

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

Samantha Jamison, as Personal Representative of the
Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

Ansley L. Hilton, MD, individually and as agent,
servant or employee of Rock Hill Gynecological
and Obstetrical Associates, PA; Christopher B.
Benson, MD, as agent, servant or employee of Rock
Hill Gynecological and Obstetrical Associates, PA;
and Rock Hill Gynecological and Obstetrical Associates,
PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

RECORD ON APPEAL
VOLUME I OF II

James W. Boyd
Post Office Box 36425
Rock Hill, SC 29732
(803) 328-2600

D. Bradley Jordan
P.O. Box 11785
Rock Hill, SC 29731
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Attorneys for Appellant

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF YORK
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP4600683

Samantha Jamison

Ansley L Hilton
Rock Hill Gynecological
And Obstetrical
Associates PA

Christopher B Benson

PLAINTIFF(S)

DEFENDANT(S)

Submitted by:

Attorney for: ☐ Plaintiff ☐ Defendant
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☐ JURY VERDICT. This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ DECISION BY THE COURT. This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ ACTION DISMISSED (CHECK REASON): ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit);
☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____
- ☐ ACTION STRICKEN (CHECK REASON): ☐ Rule 40(j) SCRCP; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other:

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☒ See attached order; (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☐ ends ☐ does not end the case.

Additional Information for the Clerk: ORDER DENYING MOTION FOR RECONSIDERATION

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Steven H. John

Circuit Court Judge

2129

Judge Code

7/15/2013

Date

For Clerk of Court Office Use Only

This judgment was entered on July 15, 2013, and a copy mailed first class or placed in the appropriate attorney's box on July 15, 2013, to attorneys of record or to parties (when appearing pro se) as follows:

David Bradley Jordan PO Box 11785 546 East Main Street
Rock Hill, SC 29731
James W. Boyd 1544 Ebenezer Rd. PO Box 36425 Rock Hill,
SC 29732

Ashby W. Davis 5 Hawthorne Park Ct. Greenville, SC 29615
David Williford

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

David Hamilton

Court Reporter

David Hamilton - Clerk of Court

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

STATE OF SOUTH CAROLINA
COUNTY OF YORK

Samantha Jamison, as Personal Representative
of the Estate of Jayden Joenelle Jamison-
Barber, Deceased,

Plaintiff,

vs.

Ansley L. Hilton, M.D., Individually and as
Agent, Servant or Employee of Rock Hill
Gynecological and Obstetrical Associates,
P.A.; Christopher B. Benson, M.D., as Agent,
Servant or Employee of Rock Hill
Gynecological and Obstetrical Associates,
P.A., and Rock Hill Gynecological and
Obstetrical Associates, P.A.,
Defendants.

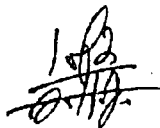
IN THE COURT OF COMMON PLEAS
FOR THE SIXTEENTH JUDICIAL CIRCUIT

CASE NO.: 2011-CP-46-00683

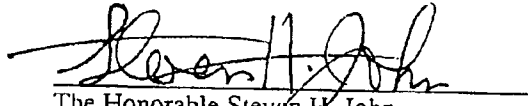
**ORDER DENYING MOTION FOR
RECONSIDERATION**

FILED-RECEIVED
2013 JUL 15 AM 9:39
DAVID HAMILTON
C.C.P. & GS
YORK COUNTY, SC

This case came before the Court for trial April 8 through April 12, 2013. After a verdict was rendered, the Defense requested to file post-trial motions within ten (10) days. The trial judge being a visiting judge declined the request pursuant to Rules 50 and 59, *SCRCP*, and required the Defendants to go forward with all of their post-trial motions. The Court heard and denied the Defendants' oral post-trial motions. The Defendants thereafter on April 25, 2013 filed post-trial motions, including a Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict, and Motion to Alter or Amend the Judgment. Because the Court denied the oral motions and did not grant leave to file motions, the Court considers the filed motions as a Motion to Reconsider. The Court has considered all of the issues raised in the filed Motion for Reconsideration. The Court espoused its reasons for denying the post-trial motions during and at the end of the case and finds that any additional hearing would be redundant and unnecessary. Therefore, the Court



denies the Motion to Reconsider based on the facts presented at trial and the reasons set forth by the Court in the record of this case.


The Honorable Steven H. John
Presiding Judge
Sixteenth Judicial Circuit

July 11, 2013
At Chambers, South Carolina

2


STATE OF SOUTH CAROLINA

COUNTY OF YORK

Samantha Jamison

IN THE COURT OF COMMON PLEAS

CIVIL ACTION COVERSHEET

2011-CP - 46- 00683

vs.

Ansley L. Hilton, M.D., Christopher B. Benson,)
M.D., et al

Defendant(s))

(Please Print)

Submitted By: D. Bradley Jordan

Address: Jordan Law Firm PC

PO Box 11785

Rock Hill SC 29730

SC Bar #:

Telephone #: 803-817-7999

Fax #: 803-817-9704

Other:

E-mail: bradjordan@comporium.net

NOTE: The cover sheet and information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law. This form is required for the use of the Clerk of Court for the purpose of docketing. It must be filled out completely, signed, and dated. A copy of this cover sheet must be served on the defendant(s) along with the Summons and Complaint.

DOCKETING INFORMATION (Check all that apply)

*If Action is Judgment/Settlement do not complete

- ☒ JURY TRIAL demanded in complaint. ☐ NON-JURY TRIAL demanded in complaint.
☐ This case is subject to ARBITRATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is subject to MEDIATION pursuant to the Court Annexed Alternative Dispute Resolution Rules.
☐ This case is exempt from ADR (Proof of ADR/Exemption Attached)

NATURE OF ACTION (Check One Box Below)

☐ Contracts ☐ Constructions (100) ☐ Debt Collection (110) ☐ Employment (120) ☐ General (130) ☐ Breach of Contract (140) ☐ Other (199)	☐ Torts - Professional Malpractice ☐ Dental Malpractice (200) ☐ Legal Malpractice (210) ☒ Medical Malpractice (220) ☐ Notice/ File Med Mal (230) ☐ Other (299)	☐ Torts - Personal Injury ☐ Assault/Slander/Libel (300) ☐ Conversion (310) ☐ Motor Vehicle Accident (320) ☐ Premises Liability (330) ☐ Products Liability (340) ☐ Personal Injury (350) ☐ Wrongful Death (360) ☐ Other (399)	☐ Real Property ☐ Claim & Delivery (400) ☐ Condemnation (410) ☐ Foreclosure (420) ☐ Mechanic's Lien (430) ☐ Partition (440) ☐ Possession (450) ☐ Building Code Violation (460) ☐ Other (499)
☐ Inmate Petitions ☐ PCR (500) ☐ Mandamus (520) ☐ Habeas Corpus (530) ☐ Other (599)	☐ Judgments/Settlements ☐ Death Settlement (700) ☐ Foreign Judgment (710) ☐ Magistrate's Judgment (720) ☐ Minor Settlement (730) ☐ Transcript Judgment (740) ☐ Lis Pendens (750) ☐ Other (799)	☐ Administrative Law/Relief ☐ Reinstate Driver's License (800) ☐ Judicial Review (810) ☐ Relief (820) ☐ Permanent Injunction (830) ☐ Forfeiture-Petition (840) ☐ Forfeiture-Consent Order (850) ☐ Other (899)	☐ Appeals ☐ Arbitration (900) ☐ Magistrate-Civil (910) ☐ Magistrate-Criminal (920) ☐ Municipal (930) ☐ Probate Court (940) ☐ SCDOT (950) ☐ Worker's Comp (960) ☐ Zoning Board (970) ☐ Administrative Law Judge (980) ☐ Public Service Commission (990) ☐ Employment Security Comm (991) ☐ Other (999)
☐ Special/Complex /Other ☐ Environmental (600) ☐ Automobile Arb. (610) ☒ Medical (620) ☐ Other (699)	☐ Pharmaceuticals (630) ☐ Unfair Trade Practices (640) ☐ Out-of State Depositions (650) ☐ Sexual Predator (510)		

Submitting Party Signature:

Date: February 17, 2011

Note: Frivolous civil proceedings may be subject to sanctions pursuant to SCRCP, Rule 11, and the South Carolina Frivolous Civil Proceedings Sanctions Act, S.C. Code Ann. §15-36-10 et. seq.

FOR MANDATED ADR COUNTIES ONLY
Allendale, Anderson, Beaufort, Colleton, Florence, Greenville,
Hampton, Horry, Jasper, Lexington, Pickens (Family Court Only), and Richland

SUPREME COURT RULES REQUIRE THE SUBMISSION OF ALL CIVIL CASES TO AN ALTERNATIVE DISPUTE RESOLUTION PROCESS, UNLESS OTHERWISE EXEMPT.

You are required to take the following action(s):

1. The parties shall select a neutral and file a "Proof of ADR" form on or by the 210th day of the filing of this action. If the parties have not selected a neutral within 210 days, the Clerk of Court shall then appoint a primary and secondary mediator from the current roster on a rotating basis from among those mediators agreeing to accept cases in the county in which the action has been filed.
2. The initial ADR conference must be held within 300 days after the filing of the action.
3. Pre-suit medical malpractice mediations required by S.C. Code §15-79-125 shall be held not later than 120 days after all defendants are served with the "Notice of Intent to File Suit" or as the court directs. (Medical malpractice mediation is mandatory statewide.)
4. Cases are exempt from ADR only upon the following grounds:
 - a. Special proceeding, or actions seeking extraordinary relief such as mandamus, habeas corpus, or prohibition;
 - b. Requests for temporary relief;
 - c. Appeals
 - d. Post Conviction relief matters;
 - e. Contempt of Court proceedings;
 - f. Forfeiture proceedings brought by governmental entities;
 - g. Mortgage foreclosures; and
 - h. Cases that have been previously subjected to an ADR conference, unless otherwise required by Rule 3 or by statute.
5. In cases not subject to ADR, the Chief Judge for Administrative Purposes, upon the motion of the court or of any party, may order a case to mediation.
6. Motion of a party to be exempt from payment of neutral fees due to indigency should be filed with the Court within ten (10) days after the ADR conference has been concluded.

Please Note: You must comply with the Supreme Court Rules regarding ADR.
Failure to do so may affect your case or may result in sanctions.

STATE OF SOUTH CAROLINA)
COUNTY OF YORK :

IN THE COURT OF COMMON PLEAS

CASE NO. 2011-CP-46- 00683

Samantha Jamison,

Plaintiff,

vs.

Ansley L. Hilton, M.D., Individually and
as Agent, Servant or Employee of
Rock Hill Gynecological and Obstetrical
Associates, P.A.; Christopher B. Benson,
M.D., As Agent, Servant or Employee of
Rock Hill Gynecological and Obstetrical
Associates, P.A., and Rock Hill
Gynecological and Obstetrical Associates
P.A.,

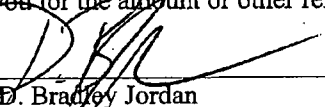
Defendants.

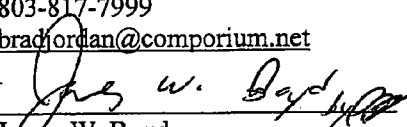
SUMMONS

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2011 FEB 17 AM 8:58
DAVID HAMILTON
C.C.P. & G.S. SC
YORK COUNTY, SC

TO: THE DEFENDANTS NAMED ABOVE:

YOU ARE SUMMONED AND REQUIRED to answer the Complaint in this Action of which a copy is herewith served upon you, and to serve a copy of your answer on the subscribed at his office, 546 East Main Street, Post Office Box 11785, Rock Hill, South Carolina 29731, within thirty (30) days after the service hereof, exclusive of the day of such service, and if you fail to answer the Complaint within the prescribed time, a judgment by default may be entered against you for the amount or other remedy requested in the attached complaint.


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Jordan Law Firm, PC
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Rock Hill, South Carolina 29731
803-817-7999
bradjordan@comporium.net


James W. Boyd
P.O. Box 36425
Rock Hill, South Carolina 29732
803-328-2600
JamesBoyd@comporium.net

Rock Hill, South Carolina
2/16, 2011

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS
SIXTEENTH CIRCUIT COURT

CASE NO.: 2011-CP-46-00683

Samantha Jamison,)

Plaintiff,)

COMPLAINT

Ansley L. Hilton, M.D., Individually and)
as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A.; Christopher B. Benson,)
M.D., as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A., and Rock Hill)
Gynecological and Obstetrical Associates)
P.A.,)

Defendants.)

JURY TRIAL REQUESTED

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2011 FEB 17 AM 8:58
DAVID HAMILTON
C.C. CP & G.S.
YORK COUNTY, SC

The Plaintiff, above named, complaining of the above Defendants would respectfully show to this honorable Court as follows:

GENERAL ALLEGATIONS

1. The Plaintiff is a citizen and resident of Chester County, South Carolina.
2. The Defendant, Ansley L. Hilton, upon information and belief, is a physician who treated the Plaintiff, Samantha Jamison, and, upon information and belief, is a citizen and resident of York County, South Carolina and is, at all times hereinafter mentioned, is a medical doctor with a practice known as Rock Hill Gynecological and Obstetrical Associates, P.A. located in York County, Rock Hill, South Carolina. Upon information and belief, at all times hereinafter mentioned, Dr. Hilton was and is an agent, servant and employee of Rock Hill Gynecological and Obstetrical Associates, P.A.
3. The Defendant, Christopher B. Benson, upon information and belief, is a physician who treated the Plaintiff, Samantha Jamison and, upon information and belief, is a citizen and resident of

York County, South Carolina and is, at all times hereinafter mentioned, a medical doctor with a practice known as Rock Hill Gynecological and Obstetrical Associates, P.A., located in York County, Rock Hill, South Carolina. Upon information and belief, at all times hereinafter mentioned, Dr. Benson was and is an agent, servant and employee of Rock Hill Gynecological and Obstetrical Associates, P.A.

4. The Defendant, Rock Hill Gynecological and Obstetrical Associates, P.A., upon information and belief, is a South Carolina corporation with its principal place of business in York County, Rock Hill, South Carolina. The Defendant, Rock Hill Gynecological and Obstetrical Associates, P.A. is engaged in the practice of medicine in York County, South Carolina, from which its shareholders derive substantial economic benefit. At all times hereinafter mentioned, Rock Hill Gynecological and Obstetrical Associates, P.A., by and through its agents, servants and employees, namely Dr. Ansley L. Hilton and Dr. Christopher B. Benson, treated the Plaintiff, Samantha Jamison.

5. On or about July 18, 2008, the Plaintiff was seen by Dr. Benson for a prenatal visit and, according to an ultrasound, the estimated date of delivery was changed to November 1, 2008 in accordance with gestational age. The ultrasound also showed that the average measurements were at twenty-four (24) weeks and six (6) days.

6. The Plaintiff was seen for a follow up visit on July 28, 2008. The gestational weeks were noted to be 30.6 weeks with fundus size noted at 29. Fetal heart tones were documented as present. The Plaintiff was again seen by Dr. Benson on August 11, 2008. Thirty-Three (33) weeks was noted on the Plaintiff's chart, but was crossed out and replaced with 28.3 weeks.

7. The Plaintiff was next seen on August 25, 2008. At that time, another ultrasound was ordered, and that ultrasound indicated that the fetus had an estimated weight of two (2) pounds eight (8) ounces. The estimated delivery date was changed to November 16, 2008. Documentation on the

ultrasound notes that the abdominal circumference was behind two (2) weeks from the previous scan and the amniotic fluid index was down to nine (9). There are no progress notes in the Plaintiff's chart to discuss why there was low amniotic fluid, nor was any test ordered to assess this condition. Further, no biophysical profile was ordered to determine how the fetus was developing.

8. On September 5, 2008, the Plaintiff was seen by Dr. Hilton. Dr. Hilton noted decreased fetal movement and heart tones, showing patterns of deceleration. The Plaintiff was in premature labor with contractions occurring every three (3) to four (4) minutes. The Plaintiff was told by Dr. Hilton to drive herself to Piedmont Medical Center and was given instructions to go directly to the labor and delivery. Dr. Hilton did not call for an ambulance so that the Plaintiff might be continually monitored as to the progression of her labor and treated as emergent upon her arrival at Piedmont.

9. At 11:40 a.m., some 2 ½ hours after arriving at Dr. Hilton's office, the Plaintiff was admitted to Piedmont Medical Center. At that juncture, the nurse's notes indicate the inability to hear any fetal heart tones. At 12:00 p.m., the records note that Dr. Benson determined intrauterine fetal demise and a C-section was performed by Dr. Benson to remove the fetus.

10. The Defendants owed a duty of due care to the Plaintiff. The Defendants breached that duty and were negligent, reckless, willful, wonton, and grossly negligent in the following particulars:

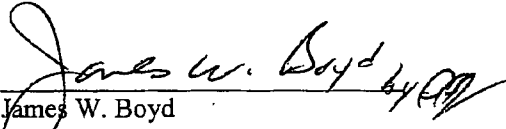
- a. in failing to properly establish a true estimated date of delivery;
- b. in failing to note in the Plaintiff's office chart, the Plaintiff's blood pressure, weight, number of weeks pregnant, and whether urine was tested during the patient's visit to the Defendant's office on September 5, 2008;
- c. in altering the patient's chart by manually striking through 33 weeks and replacing it with 28.3 weeks;

- d. in failing to properly assess the Plaintiff's condition as to a significant drop in the amniotic fluid index and identifying what problems might be causing that drop;
 - e. in failing to timely perform proper testing (biophysical profile) to ensure normal fetal development and growth;
 - f. in failing to properly assess an emergent situation on September 5, 2008, when the medical records indicated that the physician, Dr. Hilton, felt that there were complications to the Plaintiff's pregnancy;
 - g. in failing to properly assess and continually monitor the Plaintiff's premature labor on September 5, 2008;
 - h. in failing to continually monitor the patient to ensure the safety of the fetus, rather than informing the Plaintiff to get herself to the hospital, without explaining to the patient, that time was of the essence in obtaining immediate attention in labor and delivery upon her arrival at the hospital;
 - i. in failing to call for an ambulance to take the patient to labor and delivery at Piedmont Medical Center due to signs of fetal complications, namely decreased fetal movement, fetal heart rate variables, and a prior history of rupture of her uterus.
11. As a direct and proximate cause of the aforesaid negligent, willful, wanton and grossly negligent acts committed by all of the Defendants, jointly and severally, the Plaintiff sustained personal injuries including but not limited to:
- a. medical expense, past, present, and future;
 - b. loss of income;
 - c. pain and suffering, past, present and future;
 - d. loss of enjoyment of life;

- e. anxiety and emotional distress due to the loss of her unborn child;
 - f. other injuries and damages that may be determined.
12. The Plaintiff is entitled to actual and punitive damages as may be awarded.

WHEREFORE, the Plaintiff prays for judgment against the Defendants, jointly and severally, in an amount of actual damages and punitive damages as may be awarded by a jury and for such other and further relief as the Court may deem just and proper.

Rock Hill, South Carolina
February 16, 2011


James W. Boyd
1544 Ebenezer Road
P. O. Box 36425
Rock Hill, SC 29732
(803) 328-2600


D. Bradley Jordan
Jordan Law Firm, PC
546 East Main Street
P.O. Box 11785
Rock Hill, SC 29731
(803) 817-7999

ATTORNEYS FOR PLAINTIFF

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

Samantha Jamison,)
Plaintiff,)

v.)

Ansley L. Hilton, M.D., Individually)
and as Agent, Servant or Employee)
of Rock Hill Gynecological and)
Obstetrical Associates, P.A.;)
Christopher B. Benson, M.D., as)
Agent, Servant or Employee of)
Rock Hill Gynecological and)
Obstetrical Associates, P.A., and)
Rock Hill Gynecological and)
Obstetrical Associates, P.A.,)
Defendants.)

IN THE COURT OF COMMON PLEAS

C.A. No.: 2011-CP-46-00683

ANSWER OF DEFENDANTS

FILED-RECEIVED
2011 MAR 21 AM 11:43
DAVID HAMILTON
C.C.P. & GS
YORK COUNTY, SC

TO: D. BRADLEY JORDAN AND JAMES W. BOYD, ATTORNEYS FOR PLAINTIFF:

NOW COME Defendants, answering the Complaint of the Plaintiff as follows:

1. These Defendants, upon information and belief, admit the allegations contained in Paragraph 1 of the Complaint.
2. These Defendants admit the allegations contained in Paragraphs 2 and 3 of the Complaint. Answering Paragraph 4 of the Complaint, these Defendants admit that Rock Hill Gynecological and Obstetrical Associates, P.A. is a South Carolina corporation with its principal place of business in York County. Further, these Defendants admit that Rock Hill Gynecological and Obstetrical Associates, P.A. is engaged in the practice of obstetrics and gynecology in York County, South Carolina and that all times mentioned in the Complaint, Rock Hill Gynecological and Obstetrical Associates, P.A., by and through its agents, servants and employees, including Dr. Hilton and Dr. Benson, treated the Plaintiff, Samantha Jamison.

3. Answering Paragraphs 5, 6, 7, 8, and 9 of the Complaint, these Defendants admit that Samantha Jamison was appropriately treated by Dr. Benson, Dr. Hilton, and other agents, servants, and employees of Rock Hill Gynecological and Obstetrical Associates, P.A., which were all prenatal visits as documented by the office records of Rock Hill Gynecological and Obstetrical Associates, P.A. These Defendants further admit that the care rendered to the Plaintiff during each and every prenatal visit was appropriate and well within the acceptable standard of care for obstetricians and gynecologists in the same or similar circumstances. These Defendants further admit that all indicated examinations and testing was performed during the prenatal visits and that the Plaintiff was appropriately examined and appropriate diagnostic tests were performed throughout her prenatal visits including September 5, 2008. These Defendants admit that the Plaintiff was appropriately examined on that day, appropriate tests were performed, and she was appropriately instructed to immediately present to Piedmont Medical Center. These Defendants further admit that in spite of the care provided by these Defendants to the Plaintiff it was determined that there was an intrauterine fetal demise. Any allegation contained in Paragraphs 5, 6, 7, 8, and 9 of the Complaint that has not been specifically admitted is hereby denied and strict proof demanded thereof.

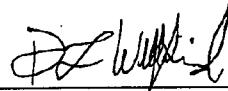
4. These Defendants admit that all the care and treatment provided to the Plaintiff by these Defendants was appropriate and well within the standard of care for a patient similarly situated and under similar circumstances and conditions.

5. Answering Paragraphs 10, 11, and 12 of the Complaint, these Defendants admit that they owed a duty of care to the Plaintiff, and these Defendants admit that all the care and treatment provided to the Plaintiff in accordance with that duty was well within the standard of care. These Defendants hereby specifically deny each and every remaining allegation contained in Paragraphs 10, 11, and 12 of the Complaint and demand strict proof thereof.

6. Any allegation contained in the Complaint that has not been specifically admitted is hereby denied and strict proof demanded thereof.

WHEREFORE, having fully answered the Complaint of the Plaintiff, these Defendants request that the action be dismissed as to them, with costs, and any other relief deemed just and appropriate by this Honorable Court.

Respectfully Submitted,



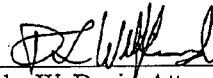
Ashby W. Davis, Esquire (SC Bar #1560)
David L. Williford, Esquire (SC Bar #73129)
DAVIS & SNYDER, P.A.
5 Hawthorne Park Court
Greenville, SC 29615
(864) 335-3500

ATTORNEYS FOR DEFENDANTS

March 18, 2011

Greenville, South Carolina.

**THESE DEFENDANTS
RESPECTUFLY DEMAND TRIAL
BY JURY.**



Ashby W. Davis, Attorney for Defendants
David L. Williford, Attorney for Defendants

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS

Samantha Jamison,

C.A. No.: 2011-CP-46-00683

Plaintiff,

v.

Ansley L. Hilton, M.D., Individually)
and as Agent, Servant or Employee)
Of Rock Hill Gynecological and)
Obstetrical Associates, P.A.;)
Christopher B. Benson, M.D., as)
Agent, Servant or Employee of)
Rock Hill Gynecological and)
Obstetrical Associates, P.A., and)
Rock Hill Gynecological and)
Obstetrical Associates, P.A.,)

Defendants.)

FILED-RECEIVED
2011 MAR 21 AM 11:43
DAVID HAMILTON
C.C.P. & GS
YORK COUNTY, SC

CERTIFICATE OF SERVICE

I hereby certify that I have this date served a copy of the within and foregoing **Answer of the Defendants, Defendants' First Set of Interrogatories to the Plaintiff and Defendants' First set of Requests for Production to the Plaintiff** upon the Plaintiff by depositing a copy of same in the United States Mail with first class postage addressed to:

James W. Boyd, Esquire
PO 36425
Rock Hill, SC 29732

D. Bradley Jordan, Esquire
Jordan Law Firm, PC
PO Box 11785
Rock Hill, SC 29732

This 18 day of March, 2011.

By:

Colette M. Kitchel
DAVIS & SNYDER, P.A.

Greenville, South Carolina.

STATE OF SOUTH CAROLINA)
)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS
SIXTEENTH CIRCUIT COURT

CASE NO.: 2010-CP-46-00683

Samantha Jamison, as Personal)
Representative of the Estate of)
Jayden Joenelle Jamison-Barber, Deceased,)

Plaintiff,)

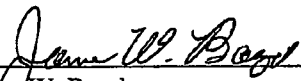
SUMMONS

Ansley L. Hilton, M.D., Individually and)
as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A.; Christopher B. Benson,)
M.D., as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A., and Rock Hill)
Gynecological and Obstetrical Associates)
P.A.,)

Defendants,)

TO THE DEFENDENT ABOVE NAMED:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action,
a copy of which is attached hereto and herewith served upon you, and to serve a copy of your
Answer to this Complaint upon the subscriber at 1544 Ebenezer Road, Post Office Box 36425,
Rock Hill, South Carolina, 29732 within thirty (30) days after the service hereof, exclusive of the
day of such service. If you fail to answer the Complaint within the thirty day period, the Plaintiff
will apply to the Court for the relief demanded in the Complaint.


James W. Boyd
Attorney at Law
1544 Ebenezer Road
Post Office Box 36425
Rock Hill, SC 29732
(803) 328-2600

D. Bradley Jordan Esq. JWB
D. Bradley Jordan
Jordan Law Firm, PC
546 East Main Street
P.O. Box 11785
Rock Hill, SC 29731
(803) 817 7999

Rock Hill, South Carolina
July 1, 2011

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

IN THE COURT OF COMMON PLEAS
SIXTEENTH CIRCUIT COURT

CASE NO.: 2010-CP-46-00683

Samantha Jamison, as Personal)
Representative of the Estate of)
Jayden Joenelle Jamison-Barber, Deceased,)

Plaintiff,)

AMENDED COMPLAINT

Ansley L. Hilton, M.D., Individually and)
as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A.; Christopher B. Benson,)
M.D., as Agent, Servant or Employee of)
Rock Hill Gynecological and Obstetrical)
Associates, P.A., and Rock Hill)
Gynecological and Obstetrical Associates)
P.A.,)

JURY TRIAL REQUESTED

Defendants,)

The Plaintiff, above named complaining of the above Defendants would respectfully
show to this Honorable Court as follows:

GENERAL ALLEGATIONS

1. The Plaintiff is a citizen and resident of Chester County, South Carolina.
2. The Defendant, Ansley L. Hilton, upon information and belief is a physician who treated the Plaintiff, Samantha Jamison and, upon information and belief, is a citizen and resident of York County, South Carolina and is at all times here and after mentioned, is a medical doctor with a practice known as Rock Hill Gynecological and Obstetrical Associates, P.A. located in York County, Rock Hill, South Carolina. Upon information and belief, at all times hereinafter mentioned, Dr. Hilton was an agent, servant and employee of Rock Hill Gynecological and Obstetrical Associates, P.A.
3. The Defendant, Christopher B. Benson, upon information and belief, is a physician that treated the Plaintiff, Samantha Jamison and upon information and belief is a citizen and resident of

York County, South Carolina and is at all times hereinafter mentioned, a medical doctor with a practice known as Rock Hill Gynecological and Obstetrical Associates, P.A., located in York County, Rock Hill, South Carolina. Upon information and belief, at all times hereinafter mentioned, Dr. Benson was and is an agent, servant and employee of Rock Hill Gynecological and Obstetrical Associates, P.A.

4. The Defendant, Rock Hill Gynecological and Obstetrical Associates, P.A. upon information and belief, is a South Carolina corporation with its principal place of business in York County, Rock Hill, South Carolina. The Defendant, Rock Hill Gynecological and Obstetrical Associates, P.A. is engaged in the practice of medicine in York County, South Carolina, from which its shareholders derive of substantial economic benefit. At all times hereinafter mentioned, Rock Hill Gynecological and Obstetrical Associates, P.A., by and through its agents, servants and employees, namely Dr. Ansley L. Hilton and Dr. Christopher B. Benson, treated the Plaintiff, Samantha R. Jamison.

5. The Plaintiff is also the Personal Representative of the Estate of the Decedent, Jayden Joenelle Jamison-Barber. The wrongful death action is brought on behalf of the statutory beneficiaries of Plaintiff's decedent, Jayden Joenelle Jamison-Barber. The survivorship action is brought on behalf of the Estate of the Plaintiff's decedent, Jayden Joenelle Jamison-Barber.

6. On or about July 18, 2008, the Plaintiff was seen by Dr. Benson for a prenatal visit and, according to an ultrasound, the estimated date of delivery was changed to November 1, 2008 in accordance with gestational age. The ultrasound also showed that the average measurements were at twenty-four (24) weeks and six (6) days.

7. The Plaintiff was seen for a follow up visit on July 28, 2008. The gestational weeks were noted to be 30.6 weeks with fundus size noted at 29. Fetal heart tones were documented as present. The Plaintiff was seen again by Dr. Benson on August 11, 2008. Thirty-Three (33) weeks gestation was noted but was crossed out and replaced with 28.3 weeks.

8. The Plaintiff was next seen on August 25, 2008. At that time, another ultrasound was ordered and that ultrasound indicated that the fetus had an estimated weight of two (2) pounds eight (8) ounces. The estimated delivery date was changed to November 16, 2008. Documentation on the ultrasound notes that the abdominal circumference was behind two (2) weeks from the previous scan and the amniotic fluid index was down to nine (9). There are no progress notes to discuss as to why there was low amniotic fluid, nor was there documentation as to any test ordered to assess this condition. Further, no biophysical profile was ordered to determine how the fetus was developing.

9. On September 5, 2008, the Plaintiff was seen by Dr. Hilton. Dr. Hilton noted decreased fetal movements and heart tones, showing patterns of deceleration. The Plaintiff was noted to be in premature labor, with contractions occurring every three (3) to four (4) minutes. The Plaintiff was told by Dr. Hilton to drive herself to Piedmont Medical Center and was given instructions to go directly to the labor and delivery. In fact, she was not advised that this was an emergent situation and she sat in admissions at Piedmont Medical Center for a significant period of time rather than being taken straight to labor and delivery. Further, Dr. Hilton did not call for an ambulance so that the Plaintiff might be continually monitored as to the progression of her labor and treated as emergent upon her arrival at Piedmont Medical Center.

10. At 11:40 a.m., some 2 ½ hours after arriving at Dr. Hilton's office, the Plaintiff was finally admitted to Piedmont Medical Center. At that juncture, the nurse's notes indicate the inability to hear any fetal heart tones. At 12:00p.m., the records note that Dr. Benson determined intrauterine fetal demise and a C-section was preformed by Dr. Benson to remove the fetus.

FIRST CAUSE OF ACTION
(Wrongful Death)

11. The Plaintiff incorporate the allegations of paragraphs One (1) through Ten (10) as if set forth hereinafter verbatim.

12. The Defendants owed a duty of due care to the Plaintiff and the Plaintiff's unborn child, Jayden Joenelle Jamison-Barber. The Defendants breached that duty and were negligent, reckless, willful, wonton, and/or grossly negligent in the following particulars:

- a. in failing to properly establish a true estimated date of delivery;
- b. in failing to note in the Plaintiff's office chart, the Plaintiff's blood pressure, weight, number of weeks pregnant, and whether the Plaintiff's urine was tested during the her visit to the Defendant's office on September 5, 2008;
- c. in altering the patient's chart by manually striking through 33 weeks and replacing it with 28.3 weeks;
- d. in failing to properly assess the Plaintiff's condition as to a significant drop in the amniotic fluid index and identifying what problems might be causing the drop;
- e. in failing to timely perform proper testing, namely a biophysical profile, to ensure normal fetal development and growth;
- f. in failing to properly assess an emergent situation on September 5, 2008, when the medical records indicated that the physician, Dr. Hilton, felt that there were complications to the Plaintiff's pregnancy;
- g. in failing to properly assess and continually monitor the Plaintiff's premature labor on September 5, 2008;
- h. in failing to continually monitor the patient to ensure the safety of the fetus, rather than informing the Plaintiff to get herself to the hospital, without explaining to the patient, that time was of the essence in obtaining immediate attention in labor and delivery upon her arrival at the hospital;

- i. in failing to call for an ambulance to take the patient directly to labor and delivery at Piedmont Medical Center due to signs of fetal complications, namely decreased fetal movement, fetal heart rate variables, and a prior history of the rupture of her uterus;
13. As a direct and proximate cause of the aforesaid negligence, willful, wanton and grossly negligent acts committed by all the Defendants, jointly and severally, the Plaintiff sustained personal injuries including but not limited to:
- a. medical expenses past, present, and future;
 - b. loss of income;
 - c. pain and suffering past, present and future;
 - d. loss of enjoyment of life;
 - e. anxiety and emotional distress due to the loss of her unborn child;
 - f. other injuries and damages as may be determined.

SECOND CAUSE OF ACTION
(Survivorship)

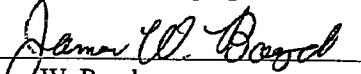
14. The Plaintiff incorporates the allegations of paragraphs One (1) through Twelve (12) as if set forth hereinafter verbatim.
15. The Plaintiff, Samantha R. Jamison, is the duly appointed, qualified and acting Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, deceased, who died in the manner alleged above on or about September 5, 2008.
16. The acts and/or omissions of the Defendants as described above were grossly negligent, reckless, careless, willful, and wonton.
17. As a direct and proximate result of the Defendants' grossly negligent, reckless, willful, and wonton conduct, Plaintiff's decedent, Jayden Joenelle Jamison-Barber, was exposed to unnecessary

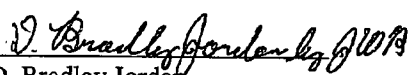
risk, thus resulting in his death. During the period when complications were duly noted and Plaintiff's decedent's death, the unborn child suffered.

18. Accordingly, the Plaintiff, Samantha R. Jamison, as Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, is entitled, on behalf of the Estate, to recover all actual and compensatory damages as to the survivorship claim of Jayden Joenelle Jamison-Barber, in an amount to be proven at trial; further, the Plaintiff, as Personal Representative of the Estate, is also entitled to recover punitive damages in an amount to be proven at trial.

19. The Plaintiff is entitled to actual and punitive damages as may be awarded.

WHEREFORE, the Plaintiff prays for judgment against the Defendants in an amount of actual damages sufficient to compensate the Plaintiff for the damages and losses suffered by the statutory beneficiaries as to the wrongful death cause of action and for all actual damages, pain and suffering for the benefit of the Estate of Jayden Joenelle Jamison-Barber. Further, the Plaintiff prays for judgment as to the survivorship cause of action, for punitive damages as may be awarded by a jury and for such other and further relief as the Court may deem just and proper.


James W. Boyd
1544 Ebenezer Road
P. O. Box 36425
Rock Hill, SC 29732
(803) 328 2600


D. Bradley Jordan
Jordan Law Firm, PC
546 East Main Street
P.O. Box 11785
Rock Hill, SC 29731
(803) 817 7999

ATTORNEYS FOR PLAINTIFF

STATE OF SOUTH CAROLINA)
COUNTY OF YORK)

Samantha Jamison, as Personal)
Representative of the Estate of)
Jayden Joenelle Jamison-Barber,)
Deceased)
Plaintiff,)

v.)

Ansley L. Hilton, M.D., Individually)
and as Agent, Servant or Employee)
of Rock Hill Gynecological and)
Obstetrical Associates, P.A.;)
Christopher B. Benson, M.D., as)
Agent, Servant or Employee of)
Rock Hill Gynecological and)
Obstetrical Associates, P.A., and)
Rock Hill Gynecological and)
Obstetrical Associates, P.A.,)
Defendants.)

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT

C.A. No.: 2011-CP-46-00683

**ANSWER OF DEFENDANTS
TO PLAINTIFF'S AMENDED COMPLAINT**

FILED-RECEIVED
2011 JUL 14 AM 10:05
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

TO: D. BRADLEY JORDAN AND JAMES W. BOYD, ATTORNEYS FOR PLAINTIFF:

NOW COME Defendants, answering the Amended Complaint of the Plaintiff as follows:

1. These Defendants, upon information and belief, admit the allegations contained in Paragraph 1 of the Amended Complaint.
2. These Defendants admit the allegations contained in Paragraph 2 of the Amended Complaint.
3. These Defendants admit the allegations contained in Paragraph 3 of the Amended Complaint.
4. Answering Paragraph 4 of the Amended Complaint, these Defendants admit that Rock Hill Gynecological and Obstetrical Associates, P.A. is a South Carolina corporation with its principal place of business in York County. Further, these Defendants admit that Rock Hill Gynecological and Obstetrical Associates, P.A. is engaged in the practice of obstetrics and

gynecology in York County, South Carolina and that all times mentioned in the Amended Complaint, Rock Hill Gynecological and Obstetrical Associates, P.A., by and through its agents, servants and employees, including Dr. Hilton and Dr. Benson, treated the Plaintiff, Samantha Jamison.

5. These Defendants, upon information and belief, admit the allegations contained in Paragraph 5 of the Amended Complaint.

6. Answering Paragraphs 6, 7, 8, 9, and 10 of the Amended Complaint, these Defendants admit that Samantha Jamison was appropriately treated by Dr. Benson, Dr. Hilton, and other agents, servants, and employees of Rock Hill Gynecological and Obstetrical Associates, P.A., which were all prenatal visits as documented by the office records of Rock Hill Gynecological and Obstetrical Associates, P.A. These Defendants further admit that the care rendered to the Plaintiff during each and every prenatal visit was appropriate and well within the acceptable standard of care for obstetricians and gynecologists in the same or similar circumstances. These Defendants further admit that all indicated examinations and testing was performed during the prenatal visits and that the Plaintiff was appropriately examined and appropriate diagnostic tests were performed throughout her prenatal visits including September 5, 2008. These Defendants admit that the Plaintiff was appropriately examined on that day, appropriate tests were performed, and she was appropriately instructed to immediately present to Labor and Delivery at Piedmont Medical Center. These Defendants deny that Plaintiff was not advised that this was a serious and/ or emergent situation necessitating Plaintiff to go directly to Labor and Delivery at Piedmont Medical Center. These Defendants further admit that in spite of the care provided by these Defendants to the Plaintiff it was determined that there was an intrauterine fetal demise. These Defendants admit that all the care and treatment provided to the Plaintiff by these Defendants was appropriate and well within the standard of care for a patient similarly situated and under similar circumstances and conditions.

Any allegation contained in Paragraphs 6, 7, 8, 9, and 10 of the Amended Complaint that has not been specifically admitted is hereby denied and strict proof demanded thereof.

7. Answering Paragraph 11 of the Amended Complaint, these Defendants hereby incorporate by reference the allegations of the previous Paragraphs of this Answer not inconsistent herewith.

8. Answering Paragraphs 12 and 13 of the Amended Complaint, these Defendants admit that they owed a duty of care to the Plaintiff and Plaintiff's unborn child, Jayden Joenelle Jamison-Barber, and these Defendants admit that all the care and treatment provided to the Plaintiff and Plaintiff's unborn child in accordance with that duty was well within the standard of care. These Defendants hereby specifically deny each and every remaining allegation contained in Paragraphs 12 and 13 of the Amended Complaint and demand strict proof thereof.

9. Answering Paragraph 14 of the Amended Complaint, these Defendants hereby incorporate by reference the allegations of the previous Paragraphs of this Answer not inconsistent herewith.

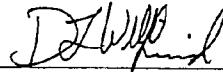
10. Answering Paragraph 15 of the Amended Complaint, these Defendants, upon information and belief, admit that Plaintiff Samantha R. Jamison is the duly appointed, qualified, and acting Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, deceased. These Defendants hereby specifically deny each and every remaining allegation contained in Paragraph 15 of the Amended Complaint and demand strict proof thereof.

11. These Defendants hereby specifically deny each and every allegation contained in Paragraphs 16, 17, 18, and 19 of the Amended Complaint and demand strict proof thereof.

12. Any allegation contained in the Amended Complaint that has not been specifically admitted is hereby denied and strict proof demanded thereof.

WHEREFORE, having fully answered the Amended Complaint of the Plaintiff, these Defendants request that the action be dismissed as to them, with costs, and any other relief deemed just and appropriate by this Honorable Court.

Respectfully Submitted,

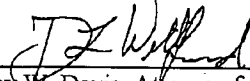


Ashby W. Davis, Esquire (SC Bar #1560)
David L. Williford, Esquire (SC Bar #73129)
DAVIS & SNYDER, P.A.
5 Hawthorne Park Court
Greenville, SC 29615
(864) 335-3500

ATTORNEYS FOR DEFENDANTS

July 13, 2011
Greenville, SC

**THESE DEFENDANTS
RESPECTUFLY DEMAND TRIAL
BY JURY.**



Ashby W. Davis, Attorney for Defendants
David L. Williford, Attorney for Defendants

STATE OF SOUTH CAROLINA)

COUNTY OF YORK)

Samantha Jamison, as Personal
Representative of the Estate of
Jayden Joenelle Jamison-Barber,
Deceased,)

Plaintiff,)

v.)

Ansley L. Hilton, M.D., Individually
and as Agent, Servant or Employee
Of Rock Hill Gynecological and
Obstetrical Associates, P.A.;
Christopher B. Benson, M.D., as
Agent, Servant or Employee of
Rock Hill Gynecological and
Obstetrical Associates, P.A., and
Rock Hill Gynecological and
Obstetrical Associates, P.A.,)

Defendants.)

IN THE COURT OF COMMON PLEAS

SIXTEENTH JUDICIAL CIRCUIT

C.A. No.: 2011-CP-46-00683

CERTIFICATE OF SERVICE

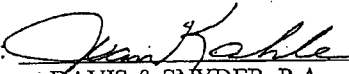
FILED-RECEIVED
2011 JUL 14 AM 10:05
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

I hereby certify that I have this date served a copy of the within and foregoing **Defendants'**
Answer to Plaintiff's Amended Complaint upon the Plaintiff by depositing a copy of same in the
United States Mail with first class postage addressed to:

James W. Boyd, Esquire
PO 36425
Rock Hill, SC 29732

D. Bradley Jordan, Esquire
Jordan Law Firm, PC
PO Box 11785
Rock Hill, SC 29732

This 13 day of July, 2011.

By: 
DAVIS & SNYDER, P.A.

Greenville, South Carolina.

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Samantha Jamison, as Personal Representative
of the Estate of Jayden Joenelle Jamison-Barb
Deceased,

☐ Plaintiff

v.

Ansley L. Hilton, Md, Individually And As Agent,
Servant Or Employee Of Rock Hill Gynecological
And Obstetrical Associates, Pa; Christopher B.
Benson, Md, As Agent, Servant Or Employee Of
Rock Hill Gynecological And Obstetrical Associates,
Pa, And Rock Hill Gynecological And Obstetrical
Associates, Pa

☒ Defendant.

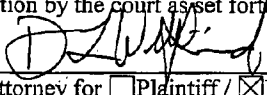
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2013 APR 25 AM 11:28
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC

IN THE COURT OF COMMON PLEAS

CASE NO.

2011-CP-46-00683

MOTION AND ORDER INFORMATION
FORM AND COVER SHEET

Plaintiff's Attorney: D. Bradley Jordan, Bar No. Address: PO Box 11785, Rock Hill, SC 29731 phone: 803-817-7999 fax: 803-328-1030 e-mail: other:	Defendant's Attorney: David L. Williford, Bar No. 73129 Address: 5 Hawthorne Park Ct., Greenville, SC 29615 phone: 864-335-3500 fax: 864-335-3505 e-mail: DWilliford@DavisSnyder.com other:
☒ MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III) ☐ FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III) ☐ PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)	
SECTION I: Hearing Information Nature of Motion: Motion to Reconsider; Motion for Judgment Notwithstanding the Verdict; and Motion to Alter or Amend the Judgment Estimated Time Needed: 15 min Court Reporter Needed: ☒ YES / ☐ NO	
SECTION II: Motion/Order Type ☒ Written motion attached ☐ Form Motion/Order I hereby move for relief or action by the court as set forth in the attached proposed order.  Signature of Attorney for ☐ Plaintiff / ☒ Defendant April 25, 2013 Date submitted	
SECTION III: Motion Fee ☒ PAID - AMOUNT: \$25 ☐ EXEMPT: ☐ Rule to Show Cause in Child or Spousal Support (check reason) ☐ Domestic Abuse or Abuse and Neglect ☐ Indigent Status ☐ State Agency v. Indigent Party ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief ☐ Motion for Stay in Bankruptcy ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRPC) ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions Name of Court Reporter: ☐ Other:	

SCCA/233 (11-03)

JUDGE'S SECTION	
☐ Motion Fee to be paid upon filing of the attached order.	JUDGE _____
☐ Other: _____	CODE: _____ Date: _____
CLERK'S VERIFICATION	
Collected by: <u>S Giles</u>	Date Filed: <u>4-25-13</u>
☒ MOTION FEE COLLECTED: <u>25</u>	
☐ CONTESTED - AMOUNT DUE: _____	

STATE OF SOUTH CAROLINA
COUNTY OF YORK

FILED-RECEIVED
2013 APR 25 AM 11:28
DAVID HAMILTON
C.C.P. & G.S.
YORK COUNTY, SC
16th JUDICIAL CIRCUIT

Samantha Jamison, as Personal
Representative of the Estate of Jayden
Joenelle Jamison-Barber, Deceased,

C.A. No.: 2011-CP-46-00683

Plaintiff,

v.

Ansley L. Hilton, M.D., Individually and as
Agent, Servant or Employee Of Rock Hill
Gynecological and Obstetrical Associates,
P.A.; Christopher B. Benson, M.D., as
Agent, Servant or Employee of Rock Hill
Gynecological and Obstetrical Associates,
P.A., and Rock Hill Gynecological and
Obstetrical Associates, P.A.,

Defendants.

**DEFENDANT ROCK HILL
GYNECOLOGICAL AND
OBSTETRICAL ASSOCIATES, P.A.'S
MOTION TO RECONSIDER;
MOTION FOR JUDGMENT
NOTWITHSTANDING THE VERDICT;
AND MOTION TO ALTER OR AMEND
THE JUDGMENT**

**TO: JAMES W. BOYD, ESQ. & D. BRADLEY JORDAN, ESQ., ATTORNEYS FOR
PLAINTIFF:**

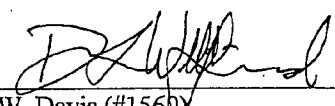
NOW COMES Defendant Rock Hill Gynecological and Obstetrical Associates, P.A.
(hereinafter "RHGO" or "Defendant"), by and through counsel, hereby moving this Honorable
Court for an Order granting Defendant RHGO's Motion to Reconsider, Motion for Judgment
Notwithstanding the Verdict, and Motion to Amend or Alter the Judgment, pursuant to Rules 50, 52
and 59 of the South Carolina Rules of Civil Procedure and applicable South Carolina constitutional,
statutory and case law.

Defendant RHGO's Motions are based on a Memorandum of Law which will hereinafter be
filed and submitted to the Court and served upon opposing counsel, as well as any pleadings,
discovery, depositions, affidavits, trial testimony, evidence, and trial exhibits, which may be

submitted to this Court and served on counsel for the Plaintiff, as well as the South Carolina Rules of Civil Procedure and applicable South Carolina constitutional, statutory and case law.

Respectfully submitted,

DAVIS, SNYDER & WILLIFORD, PA

By: 

Ashby W. Davis (#1560)

David L. Williford (#73129)

DAVIS, SNYDER & WILLIFORD, P.A.

5 Hawthorne Park Court

Greenville, SC 29615

(864) 335-3500

(864) 335-3505 (fax)

ATTORNEYS FOR THE DEFENDANTS

April 25, 2013
Greenville, South Carolina

STATE OF SOUTH CAROLINA
COUNTY OF YORK

FILED-RECEIVED
2013 APR 25 AM 11:28

IN THE COURT OF COMMON PLEAS
16th JUDICIAL CIRCUIT

Samantha Jamison, as Personal Representative of the Estate of Jayden Joenelle Jamison-Barber, Deceased,
C.A. No.: 2011-CP-46-00683

Plaintiff,

v.

Ansley L. Hilton, M.D., Individually and as Agent, Servant or Employee Of Rock Hill Gynecological and Obstetrical Associates, P.A.; Christopher B. Benson, M.D., as Agent, Servant or Employee of Rock Hill Gynecological and Obstetrical Associates, P.A., and Rock Hill Gynecological and Obstetrical Associates, P.A.,

Defendants.

MEMORANDUM OF LAW
IN SUPPORT OF
DEFENDANT ROCK HILL
GYNECOLOGICAL AND
OBSTETRICAL ASSOCIATES, P.A.'S
MOTION TO RECONSIDER;
MOTION FOR JUDGMENT
NOTWITHSTANDING THE VERDICT;
AND MOTION TO ALTER OR AMEND
THE JUDGMENT

TO: JAMES W. BOYD, ESQ. & D. BRADLEY JORDAN, ESQ., ATTORNEYS FOR PLAINTIFF:

NOW COMES Defendant Rock Hill Gynecological and Obstetrical Associates, P.A. (hereinafter "RHGO" or "Defendant"), by and through counsel, hereby submitting this Memorandum of Law in Support of its Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict, and Motion to Alter or Amend the Judgment pursuant to Rules 50, 52, and 59 of the South Carolina Rules of Civil Procedure and applicable South Carolina constitutional, statutory and case law.

BACKGROUND

Factual Background

This is a case involving allegations of medical malpractice. On July 18, 2008, Plaintiff Samantha Jamison was seen by Dr. Christopher Benson for her first prenatal visit at Rock Hill Gyn/Ob. She was a late transfer from North Central Family Medical Center and had not had a previous ultrasound. An ultrasound was therefore performed at Rock Hill Gyn/Ob to establish

her estimated due date of November 1, 2008. Plaintiff was seen and evaluated by the physicians at Rock Hill Gyn/Ob on subsequent prenatal visits on various dates, including July 28, 2008 and August 11, 2008. She also presented to Labor & Delivery at Piedmont Medical Center in Rock Hill, SC on August 9, 2008 for an evaluation.

On August 25, 2008, Plaintiff was seen and evaluated by Dr. Greg Miller at Rock Hill Gyn/Ob during a scheduled prenatal visit. She had a second ultrasound. The average gestational age by ultrasound was 28 weeks 1 day and the estimated fetal weight was 2 pounds 8 ounces. The amniotic fluid index (AFI) had decreased to 9, but was normal. Doppler studies were normal as well. The fetal abdominal circumference was "slightly behind at two weeks" from the previous ultrasound, which Dr. Miller noted was possibly due to the decreased amniotic fluid. Ms. Jamison was advised to start doing kick counts, increase her fluid intake and watch the swelling in her ankles. Plaintiff was scheduled to return to Rock Hill Gyn/Ob in two weeks for her scheduled prenatal care.

On September 5, 2008, Plaintiff presented to Rock Hill Gyn/Ob as an unscheduled patient with a complaint of decreased fetal movement. Plaintiff signed in the office at 8:40 a.m. and was subsequently evaluated by nurse practitioner Robin Pruette, NP, who listened for fetal heart tones and further examined the Plaintiff. For an additional part of her evaluation, an NST (non-stress test) was performed beginning at approximately 9:50 a.m. or 10:00 a.m. to assess the fetal heart rate on a monitor. The NST lasted for approximately 34 minutes and ended at either 10:24 a.m. or 10:34 a.m. The NST was not alarming but was considered indeterminate; therefore, Ms. Pruette ordered a BPP ("biophysical profile" ultrasound) and a physician consult in their office for further evaluation. By 10:48 a.m., the Plaintiff was having a BPP performed in the office at Rock Hill Gyn/Ob. The fetus had a normal heart rate of 158 beats per minute. While many BPPs typically last approximately 30 minutes to obtain a full evaluation of a fetus particularly at this gestational age, Dr. Ansley Hilton reviewed the BPP in progress, stopped the

BPP by 10:58 a.m., and determined that the initial score was a 2/8, which caused some concern. Given this initial finding, Dr. Hilton instructed the Plaintiff to go directly to Labor & Delivery at Piedmont Medical Center for further evaluation with the possibility that the fetus might get delivered if indicated after further evaluation. Dr. Benson was on call at the hospital and was notified by Dr. Hilton on the telephone that the Plaintiff was being sent to Labor & Delivery for further evaluation. Dr. Hilton spoke with the Plaintiff and verified that she had transportation and that she knew where to go to get to Labor & Delivery at the hospital. The Plaintiff then left the Rock Hill Gyn/Ob office at approximately 11:00 a.m. to go to Labor & Delivery at Piedmont Medical Center, which is approximately five (5) minutes away from the Rock Hill Gyn/Ob office.

The Plaintiff arrived at Piedmont Medical Center at approximately 11:40 a.m., where the nurses' notes indicate that they were unable to obtain any fetal heart tones. No fetal heartbeat was present. Dr. Benson had planned to perform a C-section immediately upon her arrival to Labor & Delivery if it was indicated after an evaluation. After being counseled on her options, the Plaintiff decided to proceed with a C-section to remove the fetus, which appeared normal. The cause of the fetal demise was unknown.

Procedural Background

The trial of this case began on April 8, 2013 and concluded on April 12, 2013 in York County with the Honorable Steven H. John presiding. At the conclusion of the Plaintiff's case on April 9, 2013, counsel for Defendants made motions for directed verdicts pursuant to Rule 50 of the South Carolina Rules of Civil Procedure on the grounds that Plaintiff failed to provide evidence sufficient to form a genuine issue of material fact on the issue of negligence. Judge John denied Defendants' motions. At the close of all the evidence, and before the case was submitted to the jury for deliberations, counsel for Defendants renewed their motions for directed verdicts on the same grounds, which were again denied by Judge John.

After deliberating, the jury returned a verdict on April 12, 2013 and found that Defendant Dr. Hilton was not negligent, that Defendant Dr. Benson was not negligent, but that Defendant RHGO "negligently departed from the standard of care in treating the Plaintiff, Samantha Jamison, and that this negligent departure from the standard of care proximately caused the Plaintiff's injuries." (See Form 4 Judgment and Verdict Form attached hereto as Exhibit "A"). The jury awarded \$90,000 in damages to the Plaintiff. *Id.* Immediately after the verdict was published sometime after 9:00 p.m. on Friday evening on April 12, 2013, and after the jury was excused, Judge John declined to allow counsel for the Defendant ten (10) days to file post-trial motions. Thus, Judge John immediately inquired of counsel for both parties whether any counsel wished to argue any post-trial motions at that time. Plaintiff's counsel did not make any motions. Counsel for the Defendants, however, made and argued the following motions specifically with respect to Defendant RHGO: a Motion for Judgment Notwithstanding the Verdict, a Motion to Alter or Amend the Judgment, and a Motion for a New Trial, on the grounds that the verdict was inconsistent and that the verdict could not be sustained as a matter of law by the evidence presented at trial. Judge John denied Defendants' motions. This Motion to Reconsider, *inter alia*, hereby follows accordingly.

ARGUMENT

Defendant RHGO is entitled to relief with respect to its Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict, and Motion to Alter or Amend the Judgment as set forth herein below.

A. MOTION FOR JUDGMENT NOTWITHSTANDING THE VERDICT

Since the evidence at trial fails to support Plaintiff's causes of action against RHGO, and since this Defendant timely and appropriately moved the Court for a directed verdict at the close of Plaintiff's case-in-chief and at the close of all the evidence, Defendant RHGO hereby moves this

Honorable Court to reconsider and enter Judgment Notwithstanding the Verdict pursuant to Rule 50(b) of the South Carolina Rules of Civil Procedure.

"In ruling on a motion for a JNOV, the court must view the evidence and all reasonable inferences in the light most favorable to the non-moving party." *Atlanta Skin v. Hallmark Gen. Partners, Inc.*, 320 S.C. 113, 122, 463 S.E.2d 600, 605 (1995). "When considering a motion for judgment notwithstanding the verdict, the trial judge cannot disturb the factual findings of a jury unless a review of the record discloses no evidence which reasonably supports them." *Force v. Richland Memorial Hosp.*, 322 S.C. 283, 471 S.E.2d 714, 715 (Ct. App. 1996). Since the record fails to include sufficient evidence to support each and every element of Plaintiff's causes of action against RGHO, particularly since the jury found Defendants Dr. Hilton and Dr. Benson not negligent, this Court should grant Defendant RHGO's Motion for Judgment Notwithstanding the Verdict as delineated below.

1. Proximate cause means direct cause under South Carolina law.

In a medical malpractice trial, the plaintiff has the burden of proof. *Gilland v. Peter's Dry Cleaning Co.*, 195 S.C. 417, 11 S.E.2d 857 (1941); *Covington v. Atlantic Coast Life R. Co.*, 158 S.C. 194, 155 S.E. 438 (1930). Additionally, the plaintiff must prove proximate cause, of which foreseeability is required. *Bessinger v. DeLoach*, 230 S.C. 1, 94 S.E. 2d 3 (1956); *Gunnels v. Roach*, 243 S.C. 248, 133 S.E. 2d 757 (1963); *Hanselman v. McCardle*, 270 S.C. 367, 242 S.E. 2d 421 (1980); *Todd v. United States*, 570 F. Supp. 670 (D.S.C. 1983); *Young v. Tide Craft, Inc.*, 270 S.C. 453, 242 S.E.2d 671 (1978). "Additionally, the plaintiff [alleging medical malpractice] must demonstrate the defendant's departure from such generally recognized practices and procedures proximately caused the plaintiff's alleged injuries and damages." *Hoard v. Roper Hosp., Inc.*, 387 S.C. 539, 546, 694 S.E.2d 1, 9 (2010); *David v. McLeod Reg. Med. Ctr.*, 367 S.C. 242, 248, 626 S.E.2d 1, 4 (2006). "In a medical malpractice action, it is incumbent on the plaintiff to establish

proximate cause as well as the negligence of the physician.” *Hoard* at 546, 694 S.E.2d 1, 9; *Ellis v. Oliver*, 323 S.C. 121, 125, 473 S.E.2d 793, 795 (1996).

The Supreme Court of South Carolina has stated that “When expert testimony is the only evidence of proximate cause relied upon, the testimony ‘must provide a significant causal link between the alleged negligence and the plaintiff’s injuries, rather than a tenuous and hypothetical connection.’” *Hoard* at 546-47, 694 S.E.2d 1, 9-10; *Ellis* at 125, 473 S.E.2d 793, 795.

The Supreme Court of South Carolina also has stated the following with respect to proximate cause:

With regard to liability for a negligent act, *proximate cause is the efficient, or direct, cause* – the thing which brings about the injuries complained of.

Hughes v. The Children’s Clinic, P.A., 269 S.C. 389, 398, 237 S.E.2d 753, 757 (1977) (emphasis added); *Burnette v. Augusta Coca-Cola Bottling Co.*, 157 S.C. 359, 154 S.E. 645 (1930). The Supreme Court in *Hughes* also stated that “Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided.” *Hughes* at 398, 237 S.E.2d 753, 757; *Gunnels v. Roach*, 243 S.C. 248, 133 S.E.2d 757 (1963).

The Court of Appeals of South Carolina has, on multiple occasions, reiterated the law that proximate cause means direct cause. For example, the Court of Appeals stated again, relatively recently, that:

Proximate cause is the efficient, or direct, cause – the thing which brings about the injuries complained of. Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided.

Singleton v. Sherer, 377 S.C. 185, 203, 659 S.E.2d 196, 206 (Ct. App. 2008) (emphasis added). The Court also said that “Proximate cause requires proof of both causation in fact and legal cause.” *Id.* Soon after the Court of Appeals decided *Singleton*, it subsequently reiterated the following month, in March of 2008, that “Proximate cause is the efficient or direct cause of an injury.” *Mellen v.*

Lane, 377 S.C. 261, 278, 659 S.E.2d 236, 245 (Ct. App. 2008). The Court also stated that "Proximate cause is the immediate cause." *Id.*; *State v. Clary*, 222 S.C. 549, 551, 73 S.E.2d 681, 682 (1952). And, just to be very clear as to what proximate cause means, the Court of Appeals repeated two months later in May of 2008 – for the third time in four months – that:

Proximate cause is the efficient, or direct, cause – the thing which brings about the injuries complained of. Negligence is not actionable unless it is a proximate cause of the injuries, and it may be deemed a proximate cause only when without such negligence the injury would not have occurred or could have been avoided.

Platt v. CSX Transp., 379 S.C. 249, 266, 665 S.E.2d 631, 640 (Ct. App. 2008) (emphasis added).

Clearly, in order for the verdict in this case to withstand legal scrutiny, the Plaintiff had the burden of proof to provide some evidence that Defendant RHGO directly and proximately caused the fetal demise in this case. However, as expressed herein below, the Plaintiff, by and through her sole standard of care expert witness, failed to do so.

2. Defendant RHGO's Motion for JNOV should be granted because Plaintiff did not provide sufficient evidence as a matter of law that the alleged negligence of RHGO directly and proximately caused damages.

This Honorable Court should grant Defendant RHGO's Motion for Judgment Notwithstanding the Verdict because there is no evidence whatsoever in the record that RHGO, by and through its servants or agents, did or did not do anything to directly or proximately cause the death or fetal demise of Plaintiff's unborn child.¹ The jury specifically found that the two named Defendant physicians – Dr. Hilton and Dr. Benson – were not negligent in this case (See the Verdict Form attached hereto as Exhibit "A"). Therefore, in order for the verdict against RHGO in the amount of \$90,000 to stand, the record must contain the existence of legally sufficient evidence to support the verdict. In other words, and more specifically, and in order for the verdict against RHGO to remain legally sufficient, the Plaintiff's only standard of care expert – Douglas R.

¹ Plaintiff's sole standard of care expert, Douglas R. Phillips, MD, testified that, in his opinion, Defendants Dr. Hilton and Dr. Benson were negligent and that their negligence proximately caused the fetal demise. However, the jury specifically found that Dr. Hilton and Dr. Benson were not negligent in this case. (See the Verdict Form as attached).

Phillips, MD – needed to opine and state that, to a reasonable degree of medical certainty, an agent or servant of RHGO (other than Dr. Hilton and Dr. Benson; since the jury found them not negligent) directly caused the fetal demise, from which Plaintiff's asserted damages flow. However, Dr. Phillips never could say – and never did say – that any agent or servant of RHGO directly caused the fetal demise in this case.

For example, other than Defendants Dr. Hilton and Dr. Benson, the only other individual, servant or agent of RHGO of whom Dr. Phillips was critical in this case was Dr. Greg Miller, who treated the Plaintiff earlier in her prenatal care, the last of which occurred on August 25, 2008 – about ten (10) days before Plaintiff's unexpected fetal demise on September 5, 2008. However, on cross examination during trial on April 9, 2013, Dr. Phillips was confronted with his deposition testimony and he agreed that he stated the following under oath:

Q. Do you believe Dr. Miller, who saw the patient on August 25th, caused the baby to die?

A. I don't think Dr. Miller caused the baby to die.
(Deposition of Dr. Phillips, 111:14-18) (Attached as Exhibit "B")

When confronted with his own deposition testimony at trial in this regard, Dr. Phillips stated that Dr. Miller *did not directly* cause the fetal demise, inferring perhaps that somehow Dr. Miller tenuously and indirectly caused the fetal demise. *Nowhere* in his deposition testimony on February 28, 2013 or during his trial testimony on April 9, 2013 did Dr. Phillips ever say that Dr. Miller, as an agent or servant of RHGO, caused or directly caused the fetal demise in this case. Such a failure to provide any expert testimony that Dr. Miller directly and proximately caused the fetal demise is fatal to the sustainability of Plaintiff's verdict for \$90,000 against RHGO under clearly established South Carolina law. Therefore, as a matter of law, this Honorable Court should grant Defendant RHGO's Motion for Judgment Notwithstanding the Verdict.

