes.

19 Q: Now, I know you're assuming it was the forces of labor.  
20 It was the -- it was the -- it was Christy's uterus that did  
21 it. I get that that's your assumption, but if, in fact, Dr.  
22 Browning used more traction than he should have or if he bent  
23 Julia's neck, your assumption that the bad, bad uterus did it  
24 goes away; true?

25 A: No. There could be a combination. The uterus can

1 predispose injury even if the physician applies the proper  
2 amount of traction. So the uterus and the force of the uterus  
3 and the internal forces are there, regardless of what the  
4 doctor does.

5 Q: But your assumption about forces of labor having some  
6 causal significance is based on your assumption that there was  
7 no unnecessarily forceful traction; true?

8 A: In this case? Are you talking about this case or just in  
9 general?

10 Q: We'll take in general first.

11 A: In general, it's not an assumption. It's established and  
12 it's written over and over again that the intrauterine forces  
13 can tear -- stretch and/or tear the brachial plexus. That's  
14 clear.

15 Q: Assuming that there's no unnecessarily forceful traction,  
16 that changes; true?

17 A: It doesn't change the fact that the intrauterine forces  
18 can cause injury and it doesn't change the fact that external  
19 forces can cause injury.

20 Q: Okay.

21 A: Therefore, force can cause injury.

22 Q: All right. So if I understand you, you're saying no  
23 matter -- no matter what Dr. Browning did, you're blaming this  
24 uterus, Christy's uterus, at least in part. Is that what  
25 you're saying?

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1 A: I'm taking the whole picture into account. I'm looking  
2 at what was said was done. I'm looking at a videotape to see  
3 what was done. I'm looking at the literature to see what  
4 people say can cause injury and I'm making the best decision  
5 based on the facts. That if you go down the list of what can  
6 cause injury, the most likely injury is that it was an  
7 endogenous or it was an intrauterine event, not something that  
8 Dr. Browning did.

9 Q: So even if you assume the uterus somehow contributed, if  
10 Dr. Browning used more force than he should have, would you be  
11 willing to admit that what Dr. Browning did was at least a  
12 cause of Julia's nerve damage?

13 A: I would say that if he used more than he should have, it  
14 could have contributed to the injury, yes. He did not, but if  
15 he did, or if any doctor used more than they should have, that  
16 can cause an injury.

17 Q: If Dr. Browning, in fact, used more traction than he  
18 should have, do you believe that would be the most probable  
19 cause of the child's injury?

20 A: I think that's probably correct, yes. If he used more  
21 than he should have, which he didn't, but if any physician  
22 used more than they should have, then we have another cause of  
23 the injury. We don't see that in this case, but if that were  
24 the case, then I would say that may very likely have caused  
25 the injury.

1 Q: Do you agree, sir, that the greater the stretch, the  
2 greater the risk of injury?

3 A: After a point, yes, that's true.

4 Q: Do you agree that the harder the pulling force, the  
5 larger the risk of harm?

6 A: In general, that's correct. Yes.

7 Q: And do you agree that the more downward traction in a --  
8 in a right shoulder top position, the greater the downward  
9 traction, the greater the risk of injury to the nerves on the  
10 right side?

11 A: No. That's not correct. Downward is not the key. It's  
12 the flexion.

13 Q: Okay. Let me rephrase. Assume -- assume a struck  
14 shoulder, right shoulder, top shoulder. If -- do you agree  
15 that if there is increasing bend of the neck that there would  
16 be an increasing risk of nerve damage?

17 A: Yes.

18 Q: All right. Now, if I understood your testimony before  
19 the lunch break, is it your position that this child was  
20 medically unstable at any time between the delivery of her  
21 head and the delivery of her body?

22 A: Yes. I explained that. That when we -- when we -- when  
23 you took my deposition, we talked about specific organs. We  
24 talked about the fetal heart rate being stable or unstable.  
25 We talked about the brain in another part of the deposition.



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1 We didn't talk about the global definition of what medical  
2 instability is and I tried to explain that before the lunch  
3 break.

4 Q: Okay.

5 A: That those systems, as we discussed, were stable. The  
6 heart rate was stable through the labor. The brain did not  
7 have any injury, although we have some changes in the cord pH  
8 that showed that things --

9 MR. GRAHAM: Objection, Your Honor.

10 A: -- were starting to happen.

11 MR. GRAHAM: That's a new opinion.

12 THE WITNESS: No, sir. That was something I put in my --  
13 into my deposition.

14 THE COURT: You asked the question. He can answer it.

15 BY MR. GRAHAM:

16 A: That was in my deposition.

17 Q: Yes, sir.

18 A: But it was in the deposition.

19 Q: Okay. Show me where it is in the deposition, sir.

20 MS. CRAIG: Your Honor, I think he needs to finish his  
21 answer.

22 THE COURT: That is very true. You may finish.

23 MR. GRAHAM: I thought he said it was in his deposition.

24 BY MR. GRAHAM:

25 Q: Were you not finished, sir?

1 A: No, I was not finished.

2 Q: Oh, please continue. I thought you were.

3 A: Okay. So the -- there's -- I think I'm finished.

4 Q: I thought so too.

5 A: I forgot the question.

6 Q: Did you find in your deposition --

7 A: I forgot the question. I'm sorry.

8 Q: -- where you told us about the cord gases?

9 A: Will I find it?

10 Q: You say it's there. Can you find it?

11 A: It may take a few minutes because the dep -- this is 200

12 pages long.

13 THE COURT: If you've got it, why don't you just go ahead

14 and find it, Mr. Graham. Speed things up.

15 MR. GRAHAM: I don't think it's there, Your Honor. So I

16 would help him if I could.

17 MS. CRAIG: Your Honor, this is --

18 BY MR. GRAHAM:

19 Q: Let me ask you --

20 THE COURT: Hold on.

21 MS. CRAIG: -- another improper use of a deposition.

22 THE COURT: Yes, it is.

23 MR. GRAHAM: I'll move on, Your Honor.

24 BY MR. GRAHAM:

25 Q: But the Byrd child -- no question the Byrd child was

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1 medically stable throughout labor, delivery, including the  
2 shoulder dystocia resolution time of 45 seconds; true?

3 A: Well, if you're quoting from my deposition, that was  
4 specifically talking about the fetal heart rate because that's  
5 what we were talking about about the brain. If you talk about  
6 the global picture, there was a medical instability because  
7 the baby had a limited amount of oxygen, it was being used up,  
8 and the situation had to be fixed promptly.

9 MR. GRAHAM: Dave, could you please queue up page 202,  
10 lines 7 through 13?

11 (WHEREUPON, the requested portion of the deposition on  
12 video was played in open court. Transcribed as follows.)

13 MR. GRAHAM: But the Byrd child -- no question the Byrd  
14 child was medically stable throughout labor, delivery,  
15 including the shoulder dystocia resolution time of 45  
16 seconds?

17 THE WITNESS: Because Dr. Browning did a very expeditious  
18 and safe delivery, that's exactly correct.

19 (WHEREUPON, the video stopped and the proceedings resumed  
20 as follows.)

21 BY MR. GRAHAM:

22 Q: That's exactly correct? Isn't it, sir?

23 A: That was part of a long discussion. If you want to read  
24 some more, I would be happy to read the part that explains --

25 Q: I'm sure --

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- 1 A: -- the part that we were talking --
- 2 Q: -- Ms. Craig will be happy to give you that opportunity,
- 3 sir.
- 4 A: Uh-huh.
- 5 Q: Right now, I'd like to ask you a different question. You
- 6 only know of -- how many babies have you delivered?
- 7 A: 5,000+.
- 8 Q: All right. And you've had how many shoulder dystocias?
- 9 A: Dozens, maybe 100 or more.
- 10 Q: Okay. And you only know of one injury to a baby's nerves
- 11 that turned out to be permanent on your watch; true?
- 12 A: One, maybe two, yes, that I'm sure about.
- 13 Q: I'm sorry. One baby two?
- 14 A: One, maybe two. One or two.
- 15 Q: All right. There's one, only one, that you know to be
- 16 permanent; true?
- 17 A: That's correct. And one that may have been permanent,
- 18 but I'm not sure about that one.
- 19 Q: You didn't -- you didn't follow up, did you?
- 20 A: I didn't have the opportunity to follow up on that.
- 21 That's correct. For more than a few months.
- 22 Q: All right. So you know that one baby born on your watch
- 23 has a permanent brachial plexus nerve injury. Do you blame
- 24 the uterus for that injury?
- 25 A: No, I blame myself and the resident because we pulled too

1 hard.

2 A: Yes, you did, sir. Yes, you did. Thank you for  
3 admitting that.

4 MS. CRAIG: Objection.

5 BY MR. GRAHAM:

6 Q: Have you ever --

7 MS. CRAIG: I move to strike.

8 BY MR. GRAHAM:

9 Q: Have you ever --

10 THE COURT: Hold on. You hear an objection, don't you?  
11 Come on up.

12 MS. CRAIG: Yes, sir.

13 (WHEREUPON, a bench conference was held in the presence  
14 of the jury but out of the hearing of the jury as  
15 follows.)

16 MS. CRAIG: I just moved to strike the editorial comment.  
17 Yes, you did, sir, or thank you for admitting that. That was  
18 not a question.

19 MR. GRAHAM: I just get excited sometimes, Your Honor.

20 THE COURT: Wind it up. Let's move on. It's 4 o'clock.  
21 I thought we were going to be done by 12.

22 (WHEREUPON, the bench conference ended and the  
23 proceedings resumed as follows.)

24 MS. CRAIG: Your Honor, was my motion granted?

25 THE COURT: It was granted.

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1 MS. CRAIG: Thank you.

2 THE COURT: No question.

3 BY MR. GRAHAM:

4 Q: And as a result of the unnecessarily forceful pulling on  
5 that baby's head, that child's nerves were ripped and torn;  
6 true?

7 MS. CRAIG: Objection. Relevance, Your Honor.

8 THE COURT: Sustained.

9 BY MR. GRAHAM:

10 Q: Well, you've talked about -- you've talked about the  
11 uterus you think caused Julia's permanent injury. In all your  
12 5,000 deliveries, have you ever had a permanent injury that  
13 you blamed on the uterus?

14 A: I don't know of any that were caused by the uterus, but I  
15 don't have that -- that information.

16 Q: All right. Does Dr. -- do you know of any of Dr.  
17 Smithson's deliveries where you blame the uterus for causing  
18 permanent nerve damage?

19 MS. CRAIG: Objection, Your Honor.

20 THE COURT: Sustained.

21 BY MR. GRAHAM:

22 Q: You don't know of any baby who has permanent nerve damage  
23 -- in your personal sphere of knowledge, you don't know of a  
24 single baby who, in fact, has permanent damage caused by a  
25 uterus; true?

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1 A: That's correct because I don't have the ability to have  
2 that understanding. I don't have the follow-up of the  
3 thousands that we've delivered.

4 Q: By the way, when's the last time you've delivered a baby?

5 A: October of 2014.

6 Q: I want to turn now to a few points that you made before  
7 the lunch break. You said something about the scary thing  
8 about a stuck shoulder is that you don't know how long it's  
9 going to take to get that shoulder unstuck or words to that  
10 effect?

11 A: I said that -- that it's concerning when you start the  
12 process because you don't know how long it will take. That's  
13 correct.

14 Q: Despite that uncertainty about how long it will take to  
15 get the shoulder unstuck, do you believe a doctor should still  
16 follow the standards of care?

17 A: Sure.

18 Q: We shouldn't give him a pass just because he's uncertain  
19 how long it's going to take to deliver a baby, should we?

20 A: The standard of care is the standard of care.

21 Q: And when you violate the standard of care and cause harm  
22 to the baby, do you believe the doctor should be held  
23 accountable for that harm?

24 A: I think any time we do something wrong, we should be held  
25 accountable for it, sure.

1 Q: Now, I was real confused about one thing you said. I  
2 think you said -- I'm looking at my notes. Maybe I didn't  
3 write it down verbatim, but I thought you said that you were  
4 very comfortable that suprapubic pressure was done correctly  
5 during the gap on the video?

6 A: Uh-huh. Yes.

7 Q: Can you explain to me how you can be comfortable about  
8 anything that happened after the video camera went off?

9 A: Uh-huh. Sure. We know what Dr. Browning said that  
10 suprapubic pressure was administered. He knows how to apply  
11 it and he knows how to direct the nurses to apply it. When  
12 you look at that video at the last part of the video after  
13 he's done the McRoberts and he's applied the traction, just  
14 before the camera gets bumped, he turns to -- in the direction  
15 of Misty. All right? Then within 10 or 15 seconds, we have a  
16 delivery. All right?

17 Q: So --

18 A: Now, we also have the information that I mentioned from  
19 Dr. Resnick's note that there was abdominal pressure as part  
20 of the delivery.

21 Q: Yes, sir.

22 A: Okay. The only abdominal pressure that -- the only time  
23 abdominal pressure could have been applied was either during  
24 the time of the video or during those 10 seconds.

25 Q: Yes, sir.



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1 A: So I'm very comfortable that putting all that together we  
2 have an experienced doctor that said he applied McRoberts and  
3 suprapubic, we have a nurse in the proper position, we have a  
4 nurse that said that she either got up -- that she did it, we  
5 have a delivery that occurred after something changed, and we  
6 have a patient that rec -- that remembers describing what  
7 suprapubic pressure would be like. So I'm comfortable that  
8 that's what happened.

9 Q: And are you comfortable that when a pediatric neurologist  
10 in Miami writes mom says her legs were up and the nurse put  
11 her hand in her abdominal area or words to that effect that  
12 that means a mom in labor who is in this chaotic environment  
13 with people yelling at her to push and in the pain of the  
14 moment with an epidural blocking her down here but still  
15 feeling pain and with a visual block, are you comfortable that  
16 those words and that pediatric neurology note mean that the  
17 mom was vouching for Misty putting her hands on Julia's  
18 shoulder instead of on Julia's -- instead of on Christy's  
19 pubic bone?

20 A: Yes, I am because it fits perfectly with everything else  
21 that happened. You can't use just those words to say that,  
22 but it fits the picture of what I would expect and it fits the  
23 picture of what appears to have happened and what was written  
24 to have happened.

25 So it fits the picture. Therefore, I think that it was

1 true. And I also have to believe that if Ms. Byrd didn't  
2 think that happened, she wouldn't have said it at the time of  
3 the appointment.

4 Q: Let's talk about the -- the engineering studies you  
5 referred to. You didn't cite them. They weren't in your  
6 stack of articles, but you were referring to the engineering  
7 publications of Michelle Grimm, the engineer from Detroit, and  
8 the OB, Dr. Ghani; true?

9 A: When was that? When was I referring to that?

10 Q: When you were talking about newtons and that sort of  
11 thing.

12 A: I was referring to the Buhimschi study, which was a  
13 clinical study that measured the intrauterine pressure.

14 Q: All right. So as you sit here today, are you relying at  
15 all on the Grimm engineering studies that you relied on in  
16 Greenville?

17 A: If you want to ask me about them, sure. They're part of  
18 my understanding, but I don't -- we don't need to talk about  
19 them unless you want to bring them up as some additional  
20 confirmation of what my opinions are.

21 Q: I just -- I wasn't clear. I thought that's what you were  
22 talking about when you were talking about newtons and pounds  
23 and all that kind of stuff. In fact -- but -- is it -- is it  
24 your testimony you were not relying on Michelle Grimm's  
25 publications in the obstetrical literature?

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1 A: I'm not sure how to answer that because I've read them.

2 I understand them. You and I have talked about them before.

3 Q: Yes, sir.

4 A: If you'd like to talk about them now, I'm happy to talk  
5 about them.

6 Q: All right. Well, just briefly.

7 A: But today, I was not specifically talking about that  
8 study I don't think.

9 Q: Okay.

10 A: I was talking about another clinical study that measured  
11 the actual force.

12 Q: Well --

13 A: So we can talk about them if you'd like.

14 Q: Well, in the -- in the literature that you were reading  
15 from, it's an obstetrical -- the ACOG book that Ms. Craig was  
16 -- was talking about being the Bible or whatever of  
17 obstetrics, you were reading from chapter 3, which Michelle  
18 Grimm wrote; true?

19 A: I don't know if she wrote it, but that's probably  
20 correct. But it is an engineering chapter, yes.

21 Q: Yes, sir. It's an engineering chapter in an obstetrical  
22 book. Do you know if that engineer has ever passed peer  
23 review for engineering books?

24 A: I don't have that knowledge. She's a well-respected  
25 engineer that's written a lot in our literature.

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1 Q: Yes, sir. She's well respected by obstetricians.

2 MS. CRAIG: Your Honor --

3 THE COURT: First of all, you're cutting him off. Now we  
4 have an objection. What's that?

5 MS. CRAIG: Yes, sir. So I don't believe this was a  
6 medical article that we went into. So if he's going to ask  
7 about the medical article, if he could let the doctor have the  
8 actual article so he could respond to it, please?

9 MR. GRAHAM: He said he relied on the article that --

10 THE COURT: Give --

11 MR. GRAHAM: -- she wrote about and she refers to her  
12 literature in here. Do you still have the book?

13 THE WITNESS: I do not.

14 MR. GRAHAM: Okay. Could we borrow your book, Ms. Craig?

15 BY MR. GRAHAM:

16 Q: You did read from chapter 3, the engineering chapter;  
17 true?

18 A: Yes.

19 Q: All right. And in that chapter, Michelle Grimm talks  
20 about her MADYMO approach; true?

21 A: Yes.

22 Q: All right. Now, MADYMO is shorthand for calling up the  
23 automotive giants in Detroit and saying how about send me a  
24 test crash dummy; right?

25 A: I think this one was from the Netherlands, but they may

1 have come through Detroit. I'm not sure.

2 Q: Yes, sir. And -- and so she took -- she took a nine-  
3 month-old baby crash test dummy and changed the sizes to try-  
4 to match a term baby; true?

5 A: She took a -- a baby crash test dummy and modified it the  
6 best that was known at the time to mimic a newborn so she  
7 could test the forces of labor, yes.

8 Q: Okay. And -- and you know that she was able to design  
9 that model to get whatever results she wanted to achieve;  
10 true?

11 A: No, that's not true.

12 Q: You don't know that?

13 A: No, I know that's not true.

14 Q: She chose a baby goat neck instead of a human neck; true?

15 A: She used data from animals to determine how much tension  
16 to put on the spring that she used in the brachial plexus,  
17 which is what measured the stretch, which is standard  
18 operating procedure for that type of study. So she used  
19 standard techniques that sound strange, but that's what we do  
20 when we study crash dummy models.

21 Q: And instead of a network of nerves like we have in the  
22 human body, she used a single nerve from an animal; true?

23 A: She used a spring to determine the stretch I believe.

24 Q: In fact, she used a single nerve from the leg of a  
25 rabbit; isn't that true?

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1 A: She used animal nerves to determine how much tension to  
2 consider normal for a human baby and then used a spring to  
3 determine how much stretch occurred.

4 Q: And then she modified that rat leg nerve to give it  
5 qualities more like a rat; isn't that true?

6 A: I'm not sure about the rat issue.

7 Q: Have you ever read Dr. Grimm's sworn testimony explaining  
8 her research?

9 MS. CRAIG: Your Honor, I'm pretty sure I didn't ask any  
10 of these questions.

11 THE COURT: I know you didn't.

12 MR. GRAHAM: She -- she had him read extensively from a  
13 chapter that Michelle Grimm wrote based on these articles  
14 that's in the footnotes.

15 THE COURT: What chapter?

16 MR. GRAHAM: Three.

17 THE COURT: Show me.

18 MS. CRAIG: May I look at my copy actually?

19 THE COURT: You may.

20 MS. CRAIG: If you could just give me a page?

21 MR. GRAHAM: Chapter 3 starts on page 23.

22 MS. CRAIG: And what are you asking about?

23 MR. GRAHAM: I'm asking about Michelle Grimm's goat necks  
24 and rat leg nerves and modification of rat nerves with rat  
25 qualities.

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1 MS. CRAIG: So, Your Honor, the portion that he read  
2 under pathophysiology and causation, that's chapter 3, is  
3 under biomechanics of nerve -- nerve injury.

4 MR. GRAHAM: Which he read from -- had the doctor read  
5 from extensively.

6 THE COURT: I was here.

7 MS. CRAIG: And I'm almost finished. And the reference  
8 -- what he said is that compression alone can result in  
9 permanent injury if the compression is maintained for  
10 sufficient period and is of a significant magnitude.

11 And the footnote is 44 and 45 and the author is Ocoa and  
12 -- actually, it's Ocoa on both. So the author that he's  
13 referencing in these questions about a goat and a rat, I don't  
14 believe was asked to be published to the jury.

15 THE COURT: I agree. I'm going to sustain your  
16 objection.

17 MR. GRAHAM: Your Honor, that's fine. Thank you.

18 BY MR. GRAHAM:

19 Q: We'll move from goats and rabbits and rats to -- to some  
20 other animal since Ms. Craig directed your attention to  
21 footnote 44 and 45. During the lunch break, I raced back to  
22 the office to read the footnotes and see where they came from.  
23 Have you done that, sir?

24 A: I read some of them.

25 Q: Have you read footnotes 44 and 45 that Ms. Craig just

1 referred to?

2 A: I think so. If they're the ones with the tourniquets on  
3 baboons.

4 Q: Tourniquets on baboons?

5 A: Uh-huh.

6 Q: Let's see. If we tie a tourniquet on a baboon's leg  
7 tight enough and leave it on there long enough, let's see if  
8 we can cause some nerve damage. That's what the article did;  
9 right?

10 A: Uh-huh. Yes.

11 Q: All right. Please explain to me what baboon tourniquets  
12 has to do with Julia B 's nerve damage in her neck?

13 A: Uh-huh. It helps us to understand that compression  
14 forces can cause injury. That's all it says. It has nothing  
15 to do with a delivery. It has nothing to do with obstetrics.  
16 It was a scientific study that was used along with others to  
17 explain that compression can cause injury, just like  
18 stretching can cause injury.

19 Q: Yes, sir.

20 A: It helps us to understand how injuries can occur when  
21 doctors don't pull too hard.

22 Q: Yes, sir. And how far back did ACOG have to go to get  
23 the studies about the baboon tourniquets?

24 A: 1971.

25 Q: Oh. You knew without looking. And what scholarly



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1 publication was cited for the compression -- the significance  
2 of compression in the birth of a human baby? What scientific  
3 magazine published the report on baboon tourniquets?

4 A: Nature.

5 Q: Nature? When was the other footnote article published?

6 A: '72.

7 Q: That's the best you can do, sir, to support your  
8 assertion that compression caused this injury?

9 A: No, sir. I can give you some other articles by Dr.  
10 Grossman if you'd like.

11 Q: Again with your new articles.

12 MS. CRAIG: Your Honor, he asked the question and opened  
13 the door.

14 THE COURT: I agree.

15 MS. CRAIG: If he would like to talk about Dr. Resnick's  
16 articles, I think he can.

17 THE COURT: If you have a question, ask it.

18 MS. GANES: Grossman.

19 MS. CRAIG: Did he say Resnick or Grossman?

20 MS. GANES: Grossman.

21 BY MR. GRAHAM:

22 Q: Do you have the article, sir?

23 A: Yes.

24 Q: May I see the article, sir?

25 A: Sure. This is an article that explains that compression

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1 can cause injury. That's what we're talking about here.

2 Q: May I see the article, sir?

3 A: Yes.

4 MR. GRAHAM: Your Honor, may I take just a moment to see  
5 what this is about?

6 (WHEREUPON, there was a pause in the proceedings, after  
7 which the proceedings resumed as follows.)

8 THE COURT: (To a juror) Let me know if we need to pick  
9 up your child.

10 THE JUROR: You need to pick her up.

11 MR. GRAHAM: Your Honor, I'll have Mr. Ruffin look at  
12 that while I move on, if that please the Court.

13 BY MR. GRAHAM:

14 Q: And now may be a good time to have you read -- sir, do  
15 you still have the ACOG book?

16 A: Yes.

17 Q: Why don't you come down, sir, like you did before and  
18 read some portions of this ACOG Bible to the jury?

19 THE COURT: Why don't we have him stay right here where  
20 he can use the microphone and the court reporter can hear him?

21 MR. GRAHAM: That's fine.

22 THE COURT: That's the problem we had last time.

23 MR. GRAHAM: That's fine. That's fine, Your Honor.

24 MS. CRAIG: Your Honor, would it be okay -- the doctor is  
25 using my copy. Could I just stand behind him while he reads

1 so I can see?

2 THE COURT: That would be fine.

3 MS. CRAIG: Thank you.

4 BY MR. GRAHAM:

5 Q: Okay. Please turn to page 29. This is in chapter 3;  
6 correct?

7 A: Yes.

8 Q: Okay. In the -- in the column -- on the left-hand  
9 column, there's a heading that says exogenous forces. That's  
10 a fancy word for pulling by the doctor; true?

11 A: That's the external force, yes.

12 Q: All right. Please go down to the second paragraph. I'm  
13 going to read the last sentence and I'd like you to tell me if  
14 I read this correctly.

