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ORIGINAL

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM GREENVILLE COUNTY
Court of Common Pleas

The Honorable D. Garrison Hill

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

RECEIVED

SEP 17 2015
SC Court of Appeals

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

Respondent,

v.

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

Of which Greenville Hospital System is

Appellant.

RECORD ON APPEAL

VOLUME I OF II

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INDEX

Verdict	1
Order of August 13, 2014	5
Order of August 28, 2014	18
Complaint	20
Amended Complaint.....	28
Answer	36
Plaintiff's Motion for New Trial Absolute	41
Plaintiff's Motion for New Trial Nisi Additur	57
Defendant's Memorandum Opposing Plaintiff's Motions for New Trial	62
Defendant's Motion to Alter or Amend.....	71
Transcript of Trial.....	73
Testimony	
Demetria Orange	
Direct	140
Cross	160
Michelle Linda Murray	
Direct	168
Cross	218
Yvonne Gomez-Carrion, M.D.	
Direct	238
Cross	345
Redirect.....	383
Recross.....	390
Further Examination	393
Alana Andrea McClure	
Direct	395
Cross	407
Kelly Williams	
Direct	415
Charles John Vanderkolk, M.D.	
Direct	420
Cross	449

Karen Shelton	
Direct	461
Cross	489
Samuel Orange	
Direct	496
Cross	520
Carrie Anne Twedt	
Direct	522
Oliver G. Wood, Jr.	
Direct	573
Cross	584
Tammy Nutt	
Direct	598
Brandi Kay Alt, M.D.	
Direct	600
William Merritt, M.D.	
Direct	613
Cross	615
Redirect	644
Trevor Resnick, M.D.	
Direct	645
Cross	655
Transcript of Post-Trial Hearing	714
Trial Exhibits	
Pl. Ex. 8	718
Pl. Ex. 11	724
Transcript of Deposition of John Grossman	731
Certificate of Appellant	741

FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP2306665

D'Metria Orange	J.B.	Greenville Hospital System	Greenville Hospital System Partners In Health
PLAINTIFF(S)		DEFENDANT(S)	

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

DISPOSITION TYPE (CHECK ONE)

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

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

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

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk: Parties have 10 days to file post-trial motions 9/15

INFORMATION FOR THE JUDGMENT INDEX

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

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)
M'Quynne Ballenger	Greenville Hospital System	\$337,500.00

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

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

Hamlin 2138 11/5/13
Circuit Court Judge D. GARRISON HILL Judge Code Date

For Clerk of Court Office Use Only

¹¹⁻⁸⁻¹³ This judgment was entered on 11-8-13, and a copy mailed first class or placed in the appropriate attorney's box on 11-8-13, to attorneys of record or to parties (when appearing pro se) as follows:

Edward L. Graham PO Box 550 Florence, SC 29503

ATTORNEY(S) FOR THE PLAINTIFF(S)

J. Ben Alexander Haynsworth Sinkler Boyd, PA P.O. Box
2048 Greenville, SC 29602

ATTORNEY(S) FOR THE DEFENDANT(S)

Paul B. Wickensimer

Court Reporter HOLLIE JENKINS

Paul B. Wickensimer Greenville County Clerk Of
Court - Clerk of Court

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

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

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF GREENVILLE) THIRTEENTH JUDICIAL CIRCUIT
) C/A NO.: 2011-CP-23-6665
Demetria Orange, as Next Friend of)
J.B. [REDACTED] a minor,)
) Plaintiff,)
) v.) VERDICT FORM
) Greenville Hospital System)
and Greenville Hospital System)
Partners in Health,)
) Defendants.)

FILED-CLERK OF COURT
GREENVILLE CO. S.C.
PAUL B. WICKENS
2013 NOV 8 AM 9 25

1. Do you find by the greater weight of the evidence that Greenville Hospital System was negligent and that such negligence proximately caused injury to J.B. [REDACTED]

~~_____~~ No: If no, go to question 3.

X Yes: If yes, go to questions 2 and 3.

