

STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Michael J. Baxley, Circuit Court Judge

Case No.: 2007-CP-10-1553

Jamesetta Washington, as Guardian ad Litem for
Jayden W., a minor.....Appellants,

v.

Edmund Rhett, Jr., M.D., Low Country Obstetrics and Gynecology, P.A.; Tenant South
Carolina, Inc. d/b/a East Cooper Regional Medical Center and AMN Services, Inc. f/k/a
Nurses RX, Inc.....Defendants,

Of Whom Edmund Rhett, Jr., M.D. is.....Respondent.

RECORD ON APPEAL
VOLUME 6

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INDEX

VOLUME I

I. ORDERS:

A. Case Management Order – 10/20/09.....	1
B. Consent Order to Amend Summons and Complaint – 11/4/09	7
C. Order Dismissing AMN Services, Inc. – 3/2/10	13
D. Order Denying New Trial Absolute - 9/1/10	17
E. Order Approving Settlement – 12/2/11	19

II. PLEADINGS:

A. Summons and Complaint – 4/16/07.....	28
B. Answer of Edmund Rhett, Jr., M.D -5/16/07	37
C. Answer of Low Country Obstetrics and Gynecology, P.A. -5/21/07	43
D. Amended Summons and Complaint -5/23/07	47
E. Answer of Tenet S.C., Inc. d/b/a East Cooper Regional Medical Center -6/25/07	55
F. Amended Summons and Complaint – 11/4/09.....	62
G. Defendant Edmund Rhett, Jr., M.D.'s Answer to Plaintiff's Amended Complaint – 12/1/09.....	72
H. Answer of AMN Services, Inc. f/k/a Nurses RX Inc-12/2/09	79
I. Answer and Cross-Complaint of Defendant East Cooper Regional Medical Center to Plaintiff's Amended Complaint – 12/9/09	87
J. Answer of Defendant AMN Services, Inc., f/k/a Nurses, RX, Inc. to Cross-Claim – 1/5/10	96
K. Defendant Edmund Rhett, Jr. M.D.'s Notice of Motion and Motion to Amend Answer – 7/1/10	103
L. Plaintiff's Motion in <i>Limine</i> – 7/25/10.....	113
M. Plaintiff's Memorandum in Support of Her Motion in <i>Limine</i> to Strike Or Preclude Certain Testimony and Evidence- undated.....	116
N. Plaintiff's Memorandum in Support of Her Motion In <i>Limine</i> to Strike Or Preclude Certain Testimony and Evidence- 7/25/10.....	129
O. Plaintiff's Motion for New Trial Absolute -8/23/10.....	145
P. Plaintiff's Memorandum of Law In Support of Plaintiff's Motion New Trial Absolute- 8/23/10.....	146
 A. Pretrial Matters:	
1. <i>Voir Dire</i> and Jury Selection.....	169
2. Motions in <i>Limine</i> and Pretrial Motions.....	220
 B. Opening Statements:	
1. Opening Statement of Plaintiff.....	331
2. Opening Statement of Defendant Rhett.....	353

3. Opening Statement of Defendant Low Country OB-GYN.....	377

C. Testimony:

1. Gary Oakes

a. Direct Examination.....	291
b. Cross-Examination.....	589

VOLUME II

1. Gary Oakes continued

c. Redirect Examination.....	640
d. Re-Cross Examination.....	661

2. Michael Katz

a. Direct Examination.....	662
b. Cross-Examination.....	703
c. Redirect Examination.....	737

3. Jayden Washington

a. Direct Examination.....	684

4. Christine Delk

a. Direct Examination.....	748
b. Cross-Examination.....	776

5. Renee Washington

a. Direct Examination.....	778
b. Cross-Examination.....	786
c. Redirect Examination.....	786

6. Yvonne Gomez-Carrion (via video recording).....

793

7. Daniel Adler

a. Direct Examination.....	805
b. Cross-Examination.....	831
c. Redirect Examination.....	848
d. Re-Cross Examination.....	859

8. Robert Zimmerman

a. Direct Examination.....	866
b. Cross-Examination.....	902
c. Redirect Examination.....	923
d. Re-Cross Examination.....	929

9. Yvonne Gomez-Carrions (via video continued)

933

10. Marie Rentz	
a. Direct Examination.....	946
b. Cross-Examination.....	969
11. Jamesetta Washington	
a. Direct Examination.....	972

VOLUME III

11. Jamesetta Washington continued	
b. Cross-Examination.....	1011
12. James Washington	
a. Direct Examination.....	1013
13. Margaret Greer-Simmons	
a. Direct Examination.....	1041
b. Cross-Examination.....	1066
c. Redirect Examination.....	1076
14. Cynthia Gadson	
a. Cross-Examination.....	1084
15. Jean Hutchinson	
a. Direct Examination.....	1086
b. Cross-Examination.....	1100
c. Redirect Examination.....	1108
16. Kristen Pierolli	
a. Direct Examination.....	1115
b. Cross-Examination.....	1128
17. Robert Voogt	
a. Direct Examination.....	1129
b. Cross-Examination.....	1166
c. Redirect Examination.....	1178
18. Oliver Wood	
a. Direct Examination.....	1183
b. Cross-Examination.....	1203

19. Edmund Rhett	
a. Direct Examination.....	1221
b. Cross-Examination.....	1321
c. Redirect Examination.....	1456

20. Aubrey Milunsky	
a. Direct Examination.....	1463
b. Cross-Examination.....	1495

VOLUME IV

20. Aubrey Milunsky continued	
c. Redirect Examination.....	1536
d. Re-Cross Examination.....	1538

21. John Weinstein	
a. Direct Examination.....	1540
b. Cross-Examination.....	1579
c. Redirect Examination.....	1593
d. Re-Cross Examination.....	1597

22. Lynn Norton	
a. Direct Examination.....	1608
b. Cross-Examination.....	1668
c. Redirect Examination.....	1697

23. Peter Van Dorsten	
a. Direct Examination.....	1706
b. Cross-Examination.....	1753
c. Redirect Examination.....	1823
d. Re-Cross Examination.....	1832

24. John Hobbs	
a. Direct Examination.....	1123
b. Cross-Examination.....	1931
c. Redirect Examination.....	1947

25. Gary Oakes	
a. Direct Examination.....	1986

VOLUME V

25. Gary Oakes continued

b. Cross-Examination	2018
c. Redirect Examination	2029
d. Re-Cross Examination	2030

D. CLOSINGS:

1. Initial Closing Arguments of the Plaintiff.....	2078
2. Closing Argument of the Defendant Rhett.....	2127
3. Closing Argument of Defendant Low Country.....	2156
4. Final Closing Arguments of the Plaintiff.....	2158

E. JURY CHARGES:

1. Jury Instruction:	
a. Charge to the Jury by the Court.....	2172
b. Charge Requests.....	2193
c. Exceptions to the Charge.....	2226

F. VERDICT.....2270

G. POST TRIAL MOTIONS:

1. Motion for New Trial Absolute.....	2278
2. Defendant's Response to Motion for New Trial Absolute.....	2279

IV. DEPOSTION TRANSCRIPTS:

A. Transcript of Yvonne Gomez-Carrion	2282
B. Transcript of Barbara Burton De Bene Esse.....	2476

VOLUME VI

C. Transcript of Barbara Burton Rebuttal	2596
D. Transcript of Lynn Norton.....	2623
E. Transcript of Aubrey Milunsky.....	2723
F. Transcript of Edmund Rhett, Jr.....	2856

VOLUME VII

V. EXHIBITS:

Plaintiff's Exhibits:

A. Exhibit 1.....	3024
B. Exhibit 2.....	3110
C. Exhibit 4	3215
D. Exhibit 5	3279
E. Exhibit 27	3294
F. Exhibit 28	3308
G. Exhibit 31	3312
H. Exhibit 33	3320
I. Exhibit 34	3322
J. Exhibit 35	3325
K. Exhibit 36.....	3326
L. Exhibit 37	3328
M. Exhibit 73	3329
N. Exhibit 75 – VIDEOTAPE	N/A
O. Exhibit 97.....	3341
P. Exhibit 102	3342
Q. Exhibit 103	3499
R. Exhibit 107	3500

VOLUME VIII

S. Exhibit 109	3508
T. Exhibit 113	3519

Court's Exhibits:

U. Exhibit 4.....	3522
V. Exhibit 11.....	3525
W. Exhibit 13.....	3595
X. Exhibit 38	3600
Y. Exhibit 39	3606

VI. OTHER MATERIALS AND DOCUMENTS:

A. Towner Article – 12/2/99	3608
B. Plaintiff's Request for Voir Dire – 2/26/10	3614
C. Stipulation of Evidence – 7/15/10	3620

D. Jury Strike Sheet- undated	3626
E. Plaintiff's Request to Charge – undated	3643
F. Verdict Form – 8/13/10	3714
G. Affidavit of Mary Watters – 8/23/10	3716
H. Notice of Appeal – 9/24/10	3719
I. Certificate by Appellant- 2/1//13	3725

1 had suggested the possibility that perhaps the
2 patient had an underlying problem with blood
3 clotting and that maybe he had a blood disorder
4 whereby the blood didn't clot normally, and this
5 would be a way to screen for those types of
6 conditions, even though there was nothing in his
7 history to suggest a condition like that.

8 Q. What was the result of the test?

9 A. It was basically normal. The
10 significant test result is the INR, which was
11 completely normal. Every other test was normal.
12 One, the PTT was just one number above the upper
13 limit of normal, but that is not a significant
14 abnormality. So there was nothing in the test that
15 suggested that the patient had any problem with
16 blood clotting.

17 Q. Okay. And which part of this test did
18 you say is the most important?

19 A. Well, the most important with regard to
20 the clotting factors is the INR. The platelet
21 count, of course, is also important. That's
22 looking at something totally separate, in other
23 words, how many platelets do you have. They're
24 little cells in the blood stream that also, besides

1 these things called clotting factor, contribute to
2 how well your blood will clot. So platelets are
3 important and clotting factors, and the platelet
4 count was also normal.

5 Q. Okay. Would you please highlight the
6 normal findings as to the ones -- the portions of
7 this test that you consider to be significant.

8 A. Okay.

9 MR. GRAHAM: Thank you.

10 And we would offer Exhibits 2 through 6
11 into evidence at this time.

12 MS. SIMMONS: I object on lack of foundation,
13 and they were not properly authenticated.

14 BY MR. GRAHAM:

15 Q. Dr. Burton, in reviewing Exhibits 2
16 through 6, can you tell me whether they appear to
17 be true and accurate copies of the test results.

18 A. They do.

19 Q. Okay. And to whom were these test
20 results forwarded?

21 A. They were -- well, they were all
22 initially sent to me. Subsequently, I forwarded
23 the results on to your office.

24 Q. Thank you.

1 Do you have any reason to question the
2 accuracy of the information set forth on those
3 exhibits?

4 A. No.

5 MR. GRAHAM: Okay. We would again offer those
6 into evidence.

7 MS. SIMMONS: And I will renew my objection.
8 Thank you.

9 MR. SCOTT: Jim Scott here. I would enter the
10 same objection and in addition object to the
11 highlighted copies being admitted into evidence.

12 BY MR. GRAHAM:

13 Q. Doctor, as a result of your work on this
14 case, your knowledge, training, experience, review
15 of the medical records, review of the depositions
16 and other materials, your physical examination of
17 this child, and your review of the test results, do
18 you have an opinion to a reasonable degree of
19 medical certainty as to whether or not Jayden's
20 brain damage was caused in any way by any genetic
21 conditions or genetic factors?

22 MS. SIMMONS: Object to the form. Leading.

23 MR. GRAHAM: You may answer.
24

1 BY THE WITNESS:

2 A. Yes, I do.

3 BY MR. GRAHAM:

4 Q. What is your opinion, please?

5 A. I do not believe that there are -- there
6 is any underlying genetic disorder or any genetic
7 factors that either contributed to or caused his
8 developmental disabilities and neurologic
9 handicaps.

10 Q. Okay. Would you explain the basis for
11 that opinion, please, ma'am.

12 A. Well, the basis of that is my complete
13 evaluation of the patient. In other words, I took
14 into account everything I knew about his medical
15 history, all of the findings that I noted on
16 physical examination, and evaluated those in light
17 of my training and the fact that I've been doing
18 this for 33 years and evaluating children with
19 developmental disabilities to determine if they
20 have had an underlying genetic cause, and on the
21 basis of my assessment, I found no evidence that he
22 does.

23 Q. Do you have an opinion to a reasonable
24 degree of medical certainty as to the most probable

1 cause of Jayden Washington's brain damage,
2 developmental problems, motor deficits, and
3 cognitive deficits?

4 MS. SIMMONS: Object to the form. Leading and
5 outside of this expert's area of expertise.

6 MR. GRAHAM: You may answer, please.

7 BY THE WITNESS:

8 A. Yes, I do. I believe it was caused by
9 the damage to his brain from the hemorrhage he
10 experienced as a newborn.

11 BY MR. GRAHAM:

12 Q. Does Jayden have any individual traits
13 or individual variations that you would consider to
14 be a birth defect, and, if so, what would that be?

15 A. Yes, he does. He has a birth defect of
16 the eye called a coloboma involving one of his
17 eyes, the right eye.

18 Q. Okay. Let me stop you there, please,
19 ma'am.

20 What is a coloboma?

21 A. It's -- basically, the term coloboma
22 means cleft. As the eye is forming in the
23 developing baby, there is a portion in the back of
24 the eye called the fissure, the optic fissure,

1 which is like a crease or a cliff that, as the eye
2 develops, it closes and seals itself up, but
3 occasionally that does not happen completely.
4 There's a gap or an opening.

5 So in his case, it's involving the
6 retina. There's a little gap there, which is a
7 developmental birth defect of the eye.

8 Q. You mentioned that some birth defects
9 are major and some are minor.

10 How would you characterize Jayden's
11 coloboma?

12 A. Well, in general, I would say a coloboma
13 is a major birth defect in the sense that it can
14 significantly affect the function of the eye. I
15 think in Jayden's case, fortunately, it's a mild
16 form of a coloboma. It does not involve either the
17 optic nerve, the nerve that conducts the visual
18 signals back to the brain, or the macula, which is
19 where central vision is located. It's kind of far
20 to the side in the eye.

21 So one would predict that it might not
22 have a severe impact on vision, and that would
23 appear to be the case, from what I know about him
24 and what I've seen in his ophthalmologic exams.

1 Q. Do you know of any treatment that Jayden
2 needs for that condition?

3 A. Well, no, no specific treatment, you
4 know, nothing like surgery or -- or medication.
5 Sometimes kids get glasses, you know, that may help
6 if they have visual loss from coloboma, but nothing
7 beyond that.

8 Q. All right. Are you aware of any visual
9 loss that Jayden has from his coloboma?

10 A. No, I'm not.

11 Q. By the way, how many eyes are affected
12 by coloboma in Jayden's case? Is it both eyes or
13 just one?

14 A. No, it's just the right eye, just one
15 eye.

16 Q. What significance, if any, does it have
17 for your opinions that Jayden only has a coloboma
18 in the one eye?

19 A. Well, it does not really have any
20 significance with regard to, you know, whether this
21 is in any way related to his developmental
22 disabilities, which was the central theme of the
23 case as I understood it.

24 It certainly has relevance when we try

1 to figure out if the cause of the coloboma is
2 genetic or nongenetic, because the ones involving
3 both eyes almost always are genetically determined,
4 sometimes just as an isolated trait. In other
5 words, it doesn't mean that there is anything else
6 wrong with the child besides the colobomas, but it
7 does mean that they could pass them on to their
8 kids and so forth, but when it's just one eye, it's
9 much less likely to be genetically caused.

10 Q. Thank you.

11 Apart from the coloboma in the one eye,
12 does Jayden have any other individual variations
13 that you would consider to be a birth defect, and,
14 if so, what?

15 A. Well, he had an inguinal hernia on one
16 side, on the left side, which you would consider to
17 be a birth defect. The way that happens is that
18 when a little boy is developing as a fetus, the
19 testes start out inside the abdomen, and then
20 around 32 weeks of pregnancy, a couple months
21 before birth, they migrate down through a canal
22 into the scrotum, and, of course, that means there
23 has to be an opening between the abdomen and the
24 scrotum, this canal for them to get down there, and

1 then that closes off.

2 That canal typically close off, and if
3 that doesn't close off normally, then a hernia can
4 develop, which is just abdomen contents moving
5 their way into the inguinal area and sometimes all
6 the way into the scrotum. It causes a bulge in the
7 inguinal area.

8 And as part of that, very often, besides
9 other things from the abdomen intestines, you get
10 fluid, and that's something called a hydrocele, and
11 also the testes can kind of pop back and forth. It
12 has a way it can crawl back up into the abdomen or
13 up into the inguinal canal.

14 So in Jayden's case, he had the inguinal
15 hernia. His testis was descended on that side at
16 birth, but apparently by the time he had his hernia
17 repaired, it had kind of moved back on up and he
18 had fluid in there.

19 So that's one birth defect. He doesn't
20 have it any longer. Of course, it's been fixed.
21 It's very common in the general population,
22 somewhere between 2 to 3 percent of all babies have
23 an inguinal herb. That's one in every 35 to 40.

24 My son, actually, one of my sons had it

1 on both sides, and he's a totally normal
2 26-year-old now. So it's common, it's not serious,
3 but you would consider it a birth defect.

4 Q. Now, you mentioned something about fluid
5 collection. Does that have a name, and, if so,
6 what?

7 A. That's a hydrocele.

8 Q. Okay. So you've referred to inguinal
9 hernia, undescended testis, and hydrocele.

10 How many birth defects are involved in
11 that -- that listing of three?

12 A. That's one birth defect. The birth
13 defect is just the opening there, the fact that
14 that space didn't close off, and, you know, that
15 causes all three of those things. So that's not
16 three separate birth defects; that's one thing.

17 Q. Apart from the coloboma in one eye and
18 the inguinal hernia on one side, did Jayden have
19 any other birth defects?

20 A. No, he did not have any other birth
21 defects, and there are no others visible now on his
22 examination.

23 Q. What relationship, if any -- well,
24 strike that. Let me rephrase the question.

1 Do you have an opinion to a reasonable
2 degree of medical certainty as to whether or not
3 there's a relationship between Jayden's coloboma
4 and his brain damage and --

5 MS. SIMMONS: Object to the form.

6 BY MR. GRAHAM:

7 Q. And brain bleeds, and if so, what?

8 MS. SIMMONS: Object to the form.

9 BY THE WITNESS:

10 A. No, there's --

11 MS. SIMMONS: Go ahead and answer.

12 MR. GRAHAM: You can answer.

13 BY THE WITNESS:

14 A. No, there's no relationship whatsoever.

15 BY MR. GRAHAM:

16 Q. Similarly, do you have an opinion to a
17 reasonable degree of medical certainty as to
18 whether or not there's a relationship between
19 Jayden's inguinal hernia, hydrocele, and
20 undescended testis and his brain bleeds and brain
21 damage?

22 MS. SIMMONS: Object to the form.

23 BY THE WITNESS:

24 A. No, there's no relationship.

1 BY MR. GRAHAM:

2 Q. I believe you mentioned that we all have
3 individual variations.

4 Does Jayden have any significant
5 individual variations that you do not consider a
6 birth defect, and what would those be?

7 A. Really, no. He had quite a normal
8 physical examination from the standpoint of, you
9 know, his structure, how everything was developed.

10 There was a mention in the medical
11 records about him having very mild branch pulmonary
12 artery stenosis when he was a young infant. What
13 that means is one of the branches of the artery
14 that goes to the lungs was a little bit smaller
15 than normal, and as a result, a murmur was heard.
16 On follow-up with a cardiologist, I believe a year
17 or so later, they were perfectly normal. So that's
18 not a birth defect.

19 I mean, obviously, if you look around at
20 people, you know, one part of the body can be a
21 little bit smaller than another, and, you know, in
22 this case, you know, one artery was just a little
23 bit smaller. That's not a birth defect, and, in
24 fact, it was normal in size a year later when it

1 was reassessed.

2 So you could say maybe that's a little
3 individual variation, but certainly not a birth
4 defect, and really there was nothing else
5 that -- that I can recall.

6 Q. In his testimony, Dr. -- or in his
7 deposition testimony, Dr. Milunsky calls attention
8 to what he says are large ears and widely-spaced
9 nipples and things such as that.

10 What's your take on this child's ears
11 and nipples? What significance, if any, did you
12 see in your physical examination?

13 MS. SIMMONS: Object to the form. Compound.
14 Leading. And pitting the witnesses.

15 BY MR. GRAHAM:

16 Q. Dr. Burton, let me ask you, did you find
17 any significance at all to the size of Jayden's
18 ears?

19 A. No, not at all. His ears were perfectly
20 normal. I found no other abnormalities on physical
21 exam. Certainly, I looked for some of the things
22 that I had noticed mentioned in depositions or in
23 the records.

24 At one point early on at 14 months of

1 age, a physician had commented that there was both
2 low muscle tone and hyperextensible joints. So I
3 checked his joints. They were completely normal.
4 There was no joint hyperextensibility. His ears
5 were completely normal. His nipples were
6 completely normal.

7 Q. Thank you.

8 What is scoliosis?

9 A. Scoliosis is a curvature of the spine, a
10 side-to-side curvature.

11 Q. How does one diagnose scoliosis?

12 A. One can diagnose it on physical
13 examination. There's a number of things that we
14 look at. We -- I look and everyone looks to see if
15 the shoulders are at the same level when the
16 patient's standing straight. If one's lower, then
17 sometimes that means there's a curve in the spine.

18 We look to see if the shoulder blades
19 are level at -- you know, directly across. You can
20 have the patient bend over, and this is the way
21 they do it in schools when they do scoliosis
22 checks, bend forward and look to see if things are
23 perfectly level on both sides and if the individual
24 bones in the spine are lining up properly. And

1 then, of course, if you suspect scoliosis on your
2 clinical examination, x-rays can assist you in
3 determining, you know, how much curve there is.

4 Q. Does Jayden W. have scoliosis?

5 A. He does not have scoliosis, no.

6 Q. Okay. Can one diagnose scoliosis by
7 reviewing a photograph?

8 A. Well, sometimes you can, you know, see
9 that the spine looks very straight when the
10 patient's standing there, but it's difficult to
11 really do the kind of examination that you can do
12 when you have the patient in person, you know,
13 because if the child is slouching a little bit or
14 the photograph's taken from an unusual angle, it
15 can look like the spine curved when in reality you
16 get the child in front of you and you make sure
17 they're straight and you can see that that's not
18 the case.

19 Q. Thank you.

20 What is a connective tissue disorder?

21 A. The term connective tissue disorder
22 within the field of medical genetics is used to
23 refer to a group of conditions in which there's an
24 inherited difference in one of the chemicals that

1 makes up the connective tissue, which is the tissue
2 that kinds of holds everything together in the
3 body.

4 It's tissue in your skin, in the joints,
5 in blood vessel walls. So patients can be born
6 with a difference in the connective tissue, which
7 causes a variety of symptoms related to -- to that
8 difference.

9 Q. Does Jayden W. have connective
10 tissue disorder?

11 A. No. There's no evidence that he has any
12 type of connective tissue disorder. There are many
13 different types, but certainly he has no findings
14 that would be suggestive of any type of connective
15 tissue disorder.

16 Q. Do you have any special expertise in
17 that area, and, if so, please describe it.

18 A. I do. Throughout my career, I've seen
19 many patients with connective tissue disorders
20 because I -- well, I currently direct a clinic for
21 Marfan Syndrome and related connective tissue
22 disorders at Children's Memorial hospital, and I am
23 the consultant to the Connective Tissue Disorder
24 Clinic for Adults at Northwestern Memorial

1 Hospital.

2 In previous settings, I've also done the
3 same thing. I directed a connective tissue
4 disorder clinic at Michael Reese Hospital
5 previously, and going back to the time I was at
6 Wake Forest, I actually directed a clinic for
7 Marfan Syndrome and related connective tissue
8 disorders there as well.

9 Q. Well, you have mentioned Marfan
10 Syndrome. What is that?

11 A. Well, that's one specific connective
12 tissue disorder. It's the condition that people
13 speculate maybe Abraham Lincoln had. It's related
14 to a defect in one protein called fibrillin that's
15 in -- it's in the skeleton, it's in -- in bones,
16 it's in blood vessel wall, it's in the eye, in a
17 variety of different -- in the joints. So the
18 symptoms of that disorder affect many organ systems
19 in the body.

20 Q. Are you aware that Jayden's mother has
21 been diagnosed as having some conditions in her
22 back, such as vertebral anomalies and --
23 abnormalities and spina bifida occulta, and, if so,
24 what significance, if any, do you attribute to

1 that?

2 A. I am aware that she has abnormalities of
3 multiple vertebral bodies in the spine. Those are
4 the individual bones that make up the spine, and
5 also have -- has some rib anomalies. That may
6 suggested that she could have a genetic disorder
7 affecting the spine and the ribs, although it would
8 be a very mild form since those disorders usually
9 cause abnormal short stature and abnormal body
10 proportions, which she does not have, but
11 nonetheless, she clearly has been found to have
12 those bony abnormalities.

13 If -- if so, then it's possible that she
14 could have passed on similar abnormalities to
15 Jayden. I don't know whether he has had x-rays to
16 look at that or not, but whether or not that
17 occurred, it would not be related to the central
18 features of this case, because patients who have
19 that type of disorder don't have any cognitive
20 defects, they don't have any neurologic
21 abnormalities. It's a bone disorder.

22 Q. What do bone disorders have to do with
23 connective tissue disorder, if anything?

24 A. Really, nothing. It's a kind of a

1 separate category of genetic disorders. Bone
2 dysplasia, as we call it, abnormal formation of
3 bone, those patients don't have connective tissue
4 problems in the sense that they don't have loose
5 joints, they don't have wound healing problems,
6 they don't have any weakness of the blood vessels
7 causing them to stretch or dilate. And similarly,
8 connective tissue disorder patients don't have
9 those kinds of birth defects, typically, of the
10 spine or of the ribs.

11 Q. Did you see any evidence that Jayden
12 W had inherited any of his mother's spina
13 bifida or vertebral problems?

14 MS. SIMMONS: Object to the form.

15 BY MR. GRAHAM:

16 Q. And, if so, please describe them.

17 A. No, I didn't find any evidence that
18 that's the case. He was of normal height, normal
19 stature. His spine exam was completely normal.
20 Again, I can't rule out the possibility that he
21 could have abnormalities on x-ray, but they
22 wouldn't be relevant to the issues in this case.

23 Q. What is a bleeding abnormality or
24 coagulation disorder?

1 A. There are some inherited disorders by
2 which patients have increased risk of bleeding with
3 trauma because they don't make enough of one of the
4 factors in the blood that helps the blood clot or,
5 in some cases, because they don't have enough of
6 these little cells called platelets that also help
7 the blood clot.

8 Q. Do you have an opinion to a reasonable
9 degree of medical certainty as to whether or not
10 Jayden W has any bleeding abnormality or
11 coagulation disorder?

12 A. Yes. He has no evidence whatsoever for
13 such a disorder. He had no abnormal bleeding with
14 any of his surgical procedures, and that's a very
15 good test of how well your blood clots, if you have
16 surgery and you don't have any abnormal bleeding.

17 He also has no history of any
18 spontaneous bleeding episodes or any abnormal
19 bruising, really any symptoms that would suggest
20 that he had any sort of underlying bleeding
21 disorder.

22 Q. In the field of genetics, I've heard
23 reference to -- to something called dysmorphic
24 features. What does that phrase refer to?

1 A. That refers to really minor
2 abnormalities in how a person is developed so that
3 they look abnormal. They may not necessarily be
4 findings or features that cause functional defects.

5 So there can be dysmorphic facial
6 features, meaning that something about one of the
7 facial features has developed abnormally. Maybe
8 the ear is not shaped normally or maybe it's
9 positioned in the wrong place on the head. It
10 still works fine, that ear's hearings's good, but
11 it's an abnormality in how things look.

12 And you can have dysmorphic features
13 also in other parts of the body. Maybe, you know,
14 there can be abnormalities in the creases on the
15 palms of the hand. As geneticists, that's
16 something that we would look at because it can give
17 us a clue as to the diagnosis that something went
18 wrong developmentally. It doesn't affect how the
19 hand works, but it would be a dysmorphic feature,
20 or the creases on the fingers, things -- things
21 like that.

22 Q. Does Jayden W have any
23 dysmorphic features?

24 A. No, he doesn't.

1 Q. What is a genetic syndrome?

2 A. A genetic syndrome is a genetic disorder
3 that is associated with more than one finding, so a
4 collection or a package of different findings.
5 Maybe it's a collection of different birth defects,
6 but they're all ones that are related to one
7 another by having a single common cause.

8 Q. Do you have an opinion to a reasonable
9 degree of medical certainty as to whether or not
10 Jayden Washington has any genetic syndrome?

11 A. He definitely does not.

12 Q. From everything you've studied on this
13 case, your physical examination, your test results,
14 do you have an opinion as to whether or not there
15 is any genetic cause for Jayden W's brain
16 bleed?

17 MS. SIMMONS: Object to the form. Leading.

18 MR. GRAHAM: You may answer.

19 BY THE WITNESS:

20 A. Yes. I find no evidence for any genetic
21 cause as the origin of his brain bleed.

22 BY MR. GRAHAM:

23 Q. Is there any -- or do you have an
24 opinion to a reasonable degree of medical certainty

1 as to whether or not there's any genetic cause for
2 Jayden's need for brain surgery, stomach surgery,
3 and the other treatment modalities that he has had,
4 other than the inguinal hernia surgery?

5 MS. SIMMONS: Object to the form. Leading.
6 And beyond the scope of this expertise -- of this
7 witness' expertise.

8 MR. GRAHAM: You may answer.

9 BY THE WITNESS:

10 A. Absolutely. He has -- there's nothing
11 about Jayden to suggest that he has any kind of
12 underlying genetic disorder, other than potentially
13 the coloboma of the eye, which might or might not
14 be genetic in origin.

15 So, of course, there could be no genetic
16 reason why he needed to have brain surgery or
17 needed to have surgery for the reflux problem.

18 BY MR. GRAHAM:

19 Q. Have you had an opportunity to review
20 Jayden's life care plan?

21 A. Yes.

22 Q. Okay. Apart from any ophthalmology
23 evaluations that might relate to coloboma, do you
24 have any opinion to a reasonable degree of medical

1 certainty as to whether any of those treatment
2 recommendations are required because of genetic
3 conditions?

4 MS. SIMMONS: Object to the form.

5 MR. GRAHAM: You may answer.

6 BY THE WITNESS:

7 A. They are not required because of any
8 genetic conditions.

9 BY MR. GRAHAM:

10 Q. Is there any genetic explanation
11 for -- strike that.

12 We know that Jayden W- was
13 diagnosed with brain bleeds shortly after birth.

14 Do you have an opinion to a reasonable
15 degree of medical certainty as to whether there was
16 anything wrong with his blood vessels in his brain
17 that burst and caused that bleeding?

18 MS. SIMMONS: Object to the form. Leading.
19 And outside this witness' expertise.

20 BY THE WITNESS:

21 A. There was no evidence of anything wrong
22 with his blood vessels, no. I don't believe that
23 there was anything wrong with his blood vessels.
24

1 BY MR. GRAHAM:

2 Q. Are there any genetic syndromes or
3 genetic conditions that may cause blood vessels to
4 be more vulnerable to bleeds than an average
5 person's blood vessels, and, if so, what is that?

6 A. Well, there are. You could have a
7 vascular malformation, an actual birth defect of
8 how the blood vessels are formed in the brain.
9 That could do it, and that was looked for,
10 certainly, and there were specific comments in the
11 records that there was no such vascular
12 malformation in the brain.

13 It was mentioned in Dr. Milunsky's
14 deposition that connective tissue disorders can
15 cause problems with bleeding in the brain, and
16 there are some connective tissue disorders which
17 can be associated with the development of what are
18 called aneurisms in the brain, more commonly
19 elsewhere, but in some cases in the brain and in
20 several disorders over time, an aneurysm being an
21 area that's weakened and thinned out, kind of
22 ballooned out, and therefore more likely to
23 rupture.

24 But I have never in all the hundreds of

1 connective tissue disorder patients I have ever
2 seen heard of or seen that occurring in a neonate.
3 This is something that occurs later in life, and,
4 in fact, because that was brought up, I actually
5 bent to a Web site called PubMed that searches the
6 National Library of Medicine to see if I could even
7 find a single case of a patient with a connective
8 tissue disorder that had a neonatal hemorrhage, and
9 I could not identify a single one.

10 So I don't think that there is any
11 described connective tissue disorder or other
12 genetic disorder where the blood vessels look
13 normal, as they did in this case, that would
14 predispose a patient to a neonatal hemorrhage.

15 Q. Do you have an opinion to a reasonable
16 degree of medical certainty as to Jayden
17 Washington's life expectancy?

18 A. Yes. I see no reason to believe that it
19 would not be normal.

20 Q. Earlier, I asked you a question about
21 what you believe is the most probable cause of
22 Jayden W. 's brain damage, and there was an
23 objection on the basis that you lack sufficient
24 qualifications to address that topic.

1 I want to ask you, Dr. Burton, what
2 knowledge, training, and experience do you have
3 that would permit you to offer a learned, helpful
4 opinion to the jury about the most probable cause
5 of brain damage in this case?

6 MS. SIMMONS: Objection to the form.

7 MR. GRAHAM: You may answer.

8 BY THE WITNESS:

9 A. Well, one of the things that I do very
10 commonly in my practice and have done for 33 years
11 is evaluate children who have neurologic handicaps
12 and developmental disabilities. The parents come
13 in asking what is the cause of their child's
14 problem, is there an underlying genetic cause, is
15 it something that's likely to recur again if they
16 have other children, or a physician refers a
17 patient asking that question.

18 And in order to be able to do that, I
19 have to be able to differentiate genetic causes
20 from causes that are nongenetic, so I have to have
21 some familiarity with what other things I might
22 find in the patient's medical history or might
23 notice on physical exam that could cause those
24 kinds of handicaps, besides an underlying genetic

1 basis, and have to be able to distinguish between
2 them.

3 So this is something that I've been
4 involved in doing, really, throughout the course of
5 my training and my career.

6 BY MR. GRAHAM:

7 Q. Given that, is there any genetic cause
8 for Jayden W. 's brain bleeds, brain damage,
9 developmental problems, motor problems, or
10 cognitive impairments?

11 A. No, there is none.

12 Q. Do you have an opinion to a reasonable
13 degree of medical certainty as to the most probable
14 cause of Jayden's brain bleeds -- brain damage,
15 developmental problems, motor impairments, and
16 cognitive impairments?

17 MS. SIMMONS: Object to the form. Leading.

18 MR. GRAHAM: You may answer.

19 BY THE WITNESS:

20 A. I believe that the cause of his
21 cognitive impairments and neurologic handicaps is
22 the brain bleed or hemorrhage that he had in
23 infancy.
24

1 BY MR. GRAHAM:

2 Q. Thank you, Dr. Burton.

3 Have all of the opinions that you've
4 expressed today been opinions that you hold to a
5 reasonable degree of medical certainty most
6 probable?

7 A. Yes.

8 MR. GRAHAM: All right. Please answer any
9 questions that Ms. Simmons may have.

10 MS. SIMMONS: Off the record for a second.
11 Quick ladies room break.

12 THE VIDEOGRAPHER: Let me read it. Going off
13 the record at 3:39 p.m. This is the end of Tape 1.

14 (WHEREUPON, a recess was had.)

15 THE VIDEOGRAPHER: We are back on the record
16 at 3:49 p.m. This is the beginning of Tape 2.

17 CROSS EXAMINATION

18 BY MS. SIMMONS:

19 Q. Good afternoon, Dr. Burton.

20 A. Good afternoon.

21 Q. I'm Chilton Simmons, and we've met
22 before?

23 A. Correct.

24 Q. Dr. Burton, you have been serving as an

1 expert in legal cases for about 25 years now;
2 correct?

3 A. Yes.

4 Q. And, in fact, you've given about 60 or
5 70 depositions?

6 A. Yes, somewhere in that neighborhood.

7 Q. And most of the time, that's been in the
8 capacity as an expert in legal cases?

9 A. Yes.

10 Q. You've testified in medical malpractice
11 cases in Illinois, North Carolina, Virginia,
12 Florida, Pennsylvania, and New Jersey?

13 A. Yes.

14 Q. And you recently testified against a
15 pediatrician in a trial in South Carolina earlier
16 this year; didn't you?

17 A. By deposition, yes.

18 Q. And therefore you didn't attend that
19 trial; correct?

20 A. Correct.

21 Q. You gave a video deposition just like
22 this one?

23 A. I can't recall if it was videotaped, but
24 I definitely recall giving a deposition.

1 Q. And you were the plaintiff's expert in
2 that case suing that pediatrician?

3 A. Yes.

4 Q. In 2007, do you recall making about
5 \$50,000 from your legal expert work alone?

6 A. I don't recall that other than I
7 remember you had asked about that in my deposition
8 and said that I had at some point several years ago
9 calculated that. I don't have any reason to
10 dispute it, but I don't have any independent
11 recollection of that, and I haven't checked.

12 Q. And, Doctor, you charge \$350 an hour to
13 review cases; correct?

14 A. Yes.

15 Q. And \$500 an hour to give a deposition?

16 A. Correct.

17 Q. You totalled about nine hours of work
18 before you gave a deposition in this case?

19 A. Yes.

20 Q. And that means you got a check for about
21 \$3,150 for that work; true?

22 A. Yes.

23 Q. And since then, you have reviewed
24 records for another three or four hours?

1 A. Yes.

2 Q. And that would total another \$1,400?

3 A. Yes.

4 Q. And that doesn't include your time
5 today; true?

6 A. True.

7 Q. And you met with Mr. Graham privately
8 before your deposition today?

9 A. That's true.

10 Q. And then you would also be billing for
11 your time and deposition today as well?

12 A. Yes.

13 Q. Is it fair to say that you've made over
14 \$6,000 in relation to your work on this case?

15 A. Yes, that seems like that's going to be
16 correct.

17 Q. Dr. Burton, you performed four genetic
18 tests on Jayden; is that true?

19 A. I -- yes, I ordered four genetic tests.
20 I actually didn't perform any of them, but I
21 ordered them, yes.

22 Q. Thank you for the clarification.

23 And there are actually hundreds of other
24 genetic tests that can be done?

1 A. Yes.

2 Q. In fact, there are thousands of genetic
3 syndromes that do not have names or tests for them;
4 true?

5 A. I don't know if there are thousands, but
6 there are many.

7 Q. Would it be fair to say there are
8 hundreds?

9 A. Yes, that's probably fair.

10 Q. Is it fair to say that there are
11 thousands of genetic disorders, and there are only
12 tests for hundreds of them?

13 A. You know, I don't know exactly how many,
14 but I certainly could say that there are many
15 genetic disorders for which we currently don't have
16 tests. Certainly, new tests are being developed
17 every week.

18 Q. And just because Jayden didn't test
19 positive on the microarray test doesn't mean that
20 he doesn't have another genetic disorder that can
21 cause developmental delay; is that true?

22 MR. GRAHAM: Object to the form.

23 BY THE WITNESS:

24 A. Well, just the information of that one

1 test result doesn't mean that, it's the global
2 assessment, including assessment of his history and
3 physical and all of the test results that -- that
4 leads to that conclusion.

5 BY MS. SIMMONS:

6 Q. And looking at your -- at the results
7 from Jayden's microarray test, on the second
8 page --

9 A. Yes.

10 Q. -- let's see, the second full sentence
11 down. I am looking at that page.

12 A. Yes.

13 Q. It states, quote, "This test is not
14 intended to detect mosaicism. Normal results do
15 not rule out abnormalities of regions not
16 represented on the array, DNA sequence changes, or
17 other genetic etiologies."

18 Would you agree that there are certainly
19 many other genetic syndromes or mutations that
20 Jayden could have that would not be positive on
21 this test?

22 A. Well, certainly. There are many
23 other -- I don't think there are many others that
24 Jayden could have, but there are many others where

1 the result would not be positive on this test.

2 Q. And, Doctor, for the Fragile X test,
3 Jayden's blood was not drawn in Chicago for that;
4 was it?

5 A. No, it wasn't.

6 Q. In fact, he went to a lab in Charleston
7 for that?

8 A. In -- somewhere in South Carolina.

9 Q. And so you didn't have any part of
10 sending him to that lab or any supervision, any
11 involvement in his actually going, reporting to the
12 lab to get his blood drawn?

13 A. No, I haven't involved with that. I
14 ordered the test but certainly wasn't involved with
15 getting him to the lab.

16 Q. And the Fragile X does not always detect
17 the syndrome, is that true, does not always -- let
18 me rephrase that.

19 The Fragile X test that you ordered does
20 not always detected Fragile X in a person?

21 A. It essentially always does, yes, to the
22 extent that any laboratory test can. In other
23 words, there's human error that can occur, but it's
24 a very highly accurate test. It specifically tells

1 you yes or no, Fragile X Syndrome, in a male
2 particularly.

3 Q. And you would agree that there are a
4 significant enough children who have multiple birth
5 defects or even one birth defect where we do not
6 know the cause; isn't that right?

7 A. Yes, that's correct.

8 Q. In fact, 40 to 60 percent of congenital
9 disorders are of unknown cause; correct?

10 A. Well, there's a large percentage. I
11 think, you know, one could argue about what
12 percentage. Unfortunately, we're identifying more
13 and more causes all the time, but there's a
14 significant fraction for which the cause is not
15 known.

16 Q. And you agree that the genetic tests
17 that you performed on Jayden -- or, excuse me, that
18 you ordered on Jayden are a tiny fraction of the
19 genetic tests that can be done?

20 A. Yes.

21 Q. And you agree that the largest cause of
22 birth defects are genetic disorders?

23 A. Yes.

24 Q. And a genetic disorder means the child

1 is born with that disorder; true?

2 A. With a genetic disorder, you're born
3 with the disorder. You don't always have symptoms
4 or findings at birth. There are genetic disorders
5 that don't show up until adult life, but you're
6 always born with the information that says you're
7 going to have it.

8 Q. And, Dr. Burton, you describe genetics
9 as hereditary information; is that true?

10 A. The term "genetics" refers to the
11 hereditary information, yes.

12 Q. And therefore, in evaluating a patient
13 as a geneticist, it would certainly be important to
14 get information on the child's blood relatives;
15 true?

16 A. Yes.

17 Q. And the most important information of
18 his blood relatives would be his immediate
19 relatives, like his mother and father and then
20 grandparents. Would you agree with that?

21 A. Yes.

22 Q. When you met with Jayden's mother and
23 asked her questions about the family history, she
24 did not tell you that Jayden's father was adopted?

1 A. She did not tell me that. I didn't
2 specifically ask her that, but she did not offer
3 that information.

4 Q. So if she told you health information
5 about Jayden's father's adopted family, that would
6 be irrelevant since they are not blood relatives to
7 Jayden; is that fair?

8 A. Yes, that wouldn't be relevant.

9 Q. And, in fact, you never met with
10 Jayden's father?

11 A. Correct.

12 Q. You relied on what Jayden's mother told
13 you about Jayden's father's health?

14 A. Yes.

15 Q. And we don't know what Jayden's father's
16 medical condition is since he's incarcerated at the
17 United States Penitentiary in Tucson, Arizona; do
18 we?

19 MR. GRAHAM: Objection. Prejudicial. Minimal
20 relevance. Any minimal relevance is outweighed by
21 the prejudicial nature and is subject to our motion
22 in limine.

23 MS. SIMMONS: And the objection is noted, but
24 I will just repeat the question for the record.

1 BY MS. SIMMONS:

2 Q. Dr. Burton, we do not know what Jayden's
3 father's medical condition is since he's
4 incarcerated at the United States Penitentiary in
5 Tucson, Arizona; do we?

6 MR. GRAHAM: Same -- same objection.

7 BY THE WITNESS:

8 A. Well, the only information I have with
9 regard to the father's medical history is what was
10 reported to me by the mother.

11 BY MS. SIMMONS:

12 Q. And Jayden's mother didn't report to you
13 that he is in jail at the moment; correct?

14 MR. GRAHAM: Same objection.

15 BY THE WITNESS:

16 A. I was aware of that from, I believe,
17 reading her deposition, but it's not something we
18 discussed. She didn't report it, but I didn't ask
19 her about his whereabouts.

20 BY MS. SIMMONS:

21 Q. Thank you.

22 Dr. Burton, are you being sued in a
23 medical malpractice case now?

24 A. Yes.

1 Q. And does it involve allegations that you
2 provided inappropriate genetic counseling to a lady
3 with a child with Angelman's Syndrome?

4 A. Yes, it does.

5 Q. But in that case, you were not provided
6 the lab reports that gave you the necessary
7 information to advise her on the future risks of
8 having another child with Angelman's Syndrome?

9 A. That's correct.

10 Q. And, in fact, you relied on what the
11 telephone mother told you, that the test was
12 normal, and it turned out she was wrong; correct?

13 A. Yes, that's partly what I relied on.

14 Q. So that plaintiff is suing you for
15 telling her that she had a 25 percent chance of
16 having another child with Angelman's Syndrome
17 rather than a 50 percent chance?

18 A. Yes, that's correct.

19 Q. Doctor, who arranged for your
20 examination of Jayden?

21 A. Someone in Mr. Graham's office. I
22 believe it was Martha Pavelek.

23 Q. And where did you obtain Jayden's
24 previous medical records from?

1 A. From Mr. Graham's office.

2 Q. How much did you charge for your
3 examination of Jayden?

4 A. You know what? I don't know what the
5 exact charge is. I think it's in the neighborhood
6 of about \$900.

7 Q. And who paid for your examination of
8 Jayden?

9 A. Mr. Graham's office.

10 Q. Did you talk with any of Jayden's
11 current or past treating doctors?

12 A. No.

13 Q. Did any of Jayden's current treating
14 doctors request your genetic testing on Jayden?

15 A. No.

16 Q. Did you report your findings on Jayden
17 to any of his current treating doctors in South
18 Carolina?

19 A. No.

20 Q. Who did you report your findings to,
21 Doctor?

22 A. To Mr. Graham.

23 Q. Jayden and his mother traveled all the
24 way to Chicago to see you; correct?

1 A. Yes.

2 Q. And Mr. Graham's paralegal Martha went,
3 too?

4 A. I believe she did. Someone from his
5 office was there.

6 Q. And someone from Mr. Graham's office was
7 present during the entire encounter that you had
8 with Jayden and his mother?

9 A. Yes.

10 Q. Is Mr. Graham's paralegal Martha related
11 to Jayden?

12 A. Not that I know of.

13 Q. Do you know why she was there?

14 A. Well, I think she was helping the
15 patient get around, get to Chicago, accompanying
16 them to make the trip easier. That's the
17 assumption I made.

18 Q. Are there doctors in South Carolina with
19 the same qualifications as you?

20 A. There are. Certainly, there are
21 qualified clinical geneticists in South Carolina.

22 Q. Would you agree that you saw this child
23 for one hour at the request of their attorney,
24 Mr. Graham, in the presence of his paralegal solely

1 for the purposes of this lawsuit and nothing else?

2 A. Well, yes, it was for the purposes of a
3 genetic evaluation, but the purpose of that
4 evaluation had to do with this lawsuit.

5 Q. Thank you.

6 You relied on some information provided
7 from a Dr. Adler in New York City; correct?

8 A. I saw a report from Dr. Adler. I don't
9 believe I relied on any information in that report.

10 Q. If you testified in your deposition that
11 you relied on some measurements that he took of
12 Jayden's head, some weight, some other analyses
13 that he did, would you dispute that today?

14 A. Well, I don't -- I wouldn't dispute that
15 I had looked at those, but since I took my own
16 measurements of his head and his height and his
17 weight, you know, if I said that I relied on them,
18 I think that would have been a bad choice of words.

19 Q. Are you aware that Dr. Adler is an
20 expert hired by Plaintiff's attorney, Mr. Graham?

21 A. Yes.

22 Q. And are you aware Dr. Adler is an expert
23 paid by Plaintiff's attorney, Mr. Graham?

24 A. Yes.

1 Q. Dr. Burton, with regard to Jayden's
2 status now, is it your understanding that Jayden is
3 in regular classes getting some special help for
4 math and reading?

5 A. Yes.

6 Q. And this is what you learned from
7 Jayden's mother?

8 A. Correct.

9 Q. And at the time that you saw him, he was
10 scheduled to move on to first grade; is that
11 correct?

12 A. Yes, that was my understanding at the
13 time.

14 Q. And he was able to write his name, all
15 17 letters of Jayden W at that time; true?

16 A. I cannot recall.

17 Q. If you testified in your deposition that
18 he was able to do that, would you defer to that?

19 A. Sure. Yes. I mean, if I looked at my
20 notes, I might see that I wrote that down. I just
21 cannot recall as I sit here today.

22 Q. Do you recall that -- that you noted
23 that Jayden was able to recognize letters at that
24 time?

1 A. You know, would it be a good idea if I
2 actually pulled out those notes?

3 Q. Sure. Absolutely. Take your time.

4 A. Yes, I did note that he was able to
5 write his name and that he recognized letters.

6 Q. You classified Jayden's developmental
7 delays as relatively mild; is that correct?

8 A. Yes.

9 Q. And Jayden's IQ was mildly mentally
10 retarded or, in fact, borderline; is that correct?

11 A. Yes. He had some measurements in the
12 mildly mentally retarded range, others in the
13 borderline range.

14 Q. And you would agree "borderline" means
15 that it may be just outside of the mentally
16 retarded zone; is that correct?

17 A. Yes.

18 Q. You would agree that a person with
19 Jayden's IQ would certainly be employable in some
20 capacities in adulthood; correct?

21 A. Well, in some capacities, you know, if
22 you include in a sheltered workshop. I don't know
23 in his individual case what capacity, but many
24 mentally retarded individuals, you know, can earn

1 money through employment.

2 Q. As well as many borderline mentally
3 retarded individuals?

4 A. Yes.

5 Q. And are you aware that Jayden is
6 scheduled to move up to second grade on time in the
7 Charleston County school system?

8 A. No, I'm not aware of what's transpired
9 since my original evaluation.

10 Q. And you would agree that's a good sign
11 for Jayden's development; true?

12 A. No, I don't think I could make any
13 judgments one way or the other from that.

14 Q. The fact that he's moving up to second
15 grade as opposed to being held back to repeat?

16 A. Well, you know, repeating usually is not
17 very helpful. I mean, kids can move right on
18 through and graduate from special education in high
19 school and be significantly medically retarded.

20 So I don't think advancement a grade
21 necessarily gives us any information about what
22 their actual achievement or intellectual level is.
23 A child's not going to be held in the first grade
24 forever, you know. We don't find any 18-year-olds

1 in first grade.

2 Q. Dr. Burton, moving on to connective
3 tissue -- excuse me.

4 A. Excuse me.

5 Q. Certainly.

6 Moving on to connective tissue disorder.

7 A. Yes.

8 Q. You did not do the test to rule out that
9 Jayden has connective tissue disorder; did you?

10 A. There is no test that one can do to rule
11 out a connective tissue disorder. That's a
12 diagnosis that you would make based on physical
13 examination and history than for certain specific
14 connective tissue disorders. There would be DNA
15 testing that could be done, but there is no general
16 test for connective tissue disorders.

17 Q. So there is no test to diagnose or rule
18 out connective tissue disorder; is that true?

19 A. Not in a global sense. That's true.

20 Q. And connective tissue disorder can
21 interfere with the integrity of a person's blood
22 vessels; correct?

23 A. Yes. Some connective tissue disorders
24 interfere with the integrity of the blood vessels.

1 Q. And some connective tissue disorders can
2 make the blood vessels weaker, for lack of a more
3 medical term?

4 A. Yes. Yes.

5 Q. And connective tissue disorders can be
6 genetic, or they can be nongenetic; true?

7 A. Yes. The types of connective tissue
8 disorders that we're discussing are typically
9 genetic.

10 Q. And you agree that findings of
11 hyperextensible joints are signs of connective
12 tissue disorder?

13 A. That would be one sign of a connective
14 tissue disorder.

15 Q. Doctor, you have no opinions on what
16 caused Jayden's hemorrhages; agreed?

17 A. Right. I don't have an opinion on that.

18 Q. And you didn't review Jayden's MRIs,
19 x-rays, or ultrasounds?

20 A. No, not the actual films. I reviewed
21 the reports but not the actual films themselves.

22 Q. And the reports are drafted by the
23 physicians that interpret those tests; is that
24 correct?

1 A. Yes.

2 Q. The physician in that particular
3 specialty?

4 A. Yes.

5 Q. You have no opinions about whether
6 Jayden has DIC?

7 A. Well, he certainly doesn't have DIC now.

8 Q. Would you dispute that he had it as an
9 infant?

10 A. I can't dispute whether he ever had it
11 as an infant. I -- I found no evidence that he had
12 it at birth or at the time that he went to surgery
13 for his brain bleed, but I can't comment on any
14 other time in infancy. It -- yeah, can't comment.

15 Q. At the time of your deposition, you did
16 not recall what the elements of CHARGE stood for;
17 is that true?

18 A. True. I recall what the elements of
19 charge are but just not which ones are specifically
20 attached to each letter.

21 Q. Okay. And so CHARGE is actually a -- I
22 can't remember the word now, but each letter
23 represents another word; is that fair.

24 A. Right. Exactly. Yeah.

1 Q. So, for example, for CHARGE, the "C"
2 represents coloboma?

3 A. Yes.

4 Q. Which Jayden has?

5 A. Yes.

6 Q. The "H" represents heart defects?

7 A. Yes.

8 Q. The "A" represents atresia?

9 A. Of the choana, of the nose, which he
10 does not have.

11 Q. And "R" represents retardation of growth
12 and development?

13 A. Correct.

14 Q. Which Jayden has?

15 A. He does not have any retardation of
16 growth certainly. He has retardation of
17 development.

18 Q. And "G" represents genital or urinary
19 abnormalities?

20 A. Yes.

21 Q. You would agree that a hydrocele and
22 inguinal hernia and/or an undescended testicle
23 are examples -- or are examples of a genital
24 abnormality?

1 A. Well, in the very broad sense you could
2 call that an genital abnormality. It's not the
3 type of genital abnormality that we see in CHARGE
4 Syndrome.

5 Q. And the last "E" in charge is for ear
6 abnormalities; true?

7 A. Right. It's for ear malformations
8 and/or hearing loss.

9 Q. And Jayden has what's called
10 cholesteatoma, which is an ear abnormality; true?

11 A. It's not an ear malformation or hearing
12 loss. It's not the type of ear abnormality that we
13 see in CHARGE.

14 Q. You didn't even suspect CHARGE Syndrome,
15 but yet you felt compelled to do the test to rule
16 it out; true?

17 A. I didn't feel compelled to do it. I
18 felt like it was a good idea since I knew that this
19 was a case that was in litigation, because if one
20 looks for the genetic disorders most commonly
21 associated with coloboma, the first is chromosome
22 abnormalities, which were certainly ruled out with
23 the chromosome analysis and microarray, but that's
24 by far the most common, and then the next most

1 common is CHARGE.

2 Q. And the test for charge is called the
3 CHD7 gene test; is that right?

4 A. Yes.

5 Q. But not all people who suffer from
6 CHARGE test positive for it on this test; is that
7 fair?

8 A. That's correct.

9 Q. In fact, 35 percent of the patients that
10 have charge do not test positive on that test?

11 A. Correct.

12 Q. And CHARGE Syndrome is associated with
13 developmental delay?

14 A. Yes, it is.

15 Q. And Jayden does have some developmental
16 delay?

17 A. Yes.

18 Q. Do you agree that Jayden has a narrow or
19 completely absent transverse sinus of the brain?

20 A. I don't have an opinion about that.

21 Q. So is it fair to say you did not review
22 his medical records that state that he is -- that
23 he has a narrow or completely missing transverse
24 sinus of the brain?

1 MR. GRAHAM: Objection. It's a
2 mischaracterization of the -- an old report. Could
3 we have the reference that you're making, please,
4 for the witness' edification. You're asking a
5 question based on the record. I think in fairness
6 you should provide it to her.

7 MS. SIMMONS: Well, I don't have the record
8 with me, but I'm happy to ask her questions about
9 it, and she can answer that she doesn't know if she
10 doesn't know.

11 MR. GRAHAM: All right. I object to the
12 question for the reason stated earlier and your
13 failure to provide her with the language in context
14 to which you refer inaccurately.

15 BY THE WITNESS:

16 A. Well, let me just say here that I -- I
17 recall -- I don't recall whether I saw that
18 specific reference in reviewing the records. I do
19 recall a comment -- I believe it was by one of the
20 neurosurgeons -- that they had evaluated the
21 sinuses and found no underlying abnormalities.

22 So I think that probably, you know, led
23 to my impression and belief that there was no
24 underlying abnormality, whether or not I had seen

1 that previous reference, and I just don't recall
2 whether I did or not.

3 BY MS. SIMMONS:

4 Q. You did review the reports of Jayden's
5 MRIs and MRA; is that fair?

6 A. Yes.

7 Q. And I don't have the MRI with me today
8 here in Chicago, but if Jayden's MRI, if one of the
9 results was that he has a narrow or completely
10 missing transverse sinus of the brain, would you
11 agree that that is a defect or abnormality?

12 MR. GRAHAM: Same objections.

13 BY THE WITNESS:

14 A. If he has that, that's an abnormality.
15 My understanding from reviewing other records was
16 that he does not have that.

17 BY MS. SIMMONS:

18 Q. Thank you.

19 And if he does have a narrow or missing
20 transverse sinus of the brain, would you agree that
21 Jayden's birth process would not cause that?

22 MR. GRAHAM: Same objections plus lack of
23 relevancy.

24

1 BY THE WITNESS:

2 A. I don't believe anything having to do
3 with the birth process would cause that in a
4 patient who has that.

5 BY MS. SIMMONS:

6 Q. Okay. Thank you.

7 And you would agree that Dr. Rhett
8 wouldn't have caused that, if, indeed, Jayden has
9 that?

10 MR. GRAHAM: Same objections.

11 BY THE WITNESS:

12 A. Right, that -- he would not have caused
13 it.

14 BY MS. SIMMONS:

15 Q. Dr. Burton, you are not an OB/GYN?

16 A. Correct.

17 Q. You're not a neurologist?

18 A. That's correct.

19 Q. You are not a neonatologist?

20 A. Correct.

21 Q. You are not here today to say anything
22 that Dr. Rhett did or did not do caused injuries to
23 Jayden W ; would you agree?

24 A. I would agree.

1 Q. In fact, you've never even talked with
2 Dr. Rhett?

3 A. No, I haven't.

4 Q. You have no opinions about whether
5 Dr. Rhett should have had used the vacuum to
6 assisted in delivering Jayden?

7 A. No, I don't have an opinion about that.

8 Q. You do not read fetal heart monitor
9 strips; do you?

10 A. No.

11 Q. You do not know if Jayden's fetal heart
12 monitor strip showed he was in distress before
13 being delivered?

14 A. No, I don't know that.

15 Q. You do not know if there was a reason to
16 quicken or hasten Jayden's delivery; do you?

17 A. No.

18 Q. You don't know if Jayden suffered brain
19 damage while in the uterus; do you?

20 A. No.

21 Q. You're not the doctor that makes the
22 decision to deliver a baby in the face of bad fetal
23 heart monitor strips; are you?

24 A. No, I'm not.

1 Q. And in this case, Dr. Rhett evaluated
2 Jayden's fetal heart monitor strips and delivered
3 him as quickly and safely as possible do you agree?