15 The key principle to minimize stretching of the brachial  
16 plexus through the application of this exogenous force is to  
17 avoid lateral bending of the neck. That is, moving the  
18 fetus's head out of alignment with the fetal cervicothoracic  
19 spine, whether toward the floor or toward the ceiling.

20 Did I read that accurately?

21 A: Yes.

22 Q: And now, please turn to the next page, page 30, the  
23 right-hand column, first new paragraph about two-thirds of the  
24 way down. There's a sentence that begins the majority. Do  
25 you see that?

1 A: Yes.

2 Q: The majority of the clinicians, 72 percent, applied less  
3 than 150 newtons, in parentheses, 33.7 pounds per foot of  
4 force at all points during the delivery.

5 And I'll just stop there. Did I read that accurately?

6 A: Yes.

7 Q: If 72 percent of the -- of the clinicians applied less  
8 than 150 newtons or 33.7 pounds of force, that means 28  
9 percent used more than that amount of force; true?

10 A: That would be correct, yes.

11 Q: Now, please turn to page 31, the very last sentence in  
12 the second column.

13 The authors concluded that the persistent injuries were  
14 associated with a perceived higher level of downward traction  
15 on the head than the transient injuries.

16 Did I read that accurately?

17 A: Yes.

18 Q: Persistent means permanent; true?

19 A: I don't know what they meant by persistent.

20 Q: All right. Transient means temporary; true?

21 A: Transient means temporary, but I'm not sure how they  
22 defined persistent in that study. I'd have to look.

23 Q: Now I'm going to ask you -- I believe -- Ms. Craig was  
24 running through these real fast and I had difficulty trying to  
25 keep up. I think you read from page 47, but let me -- let me

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1 get you to look at the left-hand column and the title of this  
2 section, head-to-body delivery interval. Drop down about  
3 halfway in that paragraph. Do you see -- let me just show  
4 you. Do you see --

5 A: I see it. I've got it.

6 Q: The risk?

7 A: The risk? Yes.

8 Q: All right. The risk of acidosis or severe hypoxic-  
9 ischemic encephalopathy remains low with less than five  
10 minutes of impaction.

11 Did I read that accurately?

12 A: Yes.

13 Q: And acidosis and hypoxic-ischemic encephalopathy  
14 translates loosely into brain damage; true?

15 A: It can lead to brain damage, yes.

16 Q: And it's got -- it's got a couple of footnotes there, 34  
17 and 35. Can you tell us what those articles are?

18 A: Number 34 is from the *British Journal of OB/GYN*. Number  
19 35 is from *Obstetrics and Gynecology*.

20 Q: All right. Was one of those authored by lead author Dr.  
21 L-e-u-n-g?

22 A: Yes.

23 Q: All right. Did you read the footnotes of the portions  
24 you read to the jury?

25 A: I don't know if I read those two footnotes.

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1 Q: Okay. Well, let me -- let me give you a copy. Is this  
2 the article cited in the footnote?

3 A: Yes. I have read this article.

4 Q: Let me get you to read on page 474, which is the first  
5 page, in the second column, the first new sentence starting  
6 attending clinicians. Do you see that?

7 A: Yes.

8 Q: All right. See if I read this accurately.

9 Attending clinicians often hasten to intervene and to  
10 expedite delivery once shoulder dystocia is recognized.  
11 However, such attempts, especially in the hands of less  
12 experienced front-line staff, may do more harm and result in  
13 more fetal injuries.

14 Did I read that accurately, sir?

15 A: Yes, you did.

16 Q: Now, please turn to page 478, under the conclusion  
17 section starting with the second sentence. See if I read this  
18 correctly.

19 However, the risk of acidosis, HIE or fatality is very  
20 low when HBDI is less than 5 minutes.

21 Okay. Now, HBDI stands for head-to-body delivery  
22 interval; true?

23 A: Yes.

24 Q: Acidosis and HIE, again, refer to the risk of brain  
25 damage?

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1 A: Uh-huh. Yes.

2 Q: So that sentence tells us that the risk of brain damage  
3 or death is very low when the head-to-body delivery interval  
4 is less than 5 minutes; true?

5 A: That's what this article found, yes.

6 Q: And in this case, there was only a 45-second head-to-body  
7 interval; true?

8 A: That's correct.

9 Q: So the risk of any -- any -- the potential future risk of  
10 any brain damage, if it's low at 5 minutes, it's exceedingly  
11 low at 45 seconds; true?

12 A: That's correct.

13 Q: It goes on to say, therefore --

14 MS. CRAIG: Your Honor, if he's going to keep reading  
15 from the article, may I have a copy?

16 THE COURT: You may.

17 MS. CRAIG: Thank you.

18 BY MR. GRAHAM:

19 Q: Now, under the conclusion, the last sentence.

20 Therefore, the target time for delivery of the trunk  
21 should be within 5 minutes.

22 The trunk is everything in the body other than the head;  
23 true?

24 A: Yes.

25 Q: In this context?

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1 A: I think that's what they mean, yes.

2 Q: So what they're telling us is to deliver -- to get a  
3 shoulder unstuck safely, you should try to do it within 5  
4 minutes; true?

5 A: That's what this group found, which is a different number  
6 from others, but yes, that's what they say.

7 Q: Well, isn't this the footnote that was cited by what your  
8 lawyer had you read to the jury earlier?

9 A: It's one of the footnotes. You remember there was  
10 another footnote that has a 2-minute interval. So the point  
11 is that we want to deliver the baby as safely and as quickly  
12 as we can, and we have around 4 or 5 minutes in most babies  
13 before we start seeing an increase -- a significant increased  
14 risk of brain injury.

15 Q: Okay. Doctor, I want to go back to the article you just  
16 sprung on us without notice, *Resolution of Brachial Plexus*  
17 *Palsy* --

18 MS. CRAIG: Objection, Your Honor.

19 THE COURT: Sustained. We don't need those kind  
20 comments. Ask a question and let the witness answer. Go  
21 ahead.

22 BY MR. GRAHAM:

23 Q: The title of the article you said was written by my  
24 expert, Dr. Grossman, and he was one of the authors. There  
25 are one -- two -- three -- four -- five -- six authors;



1 correct?

2 A: Uh-huh. Right.

3 Q: The title of the article is *Resolution of Brachial Plexus*  
4 *Palsy due to Hemangioma after Intravenous Corticosteroid*  
5 *Therapy*. Did I read that correctly?

6 A: Yes.

7 Q: All right. And you believe this article has something to  
8 do with Julia B ?

9 A: You asked me if compression has ever been reported to  
10 cause permanent injury. You did not ask me if the article had  
11 anything to do with Julia. And I said Dr. Grossman has  
12 authored an article that confirms what other people have found  
13 that compression can permanently injure babies.

14 So that's the pertinence of this that there was  
15 compression and there was traction in this delivery. And you  
16 simply asked me if there were articles that confirmed that  
17 compression can cause permanent injury and I said, yeah.

18 MR. GRAHAM: Your Honor, this is the article that they  
19 just gave us. I'd just like to use the Elmo to show --

20 MS. CRAIG: Your Honor, first of all, I haven't objected,  
21 but he needs to establish it as an 803(18) learned treatise.  
22 But secondly, assuming the doctor will agree, which he will,  
23 the proper methodology -- method with the -- under the rule --

24 THE COURT: Read it in.

25 MR. GRAHAM: -- is to publish it.

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1 MR. GRAHAM: Your Honor --

2 THE COURT: Read it to the jury.

3 MR. GRAHAM: May I show you? May we approach, Your  
4 Honor?

5 THE COURT: Yes.

6 (WHEREUPON, a bench conference was held in the presence  
7 of the jury but out of the hearing of the jury as  
8 follows.)

9 MR. GRAHAM: It's a picture, not a word that we're  
10 talking about. This is the --

11 THE COURT: I understand, but the rule says to read it.  
12 It's as simple as that.

13 MS. CRAIG: The rule is very clear.

14 THE COURT: I mean it's not in evidence. It does not go  
15 to the jury. If you start showing it to the jury, you'll make  
16 it in evidence. You can read it, but not show it to them.

17 MR. GRAHAM: Yes, sir. But this is impeachment, Your  
18 Honor. This is not --

19 THE COURT: It's not a deposition being used for  
20 impeachment. It's a learned treatise. The rule is very  
21 specific. I don't know how to say this. I thought I was  
22 going to be home by 1 o'clock.

23 (WHEREUPON, the bench conference ended and the  
24 proceedings resumed as follows.)

25 BY MR. GRAHAM:

DR. JOSEPH "MACK" ERNEST - CROSS BY MR. GRAHAM

1 Q: Doctor, I'm not going to be allowed to show a picture.

2 MS. CRAIG: Objection, Your Honor.

3 THE COURT: You don't need to do my job or say anything  
4 about what I do or how I rule. You ask a question; you get  
5 answers, please.

6 BY MR. GRAHAM:

7 Q: Under the picture of the baby who -- about whom this  
8 article was written, there's a caption. Would you please read  
9 along with me as I read the caption?

10 Figure 1. Extensive hemangioma of the right upper torso,  
11 neck, and scalp.

12 Did I read that accurately?

13 A: Yes.

14 Q: All right. Hemangioma means what?

15 A: It's a blood vessel tumor.

16 Q: Okay. So if a child has a blood vessel tumor or any kind  
17 of tumor that encapsulates their head, their neck, and part of  
18 their upper torso, do you believe such a person would be more  
19 subject to compression than a normal baby?

20 A: In some cases, and that was the point of this article  
21 that compression can cause permanent injury.

22 Q: But this -- this article has nothing to do with Julia's  
23 case, does it?

24 A: Compression has something to do with her case, but  
25 hemangioma has nothing to do with her case. That's correct.

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1 Q: Okay. One of the articles you read, sir -- on my copy  
2 it's Exhibit 4. I'm not sure what the Court's exhibit copy  
3 is, but it's the one about -- Michelle Grimm is the lead  
4 author. It starts effective clinician-applied maneuvers.  
5 Could you give us the -- do you have that?

6 A: Let's see. I'm not sure that I do have that.

7 Q: Well, since I don't know the Court exhibit number, do you  
8 mind just looking over my shoulder?

9 A: Sure.

10 Q: This is the --

11 MS. CRAIG: Your Honor, may I? The reason why there's  
12 not a Court exhibit number is because I didn't use this one.

13 THE COURT: What's that?

14 MS. CRAIG: There's no Court exhibit number because I did  
15 not use this one on direct.

16 THE COURT: All right.

17 MR. GRAHAM: She -- but he, nevertheless, identified it  
18 as being auth -- as being reliable.

19 MS. CRAIG: You know what? I have no objection to him  
20 using this. That's why this isn't a Court exhibit.

21 BY MR. GRAHAM:

22 Q: This is the one that talks about the MADYMO crash test  
23 dummy --

24 A: Uh-huh.

25 Q: -- with the animal pieces parts; right?

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1 A: She wrote several about MADYMO. That's one of them, yes.

2 Q: Yes, sir. This is the one that she wrote in 2010?

3 A: Okay.

4 Q: Right?

5 A: Yes.

6 Q: All right. Read along with me. I'm on the --

7 MR. GRAHAM: Ms. Craig, I'm in the comments section.

8 It's page 339.e3 starting with the second sentence of the  
9 second paragraph.

10 BY MR. GRAHAM:

11 Q: See if I read this correctly.

12 To minimize any added risk of an upper extremity injury  
13 to the infant, it is important to deliver the fetus with  
14 a minimum amount of clinician-applied force and to apply  
15 that force in such a way as to reduce the stretch on the  
16 brachial plexus.

17 Did I read that accurately?

18 A: You did.

19 Q: Thank you. And finally, on this article on the next  
20 page, 339.e4, the very first paragraph.

21 Previous work has shown that lateral bending of the  
22 infant's neck both causes a large amount of stretch in  
23 the brachial plexus and results in a higher amount of  
24 force needed to achieve delivery. Therefore, lateral  
25 bending of the neck is to be avoided in all deliveries.

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1 Did I read that accurately?

2 A: Yes, sir. We've been talking about that all afternoon.  
3 That's exactly correct.

4 Q: And finally --

5 MS. CRAIG: Your Honor -- I'm sorry.

6 BY MR. GRAHAM:

7 Q: You read from what's my Exhibit 15. I don't know the  
8 Court's exhibit.

9 MS. CRAIG: Your Honor, could he make that last article a  
10 Court exhibit, please?

11 THE COURT: That would be a good idea. Why don't we go  
12 ahead and do that? Just make it a Court exhibit, the last  
13 article that you used.

14 (WHEREUPON, the article was marked as Plaintiff's Exhibit  
15 Number 19 for identification, as Court's Exhibit Number  
16 19 was already in existence.)

17 THE COURT: Do I need to make arrangements to have your  
18 child picked up?

19 A JUROR: Yes, sir. And I need to be able to make a call  
20 to the school.

21 THE COURT: All right. Why don't we take a 10-minute  
22 break? You call the school.

23 A JUROR: Thank you, sir.

24 THE COURT: And we'll go ahead and send the deputy that  
25 way. Members of the jury, step into the room. Do not discuss

DR. JOSEPH "MACK" ERNEST - CROSS BY MR. GRAHAM

1 the case.

2 (WHEREUPON, the jury exited the courtroom at 4:38 p.m.)

3 THE COURT: Ms. Clerk, please let me know when you're  
4 ready. All right. You can't talk with the lawyers at this  
5 time. All right. Let's go take a break.

6 (WHEREUPON, there was a break in the proceedings from  
7 4:38 p.m. until 4:44 p.m.)

8 THE BAILIFF: Are you ready, Judge?

9 THE COURT: I'm ready.

10 (WHEREUPON, the jury entered the courtroom at 4:46 p.m.)

11 THE COURT: All right. You can continue.

12 MR. GRAHAM: Thank you, Your Honor. May it please the  
13 Court.

14 THE COURT: Sure.

15 BY MR. GRAHAM:

16 Q: Dr. Ernest, I'm almost done. I'm going to speed through  
17 just a few more questions and move right along. Sir, when you  
18 work as an opinion witness for the defense, do you charge for  
19 your time?

20 A: Yes.

21 Q: Are you expensive?

22 A: I am I think about in the middle of what is charged. So  
23 it's expensive in one sense, but it's sort of the going rate,  
24 yes.

25 Q: All right. And I'm not going to pick on you about that.

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1 I'm just going to ask you this, sir. Do you believe it's  
2 proper for someone like you to charge for your time when you  
3 work on a case like this?

4 A: Yes.

5 Q: Do you have any criticism of the plaintiff's expert  
6 witnesses for charging for their time?

7 A: I think work should be compensated.

8 Q: Thank you. Now, just one more topic. You were here this  
9 morning I believe. I don't see Dr. Smithson now, but when he  
10 testified, you were in the audience; right?

11 A: Yes.

12 Q: All right. During part of his testimony, we were talking  
13 about the definition of traction and I asked him if he -- if  
14 he believes traction is a pulling force that acts to stretch  
15 or elongate an object, and he didn't agree with that  
16 definition. Do you?

17 A: I think that's a reasonable definition. It's what ACOG  
18 -- how ACOG defines it.

19 Q: Exactly. Exactly. On page 75 of the ACOG book, it has a  
20 glossary. Follow along with me, please, as I read.

21 Traction is defined as, quote, a pulling force that acts  
22 to elongate or stretch an object, end quote.

23 Did I read that accurately?

24 A: Yes.

25 Q: Thank you.



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1 MR. GRAHAM: No further questions, Your Honor.

2 THE COURT: All right. Redirect?

3 MS. CRAIG: Thank you, Your Honor.

4 REDIRECT EXAMINATION

5 BY MS. CRAIG:

6 Q: All right. Doctor, to give your opinions in this case,  
7 did it matter when you saw the birth video?

8 A: It did not.

9 Q: How did the birth video in this case provide confirmation  
10 of your opinions?

11 A: The birth video was a visual representation of what I had  
12 seen written in the chart and read in the depositions. So it  
13 confirmed the opinions I had previously made.

14 Q: You were asked numerous questions about suprapubic  
15 pressure. I just have one. Do you have an opinion whether  
16 suprapubic pressure had anything to do with the brachial  
17 plexus injury in this case?

18 A: No.

19 Q: Thank you, sir. Do you recall when Mr. Graham pulled on  
20 his head and bent it over to the side? I think he did it  
21 several times. He went up and bent his head over to the side.  
22 Do you remember that?

23 A: Yes.

24 Q: Did you see Dr. Browning do that at any time on the  
25 video?

1 A: No, he did not do that.

2 Q: Did he bend the head over to the side as Mr. Graham  
3 continued to move his head over to the side on your cross-  
4 examination?

5 A: He did not do that. He applied appropriate traction,  
6 which is called axial traction. It was very clear on the  
7 video. It was a straightforward delivery, appropriately  
8 managed with axial traction. There was no abnormal traction  
9 or bending of the head at all.

10 Q: Doctor, do you still have your deposition close by?

11 A: Yes.

12 Q: All right. Mr. Graham directed you to page -- let's see  
13 -- 169 of your deposition?

14 A: Yes. I'm there.

15 Q: All right. And he asked you to just read lines 9 through  
16 13; correct?

17 A: Right.

18 Q: All right. Let's see if we can see this on the Elmo.

19 All right. And so at line 9 it says -- and the question is:

20 And if Dr. Browning used more traction than he should  
21 have used, he increased the risk of the damage to the  
22 brachial plexus nerves on the baby's right side; true?  
23 And then your answer was: Yes. He did not do that, but  
24 that's correct. That's a correct statement if he did  
25 that, which he did not.

1 Did you also read that -- those lines which were in  
2 follow-up to the previous question that Mr. Graham asked you?

3 A: I did not. That's a more complete answer.

4 Q: Does this portion help put into context what Mr. Graham  
5 just asked you on cross-examination?

6 A: Yes.

7 Q: Is the deposition testimony that you gave in this case  
8 the same as your trial testimony today?

9 A: Yes.

10 (WHEREUPON, the deposition of Dr. Ernest was marked as  
11 Court's Exhibit Number 22.)

12 BY MS. CRAIG:

13 Q: All right. Resnick's report. You were asked many  
14 questions about how do you know that suprapubic pressure and  
15 McRoberts were done in this case; correct?

16 A: Right.

17 Q: Do you remember those questions?

18 A: Yes.

19 Q: And you know that Dr. Resnick is one of their expert  
20 witnesses; correct?

21 A: Yes.

22 Q: And in his report, he says in the medical history -- and  
23 I have it highlighted. If you could, read that, please?

24 A: Ms. Byrd recalls that her legs were held up in a flexed  
25 position and a nurse exerted pressure on her abdomen.

1 Q: Okay. And this report was -- what was the date of that  
2 report at the top?

3 A: January 27, 2015.

4 Q: Okay. And this report by their own expert -- how does it  
5 support your opinion in this case that suprapubic pressure and  
6 McRoberts were done?

7 A: Well, Dr. Browning said it was done. We see the  
8 McRoberts and movement toward suprapubic in the video. Ms.  
9 Byrd remembers procedures that fit the description of those  
10 things. The baby was delivered shortly after the video  
11 stopped, which implies that the suprapubic pressure was done  
12 because the baby was delivered. So it all fits together that  
13 there was suprapubic pressure applied.

14 Q: Thank you. Moving on down to Court's Exhibit 19.

15 (WHEREUPON, this reference was made to Plaintiff's  
16 Exhibit Number 19 for identification only.)

17 BY MS. CRAIG:

18 Q: I believe that was an article that Mr. Graham asked you  
19 about. Thank you. He asked you to read a portion of that  
20 article and I would just like to direct your attention to the  
21 -- page 339.e4, and it's the last column on the right,  
22 starting with:

23 Maternal forces alone have been demonstrated to be a  
24 significant cause of brachial plexus stretch when one of  
25 the infant's shoulders has an impact with the maternal

1 pelvis, even in the absence of clinician-applied  
2 traction.

3 Did I read correctly?

4 A: Uh-huh. Yes.

5 Q: The three articles of the plaintiff's expert, Dr.

6 Grossman. You went through one of those articles with me on  
7 direct examination and then you provided counsel with two  
8 additional articles that you had from their expert, Dr.

9 Grossman; correct?

10 A: I believe so, yes.

11 Q: And I just have one question. Are those articles  
12 consistent with Dr. Grossman's opinion in this case?

13 A: They are not.

14 Q: ACOG book, very quickly, page 29, chapter 3. You were  
15 asked to read a portion about lateral bending of the neck. Do  
16 you recall those questions?

17 A: Yes..

18 Q: Did you see on the video or is there any evidence in the  
19 medical records that there was any lateral bending of the  
20 neck?

21 A: No.

22 Q: Page 30, you were asked about newtons. My question is  
23 why is a measurement of 50 to 60 newtons of force used by a  
24 doctor within the standard of care?

25 A: Why is it within the standard of care?

1 Q: Yes, sir.

2 A: Well, that is the normal amount that we apply for most  
3 deliveries. Remember, the intrauterine pressure can get up to  
4 160 newtons before the doctor can ever get their hands --  
5 that's the endogenous force. One hundred newtons has been  
6 shown to be able to overcome at least two shoulder dystocias  
7 in a study.

8 And so we try to keep -- based on those numbers, if a  
9 doctor applied 50 to 60, it's well below the risk that should  
10 cause any problems. So that's the -- and other studies have  
11 shown both in clinical studies and in models, simulation  
12 models, MADYMO models, crash dummy models, that that amount of  
13 force, 50 to 60, is well within the safe range.

14 Q: Thank you, Doctor. Last two questions. I'd like for you  
15 to not make an assumption. In this case, no assumptions. Do  
16 you have an opinion whether or not Dr. Browning deviated from  
17 the standard of care?

18 A: I do have an opinion.

19 Q: And that opinion is what?

20 A: He absolutely did not.

21 Q: My second -- my second question, which is actually going  
22 to be a total of four questions. Do you have an opinion, not  
23 an assumption, whether or not Dr. Browning caused the brachial  
24 -- brachial plexus injury?

25 A: I do have an opinion.

DR. JOSEPH "MACK" ERNEST - REDIRECT BY MS. CRAIG

1 Q: And what is that?

2 A: He absolutely did not.

3 Q: Thank you, Doctor. Have all the opinions you've given  
4 today been to a reasonable degree of medical certainty?

5 A: Yes.

6 MS. CRAIG: Those are all the questions I have.

7 THE COURT: All right. She used 8 minutes. I'm going to  
8 let you use 8 minutes.

9 MS. CRAIG: I don't need that much, Your Honor. Thank  
10 you.

11 THE COURT: You're welcome.

12 MR. GRAHAM: I appreciate it.

13 RE CROSS-EXAMINATION

14 BY MR. GRAHAM:

15 Q: Sir, in fact, you do not know how much traction was used  
16 by Dr. Browning; true?

17 A: I do not know the quantity, the number, but I know that  
18 it was appropriate based on what I see.

19 Q: Well, nobody knows how much traction force Dr. Browning  
20 actually used on Julia's head because it wasn't measured, was  
21 it?

22 A: It's never measured in clinical deliveries, as this one,  
23 but we see what he did and I can tell from looking at many  
24 thousands of deliveries it was within the normal range.

25 MR. GRAHAM: Dave, would you please queue up page 46,

1 lines 11 through 16?

2 (WHEREUPON, the video deposition referenced was played in  
3 open court. Transcribed as follows.)

4 MR. GRAHAM: You don't know how much traction was used?  
5 Nobody does?

6 THE WITNESS: We never know that within any delivery.  
7 That's correct. We know what the doctor said. We know  
8 what's in the report. We have to use that on which to  
9 base our numbers.

10 MR. GRAHAM: All right.

11 (WHEREUPON, the video stopped.)

12 BY MR. GRAHAM:

13 Q: Was that video -- did that video reflect accurately my  
14 question and your answer?

15 A: I was reading it. It said -- but I -- it said what I  
16 just said that we don't have a number.

17 Q: No, no. My question is did the video accurately reflect  
18 --

19 A: Oh.

20 Q: -- what you testified to --

21 A: Yes, absolutely.

22 Q: -- in your deposition?

23 A: Yes.

24 MS. CRAIG: Your Honor --

25 MR. GRAHAM: Thank you. No further questions.

26



1 MS. CRAIG: I move to strike. That was improper  
2 impeachment. This deposition says the exact same thing the  
3 doctor just testified.

4 THE COURT: I understand that. All right. You may step  
5 down.

6 THE WITNESS: Thank you.

7 THE COURT: Have a good day.

8 MS. CRAIG: Your Honor, may the witness be excused?

9 THE COURT: Yes.

10 MS. CRAIG: Thank you.

11 THE COURT: All right. Ladies and gentlemen of the jury,  
12 I need you back at 9:30 tomorrow morning and we're going to  
13 finish this case, believe it or not. I promise.

14 (WHEREUPON, the jury exited the courtroom at 5:00 p.m.)

15 THE COURT: All right. Y'all want to come on up here and  
16 take a look at the charge? I'm going to be clerkless  
17 tomorrow; so I want to get this charge and its verdict form  
18 done right.