2. Please indicate the basis for this finding:

Physician negligence: X Yes _____ No

Nursing negligence: _____ Yes X No

3. Do you find by the greater weight of the evidence that Greenville Hospital System Partners in Health was negligent and that such negligence proximately caused injury to J.B. [REDACTED]

X No

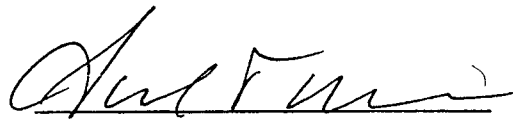
_____ Yes

4. If you answered either questions 1 or 3 "yes", please state the total amount of actual damages, if any, sustained by **J.B.**

J.B.

\$ 337,600

November 4, 2013
Greenville S.C.



Foreperson

FORM 4

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

FILED-CLERK OF COURT

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP2306665

Demetria Orange

J.B.

Greenville Hospital
System

Greenville Hospital
System Partners In
Health

2014 AUG 13 PM 3 07

PLAINTIFF(S)

DEFENDANT(S)

Submitted by:

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

DISPOSITION TYPE (CHECK ONE)

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☐ Rule 43(k), SCRCP (Settled): ☐ Other: _____
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☐ Affirmed: ☐ Reversed: ☐ Remanded: ☐ Other: _____

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

ORDER INFORMATION

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Additional Information for the Clerk: _____

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

8/13/2014

Circuit Court Judge

Judge Code

Date

For Clerk of Court Office Use Only

This judgment was entered on August 13, 2014, and a copy mailed first class or placed in the appropriate attorney's box on August 13, 2014, to attorneys of record or to parties (when appearing pro se) as follows:

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

J. Ben Alexander Haynsworth Sinkler Boyd, PA P.O. Box
2048 Greenville, SC 29602

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter

Paul B. Wickensimer Greenville County Clerk Of
Court - Clerk of Court

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

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

Haynsworth Sinkler Boyd, P.A.

Date Rec'd

8-18-14

C/M #

00505-0573

Routing

JBA/EC

Calendared

STATE OF SOUTH CAROLINA IN THE COURT OF COMMON PLEAS
 COUNTY OF GREENVILLE THIRTEENTH JUDICIAL CIRCUIT

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

Plaintiff,

v.

Greenville Hospital System and Greenville
 Hospital System Partners in Health,
 Defendants.

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

**Order Granting
 New Trial Nisi Additur**

Plaintiff Demetria Orange, as the adoptive mother and Next Friend of **J.B.**
J.B. a minor, tried this medical negligence case to a jury verdict. The jury awarded her
 \$337,500.00 in actual damages against Defendant Greenville Hospital System ("GHS").¹

The evidence at trial showed that in 2004 GHS physicians breached the standard of care
 in **J.B.**'s birth and delivery. **J.B.**'s mother experienced a protracted labor, and an
 ob-gyn medical emergency arose during **J.B.**'s delivery. The doctors attempted various
 procedures so the normal birth process could resume. When these proved unsuccessful, they
 applied traction. There was expert testimony that the traction used was excessive, tearing out the
 peripheral nerves and tissue from **J.B.**'s right shoulder, resulting in a permanent,
 debilitating and disfiguring brachial plexus injury, commonly known as "shoulder dystocia."

There was ample evidence that **J.B.**'s traumatic injury could only have been
 caused by malpractice:

¹ The jury found for Defendant Greenville Hospital System Partners in Health.

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At the time of trial [REDACTED] J.B. [REDACTED] was ten years old. She had already endured two surgeries, the first of which allowed her to recover a reasonable amount of function in her right, dominant hand. Nevertheless, she still suffers from severe shoulder deformity and disability. She can only rotate her right arm 80 degrees; 180 degrees is normal. Her right arm visibly droops, and she can only raise it about halfway. Plaintiff now moves for this court to grant a new trial or, alternatively, a new trial nisi additur.

I. Motion for New Trial

The verdict was not so grossly inadequate as to be the result of passion, caprice, prejudice or other extraneous influence. The court finds no error occurred during voir dire or jury selection, and reaffirms its rulings made on the record. Plaintiff's claims regarding the jurors' alleged use of its own standard of care so as to require intentional conduct lack evidentiary support. The court has no proof of juror misconduct of any type.

Viewing the evidence in the light most favorable to GHS, there was sufficient evidence to send the issue of breach of duty and causation to the jury. While Dr. Ernst's opinion may well have been dubious—and was rejected by the jury—credibility cannot be decided by the court at the directed verdict stage. Instead, credibility must be presumed.