4 MR. GRAHAM: Object to the form.

5 BY THE WITNESS:

6 A. No, I don't have an opinion on that.

7 BY MS. SIMMONS:

8 Q. Dr. Rhett did not cause Jayden's
9 bilateral hydroceles; agree?

10 A. Yes, he would not cause hydroceles.
11 I don't recall that Jayden had bilateral
12 hydroceles, but if he did, Dr. Rhett would not have
13 caused them.

14 Q. Or if he had one hydrocele, Dr. Rhett
15 would not have caused that?

16 A. No.

17 Q. And Dr. Rhett did not cause his
18 undescended testes; agree?

19 A. No.

20 Q. Dr. Rhett did not cause his inguinal
21 hernia?

22 A. Correct, he did not cause that.

23 Q. Dr. Rhett did not cause his coloboma?

24 A. Correct.

1 Q. Dr. Rhett did not cause his congenital
2 cholesteatoma, or ear abnormality?

3 A. Correct.

4 Q. Dr. Rhett does not cause Jayden's
5 diagnosed DIC?

6 MR. GRAHAM: Objection.

7 BY THE WITNESS:

8 A. I don't have an opinion about that.

9 BY MS. SIMMONS:

10 Q. If Jayden had DIC at any time, would
11 Dr. Rhett have caused that?

12 A. I don't have an opinion about that.

13 Q. Okay. Did Dr. Rhett cause Jayden's
14 reflux and GERD issues, or GI issues?

15 A. I don't have an opinion about
16 Dr. Rhett's care of the patient, so I can't really
17 comment on whether any aspect of his care was
18 responsible for any of the symptoms or handicaps
19 that he later experienced.

20 Q. Could Dr. Rhett or the birth process
21 have caused Jayden's pulmonary artery branch
22 stenosis?

23 MR. GRAHAM: Objection.
24

1 BY THE WITNESS:

2 A. Well, since that's just normal
3 variation, his artery was a little bit smaller.
4 You know, I don't think it's necessary to think
5 about anything that would have caused it. I mean,
6 it's not -- there was no problem, so, I mean, I
7 don't think anything he did had anything to do with
8 his pulmonary arteries and their size.

9 BY MS. SIMMONS:

10 Q. And -- thank you.

11 And did Dr. Rhett or the birth process,
12 could that have caused Jayden's heart murmur?

13 A. I don't believe so, no.

14 Q. Dr. Burton, you agree that even if the
15 vacuum did cause Jayden's hemorrhages, that does
16 not mean that Dr. Rhett committed medical
17 malpractice?

18 A. I don't have any opinion about
19 whether Dr. Rhett committed medical malpractice.

20 Q. You would agree that a patient can get a
21 bad or a negative resulted, but that does not mean
22 that the doctor was negligent necessarily?

23 A. Yes, I agree.

24 Q. Doctors cannot prevent genetic disorders

1 from occurring; can they?

2 A. They can advise patients in some cases
3 of ways to prevented genetic disorders, but they
4 can't independently prevented them from occurring.

5 Q. Because the patient -- that's something
6 that's in the -- in the person's genes; right?

7 A. Yes.

8 Q. Okay. And that happens on conception?

9 A. Yes.

10 Q. Thank you.

11 Doctors cannot prevent genetic
12 abnormalities from occurring, or birth defects;
13 true?

14 A. True.

15 Q. You don't deliver babies?

16 A. Correct.

17 Q. You don't read fetal heart monitor
18 strips?

19 A. That's correct.

20 Q. You don't interpret fetal heart monitor
21 strips?

22 A. Correct.

23 Q. You have no opinions whatsoever on
24 whether Dr. Rhett should have used the vacuum to

1 quicken Jayden's delivery?

2 A. No, I don't have an opinion on that.

3 Q. Dr. Burton, from your one-hour exam of
4 Jayden and your four genetic tests chosen out of
5 one-hundreds of tests, you conclude that there is
6 no genetic cause of Jayden's developmental delays;
7 is that true?

8 A. True.

9 Q. And you are not here to tell this jury
10 that Dr. Rhett did anything wrong or deviated from
11 the standard of care in his care and treatment of
12 Jayden and his mother, Ms. Washington; true?

13 A. I do not have any opinions with regard
14 to Dr. Rhett's care of Ms. Washington.

15 MS. SIMMONS: Thank you. I have no further
16 questions at this time.

17 MR. SCOTT: No questions from Jim Scott.

18 REDIRECT EXAMINATION

19 BY MR. GRAHAM:

20 Q. Dr. Burton, there were a number of
21 questions posed to you about hundreds or thousands
22 of tests that you chose not to order.

23 Have you ever had a patient in which you
24 ordered every available test?

1 A. Well, of course not, because that would
2 be completely inappropriate. Many of those
3 individual tests are for certain very specific
4 conditions that are obvious on physical exam.
5 There are genetic skin conditions, for example,
6 where, depending on what the skin condition is,
7 there would be a different genetic test.

8 So, actually, what was done in Jayden
9 are the most commonly used genetic tests. If you
10 added up the total number of genetic tests done in
11 this country every year, you'd probably find that
12 95 percent of them are accounted for by chromosome
13 analysis and microarray and Fragile X, so that
14 these are very commonly done tests that assess a
15 large portion of an individual's genetic make-up.

16 Tests for individual genes that we would
17 do in a specific situation, let's say a child has
18 sickle cell disease or cystic fibrosis, it would
19 clearly be very inappropriate in a case like this.
20 So there's -- there's no situation where you would
21 do every genetic test.

22 Q. What does it mean for there to be a
23 medical indication for a genetic test?

24 A. Well, it means that there's at least a

1 small possibility that the test -- the condition
2 you're testing for could explain the clinical
3 problems that you see in the patient.

4 So just as is true in every field of
5 medicine, your evaluation of the patient starts
6 with the history and physical examination, and then
7 you select which tests are appropriate given what
8 you see in the patient.

9 Q. With regard to the hundreds or thousands
10 of tests that you did not order in this case, how
11 many of those were medically indicated for Jayden
12 Washington?

13 A. None.

14 Q. Did you order every single test that was
15 appropriate in his case?

16 A. Yes.

17 Q. There was a question about what genetic
18 significance, if any, there might be to the fact
19 that Jayden's biological father was adopted.

20 Is this the first case in which you've
21 been asked to do a genetics workup on a patient who
22 has an adopted parent?

23 A. Well, of course not. Sometimes we do a
24 genetic evaluation on a child who's adopted, and

1 sometimes in those cases we don't have any
2 information about the family history, and we have
3 to work with the information that we do have
4 available. And, of course, it's not uncommon to
5 have an adopted parent either.

6 Q. Okay. What effect, if any, does it have
7 on your opinions that Jayden's biological father
8 was adopted?

9 MS. SIMMONS: Object to the form.

10 BY THE WITNESS:

11 A. It does not have any impact on my
12 opinions.

13 BY MR. GRAHAM:

14 Q. Does it change your opinions in any way?

15 A. No.

16 Q. Thank you.

17 Now, there was a question about Martha
18 Pavelek from my office traveling with Jamesetta and
19 Jayden for a visit here to your -- here to Chicago
20 for a visit with you. During your answer to one of
21 Ms. Simmons' questions, you indicated that Martha
22 was present during the encounter.

23 My question for you is by that, did you
24 mean that Martha was present in your office or that

1 she was actually present while you were examining
2 the patient and talking to his mother?

3 A. She was present, I believe, when I was
4 examining the patient and talking with his mother.
5 She did not participate in any way. She didn't,
6 you know, ask or answer any questions, and she
7 didn't participate in the examination at all.

8 Q. Okay. What effect, if any, did Martha
9 Pavelek's presence during that encounter have on
10 your work in the case or the opinions that you
11 formulated?

12 A. None. No effect.

13 Q. Have you encountered situations before
14 where patients who needed to travel to Chicago for
15 an exam were not comfortable flying in an airplane
16 without an experienced flier?

17 MS. SIMMONS: Object to the form. Leading.

18 BY THE WITNESS:

19 A. Oh, I've had all kinds of reasons why
20 patients would have other people with them. It
21 might be that. It might be they don't know how to
22 drive. It might be they don't know their way
23 around. So it's not unusual for me to have
24 patients bring with them friends, relatives, other

1 individuals, sometimes caretakers. You know, a
2 whole host of different people might be with the
3 patient.

4 BY MR. GRAHAM:

5 Q. There were a host of questions about
6 fees that you charge for your work as an expert and
7 bills that I have paid you for your work as an
8 expert.

9 How do the charges that you made to me
10 compare to the charges that you make to other
11 attorneys in similar cases?

12 MS. SIMMONS: Object to the form. Leading.

13 BY THE WITNESS:

14 A. Well, they're exactly the same. The
15 charges are the same no matter which attorney is
16 involved.

17 BY MR. GRAHAM:

18 Q. Do you limit your work to assisting
19 lawyers who are representing children allegedly
20 injured by medical negligence, or do you also
21 sometimes work on behalf of the doctor who was
22 accused of injuring a child through medical
23 negligence?

24 MS. SIMMONS: Object to the form. Leading.

1 BY MR. GRAHAM:

2 Q. And, if so, please describe that ratio.

3 MS. SIMMONS: Objection noted.

4 BY THE WITNESS:

5 A. I would say about half of the time, I am
6 work with an attorney who's representing someone
7 who alleges injury, and about half of the time, it
8 would be a defense attorney representing a doctor
9 or a hospital.

10 BY MR. GRAHAM:

11 Q. And what impact does it have on the fees
12 that you charge or the work that you do whether
13 you're asked to get involved on behalf of the
14 attorney for the baby or the attorney for the
15 doctor?

16 MS. SIMMONS: Objection.

17 BY THE WITNESS:

18 A. Well, the work that I would do would be
19 exactly the same in any case regardless of who
20 asked me to do it, and the fees, of course, would
21 be exactly the same.

22 BY MR. GRAHAM:

23 Q. And what effect does the fact that
24 you're being paid for your work on a case have on

1 the opinions that you have reached?

2 A. Well, it has no effect. You know, I'm
3 paid because evaluating a case like this takes time
4 away from my practice, which would be generating
5 income in other ways.

6 Q. There were a number of questions about
7 certain conditions and whether or not Dr. Rhett
8 had, in your opinion, caused those conditions.

9 You're not an obstetrician; correct?

10 A. Correct.

11 Q. You're not involved in this case to say
12 what the rules are for obstetricians; are you?

13 A. Absolutely not, no.

14 Q. You're not here to indicate whether or
15 not Dr. Rhett broke the rules for obstetricians,
16 because you're not an obstetrician; correct?

17 A. That's correct.

18 Q. But you are here to give opinions about
19 genetic issues?

20 A. Yes.

21 Q. And about causation?

22 MS. SIMMONS: Object to the form.

23 BY MR. GRAHAM:

24 Q. One subject that Ms. Simmons asked you

1 about repeatedly was CHARGE Syndrome?

2 A. Yes.

3 Q. How confident are you that Jayden does
4 not have CHARGE Syndrome?

5 A. I'm extremely confident that that's the
6 case. He clearly does not have CHARGE Syndrome.
7 I've seen many patients with CHARGE Syndrome. We
8 have three in the hospital right now. He does not
9 in any way, shape, or form meet the criteria for a
10 patient with CHARGE Syndrome.

11 Q. How confident are you that Jayden did
12 not have any genetic condition or factor that
13 caused his brain bleeds?

14 A. I am very confident about that as well.
15 Certainly, with a reasonable degree of medical
16 certainty, I can say that he surely did not have
17 any genetic condition that contributed to the cause
18 of his brain bleed.

19 Q. Ms. Simmons asked you a question about
20 connective tissue disorder that might have an
21 effect of weakening blood vessels.

22 Do you have an opinion to a reasonable
23 degree of medical certainty as to whether or not
24 Jayden has any such connective tissue disorder?

1 A. He has no evidence -- there's no
2 evidence that he has any type of connective tissue
3 disorder at all.

4 Q. Do you have an opinion to a reasonable
5 degree of medical certainty as to whether there was
6 anything going on in Jayden W 's brain
7 prior to the application of the vacuum in this case
8 that in any way jeopardized the well-being of his
9 brain?

10 MS. SIMMONS: Object to the form.

11 BY THE WITNESS:

12 A. No, there's no evidence that there was
13 anything going on prior to that time.

14 BY MR. GRAHAM:

15 Q. Do you have an opinion to a reasonable
16 degree of medical certainty as to the most probable
17 cause of Jayden's brain bleed, brain damage,
18 developmental problems, cognitive and motor
19 impairments?

20 A. I believe that his hemorrhage in the
21 newborn period, his brain bleed, is the cause of
22 his developmental problems, his cognitive problems,
23 his motor problems, his various neurologic
24 handicaps.

1 Q. And do you hold that opinion and the
2 other opinions that you have expressed today to at
3 least a reasonable degree of medical certainty?

4 A. Yes.

5 MR. GRAHAM: Thank you. No further questions.

6 RECROSS EXAMINATION

7 BY MS. SIMMONS:

8 Q. I do have a few follow-up questions.

9 A. Okay.

10 Q. Dr. Burton --

11 MR. GRAHAM: Excuse me. For the record, I am
12 going to object to any further questioning.

13 MS. SIMMONS: Certainly, and I'll limit it --

14 MR. GRAHAM: I think that the judge would stop
15 us now.

16 MS. SIMMONS: Well, I will limit it to the
17 scope of your redirect.

18 BY MS. SIMMONS:

19 Q. Dr. Burton, isn't having more
20 information on the health history of a blood
21 relative, particularly a parent, helpful in
22 determining what test to order for a patient in a
23 genetic evaluation?

24 MR. GRAHAM: Same objection I made earlier.

1 BY THE WITNESS:

2 A. Well, there are examples of situations
3 where that would be the case, if there are specific
4 abnormal findings.

5 BY MS. SIMMONS:

6 Q. But you would agree generally speaking
7 the more information you have on a patient's blood
8 relatives, particularly the parents, the more
9 helpful it is?

10 A. Sure, the --

11 MR. GRAHAM: Same objection.

12 BY THE WITNESS:

13 A. The more information, the better.

14 BY MS. SIMMONS:

15 Q. Thank you.

16 And turning briefly to the test results,
17 Doctor, I think you have them in front of you.

18 A. Okay.

19 Q. Thank you.

20 Looking at the Fragile X test, if you
21 would go to that first.

22 A. Okay.

23 Q. Second paragraph, last sentence,
24 starting with "Exceptions can occur," do you see

1 that?

2 A. I'm sorry. The --

3 Q. I'm look at that sentence right there.

4 A. Yes.

5 Q. If you would read that into the record,
6 please, ma'am.

7 A. "Exceptions can occur as there are rare
8 forms of FMRP deficiency not caused by CGG
9 expansion, which may not be detected by this
10 analysis."

11 MR. GRAHAM: Excuse me. I am going to state
12 an objection to all of this. I don't think it's
13 responsive to anything I asked in redirect.

14 MS. SIMMONS: Your objection's noted for
15 record.

16 BY MS. SIMMONS:

17 Q. If you would just highlight that
18 sentence for me on the exhibit.

19 MR. GRAHAM: And I'm going to object to that.
20 This whole line of questioning is improper.

21 Please don't highlight it yet.

22 THE WITNESS: Okay.

23 MR. GRAHAM: Is that one that has other
24 highlighting on it?

1 THE WITNESS: Yes.

2 MR. GRAHAM: All right. I would ask that if
3 there is to be any highlighting, it be done on a
4 separate sheet so that it doesn't mar the exhibit
5 that we have.

6 THE WITNESS: Unfortunately, I already
7 highlighted a few words here.

8 MR. GRAHAM: Okay. May we -- among counsel,
9 may we agree to recreate that as it was before the
10 last marking? Jim?

11 MR. SCOTT: Yeah. I mean, you want to
12 recreate the original exhibit and then one with
13 Chilton's addition so we can take this up at trial?

14 MR. GRAHAM: Yeah. That's what I'm suggesting
15 that we have it two ways --

16 MR. SCOTT: I don't have any objection to
17 that.

18 MR. GRAHAM: We have it two ways, we will let
19 the judge rule, and then we will have a clean copy
20 whichever way he rules.

21 MS. SIMMONS: That's fine. So I will go ahead
22 and mark as Defendant's 1 my copy of the Fragile X
23 test.

24 MR. GRAHAM: What now?

1 MS. SIMMONS: I'm going to mark my copy with
2 the sentence that I want highlighted. You've
3 already had her highlight the parts that you want
4 highlighted, so I am going to --

5 MR. GRAHAM: Okay. Well, I want to get a
6 clean copy of the one that we highlighted before
7 you instructed her to change or add to the
8 highlighting. That's my point.

9 MS. SIMMONS: Sure. And you can do that
10 whatever you want on your own time, but I don't
11 have a clean copy to give to you for you to do
12 that. So you can do that later, but in the
13 meantime, I would like to finish my cross.

14 MR. GRAHAM: Okay. I object to the exhibit
15 for the same reasons I've stated.

16 MS. SIMMONS: Defendant's 1, please.

17 (WHEREUPON, a certain document
18 was marked Defendants' Exhibit
19 No. 1, for identification, as of
20 7/15/10.)

21 MS. SIMMONS: Thank you.

22 BY MS. SIMMONS:

23 Q. And, Doctor, that sentence that's
24 highlighted states that there are other conditions

1 which may not be detected by that test, other
2 genetic conditions; is that true?

3 A. Well, what it says is that there are
4 rare forms of FMRP deficiency not caused by CGG
5 expansion, which may not be detected by this
6 analysis. Of course, there are many other genetic
7 conditions. This is only a test for Fragile X
8 Syndrome.

9 I think one could argue whether other
10 rare forms of FMRP, Fragile X -- FMR gene-related
11 protein deficiencies, whether -- what is stated
12 here, whether that's Fragile X Syndrome, so there's
13 some semantics involved, because later on in the
14 same report, it says that the detection rate of
15 this test is greater than 99 percent for the common
16 Fragile X expansion, which is typically the way one
17 conceives of Fragile X Syndrome, but the sentence
18 is as stated.

19 BY MS. SIMMONS:

20 Q. Okay. Thank you.

21 And briefly looking at the test for
22 CHARGE, in the second paragraph, the highlighted
23 portion.

24 MR. GRAHAM: Same objection. It goes way

1 beyond the scope of redirect and -- and no further
2 questioning is proper anyway.

3 BY MS. SIMMONS:

4 Q. Does that sentence state what you
5 testified earlier, which is that there is a
6 35 percent chance that that CHARGE test would not
7 pick up the CHARGE or would not diagnose CHARGE
8 Syndrome?

9 A. There's -- 35 percent of patients who
10 clinically have CHARGE Syndrome would have a
11 negative result on this test.

12 MS. SIMMONS: Thank you. You stated it better
13 than I did.

14 Let's mark that as Defendant's 2,
15 please, sir.

16 MR. GRAHAM: Same objection.

17 (WHEREUPON, a certain document
18 was marked Defendants' Exhibit
19 No. 2, for identification, as of
20 7/15/10.)

21 MS. SIMMONS: Thank you.

22 BY MS. SIMMONS:

23 Q. And looking at the chromosome analysis
24 results, if you would read the highlighted

1 sentence.

2 MR. GRAHAM: Objection. Same.

3 MS. SIMMONS: Yes, please.

4 BY THE WITNESS:

5 A. "Normal chromosome results do not rule
6 out other genetic etiologies which may be
7 associated with clinical findings in this
8 individual."

9 BY MS. SIMMONS:

10 Q. So once again, the results of the
11 chromosome analysis state that there are other
12 genetic etiologies which may be associated with the
13 patient that this test doesn't find?

14 MR. GRAHAM: Same objection.

15 BY THE WITNESS:

16 A. Yes.

17 BY MS. SIMMONS:

18 Q. True?

19 A. True.

20 MS. SIMMONS: Thank you.

21 We'll mark that as Defendant's 3,
22 please, sir.

23 MR. GRAHAM: Also object to that for the same
24 reasons.

1 (WHEREUPON, a certain document
2 was marked Defendants' Exhibit
3 No. 3, for identification, as of
4 7/15/10.)

5 MS. SIMMONS: Thank you.

6 BY MS. SIMMONS:

7 Q. And the last document is the fourth test
8 that you conducted on Jayden, the microarray.
9 Looking at the second page, if you would read the
10 highlighted two sentences into the record.

11 MR. GRAHAM: Same objection.

12 BY THE WITNESS:

13 A. "This test is not intended to detect
14 mosaicism. Normal results do not rule out
15 abnormalities of regions not represented on the
16 array, DNA sequence changes, or other genetic
17 etiologies."

18 BY MS. SIMMONS:

19 Q. And, Dr. Burton, would you state that
20 that basically says what the other test says, in
21 that this does not rule out any other genetic
22 problems in a patient?

23 MR. GRAHAM: Objection. Same objection.
24

1 BY THE WITNESS:

2 A. Yes.

3 MS. SIMMONS: Thank you.

4 We'll mark that as 4, and those are all
5 my questions for the doctor.

6 MR. GRAHAM: Same objection to that exhibit.

7 MS. SIMMONS: No further questions. Thank you
8 for your time.

9 (WHEREUPON, a certain document
10 was marked Defendants' Exhibit
11 No. 4, for identification, as of
12 7/15/10.)

13 THE VIDEOGRAPHER: Going off the --

14 MR. GRAHAM: No. No.

15 THE VIDEOGRAPHER: Going off the record at
16 4:41 p.m.. This concludes the videotaped
17 deposition of --

18 MR. GRAHAM: Wait. No. I'm not finished.

19 THE VIDEOGRAPHER: Oh, I'm sorry. I'm sorry.

20 THE WITNESS: Going back on.

21 MR. GRAHAM: Can we just go back on, or do
22 whatever you want to do.

23 THE VIDEOGRAPHER: We're back on the record at
24 4:42 p.m. I'm sorry.

1 MR. GRAHAM: That's okay.

2 RE-REDIRECT EXAMINATION

3 BY MR. GRAHAM:

4 Q. Doctor, I am going to reserve my
5 objection to the -- to the recross by Chilton
6 Simmons, but since we don't have the judge here to
7 rule on that, subject to my objection I'd like to
8 go on and ask a few questions.

9 Does Jayden clinically have any signs
10 and symptoms that indicate a need for further
11 genetic testing?

12 MS. SIMMONS: Objection. Leading, and asked
13 and answered.

14 BY THE WITNESS:

15 A. No, he does not.

16 BY MR. GRAHAM:

17 Q. Okay. Ms. Simmons asked you
18 specifically about the CHARGE test indicating that
19 if -- I believe your answer was that there can be a
20 35 percent false negative rate when considering
21 individuals who clinically have signs and symptoms
22 consistent with CHARGE Syndrome.

23 Does that apply to someone like Jayden?

24 A. No, it does not.

1 Q. And why is that?

2 A. Well, he does not have CHARGE Syndrome.
3 He doesn't have the clinical findings that tell us
4 that he has CHARGE.

5 Q. So --

6 MR. SCOTT: Let me -- this is Jim Scott. Let
7 me just add an objection. I'm not sure of what
8 Ed's qualifications were earlier, but this would
9 be, in my opinion, re-redirect, which I don't think
10 is allowed. So subject to that objection, he can
11 continue.

12 BY MR. GRAHAM:

13 Q. And similarly, there was a question
14 about the chromosome evaluation, that there may be
15 genetic conditions that are not tested for that
16 might, in a given situation, be presented
17 clinically through various signs and symptoms.

18 Does that apply to Jayden?

19 A. No.

20 Q. And the other test, the microarray and
21 perhaps also the Fragile X, there were indications
22 that those may have a false negative rate if there
23 were clinical symptoms suggestive of a genetic
24 condition that wasn't tested for.

1 Does that apply to Jayden?

2 MS. SIMMONS: Object to the form.

3 BY THE WITNESS:

4 A. Could you run that by me again. I'm
5 sorry.

6 BY MR. GRAHAM:

7 Q. Sure. Sure.

8 With respect to the microarray, I
9 believe -- I don't have that language in front of
10 me, but I believe the language was something that
11 there were certain conditions like mosaicism, or
12 something like that, and some other conditions that
13 may be present despite the negative test results.

14 Does any of that concern you about
15 Jayden?

16 A. Well, none of it concerns me about him,
17 no, because I don't believe that there's evidence
18 that he has a genetic disorder, other than
19 possibly, as we discussed earlier, the coloboma,
20 for which there currently isn't a genetic test.

21 If and when a genetic test for isolated
22 coloboma becomes available, that might be
23 appropriate for him, but otherwise, none of these
24 disclaimers on any of the laboratory reports

1 concern me, because we know that there's no one
2 test that rules out every conceivable genetic
3 disorder.

4 Q. Is there any other test or any other
5 information that you need to be reasonably certain
6 that the most probable cause of Jayden's brain
7 bleeds and brain damage was not genetic?

8 MS. SIMMONS: Objection. Leading, and asked
9 and answered.

10 MR. GRAHAM: All right. Let me rephrase that
11 question.

12 BY MR. GRAHAM:

13 Q. Do you have an opinion to a reasonable
14 degree of medical certainty as to whether or not
15 you need to perform any other tests or gather any
16 more information to reach a -- an opinion to a
17 reasonable degree of medical certainty as to the
18 most probable cause of Jayden's brain bleeds and
19 brain damage?

20 A. I feel very confident --

21 MS. SIMMONS: Objection noted.

22 BY THE WITNESS:

23 A. -- in my assessment of the cause of his
24 brain damage.

1 MR. GRAHAM: Thank you. No further questions.

2 THE VIDEOGRAPHER: Now going off the record at
3 4:47 p.m. This concludes the videotaped deposition
4 of Dr. Barbara Burton.

5 (WHICH WERE ALL THE PROCEEDINGS HAD
6 IN THE ABOVE-ENTITLED CAUSE ON THIS
7 DATE.)

8
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STATE OF ILLINOIS)

) SS:

COUNTY OF C O O K)

I, ANDREW ROBERT PITTS, C.S.R.

No. 84-4575, a Certified Shorthand Reporter of the
County of Cook, State of Illinois, do hereby
certify:

That previous to the commencement of the
examination of the witness, the witness was duly
sworn to testify the whole truth concerning the
matters herein;

That the foregoing videotaped evidence
deposition transcript was reported stenographically
by me, was thereafter reduced to typewriting under
my personal direction and constitutes a true record
of the testimony given and the proceedings had;

That the said videotaped evidence
deposition was taken before me at the time and
place specified;

That I am not a relative or employee or
attorney or counsel, nor a relative or employee of
such attorney or counsel for any of the parties
hereto, nor interested directly or indirectly in
the outcome of this action.

IN WITNESS WHEREOF, I do hereunto set my
hand and affix my seal of office at Chicago,
Illinois, this 17th day of July, 2010.

Andrew Pitts

Digitally signed by Andrew Pitts
DN: cn=Andrew Pitts, o=Amicus Court Reporters,
Inc., ou, email=info@amicusreporters.com, c=US
Date: 2013.01.15 17:11:14 -06'00'

My commission expires May 31, 2011.

C.S.R. Certificate No. 84-4575.

Jayden Washington

(MR # 1169665)

Patient Information Patient Name Washington, Jayden Sex Male DOB 7/16/2002

Collection Information Accession # W46748 Collection Date and Time 4/22/2009 1447 Received Date and Time 4/23/2009 1036 Specimen Type Blood Specimen Source BLOOD

Result Information Result Date and Time 5/13/2009 11:04 AM Status Final result

Entry Date 5/13/2009 Component Results Chromosome results: 09-0656 Washington, Jayden

REASON FOR REFERRAL: Developmental delay
Coloboma
SAMPLE TYPE: peripheral blood
DATE SAMPLE RCVD: 04/23/2009
FINAL REPORT DATE: 5/12/2009

REFERRING PHYS:
Dr. Barbara Burton

KARYOTYPE:
46,XY

IMPRESSION:
Normal male karyotype

DETAILS:
Band Level: GTG Resolution: 600 band level
Cells Recorded: 20 Cells Analyzed: 5 Karyotypes: 3

COMMENT: Normal chromosome results do not rule out other genetic etiologies which may be associated with the clinical findings in this individual. If warranted, a complete genetic evaluation should be considered.

Carrie Fitzpatrick, Ph.D.
Assistant Director, Cytogenetics Laboratory

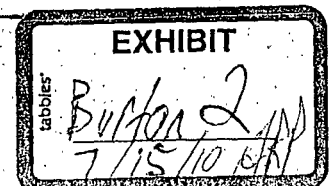
Josl Charrow, M.D.
Medical Director, Cytogenetics Laboratory

Encounter Report Patient Encounter Report

CHROMOSOME ANALYSIS, FOR CONGENITAL DISORDERS, BLOOD [80105232] (Order #: 13059984) Qty: 1

Order Providers Authorizing Provider Barbara K Burton, MD

Encounter Provider Barbara K Burton, MD



Order Information	<u>Order Date and Time</u> 4/22/2009 2:34 PM	<u>Released By</u> Katherine Kim	<u>Department</u> Laboratory
Associated Diagnoses	DEVELOPMENT DELAY COLOBOMA OF EYE		
Detailed Information	<u>Priority and Order Details</u>	<u>Collection Information</u>	
LAB Reprint Order Information	<u>CHROMOSOME ANALYSIS, FOR CONGENITAL DISORDERS, BLOOD (Order#13059984) on 4/22/09</u>		
Encounter Report	<u>Patient Encounter Report</u>		

MICROARRAY CGH, WHOLE GENOME(OLIGO) [80510770] (Order #: 13059985) Qty: 1

Order Providers Authorizing Provider
Barbara K Burton, MD

Encounter Provider
Barbara K Burton, MD

Order Information Order Date and Time
4/22/2009 2:34 PM

Released By
Katherine Kim

Department
Laboratory

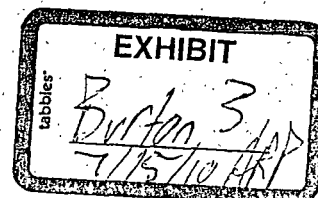
Associated Diagnoses DEVELOPMENT DELAY
COLOBOMA OF EYE

Detailed Information Priority and Order Details

Collection Information

LAB Reprint Order Information MICROARRAY CGH, WHOLE GENOME(OLIGO) (Order#13059985) on 4/22/09

Encounter Report Patient Encounter Report



New Result**MICROARRAY CGH, WHOLE GENOME (OLIGO)**
(Order: 13059985)**Additional**DetailsRouting**Entry Date**

5/29/2009

Component Results**Microarray CGH, Whole Genome(O:**

Patient name: Washington, Jayden

Date of Birth: 7/16/2002

Gender: M

Medical Record: 1169665

Referring Diagnosis: Coloboma

Developmental delay

Case Number: 09-0657

Physician: Dr. Barbara Burton

Date Collected: 4/22/2009

Date Received: 4/23/2009

Final Report: 5/28/2009

TEST: EmArray Cyto6000-Oligonucleotide Array Analysis

RESULT: arr cgh 1-22(39,986oligos)x2,X(2745oligos)x1,Y(367oligos)x1

INTERPRETATION: NORMAL MALE MICROARRAY ANALYSIS

Array Comparative Genomic Hybridization (arr cgh) analysis was performed with an oligonucleotide array designed to detect copy number imbalances (losses or gains) of specific chromosomal regions and across the genome (EmArray Cyto6000, version 2). Ratio values and sex chromosome internal controls were within acceptable normal ranges indicative of a successful hybridization. No clinically significant imbalances were identified.

Microarray analysis should be offered as an adjunct to routine G-banding chromosome analysis. If a G-banded karyotype analysis has not been completed previously, this test should be completed to rule out other chromosomal etiologies which may be associated with the clinical findings in this individual.

METHOD AND LIMITATIONS: The EmArray Cyto6000 is a custom oligonucleotide microarray that is designed to detect gains and losses across the genome by combining targeted and genome-wide array analyses. The array contains high density coverage for clinically relevant deletion/duplication syndromes as well as telomeric and pericentromeric regions. In addition, it provides genome-wide coverage with an average probe spacing of approximately 75kb to detect gains or losses at a minimum of 500kb or smaller for regions of known microdeletion/duplication syndromes or targeted genes. The array was built using a commercial platform (Agilent Technologies) and contains approximately 44,000 oligonucleotides (60mers) that represent coding and noncoding human sequences in the genome (content sourced from the UCSC hg18 human genome: NCBI build 36.1, March 2006). A pool of at least 5 normal DNA samples is used as opposite sex controls for each analysis. Data interpretation is based on

information from the UCSC Genome Browser (<http://genome.ucsc.edu/>), and the database of Genomic Variants (<http://projects.tcag.ca/variation/>).

This test will only detect gains or losses of DNA in the genome; balanced rearrangements such as translocations or inversions will not be detected. This test is not intended to detect mosaicism. Normal results do not rule out abnormalities of regions not represented on the array, DNA sequence changes (such as point mutations, small deletions or insertions) or other genetic etiologies. All abnormal results detected by the microarray are verified using karyotype or FISH analysis.

This test was developed and its performance characteristics determined by the Molecular Diagnostic and Cytogenetic Laboratories at Children's Memorial Hospital. It have not been cleared or approved by the U.S. Food and Drug Administration (FDA). The FDA has determined that such clearance or approval is not necessary. These tests are used for clinical purposes. It should not be regarded as investigational or for research. This laboratory is regulated under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) as qualified to perform high complexity clinical testing.

Lawrence Jennings, M.D., Ph.D.
Director, Molecular Pathology

Carrie Fitzpatrick, Ph.D.
Assistant Director, Cytogenetics

MyChart Status:

This result is currently not released to MyChart.

Status of Other Orders

	Lab Status	Result Date	Provider Status
CHROMOSOME ANALYSIS, FOR CONGENITAL DISORDERS, BLOOD	Final result	5/13/2009	Reviewed Wed May 13, 2009 7:11 PM

Canceled

MISCELLANEOUS TEST

From: Results Interface
Sent: Friday May 29, 2009 2:36 PM
To: Barbara Burton



LabCorp Burlington
1447 York Court
Burlington, NC 27215-3361

Phone: 800-735-4087

Specimen Number 211-102-3033-0		Patient ID		Control Number 20121838076	Account Number 329999955	Account Phone Number 336-436-3302	Route 00
Patient Last Name WASHINGTON				Account Address Atlantic LCA In-house Billable Results Transmission- Supervis 1447 York Court Burlington NC 27215			
Patient First Name JAYDEN		Patient Middle Name					
Patient SS#		Patient Phone 843-662-3281		Total Volumes			
Age (Y/M/D) 7/00/14	Date of Birth 07/16/02	Sex M	Fasting No				
Patient Address 383 WEST CHEVES ST Florence SC 29501				Additional Information CC:7739299565			
Date and Time Collected 07/30/09 11:09	Date Entered 07/30/09	Date and Time Reported 08/06/09 11:39ET	Physician Name BURTON B	NPI	Physician ID		
Tests Ordered Fragile X, PCR Reflex Southern; Drawing Fee							
General Comments This is a courtesy copy of a laboratory report.							
TESTS	RESULT	FLAG	UNITS	REFERENCE	INTERVAL	LAB	

Fragile X, PCR Reflex Southern

Fragile X DNA

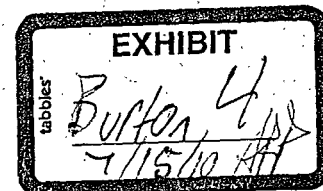
01

Molecular analysis report has been mailed.

This test was developed and its performance characteristics determined by LabCorp. It has not been cleared or approved by the U.S. Food and Drug Administration.

The FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes. It should not be regarded as investigational or for research.

01 TG LabCorp RTP Dir: Arundhati Chatterjee, MD
1912 Alexander Drive, RTP, NC 27709-9998
For inquiries, the physician may contact Branch: Lab: 800-735-4087



WASHINGTON, JAYDEN	211-102-3033-0	Seq # 0001

FINAL REPORT

Page 1 of 1

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GeneDx

207 Perry Parkway
Gaithersburg, MD 20877
Phone: 301-519-2100
Fax: 301-519-2892

E-mail: genedx@genedx.com
www.genedx.com

Genetic Testing Results

Patient Name:	WASHINGTON, Jayden	Specimen Obtained:	04/22/2009
Date of Birth:	07/16/2002	Specimen Received:	04/24/2009
GeneDx Accn.:	904354	Date Test(s) Started:	04/24/2009
Specimen Type:	Blood	Report Date:	07/20/2009
Submitters ID No:	1169665, W46749		

Test(s) requested: CHD7 Gene / CHARGE Syndrome

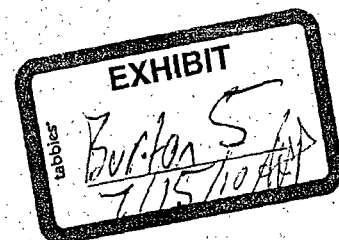
Result: **NEGATIVE**

No disease-associated mutation was identified in the entire coding region (exons 2-38) of the CHD7 gene in the submitted specimen of this individual. Heterozygosity of no known clinical significance was observed, consistent with the presence of two alleles at the position(s) noted.*

Interpretation: No mutation known to be associated with CHARGE syndrome was identified by this analysis of the CHD7 gene. In a study of 107 patients with clinical features suggestive of CHARGE syndrome, 69 individuals were identified as having heterozygous mutations in the CHD7 gene. Based on this study, approximately 65% of individuals with CHARGE syndrome will have a mutation in the CHD7 gene (Jongmans et al., 2006). There have been reports of partial and entire gene deletion of CHD7 causing CHARGE syndrome (Vissers et al., 2004 and Arrington et al., 2005).

The heterozygous positions observed in the CHD7 gene are not expected to be associated with the production of an abnormal protein. The presence of heterozygosity in this patient rules out a complete gene deletion as well as a partial gene deletion involving any of these positions.

Methods: Genomic DNA from this specimen was PCR-amplified for analysis of exons 2-38 of the CHD7 gene and their flanking splice sites. Bi-directional sequence was obtained and DNA sequence was analyzed and compared to the published gene sequence. The methods used by GeneDx are expected to be greater than 99% sensitive in detecting mutations identifiable by sequencing.



Report electronically signed by:

Sherri J. Bale, PhD, FACMG

Clinical Director

Report electronically signed by:

Bradley J. Williams, MGC

Genetic Counselor

*Heterozygous Position(s): Glu2032Glu (GAG/GAA), IVS2+34 a/g, IVS5-(43_48)dup8, IVS14-67 a/g, IVS16+51 a/c, IVS19+46 a/g, IVS30+8 c/t, IVS27+(183_166)dupATCA

cDNA RefSeq: NM_017780, counting from the ATG initiation codon.

Citations: Jongmans et al., (2006) J Med Genet 43:306-314. Vissers et al., (2004) Nat Genet 38:955-957. Arrington et al., (2005) Am J Med Genet 133:328-330.

This test was developed and its performance determined by GeneDx. It has not been cleared or approved by the U.S. Food and Drug Administration. The FDA has determined that such clearance or approval is not necessary. This test is used for clinical purposes. Pursuant to the requirements of CLIA '88, this laboratory has established and verified the test's accuracy and precision. Genetic testing using the methods applied at GeneDx is expected to be highly accurate. However, the chance of a false positive or false negative result, due to laboratory errors incurred during any phase of testing can not be completely excluded. CLIA ID#: 21D0969951. MD License #53.

RB



TO: DR BURTON

Childrens Memorial Hospital

LabCorp
Laboratory Corporation of AmericaLabCorp Burlington
1447 York Court
Burlington, NC 27215-3361

Phone: 800-762-4344

Specimen Number 029-102-3352-0		Patient ID		Control Number 20121840922	Account Number 12276150	Account Phone Number 773-880-4000	Route 00
Patient Last Name WASHINGTON				Account Address Childrens Memorial Hospital			
Patient First Name JAYDEN		Patient Middle Name		2300 Childrens Plaza CHICAGO IL 60614			
Patient SS#	Patient Phone 843-662-3281	Total Volume					
Age (Y/M/D) 7/06/13	Date of Birth 07/16/02	Sex M	Fasting No	Additional Information			
Patient Address 383 WEST CHEVES ST Florence SC 29501							
Date and Time Collected 01/29/10 14:49	Date Entered 01/29/10	Date and Time Reported 02/02/10 05:37ET	Physician Name HALL, J	NPI 1669493193	Physician ID		

Tests Ordered PT and PTT; Thrombin Time; Platelet Count; Drawing Fee					
General Comments This is a courtesy copy of a laboratory report.					
TESTS	RESULT	FLAG	UNITS	REFERENCE INTERVAL	LAB

PT and PTT**INR****1.1****0.8 - 1.2****01**

Reference interval is for non-anticoagulated patients.

Suggested INR therapeutic range for Vitamin K antagonist therapy:

Standard Dose (moderate intensity therapeutic range):

2.0 - 3.0

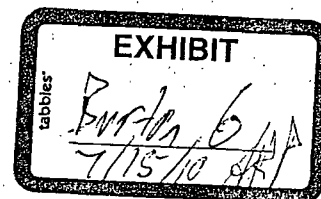
Higher intensity therapeutic range

2.5 - 3.5**Prothrombin Time****11.5****sec****8.7 - 11.5****01****aPTT****34****High****sec****24 - 33****01**

This test has not been validated for monitoring unfractionated heparin therapy. aPTT-based therapeutic ranges for unfractionated heparin therapy have not been established. For general guidelines on Heparin monitoring, refer to the LabCorp Directory of Services.

Thrombin Time**17.5****sec****0.0 - 20.0****01****Platelet Count****Platelets****388****x10E3/uL****150 - 440****01**

01 EN LabCorp Burlington Dir: William F Hancock, MD
1447 York Court, Burlington, NC 27215-3361
For inquiries, the physician may contact Branch: 800-877-3818 Lab: 800-762-4344



WASHINGTON, JAYDEN	029-102-3352-0	Seq # 0296

FINAL REPORT

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Washington v. Rhett
Barbara Burton, M.D.

Date: July 15, 2010

ORIGINAL



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Washington v. Rhett
Barbara Burton, M.D.

STATE OF SOUTH CAROLINA)
) SS:
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT

JAMESETTA WASHINGTON, as)
Guardian ad Litem for)
JAYDEN W a minor,)
Plaintiff,)
-vs-) Case No. 2007-CP-1533
EDMUND RHETT, JR., M.D.,)
and LOW COUNTRY OBSTETRICS &)
GYNECOLOGY, P.A.,)
Defendants.)

The videotaped rebuttal evidence deposition of BARBARA BURTON, M.D., called for examination, taken pursuant to the provisions of the Code of Civil Procedure and the Rules of the Supreme Court of the State of South Carolina pertaining to the taking of evidence depositions for the purpose of discovery, before ANDREW ROBERT PITTS, C.S.R. No. 84-4575, a Certified Shorthand Reporter within and for the County of Cook, State of Illinois at 300 West Adams Street, Suite 800, Chicago, Illinois, on the 15th day of July, A.D. 2010, at 2:47 p.m.

Washington v. Rhett
Barbara Burton, M.D.

PRESENT:

GRAHAM LAW FIRM, P.A.,
(383 West Cheves Street, P.O. Box 550,
Florence, South Carolina 29503,
843-662-3281), by:
MR. EDWARD L. GRAHAM,
appeared on behalf of the Plaintiff;

HOOD LAW FIRM, LLC,
(172 Meeting Street, P.O. Box 1508,
Charleston, South Carolina 29401,
843-577-4435), by:
MS. CHILTON GRACE SIMMONS,
appeared on behalf of the Defendant
Edmund Rhett, Jr., M.D.;

YOUNG CLEMENT RIVERS, LLP,
(28 Broad Street,
Charleston, South Carolina 29401,
843-720-5402), by:
MR. JAMES E. SCOTT,
appeared telephonically on behalf of the
Defendant Low Country Obstetrics &
Gynecology, P.A.

ALSO PRESENT:

MR. JOSHUA URBAN, Videographer,
Legal Visual Services,
205 West Randolph Street, Suite 1150,
Chicago, Illinois 60606, 312-551-0595.

REPORTED BY: ANDREW R. PITTS, C.S.R. No. 84-4575.

Washington v. Rhett
Barbara Burton, M.D.

I N D E X

BARBARA BURTON, M.D.

EXAMINATION

BY MR. GRAHAM

6, 21

BY MS. SIMMONS

15, 23

E X H I B I T S

NUMBER

MARKED FOR ID

DEPOSITION EXHIBIT

(No exhibits were marked.)

Washington v. Rhett
Barbara Burton, M.D.

1 THE VIDEOGRAPHER: This is Josh Urban with
2 Legal Visual Services, 205 West Randolph Street
3 Chicago, Illinois. I'm the operator of this
4 camera. We're on the record on July 15th, 2010.
5 The time is 4:57 p.m., as indicated on the video
6 screen.
7 This is the videotaped deposition of Dr. Barbara
8 Burton as being taken pursuant to South Carolina
9 Rules of Civil Procedure on behalf of Plaintiff.
10 We are at 300 West Adams, Chicago, Illinois. This
11 case is captioned Washington versus Rhett, Case No.
12 2007-CP-10-1553.
13 Will the attorneys please identify themselves for
14 the record.

15 MR. GRAHAM: Ed Graham for the Plaintiff.

16 MS. SIMMONS: Chilton Simmons for Defendant.
17 Dr. Rhett.

18 MR. SCOTT: Jim Scott for Defendant Low
19 Country Obstetrics & Gynecology, P.A.

20 THE VIDEOGRAPHER: The court reporter today is
21 Andrew Pitts from Amicus Court Reporting.

22 Please swear in the witness.

23 THE REPORTER: Please raise your right hand.

24 (WHEREUPON, the witness was duly

Washington v. Rhett
Barbara Burton, M.D.

1 sworn.)

2 MS. SIMMONS: This is Chilton Simmons for
3 Dr. Rhett. I'm noting for the record my objection
4 to this entire rebuttal deposition on the basis
5 that it's improper.

6 Today is July 15th. The trial doesn't
7 start until July 28th, at which time Defense will
8 present expert testimony, but at this time, it's
9 purely speculative for Dr. Burton and Mr. Graham to
10 anticipate what the defense expert testimony will
11 be, and therefore objecting on the fact that it's
12 improper and it's speculative. And there is no
13 defense expert testimony currently for Dr. Burton
14 to rebut. Thank you.

15 MR. SCOTT: And this is Jim Scott for the
16 Defendant, P.A., and we just will echo Dr. Rhett's
17 objections and join in the same.

18 MR. GRAHAM: That's fine. For the record,
19 what we're doing is consistent with the amended
20 notice of the deposition where we indicated we
21 would do one deposition for use in our case in
22 chief and a second deposition in which we would
23 anticipate some matters that we might want to reply
24 to in the reply or rebuttal portion of our case,

Washington v. Rhett
Barbara Burton, M.D.

1 and we won't have the luxury of time to come back
2 and do this after we hear the Defense expert.

3 So despite the difficulties of
4 anticipating what might need to be responded to,
5 we're going to make our best effort now, and the
6 usual rules will govern about whether or not it's
7 admissible and whether or not it's truly responsive
8 to matter from the Defense experts.

9 Without further ado, could we -- well,
10 we've already sworn the witness. Okay. Thank you.

11 BARBARA BURTON,
12 called as a rebuttal witness herein, having been
13 previously duly sworn and having testified, was
14 examined and testified further as follows:

15 DIRECT EXAMINATION (resumed)

16 BY MR. GRAHAM:

17 Q. Dr. Burton, in your prior testimony, you
18 indicated that there were only two birth defects
19 manifest or presented by Jayden W
20 following his birth, and in his testimony,
21 Dr. Milunsky contended that there were multiple
22 additional birth defects.

23 Would you please respond -- would you
24 please tell me why you don't believe the various

Washington v. Rhett
Barbara Burton, M.D.

1 conditions, apart from one-sided coloboma and
2 one-sided inguinal hernia, are not birth defects?

3 MS. SIMMONS: Objection. Leading and pitting
4 the witnesses.

5 BY THE WITNESS:

6 A. Yes, I could do that. Several of the
7 things mentioned, hydrocele and undescended testis,
8 are just consequences of the birth defect inguinal
9 hernia. In other words, that's one single birth
10 defect, those are not separate birth defects, and
11 some of the things that may have been mentioned are
12 not present on examination may have been suspected
13 based on photographs, things like abnormal ears or
14 widely spaced nipples, hyperextensible joints,
15 scoliosis. These things are not present on
16 physical examination.

17 I believe developmental delay or motor
18 problems, cognitive problems may have been
19 mentioned as a birth defect, and, of course, these
20 are problems that Jayden W has
21 experienced, but they can have a wide variety of
22 different causes, and I already testified earlier
23 that I believe the cause of those problems is his
24 brain hemorrhage.

Washington v. Rhett
Barbara Burton, M.D.

1 BY MR. GRAHAM:

2 Q. Thank you.

3 We've heard testimony that several minor
4 birth defects signify that there is most likely to
5 be a major birth defect.

6 Do you have an opinion to a reasonable
7 degree of medical certainty as to whether or not
8 that's true?

9 MS. SIMMONS: Objection to the form. Leading.

10 BY THE WITNESS:

11 A. Well, it's certainly true that the
12 presence of multiple minor birth defects in a
13 patient increases the risk that that patient is
14 going to have one or more major birth defects. So
15 it's very important to examine the patient
16 thoroughly to determine whether or not that is the
17 case, but once that has been done, one can
18 basically answer that question. And there are
19 certainly many people who have one, or two, or even
20 several minor birth defects who don't have any
21 major birth defects.

22 BY MR. GRAHAM:

23 Q. Do you have an opinion to a reasonable
24 degree of medical certainty as to whether or not

Washington v. Rhett
Barbara Burton, M.D.

1 Jayden W's motor impairments, cognitive
2 impairments, and developmental difficulties
3 represent a birth defect?

4 A. I don't believe they represent a birth
5 defect in that I don't believe that there was any
6 abnormality present at the moment of birth that
7 resulted in those findings later on. I believe
8 those findings are a result of his brain
9 hemorrhage.

10 Q. Let me turn to the assertion that
11 maternal alcohol consumption early in pregnancy has
12 some causal significance in this case.

13 Do you have an opinion to a reasonable
14 degree of medical certainty as to what effect, if
15 any, Jamesetta's alcohol consumption early in
16 pregnancy had on Jayden's brain bleeds, brain
17 damage, motor and cognitive impairments, and
18 developmental problems?

19 A. Yes, I have an opinion about that. I
20 don't believe it had any impact on his motor,
21 cognitive, or neurologic problems.

22 Q. Do you have any special expertise in
23 terms of dangers of alcohol during pregnancy?

24 A. Well, I have focused some attention on

Washington v. Rhett
Barbara Burton, M.D.

1 that during the course of my career. When I was at
2 North Carolina at Wake Forest, I directed a fetal
3 alcohol syndrome prevention project there where for
4 a number of years we evaluated children whose
5 mothers had had alcohol consumption during
6 pregnancy for fetal alcohol syndrome or fetal
7 alcohol effects.

8 I also did a considerable amount of
9 education regarding the effects of alcohol
10 consumption during pregnancy. So I feel like it's
11 something I am knowledgeable about.

12 Q. Do you have an opinion to a reasonable
13 degree of medical certainty as to whether or not
14 Jayden has fetal alcohol syndrome?

15 A. He does not.

16 Q. Do you have an opinion to a reasonable
17 degree of medical certainty as to whether or not
18 Jayden suffers any ill effects from his mother's
19 consumption of alcohol early in pregnancy?

20 A. I see no evidence that that's the case.
21 For starters, it's not clear that alcohol
22 consumption during pregnancy occurred during a time
23 period when it could have had any impact on the
24 patient. Excuse me.

Washington v. Rhett
Barbara Burton, M.D.

1 Everything I saw on the records suggests
2 that at least the purported alcohol assumption
3 occurred prior to four weeks after the last
4 menstrual period, so up to two weeks after
5 conception, and that's a time period when you
6 cannot produce birth defects, you can't produce
7 developmental problems. You can kill the little
8 ball of cells that's the embryo, but if you don't
9 do that, everything turns out fine.

10 If one assumes that maybe that history
11 wasn't accurate, that patients sometimes do have
12 alcohol consumption, do drink during pregnancy and
13 don't report it, and certainly we have to consider
14 that in any case, then there are certain findings
15 that we look for on physical examination that would
16 be consistent with the effects of alcohol
17 consumption during pregnancy, and none of those
18 were seen in Jayden W.

19 Q. Thank you.

20 What effect, if any, do you believe a
21 mother's consumption of tobacco or marijuana early
22 in pregnancy would have on a child's brain bleeds,
23 brain damage, motor and cognitive impairments, and
24 developmental problems?

Washington v. Rhett
Barbara Burton, M.D.

1 A. There's no evidence that either of those
2 exposures would produce any of the problems seen in
3 Jayden. What we know is that both cigarette
4 smoking and marijuana smoking can cause problems
5 with growth of the fetus, so growth retardation,
6 small size, but that was not seen in this case.
7 There can also be an increased risk of miscarriage.

8 We can see strokes during pregnancy with
9 some types of exposures, possibly even cigarettes,
10 although that's not so well documented, but
11 certainly there is no evidence that cognitive
12 problems are related to either of those exposures.

13 Q. We have heard testimony about
14 certain -- a certain type of connective tissue
15 disorder whose name escapes me right now, but it
16 involves -- the second word, it's a hyphen word
17 that includes Ehlers, I believe?

18 A. Ehlers-Danlos Syndrome is a connective
19 tissue disorder.

20 Q. And I believe we've heard testimony that
21 certain forms of that syndrome can cause a
22 weakening of blood vessels. We have also heard
23 testimony that -- that suggests the possibility
24 that Jayden may have a benign form of that

Washington v. Rhett
Barbara Burton, M.D.

1 syndrome.

2 Do you have an opinion to a reasonable
3 degree of medical certainty as to whether or not
4 Jayden has any form of connective tissue disorder
5 or that specific hyphenated name that you mentioned
6 in particular?

7 A. He absolutely has no form of
8 Ehlers-Danlos Syndrome. That's a clinical
9 diagnosis. He has no clinical findings consistent
10 with any of the forms of Ehlers-Danlos Syndrome.

11 There was another hyphenated one,
12 Loeys-Dietz Syndrome. He has no findings
13 consistent with that either. He actually has no
14 findings consistent with any type of connective
15 tissue disorder.

16 Q. If the assertion that Jayden has a
17 benign form of Ehlers-Danlos, what significance, if
18 any, would that have?

19 A. Well, it wouldn't have any, because
20 benign means benign, doesn't cause significant
21 problems. What we see in the benign or the milder
22 forms of Ehlers-Danlos are things like stretchy
23 joints, hyperextensible joints, double jointedness,
24 stretchy skin. We don't see brain hemorrhage. We

Washington v. Rhett
Barbara Burton, M.D.

1 don't see vascular fragility.

2 Later in life, we can see some
3 nonprogressive stretches of the aorta, but we don't
4 even see complications there later in life. So we
5 don't see many of the complications ever, even in
6 the more severe forms.

7 Q. Given the new testimony that we've
8 discussed, do you have an opinion to a reasonable
9 degree of medical certainty as to whether or not
10 Jayden's brain bleeds, brain damage, cognitive and
11 motor impairments, and developmental problems were
12 caused in any way by any genetic condition or
13 factor?

14 A. Yes, I have an opinion, and they were
15 not.

16 Q. Given the new testimony, do you have an
17 opinion as -- to a reasonable degree of medical
18 certainty as to the most probable cause of Jayden

19 W. brain damage, cognitive and motor
20 impairments, and developmental problems?

21 A. Yes. I believe the cause was his brain
22 bleed or brain hemorrhage in the newborn period.

23 MR. GRAHAM: Thank you very much. Please
24 answer any questions that Ms. Simmons may have.

Washington v. Rhett
Barbara Burton, M.D.

CROSS EXAMINATION

BY MS. SIMMONS:

Q. Dr. Burton, you testified that you believe Jayden's mother's alcohol consumption while Jayden was in utero did not affect Jayden's development; true?

A. True.

Q. If you would look in your --

A. Excuse me.

Q. -- sure -- original deposition.

A. Sure.

Q. At Page 65. That's the sealed copy.

A. You want me to open this?

Q. Yes, please.

A. Yes.

Q. And at Page 65 in your deposition, I was asking you questions about the effects of alcohol on a fetus.

At Line 12, my question to you was, quote, "Would you agree that a fetus can be negatively impacted as far as having developmental delays even without fetal alcohol syndrome or fetal alcohol effects?"

And your answer at Line 18 was --

Washington v. Rhett
Barbara Burton, M.D.

1 A. "We do not know the answer to that
2 question. We don't. We do not know."

3 Q. So, Dr. Burton, despite the fact that
4 your testimony on December 17th of 2009 stated that
5 you as a physician do not know the effects of
6 alcohol on a fetus without the rising to the level
7 of fetal alcohol syndrome or fetal alcohol effects,
8 it is now your testimony today that the alcohol
9 consumption by the mother did not affect Jayden; is
10 that true?

11 MR. GRAHAM: Objection. You've
12 mischaracterized the question that you asked her
13 that you referred to. It says nothing about
14 alcohol effects lesser than fetal alcohol syndrome
15 or fetal alcohol effects. You just asked her if
16 the fetus can be negatively impacted as having
17 developmental delays without fetal alcohol syndrome
18 or fetal alcohol effects.

19 MS. SIMMONS: If you look at the prior
20 paragraph, we're clearly discussing the impact of
21 alcohol on a fetus.

22 MR. GRAHAM: Well, my objection stands.
23 You've chosen a certain question and answer, and
24 it's not what you characterized it as being.

Washington v. Rhett
Barbara Burton, M.D.

1 BY MS. SIMMONS:

2 Q. Dr. Burton, the question on Page 65 at
3 Line 12.

4 A. Yes.

5 Q. Would you agree that your testimony at
6 that time was that it was not known or it is not
7 known -- when you say "we do not know," you're
8 referring to physicians in general?

9 A. Yes.

10 Q. Scientists, I guess?

11 A. Yes.

12 Q. That you as a physician does not know
13 the effects of alcohol on a fetus if the fetus does
14 not have fetal alcohol syndrome or fetal alcohol
15 effects?

16 MR. GRAHAM: Object to the question. It's
17 ambiguous and confusing.

18 BY THE WITNESS:

19 A. Well, I agree that that is what I said
20 at that time, and then I went on to qualify that a
21 little bit further, if you go on and look at the
22 additional questions, to say that there is no
23 evidence at this time of an effect on developmental
24 disabilities in the absence of any other findings.

Washington v. Rhett
Barbara Burton, M.D.

1 And then I went on further to say that
2 that does not definitively rule out the possibility
3 that in some cases that could occur, but because
4 developmental disabilities are very nonspecific and
5 occur in hundreds of different settings and are
6 reasonably common among children, it becomes
7 difficult sorting out individual components that
8 could in some individual cases contribute to that.

9 And today, the question I was asked was
10 is it my opinion that it contributed in this
11 particular case, which I think to a reasonable
12 degree of medical certainty we can -- I can respond
13 to as saying no, it did not contribute.

14 Is that different from saying that you
15 cannot definitively rule it out in an individual
16 case? I don't think that's a different answer. I
17 think with a reasonable degree of medical
18 certainty, given that there is no evidence that
19 alcohol causes -- excuse me -- isolated
20 disabilities, I can say that it did not contribute
21 in this case.

22 That's not the same as being able to say
23 that never, ever in any case in an individual
24 patient could it contribute or that we can

Washington v. Rhett
Barbara Burton, M.D.

1 absolutely rule it out with a hundred percent
2 certainty. We can't.