Additionally, Dr. Phillips testified under oath that he did not have any criticisms of the ultrasonographers or nurse practitioner from RHGO in this case, and he did not have any criticisms

of any other agent or servant of RHGO (other than Dr. Hilton and Dr. Benson). Dr. Phillips testified at trial during cross examination, as follows:

- Q. Do you have any criticisms of the ultrasonographers and nurse practitioners in this case?
- A. No, I do not.
(Deposition of Dr. Phillips, 111:3-6) (Attached as Exhibit "B")
- Q. I understand your opinions about Dr. Hilton, but – okay. Do you have any other criticisms to a reasonable degree of medical certainty, do you have criticisms of any other providers in the case, other than what we've already talked about today?
- A. No.
(Deposition of Dr. Phillips, 111:7-13) (Attached as Exhibit "B")

Other than the named Defendants Dr. Hilton and Dr. Benson, Dr. Phillips provided no testimony that any other agent of RHGO was negligent and that such negligence caused the fetal demise in this case. There is simply no evidence in the record sufficient to sustain the verdict of \$90,000 against Defendant RHGO. Therefore, as a matter of law, this Honorable Court should grant Defendant RHGO's Motion for Judgment Notwithstanding the Verdict.

B. MOTION TO ALTER OR AMEND THE JUDGMENT

Defendant RHGO respectfully moves this Honorable Court pursuant to Rule 59(e) of the South Carolina Rules of Civil Procedure to reconsider and Alter or Amend the Judgment since the verdict is improper and not supported by the evidence presented at trial.

"Rule 59(e), SCRCp, provides for a motion to alter or amend judgment and preserve the record for appeal." *Pelican Build. Centers v. Dutton*, 311 S.C. 56, 427 S.E.2d 673, 675 (1993). "The purpose of Rule 59(e), SCRCp, to alter or amend the judgment is to request the trial judge to reconsider matters properly encompassed in a decision on the merits." *Arnold v. State*, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992). A party may file a motion to reconsider under Rule 59(e) when it "believes the court has misunderstood, failed to fully consider, or perhaps failed to rule on an argument or issue, and the party wishes for the court to reconsider or rule on it." *Elam v. SCDOT*, 361 S.C. 9, 24, 602 S.E.2d 772, 780 (2004).

1. **The verdict of \$90,000 against RHGO is not supported by the evidence when fully considering the law of negligence and proximate cause.**

This Court should reconsider its denial of Defendant RGHO oral Rule 59 motion made after 9:00 p.m. on Friday evening of April 12, 2013 immediately after the jury returned their verdict, and, in particular, this Honorable Court should alter or amend the judgment by granting Defendant RGHO's Motion for a directed verdict or by granting its Motion for JNOV after having the time and opportunity to reflect upon and review the evidence presented at trial in light of the law in South Carolina on proximate cause, which is a requisite element of negligence. Without repeating the same or similar foregoing arguments mentioned herein above, this Court should reconsider the evidence presented at trial in light of the case law cited above and alter or amend the judgment against RHGO by granting Defendant RGHO's Motion for a directed verdict or by granting its Motion for JNOV.

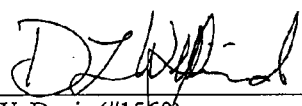
Accordingly, Defendant RHGO respectfully moves this Honorable Court to alter or amend the judgment on the above grounds.

CONCLUSION

For the foregoing reasons, Defendant RHGO hereby moves this Honorable Court for an Order granting its Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict, and Motion to Alter or Amend the Judgment pursuant to the South Carolina Rules of Civil Procedure and applicable South Carolina constitutional, statutory and case law.

Respectfully submitted,

DAVIS, SNYDER & WILLIFORD, PA

By: 

Ashby W. Davis (#1550)

David L. Williford (#73129)

DAVIS, SNYDER & WILLIFORD, P.A.

5 Hawthorne Park Court

Greenville, SC 29615

10

(864) 335-3500
(864) 335-3505 (fax)

April 25, 2013
Greenville, South Carolina

ATTORNEYS FOR THE DEFENDANTS

EXHIBIT “A”

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF YORK
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP4600683

Samantha Jamison	Ansley L Hilton Rock Hill Gynecological And Obstetrical Associates PA	Christopher B Benson
PLAINTIFF(S)		DEFENDANT(S)

Submitted by:	Attorney for: ☐ Plaintiff ☐ Defendant ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit);
☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____
- ☐ **ACTION STRICKEN (CHECK REASON):** ☐ Rule 40(j)-SCRCP; ☐ Bankruptcy;
☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____
- ☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; (formal order to follow) ☐ Statement of Judgment by the Court:

SEE ATTACHED VERDICT FORM

ORDER INFORMATION

This order ☒ ends ☐ does not end the case. Additional Information for the Clerk:

☐ Voluntary Dismissal (Check Reason) ☐ Involuntary Dismissal (Check Reason) ☐ Other: _____

☐ Judgment of Summary ☐ Other: _____

☐ Judgment of Verdict (Check Reason) ☐ Judgment of Verdict (Check Reason) ☐ Judgment of Verdict (Check Reason)

FILED-RECEIVED
2013 APR 15 PM 1:14
DAVID HAMILTON
C.C.P. & J.S.
YORK COUNTY, SC

[Handwritten signature]

INFORMATION FOR THE JUDGMENT INDEX		
Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate N/A in one of the boxes below.		
Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk. Note: Title abstractors and researchers should refer to the official court order for judgment details.

Alexander H. Jordan
Circuit Court Judge

2129
Judge Code

4/12/13
Date

For Clerk of Court Office Use Only

This judgment was entered on April 15, 2013, and a copy mailed first class or placed in the appropriate attorney's box on April 15, 2013, to attorneys of record or to parties (when appearing pro se) as follows:

David Bradley Jordan
PO Box 11785
Rock Hill, SC 29731

Ashby W. Davis
5 Hawthorne Park Ct.
Greenville, SC 29615

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

David Hamilton

David Hamilton - Clerk of Court

Court Reporter: Shirley Broom

2013
4/12/13

STATE OF SOUTH CAROLINA
COUNTY OF YORK

IN THE COURT OF COMMON PLEAS
SIXTEENTH JUDICIAL CIRCUIT
2011-CP-46-00683

SAMANTHA JAMISON,

Plaintiff,

v.

ANSLEY L. HILTON, M.D.,
INDIVIDUALLY AND AS AGENT,
SERVANT OR EMPLOYEE OF
ROCK HILL GYNECOLOGICAL
AND OBSTETRICAL ASSOCIATES,
P.A.; CHRISTOPHER B. BENSON,
M.D., AS AGENT, SERVANT OR
EMPLOYEE OF ROCK HILL
GYNECOLOGICAL AND
OBSTETRICAL ASSOCIATES, P.A.,
AND ROCK HILL
GYNECOLOGICAL AND
OBSTETRICAL ASSOCIATES P.A.,

Defendants.

VERDICT FORM

FILED-RECEIVED
2013 APR 15 PM 1:14
DAVID HILTON
C.C.P. & GS
YORK COUNTY, SC

Instructions: Mark the appropriate response to the following questions. Each response must be unanimous.

- 1.a. DO YOU FIND THAT THE DEFENDANT, ANSLEY L. HILTON, M.D., INDIVIDUALLY AND AS AGENT, SERVANT OR EMPLOYEE OF ROCK HILL GYNECOLOGICAL AND OBSTETRICAL ASSOCIATES, P.A., NEGLIGENTLY DEPARTED FROM THE STANDARD OF CARE IN TREATING THE PLAINTIFF, SAMANTHA JAMISON, AND THAT THIS NEGLIGENT DEPARTURE FROM THE STANDARD OF CARE PROXIMATELY CAUSED THE PLAINTIFF'S INJURIES?

____ YES

☒ NO

- 1.b. DO YOU FIND THAT THE DEFENDANT, CHRISTOPHER B. BENSON, M.D., AS AGENT, SERVANT OR EMPLOYEE OF ROCK HILL GYNECOLOGICAL AND OBSTETRICAL ASSOCIATES, P.A., NEGLIGENTLY DEPARTED FROM THE STANDARD OF CARE IN TREATING THE PLAINTIFF, SAMANTHA JAMISON, AND THAT THIS NEGLIGENT DEPARTURE FROM THE STANDARD OF CARE PROXIMATELY CAUSED THE PLAINTIFF'S INJURIES?

_____ YES

X NO

- 1.c. DO YOU FIND THAT THE DEFENDANT, ROCK HILL GYNECOLOGICAL AND OBSTETRICAL ASSOCIATES P.A., NEGLIGENTLY DEPARTED FROM THE STANDARD OF CARE IN TREATING THE PLAINTIFF, SAMANTHA JAMISON, AND THAT THIS NEGLIGENT DEPARTURE FROM THE STANDARD OF CARE PROXIMATELY CAUSED THE PLAINTIFF'S INJURIES?

X YES

_____ NO

NOTE: If you answered "Yes" to any part of Question 1, please answer Question 2. If you answered "No" to every part of Question 1, please stop deliberating and notify the Bailiff.

2. PLEASE STATE THE TOTAL AMOUNT OF DAMAGES, IF ANY, SUSTAINED BY
THE PLAINTIFF, SAMANTHA JAMISON.

NINETY Thousand Dollars⁰⁰ (\$ 90,000)
(Write out amount in words)

April 12, 2013
York, South Carolina

Daniel Moses
FOREPERSON 4-12-13
Daniel MOSES

NOTE: Please notify the Bailiff when you finish deliberating.

EXHIBIT "B"

1 day?

2 A. That's correct.

3 Q. Do you have any criticisms of
4 the ultrasonographers and nurse
5 practitioners in this case?

6 A. No, I do not.

7 Q. I understand your opinions about
8 Dr. Hilton, but -- okay. Do you have any
9 other criticisms to a reasonable degree of
10 medical certainty, do you have criticisms
11 of any other providers in the case, other
12 than what we've already talked about today?

13 A. No.

14 Q. Do you believe Dr. Miller, who
15 saw the patient on August 25th, caused the
16 baby to die?

17 A. I don't think Dr. Miller caused
18 the baby to die.

19 Q. Would you agree that in this
20 case, the physicians managing this patient
21 were mindful of her prior history, her
22 obstetrical history and that had already
23 planned to do a C-section or considered an
24 amniocentesis?

25 A. Yes.

STATE OF SOUTH CAROLINA

COUNTY OF YORK

Samantha Jamison, as Personal
Representative of the Estate of Jayden
Joanelle Jamison-Barber, Deceased,

Plaintiff,

v.

Ansley L. Hilton, M.D., Individually and as
Agent, Servant or Employee Of Rock Hill
Gynecological and Obstetrical Associates,
P.A.; Christopher B. Benson, M.D., as
Agent, Servant or Employee of Rock Hill
Gynecological and Obstetrical Associates,
P.A., and Rock Hill Gynecological and
Obstetrical Associates, P.A.,

Defendants.

IN THE COURT OF COMMON PLEAS

16th JUDICIAL CIRCUIT

C.A. No.: 2011-CP-46-00683

CERTIFICATE OF SERVICE

FILED-RECEIVED
2013 APR 25 AM 11:28
DAVID HAMILTON
C.C.C.P. & G.S.
YORK COUNTY, SC

I hereby certify that I have this date served a copy of the within and foregoing Defendant Rock Hill Gynecological and Obstetrical Associates, P.A.'s Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict, and Motion to Alter or Amend the Judgment, as well as the Memorandum of Law in Support of Defendant Rock Hill Gynecological and Obstetrical Associates, P.A.'s Motion to Reconsider, Motion for Judgment Notwithstanding the Verdict; and Motion to Alter or Amend the Judgment upon The Honorable Steven H. John and the Plaintiff by email and by depositing a copy of same in the United States Mail with first class postage addressed to:

D. Bradley Jordan, Esquire
Jordan Law Firm, PC
P.O. Box 11785
Rock Hill, SC 29732

James W. Boyd, Esquire
P.O. 36425
Rock Hill, SC 29732

The Honorable Steven H. John
Presiding Circuit Court Judge
1301 Second Avenue, Suite 3A30
Conway, SC 29526-5234

This 25 day of April, 2013.

Greenville, South Carolina.

By:

Caitlin M. Kital
DAVIS, SNYDER, & WILLIFORD, P.A.

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED

AUG 09 2013

APPEAL FROM YORK COUNTY
Court of Common Pleas

SC Court of Appeals

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

Samantha Jamison, as Personal Representative of the
Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

Ansley L. Hilton, MD, individually and as agent,
servant or employee of Rock Hill Gynecological
and Obstetrical Associates, PA; Christopher B.
Benson, MD, as agent, servant or employee of Rock
Hill Gynecological and Obstetrical Associates, PA;
and Rock Hill Gynecological and Obstetrical Associates,
PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

NOTICE OF APPEAL

Rock Hill Gynecological and Obstetrical Associates, P.A., hereby appeals the orders of
the Honorable Stephen H. John rendered orally on April 12, 2013, and in written form (Order
Denying Motion for Reconsideration) on July 15, 2013. The Appellant received written notice

of the Order Denying Motion for Reconsideration, which constituted Judge John's final ruling, on July 15, 2013. A copy of the written order is attached.



Thomas C. Salane
R. Hawthorne Barrett
Turner Padget Graham & Laney P.A.
P.O. Box 1473
Columbia, SC 29202
(803) 254-2200
TSalane@TurnerPadget.com
TBarrett@TurnerPadget.com

Attorneys for the Appellant

August 9, 2013

Other Counsel of Record:

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(803) 817-7999

James W. Boyd, Esq.
P.O. Box 36425
Rock Hill, SC 29732
(803) 328-2600

Attorneys for the Respondent

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
COUNTY OF YORK)	SIXTEENTH JUDICIAL CIRCUIT
	CASE NO.: 2011-GS-46-0683
Samantha Jamison, as)	
Personal Representative)	
Of the Estate of Jayden)	
Joenelle Jamison-Barber,)	
PLAINTIFF)	
vs.)	
Ansley L. Hilton, M.D.,)	
Individually and as)	
Agent, Servant or Employ-)	TRANSCRIPT OF RECORD
ee of Rock Hill Gynecolo-)	
gical and Obstetrical)	
Associates, P.A.;)	
Christopher B. Benson,)	DAY 1
M.D., as Agent, Servant)	
Or Employee of Rock Hill)	
Gynecological Associates,)	(Pages 1 - 143)
P.A., and Rock Hill)	
Gynecological and)	
Obstetrical Associates,)	
P.A.,)	
DEFENDANTS.)	

April 8, 2013
YORK, SOUTH CAROLINA

B E F O R E:
HONORABLE STEVEN JOHN

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

James W. Boyd, Esquire
Rock Hill, SC

Bradley Jordan, Esquire
Rock Hill, SC
FOR THE PLAINTIFF

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FOR THE DEFENDANTS

SHIRLEY BROOM
16TH Circuit Court Reporter

1 of society of Jayden. By the end of the trial you will
2 see why the evidence will force us to ask you for a
3 verdict for the plaintiff. We'll be asking for a verdict
4 in the amount of three hundred and ninety-five thousand to
5 compensate Jayden's mother and his heirs for their loss.
6 Thank you.

7 The Court - Counsel?

8 Mr. Williford - May it please the Court.

9 The Court - Yes, sir.

10 Mr. Williford - Good afternoon. My name is
11 David Williford, and I along with Ashby Davis represent
12 Dr. Hilton and Dr. Benson and their group, Rock Hill
13 Gynecolo -- I'll just call it Rock Hill Gyn-Ob -- in a
14 lawsuit as you have heard. Why are we here? We're here
15 because Samantha Jamison on behalf of her attorneys have
16 sued Dr. Hilton, Dr. Benson and Rock Hill Gyn-Ob for
17 malpractice causing the death of her unborn baby. That's
18 why we're here. Why are you here? You are here to
19 determine the facts, and there's ultimately one question
20 at the end of the week, and it's going to be a very long
21 week, and I apologize in advance for that, but there's one
22 question for you to decide, and that's whether Dr. Hilton,
23 Dr. Benson or Rock Hill Gyn-Ob committed malpractice and
24 caused the death of Ms. Jamison's 32 week gestational
25 baby. That's the ultimate question that will be before

1 you, and that's why you are here. Let me be clear about
2 one thing. No one would wish this on Ms. Jamison. This
3 is an incredibly unfortunate outcome for her. That's not
4 in dispute. What do we expect the evidence to show. We
5 expect the evidence to show that this was an unknowable,
6 unpredictable and unforeseeable outcome based on what they
7 knew at the time and based on the evidence in this case.
8 Briefly let me introduce you to Dr. Hilton first. Dr.
9 Hilton, will you stand and I see her husband just came in
10 the courtroom. This is Dr. Ansley Hilton, married to
11 Richard Hilton who just walked in. She started out as a
12 nurse and went back to medical school. She's a mother of
13 four, has four children. She's also a doctor. And
14 sitting next to her is Dr. Benson, Dr. Chris Benson. He's
15 an Ob-Gyn as well. He's married and has three children,
16 one in college, has been an Ob-Gyn for over 20 years and
17 they have a practice at Rock Hill Gyn-Ob. What are the
18 facts of this case? I'm going to hold up a chart. The
19 facts of this case involve this, and this is the day of
20 Ms. Jamison's son's death on September 5th, 2008, but
21 before I get to this, Ms. Jamison showed up to Rock Hill
22 Gyn-Ob late in her pregnancy in her second trimester and
23 she had two different menstrual dates, last menstrual
24 period dates, about a month apart and the physicians were
25 trying to determine what is the due date of the baby.

1 Well, you'll hear testimony in the case from the
2 physicians that the best dating criteria when you have
3 discrepancy in last menstrual periods is the first
4 ultrasound, and they did that. They did that on July
5 18th, and they determined that her estimated due date was
6 November 1st. And while it varied a little bit throughout
7 the course of her pregnancy based on different
8 measurements and timing, it ultimately remained constant.
9 She was followed then by those at Rock Hill Gyn-Ob and
10 there were some visits in normal prenatal care that she
11 would come to and they would treat her. You heard that
12 she was high risk and was not treated for that. We expect
13 the evidence to show that she was treated for that. For
14 example, her chronic hypertension. These physicians knew
15 that and they treated her. They gave her Aldomet which
16 treats that and it was controlled. They understood that
17 she had a prior uterine rupture. They knew that. That's
18 why they had scheduled -- well, they didn't schedule yet,
19 but they made plans in the records that when she was going
20 to have the baby, when it was due they were going to do a
21 c-section for her safety. They knew these things and they
22 planned accordingly. So what happened on the day of the
23 baby's death? At 8:40 a.m. Ms. Jamison signed in at Rock
24 Hill Gyn-Ob. This is when she comes in and she did not
25 have an appointment, but she came in for her complaint of

1 decreased fetal movement, not no fetal movement. The
2 evidence will show that it was decreased fetal movement
3 which is a common complaint of pregnancy. Certainly you
4 want to evaluate that and that's what they did, but it was
5 not no fetal movement. So decreased fetal starting at
6 8:40. A lot of things happened. She signed in; she was
7 an unscheduled patient; she was a third patient for Ms.
8 Pruitt. That was the earliest they could see her. Again,
9 not -- not an emergency but something they were certainly
10 going to check out. She was assigned a room, went to the
11 bathroom so they could get an urinalysis, essentially get
12 -- you know, pee in a cup and -- and test a few things,
13 whether they were leukocytes or protein, any infection,
14 sometimes they can determine that, so that's one of the
15 first things they did. She was called back to an exam
16 room. She was interviewed by the nursing assistant, not
17 a nurse practitioner yet but by the nursing assistant, got
18 the complaint. Health history was taking my Robin Pruitt,
19 nurse practitioner. What is that? Well, she comes in and
20 she evaluates her, asked her questions, how are you doing,
21 how's the baby doing, what's going on with the baby and
22 she listens to the baby. She actually hears a heart rate
23 and feels the baby, talks to Ms. Jamison, you know,
24 there's a decrease in fetal movement, but, you know, good
25 heart rate and what does Ms. Pruitt eventually do? Well,

1 she says, you know what, instead of just sending you home
2 I'm going to -- we're going to put you on a monitor,
3 what's called an NST. You'll hear that a lot throughout
4 the week. An NST is an non-stress test, and basically
5 what that is, if you haven't been pregnant before, is you
6 have -- you basically have a monitor on and see fetal
7 heart rates, and we'll show you those in this case.
8 You'll see just kind of a heart rate, and at the bottom
9 you might see a few contractions, braxton hicks
10 contractions occur and so you might see a couple down
11 here, but you'll see a heart rate, and that determines the
12 baby's heart rate. Well, heart rate was normal, was in
13 the normal range. You will hear about whether there are
14 any variable decelerations, you know, on a heart rate, and
15 initially the NST, the overall NST was started at about
16 either 9:50 or 10:00 o'clock. Mr. Jordan is right in that
17 on the strip in the records that it does say 8:50 but that
18 was looked into and they don't test the timing for that
19 when they submit their machines and that was checked out
20 by the manufacture and you will hear evidence about that,
21 and so they checked it and it was one of the two machines,
22 so it was eight 9:50 or 10:00 o'clock in the morning, and
23 again, you'll hear evidence about that, the NST was
24 started. The fetal heart rate was normal overall. It
25 runs for about 30 minutes. This lasted for about 34

1 minutes, this NST, so she's being monitored in the office
2 for 34 minutes with this NST. So again corroborate what
3 Ms. Pruitt hear to listen the heart rate, and it was
4 complete. At about 10:24 or 10:34 Ms. Pruitt she reviewed
5 the NST. What did it tell her? Well, it told her, well,
6 you know, it didn't meet certain criteria for allowing you
7 to go home, but is not an emergency. You will hear
8 testimony from all the experts and the doctors in the case
9 about this and Dr. Phillips, the expert for Ms. Jamison,
10 Mr. Jordan and Mr. Boyd, we expect evidence to show that
11 he will say that was not an emergency either. So at this
12 point 10:24 or 10:34 the NST is complete and there is no
13 emergency. The heart rate and the strips overall are
14 okay, but it's indeterminate. They need to get more
15 information. So what did -- what did Ms. Pruitt do? She
16 said, well, I'm still not going to send you home; let's go
17 ahead and get further evaluation, and a BPP, a biophysical
18 profile is ordered, and what is that? It's basically an
19 ultrasound, but they're looking for certain things, and
20 that's ordered by Robin Pruitt, and Robin also says, you
21 know what, let's also get a physician to evaluate the
22 baby, keeping in mind that at this point the gestational
23 age of the baby is 32 weeks, not full time, it's 32 weeks.
24 The risk should a c-section get performed right then and
25 there -- at this point there's no indication for that, but

1 keep in mind throughout this whole time that the
2 gestational age of the baby is at 32 weeks, not full term.
3 So BPP's ordered and a BPP is started by 10:48. We'll
4 show the evidence where it clocks the time at 10:48. It
5 may have been 10:46, 10:47 by the time she's in a room and
6 they set up her for that, but by 10:48 the BPP starts.
7 What's normal -- well, the AFI, what is that? It's the
8 amniotic fluid index. And that's -- you'll hear the
9 physicians talk about that -- but basically is a
10 reflection of the amniotic fluid, when the baby's in the
11 uterus, you have amniotic fluid in there and what that is
12 the fluid and urine from the baby, it shows that the
13 baby's kidneys are working, it shows fetal health and that
14 was normal. Now, it wasn't the only thing normal. I
15 believe Mr. Jordan said that that was the only thing
16 normal. That was not the only thing normal. The fetal
17 heart rate was normal as well. It was at a 158 beats per
18 minutes. You will see that in the record, in the
19 evidence. That was normal as well. There's a doppler
20 study performed, and that was 1.6. It's on the low side
21 of the scale, but it wasn't concerning for an emergency.
22 So there were three things that during the BPP in this ten
23 minute BPP, they said, you know, okay there's some normal
24 things going on but there were certainly some concerning
25 things as well, and basically there's a score of two out

1 of eight based on fetal tone, fetal movement and breathing
2 and of course the baby doesn't breath air in the uterus
3 but they're practicing breathing movements. So at 10:58
4 at ten minutes the biophysical profile stopped early per
5 Dr. Hilton's orders. By this time Dr. Hilton has come in
6 the room. This is what she does. You know, she comes in
7 and she's interacted with the patient, she wants to find
8 out, okay, you know, I've been ordered to see Ms. Jamison,
9 I want to go in myself and I want to go look at the
10 ultrasound, I want to look at the BPP. The BPP again is
11 stopped in ten minutes. Well, you will hear testimony
12 that a normal BPP can last for ten minutes, 20 minutes,
13 often times 30 minutes, because baby had -- babies have
14 sleep cycles. You will hear and we expect the evidence to
15 show that in this case if Dr. Hilton wanted to extend the
16 BPP for another 20 or even 30 minutes to check, okay, you
17 know, we don't want to emergilently do anything here; we
18 need to see the fetal well-being, but she stopped it
19 early. She had sense -- and intuition perhaps, but at
20 this point she doesn't know. It's got a normal heart
21 rate, normal AFI, doppler studies aren't -- aren't
22 concerning for an emergency; there are other things that
23 had the baby, with what she new at the time, had the baby
24 been watched for 20 or 30 minutes very well might have
25 changed and would've been normal, but she says, you know

1 what, I'm -- I want you to go right to hospital; I want
2 you to go for further evaluation. You will see the
3 medical records reflected that. So she tells Ms. Jamison,
4 I want you to go straight to labor and delivery; I'm going
5 to call my partner, Dr. Benson, who's on call there at
6 labor and delivery managing other patients as well, but he
7 will be there; he will have a team ready in case we need
8 to do a c-section, keeping in mind this is again a 32 week
9 gestational baby, you don't immediately do a c-section
10 when you don't have to. So what does Dr. Hilton do? She
11 says go straight to labor and delivery, don't stop at go,
12 don't collect two hundred dollars, go straight there.
13 Also keep in mind that Ms. Jamison had been to labor and
14 delivery a few weeks before, almost a month before. She
15 knew where to go. At 11:00 o'clock Ms. Jamison leaves
16 Rock Hill Gyn-Ob or thereabouts, could've been 11:01,
17 thereabouts, 11:02, she leaves Rock Hill Gyn-Ob to go
18 straight to L&D. She arrives at 11:40, and keep in mind
19 that their office -- and you'll hear testimony about this
20 -- is about five minute away from the hospital. And so she
21 arrives at 11:40. Dr. Benson eventually evaluates Ms.
22 Jamison a few minutes after the nurses receive her when
23 she arrives at L&D, and they do an evaluation. They're
24 not doing a c-section right away, because they're going to
25 evaluate the baby and they can't find fetal heart tones.

1 And they do it again, and they can't find fetal heart
2 tones, then they call Dr. Benson and they say, doctor,
3 we're not finding anything here, I want you to evaluate
4 her as well. And he does; he evaluates the baby and
5 there's no fetal heart tones. And it's tragic for
6 everyone involved, particularly Ms. Jamison. And you will
7 hear testimony about what happened at the hospital
8 thereafter. Those are the facts of the case. That's what
9 we expect the evidence to show. Also and I want to
10 reiterate, when Dr. Hilton called to talk to Ms. Jamison,
11 said go straight to L&D, the ultrasonographer, Jane
12 McCain, was there as well, and she also told Ms. Jamison
13 to go straight to L&D, don't stop at Hardee's, because
14 there's a Hardee's kind of near their office, you know,
15 don't stop at Walmart, just go straight to L&D. We expect
16 the evidence to show again that it -- with all the
17 evidence that the physicians had before then, that when
18 Dr. Hilton said go straight to L&D, no one expected this
19 baby to die within 40 minutes, whatever time that was.
20 You will hear testimony from all the doctors, every single
21 one of them will say -- we expect the evidence to show
22 that nobody knows when the baby died. Nobody knows what
23 caused the baby to die. It was unexpected, unknowable,
24 unforeseeable and unpredicted. Well, how are you as
25 jurors determine whether or not Dr. Hilton and Dr. Benson

1 should be held liable in a medical malpractice in this
2 case if it was unknowable, unforeseeable, unpredictable?
3 Well, you apply the law. So what is the law? The law
4 says -- and let me say this to you. Anything that I say
5 that is different than what Judge John says, don't -- just
6 disregard what I say. He is certainly the officer of the
7 Court, the one in charge of the law. He will give it to
8 you at the end of the case, and that'll be very important,
9 be very important to listen to him, but what I expect the
10 law to include is the fact that if this is an
11 unforeseeable event, if this is unforeseeable, there's no
12 medical malpractice, there's no negligence. I also expect
13 the law to include the fact that if there's a bad
14 unfortunate result, that in and of itself is not
15 malpractice. I also expect the law to include the fact
16 that sympathy, while there will be in this case -- no one
17 doubts that, no one questions that -- that in and of itself
18 is not a basis for a verdict. Hindsight. You will hear
19 a lot about hindsight. You know the outcome of what
20 happened. At the time that Dr. Hilton evaluated Ms.
21 Jamison and the baby at that time, what evidence did she
22 have before her to predict that this baby was going to die
23 in 30 or 40 minutes or whatever time it was -- could've
24 been five minutes, could've been three minutes after she
25 left the office. No one knows. Hindsight is not a basis

1 for a verdict. You can't look back; you can't play Monday
2 morning quarterback. Hindsight's 20/20. It's easy to
3 look back, but the law doesn't allow that. And the
4 standard of care; well, what is the standard of care?
5 What is it by which you judge Dr. Hilton and Dr. Hilton
6 and their group in this case? What's the standard of care
7 for Ob-Gyns? The standard of care is what the reasonable
8 Ob-Gyn would do or not do in the same or similar
9 circumstances. So what does that mean? Well, it means
10 was Dr. Hilton, was Dr. Benson, were they reasonable, were
11 they reasonable? That is the standard by which you should
12 judge them. So what do you do? Well, as you hear
13 evidence in the case, ask yourselves these questions. Was
14 it reasonable for Robin Pruitt to do all that she did up
15 here, to examine her, to order an NST and based on the NST
16 not send her home but, you know, get a physician consult,
17 have a physician see her, as well as getting a BPP,
18 ordering a BPP? Was that reasonable under the
19 circumstances? Ask yourself that question. When the BPP
20 started at 10:48 when there's a normal AFI, normal heart
21 rate, doppler studies were not emergently -- it wasn't an
22 emergency based on the doppler studies either. Based on
23 that, in addition to the fact that two out of eight is
24 concerning, no doubt. There's concern there. Again, not
25 an emergency, and again this test typically gets run for

1 20 to 30 more minutes to get really a full evaluation.
2 Was it reasonable for Dr. Hilton to instruct her directly
3 go -- go directly to labor and delivery, been there
4 before, go directly to labor and delivery; do you have
5 transportation? She asked that, confirmed it. Do you
6 know where to go? She confirmed that. Was it reasonable
7 for Dr. Hilton to do that? And then Dr. Benson, was it
8 reasonable for him to be ready to perform a c-section if,
9 if they had to do that? At this time no one could predict
10 the fact that this baby was going to die during that time-
11 frame. We expect the evidence to show that. We also
12 expect the evidence to show that Dr. Hilton did not say,
13 look, you need to do an emergency c-section right now.
14 No. We expect the evidence to show that, you need to go
15 to the hospital, this is a truncated test, meaning it's
16 only ten minutes, but I would rather you be at the
17 hospital to finish the test, finish an evaluation, but be
18 there in case we have to do a c-section. Was that a
19 reasonable one? Those are the questions that you should
20 ask yourself in this case. You're going to hear from
21 witnesses and experts as well. The only maternal fetal
22 medicine specialist in this case -- we've looked at the
23 case -- is going to come at this point on Friday according
24 to the schedule, so this case will go for a long week.
25 He's reviewed the case and has said that the care was

1 appropriate; there was no deviation in the standard of
2 care; there was no malpractice here. There was good care,
3 despite an unfortunate outcome. There are other expects
4 we expect to bring, Dr. Moore, who's a practicing Ob-Gyn
5 in Greenville, and he's reviewed the case as well and said
6 there is no malpractice here, unfortunate outcome, no
7 malpractice. You will hear from the witnesses, Dr.
8 Hilton, Dr. Benson, and those at their office to testify
9 about the care that they provided in this case. At the
10 end of the case -- Judge John was right; Mr. Jordan was
11 right as well in terms of weighing the evidence. At the
12 end of the case you're -- the sole thing primarily that
13 you have to do is determine whether or not Dr. Hilton and
14 Dr. Benson was really malpractice and caused the baby's
15 death. So in determining that question you weigh the
16 evidence. If -- since the plaintiff has the burden of
17 proof, that they must carry their burden and present
18 evidence. And then towards the end of the week when the
19 defense puts on our case -- we'll put on our case as well
20 -- you have to weigh all of that throughout the case. At
21 the end of the case you'll have all the evidence that you
22 need to make a decision. If the evidence tips ever so
23 slightly in favor of the plaintiff, your verdict should be
24 for the plaintiff. And if your evidence -- if the weight
25 of the evidence tips ever so slightly in favor of

1 defendants, your verdict should be for the defense. If
2 it's even -- there's a third option. If it's even, then
3 your verdict should be under the law for the defendants,
4 because the plaintiff has not carried her burden of proof.
5 This will be a long trial. I apologize in advance for
6 that. But it's important. It's very important, because
7 it's -- it's a lot of information. All the parties in
8 this case, Ms. Jamison, Dr. Hilton, Dr. Benson, they've
9 been involved in this lawsuit, all the parties, for two to
10 three years. It's really important to them. A week is a
11 long time but it takes that long to get all the
12 information that needs to come out for you to fully
13 consider and weigh the evidence in this case. It means a
14 lot to all the parties. I want to thank you in advance
15 for your time, for your attention. And again, I think
16 we're about to start. Thank you for your time.

17 The Court - All right, ladies and gentlemen, I'm
18 going to take a very short break for ten minutes. Go back
19 in your jury room and we'll be with you in ten minutes.
20 Thank you very much. Everyone remain seated, please.

21 (Jury exits the courtroom)

22 The Court - All right, we'll be at ease for ten
23 minutes.

24 (Recess taken)

25 The Court - All right, plaintiff's ready for the

1 jury to come back in?

2 Mr. Jordan - Yes, Your Honor.

3 The Court - Defense?

4 Mr. Davis - Yes, sir, could I ask the Court to
5 please sort of instruct the jury about communication with
6 attorneys. And I'm sorry --

7 The Court - Yes, sir. I'm sorry. Thank you.
8 Absolutely.

9 Mr. Davis - Thank you, sir.

10 The Court - Ask the jury to come in.

11 (Jury returns to the courtroom)

12 The Court - All right, ladies and gentlemen, I
13 meant to tell you this earlier -- remembered to -- I
14 instructed the lawyers and placed the lawyers and other
15 participants in the trial under certain rules and they
16 understand those as far as not having any contact with the
17 jurors. So I just wanted y'all to understand if you
18 happen to know any of them or even if you don't, if you
19 happen to see them outside of the confines of this
20 courtroom, they're under the rules and restrictions of the
21 Court not to have any interactions with the jury, so don't
22 -- they're not being rude. They're following my
23 instructions. All right? Thank you very much. You may
24 proceed.

25 Mr. Boyd - Plaintiff calls Samantha Jamison.

1 The Court - All right, come up to the witness
2 chair, please, ma'am. Right around here.

3 Samantha Jamison, after being first duly sworn,
4 testifies as follows -

5 The Court - All right, if you'd state your name
6 for the record, please, ma'am.

7 Ms. Jamison - Samantha Rochelle Jamison.

8 The Court - Is it possible for you to move that
9 chair up just a little bit to be closer?

10 Court Reporter - It doesn't move.

11 The Court - All right, thank you. So if you can
12 just try and maybe speak up just a little bit. Okay? All
13 right, thank you, ma'am. All right, you may proceed, sir.

14 Direct Examination

15 By Mr. Boyd -

16 Q And, Samantha, how old are you?

17 A I'm 35 years old.

18 Q Okay, and where do you live?

19 A I live in Chester, South Carolina.

20 Q And do you have some children?

21 A Yes, I do.

22 Q And are they girls or boys?

23 A They're all girls.

24 Q And how many children do you have?

25 A I have three girls.

- 1 Q Okay. What are their ages?
- 2 A My oldest is 16, 14 and 12.
- 3 Q And let me ask you. Back in 2008 did you discover
- 4 you were pregnant?
- 5 A Yes, I did.
- 6 Q And --
- 7 Mr. Boyd -- Would the Court indulge me for one
- 8 moment?
- 9 The Court - Yes, sir.
- 10 Mr. Boyd -- I don't know what's going on.
- 11 Q Okay. Approximately when did you discover you were
- 12 pregnant?
- 13 A I found out I was pregnant maybe in March or April.
- 14 Q Okay. Of 2008?
- 15 A Yes, sir.
- 16 Q Okay. And how did you discover you were pregnant?
- 17 A I took a home pregnancy test.
- 18 Q And when did you seek medical attention?
- 19 A I went to the doctor, think it might've been in April
- 20 of 2008 or --
- 21 Q You're going to need to speak up a little bit. Okay?
- 22 A Um, it might've been in April of 2008 when I went to
- 23 the doctor.
- 24 Q When did you -- who did you first go see a doctor
- 25 about your pregnancy?

1 A That was North Central Family Medicine in Chester,
2 South Carolina.

3 Q Okay. And I believe there's a medical record that
4 shows that you went to North Medical -- Central -- on July
5 the 11th of 2008. Would that be accurate?

6 A That sounds right.

7 Q Okay. And why did you not go to the doctor before
8 that time?

9 A Um, I was not able to go financially.

10 Q Okay. And when you went to North Central Medical,
11 did they refer you anywhere?

12 A Yes, they did.

13 Q And where did they refer you to?

14 A To Rock Hill Ob-Gyn.

15 Q Okay. Where was Rock Hill Ob-Gyn located?

16 A It's located -- I'm not sure if it's Herlong or
17 Ebenezer -- in Rock Hill, South Carolina.

18 Q And did you make an appointment to see them?

19 A Yes.

20 Q Okay. And I believe there's a record that says you
21 first saw them on July the 18th, 2008. Would that be
22 accurate?

23 A Yes, sir.

24 Q Okay. And um could you just describe what was done
25 on your first visit with Rock Hill Ob-Gyn?

1 A My first visit I think I um -- I talked to the nurse
2 practitioner. They started me on my blood pressure
3 medicine. They gave me my estimated due date, and they
4 scheduled a c-section for later that afternoon as well.

5 Q They did what?

6 A They scheduled me for a -- they did a c-section that
7 same -- not a c-section. I'm sorry. They did a
8 ultrasound the same day. I'm sorry.

9 Q And do you remember -- did you see a physician on
10 that day, a doctor?

11 A Yes, sir, I think I did.

12 Q Do you remember which doctor you saw at that time?

13 A It might've been Dr. Benson.

14 Q And was there a discussion concerning your due date
15 at that time?

16 A I'm not sure if it was -- they gave me a due date at
17 the appointment, but I don't think there was a discrepancy
18 or anything.

19 Q A discussion of it between you and the doctors
20 concerning the due date, was there a discussion about it?

21 A Yes.

22 Q Okay. What due date were you given, if you recall?

23 A I believe it was October or either November of 2008.

24 Q Now, after -- so at that time you were given some
25 blood pressure medicine. Is that correct?

- 1 A Yes, sir.
- 2 Q Was it your understanding that you had high blood
3 pressure at that time?
- 4 A Yes, sir.
- 5 Q Now, did you find out whether you were going to have
6 a girl or a boy at that time?
- 7 A Yes.
- 8 Q And what were you told you were going to have?
- 9 A A boy.
- 10 Q And what was your reaction to finding out that you
11 were going to have a boy?
- 12 A Me and my daughters we were -- we were happy that we
13 were having a boy.
- 14 Q Now, did you go back to the doctor during July?
- 15 A Yes, sir.
- 16 Q Okay. And, if you recall, what was done on that
17 visit?
- 18 A In July?
- 19 Q Yes.
- 20 A I want to say it was just a routine visit, blood
21 pressure, urine, measure my stomach, listen to the
22 heartbeat on that visit.
- 23 Q Okay. Now, did you -- did you tell your other family
24 that you were going to have a boy?
- 25 A Yes.

1 Q Okay. And what was the reaction of other members of
2 your family that you were going to have a boy?

3 A They were happy, because we don't have too many
4 little boys in our family, so everyone was happy.

5 Q Did you do any -- well, let me ask you this. Did you
6 decide on the name for your boy?

7 A Yes, I did.

8 Q And what was the name you decided on?

9 A Jaydeon Joenelle Jamison-Barber.

10 Q Okay. And how did you come up with that name?

11 A Jonell -- his middle name is from my brother and my
12 father's middle name together.

13 Q All right. And did you do other preparation for the
14 coming of Jayden?

15 A Yes.

16 Q And what kind of preparation did you do?

17 A My family gave me a baby shower. I had bought him a
18 baby bed. I had bottles, pampers, blankets, outfits,
19 socks, everything that he would've needed.

20 Q Okay. And were you excited and looking forward to
21 his birth?

22 A Yes, I was.

23 Q The -- now, I believe -- did you have some
24 difficulties that led you going to the hospital on August
25 the 9th, 2008?

1 A Yes.

2 Q Okay. What was going on at that time that led you to
3 go to the hospital?

4 A I was hurting.

5 Q All right, where were you hurting?

6 A In my abdomen.

7 Q Okay. Did you go to the emergency room?

8 A Yes.

9 Q Okay. So you didn't go to labor and delivery on that
10 day. Is that correct? You went to the emergency room?

11 A Went to the emergency room. I think they might've
12 sent me maybe upstairs to labor and delivery to monitor.

13 Q Okay. And were you overnight at the hospital at that
14 time or treated and released?

15 A I didn't stay overnight. I was treated and released.

16 Q Okay. And do you recall the doctor you saw at that
17 time?

18 A I -- it wasn't Dr. Benson. I think it might've been
19 Dr. Miller.

20 Q Okay. And is he another doctor with the practice of
21 Rock Hill Gyn-Ob?

22 A Yes, sir.

23 Q And do you know what they diagnosed you with at that
24 time?

25 A No, sir. They just told me that I was having mild

1 contractions.

2 Q And were you given any medicine or any treatment at
3 that time?

4 A No, sir.

5 Q Okay. Do you know if any ultrasound was done at that
6 time?

7 A No, sir.

8 Q And let me ask -- after that point, did you have a --
9 I believe -- do you recall approximately the day of the
10 week you went to the emergency room?

11 A I can't remember what day it was.

12 Q Okay. And a few days after that, did you go back in
13 and have a visit at Rock Hill Gyn-Ob?

14 A Yes.

15 Q Okay. And do you recall what was done at that time?

16 A I'm not exactly -- I can't remember what was done on
17 that visit.

18 Q But you did have a visit at that time.

19 A Yes.

20 Q And was that a followup from the visit in the
21 hospital?

22 A From the emergency room, yes.

23 Q And were you scheduled for any additional visits with
24 Rock Hill Ob-Gyn?

25 A I'm quite sure I probably was if I had an appointment

1 after that. I'm not sure from that date.

2 Q Now, a record also shows that you went to Rock Hill
3 Ob-Gyn on August the 25th. Is that correct?

4 A Yes, sir.

5 Q Okay. And was that a regular scheduled visit?

6 A Yes, it was.

7 Q Okay. Were you having any problems at that time?

8 A I had noticed that he had started moving less.

9 Q And he was moving, but less.

10 A Yes.

11 Q And did you let the doc -- who's the doctor you saw
12 at that time?

13 A I'm -- I can't remember what doctor I saw that day?

14 Q Okay. Do you remember if it was a male or a female?

15 A It was a male.

16 Q Did you -- do you know what tests were done at that
17 time?

18 A On the 25th -- I can't remember if they did another
19 ultrasound or not on that visit. I can't remember.

20 Q Okay. Were you -- besides Jayden not moving as much,
21 were you having any other difficulties?

22 A I remember my leg being -- my leg being swollen, my
23 left leg.

24 Q And were you given any kind of treatment at that
25 time?

- 1 A No.
- 2 Q Were you scheduled for a followup visit?
- 3 A I think two weeks from that date I was.
- 4 Q And did you go back to the doctor before that two
- 5 week visit?
- 6 A Yes.
- 7 Q Okay. And particularly did you go to Rock Hill Gyn-
- 8 Ob on September the 5th of 2008?
- 9 A Yes.
- 10 Q Can you tell us what led up to your going there on
- 11 that day?
- 12 A My -- Jayden still was moving less. I was told that
- 13 he would move less when it was closer time for me to
- 14 deliver him, but it just didn't feel right, so that's why
- 15 I went to the doctor.
- 16 Q Okay. And in particular, the evening before, the day
- 17 before, when did you -- at what point did you decide you
- 18 needed to go back to have that checked out?
- 19 A The night before.
- 20 Q Okay. And what particularly the night before led you
- 21 to do that?
- 22 A Nothing really in particular. I wasn't hurting or
- 23 anything. It was just he was moving less.
- 24 Q And the -- did you have discussion with your mother
- 25 or any other family about that you were going to go back

1 to the doctor?

2 A Yes, I did.

3 Q And so on the morning of September the 5th, what did
4 you do?

5 A I got my children up, ready for school. Once they
6 got on the school bus, I went home and got dressed and
7 went to the doctor's office.

8 Q Okay. Now, you live in Chester. Is that correct?

9 A Yes, I do.

10 Q So once your children are on the school bus, you got
11 ready and you drove to the doctor's office.

12 A That's correct.

13 Q And do you know what time that you got there?

14 A Maybe about 8:30, 8:35, I'm not sure.

15 Q Okay. And do you recall if you signed in or not?

16 A Yes, I did.

17 Q Okay. And I believe on the record there's a time of
18 8:30 and there's a markout 8:40. Do you recall if you did
19 that or do you know?

20 A No, I don't.

21 Q You don't remember?

22 A I don't remember.

23 Q The -- tell us what happened after you arrived there.
24 What was the first thing that you did?

25 A When I first got there I signed in; I let them know

1 that I had called beforehand and told them that I was
2 coming. I went into the bathroom, used the bathroom, and
3 I went back into the waiting room and waited for them to
4 call me to the back.

5 Q Okay. And do you recall approximately how long you
6 waited at that time?

7 A Maybe 30 minutes. I'm not quite sure.

8 Q And I want to show you a record from the medical
9 records. Was it -- let me ask -- you -- so you waited for
10 some period of time?

11 A Yes.

12 Q And where did you wait?

13 A In the front -- front lobby, in the waiting area.

14 Q Okay. And I think it's up now. If you look at that
15 and is -- is that showing that you had signed in?

16 The Court - Can you see that, ma'am?

17 A I can barely see it.

18 Q You can step down if you like.

19 The Court - If you would like to, you may step
20 down. If you need to walk around, you can walk around and
21 see it.

22 A Which one is it?

23 Q I think the top is showing that you signed in at
24 8:40. Is that correct?

25 A Yes.

1 Q Now, after you had waited some period of time, what
2 happened?

3 A They called me to the back and took me in one of the
4 rooms.

5 Q And what did they do -- who did you see at that time?

6 A I think that was the nurse practitioner.

7 Q Okay. And would that be Robin Pruitt?

8 A I think that was her name, yes.

9 Q And had you seen her before during the practice --

10 A Yes.

11 Q -- in your visit to the practice?

12 A Yes.

13 Q And what -- what did they do at that time?

14 A She took my blood pressure and fetal monitor, well,
15 listed to the heartbeat.

16 Q Okay. And did they -- I know you're not familiar
17 with medical terms, but did they hook you to a machine to
18 measure fetal heartbeat at that time?

19 A No, I don't -- not at that time I don't think.

20 Q Okay. And were you told anything at that time
21 concerning your baby?

22 A No, not until after -- nothing that -- that they were
23 going to do a non-stress test next.

24 Q And they told you they were going to do a non-stress
25 test.

1 A Yes.

2 Q Okay. And did you have to wait for the non-stress
3 test?

4 A Yes, I did.

5 Q Where did you wait for that?

6 A I made a -- I think I waited in the hallway for that
7 test.

8 Q Okay. And then did they conduct a non-stress test on
9 him?

10 A Yes.

11 Q Okay. And did they -- did anybody tell you what the
12 results of the non-stress test were?

13 A Nothing but that I was having contractions. She
14 asked me if I could feel them; I told her no.

15 Q Okay. And did they tell you they were going to do
16 anything else at that time?

17 A They would do a -- she would let the doctor see the
18 test results and see what else they needed to do after
19 that.

20 Q Okay. And did you wait any period after that?

21 A Yes.

22 Q Okay. How long did you have to wait then?

23 A I'm not quite sure how long it was.

24 Q Okay. And ultimately did they tell you you were
25 going to have to do another test?

- 1 A Yes.
- 2 Q Okay. And did they tell you what kind of test they
3 were going to run next?
- 4 A Yes.
- 5 Q All right, what did they tell you?
- 6 A The next one was I think the biofetal (sic) profile.
- 7 Q Okay. A biophysical profile?
- 8 A Yes. I'm sorry.
- 9 Q And did -- at that time did -- is your understanding
10 what they did, was that involving an ultrasound?
- 11 A Yes.
- 12 Q Okay. Tell us what happened during the biophysical
13 profile or ultrasound?
- 14 A Nothing. I just remember her doing the ultrasound
15 and usually I would hear -- they would have the monitor on
16 where you could have the baby's heartbeat during the
17 ultrasound. I don't think it -- I heard anything that day
18 while she was doing it. She didn't have it on and after
19 that was done, I remember them telling me to go wait for
20 the doctor to come back in and talk to me or come out and
21 talk to me.
- 22 Q Okay. And did the doctor come in and talk to you?
- 23 A No, I was waiting and they sent me to a room, and the
24 doctor came into the room.
- 25 Q Okay. Do you know who the doctor was that came in

1 the room?

2 A Ms. -- um Dr. Hilton.

3 Q Okay. And what did Dr. Hilton tell you at that time?

4 A That she felt sometimes babies do better out than
5 what they do in, and she was going to send me over to the
6 hospital for them to monitor me a little more, or they
7 might want to send me to Charlotte, but she wanted me to
8 go to the hospital so they could monitor me.

9 Q And did she indicate to you in any way it was an
10 emergency situation?

11 A No.

12 Q Did -- did you do what she told you, to go directly
13 to the hospital?

14 A Yes.

15 Q Now, from the doctor's office to the hospital, how
16 long did it take you to get there and get inside the
17 hospital?

18 A Not long, maybe about five minutes.

19 Q Okay. Did you drive there?

20 A Yes, I did.

21 Q Okay. And when you -- on the way to the hospital,
22 did you make a phone call to anyone?

23 A Um I can't remember if -- if I did it would've been
24 my mother to call and let her know I was going to the
25 hospital for them to monitor me.

1 Q Okay. Did -- you went -- did you think you were
2 possibly having a baby that day at that point?

3 A I -- I really didn't know. No.

4 Q So when you arrived at the hospital -- well, let me
5 ask you this. Did they tell you where to go in the
6 hospital?

7 A To ask for labor and delivery.

8 Q Okay. And what -- where -- when you got to the
9 hospital, what entrance did you go into?

10 A I went into the -- I think it's the Women's Center
11 and it was a administrator's desk I stopped at and I told
12 them that I needed to go upstairs to labor and delivery,
13 and they told me I needed to go to admissions, right next
14 door to admissions first.

15 Q Okay. And where was admissions located?

16 A It was right beside the security desk, I guess, it
17 would have been.

18 Q Okay. And did you go to admissions?

19 A Yes, I did.

20 Q Okay. What did you tell them at that time?

21 A Um, when I first got in there there was a lady
22 checking her messages and I heard her listening to a
23 message, and I told her I was the patient that the message
24 was referring to.

25 Q Okay. Why did you think you were the patient the

1 message was referring to?

2 A Because I heard the message saying that there was a
3 patient coming over by my name, my date of birth and
4 saying that they needed a baby out stat.

5 Q Was it a female voice you heard on the recording or
6 a male voice?

7 A A female voice.

8 Q And who did you think that voice was?

9 A Dr. Hilton.

10 Q And what happened then?

11 A She explained to me that she was sorry for the
12 message being played and she started getting my
13 information admitting me into the hospital.

14 Q Okay. And do you know how long it took for that
15 process to go on, the admission process?

16 A It seemed like it took maybe about 30, 35 minutes --

17 Q Were you actually timing it at that time?

18 A No, I just know that it took a while.

19 Q And the -- while you were waiting, did you hear
20 anything else from any other doctors or anything of that
21 nature?

22 A No, I know the phone kept ringing. I remember the
23 phone ringing and I heard her say that she would bring me
24 up after she finished the process. --

25 Mr. Davis - Your Honor, we respectfully object

1 to the hearsay.

2 The Court - I'm going to sustain the objection.

3 Rephrase your question, please.

4 Mr. Boyd - Thank you.

5 Q Let me -- after the admission process, did you -- did
6 anyone take you anywhere?

7 A After we finished, she took me upstairs.

8 Q Okay. And where did you go upstairs?

9 A Into a room.

10 Q All right. And once you got into a room, what
11 happened then?

12 A There were nurses, anesthesiologists in there. They
13 told me to go to the bathroom, take my clothes off, put on
14 the hospital gown and get in the bed.

15 Q And did you do that?

16 A Yes, I did.

17 Q Okay. And what happened next?

18 A They were asking me question, if I was allergic to
19 any medications. They were I think maybe starting an IV
20 and trying to get the fetal monitor on my stomach.

21 Q Okay. And did they get a fetal monitor on your
22 stomach?

23 A No, they asked me what side did they hear the
24 heartbeat on when I was at the doctor's office and I
25 showed them.

- 1 Q Okay. And what happened then?
- 2 A They kept trying and I remember hearing one of the
- 3 nurses saying that her stomach is getting hard -- I mean
- 4 her stomach is getting soft, and I heard them call for the
- 5 doctor.
- 6 Q Did the doctor come in?
- 7 A Yes.
- 8 Q And who was the doctor that came in?
- 9 A Dr. Benson.
- 10 Q Okay. And what did Dr. Benson do at that time?
- 11 A He did another ultrasound.
- 12 Q Okay. And did he tell you any results from the
- 13 ultrasound?
- 14 A He told me that my baby was in breach position and
- 15 that he no longer had a heartbeat.
- 16 Q Did he do anything else at that time?
- 17 A No. Not -- no.
- 18 Q Okay. What was your reaction from finding out your
- 19 baby did not have a heartbeat?
- 20 A I was in shock. I asked for them to do another one
- 21 to see if he could hear or pick up another heart -- I mean
- 22 pick up a heartbeat.
- 23 Q Okay. And did they do another one at that time?
- 24 A They did.
- 25 Q And was it the same result?

1 A Yes.

2 Q And what happened then?

3 A After that um -- I can't remember. I remember my
4 sister being there and I really don't remember after that.

5 Q Do you remember did they give you any medication at
6 that time?

7 A I can't remember. I don't think I did. (sic) I
8 don't think so.

9 Q And what was your emotional condition upon finding
10 out that Jayden was no longer alive?

11 A In total shock and disbelief. I had just heard his
12 heartbeat before I had came right over to the hospital, so
13 I was in shock and disbelief that there couldn't be a
14 heartbeat just that -- that fast.

15 Q Did -- let me back up a little bit. When you left
16 the doctor's office, did you go directly to the hospital?

17 A Yes, I did.

18 Q Did you stop anywhere?

19 A No, I didn't.

20 Q Okay. Did you do exactly what they told you to do?

21 A I did.

22 Q Did your family get to the hospital?

23 A They did, yes.

24 Q Who all came at that point?

25 A My mother and my sister.

1 Q Okay. And did your aunt later come also?

2 A Yes.

3 Q Who is your aunt?

4 A Jackie Chaulk.

5 Q Okay. What's your mother's name?

6 A Barbara Jamison.

7 Q And are you and your mother close?

8 A Yes.

9 Q The -- when -- did they -- did anyone discuss with

10 you about having a c-section to take Jayden out after you

11 found out Jayden was deceased?

12 A Yes.

13 Q Okay. What was -- tell us about that conversation.

14 A I think they told me -- I don't know if they told me

15 I could come back at a later date and have a c-section

16 done, come back, or I could have it done then, and I

17 rather did it then instead of coming back.

18 Q And what did you decide to do at that time?

19 A To go ahead and have the c-section done.

20 Q Okay. And did Dr. Benson tell you anything about

21 when the c-section would be done?

22 A He said it would be later; he had to -- they had to

23 take care of the live babies first.

24 Q And so do you remember approximately what time the c-

25 section was performed?

- 1 A At 6:27.
- 2 Q When?
- 3 A 6:27.
- 4 Q And that was in the evening of that day. So you
5 remained in the hospital from the time you went in there
6 until the time of the c-section. Is that correct?
- 7 A Yes.
- 8 Q Okay. And what was your -- what were you thinking?
9 What was going on with you during that period of time of
10 waiting?
- 11 A Still in total shock, not knowing what happened. I
12 mean my baby and me life and limb was -- the blink of an
13 eye it was like he was gone.
- 14 Q Once the c-section was performed, did you get to see
15 Jayden?
- 16 A I did.
- 17 Q Did you get to hold Jayden?
- 18 A I kept him in my room. All that night I kept him in
19 the room with me.
- 20 Q And did your family members get to see him also?
- 21 A (Indicating yes)
- 22 Q I'm going to show you Plaintiff's Exhibits 1 and 2
23 and ask you, are these photographs of Jayden?
- 24 A They are.
- 25 Q And were those photographs made at the hospital?

1 A They were.

2 Q And do they truly depict how Jayden looked at that

3 time?

4 A Yes.

5 Q And I think it's showing on the screen, too. These

6 photographs depict how -- these are photographs made of

7 Jayden at the hospital --

8 A Yes.

9 Q -- shortly after the c-section. Is that correct?

10 A That's correct.

11 Q How long were you in the hospital?

12 A I think I was released the following Sunday.

13 Q Did you have a -- was there a funeral performed for

14 Jayden?

15 A Yes.

16 Q Let me ask you, back at the hospital you said Jayden

17 was with you that night, and did somebody from a funeral

18 home come and get Jayden?

19 A Yes.

20 Q Okay. And then when was the funeral for him?

21 A I think the funeral was that Tuesday or Wednesday.

22 Q I believe -- I'll show you -- I show you what's been

23 marked as Plaintiff's Exhibit Number 11, and is this the

24 funeral bill for Jayden?

25 A Yes, it is.

1 Q Okay. And what was the total costs of the funeral
2 from the funeral home?

3 A One thousand and eight dollars.

4 Q Thank you. And let me -- I'm going to show you
5 another document and I'll ask you, this is Plaintiff's
6 Exhibit Number 10, and that's also on the screen. Is this
7 the death certificate of Jayden?

8 A Yes, it is.

9 Q And I believe you have been appointed as the personal
10 representative of Jayden's estate. Is that correct?

11 A Yes.

12 Q Okay. And I'll show you one more document, and this
13 is also on the screen, and I believe this is your -- the
14 certificate appointment from the Chester County Probate
15 Court. Is that correct?

16 A That's correct, sir.

17 The Court - What exhibit is that, please, sir?

18 Mr. Boyd - I'm sorry. That is Plaintiff's
19 Exhibit Number 12.

20 The Court - Thank you.

21 Q How has the death of Jayden affected you?

22 A I still don't have closure as to what happened to
23 Jayden. I know I'm not a happier -- I'm not the same
24 person as I was then. Um, I stopped going to church. I
25 lost my faith because if anything, I thought something

1 would've happened to me and not him, so I lost a lot of my
2 faith, then just being depressed. I mean I'll be in the
3 bed more, still to the fact that I don't know what
4 happened to my child, and that was my son that I was
5 having.

6 Q And let me ask you this. Did -- during the c-
7 section, was any other procedure performed?

8 A Yes.

9 Q And what was that?

10 A I had my tubes tied.

11 Q Okay. Had you planned to have your tubes tied after
12 the birth of Jayden?

13 A Yes.

14 Q Okay. And did you make a decision at that time to go
15 ahead and have your tubes tied after the c -- or during
16 the c-section?

17 A Yes.

18 Q Did -- let me ask -- the -- as far as in the weeks
19 following the death of Jayden, can you just tell us what
20 was your condition during that time, both physical and
21 emotional?

22 A Emotionally I was depressed. Physically I had
23 developed -- I had got an infection after the surgery.
24 After the c-section I had got an infection and was treated
25 with antibiotics and after that just kind of take every

1 day -- take one day at a time.

2 Q Have you -- the items that you had received at
3 showers or maybe purchased yourself anticipating the birth
4 of Jayden, what did you do with those?

5 A I still have all his stuff.

6 Q Now, this happened in 2008. Is that correct?

7 A Yes.

8 Q It's now 2013. Do you still have effects from the
9 death of Jayden?

10 A Yes.

11 Q And just describe how you feel about that?

12 A If I see another child or another child that might be
13 about the same age as Jayden, I think about him. I miss
14 family baby showers. After I had him a couple of my
15 family members had babies and I missed their baby showers
16 because I couldn't -- it wasn't a happy time, so I missed
17 a lot of stuff.

18 Q Have you received any kind of counseling or treatment
19 for your depression?

20 A No, I can't afford it financially. I been trying to
21 get through it my own way with the help of my children.
22 With their memories and my memories of Jayden, they've
23 help me to kind of get -- get through it every day,
24 because at the end of the day my children are there as
25 well.

1 Q The -- what did -- just for the record, what's your
2 date of birth?

3 A 5/28/77.

4 Q Okay. And your girls, could you just tell us their
5 names?

6 A Erica, Sidney and Kayla.

7 Q And let me -- so you've reviewed the -- I believe
8 we've entered -- we've gone over State's (sic) Exhibits
9 11, 10 -- or 10, 11 and 12 and also 1 and 2. Is that
10 correct?

11 A Yes, sir.

12 Mr. Boyd - Your Honor, I'd like to publish these
13 to the jury.

14 The Court - You may do so.

15 (Documents published to the jury)

16 Mr. Boyd - Thank you. Answer any questions
17 these gentlemen have.

18 The Court - Cross examination.

19 Mr. Davis - May it please the Court.

20 The Court - Yes, sir.

21 Mr. Davis - Thank you, sir.

22 Cross Examination

23 by Mr. Davis -

24 Q Ms. Jamison, at the time that you first went to North
25 Central for your pregnancy with Jayden, you were at that

1 time about sixteen weeks pregnant. Would that be fair?

2 A Yes, sir.

3 Q All right. And you lived at that time in Chester?

4 A Yes.

5 Q Which was about 30 or 35 minute drive away from the
6 hospital or which is right near the hosp -- right near the
7 offices of Rock Hill Gyn-Ob. Is that fair?

8 A Yes.

9 Q All right. Let me ask you just a bit about the
10 August 9 time where you went to the emergency room with
11 abdominal pain and were admitted to the labor and delivery
12 floor from the emergency room. Okay?

13 A Okay.

14 Q I believe you testified already that you able -- or
15 you were seen by a Dr. Greg Miller, and you understand
16 that he was physician that works at Rock Hill Gyn-Ob. Is
17 that right?

18 A Yes.

19 Q Okay. And he saw you during that hospitalization?
20 Is that right?

21 A Yes.

22 Q And did they put a fetal monitor on you, the doctor,
23 the nurses there while you were on the labor and delivery
24 floor?

25 A Yes.

1 Q And that's a -- sort of like a belt that they put
2 around you that hopefully will pick up the heart rate of
3 your baby. Is that right?

4 A Yes, that's correct.

5 Q And if you're having any contractions, it'll sort of
6 show that, too, even if you don't know you're having them.
7 You understand that.

8 A Yes.

9 Q All right. And how long did they have you in the
10 hospital on this fetal monitor that day? Do you recall?

11 A I can't remember exactly how many -- how long. I'm
12 going to say maybe -- I might've been there maybe between
13 three to four or five hours. I'm not quite sure.

