THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

The Honorable Michael Nettles, Circuit Court Judge

RECEIVED
APR 14 2016
SC Court of Appeals

Appellate Case No. 2015-001237

Genesie Fulton, individually and as Next Friend for Bryson F., a minor — Appellants,

v

L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, — Respondents.

RECORD ON APPEAL
VOLUME 1 of 2

Edward L. Graham
Diane M. Rodriguez
J. Layton Ruffin
GRAHAM LAW FIRM, P.A.
Post Office Box 550
Florence, SC 29503
Attorneys for Appellant

Elloree A. Gaines
Molly H. Craig
HOOD LAW FIRM, LLC
Post Office Box 1508
Charleston, SC 29402
Attorneys for Respondents

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FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

PLAINTIFF(S)		DEFENDANT(S)	
Genesie Fulton	Bryson F	L William Goldstein	L William Goldstein Obgyn
		Steven N Coker	Drs Coker & Phillips

Submitted by:

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

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):** ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

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

FILED
2014 SEP 30 PM 3:59
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

CERTIFIED: A TRUE COPY
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

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

ORDER INFORMATION

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

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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

9/30/2014

Circuit Court Judge **Judge Code** **Date**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

For Clerk of Court Office Use Only

This judgment was entered on **September 29, 2014**, and a copy mailed first class or placed in the appropriate attorney's box on **October 1, 2014**, to attorneys of record or to parties (when appearing pro se) as follows:

Edward L. Graham Graham Law Firm PO Box 550 Florence, SC 29503
Mary H. Watters 1539 Barquentine Drive Mt. Pleasant, SC 29464

ATTORNEY(S) FOR THE PLAINTIFF(S)

Marian Williams Scalise PO Box 3646 Myrtle Beach, SC 29578
Elloree A. Ganes PO Box 1508 Charleston, SC 29402-1508

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel Shearin

Court Reporter

Connie Reel-Shearin - Clerk of Court

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

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

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF FLORENCE	)	CIVIL ACTION NO. 2013-CP-21-[illegible]7
Genesie Fulton, individually, and as Next Friend of Bryson F , a Minor,	)	
Plaintiffs,	)	
-vs-	)	**STIPULATION OF DISMISSAL (with prejudice)**
L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A.,	)	
Defendants.	)	

FILED
2014 SEP 29 PM 2:12
RONNIE REEL-SHEARIN
CCP & GS
FLORENCE COUNTY, SC

The Plaintiffs herein dismiss the above-entitled action against Steven N. Coker, M.D. and Drs. Coker & Phillips, P.A. in its entirety with prejudice pursuant to Rule 41(a)(1)(B) of the South Carolina Rules of Civil Procedure.

WE SO STIPULATE:

September 15, 2014

Edward L. Graham, Esquire
J. Lleyton Ruffin, Esquire
Diane M. Rodriguez, Esquire
Graham Law Firm, P.A.
P.O. Box 550
Florence, SC 29503
Attorneys for Plaintiffs

Layton

CERTIFIED: A TRUE COPY
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

WE CONSENT:

Marian W. Scalise

September 24, 2014

Marian Williams Scalise, Esquire
Lydia L. Magee, Esquire
Richardson, Plowden & Robinson, P.A.
P. O. Box 3646
Myrtle Beach, SC 29578
Attorneys for Defendants Steven N. Coker, M.D. and Drs. Coker & Phillips, P.A.



September 15, 2014

Molly H. Craig, Esquire
Elloree A. Ganes, Esquire
Hood Law Firm, LLC
172 Meeting Street
P.O. Box 1508
Charleston, SC 29401
Attorneys for Defendants L. William Goldstein, M.D., individually and d/b/a L. William Goldstein Ob-Gyn

FORM 4

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

FILED
2015 MAY 19
JANIE REEL SHEARIN
CCCP & GS
FLORENCE COUNTY, SC

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

Genesie Fulton	Bryson F	L William Goldstein	L William Goldstein Obgyn

PLAINTIFF(S)	DEFENDANT(S)
Submitted by:	Attorney for: ☐ Plaintiff ☐ Defendant ☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☐ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

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☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):** ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

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

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

ORDER INFORMATION

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

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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

Richard Matthews — 2140 — 5/19/2015

Circuit Court Judge **Judge Code** **Date**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

For Clerk of Court Office Use Only

This judgment was entered on **May 19, 2015**, and a copy mailed first class or placed in the appropriate attorney's box on **May 19, 2015**, to attorneys of record or to parties (when appearing pro se) as follows:

Edward L. Graham Graham Law Firm PO Box 550 Florence, SC 29503

ATTORNEY(S) FOR THE PLAINTIFF(S)

Elloree A. Ganes PO Box 1508 Charleston, SC 29402-1508
Mary Agnes Hood Craig PO Box 1508 Charleston, SC 29402-1508

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel-Shearin

Court Reporter

Connie Reel-Shearin - Clerk of Court

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

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

Plaintiffs' Motion for a New Trial heard and denied.

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

Genesie Fulton Bryson F	L William Goldstein L William Goldstein Obgyn
PLAINTIFF(S)	**DEFENDANT(S)**

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

DISPOSITION TYPE (CHECK ONE)

☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):** ☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

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

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

ORDER INFORMATION

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

2015 MAY -8 PM 10:4[illegible]
FILED
[illegible] CCP & GS
FLORENCE COUNTY, S.C.

INFORMATION FOR THE JUDGMENT INDEX

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

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
L William Goldstein L William Goldstein Obgyn	Genesie Fulton Bryson F	No Money Damages

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

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

[signature] 2140 5/8/2015

Circuit Court Judge **Judge Code** **Date**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

For Clerk of Court Office Use Only

This judgment was entered on **May 8, 2015**, and a copy mailed first class or placed in the appropriate attorney's box on **May 8, 2015**, to attorneys of record or to parties (when appearing pro se) as follows:

Edward L. Graham Graham Law Firm PO Box 550 Florence, SC 29503

ATTORNEY(S) FOR THE PLAINTIFF(S)

Elloree A. Ganes PO Box 1508 Charleston, SC 29402-1508
Mary Agnes Hood Craig PO Box 1508 Charleston, SC 29402-1508

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel-Shearin

Court Reporter

Connie Reel-Shearin - Clerk of Court

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

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

Jury rendered a verdict in favor of the Defendant, L. William Goldstien, M.D., d/b/a L. William Goldstien OB-GYN, against the Plaintiff, Genesie Fulton and Bryson F , no money damages.
Attorneys has 10 days to submit Post trial motions.

FILED
2015 MAY -8 PM 10:49
CONNIE REEL-SHEARIN
CCCP & GS
FLORENCE COUNTY, SC

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 3/2013)

STATE OF SOUTH CAROLINA	**IN THE COURT OF COMMON PLEAS**
COUNTY OF FLORENCE	**TWELFTH JUDICIAL CIRCUIT**
	C/A No. 2013-CP-21-00587
Genesie Fulton, individually and as Next Friend of Bryson F , a minor	
Plaintiffs,	VERDICT FORM
Versus	
L. William Goldstien, M.D., individually and d/b/a L. William Goldstien OB-GYN,	
Defendants.	

FILED
2015 MAY -8 PM 10:49
JONNIE REEL-SHEARIN
CCCP & GS
FLORENCE COUNTY, SC

I
Obstetrical Medical Emergency Exception

Do you unanimously find that the facts of this case arise out of a genuine emergency situation where the patient is not stable and there is an immediate threat of death?

✓ **YES (if yes, the Plaintiff must prove gross negligence)**

_____ **NO (if no, the plaintiff must prove simple negligence)**

II
Breach of Standard of Care

The plaintiff has proved that the defendant breached the standard of care:

_____ **YES (if yes, proceed to Roman Numeral III)**

✓ **NO (if no, discontinue deliberation)**

*If the Obstetrical Medical Emergency Exception does not apply the Plaintiff must prove simple negligence (that the Defendant has done or failed to do something that a reasonable person would have done in the same situation.)

*If the Obstetrical Medical Emergency Exception applies the Plaintiff must prove gross negligence (that the breach was more than carelessness, but was a failure to exercise a slight degree of care).

III
Proximate Cause

Did the Plaintiff prove that the Defendant's negligence proximately caused the Plaintiff's injury?

_____ **YES (if yes, proceed to Roman Numeral IV)**

_____ **NO (if no, discontinue deliberation)**

FILED
2015 MAY -8 PM 10:49
CONNIE REEL-SIEGLER
CCCP & GS
FLORENCE COUNTY, SC

IV
Actual Damages

If you find liability then calculate actual damages:

_____ **(Numerical)**

_____ **(Cursive)**

V
Punitive Damages

If you find actual damages you may consider an award of punitive damages. If you find that punitive damages are not warranted discontinue deliberation.

If you feel punitive damages are warranted assign the amount:

_____ **(Numerical)**

_____ **(Cursive)**

Debra L. Lloyd
FOREPERSON

May 8, 2015
Florence, South Carolina

WHEN YOU HAVE COMPLETED THE QUESTIONS, NOTIFY THE BAILIFF.

VERDICT MUST BE UNANIMOUS.

STATE OF SOUTH CAROLINA COUNTY OF FLORENCE Genesie Fulton, individually, and as Next Friend of Bryson F , a Minor, Plaintiff, vs. L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A., Defendants.	IN THE COURT COMMON PLEAS TWELFTH JUDICIAL CIRCUIT C/A NO.: 2013-CP-21-587 **COMPLAINT**

FILED
2013 FEB 28 AM 9:43
CONNIE [illegible]
CCCP & GS
FLORENCE COUNTY, SC

COMES NOW the Plaintiff complaining of Defendants above named and would show unto the Court as follows:

1. Plaintiff Genesie Fulton (hereinafter, "Genesie") is a citizen and resident of Florence County, South Carolina, and brings this action individually and as Next Friend of her son, Bryson F , (hereinafter, "Bryson")

2. Defendant L. William Goldstein, M.D. (hereinafter, "Dr. Goldstein") is, upon information and belief, a citizen and resident of Florence County, South Carolina, who was, upon information and belief, at all times relevant to this action, a physician duly licensed to practice medicine within the State of South Carolina.

3. Defendant Dr. Goldstein held himself out to the public as having specialized knowledge, training and experience for the provision of high quality obstetrical and gynecological care.

4. Defendant Dr. Goldstein maintained an office in Florence, County, South Carolina, for the practice of obstetrics and gynecology.

5. Upon information and belief, Dr. Goldstein, practiced obstetrics and gynecology using the business name of L. William Goldstein, M.D., OB-GYN (hereinafter, "OB-GYN").

6. Defendant Steven N. Coker, M.D. (hereinafter, "Dr. Coker") is, upon information and belief, a citizen and resident of Florence County, South Carolina, who was, upon information and belief, at all times relevant to this action, a physician duly licensed to practice medicine within the State of South Carolina.

7. Defendant Dr. Coker held himself out to the public as having specialized knowledge, training and experience for the provision of high quality obstetrical and gynecological care.

8. Defendant Dr. Coker maintained an office in Florence, County, South Carolina, for the practice of obstetrics and gynecology.

9. Drs. Coker & Phillips, P.A. (hereinafter, "P.A.") is a professional association, organized and existing under the laws of South Carolina or another state.

10. Upon information and belief, Defendant Coker was at all relevant times a shareholder, employee and agent of the Defendant P.A., acting within the course and scope of that ownership, employment and agency.

11. Prior to August 20, 2009, Genesie, mother of Bryson, became pregnant and submitted herself to the care and attention of Dr. Goldstein for pre-natal and obstetrical care.

12. On August 20, 2009, Defendant Dr. Goldstein along with Defendant Dr. Coker attended the delivery of Bryson, son of Genesie, at Carolinas Hospital System (hereinafter, "Hospital") in Florence County, S.C.

13. Bryson was a healthy baby prior to August 20, 2009, when his mother, Genesie, was admitted to the Hospital.

14. Defendant Dr. Goldstein took charge of the health care of Genesie and her baby upon Genesie's admittance to the Hospital.

15. Defendant Dr. Coker attended and assisted with the delivery of Bryson.

16. The Defendants, Dr. Goldstein and Dr. Coker owed Genesie and her son a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar situations.

17. Defendants Dr. Goldstein and Dr. Coker breached their duties of care to Genesie and her son Bryson, and were negligent, reckless, willful, wanton, and/or otherwise wrongful in their care of them and attention to them, as a direct and proximate result of which Bryson sustained severe bodily injuries, losses and damages; and Genesie also thereby sustained losses and damages.

18. Defendant Dr. Goldstein was negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including, but not limited to, the following particulars:

(a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to manage the birthing process of Bryson;

(b) in choosing not to appreciate the heightened risk of shoulder dystocia in his delivery;

(c) in causing Genesie to have excessive uterine activity;

(d) in failing and refusing to timely recognize the signs and symptoms of shoulder dystocia;

(e) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;

(f) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;

(g) in using improper delivery technique;

(h) in using improper and excessive force, traction and/or torsion;

(i) in mismanagement of labor and delivery;

(j) in mismanagement of shoulder dystocia;

(k) in ordering, requesting or permitting Dr. Coker to perform fundal pressure;

(l) in failing and refusing to perform delivery by C-Section, or convert to a C-Section;

(m) in failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health;

(n) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition; and

(o) such other failures and refusals as may be identified during discovery and the trial of his case.

19. Defendant Dr. Coker was negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including, but not limited to, the following particulars:

(a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to assist with the birthing process of Bryson;

(b) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;

(c) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;

(d) in using improper delivery technique;

(e) in using improper and excessive force, traction and/or torsion;

(f) in mismanagement of labor and delivery;

(g) in mismanagement of shoulder dystocia;

(h) in performing fundal pressure;

(i) in failing to communicate with fellow health care team workers on a timely and

accurate basis about matters of critical importance to the patient's health;

(j) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition; and

(k) such other failures and refusals as may be identified during discovery and the trial of his case.

20. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein which joined and concurred with negligence and other wrongdoing on the part of Dr. Coker, Bryson has sustained certain injuries, losses and damages, stated with particularity as follows:

(a) Direct violent and traumatic injuries to various bodily members of Bryson, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder and arm, commonly known as Erb's palsy;

(b) Adverse effects on various other bodily members and/or functions, such as gait, balance and skeletal and muscular symmetry;

(c) Past and future medical expenses;

(d) Life care management plan expense;

(e) Permanent impairments and disabilities;

(f) Disfigurement;

(g) Physical pain and suffering;

(h) Mental, emotional and psychological harm;

(i) Adverse effect on the future career opportunities, employability, earnings and earning capacity;

(j) Loss of enjoyment of life; and

(k) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

21. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein and Dr. Coker, Genesie has sustained certain losses and damages, including but not limited to:

(a) Past and future medical expenses;

(b) Life Care Management expenses;

(c) Economic losses; and

(d) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

22. Plaintiff names Defendant P.A. as a Defendant in this case because it has *respondeat superior* liability for Dr. Coker's torts as his employer.

23. Upon information and belief, Defendant Dr. Coker aided and abetted Defendant Dr. Goldstein in his failures, acts and omissions in that he:

(a) Committed tortious acts in concert, or pursuant to a common design;

(b) Knew, or should have known, that his conduct constituted a breach of duty, and gave substantial assistance or encouragement to Defendant Dr. Goldstein to conduct himself; and/or

(c) Gave substantial assistance to Defendant Dr. Goldstein in accomplishing a tortious result, and Defendant Dr. Coker's own conduct, separately considered, constitutes a breach of duty.

24. Plaintiffs have previously complied with all statutory requirements for commencing this action. A copy of an Affidavit of Dr. Yvonne Gomez-Carrion is attached hereto in support of the liability allegations made herein.

WHEREFORE, Plaintiff prays for judgment against Defendants, jointly and severally, for an award of actual damages; for an additional award of punitive damages against one or more of the said Defendant(s) in an amount to be determined by the jury in accordance with the facts and circumstances presented at trial; for costs of this action; and for such other and further relief as this Court may deem just and proper.

GRAHAM LAW FIRM, P.A.

Edward L. Graham
Mary H. Watters

Florence, S.C. 29501
Attorney for Plaintiff

February 22, 2013

STATE OF MASSACHUSETTS)
)
COUNTY OF MIDDLESEX)

AFFIDAVIT

FILED
2012 AUG 17 AM 9:33
FLORENCE COUNTY, SC

PERSONALLY APPEARED before me, YVONNE GOMEZ-CARRION, who first being duly sworn, deposes and says:

1. I am Yvonne Gomez-Carrion, of Boston, MA. I make this Affidavit based on my professional background, education, training and experience as well as my review of certain medical records relating to the birth of Bryson F , including the following:

1. Prenatal Records from Dr. L. William Goldstein (mother);
2. Carolinas Hospital System – Mother's delivery records;
3. Carolinas Hospital System – Child's birth records;
4. University Specialty Clinics
5. BabyNet;
6. Report of Dr. John A. I. Grossman

The statements contained herein are true and correct as to my own knowledge, except as to those based upon information and belief, and as to those I believe them to be true. I am over the age of 18 and legally competent to make this Affidavit.

2. I am a physician, board certified in Obstetrics and Gynecology by the American College of Obstetrics and Gynecology. Details of my qualifications and background are set forth in my curriculum vitae attached hereto as Exhibit 1.

3. I have an active clinical practice in obstetrics and gynecology, at Beth Israel Deaconess Hospital, one of the Harvard Medical School teaching hospitals. As part of my practice I regularly manage labor and delivery of maternity patients. I am very familiar with the standards of care applicable to doctors, nurses and staff involved in managing labor and delivery in general and in particular with respect to the standards of care involved in the proper recognition, management and resolution of a complication known as shoulder dystocia.

CERTIFIED A TRUE COPY
CLERK OF COURT

4. In this case, based on my review of the medical records noted above, Dr. L. William Goldstein committed at least two deviations from the generally accepted obstetrical standards of care during the delivery of Bryson F , on August 20, 2009. In my opinion, to a reasonable degree of medical certainty, Dr. Goldstein breached generally accepted standards of obstetrical practice in the following ways: (1) he chose not to take advantage of several safe and effective maneuvers available to him to assist in the management and resolution of shoulder dystocia without injury to Bryson; and (2) he applied excessive lateral traction to the head of Bryson F .

5. I have been informed that one or more witnesses in the delivery room have described Dr. Steven N. Coker's application of forceful pushing at the top of the maternal abdomen down toward the birth canal, during the time Dr. Goldstein was attempting to resolve shoulder dystocia. Entries on the medical chart refer to Dr. Coker's application of suprapubic pressure. The witness testimony describes not suprapubic pressure, which would be acceptable, but fundal pressure, which is contraindicated in these circumstances. If Dr. Coker did in fact apply fundal pressure, that represents a breach of generally accepted standards of practice by Dr. Coker. If Dr. Goldstein requested Dr. Coker to perform fundal pressure, or permitted him to do so, that also represents an additional breach of generally accepted standards of practice by Dr. Goldstein.

6. It is further my opinion, to a reasonable degree of medical certainty, that Bryson F suffered severe and permanent injury to his brachial nerves as a direct and proximate result of these breaches of standard obstetrical practice by Dr. Goldstein. If in fact Dr. Coker did apply fundal pressure, that was a contributing cause of Bryson F 's injuries.

7. There may be other deviations from the generally accepted standards of care by Dr. Goldstein and/or other health care providers, and/or other injuries, which I may learn from additional records, information or depositions that may be provided to me in the future. Therefore, I reserve the right to change, modify, or supplement these opinions in the future, if new information and material is provided to me.

FURTHER AFFIANT SAYETH NAUGHT.

YVONNE GOMEZ-CARRION

SWORN TO BEFORE ME THIS

15 Day of August, 2012

_____ (L.S.)
NOTARY PUBLIC FOR MASSACHUSETTS

My Commission Expires: 10/31/2014

Susan Herlihy
Notary Public
State of Massachusetts
My Comm. Exp. 10.31.2014

STATE OF SOUTH CAROLINA COUNTY OF FLORENCE Genesie Fulton, individually, and as Next Friend of Bryson F , a Minor, Plaintiffs, -vs- L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A., Defendants.	IN THE COURT OF COMMON PLEAS CIVIL ACTION NO. 2013-CP-21-587 **ANSWER ON BEHALF OF STEVEN N. COKER, M.D. AND DRS. COKER & PHILLIPS, P.A.**

FILED
2013 APR 22 PM 2:11
CONNIE REEL-SHEARIN
CCCP & GS
FLORENCE COUNTY, SC

The Defendants Steven N. Coker, M.D. and Drs. Coker & Phillips, P.A., answering the Complaint of the Plaintiffs, will respectfully show unto the Court as follows:

FOR A FIRST DEFENSE

1. These Defendants deny each and every allegation of Plaintiffs' Complaint not hereinafter specifically admitted, modified, or explained. Strict proof is demanded.

2. These Defendants have insufficient information in which to admit or deny the allegations contained in paragraph one (1) of the Complaint; therefore, Defendants deny same and demand strict proof thereof.

3. With regard to the allegations contained within paragraphs two (2), three (3), four (4), and five (5) of the Complaint, these Defendants would state that these allegations pertain to a Defendant other than these Defendants and require no admission or denial on behalf of these Defendants. However, if the allegations are directed to these Defendants, the allegations are denied, and strict proof is demanded.

4. These Defendants admit the allegations of paragraphs six (6), seven (7), eight (8), nine (9), and ten (10) of the Complaint.

5. These Defendants have insufficient information in which to admit or deny the allegations contained in paragraph eleven (11) of the Complaint; therefore, Defendants deny same and demand strict proof thereof.

6. With regard to the allegations contained within paragraph twelve (12) of the Complaint, Defendants crave reference to the medical records and/or medical testimony regarding each physician's role in the delivery, when Dr. Coker arrived, and Dr. Coker's role in applying suprapubic pressure which assisted in the delivery of this child. Dr. Coker denies that he was present during the labor. Any allegation inconsistent with the medical records and/or medical testimony is denied, and strict proof is demanded.

7. These Defendants have insufficient information in which to admit or deny the allegations contained in paragraph thirteen (13) of the Complaint; therefore, Defendants deny same and demand strict proof thereof.

RPR 2

8. With regard to the allegations contained within paragraph fourteen (14) of the Complaint, these Defendants would state that these allegations pertain to a Defendant other than these Defendants and require no admission or denial on behalf of these Defendants. However, if the allegations are directed to these Defendants, the allegations are denied, and strict proof is demanded.

9. With regard to the allegations contained within paragraph fifteen (15) of the Complaint, Defendants crave reference to the medical records and/or medical testimony regarding Dr. Coker's role in the delivery, when he arrived, and the suprapubic pressure he applied. Any allegation inconsistent with the medical records and/or medical testimony is denied, and strict proof is demanded.

10. With regard to the allegations of paragraph sixteen (16) of the Complaint, these Defendants state that these allegations call for a legal conclusion to which no admission or denial

is required. However, if a response is required, these Defendants deny same and demand strict proof thereof.

11. These Defendants deny the allegations contained in paragraph seventeen (17) of the Complaint and demand strict proof thereof.

12. With regard to the allegations contained within paragraph eighteen (18) including all subparagraphs of the Complaint, these Defendants would state that these allegations pertain to a Defendant other than these Defendants and require no admission or denial on behalf of these Defendants. However, if the allegations are directed to these Defendants, the allegations are denied, and strict proof is demanded.

13. These Defendants deny the allegations contained in paragraphs nineteen (19) including all subparagraphs, twenty (20) including all subparagraphs, and twenty-one (21) including all subparagraphs of the Complaint and demand strict proof thereof.

RPR 3

14. With regard to the allegations of paragraph twenty-two (22) of the Complaint, these Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. These Defendants deny Dr. Coker committed any negligent acts and deny Defendant Coker breached any standard of care that proximately caused injury or damage to either Plaintiff. Strict proof is demanded.

15. These Defendants deny the allegations contained in paragraph twenty-three (23) including all subparagraphs of the Complaint and demand strict proof thereof.

16. With regard to the allegations of paragraph twenty-four (24) of the Complaint, these Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. These Defendants deny the allegations of negligence raised in the Affidavit of Dr. Yvonne Gomez-Carrion and demand strict proof thereof.

17. These Defendants deny the allegations as contained in the "wherefore" clause and demand strict proof thereof.

FOR A SECOND DEFENSE

18. The care and treatment administered by the Defendant Steven N. Coker, M.D. conforms to and was in full compliance with the standard of care. All care and treatment administered by Defendant Dr. Coker was within the acceptable medical standards and methods and, at no time pertinent thereto, did Defendant Dr. Coker deviate from any medical standard while caring for or tending to Genesie Fulton and/or Bryson F . Consequently, the Plaintiffs are barred from recovery against this Defendant or his employer Drs. Coker & Phillips, P.A.

FOR A THIRD DEFENSE

19. Defendant Drs. Coker & Phillips, P.A. alleges that its employees and personnel properly cared for, treated, and attended to Genesie Fulton and Bryson F under the existing circumstances, and that in the handling of Genesie Fulton and Bryson F , they followed proper standards recognized and practiced by physicians, physician offices, employers, and its employees. This Defendant further alleges that, in the handling of Genesie Fulton and Bryson F by its employees and personnel, they rendered and practiced that degree of knowledge, care, and skill equal to that of similarly qualified employees and personnel. This Defendant further alleges that the treatment, care, and service rendered to Genesie Fulton and Bryson F under the circumstances then existing were in accordance with the standards recognized and practiced by physicians, physician offices, employers, and its employees. Consequently, the Plaintiffs are barred from recovery from Drs. Coker & Phillips, P.A.

FOR A FOURTH DEFENSE

20. These Defendants admit that Dr. Coker was contacted to assist in a shoulder dystocia delivery which is a genuine emergency situation involving an immediate threat of death

or serious bodily injury. As such, neither he nor his practice may be held liable pursuant to S.C. Code Ann. § 15-32-230(A), and this case should be dismissed against them.

FOR A FIFTH DEFENSE

21. These Defendants admit that they did not have a previous doctor/patient relationship with Plaintiffs. As such, these Defendants may not be held liable pursuant to S.C. Code Ann. § 15-32-230(B), and this case should be dismissed against them.

FOR A SIXTH DEFENSE

22. That any alleged negligence on the part of these Defendants, which negligence is specifically denied, was not the proximate cause of any injury or damage to either Plaintiff.

FOR A SEVENTH DEFENSE

23. That the case should be dismissed pursuant to South Carolina Rules of Civil Procedure Rule 12(b)(6) for failure to state facts sufficient to constitute a cause of action against these Defendants.

RPR 5

FOR AN EIGHTH DEFENSE

24. Because the alleged acts of negligence occurred after July 1, 2005, this case is subject to the limitations of liability and provisions outlined in the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. § 15-32-200, et seq.

FOR A NINTH DEFENSE

25. These Defendants assert that this action is governed by the S.C. Noneconomic Damage Awards Act of 2005, S.C. Code Ann. §15-32-200, et seq. Therefore, if Plaintiff is entitled to any recovery, which these Defendants specifically deny, recovery for any alleged noneconomic damages is capped pursuant to S.C. Code Ann. § 15-32-220.

FOR A TENTH DEFENSE

26. Plaintiffs' claims for punitive damages should be dismissed pursuant to S.C. Code Ann. § 15-32-520 and S.C. Code Ann. § 15-32-530 in that there is no evidence which would support an award of punitive damages, and these Defendants assert all defenses and limitations of liability provided by statute and case law.

FOR AN ELEVENTH DEFENSE

27. That any claim for punitive or exemplary damages as set forth in the Plaintiffs' Complaint against these Defendants would violate the Defendants' constitutional rights under the due process clause in the Fifth and Fourteenth Amendments to the Constitution of the United States of America, Excessive Fines Clause in the Eighth Amendment to the Constitution of the United States of America, the Double Jeopardy Clause in the Fifth Amendment to the Constitution of the United States of America, and similar provisions in the Constitution of the State of South Carolina and/or the common law and public policies of the State of South Carolina, and/or applicable statutes and court rules, and the Defendants raise these defenses as a complete bar to the imposition of punitive or exemplary damage against them.

RPR 6

FOR A TWELFTH DEFENSE

28. These Defendants reserve any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, as is consistent with the South Carolina Rules of Civil Procedure.

WHEREFORE, having fully responded to the Complaint of the Plaintiffs, these Defendants request that the same be dismissed with prejudice together with the costs and disbursements in the defense of this matter and from such other and further relief as this Court deems just and proper.

Respectfully submitted,

Marian W. Scalise

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Attorneys for Defendants Steven N. Coker, M.D. and Drs. Coker & Phillips, P.A.

RPR
1

4-17, 2013.

Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF FLORENCE	)	TWELFTH JUDICIAL CIRCUIT
Genesie Fulton, individually, and as Next Friend of Bryson F a minor	)	C/A No. 2013-CP-21-00587
Plaintiff,	)	**DEFENDANT L. WILLIAM GOLDSTEIN, M.D., INDIVIDUALLY AND D/B/A L. WILLIAM GOLDSTEIN OB-GYN'S ANSWER TO PLAINTIFF'S COMPLAINT (Jury Trial Requested)**
Versus	)	
L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A.,	)	
Defendants.	)	

FILED
2013 APR 26 PM 1:27
CCCP & GS
FLORENCE COUNTY, SC

The Defendant, L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN (hereinafter "this Defendant"), hereby answers the Plaintiff's Complaint subject to their affirmative defenses, motions and any other pleadings, as follows:

1. This Defendant denies each and every allegation of the Plaintiff's Complaint which he does not specifically admit without qualification in this Answer.

2. This Defendant is without sufficient knowledge at this time to form a belief as to the truth of the allegations contained in Paragraph 1 of the Plaintiff's Complaint and therefore those allegations are denied.

3. This Defendant admits the allegations contained in Paragraph 2 of the Plaintiff's Complaint.

4. In response to the allegations contained in Paragraph 3 of the Plaintiff's Complaint, this Defendant admits only so much as alleges that he is board certified in obstetrics and gynecology. All remaining allegations contained in Paragraph 3 of the Plaintiff's Complaint are denied as written.

5. In response to the allegations contained in Paragraphs 4 and 5 of the Plaintiff's Complaint, this Defendant admits only so much as alleges that this Defendant provided medical care at his office in Florence County. Further responding, the allegations contained in Paragraphs 4 and 5 of the Plaintiff's Complaint state conclusions of law to which no response is required.

6. The allegations contained in Paragraphs 6, 7, 8, 9 and 10 of the Plaintiff's Complaint are not directed toward this Defendant and therefore do not require a response.

7. In response to the allegations contained in Paragraphs 11, 12, 13, 14 and 15 of the Plaintiff's Complaint, this Defendant admits only so much as alleges that Dr. Goldstein provided care to the Plaintiff during her pregnancy and delivery in 2009. Further responding, this Defendant craves reference to the Plaintiff's medical records for a more detailed description of all complaints, diagnosis and treatment. All remaining and inconsistent allegations contained in Paragraphs 11, 12, 13, 14 and 15 of the Plaintiff's Complaint are denied.

8. The allegations contained in Paragraph 16 of the Plaintiff's Complaint state conclusions of law to which no response is required.

9. This Defendant denies the allegations contained in Paragraphs 17 and 18 (including subparts a, b, c, d, e, f, g, h, I, j, k, l m, n and o) of the Plaintiff's Complaint.

10. The allegations contained in Paragraph 19 (including subparts a, b, c, d, e, f, g, h, I, j and k) are not directed toward this Defendant and therefore do not require a response.

11. This Defendant denies the allegations contained in Paragraphs 20 (including subparts a, b, c, d, e, f, g, h, I, j and k) and 21 (including subparts a, b, c and d) of the Plaintiff's Complaint.

12. The allegations contained in Paragraph 22 of the Plaintiff's Complaint state conclusions of law to which no response is required.

13. This Defendant denies the allegations contained in Paragraph 23 (including subparts a, b, and c) of the Plaintiff's Complaint.

14. The allegations contained in Paragraph 24 of the Plaintiff's Complaint state conclusions of law to which no response is required.

15. This Defendant denies the allegations contained in the WHEREFORE Paragraph, being the remaining allegations of the Plaintiff's Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(No Deviation from Standard of Care)

16. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within applicable medical standards and methods, and, at no time pertinent hereto, did this Defendant deviate from any medical standard while caring for or tending to the Plaintiff. Consequently, the Plaintiff is barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(No Proximate Cause)

17. That, even if this Defendant was negligent, as alleged in the Complaint, which is specifically denied, the negligence of this Defendant is not the direct or proximate cause of any injury alleged by the Plaintiff and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiff.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Failure to State a Claim)

18. The allegations contained in the Complaint fail in their entirety to state a claim upon which relief may be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Superseding/Intervening Cause)

19. Whatever injuries and damages, if any, may have been sustained by the Plaintiff, were due to a superseding and/or intervening cause beyond the control of this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Pre-Existing Medical Condition)

20. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of pre-existing medical conditions of the decedent, whether disclosed or undisclosed, and were not related to the incidents complained of in the Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Predisposition of Medical Condition)

21. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of the decedent's predisposition to medical conditions, whether disclosed or undisclosed, and were not related to the incidents complained of in the Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Natural Disease Process)

22. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by Plaintiff were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant pleads such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Comparative Negligence)

23. This Defendant alleges that any injuries received by the Plaintiff, as alleged in the Complaint, if any, may have been due to and caused by and may be the direct and proximate result of acts of negligence on the part of the Plaintiff or a third party, over whom this Defendant had no control, so as to bar the claims of the Plaintiff against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Lack of Foreseeability)

24. That upon information and belief, even if the damages alleged in Plaintiff's Complaint, if any, were proximately caused by the acts and/or omissions of this Defendant, which is otherwise denied except for the purpose of this affirmative defense, this Defendant did not and could not have foreseen that Plaintiff's damages, if any, could have proximately resulted from this Defendant's acts or omissions.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Reasonableness and Good Faith)

25. This Defendant alleges that he acted reasonably and in good faith at all times material herein, based on all relevant facts and circumstances known by him at the time he so acted. Accordingly, Plaintiff is not entitled to the recovery of any damages whatsoever.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Punitive Damages Unconstitutional)

26. That any award or assessment of punitive damages as prayed for by the Plaintiff would violate this Defendant' constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Application of S.C. Code Ann. § 15-38-15)

27. That, upon information and belief, even if this Defendant was negligent as described in the Complaint, which is specifically denied, this Defendant was less than fifty percent liable for the total fault alleged. Accordingly, join and several liability should not apply to this action as it relates to this Defendant and this Defendant should be held liable only for the percentage of fault, which is specifically denied, to be determined by the trier of fact. Additionally, this Defendant hereby reserves the right to seek all remedies, rights and privileges available to them pursuant to S.C. Code Ann. §15-38-15.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Noneconomic Damage Awards)

28. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code Ann. §15-32-200, et. seq. This Defendant is a health care provider as defined by S.C. Code Ann. § 15-32-210 and pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Obstetrical Care Exception)

29. Pursuant to S.C. Code Ann. § 15-32-230, this Defendant was not grossly negligent in the care provided in this case and therefore, is not liable for any damages allegedly incurred by the Plaintiff.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Reservation and Non-Waiver)

30. This Defendant reserves any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, and as are consistent with the *South Carolina Rules of Civil Procedure*.

WHEREFORE, having fully answered the Plaintiff's Complaint, subject to any motions, qualifications, or other pleadings, and having asserted these Affirmative Defenses, this Defendant, L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, prays that the Plaintiff's Complaint be dismissed with prejudice and that he be awarded costs and attorney fees for defending this matter together or with such other relief which the Court deems proper.

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Attorneys for the Defendant
L. William Goldstein, M.D., individually and
d/b/a L. William Goldstein OB-GYN

4/24, 2013
Charleston, South Carolina

2013 APR 26 PM 1:27
CONNIE REEL-SHEARIN
CCCP & GS
FLORENCE COUNTY, SC
FILED

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☒ mailing, ☐ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 24 day of April, 2013.

Melanie D. Hall

COPY

STATE OF SOUTH CAROLINA COUNTY OF FLORENCE	IN THE COURT COMMON PLEAS TWELFTH JUDICIAL CIRCUIT C/A NO.:
Genesie Prince, individually, and as Next Friend of Bryson F , a Minor, Plaintiff, vs. L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Defendants.	**SECOND AMENDED COMPLAINT** (Jury Trial Requested)

FILED
2015 APR 30 PM 4:45
REBECCA SHECKABER
CLERK OF COURT
FLORENCE COUNTY, SC

COMES NOW the Plaintiff complaining of Defendants above named and would show unto the Court as follows:

1. Plaintiff Genesie Prince (hereinafter, "Genesie") is a citizen and resident of Florence County, South Carolina, and brings this action individually and as Next Friend of her son, Bryson F , (hereinafter, "Bryson")

2. Defendant L. William Goldstein, M.D. (hereinafter, "Dr. Goldstein") is, upon information and belief, a citizen and resident of Florence County, South Carolina, who was, upon information and belief, at all times relevant to this action, a physician duly licensed to practice medicine within the State of South Carolina.

3. Defendant Dr. Goldstein held himself out to the public as having specialized knowledge, training and experience for the provision of high quality obstetrical and gynecological care.

4. Defendant Dr. Goldstein maintained an office in Florence, County, South Carolina, for the practice of obstetrics and gynecology.

CERTIFIED: A TRUE COPY
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

5. Upon information and belief, Dr. Goldstein, practiced obstetrics and gynecology using the business name of L. William Goldstein, M.D., OB-GYN (hereinafter, "OB-GYN").

6. Prior to August 20, 2009, Genesie, mother of Bryson, became pregnant and submitted herself to the care and attention of Dr. Goldstein for pre-natal and obstetrical care.

7. On August 20, 2009, Defendant Dr. Goldstein along with Dr. Coker attended the delivery of Bryson, son of Genesie, at Carolinas Hospital System (hereinafter, "Hospital") in Florence County, S.C.

8. Bryson was a healthy baby prior to August 20, 2009, when his mother, Genesie, was admitted to the Hospital.

9. Defendant Dr. Goldstein took charge of the health care of Genesie and her baby upon Genesie's admittance to the Hospital.

10. Dr. Coker attended and assisted Defendant Goldstein with the delivery of Bryson.

11. The Defendant, Dr. Goldstein owed Genesie and her son a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar situations.

12. Defendant Dr. Goldstein breached the duty of care to Genesie and her son Bryson, and was negligent, reckless, willful, wanton, and/or otherwise wrongful in the care of them and attention to them, as a direct and proximate result of which Bryson sustained severe bodily injuries, losses and damages; and Genesie also thereby sustained losses and damages.

13. Defendant Dr. Goldstein was negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including, but not limited to, the following particulars:

(a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in

particular, before attempting to manage the birthing process of Bryson;

(b) in choosing not to appreciate the heightened risk of shoulder dystocia in his delivery;

(c) in causing Genesie to have excessive uterine activity;

(d) in failing and refusing to timely recognize the signs and symptoms of shoulder dystocia;

(e) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;

(f) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;

(g) in using improper delivery technique;

(h) in using improper and excessive force, traction and/or torsion;

(i) in mismanagement of labor and delivery;

(j) in mismanagement of shoulder dystocia;

(k) in failing and refusing to perform delivery by C-Section, or convert to a C-Section;

(l) in failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health;

(m) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition;

(n) in failing to advise and disclose to the patient that a circumstance had arisen that the physician believed indicated an operative delivery and use of a vacuum, in failing to

inform and disclose this diagnosis to the mother, in failing to properly discuss and explain the general nature of a vacuum assisted operative delivery, in failing to have the physician participate in the informed consent process, in failing to properly discuss and explain the material risks involved in such a procedure, in failing to properly explain and discuss the probability of success associated with vacuum use, in failing to properly explain and discuss the prognosis of what would result if a vacuum was not used, and failure to properly disclose and discuss the existence of any alternatives to an vacuum assisted operative vaginal delivery;

(o) such other failures and refusals as may be identified during discovery and the trial of his case.

14. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein, Bryson has sustained certain injuries, losses and damages, stated with particularity as follows:

(a) Direct violent and traumatic injuries to various bodily members of Bryson, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder and arm, commonly known as Erb's palsy;

(b) Adverse effects on various other bodily members and/or functions, such as gait, balance and skeletal and muscular symmetry;

(c) Past and future medical expenses;

(d) Life care management plan expense;

(e) Permanent impairments and disabilities;

(f) Disfigurement;

(g) Physical pain and suffering;

(h) Mental, emotional and psychological harm;

(i) Adverse effect on the future career opportunities, employability, earnings and earning capacity;

(j) Loss of enjoyment of life; and

(k) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

15. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein, Genesie has sustained certain losses and damages, including but not limited to:

(a) Past and future medical expenses;

(b) Life Care Management expenses;

(c) Economic losses; and

(d) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

16. Plaintiffs have previously complied with all statutory requirements for commencing this action. A copy of an Affidavit of Dr. Yvonne Gomez-Carrion is attached hereto in support of the liability allegations made herein.

WHEREFORE, Plaintiff prays for judgment against Defendant, jointly and severally, for an award of actual damages; for an additional award of punitive damages against the said Defendant in an amount to be determined by the jury in accordance with the facts and circumstances presented at trial; for costs of this action; and for such other and further relief as this Court may deem just and proper.

GRAHAM LAW FIRM, P.A.



Edward L. Graham
Diane M. Rodriguez
J. Layton Ruffin
383 W. Cheves St.
Florence, SC 29501

Attorney for Plaintiff

April 30, 2015

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	
COUNTY OF FLORENCE)	TWELFTH JUDICIAL CIRCUIT
Genesie Fulton, individually, and as Next Friend of Bryson F , a minor,)	C/A No. 2013-CP-21-00587
Plaintiff,)	**DEFENDANT L. WILLIAM GOLDSTEIN, M.D., INDIVIDUALLY AND D/B/A L. WILLIAM GOLDSTEIN OB-GYN'S ANSWER TO PLAINTIFF'S SECOND AMENDED COMPLAINT (Jury Trial Requested)**
Versus)	
L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A.,)	
Defendants.)	

The Defendant, L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN (hereinafter "this Defendant"), hereby answers the Plaintiff's Second Amended Complaint subject to their affirmative defenses, motions and any other pleadings, as follows:

1. This Defendant denies each and every allegation of the Plaintiff's Second Amended Complaint which he does not specifically admit without qualification in this Answer.

2. This Defendant is without sufficient knowledge at this time to form a belief as to the truth of the allegations contained in Paragraph 1 of the Plaintiff's Second Amended Complaint and therefore those allegations are denied.

3. *This Defendant admits the allegations contained in Paragraph 2 of the* Plaintiff's Second Amended Complaint.

4. In response to the allegations contained in Paragraph 3 of the Plaintiff's Second Amended Complaint, this Defendant admits only so much as alleges that he is board certified in obstetrics and gynecology. All remaining

allegations contained in Paragraph 3 of the Plaintiff's Second Amended Complaint are denied as written.

5. In response to the allegations contained in Paragraphs 4 and 5 of the Plaintiff's Second Amended Complaint, this Defendant admits only so much as alleges that this Defendant provided medical care at his office in Florence County. Further responding, the allegations contained in Paragraphs 4 and 5 of the Plaintiff's Second Amended Complaint state conclusions of law to which no response is required.

6. In response to the allegations contained in Paragraphs 6, 7, 8, 9, and 10 of the Plaintiff's Second Amended Complaint, this Defendant admits only so much as alleges that Dr. Goldstein provided care to the Plaintiff during her pregnancy and delivery in 2009. Further responding, this Defendant craves reference to the Plaintiff's medical records for a more detailed description of all *Second Amended Complaint, diagnosis and treatment.* All *remaining and* inconsistent allegations contained in Paragraphs 6, 7, 8, 9, and 10 of the Plaintiff's Second Amended Complaint are denied.

7. The allegations contained in Paragraph 11 of the Plaintiff's Second Amended Complaint state conclusions of law to which no response is required.

8. This Defendant denies the allegations contained in Paragraphs 12 and 13 *(including subparts a, b, c, d, e, f, g, h, I, j, k, l m, n and o) of the Plaintiff's* Second Amended Complaint.

9. This Defendant denies the allegations contained in Paragraph 14 (including subparts a, b, c, d, e, f, g, h, i, j and k).

10. This Defendant denies the allegations contained in Paragraphs 15 (including subparts a, b, c, and d).

11. The allegations contained in Paragraph 16 of the Plaintiff's Second Amended Complaint state conclusions of law to which no response is required.

12. This Defendant denies the allegations contained in the WHEREFORE Paragraph, being the remaining allegations of the Plaintiff's Second Amended Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(No Deviation from Standard of Care)

13. That the care and treatment administered by this Defendant conformed to and was in full compliance with the standard of care. All care and treatment administered by this Defendant was within applicable medical standards and methods, and, at no time pertinent hereto, did this Defendant deviate from any medical standard while caring for or tending to the Plaintiff. Consequently, the Plaintiff is barred from recovery against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(No Proximate Cause)

14. That, even if this Defendant was negligent, as alleged in the Second Amended Complaint, which is specifically denied, the negligence of this Defendant is not the direct or proximate cause of any injury alleged by the Plaintiff and therefore this Defendant is not liable for any damages allegedly sustained by the Plaintiff.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Failure to State a Claim)

15. The allegations contained in the Second Amended Complaint fail in their entirety to state a claim upon which relief may be granted against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Superseding/Intervening Cause)

16. Whatever injuries and damages, if any, may have been sustained by the Plaintiff, were due to a superseding and/or intervening cause beyond the control of this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Pre-Existing Medical Condition)

17. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of pre-existing medical conditions of the decedent, whether disclosed or undisclosed, and were not related to the incidents complained of in the Second Amended Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Predisposition of Medical Condition)

18. Whatever injuries the Plaintiff sustained, which are specifically denied herein, were the result of the decedent's predisposition to medical conditions, whether disclosed or undisclosed, and were not related to the incidents complained of in the Second Amended Complaint.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Natural Disease Process)

19. That this Defendant would allege, upon information and belief, that any injuries or damages sustained by Plaintiff were due to, caused and occasioned by the natural disease process over which this Defendant had no control and as such, this Defendant pleads such a natural disease process as a complete bar to this action.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Comparative Negligence)

20. This Defendant alleges that any injuries received by the Plaintiff, as alleged in the Second Amended Complaint, if any, may have been due to and caused by and may be the direct and proximate result of acts of negligence on the part of the Plaintiff or a third party, over whom this Defendant had no control, so as to bar the claims of the Plaintiff against this Defendant.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Lack of Foreseeability)

21. That upon information and belief, even if the damages alleged in Plaintiff's Second Amended Complaint, if any, were proximately caused by the acts and/or omissions of this Defendant, which is otherwise denied except for the purpose of this affirmative defense, this Defendant did not and could not have foreseen that Plaintiff's damages, if any, could have proximately resulted from this Defendant's acts or omissions.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, *THIS DEFENDANT ALLEGES:*
(Reasonableness and Good Faith)

22. This Defendant alleges that he acted reasonably and in good faith at all times material herein, based on all relevant facts and circumstances known by him at the time he so acted. Accordingly, Plaintiff is not entitled to the recovery of any damages whatsoever.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Punitive Damages Unconstitutional)

23. That any award or assessment of punitive damages as prayed for by the Plaintiff would violate this Defendant' constitutional rights under the Fifth, Sixth and Fourteenth Amendments of the United States Constitution and comparable provisions of the South Carolina Constitution.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Application of S.C. Code Ann. § 15-38-15)

24. That, upon information and belief, even if this Defendant was negligent as described in the Second Amended Complaint, which is specifically denied, this Defendant was less than fifty percent liable for the total fault alleged. Accordingly, join and several liability should not apply to this action as it relates to this Defendant and this Defendant should be held liable only for the percentage of fault, which is specifically denied, to be determined by the trier of fact. Additionally, this Defendant hereby reserves the right to seek all remedies, rights *and privileges available to them pursuant to S.C. Code Ann. §15-38-15.*

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Noneconomic Damage Awards)

25. No award for noneconomic damages shall exceed the statutory limits contained in the Noneconomic Damages Awards Act of 2005, South Carolina Code *Ann. §15-32-200*, et. seq. This Defendant is a health care provider as defined by S.C. Code Ann. § 15-32-210 and pursuant to §15-32-220 of the Noneconomic Damage Awards Act of 2005, any potential recovery of noneconomic damages is limited to the amounts stated therein.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Obstetrical Care Exception)

26. Pursuant to S.C. Code Ann. § 15-32-230, this Defendant was not grossly negligent in the care provided in this case and therefore, is not liable for any damages allegedly incurred by the Plaintiff.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Informed Consent)

27. The Plaintiff with knowledge and understanding consented to treatment and therefore her claims are barred in accordance with the principles of informed consent.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Failure to Mitigate)

28. This Defendant would allege and show that the Plaintiffs had a duty to mitigate their damages and failed to do so.

FURTHER ANSWERING AND AS AN AFFIRMATIVE DEFENSE, THIS DEFENDANT ALLEGES:
(Reservation and Non-Waiver)

29. This Defendant reserves any additional and further defenses as may be revealed by additional information during the course of discovery and investigation, and as are consistent with the *South Carolina Rules of Civil Procedure*.

WHEREFORE, having fully answered the Plaintiff's Second Amended Complaint, subject to any motions, qualifications, or other pleadings, and having asserted these Affirmative Defenses, this Defendant, L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, prays that the Plaintiff's Second Amended Complaint be dismissed with prejudice and that he be awarded costs and attorney fees for defending this matter together or with such other relief which the Court deems proper.

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Brian J. Kern (SC #79719)

Attorneys for the Defendant
L. William Goldstein, M.D., individually and
d/b/a L. William Goldstein OB-GYN

May 1, 2015
Charleston, South Carolina

CERTIFICATE OF SERVICE

I certify that on this date a copy of the foregoing was served on each party or counsel of record by ☐ mailing, ☒ e-mailing, ☐ facsimile, or ☐ hand delivery in the manner prescribed by the applicable Rule of Civil Procedure.

This 1 day of May, 2015.

COPY

STATE OF SOUTH CAROLINA)	IN THE COURT OF COMMON PLEAS
)	TWELFTH JUDICIAL CIRCUIT
COUNTY OF FLORENCE)	
)	CASE NO.: 2013-CP-21-0587
Genesie Fulton, individually and as Next Friend of Bryson F , a minor,)	**MOTION AND ORDER INFORMATION**
Plaintiff,)	**FORM AND COVERSHEET**
vs.)	
L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Steven N. Coker, M.D., and Drs. Coker & Phillips, P.A.,)	
Defendant.)	

FILED
2015 MAY 15 PM 4:20
CONNIE REEL-SPEARIN
CLERK OF COURT
FLORENCE COUNTY, S.C.

Plaintiff's Attorney:	Defendant's Attorney:
J. Layton Ruffin, Bar No. 78267 Edward L. Graham, Bar No. 2483 Address: Graham Law Firm P.O. Box 550 Florence, SC 29503 Phone: 843.662.3281Fax 1.800.859.7028 E-mail: jlruffin@grahamlawfirm.netOther:	Elloree A. Ganes, Bar No. _____ Address: Hood Law Firm, LLC 172 Meeting St. Charleston, SC 29401 Phone: 843.577.1215 Fax843.722.1630 E-mail: elloree.ganes@hoodlaw.comOther:

☒ **MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III)**
☐ **FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III)**
☐ **PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)**

SECTION I: Hearing Information

Nature of Motion: Motion For New Trial Absolute
Estimated Time Needed: 30 mins Court Reporter Needed: ☒ **YES**/☐ **NO**

SECTION II: Motion/Order Type

☒ Written motion attached
☐ Form Motion/Order

I hereby move for relief or action by the court as set forth in the attached proposed order.

Signature of Attorney for ☒ Plaintiff /☐ Defendant — May 15, 2015 Date submitted

SECTION III: Motion Fee

☒ PAID – AMOUNT: $_____
☐ EXEMPT: (check reason)
☐ Rule to Show Cause in Child or Spousal Support
☐ Domestic Abuse or Abuse and Neglect
☐ Indigent Status ☐ State Agency v. Indigent Party
☐ Sexually Violent Predator Act ☐ Post-Conviction Relief
☐ Motion for Stay in Bankruptcy
☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRCP)
☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions
Name of Court Reporter: _____
☐ Other: _____

CERTIFIED A TRUE COPY
Connie Reel-Spearin
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

JUDGE'S SECTION

☐ Motion Fee to be paid upon filing of the attached order.
☐ Other: _____

JUDGE CODE _____
Date: _____

CLERK'S VERIFICATION

Collected by: ____ Date Filed: ____

☐ MOTION FEE COLLECTED: $ ____

☐ CONTESTED – AMOUNT DUE: $ ____

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA COUNTY OF FLORENCE Genesie Fulton, Individually and as Next Friend of Bryson F , a minor, Plaintiffs, v. L. William Goldstein, M.D., Individually and d/b/a L. William Goldstein OB-GYN, Defendants.	)	IN THE COURT OF COMMON PLEAS TWELFTH JUDICIAL CIRCUIT C/A NO.: 2013-CP-21-0587 **PLAINTIFFS' MOTION FOR NEW TRIAL ABSOLUTE**

FILED
2015 MAY 15 PM 4:20
CONNIE KEL-SPEARIS
CLERK OF COURT
FLORENCE COUNTY

Plaintiff hereby moves before this court for an order granting Plaintiff a new trial absolute, for the reasons stated herein

FACTS

Plaintiff tried this case to verdict, which was rendered on May 8, 2015. The jury deliberated for approximately five hours. The jury was charged on the obstetrical emergency statute found at S.C. Code Ann. § 15-32-230. Additionally, the jury was charged on the definition of gross negligence. The first question on the verdict form purported to track the language of the obstetrical emergency statute. Plaintiff objected to the language of the obstetric emergency statute as charged, the appropriateness and applicability of the obstetric emergency statute to the facts of this case, and the manner in which the obstetric emergency statute was written on the verdict form. Similarly, Plaintiff objected to the definition of gross negligence as charged to the jury. The jury found that the obstetric emergency statute applied. Therefore, the jury judged the physician's conduct according to the gross negligence standard as charged. The jury found for the defendant.

CERTIFIED: A TRUE COPY
Connie Kel-Spearis
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

The jury consisted of several members of the medical community. Additionally, plaintiff believes at least one jury was actively employed by Carolinas Hospital, the hospital where Genesie gave birth to Bryson. Other members of the jury had spouses employed by the medical community. Plaintiff believes another juror was employed by McLeod, the largest healthcare provider in the area. Plaintiff believes yet another juror's husband was the director of quality improvement at Hope Health, another large healthcare provider in Florence County. Another seated juror was a surgical tech who worked alongside a number of obstetricians in the OR. Although the jury was asked about whether any juror was employed by any plaintiff or defendant, and if any juror knew any of the witnesses, this court declined to inquire if any jurors who might be employed by a hospital or healthcare provider in the area. Moreover, this court did not ask if any jurors had spouses who were employed in the same. Finally, Plaintiff sought to have a juror stricken for cause who worked for a defense firm and specifically worked with an attorney who handled medical malpractice cases as the defense attorney. This court denied Plaintiff's request. Ultimately, Plaintiff used all available peremptory strikes but still faced a jury which consisted of a number of jurors who were either employed in the medical field or had relatives employed in the same.

As the trial proceeded, Plaintiff introduced testimony that Dr. Goldstein was not only negligent in his actions but was grossly negligent and reckless in his conduct. Plaintiff presented testimony that the proximate cause of Bryson's injury was excessive lateral traction applied by Dr. Goldstein. This testimony was elicited by obstetricians within a reasonable degree of medical certainty, most probably.

Similarly, testimony was also elicited from Dr. Hall that in this case, the mother was medically stable and the child was medically stable at all points in time from labor and delivery

to the birth of Bryson F . The defense offered no testimony at all that either the mother or the child in this case were ever not medically stable. Indeed, not even Dr. Goldstein provided testimony that he believed the mother or child were not medically stable. Plaintiff requested this court determine as a matter of law that the obstetric emergency statute did not apply to the facts of this case. The court denied Plaintiff's request.

STANDARD OF REVIEW

"The grant or denial of new trial motions rests within the discretion of the trial judge and his decision will not be disturbed on appeal unless his findings are wholly unsupported by the evidence or the conclusions reached are controlled by error of law." *Krepps by Krepps v. Ausen*, 324 S.C. 597, 608, 479 S.E.2d 290, 296 (Ct. App. 1996). Moreover, "[I]n an appeal of an order granting a new trial pursuant to the thirteenth juror doctrine, the appellant "bears the heavy burden of demonstrating to the court that it clearly appeared that the judge's exercise of discretion was controlled by a manifest error of law." *Youmans v. S.C. DOT*, 380 S.C. 263, 271, 670 S.E.2d 1, 5, (Ct. App. 2008).

ARGUMENT

Plaintiff respectfully submits to this court and argues that the verdict does not render justice, as it was the product of an unfair trial. The verdict was rendered after and affected by the following errors as listed and discussed *infra*.

1. **The Jury Charge and the Verdict Form did Not Correctly Track the Language of the Obstetrical Emergency Statute.**

S.C. Code Ann. § 15-32-230 sets forth the emergency medical and obstetrical care exceptions. Section (A) denotes the statute's applicability to care rendered in a "genuine emergency situation" involving an "immediate" threat of death or serious injury to the patient in

an obstetrical suite. Section (A) explains if these criteria are met, then the physician is not liable unless the plaintiff proves the physician was grossly negligent.

However, Section (C) specifically sets forth *when* the gross negligence standard will apply. It explains that subsection (A) applies only if the patient is ***not medically stable*** and the patient is either in immediate threat of death or in immediate threat of serious bodily injury. Thus for the obstetric emergency statute and therefore the gross negligent standard to apply, two things must be proven. Firstly, that the patient is not medically stable. Secondly, that the patient is either (1) in immediate threat of death or (2) in immediate threat of serious bodily injury.

The verdict form did not appropriately delineate the limitations of the obstetric emergency found within the statute itself. The verdict form should have listed and required the jury to find that (a) there was a genuine emergency situation, (b) there was an immediate threat of death or serious bodily injury, and (c) that the patient was not medically stable. This was not done in this case and the failure to do so was error.

Grouping the three together is not only confusing, it misleads the jury regarding what specifically must be proven by defendant to receive the benefit of the obstetric emergency statute. This is evidenced by the question asked by the jury within the first few minutes of deliberation. The jury asked whether if they answer "NO" they continue deliberations. Ultimately, they answered, "YES" to this first question. This clearly indicates confusion on the part of the jury and that they failed to properly understand all the elements necessary for the physician to receive the benefit of the obstetrical emergency statute.

Secondly, the jury charge makes no mention of the fact that the patient must be "medically stable." The language simply groups all three requirements together and fails to state that the requirement is that the patient be "medically stable." Simply asking whether the jury

finds that there was a genuine emergency situation where the patient is not *stable* fails to correctly reflect that requirements of a statute which abrogates common law. As such the statute should have tracked the language of the statute as written. This failure prejudiced the plaintiff by incorrectly presenting to the jury what is required for the obstetrical emergency statute to apply and allowed the jury to assess the physician's conduct based upon a standard of gross negligence.