3 BY MS. SIMMONS:

4 Q. And in my question on Page 65 of Line
5 12, I didn't ask whether it could absolutely be
6 ruled out; did I?

7 A. You didn't, but as I said, I went on to
8 explain my answer further as we went on with
9 further questioning. I don't think you can take
10 one sentence out of context and say that that was
11 my complete response to the questioning that was
12 going on.

13 Q. And I understand that.

14 A. Excuse me.

15 Q. You would agree once again that there is
16 no test to diagnose or rule out connective tissue
17 disorder; is that true?

18 A. Connective tissue disorders are
19 diagnosed on a clinical basis, looking at the
20 history and physical findings. There is no test
21 that rules out all connective tissue disorders.
22 There are tests for individual connective tissue
23 disorders.

24 Q. And you are not here today to say

Washington v. Rhett
Barbara Burton, M.D.

1 anything that Dr. Rhett did or did not do caused
2 injuries to Jayden?

3 A. Yes, I'm not here to comment on
4 Dr. Rhett's care of the patient.

5 Q. And you do not know if Jayden's fetal
6 heart monitor strip showed that he was in distress
7 before being delivered?

8 A. That's correct.

9 Q. And you do not know if there was a
10 reason to quicken Jayden's delivery?

11 A. No, I don't know. I have no opinion
12 about that.

13 Q. And you have no opinion whatsoever on
14 whether Dr. Rhett should or should not have used
15 the vacuum to quicken Jayden's delivery?

16 A. Correct.

17 Q. And you do not have the opinion that the
18 vacuum caused his hemorrhages?

19 A. I don't have an opinion about that one
20 way or the other.

21 Q. And it is your conclusion from your
22 one-hour exam of Jayden and your four genetic tests
23 chosen out of hundreds of tests that there is no
24 genetic cause of Jayden's developmental delays?

Washington v. Rhett
Barbara Burton, M.D.

1 A. That is my conclusion based on my full
2 evaluation of the patient, including review of his
3 medical records and my face-to-face assessment and
4 the testing that was conducted.

5 Q. And you are not here to tell this jury
6 that Dr. Rhett did anything wrong or deviated from
7 the standard of care in his care and treatment of
8 Jayden and Ms. Washington?

9 A. Correct. I'm not here to comment one
10 way or the other on Dr. Rhett's care of the patient.

11 Q. And you're not here to tell this jury
12 that Dr. Rhett caused Jayden's hemorrhages?

13 A. I'm not here to comment on Dr. Rhett's
14 care of the patient one way or the other.

15 MS. SIMMONS: Thank you. I have no further
16 questions.

17 REDIRECT EXAMINATION

18 BY MR. GRAHAM:

19 Q. Again, Dr. Burton, Ms. Simmons has asked
20 you over and over and over about obstetrical opinions.

21 Are you an obstetrician?

22 A. No.

23 Q. Do you come to this court to give the
24 jury any information, good or bad, about Dr. Rhett

Washington v. Rhett
Barbara Burton, M.D.

1 as an obstetrician?

2 A. No.

3 Q. Now, let me ask you to please turn to
4 your deposition on Page 65. Ms. Simmons asked you
5 to read starting at Line 12, but she did not ask
6 you anything about the question and answer
7 immediately preceding that, and I'd like to do that
8 now. Starting at Page 9, the question was, "And
9 did you evaluate or rule out if Jayden has fetal
10 alcohol effects?"

11 And what was your answer?

12 A. "Yes. There's no evidence for that."

13 Q. Thank you.

14 Do you have an opinion to a reasonable
15 degree of medical certainty as to whether or not
16 Jamesetta Washington did anything to cause or
17 contribute to her son's brain bleeds and brain
18 damage?

19 A. Yes. I found no evidence to suggest
20 that that was the case.

21 Q. Do you have an opinion to a reasonable
22 degree of medical certainty as to the most probable
23 cause of Jayden's brain bleeds, brain damage, motor
24 and cognitive impairment, and developmental

Washington v. Rhett
Barbara Burton, M.D.

1 problems?

2 MS. SIMMONS: Objection. Asked and answered.

3 BY THE WITNESS:

4 A. Yes. I believe that his brain damage
5 and subsequent motor and cognitive problems -- I'm
6 sorry about this coughing.

7 MR. GRAHAM: Take your time.

8 BY THE WITNESS:

9 A. Yeah. That I believe those things that
10 I just mentioned, his brain damage, his subsequent
11 motor and cognitive problems were caused by his
12 brain hemorrhage.

13 MR. GRAHAM: Thank you very much. No further
14 questions.

15 MS. SIMMONS: One last question, Dr. Burton.

16 RECROSS EXAMINATION

17 BY MS. SIMMONS:

18 Q. You have no evidence to suggest that
19 Dr. Rhett breached the standard of care and caused
20 Jayden's hemorrhages?

21 MR. GRAHAM: Objection.

22 BY THE WITNESS:

23 A. I have no opinion on Dr. Rhett's care of
24 the patient at all, one way or the other.

Washington v. Rhett
Barbara Burton, M.D.

1 BY MS. SIMMONS:

2 Q. But you are an expert on causation.

3 And my question to you is do you have
4 any evidence to suggested that Dr. Rhett caused
5 Jayden's hemorrhages?

6 MR. GRAHAM: Objection. It goes beyond the
7 course of redirect.

8 BY THE WITNESS:

9 A. Well, once again, my -- my opinion on
10 causation has to do with the fact that his brain
11 hemorrhage caused his handicaps. I don't have an
12 opinion as to whether or not Dr. Rhett caused the
13 brain hemorrhage to occur.

14 MS. SIMMONS: Thank you. No further
15 questions.

16 MR. GRAHAM: Jim?

17 MR. SCOTT: No questions. Thank you.

18 THE VIDEOGRAPHER: Going off the record at
19 5:23 p.m. This concludes the videotaped deposition
20 of Dr. Barbara Burton.

21 (WHICH WERE ALL THE PROCEEDINGS HAD
22 IN THE ABOVE-ENTITLED CAUSE ON THIS
23 DATE.)
24

Washington v. Rhett
Barbara Burton, M.D.

1 STATE OF ILLINOIS)

2) SS:

3 COUNTY OF C O O K)

4 I, ANDREW ROBERT PITTS, C.S.R.

5 No. 84-4575, a Certified Shorthand Reporter of the
6 County of Cook, State of Illinois, do hereby certify:

7 That previous to the commencement of the
8 examination of the witness, the witness was duly
9 sworn to testify the whole truth concerning the
10 matters herein;

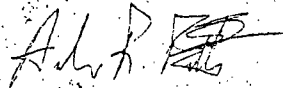
11 That the foregoing videotaped rebuttal
12 evidence deposition transcript was reported
13 stenographically by me, was thereafter reduced to
14 typewriting under my personal direction and
15 constitutes a true record of the testimony given
16 and the proceedings had;

17 That the said videotaped rebuttal
18 evidence deposition was taken before me at the time
19 and place specified;

20 That I am not a relative or employee or
21 attorney or counsel, nor a relative or employee of
22 such attorney or counsel for any of the parties
23 hereto, nor interested directly or indirectly in
24 the outcome of this action.

Washington v. Rhett
Barbara Burton, M.D.

1 IN WITNESS WHEREOF, I do hereunto set my
2 hand and affix my seal of office at Chicago,
3 Illinois, this 17th day of July, 2010.

4 
5

6 My commission expires May 31, 2011.

7
8 C.S.R. Certificate No. 84-4575.
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STATE OF SOUTH CAROLINA

COURT OF COMMON PLEAS

COUNTY OF CHARLESTON FOR THE NINTH JUDICIAL CIRCUIT

Jamesetta Washington as
Guardian ad Litem for

Jayden W. , a minor,
Plaintiff,

COPY

vs.

CASE NO. 07-CP-10-1553

Edmund Rhett, Jr., MD;

Low Country Obstetrics

and Gynecology, P.A.;

Tenet South Carolina, Inc.,

d/b/a East Cooper Regional

Medical Center,

Defendants...

DEPOSITION OF: LYNN B. NORTON, MD

DATE: May 20, 2009

TIME: 5:23 p.m.

LOCATION: Beaufort OB/GYN Associates

989 Ribaut Road, Suite 210

Beaufort, SC

TAKEN BY: Counsel for the Plaintiff

REPORTED BY: KELLY A. BALL, Court Reporter

1 APPEARANCES OF COUNSEL:

2 ATTORNEYS FOR THE PLAINTIFF

3 Jamesetta Washington as Guardian ad Litem
4 for Jayden W , a minor:

(Appeared via telephone)

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22 (Appearances continued on next page)

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(Appearances continued)

ATTORNEYS FOR THE DEFENDANT

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(INDEX AT REAR OF TRANSCRIPT)

1 LYNN B. NORTON, MD

2 being first duly sworn, testified as follows:

3 EXAMINATION

4 BY MR. GRAHAM:

5 Q. Dr. Norton, good afternoon.

6 A. Good afternoon, Mr. Graham.

7 Q. Do you still have all the materials
8 with you that you had the first go around?

9 A. Yes, sir.

10 Q. Do you have any additional materials
11 with you today?

12 A. Yes, I brought the deposition of Dr.
13 Rhett, which I had neglected to bring on our last
14 meeting.

15 Q. Okay. Thank you. And did you make any
16 notes, underlining, or turned down any page corners
17 in that deposition?

18 A. I did not.

19 Q. Okay. Have you spoken with anyone
20 about the deposition since your last -- since we
21 last adjourned?

22 A. Other than arrangements for this
23 meeting, no, sir.

24 Q. Okay. Now, last time I believe you
25 told me that if you had been in Dr. Rhett's

1 position at the time he applied the vacuum, if this
2 had been your labor and delivery, if you had
3 checked the station of the baby and determined it
4 to be in the midpelvis, you would have chosen not
5 to do a vacuum extraction, correct?

6 A. That is correct.

7 Q. Okay. Can you tell me what other
8 doctors would have done if in that same situation?
9 And if you need to use percentages, that's fine.

10 A. I -- I'm not sure. I haven't taken a
11 survey of -- of all OB/GYNs, nor of the ones in our
12 community. In general, I could say that the
13 doctors who trained prior to my training, which was
14 completed in 1995, were much more experienced and
15 proficient with operative vaginal deliveries. And
16 so they would be, I would assume, more comfortable
17 with more difficult deliveries from a higher
18 station.

19 Q. Okay. More aggressive with the use of
20 the vacuum?

21 A. I wouldn't use the term aggressive, but
22 more comfortable with operative vaginal deliveries,
23 yes, sir.

24 Q. What does the word aggressive mean to
25 you?

1 MS. SIMMONS: Objection to the form.

2 THE WITNESS: In the context of the
3 sentence that you just used?

4 BY MR. GRAHAM:

5 Q. Yes, ma'am.

6 A. I guess perhaps that it would be --
7 perhaps used in circumstances that would be unwise
8 to use.

9 Q. All right. Well, let me ask you to use
10 aggressive in a different sense, and that is in the
11 sense of an obstetrician who is willing to resort
12 to operative vaginal deliveries more frequently and
13 more quickly than other practitioners especially
14 from a -- in -- in more difficult circumstances and
15 in riskier circumstances. Do you understand that
16 definition of aggressive?

17 A. I do. It has a number of components.
18 If -- if I have to include the word "riskier," I'm
19 not sure what you mean by that term.

20 Q. What does risky mean to you?

21 A. Well, if someone is -- is high risk in
22 obstetrics, that means there's a greater chance for
23 problems. Increased complications, increased
24 morbidity, increased mortality.

25 Q. Okay. In the context of an operative

1 vaginal delivery, what do you consider to be a
2 riskier intervention?

3 A. If I use my definition of being higher
4 risk then it would be, again, increased risks of
5 morbidity and mortality and more complications.

6 Q. Okay. That makes sense to me. So
7 using aggressive in the sense that I described it
8 and with your definition of riskier, are you
9 suggesting that doctors who have trained earlier
10 than you are more aggressive in their use of a
11 vacuum?

12 A. Then I would say no.

13 Q. Why not?

14 A. Because of the definition of the -- the
15 riskier. I don't -- I feel that the other
16 components, and I haven't written down all the
17 words that you used, but terms of using them at a
18 higher station and that they're more comfortable, I
19 agree with all of those. But I don't think that
20 they would necessarily use them in a situation
21 where they felt that there was higher morbidity and
22 mortality.

23 Q. Do you consider that the higher the
24 station the riskier in the sense of increased risk
25 of morbidity or mortality?

1 A. Well, in terms of the studies that have
2 been done, it's controversial and I think we had
3 this decision in our last deposition where that --
4 it's not possible in obstetrics, usually, to do
5 these randomized control trials and so they -- they
6 do more of a -- of a retrospective analysis. But
7 when -- when midforceps, for instance, were used,
8 they looked at different parameters, such as Apgar
9 scores and long term functions, IQ scores, things
10 like that. And they found that there were no
11 differences in several studies.

12 Q. Which studies do you refer to?

13 A. I can't quote the exact -- the exact
14 ones; although, I read about them recently. I
15 haven't read the actual studies, but they've been
16 referenced in things like Williams Obstetrics and
17 the ACOG Technical Bulletin that we've referred
18 previously.

19 Q. So you've just accepted the ACOG
20 Technical Bulletin without reading the articles and
21 cites to see if they really support what ACOG
22 asserts?

23 A. In that situation, yes, I have, sir.

24 Q. Okay. Would you please furnish those
25 citations to Chilton so she can provide those to

1 us?

2 A. The ACOG Technical Bulletin, sir?

3 Q. The -- the citation that you referred
4 to in either Williams or the ACOG Technical
5 Bulletin?

6 A. I will do it.

7 Q. Thank you.

8 A. Should -- can I just pause for a minute
9 to make a list of my homework, sir?

10 Q. Certainly.

11 A. Okay. Paper -- got it. This time I
12 have my own pen.

13 Q. Good thing. It'd be kind of hard for
14 me to let you borrow mine today.

15 A. I appreciate that. So citation
16 regarding midforceps and outcome of the neonates.

17 Q. Well, my question was broader than
18 that. I believe my question was: Do you recognize
19 that the higher the station from which operative
20 vaginal delivery is performed, the greater the
21 morbidity and mortality and you, in effect, said,
22 no, you -- you don't.

23 A. Well, I believe that I -- I said that
24 it's controversial, because it's difficult to -- to
25 do the studies that would be considered the gold

1 standard, which would be a randomized control
2 trial. And, obviously, you can't even blind this
3 trial because the -- the operator would know what
4 they were doing. So I -- I don't think it's --
5 it's as -- as easy to ascertain, but I can
6 certainly give you the reference that I referred to
7 earlier in the ACOG Technical Bulletin.

8 Q. Okay. Well, what about your personal
9 beliefs, do you believe that the higher the station
10 the more danger to the baby?

11 A. I believe that the -- the important
12 factor is the -- the comfort and skill of the
13 operator.

14 Q. Just the subject and determination of
15 the comfort level of the operator?

16 A. Yes, sir.

17 Q. Is that right?

18 A. Well, you know, in so much of what we
19 do in clinical medicine, it -- it has to do with
20 what our level of comfort is. And there's
21 countless different experiences where we might have
22 to make a judgement and decide are we comfortable
23 with this, are we not comfortable with this, and --
24 and so that's -- that's what I would judge it on,
25 yes, sir.

1 Q. Okay. And is -- when -- you were
2 talking about the standard of care before, is that
3 basically what you're talking about that if -- if
4 an obstetrician feels comfortable doing a
5 particular intervention then that's within the
6 standard of care?

7 A. Using the caveat that they are
8 comfortable with reason based on their operative
9 experience, and not perhaps a megalomaniac level of
10 comfort that has no basis and experience.

11 Q. Well, my question is, do you personally
12 believe that the higher the station from which an
13 operative vaginal delivery is performed, the
14 greater the risk to the baby?

15 A. I believe that in a general sense that
16 because so few operators are comfortable with a --
17 a -- a midpelvic delivery, that it increases the
18 risk because there are so few that are comfortable
19 with it. Now, I do not feel that a station above
20 zero station nor a head unengaged or a cervix not
21 fully dilated, in those situations, I absolutely do
22 not feel that those -- that those are safe and I do
23 not --

24 Q. Why -- why is that? What makes those
25 more dangerous?

1 A. Again, it's all based on older data,
2 because it's -- it's not recommended to do that
3 type of delivery. But that there were more
4 neonatal complications and more maternal
5 complications, and more failed -- failed deliveries
6 with attempts and failure. For instance, when the
7 cervix is not fully dilated, it's -- it's difficult
8 to place the forceps or the vacuum cup
9 appropriately, because it can be caught up in the
10 maternal tissue. As well, if the cervix is not
11 fully dilating and you're trying to delivery a baby
12 CDP then the -- the head can get caught on the
13 cervix, the cervix can tear, and a number of
14 complications associated with that.

15 Q. In a doctor who claims to be
16 comfortable with a midpelvic vacuum extraction, do
17 you consider it to be no more dangerous from -- for
18 the baby to -- to have the vacuum applied at a
19 midpelvic station rather than a lower outlet
20 station?

21 A. I would say that outlet would have
22 lower risk, because the baby is -- is so close to
23 the peritoneum, it's -- it's usually a shorter
24 delivery, but I would base more of the concern on
25 the possible length of the procedure and the

1 increased risk for pop-offs as opposed to -- or the
2 possibility of more of a cephalopelvic
3 disproportion or a problem of the head fitting
4 through the pelvis properly then I would have -- of
5 -- of the -- the station per se.

6 Q. A pop-off causes no harm, does it?

7 A. It's controversial. But one of the
8 concerns with the pop-off, the -- the vacuum has
9 been designed to release if -- if pressure that is
10 exceeding the -- the recommended pressure is
11 exerted. And so that suggested there is a sign
12 that the baby is not fitting well through the
13 pelvis for whatever reason. Whether it's position
14 or whether it's the size of the pelvis, or
15 asynclitic -- I can't say that word -- asynclitic
16 head. And -- and so the pop-off is actually
17 designed as a safety function. One of the reasons
18 that people think that a -- a vacuum may be safer
19 than a forceps is because there's a limit to the
20 amount of pressure that can be placed based on the
21 vacuum.

22 Q. Okay. And in that sense, when a vacuum
23 cup pops off, it actually protects the wellbeing of
24 the baby, correct?

25 A. Well, that -- that's designed as a

1 safety valve, yes, sir.

2 Q. Okay. But for it to work properly, the
3 pressure has to be set in the correct area -- the
4 correct zone, correct?

5 A. For it to work properly?

6 Q. For the -- for the pop-off to protect
7 the --

8 A. Oh, I see.

9 Q. -- baby's wellbeing, the pressure of
10 the vacuum has to be properly set, correct?

11 A. That's my understanding, although, I
12 don't know the absolute cutoff on the -- the
13 numbers, what would be constituting an unsafe
14 amount of pressure and how they determine that. I
15 -- I don't know those absolute numbers. But, yes,
16 that's my understanding. That's the -- that's the
17 reason it was designed as it was with a -- with a
18 region of -- zone of -- of -- the green zone where
19 you have the greatest ability to hold onto the head
20 and the least danger about excessive force.

21 Q. Okay. So you believe that an outlet
22 vacuum extraction is less dangerous to the baby
23 than a low or midpelvic extraction, correct?

24 A. Yes.

25 Q. You also believe that a low vacuum

1 extraction is safer for a baby than a midpelvic
2 extraction?

3 A. I believe based on several factors, not
4 the -- the definition per se, but that those
5 factors are associated with more of operator
6 comfort with a low vacuum extraction as opposed to
7 mid. And with a greater likelihood of a longer
8 length of time of the extraction and a greater
9 chance for -- for a pop-off suggesting and -- and
10 -- and even just that the baby's head is so -- is
11 so high that perhaps there is a -- a more of a
12 problem with the sense suggesting more problem with
13 cephalopelvic disproportion.

14 Q. Are you telling me that you believe
15 vacuum extraction for a midpelvic station is more
16 dangerous than from a low station?

17 A. Yes, sir, for the reasons I stated.

18 Q. Do you know any other obstetricians
19 that would have performed a midpelvic vacuum
20 extraction, as was done by Dr. Rhett in this case,
21 if they had been in his shoes?

22 MS. SMITH-YANCEY: Objection to the
23 form.

24 BY MR. GRAHAM:

25 Q. And -- and for the purposes of this

1 question, I'm asking you to assume that the baby
2 was in a midpelvic station.

3 A. All right. For -- for the purposes of
4 this question I will assume that; although, I do
5 not agree that that is the case. I believe that
6 the baby was delivered from a low position. And I
7 -- I have not surveyed, again, obstetricians in the
8 area. When I was in training I had a number of --
9 of attending teachers that were quite comfortable
10 with midpelvic deliveries and that -- and practiced
11 them very safely.

12 Q. Do you remember the question?

13 A. Do I know any that would have done the
14 same thing? I believe that those physicians would
15 have, although, I have not asked anyone that I'm
16 currently working with whether they would have.
17 But I think I mentioned in our last meeting that --
18 that one of the interesting things about obstetrics
19 is that doctors aren't usually together during a
20 vaginal delivery. And while we share operative
21 cesarean deliveries frequently, we don't watch each
22 other do vacuums and -- and forceps and -- and
23 vaginal deliveries that are spontaneous very often.
24 So I don't know what those doctors would do.

25 Q. All right. So if you, personally, had

1 been in Dr. Rhett's shoes at the time of this
2 delivery, if you had determined the baby's station
3 to be in the midpelvis, you would have chosen not
4 to perform a vacuum extraction, correct?

5 A. That is correct. Although, it -- it
6 occurs to me that, I think when we discussed this
7 last time, that I did mention that if I felt that
8 that was the only way to get the baby out because
9 of unusual circumstances with a -- a difficulty in
10 performing a cesarean section in a timely fashion,
11 I might consider it. Because the techniques are
12 similar, but I've just not had as much experience
13 with that -- that level of delivery. So my choice
14 in -- in my hospital currently would be to pursue
15 with the cesarean section as quickly as I possibly
16 could.

17 Q. Okay. And as you sit there today, you
18 can't tell me of a single obstetrician who would
19 have performed a midpelvic extraction in this case
20 if he had been in Dr. Rhett's shoes at the time of
21 this delivery and determined the station to be
22 midpelvic, correct?

23 A. No, sir. I said that I know of a
24 number of physicians who were in my training
25 program where I spent much time watching other

1 doctors do deliveries and being present at the time
2 that they were doing those deliveries. And so I
3 don't know of any doctors here, because I'm not
4 with them while they're doing those deliveries and
5 I haven't taken a survey. But I know of a number
6 of doctors that I trained with that were very
7 comfortable with midpelvic deliveries.

8 Q. Who do you claim would have done a
9 midpelvic delivery under these circumstances?

10 MS. SIMMONS: Object to the form.

11 THE WITNESS: Are you asking me, again,
12 to name names, sir?

13 BY MR. GRAHAM:

14 Q. Yes, ma'am. That's what the "who"
15 refers to.

16 A. I appreciate that. Now, the last time
17 we met I was instructed by my lawyer not to give
18 you any names.

19 Q. I don't believe that's happened this
20 time.

21 A. I'm -- I'm just going to clarify,
22 because I wanted to know if I'm under that same
23 instruction by my legal advice.

24 MS. SIMMONS: Ed, I -- she's already
25 answered you 12 different ways that they are

1 attendings, but she's not willing to say their
2 names. Why don't you just ask her -- ask her if
3 it's standard of care instead of asking her for
4 particular names?

5 MR. GRAHAM: Chilton, I so appreciate
6 your attempts to help me ask the questions you want
7 me to ask. Thank you so very much. Are you going
8 to instruct her to answer my questions as the rules
9 require, or are you going to instruct her yet again
10 not to answer?

11 MS. SIMMONS: I'm going to instruct her
12 yet again not to answer, and she's already answered
13 the question 14 different ways so I object because
14 it's been asked and answered.

15 MR. GRAHAM: She has not answered the
16 question a single time. You haven't allowed her
17 to.

18 MS. SIMMONS: I've -- I've not said
19 anything until you just brought me into this
20 discussion. So now I'm instructing her not to
21 answer, because she's already answered the question
22 ten different ways.

23 MR. GRAHAM: So you are --

24 MS. SIMMONS: She said numerous
25 attending physicians.

1 MR. GRAHAM: -- you are instructing her
2 not to tell me the name of any doctor that she
3 contends would have performed a midpelvic vacuum
4 extraction under the circumstances --

5 MS. SIMMONS: Correct.

6 MR. GRAHAM: -- in this case?

7 MS. SIMMONS: Because she has already
8 explained that numerous doctors that she trained
9 with would have done that. And she's already
10 explained that now since she has not been a
11 resident, she doesn't practice next to doctors who
12 are doing a delivery because she's the doctor doing
13 the delivery. So she's not in the -- in the
14 circumstance to see particular doctors doing it.
15 Your question is inherently --

16 MR. GRAHAM: Dr. Norton, I'm going to
17 move on and we'll let the Judge decide whether you
18 have --

19 MS. SIMMONS: Great.

20 MR. GRAHAM: -- to answer that question
21 or not.

22 MS. SIMMONS: Let's do. Please take it
23 to the Judge --

24 BY MR. GRAHAM:

25 Q. Now, earlier you told me, the first go

1 around you told me you considered half the doctors
2 in the State of South Carolina to be stupider than
3 Dr. Rhett. You also told me you believed half the
4 doctors in -- in Charleston County or Beaufort
5 County to be stupider than Dr. Rhett. What I'd
6 like you to tell me, ma'am, is on what subjects do
7 you believe other obstetricians are stupider than
8 Dr. Rhett?

9 MS. SMITH-YANCEY: This is Lindsay
10 Smith Yancey and I object to the form of that
11 question.

12 MS. SIMMONS: I -- I object, and I'm
13 instructing her not to answer. I think your
14 questions are inherently flawed and I think they're
15 bordering on being harassive now. So please take
16 that before a Judge and we'll let him or her
17 decide.

18 MR. GRAHAM: Well, I have a number of
19 follow ups. And I -- I don't want to belabor the
20 point, but I would like to get some of these follow
21 ups on -- on the record. If you want me to stop,
22 just say so.

23 BY MR. GRAHAM:

24 Q Dr. Rhett was unable to define
25 engagement. Do you seriously contend, Dr. Norton,

1 that other obstetricians in South Carolina who are
2 board certified and still alive and still
3 practicing obstetrics do not know what engagement
4 is?

5 A. Mr. Graham, may I address any of the
6 other points that you made before, or do I need to
7 just answer that particular point?

8 Q. I don't know what -- what -- what are
9 you asking me about?

10 A. Well --

11 Q. About what subjects?

12 A. Well, you made --

13 Q. You were instructed not to answer about
14 the subjects on which you believe doctors are
15 stupider than Dr. Rhett.

16 A. Okay.

17 Q. So I --

18 A. I guess I --

19 Q. I'm going to take that up with the
20 Judge.

21 A. May I -- may I just --

22 Q. But you have not been instructed not to
23 answer my question about do you seriously believe
24 other obstetricians who are board certified, still
25 alive and still practicing obstetrics do not know

1 what engagement means.

2 A. Okay. Sir, I know I'm supposed to
3 answer in a yes or no, but may I offer an
4 explanation?

5 Q. I'd appreciate a yes or no, and then
6 you may offer an explanation.

7 A. Okay. Will you -- will you remind me
8 again of -- of whether you formed it in a positive
9 or negative? I can't remember the question now,
10 sir. Can you just rephrase it one more time?

11 Q. Do you contend that there exists board
12 certified obstetricians in the State of South
13 Carolina who are still alive and practicing
14 obstetrics that do not know what the word
15 engagement means in the context of fetal head
16 station?

17 A. Yes, I do.

18 Q. How many?

19 MS. SIMMONS: You answer the question
20 fully.

21 THE WITNESS: How many?

22 BY MR. GRAHAM:

23 Q. Yes, ma'am.

24 A. I haven't -- I haven't surveyed every
25 one that I've come into contact with, but I

1 absolutely assert that there are many practicing
2 physicians who do not give textbook definitions of
3 concepts that they use on a daily basis that
4 they're quite comfortable with.

5 Q. Right.

6 A. I don't feel that there are board
7 certified obstetricians that aren't aware of the
8 concept of engagement. That aren't aware of how to
9 -- to determine the head is engaged, is not
10 engaged, but I do believe that there are, in fact
11 possibly the majority, who are not prepared to give
12 a textbook definition, especially in the setting of
13 such a -- a high pressure situation as a
14 deposition. And that --

15 Q. Are --

16 A. I'm sorry, I'm still talking, sir. And
17 I do believe that the difficulty with using
18 textbook terms is that we don't use them on a daily
19 basis. In -- in practice of medicine, especially
20 in the practice of obstetrics and gynecology, we
21 are in the process of actively managing our
22 patients and we are doing very technical, physical
23 things that we can't perhaps not explain to -- to
24 anyone that would help them understand it in a -- a
25 clear way. And there are people that have

1 additional expertise in teaching and in writing
2 textbooks and explaining in a legal expert witness
3 situation or translating that -- that are more
4 comfortable with using those terms and using them
5 via the textbooks. But in general, obstetricians
6 and gynecologists that I have come into contact
7 with are not able, necessarily, to produce these
8 textbook definitions of a concept that they are
9 quite familiar with and -- and of procedures and
10 actions that they are extremely competent at. It
11 doesn't mean that they can't necessarily explain
12 the term.

13 Q. What do you mean when you say
14 necessarily?

15 A. I -- I said I hadn't done a survey, but
16 I have asked several obstetricians and I have
17 gotten a number of people who have not been able to
18 give me a textbook definition of those terms.

19 Q. What do you mean when you say
20 necessarily?

21 A. I mean that there may be some that are
22 able, because I mentioned before that there are
23 some people that are quite comfortable with using
24 those terms in a textbook definition. But it -- it
25 has nothing to do with their competence or their

1 expertise or their intelligence and their ability
2 to perform as an obstetrician/gynecologist.

3 Q. When you say not necessarily, do you
4 mean maybe yes maybe no?

5 A. I mean that certain doctors would be
6 able to give a textbook definition and that other
7 doctors would not.

8 Q. Okay. Now, you added all that stuff
9 about textbook definition. Do you remember what my
10 question was, Dr. Norton?

11 A. Did I believe that there were -- well,
12 no, why don't you repeat it and make sure that I
13 understand.

14 Q. My question is, do you seriously
15 contend under oath that there are obstetricians in
16 the State of South Carolina, board certified,
17 practicing, living obstetricians, who do not know
18 what engagement means?

19 A. Sir, I don't believe that's the way you
20 phrased the question before. I believe that you
21 said that are not able to describe, not do not know
22 what it means. And I've tried to draw that line
23 and that distinction, because there's a description
24 and there's a practical knowledge. And I said
25 before that the practical knowledge, I believe that

1 those obstetricians are able to use it in a
2 practical way. But whether they can convey that in
3 a descriptive term in a textbook definition, and I
4 think that that is -- is maybe yes maybe no, it
5 depends.

6 Q. All right. You've said textbook now
7 about 15 or 20 times. I don't believe I've said it
8 yet until this question. I'm not asking you,
9 ma'am, for any textbook definitions or whether
10 there are any doctors who can define textbook
11 definitions. I'm asking a very simple question.
12 You're under oath, ma'am. Can you seriously
13 testify under oath that there is any obstetrician
14 in the State of South Carolina who is alive and
15 practicing obstetrics who does not know what
16 engagement means?

17 A. Sir, if you say does not know what it
18 means and does not understand it, then I would say
19 that I -- that I think that that would be rare. If
20 you say that can they not state it and explain it,
21 then I would say that that would be common.

22 Q. Okay. Apart from Dr. Rhett, do you
23 know of even a single obstetrician in the State of
24 South Carolina who does not know what engagement
25 means?

1 A. Sir, I -- I do not believe that Dr.
2 Rhett does not know what engagement means. And so
3 I -- I don't believe you ever answered me about
4 whether I'm allowed to object to the form, but just
5 to say I don't know personally of someone who does
6 not know what -- how to use engagement in terms of
7 taking care of a patient; although, I suppose that
8 it's possible that there are people that do not.
9 But -- but I -- I will state again that I do not
10 believe that it is uncommon at all for people not
11 to be able to describe it.

12 Q. Thank you so much for that information,
13 and if I want that information I will -- I will ask
14 for it, I assure it. Let me make it very clear,
15 ma'am, you've asked me if you're allowed to object
16 to the question, the answer is no.

17 A. Thank you.

18 Q. Your attorney, Chilton Simmons, sits
19 right there. I'm sure she'll be happy to object to
20 the question --

21 A. Thank you.

22 Q. -- if she believes that's an
23 appropriate response.

24 A. Thank you.

25 Q. But let me ask you this, ma'am.

1 Putting aside Dr. Rhett, do you know of any
2 obstetrician in the State of South Carolina that
3 you contend does not know what engagement means?

4 MS. SIMMONS: Objection. Asked and
5 asks four times at least.

6 BY MR. GRAHAM:

7 Q. Do you?

8 A. Sorry?

9 Q. Do you?

10 A. No. With the qualifications, again,
11 that -- that if we are saying means by describing
12 versus means and understands. Again, as I stated
13 before, I do not know personally of someone who
14 doesn't understand the concept and is able to use
15 it with a patient. But I -- I know people who are
16 not able to give me a clear definition in -- in
17 words.

18 Q. How many?

19 A. I don't know, because I haven't taken a
20 survey.

21 Q. Why must you take a survey to answer my
22 question, which is, how many do you know who can't
23 give a textbook definition of engagement?

24 A. I'm sorry, I know a number of
25 obstetricians and I haven't asked that question of

1 the obstetricians that I know. Maybe I
2 misunderstood.

3 Q. So you don't know -- as you sit here
4 today, you don't know of any obstetrician that
5 can't give a textbook definition of engagement, is
6 that correct?

7 A. No, I asked several obstetricians and
8 they could not give a textbook -- textbook
9 definition.

10 Q. How many?

11 A. I asked three.

12 Q. What were the answers that they gave?

13 MS. SIMMONS: Objection. This is so
14 irrelevant to this case, Ed. I object. Go -- go
15 for it if you want to sit here all night and do
16 this.

17 BY MR. GRAHAM:

18 Q. What were their answers?

19 A. I don't recall the specifics of their
20 answers. They were unable to talk about the
21 biparietal diameter passing the pelvis inlet.

22 Q. Okay. Putting aside Dr. Rhett, do you
23 know of any obstetrician in the State of South
24 Carolina who does not know what -- does not know
25 how to determine a baby's station?

1 MS. SIMMONS: Object to the form.

2 THE WITNESS: Again, with -- with the
3 caveats that I explained earlier, that I don't
4 personally know of someone who is a board certified
5 obstetrician/gynecologist who is unable to
6 ascertain the station of a baby.

7 BY MR. GRAHAM:

8 Q. Okay. Putting aside Dr. Rhett, do you
9 know any obstetrician in the State of South
10 Carolina that believes a baby's brain has two
11 occiputs?

12 MS. SIMMONS: Object to the form.

13 MS. SMITH-YANCEY: Object to the form.

14 THE WITNESS: I do not know anyone
15 personally.

16 BY MR. GRAHAM:

17 Q. Putting aside Dr. Rhett, do you know
18 any obstetrician in the State of South Carolina
19 that believes occiputs are on the sides of the
20 head?

21 A. No, sir. Again --

22 MS. SIMMONS: Object to the form.

23 THE WITNESS: Pardon me. Again, not
24 that I know personally that I've asked that
25 question, no, sir.

1 BY MR. GRAHAM:

2 Q. Putting aside Dr. Rhett, do you know
3 any obstetrician in the State of South Carolina
4 that believes you determine station by measuring
5 the difference between the two occiputs?

6 MS. SIMMONS: Object to the form.

7 THE WITNESS: Same answer, sir. No, I
8 don't know personally.

9 BY MR. GRAHAM:

10 Q. Putting aside Dr. Rhett, do you know
11 any obstetrician in the State of South Carolina
12 that does not know what arrest of descent is?

13 MS. SIMMONS: Object to the form.

14 MS. SMITH-YANCEY: Object to the form.

15 THE WITNESS: Again, if it's a -- if
16 it's a definition, yes. If it is a -- if it is the
17 concept and using it clinically, I do not, no.

18 BY MR. GRAHAM:

19 Q. All right. I understand the second
20 part of your answer. In terms of the first part of
21 your answer, how many obstetricians do you know
22 that are unable to give a definition of arrest of
23 descent?

24 MS. SIMMONS: Object to the form.

25 THE WITNESS: To -- to be -- sir, to be

1 clear, I don't know. I don't know that number,
2 because I haven't asked the obstetricians.

3 BY MR. GRAHAM:

4 Q. Aside from Dr. Rhett, do you know of
5 any obstetrician in South Carolina who does not
6 know what prolonged descent is?

7 A. No, sir.

8 Q. Aside from Dr. Rhett, do you know any
9 obstetrician in South Carolina that does not know
10 what a biparietal diameter is?

11 MS. SIMMONS: Object to the form.

12 MS. SMITH-YANCEY: Object to the form.

13 THE WITNESS: No, sir.

14 BY MR. GRAHAM:

15 Q. Aside from Dr. Rhett, do you know of
16 any obstetrician in South Carolina that does not
17 know what a cranial pivot or flexing point is?

18 MS. SIMMONS: Object to the form.

19 MS. SMITH-YANCEY: Object to the form.

20 THE WITNESS: Yes, sir. Well, I should
21 say to clarify, I was not familiar with that term
22 and I looked it up and now I think I have a better
23 sense of it. But I have not used that term
24 clinically.

25 BY MR. GRAHAM:

1 Q. Okay. Aside from Dr. Rhett, do you
2 know any other obstetrician who describes the
3 difference between the baby's two occiputs as being
4 the bicipital?

5 MS. SIMMONS: Object to the form.

6 THE WITNESS: No, sir.

7 BY MR. GRAHAM:

8 Q. Besides Dr. Rhett, do you know of any
9 obstetrician that uses the word bicipital?

10 MS. SIMMONS: Object to the form.

11 THE WITNESS: No, sir.

12 BY MR. GRAHAM:

13 Q. Besides -- or putting Dr. Rhett aside,
14 do you know of any obstetrician in the south -- in
15 the State of South Carolina who believes the head
16 is crowning when the head is really in the
17 midpelvis?

18 MS. SIMMONS: Object to the form.

19 MS. SMITH-YANCEY: Object to the form.

20 THE WITNESS: No, sir.

21 BY MR. GRAHAM:

22 Q. How does blood in the brain cause
23 residual brain damage?

24 MS. SMITH-YANCEY: Object to the form.

25 MS. SIMMONS: Objection.

1 THE WITNESS: Could you be more
2 specific?

3 BY MR. GRAHAM:

4 Q. Yes, ma'am. Last time we met, you --
5 you were telling me that you believed Jayden
6 W. brain damage was caused by his brain
7 bleed, the presence of blood, and the necessity to
8 evacuate a clot. Do you remember that?

9 A. I do.

10 Q. Okay. And I believe you were telling
11 me that when a -- a blood vessel in the brain
12 ruptures and bleeds, the -- the presence of blood
13 in the brain itself causes damage even if the blood
14 is later somehow removed or --

15 MS. SIMMONS: Object to the form.

16 BY MR. GRAHAM:

17 Q. -- absorbed or what have you.

18 MS. SMITH-YANCEY: Object to the form.

19 THE WITNESS: Okay. So, can you
20 reframe that question for me?

21 BY MR. GRAHAM:

22 Q. Yes, ma'am. I'm just asking --

23 A. How did --

24 Q. -- how does -- how do you believe blood
25 in the brain causes residual brain damage?

1 A. All right.

2 MS. SMITH-YANCEY: Object to the form.

3 MS. SIMMONS: Objection.

4 THE WITNESS: I believe that -- that
5 blood in the brain can put pressure on the
6 surrounding structures, and that the pressure can
7 cause decreased blood flow to those areas and can
8 cause cellular damage or death. I believe that --
9 that blood can be an irritant and cause influx of
10 inflammatory cells that can cause, again,
11 inflammation and damage to surrounding cells.
12 Those would be the -- the main things. As well, if
13 there is an interruption in blood flow from a --
14 for instance, a ruptured artery, then there would
15 be a decrease in blood flow to that area that the
16 artery was feeding of the brain distal -- distal to
17 that rupture.

18 BY MR. GRAHAM:

19 Q. You acknowledge that the vacuum
20 extraction can damage a baby's brain, correct?

21 A. I acknowledge that it's associated with
22 -- with later problems, that it's associated.

23 Q. Do you believe that vacuum extraction
24 can cause blood vessels in a baby's brain to bleed?

25 A. Yes.

1 Q. What is your understanding of how that
2 can happen?

3 A. I'm not --

4 MS. SMITH-YANCEY: Object to the form.

5 MS. SIMMONS: I'll object as well.

6 THE WITNESS: -- I'm not sure of the
7 exact mechanics, but my understanding is that --
8 loosely that there would be increased tension that
9 perhaps would pull -- pull the vessel away. You
10 know, when -- when we're looking at superficial
11 areas like the -- the -- the scalp increased
12 bleeding that it would be a pulling force that
13 would interrupt the actual wall of the blood vessel
14 and that you could have surrounding blood be
15 extruded.

16 BY MR. GRAHAM:

17 Q. Do you consider yourself as having
18 special expertise about the physics of how a vacuum
19 extraction can cause blood vessels in the baby's
20 brain to bleed?

21 A. I would say yes and no. Yes, in that
22 I'm a practicing board certified
23 obstetrician/gynecologist. And, no, in that I have
24 not done bench research on that area.

25 Q. Okay. Is it your understanding that

1 basically the pulling force you're talking about is
2 the suction from the vacuum cup actually pulling
3 the scalp away from the brain tissue?

4 MS. SIMMONS: Object to the form.

5 THE WITNESS: I guess I'm -- I'm not
6 clear -- maybe I wasn't clear. When I was talking
7 about the scalp, that's actually not directly
8 contiguous with the brain tissue, so I would be
9 saying that it was more of a -- of a superficial --
10 a bruise situation. And so -- so, no, I would say
11 -- no, it wouldn't cause a -- goodness, that it was
12 a -- a force just directly from the scalp into the
13 brain from...

14 BY MR. GRAHAM:

15 Q. Are you now testifying that in your
16 opinion vacuum extraction cannot cause a blood
17 vessel in the baby's brain to bleed?

18 A. No, sir.

19 Q. You agree that a vacuum extraction can
20 cause a blood vessel in a baby's brain to bleed?

21 A. Yes, that's my understanding.

22 Q. Okay. And so I'm -- I'm confused about
23 the clarification you were attempting to explain to
24 me. Do you -- do you acknowledge that the way the
25 blood vessels get damaged is when the scalp gets

1 pulled away from the lower tissues inside the
2 baby's head?

3 A. I see. No, what I meant to -- to try
4 to clarify is that I am not as comfortable with the
5 actual mechanics of the vacuum extraction in terms
6 of a deep bleed. But I'm very -- more comfortable
7 with the -- the superficial, so that's why I tried
8 to talk about the superficial because the -- the
9 bruise that can form on the scalp is -- is to do
10 with the destruction and the -- the walls of the
11 vessels is my understanding. And so I was, I
12 believe, trying to clarify that I wasn't as clear
13 on the other, but I could think of an example of
14 how that would occur in the superficial structures.

15 Q. Okay. So you have a better
16 understanding of bruising to the surface of the
17 scalp?

18 A. Yes, sir.

19 Q. Okay. And that doesn't cause brain
20 damage, correct?

21 A. Well, it depends on -- on the degree of
22 bleeding and bruising in the scalp. But subgaleal
23 hemorrhages that are -- that are more superficial
24 can cause enough blood loss that that can cause
25 later problems and even cause death.

1 Q. Okay. But you don't consider yourself
2 as having expertise about the relationship between
3 vacuum extraction and deeper brain bleeds, is that
4 correct?

5 A. If you say special expertise as into
6 the physics of it than, yes, that's correct.

7 Q. Okay. But you do acknowledge that
8 vacuum extraction can cause deeper bleeds in the
9 brain beyond the -- deeper than the superficial
10 ones you were talking about, correct?

11 A. I believe that to be true; although,
12 again, I can't cite -- cite a specific reference on
13 how they would understand and ascertain that. I
14 know very clearly that it's associated.

15 Q. Okay.

16 A. But I don't know the physics of how
17 that might occur in a specific situation.

18 Q. Okay. And it's associated with deeper
19 bleeds in many different portions of the brain,
20 correct?

21 A. That's correct.

22 Q. Including the posterior portion?

23 A. Yes, that's correct.

24 Q. Okay. Thank you. Last time we met you
25 had in a very general way offered the view that you

1 had some criticism of Dr. Oakes' deposition
2 testimony. I'd like to give you an opportunity to
3 explain that now.

4 A. All right. Sir, I need to pull that
5 reference.

6 Q. Sure.

7 A. Can you wait a moment? Thank you. I
8 have it.

9 Q. Okay. And what criticisms do you have
10 of -- of the material in Dr. Oakes' deposition?

11 A. Okay. Do you recall where I stopped?
12 On what page I stopped when we discussed --

13 Q. I don't believe we ever started.

14 A. All right.

15 Q. We -- we discussed it briefly before a
16 break, but I decided to go into a different
17 direction after the break.

18 A. Thank you. I'm just reviewing it page
19 by page. It'll just take a moment.

20 Q. Sure.

21 A. All right. The first objection I have
22 or -- or -- can you tell me, again, am I supposed
23 to just mention what -- what statements that he
24 makes that I disagree with?

25 Q. If that's how you'd like to answer the

1 question, that's fine.

2 A. Okay. Bates -- oh, I don't know that I
3 have a Bates number. It's --

4 MS. SIMMONS: It's a page number.

5 THE WITNESS: Okay. Page 5.

6 BY MR. GRAHAM:

7 Q. Okay. And let me get you to clarify
8 one thing.

9 A. Yes, sir.

10 Q. I believe you're looking at a condensed
11 transcript?

12 A. Oh, yes. And so the page --

13 Q. You say page 5, are you talking
14 about --

15 A. I am -- I'm -- I apologize. Page 14
16 of exhibit --

17 Q. Page 14 of the original, page 5 of the
18 condensed?

19 MS. SIMMONS: Yes.

20 THE WITNESS: May I ask Chilton if
21 that's correct?

22 MS. SIMMONS: Yes.

23 THE WITNESS: Yes, that's correct.

24 BY MR. GRAHAM:

25 Q. Okay. Thank you for the clarification.

1 A. He -- I believe the question was: Is
2 -- is it your opinion Dr. Rhett should not have
3 used the vacuum? And yes. And what's the basis
4 for that? I don't think he has an indication. I
5 disagree. I believe that there was a strong
6 indication for a use of a vacuum in that situation.

7 Q. That being what?

8 A. The concern for -- need for urgent
9 delivery of the baby.

10 Q. Based on your interpretation of the
11 strips, correct?

12 A. Yes.

13 Q. Okay. Please continue.

14 A. He says on that same page, one looks at
15 the video one does not get the impression this
16 mother is exhausted nor lethargic, and I disagree
17 with that statement. I viewed the video as well,
18 and I feel that the mother did look exhausted and
19 lethargic.

20 Q. Okay. And what page was that?

21 A. It's again on page 14.

22 Q. Okay. Thank you.

23 A. When it says -- the end of 14 into page
24 15, that same paragraph, he said that because she
25 hadn't been pushing well that's not a test of

1 maternal Valsalva. I would disagree. In the video
2 she had an attempt to push prior to when there was
3 still a rim of cervix about 6:45, and then she had
4 several attempts with the -- with the nurse. And I
5 felt that -- that it was clear from those that she
6 was having difficulty in cooperating and bringing
7 the baby down quickly. So I feel that that is a
8 test of maternal Valsalva and so I disagree with
9 that statement.

10 Q. Thank you. Please continue.

11 A. Okay. Continuing with page 15, it says
12 that he had a problem with the way Dr. Rhett used
13 the vacuum and that he had a problem with the fact
14 that he used it at all. So I -- again, I -- I feel
15 that he did have an indication. And when he talks
16 about that -- that the no indication at the time
17 that it's done, so, again, I disagree with that.

18 Q. All right. Was part of that
19 disagreement that you disagreed with the criticism
20 of how he used it?

21 A. I don't believe that was in page 15. I
22 don't think he criticizes the -- the technique.

23 Q. Okay. I -- I misunderstand.

24 A. Okay.

25 Q. Please continue.

1 A. Sure. Okay. Again, continuing bottom
2 of 15 into page 16, he says that are of these
3 things are reassuring, that the heart rate is
4 reassuring and he and I disagree. I think -- I
5 think we went over the strips on our last visit,
6 but that is one area that I disagree. I pointed
7 out the area of late decelerations, a decreased
8 variability, that -- the variable decelerations and
9 the prolonged decelerations as well --

10 Q. I recall that testimony.

11 A. -- as well as the fact that this was a
12 mother who had an ingression at 41 weeks with a --
13 an older placenta as well as the fact that the baby
14 had a fetal scalp electrode applied, which is done
15 in situations where there's more concern about the
16 baby with that -- that prolonged bradycardia that
17 she had about noontime, that ten-minute
18 bradycardia.

19 Q. Okay. Please continue.

20 A. Okay. Okay. Again, on page 16 with
21 the next question, he said about the C-section,
22 their impression was there was going to be a
23 C-section and there was nothing said by Dr. Rhett
24 or the nurse about why there wasn't a C-section.
25 In the video there's a discussion when Dr. Rhett

1 states that he's going to try to get the baby out
2 and if he's unable to, they will proceed with a
3 C-section. As well as about an hour previously
4 when there was this bradycardia, he said if -- if
5 you keep this up we're going to have to do a
6 C-section. In the discussion with the family,
7 there was a -- they said to the patient, C-section,
8 is he not going to do a C-section. And then they
9 said that -- that that's right, if you don't push
10 hard you're going to have to have a C-section and
11 so I believe there was a understanding about why
12 there was -- that the C-section was going to be
13 needed if -- if she was unable to push the baby
14 out.

15 Q. And he never said anything about using
16 a vacuum, did he?

17 A. No, sir. I did not hear him
18 specifically talk about the tools that he was using
19 to expedite the delivery. He did mention that --
20 he did state that he was needing to proceed with
21 immediate delivery and that he was going to help to
22 assist that. And let's get this baby out.

23 Q. Please continue.

24 A. Okay. He states that, again, on that
25 same page, that he does not believe that a

1 C-section was indicated, and I disagree with that.
2 That I -- I think that if -- if this -- this --
3 because I believe that the strip necessitated
4 urgent delivery, that some intervention was
5 necessary.

6 Q. Please continue.

7 A. Okay. I'm still reading, sir. I don't
8 mean to make you wait.

9 Q. Take your time.

10 A. Thank you. Okay. I disagree on page
11 21 when they're discussing the station of the --
12 the baby when the vacuum was applied. And he
13 states that he has an opinion that the vacuum was
14 not on outlet, not a low, it's at least a mid if
15 not higher. And I disagree. I believe that this
16 was clearly a low vacuum on the basis of the
17 descriptions that Dr. Rhett gave as well as in
18 viewing the video. I noted that although it's very
19 dark and so it's hard to see the head well, there's
20 -- you know, she's dark skinned, the baby's hair
21 was dark and it was not well lite, I do know that
22 several times during the -- during the video I
23 could see where Dr. Rhett's fingers appeared to be
24 very superficially in the vaginal area. Appearing
25 to -- to abut the -- the crowning -- the presenting

1 vertex. And as well when he removed the fetal
2 scalp electrodes, it was done very superficially
3 with his fingers very close to the opening of the
4 vaginal area.

5 In addition, there's a comment on the
6 video by one of the family members that they could
7 see the baby. And this was prior to the vacuum
8 being applied when the patient was pushing. And so
9 that to me tells me that it was a low -- a low
10 vacuum or possibly an outlet although it's not
11 clear from the video that that's the case. It was
12 an outlet. It looks to me like it was more out to
13 be a low.

14 Q. Thank you. Please continue.

15 A. Okay. On page 21, I'm accessing the
16 definition of a -- of a low operative vaginal
17 delivery. He says that if you're plus two and
18 there's not a rotation it's going to be a low. But
19 there's two classifications of a low. One is with
20 a rotation, one is without.

21 Again, on the end of this paragraph he
22 talks about how high the vacuum extractor appears
23 to be in the vaginal area. And I would say that
24 because of the angle that the video was taken as
25 well as the lighting, it was not clear -- it wasn't

1 a head-on view of the -- of the application, and so
2 some of the obscuring of the vacuum would be
3 related to the angle in the maternal labia that
4 were -- that were obscuring. That it doesn't count
5 as part of the station.

6 And, again, continuing on page 22 when
7 he says the -- the third phalanges are in her
8 vagina. And so there is his head right there that
9 he's running into, it's clearly higher. I would
10 disagree with that statement. I think I mentioned
11 earlier that I felt that his fingers at one point
12 where running into the head, and that the whole
13 process of -- after I deliver a baby and that I --
14 and watching what I felt he was doing was examining
15 for the -- the position of the head -- in order to
16 examine above the presenting part and actually to
17 examine where the sutures are and where the
18 fontanelles are, where the ears are, you have to go
19 way beyond the presenting part of the head. And so
20 in every delivery that I do, I place my fingers
21 initially to -- to judge the -- the station and the
22 descent. And then I go all the way around with my
23 fingers in as far as they'll go so that I can feel
24 the maternal and fetal structures better.

25 Q. Thank you. Please continue.

1 A. Okay. And he said that he said the
2 documentation in the record of the station is never
3 below zero.

4 Q. And are you saying you disagree with
5 that?

6 A. No. I guess just that he says that --
7 at one point he said that it was higher than --
8 than a -- potentially higher than a mid but it
9 might have been a high. And because it was a zero
10 station that it would not have, by definition, been
11 a high.

12 An page 23 his answer, he says Dr.
13 Rhett never even reports that he uses a vacuum and
14 yet on the -- the Hollister forms where the
15 definition -- the description of the delivery is
16 checked. There's check boxes for the vacuum and he
17 signs on that.

18 Q. But he did not mention delivery -- he
19 did not mention vacuum in his delivery note,
20 correct?

21 A. That is correct. But he said in this
22 statement, in fact Dr. Rhett never even records
23 that he uses the vacuum. And so I'm objecting to
24 that saying that he filled it -- that it's signed
25 on the form that -- that -- it's filled out on the

1 form that he signed.

2 Q. And are you assuming that a nurse
3 filled in the information on that Hollister form
4 with vacuum references, or that the doctor did?

5 A. I'm making no assumption either way.

6 Q. Okay. Thank you. Please continue.

7 A. Uh-huh. I'm -- I'm still reading.

8 Q. That's fine.

9 A. On page 32 into page 33 when he states
10 about the type of vacuum that was used, I believe
11 Dr. Rhett said that he wasn't sure what type of
12 vacuum was used rather than he stated definitively
13 that it was the, I'm not sure now to pronounce it,
14 M-I-E-L-E vacuum.

15 Q. Okay.

16 MS. CHILTON: Dr. Norton?

17 THE WITNESS: Yes.

18 MS. CHILTON: Can I unplug this? Is
19 that bad?

20 MR. GRAHAM: Is everyone still there?

21 THE WITNESS: Yes, I'm sorry. We're
22 having an -- an environmental concern. I was
23 reading and -- and Chilton asked me if she could
24 turn off a beeping machine. Would you mind if we
25 attended to that for a moment?

1 MR. GRAHAM: No, that's fine.

2 THE WITNESS: Thank you.

3 (A recess transpired.)

4 BY MR. GRAHAM:

5 Q. Thank you, Doctor. Please continue.

6 A. Sure. I'm going to just adjust the
7 chair a moment. Ms. Smith-Yancey was having
8 trouble hearing me, so I'm going to try to turn my
9 body a little. Okay. I'm ready.

10 MR. GRAHAM: Before you say anything
11 else, madam court reporter, are you ready?

12 THE COURT REPORTER: Yes, I'm ready.

13 MR. GRAHAM: I just didn't want to
14 forget about you. Thank you.

15 BY MR. GRAHAM:

16 Q. Please continue whenever you're ready,
17 Doctor.

18 A. Thank you. I'm just reviewing.
19 Getting -- getting back to where I was, I'm sorry.

20 Q. Okay.

21 A. Okay. Okay. I'm on -- there's a -- I
22 guess page 34 -- oh, no, I -- I addressed that. I
23 apologize. On page 36 at it top, he states I'm
24 critical of his watching the video and he doesn't
25 even know what he was doing when he did it and what

1 he was using. And I -- I -- I don't agree that he
2 didn't know what he was doing when he did it. I
3 agree that he doesn't, at this time, recall the
4 exact type of vacuum that he used, but not that he
5 didn't know what he was doing when he did it.

6 Q. Thank you. Please continue.

7 A. Again, on that page 36, he said --
8 there's a question about maternal exhaustion and he
9 says that maternal exhaustion and he says that
10 maternal exhaustion has to do with a -- a long
11 second stage, but those are two different issues.
12 A prolonged second stage and different from
13 maternal exhaustion in my opinion. Okay. On page
14 38, there's a question about -- seeing the hair on
15 the baby's head and he says that the -- you can see
16 the hair several stations up as in several negative
17 stations and he says, no, not negative stations
18 plus stations. And yet earlier he said that he
19 thought that the -- that the head was potentially
20 up in the high -- high pelvic delivery and yet Dr.
21 Rhett says in the video that he can see the hair
22 and the other family member states that she can see
23 the hair. And so since he watched the video, if
24 he's saying that -- that seeing the hair means that
25 it's a plus station then I don't see how he can say

1 that -- that there's a chance that this was a high
2 forceps delivery.

3 Q. Thank you. Please continue.

4 A. Okay. Page 38 at the bottom, he's --
5 there's the question were able to get a clear shot
6 on the video of that? And he says you -- you --
7 you see that it was a clear shot and you see when
8 they're spreading the labia, you see no hair. And
9 -- and yet my viewing of the video, the combination
10 of the darkness of the picture as well as the angle
11 that the video was taken make it impossible for me
12 to have as clear a shot as Dr. Rhett would have had
13 being right there. On page 40 at the bottom,
14 there's a question about the station again. And he
15 says here, I see no reason that this isn't at least
16 a zero station. I -- I can't see that it's a
17 positive station, yet earlier he states that he
18 thought it might have been a higher station.

19 Q. Please continue.

20 A. Yes. On page 43, there's a question
21 about medical malpractice. He says my opinion is
22 not appropriately documented is malpractice, and I
23 disagree with that statement. The --

24 Q. Well, let me ask you, please, what does
25 the word malpractice mean to you?

1 A. Well, technically that would be bad
2 practice. Mal meaning -- Latin bad. So practicing
3 in a bad fashion. But, again, the -- the medical
4 malpractice would be something that would be
5 outside the standard of care. Something that a --
6 a reasonable doctor would do in similar
7 circumstances. And documentation, while extremely
8 helpful in circumstances such as being sued, is not
9 necessary for the care of a patient in -- in
10 circumstances such as these.

11 Q. Please continue.

12 A. Page 43 at the bottom says the
13 incidents of serious complications of vacuum
14 extraction is approximately 5 percent, and yet
15 there's a -- a -- that would be more for all
16 complications. There's a statement by the ACOG
17 Technical Bulletin that talked about listing a risk
18 of serious complications with the use of a vacuum
19 at 1 in 45,000, which is certainly not 5 percent.

20 Q. Please continue.

21 A. It says given the -- the maternal --
22 I'm sorry, bottom of page 43, given the maternal
23 and neonatal risks associated with operative
24 vaginal delivery it's -- I'm sorry, continuing on
25 44 -- it's important that the patient be made aware

1 of the potential complications of the proposed
2 procedure. And my understanding of the bulletin is
3 it says it would be prudent, or that the -- the
4 ratings that the bulletin and Williams said that it
5 would be prudent to -- to have that documentation
6 and that discussion but not required.