II. Motion for New Trial Nisi Additur

A. The Legal Standard

If the trial court, which had the opportunity to view the evidence as it was presented at trial, finds that the verdict did not adequately compensate Plaintiff for her injuries, the trial court may offer the Defendant a choice of either accepting an increased verdict amount or a new trial. The additur suggests an appropriate settlement amount. Vinson v. Hartley, 324 S.C. 389, 406,

477 S.E.2d 715, 723 (Ct. App. 1996). This power was first approved by our supreme court in Graham v. Whitaker, 282 S.C. 393, 321 S.E.2d 40 (1984) and has been repeatedly reaffirmed:

While the trial judge may not impose his will on a party by substituting his judgment for that of the jury, he may give the party an option in the way of additur or remittitur, or, in the alternative, a new trial. Jones v. Ingles Supermarkets, Inc., 293 S.C. 490, 361 S.E.2d 775 (Ct.App.1987). The consideration of a motion for a new trial nisi additur requires the trial judge to consider the adequacy of the verdict in light of the evidence presented. Patterson v. Reid, 318 S.C. 183, 456 S.E.2d 436 (Ct.App.1995). The trial judge who heard the evidence and is more familiar with the evidentiary atmosphere at trial possesses a better-informed view of the damages than this Court. Rush v. Blanchard, 310 S.C. 375, 426 S.E.2d 802 (1993). Accordingly, great deference is given to the trial judge. Id.

When a party moves for a new trial based on a challenge that the verdict is either excessive or inadequate, the trial judge must distinguish between awards that are merely unduly liberal or conservative and awards that are actuated by passion, caprice, or prejudice. Allstate Ins. Co. v. Durham, 314 S.C. 529, 431 S.E.2d 557 (1993). Therefore, on appeal of the denial of a motion for a new trial nisi, this Court will reverse when the verdict is grossly inadequate or excessive requiring the granting of a new trial absolute. O'Neal, supra.

Vinson v. Hartley, 324 S.C. 389, 406, 477 S.E.2d 715, 724 (Ct. App. 1996).

After Graham, our court of appeals in several decisions engrafted without explanation a requirement that the trial judge's findings that a verdict was inadequate must be "compelling." In 1993 the supreme court decided what is arguably the leading case on new trial nisi, O'Neal v. Bowles, 314 S.C. 525, 431 S.E.2d 555 (1993); which harmonized the case law and overruled several formulations of the court of appeals. O'Neal never addressed or mentioned the "compelling" requirement. Nevertheless, it silently resurfaced. Pelican Bldg. Ctrs. v. Dutton, 311 S.C. 56, 61, 427 S.E.2d 673, 676 (1993); Bailey v. Peacock, 318 S.C. 13, 455 S.E.2d 690 (1995). This gloss is tautological, for the trial court's finding of adequacy is already subject to reversal if it exceeds discretion, which includes being unsupported by the evidence. Our cases

do not define "compelling"; instead the concept appears to be malleable and driven by subjective factors, as is commonly the case with such discretionary remedies. But the requirement sets additur curiously apart from the other tools a court may use to set aside a jury verdict it finds to be against the weight of the evidence: a trial court can order a new trial absolute *if it finds* the verdict amount shockingly inadequate; and need not give reasons for such a conclusion, much less compelling ones, and a judge acting as the Thirteenth juror can "hang" the jury without any explanation whatsoever. Compare Elam v. South Carolina Department of Transportation, 361 S.C. 9, 602 S.E.2d 772 (2004) (new trial absolute) with Folkens v. Hunt, 300 S.C. 251, 387 S.E.2d 265 (1990) (Thirteenth juror doctrine).

The discretion of trial courts to grant additur under similar circumstances has been upheld. In Graham, the trial court ordered a new trial nisi additur of several times the jury verdict, increasing actual damages from \$10,000 to \$67,500. In finding no abuse of discretion in the trial judge's order, the court noted "it cannot seriously be argued that plaintiff herein was adequately compensated or even nearly so, for the injuries she sustained." Id. at 405. In Waring v. Johnson, 341 S.C. 248, 533 S.E.2d 906 (Ct. App. 2000), the court of appeals affirmed the trial court's grant of a new trial nisi additur, noting "[t]he jury failed to consider Waring's pain and suffering in reaching its verdict." Id. at 960, 533 S.E.2d at 913. In Waring, the jury made an award to Plaintiff of his medical bills. The trial court granted Plaintiff's motion for new trial nisi additur and awarded nearly double what the jury awarded to adequately compensate Plaintiff for pain and suffering. The court of appeals noted that Waring "visited numerous doctors for years after the accident," "underwent surgery for a condition... aggravated by the wreck," and "found herself unable to continue her previous active lifestyle." Id. The court ultimately concluded, "indubitably, Waring is entitled to an award for pain and suffering." Id.