19 MS. CRAIG: Yes, sir.

20 THE COURT: Before we leave today.

21 MS. CRAIG: I understand.

22 THE COURT: With no additions tomorrow or deletions  
23 tomorrow.

24 MS. CRAIG: No problem.

25 THE COURT: It should be in some form or fashion as

1 pretty much everything everybody wants.

2 MS. CRAIG: Okay.

3 THE COURT: Except the stuff that is just ridiculous.

4 MS. CRAIG: Why don't I take the first half and you take

5 the bottom half and then we'll change?

6 MR. RUFFIN: That sounds good.

7 THE COURT: You can flip over most of it. It's just

8 standard. You know, like the introduction.

9 MS. CRAIG: Okay.

10 THE COURT: You've heard that a million times.

11 MS. CRAIG: Yep.

12 MR. RUFFIN: The introduction is fine. The duty is fine.

13 MS. CRAIG: Just tell me when you're ready.

14 MR. RUFFIN: Oh, I said fine. I'm sorry.

15 MS. CRAIG: Okay.

16 MR. RUFFIN: I'm not worried about the judge's duties.

17 All right. Let's see.

18 (WHEREUPON, there was a pause in the proceedings for

19 review of the charge and verdict form, after which the

20 proceedings resumed as follows.)

21 MR. RUFFIN: Judge, are you going to charge them on

22 respondeat superior or just I mean declare it as a matter of

23 law or --

24 MR. GRAHAM: I mean --

25 THE COURT: It doesn't matter to me.

1 MR. GRAHAM: It seems to me like we ought to just go  
2 against Dr. Browning and say if he's liable for ordinary  
3 negligence, then the corporation's legal responsibility  
4 follows as a matter of law.

5 THE COURT: What's wrong with that right there?

6 MS. CRAIG: This is fine.

7 MR. RUFFIN: Nothing.

8 MS. GANES: I'd rather charge that.

9 MR. RUFFIN: I was just offering.

10 THE COURT: Okay.

11 MR. RUFFIN: Yeah, that's fine.

12 (WHEREUPON, there was a pause in the proceedings for  
13 review of the charge and verdict form, after which the  
14 proceedings resumed as follows.)

15 MR. RUFFIN: Your Honor, on the obstetrical emergency  
16 clear exception, we have the charge and I'm just saying we'll  
17 make a motion for directed verdict on it, but I'm just making  
18 sure it's --

19 THE COURT: It'll be in there.

20 MR. RUFFIN: The definition of gross negligence, there's  
21 a --

22 MS. GANES: That's probably in the next one.

23 THE COURT: I think there's more.

24 MR. RUFFIN: Is there? Okay.

25 MS. GANES: It's probably coming.

1 (WHEREUPON, there was a pause in the proceedings for  
2 review of the charge and verdict form, after which the  
3 proceedings resumed as follows.)  
4 MS. GANES: That doesn't apply.  
5 MR. RUFFIN: Wait. Lost -- yeah. It would be reduced  
6 earning capacity for future, but not lost wages.  
7 MS. CRAIG: Your Honor, do you want me to just mark  
8 through --  
9 MR. RUFFIN: There's no lost wages, just reduced earning  
10 capacity.  
11 MS. CRAIG: Okay. So you want to say the plaintiff --  
12 MS. GANES: Just say the plaintiff --  
13 MR. RUFFIN: May also claim --  
14 MS. GANES: -- claim --  
15 MR. RUFFIN: Then strike through lost wages due to  
16 absence from work. So it would be just plaintiff may also  
17 claim reduced earning ability for the future.  
18 MS. GANES: Uh-huh.  
19 MR. RUFFIN: That's fine.  
20 (WHEREUPON, there was a pause in the proceedings for  
21 review of the charge and verdict form, after which the  
22 proceedings resumed as follows.)  
23 MR. GRAHAM: Well, Your Honor, I did want to ask about  
24 the verdict form though.  
25 THE COURT: Yeah. We're doing that now.

1 MR. GRAHAM: Could we have overnight on the verdict form?  
2 MS. CRAIG: Your Honor, so --  
3 THE COURT: We're going to do all this before we leave.  
4 MS. CRAIG: The only additional three that we would have  
5 is the gross negligence, 501(c)(3), and captain of the ship.  
6 Did we submit proposed charges on those?  
7 MS. GANES: We did not because it was raised late that  
8 Dr. Browning was coming back in. Do you have a proposal?  
9 MR. RUFFIN: And I have a gross negligence.  
10 MS. GANES: It seems like we do. We have a gross  
11 negligence charge.  
12 THE COURT: Give me a short one now. Don't go Ralph King  
13 Anderson or anything like that.  
14 MR. RUFFIN: Here's my gross negligence.  
15 THE LAW CLERK: That one is in there.  
16 MS. GANES: Is that during --  
17 THE LAW CLERK: Well, that one has -- it's at the end or  
18 something.  
19 MS. GANES: Okay. Is it at the end of the obstetrical  
20 emergency statute?  
21 THE LAW CLERK: No, it's somewhere else. Hold on. It  
22 does -- there's a little blurb at the end of the obstetrical  
23 exception, but there's -- let me double check.  
24 MR. RUFFIN: Do we have a surviving punitive damages  
25 claim? Or what's -- I'm trying to --

1 MR. GRAHAM: Against --

2 THE COURT: That was granted.

3 MR. RUFFIN: Okay.

4 MR. GRAHAM: But it's only against the doctor

5 individually.

6 MR. RUFFIN: Right. I think that's how it works now.

7 MS. CRAIG: Oh, I think I've got it. It's under -- on

8 the obstetrical emergency.

9 THE COURT: Yes.

10 MR. RUFFIN: And, Your Honor, there's a few cases,

11 including a Supreme Court case, that defines it as an

12 additional sentence which says it is the failure to exercise

13 slight care and then it says gross negligence is also the

14 absence of care that is necessary under certain circumstances.

15 And that's verbatim from the cases that I've cited below.

16 And it's our opinion that removing that final sentence

17 unfairly favors the defense because it's my opinion that

18 that's broader and it's literally straight out of a Supreme

19 Court opinion or actually several, including Court of Appeals

20 opinions.

21 THE COURT: You're talking about just that last sentence?

22 MR. RUFFIN: Correct.

23 THE COURT: If they have no objection to it, you can just

24 write it on the end of it.

25 MR. RUFFIN: Well, let's see. I don't know if they do or

1 not.

2 THE COURT: That's fine with me.

3 MS. CRAIG: You're in charge of gross negligence. Go  
4 ahead.

5 MS. GANES: No, I think we would want that included.  
6 That's the law.

7 THE COURT: Go ahead and write it.

8 MR. RUFFIN: The last sentence?

9 MS. GANES: As it is.

10 MR. RUFFIN: Okay. All right. So she said as this --  
11 well, let me explain.

12 MS. GANES: Just leave the charge as it is.

13 MR. RUFFIN: No, no, no. I mean this is me. This isn't  
14 the judge.

15 MS. GANES: Right..

16 MR. RUFFIN: So you said -- I just -- I don't want to  
17 misrepresent --

18 MS. GANES: Right.

19 MR. RUFFIN: -- what you just said. I'm asking that this  
20 sentence be included as pulled directly from these cases.

21 MS. GANES: No. We would want to leave it just as the  
22 judge has it --

23 MR. RUFFIN: Okay. So they're --

24 MS. GANES: -- in the obstetrical emergency statute..

25 THE COURT: What difference is it going to make?

1 MS. GANES: Gross negligence is gross negligence.

2 MR. RUFFIN: Well -- and we believe that this last

3 sentence -- it would be prejudicial to us for it not to be

4 included.

5 THE COURT: Let's see how that one is. I don't have any

6 problem with that.

7 MR. RUFFIN: Okay.

8 THE COURT: Why don't you just write it at the end where

9 it needs to be?

10 MR. RUFFIN: Okay.

11 THE COURT: In a way that I can read it.

12 MR. GRAHAM: You just created an impossible task.

13 (WHEREUPON, there was a pause in the proceedings for

14 review of the charge and verdict form, after which the

15 proceedings resumed as follows.)

16 MR. GRAHAM: Well, surely there's another side to this.

17 THE LAW CLERK: No. That was a -- that was a note that I

18 drafted.

19 MR. GRAHAM: We need to look at --

20 THE LAW CLERK: So -- so I didn't want to -- I mean --

21 MR. GRAHAM: But he is liable for his own failure to

22 correct the nurse.

23 MR. RUFFIN: Yeah. I mean I think Browning established

24 that duty through his own words.

25 MR. GRAHAM: Yeah, absolutely.



1 MR. RUFFIN: But he's not -- how do we -- how do you do  
2 that? I mean it's not like -- if he wasn't in the room, and  
3 something happened, he wouldn't be responsible, but if it  
4 happened under his -- like, it was right there.

5 MR. GRAHAM: When he knew or should have known that it  
6 was being done incorrectly.

7 MR. JOYCE: That's for them to discern.

8 MR. RUFFIN: Yeah. Perfect. Whatever Your Honor wishes.

9 THE COURT: That's the law.

10 MR. RUFFIN: Do what now?

11 THE COURT: That's the law.

12 MR. RUFFIN: Right, right.

13 THE COURT: Just take a piece of paper and stick it in at  
14 the appropriate place.

15 MR. RUFFIN: Do that, wherever that goes. Well, I mean  
16 we'll explain --

17 THE COURT: Trust me. They aren't even going to be  
18 listening to me when I get to that.

19 MR. RUFFIN: I think --

20 MR. GRAHAM: Talk soft. Talk soft.

21 THE COURT: They're done. They're already done.

22 MS. GANES: So, Your Honor, with Dr. Browning remaining  
23 in the case, he's entitled to a specific finding of gross  
24 negligence.

25 THE COURT: You didn't see it on the verdict form?

1 MR. RUFFIN: Is this the -- oh, I haven't looked at it  
2 yet.

3 MS. GANES: I did not.

4 THE COURT: Try page 2.

5 THE LAW CLERK: It's number four.

6 MR. RUFFIN: Did the defendant Dr. Browning act in a  
7 manner --

8 MS. GANES: Okay.

9 MR. RUFFIN: Okay. Do you mind if we --

10 (WHEREUPON, there was a pause in the proceedings for  
11 review of the charge and verdict form, after which the  
12 proceedings resumed as follows.)

13 MR. RUFFIN: I do have one change. The proximate cause  
14 to a proximate cause just for consistent with the language of  
15 the charge. When it says "the" proximate cause, I changed it  
16 to "a" so it's consistent with Your Honor's jury charge.

17 MS. GANES: You did get our proposed verdict form? No,  
18 he never had it.

19 MS. CRAIG: All right. Do we have it so we can show it  
20 to him?

21 MR. GRAHAM: Because I mean the law says it can be any  
22 one or more of several proximate causes.

23 THE COURT: Show me what you want to do.

24 MR. RUFFIN: Okay. We ask for the one to be consistent  
25 with the charge. Standard of care was "a" proximate cause of

1 the injuries instead of "the."

2 MS. CRAIG: I thought the law was "the."

3 MR. GRAHAM: No. It's "a."

4 MR. RUFFIN: It's "a."

5 MS. CRAIG: Your Honor, so our -- we apologize. I  
6 thought we sent our proposed verdict form. The one --

7 THE COURT: We're waiting on them. We've been waiting on  
8 them.

9 MS. CRAIG: I know.

10 (WHEREUPON, there was unintelligible crosstalk.)

11 MS. GANES: We were going to email it to Paul and just  
12 ask for the Court's input on the specific unknown gross  
13 negligence because I knew you had a sentence. Well, we had --  
14 I'm sorry. What we had was the verdict form that Judge  
15 Nettles submitted to the jury last May and Judge Griffith was  
16 going to submit to the jury last September.

17 MR. GRAHAM: A totally different situation.

18 MS. GANES: It was the exact same case last September and  
19 we had already had one --

20 THE COURT: Is that what they were going to do?

21 MR. GRAHAM: There were --

22 MS. CRAIG: So what -- what we would propose -- and we'll  
23 get one to you shortly in just a second.

24 THE COURT: Go ahead and get it.

25 MS. CRAIG: Okay. Sure.

1 THE COURT: That way we can look at it and see what we're  
2 talking.

3 MR. RUFFIN: And I do -- I might -- is it too late to  
4 send a proposed verdict form?

5 THE COURT: Well, they're getting one.

6 MR. RUFFIN: Oh, are they? All right. Will you get the  
7 proposed verdict form?

8 THE COURT: Why don't we use the one that we used in the  
9 last one?

10 MR. GRAHAM: Let's --

11 MR. RUFFIN: Hang on. The one thing that I think is  
12 confusing is that for the affirmative defense, since there's  
13 three elements to it, was there a genuine medical emergency,  
14 was there an immediate threat of death or serious bodily  
15 injury, and was the patient medically stable, to me I think  
16 it's easier for the jury to understand that there's three  
17 separate elements to list each one out. One, two, three, sort  
18 of like you do breach -- duty, breach, causation, damages, to  
19 list out the requirements of the affirmative defense.

20 THE COURT: Let's see with the other verdict form is, the  
21 one you were going to use last time.

22 MR. GRAHAM: Oh, we -- that one is under appeal, Your  
23 Honor.

24 MR. RUFFIN: Yeah. I don't think we ever even got to  
25 that.

1 THE COURT: It never got to the jury, did it?

2 MR. RUFFIN: No.

3 MR. GRAHAM: No. Well, are you talking about --

4 MR. RUFFIN: He's talking about Fulton.

5 MR. GRAHAM: We didn't -- I'm talking about -- they're

6 talking about Fulton I think and that's what I'm talking

7 about.

8 MR. RUFFIN: Yeah. I don't think we ever even did a

9 verdict form in this.

10 MR. GRAHAM: We were very upset with the verdict form and

11 it is under appeal.

12 THE COURT: What's wrong with this one?

13 MR. RUFFIN: Well, again, my request would be --

14 THE COURT: To answer the questions properly, it's

15 possible they might not even have to get to numbers.

16 MR. RUFFIN: True.

17 MS. CRAIG: So.

18 THE COURT: It could save us a lot of time.

19 MS. CRAIG: So it's our position that if the obstetrical

20 emergency --

21 MR. GRAHAM: It doesn't say anything about --

22 MS. CRAIG: If they don't find there's gross negligence,

23 they don't --

24 MR. GRAHAM: -- medical stability.

25 MR. RUFFIN: Hold on, hold on. Okay. This --

1 MS. CRAIG: And that's why we think --  
2 MR. RUFFIN: Okay. Well, one big --  
3 MS. CRAIG: -- that it would be the first question.  
4 MR. RUFFIN: One big issue is that it leaves off the  
5 element of medical stability in its entirety.  
6 THE COURT: What were you saying now? Go back again.  
7 MR. RUFFIN: I'm sorry.  
8 THE COURT: What were you getting at?  
9 MS. CRAIG: Sir?  
10 THE COURT: What were you saying about the verdict form?  
11 MS. CRAIG: So the first question being whether or not  
12 the obstetrical emergency statute applies.  
13 THE COURT: Okay.  
14 MS. CRAIG: And then you get -- and so --  
15 MR. RUFFIN: Is that our verdict form?  
16 MS. CRAIG: And so then if they find that there is gross  
17 negligence or is not gross negligence, then their  
18 deliberations are over. If they find that there is gross  
19 negligence, then they go to the next -- next step.  
20 THE COURT: Which would be preponderance of the evidence?  
21 MS. CRAIG: Yes, sir.  
22 THE COURT: And then two?  
23 MS. CRAIG: Three.  
24 THE COURT: And then proximate cause? And then four?  
25 MS. CRAIG: Yes.

1 THE COURT: Okay.

2 MS. CRAIG: And we are getting that to you right this

3 second. Actually, they're printing them out.

4 THE COURT: That would be --

5 THE LAW CLERK: So this would be one?

6 THE COURT: That would be one.

7 THE LAW CLERK: And then this would be two?

8 THE COURT: Right.

9 THE LAW CLERK: Is that what you said?

10 THE COURT: That would be one.

11 THE LAW CLERK: That would be one.

12 THE COURT: From what she's proposing.

13 THE LAW CLERK: That would be one.

14 THE COURT: One, two three.

15 THE LAW CLERK: Well, if you do this one, it would

16 logically follow that that would be two; right?

17 MS. CRAIG: Yeah. Can I see it? I'm sorry.

18 THE LAW CLERK: I'm sorry.

19 MS. CRAIG: Sorry.

20 THE LAW CLERK: If you ask the exception first, you would

21 have to ask gross negligence second to see if you even need to

22 keep going.

23 MS. CRAIG: You're right. Yes, you're right. Yes.

24 Yeah.

25 THE COURT: It's just a matter of the order.

1 MR. RUFFIN: And --

2 THE COURT: Okay. And you want to put all kind of stuff  
3 into this part?

4 MR. RUFFIN: Well --

5 THE LAW CLERK: He wants it to be three questions.

6 MR. RUFFIN: And at the very least, it would include the  
7 -- the requirement under the affirmative defense that the  
8 patient -- during the labor and delivery, the patient is not  
9 medically stable, which is one of the three requirements under  
10 the statute.

11 THE COURT: Let me see this section.

12 THE LAW CLERK: So what do you think about was the care  
13 in this case rendered in a genuine emergency situation where  
14 the patient was not stable and involving --

15 MR. GRAHAM: Not medically stable.

16 THE LAW CLERK: Sorry.

17 MR. RUFFIN: It would be easier if I see it as written --  
18 like, once it's written.

19 THE COURT: We can turn it around.

20 MR. RUFFIN: Okay.

21 MS. CRAIG: Your Honor, I've got it pulled up.

22 MR. RUFFIN: Would you mind if I see your print out?

23 THE LAW CLERK: Because it's all "ands"; right? It's  
24 "ands"?

25 MR. RUFFIN: All of them. It's not either/or.



1 THE LAW CLERK: So if I put it as -- what if you did one  
2 question with one, two, three?

3 MR. RUFFIN: That's fine. Yes, that would be very good.

4 THE LAW CLERK: Let's see how that looks.

5 MR. RUFFIN: I think that would work.

6 THE COURT: Let me know when you've got the charge done.  
7 Put it back in order and hand it to me before we leave. And  
8 you've stuck in that part about the captain of the ship or  
9 whatever?

10 MR. RUFFIN: It was up there.

11 MS. CRAIG: Yes, sir. It's right here.

12 THE COURT: Okay. You got it in the right spot?

13 MS. CRAIG: So where would you like for me to put it?  
14 Why do I have two?

15 MR. RUFFIN: I think these are mine. Hold on.

16 MS. CRAIG: Okay. That's yours.

17 MR. RUFFIN: And if there's numbers on them --

18 MS. CRAIG: Okay.

19 MR. RUFFIN: -- at that top, they're mine. His don't  
20 have numbers on the top.

21 MS. CRAIG: All right. So captain of the ship would be  
22 --

23 MS. GANES: Before that one?

24 MS. CRAIG: Did you agree to that?

25 MS. GANES: No, but he overruled me.

1 MS. CRAIG: All right.

2 MS. CRAIG: So, Your Honor, if it's okay with everybody,  
3 what we're going to do is put the captain of the ship in  
4 between breach of standard of care and then do captain of the  
5 ship and then the obstetrical emergency exception, then  
6 proximate cause.

7 THE COURT: That's fine with me.

8 MR. RUFFIN: That's fine. I mean I don't really --

9 MS. CRAIG: Or should we -- should we do proximate cause  
10 --

11 MS. GANES: Before captain of the ship?

12 MS. CRAIG: Yeah. It's kind of awkward there. I think  
13 it makes more sense to talk about standard of care, then  
14 proximate cause.

15 MR. RUFFIN: I mean to me it makes the most sense to do  
16 it before proximate cause. So you do standard of care, breach  
17 of standard of care, and then you have this one what would not  
18 be a breach of the standard of care, but that's just me.

19 MS. GANES: Okay. I'm all right with that.

20 MR. RUFFIN: I also don't have strong feelings one way or  
21 the other.

22 MS. CRAIG: Okay. So I think it would be better after  
23 proximate cause.

24 MR. RUFFIN: Okay.

25 MS. CRAIG: Do you mind if I put it --

1 MR. RUFFIN: No, I don't.

2 MS. CRAIG: Okay. All right. So I'm going to put it in  
3 there. We're good with this. We've got the 501(c)(3) stuff.

4 MS. GANES: It's -- gross negligence is in there, but  
5 there's no charge about Dr. Browning's liability only if he is  
6 found to be grossly negligent.

7 MR. RUFFIN: You mean the charge or the verdict form?

8 MS. GANES: The charge.

9 THE LAW CLERK: You mean from --

10 MS. GANES: There's corporation, but there's no -- you  
11 know, Dr. Browning is a member of a charitable --

12 THE LAW CLERK: A charitable --

13 MS. GANES: -- entity and, you know, you can't return a  
14 verdict against him. Which I know that's not the wording, but  
15 --

16 THE COURT: Why don't the two of you all write one up  
17 real quick?

18 MR. RUFFIN: Where are we at now?

19 MS. GANES: You have a lot more faith in our writing  
20 skills than we do.

21 THE COURT: Yeah. The two of you can do it.

22 MR. GRAHAM: You can't charge a cap. Is that what you're  
23 talking about?

24 MR. RUFFIN: It's not the cap.

25 MS. GANES: It's not a cap. It's the statutory right to

1 a specific finding of gross negligence.

2 THE COURT: You've got it under control.

3 THE LAW CLERK: 15 -- what is it?

4 MS. GANES: No. It's 33-16.

5 THE LAW CLERK: 60 something?

6 MS. GANES: Right.

7 MR. GRAHAM: Doesn't the verdict form call for that?

8 MS. GANES: Right. So they need a charge to know what to  
9 do with the verdict form.

10 MR. GRAHAM: Just to know what gross negligence is.

11 THE COURT: And that the doctor is held to the standard  
12 of gross negligence. It doesn't have to be long. I mean it  
13 can just be --

14 MR. RUFFIN: The point is is that the standard of care  
15 for the -- put the obstetric emergency aside. The standard of  
16 care for the nonprofit would be ordinary negligence. The  
17 standard of care for Dr. Browning would be gross negligence or  
18 recklessness, willful, wanton I believe, not just gross  
19 negligence. I know we're getting --

20 MS. GANES: I think --

21 (WHEREUPON, there was unintelligible crosstalk.)

22 MR. GRAHAM: Wouldn't it simplify it if we just ruled as  
23 a matter of law --

24 THE COURT: I think it needs to be in there. Just  
25 something short. Y'all can come up with something.

1 MS. GANES: Yeah.

2 MR. GRAHAM: If we just ruled as a matter of law that the  
3 corporation is liable for ordinary negligence --

4 THE LAW CLERK: The obstetrician exception only says  
5 grossly negligent. The other one says willful, wanton --  
6 reckless, willful or grossly negligent. So I didn't -- I was  
7 -- you see there are different language asking the question  
8 about him. I'm going to have to ask why is there different  
9 language. I'm just trying to use gross negligence in blanket  
10 terms I guess.

11 (WHEREUPON, there was a pause in the proceedings to  
12 review the charge and verdict form, after which the  
13 proceedings resumed as follows.)

14 THE COURT: All right. Is it all right like it is?

15 MS. GANES: Okay. So this is what we propose. Did you  
16 bring the --

17 MR. RUFFIN: I did. Molly had it.

18 MS. GANES: Okay. So we propose the charge of Dr.  
19 Browning is an employee of McLeod --

20 THE COURT: Let me just ask you do you agree?

21 MR. RUFFIN: The only additional thing I would say is  
22 just somehow to clarify that this is the standard for  
23 Browning. I mean I know -- like I don't know if there's a way  
24 --

25 MR. GRAHAM: Individually only.

1 MR. RUFFIN: Individually or something.

2 MS. GANES: Or if you want to say -- I mean Dr. Browning  
3 is individually named as a defendant in this case.

4 THE COURT: Right.

5 MS. GANES: He is an employee of McLeod Physician  
6 Associates II, which is a charitable entity.

7 THE COURT: Uh-huh.

8 MS. GANES: Okay. And then straight from the statute, a  
9 judgment against an employee of a charitable organization --  
10 so we would call it a charitable organization, not entity --  
11 may not be returned unless a specific finding is made that the  
12 employee acted in a reckless, willful or grossly negligent  
13 manner.

14 THE COURT: That's fine with me.

15 MS. GANES: And that's right out of the statute.

16 THE COURT: It's is as simple as it can be.

17 MR. GRAHAM: But we need to make sure they understand  
18 that the corporation is liable for ordinary negligence by Dr.  
19 Browning.

20 MS. GANES: That's in there.

21 THE COURT: I'm pretty sure it's in there.

22 MS. CRAIG: It's under the respondeat superior charge.

23 THE COURT: And you're right. I mean you can argue it  
24 too. You got a problem with that?

25 MR. GRAHAM: It just seems -- we'd like to see it.

1 MR. RUFFIN: It's under the respondeat superior. I mean  
2 I would lodge our objection.

3 THE COURT: Let's see how it looks.

4 MR. GRAHAM: It's fraught with potential for confusion  
5 I'm afraid.

6 THE COURT: Let's take a look at it. Do you want to just  
7 add a sentence to that?

8 MS. GANES: Add this after that?

9 MR. RUFFIN: Where are we?

10 THE COURT: I think they want to -- you know, you want to  
11 distinguish that the doctor has to have gross negligence.  
12 They want the charitable organization, regular negligence. Or  
13 you could add it to -- after you get done with the doctor's  
14 part, just one sentence.