7 One of the difficulties with practicing
8 medicine is that there are so many potential risks
9 and benefits to any given procedure that it's
10 difficult to -- to enumerate all of them, and
11 there's a spectrum of approach with some doctors
12 enumerating more and some doctors enumerating less.
13 And as well there's a spectrum of -- of patients
14 with some patients enquiring more and being perhaps
15 able to -- to understand more of the potential
16 risks and benefits.

17 Q. Do you agree that it would be prudent
18 for an obstetrician to give the patient sufficient
19 information to make an informed decision?

20 A. It would depend on the circumstances.
21 If -- if there's a situation that's an emergency
22 setting, it would be prudent to -- to -- to -- to
23 perform whatever indicated procedure is in the most
24 expeditious, quick fashion as possible and it was
25 -- so it would be more prudent to -- to proceed

1 rather than to launch into an explanation so that
2 they could make an informed decision. When someone
3 consents to care by a doctor, they have a -- a
4 consent for the doctor to use their best judgment
5 and -- and so in -- in emergency setting, then --
6 then it would be prudent to proceed quickly if that
7 was the -- if -- if the need was for speed.

8 Q. Is it your testimony that this delivery
9 is an example of such a situation?

10 A. Yes, sir.

11 Q. Please continue.

12 A. Thank you. Okay. Again, on page 44,
13 he says one has to give someone informed consent,
14 which I described earlier. That and then about the
15 rocking movements. Page 44 continuing to 45, that
16 Dr. Rhett rocks the vacuum many times up and down
17 and sideways and I disagree with that statement.
18 What -- as I viewed the video what I saw him do was
19 when he was applying traction he was pulling in a
20 -- in a steady downward motion, but when he was
21 checking to make sure that there were no maternal
22 issues in the way or when he was trying to ease the
23 maternal tissues out of the way of the head, that
24 he was adjusting the vacuum handle slightly, so
25 that he could reach all the way around the mother's

1 peritoneum.

2 Q. Did you acknowledge that he was moving
3 the lever of the vacuum in an up and down and
4 sideways manner?

5 A. Yes. Just very small amounts. Not
6 when he was applying the force, but when he was
7 adjusting just so that he could get his hand around
8 the vacuum itself.

9 Q. And was the pressure maintained in the
10 vacuum during that time?

11 A. I can assume because the vacuum did not
12 come off altogether, that was -- that it was
13 maintained to some degree.

14 Q. Well, it certainly wasn't relieved in
15 between pulls, was it?

16 A. The vacuum was not removed in the --
17 the vacuum was not removed in between pulls, no.

18 Q. Well, my question was the pressure on
19 the pump was not relieved between pulls, was it?

20 A. I don't know.

21 Q. You have no evidence that it was ever
22 relieved between pulls, do you?

23 A. No.

24 Q. Thank you. Please continue.

25 A. On page 48 he says that the foley --

1 that the foley should have been removed. And in
2 the instructions on operative vaginal delivery it
3 just states the bladder needs to be drained. And
4 since removing the foley takes time, I disagree
5 with the statement that it should have been taken
6 out.

7 Q. Is there a risk to leaving the foley in
8 during a vacuum extraction?

9 A. The risk to leaving the -- the foley in
10 for a delivery of any kind vaginally is that it
11 puts a little bit more pressure on the bladder as
12 the head comes through. It expands the size of the
13 bladder slightly, and that pressure can cause
14 bruising of the -- of the bladder.

15 Q. Okay. Please continue.

16 THE WITNESS: Oh, Mr. Graham, we need
17 to stop for the court reporter for a minute.

18 MR. GRAHAM: That's fine.

19 (A recess transpired.)

20 BY MR. GRAHAM:

21 Q. Please continue.

22 A. Okay. On page 49, talking about the
23 decelerations are associated with second stage or
24 something that is expected to see, and I would
25 disagree with that. That it's an expectation to

1 have decelerations in the second stage.

2 On page 50, he talks about the PH and
3 says that it's not to usual PH of the baby, and
4 that's on the low side and that there's cord
5 compression and -- or whatever causes the baby --
6 the -- the acidosis. And he says that it's not in
7 keeping with any correlation to brain damage, which
8 I agree with, but I disagree with the assumption
9 then that -- that what Dr. Rhett did was wrong. In
10 fact, I feel this is strong evidence that what Dr.
11 Rhett did was very much in keeping with safety and
12 health of the baby, because had they continued with
13 the -- the decelerations, then the baby could have
14 moved into that asphyxia range where there could
15 have been permanent neurologic damage asphyxia.
16 And I feel this is showing that the baby was having
17 significant decreased blood flow and that therefore
18 the operative vaginal delivery was indicated and
19 was beneficial.

20 Q. Would you be willing to express an
21 opinion to a reasonable degree of medical certainty
22 that it's ever a breach of standard practice to
23 fail to intervene because of hypoxia?

24 MS. SIMMONS: Object to the form.

25 THE WITNESS: Could you repeat that

1 please?

2 BY MR. GRAHAM:

3 Q. Yes, ma'am. Let's assume we have a
4 different situation here where an obstetrician is
5 being criticized for failure to intervene when
6 there's a situation of developing hypoxia.

7 A. Okay.

8 Q. Would you be telling to testify
9 publicly that it's a breach of standard practice
10 for an obstetrician to fail to intervene in that
11 situation?

12 A. Well, I believe it's a -- it's a case
13 by case situation. It could be a -- a breach of
14 the standard of care. It would depend on the
15 situation.

16 Q. Okay. Can you be more specific,
17 please?

18 A. Certainly. For instance in a setting
19 of abruption, when there is significant blood loss,
20 it may be that to take the mother to the operating
21 room would risk her life because of disseminated
22 intravascular coagulopathy, the DIC, and therefore
23 it would be a breach of care to -- to risk the
24 mother's life to -- to help save the baby if that
25 -- if that were not what the family wanted to do.

1 There'd be situations, again, in -- in settings
2 where in order to intervene it would put a -- a
3 great risk to the -- to the mother's life and
4 health. I'm, -- I'm trying to remember -- can you
5 repeat the question one more time? I just want to
6 make sure I understand about the fetal
7 complications. Can you say that again for me?

8 MR. GRAHAM: Madam court reporter,
9 could you read it back or do I need a --

10 THE WITNESS: She's checking.

11 (The Court Reporter read the question
12 commencing on page 61 line 8.)

13 THE WITNESS: And tell me again in --
14 in that situation being...

15 BY MR. GRAHAM:

16 Q. A situation in which the baby's
17 arterial blood gases have gone down to the level of
18 mild acidity that they were in this case.

19 MS. SIMMONS: Object to the form.

20 THE WITNESS: Can I say that -- that if
21 you're phrasing it that way I'd say no, because you
22 can't know what the final PH will be before the
23 baby is delivered. And so the decision has to be
24 made on the basis of your impression of the state
25 of the baby prior to delivery.

1 BY MR. GRAHAM:

2 Q. I'll tell you what, I will -- I will
3 reframe from asking any more questions along that
4 line. Let's go back to your review of Dr. Oakes'
5 deposition, please.

6 A. Thank you. Page 52, when there's an
7 issue about it doesn't appear to me there's any
8 other explanation for this intracerebral hemorrhage
9 other than a traumatic delivery. And yet, as we've
10 discussed in our previous deposition, when you look
11 at the literature, the statistics, and I -- I did
12 go back and look, sir, those were -- those were
13 term babies that were studied in the large study
14 cited in -- in the ACOG Technical Bulletin. But
15 that because the risk of intracerebral hemorrhage
16 is increased in forceps, vacuum, and cesarean birth
17 and labor, that that's associated with a -- a --
18 the forces of labor itself that is increasing that
19 risk rather than with the actual vacuum extraction.
20 And so I would say that -- that I disagree with
21 that statement.

22 Q. The study you refer to does not control
23 for stage at which operative vaginal delivery
24 occurred, does it?

25 A. I'm sorry, what -- pardon me. What --

1 what's your question?

2 Q. The study your referred to that you say
3 involved only term babies, it does not control for
4 the station at which operative vaginal delivery
5 occurred, does it?

6 A. I -- I don't know.

7 Q. Okay. Please continue.

8 A. Thank you. I'm just reading. I'm
9 sorry to take so long.

10 Q. Take your time.

11 A. Thank you. On page 58 the question is
12 whether there are other causes of the brain bleed
13 besides the vacuum, and he says I think you have to
14 come up with one. I'm not aware of one. And,
15 again, with that -- the literature, documentation,
16 of having the -- the number of -- of brain bleeds
17 that are not occurred with a vacuum, that in and of
18 itself shows that there are other causes. In
19 addition, a problem apart from the delivery such as
20 DIC caused from another problem such as -- such as
21 HSV infection could also be a cause for bleeding
22 into the brain.

23 Q. Let me make sure I understand you. Are
24 you identifying two causes? DIC and HSV infection?

25 A. No, HSV leading to DIC. That that

1 could -- that could be a separate cause of the
2 bleeding in the brain besides that it could occur
3 spontaneously from the forces of labor.

4 Q. Okay. You have no evidence that DIC
5 existed prior to the brain bleeds, do you?

6 A. You know, I'd have to go back and --
7 and look at the timing of it, sir, to know. I'm
8 not sure. Would you like me to go ahead and look
9 at that now?

10 Q. How long do you think it would take?

11 A. I'm not sure.

12 Q. Sure. Go ahead and look.

13 A. Okay. If anyone has a Bates number,
14 feel free. I'm seeing on the MUSC Hospital
15 discharge summary, page 2 into page 3, there's a
16 discussion about the neuro -- it says initially the
17 head ultrasound was performed, which was normal.
18 And then they said the head CT was performed that
19 revealed the bleeding. And then on item 6 it says
20 early during the hospital course the patient
21 suffered from DIC. And so that would suggest to me
22 that there's potential of -- of the DIC happening
23 prior to the finding of the bleed in the brain.

24 Q. Prior to the what? The finding of it?

25 A. Yes. The -- the head CT showing the

1 bleed in the brain. There was a negative head
2 ultrasound and then a positive head CT. And I'll
3 have to go to the specific chart, I haven't found
4 that yet, where -- where it says exactly the course
5 of -- the timing of those diagnoses.

6 Q. You aren't suggesting that a negative
7 head ultrasound rules out a brain bleed, are you?

8 A. Not entirely, no, sir.

9 Q. Okay. All right. Please continue.

10 A. Is that enough information on the DIC
11 question?

12 Q. Well, let me make sure I understand
13 you. As you sit there today, you don't have any
14 evidence of DIC existing prior to the rupture of
15 blood vessels in this child's brain, do you?

16 MS. SIMMONS: Object to the form.

17 THE WITNESS: Again, I haven't found
18 the time -- the time course of the DIC and the --
19 the head CT, so I -- I was looking for that and all
20 I have is that discharge summary. So I'll have to
21 look some more. Is this something that you want me
22 to try to find and get back to you on, sir?

23 BY MR. GRAHAM:

24 Q. That would be fine.

25 A. Okay.

1 Q. If you -- if you would kindly do that
2 and let Chilton know, that would be wonderful.

3 A. Okay. I will do that. Thank you.

4 Q. All right. You may continue with the
5 take of Dr. Oakes' deposition, please.

6 A. Thank you, sir. On page 59, he states
7 that -- that a complication that occurs because of
8 the vacuum extraction. I've stated many times that
9 -- that the increase in bleeding is associated, but
10 that there's not a way to have a direct causal link
11 that that's proof that it -- that it was from the
12 vacuum extraction.

13 Q. Please continue.

14 A. Certainly. On page 66, there's a
15 discussion about the alcohol, cigarettes, and
16 marijuana use in the pregnancy. And he states that
17 -- that they have no causal consequence in this
18 situation. My concern is that -- that there's a --
19 a potential that the -- that the patient was using
20 the alcohol, marijuana, and/or cigarettes longer in
21 the pregnancy, because she has different answers on
22 those questions in multiple different spots. And
23 experiences with -- with people who are substance
24 users is that they will frequently under represent
25 their uses. In addition, there's a -- a

1 possibility with fetal alcohol -- besides the full
2 blown fetal alcohol syndrome, that there can be a
3 cluster of congenital anomalies in which this baby
4 does show with the -- multiple problems like the
5 eye problem with the coloboma. The -- the intra --
6 and echogenic intracardiac focus on ultrasounds
7 with the hernia -- the -- the heart murmur and that
8 those could be associated perhaps also with a
9 congenital weakness in the blood vessels in the
10 cerebellum, so it could be linked to alcohol use or
11 other substance uses in the pregnancy. And I don't
12 know how he knows that they have absolutely no
13 causal consequence in this situation.

14 On page 69, he states it's his opinion
15 the baby did not need to be delivered when it was
16 and I disagree. And he states that the fact that
17 it was delivered the way it was that led to this
18 consequence, and I disagree.

19 On page 70, he says that the nurse
20 misinterpreted the strips and encouraged the
21 physician to deliver the baby saying she didn't
22 want to have the mother push anymore. I -- I don't
23 agree that that's what she was doing. I felt that
24 she was concerned appropriately about the
25 decelerations and that she didn't want to push in

1 the context of not having the physician in the
2 room, which I think is the standard of care.

3 On page 71, the interpretation of these
4 being late -- repetitive late decelerations is
5 ludicrous, I disagree. On page 72, it says vacuum
6 isn't a part of a standard delivery kit. That's
7 not standard delivery. In every labor cart in our
8 hospital there's a vacuum setup with the vacuum
9 pump and -- available of different options on
10 vacuum extractors right on the delivery cart with
11 the other instruments.

12 Q. Do you know whether that's true of East
13 Cooper?

14 A. I do not.

15 Q. Please continue.

16 A. Certainly. Bottom of page 75 to top of
17 page 76, he does a delivery in a manner and method
18 that he shouldn't have done. I disagree for the
19 reasons I've stated previously. Bottom of page 76
20 to top of page 77, when he states that when -- when
21 you read Dr. Rhett's deposition you have a hard
22 time believing anything that he says because it's
23 all inaccurate. I disagree with that
24 characterization. We went over Dr. Rhett's
25 deposition in detail before about the things I felt

1 were inconsistent.

2 It says his knowledge of basic
3 obstetrics is ridiculous. Again, I described that
4 it's the -- the knowledge based on being able to
5 perform deliveries and being able to describe them,
6 two different things.

7 Again, page 77, he doesn't even
8 document that he did the vacuum. We discussed that
9 previously. Page 80, when you make inaccurate
10 conclusions, those become breeches of the standard
11 of care. And talking again about the nurse and if
12 the nurse is seeing anything that she's not
13 comfortable with then -- then the standard of care
14 for her to get help.

15 Page 85, when he says these are
16 obviously unreliable records, horrible. I
17 disagree. I -- I know there's -- and I'd actually
18 have to pull the records that he was referring to
19 to look at, but -- maybe I -- maybe I should do
20 that now just for a moment and get those strips
21 out. Just a moment. I'm looking at page 83 and
22 page 84 about where he's talking about the strips
23 and claiming that this means that -- what did he
24 say, that the -- these are obviously unreliable
25 records, horrible. So I'm going back to -- my

1 understanding -- I'm looking at the fetal monitor
2 strips ECH0310 and 331 and 312. My understanding
3 of how these -- the typing works, and I -- I guess
4 I would defer to make sure to someone whose using
5 the monitor themselves because I don't type on
6 this, but it's that the typing doesn't necessarily
7 correspond with how the strip is. That the -- that
8 the words can be in a different spot from the
9 actual occurrence on the -- on the strip. For
10 instance in 310, it says vacuum assisted delivery
11 of viable male infant. That that could have been
12 occurred at a different time it would just be typed
13 in that spot, because of -- I believe --

14 Q. When do you believe delivery occurred?

15 A. I'm just going to go back and look at
16 that exact time that they documented on the
17 summary. 19:37 is what it says here.

18 Q. Do you believe that entry?

19 MS. SIMMONS: Object to the form.

20 THE WITNESS: Just in reviewing the --
21 the strips, it corresponds with the -- the timing
22 of the typing but not the timing of the -- of the
23 fetal heart recording.

24 BY MR. GRAHAM:

25 Q. Do you believe the birth actually

1 occurred at 19:37?

2 A. I don't know.

3 Q. Okay. You wanted to tell me something
4 about Dr. Oakes' complaint about the reliability of
5 the records or the lack thereof?

6 A. Yes, sir. Just a -- a blanket
7 statement that -- that -- with a discrepancy that
8 that makes all the record unreliable, I disagree
9 with that.

10 Q. Okay. Which portions do you find
11 reliable?

12 MS. SMITH-YANCEY: Object to the form.

13 MS. SIMMONS: Objection.

14 THE WITNESS: I haven't gone through to
15 see if there's other discrepancies where it says
16 one thing on the -- the heart rate monitor timing
17 and another -- so I -- I don't know of all the --
18 but I feel the bulk of it is very reliable, and I
19 just don't know about that -- that one discrepancy.

20 BY MR. GRAHAM:

21 Q. So unless the records from the hospital
22 are self contradictory, you consider them to be
23 reliable?

24 MS. SIMMONS: Object to the form.

25 THE WITNESS: Other -- yes, I do. From

1 what I've reviewed, yes.

2 BY MR. GRAHAM:

3 Q. And when they are self contradictory,
4 do you know which one to believe?

5 A. No, sir.

6 Q. Okay. Please continue.

7 A. On page 92 in the middle talking about
8 the vacuum pump. In the reviewing the -- the video
9 there's a -- a shot of the video where the vacuum
10 pump gauge is clearly readable, and it shows that
11 it's in the green zone and that the normal pressure
12 zone of approximately 600 millimeters of mercury.

13 Q. When was that during the course of the
14 video?

15 A. I don't have the exact minute number on
16 it, but it was during the -- the process of the
17 vacuum extraction. There's a -- a panning from the
18 actual maternal peritoneum over to the -- a shot of
19 the woman holding the pump, the nurse holding the
20 pump, and you can see the damage on the pump and
21 you can see where the dial is set on the gauge. I
22 don't know that exact time, but I can supply that
23 for -- or have Chilton supply that for you if that
24 would be helpful.

25 Q. Thank you very much.

1 A. I'll put it on my list.

2 Q. Thank you.

3 A. I'm still reading. Thank you for your
4 patience.

5 Q. No problem.

6 A. That's it, sir.

7 Q. That's all of your criticisms of Dr.
8 Oakes' deposition testimony?

9 A. That I can see at this time, yes, sir.

10 Q. Thank you. Last time I believe you had
11 a bill that you were about to submit to Chilton,
12 but I can't recall if we made it a deposition
13 exhibit or not.

14 A. We did, sir. I had a separate copy
15 that was given to the court reporter at that time.

16 Q. Okay. Can you remind me of your hourly
17 rate?

18 A. Let me ask Chilton. Just one minute.

19 MS. SIMMONS: Ed, I believe it's 250 an
20 hour. If it's not 250, it's 200. And I might be
21 able to tell you right now while you continue.
22 I'll try to look it up.

23 THE WITNESS: Should I put that on by
24 to-do list?

25 BY MR. GRAHAM:

1 Q. Well, Dr. Norton, let me ask you this,
2 who determines your hourly rate?

3 A. It's a -- a process of an -- an
4 agreement between the -- between myself and Chilton
5 and the law firm. I just don't recall what we
6 agreed to. I haven't been paid yet.

7 Q. Okay. Is there a different hourly rate
8 for different types of work?

9 A. No, sir.

10 Q. Was that a no?

11 A. No, sir, that's correct.

12 Q. Okay. Thank you. But you just don't
13 remember what your hourly rate is?

14 A. Yes, sir.

15 Q. Okay. Yeah. Please -- please tell
16 Chilton so she can tell me.

17 A. All right. And I did not write down on
18 the list -- I think the other question I was
19 supposed to look up was the DIC timing and -- in
20 relation to the head CT, diagnoses of the bleed.

21 Q. Well, in -- in relation to the rupture
22 of the vessels that led to the bleed.

23 A. So I'll -- I'll get the record on the
24 timing for you and give that to Chilton as well.

25 Q. Thank you. Any other questions about

1 homework assignments?

2 A. Not at this time.

3 Q. Thank you. Remind me, Dr. Norton, do
4 you have special qualifications as a maternal fetal
5 specialist?

6 A. No, sir.

7 Q. Okay. Have you felt well throughout
8 the deposition, the other day and today?

9 A. Well, in -- in both settings I was a --
10 a little bit sleep deprived, but that's a pretty
11 normal state for me so in general, yes.

12 Q. Okay. Is there any answer you've given
13 that you'd like to change or add to, subtract from
14 in any way?

15 A. Not at this time.

16 Q. Okay. Have we covered all of the
17 opinions that you've formed in this case?

18 A. That's a broad question, sir. I --

19 Q. Well, I tell you what. Let me give you
20 a chance to list for me the opinions that you've
21 formed in this case.

22 A. And, again, I -- could you narrow that
23 question at all for me?

24 Q. Not really. Have you formed any
25 opinions in this case that you hold to a reasonable

1 degree of medical certainty?

2 A. Yes, sir.

3 Q. What are they?

4 A. I believe that the patient Jamesetta
5 Washington had a reasonable prenatal care with Dr.
6 Rhett's group, and I believe that during the course
7 of her labor and delivery she was managed
8 appropriately. I believe that the baby showed
9 signs of decreased blood flow with bradycardia as a
10 significant deceleration as well as late appearing
11 decelerations and variable decelerations. I
12 believe that -- that the decision for immediate
13 delivery was appropriate and that it was done
14 appropriately. I believe that the vacuum was
15 applied at -- at -- as a low vacuum or lower
16 perhaps of on outlet vacuum. I believe that the
17 vacuum was applied appropriately with appropriate
18 pressure. And I believe that the cause of the
19 intracranial hemorrhage could be from a number of
20 sources, and is less than a 50 percent chance of --
21 of being associated with the vacuum delivery
22 itself.

23 Q. That was just a coincidence?

24 A. I'm sorry?

25 Q. You believe the use of a vacuum in this

1 case was just a coincidence, had nothing whatsoever
2 to do with the brain bleed?

3 A. I said a less than 50 percent chance.

4 Q. Have you given me all of the basis for
5 that opinion, that last opinion?

6 A. I believe so.

7 Q. All right. Are those all of the
8 opinions you've formed in this case?

9 A. I believe those to be the major
10 opinions. I -- I -- I believe I have expressed
11 them fairly completely in that last eight plus
12 hours of deposition, but there may be other points
13 that I've left out --

14 Q. Do you plan to do any more work on this
15 case?

16 A. Yes, sir.

17 Q. Other than your homework assignments?

18 A. I plan to be available for continued
19 consultation with the -- the law firm and potential
20 appearance in trial if needed, and other -- other
21 ways that I can be of assistance as an expert
22 witness.

23 Q. Okay. If you change your opinions in
24 any way or formulate any new opinions or realize
25 that you have not expressed to me any opinions,

1 would you kindly let Chilton know so she can let me
2 know?

3 A. Adding it to my homework list.

4 MR. GRAHAM: All right. That's all the
5 questions I have for you at this time. I do
6 reserve the right to come back as we've discussed
7 before.

8 THE WITNESS: Thank you, Mr. Graham.

9 MR. GRAHAM: Thank you very much, Dr.
10 Norton. I appreciate your answering my questions.

11 THE WITNESS: Yes, sir.

12 MS. SIMMONS: I have a -- I do have a
13 few follow up questions.

14 MR. GRAHAM: Is that Chilton?

15 MS. SIMMONS: It is.

16 MS. SMITH-YANCEY: Chilton, we can
17 barely hear you.

18 MS. SIMMONS: Okay.

19 THE WITNESS: You know what? Maybe we
20 can have her move. Do we need a break?

21 MS. SIMMONS: I -- I don't think I'll
22 take but ten minutes. Can you hear me better?

23 MR. GRAHAM: I'm okay.

24 THE WITNESS: Can you hear us?

25 MR. GRAHAM: That's fine with me.

1 MS. SMITH-YANCEY: Yeah.

2 THE WITNESS: I'm sorry, was that a yes
3 from Ms. Smith-Yancey?

4 MS. SMITH-YANCEY: Yeah, I can hear
5 you. Thanks.

6 THE WITNESS: Thank you.

7 EXAMINATION

8 BY MS. SIMMONS:

9 Q. Dr. Norton, did you take note in Dr.
10 Rhett's deposition that he testified that he had
11 approximately 15 years of OB practice?

12 MR. GRAHAM: Object to the form.

13 THE WITNESS: There were different
14 points where he discussed the length of his
15 obstetrics care. And there was a -- a point where
16 he talked about being -- delivering babies for over
17 34 years. There was another point when he spoke
18 about doing things that way for the last 15 years.
19 So it appeared to be a discrepancy there in the
20 amount of time he was practicing obstetrics.

21 BY MS. SIMMONS:

22 Q. Did you place any significance on that
23 varying testimony?

24 A. I felt that it was evident that Dr.
25 Rhett was under extreme stress during the

1 deposition, and that even answers that would seem
2 to be straight forward were difficult for him to --
3 to make clear.

4 Q. Was there any evidence from the -- from
5 viewing the video of the birth that the vacuum
6 pressure was appropriate?

7 A. Yes. There's that -- that one view on
8 the -- on the video where you can see the pump
9 clearly and see the gauge, and -- and I'm to get
10 that exact time from the video and pass it on to
11 Mr. Graham, but, yes, there's an -- an appropriate
12 -- that it's in the appropriate range during that
13 -- during the vacuum extraction.

14 Q. Do you base your opinions in this case
15 on the medical records, or do you base them on Dr.
16 Rhett's deposition testimony?

17 MR. GRAHAM: Object to the form.

18 THE WITNESS: You know, the -- the
19 thing that I found most helpful in reviewing this
20 case is the contemporaneous facts that I can glean
21 from the medical record and -- and from the video
22 itself.

23 We just need to pause a moment for the
24 court reporter.

25 MR. GRAHAM: Certainly.

1 THE WITNESS: We're good now.

2 BY MS. SIMMONS:

3 Q. Dr. Norton, do you have any opinions
4 with regard to the affects on the baby if Dr. Rhett
5 had not used a vacuum to expedite the delivery?

6 MR. GRAHAM: Object to the form.

7 THE WITNESS: Yes. I believe that had
8 the baby continued in utero with the decelerations,
9 that the baby could have moved into a situation of
10 permanent neurologic harm from asphyxia, from
11 decreased blood flow to the brain.

12 BY MS. SIMMONS:

13 Q. You were asked earlier by Mr. Graham
14 for specific doctors who would have performed a mid
15 -- mid-station vacuum delivery, such as in this
16 case in these particular circumstances. Dr.
17 Norton, instead of giving particular names of
18 doctors, do you believe that it's within the
19 standard of care for a doctor who is trained in
20 mid-station vacuum deliveries to use a vacuum in
21 mid-station in the face of declining or threatening
22 fetal heart rate?

23 MR. GRAHAM: Object to the form.

24 THE WITNESS: Absolutely.

25 BY MS. SIMMONS:

1 Q. In the previous portion of this
2 deposition, which was approximately a week ago, you
3 were asked questions by Mr. Graham to assume that
4 Dr. Rhett had been reasonable. And, Dr. Norton, do
5 you have a basis to not have to assume that Dr.
6 Rhett was reasonable or not in his delivery of this
7 baby?

8 MR. GRAHAM: Object to the form.

9 THE WITNESS: Well, in reviewing the --
10 the fetal heart tracing strips as well as in
11 viewing the video, I see clear evidence of -- of
12 problems with the baby's heart rate that would
13 necessitate an urgent delivery. And I feel that --
14 and I see the evidence that -- that the vacuum
15 delivery was performed appropriately based on that
16 video.

17 BY MS. SIMMONS:

18 Q. Do you have opinions on the duration of
19 the vacuum application based on the video?

20 A. I do. It's -- I don't recall -- again,
21 I didn't -- I didn't time it independently, but it
22 was certainly under five minutes and it appeared to
23 be between two to four minutes of the -- from the
24 first application to the delivery of the baby.

25 Q. What is the appropriate standard of

1 care as far as maximum recommended timing for
2 vacuum application?

3 A. There is no recommended. Upper limit
4 in terms of -- of vacuum, the recommendation is to
5 have continued progress and to -- to minimize the
6 length of time, but there's not a specific
7 timeframe. But certainly an -- under ten minutes
8 would be considered a very -- a reasonable
9 timeframe.

10 Q. Would you -- do you have any opinions
11 with regard to the risk of using a vacuum versus
12 the risk of performing a C-section generally as
13 well as in a level 1 hospital?

14 MR. GRAHAM: Objection to form.

15 THE WITNESS: The problem with a -- a
16 cesarean section is that it involves garnering of
17 resources to -- to expedite that delivery. And
18 while the vacuum is right there in the delivery
19 room in our hospital, when we need to have a
20 cesarean birth we need to have a number of
21 resources available. We need to have anesthesia of
22 a surgical level, not just a labor level with the
23 epidural. We need to have an -- an operating room
24 that's open. We need to have a -- a persons equip
25 to assist in -- in the scrub as well as in the

1 circulating positions in the operating room. We
2 need to physically transfer the patient to the
3 operating room. We need to have -- have the --
4 have the -- the area prepped and draped, and
5 there's a number of things that take time. And it
6 is my experience that it is much more -- it takes
7 much more time to do a cesarean section, to prefer
8 for a cesarean section. Then, of course, there's
9 the time from initial incision to delivery of the
10 baby. And so that could be adding 20 to 30 minutes
11 to the time of the delivery as opposed to a -- an
12 operative vaginal delivery that can be expedited
13 within 5 to 10 minutes.

14 So, potentially, the -- the time that
15 it would take to -- to actually perform a cesarean
16 section and -- and have the baby delivered could be
17 detrimental to the baby with a continued decreased
18 blood flow to the brain and cause a potential of
19 permanent neurologic damage.

20 BY MS. SIMMONS:

21 Q. Doctor, is it within your training as a
22 board certified OB/GYN to study and counsel
23 patients on the effects of alcohol, cigarettes,
24 and/or marijuana during pregnancy early or
25 otherwise?

1 MR. GRAHAM: Objection to form.

2 THE WITNESS: Yes, it is.

3 BY MS. SIMMONS:

4 Q. Do you -- and did you have an opinion
5 in this deposition regarding a link between the
6 baby's congenital problems to possible fetal
7 alcohol syndrome?

8 MR. GRAHAM: Object to the form.

9 THE WITNESS: As I stated earlier,
10 there is a spectrum of problems with fetal alcohol
11 exposure, and that can include a cluster of
12 congenital abnormalities such as was found with
13 this baby.

14 BY MS. SIMMONS:

15 Q. Scientifically speaking, can anyone
16 rule out that -- that alcohol, marijuana or
17 cigarettes caused or was a cause to some or all of
18 this baby's problems?

19 MR. GRAHAM: Object to the form.

20 THE WITNESS: Not that I'm aware of,
21 no.

22 MS. SIMMONS: I have no further
23 questions. Thank you.

24 THE WITNESS: Thank you.

25 MR. GRAHAM: Anybody else?

1 MS. SMITH-YANCEY: Yeah.

2 EXAMINATION

3 BY MS. SMITH-YANCEY:

4 Q. This is Lindsay Yancey. I just have a
5 -- a couple of quick questions for you.

6 A. Yes, ma'am.

7 Q. Dr. Norton, thank you for your time. I
8 know this has been a very long process. As -- as
9 you know, I represent East Cooper Regional Medical
10 Center in the case.

11 A. Yes, ma'am.

12 Q. And I wanted to know whether you had
13 any criticisms of the labor and delivery personnel
14 in this matter?

15 A. No, I did not.

16 Q. Okay. And to the extent that you have
17 reviewed the chart and the strip and the video in
18 this case, do you have any criticisms of any of the
19 employees of East Cooper Regional Medical Center,
20 whether it be nursing personnel or techs or labor
21 and delivery nurses, versus nursery nurses?

22 A. No, I do not.

23 MS. SMITH-YANCEY: Okay. Thank you
24 very much. Those are all the questions I have for
25 you.

1 THE WITNESS: Thank you.

2 MR. GRAHAM: Anyone else?

3 MR. HAWK: This is Robert Hawk. Dr.
4 Norton, thank you for your time. I -- I do not
5 have any questions.

6 THE WITNESS: You're welcome. Thank
7 you.

8 MR. GRAHAM: Dr. Norton, I do have a
9 few follow ups.

10 THE WITNESS: Yes, sir.

11 EXAMINATION

12 BY MR. GRAHAM:

13 Q. What do you consider to be the signs
14 and symptoms of fetal alcohol syndrome?

15 A. Okay. I -- I believe we discussed this
16 in the first deposition, but -- but there's
17 considered a -- a spectrum. There's a typical
18 appearance of the baby that involves a -- a
19 flattened filtrum, that -- that area from the --
20 the bottom of the nose to the top of the lip.
21 There's a -- a thinner upper lip. There's a -- a
22 problem with the ears that can -- they call it a
23 railroad track ears where the ears are outside
24 formed differently. There's a problem with the
25 palm -- palmer creases of the hands that can look

1 different in a hockey stick pattern. And that
2 would be the classic appearance. In addition,
3 there could be microcephaly or small -- small head
4 small brain. But there's also other spectrum of --
5 of problems that are not as obvious that can
6 include these congenital anomaly clusters as well
7 as neurodevelopmental delays.

8 Q. Do you consider Jayden W. to
9 have a flattened area between his nose and his lip?

10 A. I don't know.

11 Q. Do you consider Jayden W. to
12 have ears with railroad track features that you
13 described?

14 A. I don't know.

15 Q. Do you consider Jayden W. to
16 have palmer creases of a hockey stick nature or
17 words to that effect as you've described?

18 A. I don't know.

19 Q. Have you formed an opinion to a
20 reasonable degree of medical certainty as to
21 whether or not you believe Jayden W.
22 suffers from fetal alcohol syndrome?

23 MS. SIMMONS: Object to the form..

24 THE WITNESS: I -- I have formed an
25 opinion that Jayden W. could be suffering

1 from a -- a variant of the fetal alcohol syndrome
2 from alcohol affects in utero. But since I have
3 not examined the patient personally, I don't know
4 if he shows the -- the characteristics stigmata of
5 a full blown fetal alcohol syndrome. And I -- I
6 can't say definitively that he is experiencing
7 consequences of fetal alcohol syndrome.

8 BY MR. GRAHAM:

9 Q. If not definitively, can you put the
10 likelihood of Jayden suffering from fetal alcohol
11 syndrome in percentage terms for us?

12 A. I -- I cannot at all with the
13 appearance, because I've not seen him. In terms of
14 the neurodevelopmental problems, I think that it's
15 likely that -- that it has an impact, but I don't
16 know to what degree.

17 Q. That what has an impact?

18 A. That the alcohol consumption in
19 pregnancy has an impact on his later
20 neurodevelopmental abilities.

21 Q. But you don't know how much alcohol was
22 consumed, correct?

23 A. That's correct. That's correct.

24 Q. And you don't know when it was
25 consumed, correct?

1 A. That's correct. All I have is the
2 information that supplied through the medical
3 records as well as the depositions, which are
4 conflicting. But do state that at least there was
5 first trimester exposure.

6 Q. And you have no evidence of any
7 damaging whatsoever, correct?

8 MS. SMITH-YANCEY: Object to the form.

9 MS. SIMMONS: Objection.

10 THE WITNESS: Again, what -- the
11 evidence that I have is from the medical record and
12 the depositions, which is -- which is conflicting.
13 And what is mentioned is a frequency of drinking,
14 but not the actual amount.

15 BY MR. GRAHAM:

16 Q. Can you testify under oath to a
17 reasonable degree of medical certainty that there's
18 even as much as a one in a million chance that
19 Jayden W. -- has fetal alcohol syndrome?

20 MS. SIMMONS: Object to the form.

21 THE WITNESS: Again, I -- I have to
22 clarify between the two but there's the full blown
23 with the physical stigmata and I've not examined
24 him so I don't -- I cannot at all testify to that.
25 But in terms of the -- the other problems with the

1 neurodevelopmental problems and with the -- with
2 the cluster of congenital abnormalities, I can
3 definitely testify that I -- I believe to a
4 reasonable degree of medical certainty that there's
5 more than one in a million chance.

6 BY MR. GRAHAM:

7 Q. More than one in a million chance of
8 what?

9 A. That some of his neurocognitive
10 difficulties are related to alcohol exposure in
11 utero.

12 Q. Can you be more specific than one in a
13 million? Could you go so far as to say there's 1
14 in 100,000 chance?

15 A. Yes. I would say that there's at least
16 a 1 in 100, but I'm not sure of the exact -- I
17 haven't thought about what exact number I would
18 place on that. Nor -- more than 1 percent, less
19 than 75. I -- I -- I don't have an exact number in
20 mind.

21 Q. Okay. But I don't have to worry about
22 you going into court in this case and telling the
23 Judge and jury that you believe it's more likely
24 than not that alcohol, marijuana, or nicotine, or
25 any other substance ingested by Jamesetta

1 Washington during her pregnancy caused cogitative
2 impairments or any other kind of neurodevelopmental
3 problems in her --

4 MS. SIMMONS: Object to the form.

5 BY MR. GRAHAM:

6 Q. -- do you?

7 A. I -- I believe that I might say that --
8 that it's more likely than not that it caused some
9 effects, but not all the effects.

10 Q. What effects?

11 A. Again, neurocognitive delays. I can't
12 say that it's all of the effects because -- because
13 of the issues of bleeding and the surgery that
14 we've discussed previously.

15 Q. Okay. You feel comfortable testifying
16 to a reasonable degree of medical certainty that
17 ingestion of some substance more likely than not
18 caused Jayden W some neurodevelopmental
19 delay?

20 MS. SIMMONS: Object to the form.

21 Asked and answered.

22 BY MR. GRAHAM:

23 Q. Is that what you're saying?

24 A. I'm -- I'm saying that that's a
25 possibility. I haven't -- I think I've stated

1 previously that I hadn't decided on the exact
2 number, but then you asked me if -- if there was --
3 that you should worry that I might say that, and --
4 and I guess if that makes you worried then I'd say
5 yes, I might say that.

6 Q. I should worry?

7 A. I don't know about should worry, but if
8 -- if that would make you worry then -- then, yes,
9 you should worry that I might say that.

10 Q. What -- what substance are you talking
11 about? Alcohol, marijuana, tobacco or something
12 else, or some combination?

13 A. Well, the alcohol was what we discussed
14 specifically as having potential harmful effects on
15 the baby's brain and -- and neurocognitive
16 developmental delays and other problems. And that
17 was the one I was specifically saying that the
18 marijuana, the problem with these is that you can't
19 randomize some mothers to smoking marijuana and
20 some not. And so it's not well known that the --
21 the full effects of marijuana. And then in terms
22 of the cigarette smoking, because that decreases
23 the blood flow through the placenta by causing vasa
24 constriction, then it can definitely cause the -- a
25 global effects; although, I was mostly referring to

1 the -- the alcohol when we were discussing that
2 previously.

3 Q. Tell me what knowledge training and
4 experience you have to support your ability to
5 testify in court to a causal connection between a
6 mother's ingestion of alcohol and a baby's
7 neurodevelopmental delay?

8 MS. SIMMONS: Objection. Asked and
9 answered.

10 THE WITNESS: I'm a board certified
11 obstetrician/gynecologist. I'm been in practice
12 for years. I've read textbooks and literature that
13 support that. That -- that -- that it's not known
14 the exact amount of alcohol that can be dangerous
15 and that alcohol is associated with neurocognitive
16 problems.

17 BY MR. GRAHAM:

18 Q. Okay. Nuclear bombs are dangerous too,
19 but are you going to -- well, I withdraw that
20 question. Ma'am, tell me what authorities support
21 your assertion that it is more likely than not that
22 alcohol ingestion by Jamesetta Washington caused
23 her son the neurodevelopmental delays?

24 A. If I could clarify, I believe that I
25 said that I wasn't sure of the exact percentage.

1 That it was somewhere between 1 percent and 75
2 percent. And you said should you worry that I
3 might say that and I said that I didn't know yet,
4 but that I might. And so I don't want to tell you
5 the exact percentage, because I -- I haven't come
6 to a definitive conclusion about what I might say
7 in court.

8 Q. Well, as you sit here today, do you
9 have an opinion to a reasonable degree of medical
10 certainty as to whether or not alcohol ingestion by
11 Jamesetta Washington was more likely than not a
12 cause of her son's neurodevelopmental delays --

13 A. I do not.

14 Q. -- or other damage?

15 MS. SMITH-YANCEY: Objection, asked and
16 answered.

17 THE WITNESS: I do not.

18 BY MR. GRAHAM:

19 Q. Okay. What literature would you refer
20 to to assist you in formulating such an opinion?

21 A. At -- at a minimum the texts that we've
22 described previously, such as ACOG Technical
23 Bulletins and -- and obstetric textbooks, as well
24 as reading obstetrics journals.

25 Q. Okay. Any substance abuse literature

1 or neurological literature?

2 A. Not that I -- I can cite right now, but
3 my intention is to be more informed at our next
4 discussion.

5 Q. Okay. And you will -- if you form any
6 opinions in that regard you'll let Chilton know so
7 she can let me know, right?

8 A. Yes. Should I add that as number 6 or
9 still part of number 5?

10 Q. I'm not going to micromanage your
11 numbering.

12 A. Just want to keep my homework straight.

13 Q. Thank you.

14 A. You know I'm a -- a little student,
15 uh-huh.

16 MR. GRAHAM: Thank you very much.
17 That's all the questions I have. As -- as noted
18 before, I reserve the right to come back.

19 THE WITNESS: Thank you, sir.

20 MS. SIMMONS: Thank you everyone.

21 (The deposition was concluded at 7:52
22 p.m.)

23 (Signature reserved.)

24

25

1 SIGNATURE OF DEPONENT

2

3 I, the undersigned, LYNN B. NORTON, MD,
4 do hereby certify that I have read the foregoing
5 deposition and find it to be a true and accurate
6 transcription of my testimony, with the following
7 corrections, if any:

8

9 PAGE LINE CHANGE REASON

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LYNN B. NORTON, MD Date

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25

1 CERTIFICATE OF REPORTER

2

3 I, Kelly A. Ball, Court Reporter and
4 Notary Public for the State of South Carolina at
5 Large, do hereby certify that the foregoing transcript
6 is a true, accurate, and complete record.

7 I further certify that I am neither
8 related to nor counsel for any party to the cause
9 pending or interested in the events thereof.

10 Witness my hand, I have hereunto affixed
11 my official seal this 21st day of May, 2009, at
12 Bluffton, Beaufort County, South Carolina.

13

14

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16

Kelly A. Ball

17

My Commission expires

November 2017

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I N D E X

Page/Line

WITNESS/EXAMINATION

LYNN B. NORTON, MD

4 1

EXAMINATION

4 3

BY MR. GRAHAM

EXAMINATION

80 7

BY MS. SIMMONS

EXAMINATION

87 2

BY MS. SMITH-YANCEY

EXAMINATION

88 11

BY MR. GRAHAM

SIGNATURE OF DEPONENT

98 1

CERTIFICATE OF REPORTER

99 1

REQUESTED INFORMATION INDEX

(No Information Requested)

E X H I B I T S

(No Exhibits Proffered)

Deposition of Aubrey Milunsky, M.D.

VOLUME: I
 PAGES: 1-133
 EXHIBITS: 1-5

STATE OF SOUTH CAROLINA
 COUNTY OF CHARLESTON
 IN THE COURT OF COMMON PLEAS
 NINTH JUDICIAL CIRCUIT COURT

C.A. 07-CP-10-1553

JAMESETTA WASHINGTON, AS GUARDIAN)
 AD LITEM FOR JAYDEN W. , a)
 minor,)
 Plaintiff,)

vs.)

EDMUND RHETT, JR., M.D., LOW)
 COUNTRY OBSTETRICS & GYNECOLOGY,)
 P.A., TENET SOUTH CAROLINA, INC.,)
 D/B/A/ EAST COOPER REGIONAL MEDICAL)
 CENTER,)
 Defendants.)

VIDEOCONFERENCE DEPOSITION OF AUBREY
 MILUNSKY, M.D., a witness called on behalf of
 the Plaintiff, pursuant to the provisions of
 the South Carolina Rules of Civil Procedure,
 before Jill Shepherd, Registered Professional
 Reporter, CSR, CLR and Notary Public, in and
 for the Commonwealth of Massachusetts, at the
 offices of FedEx-Kinko's, 10 Post Office
 Square, Boston, Massachusetts, on Tuesday,
 May 19, 2009, commencing at 1:30 p.m.

Deposition of Aubrey Milunsky, M.D.

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Deposition of Aubrey Milunsky, M.D.

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Deposition of Aubrey Milunsky, M.D.

1 I N D E X

2 WITNESS PAGE

3 AUBREY MILUNSKY, M.D.

4 Examination by Mr. Graham 5

5 Examination by Ms. Simmons 120

6 Examination by Mr. Graham 126

7

8 E X H I B I T S

9 NO. DESCRIPTION PAGE

10 1 Photograph 40

11 2-4 Photographs 48

12 5 Doctor's Notes 50

13

14

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16

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Deposition of Aubrey Milunsky, M.D.

1 P R O C E E D I N G S

2 AUBREY MILUNSKY, M.D., a witness,
3 called for examination by counsel for
4 Plaintiffs, having been satisfactorily
5 identified by the production of his hospital
6 identification, being first sworn by the
7 Notary Public, was examined and testified as
8 follows:

9 * * * * *

10 EXAMINATION BY MR. GRAHAM

11 Q. Dr. Milunsky, as you know from my previous
12 introduction, my name is Ed Graham. I
13 represent members of the Washington family in
14 this case.

15 You've been identified as an expert
16 to be used at trial by certain defendants,
17 one or more defendants; is that your
18 understanding?

19 A. Yes, sir.

20 Q. Okay. I'm sure you've given many depositions
21 before, but under our South Carolina rules, I
22 need to cover a few ground rules with you.

23 Number one, please give the court
24 reporter a verbal and audible response such

1 as yes or no, instead of a nod of the head or
2 an uh-huh/huh-uh. Let's try not to talk over
3 each other. And most importantly, if you
4 don't understand one of my questions, please
5 don't answer it. Just ask me to rephrase it,
6 explain it, whatever we need to do for you to
7 get a good understanding. If you do answer
8 my question, I will assume that you
9 understood it and that you've given me a true
10 and complete response, fair enough?

11 A. Yes.

12 Q. Okay. And if you need to break for any
13 reason, just let me know. Without further
14 adieu, Doctor, someone has kindly furnished
15 me a copy of your CV, which I understand is
16 not up to date, but could you just tell me
17 whether that is true and complete as of a
18 certain date in the past?

19 A. It's true and incomplete, and I don't
20 remember how old this is. It may be
21 something like five years old.

22 Q. Okay.

23 A. But I can provide you with a new one by
24 e-mail.

Deposition of Aubrey Milunsky, M.D.

1 Q. Thank you, sir. And I provided you with my
2 e-mail address.

3 And when do you think you could get
4 me that?

5 A. This afternoon.

6 Q. Thank you, sir.

7 Was this CV that I have in front of
8 me now complete as of five years or so ago?

9 A. Yes.

10 Q. Since then, have there been any changes to
11 your CV other than additional publications?

12 A. No.

13 Q. Do any of the additional publications relate
14 to issues involved in the Washington case?

15 A. No.

16 Q. Thank you. Sir. Now, are you currently
17 employed?

18 A. I am employed by Boston University School of
19 Medicine. I'm professor of human genetics,
20 pediatrics, obstetrics and gynecology and
21 pathology; and I am the director of the
22 center for human genetics.

23 Q. Your board certifications are in which areas?

24 A. I'm triple board-certified in pediatrics,

1 internal medicine and clinical genetics.

2 Q. Tell me about your work as a professor of

3 OB/GYN.

4 A. Well, that's really in the context of

5 reproductive genetics and teaching

6 reproductive genetics. Nothing to do with --

7 Q. With labor and delivery?

8 A. -- labor and delivery.

9 Q. And you mentioned pathology?

10 A. Same again, the same as teaching of the

11 genetics, really.

12 Q. Do you have any relatives by blood or

13 marriage in the state of South Carolina?

14 A. Not when I last looked.

15 Q. Approximately how many times have you given

16 depositions?

17 A. Many.

18 Q. Hundreds?

19 A. I have no idea of the number, but it's many

20 years' worth.

21 Q. How many times have you testified at trial?

22 A. Probably around a hundred.

23 Q. Have you testified in South Carolina before?

24 A. I believe so.

Deposition of Aubrey Milunsky, M.D.

1 Q. Okay. Do you recall the attorney for which
2 you worked in a South Carolina case?

3 A. It was a defense firm, but I don't recall the
4 name of it.

5 Q. How many years ago was that?

6 A. Many.

7 MS. SIMMONS: Ed, I know I can help
8 you with the name if you want me to.

9 MR. GRAHAM: That's fine.

10 MS. SIMMONS: You might mention the
11 Svalina firm, testifying in trial.

12 THE WITNESS: That's a plaintiff
13 firm. Some of these are plaintiff firm and a
14 defense firm. I can't remember the defense
15 firm's name.

16 MS. SIMMONS: The plaintiff firm
17 that he testified for was Sam Svalina in
18 Buford.

19 Q. What was the plaintiff's case about, do you
20 recall?

21 A. It was a brain damaged baby case, my best
22 recall.

23 Q. Let me just make sure I understand the basic
24 layout of your CV. After committees and

Deposition of Aubrey Milunsky, M.D.

1 editorial boards and peer review work,
2 honors, and then we get into the
3 publications, first, you have a section of
4 books and then medical journals?

5 A. Medical journals, both in long publications,
6 and then halfway through there is a short
7 communications [sic]. You will notice the
8 numbers change.

9 Q. Right. Okay. Gotcha. Sir, do you consider
10 any of the publications to have particular
11 relevance to the issues in this case?

12 A. Well, not as a specific publication as such,
13 but it's the overall purview of the subject
14 matter that informs opinions.

15 Q. When were you first contacted about your work
16 in this case?

17 A. Sometime last year. I don't remember the
18 specific date.

19 Q. And what was the nature of that contact?

20 A. It was a request to review the record and
21 offer an opinion as to causation.

22 Q. By whom were you contacted?

23 A. I think by Ms. Summers [sic]. Simmons, I'm
24 sorry.

Deposition of Aubrey Milunsky, M.D.

1 Q. Did you work for her before?

2 A. No.

3 Q. Had you worked for the Hood firm before?

4 A. I don't think so.

5 Q. What materials have you been furnished for
6 your view?

7 A. Well, you just looked through them so...

8 Q. Could you just highlight them for the record,
9 please, sir.

10 A. Sure. So I reviewed the medical records.

11 Jayden W. , his photographs, also of
12 his mother. I reviewed the deposition

13 transcript of Dr. Gomez-Carrion. I reviewed

14 the complaint, of course. I reviewed the

15 depositions of Dr. Adler and Dr. Michael

16 Katz, and the deposition of

17 Dr. Gomez-Carrion; I think I said that.

18 Q. You did.

19 A. I believe that that's it.

20 Q. What opinions have you formulated with
21 respect to your work in this case?

22 A. I believe that you call him Jamie?

23 Q. Jayden.

24 A. Or rather Jayden had suffered a hemorrhage

1 that was subgaleal, G-A-L-E-A-L, and in the
2 posterior fossa of his skull and the
3 causation is probably multifactorial in this
4 case.

5 Q. Could you be more specific about what you
6 mean by "multifactorial"?

7 A. I think there were multiple factors that
8 contributed to him having a hemorrhage in the
9 locations I've just enunciated.

10 Q. Including what specific factors?

11 A. The factors that we can point to here is that
12 he was subject to vacuum delivery following
13 signs of fetal distress; he probably had some
14 degree of hypoxia which contributed to a drop
15 in his platelet count, for example, which
16 contributed further to his bleeding. He was
17 born with multiple birth defects, which
18 almost certainly explains some of his global
19 delay. He almost certainly inherited a
20 connective tissue disorder from his mother
21 for which may have added to his
22 susceptibility from a vascular point of view
23 and made his vascular more vulnerable to the
24 pressure that ordinarily would be exerted by

1 a vacuum. I think those are the
2 quintessential points.

3 Q. What evidence do you have that Jayden
4 We experienced hypoxia during labor
5 and/or delivery?

6 A. Well, he was delivered with APGAR scores
7 which were perfectly adequate; however, his
8 pH of his cord was 7.2. He came out of
9 delivery with fetal distress as reflected by
10 abnormalities in the monitor requiring timely
11 and quick extraction by vacuum. And his mild
12 acidosis coupled with a progressive drop in
13 his platelet count indicated that probably
14 transient, but not severe, hypoxia, and,
15 therefore, fulfilled that particular
16 likelihood. And the events thereafter, of
17 course, became accountable through his bleed.

18 I forgot to mention earlier when you
19 asked me about the various points, I forgot
20 to mention his mother's alcohol intake as yet
21 another significant contributor to his
22 problems.

23 Q. Anything else you forgot to mention?

24 A. I hope not.

Deposition of Aubrey Milunsky, M.D.

1 Q. All right. You've said a lot. Let me focus
2 on a few things you said. One thing you said
3 was something like -- these may not have been
4 your exact words, but something on the order
5 of timely and appropriate intervention with a
6 vacuum.

7 You are not trained as an
8 obstetrician; is that right?

9 A. That's right.

10 Q. You won't be -- you don't hold yourself as
11 having special expertise in the generally
12 accepted standards of care by which
13 obstetricians should perform during labor and
14 delivery, do you?

15 A. That's correct.

16 Q. And you will not be giving any opinions at
17 trial about whether use of the vacuum was
18 appropriate or inappropriate from an
19 obstetrical point of view, will you?

20 A. That's correct.

21 Q. Nor will you testify as to any other standard
22 of care governing the practice of obstetrics,
23 correct?

24 A. Correct.

1 Q. Thank you. You also mentioned mild drop in
2 the platelet count.

3 First of all, can you direct me to
4 where in the record you're focusing about the
5 fact of a mild drop in the platelet count?

6 A. I don't know if I used the word "mild" in
7 that context. But there was a drop in the
8 platelet count by the 18th of July to 78,000,
9 and it had dropped progressively from
10 previous count of 149,000, and before that,
11 200 and something thousand, 260,000, I
12 believe. And this was typical of hypoxic
13 injury preceding delivery; in other words,
14 intrapartum.

15 Q. And is it consistent with any other factors
16 relating to this delivery and condition of
17 the baby such as brain bleeds?

18 A. The brain bleed clearly was not obviously
19 evident at or immediately after birth. So it
20 would be speculative to think that he had
21 sequestration of his platelets occurring into
22 the bleed at that period of time, but it is a
23 possibility.

24 Q. The brain bleeds could explain the drop in

Deposition of Aubrey Milunsky, M.D.

1 platelet count?

2 A. It could. It's a possibility.

3 Q. Do you hold an opinion as to the most
4 probable cause of a drop in platelet count?

5 A. Yes, I think it's most probably due to
6 transient hypoxia intrapartum.

7 Q. And what is the basis for that opinion?

8 A. I explained that there was mild acidosis and
9 the drop in the platelet count in a child who
10 subsequently has global delays that are
11 unexplained.

12 Q. Why do you consider that explanation of a
13 drop in platelet count more likely than being
14 associated with the brain bleeds?

15 A. The brain bleed, whenever it did occur, it
16 may have occurred slowly as a consequence of
17 a venus tear and become evident around about
18 the 17th, I guess. So his platelet count as
19 recorded at 78,000 was on the 18th, so it's
20 possible that, as I mentioned earlier, that
21 the platelets could have been sequestered by
22 the bleed or that it was a reflection of the
23 fetal distress for which there's evidence,
24 the acidosis and the likely degree of hypoxia

Deposition of Aubrey Milunsky, M.D.

1 that was going on intrapartum.

2 Q. What do you mean when you talk about
3 platelets being sequestered by the bleed?

4 A. They literally get gobbled up in the bleed,
5 in the clots, and drop the peripheral count.

6 Q. Are there any other explanations suggested by
7 the facts and circumstances of this case
8 other than the transient hypoxia and the
9 brain bleeds?

10 A. Yes, the record talks to the subject of
11 disseminated intravascular coagulation as an
12 explanation, which is the same basis as the
13 platelets being sequestered by blood that was
14 clotting.

15 Q. Any others?

16 A. I don't think there was any evidence of
17 infection that could account for that.

18 Q. Have you ever testified that an acidosis
19 involving a pH of 7.2 or 7.21 is associated
20 with brain damage?

21 A. No. No.

22 Q. Do you believe a pH of 7.2 or 7.21 in this
23 case is causally significant for brain
24 damage?

Deposition of Aubrey Milunsky, M.D.

1 A. I don't think that his brain damage is a
2 direct consequence of intrapartum hypoxia;
3 may be a contributing factor.

4 Q. Have you ever testified in any other case
5 that a pH in the range in this case is a
6 contributing factor in causing brain damage?

7 A. The pH by itself can't be held to be a
8 contributing factor by itself.

9 Q. Have you ever testified that the pH in
10 connection with any other factors has been
11 associated with causing brain damage?

12 A. No, I've never testified in that way.

13 Q. Have you ever published any material in which
14 you assert that a pH of 7.2 or 7.21 in
15 connection with other factors can be causally
16 significant for brain damage?

17 A. No.

18 Q. Now, you mentioned multiple birth defects
19 associated with global delays.

20 First of all, tell me what multiple
21 birth defects you are referencing.

22 A. Well, Jayden was born with coloboma in his
23 eye, one eye; he has an undescended testes,
24 unilateral with a hydrocele and an inguinal

Deposition of Aubrey Milunsky, M.D.

1 hernia, all on the right; he had a
2 right-sided pulmonary artery branch stenosis;
3 his ears are kind of prominent, and from his
4 photograph it suggests to me that he has
5 scoliosis. He also is hyperextensible as
6 noted when he was 14 months of age.

7 Q. I'm sorry, hyper --

8 A. Hyperextensible joints. And of course he has
9 a mother who has multiple fusions of her
10 vertebrae. Her thoracic six and seven are
11 fused, her vertebrae; a partial fusion of her
12 thoracic fifth and sixth vertebrae and the
13 seventh and eighth vertebrae; some unusual
14 clefting of her vertebrae at six and seven;
15 and she has multiple spina bifida occulta,
16 O-C-C-U-L-T-A, defects that were seen over
17 those vertebrae. And she has a loss of
18 normal cervical lordosis. He also has
19 strabismus.

20 Q. Any other birth defects?

21 A. What he has, of course, is mild delay in
22 speech and language, in particular.

23 Q. Any other birth defects?

24 A. Not that come to mind.

Deposition of Aubrey Milunsky, M.D.

1 Q. Okay. Any other concerns about health
2 conditions of the mom?

3 A. Well, we know from the record, at least, that
4 she, besides the items in the spine that I
5 just mentioned, also used alcohol and
6 marijuana at the very least in early
7 pregnancy.

8 Q. In the first month of pregnancy?

9 A. In early pregnancy.

10 Q. Do you have any evidence that she used
11 marijuana or alcohol after the first four
12 weeks of pregnancy?

13 A. No. I don't know the precise and exact
14 timing, except it was early in the pregnancy.

15 Q. Do you have any evidence of the amount of
16 alcohol or marijuana consumed early in
17 pregnancy by the mom?

18 A. I do not know.

19 Q. Let me go back to these multiple birth
20 defects.

21 You mentioned coloboma. Exactly
22 what is a coloboma, please, sir?

23 A. Coloboma is a word derived from the Greek.
24 It means -- in Greek, it means to mutilate.

1 But, actually, it is customarily used to
2 describe a defect most often in the eye.

3 Q. Do you always consider coloboma a birth
4 defect?

5 A. Yes.

6 Q. Do you -- explain to me what significance you
7 attribute to the presence of a coloboma in
8 this case.

9 A. It is a defect in the formation of the eye,
10 which may have been environmentally induced
11 like, for example, by alcohol, maternal
12 alcohol consumption, and occurred extremely
13 early in the formation of the embryo, fetus.