The prejudice and impact was compounded by defense counsel's repeated mention to the jury that this was a "medical emergency" without ever mentioning that the jury needed to find that the patient was medically stable in order for the physician to receive the protection of the obstetric emergency statute. Accordingly, Plaintiff requests this court grant a new trial based upon the prejudicial error found in the verdict form related to the obstetric emergency statute and in the charge to the jury on the same.

2. **The Court Erred in Failing to Find that the Obstetric Emergency Statute did Not Apply as a Matter of Law**

Defense counsel presented zero evidence throughout the trial that the patient was not medically stable. Defendant sought concessions from Plaintiff's experts that shoulder dystocia is a medical emergency. Indeed, Plaintiff's experts admitted this. However, there is a difference between a medical emergency and a patient not being medically stable. The fact that each is a requirement for the obstetric emergency statute to apply highlights the legislature's understanding that there is a difference between "medical emergency" and "medically stable." Thus, the failure to put forth any evidence as to the "medical stability" of mother or child precluded Defendant from arguing for the protection of the obstetric emergency statute.

Only the plaintiff put forth any testimony on this issue. Dr. Hall stated unequivocally that both mom and baby were medically stable. He provided this opinion within a reasonable degree

of medical certainty most probably. Defendant's failure to elicit any testimony on this issue precludes them from seeking the protection of the obstetric emergency statute. Accordingly, this Court should have found as a matter of law that the statute did not apply.

3. **The Court Erred in its Charge on the Law of Gross Negligence.**

Plaintiff requested additional language defining gross negligence be charged to the jury. This Court denied Plaintiff's request. Accordingly, from memory the jury was charged that gross negligence is absence "of even the slightest of care." Plaintiff argues this was error.

One definition of gross negligence is "the failure to exercise slight care." *Steinke v. South Carolina Dep't of Labor, Licensing, & Regulation*, 336 S.C. 373, 395, 520 S.E.2d 142, 153, (1999). However, *Steinke* also noted, "Gross Negligence "is a relative term, and means the absence of care that is necessary under the circumstances." *Id.* citing *Hollins v. Richland County School Dist. One*, 310 S.C. 486, 490, 427 S.E.2d 654, 656 (1993).

Despite numerous appellate court cases repeatedly including this second sentence when defining "gross negligence" in South Carolina, the second sentence was not included in the jury charge. The failure to properly charge the jury on the definition of gross negligence prejudiced Plaintiff by imposing a greater burden upon her than the law required. Accordingly, the failure to include the full and accurate charge of the law on gross negligence in this state prejudiced the plaintiff and is grounds for new trial.

4. **The Court Erred in Failing to Strike a Juror who was a Paralegal to a Defense Attorney Who Handled Medical Malpractice Cases.**

A juror noted that she worked for an attorney who handled medical malpractice lawsuits as defense counsel. When asked if she could be impartial she hesitated significantly before answering the question. Only after several attempts to rehabilitate this prospective juror did she

finally state that she believed she could be impartial. However, her hesitation in answering these questions certainly suggests otherwise. Moreover, the fact that she willingly volunteered information that her boss was married to a physician further indicated that she could not be impartial. For what other reason would she make this known to the court? At the very least, such answers necessitated additional probing into her partiality. Counsel requested follow up questions but this request was declined. Ultimately, she ended up on the juror list, requiring plaintiff's counsel to use a peremptory strike on this particular juror, preventing us from striking one of the other healthcare workers that remained on the jury.

5. **The Court erred in Permitting Causation testimony of Dr. Goldstein**

Dr. Goldstein readily admitted that he was not an expert in the field of causation pertaining to this case and the brachial plexus birth injury sustained by Bryson. Nevertheless, Defense counsel sought to elicit causation testimony from Dr. Goldstein at trial. Plaintiff objected but this court overruled Plaintiff's objection. Plaintiff contends this was error.

An Expert must be qualified to offer expert testimony in the area in which he intends to testify. *See Watson v. Ford Motor Co.*, 389 S.C. 434, 446-47 699 S.E.2d 169, 175 (2010). By Dr. Goldstein's own admission, he was not qualified to offer causation testimony in this case. This alone should have barred him from offering causation testimony. Nevertheless, he was permitted to testify as to the cause of Bryson's injury.

Moreover, in addition to his own admission that he was unqualified to offer testimony on this subject, the testimony he did offer was unreliable and fell short of all evidentiary requirements for the admission of competent expert testimony. Prior to his testimony, this Court should have assessed the reliability of Dr. Goldstein's testimony according to its role as gatekeeper. *Id.* Such an assessment would have revealed that Dr. Goldstein had no reliable basis

for offering his opinion that he did not cause Bryson's brachial plexus birth injury. *See also State v. Council*, 335 S.C. 1, 515 S.E.2d 508 (2008); *State v. Jones*, 273 S.C. 723, 259 S.E.2d 120 (1979).

Finally, even assuming arguendo that Dr. Goldstein (1) was qualified and (2) the basis of his opinion was reliable, Plaintiff believes Dr. Goldstein's testimony still violated the "most probable" requirement for the admission of causation testimony. *See Payton v. Kearse*, 329 S.C. 51, 495 S.E.2d 205 (1995). Never did Dr. Goldstein state that he offered his causation testimony within a reasonable degree of medical certainty, most probably. Indeed, this is most likely due to the fact that he did not even believe himself qualified to offer testimony on the subject in the first place.

Accordingly, Dr. Goldstein was unqualified to offer causation testimony, offered unreliable causation testimony, offered testimony in violation of the most probably requirement for causation testimony, and Plaintiff suffered prejudice as a result. Due to its lack of reliability, its probative value was substantially outweighed by danger of unfair prejudice and confusion. Rule 403, SCRE. Finally the admission of this testimony conflicts with prior decisions by the South Carolina Supreme Court related to the exclusion of incompetent unreliable evidence. *See e.g., Watson v. Ford Motor Co.*, 389 S.C. 434, 455, 699 S.E.2d 16+9, 175 (2010); *Graves v. CAS Med. Sys.*, 401 S.C. 63, 75, 735 S.E.2d 650, 656 (2012).

6. **The Court Erred in Permitting Dr. Salley's Testimony**

This Court permitted Dr. Salley to offer testimony as to the cause of Bryson's brachial plexus birth injury despite said testimony lacking all indicia of reliability. At no point did Dr. Salley cite to any literature which stood for the proposition that a permanent brachial plexus birth injury could be caused by anything other than excessive lateral traction. The only literature cited

to by Dr. Salley discussed temporary injuries. Moreover, it put forth a hypothesis for the cause of these injuries that has not been tested and is not accepted as an established cause. Accordingly, the testimony offered by Dr. Salley on this point was unreliable.

Secondly, his testimony fell woefully short of the "most probably" standard for admission of causation testimony set forth in *Kearse*. Dr. Salley, what one can only be called an attempt to confuse the jury, cited four things that can contribute to a brachial plexus birth injury. He mentioned genetics, asynclitism, abnormal pelvic anatomy, and expulsive forces. However, noting hypothetical possible contributing factors, generally, differs greatly from offering reliable testimony in compliance with the most probably requirement for admission of causation testimony. Dr. Salley had zero evidence of genetics as a contributing factor in this case. Dr. Salley had zero evidence of asynclitism in this case. Dr. Salley had zero evidence that Genesie had an abnormal pelvis. Finally, Dr. Salley had no evidence that suggested expulsive forces contributed to a brachial plexus birth injury in this case. Tellingly, when asked to what degree of certainty he held this opinion, he could not describe even a half percent to any of the four purported causes as being the cause of Bryson's birth injury. An expert who holds his expert opinion on the aggregate within a two percent likelihood of being the cause of a child's injury falls woefully short of stating that these factors most probably caused the child's injury. For this reason, his testimony should have been excluded.

Similarly, Dr. Salley's standard of care opinions violated South Carolina's evidentiary requirements regarding reliability and competency. His opinions were inappropriately based upon Dr. Goldstein's own opinion of how much traction he applied in this delivery. Dr. Goldstein admitted he had no memory of how much traction he applied. Moreover, his 5 shoulder dystocias over the course of 35 years is insufficient to constitute habit-based testimony.

Finally, irrespective of whether he had sufficient experience with shoulder dystocia to offer habit based testimony, Dr. Salley inappropriately considered the veracity of one witness's testimony over another in formulating his standard of care opinions. Dr. Salley is in no better position to determine whether one witness is telling the truth than another. By determining which witness to believe, he invaded the province of the jury. Thus, Dr. Salley's remaining basis for his testimony was nothing more than his own *ipse dixit* conclusions. Accordingly, his standard of care testimony should have been excluded.

7. **The Court Erred in Permitting Dr. Jacobson to Offer Causation Testimony**

Similarly, Dr. Jacobson's testimony should have been excluded for being unreliable and for falling short of the most probably requirement set forth in *Kearse*. He could not state the most probable cause of Bryson's injury. Moreover, his opinions were unreliable.

An additional ground for excluding Dr. Jacobson's opinion is that it improperly considered the veracity of statements made by others. This should not have been permitted. He is in no better position to understand whether one person is telling the truth over events than another. To do so invades the province of the jury. To form his opinions, Dr. Jacobson had to base his analysis on what the defendant said about how much traction he applied, even though Dr. Goldstein testified under oath that he had no memory of how much traction he applied. Accordingly, Dr. Jacobson's testimony should have been excluded.

8. **Dr. Gower's Testimony Should Have Been Excluded**

As with Dr. Goldstein, Dr. Gower should not have been permitted to offer any testimony on the issue of causation. Plaintiff believes Dr. Gower did in fact offer such testimony. To the extent he did, and to the extent Plaintiff objected, his offering testimony on this matter was in error. Similarly, his standard of care opinions were based upon nothing other than his *ipse dixit*

conclusions and an improper weighing of the veracity of one witness's testimony over another. For these reasons, his causation and standard of care testimony should have been excluded.

9. **The Court Erred in Failing to Adequately Voir Dire the Jury Panel**

Multiple jurors with ties to the medical community were included in the potential jury pool. Ultimately, a number of jurors with ties to the medical community of Florence were seated on the jury. At least two jurors were employed by local hospitals. The jury foreperson was employed in the field of mental health services. Yet another juror's husband was the director of quality improvement at a local medical center. One juror, a surgical tech, had worked alongside a number of obstetricians in the OR. The Court should have inquired further into these jurors ability to be fair and impartial. It is insufficient to simply ask the entire panel if they know of any reason they could not be fair and impartial. This is especially true where a suit involves medical malpractice in a medical community like Florence. Similarly, this court erred in not asking the panel the voir dire questions requested by Plaintiff. For this reason, it was error not to inquire further into the ability to be fair and impartial of those jurors who were personally employed in the medical field or were married to someone employed in the same.

10. **This Court Should Grant a New Trial Based upon Cumulative Error**

Plaintiff believes the cumulative error of these highlighted issues, along with this court's ruling on a number of other matters, when taken on the whole, require that a new trial be granted. There were a number of rulings when, taken together, also constitute error warranting a new trial. These include the exclusion of certain exhibits and the admitting of an animation lacking all indicia of reliability. The animation in question was not created by or in conjunction with the expert who referred to it. It did not accurately represent the facts of this case. Moreover, it

showed a stretch upon a baby's neck from uterine forces far beyond anything ever recorded in the medical literature.

Moreover the court erred in limiting Dr. Hall's rebuttal testimony. As a rebuttal witness, he should have been permitted to "rebut" testimony presented by the defense in trial. Dr. Hall was present for Dr. Salley's testimony. Dr. Hall was ready to offer testimony and a number of articles which explained why everything Dr. Salley testified to was at best inaccurate and at worse, knowingly false. As a rebuttal witness, he should have been permitted to testify to these matters. Moreover, his deposition addressed issues related to causation. Plaintiff further supports this basis with those objections and rulings made by the court which will be reflected in the transcript.

11. Thirteenth Juror Doctrine

Finally, Plaintiff asserts that this Court should grant a new trial based upon the thirteenth juror doctrine. "The thirteenth juror doctrine is a vehicle by which the circuit court may grant a new trial absolute when it finds the evidence does not justify the verdict." *Trivelas v. S.C.D.O.T.*, 357 S.C. 545, 553, 593 S.E.2d 504, 508 (Ct. App. 2004). "The effect is the same as if the jury failed to reach a verdict, and thus, the circuit court is not required to give any reason for granting the new trial." *Id.* "Therefore, a circuit court's order granting or denying a new trial upon the facts will not be disturbed unless its decision is wholly unsupported by the evidence or the conclusion reached was controlled by an error of law." *Id. citing South Carolina State Highway Dep't v. Clarkson*, 267 S.C. 121, 126-27, 226 S.E.2d 696, 697 (1976).

In this case, the evidence does not justify the verdict. Numerous witnesses for the plaintiff offered testimony that Dr. Goldstein's actions were not only negligent, they were reckless. Based solely upon the facts presented to this Court, this Court should use its ability to

sit as the thirteenth juror and grant a new trial. The fact that one juror was rushing to get to Disney World is evidence that jurors did not adequately consider the facts of this case and were simply ready to be finished and go home (or on vacation). Thus based upon the quality and volume of the evidence presented by Plaintiff compared to a dearth of reliable testimony on causation or standard of care by the defendant, coupled with the juror's desire to end this matter, necessitates that this Court sit as the thirteenth juror and declare a new trial.

CONCLUSION

For the reasons, stated, Plaintiff respectfully requests this Court grant Plaintiff's motion for a new trial absolute.

Respectfully submitted,

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Respectfully submitted,

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May 15, 2015

STATE OF SOUTH CAROLINA) COUNTY OF FLORENCE)) Genesie Fulton, individually, and as,) Next Friend of Bryson F ,) a minor) Plaintiff,)) v.) L. William Goldstein, M.D.,) Individually and d/b/a L. William) Goldstein OB-GYN,)) Defendants.)	IN THE COURT OF COMMON PLEAS TWELFTH JUDICIAL CIRCUIT C/A NO: 2003-CP-21-0587 CERTIFICATE OF SERVICE

FILED
2015 MAY 15 PM 4:20
CONNIE REEL-SPEARIA
CCCP & GS
FLORENCE COUNTY, S.C.

I HEREBY CERTIFY that a copy of Plaintiff's Motion for New Trial Absolute was served upon counsel of record by depositing true and accurate copies thereof in the United States Mail, proper postage affixed thereto, on the 15th Day of May 2015, addressed to:

Elloree A. Ganes
Hood Law Firm, LLC
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Charleston, SC 29401

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May 15, 2015

CERTIFIED: A TRUE COPY
Connie Reel-Spearia
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

GOMEZ-CARRION, MD, testified as follows:)

THE COURT: Have a seat in the witness chair and I'll ask that you pull up real close to that microphone and speak loudly, clearly, and slowly in order that we can hear everything that you've got to say and let's start with your full name.

DR. GOMEZ-CARRION: Slowly being an issue since I'm a New Yorker, but I will try my best.

THE COURT: Very good.

DR. GOMEZ-CARRION: My full name is Yvonne Gomez-Carrion.

THE COURT: Spell that last one for us, please.

DR. GOMEZ-CARRION: G-O-M-E-Z, as in Zebra, hyphen, C-A-R-R-I-O-N.

THE COURT: All right.

DR. GOMEZ-CARRION: May I move this so I can look this way? (Referencing microphone)

THE COURT: You sure can. Mr. Graham, you are recognized.

MR. GRAHAM: Thank you, Your Honor.

DIRECT EXAMINATION

BY EDWARD GRAHAM:

Q Good morning, Doctor.

A Good morning.

Q Tell us, please, where were you born.

A St. John's Hospital, Atlantic Avenue, Brooklyn, New York.

Q Where do you currently live?
A I live in Newton, Massachusetts. It's a suburb outside of Boston.
Q Do you have children?
A I do.
Q How many?
A Five.
Q Tell us, please, about your education, starting with college.
A I attended Princeton University. I graduated with a degree in psychology and biology in 1979, then came back across the bridge and attended Columbia College of Physicians and Surgeons for my medical school training. I stayed there for my residency training at the Columbia Presbyterian Medical Center.
Q When you talk about Columbia, you are talking about Columbia University in New York City?
A Correct, sir.
Q After medical school -- you finished medical school at Columbia?
A I did.
Q And tell us about your residency training.
A So I started my residency training in 1983 and I did my entire training at Columbia, which every now and then, they shipped us to outside hospitals. I stayed a bit of

time in New Jersey. So I was an intern, second-year, third-year, and I was elected chief resident at the time. Chief resident in 1987 was a little bit different than now. Now, everybody gets to be chief. Back then, you had to be elected by your peers to be chief resident.

Q So when you were chief, how many chiefs were there?

A Only one chief.

Q What is your specialty?

A Obstetrics and gynecology.

Q And what's the difference between obstetrics and gynecology? Please explain each one of those.

A Well, obstetrics deals with women who are pregnant, from the very early parts of pregnancy, so; from the time of pregnancy, their first missed period through their prenatal period, through labor and delivery and three months after that, so the postpartum period. Obstetricians also deal with women who are not pregnant, because often women are seeking advice in terms of how to prepare for a pregnancy, something we call pre-pregnancy counseling or pre-conceptual counseling. Gynecology, however, deals mostly with women who are in the non-pregnant state, with the exception of someone who may be pregnant and the baby is not in the right place. So that's called an atopic pregnancy. The baby

may be in the fallopian tube or attached to the ovary. I had a case where the placenta was actually attached to a woman's liver. And I also am, presently, one of the busiest gynecologic surgeons at the hospital where I work and that entails removing a woman's uterus because of bleeding or precancerous conditions, fibroids, or trying to preserve a woman's uterus by restoring normal anatomy. So I deal with a lot of women who have fibroids and often these are young women, unfortunately, who have not had any children so I'm trying to take out these benign tumorous growths to restore the normal anatomy of the uterus so a woman can go to term. I also deal with ovarian cysts, abnormal pap smears, I mean, any issues that have to do with women.

Q Thank you. In terms of the obstetrics part of your practice, how many babies have you delivered in your career?

A Well, through my residency until today, 28 years after I completed my residency training, in the beginning of my career, I was delivering about 300 babies a year. Towards the middle, more like 250, and last year, it was more like 200. So I've delivered somewhere between 8000, 9000 babies. I also had the blessing of being at Columbia and doing my core obstetrical rotation at Harlem Hospital at a time where there was the beginnings

of the diagnosis of HIV-AIDS and a lot of the attendings or my professors were busy taking care of really sick women. So if anyone came in who basically was having an uncomplicated normal delivery and they knew I was interested in the obstetrics, they said, "Yvonne will go deliver that baby," so I got to do a number of deliveries as a medical student.

Q Has anything changed in recent months about your breakdown between obstetrics and gynecology?

A Yes, unfortunately, due to back issues. After delivering babies for 32 years, I had to have back surgery and had to actually give up the practice of obstetrics, just because of the physicality of it. So September 28th, I believe it was, I delivered my last delivery of last year.

Q So the end of September of 2014?

A That is correct.

Q With all these babies you've delivered, have you become -- have you had a chance to teach younger doctors how to deliver babies?

A I have.

Q Tell us about that.

A Because when I was delivering babies I dealt with a higher risk population, a lot of diabetic women or, typically, women above their ideal body weight, having

bigger than normal babies. I also dealt with women with hypertension, seizure disorders. So once a lady, a woman, gets through the prenatal period and she's preparing to go into labor and her body -- typically, we like a woman to go into spontaneous labor. So in labor and delivery, I was honored to teach medical students, residents, and young attendees because of my experience in dealing with the various obstetrical emergencies, of which shoulder dystocia is one. But also hemorrhage. You know, a physician is trained in obstetrics to deal with all the emergencies. Luckily, most deliveries go just fine, but when it doesn't, you want to have someone there who has training to be able to deal with those challenges, whether someone is seizing or hemorrhaging or has a baby that's stuck in the vagina. And so, teaching, for me, also instilled or reinforced the knowledge that I gained over the last decades so it's kind of a two-way street. The more you teach, actually, the more you learn, yourself.

Q And what college or university were these students studying at that you were teaching?

A Well, I work at the Beth Israel Deaconess Medical Center. It's one of the teaching hospitals for Harvard Medical School. So most of the medical students are from Harvard. We get fourth year medical students from across

the country who are interested in obstetrics and want to do some rotations with us.

Q Any idea how many medical students you've taught how to deliver babies across the years?

A Many. At a six week period, there were at least six students coming in at a time, so you can do the high-level math. Quite a few medical students and then there were the residents, as well.

Q So let me ask you doctor, in the course of your delivering babies, learning how to deliver babies, teaching how to deliver babies, in delivering eight or nine thousand babies, have you become knowledgeable about the standards of care by which obstetricians are supposed to conduct themselves to make sure the baby is born without preventable injury?

A Well, the whole basis for the teachings, the whole reason for going to medical school and doing it for your residency training on how to deliver a baby is to make sure that you're well aware, and so ingrained in you, safe practices, in terms of how to deliver a baby.

Q So are you familiar with the generally accepted standards of care for obstetricians in the facts and circumstances similar to those involved in Bryson's birth?

A Absolutely.

Q You mentioned shoulder dystocia, which we've heard a little bit about already. Tell me doctor, in your career, have you encountered shoulder dystocia, and if so, approximately how many times?

A I've encountered shoulders probably more than most of my colleagues. I mean, if you look at the literature, it says somewhere between .6 and 1% or 1.2%, 1.4%. Because, again, of the nature of my patients, obesity, diabetes, large or gestational aged babies, my rate of shoulder dystocia is probably more like 5 to 7%. So on any given year, again the high-level mathematics, I can do or be involved with two dozen shoulder dystocias of my own patients and also overseeing the resident's patients.

Q Two dozen per year?

A Per year.

Q Over how many years?

A As an attending, 28. As a resident, add another 432.

Q You mentioned resident and attending. What is a resident and what is an attending?

A So a resident is a licensed physician who is getting additional training in my field, obstetrics and gynecology, so getting additional training on how to do all the things I talked about earlier, like how to deliver babies if they're going to pursue obstetrics, and so, it's a four-year training. So, each year you

gain more knowledge on how to safely deliver a baby and in obstetrics, you don't just walk into a labor room knowing how to do that. You don't. It's not an innate behavior to know, for example, how much traction one needs to use to safely deliver a baby. That comes over time.

Q What is traction?

A Traction is the amount of force needed to facilitate a delivery. You'll constantly hear us use the term, "gentle traction,". And that's something that's learned. It's a muscle-type of memory when you're delivering a baby as to how much traction, how much force, does one use. For example, have the shoulders cleared the pubic bone and you know over time, once you have reached that level of gentle traction, if you go further than that, it's no longer gentle. That's something that's learned and you gain that with experience.

Q You told us about residents, but I think I interrupted you before you told us about attendings. What is an attending?

A An attending is a physician who has completed a residency training, so someone like myself. I now am considered an attending and once you're an attending, you stay an attending until you retire.

Q In a teaching hospital, what is the role of an

attending?

A Well, in a teaching hospital, in order for me to be employed by the Harvard medical physician group, I have to teach a certain percentage of my time. Again, young attendings. I consider myself a more mature attending. I used to be a younger attending. So, I help teach young attendings, residents, and medical students and depending on what level they're on and what experience they have will dictate the type of teaching that I do.

Q All right. So, 24 shoulder dystocia per year for 32 years?

A Plus or minus. Yes.

Q How many times have you delivered a baby that was born with a severe permanent brachial plexus birth injury to the nerves in the neck?

A Never.

Q Never?

A Never.

Q What do you attribute that to?

A Knowing the risks of shoulder dystocia, being ready for shoulder dystocia. It is an emergency situation and often a woman can have risk factors and you are ready for this baby's shoulder to get stuck and the baby comes out, no problem. And there are times when you have a patient where there are really no risk factors and

you're dealt with a baby whose head comes out and the shoulders are stuck. And so, it's always in the back of your head when you're doing any type of delivery that you can get a shoulder dystocia and so you must always be ready to deal with that thought. Although it's an emergency situation depending on the condition of the baby before delivery, you have time to facilitate a safe delivery and so that's a part of the training process.

Q How much time do you have to safely get a shoulder unstuck without injury to the baby?

A You hear of many obstetricians talk about feel reserve, so if you have a baby that you are not concerned about that's coming down the vaginal vault and the head comes out and you realize, oops, the shoulder is not easily following, you have -- if you look at our literature, the obstetrical literature, six or seven minutes to safely get a baby out before you start worrying about things like brain damage or the death of a child.

Q You told us you never have had a permanent severe brachial plexus birth injury. Have you ever had any type of nerve injury to a baby that you delivered?

A Yes, I have.

Q How many times?

A I believe, two.

Q Okay.

A As an attending.

Q All right. Tell me or tell us, please, about those injuries. How long did they last and how serious were they?

A Well, I am lucky in the sense of, again, in the practice of medicine when you are doing something that you feel is correct and then you go through the experience of, in my case, I did a delivery, there was a shoulder dystocia. I thought I was using appropriate traction for delivering the baby. In retrospect, when the baby came out, there was a difference in the movement of the baby's arms and so I had to think back and remember how much traction did I actually use. I realized at that time that I actually used more traction than I should have, but while I was doing it, I felt I was doing a fine job. So this is where the experience comes into play. I was able to, from those two deliveries, and luckily those babies had what we call, transient injuries, they were fine by the time they left the hospital, but it really left a lasting impression on me that I have to be very aware of how much traction -- first of all, I was an athlete in college. I have amazing upper body strength and so I constantly when I am faced with a shoulder dystocia, have to realize, okay, Yvonne, my mantra is, "gentle, gentle, gentle" and

the other mantra I have is, "you have time". And so, you constantly have to resist that. It's an impulse. I don't know if any of you have ever been scared, but that impulse of, you just want to get it done and you have to resist that "fright/flight" response. You don't want to pull harder if you are faced with a situation that the head is stuck.

Q Have you ever ruptured a nerve?

A I have not.

Q Have you ever repulsed a nerve?

A I have not.

Q Apart from those two temporary injuries you mentioned -- you said transient. Is that the same as temporary?

A That is correct.

Q Okay. Just a few hours or days?

A One pretty much resolved in the labor room and so that was a couple of hours. The other one was more like two days, to the best of my recollection.

Q Apart from those, to the best of your knowledge, have you ever overstretched a nerve to cause any harm, whatsoever?

A Not any long-term harm. No.

Q What effect did that experience have on you when you realized two temporary injuries? What importance did that play in terms of how you dealt with deliveries

going forward?

A It had a significant, it made a significant impression on me. It also -- you know, the journey of being a physician is a very sacred one, and I feel incredibly blessed that I have been able to be on this path and by realizing how much responsibility a healthcare provider has and what our responsibility is to our patients, to make sure our patient understands our recommendations, why we are doing what we're doing, and most of all, practicing safely, as our Hippocratic oath says, "Do no harm," and the fact that I realize that my actions could have potentially harmed a baby rocked my world. So I had to really do some soul-searching and this is why I think I'm so passionate about teaching. How to, first of all, recognize the risk factors for shoulder dystocia so you are always ready and then once you're faced with a shoulder dystocia, what are the maneuvers that you can do to reduce the chance of injuring a baby.

Q Doctor, I hand you a document entitled curriculum vitae. Can you identify that, please?

A This is my curriculum vitae, also known as resume.

Q Is that accurate and current?

A Yes. I just had to redo this, because every two years at Harvard we have to justify why we should be at the level we are and I am considered an assistant professor in the

Harvard system. So, once you're an assistant professor, that's not a given. There's no tenure when you're a physician on a clinical tract and so you have to make sure that you're doing your continual medical education, your teaching to their expectations. You know, they look at your; are there lawsuits filed against you, how you interact with all the staff nurses, residents. Everyone gets to evaluate you. They call it the 360 evaluation. And so they have all that information in front of them and with this document and all that, they evaluate the information and say, you're okay to continue working for us.

Q When did you prepare this resume?

A April 3, 2015.

Q Thank you. Let's mark that as a Plaintiff's exhibit, please. I'm going to leave this Court exhibit with you. It's marked Plaintiff's exhibit #5.

MS. CRAIG: Your Honor, is he moving that into evidence?

MR. GRAHAM: We do.

THE COURT: Have you seen it?

MS. CRAIG: I just received it.

THE COURT: Let's let her have an opportunity to look at it.

MS. CRAIG: Your Honor, I've had an opportunity to look through it. There's no objection based on it.

THE COURT: All right. It's into evidence, without objection.

(Whereupon, Dr. Gomez-Carrion's curriculum vitae is entered into evidence as Plaintiff's Exhibit #5, without objection.)

MR. GRAHAM: Your Honor, at this time we would offer Dr. Gomez-Carrion as an expert witness qualified to address topics related to standards of care applicable to obstetrics, in general, and in particular, the safe and proper management of shoulder dystocia and also with respect to the causation of brachial plexus injuries.

THE COURT: Any query with regard to her qualifications?

MS. CRAIG: Your Honor, we have no questions at this time as to Dr. Gomez-Carrion's qualifications as an OB/GYN. Thank you.

THE COURT: Very good. All right. Madam Forelady, ladies and gentlemen of the jury, once again, I mentioned it previously, that normally a witness can only testify about things they see, hear and feel. There is an exception to that. When a person is qualified as an expert because of their education or their experience they've gained in a certain field, they are allowed, if qualified to do so, to testify as an expert and render opinions in their field of study. Dr. Carrion is indeed qualified as an expert in the field of obstetrics and gynecology and allowed to render

opinions in that area.

MR. GRAHAM: Thank you, Your Honor,

Q Doctor, for how long have you been serving as an expert witness in medical legal cases?

A Since the late 1990s.

Q And do you also have experience doing quality review and quality assurance, peer review-type training, and activities within the hospital itself?

A Yes. For years I served on the quality assurance committee and that was from the 1980s to 2000. This is where physicians are asked to look at medical records from their colleagues and we have certain criteria that says that a record should be pulled for review. Not necessarily that there has been a breach in the standard of care, but just to make sure there isn't an identified area that we could have done a better job and that addresses both, issues in obstetrics or if someone gets a transfusion, for example. As a pregnant woman, that's one of the things we look at. If there's a pregnant woman who seizes or has a shoulder dystocia, we look at those. The same thing for gynecology. If the case goes beyond four hours, we look at that. So, just various criteria for ways to improve or ensure quality. And then, I was also bumped up to what we call the executive committee. If there is deemed a deficiency in care and

there is another level of physicians with the department chair who then re-looks at the information and uses that as an opportunity to pull the position or midwife or nurse practitioner, physician assistant, whoever is involved in the case, residents, to let them know this could've been done better there and not just punitive, but use it as a teaching opportunity.

Q Yes, ma'am. Twice now, you've used a word I want to ask you about just to make sure we understand. You said, when a patient seized. Can you spell that word, seized?

A S-E-I-Z-E-D.

Q All right. And what does that mean?

A That's when a woman has epilepsy, is a lay term, and pregnancy can often reduce the level, or what we call the seizure threshold. If she gets, let's say, narcotics for pain relief, that can put you at more risk for seizure. If you're tired, that can put you at risk for seizure and for those of us that have experienced the state of pregnancy, you know that that's a very fatiguing stage or right after pregnancy where you have a baby that might be a little colicky and not sleeping very well, that will put you at risk for seizure, so the word is seized.

Q Thank you. Before you undertake to review a particular case to determine whether or not you believe the doctor

met the standard of care for obstetricians or fell short of the standard of care, what do you do in terms of preparing yourself for that work in preparing your state of mind?

A Well, I think it's important, again, if someone has asked me to review a record, I really want to start clean slate, no bias, and I read through the records as I can, as meticulously as I can, and as I go through, I'm also writing or jotting down whatever catches my eye in terms of certain situations, how a clinical situation was handled and if it was a good job, great. If it was a job that could have been done better, I note that and as an expert reviewer, I always try to put myself in that particular provider's position thinking about all of the factors this provider had to deal with in terms of guiding that provider's behavior at the time and try to be as unbiased as possible in rendering my opinion.

Q And when the issue relates to the cause of a baby's injury, how do you prepare for that kind of investigation and what frame of mind you put yourself in?

A Well, being a physician puts me at an advantage, because this is what physicians are trained to do. When someone is presenting to you, there's what we call a differential diagnosis. There is a whole list of

possible reasons why something could've happened and so you want to systematically go through; is this feasible, could this really have happened, or was this a cause or was it a combination? So you have to go through it step-wise to rule in or rule out certain factors.

Q Thank you. Now, I'm going to ask you to step down, if you would, Doctor, and I want to make sure we get an explanation of shoulder dystocia from somebody that knows more about that than I do. Is this a blowup that would be helpful to you? (Large board on easel in front of the jury)

A Sure.

MS. CRAIG: Your Honor, is this a new blowup?

THE COURT: I don't know. You might tell her if it's new.

MR. GRAHAM: If Your Honor please, before the first witness I told you we had some issues that might arise during Dr. Gomez-Carrion's testimony. There are some blowups that have been presented ---

THE COURT: Ladies and gentlemen of the jury, I'm going to ask if you can retire to the jury room. It's about time for a break. Refresh yourselves. But once again, do not discuss the case. Everyone remain seated as the jury exits the courtroom.

(Jury out at 10:08 AM)

MR. GRAHAM: Your Honor to clarify. To the best of my

knowledge, this and all of the blowups that I plan to use during Dr. Gomez-Carrion's testimony, have been provided in some format to the defense last week or that general time frame. I had intended to proffer them in this format, in the blowup posterboard format, before we started today, but we just -- as it turned out, we just didn't get that chance as we were all scurrying around.

THE COURT: Ms. Craig, be glad to hear from you.

MS. CRAIG: Thank you, Your Honor. If Mr. Graham would just give us the courtesy of seeing the demonstratives that Plaintiffs are using with each witness, we can look at them and I can let you know immediately whether or not we have an objection based on them, but I just have not seen the specific ones he plans to use with this witness. Would you like me to do that now?

THE COURT: Yes. (Defense attorneys look at blowups)

MS. CRAIG: We have no objection to the four that I've just looked through for demonstrative purposes, only.

THE COURT: Mr. Graham, are those the four that you are going to use?

MR. GRAHAM: No, sir. These two.

THE COURT: Mr. Graham, it might be helpful if you pre-mark them once we figure out the ones you are going to use.

MR. GRAHAM: Yes, sir.

MS. CRAIG: Your Honor, we do have an objection to,

what's been marked as Court's Exhibit #2. What is being depicted is shoulder dystocia, or what is being represented is shoulder dystocia using the maneuver to try to dislodge the shoulder, but in fact, the picture shows the baby delivered and so it's not an accurate depiction of what shoulder dystocia looks like, so we would have an objection to that.

MR. GRAHAM: I will withdraw that, Your Honor.

THE COURT: Very good.

MR. GRAHAM: We will use this one instead.

MS. CRAIG: So, Your Honor, we have no objection to -- I know we will mark these, but there's one, two, three, four, five blowups being used for demonstrative purposes only.

THE COURT: Let's mark those if we could.

MR. GRAHAM: Yes, sir. I was just trying to get them in the right order. One, at least one has already been marked.

MS. CRAIG: I just want to make sure, these are Court Exhibits? They are not ---

THE COURT: They are Court's Exhibits. We will stand at ease for five minutes.

MR. GRAHAM: And may the witness, as well?

THE COURT: Yes. Under the rules, you can't discuss the matter with either lawyer, but feel free to refresh yourself.

(Brief break)

(Whereupon, 5 large blowups are marked as Court Exhibits

#2-9. #2, Brachial plexus injury; #3, non-injured/injured brachial plexus; #4 Rubin's maneuver; #5 Causes of injury; #6 Birth after delivery; #7 Suprapubic; #8 Rubin's maneuver; #9, Posterior arm delivery.

THE COURT: We are ready for the jury.

(Jury in at 10:22 AM)

THE COURT: Mr. Graham, you are recognized.

MR. GRAHAM: Thank you, Your Honor. (Standing in front of the jury with easel)

CONTINUED DIRECT EXAMINATION OF DR. GOMEZ-CARRION BY MR. GRAHAM

Q Doctor, would you please step down and feel free to have a seat if you need to, but could you please, I want to ask you to explain shoulder dystocia to us and please feel free to use whatever blowups you have available here.

MS. CRAIG: Your Honor, may I have permission to move?

THE COURT: You may.

MS. CRAIG: Thank you. (Moves to better vantage point)

A So, you've heard us talk a lot about shoulder dystocia and the definition of shoulder dystocia is when the head comes out, so the fetal head is out and the shoulder gets stuck under the pubic bone, which is right here and you know you have a shoulder dystocia when you're using your downward gentle traction and you realize that the

shoulder is not moving. That's when you know you have an obstetrical emergency and that's when experience and training come into place, how you safely get this shoulder from underneath the pubic bone without damaging the nerves in the neck.

Q Thank you.

MR. GRAHAM: And just for the record, Your Honor, references were made to Court Exhibit #6.

Q Now, if you can -- or would you like to show more about shoulder dystocia or move on?

A I think that would be helpful, but if you can come over here, you can be the delivering mother. (Holds baby doll up in front of the jury) So basically, if Ed's hands are like this, Attorney Graham, Ed's hands are the vagina. Okay? And so the head is stuck and his thumbs are the pubic bone and so the head has come out, but the shoulder is stuck under the pubic bone and what you don't want to do as a provider is to be pulling and pulling, because this stretches the brachial plexus. If you sit in your seats and your hands on your shoulders and try to extend your neck up, you're not really stretching your brachial plexus, but do this with your hand (demonstrating) and feel the stretch in your neck. Do you feel a difference?

(Jurors indicated by nodding heads)

A So you don't want to do that when you're delivering a baby. So, again, when I talked about before, as a delivery provider, there's memory in your muscles so when I'm delivering a baby, I go to a certain point and I realize this shoulder is not being delivered and I've now gotten to the point where I know I'm going to stop. I have a shoulder dystocia and so then I start using the safer maneuvers in order to get the shoulder from underneath the pubic bone.

Q Thank you. Before we go on to those special maneuvers, let me ask you to explain a few more things, and you touched on this before, I believe. What is traction?

A So, traction is that amount of force that you need to move anything from one point to the next and that's why we're always talking about gentle traction in obstetrics.

Q Thank you. How do you explain the word "torsion"?

A So, torsion is more of a twisting sensation or twisting motion. So, downward traction is that way and axial is in alignment with the baby's spine, so that's straight out or that alignment is lateral traction. Torsion is an actual twisting or turning the fetal head in relationship to the spine.

Q You mentioned axial traction. What is the opposite of that?

A A lateral.
Q Which is safer for the baby, axial traction or lateral traction?
A Well, axial traction, again, is like you are trying to extend your neck. Gentle lateral is also safe. Those two are relatively safe. It's when you extend past that angulation. On most of these, you have a 15, maybe 20, 30 degree max of deflection of the fetal head to be in the safe range.
Q What happens if you go beyond that safe range?
A As we all experience, if you go beyond that certain angle for the neck related to the shoulder, it's much more of a chance of a stretch of the nerves coming from the spinal cord. The nerves from C5 to T1 relate to the brachial plexus.
Q What is greater than gentle traction?
A It's that amount of force, again, a learned amount of traction. It's hard to explain and this is where the experience I was talking about comes in. Experience, once you go past that memory in your muscles, what you're accustomed to using, gentle traction, and you know it's gentle because you get feedback. As I mentioned, you have a baby who moves his arms when you are delivering and so you imagine that's in the safe range of general traction. When you go beyond that, the

time to go beyond gentle traction and you don't cause an injury, that's luck, but there's certainly a point where you go beyond that and you get either a temporary injury or permanent injury. So the degrees of traction, and you want to stay as gentle as possible to minimize the risk of injury to the baby.

Q Thank you Doctor. You may take your seat.

(Witness returns it to the witness stand)

Q What is informed consent?

A Informed consent is another activity we, as health providers, go through on a daily basis. If I, as a physician, am proposing to do something invasive or whether it's giving you medication during a procedure doing, say, an operative vaginal delivery, whether it be forceps or vacuum, it's my responsibility to explain that to you and explain the benefits to you of my recommendation and also the risks, because you have the opportunity as a well-thinking adult to take in my recommendations, but you may say, you know what, doc, is there anything else we can do or I'd rather not do that. We are always presenting options to patients and it's our job to make sure you understand and when you give us permission, we consider you an informed patient and so it's an informed consent to do medication, procedures, et cetera.

Q What is -- how do you define the phrase "standard of care" with regard to obstetricians?

A Well, it's that level of care that you expect from similarly trained healthcare providers, be it physicians or a midwife, to address a clinical situation. So it's the expectation that similarly trained providers would approach a clinical entity in a safe manner.

Q What should a well-trained, competent obstetrician do in conforming with the standard of care in order to safely manage a shoulder dystocia situation?

A Well, once you've diagnosed a shoulder dystocia, the first thing you want to do, no matter how senior you are, when I have a shoulder dystocia, the first thing I do, you diagnose it and so you make sure everyone is aware that you have a shoulder dystocia. Some people say the word "shoulders", some people say the whole word "shoulder dystocia", because that should invoke a response. You want help. You want extra hands. And as you start instructing your support staff, often nurses or techs on two of the most frequently used maneuvers, because they are the easiest things to do. The physician doesn't do it or the midwife doesn't do it, but they instruct the team and so you want mom's legs back as far as they will go and so it's hyperflection, because if you put your legs up close to your ears, what that does

is open up the pelvis. It actually rotates that pubic bone where the shoulder is impacted, it rolls that bone towards her head, so the bone comes this way, that sacral promontory, which is a bone in the back, then rotates posteriorly. So, you'll hear us saying, "it opens up the pelvic floor. So, it allows more space by just that simple maneuver and I think about 40% of shoulder dystocias are resolved by just changing mom's position and so we do that. It's easy and safe. If that maneuver's been done and you've tried general traction -- and you also have mom stop pushing, because imagine, if she's continuing to push and you're trying to resolve the shoulder, that force is working against you and so you want mom to relax, you do the maneuver, you try to see if the shoulder comes out from the bone. It doesn't. So you go to your next maneuver and the most common next maneuver is called suprapubic where whoever's assisting you is, typically, on a stool. The bed is at a normal height and you want the assistant to either use fists or the palm of his or her hand to locate the shoulder. It's a downward kind of lateral motion to try to actually push the shoulder from underneath the pubic bone. So those two maneuvers can resolve 60% to 70% of your shoulder dystocia.

Q When those two maneuvers are used, should the doctor be

applying traction?

A You want the maneuver in place and then you try your gentle traction to see if it's worked.

Q When those maneuvers are being put into place, should the patient continue to push?

A While the maneuvers are being put into place, no. Because again, that's working against you,

Q You said 60 to 70% of the time, moving the mom's legs back, what do you call that position?

A That's the McRoberts.

Q And what do you call the pressure above the pubic bone?

A The suprapubic pressure.

Q Sixty to 70% of the time, the McRoberts, suprapubic pressure plus gentle traction, are all it takes to deliver the baby?

A Yes.

Q What happens if you're in one of the other 30 to 40% of the cases?

A Then you have other safe maneuvers to do. Many of us -- even an episiotomy or cut to the space between the woman's vagina and rectum, if it's intact, you often will make a cut. That's not a maneuver, but it allows us more room in order to insert our hands into the vagina, because some folks will try a rotation maneuver. When you think about it, the shoulder is stuck so what can

you do to unstuck the shoulder? It's often reducing that diameter, and so there's a procedure where you actually push on the shoulder and try to bring the shoulder toward the fetal chest. That's called Rubin's. There's a procedure where you actually change the orientation of a baby's lie, like 180°, so you're pushing posteriorly, so the thinking is ---

Q Excuse me. What does posteriorly mean?

A In this case, it would be clockwise. So you want to rotate the baby, just trying to change the axle or the axis of the way the baby's lined up. Any change between the baby's shoulder and mom's bone, any bit of change can then have that bone come from underneath or shoulder come from underneath the pubic symphysis. So, mom's in McRoberts, you've tried suprapubic, it's not worked. You can do a rotational maneuver after you've made a cut if needed, not working. There's another maneuver where you can reach in and get the arm. That's what we call posterior, so it's the anterior arm that's stuck under the bone. You reach in, flex at the elbow, and grab the wrist and sweep it across the baby's chest. And again, that motion reduces this width and often that will have the baby come out. If you've done all those maneuvers and you still have a baby in, again, someone is watching the time, you have time, because all of those maneuvers,

literally can take you a minute or less. So if those maneuvers don't work, there are other maneuvers we can do, but at that point, there should be help, another attending, possibly, who can then repeat all those maneuvers before you go on to the more kind of invasive maneuvers that we, as healthcare providers, use. There's a maneuver that was created by a midwife named Gaskin, where you actually flip mom over so she's on her hands and knees and just changing mom's position, again, makes the baby change and the baby often comes out. So you keep doing this rotation of safe maneuvers rather than using more traction on the baby's head to attempt delivery.

Q Doctor, would you mind coming down to this area once again? We have blowups available to you that would help illustrate some of those maneuvers you described.

(Witness complies)

Q Let's identify the Court Exhibit Number.

A Seven. So this is a pictorial of suprapubic pressure. So this is the pubic bone. This is someone's palm and it should be above the bone. You don't want to press on the bone, because that's not going to help dislodge the shoulder. You are actually pushing on the baby's arm and mom is not pushing. She's in McRoberts and you use gentle traction to see if that maneuver has released the

shoulder.

Q You said that mom is in McRoberts. Can you do suprapubic pressure without the mom in McRoberts?

A You can, but it is not as effective. McRoberts is typically the first maneuver just because the easiest thing to do is to get mom's legs back.

Q Can you think of any good reason to attempt suprapubic pressure with the mother's legs still in the stirrups?

A I can't, but it's been done.

Q Thank you. Do you have any -- you mentioned Rubin's maneuver. Does this Court Exhibit #8 help you illustrate the Rubin's maneuver?

A So, the Rubin's maneuver, again, the fetal head is here, you are pushing on the anterior shoulder going into a counterclockwise position.

Q Let me -- but in just a second. You said, "anterior". What does "anterior" mean?

A So, in this case, as in most shoulder dystocias, the shoulder that's closest to mom's abdomen or belly, the posterior is closer to mom's buttocks, so the anterior shoulder is the shoulder that's often manipulated to try to clear it from the pubic bone.

Q So, the anterior is the top shoulder?

A Correct.

Q Posterior is the bottom shoulder?

A Correct.

Q Thank you. You mentioned Wood's also. I don't think we have a blowup of Wood's, but how does Wood's compare with Rubin's?

A So Wood's, this is counterclockwise, pushing the baby that way. Wood's is the opposite and Wood's is more of changing the entire axis of the baby and hoping that the shoulder will dislodge with that maneuver.

Q I now hand you Court's Exhibit #9. Is this helpful to you in explaining what you mean by posterior arm delivery method?

A So, again, you have a baby whose head is out, pubic bone there, shoulder stuck there. Can everyone see?

(Mr. Graham adjusts easel)

A So, you are in that position and mom is not pushing, theoretically. She's in McRoberts, suprapubic has been tried, still not working. You've done your rotation maneuvers, still that shoulder will not come out. So, what we do is make sure we have enough room to insert our hand into the posterior part of the vagina to locate the elbow, to make sure it's flexed. You don't want to fracture the baby's arm so you want to kind of pull it out that way. So, you press on this area, flex it, and then you sweep that arm across the chest and you can see then, if you do this sweep, this distance reduces and

often the baby comes out.

Q Thank you. Please take your seat up there again, Doctor. What is an epidural?

A An epidural is a type of local anesthetic. So, you often -- nowadays, we do continuous epidurals. Back when I trained, you gave someone a spinal one-shot deal or a saddle block which would give temporary, local, pain relief. Now we can use a catheter that gets inserted through the mom's back near the spinal cord and can give a continuous infusion of an anesthetic medication which typically knocks out sensation at various levels of a woman's body making labor a lot more tolerable.

Q When you give a patient who is in labor an epidural, what effect does that have on the ability to use some of the maneuvers like Gaskin's?

A Well, it makes it more difficult, but again, that's why you want help in the room. This delivery was in 2009, so that was at a time when anesthesia was also changing. You know, back in the 90s, if you gave someone an epidural, most women felt they didn't have any lower extremities. It was such a dense, knocking out of sensation. Now, we really try to titrate the amount of the anesthetic to a woman's feedback to "I feel, but it's not painful." So it's much easier, I would think since the mid-2000s to put someone in Gaskin's as

opposed to doing it in the 1980s, but even back when a woman is in a dense epidural, with assistance, you can change her position.

Q Thank you, Doctor.

A You're welcome.

Q What is induction of labor?

A So, induction of labor is trying to bring about contractions before a woman goes into her own labor. Typically, we do inductions of labor based on various medical indications. It is an intervention, so again, this is a time of informed consent. You want to make sure that a woman is aware of the risks of Pitocin, because you are kind of overriding mother nature. You are telling the uterus, I want you to work before the uterus may be ready to do that work. So you are giving a medication to kind of cause the muscles to contract and they may not be ready. Therefore, you may have to use a larger dosage of the medication and the medication we typically use to get the uterus to contract is something called Pitocin or Oxytocin. We also, I mean, that's a medical induction of labor. There are times when a woman's cervix is checked and the cervix is what we call, not inducible and not favorable, and you can give a woman a cervical ripening agent using some type of insert of a prostaglandin prior to actually starting

Pitocin. So, that's all in the medical range of induction of labor. There's also a concept called surgical induction of labor and often this is in a woman who has dilated her cervix. Say she's 3cm, but is not in labor, and that's very common in someone who's had a baby before. You can often walk around dilated and not be in labor and so what we do is take, it looks like a little crochet hook, and break the bag of waters around the baby. It's called an amniotomy and with the breakage of that water, letting the water out of the uterus, you are decreasing the volume in the uterus and there's a concept in physics called Starling's Law. If you decrease the volume in a muscle, the muscle is more efficient in contracting, so there's a medical induction and a cervical induction. But we always have to have a reason to intervene with an induction, because there are risks to the induction. It may not work, it may increase a woman's chance of infection. You certainly can increase a woman's chance of having a caesarian delivery if she doesn't go into labor. There are benefits and risks.

Q Thank you. Doctor, have you reviewed all of the relevant medical records in this case to assist you in your investigation?

A I believe I have.

Q Have you read the depositions from various witnesses that relate to your expertise in this case?

A I have.

Q Based on your education, knowledge, training, and experience and also based upon your review of the medical records and depositions, have you formed any conclusions about whether or not Dr. Goldstein met or fell below the generally accepted standards of care for obstetricians with regard to the way he managed Bryson's shoulder dystocia?

A I have conclusions, yes.

Q What are those?

A Well, one is based on the doctor's deposition and a review of the medical records. The lack of informed consent during the pre-natal period. This is a time when you have an opportunity to really talk to your patient and make her aware of all the potential things that could happen, not only during the pregnancy, but during the labor process, itself, particularly in someone who was, at the time, obese, a type II diabetic with a large baby. So, informed consent around things that happened in her pregnancy or in labor and delivery. She was induced and in my reading of the medical record, it was not clear to me why you would induce a woman at 36 weeks who has diabetes, particularly not doing the test to

make sure the baby has the maximum ability to do well outside the uterus. There's always the, what we need to go through as delivery providers, what's safest; baby in the uterus or baby outside the uterus. So, I wasn't clear on why he was doing an induction on a premature baby without what appeared to be mom's consent to that process. So, once she arrives in labor and delivery and the induction is started, there were periods where, again, using medical intervention with Pitocin it is common to use a certain level, and you're constantly watching how is the baby reacting to the stress of labor, because when you have a contraction, there's pressure mounted around the baby and babies will sometimes say this way too much or too many contractions are coming. We are constantly looking at that as your providers. So, if you see that happening, if the baby is not tolerating that well, you have two options: Either turn off the medication or turn down the medication just to see, to give the baby a break. You know, I need to take a deep breath here, because there are too many contractions. If there is not at least a minute between contractions, or a minute-and-a-half, you're not giving the baby or the maternal fetal unit, also known as the placenta, time to adequately have blood go through that carrying oxygen and that happened a couple of times

here. So, Pitocin is not a benign medication. And then you reach the point where mom is fully dilated and pushing and according to Dr. Goldstein, he made the decision to use the vacuum in order to deliver Bryson. I didn't see any discussion -- in fact, in the doctor's deposition, he said he really doesn't discuss putting on a vacuum. He doesn't discuss the risks of the vacuum delivery and the vacuum, although it's gotten safer. This is a suction device that gets placed on a fetal head and a certain amount of pressure is built up. That carries risks. I mean, we think of it as a relatively safe intervention, but there have been babies that have had brain bleeds, have had brain damage, massive swelling, lacerations, so moms and their support need to know about these risks so they can say mom has the opportunity and the right to say, "I'd rather continue pushing or do something else other than have you put a vacuum on my baby's head". You know, looking at the tracing, and again, Dr. Goldstein said he intervened because of the decelerations. Well, the type of decelerations that I saw in the fetal heart rate tracing are pretty standard at the end. There were no late -- There are so many different types of decelerations, but the ones we look at that are of most concern to us are what we call repetitive late decelerations. A baby has

contraction -- sorry. The mom has a contraction, the baby's heart rate goes down and has a hard time getting back to its normal position. If you see that repetitively, you know that there's decreased blood flow, decreased oxygen, going to your baby. And in this case, what the standard of care would've been in a woman who is on Pitocin is, either turn it down or turn it off. You want to do what we call a intrauterine resuscitation. You can turn mom on her side, you can give her bowls of fluid to make sure there's more fluid and nutrients and oxygen getting to the baby rather than coming and saying, I'm going to do a vacuum delivery without any discussion of that risk, particularly, in a woman who is diabetic and obese and in retrospect, we knew this baby was quite large. The baby was 36 weeks and weighed 8 lbs. 6 oz. That's a big baby. I didn't see any documentation that Dr. Goldstein discussed with the mom, "I think you're having a big baby. There may be a risk if I put a vacuum on your baby's head that I will pull your baby into shoulder dystocia and Dr. Goldstein said in his deposition that he did not do those things and so that is certainly a breach in the standard of care in terms of consent.

Q Let me follow up with one point. You said something about he didn't check on a lung maturity of the baby of

a diabetic mother. What effect does diabetes have on the lung maturing process of the baby of a diabetic mom?

Q So, in a baby who sees a higher sugar environment, we know from delivering many diabetics, we know, and it's well documented in the medical dictionary, that these babies have a slower maturation of the lungs. So, even a diabetic baby of term is 37 weeks. You can have a baby come out and have respiratory issues because their lungs aren't quite ready to make that smooth transition from a water environment to air and in a diabetic mom, you definitely want to make sure you have a baby with mature lungs because you are intervening, and I'm still not clear why the intervention happened.

Q Well, have you concluded whether or not there was a good medical reason to induce labor with this woman with the drug, Pitocin, when her baby was only 36 weeks?

MS. CRAIG: Your Honor, I'm going to object to leading questions at this point.

THE COURT: Re-phrase the question.

MR. GRAHAM: Yes, sir.

Q Doctor, do you have an opinion or a conclusion, to a reasonable degree of medical certainty, as to whether or not there was a good medical reason for Dr. Goldstein to induce labor in Genesie at 36 weeks?

A No, sir.

Q Do you have an opinion as to whether or not inducing Genesie at 36 weeks without testing the child's lung maturity met the standard of care or fell below?

A That certainly fell below the standard of care.

Q And you mentioned "informed consent". Did you see anything in the records or depositions to suggest that Genesie was provided any information by Dr. Goldstein about the risks and alternatives to inducing her labor at 36 weeks?

A I did not.

Q Have you formed a conclusion or opinion about whether or not proceeding with induction without describing the risks and alternatives first would meet or fall short of the standard of care?

A The lack of that conversation, or conversations, fell below the standard of care.

Q And I think you mentioned informed consent, also, with respect to the vacuum?

A That is correct, sir.

Q Have you formed an opinion or conclusion about whether Dr. Goldstein's decision not to discuss risks and alternatives to vacuum extraction, under these circumstances, met or fell below the standard of care?

A Fell below the standard of care.

Q Now, you said that shoulder -- well, when the vacuum was

applied, was there a diagnosis yet of shoulder dystocia?

A No, sir.

Q Was there anything that you saw on the baby's heart tracings to justify the use of a vacuum at the time Dr. Goldstein chose to do that?

A No, sir.

Q Were there -- you mentioned decelerations. What do you mean by decelerations?

A Typically, during a labor, the baby will react to what's happening in the uterus. Some babies during the labor process, you'll see what we call variability. It's a baseline and you want the heart rate going up and down. It shows that you have an intact nervous system. So, the baby's reacting to the environment. So, sometimes babies are very happy with what's going on. You'll have a baseline and then you see this acceleration. Sometimes, particularly towards the end of the process when mom is fully dilated and pushing, you'll have more pressure on the baby's head and it's called a vegal response, so baby's going along and then you see a contraction, it's a different heart rate, it goes back to baseline and keeps doing that. When one is on Pitocin and you've caused contractions to be quite close together, you're going to get these decelerations as a response to that and so standard of care says get rid of that stressor or

reduce that stressor to see how the baby responds and most babies at term, well, most babies at term with reserve do very well. Premature babies may not have as much reserve so you may, instead of turning down the Pitocin, you turn off the Pitocin until the baby can regroup and while you're doing that, again, that term "intrauterine resuscitation," you want to make sure you maximize the uterine environment. So; relaxing the uterus, possibly giving mother oxygen increases her oxygen concentration which will potentially increase baby's oxygenation, fluid bolus, changing mom's position to increase blood flow to the uterus. So all those things can be done because if you intervene prematurely with the vacuum, it's not a benign procedure and it was also my conclusion as I, you know, read through the Doctor's deposition, I was very struck by the high rate of induction and the incredibly high rate of what we call "operative vaginal deliveries", his use of the vacuum. I mean, he stated that he induces, I believe, 75% of his patients. He has a 25% caesarean section rate, which is pretty standard in the United States. In today's world, it's actually higher, so that didn't strike me as much, but the fact that this physician intervenes so often in terms of pushing a woman into labor knowing what the risks of that intervention is and

then once a woman is fully dilated, his use of the vacuum. I believe he stated is 40 to 50% of his deliveries, he does by vacuum delivery. Whereas, national, if you look nationwide, depending on what part of the country, it's more like 5%, maybe 10%, but nowhere near 40 to 50%. So, you have a physician who is intervening, trying to get someone into labor before the uterus is ready or the body is ready and then trying to shorten that second stage, that time between when a woman is fully dilated to when the baby's head is out.

Q You said 75% induction rate struck you as high. What do you believe is the average induction rate in this country?

A I don't know that statistic, but you know, what goes into an induction rate is your patient population. So, if you have a high risk patient population; hypertension, preeclampsia, diabetes, you reach a point where you think the baby is better out of the uterus than in, and I know Dr. Goldstein said he has a high risk population, I believe, around 30%, so I could see inducing 40%, but that's even high. I think the statistic would probably be more or less a 30% induction rate. But there are various reasons to induce: premature rupture of membranes, infection. I mean, the list is incredibly long.

Q What does an induction rate of 75% and a vacuum rate of 40 to 50% of vaginal deliveries tell you about Dr. Goldstein's patients to let mother nature do her thing?

