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SC Court of Appeals

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

The Honorable D. Garrison Hill

C.A. No. 2011-CP-23-6665

Demetria Orange, as Next Friend of
J.B., a minor, Respondent,

Respondent,

v.

Greenville Hospital System and Greenville
Hospital System Partners In Health, Defendants

Of which Greenville Hospital System is

Appellant.

RECORD ON APPEAL

VOLUME II OF II

HAYNSWORTH SINKLER BOYD, P.A.
J. Ben Alexander, SC Bar No. 015323
Sarah P. Spruill, SC Bar No. 68337
ONE North Main St., 2nd Floor
Greenville, SC 29601-2772
Telephone: 864.240.3200
Facsimile: 864.240.3300

Attorneys for Appellant Greenville
Hospital System

GRAHAM LAW FIRM, P.A.
Edward L. Graham
Diane M. Rodriguez
J. Layton Ruffin
P.O. Box 550
383 W. Cheves St.
Florence, SC 29503
Telephone: 843.662.3281

Attorneys for the Respondent
Demetria Orange, as Next Friend of
J. B., a minor, Plaintiff

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1 raise your right hand.

2 WHEREUPON,

3 CHARLES JOHN VANDERKOLK,

4 after first having been duly sworn, testified as follows:

5 THE CLERK: State your name, please.

6 THE WITNESS: Charles John Vanderkolk.

7 THE CLERK: Thank you.

8 Please be seated.

9 DIRECT EXAMINATION

10 BY MS. RODRIGUEZ:

11 Q Dr. Vanderkolk, we have pre-marked a copy of your CV
12 and your report. So I'm just going to hand those up to
13 you, and let you use those along.

14 A Okay.

15 Q Dr. Vanderkolk, if you would, please, explain to the
16 jury -- just introduce yourself and tell them what it is
17 you do.

18 A I'm sorry?

19 Q I'm sorry. Would you introduce yourself to the jury?

20 A Charles John Vanderkolk.

21 Q And could you tell them a little bit about your
22 educational background?

23 A I graduated from a small Christian liberal arts
24 college in Michigan called Hope College. I have a
25 Master's Degree from Michigan State University in

1 rehabilitation counseling. I have a PhD from State
2 University of New York at Buffalo in rehabilitation
3 counseling psychology.

4 Q And, if you would, just explain to the jury what it
5 is that a vocational -- what your field is. They're not
6 going to understand probably. We don't encounter very
7 many people with your type of job. Explain to them what
8 it is you, actually, do.

9 A Sure. Well, rehabilitation counseling is a field
10 within psychology. And we work with people who have
11 disabilities. They may have physical disabilities, or
12 mental, emotional, all sorts of disabilities.

13 And we take a rehabilitation point of view, which
14 means what we try to do is look at -- we recognize
15 people's problems with the disability. But we try to
16 focus on the positive aspects, because everybody has
17 strengths. Even if you have a disability, you have some
18 things going for you.

19 So we try to help people, number one, adjust to the
20 disability, deal with it in an emotional positive way.
21 And we, also, help people with their vocational path.

22 So we feel like work is very important for people.
23 And that people with disabilities very often are able to
24 work if we can find what the strengths are, give them
25 proper training and education. We work with job

1 placement, helping people understand how do you get a job,
2 how do you prepare yourself for that.

3 We do vocational testing and psychologically-based
4 testing to understand the person that we're working with,
5 usually, so that we can help them plan for the future. If
6 they're having some problems with depression or anxiety,
7 we try to deal with that.

8 We try to look at abilities and interests to try to
9 help people get into a vocational path that would be
10 satisfying to them, and where they would most likely be
11 successful. And we normally follow-up with people, also,
12 to make sure if they do get on a job, hopefully, they'll
13 stay on a job. Some of you may have heard the term
14 poaching, which means follow through and work with the
15 employer and person to help them stay on the job.

16 But the more heavily psychological aspect that I did
17 in the doctor level was dealing with people's -- what we
18 call psychosocial adjustment to disability. Especially if
19 you have a fairly severe or moderate disability, a lot of
20 times you face negative attitudes from the community,
21 stigma, lack of acceptance.

22 And so people need to -- people with a disability
23 need to learn to try to cope with that and deal with it.
24 Often, there's depression. Anxiety are common factors
25 with people with a disability that we try to minimize. So

1 that's where the more heavily psychological aspect comes
2 into the picture.

3 Q Doctor, do you hold any types of certifications?

4 A I'm a licensed psychologist in South Carolina and
5 North Carolina. And I'm a nationally board certified
6 rehabilitation counselor.

7 Q And, if you could, just very briefly summarize your
8 job background, or your employment background for them.
9 And, if you would, mention your work with the Social
10 Security Administration.

11 A Okay. I'll try to briefly summarize. Let's see. I
12 worked at a V.A. hospital during my training, and then was
13 hired for a while before I went on for the doctoral
14 degree. I worked in schools as a school psychologist. I
15 worked in a children's clinic working with children who
16 had emotional problems, physical disability problems.

17 I worked in disability centers working with children
18 who had severe disabilities. I was a professor beginning
19 in 1970 at State University of New York at Albany where I
20 was employed full-time. And I did clinical work on a
21 part-time basis.

22 When I left there, I was chairman of the department
23 of counseling psychology in 1978. I came to the
24 University of South Carolina in Columbia in 1978. And I
25 became the director of the graduate program and

1 rehabilitation counseling. And I stayed there until 1995.
2 We were in the medical school at that time in the
3 department of neuropsychiatry.

4 Again, I did clinical work with people with
5 disabilities during that time. We were allowed a day a
6 week to do clinical work so that we could round out. So
7 we were in the ivory tower all the time. And, of course,
8 doing research and publishing. I published a few books
9 and about 30 articles.

10 And we, also, had a clinic where we saw people with
11 disabilities. It was a training situation for students.
12 We had a one-way mirror. And people came in with various
13 physical disabilities and social, mental disabilities.
14 And we did evaluations and follow-up counseling, and tried
15 to help with adjustment and job placement with people.

16 And since I retired, I've been working privately as a
17 consultant in vocational rehabilitation and psychology.
18 Again, mainly, I'm working with people with disabilities,
19 many of them who have been injured or somehow have
20 acquired a disability. I've been doing evaluations and
21 doing follow-up counseling with people with disabilities
22 since about 1988 or so.

23 Until about five years ago, I was under contract with
24 the federal government to provide evaluations for people
25 who were claiming disability. So I worked with the social

1 security disability office. And they asked me to evaluate
2 people who were claiming a disability. And I went to
3 hearings before an administrative law judge and testified
4 about what their capacities were, and whether there were
5 jobs that existed in the U.S. economy that they would be
6 able to perform. I think that pretty much covers it.

7 Q Thank you, Doctor.

8 And in terms of that role, do you then prepare
9 vocational evaluations or written reports based on the
10 people that you are involved with?

11 A Is that with social security disability?

12 Q No. I'm sorry. Just in general, do you form
13 vocational evaluations?

14 A In general, I go through a standard evaluation
15 procedure and, usually, provide a written report, yes.

16 Q Okay. And have you done that in this case?

17 A Yes, I have.

18 Q Now, if you could, just, again, just very generally
19 describe to the jury what your methodology is, what type
20 of materials you would review, you know, how it is you,
21 actually, come up with a vocational report?

22 A Okay. Each case is a little bit different. In this
23 case, I reviewed medical information, which is standard.
24 I need that as background information. I interviewed a
25 significant person in the family. When it's a child, it's

1 whoever would know the child the best, the current parent
2 or custodian of that child. Then carry out research, pull
3 all the information together, and arrive at conclusions.

4 And in this kind of situation, what I'm looking at
5 is, one, is there a disability? If there is, what's the
6 nature of it? Would this disability possibly impair the
7 person as far as work or income level?

8 So I investigate that. And then I come up with -- if
9 there is going to be a loss of earnings, how much might
10 that be? What would be the range? What can we estimate
11 in this particular case.

12 MS. RODRIGUEZ: Thank you.

13 Your Honor, we would offer Dr. Vanderkolk as an
14 expert in the fields of vocational rehabilitation and
15 psychology.

16 MR. ALEXANDER: No objection.

17 THE COURT: Okay. He's qualified.

18 MS. RODRIGUEZ: Thank you, Your Honor.

19 BY MS. RODRIGUEZ:

20 Q Now, in this particular instance, did you prepare a
21 report?

22 A Yes, I did.

23 Q And, if you would, as you're going along here,
24 please, feel free to take a look at your report and sort
25 of summarize for the jury what evaluation you made of

1 **J.B.** And as you're doing that, if you could,
2 just sort of address what you reviewed in that evaluation.
3 A Okay. Well, the first thing that I do is look at the
4 medical records. We have to establish that there really
5 is a disability.

6 So I went through, essentially, the discharge
7 summaries of when **J.B.** was in the hospital and
8 evaluations to establish that, in fact, she does have a
9 disability. So that was the first step, reviewing the
10 medical records.

11 And I'm not sure if you want me to go into that in
12 any more detail. Y'all probably have heard plenty of that
13 already.

14 Q Right. If you could only address those issues from
15 the medical care that are relevant, or that would have an
16 impact on her from the standpoint of the vocational
17 issues. I think the jury understands and will get
18 additional testimony of that.

19 A Sure. Okay. The vocationally-relevant information
20 is that this child, number one, has some physical
21 limitations. And she, also, has a visible disability. If
22 she's out in public, people will notice that she, in fact,
23 has something wrong with that arm because of the length,
24 and how she holds the arm, and how she doesn't really use
25 the arm in a normal fashion.

1 The functional limitations are important on a job.
2 As you all can imagine, if you can't use one upper
3 extremity, for most jobs, that's going to limit you
4 somewhat. It may not exclude you totally necessarily, but
5 it's going to limit you.

6 So the medical records document that there are, in
7 fact, limitations in range of motion. The arm is turned
8 in. She has trouble, actually, using the arm or hand in
9 any functional way. She can use it as an assist. Like if
10 she were going to pick this up, if she couldn't do it with
11 one hand, she could, at least, grab it like this and put
12 one hand on the side.

13 So she could use the right hand to help do some
14 things. But if you asked her to assemble some small parts
15 at a bench, she wouldn't be able to do that. She doesn't
16 have that kind of dexterity -- or what we call bimanual
17 dexterity to work with the hands. If she were at a
18 keyboard -- and the custodial parents indicated this,
19 also -- she would be using the left hand and not the right
20 hand.

21 So that's a pretty significant limitation. It
22 doesn't mean she couldn't write a letter or do something
23 with it. But speed would be cut, at least, in half by
24 just using one hand. So those are the kind of things from
25 the medical record. I'm looking at practical, not

1 diagnoses necessarily, but what can she and can't she do.
2 So if she can't reach out --

3 I noticed one thing in the record. In Dr. Grossman's
4 deposition, when she would grip something and lift, the
5 hand would come open automatically. Well, if on a job
6 you've got to hold onto something and you've got to move
7 it, she couldn't do something like that. There's some
8 sort of involuntary movement of the hand that would impair
9 performance.

10 So what you really have for work purposes from the
11 medical records is she's got a left hand to work with.
12 She might be able to use this a little bit for certain
13 types of things. So that's the major physical impairment.

14 And then you've got the visual impairment to deal
15 with psychosocially, you know, the adjustment factors.

16 Q Now, Doctor, did you, also, look at her school
17 records and some of the information regarding her up to
18 this point recognizing she is only in fourth grade?

19 A Yes, I did. I looked at school records for her --
20 and, of course, this can be significant, even though it's
21 quite an early age. The test scores are especially
22 important, because they have greater stability than
23 grades.

24 In the lower grades, when teachers give grades, it
25 kind of varies. Sometimes, teachers, actually, give

1 grades because a student comes to class and is attentive,
2 and pays attention, and participates. So you get a high
3 grade in the early grades. Other teachers really do look
4 more at the quality of performance and how well the person
5 is doing in arithmetic and so on and so forth, but it's a
6 little bit difficult.

7 She's getting good grades, average grades and
8 above-average grades in class up to now. So she's doing
9 well according to how the teachers are evaluating. Her
10 test scores fall, essentially, in the average range, which
11 means she has reasonable mental ability.

12 She's -- you know, we talk about a bell curve on how
13 people score on tests. And most people score toward the
14 middle. You know, most people are average. We don't
15 always like to admit that, but we're average in most
16 things. I'm not even average as a mechanic. I'm down
17 here somewhere. I mean, we all do some things better than
18 others.

19 But, generally, in mental ability, most people are in
20 the middle. And she's in the middle. She's not at this
21 bright end where people accomplish a lot academically, you
22 know, above average. But she's not down here with the
23 people who really struggle, who will say to you school is
24 difficult for me.' She won't be in that group either. So
25 those are the two important things that I looked at from

1 the school record.

2 Q Now, did you, also, conduct some interviews with
3 family members, or her adoptive parents?

4 A Yes.

5 Q And, if you would, sort of go through the -- with the
6 jury what information is relevant in terms of what you
7 know about the biological parents, and the current
8 situation, and from the -- how that's relevant from a
9 vocational standpoint.

10 A Well, my understanding is -- and I did not get into
11 depth on this. But my understanding is there was some
12 difficulties with the mother, that there was an abuse
13 problem. And that was not adequately resolved to the
14 extent she could stay with her biological parents, so
15 she's with custodial parents, with a sister. And my
16 understanding is that the adjustment there has been quite
17 good. And that she -- in spite of this difficult period
18 of time, she's adjusted pretty well in school.

19 The custodial parents, also, tell us that she's been
20 involved in soccer. The good side is that she's on a
21 team. She gets to play a little bit. But she's, also,
22 having difficulty because she only has one arm.

23 So she -- her skill level is not up to the other
24 students, as I understand it. And that students are
25 asking her questions not just related to sports, but

1 things about what's wrong with your arm? Why do you hold
2 your arm so funny? And the parents are saying she's
3 becoming more and more aware that she's different than the
4 other children. She looks different. She functions
5 differently than the other children, that this is
6 something that's beginning to really be on her mind.

7 But, on the positive side, she still tries to do
8 things. She wants to be what some people would call
9 normal. She wants to do what other kids do, so she tries
10 her best. She makes adjustments so that she is able to do
11 some things where other kids might just give up on it.

12 So she has a positive attitude, which would suggest
13 she's going to make the best of this. She's going to do
14 as well as she can. She's not sitting around crying about
15 it all the time, but it is something that's on her mind
16 that bothers her.

17 The background of the -- I always look at the
18 background of parents. So we got that information in
19 terms of -- especially, now the custodial parents, they
20 both graduated from high school. One is a forklift
21 driver, apparently, working consistently. The mother was
22 licensed as a cosmetologist. And she worked in that field
23 for a short period of time, but then went over to sitting
24 for elderly and disabled people. And she did that up
25 until the time they took on the responsibility of these

1 two little girls. So we have high school graduates. And
2 we have people who have a strong work record. In that
3 way, I think it's a good model for her.

4 I'm trying to think of what else I learned from that
5 information. I think that's mostly it.

6 Q I guess the question is, though, what's the relevance
7 of what the family's work history and educational
8 background is in terms of you evaluating her from a
9 vocational standpoint, the child?

10 A Well, I'm trying to get to a point of trying to
11 estimate what would be the education and career path for
12 **J.B.** We can't nail it down exactly. Because, you
13 know, you can't predict somebody's future and exactly what
14 they're going to do. But what might be a reasonable set
15 of decisions she might make and a range of jobs that she
16 might get into at some point. And there are a lot of
17 things that influence this as we grow and end up in some
18 occupation or some educational level.

19 So this information helped me in that I think these
20 parents are going to be quite supportive. So that's
21 helpful. They would like her to go to college, if
22 possible. Their income level tells me that financially it
23 would be a strain for them to help support her to go to
24 college.

25 Socioeconomically, students at this income level who

1 want to go to college tend to have a little bit more
2 difficult time, partly because of finances. And they,
3 also, see that their parents are doing pretty well without
4 a college education. So they -- some people start to
5 think, well, I'm not sure I really need a college
6 education because my parents are doing okay. So this is
7 laying some foundation.

8 Just as with the school, as I mentioned before, test
9 grades are a big factor. Your ability -- basic ability,
10 though, is a big factor in going on to a certain skill
11 level on a job, or going on to college and succeeding.

12 Q One of the things that I would like you to address,
13 if you don't mind, from a psychological standpoint, a
14 child such as **J.B.**, who has some self-image issues, how
15 is that likely to impact from a standpoint of looking at
16 going to college and integrating with peers at that age?
17 Sort of address that issue for the jury.

18 A Well, there are a whole range of things that happen
19 when people have a severe disability. And she has a
20 severe disability. This is not a small-time thing she's
21 experiencing. We don't run into this kind -- exact
22 disability all the time.

23 We often run into people who have a loss of most of
24 their arm, maybe down just above the elbow or a little
25 lower, all the way up to the shoulder. But in rehab, we

1 have a lot of experience with people who have lost an arm.
2 And they often get what's called a prosthesis, which
3 allows them either -- you know, with the hand or with what
4 some people call a hook, which allows some functional
5 capacity. If you can pick things up, you can, actually,
6 use that on certain kinds of jobs. And that's considered
7 a severe disability.

8 Now, J.B. is more limited than that because she
9 does not have a prosthesis. She doesn't have the use of a
10 hand and arm in the way that a person who's lost an arm
11 can function, because they have an assist in a sense. So
12 she, clearly, qualifies as having a severe disability.

13 Now, the -- I mentioned before about the functional
14 part of that. But then we, also, have the appearance. At
15 this younger age, she's starting to feel how she's
16 different. As she gets into adolescence, if y'all
17 remember when you were an adolescent and teenager, we were
18 always concerned about how we looked. Maybe not always,
19 but a lot of the time we did.

20 And we wanted to be accepted in a group. We wanted
21 friends. And we wanted people to like us. Most of us
22 still would like people to like us. But, I mean, it's
23 really important when you're an adolescent and a teenager.
24 You want to fit in. And you ought to see what happens
25 when people don't fit in or they get rejected by other

1 kids in their class, and so on.

2 Well, when you have a disability, that adds a whole
3 added dimension with this. Kids struggle when they're 13,
4 14, 18, 20. But, now, she's got this added thing that she
5 looks like an odd ball. And kids are going to question
6 her. Often, there's the assumption, well, you're not as
7 good at things. You're maybe not as smart as other
8 people. There's all sorts of stigma that go with this
9 kind of disability. So that's going to confront her.

10 Now, some kids have a very, very bad reaction to this
11 and they get very depressed. They get withdrawn. They
12 need all kinds of counseling --

13 MR. ALEXANDER: Judge, can I object on the grounds of
14 speculation?

15 THE COURT: Overruled.

16 THE WITNESS: Well, I've dealt with kids who go
17 through this. My feeling with J.B. and the
18 information that I have is I don't think she's going to
19 have a severely bad reaction. Because with these
20 supportive parents -- and I've recommended counseling for
21 her. I think that's going to help. Because a lot of
22 times, kids don't know how to cope with this. They're
23 sort of left on their own. So I think if she gets the
24 counseling that she's not going to have a severe reaction.

25 I think she's going to have some difficulties because

1 all this stuff is still going to happen. And it's going
2 to be a challenge. She's going to have some mild
3 problems. And I hope it never gets to a level where it
4 becomes a severe problem that interferes with her social
5 functioning and her grades and, you know, going on to
6 school. But we have to face the fact that this disability
7 has caused a big problem for her socially.

8 BY MS. RODRIGUEZ:

9 Q Now, Doctor, did you, also, perform some vocational
10 research in analyzing what potential jobs in the
11 marketplace would be appropriate for an individual with
12 **J.B.**'s limitations?

13 A Yes, I did. Actually, the first thing I did as far
14 as the vocational research is to take a look at if she
15 didn't have this disability, where might she have gone in
16 terms of her career?

17 And, obviously, I could not pick out a career. But
18 if -- I assumed she would, at least, get through high
19 school. And she might attend a year or two of college.
20 That might be a possibility given all of this information.
21 And what kinds of jobs.

22 So what I did is I took -- well, the U.S. Department
23 of Labor categorizes jobs. They put them in big sectors,
24 you know, like production, construction, teaching fields,
25 so on and so forth. So I took these job groupings that

1 would be consistent with, at least, a high school
2 education and maybe some college, and I found out what
3 would be the beginning level income for specific jobs
4 under these sectors, like production, personal care
5 assistance, so on and so forth. And --

6 Q Doctor, let me interrupt. I'm going to go ahead --
7 is that -- this part of your report we're talking about?

8 A It looks --

9 Q Yeah. Let me put that up for the jurors so they can
10 see exactly what you're talking about.

11 A Okay.

12 Q It's behind you on the screen.

13 A I made it fairly broad. Because, you know, I don't
14 know what job she's going to get later on, if she is able
15 to work. But these are the ones that are consistent with
16 the educational level I projected.

17 So you've got healthcare support jobs. And there are
18 all kinds of occupations under that, food preparation,
19 personal care and service, sales and related, office and
20 administrative support. You know, could she be an office
21 clerk, for example? Production jobs, could she work doing
22 bench work? Could she work at a machine?

23 So, based on looking at all these occupational
24 fields, they all pretty much would start out in the range
25 of \$9 to \$10 per hour in her geographic area. So I

1 assumed that that's probably where she would have started
2 out after high school or a little bit of college. So that
3 gives us an idea of where she would have started, how much
4 she might have made with normal increases after that into
5 adulthood if she did not have this disability.

6 Then the second thing that I looked at is the
7 Department of Labor has done job analysis for thousands of
8 jobs in the United States to find out what are the
9 requirements on these jobs. What kind of basic abilities
10 or aptitudes do you have to have? And what kind of things
11 do you do on these jobs? And I was focusing on things
12 that would require the use of fingers, hands, arms, you
13 know, strength, that sort of thing.

14 And what I found is that a high percentage of jobs in
15 the United States require use of these upper extremities
16 and these hands. And, to some extent, it's even a higher
17 percentage now because we're using computers so often on
18 what used to be fairly simple jobs like data entry. Well,
19 you're using two hands for data entry. A simple job,
20 right? Being a cashier, you've got to use the computer.
21 You're using two hands to make change. And even if you
22 get into office occupations, you're using computers an
23 awful lot. You're entering data. You need two hands to
24 really be productive.

25 And just to give you a couple of figures, if she got

1 into a production kind of setting, her dad -- her dad now
2 works, essentially, in a production setting. Manual
3 dexterity. He is required on an average to high aptitude
4 level -- and 72.4 percent of the jobs in the United
5 States. So most of the jobs require some real good manual
6 dexterity. And I've got numbers on use of the fingers,
7 just handling product demand on a constant or frequent
8 basis, 92 percent of the jobs in the United States.

9 So a lot of times, we take our hands and our arms for
10 granted. But we're using them for just about everything
11 we do and, certainly, on jobs. So I did that just to give
12 myself and, hopefully, you a picture of if you don't have
13 this one upper extremity, it is one heck of a limitation.

14 Now, the third thing that I did was in the end, what
15 we're trying to figure out is, is **J.B.** going to lose
16 money on the job in her work life because of this
17 disability? Now, fortunately, there are some other tables
18 that give us some information. The census bureau
19 periodically gathers information by surveying thousands of
20 people about their work. And the table that I looked at,
21 they surveyed people who were working.

22 And let me just say as an aside to this, the
23 research, also, shows that most people who have a
24 disability are not in the labor force. I'm not talking
25 about just people with a severe disability. I'm talking

1 about people with a disability, most are not in the labor
2 force. And there are two studies that show this. One
3 that was done by The Bureau of Labor Statistics, federal
4 agency, a national survey in 2011.

5 By the way, this is called a participation rate.
6 It's not an unemployment rate. It's different. How many
7 people are, actually, working? What percentage? And what
8 they found was that only 27 percent of people who had a
9 disability are, actually, working.

10 And these are people in the age of working. You
11 know, they didn't include people over 65. A lot of them
12 are still working. But it was just the work population.
13 And compared with that -- and that's -- that's less than a
14 third. In the general population, 69.9 percent -- we
15 could round it to 70 percent of people in the general
16 population are working. They have jobs. Now, we know a
17 lot of people choose not to work. It's not because they
18 can't necessarily. But that's an astounding difference.

19 And then there's a second one that was a survey done
20 in 2010 by Harris Corporation contracted with Kessler.
21 And they, actually, asked people -- also, asked people who
22 have a disability and others who don't have a disability,
23 are you working? Do you have any kind of a job? And only
24 21 percent of people with a disability said they had a
25 job. 59 percent of the general population had a job.

1 Again, it's a big difference.

2 So I bring that up, one, because I think it gives us
3 a clear picture of the challenge that J.B. is going
4 to have in the future. If we were to predict -- if we
5 just said statistics is going to answer this for us, we
6 would have to say most probably she's not going to work,
7 or probably not going to work most of the time.

8 If we stop there, I could get up and walk away and
9 say I gave you the facts. But I went on from there. The
10 census bureau collects data, also, on people who have a
11 disability and who don't have a disability. But, in this
12 group, they're only looking at the folks who are working.

13 So we've got a group of people with disabilities who
14 are working. They have some kind of a job. And we have
15 people without a disability, they're working. They have
16 some kind of a job. Is there a difference in the income
17 between these two groups? And what we find is that the
18 people with a disability, on average, earn between 36
19 percent and 58 percent less than people who did not have a
20 disability.

21 So these people with a disability, they're working.
22 You know, they're out there in the labor force. They
23 earned between 36 percent and 58 percent less than this
24 equivalent group here, except they don't have a
25 disability. So we've got a big disparity here. This

1 group are people with a severe disability. Because what
2 we've got here is a little girl with a severe disability.

3 So that -- those -- that's the kind of vocational
4 research I did based on actual numbers and figures to try
5 to give me a background to make some conclusions.

6 Q So, Doctor, then as a result of putting together all
7 of this data, were you able to reach any opinion as to
8 what you believe her earning capacity would be if, in
9 fact, she were to enter the labor force?

10 A Okay. If she did not have the disability, as I
11 mentioned before, I thought she would probably begin
12 between \$9 and \$10 an hour. She might have been able to
13 start a little bit more than that.

14 And I estimated that in five to seven years, she
15 would get pay raises, of course, after that time. That in
16 five to seven years, she would improve her situation to
17 the extent that she most probably would have earned in the
18 range of \$25,000 to \$34,000 per year. That's assuming
19 normal increases, maybe even an extra pay raise now and
20 then. And then after five to seven years -- and then
21 probably make normal pay raises. So that's kind of the
22 base line of what I saw her making if she didn't have a
23 disability.

24 Then the question comes in with all of her
25 limitations, could she really work? Well, first of all,

1 the stats say that she probably wouldn't be able to work
2 for a number of reasons. She couldn't get hired. Most
3 jobs, she can't perform anyway. Complications, all kinds
4 of things that could happen with someone.

5 I'm more optimistic for her. I think she's going to
6 experience some work, that somehow she's going to get into
7 the labor force and she's going to work some. But she's
8 not going to function at the level she could have if she
9 didn't have the disability.

10 So if you remember that number of loss of income that
11 we got from the census bureau of 36 to 58 percent, we
12 could easily state that and say that's what the numbers
13 show. If she does work, that's what she'll earn or that's
14 what her loss will be over time. I think with a
15 combination of her, at least, average mental ability and
16 the support of her parents that she's going to do better
17 than that.

18 So my bottom line estimate is a loss of ability 25 to
19 45 percent of earnings over her life. It's going to be a
20 struggle for her. But I think she's going to work some
21 and she's going to earn some money, just not as much as
22 she could have if she didn't have this severe disability.
23 That may be a little on the optimistic side, but I feel
24 like she's going to find a way.

25 Q Would she be able to go into a job like the military?

1 A No, she would not.

2 Q Okay. And, if I understood, then what you're saying
3 is that if the -- the jobs that she would be the best
4 qualified for, given the expectations, would range
5 somewhere in the \$25,000 to \$34,000 per year. But then if
6 you took into consideration her disability and its impact
7 on earning capacity, the national statistics are that it
8 would be the --

9 A 36 to 58 percent loss.

10 Q -- reduction from that \$25,000 to \$34,000. But
11 you're being more optimistic and predicting that it would
12 be a 25 to 45 percent loss of potential income between
13 that range; is that accurate?

14 A That's correct.

15 Q Okay. And do you hold that opinion to a reasonable
16 degree of vocational certainty?

17 A Yes, I do.

18 Q What if she does go to college? Do you think it
19 would -- what's the likelihood of success, or do you have
20 an opinion as to the likelihood of what impact that would
21 have?

22 A I think --

23 Q Or is that with college?

24 A I think she could have some success, particularly
25 like a technical school, like in a certificate-type

1 program. It's conceivable that she could get a two-year
2 degree in a certain field. That would not be terribly
3 challenging for her. I think that it's possible with her
4 test scores that she could get into certain colleges, and
5 start out in a four-year college because she's average
6 ability. I mean, a lot of kids go to college with average
7 ability.

8 As a vocational counselor, I always tell people,
9 okay, you have average ability. A lot of times, the
10 demands in college are above average and so it's going to
11 be difficult for you. And I don't want to discourage you,
12 but this could be a real tough time for you. And I try to
13 direct them towards programs that may not be as demanding
14 as others. You know, I always tell people stay away from
15 computer science, and chemistry, and places like that.

16 And I wouldn't rule out the possibility that she
17 could get through a four-year college. I'm just saying
18 that most probably she would not. Half of the people
19 don't graduate from college that start out.

20 And if you compare the group that goes to college
21 with Ja'Qulyne's test score -- and I don't mean to demean
22 her, put her down at all, because she's in that average
23 range. But the people in that range don't succeed as
24 often as the people who are at this brighter end of mental
25 ability and intelligence. I mean, that's just the reality

1 of the world.

2 So, yeah, she could make it, only 50 percent make it.
3 I think I put in my report she might -- or my deposition
4 she might have a 40 percent chance of getting through
5 college. So, yeah, she could possibly do it. I mean, I
6 wouldn't stop her from trying. But even 40 percent would
7 probably be sort of optimistic.

8 Q Now, I think you, also, had made some recommendations
9 regarding some psychological counseling. Now, was that
10 counseling specific towards vocational issues or for other
11 reasons?

12 A I think the counseling would be more helping her cope
13 with the disability, the negative comments from other
14 people, you know, fellow students, how to deal with being
15 excluded from a group or excluded from participation,
16 trying to avoid depression, anxiety, worry. The
17 vocational would be a separate kind of counseling that
18 could be offered to her.

19 Q Thank you.

20 If she were to obtain a four-year college degree,
21 what affect would that have on her earning capacity?

22 A Well, first, if she did not have the disability, she
23 would earn more money. I mean, the statistics are very
24 clear that people who have a college degree earn a good
25 bit more than people who have a high school education, for

1 example. So she would earn a good bit more money.

2 But the other tables, also, show that she would have
3 a loss of earning capacity. And I took a look at that
4 last night anticipating. It wasn't in my report. But it
5 came up in my deposition, you know, what would the loss be
6 then? If you look at the tables on severe disability --
7 and there are separate categories for people who have a
8 high school degree and some college.

9 And then there's another table for people who have a
10 college education. People with a college education make a
11 good bit more. But they still -- people with a disability
12 with a college education still suffer a loss of earnings.
13 And on average from the tables, it's a 25 percent loss for
14 people with a college degree.

15 Now, it gets a little bit complicated. So the
16 college graduate with a disability is going to make more
17 than the high school or year or two of college. They are
18 going to earn up here.

19 But let's say she started at \$35,000, instead of
20 \$20,000. If you subtract 25 percent from here and you
21 subtract 35 percent from this lower number, in the end,
22 it's going to come out pretty close to the same. There
23 may even be more of a loss for the college graduate,
24 because, you know, 20 -- I kind of made it easy on myself.
25 If it was \$40,000 and it was a 25 percent loss, that would

1 be a \$10,000 loss; right?

2 So if I got -- I'm going to use numbers I can use,
3 say, \$21,000 of income down here. And you've got a
4 one-third loss, that's 7,000. But the different -- so
5 there's more of a loss up here than there is down here.
6 So the actual loss of income numbers get bigger if she
7 gets a college education.

8 MS. RODRIGUEZ: Thank you, Doctor.

9 Please answer any questions the Defense has.

10 CROSS-EXAMINATION

11 BY MR. ALEXANDER:

12 Q Doctor, you do this a fair amount; true?

13 A What do you mean by "this"?

14 Q You do vocational reports where you then come and
15 present the testimony in court.

16 A I do a fair number of evaluations. I don't come to
17 court very often.

18 Q Okay. And what you're being asked to do is to tell
19 this jury the impact that a disability may have on a
20 particular person; true?

21 A Correct.

22 Q And what you're trying to do today is project what an
23 eight-year-old child -- what impact this will have on an
24 eight or nine-year-old child 10, 12, 15 years in the
25 future?

- 1 A Correct.
- 2 Q Okay. And, in order to do that, you reviewed some
3 medical records?
- 4 A I did.
- 5 Q How many medical records do you think you reviewed?
- 6 A Actually, I didn't count them, but I didn't review a
7 lot of records. You know, it's maybe an inch and a half
8 of records.
- 9 Q Whatever you were sent?
- 10 A Correct.
- 11 Q Okay. And then you interviewed some people; true?
- 12 A Yes.
- 13 Q All right. And who did you interview?
- 14 A That was Ms. Orange, the custodial parent.
- 15 Q Okay. And how long did you spend with Ms. Orange?
- 16 A I believe the interview was -- I didn't write it
17 down, so I'm estimating right now. It was probably an
18 hour and a half.
- 19 Q All right. Was this in person?
- 20 A No. It was by telephone.
- 21 Q All right. And when was this?
- 22 A It was May 28 of this year.
- 23 Q All right. And then did you meet with **J.B.**?
- 24 A No, I have not. I didn't feel like it was necessary.
- 25 Q Okay. Did you meet with any of her school teachers?

- 1 A No. I didn't feel it was necessary.
- 2 Q Did you meet with any family relatives?
- 3 A No. I didn't feel like it was necessary.
- 4 Q Okay. Did you meet with any of her doctors?
- 5 A No. I didn't feel like it would be useful.
- 6 Q All right. Then the next thing you did was you took
- 7 a look at her educational records?
- 8 A Yes, sir.
- 9 Q Okay. And, again, she's eight, nine years old at the
- 10 time you were doing your review?
- 11 A That sounds about right, yes.
- 12 Q Okay. So did you look at records that indicated that
- 13 she was in a pre-kindergarten program?
- 14 A Yes.
- 15 Q All right. How did she do in pre-kindergarten?
- 16 A She did well.
- 17 Q Okay. And is it -- as a vocational rehab specialist,
- 18 is it a good thing that kids are in pre-K programs?
- 19 A Well, I would recommend it, sure.
- 20 Q It provides them an advantage going forward, would
- 21 you agree?
- 22 A To some extent, it does.
- 23 Q Right. She was in one of those programs and she did
- 24 well?
- 25 A Yes.

1 Q And then did she attend kindergarten?

2 A Yes.

3 Q Okay. And how did she do in kindergarten?

4 A She did well.

5 Q All good marks?

6 A Yes, at least, average or above.

7 Q Well, were they A's and B's, or just average?

8 A I don't think they gave A's and B's. But they were

9 equivalent of, at least, say, B+'s to C's, you know,

10 passing grades and above passing grades.

11 Q They were largely above average, were they not?

12 A I didn't really count them. I think my recollection

13 is that she started more like average. And by the end of

14 the school year, she was above average.

15 Q All right. So then you looked at first grade; true?

16 A Yes.

17 Q And how did she do in first grade?

18 A Again, she did average to above average.

19 Q Okay. And then you looked at second grade?

20 A Correct.

21 Q And how did she do in second grade?

22 A Pretty much the same pattern. She was a good

23 student.

24 Q Good student. All right. And have you looked at

25 third grade?

1 A No. I believe she's in third grade now.

2 Q Okay. Have you looked at any records from this year?

3 A No.

4 Q Okay. So what records were available to you at the

5 time of your review indicated that she was average to

6 above average in all marks in her school?

7 A Right. That's what her grades would show.

8 Q Okay. And then the next thing you did was you looked

9 at test scores?

10 A Yes.

11 Q And what test scores did you look at?

12 A Well, let's see. The -- it's called the Iowa test.

13 They're basic skills or achievement tests.

14 Q And when was she given the Iowa test?

15 A Grade two.

16 Q All right. And how did she do?

17 A She did, for the most part, average.

18 Q All right. Have you been furnished any other test

19 scores like that?

20 A I didn't think there were any more. I don't find any

21 more in my file.

22 Q Were you provided MAP scores?

23 A There were math scores on this test.

24 Q I'm sorry. M-A-P scores.

25 A Let me see. I assume that's an acronym for

1 something.

2 Q I assume so, too. And, to be honest with you, I
3 don't know what that is. We were shown scores earlier
4 where she had done well on MAP scores, M-A-P?

5 A Well, I believe that's on the Iowa test. But you may
6 have found something more.

7 Q In any event, what's in your file is the Iowa test,
8 and you don't have anything beyond second grade scores?

9 A No, I don't.

10 Q Does that complete the review that you did of her
11 cognitive abilities?

12 A Yes.

13 Q So we have average to above average in all her marks
14 in school and a second grade test; true?

15 A Correct.

16 Q And then the second thing you did to determine
17 whether this little girl will go to college and graduate
18 is you took a look at her custodial parents; true?

19 A Yes.

20 Q All right. And you determined on the basis of her
21 custodial parents that they were not sufficiently good
22 role models to motivate her to go to college and graduate;
23 true?

24 A I don't think I put it that way.

25 Q All right. Tell me how you would put it.

1 A What I would put it is that one of the factors, as I
2 mentioned earlier, is that parents provide a model for
3 children in terms of education. It's not a determining
4 factor. It's just one of the many influences.

5 As I mentioned, if parents have gone through high
6 school and they are productive and they support their
7 families and they have a decent life, that can have an
8 influence on someone. In their mind, they might say, do I
9 really have to have a four-year degree in order to have a
10 decent life?

11 Q Is there anything about this family that would be
12 limiting for [REDACTED] J.B. In other words, is there
13 anything about Demetria and Samuel Orange that wouldn't
14 suggest that this child is going to go to college, do
15 well, and graduate?

16 A Just that element. But, on the positive side, I
17 think they will encourage her to go, and they would like
18 her to go to college. They would like her to succeed in
19 college.

20 It's -- there are complex variables that go on. If
21 y'all look back at how your education went and how your
22 career decisions were made, there were a lot of different
23 things that came into the picture.

24 So the positive side is I think they want her to go
25 to college. They want her to graduate.

1 Q Okay. So, on the positive side, they're encouraging
2 her, they want her to go to college and you believe they,
3 indeed, will encourage her to go to college?

4 A I do.

5 Q Okay. And you wouldn't suggest that just because
6 they haven't gone to college and graduated would mean that
7 she won't?

8 A No, I would not. The other thing is that I'm sure
9 they would like to have more money to pay for college. If
10 anybody here has college students right now, you know how
11 many tens of thousands of dollars it costs. And I'm not
12 saying that would stop her either. But the parents don't
13 have as much money as they'd like to have to encourage her
14 to go to and stay in college.

15 Q So the fact that they did not go to college and
16 graduate doesn't exclude the possibility that you -- that
17 J.B. will; right?

18 A Correct.

19 Q And the reason you know that to be true is because
20 Dr. Charles Vanderkolk's father did not go to college;
21 true?

22 A That's true. As we talked in the deposition, there
23 were many other variables going on at the same time for me
24 going to college that are different for J.B.

25 Q Are we referring to the Iowa test scores in second

1 grade?

2 A That would be one of them.

3 Q Charles Van --

4 A I mean, I did have high test scores. My parents made
5 more money. I was able to -- some of you might remember,
6 I could work full time in the summer and pay my room
7 and -- room, board, and tuition to a state college. You
8 can't do that now.

9 Q Your parents didn't pay for college either, did they?

10 A Not much.

11 Q But Charles Vanderkolk had the initiative to pay for
12 it himself?

13 A And the opportunity. I don't know how many people's
14 children here could work for a summer and pay for their
15 whole year of school, tuition, and -- that's what I'm
16 saying, the circumstances were a lot different back then
17 than they are now. And the cost of education is so much
18 higher now.

19 Q Because if ~~she~~ J.B. ~~decided~~ decided she wanted to be
20 just like Charles Vanderkolk, if her parents encouraged
21 her to go to college, just like Charles Vanderkolk's
22 parents encouraged him, and she goes to college and she
23 graduates, and she achieves at the level that you have,
24 then she could come in this courtroom and she could charge
25 \$300 an hour to review these records and make the same

1 amount of money; true?

2 A I don't know. You've built up a hypothesis here
3 that's virtually impossible for this girl.

4 Q Because of Iowa test scores in second grade?

5 A No.

6 Q Because of Demetria and Sam Orange?

7 A A number of variables. And even if she did, she
8 would suffer a loss of earning capacity over her work
9 life.

10 Q Why?

11 A One, it would be a greater struggle for her. She
12 would have more difficulty getting a job than I did. She
13 wouldn't be as easily promoted. She would not get the pay
14 raises that other people get. There are all kinds of
15 variables that interfere with an ability for a person with
16 a severe disability to achieve at the level of someone who
17 doesn't have a severe disability.

18 Q If she achieved at your academic level, why can't
19 **J.B.** come in this courtroom and do exactly
20 what you've done today?

21 A I just listed them.

22 Q What have you done today that **J.B.** can't
23 do?

24 A First of all, she's not going to achieve at that
25 level. So it's really not even a question to answer.

1 MR. ALEXANDER: Okay. Thank you, sir.
2 MS. RODRIGUEZ: Nothing further, Doctor.
3 THE COURT: All right. Thank you, Doctor.
4 THE WITNESS: Thank you, Your Honor.
5 MS. RODRIGUEZ: I believe we've admitted these
6 exhibits.
7 THE COURT: Are those in evidence? Is there any
8 objection?
9 MR. ALEXANDER: No objection.
10 Can we approach?
11 THE COURT: Sure.
12 (WHEREUPON, a bench conference was held.)
13 THE COURT: All right. Ladies and gentlemen, we'll
14 just take a break.
15 I tell you what, if you'll do one other thing than
16 not talk about the case and keep an open mind, please,
17 select someone to be the Foreperson of the jury. And
18 write their name down. And give it to the bailiff.
19 Thank you.
20 (WHEREUPON, the jury was excused from open court at
21 approximately 10:10 a.m.)
22 (WHEREUPON, a break was taken.)
23 (WHEREUPON, Plaintiff's Exhibit Nos. 7 and 8 were
24 marked for identification and admitted into evidence by
25 agreement of counsel.)

1 THE COURT: Anything before we bring the jury in?

2 MS. RODRIGUEZ: Not from the Plaintiff, Your Honor.

3 THE COURT: I apologize for the delay. I had a child
4 that they called from school and said he was sick. I'm
5 not sure if that has anything to do with the fact that
6 report cards are coming out today or not. I had to deal
7 with that.

8 So, anyway, you can bring the jury in.

9 Thank you.

10 (WHEREUPON, the jury came into open court at
11 approximately 10:44 a.m.)