14 Q. You say it may have. May is a very broad
15 concept. Can you give me -- can you be any
16 more specific than that? Can you put it in
17 mathematical percentage terms for me?

18 A. No, other than coloboma has been described in
19 part and parcel of Fetal Alcohol Syndrome.

20 Q. Okay. Do you consider Jayden W. ... to
21 have Fetal Alcohol Syndrome?

22 A. He may have what is described in the
23 literature as an incomplete Fetal Alcohol
24 Syndrome.

Deposition of Aubrey Milunsky, M.D.

1 Q. Again, you used the word "may." Can you be
2 more specific about a mathematical percentage
3 that you would be willing to assert?

4 A. No, because there isn't a specific test that
5 one can do that tells of a precise diagnosis
6 for Fetal Alcohol Syndrome. What one can say
7 is, and this would be indisputable, that he
8 was born with a number of birth defects, and
9 sitting in the history of the mother is
10 alcohol ingestion in early pregnancy; and
11 that's about as far as one can go.

12 Q. Okay. You would not testify in this case
13 that the ingestion of alcohol or marijuana
14 early in pregnancy most probably caused any
15 birth defect in Jayden W. , would you?

16 A. I wouldn't put it that way, but I would
17 certainly be pointing to an etiological
18 factor in this pregnancy that includes
19 alcohol.

20 Q. But it would be considerably less than a
21 50 percent likelihood?

22 A. I couldn't put a percentage on that. I don't
23 think anybody could.

24 Q. Right. So do I understand that you could not

1 even say, for example, that there is at least
2 a one-in-a-million chance that alcohol
3 ingestion or marijuana ingestion by the mom
4 caused the baby to have any birth defect?

5 A. I'm not sure where you are getting the
6 one-in-a-million from. But the fact is that
7 alcohol ingestion by pregnant women in the
8 United States ranks at the most common cause
9 of birth defects that we see; and, as a
10 consequence, this remains a significant
11 possibility in this case as a contributing
12 factor, which is why I talked about that
13 there are multiple factors that operate in
14 the operation of Jayden's ultimate problems.

15 Q. Yes, sir. But please answer my question.

16 Can you testify to a reasonable
17 degree of medical certainty that ingestion of
18 alcohol or marijuana by the mom creates at
19 least a one-in-a-million chance that
20 Jayden's -- that any of Jayden's birth
21 defects were caused by the ingestion of those
22 substances?

23 A. That figure, one in a million, sounds
24 difficult to come to. If you are making a

Deposition of Aubrey Milunsky, M.D.

1 hypothetical one in a million, I would say
2 it's much more likely than one in a million.
3 But nobody would be in a position to come up
4 with a precise number. For example, one in
5 100,000, one in 10,000 would be much more
6 probable than one in a million.

7 Q. Would you be willing to testify at trial that
8 there is at least -- I mean, to a reasonable
9 degree of medical certainty, there's at least
10 a one-in-a-million chance that alcohol or
11 marijuana ingestion by the mom caused any
12 birth defect of Jayden W. 1?

13 MS. SIMMONS: Object to the form.

14 A. There's no scientific basis upon which to
15 reach a statistical likelihood for the
16 alcohol role in Jayden's birth defects.

17 Q. What causes coloboma other than alcohol
18 ingestion?

19 A. It's a developmental defect. So frequently,
20 and probably most frequently, the cause is
21 not known. But it can occur as part of a
22 chromosomal abnormality, for example.

23 Q. I'm sorry. It can occur as a result of a
24 chromosomal abnormality?

1 A. Yes. Right. Correct.

2 Q. But it doesn't suggest that there is a
3 chromosomal abnormality?

4 A. Nobody studied his chromosomes to the best of
5 my understanding of this record. It can
6 occur as part of many different syndromes,
7 birth defect syndromes.

8 Q. Have you formed any opinion that Jayden
9 W suffers from any such syndrome?

10 A. Yes, he has a syndrome. And the items that I
11 already described to you -- the coloboma, the
12 cognitive and speech and language delay, the
13 pulmonary artery stenosis, the unilateral
14 undescended testes, et cetera -- this all
15 constitutes a combination of signs which are
16 therefore called a syndrome, but giving it a
17 name? No, not yet. He hasn't been fully
18 studied.

19 Q. All right. There are many genetic syndromes
20 that are well recognized, correct?

21 A. Yes, there are over 2,000.

22 Q. Okay. You don't contend that Jayden
23 W fits any of those over 2,000
24 recognized syndromes, do you?

Deposition of Aubrey Milunsky, M.D.

1 A. He hasn't been fully studied as we speak.

2 Q. But at this point, based on all of the
3 information available to you, you haven't
4 formed the opinion that he fits into any of
5 those categories?

6 A. At this point, he requires further evaluation
7 in order to determine an answer to that
8 question.

9 Q. Where is Jayden's coloboma located?

10 A. His right eye.

11 Q. Does he still have it?

12 A. A person is born with it.

13 Q. Right. And do they always have it?

14 A. Yes.

15 Q. Right. Does a coloboma necessarily cause any
16 functional problems?

17 A. It may depend on its location. If it's in
18 the choroid in the optic head, if it's in the
19 vitreous area, if it's in the iris. It
20 depends where it is. It may frequently cause
21 no specific difficulty in and of itself.

22 Q. Where is Jayden's?

23 A. Other than the right eye, I can't recall
24 precisely where his coloboma is.

Deposition of Aubrey Milunsky, M.D.

1 Q. Okay. As you sit here today, you haven't
2 formed the opinion that his coloboma will
3 cause him any functional difficulty, have
4 you?

5 A. Other than it was peripheral, I don't recall
6 where it is and I don't think it's causing
7 him any functional defect at the moment.

8 Q. What significance, if any, do you place on
9 the fact that he had a unilateral coloboma
10 limited to the right eye?

11 A. Nothing more than we've stated, that it's a
12 developmental defect.

13 Q. If it were a bilateral coloboma, would that
14 cause you greater concern?

15 A. Yes.

16 Q. And if it was bilateral coloboma, would that
17 be more consistent with a genetic
18 explanation?

19 A. It doesn't have to be genetics, but simply
20 developmental.

21 Q. Well, still, I'd like an answer to my
22 question. If it was bilateral, would that
23 give you more concern about a genetic
24 problem?

1 A. As a basic principle, all bilateral events
2 are more likely to be genetic than not. But
3 even unilateral events like a coloboma occur
4 in chromosomal and other syndromic disorders.

5 Q. If it were bilateral instead of limited to
6 the right eye, would that cause you more
7 concern as a developmental issue?

8 A. I think I mentioned that bilateral events of
9 all sorts, including all defects, point more
10 to a genetic causation.

11 Q. What number of individuals or percentage of
12 individuals have coloboma in at least one
13 eye?

14 A. I actually don't recall a precise number.
15 It's one in 10,000 or -- I don't recall a
16 precise number.

17 Q. Okay. How many, or rather what percentage of
18 individuals have bilateral coloboma?

19 A. Same answer.

20 Q. Same answer, that you don't know?

21 A. Don't know the number off the top of my head.

22 Q. Tell me why you believe undescended testes
23 has significance in this case?

24 A. It is just one other defect.

Deposition of Aubrey Milunsky, M.D.

1 Q. Is his testes still undescended?

2 A. I can't answer the question. Don't know. It
3 should have been brought down. If it wasn't,
4 that's a problem if it didn't come down by
5 itself.

6 Q. All right. Precisely, what do you mean by
7 the phrase, "undescended testes"?

8 A. The testes are not in the scrotum.

9 Q. And which side was undescended?

10 A. Right.

11 Q. What significance, if any, do you attribute
12 to it being a right-sided issue?

13 A. None.

14 Q. What causes undescended testes?

15 A. Failure to descend; either obstruction or a
16 defect along the course of the descent from
17 the rear of the abdominal wall through the
18 interior inguinal canal and through the
19 exterior inguinal canal --

20 Q. Excuse me. What percentage of male babies
21 are born with at least one undescended
22 testes?

23 A. Probably in the vicinity of one in 500.
24 Something like that.

Deposition of Aubrey Milunsky, M.D.

1 Q. It's a fairly common finding, correct?

2 A. Yes.

3 Q. What is a hydrocele?

4 A. That is like an envelope that envelopes the
5 testes in which there is fluid.

6 Q. Does Jayden still have a hydrocele?

7 A. I doubt that.

8 Q. How many male babies are born with a
9 hydrocele?

10 A. I don't know the frequency of that. It's not
11 uncommon.

12 Q. You mentioned an inguinal hernia, is that
13 also limited to the right side?

14 A. In this case.

15 Q. What suggestion do you place on that?

16 A. It's another defect. And also may be
17 associated with connective tissue disorder,
18 which he probably has.

19 Q. Please explain that connection.

20 A. Well, when connective tissue like, in other
21 words, collagen, is stretchable, weak, they
22 may well be associated with events like
23 hyperextensible joints, which he is, like
24 boney abnormalities as seen in his mother,

1. like hernias that he has.

2. Q. What are the potential causes of inguinal
3. hernia?

4. A. Again, a lot depends on age. It could be
5. congenital, literally, as is probably the
6. case here. And it relates ultimately to
7. whether or not the internal ring, that is the
8. inguinal ring, is stretchable enough to allow
9. access of the bowel to move along the canal,
10. the inguinal canal, and that's what a hernia
11. is actually. So it's stretchable tissue or
12. increased pressure within the abdomen, or
13. I've seen in older individuals or individuals
14. with chronic lung disease who keep coughing,
15. for example.

16. Q. What percentage of male babies have inguinal
17. hernia?

18. A. I don't know the exact figures.

19. Q. It's fairly common too, isn't it?

20. A. Not that common.

21. Q. Would you agree with me that undescended
22. testes, hydrocele and an inguinal hernia
23. often exist in the newborn context without
24. brain damage?

Deposition of Aubrey Milunsky, M.D.

1 A. Yes. They may certainly exist, but what
2 catches the attention here, it's in
3 association with too many other things:
4 coloboma, arterial branch stenosis in his
5 lung, strabismus, probable scoliosis. There
6 are too many other things. Global delay.
7 That's why I spoke in the beginning about
8 multifactorial items that are contributing to
9 Jayden's state of health or ill health.

10 Q. Would you agree with me that many babies with
11 coloboma in the newborn context do not have
12 any brain damage?

13 A. Absolutely. Many do not. But quite a few
14 do. Not brain damage, but deficits, nervous
15 system deficits: speech, language, learning,
16 et cetera, all the way through to mental
17 retardation.

18 Q. One of the factors you mentioned was
19 right-side pulmonary artery branch stenosis.

20 First of all, where in the records
21 do you find documentation of that condition?

22 A. I can't tell you precisely where I saw that,
23 but it's in the records. It's in this set of
24 records either from MUSC or where -- that's

1 where I think it is.

2 Q. I'd like to take the time and have you find
3 that for me, please, sir.

4 A. This may take a while.

5 Q. Okay. We've got plenty of time.

6 (Short recess.)

7 Q. Doctor, your notes -- you indicated that your
8 notes make some reference to a pulmonary
9 artery branch stenosis?

10 A. Yes.

11 Q. Is that something you gleaned from your own
12 personal review of the records as opposed to
13 someone else calling it to your attention?

14 A. Yes.

15 Q. Okay. Let me ask you, sir: Do you happen to
16 have the MUSC discharge summary in your
17 materials?

18 A. Whatever I have received, I have here in
19 front of me.

20 Q. Okay.

21 A. So...

22 MS. SIMMONS: He didn't get it from
23 me; I can promise you that.

24 MR. GRAHAM: We're off for a second.

Deposition of Aubrey Milunsky, M.D.

1 (Short recess.)

2 Q. Doctor?

3 A. Yes.

4 Q. Let me get you to redirect your attention to
5 this record I'm getting ready to hand you.

6 A. Yes.

7 Q. This is a discharge summary from MUSC, Bates
8 stamped starting at 205, on page 206, under,
9 Hospital Course by System, Number Three. It
10 refers to Cardiovascular, secondary to the
11 systolic murmur heard at admission.

12 Cardiology consult was obtained and they
13 thought the murmur was secondary to branch
14 pulmonary artery stenosis.

15 Is that what you were making
16 reference to?

17 A. Yes.

18 Q. Did you actually see any cardiology consult
19 report?

20 A. I've seen this record here someplace. I
21 can't remember where I saw it, but it's where
22 I got it from --

23 Q. All right.

24 A. -- in the record.

Deposition of Aubrey Milunsky, M.D.

1 Q. And in forming your opinions in this case,
2 did you interpret --

3 A. Here we go.

4 Q. Same page. And yours is Bates stamped
5 MUSC 206.

6 Did you interpret that reference as
7 an indication that this child did, in fact,
8 have a right-side pulmonary artery branch
9 stenosis?

10 A. Well, that's how it was interpreted is all I
11 can tell you.

12 Q. So you don't know -- what we have is a
13 discharge summary referring to a cardiology
14 consult and making the reference that they
15 thought that that's what it was.

16 But you have no way of knowing what
17 the murmur truly represented, do you?

18 A. That's correct.

19 Q. Assuming --

20 A. The concern was, of course, that this is
21 systolic murmur related to a potential heart
22 defect, which wouldn't have been surprising
23 given the alcohol background. Since 40
24 percent or more or less that number of

1 offspring of alcoholic mothers have cardiac
2 abnormalities or cardiovascular
3 abnormalities.

4 Q. Well, what percentage of babies born with
5 cardiac abnormalities had mothers who
6 ingested alcohol during pregnancy?

7 A. I think I just stated that.

8 Q. No, sir. You told me that 40 percent of
9 children with alcoholic mothers --

10 A. I didn't say alcoholic mothers, rather
11 mothers who ingested alcohol.

12 Q. All right. I will accept that. You told me
13 that 40 percent of babies of mothers who
14 ingested alcohol during pregnancy have
15 cardiac problems?

16 A. The offspring. A high percentage have
17 congenital cardiac abnormalities.

18 Q. What's the source of your statement for that?

19 A. It's all over the literature.

20 Q. Can you give me any example?

21 A. Not off the top of my head in terms of a
22 specific journal. But you could probably
23 look in the coming sixth edition of my major
24 textbook, Genetics Disorder and the Fetus:

1 Diagnosis, Prevention and Treatment.

2 Again, there's information about
3 that subject coming up soon. But that's
4 culled from the vast literature on fetal
5 alcohol.

6 Q. Right. And let me make sure I understood.

7 Are you saying that 40 percent of
8 all babies with cardiac problems had moms who
9 ingested alcohol during pregnancy or are you
10 saying that of all the babies whose moms
11 ingested alcohol during pregnancy, 40 percent
12 of those have cardiac problems?

13 A. I'm saying -- first, I'm saying that among
14 the offspring of mothers who took alcohol in
15 early pregnancy, particularly binge drinking
16 in those early weeks to months of pregnancy,
17 have cardiac -- congenital cardiac
18 abnormalities. Some will say it's
19 40 percent; some people will say it's even
20 more.

21 Q. We're not talking about ingestion of small
22 amounts of alcohol, we're talking about binge
23 drinking?

24 A. No. I mentioned binge, but not only binge

Deposition of Aubrey Milunsky, M.D.

1 drinking.

2 Q. And what percentage of babies born with
3 cardiac problems have moms who did not ingest
4 alcohol during pregnancy?

5 A. I don't know the answer to that, but about
6 .85 percent of all babies born have a
7 congenital cardiac abnormality.

8 Q. Some are far more serious than others, right?

9 A. Yes, of course.

10 Q. Okay. What exactly is a right-side pulmonary
11 artery branch stenosis?

12 A. It's exactly what it says, mainly along the
13 course of the pulmonary artery or arteries,
14 there's a constriction or narrowing or
15 stenosis along the vascular course.

16 Q. There are relative degrees of stenosis,
17 correct?

18 A. Oh, yes.

19 Q. Some relatively mild and clinically
20 insignificant, correct?

21 A. Yes.

22 Q. Was this child -- you don't know if this
23 child, in fact, truly had pulmonary artery
24 branch stenosis?

1. A. I only know what the record has reflected in
2 terms of what they thought.

3 Q. Right. And you have no information at all as
4 to whether they thought it was clinically
5 significant or not, do you?

6 MS. SIMMONS: Object to the form.

7 A. No, I don't know. For the follow-up, I don't
8 know if he still has murmur, for example.

9 Q. Now, included in your records are some
10 photographs, tell me how you got to have the
11 photographs in your possession.

12 A. I requested photographs.

13 Q. And what were you looking for when you asked
14 for the photographs?

15 A. Well, absent seeing the child, that was the
16 next best thing that I could get to see as
17 part of my initial evaluation of the record.

18 Q. Okay. And did the photographs that were
19 provided to you satisfy your request?

20 A. Yes.

21 Q. Okay. What significance, if any, do you
22 place in those photographs?

23 A. Well, the photographs turn out to be
24 additionally useful because they point to a

1 number of things. To begin with, they point
2 to the fact that you almost certainly have
3 scoliosis with a curvature of his spine; that
4 seems to be pretty evident on the photograph
5 taken from the rear. Also, his ears are
6 surprisingly prominent, as you see, which is
7 -- they sort of stick out like flaps.

8 Q. All right. Let me mark these photographs.
9 Do you need to keep these?

10 A. Yes, I do.

11 MR. GRAHAM: All right. Why don't
12 we mark it as our first exhibit and we'll --

13 Q. And then we'll let you keep it and make a
14 copy for the deposition.

15 (Exhibit No. 1 marked.)

16 Q. So in Plaintiff's Exhibit 1, you find two
17 things of significance, evidence of scoliosis
18 and prominent ears?

19 A. Yes.

20 Q. Anything else in this photograph?

21 A. No. That's as much as -- I suspect he has
22 very long arms, but I can't be certain of
23 that from the picture.

24 Q. All right. What significance do you

1 attribute to the assumed scoliosis?

2 A. That he has connective tissue disorder, which
3 is associated with vascular weakness,
4 friability.

5 Q. Connective tissue disorder didn't cause his
6 brain bleeds, did it?

7 A. They may well have contributed to a weakness
8 in the vascular wall when the vacuum was
9 applied.

10 Q. When you say it may well have, can you --
11 have you formed an opinion to a reasonable
12 degree of medical certainty as to whether --
13 first of all, whether Jayden W. , in
14 fact, has connective tissue disorder?

15 A. The answer is, yes, I believe he has
16 connective tissue disorder as evidenced
17 throughout the record, throughout the MUSC
18 notes that I even just now perused in front
19 of you, is the repetitive statement that he
20 has marked hyperextensibility of his joints
21 and that he was floppy or hypotonic. The
22 scoliosis we talked about. The big, floppy
23 ears that we've talked about.

24 Q. Are you saying that his ears are suggestive

1 of connective tissue disorder?

2 A. Yes.

3 Q. Have you formed an opinion that Jayden has a
4 connective tissue disorder which more likely
5 than not has contributed to his brain bleeds?

6 A. Like I said earlier, it is another factor
7 that is in the multifactorial mix that
8 resulted in his bleed.

9 Q. Yes, sir, but my question focuses on whether
10 you can testify that that most probably is
11 causally significant in terms of his bleeds.

12 A. Not by itself. There's certainly a high
13 degree of suspicion about that.

14 Q. Can you give me any mathematical percentage
15 of probability that you would be willing to
16 assert with a reasonable degree of medical
17 certainty as to the presumed causal
18 relationship between connective tissue
19 disorder and brain bleeds?

20 A. I would say that in his case, it is more
21 probable than not that his connective tissue
22 disorder was a contributing factor to his
23 bleed faced with the exerted force from a
24 vacuum.

Deposition of Aubrey Milunsky, M.D.

1 Q. What is the definitive test for connective
2 tissue disorder?

3 A. It should be as easy as that. There are
4 many different kind of connective tissue
5 disorders. For example, in something that is
6 called the Ehlers-Danlos Syndrome, there are
7 something like 13 different subtypes, all
8 with different genes. There is the Loeys
9 Dietz Syndrome. L-O-E-Y-S, D-I-E-T-Z.
10 There's a marfanoid kind of disorder; there
11 is Stickler Syndrome. It just goes on and
12 on. So there are many different types of
13 connective tissue disorder.

14 Q. Which connective tissue disorder, if any, do
15 you believe Jayden has?

16 A. I don't know what he has, whether he has one
17 of the benign subtypes of Ehlers-Danlos. I
18 don't know the answer. But he -- I also
19 would like to know what his spine shows in
20 terms of X-rays given what his mother has.

21 Q. What would you be looking for with spine
22 X-rays?

23 A. Well, does he have -- is there definitive
24 scoliosis, which by itself is a feature of

Deposition of Aubrey Milunsky, M.D.

1 connective disorder; does he have vertebral
2 fusions, multiple spina bifida occulta? I'd
3 like to know what he has.

4 Q. If he has a vertebral fusions, what
5 significance, if any, do you place on that?

6 A. That was directly inherited from his mother
7 as a dominantly inherited trait and that he
8 might have other features. As it is in this
9 particular picture, which we have looked at,
10 he has wide spaced nipples. His nipples sit
11 in the anterior auxiliary line instead of the
12 mid clavicular line; yet another minor
13 abnormality.

14 Q. Well, we'll get to that photo in a minute.

15 Do you consider Jamesetta
16 Washington, the mother of Jayden W
17 to be cognitively impaired?

18 A. I don't know anything about her in that
19 extent. I've never examined her or seen her,
20 haven't seen photographs of her. So there's
21 not much I can say.

22 Q. Surely, you would agree that one might have
23 vertebral fusions and have a perfectly
24 well-functioning brain?

Deposition of Aubrey Milunsky, M.D.

1 A. Oh, yes, certainly.

2 Q. And one might have scoliosis and connective
3 tissue disorder and have a perfectly bright,
4 well-functioning brain?

5 A. Absolutely, as long as there's no secondary
6 consequence.

7 Q. What did you mean when you referred to a
8 benign subtype of a connective tissue
9 disorder?

10 A. Well, for the example, the Ehlers-Danlos
11 subtypes have exactly what he has, namely,
12 his hyperextensible joints, they may have
13 scoliosis, and they maybe hypotonic and they
14 may have nothing else. They may easily
15 dislocate a shoulder, for example, or another
16 joint. They may sustain a fracture where
17 someone else may have not.

18 Q. What does the word "benign" mean in that
19 context?

20 A. Well, for example, Ehlers-Danlos type four is
21 associated with sometimes catastrophic
22 events, like blood vessels simply just
23 tearing in the bowel, in the brain, anywhere
24 else. That's not too benign. I think the

Deposition of Aubrey Milunsky, M.D.

1 aorta may stretch, may rupture.

2 Q. So the question still remains, what do you
3 mean by "benign" in the context of connective
4 tissue disorder?

5 A. It's not what I connote. It's actually
6 listed as benign. Benign being
7 non-catastrophic, non -- that's the best
8 word, because type four can literally be
9 catastrophic and fatal and this is not likely
10 to, by itself, be in that category.

11 Q. Okay. So if Jayden W. has a benign
12 subtype of a connective tissue disorder, does
13 that suggest that his connective tissue
14 disorder is not causally significant in terms
15 of brain bleeds?

16 A. No, no, no. It doesn't suggest that at all.
17 It suggests that subject to pressures exerted
18 by the vacuum, his vasculature would be
19 vulnerable -- weaker, in other words -- and
20 more easily torn or ruptured, thereby causing
21 a bleed.

22 Q. When you were talking about spine x-rays,
23 another point that you indicated you'd be
24 looking for is whether there's a multitude of

Deposition of Aubrey Milunsky, M.D.

1 spina bifida --

2 A. Occulta.

3 Q. -- occulta. What's the significance of that,
4 please?

5 A. It's incomplete fusion of the arches. The
6 vertebral arches. So, again, it's a birth
7 defect, but not clinically problematic by
8 itself. I also thought he had 13 pairs of
9 ribs, which is yet another defect.

10 Q. Okay. What's the source for that
11 information?

12 A. I guess, again, from the radiology report.

13 Q. Can you be more specific?

14 A. No, other than having read it.

15 Q. Is that in your notes as well?

16 A. Yeah, it's here [indicating].

17 Q. Do you have any idea where you got that?

18 A. Somewhere in the record. Probably wherever
19 the radiology reports are.

20 Q. Let me go ahead and ask you to hand me any
21 other photographs that you believe has any
22 significance.

23 A. Well, this shows his ears, in particular
24 [indicating].

Deposition of Aubrey Milunsky, M.D.

1 Q. All right. Let's mark this as Exhibit 2.

2 While we're at it, both of these you consider
3 significant?

4 A. Yes, this shows his wide-spaced nipples
5 [indicating].

6 Q. All right. Just hand them to me right now
7 and I will mark them and then I will ask the
8 questions.

9 (Exhibit Nos. 2-4 marked.)

10 Q. Doctor, you've handed me one photograph we've
11 marked as Exhibit 2, and you suggested this
12 is significant for showing prominent ears; is
13 that correct?

14 A. Yes.

15 Q. What percentage of babies have prominent
16 ears?

17 A. I have no idea.

18 Q. Do you consider that an uncommon finding?

19 A. Nothing is uncommon. The problem is too many
20 things are altogether in one child.

21 Q. Anything else significant to you on
22 Exhibit 2?

23 A. No, obviously, he has the scar and so forth,
24 but we're not talking about that.

Deposition of Aubrey Milunsky, M.D.

1 Q. I now hand you Exhibit 3.

2 What did you consider significant
3 about this photograph?

4 A. Sir, he has wide-spaced nipples. Again, just
5 a minor anomaly.

6 Q. What significance do you place on widespread
7 nipples?

8 A. Not another defect, another minor anomaly.

9 Q. What percentage of people have widespread
10 nipples?

11 A. No idea.

12 Q. Does widespread nipples cause any problem?

13 A. Not by itself. But, again, it's yet another
14 minor anomaly. Three minor anomalies spell a
15 serious anomaly somewhere at the rate of
16 20 percent.

17 Q. Where do you get that from?

18 A. It's standard information in all the birth
19 defect literature.

20 Q. Can one have widespread nipples without
21 having brain damage or cognitive impairments?

22 A. You can have absolutely widespread nipples
23 and not have brain damage.

24 Q. I now hand you Exhibit 4.

Deposition of Aubrey Milunsky, M.D.

1 Any significance do you attribute to
2 that photograph?

3 A. Other than the prominent ears, nothing else,
4 really.

5 Q. Let me mark your notes, if I may, please.
6 There are two pages. Why don't we -- is this
7 page one right here [indicating]?

8 A. No.

9 Q. Page one?

10 A. Yes..

11 Q. The title on the top.

12 MR. GRAHAM: Let's mark that as our
13 next exhibit, please.

14 (Exhibit No. 5 marked.)

15 Q. Could I get you to read your notes into the
16 record, please, sir.

17 A. Sure. The heading is Washington versus
18 Rhett, et al. I have abbreviations. Do you
19 want me to read the proper -- in other words,
20 I know what things mean, but --

21 Q. Yeah, if you don't mind, could you read the
22 abbreviation and then tell me what it stands
23 for.

24 A. Female sign. Mother, age 20, black. Mister

1 is in jail. Early pregnancy, alcohol (C2H5)
2 use. There was a failure to progress,
3 referring to labor, resulting in vacuum
4 extraction.

5 Q. Let me interrupt you, sir.

6 What do you mean by C2H5?

7 A. That's the -- C2H5OH is the chemical formula
8 for alcohol.

9 Q. Thank you.

10 A. Carry on?

11 Q. Please.

12 A. Failure to progress, leading to vacuum
13 extraction. You've got, I believe. Next is
14 sign of a male. So it's a boy. Date of date
15 of birth, 7/16/02 at 41 weeks. Weight
16 3470 grams. Length 52. Small post cephal
17 hematoma. C-E-P-H-A-L. APGARs, seven and
18 nine. PH of the cord, 7.2. Later, child
19 becomes hypotonic and desaturates with a poor
20 suck and respiratory distress, and systolic
21 murmur is heard at loudness of one out of
22 six; in other words, soft murmur. Bilateral
23 hydroceles and hernia on the left, I think
24 I've written here. I thought it was on the

Deposition of Aubrey Milunsky, M.D.

1 right.

2 Q. Let me stop you right there. What
3 significance, if any, do you place on the
4 hernia being on the left instead of the
5 right, if that's correct?

6 A. I would think that somebody wrote it wrong in
7 the notes someplace unless everything is on
8 the left. Also in the record there's
9 unilateral cryptorchidism on the left, and --
10 so everything is on the left. Sorry.

11 Q. Okay. So earlier you said everything was on
12 the right?

13 A. What can I tell you?

14 Q. Okay. But, in fact, everything is on the
15 left?

16 A. Looks like it. The right eye is coloboma.

17 Q. What significance, if any, do you place on
18 the coloboma being on the right and the
19 hernia, undescended testicles and hydroceles
20 being on the left?

21 A. No significance.

22 Q. Okay. Please continue.

23 A. He was intubated until he was on day of life
24 four. The right eye coloboma which was

Deposition of Aubrey Milunsky, M.D.

1 peripheral. On 7/17 the ultrasound study of
2 his brain was normal.

3 Q. Let me interrupt again. I apologize.

4 What significance, if any, do you
5 place on the coloboma being peripheral?

6 A. That's likely not to interfere with his
7 vision.

8 Q. Thank you. Please continue.

9 A. 7/17, the ultrasound was normal of his brain.
10 The EEG showed a mild abnormality and he has
11 a seizure on 7/18. Also on 7/17, he had a
12 CAT scan showing large posterior fossa bleed
13 with intraventricular extension, plus, the
14 record says subdural hematoma. The MRI were
15 done, shown a massive effect on the third and
16 fourth ventricle and the brain stem, and two
17 subdurals and a subgaleal hematoma. And on
18 7/18 still, he had an MRA showing absent flow
19 in the left transverse sinus, and they raised
20 the question of thrombosis or the absence of
21 a transverse sinus or compression.

22 He went for neurosurgery, which
23 resulted in evacuation of the posterior fossa
24 blood. I notice two focal increased signal

Deposition of Aubrey Milunsky, M.D.

1 areas in the left occipital flow.

2 Thrombophilia evaluation of was negative and

3 platelets were down to 78,000. On 8/20/02,

4 head circumference 38.5 and noted strabismus.

5 3/24/03, when he was eight months, the head

6 was 44.8, which was at the 50th percentile.

7 At 14 months, the record shows he was

8 hyperextensible and hypotonic. At 21 months,

9 gross motor delay was noted. At 4/17/04, MRI

10 showed delayed myelination and resolving

11 cerebella hematoma. 7/25/03, he had a

12 fundoplication and a G-tube was placed. On

13 6/4/04, the cardiology consult indicated mild

14 right-sided pulmonary artery branch stenosis.

15 9/18, unilateral cryptorchidism on the left

16 and left inguinal hernia, and he went to

17 surgery for repair. At 8/10/05, the head

18 circumference was in the 75th percentile.

19 And he has the suboccipital craniotomy scar.

20 There was poor speech. He was now three

21 years of age. Mild right hemiparesis, he had

22 -- a head rolling TIC, T-I-C. He loses his

23 balance and falls. He has developmental

24 delay and walks with a walker. 7/15/05, CAT

Deposition of Aubrey Milunsky, M.D.

1 scan was read as normal.

2 Q. Do you attribute any significance to that?

3 A. To what?

4 Q. The normal finding on that last study you
5 referred to?

6 A. Yes. Certainly, it's good news. An MRI
7 would have been better. I made a note in
8 here about 13 pairs of ribs and butterfly
9 vertebrae. And I made a note also about his
10 mother at the age of 14 who'd had an
11 accident, her X-ray showed fused thoracic
12 vertebrae, six and seven, and partial fusion
13 of thoracic five and six, and seven and
14 eight. The vertebrae showing also unusual
15 clefting of thoracic six and seven vertebrae.
16 He also had multiple spina bifida occulta,
17 defect seen over these vertebrae, namely C6,
18 C7 and T1. Excuse me. This is all the
19 mother, not he. Sorry. And there was a loss
20 of normal cervical lordosis.

21 And then my impression was that
22 Jayden had cerebella posterior fossa
23 hemorrhage, then a question mark, vacuum.
24 Number two, multiple minor anomalies, and I

1 list them: unilateral cryptorchidism and
2 hydrocele, unilateral inguinal hernia.

3 Q. What was the phrase you mentioned before
4 hydroceles, please, sir?

5 A. You mean, unilateral cryptorchidism and
6 hydrocele?

7 Q. Yes, sir. What is that phrase?

8 A. Undescended testes.

9 Q. Thank you. Continue.

10 A. Unilateral inguinal hernia; coloboma;
11 cognitive, plus speech, delay; right
12 pulmonary artery branch stenosis. I wrote,
13 photo, question mark, scoliosis and prominent
14 ears. Those were the multiple minor
15 anomalies I wrote.

16 And then the third item, mother with
17 a spine with skeletal abnormalities. And
18 then I said -- use the sign, similar sign,
19 raising the question to connective tissue
20 disorder with vascular vulnerability and also
21 made the note about 13 pairs of ribs.

22 I made side notes about, has he had
23 a Fragile X study, a microarray, high
24 resolution chromosomes, and whether there was

Deposition of Aubrey Milunsky, M.D.

1 any family history of stroke, hemorrhage or
2 rupture.

3 Can we take a break and get some
4 water or something?

5 MR. GRAHAM: Sure.

6 (Short recess.)

7 Q. Doctor, before the break, did you finish
8 reading into the record all of your notes?

9 A. Yes, sir.

10 (Pause.)

11 Q. You mentioned strabismus as being the list,
12 birth defect. Tell me about that.

13 First of all, what is strabismus in
14 the records, and secondly, what significance
15 do you attribute to that?

16 A. It's at least in the ophthalmology report.

17 Q. And what significance do you attribute to
18 that?

19 A. That he has crossed eyes. It's another
20 defect.

21 Q. How many babies are born with crossed eyes?

22 A. I don't know what the percentage is off the
23 top of my head.

24 Q. It's fairly common, right?

Deposition of Aubrey Milunsky, M.D.

1 A. Everything is common. He's got them all.

2 Q. By "them all," you mean he's got the ones
3 that he has?

4 A. He has a series of quite a lot, long list of
5 multiple anomalies. Minor multiple anomalies
6 is the best words.

7 Q. Does he have any anomalies that you consider
8 to be more than minor? And if so, what are
9 those?

10 A. I indicated that I thought he's likely to
11 have a connective tissue disorder, which may
12 lie at the vulnerability of his vasculature.

13 Q. You consider that more than minor, I take it?

14 A. If indeed he has that, that may lie at the
15 root of why he had the hemorrhage when vacuum
16 was applied.

17 Q. And we might have touched on this before, if
18 so, please forgive the redundancy, but how
19 would we determine whether or not this child
20 has a significant connective tissue disorder?

21 A. This may not be easy. As I explained, there
22 are at least 13 different genes that are
23 involved in just the Ehlers-Danlos Syndrome.

24 So an analysis of each of these genes is

1 expensive and not always available for all of
2 them to begin with except for the ones that
3 are serious like Ehlers-Danlos type four
4 which we analyze routinely, the sequence --

5 Q. Could you spell that, please?

6 A. Ehlers is E-H-L-E-R-S, hyphen, D-A-N-L-O-S.

7 Q. How would you test for Ehlers-Danlos?

8 A. Well, as I just said, type four is a gene
9 sequencing of a collagen gene. But I don't
10 -- what I said was the type four is the real
11 dangerous one. Many of the others are benign
12 and not life-threatening necessarily, but
13 they bring with it a predisposition, a
14 vulnerability, to a muscle and ligamentous
15 laxity; therefore, dislocations, possible
16 fracture. That kind of thing.

17 Q. What test would one do to determine whether
18 or not Jayden has type four Ehlers-Danlos?

19 A. I don't think he has type four Ehlers-Danlos.
20 There's no evidence for it.

21 Q. Okay. Can we rule that out?

22 A. We can say with a high degree of certainty
23 that he does not have Ehlers-Danlos type four
24 given the current evidence.

Deposition of Aubrey Milunsky, M.D.

1 Q. Thank you. How would we determine whether or
2 not he has any of the other conditions
3 involving connective tissue disorder?

4 A. It's a clinical conclusion based on the
5 examination -- physical examination of an
6 individual and it's beyond Ehlers-Danlos.
7 There is a wide range of connective tissue
8 disorders where the features that I've
9 described and which he has, the
10 hyperextensible joints. Some people have
11 dislocations of joints either once, twice or
12 many times. They may have fractures. They
13 may be hypertonic, they may have long arms,
14 prominent ears, prominent jaw, high-arched
15 pallet. All of these kinds of things.

16 Q. What was that last one?

17 A. High-arched pallet. Many of these are all
18 connective tissue indicators that the
19 connective tissue is loose, easily fractured,
20 broken, torn, stretched, et cetera.

21 Q. Well, is there genetics testing we can do to
22 rule in or rule out those conditions?

23 A. Except for the named conditions that I
24 suggested earlier and the ones I told you

1 about were the Ehlers-Danlos Syndrome group;
2 there's the Loeys Dietz Syndrome.

3 Q. Can you spell that, please.

4 A. L-O-E-Y-S and D-I-E-T-Z. I'm not suggesting
5 he has it. Loeys Dietz. There is Stickler
6 Syndrome, types one, two and three. There's
7 familial aortic aneurysms. There is Beals,
8 B-E-A-L-S, contractual arachnodactyly. This
9 goes on and on. I don't think he has these
10 conditions, but I do believe he has
11 connective tissue disorder that he's
12 inherited from his mother.

13 Q. Let me try to understand. You've named a
14 number of conditions.

15 Do those represent genetic
16 syndromes?

17 A. Yes.

18 Q. And do those represent genetic syndromes that
19 have as one distinguishing characteristic
20 some form of connective tissue disorder?

21 A. They are connective tissue disorders, all of
22 them.

23 Q. Do you have an opinion to a reasonable degree
24 of medical certainty that Jayden W.

Deposition of Aubrey Milunsky, M.D.

1 does not have any of those?

2 A. I don't think he has any of those that I
3 mentioned.

4 Q. Do you have --

5 A. Sorry. Excuse me. Except he might have a
6 benign form of Ehlers-Danlos.

7 Q. How many types of Ehlers-Danlos are there?

8 A. I believe 13, or somewhere in that territory.

9 Q. And how would we determine whether he has a
10 benign type of Ehlers-Danlos?

11 A. It's a clinical kind of diagnosis.

12 Q. You can't do genetic testing?

13 A. Generally, not.

14 Q. What are the distinguishing clinical
15 findings?

16 A. The ones he has.

17 Q. And the significance of those is that it
18 makes him more vulnerable to traumatic injury
19 to his blood vessels?

20 A. I would say.

21 Q. And is it your testimony that you hold an
22 opinion to a reasonable degree of medical
23 certainty that this child does have one of
24 the benign types of Ehlers-Danlos?

1 A. No. I said he has -- having not seen the
2 child, I am limited by the record and the
3 photographs. And from that, I suspect that
4 he has a connective tissue disorder and
5 that's all I can say so far.

6 Q. Can you go so far as to say that he has a
7 connective tissue disorder that makes the
8 blood vessels in his brain more vulnerable to
9 traumatic injury?

10 A. That is what I suspect.

11 Q. Can you say that to a reasonable degree of
12 medical certainty most probably?

13 A. Yes, I think I already said that earlier this
14 afternoon that it was more probable than not
15 that he has vulnerable vasculature.

16 Q. Earlier, when you were listing some minor
17 birth defects, several of them you listed
18 separately, but I believe you have discussed
19 them as being essentially related to the
20 connective tissue disorder, that is to say,
21 prominent ears, scoliosis and hyperextensible
22 joints; is that fair?

23 A. Yes. Hernia.

24 Q. So which of these birth defects that you

Deposition of Aubrey Milunsky, M.D.

1 allege exist in this case are distinct from
2 connective tissue disorder?

3 A. Probably his coloboma, although it's not
4 certain.

5 Q. That can be related to connective tissue
6 disorder?

7 A. It could be part of a syndrome. That's it.

8 Q. Do you believe that Jayden W most
9 probably does have some problems caused by
10 brain bleeds, and if so, what?

11 A. I don't think that he has residual damage to
12 his brain that accounts for his speech and
13 language and minor cognitive delay.

14 Q. You say you think he does?

15 A. Does not.

16 Q. Does not. And what is the complete basis of
17 that opinion?

18 A. That his cognitive -- the mild cognitive
19 delay that he might have, and it must be real
20 mild since he's in a normal classroom, not in
21 a Special Ed classroom, that he has some
22 speech delay. So this infers a global event
23 and not something that occurred as a result
24 of a bleed in the posterior fossa which

1 simply compressed and shifted his brain in a
2 transient fashion and then was resulted in
3 the evacuation of the clot or the bleed with
4 the brain returning to its normal position
5 and without demonstrable damage to his brain
6 by imaging studies.

7 Q. What imaging study do you refer to, the CT?

8 A. The CT scan was normal, yes, at three years
9 of age. And clinically, he's in a normal
10 classroom.

11 Q. Do you consider yourself as having special
12 expertise about what it means to be in a
13 normal classroom in South Carolina?

14 A. You don't want to say that too loudly,
15 especially in South Carolina. You may not
16 get back past state lines. I can't comment
17 about South Carolina's educational levels.
18 But he's in a normal classroom acceptable to
19 the authorities, and one assumes, therefore,
20 at best, that if he has any cognitive delays,
21 they must be mild.

22 Q. Okay. Well, what cognitive delays do you
23 associate with a need for special needs
24 classroom?

Deposition of Aubrey Milunsky, M.D.

1 A. Difficulties learning, learning behavior
2 issues.

3 Q. Right. Would you agree with me that the mere
4 fact that Jayden is in a normal classroom is
5 quite different from saying that it meets his
6 needs to be in a normal classroom?

7 A. Yes, it is different. I agree with you
8 completely.

9 Q. And that -- would you agree with me that the
10 point you're making would not be a valid one
11 if, in fact, he needs to be in a special
12 needs classroom but finds himself in normal
13 classrooms that have -- that are not
14 attributable to his mental status?

15 MS. SIMMONS: Object to the form.

16 A. I don't know exactly what that question
17 meant.

18 Q. Okay. Let me try again.

19 A. I can answer it and see if I got the gist.

20 Q. Okay. Go ahead.

21 A. He might -- I think by your question you're
22 saying that, in fact, under ordinary
23 circumstances, or other circumstances, he
24 might really belong in a Special Ed class and

1 he isn't. And he, one way or another, is
2 placed in that classroom for his benefit or
3 for the school's benefit economically and
4 that he might well have some mild delay. If
5 that is the case, that he has mild delay,
6 learning issues, some cognitive issues, even
7 behavior issues, that goes, again, to the
8 point that he has global involvement of his
9 brain unrelated to a bleed in his posterior
10 fossa.

11 Did I answer your question?

12 Q. I'm not sure. Let me get at it this way.
13 Earlier you attributed some significance to
14 the fact that Jayden is in a normal
15 classroom.

16 Would you agree with me that that
17 observation loses significance if the reality
18 is that he should not be in a normal
19 classroom?

20 A. Actually, if he should not be in a normal
21 classroom, that gains significance in the
22 sense that he has global delay that cannot be
23 accounted for by a bleed in the posterior
24 fossa that was evacuated and the absence of

1 demonstrable damage to his brain seen by
2 imaging.

3 Q. Would you agree the MRI of the brain is far
4 more sensitive than CT for determining brain
5 damage of this type?

6 A. MRI is more sensitive in that determination;
7 however, by the age of three with a normal
8 CAT scan and effectively operating for South
9 Carolina's standards in the normal range is
10 placed in a normal classroom, I have a
11 feeling his caregivers didn't think it was
12 necessary to go and do an MRI at that point.

13 Q. The same caregivers that put him in a normal
14 classroom?

15 MS. SIMMONS: Object to the form.

16 A. Yes. But the caregivers are physicians,
17 not -- I assume caregivers as opposed to
18 educational staff.

19 Q. Have you noticed that on occasion Medicaid
20 patients might not get an MRI when one would
21 be done for a privately paying patient?

22 A. Yes.

23 MS. SIMMONS: Please note my
24 objection to that.

1 Q. What damage do you believe can be caused by
2 the type of bleeds that Jayden experienced at
3 the time of his delivery or soon thereafter?

4 A. I think it's really a speculative kind of
5 answer you're asking me for. The subgaleal
6 hemorrhage may slowly resorb and leave no
7 residual anything. The -- variously, the
8 record describes subdural hemorrhage, or, in
9 fact, two subdural hemorrhages. They may
10 resorb without any eventuality or they may
11 cause a transient seizure, which he had,
12 single seizure he had. And the posterior
13 fossa hemorrhage, if not evacuated, can cause
14 grievous harm and death. But once evacuated,
15 and without interfering with brain substance,
16 may leave no residua at all.

17 So if there's no interference with
18 oxygen supply to his brain despite the
19 presence of a space occupier in the posterior
20 fossa, then he may well come out of it
21 fortunate and not damaged or harmed by the
22 eventuality of the hemorrhage.

23 Q. When you say that a subgaleal hemorrhage may
24 not necessarily have any residual damage,

1 what do you mean by the phrase, "not
2 necessarily"?

3 A. It may leave no harm once the resorption has
4 occurred.

5 Q. Okay. Does that -- does "not necessarily"
6 mean it may cause residual harm and it may
7 not?

8 A. The harm that might eventuate could only be
9 so if there was damage to the underlying
10 brain, because this is a hemorrhage that
11 occurs underneath what's called the
12 aponeurosis. It's like an envelope that
13 covers the skull, but it's outside. It's
14 extracranial.

15 Q. And what kind of residual damage can be
16 caused by a subgaleal bleed?

17 A. It might be associated with a skull fracture
18 in the first place; but if there's no
19 underlying brain damage, it's ultimately not
20 likely to cause lasting damage of any sort.

21 Q. But what do you mean when you say "assuming
22 no brain damage"? I mean it sounds like
23 circular reasoning. Assuming no brain
24 damage, there's no residual brain damage.

Deposition of Aubrey Milunsky, M.D.

1 What am I missing?

2 A. Maybe I didn't say it right. If there is a
3 subgaleal hemorrhage and the underlying brain
4 is not harmed, there's not going to be a
5 residual, other than the fact that the bleed
6 can be quite severe, may require transfusion
7 that may cause jaundice and so forth and may
8 require transfusion.

9 Q. Can the presence of the blood itself cause
10 harm?

11 A. Only in the sense of causing jaundice as the
12 blood is resorbed or requiring transfusion if
13 there's a large enough bleed. It may act as
14 a nidus for infection, but these are largely
15 speculative statements.

16 Q. What harm -- what residual damage to the
17 brain can be used by a subdural hemorrhage?

18 A. Same again: pressure, seizure, blood
19 accumulating and requiring evacuation,
20 pressure on the brain, separation of the
21 sutures, shifting of the brain, death. I
22 mean, there's a whole series of catastrophic
23 events depending on the size and situation of
24 the bleed.

Deposition of Aubrey Milunsky, M.D.

1 Q. Cognitive impairments?

2 A. If not evacuated or resorbed, yes. But
3 without demonstrable brain damage, no.

4 Q. Would you agree with me that demonstrable
5 brain damage may be present on an MRI and not
6 present on CT?

7 A. It's certainly possible, but, again, the
8 events of a subdural would be focal; in other
9 words, at the place where the pressure is
10 being exerted by the subdural. That's where
11 the damage is. It doesn't cause global delay
12 with speech issues, language issues, learning
13 issues, may cause focal Jacksonian kind of
14 seizures, for example, or a paralysis of one
15 limb, but it's not going to be a generalized
16 phenomenon.

17 Q. What residual damage will result from a
18 posterior fossa bleed?

19 A. I think I answered that question a little
20 earlier with reference to the fact that if
21 evacuated in a timely fashion, and there's no
22 involvement of the blood supply, and,
23 therefore, the oxygenation to the brain,
24 there may be no residual effect whatsoever.

1 Alternatively, if it's not done in time,
2 there could be a shift in the brain as
3 occurred in this case and death as long as
4 the brain substance is not invaded and torn
5 up by the bleed, either in the cerebellum or
6 in the -- we're talking about the posterior
7 fossa -- if the cerebellum is not physically
8 damaged by the bleed.

9 Q. Do you consider yourself as having special
10 expertise on the cause of brain damage as
11 opposed to possible genetic causes of brain
12 damage?

13 A. Whether I have the fortune or misfortune of
14 having been trained pretty extensively across
15 a broad field of medicine, including some
16 intensive neurology, at a place called Queens
17 Square in London -- so I'm not a neurologist,
18 but I spent all of my many decades seeing
19 children with issues related to the brain
20 function and dysfunction, whether it be by
21 injury or by genes or by environment.

22 Q. Have you ever testified that brain bleeds can
23 result in residual damage to the brain?

24 A. If brain substance is involved, then

1 inevitable brain damage is going to result
2 with signs and symptoms to boot. If the
3 vasculature -- if, in other words, the blood
4 supply is in some way interfered with and
5 compromised as a consequence of the bleed,
6 then, again, there's going to be inevitable
7 brain damage. But absent those phenomena,
8 that's not going to happen unless there is
9 focal injury, and then you don't have the
10 global events or global consequences that are
11 manifest in Jayden.

12 Q. Did Jayden suffer from any type of hypoxic or
13 ischemic damage resulting from the brain
14 bleeds themselves?

15 A. I don't -- I am not aware of any evidence
16 that points in that direction.

17 Q. Would you agree that Jayden's brain bleeds
18 would not have occurred in this case but for
19 the use of the vacuum extraction?

20 A. I don't think I can respond, other than
21 speculate on that. It would seem that the
22 vacuum extraction, certainly for the
23 subgaleal bleed, is clear, but, of course,
24 almost certainly indicated in the sense that

Deposition of Aubrey Milunsky, M.D.

1 the child had to be pulled out.

2 Q. You told me earlier you would not be offering
3 opinions about obstetrical matters.

4 A. Yes. I said I wouldn't be addressing
5 standards of expected care or anything to do
6 with that.

7 Q. Okay. Are you planning to tell the jury
8 whether or not there was an indication for
9 the expedited delivery?

10 A. What I noticed in the record is that there
11 was evidence on the fetal strip of fetal
12 distress and that the application by
13 Dr. Rhett of the vacuum was done in order to
14 get the child out. That's all I could say.
15 I can't comment on the appropriateness or the
16 method or how long it took, et cetera.

17 Q. Okay. And, in fact, you don't know whether
18 vacuum was indicated at the time it was
19 applied?

20 A. No, correct. I will not be commenting on
21 that.

22 Q. You don't know what the baby's station was?

23 A. No, I do know, but I'm not commenting on that
24 territory.

1 Q. You do know what the baby's station was?

2 A. I think it was -- the child was in midpelvis
3 or --

4 Q. Midpelvis?

5 A. I'm not sure. I don't remember. This is not
6 my territory.

7 Q. Let's talk, if we may, about what you can and
8 cannot testify occurred to a reasonable
9 degree of medical certainty most probably.

10 You don't know the amount of the
11 mother's alcohol ingestion?

12 A. Correct.

13 Q. You don't know the time over which she
14 ingested it?

15 A. Other than early pregnancy, no.

16 Q. You don't have any evidence that she ever
17 binged with alcohol during pregnancy?

18 A. I'm not aware of that record.

19 Q. And with that limited knowledge, you cannot
20 testify that her alcohol intake was most
21 probably causally significant in this case,
22 can you?

23 A. I can't comment on her alcohol intake; the
24 amount of her alcohol intake.

1 Q. Okay. And, therefore, you can't comment that
2 the amount that she ingested and at the time
3 she ingested it played any causally
4 significant role in the development of her
5 son's problems, can you?

6 A. I can only draw attention to the features
7 that were found that are consistent with
8 alcohol.

9 Q. But you can't testify that those are more
10 likely than not caused by alcohol --

11 (Interruption.)

12 Q. -- correct?

13 MS. SIMMONS: Object to the form.

14 A. Please ask me the question again.

15 Q. You can't testify that her ingestion of
16 alcohol most probably caused Jayden any
17 problem, can you?

18 A. I answered the question by saying that I
19 don't know the amount of alcohol she took,
20 but that the features that he shows, some of
21 which are consistent with fetal -- incomplete
22 Fetal Alcohol Syndrome.

23 Q. Okay. I don't mean to beat a dead horse
24 here. I think what you are saying is you

1 can't testify that more likely than not
2 ingestion of alcohol caused any problem, but
3 you're not giving me a direct answer to that,
4 and I want to make sure.

5 A. No, I cannot say that it's more probable than
6 not.

7 Q. Thank you. And you can't testify to a
8 reasonable degree of medical certainty that
9 the reduction in platelets was most probably
10 caused by hypoxia, correct?

11 A. I think we -- exploration of that subject, I
12 indicated that it was either due to
13 intrapartum hypoxia and/or due to the
14 sequestration of platelets in the bleed.

15 Q. Am I correct that you cannot testify to a
16 reasonable degree of medical certainty that
17 the most probable cause of the reduction of
18 platelets was hypoxia?

19 A. I just answered the question; it's one or the
20 other or both.

21 Q. Okay. But I'm really asking the probability
22 question, more likely than not. Can you tell
23 the jury -- do I have to worry about you
24 telling the jury that it's more likely than

Deposition of Aubrey Milunsky, M.D.

1 not hypoxia caused the drop in platelets?

2 A. I've answered as best as I can, namely, that
3 it's the intrapartum hypoxia and/or the
4 sequestration of platelets.

5 Q. But it could have been the sequestration of
6 platelets in and of itself?

7 A. I think I just said and/or.

8 Q. Okay. And you can't be any more specific
9 about the mathematical probabilities?

10 A. No.

11 Q. Okay. Thank you. And you would agree with
12 me that all of the abnormalities that you
13 referred to as being mild abnormalities can
14 all be explained as signs and/or symptoms of
15 a connective tissue disorder?

16 A. No. The cognitive speech delay issues are
17 not part of a connective tissue disorder and
18 probably coloboma doesn't fit there either.

19 Q. Cognitive speech delays, coloboma, and what
20 was the other one?

21 A. That's it.

22 Q. What about the motor?

23 A. There was originally some motor delay and
24 then that appears to have either disappeared

Deposition of Aubrey Milunsky, M.D.

- 1 completely or minimized now.
- 2 Q. What do you base that on?
- 3 A. That he's no longer using a walker, for
- 4 example. He's in the regular class.
- 5 Q. You interpret -- you assume that because he's
- 6 no longer using a walker he no longer has any
- 7 motor delays?
- 8 A. No, no, no. I'm saying that they are now
- 9 mild to -- if anything. I don't know what
- 10 the current status of his motor abilities
- 11 are.
- 12 Q. Coloboma can be associated with connective
- 13 tissue disorder, right?
- 14 A. It's not a characteristic feature.
- 15 Q. Cognitive impairments and speech delays can
- 16 be associated with brain bleeds, correct?
- 17 A. Yes.
- 18 Q. Motor delays can be associated with brain
- 19 bleeds, correct?
- 20 A. Yes.
- 21 Q. So the only problems this child has that are
- 22 not caused by brain bleeds are coloboma and
- 23 connective tissue disorder?
- 24 A. And strabismus.

Deposition of Aubrey Milunsky, M.D.

1 Q. Is strabismus associated with connective
2 tissue disorder?

3 A. Not usually, no.

4 Q. Any others --

5 A. We don't know about his spine, right, his
6 scoliosis.

7 Q. I thought you associated that with connective
8 tissue disorder.

9 A. Oh, yes. Yes, of course. Sorry.

10 Q. My point is, you would agree that connective
11 tissue disorder explains most of his mild
12 abnormalities?

13 A. To the extent that he's been evaluated. So
14 far, his evaluation is incomplete. He hasn't
15 had a number of tests that are necessary.
16 I've not seen an X-ray of his spine. He
17 hasn't had a chromosomal microarray, he
18 hasn't had a chromosome study. So there are
19 a number of things he hasn't had yet.

20 Q. To have a complete evaluation, what tests
21 would you recommend?

22 A. I would first want to examine the child and
23 get a closer fix on his features. I don't
24 see any consultation with a geneticist in the

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1 records I have seen.

2 Q. Okay. Are there other qualified geneticists,
3 respected geneticists, other than yourself?

4 A. I think I made that point before. In fact,
5 I'm glad you did.

6 Q. Let me add the word "alleged" in there
7 somewhere.

8 A. Too late. Too late. In South Carolina, I'm
9 sure there are board-certified clinical
10 geneticists.

11 Q. Are there others around the country that you
12 respect personally?

13 A. I respect all geneticists. Even lawyers. I
14 respect everybody.

15 Q. Are there any geneticists that you have a
16 running quarrel with or anything?

17 A. A running quarrel?

18 Q. Yes, or an intellectual dispute, any type of
19 battle of geneticists in literature or
20 anything like that?

21 MS. SMITH-YANCEY: Your arch
22 nemesis.

23 A. No, everybody loves me.

24 MR. SCOTT: That would be a Newman

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1 in the Seinfeld world.

2 Q. I'm sorry. We got off track there a little
3 bit, Doctor.

4 A. I didn't notice.

5 Q. Tell me what tests -- you mentioned you
6 wanted to examine the child or have the child
7 examined by some qualified geneticists.

8 What other tests do you believe
9 should be done for this child to be
10 thoroughly examined?

11 A. High resolution chromosome study. He needs a
12 Fragile X.

13 Q. Wait a moment. Let's take these slowly,
14 please. High resolution chromosome study.
15 All right. How do you get that done and how
16 do you do it?

17 A. You get a blood sample and send it to a
18 laboratory.

19 Q. Okay. How much does it cost?

20 A. Depends on where you are.

21 Q. Can you give me a range?

22 A. A range? 500 to 800.

23 Q. All right. And how long does that take?

24 A. Depends where you are. Two weeks, three

1 weeks.

2 Q. Okay. And what are you looking for by doing
3 that test?

4 A. If he has any kind of anomaly in his
5 chromosomes: a translocation, an inversion,
6 a partial trisomy [sic].

7 Q. Are there some potential chromosome
8 abnormalities that could be causally
9 insignificant in this case?

10 A. Causally insignificant?

11 Q. Yes, sir.

12 A. I don't know if I understand that question.
13 There are an endless array of chromosome
14 structural changes --

15 Q. Yes, sir.

16 A. -- some of which are highly relevant to a
17 diagnosis, some are variations of normal and
18 some appear to be minor but involve critical
19 genes. So there's a wide range of these
20 things.

21 Q. Is there anything in particular you'd be
22 looking for with regard to the high
23 resolution chromosome test?

24 A. Yes, to see if there's any structural change

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1 in any chromosome.

2 Q. Any type of structural change?

3 A. Yes.

4 Q. In any chromosome?

5 A. Yes.

6 Q. If so, you would point to that and say that
7 explains this child's connective tissue
8 disorders?

9 A. No. Likely his intellectual deficits,
10 et cetera.

11 Q. Any structural change in any chromosome you
12 would find to be causally significant in
13 terms of cognitive impairments?