MS. CRAIG: Objection, Your Honor, speculative.

THE COURT: Sustained. Re-phrase your question.

Q Doctor, have you formed an opinion or a conclusion about the significance of Dr. Goldstein's induction rate of 75% and vacuum rate of 40 to 50% in terms of his patients, to let the natural course of labor proceed?

A I can't comment on the Doctor's patience as opposed to patients, but an intervention, again, as a health professional, anytime you intervene there are risks and the fact that his induction rate is so off the chart compared to what the average obstetrician would do and certainly, the operative delivery intervention is 10 times almost what is normal in the United States, that just speaks to what's going on with this Doctor's clinical assessments and, again, Dr. Goldstein said he feels no need to explain this to the patients and patients, I wonder, often, do they even realize what's going on. We had the daughter testify this morning that she ---

MS. CRAIG: Objection, Your Honor.

THE COURT: Sustained.

Q Don't tell us what she said. We were able to hear what

she testified to, as you were, since you were in the courtroom.

A Right.

Q But don't tell us what she testified to, but continue with your opinion.

A Well, my conclusion from reading the record and the Doctor's deposition, is that I got the sense he doesn't really need to really inform his patients or to tell his patients the benefits and the risks. He decides what's going to be done and it's done.

Q Let me turn to, once we get past the induction and the use of the vacuum, once -- tell us, please, have you formed an opinion or a conclusion about whether or not the standard of care permits an obstetrician to just hope for the best or does the standard of care require an obstetrician to anticipate problems and prepare for problems, prepare for the worst that might occur during a labor?

MS. CRAIG: Objection, Your Honor. Leading.

THE COURT: Sustained.

Q Tell us whether or not you have a formed an opinion to a reasonable degree of medical certainty, as to whether or not the standard of care requires an obstetrician to anticipate and prepare for complications and emergencies like a stuck shoulder.

A Well, that's the basis of training. That's why we do four years of residency and continue to do so. Once an Attending -- yearly, we have to do a certain number of hours of continuing medical education, there are now simulation labs where you can practice on dolls, mannequins, so you keep your skill level up. Sure, we all wake up in the morning as obstetricians, this is going to be a great day, I'm going to have a bunch of beautiful normal deliveries, but our training makes us prepared for those times, which you often can't predict that something happens out of the ordinary and can put a mom and baby at risk. That's what separates me from your police people, your fire people, your dad's, whoever is around who you hear about delivering babies outside of hospitals. For the most part, babies deliver themselves. But as an obstetrician, trained, we are ready to deal with whatever emergency situation presents itself so we keep our patients safe.

Q Have you formed an opinion or conclusion, to reasonable degree of medical certainty, as to whether or not Dr. Goldstein possessed the knowledge and experience to be prepared to handle a shoulder dystocia?

A Reading his deposition in terms of him speaking to the type of training he received as a resident, I believe he said he did not participate in any resolution of

shoulder dystocia. He may have observed one. And as an Attending physician, someone who has had much experience with delivering babies, he stated that -- I mean, he's been practicing obstetrics for decades like myself and he's only had to resolve five to six shoulder dystocias in his entire career. So, that speaks to a lack of experience, possibly a lack of knowledge, in order to resolve, safely, a shoulder dystocia and this is also depicted by what happened at the time the baby was diagnosed as having a shoulder dystocia.

MS. CRAIG: Objection. I move to strike any comments about the hospital.

THE COURT: Sustained.

Q Doctor, you talked about a lack of experience, but this man, as you say, has been delivering babies for decades. Does delivering babies give one the experience required to be prepared to handle a shoulder dystocia situation when it arises?

MR. CRAIG: Objection. Leading.

THE COURT: Sustained.

Q Doctor, have you formed an opinion or a conclusion about whether or not Dr. Goldstein's experience at managing shoulder dystocia meets or falls short of the standard of care?

A My conclusion is that it falls short of the standard of

care.

Q Let's turn to knowledge. Have you formed an opinion or a conclusion about whether or not Dr. Goldstein's level of knowledge about maneuvers and the safe management of shoulder dystocia meets or falls short of the standard of care?

A Falls.

Objection, Your Honor. Calls for speculation.

THE COURT: I'll allow him to ask that question.

A It falls short of the standard of care.

Q Speaking of standard of care, what is the standard of care in the United States of America about how much pulling force or traction can be applied to a baby's head and neck in the first six or seven minutes after the head delivers?

A The standard of care is that you don't go beyond gentle traction.

Q Do you have an opinion or conclusion as to whether or not Dr. Goldstein is even aware of that standard of care?

A Well, as he spoke in his deposition, he clearly stated he was not.

Q Have you reached an opinion or a conclusion to a reasonable degree of medical certainty as to whether or not Dr. Goldstein has any memory of how much traction he

applied in this case or in any other shoulder dystocia encounter?

MS. CRAIG: Objection, Your Honor.

THE COURT: That being?

MS. CRAIG: She can't testify as to Dr. Goldstein's memory.

THE COURT: I sustain.

MR. GRAHAM: Your Honor, may we approach?

THE COURT: Yes.

(Brief bench conference off the record)

Q Doctor, what would your expectations be about whether or not a resident in your program would, what level of knowledge he would have about standards of care with respect to the amount of traction that could be properly applied during a shoulder dystocia?

MS. CRAIG: Objection, Your Honor. Relevance and asked and answered.

THE COURT: Sustained on both grounds.

Q Do you have an opinion or a conclusion to a reasonable degree of medical certainty, as to whether or not Dr. Goldstein met or fell below the standard of care in terms of the amount of traction and/or torsion he applied to Bryson's head and neck?

MS. CRAIG: Objection. Asked and answered.

THE COURT: I'll allow him to ask it, but I think that

has been asked and covered on a number of occasions, but I'll allow you to ask it one more time.

MR. GRAHAM: Thank you, Judge.

A It fell below the standard of care.

Q Tell us, please, what the standard of care requires in terms of whether or not the mother is to continue pushing or stop pushing after shoulder dystocia is diagnosed.

A The standard of care is that you instruct the patient to stop pushing.

Q Do you have an opinion or conclusion as to whether or not Dr. Goldstein met or fell below that standard?

A Fell below the standard of care.

Q Let me turn now to, away from standards of care, to causation. Doctor, do you have an opinion, to a reasonable degree of medical certainty, as to the cause of Bryson's brachial plexus nerve damage, most probably?

A Yes, I do.

Q And what is that, please?

A That in order to resolve a shoulder dystocia, excessive traction was used, which then led to the permanent injury of the right brachial plexus.

Q Do you believe that the natural forces of labor can cause permanent brachial plexus nerve damage?

A No, sir.

Q Do you believe that the moment of touching between the baby's top shoulder and mother's pubic bone involves any degree of force that could cause permanent injury to a baby's nerves?

A Well, there's going to be a level of force, but not to the extent that would cause a permanent injury.

Q Do you believe that after a baby's top shoulder encounters the mother's pubic bone and if the mother is allowed to continue pushing and the uterus continues to contract, if there is any stretch involved that could cause permanent injury?

A No, sir.

MS. CRAIG: Objection. Leading.

THE COURT: I'll allow him to ask that. I'll allow him some leeway in that regard.

Q Apart from the traction force involved in mismanaging a shoulder dystocia complication, are there any other rare causes of brachial plexus injury?

A Again, when you have an injury to a baby, you don't just make an assumption, particularly in shoulder dystocia, that excessive traction was used. You want to rule out other possibilities. So, one of the big areas, was there some type of genetic predisposition that would have led to this permanent injury. But as far as I know, Bryson is the only child in his family that has this permanent

injury or any injury to the brachial plexus. The other categories or one of the other categories is infection. Could have infection have made this nerve more susceptible to injury? No signs of infection. Was there some type of anatomical issue with the baby? For example, anything that would potentially in utero cause pressure on the brachial plexus, like a tumor or malpresentation? There was no descriptive of that in terms of the pediatric evaluation of this baby. Was there some type of uterine abnormality? I talked about fibroids earlier. Sometimes, there may be a fibroid that may be pushing into the cavity of the uterus and then you would see some type of dissymmetry. If you have this chronic pressure on this nerve plexus, you'd have a baby who has a healthy arm and a withered arm, most likely. If you have any type of chronic anatomical issue, you'd see something on a physical exam to show that. As far as I could see in his medical record, at the time baby was delivered, both arms were symmetric, it's just that there was a significant decrease in the ability of the baby to move his right arm. So, anatomical, genetic, infection are some of the things we think about in terms of making sure those aren't factors in what happened in this case.

Q Let me ask you about the baby's muscle tone, not the arm

that was injured, but the general muscle tone of the baby at birth. What significance, if any, do you believe that has?

A No significant factor there.

Q When a baby has poor tone and is floppy, does that make it more likely or less likely, the impaction of a shoulder against the mother's pubic bone, requiring special maneuvers?

MS. CRAIG: Objection, Your Honor. Leading and we are getting into an area that she's not qualified to answer.

THE COURT: I'll sustain the objection.

MR. GRAHAM: Your Honor, may I inquire whether that was as to leading or ---

THE COURT: Leading.

MR. GRAHAM: Okay. So I may attempt to get into...

THE COURT: Yes.

MR. GRAHAM: Thank you.

Q Doctor, have you formed an opinion about whether or not poor muscle tone has an impact on the likelihood of the top shoulder getting stuck behind the mother's pubic bone?

A No, sir. I don't think tone or lack of tone would make one more predisposed to having a shoulder dystocia. Intuitively, you'd think a baby with decreased tone would be easier to deliver.

Q Is there obstetrical literature that is reliable in your opinion that supports the conclusions you have expressed in court today?

A Yes, there is.

Q Could you offer some of the author's names of some of the literature you believe to be generally reliable on these topics?

MS. CRAIG: Your Honor, this is a new opinion. She was asked a specific question in her deposition and she said she was not relying on any medical literature in order to form her medical opinions in this case and ---

THE COURT: I'll sustain your objection.

Q Doctor, you've talked about a number of ways in which Dr. Goldstein's conduct, knowledge, experience, traction, et cetera, fell below the standard of care. What do you believe are the most important violations of the standard of care by Dr. Goldstein that most directly caused the ruptures to the nerves in Bryson's neck?

A Well, the most egregious breach of the standard of care is his use of excessive traction.

Q Does this blowup assist you in explaining and illustrating that opinion?

A Yes, sir.

Q Okay. Could you step down and explain this to the jury, please?

COURT REPORTER: Which exhibit is that?

MR. GRAHAM: Oh, it's five, Court's #5.

A So, with gentle traction, when you have a shoulder impacted under the pubic bone and you're using gentle traction to try to clear the shoulder, you're putting some stress on the brachial plexus. We don't know how much stretch it takes to reach this area, but we know we are putting a baby at risk to go beyond gentle traction. So, the more you exert traction and you are putting downward traction, which the Doctor clearly did here -- there was a description that he was actually on his knees while others in the room were up on stools trying to do the other maneuvers so the bed appeared to be at normal height and the Doctor was on his knees, so you know that the angulation of the baby's head is certainly off the axis of the spine and the more you exert excessive traction, you are not only stretching these areas, but then you go to rupture and possibly a disruption of those areas and once you've severed the nerves or made a disruption, there's no crossing over signals and that's why you loose function of that arm and the shoulder and that's what makes it a permanent injury, because of the rigidity of the injury.

Q Thank you.

(Witness returns to the witness stand)

Q Doctor, you've used words like egregious. Based on your education, knowledge, training, and experience, your review of the records, your review of the deposition testimony of Dr. Goldstein and others, do you believe his conduct in this case merely fell below the standard of care or do you believe, or have you formed an opinion or conclusion to a reasonable degree of medical certainty, as to whether his wrongdoing met the level of reckless disregard for the well-being of Bryson F ?

MS. CRAIG: Objection, Your Honor. Leading.

THE COURT: I'll allow him to ask the question. Ask her what her opinion is.

Q What's your opinion in that regard, Doctor?

A My opinion is that Dr. Goldstein, like all health care providers, wants to provide the best medicine possible for our patients. I believe: that the education, lacking; experience, lacking; the ability to call for help in a timely manner, lacking. So, all of those factors put together place this mom and baby at serious risk. Therefore, we have a serious and permanent injury in a child.

Q Do you have an opinion as to whether or not Dr. Goldstein's wrongdoing, in terms of not saying he doesn't even know a standard of care about the amount of traction, would meet the level of reckless disregard?

MS. CRAIG: Asked and answered, Your Honor.

THE COURT: I don't think she really answered that. She talked about it a lot, but I don't think she answered it.

A Would you repeat the question?

Q Yes, ma'am. Given your education, knowledge, training, and experience, your review of the records and depositions, and taking into account Dr. Goldstein's testimony that he doesn't believe there is any limits on how much traction is allowed to be put on a baby's head and neck, do you believe that his -- or do you have an opinion or a conclusion to a reasonable degree of medical certainty, as to whether or not his misconduct is merely below the standard of care or whether it rises to a higher level of misconduct involving reckless disregard of the well-being of Bryson F ——— ?

MS. CRAIG: Objection, Your Honor. Leading and it was an improper characterization of the evidence.

THE COURT: I'll allow him to ask the question.

MR. GRAHAM: Thank you, Your Honor.

A You know, that's a very serious question you've asked me, sir. It's certainly way below the standard of care. It has, as I sit here and think about your question, it does rise to the level of recklessness, not only the handling of the shoulder dystocia, but what I spoke about earlier, just the idea that one must intervene

with no justification puts patients at risk.

MS. CRAIG: Your Honor, we move to strike. This is brand new opinion we are hearing for the first time.

MR. GRAHAM: They didn't ask the question, Your Honor.

THE COURT: I'll allow the question to stand and the answer to stand.

MR. GRAHAM: Thank you, Your Honor.

Q Doctor, have you reviewed cases from our law firm before Bryson's?

A I have.

Q Quite a few?

A Quite a few.

Q Do you charge for your time?

A I do, sir.

Q Do you always tell me that there is a viable case?

A No.

Q Is your work in this medical/legal area limited to testifying on behalf of babies or do you also testify on behalf of doctors?

A I testify on behalf of doctors, as well.

Q Thank you. Please answer any questions Defense may have.

THE COURT: Defense, you are recognized.

MS. CRAIG: Thank you, Your Honor. May I have a minute to clean up a little bit?

THE COURT: Yes.

(Removes charts from in front of jury)

MS. CRAIG: May it please the Court?

THE COURT: Yes, ma'am.

CROSS EXAMINATION

by MS. CRAIG:

Good morning, Dr. Gomez-Carrion. How are you today?

A I'm well, thank you.

Q Good. The demonstration that you did with Mr. Graham with the baby and showing the jury, asking them to stretch their neck, you did that same show with Mr. Graham in a trial in Greenville recently, didn't you?

A The same show?

Q Yes, ma'am. When you had the baby and you asked them to move their head and you went through a demonstration in front of the jury back in Greenville in a case with Mr. Graham where he was suing the hospital, same allegations, shoulder dystocia, same opinions by you, excessive traction, you did that same thing in front of that jury in Greenville, didn't you?

A I don't recall doing the, actually having the jurors place their hands on their own heads. I think this is the first time I've done that.

Q How about the baby?

A Oh, the baby. Yes.

Q So let's start off with a few things that I think you

and I can agree with. We've met each other before. Shoulder dystocia is a risk to any pregnancy. Correct?

A Correct.

Q And you agree that most shoulder dystocias are unpredictable and unpreventable.

A Correct.

Q And you agree that a shoulder dystocia is a medical emergency.

A I believe I stated that earlier. Correct.

Q And if a baby is not timely delivered in the face of shoulder dystocia, a medical emergency, the baby can die.

A Correct.

Q And when I say timely, isn't it true, that in a shoulder dystocia situation, timing is critical because I think you said it was either six or seven minutes after that shoulder is lodged under the pubic bone that you have to get the baby out. Otherwise, you risk brain injury to the baby or even death. Right?

A That's correct.

Q And in this case, Dr. Goldstein was able to get that baby delivered within four minutes. Is that your understanding based on the record?

A That is.

Q Four minutes. And also, based on your review of the

record, there's no evidence that Bryson has any brain injury. Correct?

A That's correct.

Q And you know of no reason why Bryson couldn't go to college. Do you?

A Not that I'm aware of as I sit here, depending on the costs of college, whether he gets to go.

Q Well, you know, his sister went to college, so there is no reason to think that Bryson couldn't go to college.

A That's correct.

Q Okay. Now, Dr. Goldstein, when confronted with this medical emergency, he ordered McRoberts and suprapubic pressure and you agree that was the appropriate thing to do.

A Absolutely.

Q And then he extended the episiotomy. We all know what that is, that's the cut in the vagina that the doctor needs to do to make room for the baby to come out of the vagina. He extended the episiotomy to get more room so that he could try to move that shoulder. That was appropriate and that was a reasonable thing to do.

Q Well, the cut is not to allow more room for the baby, per se, without assistance to come out. It is more for the actual attempts at the maneuvering by the delivery provider.

Q Well, but Dr. Goldstein, just so that we can be clear, he extended the episiotomy for Ms. Fulton and that was the reasonable and appropriate thing to do. Do you agree?

A Yes. He did it twice, actually.

Q Okay. Now, you also agree that Dr. Goldstein should have extended the episiotomy so that he would have more room to try to get his hand inside the vagina to attempt a rotational maneuver.

A That's correct.

Q Ma'am?

A That's correct.

Q Thank you. And you are aware, based on your review of the records and based upon your review of Dr. Goldstein's testimony, that he did try to put his hand in the vagina after McRoberts was unsuccessful, after suprapubic was unsuccessful, and he tried to put his hand in the vagina to do the rotational maneuver, but he wasn't able to get his hand inside. You are aware of that from the testimony and the records. Is that correct?

A I am aware of that.

Q And, you agree again, that that was appropriate and reasonable when suprapubic pressure and McRoberts did not work, to try to insert the hand into the vagina and

try to do the rotational maneuver. That was reasonable and appropriate?

A I agree.

Q And also, I think we have a few other things we can agree on. It was absolutely within the standard of care for Dr. Goldstein to call for assistance when confronted with a shoulder dystocia?

A Absolutely. He should do that first thing ---

Q And she came pretty ---

MR. GRAHAM: Your Honor, could she finish her answer?

THE COURT: I think she did. I think she did answer it, but you may ---

DR. GOMEZ-CARRION: I don't know that they heard me, because she started talking as I was answering.

MS. CRAIG: I will be happy to re-phrase it.

THE COURT: Yes ---

MR. GRAHAM: Your Honor, we just ask that the witness be allowed to finish her answer to the last question.

THE COURT: Well, I ---

MR. GRAHAM: She was giving her answer and counsel just interrupted her.

THE COURT: And we are trying to give her an opportunity to do that. So, you can finish your answer.

Q Dr. Gomez-Carrion, it was absolutely within the standard of care for Dr. Goldstein to call for assistance when

confronted with the medical emergency of shoulder dystocia. True?

A True. But the standard of care is to do that as soon as you diagnose a shoulder dystocia.

Q And in this case, assistance came rather quickly.

A Three minutes into it.

Q But would you agree that it was rather quickly?

A That seems like a very relative term. It was before the seven minute mark, so I think that Dr. Coker came within that 3 to 4 minute mark, so considering where Dr. Coker was positioned, that was very quick, I would imagine.

Q So, do you agree or do you disagree that assistance came rather quickly?

A Assistance came quickly. I would agree with you.

Q And Dr. Goldstein, with the assistance of Dr. Coker, they were able to deliver the baby within four minutes of the shoulder dystocia being diagnosed.

A That is correct

Q All right. You would agree that a permanent brachial plexus injury after a shoulder dystocia can occur and there is no evidence of negligence on the part of the other physician?

A I agree.

Q Is that correct?

A That is correct.

Q So you can have a permanent brachial plexus injury and it does not always mean that the doctor did something wrong.

A That is absolutely correct.

Q I told you we could agree on a few things. Now, you can't say how much traction was used in this case. True?

A Just excessive traction. I can't quantify in terms of newtons or pounds, no I cannot.

A And let's talk about that, because that's an important point. In this case, nobody can say exactly or to specify how much traction was used. Correct?

A That's correct.

Q Because I think you testified that the amount of traction used is based on the doctor's experience in delivering babies. Correct?

A Experience and the situation of resolving a shoulder dystocia. Because if you've never really had the opportunity to be faced with this on more than five or six times in one's career, then you don't have the opportunity to build that arsenal in order to safely resolve a shoulder dystocia.

Q And so I think what my question was and what your testimony was previously was that a doctor knows how much traction to use based on his or her experience.

A That's correct.

Q Okay. And there is no way to measure traction, at least ethically.

A That is correct. As we sit here Cinco de Mayo, 2015, with all this technology. Maybe one day we will be able to do that.

Q Right. But in 2009 when this baby was born, there was no way to measure traction, at least ethically.

A That is correct.

Q And it's your opinion that no one knows how much traction was applied at the time of delivery. Fair?

A Would you mind repeating that?

Q Sure. I'd be happy to. It is your opinion that no one knows how much traction was applied at the time of delivery.

A Besides my characterization that it was excessive traction, no.

Q How do you know how much traction was applied at the time of delivery? Would you agree or disagree that no one really knows that?

A Correct.

Q Now, you weren't in the room, the labor and delivery room, to observe the amount of traction being used. I'm sure we can agree with that.

A Absolutely.

Q And you agree there is no evidence in the medical record

that there was excessive traction. Correct?

A It's not written by the doctor or the nurses that excessive traction was used. That is correct.

Q So, there is no evidence in the medical record, you weren't there, and you can't say how much traction was used. Correct?

A I would agree with those statements.

Q Now, it's your opinion that a vaginal delivery was appropriate in this case.

A Yes, ma'am.

Q So, you're not here telling this jury that a C-section should have been performed?

A Not based on the medical documentation I saw.

Q So, drilling down a little bit on that, so a C-section was not medically indicated in this case?

A Well, can we go back to when she was pulling and pushing and the decision was made to put on a vacuum?

Q My question is whether or not a C-section was medically indicated in this case.

A I think my problem with answering that question is the doctor's decision-making. No indication for the vacuum, but if the doctor presented to the patient and say, she said, "I don't want a vacuum," and she had been given the benefits and risks and he said, "I want to go on to a C-section or you can continue pushing," so at that

point a C-section could have been a possible alternative to the mode of delivery.

Q And we'll get to the vacuum, we'll do that in just a minute, but the question is, was the baby of a weight that you needed to move to a cesarean section, yes or no?

A That's a different question. No.

Q No?

A No.

Q Now, you are a member of ACOG, which is the American College of Obstetrics and Gynecology. Is that right?

A They most recently changed their name to American Congress. I'm not sure why, most are in obstetrics and gynecology, but they are one and the same.

Q Okay. But you are a member of that professional organization called The American Congress of Obstetrics and Gynecology?

A I am.

Q And that is the premier professional organization for obstetricians and gynecologists, like yourself. Correct?

A Well, it is the professional society, yes.

Q And you review their, we call it ACOG, for short. Is that fair?

A Yes.

Q And they issue various publications and medical

literature to obstetricians to keep them current on various medical issues.

A Correct.

Q And do you get those bulletins and, I believe, it's called the green journal?

A I do.

Q And you review those, correct?

A Correct.

Q And those are reliable sources of information for you to stay current with the medical literature.

A Well, that's one piece of it. We all know that just because something is published in a journal, it's something we do at my hospital, as well, looking at the quality of the research, the biases. So just because something is published doesn't mean this is what you should do, so.

Q Yes, ma'am, and I'm not talking about supplementing, I'm talking about what is actually published by The American Congress of Obstetrics and Gynecology, which you are a member ---

A Yes.

Q --- and most obstetricians are members of ACOG.

A I can't comment on that. I think so, but I'm not sure.

Q But you review their publications and you probably receive them in your office, don't you?

A I do.
Q And you review them, correct?
A I do.
Q And you consider those to be reliable.
A For the most part. Yes.
Q Okay. Now, a child can have a brachial plexus injury. I already asked you about a permanent brachial plexus injury and now I'm going to ask you about any type of brachial plexus injury. A child can have a brachial plexus injury and it doesn't mean that the doctor did something wrong.
A That's correct.
Q In fact, you've had two deliveries that children have had brachial plexus injuries.
A Correct. But I also did something wrong.
Q And Dr. Gomez-Carrion, bad outcomes can occur in the absence of medical negligence. Would you agree with that statement?
A Absolutely.
Q Now I believe we talked about this in your deposition. You believe that the reason shoulder dystocia are unpredictable and non-preventable is because accurate methods of identifying which fetuses will experience shoulder dystocia do not exist.
A I would agree with that.

Q I believe Mr. Graham touched on this, but you have been doing work like this, coming into to court or testifying in cases since the late 1990s?

A That's correct. I've been reviewing records since the late 1990s. This is my, I believe, 12th time being in a courtroom to testify.

Q Is it the 12th time for Mr. Graham?

A No.

Q But you have worked with him on twenty-something cases?

A Over a ten-year period, probably.

Q So, twenty cases and then in this case, you received a $1000 retainer from Mr. Graham to review these records?

A Yes, ma'am. That's my standard charge.

Q And even though you have reviewed and worked with him on all these cases, you still made him send you a retainer?

A Yes. That's what I do with all the lawyers I work with.

Q And all those cases that you worked with Mr. Graham, all of those cases have been against doctors or hospitals. Correct?

A That's the only cases he has provided to me. I take any case that comes my way. I do defense work, as well. I'd love to review for you, as well.

Q Well, specifically, with regards to Mr. Graham, you have never reviewed a case where he was defending a doctor or hospital. They've all been for the patient. Right?

A That is correct.
Q So in the year 2013, Mr. Graham paid you $51,370 to testify and give opinions in cases. Is that right?
A I submitted my forms to you. I don't have those numbers memorized, but that sounds about right.
Q Thank you, ma'am. You, at our request, gave your 2013 1099 form to the federal government and it indicated that Mr. Graham had paid you $51,370.
A That's correct.
Q And then, let's see, last year, 2014, Mr. Graham paid you $22,540.
A That sounds about right.
Q So, continuing on with your experience as a testifying witness, let's go through the states. You've testified in New Hampshire?
A Yes.
Q You testified in Vermont?
A Yes.
Q Massachusetts?
A Yes.
Q Pennsylvania?
A Yes.
Q District of Columbia?
A Yes.
Q South Carolina?

A Yes.
Q North Carolina?
A Yes.
Q Georgia?
A Yes.
Q Rhode Island?
A Yes,
Q New York?
A Yes.
Q And New Jersey?
A Yes.
Q All as a paid testifying expert. Did I miss any of those states?
A I don't believe so.
Q All right. I'm looking at your CV. I believe it is in evidence. It looks like there is a review -- in your CV, you actually do mention that you are a member of ACOG, The American Congress of Obstetrics and Gynecologists.
A Yes.
Q And then it looks as though the focus of your practices changed over the past several years.
A Just since September of 2014.
Q Okay.
A So it hasn't been quite a year yet.
Q And that's when you stopped delivering babies. Right?

A Unfortunately, but true. Yes.
Q And it looks as though you have been focusing quite a bit on minimally invasive hysterectomy for female to male transitioning. Is that transgender?
A That is correct, but your statement is incorrect, as well.
Q All right. Ma'am, I'm just looking at your CV.
A I know. You are on page -- you are looking at my achievements and ---
A I'm looking at page six. I want to know what you are doing nowadays since you are not delivering babies.
A Right.
Q And, actually, that was 2011. It says, workshop presenter for minimally invasive hysterectomy for female to male transitioning at a transgender conference.
A I presented, yes.
Q All right. And there is another transgender conference in 2012.
A I'm invited to speak yearly at this conference.
Q Okay. Thank you. It looks like 2013, as well.
A And this year, as well.
Q And this year, as well, 2014.
A Yes. Every January. Yes ma'am.
Q And you indicate in your CV, you have a little narrative report, you said that over the past three years I have

developed an expertise in the counseling and treatment of transgender patients.

A Yes.

Q So, your practice has evolved over the years. You haven't always done that. You used to just deliver babies.

A That is incorrect.

Q So, you've always done transgender work?

A No. But I've not always just delivered babies. I've been a true generalist in my entire practice until October 1st of last year. As a gynecologic surgeon, I mean, that's why I said your first statement was incorrect. The focus of my practice is not transgender surgeries. It happens to be a group of people that have accessed care and I'm one of the few gynecologists in Boston that serves that patient population. A part of my fabric as a physician and as the person that I am, I've always prided myself in not turning anyone away from my practice. So I've gotten many awards for compassionate care. I just got an award for humanitarianism. I've gotten an award for community service. I take care of anyone who comes to my door. The reason you see so much focus in terms of presentation around transgender work is because in 2006 when I first got approached to take care of a ill patient, one of my primary care doctors

was trying to refer this patient for a hysterectomy and he had called 12 other gynecologists and they all said no. When he called me, I said yes. What do you need for me to do? Your patient needs a hysterectomy removal of fallopian tubes and ovaries. That's what an operative gynecologist does and I had no issue -- I do not judge. I was not raised to judge and so, I'll take care of Jehovah Witnesses, transgender, homeless, professionals, and that says it in my verbiage, as well, in my CV. I believe it is my first sentence. "I am an OB-GYN generalist who strives to deliver outstanding care to all of my patients regardless of race, educational level, socioeconomic status, sexual orientation or religious beliefs." That is who I am.

Q Okay. But, really, I must have struck a cord, but my question really was, I just want to know what your expertise is as you are holding it out. In this case, we are dealing with the delivery of a baby and you, on your CV, you said that you have developed expertise in counseling and treatment of transgender patients. That's all my question is.

A Right. But when you made the first comment, it's like you were trying to say this was all I'm doing or focusing on and this is a small aspect of my practice. I'm very proud that I've been able to educate myself and

I do a lot of teaching in the communities and with my professional colleagues on how to more sensitively approach any patient, but particularly this very vulnerable population.

Q Okay. Thank you.

A You're welcome.

Q Moving on from your expertise and we are through with your CV. I'd like to ask some questions about informed consent. And you can't say that Dr. Goldstein didn't tell Miss Fulton about the possible risks of delivering a baby. You are not saying that. Is that right?

A My expectation would be that any obstetrician would go through risks of pregnancy and delivery.

Q Okay. And when we took your deposition, it was your criticism that Dr. Goldstein didn't document that specific conversation in the medical chart. Do you remember that?

A I do.

Q Okay. So, did you know that this was Ms. Fulton's second delivery?

A Yes, ma'am.

Q Now when you looked through the chart, you agree that Dr. Goldstein adequately and appropriately managed Ms. Fulton's diabetes. Correct?

A She seemed under reasonable care.

Q So talking about her prenatal care, Dr. Goldstein was on it. He was managing her diabetes and she was reporting her blood sugars every day to him. He was making sure that her diabetes was well-controlled throughout her pregnancy. Would you agree with that?

A She was reporting her blood sugars every day? I didn't see that document.

Q You didn't see that?

A Every day? Reporting?

Q I'm just asking, did you see the document.

A No.

Q Okay.

A I saw documentation of her reporting her blood sugars, but not every day.

Q Well, did you see that there are about 12 pages, 10 pages, of blood sugar documentation?

A Well, maybe I'm misunderstanding. There was a document of her blood sugars on a daily basis, but she wasn't reporting to the doctor every day, personally.

Q Did you see those in Dr. Goldstein's medical chart?

A Maybe I'm misunderstanding the question.

Q There are pages of documentation of various blood sugar ---

A Yes. That, I saw.

Q Was that in Dr. Goldstein's chart?

A Yes.
Q Now, you were asked questions about informed consent, but you weren't actually shown the informed consent form in this case. Have you reviewed her chart?
A Yes.
Q Have you had an opportunity to review the informed consent form?
MR. GRAHAM: Your Honor, we object to the use of the informed consent form. She is referring to the general hospital consent form.
THE COURT: I think the document speaks for itself. Any other objection?
MR. GRAHAM: No, Your Honor.
DR. GOMEZ-CARRION: (Looks at document) Okay.
MS. CRAIG: Let's mark that, please.
(Consent form is marked as Defendant's #1, without objection)
Q Now, at the top of this, it says Carolinas Hospital Systems and it is a consent for operation and/or procedure. You reviewed this document. Correct?
A Right.
Q And it says, "Acknowledgment. I received explanation about the planned operation and/or procedure for my attending physician and/or surgeons. No guarantees or assurances have been made or given by anyone as to the results that may be obtained. I understand." And I have

that highlighted. Did I read that correctly? (Shows document to witness)

A It appears that you did.

Q Okay. It also appears that Ms. Fulton signed that informed consent form. Correct?

A Correct.

Q And just look at the date. What is the date on that?

A It says 8/20/09, which is the day of delivery.

Q Yes, ma'am. Thank you. So this is informed consent for Carolinas Hospital Systems and ---

MR. GRAHAM: Your Honor, we continue to object to the reference to this general consent form as an informed consent document.

THE COURT: Your objection is overruled. The document speaks for itself.

Q Under "Consent" on the document it says, "I give consent for the following operation and/or procedure: Vaginal delivery or cesarean section to deliver the infant through the vagina or make an incision in the abdomen and remove the infant." Correct?

A Yes.

Q And then, also, on this informed consent form it says, "I understand that unexpected conditions may occur during the operation and/or procedure and by signing below, I give consent for additional or different

procedures should the doctor named below decide it is necessary or desirable." And then there is a section where you can write "exception", and it says, what, there? (Hands document to the witness)

A Where are you?

Q Sure. It says where you are supposed to note the exceptions and what is written there.

A It says, "none".

Q Thank you. Vacuums. We talked about informed consent. Now, let's talk about vacuums. You've used vacuums. I know you're not delivering babies now, but when you used to deliver babies, you used to use vacuums to deliver babies.

A Absolutely.

Q The vacuums, in and of themselves, are helpful tools to a doctor to help safely deliver a baby. Right?

A Yes.

Q And shoulder dystocia can happen even if a doctor does not use a vacuum to help deliver a baby. Correct?

A Correct.

Q And I think you testified that some of the risk of using a vacuum included brain damage, laceration, and swelling. Did I state that correctly?

A Brain damage, cerebral bleed.

Q So, brain damage, cerebral bleed, laceration, and

swelling?

A And that -- if you have brain damage or bleed, that can also lead to seizure activity and other issues that can evolve in the neonatal course.

A Yes, ma'am. But we don't have any of that in this case, do we?

A No. But you are asking the question and ---

Q Regardless of ---

A I'm trying to answer ---

Q Are you telling ---

MR. GRAHAM: Your Honor, I would ask that the witness be allowed to finish her answer.

THE COURT: You may proceed.

MS. CRAIG: Thank you.

Q In this case, you'd agree that Bryson did not have brain damage or -- what was the other thing you said? Brain damage or what?

A Or bleed.

Q Or bleed. Hematoma?

A Hematoma or laceration.

Q And Bryson did not have a laceration. Right?

A As far as I know.

Q And he did not have swelling.

A Not sure on that. Most babies have swelling whether you use a vacuum or not.

Q So, swelling, in and of itself, is not something that's going to cause harm to a baby. Correct?
A Correct.
Q You testified about Dr. Goldstein's experience as a physician. Remember those opinions and those questions you answered?
A Yes.
Q Now, you don't know Dr. Goldstein, do you?
A I do not.
Q You didn't train with him.
A I did not.
Q You have never delivered a baby with Dr. Goldstein.
A I have not.
Q Do you know that he has delivered over 3000 babies in his career?
A I saw that.
Q And he takes care of hundreds of patients here in Florence. Were you aware of that?
A Yes, ma'am.
Q Dr. Goldstein's been practicing medicine for 37 years. Did you see that in his deposition?
A I did.
Q And Dr. Goldstein is board certified in obstetrics and gynecology.
A I saw that, as well.

Q In fact, board certification involves a day, or maybe two days, I guess, of written tests and then a full day of oral testing?
A No. One full day.
Q One full day.
A Written and oral.
Q Okay. But there is a written portion and then there is an oral portion.
A And that happens, typically, not far after residency training. Within the first five years, typically.
Q And so Dr. Goldstein is board certified in obstetrics and gynecology. He passed that test. Did you know he passed it on his first attempt?
A I did.
Q And are you aware that some doctors don't pass that test on the first attempt?
A That's very true.
Q Dr. Goldstein teaches residents. Did you know that?
A Yes, ma'am.
Q He reads the medical literature. He reads the articles from ACOG, The American Congress of Obstetrics and Gynecology, to stay current on the medical literature. Were you aware of that?
A I believe so.
Q And were you aware that Dr. Goldstein is a well-

qualified member of the medical staff here in Florence? Were you aware?

A He's on the medical staff in Florence? Yes, I'm aware of that.

Q Yes, Florence, South Carolina.

A Yes, ma'am.

Q And Dr. Goldstein is a member of The American Congress of Obstetrics and Gynecology. Did you know that?

A I did.

Q And based on your review of the medical literature and The American College of Obstetrics and Gynecology that you indicated was reliable, would you agree or disagree with the publication that says there are multiple reports in the peer-reviewed literature describing the occurrence of a neonatal brachial plexus injury without concomitant, clinically recognizable shoulder dystocia at the time of a vaginal or caesarian delivery. Would you agree with that statement from ACOG?

A I would.

Q You would also agree with the statement that neither high quality nor consistent data exists to suggest that a neonatal brachial plexus injury can be caused only by a specific amount of applied force beyond that typically used by health care providers during any delivery. Do you agree or disagree with that statement?

A I would, overall, agree with that.
Q Ma'am?
A I'd agree.
Q Thank you.
Q Would you agree that mac -- what is macrosomia? What is the definition of macrosomia? What is your definition of it?
A Well, it's not my definition. It's the definition of ACOG. Baby over 4000 grams, for example. There is also that term, large gestational stage, for example. In this case, you have a large gestational baby at 36 weeks near 4000 grams, but not macrosomic.
Q Okay. That's what I wanted to ask you about. You gave testimony about the size of the baby and macrosomia or a macrosomic baby is a big baby. Correct?
A Correct.
Q And ACOG actually defines macrosomia as growth beyond a specific birth weight, usually 4000 grams, regardless of the gestational age. Would you agree with the ACOG definition of macrosomia?
A They use that standard cut-off of 4000 grams and beyond, yes.
Q Okay. So 4000 grams, that's macrosomia, that's a baby that is very big. In this case, Bryson was 3500 grams. Did you know that?

A I did.
Q Would you agree with me that if somebody asked you how you could, if you could quantify the miles per hour a baby descends through the birth canal, that that's not a fair question?
A No.
Q Would you agree or disagree with that?
A I would disagree. I mean, I would agree with that, that that is not a fair question.
Q I'm sorry. My question wasn't very clear. That's not what I'm asking. That's not a fair question for somebody to quantify how many miles-per-hour a child descends through the birth canal?
A No, ma'am.
Q Thank you. Quality nor consistent data exists to suggest neonatal brachial plexus injury can be caused only by a specific amount of applied force beyond that typically used by healthcare providers or during any delivery. Agree or disagree with that statement? Would agree with that?
A I would agree.
Q A couple more questions on Dr. Goldstein's experience. You are aware that he, as well as yourself, attends continuing medical education programs?
A Well, that's the only way you can maintain membership in

The Congress of OB/GYN.

Q Right. So, as lawyers, we have to attend legal education, a certain amount of hours a year. So, do you have to go through a certain amount of hours of continuing medical education?

A Yes, ma'am.

Q And you are aware, of course, that Dr. Goldstein does that. Correct?

A I am aware, yes.

Q And you made a comment earlier that you were chief resident at one point in your residency.

A Yes, ma'am.

Q And are you aware that Dr. Goldstein was also a chief resident?

A I was not aware of that, I don't think.

Q You weren't?

A I'm not sure if I was aware of that.

Q Now with regard to your opinion on lack of documentation, we talked about lack of documentation with regard to your opinion on informed consent. Would you agree that lack of documentation does not cause an injury?

A You are talking about writing on paper. Of course, it would not.

Q You've testified a bunch. You know that you have to

prove that there is a deviation and you have to prove that it caused an injury. Correct?

A Correct.

Q What I'm asking you is, with regard to your opinion as to lack of documentation, that doesn't prove that there was any injury in this case. Documentation can't do that.

A A documentation reflects what was discussed with the patient that may have changed the course of this delivery.

Q Yes, ma'am. And I agree that's your opinion. You've done this a lot. Right? You've testified a lot, right? You know what standard of care is. Correct?

A I do.

Q You know that you have to prove not just that there was a deviation, you also have to prove that that caused an injury. Right?

A Right.

Q Okay. And I understand that it is your opinion, the lack of documentation, is not within the standard of care. Is that correct?

A That's correct.

Q But you agree that lack of documentation does not cause an injury.

A I would agree with that.

Q Okay. And then, with regard to Pitocin, you can't say that with or without Pitocin, the shoulder dystocia could have been avoided, can you?

A I cannot.

Q So that's documentation, Pitocin. Traction, that was the other one. To give your opinions in this case, have you carefully reviewed the medical records and also the depositions that have been taken in this case, particularly the deposition testimony of the nurses, the nurses who were involved in the care and treatment?

A I have.

Q And did you take into account, in reaching your opinions, that an eyewitness to the delivery noted that Dr. Goldstein didn't do anything differently in this delivery than he does in any other delivery? Did you see that testimony?

A I did.

Q And that nurse was physically present for the delivery, was she not?

A I would assume so since she gave deposition testimony that she was there.

Q Yes, ma'am. Thank you so much.

MS. CRAIG: Those are all the questions I have.

THE COURT: Any redirect?

MR. GRAHAM: Yes, sir, Your Honor.

REDIRECT EXAMINATION

BY MR. GRAHAM:

Q I'LL try to be brief, Doctor. You were asked a question by Ms. Craig about whether shoulder dystocia is preventable and you said it's not preventable. My question is, is brachial plexus nerve damage preventable?

MS. CRAIG: Objection, Your Honor, to editorial comment and leading.

THE COURT: Sustained.

Q Doctor, have you formed a conclusion as to whether, to a reasonable degree of medical certainty, as to whether or not ruptures of four brachial plexus nerves, four or more nerves, is preventable?

A Yes, Sir.

MS. CRAIG: Objection, Your Honor. It is beyond the scope of cross and this is an area outside of her expertise. This is in the realm of pediatric knowledge.

THE COURT: Sustained.

MR. GRAHAM: May I respond?

THE COURT: Sustained.

Q You were asked questions about whether or not a baby can die if the doctor fails to deliver the baby safely with the various safety maneuvers to get the children unstuck. Is that why it is important for doctors to have

knowledge about how to safely dissolve shoulder dystocia?

A That is correct.

Q There was a question about whether or not Dr. Goldstein delivered Bryson in four minutes. In fact, Bryson delivered within four after Dr. Coker took over?

A Bryson delivered after Dr. Coker took over.

Q There were questions about suprapubic pressure and McRoberts not working. Did you see any evidence in the record that suprapubic pressure and McRoberts were used at the same time before traction was in place?

A So, I did not see that in the medical record and that was also substantiated in the depositions where it constantly stated that mom remained in stirrups and if you are in stirrups, that is not McRoberts.

Q There were questions whether or not permanent injury can occur without the doctor being at fault or without the doctor being negligent, et cetera. Do those situations involve the kinds of things you talked about before, like a tumor before birth growing into the nerves or fibroids in the uterus, those kinds of things?

A That's correct.

MS. CRAIG: Leading.

THE COURT: Sustained.

Q Would you tell us whether or not any of those non-

negligent causes of nerve damage were present in Bryson's case?

MS. CRAIG: Objection, Your Honor. Beyond her qualifications.

THE COURT: I'll allow her to answer that.

A Those conditions were not present as far as I've gleaned from the medical records and depositions.

Q You were asked questions about the American Congress of Obstetricians and Gynecologists. Does that group exist, at least in part, to lobby Congress to advocate on behalf of obstetricians?

MS. CRAIG: Objection, Your Honor. This has already been ruled on at pre-trial.

MR. GRAHAM: I don't recall that.

THE COURT: Might counsel approach the bench?

(Bench conference held off the record)

Q Doctor, can you tell us whether or not one of the purposes of ACOG is to lobby Congress?

A Yes, sir.

Q Can you tell us if one of the purposes of ACOG is to lobby on or to advocate on behalf of the professional and financial interests of obstetricians in this country?

A Yes, sir.

Q Can you tell us whether or not publications that are

published by this entity, this lobbying interest that advocates for doctors, can you tell us whether or not the articles they publish are always based on science?

A No, sir. They are not always based on science.

Q In particular, are there recent publications by ACOG and its affiliates that relate to the area of shoulder dystocia management and causation of permanent nerve damage that are not based on science?

MS. CRAIG: Objection, Your Honor. It's beyond the scope of cross. I asked about one publication from ACOG.

THE COURT: I will sustain your objection. Move on.

MR. GRAHAM: Very well.

Q What effect does the amount of money you get paid for testifying have on your opinions?

A None, sir.

Q I understand the respect that you have for all your patients, as you described. Are the transgender, is the transgender community the only community that has recognized you and honored you for your service?

A No, sir.

Q What percentage of your practice is related to transgender populations? Is that a significant part or a small part?

A It's a very small part, sir. It's just getting a lot of recognition because, again, I'm one of the few people

who are involved with this patient population.

Q There were a lot of questions about informed consent. Let me ask you first of all, this Defendant's Exhibit #1, does that reflect informed consent about anything?

A Can you define anything?

Q Well, does that, is that, is that an informed consent to an operative procedure that was involved in this case that you talked about; induction of labor or vacuum?

A Well, first of all, as I pointed out, this informed consent was dated the date of delivery, so again, that brings up much concern to me. You're now asking a woman who is presenting to deliver a baby to consent to things you may or may not have talked about. We know as providers that you don't consent someone in kind of the heat of the moment. You want to, particularly in this case with obesity, diabetes, risk of shoulder dystocia, the fact that that Dr. Goldstein delivers 40 to 50% by vacuum, this is something that should have been discussed at some point during prenatal care. Also, in Dr. Goldstein's deposition, he stated that he doesn't get the consent, nurses get the consent. So, I'm not sure how much a signature by a patient on the day she is going in for induction, how much that reflects on her knowledge, her understanding of benefits and risks, and certainly, if you are going to intervene with an

instrument that can cause harm, a general consent doesn't generally address that.

MS. CRAIG: Your Honor, at this time we would ask for a Rule 105 instruction.

THE COURT: Might counsel approach, again?

(Bench conference held off the record)

Q Doctor, what healthcare provider is identified at the top left-hand corner of Defense Exhibit #1, a doctor or a hospital?

A The hospital.

Q Carolinas Hospital System?

A Correct.

Q And what is the title of the document underneath the name of Carolinas?

A Consent for Operation and/or Procedure.

Q Does the title contain anything about informed consent?

A No, sir.

Q All right. When you were talking about informed consent not being given by Dr. Goldstein before he induced labor and before he used the vacuum, were you in any way being critical of the nurses at Carolinas Hospital or were you being critical of someone else?

A Not the nurses, Dr. Goldstein.

MS. CRAIG: Objection, Your Honor.

THE COURT: I'll allow the question.

Q You were being critical of who?
A Dr. Goldstein. Not the nurses.
Q Does that document say anything about informed consent?
A No, sir.
Q Did you read Dr. Goldstein's deposition to determine whether or not he has ever provided informed consent for vacuums?
MS. CRAIG: Objection. Asked and answered.
THE COURT: Sustained.
Q Does that document purport to give informed consent for induction?
A No, sir.
Q Does that document purport to give informed consent for vacuum?
A No, sir.
Q Does that document purport to discuss risks and alternatives to induction or vacuum?
MS. CRAIG: Objection. Asked and answered.
THE COURT: Sustained.
Q Ms. Craig says that Dr. Goldstein is board certified. Are you also?
A Yes, sir.
Q There were questions about whether reading from an ACOG publication, there were questions from Ms. Craig about whether you believed an injury to the nerves may occur

without shoulder dystocia and you said, "Of course". Do you believe that just because a chart doesn't document the presence of shoulder dystocia that that means shoulder dystocia was not present?

MS. CRAIG: Objection. Leading.

Q Do you have an opinion in that regard?

A I do.

Q And what is that, please?

A That shoulder dystocia can occur and it is not documented in the delivering provider's notes, just as you will never see in a chart that excessive traction was used.

Q Can injurious traction, do you have an opinion to a reasonable degree of certainty as to whether or not injurious traction can be applied without shoulder dystocia being ---

MS. CRAIG: Objection. Leading. Asked and answered.

THE COURT: Sustained, on both counts.

Q You were asked a question about whether to talk about the speed of a baby through the birth canal in miles-per-hour is fair. Would it be more fair to talk about inches or feet per hour?

A Possibly.

Q There were questions about whether you knew if Dr. Goldstein had attended medical education programs. Do

you recall what his deposition said about whether or not he had ever attended a continuing medical education program about safe management of a stuck shoulder?

MS. CRAIG: Objection. Leading.

THE COURT: Sustained.

Q What recollection do you have, if any, about whether or not Dr. Goldstein has ever attended a continuing education seminar about safe management of shoulder dystocia?

A In his deposition, he stated that he has never attended a continuing medical education focusing on the safe delivery or the safe resolution of shoulder dystocia. He also commented that he's never done a simulation, which is what most institutions for quite some time now, is how obstetricians do it. What a simulation is, is you have a pelvis and a baby and you go through the process of ---

MS. CRAIG: Your Honor, I object. This is not responsive.

THE COURT: It goes beyond the scope of the question. You may proceed.

Q One final question, Doctor. You were asked if you knew that Dr. Goldstein was a chief resident when he was in medical school during his residency?

A Chief resident during his residency.

Q I'm sorry. Do you remember the question, whether he was

chief resident during his residency?

A Yes.

Q Do you know whether everybody in his residency class was called "chief"?

A I don't know that.

Q Thank you.

MR. GRAHAM: No further questions.

THE COURT: You may step down. Thank you, ma'am. Madam Forelady, ladies and gentlemen of the jury, each of y'all have a lean and hungry look like y'all are ready for lunch. We are going to do that. We are going to break until 2:00. Once again, do not discuss the case, do not do any independent investigation. I will ask that you return and be here on time at 2:00, 2:00 sharp. Everyone remain seated as the jury exits the courtroom.

(Jury out at 12:26 PM)

THE COURT: Anything from the Plaintiff?

MR. GRAHAM: No, Your Honor.

THE COURT: Anything from the Defense?

MS. CRAIG: No, sir, Your Honor.

THE COURT: We will stand at ease until 2:00.

(LUNCH BREAK)

THE COURT: Madam Forelady, ladies and gentlemen of the jury, thank you for being here and being here on time. I am going to ask that you pay very close attention. I notice we

I went through their reports I'd already included it and also enumerated it and I put it in the comments section. I was right on point with Blackwell. It was almost like we had both worked together.

Q So, at some point then, did you contact Ms. Blackwell and write her and ask her for her input?

A I was not allowed to speak to her, but she was very kind and she did fill out a form for me and it was very helpful.

Q All right. I'm sorry. Go on.

A Basically, there is no occupational therapy after age 18. There is physical therapy to 18, none after that. There is psycho-social until 18 and then, situationally, anytime over his life. It's vocational assessment twice, one for summer employment and one for when he graduates. There is work site evaluation after he gets a job to make sure they can accommodate him so he -- the criteria is that the employer has to give him accommodation, but with the accommodation, the employee has to do the job ultimately the same as the non-disabled person does, the same number, the same efficiency, but not necessarily the same speed and the third evaluation is very simply is, you want to put all the controls on the steering wheel so that you can drive a car with one hand and adjust the various items like the radio and not have to

worry about the other hand.

Q Next one.

A This is a recommendation for constructive procedures and Dr. Grossman said one time and this one I did not include at all. Then, I have orthopedic podiatrist only to sixteen, one time a year as needed. No podiatrist, only two or three times and then more times as needed, which is not included. Serial casting, three or four times, and as needed. Most of that came from Dr. Grossman although it was mentioned in the deposition of the occupational therapist, which is to say he might not qualify independent to making a recommendation that relies on the documents. This is the surgery and this is what Dr. Grossman's office gave me and I validated it by calling Cincinnati, Texas, and a couple others and I got this from Dr. Grossman.

Q So, you have a range from 50 to 60 thousand dollars for the surgeries.

A Well, at that time, it was not inclusive of the hospital.

Q But what I want to verify, you did verify that with a number of brachial plexus centers in terms of whether or not that was an appropriate charge?

A If that was a reasonable rate, right.

Q And what did you determine?

A One hospital was 40,000, but most of them were between 50 and 60.

Q Thank you. Go on.

A Occupational Therapy, just till 18, a few times a week and then from 19 to 21, just one time a week. Physical therapy, till 18, two hours a week, 19-21, one hour a week and that's during the transition and I'm dating myself again, but in my office, I actually have a typewriter on top of one of my bookshelves. People come into the office and ask me what it is and so I had to be re-trained to use a computer and afterwards, my kids got frustrated with me, and I actually picked up the knowledge and so we have to be aware of the fact that our lifestyles change and it's usually between 19 and 21.

Q Now, Mr. Forman, before we go off this page, one thing that I don't know the jury has heard yet is, you have physical therapy and occupational therapy. Can you just give them a very basic explanation of whether those are the same or different?

A Physical therapy is strengthening and development of the muscular and skeleton system to improve stamina, endurance. Occupational therapy use effects stamina, endurance, physical capacity and things like tie your tie, put a belt on, comb your hair, shave, clean your

jury why we do a vocational analysis on a child like Bryson.

A It's an earning capacity analysis, a job axis analogy. It's not a pure vocational evaluation because we are unfortunately unable to determine his aptitude, his interests, all the other factors, but it is very important to do it because it will help us gear him in his further educational, explorations, activities that he can succeed at.

Q And again, if you would just highlight a few things on this issue and let's not go through every single item.

A Very simply, no difference in his intellect, no difference in his vocational preparation, no difference in his grade level. The first difference is in his strength from heavy to light. The second difference is climbing, from an occupational degree, limited. The next one is crawling, limited. Reaching, handling, fingering are limited. No more in that area. On the next page, there is no limitations in environmental conditions other than proximity to moving parts, explosives, chemicals. There is no difference in his aptitudes until we get to his motor coordination, finger dexterity, manual dexterity and all that basically says is that out of the jobs he could have done with the pre-injury profile, he's lost access to a number of those jobs and

his earnings are reduced by about $10,768.00 a year because he can't do all the jobs that he used to be able to do and I'm sorry if I went too fast or if I short circuited it for you.

Q That's fine. Okay. In terms of, had Bryson not been injured, how would that have impacted him from a vocational standpoint? What is the difference between the pre and post injury?

A I'm going to use a bad example. Okay?

Q Okay.

A He could be a teacher of some sort. Could he be a Phys. Ed. teacher? No. Okay? He could work in a jewelry store selling jewelry. Can he repair the jewelry in the back? No. He could possibly be a prime investigator, but he can't be a policeman because you've got to be able to shoot the gun with both hands. You know, there are certain occupations that he can do and can't do all of them, so his job axis is limited and his earning capacity is diminished.

Q Mr. Forman, after your evaluation of Bryson and your work-up of talking to his mother and all the work that you did on this case, do you have an opinion to a reasonable degree in the area of life care planning as to whether or not those recommendations that you made and that are reflected in your life care plan necessary

THE COURT: Very good.

MR. GRAHAM: Your Honor, we now have ---

THE COURT: And you don't have to say necessarily in great detail. You can just say, "note my objection" and I think that will preserve it.

MS. CRAIG: Thank you.

MR. GRAHAM: Your Honor, we now have the three-pound weight we intend to use through Dr. Resnick and I believe there was an objection. If you would rule on that.

THE COURT: I thought we had. I'm going to allow him to do a demonstration. We decided that. We are ready for the jury.

MR. GRAHAM: Thank you.

(Jury in at 9:14 AM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, thank you for being here and being here on time. We had some legal matters to attend to and I apologize for the late start. Plaintiff is recognized.

MR. GRAHAM: Your Honor, we would call Dr. Trevor Resnick.

THE COURT: Dr. Resnick, please come forward. Dr. Resnick, please come forward and place your left hand on the Bible and raise your right hand as the Clerk administers the oath.

(After being duly sworn by the Clerk of Court, DR.

TREVOR RESNICK testified as follows:)

CLERK OF COURT: Please have a seat and state your name for the record.

THE COURT: Have a seat in the witness chair. Pull up real close to that microphone and speak loudly, clearly, and slowly in order that we can hear everything you have to say and let's start with your full name and let's spell that last one for us.

DR. RESNICK: Trevor Jesse Resnick. R-E-S-N-I-C-K.

THE COURT: Thank you.

DIRECT EXAMINATION

BY MR. GRAHAM:

Q Dr. Resnick, good morning.

A Good morning.

Q Why don't you start off by telling us, please, where you are from and where you are now.

A I'm in the courtroom. I'm originally from Cape Town, South Africa. I went to medical school in Cape Town. I spent a few years in London doing internal medicine. I did my pediatric training at the University of Connecticut, my neurology training at Albert Einstein College of Medicine in New York. I did an epilepsy fellowship and for the last thirty years have been in Miami. I am chief of the neurology department at Miami Children's Hospital and on the faculty at The University

of Miami.

Q Thank you. And are you board certified?

A Yes.

Q In which fields?

A In pediatrics and neurology, with special competence in child neurology.

Q Tell us what child neurology is.

A Child neurology is a specialty including diseases of the brain, the spinal cord, the nervous system, including the peripheral nerves and muscles. It involves disorders such as headache, epilepsy, peripheral nerve disorders, developmental disorders, and others.

Q Thank you. In your work, in your education, knowledge, training and experience as a child neurologist, as a pediatric neurologist, have you acquired expertise related to the brachial plexus nerves and how they are involved in child health?

A Yes.

Q Are you familiar with where the nerves start and where they go in the child's body?

A Yes.

Q Do you have expertise about how those nerves can get injured?

A Yes.

Q Have you, at my request, reviewed the medical records

involved with respect to Bryson F ?

A Yes.

Q Have you also reviewed, have you had an opportunity to examine Bryson F ?

A Yes.

Q When is the first time you examined Bryson F ?

A In 2011.

Q At that time, had he had surgery performed yet?

A No.

Q When is the next time you had an opportunity to see Bryson F ?

A This morning.

Q Have you been qualified as an expert witness in various states around the country to offer qualified opinions on child neurology issues?

A Yes.

Q Let me hand you what has been pre-marked as Plaintiff's Exhibit #15. Can you identify that, sir?

A Yes.

Q What is that?

A It is my curriculum vitae.

Q Thank you. Is it true and accurate?

A Yes.

Q How current is it?

A It's not current.