When the damages evidence at trial has been "hotly contested" or disputed and the jury award is less than Plaintiff's medical bills, an order granting additur may be reversed if the sole ground supporting it is the trial judge's belief that the verdict should have included all of Plaintiff's medical costs. See Luchok v. Vena, 391 S.C. 262, 705 S.E.2d 71 (Ct. App. 2010) (improper for trial judge in case where damages were disputed to conclude Plaintiff's medical costs were "reasonable and necessary" and should have been included in full in jury award); Green v. Fritz, 356 S.C. 566, 571, 590 S.E.2d 39, 41 (2003) ("Where, as here, the evidence of damages is disputed, the mere listing of Green's claimed damages by the trial judge in his order does not constitute compelling reasons for invading the jury's province. The order offers no reasons upon which we can review the appropriateness of usurping the jury's decision on damages."). On the other hand, an additur that increased the jury award to slightly exceed the medical bills has been upheld as well within discretion. Patterson v. Reid, 318 S.C. 183, 456 S.E.2d 436 (Ct. App. 1995).

Riley v. Ford Motor Company, 408 S.C. 1, 757 S.E.2d 422 (2014) was a wrongful death case where the decedent's estate had presented \$238,801 in economic damages. After a jury award of \$300,000 in actual damages to the estate, the trial court granted additur finding the verdict inadequate in light of the evidence of the extent of noneconomic loss to the estate's beneficiaries. The court of appeals reversed, surmising that the jury had awarded \$61,199 for noneconomic loss, and the trial court's "mere disagreement" with this portion of the award did not constitute a compelling reason warranting additur. The court distinguished the case "from those in which our court has affirmed the granting of additur when the jury altogether failed to award noneconomic damages. See, e.g., Waring v. Johnson, 341 S.C. 248, 255, 261, 533 S.E.2d 906, 910, 913 (Ct.App.2000) (finding "[t]he jury failed to make any award for other damages

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such as pain and suffering," which amounted to "compelling reasons...justifying the grant of the nisi additur"; Williams v. Robertson Gilchrist Constr. Co., 301 S.C. 153, 155-56, 390 S.E.2d 483, 484-85 (Ct.App.1990), overruled on other grounds by O'Neal v. Bowles, 314 S.C. 525, 431 S.E.2d 555 (1993) (finding the trial court's reason for granting additur—the jury disregarded the testimony about the funeral bill and noneconomic losses—was compelling); Jones v. Ingles Supermarkets, Inc., 293 S.C. 490, 493-494, 361 S.E.2d 775, 777 (Ct.App.1987) (affirming the granting of additur where the jury's award of actual damages equaled the exact amount of the plaintiff's economic loss, but no damages for proven noneconomic loss)." Riley, 408 S.C. at 20 n. 10. The verdict here fits this category, as the jury failed to award Plaintiff noneconomic damages.

Although one could read Riley as suggesting that a trial court that does not agree with a jury's calculation of damages could never find a "compelling" reason for doing so, the touchstone for whether additur is permitted remains Graham's focus of whether the award adequately compensates the injured party. Although discussing remittitur, a famous decision by Judge Medina drives home the point: "[t]he very nature of the problem counsels restraint. Just as the trial judge is not called upon to say whether the amount is higher than he personally would have awarded, so are we appellate judges not to decide whether we would have set aside the verdict if we were presiding at the trial, but whether the amount is so high that it would be a denial of justice to permit it to stand." Dagnello v. Long Island R. Co., 289 F.2d 797, 806 (2d Cir. 1961).

B. The Trial Evidence

The jury awarded damages just below **J.B.**'s projected economic loss. This did not adequately compensate her given the damages evidence, which included undisputed proof of physical pain and suffering, permanent disability and injury to her right arm and shoulder.

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disfigurement and emotional pain and suffering by a child. A jury award that fails to make any award for these damages where a child has lost the use of her arm for the rest of her life cannot stand.