14 A. This word "any" is a problem there.

15 Q. Hence my concern. What are you looking for?

16 A. Looking for a chromosome abnormality that
17 might explain his features.

18 Q. That might explain, okay.

19 Are there any in particular you'd be
20 suspicious of or focusing on?

21 A. Not specifically. There are various genes,
22 for example, and locations within the
23 chromosomes themselves that indicate areas
24 that are, say, vulnerable to speech defects,

1 for example.

2 Q. Such as?

3 A. The Fox, F-O-X, group of genes, for example.

4 Q. F-O-X?

5 A. Yes.

6 Q. Which group is that?

7 A. Do you have a few hours?

8 Q. No, sir. Can you give me a short answer?

9 A. You know, there are, at last count, almost
10 26,000 genes and there are some that are
11 clearly related to the development of speech,
12 for example. The other tests that he needs
13 is a chromosomal microarray, which we
14 mentioned earlier. That gets sort of a
15 deeper magnitude of examination of, again,
16 chromosomes, but at a much higher resolution
17 than is otherwise possible. This might
18 identify tiny areas of deletions and
19 duplications throughout his genome, which we
20 all have.

21 Q. Do you also perform that first with a blood
22 sample and then send it to a lab?

23 A. Same blood sample.

24 Q. And what's the cost for that?

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1 A. Ours is \$1,895.

2 Q. How long does that take?

3 A. Four to six weeks.

4 Q. And what are you looking for there, same
5 thing?

6 A. Yes, at a higher magnitude. Yes.

7 Q. What other testing do you recommend?

8 A. We already said the three, and then the rest
9 would depend upon the physical examination of
10 whether or not a sequencing analysis of a
11 collagen gene is necessary or not. Also want
12 to see an MRI of his brain.

13 Q. You said -- in answering that question, I
14 started by saying we've mentioned the three.

15 A. That was high resolution chromosomes,
16 Fragile X, chromosomal microarray.

17 Q. Fragile X, I think we skipped that one. You
18 mentioned it earlier, but we haven't
19 mentioned it recently.

20 Tell me about Fragile X; is that
21 also determined with a blood sample sent to a
22 lab?

23 A. Yes, it's a DNA study.

24 Q. Is Fragile X abnormality associated with any

1 commonly recognized genetic syndrome?

2 A. Yes, Fragile X Syndrome.

3 Q. Okay. And what does that represent? I mean,
4 what are the signs and symptoms of that?

5 A. Mild to moderate mental retardation, speech
6 and language issues and the connective tissue
7 issues that he shows. They are
8 hyperextensible --

9 Q. Is Fragile X Syndrome usually associated with
10 dysmorphic features?

11 A. They have some dysmorphic features.

12 Q. Do you consider Jayden W to have any
13 dysmorphic features?

14 A. He has prominent ears. I haven't seen his
15 pallet. He has the marfanoid habitus.

16 Q. The what?

17 A. You've heard of Marfan Syndrome?

18 Q. Can you spell it, please.

19 A. M-A-R-F-A-N. Like President Lincoln, that
20 sort of long, lanky arms, hyperextensible
21 joints.

22 Q. So you call that Marfan Syndrome?

23 A. He doesn't have Marfan Syndrome. Marfanoid,
24 it's like a Marfan appearance with fleshy,

1 prominent ears, prominent jaw, high-arched
2 pallet.

3 Q. What kind of pallet?

4 A. High-arched.

5 Q. You're not saying Jayden has that?

6 A. I haven't seen his pallet and there's no note
7 in the record.

8 Q. Are you saying he has a prominent jaw?

9 A. No, I didn't say that. You asked me about
10 the features.

11 Q. Okay. All right. And which of these
12 features do you contend that Jayden has?

13 A. I never contended anything.

14 Q. You contended he has prominent ears?

15 A. Yes, but you just asked me about what tests
16 we do that I would be doing.

17 Q. Yes, sir.

18 A. And I told you that Fragile X would be one of
19 them.

20 Q. And I asked you what dysmorphic features, if
21 any, are associated with Fragile X, and you
22 told me marfanoid, fleshy, prominent ears,
23 fleshy, prominent jaw --

24 A. I didn't say fleshy, prominent jaw.

Deposition of Aubrey Milunsky, M.D.

1 Q. Prominent jaw?

2 A. Prominent jaw.

3 Q. And high-arched pallet?

4 A. Yes, among other things, and the speech and
5 language issues and retardation issues.

6 Q. And which of those do you contend Jayden has?
7 And I'm really focusing on the dysmorphic
8 features. I understand about speech and
9 language.

10 A. I didn't contend he had this condition. I
11 said that given a patient like this, in a
12 regular practice, that's one of the tests he
13 would automatically have had.

14 Q. Okay. I understand. Do you consider Jayden
15 W to have marfanoid features?

16 A. Yes.

17 Q. Do you consider him to have fleshy, prominent
18 ears?

19 A. He has prominent ears.

20 Q. But not fleshy?

21 A. No.

22 Q. Do you consider him to have prominent jaw?

23 A. Let me see the pictures again. Not that I
24 recall specifically.

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1 MS. SIMMONS: He needs the pictures.

2 MR. GRAHAM: I'm sorry.

3 A. (Witness reviewing document.) No, I don't
4 think he has prominent jaw.

5 Q. And you don't know about high-arched pallet?

6 A. No.

7 Q. So if you or a qualified geneticist examined
8 this child and performed high resolution
9 chromosome testing, microarray and Fragile X
10 and MRI of the brain, then and only then
11 would you be able to determine whether
12 additional tests are needed?

13 A. No, I think clinical examination by a
14 geneticist would be important.

15 Q. You said something about a frequency analysis
16 or sequencing analysis of a collagen gene?

17 A. That might be indicated to following an
18 examination.

19 Q. Okay. What would be an indication for that
20 test?

21 A. That the geneticist feels from his
22 examination or her examination that a
23 connective tissue disorder like Ehlers-Danlos
24 disorder is a possibility. But it's highly

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1 likely that that will not be the case.

2 Q. Okay. So let me understand. As you sit here
3 today, do you believe this child has a
4 connective tissue disorder?

5 A. Yes.

6 Q. Explain to me why you believe, then, that it
7 would not be appropriate to do the sequencing
8 analysis of the collagen gene.

9 A. Which gene? There are multiple genes
10 involved. That's the problem. That will run
11 probably tens of thousands of dollars when
12 you are done with it.

13 Q. All right. So I'm confused then, I believe,
14 about what the indication would be.
15 Connective tissue disorder, in and of itself
16 must not be enough to be an indication
17 because you believe Jayden has that disorder,
18 but you don't believe this test would be
19 indicated?

20 A. For the most part, it turns out that most
21 connective tissue disorders are not
22 characterized in the same -- gene sequencing
23 test. That you often encounter individuals,
24 children or adults, to have features like

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1 Jayden in which you never make a specific and
2 definitive named diagnosis, other than the
3 statement I made about connective tissue.

4 Q. When the examination of this child is done,
5 assuming it is done by a qualified
6 geneticist, what should the geneticist focus
7 on, whether or not there's a high-arched
8 pallet?

9 A. A geneticist would examine all of him, his
10 entire body, not just a few of the items that
11 I enunciated.

12 Q. Okay. And what would you be looking for if
13 you were doing it?

14 A. You would -- I mean, this is a whole, long
15 extensive examination. Do you really want
16 that?

17 Q. Is there a standard genetics physical
18 examination?

19 A. There is a standard physical examination, but
20 the geneticist pays greater attention to
21 features that point in the direction of
22 recognizable genetic disorders. But it would
23 be a regular pediatric exam in this case, and
24 regular in the sense of concentrating on

1 features that are in question.

2 Q. Okay.

3 A. But if you want to go over it, we can start
4 at the fingers, and we'd spend half an hour;
5 I'd be happy to do that and go over a
6 physical examination point by point.

7 Q. I appreciate your willingness to do that, but
8 I don't believe we need you to do that.

9 From geneticist to geneticist, is
10 there a shared understanding of what it means
11 to do a physical examination for the purposes
12 of doing a genetics evaluation?

13 A. Absolutely.

14 Q. What would you be looking for in a high
15 resolution chromosome test?

16 A. We answered the question. It was structural
17 abnormality of any chromosome.

18 Q. Right. Of any chromosome, okay.

19 And is there any possible result of
20 the high resolution chromosome test that
21 would cause you to modify your opinions that
22 you've expressed so far in this case?

23 A. No. It might add additional information.
24 For example, if there was a chromosome

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1 inversion involving, let's say chromosome
2 seven, interfering with the site of a gene
3 that has to do with the speech, speech and
4 language, that inversion could be very
5 meaningful and tell you that, yes, this child
6 not only has an inversion with a chromosome
7 break at that point but this may also explain
8 his other minor anomalies.

9 Q. In the event that a high resolution
10 chromosome test came back normal, would that
11 change any of your opinions in this case?

12 A. No.

13 Q. Why not?

14 A. Because we've stated already that it's more
15 probable than not that he has a connective
16 tissue disorder, which increased his
17 vulnerability to pressures from a vacuum and
18 in which he had a bleed.

19 Q. And you will continue to believe it's most
20 probable that he had the connective tissue
21 disorder even if all his chromosomes are
22 normal?

23 A. Yes.

24 Q. If the microarray indicates that all of his

1 chromosomes and genes are normal, would that
2 change your opinion in any way?

3 A. Unfortunately, the microarray doesn't examine
4 all the genes, but it examines at a greater
5 depth chromosome structure and down to single
6 base structure. So in the search, one would
7 be looking for what's called copy number
8 variations, in particular, in a youngster
9 like this.

10 Q. Copy number variations?

11 A. Yes, that's what it is called.

12 Q. What does that mean?

13 A. The woman upstairs who -- it was a woman,
14 wasn't it, who created man -- used four
15 blocks. These are four chemical blocks in
16 which we abbreviate A, G, C and T. And all
17 our genes are made up of a mish-mash of those
18 four blocks. The chromosomal microarray is
19 able to examine these blocks in a sequence,
20 we also call them SNPS, S-N-P-S, single
21 nucleotide polymorphisms. So you can examine
22 these singular nuclear -- nucleotide
23 polymorphisms. And you can look at blocks of
24 these, for example, runs of 200 or more, and

Deposition of Aubrey Milunsky, M.D.

1 determine whether there are duplications or
2 tiny deletions of these copy number
3 variations, we call them. And what we've
4 discovered these last few years is that all
5 of us have tiny deletions and duplications
6 throughout our genome, and that those with
7 autism, for example, have ten times the
8 number, and those with schizophrenia have
9 like ten to 20 times the number. So now,
10 every week, there are new publications
11 showing microdeletion, microduplication
12 syndromes emerging that look exactly like
13 this kind of situation with Jayden; a series
14 of features that no one has ever been able to
15 explain and suddenly it's clear that there is
16 a particular finding that we've never reached
17 before because of the technology that wasn't
18 there.

19 Q. Is it meaningful to talk about normal results
20 from a microarray test?

21 A. Yes.

22 Q. Assuming that Jayden W. results are
23 normal, would that change any of your
24 opinions?

Deposition of Aubrey Milunsky, M.D.

1 A. No.

2 Q. Why not?

3 A. It would not change the opinions with
4 reference to the issues of bleeding in the
5 vacuum and the connective tissue. It might
6 add additional understanding of why he has
7 these anomalies that we've talked about.

8 Q. If --

9 A. And his cognitive delay stuff.

10 Q. And if Jayden's Fragile X testing were to
11 come back normal, would that change your
12 opinions in any way?

13 A. No, my answer would be the same as just
14 expressed.

15 Q. If the MRI of the brain shows -- strike that.

16 If the MRI of the brain is performed
17 in 2009 and shows residual brain damage,
18 would that change your opinions in any way?

19 A. Where?

20 Q. Well, let's take all the possibilities.

21 Okay. In the posterior fossa?

22 A. In the posterior -- you mean in the
23 cerebellum itself or -- the posterior is a
24 space.

Deposition of Aubrey Milunsky, M.D.

1 Q. Okay. Well, I will start with the cerebellum
2 itself.

3 A. If he has demonstrable cerebellar damage, you
4 would expect him to have serious problems
5 with the balance right upfront.

6 Q. And are you assuming that he does not have
7 balance problems?

8 A. They do not express that -- the records that
9 I have seen so far, have not indicated that
10 he has serious, what's called ataxia.

11 Q. Okay. If Jayden, in fact, does have serious
12 balance problems, would that be consistent
13 with residual damage to his cerebellum?

14 A. Yes.

15 Q. Let's assume an MRI of the brain shows damage
16 to the cerebrum, what significance, if any,
17 would you place on that?

18 A. Are you suggesting that it's focal or
19 generalized?

20 Q. Let's take each one. First of all, focal.

21 A. Focal injury, one would be expecting him to
22 have a seizure disorder or some other --
23 depending on where exactly the injury was,
24 possibly to have some motor disability or

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1 hemiparesis or this kind of phenomenon;
2 whereas if it's generalized, he would have
3 something like cerebral atrophy. And it's
4 obvious that, to me at least, that that
5 finding will not be made given his
6 functionality.

7 Q. Is residual damage to the cerebrum consistent
8 with cognitive impairments?

9 A. If there's global -- the answer is, yes, if
10 it's global, but the reason I don't think he
11 will have cerebral atrophy either is because
12 his head has grown so well and there's no
13 indication that his brain would not have
14 grown, which would have made his head
15 smaller.

16 Q. Are there any other portions of the brain
17 where you would be interested to know whether
18 the MRI shows residual damage?

19 A. Well, I'd be interested to see that the MRI
20 shows no damage or it shows any particular
21 pattern of any injury.

22 Q. Okay. Are there areas you would be
23 interested in evaluating for residual damage
24 other than the cerebrum and cerebellum?

Deposition of Aubrey Milunsky, M.D.

1 A. When an MRI is examined, the entire brain is
2 looked at, but, in particular, in this child,
3 the concentration is, as you stated, the
4 cortex and the cerebellum.

5 Q. And let me make sure, again, I'm not -- I
6 apologize if I already asked this question,
7 but if there is damage, residual damage, to
8 the cerebrum or cerebellum as shown on
9 current MRI imaging, would that change your
10 opinions in any way?

11 A. That would tell that he has sustained damage
12 to the cerebrum or to the cerebellum as a
13 consequence of the bleed. The reason for the
14 bleed, however, is his vulnerability, the
15 connective tissue, the vacuum.

16 Q. But if he has damage to -- residual damage to
17 his brain as noted on a current MRI, that
18 would explain or could explain cognitive
19 impairments independent of those connective
20 tissue issues, correct?

21 A. Yeah, I think we need to straighten out this
22 word "brain damage." It's not clear to me
23 what you are suggesting is brain damage.
24 Findings on an MRI might show islands of

1 neurons that are caught midfield, we call
2 them heterotopias, and these are part and
3 parcel of genetic conditions, for example.
4 So there are abnormalities on an MRI, but
5 it's not brain damage, in quotes.

6 Q. Okay.

7 A. So one needs to make that distinction that if
8 there's scarring, sclerosis, gliosis in an
9 area of the brain that has been subject to a
10 direct injury or impact from, like, forceps
11 or some such direct injury, that's one thing.
12 But the nature of the change in the brain is
13 what there's a need to concentrate on. It's
14 not just brain damage.

15 Q. Okay. What findings in the brain would have
16 genetic significance?

17 A. One I just mentioned, the issue of
18 heterotopias as one example; the second would
19 be cortical atrophy; a third would be a
20 genesis or thinning of the corpus callosum.
21 I mean, there's just an endless array of
22 these things. Gyri might be thicker. It may
23 be polymicrogyria. I mean, it's just an
24 endless series of anatomical changes that

Deposition of Aubrey Milunsky, M.D.

1 could be seen and made. They might all imply
2 genetic origins for disorders, but I don't
3 believe that this is on the table kind of
4 thing. So I'm not sure where you are --

5 Q. What do you mean "this is on the table"?
6 What are you trying to...

7 A. He doesn't have polymicrogyria. He doesn't
8 have -- the disorders we're talking about I
9 don't believe he has.

10 Q. Okay.

11 A. I try to draw your attention to the
12 difference between brain damage as opposed to
13 findings on an MRI that are not normal.

14 Q. Okay. Well, going back and clarifying my
15 question to refer to brain damage that is
16 associated with trauma from a vacuum and
17 associated bleeds, would you agree that those
18 types of positive findings by MRI done
19 currently would offer an explanation of
20 cognitive impairments and motor delays
21 related to brain damage?

22 A. If they were non-focal.

23 Q. So the only thing that might change your
24 opinions in this case are positive, non-focal

1 findings of brain damage by MRI?

2 A. I'm not sure what you mean "to change my
3 opinions." We've already established the
4 core of my opinion with reference to the
5 vulnerability for his bleed from the vacuum
6 and what that was about.

7 My primary opinion is that the rest
8 of him may well be part of a birth defect set
9 or syndrome and/or the alcohol of his mother.
10 There are other features that are in the way
11 here, which is why I said right at the
12 beginning of the afternoon, that this is a
13 multifactorial story here and it's not a
14 single item that one can more probable than
15 not say, This is it, and there's nothing more
16 to it. It's not. Just like most of life and
17 medicine, there are multiple factors that are
18 operating here.

19 Q. You do believe to a reasonable degree of
20 medical certainty that but for the use of the
21 vacuum, this child would not have had brain
22 bleeds, correct?

23 MS. SIMMONS: Object to the form.

24 A. I do believe that the vacuum was instrumental

1 in the bleed.

2 MS. SIMMONS: Would you clarify

3 which bleed he's talking about?

4 Q. You're talking about the brain bleeds,

5 correct?

6 A. I'm primarily talking about subgaleal, but he

7 also had a posterior fossa bleed, so I don't

8 know if anybody can say with certainty that

9 that was related, not related, whether it had

10 to do with the platelets. I think it's

11 speculative, uncertain and I'm not sure.

12 Q. What do you consider to be speculative

13 exactly?

14 A. Whether the vacuum also caused the posterior

15 fossa bleed or did it act in concert with the

16 lowered platelets and his vulnerability to

17 tear a vessel?

18 Q. Do you have any alternative cause of the

19 posterior fossa bleed other than from the

20 back?

21 A. There are no platelets; he was down to 78,000

22 was the one count I saw.

23 Q. Is it your testimony that he did not bleed

24 into his posterior fossa until his platelets

1 went down to 78,000?

2 A. I don't think it's clear precisely when his
3 bleed began. Obviously, it was slow enough
4 not to kill him. So it is unclear exactly
5 when that timing was, when the actual
6 bleeding began and how it accumulated in the
7 posterior fossa until eventually, it was on
8 day two, evacuated.

9 Q. But you would agree that trauma from the
10 vacuum -- strike that.

11 To the extent trauma from the vacuum
12 was the cause of the posterior fossa bleed,
13 then that posterior fossa bleed, along with
14 the other bleeds, could explain the drop in
15 platelets?

16 A. There is a possibility, as we stated earlier,
17 but as we know, he was born with good APGAR
18 scores and seemed fine, so it is highly
19 likely that there was a tiny tear, a venus
20 tear, which oozed and then bled slowly. But
21 if it was catastrophic, you would know that
22 right away; he would die or go into a coma
23 promptly.

24 Q. Let's take a short break.

1 (Short recess.)

2 Q. Doctor, what significance do you attribute to
3 the assertion that Jayden has 13 pair of
4 ribs?

5 A. Just another minor anomaly. Add it to the
6 list. Almost certainly related to his
7 mother's spinal abnormalities and I'm
8 guessing that he might well have similar
9 kinds of abnormalities of the spine. But
10 that's a guess.

11 Q. You indicated you had some interest to know
12 if there was a family history of strokes,
13 hemorrhage or rupture?

14 A. Yes.

15 Q. I believe I probably gleaned the significance
16 of that, but, for the record, would you
17 please spell that out for us?

18 A. It was further evidence of connective tissue
19 disorder in the family: ruptured blood
20 vessels, strokes from a rupture, and/or
21 thrombosis.

22 Q. May we agree that Jayden W had no
23 genetic defect that caused his brain bleeds?

24 A. No.

1 Q. Please explain your answer.

2 A. I mean, I have been saying most of the
3 afternoon that he was born with a genetic
4 vulnerability -- or susceptibility, we call
5 it -- to have weaker blood vessels which
6 could tear, rupture given circumstances like
7 the vacuum.

8 Q. But that didn't cause his bleeds, right; that
9 arguably contributed to setting the stage,
10 but the vacuum caused the bleeds?

11 MS. SIMMONS: Object to the form.

12 MS. SMITH-YANCEY: Object to the
13 form.

14 A. I think we've explored that territory with
15 the reference to the subgaleal and the
16 discussion about the subcortical -- about the
17 posterior fossa.

18 Q. Do you believe that Jamesetta Washington,
19 mother of Jayden, shows signs and symptoms of
20 having connective tissue disorder?

21 A. I've not seen any pictures of the mother, but
22 we have the report about her vertebral
23 abnormalities; bone is a connective tissue.

24 Q. So do you construe from that that she has

Deposition of Aubrey Milunsky, M.D.

1 connective tissue disorder?

2 A. She absolutely has a connective tissue
3 disorder.

4 Q. Okay. And assuming that Jayden acquired a
5 connective tissue disorder from his mom,
6 would you believe that she has the same
7 vulnerability to blood vessel damage that you
8 have attributed to Jayden?

9 A. She may well have, hence my question about
10 asking about the family as well. We also
11 know nothing about the gentleman who's in
12 jail.

13 Q. Would you agree with me that one with a
14 vulnerability to blood vessel damage from a
15 vacuum, if not traumatized by a vacuum, may
16 well go through life without any brain
17 bleeds?

18 A. Absolutely. We all live with a bunch of
19 harmful genes and we may never know about
20 them our entire life.

21 Q. What do you consider to be the authoritative
22 text on the subject of genetics?

23 A. There are many texts, and I have learned from
24 you ladies and gentlemen that the word

1 "authoritative" is a problem, but there are
2 many major texts.

3 Q. Which do you consider to be generally
4 reliable?

5 A. Mine, of course, excluded. So Emery and
6 Rimoin's, a book on the Principles and
7 Practice of -- I forget what they call it --
8 Human Genetics or Genetics. It's like a
9 three-volume set. That would be one place to
10 look.

11 Q. Have you ever testified by deposition or at
12 trial in a case with issues similar to those
13 involved in this case?

14 A. I don't think so.

15 Q. Would you agree with me that we have no
16 evidence of Jayden W. 's motor delays
17 being caused by anything other than brain
18 damage?

19 A. Again, you know, you're using this word
20 "brain damage," implying that some injury
21 caused his deficits, and I have been trying
22 to explain most of the afternoon that there
23 is no evidence that his injury -- therefore,
24 his bleed -- caused his deficits. We

1 actually don't know what caused his deficits.

2 Q. Okay. Would you agree with me that there is
3 no evidence of a genetic cause of Jayden's
4 motor deficits?

5 A. We already stated that he hasn't been
6 thoroughly evaluated, so no statement can be
7 made with any reliability that he is free of
8 any genetic disorder in that context that
9 explains his deficits.

10 Q. But as we said here today, we have no
11 evidence of any genetic cause of Jayden's
12 motor deficits, correct?

13 A. The available evidence that we have in front
14 of us at the moment doesn't allow us to
15 answer the question with any degree of
16 reliability.

17 Q. And, similarly, we have no evidence as we sit
18 here today for any genetic cause of Jayden's
19 cognitive deficits?

20 A. We have major suspicions because of his
21 multiple anomalies tied up together with
22 these cognitive delays, that they are more
23 likely than not to be related.

24 Q. Can you give me the full basis for that

1 opinion?

2 A. Yes. He has multiple anomalies, the number
3 of which I have already lost count. But he
4 has multiple anomalies associated with
5 speech, speech delay, language issues and
6 some mild motor delays, and he sits in a
7 so-called special -- a normal class as well,
8 so...

9 Q. If an MRI of the brain is done which reveals
10 evidence of non-focal residual brain damage,
11 would your opinion change about the most
12 probable cause of cognitive problems?

13 A. If the MRI shows a generalized or global fit,
14 then this will further support a genetic
15 and/or developmental basis for his problem.
16 Only if he shows a focal injury can one
17 ascribe the bleed as the fundamental cause.

18 Q. So a focal area of damage by MRI would change
19 your opinion on that point?

20 A. Yes.

21 Q. And that point being, you would agree that
22 there's no evidence of a genetic explanation
23 for the cognitive deficits if we have focal
24 brain damage documented by MRI?

1 A. That is likely to be the case.

2 Q. Any genetics testing we do has no chance of
3 changing your opinions?

4 A. No, I could never make a statement of that
5 sort. The word "never" is always a problem.
6 Genetic tests may reveal one part of his
7 multi-factorial etiologies.

8 Q. I'm sorry. I didn't understand that last
9 statement.

10 A. A genetic test may reveal an abnormality that
11 doesn't explain everything, but may explain
12 his cognitive delays, his speech problems and
13 some of his anomalies, but may not explain
14 his spine, for example, or his mother's
15 spine, et cetera.

16 Q. All right. Can you conceive of the
17 possibility that Jayden may not have
18 chromosomal problems?

19 A. I think it's likely that he does not.

20 Q. Okay. But you will still believe he has a
21 genetic cause for these problems even if the
22 evidence shows he has no chromosomal damage?

23 A. You need to separate out your thinking about
24 what's chromosomal and what is a genetic

1 cause.

2 Q. Fine. Tell me what you mean by "chromosomal"
3 and what you mean by "genes."

4 A. The chromosomes are made up of genes. So a
5 chromosomal analysis reveals both structure
6 and number as is part of that examination. A
7 gene analysis, to the extent we can do it
8 nowadays, will reveal the particular
9 structure if you sequence a particular gene,
10 but it doesn't look at all genes. Not yet.
11 Maybe in ten years or so. But at the moment
12 we're confined to examining individual genes
13 of interest and where it's possible. It's
14 mostly still not possible.

15 Q. Where is it possible?

16 A. Nowhere. To examine all genes? Not yet.

17 Q. I thought you said in someplaces but not all
18 places you could examine individual genes of
19 interest.

20 A. Yes. Again, there's only -- what is it now;
21 I've lost count -- just over 1,000, 1,200
22 genes that you can individually analyze.

23 Q. Okay. And where would you go to get those
24 analyzed?

1 A. All over the map, because we, for example, we
2 do like 100. We have one of the longest
3 lists of genes that we analyze in the entire
4 nation. You have to go to Baylor, to us, to
5 the Mayo Clinic. All over the place people
6 have got their own set of genes they analyze.

7 Q. All right. So first you determine which gene
8 you are interested in?

9 A. If you can.

10 Q. And that should determine where you should
11 send it for analysis?

12 A. Yes, exactly.

13 Q. And when you were talking about the various
14 tests -- Fragile X, high resolution and
15 chromosome and microarray --

16 A. Those can all be done in one place.

17 Q. -- are we talking about examining chromosomes
18 or examining genes?

19 A. Those are -- well, to be precise, the high
20 resolution chromosomes is the chromosome.
21 Fragile X is a DNA analysis. It's not a gene
22 analysis as such. You are looking at a
23 particular region, without getting into the
24 details of that, and the microarray looks at

1 a greater number of the components of a gene,
2 components of genes, namely these blocks that
3 I described, the so-called SNPS, S-N-P-S, and
4 tells you about deletions and duplications.
5 None of those are analysis of a gene.

6 Q. Do you expect Jayden's high resolution
7 chromosome test, if it were performed, to be
8 normal?

9 A. I don't know the answer. It has to be done.
10 My betting is it would be normal.

11 Q. What significance, if any, would that have?

12 A. That it's normal?

13 Q. Yes, sir.

14 A. That you still haven't found the answer.

15 Q. Excuse me?

16 A. That you still have not found the answer.

17 Q. Can you conceive of a microarray being done
18 for Jayden with normal results?

19 A. I can certainly conceive of it, but the odds
20 are increasing at this point that one might
21 find something.

22 Q. And if it resulted in normal results?

23 A. You still don't have the answer.

24 Q. And I assume you can conceive of Fragile X

1 testing being normal?

2 A. Yes.

3 Q. What significance would you attribute to
4 that?

5 A. Don't have the answer.

6 Q. A moment ago you told me that you would not
7 say that any test results would never change
8 your opinion.

9 What can you conceive of by way of
10 test results that might conceivably change
11 your opinions?

12 A. Change which opinion?

13 Q. The opinion that Jayden's cognitive deficits
14 are more likely associated with genetic
15 problems as opposed to brain damage from the
16 vacuum?

17 A. I think the findings on the MRI would be
18 important in this case. And if that MRI
19 shows nothing, you have a problem.

20 Q. I have a problem?

21 A. You have a problem.

22 Q. And if that MRI shows focal damage?

23 A. Then they have a problem.

24 Q. "They," meaning the defendants in this case?

1 A. Yes.

2 Q. Could you be more specific about what you
3 mean by "they have a problem"?

4 A. Well, what I say, you know, the burden begins
5 to fall on them, but, of course, these
6 matters, as you know, and at my age, I know
7 that there is misadventure. There are things
8 that happen in the course of normal events
9 that the application of a vacuum can result
10 in a complication that is still within a
11 standard of expected care and that something
12 happens that happens and it's nobody's fault
13 in that sense. So that's what I mean.

14 Q. Okay. But you offered those opinions just
15 -- strike that.

16 You don't offer any opinion about
17 whether or not Dr. Rhett was appropriate in
18 using vacuum?

19 A. No, we established that long ago.

20 Q. And we haven't changed that and I don't have
21 to worry about you testifying along those
22 lines --

23 A. You don't have to worry about anything. No,
24 truthfully.

Deposition of Aubrey Milunsky, M.D.

1 Q. You will not testify that vacuum use was
2 appropriate in this case?

3 A. No, I will not testify.

4 Q. Okay. Thank you. Let me ask you about your
5 financial arrangements.

6 What do you charge?

7 A. I don't get paid for any of this, as you
8 probably know by now.

9 Q. Tell me about that.

10 A. Money is paid to Medical Genetics
11 Consultants, which I established on behalf of
12 my son and grandchildren. So I get no salary
13 and no money for the pleasure of having spent
14 the afternoon with you.

15 Q. Okay. And what are the charges?

16 A. I think, if I recall, 600 an hour for
17 deposition. It's \$5,500 a day and expenses
18 for trial.

19 Q. And how much for general review?

20 A. 475 an hour.

21 Q. Thank you, sir. I believe that's all I have
22 at this time.

23 A. Thank you.

24 * * * * *

1 EXAMINATION BY MS. SIMMONS

2 Q. I have few a quick questions, Doctor.

3 A. Yes.

4 Q. Do you believe the posterior fossa bleed was
5 caused by the vacuum?

6 MR. GRAHAM: Object to the form.

7 A. I think I answered the question earlier
8 indicating that the combination of
9 intrapartum -- brief intrapartum hypoxia, low
10 platelets and the vacuum and/or might be
11 operative in that context.

12 Q. And do you believe that the posterior fossa
13 bleed could have caused Jayden's cognitive
14 delay?

15 MR. GRAHAM: Object to the form.

16 A. I do not believe the posterior fossa bleed in
17 and of itself could have caused the global
18 delay in speech and language. No, I don't
19 believe that.

20 Q. Is that based on the location of the
21 posterior fossa?

22 MR. GRAHAM: Object to the form.

23 A. On the whole history, examination, findings,
24 and the current evidence, yes.

Deposition of Aubrey Milunsky, M.D.

1 Q. And do you hold that opinion to a reasonable
2 degree of medical certainty most probably?

3 A. Yes.

4 MR. GRAHAM: Object to the form.

5 Q. Do you have an opinion as to whether Jayden
6 would have suffered -- would suffer cognitive
7 delay despite the use of the vacuum?

8 MR. GRAHAM: Object to the form.

9 A. I think it's more probable than not that
10 given the series of multiple anomalies that
11 he has, that his cognitive and speech
12 language delays are all related, and that
13 these would have -- that he was destined to
14 be largely the way he is.

15 Q. Is that regardless of the vacuum?

16 MR. GRAHAM: Object to the form.

17 A. I believe that is more likely than not the
18 case.

19 Q. Do you believe there is any evidence that
20 either of Jayden's bleeds caused his global
21 delay?

22 MR. GRAHAM: Object to the form.

23 A. I do not believe that it is likely that that
24 was the case.

Deposition of Aubrey Milunsky, M.D.

1 Q. And is there any kind of imaging or
2 measurement studies that point to the
3 opposite conclusion?

4 MR. GRAHAM: Object to the form.

5 A. Currently, no, but an MRI is required.

6 Q. What about the 2005 CT scan, does that bear
7 on your opinions?

8 MR. GRAHAM: Object to the form.

9 A. I think that's an optimistic finding, but
10 nevertheless not as good as an MRI.

11 Q. What about the fact that Jayden's head
12 circumference was found to be normal?

13 MR. GRAHAM: Object to the form.

14 A. I think this is a positively encouraging
15 statement with reference to the fact that it
16 is very unlikely, therefore, that he has
17 cerebral atrophy as a result of his
18 intracranial bleed.

19 Q. Did you find labs -- specific lab values
20 significant in your opinions with respect to
21 genetics or developmental problems conspiring
22 to cause Jayden's delays?

23 MR. GRAHAM: Object to the form.

24 A. He had the lower platelets on at least by

1 July 18th. He had prolonged prothrombintime,
2 and high dimer, D-I-M-E-R.

3 Q. And also, did you find his mild acidosis of
4 7.2 relevant?

5 MR. GRAHAM: Object to the form.

6 A. Yes, to the extent it implied a very mild
7 acidosis.

8 Q. Can global cognitive delay such as Jayden
9 suffers, can that be a congenital problem?

10 MR. GRAHAM: Object to the form.

11 A. Yes, as part of his general presentation with
12 his multiple anomalies or separately.

13 Q. And is it your opinion that that is most
14 likely the case here?

15 MR. GRAHAM: Object to the form.

16 A. I think it is more probable than not that his
17 combination of cognitive and speech language
18 delays together with these anomalies are
19 related.

20 Q. Doctor, if indeed it was Jayden's mother that
21 had the 13 pair of vertebrae instead of
22 Jayden -- I'm sorry -- ribs -- strike that.

23 If indeed it was Jayden's mother
24 that was documented to have 13 pair of ribs

1 as opposed to Jayden, does that change your
2 opinions that you've given today?

3 MR. GRAHAM: Object to the form.

4 A. No. We've already established that the
5 mother absolutely has a connective tissue
6 disorder given her findings and her vertebral
7 X-rays.

8 Q. So if Jayden does not have 13 pair of ribs,
9 would that change your opinion or not?

10 A. No, no. It doesn't change the opinion at
11 all.

12 Q. Did the labs in this case indicate a need to
13 deliver Jayden?

14 MR. GRAHAM: Object to the form.

15 A. I don't know what you mean by that.

16 Q. Strike the question.

17 I believe you testified that you
18 could not state to a reasonable degree of
19 medical certainty that alcohol was the cause
20 of Jayden's delay or dysmorphic feature.

21 A. I did testify accordingly.

22 Q. Can you -- would it also be true that you
23 could not testify to a reasonable degree of
24 medical certainty that you could not rule it

1 out as a cause as well?

2 MR. GRAHAM: Object to the form.

3 A. That is correct.

4 Q. Is that based on what?

5 A. That's based on the knowledge that incomplete
6 Fetal Alcohol Syndrome might be associated
7 with intellectual delays, speech and language
8 delays and other anomalies.

9 Q. Do you believe that based on the information
10 you've reviewed on Jayden that it would be a
11 reasonable assessment to say that he would
12 not ever be employable in the job market?

13 MR. GRAHAM: Object to the form.

14 A. The fact that he sits in a normal classroom,
15 albeit in South Carolina, it implies that he
16 should be employable.

17 Q. Do you think the fact that he's six years old
18 and can write his full name, Jayden

19 W. would that be relevant in your
20 analysis as a physician?

21 MR. GRAHAM: Object to the form.

22 A. I think that would support the prior
23 statement.

24 Q. Do you hold your opinions to a reasonable

Deposition of Aubrey Milunsky, M.D.

1 degree of medical certainty most probably
2 today?

3 MR. GRAHAM: Object to the form.

4 A. I do.

5 Q. I think those are all my questions at this
6 time.

7 MS. SMITH-YANCEY: I don't have any
8 questions.

9 MR. GRAHAM: Jim?

10 MR. SCOTT: Nothing from me.

11 MR. GRAHAM: I have a few, Doctor.

12 * * * * *

13 EXAMINATION BY MR. GRAHAM

14 Q. You just testified that you thought Jayden
15 was destined to be the way he is, or words to
16 that effect.

17 Would you acknowledge that that
18 statement is speculative?

19 A. Yes. Based on the lack of complete evidence,
20 yes, that is an opinion.

21 Q. Okay. What training, knowledge and
22 experience do you have in terms of vocational
23 expertise?

24 A. You mean, in the placement, work placement?

Deposition of Aubrey Milunsky, M.D.

1 Q. Yes.

2 A. Is that you what you are referring to?

3 Q. Yes, sir.

4 A. Just a lifetime of seeing children and what
5 happens to them.

6 Q. Okay.

7 A. And, of course, knowing the literature.

8 Q. Okay. If a child who is unsuccessful at
9 learning in a normal classroom and who should
10 be in a special needs classroom, but instead
11 finds himself in a normal classroom with
12 little success -- strike that.

13 Did I understand you to say that the
14 sole basis for your belief that Jayden can
15 work is that he's in a normal classroom?

16 A. No, no. I indicated that he was in a normal
17 classroom and that his deficits are not
18 overwhelming in any sense. He can speak
19 according to the records I have read. He can
20 speak. He can communicate. He can write.
21 He can walk. He doesn't lose his balance,
22 seems that he's able to be employed.

23 Q. Okay. Where do you get the idea that he
24 doesn't lose his balance?

Deposition of Aubrey Milunsky, M.D.

1 A. It was no indication in the notes that I have
2 read that he has ataxia. He may be clumsy,
3 but he's not ataxic.

4 Q. Would you agree that without intelligence
5 testing and without brain MRI --

6 A. He has had intelligence testing.

7 Q. Okay. What intelligence testing do you refer
8 to?

9 A. Well, he's had the -- my recall, he's had IQ
10 estimates of 81, that territory; verbal,
11 social and performance around 79. So at the
12 bottom of the normal range.

13 Q. Without brain MRI and without more reliable
14 information about his particular motor skills
15 and impairments and learning skills and
16 impairments, would you agree it would be
17 speculative at his age to offer an opinion as
18 a geneticist about whether or not an employer
19 will offer him gainful employment?

20 A. I think at the age of six, most pediatricians
21 have a pretty shrewd idea of a projected life
22 path, but given the history and the
23 environment in which he's growing up, I think
24 one would need more time to be certain about

1 the future.

2 Q. Okay. At this point, it would be speculative
3 for you to offer an opinion about his future
4 employment?

5 MS. SIMMONS: Object to the form.

6 A. I haven't even seen him, so I wouldn't be
7 offering that.

8 Q. Thank you. Let me ask you about the feeding
9 difficulties.

10 Have you formed any opinions about
11 the cause of that?

12 A. No, I understand he had a fundoplication,
13 but, no.

14 Q. Okay. The feeding difficulties can be
15 associated with brain damage, correct?

16 A. Yes.

17 Q. Okay. And there's no evidence that those
18 feeding problems are associated in any way
19 with a genetics problem?

20 A. No evidence, as you say.

21 Q. Thank you.

22 MR. GRAHAM: That's all I have at
23 this time.

24 MS. SIMMONS: Thank you.

Deposition of Aubrey Milunsky, M.D.

1 THE WITNESS: Thank you.

2 (Whereby the proceedings were

3 concluded at 5:03 p.m.)

4 * * * * *

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C E R T I F I C A T E

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, SS.

I, Jill Shepherd, Notary Public, in
and for the Commonwealth of Massachusetts, do
hereby certify that:

AUBREY MILUNSKY, M.D., the witness
whose deposition taken on May 19, 2009 is
hereinbefore set forth, was satisfactorily
identified, and was duly sworn by me and that
the foregoing transcript is a true and
accurate record of the testimony given by
such witness and such testimony is a true and
accurate transcription of my stenotype notes
to the best of my knowledge, skill, and
ability.

I further certify that I am not
related to any of the parties in this matter
by blood or marriage and that I am in no way
interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto
set my hand and notarial seal this 23rd day
of May, 2009.

Jill Shepherd, RPR
Notary Public

My Commission expires: April 18, 2014

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Deposition of Aubrey Milunsky, M.D.

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 2 AUBREY MILUNSKY, M.D.
 3 CASE NAME: WASHINGTON VS. RHETT, ET AL.
 4 DATE: May 19, 2009

ERRATA SHEET

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 19 I have read the foregoing transcript
 20 of my deposition, and except for any
 21 corrections or changes noted above, I hereby
 22 subscribe to the transcript as an accurate
 23 record of the statements made by me.

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 2009.

 AUBREY MILUNSKY, M.D.

STATE OF SOUTH CAROLINA
COUNTY OF CHARLESTON

IN THE COURT OF COMMON PLEAS

JAMESETTA WASHINGTON, as Guardian ad Litem
for JAYDEN W, a minor,

Plaintiffs,

vs.

CASE NO. 07-CP-10-1553

EDMUND RHETT, JR., M.D., LOW COUNTRY
OBSTETRICS and GYNECOLOGY, P.A., TENET
SOUTH CAROLINA, INC., EAST COOPER
REGIONAL MEDICAL CENTER,

Defendants.

VIDEOTAPED

DEPOSITION OF: EDMUND RHETT, JR., M.D.

DATE: July 21, 2008

TIME: 3:10 PM

LOCATION: Hood Law Firm
172 Meeting Street
Charleston, SC

TAKEN BY: Counsel for the Plaintiffs

REPORTED BY: LORA L. McDANIEL,
Registered Professional Reporter

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(INDEX AT REAR OF TRANSCRIPT)

1 THE VIDEOGRAPHER: This videotaped
2 deposition is beginning at 3:10 p.m. This is the
3 videotaped deposition of Edmund Rhett, Jr., M.D., taken
4 in the case of Jamesetta Washington, as guardian ad
5 litem for Jayden W , a minor, versus Edmund
6 Rhett, Jr., M.D., Low Country Obstetrics and
7 Gynecology, P.A., Tenet South Carolina, Incorporated
8 doing business as East Cooper Regional Medical Center.

9 The case number is 07-CP-10-1553, in the
10 court of Common Pleas, for the state of South Carolina,
11 county of Charleston. This deposition is being taken
12 at the Hood law firm, 172 Meeting Street, Charleston,
13 South Carolina on Monday, July 21, 2008. The court
14 reporter is Lora McDaniel. The videographer is Joe
15 Overholser.

16 Will Counsel introduce themselves for the
17 record; Plaintiff's attorney first, please.

18 MR. GRAHAM: Ed Graham for the Plaintiff.

19 MS. CRAIG: Molly Craig on behalf of
20 Dr. Edmund Rhett.

21 MS. SMITH-YANCY: Lindsay Smith-Yancy on
22 behalf of Tenet South Carolina, Inc., doing business as
23 East Cooper Regional Medical Center.

24 MR. DAVIS: Jay Davis on behalf of Low
25 Country Obstetrics and Gynecology.

1 THE VIDEOGRAPHER: Will the court reporter
2 please swear in the deponent.

3 EDMUND RHETT, JR., M.D.
4 being first duly sworn, testified as follows:

5 EXAMINATION

6 BY MR. GRAHAM:

7 Q. Dr. Rhett, as you know from my previous
8 introduction, my name is Ed Graham. I represent
9 members of the Washington family in this case. We've
10 got this pending complaint filed against you and
11 certain other Defendants. Obviously, that's why we're
12 here today, to ask some questions about your personal
13 and professional background as well as anything you
14 might remember about the labor and delivery involved in
15 this case.

16 Before we get into the substance of my
17 questions, though, I would like to go over a few
18 background matters. First of all, have you given a
19 deposition before?

20 A. Yes, sir.

21 Q. Approximately how many times?

22 A. Ten.

23 Q. You have probably heard these ground rules
24 I'm getting ready to go over, perhaps ten times. Just
25 briefly, let me remind you that our court reporter is

1 trying to create an accurate, verbatim transcript of
2 what is stated here during your deposition. To that
3 end, I would ask that you please use audible, verbal
4 responses such as yes or no instead of a nod of the
5 head or uh-huh or uh-uh, that kind of thing.

6 And it's very important that you not
7 answer a question unless you understand it. So if you
8 don't understand one of my questions, please refrain
9 from answering it; ask me to explain it, rephrase it,
10 reword it, whatever I need to do for you to get a clear
11 understanding.

12 And if you do answer one of my questions,
13 I will assume that you've understood the question and
14 that you are giving me a truthful and complete
15 response. Fair enough?

16 A. Yes, sir.

17 Q. Thank you.

18 Finally, let's try not to talk over each
19 other. Sometimes I might think you're finished with
20 your answer, and I might start my next question. If,
21 in fact, you're not finished with your answer, I
22 apologize in advance. I don't mean to step on your
23 toes, so to speak. Just let me know if you're not
24 finished, and I'll be happy to give you every
25 opportunity to complete your answer. By the same

1 token, you might start answering before I'm finished;
2 just try not to do that, if you would.

3 If you need a break for any reason, just
4 ask, and we'll be happy to take a break. I hope to
5 move through this deposition today fairly quickly. And
6 if you can give me direct responses, we'll try to move
7 right through it as quickly as we can.

8 Without further ado, do you remember
9 Jamesetta Washington?

10 A. I remember the delivery.

11 Q. Do you remember Jamesetta Washington?

12 A. I could not pick her out of a line-up,
13 sir.

14 Q. Do you remember Jayden Washington?

15 A. Only that I know that I delivered that
16 baby.

17 Q. But you remember the delivery itself?

18 A. I do.

19 Q. What stands out in your mind to make you
20 remember this particular delivery?

21 A. I've seen a videotape of it. I've never
22 seen that of myself delivering a baby before. That was
23 quite an interesting thing.

24 I specifically remember that this baby had
25 to go to the Medical University for reasons that

1 weren't clear at the time. And I remember thinking
2 what a normal delivery it was.

3 Q. Before you saw the videotape, did anything
4 stand out in your mind about this delivery?

5 A. I had remembered that this had been a very
6 easy delivery and that I couldn't imagine that anything
7 in the delivery had anything to do with the baby's
8 problem.

9 Q. Do you remember anything else about the
10 delivery outside of what's entered on the chart and
11 what's on the videotape?

12 A. I don't know that I understand exactly. I
13 always remember certain things about anything that I've
14 done, and some of them are 30 years old and some of
15 them are last week. Sometimes you can remember
16 vividly.

17 I've reviewed the case so many times that
18 I don't know whether that's a personal remembrance or
19 something that I've embedded in my memory because I've
20 reviewed the chart.

21 Q. What do you remember about this delivery
22 in addition to the actual entries on the chart? Does
23 your memory fill in the gaps anywhere?

24 A. I remember being called in the afternoon
25 with some decelerations. We changed what we were

1 doing. Decelerations went away. That was about 1:00
2 p.m.

3 I was called again about 5:00, and we
4 seemed to be making good progress. And then I remember
5 the patient became complete -- and I know the numbers
6 just because I've read them again and again -- at 1924,
7 which is 7:24 p.m.

8 And about five minutes later, the baby's
9 heart rate started a pattern of deceleration. The baby
10 was sitting way down low. The mother seemed exhausted.
11 And at 7:35 I applied vacuum extractor.

12 At 7:37, with Momma making one push and me
13 making one pull, we delivered the baby with a healthy
14 APGAR of six and nine. I checked the acid base balance
15 of that cord blood and it was normal at 7.21. And
16 everything else seemed normal.

17 Q. What type of cord blood was that?

18 A. I don't understand your question.

19 Q. Was it venous blood? Was it arterial
20 blood?

21 A. It was arterial blood.

22 Q. How do you know that?

23 A. Because there are three vessels, and I
24 stuck the arterial side. There are two arteries in a
25 vein in a normal cord. And there's a difference

1 between the two.

2 Q. Have you sometimes had difficulty getting
3 arterial blood?

4 A. Sometimes I had difficulty getting any
5 cord blood at all.

6 Q. Which is easier to get, arterial or
7 venous?

8 A. Venous.

9 Q. How do you know you got arterial blood in
10 this case?

11 A. Because I went into the small vessel,
12 which is the artery, one of the two arteries, and I
13 removed the blood.

14 Q. What is the basis for that? Do you claim
15 to actually remember doing that?

16 A. I wrote it down as an arterial blood gas.

17 Q. The fact that you made the entry,
18 arterial, is what you're relying on?

19 A. When I do an arterial blood gas, I write
20 down ABG; arterial blood gas.

21 Q. You don't remember doing that, do you?
22 You're just assuming it to be arterial because you
23 assume your entry to be true and accurate?

24 MS. CRAIG: Objection.

25 BY MR. GRAHAM:

1 Q. Is that accurate?

2 A. I wrote down what I did at the time of the
3 delivery. I took an arterial blood gas.

4 Q. As you sit here today, do you remember
5 doing that, or are you relying on the accuracy of your
6 written entry on the chart?

7 A. I wouldn't know the difference. I
8 wouldn't know how to make the difference what I read
9 ten times or more time and what's clearly in my memory.
10 My memory is stimulated by what I wrote.

11 Q. Do you have any memory about obtaining an
12 arterial blood sample independent of what you wrote?

13 A. I don't think I can answer that question.

14 Q. Is there anything else you remember about
15 this delivery apart from the actual words on the chart?

16 A. I'd have to -- too vague of a question for
17 me. I'm not certain I understand what you're asking so
18 that I can answer it appropriately.

19 Q. What do you claim Jayden W. looked
20 like when he was born?

21 A. I don't understand that question.

22 Q. Do you remember seeing Jayden W
23 at the time of his delivery?

24 A. Do I specifically have a memory of Jayden
25 W being born?

1 Q. Yes, sir.

2 A. I do from the video. I specifically
3 remember doing this very simple vacuum extraction
4 delivery and delivering a healthy baby and everything
5 seemed normal at the time.

6 Q. Apart from seeing the video, do you
7 remember what Jayden looked like when he was born?

8 A. I can't say that I do, sir.

9 Q. With the aid of the video, can you tell me
10 what Jayden looked like to you when he was born?

11 A. No, I can't.

12 Q. Did he have any signs or symptoms of head
13 trauma?

14 A. No, sir.

15 Q. None?

16 A. Not that I remember.

17 Q. Let me ask you to define some terms,
18 please, that I've seen in the medical literature.

19 First of all, what is a pelvic inlet specifically?

20 A. Difference between -- the distance between
21 pubic bone and the sacral bones.

22 Q. The distance between them?

23 A. Yes, sir. The whole pelvic side walls,
24 too; back and front, side to side.

25 Q. What is a pelvic outlet?

1 A. It's the opening of the vagina underneath
2 the pubic psoas between the pubic rami.

3 Q. What is the introitus?

4 A. That's the opening of the vagina.

5 Q. Same as the pelvic outlet?

6 A. Pelvic -- introitus -- the vagina is part
7 of the pelvic outlet.

8 Q. What is the pelvic floor?

9 A. The muscles of the vagina separating the
10 vagina from the rectum, which includes both rectal
11 mucosa and rectal wall, denovea fascia, subcutaneous
12 tissue in the vagina and vaginal tissue itself.

13 Q. What is engagement?

14 A. Engagement means that the baby's head has
15 moved down into the pelvis.

16 Q. Can you be more specific.

17 A. No.

18 Q. Is there a certain -- does engagement
19 suggest that a certain part of the baby's head has
20 moved into a certain part of the pelvis?

21 A. Yeah, it means that -- usually it means
22 that the baby's -- I've quit thinking about this for a
23 long time now, but it means that the baby's head has
24 moved down -- you know, I don't know if I know how to
25 define that or not.

1 Q. So as you sit here today, you can't tell
2 me what it means for a baby's head to be engaged?

3 A. I'm not sure I can say a definition of it.
4 I've used it mechanically for so many years that I
5 haven't thought about how to say. I would think if the
6 baby's head was down at zero station, the baby would be
7 considered engaged in the pelvis. That would mean that
8 the cappel was passed the -- you know, I can't remember
9 that definition anymore.

10 Q. You said something about a head being at
11 zero station. What did you mean by that?

12 A. Usually that means that the baby has moved
13 down deep in the pelvis and it is -- the baby's head is
14 down about -- actually, I can't remember anymore.

15 Q. What does zero station mean?

16 A. Zero station means the baby is well
17 engaged in the pelvis and about to come out.

18 Q. Can you be more specific about well
19 engaged in the pelvis?

20 A. Well, when you do a pelvic exam, you can
21 feel the baby's head. And the baby has come past -- I
22 can't remember the name of the little bony notches
23 right now, sorry.

24 Q. Okay, that's all right.

25 If you were in the process of delivering a

1 baby today, how would you determine whether or not the
2 head is engaged?

3 A. By pelvic exam.

4 Q. What about that pelvic exam would tell you
5 whether the baby's head is engaged?

6 A. The position of the baby in the pelvis.
7 I'm sorry that I can't tell you a definition better
8 than that right now.

9 Q. How would you determine the station of the
10 baby within the birth canal?

11 A. By pelvic exam.

12 Q. What about the pelvic exam would tell you
13 the baby's station?

14 A. How far down in the pelvis it is and how
15 far away from the introitus it is.

16 Q. Can you be more specific.

17 A. Well, when the baby is at the introitus,
18 everybody considers that at least plus two. It's all
19 done in centimeters. If you go backwards two
20 centimeters from there, that would be zero station. If
21 you go above that, you would be at a minus station.

22 Q. The introitus is a plus two station?

23 A. At least.

24 Q. Well, is it a -- what is the introitus in
25 terms of a station? If it's at least plus two -- is it

1 plus two --

2 A. Yes, sir.

3 Q. -- plus three, plus four, plus five, plus
4 ten? Could you just give me a description, an overall
5 description of what the station numbering system is all
6 about.

7 A. Well, the numbering system is about
8 measuring the progress of a baby through the pelvis.
9 I'm sorry that I can't define what zero station is. I
10 know that, as baby gets closer and closer to delivery,
11 that the baby is at plus two station or so and just a
12 matter of a few pushes, and the baby will usually be
13 delivered. The baby is sitting at the introitus at
14 plus two; generally, the top of the baby's crown.

15 Q. At plus two, the baby has crowned; is that
16 what you said?

17 A. Is crowning.

18 Q. When you do vaginal examinations and labor
19 in delivery room, do you announce to the nurse what the
20 baby's station is?

21 A. I usually announce the dilation, the
22 effacement and the station.

23 Q. Is that what you were trained to do, to
24 announce to the nurse what the dilation, station and
25 effacement are?

1 A. Or write it down; one or the other.

2 Q. If you announce it to the nurse, you would
3 expect the nurse to write it down?

4 A. She may or may not. Most of the time they
5 would.

6 Q. I realize it's been a few years. Back
7 when Jayden Washington was born, did you know how to
8 determine his exact head station?

9 A. Yes, sir.

10 Q. What did you know about it at that time?

11 A. At what point in the delivery process?

12 Q. At, let's say, from -- how long --
13 counting back from the time when you delivered Jayden,
14 how long had you been in the room?

15 A. I came in the room -- I can't answer that
16 question. I don't know the answer to that.

17 MS. CRAIG: Would you like him to see the
18 records?

19 BY MR. GRAHAM:

20 Q. Certainly. You're welcome -- I will state
21 for the record that the document I'm handing you is
22 Bates stamped ECH 1 through ECH, I guess that's 322.
23 These were furnished to me by the hospital's attorney,
24 representing to be the records of the mother Jamesetta,
25 the son Jayden, as well as the strips.

1 MS. CRAIG: Are you going to mark that as
2 an exhibit?

3 MR. GRAHAM: I was.

4 BY MR. GRAHAM:

5 Q. Does that appear to be what I described it
6 as?

7 A. This appears to be the record of Jamesetta
8 and her labor and delivery, fetal heart rate
9 monitoring.

10 MR. GRAHAM: Let's mark that as exhibit 1,
11 please. May I take the first page.

12 (PLF. EXH. 1, Medical records, Bates
13 stamped ECH 0001 through 0322, was marked for
14 identification.)

15 MR. GRAHAM: May I return page 1. Thank
16 you, sir.

17 THE WITNESS: According to this, the
18 patient had a vaginal exam by the nurse; said she was
19 complete at 1924.

20 Then it says that I came into the room at
21 1931 or 32. Patient was pushing. Turned the Pitocin
22 off. I thought the baby was having decelerations back
23 from 1928 and forward; appeared to be ominous;
24 therefore, I thought delivery was required. And the
25 patient put up in stirrups at 1934-35 and I placed a

1 vacuum and then delivered the baby within two minutes.

2 BY MR. GRAHAM:

3 Q. So you were in the room from,
4 approximately, 7:31 p.m. through delivery at 7:37 p.m.?

5 A. And then on to fix it.

6 Q. I mean through delivery, though. My
7 question --

8 A. Yes.

9 Q. Going back, my question was: How long had
10 you been in the room --

11 A. Six minutes.

12 Q. -- prior to delivery? Okay. Thank you.

13 That's the time frame I would like to
14 focus on. During that time period, at 7:31 to 7:37
15 p.m., on the date of this delivery, how would you have
16 determined Jayden W 's station?

17 A. By doing the vaginal exam.

18 Q. What about the vaginal exam would lead you
19 to have been able to figure out accurately what his
20 station was?

21 A. Baby's head was crowning through the
22 introitus. It wasn't coming out.

23 Q. What do you mean by crowning through the
24 introitus but not coming out?

25 A. I mean it was -- you could see hair right

1 there at the introitus. You could see the baby start
2 to push the labia apart, but mother wouldn't push any
3 further. So it was trying to crown and get the head of
4 the baby, the baby's crown, which is what you're
5 talking about, to come out.

6 Q. When you say you could see the hair, who
7 is it that could see the hair?

8 A. I could see the hair. On the top of the
9 baby's head.

10 Q. As you sit here today, are you claiming to
11 remember that?

12 A. I do remember that. This was one of the
13 easiest vacuum extraction deliveries I ever did.

14 Q. Could you see the hair on the video?

15 A. I could not.

16 Q. You mentioned that the nurse had
17 documented the station or rather you noticed the nurse
18 had documented that cervical dilatation was complete at
19 1924; correct?

20 A. That's correct.

21 Q. At that point did she chart the station as
22 being?

23 A. She didn't.

24 Q. Pardon?

25 A. She did not.

1 Q. She did not.

2 MS. CRAIG: For the record, let's just
3 identify this document by Bates stamp ECH 0309; is that
4 right?

5 THE WITNESS: That's correct.

6 BY MR. GRAHAM:

7 Q. Okay, you're looking at the strips. So on
8 the strip, page ECH 0309, it indicates complete without
9 giving a station; correct?

10 A. That's correct.

11 Q. Is there anywhere else on the chart where
12 the nurse would've made entries about cervical
13 dilatation or station?

14 A. I don't know.

15 Q. Who made that entry on the strip? Would
16 that have been the nurse?

17 A. That would be the nurse.

18 Q. Was that based on her vaginal examination
19 or yours?

20 A. That was her vaginal examination.

21 Q. Can you be any more specific about how you
22 would have determined station back on the day of this
23 child's birth?

24 A. At 1935?

25 Q. Yes, sir.

1 A. That's when I applied the vacuum. I
2 remember this mother was having a very difficult time
3 pushing. She was tired. And the baby was sitting
4 there, and the heart rate had dropped down, in what I
5 thought was a fairly ominous-looking pattern. I
6 decided it was time to deliver the baby. The baby is
7 sitting at the introitus. I applied the vacuum. I
8 checked it for position. The Momma pushes and I pull,
9 out came the baby in less than two minutes.