15 MS. GANES: So are we talking about a sentence you want  
16 to add?

17 MR. RUFFIN: I --

18 MS. GANES: I mean come on. I had to do all this. You  
19 can do a sentence.

20 THE COURT: You can. And I think you can add it to hers  
21 and it might make more sense. That way you distinguish the  
22 doctor from the charitable organization.

23 MR. RUFFIN: Yeah. I mean if you just said that at the  
24 end of that, the doctor -- however the -- however, the  
25 charitable organization still remains negligent for the

1 doctor's ordinary negligence.

2 MS. GANES: No. They haven't decided that yet.

3 THE COURT: That's confusing. That's real confusing. We  
4 can do better than that.

5 MS. CRAIG: I don't think that one is going to fly.

6 MR. RUFFIN: I like that one. That one sounded good to  
7 me. It -- Ed?

8 THE COURT: No, no, no, no. Y'all keep going. He can  
9 stay over there where he is.

10 MR. RUFFIN: All right.

11 THE COURT: You can do it. They didn't need you. They  
12 were just joking.

13 MR. GRAHAM: Do you know what? That's a great example of  
14 hilarious.

15 MR. RUFFIN: What --

16 THE COURT: They've got it under control. Make a young  
17 man think for himself.

18 MR. RUFFIN: Where are you at right now?

19 MS. GANES: Wouldn't you like to know?

20 MR. RUFFIN: Yeah. That's what I'm trying to figure out.

21 MS. GANES: Okay. A judgment may be returned against  
22 McLeod Physician Associates II on a finding of ordinary  
23 negligence.

24 MR. RUFFIN: That sounds perfect to me.

25 THE COURT: That's perfect.



1 MR. RUFFIN: But the issue -- well, yeah, that's fine.  
2 Whatever. Respondeat superior is the one I was concerned  
3 with.  
4 MS. GANES: And it's in there.  
5 MR. RUFFIN: Yeah.  
6 MS. GANES: So this is just what he's going to say to  
7 address this statute.  
8 THE COURT: All right. Slide it in where it needs to be.  
9 MS. GANES: Okay. Let me put it all together and I'll --  
10 MR. RUFFIN: Let me just look at it one more time.  
11 MS. GANES: Yeah. So wait, let me finish my thoughts on  
12 here and then they I'll --  
13 MR. RUFFIN: All right. Let me see it before you finish.  
14 Did any changes get made to the verdict form since my last  
15 review?  
16 THE LAW CLERK: Probably.  
17 MR. RUFFIN: Can I take a peek?  
18 THE LAW CLERK: I'm reading theirs. Just a second.  
19 MR. RUFFIN: Oh, okay.  
20 THE COURT: Let me ask you seriously how long do you  
21 think you would need? You won't need 45 minutes?  
22 MS. CRAIG: I think I'm in favor of time limits, but --  
23 THE COURT: I mean I --  
24 MR. RUFFIN: I'm doing the first closing. So -- yeah.  
25 THE COURT: All right.

1 MR. RUFFIN: So I promise --

2 THE COURT: How much time you want? I would love to have

3 it to them before what I call lunch.

4 MR. RUFFIN: Well, I mean I think it benefits us to get

5 it to them --

6 THE COURT: Sure. --

7 MR. RUFFIN: -- before 5:00 p.m. I just -- I'll be

8 honest. I haven't run through it start to finish, but I mean

9 I just -- I don't think I've taken that long with anything

10 else. So I really don't think it's going to take that long.

11 THE COURT: You haven't, but I want to know.

12 MR. RUFFIN: Yeah. I'm going to be --

13 THE COURT: I'm kind of going to hold you all to it.

14 MR. RUFFIN: Yeah. I just -- I'd hate to say a time

15 limit, but again, I don't think I'm long-winded.

16 THE COURT: 45 minutes?

17 MR. RUFFIN: 45 to an hour will be good.

18 THE COURT: And can he respond in 15 minutes?

19 MR. RUFFIN: No. I don't think that's physically

20 possible.

21 THE COURT: I don't think it is either.

22 MR. RUFFIN: Can he have 30, please? Pretty please?

23 THE COURT: I'll give you 45.

24 MR. RUFFIN: Give him 30?

25 THE COURT: Give him 30 and give you 60 minutes? An

1 hour?

2 MS. CRAIG: They get how much?

3 THE COURT: They're at 45 and 30.

4 MR. RUFFIN: An hour and 15.

5 MS. CRAIG: An hour and 15? Yeah, an hour is fine.

6 MR. RUFFIN: But, Judge, if I --

7 THE COURT: One hour.

8 MR. RUFFIN: I don't think I'm going to take longer, but

9 if I push it a little bit, are you going to cut me off?

10 THE COURT: 45, one hour, 30 minutes.

11 MR. RUFFIN: Okay.

12 MS. CRAIG: I assume they don't have a reply witness?

13 MR. RUFFIN: You need to talk to Ed about that.

14 MS. CRAIG: I know they're not bringing that guy back.

15 MR. RUFFIN: Well, y'all closed discovery to keep us from

16 adding anybody else.

17 THE COURT: If you bring him back, he is in danger. I

18 can tell you that.

19 MS. CRAIG: I can't wait.

20 THE COURT: He is in danger and I will talk to him on the

21 record. I'm going to make it clear.

22 MR. RUFFIN: Yeah. But yeah, I think that we are.

23 THE COURT: There's two places. He can go home or he can

24 go to jail. And maybe the person that asked him too.

25 MR. RUFFIN: I was about to say, if he --

1 MS. CRAIG: I do think that we ought to address that  
2 because I don't think it's been --  
3 THE COURT: If he's coming back, we will address that.  
4 Is your witness tomorrow long?  
5 MS. CRAIG: No, sir.  
6 THE COURT: All right.  
7 MS. CRAIG: At least the direct is not.  
8 MR. RUFFIN: Are you all -- is there anything in any of  
9 your literature that y'all are using with him that wasn't used  
10 in the last trial?  
11 MS. CRAIG: I don't think so, but Elloreë has got that  
12 witness.  
13 MR. RUFFIN: Okay.  
14 THE COURT: It will take 30 minutes? Something like  
15 that?  
16 MS. CRAIG: Elloreë, 30 minutes tomorrow on direct?  
17 MS. GANES: Yeah.  
18 THE COURT: Are you going to cross-examine him?  
19 MR. RUFFIN: Yeah.  
20 MS. GANES: I've got to use all that?  
21 THE COURT: Tomorrow is going to be a better day.  
22 MS. GANES: Do I have to use the whole 30?  
23 MS. CRAIG: No, you do not.  
24 (WHEREUPON, there was a pause in the proceedings, after  
25 which the proceedings resumed as follows.)

1 THE LAW CLERK: I like -- I like your language because it  
2 has "ands".

3 MS. CRAIG: Yeah.

4 THE LAW CLERK: I mean it's and, and, and.

5 MS. CRAIG: It follows the statute.

6 THE LAW CLERK: Yeah.

7 MR. RUFFIN: Do you mind if I take a peek?

8 THE LAW CLERK: Yeah. It's basically the same thing.  
9 It's just written and it is -- I mean that is the statute.  
10 The statute isn't made in a list and --

11 THE COURT: I agree.

12 THE LAW CLERK: The statute is one paragraph long.

13 THE COURT: Right.

14 THE LAW CLERK: I think that it's and, and, and all the  
15 way down and I'll --

16 MR. RUFFIN: I like the way you had it before. I think  
17 that this is confusing.

18 THE COURT: I'm okay with that.

19 MR. RUFFIN: Okay. Well, if you're okay with that.

20 THE LAW CLERK: This is what I had -- I mean pretty much  
21 what I had before.

22 MR. RUFFIN: You added the medically stable in there? Is  
23 not -- the patient is not medically stable? The words appear  
24 in there somewhere?

25 THE LAW CLERK: Yeah.

1 (WHEREUPON, there was a pause in the proceedings to  
2 review the charge and verdict form, after which the  
3 proceedings resumed as follows.)  
4 MR. RUFFIN: If I -- if I use slides in my closing, am I  
5 going to have to disclose them?  
6 THE COURT: You need to get them approved.  
7 MR. RUFFIN: To do them for closing?  
8 MS. CRAIG: I'm fine with it.  
9 THE COURT: All right.  
10 MS. CRAIG: Because I'll do it.  
11 MR. RUFFIN: Yeah, she's going to have slides too I  
12 assume.  
13 THE COURT: Okay.  
14 MR. RUFFIN: We've got everything in now. I'm sure if I  
15 --  
16 MS. CRAIG: It's closing. I'm fine with it.  
17 THE LAW CLERK: It's death or serious bodily injury.  
18 MS. CRAIG: I need to get the statute.  
19 (WHEREUPON, there was a pause in the proceedings to  
20 review the charge and verdict form, after which the  
21 proceedings resumed as follows.)  
22 THE COURT: All right. So just for the record, the  
23 charge is good.  
24 MS. CRAIG: Yep.  
25 THE COURT: I don't need to make any changes, take

1 anything out?

2 MR. RUFFIN: I'm okay with the charge, yes.

3 MS. CRAIG: Yes, sir.

4 THE COURT: And the verdict form as you see it on the  
5 computer?

6 MS. CRAIG: Yes, sir.

7 THE COURT: Sounds good. You've got 45 minutes, you've  
8 got an hour, and then Mr. Graham has got 30 minutes.

9 MR. RUFFIN: Okay.

10 THE COURT: All right. Make sure he knows that.

11 THE LAW CLERK: Give me about five minutes, if even that,  
12 and I'll have this turned around.

13 MS. CRAIG: Okay.

14 THE LAW CLERK: And show it to you.

15 (WHEREUPON, the proceedings adjourned for the day at 5:40  
16 p.m.)

17

18 --- CONTINUED IN VOLUME V, DAY 5 OF 5 ---

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1     MAY 20, 2016

2             (WHEREUPON, the proceedings resumed at 9:39 a.m.)

3             THE COURT: All right. And did you discuss with -- come  
4 on up here about the --

5             (WHEREUPON, a bench conference was held as follows.)

6             THE COURT: He had sent an email about the charge.

7             MS. CRAIG: Yes, sir.

8             THE COURT: I can't remember what it was.

9             MR. RUFFIN: Oh, it was just --

10            THE COURT: Did y'all figure it out?

11            MR. RUFFIN: I just wanted to be sure. I couldn't  
12 remember. Just to make sure that there was the language that  
13 with the obstetric emergency statute that said it was an  
14 affirmative defense.

15            MR. GRAHAM: Well, the shift in the burden of proof.

16            MS. GANES: Your Honor, I'm not sure that is an  
17 affirmative defense and that the burden is shifted. It's a  
18 statutory right.

19            MR. RUFFIN: It's an affirmative defense.

20            MS. GANES: It's a statutory right and a legislative  
21 mandate that gross negligence has to be proven. So that's on  
22 the plaintiff.

23            THE COURT: I understand that. Who has to prove it? The  
24 plaintiff?

25            MR. RUFFIN: They pled it --



1 MS. GANES: The plaintiff has to prove gross negligence.

2 MR. RUFFIN: -- as an affirmative defense in their

3 pleadings.

4 THE COURT: Did they have to plead it? They have to

5 prove that it's not an emergency is what you're saying?

6 MS. GANES: No. Well, again, I think our legislature --

7 our legislature has put us in a predicament that we see

8 sometimes when we're dealing with statutes that are drafted

9 this way. The proof of gross negligence is on them.

10 THE COURT: There's no question.

11 MS. GANES: And so --

12 THE COURT: Who proves the emergency statute though?

13 MS. GANES: I think it's a legislative mandate that

14 doesn't necessarily even have to be proven or pled as an

15 affirmative defense, but we plead things because we don't want

16 to have the argument that we didn't plead it so we can't raise

17 it.

18 THE COURT: Right.

19 MS. GANES: I think it is a legislative mandate and it's

20 a statutory right of our client. And so --

21 THE COURT: Has anybody gotten me any authority on that?

22 MS. GANES: I don't think there is any authority.

23 THE COURT: Have you got any authority --

24 MR. RUFFIN: I can --

25 THE COURT: -- for your point?

1 MR. RUFFIN: I can provide you with supplemental case  
2 law, which describes what an affirmative defense is. I mean  
3 it's -- I don't -- I mean I don't think there's been any case  
4 law on it, but I mean it certainly will be an issue.

5 MS. GANES: There is no case law.

6 THE COURT: Well, that's why we went --

7 MS. GANES: There are some --

8 THE COURT: -- through the charge yesterday so I wouldn't  
9 have to do this mess today.

10 MS. GANES: And it wasn't raised yesterday.

11 THE COURT: All right.

12 MS. GANES: And there is some -- you know, some arguments  
13 --

14 MR. RUFFIN: It was raised. I said it was an affirmative  
15 defense.

16 THE COURT: Well, the issue about adding something to the  
17 charge was raised after we left court yesterday.

18 MR. RUFFIN: Well, I didn't want to finish when we left.  
19 I don't even know if I said anything about completion of being  
20 completely satisfied with it. I know there was an issue with  
21 the verdict form and I said I wanted to review it.

22 THE COURT: Go ahead and you can raise that right now if  
23 you want to.

24 MR. RUFFIN: Well, the verdict form, after looking over  
25 at, I'm okay with it.

1 THE COURT: Okay.

2 MR. RUFFIN: I just need to be sure that the jury  
3 understands on the verdict form that obstetric emergency is an  
4 affirmative defense.

5 THE COURT: And you're saying it isn't?

6 MS. GANES: And I'm saying it isn't, Your Honor.

7 THE COURT: All right. Well, I'll think about it.

8 MS. GANES: And you were clear in telling us that the  
9 charges were going to be done yesterday because Paul wasn't  
10 going to be here today and we stayed late and we worked on the  
11 charges and, when we left, we had an agreement that the charge  
12 was okay. You asked everybody before we left. And so if  
13 you're going to --

14 THE COURT: I just wanted to make sure it was right.

15 MS. GANES: If you're going to ask for a charge, you have  
16 to provide the law and there needs to be law stating that, and  
17 that element isn't met here. And, you know, there's lots  
18 written about negative defenses where the burden remains with  
19 the plaintiff and that's what it would be, rather than an  
20 affirmative defense.

21 MR. RUFFIN: It's like the charitable immunity defense,  
22 which is a statute, and there's plenty of case law which says  
23 that this statute -- for you to get the benefit of the  
24 charitable immunity defense is the burden is on the defense to  
25 prove it.

1 THE COURT: All right. Well, I'll think about it, since  
2 obviously nobody has an answer for me or any authority for me  
3 of any significance, but we'll come up with something.

4 MR. GRAHAM: Your Honor?

5 THE COURT: All right. Are y'all ready to go?

6 MR. GRAHAM: Well, will we be able to get a copy of the  
7 charge?

8 THE COURT: If I give you a copy, you're going to come up  
9 with all these objections and changes.

10 MR. GRAHAM: No. I just -- I'd just like to have it.

11 THE COURT: This thing is going to go into next Sunday.

12 MR. GRAHAM: No. I just like to have some of the  
13 language to use in my closing.

14 MR. RUFFIN: It's similar to --

15 MS. CRAIG: We reviewed it yesterday. Your Honor,  
16 yesterday we didn't get the identification of the juror who  
17 spoke to Mr. Ruffin. If we can get that on the record,  
18 please?

19 THE COURT: We're on the record.

20 MR. RUFFIN: It's an African-American male that's about  
21 in his 40s. I believe it was the one --

22 THE COURT: There's only six of them.

23 MR. RUFFIN: I know. I believe it was -- if it was one  
24 -- I'm not even sure if there's another case going on because  
25 I sat there and stared at the jury for about 15 minutes trying

1 to figure it out and all I can remember as it was a black man  
2 probably around 40. So my best guess is that it was the one  
3 that was wearing an orange shirt, but I can't even confirm  
4 that.

5 THE COURT: And he just wanted to know how old you were?

6 MR. RUFFIN: Yes.

7 THE COURT: Did you tell him?

8 MR. RUFFIN: I froze and I can't remember, but I may have  
9 said 33.

10 THE COURT: There's nothing wrong with that.

11 MS. CRAIG: I just wanted it on the record.

12 THE COURT: All right. It's on the record.

13 MS. CRAIG: In case something else comes up. And so the  
14 orange shirt?

15 THE COURT: Would he be the alternate or would he be on  
16 the jury? Do you remember?

17 MR. RUFFIN: I don't. I really don't.

18 MS. CRAIG: Do you remember the juror who had on the  
19 orange shirt?

20 THE COURT: Is he the one that sleeps all the time?

21 MS. CRAIG: Is he young? It's not the young one?

22 THE COURT: The young sleeping one?

23 MS. CRAIG: Yeah.

24 MR. RUFFIN: I don't think so.

25 THE COURT: You would know if it were him?

1 MR. RUFFIN: Yeah. I mean --  
2 THE COURT: All right.  
3 MR. RUFFIN: All right.  
4 THE COURT: Did he have an earring?  
5 MR. RUFFIN: I don't remember.  
6 THE COURT: Is he bald?  
7 MR. RUFFIN: I think so or short hair.  
8 THE COURT: Was it gray? We might be able to figure it  
9 out from that.  
10 MR. RUFFIN: Yeah.  
11 THE COURT: All right. Let's go ahead and bring out the  
12 jury --  
13 MS. CRAIG: Thank you.  
14 THE COURT: -- and move on with your witness.  
15 (WHEREUPON, the bench conference ended and the  
16 proceedings resumed as follows.)  
17 THE BAILIFF: Are you ready?  
18 THE COURT: Yes..  
19 (WHEREUPON, the jury entered the courtroom at 9:44 a.m.)  
20 THE COURT: All right. If the defense will call your  
21 next witness?  
22 MS. GANES: Thank you, Your Honor. The defense calls Dr.  
23 Michael Duchowny.  
24 THE CLERK: Sir, if you would, place your left hand on  
25 the Bible and raise your right hand. Do you swear or affirm

DR. MICHAEL DUCHOWNY - DIRECT BY MS. GANES

1 that the testimony you give in this case will be the truth,  
2 the whole truth, and nothing but the truth, so help you God?

3 THE WITNESS: I do.

4 THE CLERK: Please have a seat and state your name for  
5 the record.

6 THE WITNESS: Michael Duchowny.

7 MS. GANES: Thank you.

8 DR. MICHAEL DUCHOWNY, being  
9 first duly sworn, testified as follows:

10 DIRECT EXAMINATION

11 BY MS. GANES:

12 Q: Good morning, Dr. Duchowny.

13 A: Good morning, Ms. Ganes.

14 Q: Dr. Duchowny, can you tell the jury a little bit about  
15 yourself, please?

16 A: I am a pediatric neurologist. I practice in Miami,  
17 Florida, at the Miami Children's -- now known as the Nicklaus  
18 Children's Hospital. I have appointments at the University of  
19 Miami, Leonard Miller School of Medicine, where I'm a clinical  
20 professor of neurology and pediatrics and also an academic  
21 appointment at the newly formed Florida International  
22 University College of Medicine.

23 Q: Are you married?

24 A: I am.

25 Q: Do you have any children?

DR. MICHAEL DUCHOWNY - DIRECT BY MS. GANES

1 A: I have three daughters and a granddaughter.

2 Q: And what do you like to do in your spare time?

3 A: I like to fish, I play some racquetball, and I'm a  
4 bluegrass musician. I like to play five-string banjo.

5 Q: And how long have you been practicing medicine as a  
6 pediatric neurologist?

7 A: Over -- over 30 years.

8 Q: Do you teach medical students?

9 A: I do. I actually run the neurology training programs at  
10 our institution. We teach medical students, residents. We  
11 have fellows and we also have international observers, all of  
12 whom come to us for -- for training.

13 Q: Do you teach medical students about brachial plexus  
14 injuries like the one that this case is about?

15 A: I do. That's one of the areas that we cover, sure.

16 Q: Do you treat patients in your practice who have brachial  
17 plexus injuries like the one that this case is about?

18 A: Yes, I do.

19 Q: Are you board-certified?

20 A: Yes. I'm board-certified in three specialties: in  
21 pediatrics, neurology with special qualification in child  
22 neurology, and in clinical neurophysiology, which is the study  
23 of electrical activity in the nervous system.

24 Q: And can you explain to the jury what it means to be  
25 board-certified in those fields?



1 A: Board certification represents the highest level of  
2 competence in a field. It generally requires passing both a  
3 written test and an oral examination, and these are your peers  
4 who are judging you. And if you are board-certified, one of  
5 -- the assumption is in passing your boards that you are  
6 highly qualified to practice in that particular specialty.

7 Q: And I think you told the jury -- or you told the jury  
8 that you're joining us here this morning from Miami?

9 A: Yes, ma'am.

10 Q: Do you know Dr. Trevor Resnick?

11 A: I do.

12 Q: And did you understand that he was an expert witness for  
13 the plaintiff in this case?

14 A: I knew that, yes.

15 Q: Okay. Is it true that you work under Dr. Resnick or that  
16 he's your boss in any way?

17 A: No. He's a colleague and a friend. I know him.

18 Q: All right. Are you a member of professional  
19 organizations?

20 A: Yes. Many.

21 Q: Do you keep up with continuing medical education credits  
22 in your field?

23 A: Absolutely. It's actually a state requirement. I've  
24 always kept up with my medical -- medical certifications.

25 Q: Okay. And do you read and keep up with medical

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1 literature in the field of neurology and as it relates to  
2 brachial plexus injuries?

3 A: I do, yes.

4 MS. GANES: Your Honor, at this time, I would offer Dr.  
5 Duchowny as an expert to the jury in the field of pediatric  
6 neurology.

7 THE COURT: Any objections?

8 MR. RUFFIN: No objection, Your Honor.

9 MS. GANES: Your Honor, may I approach?

10 THE COURT: You may.

11 BY MS. GANES:

12 Q: Dr. Duchowny, I'm going to hand you a CV and is -- is  
13 that the same as a resume?

14 A: Yes, it is.

15 Q: And is that your resume?

16 A: It is.

17 Q: Okay. And is that resume relatively current?

18 A: Reasonably. It may be a few years outdated, but the  
19 additions that have -- that have come on since then haven't  
20 materially changed the CV.

21 Q: Okay. Are there any additions that would need to be made  
22 to your resume that relate to the matters in this case?

23 A: Nothing substantial that would change it, no.

24 Q: Okay. Thank you.

25 MS. GANES: Your Honor, at this time, I would offer Dr.

1 Duchowny's CV into evidence.

2 THE COURT: Any objections?

3 MR. RUFFIN: No objection, Your Honor.

4 THE COURT: That will be 7.

5 (WHEREUPON, Defendant's Exhibit Number 7, curriculum  
6 vitae of Dr. Duchowny, was admitted into evidence.)

7 BY MS. GANES:

8 Q: Dr. Duchowny, at my request, did you review the medical  
9 records and the depositions and the videotape of Julia B 's  
10 birth in this case?

11 A: I did, yes.

12 Q: And in reviewing those items, did you formulate an  
13 opinion as to the cause of Julia B 's injury?

14 A: Yes, I did.

15 Q: And what is that opinion?

16 A: After review of all the information, I thought that  
17 Julia's injury was due to forces that were operating just at  
18 the beginning of labor as she was descending into the birth  
19 canal.

20 Q: And can you tell the jury what forms the basis of that  
21 opinion?

22 A: I think there are multiple factors that went into my  
23 opinion. First of all, Julia's birthweight was eight pounds,  
24 three ounces, which is essentially in the normal range. She  
25 was not a large baby by any means. Also, the mother's birth

1 canal, the pelvic outlet, was clearly adequate to support a  
2 baby of that size.

3 I also recognized from the record review that there were  
4 no signs of trauma at the time of delivery, as one might  
5 expect if there was excessive forces. For example, there's no  
6 bruising of the head. There is no injury to the clavicle or  
7 collarbone, which also can occur with undue force.

8 I also felt in reviewing the video that it confirmed that  
9 the time of delivery, which from the head to the shoulder  
10 being delivered was approximately 45 seconds, and looking at  
11 the video, it did not appear to me that there were any undue  
12 forces in the actual delivery of Julia. And I think that my  
13 impression of the video was corroborated by Dr. Browning's  
14 testimony that he didn't apply excessive force and also by the  
15 fact that the parents didn't remember or didn't comment in the  
16 video about any excessive force being applied at the time.

17 And I think if you put all those factors together, it to  
18 me clearly shows that the -- that the time of the -- of the  
19 traction on Julia probably occurred just really at the onset  
20 of labor as she first descended into the birth canal.