12 THE COURT: Mr. Ross, you have been selected as our
13 Foreperson.

14 JUROR 108, SAMUEL ROSS: Yes, Your Honor.

15 THE COURT: And that means you'll be the liaison
16 between the Court and the jury. If anybody needs to
17 communicate with me, the only way I can communicate with a
18 member of the jury is by way of a written note that's made
19 part of the record that I'll respond to in writing, or out
20 here on the record. So you'll, also, preside over the
21 deliberations, sir.

22 And, with that, we can resume the presentation of
23 evidence.

24 And, yes, Ms. Rodriguez.

25 MS. RODRIGUEZ: Thank you, Your Honor.

1 The Plaintiff calls Karen Shelton.

2 THE CLERK: Place your left hand on the Bible and
3 raise your right hand.

4 WHEREUPON,

5 KAREN SHELTON,

6 after first having been duly sworn, testified as follows:

7 THE CLERK: State your name, please.

8 THE WITNESS: Karen Shelton.

9 THE CLERK: Thank you.
10 Please be seated.

11 DIRECT EXAMINATION

12 BY MS. RODRIGUEZ:

13 Q Ms. Shelton, I'm going to go ahead and hand you a
14 copy of your CV and a copy of your report, which we have
15 pre-marked with no objection from the Defense. So this
16 will be Plaintiff's Exhibit Nos. 7 and 8. And you can
17 feel free to review those at any point during your
18 testimony.

19 Ms. Shelton, will you, please, describe your
20 educational background to the jury.

21 A I graduated high school in Thorntown, Indiana, in
22 1964. I graduated from Perdue University in the school of
23 nursing major in 1966. Both of those schools are in
24 Indiana.

25 Q And where do you currently reside?

1 A I live in Charleston, South Carolina.

2 Q Now, in terms of your background, do you, also, hold
3 some licenses and certifications?

4 A Yes, of course. I do have a nurse registration in
5 South Carolina, which we're required to have as a
6 registered nurse. And I do have a certification in nurse
7 life care planning and some inactive certifications in
8 case management, insurance rehab, and disability
9 management specialist.

10 Q And would you just explain to the jury what case
11 management is, very generally?

12 A Very generally, a case manager is someone --
13 typically, a nurse or vocational counselor, sometimes a
14 social worker, we work with people who have been injured
15 or disabled in some way, and help them in that recovery
16 phase. We are working, interfacing with their doctors,
17 with therapists, equipment providers, et cetera, helping
18 that person obtain recovery.

19 Q And could you, also, just briefly describe your
20 employment background?

21 A My employment background started decades ago. And I
22 hate to admit how many, but decades ago. And I first
23 started working as a nurse in the acute care setting,
24 which is the hospital setting, the clinical setting. I,
25 also, worked in nursing homes, again, providing that

1 acute-care-type nursing that we're all familiar with. I
2 did that for about three or four years.

3 And then moved I into the community health type of
4 nursing. That was public health, some school health,
5 nursing, again, working with people either from very well
6 people or very sick people in their home setting, or in
7 the school setting, or sometimes in the work setting.
8 That took about the first 20 years, the first two decades.

9 And then I became very interested in working with
10 just the population of people called disabled people. And
11 that's when I achieved some additional certifications and
12 started working in case management, again, as a nurse case
13 manager.

14 The last phase of my nursing career, the last 10
15 years or so with, again, additional certification and
16 training, I've become more involved in the analytical part
17 of case management, which is called life care planning.

18 Q Now, in your background as a case manager, did you,
19 also, work with treatment and care plans?

20 A Yes, I did. And, actually, all through my nursing
21 career, I've worked with nursing care plans, which are
22 considered life care plans as such. In an acute care
23 setting, they were very short term people in the hospital
24 for a few days. We made care plans for that acute
25 setting.

1 In the community health we, also, had care plans.
2 And then, especially, in my case management experience, we
3 wrote care plans, nursing care plans, and life care plans
4 for the folks we were working with, usually about six to
5 12 months goal setting at a time.

6 Q Ms. Shelton, if you could, just explain to the jury a
7 little bit about what a life care plan is in the context
8 of what we're about here today.

9 A In the context of where we are today, the life care
10 plan is a document prepared which analyzes the future
11 medical care that's been outlined for **J.B.** in the
12 setting, as well as the associated costs with that future
13 treatment.

14 Q And over the course of your career, have you had
15 experience with other individuals or other patients,
16 children, who have had similar type of injuries to what
17 **J.B.** has sustained?

18 A I've worked with children like **J.B.** with brachial
19 plexus disability, probably about 30 kids.

20 Q Now, when you prepare a life care plan, is this a
21 document that, you know, you just write about once and
22 that's the end of it, or how do these work?

23 A It's -- we call it a dynamic document. And that
24 means it's an ongoing process. As we gather more
25 information, medical information, vocational information,

1 social, school information, educational, all the
2 information that comes into the life care planner. And as
3 J.B. ages, particularly, the life care plan changes. We
4 add and account for all that information coming into us.

5 Q Now, do you follow a specific -- or a type of
6 methodology that is recognized by the life care planning
7 profession as a way to develop a life care plan?

8 A Yes. The methodology that the nurses follow -- and
9 I'll explain that just a little bit. Nurse life care
10 planners are one track of life care planners. The other
11 track consists of sometimes doctors are life care
12 planners. Therapists are life care planners. But the
13 nurse life care planning methodology that all the nurses
14 use follows the same routine, same process.

15 MS. RODRIGUEZ: Your Honor, we'd like to proffer
16 Ms. Shelton as an expert in the field of nursing life care
17 plans.

18 MR. ALEXANDER: No objection.

19 THE COURT: All right. She's qualified.

20 MS. RODRIGUEZ: Thank you, Your Honor.

21 BY MS. RODRIGUEZ:

22 Q Ms. Shelton, do you charge a fee for your services?

23 A Yes, I do.

24 Q And have you -- do you only work on behalf of injured
25 patients like J.B.?

1 A Well, I -- a good percentage of my work involves
2 children like J.B. also, adults who have been injured
3 in some way. I, also, do -- and I'm hired by plaintiff
4 attorneys a lot to bring forth the information to the
5 juries like this.

6 I'm, also, hired by annuity companies. Or sometimes
7 the defense attorneys will hire me and ask me to help them
8 understand some of the life care plan issues. Sometimes,
9 I've had doctors hire me in helping with their patients.
10 And I've, actually, had families call me and ask me to
11 help. But the majority of my work in life care planning
12 is this.

13 Q And, in this particular instance, have you had an
14 opportunity to review materials relevant to J.B.?

15 A Yes, I have.

16 Q If you want to, basically, summarize what you've
17 looked at.

18 A Of course, I've looked at the medical records that
19 were provided to me. I've read some depositions by her
20 doctors that have evaluated J.B. I've talked to

21 J.B. And I've talked to Ms. Orange.

22 I, also, met with Dr. Maureen Nelson when she
23 evaluated J.B. a couple of years ago, I believe it was,
24 along with J.B.'s mom was there.

25 Q Now, the materials you were evaluating from the

1 medical records, are those things that pertain to the past
2 medical care she had had in terms of how she got her
3 injuries, or were you looking at what her functional
4 ability was in relation to that injury and what medical
5 care she might need?

6 A My concern is how **J.B.** -- her functional ability
7 and her medical needs now, and the treatment that she's
8 had in the past for those needs.

9 Q Now, as part of that, did you prepare a written
10 report?

11 A Yes, I did.

12 Q Okay. As I said, if you will -- at any point during
13 the deposition -- or during the testimony, feel free to
14 look at your life care plan. If you could just sort of go
15 through for the jury what you evaluated and what your
16 recommendations were. And then we'll get to your -- to
17 the long chart.

18 A Okay. When I first start any case -- and I'll just
19 keep this very specific to **J.B.**. When the Graham Law
20 Firm asked me to help with this situation, they sent me
21 medical records, which included her birth records, as well
22 as the treatment records that she's had. I prepare a
23 medical chronology just to give me a background of
24 information and an idea of what treatment **J.B.** has had
25 in the past.

1 I then arrange to have her evaluated by Dr. Maureen
2 Nelson, who's a pediatric physiatrist. And that was done
3 in November of 2010. I attended that appointment to get a
4 general overview of what Dr. Nelson found J.B. would
5 need for her future.

6 After that appointment, J.B. was evaluated by
7 Dr. Resnick and Dr. Grossman down in Florida. And I did
8 review their records, their reports, as well as their
9 depositions and their recommendations for J.B.

10 Q So what you have then done is compile a
11 recommendation -- or an evaluation of what needs J.B.
12 would have from a medical standpoint?

13 A That's correct.

14 Q Okay. And you have compiled a list, or a summary?

15 A I have. And before I go into that summary, another
16 thing that I did, a couple more things that I did. I did
17 speak with Ms. Orange very recently to get an update of
18 status for J.B. what we call an updated status, just to
19 see how she was doing and what treatment.

20 But I did, also, have an opportunity to talk with
21 Dr. Nelson again last summer. And Dr. Nelson did prepare
22 a -- I call it a check sheet, a check-off sheet that lists
23 out what her treatment recommendations would be. And
24 then, based on all of that information, I prepared the
25 chart that I think we're going to look at next.

1 Q Okay. And is this the check-off chart you were
2 talking about that Dr. Nelson filled out on your behalf --
3 or your request?

4 A That's correct.

5 Q I'm not going to put this up to go through the
6 specifics. Have you incorporated her recommendations into
7 your final recommendations?

8 A That's correct.

9 Q All right. I think it will save time if we go right
10 to your information. Now, tell the jury -- I'm going to
11 go ahead and put up your -- the summary of your sheet.
12 But explain what this is. And then if you'll kind of go
13 through it for the jury.

14 A Okay. This -- let me get to this one. This is the
15 worksheet that I prepared for the economist that lists out
16 all of the medical recommendations, vocational
17 recommendations, educational recommendations, some of the
18 things -- and I say medical, but that's a broad range of
19 recommendations. And I break it down into these
20 categories.

21 And I see that you're looking at the chart. And if
22 you look in the very left-hand side where it says
23 "Category," and you come down to surgery, and diagnostics,
24 and physician, and equipment, all of those. Those are the
25 category of things I look at when I prepare a life care

1 plan.

2 The second column is the item, and then how many
3 units per year, the unit cost, and the frequency. And the
4 frequency is very important as the economist puts together
5 the lifetime total of costs for J.B.

6 So the chart is prepared this way, in this manner so
7 that someone behind me can use it very easily.

8 Q Okay. And, if you would, go through for the jury
9 what the recommendations were and the basis -- the general
10 basis, however you want to sort of summarize that.

11 A Okay. It's hard for me to see behind me. So I'm
12 going to look down here and look at you all, especially
13 when I'm having to do this.

14 So the first category that I've listed is surgery.
15 And this is -- we're anticipating -- the doctors are
16 anticipating that, at least, one time she's going to need
17 a shoulder surgery of some type. And I put a unit cost
18 there of \$50,000, which is very conservative.

19 By, the way, my whole plan is a very conservative
20 plan. That's going to happen once in her lifetime that we
21 think. It may happen more, but we think, at least, one
22 time.

23 Following that surgery, Dr. Nelson and the other
24 physicians have recommended that there's some therapy come
25 right behind that surgery. And that's called that

1 postsurgery PT. And I put a minimum amount of sessions,
2 75 sessions for her at a unit price of \$247. And that's
3 going to happen, typically, within the year following
4 surgery, maybe 12, 14 months following surgery. It's very
5 important to have that.

6 The second surgery that I've got listed here is
7 called a contractual release. And I think you've heard
8 testimony that J.B. has a slight contracture in the
9 elbow. And we're not quite sure yet if that's going to be
10 released or repaired. So I put a to be determined figure
11 there, meaning I've not factored it in the cost projection
12 figures. But it's something for you all to be very
13 mindful of that there might be a need in the future.

14 I've, also, put in another surgery for muscle and
15 tendon transfer. J.B. has had one of those types of
16 surgery already. And in the medical records I've read,
17 and in conference with Dr. Nelson as well, there is some
18 indication that repair or that muscle transfer may be
19 repeated either in conjunction with that shoulder surgery
20 or at a different time. I've chosen to list it out
21 separately. Because I want to make sure that we have that
22 included. Again, following that surgery, I've put in
23 another 75 sessions of postsurgical PT.

24 I put in, again, incorporating recommendations from
25 the doctors. I've put in for diagnostics three total in

1 her lifetime for an MRI of the shoulder. Also, three
2 X-rays of the shoulder in her lifetime. That's,
3 typically, done before surgery as the doctors are
4 considering having the surgery done. And, usually, after
5 surgery, they will do a post-follow-up MRI or an X-ray.
6 And I've put in three over her lifetime. Because, again,
7 we don't know for sure if she's going to need that extra
8 release.

9 I put in one time for an EMG nerve conduction study.
10 And that study is usually ordered and recommended to see
11 which of the nerves or the muscle bundles are strong and
12 healthy for that muscle site to be the donor site for that
13 muscle tissue to be transferred up to the shoulder. So I
14 put that in only one time.

15 A pulmonary function testing, that's that PFT, and
16 hearing and vision, I like to do that one time. Children
17 with BPI disability sometimes have visual, or lung, or a
18 hearing condition that goes along with that disability. I
19 want to make sure that she's doing okay with that.

20 And to go along with that diagnostic, I want the ENT,
21 which is the ear, nose, and throat physician, or the
22 pulmonologist to evaluate her. That's one time only. If
23 there are findings after those tests or after that
24 evaluation, of course, that treatment is additional. I
25 don't have any treatment for that listed in my life care

1 plan.

2 I put in surgeon visits annually to age 23. And
3 often, as we go through my life care plan, you're going to
4 see that I've stopped things at age 23. Because we figure
5 that is the age that most girls will obtain their full
6 stature and their full muscle development. So we'll know
7 pretty much by the age of 23 of J.B.'s functional
8 ability, as well as her disability. But I have put in a
9 surgical evaluation annually for 15 years, up until she's
10 age 23.

11 Physiatrist. Dr. Nelson recommended that a physiatry
12 evaluation be performed twice annually lifetime.

13 Q Explain to the jury what a physiatrist is, generally.

14 A Physiatrist is a rehabilitation doctor. It's someone
15 who looks not only at the muscles, and the nerves, and the
16 bones, but how J.B. would be developing in all areas of
17 her functional life and her medical life. A physiatrist
18 is a very specially-trained physician in rehabilitation
19 issues.

20 And it's important for someone to be that gate
21 keeper, that overview person to see what other problems --
22 and to prevent those complications from happening.

23 The next two items that I've included are for
24 counseling. And this is for counseling for J.B.
25 herself, and for the family, Demetria and Sam, for all the

1 people, especially J.B. to understand and to learn how
2 to cope with the sequela or the complications of this
3 disability that she has. I have weighted a little bit
4 more counseling for J.B. I've given her 50 sessions up
5 to age 23 to especially get her through those teenage
6 years.

7 Q And why would that be important?

8 A Peer pressure. I think you've heard testimony.
9 Also, that -- we all remember and we've had our kids grow
10 up with that peer pressure. That happens when kids get
11 into those teenage years. Anything abnormal or unusual is
12 perceived as an anomaly or a problem. So I want J.B. to
13 be able to handle that very strongly, and to learn how to
14 cope with that disability.

15 Family counseling is for the family, not only
16 counseling, but some education. It's important for the
17 family. When I've talked with Demetria, she said we'll do
18 everything necessary to get J.B. into the best position
19 possible. But I think families -- families don't know how
20 to handle disability. They don't know who to turn to.
21 And some of that counseling can be for the family to learn
22 what resources are available for them.

23 The neuropsychology evaluation, one time only, is to
24 do an evaluation, a testing to see how J.B. is
25 responding to this disability, and to see how -- what her

1 strengths are. And it's so that everyone involved in her
2 treatment and her care can pull to the strengths, not to
3 the disability that she has.

4 Moving on down -- and I'm having to put this out
5 really far to see. Moving on down, that neuromuscular
6 stimulator and that neuromuscular stimulator supplies are
7 important to build up some muscle mass in this arm. And
8 we -- the stimulator is often used to not only help her
9 gain some strength in this shoulder, but whatever donor
10 site the muscles are going to be taken from, we want to
11 build that muscle up very strongly to be able to pull some
12 cells from that to do that transfer.

13 The dynamic supinator splint, and the elbow splint,
14 and the static splint, these, I've given her five only.
15 But these don't mean that she only needs five and she'll
16 be done with them at age 23. But at age 21, 22, we'll
17 give her last one because they're in sizes. And, as
18 **J.B.** grows, we'll give her a different size. And then,
19 again, at about age 23, we'll give her a size that will
20 last her pretty much the rest of her life.

21 Q Karen -- Ms. Shelton, if you could, just, basically,
22 explain to them what a supinator splint is.

23 A A supinator splint -- well, let's go to the static
24 elbow splint first. Static means it doesn't move. But
25 the static elbow splint is to help prevent that

1 contracture from developing. She has one now. And if
2 it's ever released, we want to be able to keep that splint
3 from having her arm lock back in place like this.

4 The dynamic elbow splint then -- the static one is
5 fixed. Okay. The dynamic one then allows it to be
6 adjusted and move. So one day, it might be at this angle,
7 another day, it might be at this angle. And then the
8 supinator splint is the same one. We're trying to give
9 her some movement in this arm. Okay. And those splints
10 are important for her to have.

11 Driving evaluations. **J.B.** is going to be a very
12 functional little girl. She's going to be driving, a
13 teenage girl. Maybe that's when I should give Demetria a
14 little bit more counseling when that driving starts. But
15 I will have the driving evaluation done two times in her
16 lifetime, once when she's about 15 or 16 to see if she can
17 safely drive. She's got limited mobility here -- over
18 here -- and I've been motioning to this arm, but, excuse
19 me, it's this arm that's affected.

20 And if you look at the cars the way you're set up,
21 you've got your gear shift or your radio and all kinds of
22 things happening with the right-hand side of your body.
23 So the driving evaluation is going to make sure that she
24 can drive safely for herself and safely for everyone on
25 the road. I think she'll be able to drive, but I want to

1 make sure that we get that evaluation done so that
2 adaptations and car accessibility is there for her. And a
3 little bit later, you'll see I've put in some vehicle
4 modifications. That goes along with that driving
5 evaluation.

6 The functional capacity evaluation, FCE. This is
7 very important for her to be done once in her lifetime.
8 And I've chosen the age of 18 or so to have that done. We
9 know and we hope that J.B. can work. We want to know
10 what her safe limits of lifting, carrying, pushing,
11 pulling, key boarding, repetitive work not only for her
12 affected arm, but for the non-affected arm as well. This
13 arm doesn't work and this arm has to do all of it. We
14 want to know what her strengths are and what her limits
15 will be so that she can perform work safely.

16 When I say work, I'm going to say work in a little
17 different context than Dr. Vanderkolk did. Work to me
18 means working on the job for money, but working at home as
19 well. She's going to be doing housework, laundry, raising
20 kids. And all the women know this is just as much work as
21 paid work as well and takes probably a lot more physical
22 activity.

23 Home accessibility. I have only put in a very small
24 nominal amount for home accessibility. And this is for
25 bathroom safety only. This is the grab bars in the

1 bathroom and the wet area. J.B. has a little bit of a
2 problem with balance. If she starts to slip -- she slips
3 on water, she's only got one good arm to catch herself. I
4 want that good arm to have some good support there for
5 her.

6 Kids that I've worked with in other situations,
7 sometimes I'll put in a little bit more home accessibility
8 allowance. Because we know she's, also, going to have
9 some difficulty in the kitchen reaching and lifting for
10 things there. But I've -- the only number I have put in
11 is for the safety grab bars in the bathroom.

12 Q Ms. Shelton, it seems like you're sort of taking a
13 conservative attitude with what your recommendations are.

14 A Very conservative, very -- what I call the floor,
15 baseline treatment for her. This is what we know pretty
16 much for sure she's going to need.

17 The other things are add-on's. And if y'all consider
18 that and think she needs more, please, add that in.

19 MR. ALEXANDER: Objection, Your Honor.

20 THE COURT: I sustain the objection.

21 THE WITNESS: Botox and -- Botox is a medication.
22 It's an injection. Dr. Nelson felt that with the
23 contracture that she is developing in the elbow as well as
24 the shoulder, having some loss of motion, that the Botox
25 might relax that, at some point, and then be able to do

1 some additional therapy along with that. And you see,
2 I've only put in one time for that.

3 Medications are going to be a very important part of
4 **J.B.**'s future treatment. We just don't know what those
5 medications are right now. She's eight. She's not on any
6 medication right now. But in working with therapists who
7 deal with these kids, there's many complications --

8 MR. ALEXANDER: Your Honor, I object to her
9 testifying about what other therapists do, as opposed to
10 relying on the providers in this case.

11 THE COURT: Well, I overrule the objection.

12 THE WITNESS: Medications are going to be determined
13 later. And they can be for a variety of things, including
14 pain, anti-inflammatories. But you see, I've got it to be
15 determined. I've not put any money in the life care plan
16 for medications, even though we know it's going to be an
17 important issue for **J.B.** later. It could, also, be for
18 some depression, anxiety, short-term acute-type things.

19 The one thing that I do want to stress as a life care
20 planer is the cornerstone of treatment for **J.B.** is going
21 to be physical therapy for the rest of her life. She is
22 going to develop contractures, which is the stiffening of
23 the joint. We know that already. She's going to need to
24 keep as much function going in the affected arm as
25 possible, as well as keeping the rest of her body, the

1 unaffected side, as strong as possible.

2 Also, to help her with balance issues as she grows
3 up, especially as she grows older. 55 or so, we start to
4 lose a little bit of balance normally. Someone with just
5 one-sided -- and muscle mass is different on the affected
6 side. That balance is going to be difficult.

7 Also, along with the formal physical therapy and the
8 actual movement of the body parts in therapy is going to
9 be education coming from that therapist to help J.B. be
10 able to remain independent, and to independently perform
11 her own fitness therapy. It's over in the home exercise
12 program.

13 And you see right under my annual sessions of
14 therapy, I've got fitness therapy. J.B. will have to go
15 to the gym. She's going to have to be biking. She's
16 going to have to be walking. She's going to have to be a
17 strong little body to make up for some of the loss of this
18 part of her upper extremity. But we can teach her to do a
19 lot herself.

20 BY MR. RODRIGUEZ:

21 Q Ms. Shelton, I'm not sure the jury understands. Why
22 would a problem with her shoulder impact the other fitness
23 areas?

24 A Well, the brachial plexus injury is not just a
25 shoulder injury or an arm injury. When you can't use a

1 certain part of your body, the rest of the body has to
2 take over and has to remain very strong. Not only is her
3 shoulder affected, but her back is going to start -- the
4 back muscles that are affected are going to start being
5 very much more asymmetrical, meaning not the same on both
6 sides.

7 So if one is weaker, the stronger side starts to pull
8 everything out of alignment. So having some therapy or
9 some exercise designed to pull back into place the other
10 side of the body is going to be pretty critical.

11 Bathroom safety, I talked about. I put in two times
12 for **J.B.** I'd like to see that done one time now, and
13 then one time when she's in her own house.

14 Now, I was talking -- I'm going -- I'm through the
15 whole modifications. And we're going to get into some of
16 these other categories. I just mentioned that the back
17 muscles on the affected side are weaker. These are strong
18 on the left-hand side. And these are a little bit weaker
19 over here on the right-hand side. And, as **J.B.** starts
20 to grow and develop, these strong muscles start to pull on
21 the spinal column, which can make that spinal column
22 that's nice and straight start to pull a little bit
23 causing a little bit of a scoliosis.

24 Some kids, it's very minor. Some kids, it's pretty
25 major. Some kids don't have it at all. But we want to do

1 that scoliosis screening twice a year until **J.B.** is
2 about 18 to determine if there's any intervention or
3 prevention needed to prevent that scoliosis from really
4 happening. And I think you all know what scoliosis is,
5 that curvature of the spine. The kids start looking a
6 little bit crooked. So we want to try to limit that if we
7 can.

8 The next two items I feel are very critical,
9 especially since **J.B.** has come into a new family unit.
10 The case management, I think, is very critical for **J.B.**,
11 and for Demetria, and Sam to -- and I've only put a
12 hundred hours in for a case manager to help that family
13 find the resources and to implement as much of this life
14 care plan as they possibly can get in their community.

15 A case manager is there for support, for education,
16 for intervention with the physicians, for facilitating
17 appointments, helping get equipment in place, and,
18 actually, educating that family on some of the things to
19 be looking out for.

20 And I put those hundred hours in over the next five
21 years or so. And I feel everyone, at that point,
22 including **J.B.** will be a little bit older and more able
23 to participate more fully in her care. But Demetria and
24 Sam, at that point, will be able to be hooked up with the
25 care providers that are going to continue with her

1 lifelong care.

2 Vocational assistance. This is critical. We've all
3 talked about J.B.'s ability, her school grades, her
4 ability to achieve after high school, whether it's a
5 certificate program in college or college level. I think
6 we're all very mindful that we've got to help J.B. push
7 that educational envelope as far as we can. She's not
8 going to be able to do manual labor type work,
9 housekeeper, nursing.

10 When I started out being a nurse and worked in the
11 acute setting, that was the toughest, hardest job I've
12 ever had to do physically. I needed both of my hands and,
13 usually, a few more hands to get that job done. But we
14 want that vocational assistance to start when she's still
15 in high school, well before graduation so that that
16 support can help her achieve as much education as
17 possible. I've started that at about age 14 up to about
18 23. We're hoping that she'll enter that work force.

19 The -- I'm going to skip independent aids for just a
20 moment and come back to that. But I did talk about the
21 vehicle modifications only, and that's probably little
22 spinner balls. Sometimes, if she has a car that has a
23 gear shift, that gear shift can be mounted on the
24 left-hand side for her, whatever that's going to be. But
25 I assumed she'll get a new car about every 10 years after

1 age 16. And I'd like to have that modification there for
2 her so she can drive safely.

3 The last thing I've put in the life care plan is
4 independent aids. And I do put this in as a very small
5 allowance per year of \$300. And when J.B. is young like
6 she is now, the independent aids could be something like
7 special shoes with shoe strings that don't tie, but maybe
8 Velcro fastener.

9 It could be a rolling book bag. You see all the kids
10 with the thing slung over their shoulder. But J.B.
11 shouldn't be putting it on this shoulder at all. She
12 really shouldn't be putting her book bag on this shoulder
13 to break it down. It should be a rolling book bag. As
14 she gets a little bit older, it might be a special
15 computer, key boarding that she can use.

16 As she gets older, it could be things in the kitchen.
17 She can't take a meatloaf out of the oven. She has to do
18 it one-handed. And she may need some support to cook.
19 She may need some extra aids and allowances to perform her
20 duties at home, as well as on the job site. She might
21 need an iPad.

22 There are many things available to help her become
23 independent and functional. But we've got to give her a
24 little extra allowance here to get the things in place.
25 Some years, she might need \$300. Other years, she might

1 need a hundred dollars. Other years, she might need
2 \$2,000. But, overall, I've put in \$300 every year for her
3 lifetime.

4 Q Ms. Shelton, did you, also, prepare an alternative to
5 this in the event that there's some legal issues as to
6 whether or not these will start when she's a child versus
7 when she turns 18?

8 A Yes, I did.

9 Q Could you, basically, summarize the difference? The
10 life care plan we just looked at was based on the
11 assumption from today -- or from today to adulthood
12 through her life. You've done one that begins when -- you
13 know, just kind of explain that to the jury.

14 A Okay. We're putting it up or --

15 Q Yeah. I'll find that. If you just want to start
16 explaining the difference to them while I locate the page.

17 A Well, you saw the chart that we had there. There
18 were 35 or 40 different items. And I put out when they
19 began, now, and when they ended. Sometimes, they ended at
20 18. Sometimes, they ended at 23, or they ended at
21 lifetime.

22 So the chart that we're going to look at next, I've
23 taken those same categories, that same chart, but I took
24 out everything that we think will happen before she's 18.
25 So the second chart will be only those items and the

1 occurrence scheduling for only items after 18 through
2 lifetime. And we're getting that. So -- and you can kind
3 of see on my little piece of paper it's about half the
4 items were taken out completely.

5 And then for an example, where I've said she needs to
6 see a surgeon 15 times in the original chart, I've said
7 she only needs to see the surgeon one time. So I've taken
8 into consideration anything that happens before age 18 is
9 taken out of that chart.

10 Here we go.

11 And not to go through all the items again, but you
12 can see some of the differences. The surgeon is one time
13 only between the ages of 18 and 23. The physiatrist, that
14 pediatric rehabilitation specialist, I still want **J.B.**
15 to be seen by that doctor twice yearly from 18 to
16 lifetime.

17 I've broken that individual counseling down to give
18 her -- instead of 50 sessions, I've given her only 20 from
19 age 18 to 23. And this age group is, also, very
20 important. Because this is when **J.B.** is going to be
21 dating, perhaps, marrying, perhaps, having children. And
22 that disability impact is going to be -- this is a
23 critical time for that disability impact. So I want her
24 to have a little bit of extra sessions here. Not extra
25 above the 50, but just concentrated in this age group.

1 The neuromuscular stimulator, one time between age 18
2 and 23. Remember, we talked about the women's full growth
3 is we'd consider about age 23. I'd like to have that
4 neuromuscular stimulator one time only replacement in that
5 period. And then 60 months, which is five years, between
6 the ages of 18 to 23 for those supplies.

7 I want her to have that dynamic supinator, elbow and
8 splints, and the static elbow splint one time at that
9 adult size that she'll use for a number of years. One
10 driving evaluation at age 55. I want her to have that
11 functional capacity evaluation as she enters the work
12 force that we talked about between the ages of 18 and 19.

13 The home accessibility, one time at age 23. And
14 that's at her home. I'm assuming she'll have her own --
15 hoping she'll have her own home at age 23. The therapy
16 maintains -- that's the cornerstone of her future
17 treatment is that physical therapy. That stays at 20 per
18 year. Bathroom safety in her own home, one time.

19 Vocational assistance between the ages of 18 to 23.
20 Remember, I gave her a hundred total hours. So I broke
21 that down between ages 14 and 18, about 50 hours and about
22 50 hours after to help her get into the best job possible
23 for her. The independent aids stay the same.

24 Vehicle modifications, I broke it down to five only,
25 instead of six. And still that contracture release is

1 still to be determined. Even if J.B. has that
2 contracture release before she's 18 -- just due to the
3 nature of that inability to move that arm, that
4 contracture of that elbow may become apparent again.

5 Q Now, Ms. Shelton, I noticed that you did not add up
6 any columns?

7 A That's correct.

8 Q Explain to the jury why not.

9 A I didn't add the columns up on the economic analysis
10 worksheet because that's the job of the economist.
11 There's a medical inflation factor that he'll bring into
12 the picture on this.

13 Q Now, if -- from a standpoint of a life care plan, is
14 your intent here to give J.B. the best life in the
15 world, or to give her just simply enough to be functional?

16 A My role as a life care planner is to give J.B. what
17 she needs to become as functional as possible, as
18 independent as possible.

19 Q Now, the determination of your recommendations in
20 terms of the various things, the equipment, et cetera, do
21 you -- based upon your review of the information provided
22 in the medical records, your conversations, et cetera, do
23 you hold an opinion to a reasonable degree of certainty in
24 the field of life care planning as to whether or not these
25 needs are most probably going to be what J.B. needs in

1 order to obtain minimum functional capacity?

2 A Yes, I do.

3 Q What is that opinion?

4 A My opinion is she needs this future lifelong care as
5 I've outlined to become as functional and as independent
6 as possible.

7 MS. RODRIGUEZ: Please answer any questions the
8 Defense may have.

9 THE COURT: Cross-examination, Mr. Alexander.

10 CROSS-EXAMINATION

11 BY MR. ALEXANDER:

12 Q Ms. Shelton, how long have you been doing this work,
13 ma'am?

14 A I've been a life care planner -- well, actually, I've
15 been preparing life care plans since 1966. But as a
16 certified nurse life care planner, about 12 years.

17 Q And how many do you think you've done over your
18 lifetime?

19 A Lifetime?

20 Q Yes, ma'am.

21 A Hundreds.

22 Q Hundreds?

23 A Thousands maybe.

24 Q Thousands. Okay. Overwhelmingly, for plaintiffs?

25 A As I've been hired in the last 12 years as a life

1 care planner, it's been predominantly plaintiff work, yes.

2 Q And have you worked with Dr. Nelson before?

3 A Yes, I have.

4 Q Lots of times?

5 A Probably about 30, 35 times.

6 Q How long have you known Dr. Nelson?

7 A Approximately five years.

8 Q Okay. And this sheet that we've referred to, Life

9 Care Planning Evaluation --

10 A Yes.

11 Q -- is this a sheet that you came up with?

12 A Dr. Nelson and I came up with this together. She and

13 I had many conversations about what the future treatment

14 kids -- future treatment needs of brachial plexus kids

15 would be. And she felt it would be easy for her to

16 summarize those treatments if we had a sheet of some sort.

17 And so she and I together prepared this sheet. And

18 then when we work with a specific child like **J.B.**, then

19 the sheet is presented to her and she checks it off.

20 Q This very same sheet?

21 A Correct.

22 Q When did you and Dr. Nelson get together and come up

23 with this sheet?

24 A We came up with this sheet probably about four years

25 ago, maybe closer to five. When I first began talking

1 with her is when we did all of our conferencing and
2 get-togethers to come up with what future treatment --
3 general future treatment needs are. So we came up with
4 the sheet, I would say, about four or five years ago.
5 Q Okay. In the four or five years since, how many life
6 care plans have you prepared where this sheet that you and
7 Dr. Nelson came up with has been used?
8 A Probably 20.
9 Q Okay. And, each time, you take this sheet that you
10 and Dr. Nelson prepared or came up with together, and you
11 send the sheet to Dr. Nelson?
12 A That's correct.
13 Q Okay. And then Dr. Nelson just can go down and check
14 all of those little boxes?
15 A That's correct.
16 Q Okay. And Dr. Nelson is what kind of doctor?
17 A She's a pediatric physiatrist.
18 Q Okay. She is not a surgeon?
19 A That's correct.
20 Q Okay. Is she this child's treating physician?
21 A No, not now.
22 Q Okay. How many times has Dr. Nelson seen this child?
23 A I believe one time.
24 Q One time?
25 A Correct.

1 Q When was that?

2 A I believe that was July of -- November of 2010.

3 Q So you send -- this sheet that you and Dr. Nelson

4 developed together, you send it back to Dr. Nelson, and

5 she checks the boxes, and then she sends it back to you?

6 A That's correct.

7 Q Okay. And so then we go to your preliminary

8 disability cost projection sheet. And I see there that

9 you have surgery. And as a resource, it says Dr. Resnick,

10 Dr. Nelson, and Dr. Grossman. Do you see that?

11 A I do.

12 Q And we know, at least, that Dr. -- are any of those

13 this child's treating physician?

14 A No, they're not.

15 Q Okay. And then you have -- and have you heard any of

16 the testimony in this courtroom about whether or not that

17 surgery will, actually, be done?

18 A I've not heard testimony in this courtroom.

19 Q You're aware that, at least, up until now, J.B. is

20 eight years old, close to nine, that surgery has not been

21 done. Do you know that?

22 A I do know that, yes.

23 Q Okay. Are you aware that J.B.'s mom, Alana, has

24 said she was not interested in having the surgery done?

25 A I'm not aware of that comment.

1 Q And are you aware that J.B. herself didn't want to
2 have the surgery done?

3 A I'm not aware of that, no.

4 Q And are you aware that Demetria has testified she's
5 not sure?

6 A I'm aware -- I'm not aware of Demetria's testimony.
7 But when I talked with her, she indicated she wanted to do
8 what was absolutely best for J.B., including surgery.

9 Q Okay. So you have -- you went ahead and included
10 that surgery in your life care plan. And in addition to
11 that, if that surgery were done, and only if that surgery
12 were done, I assume she would have 75 sessions of physical
13 therapy?

14 A Correct. In addition to the 20 a year normal
15 therapy. This is the post-surgical therapy.

16 Q And, obviously, she would not have that done if they
17 elect not to do the surgery; true?

18 A Correct. And I understand Demetria has an evaluation
19 in December, another surgical consultation.

20 Q Okay. And then you've included two other surgeries?

21 A Correct.

22 Q All right. And that's coming from Dr. Nelson?

23 A Dr. Nelson, yes. And, also, Dr. Grossman talked
24 about an elbow contracture surgery.

25 Q All right. And you've got 75 more sessions of PT

- 1 associated with those surgeries?
- 2 A That's correct.
- 3 Q Okay. Are you aware of any -- you have \$360,000 in
- 4 annual therapy sessions, a lifetime of that; true?
- 5 A Correct.
- 6 Q Are you aware of any of those type sessions having
- 7 been done up to now?
- 8 A No.
- 9 Q Are you aware of any occupational therapy having been
- 10 done up to today's date?
- 11 A I am aware that **J.B.** is receiving some occupational
- 12 therapy in school. And, as a young child, she received
- 13 some physical therapy and occupational therapy, I believe,
- 14 up until age three, I'm thinking.
- 15 Q And none since?
- 16 A None since, correct.
- 17 Q Indeed, none of these things have been -- she has not
- 18 chosen any of these options up to today's date; true?
- 19 A She's not been -- had available to her these
- 20 treatments. That's correct.
- 21 Q What do you mean she has not "had available to her"?
- 22 A Well, you said "chosen," I'm not sure she's chosen to
- 23 do them or not do them. But I know she's not been able to
- 24 have these treatments.
- 25 Q Well, either no one has recommended these treatments

1 or they have, and she has elected not to have them done;
2 true?

3 A I can't -- excuse me. I can't say it that way. I
4 know this is what's been needed. But for a variety of
5 reasons, the treatment has not been put in place. It
6 could be financial. It could be that she's now with a new
7 family that will be certain to put these things in place.
8 But I do know that J.B. has not had the treatment. I
9 don't know the reasons why.

10 MR. ALEXANDER: Thank you.

11 MS. RODRIGUEZ: Thank you, Your Honor.

12 REDIRECT EXAMINATION

13 BY MS. RODRIGUEZ:

14 Q Ms. Shelton, the physiatrist that Mr. Alexander has
15 been referring to, Dr. Nelson, was she, originally, in
16 Charlotte, North Carolina?

17 A Yes, she was.

18 Q And where is she now?

19 A She's in Austin, Texas.

20 MS. RODRIGUEZ: Thank you.

21 That's all I have.

22 THE COURT: Thank you, ma'am.

23 You may step down.

24 THE WITNESS: Okay. I'm leaving these here.

25 THE COURT: All right. You may call your next

1 witness.

2 MS. RODRIGUEZ: The Plaintiff calls Sam Orange.

3 THE CLERK: Place your left hand on the Bible and
4 raise your right hand.

5 WHEREUPON,

6 SAMUEL ORANGE,

7 after first having been duly sworn, testified as follows:

8 THE CLERK: State your name, please.

9 THE WITNESS: Samuel Orange.

10 THE CLERK: Thank you.

11 Please be seated.

12 DIRECT EXAMINATION

13 BY MS. RODRIGUEZ:

14 Q Sam, could you, please, introduce yourself to the
15 jury, tell them who you are?

16 A My name is Samuel Orange. I was born in Georgetown,
17 South Carolina. And I just work hard.

18 Q Where did you grow up, Sam?

19 A Georgetown, South Carolina. I graduated from high
20 school -- from Choppee High School in Georgetown, South
21 Carolina.

22 Q And then tell the jury a little bit about since you
23 graduated from high school where you've been. You've been
24 living where?

25 A Well, I lived -- I moved to Columbia, South Carolina,

1 to start working at Carolina Ceramic, a brick company.
2 And from there, I moved to the outskirts of Columbia into
3 Camden, South Carolina, and bought a house there. And I
4 just worked and survived.

5 Q Okay. Well, how did you end up here in Greenville?

6 A Well, on my computer, I was looking for someone to be
7 with, you know. I was single for about 13 or 14 years.

8 And I was on my computer going on Facebook and
9 someone caught my eye. And I was like, well, I had known
10 her. I was talking to Sheila, which is my friend that
11 graduated after me. And I was asking her who is this.
12 And she was my wife. And when I first saw her, all I know
13 is I wanted to be with her.

14 Q And that was Dee?

15 A Yes.

16 Q Now, as a result, where was Dee living?

17 A In Greenville, South Carolina.

18 Q So what did you do?

19 A Well, at first, I had to, you know, get to know her
20 and ask her for her number and everything. What I did is,
21 actually -- we, actually, started dating and started
22 talking. It was a problem because I worked in Columbia.
23 But I wanted to be with her in -- you know, she lived in
24 Greenville. So I was dating back and forth.

25 The next thing I know, I was riding from Columbia to

1 Greenville every day back and forth from work to home.

2 And the next -- I was getting tired of that. I was like,
3 you know, this is the woman I want to be with. So what I
4 did, I asked her to marry me.

5 Q Well, I'm glad to hear it wasn't the drive that got
6 you. It was that you really wanted to be with her, that's
7 why you made the move?

8 A Yeah, that, too.

9 Q Okay. Now, when you and Dee got married, initially,
10 did Dee have any children of her own?

11 A No.

12 Q And was that on the short-term plan for either one of
13 you to have some more kids?

14 A Well, I don't know. I was like whatever. All I
15 wanted to do was be with her.

16 Q And you didn't have any children living with you when
17 you first got married; right?

18 A No.

19 Q Well, what did she tell you two weeks after you got
20 married?

21 A She came to me -- see, while we was dating, we once
22 met with the girls. I was, actually, sitting down -- we
23 was just sitting down talking and she said, Let's go get
24 my girls.

25 And I said, Your girls. Wait a minute. What girls?

1 We were going to get them to go get some ice cream. And
2 that was the first time I ever met them.

3 And when she came and -- while we was married, she
4 came and told me what was going on with them. Man, it
5 took a toll, because it hurt me. It hurt me to my heart.
6 And when she told me what type of trouble they was in and
7 what was really going on, there wasn't nothing else said,
8 let's go get these girls.

9 Q Have they been with you ever since?

10 A Yes.

11 Q Now, at the time that you and Dee first became
12 involved and got married, was Dee working outside the
13 home?

14 A She was working, yes. She was working doing sitting
15 for older -- elderly people, and making sure that they was
16 all right and, you know, just making sure everything was
17 okay.

18 Q Was it your plan, as a couple, for her to continue
19 working after you got married?

20 A Yes.

21 Q Now, tell the jury a little bit about how much you
22 work.

23 A Well, I've always been a worker. See, every day --
24 well, when I was born -- since I've been a little boy, I
25 came -- when I came home and I realized what was really

1 going on -- I didn't have electricity. I had an oil light
2 to come on and light up our house. And we didn't have a
3 stove. We had like a pot belly stove to cook on.

4 So we've came a long way. And things like that is
5 still in me. And what I do, I work hard to make sure that
6 anything -- I know it takes money to get what I want. So
7 I've got to do what I've got to do.