10 Q. On the date of that birth, did you know
11 what a minus one station was?

12 A. I did.

13 Q. What was a minus one station?

14 A. That would be the baby was three
15 centimeters away from where it was when I put the
16 vacuum extractor on it.

17 Q. Back on that date of delivery, what was
18 your understanding of zero station?

19 A. That would be two centimeters back from
20 there.

21 Q. And what was your understanding of a plus
22 one station?

23 A. That would be one centimeter back from
24 plus two.

25 Q. So in your numbering system, plus two is

1 at the introitus?

2 A. Yes, sir.

3 Q. What part of the baby is at the introitus?

4 A. Crown.

5 Q. The presenting part of the crown?

6 A. The crown in this particular case.

7 Q. According to your numbering system,
8 there's one centimeter per unit for the station
9 numbers?

10 A. Yes, sir.

11 Q. What's the highest you count in terms of
12 negative numbers?

13 A. The baby is completely engaged, it would
14 be minus eight or minus seven.

15 Q. When the baby first becomes engaged, what
16 do you consider that station?

17 A. When the crown is at zero, that's probably
18 engaged. There's some other definitions that say that
19 the bicipital part has to be down further than that.
20 The common way of doing it is when the crown is -- I'm
21 sorry I can't answer that right now. I haven't thought
22 about it.

23 Q. You said something about the bicipital.
24 What is a bicipital?

25 A. That's the difference -- that's the

1 distance between the two occiputs, the frontal part of
2 the brain or skull.

3 Q. What occiputs are you talking about?

4 A. I don't know if I can answer that
5 question. I've got myself a little confused here.

6 Q. What is an occiput?

7 A. The part of the skull.

8 Q. Which part of the skull?

9 A. The lateral part of the skull.

10 Q. Lateral meaning to the side?

11 A. That isn't right. I don't know is the
12 other answer.

13 Q. You don't know what lateral is?

14 A. I know what lateral is. I know what
15 occiput is.

16 Q. I'm confused. When you said, I don't
17 know, what is it you're saying you don't know?

18 A. I'm having a hard time remembering the
19 parts of the head right now.

20 Q. So as you sit here today, can you tell me
21 what an occiput is?

22 A. The occiput is -- not as I sit here today,
23 I don't think I can accurately say. I can guess. I
24 can't tell you that I know.

25 Q. What would your guess be?

1 A. The back part of the head.

2 Q. Did you know what an occiput was on the
3 day of delivery in this case?

4 A. Yes, sir.

5 Q. What was it then?

6 A. It's the same thing as it is now. You
7 know, if I knew what it was now, I could tell you what
8 it was then.

9 Q. All right. Well, you say you would guess
10 it's the back part but earlier you said it was the
11 lateral?

12 A. That wasn't right. That was incorrect.

13 Q. And you referred earlier to the bicipital.
14 And that's when you told me --

15 A. I've got this so mixed up now I don't know
16 what I'm talking about. I can't help you at all.

17 Q. Can you spell bicipital.

18 A. No. I'm not even sure it's a word now.

19 Q. You told me bicipital was the difference
20 between the two occiputs. Can you tell me where the
21 two occiputs are.

22 A. I don't think there are two occiputs.

23 Q. How many are there?

24 A. I think there's one.

25 Q. What did you mean when you say the

1 bicipital is the difference between the two occiputs?

2 A. Obviously I'm confused, Mr. Graham. I
3 don't know what I meant.

4 Q. What is a presenting part? What does that
5 phrase refer to?

6 A. Whatever part of the baby is trying to get
7 out of the vagina first.

8 Q. So in a head-first delivery, it would be
9 part of the head?

10 A. Yes, sir, that would be your vertex.
11 Bottom would be breech.

12 Q. What is molding?

13 A. Molding is where the baby's head tends to
14 elongate to try and get out of the pelvis.

15 Q. When a baby's head is molded and
16 elongated, what part of the head should the
17 obstetrician refer to in determining whether or not the
18 baby is engaged?

19 A. Well, you see molding in most deliveries,
20 and most of us are still talking about the presenting
21 part. Sometimes the molding is more than others.
22 Sometimes it's very hard to determine how much of the
23 baby is actually down in the pelvis and how much is
24 not.

25 Q. Please explain.

1 A. When you have molding, which you have in
2 most vaginal deliveries, you'll see that the baby's
3 head becomes not pointy but less rounded and more
4 elongated. As the baby moves down, it's easier to get
5 the baby out with an elongated rather than a perfectly
6 round head. That's just a natural process that occurs
7 in delivery.

8 Q. You said something about sometimes it's
9 difficult to tell if the baby is in the pelvis or not?

10 A. No.

11 Q. Because of the molding?

12 A. I don't think it's difficult to tell if
13 it's in the pelvis. It's difficult sometimes to tell
14 how far down in the pelvis it is.

15 Q. Please explain why that is.

16 A. I missed your question.

17 Q. Please explain why it's difficult to tell
18 how far down --

19 A. You can't ever tell how much molding there
20 is. Sometimes you can't tell. Usually you can tell.
21 You can feel the baby's ears if you're not real sure.

22 Q. What is the anterior fontanelle?

23 A. That's the soft spot in the front of the
24 baby's head.

25 Q. What's the posterior fontanelle?

1 A. Soft spot in the back of the baby's head.

2 Q. What is a sagittal suture?

3 A. That's the line in between the two.

4 Q. Have you ever heard of a cranial pivot or
5 a flexing point?

6 A. I'm not familiar with those terms.

7 Q. What does it mean to refer to the position
8 of the head or orientation of the head coming through
9 the birth canal?

10 A. That's when you're trying to tell whether
11 the baby is face up or face down.

12 Q. Can you explain to me what occiput
13 anterior would mean.

14 A. Occiput anterior means that the occipital
15 bone, which is on the back of the head, is up towards
16 the anterior part of the mother's vagina.

17 Q. What would LOA and ROA refer to?

18 A. Left occiput anterior and right occiput
19 anterior.

20 Q. What is left occiput anterior?

21 A. If this is straight up and down, this is
22 occiput anterior, then if the baby is cocked off a
23 little bit to the mother's right side as I'm -- if I'm
24 the mother, then that would be right occiput anterior.
25 And if it's off to the left side, it would be left

1 occiput anterior.

2 Q. Are you familiar with a portion of the
3 pelvis referred to as the ischial spines?

4 A. Yes, sir.

5 Q. What is that?

6 A. The little bony places off of the
7 posterior part of the pubic ramus, off of the -- off
8 the posterior part of the pubic bone as it comes
9 around.

10 Q. Is that a phrase you were trying to think
11 of earlier?

12 A. Yes, sir.

13 Q. What significance do ischial spines have
14 in the context of the baby's station?

15 A. That is when the baby has gotten its --
16 now I have to think. I haven't done this in a while.

17 Probably going to get this wrong. The
18 definition is, when the baby's temporal bones are at
19 the ischial spine, that's considered zero station.
20 That is usually about two to three centimeters up from
21 the vaginal introitus.

22 Q. So from the opening of the vagina to the
23 ischial spines is two centimeters?

24 A. No, more like three. About right there.

25 Q. Could you hold that up for the camera,

1 please.

2 A. Yes, sir. About like that. You can
3 reach -- I can reach the ischial spine like that.
4 That's about --

5 Q. You're pointing two fingers --

6 A. I'm sorry.

7 Q. -- separated a little bit; is that what
8 you're showing us?

9 A. I usually measure things with this finger.
10 I didn't mean to --

11 Q. I'm sorry, which --

12 A. It's about that distance right there.

13 Q. Oh, I see. You're showing on the one
14 finger?

15 A. Yes, sir.

16 Q. I see.

17 A. I didn't mean to be rude with that
18 particular finger. It's the one I measure with. It's
19 my longest digit. I'm sorry about that.

20 Q. No offense taken.

21 As you just designated on your finger,
22 that was how many centimeters?

23 A. That's probably about four. Because an
24 inch is two-and-a-half centimeters. I estimate that to
25 be about four centimeters.

1 Q. I'm confused. First, I thought you told
2 me that, from the ischial spines to the vaginal
3 introitus was two centimeters. Then it sounded like
4 you went to three. Then it sounded like you went to
5 four.

6 A. Four may be right. You know, I'm not
7 making measurements. I'm not making an exacto thing.
8 I'm doing a clinical judgement. And, you know, as the
9 baby head comes down -- I've done this a lot. I had
10 done this a lot. And I've forgotten some of the exact
11 measurements.

12 Now that I think about it, it's probably
13 from the opening of the vagina to the ischial spines,
14 it's about four centimeters.

15 Q. In answering that question about how you
16 would use the ischial spine to determine station, you
17 referred to the baby's temporal bones. What's the
18 significance of the baby's temporal bones?

19 A. They're about halfway up the crown.

20 Q. Have you ever heard of the phrase
21 biparietal diameter?

22 A. Right.

23 Q. What is the biparietal diameter?

24 A. That's the distance between the sides of
25 the baby's head.

1 Q. Is that the temporal bones or somewhere
2 else?

3 A. It must be the parietal bones, I would
4 think. That sounds like parietal bones to me.

5 Q. What significance, if any, does the
6 biparietal diameter have in terms of determining the
7 baby's station?

8 A. I don't know.

9 Q. What significance, if any, does the
10 biparietal diameter have in terms of determining
11 whether the baby is engaged or not?

12 A. I'm not sure I know how to answer that
13 question.

14 Q. Does it have anything to do with that?

15 A. I'm certain that it does.

16 Q. What, if anything, do the ischial spines
17 have to do with whether or not a baby is engaged?

18 A. Well, the ischial spine, until the baby
19 comes down, you know, to the ischial spine, the baby is
20 not engaged.

21 Q. Until which part of the baby?

22 A. The crown.

23 Q. So the baby is engaged when the crown is
24 even with the ischial spines?

25 A. No, that's not really true. Probably has

1 to be two centimeters past that. Further down.

2 Q. When you say it probably has to be two
3 centimeters past that --

4 A. I would think that the leading part of the
5 baby's head, the crown, would have to be two
6 centimeters past that in order to consider the baby
7 engaged.

8 Q. In applying that definition of engagement,
9 what difference, if any, does it make if the baby's
10 head is molded?

11 A. A molded head would be -- presenting part
12 would be further down into the pelvis.

13 Q. What do you mean it would be further down?
14 Further down to be what? To be engaged?

15 A. Yes, sir.

16 Q. How far would it need to be down to be
17 engaged if the head is molded?

18 A. Depends on how much molding there is.

19 Q. Can you help me understand the range of
20 molding for different babies.

21 A. It goes from no molding to lots of
22 molding. Lots of molding might add three centimeters.

23 Q. To the height of the head?

24 A. Yes, sir.

25 Q. Can a head be unengaged and have a

1 positive station?

2 A. I'm sure that's possible -- no, it cannot.

3 Q. It cannot?

4 A. No.

5 Q. Why not?

6 A. Well, it has to be at least zero station
7 to be engaged. Isn't that what we just said?

8 Q. Well, I'm not sure what you just said,
9 which is why I'm asking the question. At times, you've
10 used the leading part of the head, which may or may not
11 be molded. And at times you've referred to two inches
12 below the leading part of the head, unless it's molded,
13 in which case it might be as much as five centimeters
14 below the leading point of the head. I'm really
15 confused?

16 A. Me too.

17 MS. CRAIG: I'm going to object.

18 Objection to that statement; mischaracterization of his
19 testimony.

20 BY MR. GRAHAM:

21 Q. Can you clarify for me, please, sir
22 exactly what is engagement.

23 A. No.

24 Q. Can you clarify for me exactly how an
25 obstetrician should determine fetal station?

1 A. We do the best we can by examining the
2 mother, feeling the baby's head and seeing how far down
3 it seems to be in the pelvis.

4 Q. How far down compared to what?

5 A. Compared to -- a lot of times compared to
6 the opening of the vagina.

7 Q. So you would determine station by counting
8 up from the vagina?

9 A. In clinical practice you would.

10 Q. What is the difference, in a normal adult
11 female anatomy, between the ischial spines and the
12 vagina, the vaginal opening?

13 A. What's the difference?

14 Q. The distance.

15 A. I'm sorry, I didn't hear you. Some four
16 to five centimeters.

17 Q. Have you ever heard of the phrase arrest
18 of descent?

19 A. Yes.

20 Q. What does that mean?

21 A. The baby stops descending through the
22 pelvis.

23 Q. Can you be any more specific. Does it
24 have to stop for a certain period of time, for example?

25 A. If you have adequate labor and dilatation

1 is occurring and the baby is not changed station over a
2 given period of time. It's different for first babies
3 and subsequent babies. First babies -- I'm getting
4 that wrong.

5 Q. What time interval defines an arrest of
6 descent for a woman's first baby?

7 A. I don't know.

8 Q. Is it more or less than one hour?

9 A. I don't know.

10 Q. Is it more or less than two hours?

11 A. I don't know.

12 Q. Is it more or less than three hours?

13 A. I don't know.

14 Q. Is it more or less than four hours?

15 A. Same answers.

16 Q. No matter what number I ask you, you would
17 say --

18 A. If I knew the answer to your question, I
19 would've answered it. I just didn't understand what
20 you are -- I don't know the answer to your question.

21 Q. If I were to ask you, is it more or less
22 than ten hours, would you still not know the answer?

23 A. I'm not sure that I know the definition
24 that you're asking me.

25 Q. Are you familiar with the phrase prolonged

1 descent?

2 A. Yes, sir.

3 Q. What is prolonged descent?

4 A. Descent that takes longer than average.

5 Q. Can you define what that would be.

6 A. No, sir. I can't define what average
7 descent is.

8 Q. Can you define what average descent is for
9 any delivery, first, second, third, fourth?

10 A. No, sir.

11 Q. Are you familiar with the phrase
12 Friedman's curve?

13 A. Yes, sir.

14 Q. What is that?

15 A. That's a curve that Dr. Manuel Friedman
16 worked out over a number of years at Harvard describing
17 normal labor curve, dilatation and descent.

18 Q. Can you tell me what the main points are
19 of Friedman's curve.

20 A. He described the time line for dilatation
21 and time line for descent. And he gave some variations
22 on either side of that that said this is what's normal,
23 and this is when you deviate away from that.

24 Q. What was the -- strike that.

25 When did you learn about Friedman's curve?

1 A. When I was a first-year resident or senior
2 medical student.

3 Q. What was your understanding of the
4 significance of a delay in dilatation or descent that
5 was slower than Friedman's curve?

6 A. There wasn't just one curve. The curve
7 has a wide variation of normality. If you get out of
8 the two standard deviations, which is I think what he
9 did, then it may signify that there's an inadequate
10 pelvis, and that the baby needs to be delivered a
11 different way.

12 Q. Meaning?

13 A. C-section rather than vaginal delivery or
14 might need an operative delivery depending on where you
15 are in the whole labor process.

16 Q. Please explain that. Under what
17 circumstances would an inadequate pelvis be an
18 indication to do an operative delivery -- did you mean
19 an operative vaginal delivery?

20 A. Yes, sir.

21 Q. Under what circumstances would an
22 inadequate pelvis be an indication for an operative
23 vaginal delivery as opposed to a C-section?

24 A. If you think that there is -- the only
25 time you want to do an operative vaginal delivery is if

1 you have a baby that is on the introitus and crowning
2 and you have -- I don't know that you do an operative
3 vaginal delivery if you thought there was inadequate
4 pelvis.

5 Q. If you thought there was an adequate
6 pelvis?

7 A. An inadequate.

8 Q. I thought that's what you said a minute
9 ago that --

10 A. Then I tried to think of an example like
11 you asked me to, when I would do that. I'm not sure I
12 would do that.

13 Q. Dr. Rhett, where do you reside?

14 A. 17 Country Club Drive. In Charleston,
15 29412.

16 Q. Who lives with you there?

17 A. My wife and my child; my youngest child.

18 Q. What's your wife's name?

19 A. Sally.

20 Q. Is your youngest child at least 17?

21 A. She's 25. Her name is Kathryn.

22 Q. With a C or a K?

23 A. K-A-T-H-R-Y-N. Nine ways to spell
24 Kathryn.

25 Q. Correct. Does Sally work outside the

1 home?

2 A. She has a real estate license. Sometimes
3 she sells real estate.

4 Q. Which company does she work with, if any?

5 A. William Means.

6 Q. Does Kathryn work outside the home?

7 A. She works for the Urban Land Institute.

8 Q. Is her last night name Rhett?

9 A. Yes, sir.

10 Q. Do you have any other relatives that live
11 in Charleston County?

12 A. My son, William Cogswell.

13 Q. Is he an adult?

14 A. He is. And his wife Lucille. And they
15 have two children.

16 Q. Are their children at least 17?

17 A. No, sir. Mason is three and Mead is one.

18 Q. What kind of work does William do?

19 A. William is a developer and a builder.

20 Q. Does he work under a company name?

21 A. WECCO, Wecco, which is Walker, Evans,
22 Cogswell Company.

23 Q. Does he own that?

24 A. He does.

25 Q. Does his wife work outside the home?

1 A. No, she's pretty busy at home.

2 Q. Any other relatives?

3 A. My mother. Mary Rhett.

4 Q. Where does she live?

5 A. Canterbury House, 175 Market.

6 Q. Does she work outside the home?

7 A. She works in the Canterbury House at the
8 front desk sometimes.

9 Q. I neglected to ask you about William.
10 Where does he live?

11 A. On Wadmalaw Island.

12 Q. No other relatives in Charleston by blood
13 or marriage?

14 A. Are you talking about first degree?

15 Q. Let's expand it beyond that. Any other
16 relatives?

17 A. I got -- there are a lot of second and
18 third cousins.

19 Q. Can you help me with last names, if
20 there's something other than Rhett.

21 A. Ball.

22 Q. B-A-L-L?

23 A. B-A-L-L. Townsend. There's a whole bunch
24 of Balls.

25 Q. What is your wife's maiden name?

1 A. Aichel, A-I-C-H-E-L.

2 Q. Is she from around here?

3 A. Yes, sir.

4 Q. Does she have relatives in Charleston?

5 A. None living.

6 Q. Where did you grow up?

7 A. I was born here and grew up in Atlanta.

8 Q. What's your date of birth?

9 A. 10/28/47.

10 Q. Tell me about your education starting with
11 high school.

12 A. I went to Northside High School in
13 Atlanta, which is a public school. Then I went to the
14 University of the South, which is in Suwanee,
15 Tennessee. And then I taught school for a year at
16 Avondale High School in Atlanta.

17 Then I went to the Medical College of
18 Georgia in Augusta. And I did my residency in
19 Jacksonville, Florida. And then I came to town. Came
20 to Charleston.

21 Q. Any fellowships?

22 A. No, sir.

23 Q. Are you board certified?

24 A. Yes, sir.

25 Q. In what field?

1 A. OB/GYN.

2 Q. As of when?

3 A. 1979.

4 Q. Did you pass your boards on the first
5 time?

6 A. Yes, sir.

7 Q. Have you gotten recertified?

8 A. No, sir, I'm still certified.

9 Q. You have no special training in
10 maternal-fetal medicine; correct?

11 A. No, sir.

12 Q. Since your residency, tell me about your
13 employment.

14 A. I started solo private practice in 1977,
15 and I did that for, approximately, nine years. And
16 then I joined with Granger Osborne, O-S-B-O-R-N-E. And
17 then we formed Low Country OB/GYN somewhere along in
18 there.

19 I left them. In February of '07, I went
20 into private solo GYN practice. I stopped doing
21 obstetrics on September 29, 2005. I only remember the
22 date; it was my mother's birthday. Three of those
23 patients named babies after my mother. They did.
24 Called them Mary.

25 MS. CRAIG: That's wonderful.

1 THE WITNESS: They said they did anyhow.

2 Who knows.

3 BY MR. GRAHAM:

4 Q. Why did you stop obstetrics?

5 A. Eleven years of nights in the hospital is
6 enough. I enjoyed it, and I've done my share. I'm in
7 my late 50s.

8 Q. I understand. Why did you leave Low
9 Country?

10 A. That's a big OB and GYN practice. It's
11 lots of people and lots of employees, and that's what
12 it takes to run an obstetrical practice where people
13 have enough time off. But it was too -- I started it.
14 And I built it.

15 And so I just thought it was time for me
16 to do my own thing again. I started that way, and I
17 thought I would end my practice that way. And now my
18 life is very simple. I have three employees. And my
19 own hours.

20 Q. What's the name of your practice now?

21 A. Edmund Rhett, Jr., M.D., P.A.

22 Q. Have you ever had any investigations
23 relating to your licenses or right to practice medicine
24 or privileges or anything like that?

25 A. No, sir.

1 Q. Where do you currently have privileges?

2 A. I have full GYN privileges at East Cooper,
3 and I have courtesy privileges at Roper and St. Francis
4 Hospital.

5 Q. Tell me about the process by which you --
6 your OB privileges no longer exist.

7 A. I wrote a letter and said I want to stop
8 practicing obstetrics. And I wrote letters to the
9 patients that I was taking care of and told them what
10 day I was going to stop. And I assigned all my
11 pregnant patients to other patients in my practice.

12 Q. That was a completely voluntary process?

13 A. Yes, sir.

14 Q. Where is your office?

15 A. 725 Long Point Road, Mount Pleasant 29464.

16 Q. What were the call arrangements at Low
17 Country back when Jayden was born?

18 A. Everybody was assigned to 24-hour period
19 of time that they were on-call. And doctors sometimes
20 would come in to deliver their own patients, but the
21 call doctor was always available.

22 Q. Did you become involved in this particular
23 case because you were on-call that day?

24 A. Yes, sir, that's correct.

25 Q. You mentioned 24-hour call. Was that true

1 of weekends as well?

2 A. When I did it, we would work Friday,
3 Sunday or Saturday.

4 Q. Just a single 24-hour period?

5 A. And then a day off and then a day back on.
6 You would start Friday morning, get off Saturday
7 morning, and get back on Sunday morning, get off Monday
8 morning.

9 Q. How many doctors were there?

10 A. There were up to 11 at one time. Now, as
11 many as eight of those doctors were taking call. When
12 Jayden was born, I'm not exactly how many sure -- I'm
13 sorry. I'm not exactly sure how many doctors were
14 still in the practice and how many doctors were sharing
15 call for OB and GYN.

16 Q. How many would be on-call at the same
17 time?

18 A. One.

19 Q. How did the midwives work in that
20 practice? First of all, how many did you have?

21 A. About -- we had as many as three. If you
22 talk about full-time equivalents, can we do it that
23 way?

24 Q. Sure.

25 A. I think we were down, by the time Jayden

1 came along, either one-and-a-half or two full-time
2 equivalents. Jobs may have been shared by either two
3 or three midwives.

4 Q. How did you divide the labor between the
5 obstetricians and midwives?

6 A. Midwives only took care of their own
7 patient; the patients who they had been following. If
8 they ran into difficulties, they would ask the
9 obstetrician to help them.

10 Q. In your years of private practice,
11 approximately, how many babies did you deliver per
12 year?

13 A. Somewhere between 200 and 250.

14 Q. What was your C-section rate?

15 A. About 40 percent.

16 Q. Of the 60 percent of vaginal deliveries,
17 how many of those were operative vaginal deliveries?

18 A. How many of them did I use a vacuum
19 extractor on? More than half.

20 Q. More than half of the vaginals?

21 A. I think so.

22 Q. Did you ever use forceps?

23 A. I did early in practice. Vacuum extractor
24 was actually invented to help family practitioners do
25 these semi-operative deliveries, assisting deliveries.

1 And it's so much simpler to use than forceps. After a
2 while, I just abandoned forceps and used vacuum
3 extractor.

4 Q. When did you abandon forceps?

5 A. I don't think I ever -- that's an improper
6 term. I quit using them almost and have used the
7 vacuum extractor almost exclusively; I never abandoned
8 them, the way we were all trained. We started using
9 vacuum extractors in '75 in my residency program. The
10 ones we used were the old Swedish metal ones. When
11 they came out with these Silastic vacuum extractors, I
12 think in the early '80s, they were just very easy to
13 use and very safe.

14 Q. When is the last time you used forceps?

15 A. I don't know.

16 Q. Sometime in the '70s?

17 A. No, no, that wouldn't be true.

18 Q. '80s?

19 A. '90s probably. Maybe even 2000. I didn't
20 use them very often.

21 Q. Under what circumstances would you use
22 forceps in, say, the '90s or the 2000s?

23 A. I remember using a specific kind of
24 forceps. Gosh, I can't remember. I don't remember
25 using the forceps much. I can't answer that question.

1 I almost always used a vacuum extractor if I needed an
2 operative vaginal delivery.

3 Q. When an obstetrician is alleged to have
4 negligently performed a vacuum extraction delivery, by
5 what criteria do you believe his conduct should be
6 evaluated?

7 MS. CRAIG: Object to the form.

8 MR. DAVIS: Objection.

9 THE WITNESS: I don't know that I
10 understand that question.

11 BY MR. GRAHAM:

12 Q. In this case, of course, allegations were
13 made that you departed from generally accepted
14 standards of obstetrical practice in terms of this
15 delivery. By what criteria do you believe that
16 determination should be made?

17 MS. CRAIG: Same objection.

18 THE WITNESS: I'm sorry. I lost thought.
19 Maybe we should take a break right here.

20 MR. GRAHAM: That's fine.

21 THE WITNESS: I got to go urinate. Excuse
22 me.

23 THE VIDEOGRAPHER: We're going off the
24 record at 4:20 p.m.

25 (A recess transpired from 4:20 p.m. until

1 4:29 p.m.)

2 THE VIDEOGRAPHER: We're going back on the
3 record at 4:29 p.m.

4 BY MR. GRAHAM:

5 Q. Doctor, before the break, I had asked you
6 a question that I don't believe we got an answer to
7 yet; that is, when an obstetrician is alleged to have
8 negligently performed a vacuum extraction delivery, by
9 what criteria do you believe his conduct should be
10 evaluated?

11 MS. CRAIG: Object to form. Calls for
12 legal opinion.

13 MR. DAVIS: Objection.

14 THE WITNESS: I'm not sure I know how to
15 answer that question.

16 BY MR. GRAHAM:

17 Q. Are you familiar with the phrase, standard
18 of care?

19 A. I am.

20 Q. Generally accepted standards of
21 obstetrical practice.

22 A. Yes, sir.

23 Q. Can you point me toward any published
24 standard of care material or generally accepted
25 standards of obstetrical practice that pertain to how

1 to properly perform a vacuum extraction delivery and
2 when it should be done.

3 A. No, sir.

4 Q. Does ACOG provide any such criteria?

5 A. They provide some guidelines, yes, sir.

6 Q. What guidelines?

7 A. What are their guidelines?

8 Q. Yes, sir. What's your understanding of
9 the suggestions from ACOG about when and how a vacuum
10 extraction delivery should properly be performed?

11 A. I don't know what they specifically have
12 said. I know they have some guidelines. I know I've
13 read them.

14 Q. Are there any obstetrical texts that you
15 believe are generally reliable about the subject of
16 when and how to properly perform a vacuum extraction?

17 A. There are plenty of obstetrical texts.
18 You can't say one of them is reliable.

19 Q. Do you consider any obstetrical text to be
20 reliable about the generally accepted standards of
21 practice for obstetricians in terms of when and how a
22 vacuum extraction should be performed?

23 A. There are written things, but you can't
24 call them reliable. There's no one standard. There's
25 no one text. Obstetrics is something that's practiced

1 actively, and there's no one reliable text, no, sir.

2 Q. Not a single one?

3 A. There's no one text that's reliable.
4 There are suggestions, guidelines that are helpful.

5 Q. Where would I go to get suggestions and
6 guidelines that are helpful about that subject?

7 A. Main obstetrical textbooks and published
8 things. I'm not sure you can get reliable. Reliable
9 says: This is the right way to do it and there's no
10 other way to do it. Reliable, you can't find that.

11 Q. What obstetrical texts do you have in your
12 own personal library?

13 A. I'm not sure I have any obstetrical texts
14 anymore. I don't practice obstetrics anymore now.

15 Q. When you were practicing obstetrics, what
16 obstetrical texts did you have in your library?

17 A. We had a number of textbooks.

18 Q. Can you tell me which ones?

19 A. No, sir.

20 Q. Did you have Williams?

21 A. Yes, sir, probably had Williams.

22 Q. Did you have Gabbe?

23 A. I don't recall having Gabbe. We may have
24 had him.

25 Q. Did you have Creasy and Resnick?

1 A. I don't recall.

2 Q. Do you recall any other than Williams?

3 A. No. I mean, I didn't recall Williams
4 until you said it.

5 Q. Who do you consider the leading authors in
6 terms of writings about the subject of operative
7 vaginal deliveries or use of vacuum extraction?

8 A. I don't know.

9 Q. Are there risks to the mother from use of
10 a vacuum extraction?

11 A. There are some risks, obstetrics. Those
12 risks include delivery where you can tear the vagina.
13 You can tear the vagina down into the rectum. That's
14 more of the force of the delivery rather than the --
15 and then once you've delivered the baby, you could have
16 torn the pelvic floor. You can tear the pelvic
17 ceiling, which is the bladder and bladder support.
18 Mother can have bleeding. Mother can have pain.

19 Q. Any other risk to the mother from use of a
20 vacuum extraction?

21 A. Not that I can think of now.

22 Q. Are there any risks to the baby from use
23 of a vacuum extraction?

24 A. The baby can get a small subcutaneous
25 bruise. The baby could get an intracranial bleed, but

1 there's some question as to whether that's from the
2 vacuum or from the vaginal delivery itself.

3 Q. Please explain.

4 A. You don't have -- in a number of large
5 studies that have been done, you don't have an
6 increased number of bleeds in babies that were
7 delivered by vacuum extraction compared to babies that
8 were delivered by spontaneous vaginal delivery. So
9 although you can see the subcutaneous or subdural
10 bleed, it's hard to determine whether that was done by
11 vacuum extraction or by just vaginal delivery.

12 Q. Where do you get from that assertion that
13 there's no increase in cranial bleeds from vacuum
14 extraction?

15 A. Something I've read years and years ago.
16 I've read all of this stuff and all those textbooks and
17 all those little pamphlets that come out. I don't
18 recall those by name, author or anything else.

19 Q. Did you believe that to be true on the day
20 Jayden was born?

21 A. I believe it now, too.

22 Q. And you did believe it on the day Jayden
23 was born?

24 A. Yes, sir.

25 Q. Are there any other risks to a baby from

1 use of a vacuum extraction?

2 A. You mean properly applied?

3 Q. Well, I don't want to limit it that way,
4 but sure. Let's start off properly applied.

5 A. Not that I'm aware of.

6 Q. Are there any risks to a baby from use of
7 a vacuum extractor not properly applied?

8 A. You could damage the tissue over which you
9 put it if it was not properly applied. Say you put it
10 over the baby's face, that wouldn't be a good idea.

11 Q. Where should you put a vacuum?

12 A. Between the anterior and posterior
13 fontanelle.

14 Q. Can you be more specific.

15 A. Well, that's the crown. You asked me that
16 earlier what that was. In the midline.

17 Q. The midline between the anterior and
18 posterior fontanelle?

19 A. If you can.

20 Q. If you had to do it away from midline,
21 which would be safer, closer to the anterior or closer
22 to the posterior fontanelle?

23 A. Closer to the posterior.

24 Q. But midline would be preferable?

25 A. Well, you're talking about lateral, and

1 I'm talking about the middle. I'm talking about a line
2 down the middle.

3 Q. Yes, sir.

4 A. You were talking about -- and you said
5 anterior-posterior, you said not in the middle. I
6 thought you meant lateral, I'm sorry. I misinterpreted
7 the question.

8 Q. Let's go back and make sure we understand
9 each other. You told me -- I think you told me that
10 the right place to apply the vacuum is in the midline,
11 between the anterior and posterior fontanelle.

12 When you used the word midline in that
13 context, do you mean at the midpoint between the two
14 fontanelle, or do you mean in the center of the head?

15 A. Try to get it to the center of the head,
16 in between the two.

17 Q. Would you try to get it at the midpoint
18 between the two or closer to one or the other?

19 A. Probably closer to the posterior. At that
20 point, it doesn't make much difference.

21 Q. What are the benefits of a vacuum
22 extraction?

23 A. In this particular case, it got a baby who
24 was going into fetal distress delivered quickly, with
25 one push from the mother and one easy pull from me.

1 Q. My question is not tied to this case.
2 Just in general, what are the benefits of vacuum
3 extraction?

4 A. To assist in a vaginal delivery. It makes
5 it easier for the mother and the baby. Decreases the
6 timeline between -- it makes the delivery faster.
7 Faster may not be the right term. Maybe hasten the
8 delivery is a better way to say that.

9 Q. What alternatives exist to vacuum
10 extraction delivery?

11 A. Spontaneous delivery. Forceps delivery
12 and C-section.

13 Q. How should an obstetrician evaluate which
14 is the better alternative; spontaneous vaginal
15 delivery, forceps, vacuum or C-section?

16 A. Depends on how far along the mother is
17 progressed with bringing the baby down. It depends on
18 what's going on with the baby. It depends on whether
19 or not any progress is being made. It depends on what
20 the fetal heart rate of the baby is. So all those go
21 into the decision to deliver the baby by whatever
22 method you decide to deliver the baby.

23 Q. Earlier I was asking you about
24 definitions, and I failed to ask you what the word
25 indications means. What does it mean?

1 A. Indication?

2 Q. Yes, sir.

3 A. What are you talking about?

4 Q. I'm just talking in terms of the use of
5 the word indication or indications plural in terms of
6 medicine or surgery. What does that word mean?

7 A. An indication would be a cause to do
8 something, or not do something as the case may be.

9 Q. I was going to ask you what is a
10 contraindication?

11 A. That would be something that says you
12 shouldn't do that.

13 Q. Is it appropriate for an obstetrician to
14 apply a vacuum extractor without an indication?

15 A. I would think there would always be some
16 indication as to why you should apply a vacuum
17 extractor.

18 Q. Would it be a breach of generally accepted
19 standards of obstetrical practice to apply a vacuum
20 extractor and use it to deliver a baby without there
21 being an indication for use of the vacuum?

22 MS. CRAIG: Object to the form.

23 THE WITNESS: I'm not sure I know the
24 answer to that. I know in this particular case I saw
25 an indication, which means a cause that says I need to

1 fix something. And I applied a vacuum extractor to
2 this baby and helped the mother push it out.

3 BY MR. GRAHAM:

4 Q. So you don't have an answer for my
5 question? Would it be proper or improper for an
6 obstetrician to apply a vacuum without an indication to
7 do so?

8 A. In general, the indication would be
9 delivery. I'm not sure that I know that -- I'm not
10 sure I know anybody would put a vacuum on without some
11 indication to do it.

12 Q. That's all I'm asking. Would it be
13 improper to use a vacuum if there was not an indication
14 to use a vacuum?

15 A. It's always been -- I've never seen
16 anybody put a vacuum on. I've done over a thousand
17 vacuums with, you know, an indication. An indication
18 might be fatigue or distress or -- I don't know that
19 I've ever seen anybody do what you're talking about.
20 Do a vacuum extraction without some indication to put
21 it on.

22 Q. Would it be wrong to do that?

23 A. Might be.

24 Q. What are the recognized indications for
25 using a vacuum to deliver a baby?

1 A. In this particular case, it seems to be
2 fetal distress. The baby was crowning. The mother had
3 fatigue. All of those would be some of the indications
4 to do an operative vaginal delivery, which is what a
5 vacuum extraction is.

6 Q. I asked about indications generally and
7 you answered by talking about this case.

8 A. Well, you asked me. So that was three
9 things that I thought of; maternal fatigue. There was
10 fetal distress. There was -- because of the maternal
11 fatigue, the mother was not able to push well, needed
12 some assistance. The indication here was all those
13 things.

14 Q. One is fetal distress. One is maternal
15 fatigue, and one is poor pushing?

16 A. Poor maternal effort to push the baby out.

17 Q. Poor maternal effort to push the baby.

18 A. Same idea; poor pushing.

19 Q. And understand, I'm not asking about the
20 Washington delivery. Just in general, are there any
21 indications for use of a vacuum to deliver a baby other
22 than those three that you mentioned?

23 A. I'm certain there are plenty more but I
24 just can't think of at this time.

25 Q. Those are the only three you can think of

1 as you sit here today?

2 A. Well, I focused on this case. I'm sure
3 I've done others. I don't recall any other indication
4 at this particular time.

5 Q. In general, what are the contraindications
6 to use of a vacuum, if any?

7 A. Abnormal presentation. An unsure
8 presentation. High station. An incomplete dilated
9 cervix.

10 Q. Any others?

11 A. There may be others. I just can't think
12 of any others at this time.

13 Q. What about a prolonged descent or arrest
14 of descent?

15 A. Depends on how far down the baby came. If
16 there was arrest of descent, it might have been
17 maternal fatigue. It might have been uterine fatigue.
18 Sometimes the uterus just gets tired. If the baby
19 doesn't come to or near the introitus, then I wouldn't
20 do that delivery.

21 Q. What if there's a prolonged or arrested
22 descent at minus one or zero station? Would that be a
23 contraindication to use of a vacuum?

24 A. I don't think so. I think if the baby
25 comes on past that, you know, that if it's down ready

1 to be delivered, it can get delivered. Sometimes
2 you'll have arrest of descent and then you get over the
3 arrest of descent; changing the baby's position,
4 changing the way it's turned in the pelvis. Better
5 uterine contraction. Folks can overcome a slow
6 descent.

7 Q. Is the mother's consent required before an
8 obstetrician may properly use a vacuum?

9 A. I've never gotten a mother's consent in
10 over a thousand of those that I've done. She consented
11 to obstetrical care. I assumed she trusted me to do
12 the best I knew how to do.

13 Q. What warnings, if any, do you believe a
14 mother should be provided about risks to herself or her
15 baby before the obstetrician may properly use vacuum
16 extraction?

17 A. The mother asked me to deliver her baby as
18 safely as I knew how. That's what they consent to. So
19 I do the best I can. I was educated over a long period
20 of time and have kept up with meetings and books and
21 periodicals, journal clubs, et cetera. I'm trying to
22 do the best job I can with a mother in labor.

23 Q. Do you remember the question?

24 A. Uh-huh. And I answered it. My answer was
25 that they said -- you said you wanted me to take care

1 of you obstetrically; you gave me permission to do
2 that. That's what I do. Or did. I stopped doing
3 obstetrics.

4 Q. My question was, what warnings, if any, do
5 you believe an obstetrician should give the mother
6 prior to using a vacuum extraction? Your answer didn't
7 specifically say anything about warnings. Are you
8 telling me that no warnings are needed?

9 A. I've never given a warning to a mother
10 whose baby I was delivering before. I wouldn't think
11 so.

12 Q. You did not give Jamesetta Washington any
13 warning about the risks of vacuum extraction to her or
14 her baby; correct?

15 A. No, I did not.

16 Q. You did not obtain her informed consent to
17 use of a vacuum?

18 MS. CRAIG: Objection.

19 THE WITNESS: We got consent to do
20 obstetrical care. That's part of the obstetrical care.

21 BY MR. GRAHAM:

22 Q. Apart from that general consent, you never
23 obtained any specific consent to use of a vacuum, did
24 you?

25 MS. CRAIG: Same objection.

1 THE WITNESS: No, sir.

2 BY MR. GRAHAM:

3 Q. You didn't even tell her you were going to
4 use a vacuum, did you?

5 A. We could look at the videotape. You can
6 see what I did, which was I recognized a problem with
7 the baby. I applied vacuum extraction and delivered
8 the baby. Very simple, easy delivery.

9 Q. You didn't tell her you were getting ready
10 to use a vacuum, did you?

11 A. I don't know. I'm not sure she would've
12 known if I told her that's what I was going to do.

13 Q. Once an obstetrician chooses to use a
14 vacuum, should the vacuum ever be abandoned and, if so,
15 under what circumstances?

16 (Interruption)

17 MS. SMITH-YANCY: All right, guys. You
18 saw all my efforts to not let that happen. I
19 apologize.

20 BY MR. GRAHAM:

21 Q. Do you remember the question?

22 A. No, sir.

23 Q. I wish I did.

24 MS. SMITH-YANCY: I'm so sorry.

25 MR. GRAHAM: I do. I remember it. I

1 remember it.

2 BY MR. GRAHAM:

3 Q. If an obstetrician makes a decision to use
4 a vacuum, should he ever abandon use of the vacuum and,
5 if so, under what circumstances?

6 A. If you make an effort to deliver the baby
7 by vacuum and the vacuum continues to come off of the
8 baby's crown. They say after three pop offs, that's
9 enough. That would be one indication.

10 The other is, the mother pushes, and you
11 pull, and the baby does not move down. I would stop
12 trying to deliver the baby with a vacuum extractor.

13 Q. What types of vacuum extractors were
14 available to you at East Cooper in the time frame of
15 this delivery?

16 A. I think that the brand was Miele but I
17 don't know that. I only used one kind in the last
18 thousand times. They just had it on my card. I used
19 it. And so I don't know the brand name.

20 Q. You think it was Miele?

21 A. They make some medical equipment. I might
22 have it mixed up with some other piece of equipment.

23 Q. Can you describe it, please, sir.

24 A. It's a soft Silastic cup with a head about
25 four centimeters and a cone shape that comes up and

1 then a handle that comes out of that and a tube that
2 comes out of that, that leads to a vacuum pump.

3 Q. I'm going to ask you, if you would,
4 please, draw me a picture of what it looks like since
5 you're not sure of the brand name.

6 A. (Witness complied.) I can't remember
7 exactly where the vacuum, whether it went through the
8 handle. I think it did. I think there was a tube that
9 came out of where the handle was attached up here. And
10 this sort of flares out here a little bit like that.

11 Q. This is what you referred to as the tube?

12 A. Well, you've got to create a vacuum.

13 Q. Right.

14 A. And there's a pump.

15 Q. I'm just going to ask if you would label
16 that as tube, if that's what it is. Just so when I
17 look at it later, I'll remember your testimony.

18 A. (Witness complied.)

19 Q. You're labeling that part the handle?

20 A. Yeah, handle, and then this is the stamp,
21 if you call it that. And this is soft Silastic head,
22 if you call it that.

23 Q. Whatever you want to call it.

24 A. Whatever you call it. Then you go down --
25 it sort of comes down, flares out just a little bit.

1 Q. Flares out at the top?

2 A. Like that, sort of. Of course, it's
3 enclosed. If you take a cross section, it would look
4 like that. How's that?

5 Q. Kind of like a bell shape?

6 A. Bell shape. That's exactly what it looks
7 like. Little teeny, soft Silastic bell.

8 Q. You had the one diagram on the right side
9 of the page and then you just drew a second diagram
10 here.

11 A. This is a cross section.

12 Q. Cross section.

13 A. This would be the tip. This is the tip
14 here. This would be the tip. And this would be the
15 bell. And this would be the bell. And this would be
16 the stem.

17 Q. Thank you.

18 Now, you put a number here. On the
19 right-hand diagram, you put a number at the top. What
20 is that?

21 A. About four centimeters. I can't remember
22 whether that's four or six centimeters. I don't
23 remember that.

24 Q. What dimension is that?

25 A. That's the dimension from here to here.

1 Q. Diameter?

2 A. Yeah, the diameter. Not the
3 circumference. That would be power squared.

4 Q. I'm confused. You labeled it around four
5 centimeters, but you're saying that you think it might
6 be six centimeters?

7 A. I don't know how much it is, and I'll
8 scratch through it.

9 Q. And you scribbled through the four
10 centimeters.

11 A. Yes, sir, that will make it a lot easier.

12 Q. As you sit here today, you can't tell me
13 the size of the bell or the cup that you used?

14 A. About that big. However big that is.
15 That's -- the last time I did that was September
16 of '05.

17 Q. Who at East Cooper would know your
18 preferences about vacuums?

19 A. There's a preference card for every doctor
20 up there.

21 Q. What you've labeled as the bell on this
22 diagram, is that --

23 A. You said it looked like a bell. I labeled
24 it the bell.

25 Q. And I'm using that language since you've

1 labeled it that. Is the bell a permanent part of the
2 vacuum, or is that disposable or how does that go?

3 A. The whole thing is disposable.

4 Q. The whole vacuum apparatus?

5 A. Yes, sir, everything but the pump handle.

6 Q. When you get ready to use one, what do you
7 do to put it together properly?

8 A. It comes preassembled.

9 Q. But you save the handle part?

10 A. No, you don't save any of it. The pump
11 handle.

12 Q. Oh, the pump handle; not this handle.

13 A. The nurse has a handle for the vacuum pump
14 on it. That's a reusable piece. This is a disposable
15 piece.

16 Q. Can I get you to sign and date this
17 drawing so we can make it an exhibit. We'll mark that
18 as Plaintiff's Exhibit 2.

19 MR. GRAHAM: If you'll mark that
20 Plaintiff's Exhibit 2.

21 (PLF. EXH. 2, Hand-drawn diagram, was
22 marked for identification.)

23 BY MR. GRAHAM:

24 Q. When you made your preferences for this
25 particular type of vacuum, were there choices to be

1 made about what size bell to use, or is there only one
2 size bell to go with this vacuum?

3 A. I did that so many years ago, I don't know
4 the answer to that. I've been -- until I quit doing
5 obstetrics two-and-a-half years ago, almost three years
6 ago now, I've been doing the same thing for 15 years, I
7 think.

8 Q. Can you tell me, approximately, how high
9 the bell is.

10 A. That's about the size of it. If we could
11 get an example, we could know exactly what size it is.

12 Q. Can you tell me how long the stem is.

13 A. About like that.

14 Q. About like what?

15 A. About like --

16 Q. You think you've drawn it pretty
17 accurately?

18 A. I think so.

19 Q. Thank you. Would that be true also of the
20 handle?

21 A. Yes, sir.

22 Q. Not the precise scale but pretty close?

23 A. I think so.

24 Q. Fair enough. Thank you.

25 Is there anything customized about the

1 vacuum that you used at East Cooper?

2 A. No, sir.

3 Q. Could you please take me through the steps
4 of how a vacuum extraction should properly be performed
5 from the time you -- or from the time any obstetrician
6 conceives of the idea: I'm going to use a vacuum to
7 help get this baby out. What steps do you go through?

8 A. Put the patient up in a position to get
9 delivery from. And you examine the baby's head, see if
10 you can determine which way the baby is aimed. Is it
11 occiput posterior, occiput anterior. If you've been
12 following the baby, you would think you'd know that.
13 Check that again.

14 You then get the vacuum from the nurse and
15 apply it to the baby's scalp and, hopefully, to the
16 crown. And then you see if you can -- if it's applied,
17 put teeny little vacuum on, see if you feel like it's
18 in the midline, in the area that you want it, which is
19 towards the top of the head.

20 And then once you've determined that, then
21 the next thing you do is increase the vacuum to about
22 20 millimeters of Mercury, although I can't remember
23 exactly what those numbers are anymore.

24 Subsequently, you make a gentle pull as
25 the mother pushes and, with any luck, the baby's head

1 will come on down as it did in this case and out the
2 baby will come.

3 Q. What are the dangers of improper placement
4 of the bell?

5 A. Well, if you put it over the baby's face,
6 you damage the baby just like forceps deliveries could
7 easily damage a baby's ear or face, which is one of the
8 reasons I tended to use more of these vacuum
9 extractions than forceps because I thought I would do
10 less damage to the mother and the baby.

11 Q. Is there any place the bell might be
12 placed that would entail a risk of trauma to the baby
13 other than on the baby's face?

14 A. The ear.

15 Q. Any others?

16 A. You might put it off to the side. Then
17 you can increase the amount of mass you're trying to
18 move through the vaginal opening.

19 Q. Any others?

20 A. Not that I can think of at this time. If
21 you've got it on the baby's crown, then you can lead
22 the baby's head down. The presenting part, it's
23 already almost out. Momma pushes, you pull, the baby
24 comes out.

25 Q. Is it ever acceptable to put the bell

1 directly over the anterior fontanelle or the posterior
2 fontanelle?

3 A. Sometimes that just happens. That
4 wouldn't be considered improper.

5 Q. Is it improper -- strike that.

6 Does it create a risk of danger to the
7 baby if you place the vacuum to the right or left of
8 midline? That is, to the right or left of the -- I
9 think you referred to it as a sagittal suture.

10 A. If you think about it, here's a baby's
11 head. If you want to make the baby's head as small as
12 you can to get it out, then you would want to put it on
13 the leading part. If it's off to the side, then it may
14 pull the baby and increase the width of whatever you're
15 trying to deliver, the baby's head. It would make it
16 bigger. It depends on how far lateral you are.

17 It's not an exact science. This is where
18 you get it close. And if you can get the baby out,
19 you've done a good thing. If you can't get the baby
20 out, then you find another way to deliver it.

21 Q. How should a vacuum extraction be properly
22 documented and charted in the hospital records by an
23 obstetrician?

24 A. I make a note that I did a vacuum
25 extraction, vaginal delivery.

1 Q. Is that your routine procedure just to
2 document vacuum delivery?

3 A. Yes, sir.

4 Q. You don't document the station at which
5 you applied the vacuum?

6 A. No, sir.

7 Q. You don't document the head orientation?

8 A. Sometimes I'll say that this baby was LOA
9 or ROA or even OP or OA.

10 Q. How often do you document the baby's head
11 position?

12 A. Most of the time, I think. I don't
13 remember. I haven't done that in three years now. I
14 used to have a little routine so I could remember the
15 things I wanted to write in the note. Sometimes I
16 didn't follow even my own routine when I was writing
17 the note.

18 Q. Is it important to know what the baby's
19 head orientation is when using a vacuum?

20 A. I would always know what the baby's head
21 orientation is.

22 Q. Why is that important?

23 A. Depends on the force; where you want to
24 apply force to get the baby out.

25 Q. Do you normally document how many pulls

1 you make?

2 A. No, I don't.

3 Q. Do you normally document the pressure that
4 you apply with a vacuum?

5 A. No, sir, I don't.

6 Q. Do you normally apply the -- do you
7 normally document the degree of traction you apply?

8 A. I'll note that it was very difficult pull.
9 If I had to apply a lot of traction, I'll note it; if
10 I've had a number of pop offs that I described earlier.

11 Q. Is there anything else that you normally
12 document about a vacuum extraction that you haven't
13 already told me about?

14 A. I try and document, let's see, the time
15 although I noted that I didn't have the time on this
16 delivery, although it's in the chart.

17 Whether or not there was an intact
18 perineum or I've done an episiotomy.

19 Usually I note what kind of anesthesia the
20 patient had. And then I probably would like to have
21 noted -- in general, would have noted the position I
22 thought the baby was from and then how I did it.
23 Although I think I wrote down vacuum extraction,
24 vaginal delivery at, and left it blank. And then
25 described the baby and the APGAR and the arterial blood

1 gas in this particular note.

2 Q. You have in front of you what's been
3 marked as Plaintiff's Exhibit 1. And you pulled out
4 three pages. Could we put these three pages back so we
5 don't lose sight of where they go.

6 A. Let me see. That would be the right order
7 now. I left them in order.

8 Q. They're the last three?

9 A. Yes, sir. Wait a minute; might as well
10 get them oriented right. Those are oriented like the
11 rest of them.

12 Q. Thank you, sir.

13 Before today's deposition, have you had a
14 chance to go through the records from East Cooper
15 relating to this delivery?

16 A. I reviewed, yes, sir.

17 Q. Did you see anything in the East Cooper
18 records that you considered to be false, inaccurate or
19 misleading in -- to any degree?

20 A. Do you mean now in the mother's records?

21 Q. Yes, sir.

22 A. I don't recall that.

23 Q. Did you see anything missing from the
24 mother's record that you would ordinarily expect to see
25 there?

1 A. I noted that I didn't write the time of
2 the delivery down.

3 Q. Anything else?

4 A. Let me look at my note, and I'll tell you.
5 I didn't write the time of the delivery
6 down, but I wrote down what I normally write in
7 delivery.

8 Q. Let me get you, sir, to please go through
9 this exhibit 1 and tell me every page where you made an
10 entry, either a handwritten entry or a computer entry.
11 Did you ever make computer entries, by the way?

12 A. I don't think so. I may have made a
13 computer entry on the fetal heart tones, but I don't
14 remember doing that in this case.

15 Q. Okay. If you would, go through and just
16 call to my attention every page where your handwriting
17 appears. Then I'll ask you questions about your
18 entries. Please make reference to the page by the
19 number at the bottom right-hand corner.

20 A. 0024.

21 Q. 0024?

22 A. Yes.

23 THE VIDEOGRAPHER: I'll need to make a
24 disk change in five minutes.

25 THE WITNESS: 002.

1 MR. GRAHAM: Okay, thanks.

2 BY MR. GRAHAM:

3 Q. 002?

4 A. The face sheet.

5 Q. Apart from the signature, looks like Nurse
6 Midwife Stone, is the rest of that handwriting yours?

7 A. On which page, sir?

8 Q. 002?

9 A. Correct.

10 Q. Could you please read your entries. I
11 think I can read most of them, but I want to make sure.
12 On page 002.

13 A. Pregnancy at 41 weeks. History, herpes
14 simplex virus. EFM, electronic fetal monitoring.
15 Cervidil. Pit which means Pitocin. Continuous lumbar
16 epidural. AROM, which is an amniotomy. FSC, which is
17 fetal scalp electrode. Vacuum extraction vaginal
18 delivery. Repair of second degree laceration times
19 one.

20 Q. On that fetal scalp electrode, it looks
21 like that first letter might have been something else.

22 A. I don't think so.

23 Q. That's how you make your Fs?

24 A. Well, it's got a little extra doally on
25 there. That looks more like a hand wiggle. No, that's

1 how I usually make my Fs. I don't know that I was
2 writing anything but fetal scalp electrode.

3 Q. Please continue. On what page does your
4 handwriting next appear.

5 A. I signed a -- I countersigned on page 009.

6 Q. That's the discharge summary?

7 A. Yes, sir.

8 Q. Why did Barbara Stone dictate the
9 discharge summary?

10 A. That was quite common. That was part of,
11 sort of, agreement we had with the midwives. They
12 would do postpartum rounds and do the discharge.

13 Q. Earlier I thought you told me that the
14 midwives handled their own patients.

15 A. No, you asked me about deliveries. They
16 handle their own patients for deliveries. They see our
17 patients postpartum. We discharge and then dictate the
18 discharge summary. I'm sorry if I confused you.

19 Q. That's all right. Throughout the course
20 of your private practice at Low Country, you would
21 ordinarily not do the discharge summary; you would
22 delegate that to a midwife?

23 A. That was late in there. That didn't
24 happen until about 2000 or maybe 2001.

25 Q. Where does the midwife get the information

1 from to put in the discharge summary?

2 A. From the chart.

3 Q. Any information known to the obstetrician
4 involved in the delivery, which was not charted, would
5 not be known to the person who dictated the discharge
6 summary; correct.

7 MS. CRAIG: Objection.

8 BY MR. GRAHAM:

9 Q. Do you follow me?

10 A. Say again.

11 Q. If the midwife dictates the discharge
12 summary based on chart entries, any knowledge known to
13 the obstetrician, which was not recorded on the chart,
14 would be information not available to the midwife;
15 correct?

16 MS. CRAIG: Objection.

17 THE WITNESS: They may have gotten
18 something out of the prenatal record. We usually send
19 our prenatal records over. I would think that the
20 information that she dictated in the discharge summary
21 came out of the chart.

22 BY MR. GRAHAM:

23 Q. To the extent that the chart had any
24 significant omissions, those omissions would not be
25 known to her at the time of dictating the discharge

1 summary?

2 MS. CRAIG: Objection to form.

3 THE WITNESS: Say that question again,
4 please.

5 BY MR. GRAHAM:

6 Q. If there were any significant omissions in
7 the chart, the nurse midwife wouldn't know about that
8 when she dictated the discharge summary; correct?

9 MS. CRAIG: Same objection.

10 BY MR. GRAHAM:

11 Q. Because she was relying on the chart
12 entry.

13 MS. CRAIG: Same objection.

14 THE WITNESS: Now, she does talk to the
15 patient and does, you know, get information from the
16 patient herself.

17 BY MR. GRAHAM:

18 Q. Okay.

19 A. So there may be things in here she learned
20 when she was making postpartum rounds that were not
21 part of the chart.

22 Q. Okay. She doesn't gather information from
23 the obstetrician involved in the delivery that the
24 obstetrician chose not to record; correct?

25 MS. CRAIG: Objection.

1 THE WITNESS: She would -- I was making
2 rounds, I would rely on the information in the chart.

3 THE VIDEOGRAPHER: Mr. Graham, we need to
4 make a disk change. Is now fine?

5 MR. GRAHAM: Yes.

6 THE VIDEOGRAPHER: We're going off the
7 record at 5:17 p.m.

8 (A recess transpired from 5:17 p.m. until
9 5:23 p.m.)

10 THE VIDEOGRAPHER: We are going back on
11 the record at 5:23 p.m.

12 BY MR. GRAHAM:

13 Q. Doctor, before the break, I was asking you
14 about the midwife doing the discharge summary for you.
15 To the extent that significant information might be
16 omitted from the hospital chart, there's a risk that
17 information may not be available to the midwife
18 dictating the discharge summary; correct?

19 A. That would be true.

20 Q. Please continue. You were telling me
21 where your handwriting appears.

22 A. 009.

23 Q. All right, we just did that.

24 A. 009. Triple 09.

25 Q. That's the one we just did, I believe.

1 A. I'm sorry. 0021.

2 Q. Where does your handwriting appear on
3 here? I see the signature on the bottom right-hand
4 corner.

5 A. That's my signature.

6 Q. Is there any other handwriting of yours on
7 this page?

8 A. No, sir.

9 Q. Is there anything -- strike that.
10 What does your signature on this page
11 signify?

12 A. That I looked over this, and it seemed
13 correct to me.

14 Q. Fair enough. Please continue. Where does
15 your handwriting next appear?

16 A. 0024.

17 Q. None of the writing on 23 is yours?

18 A. No, sir.

19 Q. Do you recognize that handwriting?

20 A. The first note is from Dr. Molly Joseph.
21 Second note is from Dr. Granger Osborne.

22 Q. Thank you. Does any of those notes on
23 page 23 give you concern about the well-being of
24 Jamesetta or her son Jayden?

25 A. She had multiple sexually-transmitted

1 diseases, was smoking and using drugs as well as
2 alcohol in this pregnancy. Those worried me a little
3 bit.

4 Q. Where did you see that?

5 A. Past medical history. Herpes, chlamydia,
6 Trich. Those are all sexually-transmitted diseases.
7 Further on down, it says history of
8 tetrahydrocannabinol, THC, which is marijuana
9 cigarettes. ETOH is alcohol.

10 Q. What significance, if any, does the prior
11 medical history of herpes has in terms of the care that
12 should be provided to a woman post-term?

13 A. You asked me if any of those gave me any
14 concern.

15 Q. Yes, sir.

16 A. And my answer was that those all could
17 adversely affect the baby.

18 Q. But there was no sign of any active
19 herpes, was there?

20 A. The patient had been placed on herpes
21 suppressant drug called Valtrex. That doesn't mean
22 that she doesn't have systemic herpes. Doesn't mean
23 that she couldn't transfer that herpes to the baby
24 intrautero or intrapartal.

25 Q. To the extent that herpes was a concern,

1 would you agree that C-section delivery would be
2 protective?