14 Q Okay. And during that time -- it was at night, was
15 it?

16 A Yes.

17 Q Okay. And the nurses would come and check on you
18 from time to time?

19 A Yes.

20 Q And would Dr. Miller also, did he also come and check
21 on you from time to time?

22 A Yes.

23 Q All right. And at some point that evening or maybe
24 early in the morning Dr. Miller determined it was safe for
25 you to go home.

1 A Yes.

2 Q And he wrote some discharge orders or whatever he
3 did, and you left and went on home that day. That was
4 August 9th or maybe the 10th about that time.

5 A Yes.

6 Q And did you go straight on home that early morning or
7 late night or whatever it was?

8 A Yes.

9 Q All right. And the next time you came to either the
10 hospital or to the Rock Hill Gyn office was -- was what
11 day? Do you remember? Was that the August 25 visit?

12 A Would've been August the 11th for a followup.

13 Q I'm sorry. Yes, do you remember who you saw on
14 August the 11th, Ms. Jamison?

15 A I'm not quite sure who I saw on that day.

16 Q Do you know whether it was a nurse practitioner or a
17 physician? Do you recall either way?

18 A I can't remember.

19 Q What was your understanding, ma'am, for the reason
20 for that visit on August the 11th which is in evidence,
21 but pretty much your understanding?

22 A Just a followup visit from the emergency room.

23 Q All right. And everything check out okay on August
24 11th?

25 A Yes.

- 1 Q All right. And sent on home that day?
- 2 A Yes.
- 3 Q Okay. And your next regular appointment was August
- 4 25, 2008. Is that correct?
- 5 A Yes.
- 6 Q And that's when you came in and were seen by Dr. Greg
- 7 Miller, again the same doctor who saw you in the hospital
- 8 on August 9?
- 9 A Yes.
- 10 Q And that was a regular visit. Correct?
- 11 A Yes.
- 12 Q Regular scheduled visit?
- 13 A (No response)
- 14 Q Do you know about how long that visit took?
- 15 A I'm not sure how long the visit took.
- 16 Q Okay. Your medical records indicate that the -- that
- 17 you had some high blood pressure during your pregnancy and
- 18 even before your pregnancy. Would that be fair?
- 19 A Yes.
- 20 Q And you knew that you had high blood pressure.
- 21 Correct?
- 22 A Yes.
- 23 Q And you probably told these doctors when you first
- 24 saw them that you had high blood pressure. Wouldn't that
- 25 be true?

1 A Yes.

2 Q Okay. And it's also true, is it not, Ms. Jamison,
3 that you didn't have any difficulty keeping your blood
4 pressure under control during your pregnancy with Jayden,
5 did you?

6 A Yes.

7 Q You did not have any problem with that?

8 A No, I was on medication.

9 Q Took whatever medications the doctors prescribed for
10 you, did you, and that seemed to control the high blood
11 pressure?

12 A Yes, sir.

13 Q All right. I want to look for a moment at the August
14 25 record that's in evidence if I can find it. Here it
15 is. It's part of Exhibit 2, just for the record, and I'm
16 going to try to find that record and we'll try to take a
17 look at it together. Here we go. Ms. Jamison, I'll be
18 glad to hand you a copy of what we're all looking at so
19 you won't have to come down here, ma'am.

20 A Okay.

21 Q All right. I'm going to read this and you please
22 feel free to read along with me as we look at this
23 together, the August 25, 2008 HPI, -- we'll ask the doctor
24 would he verify that --- but the note says, this patient
25 comes in today for evaluation. Ultrasound today shows

1 vertex presentation and a decreased AFI of nine. You
2 understand that that was some kind of fluid, amniotic
3 fluid index. Is that right?

4 A Yes.

5 Q Okay. She had a normal doppler study, studies, the
6 abdominal circumference was slightly behind two weeks,
7 however, because of the slightly diminished AFI, this
8 could be cause for decreased abdominal circumference. The
9 patient complains of some swelling around her left ankle
10 moreso than her right ankle and we talked about that
11 today. We've discussed that earlier. Is that right?
12 That what you were talking about? Your left ankle?

13 A Yes.

14 Q All right. PE, and I'll ask you to assume, Ms.
15 Jamison, that that stands for physical examination. Let
16 me read this and I'll ask you something about it. She has
17 a negative homans' sign -- we're going to ask the doctors
18 what all that means -- and really has no increased
19 swelling in her left calf as compared to her right leg.
20 She does have slightly increased swelling in ankle. So
21 far it's about the ankle. Is that fair and accurate?

22 A Yes.

23 Q All right. And he does an assessment and he records
24 his assessment. He's got four points. The first thing he
25 notes, ma'am, has a history of uterine rupture. Your

1 attorneys have talked about that and that's a part of your
2 history. Fair?

3 A Yes.

4 Q All right. Number two, a decreased amniotic fluid
5 index at nine. Number three, possible lagging abdominal
6 circumference. Number four, swelling of left ankle. Did
7 he seem to cover everything there in his assessment, in
8 your opinion?

9 A Yes.

10 Q All right. And he's got a plan. Dr. Miller has a
11 plan for you. First thing he notes is, the patient was
12 advised to go ahead and start doing kick counts. Do you
13 see where he says that?

14 A Yes.

15 Q Number two, I recommended increased fluid intake.
16 Told you to drink more, did he?

17 A Yes.

18 Q All right. And number three, Dr. Miller says, be
19 careful and watch the swelling in her left ankle, and if
20 it continues to increase, especially extending into the
21 calf or if she begins to develop calf pain, she will let
22 us know immediately, and then signed, Gregory A. Miller,
23 M.D. Is that a fair representation of what went on that
24 day, ma'am?

25 A Yes. Um --

- 1 Q Yes, ma'am?
- 2 A I don't remember the -- I remember him telling me to
3 drink more fluid, because I had -- when he told me my
4 fluid level was low, I asked what could I do to bring it
5 back up, and he told me to drink more fluids, so, yes, I
6 do remember.
- 7 Q All right. Thank you. You may keep that if you
8 want, if you need to look at what, if -- whatever you want
9 to do.
- 10 A I don't know if I want to keep it or not.
- 11 Q All right. September 5, 2008 was a walk-in, and you
12 walked in and were to be worked in. It wasn't a regular
13 appointment. Is that fair?
- 14 A That's correct.
- 15 Q Okay. And you mentioned to your attorney just a
16 moment ago, Ms. Jamison, that you did -- certain things
17 happened when I think you saw -- was Ms. Pruitt. You
18 remember that?
- 19 A Yes.
- 20 Q Okay. And included in those things, you've already
21 told us you went to the bathroom -- would you like a copy
22 of this?
- 23 A Um, if you have one that I can see a little bit
24 closer.
- 25 Q I'll be glad to get you that. There you go.

1 A Thank you.

2 Q Yes, ma'am. You've already testified about that day,
3 coming in and going to the bathroom, giving a urine
4 sample. Is that fair?

5 A (Indicating yes)

6 The Court - I'm sorry, ma'am, was that a yes?

7 A Yes. I'm sorry.

8 The Court - That's all right. Thank you.

9 Mr. Davis - I should've reminded you. I'm
10 sorry.

11 Q You were assigned an examination room. Would that be
12 fair --

13 A Yes.

14 Q -- after waiting some time to get worked in?

15 A Yes.

16 Q And you were called back to an exam room; you were
17 interviewed by a nursing assistant; urine sample results
18 were recorded in the chart. You may not have known that,
19 but if they're in the chart, you wouldn't dispute that,
20 would you?

21 A No.

22 Q Okay. And Ms. Pruitt you said came in and she spoke
23 to you about why you're here, how you're doing, and just
24 trying to find out, sort out what the purpose of your
25 visit that. Would that be fair?

1 A Yes.

2 Q Okay. And, Ms. Jamison, you asked about -- was asked
3 about, well, why are you here, well, my baby's not moving
4 as much, I feel like the baby's not moving as much as he
5 has. Is that fair?

6 A Yes.

7 Q Okay, so if somebody describes the reason for you
8 being there, Ms. Jamison, as decreased -- decreased or
9 less fetal movement, those -- that would be an accurate
10 description. Fair?

11 A Yes.

12 Q All right. And Ms. Pruitt examines you after she
13 spoke to you, and she -- you already told us she listened
14 to the fetal heart tones?

15 A Yes.

16 Q All right. Could you hear the fetal heart tones as
17 she listened to them?

18 A Yes, I could.

19 Q And was that because of whatever she was using kind
20 of had a speaker to it that you could hear the heartbeat?

21 A Yes.

22 Q And did she take -- did she feel your abdominal area
23 and take certain measurements? Would that have been
24 something that she did? If you recall.

25 A I -- I can't remember if she did, but they would

1 measure my stomach.

2 Q Okay. And did Ms. Pruitt discuss with you what she
3 found and what her assessment was at that time? Do you
4 remember?

5 A No. She just told me that we were going to go -- the
6 doctor would want to do a non-stress test --

7 Q Okay.

8 A -- and I told her I had never had one of those done
9 before, and she told me that since I was, you know,
10 further along enough weeks that I would start having one
11 done every time I would come to the doctor.

12 Q And your understanding on November (sic) 5th, the day
13 you walked in, was that -- according to the doctor's
14 estimate of your due date you were about 32 weeks
15 gestation. Would that be fair?

16 A Could you say the date again?

17 Q You were 32 weeks along.

18 A On the 5th of September.

19 Q Yes, ma'am.

20 A Okay.

21 Q Is that fair of what the doctors were telling you?

22 A That I was how far along?

23 Q 32 weeks out of 40. 40 weeks being normal gestation;
24 you were at 32 weeks, eight weeks shy of normal due date.

25 You understand that.

1 A I understood that they changed my delivery date, yes.

2 Q Okay. And do at -- on this day when you were seen by
3 Ms. Pruitt you were 32 weeks along according to the
4 doctor's estimates, and do you recall Ms. Pruitt
5 instructing you or telling you her thoughts about possible
6 reasons for decreased fetal movement? Do you remember her
7 telling you about that?

8 A No, I remember one of the doctors telling me that
9 babies tend to get lazy or move less.

10 Q When they get bigger?

11 A Yes.

12 Q Okay. And Ms. Pruitt -- I think you've already
13 testified to this. I just want to make sure I've got it
14 understood. Ms. Pruitt then ordered a non-stress test.
15 Is that right?

16 A That's correct.

17 Q And then from there you went out into the hallway and
18 maybe waited a little while and then a lady by the name of
19 Wendy Knox there in the office put you on -- in a room and
20 put on that belt again to check your heart -- the baby's
21 heart rate. You remember that?

22 A Yes.

23 Q Would it be fair to say if the record showed that it
24 lasted for 30 to 34 minutes would that -- that would be
25 accurate?

1 A I'm not --

2 Q I know you don't --

3 A I don't remember how long the test lasted.

4 Q Okay. All right. If the record showed that it
5 started at this time and ended at that time and there's 34
6 minutes in between, you wouldn't have any argument with
7 that, would you?

8 A No.

9 Q Okay. Then after the non-stress test was done, that
10 30 or 34 minutes, do you remember Wendy Knox, the lady
11 that was sort of -- that helped get you set up for the
12 non-stress test, do you remember her getting the papers,
13 the non-stress papers, and saying I've got to get these
14 looked at or anything? Do you remember that at all?

15 A I remember her doing that while I was still in the
16 room.

17 Q Okay. And she left your room -- left you for some
18 period of time and -- is that right?

19 A Yes.

20 Q And did she come back then and take you somewhere
21 else or did somebody else? Do you remember -- remember
22 that?

23 A I can't remember if she came back to get me, but I
24 left out of that room and I sit (sic) in the hallway to
25 wait, either for the biofetal (sic) profile --

1 Q Let's call the BPP. Is that okay?

2 A The BPP. Um, I remember waiting either -- and I

3 think it was in the hallway for that.

4 Q Okay. And so your understanding is -- I just want to

5 be sure I understand what you're saying -- is that after

6 the lady who did the non-stress test, she took those

7 pieces of paper, those strips, she left your room and she

8 came back and said we need -- the doctor's ordered or

9 Robin Pruitt has ordered that you see a doctor and you

10 have a biophysical profile. Is that fair?

11 A I -- I think I did the bio -- the BPP after that.

12 I'm not for sure.

13 Q After the non-stress test.

14 A Yes.

15 Q Okay. All right. And so your recollection is you --

16 after you were told that, you had to wait some period of

17 time --

18 A Yes.

19 Q -- until the ultrasound machine was available

20 apparently. Would that be fair?

21 A Yes.

22 Q And then they ushered you into a room where the

23 biophysical profile was done?

24 A Yes.

25 Q And would you please stand up, ma'am? Do you

1 recognize this lady? Can you see her?

2 A Yes, I can see her.

3 Q Do you remember that she is the one that did your
4 ultrasound and biophysical profile? Do you remember that
5 one way or the other?

6 A I don't remember her face.

7 Q That's okay. We'll call her, you later, and she'll
8 explain that -- what she did. If the records of the
9 office document that that biophysical profile took about
10 ten minutes, would you have any dispute or argument with
11 that?

12 A No, because I can't remember how long it took.

13 Q Okay, fair enough. Now, when -- do you recall either
14 during or after the biophysical -- I think you said after
15 the biophysical profile was over, they put you in a room
16 and your recollection is that that's when Dr. Hilton came
17 to talk to you?

18 A I might've waited again for someone to come and get
19 me to take me in the room and I remember her walking in
20 and talking to me then.

21 Q Okay. And I want to be sure that I get that on what
22 you recall of Dr. Hilton saying to you. Let me -- hold on
23 just a second. I'm going to send you over to labor and
24 delivery at the hospital and sometimes babies do better
25 out than in. Correct?

- 1 A Yes.
- 2 Q This was your third baby. Is that fair?
- 3 A Yes.
- 4 Q What did you understand her to mean when she said
- 5 that?
- 6 A That they were going to monitor me more to see what
- 7 was going on.
- 8 Q So she told you that part of the plan was she wants
- 9 you to get over to labor and delivery so they could do
- 10 more monitoring and that sometimes babies do better out
- 11 than it, and you understood that to mean the baby's coming
- 12 out.
- 13 A Yes.
- 14 Q And you're at 32 weeks pregnant and the only way that
- 15 baby's going to come out is a c-section. You understood
- 16 that, didn't you, Ms. Jamison?
- 17 A Yes.
- 18 Q All right. And it takes about five minutes to from
- 19 the office to the hospital at labor and delivery.
- 20 A That's correct.
- 21 Q Do you recall Dr. Hilton asking you do you have
- 22 transportation? Do you remember that?
- 23 A She might've did ask me if I had transportation.
- 24 Q Okay, and you would've said yes, because you did.
- 25 A Yes.

1 Q And do you remember her asking you, do you know where
2 labor and delivery is? Do you remember that?

3 A I can't remember if she asked me if I knew where it
4 was or not.

5 Q You did though, didn't you?

6 A Um, I don't know too much about Piedmont Medical
7 Center. All my previous children I had in Chester. I
8 knew to go to -- do like she said, asks for labor and
9 delivery.

10 Q And that's -- the hospital's real -- when you look at
11 it from -- I guess it's Herlong -- it's kind of real
12 spread out from one side to the other, isn't? Right?

13 A Yes.

14 Q And the Women's Center that you told us you went to
15 is on the far left side as you look at the hospital, isn't
16 it?

17 A Yes.

18 Q And that's where you went, isn't it?

19 A Yes.

20 Q And you knew that labor and delivery was on the first
21 floor I think you said. Is that fair?

22 A Um, I'm not sure what floor it was; it was upstairs.

23 Q Okay. And depending on where you come in -- if you
24 come in from the parking lot through those doors, it would
25 be a floor above, wouldn't it?

1 A Yes.

2 Q And you get on those little elevators right behind
3 that security desk and you punch two or whatever, one,
4 whatever it is, and you get to labor and delivery. That's
5 how you get that. Right?

6 A Yes.

7 Q You knew that.. Right.

8 A (No response)

9 Q All right. Ms. Jamison, you indicated a moment ago,
10 ma'am, that you were told by a security person to go to
11 admissions off to your left as you come in. Is that
12 right?

13 A Yes. Whoever it was at the front desk --

14 Q Okay.

15 A -- was the one that told me. When I told them I
16 needed to go upstairs to labor and delivery, they told me
17 I had to get admitted in first through admissions.

18 Q Do you remember the name of that person who told you
19 that?

20 A No, I don't.

21 Q What did they look like?

22 A I cannot remember. All they told -- only words that
23 I exchanged with them was that I was there and I needed to
24 be -- I needed to go to labor and delivery and they told
25 me that I needed to go to admissions.

- 1 Q And then you tell us you went to admissions.
- 2 A Yes.
- 3 Q And you went up to like the little window that you
4 would -- like an office area where there's a glass window
5 and you walked up to that little window area?
- 6 A Yes. Yes.
- 7 Q And a lady you tell us was there checking her voice
8 messages on speaker phone?
- 9 A I'm not sure if she was right at her desk when I
10 first stepped in.
- 11 Q Okay.
- 12 A I might've stepped out and when I stepped back in she
13 was sitting down playing her messages.
- 14 Q And as far as you know, these are employees of
15 Piedmont Hospital.
- 16 A Yes.
- 17 Q Not my doctors. Right?
- 18 A Yes.
- 19 Q And when you stood there at the desk, you tell us,
20 Ms. Jamison that her -- she had her speaker phone on and
21 was playing back messages. Right?
- 22 A I didn't hear any other messages. I just heard the
23 one that was currently -- that she was currently listening
24 to and --
- 25 Q And it was a female voice that you assume was Dr.

1 Hilton.

2 A Yes.

3 Q Right? And the female voice was saying, as you
4 recall, this is about Samantha Jamison and they gave your
5 date of birth and they said she needs to get a stat c-
6 section. Right?

7 A Yes, um --

8 Q Is that right? Is that what you said?

9 A I heard her say I needed a baby out stat.

10 Q Stat. And you understood stat means right now.

11 A Yes. That's why -- as soon as I heard that, I think
12 I might've called my mother and told her then that she
13 needed to get to the hospital, because I didn't know I was
14 going to have a c-section.

15 Q And after this hospital employee heard that message
16 with you standing there and you said that's me, she sent
17 you right up to labor and delivery, didn't she?

18 A No.

19 Q No?

20 A No.

21 Q What'd she do?

22 A She told me -- she apologized. She said, I'm sorry,
23 I shouldn't have been playing my messages, and she started
24 doing my paperwork. She started getting me admitted into
25 the hospital.

1 Q And you don't know how long the person in admissions
2 after hearing this message from a female person that you
3 don't know who it is saying you, Ms. Samantha Jamison,
4 needed a stat c-section. You don't know how long she kept
5 you there after that message. I mean is that fair?

6 A It was a while because it was a lot of paperwork that
7 she was going over with me.

8 Q And the person was a female, was it, that was doing
9 this at the hospital?

10 A Yes.

11 Q Do you remember her name?

12 A I cannot remember her name.

13 Q Do you remember what she looked like?

14 A Older lady. I remember her telling me -- once I told
15 her that I didn't know I was going to have a c-section
16 right then and there, she told me, don't worry, she said
17 they had a good team of neonatal doctors, that there would
18 be doctors in there to take the baby to neonatal as soon
19 as he would be born, that I would be fine.

20 Q Was she a medical doctor that you could tell?

21 A I don't think so.

22 Q Don't think so. When you heard the message of a
23 female voice you assume to be Dr. Hilton saying Samantha
24 Jamison needs a stat right away, right now, c-section, and
25 the admissions lady say, well, we got to do the paperwork

1 first -- you had a cell phone. Right?

2 A Yes.

3 Q Did you call Dr. Hilton and say, hey, I'm getting
4 hung up in admissions, I need to get up -- did you do
5 that?

6 A No, I didn't.

7 Q Did you think to do that at all?

8 A No. Not to call Dr. Hilton, no.

9 Q All right. So however long a period of time it took
10 the non-doctor admissions person to do whatever she was
11 doing with your paperwork, did she then take you up to
12 labor and delivery?

13 A Yes, she did.

14 Q Did she walk around the corner and punch the door for
15 the elevator and walk and ride up the next floor with you?

16 A Yes.

17 Q When you got off the elevator, what'd you do next?

18 A I went into one of the rooms.

19 Q Well, don't you kind of have to turn left and walk
20 down a hall and punch a buzzer so they could open the
21 door?

22 A I'm not familiar with the floors at Piedmont. I very
23 seldomly been to that hospital, so I'm not -- I don't know
24 that -- the hospital where the elevators and stuff are.

25 Q So did this person from admissions, this non-doctor

1 person from admissions, did she accompany you --
2 A Upstairs, --
3 Q -- to the elevator --
4 A -- yes.
5 Q -- and upstairs and all the way down and through til
6 you got to your room?
7 A Yes, she took me upstairs into my room.
8 Q Okay. And when did she leave?
9 A I can't remember when she left. I remember once I
10 went into the room, they told me to go into the bathroom -
11 -
12 Q Right.
13 A -- and undress and I don't know where she went. I
14 don't know what happened with her.
15 Q I think you told us a moment ago -- I want to be sure
16 that I remember this correctly, Ms. Jamison -- that when
17 you got there that the nurses were there waiting for you,
18 there was an anesthesiologist waiting for you. Is that
19 right?
20 A Yes.
21 Q And they told you to do certain things; you did those
22 things; you didn't delay; you didn't take any time doing
23 them. You got right after whatever they told you to do.
24 Would that be fair?
25 A Yes.

1 Q And then the nurse tries to find a heart rate.

2 A Yes.

3 Q And she couldn't.

4 A No.

5 Q And she kept trying, didn't she?

6 A Yes.

7 Q I mean she didn't just, well, I don't hear anything.

8 She kept trying, didn't she?

9 A Um, she kept moving it around and asked me what side
10 did they have it on at the doctor's office.

11 Q Yes, ma'am, because you heard the heart rate at the
12 doctor's office, didn't you?

13 A Yes.

14 Q Okay. And when she couldn't hear a heart rate,
15 that's when she called Dr. Benson to come and see you. Is
16 that right?

17 A Yes.

18 Q And that's when the anesthesiologist and the other
19 nurses they left.

20 A I can't remember if they left right then and there or
21 not.

22 Q Pretty soon though, didn't they?

23 A I can't remember how soon they left out.

24 Q Okay. Dr. Benson got there, you don't know -- I
25 assume and if you don't know, that's fine -- you don't

1 know how long it took him to get there after he was called
2 by the nurses, do you?

3 A No.

4 Q If the record show that it took two minutes, would
5 you disagree with that?

6 A No, because I don't know how long it took him to get
7 in the room.

8 Q Okay. When Dr. Benson came into the room after being
9 summoned by the nurses who could not find a heart rate, he
10 took the ultrasound and he tried to find a heart rate,
11 didn't he?

12 A Yes.

13 Q And he couldn't, could he?

14 A No.

15 Q And he had to tell you, didn't he?

16 A That there was no heartbeat?

17 Q Right.

18 A Yes.

19 Q And then you asked him, please do it again. True?

20 A Yes.

21 Q And he did, didn't he?

22 A Yes.

23 Q And he said there's no change; there's still no heart
24 rate. Right?

25 A That's correct.

1 Q Your mom got there a little bit after that time. Is
2 that fair?

3 A I'm not sure what time it was when she got there.

4 Q She got there after Dr. Benson had been in the room
5 and told you that your baby did not have a heart rate.

6 A She wasn't in there at that time.

7 Q Okay, so she came after that time?

8 A Yes.

9 Q You had another visitor that day, Dr. Hilton.

10 A Yes.

11 Q Around 12:30, 1:00 o'clock, 1:30 somewhere in there.
12 Her lunchtime. You remember that?

13 A Yes.

14 Q And she came over to talk to you and she told you, I
15 don't know why this happened, didn't she?

16 A Um I can't remember if -- she might've did say she
17 don't know why it happened. I just remember her saying
18 that she just didn't know or she never knew it would've
19 been that way I guess. I'm not sure.

20 Q She cried with you too, didn't she.

21 A I remembering her praying with me, yes. She asked
22 could she say a prayer with myself and myself.

23 Q She was she crying with you, praying with you and
24 telling you, I don't know why this happened, didn't she,
25 Ms. Jamison?

1 A Yes.

2 Q Dr. Benson -- do you know how many laboring mother's
3 he was responsible for on labor and delivery when you came
4 through those doors, ma'am?

5 A No, I don't.

6 Q Do you know how many c-sections he performed that
7 day?

8 A No, I don't.

9 Q Do you know how many babies he delivered that day?

10 A No, I don't.

11 Q Other than Dr. Benson, did you see -- and Dr. Hilton
12 was making -- I think they call it a social call. She was
13 coming to comfort you and express her sympathy to you for
14 losing your baby, but other than Dr. Hilton doing that,
15 Dr. Benson was the only doctor you saw that day. Would
16 that be fair? Ob-Gyn doctor?

17 A I think so, yes.

18 Q All right. And Dr. Hilton when she was there, do you
19 remember her explaining to you, look, Ms. Jamison, you
20 don't have to have your tubes tied today, we can -- we can
21 do that another day; you don't have to do that today. You
22 remember her telling you that?

23 A I can't remember, but she might've told me that. I'm
24 not sure.

25 Q And you already mentioned that Dr. Benson said, you

1 don't have to -- you don't have to have this c-section
2 done today, we can do it another day if you want to wait.
3 He offered that to you, didn't he?

4 A I remember him saying that I could wait I think on
5 the c-section.

6 Q Right. And you decided, maybe after your mom got
7 there, I don't know, but you made the decision, your
8 decision, no, I want to go ahead and let's do this right
9 now, let's do it today, didn't you?

10 A Yes.

11 Q And they did, didn't they?

12 A Yes.

13 Q And they let you hold your baby, didn't they?

14 A Yes.

15 Q And your familiar with the Open Arms Program there at
16 the hospital? Did they talk to you about that?

17 A Um the lady that --

18 Q Empty Arms. I'm sorry. I said Open Arms. Empty
19 Arms.

20 A Yes.

21 Q For grieving mothers that have lost their babies.

22 A Yes.

23 Q And they let you hold your baby as long as you wanted
24 to, didn't they?

25 A Yes, I did.

1 Q You went on home I think the next day. Is that fair?

2 A I think it was baby a couple days later I went home.

3 Q Whenever you left. Whenever -- couple days, the 7th,

4 or whenever it was. The records will show that. Dr.

5 Benson, the doctors there offered if you want to stay in

6 the hospital another day, you can stay another day and

7 that's fine with the doctors. You remember that?

8 A Yes.

9 Q And you told them, no, I would do better if I get
10 home with my girls, my other children. You remember that?

11 A Yes.

12 Q That was your decision as well?

13 A Yes, I needed to make the funeral arrangements for
14 Jayden.

15 Q Yes, ma'am. Ms. Jamison, how many times do you
16 recall going back to these doctors at Rock Hill Gyn after
17 Jayden passed away and after that day, September 5 that
18 you had a caesarean section? How many times did you go
19 back to them?

20 A Maybe three, four times.

21 Q Okay. Well, let's take a look at the records. Okay?

22 Mr. Davis - Could we dim the lights, please.

23 Q There's a --

24 The Court - Do you want the witness to step
25 down? I don't know if she can see it.

1 Mr. Davis - Just let me put one in her hand.

2 The Court - All right.

3 Q Let me put a copy of that in your hand, Ms. Jamison.
4 Okay. We'll try to do it one at a time. Can you see okay
5 with the lights down, because I can turn them back up.

6 A (Indicating yes)

7 Q Okay. That's September 17 and it was Dr. Benson.
8 See that? And again, it talks about the history and we'll
9 let him talk about all that, but down at the bottom he
10 talks about, she was on Zolof 25 daily and we switched
11 her to 50 today to see if this would help her to do better
12 with her sadness and grieving. You see that? He gave you
13 some medication, the doctors did, to help you with your
14 understandable grieving?

15 A Yes.

16 Q Okay. Did not know the cause of the fetal death is
17 what Dr. Benson says there. This patient had the tragic
18 experience of having a baby that was living in the office
19 and having concerning findings, but when she got to labor
20 and delivery, the baby no longer had a heartbeat. Did I
21 read that correctly?

22 A Yes.

23 Q All right. And on September 19th, two days later
24 you're seen by Dr. McClellen. Let me put that in your
25 hand, please. There you go. September 19th a chief

1 complaint followup of blood pressure check, and he says
2 please see Dr. Benson's note of 9/17. You and I have just
3 looked at that. Talks about blood pressure, talks about
4 his impression of postpartum hypertension, high blood
5 pressure on -- and I don't know the name of that medicine
6 -- perhaps you do -- that you were on, and it has a plan
7 and he's talking about Aldomet that's a blood pressure
8 medicine. Is that right?

9 A (Indicating yes)

10 Q Okay. I've asked to call Dr. Stone's office for PCP.
11 Would Dr. Stone be your primary care physician at that
12 time in Chester?

13 A I'm sorry. Could you repeat that again?

14 Q Yes, ma'am, I'll be glad to. Dr. Stone in Chester,
15 family practice doctor, he was your primary care
16 physician, PCP. Is that right?

17 A No, I see another physician in his office.

18 Q In Dr. Stone's office?

19 A Yes.

20 Q What's his name, ma'am?

21 A Dr. Shelby.

22 Q Okay, all right. And he's -- Dr. McClellan to see if
23 your doctor would be willing to see her next week to
24 possibly get her on a single medicine for blood pressure
25 I think. The patient has a followup appointment with Dr.

1 Benson for a postpartum visit in two weeks. She is told to
2 call with any headaches or blurred vision; my condolences
3 were given to the patient. Before that day had you ever
4 met Dr. McClellen? Did you know him?

5 A I don't -- I can't remember if I had seen him before
6 or not.

7 Q All right. Okay. Put this one and hand it --
8 October 2, 2008. There you go, ma'am. Now, let's take a
9 quick look at this. Following up for the blood pressure
10 and they also have increasing lower abdominal pain. Do
11 you understand that -- was that the time you were just
12 telling us a little while ago that you had a possible
13 infection and they were going to take care of you?

14 A Yes.

15 Q All right. Okay. So Dr. McClellen says and it is
16 noted, impression, questionable pelvic abscess status post
17 c-section, number two, third trimester fetal death. He's
18 going to check your blood, going to put you on a Levaquin,
19 which is an antibiotic, you told us about an antibiotic,
20 will check a CT scan of the abdomen and pelvis. She may
21 need to be admitted for IV antibiotics. The patient was
22 told to call for worsening symptoms or fever. Would that
23 be accurate as far as you could tell --

24 A Yes.

25 Q -- happened that day. Okay. And then October 9,

1 hand that to you, too. Sort of in the bottom of that
2 page, ma'am. This is Dr. Normal Taylor. Samantha had a
3 fetal demise in utero about at approximately 30 and 1/2
4 weeks, she underwent caesarean section and tubal. She has
5 had a low-grade fever of a 100.2 over the last several
6 days. She's on Levaquin after being seen by Dr. McClellen
7 yesterday. Her ultrasound yesterday showed possible -- I
8 don't know what that is, but we'll let the doctors tell us
9 -- talks about a CT scan and he's got a plan, she'll
10 continue on the Levaquin, she also will be given refills
11 of Motrin and Percocet. Those are pain medicines. Do you
12 understand that?

13 A Yes.

14 Q For about a week. You remember that?

15 A Yes.

16 Q All right. She is to report higher fever, increase
17 in pain; we would have her followup for a liver lesion
18 after recovery from her c-section. Is that right? Did I
19 read that correctly?

20 A Yes.

21 The Court - I'm sorry, ma'am, I didn't hear you.

22 A Yes.

23 The Court - Thank you, ma'am.

24 Mr. Davis - I'm sorry, Judge.

25 Q And then again October 17th -- I hand that to you,

1 please. Take a quick look at that, and this is again Dr.
2 Taylor, Norman Taylor. Talking about your caesarean
3 section, he's kind of talking about what's been going on.
4 He talks about that CT scan. Do you remember having the
5 CT scan? Was that done over in the hospital? Do you
6 remember that?

7 A That might've been done at the Imaging Center.

8 Q Okay. Is that like the radiology place?

9 A Yes.

10 Q All right. Okay. So they sent you for a CT scan.
11 Do you recall that?

12 A Yes, I do.

13 Q And now Dr. Taylor on October 17th is talking about
14 that, making whatever comments here he was making, and he
15 has a plan down at the bottom. You see that? Will refer
16 her to GI, gastroenterologist for evaluation, and down
17 there below, courtesy copy Digestive Disease Associates,
18 please send the CT report in the front of the charge. Did
19 I read that correctly?

20 A Where is that at?

21 Q Right down at the bottom -- there's a little -- right
22 below his signature. You see that? Where it says R.
23 Norman Taylor, III, M.D.

24 A Okay.

25 Q Okay and see that there's a little ew --

1 A Yes.

2 Q -- and right underneath there's a cc.

3 A Yes.

4 Q Okay. Do you remember going to the Digestive Disease
5 Associates office?

6 A No.

7 Q And according to the records, that was the last time
8 that you were seen by anyone from Rock Hill Gyn-Ob. Is
9 that fair? Ma'am?

10 A (No response)

11 Q I mean if there was another visit that I missed
12 please let me know. Okay?

13 A That -- this sounds like it might be correct.

14 Q Okay. I'm almost done. Thank you for your patience.

15 Mr. Davis - One moment, please, Your Honor.

16 The Court - Yes, sir.

17 Q I just ask one other thing. Could I get those pieces
18 of paper back?

19 A Yes.

20 Mr. Davis - Thank you so much. I appreciate
21 your being patient with me and answering my questions.
22 Thank you. Nothing further, Your Honor.

23 The Court - Re-Direct.

24 Re-Direct Examination

25 by Mr. Boyd -

1 Q I believe you were asked questions about you were on
2 medicines for high blood pressure. Is that correct?

3 A That's correct.

4 Q And the records will reflect what it was, but do you
5 recall despite the medication on your hospital visit of
6 August 9th, 2008, was your blood pressure high then
7 despite the medication?

8 A I can remember if it was high. I don't -- I think it
9 was under control. I don't think it was high.

10 Q Okay. Do you remember on September 5th of 2008
11 whether your blood pressure was high at that time?

12 A Could you say the date again?

13 Q September the 5th, that was the date Jayden died. Do
14 you remember if it was high that day?

15 A I can't remember what it was that day.

16 Q Let me -- did Dr. Miller on the visit of October
17 25th, 2008, I believe you testified that he told you to
18 drink more water. Is that correct?

19 A Did you say October the 25th or --

20 Q I'm sorry. August the 25th.

21 A Yes.

22 Q Okay. And in the record it indicates he told you to
23 do kick counts. Do you recall him on August the 25th,
24 2008 telling you to do kick counts?

25 A I don't remember him saying anything about kick

1 counts. I've done them before in previous pregnancy, but
2 I don't remember him going over it with me to do.

3 Q Okay. On August the 25th of 2008 do you recall was
4 there a non-stress performed on you?

5 A On that date? No.

6 Q And was there a biophysical profile performed on you
7 on that day?

8 A Not that I know of, no.

9 Q And let me ask, when you got to the hospital on
10 September 5th when you finally got up to labor and
11 delivery, did you see Dr. Benson first time -- at first
12 when you got up there?

13 A I can't remember -- I remember seeing the nurses in
14 there. I can't remember if he was in there or not.

15 Q Okay. Do you remember them -- you testified earlier,
16 you remember them calling Dr. Benson?

17 A Yes, to come in and to try to get the baby's
18 heartbeat.

19 Q All right. And do you recall seeing him before that
20 time?

21 A Not in the room. Can't remember.

22 Q And I believe you had some problems with high blood
23 pressure after September 5th, 2008 that they treated you
24 for. Is that correct?

25 A Yes.

1 Q And they also gave you some -- prescribed you
2 medication for Zoloft medicine for depression during that
3 time. Is that correct?

4 A Yes.

5 Mr. Boyd - Thank you. That's all the questions
6 I have.

7 The Court - You may step down. All right,
8 ladies and gentlemen, we're going to stop for the evening.
9 I'm going to ask that y'all be back tomorrow at 9:15. I
10 want you back in your jury room by 9:15 and we'll start
11 shortly thereafter. Please remember don't talk about the
12 case; don't allow anybody to talk to you about it. If
13 somebody attempts to do so, obviously if you can do so in
14 safety, find out who that person is and report it to the
15 Court we'll take care of that person. So I'll see you
16 back tomorrow morning at 9:15. Thank you very much. If
17 there are any other exhibits, leave them with the bailiff.
18 Okay?

19 (Jury exits the courtroom)

20 The Court - All right, anything further from the
21 plaintiff at this point in time, gentlemen?

22 Mr. Boyd - Nothing, Your Honor.

23 The Court - From defense?

24 Mr. Boyd - No, sir, thank you very much.

25 The Court - All right, gentlemen, I'll see y'all

1 A Very often we consult, not so much with obstetricians,
2 but obstetricians who specialize in high risk OB,
3 perinatologists

4 MR. BOYD - Your Honor, at this time I would offer
5 Dr. Karotkin as an expert in the field of neonatal
6 perinatal medicine.

7 THE COURT - Do you wish to voir dire the doctor
8 at to his qualifications or challenge the offer by the
9 plaintiff?

10 MR. DAVIS - No, we don't, Your Honor. We'll ask
11 him questions later. We'll stipulate he's an expert in
12 neonatology.

13 THE COURT - All right, sir, very good. He's
14 qualified then to give his opinion.

15 Q And Dr. Karotkin, let me just show you this. We've
16 briefly gone over your qualifications, but let me show you
17 this and ask is this a CV concerning your background and
18 work history, your publications?

19 A Yes, I believe it is.

20 MR. BOYD - I would offer this into evidence.

21 THE COURT - Any objection?

22 MR. DAVIS - Yes, sir. Your Honor, we think it's
23 irrelevant and superfluous and duplicative and
24 inadmissible.

1 THE COURT - All right, thank you very much.

2 Let's have it marked for ID.

3 (Document marked for ID as Plaintiff's Exhibit
4 Number 13.)

5 THE COURT - All right, I'm going to -- I'm going
6 to allow it in evidence over the objection of the defense.
7 Mark it as plaintiff's exhibit.

8 MR. BOYD - It'll be plaintiff's number 13.

9 THE COURT - Plaintiff's 13. Thank you very much.

10 (Document marked into evidence as Plaintiff's
11 Exhibit Number 13.)

12 Q Dr. Karotkin, what materials have you reviewed in this
13 matter?

14 A I reviewed the medical records of Ms. Jamison. There
15 were several depositions that were included in the medical
16 records.

17 Q Okay. And have you reviewed the medical records in
18 this case?

19 A Yes, I have.

20 Q And would that have included the medical records from
21 Rock Hill OB-Gyn?

22 A Yes, they did.

23 Q And have you reviewed records from Piedmont Medical
24 Center?

25 A I did, yes.

1 Q Are these materials of a type reasonably relied upon
2 by experts in your field in rendering opinions?

3 A I believe they are, yes.

4 Q Based on your review of these records, were you able
5 to form a conclusion as to the time of Ms. Jamison's unborn
6 child's death?

7 A Yes, I was.

8 Q Is your conclusion to a reasonable degree of medical
9 certainty?

10 A Yes, it is.

11 Q What is your conclusion?

12 A My conclusion is that the baby died in utero some time
13 between 11:00 o'clock on the morning of September 5th and
14 about 11:48 or 49 on that same morning.

15 Q And could you tell us, what is the basis of this
16 conclusion?

17 A Well, the basis of the conclusion is that it appeared
18 that the baby was alive just before 11:00 o'clock that
19 morning and that by the time the baby was examined or the
20 mother was examined with an ultrasound just before noon
21 that day, there was no evidence of fetal heart rate, so it
22 appeared to me that that baby must've died some time
23 between on or about 11:00 o'clock in the morning and just
24 before noon that day.

1 Q Okay. And can you give us -- do you have an opinion --
2 - you've said between 11:00 o'clock and 11:49. Is that
3 correct?

4 A That's correct.

5 Q Okay. Do you have a conclusion to a reasonable degree
6 of medical certainty whether or not the unborn child
7 would've lived had a c-section been performed in this time
8 period?

9 A I do believe the baby would've survived had a c-
10 section between performed prior to about twenty of 12:00 or
11 a quarter to 12:00 that day, yes.

12 Q And what is your basis for that conclusion?

13 A Well, there's a body of literature that would show
14 that when a baby is in distress in utero, there is a sudden
15 decrease in fetal heart rate over a period of minutes to
16 many minutes. Our typical understanding is that it is a
17 gradual decrease in heart rate. It's not a sudden loss of
18 heart rate, so it's not to be expected that the baby had a
19 normal heart rate just before 11:00 and then had a no heart
20 rate at 11:05, but what tends to happen is that there's a
21 gradual decrease in fetal heart rate, evidence of fetal
22 distress over several minutes. The evidence would
23 indicate that if you can get the baby delivered within 10
24 or 12 minutes of the distress, that you have a very good
25 chance of getting a normal baby. As the distress goes past

1 that 12 minute period to 18, 20, 25, 30 minutes, then
2 chances of getting an in tact baby diminish as the time
3 goes by, and that clearly by about 40 minutes, 50 minutes
4 or an hour, then the babies are typically born still,
5 stillborn.

6 Q Okay. So if the -- just to try to go through that a
7 little slower, if there's an acute event that happens, what
8 time period is -- do they have in order get a - do a c-
9 section to get a normal baby?

10 A All the literature would indicate you have about 10 or
11 12 minutes after an acute event to get the baby out and to
12 have a normal baby.

13 Q And based on your records, when Samantha Jamison left
14 the doctor's office, had an acute event occurred at that
15 point?

16 A It didn't appear to, because as I recall from reading
17 the records, the baby's heart rate was normal just prior to
18 leaving the office.

19 Q So, would it be fair to say something happened between
20 that time period of 11:00 - some time after 11:00 that
21 caused the fetal -- the child to die?

22 A Yes.

23 Q Okay. And I believe your opinion is this is somewhat
24 of a gradual ---

1 MR. DAVIS - Your Honor, I'm going to object to
2 leading question. This is a well qualified expert witness.
3 He shouldn't be led.

4 THE COURT - I appreciate it. Why don't you
5 rephrase your question.

6 Q So what kind of process would take place after 11:00
7 o'clock in this ---

8 A Well, we don't have a lot of evidence as to what the
9 nature of the episode was. There are a variety of
10 potential causes, such as a cord exclusion, some type of
11 cord accident, some type of placental accident, but
12 whatever the reason, the baby was -- after 11:00 o'clock or
13 so was being deprived of adequate blood flow to the
14 placenta and then on to the baby and adequate oxygen
15 delivery to the baby, which caused the baby's heart rate to
16 start to fall and deprive the vital organs of oxygen and
17 blood-flow.

18 Q And so within what period of time as a c-section is
19 performed would there be a normal baby?

20 A I think I said about 10 or 12 minutes literature would
21 indicate, that once you have this acute profound event, you
22 have about 10 or 12 minutes to get the baby out without any
23 ill effects of the baby.

24 Q Okay. And after that point, what period of time is
25 there to have a c-section and still have a live baby?

1 A And, again, the literature is somewhat not exact, but
2 most people feel that you have another 20 minutes, 25
3 minutes, but clearly not more than an hour. Once an hour
4 goes by, maybe even 50 minutes, then the -- there's a
5 strong likelihood that the baby's going to be stillborn,
6 that the baby's going to die in utero as a consequence of
7 the profound asphyxial event which has occurred.

8 Q And do you have an opinion to a reasonable degree of
9 medical certainty as to whether or not if a c-section had
10 been performed prior to September the 5th, 2008, whether or
11 not the baby would've been alive?

12 A I believe the baby would've been alive had the baby
13 been born before September 5th that morning.

14 Q And what is the basis for that opinion?

15 A Well, it appeared from the medical records that the
16 baby's gestational age on the 5th was somewhere around 31 or
17 32 weeks gestation. Babies born at that gestation have an
18 excellent chance of survival, and in fact, even babies born
19 a couple of weeks early at 29, 30 and 31 weeks in 2008 in
20 the United States have an excellent chance of in tact
21 survival. That's not to say the baby wouldn't remain in
22 the hospital for a period of days or week, but given modern
23 technology and given what we have to treat these babies
24 with, the long-term survival is very good, as is the in-

1 tact survival, that is to say survival without handicap,
2 without cerebral palsy, hearing defects.

3 Q Okay. And I think that was going to my next question,
4 is basically what are the prospects for a baby delivered at
5 31, 32 weeks for a normal life?

6 A Again, if you look at the statistics for the United
7 States in 2008 let's say, and you looked at all babies born
8 in similar circumstances in a community hospital at 32
9 weeks gestation, they would have a survival of about 85 or
10 90 percent. And then as you go down further in gestational
11 age, the survival would fall off a little bit but not
12 dramatically at 31 weeks. Instead of 90 percent survival
13 maybe at 31 weeks, you may have 87 percent or 85 percent
14 survival. As you get down to 23 weeks and 24 weeks
15 gestation, which is on the margins of viability then the
16 survival becomes much much less, you know, maybe 20
17 percent, 15, 20 percent, and the number of those babies
18 that survive have major problems, many of them do.

19 Q Is there -- and this goes for that, so - but what is
20 the -- for an early c-section, what are the risks involved
21 in that?

22 A Well, I want to address the risk to the mother; I
23 think probably an obstetrician could address those, but
24 certainly for a baby that is born by caesarean section of
25 30, 31, 32 weeks, most of those babies will require

1 admission to a either level two nursery or a level three
2 intensive care nursery. Many of those babies will require
3 oxygen or some form of assisted ventilation. We have the
4 ability now to provide artificial surfactant which is the
5 material that lines the lungs that many babies who are born
6 prematurely lack. We have the ability to provide IV
7 fluids, nutrition, fats, sugar, protein through the IV. We
8 have the ability to provide antibiotics. So as a
9 consequence of this type of care that's available, these
10 babies have a very good chance of survival even at the, you
11 know, 29, 30, 31, 32 weeks gestation. Obviously, the
12 bigger you are, the somewhat better your chances are.

13 Q Now, based on your review of the records from Rock
14 Hill Ob -- Gyn-Ob and Piedmont Medical Center, do you as a
15 neonatal perinatologist, do you see any signs that there
16 was any problems with the baby during the course of the
17 pregnancy?

18 A Well, it appeared to me in reviewing the records that
19 this baby's what we call growth-restricted or small for
20 gestational age. There was some discrepancies in the
21 dating, the due dates that the mother had and the size of
22 the baby. There was at least one ultrasound done I think
23 on the 25th of July which indicated the baby was only eleven
24 hundred and fifty-four grams which is just about two
25 pounds, little over two pounds, yet the gestational age I

1 think at that point was about 30 weeks or 30 weeks and a
2 day, and that weight is really smaller than you anticipate
3 for a baby that size. I think there was also some other
4 issues related to the ultrasound measurements of the fetus
5 that would indicate that this baby was growth-restricted.

6 Q And do you -- can you tell us what effect does
7 chronic-hypertension have, if any, on the child, unborn
8 child?

9 A Well, chronic-hypertension tends to decrease blood-
10 flow to the placenta and then onto the baby. The placenta
11 tends to react in the face of high blood pressure by
12 squeezing down its arteries and as a consequence of that
13 there's decreased blood-flow through the placenta to the
14 fetus in utero, and as a consequence of that these babies
15 are deprived of adequate blood-flow, adequate oxygen,
16 adequate nutrition and as a result of that may not grow
17 appropriately, may -- may have what we call intrauterine
18 growth restriction or intrauterine growth retardation.
19 They grow less well because of that hypertension in the
20 mother.

21 Q Now, I believe looking at I think some records that
22 are up here and you can step down and look, but I think
23 they showed on August the 9th, hospital, Ms. Jamison's blood
24 pressure was 146 over 72. Would that be a high reading?

1 A I can't really see it too well here, but maybe you can
2 point it out with your pointer. That is a 178 over 87.
3 Again, my understanding of hypertension in pregnancies it's
4 any systolic reading over a 140 and a diastolic reading
5 over about 90, so certainly the systolic reading would be
6 abnormal. The diastolic reading would be below what you
7 would anticipate for hypertension.

8 Q Based on your review of records, was the death of this
9 unborn child foreseeable or predictable?

10 A I believe it was, yes.

11 Q And was it knowable for that -- this to happen?

12 A I believe it was, yes. I think there were enough risk
13 factors to predict that this baby was in trouble and was
14 likely to die if intervention did not occur.

15 Q Okay. And do you have an opinion to a reasonable
16 degree of medical certainty whether or not the death of
17 Jayden was preventable?

18 A I believe it was, yes.

19 Q And can you give the basis for that conclusion?

20 A Well, I believe that there was enough evidence in the
21 weeks prior to September 5th that this baby was in trouble,
22 that the baby was not growing appropriately, that there was
23 some abnormal fetal heart rate tracings in the office on
24 the morning of the 5th all pointing to a baby that was in

1 distress and that needed to be delivered sooner rather than
2 later.

3 MR. BOYD - Court's permission to publish
4 Plaintiff's Exhibit 13 to the jury?

5 THE COURT - Yes, sir.

6 MR. BOYD - Thank you, Doctor. I have no further
7 questions.

8 THE COURT - Cross examination.

9 MR. DAVIS - Thank you, Your Honor.

10 CROSS EXAMINATION

11 BY MR. DAVIS -

12 Q Doctor, what is your definition of IUGR?

13 A A definition of IUGR would be typically made based on
14 growth charts that are published and we would have -- have
15 the ability to measure the baby's weight, head
16 circumference and length and to compare it against
17 normative values as published by growth chart presumably
18 close to sea level.

19 Q Is that typically done in the office of an Ob-Gyn,
20 sir?

21 A It's not typically done in the sense -- the way we do
22 it in the nursery where we have the baby in front of us to
23 measure head circumference and chest circumference and
24 length where could actually, obviously, do it much more
25 accurately, but I believe that there are techniques

1 by using ultrasound that might allow an obstetrician to
2 predict and to actually measure some of those and to have
3 some kind of a sense as to whether there is intrauterine
4 growth restriction, yes.

5 Q And did you see a number of ultrasounds that were
6 performed by the physicians at Rock Hill Gyn-Ob in the
7 prenatal care of Ms. Jamison?

8 A I did, and I saw that where there were some
9 discrepancies on the size of the baby and the mom's
10 estimated ---

11 Q Last menstrual period ---

12 A Last menstrual period, right, exactly - when she - her
13 due dates were, yes.

14 Q I want to see the CV. I know the jury's got their
15 hands on it.

16 MR. DAVIS - Your Honor, I was wondering if I can
17 get it now since I need it ---

18 THE COURT - Yes, sir.

19 MR. DAVIS - --- and give it back to them?

20 THE COURT - Yes, sir, you may.

21 MR. DAVIS - Thank you, sir.

22 Q Doctor, what are board certifications in a specialty
23 medicine?

24 A What are board certifications?

25 Q Yes, sir.

1 A Oh. Well, board certifications are tests that you
2 take after you complete training in a certain sub-
3 specialty, depending on the sub-specialty. In pediatrics
4 you would take a test after completion of your pediatric
5 residency. In those days it was both an oral test as I
6 recall and a written test. And then upon completion of
7 your neonatal perinatal boards, you also take a test in
8 neonatal perinatal medicine which again, I think in those
9 days was both oral and a written exam.

10 Q And you took those examinations, sir?

11 A I did.

12 Q Okay.

13 MR. DAVIS - Your Honor, the jury will have this
14 in evidence but if I can put in on here.

15 (Discussion is held regarding overhead projector
16 which was not reported.)

17 MR. DAVIS - I'm sorry, Doctor. Bear with me.
18 While it's warming up, we'll take a look at it.

19 Q What is a field of pediatrics, sir?

20 A The field of pediatrics would be a branch of medicine
21 that deals with children, typically from birth to depending
22 on where you practice, 16, 18, sometimes even 21 years of
23 age.

1 Q Okay. And neonatology, is that typically restricted
2 to a hospital-based practice in a neonatal intensive care
3 unit?

4 A Yes, I think typically you would define neonatology as
5 the practice of medicine that deals with the fetus in utero
6 and the patient, once the baby is delivered and a patient
7 either in the regular nursery, if it's a term baby or a
8 neonatal intensive care nursery, there are some
9 neonatologist who follow these babies once they are
10 discharged, but probably the minority do we have follow-up
11 clinics and whatnot, but typically our patients are
12 followed from birth til they leave the hospital.

13 Q Okay. So you as a pediatrician and as a neonatologist
14 -- am I pronouncing that right?

15 A Yes.

16 Q In your specialty, sir, you take care of the babies
17 after they're born.

18 A I do, typically, yes.

19 Q All right.

20 A I would -- do consult with our perinatal colleagues,
21 but you're right, my responsibility is the baby once the
22 baby is delivered.

23 Q And so when we see on your CV, which is in evidence
24 here, pediatric intern, that's a year you spent in a
25 hospital after medical school learning, I guess, general

1 medicine for a year. Is that -- making different rotations
2 or ---

3 A Well, we -- general pediatric medicine. We would not
4 typically see adults.

5 Q I apologize.

6 A Yes.

7 Q It does say pediatric ---

8 A Right.

9 Q --- intern. Okay. And so that's a year spent
10 beginning to learn the specialty as a medical doctor,
11 pediatrics, taking care of infants from day one to 18, 21,
12 whatever ---

13 A I think that's a reasonable explanation, sure.

14 Q All right. And then a pediatric resident is actually
15 the more special training or additional training learning
16 how to be trained as a pediatrician?

17 A Well, hopefully you've learned something over that
18 year of training and you have more responsibility, you
19 typically have rotations in some of the other pediatric
20 subspecialties like cardiology or pediatric surgery, so you
21 -- I guess a further honing your skills as a potential
22 board qualified, board certified pediatrician that would
23 allow you to take your patients outside on your own
24 practice or wherever you go.

1 Q All right. And then from '73 to '75 is the
2 neonatology clinical and research fellow, and explain to
3 the jury what a fellow is.

4 A Okay. Typically after a residency program, if you
5 elect to do a fellowship program and get additional
6 training, it's called a fellowship; why it's called a
7 fellowship, I haven't the vaguest idea, but it's either
8 referred to as a fellowship training or post graduate
9 training, and this would be an additional two years spent
10 taking care of the premature babies, consulting with
11 obstetricians and perinatologist about issues related to
12 high-risk pregnancy. There was also a requirement -- we
13 did some research in the laboratory for a period of months
14 during that training, but primarily those two years are
15 spent in taking care of babies in the intensive care
16 nursery.

17 Q And you spent a lot of years doing just that, taking
18 care of babies in an intensive care nursery? Would that be
19 fair?

20 A I think that's fair to say, yes.

21 Q All right, sir. Doctor, you've not trained, in all
22 due respect to what you have been trained in, in the area
23 of obstetrics and gynecology.

24 A That is correct.

1 Q All right. And you're not here to offer opinions in
2 the area of obstetrics and gynecology as an expert in
3 neonatology and pediatrics. Is that fair?

4 A That is fair to say, yes.

5 Q All right. I believe this is about the third case you
6 have had the occasion to review for this law firm. Would
7 that be fair?

8 A You know, I'm not sure of that. I know there's at
9 least one other case that settled I think long before I
10 either gave a deposition or went to trial, and I know there
11 are a couple or at least two other cases that are active,
12 but I have not really looked at the cases, so I -- I think
13 this is really the only case that I've really gotten
14 involved in.

15 Q All right. But you've been asked by this firm to look
16 at other cases. Is that fair?

17 A I think that's fair to say, yes.

18 Q All right. Since you've been reviewing medical
19 malpractice cases as a potential expert over the years you
20 would estimate that you have reviewed approximately 225
21 cases. Would that be fair?

22 A To the best of my knowledge; several months ago I did
23 go through my records and I tried to get some kind of a
24 rough estimate and that's the number that came out, give or
25 take I don't know how many, but that's my estimation, yes.

1 Q Okay. And out of all those cases, whatever that
2 actual number is, and that's not important right now, sir,
3 somewhere between 150 or maybe 180 of those cases resulted
4 in deposition testimony or trial. Does that sound about
5 right?

6 A I think that's what I told you during my deposition.
7 I think that was an estimate, and I think that's probably
8 to the best of my knowledge the case. That's over a 35
9 year period. Right.

10 Q And I'll tell you now as I did at your deposition, I
11 accept that as an estimate.

12 A Okay.

13 Q Good faith estimate by you.

14 A Okay.

15 Q All right. As far as actually going to trial like we
16 did today, you'd estimate that probably a couple times a
17 year, maybe one or two times a year would be an average
18 times you've actually come to Court?

19 A I would think over a 35 year period that's probably
20 generous, yes. Yes.

21 Q And about 75 percent of those cases where you served
22 as an expert witness have been for the plaintiff or a
23 patient as in this case. Would that fair?

24 A Again, that's the best of my recollection.

25 Q And again, I accept that as your estimate.

1 A Okay. I appreciate that.

2 Q Yes, sir. And you charge fees as experts charge for
3 the time that you spend reviewing depositions, coming from
4 Virginia to here.

5 A I do.

6 Q All right. And what are you charging in this case?

7 A In this case I'm charging \$375 per hour for review of
8 depositions, a review of medical records, opinion letters,
9 speaking with attorneys, \$450 an hour for testimony at
10 deposition, and if I have to travel outside of Norfolk,
11 3,500 hours (sic) a day plus my expenses.

12 Q And at the time of your deposition which it doesn't
13 seem like it was that terribly long ago, couple of months
14 or so maybe ---

15 A I think it was in February if I'm not mistaken.

16 Q Thank you. Toward the end of February?

17 A (No response)

18 Q All right. At that time didn't you tell me you'd
19 spent about 10 to 12 hours working on the case, reviewing,
20 consulting, doing whatever you felt like you needed to do
21 to come to whatever opinions you wanted to render. Is that
22 fair?

23 A I think that's what I told you, yes.

24 Q Okay. About how many hours have you spent since that
25 day the end of February?

1 A I think just another three or four trying to refresh
2 my memory and going over the records again so I'd be
3 prepared today.

4 Q Okay. And if I understand what you've told the jury,
5 in your opinion as an expert in pediatrics and neonatology,
6 do you believe that had this baby been delivered earlier,
7 the baby much likely would have survived.

8 A I did say that, yes.

9 Q Okay. On August 25, 2008 -- and again, I don't --
10 this is open-book test, Doctor; I don't expect you to have
11 memorized these records. I know you've done a very good
12 job of reviewing them and looking at them, but I want to --
13 we've got the original hospital chart -- I mean office
14 records from the practice here, and I know you've seen
15 copies of them, but I want to show you that record on
16 August 25. I think it was by Dr. Miller. You've made some
17 reference to that; so we could look at that together. And
18 I know you've seen the copies of that before today. Right?

19 A (Pause) I see it.

20 Q Okay. I just wanted to give you plenty of time to
21 review it. I know you've looked at it before today. Now,
22 referring to that record, sir, would you agree with me that
23 Dr. Miller, Dr. Greg Miller clearly documents as part of
24 his plan, his, one, two, three, four plan, that his patient
25 Ms. Jamison that day begin to do kick counts?

1 A I do see that, yes.

2 Q And he recommends as part of his plan increasing
3 fluids.

4 A Yes.

5 Q And that he asked her to let the office know
6 immediately if there was any increase in calf pain.

7 A Correct.

8 Q Doctor, can you explain -- we've seen -- the jury's
9 seen it yesterday or we've showed that record to them on
10 the overhead -- Dr. Miller talks about a Homan's sign, H-o-
11 m-a-n-s.

12 A (Indicating yes)

13 Q Can you explain what a Homan's sign is?

14 A You know, it's not something I typically do. I'm
15 trying to remember my physical diagnosis. I think it has
16 something to do with leg reflexes, maybe with deep vein
17 thrombosis, if I'm not mistaken, pain in the leg as you
18 manipulate the leg.

19 Q Okay. Is it your general understanding as a physician
20 that if a doctor does -- or a healthcare provider does a
21 Homan's sign, they're trying to test if there's any pain in
22 the lower calf from possibly blood clots?

23 A Yes. That's my understanding.

24 Q And the blood clots break -- if they're there, and
25 they break off in the lower calf and can travel up to the

1 lung or heart or brain, Doctor, is you call that a
2 pulmonary -- if it's in the lung -- a pulmonary embolism.

3 Correct?

4 A That's correct.

5 Q And you would agree that if that should happen, a
6 pulmonary embolism can cause very sudden death.

7 A It can.

8 Q Would that be perhaps something that Dr. Miller may
9 have been concerned about and that's why he did the Homan's
10 sign because she complained of ankle swelling to see if
11 there was any pain there and then to tell her, if you've
12 got any more problems with the calf pain or anything like
13 that happens, we need to know immediately? Would that be
14 appropriate just as a physician?

15 A I would think so, yes. Again, I'm not an
16 obstetrician, but I would think that would certainly be
17 appropriate, yes.

18 Q All right. And you agree that there'd be no reason to
19 believe that Dr. Miller would not have put down in his
20 chart on that day his plan to have a patient do kick counts
21 if he had not told the patient, do kick counts. Right?

22 A That's correct.

23 Q Okay. Your opinion earlier that had this child been
24 delivered prior to 11:45, 46, 47, quarter to noon whatever
25 that day on September 5, the assumption there obviously ---

1 forgive me for being simple, Doctor -- the assumption has
2 to be that there is a heart rate at that time. Correct?

3 A Correct.

4 Q As part of your review of the record, did you look at
5 the placental pathology?

6 A I did, yes.

7 Q Okay. Can you just generally describe for the jury
8 what is a placental pathology report and what's it just
9 generally based on? I'm not sure that we've gone over this
10 at any point in the jury's review to this point. Can you
11 help them understand that?

12 A Sure. My understanding of a placental pathology
13 report would be the examination of the placenta after the
14 delivery of a baby, particularly if there's some problem
15 with the delivery, if there's some problem with the baby,
16 to try to help by examining the placenta to make a
17 diagnosis to look for signs, pathological signs in the
18 tissue of the placenta to see if it can be correlated with
19 a problem in the baby or problem in the mother.

20 Q Okay. And you reviewed that report did you say?

21 A I did.

22 Q Okay. Is a pathology -- placental pathology report
23 done by a medical doctor in a specialty of pathology?

24 A I would think that it would be, yes.

1 Q Okay. Any reason to believe that it was done by
2 anybody other than a qualified pathologist in this case?

3 A I would think not.

4 Q Okay. Doctor, would you agree with me that according
5 to the examination by the pathologist of the placenta after
6 the delivery of Jayden, that there is nothing that can tell
7 you as a specialist, an expert in pediatrics and
8 neonatology, what the cause of death was?

9 A That's how I interpreted the report, yes.

10 Q And would you also agree that according to the
11 pathology report there's nothing on there within your
12 respective specialty that can tell you when this baby died?

13 A I did not find any evidence of that.

14 Q Sir, you mentioned and were asked to look at a blood
15 pressure during the time that Ms. Jamison was a patient of
16 Rock Hill Gyn-Ob, pointed that out, I think was 147 over
17 whatever it was. You probably remember and I don't, but
18 you understand too from your review of the hospital records
19 from -- excuse me -- from your review of these doctors'
20 office charts, that she came in with a history of chronic
21 hypertension.

22 A She did, and she was on a blood pressure medicine,
23 yes.

24 Q So when she came to the practice, she told them, well,
25 you know, I've got high blood pressure; I've been on

1 medicine for that, and they continued to treat her high
2 blood pressure, Aldomet, I think it is, maybe other blood
3 pressure medicines through their care of her?

4 A That is correct, yes.

5 Q I know we talked about the sign-in sheets in your
6 deposition. I just want to -- this won't take long. I
7 want to look at them again with you and the jury. Let me -
8 - so you don't have to get up and walk around, let me get
9 you a copy.

10 A Okay.

11 Q I think that's it.

12 A Thank you.

13 Q Yes, sir. There are several pages, and this is - I
14 apologize. This is a bad copy. I think the color of the
15 paper was not white and so as we copied it, it looks pretty
16 shabby, but let's look at this together. If you'd look at
17 the top page, sir. Here on the top there's a column, the
18 name and we blacked that out, because we don't want people
19 to know -- patient's name -- that's not proper, but then
20 we've got a column for doctor and a column for sign-in
21 time?