8 Q So how many days a week are you working now?

9 A Six days a week, 10 hours a day, sometimes 11.

10 Q Now, for a good while that this trial has been going
11 on, you haven't been sitting here. Why is that?

12 A Working. I've got to work, because I can't let
13 nothing go back. I can't let nothing go away because the
14 kids have got to have what they need. And I'm going to
15 make sure of that. If I've got to work harder, if I've
16 got to work on Sundays, it doesn't matter. I'll make sure
17 they have what they need no matter what it takes.

18 Q Now, when you and Dee took in the girls, did you
19 realize the financial obligations you were taking on?

20 A Oh, yes. And we sat down and we talked about it.
21 And for what the girls was going through, ain't no -- no
22 child should go through that.

23 And what I did -- and we sat down and we talked. I
24 said, Baby, let's go get these girls right now. Because
25 they was like -- I think they probably would have ended up

1 getting split up, you know, the mess that they was in. I
2 said, man, it's awful.

3 Q Well, Sam, I'm not sure that the jury heard that
4 information. If you and Dee had not taken the children
5 in, what was DSS's plan for them? Were they going to be
6 able to place them together?

7 A I don't think so. I was hoping that they would.
8 But, you know, all I could see was two sisters. You know,
9 I love my brother and sisters. I would not want to be
10 separated from them.

11 Q So since you took the girls in, has it been a bit of
12 an adjustment?

13 A Yes. It's a whole -- it's like I had to work
14 harder -- you know, I'm sorry saying working harder. But
15 I want my girls to have everything that they want. And I
16 want them to grow up and be mannerable [sic], and have
17 respect for others. And it's not easy, but I know I'm
18 doing the right thing.

19 Q Sam, do you hope that J.B. is going to be able to
20 go on to college?

21 A I hope and pray. I'm going to sure be pushing all
22 the way that she do. Because I want her to become -- I've
23 got a high school diploma. I want her to go higher, the
24 highest that she can go. So I push her every day. And
25 it's like another job. Once I get off my job, then they

1 come and ask me about homework and stuff. That's another
2 job.

3 Then I've got to let them know that daddy is here. I
4 let them know that they've got stability in their life.
5 And they've got a daddy, a father that is going to raise
6 them, and that's going to be there for them. For what
7 they already went through, it's not going to happen no
8 more. They don't have nothing to be afraid of, nothing.

9 Q I admire what you've taken on.

10 But let's get a little bit lighter here and tell the
11 jury a little bit about some of the fun things you've done
12 with the girls. I understand you've taken on teaching
13 somebody to swim.

14 A Oh, yes. See, swimming, I didn't learn it in a pool,
15 but I learned how to swim. And that's very important.
16 Anybody can -- the kids like to play around. They might
17 end up pushing each other in the water. You don't know
18 how deep that water may be. But it's always good to learn
19 how to swim. Because that's -- and I make sure I teach
20 them that's how I learned.

21 First, I teach them how to dog paddle, which is not
22 overhand. Because dog paddle is much easier for them to
23 start off. And I teach them how to hold their breath
24 under water. It's fun. And they love to swim. The girls
25 love to swim, Brittany and **J.B.**. I call her Beans.

1 Q 1, also, understands that Beans has gotten involved
2 in soccer?

3 A Oh, yeah. She's amazing. It's just that, you know,
4 she won't give. You know, she'll go out there and she'll
5 tell me, Daddy -- just last night, she said, Daddy, I'm
6 thinking about playing football. And I was like,
7 football. You can do it. Whatever you put your mind to,
8 you can do it.

9 I don't want her to think -- because of her arm, I
10 don't want her to think that there's no reason that --
11 nothing she can't do. But I want to keep her in -- you
12 know, in a zone to make sure that, you know, it's all
13 right. It's okay.

14 Q Well, we know you can't protect her all the time.
15 Tell the jury about what's happened a few times when
16 you've been out in public with her at church and other
17 places like that and people have made comments. Tell the
18 jury what y'all have been through.

19 A You know, when we -- when the family goes out and
20 it's -- I think it was -- we went to -- like going to
21 maybe the Wal-Mart or to the park, we'd be like -- you
22 know, the kids were looking at her, you know, like why
23 won't she put down her arm.

24 And she said, Daddy, why do they ask me that?

25 And I said, Well, baby, the best thing you can do

1 is -- she didn't know what to tell them. So just tell them
2 what happened. Tell them when you was born, this birth
3 defect came up. And the best thing you can do is just keep
4 on playing. Hold your head up. Don't hold it down.

5 When she comes to me, she comes to me in tears when
6 she asks me this, you know. And it's hard for me to like,
7 you know, tell her what happened. It's new to me. This
8 is brand new to me. And it's hard, you know.

9 Q Now, in terms of her medical care, there's been some
10 talk about her having surgery in the future. What have
11 y'all -- have you and Dee had conversations with her --
12 with J.B. and with each other about the surgery that she
13 needs?

14 A The only thing I can do is work harder and try to
15 make sure that whatever it takes -- whatever it takes that
16 I'm going to try to provide and make sure that she's
17 happy, and make sure she's getting her school work. And
18 the next -- making sure she grows up to be much more
19 than -- or the best that she can be.

20 And bill-wise, whatever comes up, I'm going to work
21 to try to pay for it. I -- these are my kids. I mean,
22 this is my kid, me and my wife's. And whatever it takes,
23 I'm going to try. I just pray to God that I can provide
24 the best for her. Whatever comes up, that's what I'm
25 going to do.

1 MS. RODRIGUEZ: The Court's indulgence.

2 (Pause.)

3 BY MS. RODRIGUEZ:

4 Q Sam, the -- when you and Dee got involved in this
5 lawsuit, did you request that we do anything about getting
6 her medical bills together?

7 MR. ALEXANDER: Your Honor, may we approach?

8 THE COURT: Sure.

9 (WHEREUPON, a bench conference was held.)

10 THE COURT: Ladies and gentlemen, we're going to go
11 ahead and break for lunch at this time, and take care of
12 an issue we have. Just come back at 1:30. Don't talk
13 about the case. And continue to keep an open mind. 1:30.

14 (WHEREUPON, the jury was excused from open court at
15 approximately 11:55 a.m.)

16 THE COURT: All right. Yes, sir, Mr. Alexander.

17 Sir, you can step down.

18 Thank you.

19 Yes, sir, Mr. Alexander.

20 MR. ALEXANDER: Your Honor, we are objecting to the
21 admission of any medical bills in this case on the basis
22 that the medical bills incurred in this case were incurred
23 while this child was in the physical, legal, and financial
24 custody of her biological mother. We don't believe that
25 those -- there is no claim that has been brought by the

1 biological mother. And, therefore, because they were
2 incurred by her, they are medical necessities and the
3 obligation of any biological parent. We believe that that
4 is solely her claim to bring that action.

5 We rely on a number of cases in South Carolina,
6 including Haselden v. Davis. I think that the law in
7 South Carolina is fairly clear that a minor may not
8 recover medical expenses from a tortfeasor in her own
9 personal injury action. Because that damage belongs
10 solely to the parent or guardian responsible for paying
11 for the medical services.

12 That is, certainly, the case here. The person
13 responsible for paying for those medical services, in this
14 case, at that time was Alana Mann. Any nominal expenses
15 that have been incurred since would be the financial
16 responsibility of Samuel and Demetria Orange. And like
17 Alana Mann, they, also, have not brought a suit in this
18 case.

19 There's been some writings on this issue. And I
20 think in those writings, it is fairly well established
21 that it is the current law in South Carolina that those
22 medical bills are not recoverable by parents. I think in
23 those writings people have argued that the law should be
24 changed. But I think people have agreed and it is the
25 consensus that the current state of law is that they are

1 not.

2 THE COURT: Thank you, sir.

3 Mr. Ruffin.

4 MR. RUFFIN: Your Honor, before we even get to
5 whether or not South Carolina law would or wouldn't
6 preclude an individual claiming pre-majority medical
7 expenses in her own name, this issue has been waived. It
8 was an affirmative defense that should have been pled in
9 the Defendants answer, and it was not.

10 This was the first argument that we made, I guess, in
11 round one of this trial. And we pointed out that it has
12 all the makings of an affirmative defense that under Rule
13 8(C), there's no requirement -- that the list of
14 affirmative defenses is not exhaustive.

15 For instance, charitable caps is an affirmative
16 defense statute of limitations issue, waiver of sovereign
17 immunity are all affirmative defenses not listed, although
18 the statute of limitations may be, but the other two are
19 not and are still affirmative defenses that must be pled
20 or else waived. And, Your Honor, it's our position that
21 failure to recover pre-majority medical expenses in this
22 case -- the argument to preclude the recovery of those
23 expenses has been waived.

24 And, Your Honor, if prejudice or surprise is an issue
25 that necessitates that we establish those in order to --

1 in order for argument to prevail, we have done so. We
2 have been prejudiced on these issues.

3 And it did come as a surprise knowing that we have
4 had our expert witnesses depositions taken, they've
5 offered testimony. And the case has been structured
6 around the presumption that this would not be challenged
7 and that it wasn't pled. We had our life care planner's
8 deposition taken, and it was never mentioned. We had our
9 economist -- at least, testimony has been offered --

10 MR. GRAHAM: He was deposed.

11 MR. RUFFIN: He was deposed as well and the issue was
12 not raised. So the only time it was even raised was
13 either two or three days before round one of this trial.

14 So, Your Honor, that's our first position, whether or
15 not it is or isn't the law in South Carolina is of no
16 import, because this argument has been waived by the
17 Defendants.

18 THE COURT: What is the -- what is it a defense to?

19 MR. RUFFIN: The affirmative defense is to the
20 recovery of pre-majority medical expenses of a child in a
21 child's name. For instance, in the same way if someone
22 sits on a claim and doesn't bring it within the statute of
23 limitations and by law, this individual, even if they had
24 a cause of action, had all the makings of the cause of
25 action and were able to establish all of their elements,

1 they can't recover because of a legal basis, or an issue
2 of the law. And that's under Rule 8(C).

3 And, under South Carolina law, in those cases cited
4 in my first argument, as well as in the brief that we
5 handed up in response, this case -- or this issue of
6 pre-majority medical expenses is an affirmative defense.
7 But it may not be viewed as such under our law because the
8 issue has not been ruled on by our Supreme Court. But it,
9 certainly, is an affirmative defense.

10 THE COURT: But the statute of limitations -- the
11 example you provide is a defense that bars the entire
12 claim; right?

13 MR. RUFFIN: Correct.

14 And I'm unaware of any case law which says that even
15 if part of the claim is barred that renders it not an
16 affirmative defense. What it is is an affirmative defense
17 to -- of it is a complete elimination of pre-majority
18 medical expenses.

19 And the argument is, well, even if we're able to
20 establish that those expenses were incurred by our
21 Plaintiff -- their position is even if you prove that and,
22 you know, we'll assume you could prove it for the purposes
23 of our defense, you can't recover those by operation of
24 law.

25 THE COURT: All right. I understand your argument.

1 Thank you.

2 MR. ALEXANDER: Well -- and maybe I don't. So if I'm
3 plowing ground that doesn't need to be plowed, I'll stop.

4 But there is no claim by the Oranges for which I
5 could plead an affirmative defense that they're not
6 entitled -- this action was brought by Demetria Orange as
7 guardian ad litem or next friend of **J.B.**
8 So I think it's an element of damage in this case. But
9 it's not clear to me how it could have been pled an
10 affirmative defense if the Oranges didn't bring an action,
11 nor did Alana Mann, so.

12 THE COURT: Okay. Yes, sir.

13 MR. RUFFIN: Your Honor, depending on how you decide
14 that issue, we have other arguments as well.

15 THE COURT: Go ahead.

16 MR. RUFFIN: Haselden v. Davis is a collateral source
17 case. It's not directly on point for the proposition we
18 concerted. But, more importantly, South Carolina does
19 recognize the implied waiver of claim that has -- in
20 regards to this specific -- factual circumstances of this
21 particular case. But implied waiver is recognized in
22 South Carolina law.

23 And whenever the mother didn't bring a suit in her
24 own name, these claims were impliedly waived. And it was
25 a transference of her rights to the minor child. And so

1 it is our position that once that occurred, through her
2 implied waiver, then it was her claim to bring in her own
3 name.

4 THE COURT: Okay.

5 MR. RUFFIN: And, Your Honor, our final argument is
6 the inequities of -- that the bar of pre-majority medical
7 expenses should be activated in South Carolina. Of
8 course, that's our final position.

9 Our first and stronger -- well, the first positions
10 that we relied upon are waiver of the affirmative defense
11 and the implied waiver of the pre-majority medical
12 expenses from mother to child.

13 THE COURT: Yes, sir, Mr. Graham.

14 MR. GRAHAM: Your Honor, if I may make one further
15 suggestion. I, obviously, have no idea how Your Honor is
16 inclined to rule.

17 But to the extent Your Honor might rule in favor of
18 Mr. Alexander's argument, it seems to me that judicial
19 economy would be served by allowing us to go forward with
20 the pre-majority medicals, have those dealt with on the
21 verdict form so that if that legal issue got sorted out
22 one way or another, it wouldn't require a new trial.

23 THE COURT: Yes, sir. I understand your proposal.

24 Mr. Alexander, do you have any further argument you
25 wish to make?

1 MR. ALEXANDER: No.

2 I'm reading from an older article authored by Ed
3 Graham, who argues that this is the state of the law in
4 South Carolina, that pre-majority medical expenses are not
5 recoverable in an accident like this and it should be
6 changed.

7 MR. GRAHAM: May I see the article? Is this reliable
8 authority?

9 THE COURT: May I see it?

10 Thank you.

11 (Pause.)

12 THE COURT: Where did this come from?

13 MR. GRAHAM: Your Honor, that copy came from
14 Mr. Alexander. I will state, as an officer of the Court,
15 my best recollection is that I was requested to submit a
16 proposed article for the State Bar magazine and,
17 ultimately, it has not been published.

18 THE COURT: Oh, okay.

19 MR. GRAHAM: But I don't know if Mr. Alexander is on
20 the review committee for that magazine, or exactly what.

21 THE COURT: It sounds like he has peer reviewed it
22 for you.

23 MR. ALEXANDER: I agree with him wholeheartedly. It
24 is not the law of this state.

25 THE COURT: Well, I'll read it over lunch.

1 MR. ALEXANDER: Judge, I was -- I can't remember. I
2 was in this courtroom one time and you were talking to
3 some lawyer and I can't recall what the issue was, but
4 citing, and citing, and citing. And I was sitting back
5 there getting increasingly nervous. And, at some point,
6 you said, I'm reading from your article. I was like --

7 THE COURT: I don't know. This looks very
8 interesting.

9 Thank you for providing it.

10 I'll see y'all back at 1:30, unless you have anything
11 else.

12 MR. ALEXANDER: No; sir.

13 THE COURT: All right. Thank you very much.

14 (WHEREUPON, a lunch break was taken.)

15 THE COURT: So the proposal you had, Mr. Graham,
16 about putting these discrete medical expenses on the
17 verdict form so as to, perhaps, preserve the appellate
18 issue, explain how that would occur in terms of the
19 evidence being introduced and admitted in this trial.

20 MR. GRAHAM: Well, Your Honor, it seems to me we can
21 do it in one of two ways.

22 THE COURT: Okay.

23 MR. GRAHAM: One way -- the one I kind of hinted
24 about that didn't really develop is that we go ahead and
25 put in all the evidence about pre-majority medical

1 expenses, both in the past and the first part of the life
2 care plan through age 18. And then have the jury form --
3 the jury verdict form in a series of questions whenever
4 they get down to how much in damages to allow, maybe have
5 it broken down, at that point, in terms of past medical
6 expenses, future pre-majority medical expenses, and
7 everything else. There's not a non-economic cap in this
8 case, so we don't need economic loss really.

9 But if we had -- I mean, in terms of the past -- if
10 they award for past medical expenses, that's an important
11 number to know, both for the legal reason and for Medicaid
12 lien issues. The future pre-majority medicals is
13 important to know because of the legal reason. And that
14 way, you know, we would have all that information.

15 And then once an ultimate decision is made about
16 whether or not we're entitled to recover pre-majority
17 medical expenses, we would have all the answers. If not,
18 we would just go with the rest of the verdict. And if we
19 are, we would get the other two parts.

20 It seems to me the other way to handle it would be to
21 keep it away from the hearing of the jury, go forward with
22 the jury on just the medicals after age 18, and all the
23 other damages. But make a Court's Exhibit of everything
24 else.

25 And then if the legal issue is resolved in our favor,

1 then add those to the verdict, if need be. I mean,
2 there's a 1.2 overall cap. So, you know, hopefully, we'll
3 get a verdict above that and it won't matter.

4 THE COURT: Thank you, sir.

5 MR. GRAHAM: Yes, sir.

6 THE COURT: Mr. Alexander, do you want to chime in?

7 MR. ALEXANDER: Well, my concern would be my
8 inability to unring the bell if all this comes in. And,
9 particularly, as Dr. Wood is getting ready to testify, I
10 would like to be able to exclude those amounts from his
11 testimony.

12 I guess if I have to choose among those two options,
13 then I would prefer the second one, that is that they go
14 ahead and calculate the amount of damages. Because I'm
15 concerned if they hear those numbers, they may use those
16 numbers in some way to calculate non-economic damages.
17 And I won't be able to unravel that.

18 THE COURT: Well, I don't know of any way I could do
19 it in any fashion, other than the latter way Mr. Graham
20 outlined, which I'm happy to do it that way, to let it --
21 you proffer the expenses.

22 But I don't believe, based on the state of the law as
23 it now exists, that I could admit to pre-majority
24 expenses. I understand the arguments to overturn the
25 precedent, but, also, then my place on the pecking order.

1 MR. GRAHAM: I understand, Your Honor.

2 MR. ALEXANDER: Also, it's -- so that includes both
3 actual bills incurred pre-majority, plus what Karen
4 Shelton has submitted in her report as future up to the
5 age of majority? Is that --

6 MR. GRAHAM: I believe that's right, Your Honor. And
7 it -- we've got Sam prepared to put in evidence of --

8 THE COURT: Okay.

9 MR. GRAHAM: -- the past medicals. We could do that,
10 perhaps, before the jury comes in.

11 THE COURT: Yes, sure.

12 MR. ALEXANDER: Proffer?

13 THE COURT: Proffer, yes, sure.

14 MR. GRAHAM: And then when we put Dr. Wood up, we can
15 have him go forward with the second set of charts that
16 address post-age 18, and make a proffer of the first set
17 of charts.

18 THE COURT: Okay.

19 MS. RODRIGUEZ: And, Judge, I could pull that page
20 out of Karen's exhibit that went to the pre-majority.
21 It's just a separate page. And just leave the 18 and over
22 in. If there's no objection, we could do that, add that
23 to the Court's Exhibit.

24 THE COURT: Okay, ma'am.

25 MS. RODRIGUEZ: Why don't you mark this one then.

1 And I'll pull Karen's out and we can add it to this,
2 if that is okay with the Court.

3 (WHEREUPON, Plaintiff's Exhibit No. 9 was marked for
4 identification only.)

5 THE COURT: And this article I'll make as a Court's
6 Exhibit. I enjoyed reading it. Well done.

7 MR. GRAHAM: And I enjoyed finding it in Ben's file.

8 (WHEREUPON, Court's Exhibit No. 3 was marked for
9 identification and admitted into evidence.)

10 THE COURT: Okay. As I -- now, these have not been
11 marked, but there were two other exhibits that were
12 objected to yesterday. One is entitled Phase of Active
13 Labor, and the other is called Pitocin Use. I believe
14 these came in during -- or were sought to be admitted
15 during the testimony of Ms. Murray.

16 MS. RODRIGUEZ: Ms. Murray on one, and Dr. Carrion on
17 the other.

18 THE COURT: Oh, okay.

19 And my recollection was Mr. Alexander had objected,
20 but would agree they could be admitted if -- on one
21 showing the Phases of Active Labor, if that title be taken
22 out.

23 Is that right?

24 MR. ALEXANDER: Yes, sir.

25 THE COURT: And on Pitocin Use Chronology, you just

1 wanted the doctor's notes taken out; is that right?

2 MR. ALEXANDER: Yes, sir, just because they're not
3 complete.

4 THE COURT: I would agree with that. If they'll be
5 redacted and take those things out, I think they are
6 admissible under Rule 1006 and even Rule 611 and 703.

7 I think the portions that the Defense seeks to have
8 redacted are argumentative parts of the exhibits. And,
9 therefore, they wouldn't be part of the summary because
10 they wouldn't be accurate summaries. They would be things
11 added by the lawyers.

12 So I believe that's a reasonable request and in line
13 with the rules. So that's my ruling on those.

14 What would these be -- well, I guess when y'all
15 redact them --

16 MS. RODRIGUEZ: Thank you, Your Honor.

17 THE COURT: Thank you.

18 And I'm relying on United States v. Janati, 374 F.3d
19 263, Fourth Circuit 2004 case and U.S. v. Milkiewicz, 470
20 F.3d 390, First Circuit 2006.

21 Okay. Anything else before we bring the jury in?

22 Are you going to bring Mr. Orange back up and proffer
23 that?

24 MS. RODRIGUEZ: Yes, sir, Your Honor.

25 THE COURT: Yes, sir, if you'll come back up.

DIRECT EXAMINATION

BY MS. RODRIGUEZ:

Q Sam, I'm going to hand you a document that we've marked as Court's [sic] Exhibit No. 9, and ask you, is this a summary of the bills we've received regarding the treatment that J.B. received for her surgery, and her other physical therapy, et cetera?

A Yes.

Q And can you -- the total bill is right here. Can you read and tell the Court what those were?

A \$100,055.89.

MS. RODRIGUEZ: Thank you.

I think we've already got that marked.

BY MS. RODRIGUEZ:

Q Now, Sam, is it your understanding -- is it your intent to be responsible for any outstanding bills or anything that J.B. incurs in terms of medical expenses even before she reaches the age of 18?

A Yes.

MS. RODRIGUEZ: Thank you.

THE COURT: That's it in the proffer?

MS. RODRIGUEZ: Yes.

THE COURT: Okay. Are y'all ready for the jury?

MS. RODRIGUEZ: I'm, actually, done with the witness, Judge.

1 MR. GRAHAM: But there's cross.

2 MS. RODRIGUEZ: Oh, I'm sorry. There's cross.

3 MR. ALEXANDER: It's going to take me the rest of the
4 day.

5 MS. RODRIGUEZ: I'm sorry about that.

6 (WHEREUPON, the jury came into open court at
7 approximately 1:48 p.m.)

8 THE COURT: All right. Yes, ma'am, Ms. Rodriguez.

9 MS. RODRIGUEZ: Sam, I don't have any further
10 questions. If you'll answer any questions the Defense
11 has.

12 CROSS-EXAMINATION

13 BY MR. ALEXANDER:

14 Q Mr. Orange, you have not been able to be here every
15 day of the trial; is that true?

16 A Yes.

17 Q You have been at work some of those days?

18 A Every day.

19 Q There has been an allegation made in this courtroom,
20 sir, that you are a fun dad; is that true?

21 A Yeah.

22 Q That you are the one that is -- that plays with
23 J.B. and is her encourager?

24 A Oh, yes.

25 Q And that Demetria is the disciplinarian?

- 1 A Yes.
- 2 Q The one that gets to do the hard stuff?
- 3 A Oh, yeah.
- 4 Q We have heard testimony that you have been the one
5 that encouraged her to learn to ride a bike?
- 6 A Yes.
- 7 Q To play soccer?
- 8 A Yes.
- 9 Q To take swimming lessons?
- 10 A Yes.
- 11 Q That you are the one that encourages her to be at
12 school on time?
- 13 A Yes.
- 14 Q To study hard?
- 15 A Yes.
- 16 Q To do well in school?
- 17 A Yes.
- 18 Q And that both you and Demetria are going to encourage
19 her to continue to do those things, and go to college, and
20 be successful; true?
- 21 A Yes.
- 22 MR. ALEXANDER: Thank you, sir.
- 23 THE COURT: Any redirect?
- 24 MS. RODRIGUEZ: Nothing.
- 25 THE COURT: Thank you, Mr. Orange.

1 All right. You may call your next witness.

2 MR. GRAHAM: Thank you, Your Honor.

3 We call Dr. Carrie Anne Twedt.

4 THE CLERK: Place your left hand on the Bible and
5 raise your right hand.

6 WHEREUPON,

7 CARRIE ANNE TWEDT,
8 after first having been duly sworn, testified as follows:

9 THE CLERK: State your name, please.

10 THE WITNESS: Carrie Anne Twedt.

11 THE CLERK: Thank you.

12 Please be seated.

13 DIRECT EXAMINATION

14 BY MR. GRAHAM:

15 Q Good afternoon, Dr. Twedt.

16 Ma'am, when did you finish your obstetrical residency
17 program?

18 A In the year 2000.

19 Q And where did you complete that program?

20 A At Greenville Memorial Hospital.

21 Q Doctor, do you believe that there are safety rules in
22 our country that apply to medical doctors, including
23 obstetricians?

24 A Yes.

25 Q Okay. And those safety rules are for the purpose of

1 protecting patients; true?

2 A Yes.

3 Q When you became a doctor, you had to take the
4 hippocratic oath; correct?

5 A Correct.

6 Q And even though the actual version of that is much
7 longer, that can boil down to the basic concept of doctor,
8 first, do no harm; true?

9 A Yes, it is.

10 Q When do you believe it's acceptable for a medical
11 doctor to needlessly endanger a patient?

12 A That is never a physician's goal.

13 Q Okay. Let me -- listen carefully to the question. I
14 didn't ask you anything about a goal.

15 When do you believe it's acceptable for a doctor to
16 choose to needlessly endanger a patient?

17 A It is not acceptable.

18 Q Do you believe that having a proper plan of care for
19 a pregnant woman is important?

20 A Yes.

21 Q Do you believe that effective communication among the
22 healthcare team members is important?

23 A Yes.

24 Q Do you believe that having an attending physician in
25 attendance when a relatively new resident, say, a

1 second-year obstetrical resident, is in charge of a labor
2 and delivery --

3 A It would be my goal to be in attendance any time a
4 resident was delivering a baby, no matter what their
5 experience was.

6 Q Do you believe, ma'am, that silence in healthcare
7 organizations is common?

8 A I don't know what you mean by that.

9 Q Okay. Do you believe that it's common in hospitals,
10 such as Greenville Hospital System, for certain members of
11 a healthcare team to remain silent in the face of their
12 own personal knowledge that another healthcare provider in
13 that hospital is deficient?

14 A Absolutely not.

15 Q You don't believe there's a problem with silence?

16 A Not at Greenville Memorial Hospital, no.

17 Q Not at Greenville. Do you believe that type of
18 silence about deficiencies in healthcare provider quality
19 is a problem at other hospitals?

20 A I have never worked at another hospital besides
21 Greenville Memorial Hospital.

22 Q Do you believe that when members of a healthcare team
23 do not voice their concerns about deficiencies of
24 healthcare providers that the problems are likely to
25 persist?

1 A I have never experienced that, so I can't make a
2 comment on that.

3 Q Do you believe when healthcare providers keep silent
4 about their concerns about deficiencies of other
5 healthcare providers that that needlessly endangers
6 patient safety?

7 A Again, I've never experienced that, so I cannot make
8 a comment.

9 MR. ALEXANDER: Judge, if you don't mind, let me just
10 interject an objection on the grounds of relevance, and
11 the lack of foundation for this line of questioning.

12 THE COURT: Okay. Overruled.

13 BY MR. GRAHAM:

14 Q Do you agree that the problem of healthcare
15 organization silence has been found across many healthcare
16 professions?

17 A I work at Greenville Memorial Hospital. That's where
18 I trained. That's where I'm an attending. And we do not
19 have a lack of communication between nurses, resident
20 staff, as well as attendings.

21 Q Do you believe that that problem of hospital
22 organizational silence about deficient quality of care
23 provided by certain members of the healthcare team applies
24 to residents in the obstetrical residency program at
25 Greenville Hospital System?

1 A I did not understand your question. If you could,
2 please, restate it.

3 Q Do you believe the problem of hospital organizational
4 silence about deficiencies in healthcare providers applies
5 to residents in the OB residency program at Greenville
6 Hospital System?

7 A Again, I have stated that I do not believe the
8 Greenville Memorial Hospital residency program, nurses, or
9 attendings have any aspect of silence. There's open
10 communication across all aspects.

11 Q Do you believe that problem of organizational silence
12 applies, also, to nurses at Greenville Hospital System?

13 A I do not believe that the nurses have any trouble
14 communicating with each other.

15 Q Do you believe that problem of organizational silence
16 applies, also, to attending physicians in the Greenville
17 Hospital residency program?

18 A As I've stated previously, I don't feel there's
19 silence in regards to attendings, nurses, residents, et
20 cetera, at Greenville Memorial Hospital.

21 Q Doctor, what medical journals do you regularly
22 subscribe to in the field of obstetrics?

23 A The Green and the Gray Journal would be the common
24 names.

25 Q And what is the formal name of the Green Journal?

1 A At this moment in time, I cannot tell you.

2 Q Okay. What's the formal name of the Gray Journal?

3 A The exact name, I cannot tell you.

4 Q Do you claim to read those journals regularly?

5 A I try to, yes.

6 Q Okay. Do you subscribe to them personally?

7 A Yes. They're sitting on my desk presently.

8 Q Do you stay current on those articles?

9 A In the articles in those journals, yes, as well as a

10 recertification process that our college does on a yearly

11 basis, which requires us to read over a hundred articles

12 yearly and answer questions.

13 Q Fine, Doctor. When is the last edition of those

14 journals that you've read?

15 A Within the last year.

16 Q Within the last year?

17 A Uh-huh.

18 Q What is the most recent copy of the Gray Journal

19 sitting on your desk waiting to be read?

20 A What's the most recent?

21 Q Yes, ma'am.

22 A This past month.

23 Q Past month?

24 A The current month, what would come in the mail via

25 the delivery service.

1 Q And what's the current -- I mean, I know what month
2 we're in now. But what's the current edition of the Gray
3 Journal?

4 A What is the current edition?

5 Q Yes, ma'am. Has November come out yet, for
6 example --

7 A Sir, I do not know. No, it's October, so, no, not
8 yet.

9 Q Really? Okay. What about the Green Journal, has the
10 November edition --

11 A Sir, I do not know for sure.

12 Q Now, are you familiar with a journal called the
13 American Journal of Obstetrics and Gynecology?

14 A Yes, I am.

15 Q Do you call that the Green Journal or the Gray
16 Journal?

17 A I believe that's Gray, but I would have to step back
18 and look.

19 Q Okay. Do you consider the most recent edition of the
20 Gray Journal to be reliable authority about problems in
21 terms of communication problems endangering patients
22 safety?

23 A I'm aware that there's literature that communication
24 problems can endanger safety. But, again, you asked me,
25 specifically, about communication problems associated with

1 Greenville Hospital System. And I do not believe there's
2 communication problems at Greenville Memorial Hospital.

3 Q All right. Doctor, I'm going to hand you a document
4 from the November 2013 edition of the American Journal of
5 Obstetrics and Gynecology entitled, Patient Safety Series
6 Confronting Safety Gaps Across Labor and Delivery Teams,
7 lead-on author David G. Maxfield. And I'm going to ask
8 you, ma'am, do you consider that --

9 MR. ALEXANDER: Could I be provided a copy?

10 BY MR. GRAHAM:

11 Q Doctor, do you consider this article to be a reliable
12 authority on the issue of confronting safety gaps across
13 labor and delivery teams?

14 A I would have no idea. I would have to read it.

15 Q Okay. Well, let me get you to read the parts that
16 are relevant to this case. Do you see the very first
17 page? It's Page 402, but it's in the first page of the
18 article I gave you. The third column over, the first new
19 paragraph starting with, Silence and organizations --

20 A Silence and organizations is both common and costly.
21 When people do not voice their concerns, the problems they
22 have observed persist. If a norm of silence is bolstered,
23 organizational members become less committed and the
24 system itself becomes less capable.

25 Q And would you continue with, This problem?

1 A This problem of organizational silence has been found
2 across many healthcare professions, ranging from chairs of
3 medicine, to residents, midwives, and nurses.

4 Q Would you continue with the next sentence, When
5 silence --

6 MR. ALEXANDER: Your Honor, may we approach?

7 THE COURT: Sure.

8 (WHEREUPON, a bench conference was held.)

9 BY MR. GRAHAM:

10 Q Doctor, I'm going to move on to another subject.
11 What is the regular call system for attending
12 obstetricians at Greenville Hospital System?

13 A In regards to the residency coverage, or my private
14 practice?

15 Q Well, which one was involved in the case we're
16 talking about here, the residency program?

17 A Yes.

18 Q Let's talk just about that then, please. What is the
19 call arrangement for the residents that would be taking
20 care of -- back in 2004 taking care of a woman like Alana
21 Mann?

22 A The residents, specifically, or the attendings?

23 Q The attendings call schedule.

24 A I'm a member of a group that covers the residents on
25 call. It would be on the odd days of the month. And we

1 would cover them, mainly, from 5:00 in the evening to 8:00
2 the next morning during the week, and on weekends from
3 8:00 a.m. to 8:00 a.m. the next day.

4 Q Okay. So during weekends, you have a 24-hour call?

5 A Yes, sir.

6 Q How many attendings are on call for that 24-hour
7 period of time on the weekend?

8 A Attendings on call for the residency program or, in
9 general, in regards to the hospital?

10 Q The residency program, ma'am.

11 A One primary attending is on call to cover obstetrical
12 issues. At that point in time, there, also, would be a
13 GYN attending that would not be in the hospital, but would
14 be available via phone consultation in case there was an
15 emergency from a GYN standpoint.

16 And there, also, too, would be maternal fetal
17 medicine physicians on call for consults, but, again, not
18 present in the hospital.

19 Q Okay. One OB-GYN on the premises of the hospital for
20 24 hours?

21 A Yes, sir.

22 Q One OB-GYN at the distant location for 24 hours with
23 telephone contact?

24 A Yes, sir.

25 Q And two maternal fetal folks?

- 1 A Yes.
- 2 Q Again, at a distant site available by phone. So
- 3 during the period of November 26th through 27th of 2004,
- 4 you were the 24-hour call physician?
- 5 A Yes.
- 6 Q Okay. Were you the only attending physician on the
- 7 premises of Greenville Hospital System for that 24-hour
- 8 period?
- 9 A No. I would not normally be, no.
- 10 Q But you were the only one who was required to be
- 11 there the entire 24-hour period?
- 12 A I was required to be there the 24-hour period, but,
- 13 also, too, all the services of the residency program,
- 14 which would include the benign GYN service, as well as the
- 15 gynecological GYN services, as well as the maternal fetal
- 16 medicine attendings would all be rounding during the day
- 17 on both mornings.
- 18 Q And how many residents did you have under your wing,
- 19 so to speak, with you as the attending for them back in
- 20 November of 2004?
- 21 A You, usually, have three. You'd have a chief
- 22 resident, which would be a fourth-year in the program, a
- 23 mid-level, which would be a second or third-year, and then
- 24 an intern, which would be a first-year.
- 25 Q How many labor and delivery nurses were available to

1 work with pregnant women?

2 A Labor and delivery, specifically, we had
3 approximately about 14 rooms. So the -- we, usually, have
4 probably nine to 10 labor and delivery nurses.

5 Q So during that 24-hour period, you would be allowed
6 to eat?

7 A Yes.

8 Q You'd be allowed to nap?

9 A Yes.

10 Q But you would be the only on-call obstetrician to
11 deal with every pregnant woman that went into labor during
12 that 24-hour period?

13 A No.

14 Q You would not be the only attending obstetrician on
15 the premises?

16 A No.

17 Q Okay. How many would there be?

18 A It's just depends. Not only does the residency
19 program deliver babies at Greenville Memorial Hospital,
20 but many private groups do as well. So the number of
21 attendings present would be varied on what patients were
22 in labor.

23 Q Are you saying some of the attendings are in private
24 practice?

25 A Yes.

1 Q Well, on the 24-hour period in question, from -- what
2 did you say, 8:00 a.m. on the 26th through 8:00 a.m. on
3 the 27th?

4 A Yes.

5 Q Of November 2004, how many attendings were at the
6 premises of the hospital?

7 A I could not state to that date, specifically. But on
8 the average, on a weekend, there's three to four.

9 Q Well, so you don't know how many were available that
10 particular day; is that fair?

11 A In November of 2004, nine years ago, no, I cannot be
12 specific.

13 Q Okay. As you sit here today, do you have any
14 recollection of whether there was even one more attending
15 during that Thanksgiving holiday weekend?

16 A Statistically stating that I've never been in the
17 hospital where there's just me alone without another
18 attending, I would say, yes, there would be someone else
19 there.

20 Q Do you recall the question, ma'am? I'm asking, as
21 you sit here, do you have a recollection of anyone else
22 being there that day?

23 A Again, recollection is different than regards to what
24 is usual. A recollection, no. I don't remember that day
25 at all. But I've never been in the hospital since I've

1 been an attending since the year 2000 where I've been the
2 only person in the hospital.

3 Q Thank you.

4 But you don't remember that particular 24-hour period
5 at all; true?

6 A True.

7 Q During holiday weekends like Thanksgiving, are there
8 as many folks staffing the hospital as on non-holidays?

9 A Absolutely.

10 Q Okay. So you claim that if a woman goes in to
11 deliver a baby at Greenville Hospital System during a
12 Thanksgiving weekend, they should expect the same quality
13 of care as a woman who goes in to deliver during a weekday
14 that's not a holiday?

15 A Absolutely.

16 Q Okay. That would be a reasonable expectation of a
17 healthcare consumer; true?

18 A True.

19 Q That would be a reasonable expectation of someone
20 like Alana Mann?

21 A True.

22 Q Okay. It's not open season on pregnant women where
23 you're allowed to take shortcuts on the holidays; true?

24 MR. ALEXANDER: Your Honor, objection to the
25 argumentative question.

1 THE COURT: Sustained.

2 BY MR. GRAHAM:

3 Q Doctor, do you agree that one of the keys to avoiding

4 a permanent brachial plexus injury is not to use more than

5 gentle traction on the baby's head and neck?

6 A Could you restate the question? I'm sorry.

7 Q Do you agree that one of the keys to avoiding a

8 permanent brachial plexus injury is to avoid greater than

9 gentle traction on the baby's neck down toward one of the

10 shoulders?

11 A Yes. We try to avoid more than gentle downward

12 traction in any instance.

13 Q Well, I didn't ask you about what you try to do.

14 What I asked you is, do you agree that that's a key? If

15 the goal is to avoid causing a permanent nerve injury by

16 ripping and tearing C5, C6, and C7, a key is to not pull

17 too hard down on the baby's neck toward the shoulder?

18 A Yes. I would agree.

19 Q Okay. Now, when you're -- as an attending, do you

20 claim that you teach your residents that they should not

21 use more than gentle traction?

22 A Do I claim?

23 Q Yes, ma'am. Do you claim that you teach them that?

24 A I do do that.

25 Q So you claim to teach them not to use more than

1 gentle traction?

2 A On a regular basis, I teach residents how to deliver
3 babies. And I observe them delivering babies. And, yes,
4 part of that process, we do not apply more than gentle
5 downward traction.

6 Q Okay. The question is, do you claim to teach them
7 that it's important to avoid more than gentle traction?

8 A Yes. I'm just having trouble with the word "claim."

9 Q Okay. Is it important that a resident not use more
10 than gentle traction in a lateral direction toward the
11 baby's shoulder?

12 A Yes.

13 Q Okay. Why is that important?

14 A It's not necessary to deliver a baby.

15 Q Why is it important not to apply more than gentle
16 traction to a baby's head toward the shoulder?

17 A It's not necessary to apply more than gentle downward
18 traction in a vaginal delivery. And if you do, it can
19 result in an injury to the baby.

20 Q Okay. It puts the brachial plexus nerves at risk of
21 being ripped and torn; true?

22 A Ripped is not a medical term. But, sure, you can use
23 that.

24 Q Is there a term you would prefer, Doctor?

25 A Avulsion.

1 Q Avulsion. Okay. What does the word avulsion mean to
2 you?

3 A If I were to describe it, it would be a breakage of
4 the nerve roots.

5 Q Of the root?

6 A Or the nerve itself.

7 Q Okay. Sometimes, when a doctor does this to a baby,
8 sometimes, the nerve roots can be pulled out from the
9 spinal cord; true?

10 A Yes.

11 Q Sometimes, they can be ripped and torn away from the
12 spinal cord like they were in this case; true?

13 A Yes, I would assume. I've not seen brachial plexus
14 injuries or what the nerve roots look like. I've never
15 seen a brachial plexus dissected.

16 Q Obstetricians don't look at brachial plexus nerves,
17 do they?

18 A No.

19 Q When you're training your residents how important it
20 is not to use more than gentle traction, do you explain to
21 them that if they do use more than gentle traction, they
22 can cause permanent nerve damage to the nerves in a baby's
23 neck?

24 A Yes.

25 Q Okay. Do you communicate that clearly to the

1 residents so that they can learn from your instruction as
2 the attending?

3 A Yes.

4 Q Okay. Do you tell them that it's okay to use their
5 body weight in applying traction to a baby's head and
6 neck?

7 A Have I said use your body weight to deliver a baby?
8 No.

9 Q Have you ever communicated to a resident that it is
10 acceptable for them to use their body weight?

11 A No.

12 Q Have you ever suggested to them that gentle traction
13 allows a resident to use their body weight?

14 A No.

15 Q Using one's body weight to apply traction is anything
16 but gentle; true?

17 A Yes.

18 Q It would be greater than gentle?

19 A I've never seen anyone use their body weight to
20 deliver a baby, or to apply traction.

21 Q All right. Please listen to the question. Using
22 body weight to apply traction would be greater than gentle
23 traction; true?

24 A If that occurred.

25 Q And using one's body weight to apply traction would

1 be excessive traction; true?

2 A If that occurred, yes.

3 Q And using one's body weight to apply traction would
4 put the brachial plexus nerves of that baby at risk of
5 permanent nerve damage; true?

6 A If that occurred, yes.

7 Q You said you have no memory of this delivery. In
8 fact, you have no memory of anything during that 24-hour
9 period; true?

10 A It was nine years ago, so, no.

11 Q Okay. And do you remember where you went for
12 Thanksgiving celebrations?

13 A Since I was on call, it would be here in Greenville.

14 Q Okay. But you don't remember any specifics of that
15 holiday weekend as far as your personal schedule is
16 concerned?

17 A No.

18 Q Do you remember how much time you spent napping
19 during your call?

20 A No.

21 Q Do you remember how much time you spent in the
22 cafeteria during your call?

23 A No.

24 Q If the doctor who applies the first amount of
25 traction to a baby with a stuck shoulder has never before

1 applied traction to a baby with a stuck shoulder, do you
2 believe that puts the baby in danger of nerve damage?

3 A No.

4 Q No, it doesn't. Okay. Do you believe it is more or
5 less dangerous to a patient for a doctor to have
6 experience managing shoulder dystocia, or to be involved
7 in one -- in the doctor's very first shoulder dystocia?