3 A. No, not necessarily if the baby was
4 already exposed in utero. It could already have
5 herpetic injury.

6 Q. You don't have any evidence of that, do
7 you?

8 A. When you have a baby apparently with
9 multiple problems, then some of those could be herpetic
10 relations.

11 Q. As a board certified obstetrician, it's
12 obvious to me that you have certain expertise by
13 knowledge, training and experience about the subject of
14 obstetrics. Do you consider yourself as having special
15 expertise concerning the cause of brain damage in the
16 neonatal context?

17 A. No, sir, I'm just aware of diseases and
18 problems that can run together. I do not have any
19 expertise in that field.

20 Q. When we get to trial, you're not going to
21 express an opinion to the jury that herpes caused
22 Jayden's problems, are you?

23 A. I might say that it could possibly be part
24 of this baby's problem.

25 Q. Do you consider yourself as having

1 sufficient expertise about cause of brain damage in
2 babies to be qualified to express an opinion as an
3 expert about that?

4 A. There's a whole lot written about viral
5 diseases and their effects on pregnancy, herpes being
6 one of the viral diseases, and the effects on unborn
7 babies; the use of drugs such as marijuana, the use of
8 alcohol, and then these other sexually transmitted
9 diseases. All of those are concerns as an
10 obstetrician, you know: Is this going to adversely
11 affect the baby?

12 We check for active infection with Group
13 III drugs. We check for -- we use a suppressive drug
14 so that, to put -- called Valtrex or Cyclovir to
15 suppress an outbreak of herpes during a vaginal
16 delivery. There are babies that have been born with
17 herpes when they had a primary C-section without
18 ruptured membranes. That definitely can affect the
19 baby. There are multiple effects from that.

20 Q. Okay. So I understand --

21 MS. CRAIG: Dr. Rhett, have you finished
22 your answer?

23 THE WITNESS: Well, I think, you know, you
24 asked me: Was there any concern. So my concern was
25 that this mother had multiple things that could've

1 adversely affected her baby. And so to answer your
2 question, is there anything about this that concerns
3 me, all those things concern me.

4 BY MR. GRAHAM:

5 Q. Okay. I understand. I moved past that
6 question about concerning you.

7 And now I'm asking you: Is it your
8 intention to testify to an expert opinion in this case
9 that herpes is a possible cause of Jayden's brain
10 damage?

11 A. If I'm asked that question, then I would
12 say all of these things that I just listed are possible
13 cause of brain damage, heart damage, all the other
14 things that are wrong with him.

15 Q. In what way do you contend exposure to
16 herpes can cause any of the problems that Jayden
17 suffers from?

18 A. Systemic herpes can lead to systemic
19 herpetic infection in the baby which can lead to
20 problems with the heart, problems with the brain,
21 problems with the eyes.

22 Q. But you don't have any evidence of
23 systemic herpetic infection in Jayden, do you?

24 A. I've never seen Jayden except for when I
25 delivered him.

1 Q. So the answer is, no, you don't have any
2 evidence?

3 A. No, I haven't.

4 Q. What do you contend exposure to chlamydia
5 could cause possibly with regard to Hayden's --
6 Jayden's problems?

7 A. Well, since I don't know the extent of
8 Jayden's problem, chlamydia is a sexually-transmitted
9 disease. It could lead to, and it didn't in this case,
10 premature labor, infection in the newborn, as could --
11 just as herpes could.

12 Q. And there is no evidence of that in this
13 case, is there?

14 MS. CRAIG: Objection.

15 THE WITNESS: I don't know.

16 BY MR. GRAHAM:

17 Q. What possible cause -- strike that.
18 What do you contend Trich could have
19 possibly caused to explain some of Jayden's problems?

20 A. Trichomonas is just one -- Trichomonas
21 Vaginalis is one of a number of sexually-transmitted
22 diseases. I don't know specifically that Trichomonas
23 causes anything, but I would think -- all of these
24 things put together, you've got multiple risks here.

25 I mean, you've got drug use. You've got

1 alcohol use. You've got tobacco use. And all of those
2 things have been shown, you know, to have a detrimental
3 effect on unborn babies.

4 Q. What's your understanding of during what
5 period of time Jamesetta ingested THC during this
6 pregnancy?

7 A. Well, she said in her thing that she
8 had -- was using it, and it's in the prenatal record
9 somewhere. Up and through the first trimester. Maybe
10 longer. I'd have to look. I'll have to find the
11 prenatal record. I just saw it.

12 MS. CRAIG: Do you have the Bate stamp
13 number?

14 MS. SMITH-YANCY: 50.

15 THE WITNESS: Does anybody know what page
16 the prenatal record is on, speed us up a little bit.

17 MS. SMITH-YANCY: I think it starts on 48.

18 THE WITNESS: That makes it a lot easier.

19 MR. GRAHAM: That's fine.

20 THE WITNESS: 48 did you say?

21 MS. SMITH-YANCY: I think so.

22 THE WITNESS: Yeah, there it is.

23 On Bates stamp ECH 0050, it says alcohol,
24 yes. Ages 18 to 20, twice a week. Tobacco, five times
25 a week. Marijuana, four times a week. No cocaine or

1 heroin. Caffeine four times a week. That was the
2 source of this information. Patient sworn by.

3 BY MR. GRAHAM:

4 Q. Do you recognize the handwriting?

5 A. No, sir.

6 Q. Why do you say the patient filled out this
7 form?

8 A. That's who usually fills out the top part
9 of it. That's their history.

10 Q. In the left-hand column, after alcohol and
11 drug abuse or whatever, part of that is blocked out,
12 but it clearly states stopped 10/20/01; correct?

13 A. That's what it says, yes.

14 Q. Do you have any reason to question the
15 accuracy of that note?

16 A. No, sir.

17 Q. Approximately, when do you contend this
18 pregnancy was conceived?

19 A. I don't see a last menstrual period noted
20 on here. Positive pregnancy test November. Anytime
21 after October the 1st.

22 Q. Earlier you said something about the
23 patient -- strike that.

24 Earlier you had said that Jamesetta had
25 used THC up and through the first trimester or longer.

1 A. That's the way I understood it.

2 Q. What did you base that on?

3 A. What I thought I had remembered. It looks
4 like, if she said she stopped in October, then she
5 stopped after she got pregnant.

6 Q. You have no reason to question that;
7 correct?

8 MR. DAVIS: Objection.

9 THE WITNESS: No.

10 BY MR. GRAHAM:

11 Q. Let's go back. You were talking -- how do
12 you contend that ingestion of THC could have caused a
13 problem to Jayden? What problems are you talking
14 about?

15 A. Well, marijuana usage in the mother is
16 supposed to have some slowed effects on the baby. The
17 baby doesn't respond as well. It doesn't learn as
18 well. It has difficulty with coordination and other
19 things like that.

20 Q. Do you consider yourself as having special
21 expertise about the cause, the potential causes of harm
22 on babies from smoking marijuana?

23 A. No, sir, just what I've read and heard at
24 meetings.

25 Q. You wouldn't tell the jury that they

1 should listen to your beliefs about marijuana in that
2 context as an expert witness, would you?

3 MS. CRAIG: Objection.

4 THE WITNESS: I think that, you know, this
5 baby was exposed to a lot of things. I've listed them
6 all for you. And, you know, the more things you add,
7 the worst chance this baby has of doing well.

8 BY MR. GRAHAM:

9 Q. You're not going to claim to be an expert
10 on the subject of ill effects of marijuana use on
11 babies at the trial in this case, are you?

12 A. I'm an obstetrician, and I've read what's
13 written about drug use, smoking, alcohol, and
14 sexually-transmitted diseases. And so I don't have the
15 specific expertise in the use of marijuana on the
16 effects of a baby. I do have an overall understanding
17 of the adverse effects of multiple bad things that
18 could possibly adversely affect this baby.

19 Q. The multiple bad things that you're
20 talking about include marijuana; right?

21 A. They include marijuana, tobacco, alcohol,
22 herpes.

23 Q. Yes, sir. I just want to take them one at
24 a time. In terms of marijuana, do you or do you not
25 consider yourself to be an expert on the subject of

1 brain damage or other harm caused to babies by
2 marijuana use early in pregnancy?

3 MS. SMITH-YANCY: Object to the form;
4 asked and answered.

5 MS. CRAIG: Same objection.

6 THE WITNESS: I've been to meetings for 35
7 years. I've been to -- read books and journals,
8 articles about toxic effects of various and sundry
9 things. I know that, specifically, multiple things
10 that are wrong -- that are being done by the mother
11 increase the risk to her baby.

12 BY MR. GRAHAM:

13 Q. Smoking marijuana doesn't increase the
14 risk of brain damage, does it?

15 A. It may.

16 Q. What do you base that on?

17 A. Articles I've read.

18 Q. Can you give me a citation.

19 A. No, sir.

20 Q. Could you agree to furnish that to your
21 attorney so she can furnish it to me?

22 A. I don't keep those articles anymore.

23 Q. Do you claim to be an expert in terms of
24 potential harm to a baby from use of nicotine early in
25 pregnancy?

1 A. Just what I've read.

2 Q. Do you claim that the use of nicotine
3 early in pregnancy can cause brain damage to the baby?

4 A. It's a possibility.

5 Q. What do you base that on?

6 A. Things I've read.

7 Q. Can you give me any citation?

8 A. No, sir.

9 Q. Can you furnish those articles to your
10 attorney so she can provide me with a copy.

11 A. If I can find it.

12 (This page contains information to be
13 supplied by the deponent.)

14 BY MR. GRAHAM:

15 Q. Do you claim to be an expert about dangers
16 of alcohol use early in the pregnancy on the baby?

17 A. I think it's fairly widely established
18 that fetal alcohol syndrome is a cumulative effect.
19 And then if you add that to marijuana use and tobacco
20 use, and then viral sexually-transmitted diseases, I
21 think you're putting your baby at risk.

22 Q. You have no evidence that Jayden
23 W suffers from fetal alcohol syndrome, do you?

24 A. No, sir, but he could.

25 Q. What do you base that on?

1 A. He's got a lot of difficulties.

2 Q. What brain damage, if any, do you contend
3 can be caused to a baby by ingestion of alcohol by the
4 mother early in pregnancy?

5 A. Fetal alcohol syndrome is a cumulative
6 effect in the early pregnancy; the bigger the
7 percentage of alcohol would be to the size of the
8 fetus.

9 Q. What do you base that on?

10 A. What do you mean?

11 Q. Do you base that on -- base that on
12 something you've read?

13 A. Read, been to meetings for, seen articles
14 about.

15 Q. Can you cite me any such article?

16 A. No, sir.

17 Q. Can you provide any such article to your
18 attorney so she can furnish it to me?

19 A. I doubt it. I'll make an attempt.

20 (This page contains information to be
21 supplied by the deponent.)

22 BY MR. GRAHAM:

23 Q. You directed my attention to page ECH 24
24 where your handwriting appears.

25 A. That's correct.

1 Q. Is all of the handwriting on this page
2 yours?

3 A. No, sir.

4 Q. Is it easier to tell me what is yours or
5 what is not yours?

6 A. The first three notes are mine. 7/16/02,
7 1320, 1545 and 2000.

8 Q. Does the 715 note on 7/17, is that a
9 postpartum note?

10 A. I'm sorry?

11 Q. Does 7/15 --

12 A. That's 7/17/02. That's 0715. That's a
13 postpartum note written by Barbara Stone.

14 Q. Is that your signature?

15 A. No, that's Granger Osborne.

16 Q. Could you please read the 1320 entry into
17 the record.

18 A. Yes, sir. Had an episode of decelerations
19 about four minutes, which resolved with oxygen and IV
20 fluid and stopping Pitocin. Fetal heart tones okay
21 now. Cervix four to five centimeters, 80 to 90
22 percent. Presenting part about minus one with some
23 mobile. Impression: Stable for now. Good progress
24 since admission. Plan: Restart pit. Observation.

25 Q. Did you do a vaginal exam that

1 corresponded with this note?

2 A. I think I did, but I can't swear to it. I
3 would think that I would have gone into the room and
4 done an exam. I could look on the monitor strip at
5 that time and tell you yes or no.

6 Q. Okay. Could you do that, please.

7 A. Yes, sir, I'll be glad to. 1320. Oh, no,
8 I'm doing it wrong.

9 I did that exam.

10 Q. What are you looking at?

11 A. I'm looking at ECH 0263. At the
12 right-hand side it says 1323. You come down and there
13 between fetal heart tones on the top and contraction
14 monitor on the bottom. It says ER. That's me. Right
15 lateral. ER says it's dilated 4.5 centimeters.
16 Effaced 90 percent minus one. And I asked them to put
17 the patient on her right side.

18 Q. Right lateral refer to the patient's
19 position?

20 A. Yes, sir.

21 MS. SMITH-YANCY: Did you say 263?

22 MS. CRAIG: 0263.

23 MS. SMITH-YANCY: You're right. I just
24 didn't hear you.

25 BY MR. GRAHAM:

1 Q. Thank you. Now, would you please read --
2 going back to page ECH 24. Could you read the 1545
3 notes.

4 A. Seven centimeters, 90 percent effaced,
5 minus one station. Fetal heart tones okay. ER.

6 Q. Is that -- are those notes about
7 dilatation, effacement and station based on your
8 vaginal examination?

9 A. I have to go back and look at what I just
10 did.

11 Q. Sure. Please do. Thank you.

12 A. I think so, but I don't know that. I
13 don't know. I think this goes between pages so it's
14 hard to --

15 Q. At any rate, you would not have made the
16 entry here of 290, minus one unless you were satisfied
17 that was accurate; correct?

18 A. I think it's 790.

19 Q. Excuse me. Seven.

20 A. Yes, sir.

21 Q. Saw a squiggle at the bottom.

22 A. I believe that to be accurate.

23 Q. Could you please read on page ECH 24 your
24 2000 note.

25 A. At -- and there's a blank 'cause I didn't

1 put the time in. Over an intact perineum under CLE,
2 which is continuous lumbar epidural. Seven pound, ten
3 ounce male. Apgar 6-9. Placenta spontaneous intact.
4 Nuchal cord times one. Second degree laceration at the
5 introitus. Repaired with 4-0 vicryl. Mother and baby
6 tolerated well. Arterial blood gas pH 7.21. ER.

7 Q. Is that the only note you made of
8 delivering this child?

9 A. I signed the other form that you asked me
10 about earlier.

11 Q. But it's the only note that you actually
12 made?

13 A. Yes, sir.

14 Q. Is that customary for you to not do a
15 separate delivery note?

16 A. That is my delivery note.

17 Q. If the nuchal cord was tight, you would
18 have so documented it; correct?

19 A. Yes, sir.

20 Q. The nuchal cord --

21 A. 35 or 40 percent of babies have at least
22 one nuchal cord. It's not significant unless it's
23 tight, unless it gets in the way of the delivery.

24 Q. Thank you. Would you agree with me that
25 you did not document the station of Jayden W. 's

1 head as being lower than minus one at any time prior to
2 your application of the vacuum?

3 A. I did not document it in this cart, that's
4 correct. I've told you that the baby was on the
5 introitus. The mother was exhausted. I applied the
6 vacuum without even having to push the labia apart. In
7 less than two minutes, delivered this baby with mother
8 pushing a little bit and my making a very gentle tug on
9 this.

10 Q. Say that again. You said you did not have
11 to push the labia apart?

12 A. The baby's head was pushing through. She
13 just couldn't push it out. I applied the vacuum.

14 Q. How do you know that you didn't open the
15 labia?

16 A. Because the baby's head was sticking out.
17 I didn't have to. I could simply apply the vacuum to
18 the baby's head.

19 Q. Are you going from memory?

20 A. Yes, sir, and the video that you showed
21 me. When this baby had a problem, I went back and I
22 thought about this a lot. Because I thought this was
23 one of the simplest deliveries I had ever done. So it
24 became part of my -- the things I've remembered in my
25 life.

1 Q. Please continue. Where does your
2 handwriting next appear on this exhibit?

3 A. I signed an order on -- it's not well --
4 0026. But it's not well documented on there. But it's
5 after 0025 and before 0027. There's an order that
6 Dr. Osborne had given a verbal order to start IV fluids
7 and Pitocin and Foley catheter. And I countersigned
8 that order.

9 Q. Thank you. Please continue.
10 Where did you next write on this chart?

11 A. That's it. That I'm aware of.

12 Q. Did you make any orders that were
13 documented on the baby's chart?

14 A. No, sir.

15 Q. That would be very unusual; correct?

16 A. I think so. Sometimes, when I do an
17 arterial blood gas, that will go to the baby's chart
18 because it really is part of the baby's chart. But
19 that would be the only thing I would ever see that was
20 my handwriting on a baby's chart.

21 On 0098, ECH 0098, there's an arterial
22 blood gas report.

23 Q. Yes, sir.

24 A. And that's my signature. The E with a big
25 circle around it, 7/16/02 is what I think I tried to

1 write.

2 Q. Who wrote the words cord gas?

3 A. That looks like Granger Osborne's
4 handwriting.

5 Q. Did you order any type of drug screen for
6 Jamesetta?

7 A. No. That was ordered by Dr. Ward, I
8 believe.

9 Q. Did you have any discussion with Dr. Ward
10 about this mother or this baby or this brain damage?

11 A. None whatsoever.

12 Q. Did you tell anyone of your belief that
13 this mother had been smoking pot, cigarettes and using
14 alcohol for a considerable period of time during her
15 pregnancy?

16 A. No, sir.

17 Q. Did you tell anyone that Jamesetta was a
18 known pot smoker?

19 A. Jamesetta said she smoked pot, but I
20 didn't tell anybody that.

21 Q. Did you at any time review this hospital
22 chart after I requested copies of the chart?

23 A. I have reviewed it at the instruction of
24 my attorney, yes.

25 Q. I don't want to ask you about questions --

1 I don't want to ask you any questions relating to
2 conversations between you and your attorney about this
3 case. Early on, long before there was a case, when I
4 first asked for records relating to this delivery, did
5 you get word from the hospital that a lawyer wanted to
6 get a copy of those records?

7 A. I don't independently recall getting that
8 notification. I may have.

9 Q. When I first received records from East
10 Cooper, there was a page of labor and delivery nurse's
11 notes missing, and a page of progress notes with the
12 delivery note missing. Do you have any explanation for
13 why I would not have been furnished those with the
14 other record?

15 A. No, sir, none whatsoever. You know, I
16 think I did a very good job delivering this baby. I
17 have nothing to hide. I wouldn't mess with the records
18 at all. And I have nothing to do with the way records
19 are kept at East Cooper Hospital except to sign them
20 when I'm supposed to. Or, you know, nothing to do with
21 their medical records department.

22 Q. Apart from your attorney, have you had any
23 discussions with anybody after the day of delivery
24 about this delivery?

25 A. I talked to Dr. Osborne about it when the

1 baby was transferred to the Medical University, I
2 think. He asked what happened, and I told him I
3 thought I had a, you know, easy vacuum-assisted
4 delivery. And I can't imagine that was any part of his
5 problem.

6 That was more of a peer review sort of
7 thing where we're trying to figure out: Had we done
8 the right thing? Should we have done something
9 differently?

10 Q. Was there a peer-review process involved
11 with this case?

12 A. I don't recall one.

13 Q. Are you aware of any final orders issued
14 for any deliveries involving you and children with
15 brain damage?

16 A. No, sir, there are none.

17 MR. DAVIS: I hate to interrupt. You
18 mentioned two pages I think you said might have been
19 missing from the records you initially received. Do
20 you have Bates stamp numbers on those, now since you've
21 identified them? You mentioned delivery note. I'm
22 just curious if you have a specific number you can
23 refer me to.

24 MR. GRAHAM: I don't right now. I'll be
25 happy to do that later. It's easy enough to look up

1 and see what Bates stamp is on the delivery note. In
2 terms of -- one of the pages in the chart contains my
3 letter addressing that subject.

4 MS. SMITH-YANCY: You have those records
5 now?

6 MR. GRAHAM: Yeah, assuming they're in the
7 Bates stamped copy.

8 MR. DAVIS: Right. I'm just trying to
9 make sure I know exactly which one you're talking
10 about -- pick this up a year from now and read it.

11 MR. GRAHAM: We don't need to do this with
12 all these guys here.

13 BY MR. GRAHAM:

14 Q. Would you agree no nurse ever documented
15 that Jayden's station was a positive number at any time
16 through the moment you applied the vacuum?

17 A. I don't see any notation to that effect.

18 Q. Going back to exhibit 2, which is your
19 figure diagram you drew about the vacuum extraction and
20 the bell, how much of that vacuum do you claim you had
21 to put inside the birth canal?

22 A. About that much right there.

23 Q. Could you label that line.

24 A. (Witness complied.) Baby's head sitting
25 here. That goes right around it, and it comes out.

1 Q. What you did, you drew a line on the
2 left-hand part of exhibit 2, and you labeled it inside;
3 correct? Now you drew an arrow to show which part you
4 claim is inside.

5 A. Isn't that what you wanted me to do?

6 Q. Yes, sir. I'm just saying it for the
7 record so that when people read it. We communicate in
8 many ways. Some people will be reading it, what we
9 talked about, later and they won't have the video to
10 look at what we're doing. I'm just trying to make the
11 record clear.

12 How much distance would you say there is
13 of the bell inside the vagina?

14 A. A centimeter.

15 Q. One centimeter?

16 A. (Witness moves head up and down.)

17 Q. That was a yes?

18 A. Not really inside. Because the vagina is
19 almost open. But she just can't push the baby out.
20 The baby is sitting right down there. If after you
21 apply the vacuum, that part probably got inside a
22 little bit just because, when you apply the vacuum, it
23 goes around the baby's head a little bit. And then she
24 pushes, and I pull, and the baby comes out. It's that
25 simple.

1 Q. So your testimony is that the only portion
2 of the bell portion of the vacuum that would've been
3 inside the vagina is --

4 A. A centimeter, maybe two at the most.

5 Q. It sounds like you were saying a
6 centimeter or less.

7 A. This is not an exact science. I think the
8 baby was crowning, but she couldn't push it out, and I
9 put this vacuum on and applied the vacuum and applied a
10 small amount of pressure while she pushed, and the baby
11 was delivered very simply.

12 Q. Is that based on your memory?

13 A. I have a burning memory of this delivery.
14 Because it was so simple. And then the baby ended up
15 having some difficulty.

16 Q. Is there any other basis for your answer
17 besides your memory?

18 A. No, when I looked at the video, it appears
19 that what I did was stick it on, she pumped it up, and
20 I pulled and Momma pushed. And it looked like it came
21 right out.

22 Q. There was no documentation, was there,
23 about the amount of pressure?

24 A. Pressure was less than -- there's a red
25 gauge that says don't go above this number. I think

1 it's 25 millimeters, but I can't remember that anymore.

2 We usually work in the 20 millimeter range; 20

3 millimeters of pressure, negative pressure.

4 Q. My question, though: It's not documented
5 in the chart?

6 A. No, sir, it's not documented.

7 Q. Your testimony that it was not in the red
8 zone is based on your memory?

9 A. I wouldn't allow the nurses to put the
10 vacuum in the red zone when I was doing vacuum
11 extraction deliveries.

12 Q. There's no recording of how much traction
13 you applied to accomplish this delivery; correct?

14 A. No, sir, there is no recording of that
15 except in my memory, which was minimum. Not my memory
16 but the traction.

17 Q. When did you first see evidence of
18 Jayden's scalp trauma from the vacuum?

19 MS. SMITH-YANCY: Object to the form.

20 MR. DAVIS: Objection.

21 THE WITNESS: I don't know that I saw
22 trauma to Jayden's scalp from the vacuum.

23 BY MR. GRAHAM:

24 Q. Did you?

25 A. I don't remember seeing any.

1 Q. Did you look at his head after delivery?

2 A. I did. He had a fetal scalp electrode on
3 also. Take that off after we had done the delivery.

4 Q. So you left the scalp electrode on for --

5 A. To monitor the heart rate while I was
6 trying to get this baby born.

7 Q. When did you apply the fetal scalp
8 electrodes?

9 A. At 1320.

10 Q. What do you base that on?

11 A. The record. I think I wrote it.

12 Q. In the strips?

13 A. In the strips. Let me find the other
14 note.

15 Q. Sure. Take your time.

16 A. I wrote it at 1320 that it had an episode
17 of deceleration. Let me find that. Let's see what we
18 got here. Okay.

19 Go back another page. Sorry. At 1341,
20 there was some deceleration.

21 Q. What page are you referring to, please?

22 A. I'm sorry. 0258.

23 Q. Thank you.

24 A. After that, about four minutes, those
25 fetal heart tones just came up.

1 Q. Wait a minute.

2 A. I'm sorry. It goes from 0258.

3 Q. Right.

4 A. ECH 0258.

5 Q. Got it.

6 A. And if you look at about 1341 -- I mean,
7 1241.

8 Q. Okay, that was my confusion.

9 A. I got stuck on 13 number. And then it
10 says that oxygen -- it says: Patient back for exam.
11 Pit was turned off. DEA, gave oxygen at 10 liters.
12 Put her on her right lateral position and applied the
13 fetal scalp electrode.

14 Q. And your testimony is that the fetal scalp
15 electrode stayed on the entire time that the vacuum was
16 applied and used?

17 A. I think so. I think that's why -- yes,
18 sir.

19 Q. What are you looking at now?

20 A. I'm looking at 0310.

21 Q. What does that tell you?

22 A. It just shows me continuing to monitor the
23 baby's -- what appears to be the baby's heart rate.

24 Q. We still have the tracing --

25 A. Yes, sir.

1 Q. -- is what you're saying? Okay, got you.

2 A. Yes, sir. And until -- and maybe it was
3 wound up in the baby's hair or something else.
4 Finally, we were able to get it off. That was well
5 after delivery.

6 Q. Is there any documentation of taking it
7 off?

8 A. Well, it says on page 0311, at 1940 --
9 well, at 1942, it says FECG out, which is the fetal
10 scalp electrode.

11 Q. Where was the fetal scalp electrode
12 implanted?

13 A. On the baby's scalp somewhere, I don't
14 know.

15 Q. Was it under where you applied the bell?

16 A. I don't think so. That makes it awfully
17 hard to apply the bell, to get any pressure.

18 Q. Do you recall where it was applied?

19 A. No, sir.

20 Q. Where would you ordinarily expect it to be
21 applied?

22 A. Somewhere on the presenting part of the
23 baby. Somewhere on the crown. From ear to ear, back
24 to front.

25 Q. Same area you would be targeting for

1 placement of the bell?

2 A. Well, it might be off to the side.

3 Q. Are you familiar with the concept of a
4 ghost or phantom application of a vacuum?

5 A. No.

6 Q. To the best of your knowledge, have you
7 ever done a ghost or phantom application of a vacuum?

8 A. No, sir. Since I don't know what it is,
9 that would be really hard to do.

10 Q. You told me that you believe there were
11 three indications for vacuum in this case. One of
12 which was fetal distress?

13 A. Yes, sir.

14 Q. Tell me the basis of that please, sir.

15 A. Fetal heart tracing.

16 Q. Can you be more specific.

17 A. After rocking along rather uneventfully
18 until about 1924, we started seeing a pattern of late
19 decelerations and then deep decelerations as this baby
20 came down. You will see that, at 1928, the fetal heart
21 tones dip down after a contraction into the 90s and
22 didn't recover until well into the next contraction.
23 And dipped down again.

24 It was a prolonged deceleration that ended
25 about 1934 at which time, with the next contraction,

1 the fetal heart tones did the same thing again; this
2 time dipping down as low as 65 or so. And
3 subsequently, when I saw this next deceleration, that's
4 when I said this baby is sitting right here, I can get
5 it out; Mom can push. That's exactly what happened.
6 In two minutes, we had the baby out.

7 Q. You're saying there were two critical late
8 decels?

9 A. Well, look back at -- I described them
10 just then. Starting at 1924, you see a late
11 deceleration. Then you see another one at 1926. And
12 then at 1928, you've got another one that goes down and
13 it's profound and it stays down. And then it takes
14 five minutes to recover. To me, that's a sign this
15 baby is in trouble.

16 Q. Show me where you're measuring the
17 five-minute recovery.

18 A. From 1928 until 1934. It's actually
19 six-minute deceleration.

20 MS. CRAIG: Give those Bates stamp
21 numbers.

22 THE WITNESS: Bates stamp numbers are
23 00 -- I mean, I'm sorry -- 0309 and 0310. And the
24 fetal heart tracing, which had been perfectly fine
25 until 1923, goes down at 1924 with somewhat late

1 pattern. And then another late pattern after 1926 and
2 then recovers, but then it goes down at 1928 or
3 28-and-a-half in a late pattern that lasts from 1928
4 until 1934. Actually almost 35. And it recuperates.
5 And then as soon as the next contraction came along,
6 you see a deceleration pattern again.

7 BY MR. GRAHAM:

8 Q. All right. And that's the one I want to
9 ask you about. Where's that next deceleration pattern?

10 A. 1935. You see the heart going down,
11 coming up and going down, coming up and going down, and
12 coming up and then it's staying down. Then we
13 delivered the baby.

14 Q. When do you contend that you applied the
15 vacuum?

16 A. At 1935, which is what it says on this
17 chart.

18 Q. So that last decel you talked about, you
19 were actually applying the vacuum?

20 A. I was applying the vacuum. It takes about
21 30 seconds or so to make sure that you've got it in the
22 right place and you get appropriate pressure. Then
23 Momma pushes and baby gets delivered.

24 Q. Let me ask you about these decels you're
25 talking about starting at 1924. Would you agree with

1 me that there's good variability throughout that period
2 of time?

3 A. No, there's been very little variability
4 back, going on back. If you look at 1915, there's
5 minimal variability.

6 Q. What kind of variability are you talking
7 about? Beat to beat or long-term?

8 A. There's very little beat to beat. There's
9 very little long-term variability it looks like to me.

10 Q. All right. Would you agree with me that,
11 throughout the period of these decels you identified,
12 the mother was pushing?

13 A. She's not pushing. She --

14 MS. CRAIG: Let him finish, please.

15 THE WITNESS: She is not -- I mean, she is
16 not pushing from 1924 until 1925-and-a-half.

17 BY MR. GRAHAM:

18 Q. What do you base that on?

19 A. Look at the bottom part that shows the
20 activity of the uterus and what the mother does. She
21 is pushing from 1924-and-a-half, and two-thirds until
22 just after 1926.

23 Q. What are you looking at on the bottom
24 tracing that tells where she's pushing?

25 A. I'm looking at the pressure monitor.

1 Q. Where it goes up right here?

2 A. Yes.

3 Q. So you're saying she was not pushing from
4 when to when?

5 A. She was not pushing from 1924 and a few
6 seconds until 1926 and about 40 seconds. And she
7 pushed from 1926-and-40 seconds for about 20, 30
8 seconds. And then you have a late deceleration after
9 that.

10 Then she's pushing from 1928 until -- 15
11 seconds before 1928 until about 30 seconds after 1928.

12 And then you see the fetal heart tones go
13 down. And she had been running a steady heart rate in
14 the 150 range, some beat to beat variability but not
15 very much. Not much.

16 And then as she brings this baby down,
17 there's a deceleration, and another deceleration and
18 then a prolonged deceleration from 1928 until 1934.

19 Q. Is there any other basis for your
20 contention that fetal distress existed, which was an
21 indication for the vacuum?

22 A. Recurrent late decelerations. That's a
23 sign of fetal distress.

24 Q. And you've just told me about it?

25 A. Yes.

1 Q. There's nothing else?

2 A. I don't see anything else. I don't have
3 any other evidence. That's what we rely on.

4 Q. The other indication you asserted for use
5 of the vacuum in this case was maternal fatigue. What
6 do you base that on?

7 A. Well, you look at the video that
8 Jamesetta's family took. You'll see that she is just
9 worn out. And she was not making a very valid pushing
10 effort. I thought it was because she was tired. She
11 had been in from the night before where they had done
12 something to try and help her cervix open up. And it
13 was 7:00 at night. I thought she was worn out.

14 Q. Do you make a distinction between maternal
15 fatigue as an indication for vacuum and poor pushing as
16 an indication?

17 A. I think words to the same effect. I think
18 both things happened. She wasn't able to push because
19 she was tired and, you know. Pushing will wear you
20 out.

21 Q. Earlier, I think you said that there was
22 three indications that you contended existed for use of
23 a vacuum; fetal distress, maternal fatigue and poor
24 pushing. Did I get those right?

25 A. Yes.

1 Q. The second and the third are really the
2 same point; correct?

3 A. Well, you can push well if you're tired
4 sometimes. She was tired and didn't push well and
5 needed some help, and I gave her some help.

6 Q. Tell me the basis for your contention that
7 poor pushing was an indication for vacuum?

8 A. Well, the baby needed to be delivered. We
9 have late decelerations, which means you may be
10 compromising this baby. So instead of waste any more
11 time, there's the baby sitting right there. When I
12 pulled a little bit, then she really pushed.

13 Q. Well, my question is -- I understand you
14 claim there was fetal distress that justified use of a
15 vacuum. I understand you claim there was maternal
16 fatigue displayed on the video.

17 What is your basis for contending that
18 Jamesetta Washington was not pushing very well?

19 A. Well, with each contraction, when she
20 would push, she would not move the baby very much. She
21 would make, as you can see here -- let's go back. When
22 she had a contraction at 31, really, and 30, 40
23 seconds, she made no pushing effort.

24 Q. What page are you on now?

25 A. 310.

1 Q. Run that by me again.

2 A. You can see that at 1331 and about 40
3 seconds, she had a contraction. And, you know, she
4 just didn't push.

5 Q. You're talking about 1931?

6 A. What did I say?

7 Q. I thought you said 13.

8 A. I might have. I meant 1931, I'm sorry.

9 Q. That's okay.

10 A. I apologize.

11 Q. No problem. All right. Make that point
12 again now that I follow you. From 1931 until what?

13 A. Until 20 seconds later. She's got a
14 contraction. She doesn't push. And she doesn't really
15 push until, if you go back a little bit further, to 24.
16 She made about a 25-second push at 1926. She made a
17 considerably better push at 1927 and about 40 seconds,
18 and that one lasted about 40 seconds of pushing that
19 time.

20 Q. When did you want Jamesetta to push?

21 A. When she was having a contraction.

22 Q. Throughout labor or --

23 A. When she was having a contraction after
24 she was completely dilated. You don't push until you
25 dilate.

1 Q. After she was complete, you wanted her to
2 push with every contraction?

3 A. Yes, sir.

4 Q. And the basis for claiming that poor
5 pushing was an indication for a vacuum is that she had
6 contractions where the tracing stays in the middle of
7 the chart and doesn't go up to the top?

8 A. Yes, sir.

9 Q. Indicating to you that she wasn't pushing?

10 A. That's correct.

11 Q. And also that she wasn't moving the baby
12 very much?

13 A. The baby was sitting on the perineum, and
14 she wasn't pushing enough.

15 Q. How do you determine -- what's the basis
16 for your assertion that she was not moving the baby
17 very much?

18 A. That's why I did the vacuum extraction
19 delivery. She needed to get the baby out. It's
20 sitting there. She pushes. It doesn't move. I put
21 the vacuum on. She pushes, I pull, out comes the baby.

22 Q. Do you contend that this baby ever moved
23 much?

24 A. It was sitting on the perineum. It had
25 come from minus one station all day long down to the

1 perineum.

2 Q. Over what period of time do you claim this
3 baby went from minus one station to the perineum?

4 A. Sometime between the -- I don't know. I'd
5 have to look through this whole records to see. I
6 don't know when it was. I just know that, when I came
7 into the room at 1730 -- 1934, excuse me -- that
8 baby -- 1931, that baby was sitting on the perineum and
9 having fetal heart tone problems and --

10 MS. CRAIG: Can we take a break?

11 MR. GRAHAM: Sure.

12 THE VIDEOGRAPHER: We're going off the
13 record at 6:30 p.m.

14 (A recess transpired from 6:30 p.m. until
15 6:42 p.m.)

16 THE VIDEOGRAPHER: We're going back on the
17 record at 6:42 p.m.

18 BY MR. GRAHAM:

19 Q. Doctor, do you have any criticism of the
20 labor and delivery nurses at East Cooper?

21 A. No, sir.

22 Q. Do you accept their chart entries as being
23 true and accurate?

24 A. The ones that I've looked at, I have not
25 found no mistakes with. There may have been one or two

1 I overlooked, but I thought they were fairly accurate.

2 Q. If we were to go through and see where a
3 labor and delivery nurse last documented the station,
4 you would accept that as being the true and accurate
5 station of Jayden W at that time?

6 MS. CRAIG: Objection.

7 MR. DAVIS: Objection.

8 THE WITNESS: At that time.

9 BY MR. GRAHAM:

10 Q. Correct.

11 A. At that time.

12 Q. Yes, sir. All right. As I understand
13 your testimony, you're contending that Jayden's station
14 advanced from zero station when the nurse last charted
15 it through the perineum at 1931?

16 A. When did the nurse last chart that?

17 Q. I'm not sure. Where would you look on the
18 chart to answer that question?

19 A. We don't have to do that. If she said it
20 was zero and then it came down, that's what's supposed
21 to happen. You're rocking along, you're having labor,
22 the baby's been minus one, now it's zero, then it
23 progressed forward. If they said it was zero, and it
24 had been a little while, then that would probably be
25 accurate.

1 Q. According to the Friedman curve, should
2 the descent be fairly consistent over time?

3 A. The descent can -- it's much nicer if it
4 is. If the descent all comes at the end, then that's
5 still normal descent.

6 Q. Please explain.

7 A. When the baby gets lined up right, and
8 it's making progress through the pelvis, then that's
9 descent.

10 Q. What -- excuse me. Go ahead. Were you
11 finished?

12 A. I'm finished.

13 Q. Do you acknowledge that the baby stayed at
14 minus one station for an extensive period of time?

15 A. From in the morning at 7:00 until the
16 afternoon, yes, it did.

17 Q. To what do you attribute that lack of
18 descent?

19 A. There's so many things that can cause lack
20 of descent; presentation, the slight turning of a head
21 left or right, a slight knotch in the head where the
22 baby -- well, not coming through straight up and down.
23 Baby could be too big to get out of the pelvis.

24 In this particular case, you had somebody
25 who was essentially undilated, came in and was given a

1 drug to help her get started overnight and slowly
2 during the day she dilated. And then later in the
3 afternoon the baby descended.

4 Q. That's based on your memory?

5 A. Based on what you just told me. You said
6 somewhere along the way she got to zero. By the time
7 1934 came along, she was crowning on the perineum but
8 couldn't push the baby out.

9 Q. In terms of that last descent leading to
10 what you testified is the baby on the perineum, that's
11 all based on your memory?

12 A. Well, you said it gone from minus one to
13 zero sometime. I'm telling you that the baby was on
14 the perineum when I put the vacuum extractor on.

15 Q. Your assertion that Jayden was on the
16 perineum when you applied the vacuum is based on your
17 memory?

18 A. Yes, sir.

19 Q. There's nothing to document that in the
20 charts; correct?

21 A. No, I did not document that in the chart.

22 Q. And we've got the video?

23 A. Got the video. Baby sitting right there.
24 Vacuum is applied. She pushes. I pull. The baby
25 comes out. Very simple. Very easy. No excess

1 pressure, no excess pulling.

2 Q. You contend that the video shows Jayden's
3 head on the perineum at the time you applied the
4 vacuum?

5 A. Shows the vacuum sitting right there in my
6 hand, and it's on the perineum. And I'm pulling on the
7 baby, and it's coming out.

8 Q. When Jayden was delivered, did his head
9 have molding?

10 A. It did have -- I noted molding earlier, so
11 I'm sure it had molding when it came out.

12 Q. When did you note molding?

13 A. I didn't note molding. I noted molding
14 back -- you mean in my notes?

15 Q. Yes, sir.

16 A. At 1320. Bates stamp 0024. I think
17 that's right. Let me see if I've got that right.

18 Cervix, 45 centimeters, 80-90 percent,
19 presenting part minus one with some molding.

20 Q. When you measured minus one, you were
21 measuring --

22 A. No, I was measuring where I thought the
23 baby was at minus one excluding the molding. I've been
24 doing this for so long, you asked me all those
25 definitions earlier today. You know, I've been

1 practicing obstetrics -- I haven't practiced for three
2 years now.

3 I practiced obstetrics from 1974
4 until '05. And I forgot some of those definitions.
5 And some of them, you know, they're just technical
6 terms. I'm a clinical physician. And I practice
7 things that make sense.

8 And when I said it was minus one, I
9 thought the baby had moved down. I didn't think that
10 the molding was at minus one. I thought the molding
11 was beyond that. I'm talking about the vertex itself,
12 not the little bit of edema off of the top of the
13 baby's head.

14 Q. I thought you told me earlier that when
15 you're evaluating station, you look at the highest
16 point given that -- or the lowest point in a head-first
17 delivery?

18 A. If you're talking about molding, then
19 you're not talking about where the true vertex is. I'm
20 talking about where I think how much molding there is
21 and where the vertexes come to.

22 Q. Let me understand what you meant when you
23 put minus one station at 1320 on 17 -- excuse me -- on
24 7/16.

25 A. I thought there was some molding, that is,

1 a little bit of edema that gathers up on the baby's
2 scalp, sort of makes the baby more into a cone-like
3 thing than a square-like thing. And I thought the
4 baby's head itself; the top of the baby's head had come
5 down almost to the ischial spines, which you reminded
6 me of earlier.

7 Q. How much molding was there?

8 A. I didn't note it. I just noted that there
9 was some molding.

10 Q. How many centimeters did you assume there
11 were when you were eliminating the molding to try to
12 estimate the station?

13 A. I don't know.

14 Q. So your testimony now is that you don't
15 figure station by looking at the lowest point in the
16 birth canal. You try to reconfigure the head to what
17 it would be, where it would be if the molding wasn't
18 present?

19 A. Clinically, that's exactly what I do or
20 did. I don't do that anymore.

21 Q. What is it you compare that part of the
22 head to?

23 A. The ischial spine.

24 Q. When you said minus one station at 1320 on
25 the 16th, you were saying that the head minus the

1 molding was one centimeter above the ischial spines?

2 A. No, I think it was -- you know, I don't
3 know the answer to that question, 'cause I don't do
4 that anymore. I think that what I meant was that the
5 baby had moved down to what every obstetrician on the
6 planet or the majority of us would have called minus
7 one. And I don't know how to technically say that
8 anymore.

9 That was a clinical judgment done at that
10 time. I thought the baby was into the pelvis and was
11 making some progress. And then it made much progress
12 at the end of this but couldn't come out. So I
13 delivered it with a simple vacuum extraction after it
14 got on the perineum.

15 Q. How much molding was there when Jayden was
16 born?

17 A. I don't know. I don't recall.

18 Q. Did you document any?

19 A. No, sir.

20 Q. Would you describe his molding at birth as
21 being mild, moderate or severe?

22 A. I can't answer that question. I just said
23 that.

24 Q. Can you tell me how many centimeters his
25 molding would have been above the normal head

1 configuration without molding?

2 A. No, I never measured that in the
3 30-something years I did this.

4 Q. How did -- back in the '02 time frame, how
5 did you determine where the ischial spines were?

6 A. Well, by pelvic exam.

7 Q. Could you see them or feel them or what?

8 A. You feel them.

9 Q. Feel them. What do they feel like?

10 A. Little knobs.

11 Q. Did you see any blood clots on Jayden's
12 head?

13 A. Not that I recall.

14 Q. Are you aware of any manufacturer warnings
15 about risks of brain damage from use of its product?

16 A. No, sir.

17 Q. Are you aware of any government warnings
18 about the risk of brain damage from vacuum extractions?

19 A. No, sir.

20 Q. Were there any government warnings about
21 the use of vacuum extractions?

22 A. Mr. Graham.

23 Q. Yes, sir.

24 A. I just answered that I was not aware of
25 either manufacturer or government warnings. So I would

1 not know the answer to that question now.

2 Q. Do you deny that there were any government
3 warnings?

4 A. I don't deny or affirm that there were
5 government warnings.

6 Q. If there were government warnings, you
7 didn't change your use of vacuums in any way as a
8 result of those warnings?

9 MS. CRAIG: Objection.

10 THE WITNESS: I learned a very appropriate
11 use of vacuum extraction deliveries. I've done it over
12 a thousand times when I delivered this baby. I was
13 aware of the appropriate use of vacuum extraction or
14 assisted delivery, and so I don't understand what
15 you're even asking me.

16 BY MR. GRAHAM:

17 Q. In the last five or ten years of your
18 obstetrical practice, what journal articles, if any,
19 did you read regularly?

20 A. I read a number of journal articles.
21 Might have read the Green Journal, which is Journal of
22 American College of Obstetrics and Gynecology. Then
23 there were a bunch of throwaways. There were some
24 other books and articles that I've read, and I've been
25 to a number of meetings.

1 Q. Do you consider yourself as being
2 qualified to provide special expertise about the most
3 probable cause of Jayden's brain damage?

4 A. No. I don't know what caused Jayden's
5 brain damage, although I mentioned a number of factors.
6 I'm absolutely sure this delivery was not one of them.

7 Q. Do you blame the Mom, Jamesetta
8 Washington, for her son's brain damage?

9 A. Well, Jamesetta came with a set of
10 genetics. You know, that could be a factor in this
11 child's development. So you can't blame the Mom.
12 That's the gene she was born with. Jamesetta was --
13 had sexually-transmitted diseases. She had marijuana
14 use, alcohol use and tobacco use during this pregnancy.
15 And that may have contributed somewhat to it.

16 Q. Do you have any evidence whatsoever of a
17 genetic problem with Jayden?

18 A. No, sir, I don't. But I'm just saying
19 that can lead to brain damage.

20 Q. Do you blame the father?

21 A. I don't know the father. I don't know a
22 thing about the father.

23 Q. I asked you earlier if you had any
24 criticisms of the nurses. Do you have any criticisms
25 of any hospital employee?

1 A. About this case?

2 Q. At East Cooper, yes, sir.

3 A. Not that I can think of.

4 Q. If I should later decide to drop the
5 hospital as a Defendant in this case, you're not going
6 to testify at trial that it was -- the brain damage was
7 caused by something the hospital employees did or
8 failed to do, are you?

9 A. Not aware of anything they did or failed
10 to do.

11 Q. Do you recall anything else about this
12 case you haven't already told me about?

13 A. Not at this time.

14 Q. If you do think of something, would you
15 let your attorney know so she could tell me.

16 A. Certainly.

17 Q. Can you tell me any person at East Cooper
18 who would know what your preferences were about vacuum
19 extractions.

20 A. I hadn't delivered a baby there in almost
21 three years. I'm really not familiar with who is still
22 there or who isn't. There should be a preference card,
23 which most physicians have, so that the nurses don't
24 have to guess. And the nursing staff changes, and it's
25 easier for them to pull out a card and say: This is

1 what Dr. Rhett uses.

2 Q. Do you know who has custody of those
3 cards?

4 A. Somebody in the nursing department in
5 obstetrics and gynecology I would think. There's a
6 director of women's services. And that's a nurse
7 director. She might have that.

8 Q. Have you had an opportunity to look
9 through the prenatal records from Low Country?

10 A. I've seen a three-page record from Low
11 Country.

12 Q. Just the one in the hospital chart?

13 A. Yes, sir.

14 Q. Have you seen --

15 MR. GRAHAM: Molly, may I have those.

16 Thank you.

17 BY MR. GRAHAM:

18 Q. I'm going to hand you one of these. These
19 have been furnished to me as being a copy of the
20 prenatal records at Low Country. Have you had an
21 opportunity to see these?

22 A. No, sir.

23 Q. Could you take a moment and go through
24 this and let me know if you see anything on these pages
25 that gives you concern about the well being of

1 Jamesetta or Jayden apart from what you already told me
2 in the hospital chart, the various pages that were
3 taken from the prenatal records to put in the hospital
4 chart.

5 A. Please repeat the question.

6 Q. It was garbled, sorry. You've already
7 told me about some concerns you've had from the
8 hospital chart, exhibit 1, related to --

9 A. We have to stop for just a minute, I'm
10 sorry. My left hearing aid just stopped. Can we stop,
11 please.

12 THE VIDEOGRAPHER: We're going off the
13 record at 7:01 p.m.

14 (A recess transpired from 7:01 p.m. until
15 7:03 p.m.)

16 THE VIDEOGRAPHER: We're going back on the
17 record at 7:03 p.m.

18 BY MR. GRAHAM:

19 Q. Dr. Rhett, earlier I asked you some
20 questions about your concerns about STD, alcohol
21 ingestion, marijuana use, that sort of thing. Some of
22 that was reflected in prenatal records that were made a
23 part of the hospital chart. I don't want to replot
24 that old ground.

25 Would you please go through these Low

1 Country prenatal records and let me know if you see
2 anything else that gives you concern about the
3 well-being of the mother or the baby.

4 A. Looks like little bit of continuation of
5 the same chart that we have.

6 Q. Could you refer to the page number.

7 I will make this exhibit 3.

8 A. You want me to go through the Palmetto?

9 Q. Well, is Palmetto part of this record?

10 A. Palmetto is included in what you've handed
11 me.

12 Q. Okay, then, yes, I would like you to go
13 through it.

14 A. I'm not familiar with Palmetto's way of
15 laying stuff out. This is a little bit difficult, so I
16 apologize.

17 Q. No problem. Take your time.

18 A. May I ask y'all a question about the
19 Palmetto records? Is May the 8th in 2002 in the right
20 upper hand, if you look at LC OBGYN 0023, for example,
21 if you look up in the -- right up -- is that the date
22 it was copied? Do y'all know?

23 Q. I don't know. I will point out on that
24 same page 23, there's a date here 4/8/02 and 5/8/02, so
25 I don't know. Does something on that page concern you?

1 A. I didn't understand. I now see how they
2 do it. The only thing I see in that part of the
3 prenatal record, she had a continuing Trichomonas
4 infection. She was treated a number of times in March,
5 April and May.

6 I've never seen this before, I'm sorry. I
7 assumed you wanted me to look at it also. I apologize.

8 Q. I do. No, take your time.

9 A. I'm not sure I can see it all anyhow.

10 Ask your question again.

11 Q. As you reviewed the records from Low
12 Country, which we're about to mark as Plaintiff's
13 Exhibit 3, do you see anything in those records that
14 causes you to have concern about the well-being of
15 Jamesetta or Jayden that you haven't already told me
16 about?

17 MS. CRAIG: Objection.

18 THE WITNESS: I do see that she had a
19 long-running Trichomonas infection, never could get
20 cleared up. That lasted over four months. I see that
21 she had said to her previous group that she continued
22 drinking and marijuana into November of the year before
23 her delivery. Other than that, I saw nothing else.

24 BY MR. GRAHAM:

25 Q. Can you show me the records in November,

1 please.

2 On Bates stamp 0076, under past medical
3 history, it says tobacco positive past month, her last
4 use 10/01. Alcohol use positive, last use 11/01, beer
5 and liquor. Positive drug use, last use 11/01. So she
6 didn't stop in October; she stopped in November. That
7 was just the only difference I saw.

8 Q. Okay. You're assuming these entries to be
9 true?

10 A. I'm just reading the record as it's
11 presented to me.

12 Q. Okay. Yes, sir. All right. Anything
13 else?

14 A. I didn't find anything out of 80 pages.

15 Q. I understand. Thank you, sir.

16 (PLF. EXH. 3, Low County Obstetrics and
17 Gynecology medical records, Bates stamped LC OB/GYN
18 0001 through 0098, was marked for identification.)

19 BY MR. GRAHAM:

20 Q. Doctor, do you claim to remember exactly
21 where you placed the bell of the vacuum device in this
22 case?

23 A. Placed it on the presenting crown.

24 Q. You can't be even more specific than that?

25 A. No, sir.

1 (PLF. EXH. 4, Notice of video deposition,
2 was marked for identification.)

3 BY MR. GRAHAM:

4 Q. Doctor, I hand you a document that's been
5 marked Plaintiff's Exhibit 4. This is a Notice of your
6 deposition here today. If you look at the last two
7 lines on page 1 and continuing on to the back, we asked
8 that you bring today certain documents. Have you seen
9 this before?

10 A. I think I received this. You know, I've
11 gotten a lot of stuff. Do I specifically remember
12 seeing this, no. It's just amongst all the things.

13 Q. Are you aware of any medical records
14 relating to the labor and delivery of Jamesetta
15 Washington involving her son Jayden other than the
16 records we've been over so far today?

17 A. No, sir.

18 Q. Do you have any office notes relating to
19 your involvement in this case other than what we've
20 gone over?

21 A. Not that I recall.

22 Q. Do you have any telephone notes or
23 messages relating to this case other than
24 attorney-client communication?

25 A. No, sir.

1 Q. Do you have any billing records relating
2 to this case?

3 A. No, sir.

4 Q. Do you have any typed or handwritten
5 notes?

6 A. No, sir.

7 Q. Correspondence?

8 A. No, sir.

9 Q. Memos of any kind?

10 A. No, sir.

11 Q. Do you have any calendars that would show
12 what was going on in your professional or personal life
13 during the time frame of this delivery?

14 A. No, sir.

15 Q. Any diaries or journals that would reflect
16 your activities of those dates?

17 A. No, not that I'm aware of.

18 Q. What materials have you reviewed in
19 preparation for this deposition?

20 A. The medical record that I had and talked
21 with my attorney.

22 Q. Have you reviewed any literature in
23 connection with this case?

24 A. No, sir.

25 Q. Do you have a CV?

1 A. Not with me.

2 Q. Do you have one, though?

3 A. Yes, sir, I do.

4 Q. Could you please furnish that to your
5 attorney so that she can furnish it to me. We had
6 asked that be here today.

7 A. I'm sorry.

8 Q. That's all right.

9 A. I must have missed that.

10 Q. That's all right.

11 A. I apologize. I will get that to her
12 tomorrow.

13 Q. Thank you.

14 (This page contains information to be
15 supplied by the deponent.)

16 BY MR. GRAHAM:

17 Q. Have you felt well throughout the
18 deposition?

19 A. Except when it got hot, and that little
20 spot at the end of the first break.

21 MS. CRAIG: I apologize.

22 BY MR. GRAHAM:

23 Q. We're in your attorney's office; don't
24 blame me for being hot.

25 A. Yes, sir.

1 Q. Are you under the influence of any drug or
2 substance that would affect your ability to understand
3 my questions and --

4 A. No, sir.

5 Q. -- give your answers?

6 A. No, sir. I interrupted you, and I
7 apologize.

8 Q. That's okay. No problem. Have you
9 understood all of my questions?

10 A. I think I did.

11 Q. Now, I'm going to give you a chance to go
12 back, if you would like to, and explain to me how you
13 determine when a baby's head is engaged.

14 A. Well, I hadn't thought about it in so long
15 until you asked me. And so let me think about it just
16 a second and see if I can put together a --

17 Q. Sure.

18 A. -- synopsis that would make some sense. I
19 know what I said earlier didn't make any sense. It
20 didn't make any sense to me.

21 I'll give it a shot. There's a clinical
22 evaluation that I do that is -- that I've done, until I
23 quit doing obstetrics, I've done for so long that I
24 think I almost -- it was so much a rote of what I did.

25 When you asked me the question about the

1 ischial spines, my brain just didn't want to think
2 about those things. I wasn't trying to be defensive, I
3 just couldn't think of the words. And I can promise
4 you that before I go to bed tonight I will have read
5 that part of the anatomy again. That would be
6 different than if we go to court than what I would say
7 now.

8 Basically, on a clinical basis, and
9 there's a definition that says that some part of the
10 cranium needs to come down to the level of the ischial
11 spines in order to be engaged. And if the forward most
12 part of the head in a nonmolded head doesn't get to
13 those spines, that baby's really not engaged. And
14 that's a clinical exam.

15 I've done those literally tens of
16 thousands of times because you're checking women all
17 throughout their pregnancy and you're checking them all
18 throughout labor and delivery. And so until -- and
19 when the presenting part comes down past the ischial
20 tuberosities, which are sitting right there, you have
21 some idea.

22 If ten obstetricians that were experienced
23 all examined somebody, there would be three answers as
24 to what station they are. And there would probably be
25 two or three answers as to how much dilation. It's a

1 clinical thing; it's not done with a micrometer.

2 And to answer your question, because the
3 more we went through this, the more I started thinking
4 about exactly what did I used to do. You examine
5 somebody. You can tell if a baby's head is just
6 floating up out of the pelvis; that was obviously not
7 engaged.

8 As the cervix became more dilated, you can
9 tell when that head came down. And truly, the forward
10 part of the head would be past the ischial tuberosity.
11 Not having thought about that in three years, I might
12 get a little mixed up in that terminology right now.
13 And I would have to go back and just sort of reread to
14 get that correct.

15 Q. SO as you sit here today, can you tell me
16 with confidence what engagement is?

17 A. Engagement is, no, I can't do it. It's a
18 clinical thing. I could tell you if I went and
19 examined somebody today what it was, but I couldn't
20 write out a definition so, no, sir, I could not tell
21 you.

22 Q. If a baby has just become engaged in the
23 birth canal, what is his or her station?

24 A. Minus two.

25 Q. How do you determine that?

1 A. By vaginal exam.

2 Q. Explain to me where the minus two comes
3 from. Minus two above what?

4 A. It's supposed to be some part of a head
5 above the ischial tuberosities, but I can't remember
6 that answer right now. That's what I already explained
7 to you.

8 But clinically having done this for
9 literally thousands of deliveries, I knew exactly what
10 I meant by that and, you know, it's just a clinical
11 use. It's not a definition I could write down.
12 Obviously, I can't even say it here.

13 Q. Of all the thousands of vacuum extractions
14 that you have done, how many were -- how many did you
15 consider to be an outlet delivery?

16 A. Almost all of them. It would be very rare
17 to try and assist somebody that really wasn't about to
18 push the baby out but couldn't quite make it.

19 Q. Give me your definition of an outlet
20 vacuum extraction.

21 A. Plus two station or better. By whatever I
22 meant by that.

23 Q. How do you determine plus two station?

24 A. By vaginal exam. By clinical experience
25 and vaginal exam. I can't give you a definition of

1 that.

2 Q. As you sit here today, you can't give me a
3 definition of what plus two means?

4 A. No.

5 Q. What is -- how many times do you contend
6 you have done a low vacuum extraction?

7 A. I don't know. Maybe 100.

8 Q. What is your definition of a low vacuum
9 extraction?

10 A. Just above minus two.

11 Q. How much above minus two?

12 A. Not more than a centimeter or two. It
13 looks like somebody has the ability to push a baby out.
14 They've brought the baby down so that it is low in the
15 pelvis, plus two, plus one. Then applying the vacuum
16 and giving it an attempt to deliver is very
17 appropriate. I would think that I attempted some that
18 never made it; baby wouldn't come out. And we ended up
19 doing a C-section.

20 Q. Let me make sure. When you were talking
21 about low vacuum extraction, did you say minus two or
22 plus two?

23 A. Oh, I might have said minus two, but I
24 meant to say plus two. I'm so sorry. I'm not going to
25 reach up to somebody's liver to get their baby out.

1 Q. So you meant plus two or slightly higher?

2 A. Or slightly higher.

3 Q. So plus one to plus two?

4 A. Yes, sir.

5 Q. How many times have you done a mid vacuum
6 extraction?

7 A. Zero.

8 Q. You've never done that?

9 A. I don't think -- I might have attempted.
10 How many of them were successful?

11 Q. How many have you attempted?

12 A. A few.

13 Q. What is your definition of a mid pelvic
14 vacuum extraction?

15 A. Zero. At the zero station.

16 Q. Zero station is mid pelvic?

17 A. That would be mid pelvic. Somebody who's
18 got -- but I don't think I attempted many of those in
19 the last ten years when I was practicing.

20 Q. How many times have you attempted a high
21 vacuum extraction?

22 A. Zero.

23 Q. What is your definition of a high vacuum
24 extraction?

25 A. Unengaged.