Q What would we need to do to bring it up to date?
A There are additional articles that I have written, additional studies that I have been involved in since the CV. None of those articles are pertinent to this case.
Q Thank you, sir.
MR. GRAHAM: Your Honor, we offer this into evidence.
THE COURT: Any objection from Defense?
MS. CRAIG: Yes, sir, Your Honor. Just cumulative in nature.
THE COURT: It's into evidence over objection. All CVs will be in for everybody.
MR. GRAHAM: Thank you, Your Honor.
(Whereupon, Dr. Resnick's curriculum vitae is entered into evidence as Plaintiff's Exhibit #15, over objection)
Q And you mentioned that you had seen the child back in 2011. Prior to examining the child, did you have the opportunity to read certain pertinent records from his birth and from his time in the nursery of Carolinas Hospital here in Florence?
A Yes, I did.
Q And tell me, sir, are those types of records the types of records that an expert in your field reasonably relies upon in reaching conclusions and opinions about the case?

A Yes.
Q All right. I'm going to hand you -- actually, I'm going to hand you all of these documents and we can just go through them one at a time. First of all, sir, the one that is pre-marked Plaintiff's Exhibit #10. What is -- is that one of the documents that you reviewed?
A Yes.
Q All right. What is that document?
A It's a document that is a summary of the delivery.
Q Right. And what is the typed name at the bottom of the note?
A William Goldstein.
Q Thank you.
MR. GRAHAM: Your Honor, we'd offer this into evidence as Plaintiff's #10.
THE COURT: Any objection?
MS. CRAIG: No, Your Honor, no objection.
THE COURT: It's into evidence -- Plaintiff's #10 is into evidence, without objection.
(Whereupon, a summary of the delivery from Carolinas Hospital Systems is entered into evidence as Plaintiff's Exhibit #10, without objection)
Q The next exhibit I handed you is Exhibit #11. Did you review that as a part of your investigation in this case?

A Yes, I did.
Q And what is this?
A This is a summary of the examination of Bryson F after delivery.
Q At the Carolinas nursery?
A Yes.
Q Thank you.
MR. GRAHAM: We'd offer that, Your Honor, as #11.
MS. CRAIG: No objection.
THE COURT: Number 11 is into evidence without objection from Defense.
(Whereupon, a summary of Bryson F s examination after birth is entered into evidence as Plaintiff's Exhibit #11, without objection)
Q Next, let me ask you about Exhibit #12. Did you review that in connection with your work in this case?
A Yes.
Q What is that document?
A It's the discharge summary from Carolinas Hospital Systems.
MR. GRAHAM: We'd offer Exhibit #12 into evidence, Your Honor.
MS. CRAIG: No objection, Your Honor.
THE COURT: Number 12 is into evidence without objection.
(Whereupon, a discharge summary for Bryson F is

entered into evidence as Plaintiff's Exhibit #12, without objection)

Q Next, is Exhibit #14. What is that document?

A This is a dictation of the electromyleogram and nerve conduction study that was done in 2010.

Q Thank you. And have you also had an opportunity to take into account this particular document in reaching your finalized opinions here today?

A Yes.

MR. GRAHAM: We offer that, Your Honor.

THE COURT: And that is Plaintiff's Exhibit number?

MR. GRAHAM: Fourteen.

DR. RESNICK: Thirteen.

MR. GRAHAM: I'm sorry. Thirteen.

THE COURT: Thirteen is into evidence.

(Whereupon, a dictation of the electromyleogram and nerve conduction study of Bryson F is entered into evidence as Plaintiff's Exhibit #13, without objection.

Q Now, let me get you to turn to #14. What is this document?

A This is an interpretation of the MRI scan of the cervical spine and the right brachial plexus that was done in 2011.

Q Have you had an opportunity to review this document and take it into account in terms of the finalized opinions

you are offering here today?

A Yes.

MR. GRAHAM: We offer that, Your Honor.

MS. CRAIG: No objection.

THE COURT: Fourteen is into evidence.

(Whereupon, a 2011 interpretation of an MRI scan of Bryson F is entered into evidence as Plaintiff's Exhibit #14, without objection)

Q And finally, Exhibit #16, what is that, please, sir?

A That is a copy of my medical evaluation that was done in June of 2011.

Q When you examined Bryson?

A Correct.

MR. GRAHAM: We offer that into evidence, Your Honor. Sixteen.

MS. CRAIG: No objection.

THE COURT: Sixteen is into evidence.

(Whereupon, Dr. Resnick's medical evaluation of Bryson F from 2011 is entered into evidence as Plaintiff's Exhibit #16, without objection)

Q Doctor, let me get you to step down here if you don't mind and I'd like to ask you some questions to get you to explain to the jury what the brachial plexus nerves are from the viewpoint of a child neurologist and why don't you please stand on this side so our court

reporter can hear you better. Will one of these assist you as you explain brachial plexus to the jury?

(Mr. Graham places large chart on easel in front of the jury)

MS. CRAIG: Your Honor, may I have permission to move so that I can see?

THE COURT: Certainly.

MS. CRAIG: Thank you.

Q Doctor, can you just tell us -- just to get oriented. I believe the healthy nerves are on the top left and the injured are on the top right?

A The top right are the injured nerves and the top left is just the normal brachial plexus.

Q Do you need a pointer?

A I do, yes.

Q Tell us if you would, first of all, about brachial plexus nerves, generally. Where are they in the human body and where are they on this diagram?

A Okay. If you will permit me to digress. So, this is a diagram that looks at the body from the front. This is where the head would be up around here. This is the neck and these are the nerves coming out of the neck and these are the nerves going to the arm. Where these nerves come out of the neck, you can see where they join together and they separate again and where they join together and separate is called the brachial plexus.

Q Thank you. What is the purpose of the brachial plexus nerves in the human body?

A Well, the purpose of the nerves is, the nerves come from the neck and they go down to the muscles of the arm and will supply sensation to the arm. So, the purpose of the brachial plexus and the nerves within the brachial plexus is to allow the arm to work normally.

Q And we heard some discussion earlier that there are three main branches of the brachial plexus. Which nerves go into the top part of the brachial plexus bundle?

A So, if you can see, these are labeled C4, C5, C6, C7, C8, and T1. Cervical is the name for the vertebrae and the part of the spinal cord that is in the neck. T1 stands for thoracic, which is the beginning of the thorax, which is the chest. So, these six nerves or roots that come out of the spinal cord go up to make the brachial plexus. So, the upper plexus is comprised of these three roots. The middle plexus predominantly are the C6 and C7 and then the C8 and T1 would be the lower part of the plexus.

Q What muscles in the arm or what muscles in the body are powered by C5 and C6?

A So, the easy way to think of it is, the upper part of the plexus supplies the upper part of the arm. The middle part of the plexus supplies the middle part of

the arm, around the elbow, and the lower part of the plexus supplies the hand and wrist muscles.

Q Thank you. Now, let's talk about the various ways that brachial plexus nerves might become injured or diseased or something like that. Could you just tell us the various ways in which a baby -- well, why don't we start with an adult. Why don't you give us various ways an adult's brachial plexus nerves might be injured.

A So, brachial plexus nerves or just nerves in general can be injured. They can become inflamed, infected, or there's trauma to the nerves or there is a stroke and the blood vessels that supply the nerves are damaged.

Q And in a situation involving a baby who is born with nerve paralysis in the brachial plexus, what are the possible causes of that kind of injury?

A So, in a baby, things like inflamation or infection are less with them and more likely causes of brachial plexus injuries would be any type of trauma, such as stretching or tearing of the nerves, any kind of compression of the nerve or an abnormal formation of the brachial plexus during intrauterine development and so in the same way some babies are born without an arm or malformation, you can also be born with a malformation in the area around the brachial plexus and have a malformed chest or shoulder and the brachial plexus will be abnormal and

the arm function is minimal.

Q In medicine, is there a concept known as differential diagnosis?

A Yes.

Q What is that?

A In medicine, patients come to us with a symptom. Often, our jobs as physicians is to figure out what the cause of that symptom is. So, for example, I have a cough. I don't know if that cough is due to an infection or an obstruction or asthma and a part of my history evaluation, it's my job to figure out which one of those three or four things it is. Now, those three or four things are the differential diagnosis that I use to come to a final conclusion.

Q And how do you go about coming to a final conclusion, just in general?

A In general, you take a detailed history and do a detailed examination and sometimes you have to do additional testing in order to come to a final diagnosis.

Q In reviewing the issue of what caused Bryson's brachial plexus nerve damage -- well, before we get to that, let me ask you, sir. Based on your investigation and your examination of the child and your education, knowledge, training and experience, have you been able to determine

whether or not Bryson has damage to his brachial plexus nerves and if so, what that damage is?

A Yes, he does have damage to his brachial plexus nerves. The damage that Bryson has involves the attachment of the entire brachial plexus and the examination that I did shows that he has weakness in the muscles that are related to all those nerves.

Q Thank you. Were you able to -- well, look at the top right-hand corner. What does that represent to you?

A Well, the top right-hand corner represents, well, you see these same nerves. Some of these nerves are now colored red and based upon Bryson's examination and the finding that he needed surgical intervention, this demonstrates those nerves that were damaged in the brachial plexus injury.

Q What is a neuroma?

A A -- when a nerve is torn, the part of the nerve that is still attached to the spinal cord says I should be attached. And what it does, it starts looking for the other end of the nerve and the way it does that is by growing a new nerve, but it can't find it and because it can't find the nerve it extended from, it grows in multiple different directions and so you get a ball of nerves and that ball of nerves is called a neuroma.

Q Thank you. You mentioned several possible, you mentioned

several possible causes of brachial plexus nerve damage in a newborn baby. Which of those causes or potential causes fits with Bryson's neuromas?

A Well, the only one, once you have neuromas, neuroma means that the nerve was torn. So, the only potential or only cause of Bryson's brachial plexus injury is the fact that the nerves were torn and the nerves involved in that injury were these nerves that you see in the top right-hand side of the diagram. So, in his case, there isn't a differential diagnosis that includes inflammation or infection or compression. This is an injury where the nerves are torn.

Q To get a -- well, sometimes can nerves in the neck just be overstretched? And if so, how long might that type of injury last?

A Yes, you can have stretching after the nerve has been torn and under those circumstances, you may have what's called ponzi weakness and the weakness can last from days to weeks, but there is always a return to normal function because the nerve is still attached and so even if there might be micro tears, the nerves are adjacent.

Q If you've got a baby over eight pounds going through the birth canal, what type of -- would the stretching that you described be sufficient to tear these nerves in two, be able to happen before the head delivers?

MS. CRAIG: Objection, Your Honor.

THE COURT: Sustained.

Q Doctor, can you describe please for us, what types of activities would be involved in the type of stretch that would be sufficient to cause this kind of harm.

A So, if we think of the brachial plexus as this is the neck and here are the nerves coming out of the spinal cord, the injury that occurs is an injury that stretches the brachial plexus and stretches the nerves within the brachial plexus and the only way you can stretch the nerves in the brachial plexus is if you think of the head, here is the neck and the shoulder, the only way you can stretch the nerve in the brachial plexus is by taking the head and tipping the head away from the shoulder and so if you actually do that to yourself, you can feel the stretch on your neck, so anything that will result in deviating or taking the head and moving the head away from the shoulder will cause stretching of the brachial plexus and if that stretch is significant enough, it will cause a tearing or stretching of those nerves in the brachial plexus.

Q And to cause ripping and tearing of the nerves on the right side, would the head need to be tilted towards the right shoulder or the left shoulder?

A Towards the left shoulder.

Q Were you able to determine whether or not Bryson has neuromas and if so, in which nerves?

A Well, I wasn't able to determine that, but based upon the MRI that I reviewed and based upon the operative report where he had the surgery, the neuroma information included C5, C6, C7, and C8, so there was this kind of glove of neuroma and fibrous tissue formation around those nerves.

Q Let me ask you about this point right here. As a non-doctor, looking at that, it looks like C1 and C8 come together. Would you explain that, please?

A Yes. On the brachial plexus, if you look throughout the roots separating, you can see that they separate over here, and then they join together again, so; separation, coming together, separation, coming together. And down at the bottom over here, we can see C8 and T1. We see that C8, T1 and C8, join together. And where they join together is where some of the damage was, so that T1 or the root of T1 was actually intact, but when it became a join between C8 and T1, there was damage.

Q What effect does that ball of nerves, the neuroma, have on the ability of the nerve to function normally?

A Well, where you see the ball of nerve abnormality indicates that there has been a tear within the nerve and so the nerve is not working at that point. Now, it

doesn't matter whether the nerve is torn here or here or here as long it's torn somewhere along the path, it means that the message is not getting to the muscle for the muscle to work normally.

Q So, if I decide I'm going to raise my hand, tell me what just happened in terms of those nerves.

A So, when the brain decides that you want to move your arm and the message goes from the brain down the brain stem to the spinal cord and the nerves responsible for raising your arm then goes to those muscles and those muscles elevate the arm.

Q It all happens just like that. (Snaps fingers)

A Just like that.

Q As long as the arm is working correctly.

A As long as the brain is working, as well.

Q All right. Doctor, are we done with this?

A Yes, unless you have other questions about it.

Q Let's move on. You talked about neuroma. Does this slide or this blowup help you explain more about what neuroma is and what effect it has?

A Yeah, well, it just gives you a visual picture of what a neuroma looks like and we had shown the picture of what the normal brachial plexus looks like and you see here within the middle of the brachial plexus, you see a red blob, which looks not dissimilar to what that red blob

looks like. This red blob is actually an accumulation of blood products, scar tissue, nerve and neuroma tissue, that has been formed around a nerve that's been torn or stretched. And you can see within this diagram that there is a nerve that runs along here and there are nerves within this red blob that have been damaged and torn and this is tissue forming around that region of nerves that have been damaged.

COURT REPORTER: Could you identify that, please?

MR. GRAHAM: Sure. It's Court's Exhibit #2.

COURT REPORTER: Thank you.

Q Thank you, Doctor. Why don't we, why don't you re-take your seat, please sir. I want to refer to some of these exhibits we put into evidence earlier. Exhibits #11 and #12 you've identified and #11 is the original nursery notes from when Bryson was transferred from the delivery room to the nursery. True?

A Yes.

Q All right. What relevance, if any, does that have in forming your opinions?

A It just notes that he was unable to move his right arm or his right hand indicating that something had happened to the brachial plexus, but it doesn't really define the extent to which that was the case.

Q Does it say anything about whether or not his arm at

that point was the same size or different size as his left arm?

A There is no notation that there is any difference in the symmetry or the size of the arm.

Q Now, please turn to Exhibit #12. This is the one that you identified as Bryson's discharge summary from the nursery after his birth. What relevance does this have in terms of forming your opinions?

A The same as the initial nursing notes. It, again, demonstrates the fact that there is no movement in the right arm and very little movement in the fingers of the right hand, as well. So, from the standpoint of his examination, it demonstrates the same thing.

Q Now, please turn to Plaintiff's Exhibit #13. I believe you identified this as the EMG studies done by Dr. Gilpin?

A Yes.

Q What is an EMG? What does that stand for?

A EMG means Electromyleogram and what we do is, we put very thin needles into the muscles and then measure muscle activity. So, under normal circumstances, when you put a needle into somebody's muscle, you see that the muscles are quiet. When you ask them to move the muscle, then you see an increase in muscle firing. Somebody who has damage to their muscles, with a nerve

going to the muscle that isn't working, the muscle begins to fire abnormally by itself, because it's not receiving direction or instructions from the nerve telling it what to do, so when you do an EMG or electromyleogram on somebody when a nerve to the muscle is abnormal, you see this abnormal firing in the muscle.

Q And what does that tell you? What does the EMG report on Bryson F tell you?

A Okay. So, if you look at Bryson's EMG, his EMG shows that there has been, that there is abnormal function or abnormal firing within multiple muscles involving multiple areas within the entire brachial plexus.

Q Doctor, is this the exhibit that you were just referring to?

A Yes.

Q All right. Let me see if we can magnify that so everyone can see it. All right, could you direct this up or down to the main part that you are referring to there?

A So, if you look at the middle section ---

Q Of the graph?

A Of the graph. You can see it says normal ---

Q Could you use your pointer to ---

A I think it's over there. (Mr. Graham hands laser pointer to Dr. Resnick)

Q So, on the left -- I don't want to shine this into

anyone's eye. There you go -- these are the various muscles. These muscles over here, like the infraspinatus and deltoid, are the shoulder muscles. These muscles are the triceps that straighten your elbow out and these muscles over here are all the muscles of the fingers. These are the muscles that open your fingers up. These are muscles that extend your fingers and these are the muscles that flex your fingers. And what you are looking at here are various things that are done on the EMG that look at function and you can see, for example, they are looking for fibulations and they say, "none". If you look at amplitude, they say the amplitude is normal and if you look all the way on the right-hand side of the curve, the right-hand side of the graph which gives you an idea of the recruitment pattern, which is the ability for the muscle to work properly, you can see that they are decreased to amps for all the muscle groups excepting for biceps, which they say you can see one, two, three units and the entire CI, where you see one to three units, which is also not normal, but it just gives you an idea that all those muscles are affected.

Q How many units is normal?

A You would get numbers of units. You'd see it firing up. One to three and zero is not good.

Q What would be good just on the order of magnitude?

A Ten times. Ten times more.
Q Ten times more. So, instead of one to three, like, ten to thirty?
A Ten. Ten.
Q In the second column over, I see a bunch of "normals". What does that mean?
A That's -- one of the tests that they do during the EMG, which is insertional activity. INA means insertional activity. So, when you put the needle in you look for any activity you see there and for those muscles at the time, the insertional activity was normal.
Q All right. So, what significance does that have in terms of whether or not this child is really damaged?
A Well, this is just an indirect indicator of the child's function. The most important indicator of the child's function is how they use their muscles. This really gives you an idea to some extent, electrically, the difference between the different muscle groups.
Q Okay.
A Very frequently, you can get that information from the examination, itself.
Q So, "normal" in that second column means the muscles, themselves, have activity?
A No, it just means the insertional activity where it says, IA, was normal when they put the needle in. It

doesn't mean to say the muscle is normal. The way you tell whether the muscle is normal or not is by examining the patient and this is the part that gives you the most information over here and that's the recruitment pattern. Recruitment means you tell the patient to squeeze the muscle or move the muscle and normally you should see a marked increase in the muscle firing and in all those muscles, you can see there is a notation saying there is a decrease, that the recruitment pattern was decreased, meaning that muscle was not working normally.

Q And which is worse, one to three units or decreased?

A Well, zero units is the worst.

Q Right.

A One to three is not good and decreased means it is not normal.

Q Okay. So, let me just ask you to boil all this down so I can understand it, so we can understand it. Are these numbers consistent or inconsistent with multiple nerves being ruptured after the baby's head was delivered?

A They are consistent.

Q Are these numbers consistent or inconsistent with some pre-labor, pre-delivery kind of damage?

A It could be consistent with that, as well.

Q Okay. So, if they could be consistent with that, what

other information do you need in order to make that distinction?

A The EMG and nerve conduction just tells you how the muscles are working at that time. That doesn't tell you what the cause of the injury is. What tells you what the cause of the injury is, is the presence of the neuroma, because you can only get neuroma formation when you have a stretch injury which tears the muscle. So, the EMG is just telling you about function. It's not telling you about cause.

Q Thank you. Now, let's turn to Exhibit #14, this, you identified as the report from the Miami's Children's Hospital?

A Yes.

Q By the way, we've heard about Miami Children's Hospital and Nicklaus Children's Hospital. What is that all about?

A Jack Nicklaus gave a lot of money to the hospital and so they named the hospital after him.

Q When did that happen?

A A few weeks ago.

Q So, back to Exhibit #14, the MRI report. What does this tell you that you find relevant about determining the cause of Bryson's nerve damage?

A Well, this is more important in determining the cause,

because the MRI demonstrates that there is thickening of the nerves that are consistent with what is called a post-traumatic neuroma and it tells you that there is a neuroma and it tells you what the neuroma involves and so this study, in fact, is much more of a determinative in telling you the cause of the injury and the nerves that were involved.

Q Thank you. Now, turn to Exhibit #16. This, I believe you identified as your report from the first time you saw Bryson.

A Correct.

Q Tell us, please, what was the significance with your interaction with Bryson that day. What did you do and what did you learn?

A Well, I had reviewed the medical records and taken a history and then I did my examination, which was normal excepting as it pertained to his right arm. Now, with the history, what I obtained was the fact that he had a difficult delivery and there was a shoulder dystocia so the head was stuck and there were different maneuvers applied to get him delivered and then I described the fact similar to what I mentioned previously, about the fact that there was no movement in his right arm and then there was the beginning of shoulder movement at about nine months and then involving the thumb and the

finger at about a year. I then note that there is continued gradual improvement up to age three, which is a typo, because when I saw him, he was only twenty-one months. But the mother had noted that he had improved through about one-and-a-half years and then he's, his status had pretty much stabilized. He was receiving physical therapy. At the time I saw him, he predominantly used his left arm and the way he used his right arm was a helper or stabilizer arm. What that means is, if I have an object, I put it between my arm and my chest to stabilize it and then I manipulate it with my good arm and that's the way he was using his right arm in terms of his functioning. He was able to weakly grasp objects between the right thumb and the index finger and then I mentioned what the EMG and the nerve conduction showed, which is what we just discussed. Other than that, he had some very mild developmental language issues, but the major aspect of his examination related to my examination of the right arm and what the examination showed was the fact that he had shrinkage of the right arm, which if you look just where it says brachial plexus exam -- so, can you raise it up higher? Just a little higher? Right there is just perfect. (Magnified on the screen)

Q Before you go on, Doctor, let me ask just one question.

A Yes.
Q You said something about shrinkage of the arm.
A Yes.
Q Is there any evidence of shrinkage of the arm at the time of birth?
A No.
Q Okay. So, when you talk about shrinkage of the arm, what's the time frame?
A Well, if you have damage to nerves, the atrophic or the growth influence that nerves exert by using the arm and from the nerve itself is what determines arm growth. If you don't use your arm, what happens is, the muscles in the arm shrink and the bones around the muscles also shrink and that's called -- sorry, I'll try not to shine this in anybody's eye -- atrophy. Can you see where it says "atrophy" at the top left here? There, thank you. And atrophy is another way, a medical way of saying shrinkage of the arm. And so he had atrophy of his arm and then after that, it says posture and that looks at how he holds his arm and he held his arm in a flexed position away from the side and his arm was turned inward or pronated and his scapula was high riding and so that was just a description of how he held his arm. You can see also that there is a discrepancy in the length of his arm in that is three centimeters shorter

than his left arm. I didn't find any abnormalities of sensation or temperature.

Q Let me stop you right there. You talked about abducted. Well, you used a bunch of words that I want to make sure I understand. First of all, flex.

A Flex is at the elbow, it would be extended. This is flexion, so it's flexed like this. (Demonstrating) Abduction would mean it's away from his chest, so he's holding it away from his chest in a flexed position and pronated.

Q Pronated, is what?

A That way. (Demonstrating)

Q Palm down to the floor?

A Correct.

Q What is the opposite of pronated?

A Supinated, which means palm up facing the ceiling.

Q And his was which way?

A Pronated down.

Q What are you saying about his ability to ---

A Nothing. That comes later. All I was doing was describing what his posture was like when I saw him in a normal position.

Q Thank you. And then you talked about the high-riding scapula. First of all, what is a scapula?

A A scapula is the bone at the back that a lot of the

muscles of the shoulder are attached to.

Q Right.

A And if you have weakness of any of the muscles, the scapula, instead of being low and flat against your back, is high-riding, so it's raised up which ---

Q So, are you telling me that the brachial plexus nerves that power the shoulder muscles get into these muscles, then, around here? (Indicating on chart)

A No, higher up.

Q In here?

A Yes.

Q Okay. Thank you. Now, you said the arm length was three centimeters shorter on the right. I'm used to dealing with inches, so tell me about centimeters and how they relate to inches.

A Well, two-and-a-half centimeters is an inch and so it's about one-and-a-half inches shorter than the other.

Q Thank you. Excuse the interruption. Please continue.

A So, I didn't find any abnormalities in terms of sensational temperature. There was no history of pain and I couldn't elicit any pain when I examined him. There is something called Horner's syndrome, which we always look for in patients with brachial plexus palsies, because the upper part of the plexus has a nerve that goes up one side of the face and the eye and

causes constriction of the pupil. He didn't have that, and so it wasn't an abnormality ---

Q All right. On which ---

A --- on that part of the exam.

Q On which part of the nerves does Horner's relate to?

A C4. And you can see C4 was not involved when you look at the brachial plexus. And then I examined his arm and you can see it's broken into shoulder, further down, elbow, and then further down, forearm, and probably on the next page, the ---

Q Before we do that, past range of motion and active range of motion. Can you tell me what that means?

A Yeah. I'm going to get there.

Q Oh, sorry. Sorry.

A So, I break it down into shoulder, elbow, forearm, wrist and fingers and then what I do, with each one of the muscle groups within each one of those sections, I first make sure that by moving his arm myself, I'm getting an idea of what the range of motion of the arm is and so I lift his arm up and if I can lift it all the way up without any problem, it means that there is no restriction to that movement and so that's passive range of motion. I am moving it and so it's a passive range of motion for him. Active range of motion means that's what he can do and so I check the movement and he shows me

what he can do with that group of muscles and then reflex is just the reflexes that pertain to the group of muscles that I'm testing.

Q All right. Tell us whether it's usual or unusual for a child with brachial plexus nerve damage to have a different ability to move the arm actively versus passively.

A Well, that's not just with brachial plexus. That's with anybody, so we do passive range of motion with anybody we are doing an exam with to make sure that there is no restriction of movement say from a contracture or a functional extraction and he didn't have any excepting for two areas, which I will discuss in a while.

Q All right.

A But that allows me to then get a better assessment of what his active range of motion is and what his actual strength is.

Q All right. Just go through and tell us what limitations he had in terms of what movements he could make.

A Okay. So, the first movement is abduction, which is the ability to move your arm from its side and to lift your arm up in the air to a vertical direction and I was able to do that fully with him passively, and so there was no obstruction to the movement, but when I asked him to do it, you can see under active range of motion, it says

60, which means he could do 60 degrees and so the best he could do was this. (Demonstrating) He could get it away from his chest up to about 60 degrees and so that gives me an idea of the extent to which one of the shoulder muscles, which is called the deltoid muscle, of the extent of the weakness of that particular muscle. The next thing that's important ---

Q Doctor, could you make that motion standing up? I want to make sure everybody can see you.

A Yeah, sure. (Stands) Okay. So, normal motion would be up like this and what he could do is, he could get it up to about there. That was the extent of his weakness.

Q Thank you.

A The next thing that I did, was the ability -- also a part of the shoulder function is something called external rotation. So, normally, if we stand like this, I'm externally rotating. I'm turning my arm out. I can get it out to about 60 degrees. I'm doing it above my left arm and that's the shoulder movement that's one of the muscles that turns the arm out, so when you do something, you may lift it up, but you may also want to move it up in this direction, so any movement you do when you do that, it's external rotation. It's a shoulder movement. Now, you can see that because he was so weak in his external rotator, that the action had the

restriction of my ability to passively move his external rotator and so when I moved his external rotator on the good side I could go all the way up, just like that. When I get to the bad side I could barely get it up to 30 degrees. There was a contractual disability to do that. He couldn't do it. When I actively tested his active range of motion, he had no movement, so on this side he could do this. On this side, he couldn't, so he has complete weakness to externally rotate that shoulder muscle.

Q Okay. Let me ask you. Doctors in your field sometimes use the word "weakness". How does the word "paralysis" match up to the word choice of "weakness"?

A All right. You are more accurate than I'm being. Paralysis means very severe weakness so that you cannot move the arm and that's what he did have in that muscle.

Q Thank you. Please continue.

A (Sits down) Okay. External rotation means you hold your arms in the same position, but then you move them in to touch your chest. He had full ability for me to do it passively, but actively he could only get it in about 60 degrees, so he did have some movement, but it was restrictive. And then at the elbow, he had full ability to extend, actually, and he was a little weak. So, actually, he did pretty well at the elbow. He could flex

his elbow and extend his elbow with some mild weakness, so that was a relative sparing of his function.

Q What does the five minus mean?

A Five minus means mild weakness.

Q Okay.

A And that's just when he extended his arm, he was unable to extend it fully. He had a flexion contraction so if you stretch your arm out, you can stretch it to 180 degrees and he had about a 30 degree contraction. Okay, the next two are forearm, if we could actually move the page up or turn it over. So, pronation. If you have your elbow, again, pushed out as I had before, it's the ability as if you are using a screwdriver to reverse or this. That's supranation and pronation and you can see that pronation and supranation, I had no problem doing it passively, but he had no ability to pronate or supranate, so when I asked him to turn his arm up, he couldn't do it. If I asked him to turn his arm down, he couldn't do it, but he could do it fully with his other arm. In the wrist, I can't see that. There you go, thank you. So, his wrist is your ability to flex the wrist down or extend the wrist up and he couldn't either flex or extend his wrist and then in the fingers, he had four passive range of motion, but if you look at active range of motion, he couldn't do anything with his fingers

except some minimal movement of his thumb and his pincer finger and so he could put these two together, but otherwise, he was very weak in the wrist and the fingers, as well. And then what I did was, other than testing individual muscle groups which I just described now, I got him to do some functional things. In other words, taking your hand and putting your hand on your forehead or your chin or behind your head and when I tried to do those things with him, he was unable to do that. The one thing that he could do is, he could get his hand to his neck and his hand to his mouth, but you can see in my examination, I have a little star next to that and that star means he could do it, but he had to do it with ancillary maneuvers. So, if I ask you to put your hand to your chin, you would do this. (Demonstrating) What he would have to do is, he would have to raise his shoulder, because he's weak and then put his hand on his chin and so he uses ancillary maneuvers due to his weakness in order to do it and so he can do it, but he can't do it in a normal fashion that you all would do it. And then I tried something called ADLs, which means Activities of Daily Living, such as, lifting an object with both hands. Well, obviously, he can't do that because he doesn't have function in his right arm: Tucking in his shirt, combing

his hair, putting on his shoes, taking off his shirt, putting on his shirt. Now, remember, when I examined him, he was only 21 months of age. So, kids don't do that, but the major thing that he could not do that kids do at that age is really lifting objects with both of his hands and he couldn't do that because he didn't have the use of his right arm. So, basically, my assessment was that he had a severe brachial plexus palsy due to the description of what I just went through with you and that brachial plexus palsy involved the entire plexus, but it wasn't equally involved, because he did have some flexion and extension of an elbow, so it was patchy involvement of the brachial plexus, but the entire brachial plexus.

Q Except for about three years...

A Yes.

Q Does the rest of this report and the contents in there, does that reflect you opinions and conclusions at that time to a reasonable degree of medical certainty?

A Yes.

MS. CRAIG: Your Honor, could we approach, just briefly?

THE COURT: Yes.

(Bench conference off the record)

THE COURT: Exhibit #16 was previously offered into evidence, but due to the fact that it's been published in

great detail and gone over in great detail with the jury, I'm not going to allow that into evidence as it is cumulative.

MR. GRAHAM: Yes, sir. Your Honor, we skipped over the top of page two. Since it's not in evidence, can ---

THE COURT: You can ask him what you want to ask him.

MR. GRAHAM: Thank you.

Q Since this report is not going to be in evidence, Dr. Resnick, I'm going to go back to the part that we skipped. Could you just go through this section here, "Review of Symptoms and Neurological Examination," and tell us the significance of your findings?

A Okay. There is one section before that, the developmental history was, other than his right arm was, motor milestones were completely normal. Now, anything that I found was, at the time that I saw him, his expressive language was delayed in that he was only saying a few single words and at 20 months, he should be doing more than that, but otherwise, there as nothing developmentally ---

MS. CRAIG: Your Honor, I object. Beyond the scope of his expertise.

THE COURT: I'll sustain the objection.

DR. RESNICK: I'm sorry? I couldn't hear the objection.

MR. GRAHAM: May we ask of his expertise?

THE COURT: I sustained the objection.

Q Please move on, Doctor.
A His reviewer systems which looks at other organ systems was unremarkable. He was a healthy kid. Ear infections, chest infections and so on and so forth in this specific examination. I would then, as it pertains to his right arm was completely normal as was his neurological examination completely normal. The only additional thing I found in his neurological examination was the fact that his expressive language was mildly delayed.
Q Thank you, Doctor. Now, again, this report dates after your visit with Bryson, on what date?
A I think it was June of 2011.
Q Thank you. Now, you next saw Bryson today.
A Yes.
Q After his surgery.
A Yes.
Q All right. He is actually available to come into the courtroom. Would you be kind enough to show us with Bryson in the courtroom, what you'd do to assess him right now?
A Yes.
MS. CRAIG: Your Honor, we object to these new opinions.
THE COURT: Your objection is noted, but overruled.
MR. GRAHAM: Your Honor, I think he had to take a mother nature call.

THE COURT: While we are waiting, let's have the jury stand while we are waiting on the witness. (Jurors comply)

THE COURT: Mr. Graham, you are recognized. Y'all can have a seat.

Q Doctor, can you --

MR. GRAHAM: Ladies and gentlemen, this is Bryson. Do you remember Dr. Resnick?

BRYSON F : (Nods head)

MR. GRAHAM: Why don't you listen to Dr. Resnick and do what he asks you to do. Okay, son?

BRYSON F : (Nods head)

Q What I'm going to show you is -- and Bryson, can you say hi to everybody? (He waves) So, what I'm going to show you, and Bryson is very good at this, is I'm going to show you the same kinds of functions that I described to you in my original description on the examination. So, Bryson, to start out, why don't you do this. I want you to take this arm and I want you to lift that arm up, all the way up to the -- (Bryson complies) Good job. Now, put it down again. Very good. Now, I want you to keep the shoulder where it is and I want you to do the same thing with this arm here. Go up as high as you can. Okay. Good job. Now, if you remember, I said to you that when I originally examined him, he was able to get up to 60 degrees and what he's able to do now with ancillary

maneuvers is get it up to about 90 degrees and so that has been an improvement. So, now. Very good. Keep your arms like that. Very good. Now, with this arm, I want you to keep it against the side, but move it out as far as you can and move it upwards, all the way up. Very good. So, you can see that he is able to externally rotate his arm. Move it out again? Now, this one. Very good. Now, put that arm down. Now, I'm going to hold this one up. Just try your best to see if you can get that one out, as well. So, you see he flexes it, but he's unable to externally rotate it. Now, let's do this one. You've done this already for me Bryson. You did a very good job. I want to see you turn it inwards like that. I'm going to hold this front and you put it in. Touch your tongue. Very good. Hold it out again? I'm going to hold this one for you. Now, turn this one in. Okay. He's not really using the rotator. He has some function he gets a little bit of movement. With this arm over here, I want you to go like this, straight and then in. Okay. Now, do it with your good arm. Okay. Now, with this arm. Very good. Now, you can see there is some restricted movement. Now, he can do it. I've shown you that he can do it. He does it a little more slowly than anyone. Now, I want you to hold this and I know you are a strong guy. Bend your arm. Good. Now, put your arm

down again. Now, bend your arm. Excellent job. Now, lets see if you can do it with this arm. Can you hold it? Good. You've got it. Now, try to bend it up. Okay. You can see that what he does there is uses his shoulder to bend backwards, but he can't really flex the arm. He can flex the arm reasonably well without a break, but shall we do it with this arm? Good. Now, go down. Very good. Thank you very much. Now, so far you get an A+. Make your arm into a fist. Very good. Now, what I want you to do with this fist, straighten it. Very good. Now, I want you to move it down and I want you to move it up, all the way up. Good job. Okay. Let's put that arm down and we are going to do this one, as well. Thank you very much for closing the fist for me. Now, can you make it go up? Now, can you make it go down? You can see that he's unable to flex or extend with the wrist on that side. Now, with this arm, make your hand like that. Make a fist. First, I want you to turn the wrist up so it faces the ceiling and then I want you to turn the wrist down so it faces the floor. So, start like that. First, go up so that it faces the ceiling. Good job. Now, put it back again where it was. Good. Now, I want you to turn it down so it faces the floor. Okay. Now, let's try this one. Thank you. First, make it down so it faces the floor. That's supranation and so it's a little bit of

supranation. So, make it down so it faces the floor and he's unable to rotate it down so that it faces the floor. Now, let's see your fingers. Put your fingers out like that. Now, close your fingers and open your fingers. Make your fingers go out and then in. Very good. Okay. Now, with this hand, we'll try to do the same thing. Keep them up. Good. First, make your fingers go down. Okay. Now, you have some extension, some flexion with the fingers. Now, straighten them out. I'll hold this one for you. Now, make them go down, bend them down. Now, make them go up. So, you can see now he has some flexion and some extension with his fingers, but it is minimal. That was very good. I'm going to put this under your chin like this. Can you take it off with this hand? Okay. You see what he did, he just flexes the arm and takes it off. Good job. We'll use the same one. Now, I want you to do it with that arm. Do you see what he does there? That whole arm comes up in order for him to do it. He's still pretty good at doing it. Thank you, Bryson. Now, see if you can get it off your forehead like that. (Using a sticker) No problem. Now, use a new one. Put this hand down. Same thing. He was not able to do that before. Now he's able to do it, but again, using an ancillary hand. Almost there. Very good job. Another thing I want you to notice. Okay, hands down. You can

see there is a difference in terms of the position that he holds his hands and if you will look at the size. Turn here. That's the atrophy we were talking about. Good job. Okay.

Q Thank you, Doctor. You may take your seat. (Bryson leaves) Doctor, you told us when you first saw Bryson that his nerve damage was severe and permanent.

A Yes.

Q How do you describe his current situation?

MS. CRAIG: Objection, Your Honor.

Q Can you please -- have you formed ---

THE COURT: What is the objection?

MS. CRAIG: This is a new objection based on his examination.

THE COURT: Oh, and your objection is noted.

MS. CRAIG: Thank you, sir.

Q Please continue, Doctor.

A So, my opinion is, essentially, the same. It has been some minor improvement in his function in that he now has better finger movements in that he is now better able to extend and flex his fingers and there is also some improved shoulder function, in that he was previously only able to get it to 60 degrees. He can now get it to 90 degrees and that has happened since the surgery.

Q When you saw him before, did you know he was going to go in for an attempt to reset his nerves at that age of around two?

A No.

Q Can you tell us whether or not doing that kind of surgery at age two is relatively common or is it unusual?

A Oh, it is unusual.

Q Apart from Dr. Grossman, do you know anybody in the world that would undertake that procedure at that time?

MS. CRAIG: Objection, Your Honor. Leading.

THE COURT: That's not really -- overruled.

A No.

Q If Bryson had not been evaluated and operated on by Dr. Grossman, tell us whether or not he would have had the improvement that you have seen and described today.

MS. CRAIG: Objection.

THE COURT: Sustained.

Q Can you tell us, sir, do you have an opinion or conclusion to a reasonable degree of medical certainty as to whether or not Bryson would have improved at all since your first visit without the surgery?

MS. CRAIG: Objection, Your Honor. Speculative.

THE COURT: Sustained.

Q Ordinarily, Doctor, when a child -- do you have a

conclusion or an opinion to a reasonable degree of medical certainty as to whether or not a child at age two with severe ruptures and neuromas and total plexus injury, like Bryson, is likely to improve at all after age two through any form of treatment other than surgery?

MS. CRAIG: Objection, Your Honor.

THE COURT: I'll allow him to answer that question.

A So, generally, what we see is, you do see improvement for the first six months to a year, maybe a year-and-a-half. After that, any improvement that would have occurred due to nerves that were stretched, not permanently damaged, is done. So, generally, by the time you've reached 18 months, whatever you see is what you are going to see on a continuous basis, so to answer your question, by 21 months, whatever I was seeing at that time was reflective of a permanent injury without any subsequent improvement under those circumstances.

Q And you told us in your report from your first visit that Bryson's severe injury was permanent. Now you are telling us there has now been some improvement after surgery. How do you reconcile permanency with some improvement?

MS. CRAIG: Objection. Asked and answered.

THE COURT: I'll allow him to answer it.

MR. GRAHAM: Thank you, Your Honor.

A The answer is that, first of all, there has been some improvement. It's not a huge improvement and the improvement is that once you do neurolysis and you separate the fibrosis and the scar tissue and you interpose a nerve, you can get some return of function for those with nerves that are now reattached and that's what has happened to him. He has had some mild improvement.

Q Doctor, I haven't asked you this question. Have you formed a conclusion to a reasonable degree of medical certainty as to the most probable cause of Bryson's nerve damage?

A Yes.

Q What is that, sir?

A It was a stretch injury to the brachial plexus.

Q Involving stretch, involving movement of the head in which direction?

A Away from the right shoulder towards the left shoulder.

Q So, like this?

A Yes.

Q You are not an obstetrician.

A Correct.

Q So, you are not pointing fingers at anybody about whether the standard of care for obstetricians were met

or violated.

A Correct.

Q But you can determine, but for the movement of this child's head down towards his left shoulder, would any permanent nerve damage have been caused?

MS. CRAIG: Objection. Asked and answered.

THE COURT: I'll allow him to answer.

A Sir, could you ask the question again?

Q Yes, sir. But for the movement of this child's head of the left ear down towards the left shoulder, would his nerves have been ruptured, ripped, and torn?

A No.

Q Now, let me ask you about -- I expect that we are going to hear later on in the trial about the role of this child's poor body tone throughout his body at the time he was born. What causal significance, if any, does that have to causing this kind of injury?

MS. CRAIG: Objection, Your Honor. It is an editorial comment.

THE COURT: Sustained.

Q Doctor, have you formed a conclusion to a reasonable degree of medical certainty about whether or not this child's tone at birth played any role in terms of causing his brachial plexus nerve damage and, if so, please explain you conclusions in that regard.

A No, I don't believe that it had an effect and the reason I don't believe it had an effect are for two reasons. One, the actual tone of the muscles themselves is not what is necessary to protect a child at the time of delivery. It's the bulk and natural resistance of the muscles. So, for example, if you have shrunken muscles around the brachial plexus and you don't have that natural resistence during delivery, that can actually predispose to brachial plexus damage, but he had normal formation of his muscles, so the actual bulk and inherent resistence of the muscles were still there. The decrease in the tone, if you think of examining or holding a newborn baby, they don't have that much head control and neck control when they are born and if in the process of delivery there is a need to move the head or the neck, whether they have tone or they don't have tone is not going to make any difference to an adult who is assisting in the delivery process.

Q Thank you. Have you formed an opinion and conclusion to a reasonable degree of medical certainty about whether or not the uterus contracting or the mother pushing during the labor and delivery process played any role in terms of causing the brachial plexus nerve damage?

A I don't believe it did.

Q All right. Can you explain it, please, sir?

A. There have been various hypotheses on what are called maternal uterine forces, which means the contraction of the uterus pushing the baby out and that that contraction of the uterus pushing the baby out when the shoulder is stuck stretches the brachial plexus enough to cause a brachial plexus palsy. A lot of bad data has been evaluated and by many reputable physicians found not to be accurate. It wasn't actually proven it was a mathematical model that was devised to calculate the uterine forces and even under those circumstances, if your head is in a straight position and you have your shoulder where it is, it doesn't result in any meaningful or significant stretching to the brachial plexus enough to cause tearing or stretching of the nerves. So, an example would be if I was standing under a pole, a horizontal pole, and I was pushing out from the pole and there was a pole here obstructing my shoulder and I kept on going upwards it would hurt my shoulder but it wouldn't cause a deviation in the brachial plexus enough to stretch the brachial plexus and tear the brachial plexus nerves.

Q. And is there room for the baby's head to go like this (indicating) before it comes out of the birth canal?

A. Not that I'm aware of, but I would defer that to an obstetrician.

Q Let me ask you, among the blowups, do we have a blowup here that summarizes your views and opinions and conclusions about the most probable cause of this child's nerve damage?

A (Leaves the witness stand)

Q And before you say anything about it, let me read the Court Exhibit number. Court Exhibit #5.

A So, this diagram shows a baby being delivered. It also shows the vertebrae and the nerves coming out of the neck that form the brachial plexus and the purpose of this diagram is to evaluate what kind of structural change can actually cause damage to the brachial plexus. So, the one theory is that this is the synthesis or pubic bone and if the shoulder gets stuck at the pubic bone and the head continues straight up in this direction, that you can get tearing or damage to the brachial plexus and that would be the hypothesis of uterine forces and the other would be, if this is the cervical spine and this is the brachial plexus, if the head is turned in this direction, in other words, away from the shoulder, then you will then get stretching of the brachial plexus and thereby cause stretching or tearing of the nerves.

Q I notice that on this exhibit, greater than gentle pulling on or twisting of the baby's head. Let me ask

you about the twisting. What role, if any, do you believe ---

A Only insofar as twisting or turning would increase the stretching of the brachial plexus by getting it further away from the shoulder. That's the only mechanism that can result.

Q So, not only does twisting, but you need this kind of traction, too, left ear towards left shoulder before you get a permanent ---

A And when you turn, you also do get some degree, some increased stretching, but it has to be contraction of the head away from the shoulder.

Q Thank you, Doctor. Please answer any questions the Defense may have for you.

THE COURT: Madam forelady, ladies and gentlemen of the jury, we are going to allow y'all to take a morning break and refresh yourselves. Once again, do not discuss the case. Everyone remain seated as the jury exits the courtroom.

(Jury out at 10:38 AM)

THE COURT: You may be excused, as well, but you may not discuss this matter with either attorney at this point.

DR. RESNICK: Thank you, sir.

THE COURT: We'll take about a ten minute recess.

(Break)

THE COURT: Ms. Craig, have you had enough time to gather

your thoughts concerning the new opinion?

MS. CRAIG: Yes, sir. Thank you for the time.

THE COURT: It appears to me that that is not that prejudicial in that the condition has improved, so I wanted to mention that. So, anything more from the Plaintiff?

MR. GRAHAM: No, Your Honor.

THE COURT: Anything from the Defense?

MS. CRAIG: No, sir.

THE COURT: All right. We are ready for the jury.

(Jury in at 10:52 AM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, I know that listening to testimony sometimes is certainly a sedentary activity and I'm going to ask all of you to pay very close attention, because this is very important stuff. It's important to everybody. So, everybody, keep your eyes open, stay attentive and pay attention. Ms. Craig, you are recognized.

MS. CRAIG: May it please the Court.

THE COURT: Yes.

CROSS EXAMINATION

BY MS. CRAIG:

Q Good morning.

A Good morning.

Q All right, Dr. Resnick, you started reviewing lawsuits as a paid witness for Mrs. Fulton's lawyer about four

years ago?
A Something like that.
Q 2011?
A I don't remember exactly, but, yes.
Q Well, you've reviewed quite a few cases for Mr. Graham. Correct?
A Yes, I have.
Q In fact, you've seen approximately 15 patients that were sent to you from South Carolina to Miami. Right?
A Yes.
Q To Miami. And those were all clients of Mr. Graham's. Right?
A Yes.
Q And you've actually testified for Mr. Graham in South Carolina before. Correct?
A Yes.
Q Two times?
A I think so.
Q And one of the times that you testified like you are doing right here today, the court was in another trial recently, in Greenville.
A Yes.
Q Is that right?
A Correct.
Q And you gave the same opinion in that trial, did you

not?
A Yes.
Q And in that Greenville trial, the other experts that were hired by Mr. Graham, who all you know, were Dr. Grossman, Mr. Forman, Dr. Gomez-Carrion. Is that right?
A I don't remember.
Q You don't know if all those same experts and those same opinions were in the Greenville trial as are in this trial in Florence?
A No. I don't.
Q I believe you've been doing work and testifying in a number of legal cases for 20 years?
A Yes.
Q And maybe eight to ten depositions a year?
A Correct.
Q You've been paid over $10,000.00 by Mr. Graham's office in this case?
A No.
Q How much money are you charging to be in court here today?
A Seven-and-a-half thousand dollars.
Q Seven-and-a-half thousand dollars?
A Yes.
Q And you charged him more than $10,000.00 for the case that you testified in as a paid expert in Greenville.

Correct?

A Are you talking about, in total, for the Greenville case?

Q Yes, sir.

A Yes.

Q So, over ten grand there. Seventy-five for being here and as you said, you've seen fifteen patients sent to you by Mr. Graham. Correct?

A Yes.

Q Now, you refer patients to Dr. Grossman?

A Yes.

Q And Dr. Grossman refers patients to you?

A No.

Q Okay. So, you do the referring to Dr. Grossman.

A Well, Dr. Grossman is a surgeon, so I evaluate patients and if I believe that they may be candidates for surgery, I will send them to him.

Q Okay. So, you might send him some patients and then how about Mr. Forman? You've worked with Mr. Forman. He's a life care planner who creates plans for litigation purposes. You've worked with Mr. Forman ---

A I have, rarely, in the past.

Q You were working with him in this case. Right?

A I don't remember working with him. I mean, I don't remember reviewing anything of his in this case.

Q Okay. So, you don't know about Dr. Forman being involved in this case. Do you know if he was involved in the Greenville case, too?
A I don't remember. If you tell me, yes. If that's true.
Q Now, you do not deliver babies. Correct?
A Correct.
Q And you can't say how much traction is used to deliver any baby. Correct?
A Correct.
Q And you have no criticisms in this case regarding Dr. Goldstein's care and treatment. Fair?
A Correct.
Q And, specifically, you are not here to testify that Dr. Goldstein breached the standard of care in any way.
A Correct.
Q Now, I just want to make sure that we are clear. Mr. Graham asked you a question about what's marked as Court's Exhibit #2. Do you remember those pictures?
A Yes.
Q Okay. That picture of that neuroma, that's not the child in this case. Correct?
A Correct.
Q That's just -- those are pictures out of a textbook of some sort.
A Yes.

Q Okay. Now, your report that has been marked as a Court Exhibit, now this report, you saw the child in this case, you saw Bryson at Mr. Graham's request.
A Correct.
Q And that was back in 2011.
A Correct.
Q And then you documented your findings, which you call in your report an independent medical evaluation. Is that what you call it?
A Yes.
Q Now, the Court did not ask you to do an evaluation. Right?
A Correct.
Q And I didn't ask you to do an evaluation. Is that right?
A Correct.
Q So, the only person that asked you for an independent medical evaluation was Mr. Graham?
A Correct.
Q And he has paid you for that evaluation. Right?
A Correct.
Q And it's actually his office that made the arrangements with you so that Bryson could come down to Miami and be seen by you. Correct?
A Correct.
Q Now, you did not communicate with any of the treating

doctors, the doctors here in South Carolina that are taking care of Bryson.

A Correct.

Q And you did not schedule a follow-up visit with Bryson after this 2011 examination?

A Correct.

Q There's no treatment plan.

A Correct.

Q There's no prescriptions for therapy.

A Correct.

Q No medications were prescribed.

A Correct.

Q So, this independent medical evaluation was produced for litigation purposes. Correct?

A Correct.

Q Now, during your one, your examination on this date in 2011, I believe you spent about an hour with the child?

A Correct.

Q And you'd agree that in your report, it's important to document the details of your findings. Fair?

A Correct.

Q And you understand that you are asking the jury to rely on your independent medical evaluation.

A Correct.

Q And in your report, you documented that there is gradual

improvement up until Bryson was three years of age. Correct?

A That was an error. Correct.

Q Okay. That's not right. We talked about he was not three years old when you saw him. He was actually 21 months. Correct?

A Correct.

Q Now, in your report under the developmental history, you stated that his motor development milestones were age appropriate.

A Correct.

Q And you found that he was medically healthy.

A Correct.

Q And you also found that Bryson did not have any constitutional problems or problems with his vision.

A Correct.

Q He was alert and he was interactive?

A Yes.

Q And his social interaction and comprehension were age appropriate.

A Correct.

Q And his motor examination was normal other than how it pertains to his right arm.

A Correct.

Q And, of course, Bryson was in no pain.

A Correct.
Q Now, you offered the opinion that, when Mr. Graham was asking you questions, that Dr. Grossman's surgery was late in this case because the surgery was done when the child was two years old. Correct?
A Correct.
Q Now, you are aware that Dr. Goldstein is an obstetrician, he delivers babies for a living.
A Correct.
Q And so, of course, he doesn't treat babies after he delivers them. Fair?
A I understand that.
Q And so your criticism that this surgery was too late is not a criticism directed at Dr. Goldstein?
A It's not a criticism directed at anybody. The only question, as I understood it from Mr. Graham, was that the usual time to do that kind of surgery and the answer is no, that surgery needs to be done at a much younger age. I was not criticizing anybody.
Q I just want to make sure that we are clear, because Dr. Grossman also said that two years was late.
A Yes.
Q Did you read his testimony in that regard?
A No.
Q Okay. Well, you are not criticizing Dr. Goldstein

because Bryson had surgery at two years of age instead of the recommend time frame, which is think you said, six months to a year.

A Correct.

Q All right. Let's go through what you have marked as Exhibit #10 and let's go through this. (Projects on large screen) This is, at the top you will see, Carolinas Hospital Systems and this is a medical record of Dr. Goldstein's. This is a report that Dr. Goldstein wrote regarding the delivery at issue in this case, which was, of course, August 20th, 2009. Correct?

A Correct.

Q Now, I just want to go through what was going on in that delivery. If you look at the highlighted section, it says, "We had two pulls on the vacuum extractor."

A I'm sorry. Can we just get to the beginning of that, because I don't have the lower figure.

Q Oh, I'm sorry.

A No, that's okay. As long as I'm -- I can't read that.

Q Take your time.

A Yeah, I've got it. Okay. I have it now. Vacuum extractor was applied. We had two pulls on the vacuum extractor.

Q Right. Okay, so now, delivered the head at about 13:45. That's the time. Correct?

A Yes.

Q And recognized that she had shoulder dystocia with the right shoulder under the synthesis. Correct?
A Correct.
Q She also had a nucal cord which was reduced over the head. See that? She also had a nucal cord ---
A Yes, I've got it.
Q --- that was reduced over the head.
A Yes.
Q Now, a nucal cord, that's the umbilical cord. Right?
A Yes.
Q So, the umbilical cord, when it wraps around a baby's neck, can strangulate a baby. Correct?
A It can.
Q So, what Dr. Goldstein is documenting on his chart is that he noted that the nucal cord was wrapped around the baby's neck and so he took it and took it so it wouldn't strangle the baby.
A Correct.
Q That was a reasonable and appropriate thing to do, of course, wasn't it?
A It was. But you are asking a non-obstetric expert.
Q All right. Well, then, let's now move to the next page. This is a document that your lawyer put into evidence. Just want to make sure we can go through it all in detail. We tried the McRoberts maneuver. Do you see

that?

A Yes.

Q Prior to that, a generous right mediolateral episiotomy was cut.

A Yes.

Q Suprapubic pressure was applied.

A Yes.

Q The episiotomy was extended on two occasions. Correct?

A Yes.

Q Dr. Steve Coker was called to assist and Dr. Coker applied suprapubic pressure and with that pressure, he effected the delivery of the shoulders at 13:49. Is that correct?

A Correct.

Q And from the time that the shoulder dystocia was noted, it says 13:45 and the time the baby was delivered, four minutes later, was at 13:49. Did I read that correctly?

A You did. At least from my math.

Q Thank you. Now, you are aware as a physician and somebody who has reviewed the records in this case, that when a shoulder becomes stuck under the mother's pubic bone and the baby is unable to be delivered, that, sir, is a medical emergency. Is it not?

A Yes.

MR. GRAHAM: Your Honor, I'm going to object at this

point to questions about obstetrics to a pediatric neurologist.

THE COURT: I'm going to allow her to ask, give her some leeway. If he knows, he can testify.

MR. GRAHAM: Yes, sir.

THE COURT: He's a doctor.

MS. CRAIG: Thank you.

Q I have four questions left, okay? If the shoulder is not dislodged, the baby can suffer brain damage.

A Correct.

Q Or the baby could die.

A Correct.

Q And in this case, sir, once the shoulder became stuck and there was shoulder dystocia, Dr. Goldstein delivered the baby in four minutes. Correct?

A Correct.

Q Thank you.

MS. CRAIG: Those are all the questions I have.

THE COURT: Redirect?

MR. GRAHAM: Redirect.

REDIRECT EXAMINATION

BY MR. GRAHAM:

Q Doctor, just very quickly, let me just run through a few things. Ms. Craig asked you a few questions about getting paid by me on the cases where we ask you to

evaluate our child clients. What difference does it make to you in terms of your opinions that you get paid for the work that you do?

A It doesn't.

Q She's indicated that I have sent 15 or so child clients to Miami Children's Hospital to be evaluated by you, but let me ask you this, sir. In terms of the medical legal work that you've done as a testifying expert in the last 20 years or so, how do the percentages break down for your work between representing injured children and testifying on behalf of medical doctors?

A I testify on behalf of medical doctors about 60% of the time and on behalf of patients about 40% of the time.

Q Thank you, sir. You were asked some questions about obstetrical management of a delivery and I don't want to step too far in that area because I know that you are not an obstetrician, but if you had a child that was in the process of being born whose shoulder got stuck, would you want your doctor, your wife's obstetrician to have the knowledge and skill ---

MS. CRAIG: Your Honor, objection---

Q --- to deliver that baby safely ---

THE COURT: Sustained.

Q --- without putting the ---

THE COURT: Sustained.

Q Doctor, Ms. Craig asked you questions about not getting the baby out within six or seven minutes might put the baby's brain and life at risk. My question to you, sir, do you believe that obstetricians who are well-trained and well-experienced should have the skill to get the baby delivered without brain damage, without death, and without brachial plexus nerves within the first few minutes?

MS. CRAIG: Objection. Leading.

THE COURT: Sustained.

Q Do you have an opinion or a conclusion in that regard, sir?

MS. CRAIG: Objection.

THE COURT: Sustained.

Q Do you have an opinion or conclusion, sir, whether or not obstetricians should be held to at least the standard of care required of other obstetricians in their field?

A Yes.

Q Thank you, sir.

MR. GRAHAM: No further questions.

MS. CRAIG: Your Honor, one question?

THE COURT: The way it works, direct, cross and redirect. You have an obligation to object any new material and so that goes for all witnesses.

you are pleased with his motion?

A I am pleased.

Q And are you pleased with his improvement?

A I am pleased.

Q He doesn't have any pain when he sees you on a regular basis?

A I don't see that he ever has pain.

Q Thank you very much.

THE COURT: Any redirect?

MS. RODRIGUEZ: No, sir.

THE COURT: You may step down. Thank you, ma'am. You may call your next witness.

MS. RODRIGUEZ: Plaintiff calls Genesie Fulton.

THE COURT: All right. Why don't we stand and stretch a little bit.

MS. CRAIG: Your Honor, may we approach while she's walking up?

THE COURT: Certainly.

(Bench Conference off the record)

THE COURT: Yes, ma'am. Place your left hand on the Bible and raise your right hand as the Clerk administers the oath.

(After being duly sworn by the Clerk of Court, GENESIE FULTON PRINCE testified as follows:)

CLERK OF COURT: Please be seated and state your name for the record.

THE COURT: Have a seat in the witness chair. Pull up real close to that microphone and speak loudly, clearly and slowly in order that we can hear everything that you've got to say. Yes, ma'am.

MS. PRINCE: My name is Genesie Prince.

THE COURT: Thank you, Ms. Prince. Ms. Rodriguez, you are recognized.

MS. RODRIGUEZ: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. RODRIGUEZ:

Q Genesie, I am going to try and get the jury to get a little picture of who you are. They've heard a lot about your family and a lot about Bryson up to this point and I'm going to try and not make this repetitive, but I do need to get you to give a little background information so the jury knows who you are. Can you tell the jury where you were born and raised?