21 Q: Now, Dr. Duchowny, the jury has heard extensively about  
22 the medical literature in this field. Now, I don't want to  
23 rehash all the articles that were gone through yesterday. I  
24 just have one question for you in that regard. Does the  
25 medical literature that's written about brachial plexus

1 injuries in children and at birth -- does that support your  
2 opinion that you provided to the jury?

3 A: Yes. It absolutely does.

4 Q: Now, when you said undue forces, is that the same as  
5 excess lateral traction?

6 MR. RUFFIN: Objection, Your Honor. This is asking for  
7 an obstetric opinion. He's not qualified to comment on what's  
8 excessive or not for an obstetrician.

9 MS. GANES: May we approach, Your Honor?

10 THE COURT: You may.

11 (WHEREUPON, a bench conference was held in the presence  
12 of the jury but out of the hearing of the jury as  
13 follows.)

14 THE COURT: What was the question again?

15 MS. GANES: So, Your Honor, I asked him when he said  
16 undue forces, is that the same as excess lateral traction.  
17 And so this is the same opinion that he gave in his  
18 deposition.

19 MR. RUFFIN: It's not the opinion he gave --

20 MS. GANES: Can you please let me --

21 MR. RUFFIN: No, because it's not the opinion. That was  
22 a misrepresentation.

23 MS. GANES: Your Honor, if you would ask him to let me  
24 finish?

25 THE COURT: Yeah, I agree.

1 MS. GANES: Thank you.

2 THE COURT: I'll let you talk.

3 MS. GANES: So, Your Honor, this is kind of the converse  
4 of the obstetrical opinions where they intersect with the  
5 neurological -- neurological opinions. And so his opinion is  
6 that from a neurological perspective he knows what kind of  
7 traction has to happen to stretch these nerves and to cause  
8 the injury. And on the video, he didn't see that traction  
9 happen.

10 He's not talking about maneuvers and he told them this in  
11 his deposition. He's not talking about McRoberts. He's not  
12 talking about suprapubic. He's not talking about whether the  
13 maneuvers were appropriate. He's talking about what he sees  
14 in the traction and whether that would have caused the injury.

15 THE COURT: All right.

16 MR. RUFFIN: That's exactly my problem.. He's not an  
17 obstetrician and he hasn't seen a baby delivered since the  
18 '70s. He's not qualified to talk about what is excessive and  
19 what is not in terms of the force applied by an obstetrician.  
20 That's an obstetrical opinion.

21 MS. GANES: It's not, Your Honor.

22 THE COURT: What did he say in his deposition?

23 MS. GANES: He -- I have it. I wrote it down.

24 MR. RUFFIN: And I also note that just because -- oh,  
25 she's walking up. Just because he said it in his deposition

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1 doesn't mean he was qualified to say it.

2 MS. GANES: Dr. Browning did say he did not apply undue  
3 pressure or excessive traction, and so it was discussed and he  
4 talked about the video and that what he saw on the video could  
5 not have caused this injury.

6 THE COURT: Is all that in the deposition?

7 MS. GANES: Yes.

8 MR. RUFFIN: But he wasn't qualified to talk about  
9 excessive traction. That's my problem. That's an obstetrical  
10 opinion. That's what Dr. Resnick said. I am not an OB. I  
11 cannot say what is excessive and what isn't.

12 THE COURT: And your question was?

13 MS. GANES: It doesn't matter what his expert said, Your  
14 Honor, and I can ask him from a neurological perspective.

15 THE COURT: That's what it is.

16 MS. GANES: Thank you.

17 THE COURT: All right.

18 (WHEREUPON, the bench conference ended and the  
19 proceedings resumed as follows.)

20 MS. GANES: Thank you, Your Honor. Was it overruled?

21 THE COURT: Correct.

22 MS. GANES: Thank you.

23 BY MS. GANES:

24 Q: Dr. Duchowny, from a neurological perspective, did the  
25 delivery that you saw on the videotape -- and if you need us

1 to play the video, we will, but out of respect for Ms. Byrd --  
2 the jury has seen it. If you need us to put it up, we can,  
3 but if you can recall and tell the jury from a neurological  
4 perspective, did the amount of traction that you saw in the  
5 videotaped delivery of Julia B represent the force that, in  
6 your opinion, would be necessary to cause the injury that  
7 Julia B has?

8 A: I do remember the video and, no, I don't think that there  
9 was force applied at delivery as I saw in the video that would  
10 be causing Julia B 's brachial plexus injury.

11 Q: Okay. Now, from a neurological perspective, was there  
12 force applied at an -- at a sufficient angle to Julia B 's  
13 brachial plexus area to cause the injury that is at issue in  
14 this case?

15 A: You mean at the time of delivery?

16 Q: Yes. On the videotaped delivery.

17 A: I don't believe so, no.

18 Q: Okay. And the opinions that you've provided to the jury,  
19 do you hold those opinions to a reasonable degree of medical  
20 certainty and most probably?

21 A: I do.

22 Q: Now, when the shoulder dystocia was presented or was  
23 recognized during the delivery of Julia B , was she  
24 medically stable at that time?

25 A: Well, actually I think she was in a very dangerous



1 situation. There was immediate risk of either bodily harm or  
2 death. It's a very precarious situation and, in my opinion,  
3 very potentially dangerous.

4 Q: Okay. Now, was it a medical emergency when Julia B  
5 presented with her shoulder stuck under her mother's pubic  
6 bone?

7 A: Absolutely.

8 Q: Doctor, from a neurological perspective, can suprapubic  
9 pressure or pressing down on the pubic region above the pubic  
10 bone -- can that cause any neurological damage to an infant?

11 A: No. That would not cause neurological injury.

12 Q: Okay. And if suprapubic -- whether suprapubic pressure  
13 was applied above the pubic bone or on the pubic bone, does  
14 that matter in your opinion as to whether it could cause an  
15 injury to an infant?

16 A: In my opinion, that difference is irrelevant. It's  
17 really where the pressure is being applied and the possible  
18 consequences, and suprapubic pressure would not be expected to  
19 produce the deforming forces necessary to produce an injury.

20 Q: Dr. Duchowny, are you being paid for your time here with  
21 the jury this morning?

22 A: I am, yes.

23 Q: Did you have to leave your practice in Miami and the  
24 patients that you would've seen today to come and provide your  
25 opinions to the jury in this case?

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1 A: Sure. Of course.

2 MS. GANES: Thank you. If you will, please answer any  
3 questions that Mr. Ruffin has.

4 THE WITNESS: Thank you.

5 CROSS-EXAMINATION

6 BY MR. RUFFIN:

7 Q: Good morning, Doctor.

8 A: Good morning, Mr. Ruffin.

9 Q: I couldn't help but hear you make comments about the  
10 proper way or how much force a physician -- an obstetrician  
11 should or shouldn't apply in the context of a shoulder  
12 dystocia delivery. Do you remember that?

13 A: Yes, sir.

14 Q: Okay. Well, let me ask you when is the last time you  
15 yourself delivered a baby?

16 A: Years ago.

17 Q: In the '70s?

18 A: Obviously, I'm not -- obviously, I'm obviously not an  
19 obstetrician.

20 Q: So it's been since the '70s?

21 A: Yes.

22 Q: Okay. So you haven't delivered a baby since the '70s,  
23 yet you were commenting on whether or not an amount of force  
24 used in a delivery was excessive?

25 A: Well, I mean obviously I learned to deliver babies as a

1 medical student and it's well known I think to all physicians  
2 that obstetricians -- what their role is as a -- as a  
3 healthcare provider is in the delivery to guide the baby down  
4 the birth canal, and we recognize that gentle traction is  
5 always applied by obstetricians in the delivery process, and  
6 you could see it on the video.

7 Q: And I appreciate your answer, but the question is you  
8 haven't delivered a baby since the '70s?

9 A: I already said yes. That's correct.

10 Q: And you haven't seen a live delivery since the '80s?

11 A: That's correct.

12 Q: Okay. You've never yourself seen a shoulder dystocia  
13 encounter live?

14 A: Correct.

15 Q: And you've never yourself managed a shoulder dystocia?

16 A: I haven't managed a shoulder dystocia, but I've managed  
17 the potential consequences of a shoulder dystocia.

18 Q: And --

19 A: So I've been involved in many cases.

20 Q: And we'll talk about your patient population in a minute,  
21 but I just want to be clear. You haven't seen a live birth  
22 since about 1986, you haven't delivered a baby since the '70s,  
23 you've never performed any obstetric maneuvers required to  
24 deliver shoulder dystocia, yet you made comment on whether or  
25 not what you saw in a video was excessive or not in terms of

1 delivery of a baby facing shoulder dystocia?

2 A: I'm sorry. Is that a question?

3 MS. GANES: Your Honor, I just object. I'm not sure if  
4 that was a question.

5 BY MR. RUFFIN:

6 Q: The question is despite not having delivering --  
7 delivered a baby since the '70s, despite having not seen a  
8 live delivery since the '80s, despite never managing shoulder  
9 dystocia in your life, you have come in here and offered  
10 opinions on what you saw in a video about whether or not what  
11 you saw was excessive or not; true?

12 A: That's true because as a pediatric neurologist, as I  
13 said, we are -- we take care of infants and children with --  
14 with nerve injuries due to shoulder dystocia, and it's part of  
15 our training and expertise as pediatric neurologists to be as  
16 knowledgeable about this condition as possible. So I think  
17 that's part of our expertise, yes.

18 Q: Okay. And in forming your opinions, you -- I think I  
19 heard you tell the defense attorney that you relied on  
20 deposition testimony?

21 A: Among other things. I relied on everything actually, Mr.  
22 Ruffin, and that was --

23 Q: Sure. And one of those things --

24 A: That was one of the -- one of the types of information  
25 that I relied on, of course, was deposition testimony.

1 Q: And you relied on the testimony of the nurses who were  
2 present as well; true?

3 A: I did, yes.

4 Q: Okay. And I believe you -- well, it's your opinion that  
5 the nurses, from their deposition testimony, never saw or they  
6 remember not seeing excessive traction; true?

7 A: That's correct. They didn't recall that.

8 Q: They didn't recall it or they didn't see it?

9 A: They didn't -- they didn't see it. They didn't comment  
10 on it. They didn't think it occurred.

11 Q: And you claimed that these nurses have specific memories  
12 and recollections of not seeing excessive traction; true?

13 A: Well, the specific recollection was that there was no  
14 recollection.

15 Q: Right. There's --

16 A: Nothing jumped out at them. They didn't have a  
17 recollection. Right, their recollection was that there's no  
18 recollection.

19 Q: Right. They didn't have any memory whatsoever of this  
20 delivery, did they?

21 A: Well, the way I interpreted it is nothing jumped out in  
22 their memory of something abnormal occurring at the time of  
23 delivery.

24 Q: They had no memory of this delivery whatsoever?

25 A: Correct. It was not a standout delivery in their minds.

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1 Q: They had -- they would not even have been able to  
2 recognize the mother in this case had she walked into the  
3 room; true?

4 A: Correct, because the delivery was routine. That's  
5 exactly correct.

6 Q: This was a routine delivery? A shoulder dystocia is a  
7 routine delivery?

8 A: Well, it was routine to the nurses in the sense that it  
9 didn't basically -- didn't trigger a memory that made it  
10 significant.

11 Q: And these nurses have no memory of ever being with Dr.  
12 Browning during any shoulder dystocia; true?

13 A: Well, I can't remember that, but I do know that if nurses  
14 are present in the delivery and it is a -- a very difficult or  
15 worrisome delivery, they tend to remember these things. Those  
16 are standouts for the nurses. And in this case, it wasn't.

17 Q: But they have no memories of any shoulder dystocia  
18 delivery --

19 A: Correct.

20 Q: -- that Dr. Browning had managed?

21 A: In this case, they had no memory for Julia. You know,  
22 the other deliveries, you'd have to ask them.

23 Q: And you relied on those memories?

24 A: Well, I relied on all the information. As I was saying,  
25 the deposition testimony was just one component of the

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1 information that I relied on. There was a lot of information.  
2 There are medical records, videos. You know, there's a lot of  
3 information about Julia.

4 Q: Okay. Well, let's -- let's move on and discuss Julia.  
5 Let's talk about -- in your practice, you evaluate patients  
6 from time to time; true? With pediatric issues? Pediatric  
7 neurological issues?

8 A: Every day.

9 Q: Okay. And how many times did you evaluate Julia B ?

10 A: I have not evaluated her.

11 Q: You've never seen her?

12 A: No, sir.

13 Q: Well, how long did you spend evaluating any videotape of  
14 her to assess her limitations in range of motion?

15 A: I don't remember the exact time, but I reviewed the video  
16 several times.

17 Q: I'm talking about her injury as it is today, her  
18 limitations, her range of motion. How much time did you spend  
19 evaluating that through video?

20 A: I'm sorry. I don't understand the question.

21 Q: Sure.

22 A: Are you asking me -- I don't understand the question.

23 Q: The question is have you watched any video -- since you  
24 haven't done a live evaluation of Julia B to assess her  
25 injury, have you reviewed any video of her since her birth to

1 determine her limitations in range of motion or the severity  
2 of her injury?

3 A: I see. No, I've gotten the information from the medical  
4 records.

5 Q: Okay. Well, what conversations have you had with the  
6 parents to try to determine the severity of the child's  
7 injury?

8 A: None.

9 Q: So as you sit here today, you have not evaluated the  
10 child yourself, you've never reviewed any video of the child,  
11 you haven't talked with the parents to determine the severity  
12 of this child's injury?

13 A: That is correct.

14 Q: True?

15 A: That is correct, but as I sit here today, I've also  
16 evaluated a large amount of medical records, birth videos,  
17 deposition testimonies, and evaluation findings. So I've had  
18 plenty of information.

19 Q: And let's go over the medical records a little bit.  
20 Before forming your opinions in this case, you never  
21 personally reviewed any of the EMG studies, did you?

22 A: That's correct.

23 Q: In fact, you didn't even know how many EMG studies were  
24 performed on Julia, did you?

25 A: Well, I know -- I know how many EMG studies were



1 performed.

2 Q: The question is when you formed your opinions for this  
3 case, you didn't know at the time how many EMG studies she had  
4 had performed; true?

5 A: My opinions today involve EMG studies, but that's only  
6 one component.

7 Q: Okay. But my question is very simple. It's whenever you  
8 first formed your opinions in this case, you didn't even know  
9 how many EMG studies she --

10 A: That's --

11 Q: -- had performed?

12 A: -- probably true.

13 Q: Okay. And what about the MRIs? You never reviewed any  
14 of the actual imaging of the MRIs in this case, did you?

15 A: Correct.

16 Q: You never reviewed any of the ultrasounds to see if there  
17 was any limitations in range of motion or if there was any  
18 reduced movement of the arm in the ultrasounds; true?

19 A: That's also correct.

20 Q: And in forming your opinions when you were evaluating  
21 this case, you mistakenly believed that the child had had  
22 several surgeries related to the brachial plexus; true?

23 A: No. That I think, sir, is a mischaracterization of my  
24 testimony. You asked me, as I recall, how many surgeries she  
25 had. I said two and you somehow understood that that meant

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1 two brachial plexus surgeries and I clarified it for you that  
2 she had one surgery for the brachial plexus and also had a  
3 second surgery to treat her pyloric stenosis.

4 Q: Okay.

5 A: That was my recollection of the testimony.

6 Q: If you'd give me a minute, I'm going to get your  
7 deposition.

8 A: Of course.

9 Q: So it's your recollection that you did all that  
10 clarifying and, by the way, we weren't talking about anything  
11 but brachial plexus injuries, were we?

12 A: No. I don't think that's true. You asked me -- and you  
13 can check the record, but my recollection is you asked me how  
14 many surgeries Julia had.

15 Q: And my question was we weren't talking about anything but  
16 brachial plexus injuries and you were offering opinions on  
17 brachial plexus injuries; right?

18 A: No. You asked -- the question was how many surgeries had  
19 she had. So I answered how many surgeries she had had. I  
20 mean that was your question and that was my answer.

21 Q: And you said two?

22 A: Correct. She did have two.

23 Q: If you would, read lines -- page 87, lines 12 to 4  
24 [sic.]. You can read it aloud for us when you find the page.

25 A: How many surgeries did this child have?

1 Answer: Several, at least two.

2 Q: Several?

3 A: Well, two I said.

4 Q: You said several, at least two; true?

5 MS. GANES: Your Honor?

6 BY MR. RUFFIN:

7 A: You know, I have to tell you I think there's another  
8 point in this deposition somewhere else where I answered this  
9 in greater detail, and that's not represented here. So this  
10 looks like something else. I'd have to go back and read the  
11 deposition, but I clearly remember stating that she had had  
12 two surgeries, one for the brachial plexus and one for a  
13 treatment of pyloric stenosis. I don't see that on this page,  
14 but I clearly remember it and I think I could find it at some  
15 point.

16 Q: Would you take a moment? You can probably use the word  
17 search at the back and look for pyloric stenosis. That would  
18 probably be the easiest way.

19 A: Maybe you could help with that?

20 Q: Sure. Absolutely. But in the meantime, I'm going to  
21 move on. I'm sure you --

22 MS. GANES: Your Honor, I object. This is an improper  
23 use --

24 THE COURT: Overruled. Go ahead and ask your next  
25 question.

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1 MS. GANES: -- of a deposition.

2 MR. RUFFIN: She can ask it on redirect --

3 THE COURT: Right.

4 MR. RUFFIN: -- if she needs to clarify.

5 THE COURT: Go ahead.

6 BY MR. RUFFIN:

7 Q: You didn't know whether this child would be monitored  
8 whenever she was being born, internally or externally, did  
9 you?

10 A: I did not know -- I did not know whether she had internal  
11 monitoring. Correct.

12 Q: But at least you do know that the MRI report that's been  
13 done in this case shows both neuroma and fibrosis; true?

14 A: I wasn't clear on that either. I hadn't reviewed the  
15 actual MRI.

16 Q: All right. Well, let's turn to page 26, lines 17 to 21.  
17 Tell me what you said?

18 A: I'm sorry. Which page?

19 Q: Let me get it back for you. I believe it's page 26,  
20 lines 17 to 21.

21 A: Question: Okay. So you couldn't tell us as you sit here  
22 today one way or another whether the MRI showed a neuroma or  
23 fibrosis.

24 Answer: Well, the report showed neuroma and fibrosis, but  
25 I did not personally review the study.

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1 Q: But it was your belief that they showed neuroma and  
2 fibrosis?

3 A: I stated that, but as I said, I had not reviewed the MRI  
4 report.

5 Q: So you were making --

6 A: I subsequently -- I subsequently reviewed it and it did  
7 not show it, but at that time that I answered this, I did not  
8 know.

9 Q: And even though you didn't review the EMG studies, at  
10 least you know that the studies suggest involvement of the C7  
11 nerve; true?

12 A: Well, it's a complicated issue. Clearly, there was  
13 involvement of cervical 5 and cervical 6, C5 and C6. I  
14 believe that at least one of the EMG studies showed additional  
15 involvement of C7, the seventh cervical root. I think it's  
16 conflicting. Clearly, it's C5 and C6 and possibly C7.

17 Q: So it involves C7 possibly?

18 A: Possibly. Although it depends how you define  
19 involvement. You can define it by looking at the EMG, but you  
20 can also define it by functionality and the muscles that are  
21 served by the seventh cervical root. Clinically, Julia looks  
22 like she has primarily C5 and C6 involvement.

23 Q: So let's move on to your patient practice. You said you  
24 see patients that have brachial plexus injuries; true?

25 A: Yes.

1 Q: Let's talk about how many patients you see. The truth is  
2 you maybe see only -- at least when you formed these opinions,  
3 you maybe see only one new patient a year with a brachial  
4 plexus injury, the type of injury that Julia has; true?

5 A: I thought I said one or two. These are new patients. I  
6 may see some follow-ups, but in terms of new patients, one or  
7 two.

8 Q: So one or two. And roughly only one percent of the  
9 patients you see in your practice are patients with brachial  
10 plexus birth injuries; true?

11 A: That's correct.

12 Q: Okay. And the truth is you offer your opinion in these  
13 types of cases involving brachial plexus injuries defending  
14 doctors in lawsuits related to these injuries more than you  
15 actually treat these patients in your practice; true?

16 A: Well, there are two parts to that answer. The first is I  
17 offer my opinions based on my review of the records and my  
18 understanding of the case. It's not with a bias. It's to  
19 understand the case.

20 Secondly, I would say probably I see -- I probably see  
21 more cases that are legal than -- than in my practice in any  
22 given year --

23 Q: Okay.

24 A: -- by a slight amount.

25 Q: So then you testify for the defense in brachial plexus

1 related lawsuits more than you treat patients with brachial  
2 plexus injuries; true?

3 A: Well, again, it's a two-part answer. First of all, I  
4 testify based on -- on the facts of the case, be it defendant  
5 or plaintiff, and secondly, yes, I probably see more cases in  
6 which I'm involved with a brachial plexus injury in a legal  
7 arena than in a medical arena.

8 Q: And you said for plaintiff and defendant. As you sit  
9 here today, are you representing to the jury that you have  
10 ever offered causation opinion testimony on behalf of a  
11 plaintiff in a brachial plexus birth injury case?

12 A: Well, we went through that before.

13 Q: Uh-huh.

14 A: And as I said, I have, and usually I'm not retained in  
15 the case if I -- if that -- if I feel that's the case, but in  
16 a -- in a legal proceeding, the answer is no.

17 Q: Okay. So right. The question was you've never offered  
18 sworn testimony on behalf of a plaintiff in a brachial plexus  
19 case?

20 A: That's correct.

21 Q: True?

22 A: That's correct.

23 Q: Your day-to-day practice gives you no understanding of  
24 uterine forces, does it, Doctor?

25 A: That's an odd question. Obviously, I'm not an

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1 obstetrician; so I'm not examining -- I'm not in the delivery  
2 room and I am not doing a uterine examination in my day-to-day  
3 practice. But as I said before, part of caring for children  
4 with brachial plexus injury is understanding the causes, the  
5 mechanisms. All of that goes into our care of the patient.  
6 So the answer to your question is, no, I do not do it in my  
7 day-to-day practice.

8 Q: Right. The answer is, no, your day-to-day practice  
9 gives you no understanding of the forces of the uterus, does  
10 it?

11 A: Well, it does indirectly in that you -- again, we need to  
12 learn about these things. I mean it's not like when I'm  
13 examining a child it tells me about the uterine forces, but I  
14 need to understand how that comes to bear on the injury. So  
15 I'm thinking about it.

16 Q: I see. If you wouldn't mind reading page 76, lines 1 to  
17 3?

18 A: Question: Your day-to-day practice of medicine gives you  
19 no understanding of uterine forces; true?

20 Answer: True.

21 Q: Was that my question and was that your answer?

22 A: Yes.

23 Q: Thank you. You subscribe to a magazine called *Neurology*;  
24 true?

25 A: Yes.



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1 Q: You brought no articles to this jury from that magazine,  
2 did you?

3 A: I did not.

4 Q: You subscribe to a magazine called *Annals* -- or how do  
5 you pronounce it?

6 A: *Annals*.

7 Q: *Annals* -- thank you -- of *Neurology*? Did you bring any  
8 articles from that journal?

9 A: Bring any articles where? Here?

10 A: Correct.

11 A: Today?

12 Q: Did you offer any to the Court?

13 A: No.

14 Q: To the jury?

15 A: No, I did not.

16 Q: Are you -- do you subscribe to the *Journal of Child*  
17 *Neurology*?

18 A: I do.

19 Q: Did you offer any articles from that journal to the jury  
20 to support your opinions?

21 A: No.

22 Q: Do you subscribe to a journal called *Pediatric Neurology*?

23 A: I do.

24 Q: Did you bring any articles from *Pediatric Neurology* to  
25 offer to the jury to support your opinions?

1 A: No.

2 Q: And again, you've never given sworn testimony that the  
3 injury to a child's brachial plexus was caused by physician-  
4 applied traction; true?

5 A: Correct. True.

6 Q: And you were willing to offer testimony that an injury  
7 was not caused by a physician pulling, no matter how severe  
8 the child's injury; true?

9 A: Is this a hypothetical question? I don't understand it  
10 otherwise.

11 Q: My question is even where multiple nerve roots were  
12 avulsed and the entire plexus is affected, in other words the  
13 absolute worst case scenario for this type of injury, you  
14 don't believe that such a severe injury would speak to  
15 causation; true?

16 A: Mr. Ruffin, I'm trying to answer your question, but we  
17 went through this previously and I indicated to you that I  
18 have never seen a case where all the nerves are avulsed from  
19 the spinal cord. It's a hypothetical situation that I don't  
20 think is really ever -- I'm not aware of it. I've never seen  
21 it in my practice, nor of any of my colleagues that I deal  
22 with.

23 Q: And despite never having seen such a case because it's so  
24 severe, you still wouldn't believe that that would have any  
25 impact on causation, do you?

1 A: How could you ask me to answer that question when I've  
2 never seen it or heard of it? Every case is different. This  
3 case that you're talking about has no relevance to Julia.  
4 It's a completely different scenario and, again, I've never  
5 seen it.

