THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

The Honorable Michael Nettles, Circuit Court Judge

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 2 of 2

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A Why don't you ask the question?
Q Okay. It says no, sir.
A No, sir.
Q Okay. I'm the Q, you're the A.
A Okay.
Q All right. All right. So the question,
Q No, sir. Doctor, when, if at all, do you believe it would be appropriate for a doctor to use more than gentle traction on a baby's head?
Q What was your answer?
A Well, he said inappropriate. Excuse me.
A Inappropriate.
Q Thank you.
A Yeah, and I said...
A I guess, you know, all times. It's inappropriate to use more than gentle traction.
Q And then the question is inappropriate?
A Yes, sir.
Q And then what do you say?
A That's what you're asking?
Q That's what I'm asking you.
Q Your answer?
A Yeah.
Q And then it says,
Q It's always inappropriate to use more than gentle

traction?

Q What is your answer?

A It depends on the circumstances. Each of these is-- things are different. I mean, this is not mathematics where the answer two plus two equals four.

Q Is medicine an exact science?

A No, ma'am.

Q All right. Now, the second one is at page 115, and again, we're going to put this in context and I'm almost finished. Page one. You were asked to read lines one through four and I'd like to take it up at line five. The question is...

Q Well, let me ask you this, sir: Assuming head-first vaginal delivery, head delivers easily, the anterior shoulder does not deliver with normal gentle downward traction. Should the obstetrician use the special safety maneuvers like McRoberts, suprapubic pressure, rotation maneuver or posterior arm delivery or increase the amount of traction?

Q What was your answer?

A It's hard to say. I mean, you know, it would be specific for the individual patient a lot of times.

Q Please explain.

A If you're having trouble delivering the shoulder, I

mean, you know, you're not just talking about it's a short period of time. I mean, frequently, the nurses are trained to go ahead and put them in McRoberts position.

Q Okay. Did that happen in this case?

A Yes.

Q And with regard to the nurses, do you have an opinion whether the nurses applied appropriate suprapubic pressure?

A Yes.

Q And what is that opinion?

A That they applied appropriate suprapubic pressure. Unfortunately it was not sufficient to dislodge the anterior shoulder.

Q Now, with regard to traction. You were asked a hypothetical question about traction from your deposition. Do you remember that?

A Yes, ma'am.

Q Going back and forth?

A Yes, ma'am.

Q All right. I'm not going to ask you a hypothetical question. I'm going to ask you a question that pertains to this case. How much traction did you apply to help deliver this baby?

A I applied the normal amount that we generally use in deliveries, the normal amount that I've been trained to

use over the years.

Q And if you -- how would you characterize the normal amount that you're talking about?

A Gentle. Gentle downward axial traction.

Q Dr. Goldstein, did you and nurse Lawrimore, Nurse Collins and Dr. Coker use suprapubic pressure and McRoberts to get Bryson delivered in four minutes after the shoulder dystocia was recognized?

A Yes.

Q And Dr. Goldstein, did you comply with the standard of care?

A Yes.

Q And all the opinions you've given today and yesterday to a reasonable degree of medical certainty, most probably?

A Yes.

MS. CRAIG: Thank you, sir. That's all I have.

THE COURT: You may step down.

THE WITNESS: Thank you.

THE COURT: Madam forelady, ladies and gentlemen of the jury, we're going to recess for lunch. I'm going to ask that you be back at 2:00, 2:00 sharp, and do not discuss the case amongst yourselves or with anyone else. Do not do any independent investigation and I think that we're probably going to be going a little bit longer today, so be sure not to eat, like, a meat and three at Lizard's Thicket where you

DR. GOWER: Yeah. Roger Huntington Gower. G-O-W-E-R.

THE COURT: Very good. Ms. Craig.

MS. CRAIG: Thank you.

DIRECT EXAMINATION

BY MS. CRAIG:

Q Dr. Gower, tell us where you're from, sir.

A From Greenville.

Q And what do you do in Greenville?

A I'm an obstetrician/gynecologist there.

Q How long have you lived in Greenville?

A Well, I grew up there and then after college and medical school, came back in 1982.

Q Dr. Gower, do you have any children?

A Four kids.

Q How old are they?

A Okay. Two would have been easier; right? Twenty-three, thirty, thirty-two, thirty-four.

Q All right. You said you're an OB/GYN. Tell us about your education. Where did you go to college, and then after that, please.

A Went to college in Atlanta at Emory and then medical school in Charleston for four years and then did one year of internal medicine in Jacksonville, Florida, and then after that did OB/GYN for four years at the Medical University in Charleston and that was finishing there in

1982 and then came back to Greenville and practiced there since then.

Q And how many years have you been practicing medicine?

A So, I would have been licensed in 1977, so that would be 30, this summer will be 38.

Q All right. And you -- what's the name of your practice in Greenville?

A My practice is Greenville OB/GYN Associates.

Q How many partners do you have?

A I have eight partners at this time and we're affiliated with/owned by a part of Greenville Health System.

Q And so where do you have hospital privileges?

A Just at Greenville. Greenville Memorial Hospital.

Q Are you board certified?

A I am.

Q And how many deliveries do you do, approximately, in a year?

A So, in our practice, our practice does approximately 1,000 deliveries and so my -- my numbers would vary between -- oh, 120 and maybe 150 a year at this point.

Q What teaching responsibilities do you have?

A So, we have a residency program there. We've had one for quite a while, so I cover the residents. I'm their attending physician at night so for their deliveries and then I -- we have a medical school there and this is our

third year of that and so I now have third-year students who rotate with me in the office, oh, approximately, two to three months a year.

Q Are you a member of any professional organizations?

A So, I'm a member of the American College of OB/GYN as well as South Carolina Medical Society, American Medical Society, Greenville County Medical Society, Southatlantic Association of OB/GYN. I think that's all.

Q Is the American Congress, the American College of Obstetrics and Gynecology, is that the same thing as ACOG?

A Same. That's ACOG. That's our body that, the professional body that helps us with education.

Q And that's my question. What is the purpose for you, as a physician practicing obstetrics in your community, what's the purpose of being a member of ACOG?

A So, ACOG has conferences. In fact, there's a national conference going on right now. One of my partners is there. That's educational. They have educational meetings throughout the country and then there's a good bit of publication that they do regarding guidelines and as well as original research. They publish a journal and that sort of thing.

Q Dr. Gower, have you testified in court before?

A I have testified in court previously.

Q How many times?
A So, I've testified twice in malpractice cases, in which case I was a defendant, and I've testified in three cases previously as an expert.
Q Have you ever testified as an expert witness for our law firm?
A No, I don't believe I have.
MS. CRAIG: Your Honor, at this time we would offer Dr. Gower as an expert witness in the field of obstetrics and gynecology.
THE COURT: Any query with regard to his qualifications?
MS. RODRIGUEZ: Not in obstetrics, Your Honor.
THE COURT: Very good. He is indeed qualified as an expert in the field of obstetrics and gynecology and allowed to render his opinions in that field.
MS. CRAIG: Thank you. Your Honor, at this time we would offer Dr. Gower's CV into evidence.
MS. RODRIGUEZ: No objection.
(Whereupon, Dr. Gower's CV is entered into evidence as Defense Exhibit #4, without objection)
MS. CRAIG: May I approach?
THE COURT: Yes.
Q Dr. Gower, could you just tell us, is that your most updated CV?
A It is.

Q And is a CV the same thing as a resume?
A Yeah, same thing.
Q Dr. Gower, at my request did you review the medical records in this case, the medical records from the prenatal course, the delivery records, as well as depositions of witnesses that were involved in the labor and delivery? Did you do that?
A I did.
Q And based upon your review of those medical records and that deposition testimony, did you reach an opinion as to whether or not Dr. Goldstein met the standard of care in this delivery?
A I did.
Q And what was that opinion, sir?
A So, after I had read the hospital record, the prenatal records as well as the depositions, deposition of Dr. Goldstein, it's my opinion that he met the standard of care for obstetrics throughout his management of this patient.
Q Okay. Let's start first now with your experience with shoulder dystocia. Can you just give us in your experience your -- how many times have you confronted shoulder dystocia, and I know you can't give us a specific number, but just tell us what your experience is.

A Right. So, in looking over this and considering, you know, shoulder dystocia, the incidence, I believe that I probably encounter shoulder dystocias once or twice a year. Sometimes that will be for my patients who I'm managing in labor and sometimes it will be with the residents who, who I'm responsible for. I'm an attending and in a teaching role, so probably once or twice a year and I've been in practice in Greenville 32 plus years and then in residency would have been similar, four years there.

Q Now, your practice in Greenville, do y'all have the largest obstetrical practice in Greenville?

A One of the two larger practices, for sure.

Q Between you and your seven partners, do y'all deliver a lot of babies?

A Yeah, about, about 1,000 a year, something like that.

Q Now, when you encounter shoulder dystocia, do you have an opinion whether that situation, shoulder dystocia, whether or not that is a medical emergency?

A It absolutely is.

Q Why is that a medical emergency?

A So, after the baby's head is, is out, the baby will have -- you'll have a certain amount of time when there's compression of the umbilical cord where the baby is not able to oxygenate well, so you've got a limited amount

of time to, for the baby to be born before you run the risk of neurological injury to the baby.

Q And when you encounter a shoulder dystocia, do you call for assistance?

A Absolutely. Absolutely. It's, basically, we've got a shoulder dystocia in room three and you tell the nurse and sort of an all hands on deck and we assemble a team, as I think was the case in this, with this patient. We assemble a team that includes additional nurses, sometimes surgical technicians, anesthesiologist, neonatologist or pediatrician, in attendance, as well.

Q All right. Dr. Gower, have you had a chance to review some medical illustrations at my request?

A Yes, I have.

Q Okay. And would these medical illustrations assist you in explaining shoulder dystocia to the jury?

A I think they would.

MS. CRAIG: Your Honor, may Dr. Gower come down and ---

THE COURT: He may.

MS. CRAIG: -- go through these medical illustrations? Thank you.

Q All right. Dr. Gower, I'm going to put you on this side so the court reporter can hear you and I just want you to run through these medical illustrations.

A Okay.

Q And there's a pointer. There you go. All right. Tell us, tell us what we are seeing here.

COURT REPORTER: What number? Excuse me.

MS. CRAIG: This is Court Exhibit, hold on, #12.

A Okay. So, as you can see here, the baby coming down. Usually the head is, sort of, facing face downward, so that would be occiput anterior. The occiput is the back of the head. So, the head usually comes down, sort of, under the pubic bone with the face, sort of, down, maybe tilted a little one way or the other at this point, so the head comes down below the, below the pubic bone right here. So, that's the pubic bone. That's the sacrum. That's what you call sacral promontory that sometimes hangs you up a little bit posteriorly. So, the head's coming down here. The, in this second picture here, this illustration here, the head has come down but you can see the shoulder is, sort of, stuck under this pubic bone here, so that's -- I think the attempt of this illustration is to show that the shoulder is, sort of, impinged there and it would be difficult for the baby to deliver with the shoulder, sort of, stuck under that.

Q Okay. All right. Now, the next one we have shows normal delivery versus shoulder dystocia and it's Court Exhibit #11. Please explain this blow-up.

A Okay. Okay. So, that was after the last -- the last picture you just saw where the shoulder was, was stuck there. In this case, it didn't happen and the shoulder has come down below the pubic bone, so really -- so when you're doing a delivery and you see that the head comes out and then the head turns and then you look and when you see that shoulder you're, like, great, not going to be a shoulder dystocia this time, so that's what happens when ---

Q Because you know it cleared?

A You know the shoulder cleared. You actually see it. You can -- you know, you can't see it in this diagram, but you can actually, when you stand there you can see that shoulder clear and, you know, I think we all breathe a sigh of relief. We're not going to have a shoulder dystocia this time. So, that's normal and this is not normal. This is, this is when the shoulder gets stuck. The anterior shoulder's lodged against the pubic bone so that the shoulder is stuck so this is when you say, "got a shoulder" and, you know, you can say that in any tone of voice, but the nurses hear that and that's when it's, sort of, hit the call button and they, you know, assemble the team. So, that's what happens.

Q And do you sometimes, based on your experience working with certain labor and delivery nurses, do you just give

each other the eye as there might be a problem, so you don't make people worry?

A I probably do a little more than give them the eye.

Q You do more ---

A Yeah.

Q --- than give them the eye?

A I mean ---

Q Okay.

A Yeah, there's an eye, for sure, but it's probably, probably -- I think, you know, everybody has their own style. I'm probably pretty loud.

Q Okay. All right. Last one is Court's Exhibit #13. Tell us what we see here.

A And it's kind of interesting on that point. That's an interesting point because, you know, the patient is -- you know, you want to, you want to be, you want to make clear that there's an issue and that there's an emergency, but you don't want to get the patient and the family upset at the same time, so, so there is a, you know, you don't want to, yourself, sort of, panic and that's -- so giving them the eye, I think the point there is you want to let the nursing staff know without scaring everybody else to death.

Q All right. The next one is Court Exhibit #13. If you could explain this blow-up.

A Okay. So, the shoulder's stuck. Have a shoulder dystocia. You've called a shoulder dystocia, so you start to do things and the first thing that, that I usually do and I think most people do, is this McRoberts maneuver that you've heard a lot about already. So, this just shows, just from one side, so you can't see the patient's right leg but you can see the left hip hyperflexing here and rotating outward so that's happened here and that usually moves the pubic bone, sort of, forward and allows the shoulder ---

Q Why is that? How does it move the pubic bone forward? How does that release the shoulder?

A So, yeah, the shoulder's stuck under there, so you pull the hip back. It just, sort of, opens that up and it moves that in a, in a superior fashion, actually. It moves it up and just allows the shoulder to slide out in most cases, so that that works the vast majority of the time.

Q All right.

A Just doing that.

Q And what's going on up here?

A Okay. So, you've also got suprapubic pressure. You've got whoever that is. They've got blood on them, a nurse, surgical tech, another physician, somebody because in our place, you know, sometimes there's somebody in

another practice that comes to help, so we have that happen as well. So, someone has got their hand up here right above the pubic bone where that shoulder is and, you know, sort of, sort of makes sense that it works but you can push that shoulder forward where it's, sort of, impinged and, sort of, push it down and to the side a little bit, so that's what's going on there.

Q Thank you. Have you also had a chance to review an animation of a delivery that shows the baby being, coming down the birth canal, encountering the shoulder dystocia, and then the shoulder dystocia being resolved and the baby being delivered? Have you looked at such an animation?

A I did.

Q And would that animation assist you for demonstrative purposes in showing the, showing the jury how that situation ---

A Right.

Q --- occurs?

A I think it's dynamic rather than static so you're just seeing some static, some shingle shots, so it's the difference between just, you know, points in time versus, sort of, a continuum.

Q Okay. All right. So, what I'm going to do is, I'm going to put that animation up on the screen. So, if you'll

just walk over to ---

MS. RODRIGUEZ: Your Honor, may I put my objection on the record?

THE COURT: Yes, you may.

(Bench conference off the record)

Q Okay. So, what we're going to do is I'm going to -- I'm going to put it on here ---

A Okay.

Q --- and then it will -- if I can get it straight ---

A Okay.

Q --- and then I'll start it and then, doctor, if you just tell me when to stop and you can explain to us what we're seeing. I know there's a little bit of a ---

A I'll stand on this side so I'm not blocking anybody's view.

Q I know there's a bit of a glare, but I think we're going to be okay. All right. Ready?

A Yeah, you can go ahead and start it. So, there's the baby. Head's coming down. The face is kind of looking down towards the floor, so it's in the occiput anterior position. The occiput, the back of the head, is up towards the pubic bone and the head's, sort of, coming down. So, then you have the head, sort of, rotates there. The head is coming down. The baby's looking straight down there. You've got -- see the cord there?

Q You have to explain. Explain that cord. What's going on there?

A So, that's the umbilical cord. It's actually wrapped around the neck. That doesn't show it that well, but it's actually -- you can see it. It's like a noose almost. It's wrapped all the way around. It's not that unusual though ---

Q All right.

A --- that we see that.

Q Keep going.

A Right.

Q All right.

A So, you've got that. The head's, the head's out. Shoulders, haven't seen the shoulder yet so we don't know what's going to happen with that. I think -- you can keep going.

Q Oh, sorry. I thought I did. Here we go.

A So, at this point you may or may not be able to see the umbilical cord so ---

Q Okay. I'm sorry. Hold on a second. It stopped again.

A You may or may not be able to see the umbilical cord at this point, so what you usually do is you feel right above the baby's head and see if there is the cord there at the neck, because sometimes it can be retracted and tight and actually make it impossible to deliver the

baby without actually clamping the cord, clamping the cord before the baby is born. So, there we go. Okay. So, there we begin to see the cord and the head's coming out. Things are looking -- it just retracted a little bit, so if you saw that ---

Q What does that mean when it retracts?

A So that's -- that means that shoulder that was, sort of, coming down went back under the pubic bone so it got impinged up under the symphysis pubis ---

Q All right.

A --- right there so, you know -- okay. There -- okay -- there's the cord. It's now -- the umbilical cord is visible. You may begin to think I might have a shoulder here. I don't know that you know it yet. You've got the cord to deal with first, so at some point there, you are.

Q What have we got going on here?

A So, reaching down just stabilizing the head and reducing the cord.

Q What's that called again?

A That's just reducing the umbilical cord. You know, it's interesting in this illustration, it shows the cord coming down, but you don't really know where that cord is. That cord may still be, sort of, trapped up under here so the head is out but the umbilical cord, it

doesn't really show that it's compressed in this view, but most often it is.

Q Okay.

A So, you've got the umbilical cord out of the way for delivery but maybe still compressed. You've had the -- you've now seen that turtle sign where the head, sort of, retracted back right there and so it's time to, time to do something. Hopefully, at this point you've, you've said hey, we've got a shoulder here and you begin to do some of the ---

Q What's going ---

A --- some of the numerous ---

Q What's going on here?

A So there's -- there's the McRoberts. That's the McRoberts you've heard about where that hip is being rotated way back and you probably -- I don't know if you can see this if they've illustrated the pubic bone and synthesis pubis, but it should have. Now somebody comes in and pushes it, uses the suprapubic pressure. That was a good one. You got by with just one McRoberts and suprapubic pressure and baby's born.

Q Great. Thank you, Dr. Gower. If you will go back to your seat.

A Can I take my water with me?

Q Yes. Dr. Gower, how does a doctor know how to use

appropriate amount of traction?

A Well, it's a learned skill and in thinking back about, you know, how I learned that and have taught others, earlier on in your career when you're doing, when you're delivering babies, say, as a medical student or a first-year resident, you'll have someone very closely with you and so, so at least in my experience, I think I remember the first few babies I delivered, I'm, sort of, holding traction. I don't know what I'm doing and there's somebody standing next to me that's watching me, feeling with me, maybe hands on hands and can, sort of, tell what the traction is and then I would say some point in your career, 100, 200, deliveries in, which is probably the end of your first year of residency, maybe, you really do have a feel of how much traction is, is appropriate.

Q Can you quantify the amount of traction that you use to deliver a baby?

A Well, that's just it. You can't. There's really no way to quantitate it.

Q And in this case, how do you know that Dr. Goldstein did not use excessive traction?

A So, that's the question. And so, you take all the information as an expert that you're presented with. You have the, you have the medical record of what

happened. You have the time sequence of events, when the head delivered, when the shoulders delivered, what happened in between, so you have that information to go on. In the medical record, there's really not any evidence of excessive traction one way or another, but to go further, you, you -- the other evidence you would have is the obstetrician's deposition and his description of what happened during the delivery and his telling of the events as they happened, and, and then the third thing is, I guess, that I did look over, in this case, were the nurses' depositions of the sequence of events and how they, how they responded and, sort of, how the drill went, how the emergency was handled and so on, so, and in summation of all that, it appeared to me that there was no evidence at all that there was excessive traction.

Q Is that your opinion to a reasonable degree of medical certainty ---

A It is.

Q --- most probably?

A It is.

Q Now, do you use traction to deliver babies only in shoulder dystocia situations?

A No. No. I mean, in a normal delivery you, I mean, you know, a normal delivery, you do guide the baby out.

Q Explain that, please.
A So, in that illustration you saw, the head comes, comes down. It rotates so that the baby's face is downward. The baby then, as the mom pushed or as the uterus contracts, sort of rotates to the side and that's usually when you place your hands on the side of the baby's head and, sort of make sure and, sort of guide the baby down out of the, you know, birth canal. So, so traction is a normal thing that happens in almost every delivery. There are very few deliveries where you don't, that you would not have any traction at all, where you just stand there and watch and let it happen. Some that, you know, are very rapid and occasionally if a mom's had two or three babies before it'll happen without you doing anything, but even then we don't think it's a great idea, because it's almost too fast.
Q All right. That's traction. We're now going to move to informed consent. Do you have an opinion whether informed consent was appropriate or adequate in this case?
A It appears to be adequate.
Q Now, do you agree that the hospital consent form covers the use of a vacuum?
A It does.
Q Now, when you are delivering babies, or your partners,

do you stop a delivery and have a woman sign a separate informed consent form for the use of forceps or for a vacuum?

A No, I've never done that.

Q Why is that not a reality in the practice of medicine?

A Well, mom's been in labor pushing and at that point if you, if you think that you need some intervention to help with that, whether it's a vacuum, forceps, then, you know, you simply, if it's -- if the head was sitting right there, which it was, I think, in this case, at a plus-three station, you might simply apply the vacuum to ease the baby out for, sort of, a controlled delivery. In a situation where it was, you know, maybe more difficult, where the head was higher, you couldn't see the head and you're really, you knew you were, you were at a little more risk because I think vacuum or forceps can be risky in some situations and in other situations you're simply guiding the baby out. In those more risky situations, I probably would have informed consent discussion, but would not stop to sign a piece of paper.

Q And in this case, with the use of a vacuum, do you have an opinion whether it was appropriate and reasonable for Dr. Goldstein to use the vacuum to help get the head down?

A I think it was.

Q And why is that?
A Well, towards the end of her labor the baby's heartbeat -- I don't, haven't heard any discussion of that, but the baby's heartbeat was having some dips, so you're seeing a few dips and the head is right there at a plus-three station, so I believe that at that point it appeared that the baby would be safer delivered with a heartbeat like that, so you have the option of having the mom continue to push or simply in this case using a vacuum and easing the baby out that way, and he was able to do it with, I think, two pulls.
Q Was the use of the vacuum successful or unsuccessful?
A It was successful.
Q Did it harm the baby in any way?
A No.
Q Now, in your practice typically where do your patients go to deliver a baby?
A Greenville Memorial.
Q Okay. So, they go to Greenville Memorial and when they go to Greenville Memorial, what type of informed consent form do they sign to have a baby?
A So, it's actually the, not the exact wording, but it's a similar form to the form that was with this patient at Carolinas. So, it's a permit that says for vaginal delivery or Cesarean.

Q And who reviews that informed consent with the patient?
A Well, the nurse would have the patient sign it.
Q And in your chart, in your specific office chart for each of your pregnant patients, do you have a specific informed consent form that you have every single one of your patients sign that you put into your chart?
A No, we don't use an informed consent during prenatal care.
Q Explain to the jury how you inform your patients about the various delivery options and provide informed consent throughout the prenatal course.
A Right. So, pregnancy's a unique situation in that you have multiple opportunities -- I think this patient had 19 prenatal visits, so you've got multiple opportunities to discuss pregnancy, everything related to that, and in this case, what happens at the hospital, labor and delivery. So, what generally happens our patients do a lot of reading. All of our patients do a lot of reading, a lot of internet, and so on and so you'll say hey, how's it going, you know, you're going to have the baby in a few weeks, any questions about that? So, it's a dialogue. It's not really a moment in time. It's a dialogue throughout the prenatal care which continues in the hospital.
Q And that dialogue, that's a nice way to put it,

throughout the prenatal care, is that adequate informed consent that the doctor is having with his patient?

A That's right. That's what we all do.

Q Now, what risk -- what is the risk to the mother and the baby if the doctor is not able to dislodge the shoulder when it's stuck under the pubic bone?

A So, the risk to the mom if the baby has a, if the baby's shoulder is stuck there, I think the longer it's there, there's more chance of injury to the birth canal. In this case, you know, you have to extend the episiotomy, so it's going to be a little bit more trauma for the mom for sure. For the mom also, she's going to have a little higher risk of bleeding after delivery, postpartum hemorrhage. For the baby, the risks are, you know, in the process of birthing, for having some type of injury which is in a shoulder dystocia, fortunately not that common for the baby to have an injury, but it can have a clavicle injury, can have a humerus injury. The baby can have a nerve injury to the brachial plexus, yeah, so that sort of thing, and ongoing if the baby is stuck and doesn't deliver after a certain period of time, you've got loss of oxygen to the baby so you've got brain injury and even death.

Q What happens with loss of oxygen?

A Well, after a period of time and, you know, you hear --

depends on how the baby started, what the oxygenation was with the baby when the baby started, but in general you've, you know, after five, 10 minutes the baby's going to have loss of oxygen to the brain and get hypoxic ischemic encephalopathy, but basically loss of oxygen to the brain and some brain injury.

Q And in the most severe cases, is risk of death to the baby, is that ---

A Well, cerebral palsy and then after that, yeah, death.

Q All right. Now, moving to, I'd like to talk about the prenatal care, those 19 visits you just referenced. I'm not going to go through every one of them. My question to you is do, you have an opinion based upon your review of Dr. Goldstein's office chart and all of those prenatal visits, if you have an opinion whether the prenatal care that was provided to Ms. Fulton from Dr. Goldstein, was it reasonable and appropriate?

A I think it was. He had an older mom who had some issues, some risk factors of not only age but being a little heavier. She was diagnosed fairly early with diabetes and some of her lab work did show that the diabetes was not in great control early in the pregnancy and with medical management, got the diabetes under control. So, I think the prenatal care was, was totally, totally within the standard of care.

Q Who did that management of the diabetes? Who are you referring to?

A Just Dr. Goldstein.

Q Thank you. All right. Prenatal care. Now, moving on to the delivery and I'd like for you to tell us whether you have an opinion whether it was appropriate to induce labor for Ms. Fulton.

A I think it was. She ---

Q Okay. Tell us why.

A Yeah, she was 30, a little past 36 weeks and blood pressure was elevated in the office that day. She was already five centimeters dilated. She was a diabetic patient and we know that diabetic patients do have higher risk of unexplained stillbirth, that the placenta for some reason doesn't function as well towards the end of pregnancy, so for that reason we have the patient come a couple of times a week to do fetal assessment. In this case, they did it, I believe, mostly with nonstress testing or you can do it with ultrasound too, but some way to make sure that placenta is still getting oxygen to the baby. So at 30 -- you know, he's gotten the patient to 36-plus weeks. The diabetes was pretty well controlled. Her blood pressure was starting to go up. She's already five centimeters dilated. I think it was totally appropriate to, to go ahead and induce.

Q Do you induce your patients?
A Oh, sure, sure.
Q Is that ---
A Not as often as they want to be, however.
Q Is that a normal or an abnormal thing to do as an obstetrician to induce patients ---
A Sure.
Q --- who are ready to have ---
A It's very normal.
Q Okay. How about Pitocin? Another question. Is that the regular medication that's used to help the induction process?
A Yeah, that's what we use, primarily.
Q Okay. And how does it work?
A So Pitocin is given intravenously. You have it on a pump so you start at a low dose and you gradually work up to a adequate dose to get to active labor.
Q Was the use of Pitocin reasonable for this delivery?
A Yes, it was.
Q Based on your review of the medical records, and specifically the dictated note of Dr. Goldstein's, this handwritten note discharge summary, and the nursing notes, do you have an opinion whether McRoberts and suprapubic pressure were appropriately used once the shoulder dystocia was recognized?

A Right. According to the medical record and the depositions that I read, it appears all that was appropriate, within the standard of care.

Q And in your experience delivering babies, is it abnormal or is it normal to need to get down on your knees to help get the baby delivered?

A Well, fortunately, you know, you don't have to do it too often but, but yeah, I usually sit for deliveries and if the, in the case of a shoulder dystocia, because you want the bed low enough so that whoever's helping you can get up and give suprapubic pressure, so sometimes there's no way to be in the right position without being on your hands and knees, so it's not that unusual for me to do that.

Q How about the episiotomy? Do you have an opinion whether trying to extend the episiotomy to make more room to get the baby delivered, was that reasonable?

A Right. It's not your first choice but once you've -- once you've tried the McRoberts and suprapubic, if that's not working, yeah, episiotomy is exactly the right way to go.

Q And, Dr. Gower, do you have a opinion whether Dr. Goldstein appropriately and reasonably managed the shoulder dystocia that was encountered in Ms. Fulton's delivery?

A Yes, I think that, from my reading of the record and descriptions in the depositions of what happened, both from him and the nurses, I believe it was appropriate. He appropriately managed this ---

Q And is that ---

A --- emergency.

Q I'm sorry. Is that opinion and all of your opinions to a reasonable degree of medical certainty, most probably?

A Yes, it is.

MS. CRAIG: Just one minute.

Q Those are all the questions I have, Dr. Gower. Thank you very much.

THE COURT: Cross examination.

MS. RODRIGUEZ: Thank you, Your Honor.

CROSS EXAMINATION

BY MS. RODRIGUEZ:

Q Dr. Gower, my understanding is that about 50 percent of your practice is actually not involved in obstetrics. It's involved in -- only involved in obstetrics. Correct? About 50 percent of the time?

A Right. Most -- yeah, about 50/50 or maybe a little more gynecology than OB.

Q Okay. And you work in a hospital-based practice. Correct?

A Well, I have an office.

Q But it is a hospital-owned practice ---
A Owned practice.
Q --- and you are located at a hospital?
A Yes, yeah, I never know how to define base because I don't, I don't consider the hospital my base. I spend a lot of time there, but my base would be my office.
Q Okay. The point to the question is, though, that basically your practice comes under the auspices of Greenville Hospital System.
A Right. Greenville Health System, correct.
Q Okay.
Q But that's a part of Greenville Hospital System. The old name used to be Greenville Hospital System. It's now Greenville Health System.
Q Okay. And your office practice is owned by that entity?
A Correct.
Q So, the things that you decide to do in your private practice are actually things that are part of Greenville Hospital System.
A Okay.
Q Is that correct?
A The things that we decide to do?
Q Sure, like the consent forms that you use, the policies and procedures that are done in your office. Those are integrated with the hospital system?

A They're integrated. We have -- we still have a fair amount of autonomy, but yes.
Q Okay.
A We're definitely integrated.
Q Okay. And one of the things that Greenville Hospital System does is that they are big advocates of patient rights. Aren't they?
A Sure.
Q And as part of their advocacy on patient rights, they feel very strongly, and I assume you do as a member of their staff, that patients have a right to choose and to be involved in their health care.
A I would agree with that.
Q And a part of that is including the patient in any decision-making that pertains to their health care?
A I would agree with that.
Q And some of that involves something called informed consent, which the jury has heard about.
A Correct.
Q But it also, as you commented, was a continuum of care.
A Okay. Sure.
Q So, at Greenville y'all have policies and procedures where along and along in a pregnancy such as in the prenatal case there's a lot of information that a patient needs and that they need to get and you have

booklets that you give them, informational videos that they watch. You have a whole system in place to educate them throughout the pregnancy, don't you?

A Yeah, I don't know that it's different from anywhere else but we, we don't have videos, but we do, we do have printed material and we have classes at the hospital and that sort of thing. Yeah.

Q Sure. The other thing is that in your practice, if it hasn't changed since last year or the year before that, y'all document in your record when patients get patient teaching. Is that true?

A No, not always. I mean ---

Q Not -- not always but as a general rule ---

A No, because I think most of your teach -- patient teaching is, sort of off the cuff with every visit. I don't think that we would say we -- when we give them a book we may, we should document it, but we probably don't every time.

Q Okay. You don't every time, but as a rule at Greenville Hospital System, it's your testimony that they don't generally document patient teaching?

A No, I wouldn't say they don't document it. I just don't think it's absolutely consistent.

Q Okay. So, for instance, when you sit down and have a conversation with a patient -- and in your practice you

probably have residents with you that you were teaching.

A Not at my office.

Q Not in the office any? Okay. So, it's just when you do it in the office, so you're not actually teaching in that setting?

A The office really runs very much like a private practice.

Q Okay. So, if you sit down and you have a mother who is an older mother and you counsel her about some issues dealing with her pregnancy that could impact the outcome of what happens in her pregnancy, is it your testimony that you do not document that discussion with the patient?

A Not always.

Q Not always, but as a general rule, what do you do?

A Well, you know, no. I mean, every prenatal visit may well have educational components and we don't document that.

Q That wasn't my question.

A Okay.

Q My question is, when you talk to them when it's something that could impact the outcome of the pregnancy, are you telling me you don't put a documentation as to that discussion in your medical record?

A Sometimes we do and sometimes we don't.
Q But as a ---
A I don't think, I don't think there's a rule on that. I think it depends on the discussion.
Q Okay. What do you teach the residents? What would you teach a resident who is counseling a patient about issues that could impact the outcome of the pregnancy?
A Well, it's always better to write a note.
Q So, for instance, if you have an older patient and you're going to talk to them about the possibility of something that might happen in their pregnancy like should we do a Cesarean section, and you think that this is a patient that there is a chance that a Cesarean section may end up being the route it goes, are you going to document something about it?
A Would be good. It would be good to do that. I'm sure we don't do it as much as we -- as much as we could.
Q But the reality is, that's what you train doctors to do and that's what a good doctor does.
A Best practice.
Q Sure. That's the best practice.
A Best practice. Standard of care, probably not, but best practice.
Q Okay. The other thing is if you're giving patients information that could have or, in this instance, let's

talk about medication. If you're changing a patient's medications and those could have an impact on other things in the patient's care or the patient's health, do you advise the patients about it?

A What medication are you talking about?

Q Any medication.

A Prenatal vitamins?

Q Prenatal vitamins are not likely to have a big impact on a patient's health, doctor, other than to make him a little healthier. True?

A Maybe.

Q Okay. Maybe some constipation because there's iron in them but, come on, doctor, that's not really going to have a big effect.

A So, an example of what we might, we might document?

Q Sure. If you put a patient on a medication that could have bleeding as a risk associated with it, are you going to have a conversation with the patient about that?

A It depends on what, you know, what the level of the risk is and the benefit, but, but most likely, yes.

Q Okay. And when you have that conversation with the patient, you're going to make a note that I told the patient this can happen or that there's concerns about this particular medication.

A For the most part. I mean, our patients are pretty well informed and there's so much information out there that we might write the prescription and say, are you familiar with this, and they're, like, oh, yeah, I know all about this.

Q Okay.

A And you might not feel the need to document. We document primarily so our partners, when they see that same patient, will know, you know, what was, what was discussed.

Q So, are you telling me, though, that it's part of your practice to routinely tell your patients go look on the internet?

A Oh, yeah, sure.

Q So, you don't have to teach them. Instead you say just go ---

A No, both.

Q --- look on the internet?

A No, both. Most of them have already, already have done pretty good internet searches by the time they get there.

Q Okay. The more likely scenario is they come in to you and say, "I read this on the internet. What do you think?"

A Exactly.

Q Yeah.
A Yeah.
Q Okay.
A Yeah.
Q But you're not telling them, "Go learn about pregnancy on the internet or go learn about this medicine ---
A Well, I'm not telling them not to do that.
Q Okay. But my question is, you're not telling them. You're teaching ---
A We have a website and yeah, we direct them to it.
Q Okay. That's the website at the hospital that has the information that your group has had input into putting on the internet. Correct?
A Yes, ma'am.
Q You're not just sending them out to the internet and say go Google it.
A Some of that, too, but, you know, it's both.
Q All right. In this instance, I think you gave some opinions about Dr. Goldstein's management of the prenatal care. Did you look at what the patient was initially referred to Dr. Goldstein for?
A I don't ---
Q Was she seeing ---
A I did look at that in the past.
Q Okay.

A I think a couple years ago actually.
Q Do you, did you know that he was seeing her prior to the pregnancy?
A I did.
Q Did you know that he had been seeing her for almost a year?
A I believe so.
Q Do you know what he'd been seeing her for?
A It might have been -- no, I'm not -- I won't say that I know for sure.
Q Okay.
A It'd be speculation.
Q Okay. His -- but you did have these records ---
A I did.
Q --- and were -- okay. And you knew you were coming here to testify today and that we were going to ask you questions about the prenatal care and all of her management by Dr. Goldstein.
A Sure.
Q Okay.
MS. CRAIG: Your Honor, the witness would be entitled to look at the documents that are in evidence.
THE COURT: He can.
MS. RODRIGUEZ: Absolutely.
Q Would you like to look at the records?

A If -- yeah, if you're going to ask me questions about them.

Q Sure. Here you go. Here is Dr. Goldstein's record. If you want to see if you could perhaps locate the initial evaluation in which the patient was referred to him in 2008, and I think you'll find that he was, she was referred by Dr. Morris.

A Polycystic ovary disease.

Q Well, now was that what she was referred for or is that what Dr. Goldstein diagnosed?

A That's a letter to Dr. Morris from Dr. Goldstein.

Q Okay. And does he indicate that was the diagnosis he was making?

A He said it sounds like she has had polycystic ovary disease for a number of years.

Q Okay. Do you see anything in the letter that indicates she was seeing him because she was trying to get pregnant or wanted to get pregnant?

A Yes.

Q Okay. Where do you see that?

A I'm not sure who LWG is.

MS. CRAIG: If she could just give the doctor a page number.

DR. GOWER: Yeah, I mean, I'm, kind of ---

THE COURT: Do you have a page number?

MS. RODRIGUEZ: I ---

DR. GOWER: They are numbered.

MS. RODRIGUEZ: Unfortunately, I don't know that record. I'm waiting for him to find the one that says that.

DR. GOWER: I don't see the initial H and P.

Q Okay. Why don't you try looking on page 69 of his record. I think they're numbered.

A They are numbered.

Q Okay. Is that the original visit?

A I'm getting there. Well, after 68 it goes to 59.

Q Okay. Well, I tell you what. I'm going to give you ---

A Here's 69. It's a dictated.

Q Okay. And ---

A Okay. So, yeah, I think that's -- I think that's where I was a minute ago. So, I assume LWG is Dr. Goldstein.

Q Okay. And is it your understanding from reviewing that that her request or the information provided by Dr. Morris, it says at the top referred by Dr. Morris for what?

A History of fibroids.

Q Okay. So, it's your testimony that she was actually there for management -- or because she wanted to get pregnant?

A Well, I just looked at this.

Q Okay.

A Well, I mean, I don't have ---
Q Now, before we get into this in a little more detail, let me ask you this: Just very basically, tell the jury what is polycystic ovary disease.
A Polycystic ovary disease is a pretty common problem. Probably five to 10 percent of women have it and it's a situation where the mom doesn't ovulate and the estrogen level tends to be high. The testosterone level tends to be high associated with insulin insensitivity, diabetes, hypertension, infertility, a number of other comorbidities.
Q So, those are the impact of polycystic ovary disease or the symptoms of it. Correct?
A Diagnoses ---
Q Those things that you just ---
A --- associated with it, but I don't think symptoms necessarily.
Q Okay. Well, when you have a patient who comes in for polycystic ovary disease, do you look at -- you do a differential diagnosis and you find out all of the things, the symptoms, that the patient has that may be consistent with that diagnosis. Is that right?
A Yes.
Q Okay. And that would include things like; have you been using birth control and not getting pregnant, are you

having problems with your menses, are you obese, do you have extra body hair, places where you wouldn't normally, those types of things? Would that be fair?

A Sure.

Q Okay. And so from that you come up with a differential diagnosis that says it's probably something like polycystic ovary disease. And by the way, that also includes diabetes, doesn't?

A Yes.

Q Okay. And so based on the evaluation that he did, Dr. Goldstein's assessment, if you'll look at the next page, which is page 70, it was his assessment that she had what?

A Polycystic ovary disease based on hirsutism, secondary infertility, irregular menses, obesity. I suspect most of her -- stop?

Q Well, my question is so where in this note did you understand that she came to him because of an infertility problem?

A Oh, it says secondary infertility.

Q Okay. But the secondary infertility means that one of the signs of the polycystic ovary disease is she had been infertile. It doesn't mean she's trying to get pregnant, does it?

A Well, no, we don't call it infertility unless the

person's trying to get pregnant.

Q Well, I think if you read -- if you read the record, doctor, what it indicates is, is that she was a married woman who had not been using birth control and had never gotten pregnant, and your interpretation of that is that means she came here because she wants to get pregnant?

A No, I don't see that in the history one way or the other.

Q Okay. So, if you make a change in the patient's medication that could actually change their fertility, do you think it's something that -- when the patient has told you that they're married and having unprotected sex, do you think you should tell them that, by the way, if we change that medication you could become fertile? Just philosophically, do you think the patient should know that?

A Yes.

Q Okay. So, in this case, when she arrived to see Dr. Goldstein, she had been referred by Dr. Morris for the fibroids and it notes that she was taking a medication for this blood sugar at that time, for her diabetes, and it was Glucotrol. Correct? If you look under ---

A Yes.

Q --- medical history ---

A Yeah. Yes.

Q Now, there is a medication, if I'm correct, for patients who have polycystic ovary disease, if you change their diabetic medication to other ones, it can cause them to become fertile.

A It can increase their chance of ovulation.

Q Okay. And that particular medication is something called Metformin?

A Correct.

Q So, if you were putting an elderly patient on -- by elderly I hate to say over 35, since I'm considerably older than that, but let's say a patient in this age bracket who comes to you with these symptoms and you're changing the medication to Metformin, do you not think you should have a conversation with them about fertility issues and that you could become pregnant on this?

A Yeah, I think that would be appropriate. It says that she had had a pregnancy in 1989 and unprotected intercourse for a large number of years and has been unable to conceive. Unable sort of suggests that you're wanting to.

Q Okay. But reading this note, that doesn't -- there's nothing in here that says she's trying to get pregnant.

A No, it doesn't specifically say that.

Q Okay. You're just assuming it because she had been having unprotected sex that she was trying to get

pregnant?

A Well, it says unable to conceive ---

Q Okay.

A --- so if someone's unable to do something, I assume they're -- that means they're wanting to do it.

Q Okay. So -- but let me just finish up on this. So, the issue is though, you do agree that if you were going to change your medication to something like Metformin that could increase the risk of pregnancy, you ought to have the discussion with the patient?

A Well, you should -- with every patient you should have a discussion about fertility, contraception, conception, so that's part of any discussion.

Q Okay. But when you also have a patient who is in this age bracket and has risk factors that would be of concern if she did become pregnant at this age with her health status of being diabetic, having the obesity and on diabetic medication, it would be pretty important to have that discussion.

A I think we always want to discuss contraception, conception. Just -- you know, that's a discussion.

Q And is there -- is there any such discussion documented in this medical record?

A No.

Q Okay. Now, as you understand it, she came back to see

Dr. Brown on a number of occasions -- excuse me -- Dr. Goldstein, and in January of 2009 she turns up pregnant. Do you have -- did you look at the records from Dr. Brown at all, her family practitioner?

A. At some point in the past I did, but where would those be?

Q. You don't need to reference them. I'm just going to ask you a question in general. Dr. Brown then referred her back to Dr. Goldstein for management of the pregnancy. Do you think at that time that Dr. Goldstein should tell the patient that she had polycystic ovary disease?

A. Well, it's not really quite as relevant once you conceive, but I would have thought that that would have been discussed at the original diagnosis.

Q. Okay. So, you do think she should have been told and had a right to know that she had polycystic ovary disease and that if he was changing her medication, she could become pregnant?

A. Yeah, in the context of that, there should be a discussion. Fertility and contraception should be a discussion at every visit.

Q. Okay. Now, during the course of the pregnancy, you do agree that there is no documentation throughout the course of this entire pregnancy, all 19 visits, there is nothing documented about any patient teaching or any

discussions with the patient about potential complications or risk factors associated with this pregnancy. True?

A No, I can't specifically reference any specific documentation of that discussion.

Q Okay. But you do agree that if it were a reasonably prudent physician, you'd expect them to have made some notations along the line that they had some conversations with the patient about these issues.

A No. Again, I don't think we necessarily do that. It's the assumption when, out of 19 visits that you've had that ongoing dialogue so ---

Q Okay.

A --- I would say we don't, we don't do that.

Q So, you're just assuming the discussions took place even though there's no documentation?

A Correct.

Q Okay. That documentation in this case also pertains to the fact that when there was a decision made to induce this patient, she saw Dr. Goldstein on three occasions right around the time of the delivery, and do you see in any of those visits any discussion with her about any risks that might be associated with induction?

A No.

Q But in your opinion, that's absolutely acceptable?

A Correct.
Q So, the patient going into the hospital for an induction doesn't need to know that there's any risks associated with getting induced?
A That's not what I said.
Q Okay.
A You said was there documentation of that and I don't think that the standard of care requires documentation of that. I think the conversation should occur and the standard of care should be that it, that a discussion of; what's going on, that she's going to the hospital, what are the risks/benefits, why are we doing the induction, I think that discussion should happen, but I don't necessarily think it needs to be documented as such.
Q In your practice, would it be documented?
A No.
Q Seriously?
MS. CRAIG: Objection, Your Honor.
THE COURT: Asked and answered. Sustained.
Q Do you think that the patient has a right to know if there's risks associated if you're going to use a vacuum during the delivery?
A Well, again, I think we touched on it a little bit, but I think the -- if it's going to be a difficult delivery

with vacuum, forceps, or whatever, and you think that there's more than the minimal risk then I would say yes, but in a case where -- like in this case where the baby's sitting right there at a plus-three station, the heartbeat's, kind of been bothering you, you're, like, I want to get this baby delivered, then no, I don't think it necessarily has to happen.

Q Well, in your practice do you know about how often you use the vacuum?

A Well, I don't use the vacuum. I tend to -- if I need help with outlet delivery, I use forceps.

Q So, what's your percentage of forceps deliveries?

A It's pretty low. It's probably between one and five percent.

Q Well, now, at Greenville Hospital System the patient population that you have, do you have a fairly high percentage of high risk patients?

A Yeah, I think we do. I think we probably have a normal patient population.

Q And did you, in this case, understand that Dr. Goldstein's rate of using the vacuum is 40 to 50 percent of his deliveries?

A I did.

Q You don't find that a big high?

A It's higher than average but it seems to, you know, have

worked for him and I think he's -- you know, with the vacuum, which I don't, I just never needed to use it or just haven't used it, but some people do and think that it helps sort of guide the baby out slowly so things happen maybe not too precipitously.

Q Well, in your practice, if you had patients in which you think there's a 50 percent likelihood that you would be using forceps, would you mention it to the patient?

A In -- so in a -- with one particular patient and I'm in the office, I'm not going to make that prediction in the office, probably.

Q Okay. But if you know your stats are that 40 to 50 percent of the time you're going to be using forceps, you don't think you'd have that discussion with the patient?

A Only if they brought it up. I have practiced with -- I practiced with a physician who just recently retired and he had a high percentage of forceps deliveries with no complications, or I won't say no complications, with a very low complication rate and a very happy patient population.

Q But do you have any idea of when he had the discussion with the patients about it?

A I don't know that he did.

Q Okay. But you don't know that he didn't, either.

A No, I don't.
Q Okay. Now, what's your induction rate?
A Oh, I haven't specifically looked at it, but it's probably in the 20% range, maybe.
Q Twenty percent?
A Something like that.
Q Do you think that's pretty average?
A Probably pretty average. Twenty, twenty-five percent, maybe.
Q And what's your understanding of Dr. Goldstein's induction rate?
A I think he said it was maybe -- I don't remember what he said. Fifty percent, but it was higher than that.
Q How about seventy percent?
A Seventy percent.
Q You were here during his testimony?
A I was here. I came in during part of his testimony.
Q Okay. Seventy percent chance that you're going to be induced. Do you think that's something patients ought to have the right to know?
A It's an interesting question. I don't know. Not necessarily. I think it's a discussion you would have with any individual patient when you schedule them to be induced.
Q Okay. Let me move on. I believe you were asked about the

consent, and the jury has seen this several times, so I'm not going to put it back up but I'm going to just give this to you and ask you to look under there. That is the general hospital consent. Correct? Or that's your understanding of what it is?

A Yes.

Q Okay. Now, do you intend, in your practice, for that to take the place of the patient having an opportunity to sit down with the doctor and you give them; here's the benefits of this procedure, here's the risks of this procedure, and here's some alternatives that might be available?

A No, this is just a document that that discussion has happened.

Q Okay. But the discussion that's happened, you don't know that. The patient's just being given a bunch of stuff to sign when they come into the hospital. Correct?

A This, this is only one piece of paper. I assume they sign other stuff too.

Q Okay. And you don't know what information the nurses convey to the patient when they sit down with them with those documents.

A No, I don't.

Q And in your practice, do you expect that the nurses sit down and tell the patients the risks, the benefits, and

the potential complications of when they sign these ---

A No.

Q --- documents?

A No. That's really our obligation and, as I said, we -- it's the ongoing dialogue that we have prior to, prior to that moment.

Q I want to get off of the subject of informed consent, so this is the last question I'm going to have on it. You do agree that a patient has the right to be involved in their decision-making when it pertains to their medical care?

MS. CRAIG: Asked and answered.

MS. RODRIGUEZ: That's the last one.

THE COURT: Pardon?

MS. RODRIGUEZ: That's my last question upon that. I'm going to move on.

THE COURT: Okay. Very good. Go ahead and answer.

A Yes.

Q Let me talk to you just a little bit about management of shoulder dystocia. In your practice with the residents that you're teaching, have you given them any information about proper shoulder dystocia management in any type of a formal way?

A Not in a formal way.

Q And have you ever taught the medical students or

residents about shoulder dystocia management?

A You know, I'm sure we've talked about it over the years, just, sort of an off-the-cuff situation. Whenever we've had a shoulder dystocia we do a debriefing and that sort of thing, so yeah, probably in that, in that setting.

Q Do you consider yourself to be an expert in the area of shoulder dystocia management?

A Yes, as a board certified OB/GYN, I do.

Q So, you think anybody who's board certified in OB/GYN, do you think they qualify as an expert in shoulder dystocia management?

A Well, we've all had -- it qualifies that you've had the training, education and training at some point in your career.

Q Okay. So, that's all it means, is you've had some training at some point. True?

A The certification?

Q Right.

A Yes.

Q Okay. Now, let me ask you something on shoulder dystocia at your hospital system. Do you run shoulder dystocia drills and simulations?

A We, we are going to be doing those.

Q You're not doing them currently?

A We are not doing them currently.

Q Okay. In terms of the residents, how do they learn in your program how to manage a shoulder dystocia?

A I don't actually -- I'm not involved in that particular didactic session, so I'm not, I'm not sure exactly how that takes place. They may or may not do a drill. We are moving towards doing, you know, simulations and drills and I think it's a good thing.

Q Moving ---

A But we're not ---

Q Sorry. I didn't mean to interrupt you.

A We're moving towards, towards doing that. It's being done some around the country now and so we should be starting that in the next six months.

Q Why would you do shoulder dystocia drills and simulations?

A Because it is an obstetric emergency and we do, we have intention to do; drills on eclampsia, postpartum hemorrhage, massive transfusion protocol and a number of things that may happen at our institution.

Q Would it also ---

A We have a fairly high risk population and we have actually a referral, referral center, for the obstetrics, so.

Q Would it also be important because you need to practice the skills because it doesn't occur often enough for you

to have a whole bunch under your belt?

A Yes.

Q Practice is important?

A Yes.

Q And if you do one every six, seven, eight years, that's not very much practice.

A No, that's not very much practice.

Q In terms of shoulder dystocia, I just want to verify one more thing. I think Ms. Craig gave you a CV, gave your CV here. In looking at your CV, can you point out to the jury any seminars you've given or any articles you've written or anything that you've done on shoulder dystocia?

A No.

Q Are there any on your CV?

A No. No, there's none on my CV.

Q Okay. Thank you. And just to -- I want to just absolutely be clear. You do not consider yourself an expert or to have any expertise in brachial plexus birth injuries?

A So, I would consider the answer is no and the qualification is that I think to be an expert on brachial plexus problems, you would be a pediatric -- a pediatrician, pediatric neurologist, someone who diagnoses and treats babies. So, fortunately or not, but

after we deliver the baby we don't always -- we aren't really involved in any diagnosis and treatment after that and I think to be an expert in that, you would need to be someone who actually diagnoses and treats that.

Q Now, in your own practice, how many brachial plexus injuries have happened on patients that you've taken care of?

A Transient or permanent?

Q Well, let's start out with transient. Have you ever had a transient ---

A I've had some transient, yeah. I don't remember exactly what I said in the deposition because I don't have an exact record of it, but we've -- you know, I've definitely had two or three babies that had some difficulty moving their arm for a while and as far as I know, they have all resolved within six to 12 months.

Q Okay. So, in your practice then, you've not had any permanent brachial plexus injuries?

A Not to my knowledge.

Q How about any of your partners?

A Not to my knowledge.

Q So, among the 1,000 deliveries per year that you and your partners do over, what, the last -- how many years have you been together?

A Well, I mean, I've been there 30-plus years.

Q And you've not had any permanent brachial plexus injuries?
A Not to my knowledge.
Q Okay. Have you ever seen any infant with a brachial plexus injury in which there was not a shoulder dystocia present?
A Not to my knowledge.
Q Have you ever seen anybody deliver a baby with any type of a brachial plexus injury that you believe it was caused by either maternal pushing or the uterine expulsive forces?
A Okay. So, let me go back just a minute. I thought you were asking the previous question about permanent brachial plexus, if I had seen some, and I don't think you said permanent, did you?
Q Let's -- are you ---
A Go back a couple of questions, because you said brachial plexus injury and I thought you said permanent, so I was thinking permanent when I said that but we have had transient, had babies who have had transient issues with their arm moving with brachial plexus problems, and one of them that I mentioned in my deposition was a baby delivered by one of my partners in which there was -- it was an easy, normal vaginal delivery and that baby had problems moving his arm for, for several months so I do

specifically remember that because my partner just, just as I said, he just about lost it. He was, he took it very hard even though there wasn't anything that he did, could have done, it was no shoulder dystocia, and then we've had some of the transient ones. I mean, I mentioned that I, myself, had had two or three transient, transient ones and I know one of them at least was from a precipitous delivery, so that happened from a precipitous delivery again with no shoulder dystocia.

Q Okay. So, precipitous delivery is a different physiological mechanism than what we're talking about here. Correct?

A Well, I don't -- I don't know.

Q Okay. Well ---

A In that, I'm not an expert on brachial plexus injuries.

Q Okay. Well, let's ---

A A different patient population.

Q Let's do this a little logically. A precipitous delivery means a baby that came out quickly.

A Correct.

Q So, obviously there couldn't have been an obstruction.

A Correct.

Q It could have been some other issue that caused the brachial plexus injury. Correct?

A I'm sorry. Say that again?
Q It wasn't an obstruction that caused the brachial plexus injury.
A Correct.
Q And you don't know on those cases, any that you're familiar with, whether or not traction was involved in them.
A Well, no I don't think in a precipitous delivery you'd have traction at all.
Q But you don't know that. Correct? You've never had one where that's happened to you.
A Well, a precipitous delivery sort of implies that there was no traction, the baby just came out so fast that you really didn't, you didn't even, you were hardly even touching the baby so, no, I don't think there's any traction injury.
Q Okay. So, then your definition of a precipitous delivery is a delivery that's done without touching the baby, it just pops out?
A Well, precipitous really just means that it's -- if it's rapid, but, but for the most part those rapid deliveries, you're -- there's little to no traction involved.
Q Okay. But again ---
A I'm not saying there couldn't be.

Q And my point is, you don't know on a precipitous delivery whether or not there was traction involved, specifically. You're just assuming there wasn't because your definition is, something that happened quickly.

A Correct.

Q But your cases, you've never had one, a precipitous delivery in which you had a brachial plexus injury?

A You know, I think I have.

Q Oh, you do?

A I do think I have but, you know, I can't -- it's been a while and my memory would be fuzzy on that.

Q Okay. That was not one you mentioned in your deposition?

A No, probably not so, you know.

Q And you just gave your deposition a week ago.

A It was ---

Q A week ago today. Right?

A No, 10 days ago.

Q Okay. Doctor, in order for a brachial plexus injury to occur that's associated with a delivery, do you have an opinion as to how much movement there would have had to be for the baby's head? How significant ---

MS. CRAIG: Your Honor, I think she just established he wasn't giving opinions on this area. He's standard of care.