A Clarendon County.

Q And who are your parents?

A Willie Mae Prince and James Prince.

Q Do you have any siblings in South Carolina?

A I do. I have three sisters and two brothers.

Q Tell the jury where you went to school, just to give them a very quick little bit about your education.

A East Clarendon High School.

Q Okay. And after you graduated from high school, what did you do?
A I started working with a sewing factory called Kingstree Knits and from there I went to The Department of Corrections in '97 until present. I still am there.
Q And what do you do at the Department of Corrections?
A I'm a correctional officer.
Q At what facility?
A Turbeville.
Q And in that context did you meet a gentleman by the name of Anton Hunter?
A I did.
Q And are you all currently living together?
A We are.
Q And how -- what has been his involvement in Bryson's life?
A He's Bryson's father figure.
Q Tell the jury -- I know that back in January of this year you had the privilege of having a luncheon somewhere. Can you tell the jury ---
A I did.
Q --- about that?
A I had the privilege of going to eat lunch with Governor Nikki Haley. I was involved in an arrest at the institution that I work at. We had someone trying to

introduce contraband into our facility and I -- I had the privilege of going to eat lunch with her.

Q Tell the jury what's that picture?

A That's a picture of me standing in the Governor's Mansion.

Q Genesie, in addition to Bryson do you have another child?

A I do. I have Brittany Prince.

Q And how old is Brittany?

A Brittany is 25.

Q Now, tell the jury when Brittany was growing up what your situation was.

A When Brittany was growing up it was just me and her at one point and I eventually met this -- my ex-husband which is Ernest Fulton and he had a son that was from another relationship. I got him at a very young age and I raised his son as -- like it was mine.

Q And where does he live today?

A He is currently living with me and Anton.

Q Okay. And just in case his name comes up, let's clarify.

A His name is Carlos Hickson.

Q But what do you call him?

A We call him Baldy.

Q Baldy. Okay. And so, in addition to Bryson and you and Anton, Baldy is living with you?

A Yes. At this time.
Q Do you know about how long you've been divorced?
A Since 2013.
Q And tell the jury a little bit about prior to your pregnancy with Bryson, let's, we won't go through your -- had you ever had any health problems before?
A I've got what's called diverticulitis. I was a diabetic. I had at one point a problem with, something with my kidneys. The creatinine in my kidneys was high. I think I was also advised once with that but no major health issues.
Q Now, at the time that you found out that you were pregnant, right before that, who was your primary doctor?
A Dr. Morris Brown.
Q And where is Dr. Brown located?
A In Lake City, South Carolina.
Q And did you -- had you at some point in time started having problems with your ---
A I did.
Q --- menstruation?
A I did start having problems with missed menstrual cycles for, like, maybe five months at the time or if I did, it was very heavy, so he recommended that I go to a gynecologist more in the area for females and he did

recommend that I go to Dr. Goldstein at that time.

Q And was that on, oddly, August 20th of 2008, exactly ---

A Yes, ma'am. 2008.

Q --- a year ---

A Uh-huh.

Q Okay. Genesie, I'm going to ask you to try to let me finish my question.

A Okay.

Q The court reporter next to you is taking everything down and it's real hard for her if we talk over each other.

A Okay.

Q I know you're nervous ---

A Uh-huh.

Q --- but let's try and not talk over each other. Okay. So, you were seeing Dr. Brown and then he referred you to ---

A Dr. Goldstein.

Q Now, at the time that you went to see Dr. Goldstein, had Dr. Brown put you on some medication for your diabetes?

A He did.

Q What were you taking?

A Glucotrol, like, five milligrams once a day.

Q Now, when you started seeing Dr. Goldstein, did he, at some point, change your medications?

A He did when I went to see him and I don't know whether

it was the first visit, second visit, but he did change me over to a diabetic medicine called Metformin.

Q And after he had switched you over to the metformin, a couple of months went by and what happened?

A I initially thought I had something with an achy body associated with me. I thought it was the flu. I eventually went to Dr. Brown thinking I had the flu, but when they did the pregnancy test because of me having nausea I found out I was pregnant.

Q And that was in January of 2009?

A Nine.

Q And at that point in time did you inform Dr. Brown about your medication change?

A Well, he asked me who changed me to metformin and I told him Dr. Goldstein did.

Q Now, prior to you getting changed to the metformin -- these are personal questions, but unfortunately, it's the nature of what we do, were you using any method of birth control?

A No, I wasn't.

Q And when you met with Dr. Brown, what did you learn about metformin?

A That it was a medicine that can make women fertile, if they're not ovulating, to get pregnant. This medicine can make them fertile to get them pregnant.

Q Now, when you saw Dr. Goldstein during those months when you were -- he was working you up for the problems that you were having with menstruation. Did he ever tell you when he put you on the metformin that it could have side effects such as to affect your fertility?

A He did not.

Q Now, in January then, of 2009, you ended up getting a pregnancy test?

A Yes.

Q And what happened? Was it positive?

A It was positive.

Q Okay. And then, I think you went and saw Dr. Brown for the pregnancy test?

A Yes, ma'am.

MS. GANES: Just object to the leading.

THE COURT: Sustained.

Q Where did Dr. Brown refer you for obstetrical care?

A He didn't refer me. He just said I needed to go to my gynecologist.

Q Okay. And who did you go back to?

A Dr. Goldstein.

Q Now, when you went back to see Dr. Goldstein, did he have any discussion with you about the fact that metformin could cause, could impact fertility?

A No, he didn't.

Q And after you started -- or when you went back to Dr. Goldstein after the positive pregnancy test, did he do an ultrasound on you?
A He did.
Q Did he give you a copy of the printout from it?
A Yes.
Q Do you recognize that?
A Yes.
Q Who is that?
A That's Bryson.
Q Okay. And was that a picture you actually have kept?
A Yes, ma'am.
Q Okay. Now, I do want you to explain at this point though, explain to the jury why a lot of the baby pictures of Bryson no longer exist. Can you tell them why?
A After separating from my husband and moving in with a friend, which was Tameka at the time, she had a house fire and a lot of me and Bryson's pictures, my daughter's pictures, a lot of stuff got destroyed in her house fire.
Q Now, during the period of time that Dr. Goldstein was following you with the pregnancy with Bryson, did he make a referral to a specialist at McLeod?
A Yes.

Q And why was that?
A It was for the -- because I was up in age, older, and maybe some, some babies born to older mothers have some, maybe, and I can't think of the -- Down Syndrome. Kids can be born with Down Syndrome, so he think that I should have that test done just to see if I may be set to have a baby with Down Syndrome.
Q Did you go to that appointment?
A I did.
Q Now, you, your -- Bryson's father, did he have another child?
A He did.
Q And did that child have any type of health condition?
A Yes, at that appointment I informed the -- I can't remember her name, but that my previous husband had a daughter that was born and had open heart surgery two days after she was born, so she, she suggested that I go see someone to have a echocardiogram done on the baby while he was still in me to check his heart to see if there was any need of a heart doctor at delivery or anything, so if they did they would have it already on site.
Q Did you keep that appointment?
A I did.
Q And was there anything wrong with Bryson --

A Nothing.
Q --- or were you told ---
A No.
Q Now, during the time that you went to see Dr. Goldstein and he told you, confirmed that you were pregnant, did they give you or did he give you any information about pregnancy? You know, did they give you a packet or make you watch a video or something about pregnancy?
A No, ma'am.
Q At any point in time, did he talk to you about any potential problems that could occur in your pregnancy because of the fact that you were a diabetic?
A No, ma'am.
Q Did he ever tell you that you could have a big baby?
A No, ma'am.
Q During the, during the time that you were seeing him, were you checking your blood sugars?
A I was.
Q Okay. I'm going to hand you a document here and ask you if you recognize these. Is that your handwriting?
A Yes, ma'am, they are.
Q And what are those?
A Those are blood sugar records that I took fasting before breakfast, two hours after breakfast, two hours after lunch and two hours after dinner.

MS. RODRIGUEZ: I'd like to mark these.

THE COURT: Any objection?

MS. GANES: No objection, Your Honor.

THE COURT: Into evidence as Plaintiff's Exhibit #18.

(Whereupon, a blood sugar chart is entered into evidence as Plaintiff's Exhibit #18, without objection.)

Q Genesie, I'm going to just put this up because I want the jury to actually see what it is you were doing. So, if you look at this, there's a date over here. Do you see it? Right? And then next to that is -- what were you, what were you writing down?

A That's the time that I checked -- did the check.

Q And I think you can read it from there. It says fasting blood sugar on the next column.

A Yes, ma'am.

Q Tell the jury what is that.

A That's the -- my blood where I stick myself in the morning and check my blood to see, the blood to see how high is my blood sugar level before breakfast.

Q Okay. And then the next column says two hours after breakfast.

A Uh-huh.

Q So, what were you doing then?

A I would check it two hours after breakfast.

Q Now, I, I see on there that there's some blanks.

Throughout the pregnancy, were you always checking on every day?

A No.

Q Okay. Now, was that your choice or were there different times recommended to you?

A It was different times that he told me I could just pick and, and I can't be sure that he said check it every other day or check it every day. It was -- whatever he told me to do, I did it.

Q Okay. And then in the next column, I think this one says two hours after lunch?

A Right.

Q So, you would stick yourself and check your blood sugar again?

A Yes, ma'am.

Q What happened when you were at work?

A I did it. I also took my meter to work and was allowed, because I worked in a control room while I was pregnant, so I could check my blood sugar level in the control room where I worked.

Q Okay. And so then the next column says two hours after dinner.

A Yes.

Q So, that's sometimes as much as four times a day you were checking your blood sugar?

A Sometimes, it was.
Q Okay. And I'm just going to flip to the next page. This is another month. I didn't pull them all out, but did you do that throughout your pregnancy?
A Yes.
Q So, for each month that you were asked to do that, you were keeping track of your blood sugars?
A Yes.
Q Now, at some point during your pregnancy, a couple of months before Bryson was born, did your medication change again from the, the pills that you were on? Did Dr. Goldstein make a change in your medicine?
A Yes. He started me on the insulin.
Q And just, I think everybody knows, but just tell the jury what is, what's the difference between the insulin and what you were doing?
A That's where I give myself the shot with the needle instead of by mouth.
Q Now, did there come a time after you were put on the insulin that Dr. Goldstein was gone?
A Yes.
Q And you were, I think, about that time, it might have been about June?
A Yes, ma'am.
Q So, you would have been about six-and-a-half months into

the pregnancy and tell the jury what happened that sent you to McLeod.

A I can't remember the date, but it was one night I know I had a lot of pain so I called Dr. Goldstein's office and spoke with the nurse and I asked her, I was, like, what shall I do if I have gas pain? Can I take any medication for gas pain? She said well, are you sure they was gas pains and I said I think they were, because I'm okay this morning. I said I'm dressed for work, but I just wanted to call and ask you what to do because I had a lot of pain last night, so she was, like, no, I think you need to go to McLeod so as she instructed me to, I went to McLeod to get checked to see if I was contracting.

Q And when you went to McLeod did you see a different doctor?

A I went to labor and delivery and the nurses checked me and said, actually, I was contracting.

Q Okay. And did you have to stay in the hospital ---

A No, ma'am.

Q --- or what did they do?

A They gave me a shot and I stayed there and they monitored me for a minute. They sent me home and asked me to return the next day and I did exactly what they said. I returned back to McLeod the next day to labor

and delivery. They hooked me up again. After visiting with them they told me I need to go see Dr. Dent, because Dr. Goldstein was out of town. So, I did exactly what they said. I went to Dr. Dent's office.

Q Now, when you went to McLeod, did the nurses or Dr. Dent tell you anything about your activity level?

A When I got to his office he checked me and he informed me that the cervix had widened and I need to be on complete bed rest.

Q So, that would have been in June around the 15th or the 16th ---

A Yes.

Q --- of 2009?

A Yes, ma'am.

Q And as a result of that, what did you end up doing?

A I went to work and got the paperwork for Family Medical Leave and that's what I did. I put in for it and was approved for it and was put on bed rest.

Q Now, after the episode with the contractions and you went home and stayed out, did you stay on bed rest?

A I did.

Q What, what kind of activities were you being permitted to do?

A Nothing. Bed rest, shower, back to bed. No cooking, no shopping. If I needed anything from the store or

whatever, someone else had to do it.

Q And did you, did you do that?

A I did.

Q Then did you go back and see Dr. Goldstein after that, after you had been seen by Dr. Dent?

A Yes, ma'am.

Q And was he aware that you had seen Dr. Dent?

A Yes, ma'am.

Q And did he actually complete the Family Medical Leave Act paperwork for you?

A He did.

Q And then around the day before Bryson was born, what happened?

A Well, it was the 18th. I started having pains and went to McLeod and they said that I was contracting and the baby would be here maybe the morning of the 19th. Well, some time around about three, four o'clock, they sent me home because the contractions had stopped. They said to report to the doctor. I was informed to report to Dr. Goldstein's office on the 19th, so that I did. I went on the 19th and I arrived at his office and he just, he told me that he will go ahead and induce me, to be prepared to be induced in the morning, be at Carolinas and I was, like, okay.

Q Now, when Dr. Goldstein told you that you were going to

be induced, did he tell you that there were any complications that could be associated with inducing you at the gestational age of your pregnancy?

A No, ma'am.

Q Did he tell you that there -- did he have any discussion with you about any alternatives to being induced the next day?

A No, ma'am.

Q Did he have any discussion with you about anything that he might do from a standpoint of using a vacuum during the delivery?

A No, ma'am.

Q Did he talk to you about using forceps during your delivery?

A No, ma'am.

Q Did he talk to you about the possibility of a Cesarean section?

A No, ma'am.

Q Did he express anything to you that there was any problem with the fetus or with Bryson at that point?

A No, ma'am, he just made, made a note to me that he think his lungs was developed enough that he could go ahead and induce me and he'd be okay, so I questioned because I wanted to know about the weight. Would the baby's size be affected and I was informed by him that, be prepared

that the baby may stay in the hospital for a while to gain weight, but he don't see that the baby would be coming home with me because of the weight.

Q Now, did you go to the hospital the next day on August 20th?

A I did.

Q Okay. And who went with you?

A My husband, Ernest Fulton.

Q Now, when you got to the hospital was Dr. Goldstein waiting for you?

A I didn't see him right then.

Q So, when you checked into the hospital, was there any paperwork that they gave you to sign?

A Oh, yes, ma'am.

Q Okay. I'm actually going to look at an exhibit that we've already marked. We're going to be looking at Defendant's Exhibit #1. Genesie, this was admitted by the Defense yesterday in some of the questioning and I want to ask you about this form. I've actually got some, some blow-ups of it to make it a little bit easier to see what's on it. When you signed this form, was Dr. Goldstein there?

A No, ma'am.

Q Did Dr. Goldstein tell you that you would be signing any type of a consent form when you got to the hospital?

A No, ma'am.
Q And did you actually sit down and read through this form when they handed you the paperwork to sign?
A No, ma'am.
Q Is this the only document you signed that morning?
A No, ma'am.
Q What did you sign?
A You sign stuff like no smoking. You sign a lot of paperwork when you're being admitted into the hospital. Just general papers, like, if you was to go to the emergency room they give you a stack of papers and ask you to sign here, here, and here.
Q Okay. I'm going to show you, this is a blow-up of the lower half of that document.
A Yes, ma'am.
Q And there's some writing on here.
A Yes, ma'am.
Q Just to orient, I'm in the middle of the document here and I've just blown up this lower half and somebody's handwritten in there the word, under "Exceptions", it says "none". Did you write that in there?
A No, ma'am.
Q And then it says, "To be performed on myself". Is that your handwriting?
A No, ma'am.

Q And it says, "by Dr. Goldstein". Is that your handwriting?
A No, ma'am.
Q And then over on the right, the date 8/20/09, is that your handwriting?
A No, ma'am.
Q And then under your name where it says relationship to patient, "self", did you fill that out?
A No, ma'am.
Q There is an "X" there and then your signature appears next to it. Did you make the "X"?
A I did not make that "X".
Q Okay. What was the "X" there for?
A That's where they said sign here.
Q Okay. Now, underneath it, it now appears that there's a signature right under self. I believe we'll find out later that that's Dr. Goldstein's signature. Was that signed by Dr. Goldstein at the time you signed it?
A No, ma'am.
Q And at the time that that was signed, did anybody have any discussion with you about any potential complications or risks that could be associated with inducing you?
A No, ma'am.
Q Did they have any discussion with you about the use of a

vacuum?

A No, ma'am.

Q Any discussion with you about the use of forceps?

A No, ma'am.

Q Any discussion with you about any alternatives to being induced?

A No, ma'am.

Q Now, you said that Bryson's dad was at the hospital with you. Do you remember, was it, did you get there the middle of the day, early morning?

A It was early in the morning before, I know it was before six o'clock.

Q Okay. At some point did Dr. Goldstein come in and see you?

A He did.

Q And at that point in time, was anybody present other than your husband?

A No, ma'am.

Q Did Dr. Goldstein at that time go over for you, with you, any complications or potential complications associated with induction?

A No, ma'am.

Q Did he talk to you at all about whether or not any testing should be actually done to check for the baby's lung maturity?

A No, ma'am.
Q Did he talk to you about a vacuum or forceps or a C-section?
A No, ma'am.
Q Okay. So you got admitted into the labor and delivery suites?
A Yes.
Q Did any other family members or friends come to stay with you before you had the baby?
A They came later.
Q Okay. And we've already heard the testimony from Brittany and Tamika. They were both present.
A Right.
Q Correct? And then also your aunt, I mean, your sister, Geneva was present?
A Right.
Q Okay. Now, evidently at some point Bryson's dad decided he did not want to watch the delivery?
A Yes, ma'am.
Q So, you chose to have Tamika and your daughter stay in the delivery room with you.
A Yes, ma'am.

MS. GANES: Your Honor, object to the leading.

THE COURT: Sustained.

Q Who stayed in the delivery room with you?

A My sister and Tamika, which is Bryson's godmother.
Q Okay. And then when it came time to actually do the delivery, do you remember when Dr. Goldstein came in?
A Yes, ma'am.
Q Okay. Had they hooked you up to a baby monitor?
A They did.
Q At any point during the morning, did anybody come in and tell you there were any problems with anything going on with the baby?
A No, ma'am.
Q When Dr. Goldstein got there did he tell you there were any problems with the baby ---
A No, ma'am.
Q --- or the baby monitor?
A No, ma'am.
Q When it got, when Dr. Goldstein got there what did he do?
A He talked to the nurse, asking her questions. I don't know what that meant, whatever she answered. I don't know what he was asking her, but he asked her and then he looked at me and said, "Okay, it's time to get ready to push".
Q Now, were there, was there primarily one nurse that stayed in there with you?
A It was.

Q And was it Stephanie Collins?
A It was.
Q Is that Stephanie Collins' picture?
A That is.
Q Do you remember any of the other nurses, specifically, that were in the room?
A No, not name-wise.
Q Okay. Was there more than one nurse?
A Yes, ma'am.
Q Okay. Tell me ---

MS. GANES: Your Honor, I just object to the leading with the text on the pictures, if she's going to show pictures.

THE COURT: With regard to that picture of Stephanie, I'll overrule the objection. Let's not lead her with pictures. Ask her the questions and let them answer.

MS. RODRIGUEZ: Okay.

THE COURT: Let her answer and then if you want to show her a picture you can do that.

MS. RODRIGUEZ: Yes, sir, Your Honor.

Q Dr. Goldstein came in, was talking to the nurses. Did you ever hear him have any discussion with them about any concerns about the fetal monitor or what was going on with the baby, the heart rate?
A No, ma'am.
Q Okay. Tell me what you remember from that point.

A They -- I was up on the bed getting ready to push when he tell me push. Well, when they told me to push, I pushed.

Q Okay. Were your legs, did your legs get put in the stirrups?

A They were.

Q Do you ever remember any nurse before -- and I want to be clear. Before Dr. Coker came in the room, do you ever remember any nurse ever pushing your legs back up?

A No, ma'am.

Q Did any nurse ever push on your stomach?

A No, ma'am.

Q Okay. Then tell them what happened when you started pushing.

A I pushed and Bryson's head came out. Brittany went and looked. She came back and they told me to push again very hard on the next one and I did that and all of a sudden I heard Stephanie's voice got elevated, push, push, push, just keep pushing, and then Tamika, I could hear her encouraging me also to push, push, push and at some point everything just got, they started getting hysterical with it, so I was looking at facial expressions, trying to figure out what's going on because I'm pushing and the baby's head is out. Okay. It should be easy now, but everybody still seemed like

they getting hysterical and I hear Dr. Goldstein, like, he was in a hysterical state at that time saying, "Get someone in here, get someone in here. It doesn't matter. Get a doctor, anybody. Get someone in here," and I could hear that from him.

Q Now, could you see Dr. Goldstein, where his hands were and ---

A No.

Q --- what he was doing?

A No.

Q Okay. And were you trying to look down and see what was going on down there?

A Actually, I was just, like, in, like, what's going on and I, like, was trying to get facial expressions. I kept looking at my daughter and I could see her tears like she was crying and I was, like, well, what's happening, why is she crying? What's wrong? And so I was, like, trying to get facial expressions but no one would say anything. They was just saying to get help.

Q Do you ever remember them using, stating that the shoulders were stuck?

A No, ma'am.

Q Did you ever hear anybody use the term, "shoulder dystocia"?

A No, ma'am.

Q Did anybody ever tell you to stop pushing?
A No, ma'am.
Q Okay. And tell me after Dr. Goldstein called for help, what happened? Did somebody else come in?
A A lot of people. The room was -- I can't even tell you the number of people that came in the room, but I still didn't know what was going on, but they said that the doctor came in and helped ---
Q Did you know who that doctor was?
A I did not.
Q Okay. Do you remember, was he African American or Caucasian?
A No, ma'am. Can't tell you nothing about him.
Q Okay. So, tell the jury what happened.
A And the baby was out and then I was looking to the side over at the baby and his body was limp and I kept seeing the nurses pick the baby up and his body just flopped back down. They kept picking him up. His body flopped back down and so I was crying and the anesthesiologist came to me because I heard the nurse say, "Okay, guys, that's it. Let's just say the time. Let's call the time," and I started crying and then he came and he, like, grabbed my hand. He said, "Look, we're not going to stop working on him," and I was, like, well, you know, only God can help us now and he was, like, they

kept doing, I kept seeing them doing with the pump thing across his face and I was just crying and looking over to see if I was going to hear him cry or anything and then all of a sudden I heard one of the nurses say we got a pulse and the anesthesiologist said to me, "We've got to get him out of here. We've got to get him to neonatal. It's going to be all right," and they took the baby out of the room.

Q Okay. And did -- after Bryson was removed from the room, did Dr. Goldstein have any conversation with you about what had happened?

A He didn't.

Q Did Dr. Coker have any conversation with you about what happened?

A No, ma'am.

Q Do you actually remember Dr. Coker leaving the room?

A No, ma'am.

Q Do you actually remember him coming into the room?

A I don't.

Q Okay. Did any of the nurses tell you what had happened?

A No, Dr. Goldstein, I think, came back after and said about the baby's arm.

Q And what were you told about the baby? Had you seen the baby yet?

A I had not.

Q Okay. But what were you told?
A I was told that it was his right arm that was injured but he, I don't think he exactly told me what was wrong with it at that time.
Q Okay. At some point, did you get, hear the term "shoulder dystocia" or there was a problem with the shoulders?
A Yes.
Q And who told you that?
A One of the pediatric doctors came in and spoke with me about what happened.
Q Okay. When you finally did get to see Bryson, what did you notice?
A His arm was just, the right arm was just, like, laying, but they had him, you know, I looked at his arm. It looked a little bit longer than the other arm and it was just, it was no movement in that arm, in his right arm.
Q Okay. Now, before you left the hospital with Bryson, did the, do you know if the physical therapist or the occupational therapist did their first evaluation on Bryson?
A They did.
Q And did they have any conversation with you about Bryson's arm and shoulder?
A Yes, he called it brachial plexus.

Q Okay. Hold on there. I want to show you another document. This is the hospital record from Carolinas for Bryson and I'm going to show you some -- starting at page 96 here and I'm going to put it up over here so the jury can see what we're looking at. Were you given a pamphlet or some papers, these papers, at the hospital when you went to check out?

A Yes, ma'am.

Q Okay. And do you remember what they told you that was?

A Yes, ma'am.

Q Explain to the jury what you were told.

A He said this is, was a injury that some time is, happens at birth and it was an injury to the nerves. He said sometimes it's, it's like a stretch and sometime it's more severe, more than a stretch.

Q Okay. And if you'll go to the next page, page 97. Did they go over or explain to you where the brachial plexus nerves were?

A He did.

Q Okay. And is this where he was demonstrating when they were showing you this is what the brachial plexus looked like?

A Yes, ma'am.

Q And then I think on the next page there's some, sort of, instructions. Tell the jury -- let's start out with

while he was in the hospital, how you had to handle Bryson with that arm.

A The nurses kept it -- when he came to the room with me, we had to fold it up across him like this and swaddle him with the blanket to hold it close to his body so it would just linger to the side or just linger and pull.

Q And then when you -- go to the bottom. I think they gave you some specific directions about not to flex or abduct shoulder more than 90 degrees until physician tells you it is okay to do so.

A Yes, ma'am.

Q Did you do that?

A I did.

Q When other people -- when you got Bryson home from the hospital and you had to have other people taking care of him, or helping you with him, did you have to show them how to do these things?

A I did.

Q Okay. And I'm not going to go through the whole document here, but it's several pages long and did it give you directions on, like, directions on how to pick him up?

A Yes, ma'am.

Q Was there a special way that you needed to dress him?

A Yes, ma'am.

Q And were there some specific exercises that they gave

you that the pamphlet included on what you were supposed to do ---

A Yes, ma'am.

Q --- with his arm and shoulder?

A Yes, ma'am.

Q Did you do all those?

A We did.

MS. RODRIGUEZ: I'm just going to go ahead and admit just the -- the -- I'd like to just mark and admit just the pages we referred to.

THE COURT: Have y'all seen the documents? Do you have an objection?

MS. GANES: No objection, Your Honor.

THE COURT: They're into evidence as Plaintiff's Exhibit #19.

(Whereupon, a hospital document is entered into evidence as Plaintiff's Exhibit #19, without objection)

Q Genesie, when you were ready to go home from the hospital, who went home first, you or Bryson, or did you get to go home together?

A I was released first.

Q And did you go home?

A No, ma'am.

Q What did you do?

A They -- the hospital allowed me to stay in one of the

empty rooms that wasn't being occupied by no patients and they let me stay there as long as they didn't need that room.

Q Now, after you took Bryson home from the hospital -- I'm sorry. Let me back up. Did you have any other conversations with Dr. Goldstein about what had happened that day?

A He performed my tubal ligation and I remember, because I was still -- I had, you know, I was put to sleep that morning to do that, so I was still drowsy but I know he was briefly talking to me about what happened to Bryson, but I know I was very emotional during that time and I was, like, crying when he was talking to me, but I was hurt because I knew something -- my baby was different. I wanted a healthy baby and he was alive. I thank God that he's alive and I said that to Dr. Goldstein. I just thank God he's alive.

Q Now, did Dr. Goldstein ever tell you that there had been a problem with Bryson's heart rate or Bryson on the fetal monitor?

A No, ma'am.

Q After you got out of the hospital, did you take Bryson back to your pediatrician? Did he see the pediatrician?

A We went to Dr. Morris Brown but, you know, he's not a pediatrician, he's just a family practition doctor.

Q Family practitioner?
A Yeah.
Q But he also sees babies?
A Yeah.
Q And did you get referred to a specialist to, for Bryson?
A Dr. Gilpin, and I'm thinking that that was the appointment that was made through the hospital before we left.
Q Okay. And do you have an understanding of what kind of doctor Dr. Gilpin is?
A He's a bone doctor.
Q Okay. And did you, you kept your appointment with Dr. Gilpin?
A I did.
Q Did you actually see him several times over the next year?
A Yes, ma'am.
Q And did Dr. Gilpin ever suggest to you or refer you to a brachial plexus clinic?
A He did not.
Q Did Dr. Gilpin ever tell you whether or not -- what did he tell you or what was your understanding of whether or not this was going to resolve?
A He -- his opinion and what he said to me was that it was just a stretched nerve and then eventually he would be

able to move his arm, move his fingers and everything else. It wasn't a severe injury. Brachial -- he said it wasn't a severe brachial plexus injury.

Q Now, at some point did Dr. Gilpin refer you to Dr. Walsh?

A Yes, after asking him to speak to someone else because I wasn't seeing the improvement that he said that I should be seeing, so I asked him can he please send me somewhere else to let someone else get a, to get a second opinion.

Q Okay. Now, when you asked or inquired about getting a second opinion, by that time do you remember Bryson would have been about nine months old?

A Maybe.

Q Okay. And you got to see a doctor in -- where was he at?

A Dr. Walsh at MUSC in Columbia.

Q At USC in Columbia?

A Yeah, USC in Columbia.

Q Did you find out what kind of doctor Dr. Walsh is?

A He's also a bone doctor.

Q And did Dr. Walsh ever refer you to a brachial plexus clinic?

A He did not.

Q Now, during that period of time were you also taking Bryson to see Ms. Joyce?

A Yes. Well, my sister was, like she said, was taking him to see her.

Q Why was your sister taking him?

A Because I was back to work and I work 12-hour shifts so some of the days that, that I was -- no, at that time I was on eight hours, so I worked every day during the week so I wasn't off any time, only on Saturdays and Sundays, so my sister would take him then.

Q Now, when Dr. -- excuse me. When the physical therapy appointments were -- were they occurring during daytime hours?

A It was during the week, and it's occupational, and it was Monday through Fridays.

Q Why were you living with your aunt at that time?

A I had separated from my husband.

Q Okay. And after you saw Dr. Walsh, did you go back to see, did you continue to see Dr. Gilpin?

A I did.

Q And during that period of time, did Ms. Blackwell ever make a suggestion to you?

A Yes, that I may need to see someone with nerves something, a surgeon, a neurologist, or something.

Q And did you ask Dr. -- after he had sent you to Dr. Walsh, did you ask Dr. Gilpin for another referral?

A I did.

Q And where was that to?
A He set up an appointment for me to go to the Shriners in Greenville.
Q Okay. Did you take Bryson to that appointment?
A I did.
Q And at that point in time, Bryson was about a year old?
A Yes, ma'am.
Q And did you find out what kind of doctor it was at the Shriners Hospital?
A It was a bone doctor.
Q Did that doctor refer you to a brachial plexus clinic?
A No, ma'am.
Q Now, was Bryson also being seen by Baby Net or First Steps?
A Yes, ma'am.
Q And what services did they provide to Bryson?
A Also occupational, like, worked with him on day to day movement, living.
Q Who was that? Who was the lady who did that?
A Ms. Patricia.
Q Okay. And did Bryson, did Bryson see -- let me show you this picture and ask you if you can tell me what that is.

MS. GANES: Your Honor, if I could just see the picture?

Thank you.

Q Who is that?

A That's, that's a picture of Bryson and Ms. Patricia sitting on our living room floor.

Q Okay. And what was she doing with Bryson?

A Teaching him and she actually was instructing him to try to pick up the puzzle pieces with his right hand.

Q Okay. And that's at your home?

A It is.

Q Did she see Bryson for some period of time, as well?

A Yes, ma'am.

Q Now, at some point did you also see a doctor at Levine Children's Hospital in Charlotte?

A Yes, ma'am.

Q And do you remember who that doctor was?

A I don't know the name.

Q Okay. How did you end up seeing that doctor?

A Through the Graham Law Firm.

Q Okay. And did that doctor suggest to you that you see somebody at a brachial plexus clinic?

A Yes, ma'am.

Q And as -- after that appointment did you get an appointment to see Dr. Grossman?

A I did.

Q And we know from the prior testimony that on June 7th of

2011, you had your first appointment with Dr. Grossman in Miami?

A Yes, ma'am.

Q After you met with Dr. Grossman, he evaluated Bryson?

A Yes, ma'am.

Q Did he make any recommendations to you?

A Yes, ma'am, he recommended that he thinks that, that surgery for his age is late. He should have gotten Bryson before he turned, before he turned one, but he said with some, with the surgery, he may get some better and so after going home and I talked about it with Anton and everything and I said well, a little more to help him then I'll do it, and so we decided that yeah, we want him to get the surgery.

Q And you went back to Miami Children's Hospital?

A Yes.

Q Okay. And ---

MS. RODRIGUEZ: Judge, may we approach the bench?

THE COURT: Yes.

(Bench conference off the record)

MS. RODRIGUEZ: Thank you, Your Honor. The Court's indulgence. (Brief delay) Thank you, Your Honor.

Q Genesie, I'm going to hand you some pictures and ask you if you can tell me what that is. What is that picture?

A It's pictures of him pre-opinion, before surgery.

Q And where was he at this time?
A At Miami Children's Hospital.
Q And then what was this picture?
A This a picture of him after surgery.
Q Tell the jury what that picture is.
A This is a picture of him -- someone donated Pillow Pets to all the kids in the hospital in Miami.
Q What's the bars he's behind?
A That's the crib that they keep the kids in after surgery. That's their crib.
Q Okay. And what is this picture?
A This a picture of him standing up in the crib and me or either the nurse pulling him through the hospital at Miami Children's Hospital.
Q Now, there appears to be something around -- on the picture to our right there appears to be something around his neck.
A Yes.
Q What is that?
A That's the neck brace that Dr. Grossman put around his neck to keep his neck still to keep him from moving it or breaking the nerves back that they glued together. He didn't want him to pop them loose, so that's the brace on his neck to keep his neck still.
Q And I think if you look at his right arm ---

A Yes.
Q What's that?
A And that's a body cast. They called it an airplane cast and it's a whole cast.
Q Stand up and show the jury how that -- just, sort of, demonstrate on your own body what that looked like.
A It's a cast from, like, his chest all the way around and he had a tube that extended with his arm up like this to his hand.
Q Now, could his neck brace come off?
A It can.
Q And how about the chest cast?
A No.
Q And when the neck brace would come off ---
A Well, it had to stay on there for so many weeks.
Q And then tell the jury what that picture is.
A This is a picture of him at the hotel before we left. He put the pillow in the dresser drawer at the hotel and laid in it.
Q And what's that picture?
A This is a picture after we got home and he went in the cabinets under the sink and got a bowl to put on top his head.
MS. RODRIGUEZ: Okay. Can we just mark these all as one exhibit?

THE COURT: Any objection from Defense?

MS. GANES: No objection.

THE COURT: They're into evidence without objection from defense.

(Whereupon, 8x10 photocopies of Bryson are entered into evidence as Plaintiff's Exhibit #20, without objection)

Q Now, in addition to Dr. Grossman, was there anybody else who participated in Bryson's surgery while he was down at Miami Children's Hospital, now Nicklaus Hospital?

A Yes, ma'am. Dr. Price.

Q And did -- was there a charge for Dr. Grossman's surgery?

A Yes.

Q And the jury has heard a lot about it. Did you understand that there would be a charge for that surgery?

A I did.

Q How long did that surgery take?

A That surgery was over five hours.

Q And did you also have a bill from Dr. Price for that surgery?

A I did.

Q And a charge from the hospital as well?

A I did.

Q And a charge for the anesthesia?

A I did.

Q I think ---

MS. GANES: Your Honor, we would object to the summary and the bills going into evidence as cumulative. One or the other.

MS. RODRIGUEZ: I'd like to use both, Judge.

THE COURT: I'm going to allow, I'm going to allow the -- for brevity's sake, use the summary and you can introduce, if there are otherwise no objections with regard to material in the bills, then I'm going to allow both of them to go in.

MS. GANES: Your Honor, may we approach?

THE COURT: Yes.

(Bench conference off the record)

MS. RODRIGUEZ: If we could go ahead and mark this then, Your Honor.

(Whereupon, medical bills/hospital summary are entered into evidence as Plaintiff's Exhibit #21, over objection)

Q Genesie, I'm going to hand you a document that we have, it's called up at the top, Medical Bills for Bryson, and ask you to take a look at that. Now, prior to your testimony today have you had a chance to look through, or have you received the bills from Miami Children's Hospital?

A Yes, ma'am.

Q From Dr. Grossman's office?

A Yes, ma'am.
Q From Dr. Price's office?
A Yes, ma'am.
Q From anesthesia?
A Yes, ma'am.
Q From McLeod Regional Medical Center?
A Yes, ma'am.
Q And from Lake City Occupational Therapy?
A Yes, ma'am.
Q Okay. If you could, looking at that list of bills there, just tell the jury how much was the charge from Miami Children's Hospital?
A It was over $78,000.
Q And how much was the next bill on there?
A Over 55,000.
Q And that was from Dr. Grossman?
A Grossman.
Q Okay. And then how much was the bill from McLeod for occupational therapy?
A Over 56 ---
Q 56,000?
A --- thousand dollars.
Q Okay. And then there's also a bill, I think, on there from Dr. Price?
A Yes, ma'am.

Q And that's for how much?
A Over $7,000.
Q And how much for the anesthesia?
A It's over $12,000.
Q And then how much, was there also a bill on there from Lake City Occupational Therapy?
A Yes, ma'am. It was over $1,000.
Q Okay. I apologize, but let me just glance at that. I handed it to you before I made sure I covered them all. There's also a bill on here from, one from Dr. Walsh and one from Dr. Gilpin. If you can tell the jury how much those were?
A The one from Dr. Walsh was right at $200. The one from Dr. Gilpin is right at $1,000.
Q Now, were all of those bills related to Bryson's treatment for his brachial plexus problems?
A They were.
Q How do you think Bryson has done since his surgery at Miami Children's Hospital?
A He has improved.
Q Do you think that he did have a benefit from that surgery?
A I do.
Q If you had to do it over again, would you have that surgery again?

A Yes, ma'am.
Q Now, at the time that you had that surgery by Dr. Grossman, did you also meet with Dr. Price?
A Yes.
Q And what was your understanding of their plan?
A To go in and -- because they wasn't sure at first what they could do to help improve him but they went in, is what they did, and removed the scar tissues that he had, glued the nerves back. Dr. Price went in after that and did some, something with his shoulder. His shoulder blade was, it looked like it was protruding out and it was very noticeable that his shoulder blade was sticking out into his back, so he went in and he did replacement of that and you don't see it as much. You can see it a little but not as much as it was, because you could see the blade of his shoulder just protruding out in his shirts. If he had them on or anything you could see it, but now it's not that noticeable.
Q Now, when they talked to you at that first surgery, what was your understanding as to whether or not that would be the only surgery he would need?
A It wasn't. Dr. Grossman came and, because he was the first one out of the surgery and Bryson was still in surgery with Dr. Price and he explained to me everything went well and what he removed and what he did and what

was Dr. Price in there doing at that time and he said well, I think we did good. He said but at this time I won't say, but I think he will, he may need more surgeries at a later time. He didn't say what surgeries but he did say at that day that he think that he would need more surgery.

Q Now, did you take Bryson back down there for ---

A I did.

Q --- his follow-ups? Okay.

A Yes, ma'am.

Q And you actually saw Dr. Grossman again right before he did his deposition for this case?

A Yes, ma'am.

Q And did he evaluate Bryson at that time, as well?

A Yes, ma'am.

Q Did he tell you the same thing?

A Yes, ma'am, the same thing he did right after surgery, at the visit after surgery and the visit not long ago.

Q Now, do you plan to, when Bryson is ready to look at additional surgery?

A Yes, ma'am.

Q Tell the jury from your perspective as a mom what are your concerns for Bryson?

A My concern is, I always wanted a little boy, always. Now that he's here and I thank God for him every day. No one

can pay me enough money to take him away from me, but my concerns with Bryson is him growing up and becoming a teenager and that is coming soon. It seems like it was, like, yesterday he was just a baby. He's going to have challenges. I have had to go to counseling to deal with some of the stuff that I have went through with him and other life issues, but more so, I'm constantly thinking about him and it's very stressful. I'm constantly thinking what is he, what's going on with him now. What's going on so when he become a teenager, of course, he's going to be away from me. He's always now with me or either Anton or with one of the teachers at school or with someone that I trust at a daycare, so I know we're looking out for him. Eventually, Bryson is going to be out in the community by himself with other kids his age, a teenager. He's going to be a teenager. What is going to happen to my son when we've got these other boys and they're going to say certain things to him and they're going to tease him? Maybe not, because I don't know. It's just a possibility, like ---

MS. GANES: Objection, Your Honor, to the speculation.

THE COURT: I'll allow her to ---

A He -- we all know, like the Judge said yesterday, we know kids can pick, bully or whatever. We all know that. We're human. But as a mother with a child with this

disability and physical appearance, it's going to be hard. I don't want him to feel as though I'm going to do this and I'm going to lash out. I don't want him lashing out at people because they say something about him, because I encourage him. It doesn't matter what nobody else say about you. If they say you're different, you are different. You are, but don't, I don't want him to be angered by them. When he starts dating or the age will come he's going to start dating, women, we can look at a person's physical appearance because people are human, instead of looking at his heart or his intelligence or anything and they may say, "Well, I don't want to date him. His arm look funny or his, he got a disability." They may not want to date someone with that, not looking at what type of person his character he is. They may not look at that. I'm not sure. He may not have no problems, but he could. I don't know.

MS. RODRIGUEZ: The Court's indulgence.

Q Please answer any questions that the defense may have.

THE COURT: Madam Forelady, ladies and gentlemen of the jury, it's time for a mid afternoon break. I'm going to ask that you go back to the jury room and refresh yourselves. Do not discuss the case with anyone. Everyone remain seated as the jury exits the courtroom.

(Jury out at 3:20 PM)

THE COURT: Anything from the Plaintiff before we recess?

MS. RODRIGUEZ: Your Honor, I'd just like an opportunity to redact those bills while we're in recess.

MS. GANES: Your Honor, there's a lot. There's probably 50 pages in here. All of them are stamped insurance benefits assigned and so I need -- that has to come off those pages.

THE COURT: All right. Y'all can work on that together. Otherwise, you can go with the compilation. There will be no discussion about insurance.

MS. CRAIG: Your Honor, would you like me to put that 105 motion on the record now or at the break?

THE COURT: You can do it right now if you want.

MS. CRAIG: Okay. At the sidebar I'd requested a 105 instruction to the jury based on the Plaintiff eliciting testimony from three witnesses; Dr. Grossman, Dr. Resnick and Nurse Blackwell, that the surgery in this case was done at two years and that it was done late and I thought it was confusing to the jury that that criticism, that I call a criticism, was elicited from the witnesses on direct examination when, of course, Dr. Goldstein has no involvement whatsoever in the treatment of the baby after the baby is delivered. I don't know why that was elicited and I think it's confusing to the jury to the extent that they think that somebody is at fault for not getting the child to surgery

between the six-month and 12-month window. We respectfully request an instruction that that evidence does not apply to Dr. Goldstein.

THE COURT: I would anticipate -- anticipating argument, there is a duty to mitigate damages and I can't anticipate that anybody would think that it was Dr. Goldberg's (verbatim) fault that they didn't get a surgery. I can't -- but I'll hear what the Plaintiff's got to say about it, but I just don't think that a 105 curative instruction or instruction would be appropriate, but I'll be glad to hear from the Plaintiff.

MR. RUFFIN: Your Honor, all I was going to say was we were mitigating damages. That was our intent. They amended their answer to include it as an affirmative defense which is why we thought it was a necessity.

THE COURT: I think if that's the case and if anybody is going to be, if it's going to be held against anybody, the only logical inference would be that the parents and/or the child should be held responsible because they didn't get appropriate treatment. It's certainly not Dr. Goldberg's fault, nor do I believe that a reasonable juror would say that. I think that's just their preemptive attempt to address the issue of mitigation of damages for failure to seek treatment. So, you're protected on the record in that regard and that's the reason why I think it's inappropriate. I don't

think it applies.

MS. CRAIG: Thank you, Your Honor.

THE COURT: We'll stand at ease.

(Brief break)

THE COURT: Please be seated. Anything from the Plaintiff?

MS. RODRIGUEZ: We redacted the medical bills, Your Honor.

THE COURT: We can tend -- let's go ahead and get started. As far as the medical bills, we'll get that later.

MS. RODRIGUEZ: Okay.

THE COURT: Anything else?

MS. RODRIGUEZ: No, sir, Your Honor.

MS. GANES: No, sir, Your Honor.

THE COURT: All right. We're ready for the jury.

(JURY IN AT 3:37 PM)

THE COURT: Defense, you're recognized, cross examination.

MS. GANES: Thank you, Your Honor.

CROSS EXAMINATION

BY MS. GANES:

Q Good afternoon, Ms. Fulton.

A Good afternoon.

Q Ms. Fulton, I'm going to show you this.

MS. GANES: May I approach, Your Honor?

THE COURT: Yes.

Q I'm going to show you this document that's been marked Defendant's Exhibit #1 and this is the document that you signed when you came to the hospital on August the 20th and I just wanted to be clear, Ms. Fulton. This is your signature on this document. Is that correct?

A That is my signature.

Q And Ms. Fulton, do you know if you signed a document like this when you had your first daughter?

A If you -- when you go into the hospital, I can't say it's the same document but any time you go into the hospital, even to the emergency room, they give you a bunch of papers to sign.

Q Okay. And you've done that before when you've been to the hospital for treatment?

A Right.

Q Ms. Fulton, when Dr. Goldstein came in -- I'm sorry. When you came to the hospital on August 20th, 2009, Dr. Goldstein came in that morning and checked you. Is that correct?

A Yes, ma'am, at some point.

Q And then he came back when it was time to push?

A Yes, ma'am.

Q And he told you when to push and you had no trouble pushing, initially.

A No problem.
Q And Dr. Goldstein never left the room while you were delivering Bryson. Correct?
A No, ma'am.
Q When you started pushing, Stephanie was on your right side. Is that correct?
A I think so. I'm not sure but I think so.
Q And you pushed as hard as you could when you were instructed to. Correct?
A Yes, ma'am.
Q And you were even bearing down and pushing as hard as you could when the delivery team asked you to do that. Correct?
A Correct.
Q And do you recall that within 10 to 15 minutes of Bryson being born, someone came into the room, and I think your testimony in your deposition was that you didn't remember if it was Dr. Goldstein or Stephanie, the nurse, but someone came in and explained Bryson's injury and told you about shoulder dystocia. Do you remember that?
A I remember, I remember someone telling me and I know Dr. Goldstein came back and said something happened, but I don't think he said shoulder dystocia.
Q Do you remember that that was within 10 or 15 minutes of

Bryson being born?

A After he was born?

Q Yes, ma'am.

A Yes, ma'am, it wasn't long.

Q Now, after Bryson was born you returned to see Dr. Goldstein in his office on two occasions. Do you remember that?

A Yes, ma'am.

Q And you appreciated all that Dr. Goldstein did in the delivery room to get Bryson delivered, didn't you?

A I'm glad he was delivered.

Q Do you remember telling us in your deposition that you appreciated all that he did in the delivery room to get Bryson delivered?

A Yes, ma'am.

Q You respected Dr. Goldstein as a professional, didn't you?

A I did.

Q Dr. Goldstein was never unkind to you, was he?

A I wouldn't say unkind. Like I told you in my deposition, I feel as though that his bedside manners could have been better and some of the, like, questions, like, a patient asks their doctor, if I ask okay, is my fever -- do I have a fever today, I would like for him to say yes or no, not just walk out like he didn't hear me. You

know, answer my questions.

Q Dr. Goldstein never did anything to offend you or treated you ugly, did he?

A I feel as though he did at one point.

Q Well, when I took your deposition do you remember telling me that Dr. Goldstein never did anything to offend you or treated you ugly?

A I don't know if that was your question, too, because at that time I would have explained to you it was a meeting that we had in his office at one point that I asked him a question about some of my treatment and I could tell you exactly today what he said that day and if you would have asked me in my deposition that exact question I would have explained to you then.

Q Well, let me ask you this with respect to Bryson's delivery on the day he was born: Dr. Goldstein was never unkind to you, was he?

A He was not.

Q And he wasn't unkind to you in those office visits when you came to him on two occasions after Bryson was delivered.

A He was not.

Q And in one of those office visits with Dr. Goldstein when you all were talking about Bryson's injury, you told him that you just thank God Bryson's alive and

here, didn't you?

A I did the same thing at the hospital at my tubal ligation that morning. I just thank God that he's alive.

Q And Bryson's a delightful boy in your life, isn't he?

A He is.

Q Thank you, Ms. Fulton. I have no further questions.

THE COURT: Any redirect?

MS. RODRIGUEZ: Yes, sir, minimal. I'd like to mark this exhibit. This is Carolinas Hospital System for Fulton Baby Boy.

(Whereupon, a Carolinas Hospital document is marked for identification as Plaintiff's Exhibit #22)

REDIRECT EXAMINATION

BY MS. RODRIGUEZ:

Q Genesie, see that document? I'm going to put it up so the jury can see it as well. Okay?

A Okay.

Q This is from -- according to the medical record it was in the medical record for Fulton Baby Boy and it says Genesie next to it. The date is 8/20/09. Would that be Bryson's delivery?

A It would be.

MS. GANES: Objection, Your Honor. Outside the scope.

THE COURT: Counsel, approach the bench.

(Brief bench conference off the record)

THE COURT: I think it was addressed in cross-examination ---

MS. RODRIGUEZ: Thank you, Your Honor.

THE COURT: --- and I'll allow you to address it.

Q Genesie, you were asked questions about the consent that you signed when you got, went into the hospital for your treatment with Dr. Goldstein. Correct?

A Correct.

Q Okay. This is the same consent, the identical consent, only this time it is for Fulton Baby Boy and you'll see over here it says the name. What is that name?

A Goldstein.

Q And it says, "Exceptions," exactly the same as the one you signed, "none".

A None.

Q Okay. And did Dr. Goldstein ever talk to you about any operation or procedure he planned to do on Bryson?

A No.

Q This is signed on what date here?

A The 23rd.

Q Now, my question to you is did you read this consent and have -- before you signed it?

A I didn't read it.

Q How did you come to sign it?

A I was asked that Bryson needed to have his, what do you

call it? When they do the little baby boys? They do the surgery on the penis, circumcise the baby. And I was asked at the time they said Dr. Goldstein was in the hospital, did I want him to perform that and I said well, yes, because I couldn't leave the hospital with the baby before he do it. Is it okay, and I said yes.

Q And the consent that they had you sign here, though, is identical to the one you signed when you were admitted to the hospital?

A Yes.

MS. RODRIGUEZ: Thank you. That's all I have.

THE COURT: You may step down. You may call your next witness.

MS. RODRIGUEZ: Judge, we have a couple of matters that we need to take up outside the presence of the jury and I believe that will be our last witness.

THE COURT: Okay. Madam Forelady, ladies and gentlemen of the jury, we have some matters of law to take up outside of your presence. Return to the jury room, but do not discuss the case.

(Jury out at 3:47 PM)

THE COURT: I'll be glad to hear any motions.

MR. GRAHAM: Your Honor, we -- before we get to motions and before we rest, we want to make sure that certain exhibits were actually offered into evidence. I know they

THE COURT: Be happy to entertain any further motion.

MR. GRAHAM: Yes, sir. Your Honor, subject to Your Honor's permission to put that edited DVD in tomorrow morning, we're prepared to rest.

THE COURT: Very good. Yes, ma'am.

DIRECTED VERDICT MOTION

MS. CRAIG: Your Honor, at this time on behalf of the Defendants, Dr. Goldstein and his practice, we would move for directed verdict as to all claims that have been asserted by Ms. Fulton. The Plaintiffs have not met their burden as to liability, causation or damages and we're moving for directed verdict pursuant to Rule 50.

The only reasonable inference from the testimony in the Plaintiff's case is that Plaintiff has not met her burden of proof. Your Honor, starting with -- as you know, Your Honor, the Plaintiff must prove what the standard of care is, that there is a deviation from the standard of care, proximate cause and damages.

So, starting with the standard of care, the only standard of care expert that was brought by the Plaintiff was Dr. Gomez-Carrion and she mentioned various deviations from the standard of care like Pitocin, vacuum, but these deviations did not cause any injury. That's why I asked her about the informed consent. She said it was a deviation not to have a specific informed consent for the vacuum and that's

why I asked her, because she's a professional witness, that you know that not only do you have to prove there's a deviation, but it actually has to cause the injury, and she agreed that lack of documentation does not cause an injury, so that was -- that was her opinion with regard to documentation.

Then the Pitocin, she said that was a deviation to administer Pitocin and I asked her on cross examination and she agreed that she can't say with or without the Pitocin the shoulder dystocia could have been avoided, so again they're not meeting their burden of proof. They've got a deviation, but they can't prove causation.

And then her final opinion was traction and she -- it is her opinion that too much traction was used in this case, but I asked her, I said, you can't say how much traction was used. She said that is correct. There is no way to quantify. And all of the experts will testify that there's no way to quantify the amount of traction. It's based on a physician's experience in delivering babies and so she says that.

So, we're left really with one argument with her that even gets to the, to the, past probable cause and that's traction, and so her opinion is really a res ipsa loquitur opinion that because there was a brachial plexus injury, it must have been caused by the traction. She said on cross examination not only could she not say how much traction was

used, but she also, she said that she can't tell based on the medical records, that there was no documentation anywhere in the medical chart that there was evidence of too much traction and she didn't rely on the testimony of any of the eye witnesses, so her one opinion that gets to probable cause is really a res ipsa argument, and of course, as Your Honor knows, the res ipsa is not a doctrine that's followed in South Carolina.

In the absence of any admissible evidence in the record to support their claim, the jury would simply be speculating as to the cause of the injury and I'm relying on the Watson case, Watson versus ---

THE COURT: Isn't res ipsa loquitur, or whatever the Latin term is, isn't that something where someone comes into Court and says that just by virtue of the fact it happened it had to be so and it really addresses a situation where you don't have an expert? In this case, we've got an expert who says that there was excessive traction, although she can't quantify it in pounds or however you measure traction, she says it was too much, which I think takes it out of the concept of res ipsa loquitur but I don't know. What do you think?

MS. CRAIG: Well, in reviewing the Ford versus Watson case, there is a statement about res ipsa and there is another earlier case that I can pull up.

THE COURT: That Ford case, isn't that about the cruise control?

MS. CRAIG: Yes, sir. That's the product liability case.

THE COURT: Yeah, that was kind of voodoo science they had. That was one of Mr. Bell's experts he got from somewhere that said something about radio frequency interference affecting cruise control. That ain't what we got here. We've got doctors talking about how to deliver a baby which I think is a lot different than the Ford case.

MS. CRAIG: But in that case, what the Court did say, and I, I don't think this is the exact quote, but it's close to it. It says that in the absence of any admissible evidence, which is what we have, there is no admissible evidence other than her saying that traction caused the injury because we have an injury, and that's the res ipsa. But in the absence of any admissible evidence in the record to support the claim, the jury would be speculating as to the cause of the injury. That's exactly what we're arguing here. She makes a statement, makes a, has an opinion that's based on the fact that we have an injury but she can't support it with any admissible evidence, so it's pure speculation on the part of the jury to connect that deviation to causation in this case.

Now, that's the first basis for our directed verdict. We'd also like to address the informed consent. The informed consent that was signed in this case by Ms. Fulton is a

standard informed consent that is signed by every woman in Florence County that goes to one of these hospitals to deliver a baby. It is the, it is the standard informed consent form that is signed, same type of, anywhere in the state at any hospital. You've got to sign the informed consent before you're allowed to, before having the baby. And that form clearly states the risk and gives the doctor permission to do a vaginal delivery and a C-section so that the child can be delivered, and in this case it is our position that informed consent was clear and that the facts are in compliance with the holding in the Hook versus Rothstein case.

Also, Your Honor, we would ask for a directed verdict based on the emergency medical and obstetrical care exception. It's §15-32-230 and in this statute it says in an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care in an emergency department or in an obstetrical or surgical suite, no physician may be held liable unless it is proven that the physician was grossly negligent. And in this case it was definitely a life or death situation. It was an obstetrical emergency. I think that's undisputed in this case. We were in an obstetrical suite and the Plaintiff has not proved gross negligence in this case.

The Plaintiff, in order to prove gross negligence and to pursue a punitive damages claim, as Your Honor knows, the standard is clear and convincing evidence, and we would move to strike the claim for punitive damages. The questions that were posed to Dr. Gomez-Carrion, I think it took three or four times being asked the question before she answered it and she did say that it was reckless but she did not come forth with any evidence to support that there was willful, wanton or reckless behavior, and that certainly doesn't meet the clear and convincing standard that is required for punitive damages or for gross negligence.

THE COURT: Well, that's, kind of -- that's very interesting, but really what I've got to do at this juncture is not clear and convincing, but a scintilla, a scintilla towards convincing, clear and convincing. Do you understand where I'm at as far as directed verdict? The standard is a scintilla of evidence of egregiousness. Is that right?

MS. CRAIG: Your Honor, we maintain that there isn't even a scintilla. There was no ---

THE COURT: Well, you do agree that she did reluctantly say egregious, didn't she?

MS. CRAIG: I do agree that she reluctantly said ---

THE COURT: It might be a scintilla, barely. Don't you think?

MS. CRAIG: I've been struggling with that scintilla

standard for a long time.

THE COURT: All right. I understand your point.

MS. CRAIG: So on those reasons, the Defendants move for a directed verdict on behalf of Dr. Goldstein and his practice. Thank you, Your Honor.

THE COURT: Very good. Be glad to hear from the Plaintiff.

MR. GRAHAM: Thank you, Your Honor. I don't believe this will take much time. First of all, they were talking about no testimony of how much traction. There's no testimony of how much traction in terms of Newton's, which is what physicians, what physicists may talk about or what engineers may talk about, nor was there any discussion about pounds of force, which is what engineers and physicists may talk about, but there was certainly ample testimony from a highly qualified obstetrician who's delivered eight or 9,000 babies without a single permanent injury that greater than gentle traction is below the standard. Greater than gentle traction was applied here. Lateral traction to the side is below the standard. Lateral downward traction was applied here, et cetera.

So, and the business about res ipsa, as I understand it, res ipsa means the ---

THE COURT: It speaks for itself.

MR. GRAHAM: --- the injury proves negligence. Dr. Gomez-Carrion did not in any way say negligence proves -- I mean

injury proves negligence. She did say an injury that includes four or five of the nerves being ripped and torn in two that grow back with a neuroma is something that happens during the birth process when too much traction in this is applied. She didn't say every time there's neuromas that the excessive lateral bending of the neck is negligence. Whether that's negligence or not depends upon a host of other factors; how long has the head been out, if it's more than six or seven minutes, maybe you tell the patient you're going to wrench that neck as hard as it takes to save the baby's brain and life, but that's not the situation we're in.