8 A That, again, was a confusing question. If you can
9 state it again for me, please.

10 Q All right. Let's take two situations. One is where
11 an experienced doctor who's dealt with shoulder dystocia
12 has a hands-on way and has developed a feel for how much
13 gentle traction is acceptable in that situation. That's
14 one situation. The other one is --

15 A In the situation of a shoulder dystocia, or just a
16 natural vaginal delivery?

17 Q All right. Doctor, let's assume -- let me just ask
18 you a hypothetical question. Okay. Assume this is a
19 head-first vaginal delivery. The head delivers easily,
20 but the rest of the body doesn't come out because the
21 baby's right shoulder is stuck behind the mother's pubic
22 bone. In a situation like that, let's take two possible
23 scenarios. One involves an experienced doctor, say, an
24 attending doctor who's developed a feel for how much
25 traction is gentle.

1 Let's assume the other scenario is a second-year
2 resident who has never before had any degree of
3 responsibility for figuring out how much traction to use
4 when the shoulder is stuck.

5 Which one of those scenarios do you believe is more
6 dangerous to the patient, the attending handling it or the
7 second-year resident handling it?

8 A Well, the fact that shoulder dystocia isn't something
9 that occurs on a regular basis, in reality, the attending
10 may be experiencing a shoulder dystocia for the very first
11 time. So they're similar.

12 Q Wait a minute. You're saying they're equally
13 dangerous because the attending may not have any
14 experience either?

15 A Shoulder dystocia doesn't occur except for one to
16 three percent, according to the literature, of the time.
17 So it's not something you experience every day that you're
18 on the job. You could go years and deliver babies for an
19 entire residency program without encountering a shoulder
20 dystocia.

21 Q Let me ask that question a different way. Same
22 assumptions on the hypothetical, head-first vaginal
23 delivery, head delivers easily, right shoulder gets stuck
24 behind the mom's pubic bone. And let's assume two
25 scenarios. One is a first time encounter with shoulder

1 dystocia, the other one is a doctor who has had, at least,
2 some experience and has developed, at least, some feel for
3 how much traction is appropriate in shoulder dystocia
4 management.

5 Given those assumptions, which is more dangerous to
6 the patient, the experienced doctor handling it, or the
7 second-year resident with no experience handling it?

8 A I think one of the benefits of a residency program is
9 that the second-year knows she has, in this instance,
10 someone to back her up. So whenever you're an attending,
11 the buck kind of stops with you.

12 When you're a resident, you, actually, have the
13 ability to know that there's other people there to aid you
14 in that. So you, actually, don't have to complete the
15 entire delivery process. There is help there.

16 Q Doctor, the question is, which is more dangerous to
17 the patient, when an experienced doctor applies the first
18 traction or when a second-year resident, who has never
19 been there before, applies the first traction?

20 A They both can be dangerous.

21 Q What if the second-year resident has never even seen
22 somebody handle a shoulder dystocia resolution before?

23 A An attending could never have seen a shoulder
24 dystocia resolution before.

25 Q And both of those are dangerous?

1 A Can be.

2 Q Okay. Can be if too much traction is used; right?

3 A Yes.

4 Q That causes or can cause permanent ripping and

5 tearing of the nerves; true?

6 A You have said that, yes.

7 Q Let me ask you some questions about J.B.

8 Ballenger's time at Greenville Hospital System. When

9 Cytotec was placed in her mom to induce labor, was there

10 an attending in attendance?

11 A When it was physically placed?

12 Q Yes, ma'am.

13 A No.

14 Q All right. It was placed three different times;

15 true?

16 A Yes.

17 Q Was there an attending in attendance any time Cytotec

18 was placed --

19 A That is not necessary --

20 Q The question is --

21 A In reality --

22 Q The question, Doctor, is, was there --

23 MR. ALEXANDER: Your Honor --

24 THE COURT: Hold on a second. She's got a right to

25 explain her answer..

1 MR. GRAHAM: Sure.

2 THE WITNESS: Please don't interrupt me.

3 BY MR. GRAHAM:

4 Q Okay. Please respond to my questions, Doctor.

5 A So, in reality, the placement of Cytotec, whether it
6 be orally or vaginally, is, actually, even qualified for a
7 nurse to do that. So an attending is not necessary --
8 doesn't need to be present for the insertion of vaginal
9 Cytotec or the administration of oral Cytotec.

10 Q My question, Doctor, is, was there an attending in
11 attendance at the time Cytotec was placed any of the three
12 times in Alana Mann?

13 A It is not necessary, so, no.

14 Q Was there an attending in attendance at the time that
15 Pitocin was started in Alana Mann?

16 A If you define attendance as being present in the /
17 hospital being communicated with in that regards, yes.
18 Being present whenever the Pitocin was put in an IV bag,
19 no.

20 Q Wait a minute now. You're suggesting -- what are you
21 suggesting in terms of what you believe attending means?
22 What do you claim attending means -- or attendance means?

23 A Attending and attendance are two different words.

24 Q Yes, ma'am. The attending is the teacher in a
25 teaching hospital; right?

1 A The attending would be me in this scenario in a
2 teaching hospital, who's responsible for overseeing the
3 residents and teaching them in regards to the care of
4 their patients.

5 Q And what do you claim the word in attendance or the
6 phrase in attendance means?

7 A Being there available for guidance and teaching.

8 Q Available in the hospital?

9 A Yes.

10 Q You claim that in attendance does not mean at the
11 patient's bedside?

12 A It depends on what specific thing you're speaking of
13 in regards to if I need to be in attendance.

14 Q All right. Well, I'm asking you in attendance in
15 terms of at the patient's bedside?

16 A So going forward --

17 Q When Pitocin -- excuse me.

18 A Going forward, when you say "attendance", do you mean
19 am I standing at the patient's bedside? So we can be on
20 the same page.

21 Q Unless I tell you differently, but I believe that
22 will be correct. Do you claim that there was an attending
23 in attendance when Pitocin was started in Alana Mann?

24 A It is not necessary, so, no.

25 Q Okay. Do you claim that there was an attending in

1 attendance when Pitocin was increased above 20 milliunits?
2 A It is not necessary, so, no.
3 Q Do you claim that there was an attending in
4 attendance when Pitocin was increased above 30 milliunits?
5 A It is not necessary, so, no.
6 Q Do you claim that an attending was in attendance when
7 Pitocin was maxed out at 40 milliunits?
8 A That was the same question. It was not necessary,
9 so, no.
10 Q Do you claim there was an attending in attendance
11 when the fetal heart monitor equipment in the high risk
12 unit was running at the wrong speed?
13 A It's not necessary, so, no.
14 Q Do you remember this chart we went over yesterday?
15 A Yes.
16 Q All right. From 12:10 a.m. on Friday the 26th,
17 through 12:15 --
18 MR. ALEXANDER: Objection --
19 THE COURT: Hold on. Hold on.
20 MR. ALEXANDER: Is this the one we've said will be
21 edited?
22 MR. GRAHAM: For an exhibit to go back with the jury.
23 This is demonstrative.
24 THE COURT: I overrule the objection on this
25 particular blow-up chart.

1 Go ahead.

2 MR. GRAHAM: Thank you, Your Honor.

3 BY MR. GRAHAM:

4 Q So we've got, roughly, a 12-hour period from 12:10
5 p.m. on the 26th of November, through 12:15 a.m., 15
6 minutes into the 27th. Do you remember that 12-hour
7 period?

8 A From looking at that, yes.

9 Q The period of time when there was little, if any,
10 cervical dilation?

11 A Yes.

12 Q And the period of time when there was little, if any,
13 descent of the baby's head?

14 A Yes.

15 Q Doctor, do you claim there was an attending in
16 attendance for even a minute of time during that 12-hour
17 period?

18 A In the patient's room, it is not necessary, so, no.

19 Q You admit there was no attending in attendance for
20 that entire 12-hour period?

21 A It is not necessary, so, no.

22 Q Doctor, do you believe a woman has the right to be
23 informed of the important risks and benefits of a cesarean
24 section delivery compared to a vaginal delivery when for
25 12 hours her cervix has had little, if any, dilation and

1 her baby has had little, if any, descent?

2 A A woman is aware of the risks and benefits of vaginal
3 delivery versus C-section in the prenatal period, as well
4 as through her admission to the hospital, as well as on
5 labor and delivery.

6 Q I didn't ask, Doctor, for your speculation about what
7 a patient may or may not have. My question, Doctor, is do
8 you believe a woman has the right to that information?

9 A She has a right, yes.

10 Q During that 12-hour period of time, was there any
11 attending in attendance to discuss with Alana Mann the
12 relative risks and benefits of C-section versus vaginal?

13 A It was not necessary, so, no.

14 Q Was there an attending in attendance at any time from
15 when the woman was admitted through the time the baby was
16 placed in the warmer when an attending was in attendance
17 to talk with this lady about the dangers of continuing
18 with a vaginal delivery?

19 A It was not necessary, so, no.

20 Q There was never -- you admit there was never an
21 attending in attendance from admission of this lady for
22 induction of labor until the moment her baby was put in
23 the warmer with a limp arm?

24 A It's not necessary, so, no.

25 Q Now, you have looked at the strips in this case;

1 right, the fetal heart monitoring strips?

2 A Yes, I have.

3 Q You admit that there were periods of absent
4 variability and reduced variability; true?

5 A I would state that the fetal heart rate tracing was
6 reassuring throughout the entire labor process. Yes,
7 there's points where there's some absent or decreased
8 variability. But just like your own expert witness said,
9 there's no areas within the fetal monitoring strips
10 throughout the hospitalization up to delivery that was of
11 concern.

12 Q The question is, do you admit that there were periods
13 of absent variability on the fetal heart monitor strips?

14 A That in its own -- by itself defined period is not of
15 any importance.

16 Q Do you admit, Doctor, that there were periods of
17 absent variability?

18 A All babies have absent variability. You get absent
19 variability during the sleep period. So I would
20 anticipate there would be segments of the strip that
21 showed some decreased variability because babies do sleep.

22 Q Okay. Is that a yes, you do admit there were periods
23 of absent variability?

24 A I hope so since it's normal.

25 Q Do you, also, admit, Doctor, there were periods of

1 reduced variability?

2 A I hope so because it's normal.

3 Q Do you admit, Doctor, there were periods of

4 hyperstimulation?

5 A Hyperstimulation is when there's greater than five

6 contractions for, at least, 30 minutes. There was one

7 episode of that, but it was not prolonged.

8 Q Now, wait a minute. This business about 30 minutes,

9 that wasn't around in 2004, was it?

10 A Yes, it was.

11 Q What do you base that on?

12 A ACOG guidelines.

13 Q In 2004?

14 A They weren't put out in 2004, but those were what the

15 guidelines were, as my understanding.

16 Q They weren't put out in 2004, were they, Doctor?

17 A No. I think it was prior to that.

18 Q They were not in existence in 2004, were they,

19 Doctor?

20 A I just said I believe they were put out before that.

21 Q Okay. And what do you base that on, Doctor?

22 A ACOG technical bulletins.

23 Q Number what?

24 A I don't know.

25 Q In fact, adding the 30-minute part of it didn't

1 happen until just a few years ago; true?

2 A Not that I'm aware of, no.

3 Q The same time they decided hyperstimulation was too
4 easy of a word to understand and they changed it to
5 tachysystole?

6 A I don't know what year they changed the terminology.

7 Q That was just a few years ago, Doctor, wasn't it?

8 A Yes.

9 Q And that's when they added the 30-minute part of that
10 hyperstimulation; right?

11 A I believe so. I would have to look at the technical
12 bulletin to tell you.

13 Q Okay. And getting back to the question. You admit,
14 Doctor, that there were periods of hyperstimulation in
15 this case; true?

16 A I admit that there's areas of hyperstimulation. But
17 not only do you look at the contractions when a woman is
18 in labor, but you, also, look at how the baby is
19 tolerating it. And during the time of hyperstimulation,
20 the baby's heart rate monitor -- the heart rate tracing
21 was very reassuring.

22 Q Well, in the presence of hyperstimulation with heavy
23 doses of Pitocin, there are doctors who would insist that
24 the Pitocin be stopped; true?

25 A If it persisted, yes.

1 Q And even you admit that when you have
2 hyperstimulation, you must reduce the Pitocin, at least?

3 A Not necessarily, if the baby looks reassuring.

4 Q Doctor, we would --

5 MR. GRAHAM: I mean, Your Honor, we would hand up the
6 original deposition transcript and video deposition of
7 Dr. Twedt taken on August 28th, 2013.

8 THE COURT: All right. You can open it.

9 BY MR. GRAHAM:

10 Q And I'll hand -- do you have a copy?

11 A No.

12 Q Doctor, do you remember giving a deposition that day?

13 A Do I remember? Yes.

14 Q Okay. Mary Waters from my office took your
15 deposition, I believe?

16 A Yes.

17 Q Do you remember where that took place?

18 A At our satellite office on Highway 14.

19 Q It was on part of the Greenville Hospital System
20 campus?

21 A No.

22 Q Okay. What do you mean by satellite office?

23 A I'm in private practice. And we have an office
24 that's located on Highway 14, in the conference room.

25 Q So it was in your private office?

1 A Yes.

2 Q How much of your time do you claim you spend in your
3 private office versus doing teaching for the residency
4 program?

5 A Presently, or in 2004?

6 Q 2004.

7 A In 2004, my only responsibility was covering call for
8 the resident program.

9 Q That was your only responsibility?

10 A As well as teaching them GYN surgery in the operating
11 room.

12 Q At any rate, going back to the deposition. It was
13 taken in your private office. The hospital attorney,
14 Mr. Alexander, was there?

15 A Yes, sir.

16 Q A court reporter was there?

17 A Yes, sir.

18 Q All right. Back on that day, did you -- you were
19 under oath?

20 A Yes.

21 Q All right. Do you remember being asked then what a
22 doctor should do when hyperstimulation appears?

23 A I believe I was probably asked that multiple times,
24 yes.

25 Q Okay. Do you remember what your testimony was?

1 A At that time, I'm sure, as I would now, yes, you
2 would reevaluate the Pitocin and consider turning it
3 off.
4 Q Consider?
5 A It's a greater process than just turning Pitocin off.
6 You want to look at what the baby is doing at that point
7 in time.
8 Q Consider turning it off?
9 A Consider or turn it off, yes.
10 Q Well, which is it, Doctor, consider or turn it off?
11 When hyperstimulation is present, must the doctor turn
12 down -- at least, turn down the Pitocin?
13 A Not necessarily.
14 MR. GRAHAM: Mike, could you, please, play the
15 deposition clips on Page 91 and 90 of Dr. Twedt's
16 deposition?
17 BY MR. GRAHAM:
18 Q And this is Page 91, Lines 5 to 7 --
19 A 91?
20 Q Page 90, Lines 13 to 21.
21 A What page, sir?
22 Q Page 91, Lines 5 to 7. And Page 90, Lines 13 to 21.
23 We're going to play that to refresh your memory.
24 (WHEREUPON, Plaintiff's Exhibit No. 10 was marked
25 for identification only.)

1 (WHEREUPON, a portion of Plaintiff's Exhibit No. 10
2 was played in open court.)

3 BY MR. GRAHAM:

4 Q Was there an attending in attendance when Alana
5 Mann's uterus was in hyperstimulation?

6 A At the bedside, no.

7 Q Was there an attending in attendance to tell the
8 second-year and first-year resident that you were supposed
9 to turn down Pitocin when the mom's uterus went into
10 hyperstimulation?

11 A I'm sorry. Could you, please, state that again?

12 Q Was there an attending in attendance to be able to
13 educate the residents when the mom's uterus went into
14 hyperstimulation?

15 A I would be in attendance in regards to communication,
16 but I was not at bedside, no.

17 Q Do you claim that your residents were smart enough to
18 know that they should have reduced the Pitocin at that
19 time?

20 A My residents are smart enough to know, yes. But,
21 again, it is not just looking at the contractions. You
22 have to look at the entire picture. The baby is
23 reassuring during this time period.

24 Q That's not what you said when we took your
25 deposition, is it, Doctor?

1 A I just answered a question. I wasn't having a
2 conversation.

3 Q Okay. You were answering questions at the deposition
4 just like you're answering questions today; right, Doctor?

5 A Yes, yes.

6 Q There's nothing in the chart about any discussion
7 with Alana Mann about the risks and benefits of continuing
8 with vaginal labor when her cervix had not dilated for
9 12 hours; true?

10 A True.

11 Q There's nothing in the chart about a discussion with
12 Alana Mann about the risks of continuing with vaginal
13 labor when her baby's head had not descended for 12 hours;
14 true?

15 A True.

16 Q There was no indication in the chart that the mother,
17 Alana Mann, ever gave informed consent to continuing with
18 vaginal labor after that 12-hour period, was there?

19 A A redo of the informed consent that she signs upon
20 admission to labor and delivery, no.

21 Q Doctor, you don't claim to have ever given her any
22 risks -- any information about risks and benefits of
23 vaginal labor versus cesarean section, do you?

24 A Me personally?

25 Q Yes, ma'am.

1 A No.

2 Q So any -- so you don't have any personal knowledge as
3 to whether that discussion ever truly occurred, do you?

4 A Me personally, no.

5 Q Was there an attending in attendance when **J.B.**
6 Ballenger's right shoulder got stuck behind Alana's pubic
7 bone?

8 A I was on my way to the delivery room like I am for
9 all deliveries. But, no, I was not present at the
10 bedside.

11 Q Do you claim to know what you had been doing for the
12 prior two, three, four hours?

13 A Well, in reality, it's my opinion that she only
14 pushed for 20 minutes. And when I was called to the
15 delivery room, which, usually, occurs at the time that the
16 head is crowning, I immediately was in the process of
17 getting to the delivery room to attend and be in
18 attendance for the delivery, like I am for all deliveries.

19 Q The question, Doctor, do you claim to know where you
20 were and what you were doing two to four hours before this
21 delivery?

22 A No. I am not aware nine years ago what I was doing.

23 Q Were you napping?

24 A I have no idea.

25 Q Were you in the cafeteria?

1 A I have no idea.

2 Q Were you talking on the phone to anyone about
3 personal matters?

4 A I have no idea. I would assume I was not talking on
5 the phone about personal matters since it was 4:00 in the
6 morning.

7 Q Was there an attending in attendance when Dr. Alt
8 applied downward traction to J.B.'s head for the first
9 time ever in the presence of shoulder dystocia?

10 A Since I just answered that question, no.

11 Q Was there an attending in attendance when the
12 second-year resident, Dr. Alt, tried to figure out how big
13 of an episiotomy she should cut before attempting to get
14 the posterior arm out?

15 A I had seen Dr. Alt cut an episiotomy before, so I
16 don't think she needed to figure it out. But, no, I was
17 not present.

18 Q You don't believe a first-degree episiotomy is
19 effective for posterior arm delivery, do you?

20 A I don't believe an episiotomy is necessary to deliver
21 a posterior arm, no. You may not need to make any room to
22 deliver a posterior arm.

23 Q Okay. It depends on the tightness of the fit;
24 correct?

25 A Yes.

1 Q This was a tight fit; true?

2 A I have no way to comment on that since I did not
3 deliver this baby.

4 Q Does the 12 hours of no descent give you any clue
5 about the fit?

6 A No.

7 Q Does the 12 hours of no cervical dilation give you a
8 clue about the fit?

9 A No. Because, in actuality, we never had enough power
10 for the baby to be able to descend, as well as for the
11 cervix to dilate.

12 Q In fact, the failure of the cervix to dilate and the
13 failure of the head to descend when that Pitocin was
14 maxing out is a sign of a bad fit; true?

15 A No, it is not. In reality, when you talk about
16 Pitocin, there's not a maximum of Pitocin. There are
17 protocols within a hospital system that you reevaluate at
18 a certain level.

19 But ACOG, in 2004, states there's not a maximum, that
20 each hospital can make that decision on its own. In 2004,
21 40 was the max that we stopped at and we reevaluated. In
22 the process of determining if contractions are adequate,
23 we do what's called montevideo units, which we have
24 discussed previously. And that's more of a guidance of
25 how much Pitocin you need to give.

1 Have I myself gone beyond 40 milliunits of Pitocin in
2 order to get adequate contractions? Yes. I have done
3 that in an environment that I needed stronger contractions
4 for a baby to be delivered.

5 So, therefore, I would use 40 as just a point to
6 reevaluate, and not the standard maximum. That's not the
7 highest that you can go.

8 Q Was there an attending in attendance at the time
9 shoulder dystocia was encountered to see whether Dr. Alt
10 was upset?

11 A I said I was not in the room whenever the baby's head
12 came out. So, of course, I was not there.

13 Q Was there an attending in attendance at the time of
14 shoulder dystocia to see whether Dr. Alt panicked?

15 A Since I --

16 MR. ALEXANDER: Your Honor, there's no foundation for
17 this.

18 THE COURT: Sustained.

19 BY MR. GRAHAM:

20 Q Was there an attending in attendance at the time
21 shoulder dystocia was encountered to tell Dr. Alt there
22 was no urgency to deliver this baby?

23 A I stated before I was not in the room. So, no, I was
24 not there.

25 Q Okay. There was no urgency to deliver this baby;

1 true?

2 A Urgency? It depends on what your definition of
3 urgency is.

4 Q Well, what was your definition of urgency at the time
5 your deposition was taken when you said there was no
6 urgency?

7 A There's no urgency, initially, when you have a --
8 you've diagnosed shoulder dystocia. You have
9 approximately about five to seven minutes to deliver the
10 baby safely, but that --

11 Q All right. And which is more important, to get that
12 baby out in a minute and a half or a minute and 45
13 seconds, or to get that baby out without excessive
14 traction?

15 A My goal would be to get the baby out safely and in an
16 appropriate amount of time.

17 Q Was there an attending in attendance when Dr. Merritt
18 came in and applied traction?

19 A I arrived after the baby was delivered and the baby
20 was in the warmer. So, again, I was not present in the
21 room.

22 Q And, Doctor, have you seen the delivery note where
23 Dr. Merritt wrote "Dr. Twedt present"?

24 A Yes, I have.

25 Q All right. Do you claim that was true or false?

1 A It just depends on when the definition of present is.
2 Was I present after the baby was delivered? Yes.
3 Q I'm sorry. You were present when?
4 A When the baby was being placed in the warmer, as I
5 previously stated.
6 Q You didn't get there until after the baby had been
7 permanently injured and placed in the warmer; true?
8 A Correct.
9 Q Let me go over a few matters. During that entire
10 24-hour period when you were the attending on call, did
11 you make any entry in this chart?
12 A I made an entry after the delivery of **J.B.**
13 Q Okay. During -- but throughout the period of time
14 leading up to and going through the injury to **J.B.**'s
15 nerves, you didn't make a single entry in the chart; true?
16 A I could probably sign the history and physical, which
17 would be the admission history and physical, the face
18 sheet, which is used for coding, any sort of consent forms
19 I might need to have signed.
20 Q You might have cosigned?
21 A Cosigned, yes.
22 Q Which you can do long after the fact?
23 A Yes.
24 Q Well, I'm talking about things you, actually, did
25 during the labor and delivery up to the time of the

1 injury. Do you claim you made even a single note on the
2 chart during that time?

3 A Besides my signature, no.

4 Q What signature are you talking about?

5 A The documents I just mentioned, which would be the
6 admission history and physical.

7 Q Do you claim to remember when you cosigned those?

8 A I do not know for sure, no.

9 Q Is there any entry that you can tell us today you
10 definitively made, at any point, during this child's labor
11 and delivery?

12 A No.

13 Q How many babies were born that weekend, that holiday
14 weekend?

15 A I have no way of knowing that.

16 Q This delivery occurred in the middle of the night, in
17 the early hours of Saturday morning; true?

18 A I believe so, yes.

19 Q How many cases of shoulder dystocia have you
20 encountered?

21 A Myself, 20.

22 Q And how many had you encountered as of November the
23 27th, 2004?

24 A I cannot state with accuracy.

25 Q Okay. But you had had a number of them; right?

1 A Some experience, yes.

2 Q Okay. And, in November of 2004, do you believe you
3 were more or less experienced than Dr. Alt at managing
4 shoulder dystocia?

5 A More.

6 Q If you believe silence does not exist at Greenville
7 Hospital System about deficient medical care, do you agree
8 that the nursing staff violated the standard of care in
9 this case by not speaking up and advocating for the baby?

10 A I believe the nursing staff did speak up and advocate
11 for both baby and mom.

12 Q Really? What evidence is there in the chart that
13 they did any such thing?

14 A It is what we do every day.

15 Q What evidence, Doctor, is there in the chart that
16 they, in fact, did that in this case?

17 A I would have to review the chart to tell you. But I
18 can tell you my experience at Greenville Memorial Hospital
19 since 1996 is open communication and collaboration in a
20 team effort to take care of both moms and babies, and
21 provide a safe environment.

22 Q All right. Who was in charge of the communication
23 that led to a latex catheter being inserted in Alana
24 Mann's right -- after she disclosed that she had a latex
25 allergy?

1 A I would argue that that did not happen.

2 Q You would argue it did not happen. Okay. Who was in

3 charge of the communication that led to the nurses

4 increasing Pitocin faster than the doctor's orders for

5 increasing Pitocin?

6 A Who was in charge of the communication?

7 Q Yes, ma'am.

8 A Communication -- no one is in charge of

9 communication. Communication is, obviously, communication

10 between two parties. And that avenue is open from both

11 angles.

12 So there's not a hierarchy within Greenville Hospital

13 System where there's a chain of command. It's open

14 communications between nurses, attendings, residents,

15 secretaries. So there's no one in charge of

16 communication. There's an open communication policy.

17 Q There is no chain of command at Greenville

18 Hospital --

19 A There is a chain of command, but there's not a chain

20 of command where I would not be approachable by every

21 aspect of the care to you.

22 Q All right. Does communication at Greenville Hospital

23 System permit nurses to disobey doctor's orders?

24 A Disobey a doctor's orders?

25 Q Yes, ma'am.

1 A No.

2 Q All right. Well, who do you blame for the nurses not
3 following the doctor's order about when to increase
4 Pitocin?

5 A In regards to?

6 Q The frequency with which Pitocin can be increased.

7 A I'm aware that Dr. Shepherd, who was an intern, wrote
8 an order to increase Pitocin every 30 minutes. I would
9 state, in 2004, it was our normal practice to increase it
10 every 15 to 30 minutes at the nurse's discretion. And
11 that is what is happening presently at Greenville Hospital
12 System today.

13 Q My question, Doctor, is whose fault was it that the
14 nurses in this case did not follow the doctor's orders?

15 A They could have followed the doctor's order. Because
16 there could have been a verbal order that was different.

17 Q If there's a verbal order, Doctor, you know that
18 that's to be recorded in the chart and later signed by the
19 doctor; true?

20 A That doesn't always happen on a busy labor and
21 delivery floor, no.

22 Q Well, certainly, this chart doesn't include any such
23 verbal order, does it?

24 A Correct.

25 Q What have you learned from this case about the

1 importance of making a proper plan to manage labor and
2 delivery?

3 A I always make a proper plan to manage labor and
4 delivery.

5 Q All right. Listen to the question, Doctor. What
6 have you learned from this case about the importance of
7 formulating a proper plan to manage labor and delivery?

8 A Nothing, since I do that always.

9 Q Okay. What have you learned from this case about the
10 importance of effective communication between members of
11 the healthcare team?

12 A Nothing, since I do that always.

13 Q What have you learned, in this case, about the
14 importance of an attending being in attendance when the
15 Pitocin increases over 20?

16 A That is not something that I feel is necessary.

17 Q So you haven't learned anything?

18 A No.

19 Q What have you learned about the importance of an
20 attending being in attendance when the Pitocin goes over
21 30?

22 A Nothing.

23 Q What have you learned, in this case, about the
24 importance of an attending being in attendance when the
25 Pitocin goes up to 40?

1 A Nothing.

2 Q What have you learned, in this case, about the
3 importance of an attending being in attendance when the
4 head does not descend for 12 hours of active labor?

5 A I would argue that she was not in active labor for
6 12 hours.

7 Q When do you contend active labor starts?

8 A Active labor starts once she gets beyond five to six
9 centimeters, and we see cervical change approximately a
10 centimeter an hour with adequate power greater than 200
11 montevideo units.

12 Q What have you learned, in this case, about the
13 importance of an attending being in attendance when the
14 head does not descend for 12 hours?

15 A Again, there was not enough power to cause the head
16 to descend.

17 Q Does that mean you haven't learned anything?

18 A Learned anything from this experience?

19 Q Yes, ma'am.

20 A I've learned a lot from this experience. But in
21 regards to the delivery?

22 Q Do you remember the question, Doctor?

23 A No.

24 Q What have you learned from this case about the
25 importance of an attending being in attendance when the

1 baby's head does not descend for 12 hours?

2 A Have I learned something? No.

3 Q What have you learned from this case about the
4 importance of an attending being in attendance when the
5 mother's cervix does not dilate for 12 hours?

6 A In reviewing the records, I would do everything the
7 same. So what I did in 2004, I would do again today. So
8 I have not learned anything new.

9 Q What have you learned from this case about the
10 importance of an attending being in attendance when the
11 first traction is applied by a second-year resident in
12 a -- in her first shoulder dystocia situation?

13 A It would be my goal to be present at all deliveries.
14 So that is my goal. It was my goal in 2004, and is my
15 goal presently.

16 Q The question, Doctor, is what have you learned from
17 the case about the importance of an attending being in
18 attendance when a second-year resident, who has never
19 before confronted shoulder dystocia or even seen it,
20 applies traction down on the baby's head for the very
21 first time?

22 A It would help me presently now in answering your
23 questions adequately. Let me restate that.

24 It would help me in a court of law to have been
25 present to be able to defend myself better. But beyond

1 that, I have not learned anything additional.

2 Q Nothing additional?

3 A No.

4 Q Doctor, going back to a point about Dr. Shepherd.

5 You indicated that when he ordered Pitocin to go up two
6 milliunits every 30 minutes that he was not doing that the
7 way the rest of you do?

8 A I was just stating that it was common practice in our
9 institution back in 2004, as well as presently in 2013,
10 that we increase Pitocin every 15 to 30 minutes.

11 Q And Dr. Shepherd was a first-year resident; true?

12 A Yes.

13 Q Did he have enough experience to know the correct
14 Greenville Hospital System protocol for increasing
15 Pitocin?

16 A Yes.

17 Q He had enough experience?

18 A Yes.

19 Q But he violated any knowledge --

20 A He didn't violate it. He just wrote -- that's the
21 order he chose to write.

22 Q Okay. Well, there was no communication by the nurse
23 to correct him or inform him about the way things are
24 normally done at Greenville Hospital System, was there?

25 A I would -- cannot state if that conversation

1 occurred.

2 Q Well, it's, certainly, not documented on the chart;
3 true?

4 A No.

5 MR. GRAHAM: Thank you, Doctor.

6 I have no further questions.

7 THE COURT: All right. Let's take a short recess,
8 ladies and gentlemen. Don't talk about the case.
9 Continue to keep an open mind. We'll take about a 10 or
10 15-minute recess.

11 Thank you.

12 (WHEREUPON, the jury was excused from open court at
13 approximately 3:00 p.m.)

14 THE COURT: Anything before we break?

15 MR. ALEXANDER: No, sir.

16 THE COURT: Okay.

17 (WHEREUPON a break was taken.)

18 THE COURT: All right. You can bring the jury on in.
19 Dr. Twedt, you can come on back up.

20 (WHEREUPON, the jury came into open court at
21 approximately 3:27 p.m.)

22 THE COURT: All right. Yes, sir, Mr. Alexander.

23 MR. ALEXANDER: The Defense will reserve our cross of
24 Dr. Twedt in our case in chief.

25 THE COURT: Okay. Ma'am, you can step down.

1 You may call your next witness.

2 MR. GRAHAM: Thank you, Your Honor.

3 We call Dr. Oliver Wood.

4 THE CLERK: Place your left hand on the Bible and
5 raise your right hand.

6 WHEREUPON,

7 OLIVER G. WOOD, JR.,

8 after first having been duly sworn, testified as follows:

9 THE CLERK: State your name, please.

10 THE WITNESS: Oliver G. Wood, Jr.

11 DIRECT EXAMINATION

12 BY MR. GRAHAM:

13 Q Good afternoon, Dr. Wood.

14 A Good afternoon.

15 Q Doctor, please, state your full name and address.

16 A Oliver G. Wood, Jr., Columbia, South Carolina.

17 Q Where are you from originally?

18 A I grew up in Greer, South Carolina.

19 Q How long did you live there?

20 A 18 years.

21 Q Please describe your educational background.

22 A I have a Bachelor of Science Degree in Business
23 Administration from the University of South Carolina, a
24 Masters Degree in Economics from the University of South
25 Carolina, and a Doctorate in Economics from the University

1 of Florida.

2 Q Please describe your professional background.

3 A I was hired by the University of South Carolina in
4 1965 to teach economics and banking and finance courses.
5 I taught at the university for 29 years. I'm a
6 distinguished professor emeritus. Translated, that means
7 I'm retired from teaching.

8 Q Have you served in the military?

9 A Yes, sir. I served on active duty in the United
10 States Navy from 1956 to 1961.

11 Q Have you, also, served in the reserves?

12 A Yes, sir. I served in the Naval reserves from 1961
13 to 1987 when I when I retired from the Navy.

14 Q When you retired, what was your highest rank?

15 A Captain.

16 Q What practical experience have you had in the
17 business world?

18 A I've helped start 11 banks and two savings and loans
19 associations. I served on the board of directors of
20 Republic National Bank until we sold it. And then on the
21 advisory board for Lexington State Bank until we sold it
22 to BB&T, the advisory board for South Bank, the board of
23 Bank Meridian, and the board of Edisto Farm Credit in
24 Orangeburg, which was an agency that made farm loans in
25 the lower part of the state. I served on the investment

1 policy committee at AG First Bank in Columbia. That's the
2 old Federal Land Bank. And I, also, own several farms in
3 Tennessee, which are a business.

4 Q What special experience have you had in the field of
5 investments?

6 A At several of the banks that I've been associated
7 with, I served on the investment committee. Those that I
8 was not on the investment committee, I was peripherally
9 involved with investments.

10 I taught a graduate course at the University of South
11 Carolina on money and capital markets. I taught in the
12 South Carolina Bankers School for 25 years. I directed
13 MBA field studies for most of the time I was at the
14 University.

15 Q Have you written any books in the field of economics
16 or finance?

17 A Yes. I've authored or coauthor seven books.

18 Q What is your experience in estimating the economic
19 loss in legal cases involving personal injury, wrongful
20 death, or business losses?

21 A For the last 44 years, I've made studies in cases
22 where someone has been killed, someone has been injured, a
23 business has sustained a loss due to any number of
24 reasons, or someone has been terminated from their
25 employment due to age, race, or sexual discrimination.

1 Q What experience have you had instructing lawyers in
2 the area of economic loss?

3 A Since 1972, I've been asked by the various bar
4 association groups to appear at their seminars on economic
5 damages or loss about 25 times. From 1970 to 2004, I
6 served as guest lecturer at the University of South
7 Carolina Law School in the damages course. In 2004, our
8 professor at the university retired and went to help start
9 the new Charleston School of Law.

10 So since 2004, I've been associated with them. And
11 over the last five years, I've served as their economist
12 in residence.

13 Q Is the methodology you use to evaluate economic loss,
14 generally, accepted among other economists in your field?

15 A Yes.

16 MR. GRAHAM: Your Honor, we submit Dr. Oliver G.
17 Wood, Jr., as an economic expert in the evaluation of
18 economic loss and personal injury cases.

19 THE COURT: Any voir dire?

20 MR. ALEXANDER: No objection.

21 THE COURT: All right. He's qualified.

22 Yes, sir.

23 BY MR. GRAHAM:

24 Q Dr. Wood, were you hired by my law firm to make a
25 study of the economic loss in this case?

1 A Yes.

2 Q What facts have you taken into account?

3 A All right. In the case of J.B. she was born on
4 [REDACTED] The alleged date of injury was
5 November the 27th, 2004. According to South Carolina Code
6 Section 19-1-150, which is our mortality table in South
7 Carolina, the average life expectancy for a child is ,
8 80.84 years, which would carry her to age 80.84 in the
9 year 2085.75.

10 According to her mother, before she was injured,
11 there was no reason to think J.B. would have less than a
12 normal life expectancy. Dr. Charles Vander Kolk, licensed
13 counseling psychologist, certified rehabilitation
14 counselor, evaluated J.B.'s before event and after event
15 earning capacity. According to Dr. Vanderkolk, with
16 respect to the before injury earning capacity, "It is
17 concluded that J.B. most probably would have, at least,
18 completed high school, would have had a good opportunity
19 to complete up to two years of technical school or
20 community college."

21 According to Dr. Vanderkolk, "Based on vocational
22 research, she most probably would have started at \$9 to
23 \$10 per hour in 2012." According to Dr. Vander Kolk, in
24 five to seven years, she most probably would have earned
25 in the range of \$25,000 to \$34,000. In other words,

1 \$12.50 an hour to \$17 an hour. According to
2 Dr. Vanderkolk, she would have received normal increases
3 after that point in time.

4 According to Dr. Vanderkolk with respect to after
5 injury or earning capacity, "J.B.'s loss in earning
6 capacity most probably is in the range of 25 to 45 percent
7 over her work life." Or stated another way, she will be
8 able to offset 75 percent down to 55 percent of her loss.

9 I've assumed Dr. Vanderkolk's assumptions that
10 approximately \$9.50 an hour is a reasonable measure of her
11 before injury earning capacity, that she would get the pay
12 raises that he outlined averaging \$29,500, and that she's
13 lost about 35 percent of her earning capacity. I assumed
14 that J.B. wouldn't enter the labor force until age 20
15 and would work until age 67, which is her normal social
16 security retirement age.

17 Ms. Karen Shelton, nurse certified life care planner,
18 prepared a life care plan for J.B. which I took into
19 account.

20 Q Sir, based on the these facts, do you have an
21 opinion, based on reasonable economic certainty, as to the
22 past and future economic loss to J.B.?

23 A Yes.

24 Q Have you prepared any charts to illustrate this case?

25 A Yes.

1 Q Could you present those to the jury, please, sir?

2 A Yes.

3 Can everyone see these charts?

4 Chart number one looks at present value of the after
5 trial earning capacity. There is no loss in before trial
6 earning capacity for the child. Beginning at age 20,
7 there's no loss down to there.

8 I then projected that her earning capacity would
9 follow Dr. Vanderkolk's model. That she would receive
10 cost of living adjustments averaging 2.49 percent per
11 year. I assumed no productivity increases, no merit
12 increases, and no promotions, nothing but cost of living.
13 Over her life, she would have earned \$3.299 million.

14 However, our court system requires that if we have to
15 look at money flows that are going to occur in the future
16 that have to be paid now, they have to be discounted to
17 what is known as the present cash value. So I discounted
18 all of her future earning capacity, summed it in the
19 present value as \$564,181.

20 What that means is this sum of money, plus interest
21 when drawn out over time would equal what **J.B.** would
22 have earned in the labor market. However, the relevant
23 number is the present value. This case has a life care
24 plan, which is really a game plan for future medical
25 costs.

1 I have here on chart two the consumer price index for
2 medical care items in the United States. This information
3 was compiled by the Bureau of Labor statistics. That's an
4 agency of the federal government.

5 So if we've got to look forward, let's look back. In
6 1960, the index for medical care items was 22.3. In order
7 to give that some realism, I set it equal to a hundred
8 dollars and then tracked what happened to the medical
9 inflation over this last 52 years.

10 So what costs a hundred dollars in 1960, by 1990
11 costs \$730. By the year 2000, it cost \$1,169. And by
12 2012, \$1,861. You don't have to be a professional
13 economist to understand this is a relentless inflation
14 situation. It's average 5.78 percent compounded over
15 52 years, compounded annually 5.78.

16 Now, in this life care plan, we don't have every
17 medical item. The ones that we do have, we have
18 subcategories tracked by the Bureau of Labor and
19 Statistics. For your information, the general CPI over
20 the last 20 years has been 2.49. That's rather benign
21 when you go back to 1965. Medical, however, is 3.98,
22 professional services, meaning doctors, 3.38, physicians
23 services, 3.31.

24 I always point out doctors are pretty good
25 economists. They raise the charges in the office about

1 the same way they raise their fees, 3.31 to 3.38. Medical
2 care commodities, 2.91. That's probably helped out a
3 little bit by imports. And then services by other medical
4 professionals, 2.59. Lower than the general professional
5 doctor.

6 Chart four is the life care plan presented by Karen
7 Shelton. And what I'm going to do now is go over to the
8 part of the life care plan that deals just with after the
9 age of 18. So I've carved out that part from the life
10 care plan that she presented.

11 Now, to simplify a little bit, I've taken her
12 documents and reduced it to one. A life care plan has
13 four columns, the elements, frequency, periodic costs, and
14 duration. All right. I'm not going over every one of
15 these like Ms. Shelton did, because you can read.

16 By general category, the physicians, that's a one
17 timer; counseling, 20; equipment, one timer; evaluation,
18 one timers. One timers, meaning they're not subject to
19 inflation, just one time. Here is an annual that's
20 therapy, \$4,900; home modifications, one timer; vocational
21 assistance; and then surgery.

22 Now, when she had in her plan to be determined, that
23 took me out of the game. If we don't have the parameters
24 specified, then we can't evaluate. So when it says, to be
25 determined, it's out. All right. That is your life care

1 plan.

2 Chart five is the cost of funding that life care plan
3 from now through the end of her life expectancy. And all
4 of these are age 18 forward. The present value of doing
5 any of these, you can see in this column right here.
6 Okay. \$10,000 for physicians; 4,700 for equipment; \$1,800
7 for evaluations. The most expensive item in that life
8 care plan is therapy, \$127,754. So out of the total plan
9 of \$162,000, the bulk of it is in that item right there,
10 therapy. And that's an annual deal.

11 Then you've got other things. And then you've got
12 this surgery, which I told you we can't figure out. So
13 the cost of funding her life care plan after age 18 is
14 \$162,833. Now, I work on a lot of life care plans. If
15 you've got a severely injured quadriplegic, you're in the
16 millions of dollars. This is what I call a mini-life care
17 plan, because it doesn't have that many elements.

18 Okay. I'm at chart six. Present value of total
19 financial loss. Her earning capacity we know from the
20 first chart is \$564,181, less mitigating. Mitigating
21 means offset. How much did she -- do we project she will
22 offset of that loss? 65 percent. So when you subtract
23 the mitigating earning capacity, that forces out her net
24 loss in earning capacity as \$197,463. She offset that,
25 that's the loss.

1 Then her future medical, as I just explained from 18
2 on, is \$162,833. So when you take the net loss here in
3 earning capacity, future medical, you get \$362,296.

4 Q Thank you, Doctor.

5 Now, I believe you said the -- these represent the
6 life care plan only for those items of care after age 18;
7 is that correct?

8 A Correct. I have carved out her plan and her
9 direction, the over 18 part.

10 Q Does this include anything for past medical bills?

11 A Past meaning before today?

12 Q Yes.

13 A No.

14 Q Does this include anything for future medical bills
15 that are likely to be incurred prior to **J.B.**'s 18th
16 birthday?