22 A That's correct.

23 Q All right. And we've got the date up here, 9-5-08.

24 You see that?

25 A (No response)

1 Q The doctor -- would you assume -- and if you don't
2 have an opinion on this, that's okay, but would it be fair
3 to assume that whatever doctor or healthcare provider that
4 is under this column would be the doctor that would be
5 responsible primarily for that patient as they signed in or
6 if they had an appointment that's who they'd see?

7 A I would think that's reasonable, yes.

8 Q All right. So the first one on here is 7:55 in the
9 morning, Dr. Hilton. The next one 7:55, Dr. Hilton, 7:55
10 Dr. McClelland, 7:55, Dr. Robinson, 8:00 o'clock, Dr.
11 Hilton, 8:00 o'clock, nobody, 8:00 o'clock, Robinson and
12 Hilton, Robinson and McClelland, Robinson, Robinson,
13 Robinson, I don't know. I can't read that next one.
14 Pruette maybe?

15 A Privette (sic).

16 Q Robinson, blank, Pruette, blank, blank, and then we go
17 to the next page. Now, how many do we have up here? Can
18 you just count those for me?

19 A On which page?

20 Q On the first page, sir.

21 A I have 19.

22 Q Okay. And then we turn to the next page, and again, I
23 apologize for this very poor copy. The very first name is
24 Samantha Jamison. Can you make that out?

25 A I can, yes.

- 1 Q Thank you. And at the time that she signs in, it
2 looks like 8:30 and then there's a four over the three - I
3 mean that -- looked like to me. Is that fair?
- 4 A It is, and particularly if you look at the prior page,
5 it looks like there's already an 8:35, so I think 8:40
6 sounds reasonable.
- 7 Q Okay. And there's no doctor listed there. Right?
- 8 A That's correct.
- 9 Q Okay. We know -- I mean you know from the case that
10 this -- that she came in without a scheduled appointment
11 that morning.
- 12 A Right. She was a walk-in. Right.
- 13 Q And do you know how many other walk-ins there may have
14 been that morning?
- 15 A I do not know.
- 16 Q This sheet goes to -- through 9:00 o'clock, and that's
17 another 17, 18 names?
- 18 A Correct.
- 19 Q The next sheet another 17, 18 names?
- 20 A That's correct.
- 21 Q Starts at 9:15, goes to 10:10?
- 22 A Correct.
- 23 Q The next sheet, another 15, 16 names or so?
- 24 A That's correct.
- 25 Q Starting at 10:15 through 11:20. Is that right?

1 A That's correct, yes.

2 Q And the next sheet starts at 11:30 and goes to 2:00
3 o'clock?

4 A Correct.

5 Q And I think that's it. Based on the medical records
6 and the deposition testimony, sir, that you've reviewed in
7 this case, you understand that she signed in as we've just
8 talked about at 11:48. That would have to be ---

9 A 8:40.

10 Q I'm sorry. Thank you. Eight forty. Eleven forty-
11 eight is in my mind and we'll get to that in a minute. You
12 understanding is she signs in as a walk-in on a very busy
13 morning at 8:40, and your understanding from gleanings all
14 the testimony and records that you reviewed that she
15 would've left around 11:00 a.m.

16 A That is correct.

17 Q Okay. And according to your review of the records and
18 all that you have reviewed that helps to form a basis of
19 any opinions or any part of your review in particular to
20 this case, sir, you would agree that after she signed in,
21 she waited for some period of time to be seen by the nurse
22 practitioner, Robin Pruetto?

23 A She did, yes.

1 Q And she was seen by Robin Pruetto, evaluated by the
2 nurse practitioner who ordered a non-stress test. You
3 understand that?

4 A That is correct, yes.

5 Q And Ms. Jamison had that non-stress performed, I think
6 the individual that helped her actually do it was a lady by
7 the name of Wendy Knox. I don't know if you remember that
8 detail. If you do -- if you don't that's okay. That --
9 somebody had to do that.

10 A Yes.

11 Q All right. And after the non-stress test was
12 evaluated by -- I'll ask you to assume Robin Pruetto since
13 she ordered it -- that she looked at it, saw some late
14 decelerations at the end and said, Wendy I want you to have
15 Ms. Jamison be seen by Dr. Hilton and get a biophysical
16 profile. You understand that's -- something like that
17 happened after that.

18 A That's my understanding, yes.

19 Q And that -- that she thereafter had her biophysical
20 profile. You understand that's what happened?

21 A She did.

22 Q And that Dr. Hilton reviewed part of that biophysical
23 profile pretty early on and ordered it stopped after ten
24 minutes. You understand that?

25 A That's my understandings, yes.

1 Q Typically a biophysical profile lasts about how long?

2 A I think 20, 30 minutes, something like that.

3 Q Okay. A two out of eight on a biophysical profile --
4 and please understand, Doctor, respecting your specialty,
5 if I ask you a question that's in fairness to you outside
6 of your field of expertise, let me know, and I'll just move
7 on. Is that fair?

8 A It is, yes.

9 Q All right, sir. A biophysical profile of two out of
10 eight, eight being I guess the best and only having two is
11 not good.

12 A It's worrisome, yes.

13 Q It's worrisome. And -- all right. And you agree from
14 your review of the materials in this case that after Dr.
15 Hilton ordered that biophysical profile in her presence to
16 be stopped after ten minutes, saw a two out of eight, that
17 she ordered Ms. Jamison to get to labor and delivery right
18 away.

19 A That's my understanding from reading the records and
20 testimony, yes.

21 Q Doctor, I want to ask you a hypothetical and there are
22 several parts to it and I will be glad to go back over any
23 or all of the hypothetical with you. Is that understood?

24 A That's fair.

1 Q All right, sir. Doctor, for the sake of my question,
2 I would ask you to assume the following facts: Assume that
3 Dr. Hilton was standing over the shoulder of the
4 ultrasonographer as the biophysical profile was being done
5 and that she observed -- Dr. Hilton observed several
6 minutes of that ten minute process before she stopped it at
7 ten minutes; Assume further that Dr. Hilton then told Ms.
8 Jamison she needed to go immediately to labor and delivery
9 after confirming with Ms. Jamison that she had
10 transportation and that she knew where labor and delivery
11 was; Assume further labor and delivery is five or ten
12 minutes away from the office where Ms. Jamison and Dr.
13 Hilton were at the time; Assume that Dr. Hilton told her to
14 go directly to labor and delivery and said something to the
15 effect, do not pass go, do not collect two hundred dollars,
16 go directly to labor and delivery, I'm going to call my
17 partner, Dr. Benson, who is on the labor and delivery floor
18 and he will be expecting you; Ask you to further assume,
19 sir, that Dr. Hilton said something to the effect,
20 sometimes babies do better out than in; Assume further,
21 sir, that Dr. Hilton called Dr. Benson, her partner, who
22 was then present and on duty in labor and delivery at the
23 hospital and told him Ms. Jamison was coming, had performed
24 a BPP and at ten minutes was two out of eight and that Dr.
25 Hilton was very concerned and there was a plan for quick

1 further evaluation and a probable or likely or possible
2 emergency caesarean section; Assume further that before Ms.
3 Jamison left the office, that Jane McCain, the
4 ultrasonographer, also told Ms. Jamison be sure you go
5 directly to labor and delivery, don't stop anywhere else;
6 Assume further, Doctor, that Ms. Jamison acknowledged both
7 to Dr. Hilton and independently acknowledged to Ms. McCain
8 that she understood those instructions and that she then
9 left around 11:00 a.m. for labor and delivery; Assume, sir,
10 that she arrived at the floor of labor and delivery at
11 11:40 a.m. where she was immediately assessed by nursing
12 staff who could not obtain a heart rate. My question to
13 you, sir, and I'll be glad to repeat any of those variables
14 that I need to, based on those assumed facts, in your
15 opinion, when did this baby die?

16 A Again, I think as I said before, I think this baby in
17 all likelihood died some time between 11:00 o'clock in the
18 morning and 11:40 I guess is when -- when the ultra -- when
19 the nurse ultrasonographer could not find a heart rate.

20 Q And, Doctor, do you agree that based on the records in
21 this case that you have reviewed, as an experienced board
22 certified neonatologist who personally takes care of and
23 I'm sure has probably trained other physicians in your
24 specialty through the years, that when a 32 week premature

1 infant is born, they're exposed to certain quite
2 significant risks of prematurity. Correct?

3 A Well, those are your words. They're not my words as a
4 neonatologist who takes care of loads of 32 weekers and in
5 my experience, again, not that I'm advocating being born at
6 32 weeks, but the vast majority of those babies do very
7 well, and the outcomes are really quite good in this day
8 and age.

9 Q All right, sir. I think percentage-wise you said 85
10 to 90 percent.

11 A I think I said that in my deposition. I think that's
12 probably true, yes.

13 Q All right. And I would agree that that would be
14 characterized as a vast majority.

15 A Right.

16 Q I don't take issue -- that somebody's in that 15
17 percent or ten percent, aren't they?

18 A Somebody is, yes.

19 Q And some of the risks that a 32 week premature infant
20 is exposed to, some of the risks that they have is problems
21 with breathing or lung immaturity?

22 A They could have problems, but again they're very
23 adequately treated with current technology, surfactant and
24 ventilators.

1 Q Doctor, in asking these questions I, please, would not
2 want you to think that I'm saying that this child would not
3 have had very good care. Certainly, if this baby was born
4 in Norfolk under your care, I wouldn't question that the
5 quality of care and good care that the baby would've had,
6 and I assuming the same here, but just in general, a 32
7 week infant does have a problem or risks including
8 infection.

9 A Again, there could be those, but they would be really
10 in the minority.

11 Q They could develop brain bleed.

12 A Again, very unlikely, certainly a possibility, but not
13 very likely.

14 Q If a baby gets an infection like klebsiella.

15 A Klebsiella, yes.

16 Q Thank you. Klebsiella?

17 A Klebsiella.

18 Q Thank you.

19 A Yes.

20 Q And that happens. That can happen, can't it?

21 A It certainly can, but again, very, very rarely.

22 Q And if it happens in that very, very rarely case of a
23 32 week premature infant, and that bacteria gets into the
24 spinal cord, we call that meningitis, don't we?

25 A Yes, we do.

1 Q And if that infection should get into the brain as
2 meningitis, it can cause extensive brain damage, can't it?

3 A It may certainly.

4 Q It can cause -- is it PVLs?

5 A PVLs, one term we would use for that, periventricular
6 lueukomalacia, yes.

7 Q In lay terms if you had to tell a mother and father or
8 either, that based on the studies that you're doing of an
9 infant that you're carrying for, no fault of yours, no
10 fault of anybody, that this 32 week infant has developed
11 PVLs bilateral, how do you explain that to mom and dad as
12 far as what's happened to my baby and what is the
13 prognosis?

14 A Well, again I would explain it to the best of my
15 ability based on the facts, whether there was an infection,
16 whether there was some episode of hypertension or birth
17 asphyxia. I would probably review the studies, the
18 radiological studies with them, but again, I don't want to
19 be confrontational with you. I respect you a lot ---

20 Q Thank.

21 A --- but when I counsel mothers who are getting ready
22 to deliver 32 weeks, I am very optimistic about the
23 outcome. I do not typically dwell on all these things that
24 you talked about. I tell them that the likelihood of a
25 good outcome is exceedingly rare. If they ask me what

1 some of the problems are, I certainly will tell them, but
2 again in this day and age, the outlook is exceedingly good.

3 Q But you've got to start with a baby that's born alive,
4 don't you?

5 A You do, yes.

6 Q As a physician, sir, and particularly as a board
7 certified and experienced and I will add respected
8 neonatologist, sir, responsible for taking care of 32 week
9 old premature babies -- and let me -- I probably should've
10 asked this sooner. Let me back up. Is 40 weeks typically
11 full term as your understanding?

12 A Well, by definition we would regard 37 to 40 weeks as
13 being term.

14 Q Okay. And this child was short of that, 32 weeks.

15 A Thirty-two -- between 32 and 33 I believe.

16 Q Okay. And go back to my question. As a well-
17 respected board certified neonatologist caring for a 32
18 week old premature infants, from your perspective in that
19 specialty you would agree with me that it would be a good
20 idea for an obstetrician to tell a patient to go
21 immediately to the hospital to labor and delivery if the
22 obstetrician determines in his or her opinion that there
23 may be some risk posed by the baby as evidenced by a
24 biophysical profile of two out of eight.

25 A I would agree with that, yes.

1 Q And you also agree as a neonatologist that it would be
2 a good idea for the obstetrician in the office to
3 immediately call his or her partner on labor and delivery
4 floor and tell the partner, who may not have ever seen or
5 examined this patient, I'm sending Ms. Jamison over, we
6 just had an NST, there's some questionable late
7 decelerations but it's indeterminate, but we did a BPP, a
8 biophysical profile, we got a two out of eight, I'm sending
9 her over immediately to see you, you need to get ready to
10 do a c-section right away after you evaluate her and, you
11 know, the ball's kind of going to be in your court, but I'm
12 sending her over, you know, and pass the baton over to him.
13 Would that be a good thing from a neonatology standpoint?

14 A Yes, I would think so.

15 Q And you also agree as a board certified and respected
16 and experienced neonatologist and pediatrician that it'd be
17 a good thing for the obstetrician in a hospital on the
18 labor and delivery floor, that upon receiving that
19 information from his partner in the office, to alert the
20 nursing staff that Ms. Samantha Jamison is coming, she's
21 being sent from the office, when she comes through those
22 doors at labor and delivery, I want you to get her ready
23 and do an immediate assessment, and as soon as she gets
24 settled in in the bed and you get the fetal monitor on,
25 call me, I'll be right there to take it from there and make

1 my assessment and we'll make the decision from there. Do
2 you agree that as a neonatologist that would be a good
3 thing to do?

4 A I would, yes.

5 Q Doctor, as a well qualified and experienced board
6 certified neonatologist, you do not have an opinion as to
7 the cause of death of this child, do you?

8 A I was not able to determine a cause, no.

9 Q And also you were not able -- in all fairness and
10 respecting your specialty, sir, you were not able to offer
11 an opinion within a reasonable degree of medical certainty
12 more likely than not what caused the decrease in fetal
13 movement. True?

14 A No, I think you'd only speculate, but I don't think
15 that's within my realm.

16 MR. DAVIS - One moment, please. And I want to
17 make sure I'm pronouncing your name right. Karotkin?

18 DR. KAROTKIN - Karotkin. Thank you.

19 MR. DAVIS - One moment, please, sir.

20 (Pause) Thank you, Doctor.

21 DR. KAROTKIN - Thank you.

22 THE COURT - Re-direct?

23 RE-DIRECT EXAMINATION

24 BY MR. BOYD -

1 Q Some questions were asked to you concerning the risks
2 factors for child of 32 weeks. What kind of -- just
3 describe what development child at 32 weeks has. What is
4 left to be developed?

5 A Well, again, at 32 weeks we would anticipate all of
6 the organs to be fully developed as far as size. Function
7 may not be entirely normal, in particular the lungs, and
8 probably the biggest problem a baby at 32 weeks would face
9 would be a respiratory distress syndrome sometimes referred
10 to by the old term as highland membrane disease. This is a
11 condition that is caused by premature babies lacking a
12 chemical which lines the air sacks and lines the airway.
13 Fortunately, we have the technology now to supply that
14 chemical to the babies and typically in a baby like this
15 who was delivered prematurely, we would have that material
16 available in the delivery room and we could instill it into
17 the airway immediately after delivery or shortly after
18 transfer to a level three nursery. Babies born at 32 weeks
19 would typically not be ready to eat within the first 24 or
20 48 hours, would require an IV, might require IV fluids that
21 have sugar and fats and protein in them. Most babies born
22 prematurely like this get started on antibiotics for a
23 short course just because of the risk of infection and if
24 the blood cultures are negative after 48 hours, we would
25 typically stop. Other potential problems would be feeding

1 intolerance. It wouldn't be unusual for a baby like this
2 to have some delay in the ability to suck and swallow, and
3 this baby might require a nasogastric tube or a tube put
4 into the stomach through the nose or mouth, and the baby
5 could be giving breast milk or formula that way.

6 Q All right. And what kind of brain development does a
7 baby at 32 weeks have?

8 A The brain development is certainly not as mature as it
9 is at term, but the structures of the brain that are
10 vulnerable to bleeding are actually reasonably well
11 developed, and the incidents of bleeding within the brain
12 of a baby at 32 weeks is much less than it might be at 24
13 or 25 weeks. At 24 or 25, 23 weeks gestation, the
14 structures deep within the brain where the bleeding is
15 likely to occur are very fragile. The blood vessels are
16 thin and are much more likely to cause intracranial
17 hemorrhage which is a major problem in babies born at the
18 extremes of early gestation, 24, 25, 26 weeks gestation.

19 Q And a baby in utero at 32 weeks, can they feel pain?

20 A Well, that's a very good question. I mean it's an
21 area that has been looked at. People that are anti-
22 abortion advocates have looked at it. People that are
23 interested in doing fetal surgery have looked at it, and
24 there is a body of evidence to suggest that yes, in fact,
25 fetuses particularly those after 20 weeks gestation do - do

1 feel pain and that -- and some states have used that
2 evidence to prohibit terminations of pregnancy or abortions
3 after 20 weeks gestation. So as a general rule, I would
4 have to say particularly for babies after 20 weeks
5 gestation, yes there is a body of evidence in the pediatric
6 literature, in the neurology literature that would indicate
7 they do feel pain.

8 Q And let me -- do you routinely in your practice care
9 for babies born early at 32 weeks?

10 A Very often.

11 Q Okay. The -- in this particular child the -- see how
12 I want to phrase this. This child -- I think in your
13 opinion if a c-section had been performed, the child would
14 -- is it your opinion the child would've survived?

15 A I believe so, yes.

16 Q Okay. And does the -- had the baby -- obviously a c-
17 section wasn't done and the child died. Is that correct?

18 A That's correct.

19 Q Okay. So the -- is the fact that no cause of death
20 can be determined, does that change your opinion?

21 A It does not. No, I think we've ruled out a lot of the
22 common causes of like infection, but I don't think it
23 changes my opinion, one iota.

24 Q Could you elaborate that? Why does that not change
25 your opinion?

1 A Well, you know, when we have a case of unexplained
2 death, we look for some of the common causes such as
3 infection, intrauterine infection, chorioamnionitis. We
4 look for anomalies, birth defects. We look for factors
5 that the mother may exhibited during her pregnancy, such as
6 infections, other -- other maternal diseases that may
7 caused it, and I didn't see any evidence of explainable
8 cause of death. And in many situations, unfortunately, we
9 just don't find a cause of death.

10 Q The -- there was a -- questions asked to you
11 concerning that Samantha Jamison was a walk-in. Basically,
12 as far as standard of care is concerned, is a walk-in
13 entitled to the same standard of care as a patient with an
14 appointment?

15 MR. DAVIS - Objection, Your Honor. He's just
16 been an asked an obstetrical standard of care question, and
17 he by his own honest admission is not qualified to render
18 one.

19 THE COURT - I'll allow him to answer it if he
20 feels that he has the ability to answer it.

21 A I mean I can answer it, and obviously, I'm not an
22 obstetrician, but it seems to me, again, as a neonatologist
23 that a mother that walks in complaining of decreased fetal
24 movement should be moved up to the front of the line and

1 THE COURT - All right. Do you wish to voir dire
2 the witness as to his qualifications or challenge the offer
3 by the plaintiff?

4 MR. WILLIFORD - Not at this time. I'm going to
5 reserve my questions for later.

6 THE COURT - All right, very good. I'm going to
7 qualify him to give his opinion. You may proceed.

8 MR. JORDAN - Thank you, Your Honor.

9 Q Dr. Phillips, I'm going to run through some records
10 and I'm going to ask you if you've reviewed those. If I
11 miss something, let me know. In reviewing this case, have
12 you reviewed records from Rock Hill Gyn-Ob?

13 A Yes, I have.

14 Q Piedmont Medical Center?

15 A Yes.

16 Q Both the August 9th and September 5th admissions?

17 A Yes, I have.

18 Q Have you reviewed Lowry's Family Medicine records?

19 A Yes, I have.

20 Q Records from Dr. Goldsmith?

21 A Yes.

22 Q North Central Family Medicine?

23 A Yes.

24 Q Maybe Chester Cardiovascular?

25 A Yes.

- 1 Q Have you reviewed depositions from Dr. Hilton?
- 2 A Yes.
- 3 Q Dr. Benson?
- 4 A Yes.
- 5 Q Jane Gorman?
- 6 A Yes.
- 7 Q Jane McCain?
- 8 A Yes.
- 9 Q Wendy Knox?
- 10 A Yes.
- 11 Q Michelle Sharpe?
- 12 A Yes.
- 13 Q Robin Pruette?
- 14 A Yes.
- 15 Q Dr. Goldsmith?
- 16 A Yes.
- 17 Q Lori Lette?
- 18 A Yes.
- 19 Q Dr. Karotkin?
- 20 A Yes.
- 21 Q A Dr. Roger Newman?
- 22 A Yes.
- 23 Q A Dr. Moore?
- 24 A Yes.
- 25 Q Samantha Jamison?

1 A Yes.

2 Q Barbara Jamison?

3 A Yes.

4 Q Jackie Chaulk?

5 A Yes.

6 Q I think Stephanie Walker, maybe?

7 A Doesn't ring a bell.

8 Q Are these the types of records that you review and

9 that are typically used to render opinions, medical, legal

10 opinions?

11 A Yes.

12 Q Were they sufficient for you to draw conclusions about

13 the standard of care?

14 A Yes, they were.

15 Q Doctor, do you have a conclusion that the doctors of

16 Rock Hill Gyn-Ob through their physicians breached the

17 standard of care?

18 A Yes, I do.

19 Q And what is that opinion?

20 A They did breach the standard of care.

21 Q And is that opinion to a reasonable degree of medical

22 certainty?

23 A Yes, it is.

24 Q First of all, let me ask you, as to Rock Hill Gyn-Ob,

25 not going into specific doctors at this time, can you tell

1 me, first of all with regard to the treatment, should
2 Samantha Jamison have been followed as a high risk
3 pregnancy?

4 A Yes, she was definitely a high risk pregnancy.

5 Q Did Rock Hill Gyn-Ob treat her as such?

6 A At times.

7 Q Can you elaborate on that? Let me ask -- well, let me
8 ask you, following up to September 5th, 2008, before that
9 date, did you find a breach of the standard of care with
10 regard to her treatment?

11 A Yes, I did.

12 Q Can you tell the jury what that was?

13 A Well, she has a history of chronic hypertension
14 requiring blood pressure medication. When you have chronic
15 hypertension and you are pregnant, you increase the risks
16 of certain complications that can occur to the patient, the
17 mother, or the baby. For instance, there's increased
18 incidents of the baby not growing properly, so you have
19 what you call intrauterine growth restriction. You can
20 have a condition where the placenta separates from the
21 uterus called placental abruption. You can -- you're a
22 high risk of developing what we call superimposed
23 preeclampsia which is another condition that could be life-
24 threatening to the mother and the baby, so when the patient
25 comes into your office and she's a chronic hypertensive as

1 she was, Ms. Jamison was, you have to -- you have to hope
2 for the best but expect the worst, and that patient
3 requires a different type of surveillance, a different type
4 of care than a patient who comes to a doctor's office who's
5 considered a low risk patient, a patient that doesn't have
6 any factors that make it more dangerous for her or the baby
7 during the pregnancy. Hard chronic hypertension that she
8 had put her in that high risk category requiring extra
9 surveillance and also a low threshold of intervention.
10 What I mean by that is, is that, as I said, you have to
11 hope for the best, expect the worst, so if there are signs
12 of whether it's a blood pressure reading or a test, like an
13 ultrasound that you do, if there are signs consistent with
14 a potential problem that the baby may be suffering from,
15 you have to anticipate the worst outcome and try to make
16 sure that if that does occur, it occurs at a time where you
17 can pick it up early enough so that the mother and baby's
18 life or health will not be in jeopardy.

19 Q And she had chronic hypertension.

20 A Yes, she did.

21 Q And why is that a danger?

22 A Because chronic hypertension affects the blood supply,
23 in general terms it can affect the blood supply to the
24 baby. The baby gets its blood supply, nutrients, oxygen
25 from the placenta. With chronic hypertension, it can

1 affect the blood vessels in the placenta so that the
2 adequate oxygen and blood supply does not go to the baby,
3 and that's the reason why you can get a baby that doesn't
4 grow properly like what we call a intrauterine growth
5 restricted baby. You expect the baby to grow every week a
6 certain amount of size if the baby's growing properly.
7 With chronic hypertension there could be a lag in the
8 growth of the baby to a point where it can be detrimental
9 to the baby, much more detrimental to keep the baby inside
10 the uterus than the baby could do as well outside the
11 uterus. In other words, an obstetrician always has to take
12 into consideration that you're dealing with two patients, a
13 mother and the baby. You want to keep the mother healthy
14 and you want to keep the baby healthy, so that when you
15 reach a point in a pregnancy where a baby will do better
16 outside than inside, then it's time to get the baby out,
17 and in order to determine that, the patient has to be --
18 undergo the appropriate surveillance by the obstetrician so
19 that there's a warning or a period of time where a doctor
20 can act to prevent a calamity from taking place.

21 Q Doctor, you mentioned chronic hypertension. She was
22 on medication for that. Is that correct?

23 A Yes, she was.

24 Q And you're aware that she had to go to the hospital on
25 August the 9th, 2008.

1 A That's correct.

2 Q Now, when she presented to the hospital on August 9th,
3 2008, even though she was on blood pressure medication, was
4 her blood pressure high?

5 A Yes, it was.

6 Q Looks like it's 178 over 87 on August 9th at 12:51 in
7 the morning.

8 A Yes, it's elevated. The top number is what we call
9 the systolic number and that's elevated. A patient with
10 chronic hypertension like that number to be from about 120
11 to 140, and nothing higher than that. That's the ideal
12 blood pressure, put it that way.

13 Q Now, Doctor, you mentioned the breach in the standard
14 of care following up to September 5th, 2008, and you
15 mentioned something called intrauterine growth retardation.
16 Is that correct?

17 A Well, that name isn't used anymore. It's intrauterine
18 growth restriction, but basically what it is is that as a
19 result of chronic hypertension -- there are other disease
20 entities that can cause that as well, but the baby does not
21 get sufficient nutrition and oxygenation to grow
22 appropriately as an average baby will grow in most
23 circumstances.

24 Q We've got the August 25th, 2008 office note pulled up
25 here, and you've reviewed that document. Is that correct?

1 A Yes, I did.

2 Q Here's the chart here if you'd like to refer to it, as
3 well, Doctor. Now, she was seen by Dr. Miller on August
4 25th. Is that correct?

5 A That is correct.

6 Q And he notes a history of uterine rupture.

7 A Yes.

8 Q There's a decrease in the amniotic fluid index.

9 A That's correct.

10 Q Now, is nine -- is that still normal?

11 A Nine is a normal -- it's on the low side but it's a
12 normal amniotic fluid index.

13 Q But you want to know why there's a drop in the
14 amniotic fluid index?

15 A Yes, you want to know what the trend is, because it
16 could be a perfectly normal, low normal value that will go
17 back up to a normal value a day later or that afternoon or
18 a few days later, but you want to know where it -- how it's
19 trended. It's an important parameter to follow in terms of
20 the surveillance; as I mentioned before, the proper
21 surveillance of a patient with chronic hypertension is to
22 make sure that if you have a low normal amniotic fluid
23 index, that it's not trending downward to an abnormal low
24 level. The only way you can know that is by repeating the
25 test, the ultrasound, in a timely basis.

1 Q And Dr. Miller notes here that the abdominal
2 circumference was lagging behind by two weeks. Is that
3 correct?

4 A Right. That's the first time that there's
5 appreciation of the very real possibility that the baby's
6 not growing properly. You know, sometimes you can get a
7 situation where there's a lag of one parameter versus of
8 another parameter in determining how many weeks gestation
9 the baby is, how big it should be, but it's a warning sign
10 that there's going to be a lag, a potential problem in a
11 patient who has chronic hypertension, because one of the
12 things you're watching out for is this very thing, is the
13 baby's growth starting to slow down, because this patient's
14 at a high risk for that to happen in the first place, and
15 along with the amniotic fluid index showing that the fluid
16 around the baby, although still normal, is on the low side.
17 So the question you have to ask is, is this an on-going
18 progressively bad situation, or is this just a normal
19 variant that will quickly correct itself when you repeat
20 the test at a timely basis. You can't afford to be wrong.
21 The mother can't afford to be wrong. The baby can't afford
22 for you to be wrong, so when in doubt, when it comes to
23 fetal surveillance, and there's no harm in doing it, you do
24 the proper surveillance at the proper time just to minimize
25 the chances that you will not pick up the problem too late

1 to intervene and the baby or mother can suffer as a result
2 of that.

3 Q Doctor, do you have a conclusion based on her
4 condition up until August 25th, 2008 what action should've
5 been taken on August 25th, 2008 that would've been within
6 the standard of care?

7 A Yes.

8 Q What is that conclusion?

9 A Ideally, appropriately, a non-stress test and a
10 biophysical profile would be done that day to see if the
11 baby's suffering from the lack of oxygen developing what we
12 call fetal acidosis from the lack of oxygen and the build-
13 up of waste products. At the very latest you would want to
14 do that test a week later. If you don't do it on the 25th,
15 a week later, which is September 2nd would be the
16 appropriate time to do a non-stress test and biophysical
17 profile.

18 Q Doctor, I want to jump up for just a moment to
19 September 5th, 2008. What is your understanding about what
20 time she presented that morning?

21 A Well, she presented maybe 8:30, maybe 8:40 in the
22 morning.

23 Q And what is your understanding of her condition that
24 she reported with?

25 A She came in complaining of decreased fetal movement.

1 Q And doctor, is that a concern, decreased fetal
2 movement?

3 A It's a concern. There are times and, fortunately,
4 most of the time when a mother complains of decreased fetal
5 movement, it's not necessarily a sign that the baby is
6 suffering from any problems. Sometimes as the baby grows,
7 there are periods of time where a mother perceives the
8 fetal movement decreasing and it's perfectly fine for that
9 to happen, and there are other times that decreased fetal
10 movement is a pre-cursor of no movement, if you will. It's
11 a pre-cursor or a signal to alert the obstetrician, alert
12 the caregiver of this patient that there very well may be a
13 potential problem that requires urgent analysis, so that if
14 there is a problem, the proper interventions can be done in
15 a timely basis.

16 Q Doctor, does the standard of care require an Ob-Gyn
17 group -- if a patient comes in -- well, first of all, let
18 me ask you. Is there a different standard of care for a
19 walk-in versus someone who has an appointment, or do all
20 patients receive -- or are they entitled to the same
21 standard of care?

22 A The same standard of care applies to whether a patient
23 makes an appointment or walks in.

1 Q Now, Doctor, if a patient walks in and has or
2 complains about reduced fetal movement, what should a
3 reasonable, prudent physician or a Ob-Gyn do?

4 A Well, a decreased fetal movement is a complaint that
5 has a potential of being an emergency. There are many
6 complaints when a patient walks in to the obstetrical
7 office to have the potential to be an emergency. There
8 also has the potential to be perfectly fine, a benign
9 thing, nothing to really get alarmed about, but you don't
10 always know based on the complaint whether you're dealing
11 with a potential tragedy, potential emergency or just a
12 variation of normal that will resolve by itself. So the --
13 so when a patient comes in with a complaint that could be a
14 normal complaint, nothing to worry about, or has the
15 possibility to be a potential emergency, you have to assume
16 the worst, hope for the best but assume the worst. And the
17 patient requires -- whether she comes in with a complaint
18 of bleeding during her pregnancy -- any amount of bleeding
19 during pregnancy, especially during that part of the
20 pregnancy or she's coming and complaining of a severe
21 headache or she's coming and complaining about decreased
22 fetal movement -- any of those complaints and many other
23 complaints could be perfectly benign, nothing to worry
24 about, but also could be giving the obstetrician the heads-
25 up that something bad is going to happen soon. You have to

1 expect the worst, hope for the best, and when a patient
2 comes in with decreased fetal movement, you can't assume
3 that just the patient's baby -- if she's not feeling it
4 moving properly and maybe she's not drinking enough fluid,
5 maybe this baby's sleeping too much, or whatever the case
6 may be, you can't assume that, because if you're wrong, bad
7 things can happen. Bad things can happen to the mother;
8 bad things can happen to the baby and you can't afford --
9 mother can't afford, certainly the baby can't afford a
10 mistake by the obstetrician or whoever's taking care of the
11 obstetrical patient.

12 Q Doctor, do you have a conclusion as to whether or not
13 there was a delay in the treatment for Samantha Jamison
14 when she appeared at 8:40 that morning?

15 A Yes, there was.

16 Q Okay. And, Doctor, is it your conclusion to a
17 reasonable degree of medical certainty that that delay was
18 a breach in the standard of care?

19 A Yes, it was.

20 Q Doctor, do you have a conclusion to a reasonable
21 degree of medical certainty as to whether or not that delay
22 in treatment caused or contributed to Jayden's death, the
23 death of Samantha's son?

24 A Yes, it did.

1 Q Let me ask you doctor. I want you to assume that
2 Samantha Jamison comes in at 8:40 in the morning and a non-
3 stress test is not started until 10:00 o'clock, so there's
4 a delay of an hour and 20 minutes, then the biophysical
5 profile -- excuse me -- the non-stress test was finished
6 around 10:30 and a biophysical profile started at 10:48, so
7 you have a delay on the front-end of a hour and 20 minutes.
8 Next I want you to assume another scenario, that Samantha
9 Jamison comes in at 8:40 in the morning, a non-stress test
10 is run or begun at 8:50, has ended at 9:20 that shows late
11 decelerations, and a biophysical profile is not started
12 until 10:48, some hour and 20 or 28 minutes later. Does
13 the delay on the front-end versus the delay between the
14 tests, does that affect your opinion in this case?

15 A No, there's a delay, unnecessary delay, whether it's
16 the beginning or the end; when the patient comes in with a
17 complaint of decreased fetal movement which can herald
18 impending problem that has to be addressed right away, that
19 patient goes to the head of the line, if you will, unless
20 there's somebody else in the office that has either a
21 potentially more dire problem, but you want to do the test
22 as rapidly as possible to assure the mother, make sure the
23 baby's okay and the obstetrician should deal with this
24 without any undue delays so that if there is a potential
25 problem, it's recognized in an early fashion, early enough

1 for the obstetrician to do whatever is necessary to keep
2 the mother and the baby healthy.

3 Q Doctor, I want you to -- you've read the deposition of
4 Dr. Hilton.

5 A Yes.

6 Q I think she said there were three or four
7 decelerations that were suspicious looking?

8 A Yes, she did.

9 Q And do you agree with that assessment?

10 A Yes. I think the analysis of the non-stress test by
11 Dr. Hilton was right-on.

12 Q Doctor, I'm going to try to bring up the non-stress
13 test here, and it's not a very good -- but it's in the
14 chart here if you want to refer to it. Can you indicate
15 the times where the decelerations -- where you saw the
16 decelerations?

17 A Would it be more helpful if I come up and ---

18 Q Yes, that'll be great. If you'd like to step down,
19 Doctor.

20 DR. PHILLIPS - Your Honor?

21 THE COURT - Yes, sir.

22 Q Okay, well, an insuring sign, a reassuring sign is on
23 panel 83062 where you have an acceleration. That's what
24 you'd like to see. You'd like to see two accelerations
25 within a 20 minute period of time indicative of the fact

1 that the baby is functioning properly and there's no sign
2 of any -- what we'd call fetal hypoxia, insufficient oxygen
3 going to the baby. That's -- in itself that's a good sign.
4 Okay, if I may, can I just go over with the strip showing
5 the terms of -- because it looks like two lines. Basically
6 the top -- you know what, I feel more comfortable. Let me
7 have that, if you don't mind.

8 THE COURT - Hand him the pointer.

9 A I'm going to stand over here. Okay. This is the line
10 that shows the fetal heart rate. Each of these boxes
11 represent 10 beats per minute. So you have 120, 130, 140,
12 150 and so on and so forth. So this determines the fetal
13 heart rate. When you look at a fetal heart rate, there are
14 certain things that you're looking, one of which is what's
15 the average heart rate. You look at a 10 minute strip of
16 paper and you determine on the average what that heart rate
17 is. That's called the baseline heart rate, then you're
18 looking for, like I showed you before, an acceleration
19 which is a good sign, but you're also looking for
20 decelerations. That's the fetal heart rate going down,
21 which has the potential to be a bad sign, and especially if
22 the deceleration occurs after a contraction -- that's
23 called a late deceleration. That's consistent with the
24 placenta not giving adequate oxygenation to the baby. So
25 that's -- you're looking at those strips looking for

1 accelerations so you can -- you'll be assured that
2 everything's okay, versus seeing ominous signs such as late
3 decelerations. And if you look over here there's a
4 contraction. The bottom portion registers the
5 contractions. Ms. Jamison wasn't feeling contractions, and
6 sometimes in early labor or maybe Braxton Hicks you can see
7 contractions like this when a patient doesn't feel it, but
8 when you see a contraction and then a dip after the
9 contraction -- as you see, there's a dip after the
10 contraction. Those are two dips. Those are considered
11 late decelerations. And they were approximately picked up
12 by Dr. Hilton that these were late decelerations, and
13 that's why it was concerning to her as it should be. I
14 think there was another deceleration after that maybe.

15 Q Doctor, you know, to be honest with you, I don't think
16 I've got it loaded here.

17 A Okay, no problem. There were three of those
18 decelerations one after the other, which is what made this
19 fetal heart rate tracing suspicious.

20 Q Now, Doctor, it's a suspicious looking stress test.
21 Correct?

22 A Right.

23 Q That one test in and of it self, is that an emergency?

24 A To do that test, to get the results you mean? Should
25 it be done in emergent basis? Of course it should be done

1 in emergent basis, because it could even be worse than
2 this. This is not a great test. This is a test that
3 indicates there very well could be a problem with the baby.
4 There are much worse looking strips and there are much
5 better looking strips, but this is an indication -- it's
6 consistent with the baby getting insufficient oxygenation.
7 It should be done on an emergent basis, and the next test
8 which is done after you do a non-stress test when it's not
9 perfectly fine and a patient comes in with decreased fetal
10 movement, you go on to what is called the biophysical
11 profile test, which is the next test that should be done as
12 soon as possible.

13 Q If you would, tell the jury what a biophysical profile
14 is?

15 A It's a ultrasonographic test that's done for what we
16 call fetal surveillance. It was designed basically to pick
17 up what we call fetal acidosis. In other words, if the
18 baby's not getting sufficient oxygen and builds up waste
19 products, becomes -- the blood becomes very acidic of the
20 baby, and that's called fetal acidosis, so this was
21 designed to measure certain parameters to see if the baby
22 was healthy versus a baby that is suffering from the lack
23 of sufficient oxygenation, so the biophysical profile which
24 measure four parameters, one of which is the amniotic fluid
25 index, then you have motion. You have a reflex of baby and

1 movement of the baby that you're evaluating with the
2 biophysical profile, and for each parameter you give two
3 points. I didn't say breathing. That's the fourth one.
4 So you have breathing, movement, the heart rate, which is
5 not part of it, but you measure the heart rate and the
6 amniotic fluid. You give two points if those parameters
7 are normal, and you get no points if those parameters are
8 not there, so she subsequently after this because the test
9 was so suspicious looking, a biophysical profile was done
10 and the results of which showed that the baby wasn't
11 moving, the baby wasn't breathing, there was sufficient
12 amniotic fluid, but that was the only parameter that was
13 good. Everything else was absent. So it was determined
14 that the biophysical profile was two out of eight, which is
15 very consistent with what we call fetal asphyxiation.
16 Fetal asphyxiation is the baby suffering from lack of
17 oxygen, building up waste products that make the blood
18 acidic, and that was the result of -- that was the result
19 that was obtained from the biophysical profile which is the
20 reason why the patient was sent to the hospital for an
21 immediate c-section.

22 Q Doctor, I don't have the actual ultrasound, but I
23 believe this a copy of the Ob report which shows the
24 results of the biophysical profile. Is that correct?

25 A Yes.

1 Q That's already in evidence. And it looks like the
2 fetal movement was ---

3 DR. PHILLIPS - May I stand up, Your Honor.

4 THE COURT - If you need to stand, yes, sir, you
5 certainly can.

6 Q --- fetal movement that was a zero?

7 A Yes.

8 Q Fetal breathing movements, a zero?

9 A Yes.

10 Q Fetal tone?

11 A Zero.

12 Q Zero? And the normal report or the normal parameter
13 was amniotic fluid.

14 A Right.

15 Q And that's back up.. Is that correct?

16 A Correct.. And the heart rate, which was 158 -- it's
17 not part of the test per se -- doesn't go into the
18 criteria, but the heart rate was 158.

19 Q And on this report it's handwritten, it says -- is
20 that assuming IUGR?

21 A Yes, the suspicion was intrauterine growth
22 restriction; the abdominal circumference which was two
23 weeks behind approximately a week and a half ago was now
24 five weeks behind, so it's a very small abdominal
25 circumference, so it was appropriate assumption -- yes,

1 it's a intrauterine growth restricted baby with a small
2 abdominal circumference. It was determined that the --
3 that there was abnormal doppler flow studies which indicate
4 there was -- there was a resistance to the proper amount of
5 blood going from the placenta to the baby. So the proper
6 flow wasn't taking place; it was an explanation for the
7 fact why the baby wasn't growing, and it was certainly
8 worse than it was in terms of the lag period of growth --
9 was worse than was ten days ago, and as a result of this
10 test, the patient was sent over to the hospital for an
11 immediate c-section.

12 Q Okay. Also listed there, abnormal doppler. What is a
13 doppler?

14 A It's a study that's done ultrasonographically with the
15 biophysical profile to measure the amount or the -- I
16 should say the ease of flow of blood from the placenta to
17 the baby. The harder it is for the blood to get to the
18 baby -- the slower the blood flow to the baby is, the less
19 nutrients the baby ends up getting. The less nutrients the
20 baby ends up getting, the smaller the baby is and
21 indicative of the development of intrauterine growth
22 restriction, we're having a small baby that's developing,
23 smaller than it should be for this stage of the pregnancy.

24 Q And do you agree that the doppler was abnormal that
25 day?

1 A According to this, yes, it was.

2 Q Doctor, what -- given the non-stress test with the
3 late decelerations, the bad biophysical profile, history of
4 chronic hypertension, small abdominal circumference,
5 intrauterine growth retardation -- and if I've missed any
6 other risk factors ---

7 A No, that was it.

8 Q --- what -- what does the standard of care require a
9 reasonable and prudent physician to do at that point?

10 A Get the patient to the hospital as soon as possible
11 for a delivery, and not take a chance. Now, there are
12 times when you have something like this where you can get
13 away with just waiting this out, repeating it sometime in
14 the future, whatever, but because you don't know how fast
15 the baby can turn sour in a situation like this, the
16 prudent, reasonable obstetrician is going to err on the
17 side of caution and get the mother delivered as soon as
18 possible to get that baby out of that hostile environment.

19 Q Doctor, do you have a conclusion to a reasonable
20 degree of medical certainty with regard to Drs. Hilton and
21 Benson whether or not they breached the standard of care
22 that day ---

23 A Yes.

24 Q --- in dealing with this situation?

25 A Yes.

1 Q Okay. Can you tell the jury what your conclusion is?

2 A Well, regarding Dr. Hilton there in her office, there

3 wasn't a protocol to what we call triage patients who come

4 in with complaint that's potentially catastrophic. It

5 doesn't have to be catastrophic but potentially

6 catastrophic. In terms of -- like to go to the emergency

7 room and there are a bunch of people waiting to be seen by

8 a doctor, well, they're going to take the heart attack

9 first, potential heart attack victim over someone who has a

10 splinter in their finger. That's called triaging. So when

11 a patient comes in with this type of complaint, an office,

12 an obstetrical office, and any specialty for that matter,

13 has to triage the patient and determine which patient

14 should be seen first. She was a high risk patient with a

15 potentially bad symptom, potentially bad complaint, had to

16 be seen in a timely basis and evaluated in a timely basis,

17 and there was a delay of an hour to 20, 28 minutes or so,

18 just inexcusable delay in coming to the conclusion that the

19 non-stress test was suspicious, showing late decelerations,

20 a biophysical profile was two out of eight showing almost

21 certain asphyxia. There was a delay in getting to that

22 conclusion. Once that conclusion was obtained, the

23 decision was made -- and it was an appropriate decision --

24 get the baby delivered immediately. That was the

25 appropriate decision. The patient was five minutes away

1 from the hospital. You have to tell the patient, listen,
2 this may not be a problem, but it could be a major problem;
3 we can't take a chance; we want you to get to the hospital
4 as soon as possible; I want you to go directly to labor and
5 delivery. Dr. Hilton has to instruct the patient that.
6 Dr. Hilton who has to contact the attending -- her partner
7 who was in the hospital, Dr. Benson, inform Dr. Benson, I'm
8 sending you other someone for an immediate delivery, get
9 the c-section room ready, because when she gets there,
10 she's going to have a c-section all probability. I want
11 that section room set up; the patient should be there in
12 five minutes, no later than 10 minutes. The failure to
13 insure that the patient got there in five to 10 minutes,
14 the failure to tell the patient what an emergency this was
15 so that there's no chance the patient could take a shortcut
16 someplace else or stop off for a cup of coffee for
17 instance, you want to make sure the patient goes directly
18 to labor and delivery. You want to tell that to the
19 patient, and you want to tell that to the hospital, and you
20 want to tell that to Dr. Benson.

21 Q Is leaving a voicemail with a hospital appropriate
22 communication?

23 A Certainly it's not appropriate communication. A
24 voicemail -- you don't know when that voicemail is going to
25 be answered. You don't know how busy the receptionist is

1 who's handling that voicemail. Maybe that voicemail won't
2 be picked up for 15 minutes, maybe half an hour, 45
3 minutes. That's not enough. You have to take an active
4 role when you have this potential emergency and make sure
5 that it's a timely admission to the labor and delivery room
6 so that immediate c-section can be done.

7 Q Doctor, assuming that Dr. Hilton did not make the call
8 to do the immediate c-section but was only going to
9 monitor, was that below the standard of care in this
10 situation?

11 A That's below the standard of care, but even if you
12 assume that that was the reason, just bring her there to
13 monitor and if anything was bad with the monitor to do a
14 caesarean section, you still set up the c-section room so
15 when the patient comes in, they're ready to do the c-
16 section at a moment's notice. That's at the very least
17 that has to be done. The patient still has to get there as
18 rapidly as possible and if you're going to monitor first
19 and see how bad it is before you do the c-section -- she
20 should've been c-section, but if you want to monitor her,
21 if you go that course, you still have to expect the worst
22 and get the room ready for a c-section and make sure that
23 patient gets to the hospital as soon as possible, so if you
24 have to do a c-section, it's done as soon as possible?

1 Q What about Dr. Benson? Care is being referred to
2 another doctor. What is the standard of care require of
3 the doctor receiving that patient?

4 A Well, the doctor realizes -- and based on Dr. Benson
5 admitting note, he realized that immediate c-section is to
6 be done; the doctor knows the patient left the office
7 approximately give or take a little bit before 11:00, 11:00
8 o'clock and should be in the hospital by five minutes or
9 so, and at that particular point, if the patient is not in
10 the hospital, the doctor has to contact -- try to contact
11 the patient, contact the admitting office, think about all
12 the impedances that may exist in the hospital for
13 preventing a patient from getting from the entrance of the
14 hospital to the delivery room, and expedite that patient to
15 the labor and delivery. That was not done, and that
16 should've been done. An active role has to be taken by the
17 doctor at the hospital, specifically Dr. Benson, to make
18 sure that that patient to the best of his ability gets to
19 the hospital in a timely fashion.

20 Q And I want to show you Dr. Benson's admission note
21 from September 5th, 2008. Is this the note you're referring
22 to that indicates plan was to perform c-section?

23 DR. PHILLIPS - May I step down?

24 THE COURT - Yes, sir.

25 Q Plan was to perform c-section immediately?

1 A Our plan was to perform a c-section immediately upon
2 arrival -- patient's arrival to labor and delivery. An
3 appropriate decision that she's going there for the
4 purposes of immediate c-section, except Dr. Benson failed
5 to assure that that would've happened in a timely basis.

6 Q When Samantha Jamison got to labor and delivery after
7 going through an admission process, the records indicate
8 that Dr. Benson was present?

9 A No, she got there somewhere 11:00 o'clock, 11:04
10 whatever, and Dr. Benson didn't see the patient til 11:09.

11 Q Eleven forty-nine maybe?

12 A Excuse me. I'm sorry, 11:49. She got there 11:40,
13 11:43, and Dr. Benson didn't see the patient until 11:49.
14 I'm sorry.

15 Q Doctor, have you read the deposition of Dr. Benson
16 with regard to what he says in his testimony ---

17 A Yes.

18 Q --- the plan was for that day?

19 A Yes.

20 Q And what does he indicate in his deposition that his
21 plan was that day?

22 A Just monitor the patient and we'll see what happens
23 and we'll do a c-section or delivery as needed.

24 Q So the deposition, it's inconsistent with the actual
25 note.

1 A That's right. It went from, she needs an immediate c-
2 section to let's wait and see what happens when she gets
3 there.

4 Q Doctor, based on your review of the testimony and the
5 depositions and the records, do you have a conclusion as to
6 whether or not Dr. Hilton breached the standard of care
7 pertaining to her instructions and communication to
8 Samantha and the hospital as to the need for emergency c-
9 section?

10 A Yes.

11 Q What is that opinion?

12 A There's a failure to adequately inform Samantha that
13 she needed to get to the hospital as soon as possible for
14 immediate c-section. There was a failure to assure that
15 she did get to the hospital as rapidly as possible that day
16 by properly informing the hospital, labor and delivery
17 specifically, and that a patient was going to be there in
18 five to 10 minutes and to call her if the patient doesn't
19 show up in a timely basis. That was her role. That was
20 her responsibility. That was her duty and she failed to do
21 so.

22 Q With regard to Dr. Benson, if you know you're going to
23 do an emergency c-section like we saw his note indicated
24 and the patient's not there in five, 10 minutes at tops,
25 what is your duty at that point?

1 A You basically have to say, where is that patient; what
2 can I do to find out where that patient is and to maximize
3 the chances of the patient getting here in a timely basis,
4 and that was Dr. Benson's -- one of his roles that day if
5 the patient didn't show up in a timely basis.

6 Q And Dr. Benson breached that ---

7 A Yes, he did.

8 Q --- standard of care?

9 A Yes, he did.

10 Q Doctor, what is a differential diagnosis?

11 A Differential diagnosis is when a patient presents with
12 certain symptoms or certain conditions or certain findings,
13 the examining doctor comes up in his or her mind with
14 potential reasons for the patient's problem. For instance,
15 a patient may come in with a headache which could be simply
16 a tension headache, maybe a migraine headache, maybe a
17 brain tumor, maybe preeclampsia in a pregnancy. These are
18 potential diagnosis that a doctor considers after taking a
19 history and physical and doing the appropriate testing,
20 what are the possibilities and what are the most dangerous
21 possibilities that have to be ruled out. That's called a
22 differential diagnosis.

23 Q And suppose you find a urgent or an emergency
24 situation, what does the standard of care require?

1 A That you -- if it's a potentially emergency -- an
2 emergent or urgent situation or a definite emergent, urgent
3 situation, you have to take whatever steps necessary to
4 resolve the problem before harm occurs. If your patient is
5 a mother with a baby, before harm occurs either to the
6 mother and the baby, you have to do everything
7 expeditiously within your power to minimize the chance of
8 harm to the mother and baby.

9 Q Does that require immediate intervention?

10 A Immediate intervention.

11 Q Dr. Phillips, if a doctor has the ability to intervene
12 in an emergency situation and fails or chooses not to
13 intervene with that intervention to save the life of a
14 child, is that a breach in the standard of care?

15 A That's below the standard of care, yes.

16 Q Doctor, let me ask you this. Well, let me ask you,
17 with a differential diagnosis, would you rule out the worst
18 scenarios first?

19 A The worst scenarios, which are probably the most life-
20 threatening scenarios, get ruled out first.

21 Q Doctor, do you have a conclusion as to whether or not
22 if the doctors at Rock Hill Gyn-Ob, Drs. Hilton, Benson and
23 others had acted within the standard of care and acted
24 expeditiously in ordering tests and performing a c-section,
25 whether or not Jayden would've lived?

1 A Yes.

2 Q And what is that opinion?

3 A Jayden would've lived, because there wouldn't have
4 been the delay in doing those two tests, and there wouldn't
5 been subsequent delay in getting the patient to the
6 hospital as there was in this particular case. You had
7 delays with the testing; you had the delays from the time
8 the patient left the hospital (sic) to the time she arrived
9 in labor and delivery. Those delays were sufficient enough
10 for a normal heartbeat that was present at 158 beats per
11 minute in the office to end up with no heartbeat when she
12 finally got there, and they attempted to find the heartbeat
13 after she got there on admission. So those delays, the
14 delay from the leaving the office to getting to labor and
15 delivery as well as the delays in performing those two
16 tests resulted in the demise of Jayden.

17 Q Given the situation that she presented with on August
18 25th, 2008, I believe you testified earlier that non-stress
19 test and biophysical profile could've been performed or
20 should've been performed that day.

21 A Yes.

22 Q And when should Samantha have been followed up after
23 that?

24 A A week later. Biophysical profiles, a non-stress test
25 routinely are started in some offices at 30 weeks

1 gestation, just routinely without any problems being
2 presented, routinely done every week starting at week 30
3 when you're watching a chronic hypertensive and you're not
4 expecting any particular problems. You would routinely do
5 it anyway, so now when you have a patient that comes in
6 that's high risk, chronic hypertension with superimposed
7 other problems, like a -- the fact that the amniotic fluid
8 was low normal, the fact that there was a two week lag
9 period with abdominal circumference, that increases your
10 suspicion or should increase your suspicion there may be
11 something wrong going on. So if you don't do the non-
12 stress test, biophysical profile right then and there, at
13 the very latest you have the patient come back in a week.
14 This particular case it would've been September 2nd. If she
15 came back September 2nd and had a non-stress test and
16 biophysical profile, I don't think I'd be here today.

17 Q Doctor, given all those factors, chronic hypertension,
18 lag in growth, intrauterine growth restriction, drop in
19 amniotic fluid, the high blood pressure that was shown, was
20 the death predictable by these doctors?

21 A The death was predictable, not with 100 percent
22 certainty, but the death is predictable, just like you can
23 predict that someone is going to die if they're overweight
24 -- from a heart attack, if they're overweight, they have
25 high blood pressure, they have diabetes, high cholesterol,

1 -- that person -- it's predictable if that person doesn't
2 change those habits, you can predict that that person is a
3 high risk of having a heart attack. A mother who comes in
4 with a non-stress test the way it was with a complaint of
5 decreased fetal movement with a bad biophysical profile,
6 it's predictable that within a certain period of time this
7 baby's going to die unless the baby comes out of the
8 uterus. You may not know the second, the minute or hour
9 that the baby may die, but you can't afford to be the
10 obstacle preventing a timely delivery of the baby under
11 those circumstances. The delay in doing the right thing is
12 inexcusable.

13 Q So it's predictable, knowable, foreseeable?

14 A All three.

15 Q Above that, was Jayden's death preventable?

16 A Yes, it was. If the proper testing which was done,
17 the test -- proper testing was done in a timely fashion and
18 she got to the hospital in a timely fashion, based on the
19 plan to do immediate c-section, the death would've been
20 prevented.

21 Q Doctor, you mentioned earlier about an office group --
22 Ob-Gyn group needing a policy with regard to patients that
23 walk in with potential emergencies.

24 A Yes.

1 Q Should -- does the standard of care require an Ob-Gyn
2 group have a policy with regard to women who come in with
3 potential emergency?

4 A Yes, so a potential disaster like this would not
5 happen in the future.

6 Q What is fundal height?

7 A Fundal height is a measurement of -- from the pubic
8 bony area to the top of the fundus, which is the top of the
9 uterus which is consistent with the gestational age of the
10 baby, specifically towards the end of the pregnancy.

11 Q And what does the fundal height -- if you have a
12 decreasing fundal height, what is the significance of that?

13 A Well, decreasing fundal height could be a normal
14 finding, could be that the baby just moved around, so maybe
15 the maybe was out stretched and made the uterus look bigger
16 and now it's in a different position altogether. It could
17 be indicative that the fact the mother is losing fluid from
18 the amniotic sack, that she ruptured membranes maybe and
19 she doesn't even realize it. Some patient's don't. It
20 could be indicative of the fact that the baby's not growing
21 properly, and sometimes the fundal height will not grow as
22 fast as it should be. It's just another parameter that has
23 to be investigated to see if it's consistent with a problem
24 that the baby may be suffering from.

1 Q Okay. Was there an issue with the number of weeks or
2 the estimated date -- estimated date of delivery in this --

3 -

4 A Yes, there was.

5 Q Can you tell the jury why that's significant?

6 A Well, you want to know as accurately as possible what
7 the due date is, because your management of the patient
8 depends upon knowing the due date, because how close to the
9 due date she is determines a course of action; whether
10 she's going past her due date for instance requires certain
11 intervention, whether a problem occurs prior to a due date,
12 depending upon how many weeks age the baby is requires a
13 specific type of intervention. So the best way of
14 determining a due date is based on the patient's last
15 menstrual period and doing an ultrasound, preferably in the
16 first 13 weeks or so of the pregnancy to confirm the due
17 date based on the last menstrual period's important. If
18 the first ultrasound could not be done or was not done for
19 whatever reason, then you do an ultrasound during the
20 second trimester, somewhere between 13 and 29 weeks or so
21 of the pregnancy, 27 weeks in the pregnancy, the second
22 trimester, you're going to do an ultrasound if it wasn't
23 done already. The problem with doing an ultrasound the
24 second trimester compared to the first trimester is the
25 accuracy changes. The earlier you do the ultrasound to

1 determine if the due date based on the last menstrual
2 period is accurate, you're better off with early first
3 trimester ultrasound, it's more accurate than the second
4 trimester ultrasound which can be plus or minus one to two
5 weeks for instance. So you want to -- you want to get a
6 due date -- if you can't get a due date that's accurate
7 based on the last menstrual period and you don't do an
8 ultrasound on the first trimester, the earliest time you
9 can do a ultrasound is the most accurate ultrasound, and if
10 you do an ultrasound subsequently later on, you don't
11 change the due date, because it won't be as accurate as the
12 due date based on a earlier ultrasound.

13 Q Doctor, you mentioned several times asphyxia or lack
14 of oxygen. Could you explain to the jury a little bit more
15 about that?

16 A Well, a baby to a large extent is like an adult. The
17 baby is like any -- for that matter -- any animal. It
18 requires oxygen. And part of the process, when the baby
19 takes in oxygen and the oxygen is utilized by the body,
20 waste products develop and the waste products consists of
21 carbon dioxide and lactic acid and other types of bi-
22 products. That's the normal process. If the baby is not
23 getting sufficient oxygenation, there's a cumulation of bi-
24 products that decrease the PH of the blood of the baby,
25 because it's a reflection of the fact that the baby's blood

1 is becoming more and more acidotic, less and less oxygen it
2 gets and the more these waste products build up.

3 Q Do you have a conclusion to a reasonable degree of
4 medical certainty as to the cause of death of Jayden?

5 A No, I do not know what caused the death. We know what
6 the baby was suffering from intrauterine growth restriction
7 apparently based on the ultrasounds. Pathology couldn't
8 come up with a reason for the death. There was no
9 abnormality of the placenta that was detected. There was
10 no abnormality of the cord. No one can say for certain
11 what caused the death. What you can say, however, is the
12 death was preventable with the timely intervention of these
13 tests, the non-stress test and biophysical and arriving at
14 the hospital in a timely fashion to have that immediate c-
15 section.

16 Q Is a biophysical profile of two out of eight, two out
17 of ten consistent with asphyxia?

18 A Yes, it is. It's consistent with almost certain
19 asphyxia.

20 Q And is it consistent with almost certain death in the
21 near future?

22 A If something does not happen within a certain period
23 of time without intervention, it's almost certain for most
24 patients with biophysical profile of two out of eight that
25 stays two out of eight that the baby will die.

1 MR. JORDAN - Beg the Court's indulgence. (Pause)

2 Q Doctor, you'd indicated that the standard of care
3 required a biophysical profile, non-stress test,
4 biophysical profile, would you not, on August 25th or within
5 a week of that. Correct?

6 A Correct.

7 Q Do you have an opinion to a reasonable degree of
8 medical certainty as to if it had been run, what it
9 wouldn't shown?

10 A Well, it would have been no worse than what it was
11 September 5th and could be better, but abnormal enough that
12 intervention should have taken place.

13 Q And, Doctor, given the situation on September 5th ---

14 (WHEREUPON, courthouse lost all power)

15 Q Doctor, I had asked you before the power failure if
16 you could elaborate on the risk of c-section versus the
17 risk of not performing a c-section. In other words, the
18 risk of having a premature baby versus the risk of not
19 performing a c-section.

20 A Well, a c-section is a major operation. Maybe 25 to
21 30 percent of all deliveries in the country end up with a
22 c-section, so it's a very common operation, like every
23 operation has risks. Most the risks, however, no matter
24 how major the risk is, is not life-threatening. Sure you
25 can have a reaction to general anesthesia if general

1 anesthesia's required and the mother can die. General
2 anesthesia is not used in most c-sections anymore.
3 Epidurals and spinals are used. The risk of death is
4 minimal to the mother even though there are risks of doing
5 a c-section. And you have to compare the risk of that
6 with the risk of having a baby of 32 weeks gestation.
7 Certainly the baby can develop respiratory distress
8 syndrome because the lungs aren't developed, but you can
9 give medication for that and the babies do very well. And
10 there are other small risks that are associated with a
11 premature baby that stage, but most of the time the babies
12 will do well. The overwhelming majority of babies of 32
13 weeks are delivered so extremely well. Well above 90
14 percent will survive. So you have to weigh the risk of
15 that with the risk of harm to the mother doing a caesarean
16 section and come to the conclusion that when a section is
17 needed with a baby that's 32 weeks to potentially prevent
18 the baby from dieing, the c-section should be done even
19 with its risks. It's done all the time. C-sections are
20 done all the time throughout the entire country, the world,
21 and patients can even ask for a c-section today if they
22 want to an elective c-section, but if it's so risky, why
23 would that be allowed. There are risks, but as long as a
24 patient's informed beforehand about what the risks are to
25 both the baby and the mother then the - after that

1 discussion, the c-section should be done and in order to
2 save -- potentially save the life of the baby.

3 Q Intrauterine growth restriction, did Jayden have that?

4 A Yes.

5 Q Doctor, you agree that a doppler study is not a
6 substitute for biophysical profile?

7 A No.

8 Q What is preeclampsia?

9 A Preeclampsia is a very complex condition that involves
10 a pregnant woman who develops high blood pressure and
11 spillage of a significant amount of protein in her urine.
12 There are other symptoms and signs associated with it, but
13 those are the two major components. It's potentially life-
14 threatening for the mother, potentially life-threatening
15 for the baby, for the fetus, and it is one of the risks
16 that you have to worry about when a mother especially comes
17 in with chronic hypertension. It can occur without chronic
18 hypertension, but a patient who has chronic hypertension
19 like Ms. Jamison had or has, is more at risk of developing
20 preeclampsia with its own set of complications that have to
21 be dealt with.

22 MR. JORDAN - Thank you, Doctor. Please answer
23 any questions that counsel may have.

24 THE COURT - Before we go into cross-examination,
25 I'm going to take a short break for about 10 minutes,

1 ladies and gentlemen. If you'll go to the jury room and
2 we'll be with you shortly. Everybody else remain seated.

3 (Jury exits the courtroom)

4 THE COURT - All right, we'll be at ease for 10
5 minutes. Doctor, you may step down, but you may not talk
6 to the attorneys at this point in time. Thank you.