Also, if a doctor has used all the various safety maneuvers unsuccessfully and gone back and tried to perfect those, then if you get to six or seven minutes maybe it's not negligence to choose life and brain over nerves, but that's not this case. In this case we have a man who performed -- the evidence shows McRoberts after Coker arrives, suprapubic pressure by three different providers, and the one by Dr. Coker is the one that delivered the baby. No internal maneuvers; not Woods, not Rubin's, not posterior arm delivery method, and no attempt. Then Dr. Coker, the former boss, is called to bail Dr. Goldstein out. He comes in and in -- I mean, he's told Dr. Goldstein is on the floor. Being on the floor pulling down on the head is also a breach of the standard under these circumstances. So, Dr. Coker gets the

message Dr. Goldstein's on the floor, we need your help immediately. He rushes in expecting to see Dr. Goldstein having a heart attack on the floor but instead he sees Dr. Goldstein on his knees pulling down on the head and neck. He sizes the situation up, leaps up and gets the baby delivered all in less than a minute and this man was there for four minutes according to part of the records. He was there for five minutes after the head delivered and he just, he wasn't properly trained. He wasn't properly calm to do the maneuvers that are necessary to protect the baby's brain, life, and the brachial plexus nerves.

Also if Your Honor please, there was a reference about vacuum not being a direct cause of a brachial plexus nerve injury. That's true enough but there is testimony that vacuum is -- is a -- an increased risk factor for the shoulder getting stuck and if a doctor who doesn't know how to get a shoulder unstuck safely increases the risk of the shoulder getting stuck, that's additional negligence.

We've also got -- and Dr. -- in terms of causation, Dr. Gomez-Carrion went through a differential diagnosis which is what doctors do. The Supreme Court of this state has approved that differential diagnosis approach. She had very good reasons for why she ruled out other causes and counsel didn't even mention Dr. Resnick or Dr. Grossman. They testified about causation issues, not standard of care, but their

causation testimony dovetails with Dr. Gomez-Carrion's standard of care testimony.

THE COURT: Very good.

MR. GRAHAM: Thank you.

THE COURT: All right. I believe that the only thing that you did not address was the punitive damages.

MR. GRAHAM: Yes, sir. On punitive damages, if Your Honor please, I've heard comments about hesitation from Dr. Gomez-Carrion, about testifying truthfully to her genuine belief that this man was -- this man did, in fact, recklessly endanger Bryson F and her hesitation should not be viewed in terms of a lack of confidence but in terms of a recognition that she was about to make a very serious accusation and I -- I saw her taking a deep breath, because it's a courageous thing for one physician to say that about another physician. She's not one to lightly utter those words.

THE COURT: Very good.

MR. GRAHAM: Thank you.

THE COURT: All right. Very good. I'm going to deny all motions for directed verdict. However, I am going to take the issue of punitive damages under advisement. Anything else before we bring the jury out?

MS. CRAIG: No, sir, Your Honor, if we could just have a second to get set up?

THE COURT: And while we're doing that have we reached an agreement with regard to the medical records?

MS. GANES: She's just handing them to me, Your Honor.

THE COURT: Take a look at them and by the time -- before we bring the jury out, we'll see if we've gotten it done.

(Brief break)

THE COURT: We are going to proceed. If y'all could have a seat. There's going to be some time when we conclude today to, kind of, get everything straight for tomorrow, but you're prepared with regard to your first witness?

MS. CRAIG: Yes, sir, we are.

THE COURT: Very good. We'll start right now. We'll keep going until -- do you anticipate how long this will take?

MS. CRAIG: I would bet an hour-and-a-half, at least, maybe more. Maybe two.

THE COURT: Okay. We'll probably break some time in the middle of testimony, but let's just go and get as much as we can get done. We aren't in a terrible hurry so we'll just see how far we can get. We're ready for the jury.

(Jury in at 4:16 PM)

THE COURT: Ms. Craig, you're recognized.

MS. CRAIG: Thank you, Your Honor.

THE COURT: Excuse me.

MS. CRAIG: Yes, sir.

THE COURT: Madam Forelady, ladies and gentlemen of the jury, the Plaintiff has rested. They have completed their case in chief. At this point in time, the Defense will move forward. At the conclusion of their presentation, Plaintiff will be given an opportunity for reply. Ms. Craig, you're recognized. I'm sorry.

MS. CRAIG: Thank you, Your Honor. May it please the Court.

THE COURT: Yes.

MS. CRAIG: The Defendants call Dr. Bill Goldstein.

THE COURT: Dr. Goldstein, if you could come forward and place your left hand on the Bible and raise your right hand as the Clerk administers the oath.

(After being duly sworn by the Clerk of Court, Dr. Goldstein testified as follows:)

THE CLERK: Please be seated and state your name for the record.

THE WITNESS: L. William Goldstein, M.D.

THE COURT: Dr. Goldstein, make yourself comfortable. Have a seat in that witness chair. Pull up real close to that microphone. Speak loudly, clearly and slowly and let's start with your full name once again.

DR. GOLDSTEIN: L. William Goldstein, M.D.

THE COURT: Thank you. Ms. Craig.

MS. CRAIG: Thank you.

DIRECT EXAMINATION

BY MS. CRAIG:

Q Dr. Goldstein, I'd like to introduce you to this jury. Tell us where you live, sir.

A I live in Florence, South Carolina. I live on Cherokee Drive.

Q And are you married?

A I am.

Q Is your wife here?

A My lovely bride is sitting right back there.

Q Okay. And how long have you and Sara been married?

A Forty-seven years.

Q Good thing you got that right.

A Yeah. I had to fact-check that before.

Q Dr. Goldstein, do you have any children?

A We have three.

Q And how about grandchildren? Any grandchildren?

A Five.

Q Tell us what you and your wife like to do in your spare time.

A Well, we enjoy -- we have dogs. We have Labrador retrievers and I enjoy training them and we enjoy competing with them in field trials. We've been doing this ever since I got out of my residency and I've had the pleasure of running in the national amateur several

times and my dogs have competed in the national open several times. I think on three occasions my dogs have been finalists in these national events. I've been the president of the National Open Club.

Q Is this something that you and your wife enjoy doing together?

A Indeed.

Q I saw you in that big old truck of yours coming to the courthouse. What's that thing on the back of your truck? What is that for?

A It's called a topper dog box. It's a topper that fits on top of the pickup. A lot of people have accused me of, is that an ice cream truck, so I've had to tell them I don't have any Eskimo Pies in the back.

Q All right. Dr. Goldstein, tell us where did you grow up?

A I was born and raised in Spartanburg, South Carolina.

Q Where did you go to college?

A I attended Clemson University.

Q And how about schooling after Clemson? Where did you go to graduate school?

A Well, after I graduated from Clemson I did two years in the Army and then I attended graduate school at the University of South Carolina in Columbia and from there I went to medical school at the Medical University of South Carolina.

Q How long was graduate school? How many years?
A Two years.
Q Two years of graduate school. How many years was medical school?
A Four.
Q Four years of medical school. How many years of residency?
A Four.
Q Tell us why you wanted to be a doctor.
A I always wanted to be a doctor. It's just something that I, an aspiration that I had all my life. When I was in high school I worked as a surgical tech at Spartanburg General. During college, I worked as a tech in the urology clinic at Grady Memorial and then, you know, just followed my dream.
Q Dr. Goldstein, are you board certified by the American Board of OB/GYN?
A Yes, ma'am.
Q Explain to us what it means to be board certified.
A That means that you've taken a test to assure that your training is adequate and it's -- it involves case presentations of patients that you see during the first two years of private practice, as well as a written test and an oral board exam.
Q Let's start with the written test. How many days is

that?
A I think -- it's hard to remember, but I think it was over one day.
Q And -- okay. So, that's just for the written portion?
A Right.
Q All right. How long for the oral portion?
A For the oral portion you presented your cases and discussed cases and then they have the oral boards afterwards.
Q Did you pass your board certification, your written and orals, on the first attempt?
A Yes, ma'am.
Q Does everyone pass on the first attempt?
A Not usually.
Q Dr. Goldstein, how long have you been practicing in the field of obstetrics and gynecology?
A I'm going to have to add in my head. Let's see. Thirty-seven years.
Q And in the 37 years, approximately how many babies have you delivered?
A I'm guess-timating it's somewhere between 3000 and 3500.
Q Tell us where you currently practice.
A I practice here in Florence. My office is on Coit Street. I'm on the staff at Carolinas Hospital and McLeod Regional Medical Center.

Q Do you work with anyone else?
A Only in that we have a call group and we share calls and so, generally, I see my patients all during the week and then on the weekend we switch out being on call and cover for the other doctors.
Q With whom do you share call?
A Dr. Brent Baroody, Dr. Ami Chaudhry and Dr. Sue Fran.
Q So, before going out and establishing your own practice, where did you work?
A I worked a year with Coker and Phillips and prior to that I was in Camden, South Carolina, with John Moore.
Q So, why did you leave Camden and come to Florence?
A Basically, we had a disagreement so I decided to move on and came to Florence, because it was a good opportunity.
Q And then when you started working with Dr. Coker and Dr. Phillips, tell us why you decided to leave that practice and open your own.
A It became evident that this wasn't going to lead to a partnership in the near future, so I decided to go out on my own.
Q All right. Let's move now to teaching opportunities that you've had. Tell us about your involvement with teaching medical residents.
A Well, of course, while I was in residency, we taught the medical students as well as the residents. When I

graduated and went into private practice, I don't think we had any in Camden, but in Florence I've had a number of PA students from the Medical University that have done one-month rotations with me at my office. I had one osteopath third-year medical student from Virginia Tech School of Osteopathic Medicine in Spartanburg that came down and did about a month's rotation with me.

Q Where do you have hospital privileges?

A McLeod and Carolinas.

Q What does it mean to have hospital privileges?

A It means that you have privileges, you've been approved by the board and they renew your privileges about every two years, check your credentials and make sure that, you know, everything is going okay at the hospital with your patients and with your practice.

Q Were you Chair of the Department of Obstetrics?

A I was Chair of the Department of OB at McLeod. I think that was a two-year appointment and then I did two two-year stretches.

Q Dr. Goldstein, are you a member of any professional organizations for your medical specialty?

A Yes. I'm a member of American College of OB/GYN or the American Congress of OB/GYN, as it's now referred to.

Q Tell us what the American Congress of OB/GYN is.

A It's a professional organization for all OB doctors that

deals with issues that affect the OB/GYNs, educational. I'm sure they do a collection of funds. They send out educational materials and are also involved in the political aspect of it.

Q Now, Dr. Goldstein, as a member of the American Congress of Obstetrics and Gynecologists, I'll just call it ACOG, what publications do you receive from that professional organization?

A Well, they have a compendium that has committee opinion reports as well as articles on various topics of interest in OB/GYN. They also put out some other, other issues. They have precise -- there is a handbook that, a monograph that they publish and this has to do with, the latest one I've seen was anemia, they have one concerning hypertension, others concerning elevated cholesterol. These are just general topics and they give CME credits for these.

Q Do you read these publications from ACOG and from other medical professional organizations?

A Yes, ma'am.

Q Are you a member of the Florence Medical Society?

A I am indeed.

MS. CRAIG: Your Honor, at this time we would offer Dr. Goldstein as an expert witness in the field of Obstetrics and Gynecology.

THE COURT: Any query with regard to his qualifications?

MR. GRAHAM: None as to his status as an OB/GYN but ---

THE COURT: That's what my question is. Do you have any query or any questions of him about his qualifications?

MR. GRAHAM: Not at this time, but we reserve the right to do that before he gets into certain opinions.

THE COURT: Well, that's not what I'm asking. I'm just, we're wanting to know whether you feel you need to ask him questions about whether he's qualified as an expert.

MR. GRAHAM: No, sir, Your Honor.

THE COURT: If you have questions or concerns concerning scope, you can object at a later date and time.

MR. GRAHAM: Thank you, Your Honor.

THE COURT: But my question to you is, do you have any query with regard to his qualifications?

MR. GRAHAM: No, sir.

THE COURT: All right. He is indeed qualified as an expert in the area of Obstetrics and Gynecology and allowed to render his opinion in that field. Ms. Craig.

MS. CRAIG: Thank you, Your Honor.

Q Dr. Goldstein, did you comply with the standard of care in your care and treatment of Ms. Fulton and her son?

MR. GRAHAM: Objection, Your Honor.

THE COURT: That being?

MR. GRAHAM: In his deposition ---

THE COURT: You know, state your grounds for it. We aren't going to argue it.

MR. GRAHAM: Lack of knowledge, if Your Honor please.

THE COURT: Overruled.

Q Dr. Goldstein, did you comply with the standard of care in your care and treatment of Ms. Fulton and her son?

A Yes, ma'am.

Q Did you cause the injuries that are alleged in this case?

A No, ma'am.

MR. GRAHAM: Objection, Your Honor. Lack of knowledge; lack of expertise.

THE COURT: He has knowledge. He was there and he's an expert and if he feels as though he didn't cause it, he's an expert. He can do that.

MR. GRAHAM: Well, if Your Honor please, if I may respectfully -- may we approach?

THE COURT: Yes.

(Bench conference off the record)

THE COURT: Ms. Craig, you're recognized.

MS. CRAIG: Thank you, sir.

Q Dr. Goldstein, what is shoulder dystocia?

A Well, shoulder dystocia, in essence, is where the shoulder becomes stuck under the public symphysis and the opposite shoulder is stuck under, behind the sacral

promontory. It's also defined by -- it takes ancillary maneuvers to deliver the baby's shoulders after failure of gentle downward traction.

Q Tell us what training you received during your residency about how to manage the medical emergency of shoulder dystocia.

A First of all, didactic instruction ---

Q What does that mean?

A That means reading it in the textbook and in the literature and I'm sure we discussed it at the board. We had one case in my residency in which a private attending had a baby that had got stuck and the baby ultimately died, so we usually talked about these cases at the board in the morning as we, you know, did rounds.

Q I want to follow up on that. If you are confronted with a shoulder dystocia and you're unable to get the baby out, you indicated you had an experience or someone in your residency that the baby died. What are some other problems that can result because of shoulder dystocia if you're not able to get the baby delivered within six or seven minutes?

A Well, ultimately the worse thing that can happen is that the baby can die and that happened in this case in my residency. Another thing is that you can get what they call, hypoxic ischemic encephalopathy, which ---

Q What does that mean?
A Which basically means that the blood supplied to the baby and to the baby's brain has been cut off so that they get damage to the brain because of lack of oxygen, lack of blood supply.
Q Do you know what McRoberts is?
A I do.
Q Tell us what McRoberts is.
A It's hyperextension and flexion -- I mean, excuse me. Hyperextension of the thighs so that the thighs go towards the patient's armpits and abduction of the thighs is outward.
Q So, the woman's legs are pulled all the way back. Correct?
A Correct.
Q And what does that do when you're confronted with shoulder dystocia? If the legs are all the way back, what's going on with the pelvis?
A Well, say, if the patient is sitting -- I mean, on the supine -- I mean, supine on a surface ---
Q Supine, you mean on your back ---
A --- on your back.
Q --- having a baby.
A Yeah. Then when you extend the thighs back it opens up the pelvis. Normally the pelvis is, kind of, pointing

down a little bit off the plane of the floor so it, kind of opens up the pelvis.

Q Do you know what suprapubic pressure is?

A Yes.

Q Tell us what it is.

A It's pressure applied in the suprapubic area generally in reference to helping dislodge the entrapped shoulder from under the symphysis pubis.

Q Were you taught McRoberts and suprapubic pressure when you were in your residency?

A Yes, ma'am.

Q Were you also taught rotational maneuvers?

A Yes, ma'am.

MR. GRAHAM: Your Honor, at his point I object to the leading.

THE COURT: I'll allow her some leeway in that regard. Go ahead.

Q What training on all of these types of maneuvers in your residency to resolve a shoulder dystocia situation, did you receive?

A Well, again, didactic instruction, discussion on rounds, and I'm sure since then I've, you know, read some articles about it.

Q Dr. Goldstein, do you know how to manage a shoulder dystocia emergency?

A I do.
Q And did you do that in this case?
A I did.
Q All right. We're going to go through the records. I'm going to give you a copy of your original chart as well as a copy of the hospital chart.

(Ms. Craig hands a document to Dr. Goldstein and a document to Mr. Graham)

MR. GRAHAM: No objection, Your Honor, to this.

MS. CRAIG: All right. So, we'd like to mark your original chart as a Defendant's Exhibit as well as a copy of the hospital chart from this delivery as a Defendant's Exhibit. Your Honor, we would move into evidence Defendant's #2 and Defendant's #3.

THE COURT: They're into evidence without objection from the Plaintiff.

(Whereupon, Dr. Goldstein's medical records are entered into evidence as Defense Exhibit #2 and hospital records are entered into evidence as Defendant's #3, without objection)

Q So, Dr. Goldstein, we're going to walk through ---

THE COURT: Just one second.

MS. CRAIG: Oh, I'm sorry.

MR. GRAHAM: The Court's indulgence. Your Honor, as we discussed earlier we have no objection to any page of the records that is actually discussed by a witness, but we don't

believe any other pages that are not addressed in the courtroom by a qualified witness should be admitted.

THE COURT: What does the defense have to say about that?

MS. CRAIG: Your Honor, these are the -- this is the complete chart of the hospital delivery as well as the complete chart, Dr. Goldstein's complete chart for Ms. Fulton. He's reviewed these documents, relied on them, and we would like him to have all of the information. We believe it's all relevant to this case.

THE COURT: Under the business records exception and you're going to be -- anything that's not talked about, if she doesn't talk about it, you can talk about it, as well as your objection is overruled. The medical records are in evidence.

Q As we're going through, Dr. Goldstein, we're going to start -- we're going to go in chronological order. We're going to start with prenatal and then we're going to go through the delivery. At any time, if you need to review the actual medical records, please feel free to do so and I'll try to reference certain pages to help you. Okay?

A Yes, ma'am.

Q Do you have an opinion whether shoulder dystocia is unpredictable and unpreventable?

A Yes, I do. Pretty much the literature states that

shoulder dystocia is unpredictable and unpreventable. I think there are a couple of exceptions, one being the patient has had a previous shoulder dystocia with a bad outcome. They suggest on those cases, maybe considering operative vaginal -- I mean, C-section delivery.

Q Did Ms. Fulton have a previous shoulder dystocia with her first child?

A No, ma'am.

Q First delivery?

A No.

Q When the shoulder dystocia occurred in this delivery, did you immediately recognize it?

A Yes, ma'am. She demonstrated the turtle sign. That is, the head delivers but then retracts back into the perineum, you know, with the chin against the side wall of the vagina and the back of the head against the other side.

Q Okay. Let's start with your chart. You've got your original chart up there.

A Yes, ma'am.

Q If you will tell us how Ms. Fulton became your patient.

A She was referred by Dr. Morris Brown from Lake City.

Q And who's Dr. Brown?

A He is a family practitioner in Lake City, very nice guy.

Q All right. So, Dr. Brown referred the patient to you.

When is the first time you saw Ms. Fulton as a patient?

A 8/20/08.

Q All right. And it's in your record, page 69. We're going to pull it up for you (on screen) and while we're waiting for it to come up, if you can -- this is -- how many pages is this note, this office visit on this one day?

A Two pages.

Q All right. Tell us about your evaluation of Ms. Fulton at this time.

A At that time, she was referred by Dr. Brown with excessive menstrual bleeding and the suggestion from them was that she had fibroids and this was causing her excessive bleeding. She also had secondary infertility. She'd had one pregnancy in 1989 and had been unable to conceive since that time.

Q Doctor, if you'd speak up a little bit just so that we can hear you. I think you were referring to number three on your actual office chart and you're talking about infertility. Why did you document that she had secondary infertility?

A Because we discussed her being unable to conceive and she desired to conceive.

Q Okay. And then you go through and it looks like there's a past medical history. Correct?

A Diabetes mellitus, type two.
Q So, she had diabetes before her pregnancy?
A Right. She was on Glucotrol, five milligrams, once a day.
Q Okay.
A She had elevated cholesterol. She had complained of some back pain, back spasms, was being treated with Flexeril and she had a prescription for nausea, but her biggest complaint when she came in was the heavy, prolonged, irregular bleeding.
Q It looks like you obtained her past surgical history, her OB history, her family history, her social history and then pertinent physical findings of your exam. Correct?
A Yes, ma'am.
Q What kind of exam was that?
A Complete exam including vital signs. Generally, I check their neck and feel for thyromegaly or lymph nodes, I listened to her lungs, listened to her heart, checked her breasts, palpated her abdomen, and then did a pelvic exam with a Pap smear and I did a STANDARD check also.
Q Okay. Then if you look on the second page, it says GYN endovaginal probe ultrasound. Did you actually do an ultrasound on that visit?
A Yes, I did. I did an ultrasound at that time because

number one, she was referred for fibroids but number two, I was suspecting that she had polycystic ovary disease so we did an ultrasound and revealed the uterus to be fairly normal size, 8.7, about 4.5 by 5.0, and it was a small fibroid. I think it was 1.9 centimeters in the fundus so that's, you know, less than two centimeters, maybe that big. But I did notice that she had typical polycystic ovaries.

Q What does that mean?

A Well, for example, the right ovary was enlarged 5.1 by 2.6 by 4.1 and it had what we refer to as the typical chain of pearls appearance in the periphery of the ovary, so generally with polycystic ovary disease the -- when you look at it on ultrasound you can see that the capsule is thickened and then under the, under the capsule are a lot of small follicular cysts that looks like a chain of pearls under the capsule so that's, kind of, it's not a sine qua non diagnosis of polycystic ovary disease, but it's one of the things that helps in your differential -- I mean, in your diagnosis of polycystic ovary disease.

Q Okay. So, the ultrasound was done in your office?

A By me.

Q By you. All right. Then going down, next, is your assessment on this record ---

A Right.
Q --- and it says that polycystic ovary disease. That was a diagnosis that you made. Correct?
A That's right. No, I mean, these assessments, the hirsutism, secondary infertility, irregular menses, obesity, these are all part of the thing that you add up to get the diagnosis of polycystic ovary disease. You can have signs of excess androgen, which would be the hirsutism, or you could have chemical or laboratory proven excess androgen, but she had all the biggies, including an ultrasound picture that was consistent with polycystic ovaries.
Q So, under assessment, you state what? What is written there in your chart?
A Polycystic ovary disease based on hirsutism, secondary infertility, irregular menses, obesity.
Q And then continue please.
A I suspected most of her problems with irregular bleeding, heavy bleeding were a result of PCO disease. I also suspected that her diabetes was related to the PCO disease as well as her infertility.
Q All right. So, with regard to the plan, it says you discussed with her the treatment options and you changed medication. Explain the change in the medication, please.

A Well, we discussed the various options. I mean, and some of the options are just simply to be on birth control pills to regulate your cycles, but she was more desirous of pregnancy so we simply changed her diabetic regimen to Metformin because Metformin is the type of, it is an agent used to treat diabetes, but it's also usable in patients with polycystic ovary disease in helping them achieve pregnancy.

Q Thank you, sir. All right. So, that was August 20th, 2008, first visit. Correct?

A Yes. Yes, ma'am.

Q I've got a time line that might help us stay on track. When was the second visit?

A Well, she had a colposcopic exam on 9/4/08 for -- her Pap smear was atypical squamous cells of undetermined significance.

Q Are you looking at page 57?

A I'm looking at page 66.

Q All right.

A And the colpo picture is on page 63.

Q All right. What does that mean?

A The colpo picture?

Q Yes, sir.

A Basically it just -- just shows some areas of white epithelium and I biopsied the areas at, it looks like 12

o'clock, four o'clock and eight o'clock, and I sent those for pathological evaluation and the pathology said eight o'clock benign into cervix, five o'clock focal cytopathic effect consistent with HPV infection, low grade squamous intraepithelial lesion CIN 1. I'll explain that if you want but ---

Q So this ---

A --- basically ---

Q --- this is a test that you'd ordered after her first visit. Correct?

A Well, see, her Pap ---

Q These are the results?

A Yeah, her Pap smear came back as abnormal so generally if we get an abnormal Pap smear, the way we follow that is by doing a colposcopic exam and a colposcopic exam is simply taking a lighted microscope so you can look at the cervix under magnification with light and then we stain the cervix and abnormal areas that we see on the colposcopic evaluation. We can evaluate those, but generally, you know, we take biopsies of the areas suggested by the colposcopic exam and send those to the pathologist and then they give us a pathologic diagnosis of what's going on with her cervix.

Q And you did all that?

A Yes, ma'am.

Q Then Ms. Fulton comes back for her second visit with you and I think that's January 29, 2009, on page 57.
A I think ---
Q If I missed something tell me.
A Nine four, that's page 61, so we discussed her diabetes at that visit.
Q Which visit are you talking about?
A Well, this is -- I guess this is on 9/4, too. So I dictated a note about the colposcopic exam.
Q Okay. That was the finding after the abnormal Pap smear.
A Right.
Q All right. So ---
A So, I mean, you know, we talked about the abnormal Pap smear, but then we talked about her diabetes and her -- I mean, her irregular periods and discussed those things while we, at the same visit, went over the colposcopic exam.
Q Okay. You're evaluating your patient. You're monitoring your patient. Correct?
A Right. Yes, ma'am.
Q All right. Let's go to the second visit and it's page 57 and the date is January 29, 2009.
A Page 57?
Q Yes, sir.
A I've got 56 and I've got 58.

Q I've got a copy.
A I think it's out of order in my chart. I'm looking.
Q So we can keep moving, do you want to look at my copy?
A Yeah.
Q All right. Just tell us what her condition was on this date and tell us what you did for her.
A This is, this is her history and physical from when she came in for her first pregnancy evaluation and I've got that here, so.
Q Okay. So, she was able to get pregnant. Correct?
A That's correct.
Q All right. So, tell us what her condition was on January 29, 2009, as documented in your medical record.
A She was certain that her last menstrual period was 11/06/08. That gave her a due date of 8/13/09 and that made her estimated gestational age or her ETA 12 weeks and we did an ultrasound that day that the measurement of the crown/rump length, you know, how, the distance from the baby's, top of the baby's head to the bottom of the baby's bottom was consistent with seven weeks and two days.
Q Did you do that on ultrasound?
A Yes, ma'am.
Q Okay.
A So, that would make her due date by ultrasound, 9/16/09,

and that was later confirmed by the physicians at McLeod Maternal Fetal Medicine.

Q All right. So, she comes in on January 29, 2009, and she is pregnant. So, do you take care of her for her prenatal course?

A Yes, ma'am.

Q So, I think it's a few weeks later you see her on February 12th, 2009, at page 39. Is that right?

A Yes, and she's nine weeks pregnant.

Q So, she's nine weeks pregnant. How is she doing?

A She'd been to the emergency room for abdominal and back pain.

Q And what do you do?

A And she was having nausea. So, the pain was better at that time. She was having morning sickness or AM nausea, and then we adjusted her diabetic medicine. We increased her Glipizide to five milligrams twice a day and her blood sugars were relatively good at the time so we decreased the requirement for her checking her blood sugars to twice a day.

Q Did you carefully monitor her blood sugar, her diabetes, throughout the pregnancy?

A Yes, ma'am. I've got, I've got a bunch of blood sugar sheets here and --

Q Yeah --

A --- you know, we ---
Q --- we saw that earlier. The Plaintiff's attorney put, I think they showed one of those blood sugar records. Is this what the blood sugar record looks like?
A That's it.
Q Okay. How many pages of these blood sugar records do you have in your chart monitoring ---
A Well, I was counting, but I got lost.
Q I'm sorry.
A Let's see. One, two, three, four, five, six, seven, eight, nine, ten, eleven, twelve, thirteen. But some of these sheets overlap. I mean, you know, I've got one printed from 7/28 to 8/4 and then I have a 7/28 to 8/11, so basically when they come in, we Xerox the blood sugar sheet and put it in the chart.
Q Were you monitoring her blood sugar?
A I was, indeed.
Q And it looks from these records that there's a fasting blood sugar. Correct?
A That's right.
Q Two hours after breakfast, two hours after lunch, two hours after dinner.
A Yeah, and that's how we ask them to check their blood sugar so, you know with meals what their blood sugar goes up to.

Q All right. Continuing along our time line. You saw her at nine weeks and then you again saw her at 11 weeks. Is that correct? That's February 26th, 2009.

A Yes, ma'am.

Q You do a random blood sugar. Did you modify the diabetic medication?

A That's on 2/26?

Q Yes, sir.

A Let's see. We increased her Glipizide or Glucotrol to three times a day. She had a hemaglobin A1C that we checked the week before that was elevated at 7.0 so optimally we -- you know, to reduce the risk of heart disease you want it below 6.9 but, you know, in pregnancy we like to achieve tighter control so we'd like to see it below 6.5.

Q So, after this visit you see her again three weeks later. Now, she's 14 weeks pregnant and that date is March 24, 2009. Do you see that in your record? We don't have to go through all of them. We just want to establish how many times you saw Ms. Fulton for prenatal care.

A I think that time she was complaining of symptoms of a urinary tract infection, however we looked at her urine and it was clear and, you know, we evaluated her and it seemed to be that her uterus was tender so we gave her

some Vittaria to take whenever she had discomfort.

Q And then after that visit, I assume maybe because of the discomfort, you saw her just one week later at 15 weeks?

A No, that time was -- this was, that's 15, 15 and 5/7ths. She had an abnormal AFP.

Q What does that mean?

A It was elevated slightly. I mean, the risk of Down Syndrome was given as 1/181 so admittedly, you know, this wasn't a real high elevation but anything over 1/180 is considered elevated and with her maternal age being 37, we gave her the option of what to do and ended up referring her to McLeod Maternal Fetal Medicine for a consult concerning her risk of Down Syndrome.

Q Did you discuss with Ms. Fulton the abnormal AFP?

A Indeed.

Q Based on your observations did she understand what you were relaying to her regarding that abnormal finding?

A Yes, ma'am.

Q And then you said you actually referred to her high risk?

A To, yeah, to the maternal fetal medicine doctors at McLeod. The maternal fetal medicine doctors from Charleston come up to McLeod and do a clinic. I think it generally has been on Tuesdays but they see patients, do ultrasounds, consult and also consult in the hospital.

Q And who made that referral?
A I did.
Q And it's actually documented in your chart on April 6, 2009, that the AFP was discussed with Ms. Fulton. Is that what you just testified to?
A Yes, ma'am.
Q All right. And it says that you set up an appointment at a perineonatologist?
A That's right.
Q Who did that?
A I'm looking for that. Here it is. That's on page 42 and the ultrasound is page 95 and then 96 is the comment. Patient was seen by one of our genetic counselors. The risk of fetal chromosome abnormalities was reviewed with options for prenatal diagnosis. A letter detailing that encounter will follow under separate cover. Patient declined amniocentesis for karyotype.
Q Okay.
A And that was Donna Johnson, Dr. Donna Johnson from Charleston, who saw her.
Q That's Dr. Johnson that works at the Medical University?
A That's right.
Q Okay. So, that was at 16 weeks. Looks like you see her three weeks later at 19 weeks and the date is April 28th, 2009. Based on your review of the record, what

were you concerned about at this time?

A April the 28th?

Q Yes, sir.

A Again, about her diabetic control. I noted that her blood sugars were out of control, so we increased her Glipizide to 7.5 milligrams three times a day with meals.

Q Who's making these changes to her medication?

A Me.

Q Who's following this patient who's pregnant?

A Me.

Q Who's monitoring Ms. Fulton?

A I was.

Q All right. Next time you see her it looks like it's 22 weeks. This is three weeks later.

A Well, another point was the perinatologist had recommended that because of her diabetes that she get a fetal, I mean, a fetal echo so we referred her to Dr. Dent in town for the echocardiogram on the baby.

Q So, did you make that referral?

A I think so.

Q All right. Now, going to May 13th, 2009, 22 weeks pregnant. It looks like there was another visit and you were a little, you were happier with the blood sugar.

A Yeah. I made the comment that the blood sugars after

dinner were a little bit high at 167 to 177 and we discussed decreasing her carbs at dinner time but, you know, they were good enough that we told her to decrease her blood sugars to twice a day.

Q Who -- when you say "we" discussed, who discussed with Ms. Fulton about monitoring her carbs and keeping her diabetes in check?

A I did.

Q You had those conversations?

A Yes, ma'am. And usually I give them a, I have a diabetic diet handout that I give them and I may have given it to her at that visit or earlier.

Q Next, you mentioned the fetal echo. The date appears to be May 22, 2009. Who ordered that? Was that ordered by you or Dr. Johnson from MUSC?

A I think she suggested it and I think we followed up and ordered it. Here's the...

Q When you would receive these reports, like, we've already gone through the AFP that was abnormal, but when you would receive the report from the doctor who performed the fetal echo, who would relay the results to Ms. Fulton?

A I would.

Q You would?

A Yes, ma'am.

Q Who was updating Ms. Fulton throughout her prenatal course regarding any of the issues or problems that she had and treatment that she needed? Who was educating her and giving her that information?

A Me.

Q All right. After the echo it looks like at 25 weeks, she came in for another office visit and that date was June 3, 2009, and it's on page 36. Tell us what you did for this visit.

A June the 3rd, 2009. Her random blood sugar in the office was 111. Evidently, blood sugars on the sheet were elevated, so at that point in time we decided to convert her from oral hypoglycemic agents to insulin, so we started her out on NPH 20 units twice a day.

Q Who made that modification?

A I did.

Q Did you explain that to Ms. Fulton?

A Yes, I did.

Q Why would you explain all of these changes in the medication? Why would you explain the results of the tests that you were ordering? Why were you explaining this to Ms. Fulton?

A It was part of her prenatal care.

Q And it looks like she missed an appointment on June 5, 2009, but she came in for the next visit, which was June

15, 2009.

A That was just a note in the chart by the nurse.

Q Okay. And what does that note say?

A Patient called with pain, with cramps, lower abdomen and back. Spoke with Cindy at Dr. Dent's office on call and she advised to send her MRMC. We faxed the records over.

Q What is MRMC?

A That's McLeod Regional Medical Center. We also ordered her RhoGAM at that time too, since she was RH negative. I'm sorry.

Q Excuse me?

A She also had the order for RhoGAM. The mother's blood type was O negative, or RH negative, and so in order to prevent a possibility of developing an antibody to the baby's blood they get RhoGAM.

Q Who made that order?

A That's kind of a standard. We usually do that about 28 weeks and then, you know, we check the baby after the baby's born to, if the baby is RH positive, then we give them another RhoGAM shot at the end of the pregnancy.

Q All right. Now, 27 weeks, it appears like the next office visit was on June 22, 2009, and it's in your records on page 36.

A Right.

Q What's happening?
A This is, you know, when I saw her in the office she'd gone into McLeod as per Dr. Dent and evidently was having some contractions, so Dr. Dent treated her with some terbutaline and stopped her contractions.
Q What's terbutaline?
A Terbutaline is, it's actually an agent that they use for diabetes. It's a bronchodilator, but it's been shown, you know, to be very effective at stopping uterine contractions. We used to use it in a terbutaline pump in days gone by but, you know, it has some side effects so we switched to other things, other agents.
Q Okay. After she was given the terbutaline for early contractions, what happened?
A Well, Dr. Dent put her on Nifedipine which is, it's an oral anti-hypertensive, but it also has an off-label use as stopping or preventing pre-term contractions.
Q Did you discuss these medications with Ms. Fulton on her next office visit?
A Yes.
Q Okay.
A As a matter of fact we -- you know, she was having to take it three times a day so we put her on an extended release tablet that she only had to take once a day.
Q That was June 22, 2009. Moving on to -- let me ask you,

based on those pre-term contractions that she was having, did you put her on bed rest?

A Yes, she was.

Q Who made that decision?

A I think that was me. I've got bed rest here in the chart, but I'm not sure if I was the one that ordered it. You know, on the 22nd, I said continue bed rest.

Q Did you communicate to Ms. Fulton the importance of bed rest and staying off of your feet because of the pre-term contractions?

A Right.

Q Did you have that conversation with Ms. Fulton?

A Well, you know, it hasn't been proven, but it certainly does seem to help and so it's better to err on the side of too much than too little.

Q During all these conversations that you would have during these various office visits and the tests that you were ordering, did you have any concern that Ms. Fulton did not understand what you were communicating to her?

A No, she was a very compliant patient.

Q Now, on page 35, you saw Ms. Fulton again on June 29, 2009. She's now 28 weeks pregnant.

A Yeah.

Q Looks like you measured her uterus.

A Well, that's the same -- same day. I dictated a note on that day because there was a lot going on so I dictated a note.

Q Okay. Got it. So, let's go two weeks later. Looks like 30 weeks.

A Well, also one thing ---

Q Yes, sir.

A --- on that note, you know, she'd gone to McLeod and her labor was stopped, but Dr. Dent sent her in for a Celestone series.

Q What does that mean?

A That's -- we give them steroids to help mature the baby's lungs, so they get a shot of 12 milligrams of Celestone 24 hours apart so she'd gone in for a Celestone series, or a steroid series.

Q So, the steroid series, the purpose is what?

A To mature the baby's lungs.

Q Did you communicate that to Ms. Fulton?

A Yes, ma'am.

Q Did you have any concern that she didn't understand why she was receiving steroid shots?

A No. Another thing, you know, Dr. Dent had done an ultrasound to measure her cervical length and then I did a cervical length measurement and it was, it was okay. It was 2.94.

Q Now, when, when Ms. Fulton went to see Dr. Dent and he checked Ms. Fulton and his findings, were those findings relayed to you?
A Yes, ma'am.
Q Do doctors communicate with each other when they share a common patient?
A Yes.
Q Did that happen in this case?
A Yes. I've got a copy of his note and I think we have a copy of his ultrasound.
Q All right. Now, moving to, I think, the next one is July 13th, 2009.
A Right.
Q That's page 34 in your record.
A Right.
Q Looks like she's still on bed rest and her blood sugars look good.
A Random blood sugar was 121, a teeny bit high, but she could have had something to eat on the way but evidently from the blood sugar she -- they were all good, all less -- I mean, the postprandials or after meals were less than 140, which is where we like to keep them.
Q Any concern on this day at 30 weeks, July 13, 2009?
A Well, she's on Nifedipine, 30XR to prevent pre-term labor, but the cervical exam or cervix was two to three

centimeters, 50 percent, but minus three.

Q Now, it looks like from your records that you now see her once a week. Why is that?

A Just following her blood sugars. We're doing -- we did a non-stress test to check on the baby's well-being.

Q Okay. What was the non-stress test finding?

A It's kind of -- you know, it's either positive or negative or somewhere in between but if it's a reactive test, that means they have 10 to 15 beat acceleration for 10 seconds during a strip of 20 minutes.

Q Was the results of the nonstress test relayed to Ms. Fulton?

A Generally, you know, we go -- I mean, they're on the monitor in our office and, you know, usually we put them on the monitor and pop in and out and look at the strip and, you know, once it's reactive then we take them off the monitor and let them go home and generally tell them your strip is reactive.

Q Who is doing that?

A The nurse puts them on and then I check the strip.

Q Okay. So now we're on a one-week follow up. You see her next at July -- I think the next one is July 20th, 2009. She's 31 weeks; correct?

A Yeah.

Q Was she still on bed rest?

A Yeah.
Q All right. Next week, July 27th, 2009, 32 weeks. What's going on with her pregnancy?
A Blood sugar -- random blood sugar was okay, cervix 4 to 5. Now she's more effaced. We did a non-stress test and it was reactive.
Q What does it mean to be more effaced?
A It's thinned out. The cervix is thinned out. Typically, when the head, the fetal head comes down and is applied to the cervix, generally the cervix is, you know, two, maybe three centimeters but, you know, as they approach term not only does the cervix dilate or open up, but it effaces and it thins out.
Q Is that normal or abnormal?
A That's normal.
Q It means the baby's coming?
A Yeah.
Q All right.
A But, you know, it's abnormal in the fact that she's 32 weeks here.
Q All right. That is July 27th, 2009. Is that right?
A Yeah.
Q All right. Next one, one week later, July 30th, 2009. What's going on at this visit?
A July 30th, checked her cervix. It was unchanged. She

complained of contractions every 10 minutes. Blood sugars were good.

Q Then the next one is at page 33 in your record. She's 33 weeks.

A Closer to 34.

Q Okay. What about her uterus? It looks like you measured it. What was the significance of the measurement?

A There I think -- her fundal height on that day was 43. That's just the height of the top of the uterus, you know, when measuring from the symphysis pubis to the top.

Q Why did you document on this day that the head -- it says head out of pelvis. What does that mean?

A Well, just when I do a cervical exam that means the head is still high. It's not slammed against the cervix and down in the pelvis.

Q All right. Let's go to the next week. We see her at 34 weeks. That's August 11, 2009.

A That's -- she's close to 35 there.

Q Close to 35. Okay.

A She's 34 6/7ths, so that's 35.

Q Yes, sir. How is she doing?

A Her cervix was soft and maybe two centimeters, 25 percent so, you know, generally we discontinue the Nifedipine after 35 weeks, so I discontinued her

Nifedipine the following week.

Q Did you communicate that to Ms. Fulton?

A Yes.

Q Did she appear based on your observations to understand?

A Yes.

Q All right. One week, next week, it looks like August 17th, 2009.

A Right.

Q What do you document about this visit?

A She complained of pressure. She complained of swelling in her ankles. Complaints of body aches all over. Blood sugars were good. Her cervix was four, 50 percent minus two. We discontinued the Nifedipine. She's close to 36 weeks.

Q What is causing the pressure in the pelvis that you mentioned?

A That's the baby's head.

Q The next week the uterus is measuring 44 weeks and the date of this is August 19, 2009. What significant findings are documented on this office visit?

A Well, basically she'd been to McLeod the previous night and was evaluated in labor and delivery and was having some uterine contractions.

Q Can I stop you right there? You said that she was at McLeod the night before.

A Right.
Q Why did she go to McLeod?
A I'm not sure.
Q But she was having some ---
A She was having ---

MR. GRAHAM: Objection, Your Honor. I've been trying not to object to the leading but at this point, I must ---

THE COURT: I'll sustain the objection, but just one moment. Let's let the jury stand up and stretch for just one moment. Madam Forelady, ladies and gentlemen of the jury, we're going to allow you to retire to the jury room and refresh yourselves and we'll be back in, momentarily. Do not discuss the case.

(Jury out at 5:17 PM)

THE COURT: We'll stand at ease for about five minutes. We had some of the jurors wanting to use the restroom.

MS. Craig: Your Honor.

THE COURT: Yes, ma'am.

MS. Craig: I know Mr. Graham didn't care about juror number 21 sleeping in his case, but he is, he is sleeping still, and I just want to bring it to the Court's attention.

THE COURT: What is the Plaintiff's position?

MR. GRAHAM: I haven't noticed any significant difference from the last time.

THE COURT: It's kind of odd that Mr. Graham did not

object to him sleeping during his presentation, which would have been most important to him, and you objected when he was sleeping during his presentation. Seems like, it seems kind of odd, but at any rate, I think that he is doing fine. I've watched him consistently. His head is not nodding. He just looks downward or closes his eyes and we'll continue to monitor him. We do have two alternate jurors and we'll monitor his activity for the balance of the trial. We'll stand at ease for five minutes.

(Brief break)

(Jury in at 5:24 PM)

THE COURT: Ms. Craig, you're recognized.

MS. CRAIG: Thank you, Your Honor. May it please the Court.

CONTINUED DIRECT EXAMINATION

BY MS. CRAIG:

Q August 19, 2009, that's where we left off and actually a good place to leave off, because it's looks like it was the last prenatal visit.

A That's correct.

Q Okay. How many weeks pregnant was Ms. Fulton on this visit?

A Thirty-six and 07ths.

Q Okay. And tell us what your findings were based on your medical record on this last prenatal visit.

A She was five centimeters dilated.
Q Okay. What does it mean to be five centimeters dilated?
A That's, kind of halfway there.
Q That's pretty dilated.
A Ten centimeters is complete cervical dilation ---
Q Okay.
A --- so she was over -- I mean, she was five centimeters dilated. She'd been having uterine contractions. We had stopped the Nifedipine. She, you know, when they're over 35 weeks and they've had pre-term labor then, you know, the tradition is to stop the Nifedipine or whatever you're using to inhibit labor at that time.
Q And how did you determine that Ms. Fulton was five centimeters dilated on August 19, 2009?
A I did a cervical exam on her, as I did with each previous exam.
Q What's the difference between a cervical exam and a vaginal exam?
A Well, the same thing essentially. Yeah. I mean, you could do a -- well, if you did a vaginal exam you'd be checking the cervix too. I was, kind of, thinking maybe there was a difference between a gynecology patient and an obstetrics patient, but in gynecology you check the cervix too.
Q Based on the fact that Ms. Fulton was five centimeters

dilated on August 19th, 2009, do you have an opinion whether induction was reasonable?

A Yes, and we discussed that. I mean, she lived in Olanta, I think, and, you know, a fair distance from the hospital so if you're walking around and you're five centimeters dilated and all of a sudden you decide to go into labor at two o'clock in the morning and it takes a while to get to the hospital, you might be having the baby in Scranton or some place on the way to the hospital.

Q All right. What discussions, Dr. Goldstein, do you have with your patients to provide informed consent regarding the delivery of their babies?

A Usually when -- you know, as we approach term we discuss, you know, various things that they are to expect when they go into labor. You know, they're going to go into labor some time so, I mean, we discuss these things. You know, I noted on the chart that we had discussed tubal ligation at some time in the past. We discussed anesthesia. I generally ask them if they, you know, if they want an epidural or not and generally, you know, there's a discussion about vaginal delivery versus C-section delivery and I generally tell them that, you know, you've had a baby before so the probability is high that you'll have another vaginal delivery.

Q Why do you have these conversations with your patients during the 19 plus prenatal visits that you may have with any patient?

A Well, it's just a part of the, a part of the care that we provide.

Q And how do you know that you provided informed consent to Ms. Fulton?

A We -- like my other patients, we discuss these issues when they come in, you know, especially when, you know, they get above 32, 34, 36 weeks.

Q And did you relay all medical information to Ms. Fulton regarding the tests that you ordered, the tests other doctors ordered, the treatment, the changing in medication, the bed rest and the delivery ---

MR. GRAHAM: Objection, Your Honor.

THE COURT: I'll overrule. I'll allow her some leeway in that regard.

MS. CRAIG: Thank you.

Q Dr. Goldstein, did you relay the medical information to Ms. Fulton related to the medication, the treatment changes that you made, the tests and the results of those tests that you ordered? Did you relay that information to Ms. Fulton?

A Yes.

Q And did you also relay to her adequate informed consent

for delivering this baby?

MR. GRAHAM: Objection, Your Honor. Leading.

A Yes.

THE COURT: Overruled.

MS. CRAIG: Your Honor, may I have permission to have Dr. Goldstein come down and explain a couple of medical illustrations?

THE COURT: Certainly.

MS. CRAIG: Thank you.

Q So Dr. Goldstein, if you will come down. Let's start with this one.

COURT REPORTER: Could he stand on the other side, please?

MS. CRAIG: Yes, certainly.

COURT REPORTER: Thank you.

MS. CRAIG: Dr. Goldstein, if you'll stand right here and I need you to speak loudly.

DR. GOLDSTEIN: Okay.

MS. CRAIG: Let me mark this as a Court exhibit.

(Whereupon, a large medical illustration of a normal delivery/shoulder dystocia is marked as Court's Exhibit #11)

Q All right. We've marked as a Court's Exhibit, Defendant's #1. Explain to us, we've got a normal delivery on the left side and a shoulder dystocia on the other, so explain to us what we're seeing on a normal

delivery and then I want you to show us what's going on when shoulder dystocia is encountered.

A Well, this is a normal vaginal ---

Q You have to speak up.

A --- normal vaginal delivery and the uterus is contracted. There's not that much free space here between ---

Q Doctor, you've got to come back here so everybody can see. That's okay.

A I can't see ---

Q Okay. I know. You've just got to lean over. Just do that.

A All right. Here's the baby's bottom and there's the uterus. This looks like the placenta there and so the baby's head is delivered here. The head is out and so in this, the shoulders are kind of rotated to the side so the anterior shoulder has slipped under the symphysis pubis right there. Here's the ---

Q What's the symphysis pubis? We've heard that a lot. Show us.

A That's the pubic bone ---

Q Okay.

A --- right there.

Q Got it.

A Okay. And here's the sacral promontory. So, the

posterior shoulder is, you know, the baby's shoulders are kind of twisted and so it slid out between this obstruction, if you will.

Q All right. Now, you come over here and tell us what you see on this side of the Defendant's #1.

A All right. And this depicts the shoulder dystocia. So, here the head is delivered. This is the, I guess the cervix right there but, you know, again, here's the placenta and here's the baby's bottom and here's the anterior shoulder and it's more of in a straight up and down plane, so the anterior shoulder is stuck under the symphysis pubis right here and the posterior shoulder is stuck against the sacral promontory right there.

Q Okay. Thank you. Stay right there. All right. I've got another one.

MS. CRAIG: We'll mark it as #2.

COURT REPORTER: Will this be a court's exhibit?

MS. CRAIG: Yes.

COURT REPORTER: Okay. This will be Court's #12.

(Whereupon, a large medical illustration of the crowning of a baby's head is marked as Court's Exhibit #12)

MS. CRAIG: I'm sorry. So, the first one was Court's Exhibit #11 that we just went through and this one is Court's Exhibit #12.

Q So, tell us what we are seeing in this medical

illustration.

A Well, this is virtually the same as the last exhibit here. Here's the baby's shoulder. Basically, the baby's at a higher station. Here's the cervix right here and so the baby's crowning. The head is just presenting at the vaginal opening there, so ---

Q Now, explain to us, in this situation, is the baby getting oxygen?

A The baby should be getting oxygen. I mean, here's the placenta, but you can't see the cord here so, you know, the cord could be, you know, trapped between the back of the head, or the cord could be wrapped around the neck. I've seen as many as three wraps around the neck. I've seen true knots, double true knots in the cord, but, you know, we can't see the cord so, you know, the baby should be getting adequate oxygen.

Q When you say it's wrapped around the neck, what are you talking about?

A I mean some babies have long umbilical cords and during the process of growth and development the cord becomes looped around the neck and, you know, sometimes it can be real tight and that can -- you know, when the baby has a contraction, or when the mother has a contraction and pushes on the baby and pushes the baby down, the cord can constrict around the neck and it doesn't cut

off the breathing of the baby, but it cuts off the blood supply to the baby which is where the baby gets the oxygen.

Q All right. One more?

A This next one is pretty much the same one that we talked about before. Here's the anterior shoulder stuck behind the symphysis pubis. The posterior shoulder. You can see the head is delivered and rotated.

(Whereupon, a large medical illustration of McRoberts maneuver is marked as Court's Exhibit #13)

Q Okay. Thank you. This is Court Exhibit #13. Tell us what we are seeing on this medical illustration.

A Well, this is shoulder dystocia during delivery, McRoberts maneuver with simultaneous suprapubic pressure.

Q Would you like to use this? (Referring to laser)

A Does it work?

Q That's a good question. There you go.

A Here's -- here's the mother's feet and so there -- I can't remember if this is extended or flexed, but the knee goes up towards the armpit.

Q And that's what I want -- so what is this?

A That's the knee.

Q So that's the -- that's the mama's knee is all the way back.

A Right.
Q Now, keep going, please.
A So, I assume the other leg is back, so they're extended and abducted, so the knee goes out and so that's the McRoberts.
Q Okay.
A And the same guy that looks like he's holding the foot is doing suprapubic pressure, so here's the symphysis pubis right there. He's pushing down with the ball of his hand and trying to dislodge the anterior stuck shoulder from behind the symphysis pubis and basically that just, you know, it can dislodge it under there or it could rotate the shoulders posteriorly towards the baby's back or interiorly and that changing the position tends to free up the action.
Q Explain -- this looks like a fist. What is this? What's going on here?
A That's the suprapubic pressure. That's the attendant, or whoever, putting pressure just above the pubic symphysis in conjunction with McRoberts.
Q Okay. Thank you, sir. You can go back to the stand please.
Q Dr. Goldstein, what is gentle downward traction?
A I guess gentle downward pulling on the baby or guidance. It's a term that's difficult to quantitate but, you

know, in medical school and residency we learn what gentle downward traction is.

Q Explain why during every delivery, not just in shoulder dystocia, but why in every delivery some traction is needed to help deliver the baby. Explain that.

A Well, basically, you're guiding the baby out of the birth canal and some degree of pulling or guidance or traction is necessary to get the shoulders delivered out of the pubis. I mean, generally, the head delivers and then you still need to get the anterior shoulder delivered and then the posterior shoulder and once you get the two shoulders delivered, basically it's a matter of catching the baby as the baby falls out by gravity.

Q Explain how you and an obstetrician knows how -- what the appropriate amount of traction is to use during a delivery. How do you know that?

A Well, I guess we were -- I mean, we started out in medical school when we did our OB rotation and did our first deliveries and then when we were residents, you know, we generally did, even as interns, you know, our upper residents did deliveries with us and our attendings did deliveries with us and they instilled on us the proper traction to deliver a baby.

Q And how do you know that you used gentle downward traction during this delivery?

MR. GRAHAM: Objection, Your Honor. Leading.

THE COURT: I'll overrule the objection.

A Because that's what I do in all my deliveries. I've done over 3,000 deliveries in my lifetime and, you know, I do them pretty much all the same.

Q How many times have you ever used excessive traction in a delivery?

A None, that I know of.

Q Did you do it in this case?

A No.

Q How many other shoulder dystocias have you encountered throughout your practice, that you can recall?

A About five or six.

Q And tell us how you -- did you resolve those shoulder dystocias?

A Yes.

Q Okay. How did you do it?

A Generally, all of them resolved with McRoberts and suprapubic pressure.

Q And how many times have you had to use a rotational maneuver?

A I don't think I've ever had to use a rotational maneuver.

Q Does that mean you don't know how to use -- do one?

A No, ma'am.

Q Tell us about that.
A We -- like, in residency we've been instructed in the proper performance of Rubin's and Woods and posterior arm. We study it in our textbooks. There's also review articles that come out and update precise, those kind of things, that go over this.
Q You've been sitting here as well as everybody else for the past several days. There's been testimony about your knowledge and experience. My question to you is, Dr. Goldstein, do you have the knowledge and experience to manage the obstetrical emergency of a shoulder dystocia?
A Yes, ma'am.
Q Did you do that in this case?
A Yes, ma'am.
Q And how long did it take to deliver the baby?
A About, less than five minutes.
Q Let's walk through, now, the delivery. We've gone through the prenatal care and treatment that you provided to Ms. Fulton. Now, I'd like to move to the delivery and I've got a blow-up of your history and physical. Just one second and I will get that for you. Let's pull it up. Doesn't look like we have a blow-up of it right here, but let's pull it up on the screen and doctor, we will now be moving to the hospital chart that's in evidence. Back when I asked you if you had the

knowledge and the experience how to handle the obstetrical emergency of a shoulder dystocia, what was your answer?

A Yes, ma'am.

Q Is that your opinion to a reasonable degree of medical certainty?

A Yes, ma'am.

Q Now, let's move on to the actual delivery. Looking at the history and physical and it's page 22 and 23.

A Is that on the hospital record?

Q Yes, it looks like it was on the hospital record. Let me see if I ---

A No, it's not on mine.

Q All right. Well, they are pulling up the H and P. What number is it? Oh, excuse me. I'm sorry. It's your record. I told you to go to the hospital records. Actually, do you, as the delivering physician, does the hospital send you the records of the delivery?

A Yes, ma'am.

Q Okay. Do you keep those in ---

A Yes.

Q --- the chart of your patient?

A Yeah. I have it.

Q Let's go back. Sorry about that If you want the hospital record, it's here, but we think we can, do it

all through your chart.

A It'll be easier.

Q All right. Just let me know when you're there.

A I'm there.

Q Okay. All right. Let's start from the beginning. It looks like the date of admission is August 20th, 2009. Is that correct?

A That's correct.

Q What was the purpose of the admission to the hospital?

A Admitted for induction.

Q All right. Tell us about the present illness and it's going to be blown up on the screen.

A Simply read it or ---

Q Yeah, let's first read it so that we all know exactly what you documented and then we'll ask you some questions.

A Ms. Fulton is 38 years old ---

Q Speak up please, doctor.

A Ms. Fulton is 38 years old, AAF G2, P1, 001. That means she's been pregnant twice, she's delivered a full-term once, she's had no pre-terms and no miscarriages or abortions and one living child.

Q All right. Please continue.

A LMP, last menstrual period November 6th, 2008, making EDC by dates August 13th, 2009. Ultrasound gave an EDC

of August 16th. That's a mistake. It should have been September the 16th.

Q Okay.

A ETA by ultrasound is 36 weeks. She admitted at this time for induction of labor secondary to gestational diabetes and pre-term labor with cervix dilated to five, 75 percent effaced. Five centimeters dilated, 75 percent effaced.

Q Doctor, let me stop you right there. So, is this history and physical, is the five centimeters dilated, is that consistent with your office note that we've already gone through?

A Yes, ma'am.

Q Okay. All right. Please continue. She has repeated complaints of...

A She has been to McLeod a number of times complaining of contractions, most recently on August the 18th, where she was evaluated for regular uterine contractions. Most recently when she -- her cervix did not progress beyond five centimeter, dilated state. She has had repeated complaints of pelvic pressure, pelvic pain, et cetera. She has other problems with type two diabetes mellitus. Initially, on her first exam she had a history of being diabetic and, and was being treated with Glucotrol XL 2.5.

Q What is that? Is that the diabetic ---
A Yeah.
Q Sir?
A That is. Glucotrol is Glipizide with Metformin.
Q Okay. For what condition?
A For her diabetes.
Q Okay.
A However, her random blood sugar at that time was 216 and hemoglobin A1C on admission was 8.1. Patient was instructed on four-times-a-day blood sugar monitoring and eventually we switched her over to dosing with NPH insulin 20 units twice a day.
Q Did she do that? Did she do the blood sugar monitoring as you suggested?
A Yes.
Q Okay.
A She was very, very good with that.
Q Okay.
A Her two-hour postprandials have been less than 130.
Q What does that mean, postprandials?
A That's the blood sugars that we check after breakfast, lunch and dinner.
Q All right.
A After meals.
Q Finish this up?

A Yeah. She's thought to have PTO-type pitcher. She also has a history of diverticular disease and kidney infection in the past. In March of 2008, she was hospitalized at Lake City diagnosed with diverticular disease.

Q Okay. So, that's the present illness. Whose document is this? Who dictated this note?

A I did.

Q And then you have allergies and then let's not go through everything. This is a very detailed note so under allergies, what's the next? It says -- what's the next big topic?

A Well, about her past history and then pertinent physical findings, pelvic five centimeters, 50 percent minus two. Membranes were artificially ruptured. Scalp electrode placed. Pit is running and uterine contractions about every three to four minutes.

Q All right. Why do you put a fetal electrode, the scalp electrode on the baby? Why do you do that?

A Because it maintains the baby's fetal heart tracing a lot better than the ultrasound external monitor because, you know, when the uterine contracts, when the baby moves, it moves the heart rate off the signal so with the scalp electrode which is just a little, a little wire in a screw-type fashion, we screw that into the

baby's scalp and it records their fetal heart rate tracing more effectively.

Q Is that internal of external?

A It's internal.

Q And externally, where is the fetal monitor?

A Externally, there's a contraction monitor which is more towards the fundus of the uterus and then there's a fetal heart tone monitor which is an ultrasound monitor and it's more where the baby's heartbeat is best picked up on the mother's abdomen and generally that's over the back.