17 A No.

18 Q Does this include anything to pay **J.B.** for the
19 things that can't be fixed or helped, like her pain and
20 suffering?

21 A Do you mean non-economic losses?

22 Q Yes, sir.

23 A No.

24 Q So it does not include anything for pain and
25 suffering?

1 A No.

2 Q Does it include anything for the disfigurement?

3 A No.

4 Q Does it include anything for the loss of enjoyment of
5 her life?

6 A No. Those are non-economic losses. And I don't
7 address those.

8 Q So let me ask you this. The surgeries that we heard
9 about from Dr. Grossman and from Karen Shelton in terms of
10 fixing the shoulder and other -- another follow-up
11 surgery, I believe Dr. Grossman said a 50/50 percent
12 chance. Have you included those in this plan since they
13 were apparently expected to be likely before age 18?

14 A No. This surgery she couldn't specify. So, as I
15 explained, you can't evaluate it if you don't have these
16 parameters.

17 Q Now, if the surgeries that Dr. Grossman recommended
18 were to, actually, get performed after J.B. is 18 years
19 old, these numbers wouldn't account for that cost?

20 A No.

21 MR. GRAHAM: Thank you.

22 Please answer any questions Mr. Alexander may have.

23 CROSS-EXAMINATION

24 BY MR. ALEXANDER:

25 Q Doctor, you, obviously, are the type of doctor that

1 teaches us economics, as opposed to those that treat us
2 for medical conditions?

3 A Four years short of finishing medical school.

4 Q I hear you. Therefore, you would not have -- it
5 wouldn't be pertinent to what you're doing to have
6 examined the child; true?

7 A That's true.

8 Q Nor spoken to any of the providers, or the parents,
9 or anything with regard to that?

10 A No --

11 Q So in doing -- I'm sorry.

12 A That's somebody else's area.

13 Q So in doing your work, obviously, you have relied on
14 the information that's been provided to you by others?

15 A Yes.

16 Q All right. And that would include, for instance,
17 Dr. Grossman?

18 A (There was no response.)

19 Q Do you recall reading any of his reports?

20 A Unless it made it into the life care plan, no.

21 Q Okay. What about Dr. Maureen Nelson, do you know
22 her?

23 A If it made it in the life care plan, yes.

24 Q Okay. In any event, when those folks supply you
25 information, you rely on the totality of that information,

1 and the truthfulness of that information, and the accuracy
2 of that information?

3 A You're right.

4 Q And you make no independent investigation of that
5 yourself?

6 A Correct.

7 Q Now, the same with respect to lost earning capacity.
8 You've relied on what Dr. Vanderkolk has said with respect
9 to her -- the extent to which her earning capacity has
10 been diminished; true?

11 A Correct.

12 Q So if this jury concludes that this child -- this is
13 a bright child, who is very motivated, who is now in the
14 custody of parents who will encourage her to do well in
15 school, and go on to college, and graduate from college,
16 and she ends up in a job that is what one might refer to
17 as a white-collar-type job. Did you do any analysis or
18 anything that would give us the present value of that lost
19 earning capacity?

20 A No.

21 Q As opposed -- okay.

22 A What you're asking is suppose she overachieves,
23 suppose she overachieves more than Dr. Vanderkolk opines
24 for her potential, no, we haven't taken that into account.

25 Q Okay. If the jury wanted to do that, can you assist

1 them with how they would do that? In other words, using
2 the charts, what you've shown them, can you assist them in
3 how they would take that into account?

4 A Yes. You could take the present value of her lost
5 earning capacity, as opined by Dr. Vanderkolk. Remember,
6 that starts out at about \$9.50 an hour, then progresses to
7 \$29,000. Well, \$29,000 is about what an assistant
8 restaurant manager earns in South Carolina, \$15 an hour.

9 So if you say, well, let's suppose she's going to
10 earn a hundred thousand dollars a year, about \$50 an hour.
11 So if we've got her earning 15 and she might make 50, then
12 it would be three and a third times what I've got would
13 elevate the present value. Similarly, you can take the
14 mitigating earning capacity and adjust that. We've got
15 her offsetting 65 percent of her loss.

16 If you think she's going to 75 percent, you could
17 take that number and raise it by 10 over 65, you know, 12
18 or 13 percent. If you think she's going to offset just
19 50 percent, you can take that mitigating earning capacity
20 and notch it down, also. So my final numbers can be used
21 in a model to get different answers.

22 Q So the mitigating number that's in parenthesis would
23 be elevated if she should make more?

24 A Right, or diminished if she wasn't up to what
25 Dr. Vanderkolk thinks she could do.

1 Q Okay. Fair enough. So they would go to that chart
2 to do that. If the jury concludes that she has yet to
3 avail her -- that she's not gotten treatments up to now
4 and is unlikely to get them in the future, because they're
5 not necessary or she chooses not to do that, how do they
6 adjust your numbers for that purpose?

7 A Go to the life care plan and suppose that you say,
8 well, we think she's not going to need -- let's pick out a
9 number. Let's take therapy. We've got annual therapy
10 sessions at \$4,949 a year. You say, we think she's not
11 going to need but half that.

12 Then you could go to the present value of therapy
13 sessions, \$127,754, cut it in half. And you would have
14 calculated a new therapy number assuming only half of the
15 therapy sessions. Similarly, if you think she needs
16 double, you can double it. But since these are present
17 value numbers, you can manipulate them to find or adjust
18 the answer, you're correct.

19 MR. ALEXANDER: Thank you, sir.

20 MR. GRAHAM: Your Honor, I just want to make sure we
21 have offered into evidence Dr. Wood's charts. I believe
22 we handed it to the court reporter. I just wanted to make
23 sure that was in evidence.

24 Any objection?

25 MR. ALEXANDER: I'm sorry?

1 MR. GRAHAM: Any objection to Dr. Wood's charts in
2 evidence?

3 MR. ALEXANDER: No objection.

4 THE COURT: They're in evidence.

5 (WHEREUPON, Plaintiff's Exhibit No. 11 was marked for
6 identification and admitted into evidence.)

7 MR. GRAHAM: And if Your Honor please, may we
8 approach?

9 THE COURT: Yes.

10 (WHEREUPON, a bench conference was held.)

11 MR. GRAHAM: Thank you, Dr. Wood.

12 You may step down, sir.

13 THE WITNESS: Thank you, sir.

14 MR. GRAHAM: Your Honor, that completes the
15 Plaintiff's case that we're able to put up right now. We
16 have one witness, as Your Honor knows and we've discussed,
17 who will not be available until Friday --

18 THE COURT: Okay.

19 MR. GRAHAM: -- morning, Dr. Resnick. But we're
20 ready to let the witness put up their -- I'm sorry -- let
21 the Defense put up their defense.

22 THE COURT: Okay. So you're the first witness I've
23 ever had that brought his own easel.

24 THE WITNESS: I learned a long time ago not to trust
25 lawyers.

1 THE COURT: Nor trust the Government.

2 All right. Mr. Alexander.

3 MR. GRAHAM: Your Honor, I hate to do this, but may
4 we approach?

5 THE COURT: Sure.

6 (WHEREUPON, a bench conference was held.)

7 THE COURT: Yes, sir.

8 MR. ALEXANDER: Your Honor, by way of video
9 deposition, the Defense would call as its first witness
10 Dr. John Shepherd.

11 (WHEREUPON, Court's Exhibit No. 8 was marked for
12 identification and admitted into evidence.)

13 (WHEREUPON, a portion of Court's Exhibit No. 8 was
14 played in open court.)

15 THE COURT: Is there any way to turn that volume up?
16 Thank you.

17 (WHEREUPON, a portion of Court's Exhibit No. 8 was
18 played in open court.)

19 THE COURT: We're going to take a break and they're
20 going to try to fix this. So let's take a short recess.

21 (WHEREUPON, Plaintiff's Exhibit Nos. 12 and 13 were
22 marked for identification only.)

23 (WHEREUPON, the jury was excused from open court at
24 approximately 4:50 p.m.)

25 THE COURT: Do y'all want to -- this is an old charge

1 I've got that I just want y'all to look at. You don't
2 have to -- I made a bunch of edits on it and it's marked
3 up. I don't have a copy. If y'all want to make copies of
4 it and give it back to me tomorrow.

5 MR. GRAHAM: That would be awesome.

6 THE COURT: And then once we -- I can e-mail it to
7 you.

8 MR. GRAHAM: Like now?

9 THE COURT: Sure.

10 MR. GRAHAM: Would you rather e-mail it to us, or
11 have us make copies?

12 THE COURT: Well, see, I don't have these edits on
13 e-mail. Do you see what I'm saying?

14 MR. GRAHAM: All right. We've got -- I need to find
15 a paralegal to take --

16 THE COURT: That's fine.

17 MS. RODRIGUEZ: I'll get it.

18 MR. GRAHAM: Your Honor, while -- could we -- could I
19 bring up one matter before I forget about it?

20 THE COURT: Okay.

21 MR. GRAHAM: Could we ask that Dr. Twedt be cautioned
22 that she's not allowed to talk to Mr. Alexander overnight
23 since she's still under oath and she's on the bench [sic],
24 or anybody else about her testimony?

25 THE COURT: Okay. So I have to tell every witness

1 this who's a party. Just because of the fortuitous
2 circumstance that you've already testified and you're
3 going to be coming back on, you can't talk about your
4 testimony with Mr. Alexander.

5 MR. GRAHAM: Or anybody else.

6 THE COURT: I'm not sure -- actually, I'm not sure
7 that applies. This is not cross-examination.

8 MR. ALEXANDER: No. I'm going to call her in my case
9 in chief.

10 THE COURT: Yes. So it's a little different than a
11 break.

12 MR. ALEXANDER: Yeah. This is --

13 MR. GRAHAM: I always thought once she's under oath
14 that until she was released that she couldn't talk to her
15 attorney, or anybody else about her testimony.

16 MR. ALEXANDER: No. I'm going to call her in my case
17 in chief.

18 THE COURT: I don't know about that.

19 MR. GRAHAM: And she's not a defendant. So there
20 wouldn't be any fairness argument related to the
21 attorney-client privilege, or something in that regard.

22 THE COURT: I don't know about that. I mean, I
23 know -- I'll be glad to look at any authority you've got on
24 that. But I think even in criminal contexts, there's an
25 issue there about admonishment of counsel not being able to

1 talk to their witness. So it's different than a break. I'm
2 confident that Mr. Alexander is not going to do anything
3 unethical, nor Dr. Twedt.

4 So thank you.

5 (WHEREUPON, a break was taken.)

6 THE COURT: Do y'all want to put something on the
7 record?

8 MR. GRAHAM: Yes, Your Honor.

9 Your Honor ruled -- I can't remember if it was on the
10 record or off.

11 THE COURT: Yes, sir.

12 MR. GRAHAM: But you ruled that the Plaintiff would
13 not be allowed in this case to go before the jury with a
14 claim for pre-majority medical expenses of the minor tort
15 victim. And you agreed that we could make a proffer. I
16 believe we've already made a proffer of the medical bills,
17 I believe. I'll have to check with Diane about that.

18 But, at this time, I'd like to make a proffer of
19 three charts from Dr. Oliver Wood that he was planning to
20 introduce through his testimony. It consists of a total
21 of five pages, chart four, which is two pages; chart five,
22 which is two pages; and chart six, which is one page.

23 Chart six really summarizes the difference. The
24 earning capacity net loss stays the same, what he
25 testified to. The future medical costs under this proffer

1 are \$378,858. So the total after trial loss, including
2 pre-majority and post-majority, under this proffer would
3 be \$576,321.

4 THE COURT: All right. You can make that a Court's
5 Exhibit.

6 MR. GRAHAM: Yes, sir.

7 Thank you.

8 THE COURT: Anything else before we break?

9 MR. ALEXANDER: No, sir.

10 MR. GRAHAM: Let me see --

11 THE COURT: Yes. Sure.

12 MR. GRAHAM: -- if Diane -- I lost track of whether
13 she put those medical bills in or not.

14 (Pause.)

15 MR. GRAHAM: If Your Honor please, I believe the
16 medical bills went in as exhibit.

17 THE COURT: That's fine. You can make it a Court's
18 Exhibit. Okay.

19 MR. GRAHAM: That will be Court's Exhibit No. 2.

20 THE COURT REPORTER: Court's Exhibit No. 4.

21 THE COURT: Okay.

22 (WHEREUPON, Plaintiff's Exhibit No. 9 was remarked as
23 Court's Exhibit No. 4 and entered into evidence.)

24 MR. GRAHAM: Thank you, Your Honor.

25 THE COURT: Okay. We'll see you back at 9:00 a.m.

1 MR. GRAHAM: Oh, on the matter about discussion
2 between Mr. Alexander and his client, we did make a motion
3 that they be precluded from talking, and that Dr. Twedt be
4 precluded from talking to anyone with Mr. Alexander's
5 firm, or anybody else about her testimony in this case
6 until she retakes the stand.

7 And, Your Honor, we didn't know this would be an
8 issue that we needed to brief. So may we send out e-mails
9 to you and Mr. Alexander if we find --

10 THE COURT: Sure.

11 MR. GRAHAM: -- authority?

12 THE COURT: I would be glad to look at that. As I
13 indicated earlier, I think my intuition on that, which is
14 often flat wrong. But my intuition is that the rule that
15 a lawyer cannot talk to his client during breaks is
16 based -- once the client takes the stand is based on the
17 idea that, certainly, if no break had occurred, the lawyer
18 couldn't run up and talk to his client or a witness during
19 the trial.

20 And so just as I earlier said, the fortuity of the
21 break doesn't offer the witness a greater opportunity than
22 the witness would have at a trial to discuss matters with
23 their counsel. But I just can't see how that rule has any
24 basis and reason when the witness has been subject to direct
25 examination and the opportunity for examination by

1 Mr. Alexander, and the witness is off the stand.

2 She may or may not be called in his case, although he
3 reserved the right to do so. But I'm happy to look at any
4 authority on that point. But I just don't see how it
5 would make logical sense.

6 MR. GRAHAM: I understand, Your Honor.

7 THE COURT: All right. See you all in the morning.

8 Thank you.

9 (WHEREUPON, Court's Exhibit No. 5 was marked for
10 identification and admitted into evidence.)

11 (WHEREUPON, the proceedings were concluded at
12 approximately 5:16 p.m., to be reconvened on
13 Thursday, October 31, 2013.)

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1 THURSDAY, OCTOBER 31, 2013

2 THE COURT: Anything before we bring the jury in?

3 MR. GRAHAM: Yes, sir.

4 One matter that came up a while back and just kind of
5 got lost in the shuffle Monday morning, and we didn't
6 bring it up at the time is that the two expert witnesses
7 for the Defense in their depositions identified certain
8 documents that they were relying on, or that they used to
9 teach residents with that we had asked for in discovery
10 and in the notice of deposition. They agreed to furnish
11 those documents to Ben. And we were hoping that Ben would
12 just promptly forward them to us. He -- we got an e-mail
13 from him that said one of them was attached. And we wrote
14 back, because it wasn't attached.

15 But, anyway, we'd like to move to compel the
16 production of those before the witnesses take the stand.
17 Both witnesses involve a PowerPoint presentation that they
18 use to train their residents and other doctors related to
19 the proper management of shoulder dystocia. So it's
20 directly relevant to the issues in the case.

21 Other ones relate to certain articles that they
22 referenced. One of them was citing a proposition from
23 literature without being able to cite the source. And he
24 said he could furnish that source with five minutes
25 attention, that sort of thing. There were about two or

1 THE COURT: You can call your next witness.

2 MR. ALEXANDER: Your Honor, the Defense would call
3 Tammy Nutt.

4 THE CLERK: Place your left hand on the Bible and
5 raise your right hand.

6 WHEREUPON,

7 TAMMY NUTT,
8 after first having been duly sworn, testified as follows:

9 THE CLERK: State your name, please.

10 THE WITNESS: I'm Tammy Nutt.

11 THE CLERK: Thank you.

12 Please be seated.

13 DIRECT EXAMINATION

14 BY MR. ALEXANDER:

15 Q Ms. Nutt, let's introduce you to these folks. Can
16 you tell us your name, please?

17 A Yes, sir. My name is Tammy Nutt.

18 Q Okay. And let's let them get to know you a little
19 bit. Where were you born, where were you raised, that
20 sort of thing?

21 A I was born in Spartanburg, South Carolina.

22 Q Raised there?

23 A Yes, sir.

24 Q And did you go to high school in Spartanburg?

25 A I did.

1 aggressive interventions to help her have her baby.

2 Q And is she, again, hooked up to monitors, and that
3 kind of thing?

4 A Yes, sir.

5 Q And, in this case, Pitocin was, ultimately, begun, I
6 believe at 1632, 4:32, something like that?

7 A Uh-huh.

8 Q After -- well, let me ask you this. What is Pitocin?

9 A Pitocin is the synthetic form of our natural hormone
10 that women have, Oxytocin. So it's -- you place it in
11 their IV.

12 Q And used to do what?

13 A Used to strengthen contractions.

14 Q And is that something that is commonly used in labor
15 and delivery?

16 A Yes.

17 Q More so for women who are being induced in labor?

18 A Yes.

19 Q And you said that the purpose was to strengthen
20 contractions. How are contractions measured?

21 A When you have the external monitor on, we can see
22 the -- how often the contractions are coming and the space
23 in between contractions. For intensity, you, actually, have
24 to put your hands on the maternal abdomen. With an
25 intrauterine pressure catheter, which you guys have heard of

1 WHEREUPON,

2 BRANDI KAY ALT, M.D.,

3 after first having been duly sworn, testified as follows:

4 THE CLERK: State your name, please.

5 THE WITNESS: Brandi Kay Alt.

6 THE CLERK: Thank you.

7 Please be seated.

8 DIRECT EXAMINATION

9 BY MR. ALEXANDER:

10 Q All right. Good afternoon, Dr. Alt.

11 Let's get you introduced to these folks. Tell us
12 your name, please.

13 A My name is Brandi Kay Alt.

14 Q And tell us a little bit about yourself. Where were
15 you born, where you grew up, that kind of thing?

16 A I was born in Winchester, Virginia. I grew up in
17 West Virginia. I did my undergraduate at West Virginia
18 University.

19 Q All right. And are you married?

20 A Yes.

21 Q And do you have children?

22 A I do.

23 Q What are your children's names and ages?

24 A My -- I have twin boys. Their names are Cole and
25 Cate [phonetic] Alt. And they are six years old.

1 Q So what's the purpose of pushing at 2:00 a.m. when
2 she's not yet complete?

3 A The purpose is that she was feeling a lot of
4 pressure. And the thought was let's try a practice push
5 or two. And let's see if we can get that anterior lip to
6 reduce. Because she was uncomfortable. She had had a
7 long induction course. And let's see if we can have
8 imminent delivery.

9 We tried a couple of pushes. It wasn't able to be
10 reduced at that point. We decided to get her calm, give
11 her another sitting dose of medicine to make her more
12 comfortable, and just allow her a little more time.

13 Q And is that called laboring down?

14 A Yes.

15 Q So, at 2:00 a.m. when you were doing this brief
16 period of pushing, how was mom doing?

17 A Mom was doing fine.

18 Q How was baby doing?

19 A Baby, also, was doing fine.

20 Q All right. And so you labored down for how long?

21 A We labored down -- it looks like she's complete at
22 3:47, actually.

23 Q Okay. So you started pushing at roughly 2:00?

24 A Yes.

25 Q And labored down at what time?

1 A Labored down -- well, she was noted -- her cervical
2 exam at -- she was 10 centimeters, 100 percent effaced and
3 minus one station, it looks like, around the time of 3:47.
4 Q But you, initially, pushed from 2:00 to when?
5 A Roughly, five to 10 minutes.
6 Q Okay. And then labored down and began pushing again
7 at what time?
8 A Let's see. It looks like 3:47.
9 Q And then do you have a page up there that has a
10 vaginal exam at 3:47?
11 A Yes.
12 Q And tell us about that.
13 A That was 10 centimeters, completely dilated, a
14 hundred percent effaced, and plus one station.
15 Q So tell us what the result of the laboring down was.
16 A I mean, in my mind, she had gone from minus one
17 station to a more favorable. And that's in relation to
18 the issue of spines. It's just closer to the vaginal
19 opening. Her cervix is completely dilated. And it was
20 time to have the baby.
21 Q So the 95 went to 10, or complete?
22 A Yes.
23 Q And that's what you were aiming for?
24 A Yes.
25 Q And gestation went from what to what?

1 A Minus one to plus one.

2 Q And was that what you were looking for?

3 A Yes, sir.

4 Q Is she ready to push now?

5 A Yes.

6 Q Do you have fetal heart rate strips up there? I

7 believe they're 550 to 552 bates number.

8 A They're labeled number 12, and 13, and 14.

9 Q If I've put the right ones in front of you -- I

10 intended to put in front of you the few minutes or

11 segments prior to delivery.

12 A Yes. That is this, yes.

13 Q Tell us about those strips.

14 A The strips -- I mean, actually, this lady's baby

15 looked beautiful. It had accelerations, even 15 by 15

16 accelerations. And that's above the baseline. And that,

17 to us, is fetal reassurance, meaning the baby's

18 oxygenated, well tolerating this pushing effort.

19 Q Okay. There's been a suggestion in this case that

20 this baby had fetal distress for so long prior to delivery

21 that there was a sudden circulatory collapse at the end.

22 Is that what you see in the 10 or 15 minutes prior to this

23 delivery?

24 A No, sir.

25 Q You see a completely reassuring strip?

1 A Yes.

2 Q You don't see a strip that looks like a baby that's

3 had Pitocin overdose?

4 A No, sir.

5 Q That's about to have a sudden circulatory collapse --

6 MR. GRAHAM: Objection to leading.

7 THE COURT: Yes, sir. I sustain the objection.

8 MR. ALEXANDER: All right. Thank you.

9 BY MR. ALEXANDER:

10 Q Now, what do you see right at the time of delivery?

11 A I do see a terminal bradycardia where the baby's

12 heart tone gradually goes from a baseline of about 150,

13 gradually, gradually down to 90's. And then, roughly,

14 it's hovering between 60 and 70 for probably about two or

15 three minutes.

16 Q And how often do you see that kind of bradycardia at

17 the moment of delivery?

18 A You probably can see it in half of your tracings.

19 Usually, it's a vasovagal response, that the head is

20 either on the perineum or about to be -- the perineum is

21 the opening right outside the vagina -- or about to come

22 out. Sometimes baby's do have a vasovagal response.

23 Q Okay. And if you have a baby whose head delivers,

24 but the body does not, do you expect that bradycardia

25 period to be longer?

1 A Yes.

2 Q Okay. And if that baby has a prolonged bradycardia
3 period or prolonged decel right prior to delivery and
4 after delivery of the head, would you expect that baby to
5 be slightly acidotic after delivery?

6 A Likely, it would be.

7 Q And what is -- is core blood gas one way that we can
8 measure acidosis?

9 A Yes.

10 Q And what is a normal blood gas?

11 A Usually, roughly, 7.2 to 7.4.

12 Q All right. And what was -- do you recall what this
13 baby's was?

14 A This was 7.15.

15 Q Is that slightly acidotic?

16 A Slightly, just barely.

17 Q Is that completely consistent with a prolonged decel
18 at the point of delivery?

19 A It's consistent with a decel possibly at the time of
20 delivery. It's not consistent with a stressed out labor
21 course.

22 Q Well, I was going to ask you, is it consistent with a
23 baby who's been in fetal distress for hours and hours
24 prior to delivery?

25 A No, sir.

1 Q All right. Dr. Alt, you've told us that you don't --
2 or -- well, I shouldn't put words in your mouth. Tell us
3 what you recall about this actual delivery.

4 A What I recall about this delivery is mom was pushing.
5 And it looked like delivery was going to be imminent. You
6 could see the head right at the vaginal opening. I
7 alerted the day shift call for our extra team to come,
8 which is what you did right before a delivery was about to
9 happen. And giving them probably anywhere from five to 10
10 minutes.

11 At this stage, mom is going to push another minute,
12 or they could push another 45 minutes. But you try to
13 anticipate within a five to 10-minute time span to let the
14 rest of your delivery team come to the delivery.

15 I remember seeing that, calling for the team. And
16 the next push, the baby's head popped out.

17 Q Okay. And what did you do at that point?

18 A So, at that point, I went to mom's perineum and
19 guided the baby's head, I guess, because of the left
20 anterior shoulder, you know, guided the baby's head to the
21 left and then attempted gentle downward traction.

22 Q When was the call for help put out? Was that before
23 the application of downward traction, or after?

24 A I had called for a delivery team before the attempted
25 delivery.

1 Q So you did a general attempt --

2 MR. GRAHAM: I object to the leading, Your Honor.

3 THE COURT: Sustained.

4 BY MR. ALEXANDER:

5 Q Tell me about the attempted delivery.

6 A So I attempted downward gentle traction. It didn't
7 happen. The baby's head did not deliver. I don't quite
8 remember telling the nurses what to do next, but my nurses
9 were very experienced.

10 At that point, they immediately put the baby's -- or
11 the mom's legs in hyperflexion and did suprapubic
12 pressure, and, again, attempted gentle downward traction
13 of the baby's head.

14 Q Okay. And you're saying "gentle downward traction."
15 What does that mean?

16 A That means just -- that's what we're always taught is
17 that you really don't want to torque, or twist, or
18 excessively strain. You just gently guide the anterior
19 shoulder out of the pubic symphysis.

20 Q And the traction that you applied, how does it differ
21 from what you would apply in an ordinary delivery?

22 A I apply the same amount of traction in every
23 delivery.

24 Q All right. Do you have a recollection of nurses
25 coming into the room after the call for help?

1 A I know that -- because two people are required to
2 flex her legs back in suprapubic pressure, there were
3 already two nurses present. I don't recall who came in
4 when.

5 Q Do you recall Dr. Merritt coming into the room?

6 A I do.

7 Q All right. What do you recall about that?

8 A After I had tried gentle downward traction, I then
9 attempted to cut a generous episiotomy, and tried to put
10 my hand posteriorly. At that point, I couldn't get my
11 hand in posteriorly. And he arrived to the delivery.

12 Q And we've had some testimony about that as well.
13 Tell us about cutting an episiotomy, why do you do it, how
14 do you do it, that kind of thing.

15 A You would attempt to -- you never want to injure the
16 baby. You try to shield your hand between the baby's head
17 and -- it's, honestly, right above the anus. And you
18 attempt to cut, at least, a second degree, cut the skin or
19 the actual area. That isn't really what's felt to hold
20 the baby up. But it gives me enough room to put a hand
21 posteriorly or behind the baby's shoulder.

22 Q And do you recall trying to do that, that is get your
23 hand in to do a rotational maneuver?

24 A Yes, sir.

25 Q All right. And were you able to do that?

1 A No.

2 Q All right. And as you were attempting to do that, do

3 you recall Dr. Merritt coming into the room?

4 A Yes.

5 Q And what do you recall about that?

6 A I remember stepping away from the delivery and told

7 him, gosh, I've tried to deliver the baby and can't. And

8 then he took over.

9 Q And how long -- do you have a recollection of how

10 long it was before he was able to effect delivery?

11 A I think I had been at the perineum about a minute

12 doing my maneuvers. And I think his delivery note was

13 about 90 seconds of what he additionally did.

14 Q I think his note talks about the baby's head being at

15 the perineum for a minute --

16 MR. GRAHAM: I object to the leading, Your Honor.

17 THE COURT: Sustained.

18 BY MR. ALEXANDER:

19 Q -- to a minute and 45 --

20 MR. GRAHAM: I object to the leading.

21 THE COURT: I sustain the objection.

22 BY MR. ALEXANDER:

23 Q Dr. Alt, there's been -- let me ask you this,

24 Dr. Alt. Have you ever leaned your body weight onto a

25 baby's head to deliver a shoulder?

1 A No, sir.

2 Q Would you ever lean your body weight onto a baby's
3 head to deliver a shoulder?

4 A No, sir.

5 Q Have you ever heard of anyone leaning their body
6 weight in to deliver a baby's shoulder?

7 A No, sir.

8 Q Did you ever say in your deposition that you leaned
9 your body weight in to deliver this shoulder?

10 MR. GRAHAM: I object to the form, Your Honor. The
11 deposition speaks for itself.

12 THE COURT: Overruled.

13 THE WITNESS: That means I can answer?

14 BY MR. ALEXANDER:

15 Q Yes.

16 A During my deposition, which was definitely my first
17 deposition I had ever given before, I felt like the
18 attorney asked me a lot of different ways how much force,
19 did I apply excessive force. In training, you were taught
20 gentle downward traction and enough to exert that the
21 shoulder will come under the pubic bone.

22 I felt like she wanted me to say pounds or Newtons.
23 And I remember saying something to the effect of, you
24 know, I'm a white female this size, you know, this is --
25 downward traction would be, I guess, equivalent to my body

1 weight. So they may have interpreted that as leaning.
2 But in no way did I lean in during this delivery, or have
3 I ever to deliver a baby.

4 Q Did you see anywhere in your deposition where you
5 said you leaned into the body?

6 A I don't remember seeing that.

7 MR. ALEXANDER: All right. Thank you, ma'am.

8 THE WITNESS: Thank you.

9 THE COURT: All right. I think we're going to go
10 ahead and break for lunch.

11 Just be back in the jury room at 2:00. Ladies and
12 gentlemen, don't talk about the case. Continue to keep an
13 open mind. And don't do any outside investigation.

14 (WHEREUPON, the jury was excused from open court at
15 approximately 12:45 p.m.)

16 THE COURT: All right. Yes, sir.

17 MR. GRAHAM: Your Honor, we noticed that Dr. Alt
18 brought some notes with her. We'd like to examine those
19 during the lunch break.

20 THE COURT: All right. What are we doing as far as
21 time wise? Come back at 2:00. She's got to finish up.

22 And then what have you got?

23 MR. ALEXANDER: I have an expert that should be here
24 momentarily. So that would be great if we could get him
25 in. And that should take us to the end of the day.

1 THE COURT: And then what do you have left? I'm
2 trying to figure out --

3 MR. ALEXANDER: So left would be Dr. Merritt and
4 Dr. Twedt. And I think -- and then I have another expert.
5 And I have to make a judgment about whether I'm calling
6 him.

7 THE COURT: And then -- so how are we going to get
8 done by tomorrow?

9 MR. ALEXANDER: I think we're --

10 THE COURT: Well, he's got an expert, too.
11 Don't y'all have an expert?

12 MS. RODRIGUEZ: Yeah, Dr. Resnick.

13 MR. ALEXANDER: Oh, yeah.

14 THE COURT: Well --

15 MR. ALEXANDER: I mean, we'll be --

16 THE COURT: Just let me know.

17 MR. ALEXANDER: That went a long time. But we laid
18 everything out, so I think we can really move.

19 THE COURT: Is there another video?

20 MR. ALEXANDER: Well, there is, but I'm not sure what
21 I'm doing with this.

22 THE COURT: You're going to deprive us of that
23 opportunity.

24 All right. We'll see you back at 2:00.

25 (WHEREUPON, a lunch break was taken.)

1 (WHEREUPON, Plaintiff's Exhibit Nos. 14 and 15 were
2 marked for identification only.)

3 THE COURT: All right. Mr. Graham, are y'all ready
4 for the jury?

5 MR. GRAHAM: Yes, Your Honor.

6 THE COURT: Okay. Bring the jury in.

7 (WHEREUPON, the jury came into open court at
8 approximately 2:14 p.m.)

9 THE COURT: Yes, sir, Mr. Alexander.

10 MR. ALEXANDER: The Defense would call Dr. Will
11 Merritt.

12 THE CLERK: Place your left hand on the Bible and
13 raise your right hand.

14 WHEREUPON,

15 WILLIAM MERRITT, M.D.,
16 after first having been duly sworn, testified as follows:

17 THE CLERK: State your name, please.

18 THE WITNESS: William Merritt.

19 THE CLERK: Thank you.

20 Please be seated.

21 DIRECT EXAMINATION

22 BY MR. ALEXANDER:

23 Q Doctor, we want to give this jury an opportunity to
24 get to know you, find out a little bit about you. Tell us
25 your name, please, sir.

1 A Okay. Let's see. The date and time I abbreviated.
2 But called to patient's room for delivery. And upon
3 arrival, infant's head was at perineum. Approximately one
4 minute upon intervening, an episiotomy enlarged,
5 McRoberts, suprapubic applied and with downward traction
6 little movement of shoulder. Posterior shoulder and
7 anterior shoulder rotated and this allowed delivery of the
8 anterior shoulder. Body delivered without difficulty.
9 Infant floppy and placed in warmer. NICU arrived.

10 Of note, fetal heart tones 70's to 30's. Upon
11 resuscitation times one and a half minutes, infant cried
12 with O2 supplementation. No movement in right arm. Left
13 arm good movement. Dr. Twedt present. Episiotomy
14 repaired (partial third). Fundus firm after delivery --
15 fundus firm after placenta delivery. Time of delivery of
16 head to body approximately one minute and 45 seconds.

17 I can't tell what this word is. Discussed with
18 patient's mom -- I'm sorry, delivery discussed with
19 patient's mom and father of the baby (mom given pain
20 medicines after delivery). And then I wrote sort of the
21 APGAR's, weight, female sex, and time of delivery.

22 Q I note in here that you have put in your progress
23 note, Dr. Twedt present. Do you see that?

24 A Correct.

25 Q All right. If will look at the next progress note

1 A I'd have to presume that -- I mean, knowing the
2 knowledge going in, it was not something you had never
3 heard of it. Either -- you talked about in didactics.
4 Certainly, you had read about it. And I probably had
5 observed some cases of shoulder dystocia during --
6 watching deliveries.

7 Q And was that something that you were taught during
8 the lectures?

9 A Both. I mean, lectures as well as maybe that morning
10 check out. That was, certainly, an opportune time to have
11 discussions about delivery. And if there was extra time,
12 we may talk about a specific subject.

13 We had one attending that almost every morning he was
14 on labor and delivery, he talked about a specific subject.
15 And that, certainly, being one of those. And, as I
16 mentioned, observation as well.

17 MR. ALEXANDER: Okay. Thank you, sir.

18 THE COURT: Cross-examination.

19 MR. GRAHAM: Yes, sir.

20 Thank you, Your Honor.

21 CROSS-EXAMINATION

22 BY MR. GRAHAM:

23 Q Good afternoon Dr. Merritt.

24 A Good afternoon.

25 Q First of all, you know this case is against

1 Greenville Hospital System; true?

2 A Yes, sir.

3 Q Okay. You know you're not a party to this case.
4 Nobody is -- nobody has brought you into this lawsuit. Do
5 you understand that?

6 A Yes, sir.

7 Q Thank you.

8 Let me talk, first of all, about whether or not an
9 attending is in attendance. You just read from your
10 delivery note the one that's hard to read because of your
11 tiny print -- or tiny handwriting. When you said,
12 Dr. Twedt present, was it your intention to put into the
13 chart that she was present during the delivery?

14 A I'd have to say my intention was to put she was
15 present at some point.

16 Q Okay. Well, you said earlier that when you looked --
17 after you put the baby in the warmer, you realized she was
18 standing behind you, and so you put that she was present.
19 When you put that she was present, did you mean to say
20 that she was present after you put the baby in the warmer,
21 or that she was present for the delivery?

22 A I don't think I, specifically, was trying to imply
23 one way or the other.

24 Q Okay. Well, I was just trying to figure out if you
25 were contending today that that entry was true and

1 accurate?

2 A I mean, if she was present, she was present. I don't
3 know at what point she arrived in the room. I'd have to
4 say that's what I meant. You know, as opposed to her
5 never being seen, she was seen at the delivery. I don't
6 know at what point she walked in the room. I was focusing
7 on mom and baby.

8 Q At any rate, if someone reads that to say she was
9 present during the delivery, that would be a false
10 conclusion; true?

11 A If somebody inferred that from my note, I guess,
12 yeah, that could be --

13 Q I mean, she was not there for the delivery; true?

14 A Based on -- yeah.

15 Q She had not been there for any moment in time from
16 the beginning of induction through the delivery; true?

17 A Been in that room?

18 Q Yes.

19 A I don't know if she had been in the room or not.

20 Q Okay. Well, there's, certainly, no indication from
21 the chart that she was in the room; true?

22 A If you say so.

23 Q Now, let me follow-up. There was a question about
24 the doctor who did the discharge summary dictating your
25 note into the discharge summary. If it was inaccurate --

1 an inaccurate inference, at least, that Dr. Twedt was
2 present in your delivery note, that mistake was
3 perpetuated in the delivery note -- I mean, in the
4 discharge summary as well; true?

5 A If he dictated verbatim what I wrote and if you
6 inferred that from the delivery note, then I guess, yeah,
7 you could make the same connection.

8 Q And have you looked through the chart to see if other
9 people repeated that inaccurate statement that Dr. Twedt
10 was present?

11 A I did not.

12 Q What does in attendance mean? When we talk about an
13 attending being in attendance, what does that mean to you?

14 A Attending being in attendance. I'd have to say being
15 available, being there. I mean, that's what an attending
16 does.

17 Q So an attending being in attendance doesn't mean
18 attendance at bedside to you?

19 A Not necessarily, no.

20 Q Okay. What does supervising mean? Does supervising
21 mean supervising from afar or supervising at bedside?

22 A It could be either one.

23 Q Okay. Well, Dr. Twedt never supervised anybody at
24 the bedside of Alana Mann, did she?

25 A She wasn't there when I was delivering the baby. She

1 wasn't beside me, if that's what you mean.

2 Q And the chart, certainly, doesn't reflect she was at
3 bedside supervising anybody else; true?

4 A True.

5 Q So I gather it's sort of a domino effect, when one
6 person writes something on the chart that somebody else
7 misunderstands, they repeat it on the chart and it could
8 be repeated on and on?

9 A I mean, based on the dictation, that's what he did.

10 Q Do you recognize that it's dangerous to rely with
11 confidence on what is written on the charts at Greenville
12 Hospital System?

13 A Can you repeat the question?

14 Q Yes, sir.

15 Do you recognize that it is dangerous to rely on --
16 to rely with confidence on the chart entries at Greenville
17 Hospital System?

18 A I'm not sure what you mean by "dangerous." I guess
19 I'm trying to understand. What do you mean by
20 "dangerous"?

21 Q Well, might one make mistakes if one relied upon the
22 entries being true and accurate if, in fact, they are not
23 true and accurate?

24 A Well, if something was misdictated, then, yeah. That
25 may not be exactly what happened, whether when it was

1 transcribed if someone typed something wrong, yeah. If
2 something was incorrect and got carried on.

3 Q Just because something says Dr. Twedt was present in
4 the delivery room, that doesn't mean she was, in fact,
5 present; true?

6 A She was present in the room. I mean, it never said
7 she was present at the time of delivery. It said she was
8 present. And that's exactly what he wrote, so.

9 Q If somebody like the doctor who prepared the
10 discharge summary, if he interpreted that to mean she was
11 there during the delivery and, in fact, that was untrue
12 and inaccurate, then it would be easy for him to reach a
13 false conclusion; true?

14 A I presume he could read that and assume differently,
15 yes.

16 Q And just because it says on the chart that an
17 attending was in attendance, that doesn't mean she was
18 necessarily in attendance, does it?

19 A If I -- in my experience, whenever I wrote a note
20 that says an attending was present, the attending was in
21 the room at some point.

22 Q At some point. Okay. And if the note said, for
23 example, that this child was a male child, that doesn't
24 mean that it was a boy, does it?

25 A I hope that would be accurate.

1 Q I would hope so, too, Doctor. But at Greenville
2 Hospital --

3 A I've seen it happen before where, you know, medical
4 records have been requested and somebody wrote a female
5 and it was a male. I mean, certainly, there can be errors
6 in transcription and dictation.

7 Q What was the gender of the baby in this case?

8 A A female.

9 Q A female?

10 A Correct.

11 Q What's reflected in the discharge summary?

12 A Let me get to it.

13 Male. Let's see. A male.

14 Q All right. So what I'm really driving at, Doctor,
15 and I, certainly, don't want to get in a quarrel with you
16 about how accurate or inaccurate these records are. But
17 you would admit that a chart at Greenville Hospital System
18 sometimes includes errors; true?

19 A Sure.

20 Q Sometimes it includes very serious errors; true?

21 A I assume you could say they were serious errors. I
22 don't know.

23 Q For an expert witness to rely on the records at
24 Greenville Hospital System being true and accurate and
25 complete would be a dangerous assumption to make; true?

1 A I think if there were inconsistencies, that would be
2 a tough assumption to make.

3 Q And if something is not in the chart at all, it would
4 be even more dangerous for an expert witness to assume
5 that that means everything unreported was within the
6 standard of care; true?

7 A I want to make sure I clarify what you're asking. If
8 somebody were to read my delivery note and something that
9 wasn't written in there, they assumed it happened, is that
10 dangerous? Is that what you were asking?

11 Q Well, it was probably a bad question I asked. Let me
12 withdraw that and try again.

13 If someone claimed on the chart that they did
14 something correctly and within the standard of care, that
15 doesn't necessarily make it so; true?

16 A If they claimed they did something and wrote it down,
17 they're claiming they did that.

18 Q Yes, sir.

19 A If they wrote it down and are claiming they did that,
20 then I would assume they did that.

21 Q But these records often contain untruths and
22 inaccuracies; true?

23 A I mean, there are some inconsistencies, yeah. I
24 mean, you dictate a word and the transcription may see it
25 another way. If you're trying to sign off on 50 charts

1 and there's one word that's off, you may miss that word.

2 Q I understand.

3 A Yeah.

4 Q But if somebody delivers a baby and applies traction
5 to the baby's head and causes permanent severe brachial
6 plexus damage by ripping and tearing C5, C6, and C7, but
7 doesn't put anything about any of that in the chart, it
8 would not be a fair conclusion from the doctor's silence
9 that what they did was appropriate; true?

10 A You mean if that was omitted? I'm still -- I'm
11 sorry. I'm trying to follow your line.

12 Q When a record is silent about whether or not a breach
13 of the standard of care occurred, that doesn't really tell
14 you anything about whether or not a breach of the standard
15 of care occurred; true?

16 A If something is not written down, I mean, it's not
17 written down.

18 Q Okay. And if somebody fails to disclose the harm
19 caused, their silence on that point doesn't tell you
20 whether they caused the harm or not, does it?

21 A I'm trying to understand what you're saying. So if
22 you did something you thought was wrong and you didn't put
23 it in the chart --

24 Q Yes, sir.

25 A -- you're saying that -- tell me how you interpret, I

1 guess, that specific scenario.

2 Q Let's just say if doctor A -- let's say doctor A
3 breaches the safety rules, breaches the standard of care
4 by applying greater than gentle downward traction on a
5 baby's head and neck, thereby ripping and tearing three
6 brachial plexus nerves, but chooses not to say anything in
7 the chart about doctor A's involvement. If someone else
8 came along and looked at that chart and saw no mention of
9 doctor A's involvement, that doesn't tell you a whole lot
10 about what doctor A did, does it?