7 (Recess taken)

8 THE COURT - All right, plaintiff ready for the
9 jury to come back in?

10 MR. JORDAN - Plaintiff's ready.

11 THE COURT - Defense?

12 MR. WILLIFORD - Yes, Your Honor.

13 THE COURT - All right, very good. Ask the jury
14 to come on in. Thank you, sir.

15 (Jury returns to the courtroom)

16 THE COURT - All right, cross-examination.

17 MR. WILLIFORD - May it please the Court.

18 CROSS EXAMINATION

19 BY MR. WILLIFORD:

20 Q Dr. Phillips, it is your opinion that the NST, the
21 heart rate strips that we saw that you pointed out to the
22 jury -- the heart rate strips on September 5th, 2008 were in
23 a category that was not emergent to do a BPP. True?

24 A It was a non-stress test abnormal enough that there
25 was no reason not to do an emergent biophysical profile.

1 Q Doctor, I want ---

2 MR. WILLIFORD - Your Honor, if I may approach.

3 THE COURT - Certainly.

4 Q I want to hand you a copy of your deposition.

5 A Yes.

6 THE COURT - Is that the original?

7 MR. WILLIFORD - That's the original. Yes, sir.

8 Would you like to open it?

9 THE COURT - Yes.

10 MR. WILLIFORD - Okay. Let me hand it to Judge.

11 THE COURT - All right, ladies and gentlemen, a
12 deposition is the testimony of any witness that has been
13 previously taken under oath. The procedure is that a
14 person is notified to be at a certain place at time. They
15 are placed under oath. There's a court reporter there.
16 The attorneys asks questions, and their testimony is
17 recorded at that point in time. It can be used at trial to
18 substitute for somebody's testimony if proper procedures
19 are followed or to ask a question about a previous question
20 and answer. Doctor, here's the original. Point to him
21 the page and line, please.

22 MR. WILLIFORD - Yes, Your Honor.

23 Q Page 87, line 14. And before I ask that question, I
24 just want to show the jury what we're talking about just to
25 be clear. The NST was this strip.

1 THE COURT - Are you asking him a question?

2 MR. WILLIFORD - Yes, sir.

3 Q Doctor, this is the NST from September 5th.

4 A Correct.

5 Q Correct. Okay. All right, so it is your opinion that
6 the NST, this strip, performed on September 5th, 2008 was in
7 a category that was not emergent to do a BPP. Correct?

8 A It wasn't emergent enough that if someone else had a
9 biophysical profile going on at the same time for that
10 person to be bumped and for that person to jump ahead of
11 the line, if you will, but it was abnormal enough that
12 there's no reason not to do one immediately. There's a
13 difference between the two.

14 Q Doctor, turning to page 87, line 14, I asked you a
15 question at your deposition. And you were under oath.
16 Correct?

17 A Correct.

18 Q And in all fairness to you, you had not reviewed the
19 NST when I took your deposition on February 28th. Correct?

20 A Yes, that's true.

21 Q It's true. You had not reviewed it. Mr. Jordan and
22 Mr. Boyd had not provided it to you at the time I took your
23 deposition. Correct?

24 A That's correct.

1 Q All right. And when I handed you the NST, I asked you
2 this, I want to hand you a copy of the NST, because I think
3 it's important for me to get your opinions on that. Take a
4 look at that and tell me what your opinions are with regard
5 to that NST, as perusing. You were looking at it.

6 A Correct.

7 Q Took all the time you needed. Correct?

8 A Correct.

9 Q And your answer was, there were variable
10 decelerations, but I would put this into the category of a
11 non-stress test that's not an emergency to do a biophysical
12 profile.

13 A That's correct.

14 Q True.

15 A (No response)

16 Q In other words, they did not have to even do a BPP, a
17 biophysical profile, right away.

18 A Its - you're taking it out of context, because we're
19 talking about the need to do a biophysical in emergent
20 basis after the -- after the non-stress test. When he saw
21 the non-stress test, I said this is not emergency that has
22 to -- there's no talking about bumping people who may have
23 been in the -- having a biophysical profile at the time and
24 whether or not this non-stress test was sufficiently
25 emergent to bump other people and wasn't the type of non-

1 stress test. It was suspicious but had -- and should be
2 done without any delay, but to bump someone else having a
3 biophysical profile that could be having emergency, this
4 did not take over precedence for the other biophysical
5 profile.

6 Q So it really wasn't that emergent?

7 A That's not -- that's what I'm saying. There's degrees
8 of emergencies. This was a -- this was a degree that if
9 someone else was having a biophysical profile in the office
10 for an emergent situation, this would not take precedence.

11 Q Doctor, they did an NST. At that point it wasn't an
12 emergency to do a BPP, but they did it anyway. True?

13 A It was a non-stress test that should be followed by a
14 biophysical profile as soon as possible unless the bio --
15 the ultrasound was being used by a patient that had an
16 emergent situation that takes precedence over this.

17 Q Doctor, let's -- let's look right above at your
18 deposition at page 86. Line 21, I asked you, if a non-
19 stress was equivocal or indeterminate then would 20 minutes
20 by the end of the NST, the end of that happening, to the
21 beginning of the BPP, the biophysical profile, would that
22 be a time-frame that would be sufficient to follow the
23 standard of care? Your answer, then it takes away the
24 emergent situation, doing it expeditiously, you can wait 15
25 minutes. What about 20 minutes? Um, you can wait until

1 the patient in front of her gets done. And just to
2 complete the answer, most of the patients in an Ob office
3 that's getting ultrasounds is not a emergency, it's either
4 measuring for growth, it's for looking for congenital
5 anomalies, so there's not too many emergent ultrasounds
6 going on, and then that's when I asked you, well, let me --
7 let me let you take a look at the NST, and that's what we
8 talked about earlier. Correct?

9 A That's correct, but preceding that page 86, you were
10 asking if the non-stress test was equivocal or
11 indeterminate that it would be okay to wait 20 minutes.
12 This was not -- the equivocal indeterminate, this was non-
13 reactive suspicious non-stress test. There's a different
14 type of non-stress test result that required a follow-up
15 with a biophysical profile, not to bump someone else with
16 emergent biophysical profile, but to do it as expediently
17 as possible.

18 Q But in your opinion there were variable decelerations
19 looking at it. Right? In your testimony ---

20 A There were variable decelerations or late
21 decelerations. As I said before, there's a late
22 decelerations that have -- look like variables.

23 Q But when you looked at the NST at your deposition, you
24 said variable. You didn't say anything about late
25 decelerations.

- 1 A I did not.
- 2 Q And your point was that they should do a BPP and they
3 did that. Right?
- 4 A As expediently as possible. Correct.
- 5 Q They did it. All right. And just to show you a
6 picture -- and all I want to do is show the time. If we
7 look in the upper right corner, you see a time here. It's
8 an ultrasound, and at 10:48 a.m. at 47 seconds, that's at
9 least the first capture that we have of this biophysical
10 profile. Correct?
- 11 A Correct.
- 12 Q Doctor, the gold standard when a patient comes in and
13 complains of decreased fetal movement, the gold standard in
14 terms of what to do is to do an NST and a BPP. Correct?
- 15 A Correct.
- 16 Q And Dr. Hilton, Dr. Benson and their group, they did
17 that?
- 18 A Oh, they did the two tests that were required.
19 Correct.
- 20 Q Let's look back at the BPP. Here's the first page at
21 10:48, flip through, here's 10:49, and there are different
22 pages, but I want to flip to this one at 10:52. Down here
23 it says fetal heart rate of 158 beats per minute. Do you
24 see that?
- 25 A Yes.

1 Q Okay. You're going to agree that a heart rate of 158
2 beats per minute is normal.

3 A If it was consistent fetal heart rate of 158 with a
4 proper variability it'd be normal. In and of itself that
5 one heart rate of 158 is within normal limits.

6 Q Okay. The baby was alive at the time of the BPP.

7 A The ba -- based on the heart rate? Probably that's
8 the only parameter to show that the baby was alive at that
9 time.

10 Q But no dispute that the baby was alive.

11 A No dispute.

12 Q Doctor, the typical BPP or biophysical profile, the
13 typical one last for 20 to 30 minutes. Correct?

14 A Most of the time. Correct.

15 Q Most of the time. And in this case it only lasted for
16 10 minutes because Dr. Hilton decided, let's go ahead and
17 send you to the hospital. Correct?

18 A Well, I think that was an appropriate decision, yes.

19 Q Lasted for 10 minutes, because the last BPP that we
20 have -- well, we have a report. The report shows that at
21 10:58 that it was printed out and that's the end of the
22 BPP. Correct?

23 A Correct.

1 Q To do a full BPP at this gestational age, Dr. Hilton
2 would have been appropriate and within the standard of care
3 to do it for another 20 to 30 minutes. Correct?

4 A If there are no extraneous circumstances that made her
5 decide I better cut it short and get her to the hospital
6 for an emergency c-section.

7 Q She had a -- apparently an instinct to say, you know,
8 you need to go to the hospital.

9 A That's appropriate.

10 Q Okay. But she could have waited -- within the
11 standard of care waited another 20 or 30 minutes.

12 A It wouldn't been the appropriate decision to continue.
13 She appropriately made the right decision to curtail it in
14 10 minutes. Under regular circumstances when you don't
15 have the results that were obtained with this biophysical
16 profile, if you want to continue it longer, you could. You
17 could continue it for another 20 minutes, but she
18 appropriately made the decision that this was bad enough
19 for the patient, got to get the hospital as soon as
20 possible.

21 Q If she had decided to wait and extend it to the full
22 BPP time of 20 or 30 minutes later, that would have fallen
23 within the standard of care. True?

24 A Not under these circumstances. In general what you're
25 saying -- but you have to specifically, depending upon how

1 a patient presents with the history and the findings,
2 individualize the appropriate treatment. You can't
3 generalize and make a statement with a biophysical profile
4 that only lasted 10 minutes, then it would be within the
5 standard of care just to keep it going. Depends upon what
6 the results are, depends upon what the patient's presenting
7 with, depends upon what the complaints are, what the
8 history is.

9 Q Doctor, you realize that with biophysical profiles
10 babies have sleep cycles. Correct?

11 A That's correct.

12 Q All right, and that's why often times it's extended
13 for a period of time to about 30 minutes. Correct?

14 A It's extended unless there are extraneous
15 circumstances that curtail it. If it's just a matter of
16 evaluating a sleep cycle, then you can, but when you have a
17 situation where the doppler flow studies were abnormal,
18 there's a five week lag period with abdominal circumference
19 with a chronic hypertension history, it's appropriate to
20 curtail it and take it to the next level when you realize
21 that it's a potentially dire emergency to get the baby out.

22 Q And we saw that the doppler flow was 1.6 in this case.
23 True?

24 A I don't recall what the number was exactly.

1 Q Okay, assume it's 1.6. It's abnormal in terms of an
2 increased flow resistance if it's above 3.0. Correct?

3 A That's correct.

4 Q So if it's lower, there's less resistance, meaning
5 there is less obstruction of blood flow between the
6 placenta and the baby.

7 A That's true.

8 Q Okay. So this was on the lower side. There was no
9 obstruction in terms of abnormalities like it would be if
10 it was three or above.

11 A That's correct. I was relying on the interpretation,
12 Dr. Hilton who did the biophysical profile who thought her
13 values indicated that there was an abnormality of umbilical
14 blood flow.

15 Q Abnormal but -- on the low side, and that's different
16 than increased resistance or reverse flow.

17 A It's different, yes.

18 Q Okay. So we had that. We have a normal AFI, the
19 fluid, the amniotic fluid index of 14 ---

20 A That's correct.

21 Q --- at this biophysical profile.

22 A That's correct.

23 Q And had a normal heart rate.

24 A That heart rate was normal in that time period.

25 Correct.

1 Q Doctor, in your training, experience, education, you
2 understand that the recommendations for evaluating a baby
3 that has a BPP of two, the recommendations, according to
4 obstetrical textbooks is extended for two more hours.
5 True?

6 A That is a generalized statement not taking into
7 account individual situations.

8 Q Okay, but generally, when you get a score at a two,
9 it's recommended to go ahead and extend it for two more
10 hours.

11 A Yes, it could be extended if there aren't extraneous
12 circumstances, and certainly the patient could've been sent
13 to the hospital for immediate c-section as a backup if they
14 wanted to extend the biophysical profile in the hospital,
15 but they chose, and appropriately so, to send her to the
16 hospital for immediate c-section, because in this
17 individual case that was the best way of handling the
18 situation to prevent an emergency such as what happened.

19 Q You would agree that in the overwhelming majority of
20 patients, babies who have a BPP of two out of eight, that
21 if they're going to pass away, it will occur in a time-
22 frame of about a week.

23 A That's true.

24 Q True.

1 A That's true that they -- it's almost certainly the
2 majority will die in a week, but it's unpredictable as to
3 when that will occur.

4 Q Exactly. It's unpredictable. And you will agree that
5 it's fair to say ---

6 A But death is predictable. The timing of it is not
7 predictable.

8 Q Okay. Isn't it fair to say that in this particular
9 case for a baby to have a normal heart rate, normal fluid,
10 not increased dopplers, but a two out eight BPP is
11 certainly concerning, no doubt about that, that in this
12 particular case for Ms. Jamison's baby to pass away within
13 30, 40 minutes, whatever time it was, that was not
14 foreseeable, was it, at that point?

15 A What's not foreseeable is the time that that's going
16 to occur. You can't predict when it's going to happen.
17 That's why you have to err in doing it early rather than
18 later, not after the fact but before it happens.

19 Q Doctor, you don't know when the baby died, do you?

20 A No, I -- the baby died somewhere between leaving the
21 office and when there was no heartbeat that was detected in
22 the hospital.

23 Q You agree that the baby -- Ms. Jamison's baby -- had a
24 very rapid decline in utero on September 5th. Correct?

1 A If you mean rapid decline, you mean went from a normal
2 heart rate to no heart rate? That's relatively fast, yes.

3 Q Doctor, you would agree that sometimes fetal demises,
4 they occur without explanation. True?

5 A That is true.

6 Q Dr. Phillips, you have no criticisms of the
7 ultrasonographers or Nurse Practitioner Robin Pruette in
8 this case. Correct?

9 A Other than they should've expedited doing the non-
10 stress test as well as the biophysical profile if -- unless
11 there was any extraneous circumstances preventing them from
12 being done as rapidly as possible.

13 Q Doctor, will you turn to your deposition on page 111.

14 A (Witness complies)

15 Q Are you there?

16 A Yes.

17 Q Okay. I want you to look at line 3 -- beginning at
18 line 3. Now, I asked you under oath, line 3, do you have
19 any criticisms of the ultrasonographers and nurse
20 practitioners in this case. Your answer, no, I do not.

21 Was that true?

22 A Yes, it was true. But the reason why I said that now
23 is because after reading the deposition and testimonies of
24 the ultrasonographer and nurse practitioner, they didn't do
25 what was necessary to expedite the non-stress test and the

1 ultrasonogram, the biophysical profile, transcripts of
2 which I had since the deposition.

3 Q Doctor, I want you -- well, you never told me about
4 that opinion at your deposition.

5 A No, I did not.

6 Q Okay. I want you to turn to page 14 of your
7 deposition.

8 A (Witness complies)

9 Q Line 24. Are you ready?

10 A Yes.

11 Q Okay. Question, line 24, maybe I can ask you if we
12 can have an agreement, if after today you change your
13 opinions in any way, will you let counsel for the plaintiff
14 now, Jim Boyd or Brad Jordan, or their assistant, Diane,
15 know? Your answer, they will be the first to know. And
16 then following that, now I would anticipate that they would
17 let us know if there's a change in your opinion and if
18 there is a change in your opinion, would you be amenable to
19 either myself or another attorney from our firm deposing
20 you, perhaps, by telephone? Your answer, certainly, that
21 will be fine.

22 A That's correct.

23 Q All right. And then let's turn to page 117 in your
24 deposition.

25 A (Witness complies)

1 Q Line 3. Well, let's start right above it, 116, line
2 24. Based on what you have reviewed today, have you given
3 me your full set of opinions today? Your answer, yes.
4 Likewise, as we discussed earlier, if you change your
5 opinions in any way, would you let counsel for the
6 plaintiff know? Your answer, yes.

7 A Yes.

8 Q And again, and then would you be amenable to us taking
9 your deposition for any further opinions you might have?
10 Your answer, yes. And then following up, have you
11 understood my questions today? Your answer, yes, I have.

12 A Correct.

13 Q And I gave you multiple and ample opportunity and
14 clarity in telling me if you have any change in your
15 opinion as to when you testified to under oath, and you
16 never did that, did you?

17 A No, I didn't. I didn't tell you, is the plaintiff
18 counsel. ---

19 Q And they didn't -- obviously didn't tell us; we didn't
20 take your deposition again.

21 A Because it wasn't significant for the case, so they
22 decided that I was not going to give that opinion during
23 trial testimony. I only answered that way because you
24 asked me that.

1 Q Dr. Miller who saw Ms. Jamison on August 9th in the
2 hospital when she went to the hospital, as well as August
3 25th, 2008, Dr. Miller who's not a named defendant in this
4 case -- you agree that Dr. Miller did not cause Ms.
5 Jamison's baby to die. True?

6 A Not directly, but if Dr. Miller ordered a non-stress
7 biophysical profile on the 25th or a week later, certainly
8 that contributed to the fetal demise.

9 Q Doctor, will you turn to page 111 again in your
10 deposition.

11 A (Witness complies)

12 Q Line 14. Question, do you believe Dr. Miller who saw
13 the patient on August 25th caused the baby to die? Your
14 answer, I don't think Dr. Miller caused the baby to die.
15 That was your answer.

16 A That's the same answer I have now. Not directly.

17 Q Dr. Phillips, if Dr. Hilton instructed Ms. Jamison to
18 go straight to labor and delivery, don't stop at go, don't
19 collect \$200 dollars, go straight there, verifying then Ms.
20 Jamison had transportation and verifying that she knew
21 where to go, you would have no criticisms of Dr. Hilton.
22 Correct?

23 A If she instructed the patient appropriately,
24 instructed Dr. Benson appropriately, that is true.

1 Q Well, there's a little bit of qualification in that
2 answer, and I want to repeat my question. If Dr. Hilton
3 instructed Ms. Jamison to go straight to labor and
4 delivery, don't stop at go, don't collect \$200 dollars, go
5 straight there, verifying that Ms. Jamison had
6 transportation, verifying that she knew where to go, if
7 that occurred, you would have no criticisms of Dr. Hilton.
8 Correct?

9 A I wouldn't say no criticisms, but that takes away the
10 major criticism I have, that still is, she had the
11 responsibility of assuring that she got to the hospital in
12 a timely basis, but the major criticism of not giving an
13 (sic) information to the patient, I agree the
14 responsibility would've been off her and onto the patient.

15 Q Okay, well, I -- just to be clear, let's turn to page
16 110 of your deposition.

17 A (Witness complies)

18 Q Well, let's start at line 11. If after the NST that
19 you looked at today which we talked about, within 15 or 20
20 minutes of the end of that NST a BPP was started and a BPP
21 was stopped in 10 minutes, less than it normally is, with
22 Dr. Hilton instructing the witness to go directly to L&D
23 which is labor and delivery, would her care be appropriate?
24 Your answer, again it depends to the extent of how she
25 instructed the patient. So I followed up with a question.

1 And the question is, well, assuming she instructed the
2 patient go straight to L&D, don't stop at go, don't collect
3 \$200 dollars, go straight there; she verified she had
4 transportation, verified she knew where to go, would you
5 then not have criticisms of Dr. Hilton that day? Your
6 answer, that's correct. True?

7 A That's what I said that day. It's slightly modified
8 when I read the transcripts I received after deposition,
9 not enough to change my opinion.

10 Q Doctor, you're of the opinion that there isn't
11 anything Dr. Benson did or didn't do that caused the baby
12 to die. True?

13 A Other than making sure that the mother, Ms. Jamison,
14 got to the hospital in a timely -- got to labor and
15 delivery in a timely fashion.

16 Q But there's nothing he did or didn't do that caused
17 the baby to die.

18 A Directly? Nothing he directly did other than not
19 assuring she got there in a timely basis.

20 Q Well, Doctor, in the past you have worked on labor and
21 delivery. Correct?

22 A Yes.

23 Q And being on labor and delivery there are a lot of
24 things that you're doing as a physician. Correct?

25 A Correct.

1 Q Okay. And when a patient -- when a doctor knows a
2 patient knows where to go and knows where to come and, you
3 know, clearly been instructed to go, there's nothing that
4 he, Dr. Benson in this case in that situation, did to cause
5 the baby to die. I mean he didn't cause the baby to die.

6 A Well, I'm having trouble with that question. I'm
7 basically saying that he didn't directly cause the baby to
8 die. He just did not insure, maximize the chance of the
9 mother getting to labor and delivery in a timely basis. He
10 didn't do anything to insure that.

11 Q Okay. Let's turn to page 105 in your deposition.

12 A (Witness complies)

13 Q Are you there?

14 A Yes, I'm there.

15 Q Okay. Line 23. We're talking about Dr. Benson, right
16 up here, Dr. Benson ---

17 A Yes, I see.

18 Q And I asked, line 23, do you feel like anything that
19 he did or didn't do that day, caused the baby to die? Flip
20 over. Your first answer to that is, no. Then you qualify
21 it, you say, well, let me say it this way, if he could have
22 gotten the patient there sooner, expedite her getting up to
23 the floor sooner that may have been a critical time period
24 when the baby would have been alive. Correct? I mean that
25 was your answer.

- 1 A That's my answer now.
- 2 Q But you don't know when the baby died.
- 3 A No, but you're asking me did he do -- did anything
4 that contributed to the death of the baby, and I said not
5 directly.
- 6 Q And you said no.
- 7 A I qualified that.
- 8 Q But you did say no.
- 9 A But I qualified the no.
- 10 Q Doctor, if there is anything you specialize in, it
11 would be hysteroscopic or laparoscopic procedures. True?
- 12 A And gynecological procedures of particular interest,
13 yes.
- 14 Q And gynecological, that's different than babies.
15 Obstetrics is babies.
- 16 A Sure is, yes.
- 17 Q Gynecology is ---
- 18 A Sure is.
- 19 Q --- women's ---
- 20 A Yes.
- 21 Q Okay. Now, I heard some testimony about being a
22 fellow of the American College of Obstetrics and
23 Gynecology. Correct?
- 24 A Yes.

1 Q Okay. Being a fellow of ACOG, which is what it's
2 called I believe. Right?

3 A Yes.

4 Q Okay. Being a fellow ACOG does not mean you are
5 fellowship trained.

6 A No, it's not.

7 Q So after med school, you don't have a fellowship
8 training certification. True?

9 A True.

10 Q Have you -- doctor, you have never given any
11 presentations or authored any articles on the subject of
12 fetal demise. True?

13 A Well, I don't -- I never published any. I may have
14 given lectures on fetal demise. As I mentioned, that my CV
15 is deplete from 1989 on, but prior to 1989 I may have given
16 some lectures that I don't know about. I don't recall any.

17 Q Well, let's -- let's just be real clear. Let's turn
18 to page 28 in your deposition.

19 A (Witness complies)

20 Q Line 20. Have you ever done -- question, have you
21 ever done any presentations or authored any articles on
22 fetal demise? Your answer, no, I have not. Correct?

23 A Right. On page 29, I said, when you asked me again,
24 are you asking me if I authored -- this is what I'm asking
25 you -- or gave any lectures, and you said, yes, I said I

1 A During the biophysical profile.

2 Q Some time between 10:48 and 10:58?

3 A Ten fifty-eight.

4 Q Okay. So she's been in the office over two hours and
5 ten minutes?

6 A Correct.

7 MR. WILLIFORD - Your Honor, objection to the
8 leading. It's his witness.

9 THE COURT - I'm going to allow it. Thank you.

10 Q Two hours and ten minutes.

11 A Correct.

12 Q And she's first seeing a doctor at that point?

13 A That is correct.

14 Q With someone who -- a woman who comes in with a lack
15 of fetal movement is below the standard of care to not see
16 an M.D.?

17 A In a prompt fashion, yes.

18 Q Is a two hour and ten minute delay in seeing an M.D.
19 when there's a reduced fetal movement a breach of the
20 standard of care?

21 A Yes, it is.

22 Q Doctor, you've been doing medical legal work for 30
23 years.

24 A Approximately.

1 THE COURT - Thank you very much. You may be
2 seated. All right, Mr. Boyd, did you check and see if you
3 had all your exhibits and everything in evidence?

4 MR. BOYD - We do, Your Honor, and at this time,
5 the plaintiff rest.

6 THE COURT - All right, very good. All right,
7 motions on behalf of defense.

8 MR. WILLIFORD - Yes, Your Honor, we would like to
9 make a motion for a directed verdict based on the grounds
10 that the plaintiff has not proved her case. Basically, Dr.
11 Phillips, while he testified to the standard of care,
12 ultimately on cross examination opined under oath here in
13 Court that anything that they did or didn't do caused the
14 baby to die, so on the basis of the fact that he had --
15 ultimately had no opinion that the defendants, any of the
16 defendants cause the baby's death is subject for a directed
17 verdict and on that -- on that ground. Our second motion
18 is on ---

19 THE COURT - Well, let's -- we'll just deal with
20 them one at a time.

21 MR. WILLIFORD - Yes, sir.

22 THE COURT - All right, Mr. Boyd or Mr. Jordan?

23 MR. BOYD - Your Honor, I don't think -- it's not
24 that he caused the baby to die, it's the fact that the
25 physicians failed to do something which would've prevented

1 the baby from dieing. That's the key. I think there was
2 ample testimony concerning that issue.

3 THE COURT -- All right, sir. All right, based
4 upon the testimony of Dr. Phillips in this matter, the
5 Court does find that there is more than sufficient evidence
6 in the record regarding the standard of care and the breach
7 of care both for -- by all three named defendants, those by
8 Ansley L. Hilton, M.D., Christopher B. Benson, M.D., and
9 the Rock Hill Gynecological and Obstetrical Associates,
10 P.A. He went through a laundry list of things that the
11 corporation, as well as Dr. Hilton did not do in their
12 office that caused a delay. He went through what Dr.
13 Benson should've done at the hospital that contributed to
14 the delay and he stated that the deceased Jayden Joenelle
15 Jamison-Barber would have lived but for the delay in the
16 office and the hospital. That's clear in his testimony.
17 Now, I just use that as an example, taking all the other
18 evidence that has been presented in this case but on the
19 issue that you have presented regarding that motion for a
20 directed verdict, your request is denied. Regarding a
21 directed verdict motion, it's clear obviously that I have
22 to view the evidence and all reasonable inferences in the
23 light most favorable to the non-moving party to determine
24 whether or not a verdict for the non-moving party would be
25 easily possible under the facts as liberally construed in

1 that party's favor, and on that basis I respectfully
2 decline to grant your motion for a directed verdict on the
3 ground you have stated. You may continue.

4 MR. WILLIFORD - Thank you, Your Honor. The other
5 grounds for a directed verdict is based on the fact that no
6 expert for the plaintiff stated that any defendant was
7 either reckless, grossly negligent or acted with a
8 conscience disregard for the patient in this case. Nowhere
9 did that come out in testimony and on that basis, plaintiff
10 has failed her burden of proof, there wasn't any evidence
11 whatsoever in that regard, and therefore, we ask that the
12 Court direct a verdict based on that as well as punitive
13 damages related thereto.

14 THE COURT - So you're asking that punitive
15 damages be struck from the case is what you're asking?

16 MR. WILLIFORD - Yes, sir.

17 THE COURT - Counsel?

18 MR. BOYD - Your Honor, we won't make any claim
19 for punitive damages.

20 THE COURT - That issue is resolved.

21 MR. WILLIFORD - Thank you, Your Honor.

22 THE COURT - Anything else?

23 MR. WILLIFORD - That'll be all, Your Honor.

1 THE COURT - All right, I understand from defense
2 counsel that you do have a witness that can be put up in a
3 reasonable amount of time this afternoon. Is that correct?

4 MR. DAVIS - That's correct, Your Honor.

5 THE COURT - All right, very good.

6 MR. DAVIS - In fact, we've got two if we need
7 them ---

8 THE COURT - All right, very good.

9 MR. DAVIS - We're ready.

10 THE COURT - So is the plaintiff ready for the
11 jury to come in?

12 MR. BOYD - Yes, Your Honor.

13 THE COURT - All right, very good. Ask the jury
14 to come in. When the jury comes in, Mr. Boyd, I'll just --
15 or whichever you want to do that -- Mr. Boyd -- I'll ask
16 the status of the plaintiff's case and you just tell me the
17 plaintiff rest and then we'll move on to defense. All
18 right?

19 MR. BOYD - Yes, sir.

20 (Jury returns to the courtroom)

21 THE COURT - All right, the status of the
22 plaintiff's case at this point in time now?

23 MR. BOYD - Plaintiff rest, Your Honor.

24 THE COURT - All right, very good. The defense
25 prepared to go forward with the first witness?

1 MR. DAVIS - Yes, sir, we are, Your Honor. We'd
2 like to call Wendy Knox.

3 THE COURT - Please come around and be sworn. If
4 you'll just meet the clerk right here at the corner,
5 please, ma'am.

6 WENDY KNOX, AFTER BEING FIRST DULY SWORN,
7 TESTIFIES AS FOLLOWS -

8 THE COURT - All right, ma'am, state your full
9 name for the record, please.

10 MS. KNOX - Wendy Ferrell Knox.

11 THE COURT - You may go ahead, sir.

12 MR. DAVIS - Thank you, Your Honor.

13 DIRECT EXAMINATION

14 BY MR. DAVIS:

15 Q Ms. Knox, you've got some laryngitis?

16 A I do, got it last week.

17 Q Okay. I've poured you some water and if you need to
18 have some water from time to time, please feel free.

19 A Thank you.

20 Q Wendy, would you tell the jury where you work?

21 A I work at Rock Hill Gyn-Ob Associates.

22 Q How long have you worked there?

23 A Going on 17 years this September.

24 Q What do you do? What are your responsibilities -- let
25 me bounce back a bit. Back in August, September of 2008 in

1 that time-frame that we're talking about in this case with
2 Ms. Jamison, explain to the jury what your duties and
3 responsibilities were there, ma'am.

4 A Okay. My position for about 12 years including that
5 time was the extra nurse, and that involved taking care of
6 patients coming in for a scheduled non-stress test, all
7 kinds of other things like IV fluids if they needed them,
8 giving lots of shots, injections and other duties, just
9 taking care of patients.

10 Q All right. And what sort of education, training do
11 you have in that field other than on-the-job training?

12 A Just on-the-job training.

13 Q Okay. Ms. Knox, were you working back on September 5
14 of 2008?

15 A Yes.

16 Q All right. Are you familiar with the -- can we call
17 them the NST for non-stress test machines? Would that be a
18 okay way to call those machines?

19 A Correct.

20 Q Try to describe to the jury what those machines do --
21 and I guess you run them. Right?

22 A Right.

23 Q All right. What do they do?

24 A They record the fetal heart rate and record
25 contractions.

1 Q Okay. Let's see if I can find those ---
2 A Mr. Davis, were you asking me my qualifications as a
3 nurse or as ---
4 Q Yes, right.
5 A --- or as to do non-stress test?
6 Q Both.
7 A Okay, well, I am licensed as a practical nurse.
8 Q You're licensed as a practical nurse?
9 A I am licensed as a practical nurse.
10 Q Tell the jury what you had to do to become licensed as
11 a practical nurse?
12 A I went to -- I went to practical nursing school,
13 Chester School of Practical Nursing from 1993 to 1995, took
14 my state boards exam and received my license in September
15 of '95.
16 Q Of what year?
17 A Ninety-five.
18 Q Okay. Thank you, Wendy. I'm looking for, and you can
19 probably find it quicker than I can. Of course it wouldn't
20 be here.
21 MR. DAVIS - Anybody seen the NST strips from the
22 original file? They were in that folder?
23 MR. JORDAN - It's inside the plastic ---
24 MR. DAVIS - Well, I know. I'm looking inside the
25 plastic thing and there's none here. Excuse me just a

1 moment, Your Honor. Your Honor, it was in here at one
2 time. I don't know what happened to it.

3 THE COURT - Well, we'll have to locate it.

4 MR. DAVIS - All right, we'll search around. I've
5 got copies of it.

6 THE COURT - All right, sir. Use those at the
7 present time.

8 MR. DAVIS - Thank you, Your Honor.

9 Q I'm going to hand you this copy of where this is in
10 evidence. Is that a copy of the NST that was done at the
11 office on September 5, 2008 on Samantha Jamison?

12 A Yes, sir.

13 Q Ma'am?

14 A It is. It has her name on it.

15 Q Okay. And do you know who ordered that NST?

16 A That would've been Robin Pruette. Her signature is
17 here. It's says -- well, it's got her signature, so she
18 ordered it and I would've performed it.

19 Q Okay. And are you trained to read and interpret non-
20 stress test?

21 A No, sir, just to -- just to actually set the patient
22 up on the monitor, get the recording and then provided it
23 to the provider that ordered it.

24 Q Walk through with the jury a patient such as Ms.
25 Jamison in comes to the office, a walk-in, and she's seen

1 by a nurse practitioner, Robin Pruetto, and Robin decides
2 for whatever reason to order a non-stress test, and she
3 asks you to do it. Walk the jury through what you would
4 do at that point until the non-stress test is completed.
5 What do you do?

6 A I would take the patient back to the room. At the
7 time she would already be in a room because another nurse
8 would've taken her back, then they would've notified me to
9 do the non-stress test, and then I would take the patient,
10 put her on the monitor, put two straps around her. You put
11 the part that monitors contractions at the top of the
12 uterus and then you find the fetal heart rate with the
13 other one and belt it down and start the monitor.

14 Q You stay there with the patient through the whole NST?

15 A No, sir.

16 Q Okay. You leave the patient by herself for some
17 period of time?

18 A You go in and out and check on the patient. I had
19 other patients at the time?

20 Q Did you?

21 A Yes, I have -- I had a lot of NSTs going on that were
22 scheduled and work-ins and also injections and other things
23 like pregnancy tests and urinary tract infections, what
24 have you, patients coming in for many different things.

1 Q All right. Now, Wendy, how long did that NST, non-
2 stress test on Ms. Jamison take according to those strips
3 if you can tell us?

4 A It took about 30 minutes, maybe 34 if you count every
5 -- every segment of the paper.

6 Q Okay. Now, printed on those strips, there's a time
7 stamp. I think it starts at like 08:50 or something of
8 that order. Is that right?

9 A Yes, it says 8:50.

10 Q All right, let me ask you this. How many machines at
11 that time did you have in the office in Rock Hill?

12 A Two.

13 Q Were you present, were you in the office when those
14 two machines were purchased and set up?

15 A I was.

16 Q Do you know the name of the person, the sales person,
17 that sold the machines and brought the machines in?

18 A That's Michelle Sharpe.

19 Q All right. And when Michelle brought those two
20 machines, one of which was used this day, to the office, do
21 you know whether she set the time to be right?

22 A No, sir. I just remember I ordered the machines, and
23 when they came in, I know Michelle had scheduled a time to
24 come and actually give a demo of the machine. I can't
25 actually recall what happened back then. I just remember -

1 -- I handled -- I also handled ordering the supplies at
2 that time, and so I was in touch with Michelle on a
3 regularly basis, depending on the needs for supplies. And
4 I remember when they got the machines, it was either
5 January of '07 or '08.

6 Q When you -- you're the one that's using the machines,
7 like you did in this ---

8 A Right. For 12 years I was the extra nurse.

9 Q When you used those new machines, did you ever notice
10 that the time wasn't accurate on the stamp on the machine?

11 A Yes, I did. The time had always been an hour off. I
12 always had noticed the time was off on the machines about
13 an hour.

14 Q So if that paper copy says 8:50, it was really more
15 like 9:50.

16 MR. JORDAN - I'm going to object to the leading.

17 MR. DAVIS - All right, I'll respect that. Your
18 Honor, don't even have to rule. I'll withdraw and ask it a
19 different way.

20 Q Wendy, was the time -- the hour -- was it fast or
21 slow?

22 A The time according to from what I've learned from this
23 case, she signed in around 8:40 ---

24 Q Right.

25 A --- and I know she had to see Robin first, ---

1 Q All right.

2 A --- and then they had to -- you know, get an NST which
3 I was occupied doing, so that would've taken some time, but
4 there's no way she could've been on at 8:50, so I know the
5 time here had to be slow, because it was an hour off.

6 Didn't know whether it was slow or fast until I looked at
7 the whole ---

8 Q Looked at her sign-in sheet at 8:40?

9 A Right. I looked at the sign-in sheet. It said 8:40.

10 Q Okay. So then if we see on that piece of paper 8:50
11 stamped by the machine, it's really 9:50. Correct?

12 A Nine fifty or ten.

13 Q Or 10.

14 A Because I think they established that once Michelle
15 came in and checked them, she said one was off and hour ---

16 MR. JORDAN - Your Honor, I'm going to object to
17 anything that Michelle had said.

18 MR. DAVIS - Your Honor, -- Your Honor, may it
19 please the Court. Could we approach the bench on that? I
20 don't want to take it up in the front the jury.

21 THE COURT - Yes, sir. Please. Y'all come up
22 here.

23 MR. DAVIS - Thank you.

1 (Bench conference was held in the presence of the
2 jury but out of the hearing of the jury which was not
3 reported.)

4 THE COURT - Move on.

5 MR. DAVIS - Yes, sir.

6 Q The time's were off.

7 A An hour.. I knew they were off around an hour.

8 Q Okay. At the end of that NST, what would you have
9 done?

10 A Take it to see to (sic) the provider that ordered it,
11 which apparently was Robin.

12 Q Okay. Do you actually take the pieces of paper to
13 Robin?

14 A Normally I do, but if I see any decels, I'll have the
15 provider come into the room while the patient's on the
16 monitor.

17 Q Do you remember which you did on this day?

18 A No, I can't remember what happened that day.

19 Q All right. Is it your understanding that Robin would
20 have reviewed those, because her initials are on the strip?

21 A Right. That's what I see. I just see -- and I only
22 know I did it because it's my handwriting and then I see
23 Robin's handwriting that says BPP and M.D. with her
24 signature.

- 1 Q What do you understand it to mean when Robin, the
2 nurse practitioner, writes on the fetal monitor strips BPP
3 and M.D.? What'd that mean to you?
- 4 A She wants the patient to go have a biophysical profile
5 next and then see the M.D.; the M.D. is to read the
6 biophysical profile.
- 7 Q What is the time stamp of when -- knowing it's off an
8 hour -- the time stamp at the end of that NST was at what
9 time?
- 10 A At the end of it is -- last recorded is 9:20.
- 11 Q Zero nine twenty? Was that time off as well to your
12 knowledge?
- 13 A Well, yes, it's off an hour.
- 14 Q Okay. After receiving either instructions or just
15 seeing it on the piece of paper that you talked to us about
16 where Robin wrote M.D. or BPP and M.D., what would you have
17 done?
- 18 A After I take the patient off the monitor?
- 19 Q Yes, ma'am.
- 20 A I would take them down for an ultrasound.
- 21 Q When you say take them down, where do you take them
22 from and where do you take to, Ms. Knox?
- 23 A We take them from the room the patient's in where
24 Robin was working ---
- 25 Q Okay.

1 A --- down to wait for the ultrasound.

2 Q Where do the patients typically wait for an
3 ultrasound?

4 A Well, there's a couple of chairs sitting right outside
5 the ultrasound now. At that time they would have probably
6 had to wait in a couple of chairs sitting by checkout.

7 Q Okay. And is Jane McCain employed at Rock Hill Gyn-
8 Ob?

9 A She's an ultrasound tech nurse, a sonographer.

10 Q Do you know whether she was there and working that
11 particular day?

12 A Personally I don't remember, but I believe during this
13 trial I found out that she was.

14 Q Okay. Were you present in the office when the sales
15 person, Michelle Sharpe you talked about earlier, came to
16 your office in Rock Hill and sat the clocks on those
17 machines?

18 A Yes, and I do remember that.

19 Q Tell the jury what you remember.

20 A When Michelle came in, Lori had told me she was
21 coming. Lori's the ---

22 MR. JORDAN - Your Honor, I'm going to object to
23 anything Lori may have said.

24 Q Yes, don't say anything about anybody else said. Just
25 tell me what happened.

1 A Okay, Michelle came in and showed me how to set the
2 time and she reset them, took her about 10 minutes.

3 Q And that was you and Michelle?

4 A Right, me and Michelle.

5 Q Who is Lori Lette?

6 A She is the clinical manager, the nursing supervisor.

7 Q Was she supposed to be there that day with Michelle?

8 A She was. We were in her office when she reset them.

9 Q Do you know whether or not something called Lori away
10 that particular time when Michelle got there to set the
11 clocks on the machines?

12 A Well, she came looking for me, because Lori wasn't
13 there.

14 Q Michelle came looking for you, because Lori wasn't
15 there.

16 A Yes, and Lori -- apparently, there was an e-mail that
17 she had talked to Michelle and said she wasn't there.

18 MR. JORDAN - Your Honor, I would object to
19 anything about e-mail or anything that Michelle may have
20 said.

21 MR. DAVIS - Your Honor, they've got copies of
22 those e-mails.

23 THE COURT - I appreciate that. Again, is this
24 any matter that's going to be covered in the other de bene
25 esse deposition?

1 MR. DAVIS - Probably. We'll wait.

2 THE COURT - All right, let's --- we'll just wait
3 for that.

4 MR. DAVIS - Yes, sir, we'll wait.

5 Q Okay. Let's don't talk about anybody else. Okay?

6 A Okay. What was the question? I'm sorry.

7 Q I mean it wasn't your e-mail anyway. Is that fair?

8 A Right.

9 Q It was somebody else's. So let's -- we'll just talk
10 about something else. The question is this. Were you
11 present when Michelle Sharpe came to correct the times on
12 those NST machines?

13 A Yes.

14 Q Did she teach you how to set the clocks?

15 A She did.

16 Q Do you do that now?

17 A Yes, I do.

18 Q Okay.

19 MR. DAVIS - One moment, please, Your Honor.

20 (Pause)

21 THE COURT - Yes, sir.

22 MR. DAVIS - Wendy, thank you very much. If
23 either of these gentlemen have any questions, please feel
24 free to answer their questions.

25 THE COURT - Cross examination.

1 MR. JORDAN - Thank you, Your Honor.

2 CROSS EXAMINATION

3 BY MR. JORDAN:

4 Q Now, you've got in your hand a copy of the non-stress
5 test. Is that correct?

6 A Yes, sir.

7 Q Does it have a serial number from the machine?

8 A It has a number.

9 Q Okay. What is the serial number of that machine?

10 A If that's the serial number, the number printed is
11 FA003099.

12 Q Okay. And the serial number of the two machines that
13 Michelle Sharpe reset, they don't match that serial number,
14 do they?

15 A The serial numbers? I'm sorry.

16 Q The serial number for the two machines that Michelle
17 Sharpe showed you how to set the time on, the serial
18 numbers don't match, do they?

19 A I don't know the numbers that she set the time on it.
20 The two machines that were in Lori's office were the two
21 machines that we had at that time.

22 Q Do you remember giving a deposition in this case on
23 July 19th, 2012?

24 A I do.

25 MR. JORDAN - Your Honor, I have ---

1 THE COURT - Yes, sir.

2 MS. KNOX - Thank you.

3 THE COURT - As I told you earlier, ladies and
4 gentlemen, the deposition is the recorded testimony of the
5 witness under oath at a prior time. Thank you very much.
6 You may continue.

7 MR. JORDAN - Thank you, Your Honor.

8 Q If you would turn to page 10.

9 A (Witness complies)

10 Q Beginning at line 17 you were asked, do you know or
11 have an explanation as to why the serial numbers would not
12 match up? And what did you say?

13 A I said, no, I tried to figure that out yesterday.
14 That was when we had talked to lawyers about the
15 depositions coming up. I tried to figure that out
16 yesterday. I don't know if that's the serial number, but
17 that's the number that we looked at. The number on the
18 machine also starts with the letters FA but they don't
19 match up either machine.

20 Q Okay. So the serial number on the non-stress test
21 didn't match either of the serial numbers where the time
22 was reset, did they?

23 A Correct.

24 Q Now, these times were reset in July of 2011. Is that
25 correct?

- 1 A Yes, I believe so.
- 2 Q Okay. And that was after this lawsuit.
- 3 A That was before I was ever called in this lawsuit,
- 4 before I was aware of this lawsuit.
- 5 Q It was after this lawsuit was filed or do you know?
- 6 A Sir, I don't when it was filed.
- 7 Q What prompted you to have the time reset?
- 8 A What prompted me to have the time reset. Okay, right
- 9 -- I had heard there was a case, so, yes, that means it had
- 10 been filed. I had heard there was a case that came about
- 11 and somewhere in there I made the office aware that that --
- 12 machines were off an hour. I don't remember exactly when
- 13 all that was, but I made them aware that I knew the
- 14 machines were off an hour, and then that's when it came,
- 15 you know, to the manager's attention that it needed to be -
- 16 - that needed attention.
- 17 Q Now, when you were doing the non-stress test, Robin
- 18 Pruette was seeing other patients. Is that correct?
- 19 A That's right.
- 20 Q And you were doing a lot of non-stress tests you said.
- 21 A Right.
- 22 Q And your testimony was the non-stress test there with
- 23 that serial number didn't start until 10:00 o'clock. The
- 24 report says 8:50. Correct?
- 25 A Right. The report says 8:50 and I'm ---

1 Q But you said 10:00 o'clock.

2 A I'm saying it was off an hour and I later was told
3 that when she ---

4 Q Not asking what anyone else said, just ---

5 A Okay. Yes, I'm saying it must've been around 10:00
6 o'clock.

7 Q But that serial number doesn't match either of the
8 serial numbers on the other machines.

9 A No, apparently not.

10 Q And she got there -- Samantha got there at 8:40 that
11 day.

12 A Right.

13 Q And the non-stress test started by your testimony at
14 10:00 o'clock.

15 A That's what I believe.

16 Q An hour and twenty minutes. Is that correct?

17 A That's what I believe.

18 Q And it's your understanding that she got to the office
19 that day complaining of uh -- that her baby wasn't moving
20 as much?

21 A Decreased fetal movement, correct.

22 Q And Samantha -- is it your understanding that Samantha
23 was actually seen by a doctor that day until after 10:48?

24 A It's my understanding that she saw Robin Pruette, a
25 nurse practitioner.

1 Q Robin Pruette is not a physician in Rock Hill Gyn-Ob,
2 is she?

3 A No, she's a women's health nurse practitioner.

4 Q And you would agree that when you have decelerations
5 on a non-stress test that are related to a contraction,
6 that's a concern, wouldn't you?

7 A I would agree that -- say that again. I'm sorry.

8 Q When you have decelerations on a non-stress test and
9 they're related to a contraction, that's concerning to you.

10 A Yes, that should be a concern. Right.

11 Q That's a possible sign of distress, isn't it?

12 A It's a possible sign.

13 Q And that would be up to the physician to read and
14 diagnosis that.

15 A Well, a provider. Robin also diagnosed patients and
16 read non-stress test, and Robin was seeing the patient that
17 day, so she would interpret the test.

18 Q And the decelerations that you saw that day there were
19 concerns, weren't they?

20 A Yes, there were some, but any kind of decel, since I'm
21 not qualified to read them, if I see any decels, then I'll
22 let the provider know and they make the call.

23 Q And you would've taken that strip directly to the
24 provider that ordered the non-stress test and let them
25 determine what needed to be done.

1 A That's normally what I would do. I don't remember,
2 you know, exactly this situation back in '08.

3 Q You don't have an independent recollection ---

4 A I have none.

5 Q --- of Samantha.

6 A I have none.

7 Q But normally what you would do when you see concerns
8 like are on this strip right here, you would take them
9 directly to the provider. Is that correct?

10 A Right, I would run the -- run the non-stress test and
11 then take the whole strip to the provider and let them
12 determine what's next.

13 Q Because you want a doctor to know what's going on.
14 Correct?

15 A I want -- well, at this point I would want Robin to
16 know.

17 Q Okay. Because you want to be safe for the mother and
18 the baby. Right?

19 A I want to perform my job properly, yes, sir, and --
20 and hopes to take good care of patients.

21 Q And in your mind with the decelerations there was a
22 concern for distress of the baby. Would you agree?

23 A Yes, I -- I was -- I did see some decels that looked
24 like potential -- potential problem.

1 Q And when you have a concern for distress of a baby,
2 you want the mother and the baby to be checked as soon as
3 possible. Correct?

4 A Sure. Right. Correct. (Pause) As soon as we could.

5 Q Was it your understanding that Samantha had chronic
6 hypertension or did you know of anything else in the chart?

7 A Well, I had read the chart, and I had made a couple of
8 notes on the chart that she had chronic hypertension.

9 Q And she had a drop in the amniotic fluid down to nine.

10 A I didn't know the fluid level ---

11 Q Okay. And ---

12 A --- but I -- I saw --

13 Q And was she around 32 weeks at this point?

14 A It said thirty-one and six on the chart.

15 Q Would you agree that decreased fetal movement is
16 always a reason for a non-stress test?

17 A It is. Decreased fetal movement -- we did a lot of
18 non-stress tests and still do almost daily for decreased
19 fetal movement.

20 Q And would you agree that you always want to know
21 what's going on with the child if the child's in distress.
22 Correct?

23 A Correct.

24 Q And that's because if you don't know, you can't
25 provide safe care, can you?

1 A That's true.

2 Q How many non-stress tests did you run for Samantha?

3 A Oh, for Samantha I have no idea. I know I ran this
4 one, because I see my handwriting, but I have not pulled
5 any other ones out if she had any other ones, but ---

6 Q Do you recall doing any others?

7 A No, sir.

8 Q And the baby was alive when you were doing that non-
9 stress test.

10 A The baby was alive. Correct.

11 MR. JORDAN - Beg the Court's indulgence.

12 THE COURT - Yes, sir.

13 MR. JORDAN - No further questions, Your Honor.

14 THE COURT - Any re-direct?

15 MR. DAVIS - Briefly, Your Honor.

16 THE COURT - Yes, sir.

17 MR. DAVIS - Thank you, sir.

18 RE-DIRECT EXAMINATION

19 BY MR. DAVIS:

20 Q Wendy, are you aware of a third NST machine being
21 acquired by Rock Hill Gyn-Ob in addition to the two you've
22 talked about?

23 A Yes, there was a third one. It was acquired later and
24 sent to our Fort Mill location.

25 Q Sent to the Fort Mill location.

1 had some technical issues with equipment this morning we're
 2 working on. The county informs me that they're going to
 3 have one of their periodic test of their outdoor warning
 4 system that's going to take place some time around noon
 5 today. I don't know that we're going to hear it inside the
 6 building, but if you happen to hear the outdoor warning
 7 sirens, that's part of their periodic testing, so there's
 8 no emergency. So the dog might hear it, so you might want
 9 to tell him it's okay. All right. Is the defense ready to
 10 get started?

11 MR. DAVIS - Yes, sir, thank you.

12 THE COURT - All right, let's call your next
 13 witness then.

14 MR. DAVIS - Yes, sir. Your Honor, I'd like to
 15 call Dr. Greg Miller.

16 THE COURT - All right. Please come around and be
 17 sworn, sir? If you'll just meet the clerk right here at
 18 the corner, sir.

19 DR. GREGORY MILLER, AFTER BEING FIRST DULY SWORN,
 20 TESTIFIES AS FOLLOWS:

21 DIRECT EXAMINATION

22 BY MR. DAVIS -

23 Q Sir, would you please introduce yourself to the jury?

24 A My name is Dr. Greg Miller.

25 Q Dr. Miller, where are you employed?

1 A I am employed at Rock Hill Gyn-Ob.

2 Q And give the jury just an overview of your education
3 and your training and your experience in the specialty
4 medicine that you practice in.

5 A Okay. I grew up in Richmond, Virginia, went to
6 undergraduate at the College of William and Mary in
7 Williamsburg, Virginia, did my medical school training at
8 The Medical College of Virginia in Richmond, Virginia. I
9 went on to do my internship and residency at The University
10 of Florida down in Gainesville. I spent the next three
11 years stationed with the Marine Corp at Camp Lejeune as a
12 navy officer and physician. And I've been in Rock Hill I
13 think for 17 years. I've been practicing Ob-Gyn now for
14 almost 25 years.

15 Q Doctor, are you board certified in any specialty in
16 medicine?

17 A I am board certified in obstetrics and gynecology.

18 Q And was that a written and an oral examination you had
19 to take in the past?

20 A Yes, it was.

21 Q And did you pass both?

22 A Yes, I did.

23 Q Have you been required to become recertified in your
24 specialty in medicine?

25 A Yes. We actually have to be recertified every year.

1 Q And have you done that?

2 A Yes, I have.

3 Q Describe for the jury, Dr. Miller, your practice over
4 these years and maybe more recently within the last five to
5 ten years, what do you do day-to-day, week-in, week-out,
6 year-in, year-out in that practice?

7 Q Well, what we do, myself and Dr. Hilton and Dr.
8 Benson, we actually sort of practice two different versions
9 of medicine. We practice gynecology which is taking care
10 of women and female issues and we practice obstetrics,
11 which, of course, is taking care of women when they're
12 pregnant. And in our practice that's about -- it's
13 probably about 50 percent of each. We have seven partners,
14 and of those seven partners we all take equal call. So
15 you're on call at least one day a week, and usually one
16 weekend out of every two months. We -- in the office in a
17 typical, for example -- today I'm actually on call, so I
18 have a friend of mine who's actually taking call. I
19 actually had three c-sections scheduled this morning and
20 had to move those. And then as soon as I'm done here I'll
21 go back to taking call. We actually take call in-house 24
22 hour for seven days a week, so one of us is in the hospital
23 or in our office, which is less than five minutes away from
24 the hospital. So I'll be on call today. Tomorrow I have
25 surgery in the afternoon and I'm going back in the office

1 tomorrow, but just -- we need -- we need to have physicians
2 there taking care of the patients. We're sort of -- we're
3 obviously down-staffed this week, but on average you'll do
4 about -- about half your work is obstetrics and half is
5 gynecology..

6 Q You mentioned today for example you will be on call
7 for the hospital?

8 A We're actually on call -- we actually are on all call
9 for all of our patients ---

10 Q Okay.

11 A --- and we're also on call for any patient that comes
12 into the hospital that has no provider, so we take all the
13 indigents; anybody that doesn't have a provider that comes
14 in the hospital, we actually take care of them as well.

15 Q Dr. Miller, when you are in the hospital on call, and
16 as you're going to be I guess later today, have been in the
17 past, will be in the future, when you or anyone in your
18 office is on call in the hospital on labor and delivery,
19 describe for the jury the responsibilities that you have,
20 the things that come up from time to time, the things that
21 you are doing while you are there on the floor.

22 A Actually, it changes every day, and there's multiple
23 responsibilities. You know, I think all of us would
24 believe that our first and foremost responsibility is to
25 the obstetrics ward, and so that's taken care of, all of

1 the patients that are currently in labor or patients who
2 might have a problem and were evaluated. That's one of our
3 first -- that's probably our first and foremost
4 responsibility, but you also have responsibility to all the
5 patients that are already in the hospital. They might be
6 women who have an antenatal or a problem pregnancy that
7 they're not going to be delivered, but we're trying to
8 monitor and watch them closely, then might be somebody who
9 has delivered and we're just monitoring, taking care of
10 them before they go home. They could be post-surgical
11 patients, somebody who has done some surgery, you're going
12 to take care of those patients while you're there. You're
13 responsible for any calls and any other physician in the
14 hospital who might have a problem with a patient, a
15 gynecological or obstetrics problem with their patient to
16 do a consultation on that. You're also responsible for
17 surgeries. Okay, you're responsible for any patient that
18 comes into the emergency room that has potentially a life-
19 threatening illness that might require surgery or might
20 require hospitalization. So we're responsible for any of
21 the ER patients as well.

22 Q On August 9th of 2008 when -- we'll look at the records
23 in a moment -- when you saw Ms. Jamison, was she admitted
24 through the emergency room?

1 A That's sort of a play on words. You know, labor and
2 delivery has sort of -- what we call sort of a triage unit,
3 and we really prefer our patients not to go to the emer --
4 the true emergency room which is at the other end of the
5 hospital. We'd rather them come -- you know, once they've
6 reached 20 weeks, we'd rather them come straight to labor
7 and delivery. That just cuts down some of the beurocracy
8 that goes on at any hospital, but it gets the patients to
9 labor and delivery faster, so she wasn't technically in the
10 ER but in a way sort of an obstetrics ER. She was on our
11 triage when she came in that night.

12 Q Okay. And was that a day or a night or a shift where
13 you were the physician on call in house in the hospital for
14 labor and delivery?

15 A Yes, it was.

16 Q All right, sir. Let me -- the records that we've
17 subpoenaed from the hospital and I've put a little sticky
18 note on there that says 8-9-08 admission. This is
19 everything that the hospital sent to us, but subpoena --
20 feel free to look through any of those records, because I
21 want to ask you about your care, what happened on August 9th
22 and then kind of walk through some of those issues. All
23 right, sir?

24 A Yes, sir.

1 Q What do you understand, recall from what is recorded
2 for the reason for Ms. Jamison to be admitted on August 9th?

3 A Ms. -- and I'm sorry, I just want to make sure ---

4 Q Tell me what you're looking for. I might be able to -
5 --

6 A I'm looking for that initial nurses' note saying - to
7 my recollection it was abdominal pain, it was concern of
8 possible of pre-term labor.

9 Q All right. I've got a copy here. I know it's
10 probably in there somewhere, but is this what you're
11 looking for, sir?

12 A Yes.

13 Q Okay. Can you find that among the documents?

14 A Not yet. Yes, it looks like I've got that.

15 Q You've got it?

16 A (Indicating yes)

17 Q Okay. This is my copy that we're looking at with the
18 jury. In looking at that, what is the time that you see of
19 admission? You see that?

20 A It looks like it's forty-five after midnight.

21 Q Okay. It says admitted from emergency department.

22 Is that -- would that be accurate, what you told us?

23 A Again, they don't -- they typically -- that's sort of
24 a -- more of a hospital notation, but to my knowledge most
25 of these people are not actually admitted from the

1 emergency department. They just come straight to labor and
2 delivery.

3 Q Okay. Reason for admission is blank; other reason for
4 admission. Would you tell us what that -- what that is?
5 Can you see that? Doctor, you can come down.

6 THE COURT - He can come down.

7 A I'm sorry.

8 Q That's fine. Other reason for admission. I've got it
9 highlighted, but what is that?

10 A Lower abdominal pain.

11 Q All right. And new diagnosis of -- what is a PIH?

12 A PIH is pregnancy induced hypertension.

13 Q What is pregnancy induced hypertension.

14 A Pregnancy induced hypertension is a condition that
15 some -- some pregnant women will get where they'll start
16 seeing their blood pressures elevate. Typically happens
17 either toward the latter part of the second trimester or
18 the beginning of the third trimester.

19 Q Did she present to the office with a history of high
20 blood pressure?

21 A She presented to the office with a history of chronic
22 hypertension.

23 Q Okay. Did you and your partners treat her during her
24 pregnancy and care at Rock Hill Gyn-Ob for her high blood
25 pressure?

1 A Yes, sir, we did.

2 Q Do you have an opinion whether or not the medication
3 and treatment you provided to Ms. Jamison for high blood
4 pressure was effective, sir?

5 A No, it was not.

6 Q So what happens when a lady is pregnant and she gets
7 high blood pressure?

8 A Well, one of the hardest things we have to find out is
9 trying to decide if somebody has pregnancy induced
10 hypertension or in this case, if somebody has chronic
11 hypertension, if it's a chronic hypertension, just how the
12 chronic hypertension is behaving, and sometimes trying to
13 make a distinction is hard, but typically when somebody has
14 chronic hypertension we'll often -- initially when they
15 come in, they're often on blood pressure medicines that
16 they shouldn't take when they're pregnant, because, in
17 fact, most blood pressure medicine aren't safe during
18 pregnancy, not for the baby. And so typically what we'll
19 do is stop that blood pressure medicine and we just have a
20 handful of blood pressure medicines that we can actually
21 use when they're pregnant, and so she was started on a drug
22 which we've used and has been used extensively called
23 Aldomet. Once that's done, the next things that you want
24 to do is you want to have her come back on a regular basis.
25 You want to do ultrasounds to document that the growth of

1. the baby is appropriate, because pregnancy induced
2. hypertension and chronic hypertension can affect the baby's
3. growth. And typically in our practice what we do, once
4. somebody turns 32 weeks, then we start doing more advance
5. anti-pardum testing including something we call non-stress
6. tests and we start doing those 32 weeks or so, and that was
7. -- I think on the chart that was listed -- that was part of
8. the plan or the progress for her.

9. Q What did you order for her? What did you recommend?
10. What was done for her upon her admission on August 9th until
11. whenever she went home?

12. A Well, you know, initially she came in and the issue
13. wasn't about her hypertension. You know, she didn't -- she
14. didn't come in complaining of issues with her hypertension.
15. She actually came in complaining of abdominal pain, you
16. know, a separate issue, you know, and at her gestation what
17. we considered pre-term labor. And so the most important
18. thing we want to do is first, put the baby on a monitor,
19. make sure the baby looks good, and also monitor for
20. contractions and make sure there's no evidence that
21. somebody's in pre-term labor. When she is first put on the
22. monitor, one of her first blood pressures was elevated, and
23. I think it was 170 something over 87. The nurse alerted to
24. me to that, say, hey, you know, this lady's blood pressure
25. is slightly elevated, she has a history of chronic

1 hypertension, she has her chart there. And so at that
2 point, you know, the decision is made, okay, well, now we
3 need to do serial blood pressure. We want to watch this
4 blood pressure. You know, we would like to watch it for
5 maybe a period of time, maybe six hours or so to see if
6 there is a trend. After doing that we also decide -- one
7 of the best ways and probably really the only way to
8 distinguish between chronic hypertension and pregnancy
9 induced hypertension is you draw labs, and you're drawing
10 labs, blood work, and you're also looking at the urine and
11 you're looking for protein in the urine suggesting that
12 there's now kidney involved, that's part of the problem.
13 And so we said, let's go ahead and order the appropriate
14 blood work and let's go ahead and check for protein in the
15 urine. So over the next five or six hours she had serial
16 blood pressures taken, had lab work done, the urine checked
17 and that's what we did.

18 Q And this is in your packet, but I'll -- and if you
19 need to come down, please feel free to do so -- physicians
20 orders -- these your orders?

21 A Yes.

22 Q Would you -- is this what you just talked about,
23 things you were ordering to be done?

24 A Yes, sir.

1 Q All right. Electronic fetal monitoring. What is
2 that?

3 A That gets -- that's putting a baby on -- you know,
4 anybody that's been pregnant or had their wives pregnant,
5 they know, they come in and we strap a strap across their
6 belly, and we hook that up to a machine next to the bed and
7 that machine is going to record the baby's heartbeat and
8 we're looking for certain -- certain features of that
9 heartbeat to tell us that everything's reassuring.

10 Q You also have an X by complete blood count. What is
11 that?

12 A That's checking a CBC differential and ---

13 Q What's a differential?

14 A Well, the main thing that we're looking at for
15 preeclampsia or -- excuse me -- toxemia or pregnancy
16 induced hypertension -- they're sort of all the same -- the
17 main thing we're looking for is their platelet count, and
18 that's sort of a critical abnormal value that happens early
19 on in preeclampsia, so we're looking for that platelet
20 count, and that's part of that CBC.

21 Q When you look at the platelet count, is that a
22 property of the blood that's obtained from a complete blood
23 count study?

24 A Yes, it is.

25 Q If it's high or low, does that mean anything to you?

1 A Well, we're worried -- we're worried first if it's
2 low, and then we're also worried about possible trend.
3 Platelet count can be just low on it's own, but we're -- so
4 we want to see what it is, but then, you know, depending on
5 what that comes back, if it is low, then we're going to
6 look for what the trend is..