6 Q: Okay. Well then if you'll just turn to page 185 and read  
7 lines 16 to 24? I'm going to take these off here.

8 A: Question: Okay. So if we have a case, a hypothetical  
9 case, where multiple nerve roots were avulsed and the entire  
10 non-plexus -- I'm sorry -- entire pan plexus were affected,  
11 how, if in any way, would that impact your causation  
12 testimony? Ms. Ganes: Object to form.

13 Q: Keep reading.

14 A: Answer: I'd have to see the case, but as I say, I think  
15 that would be -- on the spectrum be a very severe brachial  
16 plexopathy, but it wouldn't necessarily speak directly to  
17 causation.

18 Q: Thank you.

19 A: You're welcome.

20 Q: You've been paid by the defense to testify on behalf of  
21 defendant doctors in these types of cases in at least half  
22 this nation's states; true?

23 A: I've been -- I haven't -- I've testified probably in -- I  
24 don't know half, but many states.

25 Q: Okay. And in many times in South Carolina as well?

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- 1 A: Several, yes. That's correct.
- 2 Q: And you've even done it recently in the past few years?
- 3 A: Yes, sir.
- 4 Q: And you've reviewed cases for the very law firm defending
- 5 this case before; true?
- 6 A: Yes. A few, maybe two or three. I'm not sure exactly
- 7 how many.
- 8 Q: And you've testified alongside some of the same experts
- 9 for the defense that are testifying in this case before; true?
- 10 A: Yes.
- 11 Q: You don't happen from time to time to travel as a guest
- 12 to legal conferences being held for defense attorneys, do you?
- 13 A: I've traveled rarely for conferences for both defense and
- 14 plaintiff attorneys.
- 15 Q: You've spoken at conferences for groups of defense
- 16 attorneys, haven't you?
- 17 A: Defense and plaintiff, yes.
- 18 Q: And you personally believe it's a bad idea to testify
- 19 against doctors in an area where you think it might affect
- 20 your referral base; true?
- 21 A: Well, we've talked about that too. Yes. I think that --
- 22 as a physician, I think it's -- with a -- with a large
- 23 referral practice -- in our practice, we -- we have patients
- 24 that come, for example, from all over the state of Florida and
- 25 -- and I think from a professional standpoint it's -- it

1 probably is ill advised to testify against -- in a legal case  
2 on the opposite side of a doctor who is part of a practice or  
3 institution that refers cases to our institution.

4 Q: Okay. So you don't do it because you're afraid it might  
5 affect your referral base?

6 A: Well, you know, I think it would affect -- it would  
7 affect the referral base, but actually the sad thing is that  
8 if -- we are a referral center for the most difficult cases  
9 anywhere. We're -- our neurology department is in the top 10  
10 departments in *U.S. News & World Reports*, and we get referrals  
11 from all over. And I think if physicians don't refer cases to  
12 us because, for example, of legal testimony, ultimately the  
13 person who is hurt the most is the child, and that is  
14 certainly a situation that I would -- I think should be  
15 avoided.

16 Q: Right. And you also know it will affect your finances if  
17 you receive fewer referrals?

18 A: Actually, that's de minimis. The real issue is that it  
19 would affect care. It would affect referral care patterns and  
20 I actually think it would be tragic for the child if they  
21 didn't get referred just because of some ancillary reason on  
22 the part of referring physicians. I think that would be  
23 unfortunate.

24 Q: And you yourself are afraid of the ill will it might  
25 create in the medical community if you start testifying

1 against doctors in your region; true?

2 A: Well, I think it would create an atmosphere, again, of  
3 non-referral, at least in our area, and ultimately the person  
4 who would get hurt the most is the child.

5 Q: Right. But the question is you yourself are afraid of  
6 the ill will it might create in the medical community?

7 A: Of course.

8 Q: Thank you. Doctor, you've received millions of dollars  
9 over the years testifying as an expert witness, haven't you?

10 A: I have. I've been -- I've testified over many, many  
11 years and, frankly, I've been blessed because I've been able I  
12 think to give generously to charities with my income and also  
13 to give back to the community. So I think I've been very  
14 lucky that way.

15 Q: Well, I have no record of how you do and do not donate to  
16 charities, but I do have a question, which is you've received  
17 millions of dollars over the years testifying as an expert  
18 witness; true?

19 A: Well, if -- true. If you add up 20 years of testimony, I  
20 think that's true.

21 Q: Thank you. It's your opinion obstetricians have over 5  
22 to 6 minutes of lack of oxygen until there's a risk to the  
23 baby; true?

24 A: I'm sorry. Could you repeat the question?

25 Q: Sure. It's your opinion obstetricians have over 5 to 6

1 minutes of lack of oxygen until there's a risk to the baby;  
2 true?

3 A: In general, that's true, but there are two points to make  
4 here. One is that, firstly, it's different for every baby  
5 and, secondly, it's a continuum. It's not like suddenly a  
6 switch gets thrown at six minutes to say that you're in the  
7 danger zone. The longer the period of time that any of us are  
8 without oxygen, the higher the likelihood of some type of  
9 brain injury.

10 Q: And I appreciate that, but the question was you know that  
11 obstetricians have over 5 to 6 minutes of lack of oxygen until  
12 there's a risk; true?

13 A: Well, I'm sure I stated that and I think that is true,  
14 but you need to -- in general, as a statistic, a longer period  
15 of time, six minutes or so, is a cutoff that's used, but it's  
16 -- again, it's a very worrisome situation and it's potentially  
17 dangerous and there certainly are cases that have had a brain  
18 injury after only a couple of minutes of oxygen deprivation.  
19 So I mean this is a -- if there's any situation of oxygen  
20 deprivation, it is dangerous.

21 Q: And yet you describe this worrisome situation -- it's a  
22 worrisome situation that you have never managed yourself in  
23 your entire life; true?

24 A: I'm sorry. I'm not understanding your question.

25 Q: Shoulder dystocia. You're talking about a worrisome

1 situation.

2 A: That's --

3 Q: Since this is a worrisome situation that you have zero  
4 experience with personally; true?

5 A: That's true, but I've had great experience with many  
6 patients who have stopped breathing.

7 Q: And a fetus and a newborn have reserves which prolong the  
8 period of oxygen deprivation without injury to the baby; true?

9 A: They do have reserves and, again, it's very variable for  
10 each fetus and for each newborn.

11 Q: Okay. And you do a lot of testifying in brain damage  
12 cases, don't you?

13 A: I testify in different cases.

14 Q: Sure.

15 A: Brain damage is one of the issues.

16 Q: And one of the issues is oxygen and lack of oxygen?

17 A: Sure.

18 Q: And you've offered testimony in those cases on how long a  
19 baby can go without oxygen, haven't you?

20 A: You would have to basically -- each case is different and  
21 you'd have to give me the context. I'm happy to talk about  
22 it, but I --

23 Q: Sure.

24 A: I think -- again, I think the longer you go, the greater  
25 the danger, and it begins -- you know, the clock stops --



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1 starts running at the time when you stop taking in oxygen.

2 Q: I'm curious, Doctor. What is the longest you've ever  
3 testified to that a baby has gone without oxygen or with an  
4 impinged supply of oxygen without injury to the brain?

5 A: I don't know.

6 Q: You've said over 15 minutes before, haven't you?

7 A: I think it's possible. Each case is different, sir.

8 Q: Thirty minutes?

9 A: Each case is different. So I don't know.

10 Q: You've offered testimony that 30 minutes of effect upon  
11 the oxygen supply to a baby and the baby had no injury; true?

12 A: Sure. There are cases of something called Lazarus  
13 syndrome in adults and children. We've all heard about  
14 patients, for example, who are submerged in water for an hour  
15 and come out to be normal. We've seen it in newborns who  
16 haven't breathed for a long period of time, but, you know, no  
17 one is going to bet the store on that -- on that outcome. It  
18 certainly is possible, but it's -- again, for all of us in  
19 medicine, the clock starts ticking the second the patient  
20 isn't breathing.

21 Q: Okay. And let me ask you this. I mean you said it  
22 depends on the facts and circumstances of each case; true?

23 A: Yes.

24 Q: All right. In this case, it's your understanding there  
25 was no issue with the fetal heart monitoring strips in the

1 context of this delivery; true?

2 A: Yes.

3 Q: Okay. And the Apgar scores were 9 and 9; true?

4 A: Yes.

5 Q: True?

6 A: Yes, sir.

7 Q: And there was no indication in this case that either  
8 mother or baby were not medically stable; true?

9 A: They were unstable. Any situation where a baby is hung  
10 up in the birth canal is potentially a very dangerous  
11 situation and it is one that presents an immediate danger of  
12 bodily harm of either -- either morbidity, brain injury or  
13 death.

14 Q: If you would, read for the jury page 55, lines 6 to 9?

15 A: Question: Did you see any indication that either mother  
16 or baby were not medically stable?

17 Ms. Ganes: Object to form.

18 Answer: No.

19 Q: Thank you. Was that my question and your answer?

20 A: At that time, yes.

21 Q: Did you ask for clarification of the question at the  
22 time? Would you like to see if you did?

23 A: Sure. Let me look.

24 Q: Absolutely.

25 A: I don't know. On the next question, you are off on a

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1 different tangent. So the answer to your question is, no, I  
2 did not, but you were off on a different tangent.

3 Q: Okay. Right. I moved on to the next question because  
4 you --

5 A: You immediately moved on.

6 Q: Right.

7 A: That's correct.

8 Q: Because you didn't ask for clarification on that  
9 question; true?

10 A: I did not.

11 Q: Okay. And was there anything -- did you ever at any  
12 point tell me at the end of the deposition when I asked you if  
13 you understood all my questions, did you say, well, no, there  
14 was a question about medical stability that could have meant  
15 more than one thing?

16 A: No, sir.

17 Q: That's right. All right. The truth is, you have no  
18 reason to believe Christy's contractions were any stronger  
19 than would be in any other delivering mother; true?

20 A: That's true.

21 Q: And the truth is you've seen nothing in the medical  
22 records to suggest that Julia B 's brachial plexus was  
23 caused by any sort of intrauterine insult; true?

24 A: I'm sorry. Could you repeat the question?

25 Q: Sure. You've seen nothing in the medical records to

1 suggest that Julia B 's brachial plexus injury was caused by  
2 an intrauterine insult?

3 A: That's correct. There's no information in the medical  
4 record. I mean it's possible, but there's no information in  
5 the medical record.

6 Q: Right. Nothing that you reviewed would suggest such a  
7 thing?

8 A: Nothing that I reviewed, although brachial plexus injury  
9 can occur intrauterine and they have been described in women  
10 who have delivered by cesarean section.

11 Q: And this is the opinion you've offered in line with the  
12 opinions that you've offered before in order to receive  
13 millions of dollars as an expert witness; true?

14 A: That is a mischaracterization --

15 MS. GANES: Your Honor --

16 BY MR. RUFFIN:

17 A: -- of what I do. I'm sorry. I -- as I said, I review  
18 records. I try and understand a case and, frankly, I see my  
19 role as trying to basically clarify the information and  
20 present it.

21 Q: And nothing I said would make you change your opinions in  
22 any way, would it?

23 A: About what?

24 Q: The questions that we've just gone back and forth with.

25 A: I don't understand.

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1 MR. RUFFIN: No further questions.

2 THE COURT: All right. Redirect?

3 MS. GANES: Yes, sir, Your Honor, just briefly.

4 REDIRECT EXAMINATION

5 BY MS. GANES:

6 Q: Dr. Duchowny, did Mr. Graham's law firm allow you the  
7 opportunity or offer you the opportunity to --

8 MR. RUFFIN: Objection, Your Honor.

9 Q: -- examine Julia B ?

10 MR. RUFFIN: They've never asked to review the Byrd  
11 child.

12 THE COURT: I haven't even heard the question yet. Let  
13 me hear the question.

14 MR. RUFFIN: May we approach?

15 THE COURT: All right.

16 (WHEREUPON, a bench conference was held in the presence  
17 of the jury that out of the hearing of the jury as  
18 follows.)

19 MR. RUFFIN: There's a proper procedure if they want to  
20 evaluate the child.

21 MS. GANES: Your Honor, the jury is present.

22 THE COURT: All right. I haven't even heard the  
23 question.

24 MR. RUFFIN: There's a proper procedure to evaluate a  
25 child, if a defense wants to. They're allowed and entitled to

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1 evaluate the child. No such motion or call was ever made to  
2 our firm; so it is inappropriate to ask a question that  
3 conveys to the jury that we withheld the child from this  
4 expert.

5 MS. GANES: Your Honor, he asked. My question was did  
6 Mr. Graham's law firm allow you the opportunity to examine  
7 Julia B . He asked this witness numerous questions about  
8 having not examined her.

9 MR. RUFFIN: Because he didn't ask to.

10 MS. GANES: He wasn't offered.

11 MR. RUFFIN: Under the rules, he was supposed to. I  
12 don't have to say would you like to. You need to ask.

13 THE COURT: I sustain the objection.

14 MR. RUFFIN: Thank you, Your Honor.

15 (WHEREUPON, the bench conference ended and the  
16 proceedings resumed as follows.)

17 MR. RUFFIN: So the objection was sustained?

18 THE COURT: Sustained.

19 MS. GANES: All right.

20 BY MS. GANES:

21 Q: Dr. Duchowny, I want you to go back to your deposition,  
22 if you have it. Do you have it?

23 A: I do not. I'm sorry.

24 MS. GANES: Mr. Layton, can I have the deposition that  
25 you took back to your table?

1 MR. RUFFIN: Absolutely.

2 MS. GANES: Thank you. All right.

3 BY MS. GANES:

4 Q: If you'll please turn to page 85, I just want to allow  
5 you the opportunity to continue with a line of questions that  
6 were published earlier.

7 A: Okay.

8 Q: All right. On line 85, page 16 [sic.], do you see where  
9 it says, okay, so if we have a case, a hypothetical case,  
10 where multiple nerve roots were avulsed and the entire pan  
11 plexus were affected, how, if in any way, would that impact  
12 your causation testimony? Can you read your response on line  
13 21?

14 A: Answer: I'd have to see that case, but as I say, I think  
15 that would on the spectrum be a very severe brachial  
16 plexopathy, but it wouldn't necessarily speak directly to  
17 causation.

18 Q: Okay. Is that a more accurate representation of your  
19 testimony at your deposition, Dr. Duchowny?

20 A: Yes, ma'am.

21 MR. RUFFIN: Objection, Your Honor.

22 MS. GANES: All right.

23 MR. RUFFIN: That's exactly what I had him read word for  
24 word.

25 THE COURT: Overruled.

DR. MICHAEL DUCHOWNY - REDIRECT BY MS. GANES

1 BY MS. GANES:

2 Q: Dr. Duchowny, does -- can you tell the jury what pyloric  
3 stenosis is, please?

4 A: So this is a narrowing of one of the sphincters in the  
5 stomach and what happens is that a baby presents with  
6 protractile vomiting and unless you can open up that  
7 sphincter, that tightening of the entry to the stomach which  
8 is called the pylorus, a baby obviously would be -- would have  
9 real nutritional distress. So it's a -- it's a real medical  
10 emergency.

11 Q: And does it have anything at all to do with the facts in  
12 this case?

13 A: Zero.

14 Q: But does it support your testimony that you provided to  
15 Mr. Ruffin --

16 MR. RUFFIN: Objection. Leading.

17 THE COURT: Sustained.

18 BY MS. GANES:

19 A: Yes, it does. I clearly -- I clearly remember --

20 MR. RUFFIN: He's answering the question that was  
21 sustained.

22 THE COURT: Rephrase the question and don't lead.

23 BY MS. GANES:

24 Q: Doctor, did you -- do you remember today that Julia B  
25 had more than one surgery?



1 A: Yes, I do.

2 Q: And was that your testimony in your deposition?

3 A: It was. I was asked how many surgeries she had. I said  
4 two, and she had.

5 Q: And is that a congenital abnormality, the pyloric  
6 stenosis?

7 A: It is.

8 MR. RUFFIN: Objection. Relevance.

9 THE COURT: Overruled.

10 MS. GANES: Okay. All right. Your Honor, may I  
11 approach?

12 THE COURT: You may.

13 MS. GANES: Okay.

14 BY MS. GANES:

15 Q: Dr. Duchowny, do you remember when Mr. Ruffin asked you  
16 if you brought any articles from any neurological journal to  
17 support your opinions?

18 A: Yes.

19 Q: Okay. Now, I'm going to hand you what's been marked as a  
20 Court's exhibit, Number 17, and it is an article from the  
21 *Journal of Child Neurology*. Will you look at that and tell me  
22 whether that is a reliable learned treatise in your field?

23 A: Well, yes, I hope so. I've been an associate editor of  
24 the journal; so I would --

25 Q: Okay.

1 A: I would assume it's a reliable journal.

2 Q: All right. And if you'll hand it back? Just for time's  
3 sake, I'll direct you to an area that I'd like for you to  
4 publish to the jury. All right. And if you will, just read  
5 right here the two highlighted portions under discussion to  
6 the jury, please?

7 A: Finally, our study confirms that the obstetric brachial  
8 plexus palsy can occur following routine delivery. Therefore,  
9 our study clearly demonstrates that the normal forces of labor  
10 and delivery can lead to obstetric brachial plexus palsy.

11 Q: Thank you. And is this medical literature from your  
12 field of neurology that supports your opinions in this case?

13 A: It is, sure.

14 Q: And is -- I'm sorry.

15 A: Yes.

16 Q: And is it from a periodical that you subscribe to?

17 A: I'm on the -- yes, and I'm on the editorial board. So I  
18 will vouch for the quality.

19 Q: Okay. And then I'll also hand you -- Doctor, are you  
20 familiar with Dr. John Grossman?

21 A: Yes.

22 Q: And are you aware that he was a plaintiff's expert in  
23 this case?

24 A: I've been made aware of that, yes.

25 Q: And are you familiar with his writings that also support

1 the opinions that you have given to this jury?

2 A: Yes. I've read them.

3 Q: Did anything that Mr. Ruffin asked you affect your  
4 opinions in this case or change your opinions that you  
5 provided to the jury in any way?

6 A: No, not at all.

7 Q: Have all of the opinions that you have provided to the  
8 jury in this case been provided to a reasonable degree of  
9 medical certainty and most probably?

10 A: Yes, they have.

11 MS. GANES: Thank you, Dr. Duchowny.

12 THE COURT: Recross?

13 MR. RUFFIN: Just a few.

14 RECROSS-EXAMINATION

15 BY MR. RUFFIN:

16 Q: For starters, you never even brought in that article that  
17 Molly -- that Elloree just had you read from, did you?

18 A: No.

19 Q: She just handed to you and you read it?

20 A: I was aware of that article.

21 Q: Right. But you didn't bring it when you are asked to do  
22 research to support your opinions. You waited for defense  
23 counsel to give it to you and then you just read it without  
24 even looking at the citations or anything else; true?

25 A: No. I didn't wait for the defense counsel to bring it.

1 Defense counsel brought -- brought it -- brought it up. I had  
2 already read it, you know, several times before. It was not  
3 new to me.

4 Q: Okay. And I believe that when we were talking about the  
5 surgeries and in your deposition testimony, you said it least  
6 several -- or several, at least two, and then you said, oh, I  
7 mentioned something about pyloric stenosis. I've separated  
8 them out. Now, you said, well, I'm sure you can find it in  
9 the deposition transcript.

10 MS. GANES: Excuse me, Your Honor.

11 BY MR. RUFFIN:

12 Q: Was that brought to your attention?

13 MS. GANES: May we approach?

14 THE COURT: You may.

15 (WHEREUPON, a bench conference was held in the presence  
16 of the jury but out of the hearing of the jury as  
17 follows.)

18 MS. GANES: So, Your Honor, I'm going to need to -- where  
19 he has testified to, it's in the previous trial.

20 MR. RUFFIN: She's trying to use --

21 MS. GANES: He testified to the pyloric stenosis in his  
22 previous testimony under oath at the prior trial. So I would  
23 either ask that we discontinue the line of questioning or that  
24 I get to show him the testimony.

25 MR. RUFFIN: I'll move along.

1 THE COURT: Okay.

2 (WHEREUPON, the bench conference ended and the  
3 proceedings resumed as follows.)

4 BY MR. RUFFIN:

5 Q: And you just finished vouching for the *Journal of Child*  
6 *Neurology* as an authoritative and reliable journal; true?

7 A: Well, I don't know that it's authoritative. I think it's  
8 reliable. I think it's a good Journal.

9 Q: Do you mind reading for me my highlighted text?

10 MS. GANES: Objection, Your Honor. Under Rule 803, he  
11 has not said that what he was handed was a reliable source.

12 THE COURT: Why don't you go ahead and line up your  
13 questions and go from there?

14 MR. RUFFIN: Okay.

15 BY MR. RUFFIN:

16 Q: This article was testified to by a previous expert as  
17 being reliable authority. Do you yourself consider this  
18 article reliable?

19 A: I haven't seen it before, at least not that I recall.  
20 You've highlighted the summary. I haven't read the article.

21 Q: Uh-huh. So this article, the one that I want you to read  
22 from, you've never read?

23 A: I don't recall this article. I probably have read it at  
24 some point. I just don't -- I don't recall the actual  
25 substance of it right now.

1 Q: Okay. Well, would you mind reading the highlighted text  
2 for the jury?

3 MS. GANES: Objection, Your Honor.

4 THE COURT: Sustained.

5 BY MR. RUFFIN:

6 A: I would, yeah.

7 Q: Okay. But you agree that the *Journal of Child Neurology*  
8 is a journal you subscribe to and rely upon articles from,  
9 just not this one?

10 MS. GANES: Same objection, Your Honor. That's not a  
11 proper use of an article.

12 MR. RUFFIN: At this point, I'm all right with it. If  
13 you don't want to read it, that's fine. No further questions.

14 MS. GANES: Your Honor, I just object. I move to strike  
15 that.

16 THE COURT: Sustained. All right. You may step down.  
17 Thank you.

18 THE WITNESS: Thank you.

19 MS. GANES: Your Honor, may Dr. Duchowny be excused?

20 THE COURT: Any objections?

21 MR. RUFFIN: No; Your Honor.

22 THE COURT: Have a good day.

23 THE WITNESS: Thank you, Your Honor.

24 MS. GANES: Thank you.

25 THE COURT: All right. Call your next witness.

1 MS. CRAIG: Thank you, Your Honor. At this time, the  
2 defense rests.

3 THE COURT: All right. Ladies and gentlemen of the jury,  
4 if you would, step into the jury room. We have to take up  
5 some matters and we're going to come back and try to finish  
6 this case.

7 (WHEREUPON, the jury exited the courtroom at 10:41 a.m.)

8 THE COURT: All right. Let me speak to you, Mr. Ruffin  
9 and Ms. Ganes.

10 (WHEREUPON, a bench conference was held as follows.)

11 THE COURT: You state in your brief that it's an  
12 affirmative defense.

13 MS. GANES: Well, I think what we did is say that we pled  
14 the following affirmative defenses.

15 THE COURT: You said a limitation on liability is an  
16 affirmative defense and, as such, the defendant physician has  
17 the burden of proving that the limitation applies. The burden  
18 of proof for which the plaintiff patient bears the burden of  
19 proof is negligence.

20 MS. GANES: So that --

21 THE COURT: All right. And that is from Molly and  
22 Elloree's brief on appeal from the shoulder dystocia case that  
23 was tried in front of Judge Nettles.

24 MS. GANES: But the gross negligence is not --

25 THE COURT: I know.

1 MS. GANES: -- the burden.

2 THE COURT: I agree with that.

3 MS. GANES: And so that's where the legislature has kind  
4 of hooked us up on this statute.

5 THE COURT: But that doesn't make it not an affirmative  
6 defense. And an affirmative defense in a civil case is a fact  
7 or set of facts other than those alleged by the plaintiff or  
8 the prosecution which, if proven by the defendant, defeats or  
9 mitigates the legal consequences of the defendant's otherwise  
10 negligent conduct.

11 MS. GANES: So --

12 THE COURT: That's exactly what this says.

13 MS. GANES: So -- but how do we fix the fact that the  
14 gross negligence they have the burden of, but the limitation  
15 we have the burden? And so I guess what we need to do --

16 THE COURT: That's addressed in the jury charge.

17 MS. GANES: -- is hash out the wording.

18 THE COURT: I think that's addressed in the charge, but  
19 yeah.

20 MS. GANES: Okay.

21 THE COURT: The way I think it could be worded is that --  
22 keep it simple. All right. In an action involving so and so  
23 -- what this situation is -- unless it is proven -- we could  
24 say --

25 MS. GANES: By the defendant?



1 THE COURT: By the defendant.

2 MS. GANES: Okay.

3 THE COURT: Unless it is proved -- no.

4 MR. RUFFIN: I would change --

5 THE COURT: Unless it is proven by the plaintiff that the  
6 defendant was grossly negligent.

7 MS. GANES: Right.

8 THE COURT: In regards to the emergency exception, the  
9 defendant must prove this by a preponderance or a greater  
10 weight of the evidence.