Several experts testified and wrote reports that were admitted as exhibits about the effect of J.B.'s injury on her future earning capacity. J.B.'s Vocational Rehabilitation Expert, Dr. Charles J. Vander Kolk, testified that but for J.B.'s disability, she most probably would complete high school and have a good chance to complete up to two years of technical school or a community college. She would not have physical or psychological factors that would likely interfere with her development and progress in a school setting. Dr. Vander Kolk opined she most probably would have entered the workforce earning \$9.00 to \$10.00 per hour in 2012 dollars. In five to seven years, she most probably would have earned in the range of \$25,000 to \$34,000 per year, and received normal increases in income during her work life.

Dr. Vander Kolk explained that physical impairment of one upper extremity is considered a severe disability. J.B. will have little to no use of the right upper extremity in performing job tasks. Over 90% of jobs in the U.S. economy require good use of both upper extremities in order to be productive, and thus J.B. will be extremely restricted in terms of access to the labor market. She will have great difficulty in finding and keeping an appropriate job. While her limitations may not exclude her from the labor force, her disability significantly reduces her opportunities and earning capacity. J.B.'s loss of earning capacity would most probably be in the range of 36% to 58%. However, considering her ambition, mental ability and support of her custodial parents, Dr. Vander Kolk surmised that the loss will most likely be in the range of 25% to 45% over her work life. Furthermore, psychological factors could impact J.B.'s earning capacity and reduce the above earning ability because she will

most probably experience a mild psychological impairment as a result of the physical disability beginning in her teenage years.

Dr. Oliver Wood testified as an economic expert in the evaluation of economic loss in personal injury cases. He testified that over the course of her life, **J.B.** would have earned \$3.229 million, which results in a present cash value of \$564,191.00. Dr. Wood opined that by working at a job that can accommodate her disability, she will offset 65% of that loss, or \$366,718.00, resulting in a net loss in earning capacity of \$197,463.00. Based on a Life Care Plan developed by Ms. Karen Shelton, RN, Dr. Wood calculated the present value of **J.B.**'s future medical care costs from the age eighteen until age 80.84, her life expectancy. Dr. Wood computed the costs of physicians, equipment, evaluations, therapy, home modifications, and other assistance and allowances and found the total future medical care costs, or cost of her life care plan after age eighteen, to be \$162,833.00. Dr. Wood testified that this amount does not include past costs or costs incurred before **J.B.**'s eighteenth birthday. Furthermore, the amount does not include the cost of recommended future surgeries. Finally, the amount does not include any noneconomic damages, such as pain and suffering, disfigurement, or loss of enjoyment of life. By adding the net loss in earning capacity (\$197,463.00) and the future medical care costs (\$162,833.00), Dr. Wood concluded that **J.B.** total financial loss will be \$360,296.00.

No testimony or other evidence was offered by defense counsel to refute any of Plaintiff's economic damages. No testimony was presented by anyone on behalf of the defense to question any of the future treatment, care or cost figures in the life care plan or lost earnings. In this light, the verdict of \$337,500 appears even more inadequate because it is less than the Plaintiff's evidence of economic damages, and makes no award for noneconomic damages.

The jury could have discounted the economics damages entirely, and awarded the curious figure of \$337,500.00 for pain and suffering, permanent disfigurement, loss of enjoyment of life and mental distress. But this is unlikely, and the very nature of a general verdict prevents the parsing out of various elements of damages. Perhaps the jury did reject Plaintiff's economic damages wholesale, but that would mean the jury believed a person with a traumatic limitation of an arm will suffer no impairment of earning ability over her lifetime, a conclusion so at odds with reason and experience that no court could approve it. The essence of Defendant's cross examination of Dr. Wood and Dr. Vander Kolk was that J.B. could possibly overcome her physical condition and other limitations and outperform her own expert's expectations. Yet in law such possibilities are called speculation, and cannot form the factual basis for the serious and important findings of a jury. If the tables were turned, and the jury had awarded economic damages exceeding the expert's calculation, the Defendant would be certain to claim the verdict bore no rational basis to the evidence. For example, suppose Plaintiff's expert had testified that J.B.'s economic damages were \$100,000.00, but the expert also stated it was "possible" that she would suffer more than \$100,000.00 in economic loss. If the ensuing economic loss award exceeded \$100,000.00, then Defendant would surely maintain the jury's unilateral increase was driven by unwarranted speculation. Defendant would likely view such a result not simply as a jury exercising its prerogative to decide credibility, but as a runaway award fueled by rank guesswork.