THE COURT: Objection is sustained.

MS. RODRIGUEZ: Okay.

Q Well, doctor, the animation that we watched, did you help prepare that animation?
A No.
Q Do you think it -- can you in any way say it really reflected what happened in this case?
A No, I think this was a shoulder dystocia where the two maneuvers worked pretty quickly, in less than a minute, so it was nice.
Q In this case?
A I wish -- no, that video was. I mean, that'd be great if they all, if they all worked that way and most of them do, actually.
Q In preparation for your work in this case, you mentioned that you were a member of ACOG?
A Correct.
Q And I think we now have established through other witnesses that it's now actually no longer the American College of Obstetrics and Gynecology. It's the American Congress of Obstetrics and Gynecology. Correct?
A Correct.
Q You're a member of it?
A I am.
Q Is Ms. Craig a member of it, too? Do you know?
A Is she a member of ACOG? No.
Q Okay. Now, in preparation for your deposition did you do

some research on shoulder dystocia or look at some of the literature?

A There are a couple of ACOG practice bulletins that, that I think someone had furnished her and she just sent them along to me and said that these were going to be potentially a matter of discussion, so I did look at them.

Q Okay. So, you didn't do the research. Ms. Craig did the research and supplied it to you?

A Yeah, I'd actually already read those.

Q Okay. Well, in fact, it's, like, a 28-page booklet. Correct?

A Well, I didn't read all that.

Q Oh, you didn't?

A No.

Q What did you read? You read the Cliff notes version?

A I read the Cliff -- I read the four-page summary. Well, because it was ---

Q Got you.

A --- it was quite a bit of detail on brachial plexus and problems and going into the nerve roots and, you know, the diagrams, and no, I did not read that.

Q Okay. Got you. Do you even know who the authors were?

A No.

Q Did you look at any of the articles that they talked

about in it?

A No.

Q Got you. Okay. I understand.

A I had no intention of testifying about that.

Q Okay. Did Ms. Fulton have any risk factors for shoulder dystocia?

A She did have a couple of risk factors. It was -- the diabetes was a risk factor and again, she was, you know, a little heavier. That's a risk factor as well.

Q Would those be something that you'd, you'd sort of discuss with your patient and let them know that they were risk factors for potential complications during the delivery?

A I don't know that those rose to the level of being high-risk enough for us to, for me to mention that shoulder dystocia was a risk. I don't know that I would have had that discussion. Now, if we'd gotten to, you know, 40 weeks and then an ultrasound where it looked like the baby was, you know, going to be 10 pounds, then yeah, we would definitely have a discussion of that.

Q Well, now she never got to 40 weeks.

A Right. That's why I say probably the discussion may have come up later but at 36 weeks, I probably would not have had that discussion.

Q Okay. Even if you were going to go ahead with, go

forward with the delivery by induction at that time, you wouldn't have had the discussion with the patient about potential risks?

A I don't think I would have talked about shoulder dystocia because I don't think it was -- I didn't think -- I wouldn't have thought that it would have happened. I would have thought it would be very unlikely.

Q Well, is shoulder dystocia something that you should always anticipate?

A Well, yes, I mean, as I said, you know, when the baby delivers and you see that anterior shoulder, you -- there's just always a relief there, so we're always thinking about it, if that's what you mean by anticipate.

Q Well, that's the point, isn't it? Sort of, that shoulder dystocia can happen at any time whether you have risk factors or not, so you always have to be prepared?

A Absolutely.

Q And that's another reason why practice is so important, because it can happen in any delivery.

A Yes.

Q Okay.

A Yeah, sure.

Q Do you intend continuing medical education?

A I do.

Q And you're part of the southeastern group here in, the group here that covers the OB/GYN for the State of South Carolina, that specialty, sort of a division of ACOG that covers South Carolina?
A Yes, I don't go to their meetings, usually, but yes, I'm a member.
Q Okay. You've never attended one and run into Dr. Goldstein?
A No, I've never met him until today.
Q And one thing I did remember you talking about in your direct testimony was about the episiotomy. In this case, there were several attempts to cut the episiotomy and there were attempts to extend it. Correct?
A Correct.
Q What's your understanding how many times it was cut?
A I think there was an initial episiotomy followed by two additional extensions.
Q Okay. So, three times it was extended.
A Correct.
Q Would that be fair? In your practice how many times have you extended an episiotomy three times and been able to complete an internal rotational maneuver?
A Extended the episiotomy and been unable to complete?
Q Three times. You've done three ---
A Well, yes, to the first part. No, to the second part. I

have extended episiotomies, but I've not had the situation where I was not able to deliver the baby with the other maneuvers.

Q Okay. And by that, I mean you were able to get your hand into the vaginal canal and do the rotational maneuvers that were necessary.

A Right. It hasn't happened much, but it has happened.

Q Okay. I want to cover that video for one second. One of the things is you -- that video did not necessarily reflect what happened in this case.

A Correct.

Q Okay. And in terms of the nuchal cord, you don't know that there were any problems reducing the nuchal cord in this case. Correct?

A No, I don't.

Q In fact, in this case was there ever in your opinion any indication that Dr. Goldstein feared for the baby's life?

A No, I didn't have any indication of that.

Q Was there any information you ever got or anything that you ever read that indicated to you that Dr. Goldstein was concerned that there was an imminent risk of brain damage?

A No, I don't have any indication about what he was thinking about that.

Q Well, and including your review of the records, et cetera, in this case, there was nothing there that occurred during this shoulder dystocia and the way it was managed that raised a concern to you that there was an imminent risk of brain damage.

A Well, you know, we're talking about four or five minutes to, to get the baby out and we're talking about umbilical cord compression and we know there is a time in that the baby is not getting adequate oxygen and your pH is going down and your oxygen level's going down, your carbon dioxide is going up and so you have that, so yeah, it would be incumbent on any of us in that situation to begin at some point to be thinking about how is this, how's this baby doing as far as the blood flow to the brain.

Q But I thought you just told me that you didn't see any indication that Dr. Goldstein had any concerns of those. Is that -- do you think he should have and didn't?

A Well, I mean, I would have had to know what he was thinking at the time and so I -- he wouldn't have -- that would have been maybe his thought process, but I don't know how I would know, so I guess my assumption is that we're always thinking about that.

Q Okay. So, you're just assuming he may have had that. You didn't actually see anything in the ---

A Correct.
Q --- medical records or any documentation ---
A That's exactly right.
Q --- or deposition. Okay. So, there was nothing that you ever saw that indicated he was in fear of the baby's life or that there was an imminent risk of brain damage?
A No, I don't have indication of that.
Q Okay. One more section here and we're done, so let me finish up real quick here. Are you here testifying as a favor to Dr. Goldstein or are you being paid?
A I'm being paid.
Q Okay. And in the times that you've been involved as a legal expert, medical/legal expert before, not including cases of your own where you've testified but where you've testified on behalf of another provider, you've only testified on behalf of doctors. Correct?
A I've only been asked to testify. I've never been asked by plaintiffs to review a case.
Q So again, the point is you've never testified for anybody ---
A No.
Q --- but a doctor.
A Correct.
Q Okay. And in the conduct of your work in this case, will you be paid for your travel here back and forth to

Greenville?

A I hope so.

Q Will you be, will you be paid for the time that you testified?

A I hope so, because I've got a -- I cancelled a bunch of patients to be here.

Q So, you expect to get paid for what you did when you have to take time off to be involved in these matters?

A Yes, ma'am.

Q Do you get paid for doing the research that was provided to you?

A Yes, ma'am.

Q So, because you're getting paid for your testimony, has it changed anything that you would testify to? Does that influence what you're testifying to?

A No, this is -- this is not fun for any of us.

Q Okay.

MS. RODRIGUEZ: Court's indulgence.

Q Doctor, I have one more concern I need to address with you. Did you assume in this case that an obstetrician would know how much traction he was applying?

A That's a good question. The -- there were some assumptions and I think the assumption is in reading over the medical record and reading over the depositions of the nurses, Dr. Goldstein, you know, I wasn't there

holding the baby. I have to make, I have to make some assumptions, so in reading that, I saw no evidence that there was anything other than normal traction.

Q Okay. Did you get, receive the depositions of the family members who were attending at the deposition?

A I did.

Q Excuse me. At the delivery.

A I did.

Q Did you read those?

A I did.

Q And did -- if, in fact, there is testimony that Dr. Goldstein was rocking when he was trying to pull the baby out, does that indicate to you that he was using traction?

A Well, I read all of those and, you know, I read all, all those depositions and they were so -- they're what you'd expect a family to say, in that their observations are, you know, emotionally charged and, you know, understandably so, and there was a lot of things in there that, about leg positioning and there was, like, one reference to a scalpel being used. Well, you know, I know that didn't happen. I mean, I know, I mean, no one would ever have a scalpel at a, at a delivery. It's just, like, observations so you have to take all that into consideration. So, in summary, in reading that, I

didn't, I didn't put too much validity in that.

Q So, you discounted their -- you ignored their testimony?

A Well, I didn't ignore it. I read it and I took it in consideration of everything, but I think I did put some discount value on it, sure.

Q Okay. Well, let me ask you this: If you assumed it was one of the nurses who was observing a delivery and they noted that when he was pulling his arms were trembling, would that be an indication to you that there was a use of traction?

A Well, no, not necessarily. I'd have to take that all into consideration.

Q Okay. So, if they indicated that he was twisting and turning on the baby's head, would it indicate to you that there was a use of traction?

A If the nurse taking care of the patient said that? Is that your question?

Q Yes. If a nurse observing the delivery said that.

A I think if it were, you know, a qualified labor and delivery nurse who, with experience, that -- I would certainly be interested in delving into that more, but I wouldn't take it necessarily at face value. I think you have to, have to dig into it a little more.

Q Okay. And in this case, you do agree that there is no place in any of the medical records that Dr. Goldstein

documented traction and how much was used?

A I don't remember any quantitation on traction.

Q Not quantitation. Is there any mention of traction, period?

A No, I don't think so.

Q Did he write, handwrite, a delivery note?

A He did.

Q Did he type a delivery note?

A He dictated.

Q Dictated a typed delivery note?

A He did.

Q And also a discharge summary?

A Correct.

Q And by the way, is that standard practice for all obstetricians, that you handwrite a note and then also do a dictated note?

A I think in a shoulder dystocia you usually do.

Q And any place that you've seen where he described the traction that he used?

A No.

Q So, you made an assumption as to how much traction he used?

A I did based on all the things that I just mentioned.

Q Okay. You do agree that your assumption could be wrong.

A That I could ever be wrong about my assumptions? I'm

very human.

Q And you do agree that if he did use an increase in the amount of traction, that that would explain a brachial plexus injury?

A Well, I think that again gets into the causation that I was hoping to sort of avoid because I don't know enough about brachial plexus to testify about that.

Q Okay. Well, let me ask you this then: If Dr. -- if there was testimony that Dr. Goldstein used excessive traction in this case, would you be able to say that that caused the brachial plexus injury?

A Well ---

MS. CRAIG: Objection, Your Honor.

THE COURT: I'll sustain it. I think everybody's agreed that he's not here on causation. He said that --

DR. GOWER: Yes.

THE COURT: --- and established that from the very beginning.

Q Would you agree that if there was excessive traction used, it violated the standard of care for an obstetrician?

A Yes, I would agree with that.

MS. RODRIGUEZ: Thank you.

THE COURT: Any redirect?

MS. CRAIG: Very briefly. Thank you.

REDIRECT EXAMINATION

BY MS. CRAIG:

Q Dr. Gower, is there any evidence in the medical record that there was excessive traction used during the delivery of this baby?

A No, no evidence at all.

Q Do any of the questions that you have been asked by Ms. Fulton's lawyer change your opinion that Dr. Goldstein met the standard of care in the care and treatment of Ms. Fulton and her child?

A Right. I think he met the standard of care and not only that, you know, to get a live, warm baby out of this is, is good.

Q Is that your opinion to a reasonable degree of medical certainty?

A It is.

Q Thank you, doctor.

MS. CRAIG: May this doctor be excused ---

THE COURT: Yes.

MS. CRAIG: --- to go back to Greenville?

THE COURT: Thank you for being here. You're free to leave.

DR. GOWER: Thank you.

THE COURT: We're going to take about a five-minute recess and we'll come back in and hear some more testimony.

THE COURT: Thank you, Ms. Collins. Ms. Ganes.

MS. GANES: Thank you, Your Honor. May it please the Court.

DIRECT EXAMINATION

BY MS. GANES:

Q Ms. Collins, where do you live?

A I live at 1439 Chandler Circle, Florence, South Carolina.

Q And are you from Florence?

A I'm not. I'm originally from Fayetteville.

Q Did you go to high school in Fayetteville?

A I did.

Q What did you do after you graduated from high school, education-wise?

A I went to N.C. State for a short amount of time and transferred back to Methodist College and ---

Q I'm sorry. Go ahead.

A --- then I had a son and decided that my calling was nursing, so I immediately enrolled in nursing school.

Q And how long did it take for you to get your nursing degree?

A I graduated from high school in 1990 and I had my nursing degree in 1995.

Q Where are you currently employed?

A Carolinas Hospital System.

Q And how long have you worked at Carolinas?
A This April was 15 years.
Q And what do you do as a nurse at Carolinas? What type of nurse are you there?
A I'm a staff nurse, charge nurse. I work in the O-R. We triage.
Q What area of practice are you in as a nurse at Carolinas?
A Obstetrics.
Q And how long have you been involved in obstetrics as a nurse?
A Fifteen years.
Q Did you devote your entire nursing career so far to obstetrics?
A I've been a nurse for 20 years. The first three years was at an OB/GYN clinic in the health department in Fayetteville. Then we moved to Florence and I worked postpartum, which is after delivery, at McLeod. Then I came to Carolinas, so since I've been at Carolinas it's all been obstetrics.
Q Have you been involved in shoulder dystocia simulations that you've heard talked about here today as an employee at Carolinas?
A I have. Fortunately, our hospital recognizes that the things that cause injury to moms and babies 20, 200

years ago, 40 years ago, still cause injury to moms and babies, so we do drills on postpartum hemorrhage, which is when you bleed too much; we do drills on shoulder dystocia, which is when the baby gets stuck; and we do seizure drills, hypertensive crisis.

Q And are those drills required for the nurses?

A They are and when I gave my deposition I wasn't sure how long we'd been doing the drills because, just as long as I could remember, but I went back and talked to an older manager and it's been since 2002.

Q Are those drills required for doctors who have privileges at Carolinas?

A No, the drills are not to educate the doctors because they're experts. It's to educate the ancillary staff, the O-R techs, what the nurse's job is, how we get the help that we need to manage the emergencies.

Q Now, do some doctors participate in those drills?

A Uh-huh. Dr. Rainwater has in the past. Dr. Coker has.

Q And Dr. Rainwater and Dr. Coker. Do they have offices on the campus of Carolinas?

A They're right down the hallway. Uh-huh. Sometimes we've done the drills with a mock physician, where someone stands in. We don't always have a physician there.

Q Okay. Now, do you have experience in managing actual cases of shoulder dystocia?

A I have seen probably, in my career, 20 to 30 shoulder dystocias. Now, you have to understand, they can be mild, moderate, severe. In a mild one, you bring the knees back, do McRoberts, and that releases the shoulder. Probably three cases where there's been sequella and problems with the baby, one being Ms. Fulton's case. Another case being a broken clavicle with a short-term brachial plexus injury, and then another where there was a seizure with the baby from hypoxia.

Q Are shoulder dystocias anticipated outcomes?

A We don't anticipate them. In fact, just recently, one of our nurses, one of our labor and delivery nurses, had her second baby, had a perfectly normal labor curve. We had no anticipation but thank God, we're always ready, and she had a three-minute shoulder dystocia.

Q Are shoulder dystocias medical emergencies?

A Absolutely.

Q Have you learned in your training that shoulder dystocias are unpredictable?

A Absolutely.

Q And have you learned that they are unpreventable?

A They are.

Q Do you have to just be prepared to manage them when they occur as a labor and delivery nurse?

A We always have two nurses, typically the charge nurse

and another labor nurse. We stand on each side, one on the right and one on the left, and the reason we do that is because you don't know which way the baby's head is going to come out and we have stools on each side that we stand on and those are for two reasons: One is because the bed is up and we can't see over the patient's leg to see which way the head comes out; and the other is because if we have to do interventions you have to be at an elevation.

Q Now, is it true also that the bed does lower and that sometimes the bed is lowered ---

A Uh-huh.

Q --- during shoulder dystocias?

A Uh-huh.

Q And that it raises back up, as well?

A With a button.

Q And does that happen in the management of shoulder dystocias?

A It does.

Q Comes up, comes down.

A Whatever we have to do to relieve the dystocia.

Q Okay. Now, do you remember Ms. Fulton ---

A I do.

Q --- and the delivery that's at issue in this case?

A Uh-huh. She and I had a very good relationship.

Q And you were involve, were you involved in taking care of Ms. Fulton when she came to Carolinas for her delivery on August 20th, 2009?

A I was actually the charge nurse that day and I don't know the circumstances for which I took care of her the second half of the day primarily.

Q Now, I want to show you a document that's in evidence and we've seen it earlier this morning. Do you recall documenting in the chart?

A I do.

Q This is 140. Let me just ask you while we're waiting for that, Ms. Collins, did you assist in the monitoring of Ms. Fulton and the progress of her labor throughout the day on August 20th, 2009?

A I did.

Q And did you report to Dr. Goldstein as necessary to keep him informed of the progress of his patient?

A I did.

MS. GANES: Your Honor, may I approach?

THE COURT: You may.

Q I just want to give you a copy of the record so that you won't have to glare across the room. And I'll just keep going because I actually have a copy here and we don't want to have to be eating at this courthouse tonight, so on page 140 if it comes up we can -- this is in evidence

and the jury can see this when they go back, but do you recognize any notes that you made on that document, Ms. Collins?

A I do. Looks like starting at 11:05.

Q Put it up here so everybody can see.

A Probably a better representation would be the 15-minute checks that we do because our signatures are at the bottom of those and they would be the two pages prior to this.

Q Let me hand you this document. Is that at 138?

A 141 and 142.

Q Okay. I'll put that up. My IT staff is ---

A That's okay.

Q --- having an afternoon slump. Okay. Ms. Collins, will you tell the jury -- these are also in evidence -- will you tell the jury what it is that's displayed here for everybody to see?

A When we have a patient on IV Pitocin or in active labor, we have to do 15-minute checks where we do vital signs. We do fundal checks to see how the uterus is responding to the Pitocin, how quickly the contractions are coming, how long they last and how the baby's heartrate is responding. And any patient care that we do, we also document it on this and in the narrative.

Q And do you report any significant factors in those

15-minute checks to Dr. Goldstein or the attending physician?

A We do. Uh-huh.

Q And did you do that in the case of Genesie and Bryson F ?

A Yes, ma'am.

Q Do you remember anything significant about Bryson's heartrate that you were checking on on August 20th, 2009?

A Let me refer back to my 15-minute checks. I do remember that right after we started pushing, he had some variables. I think he had a variable to the 60s when Dr. Goldstein decided to put the vacuum on.

Q And will you tell the jury what that means? What does a variable to the 60s mean?

A You can see it on the heartrate tracing on the monitor -- in the record that we have. It's just where there's a decel of the heartrate. His normal heartrate -- did I give you my two sheets of paper? I did. Uh-huh.

Q If you want to mark it, I'll put it up.

A Okay. At about 13:15 is when we started documenting the variables and how long they lasted.

Q All right. Ms. Collins, were you referring to the three "V"s that you circled here on this document?

A Yes, ma'am.

Q Okay. Now, and this is in evidence and it's marked 142. I'll just put it here. Ms. Collins, do you remember Dr. Goldstein using a vacuum during the delivery of Bryson F ?

A I do. I remember him asking for it and I got it out of the delivery cart and gave it to Rebecca.

Q Now, the "V"s that you circled on the document that we just showed to the jury, do they have any corresponding significance to the use of the vacuum by Dr. Goldstein?

A Variables are usually caused from head compression or cord compression. We didn't know at that time he had a nuchal cord, but a safe assumption would be that that nuchal cord with the contraction causes variables and whenever babies have persistent variables, it can decrease the oxygen that they have and decrease their reserve, and so expedited delivery is the best plan.

Q Now, do you remember whether the use of the vacuum by Dr. Goldstein during Bryson F 's delivery was complicated in any way?

A I don't remember it standing out in my mind at all.

Q Okay. Now, do you recall that during the delivery of Bryson F a shoulder dystocia was recognized?

A Absolutely.

Q Do you remember that independently of your review of your medical records?

A Yes.
Q Can you tell the jury what you remember about the recognition of the shoulder dystocia in Ms. Fulton's delivery?
A I will and I'll start by telling you that whenever I went back and read my notes several years later, there was a complete omission of some events in that note. Whenever we started pushing, I was actually on the patient's left side and Rebecca was on the right and I can remember opening the vacuum, handing it to Rebecca and she managed the vacuum and I walked around behind Goldstein, probably as he was placing the vacuum on the baby's head and then I got on my stool and then whenever the head delivered very quickly and very easily, immediately there was the turtle sign and that is a, sort of -- it's, sort of, like whenever you're driving down the road and a cop pulls up behind you and your stomach get sick real fast. When you see that sign in obstetrics, your stomach get sick real fast because you know there's a potential complication. The head protracts onto the perineum and the cheeks bulge up and in this case, it was very significant and everyone identified it, and the reason as labor nurses we watch the perineum as the baby's head is coming out, because you don't know what babies are going to retract. You

don't know which babies are going to have shoulder dystocias, so you have to be ready because where you push and where you deliver suprapubic pressure is dependent on how the baby's head is positioned.

Q Now, did you know instantly that you were dealing with a shoulder dystocia when Bryson's head came out and retracted?

A Yes.

Q Okay. Was there any reason for anybody to scream out shoulder dystocia or yell shoulder or anything in the room?

A We didn't say -- we didn't scream it out, but I said to the nursery we've got a shoulder dystocia, get more help simultaneously, and you have to understand too that things are happening in, sort of, a fluid motion. Dr. Goldstein looks at us. I don't remember if he said we've got a shoulder dystocia, but we all knew. The sign was there.

Q Okay. And did you take part in any medical procedures or interventions to try and relieve the shoulder dystocia that the delivery team was presented with?

A Absolutely. The first thing we do is we lower the head and at the same time we're pulling the patient's feet back and to do McRoberts from us standing on the stool, the easiest way is to grab, sort of, the heel of the

foot and pull that leg back and the doctor tells us to do the McRoberts, so we did that and he's coordinating her pushing efforts with his guidance efforts from down below. After that did not successfully deliver that shoulder, I tried doing suprapubic pressure standing on the stool and even though we're on a stool that's probably six inches tall, you have to remember we're going over someone's legs and the legs stay in McRoberts the entire time so when we're not physically holding the leg, the O-R tech -- and we don't even have to tell the O-R techs. We've been doing these drills since 2002. The O-R tech who's in a sterile gown will sometimes even take her shoulder and push that leg back while you're doing suprapubic pressure. If not, you have two nursery nurses that are at the deliveries, so to get over that leg that's pushed back it's a little difficult, so I tried it from the stool and when I didn't get adequate leverage to be able to push that shoulder out, I actually got up on the bed with my knees so that I was -- my knees were on the bed and I was leaned over here attempting to relieve the shoulder.

Q And when you say attempting to relieve the shoulder, are you describing for the jury your attempts at suprapubic pressure?

A Uh-huh.

Q Now, was the -- now, and when you were doing suprapubic pressure, was Ms. Fulton still in the McRoberts position?

A Absolutely.

Q Her legs were still up?

A Uh-huh.

Q Okay. Now ---

THE COURT: You're going to need to say yes instead of uh-huh.

MS. COLLINS: I'm sorry.

THE COURT: It's hard for her to take down.

MS. COLLINS: I'm sorry.

THE COURT: Uh-huh sometimes comes out as huh-uh.

MS. COLLINS: Okay.

A Yes, ma'am.

THE COURT: So, yes, would be a good way if that is an uh-huh.

Q Was that a yes, Stephanie?

A That was a yes.

Q Now, were those maneuvers successful in relieving the shoulder dystocia that you all were presented with?

A No.

Q While you were doing the maneuvers of the suprapubic pressure and McRoberts that you have described, what was Dr. Goldstein doing?

A I'm going to tell you, when you're doing that you're so focused on what's happening and what's going on around you. His hands were on the baby, but I can't tell you where his hands were.

Q During the entire time of the shoulder dystocia management, other than when Dr. Coker came in -- and we'll talk about that -- did Dr. Goldstein ever leave the position that he was in assisting in the delivery of Bryson? While you were doing suprapubic and the McRoberts, was he still at the ---

A He was in between the patient's legs.

Q Okay. And so what did you do next after the McRoberts and the suprapubic that you attempted were not successful?

A Rebecca is about four inches taller than I am, so I looked up at Rebecca and I said let's switch sides. I can't get it. Let's see if you can get it.

Q Now, tell the jury, are you referring to Rebecca Lawrimore?

A Rebecca Lawrimore, uh-huh.

Q Okay. And who is she?

A Rebecca is a coworker. She's been there longer than I have. She's another ---

Q Was she ---

A --- labor and delivery nurse and she was actually Ms.

Fulton's primary nurse ---

Q All right.

A --- that day.

Q And so the two of you decided to switch sides?

A We did.

Q And what happened next?

A We switched sides and she got up on the stool on the left and I was on the stool on the right and she attempted the coordinated efforts of the pushing out that shoulder via suprapubic pressure. I don't remember if I took over the foot on the right, because I remember sticking my head out the door and yelling has anyone got Dr. Coker.

Q Okay. Now, was Ms. Fulton still in McRoberts when you and Rebecca switched sides?

A We keep them -- we -- we don't deviate from that. You put them in McRoberts and you leave them, because you've got to open up that pelvis even if it's a couple millimeters and that's just the practice that you don't deviate from.

Q Okay. Now, you said that -- did you say that you stuck your head out and asked ---

A I yelled out the door did somebody get Dr. Coker.

Q Okay. Who had requested that anyone get Dr. Coker?

A And you know, I can't tell you exactly if he called out

specifically for Dr. Coker. When we called out for more help, we need extra nurses. We need anesthesia because after a certain point if you can't get the baby delivered cephalic replacement is the next option and that's actually where they take the baby's head and they push it back through the vagina back into the uterus, then rush to the O-R and do a C-section, and if you go to the O-R you need anesthesia.

Q Okay. And so was the call for Dr. Coker the first or second request for help to the room?

A I -- I don't know the answer to that.

Q Okay.

A I know that we called for help and I don't know if, if those people who called for help called for him at that time.

Q Okay. Now, what did you do when you switched sides and Rebecca attempted the suprapubic pressure? Is Ms. Fulton still in McRoberts?

A Uh-huh.

Q Okay. And what happened next?

A He -- Dr. Coker was there shortly after I asked if he was there. Dr. Goldstein was still attempting to deliver. I do remember, you know, seeing him make an extension in that media lateral piece and I -- I saw -- and I can't say what he did, because he doesn't tell me

what he's doing, but I saw him attempting to get posterior unsuccessfully.

Q Okay. And when you motion like this ---

A Uh-huh.

Q --- and say attempting to get posterior, what do you mean? Explain to the jury what you mean by that.

A Internal rotation is something that nurses can't do, but it's something physicians can do where they can put their hand in and internally rotate the baby's shoulders. I've seen it done successfully once in a shoulder dystocia and that's the one with the broken clavicle and it was a coworker/physician and she's -- I have about a size seven and a half hand glove and she's about a size six. She's got petite little hands and she stuck her hand underneath the baby's cheek into the posterior vagina which means the back part of the vagina that faces the rectum, and she was able to do a Woodscrew maneuver with her two hands in the vagina and that's the one time I've seen it successfully done.

Q Have you seen other physicians attempt, unsuccessfully, at the rotational maneuver?

A Right. Yes.

Q Now, during the delivery and the management of the shoulder dystocia, was Dr. Goldstein calm?

A We were all -- we were all very nervous at the two or

three-minute point. There was -- you know, we were excitable, but I don't feel like we were out of control.

Q Okay. Did Dr. Goldstein continue to manage the situation?

A He did.

Q Did he direct the nurses through the use of McRoberts and suprapubic pressure?

A He did.

Q Did he continue also to do what he was doing at the foot of Ms. Fulton's bed?

A To try to deliver the baby, yes.

Q Did you ever see Dr. Goldstein's arm trembling as if he was forcefully pulling on the baby?

A I didn't.

Q Did you see him rocking back and forth as if he was forcibly pulling on the baby?

A I didn't and you -- whenever a baby is stuck it's not a rocking situation. The baby's not giving and letting go and giving and letting go. That head is there. It's not like it's jerking back and forth. It's stuck. It is ...

Q Did you see any motion of Dr. Goldstein's body that indicated to you that he was using anything other than gentle traction ---

A I didn't.

Q --- to get the baby delivered?

A No, ma'am.
Q Did you see Dr. Goldstein do anything other than he or any of the other physicians that you have worked with have done in a normal delivery ---
A He managed the shoulder dystocia ---
Q --- related to the ---
A --- as I've seen it managed in previous shoulder dystocias and he did a very good job of delivering that baby.
Q Did you see him do anything that you thought would hurt the baby?
A No, ma'am.
Q Now, did Dr. Coker eventually come in?
A He did.
Q And what happened when Dr. Coker came in the room?
A Dr. Coker, I remember him assessing the position of the baby's head, feeling the body and I'm assuming that he was making sure that the lie of the body was ---
MR. GRAHAM: Objection, Your Honor, speculation.
MS. COLLINS: Okay.
A I can't assume but we do Leopold's in labor and delivery to see where the head is in relation to the spine and the butt and the body, so I saw him feel around and then he, he put his hands down in the suprapubic area and pushed and within just a few seconds the baby was out.

I did hear him say y'all have almost got it, y'all have almost got it.

Q Now, did Dr. Coker do the same thing that you and Rebecca had been doing?

A He did.

Q And was Ms. Fulton still in McRoberts ---

A The exact same ---

Q --- when Dr. Coker came in?

A --- position we'd had her in the whole time. We didn't deviate her position at all.

Q Do you feel confident that you were properly trained to manage the shoulder dystocia that you were presented with during the delivery of Bryson F ?

A I do.

Q Do you feel confident that you applied the delivery techniques appropriately during the delivery of Bryson F ?

A I do.

Q Now, when Bryson was delivered was he floppy?

A He was.

Q Does someone keep time during the shoulder dystocia?

A What we do is, we tell the nursery we've got a dystocia. Nursery is the -- they're the freest at that moment because they don't have the baby yet, so typically the nursery calls out the time and Edie Lee was the one who

was standing there immediately and then whenever we had an influx of help, I think Jenny Johnson came in, Tanya Mannis came in, Fran came in, Dr. Phillips came in, and I don't know what order they came in. I was, sort of, focused on what I was doing.

Q Did you see Dr. Goldstein do anything that was reckless during the delivery of Bryson F ?

MR. GRAHAM: Objection ---

A No.

MR. GRAHAM: --- Your Honor. That calls for a doctor's --

THE COURT: Overruled.

Q Did you see Dr. Goldstein do anything, Ms. Collins, that you felt was reckless during the delivery of Bryson F ?

A I felt like Dr. Goldstein did what any physician would do in that position in managing that shoulder dystocia and getting a live baby out in a timely manner.

Q Ms. Collins, are you -- in your training have you learned that it's important for the baby to be delivered within a certain amount of time after you're presented with shoulder dystocia?

A We've heard different times sitting here with the different experts but, sort of, five minutes is the golden rule that they teach us and the other thing, when they do blood gasses, there's a little saying below

seven go to heaven and you want this baby's gasses to be above seven so that you're not dealing with neurological hypoxic insults, and I think his were 7.14, so he was teetering.

Q Now, Ms. Collins, are you proud that you were a part of the delivery team that, that delivered this baby in under five minutes after being presented with a shoulder dystocia?

A I am and I had a good relationship with, with Ms. Fulton. She came back to see us twice with the baby after the delivery and we all afterwards said thank God we got him out because we know how devastating that emergency can be.

MS. GANES: Thank you, Ms. Collins. If you'll answer any questions that the Plaintiff's attorneys have.

THE COURT: Cross examination.

CROSS EXAMINATION

BY MR. RUFFIN:

Q Good afternoon.

A Good afternoon.

Q I don't think we've met yet. I think Diane maybe took your deposition at some point, previously.

A You're correct.

Q I just want to ask you a few questions. So, you as a nurse, you personally participate in emergency drills

for shoulder dystocia. Correct?

A I do.

Q And as all nurses at Carolinas do, or labor and delivery nurses.

A Labor and delivery nurses, correct, and nursery nurses and O-R techs.

Q And nursery and the O-R techs. And you do this because, I think you said, that for four years you've been having, it's documented that over four years, certain problems have come up and you've had the same issue over and over?

A No. Huh-uh.

Q Okay.

A What I said was, the same thing that killed women 200 years ago, 40 years ago and currently; infection, hemorrhage and the baby ultimately not coming out, are the same problems that we have today, so we have to come up with algorithms and plans to be prepared for those emergencies.

Q To be prepared for ---

A I'm not saying that at Carolinas we have an exorbitant amount of shoulder dystocias or hemorrhages or infections.

Q And I'm not saying that either.

A Okay.

Q I'm just ---
A I just want to be clear that you're clear ---
Q Sure.
A --- what I'm ---
Q Absolutely.
A --- telling you.
Q And you do this yearly?
A We do it yearly. Uh-huh.
Q Not every five years?
A Correct, every year. In fact, and last week we had two shoulder dystocias. I mean, the rate and occurrence is just unpredictable.
Q Why don't you just do it every five years?
A Because we have turnover of nurses and our nurses, when they're trained for labor and delivery, they train for three months with a preceptor. Then for six months they're guided with their training, which means a seasoned labor nurse has to sign off on their strips and what they do, and then they can't triage people for three years just because out area of expertise is so -- we have two patients that we have to take care of, so doing it yearly is what our hospital has decided is a good practice to keep everybody on the same page.
Q And do you believe that's beneficial to you ---
A Absolutely. Every year I learn something new.

Q And sometimes physicians participate or head the O-B, obstetric drills, or the simulations ---

A Sometimes they do ---

Q Okay.

A --- and sometimes they don't.

Q And Dr. Coker has been present for those sometimes?

A He has. He was -- I think he was chief the year that he was present.

Q And you work at Carolinas Hospital as a nurse?

A I do.

Q In labor and delivery?

A Yes, sir.

Q And you work with the -- many of the obstetricians that deliver babies at Carolinas?

A All of them.

Q And I believe we have a lady from hospital administration sitting in the audience.

A Donna Sullivan.

Q That's right ---

A She's the previous director.

Q --- and you have an attorney in the audience, as well.

A We do.

Q Okay. And both Carolinas Hospital's attorney and the hospital administration employee are sitting behind Dr. Goldstein?

A Yes.
Q And Dr. Goldstein delivers babies at Carolinas still?
A He does.
Q And you know you'll be working or seeing Dr. Goldstein again in the near future.
MS. CRAIG: Objection, Your Honor, relevance.
THE COURT: I'll allow him to ask it.
A I hope to continue to work with Dr. Goldstein for many years.
Q And, in fact, part of the reason you're selected to be a charge nurse is because you've been at the women's center for a while and you know the physicians.
A Part of being a charge nurse is not just knowing the physicians; it's knowing and being qualified in what you do, at making decisions, at knowing the staff's strengths and appropriately assigning patients and coordinating efforts.
Q And you remember specific events about the actual delivery in this case?
A I absolutely do.
Q But you don't have any memory about the laboring process because nothing stood out as having been unusual to you?
A Now, when you say I don't have any memory, that's -- no, that's not true.
Q Okay. Would you mind -- I have a copy of your

deposition. If you wouldn't mind opening it ---

A Uh-huh.

Q --- and I'm going to give you a page number to turn to. Would you mind turning to page 30?

A Okay.

Q Okay. And I believe it says -- starting at line six.

Q Okay, so if I understand you, what you're saying is, you remember basically nothing stood out as having been unusual about the laboring process.

Q And the answer was, right.

A You're taking my answer out of context. If you read back she said, question, do you remember that she was five centimeters? Do you remember exactly what her labor curve was or are you basing it on what you've looked over? And I said I remember looking over it, but I also remember there being nothing odd about the labor process. I didn't say I don't remember anything about the labor process.

Q Okay. But you certainly still remember or your position still today is that basically nothing stood out as having been unusual about the laboring process.

A Nothing was unusual about her laboring process.

Q And you would agree that Ms. Fulton was cooperative throughout the entire ---

A Very cooperative.

Q --- course of her labor and delivery?
A Uh-huh. Yes, very pleasant, very.
Q We talked a little bit about what you can remember, but let's talk a little bit about what you can remember specifically and in the past what you had some trouble remembering. Do you remember there being only one family member present with Genesie at the time of her delivery?
A During the day we met several female family members. We never met any male family members. I do remember that and I don't have that anywhere on my deposition and -- but I do remember several females, and I don't remember specifically how many were in the room, but I do remember one standing beside me.
Q Sure, because there was a lot ---
A Going on.
Q --- that you had responsibility for. True?
A Yes.
Q Okay. And you don't recall seeing Dr. Goldstein actually apply the vacuum?
A No, and I had to get the vacuum out of the cart once he asked for it because my position would have been on a stool at the side, so when he asked for it, I came around, got it out of the cart, handed the vacuum pump to Rebecca, opened the vacuum to the O-R tech, and then I would have had to come back around and get back on the

stool, so I don't remember seeing him placing the vacuum.

Q Okay. And you don't remember there being anybody else there present during the delivery from the family ---

A I don't remember specifically who else was present from the family.

Q And you were performing whatever tasks you were assigned during this period of time, during the delivery, and you would have had things that you were responsible for.

A Correct.

Q And at times, the times when you were administering suprapubic pressure, you don't know what Dr. Goldstein was doing. True?

A I was above the patient on the bed ---

Q Right. You weren't ---

A --- focusing on ---

Q Oh, I'm sorry.

A --- focusing on the coordinated efforts of her pushing, his gentle downward traction which I -- yeah.

Q Okay. Well, let me ask you about that. Why -- how do you -- you just said that you were not in a position to see him so you weren't really in a position to know whether he was using gentle downward traction or excessive traction or any form of traction. True?

A I've been in the deliveries with them and there's

nothing that stood out. I was focusing my effort. He didn't have his foot up on the bed, no one was pulling on him. It was just a coordinated effort from my vantage point.

Q And to be clear, I'm not talking about any other delivery that you might have memory about ---

A Right.

Q --- involving Dr. Goldstein. I'm saying in this particular delivery, you, you don't actually, you weren't able to see or you don't have any memory of what Dr. Goldstein was doing at the time he was -- at the time you were applying suprapubic pressure. True?

A That's correct.

Q And so you have no way of knowing how hard he was pulling or how soft he was pulling, true, ---

A I can't ---

Q --- from that delivery from what you saw?

A Right. And even if I could see him, I can't qualify the amount of traction that someone's putting. That's a ---

Q But you just said he used gentle traction. Isn't that a qualification of how much ---

A I ---

Q --- how much traction is being used?

MS. CRAIG: Your Honor, if he could let her finish her answers.

A Well, I feel like my words are being minced. The doctors put their hands on the baby and do a maneuver of traction with delivery. The only time I've never seen that happen is whenever a baby delivers in the bed without a physician. Even whenever the nurses have to do precipitous deliveries, we are guided and we know how to do deliveries and we know what we have to do for that gentle traction, and I've probably done about eight physician-absent deliveries, not on purpose but because patients come in completely dilated and we have to deliver the babies.

Q And tell me about those that involve shoulder dystocia that you were involved with where you had to deliver the baby.

A I've never had to deliver a baby with shoulder dystocia.

Q Okay.

A Uh-huh. Thank God.

Q But to be clear, you weren't able to see what Dr. Goldstein was doing with his hands whenever you were in the process of working on giving suprapubic pressure ---

A In that moment with me above her pushing.

Q And when you were doing McRoberts, you can't say what Dr. Goldstein was doing. True?

A You can see what he's doing when you're doing McRoberts because you just have one hand on the foot and you're

pulling that leg back.

Q So is your testimony today that you do, in fact, have memory of what Dr. Goldstein was doing with the delivery of Bryson F when you were applying McRoberts?

A What you need to understand is everything is fluid. As soon as we recognize that there's a shoulder dystocia, we're lowering her head -- sorry -- we're pulling her feet back, we're looking to see the position of the head and the person who needs to be applying suprapubic pressure is getting into that position, and that was me, so I was more focused on my task.

Q Okay. And I think that that's an appropriate thing to do and I'm not saying that you should have memory of every movement. I'm just trying to determine what you actually saw. So, is it still a fair statement that whenever you were doing McRoberts maneuvers, you were not able to see what Dr. Goldstein was doing? True?

A True.

Q Okay. So, you can't recall if he was sitting on a stool?

A I don't recall.

Q And you can't recall if he was standing?

A I don't recall.

Q And you can't recall if he was sitting on the floor?

A I don't.

Q And you can't say whether he was on his knees?

A I don't remember. I don't know.
Q And you can't say how hard he was pulling?
A I can't.
Q At some point, Dr. Coker did enter the room.
A He did.
Q Okay. But you can't -- or you don't know where Dr. Goldstein was standing when Dr. Coker entered the room. True?
A Dr. Goldstein was between her legs. He never left between their legs. I don't recall what position he was in between her legs.
Q Okay. Okay. And is that because you assume you don't know where else he would have been if he wasn't between her legs?
A No, with the baby's head out, he would not have left from between her legs.
Q Okay. Would you mind turning in your deposition to page 50 and I'd like for you to read line -- page 50, line 25 to -- I don't want to parse it out -- you can read as far as to 51, line 16, if you would like.
A Page 50, line 25 to ---
Q Page 51, line 16.
A Do you want me to read it out loud?
Q That'd be fine.
A Okay. The question is: Okay, where was Dr. Goldstein at

this point? And I said, still at the foot of the bed. They were both between the legs. I'm sure that's probably where he was. I don't know where else he would have been if he wasn't in between her legs. Okay. But what I want to know is what you specifically remember. Don't assume. Well, I wasn't really focusing on Goldstein. I was standing there to the right. Coker was immediately beside me, the first person beside me and focusing on the abdomen, the baby's head, and what was going on, so I don't know where Goldstein was standing. Okay. And you remember Dr. Coker said putting one hand in the vagina, using the other externally over the abdomen. Answer ---

Q I think we're going on to a different subject matter ---

A Okay.

Q --- on that. Sixteen was where ---

A Okay.

Q --- I think this ---

A I never saw Dr. Goldstein leave from between her legs.

Q Okay. But at least when you had your deposition taken, you stated I don't know where Dr. Goldstein was standing and you commented that ---

A That was in relation to Dr. Coker.

Q Right. And when you were asked about where he was standing you said, "Well, there's probably nowhere else

-- I mean, I don't know where else he would have been." True?

A I'm not even sure.

Q I guess what I'm trying to get at is, are you assuming that he was there or do you have ---

A No, he was in the room the whole time ---

Q Okay.

A --- and he had his hands on the baby and I don't know where else you're thinking he would have been.

Q Well, it's not so much where I was thinking. I'm just wondering about the answer to some of the questions you were asked where you testified that I don't know where Dr. Goldstein was standing.

A I think that answer though was in relation to where Coker was, because then she follows with questions about who cut the cord, who actually delivered the baby and---

Q Well, do you remember -- I'm sorry. Finish.

A I don't remember who cut the cord.

Q Do you remember ---

A I don't really remember who had their hands on the baby. I saw Coker put his hands in that suprapubic position and I was, sort of, behind him. He's six-something and then within not very long at all, less than a minute, the baby was out.

Q Okay. And you don't know where Dr. Goldstein was

standing at the time the baby came out?

A Right. I don't know if he delivered the baby. I don't know that. I don't know who had their hands on the baby when it came out, but I'm assuming Dr. Goldstein because the last thing I saw was Coker putting his hands in that suprapubic position.

Q And also you can't recall any conversation occurring between Dr. Goldstein and the patient prior to Dr. Goldstein's application of the vacuum to Bryson's head. True?

A I don't.

Q And do you still agree that usually when a physician applies the vacuum, he'll say I'm going to assist in the delivery of the baby because of whatever, whatever the reason to be?

A Sometimes they do. Sometimes they'll put forceps on and the doctor is so focused on what he's doing that a nurse will say he's going to assist in the delivery of the baby and I don't know at that point if we did or who did.

Q But usually when a physician applies the vacuum, either he or you said sometimes a nurse will explain to the patient what's about to happen.

A Sometimes.

Q And you have no memory of Dr. Goldstein doing that in

this case?

A I don't remember either way.

Q And you don't remember from the times you were observing Dr. Goldstein -- you don't remember Dr. Goldstein attempting the other types of maneuvers beyond McRoberts and suprapubic pressure?

A I remember seeing him extend the episiotomy in attempting to get into the posterior aspect of the vagina unsuccessfully. I do because I was standing at the door whenever I yelled, is Coker here yet or has someone gotten Coker.

Q What was his posture at that point?

A I can't remember his posture. I just remember seeing that media lateral epis and if you ever see a cut into tissue you don't forget some things, and he extended it to try to make room and I just remember seeing him try. I don't know if he was standing or sitting or kneeling.

Q Out of the four minutes that it took to get the shoulder dystocia resolved, how much of the four minutes were you spending actually watching what Dr. Goldstein was doing with his hands?

A I was probably on my stool and attempting probably for about a minute and 30 seconds. I don't know exactly I didn't document and, like I said, I didn't even document that I did the first round of suprapubic pressure and it

doesn't mean it didn't happen, but I did -- I did it probably for a minute-and-a-half to two minutes.

Q And you realized or knew that this child, Bryson, didn't have any tone in his arm shortly after his birth?

A I did. I did because ---

Q That was apparent ---

A --- after we ---

Q --- to you? I didn't mean to cut you off. Sorry.

A That's okay. After we got mom stabilized and the bed put back together, I came to the nursery to check on the baby because, if I remember correctly, they intubated the baby in the room and then transported the baby to the nursery, so I wanted to see how the baby was doing overall. The arm was, sort of, not the first concern because the baby was very floppy and not very responsive, but I did notice when I went to the nursery that it did not have tone in that right arm.

Q And you stated in your direct that you didn't see Dr. Goldstein's hands trembling or see any rocking, but you do admit there were extended periods of time during the shoulder dystocia where you were not watching what Dr. Goldstein was doing.

A That's correct.

MR. RUFFIN: No further questions.

THE COURT: Redirect?

MS. GANES: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. GANES:

Q Ms. Collins, the things that you read out of your deposition in response to Mr. Ruffin's questions, were they consistent with the testimony that you provided to the jury today?

A Uh-huh. They just -- it's just hard to remember what you said a year ago and exactly how you said it and what context it was in.

Q But it was the same truth in your deposition ---

A Yes.

Q --- as it was here today?

A Absolutely.

MS. GANES: Thank you. Your Honor, may this witness be excused if she desires?

THE COURT: She may.

MS. COLLINS: Thank you.

THE COURT: Thank you very much. You may call your next witness.

MS. GANES: Your Honor, the Defense calls Rebecca Lawrimore.

THE COURT: Ms. Lawrimore, please come forward. Yes, ma'am, 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, REBECCA LAWRIMORE testified as follows:)

CLERK OF COURT: Please be seated and then state your name for the record.

THE COURT: Watch your step and have a seat in that witness chair. There you go. Pull up real close to that microphone, speak loudly, clearly and slowly in order that we can hear everything that you have to say and what's your full name?

MS. LAWRIMORE: Rebecca Lawrimore.

THE COURT: Thank you, Ms. Lawrimore.

DIRECT EXAMINATION

BY MS. GANES:

Q Ms. Lawrimore, I apologize that I've been out of the Pee Dee long enough to forget the correct pronunciation of your last name. I've got it now. Ms. Lawrimore, where do you live?

A 2766 Old Mill Road. That's here in Florence.

Q And are you from Florence?

A I'm from Effingham.

Q Did you go to high school here?

A South Florence, yes.

Q And what did you do education-wise after you graduated from high school?

A I went to Florence Darlington Technical College.
Q What did you study there?
A I got an associate degree in nursing.
Q And what year was that?
A That was '87, 1987.
Q And did you begin a career as a nurse in 1987?
A Yes.
Q And where do you currently work as a nurse?
A The women's center at Carolinas Hospital System.
Q What is your job there?
A I'm a staff nurse.
Q And have you been there at the women's center for 22 years?
A About 23 now, I think.
Q Ms. Lawrimore, did you participate in the care of Genesie Fulton when she presented to Carolinas for the delivery of her son on August 20th, 2009?
A I did.
Q Do you remember Ms. Fulton?
A I do.
Q Did you monitor her in the progress of her labor throughout that morning?
A I did.
Q And were you the nurse in charge of her care when it was time for Bryson to be delivered?

A Stephanie and I both were in there.
Q Okay. Now, is there some significance to one nurse being on the right side closest to the monitor and the other nurse being on the left side?
A I was the primary nurse that was assigned to her that morning, so usually, usually, the primary nurse is on the monitor side.
Q Okay. And do you remember whether you were on the monitor side of Ms. Fulton's bed during the delivery of Bryson?
A Yes, initially, I was.
Q Okay. Now, throughout the day when you were taking care of Ms. Fulton, did you report to Dr. Goldstein as necessary to keep him informed of Ms. Fulton's progress?
A Yes.
Q And do you remember making notes in the medical record related to Ms. Fulton?
A Yes.
MS. GANES: These are your notes. Let's see if we have any technology. (Referring to screen) Your Honor, may I approach?
THE COURT: You may.
Q There should be a record up there that won't have you squinting across. All right. I'll hand you this one and it's got yours highlighted, I believe. Is that your

documentation, your handwriting up on the screen that the jury can see now?

A Actually, now, what's highlighted here is Stephanie's.

Q That's right. That's right. What's not highlighted on the one that you have.

A Right.

Q Okay. And where do your notes begin on this document? This document is in evidence. It's number 140 in the mother's medical chart.

A It looks like 7:18.

Q Is that seven o'clock in the morning?

A Yes, ma'am.

Q What were you doing for Ms. Fulton at that time?

A Dr. Goldstein had come in and he ruptured her membranes and he attempted to put a fetal scalp electrode on at that time.

Q Okay.

A And I would have been in there with him.

Q All right. And it looks like you have another entry right below that.

A Right. At 7:50, he came back in again and at this time he actually did apply the fetal scalp electrode.

Q Okay. So, that's twice -- is that twice within the hour that Dr. Goldstein was at her bedside?

A That's correct.

Q Okay. And then what happened next according to your documentation?

A Looks like at 8:28 I did a time-out for the epidurals, so we would have been sitting her up and getting ready to put her epidural in.

Q Okay. And then what did you do next?

A 8:31, she was actually sitting. Looks like 8:32, the test dose was given for the epidural and 8:35, the epidural was being dosed.

Q Okay. And do you have any other notes related to the care that you provided for Ms. Fulton that morning?

A Yes, at 8:45 I've documented that the patient states she's comfortable. This was after the epidural had been put in.

Q Okay. Now, do you remember when it came time to push for Bryson to be delivered that day?

A Yes.

Q Okay. And I think your last note here is at 11 and then Stephanie's notes pick up for the delivery process. Is that right?

A Right.

Q Okay. Tell the jury what you remember about what happened when it was time for Ms. Fulton to push for the delivery of Bryson.

A She, she was pushing. Dr. Goldstein would have been in

there at that point. The head delivered. We recognized the shoulder dystocia. I was on the patient's right side. Stephanie was on the patient's left and the, the vacuum extraction was done. The head was delivered and then when we recognized the shoulder was not coming out. Immediately, the bed, the head of the bed, was put down. The patient was put in McRoberts. The legs were immediately pulled back and then when that maneuver did not get the shoulder to come on out, Stephanie was on the left side and she did suprapubic at that time. She was unable to, to get the shoulder to come under the pubic bone, so then we traded sides of the bed and I then went to the other side and attempted suprapubic.

Q Okay. Ms. Lawrimore, have you been trained in the use of the McRoberts maneuver and the use of suprapubic pressure to relieve a shoulder dystocia in your employment of over 22 years at Carolinas?

A Yes, we do annual drills.

Q Okay. And did you -- do you have any doubt that you have the skill and knowledge required when the delivery team was presented with the shoulder dystocia in this case to properly execute those maneuvers?

A No doubt at all.

Q Now, I want to ask you, was there clear communication among the delivery team from the very first recognition

of shoulder dystocia in this case?

A Yes, and it's not necessarily something that's, that's verbal. Sometimes, it's just a look. We're -- we're all, you know, anticipating. We're trained for this so as soon as that head is out and it's not, that shoulder is not delivering, then we start making moves to get those legs back and it's not necessarily that the doctor even says get the legs back or I need you to do McRoberts. It's understood on our part that we get those legs back immediately.

Q Okay. And was that done in this case?

A Yes. Yes, it was.

Q Now, after Ms. Fulton was put in McRoberts, I think you told the jury that Stephanie attempted suprapubic pressure.

A Right.

Q Is that right? And then did you -- and then you switched sides?

A Right.

Q Now ---

A That's correct.

Q --- when you attempted suprapubic pressure, was Ms. Fulton still in McRoberts?

A Yes.

Q Okay.

A She remained in McRoberts the entire time.
Q Okay. Have you ever, in managing any case of shoulder dystocia and executing the maneuvers, the McRoberts or the suprapubic pressure, have you ever used suprapubic pressure with a patient not in McRoberts?
A No.
Q Now, were the attempts at suprapubic pressure by yourself and Stephanie successful?
A No.
Q Was Dr. Goldstein directing you and Stephanie on the use of McRoberts and suprapubic pressure during Bryson's delivery?
A I mean, not necessarily. It's just -- you know, he could have told us to do it or we could have just looked at him and asked him, do you want this. I don't recall that part, specifically, but it was carried out.
Q Was Dr. Goldstein managing ---
A Yes.
Q --- the shoulder dystocia ---
A Yes.
Q --- of Bryson F ? During that process -- and I understand it was only four minutes, or almost five minutes, was Dr. Goldstein calm?
A Yes, he was very calm. That's -- that's what was so impressive afterwards. I remember thinking how, how cool

and collected he was because, I mean, it -- like Stephanie said, it can be a very excitable time.

Q Did you see Dr. Goldstein at the end of the bed attempting to effect the delivery of Bryson during the maneuvers of suprapubic pressure and McRoberts being applied by the delivery team?

A Yes, he was between the legs when these maneuvers were being done.

Q Did you ever see Dr. Goldstein's arms trembling as if he were forcefully pulling on the baby?

A I did not.

Q Did you ever see him rocking back and forth as if he was forcefully pulling on the baby?

A I did not.

Q Did you see any motion of his body at all that indicated to you that he was using anything other than gentle traction to deliver the baby?

A No, there was nothing in his body language at all that indicated that.

Q Did you see Dr. Goldstein doing anything that you thought would hurt the baby?

A Absolutely not.

Q Did you see him cut the episiotomy?

A I do recall that.

Q And did you see him extend it?

A I don't remember the extension part, but I do remember the initial cut.
Q Okay. And when he was doing those things, was he still at the end of the bed trying to get the baby delivered?
A Yes.
Q Did Dr. Goldstein ask for the assistance of Dr. Coker?
A I do recall that.
Q Do you remember hearing Dr. Goldstein specifically ask for Dr. Coker?
A I do.
Q Now, by the time that that request was made, was there already additional help in the room?
A I don't recall exactly at what point the additional help came in. I know Stephanie or I one would have asked for additional help, because in this situation we're always, you know, calling for backup, but I don't know who actually arrived first. I don't recollect that.
Q Okay. So, that we're clear for the jury, do you understand or do you recall there being two requests for help during the management of the dystocia of Bryson F ; one for Dr. Coker and one for Dr. Phillips and the O-R techs?
A I recall him asking for Dr. Coker and Stephanie asking for additional help.
Q Okay. Now, did Dr. Coker eventually come in?