11 MS. GANES: Okay.

12 THE COURT: All right. And then I think we need to go  
13 one step further. Since we are stating in the verdict form  
14 that the plaintiff prove by a preponderance of the evidence  
15 that, I think we need to say right here did the defendant  
16 prove by a greater weight or a preponderance of the evidence  
17 that the facts of this case arise to --

18 MR. RUFFIN: I agree.

19 MS. GANES: Okay. Let me -- can I just ask Molly if  
20 she's okay with that?

21 THE COURT: You can, but that's what I'm going to do.  
22 I'm telling you that right now.

23 (WHEREUPON, the bench conference ended and the  
24 proceedings resumed as follows.)

25 MS. GANES: Instead of ask, may I inform?

1 THE COURT: You may. And, Mr. Ruffin, did you discuss  
2 your time limitations with --  
3 MR. RUFFIN: I have.  
4 THE COURT: Think you can do that?  
5 MR. RUFFIN: 45 and 30.  
6 MR. GRAHAM: You said I had an hour and 30?  
7 THE COURT: He's going to go 45, you got 30, and I'm just  
8 giving them an hour. Since y'all had the burden of proof, I'm  
9 giving you more time.  
10 MR. RUFFIN: Okay.  
11 MR. GRAHAM: Thank you, Your Honor.  
12 MS. GANES: Thank you, Your Honor. Sorry to make you  
13 work on this this morning.  
14 THE COURT: That's fine.  
15 MS. GANES: We should have done this last night.  
16 THE COURT: That's my job. Tell you what. Let me -- why  
17 don't we hear motions and I'll take this back --  
18 MS. GANES: Okay.  
19 THE COURT: -- and get it printed up? We'll go from  
20 there. All right. Any motions at this time?  
21 MS. CRAIG: Yes, sir, Your Honor. On behalf of the  
22 defendants, we would renew our motion for directed verdict.  
23 First, we would request that Your Honor -- now that we've  
24 heard all of the evidence in this case, that Your Honor direct  
25 a verdict with regard to the emergency medical and obstetrical

1 care exception statute, which is 15-32-230.

2 The plaintiff in this case has not proved gross  
3 negligence as to Dr. Browning and we would ask that a directed  
4 verdict be granted on those grounds, as well as a directed  
5 verdict for liability, causation, and damages, as the only  
6 inference at the close of the case as to all of the testimony  
7 is that the plaintiff has not met their burden of proof.  
8 Thank you, Your Honor.

9 THE COURT: All right. I'm going to deny that motion.

10 MR. RUFFIN: We would move to -- for a directed verdict  
11 on the affirmative defense of the obstetric emergency on the  
12 grounds that no witness has offered testimony as to the  
13 necessary elements, which include medical instability,  
14 immediate threat of death or harm. Neither of those two of  
15 the three elements have been satisfied. The only testimony  
16 that has come in on that has come in in direct contradiction  
17 of -- of witnesses' own sworn testimony. And so we believe  
18 that it's rightfully excluded and that a directed verdict be  
19 granted on that issue.

20 THE COURT: All right. I'm going to deny that motion as  
21 well.

22 MR. RUFFIN: Thank you.

23 THE COURT: All right. We are going to take a --

24 MR. GRAHAM: Do we have time for a quick break?

25 THE COURT: Yeah. We're going to take a quick break and

1 then we're going to come back and you're going to go 45  
2 minutes and you get an hour and then you get 30 minutes in  
3 reply.

4 MR. GRAHAM: Thank you, Your Honor, but we do have a  
5 rebuttal witness.

6 THE COURT: You sure?

7 MR. GRAHAM: Yes, sir.

8 THE COURT: The same one you had last time?

9 MR. GRAHAM: Yes, sir.

10 THE COURT: All right. Why don't you bring him on up  
11 here and let me talk to him?

12 MS. CRAIG: Your Honor, may I be heard?

13 THE COURT: You may.

14 MS. CRAIG: As Your Honor heard yesterday, this is the  
15 gentleman who was the cause of the mistrial, and I'd like to  
16 mark as a court exhibit what happened in the first trial so  
17 that if this matter goes up on appeal that the appellate court  
18 has the benefit of the egregious conduct that occurred during  
19 the first trial.

20 And for the benefit of Your Honor, this witness, Mr. --  
21 Dr. Strickland, in response to an open-ended question that Mr.  
22 Graham asked, which was please explain, he offered as  
23 testimony -- during the direct examination, he said that what  
24 they do is attempt to try to help defend doctors from doing  
25 bad things, like pulling too hard and causing an injury to a

1 baby, but we should apologize and make amends and compensate  
2 and that's why we have insurance.

3 Later, after this egregious comment was made, Mr. Graham  
4 represented to the Court that in preparation for this today, I  
5 did not specifically have a discussion with Dr. Strickland  
6 about not commenting on insurance. I didn't anticipate it.

7 I'd like to offer this as a -- as a Court's exhibit.

8 First of all, in light of this conduct, the fact that  
9 this witness is back here to try to testify again is  
10 absolutely shocking.

11 Secondly, under the case law, Your Honor, this is not a  
12 proper rebuttal testimony. I point Your Honor to *McGaha vs.*  
13 *Mosley*, which is 283 S.C. 268, and it says that a plaintiff in  
14 a civil action must first produce and disclose the entire  
15 evidence in support of his case. After the defendant has  
16 offered all of his evidence, the plaintiff may reply. Reply  
17 testimony should be limited to rebuttal of matters raised in  
18 the defense. It should not be used to complete the  
19 plaintiff's case in chief. Admission of reply testimony is  
20 within the discretion of the trial judge.

21 Your Honor has the full discretion whether or not Dr.  
22 Strickland can testify in this trial. And, Your Honor, there  
23 has been no new material. There is no reason to delay this  
24 case any longer from getting to a jury. There's absolutely no  
25 reason for a rebuttal witness to testify.

1       Your Honor, if I may, I'd like to offer as the next  
2 Court's exhibit the trial testimony from the first trial.

3       THE COURT: You may.

4       (WHEREUPON, the trial transcript portion was marked as  
5 Court's Exhibit Number 20.)

6       THE COURT: All right. Mr. --

7       MR. GRAHAM: May I inquire does that include pages 252  
8 and 253?

9       MS. CRAIG: Your Honor, it's the entire direct  
10 examination of Dr. Strickland and then all of the commentary  
11 following the mistrial. And for the record, it appears to be  
12 page 227 through 260.

13       THE COURT: All right. Mr. Graham?

14       MR. GRAHAM: Yes, sir.

15       THE COURT: Briefly.

16       MR. GRAHAM: If Your Honor please, I'd like to read for  
17 Your Honor what Judge Griffith said about this matter in terms  
18 of his judgment, his evaluation of the demeanor and  
19 credibility of Dr. Strickland that he personally observed on  
20 page -- starting on page --

21       THE COURT: Now, you do understand that it was your  
22 witness that denied these people from getting a verdict last  
23 time? They deserve a right to have a verdict.

24       MR. GRAHAM: We do too, Your Honor.

25       THE COURT: You are very smart. You are very -- I'm

1 talking about your clients. You are very smart.

2 MR. GRAHAM: Okay.

3 THE COURT: You are very professional. Your witness is  
4 educated beyond belief.

5 MR. GRAHAM: Yes, sir.

6 THE COURT: That trial was thrown on the last day by that  
7 witness.

8 MR. GRAHAM: We were all thrown, Your Honor, including  
9 Dr. Strickland because he didn't realize he had done anything.  
10 He's done a lot of depositions.

11 THE COURT: He's way too smart for that.

12 MR. GRAHAM: It had been -- it had been years since he  
13 had testified at trial. I didn't realize that. And let me  
14 read you what Judge Griffith said starting on page 252, at  
15 line 23.

16 You know, I think he was just -- I watch and evaluate  
17 witnesses so very much, as much as y'all do, maybe more, and  
18 he comes across to me as being straightforward and candid and  
19 a man's man, and that's what you do. You do the right thing.  
20 That's just how he's testifying with that positive posture  
21 and I do -- I can't imagine -- I mean if I had known he would  
22 know that he shouldn't say that, I don't think he would  
23 recognize that it would impact a mistrial. I don't know that  
24 and I don't think that would be proper for me to place that on  
25 him.

1 And as it -- he shouldn't have said it, but he did. It  
2 didn't come across to me as being with ill will. It was a  
3 mistake, but he was candid and forthright with it. And I  
4 don't think that he did it with any -- Mr. Graham, I'm so  
5 sorry for her. I really am. I mean there's no question it's  
6 been emotional on both sides.

7 And, you know, Judge Griffith -- that's what he said on  
8 the record. He said some things that went farther off the  
9 record when we were waiting around after -- after he granted  
10 the mistrial.

11 Dr. Strickland, if Your Honor please, was emotionally  
12 distraught after this happened. He -- he thought seriously  
13 about not ever testifying again.

14 In terms of us calling Dr. Strickland as a rebuttal  
15 witness, the defense made a motion that we be limited to the  
16 same witnesses that we had in the first trial. Judge Griffith  
17 granted that and now they're trying to say even though at  
18 their motion we're required to use the same witnesses as  
19 before, now somehow we shouldn't be allowed to use the same  
20 witnesses as before.

21 Dr. Strickland is not going to say anything about  
22 insurance. He's not going to say any personal opinions about  
23 I believe they need to compensate.

24 THE COURT: I have a question. What is he going to add?

25 MR. GRAHAM: Oh, yes, sir.



DR. DANIEL STRICKLAND - CROSS BY MS. CRAIG

1 Q: Thank you. Now, when you did locum tenens work --  
2 actually, let me back up. You agree that Dr. Browning is an  
3 experienced physician, would you not?

4 A: Yes.

5 Q: Now, when you did locum tenens work in Dillon, you would  
6 actually refer patients to Dr. Browning's practice, didn't  
7 you?

8 A: Indirectly, yes.

9 Q: Now, you agree that presentation of shoulder dystocia is  
10 a medical emergency; is that right?

11 A: Yes.

12 Q: And that when it happens, when this medical emergency  
13 occurs, time is of the essence? Is that a fair statement?

14 A: Well, in a nonquantitative way, yes.

15 Q: Okay.

16 A: But it doesn't mean rush is of the essence.

17 MR. GRAHAM: Your Honor, may we approach?

18 THE COURT: You may.

19 (WHEREUPON, a bench conference was held in the presence  
20 of the jury but out of the hearing of the jury as  
21 follows.)

22 MR. GRAHAM: I promised just those two areas, but this --

23 THE COURT: I agree.

24 MR. GRAHAM: -- is going wide, wide --

25 THE COURT: Shhh. It is. Let's go ahead and just reply

DR. DANIEL STRICKLAND - RECROSS BY MS. CRAIG

1 BY MR. GRAHAM:

2 Q: So what have you --

3 THE COURT: You're done. That's three. All right. Your  
4 turn. You've got three if you want them.

5 MS. CRAIG: I'm only going to use one.

6 RECROSS-EXAMINATION

7 BY MS. CRAIG:

8 Q: Have you reviewed the birth video in this case?

9 A: Yes, ma'am.

10 MS. CRAIG: Thank you. Those are all the questions I  
11 have.

12 THE COURT: All right. You may step down. Have a good  
13 day and thank you very much. All right. Members of the jury,  
14 step into the jury room for just a moment. We're going to try  
15 to get this thing to a conclusion.

16 (WHEREUPON, the jury exited the courtroom at 12:12 p.m.)

17 (WHEREUPON, the transcript of Dr. Strickland's deposition  
18 was marked as Court's Exhibit Number 22.)

19 THE COURT: Is that door closed over there as far as you  
20 can tell?

21 THE BAILIFF: Yes, sir.

22 THE COURT: All right. Do you need to renew motions,  
23 anybody? Or are we all good?

24 MS. CRAIG: We would just renew our -- our motion for a  
25 directed verdict at this time for all of the grounds

1 previously stated.

2 THE COURT: All right. Those motions are denied. Mr.  
3 Ruffin, if you'd like to renew yours, you may.

4 MR. RUFFIN: We would. We'd like to renew our motions.

5 THE COURT: All right.

6 MR. RUFFIN: Or our request that you direct a verdict on  
7 obstetric emergency.

8 THE COURT: All right. Those are denied as well. Come  
9 take a look at the verdict form. I've changed it like I said  
10 I would.

11 MS. CRAIG: Okay.

12 MR. RUFFIN: Perfect.

13 MR. GRAHAM: May I see it?

14 MR. RUFFIN: I think it's good.

15 MS. GANES: That's fine.

16 MR. GRAHAM: Okay. Got it. Got it.

17 THE COURT: That was in your favor.

18 MR. GRAHAM: I was just hopeful --

19 MS. GANES: Thank you, Your Honor.

20 MR. GRAHAM: Before I said anything to the contrary --

21 THE COURT: All right.

22 MR. GRAHAM: -- I wanted to verify it.

23 THE COURT: Go ahead and set up whatever you need to set  
24 up. We're going to bring them out and we'll start.

25 (WHEREUPON, there was a break in the proceedings from

1 wrong. You can have all the doubts in the world. All we have  
2 to prove is what's more likely right than wrong, what's more  
3 likely true than false. A little bit more and the case tips  
4 in our favor.

5 The same thing applies to the amount of money. I suggest  
6 to you that \$2.5 million is a symbol of justice.

7 MS. CRAIG: Your Honor, I let it go the first time. This  
8 is improper.

9 THE COURT: Go ahead and move on, Mr. Graham. You've got  
10 4 minutes.

11 MR. GRAHAM: This has been a hard week for all of us, for  
12 you too I'm sure. I told you the story of this case in  
13 opening. I set the stage with the monitors, the bed, the  
14 nurse, the dad, the doctor coming in. The little girl born  
15 with an arm with just a few fingers moving.

16 The final chapter is yours to write. I have faith that  
17 you will have the strength and the courage to do the right  
18 thing and make this a happy ending for Julia. The money that  
19 she gets in this case will be protected for Julia by our court  
20 system. The probate court system requires that money to be  
21 protected for Julia. We ask you to give her a happy ending.  
22 Thank you.

23 CHARGE ON THE LAW

24 THE COURT: Members of the jury, it is now my duty as the  
25 trial judge to instruct you on the law applicable to this case

1 and, in that regard, it is your duty as jurors to accept and  
2 apply the law as I now state it to you.

3 Furthermore, it is your exclusive duty to decide all the  
4 issues of fact in this case and to determine the effect,  
5 value, weight, and truth of the evidence presented. All the  
6 parties have the right to expect that you will carefully  
7 consider and evaluate the evidence and apply the law of this  
8 case to it so that in the end all the parties will have  
9 received a fair and impartial trial.

10 During this trial, you and I have separate duties to  
11 perform. As the trial judge, it is my responsibility to  
12 preside over this trial and to rule upon the admissibility of  
13 the evidence offered during the trial. In that regard, you  
14 are to consider only the evidence before you. Thus, you are  
15 to consider only the testimony which has been presented from  
16 this witness stand, together with any exhibits admitted into  
17 the record of this case.

18 Furthermore, I have the additional duty to charge you on  
19 the law applicable to this case and, in that regard, it is  
20 your duty to accept and apply the law as I now state it to  
21 you. If you have any preconceived ideas as to what the law is  
22 or what you think the law ought to be and it does not agree  
23 with what I tell you the law is, then you are obligated under  
24 your oath to abandon these preconceptions and accept the law  
25 as I now give it to you.

1        In this trial, you are the sole and exclusive judge of  
2 the facts. Do not infer that I have any opinion about the  
3 facts in this case from anything I have said or done during  
4 the course of this trial. In this regard, the law simply does  
5 not permit me to have an opinion about the facts. As jurors,  
6 it is your duty alone to determine the effect, value, weight,  
7 and truth of the evidence presented during the course of this  
8 trial.

9        Furthermore, it is your job as jurors to determine the  
10 credibility and believability of the witnesses who have  
11 testified in this case. You must evaluate the evidence and  
12 determine which evidence convinces you of its truth.

13        In determining the believability of witnesses who have  
14 testified in this case, you may believe one witness over many  
15 or many over one. You may believe a part of the testimony of  
16 a witness and reject the remaining part. You may believe the  
17 testimony of a witness in its entirety or reject it in full.

18        You may consider whether the witness has an interest in  
19 the result of the trial, whether the witness is prejudiced  
20 toward either party, the opportunities for the witnesses to  
21 have seen the manners and things about which they may testify,  
22 and the way the witness acts on the witness stand.

23        Furthermore, evidence may be direct or circumstantial.  
24 Direct evidence is testimony by a witness about what the  
25 witness personally saw or heard or did. Circumstantial

1 evidence is indirect evidence. In other words, it is proof of  
2 one or more facts from which one can find another fact. You  
3 may consider both direct and circumstantial evidence equally.

4 The burden of proof in this case is by a preponderance of  
5 the evidence. A preponderance of the evidence simply means  
6 the greater weight of the evidence. In other words, it is  
7 evidence that as a whole shows that the fact sought to be true  
8 is more likely true than not true.

9 This can be illustrated by imagining a set of scales.  
10 When the scales begin -- when the case begins, the scales are  
11 even. After all of the evidence has been presented, if the  
12 scales remain even or if they tip even slightly in favor of  
13 the defendant, then the plaintiff has failed to meet the  
14 burden of proof and would not be entitled to recover in this  
15 case. If, on the other hand, the scales tip even slightly in  
16 favor of the plaintiff, the plaintiff will have met the burden  
17 of proof and you should return a verdict for the plaintiff.

18 The preponderance of the evidence is not determined by  
19 the number of witnesses. Instead, it must be determined by  
20 the greater weight of all of the evidence.

21 Furthermore, the rules of evidence ordinarily do not  
22 permit witnesses to testify as to opinions or conclusions. An  
23 exception to this rule exists for witnesses we call expert  
24 witnesses. A witness who by education and experience has  
25 become an expert in some art, science or profession may give

1 an opinion as to the subject the witness claims to be an  
2 expert in and may also give the reasons for the opinion.

3 You should consider any expert opinion and, like any  
4 other evidence, give it the weight you think it deserves. If  
5 you decide that an expert witness's opinion is not based on  
6 sufficient education and experience or if you decide that the  
7 reasons given in support of the opinion are not sound or that  
8 the opinion is outweighed by other evidence, you may disregard  
9 the opinion entirely.

10 An expert witness's testimony is to be given no greater  
11 weight than that of any other witness simply because the  
12 witness is an expert. Furthermore, you do not have to accept  
13 an expert's opinion even though it is uncontradicted.

14 In this case, there has been a conflict in the testimony  
15 of expert witnesses. To that end, you must weigh one expert's  
16 opinion against that of the other and you must consider the  
17 reasons given by one as compared with those of the other and  
18 you should consider the relative credibility and knowledge of  
19 the experts who have testified. Then you should find in favor  
20 of that expert testimony which in your opinion is entitled to  
21 the greater weight.

22 In this case, certain testimony has been presented into  
23 evidence by deposition. A deposition is testimony --  
24 testimony taken under oath before trial and preserved in  
25 writing or by some other mechanical device such as a video.



1 You are to consider that testimony as if the witness had given  
2 it here in court.

3 Furthermore, in our courts, no distinction is made  
4 between corporations and individuals. A corporation is a  
5 person in the eyes of the law. A corporation is entitled to  
6 the same fair and impartial consideration and to justice by  
7 the same standards as an individual.

8 Furthermore, respondeat superior makes an employer liable  
9 to a third party for injuries caused by his employee committed  
10 within the scope of his employment. When an employee/employer  
11 relationship exists, the tort of the employee is imputed to  
12 the employer by law without any requirement or fault on the  
13 part of the employer.

14 Dr. Browning is named individually as a defendant in this  
15 case. He is an employee of McLeod Physicians Associates II.  
16 McLeod Physicians Associates II is a charitable organization.  
17 A judgment against an employee of a charitable organization  
18 may not be returned unless a specific finding is made that the  
19 employee act -- acted in a reckless, willful or grossly  
20 negligent manner. However, a judgment may be returned  
21 against a charitable organization on a finding of ordinary  
22 negligence.

23 The plaintiff claims that the defendant committed medical  
24 malpractice, which is a form of carelessness or negligence.  
25 In order to recover for medical malpractice, the plaintiff

1 must prove by a preponderance or greater weight of the  
2 evidence, one, the standard of care, two, a breach of the  
3 standard of care, three, proximate cause and, four, damages.

4       The plaintiff must prove the standard of care the  
5 defendant owed to the plaintiff in treating the plaintiff.  
6 When a doctor treats a patient, the law does not require  
7 perfection. However, the law does require that the doctor use  
8 that degree of knowledge, care, and skill ordinarily possessed  
9 and used by doctors in good standing in the doctor's field of  
10 medicine under the same or similar circumstances and that the  
11 doctor follow the generally accepted practices and procedures  
12 in the profession.

13       Also, understand that a physician who holds himself out  
14 to be a specialist is bound to bring to the discharge of his  
15 professional duties as a specialist that degree of skill,  
16 care, and learning ordinarily possessed by a specialist of a  
17 similar class under the same or similar circumstances.  
18 Accordingly, one who holds himself out as a specialist who  
19 undertakes a service in a special branch of medical science  
20 owes to his patient the duty of possessing that degree of  
21 learning and skill ordinarily possessed by specialists of good  
22 standing.

23       Next, the plaintiff must prove that the defendant  
24 negligently departed from the standard of care in treating the  
25 plaintiff. Negligence is the failure to do what an ordinarily

1 careful doctor in the defendant's field of medicine would have  
2 done under the same or similar circumstances or the doing of  
3 something that an ordinarily careful doctor would not have  
4 done under the same or similar circumstances.

5 A doctor is not an insurer of a cure or even a positive  
6 result. Therefore, the mere fact that a treatment did not  
7 benefit the patient or that it even harms the patient does not  
8 in and of itself mean that the defendant was negligent. A bad  
9 result, injury, death or failure to cure is not by itself  
10 enough to show that the defendant was negligent.

11 Similarly, a doctor's mistake or error in making a  
12 decision alone does not constitute negligence. If, however, a  
13 doctor fails to gather information reasonably available which  
14 a reasonable doctor would have gathered before making a  
15 decision, then in that case the doctor fails to comply with  
16 the recognized standard of medical care which would be  
17 exercised by a similar doctor under similar circumstances.

18 The mere fact that the plaintiffs experienced  
19 complications, if any, or the mere fact that the defendant's  
20 treatment failed to cure the plaintiff's ailments is not  
21 evidence in and of itself of negligence on the part of the  
22 defendants. The difficulties and uncertainties in the  
23 practice of medicine and unpredictable variations in the  
24 response to treatment are such that no doctor can guarantee  
25 results.

1       Where there is more than one recognized diagnosis or  
2 treatment and no one of them is used exclusively or uniformly  
3 by all doctors in good standing, it is not negligence for a  
4 doctor in making a decision to choose one of the approved  
5 methods even when the choice later turns out to be a wrong  
6 selection. Qualified doctors and experts may differ as to  
7 what constitutes the best course of treatment and these  
8 differences do not amount to malpractice.

9       Where doctors in good standing disagree or when medical  
10 authorities are divided with regard to a specific course of  
11 treatment or care, then the doctor is bound only to exercise  
12 his best judgment in determining which course on the whole is  
13 best for the patient:

14       Just because another doctor might have used a different  
15 course of treatment does not make the defendant negligent.  
16 However, if a doctor does not have the degree of learning and  
17 skill required or if the doctor does not use the care  
18 required, it is no defense to a charge of negligence that the  
19 doctor did the best that he could.

20       The question of whether a physician is making a diagnosis  
21 -- in making a diagnosis deviated from the applicable standard  
22 of care, either by not employing a particular procedure or by  
23 not ordering a particular test, is to be determined by what an  
24 ordinary careful and prudent physician would have done under  
25 the same or similar circumstances. Negligence on the part of

1 the physician is not presumed, but must be affirmatively  
2 proved.

3 In considering whether defendant made a reasonable  
4 decision, you must consider the decision in relation to the  
5 facts as they existed at the time and not in light of what  
6 hindsight may reveal. In a medical malpractice case, both  
7 the standard of care and the physician's failure to conform  
8 with the required standard must be established by expert  
9 testimony.

10 Finally, the plaintiff must prove that the defendant's  
11 negligence proximately caused the plaintiff's damages.  
12 Proximate cause is something that produces a natural chain of  
13 events which in the end brings about the injury. It is the  
14 direct cause of the injury.

15 To prove that the defendant's negligence proximately  
16 caused the plaintiff's injury, the plaintiff must first prove  
17 causation in fact. This is proven by showing that the injury  
18 would not have occurred but for the defendant's negligence.

19 The plaintiff must also prove legal cause. Legal cause  
20 is proven by showing that the injury was foreseeable. This  
21 means that the injury occurred as a natural and probable  
22 consequence of the defendant's negligence. The plaintiff must  
23 prove that some injury from the defendant's negligence was  
24 foreseeable, but does not have to prove that the particular  
25 injury that occurred was foreseeable.

1       However, the defendant cannot be held responsible for  
2 something which does not -- which -- which could not be  
3 expected to happen. Proximate cause does not mean the only  
4 cause. There may be -- there may be more than one proximate  
5 cause. The defendant's acts can be a proximate cause of the  
6 plaintiff's injury if it was at least one of the direct  
7 concurring causes of the injury.