11 A If there's no note from doctor A in the chart, then
12 you can't infer what doctor A did or didn't do.

13 Q Yes, sir.

14 Now, you said in your direct testimony that most
15 deliveries do not involve traction?

16 A For the most part, from what I recall.

17 Q And traction is a pulling force on the baby's head in
18 this context?

19 A No. From what I recall -- I mean, when I -- going
20 back to the technical part of delivering a baby is when
21 the baby comes out, the head comes out. The way I was
22 taught is, again, you're controlling the delivery. You're
23 not trying to deliver the baby. You're trying to control
24 the delivery.

25 And the way I controlled the baby is you want to

1 control the head and the body. And so any time I start
2 with delivering a baby, my hands went around the baby's
3 head and on the shoulders. So I was never -- I mean, it
4 wasn't like I was cupping the baby's head like a ball. So
5 I guess I want to make sure --

6 Q Well, maybe I confused you with my question. What I
7 was really trying to ask you is what is your definition of
8 traction?

9 A Traction is pulling.

10 Q Okay. That's what I thought. And may we agree that
11 it is against the safety rules for a resident to apply
12 more than gentle downward lateral traction on a baby's
13 head in the presence of shoulder dystocia?

14 A What do you mean by "safety rules"?

15 Q Well, let's change it to the standard of care. Well,
16 do you believe there are any safety rules in medicine to
17 protect the wellbeing of patients?

18 A I've personally never heard safety rules, certainly.

19 Q Well, let's talk about that a minute.

20 A Okay.

21 Q When you became an M.D. -- you are an M.D.; right, I
22 mean, as opposed to a D.O.?

23 A Yes.

24 Q Some of the residents are D.O.'s, instead of M.D.'s?

25 A Correct.

1 Q Was Dr. Alt an M.D. or a D.O.?

2 A I don't recall.

3 Q At any rate, when you took the oath of being an M.D.,
4 do you remember taking the hippocratic oath?

5 A Vaguely, but I do, yeah.

6 Q Okay. And I realize the hippocratic oath is the kind
7 of wording that goes on and on. But is it a fair summary
8 of the hippocratic oath to say that it means first,
9 doctor, do no harm?

10 A First do no harm, I do recall, yes.

11 Q And do you consider that a safety rule for the
12 protection of patients?

13 A I consider that, certainly, should be the way you
14 practice medicine is first do no harm.

15 Q And are you -- you've answered a lot of questions for
16 Mr. Alexander about the standard of care. Do you
17 recognize that standards of care for obstetricians are put
18 in place to protect the safety of their patients?

19 A Certainly. I mean, the standard of care should be
20 what a reasonable physician does.

21 Q And the whole purpose for that is to protect all
22 patients in the community from any substandard care that
23 obstetricians might provide; true?

24 A That should be the -- I mean, that should be the care
25 you try to give each patient, standard of care.

1 Q And so, anyway, when you asked what I meant by safety
2 rules, whether you want to call them safety rules or
3 standards of care, they're both there to protect the
4 safety of patients; true?

5 A True.

6 Q So let's go back to my question.

7 A Okay.

8 Q Do you agree that it is not proper for a doctor to
9 use greater than gentle downward lateral traction on a
10 baby's head when the shoulder is stuck behind the pubic
11 bone?

12 A By greater than gentle traction, you mean -- I mean,
13 that's the term I always -- you know, I struggle with.
14 What do you mean by greater than gentle traction?

15 Q Okay. Do you remember my -- do you remember Mary
16 Waters from my office taking your deposition?

17 A I do, yes.

18 Q Do you remember where that took place?

19 A It was in Columbia.

20 Q And you were under oath?

21 A I was.

22 Q Mr. Alexander was there, or someone from his office?

23 A Mr. Alexander was there.

24 MR. GRAHAM: Could you, please, go to Page 62, Lines
25 17 through 19?

1 BY MR. GRAHAM:

2 Q All right. See if this refreshes your memory. Okay.

3 Well, in your opinion, would it be appropriate to use
4 greater than gentle traction?

5 What was your answer?

6 A In my opinion, no.

7 Q Thank you.

8 In fact, you were trained to avoid greater than
9 gentle traction in your residency program; true?

10 A I was trained to apply traction that I would normally
11 use during delivery. I mean, my traction is -- you know,
12 as Dr. Ernest said, everybody has their own way of
13 traction. Everybody's traction is different. So greater
14 than gentle traction is pretty broad, I guess.

15 Q Let's talk about your training for a minute.

16 A Okay.

17 Q This is important to everybody in the community that
18 might rely on Greenville Hospital System for baby delivery
19 services. In the residency program at Greenville Hospital
20 System, are doctors trained -- are residents trained that
21 they should avoid greater than gentle downward lateral
22 traction when the baby's shoulder is stuck behind the
23 mom's pubic bone?

24 A Residents are taught, basically, how to provide
25 traction and when not to apply too much traction.

1 Q Are they taught -- I think this is a question you can
2 answer "yes" or "no," and then any explanation would be
3 fine. But, please, start with the "yes" or "no."

4 A Okay.

5 Q At Greenville Hospital System residency OB-GYN
6 program, when you were there, were the residents taught
7 that it is unacceptable to apply greater than gentle
8 downward lateral traction in the first several minutes
9 after the head delivers when the shoulder is stuck?

10 A I'd have to say yeah.

11 Q You were taught that?

12 A If I recall. I mean, that was a long time ago. I
13 don't know if that was, specifically, somebody sat me down
14 and said don't do this.

15 In a setting of a shoulder dystocia, you learned how
16 to manage a shoulder dystocia based on the whole big
17 scenario. I don't recall somebody saying don't do this.
18 I mean, you learned how to manage it from the time you
19 recognize it with the maneuvers you do.

20 Q And, see, that's what I really want to drive at,
21 because I know you were a chief resident. You did well.
22 You were in your fourth year. You knew a lot more than
23 younger residents.

24 But, you know, I'm just trying to figure out how much
25 training did you receive going through this OB program.

1 Because if they didn't train you that it's dangerous to
2 use more than gentle downward traction, then I think
3 that's an important thing for us to know in this case. I
4 mean, so did they teach you that or not?

5 A I'd have to say learning how to manage a shoulder
6 dystocia, that was part of the discussion on how you
7 manage it.

8 Q Okay.

9 A You know, that's not how you -- if you have a
10 shoulder dystocia, there's ways to deliver a shoulder
11 dystocia.

12 Q Okay. Did they train you that if you used more than
13 gentle downward traction, it would put the baby at risk of
14 having a permanent brachial plexus injury that messed up
15 her arm for life?

16 A I don't know if they put it in those exact terms.

17 Q Okay. Did they put it in terms in that general
18 effect about a permanent brachial plexus injury may result
19 if the doctor applies greater than gentle downward
20 traction?

21 A I don't know if they, specifically, said that. I
22 would have to say the reason you do the maneuver is to try
23 to prevent harm to the baby. So it may have been in that
24 part of the discussion.

25 MR. GRAHAM: Could you, please, turn to Page 83,

1 Lines 14 through 19?

2 BY MR. GRAHAM:

3 Q Starting at Line 14.

4 And my question was: Do you believe that you were
5 taught that because the application of greater than -- I'm
6 sorry.

7 My question was: Do you believe that you were taught
8 that because the application of greater than gentle
9 downward traction put the baby's brachial plexus nerves at
10 risk of injury?

11 What was your answer?

12 A I said, Yeah. I would say that's a reasonable
13 statement.

14 Q And you were, also, taught that you must not use
15 greater than gentle traction when there's an untried
16 safety maneuver; true?

17 A I was taught what maneuvers you would do to try to
18 alleviate a shoulder dystocia. And, I mean, that's -- in
19 each maneuver, you know, excessive downward traction was
20 not part of the maneuver.

21 Q Okay. Well, if excessive traction is used, if
22 greater than gentle downward traction is used in a way
23 that causes permanent brachial plexus damage, doing a
24 safety maneuver after that doesn't provide much safety,
25 does it?

1 A Do you mean if already an injury occurred and you did
2 the maneuver?

3 Q Yes.

4 A Well, doing the maneuver -- there's the baby. If
5 there was an injury that had already happened by
6 delivering the baby by maneuver, you aren't fixing the
7 injury.

8 Q Well, the whole point of safety maneuvers is to use
9 safety maneuvers instead of greater than gentle traction;
10 true?

11 A Yes. That's why -- yeah.

12 Q If someone panics, or whatever, and uses greater than
13 gentle traction and then causes injury, doing a safety
14 maneuver after that is kind of like, you know, the injury
15 has already occurred?

16 MR. ALEXANDER: Your Honor, I would object on --
17 there's no foundation for this.

18 THE COURT: All right. Overruled.

19 Go ahead.

20 BY MR. GRAHAM:

21 Q Safety maneuvers after an injury doesn't provide the
22 safety that the safety rule is designed to provide; true?

23 A If something already happened and you -- I mean, from
24 what I'm understanding, in relation to a shoulder
25 dystocia, if there was already an injury and that baby is

1 delivered through a maneuver, that doesn't go back and fix
2 it if something happened.

3 Is that what you're saying?

4 Q Yeah.

5 Once greater than gentle traction causes permanent
6 damage, using a safety maneuver after that doesn't undo
7 the damage; correct?

8 A I'd have to say so. I don't know for sure. But I
9 would have to say that a maneuver to deliver the baby --
10 if there was something that had already happened to the
11 baby, the maneuver itself doesn't fix that.

12 Q All right. Well, let's just say, in this case, to
13 your credit, you got this baby out with a rotation
14 maneuver; true?

15 A True.

16 Q If that rotation maneuver had been performed before
17 greater than gentle traction, then that would be better
18 for the baby than if the rotation maneuver was done after
19 the baby was already permanently damaged; true?

20 A I -- so you're going back and inferring that, in this
21 particular case, something had already been done and when
22 I came in -- I guess I'm trying to make sure I understand.

23 Q Well, let me give you this scenario.

24 A Okay.

25 Q Let's assume for the purposes of this question that

1 Dr. Alt caused injury to the brachial plexus and tore and
2 ripped three nerves with greater than gentle downward
3 traction before you did your rotation maneuver.

4 A Okay.

5 Q Your rotation maneuver, while it was successful in
6 getting the baby out, it can't fix the harm that's already
7 been caused; true?

8 A I mean, that's true for any delivery.

9 Q Thank you.

10 A Okay.

11 Q This injury definitely occurred after delivery of
12 J.B.'s head; true?

13 A I don't know that. I mean --

14 Q You don't know that?

15 BY MR. GRAHAM: All right. Let's, please, pull up
16 Page 73, starting at Line 21.

17 BY MR. GRAHAM:

18 Q Question: Having now reviewed these records and
19 familiarized yourself with this delivery, will you agree
20 with me that the injury to this baby occurred after the
21 delivery of her head?

22 And we'll have your answer in a moment.

23 MR. GRAHAM: Page 74, Lines 1 to 2.

24 BY MR. GRAHAM:

25 Q And your answer was?

- 1 A Yes. That would be my suspicion.
- 2 Q Brachial plexus injury is a foreseeable risk of
3 greater than gentle downward traction; true?
- 4 A Yes.
- 5 Q And greater than gentle downward traction can injure
6 anybody's baby; true?
- 7 A I mean, if you pull too hard, you can cause an
8 injury.
- 9 Q Yeah. Greater than gentle traction puts the brachial
10 plexus nerves at risk of whichever baby receives the
11 greater than gentle traction; true?
- 12 A If you pull too excessively, you can cause injury.
- 13 Q It doesn't have to be an eight-pound, eight-ounce
14 baby? It can be a bigger baby or a smaller baby; true?
- 15 A That's correct.
- 16 Q Okay. It can be -- it doesn't have to be the child
17 of a Jehovah's Witness. It can be a child of someone of
18 any religious faith; true?
- 19 A That's correct.
- 20 Q It can be a child -- not only a child with -- well,
21 it can be a child of any socioeconomic circumstance; true?
- 22 A Yeah.
- 23 Q Rich or poor, any race; true?
- 24 A True.
- 25 Q All right. Let's talk about what was going on with

1 you back on Thanksgiving weekend, 2004. I know that's a
2 long time ago, but that's when this baby was born at 4:00
3 something a.m. on Saturday morning, November 27th. You
4 were on call as the chief resident?

5 A That's correct.

6 Q All right. Was that a 24-hour call?

7 A I think -- we were trying to figure this out during
8 my deposition.

9 Q Right.

10 A That morning -- is that a Saturday morning?

11 Q Yes, it was.

12 4:00 something a.m. was the delivery time on a
13 Saturday morning.

14 A So how that schedule worked is I probably worked the
15 day during Friday. I don't know if I was on labor and
16 delivery. I don't think I was on labor and delivery just
17 by reading the notes. I probably was on one of the other
18 rotations like I mentioned. And checkout, which is
19 normally around 5:00 or 6:00, is when I came and took
20 on-call responsibility.

21 So, technically, a 12-hour call. So my call stopped
22 Saturday morning at 7:00.

23 Q Okay. But whatever the length of your call was, you
24 had a full duty before the call started; right?

25 A Correct, like the day of Friday.

1 Q So you had been up for like 20 straight hours, or
2 more?
3 A No. I came to work Friday morning.
4 Q Okay. At what time?
5 A 6:00.
6 Q 6:00 a.m.?
7 A I mean, I'd be guessing. Depending on what rotation
8 I was doing.
9 Q Okay.
10 A Oncologist, we like to get up early. Reproductive
11 doctors didn't like to get up early. So it really varied
12 on when we got there.
13 Q And you chose getting up early?
14 A You get a lot of stuff done.
15 Q And thank you for that work you're doing.
16 But going back then. So you started your work that
17 weekend -- or, at least, starting on Friday around 6:00
18 a.m., or thereabouts; true?
19 A That's correct.
20 Q And you did a regular full shift; true?
21 A True.
22 Q You immediately without any break started your call
23 for OB; true?
24 A True.
25 Q So you had been up from 6:00 a.m. on Friday to 4:00

1 something a.m. on Saturday at the time of this delivery?

2 A I may have -- I mean, it's very well I could have
3 gone to sleep at 10:00 or 9:00 that evening, if there was
4 nothing going on, or I could have taken a nap.

5 Q Sure. I understand that doctors on call do take
6 naps, and go to the cafeteria, and all that kind of stuff.
7 But the point is, you were on duty for over 22 hours;
8 true, at the time of this delivery?

9 A From a call standpoint, I mean, I've been on call for
10 six hours. But, yes, I had been working since 6:00 a.m.
11 that morning.

12 Q And when you were working a regular shift or on call,
13 you were still on duty; right?

14 A If I -- during the day, I didn't have any obstetrical
15 responsibilities on Friday.

16 Q Okay. But you had a duty of some patients of some
17 kind in some department; true?

18 A Correct.

19 Q That's what I meant by on duty.

20 A Yes.

21 Q In that sense, you were on duty for 22 plus hours at
22 the time of this delivery; right?

23 A I mean, yeah, from when I finished my work until
24 call, yes. I was not able to go home until, I guess, 7:00
25 checkout time.

1 Q And you have no memory of this labor and delivery?

2 A I don't have any specific recollection.

3 Q No memory of applying traction to this baby's head
4 and neck?

5 A I don't.

6 Q And, certainly, no memory of how much traction you
7 applied to this baby's head and neck?

8 A I do not.

9 Q Now, it really doesn't matter to me and my client
10 whether the injury was caused by greater than gentle
11 traction by Dr. Alt or by you. But may we agree that this
12 injury was most probably caused by greater than gentle
13 traction applied by one of you?

14 A Well, I think that the injury could have happened, as
15 I've learned, for many reasons.

16 MR. GRAHAM: Let's, please, play 141, Lines 4 --
17 well, I'll wait for it to get blown up. Lines 4 through
18 16. If that's too much to blow up, we can break it up.

19 BY MR. GRAHAM:

20 Q Question: We agreed earlier that the injury to
21 **J.B.**'s brachial plexus nerves most probably
22 occurred after delivery of the head. Are you able now to
23 determine at what point her brachial plexus nerves were
24 injured in the course of this delivery?

25 Your answer was, No.

1 Question: Are you able to determine whether or
2 not -- or whether it was during the time that Dr. Alt was
3 attempting delivery, or when you were attempting the
4 delivery?

5 What was your answer, sir?

6 A I can't tell if it was with Dr. Alt or Dr. Merritt.

7 Q Okay. Just out of curiosity, do you often refer to
8 yourself as Dr. Merritt?

9 A I normally don't, but this was a long day. That was
10 probably about 9:00 at night or so when we were getting to
11 this point. I normally do not, no.

12 Q Now, when you did your first shoulder dystocia
13 delivery, you had already watched other doctors do that?

14 A I'd have to say yes. I mean, I know there was some
15 during residency, so.

16 Q So even if it was the first time you had hands on,
17 were there other doctor in attendance?

18 A When I did my first shoulder dystocia?

19 Q Yes, sir.

20 A I would have to say yes.

21 Q Okay. You -- had you watched videos?

22 A You know, I can't remember, specifically, videos. I
23 mean, like during our didactic, there very well could have
24 been a video. It could have been a simulation. I don't
25 recall.

1 Q But you're satisfied that you had real time
2 opportunities to watch a real life situation unfold where
3 a stuck shoulder was delivered by a trained obstetrician?

4 A I feel that I had seen some shoulder dystocias
5 delivered.

6 Q Do you know whether Dr. Alt had ever seen a video of
7 a shoulder dystocia delivery the first time she was called
8 upon to figure out how much traction to use in a shoulder
9 dystocia context?

10 A I don't. I mean, she was in the didactics with me.
11 She went through some of the same training I went through.
12 But I don't know if it was a video.

13 Q Do you know whether or not Dr. Alt ever watched a
14 trained obstetrician manage a shoulder dystocia delivery?

15 A I don't know.

16 Q Watching other doctors before you're put in the arena
17 under the stress of the moment, at least, gives you a
18 better chance to deliver the baby safely; true?

19 A Well, certainly, the more experience you have, that
20 helps with everything. It helps whether you're watching
21 or doing it.

22 Q Do you know how many shoulder dystocias Dr. Alt had
23 managed before she attempted to manage the delivery of

24 **J.B.**?

25 A I do not.

1 Q When you walked into the room that day, did you have
2 the sense that your presence was providing some calm?

3 A I don't think that was the first thing in my mind
4 when I walked in the room.

5 Q In fact, when you walked in the room, you saw a
6 chaotic scene; true?

7 MR. ALEXANDER: Objection to leading.

8 THE WITNESS: I don't recall anything chaotic about
9 it. I mean, I've been in chaotic situations, and I don't
10 think this was chaotic. I mean, from reading the note, I
11 didn't describe anything about that being chaotic. I
12 would have to go strictly on this.

13 BY MR. GRAHAM:

14 Q I understand. I understand that you didn't describe
15 chaos in your note. If there was an accurate description
16 of what happened that day before you arrived, do you
17 believe that a true and accurate note would have revealed
18 that there was, in fact, chaos without an attending in
19 attendance and with a second-year resident having to
20 manage a shoulder dystocia with no clue how to do that?

21 A You're saying that somebody wrote something, you read
22 it and says that could determine that was chaotic?

23 It seems to me like a stretch that you could read
24 something and say chaos was going on, I mean, unless it
25 was somebody's personal recollection of the event and said

1 things were chaotic. It may have been chaotic for that
2 person, but not to somebody else.

3 Q All right. Well, you said nothing in your note
4 reflected a chaotic scene. Your note only describes the
5 observations and actions after you arrived in the delivery
6 room; true?

7 A Correct.

8 Q You have no personal knowledge as to whether or not
9 there was chaos before you took over; true?

10 A No. I'd have to say if it was chaotic, it's not like
11 I would expect the chaos to stop, say, hey, Dr. Merritt is
12 coming, let's's calm down. I mean, I would think the
13 chaos would have been present when I walked in the room,
14 if I had to assume that's what was going on.

15 Q Doctor, I don't know if you can read this. Let me
16 show you what I'm going to ask you about, and then I'll
17 stand back.

18 A Okay.

19 Q Okay. Doctor, I'm -- and this document is entitled
20 GHS labor and delivery summary for Alana Mann. Okay.

21 A Okay.

22 Q Doctor, Page 42, entitled GHS labor and delivery
23 summary has a line where it says the attending's name,
24 that's Dr. Twedt; true?

25 A Oh, yes. I'm sorry. I thought you were asking them.

1 I'm sorry.

2 Q I'm just trying to make sure the jury can see what we
3 were looking at since we had a technical issue there.

4 And it, also, says attending present. What was the
5 answer?

6 A Dr. Twedt..

7 Q The answer is yes; correct?

8 A Oh, yes. I'm sorry.

9 Q Okay. And under attending supervised, the answer is
10 yes; true?

11 A Yes.

12 Q All right. In fact, Dr. Twedt was never present at
13 bedside at any point during this delivery; true?

14 A She wasn't standing beside the patient.

15 Q She was never supervising at bedside during this
16 delivery; true?

17 A True.

18 MR. GRAHAM: Thank you.

19 Nothing further.

20 THE COURT: Redirect.

21 REDIRECT EXAMINATION

22 BY MR. ALEXANDER:

23 Q You were asked about your experience with shoulder
24 dystocia. Is it possible to go through a whole residency
25 without ever seeing a shoulder dystocia?

DIRECT EXAMINATION

BY MS. RODRIGUEZ:

Q Doctor, could you, please, give the jury the benefit of your educational background starting with college and bringing them up to date?

A Yes. I am originally from South Africa. I went to medical school at the University of Cape Town. I spent two years in London at Saint Stevens Street Hospital. I did my pediatric training at the University of Connecticut. I did my neurology training at Albert Einstein College of Medicine in New York. I did an epilepsy fellowship at Albert Einstein in Columbia.

And then I moved to Miami. And I've been on the faculty at Miami Children's Hospital and the University of Miami since 1985.

Q Are you certified, Doctor?

A Yes.

Q Could you, please, explain what you're certified in?

A I'm board certified in pediatrics and in neurology with special competence in child neurology.

Q Can you explain to the jury just, basically, what pediatric neurology involves?

A Pediatric neurology involves diseases of the nervous system, both the central nervous system, meaning the brain, and the peripheral nerves and muscles in children

1 ones that are brachial plexus caused by a pathological
2 entity. Whether the babies may be personally predisposed,
3 I don't know.

4 Q Okay. And in terms of those that can occur at birth,
5 if you could, explain that mechanism to the jury.

6 A Well, the mechanism at birth is related to the fact
7 that I was explaining in the diagram where the brachial
8 plexus is, basically, a number of nerves. And if there's
9 any circumstance where those nerves are stretched and
10 torn, you will get a brachial plexus injury resulting in a
11 palsy and a weakness in the arm.

12 Q Now, in this particular instance, did you have an
13 opportunity to review [REDACTED] J.B. [REDACTED]'s medical records?

14 A Yes.

15 Q And did you, also, have an opportunity to evaluate
16 [REDACTED] J.B. [REDACTED]?

17 A Yes.

18 Q And I believe your first visit with her was back in
19 June of 2011?

20 A Yes.

21 Q And were you, at that time, able to make a
22 determination as to whether or not the brachial plexus
23 injury that [REDACTED] J.B. [REDACTED] sustained was likely related to a
24 congenital birth condition, or whether she had some
25 vulnerability in utero?

1 A No. She, clearly, had torn nerves resulting in
2 neuroma. You don't get a neuroma formation unless the
3 nerves are torn. The fact that she had torn nerves and
4 the neuroma formation indicates that there was a stretch
5 injury resulting in torn nerves and a neuroma. So the
6 other causes would not apply in her case.

7 Q Okay. Now, in terms of your evaluation of **J.B.**
8 can you explain to the jury, basically, what your
9 examination involved, and what observations you made?

10 A Specifically, in terms of my examination of her, what
11 I look for is I look for any asymmetries of her left arm
12 and her right arm. And I look for abnormal position, if
13 she holds her arm in a specific position. Because if you
14 don't hold your arm in a normal position, it's mean either
15 your gravity or antigravity muscles are abnormal and
16 you're holding it in that fashion because of weakness of
17 the muscles.

18 I, also, look for any asymmetry in terms of size of
19 the muscles or any contractors in the muscle, where it's
20 held in a certain position and she cannot move her arm in
21 the full range of motion that one would expect.

22 What I then do is do a neurological exam. And even
23 though I do a full neurological exam, specifically, as it
24 relates to brachial plexus, I'm looking for which muscles
25 and which movements are predominantly effected in any case

1 of brachial plexus palsy.

2 So what I would do in her is have her do specific
3 movements that would give me an indication of what is weak
4 and what isn't weak.

5 Q Doctor, we have [REDACTED] J.B. here this afternoon. I would
6 like to bring her in and let you show the jury what the
7 evaluation is you did on her.

8 A Sure.

9 (WHEREUPON, [REDACTED] J.B. entered the
10 courtroom.)

11 MS. RODRIGUEZ: Hey, [REDACTED] J.B. Do you remember
12 Dr. Resnick?

13 [REDACTED] J.B.: Yes.

14 MS. RODRIGUEZ: Okay. He's going to take a look at
15 you. Okay.

16 Sam, why don't you stay over here for her just in
17 case.

18 THE WITNESS: Now, we're going to play some games.
19 We're going to do the same things we did before.

20 So do you want to take that off?

21 Thank you.

22 Okay. And I'm going to talk to these people. And
23 when I talk to them, don't take any notes.

24 [REDACTED] J.B.: ([REDACTED] J.B. nodded.)

25 THE WITNESS: And I'll ask you what to do afterwards.

1 So what I'm going to show is I'm going to show J.B.
2 doing certain movements that will demonstrate where she
3 has weakness and where she doesn't have weakness.

4 And, basically, what we do is we look at different
5 sections. We look at her ability to move her shoulders,
6 her ability to move her elbow, and her ability to move her
7 hand and her forearm.

8 So we'll start with the shoulder and we'll go down
9 from there. I'm going to do this in an abbreviated
10 fashion. Otherwise, she'll get bored.

11 So I'll demonstrate to you pretty much what I was
12 talking about. So if you look at J.B. and you see the
13 way she's holding her right arm. She's holding her right
14 arm with flexion at the elbow and slightly abducted away
15 from the side of her body. And that's because of the
16 specific pattern of muscle weakness.

17 And, also, if you look at the arm, if you measure it,
18 you'll see that that arm and the muscles of that arm are
19 smaller than the other arm. She's pretty strong with this
20 arm.

21 Okay. J.B. this is what I want you to do first.
22 I want you to look straight ahead. But, first, look at
23 me. And I want you to put your arms straight up in the
24 air like I showed you. Do the best you can.

25 Good job.

1 You can see when she puts her arm up, she can get the
2 left up pretty well. And the right arm she can get up to
3 almost horizontal. And when she does it, she elevates her
4 shoulder to help her do it. So there's a weakness of this
5 muscle over here that elevates the arm. And that's one of
6 the nerves that supplies the upper brachial plexus that I
7 showed you in the diagram.

8 Now, put your arms like this.

9 Now, the other thing that happens with the other
10 muscles around the shoulder are the ability to do this and
11 this. And this is called external rotation. And this is
12 called internal rotation.

13 So, **J.B.** the first thing I want you to do is I
14 want you to hold your hands like this. And I want you to
15 turn them out as far as you can.

16 Good job.

17 So you can see that she has no ability to externally
18 rotate on the right side.

19 And, now, what I want you to do is hold them like
20 that. That's fine. And I want you to try to turn -- I'm
21 going to hold it for you. And I want you to turn it in.

22 Good job.

23 So she does have some internal rotation. But
24 external rotation, which means turning your arm to reach
25 for things and lifting your arm up, is what she cannot do.

1 The other important thing --

2 Hold your hands like that again.

3 . Good job.

4 It is something called supination, which is turning
5 your hands up so your palms face upwards, and pronation,
6 which is turning your hands down. So any time you unscrew
7 a bottle top, or a screwdriver, or anything that requires
8 this action is this muscle that turns your forearm like
9 this.

10 So, **J.B.** I'm going to ask you to do it with both
11 hands. I want you to, first of all, turn your hand down.

12 She has excellent pronation in both hands.

13 Hold it like that again. Now, I want you to turn
14 your hands up.

15 And she's able to supinate fully with the left arm,
16 but she cannot supinate at all with the right arm. So the
17 major deficits that she has are shoulder elevation,
18 external rotation at the shoulder, and the inability to
19 supinate. Those are the three major weaknesses that she
20 has. If you'll look at her hands.

21 Will you squeeze my hands?

22 And she's pretty good on both sides. So the hand use
23 is very good.

24 And can you do that for me?

25 And she's got good fine motor coordination in her

1 hand. If she can get her hand in the right position,
2 she's pretty good in terms of what you can do with your
3 hand.

4 But any action of your hand that requires you to turn
5 your hand up and manipulate, she can't do. Any action of
6 getting her hand up in the air to do something, she can't
7 do. Because even though her hands are good, she can't get
8 her hand into the position so that it can be effective.

9 You did well.

10 BY MS. RODRIGUEZ:

11 Q Doctor, if I could get you to show one more thing.

12 MS. RODRIGUEZ: **J.B.** before you disappear on us.
13 Turn sideways and face the Doctor.

14 Could you do that?

15 And, now, put your hands over your head. Put your
16 hands way up.

17 BY MS. RODRIGUEZ:

18 Q Doctor, can you talk about what happens here when she
19 takes that position?

20 A Well, what happens is she -- when she takes that
21 position -- the muscles around the scapula, also, have
22 lost power. So, because of that, she has an odd position
23 of the scapula as well. From a functional standpoint --
24 and thank you for interrupting me.

25 What I want you to do is I want you to do a couple of

1 other things. Can you put this hand behind your head?

2 Good job.

3 Can you do the same thing with your other hand?

4 [REDACTED] J.B. [REDACTED] ([REDACTED] J.B. [REDACTED] shook
5 her head.)

6 THE WITNESS: Can you put this hand behind your back?

7 Can you do the same thing with the other hand?

8 [REDACTED] J.B. [REDACTED]: ([REDACTED] J.B. [REDACTED] shook
9 her head.)

10 THE WITNESS: So that's the internal rotation, and
11 the external rotation, and the ability to elevate. And
12 so, for example, in terms of [REDACTED] J.B. [REDACTED] being able to brush
13 her hair or get her hands up, that she's unable to do.
14 Because anything above the shoulder level is going to be
15 very difficult for her.

16 But your hair still looks nice.

17 MS. RODRIGUEZ: Sam, why don't you let her put her
18 shirt back on.

19 Thank you.

20 Thank you, [REDACTED] J.B. [REDACTED]

21 You can go with daddy.

22 Thank you.

23 (WHEREUPON, [REDACTED] J.B. [REDACTED] exited courtroom.)

24 BY MS. RODRIGUEZ:

25 Q Doctor, in comparing when you saw [REDACTED] J.B. [REDACTED] in 2011 and

1 today, has there been any significant improvement in her
2 functional abilities?

3 A No.

4 Q Have you arrived at an opinion -- excuse me, based
5 upon your training, education, and experience with
6 brachial plexus injuries, can you rule out a congenital
7 condition as the most probable cause of **J.B.'s** brachial
8 plexus injury?

9 A Yes.

10 Q And why is that?

11 A For the reason I told you before. There's two
12 reasons. The one is that at surgery, it was demonstrated
13 that she had a tear. Congenital conditions don't manifest
14 as a tear. The tear is, specifically, due to traction and
15 stretching of the brachial plexus.

16 A second issue is that she had neuroma formation,
17 which is a reaction to the tear. And the third thing is
18 that when she was born, she wasn't born with a shrunk
19 arm or abnormal muscles. She was born without any
20 asymmetry, but just weakness.

21 Q And, Doctor, have you arrived at an opinion as to the
22 most probable cause of **J.B.'s** brachial plexus injury?

23 A It was -- her injury was due to traction on the
24 brachial plexus, which is stretching of the brachial
25 plexus resulting in a tear.

1 Q And do you have an opinion as to when that most
2 probably occurred?

3 A It was during the birth process.

4 Q And do you hold that opinion to a reasonable degree
5 of medical certainty?

6 A Yes.

7 Q And, Doctor, do you have an opinion as to whether or
8 not **J.B.**'s brachial plexus injury is permanent or
9 temporary?

10 A Yes.

11 Q And what is that opinion?

12 A It is permanent.

13 Q And do you hold that opinion to a reasonable degree
14 of medical certainty?

15 A Yes.

16 MS. RODRIGUEZ: The Court's indulgence.

17 THE COURT: Yes, ma'am.

18 (Pause.)

19 MS. RODRIGUEZ: That's all I have.

20 Please answer any questions the Defense may have.

21 CROSS-EXAMINATION

22 BY MR. ALEXANDER:

23 Q Good afternoon, Doctor.

24 A Good afternoon.

25 Q Just to be clear, you are a pediatric neurologist?

- 1 A Yes.
- 2 Q Not an obstetrician?
- 3 A Correct.
- 4 Q You have no training as an obstetrician?
- 5 A Correct.
- 6 Q Obviously, delivering babies would not be a routine
7 part of your practice?
- 8 A That would be correct, too.
- 9 Q And is it true that you're unable to tell us how much
10 traction is applied in an ordinary delivery?
- 11 A Correct.
- 12 Q And how much traction would be required to stretch a
13 nerve?
- 14 A Correct.
- 15 Q How -- you're unable to tell us how much traction
16 would be required to rupture a nerve?
- 17 A Correct.
- 18 Q And you're unable to tell us how much traction would
19 be required to avulse a nerve; is that true?
- 20 A Correct.
- 21 Q And, certainly, you were not present for this
22 delivery; true?
- 23 A Correct.
- 24 Q And you would have no way of quantitating how much
25 traction may have been applied, if any, in this delivery;

1 true?

2 A The only thing I can say, because I can't -- all the
3 questions you're asking me, you're absolutely correct.
4 There's no way I know. The only thing that I do know is
5 there was sufficient traction to result in tearing of
6 nerves.

7 Q And that's your opinion on causation. And you don't
8 mean to suggest -- to offer an opinion as to whether or
9 not any traction applied in this delivery was within the
10 standard of care. That's not within the scope of your
11 opinion; true?

12 A No. I'm not an obstetrician.

13 Q Indeed, you would not suggest that the injury itself
14 is evidence of negligence; true?

15 A Correct.

16 MR. ALEXANDER: Thank you, sir.

17 THE COURT: Any redirect?

18 MS. RODRIGUEZ: That's all.

19 Thank you.

20 THE COURT: All right. Thank you, Dr. Resnick.

21 MS. RODRIGUEZ: May we approach the bench?

22 THE COURT: Sure.

23 (WHEREUPON, a bench conference was held.)

24 MS. RODRIGUEZ: I believe we've admitted these,
25 Judge, with no objection.

1 THE COURT: Okay.

2 (WHEREUPON, Plaintiff's Exhibit Nos. 14 and 15 were

3 admitted into evidence.)

4 MR. GRAHAM: Your Honor, we would like to introduce

5 the deposition page from Dr. Ernest, from his testimony

6 where he admitted that that second injury had resulted

7 within a year.

8 MR. ALEXANDER: I think that's appropriate.

9 MR. GRAHAM: At least, as a Court's exhibit.

10 THE COURT: We can put it in as a Court's Exhibit.

11 I sustain the objection.

12 All right. Yes, sir, Mr. Alexander.

13 (WHEREUPON, Court's Exhibit No. 9 was marked for

14 identification and admitted into evidence.)

15 MR. ALEXANDER: The Defendant would call Dr. Carrie

16 Anne Twedt.

17 THE COURT: All right. Dr. Twedt, you're still under

18 oath, ma'am.

19 Yes, sir.

20 DIRECT EXAMINATION

21 BY MR. ALEXANDER:

22 Q All right. Doctor, how do you feel?

23 A Overwhelmed.

24 Q Okay. Are you ready to talk to these folks?

25 A Absolutely.

1 CHARGE ON THE LAW

2 THE COURT: Thank you, Mr. Graham.

3 Ladies and gentlemen, you've heard all the evidence
4 in this case. You've heard the arguments by the lawyers.
5 It is now my duty to instruct you on the law that applies
6 to this case.

7 And it's your duty to determine the facts from all
8 the evidence in this case. And to those facts, you must
9 apply the law as I give it to you. And you should not be
10 concerned with what the law should be, but what it is.
11 And you must not be influenced by any personal likes or
12 dislikes, undue sympathy, or biases, or prejudices. And,
13 you will recall, you took an oath to do just that when we
14 began the case. And that was to decide this case solely
15 on the evidence before you and according to the law.

16 Now, in following my instructions, you must follow
17 all of them, and not single out some and ignore others,
18 because they're all equally important. And you must not
19 read into these instructions or into anything I may have
20 said or done during the course of this trial as any
21 indication as to what I think the facts are, or what your
22 verdict should be.

23 I told you at the beginning that you were the sole
24 judges of the facts and the exclusive judges of the facts.
25 That's the way our system of justice and Constitution

1 makes it. And I'm, certainly, not going to interfere with
2 your prerogative to determine what the facts are as the
3 jury, just as I know you're not going to intrude on my
4 prerogative in telling you what the law is that you must
5 apply to those facts.

6 Now, how do you decide what the facts are? You do
7 that by evaluating and weighing the evidence. There's no
8 way for you to weigh evidence in the literal sense. I'm,
9 certainly, not going to give you a set of scales to take
10 back there and conduct experiments. That's not what I'm
11 talking about, obviously. Instead, you weigh and evaluate
12 evidence by using your good common sense, your life
13 experiences, and your sense of logic and reason. And you
14 bring those things to bear on the evidence you've heard in
15 this trial.

16 I told you what evidence is, and in this case we've
17 had several forms. We've had witness testimony and we've
18 had exhibits. We've, also, had some stipulations. And
19 all three of those are sources of evidence that you would
20 use to determine what the facts are. Everything else is
21 not evidence.

22 As I told you at the outset, what the lawyers say,
23 though while extremely important, it is not in itself
24 evidence. So if your memory differs from the lawyers,
25 your memory controls. Anything I may have told you to

1 disregard or was taken out of the record is not evidence,
2 and you may not consider it in any way in determining the
3 facts of this case.

4 Now, I, also, told you that the Plaintiff has the
5 burden of proof. And I told you the burden of proving the
6 Plaintiff's case was the burden of proof called the
7 greater weight of the evidence.

8 And that means the Plaintiff must produce evidence,
9 which when considered in light of all the facts, leads you
10 to believe that what she is claiming is more likely true
11 than not true. To put it differently, if you were to put
12 the Plaintiff's and the Defendants evidence on opposite
13 sides of a set of scales, then the Plaintiff would have to
14 make the scales tip slightly on her side in order to
15 receive a verdict. That is, the greater weight of the
16 evidence must be on her side.

17 So after you weigh and evaluate the evidence, if the
18 greater weight is on the Plaintiff's side, the Plaintiff
19 would be entitled to a verdict. If, however, after you
20 weigh the evidence, you decide the scales tilt in the
21 Defendant's favor, the Plaintiff would not be entitled to
22 a verdict, but, rather, the Defendant would.

23 If after your weighing of the evidence, those scales
24 remain evenly balanced, then, again, your verdict would
25 have to be for the Defendant. Because then there would

1 not be a greater weight on either side, and the Plaintiff
2 would not have carried her burden of proof. So what you
3 do then is mentally weigh the evidence and mentally place
4 it on the scales, and see which side's evidence has the
5 greater weight in your mind.

6 Now, ladies and gentlemen, I told you about the
7 different sources of evidence. I'm, also, going to tell
8 you about different types of evidence. And what I'm
9 talking about now is direct evidence and circumstantial
10 evidence.

11 Direct evidence is the testimony of one who claims to
12 have direct and actual knowledge of a fact, such as an
13 eyewitness. It is evidence that, if believed, directly
14 proves a fact. Circumstantial evidence is indirect
15 evidence. It is proof of a chain of facts from which you
16 could find another fact exists, even though it has not
17 been proven to you directly.

18 Now, the law makes no distinction about the weight to
19 be given to either direct or circumstantial evidence. You
20 may consider them both. And there's not a greater degree
21 of certainty required of one over the other.

22 I told you, also, at the beginning that, as the
23 judges of the facts, you would have to, by necessity,
24 gauge and evaluate the credibility of all the evidence.
25 And I'm not going to go back over that with you now,

1 because I know you heard me the first time.

2 But I will tell you that you may believe everything a
3 witness says. You can believe nothing a witness says.
4 You can believe parts of their testimony, and disbelieve
5 other parts. You may believe one witness over several, or
6 several over one. But you, certainly, don't decide this
7 matter of credibility simple by counting the witnesses on
8 each side as to who produced the greater number of
9 witnesses. Instead, your job is to find the true facts of
10 this case. And it does not matter to you whether that
11 truth comes from a witness for the Plaintiff or the
12 Defense.

13 Now, you have heard deposition testimony. And I told
14 you, at one point, that a deposition is the sworn recorded
15 answers to questions asked of a witness before trial.
16 Sometimes, witnesses can't be here present in the
17 courtroom. But, under our rules of evidence, deposition
18 testimony is entitled to be considered just as if the
19 witness were sitting here on the stand with us in the
20 courtroom.

21 I, also, told you a little bit about taking notes,
22 and some of you have been taking notes. I just want to
23 remind you that your notes are not to be used to trump
24 someone else's independent memory. And they will be
25 collected and destroyed after the trial is over.

1 Now, ladies and gentlemen, this case involves
2 stipulations. One of which is as follows, if you find the
3 jury -- if you find that either Dr. Alt, or Dr. Merritt,
4 or both was negligent, you should find that Greenville
5 Hospital System was negligent. If you find that Dr. Twedt
6 was negligent, you should find that Greenville Hospital
7 System Partners in Health was negligent.

8 I'm, certainly, not suggesting to you what your
9 verdict should be. Again, I'm just reading in the
10 stipulation the parties have reached as to the
11 consequences of any verdict regarding the parties.

12 Since there are two parties in this case, and they
13 are Greenville Hospital System and Greenville Hospital
14 System Partners in Health, you should know that each party
15 in a lawsuit is entitled to separate and individual
16 consideration. And that is, your verdict on one should
17 not influence your verdict on the other. You're to weigh
18 and evaluate the evidence separately as to each Defendant.

19 I will tell you, furthermore, that businesses and
20 corporations are in the eyes of the law treated the same
21 way as individuals and are entitled to the same
22 consideration as an individual.

23 This is a medical malpractice case. So it is, of
24 course, essential for you to understand the law of medical
25 malpractice. And to recover on a claim for medical

1 malpractice, a plaintiff must prove four essential
2 elements by the greater weight of the evidence.

3 First, the Plaintiff must prove the standard of care.
4 Second, that there was a breach of that standard of care,
5 or a departure from the standard of care. Third, they
6 must prove proximate cause. And, fourth, they must prove
7 damages.

8 The accepted standard of care for a doctor is this,
9 the law requires that the doctor have and use that degree
10 of knowledge, care, and skill ordinarily used by doctors
11 in good standing acting under the same or similar
12 circumstances, and that the doctor follow the, generally,
13 accepted practices and procedures in the profession.

14 The degree of skill and care a doctor must use is
15 that which would be used by a competent doctor in his
16 field of medicine. A doctor must exercise reasonable care
17 and diligence in using his skill and in applying his
18 knowledge.