A Yes, he did.
Q And what happened when Dr. Coker came in?
A He came in and he did suprapubic. He did the same thing Stephanie and I had done, but he's a lot taller so he had that height advantage, and he was able to get the baby out. He did the maneuver and Dr. Goldstein delivered the baby.
Q Do you feel confident that you were properly trained in managing shoulder dystocia during delivery ---
A Yes, I do.
Q --- in August of 2009?
A Yes.
Q Do you feel confident that you properly applied the delivery techniques during the delivery of Bryson F ?
A I do.
Q When Bryson was delivered, was he floppy?
A I don't recall that part, specifically.
Q Okay. Do you recall seeing him at all or you just didn't see him?
A I mean, I was in the room, of course, still at that time but he would have been passed off to the nursery personnel and so I would have been, you know, at this point, taking care of mom.
Q Okay. Did you see Dr. Goldstein do anything that was

reckless --

A No.

Q --- during the delivery of Bryson?

A I did not.

Q Have you been present in other deliveries where shoulder dystocia was encountered?

A Yes.

Q Did you see Dr. Goldstein do anything different than you've seen any other physician do during the management of shoulder dystocias?

A No, I did not.

MS. GANES: If you'll answer any questions that Plaintiff's attorneys have, please.

MS. RODRIGUEZ: May it please the Court.

THE COURT: Yes, ma'am.

CROSS EXAMINATION

BY MS. RODRIGUEZ:

Q Hello.

A Hello.

Q We've met before, haven't we?

A Yes, we have.

Q In preparation for your testimony today, who did you meet with?

A I met with Barbara Chesley and Marian Scalesa, I believe is her name.

Q Two attorneys for the hospital?
A Yes.
Q Did you go over your deposition with them?
A Yes.
Q And is Marian Scalesa's assistant, Ms. Lydia McGee, sitting over there ---
A Yes, ma'am.
Q --- behind Dr. Goldstein? And Ms. Collins prepared with you?
A Ms. Collins was not at the ---
Q The same time ---
A --- the same time. No, ma'am.
Q Okay. How long did you spend preparing for your testimony?
A I met with Barbara, I think, two or three times, and I met with Marian once. I can't give you a specific times.
Q Okay. So, you got pretty well prepared for this today?
A Yes, ma'am.
Q Okay. Now, let me ask you a couple of questions about what you actually remember about that day. Do you recall any conversations that Dr. Goldstein had during the course of the labor and delivery?
A I don't, specifically.
Q Now, when Dr. Goldstein put that fetal scalp electrode in, that hooks up to the fetal monitor to tell you the

baby's heart rate. Correct?

A That's right.

Q And it also measures the mom's contractions.

A The fetal scalp electrode does not.

Q But the monitor that it's on is also hooked to the one that goes around her abdomen so that you're monitoring simultaneously, both the fetal heart rate and the contractions. Correct?

A Yes, ma'am.

Q Okay. And so, that's a way for you to tell during the labor process how the baby is responding and whether or not there's any big problems. Right?

A Right.

Q And there are some changes in fetal heart rates that can occur. One is called a bradycardia.

A Right.

Q Is that when the baby's heart rate drops low?

A Right.

Q I think Ms. Collins may have described that but there's also instances where the baby's heart rate goes up. Correct?

A Right.

Q Now, when you're concerned because the baby has got a nuchal cord or the head is being compressed or there's some problem, the real concern or the real thing you

have to be conscious about is those bradycardias where the heart rate's dropping.

A Right.

Q Correct? If you'll look at the record from the hospital, page 114, are you familiar with the labor and delivery summary?

A Yes, ma'am.

Q Is that a document you feel out? Do you -- I'm sorry. Did you need assistance? It's the bound records here. I'm sorry. I should have given her -- it's my fault. Oh, this is rehab. Is it that one? Yes, this one. Sorry. And I'll just find it for you. They're both sides. They've done them back to back, so. Are you familiar with that document?

A Yes, ma'am.

Q And if I'm correct, it's called the labor and delivery summary?

A That's correct.

Q And that's where you document -- can you tell by looking at it if that's your documentation?

A Some of it is. Some of it's not.

Q Okay. Well, if you can go down to where I've got highlighted right about here under the heart rate. Baby was having accelerations spontaneous.

A Right.

Q Is that checked off?
A That is checked off.
Q Right above it I see fetal bradycardia, fetal tachycardia. None of those are checked off. Right?
A That's right.
Q Okay. So, this baby was responding okay according to the fetal heart rate.
A Right.
Q Okay. There was no evidence from that that the infant was in imminent risk of brain damage based on that information.
A Not based on this. I do recall from the -- the strip right at the end, there was, as Stephanie described, a decrease in the heart rate. The variable deceleration, as we call it, where there's cord compression and the heart rate drops because of that.
Q Okay. And that's right at the end as the baby's about to come out?
A That was in this case. There were -- there were ---
Q And that happens in a lot of deliveries, even if there's not a shoulder dystocia?
A It does.
Q That's pretty much sort of the course of what happens with the delivery; right as the baby's ready to come out at the end, that heart rate may drop a little bit.

A It can.
Q Okay. Now, do you recall having any conversations with Dr. Coker during the delivery?
A Not during the delivery. I remember asking him afterwards how did you do that because Stephanie and I had done the exact same thing.
Q So, who initiated the conversation with Dr. Coker? Did you?
A Yeah, I just asked him, I said, "What did you do or how did you do that," because I know he did suprapubic and Stephanie and I had done the same thing.
Q Okay. Now, when he did the suprapubic though, the legs were up in McRoberts. Correct?
A Correct.
Q Now, when you and Stephanie -- excuse me -- you and Ms. Collins were doing the suprapubic, the legs weren't always up in McRoberts.
A The legs were in McRoberts the entire time.
Q Are you certain?
A I'm positive.
Q Okay.
A Once you recognize shoulder dystocia, the legs remain back.
Q Okay. If you don't mind --
MS. RODRIGUEZ: May I open it?

THE COURT: We do have some scissors.

MS. RODRIGUEZ: Thank you. I don't know who came up with this method. Thank you.

Q Now, your deposition was taken. Do you remember that?

A Yes, ma'am.

Q And, in fact, Ms. Collins was there. Ms. McGee was there. Ms. Ganes was there. Correct?

A Correct.

Q You were there and I were there -- I was there. That was back last year, a year ago.

A Right.

Q If you'll turn to page 25 of your deposition. Did I ask you at line 23, while Stephanie was applying the suprapubic pressure, was she still in McRoberts and what was your answer?

A I said no. This is a misunderstanding though because what I'm referencing is, is Stephanie doing the McRoberts and the suprapubic and the answer is no. She would have been doing one maneuver, not both.

Q See, that wasn't the question and it was a very clear question, was it not? I asked you when Stephanie was applying suprapubic, was she, Ms. Fulton, still in McRoberts.

A Right. But Stephanie was not the one holding her in McRoberts during that.

Q Okay. Now, when you looked at your deposition afterwards, did you correct that?

A Not at the time.

Q And never until today?

A No, like I said, I discussed it with Marian because when we were looking back over it, I brought that -- you know, I was discussing that.

Q Okay. So, after you met with the attorneys for the hospital, your testimony now is that this was incorrect?

A It was a misunderstanding on my part as to what you were asking. You have to understand this is very nerve wracking. We don't do this every day and when you've got people firing questions at you, there's -- there's misunderstandings. The legs always remain back once that shoulder -- we realize it's not coming out, the legs get back the entire time.

Q Now, Ms. Lawrimore, I just want to clarify something. During your deposition, were you under the impression I was firing questions at you?

A No, not that but, I mean, like I said, this is a nerve wracking experience. This is not something we do every day.

Q But during your deposition, we were quite cordial?

A Oh, yes, you, yes, you were absolutely cordial.

Q And we were -- I was actually very friendly to you, was

I not?

A Yes, absolutely.

Q Okay. And at no point, did you indicate that you -- I told you, you could make any corrections?

A Right. And I don't feel like you were hostile but again, like I said, it's a very nerve wracking experience.

Q Okay. So, after meeting with the attorneys, then we got a correction on this. Okay. And I believe in terms of the -- when the actual shoulder dystocia was recognized and it was clear that Dr. Goldstein was unsuccessful in effectuating the delivery and he needed help, he specifically asked for Dr. Coker. Correct?

A Right. I recall him asking for Dr. Coker.

Q And you do remember that this was after hours, after practice hours? Dr. Coker's office would have been closed already.

A No, I believe this was -- I believe this was one -- one-something in the afternoon, so he would have -- he would have been in the office. Let's see. Where ---

Q I'll tell you what. We're going to hear from Dr. Coker later ---

A Okay.

Q --- on that very issue but it's your recollection he was in the office. It was a regular day for him?

A Right.

Q Okay.
A Right.
Q Do you remember if Dr. Coker was the first one to arrive after you called for the help?
A I don't recollect that, specifically.
Q Okay. Now, I want to talk about -- you talked about how -- Dr. Goldstein's management of the shoulder dystocia. I want to ask you some specifics about what you recall. Do you recall if, while you and Stephanie were performing suprapubic, was Dr. Coker -- excuse me -- Dr. Goldstein pulling on the baby?
A He was using gentle downward traction.
Q Gentle downward traction.
A That's correct.
Q Where did you, where did you learn that terminology?
A That's how you deliver a baby. Babies don't fall out as a rule. When you have a shoulder dystocia they definitely don't, so there has to be some, some degree of traction.
Q Okay. This is what I want to ask you. You gave a deposition that's quite lengthy. You never used the term gentle downward traction, did you?
A I -- can I look at that?
Q Sure.
A Where -- where would that be?

Q Well, let's read what you actually said. Okay?
A Okay.
Q How about if we do that?
A Okay.
Q So, your testimony is that he was exerting gentle downward traction.
A That's correct.
MS. RODRIGUEZ: Okay. If you could pull up her deposition at page -- let's start out with page 30, line 25.
Q I asked you -- are you at that point? Did you find it?
A I'm on page 35?
Q Page 30.
A Oh, page 30. I'm sorry.
Q And if you look on the right-hand column, you'll see page -- the line numbers are numbered. If you'll just go down to number 25.
A Page 30. Okay. And down to line 25?
Q Right. And you're going to go on to the next page, but it says, do you recall if he was pulling at the time you performed suprapubic pressure. And what did you say?
A Yes.
Q And if you look at the next question on page 31, he was pulling at that point, and what's your answer?
A Yes, ma'am.
Q And I asked you, do you recall if he was -- well, let's

start with -- let's start with McRoberts. Was he pulling while you were doing McRoberts, and what's your answer?

A Yes.

Q Was he pulling when McRoberts was not successful?

A Correct.

Q And then did Stephanie do the first episode of suprapubic. Correct?

A Correct.

Q And I asked was he pulling while Stephanie did suprapubic, and ---

A Yes.

Q --- your answer?

A Yes.

Q You never used the term gentle downward traction. Correct?

A It doesn't seem to be at this point.

Q Okay. Do you have any recollection of the vacuum being used in this case?

A Not specifically, not the details.

Q And do you actually recall the delivery of the head?

A I don't remember, specifically, that as far as they said they saw the turtle sign. I can't say that I definitely recall that.

Q Okay. During the course of the delivery, was there any point in time when Ms. Fulton was uncooperative or

causing any kinds of problems for you?

A No, not at all.

Q She was very cooperative with you?

A Yes, ma'am.

Q And was she asking what was wrong?

A I don't recall that.

Q Do you recall anybody telling her what was going on?

A I don't recall that.

Q Do you remember Dr. Goldstein having any conversation with her prior to the delivery?

A Not specifically, no, ma'am.

Q Do you recall when Ms. Collins gave you the vacuum that was going to be put on the baby's head, was there any conversation between either you and Ms. Collins or Dr. Goldstein and the patient to let her know what was going on?

A I don't specifically recall.

Q You are still working at Carolinas?

A Yes, ma'am.

Q Still going to be working with Dr. Goldstein?

A Yes, ma'am.

MS. RODRIGUEZ: That's all I have. Thank you, Your Honor. Excuse me, Your Honor. I'm being paged here. Court's indulgence. One quick check.

Q Let me ask you one more question. You commented when we

were talking about the suprapubic pressure, you said the legs were always in McRoberts.

A Right.

Q So, do you recall when Stephanie was doing it, whether or not in applying the suprapubic pressure, whether the legs were in stirrups or were they up in the McRoberts?

A They were McRoberts.

Q So, if they're in McRoberts, they can't be in the stirrups.

A Right. They could be touching the stirrups, because depending on the -- how long or short the patient's legs are, we're pushing them back and sometimes we lift and they're actually, you know, up in the air and back, and sometimes if the patient, you know, like I said, depending on length of their leg when they're back, the actual foot or the heel can rest against the stirrup. The stirrups remain in the same position the entire time. We don't do anything with the stirrups, so they're -- they're still present and there and so if the leg length is such when we push back, the actual foot can rest against them, but they are still in McRoberts the entire time.

Q Okay. So...

MS. RODRIGUEZ: I think we already read that excerpt. I'm not going to go back there.

THE COURT: Very good. Any redirect?

MS. GANES: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MS. GANES:

Q Ms. Lawrimore, if you'll turn in your deposition that you've been handed to page 48.

A Okay.

Q Actually the top of page 49, line one.

A Forty-nine, line 1. Okay.

Q All right. I'm going to read my question.

Q You talked with Ms. Rodriguez about Dr. Goldstein pulling on the baby and do I understand you in your last testimony to her that you have no quantification as to how much force Dr. Goldstein was using to effect the delivery of this baby? Is that right?

Q And what was your answer?

A That's correct.

Q And my question ---

MS. RODRIGUEZ: Objection, Your Honor, I think she's going beyond.

MS. GANES: The Rule of Completeness, Your Honor. I'm redirecting her on what they read.

THE COURT: I'll allow you to do so.

Q My question,

Q And is it your intention at all to testify that Dr. Goldstein was using anything more than gentle traction to deliver baby Bryson just like he would in any other delivery?

Q And then you asked me to repeat that and so I said sure.

Q Is it your intention to testify that Dr. Goldstein used anything more than gentle traction to deliver baby Bryson in the same manner that he would in any other delivery?

Q And what was your answer, Ms. Lawrimore?

A No, he didn't do anything different than he would have done in any other delivery.

Q And ---

A Or that any other physician would have done that I've witnessed.

Q I'm sorry. And my question was okay, no forceful pulling.

Q And what was your answer?

A No force, no.

Q And then my question...

Q Nothing at all that you perceived that would have injured baby Bryson. Correct?

Q And what was your answer?

A No, absolutely not.

Q All right. Ms. Lawrimore, were you nervous about coming

to testify here today?

A Absolutely.

Q Have you met with the lawyers that you described in the manner that you talked to Ms. Rodriguez about when you gave this deposition?

A I'm sorry? What ---

Q She asked you about meeting with the hospital lawyers prior to coming here today.

A Right.

Q Do you remember that? That didn't happen before this deposition, did it? You had already given this testimony under oath?

A Right, yes.

Q Okay. And was this testimony truthful that we just talked about?

A Absolutely.

Q And was it consistent with what you told this jury today?

A Yes, ma'am.

MS. GANES: Thank you, Ms. Lawrimore. Your Honor, may this witness be excused, if she desires?

THE COURT: Yes. Thank you, ma'am. You may call your next witness.

MR. HOOD: Dr. Stephen Coker.

THE COURT: All right. Dr. Coker, please come forward.

I'm going to ask you, jury, if y'all could stand up for just one moment while we're getting ready. (Jurors comply) Dr. Coker, please come around, around this way. I'll ask you to come forward and place your left hand on the Bible, raise your right hand as the Clerk administers the oath.

(After being duly sworn by the Clerk of Court, Dr. Coker testified as follows:)

THE CLERK: Please take your seat and state your name for the record.

THE COURT: Dr. Coker, have a seat in that witness chair. Please pull up that microphone, speak loudly, clearly and slowly in order that we can hear everything that you have to say, and let's start with your full name, Dr. Coker.

THE WITNESS: Stephen Nathaniel Coker.

THE COURT: Thank you. Mr. Hood.

DIRECT EXAMINATION

BY MR. HOOD:

Q Afternoon, doctor. Thank you for sitting out there waiting for your turn. We appreciate you coming. You got a call, there was an emergency, and you were leaving.

A Yes.

Q Tell the jury what you did. Tell us what happened.

A Well, I happened to be in my office. Actually, the office was closed at 12 or one, so I was in my office at that point by myself. Usually. staff is around, but I

was there by myself. I was working on charts and then I got called from the secretary who was saying, literally said, "They need you in 117. Dr. Goldstein is on the floor." That's all the message I had, so I didn't know what was going on. In my mind, I thought Dr. Goldstein was actually on the floor in cardiac arrest or something, so I literally ran from my office, ran down the hall, ran into the room and then all of a sudden I'm greeted with a room full of people and obviously a delivery going on. So, it takes me just a second to say, "What's going on," and then I walk in and I see Stephanie and Rebecca at the bed, and I see Dr. Goldstein attempting a delivery and I said, "What's going on," and I think Dr. Goldstein said, "I have a shoulder". That's -- that's my recollection, so I ran up and said, "Stephanie, show me what you've done," and they showed me where they were applying pressure, so I told Bill to wait a -- I said stop, let me check. I wanted to see what position the baby was in to see what kind of maneuver might need to be done in this situation because it was -- I was having to hurry because I didn't know how long it had been. So, I checked and the -- I can't remember this long ago whether it was right or left. I just remember checking the shoulder and thinking the shoulder is almost clear of the symphysis, so what

the shoulder is almost clear of the symphysis, so what they were doing was working, just not quite far enough. So I told them to stop that. I didn't feel like a Woodscrew maneuver was needed, so I jumped back around, got up and then put more pressure, suprapubic, and as I put the pressure, immediately you could see the baby literally slide out and Dr. Goldstein got it out. He didn't have to apply any sort of traction, and once the baby cleared and saw it, he turned to the nursery then I said, "Well, I've done what I came to do," and I left.

Q All in about a minute?

A And I think from the time I went -- came in the room until I left it was probably about one minute.

Q Thank you, doctor. I don't have any other questions.

A Okay.

THE COURT: Cross examination.

MR. GRAHAM: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. GRAHAM:

Q Good afternoon, doctor.

A Good afternoon.

Q Thank you for your service in helping to get that shoulder unstuck. Let me ask you this, doctor: When you first came into the room where was Dr. Coker, I mean -- excuse me -- where was Dr. Goldstein? Was he, in fact,

on the floor?

A Not as I had envisioned, no. He was on his, on his knees.

Q All right, sir. And was -- what was the mother's posture at the time, the laboring mother?

A I don't -- all I remember is from, like, the waist down. Her legs were back.

Q Okay. Stephanie had one of the legs in McRoberts?

A I don't recall. Stephanie was on the right side.

Q The mother's right side ---

A I ---

Q --- or Dr. Goldstein's right side?

A No, no, the mother's right side and I think Rebecca was on the other side.

Q I see. So, those two nurses were holding the mother's legs up in McRoberts?

A Well, I'm not, I can't -- you know, running in the room in just a few seconds, that's where they were and whether one was pulling one and the other just happened to stay back, I don't know who was holding what. I know I said show me what you've done and they stepped back and showed me.

Q Right. And did you order them to push the legs back?

A No. No.

Q You're sure of that?

A I didn't -- I don't think I ordered -- well, at that point I said step aside so I can check ---

Q Right.

A --- and then I told Bill to step aside so I could check and see what position the baby was in.

Q But you don't remember any other nurses assisting with the legs other than Stephanie and Rebecca?

A No, I don't even know who else was there.

Q Fair enough. It was kind of chaotic at that point.

A Yeah.

Q And Dr. Goldstein needed help?

A Yeah.

Q And you were there to provide it.

A Yeah.

Q You took over?

A Well, I can't say I took over. I just applied the amount of pressure, suprapubically, to help him accomplish the delivery.

Q Yes, sir. In terms of getting the baby's shoulder unstuck from behind that pubic bone, you took over.

A Yeah.

Q And then there was nothing else to do except catch the baby?

A Right.

Q Dr. Goldstein caught the baby.

A Yeah.
Q You extracted the baby by getting the shoulder unstuck.
A Yeah.
Q And Dr. Goldstein, when you were up there applying shoulder -- I mean, when you're up there applying suprapubic pressure to try to relieve the shoulder dystocia, do you remember that Dr. Goldstein was still on his knees?
A I don't -- well, he got up when I came around.
Q Yes, sir, but do you remember ---
A So, I don't think -- I'm not sure whether he went back to his knees. I don't -- he wouldn't have had to because it came on out then.
Q Do you remember he got back on his knees and continued to pull on that baby's head?
A No, I don't remember that.
Q You were focused on the suprapubic ---
A I was -- yeah. I'm looking down as I pushed. I could see the baby coming on, the baby just coming on out.
Q Okay. So, I mean, to do the heroic job you did to take over for Dr. Goldstein to get that shoulder unstuck required what percentage of your attention? One hundred percent?
A Well, pretty much most -- I mean, you -- still, you've got your attention there, but you're still aware of

what's happening.

Q All right. Just with your peripheral vision?

A Yeah.

Q But you can't tell us with any, any certain memory what Dr. Goldstein was doing while you were applying the suprapubic pressure. True?

A Well, that was about 15, 15 seconds, so ---

Q During that 15 seconds, you were focused on the suprapubic pressure?

A Yeah.

Q You don't know what Dr. Goldstein ---

A Well, he didn't apply -- I know he was -- he couldn't have gotten there until I got out the way, so he wasn't doing anything until I got up there.

Q All right. Well, tell me this: You're a pretty tall man.

A Yeah.

Q How tall?

A Six-three.

Q Okay. Which side of the bed were you on from the mother's perspective? Were you on the ---

A Right side.

Q --- right or the left?

A Right.

Q Right.

A As I came in the room, yeah.

Q All right. And we know from earlier testimony the baby's, the baby's right shoulder was on top. Right?
A I didn't know that.
Q You didn't know which shoulder was on top?
A Well, I mean the -- no. Like I said, I couldn't tell. I don't remember which way the baby was facing this many years later.
Q Yes. Oh, I understand. I understand. When you apply suprapubic pressure, is that something you normally do or you rely on nurses?
A Nurses.
Q Is this the first time you've done suprapubic?
A No, I've had to help my partners before.
Q Yes, sir, so when you stepped in to help with suprapubic, was it your intention to push down toward the floor or, kind of, in an oblique angle?
A I generally push in an oblique angle.
Q Okay. Because you're trying to rotate the shoulder ---
A Right.
Q --- as best you can to get it around the pubic bone. Right?
A Yeah.
Q All right. So, with you on the right side of the bed ---
A Uh-huh.
Q --- what was the first thing that you did to get into

position? Did you climb the stool?

A I -- yeah, I probably got on the stool which made me, of course, even taller ---

Q All right. And then did you ---

A --- because it was there.

Q And then did you hop up on the bed?

A No.

Q No, you did not ---

A No.

Q --- hop up on the bed?

A Not at all.

Q Okay.

A No way. Not enough room for me.

Q Did you pull the shoulder down toward you or how did that -- did you use your fist or open palm or...

A No. I put one hand on top of the other, put my palm there and pushed down. I can't recall this way or this way. I know I went straight down and then ---

Q Yes, sir.

A --- I don't know which way it was. I just remember seeing, once I pushed I could see the baby coming out.

Q Yeah, but you had already checked the vagina to see which way the baby's shoulders were oriented. Right?

A Yeah.

Q Would you ordinarily push down at an oblique angle back

toward the baby's back or ---

A Not ---

Q --- toward the baby's front?

A Generally, towards the front.

Q Okay. So, you would have -- if the baby's right shoulder was on top and you were on the right side, you would have been pushing back towards yourself?

A That's the general maneuver, yeah, but you do whatever works.

MR. GRAHAM: If Your Honor would indulge me just a moment to get the depositions.

THE COURT: Certainly.

Q Do you recall, doctor, that when you first got in the room, Dr. Goldstein was on his knees on the floor trying to deliver a baby?

A Yeah.

Q And how high up was he reaching to get his hands on the baby?

A Well, he had hands on the baby's head. He was not up inside.

Q Right. So, how -- where was, where was the, where -- how high was the mother's table or bed?

A It's, sort of, relative. Everything's a little relative to me, so I don't know.

Q Yes, sir. Did you ask them to raise the bed for you?

A No.
Q Did they raise it anyway?
A I don't recall the bed moving.
Q Okay. Do you remember how high Dr. Goldstein was reaching up to get to the baby's head?
A It wasn't that high, no.
Q Do you recall -- the question is, do you recall how high Dr. Goldstein was reaching up to get to the baby's head?
A Nothing that I would say was, that looked strange or ...
Q All right, sir. Do you deliver -- do you resolve shoulder dystocias on your knees?
A No.
Q I didn't think so. Let me ask you, sir, you said you did not hop up on the bed?
A No, I don't think I've ever done that maneuver.
Q Yes, sir. So, any hopping you did would have been to hop up on the stool?
A Yeah.
Q And pull the shoulder back down?
A Push. Suprapubic pressure.
Q You came, you saw, you conquered.
A No, if we conquered we wouldn't be here.
Q And then you left?
A Yeah.
MR. GRAHAM: No further questions.

THE COURT: Any redirect?

REDIRECT EXAMINATION

BY MR. HOOD:

Q Were you helping as an assistant to Dr. Goldstein to deliver this child?

A Yes.

Q Was it a team effort by both of you?

A Yes.

Q When Dr. Goldstein left your practice, did he leave on good terms?

A Yes.

MR. HOOD: Thank you.

THE COURT: You may step down. Go ahead and call your next witness.

MR. HOOD: May the doctor be excused?

THE COURT: Certainly.

MR. HOOD: He probably wants to go back to work.

THE COURT: There you go.

MR. HOOD: Dr. Jacobson, your turn.

THE COURT: Yes, sir. Please come forward, place your left hand on the Bible and raise your right hand as the Clerk administers the oath.

(After being duly sworn, Dr. Richard Jacobson testified as follows:)

THE CLERK: Please take your seat and state your name

for the record.

THE COURT: Have a seat in this witness chair, pull up real close to that microphone and speak loudly, clearly and slowly in order that we can hear everything that you have to say, and what's your full name?

DR. JACOBSON: Richard David Jacobson.

THE COURT: Very good. Mr. Hood.

MR. HOOD: Madam court reporter, please mark this CV as our first exhibit.

DIRECT EXAMINATION

BY MR. HOOD:

Q Okay. I'm looking at Exhibit #5, Defendant's Exhibit #5. It's your curriculum vitae, your biographical sketch.

A Yes.

Q You're a pediatric neurologist?

A Yes.

Q What is that the specialty of, doctor?

A We deal with diseases of the brain, the central nervous system, and the peripheral nervous system in children.

Q And where do you practice that specialty?

A I practice in Charlotte, North Carolina.

Q And have you had hands-on experience dealing with children who have had brachial plexus injuries?

A Yes, I have.

Q A considerable number?

A Yes.
Q Let's go through your background just a minute so we can introduce you to the jury. You've got several degrees. After college you got a Ph.D. in neurobiology.
A Yes.
Q And then you went on to med school and got a degree in medicine?
A Yes, I was in an M.D./Ph.D. program.
Q Okay. And then you did a residency in pediatrics at Stanford University?
A Yes.
Q Out on the west coast?
A Correct.
Q And then you came back to Harvard, did something, and you even taught there later.
A Yes, I did two years of pediatrics at Stanford. I did two years of research at Stanford and then went to Boston to do my neurology training, which was neurology with a special concentration on child neurology.
Q Okay. And you were an instructor at Harvard?
A Yes, for a year after I finished my residency.
Q Okay. Ultimately, ended up in Wisconsin?
A Yes.
Q And there is where you had the vast experience with shoulder dystocia?

A With children with brachial plexus injuries.
Q Okay. I'm sorry. Brachial plexus injuries in children?
A Yes.
Q About how many do you think that you've treated over the years?
A Well, I was involved with the specialty clinic that they had there. This is at the Children's Hospital of Wisconsin in Milwaukee, Wisconsin, affiliated with the Medical College of Wisconsin. They had a program for children with infantile brachial plexus injuries. I was in that program for, I think, 16 years and I think over that time, I probably saw at least two or three hundred children with infantile brachial plexus injuries.
Q Two or three hundred.
A Correct. It may be more.
Q Yes, sir. And you've -- you're board certified in pediatrics, neurology, and pediatric neurology?
A Yes.
Q Are there three different boards?
A Pediatrics is a separate board. I've let that, my certification, lapse and neurology is a single certification but when you've had training in child neurology, specifically, you -- it has an extra tag line on it that says with special qualification in child neurology, and that reflects that you have a background

in general pediatrics and you've done much more pediatric neurology than the average neurology resident.

Q This CV gives us all the organizations, and there's quite a list of them, that you're a member of and that you're active in. You've been the head of some of these?

A Well, the different hospitals, clinics, appointments, hospital staffs, board certifications, awards and honors that you've gotten, memberships in honorary professional societies. The list is very extensive.

A Yes, I had some administrative and medical staff responsibilities in Wisconsin, as well. Yes.

Q You've even written textbooks. You've written medical articles.

A I've written medical articles, a few, and have written a chapter in pediatric clinics.

Q Okay.

MR. HOOD: Your Honor, we offer Dr. Jacobson as an expert in pediatric neurology, brachial plexus injury, and causation effective causation applicable to this particular case.

THE COURT: All right. Any query with regard to his qualifications?

MR. GRAHAM: Your Honor, we need to take up a matter with the Court.

THE COURT: Okay. Madam forelady, ladies and gentlemen of

the jury, we're going to ask that you retire to the jury room. Do not discuss the case. I want everybody to know the pizza's going to be here at six.

(Jury out at 6:05 PM)

THE COURT: Mr. Graham.

MR. GRAHAM: Thank you, Your Honor. May it please the Court. May I ask the witness some questions?

THE COURT: You may.

MR. GRAHAM: Thank you.

INQUIRY ON QUALIFICATION BY MR. GRAHAM

Q Dr. Jacobson, good afternoon. We first met last Friday, I believe.

A Yes.

Q Six days ago. That's when we were offered our first opportunity to take your deposition.

A Yes.

Q And during your deposition, you expressed two primary categories of opinions; one having to do with the nature and severity of Bryson F 's injuries and the other having to do with possible factors that may have been involved in causing his injury. True?

A Yes.

MR. GRAHAM: With respect to the first category, Your Honor, we have no questions about this witness's qualifications and scientific reliability of his opinions.

However, we do have some questions about reliability as to the causation and I thought this might be the appropriate time to do it so we don't get confused later.

Q Doctor, you've told me at the deposition several times that your opinions were based on assumption and speculation. True?

A Based on my experience with actual patients.

Q Yes, sir, and further based on your assumption and speculation about what factors might possibly have been involved in their medical history that you had no personal knowledge of. True?

A Did I use the words assumption and speculation? I might not ---

Q Would you like ---

A --- or you might have asked me questions containing those words?

Q Would you like me to pull out the deposition?

MR. HOOD: Your Honor, I don't know if he's going to give specifics but, I mean, this is cross examination.

THE COURT: Seems like it's more of a discovery.

MR. HOOD: It's a total waste of time.

THE COURT: What is your -- what is the nature of your -- why don't you just, in summary form, tell me what your objection is?

MR. GRAHAM: Yes, sir. This witness theorizes that there

might have been some children born without -- without traction on their head. He bases that on the fact that the charts don't say there was traction on the head. He's never seen a chart that says there's traction on the head. Doctors who applied injurious traction never or hardly ever admit that they put traction on the head. His position is if they don't confess to excessive traction, he's willing to assume that there was no excessive traction and he's willing to speculate that there was no excessive traction. From that set of assumptions and speculations, he then builds a case that says oh, well, this is just another one of those cases where I'm willing to assume and speculate that there was no excessive traction that caused the injury. Then he says, then he says it must have been caused by the child's poor tone and the maternal expulsive forces, but he doesn't -- he's not able to say that the maternal expulsive forces stretched the brachial plexus more than a quarter of an inch. He's not able to say that that amount of stretch can cause any injury. There's no literature. He admits there's no literature or other scientific authority to base that leap of faith on. He just -- he just says I -- and he also says he has no knowledge that a baby's head can deviate more than one or two degrees to the left or right in the birth canal. After the baby's head comes out, it can move by 45 to 60 degrees, thereby causing injury. But if he -- but he creates all these

assumptions and speculations that are not based on science. They're not based on literature. He's not -- he can't cite a single article in the history of the world to support the theory that he's expressing here today that, that maternal expulsive forces and poor tone can cause four or five nerve ruptures.

THE COURT: All right. I think I understand what your -- what your objection is and I'll be glad to hear from the Defense.

MR. HOOD: Your Honor, I think that may be proper cross examination, but at this stage of the proceedings, you haven't heard his opinions. He's certainly well qualified. He's dealt with hundreds of children like the Plaintiff.

THE COURT: That's my initial impression, is that certainly he's a smart fellow. He's been to Stanford and Harvard and he's qualified. He's got a wealth of experience and I think he's entitled to render his opinion in that regard. However, what you're talking about is fertile grounds for cross examination and I'm going to charge the jury at the conclusion of the case that they can disregard an expert's opinion. If they find as though it's not founded and substantiated by their education or their observations, then they can disregard it in its entirety and he's just like every other witness, and I think he's entitled to render his opinion. He's certainly qualified as an expert and I do

believe, like Mr. Hood says, it's a question of fact for the jury.

MR. GRAHAM: I just wanted to get it on the record, Your Honor. I understand the ruling.

THE COURT: Very good. All right. We're going to take about a five-minute recess.

(Brief Break)

THE COURT: Please be seated. We're ready for the jury.

(Jury in at 6:27 PM)

THE COURT: Mr. Hood, you're recognized.

MR. HOOD: Thank you, Your Honor.

Q So now, let's talk about Wisconsin and the hundreds of children who had brachial plexus injuries or problems that you've dealt with. As you apply that knowledge with your extensive education and experience, to the facts of this case and what you've read about this case, the medical records, key depositions, you've actually heard some of the key testimony today waiting for your turn, in your professional opinion to a medical degree of certainty, did Dr. Goldstein use excessive traction and cause an injury to this child?

MR. GRAHAM: Objection, Your Honor. He's not an OB expert.

MR. HOOD: He's a pediatric neurologist.

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

MR. HOOD: Thank you, Your Honor.

A Could you repeat the question?

Q No, I can't repeat. Of course I can repeat. Let's see. The issue in this case is, did my client, Bill Goldstein, cause harm to this child, Bryson F , by using excessive force in the delivery of the child.

A I do not think that -- it is my opinion that this child's brachial plexus injury did not result from excessive traction by the delivering physician.

Q All right. Now, you take over and I'm going to back off and you explain to all 12, 14, jurors exactly why, scientifically, you reach that conclusion.

A Well, based on my experience in the brachial plexus clinic, my participation as a neurologist was to see and examine the babies who had had these problems resulting from the birth process, and many of them were severe enough that they were candidates for surgery. I worked with a team of surgeons who did the operations to try to improve their function. My role in those surgeries was to do interoperative monitoring. One of my areas of expertise in pediatric neurology is what's called clinical neurophysiology. That involves stimulating nerves and looking at the responses of the nerves and the muscles to see if there's a disorder going on, and that's the kind of thing you have to do in -- during the

surgery. You need to stimulate the nerves that are exposed and then you record from the muscles in the arm. What you're trying to do during the surgery is determine what branch of the plexus is connected to what muscle, because you want to be sure -- the surgeons want to be sure that they're not cutting something that's still important for keeping that arm moving. So, that was my participation in the surgery. In that capacity, I had a sense as to -- and we -- we did probably at least 50 to 100 surgeries over the time that I was involved in the program, and in many of them you could see that the degree of injury was quite severe and in assessing the patients from their presentation on, and then participating in their surgeries, I came to see a number of patients who didn't have any history of trauma during birth of shoulder dystocia. Dr. Gowers' testimony that I was listening to, did remind me that I -- I think I have seen at least a couple of babies who had brachial plexus injuries after a precipitous delivery and I had the sense that these injuries can take place without any excessive pulling by the person who is making the delivery. I base that on my experience with the patients that I've seen, reviewing their charts and also taking the history from their families about what the birth process was like for them.

Q And what was it in the birthing process of this young man that confirms your opinion that excessive traction was not used by Dr. Goldstein?

MR. GRAHAM: Again, Your Honor, he's phrasing it -- objection, Your Honor. He's phrasing it ---

THE COURT: And what is your objection? What is your objection? The grounds, without arguing.

MR. GRAHAM: He's asking standard of care questions.

THE COURT: I'm going to allow him to ask the questions.

A Could you repeat the question?

Q What is it about the delivery of this young man, Bryson F , in your professional opinion and experience that you've had, that tells you scientifically so you can tell the jury to a medical degree of certainty most probably, this child's injury did not occur because of excessive traction, too much traction, in the delivery by Dr. Goldstein?

A He had a shoulder dystocia and as has been explained, the shoulder was not moving while the head was moving during birth process. It was a shoulder dystocia that was difficult to reduce and so there was a period of time when there was continued movement of the baby back and forth, or lack of movement. He -- he had a nuchal cord and he came out hypotonic with a very low APGAR score. An APGAR score of one means that the tone is

very low and it also signifies that the baby has had significant stress and significant hypoxy, and there was nothing in the record that indicated that anybody involved in the delivery had to pull hard on the baby's head in any way that -- in order to get the baby delivered, and so on all of those indications I based my conclusion that the injury resulted from a variety of factors including the shoulder dystocia, the movement of the baby just from the birth expulsive processes, and the baby's hypotonia, floppiness. The floppiness can make the baby more vulnerable to -- make the baby's nerves more vulnerable to stretching than a baby who is vigorous and intact.

Q So, it's the floppiness or hypotonia ---

A Hypotonia, yes.

Q Hypotonia ---

A Floppiness ---

Q --- which means floppy. Right?

A Yes.

Q All right. No question this baby was floppy at birth. APGAR was one.

A No question.

Q But it perked up pretty quick after birth. The baby's APGARs went up ---

A Yes.

Q --- pretty quickly, but starting at birth, it's floppy.
A Correct.
Q Second thing is the -- what do you call the -- the force, the force from just having a baby and having contractions? That force on the baby in utero in the birth canal trying to get down, trying to come out?
A Well, I've heard that referred to as maternal expulsive forces or natural forces, natural intrapartum forces, meaning during birth.
Q And is that present in this case?
A It's my opinion that yes, it is the case.
Q And that opinion is to a reasonable degree of certainty, most probably?
A Yes, it is.
Q Now, the organization that writes for and sends out books, called the American College of Obstetrician and Gynecologists, the neonatal brachial plexus palsy publication. Have you seen this before I just held it up?
A Yes, I have.
Q And I'm trying to see when it was published. Can you help me with that?
A 2014, sometime.
Q 2014?
A I believe so.

Q Okay. So, it's a pretty recent scientific publication.
A Yes.
Q Do you agree with the statement and consider it to be authoritative that states 12 reports published between 1990 and 2011 have been ---

MR. GRAHAM: Your Honor, I object to the leading. It hasn't been identified as being reliable. It comes from an obstetrical text posed to a pediatric neurologist. Yes, sir.

THE COURT: Your objection is leading?

MR. GRAHAM: My objection is it's leading, it's outside the scope of the expertise of a pediatric neurologist.

THE COURT: That's more in the form of argument but the nature of your -- initially, is leading?

MR. GRAHAM: Leading, beyond the scope of his expertise.

THE COURT: Your objection is noted, but overruled.

MR. HOOD: Thank you very much.

Q So I don't misread what I've got highlighted here with big stars next to it, would you read it to the jury and tell them what it says?
A Twelve reports published between 1990 and 2011 have described NBPP, that's neonatal brachial plexus palsy, and it indicates that 46 percent of NBPP occurred without documented concomitant shoulder dystocia. From these reports, the rate of NBPP without shoulder dystocia can be estimated at approximately 0.9 per

thousand births. Even when the injury to the brachial plexus was documented as lasting more than one year, 26 percent occurred in the absence of a documented shoulder dystocia.

Q Why is what you're reading important to this jury in accepting your scientific opinion?

MR. GRAHAM: Objection to leading, Your Honor.

Q Why is that important?

THE COURT: I'll ask him to re-phrase the question.

MR. HOOD: Yes, sir.

Q Explain the importance of what you just read to this jury in the context of this case, please.

A Its importance to me is that it represents an independent conclusion reached by the, by ACOG, in reviewing the literature on the situation. It, it supports the impression that I've had from my personal experience as a pediatric neurologist.

Q Do you consider it to be an authoritative publication, what you just reviewed?

A I'm not sure what authoritative means.

Q It's a legal term that you probably don't know as a doctor, but it means everything in our context of rules of evidence.

MR. GRAHAM: Your Honor, we renew our objection to asking a pediatric neurologist as to whether an obstetrical text is

authoritative.

MR. HOOD: It's the article I'm talking about, not the whole publication, just that one article.

THE COURT: Your objection is noted, but overruled.

A I think it represents the best effort at putting together all of the information available.

Q There you go. Can we say that's authoritative?

A If that's the legal definition of the word.

Q Thank you.

A Yes, I would say ---

Q It is.

A --- it's authoritative.

Q Doctor, I appreciate you driving down here through that awful traffic in your hometown Charlotte. I hope you don't hit rush hour going home.

A That doesn't seem likely.

Q We appreciate you coming and waiting. I'm sorry I couldn't get to you earlier. Thank you for being here. Unless I've got something I've left out -- I've got one question, maybe more.

Q Since there was a comment about that not being authoritative, look at the list of organizations that have endorsed what you just read.

MR. GRAHAM: Objection, Your Honor.

A Oh ---

THE COURT: Your objection being?

MR. GRAHAM: It's irrelevant. It's beyond the scope of this man's authority to address ACOG texts.

THE COURT: Your objection is noted. You may proceed.

Q Could you read those, please?

A The American Academy of Pediatrics, the American Academy of Physical Medicine and Rehabilitation, the American College of Nurse Midwives, the American Gynecological and Obstetrics Society, the American Society for Reproductive Medicine, the Child Neurology Society, the Japan Society of Obstetrics and Gynecology, the Royal Australian and New Zealand College of Obstetricians and Gynecologists, the Society for Maternal Fetal Medicine, the Society of Obstetricians and Gynecologists of Canada.

Q Like a Who's who in the world. Thank you. On this subject. Thank you.

THE COURT: Cross examination.

CROSS EXAMINATION

BY MR. GRAHAM:

Q Good afternoon, Dr. Jacobson.

A Good afternoon.

Q We met last Friday?

A Yes.

Q When you were presented for deposition as an expert

witness identified by the defense? Yes, sir?

A Yes.

Q Thank you. You were asked questions by Mr. Hood about your vast experience with brachial plexus matters. When you first went to Wisconsin and decided that you needed to set up a brachial plexus clinic, you needed help. True?

A I didn't set up the brachial plexus clinic.

Q Yes, sir, but when one was being set up in Wisconsin, you were one of the folks that was charged with the responsibility of trying to figure out how to do it. Right?

A I was asked to participate.

Q Yes, sir, and among other -- I mean, you had to go somewhere where there was a good brachial plexus center. Right?

A Yes.

Q All right. One of the places at the time was in Texas when Dr. Laurent was alive. True?

A Yes.

Q All right. And one of the leading lights of that institution was Dr. Maureen Nelson, a pediatric physiatrist, physical medicine and rehabilitation doctor. True?

A Yes.

Q You believe that she is, in fact, a brachial plexus expert. True?
A Yes.
Q And you saw her name mentioned in this child's medical records, Bryson F . True?
A Yes.
Q All right. And you were pleased that Bryson had been evaluated by such an esteemed specialist with expertise in brachial plexus. True?
A I didn't really have any emotional content to my reaction. I think it's a -- she's a good person to be taking care of a child with the problem.
Q Well, in fact, you thought that the doctors in the referral network locally were not experts in treating brachial plexus. True?
A Locally where?
Q In -- in the Carolinas. South Carolina, in particular.
A I didn't really have any opinion about ---
Q You had no opinion about Dr. Gilpin and Dr. Walsh about whether or not they were experts in brachial plexus?
A I'm not sure that they're experts compared to centers where they see hundreds of patients ---
Q Yes, sir.
A --- all the time.
Q And did you or did you not state at your deposition that

they were not experts in brachial plexus?

A I probably said that they were not.

Q Thank you. At this point in your career, having relied on Dr. Nelson -- and by the way where was she when Bryson went to see her?

A She was in Charlotte.

Q At Levine Children's Hospital?

A Yes.

Q All right. Were you here when the mother testified about how she got to Levine's?

A No.

Q So, you don't know how -- you don't know who made the arrangements for the child to be seen by a brachial plexus expert?

A No.

Q But you respect Dr. Nelson's referral service, including the Miami Brachial Plexus Center. True?

A Yes.

Q In fact, you consider that to be one of the top four at least in the world. True?

A Of the ones I can think of, there -- yes, I would say it falls into the top category.

Q One in Paris and three in the United States. True?

A Yes.

Q And the one that's in the United States closest to

Florence is in Miami. True?

A Yes.

Q And the head of that brachial plexus center, Dr. John Grossman, is one of the top four surgeons doing brachial plexus nerve repair in the world. True?

A I don't really know all of the surgeons that do this kind of surgery. He's one name that I am familiar with and he's well known and I think the number of patients that that center does is very high, so that's -- it's a very good place.

Q And it's sad when the child doesn't get surgery on multiple ruptures of brachial plexus nerves before six months, but in terms of a surgeon having the expertise to do a reconstruction at age two years, Dr. Grossman stands alone, doesn't he?

A I don't know.

Q If you had a loved one who was born with a brachial plexus nerve injury that ripped and tore their nerves and their brachial plexus, what is the first brachial plexus treatment center that would come to your mind?

A The Medical College of Wisconsin. That was where I worked. That's why it would come to my mind first.

Q Doctor, I'm going to hand you the original of your deposition. Doctor, would you please turn to page 32 of your deposition, starting with line 14, and let's focus

on lines 14 through 18.

A Through -- okay. Okay.

Q Okay, but if you had a loved one you would want to refer out for brachial plexus reconstruction surgery, you would choose among that list of four?

A Yes.

Q All right. Now please turn to page 43, line 18.

A What line?

Q Eighteen.

A This is part of a question.

Q What do you consider to be the top five brachial plexus centers in the world?

A I would say Miami, Boston Children's. I don't know if they are still doing them at Children's Hospital of Wisconsin. I know that the Mayo Clinic has been doing more of these procedures.

Q Please turn to page 44 starting at line 22.

A Question.

Q But if it was your loved one you would want them to go to Miami?

Ms. Ganes: Object to form.

A Off the top of my head that's the first place I'd think of that's closest. I would probably research it before making a decision.

Q Miami Brachial Plexus Center is the first place you

would think of if a loved one needed help with multiple nerve ruptures. True?

A That's -- that's the answer that I got to.

Q Yes, sir.

THE COURT: All right. Mr. Graham.

MR. GRAHAM: Yes, sir?

THE COURT: Madam forelady, ladies and gentlemen of the jury, we're going to take a break and bring some pizza back. Eat it. Eat as much as you want and as quickly as you want and we'll get started when y'all get satiated. How about that? So, do not discuss the case in any way, shape or form.

(Jury out at 6:05 PM)

THE COURT: Doctor, during the break you're not allowed to discuss the case with either lawyer, but you are able to get up, refresh yourself and maybe even have a piece of pizza.

DR. JACOBSON: Okay.

(Dinner Break)

THE COURT: Let's come to order. Madam forelady, ladies and gentlemen of the jury, I hope the pizza was good. I hope you're satisfied with regard to your appetite. Pay close attention. Mr. Graham, you're recognized.

MR. GRAHAM: Thank you, Your Honor. May it please the Court.

CONTINUED CROSS EXAMINATION OF DR. JACOBSON BY MR. GRAHAM

Q We were about to finish up with a matter related to Dr. Grossman but, Dr. Jacobson, do you agree that there is no better surgeon in the world to predict future surgery needs of Bryson F than Dr. John Grossman?

MR. HOOD: If the Court please, I guess this is the fourth time the same question has been asked.

THE COURT: I'm going to allow him some leeway. We've had a break and I think that's a little bit different than what he's asked.

MR. GRAHAM: Thank you.

A I don't think in terms of best in the world. I think that he's as good as any for assessing the patient's needs based on his experience.

Q Do you know of anyone better to defer to for surgical recommendation in the future, other than Dr. Grossman?

A No.

Q Thank you. Now, just to be clear, when you -- when you set up the or helped to set up the Wisconsin Brachial Plexus Center, you required help from folks around the country to do that. True?

A There was a -- the pediatric neurosurgeon and children's hospital wanted to set up a program. The only program that was really active at the time, this was in 1993 or '94, was Dr. John Laurent's program at Texas Children's.

Q He's -- oh, I'm sorry. Go ahead.

A He is now deceased, yes, but at the time he was, kind of, a pioneer in actually rejuvenating those surgeries and Ken Rikard, the neurosurgeon, wanted to learn to do the procedures and start doing them in Wisconsin and he asked me to participate, so we did go down there for a couple of weeks to observe his program and observe his surgeries at his clinic.

Q Yes, sir, and Dr. Maureen Nelson was among those in Texas that helped you out tremendously. True?

A Yes.

Q And now, you've left Wisconsin and you don't even know if they're doing these surgeries anymore. True?

A In Texas Children's?

Q At Wisconsin.

A I -- I don't know how active they are at this time.

Q And since Dr. Laurent died, you don't know if they're still doing these surgeries in Texas or if they are, you don't know who's doing them. Right?

A Well, I -- for a while there was a Dr. Nath who used to be in their program who set up an independent program in Houston and Dr. Nelson has returned from Charlotte to Houston last I heard. I don't know what she's doing, in what capacity.

Q I think she's in Austin, Texas. Correct?

A That may be where she is. You're probably more accurate

than I am.

Q I believe when we stopped I was getting ready to ask you now that you're in Charlotte, what percentage of your professional time is spent dealing with children that have brachial plexus birth injuries?

A I've only seen four or five patients in the few years I've been there.

Q How many years have you been there?

A It'll be five coming September.

Q So how many in those five years?

A About four or five.

Q So one per year at most?

A Yes.

Q Less than one percent of your professional time?

A Yes.

Q Now, we've heard you talk today about certain assumptions. I mean, you admit that what you said earlier about no greater than gentle traction, no excessive traction, that's just an assumption on your part. True?

A In respect to this case?

Q Yes, sir.

A It's based on the medical record.

Q Based on the fact that the medical record does not contain a confession from Dr. Goldstein that he wrenched

the baby's neck to cause permanent brachial plexus nerve damage?

A You could call my assumption that that was not recorded an assumption, yes.

Q So, you assume when a doctor doesn't confess in the medical records to inflicting permanent damage on the baby's neck that he didn't inflict permanent damage on the baby's neck. Fair?

A Yes.

Q But let's be clear, doctor. What puts stretch on a baby's neck? Axial traction or lateral traction?

A Well, stretch on a baby's neck, either axial or lateral traction ---

Q Yes, sir.

A --- will stretch the neck.

Q And which one stretches the brachial plexus nerves beyond the breaking point? Axial traction or lateral traction?

A Lateral traction or axial traction if the shoulder is immobile. It can tilt downward.

Q Do you believe that the brachial plexus nerves can be stretched more before or after the head is delivered?

A Yes.

Q Before or after, sir?

A Before or after what?

Q The head delivers.
A You mean comparing before or after?
Q Yes, sir. When this ---
A I don't know.
Q --- when this head of a 36-week-old baby weighing over eight pounds is going down through the birth canal at a slow rate of speed because it's such a tight fit, are you claiming that this, this baby's head can't tilt more than one degree at most?
A I think it's possible if the shoulder is stuck.
Q Do you have any scientific reliable authority to support your assumption that there's a possibility that this baby's head can deviate from axial even one degree?
A I don't know of any data that's been gathered to measure the position of the shoulder and the head and the neck in real time during the birth process to determine what that angle is.
Q Yes, sir, and what about after the baby's head comes out? Can the baby's head be tilted more than one degree? Could you demonstrate what a one-degree tilt is?
A Not exactly, I don't think so.
Q Okay. Do you believe a baby's head can tilt at least one degree after the head comes out?
A Yes.
Q In fact, it can tilt 45 to 60 degrees if manipulated in

that direction. True?

A Yeah, I think the range -- it's probably up to 60 degrees. It may be farther.

Q So the -- in terms of angle of traction and force applied to a baby's head, once the baby's head comes out of the birth canal, the ability of the head to be moved from the axis, you know, straight in line with the skeleton, deviated toward the left shoulder is 45 to 60 times, at least, compared to its ability to move inside the birth canal. True?

A I don't know if that ratio applies. I don't know how much it can deviate ---

Q Do you have any ---

A --- while it's still in the birth canal.

Q As a -- as a hired expert coming here to try to defend Dr. Goldstein, you come into court today and you say all these things can happen before the baby's head comes out, but tell us the truth, sir. Do you have any authority, any science, any literature in the history of the world to support the proposition that a baby's head at over eight pounds at 36 weeks can deviate more than one degree before the head comes out?

A I have no direct data to support that.

Q No data. What about -- and you admit, sir, that if you, if you were so inclined to apply this kind of traction

to a baby's head, that would put the right side brachial plexus nerves at risk of being ripped and torn in two. True?

A Yes.

Q Sir, do you have any science or any authority in the history of the world to support your theory that maternal expulsive forces, the uterine pushing and the mama pushing, can cause permanent brachial plexus nerve damage without making assumptions?

A The information that I base it on is indirect. There's no direct, there's no direct measurements to support that that can happen.

Q No direct measurements. In fact, to come up with that theory you have to make a leap of faith, don't you?

A It's -- it's the way I interpret my observations.

Q Yes, sir. Let me see if I got this straight. Mr. Hood started reading you a sentence or a paragraph from a, from an obstetrical book -- and by the way, did you read that book before they asked you to?

A I didn't read the whole thing. I saw the reference, I think, before I took this case.

Q But did you decide you wanted to bring that book to court today or did the lawyers over here for Dr. Goldstein want you to read from that book?

A They gave it to me to read.

Q Yes, sir, and what you read was that according to certain members of the lobby organization, American Congress for Obstetricians and Gynecologists, wrote that 46 percent of certain brachial plexus injuries occur without shoulder dystocia being written in the chart. True?

A Well, it was worded that there was no recorded -- I forget how it was worded, but ---

Q Yes, sir.

A --- it wasn't necessarily worded in terms of just it being recorded in the chart.

Q Yes, sir.

A Just not associated with shoulder dystocia.

Q Yes, sir, they made ---

A But I take your point.

Q --- a leap of faith that if it's not written in the chart, it didn't happen.

A Yes.

Q And you're willing to come into this court and make that same leap of faith?

A Yes.

Q There is no authority in the history of the world to connect the dots between a chart that doesn't say shoulder dystocia and no traction, is there, doctor?

A I'm not aware of any authority that knows what really

happened in comparison to what gets recorded in all the charts.

Q On those, those reports you read in the ACOG journal or book, those are based on certain articles in the literature supposedly that are cited in the footnotes, how many of those footnotes did you read?

A I, I've read some of the articles over the years that I think some of them may be contained in those footnotes.

Q Yes, sir, how many of the footnotes did you read?

A I don't know.

Q How many footnotes are there in this?

A I don't know.

Q Hundreds?

A Probably.

Q Thousands?

A Probably not.

Q You really don't know.

A Well, I don't think there are thousands.

Q Have you read any of them?

A I'd have to look at what articles they're footnoting to see.

Q Yes, sir, you told me you only read part of the article. Sir, did you read the footnotes, any of the footnotes to see what sources were cited for the conclusion in the main text?

A I -- I think I looked at the titles of some.
Q Did you -- you really can't even support the proposition that the footnotes support the text, can you?
A Not knowing which ones I've read and which ones I haven't, it's hard to answer that question.
Q All you know is that Mr. Hood wanted you to read the sentence that says 46 percent of babies who have their necks wrenched and permanent brachial plexus damage don't have the word shoulder dystocia written in the chart.
A Yes.
Q And when those authors write those articles, they're not watching any deliveries, are they?
A At the time that they're writing the articles or ---
Q Yes, sir.
A No.
Q They're looking at a different doctor's hospital chart, delivery notes. True?
A True.
Q They have no idea of whether the doctor who wrote the entries on that chart has any integrity or not, do they?
A Probably not.
Q They don't know if shoulder dystocia was present, do they?
A I -- I'm not sure what they know or they don't know.

Q All right. And if shoulder dystocia was present, that makes it more likely that traction was used with the shoulder pinned back in a way that can cause permanent damage. True?