8       South Carolina does not recognize liability for a  
9 physician as captain of the ship and liability cannot be  
10 presumed against a physician merely because a person on the  
11 operating team assisting in the operation may have been  
12 negligent. A physician cannot be held liable solely because  
13 he is the head of an operating team and he cannot be held  
14 liable for the negligence of a person assisting in the  
15 operation.

16       In an action involving medical malpractice -- in a  
17 medical malpractice claim arising out of care rendered in a  
18 genuine emergency situation in an obstetrician suite where the  
19 patient is not stable and there is an immediate threat of  
20 death or serious bodily harm to the patient, no physician may  
21 be held liable unless it is proven that the physician was  
22 grossly negligent. In regards to this emergency exception,  
23 the defendant must prove this by the preponderance or greater  
24 weight of the evidence.

25       Also, gross negligence is the failure to exercise a

1 slight degree of care. A person who is so indifferent to the  
2 consequences of his conduct as to not give a slight care as to  
3 what he is doing acts with gross negligence. Gross negligence  
4 is also the absence of care that is necessary under the  
5 circumstances.

6 Furthermore, if the opinions of medical experts are  
7 relied on to establish proximate cause, the expert must state  
8 with reasonable certainty that, in his or her professional  
9 opinion, the plaintiff's injuries most probably resulted from  
10 the negligence of the defendant. It is not necessary that the  
11 expert use the words most probably. It is enough for the  
12 expert to state that it is the expert's professional opinion  
13 that the defendant's negligence was most likely one of the  
14 possible causes of the plaintiff's injuries.

15 You must decide issues involved in this proceeding based  
16 solely upon the evidence which you hear during the course of  
17 this trial. Your verdict must be without bias and without  
18 prejudice toward any party. You cannot allow yourselves to be  
19 governed by sympathy, by prejudice, by passion, by public  
20 opinion or by some other consideration not found in the  
21 evidence.

22 If you decide that the plaintiff is entitled to a  
23 verdict, your next step would be to decide how much money the  
24 defendant should be required to pay. Actual damages are to  
25 compensate the plaintiff for the plaintiff's injuries or loss

1 and to put the plaintiff as near as possible in the same  
2 position that the plaintiff was in before the accident  
3 occurred. In other words, actual damages would be the actual  
4 losses and expenses which the plaintiff has suffered because  
5 of the defendant's negligence.

6 Furthermore, the plaintiff must prove that the expenses  
7 caused by the injury were reasonable and necessary. In  
8 determining the amount of compensation for personal injuries,  
9 it is proper to consider past and present aspects of the  
10 injury. This would include physical and mental pain and  
11 suffering, expenses incurred for necessary medical treatment,  
12 loss of time and income which resulted from the impairment of  
13 the ability to work and earn a livelihood, the loss of  
14 enjoyment of life suffered as a result of the injury, and any  
15 other losses which are reflected by the character of the  
16 injury.

17 Medical treatment may include such amounts necessary for  
18 medicine, medical services, hospital expenses, and care and  
19 nursing. The injured party may recover for those future  
20 damages that are reasonably sure to result from the injuries.

21 The principle underlying compensation for future damages  
22 is that only one action can be brought and therefore only one  
23 recovery had. It is proper to include in the estimate of  
24 future damages compensation for loss of capacity for work,  
25 future medical expenses, and pain and suffering which will



1 with reasonable certainty result. The plaintiff may also  
2 claim reduced earning ability for the future.

3 Pain and suffering compensates the plaintiff for physical  
4 discomfort and emotional response to the sensation of pain  
5 caused by the injury itself. There is no definite standard by  
6 which to compensate the plaintiff for pain and suffering. You  
7 have the authority to determine the amount, if any, to be  
8 allowed for pain and suffering using calm and reasonable  
9 judgment to ensure that the damages are just and reasonable in  
10 light of the testimony and evidence presented in this case.

11 Mental suffering, apprehension, shock, fright, emotional  
12 upset, humiliation, and anxiety, either present or expected in  
13 the future, can be properly considered as an element of  
14 damages. The amount of damages for mental suffering cannot be  
15 exactly measured.

16 Loss of enjoyment of life compensates the plaintiff for  
17 limitations on the plaintiff's ability to participate in and  
18 derive pleasure from the normal activities of daily life.

19 A plaintiff is never entitled to recover conjectural or  
20 speculative damages, but if you find that the plaintiff is  
21 entitled to a verdict for actual damages, your verdict should  
22 include any amount to cover any past, present, and future  
23 damages which were proximately caused by the defendant. Any  
24 future damages must be reasonably certain to occur in the  
25 future as a result of the defendant's acts.

1 Actual damages need not be proven to a mathematical  
2 certainty or based on evidence of the precise amount of the  
3 damages the plaintiff has suffered. Instead, the evidence  
4 must allow you to determine what amount of damages is just,  
5 fair, and reasonable.

6 In this case, the plaintiff has requested damages for  
7 permanent impairment of physical condition and alleges such  
8 permanent impairment. In evaluating the plaintiff's permanent  
9 disability or impairment, it is up to you to determine based  
10 upon the evidence the extent and degree of the plaintiff's  
11 disability and impairment as a result of these injuries.

12 Permanent disability or disability does not only relate  
13 to the workplace. When an individual leaves her workplace,  
14 her job, her permanent impairment or limitations do not  
15 automatically cease. She takes them home with her.

16 Therefore, in evaluating permanent impairments and  
17 disabilities, you should consider the effect on all aspects of  
18 the plaintiff's life. This may include such things as her  
19 ability to carry out household chores or activities, enjoyment  
20 of leisure time or recreational activities, social functions,  
21 et cetera. There is no set measure of damages for this type  
22 of loss. The law allows that you should -- that should you  
23 determine to award damages for permanent impairment, you  
24 should only award an amount that is fair, just, and  
25 reasonable.

1 Any future damages must be reasonably calculated to have  
2 resulted from the alleged injury or damage sustained in the  
3 case. Future damages must be reduced to their present cash  
4 value. The estimation of damages cannot be based on  
5 conjecture or speculation. It must pass -- it must pass the  
6 realm of opinion not founded on facts and must rest on  
7 evidence which a reasonably accurate conclusion regarding the  
8 amount of loss can logically and rationally be drawn.

9 The loss of impairment of earning capacity resulting from  
10 the injuries to the plaintiff is a proper element of damages.  
11 In determining the amount of damages due the plaintiff for  
12 loss or impairment of earning capacity, you should consider  
13 the following.

14 The loss of future earning power. This requires you to  
15 consider all matters that relate to the issue of any  
16 impairment. The effect which the impairment will have on the  
17 plaintiff's capacity to work. The extent to which the  
18 impairment will impair the plaintiff's earning capacity, and  
19 the present value of all losses due to the plaintiff's  
20 impairment, earning power, and the physical pain and suffering  
21 as reasonably certain will result in the future from the  
22 injuries to the plaintiff.

23 In awarding damages for loss or impairment to earning  
24 capacity, the plaintiff may recover for the loss or decrease  
25 of earning capacity during her entire expectancy of life. In

1 determining the loss of earning capacity which may result in  
2 the future, the fact that the plaintiff is making the same or  
3 more earnings since the injury is only one factor to consider.  
4 If you determine that the plaintiff is entitled to damages for  
5 impairment of earning capacity, then you must decide the  
6 amount of damages using the life expectancy table as a guide.

7 In determining amount of money to include in your award  
8 of future damages, it will be necessary for you decide -- to  
9 decide the probable life expectancy of the plaintiff. To aid  
10 you in making this determination, you may consider as evidence  
11 a mortality table. Life expectancy is merely an estimate of  
12 the probable average remaining length of life of all persons  
13 in our state of a given age and that estimate is based on a  
14 limited record of experience.

15 So the inference which may be drawn from the table is  
16 evidence bearing on the life expectancy on the plaintiff  
17 including her state of health, habits, and occupation. You  
18 will take into consideration the plaintiff's age and life  
19 expectancy. The evidence in this case has established that  
20 the plaintiff is a six -- is six years of age. According to  
21 the governing mortality tables, the plaintiff has a life  
22 expectancy of an additional 74.97 years.

23 Ladies and gentlemen, I'm now drawing near the end of my  
24 charge and I want you to clearly understand that you are not  
25 partisans or advocates for the plaintiff or for the defendant.

1 You do not serve as jurors to reward your friends or punish  
2 your enemies.

3 In this regard, you have been selected by all the parties  
4 to be fair and impartial jurors. It is your duty by your  
5 joint deliberations to determine the truth in this case. Then  
6 to the facts which you determine to be true, you should take  
7 and apply the law which has been given to you by this Court  
8 and thus arrive at a verdict which speaks the truth in this  
9 case. In fact, the word verdict, which has a Latin  
10 derivative, means a true saying. Thus, when you have  
11 accomplished these responsibilities, you will have satisfied  
12 your oath as jurors and you will have discharged your duties  
13 to this Court.

14 Now, Mr. Foreman -- if the clerk would hand him the  
15 verdict form? Thank you.

16 Mr. Foreman, I have handed you the verdict form. When  
17 you arrive at a verdict in this case, you will write the  
18 verdict on the form and sign it. The verdict that you render  
19 in this case must be the verdict of each and every juror. It  
20 must be your unanimous verdict. All 12 jurors must agree on  
21 the verdict which you authorize the foreman to write for the  
22 jury.

23 Mr. Foreman and members of the jury, I want you to  
24 further understand that the orders in which the choices of  
25 verdict appear on the verdict form are not suggestive of any

1 verdict on the part of this Court. The verdict in this case  
2 is to be determined by you, the jury, and not the Court.

3 Furthermore, ladies and gentleman, please understand that  
4 even though I have given the verdict form to the foreman, it  
5 is not his verdict alone. It is the verdict of all 12 of you  
6 and I emphasize again it must be unanimous.

7 In a moment, you will retire to the jury room. However,  
8 I would ask that you do not begin your deliberations until you  
9 are told to do so. The law requires that I now consult with  
10 the attorneys to make sure that I have not left anything out  
11 of these instructions. After I have checked with the  
12 attorneys, the bailiff will bring in the items of evidence and  
13 instruct you to begin your deliberations at that time.

14 Also, should you have any questions during your  
15 deliberations, you must put them in writing and send them to  
16 me by way of the bailiff. The court bailiff will be placed  
17 immediately outside of the jury room door to provide  
18 assistance for you during your deliberations.

19 Once you have reached your verdict, knock on the jury  
20 room door and advise the Court that you have reached a verdict  
21 and we will return you to the courtroom as promptly as  
22 possible thereafter.

23 Thank you. You may retire to the jury room but do not  
24 begin your deliberations until you are told to do so.

25 (WHEREUPON, the jury exited the courtroom at 3:03 p.m.)

1 THE COURT: Any objections to the charge from the  
2 plaintiff?

3 MR. RUFFIN: I'm sorry, Judge.

4 THE COURT: Any objections to the charge from the  
5 plaintiff?

6 MR. RUFFIN: No, Your Honor.

7 THE COURT: How about the defense?

8 MS. CRAIG: No, sir, Your Honor.

9 THE COURT: All right. Why don't you take a look at all  
10 of the items that are in evidence and make sure they're in  
11 order and they're proper and we'll submit them to the jury.  
12 And we'll bring out the alternate at that time.

13 (WHEREUPON, there was a pause in the proceedings to check  
14 the evidence, after which the proceedings resumed as  
15 follows.)

16 THE COURT: All right. Everything in order from the  
17 plaintiff?

18 MR. RUFFIN: I'm just now looking at them.

19 THE COURT: How about from the defense?

20 MS. CRAIG: Yes, sir. All of ours are ready to go.

21 MR. RUFFIN: All right.

22 MS. CRAIG: All right. We're good to go.

23 THE COURT: All right. Go ahead and send them in. Send  
24 out the alternate and tell them to begin.

25 (WHEREUPON, the jury deliberations began at 3:08 p.m. and

1 the alternate juror was brought from the jury room into  
2 the courtroom and the proceedings resumed as follows.)  
3 THE COURT: All right. Mr. Alternate, you are done for  
4 the week. You were our backup quarterback if the quarterback  
5 got sick or had a family emergency or something came up and I  
6 needed for you to step in and throw that ball.  
7 THE ALTERNATE JUROR: Okay.  
8 THE COURT: But your job is done.  
9 THE ALTERNATE JUROR: Thank you.  
10 THE COURT: You can go. Thank you. Have a good week.  
11 THE ALTERNATE JUROR: Thank you so much.  
12 THE COURT: Thank you. All right. We'll be at ease  
13 until something happens.  
14 (WHEREUPON, there was a break in the proceedings from  
15 3:09 p.m. until 3:58 p.m., after which the proceedings  
16 resumed as follows.)  
17 THE COURT: We have a question. It says: Can we see the  
18 birth video. It looks like either a two or a question mark.  
19 I'm not sure what. And that's it. Of course, it's into  
20 evidence. I'm assuming they can see it.  
21 MR. GRAHAM: That sounds right to me, Your Honor.  
22 THE COURT: How do we do it? Do they come out here or do  
23 they see it in there or how do --  
24 MS. CRAIG: They can come out here and see it.  
25 THE COURT: All right. Is the screen put up?



1 MR. GRAHAM: We've broken down, Your Honor.

2 THE COURT: Can you put it back up? I knew that question  
3 was coming.

4 MR. GRAHAM: We've got a laptop that we could send back  
5 there or we could do it -- I mean --

6 THE COURT: What do you all say?

7 MS. CRAIG: It can be -- it can be -- the problem is is  
8 we can't control what happens back there. They want to see  
9 the video.

10 THE COURT: Can you put up the screen?

11 MR. RUFFIN: Yes, sir, Your Honor.

12 THE COURT: You've been mighty good.

13 MR. RUFFIN: It would just take me a few minutes to --

14 THE COURT: Go ahead.

15 MR. RUFFIN: -- set back up everything.

16 THE COURT: That would be fine.

17 MR. RUFFIN: No problem.

18 MS. CRAIG: Or he can maybe show the -- use that screen  
19 from your computer to show it to them?

20 THE COURT: Just let them look at the computer?

21 MS. CRAIG: I mean I'm trying to make it quicker.

22 THE COURT: I don't know. I think -- I don't think 12  
23 people could see that little screen.

24 MR. GRAHAM: I think we need to get the screen if we can  
25 do it out here.

1 THE COURT: Go ahead and get it up.

2 MR. GRAHAM: Okay.

3 (WHEREUPON, there was a pause in the proceedings for

4 setup, after which the proceedings resumed as follows.)

5 (WHEREUPON, the jury note was marked as Court's Exhibit

6 Number 23.)

7 THE COURT: Do we play the whole video or do we ask them

8 is there a particular part you want to see or how do -- or

9 play the whole thing and then if they want to see something

10 specific?

11 MR. GRAHAM: Your Honor, I --

12 THE COURT: I'm just asking. I don't know.

13 MR. GRAHAM: It suits me to ask them what they want to

14 see and let them see what they want to see.

15 THE COURT: That suits me.

16 MR. GRAHAM: We need to find out if they want to see it

17 in real time or frame by frame.

18 THE COURT: What do y'all think?

19 MS. CRAIG: I think that they've asked to see the birth

20 video. So we show them the birth video.

21 THE COURT: Show them the whole thing? All right.

22 MS. CRAIG: We're presuming that they --

23 THE COURT: I am assuming the next question is going to

24 be can we see certain parts of it, but I was just trying to

25 get it out before --

1 (WHEREUPON, there was a pause in the proceedings for  
2 setup, after which the proceedings resumed as follows.)  
3 MR. RUFFIN: Your Honor, I think I've --  
4 THE COURT: Are you ready?  
5 MR. RUFFIN: We are ready to go, Your Honor.  
6 THE COURT: All right. Go ahead and bring them in. Why  
7 don't we dim the lights a little bit once they get in here?  
8 (WHEREUPON, the jury entered the courtroom at 4:05 p.m.)  
9 THE COURT: All right. Why don't you go ahead and dim  
10 the lights? Go ahead and play the video.  
11 MR. RUFFIN: Yes, sir, Your Honor.  
12 (WHEREUPON, Plaintiff's Exhibit Number 5, the birth  
13 video, was played in open court, after which the  
14 proceedings resumed as follows.)  
15 THE COURT: All right. If you'll step back into the jury  
16 room and continue?  
17 (WHEREUPON, the jury exited the courtroom at 4:20 p.m.)  
18 THE COURT: We'll be at ease until something else.  
19 (WHEREUPON, during the break, the deposition of Dr.  
20 Duchowny was marked as Court's Exhibit Number 24.)  
21 (WHEREUPON, there was a break in the proceedings from  
22 4:20 p.m. until 4:31 p.m., after which the proceedings  
23 resumed as follows.)  
24 THE COURT: All right. The question says: Can you define  
25 grossly negligent? And I figured what I would do is -- I

1 referred to it twice in the charge -- just read that to them  
2 again. Any objections from the plaintiff?

3 MR. GRAHAM: No, sir.

4 THE COURT: I mean we defined it. Any objections from  
5 the defense?

6 MS. CRAIG: I think that's our only option.

7 THE COURT: Sounds good to me. All right. Go ahead and  
8 bring them out.

9 (WHEREUPON, the jury entered the courtroom at 4:33 p.m.)

10 THE COURT: All right. Gross negligence is the failure  
11 to exercise a slight degree of care. A person who is so  
12 indifferent to the consequences of his conduct as to not give  
13 a slight care as to what he is doing acts with gross  
14 negligence. Gross negligence is also the absence of care that  
15 is necessary under the circumstances.

16 All right. With that being said, you may return to the  
17 jury room, but do not begin your deliberations until I tell  
18 you to.

19 (WHEREUPON, the jury exited the courtroom at 4:34 p.m.)

20 THE COURT: Any objections from the plaintiff?

21 MR. RUFFIN: No, Your Honor, if that's how the charge  
22 reads.

23 THE COURT: Any objections from the defense?

24 MS. CRAIG: No, sir, Your Honor.

25 THE COURT: All right. You can tell them to begin. That

1 one juror needs to call her child again. Any objections to  
2 her making that phone call?

3 MR. RUFFIN: No, Your Honor.

4 MS. CRAIG: No, sir.

5 THE COURT: Does she have her phone with her?

6 THE BAILIFF: Do you want me to get her cell phone and go  
7 in there?

8 THE COURT: And tell the jury not to deliberate while  
9 she's gone.

10 THE BAILIFF: Okay.

11 THE COURT: And I guess go ahead and get the child. Let  
12 me know when she's made that call.

13 THE CLERK: Yes, sir.

14 (WHEREUPON, the two jury notes were marked as Court's  
15 Exhibit Number 25 and Court's Exhibit Number 26.)

16 (WHEREUPON, there was a break in the proceedings from  
17 4:34 p.m. until 6:09 p.m., after which the proceedings  
18 resumed as follows.)

19 THE COURT: All right. It's my understanding that we  
20 have a verdict and I've asked the lawyers to speak to both of  
21 the clients. And have you done that?

22 I just want to let you know again -- I want to emphasize  
23 that that jury has been here all week and they have a hard job  
24 to do. They're under a lot of pressure and they have to make  
25 a decision in this case. It may be good or bad. It may be

1 good or bad for you all. I don't know and I'm not asking you  
2 to agree with the verdict, but I need for you just to be cool,  
3 just to be calm, not to yell out if you're happy and not to  
4 show emotion if you're angry. Can y'all do that?

5 THE DEFENDANT: Yes, sir.

6 THE COURT: How about the mom? All right.

7 Now, if you don't do that, we're going to have problems  
8 in the court. When you leave the courthouse, you can do  
9 whatever you want, while this jury is here and while I'm here  
10 and everybody's here, we just need to be calm, just be a knot  
11 on a log. Okay?

12 She's nodding yes. Okay. Go ahead and bring in the  
13 jury.

14 (WHEREUPON, the jury entered the courtroom at 6:10 p.m.)

15 THE COURT: All right. Mr. Foreman, has the jury reached  
16 a verdict?

17 THE FOREMAN: Yes, sir.

18 THE COURT: If you would, hand it to the bailiff right  
19 there and she will hand it to me. Thank you.

20 All right. I find the verdict form in order. If you  
21 would, publish the verdict, please, ma'am.

22 VERDICT

23 THE CLERK: State of South Carolina, County of Florence,  
24 in the Court of Common Pleas for the 12th Judicial Circuit.  
25 Civil Action Case Number 2013-CP-21-690, Christy Byrd as next

1 friend of Julia B , a minor, plaintiffs, versus McLeod  
2 Physician Associates II and Dr. John B. Browning, defendants.

3 Did the defendants prove by a greater weight or  
4 preponderance of the evidence that the facts of this case did  
5 arise out of the genuine emergency situation where the patient  
6 is not medically stable and there is an immediate threat of  
7 death or serious bodily injury?

8 Yes.

9 Did defendant John -- Dr. John B. Browning act in a  
10 manner that was grossly negligent?

11 No.

12 I certify this decision was a unanimous decision of the  
13 jury. Signed, Malcolm Davenport, foreperson, May 20<sup>th</sup>, 2016.

14 THE COURT: All right. Is this your verdict? If so,  
15 raise your right hand?

16 (WHEREUPON, all jurors complied.)

17 THE COURT: All right. Any need for further polling from  
18 the plaintiff?

19 MR. GRAHAM: Yes, sir, Your Honor.

20 THE COURT: All right. If you would, poll the jury,  
21 please, ma'am.

22 THE CLERK: As I call your name, please stand and answer  
23 the question.

24 Mark Huber. Is this your verdict?

25 JUROR NUMBER 62: Yes.

1 THE CLERK: Is this still your true verdict?  
2 JUROR NUMBER 62: Yes.  
3 THE CLERK: Thank you. Sandra Fulton, please stand. Is  
4 this your verdict?  
5 JUROR NUMBER 45: Yes.  
6 THE CLERK: Is this still your true verdict?  
7 JUROR NUMBER 45: Yes..  
8 THE CLERK: Thank you. Cynthia Coward. Is this your  
9 verdict?  
10 JUROR NUMBER 30: Yes.  
11 THE CLERK: Is this still your true verdict?  
12 JUROR NUMBER 30: Yes.  
13 THE CLERK: Kelvin Jones Jr. Is this your verdict?  
14 JUROR NUMBER 71: Yes.  
15 THE CLERK: Is this still your true verdict?  
16 JUROR NUMBER 71: Yes.  
17 THE CLERK: Malcolm Davenport. Is this your verdict?  
18 JUROR NUMBER 34: Yes.  
19 THE CLERK: Is this still your true verdict?  
20 JUROR NUMBER 34: Yes.  
21 THE CLERK: Gearl Roberts. Is this your verdict?  
22 JUROR NUMBER 106: Yes.  
23 THE CLERK: Is this still your verdict -- true verdict?  
24 JUROR NUMBER 106: Yes.  
25 THE CLERK: Shanda Williams. Is this your verdict?



1 JUROR NUMBER 136: Yes.

2 THE CLERK: Is this still your true verdict?

3 JUROR NUMBER 136: Yes.

4 THE CLERK: Thank you. Sherlie Thompson. Is this your  
5 verdict?

6 JUROR NUMBER 121: Yes.

7 THE CLERK: Is this still your true verdict?

8 JUROR NUMBER 121: Yes.

9 THE CLERK: Thank you. Terica Austin. Is this your  
10 verdict?

11 JUROR NUMBER 3: Yes.

12 THE CLERK: Is this still your true verdict?

13 JUROR NUMBER 3: Yes.

14 THE CLERK: Danielle McCray. Is this your verdict?

15 JUROR NUMBER 82: Yes.

16 THE CLERK: Is this still your true verdict?

17 JUROR NUMBER 82: Yes.

18 THE CLERK: JC Godbolt. Is this your verdict?

19 JUROR NUMBER 51: Yes.

20 THE CLERK: Is this your true verdict still?

21 JUROR NUMBER 51: Yes.

22 THE CLERK: Brandon Gerald. Is this your verdict?

23 JUROR NUMBER 49: Yes.

24 THE CLERK: Is this still your true verdict?

25 JUROR NUMBER 49: Yes.

1 THE COURT: All right. Is that everybody?

2 THE CLERK: Yes, sir.

3 THE COURT: All right. Members of the jury, I want to  
4 thank you for your service this week. You have had a hard  
5 week and had a long week, but you have done your job. You are  
6 now dismissed and I thank you. Everybody else remained  
7 seated.

8 (WHEREUPON, the jury was released and exited the  
9 courtroom at 6:15 p.m.)

10 THE COURT: All right. Would the plaintiff like 10 days  
11 to file any post-trial motions?

12 MR. RUFFIN: We would, Your Honor.

13 THE COURT: All right. Thank you very much. All right.  
14 That concludes this trial. You all have a good weekend.

15 MS. GANES: Thank you, Your Honor.

16 THE COURT: Thank you.

17 (WHEREUPON, the proceedings ended at 6:16 p.m.)

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19 --- END REQUESTED TRANSCRIPT ---

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