7 Q Okay. Comprehensive metabolic panel, what is that and
8 why would you order that?

9 A The main thing that -- the comprehensive medical panel
10 basically includes the next item, which is the uric acid
11 and it's basically ordered the one and you actually get the
12 other, but basically at that point we're looking for the
13 uric acid, but we're also looking for what we call liver
14 function test or LFTs, and again, somebody that has
15 toxemia, preeclampsia or pregnancy induced hypertension,
16 you're going to start noticing that the liver is going to
17 start to be involved; it's going to start to be irritated
18 and inflamed and we're going to see those values rise.

19 Q Doctor, what is a differential diagnosis, sir? What
20 is that?

21 A Well, a differential diagnosis basically, you know,
22 whenever you see a patient, you know, the first -- you
23 check the patient, you gather a history, do your physical,
24 you find out what the complaint is, and based on all these
25 things, you put all this together and you try to come up

1 with, okay what are the things that could possibly be going
2 on, and that's what a differential diagnosis is.

3 Q Did you form a differential diagnosis based upon the
4 situation that Ms. Jamison presented herself with to labor
5 and delivery that night?

6 A There really -- there were two issues, you know, sir,
7 on my mental problem list, one, is the first thing she came
8 in with, you know. And right now we're talking about
9 something that she had no complaint of, but we've sort of
10 picked up on this. The first thing she came in with was
11 abdominal pain, and that's still probably the first thing
12 we want to make sure, that there's no evidence of pre-term
13 labor, so that's the first thing on my list of -- my
14 problem list. And the second thing is chronic hypertension
15 versus PIH or pregnancy induced hypertension, so now since
16 we saw, you know, a slightly elevated blood pressure, we
17 want to make sure that that's not something that we need
18 to, you know, act or do something about as well.

19 Q What, if anything, did you do to rule in or rule out
20 pre-term labor based on her presenting complaint of
21 abdominal pain, sir.

22 A It gets back to that first thing, the electronic fetal
23 monitoring. You know, we put somebody on a strip -- we're
24 putting them on two different belts. One belt is a belt
25 that's to monitor the fetal heartbeat; the other is to

1 monitor uterine contractions, and so we're doing that first
2 and foremost. If we see multiple regular contractions on
3 that monitor, then we'll go -- we'll either do an exam - if
4 we don't see that, particularly if somebody's symptoms are
5 steadily improving, we don't necessarily do an internal
6 exam check or check or cervix. And so that's what we did
7 for that.

8 Q Thank you. You talked about ordering labs. Did the
9 labs come back as you had ordered them?

10 A Yes, they did.

11 Q They're in your packets somewhere and I'll show the
12 copies - yes, please feel free to come down, sir. Having a
13 hard time looking at those darkened areas where the numbers
14 are, but I can see them. What is ordered complete
15 metabolic uric acid, BLD? What is all that?

16 A Well, what I'd say it that um, -- and that's what I
17 was talking about before, when you do this, the complete
18 metabolic panel, it includes uric acid. Uric acid is
19 buried in this whole panel and that uric acid is right
20 here. And really when we're looking for PIH, when we're
21 trying to make sure if somebody has a little elevated blood
22 pressure, we're trying to make sure that it's just an
23 elevated blood pressure and it's not PIH. Her uric acid is
24 entirely normal and then the other things - when I was
25 talking about the liver function test, that's the SGOT and

1 the SGPT and these values are 15 and 10 which are
2 absolutely normal as well. We're looking for the uric acid
3 to go up if there's a problem, and we're looking for the
4 liver function test to go up and they're normal reading
5 low, so that's reasonable.

6 Q Anything on the lab report here that we're looking at
7 that is concerning to you as a physician for this patient
8 that in your opinion requires intervention or treatment?

9 A No.

10 Q The next one -- well, it may be a copy of the same
11 one; so -- all right. Hematology urinalysis, what is a --
12 what is that? Hematology -- what's hematology?

13 A Hematology -- just blood.

14 Q And this is the CBC?

15 A Yes, this is the CBC.

16 Q Complete blood count.

17 A And this is looking at markers in her blood, and
18 again, what we're looking for here is this platelet count.

19 Q Is that normal?

20 A Two hundred and twenty-three thousand is normal.

21 Q Well, and you got some Ls there. What's L for?

22 A The Ls are -- suggest the hemoglobin, hemotocric, are
23 signs of anemia, which is -- actually normal in pregnancy,
24 actually -- there's something called delusional anemia
25 where every -- almost every pregnant woman will have sort

1 of a sudo-anemia. That's the way that -- way that -- when
2 a woman gets pregnant, what happens is, their overall blood
3 volume, particularly the plasma, sort of a liquid in the
4 blood, increases by up to 40 to 50 percent, but the red
5 cells only increase by maybe 20 to 30 percent, and it comes
6 back in sort of a relative anemia, although in fact, their
7 counts probably higher than they were when they weren't
8 pregnant. And so we see sort of -- we see sort of this
9 picture a lot, and typically I don't start doing anything -
10 - and usually what we do when somebody has a low
11 hemoglobin, start them on iron, and I typically don't start
12 people on iron until they are at least less than 10.

13 Q Okay. So any of those Ls on the blood property,
14 hemoglobin, hematacric, MCV, MCH, they're all low in your
15 opinion. Did that raise any concern that in your opinion
16 required any treatment or intervention?

17 A No.

18 Q All right. Down below there's a NEUT something 6.7.
19 I don't know if that's an H or what, but ---

20 A Yes, that looks like that ---

21 Q H high?

22 A Yes, the H is high, and I -- honestly, that looks like
23 that's some measure of neutrofil count.

24 Q What does that mean?

1 A That's one of the typical type of white blood cells in
2 your system, but it's not even -- you know, it's not
3 relevant. We don't even -- that's not what we're looking
4 at or worried about. I mean -- so we don't even -- we
5 don't even worry about that.

6 Q Dr. Miller, can an increased neutrafil count on a CBC
7 indicate the possibility or a potential of infection, sir?

8 A No, not with -- not with a normal white count, not
9 with -- a normal white count -- it -- no.

10 Q If you had an elevated white count and an elevated
11 neutrafil count, would you be more concerned about
12 potential of an infection?

13 A Possibly.

14 Q Does that elevated neutrafil indicate any infection?

15 A No.

16 Q All right. Underneath that on the same sheet -- and
17 it carries on to the next page I'll put up, and I apologize
18 for the holes be punched right through some words but
19 urinalysis. What is the urinalysis and what's that showing
20 us?

21 A Again, in this situation what we're most interested in
22 doing is we're looking for the protein in the urine, and
23 again this gets back to trying to decide between chronic
24 hypertension versus PIH or pregnancy induced hypertension.
25 When you start seeing protein in the urine, again that

1 suggest that the kidneys are becoming infect -- affected,
2 not infected, but affected, and that suggest that somebody
3 does have preeclampsia or toxemia and her protein count is
4 negative, so there's no protein in the urine whatsoever.

5 Q So when it says negative, is that good, bad ---

6 A That's very good.

7 Q Okay. Glucose, ketones, negative, negative. Is that
8 good or bad?

9 A That's -- that's all good.

10 Q All right. I don't know what that next word is.

11 Eurolegin (phonetic) ---

12 A -- malign, (phonetic) normal.

13 Q What is that?

14 A That's just one of the products that is dumped into
15 your urine. It has to do with your gall bladder and gall
16 bladder function. It's negative.

17 Q What's PH?

18 A PH is -- that's just the acid-based balance of the
19 urine, and that's normal.

20 Q Okay. Down here we've got on this urinalysis, WBC and
21 RBC with high. Correct?

22 A Right.

23 Q What does that tell you?

24 A The problem with most urine samples is what we call
25 clean-catch.

1 Q What is that?

2 A Most women don't really want us to stick a catheter
3 and get a urine sample, and so what we ask them to do is
4 they go to the restroom and they give a urine sample and
5 they clean off. Unfortunately, you know, what happens is -
6 - and most women have a lot more discharge when they're
7 pregnant, and that discharge is included or collected in
8 the urine sample itself, and so we'll see -- we'll see
9 sometimes white cells; we'll sometimes see red cells; we'll
10 sometimes see a little bacteria. That's not uncommon. The
11 urine squam suggest that it might be a contaminated
12 specimen meaning that, you know, it's not infectious.

13 Q Squamous cells are skin cells?

14 A (Indicating yes)

15 Q All right. Down here on the lab is chemistry. What
16 is -- what's that telling you?

17 A Well, this is actually -- if I'm not mistaken, this is
18 just a repeat of the other one that we looked at it,
19 without ---

20 Q Okay.

21 A --- things blocked out. Again, the urine acid being
22 four and normal. You can see the SGBT a little bit better,
23 10, which is low, but excellent, because we're worried
24 about it being elevated. You can see the SGOT which is 15

1 and normal, so this is actually just a copy of something we
2 looked it.

3 Q Okay. Thank you, sir. Will the nurses generate
4 electronically at Piedmont Hospital for your patients notes
5 from time to time?

6 A Yes, they will.

7 Q And they are contained in that exhibit that you've
8 reviewed?

9 A Yes.

10 Q I want to go through some of these, and what I'm
11 looking for, and the jury will have all these in evidence,
12 but what I'm asking you to look for with me, any recorded
13 blood pressures. All right, sir?

14 A Yes.

15 Q And if you would come, -- you came down and look at
16 those, whichever you'd like. It doesn't matter.

17 A Okay. It's probably easier.

18 Q All right, sir. And again this is a copy but 0051,
19 that's 51 minutes past midnight?

20 A Yes. See -- I would say the first blood pressure
21 that's recorded is 178 over 87.

22 Q And that's what you told us earlier.

23 A Yes.

24 Q All right. On that page do you see any other blood
25 pressures?

1 A No.

2 Q Okay. Any blood pressures on this document?

3 A No.

4 Q What about here?

5 A Again, the one that we saw before, the 178 over 87 and

6 now 143 over 83.

7 Q Okay. And that's at ---

8 A And that one's taken, looks like at 1:18.

9 Q There's another one at 1:20?

10 A One thirty and it's 130 over 74.

11 Q Are those normal, abnormal in any way?

12 A What I would -- you know, -- can I start -- I'm just

13 going to start from the top -- describe the top one first.

14 Q Yes, sir.

15 A Okay. First of all, it's not uncommon for us to see a

16 blood pressure that's elevated in somebody's in pain. You

17 know, -- and you can think about it, if you just hit your

18 finger with a hammer, it hurts, and your blood pressure

19 goes up in response to that. A lot of times with pregnant

20 what we'll see is we'll see just this. We'll see the

21 diastolic where the low number stays normal, and the

22 systolic will go up and see sort of a separation with pain.

23 Q Is the systolic the first number ---

24 A Is the top number.

25 Q And the diastolic is the second number?

1 A Is second number.

2 Q Okay.

3 A And so, when you first look at that, you know, our
4 impression is that's probably just from her coming in;
5 she's in pain. Her chief complaint is pain, not blood
6 pressure or any of the blood pressure -- other signs or
7 symptoms of blood pressure, but with her history of chronic
8 hypertension, you know, we -- that's her -- you know, in
9 some ways just in the back of your mind, say, okay, we
10 can't just assume that that's the problem; we need to, you
11 know, maybe investigate it. And so, you know, at that
12 point that's when we start saying, well, we need to do
13 serial blood pressures and we're going to go ahead and get
14 labs, and we're trying to do everything to make sure --
15 even though she came in for something separate, we want to
16 make sure that we're not picking up something that might be
17 going on and she doesn't realize that. So any -- any --
18 the way that we typically look it, the way it's defined is,
19 any blood pressure 140 over 90 and less is normal. Okay.
20 Any blood pressure that's -- if it's 141 to 150, the top
21 number 141 to 150, the next number is 91 to 100 is
22 considered to be mild hypertension, and it goes up in
23 increments of 10, but when you get to over 160 for the top
24 number and -- and it needs to be both -- and over 110 for
25 the bottom number, then that's considered to be severe

1 hypertension, and that's really the number that we start
2 worrying about when somebody has chronic hypertension.
3 We're starting to think, okay, now wait a second, is this
4 something serious, is this something more than just her
5 chronic hypertension. So when we're looking at these, you
6 know, 143 over 83 -- 83 is normal; technically 143 is a
7 little bit above 140. Okay, 131 over 74, both of those are
8 normal. The 146 is slightly elevated, consistent with her
9 chronic hypertension; the 72 is normal. The 160, this
10 one's a little bit high. The 98 is consistent with her
11 pre-existing hypertension. Okay. And, in fact, I think
12 it's -- yes -- it's at this point, you know, the nurse is
13 calling and I say, well, let me come in and, you know, --
14 you know, let me get up, let me come take a look at this
15 strip. So, you know, it's about 2:00 o'clock in the
16 morning and I'm coming by and, you know, so -- she's told
17 me -- you know what, this young lady came in with one
18 borderline blood pressure and she's saying -- she's got
19 another high one, and she's calling me and I said, okay,
20 well, I'm going to get up and come down and I'm going to
21 take a look at this. And so I got up and came down and
22 took a look at it, and I said at this point, said you know
23 what, we could have something else going on here, let's go
24 ahead and order the labs and the protein. The next blood
25 pressure 152 over 79. So again slightly elevated, normal;

1 118 over 66, both of those values are normal; 138 over 77,
2 both those values are normal; 123 over 66, both of those
3 values are normal; 120 over 61, both of those values are
4 normal; 136 over 76, both of those values are normal; 147
5 over 72, 147 borderline consistent with her chronic
6 hypertension and a 72 which is normal. And it looks like
7 the last one -- I don't see any here -- the last one is
8 here, 143 over 75, 143 slightly elevated and the 75 normal,
9 again, the 143 consistent with her chronic hypertension.

10 Q Let me read the annotation comments and just ask you a
11 moment about that. Patient given discharge instructions
12 and has an appointment with doctor on Monday, 8-9-08, 4:17
13 in the morning, Amy Martin, RN. Is that RN for nurse,
14 registered nurse?

15 A Yes.

16 Q And it's got some other things we're going to talk
17 about in a second, and then -- all right, well, that's it.
18 Okay, let me just look through the rest of the nurse's
19 annotations, and they also do OB progress notes. And the
20 blood pressures we see here are just repeated from those
21 we've already looked at. Would that be fair?

22 A Yes.

23 Q Just in a different format?

24 A Yes.

1 Q Okay. When the nurses discharge, would they discharge
2 a patient upon your orders, sir?

3 A Yes.

4 Q All right. Nursing discharge summary, would -- and
5 this would be pursuant to your orders.

6 A Yes.

7 Q It's got some things for labor, ruptured membranes,
8 vaginal bleeding, decreased fetal movement. Would you read
9 that, please?

10 A After eating complete meal, lie on your side, you
11 should feel 10 movements in two hours.

12 Q Okay. And that's got other things in there that are
13 instructed, and would the nurse being doing these
14 instructions ---

15 A Yes.

16 Q --- pursuant to your orders?

17 A Yes.

18 Q And the patient signs that.

19 A Yes.

20 Q Okay. Thank you, sir. If you'll please take the
21 stand.

22 A (Witness complies)

23 Q So according to the nursing record -- I was looking at
24 the time of discharge to see if it was on there -- the time

1 the document was printed was 3:55 in the morning. Does
2 that sound about the time that she would've gone home?

3 A Probably around 4:00 o'clock, yes.

4 Q You still on duty then?

5 A Yes, I am.

6 Q Okay. Did you have other patients that you would have
7 been responsible for, sir, besides Ms. Jamison, in addition
8 to her that day?

9 A I'm sure I did, yes.

10 Q Would it include like people, patients in various
11 stages of labor?

12 A Yes.

13 Q How many stages of labor are there?

14 A There's three stages of labor.

15 Q What are those stages?

16 A There is basically -- well, it's broken down different
17 ways. There's sort of -- there's sort of a latent labor,
18 active labor and we sort of base that on contractions and
19 cervical change.

20 Q How long typically do those various stages last?

21 A It varies for every single -- every single woman even
22 from one pregnancy to the next that they vary. It can last
23 anywhere from just couple of hours. It can last more than
24 24 hours.

1 Q You were able to see her again in the office on August
2 25, 2008. Correct?

3 A Yes.

4 Q I want to put this note up. Also having some -- put
5 the original, sir, in your hand. This is the original
6 office chart. It's been Joint Exhibit Number 2, and it'll
7 be right here, sir. This is the original chart. Here we
8 go. There's your -- oh, I forgot to do something. Hand me
9 those things right there.

10 A (Witness complies)

11 Q Back in the hospital you had ordered her to be on a
12 fetal monitor, and you may had some discussion with that.

13 A Yes.

14 Q What are these that the hospital brought over pursuant
15 to our subpoena with the August 9 admission records? What
16 are those?

17 A This is her fetal and uterine monitoring.

18 Q Okay. Could you come down here for a minute and let
19 me ask you to put any portion of those fetal monitor strips
20 on there to help explain to the jury what -- when they see
21 this in evidence what they're looking at.

22 A (Witness complies)

23 Q Is that line generated by ink in the machine -- looks
24 like the ink has been out.

25 A (No response)

1 Q Just kind of give us an idea what -- when they look at
2 this what we're looking at.

3 A Other way.

4 Q You want to use your pointer?

5 A I think I need my -- basically -- the bottom here is --
6 - that's looking for uterine activity. The top is looking
7 for fetal heart rate, and basically there's -- there's
8 several things we're looking at. We're trying to decide --
9 we break fetal strips into -- now -- in the last couple
10 years into three categories, category one, category two,
11 category three. It's a designation or distinction trying
12 to make it easier from one doctor one place to talk to
13 another doctor in another place so they can explain it to
14 each other, other than trying to go through all this, but
15 basically there's four -- when you're trying to look for a
16 reassuring or category one tracing, you're looking for four
17 things. You'd like to see the baseline, and I'm sorry,
18 that -- 120 -- you'd like to see the baseline somewhere
19 between 110 and 160, and that -- that's one of the first
20 signs you're going to look for. You'd like to see the
21 presence of accelerations. Okay? And accelerations are
22 these episodes where you see this heartbeat rise like this.
23 You see these mountains, acceleration here, acceleration
24 here, acceleration here, acceleration here, so you want to
25 see accelerations. Accelerations mean that basically when

1 the baby moves, the heart rate responds to it, and it's
2 like if any of us went out -- if we go out and do work in
3 the yard, and, you know, especially probably this weekend
4 when it gets hot, your heart rate goes up when you start
5 working. Babies do the same thing, and it's a sign that
6 the baby's in tact, that the baby's reassuring. You want
7 to see that. You also want to see that there's no
8 decelerations, variable decelerations or late
9 decelerations. And so typically when you're looking at
10 decelerations, you've got to look at contractions and where
11 these decelerations might occur with respect to
12 contractions, so we're going to say, here's a contraction
13 here. A late deceleration, if you look at the top of the
14 contraction, the -- what we'd see is we'd see the heart
15 rate go down here, and you'd see the very bottom of the
16 decel would be behind the top of the contraction. You
17 don't want to see those. In a reassuring tracing, that's
18 something that you don't want to see, and so that's the
19 third part of it. The last part is something we call beat-
20 to-beat variability, and that's probably the hardest thing
21 to see on this because of the focus, but beat-to-beat
22 variability is how well the baby's heartbeat is beating
23 from one beat to the next, and we know that that baby's
24 heartbeat should be -- that range is somewhere between six
25 and 25. Okay? And this baby has outstanding -- these

1 little outstanding beat-to-beat variability, anywhere from
2 six to 25 units, and right here this is 10 units, so this
3 baby -- this is a category one tracing to suggest that this
4 baby's absolutely fine at this time.

5 Q What if it's interpreted as a category two? What do
6 you call that?

7 A Um, a category two -- probably it's a little easier to
8 talk about a category three and then say category two
9 basically incorporates everything else.

10 Q Okay.

11 A A category three tracing has what we call repetitive
12 late decelerations, late deceleration, late deceleration,
13 late deceleration or has repetitive variable deceleration,
14 variable deceleration, variable deceleration, variable
15 deceleration or it has chronic bradycardia, the heart rate
16 drops and it is staying down, so it's less than that 110
17 and it's less than 110 for an extended period of time.
18 There is something called a sinusal pattern which might be
19 actually the worst thing that we can see of all, and it's a
20 tracing that just goes -- it's very flat; it just goes up
21 and down, up and down, up and down. And then lastly,
22 sometimes, you can see still have this pretty good beat-to-
23 beat variability, but you'll see occasionally the late
24 deceleration, variable deceleration. Those are -- those
25 are what you always -- when you look those, those are

1 things you're thinking, okay, this is category three.

2 Category two is everything else.

3 Q Is category three good, bad ---

4 A Category three's bad.

5 Q Okay.

6 A Category three says, you know, you need to do

7 something, you know, about it.

8 Q All right.

9 A A category two -- so it's everything in between. Now,
10 a category two typically -- the first thing that you're
11 going to do is you're going to do additional testing, so if
12 you get a non- -- if you get a non-stress test and you get
13 a category two, you're going to say there is some other
14 tests that we do; biophysical profile is probably the most
15 common one, and so you would do this study called
16 biophysical profile and that's when your ultrasonographer
17 scans the baby and is looking for certain things. They
18 look for the fluid volume around the baby, breathing
19 movements, tone, fetal movement and you actually -- each
20 one of those things maybe either scores or zero or two.
21 It's a simple test. So the total -- the best the baby can
22 get is a 10, because the last part of it is actually the
23 NST, but typically an eight or a 10 is considered to be
24 very, very reassuring with a biophysical. So if you get a
25 category two NST, you're going to do something else. Now,

1 you don't just stop just doing something else. Even if
2 this is a category two, you're going to do that, you're
3 going to do the next test, but then even if the next test
4 looks good, you're going to put this baby on a monitor for
5 an extended period of time. You're not just going to say,
6 well, that -- you know, the bio -- a good biophysical
7 trumps a suspicious NST. You're going to say, you know
8 what, we need to put you on a monitor; we're -- what we
9 usually do is we'd send somebody to labor and delivery, put
10 them on the monitor for a minimum of four to six hours to
11 watch. The other thing you do is that sometimes, sometimes
12 these patients are already in labor and delivery, but you
13 want to try and do some sort of non-invasive things to try
14 and help that baby. If you have a suspicious tracing,
15 there are some times you can do to help that baby. You
16 know, one is you can put oxygen on the mom. You know, and
17 it sort of makes sense. You know, if you're worried the
18 baby -- the baby's not getting enough oxygen currently, if
19 maybe increase mother's oxygen, then maybe she's going to
20 send a little bit more oxygen to the baby, something that's
21 going to help the baby. You also will have the mother
22 move, because, you know, babies sometimes lay on their
23 cord, on their umbilical cord, and so they don't get as
24 much blood supply, it's not working quite as well. So
25 you'll see, you know, we'll rotate moms around. Sometimes

1 we'll give them some fluid; we'll stick an IV in them and
2 giving them glucose; we're worried in that sense that they
3 might be dehydrated, so mom's blood vine's a little bit
4 low. If we can pump up that blood vine, increase that --
5 her pressure inside her blood, her blood vessels, maybe
6 that will help the baby. If the mom's in labor and we see
7 some of these -- and sometimes we do -- it might be because
8 we just gave her medicine because she was in pain, and so
9 we say, well, we can't give her anymore narcotics, because
10 we can't -- we can't be sure what's going on with the baby.
11 It might be we give a medicine that's designed to stop pre-
12 term labor, but sometimes that will sedate a baby, so we
13 have to be careful with that. So when you get a category
14 two, you're going to do additional testing first and
15 foremost, then you're going to do extended monitoring and
16 then you're going to try and do some of these sort of non-
17 invasive tricks to try and see if you can't get that strip
18 to improve.

19 Q Dr. Miller, these things, IV, turning the mother,
20 getting oxygen, extended monitoring, that's done in a
21 setting of a hospital labor and delivery room?

22 A Yes, absolutely.

23 Q Thank, sir. Do you know how to fold that back up?

24 A Yes, sir.

25 Q I'm afraid I'll tear it.

1 A Years of experience.

2 THE COURT - Is that one part of Joint Exhibit
3 Number 2?

4 MR. DAVIS - Yes, sir, it's part of Joint Exhibit
5 2.

6 THE COURT - I didn't know if it was a separate
7 exhibit that you pulled out.

8 MR. DAVIS - Thank you, Your Honor.

9 Q And just put them all -- those records. And let's put
10 all -- all those things together. And while you're doing
11 that, I want to turn to the Joint Exhibit Number 2, which
12 is your original office chart at Rock Hill OB, and I have
13 turned for you to the office note dated August 25 of 2008.
14 Is that your note?

15 A Yes, it is.

16 Q All right. Little fuzzy. Would you read HPI at the
17 top of the note for us, please, sir?

18 A HPI, patient comes into today for an evaluation.

19 Q All right, what does that mean?

20 A Looking at her chart, you know, the previous note one
21 of my partners saw her, Joe Robinson, we are having issues
22 with trying to establish her due date. What we consider
23 the best -- best way to establish somebody's due date is
24 when they have an accurate last menstrual period, and
25 somebody comes -- and a lot of women do. A lot of women,

1 you know, document when their last menstrual period is,
2 especially when they're trying to get pregnant. And so
3 that's what we like to use. After than, then ultrasounds
4 become our best way of trying to decide what -- how -- what
5 somebody's due date is. Now, ultrasounds between five and
6 11 weeks are the most accurate, so actually when the baby
7 is at its smallest, that's the best time to try and decide
8 and figure out exactly how far along a pregnancy is or a
9 baby is. And, in fact, it's within seven days accurate,
10 and so if I had a last menstrual period, a woman's last
11 menstrual period, and it said that her due date was today,
12 which is April 10th, but an ultrasound said that no it's not
13 today, it's actually April 12th or -- or excuse me -- it's
14 actually April 22nd or it's actually April 24th, we would say
15 the ultrasound's more accurate. Now, if I did an
16 ultrasound between 12 and 20 weeks, and so it's plus seven
17 days that the ultrasound's really accurate, between 12 and
18 20 weeks it's 10 days, okay, so, you know, -- and if it's
19 after -- if the patient comes in and our first ultrasound
20 is after 20 weeks, 20 to 24 weeks, it's close to two weeks.
21 And so as the patient gets further along, ultrasounds
22 become less accurate to determine gestational age. So when
23 -- when Dr. Robinson -- when she was first seen, and I
24 think her prenatal care -- I think it started out at North
25 Central ---

1 Q Yes, sir.

2 A --- she gave them one due date or one last menstrual
3 period, and she gave us another last menstrual period, and
4 they were off by maybe three or four weeks, and so that
5 made it hard for us know and she started her prenatal care
6 late. You know, most women will start their prenatal care
7 anywhere from six to 12 weeks, and I think we were
8 starting, you know, well after 20 weeks maybe. I think her
9 first ultrasound was around 24 -- by the best of our
10 judgment 24, 25 weeks. So Dr. Robinson -- when we -- when
11 we have somebody that starts late, we get an ultrasound,
12 but we want to try and confirm that maybe that ultrasound's
13 accurate, so we do one ultrasound, then we try to get
14 another ultrasound and so then hopefully they sort of
15 agree. So she was coming in -- for me, she was coming in
16 to have a -- just a regular visit but also to get that
17 second sort of ultrasound to try and hopefully improve our
18 knowledge of her dates.

19 Q Okay. Did you do an ultrasound that day?

20 A Yes, sir.

21 Q Could you find that for us in your chart?

22 A Yes.

23 Q Okay. It's kind of fuzzy, but can you see that okay?

24 A Yes.

1 Q I can get it zoomed up a little bit. So that's 8-25-
2 2008.

3 A Yes.

4 Q Average USGA. What does that mean?

5 A The gestational age based on this particular
6 ultrasound says that her -- her -- she's 28 weeks and one
7 day at this point.

8 Q Okay. And it's got a EDD. What is a EDD?

9 A That's estimated date of confinement or when based on
10 this ultrasound we expect her to deliver.

11 Q Okay. And it's got a lot of numbers.

12 A Yes.

13 Q Did you actually look at the film and the numbers?

14 A You know, I didn't look at the film. I looked at the
15 numbers.

16 Q Is this the film that's in the evidence here?

17 A Yes.

18 Q How many little photos are there?

19 A There's five.

20 Q Okay. And who does the ultrasounds in your office?

21 A We have two certified ultrasonography technicians.

22 Q Jane McCain one of them?

23 A Yes, she is.

24 Q Okay. And why did you order this ultrasound?

1 A Again, we're trying to establish -- we're sort of
2 playing catch-up. We don't have a real -- we don't have a
3 good due date. Establishing a due date is important to us,
4 and we're trying to establish a due date, so this is the
5 second ultrasound in a series trying to -- trying to give
6 us more information of how far along she is.

7 Q There's something that's signed by Julie or looks like
8 Julie.

9 A Yes.

10 Q Is that one of your technicians?

11 A Yes.

12 Q Can you read what she has written there and let me ask
13 you about it?

14 A Yes. Vertex ---

15 Q What does that mean?

16 A --- meaning the baby is head down. Decrease AFI,
17 which is amniotic fluid index of nine.

18 Q Does that mean it's low?

19 A It's normal, but she's saying that, you know, based --
20 it's -- anything over five basically we -- is normal.

21 Anything over 25 is too high. Anything less than five is
22 too low. Anything between five and 25 is normal. This is
23 normal.

24 Q Well, why the number down AFI, not if it's normal?

1 A Well, I think that -- you know, what we're always
2 trying to do -- you know, she's probably looked at the
3 chart and knows that we're trying to figure out dates, and
4 this lady has -- you know, some hypertension -- some
5 hypertension and so she's saying, well, even though it's
6 normal, she wants to just make -- make us aware to keep an
7 eye on that AFI number of nine.

8 Q Okay. AC behind two weeks?

9 A Yes.

10 Q What does that mean?

11 A Abdominal circumference behind two weeks from previous
12 scan.

13 Q Does that mean this baby is IUGR, intrauterine growth
14 restricted or growth retarded?

15 A No, this baby is not IUGR.

16 Q Why can you say -- how can you that if the abdominal
17 circumference is lagging behind by two weeks, sir?

18 A Well, in fact, if you really -- if you look down a
19 little bit closer, abdominal circumference -- and when you
20 look at the composite size of the baby, 28 weeks and one
21 day, the abdominal circumference is only 27, so it's really
22 -- it's really closer to one week than it is two weeks.
23 And if you look at the abdominal circumference number and
24 this -- this gets to the fact that, you know, ultrasounds
25 are good looking at structure, but not necessarily

1 establishing dates, but the abdominal circumference here --
2 and I'm sorry, I might be in the way, but it says 27 weeks
3 -- it says plus minus 15 days, and so that's sort of the
4 accuracy of the ultrasound at this -- at this gestation, so
5 -- so the abdominal circumference possibly was a little bit
6 -- a little bit small but still appropriate, and, you know,
7 there's other -- you know, IUGR is by definition a baby
8 who's what we call less than 10th percentile. So if you
9 took a hundred babies born in York County, and you said,
10 okay, the biggest baby is number 100, and the smallest baby
11 is number one, IUGR, intrauterine growth retardation
12 represents those bottom 10 babies, and even when you see
13 those bottom 10 babies, some of those babies are not IUGR.
14 They're just what we call S -- sorry, a lot of initials --
15 but SGA and small for gestation. They're just babies that
16 are designed to be small. They're genetically -- they're
17 going to be small. There's actually no growth retardation
18 going on, but IUGR by definition is less than 10th
19 percentile, and this lady -- and I asked -- I think asked
20 my ultrasonographer to compute. This lady's actual
21 percentage was twenty-seventh percentile. And twenty-
22 seventh -- and so this baby is a small baby, but then you
23 take a look back, and if you look back at her history, and
24 we've got her history and she's -- she's never delivered a
25 baby with us, but her history is that she's had a 40 week

1 baby, a 40 week baby and a 38 week baby and these babies
2 are six two, five eleven, five thirteen. Genetically she
3 just -- she's somebody who has small babies. She would
4 shock me if she came up with an eight-pound baby, so a 27th
5 percentile in my mind is entirely in line with historically
6 the size baby that she has.

7 Q And would that be something that you would've
8 considered at the time, her delivery history?

9 A Oh, yes, absolutely.

10 Q Is it appropriate for you to have done so?

11 A Yes.

12 Q All right. So the last thing that is written here is
13 NL dopplers. What does that mean?

14 A Normal dopplers. And so Julie is doing -- you know,
15 we talk about the NST, if you have a -- you know, a
16 category two NST you're going to do additional testing.
17 Julie's trying just to make sure and we're trying to make
18 sure that there's nothing wrong, and in this situation when
19 you're looking at IUGR or preeclampsia, the best test at
20 this point in this situation is to do a doppler study.
21 Now, a doppler study is looking at the umbilical artery and
22 it's looking at blood flow through the umbilical artery and
23 the way the umbilical artery works, the umbilical artery is
24 actually taking blood away from the baby and distributing
25 to the placenta. And when you look at dopplers, you're

1 looking at what's called -- what we call the systolic flow
2 and the diastolic flow and you're comparing it to them.
3 The systolic is when the heart is beating, so when the
4 heart beats, there's a certain amount of flow, there's a
5 certain amount of pressure, certain amount of flow going in
6 that direction to the placenta. When the heart's not
7 beating, when the baby's heart's not beating, there's still
8 flow going in that direction, and that's a good sign.
9 Okay, that means that there's plenty of flow going to the
10 placenta, that blood goes to the placenta, it gets mixed in
11 the placenta, all the bad things in the blood, all the
12 waste products from the baby, basically the mom's now going
13 to take out the trash for me. It's -- she's going to
14 eliminate all this stuff. So doppler studies are a measure
15 of how well the flow is running through those umbilical
16 vessels and this is normal. We get -- when we do a
17 doppler study -- so, you know, and it's not just looking at
18 that -- this ratio. We're looking at not only a ratio, but
19 if that ratio is abnormal, the next step -- and these two
20 things are more important than the doppler study, the next
21 step is what we call absent end diastolic flow. That baby
22 -- as the baby gets older -- okay -- there's actually more
23 flow going to the placenta as the pregnancy goes and gets
24 older. When the baby's heart rate -- when the baby's heart
25 is resting, diastolic, so when the baby's heart rate is

1 resting, there's actually more flow as the baby gets older.
2 Okay? A problem is is when we see them called absent end
3 diastolic flow. When we see that -- in fact, there is flow
4 going when the baby's heart rate is beating, but there's no
5 flow going when the baby's heart rate is resting, and
6 that's a worrisome thing. As a matter of fact, basically
7 if you see that and you have a baby that's 34 weeks or
8 beyond, you're going to probably try and deliver that baby,
9 because you realize that that placenta is damaged and it's
10 probably not going to -- it's not going to get any better,
11 it's going to get worse, and you're going to go ahead --
12 and you feel like the safest thing is to deliver that baby.
13 The even worst thing is something we call reversal of flow.
14 And so, you know, we talk about when the heart rate's
15 beating, flow is happening. When the heart's resting, flow
16 should be happening. The heart's resting and now we see no
17 flow. That's not good. But if the heart's resting and you
18 actually see flow coming back, that's really bad, and, in
19 fact, you know, if a baby has absent end diastolic flow, 34
20 weeks and beyond, we're going to probably work toward
21 delivery. That number is at around 28 weeks. If we see
22 reversal of flow, there's a good chance -- we're going to
23 work to try to deliver that baby, because we realize that
24 placenta is really in trouble. This lady didn't have any

1 of those things. I mean she -- she had none of those
2 things. This is a very reassuring test.

3 Q Back to your notes, sir, ultrasound today shows vertex
4 presentation and decreased AFI of nine. We've talked about
5 that. She had normal doppler studies. We have talked
6 about that. The abdominal circumference is slightly behind
7 at two weeks. We've talked about that. However, because
8 of the slightly diminished amniotic fluid index, this could
9 be cause for decreased abdominal circumference. That's
10 your note. Right?

11 A Yes, it is.

12 Q Was that recording your thinking at the time?

13 A Yes.

14 Q The next paragraph, the patient complains of some
15 swelling around her left ankle moreso than her right ankle
16 and we talked about that today. Let me ask you this, Dr.
17 Miller. When a patient comes in as Ms. Jamison, as any
18 patient would come in for a regularly scheduled appointment
19 on a day like this, do you have a practice of asking the
20 patient how they're doing?

21 A Oh, absolutely.

22 Q Tell the jury what your routine is.

23 A Well, you know, first of all, if a patient has a
24 complaint, you know, my job is to address that complaint.
25 And, you know, Ms. Jamison did have a complaint on that

1 day, and that's decreased swelling (sic). What we also
2 have -- probably the most important thing we do is we ask
3 is anything wrong with your pregnancy, are you -- any
4 problems, and then we always asks -- and there's actually a
5 little box in the chart, how's your baby doing, and that's
6 -- I say that every single time. I've said that ten
7 thousand - how's your baby doing. And if a woman says, my
8 baby's doing fine, she gets a check, and there's a check in
9 her box. When I asked her how her baby's doing ---

10 Q Where is that?

11 A --- and she said -- and she said that's fine.

12 Q Show that to us, the check in the box.

13 A (Witness complies)

14 Q And this is from the original chart?

15 A This is the original chart and so it's the check right
16 here, under activity.

17 Q Okay. Right here?

18 A Right here.

19 Q Okay. Thank you. And that's on ---

20 A That's on 8-25.

21 Q Eight, twenty-five, the third activity is checked, and
22 that means what now?

23 A That means I've asked her, how's your baby doing, and
24 she told me the baby's doing fine. And -- you know, and
25 it's important because you can look at that and you can

1 look at my note and my note describes, you know, her main
2 complaint was, you know, I had some swelling in my ankle,
3 and that's what I listed. You know, we put a check there.
4 The first thing that happens when a patient comes in our
5 office is the first person they see is a nurse, and
6 particularly if they come in for a non-scheduled visit, the
7 nurse says, you know, Ms. XYZ, what's your problem. And
8 the first thing that happens in that chart is that nurse
9 makes a little notation for the doctor. Okay? There's no
10 notation because her only complaint -- she didn't tell the
11 nurse of the complaint; she just told me the complaint.
12 But you can -- you can look at the very next note. Okay?
13 The very next note is the next -- is the next visit on
14 September 5th, and this decreased fetal movement, decrease
15 arrow down, FM, that's the nurse notation; she came in the
16 next time and saw Dr. Hilton that she was complaining of
17 decreased fetal movement, so she did not complain of that
18 when I saw her. She did complain of it when Dr. Hilton saw
19 her. And Dr. Hilton then did the appropriate thing, she
20 said, okay, what we typically do, if somebody complains of
21 decreased fetal movement, she took it very seriously; she
22 said, let's get an NST, and that's the first thing that we
23 do. She did the NST. The NST was that category two we
24 talked about. And the category two is what we describe as
25 indeterminate. So she said, listen, I've got an

1 indeterminate finding, it's not telling me that the baby's
2 doing well, it's not telling me the baby's doing bad, I
3 need to do more. And again, the next thing that we do is
4 we additional testing. She did the biophysical, and after
5 that she wanted to send the patient over to labor and
6 delivery to do extended monitoring and potentially even
7 deliver. So, you know, -- so, when Ms. Jamison came in the
8 next time, she did have that complaint of decreased fetal
9 movement. She did not have that complaint when I saw her.

10 Q You mentioned just a moment ago that Dr. Hilton saw
11 her and ordered the NST. I want you to assume for the sake
12 of the question that your nurse practitioner Robin Pruitt
13 initially saw her on 9-5. Would that change anything you
14 said about ---

15 A No, no. You know, in that situation when somebody
16 comes in as sort of a walk-in ---

17 Q Yes, sir.

18 A --- you know, they'll sign -- there's a sign-in list;
19 they'll sign in.

20 Q Yes, sir.

21 A And basically, you know, we're going to -- we're going
22 to triage that patient, you know, to the first available
23 person that can see them. And Robin's an excellent nurse
24 practitioner.

1 Q Well, does she have the training and the licenser and
2 authority to order on her own a non-stress test?

3 A Yes, she does.

4 Q Does she have the ability, training and authority to
5 interpret that non-stress test?

6 A Yes, she does.

7 Q Does she also have the training, experience, knowledge
8 and authority in the office to then order the patient to be
9 evaluated by a physician and to order a biophysical
10 profile?

11 A Yes.

12 Q So if she had done all those things, would she have
13 been authorized and trained and experienced to have done
14 that?

15 A Absolutely.

16 Q All right. Well, let's look back at your note, and
17 you've got PE. What does PE stand for?

18 A PE stands for physical exam. It also stands for
19 pulmonary embolism, but physical exam.

20 Q Okay. And ---

21 A And so, you know, again -- so the patient comes in,
22 she has not complained of decreased fetal movement. That's
23 been -- not documented by the nurse and it's been
24 documented by me that the baby's fine ---

25 Q Okay.

1 A --- what she's telling me. She has complained of this
2 swelling in her left and ankle, and that's one -- you know,
3 pregnant women swell. Anybody who's been pregnant knows
4 it; anybody who's had a wife knows it, they swell.

5 Q Why?

6 A It's because -- what we believe is in the process of
7 building a placenta and building a baby, a lot of pregnant
8 women's protein requirements go to that process of those
9 building -- and so their protein in their blood stream is
10 lower and because it's lower, their -- you know, it's
11 something called oncotic pressure, but it helps keep fluid
12 in your bloodstream as you decrease that fluid -- protein
13 and fluid's able to leak out a little bit and that's what
14 happens. But the one thing we want to worry about is
15 what's called a DVT or a deep venous thrombosis, because
16 pregnant women are also at higher risk for Dots or deep
17 venous thrombosis, and that's a dangerous thing, so again,
18 when somebody comes in with a complaint, we want to address
19 that complaint. And in this situation she came in saying,
20 you know, I have some swelling in my left ankle.

21 Q That was her complaint that day.

22 A That was her complaint that day.

23 Q Right.

24 A And so on a physical exam, you know, what we're going
25 is we're looking -- we're looking predominantly in the

1 calf. Okay? And we're comparing one calf to the other,
2 size of the calf. And then what we also do is we flex the
3 ankle and then we hit on the palm or the base of the foot,
4 and that's called a honing sign, and what -- and flexing
5 the ankle and hitting on the base of the foot, if somebody
6 has a clot in their leg, that clot is basically a vein that
7 has flood that's collected, that's clotted, and now -- and
8 it hurts because it starts to irritate the surrounding
9 skin, or excuse me, the surrounding muscle. When you flex
10 the ankle, you're putting that muscle on stretch, you're
11 putting more pressure on that clot, and when you hit on the
12 base of the heel, you're also stimulating -- if there's a
13 clot -- you're trying to elicit pain. We -- hopefully
14 you're not going to have pain, but you're trying to see if
15 there's pain. And if somebody says, ouch, you know, that
16 really hurts, then your index or worry for their being a
17 blood clot in your leg goes up.

18 Q Then what do you do?

19 A Then you -- then you actually order Doppler studies of
20 the calf.

21 Q Did she have that pain when you did that sign?

22 A No, she did not.

23 Q Okay. What did you -- you've got assessment. Tell
24 the jury what an assessment -- what do you mean by that?

1 A Well, you know, in this situation, an assessment, I'm
2 trying to pull together, you know, everything that we've
3 done that day and in some ways I'm trying to do it for
4 myself just to organize my thoughts, but I'm also trying to
5 organize my thoughts for the next person that sees her so
6 they can say, well, you know, why -- why did he do this,
7 why did he - oh, well, because she complained of that.
8 Okay? And so you're sort of trying to, you know, not only
9 organize your thoughts for that day, but you're trying to,
10 you know, set the stage for the next person -- they can see
11 what you're thinking. So, you know, history of uterine
12 rupture, decreased AFI at nine.

13 Q Talked about that.

14 A Possibly lagging abdominal circumference.

15 Q Talked about that.

16 A And swelling in the left ankle.

17 Q All right. And you talked about that. Now, what's
18 your plan? What is your plan here that you recorded?

19 A My plan was to go ahead and start doing kick counts,
20 increasing fluid intake, be careful and watch the swelling
21 in your left ankle and if it continued to increase,
22 especially the extent of the calf or begins to develop calf
23 pain to let us know immediately.

24 Q Why immediately?

1 A Because, you know, even though on the exam that I --
2 the day that I saw her my exam was negative, you know, who
3 knows, maybe the next day or the next day or the next day
4 that exam becomes positive, that maybe she didn't have a
5 blood clot on the day that I saw her that we could
6 identify, but I wanted to make sure that if this continued
7 to bother her, that she knew that -- just -- you know,
8 because sometimes people think, well, the doctor said I'm
9 fine this day, so I'm fine, and then three weeks later
10 said, well, I saw the doctor three weeks ago, so I didn't -
11 - don't -- I wasn't worried about it, and I wanted to let
12 her know that, no, deep venous thrombosis, Dots are
13 dangerous and just because on the day I saw her it wasn't
14 there, it doesn't mean two or three days later it couldn't
15 be there.

16 Q And you want to know immediately if that changed.

17 A Yes.

18 Q Explain to the jury, sir, what you tell any patient
19 that you recommend start doing kick counts. How --
20 assuming they -- it's their first pregnancy and they don't
21 know what you mean, how do you describe and explain it to
22 your patients including Ms. Jamison what you mean by doing
23 that?

24 A Well, I describe it the same way, and I've been doing
25 it the same way probably since my residency.

1 Q How long ago was that?

2 A A long time.

3 Q Okay. We'll leave it at that.

4 A 1993 is when I finished.

5 Q A long time.

6 A Long time. Twenty years. But -- and I try to tell
7 everybody, every single patient; I don't care if somebody's
8 had two or three babies; I say do your kick counts. And I
9 start -- and I usually try to -- if I see that patient
10 between 28 to 30 weeks, that's sort of when I start trying
11 to tell them. And kick counts are -- you need to pick a
12 time a day where you know your baby tends to be active.
13 Now, studies have shown -- and I tell patients -- most
14 babies are active between 9:00 o'clock in the evening and
15 1:00 o'clock in the morning. And say what I want you to do
16 is I want you to put your hand on your tummy and I want you
17 to count the movements. The baby needs to make 10
18 movements in two hours. Hiccups count. Big movements
19 count; small movements count. If the baby does it in five
20 minutes one day but an hour and 20 minutes the next day,
21 doesn't mean something's wrong the second day. It just
22 means you might've caught the baby in a sleep cycle, but
23 you need to do this everyday. I say if the baby fails --
24 if you do it and your baby doesn't make 10 movements in two
25 hours, then I want you to eat something and I want you to

1 do it again. If the baby fails a second time, you've got
2 to call us. And I tell everybody the same thing, and I've
3 -- anybody that's ever -- they would know. They've heard
4 that before.

5 Q How do you know your patient understands what you're
6 saying?

7 A Well, they're paying attention. They want to hear --
8 they want to know. At least -- patients are interested in
9 knowing what we have to say. And they're vested in this.
10 This is important to them.

11 Q Doctor, what was her estimated gestational date when
12 you saw her on August 25, 2008?

13 A You know, we were estimating somewhere 29 to 30 weeks
14 at that point.

15 Q Why at 29 and 30 weeks do you tell Ms. Jamison start
16 doing kick counts? Why?

17 A In my residency that's the way we were taught, that's
18 what you do. At that point a mother should feel that baby
19 every day. Before that -- sometimes it's sporadic;
20 sometimes they might not, but at that day -- and
21 unfortunately 20 years ago, 28 weeks was really sort of an
22 important time. Before 28 weeks science and technology,
23 medicine wasn't quite as good. Those babies often didn't
24 do well. At that point, 28 weeks, we knew babies did well,
25 and we knew those kick counts really were important. But

1 that -- I was trained to start doing those at 28 to 30
2 weeks.

3 THE COURT - Can the witness resume the ---

4 MR. DAVIS - Oh, yes. Thank you very much. Yes,
5 sir.

6 Q Please have a seat.

7 MR. DAVIS - Thank you, Judge.

8 Q Dr. Miller, you didn't order a non-stress test.

9 A No, it was not indicated.

10 Q Why was it not indicated, sir?

11 A When I saw her on August 25th, every study, every
12 analysis, everything that we did was entirely normal. It
13 starts from her blood pressure's normal, she had gained
14 weight. She had told me her baby was moving well. Her
15 fundal height measure, reasonable; her urinalysis was
16 negative; she had an ultrasound that showed that she had a
17 baby who was the proper size for her. Her amniotic fluid
18 index no matter how you measured it, whether you measure -
19 - what we call the amniotic fluid index, which is -- in
20 this way the way we did it, we basically take the mother's
21 tummy and we make it in four quadrants with the belly
22 button being the center, and they measure the fluid in each
23 four of those quadrants and they add it up. Nine point
24 four two is appropriate. The other really accepted way of
25 doing this is doing what they call single deep pocket

1 measurement. And the single deep pocket measurement means
2 you only measure the deepest pocket, and there needs to be
3 at least two centimeters in depth and all of her -- she had
4 three out of four pockets were measured. One was 4.42; the
5 other was 2.69; the other was 2.31. She had three single
6 deep pocket measurements over two. So she had an AFI that
7 was normal, and she even had doppler studies normal. And
8 it's important to know that dopplers precede fetal heart
9 rate. What I mean by that is, when you're doing testing,
10 and particularly for IUGR and preeclampsia, the doppler
11 study is going to turn abnormal before you fetal heart rate
12 will turn abnormal. With a normal doppler study, normal
13 AFI, there was no indication of doing an NST or anything
14 further.

15 Q Did the standard of care in your opinion require you
16 to perform a non-stress test on Ms. Jamison on August 25,
17 2009 (sic), sir?

18 A No, it did not.

19 Q Doctor, she was a high risk patient. True?

20 A Yes, she was.

21 Q Why was she a high risk patient?

22 A She was a high risk, uterine rupture -- I think it was
23 her last pregnancy. She had elected to terminate a baby at
24 16 weeks.

25 MR. BOYD - Objection, Your Honor.

1 THE COURT - Sustained.

2 Q She had uterine rupture.

3 A And there was a uterine rupture in that process.

4 MR. BOYD - Your Honor, may we approach?

5 THE COURT - Yes, sir.

6 (Bench conference was held in the presence of the
7 jury but out of the hearing of the jury, which was not
8 reported.)

9 THE COURT - All right, ladies and gentlemen, you
10 will disregard the last answer of the witness. It's not
11 part of this record. Thank you very much. Move on.

12 Q What made her high risk, Doctor, was prior uterine
13 rupture.

14 A She had a uterine rupture.

15 Q High blood pressure.

16 A There was -- well, in medical history, chronic
17 hypertension at least one of the things we're concerned
18 about.

19 Q Okay.

20 A She was a smoker. She had a history of herpes. And
21 so when the pregnancy started, those were the issues going
22 forward.

23 Q Okay. Well, she was high risk. Didn't that put her,
24 sir, in your opinion in the category of needing to do an
25 NST on August 25?

1 A No.

2 Q Why not?

3 A She had -- actually everything that she had done on
4 that day was normal.

5 Q Okay. What was your plan for her?

6 A My plan was for her to come back in in two weeks and
7 have the AFI rechecked as well -- and actually check the
8 baby's size at that time. And it was also -- you know, we
9 talked about doing the kick counts and we talked about
10 asking her to drink more, and, you know, sometimes if --
11 you know, one way to try and manage an AFI and we always
12 try to do things as non-invasive as possible, but one way
13 is, when somebody has an AFI, you can ask them to drink
14 more, and that does sometimes seem to improve the amount of
15 amniotic fluid. Amniotic fluid is basically the baby's --
16 the baby urinating, and it's a balance between the baby
17 urinating and the baby swallowing. Okay? And if the
18 baby's getting a lot of profusion, you know, if the
19 placenta's working well, and is well perfused, then the
20 feeling is that, you know, the potentially the baby will
21 increase their urine output and you can increase their AFI.
22 And, in fact, her AFI did go up. It went from 9.42 to the
23 next visit it was over 14.

24 Q Was that a good thing or a bad thing?

25 A That's a good thing.

1 Q Okay. Doctor, in looking at your care provided when
2 you were on call for labor and delivery August 9, do you
3 feel that you did anything that was below the standard of
4 care in the care and treatment of Ms. Jamison in that short
5 hospitalization?

6 A No.

7 Q On August 25 do you feel or think that you did
8 anything that was below the standard of care in your
9 examination and evaluation and care and treatment of her
10 that day, August 25, in the office?

11 A No.

12 MR. DAVIS - One moment, please, Your Honor.

13 THE COURT - Yes, sir.

14 MR. DAVIS - Thank you, sir. Answer any questions
15 either of these gentlemen may have, sir.

16 THE COURT - Cross examination.

17 CROSS EXAMINATION

18 BY MR. BOYD -

19 Q Good morning, Dr. Miller.

20 A Good morning.

21 Q Dr. Miller, on August the 9th I believe you testified
22 you were on call. Is that correct?

23 A Yes.

24 Q At the hospital.

25 A Yes.

1 Q And when you saw Ms. Jamison at that time, did you
2 have knowledge at that time that she was also a patient in
3 your practice?

4 A Yes.

5 Q Okay. And so she came in during the night. Is that
6 correct?

7 A Yes.

8 Q Okay. And she was concerned about the abdominal pain.
9 Is that correct?

10 A Yes, it is.

11 Q Okay. Did you -- and I understand you ran certain
12 tests. Did you determine a cause of the abdominal pain at
13 that time?

14 A Yes. The abdominal pain -- you know, at this point in
15 a pregnancy, it's not uncommon for somebody to have what we
16 call Braxton Hicks contractions, which are contractions,
17 but they're not contractions that lead to labor or
18 delivery.

19 Q All right. The -- and you were -- at that time you
20 noted also that she had high blood pressure and she had a
21 history of that. Is that correct?

22 A She had a history of chronic hypertension at least
23 detailed initially in our note, yes.

24 Q Okay. And the -- that was something that your pract -
25 -- had you seen her previously to that date?

1 A I had not seen her previous to that day.

2 Q So did you have the office chart available to you
3 while you were at the hospital?

4 A Yes.

5 Q Okay. And she was on -- I believe you testified she
6 was on medicine for the high blood pressure. Is that
7 correct?

8 A Yes.

9 Q That had been prescribed your office. Is that
10 correct?

11 A Yes.

12 Q And that medication I believe you testified earlier it
13 was not affective in controlling the high blood pressure.
14 Is that correct?

15 A No, I did not testify to that.

16 Q I thought you said that, but ---

17 A No.

18 Q --- you may correct me. Was it affective?

19 A Yes.

20 Q Okay. And she was having -- your test I believe
21 showed there was blood pressure checked during the course
22 of her visit on August the 9th. Is that correct?

23 A That is correct.

24 Q Okay. And when she left, the last blood pressure
25 reading was 143 over 75.

1 A Yes.

2 Q Okay. And is that -- the first number is that

3 slightly elevated?

4 A Yes, the first number -- it's slightly elevated for

5 somebody who doesn't have hypertension.

6 Q Now, you -- you were concerned at that time upon her

7 initial visit. You wanted to rule out preeclampsia. Is

8 that correct?

9 A Yes.

10 Q And just tell us what preeclampsia is.

11 A Preeclampsia is a condition, pregnancy induced

12 hypertension toxemia where we'll see the blood pressure

13 elevate with other possible things, laboratory evaluations,

14 liver function tests will go up, platelet count will go

15 down, uric acid will go up; we'll see protein in the urine

16 and that's in a nutshell preeclampsia.

17 Q The -- so basically there's two issues you're dealing

18 with at the hospital; one is the pain she was having.

19 A Yes.

20 Q And the other is the blood pressure, which you happen

21 to find. Is that correct?

22 A Yes.

23 Q And with someone with hypertension or high blood

24 pressure, they don't necessarily feel or know that they're

25 having that.

1 A No, they don't.

2 Q I mean I could have it right now and not even feel it
3 or know it.

4 A That's correct.

5 Q And that's why it's important that that be checked
6 periodically if you have an inclination to have that.

7 A That's correct.

8 Q The -- so that -- again, that's no something she would
9 necessarily know she has at the time.

10 A That's correct.

11 Q Now, the -- and again, she was having the high blood
12 pressure on that day. She was already on medication
13 prescribed by your office for the high blood pressure. Is
14 that correct?

15 A Most of those blood pressures on that day were not
16 elevated.

17 Q Okay, but I -- but you found -- and that was a concern
18 of yours. Is that correct?

19 A I wanted to make sure there was no evidence of toxemia
20 or preeclampsia.

21 Q Right. And so the -- even though -- some of them were
22 normal; some of them were elevated. Is that correct?

23 A The majority of those were actually what I considered
24 normal. You know, I want to see both those numbers
25 elevated to document that one is considered to be abnormal.

1 Q And my question was, she was already on high blood
2 pressure medication.

3 A She was put on Aldomet, I think, by Dr. -- by Dr.
4 Robinson.

5 Q Okay, who is with your practice.

6 A Yes. Oh, I'm sorry. I take that back. She was put
7 on Aldomet by -- I'm looking at the chart here -- by Dr.
8 Taylor on July 28th.

9 Q So -- and he is with your practice. Is that correct?

10 A Yes, he is.

11 Q Okay. And that is a medication for high blood
12 pressure. Is that correct?

13 A That is correct.

14 Q Now, so -- now, the next visit -- I'm sorry -- next
15 visit -- but you actually saw her in the office as part of
16 a regularly scheduled visit on August 25th, 2008.

17 A That's correct.

18 Q Now, the -- during pregnancy, is it the practice of
19 your office that different physicians see a patient who is
20 undergoing a pregnancy?

21 A Yes.

22 Q Okay. And basically the -- you really don't know
23 whose going to end up doing the delivery. Is that correct?

24 A That's correct.

1 Q So the different physicians all see -- the patient may
2 see any particular physician during -- at a practice. Is
3 that right?

4 A That's true.

5 Q Okay. And basically as part of what you do, you keep
6 records of each visit. Is that correct?

7 A Yes.

8 Q And you keep records of the tests you do, your
9 impressions. Is that correct?

10 A That's correct.

11 Q Okay. Because basically the physician who next sees
12 the patient needs to have a record of what the last
13 physician found and did. Is that correct?

14 A Yes.

15 Q Okay. And not only that physician, you see a lot of
16 patients in your practice. Is that correct?

17 A Yes, we do.

18 Q Okay. So you need -- even if you're the doctor seeing
19 a patient next, you need to have a record of what you did
20 last time because you're not going to necessarily remember
21 what you did last time. Would that be fair to say?

22 A We always try to record everything.

23 Q So it's very important to keep a accurate record of
24 what you've done.

25 A Yes.

1 Q Now, on August the 9th you were concerned -- your
2 initial -- you were concerned about preeclampsia. Is that
3 correct?

4 A I want to -- you know, we knew -- or -- she had
5 chronic hypertension, and we wanted to make sure that she
6 did not have preeclampsia developing also.

7 Q And preeclampsia is a very serious condition. Is that
8 correct?

9 A It can be, yes.

10 Q And basically you determine in the course of your --
11 that August the 25th that she wasn't -- did not have
12 preeclampsia. Is that correct?

13 A That's correct.

14 Q Okay. But that was something you wanted to rule out
15 at that time. Is that correct?

16 A Yes, it is.

17 Q Because basically as part of the differential
18 diagnosis, you want to rule out the most serious
19 possibilities. Is that correct?

20 A We want to try and evaluate the patient and decide
21 what's going on with the patient at that time.

22 Q Exactly. And you want to rule out anything that could
23 be serious. Is that correct?

24 A We're trying to evaluate the patient for, you know,
25 things that are serious. At times you can't rule

1 everything out. You know, everything has risks and you
2 can't rule everything out all the time.

3 Q Okay. But if there's a serious condition you
4 certainly want to try to rule that out if possible or if
5 they have it, you want to find out if they have it and
6 treat it. Would that be fair to say?

7 A If it -- I'm sorry. Can you say that again.

8 Q Yes. If there's a potential serious condition, you
9 want to either rule that condition out or find that that
10 condition -- if the patient has that condition and then
11 treat it. Is that correct? Is that fair to say?

12 A We -- yes. We always want to try and rule things out.
13 Unfortunately we can't always rule everything out. There
14 are unfortunately risk to everything.

15 Q You had -- you saw her on -- I may have said August
16 25th from the hospital visit a minute ago. I meant August
17 the 9th. That's the date you saw her in the hospital. Is
18 that correct?

19 A That's correct.

20 Q Okay. And you saw her on August 25th and basically
21 that was a regularly scheduled visit. Is that correct?

22 A Yes.

23 Q And she had had other visits to your office, not seen
24 by you, but seen by other physicians in the office, between
25 August the 9th and August 25th. Is that correct?

1 A (Indicating yes) Yes.

2 Q The -- now, August the 25th when you saw her, now this
3 was -- this presenting a history -- you had a woman who was
4 having some difficulty determining a due date. Is that
5 correct?

6 A Yes.

7 Q Okay. So you had some difficulty in determining what
8 -- when -- how far along she was in the pregnancy. Is that
9 correct?

10 A Yes.

11 Q Okay. You had a patient also that had had -- had a
12 history of hypertension. Is that correct?

13 A Yes.

14 Q And a hypertension is a risk factor. Is that correct?

15 A Yes, it is.

16 Q You think she presented also -- she had some swelling
17 in her ankle. Is that correct?

18 A She had some swelling in her left ankle.

19 Q Okay. You had a patient who had been to the emergency
20 room and you had seen at the emergency room on August the
21 9th suffering with abdominal pain. Is that correct?

22 A It wasn't the emergency room, but it was obstetrics
23 triage unit, but yes, I had seen her for abdominal pain at
24 that time.

1 Q Okay. And the -- you also had a patient who had a
2 history of uterine rupture. Is that correct?

3 A Yes, sir.

4 Q Now, the -- you want to do -- you want to do the
5 safest thing for the patient. Is that correct?

6 A We're always trying to do what we believe is the right
7 thing and the safest thing. You sort of take a risk
8 benefit analysis, and by doing that risk benefit analysis
9 we determine what we need to do.

10 Q All right. Now, is it fair to say the safety of both
11 the mother and of the child is your primary concern?

12 A We're always, yes, very interested in taking care of
13 the mother and the baby to the best of our abilities.

14 Q Okay. And if there's two treatment plans or more than
15 two treatment plans, isn't it best to err on the side of
16 safety?

17 A Unfortunately, it's not quite as simple of just erring
18 on the side of safety. Again, we -- we go through
19 training, and it's not -- you don't talk -- the training is
20 not about safety. It's about, you know, evaluating the
21 patient, evaluating the disease, evaluating your options,
22 doing a risk benefit analysis, and every condition we deal
23 with has risks to it.

24 Q And you want to do the thing that's safest for the
25 patient. Is that correct?

1 A We look at a risk benefit analysis and we determine
2 what's the right thing to do.

3 Q Let me ask you, back on August the 9th, did she have
4 high white blood cells on that date?

5 A No, she did not.

6 Q Doctor, that's your August the 25th note ---

7 A So are we going ---

8 THE COURT - Would you like him to step down and
9 look at it?

10 Q If you would or you could have it right there ---

11 A No. So no more question about the white count?

12 Q Well, if you have a different answer ---

13 A No. No. I looked in the chart, and no she did not
14 have an elevated white count.

15 Q All right, you can -- the -- now you said there was an
16 ultrasound at that time. Is that correct? That's the note
17 of August 25th that may be cut off.

18 A Yes.

19 Q Was the ultrasound that was done on that date the same
20 as the biophysical profile?

21 A No.

22 Q Okay. Tell us the difference between an ultrasound as
23 it was done on that date and a biophysical profile.

24 A An ultrasound done on that day -- the purpose of the
25 ultrasound that day ---

1 COURT REPORTER - I can't hear the witness with
2 his back to me.

3 Q If you'd just stand back that way ---

4 A The purpose for the ultrasound on that day was to look
5 at the size of the baby, and that sort of -- that's when
6 you look at the head circumference, the abdominal
7 circumference, the biparietal diameter, but we're looking
8 at the size of the baby, we're looking at the presentation
9 of the baby. We're looking at the fluid volume of the
10 baby, and that was the purpose of that ultrasound.

11 Q Okay. Now, ---

12 THE COURT - Is it still necessary for him to
13 stand up or ---

14 MR. BOYD - No, I don't think so.

15 THE COURT - Can we turn the lights back on.

16 Q She had the swelling in the left ankle. Could that
17 swelling in the left ankle suggest -- be a result of
18 hypertension?