A Can you say that again?

Q If, in fact, there was shoulder dystocia clinically -- in other words in the real world, even though it wasn't written down, if there was shoulder dystocia in the real world, that creates a golden opportunity for a doctor to injure the brachial plexus. True?

A If a shoulder dystocia is present it may be more likely that that kind of displacement can take place.

Q Especially if it's mismanaged. True?

A I don't know how you define mismanaged.

Q And even if it's right, even if it is correct that the chart not saying shoulder dystocia is -- even if -- even if your inference is correct that no shoulder dystocia written in the chart means that there was no shoulder dystocia, that doesn't rule out traction by the doctor, does it?

A Well, I think it's a standard to record what happens.

Q There are lots of standards in medicine, sir, but you don't know to what extent obstetricians meet those standards or violate those standards, do you, sir?

A I don't.

Q In fact, I know you're not an obstetrician so I don't want to be unfair here, but you went to medical school and you've delivered a couple dozen babies. Right?

A Correct.

Q Do you know enough about delivering babies to know that in C-section deliveries, obstetricians apply traction to a baby's neck?

A Based on my experience scrubbing in on C-sections, I think I wasn't really cognizant of how things were going at the time.

Q So, you don't know ---

A I think that that is a -- that definitely happens because we know the brachial plexus injuries can occur with Cesarean sections, whether it's due to traction by turning the baby around or getting the baby out through the incision, I think, is not known.

Q At any rate, it's the traction, especially in a lateral sideways direction, that causes the injury to those babies being born by C-section. True? Whether it's, whether it's turning the baby around or pulling the baby through the little hole.

A I think that can definitely be a factor in injuring the plexus, yes.

Q And when -- when there's a delivery that does not involve shoulder dystocia, that doesn't stop doctors

from pulling down on the baby's head, does it?

A No.

Q It doesn't stop them from pulling up on the baby's head, for that matter, does it?

A No.

Q We've heard in this case that Dr. Goldstein says he -- I believe he testified -- somebody testified that they routinely apply downward traction to try to get the top shoulder out, and then upward bending of the neck to try to get the bottom shoulder out. Is that your understanding of how doctors delivery babies?

A I think that's a part of the process. That can be a part of the process, yes, and I think when it gets done it often results in a baby who is not injured.

Q Yes, sir, that's true. If -- if the doctor handles the baby's head ---

MR. HOOD: At this hour we don't really need to get into obstetrics.

MR. GRAHAM: I didn't start it, Your Honor.

THE COURT: I'm going to allow him some -- some leeway in that regard.

MR. GRAHAM: Thank you.

Q If a doctor is gentle in his manipulation of the head, injury is far less likely. True?

A It depends on the state of the baby.

Q Doctor, the more the traction the greater the risk of injury. True?
A Externally applied traction?
Q Yes, sir.
A Yes.
Q The greater the force of the traction, the more likely the injury will be permanent. True?
A Possibly, yes.
Q Possibly?
A Yes.
Q The greater the traction the more likely the injury will encompass the entire plexus from C-5 down to T-1. True?
A I'm not sure about that.
Q At any rate, this business about babies being born with brachial plexus injuries and shoulder dystocia not being in the chart, you don't know whether traction caused those babies' injuries or not, do you?
A In any one baby I couldn't say.
Q In fact, I know you've seen a few hundred babies with this injury, I believe you said. How many charts have you seen where there was a confession from the doctor that he broke the rules, he broke --- he fell below the standard of care and by applying too much forceful traction to the baby's head and neck, ruptured and damaged all the nerves in the brachial plexus?

A I've never seen that.
Q You've never seen a confession?
A Confession?
Q By a doctor that he committed medical malpractice in the hospital chart.
A Not in my experience.
Q Okay. Not in mine either, sir, but you're willing to come into this court and tell these ladies and gentlemen of the ---
MR. HOOD: I move to strike counsel's testimony.
THE COURT: Overruled. Go ahead.
MR. GRAHAM: Thank you, Your Honor.
Q And yet you're willing to come into this court and tell these ladies and gentlemen that you're willing to assume that if there was no confession, there was no, there was no negligence. That's what you're telling us. Right?
A Yes.
Q That's pure speculation, isn't it, doctor?
A It's -- it's a conclusion reached by observation and my own sense of human nature, knowing what physicians do, in general.
Q Are you willing for me to hold my hands on your shoulders and you show me how high you can lift your neck?
A Sure.

Q How high do you think you can lift your neck?
A I don't know.
Q All right. Are you willing to lie down on this table with your head over the side and let me push your head down toward the floor?
A Sure.
Q Seriously?
A Well ---
Q Are you willing to ---
A I was -- I have people in the room to protect me.
Q Are you willing to assume the risk of injury from that maneuver?
A Well, I think I would be able to know when it was going too far and resist.
Q Little babies can't do that, can they?
A Some babies do better than others.
Q Let me talk to you briefly about hypotonia. Is there any more science to that theory than these other theories? Can you point to a single case in the history of the world where the baby's tone and the mother's pushing forces and the uterus working somehow ruptures four or five brachial plexus nerves?
A I can't think of any individual case where it's known with certainty that that was all that happened.
Q Yes, sir, by the way, you came here today talking about

obstetrics, but do you recognize any leading authorities, reliable authorities, on the topic of nerve injuries to the newborn babies?

A The one I think of is -- I'm sorry. If I can think of his name. Used to be at Leahy Clinic.

Q Used to be where?

A At Leahy Clinic.

Q First name Joseph?

A No.

Q Joseph Volpe?

A I know Dr. Volpe, yes.

Q All right. Do you recognize ---

A He was at Boston Children's.

Q Do you recognize Dr. Volpe as being one of the leading authorities on the topic of nerve injuries in the newborn?

A Not peripheral nerve injuries, no.

Q You don't?

A No.

Q Do you own this book, Neurology of the Newborn, fifth edition?

A I -- no, I've had it out of the library. I've read it.

Q Do you have any of the older editions?

A No, I've always just looked at it in the library.

Q And you're telling -- let me just ask you ---

MR. GRAHAM: Could we mark this as a Court Exhibit?

MR. HOOD: If the Court please, I'd ask that counsel follow Rule 803(e).

MR. GRAHAM: I'm not showing it to anybody.

THE COURT: Okay. Very good.

MR. GRAHAM: I'm just marking it as a Court Exhibit.

THE COURT: Show it to him first. Have you showed it to him?

MR. HOOD: It doesn't say where it's from.

MR. GRAHAM: It's from Volpe.

MR. HOOD: Let's see the book that it's coming out of, not some blow-up that you introduce.

MR. GRAHAM: Here you are, sir.

MR. HOOD: I'd like a copy.

MR. GRAHAM: Yes, sir, it's on -- my glasses -- it's on page 972.

(Mr. Hood looks at document)

Q Doctor, I hand you Neurology of the Newborn by Joseph J. Volpe, fifth edition. Have you seen this before?

A Yes.

Q You've checked it out from the library?

A I don't think I've seen this edition.

Q You've looked at the older editions?

A Yes.

Q Do you stay current in the literature related to nerve

injuries in the newborn, sir?

A I have tried to. I haven't -- actually the last time I searched it was about the time that I saw the ACOG consensus statement.

Q Yes, sir, and this -- this most recent edition has been around since before then. True?

A Yes.

Q But you're not sure you've seen this current edition?

A I have not seen this current edition.

Q All right. At any rate, do you recognize this publication as being a reliable authority or a reliable source with respect to the injuries, nerve injuries in the newborn?

A I don't think of Dr. Volpe's textbook as being authoritative. The chapters written on nerve injuries are a summary of previous textbooks and articles written on the subject.

Q Yes, sir, and this blow-up here has been written by Dr. Volpe. True?

MR. HOOD: Your Honor, the inquiry as a rule ends with that answer he just gave.

A Well, it could be. I'm not sure where it would be.

THE COURT: Hang on one second. Might counsel approach the bench?

(Bench conference held off the record)

Q Doctor, do you agree that brachial plexus birth injuries are believed to result primarily from stretching of the brachial plexus by extreme lateral traction, especially when there's a breech delivery and the arms are pulled or when there's a stuck shoulder and the head is pulled down with force?

A I agree that that's what is believed.

Q Excuse me?

A I agree that that is what is believed.

Q That's believed by -- by scientists in the field of nerve injury in the newborn, pediatric neurology and others. True?

A I think many people have that belief, yes.

MR. GRAHAM: No further questions, Your Honor.

THE COURT: Redirect.

REDIRECT EXAMINATION

BY MR. HOOD:

Q Doctor, did he ask you anything that changes your opinions in this case?

A No.

Q In your professional opinion, did Dr. Goldstein cause harm to this child?

A No.

MR. HOOD: Thank you for coming.

THE COURT: You may step down. Ms. Craig, do we have

another witness? You're free to leave. You're excused.

MS. CRAIG: No, sir, we have one witness tomorrow.

THE COURT: Very good. Madam forelady, ladies and gentlemen of the jury, thank you for working long and hard today. We're going to start once again at nine o'clock in the morning. Be here at nine o'clock sharp. Do not discuss the case. Do not do any independent investigation. We're getting in the short rows, so y'all show up at nine o'clock. We've got probably two more witnesses and then we'll have argument and charge. Very good. We're making progress. Thank you very much. Everyone remain seated as the jury exits the courtroom.

(Jury out at 7:00 PM)

THE COURT: It might be a little bit premature, but I'm going to, kind of, go over, in summary form, the charge. I'm going to charge: the duty of the judge and jury, preponderance of the evidence, direct and circumstantial evidence, credibility of witnesses, expert witnesses, expert witnesses as it relates to proximate cause, charge the general law with regard to medical malpractice. I'm going to charge that in this circumstance the doctor/patient relationship has been established as a matter of law. There's no contention about whether or not there's a doctor/patient relationship, so I'm making that finding as a matter of law. Charge the standard of care, breach of the

standard of care; general law with regard to proximate cause. I'm going to charge the law with regards to appropriate evaluation in the medical malpractice sense, I'm going to charge the law on informed consent. I'm going to charge the law with regard to emergency situation and how it relates to informed consent, actual damages. I'm going to talk about actual damages as it relates to personal injuries in a general way. I'm going to define what pain and suffering is. I'm going to define loss of enjoyment of life. I'm going to define mental suffering. I'm going to charge the law with regard to respective damages, future damages, loss of earning capacity. I'm going to charge life expectancy table and based on what I've heard here in court, he's five years old and has a life expectancy of 71.8 years. Is that correct?

MR. GRAHAM: He'll be six in August, Your Honor, so I'm not sure how that factors into the half year rule.

THE COURT: All right. Well, does anybody object to five years and 71.8?

MR. GRAHAM: We do not, Your Honor.

MR. HOOD: We don't.

THE COURT: All right. Very good. I'm going to charge the law of the duty to mitigate damages as it relates to personal injury and reasonable attempts to seek medical attention and physical therapy. What is the Defense's position with regard to punitive damages?

MS. CRAIG: Your Honor, we would plan to renew our motion to strike punitives at the close of all the evidence, but there is no testimony of reckless, willful, wanton conduct. Everyone, the nurses, all the people in the room testified it was an emergency, everybody was doing the best that they could. They are proud of the delivery that they were able to accomplish. The only ---

THE COURT: What about the lady from Harvard who said it was, indeed, egregious? I might be have a different opinion and, certainly, you have a different opinion about it, but don't you think it would be reversible error if that doctor said that the conduct rose to the level of egregious conduct? Recklessness, I believe, she said.

MR. GRAHAM: If I may, Your Honor. She did say egregious. She also said, I believe, reckless ---

THE COURT: All right. Mr. Graham, I'm going to give you an opportunity. This is Ms. Craig's time. Didn't she say that?

MS. CRAIG: She said reckless and maybe she said egregious, I'll have to check that.

THE COURT: All of those kind of go one and the same.

MS. CRAIG: Yes, sir.

THE COURT: I think that may pose a problem and this might turn into a preliminary hearing and we might end up trying it again.

MS. CRAIG: We don't want that.

THE COURT: We don't want that. It would be a very expensive endeavor.

MS. CRAIG: I think Your Honor defines as a matter of law, that that doesn't rise to the level of clear and convincing evidence. That's ---

THE COURT: I believe a jury could conclude, if they believed her testimony and did not believe any of the other testimony, that could rise to the level of clear and convincing. Whether it convinces me is different than -- I'm not the trier of fact. I kind of have a tendency to agree with you but I believe if I were not to allow punitive damages to go to the jury, it would be reversible error. I was just wanting you to convince me to do otherwise.

MS. CRAIG: May I have this evening to do some research to see if I can?

THE COURT: Yes. I think that would be a good idea, because I think it would be a real...

MS. CRAIG: All right. If I could have the evening to find some law to support. I mean, in a nutshell, it's a conclusory statement that she made after she had been asked three times or four times to actually get it out of her and it's just not based on any of the facts in the case. So, but I'll see if I can find a point on that.

THE COURT: That's fine. I want y'all to come look at the

verdict form and see if it -- and we have the -- and obviously we still, the verdict form contemplates punitive damages, but if we make a determination otherwise, it will be taken out. I'll ask y'all to come forward and look at the verdict form. (Attorneys comply)

MS. CRAIG: One thing that I've seen, first of all, I've never seen that stated on a verdict form. I've heard it in a charge before, as a matter of law.

THE COURT: The thing about it, you're explaining them the law and the law says they have to have a doctor/patient relationship and there's been no indication there has not been a doctor/patient relationship and I think that it's appropriate to do it that way. You don't certainly have an objection to that, do you?

MS. CRAIG: I just, I mean, you're going to be charging them on that, right? And I just don't see a reason why it should be stated on a verdict form.

THE COURT: Because in the law, it says that you've got to find these four elements and I'm telling them that they can pass beyond that as a matter of law. I think for clarity. It's certainly not going to hurt anything. Tell me how it would prejudice you?

MS. CRAIG: I'm not saying -- I'm not sure it's preju --- I just think it's confusing.

THE COURT: You just think it's bad form?

MS. CRAIG: Well, it's confusing. I'm not sure I object to it.

MR. RUFFIN: I think it makes it less confusing.

THE COURT: I think they need to know that and I think when they are going through, it's a good idea to say that I've decided that as a matter of law, but if y'all have an objection, you can put it on the record.

THE COURT: Have you seen the verdict form? (Speaking to Mr. Hood)

MR. HOOD: I don't think the doctor/patient relationship is needed. The rest of your verdict form is magnificent.

THE COURT: I thought it was a pretty good job, too.

MR. HOOD: Except for the punitive damages. That needs to come out.

THE COURT: All right. We'll talk about that tomorrow. Your daughter is going to work on that.

MS. CRAIG: May I make one suggestion? I do think it's more clear. I like the way you've broken out all the questions. I think that's great. One thing that I like, if you've reached a verdict, if your answer to question one is no, you end your deliberations, if not, continue to question two. So, they have instruction on it. If you answer no, your deliberations are over, if you answer yes, you go to two. And then the same thing with two.

THE COURT: I think it says that on there, doesn't it?

I'm going to read it to them and I'm going to explain it to them.

MS. CRAIG: Yes, that's fine.

THE COURT: Any objections from the Plaintiff with regard to the verdict form?

MR. GRAHAM: No, Your Honor.

THE COURT: And the objection from the Defense is that you think the doctor/patient relationship should not be on there and the objection with regard to punitive damages. Is that correct?

MS. CRAIG: Yes, and of course, with punitive damages and with regard to the physician/patient relationship, you are going to charge that in your charge so, that's duplicative.

THE COURT: All right. Very good. I will be happy to entertain any request to charge any time between now and I do it and probably in the morning would be a good time, but I will certainly entertain any up until I charge the law.

MS. CRAIG: I have a couple if you want to address it now?

THE COURT: Yes.

MS. CRAIG: I was looking through and I might have missed it, but I didn't hear bad result, not a guarantor or insurer.

THE COURT: That's all in there.

MS. CRAIG: It is in there?

THE COURT: I didn't really say that, but you know, when

I talk about general medical malpractice, it says all of that in there.

MS. CRAIG: All right. And I didn't hear sympathy, but I'm sure you have that somewhere, right?

THE COURT: Actually, I don't.

MS. CRAIG: Sympathy?

THE COURT: Well, I'll be glad to charge that specifically, but in a reverse way, I think I say that it has to be based on the evidence. It doesn't say anything in a negative way about sympathy, but if you have one and it's a good one, I'll be happy to charge it.

MS. CRAIG: All right. We submitted a few in our proposed charges, but I can pull it out and give that to you.

THE COURT: Yes.

MS. CRAIG: Give you hard copies, but given their case and the presentation of the case and the extensive damage testimony, I think we really need a sympathy charge.

THE COURT: All right.

MS. CRAIG: Please.

MR. RUFFIN: Your Honor, we would just like to see a copy of the charge given to the Court. I don't believe we've seen a copy.

THE COURT: Apparently, they sent it to both of us.

MS. CRAIG: They have everything from us.

MR. RUFFIN: Okay. I just wasn't sure.

MS. CRAIG: And I'll provide a hard copy of the sympathy charge so you won't have go looking in the computer.

THE COURT: All right.

MS. CRAIG: And we would also object to the informed consent charge.

THE COURT: And the grounds for that being?

MS. CRAIG: I don't think they've proven that. There was a statement by Gomez-Carrion about documentation and informed consent and I asked her, I said, "You agree with me that even though you say that's a deviation of standard of care, the lack of documentation, the lack of a specific form that says, "I got informed consent," does not cause any injury and so she says a deviation, but she doesn't make it past causation, and so they can't meet their burden of proof.

THE COURT: Would there ever be a case where informed consent would result in an injury? The failure to get informed consent?

MS. CRAIG: Well, that's what's so interesting in this case, because the informed consent, that issue -- they are trying to connect informed consent with induction, Pitocin, and the vacuum and none of that caused the injury and so everything that they are saying was a lack of informed consent, they don't meet any probable cause on that. There's a disconnect. It ends at deviation and they can't meet their burden of proof to show that it probably caused the shoulder

dystocia in this case. All the testimony is that the shoulder dystocia was unpredictable and unpreventable. It had nothing to do with informed consent. There has been no -- the only other option, she's going to have to have this baby delivered one way or the other and there are two options, vaginal or C-section and their own expert, Gomez-Carrion, the only one who testified on standard of care said that a C-section was not medically indicated and it was not a deviation from standard of care to deliver a child with vaginal labor and so informed consent gets them nowhere. It's very confusing and it's just a red herring of something that they say, we didn't get informed consent for Pitocin, we didn't get it for the vacuum and we didn't do it for the induction of labor, but none of those things caused the shoulder dystocia or caused the brachial plexus injury.

THE COURT: Be glad to hear from the Plaintiff. The only thing I would say about that is it seems like the only thing, really -- I agree, the Pitocin and all that other stuff is certainly not related, the suction, the Pitocin and all those other things really didn't cause any injury, it really doesn't come into play, but I imagine the C-section versus vaginal delivery might. What do you think?

MR. GRAHAM: Your Honor, I believe that there was testimony from Dr. Gomez-Carrion that the use of a vacuum increased the likelihood of a stuck shoulder. It's the

mismanagement of the stuck shoulder that was the direct cause that created that new risk factor without informed consent certainly was a substantial factor in contributing to that shoulder dystocia and the mismanagement thereof. I mean, it contributed to the shoulder dystocia which wouldn't have been a problem except for the mismanagement.

THE COURT: Ms. Craig, do you remember her saying, Dr. Gomez-Carrion, I know you certainly don't agree with it, but do you recall her saying that the use of the suction would increase the traction and the chance of a brachial plexus injury?

MS. CRAIG: You know, I don't remember exactly what she said with regard to that. I was just asking the others if they have it in their notes. I'll have to look through my notes, but what she did say and what the other witness -- every time they brought up the whole vacuum thing, I asked the question, did it cause all of these problems. The vacuum didn't cause anything. So, the vacuum -- I'm so glad this case up, because the vacuum was used before the shoulder dystocia even occurred and so the vacuum didn't cause any injury and so this whole thing about vacuum and having it be a deviation from the standard of care, what's the injury? There is no injury. The injury was not because of the vacuum. He used two pulls and he got the head down. It didn't cause the hematoma, the swelling and the litany of things that they

kept asking about. This whole informed consent was a brand new thing to all of us, as of, whenever we had our pre-trial last week, Thursday. This is a brand new thing that they -- it has nothing to do with anything in this case. It has nothing to do with the brachial plexus injury.

THE COURT: All right. Anything further? I'm going to contemplate that over the evening.

MR. GRAHAM: I don't want to burden you. I know the hour is late, but I'll be happy to speak up if you'd like.

THE COURT: Very good. All right. Well, we will stand at ease until 9:00 in the morning.

MAY 8, 2015 - MORNING

THE COURT: Please be seated. Good morning, everybody. 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: All right. We're ready for the jury.

(Jury in at 9:02 AM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, good morning. I anticipate we have two more witnesses and then we'll proceed forward with closing arguments and charge. Bear with us and pay very close attention. Ms. Craig, you're recognized.

MS. CRAIG: Thank you, Your Honor. May it please the

Court. The Defendants call Dr. Mark Salley.

THE COURT: Dr. Salley, please come forward. You're going to have to come around between these tables here. I'm going to ask if you can place your paperwork down on the counter here, put 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. MARK SALLEY testified as follows:)

THE CLERK: Please be seated.

THE COURT: Watch your step. Watch your step. Very good. All right. Pull up real close to that microphone, speak loudly, clearly and slowly in order that we can hear everything that you have to say. Have a seat and state your full name please, sir.

DR. SALLEY: Yes, sir. Mark Hedrick Salley.

THE COURT: Thank you, Dr. Salley. Ms. Craig.

MS. CRAIG: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. CRAIG:

Q Good morning, Dr. Salley.

A Good morning.

Q Tell us where you live, sir.

A Columbia, South Carolina.

Q And are you married?

A I am.

Q Do you and your wife have children?
A We have three.
Q What are their ages?
A Dillon is 20, Jackson is 17, and Eliza is 14.
Q What do you do for a living, Dr. Salley?
A I deliver babies, take care of women.
Q What's the name of your practice?
A South Carolina OB/GYN.
Q And how many partners do you have at that practice in Columbia?
A There are eight of us now.
Q Tell us your education, starting with college and then take us from there please.
A Well, I jumped around. I went to University of Colorado and then found out it was too far away and went to University of South Carolina, and then to the University of North Carolina and then graduated from the University of North Carolina and moved to the Medical University of South Carolina in Charleston, and then from there went back to North Carolina in Chapel Hill and finished my residency.
Q And Dr. Salley, are you board certified?
A I am.
Q Tell us what teaching responsibilities you have.
A I teach physician assistant students from MUSC. Also, we

have residents that scrub with us in surgery at the hospital I work in, and we also have third-year medical students that rotate through our office.

Q Could you give us an idea, and just an estimate, how many babies you deliver a year?

A It ranges. It's changed a little bit as I've gotten more partners and have gotten older. I'm not doing as many deliveries, but I, I would say that I would deliver in the, in the busy years, 200 to 250. Now, it's around 80 to 100 deliveries.

Q And how long have you been practicing medicine?

A Well, as a physician outside residency, 25 years. When you include residency, which is four years of training, 29 years.

Q Where do you have hospital privileges?

A At Palmetto Health Baptist, which is in the center of Columbia, and Palmetto Health Richland, which is very close to that.

Q Okay. And looking at your CV, it appears as though you have the American Board of Obstetrics and Gynecology, you're a fellow at the National Board of Medical Examiners. Is that right?

A Correct.

Q What's the State Board of Medical Examiners?

A That's -- I'm actually not on that board now.

Q How about the National Board?
A I'm not on that board now either.
Q Okay. So, at some point you were and then ---
A Right.
Q --- you aren't currently. How about ACOG? Are you familiar with that professional organization?
A I am. That is -- that is our parent organization where much of our information and research is synthesized and spread out through the country with our doctors in OB/GYN.
Q Now, as an OB/GYN do you keep current with the medical literature that applies to your medical specialty?
A I do.
Q And do you consider yourself an expert on the medical literature that applies to your practice as an OB/GYN?
A I do.
Q And would that include the medical literature that includes various causes of brachial plexus?
A It does.
Q And have you actually done some research and reviewed medical articles to testify about those articles in this case?
A I have.
Q And are those medical articles, articles from journals, publications and various literature that doctors like

you, OB/GYNs, would rely on to stay current in the medical literature?

A They are.

MS. CRAIG: Your Honor, at this time we would offer Dr. Mark Salley as an expert witness in the field of obstetrics and gynecology.

THE COURT: Any query with regard to his qualifications, Mr. Graham?

MR. GRAHAM: Your Honor, there is a matter we need to take up outside of the jury's presence.

THE COURT: Very good. Madam forelady, ladies and gentlemen of the jury, may I ask that you retire to the jury room but once again, do not discuss the case.

(Jury out at 9:08 AM)

THE COURT: Mr. Graham, you're recognized.

MR. GRAHAM: Thank you, Your Honor. And if Your Honor please, there are a couple of ways I could do this. In light of the way you wanted me to do it yesterday, I'm happy to just tell you or I can do it by question and answer with the witness, whichever you prefer.

THE COURT: Why don't you summarize it? There's no sense in going through cross examination twice.

MR. GRAHAM: Fair enough. Your Honor, we -- first of all there are three categories of opinions that I believe Dr. Salley may be preparing to testify to. One is the applicable

standard of care. We have no problem with that. He's qualified to that. His opinion is based on an appropriate foundation. Secondly, with respect to the, to whether or not Dr. Goldstein breached the standard of care, he said repeatedly in his deposition that he didn't know and that he couldn't comment on whether or not Dr. Goldstein breached certain standards of care. All he could do is state what the standard is and let the jury determine what the facts are about what Dr. Goldstein did and whether Dr. Goldstein met or fell below the standards would rise or fall with the jury's factual determination, so we don't believe -- I mean, if he's now going to express opinions about a breach, that would be a surprise.

THE COURT: It would seem to me as though he is qualified in the area of obstetrics and gynecology and he would certainly be able to testify as to the standard of care ---

MR. GRAHAM: Yes, sir.

THE COURT: --- and if he has previously taken a position, you can cross examine him on that, but I think that if he's an expert, perhaps he could render testimony about the breach today if he wanted to.

MR. GRAHAM: The third category, if Your Honor please, has to do with causation. Dr. Salley kind of waffled back and forth at his deposition about whether or not he was going to express an opinion about causation. At first, he gave a very

general opinion, then once I asked some questions that exposed his lack of knowledge on the subject, he said I retract that, I will not be an expert at trial on causation. You can rely on that. Later on in the deposition he said I've changed my mind. Now, I have an opinion on causation and he said it was multi factorial. He listed four elements. He had no evidence to support the existence of any of the elements, and he said that to the extent any of them had causal significance in his opinion, it did not rise to the level of even one half of one percent causal significance for any of those four factors. Under our case, and I think it's -- Pink verus Kearse, evidence is not admissible on causation by a medical expert unless it reaches the level of most probably. If you sum up his four elements, it's less than two percent without any evidence to support it, so we believe this is just a mockery of the rules of law in South Carolina about causation. We believe Your Honor, as gatekeeper, is bound to stop them from offering any causation testimony.

THE COURT: Ms. Craig?

MS. CRAIG: A mockery? He's been practicing medicine as an O-B for 29 years. He's delivered thousands of babies. I think that Your Honor asked him if he had any questions on his qualifications, and so all of what he just talked about goes to the weight of the evidence and Dr. Salley -- and this was a long deposition last week. I don't think I got home

until 10:30 at night.

THE COURT: How long was it?

MS. CRAIG: It was ---

DR. SALLEY: Five-and-a-half hours.

MS. CRAIG: How long?

DR. SALLEY: It was five-and-a-half hours.

MS. CRAIG: It was five -- I mean, it was -- it went on and on and on.

DR. SALLEY: After Mr. Graham was 30 minutes late.

MS. CRAIG: And without a doubt the last question that I asked him, because we were back and forth, back and forth, I said in this case, one more time, your opinion is that most likely the cause of the brachial plexus injury in this case was a combination of factors. Is that correct? That is correct. That's on the last page of the deposition transcript. They had an OB/GYN, Gomez Carrion, testify about what she thought was the most likely cause. She says it's excessive traction. Dr. Salley is an expert in the medical literature, has medical literature to support his opinions and all of the issues that Mr. Graham raised all go to the weight of the testimony.

THE COURT: It's factual questions.

MS. CRAIG: Yes, sir.

THE COURT: All right. Well, I do find that he is qualified as an expert and he can render opinions in all of

the areas, standard of care, breach and causation. However, he's obviously going to be held to the -- to his previous testimony, whatever that might be, and it might be inconsistent. I think all of these things are questions of fact for the jury to resolve. Anything further, Mr. Graham?

MR. GRAHAM: No, Your Honor. We just wanted to get that on the record.

THE COURT: You're protected on the record. All right. We're ready for the jury.

(Jury in at 9:13 AM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, this witness is qualified to testify in the field of obstetrics and gynecology and allowed to render opinions in that area. Ms. Craig.

MS. CRAIG: Thank you, Your Honor. May I approach the witness?

THE COURT: You may.

Q Dr. Salley, is this a copy of your most updated or your most recent CV?

A It is.

MS. CRAIG: At this time, Your Honor, we would offer Dr. Salley's CV into evidence.

THE COURT: Any objection from ---

MR. GRAHAM: No, Your Honor.

THE COURT: The CV is into evidence.

MS. CRAIG: Thank you.

THE COURT: And that's denominated as Defense exhibit...

COURT REPORTER: Six.

THE COURT: Six is into evidence.

MS. CRAIG: Thank you.

(Whereupon, Dr. Salley's CV is entered into evidence as Defense Exhibit #6, without objection)

Q Dr. Salley, do you have experience delivering babies where the baby's shoulder gets stuck under the mother's pubic bone?

A I do.

Q Okay. What is that called?

A Shoulder dystocia.

Q And tell us about your experience in that regard.

A I have, through 25 years, encountered probably five to six severe shoulder dystocias where the baby's head is delivered and you cannot get the rest of the body out, and it's truly an emergency. It's a nightmare. It's a nightmare for the mother. It's a nightmare for us and you have to perform certain maneuvers to try to get the baby out, all the time you're worried about the oxygen status of the baby and brain injury.

Q Dr. Salley, at my request did you review the medical records of Ms. Fulton from Dr. Goldstein and the hospital and review the depositions taken in this case,

and also the current medical and scientific literature, and based upon all of that information do you have an opinion whether or not Dr. Goldstein met the standard of care?

A I absolutely believe that Dr. Goldstein met the standard of care.

Q And based upon that same information, do you have an opinion whether Dr. Goldstein caused the injuries to this child?

A I do not believe Dr. Goldstein caused the injuries to this child.

Q And Dr. Salley, are those your opinions to a reasonable degree of medical certainty, most probably?

A They are.

Q All right. Let's start with traction. Do you use that word traction in your everyday practice?

A I don't.

Q What word do you describe to provide the -- to help deliver a baby?

A I deliver the anterior shoulder, is what I usually say.

Q Now, when a doctor uses traction or gentle guidance, is that something that's only specific for shoulder dystocia-type situations or for every delivery?

A For every delivery you always have to have some -- now, there are some women that they are delivered in the

elevator and so you're just trying to hold the baby and keep the baby safely in a comfortable position, but for most deliveries you almost always have to have some downward motion and guidance with the baby's shoulder to get it delivered.

Q Is that reasonable to use gentle guidance to try to deliver any baby?

A It is standard.

Q You have reviewed the prenatal care that Dr. Goldstein provided to Ms. Fulton. Correct?

A I have.

Q You looked at that entire office chart and based upon your review of the office chart, do you have an opinion whether the prenatal care that Dr. Goldstein provided to Ms. Fulton met the standard of care?

A It did.

Q Dr. Salley, was there any indication for a Cesarean section for Ms. Fulton?

A There was not.

Q And how about macrosomia? What does that mean?

A Macrosomia is a term we use to describe a large baby, usually -- and we talk about grams a lot, but 4,500 grams is, 4,000 some authorities will say, 4,500 other authorities will say, but that's in the 10 and 11 pound range.

Q Was this baby macrosomic?
A It was not.
Q Now, again, based on your review of all the testimony and the records, do you have a opinion whether the shoulder dystocia in this case was predictable?
A Absolutely not.
Q Was it preventable?
A It was not.
Q In any shoulder dystocia case, is it predictable and preventable?
A It is not.
Q You talked about just a moment ago that shoulder dystocia is a medical emergency and I'd like for you to explain to us what the risks are to the baby in a shoulder -- in an emergent situation like shoulder dystocia.
A Well, the number one risk, again, is oxygen deprivation to the baby where the baby doesn't get enough oxygen and that creates injury to the baby's brain. I don't know if any of the jurors have seen a child with cerebral palsy, but that's one of the consequences of low oxygen, so that's always the most concerning problem when you have a baby that's stuck. The other problem is injuries to the baby coming through the birth canal, the shoulder, the brachial plexus which is what this case is about,

and also injuries to the mom. That can be a problem, too.

Q Now, in your experience in delivering babies, have you ever had the situation where the shoulder got stuck and you were not able to dislodge it or get it unstuck?

A I have and, in fact, one of the reasons that, that I looked at his case and wanted to be here today is because I've had a very similar experience with a patient some years ago, almost identical to Dr. Goldstein's situation, and it's -- you -- you do everything you can to try to get the baby out safely and try to protect the mother and the baby's oxygen status, and the maneuvers we do, sometimes they work and sometimes they don't, and you, you know, it looks good on a textbook or a diagram. It looks easy. Oh, you just put your hand in there and grab the arm and pull it out and it's not easy and many times we have to do things multiple times to make it happen, and then it still doesn't happen. In fact, I've actually had, in a couple of cases, to push the baby back up and do a Cesarean section and in this case, you couldn't do that because the head was already delivered. In the cases that I had to do that, tried every maneuver I could and actually the head was only this far out. I was able to push it up and deliver the baby by Cesarean, so it really is truly

the worst, one of the worst emergencies we have in our field.

Q Are there other extreme measures that doctors would have to take to get the baby delivered? If you can't get that shoulder unstuck, you said that you've had to push the baby back up. Are there other extreme measures that doctors would have to take to get that baby delivered?

A Well, there are a couple that I just can't bring myself to do. One is to intentionally try to break the collarbone of the baby and I think that tells you how bad this is, when you're actually trying to get your hand in there to break the collarbone. Even though they're small, they're not adult collarbones. They're still very difficult -- it's hard to do that anyway, but I just can't bring myself to do that. It just seems like, you know, you could puncture the lung. The collarbone can go down and puncture the lung of the baby and you can get into worse problems. There's also discussion in years past of actually taking a knife and scissors and separating the mom's pubic bone and trying to widen the pubic bone, which that's like medieval torture to me. I don't believe I could ever do that. But, those are the things that are talked about that I just wouldn't be able to do.

Q In this case, when Dr. Goldstein recognized this

emergency, how long did it take Dr. Goldstein and those nurses to get this baby delivered?

A I believe it was four minutes.

Q And based upon your review of the records, were the McRoberts and suprapubic pressure that they were applying, those maneuvers, were they successful or unsuccessful?

A They were successful.

Q Have you ever had the experience when you're delivering a baby and the baby's head comes out and you try to put your hand inside the vagina so that you can move the baby, but you've been unable to actually get your hand inside?

A I have.

Q Can you explain why that happens from time to time?

A Well, again, it's hard to really -- to get y'all to understand what happens when you're looking at a diagram or a textbook. It -- you can't, you can't even get your fingernail in there. I mean, there's just no room. The mom's lower part of her vagina is here and the chin just barely gets over that and you couldn't get a toothpick in there. I mean, it -- and you try and you try and, you know, you've also got to worry about the mom. She's got -- you know, you can tear her tissues and cause bad damage to the mom, so you, you do the only thing you can

do, and again, I had a case very similar to this and it was repetitive suprapubic pressure that got that baby delivered, because I couldn't ever get my hand in. I couldn't even get a pinky in and those are the worst kinds and that's what Dr. Goldstein was faced with. He was faced with one of the worst types of shoulder dystocia you can have.

Q Dr. Salley, have you looked at an animation that we've provided to you showing the child coming down the birth canal and encountering shoulder dystocia and ultimately being delivered?

A I have.

Q And would that animation assist you in explaining shoulder dystocia and what you've just described to the jury?

A It would.

MS. CRAIG: Your Honor, may Dr. Salley come down and ---

THE COURT: Yes, ma'am.

MS. CRAIG: --- the animation?

MR. GRAHAM: Your Honor, for the record, we would renew our objection.

THE COURT: You're protected on the record.

Q All right. Dr. Salley, we're going to give you this right here. If you'll just come up to the screen right here and point out and explain what we're seeing. I'm

going to put this up on the ELMO. Let me get it as big as I can.

A So, the baby is in the uterus. Here's the, what we call the symphysis pubis. That's the, the top part of the pubic bone and the umbilical cord is around the baby's neck and that can be very dangerous and as the baby comes down, the head rotates to a front -- in a straight up and down position and the shoulder sometimes does not get -- it does not complete -- we want the shoulder to be at an oblique angle and it doesn't get in the oblique angle in the shoulder dystocia case. It gets wedged underneath the symphysis pubis right here. The problem that happens also in this case, you see the cord gets compressed and when the cord is compressed, the baby's losing oxygen. In Dr. Goldstein's case, in Ms. Fulton's delivery, there was a big drop in the baby's heart rate and he went ahead and put a little suction cup on the baby's head to try to get the baby delivered before there was too much compression on the cord, too much oxygen loss that would affect the baby's brain. So, he was able to and this is something I'll give him a lot of credit for. When you've already got this tight squeeze where the head is really tight here, he was able to reduce this cord. I think if you go further...

Q Okay.

A Okay. So, the head's coming out and you think, oh, I've got this, everything's going great. I've got the head coming out. I'm getting ready to suction the mouth and nose and then all of a sudden, the head retracts back in. That's actually called the turtle sign. In that case, a turtle sign means -- it's like a turtle will take his head and push his head out and then retract it back if he sees something harmful. The baby will retract. Okay. So, here, here's what -- that I -- I was amazed he was able to do that. He was able to reduce that cord in this situation and actually help the baby's oxygen status, and if he hadn't been able to do that, he might, we might be really in trouble. Bryson might have some serious brain damage because in four minutes if he hadn't reduced that cord, there would have been some real problems. But here's the brachial plexus right there, so those nerves are in a baby that's also -- has some blood supply loss and some oxygen deprivation, those -- the baby's muscles become very flaccid and limp and that actually exposes those nerves to more damage, so what's happening here is the attendant is trying to get the head delivered. Okay.

Q And what's going on with the legs, the mother's legs?

A Mother's legs go back. So, in a McRoberts maneuver, what happens there, the legs are pushed back. That's one of

the first things we do and that actually brings this bone back a little bit and opens up the pelvis so hopefully the shoulder will then maneuver underneath the pubic bone or the symphysis pubis, which did not happen in this case. And so the next thing that happens is suprapubic pressure. So, that's when you try to get the shoulder to rotate down, and again, it looks easy in this diagram, but I'm going to tell you, many, many times that does not work. If you go back one minute.

Q Hold on.

A What happens here is you try to get your hand in, maybe this is shown later, I can't remember, but there's just no room right here. I mean, you can't, you can't get a hand in at all and you're, you know -- so minutes seem like hours. You can't get your hand in there so you have to just repeat what you've done already and, you know, I've talked about the Zavanelli maneuver when you push back. You can't do that when the head is all the way out, so I don't think Dr. Goldstein would have had a chance to do that. But -- all right. Keep going.

Q Almost finished. That's -- what's that?

A That's suprapubic.

Q Okay.

A Try to push the shoulders down. There you go. It's delivered.

Q Great. Thank you, Dr. Salley. All right. You can go back to the witness stand. Dr. Salley, I'd like to ask you a couple of questions about induction.

A Yes, ma'am.

Q Do you have an opinion whether it was appropriate to induce Ms. Fulton when she was five centimeters dilated?

A I do. I think that was appropriate. The problem that happens there, when you're that much dilated -- I bet some of the women in the jury probably know about this, that you could, if your water breaks at home or if you have some problem at home and you're already that much dilated, then you could have the baby in the closet. You know, you could have the baby trying to get in the car. You could have the baby in the bathroom. You don't know when it's going to happen. Of course, retrospectively, we know this was going to be a shoulder dystocia case, but you don't know that ahead of time. You don't know how -- this baby could have come out in a situation where there's no attendant, nobody to help with the baby's condition at birth.

Q Okay. So, that's induction. How about Pitocin? Did you review the medical records and determine whether Pitocin was used to help the induction process?

A It was. You, you really can't do an induction without pitocin. That's a medicine that we give that mimics the

mom's own pitocin that comes from her brain. We can give it by IV and that starts the uterus to contract.

Q Do you have an opinion whether it was appropriate and reasonable in this case to use Pitocin during Ms. Fulton's delivery?

A Absolutely. I mean, you couldn't -- again, you couldn't do it without Pitocin.

Q All right. Next is vacuum. Do you use a vacuum to bring the heads, the head of the baby down during deliveries?

A I do.

Q And what station was this baby?

A Plus-two to plus-three.

Q And what relevance does the station of the baby have in terms of whether or not the use of the vacuum is appropriate?

A When the station is low, meaning the head's almost ready to come out, it is not a risk to put a vacuum on and get the baby delivered, and when you're worried about the heart rate had dropped on this baby, on Bryson, what Dr. Goldstein did was to go ahead and effect delivery right then so you don't have to worry about, is that going to happen again, is it going to keep happening.

Q And do you have an opinion, Dr. Salley, as to whether or not the vacuum that was used to bring the baby's head down, did that cause any injury to Bryson?

A It did not.
Q And when you use -- in your experience when you use a vacuum to help deliver a baby, do you stop the delivery process and have the mama sign another informed consent form as to the specific use of the vacuum?
A I do not.
Q Okay. Explain why that is unreasonable.
A Well, again, in our field things happen very quickly. Emergencies happen very quickly. When a heart rate drops you really don't have time. You need to get a baby out. You're thinking about, I need to get this baby out. You're not thinking about should I have a patient sign a consent to do this. You've got to do it. I mean, you don't have time to do that. You just have to go ahead and proceed with what's best for the mom and the baby.
Q All right. Induction, Pitocin, vacuum; now, informed consent. Do you have an opinion whether there was appropriate informed consent in this case?
A I do believe so.
Q So, in your practice do you have your patients sign a separate informed consent form during the prenatal visits that, that acknowledges that you have discussed all of the various delivery options and you've talked to her about the delivery? Do you have a separate informed consent form that you put in your chart?

A I do not.
Q Tell us what your practice is.
A Well, most of our patients will go to some type of birthing class and they will, they will ask us questions throughout the pregnancy and when we get to about the last six weeks of pregnancy, we're talking about more of the labor process. But honestly, women that have had a baby before, they don't really necessarily need to hear all that again. Some of them do, some of them don't and so if they have questions we answer them, but we can't possibly tell them all the -- I mean, first of all it would scare them to death. I mean, you can't do that. You, you want to give them general information, but you can't possibly talk -- starting talking about every scenario that's going to happen. I mean, nobody would get pregnant. But we just, we don't do that.
Q But they are pregnant and is it fair to say they're going to have that baby?
A They are.
Q All right. So, based on your experience in your practice, is it reasonable for a doctor to talk about the delivery and the various issues that could be related to delivery throughout the prenatal course?
A Correct.
Q And are you aware that there were 19 prenatal visits

that Ms. Fulton had with Dr. Goldstein?

A I didn't realize there were that many, but that's, that's a good number.

Q Now, we have marked this. This is a blow-up of what's already been marked as Defendant's Exhibit #1 and this is the informed consent form that Ms. Fulton signed at the hospital. If you'll just take a look at this, and what I want to ask is, in the hospitals where you deliver babies, is this a similar type informed consent form that your patients sign?

A It is, I believe. I haven't looked at mine as closely as this, but I know they have a -- excuse me -- a similar type form. Yes, ma'am.

Q Okay. Thank you. That's it on informed consent. Now, let's get to the medical articles that you brought today.

Q And Dr. Salley, you said that you stay current on the medical literature?

A Yes, ma'am.

Q And do you base your opinion in this case that Dr. Goldstein did not cause the injury in this case, based on the medical literature ---

A Yes.

Q --- and your experience ---

A Yes, ma'am.

Q --- and your education and training. Is that correct?
A Correct.
Q All right. First of all, this ACOG article "Neonatal Brachial Plexus Palsy", is this the type of article -- first of all, are you a member of this ACOG?
A Yes, ma'am.
Q Okay. And do you receive their publications from time to time as a member?
A I do.
Q And do you review those publications to stay current in the medical literature?
A I do.
Q And is this the type of medical literature that doctors like you would rely upon to stay up to date with current medical and scientific issues?
A Yes, ma'am.
Q Okay. And have you reviewed this "Neonatal Brachial Plexus Palsy"?
A I did.
Q Okay. And do you consider it reliable?
A I do.
Q Explain -- before we get into the specifics of the basis of your opinions with regard to this, tell us what the task force was that actually issued the "Neonatal Brachial Plexus Palsy" from ACOG.

A I would. I would tell the jury that this is probably the most authoritative unbiased information we have on neonatal brachial plexus palsy. There are a number -- they're not just OB/GYNs here. There are pediatricians, there are neurologists, pediatric neurologists, nurse practitioners in some cases -- I'm not sure there were here -- midwives in some of our publications, orthopedic surgeons, so it's not -- from around different parts of the country, so it's not just OB/GYNs. It's general OB/GYNs and maternal fetal medicine obstetricians that do even more high risk practice. They're all gathered together and come up with the best information we have about this, this issue, and so they, they take a pledge that they don't have a bias that would affect their opinions in the production of this opinions. And they synthesize all the information that's been out there for 30, 40 years, and give us the best information we have of how, how to practice.

Q Now, to your point about the various medical specialties and the different doctors that went in to publish this "Neonatal Brachial Plexus Palsy" journal, there's a list of endorsements. It's on page Roman numeral 14.

MS. CRAIG: Your Honor, may I publish on ELMO?

THE COURT: You may.

A Yes, ma'am.

Q All right. So, let's go through all of those professional organizations and tell us all the endorsements from these groups regarding the reliability of this publication.

A Well, these groups will actually have scrutinized this publication and you can see that it's not just America, it's international, and it's some of the major groups that we have in medicine: The American Academy of Pediatrics, The American Academy of Physical Medicine and Rehabilitation. These are doctors that actually deal with, with nerve and muscle injuries. It's American College of Nurse Midwives, the American College of OB/GYN, American Society of Reproductive Medicine, Child Neurology Society, the Japan Society of Obstetrics and Gynecology, the Royal Australian and New Zealand College of OB/GYN, Society of Maternal Fetal Medicine here in the United States, Society of Obstetricians and Gynecologists of Canada. So, it's pretty broad and encompassing.

Q Okay. All right. Let's start then at page Roman numeral 16. I have this highlighted so we can go directly to the portion. I want you to read this portion and tell us why this is relevant to your opinions on what the cause of the brachial plexus injury was in this case.

A Neither high quality nor consistent data exists to

suggest that neonatal brachial plexus palsy can be caused only by a specific amount of applied force beyond the typically used -- beyond that typically used by health care providers during any delivery. Instead, available data suggests that the occurrence of neonatal brachial plexus palsy is a complex event dependent not only on the forces applied at the moment of delivery, but also the constellation of forces, vector rate and application, that have been acting on the fetus during the labor and delivery process, as well as the individual fetal tissue characteristics, strain, the oxygen status of the baby. Acid/base balance is what they're saying there.

Q Does this medical text say that the only cause of a brachial plexus injury is excessive traction?

A It does not.

Q All right. Let's go now to page 18, Roman numeral 18.

A Roman numeral 18.

Q This is at the end. Tell us what the task force recognizes.

A What is known this time and with reasonable medical certainty is that neonatal brachial plexus palsy occurs infrequently and can be caused by maternal or indogenous forces, or clinical applied exogenous forces or a combination of both. Similarly, neonatal brachial plexus

palsy can occur with and without associated clinical recognizable shoulder dystocia. Finally, in the presence of shoulder dystocia all intervention by the physician, no matter how expertly performed, will necessarily increase strain on the brachial plexus.

Q All right. I'm going to get some water. Will you explain that while I get some water please?

A Well, basically what that means is, is when you're in the situation you already have a strain on the brachial plexus that is there from mom pushing, from the baby's condition. If the baby's hypoxic or has a low oxygen status, its muscle tone is down. All those factors can put that brachial plexus in a very bad strain situation and you can do the usual amount of pulling or guidance that you would normally do with a baby and get this injury when you haven't done anything differently than what you would normally do in another situation, another delivery.

Q Okay. I'm back. All right. So, let's go to the next one which is page 17, and this is under, "Risk and Predictive Factors". If you will tell us -- please read what is highlighted and why that is important to your opinions on the cause of the injury in this case.

A Clinician-applied traction and lateral bending of the fetal neck have been implicated as causative factors in

some cases of neonatal brachial plexus palsy. However, neonatal brachial plexus palsy also has been shown to occur entirely unrelated to traction, with studies demonstrating cases of both transient and persistent neonatal brachial plexus palsy in fetus, fetuses delivered vaginally without clinically evidenced shoulder dystocia or fetuses delivered by Cesarean section without shoulder dystocia. Other studies have reported neonatal brachial plexus palsy occurring in the posterior shoulder in the presence of a delivery complicated by an anterior shoulder dystocia impaction, meaning that even though this shoulder was caught underneath the pubic bone, the other shoulder had the injury.

Q Okay. Next one is on page 34, talking about compression. Before you explain this part of your opinion, what is compression?

A So, compression is when there is a squeeze, a pushing effect and shortening of the length of tissue, so a -- I think it's the same thing you would use in just every day -- it doesn't have to do with a baby, but there's stretching and there's compression which is the opposite of stretching. It's a pushing force that compresses tissue.

Q All right. What does this ACOG journal say about

compression? You can just read the highlighted portion.

A Compression alone can result in permanent injury if the compression is maintained for a sufficient period and is not a significant, and is of significant magnitude.

Q Okay. And I have it highlighted just to kind of move us along but if at any point you want to read more than what's highlighted, you just tell me. Okay?

A Okay.

Q Then the summary to this article is on page 37. Hold on a second.

A Neither, neither high quality nor consistent data exists to suggest that neonatal brachial plexus palsy can be caused only by a specific amount of applied force beyond that typically used by a health care provider and experienced during a delivery without neonatal brachial plexus palsy. Instead, much of the data suggests that the occurrence of neonatal brachial plexus palsy is a complex event dependent not only on the forces applied at the moment of delivery, but also on the constellation of forces, vectors, rate of application, that have been acting on the fetus during the labor and delivery process as well as the individual characteristics of the baby, the tissue characteristics, the strain that's already there and the acid/base status of the baby, how much oxygen the baby has.

Q I want to focus in here on the part that says that the occurrence of a neonatal brachial plexus palsy is a complex event. Can you explain what that means?

A It's a complex event. Well, again that's -- it's -- so it's not just a doctor pulling too hard. You got, you've got a situation where the shoulder's already strained because it's on the mother's pubic bone. You've got a mom who now has three or four, five people screaming at the top of their lungs, push as hard as she can, so maybe she wasn't an effective pusher before but I can guarantee you when she thinks my baby's not coming out and everybody's screaming at me to push, she can generate a lot of power and so that is one of the big factors that we don't think about, but also the baby's, the baby's oxygen status is so important and I think that's a big factor here, because when Bryson was born his first APGAR was one. That basically means the only thing he had was a pulse and it was less than 100. He didn't have -- his color was blue. He didn't have any tone. When they put the suction in his mouth to suction his mouth, he didn't have any response to that. Basically, he was lifeless. He was limp, so he's got no muscle tone to protect his nerves. When you think about when you get -- when you hit something, what's the first thing you do? You body tenses up and you have muscle

contraction that protects your nerves and bones. Well, Bryson didn't have any of that because he -- his first APGAR was one. That's about as bad as it gets. So, that's a big factor in this case, in my opinion

Q All right. And I think we've got one more in this particular publication, and it's on page 47, Dr. Salley. "Head to Body Delivery Interval". What does that say?

A During shoulder dystocia delivery, shoulder impaction and prolonged head to body delivery interval can lead to birth asphyxia and subsequent neonatal hypoxic ischemic encephalopathy, which is big words for saying brain damage for not enough oxygen. In 1998, a case-controlled study of 15 infants with permanent brain injury after recognized shoulder dystocia demonstrated that a head to body interval of seven minutes or more had a 76 percent -- 67 percent sensitivity of predicting permanent brain damage. Since then, two large studies have shown that permanent neurological injury can occur as soon as two minutes after shoulder impaction, although the risk of acidosis and severe hypoxic ischemic encephelopathy remains low at less than five minutes. But when you're in that situation, you're not thinking about that. You know that you've got to get that baby out before -- and you've also -- in Bryson's case you've had the heart rate drop already before the delivery, so you're already

thinking, you know, this baby could be low in oxygen. And you don't know. You don't know the outcome when you're in that situation. Retrospectively, you can look back and say one thing but when you're in that situation, you've got to do everything you can to get that baby delivered, and you're worried. Like I said before, a minute seems like an hour.

Q Thank you, Dr. Salley. All right. In addition to the ACOG bulletin and booklet we just went through, did you bring some other medical articles ---

A I did.

Q --- that support your opinions in this case? All right. Let's start with "Permanent Erb Palsy, A Traction Related Injury". Do you consider this text to be reliable, this publication?

A I do.

Q All right. And if you look now at the -- by the article at the top, is that the title?

A Yes, ma'am.

Q And those are the authors?

A Yes, ma'am.

Q Okay. And if you look at the highlighted portion, it says, "we identified". What does that say?

A We identified four cases that occurred in the absence of shoulder dystocia and four cases that occurred in the

posterior arm of infants -- meaning the arm that's not impacted, the other arm, the opposite arm -- with anterior shoulder dystocia. These data further support the notion that the etiology of permanent brachial plexus palsy associated with birth may not be related to traction.

Q Why is that relevant in terms of your opinions in this case?

A Well, it just shows you that there are other factors going on. Again, it's not just the doctor pulling on babies or there are things that are happening before you even put your hand on a baby that can cause a severe brachial plexus palsy.

Q And, Dr. Salley, just because you're doing everything you can to get that baby delivered, does that mean that you're always using excessive traction?

A It is not.

Q All right. Same article, next page. Let's read that please.

A In -- in the cases with permanent ERB palsy in the posterior shoulder, meaning not the shoulder that's underneath the pubic bone that's stuck but the opposite shoulder, we hypothesize that injury was not a product of traction applied at delivery but rather preceded expulsion of the fetal head. The nerve injury possibly

occurred during descent of the fetus through the maternal pelvis via impaction of the posterior shoulder on the sacral promontory which is a prominent projection from the lower spine.

Q All right. These are the maternal expulsive forces again?

A Again.

Q Another article saying -- agreeing with ACOG. Correct?

A Correct.

Q All right. Let's move to the next one. "Shoulder Dystocia, An Evidence-Based Evaluation of the Obstetric Nightmare". Did you review that medical article?

A I did.

Q Okay. And do you consider it to be reliable?

A I do.

Q All right. Let's go to the last -- first of all, it's identified at the top. That's the title and are those the, that's the author, Mr. Gherman. Dr. Gherman.

A Yes, ma'am. Yes, ma'am.

Q Okay. Let's review the back, last page, 358 and this is the highlighted portion. What does that say?

A They found that the contact stress caused by exogenous or clinician applied forces was one-fourth to one-ninth resulting -- that resulting from indogenous forces, meaning what the mother was generating during the second

stage of labor.

Q And is this talking about maternal expulsive forces again?

A Correct.

Q Okay. And when we say maternal expulsive forces, that's the, that's the mama trying to push the baby out?

A That's mama pushing, contraction of the uterus pushing down, everything.

Q Okay. Next one? "Severe Brachial Plexus Palsy in Women Without Shoulder Dystocia," by Dr. Twerky and others. Did you review this article in order to give your opinions on the cause of the brachial plexus injury in this case?

A Yes, ma'am.

Q And do you consider it reliable?

A I do.

Q If you turn to the second page of this article, it provides a table for maternal and labor characteristics of brachial plexus palsy cases. Tell us what we are looking at and why this is important for your opinions.