19 When a doctor treats a patient, the law does not
20 require absolute accuracy either in practice or decision
21 making. The law does not hold the doctor to a standard of
22 perfection, infallibility, or omniscience, nor does it
23 condemn a doctor because his efforts prove to be
24 unsuccessful. The law does not even require the highest
25 degree of care or skill for which the human mind is

1 capable. In deciding whether a physician has exercised
2 reasonable judgment, you must consider such judgment in
3 relation to the facts as they existed at the time, and not
4 in light of what hindsight may reveal.

5 You are not allowed to make up your own standard of
6 care in deciding whether the Defendant's learning skill
7 and conduct fulfilled the duties upon a physician. You
8 must use the standard of care that I have explained to
9 you.

10 The Plaintiff must next prove that the Defendant
11 negligently departed from the standard of care in treating
12 the patient. Negligence is the failure to do that which
13 an ordinary careful and prudent physician would do under
14 the circumstance shown by the evidence to have existed at
15 the time of the treatment in question, or is the doing of
16 that which an ordinary careful and prudent physician would
17 not have done under the same or similar circumstances.

18 A doctor's duty in treating a patient is being
19 measured both by the doctor's skill and his diligence. If
20 you find the Defendant did not possess the required skills
21 and because he did not possess the required skills, he
22 failed to properly treat the patient so the patient is
23 injured or damaged as a result, then the Defendant would
24 be responsible for any injury proximately caused to the
25 patient.

1 The physician would, also, be responsible for an
2 injury caused to the patient if having the required skill,
3 the physician negligently failed to use the skill, or was
4 not as careful in his treatment of a patient as he should
5 have been. A doctor does not guarantee a cure, or even a
6 positive result. Just because a treatment does not
7 benefit the patient or the treatment even harms the
8 patient does not in and of itself mean the Defendant was
9 negligent. A bad result, injury, or failure to cure is
10 not enough to show that the Defendant was negligent.

11 If you find that the Defendant physician used due
12 care and skill in treating the patient, and you find the
13 Defendant physician followed generally recognized
14 practices and procedures, and you find, despite this, the
15 patient suffered damages and injuries, then you should
16 return a verdict for the Defendant physician.

17 A doctor's mistake or error in judgment alone will
18 not support a verdict in a malpractice lawsuit. A doctor
19 cannot be held liable for a mere mistake in judgment
20 where, according to standard medical practice, the care
21 and treatment involved are matters to be subjected to the
22 judgment of the doctor. A doctor must be allowed to
23 exercise his judgment, but he must exercise his judgment
24 reasonably and not negligently.

25 If you find the physician fails to gather information

1 reasonably available to him which a reasonable physician
2 would have gathered before exercising his judgment and
3 thereby fails to comply with the recognized standard of
4 medical care which would be exercised by a similar doctor
5 under similar circumstances, then liability would attach
6 to the physician's mistake or error in judgment if it
7 proximately resulted in an injury to the patient.

8 A doctor would, also, be liable if having the
9 requisite skill he negligently fails to use it, or he's
10 not as careful and diligent in the treatment to an extent
11 that he should, which is to say as careful and diligent as
12 a physician of ordinary prudence would have been under the
13 same circumstances.

14 Furthermore, a patient who is treated by a doctor is
15 entitled to a careful evaluation, such as the condition of
16 the patient and attending to the circumstances required
17 with such diligence and methods of diagnosis for
18 discovering the nature of the ailment as are usually
19 approved and practiced by a physician of ordinary and
20 average learning, judgment, and skill acting under the
21 same or similar circumstances. An incorrect diagnosis
22 does not by itself constitute malpractice.

23 When a doctor undertakes to render medical services
24 for the protection of another, he must use due care to
25 avoid increasing risk of harm to the patient. A doctor

1 may be found to be negligent in making a diagnosis if in
2 making it, the doctor did not follow the standard of care
3 that a reasonable careful physician in the same field or
4 speciality would have followed under the same
5 circumstances.

6 However, a mere mistake in diagnosis is not negligent
7 or careless where the physician uses the proper degree of
8 care and skill. Liability is not imposed on a doctor or a
9 mistake in diagnosis or an error in judgment, except for
10 when that mistake results from a failure to comply with
11 the recognized standard of medical care exercised by
12 physicians in the same specialty under similar
13 circumstances.

14 A doctor does not guarantee the correctness or safety
15 of his treatment and ordinarily, he is not responsible for
16 any adverse consequences of treatment if he uses the
17 requisite degree of skill and care. Generally stated, a
18 doctor is not liable for an error or mistake in judgment
19 if he applies ordinary reasonable skill and care, keeps
20 within recognized and approved methods, and forms his or
21 her judgment after a careful and proper examination or
22 investigation in light of the knowledge possessed by the
23 medical professional at the time he renders the service.

24 A doctor is responsible for exercising due care
25 towards his patient. This responsibility includes the

1 determination of whether specific treatment is warranted
2 by the conditions as presented to the physician. If you
3 find by the greater weight of the evidence that the
4 physical conditions existing in the patient were such to
5 require a careful and prudent physician to make a further
6 investigation before continuing a course of treatment or
7 care, and if you find the Defendant did not make such
8 investigation, and you further find that as a direct and
9 proximate result of such failure the patient received
10 improper treatment or care from which she later suffered,
11 then you may consider the doctor negligent.

12 The difficulties and uncertainties in the practice of
13 medicine and the unpredictable variations in response to
14 treatment are such that no physician can guarantee
15 results. Qualified doctors and experts may differ as to
16 what constitutes the best course of treatment. And these
17 differences do not amount to malpractice.

18 Where there is more than one recognizable diagnosis
19 or treatment and not one of them was used exclusively and
20 uniformly by all doctors, it is not negligence for a
21 doctor if, in exercising his or her best judgment, he
22 selects one of the approved methods which later turns out
23 to be a wrong selection or one not favored by other
24 doctors.

25 Where doctors disagree or when authorities are

1 divided with regard to a specific course of treatment or
2 care, then the doctor is bound only to exercise his best
3 judgment in determining which course is on the whole the
4 best for the patient. In short, it is quite possible for
5 a doctor to be unsuccessful in his treatment or disagree
6 with others in his profession without his being negligent.

7 Now, as I said, negligence on the part of the doctor
8 is never presumed. It must be affirmatively proved by the
9 Plaintiff by the greater weight of the evidence. It will
10 be presumed in the absence of evidence to the contrary
11 that a doctor has fully discharged his or her duty to the
12 patient, including the exercise of reasonable care and
13 skill in his or her treatment.

14 It follows, therefore, that the only way you may
15 properly decide whether a doctor's conduct measures up to
16 the standard of care is through evidence presented in the
17 trial that is known as expert testimony. Expert testimony
18 is usually necessary to establish the generally recognized
19 and accepted practices and procedures which would be
20 followed by average competent practitioners in the
21 Defendant's field of medicine under the same or similar
22 circumstances.

23 Expert testimony is, also, required to establish that
24 the Defendant's departed from the recognized and generally
25 accepted standards, and to establish that the Defendant's

1 departure was a proximate cause of the Plaintiff's alleged
2 injuries and damages.

3 If the opinions of medical experts are relied upon to
4 establish the causal connection of negligence to an
5 injury, the expert must state with reasonable certainty
6 that in his or her professional opinion the injuries
7 complained of most probably resulted from the alleged
8 negligence of the doctor. The Plaintiff must establish by
9 expert testimony then both the standard of care and the
10 Defendant's departure from it.

11 A plaintiff in a medical malpractice case must prove
12 by the greater weight of the evidence that the Defendant's
13 negligence most probably resulted in the injuries alleged.
14 It is not necessary that the expert use the words most
15 probably. It's enough that if he says the expert's
16 professional opinion is that the Defendant's negligence
17 was most likely one, among the possible causes, of the
18 patient's injuries.

19 In resolving any conflict that may exist in the
20 testimony of expert witnesses, you should weigh the
21 opinion of one against that of the other. And you should
22 consider the relative qualifications of the expert
23 witnesses, as well as the reasons for their opinions, and
24 facts, and other matters upon which they were based.

25 Expert witnesses are to be viewed the same as you --

1 the same as you view other witnesses in this one important
2 respect, and that is that you are the sole judge of their
3 credibility. You're not required to accept their
4 testimony, and you may give it such weight as you think it
5 deserves. The fact that a witness is not a specialist in
6 a particular branch may be considered by you as to what
7 weight, force, and effect you may give the testimony.

8 And, ladies and gentlemen, unless circumstances would
9 put a reasonable person on notice otherwise, a person has
10 the right to assume that others will act with due care and
11 in accordance with the law. By taking a case, a
12 healthcare provider impliedly represents that he possesses
13 a reasonable degree of skill and training that is
14 ordinarily possessed by health care providers of the same
15 specialty.

16 Under the doctrine of informed consent, a physician
17 has a duty to disclose the diagnosis, the general nature
18 of the contemplated procedure, the material risks involved
19 in the procedure, the probability of success associated
20 with the procedure, the prognosis if the procedure is not
21 successfully carried out, and the existence of any
22 alternatives to the procedure. The scope of a physician's
23 duty to disclose is measured by those communications a
24 reasonable practitioner in the same branch of medicine
25 would make under the same or similar circumstances.

1 It is the duty of the doctor to inform the patient of
2 these matters. And the patient must have a true
3 understanding of the procedure and its seriousness. The
4 basis of the doctrine of informed consent is that the
5 patient's right to exercise control over his or her own
6 body by deciding intelligently for his or herself whether
7 to submit to a particular procedure.

8 Now, ladies and gentlemen, it is not necessary that a
9 plaintiff prove each act of negligence alleged. In order
10 to recover, a plaintiff must prove only one allegation by
11 the greater weight of the evidence.

12 The law does not require that for every injury there
13 must be a recovery of damages, but only imposes liability
14 for a breach of legal duty by a doctor that proximately
15 causes injury to the patient. If a defendant neglects a
16 duty that proximately causes injury to another, recovery
17 is warranted. In order for conduct to be actionable
18 negligence, the doctor must have foreseen or by the
19 exercise of ordinary care could or should have foreseen
20 the probability that his or her conduct would likely cause
21 injury to the patient.

22 Proving an alleged negligent treatment caused an
23 injury cannot be made by conjecture or speculation, that
24 is by guesswork. And the mere possibility of such
25 causation is not enough to sustain the burden of proof the

1 Plaintiff bears. Again, the Plaintiff must prove by the
2 greater weight of the evidence that the injury most
3 probably would not have occurred but for the negligence of
4 the doctor. Negligence may be deemed a proximate cause of
5 a patient's injury only when without that negligence, the
6 injury either would not have occurred or could have been
7 avoided.

8 A defendant's conduct is not a proximate cause of the
9 injury if the injury would have occurred without the
10 conduct. A mere possibility of causation is not enough.
11 And proximate cause is something that produces a natural
12 chain of events that, in the end, brings about the injury.
13 It is the direct cause of the injury.

14 To prove that a defendant's negligence proximately
15 caused the patient's injury, the Plaintiff must prove two
16 things. First, the Plaintiff must prove causation and
17 fact. And this is proven by showing the injury would not
18 have occurred but for the Defendants negligence.

19 Second, the Plaintiff must, also, prove legal cause.
20 And that is proven by showing the injury was foreseeable.
21 That means the injury occurred as a natural and probable
22 consequence of the Defendants negligence. The Plaintiff
23 must prove that some injury from the Defendants
24 negligence was foreseeable. But the Plaintiff, however,
25 does not have to prove that the specific injury that

1 occurred was foreseeable.

2 The law does not hold anyone responsible for
3 something that could not be expected to happen. However,
4 if an injury occurred that could have been foreseen as a
5 natural and probable consequence of the Defendant's
6 negligence, the law would hold the Defendant liable.

7 And, finally, proximate cause does not mean the only
8 cause. A defendant's act can be a probable cause of the
9 Plaintiff's injury if it was, at least, one of the direct
10 concurring causes of the injury.

11 Now, if you find that the Plaintiff has proven that
12 one or all of the Defendants were negligent, and that that
13 negligence proximately caused the injury to the patient,
14 you would next consider whether he or she has proven what
15 those damages or injuries amount to. That is, you must
16 decide how much money you should award to the Plaintiff.

17 These are called actual damages or sometimes called
18 compensatory damages. Because they're designed to
19 compensate an injured party and make that person whole and
20 to put him in the same position he was in before the
21 accident and the injuries in so far as that is possible.
22 If one is injured by the negligence of another, the
23 injured person is entitled to be fully compensated for all
24 injuries that directly and proximately resulted by the
25 negligent acts or omissions by a defendant.

1 Now, actual damages for someone who has been
2 physically injured include pain and suffering, both past,
3 present, and future, as well as mental anguish, impairment
4 of health, physical condition, and disfigurement. The
5 Plaintiff may, also, claim lost wages and reduced earning
6 ability for the future.

7 If you find the Plaintiff is entitled to a verdict
8 for actual damages, your verdict should include an amount
9 that covers any past, present, and future damages
10 proximately caused by the Defendant. Any future damages
11 must be reasonably certain to occur in the future as a
12 result of the Defendant's acts.

13 Now, actual damages need not be proven to a
14 mathematical certainty, or be based on evidence of the
15 precise amount of damages the Plaintiff has suffered.
16 Instead, the evidence must allow you to determine what
17 amount is just, fair, and reasonable. Any future damages
18 must be reasonably calculated to have resulted from the
19 alleged injury or damage sustained in this case. And
20 future damages must be reduced to their present cash
21 value.

22 The general rule in a personal injury case is that a
23 plaintiff may recover for the necessary and reasonable
24 expenses caused by the injury, such as amounts necessarily
25 incurred from medicine, medical services, hospital expense

1 and care, and nursing. A plaintiff may recover amounts
2 incurred for medical care including hospital, physician,
3 and nursing care costs, medicine, and other out-of-pocket
4 anticipated expenses such as vocational, physical, and
5 other rehabilitation efforts.

6 Recovery for these services and expenses is
7 controlled by what the services were reasonably worth and
8 not by what was, actually, paid or contracted to be paid.
9 And the Plaintiff bears the burden of proving that the
10 expenses are necessary and reasonable.

11 A minor may not recover past medical expenses in her
12 own personal injury action, nor may she recover future
13 medical expenses to be incurred before the age of
14 majority.

15 Pain and suffering compensates a plaintiff for
16 physical discomfort and emotional response to the
17 sensation of pain caused by the injury itself. Mental
18 suffering, apprehension, shock, fright, emotional upset,
19 humiliation, and anxiety either present or expected in the
20 future can be properly considered as an element of
21 damages. Mental suffering covers not only the pain
22 associated with the injury, but, also, the mental reaction
23 to that pain and possible consequences of the injury.

24 Loss of enjoyment of life is an appropriate area of
25 recovery in certain cases. And loss of capacity to joy

1 life resulting from personal injury is a proper element of
2 damages.

3 If you find evidence of loss of enjoyment of life,
4 you may award damages for this loss. Damages for this
5 type of loss of enjoyment of life compensates one for the
6 limitations resulting from the Defendant's negligence on
7 the injured person's ability to participate in and derive
8 pleasure from the normal activities of daily life, or for
9 the individual's inability to pursue his talents,
10 recreational interest, hobbies, and advocations. These
11 type of damages compensate a plaintiff not only for the
12 subjective knowledge that one can no longer enjoy all of
13 life's pursuits, but, also, for the objective loss of the
14 ability to engage in them.

15 Now, these elements I've gone over with you, pain and
16 suffering, mental anguish, and loss of enjoyment of life,
17 they don't have price tags attached to them. There's no
18 store you can go to buy them, of course. And they are not
19 capable of exact measurement. And there's no yardstick or
20 precise standard I can furnish you to measure them with.

21 Therefore, the damages to be awarded by you for these
22 types of losses is left to your judgment. And you must
23 apply the cardinal rule that says the compensation must be
24 equal to the loss or the injury. And you must decide what
25 amount is just and reasonable, according to your view of

1 the evidence, should you decide the Plaintiff has proven
2 entitlement to receive damages.

3 The loss or impairment of earning capacity resulting
4 from injuries is a proper element of damages you should
5 consider if you decide to award these types of damages for
6 loss of earnings capacity, the loss of future earning
7 power. And this requires you to consider all matters
8 relating to the issue of any impairment, the affect the
9 impairment will have on the Plaintiff's capacity to work,
10 the extent to which the impairment will impair the earning
11 capacity, the present value of all losses due to the
12 Plaintiff's impaired earning power, and the physical pain
13 and suffering as reasonably certain to occur.

14 Now, if you find the Plaintiff was permanently
15 injured as a result of the Defendant's actions, you must
16 decide how, if at all, that will affect the rest of her
17 life. And a person's life expectancy is determined by a
18 life expectancy table that our legislature has adopted and
19 passed as the law. And it is part of the law of this
20 state. And the life expectancy table is simply an
21 estimate of the probable average remaining length of the
22 life of someone in our state at a given age.

23 This table reflects that **J.B.** has a life
24 expectancy of 80.84 years. And this may be considered by
25 you, along with all the other evidence, in deciding the

1 amount of damages to be awarded to the Plaintiff if you
2 decide she has proven them by the greater weight of the
3 evidence.

4 Now, ladies and gentlemen, the Plaintiff bears the
5 burden of proving by the greater weight of the evidence
6 that she is entitled to damages. And the existence, the
7 causation, or the amount of damages cannot be left to
8 guesswork or speculation. You, the jury, must determine
9 what amount is fair, just, and reasonable. And the
10 Plaintiff is required to prove damages to a reasonable
11 degree of certainty to allow you to do that.

12 Now, I believe that covers all of the substantive law
13 in this case. So let me just go over with you a little
14 bit about your deliberations. You were chosen to be
15 jurors in this case, not to be partisans or advocates
16 either for the Plaintiff or the Defense. You were chosen
17 because both sides believed you could be fair and
18 impartial. And that means you are to put aside any biases
19 or prejudices you may have, or any preconceived notions.

20 And you must decide this case fairly, and
21 impartially, and solely on the evidence. And that means
22 you use your experiences in life, and your good common
23 sense, and your sound judgment. And you bring those
24 things to bear on the evidence. And then you take the law
25 I've just given to you and you apply it to the facts you

1 find from the evidence. And once you've done that, you'll
2 be able to reach a decision and verdict in this case.

3 So, remember, you are judges, judges of the facts.
4 And your sole interest is to determine the true facts of
5 the case and determine whether the Plaintiff has met her
6 burden of proof. And you'll recall that I told you that
7 at the very beginning of the trial when I first spoke to
8 you as a group.

9 If you looked up the word deliberation in the
10 dictionary, you would see it is defined as a weighing up
11 with a view to a decision. I've already talked to you
12 about this idea of weighing and evaluating the evidence.

13 If you went to the same dictionary and looked up the
14 word jury, you would see it is defined as a group of
15 people sworn to render a true answer. So that is your
16 task.

17 And I want to tell you that the genius of our jury
18 system is it allows 12 people from different walks of
19 life, and backgrounds, and perspectives to come together,
20 discuss the evidence they've heard, consider each others
21 points and point of views, and, ultimately, reach a
22 verdict.

23 Thomas Jefferson said that the right to a jury trial
24 was probably the most important right of all, because in
25 the end, all of our other rights depend upon it. But the

1 collective wisdom of a group is something we, obviously,
2 revere in this country. And you've made it possible for
3 these parties to have their guarantee of a right to a jury
4 trial a reality.

5 Now, you are keenly aware this has been a long trial,
6 by South Carolina standards, at least. And I want to
7 thank you again for your patience.

8 And, Mr. Foreman, you're only authorized to sign the
9 verdict when the verdict is unanimous.

10 You each have a vote. And your vote is exactly that,
11 it's your vote and nobody else's. This is a very
12 important case for both sides. And if after your
13 discussion of the evidence you -- if there is a differing
14 mindset -- and I, certainly, don't know. But I have to
15 tell every jury the following things, if after your
16 discussion of the evidence you believe that you should
17 change your mind from that of other jurors, don't hesitate
18 to do so. But don't surrender an honestly and
19 conscientiously held belief simply to get this case over
20 with or to reach a unanimous verdict. The parties are
21 entitled to your fair, careful, and impartial
22 consideration.

23 Now, if you need to communicate with me, Mr. Foreman,
24 as I told you before, I can only do so by way of a note or
25 out here on the record.

1 If -- and, again, I tell this to every jury, so don't
2 read anything into it. But if there is some type of
3 division on the jury, please, don't tell me the numerical
4 division, or anything of that nature. I don't want to
5 know. But, hopefully, you won't need to communicate with
6 me, except to tell us you have a verdict. And you can now
7 go back to the jury room, except for the alternates.

8 I'll talk to y'all separately.

9 But, for the rest of you, don't start talking about
10 the case. And I know you're tired of me telling you that.
11 But when you get the exhibits, that will be your signal
12 that you can start deliberating.

13 Because, believe it or not, for as long as I've been
14 talking, I may have left something out. And they'll tell
15 me. But just go back to the jury room. And when you get
16 the exhibits, you may start deliberating.

17 Thank you again for your patience.

18 (WHEREUPON, the jury was excused from open court at
19 approximately 3:41 p.m.)

20 THE COURT: Okay. Unfortunately, the law doesn't
21 allow you to go back in the jury room at this stage. So
22 I'm going to go ahead and dismiss y'all. If you need
23 something for your work, they've got it downstairs in the
24 jury assembly room.

25 And thank you very much for your extended service.

1 You have earned a three-year exemption from circuit court
2 jury duty. And I hope it's been an enjoyable experience
3 to you to the extent it can. And you have our gratitude
4 and appreciation.

5 Thank you again.

6 (WHEREUPON, the alternate jurors exited the
7 courtroom.)

8 THE COURT: Any objection or exception to the charge?

9 MR. GRAHAM: Your Honor, I heard you say something
10 about possible causes that gave me some heart
11 palpitations. And I'm not sure exactly what you said in
12 context.

13 But since we had all the discussion earlier about
14 most probable cause being the standard, I was concerned
15 that you might have said they could consider possible
16 causes. But I'm not certain exactly what you said in that
17 regard and --

18 THE COURT: I don't know what you're talking about.
19 But I gave that jury charge to y'all days ago. Nobody
20 said anything about any problem with it before. I read it
21 to the jury.

22 Anything else?

23 MR. ALEXANDER: No, sir.

24 THE COURT: Okay. We'll be at ease.

25 Just make sure all the -- why don't we go ahead, for

1 the record, and confirm the exhibits and what each one is
2 if y'all have the energy to do that right now.

3 (Pause.)

4 THE COURT: Have you got all the exhibits?

5 MS. RODRIGUEZ: Yes.

6 THE COURT: Y'all can go ahead and take that back.

7 We'll let you know when we hear something.

8 Thank you.

9 (WHEREUPON, the proceedings were recessed at
10 approximately 3:45 p.m.)

11 QUESTION FROM THE JURY

12 THE COURT: We have a note from the jury. It will be
13 made part of the record.

14 It states, "Can we get a copy of the Judge's order to
15 the jury, what was read before deliberation?" It's signed
16 by the Foreperson.

17 My inclination would be to send it back, this note
18 that is, asking them what, specifically, they wanted to
19 hear. But I'm open for suggestions.

20 MR. GRAHAM: I agree with your suggestion, Your
21 Honor.

22 MR. ALEXANDER: It just says --

23 THE COURT: You can -- do you want to see it?

24 I mean, there have been cases recently about sending
25 back the written charge. There's some dispute about -- I

1 think there was, actually, a dissent in a case about not
2 sending back the whole charge. And I think we need to
3 know exactly what they're interested in seeing, though.

4 I can say, Do you want the whole charge or just
5 specific parts? Or I can say, What part do you want? If
6 they come back and say we want the part that deals with
7 proximate, for example, I don't know if one side or the
8 other is going to want me to send back the whole rest of
9 the charge. Those are just some of the issues I think
10 that arise from a note like this.

11 MR. GRAHAM: Your Honor, I like your original idea of
12 just finding out what it is that they feel like they need
13 more information about, or repeat information about.

14 THE COURT: Okay.

15 MR. GRAHAM: And then, just depending on what they
16 say, we can figure out how narrowly or broadly to proceed
17 with recharging them.

18 MR. ALEXANDER: I agree with that.

19 THE COURT: Okay. We'll just mark this and take it
20 back.

21 (WHEREUPON, Court's Exhibit No. 12 was marked for
22 identification and admitted into evidence.)

23 THE COURT: All right. So we'll be off the record
24 until they come back.

25 (WHEREUPON, a break was taken.)

1 THE COURT: Do you want to come look at this one?

2 MS. RODRIGUEZ: Does that mean they want to be
3 recharged on negligence?

4 MR. ALEXANDER: Part of Your Honor's charge covers
5 the --

6 THE COURT: Do y'all want this on the record?

7 MR. ALEXANDER: Sure.

8 I'm just trying to recall your charge, whether your
9 charge covers that the fact that an injury is not
10 negligence.

11 THE COURT: It does say that.

12 MR. ALEXANDER: And I think that's what they're
13 attempting to address.

14 THE COURT: I can -- I mean, we can ask them.
15 There's two ways to do it, in my view. We can write them
16 back and say, Do you want the entire negligence charge, or
17 just the part that -- I don't know how to isolate it
18 without -- a second way is to bring the Foreperson out,
19 which is risky, but just asking him, basically, the same
20 question. But that's probably a little less controllable,
21 but it's more interactive.

22 MR. ALEXANDER: My preference would be to address the
23 question that was posed, which was whether the injury
24 itself is evidence of negligence.

25 MR. GRAHAM: Well, what it says is injury in itself

1 speaks to negligence.

2 THE COURT: Right.

3 MR. GRAHAM: So I'm not sure what that means.

4 MS. RODRIGUEZ: Without looking at the charge --
5 where it came from in the charge --

6 THE COURT: Let me see if I can find that portion of
7 it.

8 (Pause.)

9 THE COURT: I said at one point, Just because a
10 treatment does not benefit the patient or the treatment
11 even harms the patient does not in and of itself mean the
12 Defendant was negligent. A bad result, injury, or failure
13 to care is not by itself and does not show that the
14 Defendant was negligent. If you find that use -- and I'm
15 paraphrasing -- if you find due care was used -- if you
16 find the doctor used due care and skill in treatment and
17 followed generally recognized practices, and you find
18 despite this, the patient suffered damages and injuries,
19 then you should return a verdict for the Defendant. Also,
20 a doctor's mistake or error in judgment alone would not
21 support a verdict in a medical malpractice suit.
22 Incorrect medical diagnosis does not in and of itself
23 constitute malpractice.

24 MR. ALEXANDER: I do think Page 6 in your charge
25 addresses the question that they have raised.

1 THE COURT: And you never know what's driving this.
2 It may be just one juror wants to see this, or maybe all
3 of them do. I've, certainly, had them ask for a
4 particular point and before I can give it to them, they've
5 got a verdict that is counterintuitive to their notes.

6 We could send them -- this is just an idea. But we
7 could send them, basically, either that Page 6, or I could
8 send them all -- Pages 1 through 16, which pretty much
9 covers the standard of care and duty and breach before it
10 gets to proximate cause.

11 MR. GRAHAM: Your Honor, our preference would be that
12 you recharge them, as opposed to sending it back. And
13 that you do the entire standard of care section -- or
14 standard of care and breach section, and not isolate it to
15 just the pro-Defense language on Page 6.

16 THE COURT: I'm happy to do that, too. Frankly, it
17 might be easier. I don't -- I mean, this charge is all
18 marked up.

19 MR. GRAHAM: That was part of my concern, Your Honor.
20 We really have to --

21 THE COURT: You were concerned about me, Mr. Graham?

22 MR. GRAHAM: Yes, Your Honor.

23 THE COURT: No. I'm --

24 MR. GRAHAM: I mean, I'm concerned that you don't
25 have a clerk. We'd have to get a clean copy typed. It

1 just seems like it would be more expedient to recharge on
2 that point.

3 THE COURT: Normally, I prefer sending back the
4 written charge. Because, you know, we ask these jurors to
5 perform all of these intellectual tasks and then tell them
6 they can't have their written charges. I think it may
7 help.

8 But, in this particular case, given the fact that the
9 charge that I gave y'all has been substantially revised by
10 hand, and there were portions just taken out that I didn't
11 read to the jury, and portions added by the time we did
12 all that -- I suppose after I charge them if they still
13 want a copy of it in writing, we can revisit it. But that
14 would be my preference.

15 Now, what do you say, Mr. Alexander?

16 MR. ALEXANDER: I think I'm okay with that, Judge.

17 THE COURT: Okay. Just bring them on out.

18 MR. GRAHAM: Your Honor, there are some charges on
19 Page 4 that it looks like you may have taken out.

20 THE COURT: Right.

21 MR. GRAHAM: That looks like it might balance out
22 some of the other parts of your charge, if you would put
23 them back in.

24 MR. ALEXANDER: We would prefer what's already been
25 charged.

1 THE COURT: I don't know exactly -- are you talking
2 about a defendant physician is negligent if he fails to do
3 what an ordinary care provider would have done?

4 MR. GRAHAM: Yes, sir.

5 THE COURT: I mean, I already tell them that, at
6 least, twice.

7 MR. GRAHAM: Oh, okay.

8 And then the one about a defendant physician is
9 negligent at the bottom of the page.

10 THE COURT: Same thing. It was just repetitive.

11 MR. GRAHAM: I was just concerned because the
12 pro-Defense parts were repeated so many times. That's
13 what bothered me.

14 THE COURT: Well, I mean, you can say that in the
15 abstract. But I don't know of a concrete example you
16 could use to show that there are more pro-Defense remarks
17 in this charge than there are pro-Plaintiff remarks.

18 MR. GRAHAM: Your Honor, I haven't counted them. I
19 guess I'm hypersensitive.

20 THE COURT: Sure. But I spent a lot of time making
21 this balance over the years. And I don't -- if you point
22 me to some particular slant or emphasis you think it has,
23 I'll, certainly, be happy to consider and respect your
24 views.

25 MR. GRAHAM: Yes.

1 The single biggest concern I have, Your Honor, is
2 when you get into some of these statements, a pro-Defense
3 statement about judgment, mere mistake, mere injury is not
4 grounds for liability, if you could just add, unless there
5 is a breach in the standard of care, that would satisfy
6 us. It's when you get away from the standard of care
7 pro-Defense charges.

8 I think a lot of juries that I've talked to in the
9 past get confused about that. And they think that if
10 there's -- if there's certain circumstances here, they
11 don't even have to think about the breach of the standard
12 of care anymore. And that's what concerns me just -- just
13 any pro-Defense charges be tied to as long as there's not
14 a breach in the standard of care.

15 THE COURT: Well, your objection is noted.

16 Thank you.

17 (WHEREUPON, the jury came into open court at
18 approximately 5:22 p.m.)

19 THE COURT: All right. Ladies and gentlemen, I
20 received your note. And I'm just going to have to
21 instruct you again on the standard of proof for medical
22 malpractice.

23 And to recover on a claim for medical malpractice, a
24 plaintiff must prove four essential elements by the
25 greater weight of the evidence. The four elements are the

1 standard of care, a breach or departure from the standard
2 of care, proximate cause, and damages.

3 The law requires that the doctor have and use that
4 degree of knowledge, care, and skill ordinarily used by
5 doctors in good standing acting under the same or similar
6 circumstances. And that the doctor follow the generally
7 accepted practices and procedures in the profession.

8 The degree of skill and care a doctor must use is
9 that which would be used by a competent doctor in his
10 field of medicine. A doctor must use -- must exercise
11 reasonable care and diligence in using his or her skill
12 when applying his or her knowledge. When a doctor treats
13 a patient, the law does not require absolute accuracy
14 either in practice or in decision making.

15 The law does not hold the doctor to a standard of
16 perfection, infallibility, or omniscience, nor does it
17 condemn a doctor because its efforts prove to be
18 unsuccessful. The law does not even require the highest
19 degree of care and skill of which the human mind is
20 capable.

21 In deciding whether a doctor has exercised reasonable
22 judgment in a given case, you must consider such judgment
23 that existed at the time and not in light of what
24 hindsight may reveal. You're not allowed to make up your
25 own standard of care in deciding whether the Defendants

1 learning skill and conduct fulfilled the duties imposed on
2 a doctor. You must use the standard of care that I have
3 explained.

4 The Plaintiff must next prove that the Defendant
5 negligently departed from the standard of care in treating
6 the patient. Negligence is the failure to do that which
7 an ordinary, careful, and prudent doctor would do under
8 the circumstances shown to have existed at the time of the
9 treatment, or it is the doing of that which an ordinary,
10 careful, prudent physician would not have done under the
11 same or similar circumstances.

12 A doctor's duty in treating a patient is to be
13 measured by the doctor's skill and his diligence. If you
14 find the Defendant doctor did not possess the required
15 skills and because he did not possess those skills, he or
16 she failed to properly treat the patient so the patient is
17 injured as a proximate result, then the Defendant would be
18 responsible.

19 The Defendant physician would, also, be responsible
20 for any -- for an injury caused to the patient if having
21 the required skill, the doctor negligently failed to use
22 his skill or was not as careful in his treatment as he
23 should be. A doctor does not guarantee a cure, or even a
24 positive result.

25 Just because a treatment does not benefit the patient

1 or the treatment even harms the patient does not in and of
2 itself mean that the Defendant was negligent. A bad
3 result injury or failure to cure is not by itself enough
4 to show that the Defendant was negligent.

5 If you find the doctor used due care and skill in
6 treating the patient, and if you find the doctor followed
7 generally recognized practices and procedures, and you
8 find despite this that the patient suffered damages and
9 injuries, then you should return a verdict for the doctor.

10 Also, a doctor's mistake or error in judgment alone
11 would not support a verdict in a malpractice suit. A
12 doctor cannot be held liable for a mere mistaken in
13 judgment where, according to standard medical practice,
14 the care and treatment involved are matters to be
15 subjected to the judgment of the physician. A physician
16 must be allowed to exercise his judgment. But he must
17 exercise his or her judgment reasonably and not
18 negligently.

19 However, if you find the doctor fails to gather
20 information that is reasonably available to him which a
21 reasonable doctor would gather before exercising his
22 judgment and, thereby, fails to comply with the recognized
23 standard of medical care which would be exercised by a
24 similar physician under similar circumstances, then
25 liability would attach to the doctor's mistake or error in

1 judgment if it proximately results in injury to the
2 patient.

3 A doctor would, also, be liable if having the
4 requisite skill he negligently failed to use it, or is not
5 as careful and diligent in the treatment to an extent that
6 he should be, which is to say as careful and diligent as a
7 physician of ordinary prudence would have been under the
8 same circumstances.

9 A patient who is treated by a doctor is entitled to
10 careful evaluations such as the condition of the patient
11 and attending circumstances require with such diligence
12 and methods of diagnosis for discovering the nature of the
13 ailment as are usually approved and practiced by a doctor
14 of ordinary and average learning, judgment, and skill
15 acting under the same or similar circumstances.

16 An incorrect medical diagnosis does not by itself
17 constitute malpractice. When a physician undertakes to
18 render medical services for the protection of another, he
19 must use due care to avoid increasing risk of harm to the
20 patient. A doctor may be found negligent in making a
21 diagnosis if in making it he or she did not follow the
22 standard of care that a reasonably careful physician in
23 the same field or speciality would have followed in the
24 same or similar circumstances.

25 However, a mere mistake in diagnosis is not negligent

1 or careless where the physician uses the proper degree of
2 care and skill. Liability is not imposed on a doctor for
3 a mistake in diagnosis or an error in judgment, except
4 where that mistake results from a failure to comply with
5 the recognized standard of medical care exercised by
6 physicians in the same specialty under similar
7 circumstances.

8 Ordinarily, a doctor is not responsible for any
9 adverse consequences of treatment if he uses the requisite
10 degree of skill and care. A doctor is not liable for an
11 error or mistake in judgment if he applies ordinary
12 reasonable skill and care, keeping within recognized and
13 approved methods, and forms his or her judgment after a
14 careful and proper examination and investigation in light
15 of the knowledge possessed by the medical profession at
16 the time he renders the service.

17 A doctor is responsible for exercising due care
18 towards his patient. And this responsibility includes the
19 determination of whether specific treatment is warranted
20 by the conditions as presented to the doctor. If you find
21 from the greater weight of the evidence that the physical
22 conditions existing in the patient were such as to require
23 a careful and prudent doctor to make a further
24 investigation before continuing treatment or care, and if
25 you find from the evidence that the Defendant did not make

1 such a investigation, and if you find further that as a
2 direct and proximate result of such failure, if any, the
3 patient received improper treatment or care from which he
4 later suffered, then you may consider the Defendant
5 negligent.

6 The difficulties and uncertainties in the practice of
7 medicine and the unpredictable variations and responsive
8 treatment are such that no doctor can guarantee results.
9 Qualified doctors and experts may differ as to what
10 constitutes the best course of treatment. And these
11 differences do not amount to malpractice.

12 When there is more than one recognizable diagnoses or
13 treatment and not one of them is used exclusively and
14 uniformly by all practitioners, it is not negligence if a
15 doctor -- if in exercising his best judgment, he selects
16 one of the approved methods which later turns out to be a
17 wrong selection, or one not favored by other doctors.

18 Where doctors disagree or when authorities are
19 divided with regard to a specific course of treatment and
20 care, then the doctor is bound only to exercise his best
21 judgment in determining which course on the whole is best
22 for the patient. In short, it's quite possible for a
23 doctor to be unsuccessful in his treatment or disagree
24 with others in his profession without it being negligence.

25 Negligence on the part of a doctor is not presumed,

1 but must be affirmatively proved. And the burden of proof
2 is on the Plaintiff to prove her case by the greater
3 weight of the evidence. In the absence of evidence to the
4 contrary, it will be presumed that a physician has fully
5 discharged his duty to the patient including the exercise
6 of reasonable care and skill in his or her treatment.

7 It follows, therefore, that the only way you may
8 properly determine whether the Defendant's conduct
9 measures up to that standard is through expert testimony
10 to establish the generally recognized and accepted
11 practices and procedures that would be followed by average
12 competent practitioners in the Defendant's field of
13 medicine under the same or similar circumstances to
14 establish a departure from the recognized and generally
15 accepted standards, and to establish the departure was a
16 proximate cause of the Plaintiff's alleged injuries and
17 damages.

18 If the opinions of medical experts are relied upon to
19 establish the cause of an injury, the expert must state
20 with reasonable certainty that in his or her professional
21 opinion the injuries complained of most probably resulted
22 from the alleged negligence of the Defendant. A plaintiff
23 in a medical malpractice action must establish by expert
24 testimony both the required standard of care and the
25 Defendant's failure to conform to that standard. And a

1 medical malpractice plaintiff who relies upon expert
2 testimony must prove by the greater weight of the evidence
3 that the Defendant's negligence most probably resulted in
4 the injuries alleged.

5 It's not necessary that the expert use the phrase
6 most probably or those magic words. It's enough for the
7 expert to state that it is his professional opinion that
8 the Defendant's negligence was most likely one among the
9 possible causes of the patient's injuries.

10 Unless circumstances would put a reasonable person on
11 notice otherwise, a person has the right to assume that
12 others will act with due care and in accordance with the
13 law. By taking a case, a healthcare provider impliedly
14 represents that he possesses a reasonable degree of skill
15 and training that is ordinarily possessed by healthcare
16 providers of the same specialty.

17 It is not necessary that a plaintiff prove each act
18 of negligence that they have alleged. In order to
19 recover, the Plaintiff must only prove one allegation of
20 negligence. However, he must prove, at least, one by the
21 greater weight of the evidence in order to prevail.

22 Now, you are not allowed to arbitrarily set up your
23 own standard of care in deciding whether a defendant's
24 learning, skill, or judgment in conduct fulfilled the
25 duties imposed upon a doctor by the law. The standard is

1 the one I have charged you, did the doctor exercise that
2 degree of knowledge, care, judgment, and skill possessed
3 by members of his profession similarly situated under the
4 same or similar circumstances.

5 The law does not require that for every injury there
6 may be a recovery of damages, but only imposes liability
7 for a breach of legal duty by a doctor proximately causing
8 injury to the patient. If the Defendant neglects a duty
9 that proximately causes injury to another, then recovery
10 is warranted. For conduct to amount to negligence, the
11 doctor must have foreseen or by the exercise of ordinary
12 care could or should have foreseen the probability that
13 his conduct would likely cause injury to the patient.

14 All right. That covers, I think, the portion that
15 included the part y'all have written me about, and that
16 you've been recharged on. So I'll just ask you to go
17 return to your deliberations.

18 Thank you.

19 (WHEREUPON, the jury was excused from open court at
20 approximately 5:34 p.m.)

21 THE COURT: Any objection or exception to that?

22 MR. GRAHAM: No, Your Honor.

23 MR. ALEXANDER: No, sir.

24 THE COURT: All right. Let's see what they do in the
25 next 30 minutes or so. Then we might want to talk about

1 seeing if they want to come back in the morning. But
2 y'all can be deliberating yourselves about that.

3 Thank you.

4 (WHEREUPON, the proceeding were recessed at
5 approximately 5:35 p.m.)

6 (WHEREUPON, Court's Exhibit No. 13 was marked for
7 identification and admitted into evidence.)

8 THE COURT: Okay. They said, "We don't think we can
9 reach a verdict tonight and want to return in the
10 morning."

11 MR. GRAHAM: Okay.

12 THE COURT: So we'll bring them out.

13 (WHEREUPON, the jury came into open court at
14 approximately 6:35 p.m.)

15 THE COURT: Okay. Mr. Foreman -- Mr. Ross, we
16 received your latest note.

17 Do y'all want to come back at 9:00 or 9:30?

18 JUROR #108, SAMUEL ROSS: 9:00 is good.

19 THE COURT: All right. So just come back in the
20 morning.

21 Let me just again admonish you not to do any kind of
22 outside investigation. Don't get on social media or
23 anything -- you wouldn't -- you'd be astonished at the
24 number of trials that have been irreversibly mistried
25 because somebody got on social media and said I'm on the

1 jury of such and such case. And it would be easy for me
2 to just stop right there and say don't do this kind of
3 stuff, but let me tell you why it's important.

4 If you did some kind of outside investigation, you
5 might run across some kind of information that's
6 incomplete, or biased, or has some agenda behind it, or
7 might not be relevant to this case for sound reasons. And
8 our trial system relies on the adversarial system where
9 the parties present the evidence to the jury, and the jury
10 makes its decision on that evidence alone and no other
11 influence.

12 And that system has been around for a long time. And
13 it's the envy of the world. And it, certainly, was around
14 before the Internet was even heard of. So it would not be
15 in keeping with your oath to do any kind of outside
16 investigation.