Q Okay. And then if we go to the second page of your history and physical, and again we're not going to go through all of this detail, but at the top it looks like cardiovascular abdomen extremities pelvic and then you do a full assessment. There are nine points to your assessment. Is that correct?

A I guess, yeah.

Q Okay. And down at the bottom that's your -- you dictated this and then is that your signature, your electronic signature?

A No.

Q Okay.

A That's where my signature should be but, you know, the ones we send to the office I don't sign them. I do sign

them when I read them.

Q Does this appear to be an accurate history and physical of Ms. Fulton when she came in to deliver her baby on August 20th, 2009?

A Yes, ma'am.

Q These were the findings based on your evaluation of her at that time?

A Yes, ma'am.

Q All right. Now, let's walk through, I want to go through the delivery and so let's start with going through the nurses' notes and then we're going to go through your handwritten notes and we're going to go through your dictated notes, but first of all, explain to us what the nurses are documenting during a delivery.

A Well, let me have an example of what page we're talking about.

Q Sure. If you look at the nursing notes, and this is in the hospital chart, looking at page, starting at page 155. Just generally, if you can tell, tell us -- explain the nurse's document throughout labor and delivery.

A Well, the one I'm looking at is -- did you say 1...

Q 155.

A Okay. Okay. Yeah, these are actually postpartum notes.

Q Okay.

A The mother's already delivered.

Q All right. I don't want postpartum. I want the notes from during the delivery.
A Uh-huh.
Q And I want to start -- the first note from the delivery from the nurse was at six o'clock when the Pitocin was started.
A Do you have a page reference?
Q Yeah, I'm going to look for that. I'll let them look for that. If you'd look for that for me while we keep moving.
A This is, kind of, what I was looking through before when we flipped through earlier or when I flipped through earlier.
Q So, let's start with page 140.
A Uh-huh. There you go.
Q All right. Are we on the right page now?
A Yes.
Q All right. Let's just back up ---
A This is a labor progress chart so this is while she's in labor. This is what the nurses are recording while she's in labor.
Q And that's my question. Is that common? Is that -- do the nurses document ---
A Yes.
Q --- during labor and delivery? Okay.

A So, their first note was, like, at 6:15.
Q All right. So, at 6:15, what's going on?
A Well, there are two sides to this, but their first note was, admitted to unit for induction. Consents explained and signed. Admission paperwork done. IV started times, one attempt.
Q Let's -- let's highlight that right there. On the first line it says admitted to unit for induction. Consents explained and signed. What, what consent is that referencing?
A I imagine that's the standard consent.
Q Okay. Consent for what?
A Consent for delivery.
Q Okay. So, based on these nursing notes, was Pitocin started?
A Let's see. They started her IV. It was infusing well.
Q Let's talk about Pitocin.
A All right.
Q What is Pitocin?
A It's oxytocin. It's a hormone that's secreted by the posterior pituitary, I think it is, and it helps the milk let down and helps stimulate uterine contractions.
Q In this case for Ms. Fulton, do you have an opinion whether it was appropriate to give her Pitocin to start her labor?

A Yes.
Q And what is that opinion?
A That it was appropriate. We did an amniotomy and we also added dilute Pitocin to her IV fluids. This is given with a pump and it's very regulated and generally we start out at one or two milliunits per minute and gradually increase it to, until we get a good adequate contraction pattern.
Q Okay. At any point during the delivery, did you actually reduce the Pitocin?
A I did and I think that was -- let me see. I'm looking in the nurse's notes here. Oh, yeah, here it is. 11:50, Dr. Goldstein at bedside. Vaginal exam. Eight, 100 percent, minus one, pit decreased to 10 milliunits, straight cath, 450 CCs of urine.
Q Okay. Hold on. That's a lot of information. When you say that pit is decreased, what does that mean?
A Well, basically, I mean, I looked at her tracing and she was having a little bit more than -- you know, she was having more frequent contractions than we like to see and there was a slight change in the, what we call the beat to beat variability of the baby's heart rate, so you have long term variability and you have short term variability, you know, so, you know, if you can imagine an EKG going across the page, you know, if the -- the

QRS complex, kind of, comes down like that then, you know, that would be decreasing their beat to beat variability. So, I mean, she wasn't having decelerations but she had, you know, these subtle changes so we felt like, you know, I think she was at 16 milliunits then, you know, so we decreased her Pitocin and slowed the contractions down and I think her, the fetal heart tracing improved.

Q Were you monitoring the Pitocin?

A Yes.

Q How about the nurses? Did they assist in the monitoring of the Pitocin?

A Yes, and they let us know if something doesn't seem to be going right with the Pitocin.

Q Did that happen in this case?

A I think I noticed it. I mean, you know, but, you know, if the baby's having variable decelerations or late decelerations, which are long term decels then, you know, the nurses are supposed to turn the pit off.

THE COURT: Counsel approach the bench.

(Bench Conference off the record)

THE COURT: Madam Forelady, ladies and gentlemen of the jury, y'all have worked hard today. Y'all have paid very close attention. Thank you for that. We're going to recess for the evening. Once again, do not do any independent

investigation and do not discuss the case amongst yourselves or with anyone else. We'll see you bright and early at nine o'clock in the morning. Nine o'clock sharp here. Nine o'clock sharp. Everyone remain seated as the jury exits the courtroom.

(Jury out at 5:59 PM)

THE COURT: Anything from the Plaintiff before we recess for the evening?

MR. GRAHAM: None, but we would just ask that you admonish Dr. Goldstein that he's not supposed to talk with anyone about his ---

THE COURT: I will. Have y'all gotten the medical records straight yet? Now would probably be a good time to do that. I know y'all are tired, but I think now is the time to do that. You can't take them out of the courtroom, so I'll let y'all do that. Ms. Rodriguez, it might be a good idea for you to do that and you can check behind her tonight or check in the morning.

MS. GANES: I'd like to check in the morning, Your Honor. I think the biggest problem was the pen that she had to redact it. It's not her fault, but it just wasn't the same redaction ink that had been used on the others and you could read through it, and then there were ones that weren't redacted at all.

THE COURT: Anything from the Defense?

MS. Craig: No, sir, Your Honor.

THE COURT: All right. We'll stand at ease until nine o'clock in the morning. Nine o'clock sharp.

MR. GRAHAM: Could you admonish him not to talk ---

THE COURT: I will.

MR. GRAHAM: Oh, thank you.

THE COURT: Very good. Under the rules of the Court, you can't discuss the case with any of the lawyers, Mr. Graham, nor any of the team of defense lawyers. You can't talk to them about it while you're still on the stand.

DR. GOLDSTEIN: Okay.

THE COURT: Okay? Does that sound fair enough?

DR. GOLDSTEIN: That's fair enough.

THE COURT: All right. We'll see you at nine o'clock in the morning.

MAY 7, 2015 - MORNING

THE COURT: Good morning, everybody. Please be seated. Anything from the Plaintiff before we proceed?

MR. GRAHAM: Yes, sir, Your Honor, I thought now might be an opportune time for me to mention that in the event we need to do any impeachment of Dr. Goldstein with his deposition we would ask Your Honor's indulgence to be allowed to do that with video clips. They are, they are critically important to our case because they show Dr. Goldstein's demeanor. They show his body language. They show his facial expressions.

They show lengthy pauses between the answers and a number of things that really affect the credibility and we've gone to a lot of expense to do that and we believe, we would ask Your Honor to allow us to do that.

THE COURT: Let's hear from ---

MR. GRAHAM: We've got them ready to do it.

THE COURT: Let's hear from the Defense with regard to that.

MS. CRAIG: Thank you, Your Honor. Good morning.

THE COURT: Good morning.

MS. CRAIG: With regard to the video clips, I anticipate what we're going to have are little snippets that are taken out of context or the same sound bites that he tried to use with Dr. Gomez-Carrion, and so they're going to be out of context and I would object because I think it's easier and quicker just to use the deposition like we've been using it in the written form, but if he's going to be going through video clips we would ask that we stop, we review it, and I have an opportunity if he's going to show a video clip that it be put in context. It's not a sound bite. It's not one line out of an answer and that's what those little clips were with Dr. Gomez-Carrion, so I ask that we stop it and do that and make sure it's in context so -- because otherwise I can't undo the harm that that taking something out of context like that would do. It would be extremely prejudicial to the

defense.

MR. GRAHAM: Your Honor, this is cross examination we're talking about. They tried to impeach our folks by pulling snippets out of context out of the deposition. They just, they want to prejudice us by not allowing the jury to see the demeanor and body language and pauses that are so significant.

THE COURT: What about just playing the whole video? How long is it?

MR. GRAHAM: Oh, it's very long.

MS. CRAIG: Oh, my word, it was eight hours.

MR. GRAHAM: A lot ---

THE COURT: Oh.

MR. GRAHAM: A lot of it ---

MS. CRAIG: It was excruciating.

MR. GRAHAM: A lot of it -- I mean, we've got it -- we've got it culled down to clips that we can play.

THE COURT: Well, we don't need to address that now. The jury is here ready to go.

MR. GRAHAM: Yes, sir.

THE COURT: We're going to -- we'll talk about that later. We're ready for the jury.

MS. CRAIG: Would you like Dr. Goldstein to take the stand?

THE COURT: Yes.

(Jury in at 9:06 AM)

THE COURT: Madam Forelady, ladies and gentlemen of the jury, everybody looks well rested and happy to be here. Thank you for being here and being here on time. We're going to proceed forward with the testimony of Dr. Goldstein. Dr. Goldstein, good morning.

DR. GOLDSTEIN: Good morning.

THE COURT: I want to remind you that you're still under oath. Very good. Yes, ma'am.

MS. CRAIG: Thank you, Your Honor.

THE COURT: Ms. Craig.

CONTINUED DIRECT EXAMINATION

BY MS. CRAIG:

Q Good morning, Dr. Goldstein.

A Morning.

Q Did you get some rest last night?

A A little.

Q Okay. All right. Let's finish up with yesterday before we broke for the evening. We had gone through all of the prenatal visits, 19 prenatal visits that Ms. Fulton had with you, so now where we are at the actual delivery. Okay? We're not going to go back through that. All right. Now, I was asking about -- we had just started the nurses' notes and Brian will pull that up on the screen, but you have -- let me show you. It's in the

mother's chart. It's page 140.

MS. CRAIG: May I approach, Your Honor?

THE COURT: Yes.

MS. CRAIG: Thank you.

Q There you go. All right. So, you're at 140?

A Well, I think it's out of order here but ...

Q Here. I'll give you my copy. Here you go, doctor.

A Here it is.

Q Okay.

A It's on the back.

Q Yeah, we were trying to save some paper, so front and back. All right. Dr. Goldstein, first, let's identify what we have into evidence which is out of Ms. Fulton's chart. Whose chart is this? Who keeps this chart?

A This is the hospital chart.

Q Okay. Tell us whose handwriting is on this document.

A That's the nurse's handwriting. I can't read the signature but I assume it's ...

Q Well, that's, and that's my question. We'll get to the nurses that are involved in the delivery, but who -- in just general, who documents a labor progress chart?

A That would be the nurses.

Q Okay. And in the context of the delivery?

A We also have a progress chart that we keep on the patient during delivery.

Q All right. When you say "we" who are you talking about?
A The physicians.
Q Okay. The doctors.
A Yeah.
Q We're going to go through that, but right now we're going to go through what the nurses documented. Tell me, when is this nursing documentation done?
A At the time that the event occurs.
Q Okay. Contemporaneous with the care?
A Contemporaneous with the care.
Q Do you document anything in the labor progress chart that we have up on the screen?
A The nurses' progress, no.
Q All right. So, let's go through the nurses' notes. We'll start at the very first one. It's a little difficult to read so just let us know if you have any trouble. There's that first one and it says admitted to unit for induction. Consents explained and signed. Admission paperwork done. IV started. What does that say? One or two attempts ---
A One time, two attempts.
Q Okay. Infusing -- what else does that say?
A With number 18 jelco. That's the size of the needle that they use.
Q Okay. That's at six o'clock, and who started the

Pitocin?

A The nurses did.

Q All right. And we talked about Pitocin, but one more question on Pitocin. How often, in your experience, do doctors use Pitocin to start a mama's labor?

A Ninety percent of the time.

Q Was it appropriate to use Pitocin?

A Yes.

Q All right. Let's go to the next entry that the nurses have. I believe it's at 6:20 and this is bright and early in the morning. Right?

A Yeah.

Q 6:20 AM?

A Yes.

Q Okay. Why was penicillin given via IV?

A Ms. Fulton was group B strep positive.

Q What does that mean?

A That means we did a culture of her vagina and there was a colonization of group B strep, so we prophylactically give penicillin during labor to those that are not penicillin-allergic to prevent the possible infection of the fetus when he passes through the birth canal.

Q Who issues that order? Who gives the order for the penicillin?

A I do.

Q Is that ---
A The physician does.
Q Is that reasonable?
A That's reasonable.
Q Okay. After you gave the order for the penicillin course, nurses gave the penicillin. Right?
A Correct.
Q All right. Now, let's look at the next entry by the nurses. I think it's 6:55 a.m. It says BS 80. What does that mean?
A Blood sugar 80.
Q Okay. What are you checking here?
A We're checking her blood sugars to make sure that she doesn't have a real deviation in her blood sugars, that she's not either hypoglycemic or hyperglycemic.
Q Okay. And the next ---
A This is ---
Q --- documentation from the nurses is 7:18. It says Dr. Goldstein AROM. What does that mean?
A Artificial rupture of membranes.
Q What does that mean in terms of where were you physically at 7:18 AM?
A I was at the bedside.
Q Is the first time you saw Ms. Fulton for this delivery when it was time to push?

A No. I saw her throughout the morning.
Q So, at 7:18 -- and just quickly, what does it mean to rupture the membranes? What does that mean?
A That means that we break her bag of waters and this also helps stimulate her labor.
Q Now, it also says the fetal scalp electrode is attempted. Is that correct?
A Yes.
Q I think we might have talked about this yesterday. What's the purpose of that?
A That's an electrode that we apply to the baby's scalp and it enables us to monitor the baby's heart rate much better than an external monitor.
Q All right. Next time that the nurses document is at -- about 20 minutes later, 30 minutes later, 7:50.
A Yes.
Q It says Dr. Goldstein at bedside. What does that mean?
A That means I was there checking the patient and at 7:18 I attempted a fetal scalp electrode, but was not successful and then I came back later and applied it.
Q Next documentation is 8:32. It states test dosed for epidural. What's going on now?
A The anesthesiologists are there and they've placed the epidural catheter and they give a test does first to make sure that the catheter is not in the subarachnoid

space and, you know, if they gave too much of a dose and it was a spinal instead of an epidural, then they get complete paralysis so they do a test dose initially.

Q All right. And that was done by whom?

A I can't read the signature, but I did -- it's the nurse's note, but she's noting that the anesthesia department placed the epidural and gave the test dose.

Q Okay. All right. Moving down our delivery time line. The next notation from our nurses is, it says VE. What does that mean?

A Vaginal exam.

Q Okay. And in a vaginal exam you are checking on how far the mama's dilated?

A Yes.

Q Okay. And what is documented?

A She's six centimeters, 80 percent effaced, minus two station.

Q Is the delivery progressing?

A The labor is progressing.

Q Thank you. All right. Five minutes later the nurses document 10:45 penicillin given via IV. Why is that being done?

A I don't see that, but I guess that's the second dose of penicillin.

Q Okay. And that was group B strep positive?

A Right.
Q Next time -- next documentation looks like 11 o'clock FSBS 67. What does that mean?
A Finger stick blood sugar is 67.
Q Why are you monitoring her blood sugar so carefully during this labor?
A She has diabetes, insulin-dependent diabetes, and we hold the dose of insulin on the morning of labor and we're monitoring here blood sugars to make sure her blood sugars are within optimal limits.
Q All right. Next, it looks like 20 minutes later. The nurses document at 11:20. What is documented here?
A I think that the next notation is Dr. Goldstein at bedside, vaginal exam, 800 percent minus one. Pitocin decreased to 10 milliunits. Straight catheter for 150 ccs of urine.
Q All right. Who is at bedside?
A Dr. Goldstein.
Q Next notation that the nurses make is 10 minutes later. What's going on now?
A Dr. Goldstein here, strip viewed, vaginal exam, 800 percent, zero station.
Q First of all, who reviewed the fetal monitor strip ---
A I did.
Q --- based on this note?

A I guess me and the nurse together.
Q Is that what you usually do ---
A Right.
Q --- during the ---
A Yeah.
Q --- labor? And then tell us what significance it is with regard to the vaginal exam, your findings there.
A Well, she's still eight centimeters. She's 100 percent effaced, but she's coming down through the pelvis. She's now at a zero station. That's the head at the level of the ischial spine and the pelvis.
Q Okay. Ten minutes later what did the nurses document? The next ---
A Straight cath for 120 ccs. Fetal heart rate 140 with spontaneous accels. Peri care done. Vaginal exam complete, 100 percent plus two. Oh, I'm sorry. I skipped down too far.
Q Yeah, I think you missed one.
A Yeah.
Q Let's go back up to the one before it.
A 12:05?
Q Yes, sir.
A Dr. Goldstein here. Strip reviewed. Vaginal exam, eight, 100, zero station.
Q What time based on the notes was Ms. Fulton complete?

A Based on the notes she was complete, I think that's 13:05.
Q And what does it mean to be complete?
A She's completely dilated, completely effaced, plus two station.
Q And when a pregnant woman is completely dilated, it's time to do what?
A Time to begin pushing.
Q Now, when it was time to push who was in the -- what other medical professionals were in the room with you?
A Pushing. The next note says pushing with patient, family at bedside, Stephanie Collins.
Q Okay. And who's Stephanie Collins?
A She's the nurse that was in charge of that patient that day.
Q And do you have the pleasure of working with Nurse Collins from time to time?
A I do.
Q She's a labor and delivery nurse?
A Yes. She's a labor and delivery nurse.
Q All right. Let's go through. It appears, then, that the nurses next document is at 13:40. What time is that?
A That's 1:40 PM.
Q All right. So, we're at 1:40 PM and what is, what's, please tell us what the nurse is documenting.

A Dr. Goldstein at bedside, vaginal exam, plus three station. Patient placed in stirrups. Perineum prepped and patient draped. Newborn nursery present. Stephanie Collins.

Q Okay. Then at 13:44 what does the -- so what's going on at 13:44? That's 1:44 in the afternoon, Right?

A Yeah, 1:44.

Q So, we're at 1:44 p.m. What's documented in the note here?

A I think that says Mityvac placed here, Dr. Goldstein, with contractions. Pressure 250 centimeters, murphy pressure times 30 second, head delivered with two pulls. Shoulder dystocia recognized. Rebecca Lawrimore, RN, on stool on patient's left. I'm sorry. I just can't...

Q That looks like writer.

A Yeah. Left writer. I'm not sure what that means.

Q Okay. Keep going.

A On stool on patient's right side. Episiotomy per MD. McRoberts maneuver performed. Episiotomy extended per MD. Suprapubic performed per Rebecca Lawrimore. Dr. Coker called to delivery. Delivery of infant post suprapubic pressure per MD at 13:49. Anesthesiologist present to assist newborn nursery. Stephanie Collins.

Q Okay. Doctor, let's -- now, I need you to speak up a little bit. Is this your first time in a witness chair?

A Yes, ma'am.
Q Okay. So, you need to speak up so that we can hear you. This is an important note and I want to go through it with you. Who documented and who, based on our review of these records, who wrote this note?
A It says S-C at the end, so I assume that's Stephanie Collins.
Q Okay. All right. In those notes it says that -- I want you to explain what is documented contemporaneous with the delivery. Okay? So, I want you to explain that first, that first sentence. It says something is placed per Dr. Goldstein. What is that?
A I think that's mother or mom placed per Dr. Goldstein with ---
Q Okay. And then what do you ---
A Oh, no, no. I think that was the Mityvac.
Q All right. Let's talk about -- okay. What is the Mityvac?
A That's a type of vacuum extractor.
Q Okay. Why did you use the vacuum to help deliver Ms. Fulton's baby?
A She was not -- she had an epidural and the head was at a plus three station and basically we used it as an outlet instead of forceps to help the baby over the perineum.
Q What does it mean when a baby is at a plus three

station?

A The baby's right at the -- the head is at the vaginal introitus so that you can see the head.

Q When a baby is at a plus three station, is it reasonable to use a vacuum?

A Yes.

Q Did you have any problems using the vacuum to help deliver the baby?

A No.

Q Was there any harm to the baby based on your use of the vacuum?

A No.

Q All right. That's it on the vacuum. Let's move now to the, to the second line here. It says; head delivered at two pulls and then right here it says shoulder dystocia recognized. Correct?

A Correct.

Q Dr. Goldstein, did you and the nurses involved in this delivery know exactly what you were confronted with as documented by the nurse?

A Yes, ma'am.

Q And when you were confronted with a shoulder dystocia, were you confident in your previous experience working with the nurses that they knew what to do?

A Yes.

Q And did you and the nurses, as a team, do everything that you could to help relieve the shoulder dystocia and dislodge the shoulder?

A Yes, ma'am. You know, they -- I mean, you know, routinely we'll start out with McRoberts, you know, when a problem occurs like this so they pretty much grab the legs and flex the legs, hyperflex the legs and abduct the thighs for McRoberts so that was, that was one of the first things they did.

Q Did those nurses do a good job?

A They did an excellent job.

Q All right. After shoulder dystocia was recognized, it says Rebecca Lawrimore, RN -- who is that?

A That's one of the other labor and delivery nurses.

Q How many labor and delivery nurses do we have in the, in the, helping with the delivery?

A Well, there were at least two.

Q Okay. So, we have Nurse Lawrimore and she's on a, it says, a stool.

A Right.

Q Where?

A It says on patient's left. Stool on patient's left.

Q Okay. Now, why would Ms., Nurse Lawrimore be on a stool?

A Oh, I'm sorry. Lawrimore, RN, on stool on patient's left and then there's slash writer. I'm not sure what that is

on stool on patient's right side.

Q Okay. And we'll have the nurses look at -- she'll read her handwriting later, but what I want you to explain is why would the nurses need to get on a stool once you and the nurses recognized this medical emergency?

A To apply -- they keep a stool in most delivery rooms in order to get elevation so that they can apply suprapubic pressure.

Q Was that the appropriate thing to do?

A Yes.

Q All right. So, the nurses are applying suprapubic pressure and then it says episiotomy per MD. Right?

A Yeah.

Q That's hard to see up there.

A Yeah.

Q But right there ---

A They kind of jam it together.

Q --- highlighted. Okay. What's going on here? Who's doing this episiotomy, per MD?

A That would be me.

Q And why are you doing that?

A To get more room to attempt the rotational maneuvers.

Q All right. Then the nurses say McRoberts maneuver performed.

A Right.

Q Did that happen?
A Yes.
Q Based upon your notes, the nurses' notes that you reviewed, do you have an opinion whether McRoberts was used before Dr. Coker came into the labor and delivery room?
A Yes, the McRoberts maneuver was the first thing we, we did.
Q Is this a medical demonstration, a medical illustration showing the McRoberts that you and the nurses did after the shoulder dystocia was recognized?
A That's actually showing McRoberts plus suprapubic pressure.
Q Okay. So, let me change my question as to both. Is this a medical illustration that shows the McRoberts and the suprapubic pressure that you and the nurses were doing prior to Dr. Coker coming into the labor and delivery room?
A Right. Yes. I think Ms. Collins, I mean, Rebecca Lawrimore ---
Q Speak up.
A --- Rebecca Lawrimore was doing the suprapubic pressure and I assume Stephanie was holding one leg and somebody else was holding the other leg for the McRoberts.
Q And when you describe the legs, what are you describing

or what is that maneuver? When you said holding the legs, what is that called?

A The legs are hyperflexed and abducted, so the knees go up towards the -- I mean, towards the shoulders.

Q Yes, sir.

A And they're extended out as much as they can go.

Q And what is that maneuver called?

A McRoberts.

COURT REPORTER: Could you identify that exhibit please?

MS. CRAIG: Yes, ma'am. Court's, madam clerk, it is #13.

Q All right. So, after McRoberts maneuver is performed, why did you extend the episiotomy a second time?

A To get more room, basically.

Q And then suprapubic is performed per Rebecca Lawrimore?

A Correct.

Q Doctor ---

A And I think at that point, you know, we dropped the table down as far as we could get it to go. Usually when I do a delivery, I bring the table up as high as I can because I usually stand when I do my deliveries but, you know, with the table up high she wasn't able to give effective suprapubic pressure so we dropped the table down as low as we could for her to be able to apply suprapubic pressure.

Q Okay. I'm glad you brought that up. So, tell us, when

you say that you dropped the bed down or you lowered the bed, what part of the bed was lowered? Thank you.

A The whole bed. It's an electric bed so it goes up and down and it, you know ---

Q Okay. So I'm going to ---

A --- we lowered the bed towards the floor.

Q Tell me about how far the bed went down. Just estimate, about how far did you put that bed?

A Well, usually ---

Q Do you want to stand up and just show us just so we have an idea?

A (Complies) Usually, you know, we have the bed about there, you know, parallel to the floor and then so it'll go down to about there.

Q Okay. So, this is where the bed is. This is where Ms. Fulton's body is.

A Right.

Q Okay. Thank you. All right. Given that the bed was that far down to help with the suprapubic pressure, what was your positioning at, at the bottom of the bed to try to help deliver the baby?

A Well, at that point, I mean, since the bed was so low and I'm kind of tall, so I had to kind of get down on my knees to apply pressure in the axial ---

Q What is odd or strange to you about having to get down

on your knees when the bed is low to help deliver a baby?

MR. GRAHAM: Objection, Your Honor. I've been holding back, but I object to the leading.

THE COURT: I don't think that's a leading question. What is odd about -- repeat the question.

MS. CRAIG: What is odd or strange about you having to get on your knees to deliver a baby when the bed is ---

THE COURT: Certainly not a leading question. I think that's an appropriate question.

A Well, it's -- I mean, it's not the usual thing that we do because normally, you know, in a delivery, a normal delivery, I have the bed up and, you know, I can stand there and deliver the baby at arm level, but with the bed down so that Ms. Lawrimore could apply suprapubic pressure, I had to get down closer to the floor to manipulate the baby to effect delivery.

Q Okay. Thank you. All right. Let's keep going. We're almost through with the nurses' notes. It says Dr. Coker called to delivery. Is that accurate?

A Let me get to the back of my page.

Q Sure. We've got it, actually, you can come see this part up here, Dr. Goldstein.

A Let me look here.

Q Okay.

A All right. Let's see. We're in that same note. Episiotomy. Dr. Coker called to delivery. Delivery of infant post suprapubic pressure per MD at 13:49.

Q Okay. Let's stop right there. What does this note say occurred after Dr. Coker came in?

A Dr. Coker came in, he assessed the situation. I think he examined, I mean, visually examined the patient and then he got up on the stool. We raised the bed back up and he applied suprapubic pressure that manipulated the shoulders under the pubic symphysis and the shoulders delivered.

Q And where were you, physically, when Dr. Coker was at bedside at the side of Ms. Fulton? Where were you?

A I was between the patient's legs delivering the baby.

Q When Dr. Coker came in, did he take over the delivery?

A No, he assessed what the problem was. We discussed what the problem was. He looked at the patient and, you know, said let's try suprapubic pressure so he was more -- he's a tall guy and he was better able, capable of applying suprapubic pressure and when he applied suprapubic pressure, then the anterior shoulder came under the pubic symphysis and the shoulders delivered, the baby delivered.

Q So, who was in the team of medical professionals that helped deliver this baby within four to five minutes

after the shoulder dystocia was recognized? Who were those individuals?

A Well, one of the first things, you know, when you have a shoulder dystocia is to call for adequate help and so one of the first things I did is tell one of the ancillary personnel there to go down to Dr. Coker's office or, you know, Dr. Phillips and Coker's office, because they're in the building, and to obtain more help for us but, you know, when we called this shoulder dystocia emergency then Dr. Phillips, the son of Dr. Phillips who is the anesthesiologist who was on call that day, came in. The newborn nursery nurses were already there and a lot of other personnel came into the room to assist in the delivery.

Q And as far as how many nurses, I'm talking labor and delivery nurses. How many labor and delivery nurses assisted you and Dr. Coker?

A Well, at least Rebecca Lawrimore and Stephanie Collins, but I'm not sure who else was in the room but the room was fairly crowded with personnel there.

Q Now, it says the baby was delivered at what time?

A 13:49.

Q What time is that?

A That would be 1:49 PM.

Q And where was the baby? Where did the baby go after the

delivery?

A After the delivery, the baby was fairly obtunded from the delivery and so once the cord was cut and clamped and cut, we handed the baby off to the pediatric staff. I'm not sure if one of the perinatologists or pediatricians were there, but I think Dr. Phillips was there and that's Dr. Phillips, the anesthesiologist, was there, and he intubated the baby so that they could effectively oxygenate or effectively breathe for the baby to help revive the baby.

Q Okay. Based on this labor progress chart, and we've gone through every single entry in here, based on these nursing notes which were documented at the time that the care was given, do you have an opinion whether you were monitoring, evaluating, and assessing Ms. Fulton throughout her delivery?

A Indeed, I was.

Q And is that your opinion to a reasonable degree of certainty, most probably?

A That's my opinion to a reasonable degree of medical certainty.

Q All right. Now, we've gone through the nurses' notes. Now, I want to go through your notes. Okay?

A Okay.

Q I've got another blow-up of your handwritten delivery

note and before I ask Your Honor if you can get off the stand and tell us, and read through your notes, explain to us why a doctor has a handwritten note from a delivery as well as -- just a minute. Tell me why a doctor has a handwritten note and a dictated delivery note.

A Well, I traditionally do both because the dictated note doesn't get to the chart until the dictation staff types it up and sends it out, so I traditionally dictate a note and then write a note as a summary note on the chart so that it's concurrent with the patient's hospitalization. The dictated note may not get to the chart for two or three days.

Q Is that a common practice?

A Well, it was back then. I mean, they're getting them there pretty quick now. It's within a day.

Q When you say they are getting them pretty quick now ---

A Well, back at that time they had a, a staff of typists, I guess, that would listen to the dictation that we gave and type them up and send them over in hard copy to the chart.

Q Okay. Is technology different now?

A Technology is different now. They've gone to computer charts and electronic medical records.

MS. CRAIG: Now, Your Honor, may Dr. Goldstein get off

the stand to review his handwritten note?

THE COURT: Yes, ma'am.

MS. CRAIG: Thank you.

Q All right. Dr. Goldstein, come on down and let's go through this. All right. So, I got you something really high tech last night, so you can stand right here so the court reporter can hear you and I want you to identify this document which, for the record, is "Mother 126" out of the mother's chart. All right. Now, tell us, first of all, identify what this document is.

A This looks like my delivery note. My see dictation note.

Q Okay. And we're going to go through the dictated note in just a minute, but whose signature is this at the bottom?

A That's mine.

Q Okay. And when do you write this, these handwritten notes? When is this written?

A Usually immediate, I mean, not immediately, but very shortly after the delivery.

Q Okay. I need you to just move back a little back. All right. Just tell us exactly -- and it's up on the screen as well. Tell us what you documented. Just start at the top.

A A complete, complete plus three. Epidural in place. Pushed well. Vacuum extractor with two pulls.

Q Okay. Hold on just a second. Now, we went through with the nurse's note on vacuum extractor. How many, how many pulls did the nurse's document?

A Two pulls.

Q How many pulls did you document?

A Two pulls.

Q Okay.

A And these pulls are, you know, we wait until the mother is having a contraction so that we can use the force of her pushing along with us pulling to effect delivery.

Q Okay. What is, what are these? What does this stand for, R-M-L-E?

A Right medial lateral episiotomy. That's -- traditionally we cut down to the right. This avoids fourth degree lacerations where the episiotomy -- you know, with a large head or something the episiotomy can extend into the rectum so that's a problem, so with the right medial lateral episiotomy, that doesn't occur.

Q Okay. Then what is 14:30? And again, speak up so everybody on our jury can hear you. You've got to speak up a little bit, so let's do this. Why don't we go over here so I can make sure everybody can hear you and they can also see it, so let's just walk over here and if you'll just tell us.

A On this?

Q Yeah, and speak up.
A Okay. Delivered head about 13:44. Shoulder dystocia. Nursing staff in place.
Q All right. I'm going to stop you right there. When the nurses document -- what time did the nurses document list the shoulder dystocia, based on their note?
A 13:44, I think.
Q What time did you document shoulder dystocia?
A 13:44.
Q Okay. All right. Now, so, it's nursing staff. Please continue.
A She had a nuchal cord and fortunately we were able to reduce the cord over the baby's head.
Q Okay. Now, I want you to stop right there and in your delivery note, I want you to explain the medical significance of where the nuchal cord was.
A The cord is looped around the baby's neck so, you know, sometimes these are tight nuchal cords and when they're tight then they, they compress the umbilical cord and that compresses the blood flow to the baby and reduces the baby's oxygenation during labor and during pushing.
Q Okay. And when you saw that the nuchal cord was wrapped around the baby's neck, what did you do?
A Well, fortunately, in this case, we were able to slip it over the head.

Q Okay. What I'm trying to find out is what does it mean when you say nuchal cord reduced.
A That means that we slipped the cord over the baby's head and reduced it from being around the baby's neck.
Q Okay. Got it. All right. Let's move on to the next portion.
A All right.
Q What does that say?
A Extended the episiotomy times two.
Q All right. What does that mean?
A That we extended the episiotomy or we made the episiotomy wider or deeper.
Q How many times, based on the nurses' note, was it documented that the episiotomy was extended?
A Twice.
Q Is that consistent with your note?
A Yes, ma'am.
Q Okay. Keep going, sir.
A Dr. Coker was called and assisted with suprapubic pressure. Head delivered at 13:49. Eight pound, six ounce male. Infant APGARs one, four, five. The APGAR at one minute was one, at five minutes was four, and I think the next one was five at ten minutes.
Q And what does that say about the baby's condition, that the APGAR score got higher?

A Well, the baby was improving with -- uh-oh.
Q I told you it was high tech.
A It is. I'll just use -- so the baby was being resuscitated by the pediatric staff and Dr. Phillips was assisting with the respirations and the baby and the baby was improving.
Q Okay.
A But the baby was obtunded -- you know, fairly obtunded when he delivered.
Q All right. So keep going. Tell us what else is in this note.
A Cord gasses sent and then down here at the bottom we have the poor pH at 7.19.
Q Okay. What does that mean?
A That shows that the pH was a little bit low. We like to see them above 7.2.
Q All right.
A So ---
Q All right. Stay right there, Dr. Goldstein. Now, we've mentioned your dictated delivery note. All right. And for the record, it looks like your delivery note is Goldstein 21. It's out of your chart. All right. So let's -- let's walk through again. Identify the document and the time, the date on the document.
A Let's see. The date is 8/20 at about 13:45.

Q Okay. And I'm going to -- excuse me. I'm going to go through each thing that you did on this date, so let's talk about the, what time was the delivery, by the way?

A I think we said the baby's head delivered at 13:49.

Q But at the top it says date of delivery, 8/20/2009 at about 13:45. Why is that?

A The date, on the date of delivery, I guesstimated the time.

Q Okay. All right. Let's walk through your dictated note. Starting at the top, what did you document?

A In review, the ---

Q Got to speak up, doctor.

A In review, the patient was admitted this morning for induction into labor at 36 weeks. Has gestational onset diabetes. She was admitted this morning. Cervix was about five centimeters but minus two, minus three. Membranes were artificially ruptured. She was given dilute Pitocin. Scalp electrode was placed. She progressed well through the active phase of labor before she gets to complete.

Q Okay.

A She progressed well through the active phase of labor. Epidural catheter was placed and dosed. She was eight, complete, minus one at 11:30 and complete, complete, plus one to plus two and pushing at 1 PM. She brought

the head down to plus two to plus three position. She pushed to the perineum and vacuum extractor was applied. We had two pulls on the vacuum extractor. Delivered the head about 13:45 and recognized that she had a shoulder dystocia with the right shoulder under the symphysis.

Q Okay. Let's stop right there. Now, the information that you've gone through so far on your dictated delivery note, is that, is that consistent with the documentation from the labor and progress chart from the nurses?

A Yes.

Q Is that consistent with your handwritten delivery note?

A Yes.

Q Okay. Keep -- continue please.

A It said she had a nuchal cord we reduced over the head. We tried the McRoberts maneuver. Prior to that, a generous right mediolateral episiotomy was cut. Suprapubic pressure was applied. The episiotomy was extended on two occasions.

Q Okay. Hold on just a second please. All right. So, in your dictated delivery note you say -- do you want to hold that for a second? You say we tried the McRoberts maneuver. Is that correct?

A That's correct.

Q When did you try the McRoberts maneuver?

A Shortly after the shoulder dystocia was recognized.

Q Was that before or after Dr. Coker came in?
A That was before.
Q Okay. And then I think you already talked about the generous right medial lateral episiotomy. Let's go to suprapubic pressure.
A Suprapubic pressure was applied.
Q Okay. When was suprapubic pressure applied?
A Probably after we applied -- after we did the McRoberts maneuver.
Q All right. Was suprapubic pressure applied before or after or/and after Dr. Coker arrived?
A Before and after.
Q All right. Please continue.
A The episiotomy was extended on two occasions. Next, it says Dr. Steve Coker was called to assist and Dr. Coker applied suprapubic pressure and with that pressure we effected delivery of the shoulder at 13:49. The baby had one cry. The pediatric staff was, was in attendance. The baby was floppy on delivery which means the baby didn't have a lot of tone.
Q Okay. What does that mean? If a baby does not have a lot of tone, what does that mean?
A It just means that the baby is obtunded from the delivery, you know.
Q All right. Keep going.

A Baby was floppy on delivery. Dr. Phillips was in attendance and intubated the baby. It was a viable male infant, eight pounds and six ounces. APGARs were one at one minute, four at five minutes, five at 10 minutes, seven at 15 minutes.

Q Okay. Let's go through and see the rest of it. I can pull the rest of it up for us.

A Cord blood was sent. Cord blood was sent for pH. The placenta sent to pathology. The right medial lateral episiotomy was repaired in multiple layers using 2/0 chromic and 3/0 chromic. Estimated blood loss is less than 400 milliliters. Patient tolerated delivery without problem.

Q Okay. Thank you, Dr. Goldstein. All right. So, hold on. So, after -- you did the handwritten delivery note and then you did the dictated delivery note. We just went through that. Correct?

A Yes.

Q What is a discharge note?

A When we send patients home from the hospital we frequently dictate a discharge summary.

Q Okay. And did you do that in this case?

A Yes.

Q Let's pull that up.

MS. CRAIG: And the discharge summary is Exhibit #9,

Brian.

Q All right, doctor, again let's go from the top and we're not going to go read the -- this is a long document. Is this actually two pages long?

A No, it's -- well, I think it's not a whole lot on the second page.

Q Okay.

A But it is two pages.

Q All right. So, identify the document at the top.

A Discharge Summary.

Q Okay. And who wrote the Discharge Summary?

A I dictated the Discharge Summary.

Q All right. Let's start from the top. What -- let's start with that first paragraph. What does it say?

A Dictated H and P and details of admission history and physical. Briefly, 38 years old. A-A-I, G2, P1, 001. That means she's been pregnant twice and delivered one previously. EDC by ultrasound 9/16.

Q What does EDC mean?

A Estimated date of confinement. That's the due date.

Q All right.

A I'm sorry. That's by her ultrasound, 9/16, but her date said 8/13.

Q All right.

A So, we relied on the ultrasound date. EGA ultrasound

estimated gestational age by ultrasound 36 weeks. She's had problems with gestational diabetes and pre-term labor since about 28 weeks. At 28 weeks she was admitted to McLeod, treated with Celestone and treated with Terbutaline and was maintained on Nifedipine until earlier this week. She has been to McLeod within the past 24 hours complaining of contractions. Cervix today in the office was five centimeters dilated and the head had come down and pressing on the cervix. She was therefore admitted for induction.

Q Okay. Is that note -- is that consistent with other documentation that we've already gone through?

A Yes, ma'am.

Q Next, you document the laboratory data on admission and without going through all of this, what's the importance of the hemoglobin and the hematocrit?

A Her -- I mean, this is okay. I mean, it's a little bit lower than we like to see but, you know, with pregnancy there's hemo dilution and so, you know, we weren't thinking about transfusing this lady but just watching her blood counts.

Q All right. And then so -- and who's watching those blood counts?

A That would be me.

Q All right. How about platelets? Were you watching those?

A Yes, and the platelets are important because, you know, if they have low platelet count then the anesthesiology department is reluctant to put an epidural in.

Q Who's the one that's ordering these tests and following this patient?

A Me.

Q All right. Let's go to hospital notes and again, this is a very detailed note. I'd like to direct your attention to a few lines down where it says when she was complete subsequently at 2:30 we effected delivery with a vacuum with about two pulls of vacuum, deliver the head, but there was shoulder dystocia so let's start right there after you recognize shoulder dystocia. Now, what does that say?

A This is a little behind there but this says she advanced through the active phase of labor about 11:20. She was eight, complete, minus one. She was having hyperstimulation. We cut back on the Pitocin level. The hyperstim resolved. Reactivity improved. About one p.m. she was pushing when she was complete, complete plus one. Subsequently, about 2:30 -- that's kind of a mistake on the time there.

Q Okay. Because we know based on the nurses' notes and your delivery note and the dictated delivery note, what time was the baby delivered?

A The shoulders delivered at 13:49.
Q That's military time. What's that regular time?
A 1:49 p.m.
Q Okay. Let's go to -- see where it says Dr. Coker, and Brian can pull up that sentence.
A Dr. Coker came and added suprapubic ---
Q Hold on just a second.
A Dr. Coker came and added suprapubic pressure to the already applied McRoberts maneuver and other measures in an attempt to get the anterior shoulder delivered under -- it says this pubis, but it should have been the pubis ---
Q Okay. Let's stop right there. It says Dr. Coker came and added suprapubic pressure to the already applied McRoberts maneuvers. What does that mean when you document already applied McRoberts maneuvers?
A That we'd already applied McRoberts to the patient before he got there.
Q Okay. And when you documented after the already applied McRoberts maneuvers, you documented other maneuvers. What did you mean when you documented other maneuvers?
A That would be suprapubic pressure and we attempted to get our hand in the birth canal to effect some of the rotational maneuvers, but were unable to do so because the head cheeks were pulled up against the perineum and

limited the room to place our hand in the vaginal ---

Q Okay. Doctor, that's an important point. Why don't you come back to the witness stand so we can make sure everybody can hear you.

MS. CRAIG: And let's keep this up please, Brian.

A Do I get to keep my stick or do you want that?

Q All right. You mentioned -- when I asked you what other maneuvers was or what you mean by that, you said about your hand and trying to do the maneuvers. I want you to explain in detail what happened when you tried to do the other maneuvers.

A Well, this is -- this wasn't just one point in time. I mean, while -- I mean, after we recognized that the patient had a shoulder dystocia, I think the first thing we did is McRoberts and then when we were not able to effect delivery with McRoberts alone, I think it was Rebecca that was asked to apply suprapubic pressure. We lowered the bed so she could apply suprapubic pressure more effectively and when the shoulder did not deliver, we -- we did an -- we had an episiotomy. We extended the episiotomy. I tried to get my hand into the birth canal to effect some of the rotational maneuvers and was unable to get my hand in, so ---

Q Why couldn't you get your hand in? Explain that to us.

A Well, with shoulder dystocia, you know, the shoulders

are stuck under, the anterior shoulder is stuck under the pubic symphysis and the posterior shoulder is wedged into the sacral promontory and frequently the head delivers, but it retracts back up against the perineum, the tissue surrounding the vagina, so this is a baby's head that's in the way so, you know, you're trying to work your hand in there but there was just no room to get my hand in there, so I extended the episiotomy and tried again and when that didn't, when I couldn't get my hand in again, I extended the episiotomy a second time and so this -- you know, the head delivered at 13:44 and I think the shoulders delivered at what, 13:49. While we were attempting these things I think we re-attempted, I mean, she was in McRoberts and we re-attempted suprapubic pressure with the nurses and in the interim Dr. Coker came down. I think he ran all the way from his office and he assessed the baby or he assessed the situation, took a look at the mom and where the baby's head was and he suggested that we try suprapubic pressure, so he got up on the stool and pushed on the suprapubic pressure region and was able to dislodge the baby's shoulder from behind the pubic symphysis.

Q Why were you, the nurses and Dr. Coker, why were you using McRoberts, using suprapubic pressure and attempting other maneuvers? Why were you doing all that?

A Trying to effect the delivery of the anterior shoulder or trying to resolve or take care of the shoulder dystocia, get the baby delivered. We wanted to deliver the baby before, you know, a prolonged period of time occurred because these babies, if they stay in the birth canal for a prolonged of time, they can get what's called hypoxic-ischemic encephalopathy which means brain damage due to lack of oxygen.

Q What else can happen to the baby?

A Babies can die.

Q Were you successful in delivering this baby?

A Yes, ma'am.

Q All right. You mentioned one thing I wanted to follow up about. When the baby's head was delivered you said it went back into the vagina.

A It retracted.

Q Retracted.

A Yeah.

Q That's what you said.

A Yeah. I mean ---

Q What -- what is that called?

A --- the head delivers, but the shoulders don't come under the pubic symphysis so the head retracts and this is known in obstetrics circles as the turtle sign.

Q All right. Just make sure I've got, that I've checked

off all of these. With regard to the vacuum, I've asked you some questions. What was concerning to you regarding the fetal heart tracing that you saw during the delivery?

A Well, during the late second stage she started having some variable decelerations, variables with late return, and then there was an episode in there when she had some bradycardia too, prolonged decelerations.

Q Is that why you used the vacuum?

A Well, one of the reasons.

Q We've gone through vacuum, Pitocin, the bed was down. Was all that reasonable?

A It was, yes.

Q Now, when Mr. Graham held up the baby doll, when we had the baby doll demonstration, and he was jerking the baby's head around and jerking the arms and the legs, is that what you did in this delivery?

A No, ma'am.

Q How do you know that you used downward gentle traction to deliver this baby?

MR. GRAHAM: Objection, Your Honor. Leading and assuming facts not in evidence.

THE COURT: That's not leading. It's an open-ended question by it's very nature and I think it's an appropriate question. He's an expert. He was there. I think it was an

appropriate question at this point.

Q So, Dr. Goldstein, how do you know that you used downward gentle traction?

A Because that's what I've used for all these 37 years that I've been practicing obstetrics.

Q And what did you do in this case? What kind of traction did you use, sir?

A Gentle downward axial traction.

Q And is that your opinion to a reasonable degree of medical certainty, most probably?

A Yes.

Q All right. We've gone through all the prenatal. We're wrapping up here. We've gone through all of the delivery. I believe that Ms. Fulton came to see you after the delivery for some postpartum visits. Correct?

A Yes.

Q Okay. So, the first one was approximately a week after the delivery.

A Right.

Q Who saw Ms. Fulton on the first postpartum visit?

A That would be me.

Q Okay. And how was she doing?

A Can I refer to my notes?

Q Of course.

A She was doing well.

Q I'd like for you to -- what date is that?
A Let's see. Well, I have it in my chart. I can find it.
Q I would like to get the ---
A That was on 9/1/09.
Q Okay. Great. 9/1/09. That's the first postpartum visit.
A Right.
Q And what did -- what did you and Ms. Fulton discuss regarding the delivery?
A As indicated on my notes or...
Q Well, is it your notes or your recollection, sir?
A We discussed the baby and the fact that the baby had had a shoulder dystocia. I noted in my note that the baby has no movement on the right arm secondary to brachial plexus injury. I also noted she was taking the baby to an orthopedic PT specialist, a physical therapy specialist, and is going to be seen there and I reminded her about exercises with the baby and said hopefully the baby will start moving the right arm soon, and then we discussed her diabetes and anemia, blood pressure and her episiotomy.
Q And what did you and Ms. Fulton discuss regarding the baby?
A About the shoulder dystocia and the injury to the right arm. We just discussed what was going on and what her plans were with the orthopedic physicians and the PT

specialist.

Q And did you, did you give her advice at this visit? Did you consult with her?

A Yes, ma'am.

Q And did you answer her questions?

A Yes, ma'am.

Q And what did Ms. Fulton say regarding the birth of the baby?

A She told me she was just happy that she had a live, healthy baby and thanked me for delivering her baby.

Q Okay. Dr. Goldstein, Ms. Fulton came back to you a second time. Now, this is for a six-week postpartum visit. Is that correct?

A Right.

Q And on this visit did you evaluate her?

A Yes, ma'am.

Q Did you answer her questions?

A Yes, ma'am.

Q Dr. Goldstein, did you provide appropriate and reasonable care to Ms. Fulton and her child?

A Yes, ma'am.

Q Do you care about your patients?

A Always.

Q Did you care and do you care about Ms. Fulton?

A Yes, ma'am. I hope for the very best for both of them.

Q Do you have the knowledge and the experience to deliver a baby when confronted with the medical emergency of shoulder dystocia?

A Yes, ma'am.

Q And based on that knowledge and that experience of 37 years, how long did it take you to deliver the baby after the shoulder dystocia was recognized?

A Five minutes or less.

Q And if you and Nurse Lawrimore, Nurse Collins, and Dr. Coker had been unable to dislodge the shoulder what could have happened to the baby?

A Well, one thing is the baby could have hypoxic-ischemic encephalopathy or brain injury. The other thing is fetal death.

Q Now, we did this yesterday, but I want to wrap everything up. Going back to the prenatal visits, based upon your review and your recollection of the 19 prenatal visits that Ms. Fulton had with you, what is your opinion as to whether you were carefully monitoring and following Ms. Fulton throughout her pregnancy?

A I was. She had more prenatal visits than most people, but she had more problems so we addressed those problems and took care of them. I thought we managed her diabetes very well. We addressed all of the issues.

Q And do you have an opinion whether you were carefully

monitoring and following her throughout her ---

A Oh, yes.

Q --- pregnancy?

A I was carefully monitoring her.

Q Now, moving to the delivery, based on the nursing notes, the, your handwritten note, your dictated delivery note, your discharge summary, do you have an opinion whether you were carefully monitoring, evaluating and taking care of Ms. Fulton throughout her labor and delivery?

A Yes, ma'am, I was very careful in taking care of Ms. Fulton.

Q And are all of those opinions that you've given to a reasonable degree of medical certainty, most probably?

A Yes, ma'am.

MS. CRAIG: Court's indulgence.

Q This is the best part of working with your dad. A few more questions, then I'll sit down. Dr. Goldstein, did you twist or turn the baby in any inappropriate way that would cause the injury in this case?

A No, ma'am.

Q And please tell the jury how much pressure or traction you used in the delivery of this baby.

A Well, it's hard to quantitate, but I used the same downward traction that I use to effect delivery in all of my OB patients.

Q And we do need to explain that a bit. When you say it's hard to quantitate or it's hard to -- to quantify the amount of pressure or traction, you need to explain why that is.

A Well, it's hard to take a series of 100 women and put pressure on the baby's head to effect delivery and quantitate how much pressure is being applied.

Q Did you do anything to cause harm to Ms. Fulton or her baby?

A No, ma'am.

Q And were you ---

A I did the best I could to deliver her baby safely and effectively.

Q Were you negligent in this delivery?

A No, ma'am.

Q And Dr. Goldstein, were you reckless in delivering this baby within four minutes of recognizing the shoulder dystocia?

A No, ma'am, I did the very best I could for Ms. Fulton and her baby.

Q Are all of the opinions that you've given today and yesterday are to a reasonable degree of medical certainty, most probably?

A Yes, ma'am.

MS. CRAIG: I got the nod, so those are all the questions

I have.

THE COURT: Madam forelady, ladies and gentlemen of the jury, I'm going to ask if you could retire to the jury room for one moment. Do not discuss the case in any way, shape or form. Everyone remain seated.

(Jury out at 10:11 AM)

THE COURT: Madam bailiff, I'd like to see the juror out with the white shirt and red collar. He sits about midway in the front row and he wears glasses, sometimes. White shirt, red collar.

(The juror enters the courtroom.)

THE COURT: Yes, sir, how are you doing? Come on up right here. Counsel, feel free to come up here. I just want to speak with him on the record up here at the bench. How are you doing this morning? Well, let's wait until these lawyers get up here.

First of all, I want to thank you for being here. I know that it's a long, arduous process. The wheels of justice grind, kind of, slowly and you're certainly not being paid for your services, legitimately. One of the things I've noticed throughout the trial is that sometimes you shut your eyes and I need to make a determination as a trial judge as to whether or not you're asleep or simply just closing your eyes and listening. We quite often do that. I need to make that determination to determine whether or not you've been

paying attention. Have you been paying attention?

JUROR: Yes, sir, I have.

THE COURT: I thought so. When I was looking at you, you know, your head wouldn't nod. It's just, some people listen better with their eyes shut. Have you been paying attention?

JUROR: Yes, sir.

THE COURT: Okay. Very good. And thank you. That's what I wanted to ask you and I want to thank you for your service. Very good. Thank you so much. You may return to the jury room.

(The juror exits the courtroom.)

THE COURT: I wanted to do that. Of course, the case law in South Carolina kind of encourages you to, in fact, do that, to ask them whether or not they have been paying attention and it appears to me as if he has and one of the things I've noticed, I quite often will go to the picture show and I always get Raisinettes and a big old soda and it makes me, when they turn off the lights, I usually last about 10 minutes in a picture show. When I do, my head always falls backwards and falls forward. In this case, he has not done any of that. I've watched him closely. His eyes are shut, but I don't believe he's fallen asleep. I've asked him and he says that he's paying attention. The predicament that puts me in is, you know, if there's ever an accusation that somebody has fallen asleep, you know, if someone shuts their eyes and

I just automatically just take them off, I think that's unfair to perhaps the other party. It's unfair to everyone. They have a right to serve and the law seems to indicate that it's incumbent upon the person moving to have the juror excluded to determine -- or to show prejudice and Ms. Craig, you're recognized as to how you've been prejudiced.

MS. CRAIG: Yes, sir, and just so it's clear, I've noticed him with his eyes closed since Monday.

THE COURT: Right.

MS. CRAIG: And I know that we were in -- you know, in jest, teasing that it's okay for him to sleep during, you know, Mr. Graham's case or when Mr. Graham was questioning witnesses, but it really isn't, because he's not getting all of the information or the education and so when I -- so I saw him with his eyes closed on Tuesday off and on and I clearly saw him today. I mean, I kept raising my voice a little bit and moving around, trying to wake him up and he had his eyes closed during the examination of Dr. Goldstein. I noticed yesterday that he did have his hand up on his, on his cheek and I don't know if that was helping him from bobbing his head back and forth. But given, regardless of whose case he's sleeping in, now he's sleeping in our case. He slept on and off throughout Mr. Graham's case.

This is a very complex medical malpractice case that needs the attention of every single one of those jurors and

the two -- the easy fix here is just to seat one of the alternates, because they have been very attentive and I haven't seen them fall asleep at all and they are listening intently to all of the evidence and it's just my concern that regardless of when he is closing his eyes, that it's been in both Mr. Graham's case and in our case now, but regardless of when he's doing that, he's just not getting all of the information and this is a lot of information about a complicated medical obstetrical emergency and I just, I'm concerned that he's getting bits and pieces and, and there's such an easy fix for this and that we don't have to worry about whether or not he's really sleeping when he closes his eyes or if he's thinking when he's closing his eyes.

THE COURT: Thank you.

MS. CRAIG: And another point is with regard to this morning, I had several Court exhibits, blow-ups, and yesterday used the medical illustrations, so to the extent that he not only needs to hear what we're saying, he needs to see what we're showing him and the educational piece of this and to the extent that he is closing his eyes, I'm not only worried about him sleeping, but he's not clearly seeing the evidence that we're trying to explain and present to the jury.

THE COURT: All right. You know, in looking at the cases that deal with sleeping jurors, one of the things that's

clear is it's treated differently in a criminal case than a civil case. One of the things -- this is what the state of the law is and in South Carolina says indeed the great majority of courts in other states considering the sleeping juror have utilized this approach and South Carolina assumes this approach. It says to cause harm to a defendant does not automatically follow a determination that a juror is sleeping. Most states require a defendant to show prejudice such as the juror failed to follow some essential part of the proceeding.

MS. CRAIG: Your Honor, that's what we've got. He's not reading any of the evidence that's been up on the screen, that I've got blow-ups on. That's the problem we've got. His eyes, we all -- nobody disputes his eyes are closed so he can't see the evidence. I do have to say that I'm slightly worried that, that he would now blame us for coming in and being asked questions. I understand why Your Honor did that and that's not my issue, but I think that since he was called in now and I was the one doing the presentation, it's pretty obvious that we all saw him sleeping and that I would probably be the one to complain about it.

THE COURT: Mr. Graham, what do you have to say about it?

MR. GRAHAM: A few things, Your Honor. First of all, there's absolutely not a shred of evidence that this man has fallen asleep, once. He's had his eyes closed from time to

time. I've had my eyes closed from time to time. Looking around the courtroom, several jurors have had their eyes closed from time to time. Several lawyers have had their eyes closed from time to time. That's just human behavior and from, from an outward appearance you can't tell if eyes closed equate to sleeping or not. From all indicia, all objective indicia, the man has been awake. As Your Honor noted, his head hasn't been nodding back or forward. He testified in front of Your Honor that he has been listening. He has not fallen asleep. It's as thought the defense wants to have a fifth peremptory strike. And, Your Honor, every single exhibit put up by the defense has either been read verbatim, or substantially verbatim, and even with my poor eyesight standing back there, I didn't feel the need to actually read what was up here because they were reading it for me.

MS. CRAIG: Briefly, Your Honor. Whether other people have been nodding off is completely irrelevant. What ---

THE COURT: Say that again now?

MS. CRAIG: Whether or not other people have been nodding off is completely irrelevant. What's important is that this jury is listening to the evidence and Mr. Graham just admitted that he has had his eyes closed. I mean, there's no way anyone can say, that's been in this trial, that this man hasn't had his eyes closed.

THE COURT: Well, these cases -- you know, he says his eyes are closed but he hasn't been asleep. These cases contemplate somebody actually going to sleep and it being appropriate to keep them on the jury under certain circumstances.

MS. CRAIG: In a highly complex medical malpractice case where something as serious as this, when we have -- we have two alternates who have been paying attention the whole time. I just ask in your discretion and it's such an easy way to fix this problem. Then, we know that we have 12 jurors who have been attentive to the evidence.

THE COURT: Well, how do I deal with the fact that he's testified here in Court that, that he was awake and paying attention?

MS. CRAIG: Because I think that if you're called in front of the Judge and asked questions in front of the Judge in Court, he's going to, he's going to be nervous, possibly intimidated and with all due respect, he's going to say he's paying attention. He's not going to admit to you and to this courtroom full of people that he's sleeping and not listening to the evidence.