A Well, of course, these are cases where there wasn't a shoulder dystocia and I know that some people will say well, they just didn't report the shoulder dystocia and so it was improper diagnosis by the physician involved, but I want you to look at number three. This is a mom

who has delivered at 30 weeks, almost two-and-a-half months before her due date, and she has a three-pound baby and a three-pound baby doesn't get stuck. You want to make sure a three-pound baby doesn't shoot out and you miss it. You are just trying to hold the baby in and do a controlled delivery and this baby had a severe brachial plexus palsy, so I think it just speaks to the fact that some people will say well, they just didn't say it was shoulder -- there's no way you could have a shoulder dystocia in that case. The other one, in number five, the baby was delivered by Cesarean section so in a C-section we're not -- there's no bone there. Okay? You've made an incision in the mother's abdomen and you've got the uterus there and you're delivering the head, and if the shoulder gets stuck in that situation you just make a bigger incision in the uterus to get the shoulder out, so I've heard people also say that well, the doctor just put too much traction on the baby with a C-section. I think that's baloney because you don't have a bone there, so you can get the baby out without having too much traction or however you pull or whatever you want to say. And even with a C-section these babies have severe brachial plexus palsy.

Q Now, just to be clear, the table that you are referencing, those are all brachial plexus injuries that

occurred in the absence of shoulder dystocia?

A Correct.

Q All right. Next medical article. "Spontaneous Vaginal Delivery; a Risk Factor for ERBs Palsy". Did you review this article to reach your conclusions in this case?

A Yes, ma'am.

Q And is it reliable?

A Yes, ma'am.

Q All right. To identify the article at the top we have the title and all of the authors. Let's go to the last page please, second to last page and starting with, "no specific pattern", if you could tell us what this article stands for.

A "No specific pattern of perinatal events appear to be reliably predictive of ERBs Palsy. Moreover, as many as 50 percent of brachial plexus injuries may be attributable to unavoidable intrapartum or antepartum events and not to shoulder dystocia, meaning things that happen even prior to labor. Sometimes, there can be compression of a nerve based on the -- with the baby's position, the mother's status, body status, and during -- intrapartum means during the actual labor process. When there's not an impaction of the shoulder, you can still have a significant brachial plexus injury, even permanent. Many of the factors that predisposed the

shoulder dystocia may place increased tension on the brachial plexus before delivery of the fetal head. For example, fetal macrosomia, that just means a big baby; increased bisacromial diameter, that means just the size of the, the width of the shoulders; and a fast labor with, when a labor occurs very quickly. I don't know if you remember when I was showing you the diagram, the shoulders need to be in an oblique plane. That's the largest plane for the shoulders to get through the pelvis and if it happens too quickly, they get stuck in this up and down plane and that can actually lead to injury.

Q Anything else on this one?

A I think that those are the main things.

Q Okay. And again, this medical article supports that a brachial plexus injury can occur without excessive traction. Correct?

A Correct.

Q We have another ACOG practice bulletin entitled, "Shoulder Dystocias Clinical Management Guidelines for Obstetrician and Gynecologists." Did you review this article?

A Yes, ma'am.

Q And do you consider it reliable?

A I do.

Q And I think here at the top, ACOG practice bulletin, shoulder dystocia, based on your review of the article does it also, is it also supported by all the other medical articles and texts that we have already gone through?

A Yes, ma'am.

Q Okay. Now, Dr. Salley, based on all of the medical science and medical literature, the depositions, the medical records, do you have an opinion whether Dr. Goldstein met the standard of care?

A He did.

Q And do you have an opinion based on all of that information, based on all of this medical and scientific data, whether or not Dr. Goldstein caused the injury to this child?

A He did not.

Q What in your opinion is the most probable cause of the child's injury?

A What I said earlier, constellation of things, the child having a low oxygen status and being limp, mom pushing as hard as she can trying to get her baby out when she know it's -- knows it's stuck, the individual characteristics of a child. Every -- everybody's different. I think we know this. For instance, I have patients that every single member of the family has a

rotator cuff surgery. They have just a weak problem there. Now, whether Bryson did or not we don't know. He doesn't have a lot of siblings, but I think it's always more than -- in this case it's definitely not the traction of Dr. Goldstein. It's all the other factors that we've talked about.

Q And is your opinion to a reasonable degree of medical certainty, most probably, that the cause of the injuries in this case was a constellation of factors unrelated to excessive traction during delivery?

A Correct.

Q And are all of the opinions that you have given today, Dr. Salley, to a reasonable degree of medical certainty, most probably?

A Yes, ma'am.

Q Thank you, sir.

MS. CRAIG: Those are all the questions that I have.

THE COURT: Cross examination, Mr. Graham.

MR. GRAHAM: Thank you, Your Honor.

CROSS EXAMINATION

BY MR. GRAHAM:

Q Dr. Salley, do you believe this is an important case?

A I do.

Q Do you believe that in an important case a so-called expert witness, who comes into this courtroom to try to

defend this man over here, should be consistent in his opinions or should he vacillate from one side to the other like a flip-flopper?

A I think he should be consistent.

Q I do too, sir. You weren't consistent in your opinions, were you, between the depositions and today?

A Well, you brought that up before and I will tell you this: I'm not a legal expert. I'm not -- this is the second time I've ever testified in a trial in 25 years.

Q Yes, sir.

A And I don't study how to testify. I don't study what causation is. I don't study all the legalese and the legal jargon that you use, so I was confused when we were talking about that issue.

Q How many times were you confused, sir, in the deposition?

A Well, you know, it was a five-and-a-half-hour deposition. I'd been on-call the night before and I'd been up delivering babies and it was exhausting, and so at the end, you know really after about the first hour-and-a-half I was pretty tired.

Q Okay. Are you tired today, sir?

A I'm not.

Q Are you confused today?

A I'm not.

Q Were you confused in the opinions you just stated in response to Ms. Craig's questions?
A I was not.
Q All right. Let me ask you this: One thing I found of interest in your testimony today, you said that some women deliver in an elevator. Is that true or are you just making that up?
A We've had a delivery in the elevator not long ago.
Q Was there an obstetrician in the elevator?
A No, sir.
Q How did that baby do?
A I'm not sure. It wasn't my patient and I had just heard that that had happened.
Q In fact, mother's can delivery babies safely in an elevator or a taxi cab or anywhere else on the planet earth as long as there's not an emergency. True?
A That can happen.
Q It's only when there's an emergency that you need an obstetrician to manage the delivery safely. True?
A I disagree with that.
Q You disagree?
A Yes.
Q But, in fact, women can deliver in an elevator without any kind of doctor present and the baby is fine as long as there's no emergency. True?

A That's a rare event.
Q True?
A That's true, but that's a rare event.
Q And you're the one that brought it up today. Right?
A I think most of the jurors have probably heard of instances like this, as well.
Q Yes, sir. Let's talk about your vacuum rate, or not. First of all, let me ask you about your induction rate. Induction is when you decide we're not going to wait on mother nature. We're going to give some drugs. We're going to take a blade and cut the membranes and start this birthing process on our own. True?
A We don't take a blade.
Q What do you use to rupture membranes?
A I have a little -- it's called a finger cot. It's a little glove that goes over your finger and it has a little tiny plastic edge.
Q A plastic sharp edge?
A Right.
Q A plastic sharp blade.
A It's not a blade.
Q But it's a sharp edge.
A Call it a hook if you'd like, but it's not a blade.
Q Okay. A hook or sharp edge and you cut. The purpose of this instrument is to cut a woman's membranes to speed

up the delivery process. True?

A Puncture.

Q Puncture and speed up the delivery process. True?

A True.

Q Then you pump her up with some Pitocin to make the uterus pump faster and harder. True?

A To make it contract.

Q Harder and faster.

A From what -- it wasn't contracting before.

Q Yes, sir, and -- so if you give it after she started contractions, it makes it faster and more powerful. If you give it before she contracts, it starts the contractions and speeds them up and makes them stronger. True?

A True.

Q So, in your practice do you sometimes make the decision to induce a woman's labor?

A Yes, sir.

Q How frequently?

A I can't honestly tell you. Induction of labor can be done electively. You've got a woman who's made it to 39 weeks or just a week before her due date. Her cervix is favorable, meaning it's dilated and thinned out enough and the head's low enough to safely do an induction, and she decides she's, she's tired of carrying this baby

around and it's perfectly safe to do that. There's no issue with that and we do that quite frequently. I can't tell you exactly at what rate, but that's something I did two days ago.

Q Yes, sir. How many patients have you delivered so far this year?

A Forty. I don't know. I -- I just don't know.

Q And what percentage this year have you induced?

A A good number of the patients that I've delivered this year were induced.

Q Just give us your best reasonable estimate, sir, please.

A All right. So, I will usually have at least one or two inductions every time I'm on call, which is once a week, and weekends is about once every seventh weekend, so -- seventh to eighth.

Q And so, when you're on call, approximately, how many deliveries do you handle?

A One to three, sometimes more.

Q So, just help me out here.] Do you have a reasonable estimate for how many -- with what frequency you induce women into labor?

A Probably one in five.

Q Twenty percent?

A (Nods head)

Q Yes, sir? That's a yes?

A Yes. Yes.
Q Thank you, sir. Have you read Dr. Goldstein's deposition well enough to know what his frequency of induction is?
A I have read his deposition. I can't remember that particular fact.
Q Can you remember if it was more or less than 20 percent?
A I'm not sure.
Q Do you remember that it was 70 to 75 percent?
A I didn't know that, but ...
Q Good bit higher than yours. Right?
A It is.
Q When you do yours, do you do it for the patient's convenience or for your personal convenience?
A Primarily for the patient's convenience.
Q It would not be proper for a doctor to induce the vast majority of his patients for his personal convenience, would it, sir?
A I don't think that would be a good way to practice.
Q No, sir. What about vacuum rate? Did you read -- tell us please what percentage of your babies you deliver by vacuum suction?
A Well, I have to tell you that I don't really keep track of it. It's a low number, less than five percent, probably in the one to two percent range.
Q One to two percent range?

A Uh-huh.
Q That's what you said at your deposition. Right?
A I, I can't remember exactly but I will just tell you that I have to have a reason, and if I have a heart rate drop like Bryson did in this case I would have done a vacuum delivery.
Q Yes, sir. Did you read Dr. Goldstein's deposition well enough to know what his vacuum rate is?
A He's higher, I think, but I don't remember how much.
Q Is he as high as 10 percent?
A I'm not sure.
Q Is he as high as 15 percent?
A Again, I don't know.
Q You didn't read his deposition very well, did you, sir?
A I read it a few weeks ago and you know what, the depositions that you -- his deposition was eight hours, so it's like reading the Bible and it was a long time ago, so I can't remember every exact quote in there.
Q Yes, sir. Well, you told me this was an important case. Do you still believe that, sir?
A I do.
Q But you didn't believe it was important enough to get your facts straight about Dr. Goldstein's testimony before you came in here to talk to us?
A I believe everything you brought up so far has really

nothing to do with why we're here.

Q Your opinion on that subject is noted on the record, sir.

MS. CRAIG: Your Honor ---

THE COURT: Let's move on.

MR. GRAHAM: Yes, sir.

THE COURT: No need to engage in an argument.

MR. GRAHAM: Yes, sir.

Q Doctor, do you -- in fact, do you remember that Dr. Goldstein testified, under oath, that 40 to 50 percent of his babies he delivers by pulling them with a suction on their head?

A And that's fine.

Q Did you remember that is the question, sir?

A I did not.

Q You only use a vacuum when the situation requires it in the patient's safety interests. True?

A Correct.

Q And that adds up to one to two percent of the time. True?

A It's my best guess.

Q That's your best reasonable estimate as you sit here today?

A Yes.

Q So, just so we're clear, Dr. Goldstein uses a vacuum 20

to 50 times as frequently as you do?

A If his estimate is correct.

Q Twenty to fifty times more frequently. Does that give you any discomfort about coming into this court and talking about what a great doctor he is for meeting the standard of care?

A First of all, the practice of medicine is very individualized. There's nothing in our literature or in what we read that says your vacuum rate should be this or that. I mean, I can't -- everybody practices in a different manner and I have no idea that that's bad or good. If he has more elective inductions, he may have a situation where he has to do that more. I just -- you know, I don't know all the details of his day in and day out practice, but I will tell you that there's nothing out of the standard of care.

Q Well, we can certainly agree on one thing, sir. Some doctors meet the standard of care and some fall below it, don't they?

A That can happen.

Q And you don't know whether Dr. Goldstein met the standard of care or fellow below it, do you?

A I think he met the standard of care with all the information that I have.

Q And when did you decide that, sir?

A When I decided to take the case.
Q That was before I took your deposition?
A I had made that conclusion before the deposition.
Q Do you believe before the deposition you had enough information to be able to tell us today whether or not Dr. Goldstein met the standard of care?
A I do believe I did.
Q Have you learned anything new about what happened that day since the deposition?
A I think most of the information -- all the information I have is what I'd already gleaned before the deposition.
Q Thank you, sir. You said you haven't done much expert witness -- opinion witness testifying, but that which you have done has always been on behalf of the doctor. True?
A Yes, sir. Yes, sir.
Q You're not interest in speaking up to talk about what really happened to the baby.
A I've never been asked.
Q You're just here to defend the medical community. True?
A I've never been asked by a plaintiff attorney to look at a case, first of all, and second of all I don't -- the vast majority of defense cases that come my way I don't take them.
Q Now, let's talk about definition of shoulder dystocia.

You agree there's lots and lots of definitions of shoulder dystocia; right?

A There are some nuances with shoulder dystocia but I think the vast majority of practicing OB/GYNs and nurse midwives use the definition that the -- after the head delivers with gentle guidance and the shoulder does not deliver, you have to use maneuvers to help the shoulder delivery.

Q Yes, sir. And -- but you acknowledge that both individual obstetricians and the literature that you've brought into Court with you today recognize that there are lots and lots of different definitions of shoulder dystocia. True?

A There are different definitions.

Q Okay. What do you believe is the rate of shoulder dystocia, the frequency of shoulder dystocia, in this country, using your definition?

A About one percent.

Q Okay. Are you aware that ACOG recognizes that other definitions bring that rate up to 10 percent?

A I am.

Q And so you come in here today in an important case and you tell us that there are a bunch of babies who were born where the doctor didn't write shoulder dystocia and then they wound up with a wrenched neck with permanent

damage and somehow the fact that the doctor didn't write shoulder dystocia on the chart means he didn't wrench the neck and damage the plexus?

A What I would tell you is that in that 10 percent category, there are many, many shoulder dystocias that are relieved in just a few seconds. I mean, you had to do the McRoberts maneuver. You had to bring the lady's thighs back like we saw on the animation and that released it so it wasn't -- to you, in your mind it wasn't a big deal and maybe you wrote shoulder dystocia but maybe you didn't because it happened in five seconds.

Q Yes, sir. In fact, the absence of a shoulder dystocia diagnosis on a medical chart means only one thing. True? Or it could mean one of two things: Either there was no shoulder dystocia or there was shoulder dystocia, in fact, but nobody wrote it down. True?

A If you're referring to the articles I've already referred to, they have to be peer reviewed. They have to go through a publisher. They have to go through an editorial board. They have to be scrutinized and I don't think they would allow that to happen.

Q You don't think they would allow that to happen. Sir, have you ever done a prospective study like the ones you brought into Court with you today?

A Well, there's no way to do a -- I haven't but there's no way to do a prospective study humanely in this situation.

Q No way to do a prospective study. Are you -- you're an expert on the literature?

A I am. It's very difficult to -- to tell one woman I'm not going to do this and another woman -- again, it's an emergency so you're not sitting there thinking about a protocol for a study. You're trying to get a baby out.

Q Are you aware of any prospective studies that watched objectively to see what happened during a delivery to see how many damaged brachial plexus nerves involved the shoulder were being impacted, and then looking at how many times the doctor wrote down shoulder dystocia?

A I've heard something about that study, but I'm not exactly sure.

Q Was that a prospective study, sir?

A You can have a prospective study but when you -- a study that we want to really use is the best study in science, is a randomized, blinded, double-blinded study which is impossible to do.

Q Yes, sir. But that prospective study with secret objective observers watching for the true facts noticed that 97 percent or so of the permanent injuries involved the shoulder being impacted and the head manipulated.

True?

A I don't know that study so I can't really comment on that.

Q And, in fact, there were only 30-something -- 34 or 37-something percent of those permanent injuries that involved shoulder dystocia being written on the chart. True?

MS. CRAIG: Your Honor, objection. learned treatise and I ask that he follow the rules.

THE COURT: Sustained.

Q Are you familiar with Dr. Mahlberg's studies?

A I am not.

MR. GRAHAM: We'll save that for later, Your Honor.

Q But at any rate, let's get back to the point. If no shoulder dystocia was written on the chart, maybe there was a shoulder dystocia. That is a possibility. True?

A True.

Q And maybe there was shoulder dystocia that wasn't written down. True?

A True.

Q And whether there was shoulder dystocia or not doesn't tell us whether or not the doctor applied traction on the head, does it?

A No.

Q So, you can't connect the dots, can you, sir, between a

permanent injury following delivery where the doctor chose not to write shoulder dystocia with no traction, can you?

A I'm not following you there. I'm sorry.

Q The mere fact that a chart doesn't say there was shoulder dystocia is silent about whether or not there was traction. True?

A True.

Q And it's the traction that causes the injury, not the shoulder dystocia. True?

A I disagree with that.

Q Do you deny that forceful downward traction of the baby's head down toward the left side causes or puts the baby at risk for permanent brachial plexus nerve damage?

A It can.

Q It can?

A Yes, sir.

Q We were talking a minute ago about shoulder dystocia definitions. Are you aware that there are some doctors, some obstetricians who are board certified who claim that for shoulder dystocia to be present the special safety maneuvers have to be used to resolve it?

A Correct.

Q You're aware of that?

A Correct.

Q So, are you aware that there are some doctors in this country, some obstetricians board certified in this country, who think that when the shoulder gets stuck if the doctor doesn't use McRoberts, doesn't use suprapubic, doesn't use an internal maneuver, but instead pulls down hard on the neck and tries to pry the shoulder out, that that's not shoulder dystocia because there were no safety maneuvers used? Have you ever heard of such a thing?

A I really haven't heard of such a thing but I think that it would be very difficult. I don't know of an obstetricians who would ever do that. I'm completely clueless where that information comes from, but I will just tell you that Dr. Goldstein did not do that. He documented repeatedly what he did.

Q Sir, I'm going to hand you a copy of your -- or the original of your deposition that I've just unsealed. You were present for a deposition just very recently, on April 30th of this year. True?

A True.

Q And your lawyer was there, Ms. Craig?

A She was.

Q You were under oath?

A I was.

Q You say you were confused?

A Some of your questions are very compound and long and it's very difficult and I -- you know, I noticed when I was reading other depositions, many times the deposed had to be, had to ask you to repeat the question over and over again. It wasn't just me.

Q In fact, I ask all witness to not answer unless they understand the question and to let me know and I'm happy to repeat it. True?

MS. CRAIG: Your Honor, he's -- objection. I'd ask if he's using the deposition, that we have the page and the line and he refer to the specific question.

MR. GRAHAM: Your Honor...

Q Could you please pull up page 23, lines three through page 24, line one?

MS. CRAIG: Your Honor, just for the record, I don't represent Dr. Salley. I'm not his lawyer. That was -- I would move to strike that.

THE COURT: Sustained.

THE COURT: And that is true.

Q Doctor, I'm going to ask you ---

A I'm sorry. Where are we again?

Q We're starting on page 23, at line three --

A Okay.

Q --- going through page 24, line one. At this point in the deposition on page 23, were you already confused?

A Page 23?

Q All right. I'm going to read the question and answer and ask you if I read it correctly.

Q Okay, and are you saying if McRoberts is not ordered that there is no shoulder dystocia?

A I would say that if there is a shoulder dystocia, what I would define as a shoulder dystocia in my personal definition, there is going to be a maneuver performed. McRoberts is one of those maneuvers before the shoulder is delivered.

Q Okay, let me follow up with a hypothetical just to see if I can understand your definition. Assume please, sir, a situation where there's a head-first vaginal delivery. The head delivers easily but the anterior shoulder does not deliver with normal gentle traction. At that point, rather than using one of the special maneuvers available to a well trained competent obstetrician to facilitate the safe resolution of shoulder dystocia, like McRoberts, suprapubic, Woods, Rubin's, posterior arm delivery method, the obstetrician for whatever reason chooses to increase traction above and beyond what is normal gentle traction. Is that shoulder dystocia?

Q And your answer, sir? Would you read it at line one on

page 24?

A Not in my definition.

Q In your definition, if more than gentle traction is used to try to pry the shoulder out and the safety maneuvers are not used, it's not shoulder dystocia?

A Well, first of all, I don't call them safety maneuvers. But what I would tell you is I can't imagine anyone doing that, and I certainly would never do it, so I guess I'm thinking about how I would deliver a baby and I just -- I can tell you, I can't imagine anybody would ever try to pry a baby out without trying to do the maneuvers that we do.

Q Some of those doctors who don't chart -- don't chart shoulder dystocia on the chart don't chart it because they didn't use any safety maneuvers. True?

A I don't know.

Q But depending on the definition, there may be a 10-fold increase in how many times shoulders really get stuck. True?

A I don't know that answer either.

Q Didn't you already say that it's normally one to two percent, but according to ---

A Okay. I see what you're saying.

Q --- 10 percent?

A Yes. Okay.

Q Your definition brings it down to one to two percent.
A Correct.
Q Other definitions, such as yanking the head, means it's not shoulder dystocia. That other definition brings it up to 10. True?
A Well, I don't -- I disagree with you again, because I personally can't imagine somebody that's a board certified obstetrician just yanking the head and not trying some maneuvers.
Q Let's talk about standard of care. Do you -- I know you told Ms. Craig you agreed with her question about Dr. Goldstein didn't do anything to fall below the standard of care, but the truth is, you don't know what he did that day, do you?
A Well, I was not standing there. You're right.
Q Okay. All you can really do is tell this jury that you're not supposed to pull on a baby's head. Right?
A Well ---
Q In those first five, six minutes, you're not supposed to apply more than gentle traction to the baby's head. True?
A True. But there were nurses that were standing right there with him that were with him the whole time that testified he did not do any more than, than what he always does.

Q They testified they were looking at -- they were focused on their job for most of the time. True?

A Well, they were focused on their job, but when you're sitting there in the delivery room and you're an OB nurse, you're looking to see when the baby's delivered. You're looking down there. You've got to know when the baby's delivered, because you've got other things to do when it is.

Q Yes, sir, and if you're up here trying to do McRoberts or suprapubic pressure, you might not even know what the doctor's position is. True?

A I think that's crazy. You're right there with him. I mean, you're this far from him. If you're doing suprapubic pressure, you're standing up like this. The doctor's right there.

Q Yeah, so ---

A You can't possibly miss what he's doing.

Q Okay. So, you believe that if the nurse is doing suprapubic pressure, she should be able to tell whether or not the doctor is standing or sitting or some other posture?

A She might not know exactly what posture he's in, but she knows what's going on with, is the baby delivered and what's -- is he pulling too hard. I mean, but that's what the testified.

Q Did you read Dr. Goldstein's deposition well enough to know what his posture was when he was pulling on the neck?

A I think he was in a regular delivery posture.

Q You think Dr. Goldstein was in a regular delivery posture, and what does that mean to you, sir? Is that standing or sitting on a stool?

A Some of us stand. Some of us sit. I actually do both and sometimes I think that there was a reference to Dr. Goldstein being on his knees and when, again, you have a situation where you can't get a toothpick, a fingernail or anything in to try to do the rotational maneuvers, you might get on your knees to see if a different angle can help.

Q Okay. May we agree on one thing, doctor. If Dr. Goldstein was on his knees pulling down on that baby's head, that would violate the standards of care for obstetricians. True?

A I can't say that it would.

MR. GRAHAM: In the interest of time, Your Honor, I'll come back to that point if I may.

Q Let me move quickly through some other points first, sir. You would only use gentle downward traction -- or you don't even like the word traction. You would use gentle downward guidance to get a shoulder unstuck.

True?

A True.

Q You believe that if someone uses more force than gentle guidance, that would violate the standards of care. True?

A It could.

Q It would. Right?

A Correct.

Q And you don't know if Dr. Goldstein did that or not, do you?

A I have to rely on his testimony and the obstetrical nurses that were with him.

Q Yes, sir. And did you read his deposition? Were you in court when he testified?

A I was not.

Q So, the only testimony you know of from Dr. Goldstein is the version he gave in his deposition?

A Correct.

Q In that deposition, he didn't say anything about how much force he put on that baby's head, did he?

A I can't remember, specifically.

Q In fact, he said I don't remember how much force I used. I don't remember how much force I've ever used in any shoulder dystocia situation. Do you remember that?

A I think that's a true statement. I think you don't --

you know, we don't have pressure gauges on our arms. We, we have to think about -- this is the art of medicine. When you deliver three to four thousand babies, you have a feel for it. You can't exactly tell people. It's hard to tell somebody exactly how -- what you do.

Q And in this important case, you come into this courtroom and you tell these ladies and gentlemen that, in your opinion, Dr. Goldstein met the standard of care in terms of how much traction he used because in his deposition he said he didn't remember.

A He says that he always uses the same amount of traction, or however you want to call it, when he delivers a baby.

Q He did not say that in his deposition, did he, sir?

MS. CRAIG: Your Honor, that's a mischaracterization of the testimony.

THE COURT: All right.

MR. GRAHAM: The witness is ...

THE COURT: All right. Well, I'm going to ask that you re-phrase the question.

MR. GRAHAM: Yes, sir.

Q It's going to take time, but I'm going to ask you, sir, to either retract your assertion that Dr. Goldstein said he always uses the same amount of traction or I'm going to ask you to find it in his deposition. Which do you choose, sir?

A I'll retract it.
Q Thank you. Avulsions cannot heal. True?
A True.
Q Ruptures cannot heal. True?
A True.
Q Mere stretches can heal. True?
A Sometimes.
Q All right. And the literature that you brought in here today makes no distinction between injuries that involve permanent damage and injuries that just involve a stinger that recovers on its own. True?
A Some of these are permanent injuries.
Q Well, the ones that are permanent injuries don't make any effort to determine whether traction was present or not, do they?
A They say that shoulder dystocia is not present and I don't know. You always have some downward guidance to deliver a baby.
Q And you don't know how much was involved in those cases where the doctor ripped the nerves, do you?
A I don't think the doctor ripped the nerves.
Q Yes, sir. In all the history of the world's literature of all reported cases, normal and unusual, can you tell us today of a single believable article that connects the dots between no traction and permanent injury?

A No shoulder dystocia.
Q The question, sir, can you connect the dots between no traction and no injury with any medical literature?
A That's because besides the woman that delivers in the elevator, there's always some traction.
Q And you don't know how much traction there is. True?
A That's true.
Q So, all this stuff that you brought to court today, all the blow-ups, all the highlighting, all the fancy medical talk, none of that supports the proposition that permanent damage can be caused by anything other than traction. True?
A I disagree with that.
Q Oh, well, let me re-phrase the question. Let me re-phrase the question. None of that supports the proposition that multiple rips of brachial plexus nerves with neuroma formation can be caused by anything other than traction. True?

MS. CRAIG: Objection, Your Honor. This is beyond the direct.

DR. SALLEY: Well ---

MS. CRAIG: He wasn't offered to discuss the ---

THE COURT: I think he ---

MS. CRAIG: --- mechanism of the injury.

THE COURT: Cross examination is wide open.

MS. CRAIG: Okay.

THE COURT: Thank you, ma'am.

A So, what I would tell you is that some of the examples that I'd mentioned in there, the three-pound baby that delivers, there's no traction in a three-pound baby delivery. That baby is, is tiny. The woman that has a C-section, there's no traction in the C-section delivery. The baby that has a posterior arm that has a brachial plexus injury when the anterior shoulder is what we worry about, there's no traction in that injury.

Q We'll get to those in a moment, sir. What I'm asking you is, can you point me to any reported case in the history of mankind where multiple nerves were ripped and torn with neuroma formation that was not caused by forceful substandard obstetrical traction?

A When you add the neuromas and so forth, I can't, because there's not the detail of that description in the brachial plexuses in those articles.

Q Okay. So, when you came into court today in this important case to tell us what really caused this injury, you didn't tell us that you don't know anything about neuromas. True?

A I -- I don't think that's relevant.

MS. CRAIG: Your Honor ---

Q Do you know if this ---

MS. CRAIG: --- this is the third time he's laughed at the witness.

THE COURT: All right. We probably need to reduce the editorializing ---

MR. GRAHAM: Yes, sir.

THE COURT: --- and the arguing. Just ask him the facts.

MR. GRAHAM: Yes, sir.

THE COURT: That's what we need to hear.

MR. GRAHAM: Yes, sir.

THE COURT: And the bantering back and forth is not productive.

Q Do you know if this --

MR. GRAHAM: Thank you, Your Honor.

Q Do you know if this witness (verbatim) has multiple nerve root ruptures with neuromas?

A Only from your descriptions and I did read -- I'm not an expert on the type of nerve injury and what, what happens in certain nerve injuries as far as neuroma formation and nerve avulsion. I'm not.

Q And you don't know what a neuroma signifies?

A I do.

Q You know what a neuroma signifies?

A Yes, sir.

Q Please, let's pull up page 32, lines 20 through 22. Doctor, I'm going to read the following question and

answer and ask you if I read it correctly, starting page 32, line 20. Question, I see ---

MS. CRAIG: Your Honor, I object. This is a different question.

MR. GRAHAM: In an abundance of caution, I'm happy to ---

MS. CRAIG: This is a different question to what he just asked him. He's impeaching him improperly.

THE COURT: Okay. I'll ask that you lay the proper foundation. Ask him the information that's contained in this question and then you may impeach him about it.

Q Doctor, do you claim to know what a neuroma in the brachial plexus nerves signifies?

A (Nods head)

Q That's a yes?

A Well, I have looked at it more since I answered that.

Q Do you believe that you can become an expert witness in a court of law in an important case by starting to read up on a subject between last week's deposition and today's trial?

A I actually didn't say that I was an expert in the actual nerve injury just now. Can I finish?

Q Yes, sir.

A I didn't say I was an expert, but since my deposition I know a little bit more about neuroma formation, because you went over it pretty extensively.

Q All right. When I took your deposition, did you claim to know what a neuroma in the brachial plexus nerves signifies?
A What I would tell you is I know what a neuroma is. Exactly what it signifies in the brachial plexus, no.
Q All right. And that's what you told us at the deposition. True?
A Correct.
Q Thank you. I'll move on. But now that you've become more well read about neuromas in the brachial plexus, do you realize that none of the literature you brought here today references whether or not there was a neuroma?
A I don't believe they did.
Q So, none of those articles are really on par clinically with what happened to Bryson, are they?
A I think those articles demonstrate the fact that there is not traction in many cases of brachial plexus injury, but it can't specifically speak to neuroma formation.
Q Not a single one of those cases you went over involve a reported neuroma of even a single nerve. True?
A Not that's reported.
Q By the way, you said something about finding significance when a baby's top shoulder is stuck and the bottom shoulder gets hurt, the bottom brachial plexus nerves get hurt. In fact, doctors routinely apply --

just like you apply downward traction, you apply downward traction in a gentle way or downward guidance in a gentle way to deliver the top shoulder, obstetricians apply traction in an upper direction to deliver the bottom shoulder. True?

A True.

Q Traction downward puts the top nerves at risk. Traction upward puts the bottom nerves at risk. True?

A The problem with your assumption is there's no bone on the back side of the baby -- I mean, the back side of the mom.

Q Are you testifying that you require a presence of a bone in order to pull too hard on a baby's neck?

A I'm saying that the posterior arm comes out easily no matter what you do. It's an easy part of the delivery.

Q You don't know how hard traction was applied in an upward direction on any of those babies whose bottom plexus was injured. True?

A I don't.

Q So, you can't connect the dots between a bottom side brachial plexus injury and no traction. True?

A I can as a doctor that's delivered three to four thousand babies and has been in practice for 30 years tell you that the posterior shoulder is never a problem delivering a baby.

Q In your experience, neither side has been a problem in terms of a permanent injury. True?
A Not that I know of.
Q Okay. Well, let's talk about that. How many thousands of babies have you delivered?
A Again, estimating three to four thousand.
Q Three to four thousand. Three to four thousand, and how many of those do you believe have shoulder dystocia? Had it during delivery?
A One percent.
Q Okay. So, that would be 30 to 40?
A Correct.
Q And in the deposition you actually gave two different ranges depending on definition. True?
A Because it's a very big guess.
Q You said 15 to 20 once, then you changed it to 30 to 40. Right?
A Right. And, honestly, I don't keep track of this. I mean, I'm not, I'm not making notes about how many I have done and I'm just having to guess as best I can.
Q If you - if you assumed -- if you take the definition of shoulder dystocia that is the lowest, in other words, the lowest percentage ---
A Okay.
Q --- one to two percent ---

A Okay.
Q --- and if you assume that you've had the lowest average, that would be one percent. True?
A Correct.
Q One percent of three to four thousand is 30 to 40 babies with shoulder dystocia. True?
A Correct.
Q So, that's a bottom number.
A That's my estimate.
Q Okay. Fair enough. And with gentle traction, with gentle guidance that you use, how many times have you caused permanent injury to the babies that you deliver?
A Again, I don't know. I think I spoke with y'all earlier about the fact that I've had a case very similar to this that was relieved simply with McRoberts and suprapubic pressure over time. I wasn't able to do any of the Woodscrew maneuvers. I wasn't able to push this baby back up to do a C-section and that baby did have a brachial plexus injury that lasted for some time. That couple moved away and so I don't know the ultimate outcome of the baby, but so I truly don't know whether there was a permanent injury there but I know that baby had problems. I kept hearing that there were problems with the shoulder and an arm.
Q The baby was healing when you last were aware. True?

A Correct.
Q As far as you know, the baby was well on the way to a complete recovery. True?
A I don't know that.
Q To the best of your knowledge there's no permanent injury in that case?
A I haven't seen that couple or the baby again. They've moved to another part of the country.
Q Shall I pull up the deposition about that issue or do you want to concede that as far as you know there was no permanent injury?
A Again, I don't know that there was a permanent injury, but I don't have long term follow-up with that couple or baby.
Q You also talked about C-sections and somehow if a baby gets a permanent brachial plexus injury following a C-section, somehow you think that relates to this case. Can you point me to a single case -- Well, let me re-phrase that. In C-sections, babies don't just pop out, do they?
A They don't.
Q You cut a hole on the outside of the mom. You go in. You cut a hole on the uterus. Cut an incision.
A Correct.
Q And then you get a nurse or assistant, surgical tech or

somebody, to push down on the mother's fundus to try to squeeze the baby down through the birth canal so you can reach the head. True?

A Correct.

Q And then you have to pull the head, pull the head up to get it out through the hole. True?

A Correct.

Q Sometimes it's so hard to pull a baby's head out through that hole that you have to use forceps or vacuums to suction the baby out. True?

A Well, you put the suction on simply to get the head out, not the shoulders.

Q Yes, sir, but you're not telling us here today that babies don't receive traction on their brachial plexus nerves when they're delivered by C-section. True?

A I'm sure there's some.

Q Are you aware of any literature, any of the cases you brought in these articles about today, involving injury following C-sections where there was no injurious traction?

A Well, of course, we don't have a detailed description of what the doctor did as far as how much -- again, nobody has a pressure gauge on their arms to tell you. I can just tell you when you do a C-section, it's a whole different ballgame. Like I'd said before, you can make

your incision bigger. You can do a lot of things you can't do with a vaginal delivery to make sure that baby's coming out easy. I mean, it's easy, so how -- how you get a -- I mean, how you get a brachial plexus injury, even a permanent one, when you're doing a C-section speaks to the fact that there are other things than just a doctor pulling too hard that causes it.

Q Doctor, in fact, you cannot connect the dots between whether or not there was traction applied in those C-section deliveries that injured the nerves and the permanent injury. True?

A All I can speak to is the fact that when I do a C-section it's a whole different ballgame. You're not worried about a brachial plexus injury from, from pulling because it's -- you can make a bigger incision in the uterus. You can make it easier to get the baby out. There's no bone there to cause a problem and you can get the baby out easy ---

Q And you ---

A --- and despite that, these babies can still have a permanent brachial plexus problem.

Q Whether traction is applied in a C-section gently or in a vaginal delivery gently, that amount of traction doesn't put the nerves at risk of injury. True?

A True.

Q But if you increase the traction to a forceful traction with bending of the neck, that puts the nerves at risk whether it's a vaginal delivery or a C-section. True?
A It could.
Q You -- you were talking earlier about how in one of your, one or maybe more of your deliveries, you weren't able to get your hand in the birth canal.
A Correct.
Q And, I mean, let's be candid. Let's be frank. We're talking about a situation where the mother's private parts are exposed.
A Correct.
Q So I want -- do you believe that an obstetrician should use sensitivity in terms of a vaginal examination or an attempt to enter the woman's vagina?
A Yes, sir.
Q And so when you attempt to put your hand up inside the birth canal to do a rotation or a posterior arm delivery method, do you -- do you do that with sensitivity for the situation?
A Well, you try to. Again, this is an emergency. You've got a baby whose heart rate is down and I'll be honest with you, you have to just start -- you have to think about the baby. You don't want to injure the mother, but you're not thinking about -- you're not saying excuse

me, ma'am, I need to put my hand in your vagina. You've got a baby to get out, so you're doing everything you can to get the baby out and you know you can, you can fix the mom afterwards, and so that's ...

Q But -- and we're not complaining about tears to the mother's private parts, but do you believe an obstetrician, a well-trained, experienced obstetrician, should use his knowledge, skill and experience to insert his hand carefully where it needs to go without just trying to ram it in it?

A Well, you always try to do it carefully. I mean, you, you have -- in our field you have two patients. There's no question. You have a baby, you have a mama, and you're trying to do the best for both of them. In this particular situation, you, again, you may not -- you want to be gentle with the mom but you also have a baby that's stuck so you have to -- you're not -- you're not getting informed consent. You're doing it.

Q The question is, should you put your hand in there carefully and with skill or should you try to just jam it in there?

A You try to put it in with care and skill.

Q Yes, sir. By the way, were you here when Dr. Coker testified?

A I was not.

Q So, can you tell us whether Dr. Coker was able to get his hand inside Genesie's birth canal?
A I'm not sure that he was.
Q Do you know?
A I don't know. I know that he ---
Q And you don't know what he testified to under oath here yesterday, do you?
A Well, I know that he was able to, to get the shoulder underneath the pubic bone by more suprapubic pressure.
Q Do you believe Dr. Coker's hands are larger or smaller than Dr. Goldstein's?
A I have no idea.
Q Do you know if Dr. Coker is a tall man?
A I think I remember that he was taller.
Q If you -- if -- if, in fact, a skilled obstetrician were not able to get his hands in, if that were the case here, then you should go back and repeat the other maneuvers. Right?
A Correct.
Q You're not given license to yank down on the baby's head forcefully, are you?
A No, sir.
Q And, in fact, when you did that in your case you were able to deliver the baby. Right?
A I -- we delivered the baby with more suprapubic pressure

very much like this case.

Q Let me go over just a few quick points with you, sir. In any hands-on delivery that you've managed, you've never seen even a mild brachial plexus birth injury following a C-section delivery, have you?

A That I've managed?

Q Yes, sir.

A Not that I'm aware of, no, sir.

Q And in the deliveries that you've managed, you've never had a baby born with even a mild injury to the bottom shoulder, have you?

A No, sir.

Q You've never had a baby born with even a mild injury without shoulder being -- shoulder dystocia being present. True?

A Not that I'm aware of, no, sir.

Q And you've never had a baby born with even a mild brachial plexus injury unless you applied traction. True?

A Correct.

Q Have you ever delivered a baby with even mild nerve problems that you thought was caused by maternal expulsive forces?

A Well, in the -- with shoulder dystocia, yes, yes, sir, but not that I know of in a case where there wasn't

shoulder dystocia.

Q All right. Please turn to page 77 of your deposition, starting with line four.

A Yes, sir.

Q I'm going to read it and you tell me if I read it right.

Q Have you ever had a baby born on your watch with signs or symptoms of brachial plexus nerve damage that you thought was caused by maternal pushing or uterine expulsive forces?

A No.

Q Did I read that accurately, sir?

A Yes, sir.

Q In fact, you've never seen a baby delivered by anybody else that you thought got a brachial plexus nerve injury from C-section or bottom shoulder without shoulder dystocia or without traction. True?

A True.

Q In fact, you've never even seen a baby born with a brachial plexus injury that you thought was caused by maternal forces of labor. True?

A True.

Q So, when you talk about your knowledge and experience that other things besides forceful traction can injure a brachial plexus, the knowledge part is based on the books?

A Correct.
Q And the books don't talk about neuromas.
A Correct.
Q And the experience part is based on your experience ---
A Correct.
Q --- where that never happened.
A I'd like to remind the jury that these are very rare events. Even though it seems like every other baby has this happen, this is about one in a thousand times that this happens, so if I've delivered 3,000 babies and I happen to be in that -- that little bracket, then maybe I see it once, but it's not unusual for you to go your whole career and not see what he's talking about, simply because this is such a rare event.
Q Yes, sir. But you said you relied on your knowledge and experience. The knowledge is the books, the experience is no injury without traction. True?
A That's -- yes, sir.
Q You've never even heard from your colleagues any locker room story, if you will, about a brachial plexus injury being caused by what they thought was natural forces of labor. True?
A True.
Q When the baby goes through the birth canal, until the obstetrician gets involved with hands, forceps or vacuum

suction, the baby's being pushed from behind. Right?

A Correct.

Q And when that baby -- before the doctor intervenes, the pubic bone stops the progress of the body through the birth canal. True?

A Correct.

Q You said something about stretches being involved before the head delivers. Can you tell us, do you believe the stretch on a baby's brachial plexus when the top shoulder is held back by a bone, can you tell us whether that stretch has ever exceeded, say, a quarter of an inch?

A Again, we don't have protractors. We don't have rulers. I'm not exactly sure what, what a quarter of an inch is when I'm doing this. I'm just trying to get the baby out as safely as I can and I'm not sure what -- you know, how many inches things are changing.

Q Yes, sir. You vouch for the animation that appears to show several inches of neck stretching, but you've never seen that in real life, have you?

A Well, with shoulder dystocia you don't get to see that because the neck never appears.

Q In all your knowledge, in all of your training, in all of your experience, do you have any science, any article, any personal experience, to suggest that the

neck can stretch in a shoulder dystocia situation more than maybe a quarter inch?

A I don't think anybody does.

Q Did it give you any discomfort to vouch for an animation that shows several inches of neck stretching?

A I didn't see how many inches were -- I didn't see a ruler up there measuring it.

Q Do you believe it's reasonable for citizens of Florence County to expect their doctors to refrain from needlessly endangering Florence patients ---

MS. CRAIG: Objection, Your Honor. That's a violation of the Rule.

THE COURT: Sustained.

Q Now, you freely admit that any doctor who uses more than gentle guidance on a baby's head in a shoulder dystocia situation is guilty of violating standards of care ---

A Yes.

Q --- at least in the first five or six minutes. True?

A Yes, sir.

Q And this case was -- the baby was delivered in four minutes. True?

A Yes, sir.

Q So, if the jury finds Dr. Goldstein used more than gentle guidance or traction that would be a violation of the standard of care. True?

A Yes, sir.
Q But as I remember your deposition testimony, you weren't really concerned about the angle of traction.
A No, sir.
Q Your testimony, if I remember, was you need to pull down on the head ---
A Correct.
Q --- to get the top shoulder out.
A Correct.
Q But you need to do it carefully and gently.
A Correct.
Q And you said -- do you believe as you sit here today that the amount of the angle doesn't matter in terms of putting the nerves at risk?
A I think the angle could matter. It's just, again, we don't have protractors. We don't have rulers. We don't -- you have to -- this is the art of medicine. You have to know how to do it because you've done it repeatedly.
Q Yes, sir. Do you have the book that you were talking about so much, "Neonatal Brachial Plexus Palsy"?
A Yes, sir.
Q All right. Could you please turn to page 19? I'm sorry. I may have given you the wrong page. One of the nine numbers. Let's try 29. Okay. And doctor, I want to direct your attention in the left-hand column, the last

column. Do you see that?

A Yes, sir.

Q This is a book you believe is reliable. True?

A True.

Q Do you believe -- do you agree with this proposition: The key principle to minimize stretching of the brachial plexus through the application of exogenous force -- let me stop there. Exogenous force is obstetrician force. Right?

A Correct.

Q All right. The key principle to minimize stretching of the brachial plexus through the application of obstetrician force is to avoid lateral bending of the neck; that is, moving the head out of alignment with the fetal cervicothoraxic spine whether toward the floor or the ceiling.

A Correct.

Q Downward toward the floor or up toward the ceiling puts the opposite side at risk of nerve damage. True?

A True.

Q As a defense expert in this case, you, you tell us that lateral bending doesn't matter?

A I didn't say that. I said that I don't really have a protractor, I don't have an angle measurement to know, but I -- I'm definitely not going to -- can I see the --

the mannequin please?

Q The doll?

A Yes, sir. So, when Mr. Graham is showing y'all this, he's doing this very freely. (Indicating) When you've got shoulder dystocia only that much of the head is showing so you really can't do what he -- what he's saying you can with this. The head is out, but is not out far enough for you to be able to do that, so that's why it's not that critical for me. I mean, I'm trying to make sure that I'm gentle, but this head -- the mom's opening of her vagina is keeping you from being able to do that.

Q ACOG warns you not to do that. Right?

A Yes, sir.

Q By the way, you've talked so much about ACOG. What does the "C" in ACOG stand for?

A Congress. They changed it.

Q Okay. It used to be a college.

A Yes, sir.

Q Now they've changed to a congress.

A Yes, sir.

Q And they used to be an educational organization. Now they've changed to a lobbying group. True?

A They have a component of a lobbying group, but it's not ACOG. It's a PAC.

Q All right. Do you -- I mean, if we were to Google ACOG we would see that one of the primary purposes is to advocate for the financial interests of obstetricians in this country. True?

A I'm not sure about that.

Q And also to advocate for the professional interests in litigation. True?

A I'm not sure about that.

Q And also to lobby Congress for various reasons. True?

A I'm not sure about that.

Q When a doctor pulls down on a baby's head and neck, what is the most foreseeable risk of harm?

A That you could tear the mom's vagina into the rectum or that you could have injury to the brachial plexus.

Q And the harder the traction, the more forceful the traction, the greater damage to the nerves. True?

A Possibly.

Q In fact, the greater the traction the greater the risk of significant injury. True?

A Well, I think you're simplifying it too much. I think that you have so many other factors that we alluded to earlier. You have a baby's condition. You have genetic predisposition to injury that he never seems to remember. That you have a child that maybe doesn't have as strong ligaments here as another child, and so maybe

the exact same scenario with another delivery, there's no injury at all. You have a child that is, as we said, hypoxic, low -- has an APGAR of one, so it's very limp. There's no muscle tone helping protect those nerves at all, so that's a factor in this and I think that's a big factor in this particular case.

Q Let's please turn to page 120, line five, starting at line five. I'm going to read this and have you tell me whether I read it accurately, sir.

A Now, where -- we're in ---

Q Page 120 of your deposition, lines five through 10.

Q Doctor, do you believe that the greater the traction applied to the baby's head and neck in a shoulder dystocia situation, the greater the risk of significant injury to the brachial plexus nerves?

A I would agree.

Q Did I read that accurately?

A Yes, you did.

Q And you admit you don't know how much traction Dr. Goldstein used. True?

A True.

Q If he used gentle guidance or traction, that's okay. If he used more or bent too much, that's a violation.

A Yes, sir.

Q All you can do is point out the standard and let the jury determine whether he met the standard or fell below. True?
A True.
Q Now, did you read Nurse Rebecca Lawrimore's deposition?
A Yes, sir.
Q Did you read it carefully enough to see what she said about the legs were while she was applying suprapubic traction ---
A I don't ---
Q --- I mean, suprapubic pressure? I'm sorry.
A Again, that was some time ago. I don't remember exactly what she said in that scenario.
Q So, you don't remember how many times she said the feet were in the stirrups?
A Not exactly, no, sir.
Q But if the feet were in the stirrups as opposed to being in McRoberts, it would be a violation of standard of care to get chaotic and start using traction if you hadn't even tried suprapubic and McRoberts at the same time. True?
A At the same time really isn't necessarily a standard of care. You can -- you can do McRoberts without suprapubic pressure and try that. Then you can bring McRoberts down, do suprapubic pressure. You can do any combination

but, there's not a standard that says we need to be doing it together.

Q But it would be -- if -- if you haven't done McRoberts and suprapubic pressure simultaneously, it would certainly be reckless to use gentle traction instead of using the two maneuvers together.

A I think you would do the two maneuvers together at some point, yes, sir.

Q All right. It would fall well below the standard of care to apply traction to a baby's head and neck if you hadn't applied suprapubic and McRoberts at the same time?

A And/or. In other words, you don't have to do them at the same time. I mean, you technically almost always when you're in McRoberts you're going to do suprapubic pressure but maybe you try something else. Maybe you get the legs down because that didn't work for you, so it's not a standard that says you have to do McRoberts and suprapubic pressure at the same time.

Q Please turn to page 125, starting at line 23.

A Line which, sir?

Q Just to try to speed things up, I was going to start at line 23. Question, starting with the words, "do you believe".

Q Do you believe that would be a violation or a

breach of the standards of care to not try McRoberts and suprapubic together before and instead increase traction?

A Yes.

Q Did I read that accurately?

A You did.

Q We've heard some talk about the bed and apparently these hospital beds can be moved up or down?

A Correct.

Q When you are called upon to manage a shoulder dystocia emergency and your goal is to use the safety maneuvers to get the baby out effectively, to get that shoulder unstuck effectively and to get the baby out without damaging the nerves, do you want that bed as high as possible or as low as possible?

A I don't really think about a height requirement when I'm doing this. Again, it's an emergency. I personally don't tell the nurse to change the height necessarily. I always have it higher. I mean, I always like the bed higher just because for my anatomy and my torso length, that's what works the best for me, but I'm not necessarily changing the height of the bed when I have a shoulder dystocia.

Q Yes, sir. And when you manage a shoulder dystocia the height of the bed for you is always as high as it will

go. True?

A That's probably true.

Q Kneeling to apply traction on the baby is a breach of standard of care. True?

A I can't think of a situation where kneeling and traction would be what you'd want to do.

Q In fact, to apply pulling force on the baby's head and neck from a kneeling position would violate the standard of care. True?

A Yes, sir.

Q Do you believe that an obstetrician should have experience about how to perform an internal maneuver as well as the traction-based maneuvers of suprapubic pressure and McRoberts?

A Yes, sir.

Q Do you believe that the standards of care require that an obstetrician have that degree of knowledge and experience that he can correctly perform internal maneuvers as well as the traction-based maneuvers?

A Yes, sir.

Q Do you believe it would be a breach or a violation of the standards of care for an obstetrician to attempt to manage a shoulder dystocia without that degree of knowledge and experience?

A Yes, sir.

Q I've heard it said that some expert witnesses, some opinion witnesses, before they -- or when they agree to take on a role in a case to offer opinions to a jury, that they, they first want to get their mind in the right place to make sure they're being fair and objective to everybody.

A Yes, sir.

Q Do you do that?

A I do.

Q You do that?

A Yes, sir.

Q In fact, if a doctor says he doesn't know how much traction he put on a baby's head because he doesn't remember how much he used in this case and how much he's ever used, you're willing to assume that he used only gentle guidance. True?

A I would and I, instead of -- my thoughts when I -- if you want me to go into more detail about my thought of why I took this case, as I think I've explained to y'all earlier, is that I had a case very similar to this and in my opinion, instead of dragging Dr. Goldstein through this mud for the last three or four years, or whatever it's been, we ought to be handing him an award for not having a brain damaged baby, and that's what I strongly feel about it. I think that he saved this baby's life.

He's kept Bryson out of a wheelchair. Bryson could have cerebral palsy and be in a wheelchair right now.

Q Who got the shoulder unstuck, doctor?

A Who got the shoulder unstuck?

Q Yes, sir. You're praising Dr. Goldstein, the hero, who saved this baby's life. Did Dr. Goldstein get the shoulder unstuck?

A No, but in my case the nurse that came in and gave additional suprapubic pressure in my case got the shoulder unstuck. I didn't do it.

Q Yes, sir. And the legs were in McRoberts when suprapubic pressure got the baby's shoulder out. Right?

A I -- probably.

Q That's the right way to do it if you want to maximize the room to get the shoulder out. True?

A I think it's a very similar situation. In my case, I was struggling. I was in the same situation Dr. Goldstein was in. A nurse came in and applied additional suprapubic pressure and the baby delivered.

Q And when Dr. Goldstein does not confess that he used forceful traction, you're prepared to assume that that means he didn't use forceful traction to cause these neuroma-based injuries. True?

A Yes, sir.

Q You're prepared to accept that hook, line and sinker.

A Yes, sir.
Q True? At the deposition do you recall that there was a time when you decided you didn't want to be a causation expert in this case?
A Yes, sir.
Q You told me at the outset of the deposition that you didn't claim to have an opinion about the ---
MS. CRAIG: Your Honor, asked and answered. He started with this line of questioning.
MR. GRAHAM: I'm just getting to causation, if Your Honor please.
THE COURT: I think we probably do need to move forward. We've covered a lot of that. You're going to have plenty of opportunity to do it, but let's not re-plow the same ground.
MR. GRAHAM: All right.
Q You told us you wanted to retract your status as a causation expert. True?
A I didn't truly understand. I think I said earlier that I don't -- this is the second time I've ever testified in a courtroom. I -- there are people including his experts that do this 10, 15, 20 times a year and -- or a lot. I don't know exactly what the number is, but way more than I do. I'm not -- I don't know the legalese. I don't know the legal jargon and I was confused and honestly, I just really didn't know. I thought he was talking about do I

know the exact one cause of how this happened and I don't. I think it was a constellation of a lot of things, so ---

Q Yes, sir.

A --- it was -- can I finish?

Q Yes, sir. Yes, sir. I thought you were. Sorry, sir.

A It was -- it was my misunderstanding of legal jargon and, you know, again, I was tired when I did the deposition. It was a very long deposition, and so forth. I'm not making excuses. I'm just not somebody that does this all the time. I haven't gone to a course about; this is causation, this is that, this is ...

Q Speaking of that, doctor, you -- you told us in this courtroom that the folks that signed -- that were on the committee to create this Neonatal Brachial Plexus Palsy by the Congress of OB/GYN lobbying group ---

A Yes, sir.

Q --- you told us that they had signed a pledge that they had absolutely no financial interest, no personal stake in the issues being discussed. Do you remember that?

A I don't know if I actually said that. I can't remember. I think we did go over all the endorsements.

Q I'm talking about the authors, the committee members.

A I can't remember if I said that or not.

Q All right. At any rate, the chair of this committee is

Dr. Robert Gherman. Right?

THE COURT: Might counsel approach the bench for a moment?

(Brief bench conference off the record)

Q All right, doctor. We won't -- I'm not going to ask you about the bias of those committee members, but let me do this; let me move right along.

MS. CRAIG: Move to strike, Your Honor

THE COURT: Sustained. No more editorial comments.

Q When you finally decided that you were going to give causation opinions in this case, you came up with four factors that you claim caused the injury together. Right?

A Correct.

Q And let's talk about those. The first one, I believe, was maternal forces.

A Yes, sir.

Q The truth is, you don't know what the maternal forces were in this case, do you?

A I don't.

Q And you don't have any evidence of maternal forces, no experiences with maternal forces ever causing a brachial plexus injury, even temporary. True?

A Correct. But what I do know after being in this business for 30 years, and I think I've said this earlier but

I'll say it again, when a woman knows that her baby is not coming out and there are people in the room screaming at the top of their lungs to push, I can promise you she is creating a lot of energy.

Q Yes, sir. Do you remember why -- do you remember that one of the reasons Dr. Goldstein said he decided to use the vacuum was because the mother wasn't pushing effectively?

A Again, before her baby was stuck and before she had everybody screaming at the top of their lungs.

Q Yes, sir. And Dr. Goldstein was screaming at the top of his lungs push, push, push. Right?

A I would imagine.