17 So I thank you for adhering to that.

18 And I appreciate your diligence in this case.

19 And we'll see you back in the morning at 9:00.

20 Thank you.

21 JUROR #108, SAMUEL ROSS: Judge, what do I do with
22 this?

23 THE COURT: They'll just keep it back in the jury
24 room.

25 THE BAILIFF: We'll bring it all back out here.

1 THE COURT: They'll take the exhibits up.
2 (WHEREUPON, the jury was excused from open court at
3 approximately 6:37 p.m.)
4 THE COURT: Any objection or exception to that
5 charge?
6 MR. ALEXANDER: No, sir.
7 MR. GRAHAM: No, Your Honor.
8 THE COURT: All right. See you back in the morning.
9 (WHEREUPON, Court's Exhibit No. 14 was marked for
10 identification and admitted into evidence.)
11 (WHEREUPON, the proceedings were concluded at
12 approximately 6:38 p.m., to be reconvened on
13 Tuesday, November 5, 2013.)
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1 TUESDAY, NOVEMBER 5, 2013

2 (WHEREUPON, the jury resumed deliberations at
3 approximately 9:00 a.m.)

4 NOTE FROM THE JURY

5 THE COURT: We have another note, which will be made
6 a Court's Exhibit. It says, "We would like a dictionary,
7 please."

8 Obviously, based on State v. Harris and plenty of
9 other cases, they're not authorized to have a dictionary.

10 So my suggestion is just to respond to them and say
11 we can't -- I cannot furnish you a dictionary.

12 MR. ALEXANDER: I'm okay with that.

13 THE COURT: Do you have any other suggestions?

14 MR. GRAHAM: No, Your Honor.

15 I assume that was the entirety of their question.
16 They didn't say the word they wanted to find, did they?

17 THE COURT: No, sir.

18 I'll let y'all look at this and see if it's okay.

19 (Pause.)

20 THE COURT: All right. If you'll mark that and send
21 it back.

22 (WHEREUPON, Court's Exhibit No. 15 was marked for
23 identification and admitted into evidence.)

24 THE COURT: We could ask them if they want lunch.

25 Let me add that to the note.

1 (Pause.)

2 THE COURT: All right. Thank you, Ms. Fryer.

3 THE BAILIFF: Yes, sir.

4 THE COURT: We'll see what they say about lunch, and
5 maybe get a quick answer back.

6 (WHEREUPON, a break was taken.)

7 THE COURT: Yes, ma'am.

8 THE BAILIFF: Yes. They would like lunch.

9 THE COURT: All right. Well, we'll get them menus.
10 And I would think that that means we can all go to lunch,
11 too. Y'all just leave your cell numbers. It takes about
12 an hour for the lunch to get here.

13 (WHEREUPON, the proceedings were recessed at
14 approximately 11:46 a.m.)

15 THE COURT: I understand we now have a verdict.
16 Anything before we bring the jury in?

17 MR. GRAHAM: No, Your Honor.

18 MR. ALEXANDER: No, sir.

19 THE COURT: I appreciate the fine advocacy on both
20 sides.

21 This goes without saying, but, of course, we're not
22 going to have anyone reacting to the verdict. If you
23 don't think you can maintain decorum, now is the time to
24 leave.

25 Bring the jury in.

1 Thank you.

2 (WHEREUPON, the jury came into open court at
3 approximately 1:37 p.m.)

4 THE COURT: Mr. Foreman, has the jury reached a
5 unanimous verdict, sir?

6 JUROR #108, SAMUEL ROSS: We have.

7 THE COURT: If you'll hand it to the bailiff, we'll
8 receive it and publish it.

9 JUROR #108, SAMUEL ROSS: Okay.

10 THE COURT: Yes, ma'am, Ms. White.

11 VERDICT

12 THE CLERK: Your Honor, this is case number
13 2011-CP-23-06665, Demetria Orange as Next Friend of
14 J.B. a Minor v. Greenville Hospital
15 System and Greenville Hospital System Partners in Health.

16 Do you find by the greater weight of the evidence
17 that Greenville Hospital System was negligent and that
18 such negligence proximately caused injury to J.B.

19 J.B. Yes.

20 If yes, go to questions two and three. Please
21 indicate the basis for this finding. Physician
22 negligence? Yes. Nursing negligence? No.

23 Do you find by the greater weight of the evidence
24 that Greenville Hospital System Partners in Health was
25 negligent and that such negligence proximately caused

1 injury to [REDACTED] J.B. [REDACTED]? No.

2 If you answered either questions one or three yes,
3 please, state the total amount of actual damages, if any,
4 sustained by [REDACTED] J.B. [REDACTED] \$337,500, dated
5 November 5, 2013, signed Samuel Ross, Foreperson.

6 If this is your verdict, so say you all. Please
7 signify by raising your right hand.

8 (WHEREUPON, all jurors raised their right hand.)

9 THE CLERK: Thank you.

10 THE COURT: Any matters before the jury is discharged
11 from the Plaintiff?

12 MR. GRAHAM: Your Honor, may we move that the jurors
13 be polled individually, please.

14 THE COURT: Yes, sir.

15 THE CLERK: The verdict that was just published was
16 the verdict you reached in the jury room. I ask you was
17 it your verdict then and is it your verdict now?

18 When I call your name, please, answer "yes" or "no."
19 Franklin D. Heath?

20 JUROR #55, FRANKLIN HEATH: Yes.

21 THE CLERK: Charlene E. Meadows?

22 JUROR #87, CHARLENE MEADOWS: Yes.

23 THE CLERK: Margaret A. Forrest?

24 JUROR 337, MARGARET FORREST: Yes.

25 THE CLERK: Eric F. Hutchinson?

1 JUROR #61, ERIC HUTCHINSON: That should be Eric E.
2 Hutchinson.
3 THE CLERK: E. Hutchinson. I'm sorry.
4 JUROR #61, ERIC HUTCHINSON: Yes.
5 THE COURT: Angela H. Alford?
6 JUROR #2, ANGELA ALFORD: Yes.
7 THE CLERK: Lindsey M. Rodgers?
8 JUROR #106, LINDSEY RODGERS: Yes.
9 THE CLERK: Samuel Ross?
10 JUROR # 108, SAMUEL ROSS: Yes.
11 THE CLERK: Tabitha Belcher?
12 JUROR 313, TABITHA BELCHER: Yes.
13 THE CLERK: William Crawford?
14 JUROR #25, WILLIAM CRAWFORD: Yes.
15 THE CLERK: Nancy Weatherford?
16 JUROR #134, NANCY WEATHERFORD: Yes.
17 THE CLERK: Virginia Crews?
18 JUROR #26, VIRGINIA CREWS: Yes.
19 THE CLERK: Shannon Grant?
20 JUROR #44, SHANNON GRANT: Yes.
21 THE CLERK: Thank you.
22 THE COURT: Anything further before the jury is
23 discharged?
24 MR. ALEXANDER: No, sir.
25 THE COURT: All right. Ladies and gentlemen, thank

1 you very much for your service.

2 We don't have professional jurors in this country.
3 Instead, we have to rely on citizens like you who have
4 other responsibilities and demands on your time. And we
5 have to take you away from those responsibilities and
6 obligations, and ask you to come up here and decide
7 difficult issues.

8 The cliché is that jury service is the most important
9 service you can offer your country during peacetime. Like
10 most inspirational clichés, it's, also, a tribute to
11 Winston Churchill. I don't know if that's true or not.
12 I've never been able to determine that. But there's some
13 kernel of truth in that statement.

14 But there's no question that jury service is the most
15 direct and hands-on participation you can have in our
16 democracy. And you have, certainly, exercised your duties
17 diligently. And I thank you for your service. And we're
18 grateful for it.

19 I understand -- the Clerk has told me that they,
20 actually, have your checks ready downstairs. So if you go
21 down there, you can pick them up. And once you see the
22 amount, you'll realize that you did donate your time and
23 services to your community.

24 But, again, thank you very much for your patience and
25 cooperation throughout this process.

1 And have a good afternoon.

2 (WHEREUPON, the jury was excused from open court at
3 approximately 1:43 p.m.)

4 MOTIONS

5 THE COURT: Any motions at this stage?

6 MR. GRAHAM: Yes, sir.

7 Your Honor, the Plaintiff would respectfully move for
8 a new trial absolute and, also, would move for a new trial
9 nisi additur. If you would like for me to address the
10 grounds now, I will do my best to do so. We would ask for
11 some extra time to get you all of the grounds. But we
12 believe that -- well, may I have more time to --

13 THE COURT: I'll, certainly, grant you the time to --
14 10 days, if you'd like. Are you asking for 10 days under
15 the rule?

16 MR. GRAHAM: Yes, sir.

17 THE COURT: I'll grant you that, sir.

18 MR. GRAHAM: Thank you.

19 THE COURT: Any motions from the Defense?

20 MR. ALEXANDER: No, sir.

21 THE COURT: All right. Well, we're adjourned.

22 Thank you.

23 *****END OF TRANSCRIPT OF RECORD*****
24
25

CERTIFICATE OF REPORTER

STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)

I, HOLLIE JENKINS, Official Court Reporter for the Thirteenth Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate, and complete Transcript of Record of the proceedings had and the evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Greenville County, South Carolina, on the 28th, 29th, 30th, and 31st days of October, 2013, and the 1st, 4th, and 5th days of November, 2013.

I do further certify that I am neither of kin, counsel, nor interest to any party hereto.

February 25, 2015

Hollie M. Jenkins, Court Reporter
My Commission Expires: 09/24/20

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF GREENVILLE	)	2011-CP-23-0665
	)	
	)	
	)	
DEMETRIA ORANGE, AS NEXT	)	
FRIEND OF J.B., A MINOR,	)	
PLAINTIFF,	)	
	)	
vs.	)	TRANSCRIPT OF RECORD
	)	
GREENVILLE HOSPITAL SYSTEM	)	
AND GREENVILLE HOSPITAL	)	
SYSTEM PARTNERS IN HEALTH,	)	
DEFENDANTS.	)	
	)	

December 9, 2013
Greenville, South Carolina

B E F O R E:

THE HONORABLE D. GARRISON HILL, JUDGE.

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

EDWARD L. GRAHAM, ESQ.
Attorney for the Plaintiff

J. BEN ALEXANDER, ESQ.
Attorney for the Defendants

HOLLIE M. JENKINS
Circuit Court Reporter

1 impartial jury. Your Honor undertook a number of
2 precautionary measures to ensure that the jurors seated
3 were fair and impartial. They were properly qualified.
4 They were questioned by the lawyers, initially, in this
5 case. They were further questioned by Your Honor where
6 there were some issues raised from our initial questions.

7 Your Honor then permitted primarily both of us, but
8 primarily the Plaintiff availed themselves of this
9 opportunity to extensively question each and every juror
10 who raised any imaginable issue with respect to their
11 ability to be fair and impartial. Some of whom said
12 repeatedly said they could be fair and impartial, went and
13 sat down, were called back up and extensively questioned a
14 second, maybe even a third time, about whether they could
15 be fair and impartial. If they gave any doubts about
16 that, it's my recollection that Your Honor struck those
17 jurors.

18 And so I believe that the jurors that were impanelled
19 in this case could not possibly have been questioned more
20 extensively to ensure that they were fair and impartial,
21 and had the ability to do their job in a manner consistent
22 with case law. And, you know, there's a number of cases
23 that talk about different relationships, and that those
24 are not necessarily reasons for striking for cause. And
25 Plaintiff was able to use preemptory strikes to take care

1 of jurors that they did not want impanelled.

2 Once the jurors were impanelled, I believe that the
3 evidence was presented to them. They listened attentively
4 for a long, long time. They deliberated extensively and,
5 ultimately, found a verdict against my client.

6 Ultimately, Plaintiff got what Plaintiff wanted. And
7 I think that the verdict reflected the evidence in the
8 case. It is absolutely supported by the evidence. This
9 is not a case where we have in the case law of examples
10 for a new trial or nisi additur in the sense that it was
11 inconsistent. It was not an inconsistent verdict. It was
12 not a case where they looked at just medical bills and
13 paid only medical bills, and presented no -- awarded no
14 money for non-economic damages.

15 In this case, they had every reason to discount, if
16 not completely disregard, economic damages in this case
17 and still award a very sizable amount for non-economic, or
18 they may have done some combination of both. That is,
19 they may have discounted some of the economic. Who knows?

20 But the verdict they, ultimately, awarded was
21 imminently supported by the evidence in this case. The
22 idea that evidence on damages has to be contested with
23 testimony is inconsistent with case law. Evidence of
24 damages can be uncontested with testimony but disputed by
25 facts. That's the jury's job.

1 And we disputed a number of the items of damages in
2 this case. For instance, Your Honor ruled about the
3 pre-majority medical expenses. We had the issue of
4 whether or not they could avail themselves of many, if
5 any, of these pre-majority services. And the jury very
6 well could have contended that they had not and,
7 therefore, would not in a post-majority setting either.

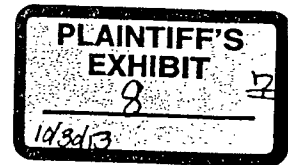
8 So I think all of those things were very much
9 disputed. And I think the jury's verdict in light of all
10 that was very reasonable.

11 THE COURT: What would a worker's compensation award
12 be for an injury like this?

13 MR. GRAHAM: Your Honor, I quit taking new worker's
14 comp cases a few years ago. So I haven't kept up with the
15 recent changes in the general assembly. Although, I still
16 have some of appeal.

17 But my recollection is there are two primary
18 components of such an award -- well, I mean, first of all,
19 there's a question is she totally and permanently
20 disabled, or is it a scheduled injury, meaning limited to
21 the shoulder and arm? If it's limited to the shoulder and
22 arm, I don't recall the exact number of weeks, but since
23 she's not employed now, we couldn't carry out that
24 calculation.

25 Because each week would be two-thirds of the average



ProjectWorks, Inc.

August 29, 2013

Attorney Ed Graham
Graham Law Firm
383 W. Cheves
Florence, SC 29501

RE: Your Client: J.B.
Date of Birth: [REDACTED]
SSN: [REDACTED]
Report: Preliminary Report #2

Dear Attorney Graham:

As referenced in my Preliminary Report #1, dated November 2, 2010, J.B. was scheduled for evaluations, for life care planning purposes, with various specialty physicians. Summaries of these specialty evaluations, as documented in reports as indicated, are outlined below.

Per Dr. Maureen Nelson, M.D., Carolinas Rehabilitation Hospital, Charlotte, NC:

On November 23, 2010, J.B. saw Dr. Maureen Nelson for brachial plexus evaluation. Dr. Nelson's recommendations were as follows:

- Supination splint
- Surgical evaluation

Per Dr. Trevor Resnick, M.D., Pediatric Neurologist, Miami, Florida:

On June 2, 2011, J.B. saw Dr. Trevor Resnick for a Neurological evaluation. Dr. Resnick's recommendations were as follows:

- Deficits are permanent in nature
- No future treatment recommendations outlined in report

Per Dr. John Grossman, M.D., Reconstructive Surgery, Miami, Florida:

On June 2, 2011, J.B. saw Dr. John Grossman for surgical evaluation. Dr. Grossman's recommendations were as follows:

- Additional surgical treatment of the shoulder deformity
- Imaging

ProjectWorks, Inc. P.O. Box 997, Charleston, SC 29402-0997 (843.270.0140)

Per Dr. Maureen Nelson, M.D., Pediatric Physiatrist:

On July 15, 2012, Dr. Nelson completed a Life Care Planning evaluation worksheet and outlined future treatment recommendations for J.B. It is noted Dr. Nelson recommended additional evaluations with various specialists who may offer additional recommendations related to the brachial plexus injury and secondary complications. Dr. Nelson's recommendations are outlined in the Economic Analysis Worksheet attached to this report. A copy of this worksheet is also attached.

This Preliminary Report #2 is submitted as information for pending mediation. As a Certified Nurse Life Care Planner, I will follow standard methodology to finalize a life care plan for J.B. that includes additional specialty evaluations as recommended by Dr. Nelson, conferences with treating physicians, review of additional medical records and medical depositions, and conferences with family members for updated status.

Costs for treatment recommendations are based on usual and customary pricing, not reduced to present day value or factored for inflation. An economic analysis will provide projections and life expectancy.

Respectfully submitted,



Karen Shelton, RN
Certified Nurse Life Care Planner

ProjectWorks, Inc.

November 2, 2010

Attorney Ed Graham
Graham Law Firm
383 W. Cheves
Florence, SC 29501

RE: Your Client: [REDACTED] J.B.
Date of Birth: [REDACTED]
SSN: [REDACTED]
Report: Preliminary Report #1

Dear Attorney Graham:

As requested, I am preparing a Life Care Plan for [REDACTED] J.B. who was born on [REDACTED] with a diagnosis of brachial plexus injury. This Preliminary Report is submitted following a medical records review, medical records chronology, and a needs-based nursing assessment.

Medical History:

[REDACTED] J.B. was born on [REDACTED] with a diagnosis of right shoulder dystocia and right brachial plexus palsy. On September 16, 2005, she was seen by Dr. Ann Schwentker for consultation who recommended surgery. [REDACTED] J.B. underwent surgery on October 18, 2005, a right brachial plexus reconstruction with sural nerve graft. A CT scan on December 5, 2007 done at Shriners' Hospital in Greenville, South Carolina revealed significant subluxation of the right glenohumeral joint, surgery scheduled. On March 11, 2008, [REDACTED] J.B. underwent a second surgery, a closed reduction of the right shoulder, tenotomy of the pectoralis tendon, transfer of the teres major and latissimus dorsi to supraspinatus insertion with spica cast application.

List of Diagnoses:

Right shoulder dystocia
Right side brachial plexus injury
Subluxation of the right glenohumeral joint

Nursing Assessment:

[REDACTED] J.B. is almost six years old and lives at home with her mother and older sister in Spartanburg, South Carolina. She is in Kindergarten at Thomas E. Kerns Elementary School. [REDACTED] J.B. can lift her right arm to shoulder height but cannot turn it over without help. She is currently working on balance, climbing, pushing, and pulling in Occupational

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Therapy. She is able to work buttons and snaps but has trouble with cups and spoons with liquid.

Current Treating Physicians:

North Hills Medical Center – Pediatrician

Dr. John Davids – Shriner's Hospital, Greenville, South Carolina

Current Treating Providers:

Occupational Therapy – CDS, weekly

Life Care Planning Opinion:

J.B. has functional loss due to brachial plexus injury. She will require lifelong medical treatment and therapy services to promote functional ability. Evaluations with specialty physicians and providers will provide additional medical information regarding future treatment recommendations.

Recommendations:

Schedule appointment with Dr. Maureen Nelson for brachial plexus evaluation

Schedule appointment with Dr. John Grossman for surgical evaluation

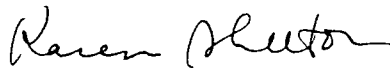
Schedule appointment with Dr. Trevor Resnick for Neurology evaluation

Schedule appointment with Dr. Cindy Dodds for Physical Therapy evaluation

Schedule appointment with BJ Warner for educational evaluation

I will submit Preliminary Report #2 after completion of conferences with all treating and specialty physicians and providers. I will also meet with the family to discuss the medical recommendations.

Respectfully submitted,



Karen Shelton, RN

Certified Nurse Life Care Planner

Name: [REDACTED] Life Care Planning Evaluation

Karen Shelton RN

Date: 7/15/12

Certified Nurse Life Care Planner

Category	Service	Frequency	MD
diagnostics	MRI or CT shoulder, elbow, hand	3 in lifetime	✓
diagnostics	xray shoulder, elbow, hand	3 in lifetime	✓
diagnostics	EMG/NCS	2 times	✓
diagnostics	PFT, hearing, vision testing	once in lifetime	✓
Equipment	neuromuscular stimulator supplies	monthly	✓
Equipment	neuromuscular stimulator	every 3 years lifetime	✓
evaluations	driving	2 times at 16 and 55	✓
evaluations	functional capacity evaluation	once in lifetime	✓
evaluations	home accessibility	once in lifetime	✓
evaluations	ENT, pulmonologist, speech	once in lifetime	✓
injections	botox (elbow, shoulder, hand)	3 injection sites, 1 each	✓
provider	family counseling	20 sessions/lifetime (periodic)	✓
provider	individual counseling	50 sessions/lifetime (periodic)	✓
provider	neurologist	2 times over lifetime	✓
provider	neuropsychologist	1 time over lifetime	✓
provider	pediatric and adult physiatrist	2 times yearly	✓
provider	pediatrician and family practice	one additional visit per year	✓
provider	surgeon: plastic, neuro, or orthopedic	yearly through lifetime	✓
splints	dynamic splint elbow	yearly to 18, then every 3 years	✓
splints	dynamic supinator	yearly to 18, then every 3 years	✓
splints	static elbow	yearly to 18, then every 3 years	✓
splints	static hand	yearly to 18, then every 3 years	✓
splints	static wrist	yearly to 18, then every 3 years	✓
support	nurse case management	100 hours lifetime, periodic	✓
support	home modifications: safety bars	2 times in lifetime	✓
support	independent aids allowance	yearly allowance for variety	✓
support	vehicle modifications	every 10 years after 16	✓
support	vocational assistance	100 hours lifetime, periodic	✓
surgery	shoulder		✓
surgery	elbow		✓
surgery	wrist		✓
surgery	forearm		✓
surgery	muscle		✓
surgery	nerve		✓
therapy	fitness/recreational therapy	monthly after age 3	✓
therapy	OT/PT after surgery	75 sessions/each surgery	✓
therapy	OT/PT yearly	20 sessions yearly	✓
therapy	OT/PT monthly to age 3	6 hours monthly to age 3	✓
chronic pain	medications, diagnostics, physicians	to be determined	✓
scoliosis	monitoring and diagnostics	yearly screening ages 9-18	✓
Note: the following evaluations are recommended to establish current status and determine appropriate surgical, medical, psych-social, vocational, educational treatment plan:			
	evaluation with surgeon (plastic, neuro, or hand)	once in next year	✓
	evaluation with neurologist	once in next year	✓
	evaluation with occupational physician	once in next year	✓
	evaluation with pain management specialist	once in next year	✓
	evaluation with disability behavioral psychologist	once in next year	✓
	evaluation with physical therapist	once in next year	✓
	evaluation with occupational therapist	once in next year	✓
	evaluation with speech therapist	once in next year	✓
	evaluation with neuropsychologist	once in next year	✓
	evaluation with educational placement specialist	once in next year	✓
	evaluation with vocational evaluator	once in next year	✓
	diagnostic package: MRI, EMG/NCS, or xray	once in next year	✓

I reviewed the above list of treatment options and it is my opinion, to a reasonable degree of medical certainty, that these services will be needed to promote recovery, improve function or to maintain current level of functional ability. Additional recommendations will be made pending completion of all scheduled evaluations.

Physician Signature: [Signature]

Date: 7/15/12

No. 0075 R 5

Sep. 5. 2012 11:00AM

Name: [REDACTED]
 Date of Birth: [REDACTED] (8)

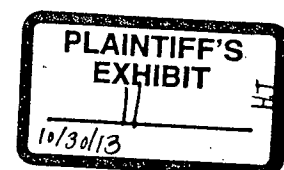
Economic Analysis Worksheet

August 29, 2022
 Karen Shelton, RN, CNLCP, MSCC

Category	Item	Units/year	Unit Cost	Frequency	Begin	End
Surgery	shoulder surgery	once/life	\$50,000.00	once lifetime	2015	n/a
Post surgery PT	shoulder	75 sessions	\$247.00	75 sessions following shoulder surgery	2015	n/a
Surgery	contracture release	TBD	TBD	not factored in cost projection	n/a	n/a
Surgery	muscle, tendon surgery	once/life	\$35,000.00	once lifetime	2015	n/a
Post surgery PT	muscle, tendon	75 sessions	\$247.00	75 sessions following muscle/tendon	2015	n/a
Diagnostics	MRI shoulder, hand	3 lifetime	\$1,678.00	periodically to age 18	2013	2022
Diagnostics	Xray shoulder, hand	3 lifetime	\$123.00	periodically to age 18	2013	2022
Diagnostics	EMG/NCS	once/life	\$539.00	once lifetime	2015	n/a
Diagnostics	PFT, hearing, vision	once/life	\$1,062.00	once lifetime	2013	n/a
Physician	ENT or pulmonology	once	\$172.00	once lifetime	2013	n/a
Physician	surgeon	15 only	\$225.00	annually to age 23	2013	2028
Physician	Physiatrist	2	\$95.00	twice annually lifetime	2013	lifetime
Physician	Counseling, individual	50 only	\$248.00	50 sessions periodically to age 23	2013	2028
Physician	Counseling, family	20 only	\$214.00	20 sessions periodically to age 18	2013	2022
Physician	Neuropsychologist	once	\$1,500.00	once lifetime	2013	n/a
Equipment	neuromuscular stimulator	5 lifetime	\$750.00	periodic replacements to age 23	2013	2028
Equipment	NMS supplies	180 months	\$80.00	periodic monthly replacements/age 23	2013	2028
Equipment	Dynamic supinator splint	5 only	\$327.00	periodic replacements to age 23	2013	2028
Equipment	dynamic elbow splint	5 only	\$122.00	periodic replacements to age 23	2013	2028
Equipment	static elbow splint	5 only	\$106.00	periodic replacements to age 23	2013	2028
Evaluation	driving	2 times	\$472.00	twice lifetime	age 16	age 55
Evaluation	FCE	once	\$1,824.00	once lifetime	age 18	n/a
Evaluation	home accessibility	once	\$500.00	once lifetime	age 23	n/a
Injection	botox shoulder	once	\$1,395.00	once lifetime, sometime in next 5 years	TBD	n/a
Medications	botox elbow	once	\$1,395.00	once lifetime, sometime in next 5 years	TBD	n/a
Medications	to be determined	lifelong	TBD	not factored in cost projection	n/a	n/a
Therapy	annual sessions	20	\$247.00	20 sessions annually, lifetime	2013	lifetime
Therapy	Fitness therapy	TBD	TBD	not factored in cost projection	n/a	n/a
Home mods	bathroom safety	2 times	\$500.00	twice lifetime	2013	age 23
Other	scoliosis screening	18 only	\$175.00	twice annually to age 18	2013	2022
Other	case management	100 hours	\$125.00	periodically over next 5 years	2013	2018
Other	vocational assistance	100 hours	\$125.00	periodically during pre-vocational years	age 14	age 23
Other	independent aids allowance	1	300.00	annual allowance	2013	lifetime
Other	vehicle modifications	6 only	\$2,000.00	every 10 years after age 16	2020	lifetime

CHART 1
PRESENT VALUE OF AFTER-TRIAL LOSS IN
EARNING CAPACITY
(10/22/13 TO WORK-LIFE EXPECTANCY
AT AGE 67 ON 2071.91 = 58.10 YEARS)

Year Ending	Annual Amount	Discounted to Present Value
2014.81	\$0	\$0
2015.81	0	0
2016.81	0	0
2017.81	0	0
2018.81	0	0
2019.81	0	0
2020.81	0	0
2021.81	0	0
2022.81	0	0
2023.81	0	0
2024.81	0	0
2025.81	0	0
2026.81	25,523	13,535
2027.81	28,149	14,217
2028.81	31,046	14,934
2029.81	34,240	15,686
2030.81	37,763	16,476
2031.81	41,239	17,136
2032.81	45,929	18,176
2033.81	47,073	17,741
2034.81	48,245	17,317
2035.81	49,446	16,903
2036.81	50,677	16,499
2037.81	51,939	16,105
2038.81	53,233	15,720
2039.81	54,558	15,344
2040.81	55,917	14,977
2041.81	57,309	14,619
2042.81	58,736	14,270
2043.81	60,198	13,928
2044.81	61,697	13,596



Year Ending	Annual Amount	Discounted to Present Value
2045.81	63,234	13,271
2046.81	64,808	12,953
2047.81	66,422	12,644
2048.81	68,076	12,342
2049.81	69,771	12,046
2050.81	71,508	11,758
2051.81	73,289	11,477
2052.81	75,114	11,203
2053.81	76,984	10,935
2054.81	78,901	10,674
2055.81	80,865	10,419
2056.81	82,879	10,170
2057.81	84,943	9,927
2058.81	87,058	9,689
2059.81	89,226	9,458
2060.81	91,447	9,232
2061.81	93,724	9,011
2062.81	96,058	8,795
2063.81	98,450	8,585
2064.81	100,901	8,380
2065.81	103,414	8,180
2066.81	105,989	7,984
2067.81	108,628	7,793
2068.81	111,333	7,607
2069.81	114,105	7,425
2070.81	116,946	7,248
2071.81	119,858	7,074
2071.91	12,284	722
Totals	\$3,299,132	\$564,181

CHART 2
CONSUMER PRICE INDEX
MEDICAL CARE ITEMS IN U.S.
(1960 - 2012)

(1982 - 1984 = 100)

Year	Index	\$100
1960	22.3	\$100
1965	25.2	113
1970	34.0	152
1975	47.5	213
1980	74.9	336
1981	82.9	372
1982	92.5	415
1983	100.6	451
1984	106.8	479
1985	113.5	509
1986	122.0	547
1987	130.1	583
1988	138.6	621
1989	149.3	669
1990	162.8	730
1991	177.0	794
1992	190.1	852
1993	201.4	903
1994	211.0	946
1995	220.5	989
1996	228.2	1,023
1997	234.6	1,052
1998	242.1	1,086
1999	250.6	1,124
2000	260.8	1,169
2001	272.8	1,223
2002	285.6	1,281
2003	297.1	1,332
2004	310.1	1,391
2005	323.2	1,449
2006	336.2	1,508
2007	351.1	1,574
2008	364.1	1,632
2009	375.6	1,684
2010	388.4	1,742
2011	400.3	1,795
2012	414.9	1,861

Source: Bureau of Labor Statistics.

CHART 3
ANNUAL COMPOUNDED GROWTH RATES FOR THE
GENERAL CPI, GENERAL MEDICAL CPI, AND
SELECTED MEDICAL CARE ITEMS,
1992 - 2012

1. General CPI	2.49%
2. General Medical CPI	3.98%
Medical care commodities and medical care services.	
3. Professional Services	3.38%
Physicians, dentists, eye care providers, and other medical professionals.	
4. Physician Services	3.31%
Includes services by medical physicians in private practice, including osteopaths, that are billed by the physician. Includes house, office, clinic, and hospital visits. (Excludes ophthalmologists.)	
5. Medical Care Commodities	2.91%
Prescription drugs, nonprescription over-the-counter drugs, and other medical equipment and supplies.	
6. Services by other medical professionals	2.59%
Includes services performed by other professionals such as psychologists, chiropractors, physical therapists, podiatrists, social workers, and nurse practitioners in or out of the office.	

Source for data: Bureau of Labor Statistics.

CHART 4
ELEMENTS OF LIFE CARE PLAN

Elements	Frequency	Average Current Periodic or Annual Cost	Duration
A. PHYSICIAN			
1. Surgeon	1 time	\$225	2022 - 2027
2. Physiatrist	annual	190	2022 - life
3. Counseling, Individual	20 sessions	248 (per session)	2022 - 2027
B. EQUIPMENT			
1. Neuromuscular Stimulator	1 time	750	2022 - 2027
2. NMS Supplies	annual	960	2022 - 2027
3. Dynamic Supinator Splint	1 time	327	2022 - 2027
4. Dynamic Elbow Splint	1 time	122	2022 - 2027
5. Static Elbow Splint	1 time	106	2022 - 2027
C. EVALUATION			
1. Driving	1 time	472	age 55
2. FCE	1 time	1,824	age 18
3. Home Accessibility	1 time	500	age 23
D. THERAPY			
1. Annual Sessions	annual	4,940	2022 - life
E. HOME MODIFICATIONS			
1. Bathroom Safety	1 time	500	age 23
F. OTHER			
1. Vocational Assistance	50 hours	125 (per hour)	2022 - 2027
2. Independent Aids Allowance	annual	300	2022 - life
3. Vehicle Modifications	1 x 10 years	2,000	age 26 - life
G. SURGERY			
1. Contracture Release	to be determined	to be determined	to be determined

Source: Ms. Karen Shelton, RN, CNLCP.

CHART 5
PRESENT VALUE OF FUTURE MEDICAL CARE COSTS
(AGE 18 - LIFE EXPECTANCY AT AGE 80.84 ON 2015.75)

Elements	Present Value
A. PHYSICIAN	
1. Surgeon	\$186
2. Physiatrist	6,369
3. Counseling, Individual	<u>3,662</u>
	\$10,217
B. EQUIPMENT	
1. Neuromuscular Stimulator	596
2. NMS Supplies	3,666
3. Dynamic Supinator Splint	260
4. Dynamic Elbow Splint	97
5. Static Elbow Splint	<u>84</u>
	4,703
C. EVALUATION	
1. Driving	~~148~~
2. FCE	1,410
3. Home Accessibility	<u>340</u>
	1,898
D. THERAPY	
1. Annual Sessions	127,754
E. HOME MODIFICATIONS	
1. Bathroom Safety	340
F. OTHER	
1. Vocational Assistance	4,613
2. Independent Aids Allowance	8,597
3. Vehicle Modifications	<u>4,711</u>
	17,921
G. SURGERY	
1. Contracture Release	<u>to be determined</u>
TOTAL FUTURE MEDICAL CARE COSTS	\$162,833

CHART 6
PRESENT VALUE OF TOTAL FINANCIAL LOSS
(AGE 18 - LIFE EXPECTANCY AT AGE 80.84
ON 2085.75 = 80.84 YEARS)

Earning Capacity	\$564,181
Less: Mitigating Earning Capacity	<u>(366,718)</u>
Net Loss in Earning Capacity	\$197,463
Future Medical Care Costs	<u>162,833</u>
Total After-Trial Loss	<u>\$360,296</u>

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS

C.A. No: 2011-CP-23-6665

DEMETRIA ORANGE, as Next friend of
[REDACTED] J.B. [REDACTED] a minor,

Plaintiff,

vs.

GREENVILLE HOSPITAL SYSTEM and
GREENVILLE HOSPITAL SYSTEM PARTNERS
IN HEALTH,

Defendants.

_____/

3100 Southwest 62nd Avenue
Suite 2203
Miami, Florida
Thursday, September 12, 2013
2:00 p.m. - 3:15 p.m.

DEPOSITION OF JOHN GROSSMAN, M.D.

Taken before Marlene Marban, FPR, Notary
Public, State of Florida at Large, pursuant to Notice of
Taking Deposition filed in the above cause.

- - - - -

1 other reason to call it something else.

2 Q So you were contacted by Ed Graham's office.

3 What were you asked to do?

4 A They just, you know, wanted a medical
5 examination and IME report.

6 Q And so what happens from there?

7 A My office schedules the patient. They bring
8 the patient to see me.

9 Q And when did that occur?

10 A June 2nd, 2011.

11 Q And who was present at that IME?

12 A I have no idea. The patient was brought, I
13 know, by somebody from Mr. Graham's office, and I guess
14 this woman, maybe who is in the picture with this kid is
15 the one that came with her, but I don't specifically
16 recall.

17 Q Other than someone from Mr. Graham's office, do
18 you recall anyone else being present for that IME?

19 A Well, there's always, you know, a guardian or a
20 parent or somebody there.

21 Q But do you recall that in this case?

22 A Well, the child wouldn't come alone.

23 Q I'm just asking if you have an independent
24 recollection of meeting with a human being?

25 A No, I don't have an independent recollection,

1 but I suppose it was this woman whose picture is there.

2 Q Do you remember anything about that?

3 A No.

4 Q Just a standard IME that you've done hundreds
5 of times?

6 A Pretty much standard IME. I don't know if I've
7 done hundreds of them.

8 Q Nothing unusual about this one?

9 A Nothing that I recall. I didn't note anything
10 in my record.

11 Q Do you have a template like this, like your
12 report on your office computer?

13 A No.

14 Q Who authors these reports?

15 A I do.

16 Q Do you dictate them or type them?

17 A I dictate them.

18 Q Tell me about your IME.

19 A I mean, I can read it. Do you want me to read
20 you the report?

21 Q No. I want to know how you do them.

22 A I examine the patient. I have them move the
23 extremity, you know, and examine the joint motion,
24 active motion, passive motion and that's about it.

25 Q You examine the patient. You have them move

1 their extremity, active motion, passive motion, and
2 that's about it. Anything else?

3 A No. I examine the shoulder, elbow, forearm,
4 wrist, hand.

5 Q Anything else?

6 A It's a standard exam. You know, we do them all
7 of the time.

8 Q Ten minutes?

9 A Probably 15, 20 minutes, or a little bit more,
10 depending on the individual findings and, you know,
11 whether there are other people in the room with me who
12 I'm teaching and that sort of thing.

13 Q But we don't know who was in the room in this
14 case?

15 A No.

16 Q And nothing unusual about the findings in this
17 case?

18 A No.

19 Q So 10 or 15 minutes or 15, 20?

20 A Probably.

21 Q And what do you charge for the IME?

22 A I think it's now \$3,000.

23 Q How many of these do you do in a month?

24 A I may do none.

25 Q None?

1 A None.

2 Q How many do you do in a year?

3 A Eight or ten, maybe.

4 Q What is an internal rotation and contracture?

5 A It's where the shoulder joint is fixed in an
6 internally rotated position.

7 Q What causes that?

8 A Muscle imbalances and bony deformity as a
9 result of the injury.

10 Q What would be the bony malformity that would
11 cause that?

12 A The shoulder joint doesn't develop properly
13 because of the brachial plexus injury.

14 Q And then palpable posterior subluxation of the
15 humeral head, what is that?

16 A It means that her shoulder joint is so badly
17 deformed that the shoulder is actually dislocated.

18 Q And I assume unable to be relocated?

19 A At her age you probably couldn't relocate it.

20 Q Could that have been done earlier?

21 A Yes.

22 Q And do you know why it was not?

23 A I think it was attempted, and she underwent an
24 operation in 2008 with a muscle transfer and a closed
25 reduction, but obviously that operation failed. It

1 probably failed because either the transfer didn't work
2 or there was such significant deformity of the shoulder
3 joint at that time that they couldn't maintain the
4 reduction.

5 Q Do you know who did that surgery that you're
6 referring to?

7 A I think it was done at Shriners Hospital. I am
8 not sure. I have a record of it. Done at the Shriners
9 Hospital in Greenville.

10 Q Is it Dr. Davids?

11 A Yeah.

12 Q She has forward flexion of about 80 percent and
13 postures in an internal rotation. Tell me what that
14 means.

15 A It means she can bring her arm up not quite
16 parallel with her shoulder and she's internally rotated.

17 Q Examination of the elbow showed the biceps and
18 triceps in relative balance. Is that both as one to
19 another as well as left and right or just as one to the
20 other?

21 A One to the other on that side.

22 Q What is the significance of that?

23 A Sometimes you don't recover one or the other of
24 the muscles. One is stronger than the other. That
25 wasn't the case here.

1 Q So she has approximately 15 percent elbow
2 flexion contracture. Tell me about that.

3 A Her elbow is permanently bent 15 degrees.

4 Q Is that an issue with the bone?

5 A Soft tissues.

6 Q Which soft tissues?

7 A Muscles, skin.

8 Q In and around the elbow?

9 A Yes.

10 Q And tell me what causes that.

11 A Imbalances of the muscles due to the brachial
12 plexus injury.

13 Q So is it lack of use that those don't develop
14 because of lack of use?

15 A Well, some are stronger than the others for a
16 long period of time so they created a deformity that
17 then becomes fixed.

18 Q So she's not able to supinate past neutral.
19 Tell me what that means.

20 A She can't bring her palm straight up.

21 Q And what causes that?

22 A Same thing, weakness and imbalance of the
23 muscles.

24 Q Which muscles?

25 A It comes from weakness of the biceps muscles,

1 weakness of the supinator muscle, you know. The whole
2 forearm is involved.

3 Q She has ongoing satisfactory recovery of the
4 wrist and hand function. So was that within normal
5 limits?

6 A No.

7 Q Tell me what limitation she had in that regard.

8 A I didn't do any occupational therapy testing.
9 I just did a general.

10 Q So we don't know the extent of her dysfunction
11 of the wrist?

12 A No. We can certainly measure that before
13 trial, you know, and do specific hand testing and such
14 on her to know exactly what other fine motor functional
15 losses and that kind of stuff.

16 Q Is there a reason that you did not do it on
17 this IME?

18 A It's very -- you know, it's quite
19 time-consuming. We generally don't do that kind of
20 stuff on these IMEs, but certainly can be done.

21 Q Are you recommending additional surgeries for
22 this child?

23 A I did.

24 Q And what additional surgeries?

25 A Like I said in my report, I'm not sure exactly

1 how you would treat her shoulder until we were able to
2 get, you know, a good CAT scan and three-dimensional
3 reformatting of her shoulder and sort of figure out what
4 the best approach would be to improve that.

5 Q You saw her in 2011?

6 A Yes.

7 Q Did you make the recommendation at that time
8 that she get a CAT scan done of her shoulder?

9 A No. I think she would benefit from additional
10 treatment to the shoulder deformity.

11 Q But in order to decide what treatment of the
12 shoulder deformity she would need, she would need a CAT
13 scan first?

14 A She's not my patient so it's not for me to
15 start ordering tests for her.

16 Q Was there a recommendation made to someone to
17 get a CAT scan done?

18 A No. She's not my patient. It's not for me to
19 refer her or speak to anyone. I wrote a report for
20 Mr. Graham. That was the extent of it.

21 Q So are you able to say specifically any surgery
22 that she will need?

23 A She'd certainly benefit from, you know, a
24 reattempt at a shoulder reconstruction, but aside from
25 that, I can't be any more detailed until we know a

1. little bit more about what's going on.

2. Q This case goes to trial in October. Is it your
3. understanding that you're going to get the information
4. that you need to make that determination between now and
5. October 21st or do you know?

6. A I would doubt it.

7. Q So tell me about the shoulder surgery, the
8. reattempt at a shoulder surgery.

9. A Like I said, I can't tell you anything because
10. I don't have the information to tell you anything of any
11. substance what will be required. And some things you
12. won't know actually until you get back in there and see
13. what the muscle transfer looks like and such.

14. Q So as of September 12th, 2003, at whatever time
15. it is today --

16. A 2013.

17. Q What did I say?

18. A 2003.

19. Q You are unable to say what surgery she would
20. need in the future?

21. A What the specific details of the shoulder
22. reconstruction would entail, because you have to
23. remember, she's already had one attempt at it which
24. unfortunately didn't work out that well. So it's quite
25. a complicated situation.

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

RECEIVED

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

SEP 17 2015

The Honorable D. Garrison Hill

SC Court of Appeals

C.A. No. 2011-CP-23-6665

Demetria Orange, as Next Friend of
J.B., a minor, Plaintiff,

Respondent,

v.

Greenville Hospital System and Greenville
Hospital System Partners In Health, Defendants

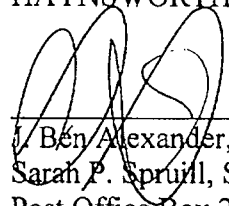
of whom, Greenville Hospital System is

Appellant.

CERTIFICATE OF APPELLANT

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material except as noted below. The parties have agreed pursuant to Rule 212, SCACR to include Defendant's Memorandum Opposing Plaintiff's Motions for New Trial in the Record on Appeal.

HAYNSWORTH SINKLER BOYD, PA



Ben Alexander, SC Bar No. 015323

Sarah P. Spruill, SC Bar No. 68337

Post Office Box 2048

Greenville, South Carolina 29602

(864) 240-3200

Attorneys for Appellant Greenville Hospital
System

September 17, 2015