MR. GRAHAM: Your Honor, I would just remind Your Honor that during voir dire, Ms. Craig asserted the exact opposite: That whatever a juror stated to Your Honor should be accepted as the truth. I don't believe it's proper for Defense counsel

to be the judge of the credibility of a juror who testifies before Your Honor that he's been listening and has not been asleep. There is absolutely not a shred of evidence to suggest that that is anything but the truth.

MS. CRAIG: You know, that's completely different than when you brought up all the different jurors to ask them specific questions about their qualifications. I mean, there are a lot of people coming up. There's a lot of discussion. I mean, he's the only juror, other than the CNA the other day, that's been asked to come out and been asked, are you sleeping. I mean, what is he supposed to say with a courtroom full of people with a judge? If he says yes, I'm sleeping ---

THE COURT: And he might say ---

MS. CRAIG: --- and he's scared he's going to get in trouble.

THE COURT: --- that you and Mr. Graham are very boring and I did go to sleep. That's what he might say. I don't know. But one of the -- the beauty of it is that there's been a lot of repetition in this trial, as well. Even if you assume there was a little bit of sleeping, we've heard it at least twice, a lot of everything, so I'm going to -- you know, we don't have to make a decision right now, but I'm going to take it under advisement. We still have two alternate jurors, so I just want to put that on the record and hear what you had to say about it.

MS. CRAIG: Thank you, Your Honor.

THE COURT: All right. With regard to Ms. Craig concerning the playing of video snippets as a part of cross examination, have you had an opportunity to prepare reply video snippets?

MS. CRAIG: No, Your Honor, he hasn't -- the only video snippets that we received were for the use with Gomez-Carrion so, I mean, I don't know if he was going to use the same snippets, but as far as specific snippets that he plans to use for Dr. Goldstein, those have not been identified at all.

THE COURT: So you don't even know what ---

MS. CRAIG: I have no clue, Your Honor.

THE COURT: All right. Based on that, I'm not -- I'll be glad to hear from you. Yes, sir.

MR. GRAHAM: Yes, Your Honor. First of all, Your Honor, for me to, to -- I don't know of any rule in the civil procedure rules that requires me to share with Defense counsel my cross examination questions ahead of time.

THE COURT: If it deals with a deposition you do.

MR. GRAHAM: Well, they -- excuse me?

THE COURT: If it deals with a deposition, don't you have to designate it?

MR. GRAHAM: No, sir. If we're doing a de bene esse ---

THE COURT: Right.

MR. GRAHAM: --- but if, but this is impeachment. I have

no idea until I hear his testimony when he's going to testify consistently with his deposition and when he's going to say things that are the total opposite of what he said under oath at his deposition. We'd like the right when he testifies at a totally opposite position today compared with deposition it prejudices our case if we're limited to the cold words in the transcript. We need to be able for the jury to see ---

THE COURT: Well, I understand. I understand your position.

MR. GRAHAM: --- and if Your Honor please, in terms of, in terms of giving advance notice, certainly the impeachment that we received from our witnesses, we had no prior notice of and I didn't expect it because I've never gotten that and I've never given that and nobody's ever complained about it.

THE COURT: What do you have to say about that, Ms. Craig?

MS. CRAIG: Your Honor, first of all, we're not preventing him from -- if he thinks he's got proper impeachment, he knows how to do it with a deposition. The same way I did it with his witnesses, but the Rule of Completeness is very clear. This is Rule 32.4 and it says if only part of a deposition is offered in evidence by a party an adverse party may require him to introduce any other part which ought, in fairness, to be considered with the part introduced and any party may introduce any other parts. So,

if he wants -- first of all, there was no notice on this. Second of all, if he wants to do this, we're going to need to stop and set a -- and we're going to have to go through and then put it into context with the Rule of Completeness to make sure because I -- I have a pretty good feeling based on some designations I saw for Gomez-Carrion, that they're out of context. They're little snippets. They're parts of answers. It's not the whole thing and it's so confusing and prejudicial.

THE COURT: I understand your position in great detail. You articulated it very well, but under these circumstances I'm not going to allow cross examination with video. However, you can have ample opportunity to use the deposition in any way in written form. That's my ruling and you're protected on the record. We're ready for ---

MR. GRAHAM: Your Honor, may we have a short break before we bring the jury back?

THE COURT: Just one moment. All right. We're going to take about a five-minute recess.

(Brief break)

THE COURT: Are y'all ready to proceed?

MR. GRAHAM: Yes, sir, Your Honor.

THE COURT: Anything from the Plaintiff before we proceed?

MR. GRAHAM: No, Your Honor.

THE COURT: Anything from the Defense?

MS. CRAIG: No, sir, Your Honor.

THE COURT: We're ready for the jury.

(Jury in at 10:36 AM)

THE COURT: Mr. Graham, you're recognized for cross examination.

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

CROSS EXAMINATION

BY MR. GRAHAM:

Q Dr. Goldstein, good afternoon.

A Good afternoon or good morning.

Q That's right. It's been a long morning. Sir, let me ask you, with respect to what you and your lawyer have been calling an informed consent document, that's really just the hospital admission consent form. That's the only consent form that was ever signed by Genesie. True?

A True.

Q With respect to that consent form, you don't have any personal involvement until much later, do you?

A In signing the consent?

Q Yes, sir.

A No. They sign the consent when they come into the hospital.

Q Okay. But you don't have any personal involvement in

that process, do you?

A No. I sign the consent after, after the fact.

Q Yes, sir, and, in fact, in this case what was the date of this child's birth?

A 8/20/09.

Q Okay. And is that your signature on the bottom right where it says physician signature?

A Correct.

Q Is that the date to the left?

A Yes.

Q Is that your handwriting?

A No.

Q Do you have any reason to question the accuracy of the date to the left of your signature?

A No. That's the date that I signed it, date and time.

Q That was on October the 5th?

A Right.

Q Some month-and-a-half after this child was delivered?

A That's probably when the chart appeared in my box.

Q Yes, sir, and when it comes to -- when it comes to talking to a patient about giving consent to enter the hospital and delivery a baby, you don't have any involvement with talking to the patient about the risks of induction or vacuum and the alternatives, do you?

A Well, those are things that we discuss in the prenatal

course.

Q Sir, have you ever obtained a specific informed consent for the use of a vacuum?

A Not specifically for the vacuum.

Q Have you ever obtained a specific informed consent for induction of labor with Pitocin?

A Not specifically.

Q And do you know how many -- do you know what an average obstetrician, the percentages that an average obstetrician induces labor in?

A No, I don't know the average.

Q All right. But your personal rate is 75%. Correct?

A Not sure if that's exactly correct, but somewhere in that range.

Q Well, that's the figure you gave us in your deposition. Right?

A That's, approximately.

Q And of all those 75% or so times you decided to induce a pregnant lady's labor and delivery with drugs, with the drug Pitocin, how many of those times did you talk to her and inform her about the risks of inducing her labor with a drug like Pitocin?

A We discuss the process during the prenatal period, especially beginning at 32, 34 weeks, 36 weeks, when they're getting close to term. We discuss this and what

the plans for delivery are and what their plans for anesthesia are.

Q Sir, you've never asked -- you've never informed a patient and obtained her informed consent about the risks of induced labor, have you?

A No.

Q And do you know how many obstetricians, or what the average percentage is of vacuum extraction deliveries by a typical obstetrician in this country?

A No.

Q You deliver at least 25 percent of your babies by C-section. True?

A Correct.

Q And of the, of the vaginal deliveries you deliver 40 to 50% of those women with a vacuum extractor. True?

A True, but it's used as, what we used to refer to as an outlet forceps, almost 90% of my patients have epidurals and a lot of times when it gets to the time to push they are unable to generate enough force to deliver the baby's head, so we apply the vacuum and assist and as I tell them, you push and I'll pull. So, it's basically just to help the baby over the perineum.

Q You push and I'll pull. Before the doctor puts his hands on the baby's head, either directly with his hands or indirectly with forceps or a vacuum suction device,

mother nature is pushing the baby from behind. True?
A That is correct.
Q It's -- this business about you push and I'll pull, that only happens when the doctor decides he's going to intervene into the natural delivery process. True?
A Well, the natural delivery process sometimes is not effective at getting the baby out that last little bit and it depends on the mother's ability to push and how well and effectively she does push, so frequently, it's simply to help the mother out.
Q And when you induce labor that's to help the mother out with her schedule planning, not to help yourself out. True?
A Well, some of these patients live in Lake City and Johnsonville and other parts out. It's difficult for them to get into the hospital at night, so frequently, you know, we set up a time where it's convenient for them to be there and it progresses well.
Q Inducing labor is convenient for you, isn't it, Dr. Goldstein?
A It's convenient for me and the patient.
Q Yes, sir, and when you deliver a baby by induction you can make sure you have a nine-to-five type job in terms of delivering that baby. True?
A Well, it doesn't always work out that way.

Q But that's what you intend to happen.
A Not necessarily.
Q You intend ---
A I intend to be there when they have their delivery.
Q Yes, sir, and you intend to influence the time of day during which they have their delivery. True?
A Well, when we have them come in at that hour of the morning, it certainly does occur during the daylight hours, but sometimes these deliveries occur in the night. Frequently, they come in on their own.
Q And despite, despite, despite your intervention with mother nature with induction and vacuum, you have never obtained an informed consent for either one. True?
A Despite my intervention with mother nature.
Q Yes, sir.
A What was the rest of the question?
Q You've never, ever, obtained an informed consent from any of your patients for induction or labor or use of a vacuum. True?
A Well, other than the standard consent that they sign when they come into the hospital.
Q That you have nothing to do with.
A That I have nothing to do with.
Q The Mityvac is what you said today that you used to deliver this child?

A I think that's the name of it. It's the, the cup that is a bell-shaped cup.

Q Have you read the product description about the dangers of using Mityvac?

A At some time in the past.

Q Yes, sir, then you would be familiar that one of the contraindications is when there's a suspected risk of shoulder dystocia, you're not supposed to use a Mityvac. You knew that, didn't you, doctor?

A I think the operative delivery that is a risk that's associated with shoulder dystocia is in the, in that this occurs in some patients, but it's not a predictive risk.

Q All right. But you admit that the contraindications for the Mityvac product warning sheet says, and I quote, do not initiate vacuum if any of the following conditions exist, and I'm going to skip down to number four, the second part of which is risk of shoulder dystocia.

A That's correct.

Q You're not supposed ---

A I mean, you're reading it. I'm assuming that that's correct.

Q Would you like to see it, sir?

A So, number four says suspected macrosomia or risk of shoulder dystocia.

Q Yes, sir.
A So, we didn't suspect that there was macrosomia in this patient.
Q Okay. But you knew there were risks for shoulder dystocia. True?
A It's a risk, but it's not a predictive risk. It doesn't predict.
Q When you say "it" doesn't predict, what is "it"?
A Macrosomia or operative delivery.
Q All right. Well, this says do not initiate vacuum if any of the following conditions exist: number four, suspected macrosomia or risk of shoulder dystocia. True?
A Well, there wasn't a risk of shoulder dystocia in this patient. We didn't -- I mean, shoulder dystocia was not diagnosed until after the head was delivered and it was the anterior shoulder that was stuck under the symphysis pubis.
Q In fact, doctor, you've known since you were a resident that diabetes in a woman is a risk factor for shoulder dystocia. True?
A Diabetes is a risk factor in that it's associated with macrosomia.
Q It's a risk factor for a shoulder getting stuck. True?
A No, it's a risk factor for macrosomia and again, like the other things, it's not predictive. There's no way of

predicting or preventing shoulder dystocia.

Q But when there's a risk of shoulder dystocia, a vacuum extraction is contraindicated according to the manufacturer of the device you chose to use without informed consent. True?

A According to that sheet, yes.

Q Yes, sir. And according to this sheet, there are risks of numerous adverse events to the baby and the mama. True?

A Where are you? Adverse events?

Q Yes, sir.

A All right. So, head trauma, bruises, contusions, lacerations, scalp edema and so how, how significant do you think those are.

Q Do you think they're significant enough to talk to the patient about?

A Well, these, these are things that, you know, that are very minor. They have fractures, cephalohematoma, subgaleal hematoma and that's a possibility, but it's very rare. It's less than .1%.

Q The manufacturer of the Mityvac vacuum device that you chose to use in this case without warning to the mother provides you with warnings that adverse events include the following for the mom: vaginal, cervical, uterine, bladder and rectal tissue tears. Did you tell Genesie

about any of those risks?

A No.

Q It -- this form from the manufacturer indicates fetal injuries that include; head trauma, bruises, contusions, lacerations, scalp edema. That's swelling of the head. Right?

MS. CRAIG: Objection, Your Honor. Relevance. These are none of the, none of the issues involved in this case.

MR. GRAHAM: It goes to informed consent, if Your Honor please.

THE COURT: I'll allow him some leeway.

Q Scalp edema, that's swelling of the head. Right?

A That's swelling at the site at which the Mityvac is applied.

Q Skull fracture, cephalohematoma. That's a, that's a ---

A Edema of the scalp in which there's some blood collected under the skin.

Q Subgaleal hematoma. That's a blood clot in the brain. True?

A That's correct.

Q Subdural hemorrhage. That's bleeding inside the brain. True?

A That is true, but it's an awful rare occurrence.

Q Parenchymal hemorrhage. That's another form of bleeding inside of the baby's brain. True?

A I'd, I'd have to refer to the literature for that.
Q Yes, sir.
A But I think if you Google these things you'll find out that they're extremely rare.
Q They're important enough for the manufacturer to warn you that you should warn the patient. True?
MS. CRAIG: Objection, Your Honor. Standard of care is not what the manufacturer says.
THE COURT: I'll -- might counsel approach the bench?
(Bench conference off the record)
MS. CRAIG: Your Honor, just object if they don't have another copy. I haven't seen this or this is the first I've been made aware of this.
MR. GRAHAM: Your Honor, during direct exam they identified the Mityvac.
(Bench conference resumes)
MR. GRAHAM: Thank you. May it please the Court.
Q Doctor, before that break in my questioning, we were going through various fetal injuries, some of which are relatively minor like bruises and cuts, but others are quite serious like head trauma, skull fracture, brain bleeding in different parts of the brain, blood clots. How many times have you ever warned any of your maternity patients that you delivered, whose children you delivered with a vacuum, that there were these

dangers involved in your choice to use a vacuum?
A Probably, not very many.
Q In fact, you've never done that, have you, doctor?
A No, that's, that's not one of the things I do.
Q You've never warned a patient about any of the risks of vacuum extraction. True?
A Well, I've never had any of the risks occur other than maybe an edema of the scalp.
Q In terms of informing the patient so she can participate in important decisions about her health and her baby's health, you've never provided those warnings to the patient, have you?
A No.
Q That was no?
A No.
Q Thank you. Let's talk about standard of care. Sir, do you believe that there exists certain standards of care for obstetricians that all obstetricians are supposed to meet or exceed, not fall short of? Do you believe that there are standards of care that place a limit on how much traction can be used on a baby's head and neck during shoulder dystocia?
A I believe there are standards of care but the standards of care are legal terms and I think the legal term is what a corresponding physician under similar

circumstances in a similar position would do prudently.

Q Yes, sir, and despite your testimony here today you gave deposition testimony before. Do you recall that?

A I do.

Q All right. We videotaped it?

A Yes.

Q You had at least two lawyers present with you?

A Yes.

Q You were sworn to tell the truth?

A Yes.

Q And at that time ---

MS. CRAIG: Your Honor, this is improper use of deposition. If he has a question he needs to ask it.

THE COURT: That is correct. You need to ask whatever information was asked in the deposition and if he agrees with it you don't have to talk about the deposition, but if he says something different you can cross examination him and impeach him with it.

MR. GRAHAM: Yes, sir. All right.

THE COURT: So ask him the question first and see what his response ---

MR. GRAHAM: Well, I already did, Your Honor. I asked him if he believed there were certain standards of care placing limits on traction.

THE COURT: Okay. All right. I assume he said something

different in his deposition. If so ---

MR. GRAHAM: Absolutely, Your Honor.

THE COURT: --- you can ask him about it.

DR. GOLDSTEIN: No, you asked me about standard of care and I told you that there is a standard of care and it's a legal term and it has to do what a physician or physicians under certain or similar circumstances would do.

MR. GRAHAM: Yes, sir, I understand that definition.

Q My question, sir, is, do you believe there exists a standard of care that puts a limit on how much traction a doctor is allowed to put on a baby's head and neck during shoulder dystocia?

A I don't think that -- I mean, the standard of care is something that particularly, I mean, we don't have a standard of care for each and everything that we do. We don't have standard of care for placing the IV. We don't have a standard of care for tubal ligation or removing the tube or, you know, any of the procedures that we do.

MR. GRAHAM: Your Honor, may I ---

A It's a -- it's a legal term.

MR. GRAHAM: Your Honor, may I unseal the deposition?

THE COURT: Yes, you may.

MR. GRAHAM: And, if Your Honor please, we have video discs as well as the original deposition.

Q Please, sir, turn to page 109 of your deposition.

Starting at line 17 through 25.

MS. CRAIG: I'm sorry. Seventeen...

MR. GRAHAM: Page 109, lines 17 through 25.

MS. CRAIG: Okay. Thank you.

MR. GRAHAM: Sure.

Q Was this my question and your answer, sir?

Q Sir, do you believe that there exists certain standards of care for obstetricians that place a limit on how much traction can be used on the baby's head and neck in the context of managing a shoulder dystocia complication? And your answer was:

A Well, once again it's, it's hard to quantitate traction, if not impossible, and I don't think that there's a standard of care for traction.

Q Was that my question and your answer?

A That was my -- that's true. That was the answer, but also above that on line four you asked the same question and I answered that I didn't understand.

MS. CRAIG: And, Your Honor, under the Rule of Completeness, we'd ask that the next question be asked and the next answer given.

THE COURT: I think that would probably be more appropriate for redirect.

MS. CRAIG: Yes, sir. Thank you.

THE COURT: Just make a note of it and you'll be given ample opportunity to address all those issues.

MS. CRAIG: Thank you.

Q Doctor, are there any safety rules in medicine that place limits on how much traction can be used by an obstetrician trying to deliver an anterior shoulder that is lodged behind the mother's pubic bone?

A I don't think ---

MS. CRAIG: Objection, Your Honor. We don't -- we don't operate under rules. We dealt with this in pre-trial. It's what the standard of care is.

MR. GRAHAM: And if Your Honor please, Dr. Gomez-Carrion has already indicated that the purpose of standards of care are to...

Q Doctor, do you believe that it would ever be inappropriate to give more than gentle traction and if so, under what circumstances?

A Are you reading from the deposition again, or is that a question?

Q I'm asking you a question, sir.

A Could you repeat please?

Q Sure. Doctor, do you believe that it would ever be inappropriate to give more than gentle traction and if so, under what circumstances?

A Well, generally in our practice of obstetrics we learn

gentle downward traction and that's generally what we use and that's what I used in this case.

Q Sir, please turn to your deposition at page 130, lines one through seven. Did I ask the following question and you give the following answer?

Q Do you believe that it would ever be inappropriate to give more than gentle traction and if so, under what circumstances? And your answer.

A Inappropriate to give more than gentle traction? So, well, I guess I'd have to say I don't know. I'm trying to help you out here but I'm, I'm, I'm not certain of these.

Q Was that my question and your answer?

A Evidently, so.

Q Yes, sir. Doctor, do you believe there are any circumstances under which you believe an obstetrician must refrain from using greater than gentle traction on the baby's head and neck and if so, what are they?

A Refrain?

Q Yes, sir.

A Well, I think that in our practice we refrain from giving more than gentle downward traction traditionally. That's what we learn in our medical school. That's what we learn in residency and that's what we practice in, in

our practice.

Q Page 128 please, line 23, through page 129, line 6. Doctor, at your deposition did I ask the following question and you give the following answer?

Q Are there any circumstances under which you believe an obstetrician must refrain from using greater than gentle traction on the baby's head and neck and if so, what are they?

A Are there any circumstances? Now, this is the other way. Are there any circumstances in which the doctor must refrain.

Q Yes, sir.

A I don't know.

Q Was that your answer under oath to my questions on those subjects at your deposition?

A Yes, sir, but again, I don't -- you know, I'm not sure if I could explain in what context. You know, practicing medicine is not an exact art. It's the art of taking care of the mother and infant as the mother and the infant pair, doing the best we can for the babies, doing the best we can for the mother and in this case that's what I did for the patient, Ms. Fulton.

Q Sir, do you claim to have any experience dealing with shoulder dystocias in medical school or residency with, in a hands-on way?

A Resident? No, not in a hands-on way.
Q Yes, sir, and then when you started practicing, doctor, in Camden before you moved to Florence, did you have any experience with shoulder dystocias there?
A Yes, during my years of practice I maybe had five or so shoulder dystocias.
Q Okay. I'm asking about Camden, not Florence.
A Well, I can't separate them out specifically and I can't remember them individually, but I know I've had cases of shoulder dystocia.
Q And then you left ---
A And fortunately, fortunately, most of these resolved with suprapubic pressure and McRoberts.
Q In fact, you've never successfully performed any internal maneuver ever. True?
A I've never had to.
Q You've never -- how many -- you claim that you've only attempted any internal maneuver one time. True?
A That was in Ms. Fulton's case.
Q Yes, sir.
A The other cases resolved with suprapubic pressure and McRoberts.
Q The point, sir, you've, you've had zero experience performing a Wood's maneuver ---
A But that doesn't mean I don't know how to do them.

Q Well let me finish my question, sir.
A Okay.
Q Before Genesie was induced and her baby's head delivered with a vacuum, you had never even attempted to perform a Woodscrew maneuver. True?
A No, I hadn't but I hadn't needed to ---
Q So ---
A --- but that doesn't mean that I do not know how to do them. I've studied in the text, in the literature. I've had residency training and, all of which, you know, instructed me how to do these things.
Q And until you induced Genesie and pulled Bryson's head with a vacuum that day, you had never even attempted a Rubin's maneuver. True?
A I've not attempted the, I've not had to do the rotational maneuvers and in Ms. Fulton's case, I was unable to get my hand in there to do the rotational maneuver, but that doesn't mean that I wasn't fully capable of doing it if I had the opportunity.
Q It does mean you were completely inexperienced. True?
A It doesn't mean I was completely inexperienced, no. I had the knowledge and the skills but I've never had to do it in real life.
Q How many experiences in real life or pretend life have you had where you performed a Wood's maneuver? Is it

more than zero?

A How many -- please, repeat.

Q Yes, sir. You said something about real life. Whether real life or some other kind of life, how many experiences do you claim you've ever had attempting a rotational maneuver before Genesie?

A I've never had to do one.

Q Zero experience?

A I could -- you could call that zero experience ---

Q Before Genesie ---

A --- but that doesn't mean that I don't know what to do given the opportunity or the circumstances in which it's required.

Q And when it was required you couldn't even get your hand in. True?

A When it was required, the head was in the way and I attempted or I did extend the episiotomy in an attempt to get the rotational maneuvers performed, but was unsuccessful in being able to jam my hand into the vaginal canal around the baby's head so that I could do the rotational maneuvers.

Q So, you were unsuccessful in trying to jam your hand in there?

A Exactly.

Q How much experience had you had, trying to jam your hand

in there before, in a shoulder dystocia situation?

A I'm sorry? I've not had to do the rotational maneuvers before. Fortunately, these other cases resolved with simply McRoberts or McRoberts plus suprapubic.

Q Yes, sir. How much ---

A And those, I mean, most of the literature calls to perform McRoberts and suprapubic first before you have to attempt rotational maneuvers or posterior arm delivery.

Q And when you were unable to get Bryson's head out before Dr. Coker came to the rescue, how many -- you, in fact, tried to jam your hand into Genesie's vagina. True?

MS. CRAIG: Your Honor, asked and answered.

A The head was delivered.

THE COURT: I'm -- we'll move on. You've asked that at least twice.

Q And with respect to the posterior arm delivery method, you had zero experience even attempting that before Genesie's delivery. True?

A Well, the same situation. In this case, I couldn't get my hand in to sweep the arm but I certainly know how to, how the maneuver is done and what, what to do. You put your hand in the vagina, you flex the elbow by pressure on the antecubital fossa, you sweep the arm over the chest and grab the arm and deliver the posterior arm.

So, I know how to do it.
Q You've never done it successfully.
A That doesn't mean I don't know how to do it.
Q How many years had you been practicing when you jammed your hand in with Genesie?
A How many years?
Q Yes, sir.
A This was in 2008, so, 30 years.
Q Okay. In fact, it was '09. True?
A Oh, 31 years.
Q In 31 years you've had, according to your testimony you've had five or six ---
A Shoulder dystocias.
Q --- shoulder dystocias.
A Yeah.
Q All right. So, you are telling us that you've had the experience of dealing with this emergency one time every six years or so?
A I guess you could boil it down to that.
Q Let's talk about your personal knowledge. You told us that you read books and you learned how to do these special maneuvers that you've never attempted successfully in over 30 years of practice and we heard in opening, or maybe your direct testimony, that you go to CME courses, continuing medical education courses?

A Uh-huh.
Q You've never once gone to a CME course to learn how to safely manage shoulder dystocia, have you?
A I don't think specifically that was the topic but there were -- I've been to a lot of, I mean, to review courses in which there were complications of obstetrics discussed and ...
Q Have you had any CME courses that dealt with safe management of shoulder dystocia complications?
A CME specifically to that, shoulder dystocia?
Q Yes, sir.
A No.
Q A moment ago you said something about never successfully doing an internal maneuver in the real world. How many times have you participated in shoulder dystocia simulations?
A None.
Q How many times have you participated in shoulder dystocia drills at the hospital?
A None.
Q How many times have you had measured the amount of traction that you apply pulling down on a baby's head and neck?
A How many times have I had that measured?
Q Yes, sir.

A None.
Q Sir, are you aware of the simulation studies that show when obstetricians pay attention to CME courses and measurement of their traction and use/practice on simulation equipment and drills in the hospital that the safety of babies goes up?
A I'm aware of studies.
Q All right, sir. And you're aware of the studies that conclude shoulder dystocia drills and simulation, if participated in by doctors as well as nurses ---
MS. CRAIG: Objection, Your Honor.
Q --- facilitates patient safety?
MS. CRAIG: If there is such a study I would ask ---
THE COURT: Your objection being?
MS. CRAIG: That he's being asked about a study and I would -- my objection is he doesn't have whatever study he's referring to, if there is one.
THE COURT: All right. I think he's asking in a general way. I'll allow him to ask the question.
Q Are you aware, sir?
A Aware of the studies?
Q That, that have concluded that ---
A I'm aware of the studies, but I'm not aware of their conclusion.
Q So, you heard about the studies but didn't bother to

find out what the conclusion was?

A No, I just can't remember what the conclusions were, but if you have a specific study I'll be glad to review it and give you my thoughts on it.

Q Yes, sir. You've told us a few times in this trial that you were trained in residency that obstetricians should avoid using more than gentle traction on a baby's head and neck. Do you remember that?

A I think I told you that in residency we learned the appropriate amount of traction and downward force that we apply to babies and it was, kind of, a learned thing over the years, medical school, residency, that we -- it comes to muscle memory.

Q Sir, were you trained in residency that obstetricians should avoid using more than gentle traction in the course of managing shoulder dystocia?

A Wasn't this a question that you asked me before?

Q Yes, sir.

A I'm not sure what I said then.

Q Could you please -- page 113, lines nine through 14. Was this was my question and your answer.

Q Okay, were you trained in residency that obstetricians should avoid using more than gentle traction in the course of managing shoulder dystocia?

A I don't remember specifically. That was a long time ago.

Q Was that my question and your answer, sir?

A That, indeed it was.

Q As you sit here today, sir, in this courtroom, do you believe it's appropriate for an obstetrician managing a shoulder dystocia complication to use greater than gentle downward traction to deliver the anterior shoulder?

A Could you repeat?

Q Yes, sir. As you sit here today, do you believe it's appropriate for an obstetrician who is managing a shoulder dystocia complication to use greater than gentle downward traction to try to deliver the anterior shoulder?

A And -- no, I don't believe it's appropriate and that's not what occurred in this case. We used gentle downward traction.

Q Page 114, lines 13 through 21 please. Doctor, at your deposition did I ask the following question and you give the following answer?

A What line was that?

Q Line 13 through 21, page 114.

A Thirteen through 21?

Q Yes, sir. On page 114.

MS. CRAIG: Your Honor, this is improper.

THE COURT: You may approach.

(Bench conference off the record)

Q Doctor, before we read this question and answer up here ---

MS. CRAIG: Your Honor, he's going back several pages.

THE COURT: Well ---

MS. CRAIG: All he needs to do is tell him what kind of question it is.

THE COURT: Right.

Q Doctor ---

THE COURT: If the response in the deposition was in response to a hypothetical, you need to ask him the same hypothetical question here today.

MR. GRAHAM: It wasn't, Your Honor. The hypothetical was several pages before. I had changed subjects several times.

THE COURT: All right. Put up on the screen what you're going to be asking. That's the same question. It says -- look at -- you've got it starting on 13. Start on 12. If you're going to ask him that question here today, you need to ask him the hypothetical here in Court. Start at 12.

MR. GRAHAM: She's talking about several pages earlier.

THE COURT: Let me see that. That's not what's up there. Look at number 12 up there. Yeah, ask him a hypothetical if you want to talk to him about that response or move on.

MR. GRAHAM: Could you please back up to page 113, line nine, so we can get the full context? And, Your Honor, I apologize. This -- this goes back over the question I just went through, but just to get the full context.

Q Starting on page 113, line nine.

Q And doctor, I'm going to ask you a series of questions and -- I'm going to read a series of questions and answers and ask you if that accurately reflects ---

THE COURT: You can't do that. You can ask him the questions and ask what his response is here today. We aren't publishing depositions.

MR. GRAHAM: Yes, sir.

THE COURT: Ask him the question and what his response is here today and if it's different than what's in the deposition you can ask him. You can impeach him. We just aren't going to read depositions.

MR. GRAHAM: Yes, sir, but I thought you asked me to give the context leading up to what I already asked him about.

THE COURT: Well, that's absolutely correct but you need to ask him the question here today. If it's different in the deposition, then you can talk about it.

MR. GRAHAM: May we approach?

THE COURT: Yes.

(Bench conference off the record)

MR. GRAHAM: Thank you, Your Honor.

Q Sorry about that. Doctor, hypothetically, any time a doctor who is delivering a baby, managing the labor, encounters a shoulder dystocia situation, do you believe it is appropriate for the obstetrician to use greater than gentle downward traction to try to deliver the anterior shoulder?

A I think in those same studies that you referred to earlier about doing the mechanical studies to determine pressure, I think they found that, you know, detraction in shoulder dystocia was a little bit higher than that used in a regular vaginal delivery, but I don't think normally we use gentle downward traction and that's what we use in shoulder dystocia as well as vaginal deliveries uncomplicated by shoulder dystocias.

Q Doctor, I'm going to read the following question and answer and tell me if I read it correctly, please.

A Hypothetically?

Q Tell me if I read the question and answer ---

A Oh.

Q --- accurately, please, sir. Starting at line ---

A What page are you on?

Q Page 114, line 11.

A All right.

Q All right, sir, when -- when you -- Then you

interrupt with answer:

A Hypothetically.

Q Okay, when -- when do you -- as you sit here today, do you believe it's appropriate for an obstetrician who is managing a shoulder dystocia complication to use greater than gentle downward traction to try to deliver the anterior shoulder?

A I think they have to use the traction that's necessary to get the baby delivered -- to deliver. These are emergency situations here.

Q Did I read my questions and your answers correctly?

A Yes, sir. And then I go on to say all right, is that what you do in your practice when you encounter shoulder dystocia and then I answered, fortunately, I haven't encountered that many and I couldn't recall, specifically.

Q Yes, sir, in fact, not recalling specifically was a recurrent theme in your deposition. True, sir?

A Well, these things are hard to quantitate and they're -- you know, you're talking about events that occurred over maybe a 37-year period of time.

Q Yes, sir. Do you claim to have a better memory today about this August of 2009 delivery than you had back when this deposition was taken on December the 12th, 2013?

A Well, I have read over my hospital records and my prenatal records, so that's probably helped to jog my memory.

Q Yes, sir. And you had read those over before your deposition. True?

A Well, not as, not as much, but yes, I've, you know, read more in depth since then.

Q And you had prepared for that deposition with your lawyers in advance. True?

A Probably to some degree, but I don't think I read the records as much and as frequently as I have since then.

Q All right. Have you prepared with your lawyers for your trial testimony more than or less than you prepared for your deposition?

MS. CRAIG: Your Honor, to the extent he's getting into attorney/client privilege ---

DR. GOLDSTEIN: Yeah, I think that ---

MR. GRAHAM: I'm not.

DR. GOLDSTEIN: --- that was going to be my answer.

THE COURT: We'll move on.

MR. GRAHAM: Yes, sir.

Q Doctor, do you have a specific memory of the downward traction in this case?

A In this case?

Q Yes, sir.

A Not specifically. I mean, I can't tell you how many Newtons of pressure I applied, but I know it was the, you know, my standard for doing a delivery.

Q You don't remember how much traction you used at any point during this delivery. Is that fair? Is that fair?

A Is that fair?

Q Yes, sir.

A I don't remember specifically how many Newtons it was, but I know that it was no more than my usual traction that I used in 3,000 or so other deliveries.

Q Page 179, line 25, through page 180, line 6.

A 179?

Q Yes, sir. 179, line 25, through 180, line 6.

A 179, line what?

Q 179, line 25, through page 180, line 6. Please tell me if I read this, these two questions and answers correctly.

Q Do you have a specific memory of the downward traction?

A No, not specifically.

Q So, you don't remember how much traction you used at any point during this delivery? Is that fair?

A No, I don't remember.

Q Did I read that accurately?

A You read it accurately and that's basically what I

responded to you before. I mean, you can't quantitate, but it was the same that I used for my other deliveries.

Q Sir, do you claim to recall how much traction you've used on any of your shoulder dystocia complications?

A Not in Newtons. I mean, it's the same that I use. It's what we were taught in our residency. It's more muscle memory and experience.

Q Page 115, lines 1 through 4 please. Tell me if I read this question and answer correctly.

Q Do you claim to recall how much traction you used on any of your shoulder dystocia complications?

A No.

Q Was that a correct reading of your testimony?

A That was correct, word for word.

Q You told me earlier that you have no memory of how much traction you applied at any time during this delivery. True?

A True, but the standard amount that I've used on all of my deliveries.

Q You believe that the proper way to do suprapubic pressure is to, for the doctor or nurse to feel above the pubic bone and push straight down toward the floor. True?

A Above the pubic bone.

Q Straight down toward the floor. True?

A True, but you can also push one way or the other, whatever dislodges the anterior shoulder from under the pubic symphysis.

Q And do you believe that's how a properly trained labor and delivery nurse should correctly perform suprapubic pressure?

A I think that's how anybody should perform suprapubic pressure.

Q Page 31, lines 2 through 18, please.

A What lines?

Q Page 31, line 2 through 18.

MS. CRAIG: Objection, Your Honor.

THE COURT: Objection being?

MS. CRAIG: The nurses aren't involved in the suit. Hospitals aren't involved in the suit.

MR. GRAHAM: Goes to his knowledge.

THE COURT: Might -- might counsel approach the bench?

(Bench conference off the record)

Q Did I ask the following questions and answers starting on page 31 at line 2:

Q Do you know how a properly trained labor and delivery nurse should correctly perform suprapubic pressure?

A Yes.

Q How should they?
A Pressure in the suprapubic, downward pressure, straight downward pressure in the suprapubic area.
Q All right. Now, in the context of a mom who is somewhat on her back, either on her back or someone on her back, when you talk about downward pressure, are you talking about downward toward the floor?
A Toward the floor.
Q Okay. All right. Not toward either side, but directly toward the floor. Is that right?
A Yes.
Q Did I read that accurately?
A You certainly did.
Q Let's turn to the topic of causation please, sir. You don't consider yourself to be an expert about the cause of brachial plexus birth injuries, do you?
A No, I wouldn't think so.

MR. GRAHAM: Your Honor, at this time we would move to strike his earlier opinions about causation that he expressed.

THE COURT: Glad to hear from you.

MS. CRAIG: Sure, Your Honor. He's not -- he wasn't ---

THE COURT: If you could approach the bench.

MS. CRAIG: Yes, of course.

(Bench conference held off the record)

Q And, sir, you do not claim to have an opinion about the most probable cause of Bryson's injury, do you?
A Could you repeat please?
Q Yes, sir. You do not claim to have an opinion as to the most probable cause of Bryson F 's brachial plexus birth injury, do you?
A I probably have an opinion.
Q Could you please turn to 86, lines 17 to 20?
A Eighty-six?
Q Yes, sir.
A Line what?
Q Seventeen to 20.
A Eighty-six, line?
Q Seventeen to 20.
A Okay.
Q Did I ask the following question and you give the following answer?
A Yes.
Q Fair enough.
Q Do you claim to have an opinion as to the most probable cause of Bryson F 's branchial plexus birth injury?
A No.
Q Did I read that accurately, sir?
A You did, indeed.

Q Doctor, you don't believe that an obstetrician can become an expert on causation of brachial plexus birth injuries by reading medical literature on that subject, do you?
A Depends on how extensively he reads.
Q Please turn to page 147, lines 21 to 24. See if I read this question and answer accurately, sir.
Q Do you believe that one can become an expert by ---
A I'm sorry. I must have the wrong page.
Q Oh, I'm sorry. Page 147, lines 21 through 24. Ready?
A Yes.
Q Do you believe that one can become an expert by reading certain medical literature on that subject?
A I don't think they'd be an expert.
Q Did I read that accurately?
A Yes, and I stated that it depends on how much they read. It doesn't necessarily depend on how many cases of shoulder dystocia they've managed.
Q Yes, sir, but with the amount of reading that you've done on the topic, you agree you're not an expert. True?
A I don't purport to be an expert.
Q Right. In your direct testimony when Ms. Craig was asking you questions, one of the questions was about nurse Lawrimore, I believe, doing suprapubic pressure while climbing up on the stool and then climbing up on

the bed and pushing down on the mother above her pubic area, and you testified that you assumed people were holding her legs as Rebecca Lawrimore was doing suprapubic pressure. In fact, you don't have any memory of McRoberts and suprapubic pressure ever being performed at the same time, do you?

A I have a memory that they were done, but this is a complex situation where there's a lot of things going on and ---

Q Yes, sir.

A --- so the particular point in time between 13:44 and 13:49 in which these things occurred escapes me ---

Q Yes, sir.

A --- but I know that suprapubic pressure was applied while McRoberts was in place.

Q After Dr. Coker arrived to the rescue. True?

A No, that's a complete misrepresentation. Dr. Coker came in after we'd already attempted these maneuvers.

Q If a -- if a maternity patient's legs were in McRoberts they're way up here in the air. True?

A That's correct.

Q If her legs are in stirrups, they're over here in front of her. True?

A That's true. So, at some point her legs were in the stirrups, but then when McRoberts is applied then we

take her legs out of the stirrups, we hyperflex them and abduct them so they're not in the stirrups anymore.

Q Not during McRoberts.

A Not during -- you know ---

Q But Genesie's legs were in the stirrups when Rebecca Lawrimore was applying suprapubic pressure. True?

A I'm not sure that that's documented in the record.

Q All right, sir. Do you deny that Genesie's legs were in the stirrups ---

A No, her legs were in the stirrups.

Q Let me finish please, sir. Do you deny that Genesie's legs were in the stirrups at the time that Rebecca Lawrimore and the nurses in that room, I believe it was Rebecca, were applying suprapubic pressure? Do you deny that?

A I don't -- I can't deny it because I have no specific knowledge that her legs were in the stirrups.

Q In fact, you don't have any memory of legs being in McRoberts when suprapubic pressure was ---

A Yes, I have ---

Q --- until ---

A --- some memory, yes.

Q --- until Dr. Coker was there. True?

A No.

Q But you can't deny that the legs were in the stirrups at

that time. True?

A I certainly admit that the legs were in the stirrups, but that may be, may have been at 13:40, 13:41, 13:42, but once the shoulder dystocia was recognized, the first thing they do is take the legs out of the stirrups and apply McRoberts.

Q And if you're going to deliver a baby safely, you do suprapubic pressure with the legs still in McRoberts. True?

A Generally, but you can do them separately.

Q Of course you can do them separately, but it's best to do them at the same time if you want to get the baby out safely without brachial plexus nerve injury. True?

A That's -- it says in the literature you can do McRoberts and then move to suprapubic and then a combination of the two.

Q Besides yourself, do you know any obstetrician who is board certified who would apply traction on a baby's neck before attempting suprapubic and McRoberts at the same time?

A Well, since the diagnosis of shoulder dystocia is that, that the head does not, I mean, the shoulders do not deliver with gentle downward traction and the application of accessory maneuvers, then there's got to be some downward traction applied somewhere at some

time.

Q Yes, sir, you lost me there ---

A Well, you lost me several times.

Q Let's refocus. Okay? Can you tell us where Genesie's legs were when Rebecca Lawrimore was applying suprapubic pressure?

A I can't tell you specifically at -- you know, this is a continuum of care.

Q You cannot?

A I cannot.

Q How long was it that you had been working with Dr. Coker and Phillips before you realized that they didn't want you to be their partner?

A Towards the end of my year's contract.

Q Toward the end of year number one?

A Yeah.

Q Good thing Dr. Coker was around that day. True?

A It would have been a good thing if anybody was around that day. Dr. Coker, Dr. Clary, Dr. Phillips, Dr. Sufrant or Dr. Jackson, at that time.

Q Yes, sir, and it would have been a good thing if you called for help before you couldn't get your hand into Genesie's vagina. True?

A No, I called for help as soon as we recognized shoulder dystocia.

Q There's nothing in the records about that, is it, sir?
ANo, that's not something that we typically, you know, at 13:33, we recognized shoulder dystocia and at 13:33-and-a-half we called for Dr. Coker, for assistance. That was one of the first things that occurred after we recognized shoulder dystocia.
Q After ---
A There's some distance between the delivery room and Dr. Coker's office. One of the ancillary personnel ran down there to get him and I don't think he showed up for maybe two or three minutes, possibly.
Q In fact, you didn't call for help until you had been unsuccessful with getting the head out or the shoulder out safely with McRoberts and suprapubic pressure. True?
A That's not true. That's completely not true.
Q So, now you claim to know the timing of all these events?
A No, but I remember as soon as we recognized that there was a shoulder dystocia, then we called for help which is the standard thing to do.
Q It is standard, yes, sir, but are you claiming -- are you telling us here today that you called for help as soon as you saw that turtle sign?
A Maybe not as soon as I saw the turtle sign, but as soon as we recognized that we had a problem we called for

help ---

Q As soon ---

A --- and that was not only Dr. Coker, but additional nursery staff, Dr. Phillips, the anesthesiologist was there, additional nursing staff came in.

Q Yes, sir, but the nurses didn't get there when Rebecca was having to push on the suprapubic area without a nurse to hold the legs. True?

A I'm not sure. I mean, there -- I mean, McRoberts was applied and I'm not sure exactly of the timing of the event, but Rebecca certainly applied suprapubic pressure at some point during the, the delivery process and McRoberts was certainly applied at some point.

Q Yes, sir. Do you remember -- do you claim it was four minutes or five minutes between the head coming out and the shoulders coming out?

A I think the shoulder dystocia was recognized at 13:45 and shoulder delivered at 13:49, so that's four minutes.

Q Yes, sir, I saw that in one of your records. I saw a different time in the other, so just to be clear in this courtroom during this trial, there was four minutes between the delivery of the head and delivery of the baby's body. Is that true?

A That's true ---

Q Yes, sir.

A --- as far as I know.
Q Yes, sir. And during that four minutes, except for when you were cutting an episiotomy, you were pulling down on the baby's head. True?
A No, not all during the four minutes.
Q Do you claim to remember stopping traction?
A Yes, I had to stop to cut the episiotomy. We had to stop to put McRoberts in place. We had to pause to get the suprapubic in place.
Q All right. You might reason it out now, but in fact, you don't claim to remember stopping traction, do you?
A I reasoned that out.
Q Yes, sir. And while Dr. Coker was there saving the day, you were still pulling on the baby's head, down on your knees. Right?
A No, no. Dr. Coker came down. We talked about what was going on. He looked at the patient, looked at the baby and said let's, let's try suprapubic again, so Dr. Coker is 6'4" or so. He's a tall guy. He got up on the stool and he applied suprapubic pressure while I did downward traction on the baby's head and we effected delivery of the anterior shoulder.
Q Yes, sir, he's tall, well over six feet, but he still had to climb on the stool as a stepping stone before he was able to climb higher up onto the bed. True?

A He didn't climb on the bed. He did suprapubic from the stool.
Q You deny that Dr. Coker climbed up on the bed?
A I don't know, specifically but no, I don't remember him being on the bed. I remember nurse Lawrimore getting up on the bed and that's when we dropped the bed down.
Q And the reason you don't remember Dr. Coker being on the bed is because you were down there on your knees pulling on this baby's head.
A No, I wasn't ---
Q --- Right?
A --- on my knees at that time.
Q You weren't on your knees?
A No, I wasn't.
Q You deny ---
A We raised the bed ---
Q --- you were on ---
A We -- no, I -- we were down on our knees at some point in time, but not the whole time.
Q Do you deny being on your knees ---
A No, I do ---
Q --- when Dr. Coker came into the room to get the shoulder unstuck?
A I'm not sure when I got off my knees, but I know we raised the table back up because he was taller and could

give more forceful suprapubic pressure.

Q I hear you say you raised the table up and you stayed on your knees. Didn't you, doctor?

A No.

Q You stayed on your knees pulling down on that baby's head ---

A No.

Q --- and neck.

A No, I ---

Q You deny that?

A I deny that.

Q Tell me every -- how would you summarize Dr. Coker's involvement in delivering Bryson?

A Do you want what's in the record here?

Q No, sir. Do you remember telling me at the deposition---

Q All right.

A --- he came, he saw, he conquered?

Q And then he left.

A Right.

Q He was there for less than one minute.

A Approximately, a minute. I didn't have the stopwatch on.

Q He came, he saw ---

A Uh-huh.

Q --- he conquered.

A He applied sufficient suprapubic pressure to manipulate

the anterior shoulder from out, out from under the pubic symphysis.

Q He came, he saw, he conquered, he left.

A Right. That's just to say that he came down to the delivery room. We conferred. He looked at the patient and then we decided, between us, to apply suprapubic pressure and he applied sufficient suprapubic pressure to effect delivery of the anterior shoulder.

Q Doctor, you're not telling us here today that it's appropriate for a doctor to needlessly endanger a baby's brachial plexus nerves, are you?

MS. CRAIG: Objection, Your Honor. To needlessly endanger?

THE COURT: It's argumentative. Sustained.

Q When do you believe it's appropriate for a doctor to needlessly endanger a baby's brachial plexus nerve?

MS. CRAIG: Same objection.

THE COURT: Argumentative. Re-phrase the question.

Q When do you believe it's appropriate for a doctor managing a shoulder dystocia delivery to apply greater than gentle downward traction on a baby's head and neck?

A When do I believe it's appropriate?

Q If ever.

A I don't believe it's, you know, appropriate but, you know, you're bending the baby's head down. What we're

talking about is downward axial traction.

Q Right.

A And we're not ---

Q To be clear, you admit it is never appropriate to apply greater than gentle downward traction on a baby's head. True?

A True, and that's not, I mean, that's not what we did in this case.

Q We've heard a lot from Ms. Craig asking you questions. We've heard a lot about how dangerous shoulder dystocia can be for a baby's brain and indeed for a baby's life. Do you agree that it can be dangerous to a baby's brain and a baby's life if an obstetrician does not have the knowledge and the experience and the skill to effectively and safely manage shoulder dystocia?

A Could you repeat that? That was a pretty long question and ---

Q It was. It was. I plead guilty, sir. Let me try to break it down. We heard you talk about risk of brain damage. All right? You're not claiming there was any imminent risk of brain damage that justified you in using too much traction, are you?

A No, I'm not implying that I used too much traction ---

Q All right.

A --- but from the literature there's been episodes of

hypoxic ischemic encephalopathy that occurred within two minutes of the head to shoulder interval.

Q Only if there's a placental abruption or some other emergency superimposed ---

A Or maybe a cord, a nuchal cord or other things like that.

Q All right. Let's talk about the nuchal cord. This nuchal cord was not tied in a not. True?

A No, no.

Q It was not so tight that you had to doubly clamp it and cut it. True?

A Fortunate.

Q It's just like taking a big necklace off of a woman's neck.

A No, no.

Q You just lifted it up and over. True?

A I slid it over the head but, still, with the contractions, the downward momentum of the baby can tighten that cord and cause reduction in the blood flow through the umbilical cord.

Q Literature shows that you should never think about using greater than gentle traction until six or seven minutes have passed and then only if you have fear that the baby is in imminent danger of brain damage or death. True?

MS. CRAIG: Objection, Your Honor. He's referencing

literature that we haven't seen.

THE COURT: Sustain the objection. Move on.

Q This baby was delivered well before the six to seven minute mark. True?

A That's true and I'm proud of that fact.

Q Yes, sir. Are you proud, sir, of your skill set and experience for getting baby's shoulders unstuck?

A Yes, sir.

Q You're proud of that, too?

A Yes, sir.

Q Doctor, you...

MR. GRAHAM: Court's indulgence, please.

Q Doctor, we started off your testimony yesterday with your lawyer presenting you as an expert witness to testify in this case to defend your own actions. True?

Q Yes, sir.

A You've told us today that, in fact, you don't even claim to be an expert about what causes brachial plexus nerve damage. True?

MS. CRAIG: Your Honor, objection. Qualifications were addressed yesterday. There was no objection and Your Honor qualified ---

MR. GRAHAM: I ---

THE COURT: I think he's allowed. I'm going to give him some leeway with regard to talking about the scope of his

expertise.

MR. GRAHAM: Thank you.

MS. CRAIG: Yes, sir.

Q You don't even claim to be an expert on what causes brachial plexus nerve damages in babies, do you?

A That's a little bit out of my field but ---

Q Yes, sir.

A --- I'm not an expert, but I'm well versed in the subject.

Q Yes, sir, and can you tell me, sir, I know you still claim to be an expert on standards of care. Right?

A I guess.

Q All right. A standard of care is that degree of knowledge, skill and attention and care to the patient that would be, that would be brought to the doctor/patient relationship by obstetricians who are careful and prudent in same or similar circumstances. True?

A Could you break that down? That was a lot ---

Q Yes.

A --- in one statement and I'm not sure that I agree with every single thing you said.

Q Do you believe that a standard of care requires of all obstetricians in this country to conform or comply or honor that level of knowledge, skill, and care that

reasonably careful, reasonably prudent, obstetricians would apply in the same or similar circumstances?

A I think that's a fair representation of the legal term of standard of care.

Q Thank you, sir. And as an expert on standard of care issues, do you recognize that when an obstetrician falls short of the standard of care and harm results to the patient because of that, the doctor is held accountable for all of the harm he causes by falling below the standard of care? Are you aware of that, sir, as an expert on these issues?

A Could you repeat the question and, kind of, simplify the multiple ---

Q When a doctor ---

A --- components?

Q --- violates the standard of care and causes harm to a baby, the doctor should be held liable in a court of law for all the harm he causes. True?

MS. CRAIG: Your Honor, I believe you ruled on this.

THE COURT: Well, I sustain the objection. It calls for a legal conclusion.

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

THE COURT: I sustained the objection.

MR. GRAHAM: I'll move on, Your Honor. Thank you.

Q As an expert on standard of care issues, sir, do you

believe it meets or violates the standard of care in this case for an obstetrician to apply greater than gentle downward traction on Bryson's head and neck?

A I'm sorry. Again, I got lost on that question. Could you repeat it, please?

Q I'll be happy to, sir. As an expert on standard of care issues for obstetricians, do you believe that if the obstetrician who delivered Bryson F put more than gentle downward traction on his head and neck, that doing so would meet the standard of care or fall below?

A I think it would meet the standard of care, but it's a relative thing. You know, I'm still not sure I understand the question that you're posing to me.

Q Yes, sir. Do you consider it a breach of the standard of care for a doctor managing a shoulder dystocia situation within the first four minutes after the head comes out to use greater than gentle downward traction on a baby's head?

A Yes.

Q You believe it's acceptable or you believe it's a violation?

A I believe it's a violation, but in this case we applied gentle downward traction, so it doesn't apply to this situation.

Q Sir, in fact, you don't remember how much traction you

applied in this delivery, do you?

A I remember it was my standard amount ---

MS. CRAIG: Your Honor, this has been asked and answered.

A --- of ---

THE COURT: At least twice, so let's move on.

DR. GOLDSTEIN: Yeah. Fifteen during the deposition.

MR. GRAHAM: No further questions, Your Honor.

THE COURT: Ms. Craig, you're recognized.

MS. CRAIG: May it please the Court.

REDIRECT EXAMINATION

BY MS. CRAIG:

Q Dr. Goldstein, you were asked about informed consent.

A Yes.

Q I want to show you the informed consent form.

MR. GRAHAM: Objection, Your Honor, it's not new.

THE COURT: You did talk about informed consent.

MR. GRAHAM: Yes, sir, in response to what they did on direct.

THE COURT: Well, if you talked about it, she can talk about it. Go ahead.

Q Dr. Goldstein, just, can you tell us whether or not that's your signature?

A Yes, ma'am.

Q Thank you. Dr. Goldstein, did you discuss with Ms.

Fulton her delivery during any of those 19 prenatal visits that she had with you?

A Yes, ma'am.

Q And did you provide informed consent to Ms. Fulton?

A Not during our prenatal visits, but she had informed consent when she came into the hospital.

Q And when I'm talking about informed consent, the various risks that and the various modes of delivery that a woman can have. Tell us what your custom and practice is for telling your patients about that.

A Well, generally in the last few visits when we get close to time for delivery we go over the proposed delivery method, whether it be vaginal delivery or C-section and the proposed anesthesia. We discuss about some of the factors that occur with C-section as opposed to vaginal delivery.

Q And when you are discussing the various modes of delivery and the various risks, is that adequate informed consent?

A Yes, I would suppose so. Yes.

Q Now, does the standard of care -- you were just asked a bunch of questions on standard of care, but does the standard of care require that there be a specific document where you have the patient sign that you, in fact, went through all the various modes of delivery, et

cetera? Does the standard of care require such a document in your file?

A No, ma'am. It would be like the standard of care requiring us to have a signed consent for starting the IV, for starting the Pitocin, for starting the -- you know, everything that's done, you know, drawing the blood for CBC, drawing the blood sugar. I mean, you just can't get informed consent for every single solid thing that you do. And then, each one of these things does have a little bit of risk so, you know, it would be unusually cumbersome.

Q But with your patients, including Ms. Fulton, are those risks discussed throughout the prenatal course?

A Indeed.

Q And in your experience, do most pregnant women want to have their babies delivered?

A Yes, especially by that time they're ---

Q They're ---

A --- pretty ready.

Q --- uncomfortable, aren't they?

A They're uncomfortable.

Q All right. You were asked about mother nature. In this case, if you had not intervened with mother nature, would Bryson be alive?

MR. GRAHAM: Objection, Your Honor.

THE COURT: Overruled.

A Well, again, like I said, she was five centimeters and that's over half. I mean, if she went into labor, broke her water and, Katie bar the door, she couldn't get to the hospital in time, you know, she could have delivered in Lake City or somewhere way -- somewhere on the way to the hospital and it could have been a different circumstance.

Q Yes, sir, and I know we've talked about the induction, the Pitocin, but mother nature with regard to the shoulder dystocia. Was the shoulder dystocia in this case predictable or preventable?

A The shoulder dystocias are unpredictable and unpreventable.

Q Okay. And when mother nature, when you had this situation with shoulder dystocia, that's what I'm talking about, mother nature, ---

A Yeah.

Q --- in that situation, if you had not intervened would Bryson be alive?

A No, I don't think so. Bryson would maybe still be stuck in the pelvis.

Q Okay. Now, some questions about a vacuum and I'm going to -- I don't think you were provided the document, so I'm going to give you a copy of it. First of all, this

appears to be one of several pages. Look at the bottom. It says "continued" at the bottom.

A Yeah.

Q Okay. You just got this one page. Right?

A Right.

Q And then the date at the bottom looks like it's August 13. Is that correct?

A Right.

Q And when was this baby born?

A August of 2008.

Q 2009.

A 2009, excuse me.

Q So this -- this document didn't exist at the time of delivery. Correct?

A That's correct.

Q All right. And you were asked about head trauma, bruises, contusions, lacerations, scalp edema, skull fracture, cephalohematoma, cephalohematoma, subdural hemorrhage, et cetera. Did any of those happen in this case?

A No.

Q Does this have anything to do with the vacuum that you used?

A I don't think this is the one we used.

Q And were you present in the courtroom when the

Plaintiff's expert says that she uses the vacuum and it's a helpful tool for delivery?

A Yes.

Q Is a vacuum a helpful tool for delivery, in your experience?

A Yes, ma'am.

Q Your deposition. Do you remember how long your deposition was, doctor?

A I think it was seven hours.

Q And do you remember how many times you were asked about traction in your deposition?

A Well, I lost count at 15.

Q Let's go through -- I'm not going to go through all. Just a couple. We've got to put these in context. You were asked -- if you'll look at your deposition, you were asked a question at page 130. Please let me know when you're there.

A There.

Q Okay. Now, Mr. Graham wanted you to read only lines one through seven ---

A Yes.

Q --- and I'd like for you to read the rest of your -- I'll ask a question, you can answer it with the rest of your response on that page and starting at line eight, the question is well, what -- what was your answer?

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

Michael Nettles, Circuit Court Judge

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APR 14 2016
SC Court of Appeals

Appellate Case No. 2015-001237

Genesie Fulton, individually and as Next Friend for Bryson F., a minor — Appellant,

v. v.

L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, — Respondents.

PROOF OF SERVICE

I hereby certify that one copy of the ***Record on Appeal*** in the above-referenced matter was served by U.S. Mail, postage prepaid, on April 14, 2016 addressed to the following counsel of record:

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GRAHAM LAW
Shining a Light on Safety, Guiding the Way to Justice.

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J. Layton Ruffin

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SC Court of Appeals

April 14, 2016

Via hand delivery
THE HONORABLE JENNY ABBOTT KITCHINGS
CLERK, SOUTH CAROLINA COURT OF APPEALS
1220 SENATE STREET
COLUMBIA, SOUTH CAROLINA 29201

Re: *Genesie Fulton, individually and as Next Friend of Bryson F., a minor, Appellants v. L. William Goldstein, M.D., individually and d/b/a L. William Goldstein OB-GYN, Respondents.*
Appellate Case No. 2015-001237

Dear Ms. Kitchings:

I am enclosing for filing fifteen (15) copies of the Record on Appeal, fourteen copies bound and one unbound, in the above case. Additionally, please find enclosed the Proof of Service. The Certificate of Counsel required pursuant to 210(g), SCACR is included with the Record on Appeal. By copy of this letter, I am serving attorneys Elloree A Gaines and Molly H. Craig with the same.

With kindest personal regards, I am.

Very truly yours,

J. Layton Ruffin

JLR/ddb
Enclosure
cc: ELLOREE A GAINES ESQ
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