Q He should have been saying stop pushing, stop pushing. True?

A Sometimes.

Q The standard of care requires an obstetrician to stay calm. True?

A I don't know that he wasn't.

Q The standard of care, sir, requires an obstetrician managing a stuck shoulder to stay calm, doesn't it?

A I don't think there's a standard of care about staying calm because I've never read that. We try to stay calm. I think we're -- we're just individuals. We're -- we're like everybody else and there are some of us that are

calmer than others and, you know, I think I can't speak to how calm Dr. Goldstein was because I've never seen him deliver a baby, but I do know he has 30-plus years of experience and those kinds of operators typically know how to stay calm and my father did this for 50 years and the older he got the calmer he was, so I can't speak to Dr. Goldstein specifically on that day. I can tell you that experience does help. Staying calm does help, but it's not a standard of care.

Q Experience doing the job well is far more beneficial than experience doing the job poorly. True?

A True.

Q And the standard of care requires not only that the doctor stay calm, but it also requires that the doctor tell the patient to stop pushing. True?

A When there -- when you're doing certain maneuvers, you do want to have the patient stop pushing.

Q He didn't do that in this case, did he?

A I don't -- I don't know.

Q So, you think maternal forces played a role here despite the fact that you can't point to any article in the literature where that's ever happened and you can't point to anything in your experience where that's ever happened. True?

A Well, the literature -- I think we went over it clearly

earlier -- does show that there are factors other than physician traction that creates brachial plexus injury.

Q You couldn't connect the dots with no traction on any of those hypotheses, could you?

A I can only say that my intuition and common sense reveals it over years and repeatedly scrutinized articles, that all of them are not going to be incorrect.

Q And you don't know how much traction -- or how much pushing force her uterus or her pushing efforts generated. True?

A True.

Q Taking all that into account, all those theories, are you able to tell this jury that maternal pushing force added up to even as much as one half of one percent of the cause of the injury in this case?

A I'm not sure about the percentage.

Q You cannot say to a reasonable degree of medical certainty that that plays a role -- a significant role of even one half of one percent, can you?

A Again, I'm not sure of the legal jargon here, but I will tell you that I think it's a big factor in this case. Yes, I do.

Q Do you want me to pull the deposition or do you want to concede you said at deposition ---

A I can't remember what I ---
Q --- it's not even that.
A --- at the deposition.
Q All right. We'll get to that in a moment. Let's talk about genetic predisposition. You claim that one of the factors in this case is that, is that Bryson's gene pool makes him predisposed to brachial plexus injuries. How many -- if you go back all the generations of his family tree, how many other children have even a mild brachial plexus injury?
A I don't know how many other children had a difficult delivery.
Q Bryson's the only one that was delivered by Dr. Goldstein. Right?
A Right, and he ---
Q And he ---
A --- he has one sibling that was 20 years senior.
Q She doesn't have a brachial plexus injury, does she?
A I don't think she had a difficult delivery but -- you know.
Q Nobody in her -- if you go back to the parents, grandparents, all the way back to Adam and Eve, you can't point to a single person who had a brachial plexus injury, can you, in her family tree?
A I do not know.

Q And yet you come here in this important case and tell these folks that this was a genetic predisposition.
A I was saying that that's one of the factors that's involved in a brachial plexus injury with shoulder dystocia.
Q But you can't say to even a half of one percent significance, can you?
A Again, I don't know about your percentages.
Q The third factor you've mentioned was anatomy of Genesie's pelvis. How many times have you examined Genesie's pelvis?
A I have not examined Ms. Fulton's pelvis. I simply know that that's one of the factors that can lead to this problem.
Q Can lead. Do you any evidence that it had anything to do with Bryson's delivery?
A I have -- all I can say is that Bryson was a stuck baby.
Q Yes, sir. Tell me everything that you say was abnormal about Genesie's pelvis.
A I don't know.
Q And yet you come here in this important case and say it was the pelvis's fault. Do you feel good about saying that in this important case, sir?
A I didn't specifically have any concern with Ms. Fulton. I mean, I didn't say that it was her fault at all.

Q You said it was her pelvis's fault. Right?
A I said that's one of the factors that's involved with this injury.
Q That factor doesn't apply to Bryson's case, does it?
A I don't know.
Q You have zero evidence to support that theory. True?
A I have not examined Ms. Fulton, so I don't know.
Q Your last causation multi-factorial theory is asynclitism of the head. That's a big word that basically means the head was tilted. True? It wasn't lined up directly with the spine. It was tilted.
A Correct.
Q You have no evidence of that either, do you?
A I don't, but that's one of the factors that can be involved in this.
Q But it's not in Bryson's case, is it?
A You don't know.
Q You have zero evidence, sir. True?
A I have as much evidence as you do that it wasn't.
Q There's nothing in the medical records about the head being tilted, is there?
A We -- I rarely document that.
Q If Dr. Goldstein thought he could come into this Court, sworn to tell the truth, and make that assertion, don't you think we would have heard it by now?

MS. CRAIG: Objection, Your Honor. Pitting.

THE COURT: Sustained.

Q All right. So, when we look at maternal forces, genetic predisposition, anatomy of the pelvis and tilted head, asynclitism of the head, the truth is you have zero evidence for any of those things in Bryson's case. True?

A Well, and what I would tell you that, in the genetic issue, that -- you know, we have some people have injuries more and I think I talked about a rotator cuff injury as an example, but we also have a baby that doesn't have the oxygen supply to keep its musculature. He was delivered a very limp baby and that's part of the factor here.

Q You have no evidence of any of those four factors being present here. True?

A True.

Q All right. Let me try to move through the rest of this real fast. You admitted in the deposition that all those four factors were all speculative and wild assumptions. True?

A I know that those are things that occur in deliveries of this nature where there is a brachial plexus injury.

Q Maybe in somebody else's case but not Bryson's. True?

A I don't know.

Q You have zero evidence, sir. Right?

A Well, I know that he had a brachial plexus injury and those are factors that are involved in brachial plexus injury.

Q So, let's blame it on the uterus.Let's blame it on the pelvis. Let's blame it on his gene pool and let's blame it on the way he came through the birth canal. By the way ---

MS. CRAIG: Objection, Your Honor.

THE COURT: Sustained. It's argumentative. Ask a question that elicits information.

MR. GRAHAM: Yes, sir. Thank you, Your Honor.

Q Doctor, one of the articles you brought forth today was the Twerky article. The Twerky article doesn't say whether or not shoulder dystocia was present. It says whether or not there were risk factors. True?

A Okay. Yes, sir.

Q Correct?

A Correct.

Q And you told us that it said there was no shoulder dystocia, but instead the article says there were no risk factors for shoulder dystocia. True?

A I think that's true.

Q Yes, sir. They didn't make an effort to figure out whether there was any shoulder dystocia or traction. They focused on risk factors for shoulder dystocia.

True?

A Well, eight cases without shoulder dystocia but with severe brachial plexus palsy requiring neonatal intensive care unit were identified.

Q All right. Did you know that one of the co-authors of that article, Ouzounian, that Twerky works for, did you know that Ouzounian has testified under oath that the assertions in that article are not true about there being an absence of risk factors?

MS. CRAIG: Objection, Your Honor.

A I did not know that.

THE COURT: Might we approach the bench?

(Bench conference off the record)

THE COURT: The last question and the answer concerning this article is stricken.

Q Doctor, the article by Dr. Twerky and Dr. Ouzounian, who has not testified in this case, that didn't talk about permanent injury, did it?

A I don't think they qualified whether it was permanent or not.

Q So, when you came in and started talking about what can cause nerves to be ripped and torn permanently with neuroma formation, the truth is you brought in articles that talk about temporary injury. True?

A No, some of these articles talk about permanent injury.

Q Well, we'll see about that, but the Twerky article does not. True?
A I don't think it specifically mentions permanent injury.
Q Okay.
A The point of the article though is to say that, that with all these factors that come into place without traction and so forth that you keep referring to, that you can get a significant injury.
Q They don't connect the dots between whether or not there was traction.
A This one may not.
Q What?
A This -- this article may not.
Q In fact, it does not. True?
A Not -- I'm not aware that it does.
Q Not a single article you brought in today does. True?
A No.
Q Which article do you claim connects the dots between no traction and a permanent injury?
A Well, that's where you say there's no traction. I would tell you that there's always some traction or some guidance to a baby delivered. There's always.
Q All right. A moment ago you told me that you brought an article, one or more articles into this courtroom that connects the dots between no traction and a permanent

injury. Are you retracting that statement now?

A We have encountered several cases of permanent ERB palsy associated with ---

Q We need to make sure what he's ---

A This is from ---

Q Could you identify the article please?

THE COURT: You asked him the question. He's ---

DR. SALLEY: I'm trying to answer it.

Q Could you identify the author first?

A Ouzounian.

Q Okay. Please continue.

A We have encountered several cases of permanent ERB palsy associated with birth that were not attributable to traction applied at delivery.

Q All right. And what he bases that on is there were four cases where the doctor didn't say there was shoulder dystocia on the chart and there were four cases where the bottom side is the one to have the injury. True?

A Yes, sir.

Q None of those say anything about whether traction was applied. He just guessed that, based on the fact that there was no shoulder dystocia on the chart and the injury was to the bottom side. True?

A Yes, sir.

Q Did you bring any article today that you believe rises

above the level of speculation in connecting a permanent injury to no traction?

MS. CRAIG: Asked and answered, Your Honor.

THE COURT: I'll sustain the objection. We probably need to stick to the facts of this case and get off the articles.

MR. GRAHAM: Yes, sir, but I do want to respond to the literature that they've put in briefly.

Q Doctor, at one point you were telling us something about a three-pound baby.

A Yes, sir.

Q And you said a three-pound baby isn't going to get a stuck shoulder.

A In my experience I've never seen that.

Q Yes, sir, but do you know whether or not that baby had a tumor that affected the nerves?

A I think it would have been discussed.

Q Do you know, sir, whether that baby had a tumor that affected the nerves?

A I don't.

Q Do you know whether that baby had an infection that affected the nerves?

A I'd have to say that the editorial board and the publishers that scrutinize these articles would want to know about that and when they published it, that they, that would have been a case they would have asked the

author not to include.

MR. GRAHAM: Move to strike the non-responsive part of that, Your Honor. He's speculating about what the editorial board may or may not do.

THE COURT: Might counsel approach the bench for a moment?

(Bench conference off the record)

Q I want to try to see if we can move away from this subject, sir. In terms of all of these articles, which I don't really want to talk about in any detail anymore in the interest of time, you can't point to a single one that says a baby's permanent brachial plexus injury was caused by natural forces of labor, can you?

MS. CRAIG: Objection, asked and answered.

THE COURT: That's been asked and answered at least twice.

Q Nor can you point to any article where a permanent injury was caused by the baby's tone at birth. True?

MS. CRAIG: Same objection.

THE COURT: Sustained.

MR. GRAHAM: In the interest of time, Your Honor, I have no further questions.

THE COURT: Very good. All right. Any redirect?

MS. CRAIG: I will be -- I will move through it quickly. May it please the Court?

THE COURT: Yes, ma'am.

REDIRECT EXAMINATION

BY MS. CRAIG:

Q Dr. Salley, is there any evidence in the medical records that excessive traction was used during this delivery?

A No, ma'am.

Q And, in fact, based on Dr. Goldstein's testimony and the nurses who assisted with the delivery, is it your opinion that gentle traction was used at all times?

A Yes, ma'am.

Q Now, you were asked some questions about ACOG. Is ACOG the premier professional organization for obstetricians?

MR. GRAHAM: Your Honor, this is not new.

A It ---

THE COURT: I'll -- I'm going to allow it. We've talked about it for an hour now. I'm going to allow her to say whatever she wants to say about it. Go ahead. Ask your questions.

MS. CRAIG: Yes, sir, just two questions.

Q Is it the premier medical organization for doctors like you?

A It is.

Q And does ACOG advocate for female patients?

A Yes.

Q You were asked about induction. Was there any evidence

in this case that Dr. Goldstein induced Ms. Fulton for his own convenience?

A No, ma'am.

Q And based on your review of the records, was it appropriate to induce Ms. Fulton in this case because she was five centimeters dilated?

A Yes, ma'am.

Q What does the vacuum have to do with anything in this case?

A Nothing.

Q You were asked in your deposition, just very quickly, you were asked -- and let me tell you which line, which page -- page 24. While you're getting there, you were asked questions about a definition of shoulder dystocia. It was a while ago but ---

A Right.

Q You do remember that? And you answered at the top of the page but you did not read the rest of your answer, so I'd like to put it into context. It says at line three,

Q Okay, in your definition it's not shoulder dystocia unless one of the correct ancillary maneuvers is used?

Q And you said what?

A Correct.

Q And do you believe that there are other definitions

of shoulder dystocia that exists?

Q And your answer?

A I do.

Q And what do you believe is the rate or the frequency of shoulder dystocia in this country?

A What was your answer?

A Somewhere around one to two percent.

Q Now, you were asked also about whether or not you testified in your deposition that Dr. Goldstein met the standard of care. Remember that line of questions?

A Yes.

Q Okay. Look at page 194 of your deposition. Okay? And it says this is at the very end of the five hour, five-and-a-half hour deposition. I'm asking you questions. It says:

Q Dr. Salley, I know we've been here for over five hours, so I'm going to be brief so we an all go home to our families. Based upon your review of the medical articles and the deposition testimony that you have reviewed, and based upon the medical records that you have reviewed, do you have an opinion to a reasonable degree of medical certainty whether Dr. Goldstein met the standard of care in the care and treatment he provided to Ms. Fulton -- and then at the top of the next page -- and child?

Q And then it says witness at line three, what did you say?

A He did, based on everything we have just described.

Q And then I asked again:

Q Okay, and is your opinion to a reasonable degree of medical certainty that he met the standard of care?

Q What was your answer?

A It is.

Q And then the very last page of your deposition, last question I asked you on line 202 -- page 202, line 22, it -- are you there?

A Yes, ma'am.

Q It says:

Q But in this case, in this case, one more time, your opinion is that the most likely cause of the brachial plexus injury in this case was a combination of factors. Is that correct?

A What was your answer?

A That is correct.

Q And is that your opinion to a reasonable degree of medical certainty?

Q What was your answer?

A Yes.

Q Is your deposition testimony consistent with your testimony in court here today?

A Yes.
Q And you were asked about Dr. Goldstein's deposition. Did you read in Dr. Goldstein's deposition where he explained that a physician cannot quantify the amount of traction used during any delivery?
A Yes, and I agree.
Q And I don't want to re-hash, but you talked about pressure gauges.
A Right.
Q Okay. And, of course, you don't use pressure gauges when you're delivering babies.
A Do not.
Q You were asked about being gentle with the mom. Dr. Salley, when you are confronted with a medical emergency and trying to save a baby from brain damage or even death, do you stop what you're doing and say okay, I'm going to now enter the vagina and I'm going to try to do X, Y and Z? Is that -- does that happen in the reality of medicine?
A No, ma'am.
Q What is -- what are you trying to do? What's the most important thing?
A Get that baby delivered.
Q And did that happen in this case?
A Yes, ma'am.

Q Dr. Salley, is there any evidence that Dr. Goldstein acted recklessly during this delivery?

A No, ma'am.

Q And, in fact, did Dr. Goldstein save the baby's life?

A He did.

Q And last question: Do you have an opinion whether Dr. Goldstein has the experience and the knowledge to manage a shoulder dystocia case and specifically manage the shoulder dystocia that occurred in this delivery?

A I do.

Q And what is that opinion?

A That he has the skill and knowledge and experience to do that.

Q And are all of the opinions that you've given today to a reasonable degree of medical certainty, most probably?

A Yes, ma'am.

MS. CRAIG: Thank you, Dr. Salley.

THE COURT: You may step down, Dr. Salley.

MS. CRAIG: May Dr. Salley be excused, Your Honor?

THE COURT: Certainly. Any objection from the Plaintiff?

MR. GRAHAM: No, Your Honor.

THE COURT: Thank you, Dr. Salley. You're free to leave.

DR. SALLEY: Thank you.

THE COURT: Unless you want to stay.

DR. SALLEY: I might think about it.

THE COURT: Madam forelady, ladies and gentlemen of the jury, I'm going to ask that you be back at 1:00. That's going -- we aren't going to be able to sit down for an executive lunch. We have to get something quick and come back. We're going to need to proceed forward. We have at least one more witness and we have closing arguments and we have the jury charge and there will need to be ample time for deliberations, so be back at 1:00, 1:00 sharp. Do not discuss the case in any way, shape or form.

(Jury out at 11:50 AM)

THE COURT: Anything? Be glad to hear from the Defense. Do you have anything further?

MS. CRAIG: Your Honor, that was our last witness. But before we rest, if I could just take a look at the exhibits to make sure we have everything in order. I think we do.

THE COURT: Why don't you take an opportunity to do that?

MS. CRAIG: Yes, sir, be happy to.

(Attorneys look at evidence)

MS. RODRIGUEZ: Judge, that's an issue on all of these records, that you can tell that, obviously, they've been redacted. Do you plan to say anything to them, to explain that we have -- that it's a trial and there's certain information that is not in. I'm not sure how we address that, because it's clear on all these records and everything that's been entered. It looks like we are trying to hide something

THE COURT: The only thing I can do to explain it is to say we are covering up inadmissible evidence, but I don't think that's necessary.

MS. RODRIGUEZ: Okay.

THE COURT: The more you talk about it, the worse it would be.

MS. CRAIG: I just asked Diane if she'd agree to us putting a copy of Dr. Goldstein's chart in as opposed to the original, because the original has the actual taped redaction and so you could take the tape off if you wanted to.

MS. RODRIGUEZ: Yeah, and that's my problem, Judge, that it now looks like if we admit their clean copy, it looks like this hasn't been redacted. This clearly, like all the other records, looks like it's been redacted.

MS. CRAIG: Diane, that's been redacted.

MS. RODRIGUEZ: I know that, but I'm saying that because of the copying process, you can't tell it's been redacted. Everything else is apparent that it's been redacted.

THE COURT: We are going to -- if y'all can agree to it, fine. Otherwise, it's going in. That's really not -- if you wanted it done differently, it should have been done differently, but now at this juncture, they have to be redacted like they are redacted unless you can see the information on there and then we aren't going to send them back.

MS. GANES: No, ours is perfectly redacted, like you can't even tell. It was redacted and copied and so you can't tell there's a redaction.

MS. CRAIG: Judge, you know, if she wants, we can put the original in.

THE COURT: You can put the original in. That's fine.

MS. RODRIGUEZ: I tried to get this done before.

MS. GANES: That's not true at all.

MS. CRAIG: Let's keep going, guys. So, Diane are you going to agree or disagree?

MS. RODRIGUEZ: I'm not agreeing to anything.

MS. CRAIG: All right. That's good to know.

MS. RODRIGUEZ: That's highlighted.

MS. CRAIG: Well, I can give you an un-highlighted copy.

THE COURT: Will you agree to the un-highlighted copy?

MS. RODRIGUEZ: Yes.

THE COURT: You will? All right. She will agree to the un-highlighted copy.

(Whereupon, Defendant's #1 is marked as Court's Exhibit #15, without objection)

THE COURT: Mr. Graham, we are going back on the record. Ms. Craig, you are recognized.

MS. CRAIG: Yes, Judge, we have reviewed the Defendant's Exhibits and they are in order and we are ready to rest when the jury gets back.

THE COURT: Very good. Any motions at this time from anybody?

MS. CRAIG: Yes, sir. On behalf of the Defense, we would now renew our motions for directed verdict and I can restate all the bases if you'd like, but move for directed verdict again under Rule 50, that the Plaintiff has not met her burden of proof. The only inference from the evidence presented is that they cannot meet their burden of proof on liability, causation and damages.

THE COURT: You are protected on the record and your motions have been renewed.

MS. CRAIG: Thank you.

THE COURT: Anything from Defense?

MS. CRAIG: Oh, I'm sorry, and also our motion to strike punitives.

THE COURT: Very good.

MS. CRAIG: Thank you.

THE COURT: I think, probably, prior to the charge, we will hear those arguments concerning punitive damages. I will allow y'all an opporutunity to get at least a cracker.

MS. CRAIG: And, Your Honor, I know I renewed all of the objections, I mean all the bases for the directed verdict, but also specifically, the Obstetrical Emergency Statute that I referenced earlier. Do you need the statute?

THE COURT: Yes. And you are requesting that be charged?

MS. CRAIG: Yes, sir, that it be charged and, also, as a matter of law that the statute applies and it's §15-32-230, Obstetrical Emergency Care Exception.

THE COURT: Do you have a copy of that?

MS. CRAIG: Yes, sir. I do. So, on that basis and all the bases stated previously we move for directed verdict on causation and liability and damages.

THE COURT: Be glad to hear from the Plaintiff with regard to the motions.

MR. RUFFIN: Your Honor, we take exception to their request for inclusion of the Obstetrical Emergency Statute. It is inapplicable as a matter of law to this case based on one of the exceptions included. They have offered zero testimony that Bryson F was medically unstable in this case. They've certainly talked about all the risks that can possibly happen to a child that is not gotten out in a certain amount of time, but they also offered testimony from their own witnesses that the child was gotten out within four minutes and that it takes at least six minutes for there to be any risk of brain damage. During the period of time that the events that are the subject of this litigation were occurring, Bryson F and his mother were medically stable and they've offered no, elicited no testimony from anyone on that point.

THE COURT: All right. Mr. Ruffin, be glad to hear from

you with regard to the motions for directed verdict.

MR. RUFFIN: Your Honor, with regard to the motions for directed verdict, they haven't -- we have still met our burden of proof and we established through multiple experts what the standard of care was and there was a breach of it. Dr. Gomez-Carrion did that and she also discussed breaches in the terms of rising to the level of recklessness. Causation was covered through Dr. Gomez-Carrion, through Dr. Resnick, Dr. Grossman. We certainly handled that issues. As to damages, we had life care planner, Mr. Forman and I don't think damages are really in question. Nothing that they have put up has in any way undermined any of the arguments that we previously made. They certainly spent a lot of time talking about what might have happened. You know, it might have caused brain damage, but that has nothing to do with what happened in this case.

THE COURT: All right. The motions for directed verdict are denied. I think there is at least a scintilla of evidence in that regard and that's the standard I'm held to at this stage. What do you think about the charging of the Emergency Medical Obstetrical Care Exception?

MR. RUFFIN: Your Honor, I don't think there has been any evidence presented. My position is that, I mean this is certainly an important issue. Our position is that -- and I've been paying very close attention to this area, because

we knew this was going to come up and they were going to attempt to include this in the jury instruction and even, perhaps, on the verdict form, but nobody said anything about this child being medically unstable. All they've done is ---

THE COURT: Well, they have talked about the five or seven-minute window to get all this done.

MR. RUFFIN: Which wasn't present in this case. Now, had he gone to the five or six-minute window, then there would be good argument this child was medically unstable, but as it stands right now, all they've done is said, "Well, the child could have been if this had happened," and then created the fear that this child could have been brain damaged, but the fact is ---

THE COURT: Do you think it's a question of fact? That the jury ought to ---

MR. RUFFIN: I don't think so. I think it's a matter of law and this is ---

THE COURT: We've had a lot of doctors say that this is an emergency and that if they didn't do something and do something in a hurry, the child would die.

MR. RUFFIN: Well, it's not a matter of being a medical emergency, because we know it's a medical emergency. The question is under the exception, is this child medically stable, and I argue that would be an objective standard, but even if it was subjective standard, nothing -- Dr. Goldstein

never said this child was not medically stable, he never said anything about, yeah, we were at the five to six-minute mark, the child -- I mean, as the term is defined as an exception, he was medically stable. The mother was medically stable, the child was medically stable, they were medically stable objectively based on all the expert's opinions of it and from subjective position of what Dr. Goldstein thought, himself. I mean, there were certainly conditions under which one might later become medically unstable, but that's not what the statute addresses. It says is this a situation where at this point in time ---

THE COURT: A genuine emergency situation. You concede that?

MR. RUFFIN: Yes. Shoulder dystocia is a medical emergency.

THE COURT: Involving an immediate threat of death or serious bodily injury.

MR. RUFFIN: The threat is there. If it had been seven, eight, nine minutes, that would have possibly become a reality. But the section 1, I believe it is, is applicable. We argue the exception to, a little bit further down, I can't quite remember exactly what sub-part it is, but it says A and B can be applied unless, and then it says, the patient is medically stable.

THE COURT: Okay, that's the point I'm asking you,

whether or not that's a question of fact.

MR. RUFFIN: Your Honor, I believe that, first of all, I believe it would be a question of law for the judge to handle what gets included in the jury instruction and on the verdict form, but more importantly, even if it is a question of fact, they have not introduced any evidence that Bryson F was medically unstable. They've talked about what might have -- they've certainly discussed ---

THE COURT: They talked about a peak in his heart rate or a drop, one of the two.

MR. RUFFIN: They did mention that, but that doesn't mean someone is medically unstable.

THE COURT: I think they all said if he didn't do it, there was going to be cerebral palsy or death.

MR. RUFFIN: Right, after eight minutes. The child might become medically unstable if enough time passes.

THE COURT: If I was in a spot where eight minutes might get cerebral palsy or dead, I would consider that to be an emergency.

MR. RUFFIN: I would agree 100%, it is an emergency, but he's also medically stable. That's the reason the subsection got put in there, unless he's -- if he's medically stable, it doesn't apply.

THE COURT: What do you have to say about that, Ms. Craig?

MS. CRAIG: Well, first of all, Your Honor, everybody testified it's a medical emergency and so that's undisputed. Secondly, even from the last witness, we have all of the conditions of the baby at birth is in evidence. We've moved all of the chart in. The baby, when it was born, had an APGAR score of one. That's the worst reporting that you can have. The documentation in the discharge summary was that the baby was floppy, hypotonic. The APGAR was one, the child was not medically stable. The pH was at a point where -- and this came from Nurse Collins yesterday, the pH was, when she said, "Seven go to heaven," I mean, it was barely at seven and so the child was not medically stable. In fact, there's been plenty of evidence about that and I do think it's a question of fact and I do think it would be appropriate to charge the jury on that statute, because this clearly was an emergent situation and if there's ever been a situation, a set of facts where that statute applies, it's this case.

MR. RUFFIN: And if I may reply briefly, first, she referenced the -- by Goldstein's own admission ---

THE COURT: What do you think about the APGAR score? I mean, that's probably the most telling ---

MR. RUFFIN: When it comes to the APGAR score, Your Honor, medically stable is the condition that the patient was at the time care is being provided. If the care provided is negligent and as a result the patient becomes medically

unstable, that's not what the statute is meant to cover. That's the reason the exception is there. If someone comes into your E-R and he's complaining of something and you leave him there for nine hours ---

THE COURT: I mean, those were clearly negligible. They, obviously, take the position that it was the shoulder dystocia that brought about all this medical emergency. Y'all say that it was the torsion of the neck and the traction that caused all these difficulties, but therein lies the problem and it seems like to me that y'all have plenty of evidence and you are arguing strenuously why they are the ones that caused the unstable condition, but they say that it was something else and that's why a jury is impaneled for, isn't it?

MR. RUFFIN: Well, Your Honor, I don't believe that that is exactly correct in terms of what is at issue here. The shoulder dystocia is what prevented the child from delivering out with obstetrical maneuvers. The shoulder dystocia, itself, did not cause the child to become medically unstable. The shoulder dystocia, itself, they may argue caused the brachial plexus injury, but that also has nothing to do with whether the child is medically stable or medically unstable. What I'm simply presenting to the Court is they have not provided any testimony at all that during the period of time that Dr. Goldstein was caring for this child, and the

shoulder dystocia was encountered, that the child, in any way, was not medically stable and through the course of four or five minutes, the child remained medically stable. We would argue that the child was medically stable under the definition of medical stability, I don't think that it's been defined yet, but certainly, it was stable. Now, if you want to argue that you believe that it's a question of fact as to whether or not an APGAR score of one means medically unstable, I submit to the Court that the mismanagement of an event that leaves one to become medically unstable does not meet the criteria for the Obstetrical Emergency Statute.

THE COURT: I think, probably, it's a question of fact. I'm inclined to charge. I'm going to give it some thought, but I'm inclined to charge that. Ms. Craig, do you have anything to add?

MS. CRAIG: I think this is the classic case for this statute to be charged. The child was very unstable. Not only was it the pH, the APGARs, the hypotonia, he was floppy, he was blue, he was limp. The nucal cord. I mean, what was going on was the baby was being strangulated every time the contractions would come, the cord would do this to the baby. That's why when he was born the APGARs were what they were and the pH was 7.1. So, the child was not medically stable. A far cry from it when he was born and during.

THE COURT: I understand the dilemma and my initial

impression is that it is indeed a factual question for the jury. There's plenty of ammunition on both sides for argument, and that's probably what y'all are going to do in a very able way. We are going to recess until 1:00. Hopefully, y'all will be able to get something to eat.

(Lunch Break)

THE COURT: Ms. Craig, I'm going to bring the jury out and recognize you.

MS. CRAIG: Yes, sir.

(Jury in at 12:59 PM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, that was a quick lunch, but thank you for being back, being back on time. We appreciate your patience and attention. At this time, I am going to recognize Ms. Craig.

MS. CRAIG: Thank you, Your Honor. At this time, the Defense rests.

THE COURT: Very good. Madam forelady, ladies and gentlemen of the jury, the Plaintiff has finished their case in chief. The Defense has completed their presentation of their case and under the rules of evidence, the Plaintiff has the burden of proof and so they have the opportunity for reply witnesses and so, Mr. Graham, you are recognized.

MR. GRAHAM: Your Honor, the Plaintiff calls Dr. Hall.

THE COURT: Dr. Hall, please come forward. Dr. Hall, place your left hand on the Bible and raise your right as the

clerk administers the oath.

(After being duly sworn by the Clerk of Court, MICHAEL HALL, MD, testified as follows:)

CLERK OF COURT: Please be seated and state your name for the record.

THE COURT: Dr. Hall, pull up real close to that microphone, speak loudly, clearly and slowly in order that we hear everything you've got to say. Let's start with your full name, please, sir.

DR. HALL: Michael L. Hall.

THE COURT: Spell that last one?

DR. HALL: H-A-L-L.

THE COURT: Very good. Thank you. Mr. Ruffin.

DIRECT EXAMINATION

BY MR. RUFFIN:

Q Dr. Hall, where are you from?

A I'm from Denver, Colorado.

Q How long have you lived in Denver?

A All my life.

Q Would you mind describing your educational background for us?

A Well, I went to the University of San Diego College and transferred up to the University of Oregon where I went to medical school and then I came back to Colorado to do my obstetrical and gynecology residency in Denver and

I've stayed there ever since.

Q Tell us something about your current practice.

A Currently, I'm in full time practice. I do about 50% obstetrics and gynecology and 50% gynecology and so I deliver about 15 babies a month. I am solo. I cross-cover with other physicians that are in our hospital.

Q Have you ever taught obstetrics?

A I've been teaching 35 years. I've been an assistant and a clinical professor. For most of that time I've taught obstetric residents. For about 20 years, I've taught family practice residents how to OB. I'm a clinician. I teach the hands on part of it. I don't do a lot of classroom teaching, but I do some, but I've been teaching physician assistants now every month. They come do rotations with me and so I have one with me about 40 to 50 hours a week. I have family practice residents rotate through my office. I teach them on a regular basis as they go through their rotations at the hospital.

Q I'm handing you a document. Could you please tell me what this is?

A My curriculum vitae.

Q And on your curriculum vitae, does it include anything related to quality assurance work?

A Yes, sir. When I was in the hospital where I did my

residency program, I was on staff there for 20 years and for 10 years I was on the quality assurance committee and I also was chairman of that committee and I was also on the committee at another hospital as far as revealing problems that we had and all that involved looking at the records.

Q Tell me a little bit more about this so I can have an understanding of what Q-A is and what is the objective of quality assurance.

A Quality assurance is where we actually try to police our own physicians to make sure their quality of care is meeting the standard of care. We look at their records. We look at trends and when a physician starts to have lots of problems, we look at why that might be. Some times it's drugs, sometimes alcohol, and we have to implement plans for those physicians.

Q And when you were doing this reviewing, would you, would you -- hold on one second. How many times during your quality assurance peer review, did you come across an admission from a care provider that he had actually committed malpractice?

MS. CRAIG: Objection, Your Honor. Relevance.

THE COURT: Sustained.

Q Fair enough. I'll move on. On your resume, I'm curious about one thing. What is the Denver Police Department

commendatory letter?

A It is a letter where I saw a wreck where a motorcycle was hit. I went and resuscitated the motorcycle rider until the ambulance got there and without that, he probably would have died and he was in the hospital for quite some time and what was kind of interesting, a couple of years later, he ended up coming down to my hospital and his wife was pregnant and in labor and they were coming to my hospital and they couldn't make it to the hospital because she was coming too fast and I ended up delivering that baby, and he looked at me and said, "Well, do you know who that is?"

Q One more question, did you point some fingers in this case?

A Yes, sir.

Q And was the methodology that he used to reach your expert conclusions accepted among those in your fields?

A Yes, sir.

MR. RUFFIN: Your Honor, at this point, I'd move to have Dr. Hall qualified as an expert witness in obstetrics, gynecology and causation of brachial plexus injuries.

THE COURT: Any query with regard to his qualifications?

MS. CRAIG: Yes, sir, Your Honor, but we have no objection with regard to Dr. Hall as an OB-GYN expert, but in his deposition that was just recently taken, he gave no

opinions as to causation and on page 86 of his deposition, he said he had no further opinions and on page 101, he said if he did have additional opinions, he would let the attorneys for the Plaintiff know so that they could let us know.

THE COURT: All right.

MR. RUFFIN: Your Honor, he answered the questions that were asked in a very short deposition and they asked him nothing about causation.

THE COURT: All right. Madam forelady, ladies and gentlemen of the jury, he, indeed, is qualified as an expert witness. You may proceed.

MS. CRAIG: Your Honor, may I be heard at side bar for just one minute?

THE COURT: Certainly.

MS. CRAIG: Thank you.

(Bench conference off the record)

MR. RUFFIN: Your Honor, may I continue?

THE COURT: Certainly.

Q Dr. Hall, what is your opinion, most probably, with a reasonable degree of medical certainty, as to whether or not there was a breach in the standard of care in this case involving the management of shoulder dystocia?

A There was a breach in the standard of care.

Q And what was that?

A Dr. Goldstein breached the standard of care in failing

to properly execute the maneuvers required to deliver a baby safely and he used excessive lateral traction, which is what caused the injury to this baby.

Q And how do you know that he used excessive lateral traction?

A A few things. This baby's injury included injury to all the nerves, which is a very severe injury, including neuromas ---

MS. CRAIG: Objection, Your Honor.

A --- which did not include...

MS. CRAIG: He's giving causation.

MR. RUFFING: I asked about the standard of care and didn't say anything about causation.

THE COURT: I'm going to allow him to testify in that regard. He's not really speaking about causation. He's talking about the severity of the injury. Go ahead.

A So, this very case tells me that he used excessive lateral traction, because that severe an injury doesn't come from just gentle maneuvering, gentle guidance of the head. It comes from severe lateral traction, which we have a history in the United States of many, many articles about injury being caused by excessive lateral traction. Another indication is that the nurse kept saying in her deposition he kept pulling and pulling and pulling and even in his own testimony, he says he's

using traction and pulling and that's the evidence of lateral traction and it's excessive because of the severity of the injury.

Q What about all the discussion of all the potential risks that might happen during a shoulder dystocia after six, seven, minutes passed? How does that affect your standard of care?

A Well, when an obstetrician is faced with an emergency, it's like a pilot being faced with an emergency. The first thing you have to do is calm down. You calm down, be cool, collected. We know that when faced with an emergency, we know that some physicians use more traction than they think they are using. They don't calm down and slow down. The -- what was the question again?

Q I was asking for the basis for that opinion.

A Oh, the basis for that opinion? So, that would be one of the bases used in excessive lateral traction. We have literature to support that. Most literature does support excessive lateral traction. The articles we saw today are in the minority and brought out as "what if's".

Q And when you are mentioning "what if's", did you notice anything in the medical record that indicated there was anything abnormal about the mother's pelvis?

A No, sir.

Q Was there anything to indicate that there was any

genetic predisposition?

MS. CRAIG: Objection, Your Honor.

A No, sir.

MS. CRAIG: You ruled on this. He's asking causation.

THE COURT: We are going to limit the inquiry to standard of care.

Q The shoulder dystocia -- actually, let me re-phrase that. What impact, if any, did Dr. Goldstein's induction rate have on your standard of care opinions?

A Well, that's kind of interesting. His induction rate is very, very high. An induction of labor, you know, in this case, was warranted because of the diabetes and they did it at an earlier age, but when you are inducing patients 75% of the time, that tells me as an obstetrician on a peer review committee, that that's excessive and that is putting the mother in danger. As we know, C-section rates are much higher if you induce patients unnecessarily.

MS. CRAIG: Objection, Your Honor. Move to strike.

THE COURT: Sustained.

Q How frequently -- what does his rate of the use of a vacuum tell you -- what does his operative vaginal delivery use of vacuum rate tell you about whether he's met the standard of care?

MS. CRAIG: Objection, relevance.

THE COURT: Overruled.

A We use vacuums and forceps in many cases and, you know, my rate is about 5% and that's fairly high because I do a high risk population. I have to do a lot of operative vaginal deliveries because I work with mid-wives and when they can't get a child out, obviously, they send them over and I usually either do a C-section or operative vaginal delivery. Forty percent, and my being chairman of the OB Department, 40% vacuum rate is very, very high and it tells me they are doing something in excess of what a normal, reasonable and prudent physician would do.

Q In light of a vacuum usage rate of somewhere around 40%, if a physician has a vacuum usage rate that high, what requirements would there be regarding informed consent and timing of informing a patient of the risks and benefits in the use of a vacuum?

MS. CRAIG: Objection --

A As for that, most patients should know ---

THE COURT: Hang on a minute.

A --- the procedural risks required ---

THE COURT: Excuse me.

MS. CRAIG: Relevance. May we approach?

THE COURT: Yes.

(Bench conference off the record)

Q If a physician uses a vacuum nearly half the time that he is delivering babies, what impact does that have on whether or not a physician should advise a patient of the risks and benefits of the vacuum usage?

A Well, if you use it that much, they should know it's a high possibility, at least 50%, that they are going to have an operative vaginal delivery and the risks of that.

Q And what about if a physician doesn't advise earlier on and elects to wait to use it during the course of delivery, should a physician at that point, still advise the mother of the risks and benefits of vacuum usage before it's placed on a baby's head?

MS. CRAIG: Objection, Your Honor, This is new opinion. There was not one question about informed consent in his deposition.

THE COURT: Sustained. Let's limit it to standard of care.

Q With regard to informed consent and the mother's prenatal care, do you have -- what is your opinion regarding the use of and change of this mother's medication to Metformin, a drug known to increase fertility?

MS. CRAIG: Objection, Your Honor. This is new opinion.

THE COURT: I'll allow him to answer it.

A During her prenatal care, she was switched to a medication often used in diabetes called Metformin. She was switched to that prior to getting pregnant, actually, and it does increase fertility rates in patients with polycystic ovaries and are not ovulating on a consistent basis and it helps them to ovulate. Polycystic ovaries is associated with diabetes and she also had gestational diabetes. We would tell them, certainly, if you were to use this drug, you are apt to get pregnant.

Q How does -- we know that the mother encountered, or the child encountered shoulder dystocia. Right?

A Yes, sir.

Q And a period of time passed during shoulder dystocia, when the baby was in shoulder dystocia. True?

A True.

Q Okay. Please tell us whether or not this child, for the period of time that the shoulder dystocia was encountered, was there any risk of brain damage?

A Well, during the four minutes directly before delivery, we see some variables. It's very common we see a cord wrapped around the neck, probably 17% of our babies, and a lot of those babies are delivered fine, they don't have shoulder dystocias, but they still have a low APGAR initially just because they have a cord around its neck

and so we unwrap it and give that baby a bath and stimulate their blood so that it can be resuscitated and during that four minutes, that baby was stable and had not deteriorated at that point.

Q How big of a deal is it for a well-trained obstetrician?

A We see it very commonly. We see the variables very commonly. I don't disagree that, you know, once those variables and the decelerations that they talked about become more significant, that the vaginal delivery was indicated and I don't have a problem with that. It's just very easy to say to the mother, "I can do a C-section now or I can put this suction cup on the baby's head and take it out and, you know, give her at least a two-second warning that you're going to do an operative vaginal delivery, which has some risk, but so does a C-section, but it seems to be a part of that.

Q At any time during the course of management of a shoulder dystocia, do you believe that conditions were such that a physician would have been justified to apply excessive lateral traction?

A No. We are all well trained not to do that in an emergency just like our pilots are trained to act quickly and not delay. We know if we've got to act in a responsible way that we have to use the maneuvers that we know are safe. We can't use excessive lateral

traction. We have to stop. We have plenty of time.

Q And when the mom and child were admitted to the hospital, were they medically stable at that time?

A Yes, sir.

Q And when the doctor applied the vacuum, were the mother and child medically stable?

A Yes, sir.

Q And during the course of the management of the shoulder dystocia, were the mom and child medically stable?

A Yes, sir.

Q And at the time of birth when the child was delivered, was the baby medically stable?

A Yes. It just needed some oxygen, he needed the cord unwrapped around its neck and get oxygen. Many of our babies have a low APGAR, but that doesn't mean they are not stable.

Q Explain to me the significance of a low APGAR score at one minute and five minutes.

A Well, a low, if you have a five-minute APGAR score that's low, you've probably got an asphyxiated baby or a baby that's in trouble and needs some more resuscitation. One minute APGAR scores are commonly low, especially with a nucal cord with or without dystocia.

Q Can you explain to the jury the difference between the risks that over a period of time a patient might become

medically unstable, and the presence of an obstetrical emergency?

A I'm not sure exactly what you mean.

Q What's the difference between a patient actually being medically unstable and the patient being in a situation where, if enough time passes, the patient may become medically unstable?

A All right. Potentially, any of our patients in labor can become medically unstable. There are lots of conditions where that can happen, especially after labor and they are hemorrhaging. If you don't do something about it, they will become unstable, but generally we do what's appropriate and meet the standard of care in order to treat those patients prior to that happening.

Q Did you see any evidence in the record at any particular point in time when Dr. Goldstein, himself, believed that the baby was medically unstable?

A No, sir.

Q And is a pH of 7.19 good, bad, in between?

A It's a little acidic, but it's not terrible.

Q Is it medically unstable?

A It depends on what you mean by unstable. I think this baby resuscitated very nice, did quite well. It did not get any evidence of Hib, which is brain damage that they were talking about earlier.

Q Based upon your review of the care provided by Dr. Goldstein and the testimony of pulling, pulling, pulling on the child's head, the testimony that he was on his knees, the testimony that he used the vacuum 75% of the time -- no, induces 75% of the time and uses the vacuum 40-50% of the time, please provide us, please tell us what your opinion of the quality of care that he provided to this patient.

MS. CRAIG: Objection, Your Honor.

THE COURT: Overruled.

A Given all that, that's in the record and in the depositions, he provided sub-standard care. He fell way below the standard of care. Excessive lateral traction, really, is the key issue. You can't do that, you can't blame something else for it, and especially if you don't know what that is. As in this case, with all the evidence, excessive lateral traction was the issue and it is due to excessive lateral traction that it is the majority of the time, especially when this severe.

Q Let's talk about that. When you have an injury where the C5, C6, C7, C8 and T1 are partially impacted, what does that tell you about how hard ---

MS. CRAIG: Objection, Your Honor.

Q --- he was pulling?

THE COURT: Your objection?

MS. CRAIG: Causation opinion.

MR. RUFFIN: No, it's standard of care. It's showing how hard the doctor pulled, which is the excessive traction.

MS. CRAIG: Your Honor, if I could just finish my objection?

THE COURT: Yes.

MS. CRAIG: The neurological issues that he is asking about, it's in the realm of a pediatric neurologist, which was previously addressed when the neurologist testified. And this opinion that he is trying to give is not in the realm of an OB-GYN.

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

Q Dr. Hall, for an injury, when you are looking at an injury and it affects C5, C6, C7, C8 and a part of T1, and includes a neuroma, what does that tell you about how hard the doctor was pulling on the baby's head?

A Within a reasonable degree of medical probability of more likely than not, the stronger the traction, the worse the injury.

Q What does the testimony about his arms trembling tell you about the amount of traction he was applying?

MS. CRAIG: Objection, Your Honor. Speculation.

THE COURT: Overruled.

A It shows excessive lateral traction and I think that's one of the issues. You have to be able to step back on

them and not use a lot of traction, but also the testimony did not describe using the internal maneuvers that do not put traction on the baby's head and just pushes the shoulder, which is how you reduce the shoulder dystocia, and so Dr. Coker actually came in and was able to reduce that very quickly after they called him.

MR. RUFFIN: Your Honor, we would like to proffer his proximate cause testimony.

THE COURT: All right. Madam forelady, ladies and gentlemen of the jury, I'm going to ask that you retire to the jury room. Do not discuss the case.

(Jury out at 1:32 PM)

THE COURT: Yes, sir.

MR. RUFFIN: Your Honor, we would like to admit into evidence the deposition transcript and the exhibits which include multiple articles which serve no other purpose than to discuss causation of brachial plexus birth injuries.

THE COURT: What do you have to say about that, Ms. Craig?

MS. CRAIG: I do not have the exhibits to the deposition. Could I see your exhibits? We only have a sealed copy. (Speaking to Mr. Ruffin) (Looks at document) Your Honor, it appears that most -- these are notes, there's a contract with the Graham Law Firm, he had a copy of the old ACOG bulletin,

the last article we used with Dr. Salley. There are, it looks like an index of something in here that I don't know what it is and there is an article by Margeta Moulder that is attached. But Your Honor, none of this is new material or reply testimony and I move to strike his entire testimony at this point. Like I said up at sidebar, with regard to the vacuum opinions, he was asked, in this case, he testified specifically the use of a vacuum is reasonable and then he was asked questions about the vacuum rate. That's not relevant in this case. The vacuum rate doesn't have anything to do with the actual use of the vacuum. The actual use of a vacuum, he said that was a reasonable thing to do, so I would move to strike all of his testimony as not proper reply and also, the opinions on causation. He was asked specifically if he had additional opinions and he didn't say that he had opinions about the most probable cause of the brachial plexus injury. He does have an article in here and he references one that I used, but he was asked specifically if he had new opinions that he let us know and we would reopen his deposition.

THE COURT: Very good. Well, you can proffer his testimony with regard to causation.

PROFFERED EXAMINATION

BY MR. RUFFIN:

Q Dr. Hall, what is your opinion within a reasonable

degree of medical certainty, most probably, as to the cause of Bryson's brachial plexus birth injury?

A The most probable cause is the excessive lateral traction which stretches the nerve to the point where it breaks.

Q Can you identify for me the articles where we discussed causation that are attached as exhibits to your deposition?

THE COURT: That particular question you've already proffered has actually been admitted into evidence, hasn't it? Didn't he say that?

MR. RUFFIN: I did, but I thought it would be helpful for him to identify them, but I can move on if it will save time, but I would like for him to just identify them.

THE COURT: If you are talking about questions you asked him about proximate cause, it's already been testified to in front of the jury, I believe.

MR. RUFFIN: I thought they objected to it.

THE COURT: I think he testified to it before the objection, but go ahead.

Q And the basis of your opinion is what?

A The basis of the opinion is the literature and knowledge I've gained over the years, but there is literature about excessive lateral traction, which has been established over the last 100 years and there are

references in many of the books like "Williams Obstetrics". They talk about excessive lateral traction as the cause. We have literature from clinics in perinatology, from clinics in perinatology, and I have a whole page that lists all the references that have to do with excessive lateral traction and that the forces applied to the head during labor as causative for this birth injury and, in fact, worldwide, the cause of the injury, more likely than not, was excessive traction.

Q What about the articles that were discussed about cases that discussed brachial plexus injuries without the presence of shoulder dystocia?

A Well, they presented one of those articles. It was Gerber's article that suggested that vaginal delivery is a risk factor and if you actually look at the data that suggests that, maybe 1% of brachial plexus injuries are due to an absence of shoulder dystocia, but their data shows that 99% of the time, it's associated with shoulder dystocia.

Q And what about any articles that discuss case examples that purport to be brachial plexus birth injuries in the absence of shoulder dystocia?

A Well, there was one that was listed as a reference in there neonatal sent a letter the brachial plexus treaties of 2004 that he had up here earlier in that

their reference to that specific cause of a permanent brachial plexus injury without shoulder dystocia or traction is actually a case that went to court and that case showed that yes, there was traction, there was a shoulder dystocia and so that is the basis of their opinion, which is wrong.

Q In this case, did you see, are you aware, do you offer any opinion whether or not genetics played a factor in causing this child's brachial plexus birth injury?

A There's no evidence of that.

Q Okay. And in this case, what is your opinion about whether or not the size of the mother's pelvis or the pelvic anatomy had any impact on the cause of this child's injury?

A There's no evidence that the pelvis was abnormal.

Q And did you see any indication from the medical record that there was incynclivism present in this case?

A No, sir.

Q Do you have an opinion of whether or not incynclivism was present in this case?

A No. Either way, I don't know if there was or not. If it is, it doesn't deviate the head that much.

Q Before the head delivers, is there enough room for the head to stretch sufficiently to cause a brachial plexus birth injury, a permanent injury?

A No. If that were to happen, then everybody that does obstetrics and done more than 1000 deliveries would have a permanent brachial plexus injury and that's just not the case. Sixty percent of physicians know how to do the maneuvers in an emergency to prevent that.

Q What about after the head delivers? Is there sufficient room after the head delivers when shoulder dystocia is encountered to stretch the nerves sufficiently to cause a permanent brachial plexus injury?

A After the head comes out there is then more room, especially when you are performing an episiotomy, there's more room that stretch and deviate the head. We've all seen that.

Q If it were possible for the brachial plexus to be injured prior to delivering the head, what requirements would there be of the physician with regards to Pitocin with use of forceps or use of a vacuum?

A I'm not sure I understand how that relates. If a brachial plexus injury occurs before the head delivers?

Q If it's possible.

A If it's possible, then certainly Pitocin increases the forces. Certainly, the vacuum, all it does is increase the risk of shoulder dystocia by pulling it through a small, narrow pelvis. Without it, it's associated with shoulder dystocia. It doesn't pull on the nerves in

particular, it just sets up the shoulder dystocia.

Q What is your understanding of whether or not shoulder dystocia is always reported in the literature when it is encountered?

A Say that again?

Q Is shoulder dystocia always charted when it's encountered?

A Of course not. There are plenty of studies that show that.

Q What significance does that have with regards to certain opinions that brachial plexus birth injuries can be caused in the absence of shoulder dystocia?

A Well, it certainly dilutes it. We've seen that. That's been discussed many times. A lot of the articles that I've used in my research has shown that and when it does, it also concludes that just because there's not shoulder dystocia doesn't mean that they didn't pull too hard prior to that and never recognized a shoulder dystocia.

Q Are you aware of any article that exists which provides evidence that a permanent brachial plexus birth injury with damage to multiple nerves can be caused by anything other than excessive traction applied by the person delivering the baby?

A There aren't many articles. There may be a few reports

on cause and compression, but then you would see the evidence in the baby of those issues. Outside of that, outside of other tumors, outside of amniotic banding, outside of other issues that are potential, but rare, no, there aren't any.

Q What about the baby's tone? What role does tone play, if any, to the susceptibility of a baby to a brachial plexus birth injury?

A Tone?

Q Tone, right. Whether he is floppy or not.

A We see that quite often. Most babies don't get brachial plexus injuries because they are floppy.

MR. RUFFIN: In the interest of time, I'm done with proffer.

THE COURT: Very good.

MS. CRAIG: Your Honor, may I add something to my objection, please?

THE COURT: Yes.

MS. CRAIG: You might recall that this is the way this lawsuit was identified in March of this year, but was actually was retained by the Graham Law Firm in 2013. We moved to exclude him and with regard to our request to limit him to standard of care only, because he wasn't identified as a causation expert, I would like to mark as a Court's Exhibit, Plaintiff's second supplemental answers to standard

interrogatories dated March 20, 2015, where Dr. Hall was identified as a witness and the Plaintiff said, "The Plaintiff has selected the following additional expert witness on standard of care" and it says, "Dr. Hall."

THE COURT: Very good.

MR. HOOD: I'd like to say something?

THE COURT: Yes.

MR. HOOD: I have never seen, in hundreds of trials, reply like that. This is nothing new. This is exactly what each of their witnesses have said. This is what has been gone into at length in cross of our witnesses. He's brought not one fact to this jury that's new. We've wasted an hour. I don't know why they are filibustering. Maybe they want to work on Saturday. I don't. And unless they have some true reply, let's end this mess and get on with closing arguments and end the case. Thank you. I've never had a circuit judge to allow this in South Carolina.

THE COURT: Very good.

MR. HOOD: Thank you.

THE COURT: Does that conclude your presentation?

MR. RUFFIN: Of the proffer. I've got maybe one or two questions.

THE COURT: Very good. We are ready for the jury.

(Jury in at 1:48 PM)

THE COURT: Mr. Ruffin, you are recognized.

MR. RUFFIN: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. RUFFIN:

Q What would Bryson's condition today be if Dr. Goldstein had not applied excessive lateral traction to his head during delivery?

MS. CRAIG: Objection, Your Honor. Speculative.

THE COURT: I'll allow him to answer.

A More than likely he would be a normal child.

MR. RUFFIN: Thank you. No further questions.

THE COURT: All right. You may step down. Oh, cross examination.

MS. CRAIG: Thank you, Your Honor.

CROSS EXAMINATION

BY MS. CRAIG:

Q Good afternoon, Dr. Hall.

A Good afternoon.

Q You were asked questions about prenatal care. Do you remember those questions?

A Yes, ma'am.

Q Would you agree that prenatal care that Dr. Goldstein provided to Ms. Fulton was reasonable and within the standard of care?

A Yes, ma'am.

Q So, all those questions you were asked about prenatal

care don't change your opinion that Dr. Goldstein provided reasonable and appropriate prenatal care to Ms. Fulton?

A Correct.

Q And based on your review of Ms. Fulton's prenatal care, Dr. Goldstein monitored her diabetes throughout her pregnancy. Correct?

A Yes, ma'am.

Q And it was reasonable and within the standard of care to do so?

A Yes, ma'am.

Q I think you were also asked about a C-section in your direct examination. You have no criticism of Dr. Goldstein for not ordering a C-section on Ms. Fulton. Correct?

A Correct. The mother wasn't unstable. The baby wasn't unstable. There was no reason to order a C-section.

Q Okay. So, in this case, all the talk about C-section really doesn't matter because a C-section was not medically indicated for Ms. Fulton. Correct?

A Well, not because of some of the issues. Had they continued the Pitocin, had they stopped the Pitocin for the abnormal fetal heart tones, then they may have gotten to the position of a C-section, which would certainly have avoided the injury.

Q But specifically, Dr. Goldstein did not violate the standard of care by not performing a C-section on Ms. Fulton. Yes or no.
A Well, given -- at that time, no.
Q No? I'm sorry. I didn't hear you.
A Would you repeat the question so I get it right?
Q Yes. Be happy to. Specifically, Dr. Goldstein did not violate the standard of care by not performing a C-section on Ms. Fulton. Do you agree or disagree with that?
A I agree with that.
Q All right. Moving on to Pitocin, your opinions on Pitocin. You saw the medical record where Dr. Goldstein ordered that the amount of Pitocin Ms. Fulton was receiving actually be reduced, go down. Correct?
A It should have been turned off because of the tacky system and the abnormal fetal heart pumping the nurse documented. Dr. Goldstein certainly should have been in control ---
MR. RUFFIN: Your Honor, I object to that.
A --- and he did turn it down, but he didn't turn it off.
MR. RUFFIN: I asked about that during the proffer.
THE COURT: I will sustain the objection.
Q All right. I think you were also asked questions about the vacuum rate. Correct? Do you remember that?