19 A No, I don't think it was in this situation.

20 Q Is swelling sometime a result of hypertension?

21 A Not unilateral, no. And her blood pressure was normal
22 on that day.

23 Q And on that date, also, the abdominal circumference
24 was down two weeks from a previous ultrasound. Is that
25 correct?

1 A But it was only one week in this particular
2 ultrasound.

3 Q Okay. But it was down two weeks from a prior.

4 A Yes.

5 Q Okay. And there was a possibility of lagging growth
6 because of that?

7 A No, I don't think so. I think the studies show that
8 there was no possibility of a lagging growth.

9 Q Did the -- was there any sign that fetal height was
10 decreasing?

11 A No, I think this baby was appropriate for that
12 gestational age.

13 Q So, basically what you had, you had a drop in anatomic
14 (sic) fluid, although it was within normal limits. Is that
15 correct?

16 A It was normal. I would not say it was a drop. The
17 amniotic fluid is a very fluid, so-to-speak environment,
18 and it changes on an almost hourly basis depending on how
19 much the baby's swelling, how much the baby's peeing, you
20 know, so no, I would not say it was a drop. It was a
21 normal value.

22 Q All right. And if you'd step down and look at what
23 you put in the notes. I believe this is what you dictated.
24 Is that correct?

25 A That's correct.

1 Q All right. It says decreased AFI, which is amniotic
2 fluid at nine. Is that correct?

3 A Yes, but that's not a drop. I'm not saying that is
4 necessarily a drop. I'm saying at that point it's
5 decreased, but it's not a drop -- and if we'd scanned her
6 four hours later, it could've been 10, could've been 12,
7 could've been more, and as a matter of a fact, little over
8 a week later it was close to 15.

9 Q All right, have a seat. Now, Doctor, you said -- you
10 said it's not a drop. Doesn't decrease mean the same
11 thing?

12 A Not in the way I'm using it, no.

13 Q So decreased means it was decreased from what it was
14 previously. Is that correct?

15 A Decreased is actually the term that the
16 ultrasonographer used, and I think she's just trying --
17 she's trying to just prevent, you know, a global image that
18 she's looking at the amniotic fluid and that's her
19 impression, but it's a normal value.

20 Q I believe these are your notes, aren't they? You
21 dictated them. Is that correct?

22 A Right. That's right.

23 Q So that's your word, not the sonographer's. Is that
24 correct?

25 A (Indicating yes) Yes.

- 1 Q And you say decrease? Is that correct?
- 2 A I wrote decrease, but not drop. And it is normal.
- 3 Q And your testimony is that decrease and drop means two
4 different things.
- 5 A Yes, it does.
- 6 Q And she had -- again she had the history of
7 hypertension. Is that correct?
- 8 A Yes.
- 9 Q She had swelling of the ankle on that visit. Is that
10 correct?
- 11 A Yes.
- 12 Q She had been to the emergency room on August the 9th
13 with abdominal pain. Is that correct?
- 14 A Yes.
- 15 Q Okay. And what's in the chart, she had a history of
16 intrauterine rupture. Is that correct?
- 17 A Yes.
- 18 Q Now, on August the 25th, is there any medical reason
19 not to do a non-stress test? Is there any -- would that
20 cause any harm to the patient to do a non-stress test?
- 21 A We don't do unnecessary testing.
- 22 Q All right. That wasn't my question. My question was
23 would it do any harm to the patient to do a non-stress
24 test?

1 A Well, actually you said was there any medical reason
2 not to, and there was no medical reason to do it.
3 Medically speaking we're trained and taught to do what's
4 medically necessary, and there was no medical reason to do
5 a non-stress test on this patient.

6 Q My question is is there any medical reason not to do
7 the test?

8 A There was no medical reason to do the test and that's
9 my answer.

10 Q Okay. Let me ask it this way. Would there be any
11 harm to the patient to do a non-stress test on August the
12 25th?

13 A Yes, there's poss -- possibly there is harm.

14 Q All right. What is the harm that can come from it?

15 A There is a reason why you don't test everybody for
16 everything every time they come into your office. Okay? I
17 mean I could do an ultrasound on every single person that
18 comes into my office, and I might find ovarian cyst on 25,
19 30 percent of those women and then I have an ovarian cyst
20 on 25 to 30 percent of those women when 95 percent of those
21 cysts are normal, but now that I've documented on the chart
22 that she has a cyst on her ovary, now I have to do another
23 ultrasound four to six weeks later. Then what if she has
24 pain? Well, now I have to say, well, is that pain from
25 that ovarian cyst or is that pain not from -- maybe I need

1 to operate on this patient now. There is really a reason
2 why we don't do unnecessary testing, and that's because
3 unnecessary testing can lead to additional unnecessary
4 testing. It can lead to -- it can lead to unnecessary
5 surgery and unnecessary outcomes.

6 Q If I understand what you just said, you said in that
7 scenario, which is not the scenario we have here, but in
8 that scenario because you may find ovarian cyst, you may
9 find something wrong, it's better not to find it? Is that
10 what you're telling us?

11 A No. Ovarian cysts are normal. They're normal
12 findings in a woman, but if you tell a woman that she has
13 an ovarian cyst, you know, that can -- that can scare
14 somebody. That can bring on a lot of anxiety, and so we
15 don't -- you know, in this particular case on August 25th
16 she had an extensive evaluation, and that extensive
17 evaluation was entirely normal. You know, we talk about
18 chronic hypertension. Her blood pressure's normal. She's
19 gaining weight properly. Her fundal height is appropriate.
20 She has no protein in the urine. There's no evidence of
21 preeclampsia. She gets an ultrasound done to try and help
22 us with the dates. The ultrasound shows the baby is vertex
23 presentation. It shows the baby has an AFI which is
24 normal, by definition is normal. It's normal by any
25 definition you do. Whether you do the single deepest

1 pocket or whether you do an AFI, less than five's abnormal
2 but over five is normal. Now, we always are trying to be
3 conservative. If we see something, we say, well, we need
4 to keep an eye on it. That's just like what I did in
5 triage when she was -- you know, she had one blood pressure
6 there; we said let's keep an eye on it, let's make sure.
7 That -- make no mistake, that AFI is normal. She even went
8 on to have doppler studies. Now, doppler studies are --
9 would be the next step if she had IUGR, if she had toxemia.
10 That would be a reasonable thing to do. Her doppler
11 studies are normal. She had no absent end diastolic fluid.
12 She had no reversal of flow. The doppler study is by
13 definition -- that will turn abnormal before an NST turns
14 abnormal, and that's what we're trained. The doppler
15 studies are going to be abnormal before an NST, so with a
16 normal doppler, an NST would've been absolutely normal at
17 that time and it's not indicated.

18 Q All right. You said a lot there that had nothing to
19 do with what I just asked you, but my -- what you've just
20 answered about unnecessary tests, you gave the example of
21 an ovarian cyst. What you're saying, basically to answer
22 that question, it's better for a woman not to know she has
23 one? I think that was your answer. Is that correct?

24 A Every -- yes, because they're normal, but they can
25 create a lot of anxiety. Every woman until they go through

1 menopause develops ovarian cysts on their ovaries. When
2 they start menstruating until when they go through menopause
3 every month they have a cyst on one of their ovaries, and
4 if you tell somebody I've got a cyst, you are -- or excuse
5 me -- you've got a cyst, that brings on anxiety, and then
6 you say, well, -- and you scare somebody and you have to do
7 additional testing that show that the cyst goes away.

8 Q So it's better that they not know.

9 A It's better if they not know that they're normal.

10 Q Now, the other -- back to what I was asking you about,
11 the non-stress test, you said -- from a physical
12 standpoint, is there anything that would physically harm a
13 woman from a non-stress test being performed?

14 A No.

15 Q Okay. Is there anything physically that will harm a
16 woman from a biophysical profile being done?

17 A No.

18 Q So Samantha Jamison on August the 25th, there was no
19 harm that could be done for her from a physical standpoint
20 by conducting a non-stress test.

21 A It was not indicated.

22 Q Okay, but my question was is there anything that
23 would've physically harmed her or the baby in any way to
24 conduct a non-stress test?

25 A No.

1 Q From a physical standpoint, was there anything that
2 would've done that could've harmed her or the baby from
3 doing a biophysical profile?

4 A No, there's nothing physical that would harm them.

5 Q Now, assuming that a non-stress test be conducted a
6 week later, was there any physical reason a non-stress test
7 would've done any harm to her or the baby a week later from
8 August the 25th, 2008?

9 A There's no physical reason, but there's no medical
10 indication.

11 Q Is there any physical reason that a non -- a
12 biophysical profile couldn't be done a week later from
13 August the 25th, 2008?

14 A No. There's no physical reason and there's no medical
15 indication.

16 Q Are there any written policies -- or let me go back --
17 2008. In 2008 were there any written policies in your
18 office for your employees concerning what to do in
19 particular situations?

20 A I don't quite understand the question.

21 Q Well, for example -- for example, is there any written
22 policy concerning what to do if a woman comes in with
23 decreased fetal movement?

24 A No, there are no written policies.

25 Q There were not in 2008.

1 A No.

2 Q The -- of course, you were not the attending physician
3 on September the 5th. Is that correct?

4 A The attending physician where?

5 Q At the office when she came in on September ---

6 A I was not the physician that saw her.

7 Q And the -- you said, I believe, -- (pause) -- basically
8 you've talked about movement, kick counts and that type of
9 thing; fetal activity is basically sensitive to a decrease
10 in fetal oxygen -- the fetus getting oxygen. Is that
11 correct?

12 A It can be.

13 Q Okay. And would you agree that the absence of fetal
14 activity requires further assessment before -- to conclude
15 that a fetal compromise might exist?

16 A I guess -- that's a pretty general statement. Can you
17 sort of qualify what you're talking about?

18 Q Well, if there's a less fetal activity, the mother
19 doesn't feel the baby moving. Okay?

20 A Are we talking about less or no fetal movement.

21 Q I'm talking about less.

22 A Okay. Okay.

23 Q Would that require further assessment in your opinion?

24 A If a mother calls us and describes less fetal
25 activity?

1 Q Yes.

2 A Now, is this somebody that's -- I'm on call and she's
3 calling me and saying my baby has decreased fetal activity?

4 Q For purpose of this question, yes.

5 A Okay. Okay. Well, first we do -- as I would say, I
6 would talk to her. I would find out where she was, what
7 she was doing, you know. You know, if she had been, you
8 know, at work, if she'd been at the store, and a lot of
9 times women will call us and they'll say, you know, my
10 baby's not moving as much, and you say, well, what have you
11 been doing; well I had my daughter at a birthday party and
12 I just haven't felt the baby move. And we'll say, you know
13 what, why don't you do this, go home, let's -- get off your
14 feet, put your hand on your tummy, then you'll say, you
15 know, are you having any contractions, are you having any
16 bleeding, is there anything that make you think that there
17 might be something ongoing. You say, go and do your kick
18 counts, and I would go through the same routine that I --
19 you know, I spoke earlier, you go do the kick counts. Now,
20 then if said, well -- you know, because a lot of times
21 people say, well, I have decreased fetal movement and you
22 tell me to do the kick counts, and they come back and say,
23 oh, my kick counts are fine. You know -- and so, you
24 know, I would first do that.

1 Q Okay. Now, what is -- you may have testified to this
2 already. What did you say the normal number of kicks the
3 mothers should have, the normal amount of movement?

4 A Usually I tell people 10 movements in two hours.

5 Q And is it important to document if you have a woman
6 call you concerning decreased fetal movement? Is it
7 important for you to document -- to document that in the
8 record?

9 A Is it important to document in a record? If she calls
10 me and I'm on call, honestly we don't have a way of
11 documenting a phone call when you're on call.

12 Q Okay. Is there -- if you're not on call, if you're at
13 the office, do you document that?

14 A If somebody calls the office, if somebody calls the
15 office and complains of a decreased fetal movement, they're
16 universally told to come in and get checked.

17 Q And look -- if you can look at -- step down again. I
18 believe the bottom part, that's your record from August the
19 25th. Is that correct?

20 A Can you tell me where ---

21 Q Scroll down.

22 A August 25th stops right here.

23 Q Okay. That's what my question was.

24 A Okay. Do you want me up more?

1 Q Just for a second. All right. You wanted her to
2 start doing kick counts. Is that correct?

3 A That's correct.

4 Q Okay. In that record on September the 5th, and I
5 realize you wasn't the doctor who saw her on that day, but
6 on that date, September the 5th, she's there because of
7 decreased fetal movement. Is that correct?

8 A Yes.

9 Q Okay. Is there anything in the record on that date
10 that shows how much the decreased fetal movement was?

11 A No.

12 Q Any report whether it's down to a few kicks or no
13 movement or anything?

14 A No.

15 Q The record is completely absent of that. Is that
16 correct?

17 A That's correct.

18 Q You can have your seat. So I think your testimony is
19 that it wouldn't be medically indicated to do an ultrasound
20 or a biophysical profile on August the 25th. Is that
21 correct?

22 A An ultrasound was done.

23 Q Oh, I'm sorry. Let me rephrase the question. I
24 realize that. Your testimony it wasn't necessary to do a

1 non-stress test or a biophysical profile on August 25th,
2 2008.

3 A That's correct.

4 Q Okay. And your testimony again, it wasn't indicated
5 to have her follow-up a week later for a biophysical
6 profile or a non-stress test.

7 A That's correct.

8 Q And that was August 25th. Is that correct?

9 A Yes, it was.

10 Q But on September the 5th, 2008, you have a dead baby.
11 Is that correct?

12 A Yes, there was.

13 MR. BOYD - That's all.

14 THE COURT - Re-direct.

15 MR. DAVIS - One moment.

16 RE-DIRECT EXAMINATION

17 BY MR. DAVIS -

18 Q Dr. Miller, what's a routing sheet? Do you know what
19 a routing sheet is?

20 A Yes, a routing sheet is something that we fill out, we
21 give to the patient, the patient takes it up to the front
22 desk and that's to set up what the next -- next visit and
23 any testing or any consults -- excuse me -- any consults
24 that we might want.

1 Q Okay. On this routing sheet it says next appointment
2 two weeks. Right?

3 A That's correct.

4 Q And the date of this routing sheet was following your
5 visit of August 25. Is that correct?

6 A That is correct.

7 Q So she would've been told she had a follow-up
8 appointment with you in two weeks.

9 A That's correct.

10 Q Per that document.

11 A Yes.

12 Q Okay. Dr. Miller, you were asked a good bit about
13 blood pressure. I've got a couple of questions to follow-
14 up with you, sir, on that in that regard. Do you know
15 whether or not in a reasonable practice of obstetrics and
16 gynecology in an office-based practice, if a patient
17 presents with a history of chronic hypertension as Ms.
18 Jamison did, do you know whether or not there are goals to
19 manage that blood pressure or hypertension during
20 pregnancy?

21 A Yes.

22 Q What are those goals, sir?

23 A First of all, you're going to see that patient back on
24 a regular basis assessing the blood pressure; you're going
25 to be looking for preeclampsia or toxemia; typically you're

1 going to do serial ultrasounds to document appropriate
2 growth, and typically those are done every four weeks. At
3 32 weeks -- we typically start non-stress test at 32 weeks
4 to assess continued fetal well-being.

5 Q Were those goals met or on the way to being met with
6 this patient?

7 A Yes, they were.

8 Q In your opinion does the standard of care indicate,
9 recommend or require a non-stress test and/or biophysical
10 profile be done on every patient with a history similar to
11 Ms. Jamison, sir?

12 A No, it does not.

13 Q Just because a test physically can be done and is not
14 harmful or non-invasive, do you have an opinion whether or
15 not it should be done?

16 A No, it shouldn't. You know, our job as physicians
17 using, you know, our years of experience, our training, our
18 clinical expertise is to decide, you know, when these tests
19 should be done, when they're appropriate, and so, no, it
20 should not be done.

21 Q Is there any way you or anybody else can have an
22 opinion -- well, forget anybody else. Do you have an
23 opinion if she had had an NST and a BPP done one week after
24 your visit of August 25, do you have an opinion what either
25 one of them would've shown?

1 A No.

2 Q Why not?

3 A There's no way of knowing.

4 Q Then why not do one?

5 A It wasn't indicated.

6 Q What is -- the 9-5 there was an NST. You know that.

7 A Yes.

8 Q You looked at it.

9 A I've looked at it, yes.

10 Q Was it a category one, category two or category three
11 if you looked at that strip on 9-5?

12 A It was a category two.

13 Q And that means indeterminate?

14 A Indeterminate.

15 Q What does the standard of care require of a physician,
16 a reasonably prudent Ob-Gyn in an office-based practice
17 with a patient like Ms. Jamison with her history and
18 findings on that day, what does the standard of care that
19 indicate or require be done appropriate?

20 A Additional testing first and foremost, extended
21 monitoring secondly, and then you're going to try to do
22 some of the maneuvers we talked about to try and improve
23 that tracing, oxygen, IV, therapy, or fluid, positional
24 change. If there's medications that need to be

1 discontinued, you're going to try to do things to improve
2 that strip.

3 Q And you indicated to us earlier that those are best
4 done in a hospital.

5 A Absolutely.

6 Q First thing in the office is what? After the NST
7 indeterminate, the first test you need to go to next is
8 what?

9 A Biophysical profile.

10 Q How long do they normally take?

11 A Biophysical profiles typically take 30 minutes. They
12 are supposed to be done for 30 minutes, and they're
13 supposed to be done for 30 minutes because babies
14 experience sleep cycles that last anywhere from 20 to 40
15 minutes. Because of that, if you do a biophysical during a
16 baby's sleep cycle, you're going to get an abnormal
17 biophysical profile, and so you want to really, if at all
18 possible, extend it for at least 30 minutes and even
19 sometimes up to 40 minutes.

20 Q Well, what if it's cut off at two minutes because
21 you've got a two out of eight and the patient's sent
22 immediately to the hospital? What about that?

23 A Well, I think that that biophysical could've been
24 extended in the office, but it certainly -- that was --
25 that's up to the clinical judgment of the doctor that's

1 taking -- and evidently -- in that situation that doctor
2 feels that they've got enough information with what they
3 see, and they want that patient in the hospital.

4 Q That doctor you understand from the records is Dr.
5 Ansley Hilton, one of the named defendants in this case.

6 A Yes.

7 Q Your partner.

8 A Yes.

9 Q Doctor, in your opinion, does the standard of care
10 require a written policy of what a doctor in a practice
11 like yours is supposed to do or should do when a patient
12 like Ms. Jamison comes into the office with a chief
13 complaint of, I think my baby's not moving as much, what is
14 documented as a down arrow, FM, decreased fetal movement,
15 sir?

16 A No.

17 Q Why not?

18 A It's not indicated, because there's so many different
19 variations on that -- on that statement, on what that
20 means. You know, it's better if the physicians are able
21 to use their clinical judgment and expertise to decide what
22 to do about that. You know, the important thing is that
23 the patient is there and the patient is put onto a monitor,
24 and that's the important thing.

1 Q Does a board certified obstetric -- Ob-Gyn in your
2 opinion such as yourself, such as Dr. Benson, such as Dr.
3 Hilton, of your partners in your practice, are they
4 trained, educated and experienced and knowledgeable about
5 how to treat or handle a situation if a patient comes in 32
6 weeks pregnant, history exactly like Ms. Jamison with a
7 complaint of decreased fetal movement absent a written
8 policy?

9 A Yes, they are.

10 Q All right, sir. Doctor, you were asked about there's
11 no documentation on that note of Dr. Hilton's September 5,
12 2008 about the number of kick counts and what they were in
13 the intervening time from the time she last saw you on
14 August 25 until the time she presented with the chief
15 complaint of decreased fetal movements. There's nothing
16 that Dr. Hilton documents about decreased fetal -- I mean
17 kick counts. You were asked about that. Right?

18 A Yes.

19 Q I want you to assume for sake of the question that
20 that note was dictated by Dr. Hilton after she had seen the
21 BPP of two of eight, had instructed the patient to go
22 immediately to labor and delivery, had called your partner,
23 Chris Benson, Dr. Chris Benson, another named defendant in
24 this case, and alerted him that she was on the way, and
25 that she had a BPP of two of eight with an indeterminate

1 NST and for him to prepare to examine, evaluate her for a
2 possible emergent c-section. Assume that as part of this
3 question. And then she dictated her note. Would it change
4 that plan any, sir, if she had documented or known, well,
5 Ms. Jamison had kick counts in the last week or so of XYZ?

6 A No, it would not.

7 Q Doctor, based on your examination of Ms. Jamison on
8 August 25, 2008, all the normal findings that you had, all
9 the studies that you performed, all the conversations with
10 her, your assessment, your plan, all the things that you
11 did, based on that note and your knowledge of her and her
12 situation that day, do you have an opinion that based on
13 what you knew, that it was reasonably predictable or
14 reasonably foreseeable that this child would be dead on
15 September 5 by 11:45 or 11:50 a.m. that day?

16 A No, absolutely not.

17 MR. DAVIS - Nothing further. Thank you.

18 THE COURT - Any new matter?

19 RE-CROSS EXAMINATION

20 BY MR. BOYD -

21 Q When you were asked a question about would it have
22 changed anything about what was done concerning the kick
23 counts or amount of fetal movement, does the amount of
24 fetal movement, amount of decrease, would that affect how
25 fast the patient is seen?

- 1 A No. You know, basically if somebody describes
2 decreased fetal movement, in all honestly we don't even
3 ask, you know, if they -- if it was eight, you know,
4 instead of 10 or six out of ten. If they describe
5 decreased fetal movement, it doesn't matter the number.
6 We're going to take care of them regardless; we're going to
7 take care of them the same way. If they said it was one,
8 if they said it was eight, we're going to take care of them
9 the same way.
- 10 Q Okay. Is that a high priority at that point?
- 11 A Decreased fetal movement?
- 12 Q Yes.
- 13 A I guess I would wonder what your definition of high
14 priority is.
- 15 Q Well, is that person moved to the front?
- 16 A What person? Decreased fetal movement?
- 17 Q The patient. The patient. Is the patient seen faster
18 rather than someone who's just there on a routine visit?
- 19 A I guess you have to -- you have to tell me what you
20 mean faster. I mean when somebody walks into the office,
21 and we get people to walk in for, you know, a number of
22 reasons, they sign in and we see them as -- in a timely
23 fashion.
- 24 MR. BOYD - No further questions.

1 THE COURT - Thank y'all very much. All right,
2 bring the jury back in, please.

3 (Jury returns to the courtroom)

4 THE COURT - All right, counsel, you may proceed.

5 MR. WILLIFORD - May it please the Court. Call
6 Jane McCain.

7 THE COURT - All right, please come around and be
8 sworn, ma'am. Just meet the clerk right here at the
9 corner, first, please, ma'am.

10 JANE MCCAIN, AFTER BEING FIRST DULY SWORN,
11 TESTIFIES AS FOLLOWS:

12 THE COURT - If you could state your full name for
13 the record, please, ma'am.

14 MS. MCCAIN - Jane N. McCain.

15 THE COURT - All right, go ahead, sir.

16 DIRECT EXAMINATION

17 BY MR. WILLIFORD:

18 Q Ms. McCain, tell the jury where you currently work and
19 what you do for a living?

20 A I work for Rock Hill Gyn-Ob and I am a staff
21 sonographer.

22 Q And what is a staff sonographer? Is that the same as
23 a ultrasonographer?

24 A It is, yes.

25 Q Okay. Tell the jury what you do and what that job is?

- 1 A I am a technologist technician that performs the Ob
2 ultrasounds and Gyn ultrasounds.
- 3 Q How long have you worked at Rock Hill Gyn-Ob?
- 4 A It will be 15 years next week.
- 5 Q How long have you been an ultrasonographer?
- 6 A Close to 20 years.
- 7 Q Tell the jury about your education, experience,
8 training in the medical field and ultrasonography if you
9 would.
- 10 A Okay. I have an associate's degree in x-ray and then
11 I have a -- I'm registered for ultrasound. I worked in
12 Jacksonville, Florida for the University of Florida
13 Hospital. I was hired on there after school. I went to
14 school there and was hired on there and then worked for a
15 perinatologist office there, and then moved to Fort Mill
16 and was hired with Rock Hill.
- 17 Q Are you certified in your field of ultrasonography?
- 18 A I am, yes.
- 19 Q Okay. And which one? What are your certifications?
- 20 A I'm certified in abdominal ultrasound, small part
21 ultrasound, Ob ultrasound, Gyn ultrasound and nuchal
22 translucency ultrasound.
- 23 Q And how long have you been certified?
- 24 A Close to 20 years.
- 25 Q Are you married?

1 A Yes, I am.

2 Q Children?

3 A I have two.

4 Q What ages are your children?

5 A Twenty and fifteen.

6 Q Tell the jury in your training and experience what a
7 biophysical profile is. We've heard some of that, but
8 you're the ultrasonographer, so just tell the jury from
9 your perspective what a biophysical profile is.

10 A It is an ultrasound that I perform. Basically I am
11 watching the baby throughout a time period and I watch for
12 breathing motion, fetal movement, fetal tone and amniotic
13 fluid.

14 Q How long does a typical BPP or biophysical profile
15 last?

16 A It can take up to 30 minutes, typically around 20
17 minutes.

18 Q What if it's 10? You know, is it often 10?

19 A It is often 10, yes.

20 Q Why would it be 10?

21 A Because a lot of times the babies react and do well at
22 10 minutes.

23 Q So I assume you see what you have to see and you don't
24 have to go on testing.

25 A Exactly, yes.

1 Q Okay. Why do it for 20 or 30 minutes?

2 A Because if I don't see what I need to, I have that
3 amount of time to complete this test, whether they pass or
4 they don't pass.

5 Q All right. I want to move to this case. Let's talk
6 about this case. On September 5th, 2008, did you perform
7 the ultrasound biophysical profile?

8 A I did.

9 Q Okay. Let me hand you a set of pictures. And what is
10 this, these set of pictures, I guess.

11 A These are -- this is an ultrasound; the first picture
12 here is ---

13 Q Well, you don't have to go through all them.

14 A Okay.

15 Q Just kind of basically identify them.

16 A It's the fetal measurements of the baby, head,
17 abdomen, leg, the amniotic fluid. That's the fetal heart
18 rate and the doppler study, and then my report.

19 MR. WILLIFORD - Your Honor, at this time we'd
20 like to mark this as defense exhibit number ---

21 THE COURT - You don't want them separately? You
22 want them all as one exhibit?

23 MR. WILLIFORD - One exhibit would be great.

24 THE COURT - Do you have a paperclip or something
25 to put them all together?

1 MR. WILLIFORD - Just staple them.

2 THE COURT - Staple. All right, very good. What
3 exhibit is that?

4 MR. WILLIFORD - Sure. This is defense exhibit
5 number two.

6 THE COURT - Okay. Any objection to defense two?

7 MR. BOYD - No objection.

8 THE COURT - All right, sir. Defense two is in
9 evidence without objection. You may proceed.

10 (Documents marked into evidence as Defendant's
11 Exhibit Number 2.)

12 Q Ms. McCain, if you would, come down from the stand. I
13 just want you to show the jury what we're looking at.

14 THE COURT - Okay, you need to stand next to the
15 court reporter when you come down so she can hear you.

16 MS. MCCAIN - Stand right here? Okay.

17 Q At any time, Ms. McCain, if you need me to zoom in,
18 you let me know.

19 A Okay.

20 Q All right, tell us what we're looking at here. This
21 is the first page.

22 A You're looking at the top of the baby's head, the head
23 circumference.

24 Q And what date is this again?

25 A September the 5th.

1 Q Okay. And what's the time?

2 A Ten forty-eight.

3 Q Okay. Now, if this picture is taken at 10:48, at what
4 time had Ms. Jamison come to the ultrasound room?

5 A Probably a minute or two before that. I would have to
6 put in my information into the computer, probably a couple
7 of minutes before that.

8 Q And what do you in preparation to get a patient ready
9 for an ultrasound? What's the process? When they come to
10 the room and before you get this picture, what happens?

11 A I get their charts; I look at their chart and get
12 their last menstrual period or if their EDC and that's what
13 we have. I calculate that into the computer with our chart
14 number and her name.

15 Q Let's flip to the next page. And what is this?

16 A That is the femur length, the leg.

17 Q And what are you doing with the head and now the demur
18 length? What are you doing?

19 A I'm just measuring, calculating size of baby to get an
20 overall gestational age, weight.

21 Q Okay. Now, this is a biophysical profile, so why are
22 you doing measurements?

23 A That's just what I do, and if it's been a couple
24 weeks, it's the right thing to do, I would do it.

1 Q Are you evaluating the various things while you're
2 doing the biophysical profile?

3 A I am. As soon as I -- if I would look at that head
4 initially -- before I did that, I would scan over the baby
5 so to make sure there was a heartbeat, and at that time in
6 my mind I'm watching the baby, watching for any type of
7 movement, any type of tone, just kind of scanning over the
8 fluid before I start measuring.

9 Q Let's flip to the next one. And what do we see here?

10 A That's the abdominal circumference and that's just
11 measuring about midway in the abdomen.

12 Q Okay. And we'll get back to the abdominal
13 circumference in a minute. And then what about -- what
14 about this?

15 A That -- those are two pockets of amniotic fluid.

16 Q Okay. Can you show the pockets? I think we had a
17 pointer somewhere.

18 A Okay.

19 Q And, Ms. McCain, if you don't mind showing the jury.

20 A These are the pockets. That black on ultrasound is
21 fluid, so you measure the deepest pocket in each quadrant
22 from anterior to posterior here and here, so the smaller
23 one here, but this one here looks like it was 5.5.

24 Q When you have a deep pocket of 5.56, right here ---

25 A Right. (Indicating yes)

1 Q --- what does that tell you as an ultrasonographer?

2 A That I wouldn't even have to measure all four
3 quadrants. This would be sufficient, one pocket more than
4 two centimeters.

5 Q And then what about the next picture?

6 A Those are two more pockets, and this one looks like
7 it's -- I'm assuming this is 3 -- at 3.0 and the 4.4.

8 Q Based on what we're looking at, you have a 5 point
9 something and a 4.4, a 3.07, what does that tell you as an
10 ultrasonographer?

11 A That there's completely normal amount of fluid around
12 the baby in the sack.

13 Q All right, and then the next page, what are we looking
14 at here?

15 A This is the fetal heart rate 158. And typically with
16 a BPP you don't have to do fetal heart rate. I just do it
17 to document that we have documentation that there is
18 heartbeat.

19 Q Was there a heartbeat throughout?

20 A Yes, absolutely.

21 Q Okay. Can you hear the -- osculate or hear the -- a
22 heart rate when you're doing an ultrasound?

23 A When you put the doppler on you hear, but you see it
24 throughout. You don't hear it.

1 Q Okay. If there was no heart rate at any time during
2 your BPP, would you note that?

3 A Yes.

4 Q Did you note that in this case?

5 A No.

6 Q Okay. So as far as you could tell, she had a heart
7 rate the whole time during ---

8 A Whole entire time, yes.

9 Q And just to show the jury, that's what you document
10 right here, fetal heart rate 158 beats per minute.

11 A That's right. (Indicating yes)

12 Q And that's normal?

13 A Yes, it is.

14 Q Is that a good heart rate?

15 A That's very good. I think it's normal from 120 to
16 170.

17 Q All right. And then, Ms. McCain, what are we looking
18 at here?

19 A This is the doppler study that I did. Again, it
20 doesn't go with a BPP; it's just something extra that I do.
21 It is a study that shows the blood flow in the umbilical
22 cord.

23 Q How can you tell that from this picture? What are we
24 looking at?

- 1 A Well, right here is just where my calipers are, and
2 this would be just a little area of the umbilical cord.
3 It's really kind of hard to see here, but where the gate is
4 here would be a portion of a cord.
- 5 Q So what are you measuring with a doppler for?
- 6 A We're measuring the blood flow in the umbilical cord
7 to the placenta.
- 8 Q And what was the ratio that -- the doppler flow ratio?
- 9 A The S/D ratio?
- 10 Q Right.
- 11 A Was 1.6.
- 12 Q Okay. Now, is that -- is that normal, abnormal?
- 13 A That's on the low normal side. It was greater than
14 fifth percentile. There's a percentile -- there's a chart
15 that I use and it's based on gestational age on what this
16 number should be, and I just documented that. It was above
17 the fifth percentile, 50th being completely normal. Above
18 the fifth -- I mean above the fifth would still be normal.
19 It's not zero or it's not above ninety. It's just a low
20 normal.
- 21 Q Let me just flip real quick to the very end and I'll
22 come back to the other pictures, but right here we could
23 have -- this is your handwriting down here. Correct?
- 24 A It is, yes.
- 25 Q Now, you have -- is that ABNL doppler ---

- 1 A (Indicating yes) It is, yes.
- 2 Q -- S/D ratio 1. - it says abnormal doppler.
- 3 A (Indicating yes)
- 4 Q Explain that, why you would have normal.
- 5 A Because wasn't in -- completely in the normal in the
- 6 50th percentile. Anything, you know, that's not in the
- 7 50th, below it or above it, you document it as not normal,
- 8 but it was still above the -- in my chart above the fifth
- 9 percentile which is okay.
- 10 Q How does that compare -- a 1.6 doppler flow, how does
- 11 that compare to other findings in doing a doppler?
- 12 A If I saw on this patient, on Samantha's doppler that
- 13 it still -- the baby still had systolic and end diastolic
- 14 flow, if I was scanning that patient and there was no end
- 15 diastolic flow at all or if there was reversal of flow,
- 16 that would be a complete red flag that there was something
- 17 wrong.
- 18 Q Were there those red flags that you described -- did
- 19 you find that when you did the September 5th ---
- 20 A No, sir. There was systolic flow and there was end
- 21 diastolic flow.
- 22 Q All right, and then what are we looking at here? This
- 23 is the picture after the doppler?
- 24 A This is another -- another doppler.
- 25 Q Okay. Just a continuation?

- 1 A Yes, it is. The last image that I took.
- 2 Q And now let's go back to your note. Okay, explain to
- 3 the jury what this is.
- 4 A This is my report. Basically I put in the last period
- 5 by what we have or EDC by what we calculated. Her last
- 6 period -- her EDC -- EDD by last period was 10/30. The EDC
- 7 which is when the baby's due by the gestational age, the
- 8 size, would be this. So gestational age by the last period
- 9 she should've been 32 weeks and a day.
- 10 Q And you have fetal biometry down here.
- 11 A (Indicating Yes)
- 12 Q Right here. Fetal biometry. What's going on here?
- 13 A Okay, BPD is the head circumference, is the head
- 14 measurement which was 31 weeks and two days, which is
- 15 pretty good with a 32 week and one day by L&P. The head
- 16 circumference is the measurement again around the head, 31
- 17 and two. The abdominal circumference is 26 weeks and four
- 18 days, and the FL is the femur length and is 31 weeks and
- 19 four days.
- 20 Q And then right here is the AFI, and we talked about
- 21 that.
- 22 A (Indicating yes) 14.73.
- 23 Q That's the total.
- 24 A Right.
- 25 Q And that's normal.

1 A Yes.

2 Q All right, and then what's all this right here?

3 A That just calculates the ratio between the femur and
4 the abdomen, the femur and the head, the femur and the
5 abdomen.

6 Q Okay. Now, you did a -- the ultrasound, the first
7 ultrasound on Ms. Jamison back in July.

8 A I did, yes.

9 Q Okay. You've looked at that report.

10 A (Indicating yes)

11 Q Comparing that to the second ultrasound to this
12 ultrasound, what did you find in terms of growth?

13 A The growth was lagging, but there was growth.

14 Q Was there growth continuously?

15 A Yes, there was.

16 Q Okay. Was everything but the abdominal circumference
17 growing as expected?

18 A Yes.

19 Q Okay. Now, what about the abdominal circumference,
20 was that really far behind or was it growing still but a
21 little bit lagging in terms of the rate at which it ---

22 A The rate is what it was lagging. It -- the baby grew
23 but lagged a little bit if that makes sense.

24 Q All right, and right here we have again you document
25 the fetal heart rate, 158.

- 1 A Yes.
- 2 Q And then this the BPP. Now, what were your findings?
- 3 A Fetal movement, you get a score from zero to two, and
4 it was zero. Fetal breathing, zero; fetal tone, zero, and
5 then AFI, amniotic fluid was two.
- 6 Q And when you have -- and that was a two out of eight.
- 7 A Yes, sir.
- 8 Q Okay. And right down here we see that you have a
9 time, 10:58 and looks like 20 seconds, 10:58.
- 10 A Right.
- 11 Q Tell the jury about that. When does this get printed
12 out?
- 13 A That's at the end of the ultrasound as I'm preparing
14 the patient to come off the table, wiping her off, I hit my
15 machine and it generates my report.
- 16 Q Because this pretty much comes out immediately ---
- 17 A Immediately.
- 18 Q --- while Ms. Jamison is there in the room.
- 19 A Yes.
- 20 Q Okay. So the BPP lasted 10 minutes.
- 21 A Correct.
- 22 Q You have a two out of eight. You have normal AFI.
- 23 A Yes.
- 24 Q Doppler's not a concern.
- 25 A Yes. Right.

1 Q Normal heart rate.

2 A Normal heart rate, yes.

3 Q Okay. And then -- and tell the jury what you did or
4 what happened, you know, at that point, at the end of this
5 BPP in terms of Dr. Hilton?

6 A Well, toward the end of the ultrasound, the BPP, I was
7 standing and Dr. Hilton came in, as she typically does, and
8 kind of finished up watching me scan, and assuming that she
9 was not comfortable with this, she was talking to Ms.
10 Jamison telling her to go straight to labor and delivery; I
11 remember her outside my ultrasound room -- there's a ledge
12 and a telephone there, and she gets on the phone -- I'm
13 assuming it's Dr. Benson -- she's talking to someone,
14 giving them details about the BPP that we just had done and
15 the NST. I don't know verbatim what she said but she was
16 talking, giving details, and I'm wiping Ms. Jamison off,
17 and at that time I make conversation with her and I say, I
18 just reiterate what Dr. Hilton said, go straight to labor
19 and delivery -- I always say -- this is just my statement --
20 - don't go to Hardees, which is outside out office, don't
21 stop at our front desk and drop off this paperwork, because
22 you don't need to, don't go to Walmart, don't worry about
23 your bags being packed, go straight to labor and delivery
24 upstairs, they're waiting on you. That's just the standard
25 statement I made.

1 Q Thank you. You may have a seat.

2 MR. WILLIFORD - I may be done. Just give me one
3 minute. (Pause) That's all I have, Ms. McCain. Please
4 answer any questions plaintiff's counsel may have.

5 THE COURT - Cross examination.

6 CROSS EXAMINATION

7 BY MR. BOYD -

8 Q Ms. Cain, I'm trying to get a record pulled up.

9 A Okay.

10 MR. BOYD - Can you dim the lights.

11 Q I believe what I have up in front of you is your
12 report of July the 18th. Is that correct? Can you see ---

13 A No, I can't see it. Want me to come around?

14 THE COURT - If you want to step down, you may.

15 A I can't see it.

16 THE COURT - Go ahead, sir.

17 Q Would that be your report? You did a -- well, let me
18 ask -- you did an ultrasound also on July the 18th. Is that
19 correct?

20 A I did, yes.

21 Q And the -- that was -- that was not a biophysical
22 profile. That was just an ultrasound. Is that correct?

23 A Yes, that's correct.

1 Q And let me ask you the -- on the ultrasound you
2 estimated certain dates, how far along the child was. Is
3 that correct?

4 A By the size, by the measurements I put in, by the L&P
5 that she gave me.

6 Q Okay. And is it fair to say the BPD which is the head
7 circumference -- is that correct?

8 A The BPD is the bioparietal diameter. It's from side
9 to side.

10 Q Side to side.

11 A (Indicating yes)

12 Q And I think you estimated it at 24 weeks and six days.
13 Is that correct?

14 A Yes.

15 Q And the -- what else did you estimate on that report
16 size-wise -- oh I'm sorry -- how far along the baby was?

17 A I estimated from the fetal biometry the head
18 circumference also, which was 24 weeks -- calculated 24
19 weeks and five days. The head -- or the abdominal
20 circumference at 23 weeks and six days, and the femur
21 length at 26 weeks and one day.

22 Q Okay. So -- you can have a seat.

23 A Okay.

24 THE COURT - Just a second while she sits down.

25 Go head.

1 Q So at that time the abdominal circumference was
2 slightly lagging behind other parts of the child. Is that
3 correct?

4 A Slightly lagging? It was --

5 Q I think you said 23 weeks.

6 A I need to stand up and look at that again.

7 MS. MCCAIN - Can I stand up and look at it again?

8 THE COURT - Yes, ma'am.

9 A The abdominal circumference was 23 weeks and six days
10 plus or minus 15 days. Based on the rest of the
11 measurements it was -- if you compare it to the head, 23
12 weeks and six days or 24 weeks and six days from the head
13 which is about a week.

14 Q Okay, so about a week.

15 A About a week. (Indicating yes)

16 Q Have a seat. And now it was a biophysical profile
17 that you did on the 5th of September. Is that correct?

18 A Yes.

19 Q And what is the difference between a normal ultrasound
20 and a biophysical profile?

21 A The difference is on biophysical profile you typically
22 don't do a measurement. You just are evaluating the well-
23 being of the baby as far as the breathing motion, the tone,
24 the fetal movement and the fluid.

1 Q Okay. And so did you not do any measurements at that
2 time?

3 A Of the biophysical profile?

4 Q Yes.

5 A Yes, I did.

6 Q Okay. On the bio -- so you did do measurements?

7 A Yes, sir.

8 Q Okay. And what were those on that day? Let's go
9 through -- and you can step down. I apologize for keeping
10 you up and down but ---

11 A That's okay.

12 Q If you could go -- what was the head circumference at
13 that time?

14 A It was 31 weeks and two days.

15 Q And what was the femur when ---

16 A Thirty-one weeks -- I guess it's six or four.

17 Q That'd be four days?

18 A (No response)

19 Q And how about abdominal circumference?

20 A It was 24 -- 26 weeks and four days, I believe it
21 says.

22 Q You can have a seat again. So at that time the
23 abdominal circumference was -- it would look -- that's
24 approximately a lag of about five weeks. Is that correct
25 at that time?

- 1 A Approximately, that -- (Indicating yes)
- 2 Q Okay. So it was about a week's lag time in July had
- 3 become five weeks at that time. Is that correct? On
- 4 September the 5th.
- 5 A Correct.
- 6 Q Okay. Now, as far as the other what you had -- the
- 7 fetal breathing, you said there's a score of zero to two.
- 8 Is that correct?
- 9 A Yes.
- 10 Q Okay. Now, but the baby's not actually breathing in
- 11 the womb but is practicing breathing, it's making motion,
- 12 breathing motions.
- 13 A Yes.
- 14 Q Is that basically ---
- 15 A Yes, we watch for the motion.
- 16 Q Okay. And at 32 weeks a baby should be doing that.
- 17 Is that correct?
- 18 An It's a sporadic event. It's not a constant.
- 19 Q But on fetal breathing it was a zero. Is that
- 20 correct?
- 21 A Yes.
- 22 Q Okay. And that's the worst score possible. Is that
- 23 correct?
- 24 A Yes.

1 Q Okay. Fetal movement -- in fetal movement you're
2 talking about a baby will move things like his hands. Is
3 that correct?

4 A Arms, back, yes.

5 Q Okay. And that's also scored from zero to two. Is
6 that correct?

7 Yes..

8 Q Okay. And on that there was a zero score. Is that
9 correct?

10 A That's correct.

11 Q Okay. Which is the worst score possible.

12 A Correct.

13 Q That's not what you want to see. Is that correct?

14 A Correct.

15 Q And fetal tone, tell me what -- what is fetal tone?

16 A Tone is where you watch the hands open and close.

17 That's more of a tone of the baby.

18 Q Okay. And that's also scored between a zero and a
19 two. Is that correct?

20 A That's correct.

21 Q And on this instance there was a zero.

22 A Yes.

23 Q Okay. And that's also the worst score possible.
24 Correct?

25 A Yes.

1 Q Okay. You also had abnormal -- well, I believe you
2 said it was an abnormal doppler and -- or I think you
3 testified it was a normal doppler, but you put it down as
4 an abnormal doppler. Is that correct?

5 A I put it down as abnormal, because it wasn't in the -
6 50th percentile would be completely normal, so anything
7 below or above that norm as -- that I document abnorm and
8 then the physician looks at it.

9 Q Okay. And do you have an actual percentile it was in?

10 A It was greater -- fifth percentile, 10th percentile.
11 I believe it goes by that, and it was greater than the
12 fifth percentile.

13 Q Let me just show you this and are you -- well, let me
14 ask you first. Are you familiar with the umbilical artery
15 resistance index?

16 A I am.

17 Q Okay. And this may be something different, but is the
18 index you're referring to of what you were ---

19 A Yes.

20 Q --- calculating that?

21 A (Indicating yes) Yes, it is.

22 Q Okay. And if you'd look with me here at 32 weeks,
23 fifth percentile should be 2.17. Is that correct?

24 A So at 32 weeks ---

1 Q All right, this is the number of weeks on the left-
2 hand side.

3 A Right. Correct.

4 Q Is that correct?

5 A That's correct. The resist of index -- going by the
6 size ---

7 THE COURT - You need to speak up just a little
8 ma'am, so everybody can hear.

9 A I'm looking at the 32 weeks and the size -- it's
10 called -- the size slash due ratio is 1.6. It's still in
11 the fifth percentile, and it's at 2.17 would probably be
12 the top -- well -- of the fifth percentile, so this is
13 going fifth percentile, 50th and 95th, so it categorizes it
14 with that.

15 Q Okay. Okay, so anything up to 2.78 is 50th percent --
16 between 2.7 -- 17 and 2.70 is fifth percentile -- 50th
17 percentile?

18 A Fiftieth percentile, yes, sir.

19 Q Now, the doppler is basically -- that's the blood flow
20 -- well, you can tell me what doppler is.

21 A It's the blood flow in the umbilical cord.

22 Q Okay. So basically -- and this biophysical profile
23 was began at 10:48 I believe.

24 A Yes, sir.

1 Q --- and terminated at 10:58. Is that correct? It
2 lasted about 10 minutes ---
3 A Yes, sir.
4 Q --- give or take a few seconds.
5 A Correct.
6 Q And the -- when you have the -- you have a heartbeat.
7 Is that correct?
8 A The whole time, yes, sir.
9 Q Okay. And did that appear to be a normal heart rate
10 at that time?
11 A Yes, sir.
12 Q Okay. So what you had is a -- do you score the
13 biophysical profile -- is it a score of eight factors?
14 A Yes, from my part.
15 Q Okay. And what was the total score of this child?
16 A Was two out of eight.
17 Q Two out of eight. Eight being the best.
18 A Correct.
19 Q And zero being the worst.
20 A Correct.
21 Q The -- so basically it was zero on fetal breathing,
22 zero on fetal movement and zero on fetal tone. Is that
23 correct?
24 A That's correct.
25 Q Okay. And -- but the baby did have a heartbeat.

1 A The whole entire time, yes.

2 Q Okay. So that means at 10:48 -- well at 10:58 when
3 the test stopped, the baby was alive. Is that correct?

4 A That's correct.

5 Q The baby had a heartbeat.

6 A That's correct.

7 Q Despite these other concerning factors. Is that
8 correct?

9 A That's correct.

10 MR. BOYD - That's all I have.

11 THE COURT - Yes, sir.

12 MR. WILLIFORD - Just very briefly.

13 RE-DIRECT EXAMINATION

14 BY MR. WILLIFORD -

15 Q Ms. McCain, if Dr. Hilton did not come in at 10
16 minutes and say, Ms. Jamison, go straight to labor and
17 delivery, with a two out of eight in a normal circumstance
18 what would you have done?

19 A I would've continued the test for 20 to 30 more
20 minutes, because that's the amount of time I have to watch
21 the baby and to get a complete score of two out of eight or
22 eight out of eight, but she came in and at that point said,
23 stop, we're done, but I would've continued for 20 to 30
24 more minutes without her being in the room and taken my
25 report to her.

1 THE COURT - All right, the next witness for
2 defense?

3 MR. DAVIS - Your Honor, we'd like to - when my
4 partner gets his electronics situated -- appreciate that.
5 I'd like to call Dr. Ansley Hilton.

6 THE COURT - All right, if you can please come
7 around and be sworn, ma'am. If you'd just meet the clerk
8 at the corner right there, please.

9 DR. ANSLEY HILTON, AFTER BEING FIRST DULY SWORN,
10 TESTIFIES AS FOLLOWS:

11 THE COURT - All right, if you'd state your full
12 name for the record, please ma'am.

13 DR. HILTON - Ansley Hilton.

14 THE COURT - Go ahead, sir.

15 MR. DAVIS - Thank you, Your Honor.

16 DIRECT EXAMINATION

17 BY MR. DAVIS -

18 Q Introduce yourself, please, ma'am, to this jury.

19 A I'm Dr. Ansley Hilton.

20 Q Dr. Hilton, where do you practice?

21 A At Rock Hill Gyn-Ob.

22 Q How long have you practiced there, ma'am?

23 A Seven years.

24 Q I want you to give the jury if you would, please,
25 ma'am, sort of a brief overview of your education, your

1 background, training and experience that got you to Rock
2 Hill Gyn-Ob as a physician.

3 A Sure. I went to undergraduate at the University of
4 South Carolina and I graduated with -- in nursing and I
5 worked as a labor and delivery nurse for about five years,
6 and then I decided I was going to go back to medical
7 school; went back to medical school in 1998 and graduated
8 from medical school in 2002 at the University of South
9 Carolina as well, and then did a four year residency in
10 Charlotte in a UNC affiliated program there and then came
11 to work at Rock Hill Gyn as a private practitioner.

12 Q To become a registered nurse, do you have to take a
13 certifying examination?

14 A Yes, sir.

15 Q Did you do that?

16 A Yes, sir.

17 Q And you passed it?

18 A Yes, sir.

19 Q And you worked in labor and delivery as a registered
20 nurse for five years?

21 A I did.

22 Q And where was that? I'm sorry.

23 A At Richland Memorial Hospital in Columbia.

24 Q In Columbia?

25 A (No response)

1 Q All right. Do you have to take or did you take any
2 qualifying examinations as an OB-Gyn to become board
3 certified?

4 A I did, a written exam and an oral exam.

5 Q And explain to the jury how long is a residency and
6 what is a residency in Ob-Gyn. We've heard some of that,
7 but would you explain it to them.

8 A Sure. Sure. It's four year course training to be
9 specialized in your specialty. The first year you make
10 general rotations and you also act as an internist at some
11 point in time. You also learn a little bit about
12 pediatrics because we do take care of fetal medicine as
13 well, and then the last three years are more specialized in
14 obstetrics and gynecology and surgery.

15 Q And those four years of residency, are they after four
16 years of medical school?

17 A Yes, they are.

18 Q So were you already a medical doctor when you started
19 your residency?

20 A Yes, I was.

21 Q You're a physician when you do the actual four years?

22 A Absolutely.

23 Q All right. And then after that four years, is that
24 when you take the examinations you spoke of?

25 A It is.

- 1 Q And you began working at the Rock Hill office ---
- 2 A I'm sorry, I have a cold, so y'all excuse me if I ---
- 3 Q If you need more kleenex, I'll get you some.
- 4 A I got it. I'm good.
- 5 Q Okay. What year did you begin working in Rock Hill at
- 6 the practice?
- 7 A So I graduated from -- I get confused on all this, but
- 8 2006.
- 9 Q From medical school?
- 10 A No, that's when I came to work at Rock Hill.
- 11 Q Oh, okay. I was going to ask.
- 12 A Yes.
- 13 Q Thank you. Describe if you would your general
- 14 practice that you were involved in from day-to-day there in
- 15 Rock Hill since you've been there.
- 16 A I take care of obstetrical patients as well as
- 17 gynecological patients.
- 18 Q Do you perform surgeries?
- 19 A I do.
- 20 Q Do you perform cesarean sections?
- 21 A I do.
- 22 Q Elective and emergent?
- 23 A I do.
- 24 Q Do you perform vaginal deliveries?
- 25 A Yes, sir.

1 Q Do you perform gynecological surgeries?

2 A I do.

3 Q Both elective and emergent?

4 A I do.

5 Q I want to draw your attention to September 5, 2008.

6 We've been here all week and we're here and this is your
7 opportunity to explain to the jury what was going on that
8 day and what you understand happened. Would you outline
9 for the jury what your understanding is that was going on
10 that day with Ms. Jamison from the time she signed in as a
11 walk-in at 8:40 in the morning ---

12 A Sure.

13 Q --- of the 20th patient to come in that day according
14 to the sign-in sheets, explain to the jury your
15 understanding of how she was -- what she was doing -- what
16 was going on.

17 A Well, first and foremost I guess what I was doing is I
18 was seeing patients. I started seeing patients probably
19 around 8:00 o'clock that morning and I was seeing patients.
20 I think Dr. Robinson was in the office seeing patients.
21 Dr. McClelland was in the office seeing patients, and we
22 also had a nurse practitioner, Robin Pruette that was
23 seeing patients on that day, and to the best of my
24 knowledge Ms. Jamison came in about 8:40 in the morning
25 asking to be seen. I don't know what her complaint was at

1 that point in time, but now I found out it's probably
2 decreased fetal movement. She was worked into Robin's
3 schedule probably because Robin had the lightest schedule
4 of all of us and that would've been the quickest person
5 that she could see, and she would've seen Robin and Robin
6 would've asked her questions about what was going on, why
7 she was there and she would've elicited that the baby was
8 not moving as much as it had been and she would've ordered
9 a NST which was the appropriate management.

10 Q When a patient reports to your office on a walk-in
11 basis, one of your patients for the practice with decreased
12 fetal movement, in your opinion does that constitute an
13 emergency?

14 A Well, you have to understand we see a lot of
15 obstetrical patients and that is a very common complaint of
16 obstetrical patients, because babies do change as they get
17 bigger and grow and the -- the amount of movement, the way
18 they move it always changes and so it's not an emergency in
19 and of itself for us to have a complaint of decreased fetal
20 movement. It's a very common complaint.

21 Q You can't ignore it though.

22 A Absolutely not.

23 Q Was this complaint ignored?

24 A No, sir.

25 Q What was done?

1 A She was worked in as quickly as she could. She saw
2 the first person available and appropriate test was
3 ordered.

4 Q If you had been the first person available, would you
5 have been the one to see her?

6 A Absolutely.

7 Q Or any of the other physicians there?

8 A Absolutely.

9 Q Robin was the first one available?

10 A Absolutely.

11 Q In your office a nurse practitioner -- are you
12 familiar with the education, training and experience that a
13 nurse practitioner, particularly with your nursing
14 background and your MD ---

15 A Sure.

16 Q --- degree?

17 A Yes, sir.

18 Q Tell the jury, how does that work? What do they do?

19 A Well, they're certified and boarded nurse
20 practitioners, and Robin in particular had special interest
21 in women's and children.

22 Q And she had experience prior to coming to your
23 practice in labor and delivery, in that area? Do you
24 remember?

25 A I'm not sure. I'm -- she was there when I came.

1 Q Okay. Do you know whether or not a nurse practitioner
2 is licensed and authorized in the State of South Carolina
3 to make diagnosis?

4 A Yes, they are.

5 Q Do you know whether or not a nurse practitioner like
6 Robin Pruette is licensed and authorized by the State of
7 South Carolina to diagnose problems and to prescribe
8 treatment including medications?

9 A Absolutely.

10 Q What did you understand Robin to have done that day
11 after she spoke to and examined Ms. Jamison? What is your
12 understanding what she ordered then?

13 A Well, she would've assessed the patient. She listened
14 to fetal heart tones and I believe that, you know, that was
15 -- that was really, really reassuring to Ms. Jamison. She
16 said good; I hear his heartbeat, and then she ordered a
17 NST, a non-stress test.

18 Q Do you have an opinion whether or not that ordering of
19 a non-stress test, based on the complaint of the decreased
20 fetal movement was appropriate?

21 A Absolutely. It was appropriate.

22 Q There has been testimony earlier in this case by Wendy
23 Knox. She works in your office?

24 A (Indicating yes)

1 Q The jury heard from her. That she was the one that
2 administered the non-stress test, set her upon the machine
3 and would come and monitor her over that 30, 34, minutes.

4 A Sure, yes.

5 Q Is that routine?

6 A That is very routine.

7 Q All right. And prior to today you have seen those
8 non-stress test that were generated that day?

9 A Absolutely.

10 Q Let me find them if I can. Here we go.

11 A Thank you.

12 Q Be sure -- are those the ones -- they're from exhibit
13 2, Joint Exhibit 2. Are those the non-stress test, the
14 actual strips that were generated that day?

15 A Yes, sir.

16 Q Have you reviewed those prior to today?

17 A Yes, sir.

18 Q Did you review those on September 5th?

19 A I did, briefly.

20 Q After Robin looked at those non-stress tests, there's
21 a note in the record, CMD and BPP. Right?

22 A Yes.

23 Q Was that in your opinion appropriate order based on
24 those fetal monitor strips?

25 A Yes, it was.

1 Q Jane McCain who testified earlier this morning was the
2 ultrasonographer that day?

3 A She was.

4 Q And she did the biophysical profile that they've heard
5 about earlier today?

6 A She did.

7 Q Looking at those non-stress tests, tell me what you
8 see, if anything, that is abnormal, concerning, alarming
9 and however you want to characterize it, it's anything in
10 that category or you describe how you want to.

11 A Independent of the biophysical profile?

12 Q Independent of the biophysical profile. That's all we
13 want.

14 A Okay, independent of the bio ---

15 Q Wait a minute. We've got a lady that's about 32 weeks
16 pregnant, ---

17 A Right.

18 Q --- we've got a lady that's high risk;

19 A Right.

20 Q She's chronic hypertension and she has a history of
21 uterine rupture, ---

22 A Yes.

23 Q -- she was your patient, ---

24 A Right.

25 Q --- this is her third child I believe.

1 A But she's in -- not any acute distress, she's not
2 hurting, not complaining, not bleeding.

3 Q Right.

4 A Okay.

5 Q But she has this non-stress test which complain of
6 decreased fetal movement, otherwise no complaints.

7 A Right.

8 Q You look at those strips and tell the jury what you're
9 seeing as a physician.

10 A Okay. We have a 32 weeker, approximately 32 weeker;
11 she's got a baseline heart rate of 130s, 140s, has got
12 average long-term variability which is a good sign; the
13 variability is a good sign, then she's got acceleration,
14 one acceleration on here that's up to the 150s that last
15 for at least 10, 20, 30, almost 40 seconds, then she's got
16 smaller accelerations but not quite 15 by 15. She's got
17 some decelerations on here, some of which are associated
18 with some contractions, and some of which are not
19 associated with some contractions, and she's 32 weeks and
20 she has some contractions, although she's not complaining
21 of feeling them or hurting. You know, it's still unusual
22 for a 32 weeker to be having contractions on the monitor.
23 Q Do you see anything that would represent what we've
24 heard as late decelerations?

1 A There are things on here that are suspicion,
2 suspicious for late decelerations, decelerations that
3 happen after the peak of contraction and go down gradually,
4 but not consistent. They're not repetitive in nature;
5 they're not with every contraction, therefore, it's a
6 indeterminate strip.

7 Q You said they're suspicious for late decelerations.
8 Are they late or are they not?

9 A Well, you can't really tell in this situation, because
10 most of the time when we're categorizing late decelerations
11 they're repetitive in nature. Typically they might be
12 internal monitors meaning that they're not the monitors
13 that are sitting on the outside of the belly. They are
14 monitors that are inside of the uterus and attached to the
15 actual baby's head to get the exact heartbeat, so this is -
16 - this is a estimate of what the baby's heartbeat is based
17 on a doppler and movement adjustments, the patient's
18 movement. A lot of different things go into play with
19 these type of monitors.

20 Q You mentioned that those fetal monitor strips indicate
21 on the lower portion. That's the mom's uterine activity?

22 A It is.

23 Q You talked about that she's having contractions. Is
24 she in labor?

25 A I do not believe she is in labor. She did not ---

1 Q What's that based on?

2 A Cervical change. She would've been having to have
3 cervical change. Most labor is accompanied by pain as
4 well, and this patient was not having any pain.

5 Q Okay. Do you have an opinion within a reasonable
6 degree of medical certainty whether or not at that time
7 based on those strips and the history that was recorded and
8 her complaints that day whether or not she was in active
9 labor?

10 A I do not believe she was in active labor.

11 Q All right. She is sent to have the biophysical
12 profile done that Ms. McCain earlier today testified about.
13 Ms. McCain testified as you know, you were here, that at
14 some point in that 10 minutes, you came into the room.

15 A I did.

16 Q Had you ever seen Ms. Jamison prior to that day?

17 A I had not.

18 Q Okay. Do you recall who did or who would have most
19 likely notified you to come into that ultrasound room?

20 A I think probably what happened is as -- this is the
21 best recollection that I can have -- but Wendy would've --
22 after the NST was performed, she would've told Jane that
23 she had a patient for a biophysical profile and then was
24 going to be seen by a doctor afterwards, and so she
25 probably came down to whichever pod that I was working at

1 and told me, Robin saw a patient, she had a indeterminate
2 NST with some decelerations, she's getting a biophysical
3 profile and she wants you to look at it, and I would've --
4 I would've gone down to the -- I'm pretty -- I don't want
5 to -- the only word I know for it is anal, so I would've
6 gone several minutes later into the ultrasound room and
7 looked at what was going on.

8 Q When you walk into the room where Ms. Jamison was
9 having -- would she have been lying on the table ---

10 A (Indicating yes)

11 Q --- with her clothes pulled up so that her abdomen
12 would've been exposed to do the ultrasound?

13 A Exactly.

14 Q And do they use some kind of gel to allow the
15 transducer to slide across the skin?

16 A They do. It's an ultrasonic gel.

17 Q All right. And that process, her lying on the table
18 and Jane moving the machine around, getting her different -
19 - whatever she was doing ---

20 A Right.

21 Q --- that was going on as you came in the room.

22 A It was.

23 Q Were you able to -- is there a screen that you
24 could've monitored that you can you see what Jane is
25 seeing?

- 1 A Absolutely.
- 2 Q And did ---
- 3 A And the patient.
- 4 Q And did you look at that?
- 5 A I did.
- 6 Q Was there a heart rate you could either see evidence
7 of or hear?
- 8 A Yes, it was.
- 9 Q And was there a heart rate?
- 10 A There was a heartbeat.
- 11 Q Was it in the normal range?
- 12 A Well, I know by looking at the report that it was in a
13 normal range, but she was actively scanning, so she wasn't
14 sitting on the heartbeat nor was I counting it, but it was
15 normal on the -- when she counted it with the machine.
- 16 Q The machine would've counted the ---
- 17 A The doppler.
- 18 Q --- heart rate.
- 19 A Right.
- 20 Q Now when it registers 158 beats per minute, do you
21 have an opinion whether that is within a normal range for a
22 32 week gestation?
- 23 A It is normal.
- 24 Q I'm sorry?
- 25 A It is normal.

1 Q Okay. Did you see anything on the biophysical profile
2 as it was being unfolded -- or at -- excuse me -- as it was
3 being done there in your presence -- it had already begun -

4 ---

5 A Right.

6 Q --- that caused you any concern or alarm for Ms.
7 Jamison or her baby?

8 A Yes. Um ---

9 Q Tell the jury about that.

10 A Sure. This baby was in a breach presentation and I'm
11 -- I'm looking at it in realtime and it just appears
12 listless. It's not moving; it's not doing its practicing
13 breathing; it's not -- it's not moving its hands; it's not
14 -- it's not doing the things that we would normally think a
15 32 weeker would do, and we're -- we're giggling her belly,
16 we're trying to make it move, and it's just not responding
17 to us.

18 Q Dr. Hilton, when you saw that, obviously Jane saw it,
19 and you saw it too, did you order that BPP to be stopped?

20 A I did.

21 Q How long does it normally -- normal circumstances,
22 nothing abnormal about it, how long does that usually run?

23 A It can run 30 to 40 minutes.

24 Q Have you in your experience, either as a labor and
25 delivery nurse -- you had that opportunity -- but certainly

1 as physician practicing as a obstetric gynecologist, have
2 you seen in your experience a biophysical profile register
3 a two out of a eight for 10 minutes and then the next 20
4 minutes change to six or eight out of eight?