A Yes.
Q Do you remember that?
A Correct.
Q Okay. You were asked questions about a vacuum rate, but you weren't asked questions about whether or not it was reasonable for Dr. Goldstein, in this case, to use the vacuum and I'd like to ask you, Dr. Hall, do you agree with me that it was reasonable and appropriate for Dr. Goldstein to use the vacuum in this case?
A It is reasonable in this case given some of the variables that were showing up because of the nucal cord to do that, but having known that, yes, vacuum rate does increase your risk of shoulder dystocia sevenfold and, in this case, you've got a diabetic with a large baby and if you are using a vacuum you are certainly increasing the rate of shoulder dystocia, but you have to know that going in.
Q So, Dr. Hall, do you agree or disagree that it was reasonable for Dr. Goldstein to use the vacuum in this case?
A I answered that, yes.
Q Yes. Thank you. When confronted with severe decelerations during the delivery, a reasonable doctor would attempt to expedite delivery. Correct?
A Well, you have to look at the degree and length of time

and I don't have any problems with him -- but he has to know when he's doing that he's increasing the risk of shoulder dystocia.

Q Do you agree or disagree that when confronted with severe decelerations during a delivery, a reasonable doctor would attempt to expedite delivery? Is that something you agree with or disagree with that?

A Depending on what they are seeing, I don't disagree with that.

Q Okay. ACOG, you'd agree that ACOG is the primary association for members of your profession ---

MR. RUFFIN: Objection, Your Honor. I did not ask any questions about ACOG.

THE COURT: Sustained.

Q You were asked some questions about shoulder dystocia and you'd agree that it would be unpredictable. Correct?

A It's foreseeable. It's also, we have to anticipate it. Predictability, there are a lot of things we can't predict in life.

Q Okay. Why don't we go ahead and get your deposition out.

MS. CRAIG: Your Honor, may I approach?

THE COURT: Yes.

Q Your deposition was taken recently, correct?

A Yes, sir.

Q And you've testified in a lot of cases for Mr. Graham

and for other Plaintiff attorneys, so ---

MR. RUFFIN: Objection.

THE COURT: It's cross examination. It's wide open cross examination. She may ask anything she wants to.

Q Doctor, you are familiar with depositions, correct?

A Yes, ma'am.

Q You've given a lot of them. Right?

A Yes, ma'am.

Q Okay. So, let's start with page 56, line 9, and it says, "Okay, on a general level you would agree that shoulder dystocias can be unpredictable," and then you said, "They can be." Is that correct?

A Yes.

Q Okay. And then how about they can be unpreventable. Do you agree or disagree that they can be unpreventable?

A Shoulder dystocia?

Q Yes, sir.

A Sure.

Q Do you agree that Dr. Goldstein ordered and tried to use McRoberts position and suprapubic pressure. Correct?

A He tried.

Q And that was a reasonable thing to do?

A Along with lateral traction, he used those two. Yes.

Q Was it a reasonable thing to use McRoberts and suprapubic pressure? Yes or no.

A Yes.
Q And it was within the standard of care. Correct?
A Yes.
Q Now, I believe that you are aware of were involved in a delivery where a baby's shoulder was stuck and you were unable to get the baby out. Do you remember that testimony from your deposition?
A No. I had a rapid delivery and the baby wasn't stuck.
Q Okay, and the baby died?
A No.
Q Let's look at page 80 and the question at line 11 says:
Q Can there be a situation where you've hit the four-minute mark and the baby hasn't delivered, you hit the six-minute mark and the baby hasn't delivered, is there some time after that, that it would be appropriate to use excessive lateral traction or by whatever means necessary to get the baby out?
Q Your answer?
A You know, again, it depends on the situation, what's going on.
Q And at line 19, you're asked"
Q Could that be a situation like that?
Q And you said:
A Well, I've had a situation where they couldn't get it out in 15 minutes and the baby died. I mean,

there are those situations. They are not common, but they are possible.

Q Did I read that correctly?

A Well, that was a case of a situation that I was reviewing. It wasn't my case. It was a situation in another case.

Q Yes, sir. And my question was, did I read that correctly.

A And I was explaining what that meant.

Q Yes, sir, but did I read it correctly?

A And I'm explaining that situation wasn't my situation. It was another person's situation.

Q Okay, but ---

A I just wanted to clarify that.

Q But did I read the portion of your testimony that was taken in Denver on April 21, 2015, did I read that correctly?

A I think you read it correctly. I'm not sure it was interpreted correctly.

Q Okay. Now, you cannot quantify the amount of traction that a doctor uses during delivery of a child. True?

A Well, we can because we've delivered hundreds and hundreds of babies. We know what a normal amount of traction is just from our technique over the years. We can't quantify it with a number with a pressure gauge.

We don't do that.

Q Okay. Let's go to page 26 of your deposition. Just let me know when you are there.

A Okay.

Q At line 19, you are asked:

Q Would you agree that it is difficult to quantify the amount of traction that a physician uses during the delivery of a child?

Q Your answer at line 22 was:

A Well, we can all quantify it by the fact that we've done hundreds of normal vaginal deliveries. We know what normal traction is. The quantification is something we learn with hands-on delivery.

Q Is that correct?

A Correct.

Q So, you cannot quantify traction. Is that fair?

A Quantify in terms of numbers? No, we can't. We don't. We quantify it in how we normally would deliver babies. So, you would know how much pressure you normally would use. That's what I said there.

Q And in the years of your experience, you would agree that the amount of traction that you feel is normal versus the amount you think is excessive cannot be quantified. Is that right?

A Technically. We don't have sensors on our fingers.

Q Thank you. That's my question. And you cannot put a figure on the amount of traction that Dr. Goldstein used in the delivery of Bryson F . Would you agree with that statement?

A Correct.

Q You would agree that the use of gentle downward traction is appropriate during the delivery of a child?

A Yes, ma'am.

Q And, in fact, all doctors have to use some degree of gentle downward traction during every delivery or most deliveries. Correct?

A Most deliveries.

Q Well, you use downward traction in just about every delivery you do.

A Just about.

Q Now, a physician, like yourself, can deliver a baby with brachial plexus injury and it does not always mean that the doctor did something negligent. Correct?

A It depends on each case.

Q Now, you've had a case where you had to delivery a baby with a brachial plexus injury.

A That was a temporary injury.

Q And you consider yourself not negligent in the course of that delivery. Right?

A Correct.

Q Now, you are aware that in this case, Dr. Goldstein attempted to do rotational maneuvers after the initial McRoberts and suprapubic pressure did not work. Correct?
A That was not mentioned in his delivery notes. That maybe was mentioned later in his deposition that rotational maneuver was tried, but he said he couldn't get his hand in there and so I don't know how he did that.
Q Okay. So, you didn't see the notation by Dr. Goldstein where he said other rotational maneuvers were attempted? Did you see that documented in the medical records?
A I don't recall that.
Q Okay. But you do agree that he attempted to do these maneuvers, but he couldn't get his hand in. Is that right?
A That's what I said, he couldn't get his hand in.
Q And it's reasonable in light of the fact McRoberts wasn't working and suprapubic wasn't working, it was reasonable for Dr. Goldstein to attempt to put his hand inside the vagina to try to do rotational maneuvers. Would you agree with that?
A Yes, ma'am.
Q And Dr. Goldstein, when he was unable to get his hand in the vagina, he extended the episiotomy. Right?
A Yes.
Q And that's something that you would do if you had the

situation of a shoulder dystocia, McRoberts wasn't working, suprapubic pressure wasn't working and you weren't able to put your hand inside to do a rotational maneuver, you would go ahead and extend the episiotomy?

A Correct. And then you can put your hand in once you've extended that episiotomy and do the appropriate maneuvers and the rotational maneuvers

Q And was it the standard of care to extend the episiotomy? You have no criticism of that. Right?

A And then go ahead and do the maneuvers you need to do. He didn't do those, but... He extended the episiotomy, but he didn't do the maneuvers after that.

Q Okay. You said that you haven't seen any medical records that mentioned other rotational maneuvers were attempted. Correct?

A He attempted them. He didn't do them.

Q Did you see the medical record that documents that other rotational maneuvers were attempted? Did you see that?

A It said, "attempted".

Q You saw that medical record. Correct?

A Correct. And then if he did the episiotomy, that would actually allow him to actually do those maneuvers.

Q But you don't know where that head was and how much room there was and whether or not you could get your finger in based on where that baby was at that specific time

after that episiotomy was extended. Correct?

A Well, he had more room at that time and you would have to assume that he would be able to get in at that point. Sure.

Q And that's an assumption. Right?

A Well, no. When I do an episiotomy, I have to put my fingers in there to do an episiotomy and so there's room. Otherwise, you would be cutting the baby.

Q But that's an assumption. Correct, sir?

A No, that's something I do when I do episiotomies. I've done them hundreds of times.

Q All right. Let's get back to the episiotomy. Do you agree or disagree that it was the standard of care to extend it? Yes or no.

A I agree that that's within the standard of care.

Q All right. And it's also within the standard of care when this emergency was noted was to call for help from another doctor or ask for additional nurses. Correct?

A Yeah, but it could have been done minutes earlier.

Q Okay. And you would agree that this was a medical emergency?

A Sure.

Q Now, let's talk about your experience as an expert witness. You've been doing this type of work testifying as an expert witness for over 15 years?

A For 15 years. Yes.
Q And 95 to 100% of the work that you do are on behalf of the plaintiffs, the party who sues another party. Correct?
A Correct.
Q You've given over 100 depositions.
A Correct.
Q And you even advertise your services as an expert witness so you can get more cases.
A No, I don't.
Q You didn't use to advertise your services as a paid expert witness?
A I used to.
Q You used to. Now, you've testified for Ms. Fulton's lawyer in at least four other cases. You've helped Mr. Graham with four other cases. Correct?
A Probably.
Q Okay. Twenty percent of your income comes as your work as a paid expert witness. Correct?
A Correct.
Q And you've never testified in a deposition or in a trial on behalf of the doctor, that the doctor complied with the standard of care when presented with a shoulder dystocia during delivery. Is that right?
A Correct.

Q And you've never testified in a case where a child suffers a brachial plexus injury that was caused by something other than excess traction.

A I don't take those cases. I've reviewed them, but I don't take them.

Q What is the answer to my question, sir?

A What was your question?

Q You have never testified in a case where a child suffers a brachial plexus injury that was caused by something other than excess traction.

A Correct. But I never take those cases.

Q And you've never testified on behalf of the doctor in a case where there was a shoulder dystocia. Correct?

A Correct.

Q Now, you were hired in this case by Ms. Fulton's lawyers back in 2013, I believe it was June 14, 2013. Is that correct?

A Correct.

Q And you sent them a retainer. Correct?

A They sent me a retainer.

Q A contract for a retainer.

A Correct.

Q But you were identified as a witness in this case in March of 2015. Were you aware of that?

A No, ma'am.

Q So, you don't know why you were hired in 2013, but you weren't identified by the lawyers as being a witness in the case until March of 2015?
A I have no idea.
Q You received a retainer from the Graham Law Firm so you could give your opinion. Correct?
A That was the idea.
Q And you charge $500.00 an hour?
A Yes, ma'am.
Q Four thousand dollars a day for your trial testimony?
A Correct.
Q Do you charge for flying from Denver, Colorado, to Florence?
A They pay for that, technically.
Q Now, you recently testified for Mr. Graham in another trial in Greenville, South Carolina. Correct?
A Which one was that?
Q It was the last time you testified in South Carolina. It was a Greenville trial where there was a hospital being sued and you were an expert witness for Mr. Graham and you were the reply witness at that trial. Do you remember that? You were the last witness to testify.
A The Ballenger case? Yes.
Q And do you remember how you used the same analogy in that trial about the pilot? Do you remember talking

about the pilot in that trial, the same way you are doing in this trial? Do you remember talking about that in that trial?

A I don't recall that, but I wouldn't doubt it.

Q In that trial where you testified for Mr. Graham, in that case there was excessive traction. Correct?

A Correct.

Q The same opinion that you are giving in this case. Correct?

A Correct.

Q And you also testified in that case along with Dr. Grossman, Dr. Resnick, Mr. Forman, and Dr. Gomez-Carrion. Is that correct?

A As I recall, yes.

Q All the same experts that are in this case. Correct?

A Correct.

Q Same opinions?

A Different facts, same opinions.

Q Nothing but a factory line, isn't it?

MR. RUFFIN: Objection. Argumentative.

THE COURT: Sustained.

Q Those are all the questions I have. Thank you.

THE COURT: Any redirect?

MR. RUFFIN: A little bit, Your Honor.

REDIRECT EXAMINATION

BY MR. RUFFIN:

Q Dr. Hall, you were asked whether you had supported a case that was caused by something other than traction. How many cases have you seen where there has been a significant, severe injury to the brachial plexus that was caused by anything other than physician applied traction?

A Very rare and even the literature supports that fact.

Q You were asked some questions about some case where it took 15 minutes to deliver a baby. Was that a baby that you were in charge of?

A No, that was a case that -- a situation in a case that I had.

Q What do you mean in a case that you had?

A I reviewed a case where the baby wasn't delivered for 15 minutes and died. I didn't take that case. It was a shoulder dystocia case.

Q And why wouldn't you have taken that case?

A It was just no way to have gotten the baby out and the baby died. It took two of them to get the baby out. It was that big.

Q How big was the baby?

A It was 11 pounds.

Q How many babies have you delivered in your career?

A About 8000.

Q And how many permanent injuries have you had ---

MS. CRAIG: Objection, Your Honor. Beyond the scope.

MR. RUFFIN: It's not. She asked a question about his temporary injury, I can certainly follow-up about a permanent one or if there has been a permanent one.

THE COURT: I'll allow the question.

Q Of the 8000 babies that you have delivered or overseen in the course of your career, how many children have been born with a permanent brachial plexus birth injury?

A None.

Q What do you attribute that to?

MS. CRAIG: Objection.

THE COURT: I'll allow him to answer.

A Well, most physicians, 60% of physicians know how to deliver a baby without injuring the brachial plexus. Even though we know it's an emergency, we have to act calmly in order to do that and I just attribute that to using the safety maneuvers we know how to use and don't put excessive traction. We stop and don't use excessive traction, which I know to be what I usually use, which is gentle traction, and we all know what that is, because we've done it so many times. We know to be calm and not use excessive force. The first thing I teach the residents is not to use excessive traction. We tell them that, just use the traction you are used to using and

don't go beyond that. If you have to, then you have to use those other maneuvers.

Q You were asked about the Ballenger trial that you offered testimony in. Do you recall that case involving a first-year resident?

A Yes, I recall.

Q What is the experience level of first-year resident in terms of managing shoulder dystocia?

MS. CRAIG: Objection, Your Honor. Relevance.

THE COURT: Sustained. We don't need to be trying the Greenville case.

Q And you were asked some questions about quantifying, I guess in Newtons and pounds of force, the actual quantitative amount of traction that Dr. Goldstein applied. Do you remember that?

A Yes.

Q Can you explain to us by what you mean by excessive traction?

MS. CRAIG: Objection. Asked and answered.

THE COURT: Sustained.

MR. RUFFIN: One final question.

Q We know it was enough traction to rip apart the nerves in his neck, though. True?

MS. CRAIG: Objection. Argumentative and leading.

THE COURT: Sustained. You may step down.

MR. RUFFIN: May he be excused?

THE COURT: Yes. Any further witnesses from the Plaintiff in reply?

MR. GRAHAM: No, Your Honor.

THE COURT: Very good. Madam forelady, ladies and gentlemen of the jury, I'm going to ask that you retire to the jury room. Once again, do not begin deliberations. Do not discuss the case.

(Jury out at 2:13 PM)

DISCUSSION OF THE VERDICT FORM

THE COURT: Anything from the Plaintiff?

MR. GRAHAM: Your Honor, we looked at the verdict form yesterday. That was before the issue came up about the emergency statute and the issue about medically stable or unstable. Does Your Honor intend to have anything -- I mean, we don't know what you've ruled yet. I guess you implied you were inclined to let that in, but in case you didn't, have you given thought to whether that would be on the verdict form?

THE COURT: I have thought about it. What is your position?

MR. GRAHAM: Well, if Your Honor, please, we don't believe there has been a showing -- especially now that Dr. Hall has testified, we don't believe there is an adequate factual showing ---

THE COURT: Let's move beyond the factual. I know what the factual arguments are. I know what you are going to say. I know what Ms. Craig is going to say. The issue is, whether or not, if I charge it, should it be on the verdict form and if it is, I anticipate it being almost like an interrogatory asking those questions and then if they find it was, indeed, a medical emergency and there was immediate threat of death and serious bodily injury then the patient was not medically stable. Just ask that interrogatory and if they find in favor of that, they stop deliberations and don't move further, move beyond that.

MR. GRAHAM: Well, then they would go on to whether we met the heightened standard of care.

THE COURT: The gross negligence. Yes. All that will be on there in the form of an interrogatory, but if they were to find that this statute applies, it would end it.

MR. GRAHAM: I respectfully disagree, Your Honor. I mean, we know there's an emergency. Either we are at a crossroads where they need to find whether or not the patients were medically stable. If they were, that statute has no effect on whether their deliberations. If they find the patients were medically unstable, then we have to meet a heightened standard of culpability, more than simple negligence.

THE COURT: All right. What is your position with regard to the verdict form?

MS. CRAIG: Your Honor, just like on a tort claims act. You would put it in there like a special interrogatory. I see no difference between that in a torts claim's special interrogatory and this statutory. I agree that if they find this was an obstetrical emergency, the absence of gross negligence, then their deliberations are over.

THE COURT: And you say that it is not.

MR. GRAHAM: No, sir. I may have misunderstood you, Your Honor. I thought you said that if they found that the statute applied, then their deliberations were over.

THE COURT: No. They've got to meet a heightened standard of gross negligence.

MR. GRAHAM: Yes, sir. If they find that the patients were medically unstable and we've failed to meet the heightened standard of culpability, then at that point I agree their deliberations would be over. If that's what you said, then I just misunderstood you.

MOTIONS

THE COURT: Okay. All right. Any motions at this time?

MR. GRAHAM: Your Honor, we move for a directed verdict on two minor points. One is, that general hospital consent form is not informed consent. It does not purport to be. It does not represent informed consent as a matter of law. And number two, we believe that we meet all of the elements of a cause of action for informed consent as a matter of law. They

keep saying there is an emergency, but there was not an emergency the day before when this man with a 40 to 50% vacuum rate sat down with his patient and had every opportunity to tell her she had a 50% chance of getting, at least a 50% chance, of getting a vacuum used the next day. A vacuum is implicated as significantly increasing the risk of shoulder dystocia which caused all the problems, because it was not managed properly.

THE COURT: All right. You are noted on the record. Any other motions?

MR. GRAHAM: No, Your Honor.

THE COURT: Any from the Defense?

MS. CRAIG: Your Honor, do you need to be heard from me on the informed consent?

THE COURT: No.

MS. CRAIG: All right. Then, we would renew our motion for directed verdict and we also renew our motion to strike punitive damages.

THE COURT: Your motion for a directed verdict is denied. I believe there is, indeed, a scintilla of evidence and given the evidence that's been presented, I think it would be reversible error for me not to charge punitive damages and I will, indeed, do that.

I have never, since I've been on the bench, limited someone's closing argument, but I can have a tendency to

believe that there might be a too long closing argument.

MR. GRAHAM: Oh.

THE COURT: I'm sorry. Ms. Rodriguez?

MS. RODRIGUEZ: I'm doing it.

THE COURT: All right. How much time do you need, Ms. Rodriguez? I will give you the time that you need, but I just don't think we need to spend all day on it.

MS. RODRIGUEZ: We're not. We've been trying to cut down on it. My hope is to go 30 minutes, so I would say 45 would be my max. But I'm hoping to get it done in 30, because I'm not going to do all the medicine and all that.

THE COURT: That would certainly be reasonable, I think. Do you think that gives you enough time?

MS. RODRIGUEZ: I'll try my best. Obviously, I think 45 minutes would be the longest I'd go, but here's my question to you. I really need to know what you are going to do with the verdict form, because I will need to address that and how that is going to read in terms of the, in light of the emergency statute. We've always had a charge conference before I've done closing and I know they submitted a lot of charges this morning and a lot of them seem duplicative to me and we had talked before about the insured versus the guarantor language. I noticed the charge that they submitted puts the word insured back in there. You know, they've put in some judgment charges. I'm not sure what you are going to end

up charging.

CHARGE CONFERENCE

THE COURT: Well, I'm not going to read the whole charge to you, but I am going to say that ---

MS. RODRIGUEZ: And Judge, I think we didn't -- the gross negligence issue didn't come ---

THE COURT: "When a doctor treats a patient, the law does not require perfection. The law does requires that the doctor use that degree of knowledge, care, and skill ordinarily possessed and used by doctors in good standing in the doctor's field of medicine, under the same or similar circumstances and that the doctor follow the generally accepted practices and procedures in the profession." And there's other language in here that says they don't guarantee the results. "A doctor is not an insurer of a cure or even a positive result."

MR. GRAHAM: Your Honor, I thought that ---

THE COURT: "A doctor is not an insurer of a cure or even of a positive result. Therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not, in and of itself, mean that the defendant was negligent. A bad result, injury, death, or failure to cure is not, by itself, enough to show that the defendant was negligent." It goes on to say, "Similarly, a doctor's mistake or error in making a decision, alone, does

not constitute negligence. If, however, a doctor fails to gather information reasonably available which a reasonable doctor would have gathered before making a decision and the doctor fails to comply with the recognized standard of medical care which would be exercised by a similar doctor under similar circumstances." That addresses that particular issue.

As far as the Plaintiff's request to charge, I'm not going to charge the first one. To some extent, it's covered in my charge, but I think, that in and of itself, I'm not going to charge. I'm not going to charge No. 2. I've never charged concerning insurance. And No. 15, pre-existing condition, I'm not exactly sure where that came from. Who put that in there? I don't think that applies.

MR. RUFFIN: I'm not sure it does, either, Your Honor. I withdraw it.

THE COURT: It was a mistake, then?

MR. RUFFIN: I was thinking about a pre-existing condition and put it in there.

THE COURT: And No. 17, tort law seeks to protect safety, interest and is rooted in the concept of protecting society as a whole from physical harm. That very well might be covered somehow in my charge, but I'm not going to charge that. The rest of them are covered in my charge. That's the Plaintiff's requests.

Burden of proof, that's covered in the Defendant's request. Burden of proof, malpractice. That's covered. Burden of proof, proximate cause. No. 5 is covered. No. 6 is covered. No. 7 is covered. No. 8 is covered. I think I actually read a portion of that. Expert testimony, that's covered. Standard of care, that's covered. Expert testimony, that's covered. No. 12 is covered. No. 13 is covered. No. 14 is covered. No. 15 is covered. No. 16 is covered. No. 17 is covered. No. 18 is covered. No. 19 is covered. No. 20 is covered. No. 21 is covered. No. 22 is covered. Sympathy charge, I'm going to charge. No. 26 is covered. No. 27 is covered. No. 28 is covered. No. 29 is covered. No. 30 is covered. No. 31 is covered. No. 32, 33, 34, 35, 36, 37 is covered. No. 38 is covered, 39 is covered, 40 is covered, 41, and 42, and obviously, y'all are going to have the opportunity to listen to my charge and make additional requests afterwards.

MS. GANES: Your Honor, No. 25, I'm not sure if I missed it or maybe...

THE COURT: That's the sympathy?

MS. GANES: No, bad results.

THE COURT: That is, indeed, covered.

MS. GANES: Okay. I figured. I just wanted to bring it up. I didn't hear you call it out for the record.

MR. HOOD: Judge, the ones from the Plaintiff that you

did not read out. Are you going to charge them or are you going to use your own form?

THE COURT: I'm going to use my own form of those, but the ones I specified will not be charged.

MR. HOOD: Okay. We would add to that, based on what we argued earlier about informed consent. We request their No.4 not be charged. I mean, they've got very detailed charges in here on the different elements of law, like: concurrent cause, proximate cause, standard of care, but you have your standard charge?

THE COURT: I do.

MR. HOOD: So, we won't argue about those. They've got something in here about respondeat superior. That doesn't apply to this case.

THE COURT: I think there are two different -- I didn't think so, either, but there are two different parties who are named; the business and Dr. Goldstein.

MR. HOOD: There hasn't been any testimony about it.

THE COURT: I think they've been named as a party and I think they are one and the same and it doesn't make any difference.

MR. HOOD: That's No. 21.

THE COURT: What is the Plaintiff's position on that?

MR. GRAHAM: Your Honor, it suits us just fine to combine those into just a single liable party. I think the liability

or non-liability of the business rises and falls with the evidence.

THE COURT: I agree. In view of the fact there are two parties, I do think we need to charge respondeat superior and I plan on doing that.

MR. HOOD: The last two, foreseeable intervening actors. I don't know what that's about.

THE COURT: Well, you know, as far as proximate cause, all of that is simplified in my charge. It's not ---

MR. HOOD: That's their No. 22.

THE COURT: Right. And I'm also going to charge No. 43, Defendant's request to charge No. 43.

MR. HOOD: Thank you.

MS. RODRIGUEZ: Judge, could you tell us which one that was? I lost my track here.

THE COURT: It's the obstetric emergency care exception.

MR. RUFFIN: And Your Honor, one minor point. There's been some previous discussion about whether or not to, when there is a discussion about guarantor, but you use the word insure in the charge that says a physician cannot insure a certain result or even a positive result. It's our position that it cannot be a guarantee of a cure or certain result ---

THE COURT: All right. Your objection is noted, but that's what has been approved by -- the law supports that language and so, that's what I'm going to charge.

MR. RUFFIN: And, Your Honor, are you including a charge that defines gross negligence and, if so, I was wondering how it is defined?

THE COURT: It says, "Gross negligence is the failure to exercise even the slightest care, while negligence is the failure to exercise due care. That's about as simple as you can get.

MR. RUFFIN: Your Honor, I think there is another definition that I've found that says, it means, "The absence of care that is necessary under the circumstances." It says it's also been defined as. And that's found in Pack and Associates versus Marine Institute.

THE COURT: There's also going to be some discussion about gross negligence and willfulness and the punitive damage charge, but as far as it relates to this, there's just going to be a short definition of what gross negligence is.

I have not prepared the verdict form, but what I'm going to do is do it in the form of an interrogatory and if, indeed, their finding is such that the obstetrical emergency care exception is met, then it would end the deliberations and there would have to be a finding of gross negligence, thereafter. Now, I'm not sure exactly how I'm going to fashion that verdict form, but I'm in the process of doing that and I will, indeed, share that with you before I give it to them.

We are going to take about a five minute recess and then we will come back and you indicated that 45 minutes would be the most that you would need and since you indicated that, I'm going to kind of give you an indication around 40 minutes if you haven't finished and I will give you some leeway in that regard, but I think that would be reasonable given the length of the case.

MS. RODRIGUEZ: Okay. And then he's going to do the second closing.

THE COURT: All right. And how much time would you need, Ms. Craig?

MS. CRAIG: I'll keep it, I'll try to do 45 minutes, as well.

THE COURT: Okay.

MS. CRAIG: And if I talk more than that, there will be a lot of people on this side fussing at me.

THE COURT: All right. So, what will be a reasonable amount of time in reply, Mr. Graham?

MR. GRAHAM: We ask that the Plaintiff open fully as the rule applies.

THE COURT: And I anticipate that they will.

MR. GRAHAM: Thirty minutes, Your Honor.

MS. CRAIG: Oh, wow.

MR. HOOD: Thirty minutes is not reply. That means he doesn't contemplate a full opening. He's playing games with

you and us. If he gives an argument, he should give a proper reply argument.

THE COURT: All right. I'm not really going to engage on limiting -- certainly no more than 30 minutes and you will be held to that, but obviously, you need to be aware of the jury's attention.

MR. GRAHAM: Yes, sir.

THE COURT: All right. We are ---

MS. CRAIG: Your Honor, after they do their closing, could we just take a break so we can set up things?

THE COURT: Yes.

MS. CRAIG: Okay. Thank you.

THE COURT: We'll take about five minutes.

(BREAK)

THE COURT: The verdict form is going to have a Roman numeral I, that applies to the obstetrical medical emergency exception. It's going to say, "Do you unanimously find that the facts of this case arise out of a general emergency where the patient is not stable and there is an immediate threat of death," and it has a "yes" where they can check yes or no. It says, if yes, the Plaintiff must prove gross negligence. If no, the Plaintiff must prove simple negligence." Any objections from the Plaintiff?

MS. RODRIGUEZ: Yes, sir, Your Honor.

MR. RUFFIN: Your Honor, is it separated out so that it's

not stable and then immediate harm or is it not stable and, and just one check? Because if it's not stable, if it's just medically stable, then I think the exception doesn't apply. It would have to be both, not stable and.

THE COURT: What does the Defense have to say?

MS. CRAIG: I think you read exactly what the statute says.

THE COURT: Yes.

MS. CRAIG: So, that's ---

THE COURT: Now, you can argue and/or if you want to, but that's the way it's going. Any objection from the Defense with regard to the verdict form?

MS. CRAIG: No, sir, Your Honor.

THE COURT: All right.

MS. CRAIG: And is the physician/patient relationship still on there?

THE COURT: It is not.

MS. CRAIG: Okay. Then, no objection.

MR. RUFFIN: May we see ---

THE COURT: Why would anyone care about that one way or the other? I just did that as a matter of form because that's something they are required to prove, but why would that -- Ms. Rodriguez, you seem to be grimacing over there, but why would that make any difference whatsoever? It aggravated me more because I had to change the verdict form, but it makes

absolutely no difference. How could that make a difference?

MS. RODRIGUEZ: Judge, it seems odd things make a difference to a jury and the same reason they don't want it on there, I want it on there.

THE COURT: I just don't understand it either way, but at any rate, it's off and if you object to me taking it off, you can make the necessary objection.

MR. GRAHAM: May we have it, Your Honor?

THE COURT: Well, I don't have it yet.

MR. GRAHAM: Oh.

THE COURT: But I can show you in the handwritten form what it looks like if you want to see it.

MR. GRAHAM: Will we have the typewritten form before closing starts?

THE COURT: Well, we are fixing to start here in about two seconds. Come look at this.

MS. CRAIG: Your Honor, I think he wants to use it to show it to the jury and since we both don't have it, just ask that we just talk about the verdict form.

THE COURT: Just talk about it.

MS. CRAIG: And we don't want him to use it in reply.

(Bench conference)

THE COURT: All right. Ms. Rodriguez, are you ready?

MS. CRAIG: Your Honor, it looks like Ms. Rodriguez is going to use this blowup from a text. This is the text that

our expert, Dr. Jacobson, was asked if it was authoritative and reliable and he said, "No", and so, of course, under 803(18), that ends the questioning and that is not in evidence, so.

THE COURT: We certainly can't use that.

MS. RODRIGUEZ: I thought it was.

MS. CRAIG: Is there anything else that is not in evidence that I need to look at? Otherwise, I'll be fine with it.

MS. RODRIGUEZ: All that I have out is the progress notes and the consent.

MS. CRAIG: The what?

MS. RODRIGUEZ: The consent.

MS. CRAIG: As long as it is in evidence.

THE COURT: Ms. Rodriguez, are you ready?

MS. RODRIGUEZ: Yes, sir.

THE COURT: Ms. Craig, are you ready?

MS. CRAIG: Yes, sir.

THE COURT: All right. We are ready for the jury.

(Jury in at 2:50 PM)

THE COURT: Madam forelady, ladies and gentlemen of the jury, you've heard all the evidence to be presented in this case. Now, we are going to move forward with closing arguments. Closing arguments are very similar in form to the opening statements that you heard at the beginning of the

approach the bench?

(Bench conference off the record)

THE COURT: Mr. Graham, do you have an objection to the verdict form?

MR. GRAHAM: Your Honor, we would ask that Your Honor remove the footnotes from the bottom of the page.

THE COURT: What does the Defense have to say about that? We are talking about the breach of the standard of care. It reiterates what simple negligence is, what gross negligence is, in a very simple way. Do you have an objection to that?

MR. HOOD: No, sir. I think it's a good idea to have it and I think it will help them.

THE COURT: And do you have an objection to that?

MR. GRAHAM: To the footnote, yes, sir.

THE COURT: All right. Your objection is noted. I think it helps them understand that there are two different levels of misconduct on that particular breach. If the exception applies it's got to be gross negligence and I think they need to know what that is.

MR. GRAHAM: Yes, sir. Your Honor, also, it tells her that we must prove gross negligence.

THE COURT: What do you suggest we do?

MR. GRAHAM: I don't know.

THE COURT: That's what negligence is, the breach of the standard of care and one requires careless negligence and

case.

(Jury out at 5:13 PM)

THE COURT: Anything from the Plaintiff before we proceed?

MR. RUFFIN: Your Honor, I just want to make sure we are protected with our objection to the obstetrical emergency exception on the verdict form and we just believe that the not medically stable or medically stable is it's on basis by which to avoid the obstetric medical emergency exception.

THE COURT: My position is it's a question of fact for the jury. We are ready for the jury.

(Jury in at 5:22 PM)

CHARGE ON THE LAW

Madam forelady, ladies and gentlemen of the jury, you have heard all of the evidence, you have heard the closing arguments and now it's going to be incumbent upon you to deliberate. But before you do that, your job is going to be, you've taken a solemn oath to listen to the evidence, to determine what the truth is and apply it to the law. You've spend about a solid week hearing the facts and now it's my responsibility to charge you the law. I wish there was an easy way to do that, but it's sort of like taking medicine. There ain't no easy way to do it. It's late in the evening. I understand that, but this is important stuff. So, I want you to perk up, sit on the edge of your seat and pay very close

attention. It's a lot of information that you need to know in order to do this right. Pay very close attention.

I remind you that, during this trial, you and I have certain duties to perform. As the trial judge, it is my responsibility to preside over the trial of this case, and I also have the duty to rule on the admissibility of the evidence offered during this trial. You are to consider only the evidence before you. You are to consider only the testimony which has been presented from this witness stand, any exhibits which have been made a part of the record in this case, and any stipulations of counsel.

I have the additional duty to charge you the law. It is your duty as jurors to accept and apply the law as I now state it to you. If you think you have any idea as to what the law is or what the law ought to be and it does not agree with what I tell you the law is, you must forget that idea because you are sworn to accept the law and apply the law exactly as I state it to you.

In every case tried in this court before a jury, the jury becomes the sole and exclusive judge of the facts. A trial judge cannot comment on or make any statement about the facts in a case. Since you are the sole judges of the facts, do not think by anything I have said during the trial that I have any opinion about the facts in this case. The law does not allow me to have an opinion about the facts.

The burden of proof in this case is by a preponderance of the evidence. A preponderance of the evidence simply means the greater weight of the evidence. It is evidence which, as a whole, shows that the fact sought to be proved is more likely true than not true.

This can be illustrated by imagining a set of scales. When the case begins, the scales are even. After all of the evidence has been presented, if the scales remain even or if they tip even slightly in favor of the Defendant, then the Plaintiff has failed to meet the burden of proof and would not be entitled to recover in this case. If, on the other hand, the scales tip even slightly in favor of the Plaintiff, the Plaintiff will have met the burden of proof and you should return a verdict for the Plaintiff. The preponderance of the evidence is not determined by the number of witnesses. Instead, it must be determined by the greater weight of all of the evidence.

There are two types of evidence generally presented during a trial - direct evidence and circumstantial evidence.

Direct evidence is the testimony of a person who claims to have actual knowledge of a fact, such as an eyewitness. It is evidence which immediately establishes the main fact to be proved.

Circumstantial evidence is proof of a chain of facts and circumstances indicating the existence of a fact. It is

evidence which immediately establishes collateral facts from which the main fact may be inferred. Circumstantial evidence is based on inference and not on personal knowledge or observation. It is proof that does not actually establish the fact in question, but that asserts or describes something else from which you may either reasonably infer the truth of the fact or at least reasonably infer an increase in the probability that the fact is true. For circumstantial evidence to be sufficient to warrant the finding of a fact, the circumstances must lead to that fact with reasonable certainty. The facts and circumstances should be considered in light of ordinary experience and common sense. The existence of a fact cannot be based on speculation, surmise, or conjecture.

The law makes absolutely no distinction between the weight or value to be given to either direct or circumstantial evidence. Nor is a greater degree of certainty required of circumstantial evidence than of direct evidence.

Necessarily, you must determine the credibility of witnesses who have testified in this case. Credibility simply means believability. It becomes your duty as jurors to evaluate the evidence and determine which evidence convinces you it is true.

In determining the believability of witnesses who have

testified in this case, you may believe one witness over several witnesses or several witnesses over one witness. You may believe a part of the testimony of a witness and reject the remaining part of the testimony of that same witness. You may believe the testimony of a witness in its entirety or reject the testimony of a witness in its entirety. You may consider whether the witness has an interest in the result of the trial, whether the witness is prejudiced toward either the Plaintiff or the Defendant, the opportunity for the witness to have seen the matters and things about which the witness may testify, and the way the witness acts on the witness stand.

The rules of evidence ordinarily do not permit witnesses to testify to opinions or conclusions. An exception to this rule exists for witnesses we call expert witnesses. A witness who, by education and experience, has become expert in some art, science, or profession, may give an opinion as to the subject the witness claims to be an expert in, and may also give the reasons for the opinion.

You should consider any expert opinion given by a witness and, like any other evidence, give it the weight you think it deserves. If you decide that an expert witness' opinion is not based on sufficient education and experience, or if you decide that the reasons given in support of the opinion are not sound, or that the opinion is outweighed by

other evidence, you may disregard the opinion entirely.

An expert witness' testimony is to be given no greater weight than that of other witnesses simply because the witness is an expert, and you do not have to accept an expert's opinion, even though it is uncontradicted.

The Plaintiff claims that the Defendant committed medical malpractice which is a form of carelessness or negligence. In order to recover for medical malpractice, the Plaintiff must prove by a preponderance, or greater weight, of the evidence: (1) the standard of care; (2) a breach of the standard of care; (3) proximate cause; and (4) damages.

In order for a doctor to owe a duty of care, there must be a doctor/patient relationship. The relationship of doctor and patient is a consensual one where the Plaintiff knowingly seeks the assistance of the doctor, and the doctor knowingly accepts the Plaintiff as a patient.

Normally, a doctor is not legally required to give medical services to anyone, even in the case of an emergency. However, a doctor/patient relationship can arise under a variety of circumstances. There may be a direct agreement or an implied agreement.

If a doctor voluntarily gives medical services, the doctor must use due care in treating the patient.

Whether the Defendant and the Plaintiff in this case had a doctor/patient relationship is a question of fact for you

to decide, considering all of the evidence before you. If you find that a doctor/patient relationship existed, then you must decide the standard of care the Defendant owed ot the Plaintiff.

The Plaintiff must prove the standard of care the Defendant owed to the Plaintiff in treating the Plaintiff.

When a doctor treats a patient, the law does not require perfection. The law does requires that the doctor use that degree of knowledge, care, and skill ordinarily possessed and used by doctors in good standing in the doctor's field of medicine, under the same or similar circumstances and that the doctor follow the generally accepted practices and procedures in the profession.

Next, the Plaintiff must prove that the Defendant negligently departed from this standard of care in treating the Plaintiff.

Negligence is the failure to do what an ordinarily careful doctor in the Defendant's field of medicine would have done under the same or similar circumstances or the doing of something that an ordinarily careful doctor would not have done under the same or similar circumstances.

A doctor is not an insurer of a cure or even of a positive result. Therefore, the mere fact that a treatment does not benefit the patient or that it even harms the patient does not, in and of itself, mean that the Defendant

was negligent. A bad result, injury, death, or failure to cure is not, by itself, enough to show that the Defendant was negligent.

Similarly, a doctor's mistake or error in making a decision alone does not constitute negligence. If, however, a doctor fails to gather information reasonably available, which a reasonable doctor would have gathered before making a decision, the doctor fails to comply with the recognized standard of medical care which would be exercised by a similar doctor under similar circumstances. The fact that a doctor acts on the advice of another doctor who is a specialist is not an absolute defense to a claim that the doctor failed to use the required skill in treating the patient.

The difficulties and uncertainties in the practice of medicine and the unpredictable variations in the response to treatment are such that no doctor can guarantee results. Where there is more than one recognized diagnosis or treatment and no one of them is used exclusively and uniformly by all doctors in good standing, it is not negligence for a doctor, in making a decision, to choose one of the approved methods, even when the choice later turns out to be a wrong selection. Qualified doctors and experts may differ as to what constitutes the best course of treatment and these differences do not amount to malpractice. Where

doctors in good standing disagree or when medical authorities are divided with regard to a specific course of treatment or care, then the doctor is bound only to exercise his best judgment in determining which course on the whole is best for the patient. Just because another doctor might have used a different course of treatment does not make the Defendant negligent. However, if a doctor does not have the degree of learning and skill required or if the doctor does not use the care required, it is no defense to a charge of negligence that the doctor did the best that he could.

In considering whether the Defendant made a reasonable decision, you must consider the decision in relation to the facts as they existed at the time, and not in light of what hindsight may reveal.

Finally, the Plaintiff must prove that the Defendant's negligence proximately caused the Plaintiff's damages.

Proximate cause is something that produces a natural chain of events which, in the end, brings about the injury. It is the direct cause of the injury.

To prove that the Defendant's negligence proximately caused the Plaintiff's injury, the Plaintiff must first prove causation in fact. This is proven by showing that the injury would not have occurred but for the Defendant's negligence.

The Plaintiff must also prove legal cause. Legal cause is proven by showing that the injury was foreseeable. This

means that the injury occurred as a natural and probable consequence of the Defendant's negligence. The Plaintiff must prove that some injury from the defendant's negligence was foreseeable, but does not have to prove that the particular injury that occurred was foreseeable. However, the Defendant cannot be held responsible for something which could not be expected to happen.

Proximate cause does not mean the only cause. There may be more than one proximate cause. The Defendant's act can be a proximate cause of the Plaintiff's injury if it was at least one of the direct, concurring causes of the injury.

A patient who is treated by a doctor is entitled to a careful evaluation. An evaluation should be made with diligence and diagnoses that are usually approved and practiced by doctors of ordinary learning, judgment and skill acting under the same or similar circumstances. In order to prove that the Defendant was negligent, the Plaintiff must prove that: 1)the patient's physical condition required a sufficient need to investigate further before continuing the course of treatment or care; 2) the Defendant did not make this investigation; 3)it was a direct and proximate result of the Defendant's failure to investigate, the patient received improper treatment or care in which the patient later suffered injury.

I'll charge the law with regard to informed consent.

A doctor has the duty to inform a patient of known risks or endangerment of the treatment or procedure that the doctor proposes so that the patient will be able to make an intelligent decision of whether or not to follow the doctor's proposed treatment.

In the absence of an emergency which requires immediate treatment, a doctor must tell the patient of: 1) the diagnosis 2) the general nature of the proposed procedure 3) the material risk involved in the procedure, 4) the probability of success associated with the procedure, 5) prognosis if the procedure is not done and 6) the existence of any alternative to the procedure. Risks which a doctor has to disclose are those risks material to the proposed procedure.

A risk is material if a reasonable person in the patient's position would find it significant whether or not the proposed treatment procedure, the possible injury greatly outweighs the possible benefits to be gained from the procedure this may be a material and significant factor the patient will be entitled to know before giving consent to the procedure. As a probability or severity of the risk to the patient increases, the duty of the doctor to tell the patient of the risk increases. The doctor must tell the patient of those risks an average, competent doctor with similar training in the same branch of medicine would tell a patient

of under the same or similar circumstances.

In determining whether and how much to tell a patient the doctor must consider what effect the information may have on the patient considering the patient's psychological, emotional, and physical condition. When a doctor reasonably believes a complete and truthful disclosure of the risks might have a detrimental effect on the physical or psychological well-being of the patient, the doctor is not required to disclose the risks.

In addition, the doctor must evaluate how great the risk is, how often it happens and the feasibility of alternative treatment. A doctor is not ordinarily required to disclose a risk to a patient where the risk is small and remote. In order to prove the Defense's failure to inform was a proximate cause of the patient's injury, the Plaintiff must prove that a reasonable person in the patient's position would have refused the treatment or procedure had the doctor informed the person of the risks that resulted in the patient's injury, not simply that the patient would have refused the treatment.

Informed consent is not required in an emergency situation because consent to a serious emergency operation may be implied. Even under the emergency exception to the informed consent doctrine, a physician should seek the consent of the patient or if the patient is incapable of

providing consent, consent of a family member before administering the treatment. In practicability of conferring with the patient is a prerequisite to dispensing with informed consent under the emergency exception. A physician's duty to disclose is suspended if an emergency of such gravity and urgency exists that it is impractical to obtain the patient's consent in which case consent is implied.

In an action involving a medical malpractice claims arising out of care rendered in a genuine emergency situation in an obstetrical sweep where the patient is not stable and there is a threat of death or serious bodily injury to the patient, no physician may be held liable unless it is proven that the physician was grossly negligent.

Grossly negligent. Let me define what that is. Gross negligence is the failure to exercise even the slightest care while negligence is the failure to exercise due care.

Actual damages. If you decide that the Plaintiff is entitled to a verdict, your next step should be how much money the Defendant should be required to pay. Actual damages will compensate the Plaintiff for the injuries or loss. You put the Plaintiff in as near as possible in the same position the Plaintiff was in before the incident occurred. In other words, actual damages will be the actual losses and expenses which the Plaintiff has suffered.

The Plaintiff must prove that the expenses caused by the

injury were necessary and reasonable. Actual damages for a Plaintiff who has been injured include: pain and suffering, both past and future as well as mental anguish, impairment of health or physical condition and disfigurement. The Plaintiff may also claim reduced earning ability for the future.

In determining the amount of compensation for personal injuries, it is proper to consider past and present aspects of the injury. This would include physical and mental pain and suffering, expenses incurred for necessary medical treatment, loss of enjoyment of life suffered as a result of the injury and any other losses that are reflected by the character of the injury. The injured party may recover for those future damages that are reasonably assured to result from the injuries. The principle underlying compensation for future damages is that only one action can be brought and, therefore, only one recovery had.

It is proper to include, in the estimate for future damages, compensation for the loss for capacity for work or potential Plaintiff's ordinary business, future medical expenses and pain and suffering which will, with reasonable certainty, result.

Pain and suffering compensate the Plaintiff for physical discomfort and the emotional response to suffering and pain caused by the injury itself. There's no definite standard by which to compensate the Plaintiff for pain and suffering. You

have the authority to determine the amount, if any, to be allowed for pain and suffering using calm and reasonable judgment insuring that the damages are just and reasonable in light of the testimony and evidence presented in this case.

Loss of enjoyment of life compensates the Plaintiff on the limitations of Plaintiff's ability to participate in and derive pleasure from the normal activities of daily life.

Mental suffering, apprehension, shock, fright, emotional upset, humiliation, anxiety either present or expected in the future can be properly considered as an element of damages. The amount of damages for mental suffering cannot be exactly measured.

Ladies and gentlemen of the jury, the Plaintiff's entitled to cover -- is never entitled to recover for conjectural or speculative damages. If you find the Plaintiff is entitled for actual damages, your verdict should include an amount to cover past, present and future damages which were proximately caused by the Defendant. Any future damages must be reasonably certain to occur in the future as a result of the Defendant's acts.

Actual damages may not be proven to a mathematical certainty or, based on the evidence, a precise amount of damages that the Plaintiff has suffered. Instead, the evidence must allow you to determine what amount of damages are fair and just and reasonable under these circumstances.

Any future damages must be reasonably calculated to result from the alleged injury or damages sustained in this case. Future damages must be reduced to their present cash value.

The loss of impairment of earning capacity resulting from the injuries to the Plaintiff is a proper element of damages. To determine the amount of damages due to loss or impairment of earning capacity, you should consider the following: Future earning power. This requires you to consider all matters that relate to any impairment. The effect in which the injury will affect the Plaintiff's capacity to work, the extent to which the impairment will impair the Plaintiff's earning capacity, the present value of all losses due to the Plaintiff's impaired earning power, the physical pain and suffering reasonably certain that will result in the future from the injuries to the Plaintiff.

In awarding damages for impairment of earning capacity, the Plaintiff may recover from the loss of increased earning capacity during his entire expectancy of life. If you determine the Plaintiff is entitled to damages for impairment of earning capacity, then you must decide the amount of damages using the life expectancy table as a guide.

I'll explain what the life expectancy table is. If you find that the Plaintiff was permanently injured as a result of the Plaintiff's actions, you must then decide, if at all,

how, if at all, that injury will affect the rest of the Plaintiff's life. A person's life expectancy is determined by the life expectancy table, which is a part of the laws of the state. The life expectancy table is only an estimate of the probable average of any length of the life of all persons in our state at a given age. The Plaintiff, a five year old male with a life expectancy, according to the life expectancy table, is 71.8 years. This fact is to be considered by you along with any other facts and circumstances from the evidence bearing on the Plaintiff's life expectancy.

The Plaintiff is required to use reasonable diligence and care to reduce the seriousness of the injuries caused by the Defendant. The duty includes making a reasonable attempt to see a doctor and to take part in physical therapy programs. If you find that the Plaintiff failed to do this, the Plaintiff may recover damages for the injuries, themselves, but not damages for the aggravation of the injuries.

I'm going to charge you the law regarding punitive damages. If you award actual damages, you may also consider the award of punitive damages. Punitive damages are intended to punish the Defendant for extraordinary and outrageous misconduct to prevent the Defendant and others from committing similar acts in the future. Punitive damages can only be awarded when the conduct of the Defendant has been

something more than mere negligence. The evidence must establish that the Defendant's acts were reckless, willful and wanton, meaning there was a conscious failure to exercise due care or a conscious indifference to the rights and safety of others in reckless disregard thereof.

If you find that the Defendant's conduct was willful, wanton or reckless, you made award the Plaintiff punitive damages. It's important, for punitive damages, the Plaintiff must prove by clear and convincing evidence that the conduct complained of included a consciousness of wrongdoing at the time of the conduct.

Clear and convincing is more than a preponderance or greater weight of the evidence, which requires only proof which persuades you that the party's claim is more true than not true. On the other hand, clear and convincing proof is not as high a standard as proof as in a criminal case, which is proof beyond a reasonable doubt. Clear and convincing proof leaves no substantial doubt in your mind. It means that the evidence is not ambiguous doubtful, inequitable or contradicting. Convincing means persuading by proof or argument causing one to believe the truth of what is asserted. Clear and convincing proof establishes in your mind, not only the fact is probable, but it is highly probable.

Before awarding punitive damages, you must weigh and

consider four elements which may be pertinent to the facts in this case. You must first consider the relationship between any punitive damage award and the harm caused. Any penalty imposed shall take into account the reprehensibility of the conduct, the harm caused, the Defendant's awareness of the conduct, of the conduct's wrongfulness, the duration of the conduct and any concealment. Thus, any penalty imposed should bear a relationship to the nature and extent of the conduct and the harm caused, including any compensatory damage aware made by you.

Secondly, any penalty imposed should take into account as a mitigating factor, any other penalty that may be imposed for the conduct involved including any criminal or civil penalty or any other punitive damage award arising out of the same conduct.

Next, you should consider whether the award of the amount of -- the amount of punitive damages award may deprive the Defendant of any profit derived from the improper conduct or whether ill-gotten profit should be properly awarded to the Plaintiff.

Finally, any award of punitive damages should be limited to punishment, thus may not affect economic bankruptcy. To this end, the Defendant's ability to pay any punitive damage award should be considered. However, the economic bankruptcy factor is not an absolute bar to the award of punitive

consider four elements which may be pertinent to the facts in this case. You must first consider the relationship between any punitive damage award and the harm caused. Any penalty imposed shall take into account the reprehensibility of the conduct, the harm caused, the Defendant's awareness of the conduct, of the conduct's wrongfulness, the duration of the conduct and any concealment. Thus, any penalty imposed should bear a relationship to the nature and extent of the conduct and the harm caused, including any compensatory damage aware made by you.

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Next, you should consider whether the award of the amount of -- the amount of punitive damages award may deprive the Defendant of any profit derived from the improper conduct or whether ill-gotten profit should be properly awarded to the Plaintiff.

Finally, any award of punitive damages should be limited to punishment, thus may not affect economic bankruptcy. To this end, the Defendant's ability to pay any punitive damage award should be considered. However, the economic bankruptcy factor is not an absolute bar to the award of punitive

damages.

I charge you that as jurors you must decide the issues in this proceeding based solely on the evidence which you hear during the course of this trial. Your verdict must be without bias and without prejudice to any party. You cannot allow yourself to be governed by sympathy, prejudice or compassion or by some other consideration not found in the evidence.

Bear with me as I come forward to share with you the verdict form. Mr. Hyman and Ms. Reeves, you are the alternates. I'm going to send the jury back momentarily. I'm going to ask that you stay in the jury room. Bear with me as I go over the verdict form with you. (Stands in front of the jury)

Madam forelady, I'm going to ask that you stand as I go over this verdict form. This is just a document entitled "Verdict Form" and it seems fairly lengthy, but it's simple as we go through it. It says: The State of South Carolina, County of Florence, and it's got the names of the parties and names of the Defendants. We are in the twelfth circuit, here in Common Pleas in Florence County. It's entitled "Verdict Form". The first item deals with the law that I've charged you dealing with Obstetrical Medical Emergency Exception and it says: 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? If yes, the Plaintiff must prove gross negligence, a higher standard. If no, the Plaintiff must prove simple negligence.

The second one deals with the breach of the standard of care. The Plaintiff must prove that the Defendant breached the standard of care. If you say yes, proceed forward to roman numeral one. If no, discontinue deliberations, because for there to be a recovery, as you've understood the law, it has to be a breach of the standard of care. With regard to the breach, there is a footnote that deals with the standard that you have to apply. If the obstetrical emergency Exception does not apply, the Plaintiff must prove simple negligence, that the Defendant has failed to do something that a reasonable person would have done in the same situation. If the Obstetrical Medical Emergency Exception applies, Plaintiff must prove gross negligence, that the breach was more than carelessness, but a failure to exercise even a slight degree of care.

It goes on: In order for there to be a recovery, there has to be proximate cause. There is a place for you to determine and it is completely within your province to make all these calls and then if you do determine that there is liability, you will be called upon to calculate the actual damages consistent with the law that I've charged you and the evidence that you've heard. There is a place right here,

numerical. It's sort of like a check. You write down the numbers here and you write down in cursive, like you would a check so that we make sure there is no confusion with regard to decimals. I say, cursive, but young people write print now, but cursive is the way old people do it, they write it out.

Punitive damages. If you find actual damages, you may consider punitive damages. That is completely within your province. You make that call as to whether or not you do that. If so, and you were to determine in your discretion and in your collective wisdom, you determine that punitive damages are appropriate, then you would do the same thing, numerical and cursive. There is a place for you to sign and date. When you have completed the questions, notify the bailiff. I hear tell up in Greenwood County that there was a jury that stayed back there three days. They didn't knock on the door, so we want to make sure that you knock on the door.

The verdict must be unanimous. I've told you when you've exited the courtroom not to begin deliberations. Once again, I'm going to ask that you not do that. I'm going to talk to these very fine lawyers as to whether or not they have an objection to the way I charged the law. If they don't have an objection, I'll send all the documentary evidence into the jury room and tell you to begin deliberations. It might be necessary for you to come back out so I can clarify some

point of law.

If there is a question that comes up, Madam forelady, reduce that question to writing, give it to the bailiff and I will be happy to answer it, but I don't think there are going to be any questions, because y'all have heard the evidence and the hard questions in this case, y'all are going to have to answer them, the factual ones. I can't have an opinion as far as the facts. If there is a question about the law, I can answer that. If in your mind you can't decide whether or not it is a legal question or a factual question, write it down and I'll help you in that regard, but I don't feel you will have a question because you've heard the evidence and you've paid close attention to the law. I don't anticipate that.

The verdict must be unanimous. It can't be eleven to one, six to six, eight to four. Everybody has to agree. Madam forelady, it is your job to preside over the deliberation process. Essentially, what that means is, you are to ensure that everybody's voice is heard. Does that sound fair?

MS. FLOYD: Uh-huh.

THE COURT: All right. I'm going to ask, if you could, to take the verdict form, retire to the jury room, but do not begin deliberations.

(Jury out at 5:56 PM)

THE COURT: Mr. Hyman, Ms. Reeves, thank you so much for being here. I know y'all feel like y'all got invited to the

dance, but didn't get to dance, but y'all are welcome to stay and find out what the results are. I know it's Friday evening and you have other things to do. If you have some curiosity about it, you can call the clerk's office and they will be happy to share the result of this matter or this is a public forum, you may stay if you'd like.

MR. HOOD: Your Honor, before you excuse them, we may need one of them if you agree with us.

MS. CRAIG: May we have a sidebar?

THE COURT: Yes.

(Bench conference off the record)

THE COURT: I want to thank y'all so much for your participation and your willingness to be here. We appreciate y'all so much, we want to keep you around in case we need you, so the clerk is going to find a place for y'all and y'all were able to order a sandwich, weren't you?

MS. REEVES: Yes, sir.

THE COURT: So, the sandwiches are here. Why don't y'all sit there and then we will move forward. Do not discuss the case amongst yourselves and we will ask that you stay with us. I know that seems like sort of a hardship, but this case has taken a lot of -- you've heard how expensive it is and how much time it's taken and it very well might be that we need you here, so please stay with us and follow William and he'll bring you your sandwiches.

I'm going to ask that the Plaintiff and Defendant to come forward and I want everybody to put the articles of evidence right in front of the court reporter and we will make a determination that everything going back is into evidence and there's not anything in this pile that's not in evidence. (Attorneys comply)

THE COURT: Ms. Rodriguez, is everything in this pile in evidence?

MS. RODRIGUEZ: As far as I can tell, Your Honor.

THE COURT: Well, do you want to look anymore?

MS. RODRIGUEZ: I'm satisfied.

THE COURT: Is there anything in that pile that is not in evidence?

MS. RODRIGUEZ: No, sir.

THE COURT: All right. Ms. Craig, is everything in this pile in evidence?

MS. CRAIG: Yes, sir.

THE COURT: Is there anything in that pile not in evidence?

MS. CRAIG: No, sir.

THE COURT: I'm going to ask that you take the documentary evidence and put it in this box and give them some pens and blank pieces of paper.

THE COURT: Any objection with regard to the charge, Mr. Graham?

MR. RUFFIN: Do you mind if I address it?

THE COURT: No, sir. Not at all. All right. Let's have order.

MR. RUFFIN: Your Honor, nothing other than what I said previously about the gross negligence. There are two or three definitions that are included and I think that just including the slight care one is the one most favorable to the Defendant and I think it would be more accurate to include the other definitions, as well. I think that's it. I mean, if we start, you know, we've already got our question about the verdict form...

THE COURT: Your objection is noted. Anything further?

MR. RUFFIN: No, sir.

THE COURT: Ms. Craig, any objection to the jury charge?

MS. CRAIG: No, sir. Just, when you are ready, I would like to put about juror #21 on the record.

THE COURT: All right, and you can do that.

MS. CRAIG: You want me to do that now?

THE COURT: Yes.

MS. CRAIG: We had requested at sidebar, given that juror #21 was, had his eyes closed, seemed to be sleeping throughout both the closing arguments from time to time of Ms. Rodriguez and me and during your charge, I request that Your Honor consider seating one of the alternates and excusing juror #21 since he has been dozing off or has his

eyes closed every day of this trial, from the time of both the Plaintiff's presentation of the case and the Defense's presentation of the case and for that reason, we request that that juror be excused and the first alternate be seated.

THE COURT: I'm not going to replace the juror for a number of reasons, one of which is, I asked him on the record if he was paying attention and he told me he was. I watched him throughout the week and he was not nodding off and his eyes were shut at some point in time but he was not nodding off and his head was not going forward and backwards.

The other reason why I'm hesitant is, you know, if you look at the line of cases that you don't see a whole lot of discussion about in civil court, but in criminal court, the Batson case talks about the juror's right to serve and, you know, he's testified that he's paying attention and I believe him.

The other thing that causes me some concern about replacing him is that from a practicable standpoint from the way you look at it that most lawyers would consider a filler, but the other two, I've looked at them and they seem to be responding probably more to the Defense's theory than -- who knows what this particular juror who is allegedly going to sleep, juror number...

MS. CRAIG: I believe it's juror #21, Your Honor.

THE COURT: Juror #21, he is sort of stoic and it's kind

of hard to tell which way he's leaning and, of course, what is more of a concern is, do we want to keep him on or take him off based on which way they might lean. I don't know. There are other demographic issues there at play and I think given all of those circumstances and given the fact that I believe he was paying attention and I've had an opportunity to observe him, that I think he needs to stay on with us.

MS. CRAIG: Thank you, Your Honor.

THE COURT: All right. You can carry the evidence back and tell them to begin deliberations.

(Evidence taken to the jury at 6:09 PM)

MR. GRAHAM: Judge, could we get heard on one more point? I wanted -- it has nothing to do with that, but when we were in chambers several days or weeks ago, I've lost track of time, you approved the high/low agreement, but you said that you wanted to talk to the mom about it and I didn't know if you thought this would be an appropriate time to do that.

THE COURT: Yes. Yes, ma'am, if you could stand right where you are and state your full name, please, ma'am.

MS. PRINCE: Genesie Prince.

THE COURT: All right. You and your very fine lawyers have spent a lot of time preparing this, you've had a lot of discussions. Do you understand what the high/low agreement is?

MS. PRINCE: Yes.

THE COURT: And do you approve it?

MS. PRINCE: Yes, sir.

THE COURT: And you understand the advantages of doing that?

MS. PRINCE: Yes, sir.

THE COURT: And you understand the disadvantages of doing that?

MS. PRINCE: Yes, sir.

THE COURT: Primarily, if you were to get a verdict more than that you might could go after someone's individual assets. Do you understand that?

MS. PRINCE: Yes, sir.

THE COURT: And you are willing to give that up in view of the fact that you have a minimum amount that can be recovered if there is liability?

MS. PRINCE: Yes, sir.

THE COURT: All right. I'll approve the high/low agreement.

MR. GRAHAM: Thank you, Your Honor.

THE COURT: All right. We will stand at ease. Well, wait a minute. We already have a question from the jury.

FIRST QUESTION FROM THE JURY

THE COURT: It says, to Number one, if we answer no, do we continue? The answer is yes. I thought it was fairly clear on the verdict form, but do you have any objection to me

responding yes?

MS. CRAIG: Do you have an extra copy of the verdict form, Your Honor?

THE COURT: I need to look at that. Hang on one second. I do not have a copy of the verdict form.

MR. RUFFIN: I have one here. Do you want me to read it?

THE COURT: Yes.

MR. RUFFIN: It says no. If no, the Plaintiff must prove simple negligence.

THE COURT: Okay. Yes. So, they do continue. Either way, they continue.

MR. RUFFIN: Correct.

THE COURT: We're ready for the jury. If they could bring them back in.

(Jury in at 6:16 PM)

THE COURT: The question was presented: If we answer no to question number one, do we continue. The answer to that is yes. Whether you answer yes or no, you continue and it just depends upon whether or not, how you answer determines whether or not it's gross negligence, which is a standard or simple negligence. So, follow the instructions as it goes through and I'm going to ask that you retire to the jury room.

(Jury out at 6:17 PM)

THE COURT: We'll stand at ease.

SECOND QUESTION FROM THE JURY:

THE COURT: I understand that they have a question: Can we get depositions of two nurses, Debra Floyd. My response to that is no, they are not in evidence.

MR. HOOD: Your Honor, they have a right to listen to the testimony if they need to know that.

THE COURT: That's not really what they asked. Do you want to invite them to listen to testimony?

MR. HOOD: Yes, sir. It's brief. I don't believe it's that long.

MR. GRAHAM: We object to that, Your Honor.

MR. HOOD: They don't know what to ask for when they say deposition.

MR. GRAHAM: They know exactly what to ask for.

THE COURT: All right. I'm not inclined to do that, but they've asked if they can get the depositions of the two nurses and I don't want to add to or take away from that and I'm just going to tell them, no. If they say, Well, can we listen to testimony, then I'll be happy to do that. Let's see if they have a follow-up question. Let's do it that way.

MR. HOOD: And so your response would be, no, or no, not ---

THE COURT: It says: Can we get the depositions of two nurses. No, they are not in evidence.

THE COURT: We are ready for the jury.

(Jury in at 6:50 PM)

THE COURT: Madam forelady, the question has been posed: Can we get depositions of two nurses? The answer to that is, No, they are not in evidence. You may return to the jury room.

(Jury out at 6:51 PM)

THE COURT: We will stand at ease.

(Break)

VERDICT

THE COURT: I understand that they have a verdict. One of the jurors is leaving for Disney World early in the morning and she wants to leave and one of the alternates wants to watch the verdict, so we can bring them in. We are ready for the jury.

(Jury in at 10:13 PM)

THE COURT: Is the alternate here?

OFFICER: I believe they both left.

THE COURT: All right. Very good. Madam forelady, have you reached a verdict?

MS. FLOYD: We have, Your Honor.

THE COURT: Is it, indeed, unanimous?

MS. FLOYD: Yes, it is, Your Honor.

THE COURT: I'm going to ask if you would give the verdict form to the Clerk. (She complies and Clerk gives the document to Judge Nettles who looks at it and gives it back

to the Clerk) Madam Clerk, you may publish the verdict.

CLERK OF COURT: State of South Carolina in the Court of Common Pleas, case number 2013-CP-21-00587, Genesie Fulton, individually and as next friend of Bryson F , a minor versus Dr. L. Goldstein, MD, individually, and doing business as L. William Goldstein, OB-GYN. Do you find that the facts of this arise out of a genuine emergency situation where the patient is not stable and there was an immediate threat of death? Yes. The Plaintiff has proved that the Defendant breached the standard of care? No. Signed on May 8, 2015 by foreperson, Debra Floyd. Madam forelady, members of the jury, is your true verdict? If so, please raise your right hand. (All jurors comply)

THE COURT: Thank you Madam Clerk. Any additional request for polling from the Plaintiff?

MR. GRAHAM: Yes, Your Honor.

CLERK OF COURT: Debra Floyd, please stand. Please answer my questions. Is this your verdict?

MS. FLOYD: Yes.

CLERK OF COURT: Is this still your verdict?

MS. FLOYD: Yes.

CLERK OF COURT: Thank you, you may be seated. Calvin Eaddy, is this your verdict?

MR. EADDY: Yes.

CLERK OF COURT: Is this still your true verdict?

MR. EADDY: Yes. Paula Grice, is this your verdict?
MS. GRICE: Yes.
CLERK OF COURT: Is this still your true verdict?
MS. GRICE: Yes.
CLERK OF COURT: Bryant Washington, is this your verdict?
MR. WASHINGTON: Yes.
CLERK OF COURT: Is this still your true verdict?
MR. WASHINGTON: Yes.
CLERK OF COURT: Raymond Burroughs, is this your verdict?
MR. BURROUGHS: Yes.
CLERK OF COURT: Is this still your true verdict?
MR. BURROUGHS: Yes.
CLERK OF COURT: Roberta Washington, is this your verdict?
MS. WASHINGTON: Yes.
CLERK OF COURT: Is this still your true verdict?
MS. WASHINGTON: Yes.
CLERK OF COURT: Amos Mack, is this your verdict?
MR. MACK: Yes.
CLERK OF COURT: Is this still your true verdict?
MR. MACK: Yes.
CLERK OF COURT: Bridget Beckett, is this your verdict?
MS. BECKETT: Yes.
CLERK OF COURT: Is this still your true verdict?
MS. BECKETT: Yes.

CLERK OF COURT: Lavon Sherman, is this your verdict?

MS. SHERMAN: Yes.

CLERK OF COURT: Is this still your true verdict?

MS. SHERMAN: Yes.

CLERK OF COURT: Robert Hawthorne, is this your verdict?

MR. HAWTHORNE: Yes.

CLERK OF COURT: Is this still your true verdict?

MR. HAWTHORNE: Yes.

CLERK OF COURT: Gauge Creel, is this your verdict?

MR. CREEL: Yes.

CLERK OF COURT: Is this still your true verdict?

MR. CREEL: Yes.

CLERK OF COURT: Tai, is this your verdict?

MR. NGUYEN: Yes, ma'am.

CLERK OF COURT: Is this still your true verdict?

MR. NGUYEN: Yes.

THE COURT: Thank you, Madam Clerk. Madam forelady, ladies and gentlemen of the jury, I want to thank you for your service. Y'all have really worked this week. We started early and we finished late. I know that when you showed up on Monday morning you had no idea. A lot of people show up on jury duty and they answer the role and go home, but y'all have really been called upon to participate in an important case and y'all have obviously listened to the evidence and spent a lot of time deliberating the case and for that, we

are appreciative. I know y'all had other things y'all would rather do when you showed up on Monday, but if you think about it, our system can only work that way if we subpoena people here to participate. If you think about it logically, the only other alternative would be for the clerk to go out on the street and find people who have absolutely nothing better to do. We wouldn't have the same wisdom that you have brought to this particular case. We appreciate that. You have earned a three-year exemption. That means if you are summoned to participate in common pleas or general sessions court here in Florence County over the next three years, tell them that you participated this week, that I presided. They will have a record of it. You can exercise an exemption. However, if you wanted to serve, you could, but if you feel as though you'd like not to serve, you have earned that exemption. However, it does not apply for federal court, municipal court or magistrate's court, but if you are subpoenaed in this courtroom, you will have earned an exemption. I've always asked jurors if there are any questions that you have about the proceeding, I will be happy to answer them, but before we do that, how many of you have never served on a jury before? How about that. I hope that it's been not that burdensome of an obligation. I hope that you've learned something. You know, I practiced law for about 20 years and been on the bench about 10, but I've never participated in a trial that I

didn't learn something. I know more about shoulder dystocia. I didn't even know what shoulder dystocia was until we showed up here today, but we did learn something and that's always good and these very fine lawyers have done a great job in being advocates for their various positions and we are grateful. Hopefully, it's been a good experience. Do y'all have any questions? It's 10:30. Y'all probably don't want to hear me talk anymore. Very Good. Everyone remain seated while the jury exits the courtroom. Thank you very much.

(Jury out at 10:23 PM)

THE COURT: Be happy to entertain motions at this time.

MR. GRAHAM: Yes, sir. If Your Honor, please, we respectfully move on behalf of the Plaintiff for a new trial absolute. May we have time to get the various grounds?

THE COURT: If you absolutely want to do that, you can, but you know, it's fresh in our minds right now and the issues are fairly defined and fairly limited. If you want to do that, we can reconvene. I'm going to be in Horry County next week. I don't know where I'm going to be. Hang on one second.

MR. GRAHAM: Your Honor, with the hour being as late as it is, I just, after a tough week, I'm afraid if we try to cover everything right now, we might inadvertently leave something out that could possibly prejudice our client and so I would ask for more time, if Your Honor please.

THE COURT: Actually, I will be in Florence for common pleas on the 4th and I'll ask that y'all get together and find a mutually convenient time on the week of May 4th. I think there were two day certains, both of which have resolved themselves and it is a fairly limited roster that week and so I think we could probably do it that week.

MR. GRAHAM: Your Honor, you said May 4th, I think?

THE COURT: I meant May 18th. And y'all get together and find a mutually convenient time. If you will speak with my secretary, Ms. Charlene, we will set it up.

MR. GRAHAM: Thank you.

THE COURT: Anything from the Defense?

MS. CRAIG: No, sir, Your Honor.

THE COURT: Both of y'all did a very fine job representing your clients. It was a long, long, long week and I appreciate that. Thank y'all for being prompt, efficient and on time. We will stand at ease.

STATE OF SOUTH CAROLINA)	IN THE TWELFTH JUDICIAL CIRCUIT
COUNTY OF FLORENCE)	THE COURT OF COMMON PLEAS
)	2013-CP-21-00587
GENESIE FULTON,)	
INDIVIDUALLY, AND AS)	
NEXT FRIEND OF BRYSON)	
E , A MINOR,)	
)	
PLAINTIFFS,)	
)	
VERSUS)	
)	
L. WILLIAM GOLDSTEIN, MD,)	
INDIVIDUALLY AND)	
d/b/a L. WILLIAM)	
GOLDSTEIN OB/GYN,)	
)	DATE: MAY 19, 2015
DEFENDANT.)	PLACE: FLORENCE, SOUTH CAROLINA

MOTION FOR A NEW TRIAL

B E F O R E:

THE HONORABLE G. MICHAEL NETTLES

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

J. LAYTON RUFFIN, ESQUIRE
ATTORNEY FOR THE PLAINTIFF

BRIAN J. KERN, ESQUIRE
ATTORNEY FOR THE DEFENDANT

PROVIDED FOR: THE GRAHAM LAW FIRM

COURT REPORTER: JO RICE
jrice@sccourts.org
SOUTH CAROLINA JUDICIAL DEPARTMENT

THE COURT: Mr. Ruffin, you may start when you are ready.

MR. RUFFIN: May it please the Court?

THE COURT: Yes.

MR. RUFFIN: We have made a motion for a new trial under Rule 59(e) and under whatever basis under common law there exists for a new trial. Our first argument -- and I'm going to skip through the facts because,, I think after a week, you are pretty familiar with those.

THE COURT: I am familiar with the facts.

MR. RUFFIN: The first argument or arguments relate to the jury charge and the verdict form as written as it relates to the obstetric emergency statute found at §15-32-230. That statute sets out, and it has been argued by Defense and listed as an affirmative defense and the elements of it include -- and I'll just go through it very quickly.

First, it has to be an obstetric emergency, which we conceded that shoulder dystocia was an emergency, but in addition to being an emergency, there has to be other requirements, such as; the patient not being medically stable. It has to be that the patient is not medically stable and that the patient is either at risk of immediate threat of death or immediate threat of serious bodily injury and it's our position that the jury charge and the verdict form did not accurately present the law as it is represented in the statute.

We have a couple of issues. Number one, it didn't say, "medically stable", it just said the patient was not stable and secondly, the way the first section or the way it was listed, the three requirements were listed in one paragraph and we believe it was confusing as listed and that the elements should have been broken down so that they would have had to find that the patient, in order for the obstetrical emergency to apply, that the patient: was not medically stable, that there was an emergency, the patient wasn't medically stable and that the patient was at risk for immediate threat of injury or immediate bodily harm and we believe that the verdict form did not appropriately list out the requirements as set forth by the ---

THE COURT: What you are saying is that it should have been each one of those elements and a check mark for them to affirmatively say that, one way or the other, that ---

MR. RUFFIN: Correct. That's our first argument, Your Honor. We believe that it should have been listed out so as to avoid confusion with regards to ---

THE COURT: What was the -- do you have your written request for a verdict form?

MR. RUFFIN: I don't know that we submitted a written request for one because we didn't know, at the time, that it was going to be included on the verdict form. Actually, I take that back. We did submit one, but it did not address the

obstetric emergency on ours because we didn't believe it was applicable to this case and that gets us to the next argument I'm getting ready to get to and that's, well, I'll answer any further questions that you have as far as...

THE COURT: All right. Well, let's talk about this verdict form.

MR. RUFFIN: Sure.

THE COURT: And we'll do it one at a time. I think that's probably a more effective way to do it. How would you suggest that the verdict form be written?

MR. RUFFIN: Okay. Assuming that the verdict form did include the obstetric emergency provision, and, again, that's my next argument that it shouldn't have been included at all, but if it is going to be included, it's our position that each of the elements should have been listed and required a check or something ---

THE COURT: Did you specifically make that request at the trial?

MR. RUFFIN: We objected to it as written and I believe -- and of course, the record will reflect when we get a copy of the transcript, what I said, specifically ---

THE COURT: So, you aren't sure if you did or not?

MR. RUFFIN: I know I objected to it, but I don't know if I was as clear as saying each one needed to be listed out. I objected to them being grouped together and I believe Your

Honor's comment was, "Well, I don't really see the difference if it's this way or another way." I just don't want to make a representation to the Court of exactly what I said two weeks ago in the heat of a trial. I do know that I objected to it and I said that I don't think that it should be listed as it was with "immediate threat" and "medically stable" together.

The other issue as to "medically stable", on the verdict form, as written, it just says "stable".

THE COURT: Did you specifically make that objection in trial, that it didn't say "medically stable"?

MR. RUFFIN: Again, without reading the transcript, I can't be 100% sure. I believe I objected to the verdict form as written as not representing the statute as ---

THE COURT: What do you think about the general fairness of not giving me the opportunity to correct that?

MR. RUFFIN: Your Honor, I think the best that we could do is, once we saw the verdict form that you intended to charge, the best we could do is give you our objections to something, you know, within minutes. We were presented with the verdict form that you intended to use and ---

THE COURT: Well, certainly, that wasn't the first time that y'all have heard "obstetrical medical emergency".

MR. RUFFIN: It's the first time that we've had it presented to a jury.

THE COURT: Okay. But y'all knew that was an issue in

this case.

MR. RUFFIN: We knew that they had raised it as an affirmative defense and getting to our second issue, as an affirmative defense, they have to establish the elements thereof and not once during the trial did they present any testimony that the mother or child was not medically stable. Nowhere ---

THE COURT: It was throughout, wasn't it?

MR. RUFFIN: I think there was discussion of what risk might be posed if a shoulder dystocia extends beyond 6 minutes, which wasn't present in this case. I do not believe the statute is intended when it says, "medically stable" to presume that at some point during the process or sometime during medical treatment, that they might later become medically unstable. The question is at the time of treatment was the patient medically stable.

THE COURT: I think they said that the child was, there were changes in the child's vital signs, weren't there?

MR. RUFFIN: There was representation that there was one brief deceleration in the fetal strips which does not mean the patient was not medically stable. If that were the case, an emergency C-section would have been required. It simply is the basis by which Dr. Goldstein justified using a vacuum. It does not mean Dr. Goldstein thought the patient was not medically stable. He just believed that it was, according to

his testimony, time to expedite the delivery, but that's different from medically stable.

THE COURT: Once they get to a certain point, they've got to do it and do it in a hurry or the child dies and the mother could die.

MR. RUFFIN: And again, there ---

THE COURT: There are a bunch of experts that said that because I didn't dream it up.

MR. RUFFIN: Correct. But there is a difference between what might happen and what, in fact, is the condition at the time this patient was receiving treatment and the statute says that it must be found that the patient was not medically stable. It does not say, "might become medically unstable".

THE COURT: I don't know. That may seem like semantics, but if I were to win -- say if I were in a box and only had seven minutes to get out, that seems to be a medical emergency and if there is a change in vital signs, it's a factual question for the jury to make that determination.

MR. RUFFIN: As far as obstetric emergency, we have not once argued that there was not an emergency. We believe, as the statute is written, it certainly differentiates between medical emergency and medically stable and the reason we know that is that it says both in the statute. It says medical emergency and then it says this statute only applies if not medically stable and immediate threat of injury and so even

if we assume that based upon the seven minutes that, maybe there is testimony that in seven minutes there would have been an immediate threat of harm and so that testimony from Defense counsel might have arguably created a question of fact as to whether or not there was immediate risk of harm. However, what it doesn't do and nowhere in the testimony presented to the jury was there ever an argument made that the patient at time of treatment or throughout the course of treatment was not medically stable and that determination is one that must come from an expert witness. It's not one that the jury, anymore than -- the jury may hear two versions of what the standard of care is, but it's not the jury's position to make up their own standard of care beyond what an expert witness says and I think the same rule now goes to the determination of medical stability. It's a term that has connotations of a requirement that a physician in the area opine as to what medically stable is and they are the ones that should be commenting on whether this patient was or was not medically stable and that was not done at any point during the trial by Defense counsel and the only person who made a comment one way or the other was Dr. Hall in rebuttal where he said, "Yeah, the patient was medically stable." The mother and baby and not only were mother and baby medically stable, but Dr. Goldstein's own testimony was that the baby was never not medically stable.

THE COURT: Okay. Let's hear from Defense about the obstetrical medical emergency exception.

MR. KERN: Yes, Your Honor. May it please the Court. The Defense's position is that the exception applies and that the facts and testimony indicate and support that it be included not only in the jury charge but on the verdict form.

The issue of medical stability was discussed at length throughout the week of trial. Issue number one, of course, was the timing of delivering the child, but also the baby's heart decelerations and muscle tone at point of delivery. His APGARs were a score of one.

THE COURT: Yeah, that is correct.

MR. KERN: And that was discussed at length throughout the course of the trial. Whether there is a requirement to use the buzzword "medical stability" through our experts, I don't know of such a requirement.

THE COURT: Mr. Ruffin, what do you say about the APGAR score and I, for whatever reason forgot about that, but APGAR, nobody really talked about that a lot, but I assume they thought I and the jury knew what APGAR is, but it's just, I think it's generally a scale to show how responsive a child is when they are born. If they have a good looking color and they are very active and they cry spontaneously, they get a high mark, but if they are pale and blue and non-responsive and not crying and not breathing, then it's real

low and it was very limp, it was very limp, so wouldn't you think that that could be some evidence for which the jury could conclude that the child was not stable? As a matter of fact, your own client, it wasn't just the doctors, your own client said the child wasn't', was limp, and she thought the child was dead, if I recall correctly.

MR. RUFFIN: Your Honor, the medical significance of the APGAR score is within the realm of expert testimony. It is something that people have heard of before, but they don't know the significance of an APGAR and here's why: a one minute APGAR score has a substantially different meaning than the five minute APGAR score. The one minute APGAR score is typically low in many situations where there is a newborn, but what's important and what determines the well-being of the baby is whether the baby at the five-minute APGAR score has recovered and in this case, the five-minute APGAR score was fine. The child was fine. Now, understandably, the mother might be concerned. Because it's their baby they will be concerned no matter what, I mean, I've been present in the delivery room before and even if everything is perfect, there is always great concern by a mother when the child comes out, but that doesn't necessarily mean her point of view or even a jury's understanding of what an APGAR score is or how a baby appears is indicative of the stability or medical stability of the child and, Your Honor, in this particular

case when we are talking about medical stability as a term included in a statute by the legislature, in a provision in which the Defense has listed it as an affirmative defense, it was upon them to prove the elements of their affirmative defense and if they did not present any testimony that this child was not medically stable then they should not have had that jury charge or the verdict form or the inclusion of the obstetrical emergency statute go to the jury. It's an element that went unsatisfied by the Defense. Now, in an attempt to rectify that, they point back to the fact that it was an emergency, which we've never argued. We've always said it was an emergency. Shoulder dystocia is an emergency. Secondly, they go back to well, we believe perhaps there was a question of fact as to whether it posed an immediate threat of harm and Defense counsel's expert made comment about, "Yeah, if you don't do something within seven or eight minutes, then you can have an injury that is permanent to the baby in the form of hypoxic, some sort of hypoxic asphyxiation, a lack of oxygen. But that doesn't happen until seven or eight minutes and the only evidence presented to the jury was that the child bounced back at five minutes on the APGAR score. There is only one decel from which the child recovered from and we know that even Dr. Goldstein believed that because had he thought otherwise, he would have done an emergency C-section instead of continuing on with the vaginal delivery.

THE COURT: I don't think you can do an emergency C-section once they've already crowned out, can you? Or can you?

MR. RUFFIN: It didn't come up in this case and so I'm not going to serve as an expert witness in obstetrics right now.

THE COURT: Well, it wasn't even an issue, but you kept saying that, you know, that would call for a C-section.

MR. RUFFIN: Well, he never indicated in the charts nor his testimony that after the vacuum was applied he was concerned about the well-being of this child at the time the delivery was occurring. There was one decel. There has been no other evidence nor testimony by anyone that this child was not medically stable. There was testimony that the child was at risk of damage, of brain damage. There was testimony that this was an emergency, but there was no testimony that the child was not medically stable at that time, nor the mother.

THE COURT: All right. And I interrupted you. You were at the APGAR score.

MR. KERN: Yes, Your Honor. I don't think there's much left for me to say.

THE COURT: What do you think about the fact that I didn't say "medically stable"? I don't think anybody objected to that until today, did they?

MR. KERN: I don't believe so, Your Honor. I know that

Plaintiff's counsel did -- there was an objection and some conversation at the time of the jury verdict. I can't recall the specific details. Ultimately, I think some language was agreed upon about whether or not the objection addressed certain phrases. I can't recall and counsel has a better recollection of that than I do since he made the objection. but I think the APGAR score speaks for itself. And, again, Mr. Ruffin makes a good point. I'm not a medical expert. I'm not an OB/GYN, but there's evidence that after this boy's head was delivered and turtle signs were observed, now he's hanging out of his mother with a nucal cord. All those things were going on and I think those all go towards the facts of medical, the presentation of medical instability and also the emergency situation Dr. Goldstein faced delivering this child.

THE COURT: Have you ever seen the obstetric medical emergency exception put on the verdict form?

MR. KERN: I have not, Your Honor.

THE COURT: Okay. Very good.

MR. RUFFIN: Just one final issue on that and I'll be brief. It's just that the statute is also under the delegation of the common law and so we believe that it should be strictly construed and it should have been presented verbatim as written by the legislature.

THE COURT: Very good. And your next motion.

MR. RUFFIN: Okay. So, the second issue, and this sort of relates back to the first and so I'm going to go through this one a little more expeditiously, but it is that as a matter of law, we believe that the Court should have found that the obstetric emergency statute should have been, I guess, stricken or denied the application of it based upon the fact that there was no evidence to establish that the patient was not medically stable and I think I covered that in my first one. So, unless Your Honor has any further questions.

THE COURT: All right. I understand.

MR. RUFFIN: We believe, and this was also objected to, the definition, assuming that it was permissible and appropriate to include the obstetric emergency, that the definition used for gross negligence was not the full definition, was not the correct, complete, and full definition as defined by case law in South Carolina. We believe in all, or at least in my review of the cases, in many of the cases there are three sentences provided whenever gross negligence was discussed and one of those is the failure ---

THE COURT: Didn't we talk about gross negligence to some extent in the punitive damage charge? It was kind of defined in that respect, wasn't it?

MR. RUFFIN: I read, I believe I read back through it and I do not believe it accurately or fully presented the

definition of gross negligence and especially in the situation where you are doing something that is in derogation of the common law which is the statute that puts an onerous burden ---

THE COURT: I at least said what gross negligence was. I think I said it was more than mere negligence and a few other things, but later on in the charge, I do know that I charged gross negligence.

MR. RUFFIN: It's my recollection that it was stated that gross negligence is the failure to exercise even the slightest care.

THE COURT: That's correct.

MR. RUFFIN: And it's my belief that to appropriately charge the jury on gross negligence, the additional language, that gross negligence is a relative term and needs the absence of care necessary under the circumstances, which is found in Steinke, S-T-E-I-N-K-E, v. The South Carolina Department of Labor, Licensing, and Regulation, 336 S.C. 373. I believe I did raise that specifically in terms of the discussion of how gross negligence was to be defined to the jury and this is important to us because we have two issues here. One, you have the derogation of common law which is imposing a burden of gross negligence simply to find a physician liable for tortious conduct and that in connection with the definition that says, "even the slightest care", we

believe is a standard by which the legislature, it's a burden by which the legislature did not intend and the definition doesn't accurately represent the common law definition and explanation of gross negligence.

THE COURT: Well, this is what I did say in the later part of the charge. It goes, "When the conduct of the Defendant has been something more than mere negligence, the evidence must establish that the Defendant's acts were reckless, willful, or wanton, meaning there was a conscious failure to exercise due care or a conscious indifference to the rights and safety of others by a reckless disregard thereof."

MR. RUFFIN: Correct. And we have two issues with that. One, it's separation and distance from -- well, first, it doesn't really define what gross negligence is. It goes into a discussion of recklessness which is more appropriate for determining whether punitive damages are to be found. Secondly, the verdict form just said, "gross negligence," and we ---

THE COURT: Gross negligence is reckless. Isn't it?

MR. RUFFIN: It says gross negligence in the charge and in the verdict form and in the statute and so I think it would be confusing or at least I think it would be hard to understand how a jury, when they hear reckless and reckless defined as conscious disregard ---

THE COURT: Do you really think, as a practical matter, that if it had been read any different that the verdict would have been any different?

MR. RUFFIN: I do, Your Honor. I think we were prejudiced as a result of whenever they heard gross negligence they heard, "even the slightest of care," and then they harped on that in closing argument, the absence of even the slightest care and the issue is, if that was the only way they understood it and we were denied the ability to argue in our closing that the definition includes the language that it is a relative term which means the absence of care that's necessary under the circumstances, we couldn't say that to the jury so they went back there thinking, can we really say that this doctor didn't exercise even the slightest of care? I think that's an onerous burden that, I mean, it's clear that we were prejudiced by that being their understanding of the threshold by which they needed to find the physician essentially, liable. Do you need anything further from me on that?

THE COURT: No, I think that's -- I understand that objection.

MR. RUFFIN: Okay, Your Honor. The next objection ---

THE COURT: Let's hear from Defense.

MR. RUFFIN: Oh, I'm sorry. My apologies.

MR. KERN: I was just, Your Honor, thank you, reading

over the case that counsel sent over on that gross negligence and I believe the language you used in your charge echoes the language cited in the case cited in their brief and so I just want to point out that I think it was an appropriate charge under the circumstances.

THE COURT: Okay. Mr. Ruffin.

MR. RUFFIN: Your Honor, the next argument we have is that the Court erred in failing to strike a juror. It was a paralegal that worked for a defense attorney that handled malpractice cases. This juror was exceptionally hesitant in answering questions by Your Honor about her ---

THE COURT: Was this juror seated?

MR. RUFFIN: She was included in the pool and we had to use one of our peremptory strikes to remove her and the fact that we had to use a peremptory strike on her and not someone else made ---

THE COURT: Okay. Well, her responses sort of stand for themselves. What does the Defense have to say about that?

MR. KERN: Nothing further, Your Honor, other than the jury pool was equally divided, probably, amongst potentially pro and con jurors for each side and each side exercised their peremptory strikes as appropriate. I believe the Defense struck a juror who was a paralegal at a plaintiff's firm here in town, the Wukela Firm, who does medical malpractice. The juror ---

THE COURT: I had forgotten about that paralegal. Did she make it onto the pool?

MR. KERN: She did and she was struck.

THE COURT: So...

MR. KERN: By the Defense.

THE COURT: Yes. Both of them, as I recall, said that they could be fair and impartial, didn't they?

MR. KERN: Yes, Your Honor.

MR. RUFFIN: The only follow-up I have, Your Honor, is, whether or not they had to use a peremptory strike, I don't think for purposes of review that's the critical issue here in ---

THE COURT: No, I'm -- it seems kind of odd ---

MR. RUFFIN: I don't know if they objected to her not being struck, so essentially, I'm -- they might have even waived that. All I know is that I'm taking the position that when I observed this paralegal answer questions that Your Honor asked her about her ability to be fair and impartial, she hesitated, she said, "I don't know, I guess." And then I think she disclosed that, I'm trying to remember if it was her or the attorney she worked for, was married to a physician and I think everything included is clear evidence that she could not be fair and impartial.

THE COURT: Well, she said she could.

MR. RUFFIN: I think she was interested in giving Your

Honor the answer she believed she was supposed to give whenever she was questioned by a judge as to her partiality.

THE COURT: All right. She said she could be fair and I believed her. I talked with her.

MR. KERN: Your Honor, I think that this was a unique trial, in my experience, and there were questions throughout about juror attention, so to speak, during the course of the trial and I thought it was abundantly clear that the jury pool that was picked was given the full opportunity to state, number one, whether they were biased and had the ability to provide a fair trial and number two, during the course of the trial paying attention and these sorts of things. With regard to a potential juror's spouse, I don't think South Carolina recognizes that as ---

THE COURT: A lot of spouses don't pay attention to what other spouses have to say, do they?

MR. KERN: Right. So, with regard to that, I would just argue that the jury pool seemed to be fair for everybody.

MR. RUFFIN: And Your Honor, the only comment I have about that is that characterizes one juror as not paying attention in no way addresses the issue of fairness concerning ---

THE COURT: I didn't follow you there. What are you talking about, one juror?

MR. RUFFIN: Well, he said that one juror was inattentive

and I thought that he was referring to the fact that one of the jurors, that they made multiple objections to one juror who appeared he was asleep.

THE COURT: Did you say something -- did I hear...

MR. KERN: Just that the context of that comment is essentially that the jurors are afforded the right to participate in the jury trial process as long as they represent to the Court that they are fully able and capable of providing impartial observation and service and I think that was evident throughout the course of the trial as well as voir dire.

THE COURT: Okay. What you are saying is that one of the reasons that I kept the juror that y'all said was being inattentive was that he had a right to serve on the jury and you say that this lady, although she works for a defense firm, has a right to serve on a jury.

MR. KERN: That's correct, Your Honor. Thank you.

THE COURT: I understand. I missed that point, but you brought it out. Very good.

MR. KERN: In a very inarticulate form.

THE COURT: He caught it, I didn't. There you go.

MR. RUFFIN: Unless Your Honor has any further questions on that issue, I'll move on.

THE COURT: Okay. Move on to the next one.

MR. RUFFIN: The next one is essentially a grouping of a

challenge that we had essentially to every expert that offered causation testimony by the Defense and starting with Dr. Goldstein, I believe he said that he was not qualified to be an expert in causation, and yet from my memory, I believe that he did actually offer causation testimony and to the extent he did offer causation testimony we believe it was error for it to be admitted.

THE COURT: All right. Let's hear from Defense on that one.

MR. KERN: Nothing really to say other than he's a medical doctor practicing for 37 years as an OB-GYN and offered testimony in that capacity. All of the experts and medical witnesses were provided wide latitude by the Court to testify in this case.

THE COURT: Do you think that you have to disclose to them -- if he's being sued and he's an expert in the area, do you think you have an obligation to disclose to him that he's going to be testifying as to causation?

MR. KERN: I don't have the deposition memorized, but I think he did provide testimony about what he thought the potential causes were even if he did testify that he was not necessarily an expert in causation, he testified in his capacity as a witness, as a medical doctor.

MR. RUFFIN: And Your Honor, I think that's the very issue and, in fact, I think that's what we ran into with Dr.

Hall. They made the argument that we didn't disclose that he was going to provide causation testimony and yet he was ultimately excluded. In this case, we didn't question -- there are two issues here. One is qualifications to testify and the reliability of the testimony one intends to offer and in this case, there are both of them. We didn't even get to the reliability of what his testimony would be because he said, "Well, I'm not qualified and I'm not going to offer causation testimony," and he did anyway.

MR. KERN: Your Honor, my recollection of the trial is that there was no cross examination, necessarily, on that. There was no voir dire to the witness on qualification and these sorts of things.

THE COURT: They were all given the opportunity to query with regards to qualifications. Right?

MR. KERN: Yes, sir, Your Honor. And just as a qualification, strictly by memory, I haven't read the transcript, so I can't speak specifically to what was asked and not asked during the course of the trial.

THE COURT: All right.

MR. RUFFIN: And Your Honor, with all these witnesses, except for Dr. Goldstein, we can assume arguendo that they might be qualified to argue these opinions that they are offering, in the field of obstetrics as an obstetrician. The issue we have under Watson, also cites to Daubert, it cites

to Jones, I believe, Council v State is that qualification is not the only requirement and they, of all these cases discuss the Court's role as gatekeeper of evidence and in that role can rule and determine the reliability of such testimony and we tried and I believe we often did make the argument that this testimony was unreliable and after we said unreliable the discussion shifted back to whether this person was qualified and so even though we were saying, no, no, no this is a reliability issue and not a qualification issue, to the extent that we didn't and were not able to explain why this testimony was unreliable, it was more of an inability to do so other than to say reliable and then Your Honor's position was to say well, this person is qualified, you have testimony from both sides as an expert witness, and so Your Honor our position is two-fold on reasons why the expert's testimony should not have been admitted. One, is that it was unreliable and that ---

THE COURT: You know, all of these cases that you are talking about as far as reliability, as I recall, what is the name of the case that involved Ed Bell and the cruise control?

MR. RUFFIN: There are a group of cases that are relevant. I believe that might be Watson.

THE COURT: Watson.

MR. RUFFIN: There's also Graves.

THE COURT: What I'm saying is that also encompasses the type argument that you are making, which makes a lot of sense. You just get somebody -- I think he was some kind of unusual engineer that worked in England and he did something that didn't have anything to do with cruise control and he started testifying with regard to theories that really weren't scientifically tested, but that's different from somebody who spent four years in college, four years in medical school, who knows how many in residency, attendings, and all. They are usually thirty years old before they draw a check, a substantial check, and I think they are allowed to testify and the fact that they have all that education and all that experience, they are allowed to testify as to causation and damages and everything else.

MR. RUFFIN: And Your Honor, one of the cases, and I do not remember which one I referenced, whether it was Graves, Watson, Grantham, discusses scientific versus non-scientific and they say that some medical testimony might be scientific, some of it might not be scientific in the terms of an engineer, but they also stated I believe in those cases, that the role of the Court as gatekeeper for reliable testimony applies to both situations and in this particular case, whenever you are arguing that, you know, well, it might have been ---

THE COURT: What was so particularly unreliable about the

Defense witnesses and what made yours so reliable that testified to the same thing?

MR. RUFFIN: Okay. Ours took a differential diagnosis approach to determining the cause of injury in this case which is supported by South Carolina case law and case law around the state. It says, okay, what is known by science? What has been scientifically proven and determined to cause a brachial plexus birth injury? And it is without question established that excessive lateral traction, pulling too hard, rips up nerves in a baby's neck. What has not been established and is nothing more than hypothesis and conjecture and there is nothing to support the hypothesis that uterine forces causes injury, that there might be some difference in tone that causes an injury. In this case, it was put forth that there was something about the size of the pelvis that might have caused the injury, yet the doctor that said, "Oh, well, that might be a cause," never evaluated the mother and so he has no basis by which to make comment one way or the other if this mother's pelvis ---

THE COURT: Y'all were able to cross examine him on that issue, weren't you?

MR. RUFFIN: Well, that's the whole point. He shouldn't have been allowed to say it in the first place because it's unreliable. His testimony, he said that this injury was not caused by excessive traction because it was caused by

something else.

THE COURT: One of things that one of the defense experts said that made a difference to me and probably to the jury is, that once the child's head had crowned and "turtled" as they say, it goes out and then it comes back in, they say "Oh, we've got a problem". Once that happens, the child's head cannot be moved, because there is a band of vagina keeping it from being moved. That's what one of the experts said. I can't remember what his name is, but it kind of had a ring of truth to it.

MR. RUFFIN: And in all honesty and fairness and in all candor to the Court, there is no truth to that, because these injuries regularly occur after the head has crowned and that's where these injuries happen and that's been documented for hundreds of years.

THE COURT: I can see, maybe, if the child -- it would make sense to me if the child was already out of the vagina and up to the neck, maybe.

MR. RUFFIN: When a shoulder dystocia is encountered, some of the head comes out and does the turtle sign. The physician puts his hands on the baby's head and if their allegation is that, "Oh, you just can't ever have enough movement or enough force to cause an injury that's permanent at that point," I can't imagine how he, under oath, could ever say anything like that, because over two hundred years

of medicine and science and recorded in all their own literature, including the literature they cited, there is clearly enough in that, they all state that, "Oh, yes, you can get a permanent injury from excessive lateral traction." If that were the case, there would be no injuries and there would never have all this literature saying you shouldn't apply excessive lateral traction, because the argument would be, "Well, you never apply excessive lateral traction because there is not enough room to do it after the head delivers," is nonsense and after not having the opportunity to challenge him on the reliability of his testimony, I mean, he would have had to concede that that was nonsense.

THE COURT: But you did have an opportunity to challenge him on the reliability of his testimony.

MR. RUFFIN: We did, Your Honor, and we believe -- well, we did in deposition and we believe that when we raised the issue to the Court, that it was at that time that it should have been determined that the testimony provided was unreliable and should never have been heard by the jury, not that we had an opportunity on cross examination to try to show that his testimony is unreliable. It's in all the discussion of the infallibility of an expert and in all the Supreme Court case opinions that say, "No, no, no. It's not good enough to just try to fix this on cross. If it's bumped to begin with, it shouldn't be heard by the jury in the first

place. If it's unreliable, it shouldn't be heard at all and that's where we believe, especially in this case where, I mean, their standard of care opinion is, essentially, derived from their causation opinion that, "Oh, this was caused by one of these other things and therefore, it must not have been excessive lateral traction." And it's the fact that their testimony about causation was unreliable. I'm trying to think, Dr. Salley, I believe ---

THE COURT: That's the name, Dr. Salley.

MR. RUFFIN: Dr. Salley gave four reasons for the basis of his testimony that this injury was caused by something other than excessive traction. They were: shape of the pelvis, never evaluated mom to see the shape of her pelvis. Uterine forces, hypothetical theory, which their own literature now acknowledges it's not a basis that can cause a permanent injury on its own. Third was genetics, yet he never did any genetic testing by which to make a genetic assessment or determination that genetics played any role in this case and fourth, was a synclitism or asynclitism, which is malpositioning, for which there was no evidence or discussion anywhere in the medical record. And tellingly, when he was asked, "What's the probability by which you assigned all of these as being the most probable cause or the cause and he couldn't even say it was 2%, that there was a 2% likelihood that these four things, even when all grouped together,

caused the injury and that's a violation of Peyton v Pierce, which puts the burden upon any physician offering medical testimony, to do so within a reasonable degree of medical certainty, most probably, and it is our position that 2% or less is not sufficient to meet a "most probably" standard for admission of reliable testimony or competent testimony. And so, his testimony, without question, should have been excluded and he said, "Well, the doctor didn't apply excessive lateral traction because it was one of these other things that caused the injury even though I can't say but with 2% certainty that they contributed to the injury.

THE COURT: All right. Yes, sir.

MR. KERN: He also said that in the face of shoulder dystocia and when the turtling sign occurs, that the manner with which Mr. Graham was exhibiting to the jury with the baby doll, "excess lateral traction", was impossible in his experience. If you will recall, Mr. Graham was nearly bending the baby doll in half to exhibit what he considered excess lateral traction. Our experts agreed with that. All that aside, the counsel challenge, I don't recall there being a formal counsel challenge on any of our expert's testimony. I could be wrong. I'd have to look at the transcript, but I do believe that, there was ample opportunity when these experts were offered to the Court as testifying for the Defense, at that point, there was an opportunity to present all this

information. Dr. Salley was deposed only the week before. His testimony was fresh in everybody's mind and so I don't think it was a surprise to anybody as it what he was going to testify to, including the literature, including potential alternative causation theories in addition to what he offered at trial as to the physical impossibility to what the Plaintiff's were presenting to the jury. I would have to look at the transcript to confirm all of that, but... Thank you, Your Honor.

MR. RUFFIN: And a couple of points on that. I believe, from memory, that in his deposition he said he was not going to give causation testimony, either. There might have been some vacillation on that issue whether he really was going to or not, I can't remember, but I think he said, "I'm not offering causation testimony". And then when he took the stand he said, "Well, you know, you did those lawyer tricks, I don't remember, I was tired, I might have said that but I didn't really mean it." So, I just want it to be clear that sure we had the opportunity and when we asked him questions in his deposition about it after he said, "Well, I'm not going to offer causation testimony," then again, that should have been the end of it.

Secondly, with several of these expert witnesses, they essentially relied upon the veracity of one witness' testimony over another in terms of what the people in the

room saw and under our case law it is also inappropriate for an expert to comment on the credibility or veracity of what they saw and it is especially inappropriate in this case where the physician, upon whose deposition testimony upon which they were relying, had zero memory of the delivery in this case and couldn't testify as to what he did habitually because he had only seen these shoulder dystocias five times over the course of thirty-six years and so our next point is, to rely on the veracity of one witness over another, was also inappropriate and secondly, that any witness that gives a comment about, "I say, therefore, it's true," as an expert is also inappropriate even if they are a trained physician in the field.

THE COURT: Of course, I charged them they didn't have to believe an expert witness any more so than a lay witness. Didn't I?

MR. RUFFIN: You did, Your Honor. It's our position that a charge that you don't have to believe a witness does not undo harm caused by the admission of incompetent and unreliable testimony and I believe that's borne out by the case law of South Carolina where our appellate court has overturned cases by which our appellate court has determined that the decision was reached upon expert testimony that was unreliable.

THE COURT: Very good. Anything further?

MR. RUFFIN: From the Defense or from the Plaintiff?

THE COURT: From you.

MR. RUFFIN: Your Honor, we believe that greater effort should have been taken to voir dire the jury panel and as a result of that we were unable to explore biases and prejudices of several members of the jury or even determine if they could be fair and impartial given their relationship with the medical community. We had several members of the jury that were seated that were active employees of Carolinas Hospital and McLeod, one of which had worked with several obstetricians in the OR and one of which, at Carolinas and one of which had worked at McLeod, the jury forelady, I believe, was a director of a mental health institution. Another juror's husband was in charge of quality assurance with Home Health and so we had a number of jurors intricately tied to the medical community and Your Honor asked two questions: One of which was, does anyone know any of the witnesses and is anyone employed by any of the parties, which we believe was an appropriate question. And secondly, Your Honor did ask ---

THE COURT: Was appropriate or inappropriate?

MR. RUFFIN: Was appropriate. It was a good question.

THE COURT: An appropriate.

MR. RUFFIN: It was a good question. Sorry. And the second question, which was, is there any reason anyone knows

by which they can be fair and impartial and although we also believe that question was appropriate, as well, when you have a medical malpractice case in a medical community, more needs to be done and one of the questions we asked that Your Honor didn't, that we asked be charged or requested that was not asked the jury was, "Is anyone employed or have spouses or significant others employed in the medical community." When we did the trial in Greenville, the question was asked ---

THE COURT: I keep hearing about this trial in Greenville. What happened in Greenville?

MR. RUFFIN: The same kind of case. And again, I don't, I won't go into ---

THE COURT: I'm just curious. I want to know, what was the result in Greenville?

MR. RUFFIN: Plaintiff's verdict, not with this party, though. There was another party to it. I only mention that as something that happened in another trial that we believed was fair and we believe would have been necessary in this trial and it's not that Your Honor's ruling is in any way dictated by what another judge did, but we do believe that it is an error that would warrant a new trial not to have done it and that's the argument that we are trying to preserve today.

THE COURT: All right.

MR. RUFFIN: And the point is, we are in a medical community like Greenville or Charleston and when you have a

number of people that have financial ties and career ties to the medical community, we believe ---

THE COURT: Who's to say that if you are a member of the medical community that they aren't absolutely, 100% aware of the fact that the medical community is governed by human beings that make a lot of mistakes? As a matter of fact, they get sued a whole lot. As a matter of fact, if you show up next Thursday, we will have an entire day of day certain cases where doctors are being sued.

MR. RUFFIN: And your Honor, we believe that is the issue, that they see that a lot and I'm not saying that that necessitates that every member of the medical community will always be biased. What I'm saying is, when the questions aren't put to them that ask ---

THE COURT: Well, I think the appropriate question is not whether they are associated with the medical community, but whether or not they can be fair and impartial and I asked that a number of different ways.

MR. RUFFIN: You did, Your Honor. It's our position that asking it generally without some prompting of, "Well, here's where you are. Let's think about this a little bit more," you are employed or your husband is employed by the medical community, let's talk about that and try to figure out if you bring to the table certain biases and prejudices that would disable or would not allow you to be fair and impartial."

THE COURT: All right. What does the Defense have to say about that?

MR. KERN: Nothing Your Honor, other than, the jury panel is what it was. The voir dire was what it was and it was the purview of the Court to voir dire the potential jurors and that's what was done in this case and it was appropriate.

THE COURT: All right. Anything further?

MR. RUFFIN: Just briefly, with the same reason as with the paralegal. These members that were placed on the jury pool, we used all of our peremptory strikes and based upon our use of all our peremptory strikes, we were also prejudiced.

The next issue is, and this one is just to preserve it for the appeal, we believe that a new trial should be granted based on cumulative error. This is a basis by which a trial can be granted even if one were to deem that there had been several errors, but one of them, individually, might not rise to the level of being prejudicial, even though we, I submit to the Court, each of the ones I previously discussed was sufficient to establish prejudice. If one were to look at the arguments made and say well, this one isn't alone sufficient to establish prejudice, we argue that the cumulative effect under the Cumulative Error Rule, all combined, is a basis by which prejudice can be established and that's more for preservation purposes.

THE COURT: All right. Anything you have to say about the cumulative effect?

MR. KERN: Nothing, Your Honor.

THE COURT: All right. Anything else?

MR. RUFFIN: The last one. Thirteenth juror doctrine. We ask that Your Honor use your power to sit as the thirteenth juror and hang the jury and have a mistrial be declared, based upon Your Honor's power to do so, based on Your Honor's view of the evidence submitted to the jury; based upon the standard of care evidence submitted, the fact that all the experts agreed that excessive lateral traction is without question a cause of a permanent brachial plexus injury, that the causation testimony submitted by Defense counsel to say it wasn't caused by excessive lateral traction was unreliable and falls well short of establishing that there was anything but excessive lateral traction that caused the injury and that there was no evidence that the patient was not medically stable, therefore, it's simply a negligence standard by which to judge the physician's conduct and that all the evidence as presented to Your Honor would allow Your Honor to sit as the thirteenth juror and hang the jury.

THE COURT: As far as the thirteenth juror, I think there was ample evidence for a reasonable jury to find just what they found. Whether or not I might have found something different, I'm not saying I would have or wouldn't have, but

it takes more than that. It takes whether or not a reasonable juror had the ability based on the evidence presented to reach that decision and I think they did. So...

MR. RUFFIN: The only final thing on that matter, even after they rendered their verdict, well, two things: Number one, there was clearly confusion about how to answer the first question when they sent a note asking about it. Secondly, one of the jurors ---

THE COURT: Well, they asked the question and I answered it and they did just fine, didn't they?

MR. RUFFIN: Well, they ended up, they didn't answer "no", they answered, "yes", but we believe that showed there was some confusion on the part of the jury. Secondly -- and that also relates back to our previous objections we raised to the obstetric emergency as charged and on the verdict form.

The second issue as it relates to the thirteenth juror doctrine, was the fact that one of the jurors after the verdict had been rendered said, "She had to get out of here, she's going to Disney World," and we think that's clear evidence that they didn't consider ---

THE COURT: She was an alternate, wasn't she?

MR. RUFFIN: I think she was one of the ones that were seated.

THE COURT: She was an alternate.

MR. RUFFIN: She might not have been, Your Honor, but I would ---

THE COURT: She was an alternate.

MR. RUFFIN: Never mind. My apologies if she wasn't seated, then.

THE COURT: All right.

MR. KERN: Your Honor, if I may?

THE COURT: Yes.

MR. KERN: Just as to the thirteenth juror doctrine and, really, as to the rest of the motion. With regard to the jury and the question on the obstetrical care emergency statute, I think it would be difficult for anybody to infer what the jurors did or did not understand with regard to the question they posed to the Court and for the fact that they then went in and deliberated for a significant amount of time. I don't see how anybody standing here today could know anything about what they were or were not confused about. Finally, just with regard to the thirteenth juror doctrine and also the other arguments enumerated by, elegantly, by Plaintiff's counsel, it's the Defense's position that it was a clean trial, there was ample opportunity on both sides for parties to present their evidence and both parties utilized the opportunity to the best of their abilities and we got to the jury verdict, as hoped, within one week.

THE COURT: All right. Anything, further, Mr. Ruffin?

MR. RUFFIN: Nothing, Your Honor.

THE COURT: Do you want to talk about medical malpractice in general or anything?

MR. RUFFIN: Do you want to hear our motion to continue another trial or do you want to try that one?

THE COURT: No, we will be all right. Well, I've heard your motions and you are protected on the record, but I'm going to deny your motions for a new trial, but you are protected on the record. Very good. And I'm going to ask that you just do a form four order for that. Good to see y'all.

MR. KERN: Thank you, Your Honor.

MR. RUFFIN: Thank you.

STATE OF SOUTH CAROLINA)
)
COUNTY OF ANDERSON)

CERTIFICATE

BE IT KNOWN THAT I, THE UNDERSIGNED JO RICE, OFFICIAL COURT REPORTER FOR THE TENTH JUDICIAL CIRCUIT OF THE STATE OF SOUTH CAROLINA, DO HEREBY CERTIFY THAT THE FOREGOING TRANSCRIPT REPRESENTS A TRUE, ACCURATE AND COMPLETE TRANSCRIPT OF RECORD OF THE HEARING IN THE CAPTIONED CASE, RELATIVE TO APPEAL, BEFORE THE CIRCUIT COURT FOR FLORENCE COUNTY, SOUTH CAROLINA, SO GIVEN ON MAY 19, 2015 TO THE BEST OF MY SKILL AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

IN WITNESS WHEREOF I HAVE HERE UNTO SET MY HAND AND SEAL THIS 5TH DAY OF OCTOBER, 2015.

JO RICE
OFFICIAL COURT REPORTER

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

Michael Nettles, Circuit Court Judge

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.

CERTIFICATE OF COUNSEL

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.

By: _____

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April 12, 2016