5 A Absolutely.

6 Q That's known to happen isn't it?

7 A Yes.

8 Q So why'd you stop it at 10 minutes?

9 A Because we were in an office setting, and if there was
10 something that we needed to be ready and prepared to do,
11 then I wanted her to be in a hospital setting.

12 Q Tell the jury, please, ma'am, when you ordered Ms.
13 McCain to stop the biophysical profile, what you at that
14 time did or said to Ms. Jamison.

15 A Well, as I'm probably in there I'm looking at her, I'm
16 telling her, you know, Ms. Jamison, I don't know exactly
17 what's going on, but this concerns me that the baby's not
18 moving around, it's not reacting to what we think it should
19 react to, and with your history of the high blood pressure
20 and the previous uterine rupture, you know, I would just
21 feel more comfortable if you were in the labor and delivery
22 unit so that if we have to deliver this baby early, we will
23 have -- we can do that, and I think that she said I said
24 something like to the point of, you know, sometimes babies
25 do better out than in even when they're premature, and she

1 -- I felt like she understood me; she was appropriately
2 concerned and a little bit tearful and she was trying to
3 get in touch with her mom on the telephone, and I asked her
4 if she had a way to the hospital and how she had gotten to
5 the office, because a lot of times our patients are dropped
6 off or they ride the bus or a van or something, and she
7 said, no, she had driven there, and I asked her if she knew
8 where labor and delivery was, and she said she did, she had
9 been there weeks prior, so she knew where she was going,
10 and so I told her I want you to go directly from here to
11 labor and delivery; I don't want you to pass go; I don't
12 want you to collect two hundred dollars; I want you to go
13 straight over there, and I'm going to call my partner and
14 let him know that you're coming.

15 Q I've got to ask this. Why did you say, don't pass go,
16 don't collect \$200 dollars. What's that in reference to?

17 A Well, monopoly. You know, the monopoly game. Yes,
18 the game.

19 Q Okay. Is that what you -- the kind of thing you would
20 tell a patient?

21 A All the time.

22 Q Okay. Did she seem to you to understand what you were
23 telling her?

24 A She did.

1 Q After you finished giving her those instructions, Dr.
2 Hilton, what, if anything, did you then do?

3 A I -- the ultrasound room is right outside of Dr.
4 Robinson's pod, and I walked out of the room with her chart
5 and I called labor and delivery. I gave the nurses that
6 answered the telephone the report and told her that this
7 patient -- told them this patient was coming over and then
8 I asked to speak to Dr. Benson who was on the unit, and I
9 talked to Dr. Benson, and I told Dr. Benson the story and
10 told him about the previous uterine rupture, because that
11 is considered something that we don't want patients to
12 labor against, and so if she did need to be delivered, then
13 she would need a cesarean section and I wanted him to be
14 aware of that.

15 Q Dr. Hilton, did you tell Ms. Jamison in your
16 instructions to her, this is an emergency? Did you tell
17 her that?

18 A No, I did not.

19 Q Ma'am?

20 A No, I did not.

21 Q Why not?

22 A Because I did not feel it was an emergency.

23 Q Why not?

24 A I felt like it was concerning and that we needed to
25 get her in a place that we could evaluate her further, but

1 like I said before, most of the times this was -- this was
2 an abbreviated test. Most of the times a patient would get
3 to labor and delivery, we'd put her on the fetal monitor,
4 we might change her position, we might give her some IV
5 fluids, we might give her something to drink even and the
6 baby would perk up and look better and have a normal fetal
7 heart rate monitoring at that point or have a normal
8 biophysical profile at that point.

9 Q Why not just do all that in the office? Why send her
10 to the hospital?

11 A Because we have to be prepared for the worst but hope
12 for the best. So we can't do those things in our office.

13 Q You can do those on labor and delivery?

14 A We can.

15 Q Why didn't you walk her over, make sure she got there?

16 A She -- she told me that she knew where she was going
17 and she had transportation.

18 Q Okay. What was your expectation of what would happen
19 with her, to her, to her child, for her child as she left
20 your office around 11:00 a.m. that morning?

21 A My honest expectation is that she would go over to
22 labor and delivery, she would be put on the monitor, that
23 the fetal heart rate would be improved and that she may
24 show some signs of concern that would respond to the fluids
25 that -- the IV fluids, the oxygen, possibly changing

1 position, she would -- if she needed to be delivered early,
2 she would receive some steroids to help to mature the
3 baby's lungs and some antibiotics to make sure the baby
4 didn't get an infection when it was born.

5 Q When you spoke with Dr. Benson, did he seem in your
6 opinion to understand what you were telling him?

7 A Absolutely.

8 Q Did he agree to implement a plan?

9 A Absolutely.

10 Q Dr. Hilton, that day, September 5, 2008, any time
11 after you had seen Ms. Jamison -- and we know we've got the
12 ultrasound between 10:48 and 10:58, about 10 minutes -- and
13 before she left the office or after she left the office
14 anytime day that did you ever call the admissions office
15 and leave a voice message about -- to anybody in the
16 admissions office about Ms. Jamison, ma'am?

17 A Absolutely not.

18 Q Have you ever done that?

19 A I have not.

20 Q You generated after all this a note in the chart.

21 A I did.

22 Q You dictated that note, did you?

23 A I did, probably as soon as I made the phone call.

24 Q All right. I hand you the original exhibit, Joint
25 Exhibit 2, and if you would look at information written and

1 then your dictated note on September 5, 2008. I'm going to
2 get a copy and put it on the overhead so we can look at it
3 together. Okay?

4 A Okay.

5 Q If I can find it. While this is warming up, would you
6 read for me the top portion that is in handwriting
7 underneath the signature of Gregory A. Miller, MD. I
8 believe it was done on August 25.

9 A Yes. There's an arrow that is pointing downward, and
10 that stands for decreased fetal movement. There's a
11 urinalysis report right there. There's a gestational age,
12 31 and 6/7ths weeks and positive fetal heart tones and will
13 check NST and then a dash biophysical profile and MD and
14 then Robin Pruette's initials.

15 Q Okay. Do you know what this thing is on the left
16 margin? Is that a signature or note or -- can you tell ---

17 A Where are you pointing ---

18 Q I'm sorry.

19 A --- Mr. Davis?

20 MR. DAVIS - May I approach, Your Honor?

21 THE COURT - Yes, sir.

22 Q I'm pointing to whatever that is. Do you know what
23 that is?

- 1 A That I believe is Kelly Alexander. She's the clerk in
2 our office that makes sure that our dictations are in tact
3 and get to the chart and are applied to the chart.
- 4 Q Okay. And all this, down arrow, FM, all the other
5 writing, it's got an initial R something ---
- 6 A More than likely that first line was the nurse's
7 intake ---
- 8 Q Right, okay.
- 9 A --- and then the second line of writing, handwriting
10 is Robin Pruette's.
- 11 Q What about the UA one plus leuk TRBLD. What's all
12 that?
- 13 A One plus leukocytes and trace blood.
- 14 Q What is UA?
- 15 A Urinalysis.
- 16 Q Okay. Is that done there in the office?
- 17 A It's routine every -- pretty much every time a
18 prenatal patient comes in they get a urinalysis.
- 19 Q Okay. Why do you do that?
- 20 A Sometimes pregnant women can have unrecognized urinary
21 tract infections that can put them at risk for preterm
22 labor.
- 23 Q There is no blood pressure registered on this chart,
24 is there?
- 25 A There is not.

1 Q Why?

2 A She was not there for a routine prenatal visit.

3 Q She was a high risk patient for chronic hypertension,

4 Dr. Hilton. Why was her blood pressure not taken?

5 A She was there for a complaint of decreased fetal

6 movement, and that was what was addressed.

7 Q Your note -- when was this dictated?

8 A Right after I made the phone call to labor and

9 delivery.

10 Q Was it after you had seen the NST?

11 A I had already seen the NST and the biophysical

12 profile.

13 Q Okay.

14 A Together.

15 Q Read your note and let's go over it. Okay?

16 A Sure. Patient comes ---

17 Q What is HPI mean?

18 A History of present illness.

19 Q Okay.

20 A Patient comes in for decreased fetal movement today, a

21 non-stress test and an ultrasound were ordered. The non-

22 stress test shows fetal heart tones 130s, 140s with

23 suspicious looking decelerations. There is one area that

24 does appear to have a acceleration to the 150s.

25 Q Is that good or a bad, an acceleration?

- 1 A It's good.
- 2 Q Okay.
- 3 A She is given -- she is having regular contractions
4 every three to four minutes with suspicious decelerations
5 and ultrasound was ordered.
- 6 Q Now, you've already told us that in your opinion that
7 did not constitute in your opinion active labor.
- 8 A No, it did not.
- 9 Q Okay. Go ahead.
- 10 A Ultrasound today shows two out of eight biophysical
11 profile with a fetus in a breach presentation and a very
12 small abdominal circumference.
- 13 Q What is a breach presentation?
- 14 A That means that the baby was presenting with the butt,
15 hiney.
- 16 Q Back side down?
- 17 A Yes, back side down.
- 18 Q What is -- I don't know how to ask this question. Is
19 there a normal position of an infant at 32 weeks?
- 20 A Babies at that gestational age can vary. They can be
21 vertex, head-down, or they can be hiney down, depending --
22 and they can move pretty regularly up to about 36 weeks.
- 23 Q Okay. So at breach position on an ultrasound at 32
24 weeks, does that mean that's how they're going to deliver?
- 25 A No, sir, not necessarily.

1 Q Could be?
2 A Possibility.
3 Q Or they could change their position?
4 A Absolutely.
5 Q All right. Any reason for concern of the breach
6 position at 32 weeks with this infant at this time?
7 A No, sir.
8 Q All right, you note a very small abdominal
9 circumference, and we've heard Jane talk about ---
10 A Right.
11 Q --- the abdominal circumference, the measurements --
12 if we need to go back over that, I'm happy to do that, but
13 you're the physician, you were there and you saw what was
14 going on. What significance, if any, to you -- was it to
15 you that a very small abdominal circumference was noted?
16 A Well, I'm trying to put the picture together. I'm not
17 really sure. This is the first time I've seen Samantha
18 Jamison. I'm looking at her history, I'm trying to figure
19 out what exactly is going on with this baby, why would this
20 baby be having any decelerations, why would this baby be
21 not moving on the monitor, and then I'm looking at the
22 growth, and I'm really just looking at what's going on at
23 this particular time. Now, since then I've had a chance to
24 look at all the ultrasounds and the abdominal circumference
25 was increasing, but it was behind the rest of the

1 measurements, and sometimes that can be an early sign that
2 the baby is not growing appropriately, and so I'm trying to
3 put all the small details together to figure out what is --
4 what's making this baby possibly sick.

5 Q Let me stop there. We'll finish -- pick it up in a
6 minute. You have heard the term intrauterine growth -- is
7 it restriction or retardation? I don't -- I never know.

8 A They go back and forth.

9 Q Can we just say IUGR?

10 A Sure.

11 Q What is IUGR?

12 A Growth in -- less than the 10th percentile, estimated.
13 Estimated growth.

14 Q Okay. And how is IUGR diagnosed?

15 A It is a prenatal diagnosis that we use an ultrasound
16 to estimate the fetal weight by doing the measurements that
17 Jane talked to you about earlier, and when the total adds
18 up to be less than the 10th percentile, again, remember the
19 range of one to a hundred babies, those 10 in the bottom
20 part of the -- if it's less than the 10th percentile, then
21 that is considered IUGR in most cases.

22 Q All right. Well, with this child on this day with a
23 very small abdominal circumference that has been slipping
24 in growth from the last ultrasound of August 25 -- Right?

25 A Right.

1 Q Tell the jury why that doesn't make this baby IUGR.

2 A This baby's growth was in the seventeenth percentile
3 even at this particular time when we did this ultrasound.

4 Q Is that determined -- the seventeen percent, the ten
5 percent and all these percentages you've thrown around, is
6 that determined by just a guess or is there some objective
7 criteria by which you as a physician come to that
8 conclusion, ma'am?

9 A I think that it's correlated from multiple charts,
10 multiple babies that they've looked at with ultrasounds
11 over the years and come up with averages.

12 Q I mean you didn't just make that up that day, did you?

13 A No, sir. And it's computerized. The computers have
14 that -- I mean the reports give us that information based
15 on the fetal weight that we come up with.

16 Q So the studies are done over thousands of babies.

17 A Right.

18 Q Compiled in some databank and put into these machines
19 so they have these averages?

20 A That's right.

21 Q Next sentence. AFI, that's the ---

22 A Amniotic fluid index.

23 Q Amniotic fluid index.

24 A Right.

25 Q What is amniotic fluid?

- 1 A That is the measurement of the amniotic fluid around a
2 baby, which in this case makes no sense.
- 3 Q What do you mean, makes no sense?
- 4 A It's normal amniotic fluid, great and you would think
5 if a baby was even on the way to growth restriction or
6 having problems or concerning features that the amniotic
7 fluid would be decreased and oligo.
- 8 Q What's oligo?
- 9 A Oligohydramnios.
- 10 Q What's that mean?
- 11 A Amniotic fluid index less than five.
- 12 Q Was this baby oligo?
- 13 A No, it was not.
- 14 Q AFI is noted to be increased at 14 which is up from
15 nine previously, and the nine previously was Dr. Miller's
16 note of July -- excuse me -- August 25?
- 17 A Right.
- 18 Q Is that good or bad?
- 19 A That's good.
- 20 Q Goes from Nine to 14 ---
- 21 A It's great.
- 22 Q Okay. Would that indicate that mom had been following
23 instructions and ---
- 24 A Absolutely.
- 25 Q --- and drinking her fluid?

1 A Absolutely.

2 Q Okay. So you know you've got a compliant patient

3 here.

4 A Yes.

5 Q Next sentence. She does have increased dopplers noted

6 as well. What does that mean?

7 A Well, this is actually really a thing too, and I've

8 touched on this when I was looking back over this case.

9 When I looked at that ultrasound and saw that number of

10 1.6, I really thought it was a resistance index which is

11 how I trained to look at these numbers was resistant index

12 which is an abnormal resistant index, but in all actuality,

13 this was a normal doppler, and so ---

14 Q Well, it wasn't a resistance index, was it?

15 A It wasn't a resistant index.

16 Q On Jane's report it says S/D 1.61.

17 A That's right.

18 Q What does S/D stand for?

19 A A systolic/diastolic ratio.

20 Q Not a resistance index.

21 A Right.

22 Q You misread that, didn't you?

23 A I did, but in this case it really encouraged what I

24 was thinking that this baby might be sick, and so it

25 might've been a God thing to send her on to the hospital.

1 I mean it was one of the things that I looked at and
2 thought it was abnormal, but it really wasn't.

3 Q So looking at that number, misreading it, can you
4 state whether or not that was in favor of Ms. Jamison or
5 against her?

6 A Absolutely it was.

7 Q It was in her favor, wasn't it?

8 A Yes. Yes.

9 Q If you had read it as a S/D ratio of 1.61, would you
10 have done anything differently?

11 A No, it would not have changed what I did.

12 Q You still would've sent her to the hospital?

13 A Absolutely.

14 Q Still would've told her the same thing?

15 A Yes.

16 Q Still would've called Dr. Benson?

17 A Yes.

18 Q And still would've generated this report?

19 A Yes.

20 Q Paragraph, assessment and plan.

21 A Yes.

22 Q Given these concerning findings -- what concerning
23 findings?

24 A The biophysical profile two out of eight, the non-
25 reactive NST ---

1 Q Indeterminate?

2 A Indeterminate.

3 Q Okay. Possible late decels?

4 A Possible late decelerations.

5 Q Given these concerning findings, the patient is
6 instructed to go directly to labor and delivery likely for
7 an early delivery. That's cesarean section. True?

8 A It is. It is.

9 Q You're not going to induce this lady and have her
10 deliver vaginally at 32 weeks with this condition, are you?

11 A Not with her history, no.

12 Q She had a prior uterine rupture?

13 A Yes, sir.

14 Q Did that mark her early in your care by your office
15 for a cesarean section? You told me that.

16 A It did. We treat her like a vertical c-section, a
17 prior vertical c-section.

18 Q Okay. Next sentence. Dr. Benson is on call and is
19 notified of patient being sent to labor and delivery for
20 further evaluation. Ma'am, was the further evaluation, did
21 it include the contingency for an emergency cesarean
22 section?

23 A Potentially, yes. That's why I wanted her in the
24 hospital setting versus the office setting, but I was not
25 in any way, shape or form thinking that she was going to go

1 directly out of her car into the operating room. She was
2 going to be evaluated, placed on a fetal monitor. If the
3 fetal monitor was indicative of needing a c-section, then
4 she would've gotten one. If the biophysical profile had
5 been completed at that point in time per Dr. Benson and
6 continued to be poor, then she would've gotten a c-section.

7 Q Ma'am, when did you learn that day that Jayden had not
8 survived the day?

9 A Um -- sorry -- after I was finished with my office.

10 Q Some time early afternoon?

11 A It was, about 2:00 o'clock, 1:30 or 2:00 o'clock.

12 Q What did you do, ma'am?

13 A I had -- I called over there to see what had happened
14 with Samantha, to see, you know, if her -- what her monitor
15 looked like, and, you know, what Dr. Benson had thought and
16 he told me that the baby had passed away.

17 Q Dr. Hilton, what did you then do?

18 A I went over from my office -- sorry -- to the
19 hospital.

20 Q You need a break?

21 MR. DAVIS - Your Honor, could we take a break?

22 DR. HILTON - I'm all right.

23 MR. DAVIS - You okay?

24 DR. HILTON - I'm all right. Yes. Yes.

25 Q Okay. Did you see Ms. Jamison there?

1 A I did.

2 MR. DAVIS - You want some water?

3 DR. HILTON - Yes. Yes. Thank you. Sorry.

4 Q Did you go to the room of Ms. Jamison?

5 A I did. I did.

6 Q What went on?

7 A Um, I just went in there and I told her that I was
8 really sorry, and I didn't really know why this had
9 happened to her and, you know, don't understand why bad
10 things happen to good people and, you know, I just cried
11 with her and asked her if I could pray for her and put her
12 on a prayer chain.

13 Q Dr. Hilton, do you have an opinion based on your
14 knowledge as a board certified and experienced OB-Gyn
15 having taken care of Ms. Jamison in the office that day, do
16 you have an opinion what caused Jayden to die that day?

17 A I have no idea.

18 Q Do you have an opinion between 11:00 a.m. and 11:45,
19 11:50, when -- at what point in time Jayden's heart
20 stopped?

21 A I do not.

22 Q Do you have an opinion whether your partner, Dr.
23 Benson, fell below the standard of care in discharging his
24 responsibilities following your phone call to him?

25 A He did not.

1 Q Do you have an opinion whether Dr. Miller in his care
2 of her on August 25, 2008, fell below the standard of care
3 by not ordering an NST, by not doing a biophysical profile
4 that day would've been one either?

5 A It did not.

6 Q Did the standard of care indicate on August 25 in your
7 opinion that that be done?

8 A No, it did not.

9 Q Why not?

10 A It wasn't indicated, that the baby had normal findings
11 on the ultrasound.

12 Q Do you have an opinion whether you fell below the
13 standard of care on September 5, 2008 in your care,
14 treatment, conversations and discussions with Jane McCain,
15 with Samantha Jamison or your partner, Dr. Chris Benson,
16 that day?

17 A I did not.

18 Q Do you have an opinion having been there that day,
19 whether Jayden's death was reasonably foreseeable?

20 A It was not foreseeable. It was not predictable.
21 There was no way to know based on that monitor strip in our
22 office that that baby would die within an hour to two
23 hours. It was completely unpredictable.

1 Q But you had a two out of eight biophysical profile
2 that followed that non-stress test. Didn't that tip it
3 over into predictable and foreseeable?

4 A Absolutely not. I knew -- I was worried about the
5 baby. I was concerned about the baby, but that is -- that
6 was not what -- most babies most likely you would've gotten
7 over there and the baby would've been perfectly fine.

8 MR. DAVIS - A moment, please, Your Honor.

9 (Pause) Thank you, Dr. Hilton. Answer any questions
10 either one of these gentlemen have for you.

11 THE COURT - Cross examination.

12 CROSS EXAMINATION

13 BY MR. BOYD -

14 Q Good afternoon, Dr. Hilton.

15 A Hello, Mr. Boyd.

16 Q You mentioned going over there to see Samantha when
17 you learned that the baby had died.

18 A I did.

19 Q I would anticipate you've had to deal with those
20 situations from time to time both as a physician and as
21 your time as a nurse. Is that correct?

22 A Yes, I have.

23 Q And grief and sorrow are natural reactions for a
24 mother in those circumstances. Is that correct?

25 A Yes.

1 Q Okay. And the -- it's to be anticipated when speaking
2 -- you're a mother yourself aren't you?

3 A Yes, I am.

4 Q And as a doctor and as a mother, that's probably the
5 hardest thing for a mother to deal with is the death of a
6 child. Would you agree?

7 A I would agree.

8 Q And it's to be expected that a mother would be
9 depressed and have a hard time over the loss of a child.
10 Is that right?

11 A I would agree.

12 Q And you've seen that as part of you -- as the time --
13 during your practice both as a nurse and a doctor. Is that
14 correct?

15 A Yes.

16 Q The -- now -- (pause) -- now, you keep records every
17 time you see a patient. Is that correct?

18 A Every time I see a patient? The majority of times I -
19 --

20 Q Don't you put it in the medical records at your
21 office?

22 A In the office, yes.

23 Q And your office keeps records or tries to keep records
24 every time there's contact with a patient. Is that
25 correct?

1 A Yes, sir.

2 Q And basically what the medical record is is a detailed
3 account of the patient's history and what you have done,
4 what your nurses do, other practitioners do in the practice
5 with regard to that patient. Is that correct?

6 A Yes.

7 Q Okay. And that is put in the patient's chart. Is
8 that correct?

9 A It is.

10 Q Okay. And that history should include any factors
11 that might help you or other doctors who provide care for a
12 patient to provide good and safe care for the patient. Is
13 that correct?

14 A Yes.

15 Q Now, the doctors in your office see a lot of patients.
16 Would that be fair to say?

17 A Yes.

18 Q And the -- you can't remember everything about a
19 patient from one visit to the next necessarily. Is that
20 correct?

21 A No, sir.

22 Q And patients who are pregnant, basically it's the
23 practice of your office to have different physicians see
24 that patient. Is that correct?

25 A Yes, sir.

1 Q Okay. Whereas somebody coming in for just
2 gynecological problems may -- or routine problems may have
3 a particular physician that just handles them, a pregnant
4 person, a woman sees different physicians. Is that
5 correct?

6 A Possibly, but we -- we share a good bit of gynecology
7 patients as well.

8 Q Okay. And -- but one reason you want to have
9 different doctors see the patient routinely is you don't
10 know who's going to be actually on call at the time of the
11 delivery, do you?

12 A That's right.

13 Q And the record -- what you do with medical records, is
14 a record lets the attending doctor know what the other
15 doctor has found concerning the patient. For instance, if
16 a patient comes in on a certain date, you can look at the
17 record and see what's gone on with that patient and what
18 the other doctors have done before that time.

19 A The word attending we don't -- we don't use very
20 often; in this setting we're all private practitioners.
21 Attendings are basically overseeing doctors during
22 residency programs and stuff, and so you have residents and
23 you have attending. I think that what you're referring to
24 is maybe the on-call physician that we have at the
25 hospital.

1 Q Well, I'm referring to -- even to your office. An
2 attending may have not been the correct word.

3 A Right. That's what I'm saying, the doctor that is
4 seeing the patient. Right.

5 Q Yes, the doctor who's seeing the patient can look back
6 and see what the doctor who has previously ---

7 A Before.

8 Q --- seen the patient.

9 A Yes.

10 Q Or if not a doctor, what some other person in your
11 office has done. Is that correct?

12 A Right.

13 Q And the attending -- the standard of care does require
14 physicians to keep well-documented records. Is that
15 correct?

16 A I assume it does.

17 Q The -- now, one thing you may want to know from a
18 record concerning an expectant mother is the last time the
19 mother felt fetal movements. Would that be fair?

20 A Well, no, sir, we don't ask them the last time they
21 felt fetal movement. We ask them if they are feeling fetal
22 movement.

23 Q Okay. And if they say they are feeling fetal
24 movement, that would mean they're feeling ---

25 A Check.

1 Q --- it during that period of time.

2 A That's right.

3 Q If they are not feeling fetal movement ---

4 A Or they -- or they say that they are feeling decreased
5 fetal movement ---

6 Q You would want to know how much it's decreased or the
7 last time that they felt it.

8 A I don't -- no, sir, it's not like that. We don't
9 really quantify that number. We just -- if they come in
10 complaining of decreased fetal movement after a certain
11 gestational age, we will order a non-stress test.

12 Q All right. Well, but there is a difference between a
13 baby say kicking seven times an hour and not 15 times or 10
14 times versus not having moved in days.

15 A Well, not having moved in days, yes, sir.

16 Q I mean one situation may be an emergency and one may
17 not.

18 A Um, it may not be an emergen -- you have to remember,
19 sometimes you don't feel fetal movement. At different
20 gestational ages you don't feel fetal movement regularly,
21 and so it's not until the baby gets a certain size that you
22 can even feel the fetal movement, and then there's a lot of
23 different variables that affect that, like whether or not
24 the woman has an anterior placenta or not. They may not

1 feel their baby moving very much at all just because
2 there's a cushion between she and the outside.

3 Q I mean there's a variety of reasons why a mother may
4 not feel a baby move.

5 A Absolutely.

6 Q And there's a variety of reasons why a mother may have
7 a decreased fetal movement.

8 A Yes.

9 Q Some of those reasons may be perfectly normal.

10 A Yes.

11 Q Some of them may not.

12 A Yes.

13 Q Some of it may be no problem at all.

14 A Yes.

15 Q Correct? And some may be a very serious situation.

16 A Potentially.

17 Q The -- now, in your record of that date -- and it's up
18 on the board. I think you've looked at it earlier -- is
19 there any documentation of what Samantha Jamison felt? It
20 says decreased fetal movement. Is there any documentation
21 of how much or what that means?

22 A No, sir.

23 Q Now, you were not the first person to see Samantha
24 Jamison. Is that correct?

25 A Correct.

1 Q Okay. According to the record, she arrived I believe
2 -- and you've looked at the record. Is that correct?

3 A I have.

4 Q Okay. She arrived at 8:40. Is that correct?

5 A Yes, sir.

6 Q Okay. And the non-stress test, according to your
7 records -- well, according to I believe based on what has
8 been said about the machine being slow, begins at 10:00
9 o'clock. Would that be correct?

10 A Yes, sir.

11 Q So there was approximately an hour and 20 minutes
12 before the non-stress test began. Is that correct?

13 A Um, if that's what it figures out ---

14 Q From the time she came in.

15 A (Indicating yes) Is that the complete -- what'd you
16 say? That's the completion of the ---

17 Q From the -- to the beginning of the non-stress test.

18 A Let's see. I believe it's stated here -- so 8:50, and
19 we think it was more like 9:50 or 10:00 o'clock, yes.

20 Q Okay. So the time was off. According to that it's
21 8:50.

22 A Right, but there's no possible way it was 8:50,
23 because she signed into the office at 8:40 and she had to
24 be seen by a nurse practitioner, evaluated and the test
25 ordered.

1 Q And that was Robin Pruette who saw her. Is that
2 correct?

3 A That's right.

4 Q Now, I just have the sign-in record up there for you
5 to look at and that's in evidence. I'm just looking at
6 that, and if you'd look at that and you can step down if
7 you'd like to.

8 A Do you need me to? I can ---

9 THE COURT - If you can see if from there, you can
10 ---

11 Q That's fine.

12 A I can. Yes.

13 Q Now, that says the time and the doctor an individual
14 is seeing. Is that correct?

15 A Yes, it is.

16 Q Okay. It looked like you had two people coming in to
17 see you at 7:55. Is that correct?

18 A Yes, sir.

19 Q Okay. And is there any indications whether those are
20 appointments or just walk-ins?

21 A They're never pointless.

22 Q They're never what?

23 A Pointless.

24 Q Not pointless. I said appointments.

25 A Oh, appointments. I was like um ---

1 Q I'm not saying ---
2 A I'm like -- no, I -- they were probably scheduled at
3 7:55.
4 Q Okay. And ---
5 A Or 8:00 o'clock.
6 Q -- so you had two appointments at 7:55 and then
7 looking down again, it looks like you had an appointment at
8 8:00 o'clock. Is that correct?
9 A So 7:55, 7:55, 8:00 o'clock.
10 Q You have another at 8:00 o'clock that appears to be
11 struck through.
12 A Eight o'clock. (Indicating yes)
13 Q Okay. And then going on down -- okay, you had an
14 appointment at 8:50 that's struck through. Is that
15 correct?
16 A (Indicating yes)
17 Q And you have another appointment at 8:55?
18 A Yes, sir.
19 Q Okay. And then we go to 9:00 o'clock; it appears you
20 may have had three appointments at 9:00 o'clock?
21 A Possibly, and I don't know that these are all
22 appointments. They're -- I mean they could be patients
23 that are signed in -- I don't know.
24 Q They're either sign-ins or walk-ins.
25 A Appointments or walk-ins. (Indicating yes)

1 Q Appointments or walk-ins, but you had three at 9:00
2 o'clock. Is that correct?

3 A Okay. Yes, sir.

4 Q Okay. You had an appointment -- or a walk-in at 9:15.

5 A (Indicating yes)

6 Q There's another sign-in that appears to be -- time's
7 not on it, but it's somewhere between 9:19 and 9:30.

8 A Yes, sir.

9 Q You had one at 10:00 o'clock or two at 10:00 o'clock
10 actually.

11 A Yes, sir.

12 Q Okay. You have one at 10:05.

13 A Yes.

14 Q You got one at 10:15.

15 A Yes.

16 Q You have one at 10:20.

17 A Forty.

18 Q That may be 10:40. That's 10:40 I believe.

19 A (Indicating yes)

20 Q You have appointment at 11:00 o'clock.

21 A Yes.

22 Q Appointment at -- or a walk -- a sign-in at 11:05.

23 A Yes.

24 Q Then your next one is a 1:40 and that appears to be
25 struck through. Is that correct?

- 1 A Yes.
- 2 Q And then 1:50 you have one and then one at 1:55.
- 3 A Yes.
- 4 Q I believe I saw ---
- 5 A Two at 1:50 and one at 1:55.
- 6 Q All right, you can be seated.
- 7 A Okay.
- 8 Q You had quite a busy morning that morning.
- 9 A I did.
- 10 Q And that probably is typical. Is that correct?
- 11 A It is.
- 12 Q Now, the -- the non- -- the non-stress test began you
- 13 say 9:50, 10:00 o'clock, something of that nature. Is that
- 14 correct?
- 15 A Yes, sir.
- 16 Q And at that point, now you haven't seen Samantha
- 17 Jamison. Is that correct?
- 18 A No.
- 19 Q You're not aware she's there at that point.
- 20 A No.
- 21 Q And the -- the non-stress test showed heart tones in
- 22 the normal range.
- 23 A It did.
- 24 Q And what that means, that the heart's beating, that
- 25 means the baby's alive at that point.

1 A Yes.

2 Q Now, there was some suspicious-looking decelerations.

3 Is that correct?

4 A In my opinion, yes.

5 Q Okay. And just tell us, what is -- and there were

6 also some contractions. Is that correct?

7 A Yes.

8 Q Okay. She didn't actually feel the contractions but

9 the machine is picking them up.

10 A Yes.

11 Q Is that right? And I believe that's the chart.

12 A Yes.

13 Q That's correct?

14 A (Indicating yes)

15 Q And tell us what a deceleration is.

16 A A drop in the baby's heart rate below -- below what

17 the baseline is.

18 Q And do you -- how many decelerations do you see?

19 A One, two, three, possible four.

20 Q You can fold that up. So based on that non-stress

21 test, Nurse Pruette decided to order a biophysical profile.

22 Is that correct?

23 A Yes.

24 Q You can fold that if you ---

25 A That's all right. If you have any more questions ---

- 1 Q And the biophysical profile involves an ultrasound.
2 Is that correct?
- 3 A Yes, it does.
- 4 Q Now, at this point you're not involved in the care of
5 Samantha Jamison. Is that correct?
- 6 A Yes, sir.
- 7 Q And you had -- in fact, you hadn't been one of the
8 physicians that's even seen her in the practice up to that
9 point.
- 10 A Yes, sir.
- 11 Q Now, the -- the biophysical profile involves an
12 ultrasound. Is that correct?
- 13 A Yes, sir.
- 14 Q And basically -- tell us the things you're looking for
15 in a biophysical profile.
- 16 A Sure. Fetal movement, fetal tone, fetal breathing and
17 amniotic fluid.
- 18 Q Okay. And the biophysical profile starts at 10:48
19 according to the record. Is that correct?
- 20 A Yes, sir.
- 21 Q Or is it 11:48?
- 22 A No, 10.
- 23 Q Ten forty-eight?
- 24 A Yes.

1 Q You were still not involved at that point. Is that
2 correct?

3 A I don't know exactly when I came into the room during
4 the biophysical, but I was there during the biophysical.

5 Q Okay. But at some point during the biophysical
6 profile you came in. Is that correct?

7 A That's correct.

8 Q Okay. And you saw what was going on with the
9 biophysical profile.

10 A Right.

11 Q Okay. Now, the -- there were certain normal findings
12 on the biophysical profile. Right?

13 A There were.

14 Q One was the amniotic fluid was normal.

15 A It was.

16 Q Okay. Which was a good sign.

17 A Yes.

18 Q Okay. The heart was beating.

19 A The heart was beating.

20 Q And that's obviously a good sign.

21 A And the overall growth was normal.

22 Q And that's -- so the baby was alive; the heart was
23 beating, again, the baby was alive at that point.

24 A Yes.

1 Q The biophysical profile also measures fetal breathing
2 movements. Is that correct?

3 A We're looking for fetal breathing motion.

4 Q Okay. Its ---

5 A It's not measuring it.

6 Q Maybe the better word would be detects fetal
7 breathing.

8 A You're watching for it, ---

9 Q All right.

10 A --- the movement.

11 Q And basically babies practice breathing when they're
12 in utero and they -- it picks that up hopefully.

13 A We're -- we're watching for it. The ultrasound
14 machine doesn't register it.

15 Q Okay. And there were none. Is that correct?

16 A There wasn't.

17 Q And there was no visualized movement. Is that right?

18 A I don't remember if there was no movement at all, but
19 there was not any -- any gross movement, enough to get any
20 points. There was no -- there was tone. There was no
21 opening and closing of the fists, there was no -- there was
22 no large movement of the baby.

23 Q And you mentioned fetal tone, but the fetal tone
24 basically that's the extension and flexion of the small
25 muscle parts, like the hands.

1 A Yes.

2 Q Like opening and closing hands, something of that
3 nature.

4 A Right.

5 Q You didn't see any of those.

6 A I did not.

7 Q And the abdominal circumference was behind the rest of
8 the measurements.

9 A That -- that would've been something that Jane
10 would've told me when I walked in.

11 Q Okay.. So you're aware of that at that time.

12 A Yes.

13 Q And I believe you said at that time you thought it was
14 an abnormal doppler, but you now think it was ---

15 A A normal doppler.

16 Q The -- and based on the findings you found there,
17 these were serious findings.

18 A They were concerning.

19 Q And you testified earlier that it could be something
20 that the baby would ---

21 A Do better out than in.

22 Q --- can do better afterwards. But it also could be
23 something much more serious.

24 A I -- I testified that some babies at this point would
25 do better out than in.

1 Q All right. And so it could be a matter of life and
2 death for the baby at that point.

3 A It could potentially be concerning that she may
4 require an early delivery.

5 Q And based on that you thought it was best for her to
6 go immediately to the hospital.

7 A I wanted her to go to the hospital.

8 Q And you notified Dr. Benson she was coming.

9 A I did.

10 Q And it was important at that point that she go
11 directly to labor and delivery.

12 A Yes, it was.

13 Q The -- you -- now, of course, you kept on -- according
14 to the record, you kept on -- after you dealt with that,
15 you kept on seeing patients. Is that correct?

16 A I did.

17 Q Now, there was no record in the records of how much
18 movement she had been having, how much -- how much the
19 movement had decreased or anything of that nature put down
20 on the record on September the 5th, was there?

21 A On September the 5th it just is documented decreased
22 fetal movement.

23 Q Now, you mentioned -- you mentioned something called
24 oligo in your direct examination. Is that correct?

25 A Just a minute ago?

1 Q Yes.

2 A Yes.

3 Q Okay. And that has a longer name. Is it oligo ---

4 A Oligohydramnios.

5 Q --- hydramnios or ---

6 A Oligohydramnios.

7 Q Hydramnios. Tell us again what that -- what is that?

8 A An amniotic fluid index less than five.

9 Q Okay. The -- and you -- you said that that child in

10 this case -- or Ms. Jamison in this case did not have that.

11 Is that correct?

12 A That is correct.

13 Q Okay. Let me show you a document. This appears to be

14 a billing report from your office. Can you look at that?

15 A I can.

16 Q Okay.

17 A I've never looked at one of these before.

18 Q Okay. But somehow what you do gets into a billing

19 record. Is that correct?

20 A It does. It does.

21 Q And if you look up there on September the 5th, does it

22 look like -- I'm going to call it olig -- one of the ---

23 A I know. Oligohydramnios.

24 Q --- one of the diagnoses.

1 A Yes, it does, but I don't have any idea how that got
2 documented.

3 Q But it is in the billing record.

4 A It is in the billing record, and I think it's on her
5 sheet. If you'll hand me her router, I think that Robin
6 Pruette had put that on her router, but she did not have
7 oligohydramnios.

8 Q Now, at the ---

9 A And -- I mean I clearly state that her AFI is 14 on
10 September the 5th.

11 Q Okay. It's on that record, but it did get into the
12 billing record.

13 A Right.

14 Q Is that correct?

15 A Right.

16 Q Now, the -- at the time -- at 10:40 -- 10:58 when the
17 biophysical profile was completed, the baby was alive at
18 that point and the heart was beating.

19 A Yes, sir.

20 Q Okay. The -- at -- so some time between that time and
21 approximately 11:48 ---

22 A Yes.

23 Q --- the baby died during that period of time.

24 A Yes, sir.

1 Q Now, I want to ask you -- concerning -- did you -- at
2 the time that you saw Ms. Jamison, did you see -- did you
3 have -- what record did you have in front of you? Did you
4 have a record of her visits on -- to the hospital on August
5 the 9th and her record of the visit on August 25th to your
6 office?

7 A I probably was handed the chart, but honestly what I
8 probably looked at, when I was making her assessment I was
9 not -- I was not reviewing her entire chart at that point
10 in time. I probably had this sheet in front of me which is
11 -- basically tells me what her problem list is and, you
12 know, follows a course of what her prenatal care was, and
13 then I had the information at hand, that she was 31 and
14 6/7ths, she had this NST and this biophysical.

15 Q Okay. Were you aware at that time that she had
16 chronic hypertension?

17 A I was.

18 Q Okay. Were you aware that she had had a previous
19 uterine rupture?

20 A Yes, I was.

21 Q Now, the biophysical profile is scored in a certain
22 way. Is that correct?

23 A It is.

24 Q Okay.

1 A And I -- you know, I did want to clarify that because
2 there's nothing in between. You either get zero if it's
3 not there, or you get two if it is there. There's no one.
4 I don't know why they did it that way, but there's no in-
5 between. It's either there or it's not there. So you
6 can't have odd numbers.

7 Q Let me -- bear with me one minute. Now, -- but there
8 is a scoring system concerning the biophysical profile. Is
9 that right?

10 A Yes.

11 Q Okay. And one thing -- I think on your index, the --
12 one of the things about the biophysical profile on your
13 index is -- I think she was awarded a two out of eight. Is
14 that correct?

15 A Yes.

16 Q Or that was the score?

17 A Yes.

18 Q I want to ask you about that. But -- the -- I wanted
19 to ask you about -- if you'd look at that record, I believe
20 that's the hospital record. I'm sorry. It's up on the
21 board. Patient admitted doctor's office, was a diagnosis
22 of oligo again.

23 A (Indicating yes)

24 Q Do you have any idea how that got in the record?

25 A I do not.

1 Q Okay. So it got into the billing record and also in
2 the Piedmont Medical Center record.

3 A Yes.

4 Q You have no explanation for that?

5 A I do not. I did not diagnosis her with that, nor did
6 I state that.

7 Q Now, your attorney asked Dr. Phillips yesterday I
8 think some questions from a book of Gabby by Obstetrics.
9 Are you familiar with this book?

10 A Gabby.

11 Q Gabby. Okay.

12 A Yes, sir.

13 Q You're familiar with that book?

14 A Well, I don't know about this particular edition, but
15 I have used Gabby in the past.

16 Q Okay. Would you recognize that as reliable source for
17 information?

18 A No, sir, not -- not up to date.

19 Q Not up to date.

20 A Not typically.

21 Q So did your lawyer ask the witness a question from
22 books that wasn't up to date yesterday?

23 A I'm not sure what edition they were referring to, but,
24 you know, they're always changing the information and -- so
25 -- I mean we do the best we can keeping everything up to

1 date, but textbooks are, you know, as good as they were
2 when they were printed.

3 Q Let's see. This is a 5th edition -- looks like
4 copyrighted in 2007. Do you know if there's an additional
5 edition after that?

6 A I am not sure.

7 Q Well, let me ask you about the biophysical profile.
8 If you include the non-stress test in that, do you score it
9 on a system of 10, instead of ---

10 A Yes. Yes, two out of 10.

11 Q Okay. If -- if the Gabby book stated that twice
12 weekly test is in (sic) recommending in pregnancies
13 complicated by restrictive growth ---

14 A This baby did not have IUGR.

15 Q Okay. I'm just ask -- let me ask the question ---

16 A Okay.

17 Q --- before you answer it, then you can explain it. Or
18 diabetes or long gestation or hypertension with
19 proteinuria. Would you agree with that?

20 A I'm unsure what your question is.

21 Q Well, I ask you, if those items I mentioned, if
22 testing is recommended, that book recommends testing twice

23 ---

1 MR. DAVIS - Objection, Your Honor. Objection.
2 He's quoting from a book that has not been established by
3 the 803-18. Improper foundation.

4 THE COURT - Not the same book you used yesterday?

5 MR. DAVIS - Your Honor, there's been no 803-18.
6 That foundation ---

7 THE COURT - All right, so when you used it
8 yesterday it wasn't proper either. So what do I tell them?

9 MR. DAVIS - Well, I didn't use it; my partner
10 did, but I'm telling the Court ---

11 THE COURT - All right, sir, you can't use it.

12 MR. DAVIS - Thank you, Your Honor.

13 MR. BOYD - What was your ruling?

14 THE COURT - You can't use it until it's been
15 properly authenticated under 803. Thank you.

16 Q Let me ask you. If -- would you agree that the --
17 that there's no danger to a mother from a non-stress test?

18 A Danger to a mother ---

19 Q To the mother. It's not an invasive test is it?

20 A It is not an invasive test.

21 Q I mean you don't stick a needle in the mother ---

22 A We do not.

23 Q --- or anything like that. Okay. So I mean it's no
24 harm in running a non-stress test.

1 A Well, non-stress test are only as valuable as, you
2 know, they can be predictive and sometimes non-stress test
3 are not predictive. You can't -- you can't just -- you
4 couldn't get a non-stress test on a 20 week baby.

5 Q Okay. I understand. I'm not asking you the value of
6 it.

7 A Okay.

8 Q I'm asking you, it's no. ---

9 A It's not harmful.

10 Q --- there's no harm.

11 A There is not a harm.

12 Q And based on your training and experience, what is the
13 earliest that a non-stress test can be used?

14 A It depends on the situation at hand, but we do start
15 ordering non-stress test if the patient comes in with a
16 complaint around 28 weeks.

17 Q About 28 weeks.

18 A You can.

19 Q And Ms. Jamison is at 32 weeks.

20 A That's right.

21 Q Estimated at this time.

22 A Yes, sir.

23 Q Okay. And how about a biophysical profile? When is
24 the earliest a biophysical profile can be conducted?

1 A Again approximately the same gestation, 28 to 30
2 weeks.

3 Q And again Samantha Jamison is at approximately 32
4 weeks.

5 A Right.

6 Q So she's of appropriate age that either of those --
7 she's at the appropriate gestational period that any of ---
8 either of those tests can be used. Is that correct?

9 A If they were indicated, yes.

10 Q Okay. And basically two weeks before she's at the age
11 where either of those tests can be done.

12 A If indicated.

13 Q And the -- a biophysical profile, is that non-invasive
14 test also?

15 A It is.

16 Q Okay. It's no harm in doing that test.

17 A No, sir.

18 Q The -- now, there's a scoring system and basically you
19 said she scored a two out of eight on the biophysical
20 profile that was done in your office. Is that correct?

21 A Yes.

22 Q If -- and the -- that required some further testing in
23 your opinion.

24 A Further evaluation.

25 Q Further evaluation.

1 A Yes.

2 Q Okay. And it's within the standard of care to do
3 further evaluation under those circumstances. Is that
4 correct?

5 A Yes, it is.

6 Q In fact, not to do further evaluation at that point
7 would be a violation of the standard of care.

8 A I would think that you would need to complete the
9 test.

10 Q And let me ask -- if it's a score of -- not of two,
11 but a score of four, would that mean further evaluation
12 also?

13 A It would.

14 Q Okay. And it would be -- would that be a violation of
15 the standard of care not to conduct further evaluation if
16 there was a score of four?

17 A You would need to repeat the test, yes.

18 Q How about if there's a score of six? And we're going
19 in increments of twos.

20 A Right. Right. You're going to follow it up.

21 Q Okay. If a score of six, would that require also
22 follow-up?

23 A Yes.

24 Q Okay. Would it be a violation of the standard of care
25 not to follow-up with a score of six?

1 A Yes.

2 Q How about a score of eight? Would that require
3 follow-up?

4 A Well, a perfect -- that's a perfect score on this test
5 and she would need to be evaluated according to her medical
6 history.

7 Q Okay. How about if it was a score of eight on the
8 biophysical profile with problems as Ms. Jamison ---

9 A The strip.

10 Q --- had on the non-stress test?

11 A She would've still gone to labor and delivery for
12 prolonged monitoring.

13 Q Okay. So if she had scored an eight that day on the
14 biophysical profile, you would've still ---

15 A I would've still sent her to labor and delivery.

16 Q --- sent her to the hospital. Okay. So an eight
17 would be a perfect score. Is that correct?

18 A Well, if you include the NST a 10 would be, but if
19 you're just talking about the ultrasound portion, it'd be a
20 eight.

21 Q Okay. The ultrasound portion would be an eight. So
22 what you're saying is, regardless of the outcome of the
23 biophysical profile on that date, just based on the non-
24 stress test you are going to send her to the hospital.

1 A She would've gone for prolonged monitoring most
2 likely, yes. Yes.

3 Q Okay.

4 A But I would've been much more reassured with an eight.

5 Q Of course, the higher the score, the better.

6 A Yes.

7 Q Okay, the lower the score, the worst.

8 A That's right.

9 Q I mean two -- two was a very bad score.

10 A A very concerning score on a truncated test.

11 Q Was there any medical reason that a non-stress test
12 couldn't have been done a week earlier?

13 A It was not indicated.

14 Q I'm not asking you if it was indicated. Was there any
15 medical reason, any reason of harm to the patient or the
16 child not to do it.

17 A Again, as doctors we have to order tests that we feel
18 are indicated, and so there was no reason for her to get an
19 NST a week earlier.

20 Q But Ms. Jamison was a high risk patient. Is that
21 correct?

22 A She was. She was.

23 Q Okay. She was a patient who had chronic hypertension.

24 A She did. Always controlled in the office. Always
25 controlled.

1 Q Had a prior uterine rupture.

2 A Yes, sir.

3 Q She had been to the hospital on August the 9th with
4 abdominal pains. Is that correct?

5 A Yes, sir.

6 Q Okay. She had had also on her August 25th visit had
7 ankle swelling. Is that correct?

8 A Completely within normal limits for a pregnant woman.

9 Q Well, that -- that can be a sign of hypertension.

10 A Not -- not when it's just one ankle; no, typically
11 not.

12 Q She -- and she had -- also -- well, at the time you
13 saw her had reported decreased fetal movement. Is that
14 correct?

15 A Well, that's at 32 weeks, yes.

16 Q Bear with me one minute. (Pause) Basically you told
17 her to go to labor and delivery. Is that correct?

18 A Yes.

19 Q Okay. And that Dr. Benson would be assessing her
20 there. Is that correct?

21 A Yes.

22 Q Okay. And the -- did you think it was probable that
23 she would have a c-section at that time?

24 A Didn't know. She could potentially need a c-section
25 later on that day or urgently. I didn't know.

1 Q Do you think it was incumbent upon her -- incumbent
2 upon the personnel receiving her at the hospital to be
3 prepared to do a c-section?

4 A We're always prepared to do a c-section in labor and
5 delivery.

6 Q Okay. So that can be done ---

7 A Pretty quickly.

8 Q Within a matter of minutes that can be ready?

9 A Yes, sir.

10 Q Okay. And looking at the admission date -- and that's
11 down here -- again, if you can look at it ---

12 A Yes.

13 MR. DAVIS - Your Honor, can we have an
14 identification of what the portion of this record is we're
15 looking at, please, sir.

16 THE COURT - Please do that.

17 MR. DAVIS - Thank you.

18 Q That's the -- I believe the hospital admission date --
19 -

20 A That's a discharge summary.

21 Q --- on the discharge summary of -- signed off by Dr. -
22 --

23 A So that's back in the back.

24 Q Right. Signed off by Dr. Benson.

25 A Okay.

1 Q Wait a minute. I'm not through down here.

2 A Oh, okay.

3 Q I'm sorry. We just got to get it focused a little
4 better. He states in his -- in that report, I was
5 contacted by Dr. Hilton, and our plan was to perform a c-
6 section immediately upon the patient's arrival to labor and
7 delivery.

8 A Yes, sir.

9 Q Okay. You can have a seat. So that states the plan -
10 --

11 A Well, you have to -- this is ---

12 THE COURT - All right, hold on. Hold on one
13 second. Apparently the witness wants to finish answering
14 the question. Allow her to do so and you can ask the next
15 question.

16 A Okay.

17 THE COURT - Go ahead, ma'am.

18 A This is a discharge summary, so the outcome is already
19 known that the baby's passed away. Obviously my plan was
20 the most perspective plan that we had, and that's what's
21 documented in our chart, and she was going to go for
22 evaluation, and should she need an emergency c-section, she
23 would've had one done, which we're prepared to do when
24 patients present to labor and delivery. After the fact,
25 Dr. Benson knows the outcome here, and he's already

1 dictated knowing what has already happened, but he was just
2 telling the story about what we would've done had we needed
3 to do it.

4 Q Well, he says our plan was to perform a c-section.

5 A I understand ---

6 Q That's looking into the past.

7 A -- and if the evaluation had shown that she had needed
8 one, we would certainly done it.

9 Q Was Robin Pruette, Nurse Pruette, basically -- let you
10 drink your water -- Nurse Pruette was the primary caretaker
11 for her on September 5th up until the time you got involved.
12 Is that correct?

13 A She was the person who initially evaluated her,
14 ordered the NST and the biophysical profile.

15 Q Okay. Well, she got -- Nurse Pruette ordered the
16 biophysical profiled -- ordered the non-stress ---

17 A And to see me.

18 Q --- test. Is that correct?

19 A She - and it's ---

20 Q You got involved with the patient approximately 10 --
21 some time after 10:50 or thereabouts. Is that correct?

22 A Yes, sir.

23 Q Okay. So for the -- from 8:40 to 10:50, that two hour
24 and 10 minute period or something, you weren't involved
25 with the patient. Is that correct?

1 A Not to my knowledge.

2 Q Okay. So Nurse Pruette would've been the person
3 primarily responsible for her care in the office up until
4 the point you got involved for that two hours and 10
5 minutes. Would that be correct?

6 A Yes.

7 Q Okay. And did you see in the records, was there any
8 blood pressure taken in the office on September the 5th?

9 A No, there was not that I can - that was documented.

10 MR. BOYD - That's all the questions I have.

11 THE COURT - Re-direct.

12 MR. DAVIS - Thank you, Your Honor.

13 RE-DIRECT EXAMINATION

14 BY MR. DAVIS -

15 Q Let's start with this nurses' record that he showed to
16 the jury.

17 THE COURT - All right, ma'am, just -- if you can
18 get just a little bit closer to the court reporter because
19 she's got to be able to hear you.

20 DR. HILTON - Okay. I'm sorry.

21 Q And this - this is already in evidence as part of the
22 hospital record that was generated by personnel at Piedmont
23 Medical Center and others, your partner, Dr. Benson. This
24 is in evidence and I want to -- can you read that okay?

- 1 A Yes.
- 2 Q I've got it highlighted, so it might be more
3 difficult, but do you know Betsy Peake?
- 4 A I do.
- 5 Q Who is Betsy Peake?
- 6 A She's a nurse at -- she was a nurse in labor and
7 delivery at that point in time. She's a nurse at North
8 Central now.
- 9 Q Is she a labor and delivery nurse as you used to be?
- 10 A She is.
- 11 Q Let's read this together. Late entry. First of all,
12 what does late entry mean? You were a nurse at labor and
13 delivery. You've done that. What does that mean?
- 14 A That means that when a patient comes in, you're taking
15 care of the patient, you're doing all the things that a
16 patient (sic) needs to do, but you're not actually
17 documenting or writing in a chart at that particular time,
18 so you have to sit down after all -- all the care that
19 you've given and document it.
- 20 Q As a nurse, in your experience as a nurse, would there
21 be occasions from time to time where you were involved with
22 patient care to the point that you had to make late entries
23 in the record?
- 24 A Yes.

1 Q What's more important as a nurse, you having been a
2 registered nurse on labor and delivery, taking care of
3 patients or documenting in the chart?

4 A Taking care of patients.

5 Q But you've got to do both, don't you?

6 A You do.

7 Q That why we have late entries?

8 A That's right.

9 Q Let's read this one. Late entry, 11:40, patient
10 admitted AMB. What's that stand for?

11 A Let's see -- patient admitted ambulatory, meaning she
12 walked.

13 Ambulatory from -- is that doctor's office?

14 A Right.

15 Q We have diagnosis of -- there's that great big word --
16 oligo whatever ---

17 A Hydramnios, yes.

18 Q --- slash IUGR slash -- and a biophysical profile of
19 two.

20 A Yes.

21 Q Is that accurate?

22 A It is not accurate.

23 Q Did she have oligo?

24 A She did not.

25 Q Did she have IUGR?

1 A She did not.

2 Q This is not your note.

3 A It is not.

4 Q Is it Dr. Benson's note?

5 A It is not.

6 Q Patient arrived -- where we were -- biophysical --

7 patient frightened, reassured, her mom is on the way, to

8 bed, EFM placed. What's an EFM?

9 A External fetal monitor.

10 Q I was unable to auscultate. What does auscultate

11 mean?

12 A Hear.

13 Q And what does FHTS stand for?

14 A Fetal hear tones.

15 Q Slash Joan Allen, RN. Who's Joan Allen?

16 A Another labor and delivery nurse.

17 Q All right. Next line. Assisted with the effort --

18 oh, I'm sorry -- Joan Allen, RN ---

19 A Right.

20 Q --- assisted with the effort.

21 A Right.

22 Q I apologize.

23 A So that means when she couldn't hear the heart tones,

24 she called in another nurse to listen for the heart tones.

25 Q As a labor and delivery nurse, was that often done?

1 A Yes.

2 Q I ---

3 A That's a thousand CC, ringers lactated IV left arm
4 times two stick, meaning that they are sitting there
5 waiting on her, waiting to be evaluated, they've already
6 got IV stuff in the room, they're starting a IV, so it
7 tells me that Dr. Benson must've already said, hey, we got
8 this lady coming, we need to jump on her when she gets
9 there.

10 Q The very second line, I was unable to hear fetal heart
11 tones and got another nurse to assist.

12 A Yes.

13 Q It was after that that we got the IV starting to go
14 in. Right?

15 A Right.

16 Q As we wait for Dr. Benson, what is that, ultra ---

17 A Ultrasound, right. So the ultrasound ---

18 Q What's going on there? What are they going?

19 A Right, the ultrasounds are not in the room, so in
20 these triage rooms there are fetal monitors, and so the
21 nurse would listen for -- when a patient comes up listen
22 for the fetal heart tones, you know, try to move the
23 monitor around, get the patient in a different position,
24 keep moving the monitor around. When they both cannot find
25 the heart tones, they would call for the doctor and -- who

1 -- or another nurse would bring the ultrasound inside the
2 room, and the doctor would perform the ultrasound in the
3 room.

4 Q Okay. Next time, 11:49, ultrasound, Dr. Benson
5 reveals an IUFD. What does that stand for?

6 A Intrauterine fetal demise.

7 Q Patient very upset as she had heard the ---

8 A Fetal heart tones ---

9 Q --- prior to leaving the doctor's office breathing
10 appropriately; awaiting mom's arrival, 1310 mom arrived.
11 Dr. Benson back in -- what is that?

12 A Dr. Benson back in to do a second ultrasound,
13 revealing intrauterine fetal demise.

14 Q Plan of care discussed with mom and her mom.

15 A Right.

16 Q She can have a primary ---

17 A Primary cesarean section ---

18 Q --- today.

19 A --- today.

20 Q And what's that? What's the rest of that?

21 A History of ruptured uterus.

22 Q Is that in parenthesis?

23 A Yes.

24 Q Okay. Or she can opt to go home and return within a
25 week; 1340 patient called out and she has decided to

1 proceed with a primary cesarean section today; 1347, Dr.

2 Hilton came by; 1400, patient thinking about -- what's

3 PPTL?

4 A Postpartum tubiligation.

5 Q Was given the opportunity to return at a later date.

6 Did you also have a discussion with her about that?

7 A I believe I did, and um -- because actually they had

8 testified to it in their deposition, but it would've been

9 my practice when I came to talk to her to encourage her not

10 to tie her tubes during this event, because she may regret

11 it. We know people that have bad outcomes and like this,

12 you know, may even though it's really sad at this point in

13 time and they think that they don't want to ever go through

14 this again, they may indeed want to have another child, and

15 so we encourage them not to tie their tubes after an event

16 like this immediately.

17 Q And -- and they can come back later?

18 A Absolutely.

19 Q Did you advise her of that?

20 A I did.

21 Q For an outpatient PPTL, tubiligation, IV site clean.

22 Is that right?

23 A Clean, no abdominal tenderness, no vaginal bleeding,

24 out of bed to bathroom voids, um ---

25 Q What's QS? Quantity sufficient?

- 1 A As needed. Yes, quantity sufficient as needed.
- 2 Q All right.
- 3 A Dr. Benson notified of patient's decision to proceed
4 with c-section today.
- 5 Q Thank you, ma'am. Few more questions if I could. You
6 were asked about when a patient comes in the office walking
7 in as Ms. Jamison did on that day with the complaint to the
8 healthcare provider, to the office, of decreased fetal
9 movement, you were asked the question about sometimes that
10 can be okay and sometimes that can be real serious. Right?
- 11 A Yes.
- 12 Q How do you sort it out? What do you do? What's the
13 standard of care require you to do?
- 14 A We evaluate the patient.
- 15 Q How do you do that?
- 16 A With a NST.
- 17 Q And if that is indeterminate, then what do you do?
- 18 A A biophysical profile.
- 19 Q Is that what the standard of care requires you to do?
- 20 A Yes, sir.
- 21 Q And that was done this time?
- 22 A Yes, sir.
- 23 Q And then you sent her to labor and delivery based on
24 all those things.
- 25 A Yes, sir.

1 Q If Ms. Jamison had to wait for that 8:40 in the
2 morning, on this morning, and we've seen all the patients
3 that signed in ahead of her, 19, until about 10:30 or
4 10:20, to be called back and seen by Robin Pruette an hour
5 -- if she had to wait an hour before that happened, do you
6 have an opinion with her history and her complaint that day
7 whether that would constitute an inexcusable delay?

8 A No, I do not feel like that's an inexcusable delay.

9 Q In your opinion would that passage of time with her
10 that day knowing everything that we knew at that time, not
11 what we ---

12 A Well, at that time, yes, it was completely within
13 normal limits.

14 Q Okay. Dr. Hilton, do you and does your office to your
15 knowledge treat walk-ins the same as you would a patient
16 with an appointment?

17 A Absolutely.

18 Q Same standard of care followed.

19 A Absolutely.

20 Q Do you -- is it your practice to spend your time with
21 your patients, whether it's walk-in or appointment?

22 A Yes, sir.

23 Q What does the standard of care require you as to
24 giving that patient that you have, whether it's a walk-in,
25 whether it's an appointment, your attention?

1 A To be properly evaluated and taken care of.

2 Q Did you do that with Ms. Jamison?

3 A We did.

4 Q They asked you about a billing record. Did you
5 generate that billing record?

6 A I did not.

7 Q Did she had oligohydramnios?

8 A She did not.

9 Q Did I pronounce that right?

10 A Oligohydramnios.

11 Q Can we say oligo?

12 A Oligo's fine.

13 Q She didn't have it, did she?

14 A She did not.

15 MR. DAVIS - All right. Hold one second. I think
16 I've done. Thank you, Doctor.

17 THE COURT - Questions on new matter only.

18 MR. BOYD - None.

19 THE COURT - You may step down, ma'am.

20 MR. DAVIS - Thank you, Your Honor.

21 THE COURT - All right, ladies and gentlemen,
22 we're going to take a break. Please go back to your jury
23 room for about 10 minutes or so and we'll resume after
24 that. Everyone else remain seated while the jury retires.

25 (Jury exits the courtroom)

1 THE COURT - All right, anything from the
2 plaintiff at this point in time?

3 MR. BOYD - No, sir.

4 THE COURT - All right then. From defense?

5 MR. DAVIS - No, sir, thank you.

6 THE COURT - All right, we'll take a short break
7 for about 10 minutes.

8 (Recess taken)

9 THE COURT - Thank you very much. You may be
10 seated. Thank you. All right, as I understand it,
11 counsel, Dr. Benson is the next witness. Correct?

12 MR. DAVIS - Yes, sir.

13 THE COURT - All right, we will continue on. We
14 will certainly get through the direct examination today.

15 MR. DAVIS - Okay.

16 THE COURT - We're going to finish the direct
17 examination.

18 MR. DAVIS - Thank you.

19 THE COURT - Whatever -- however long that takes.

20 MR. DAVIS - Thank you, Your Honor.

21 THE COURT - At that point in time I'll make a
22 determination if we're going to stop or go through the --
23 or go through the cross examination today. We'll see. How
24 about that? Probably what I'll do is after you're done

1 with the direct, I'll most likely probably call all y'all
2 up here and we'll talk about this.

3 MR. DAVIS - We're at your pleasure, Judge, and if
4 you want to -- and I told your law clerk during the break,
5 if in your discretion you wish to break the direct
6 examination at any point, I'm perfectly ---

7 THE COURT - I'm not -- that I'm not going to do.
8 I'm definitely not going to do that. We will finish the
9 direct examination today. It'll be done. However ---

10 MR. DAVIS - Thank you so much.

11 THE COURT - Okay? All right, let's have the jury
12 come in, please.

13 (Jury returns to the courtroom)

14 THE COURT - All right, your next witness,
15 counsel.

16 MR. DAVIS - Your Honor, defense would call Dr.
17 Christopher Benson.

18 THE COURT - Please come around and be sworn,
19 please. Meet the clerk right there at the corner, please.

20 DR. CHRISTOPHER BENSON, AFTER BEING FIRST DULY
21 SWORN, TESTIFIES AS FOLLOWS:

22 THE COURT - State your full name for the record,
23 please.

24 DR. BENSON - My name is Christopher Bruce Benson.

25 THE COURT - All right, sir. Go ahead, sir.