The jury could also possibly have awarded the lost earnings but subtracted out the cost of future medical care. Yet they could not simultaneously ignore the obvious disfigurement and other noneconomic damages that J.B. has suffered and will continue to suffer for the next 70 years.

This court is acutely mindful that jury verdicts are entitled to substantial deference and may not be disturbed if they can be logically reconciled with the evidence.² Try as it might, this court cannot tie the verdict amount to any logical anchor. Efforts of courts to divine the murky workings of juries are often clumsy and almost always futile, and we would do well to remember Kant's injunction that when considering human behavior "we can never, even by the strictest examination, get behind the secret springs of action." It is true that the jury alone is entitled to weigh the evidence and gauge credibility; indeed a jury is not even required to accept uncontradicted testimony. But these abstract principles surely do not mean the judge who tried the case --and who "alone has the power to grant a new trial nisi when he finds the amount of the verdict to be merely inadequate or excessive," Vinson v. Hartley, supra (emphasis added) -- is forbidden from doing what the law expressly empowers him to do when he finds the remedy fails to adequately compensate an injured party.

The jury's prerogative to find the facts is not immune from review. Black v. Hodge, 306 S.C. 196, 410 S.E.2d 595 (Cl. App. 1991) and other cases emphasize that a jury is free to reject undisputed testimony as part of its role in determining credibility. But this reasoning, carried to its logical ends, would effectively abolish the new trial and new trial nisi doctrines. No one would contend that the jury could have found, for instance, that Ja'Quylynie's arm and shoulder were not damaged, or that she had proven no pain and suffering, disability, or future economic loss. Cf. Collins v. Bisson Moving & Storage, Inc., 332 S.C. 290, 301, 504 S.E.2d 347, 353 (Cl. App. 1998) (principle of Black v. Hodge inapplicable where damages evidence admits of only one reasonable inference). Verdicts often pose imponderables, but when an award is conspicuously inadequate it is not enough for the court to throw up its hands and claim

² This court has never before granted a new trial nisi additur.

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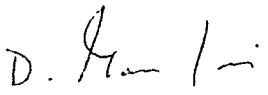
powerlessness. Jury trials are not journeys into metaphysics; they are supposed to be attempts to achieve justice.

It is enough to say that an award of \$337,500.00 on this record is not adequate. This finding is based on the compelling reason that it does not reasonably compensate a 10-year-old child for her grievous, life-altering injuries and make her whole, to the extent money damages can. The award was less than her economic damages, and made no apparent provision for her substantial noneconomic damages. This is more than a mere disagreement with the jury's verdict. It is the firm conclusion of this court—which saw and heard the witnesses, watched Ja'Qulyne demonstrate her deformity to the jury, scrutinized the exhibits, and observed the trial unfold over many days—that the jury's award failed to account for the profound magnitude of her loss.

IT IS THEREFORE ORDERED:

1. The court grants Plaintiff's motion for new trial nisi additur and increases the verdict to \$650,000.00. GHS of course can refuse to accept this suggested settlement figure, and a new trial will be promptly scheduled.

IT IS SO ORDERED.


D. Garrison Hill
Circuit Judge

August 13, 2014
Greenville, South Carolina

A Certified Copy
Paul B. Wickens
Clerk of Court C.P. & G.S.
Greenville County, SC
Dated 8/13/14

FORM 4

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

FILED - CLERK OF COURT
GREENVILLE CO. S.C.

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2011CP236665

Demetria Orange

PAUL J. JENKINS

2014 SEP 2 AM 11 02

Greenville Hospital
System

Greenville Hospital
System Partners in
Health

PLAINTIFF(S)

DEFENDANT(S)

Submitted by:

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

DISPOSITION TYPE (CHECK ONE)

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

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

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

Defendants' Motion to Alter or Amend is respectfully denied. In addition, the August 18, 2014 Order Granting New Trial Nisi Additur only applies to Defendant Greenville Hospital System, as it was the only Defendant against whom the jury found.

ORDER INFORMATION

This order ☐ ends ☒ does not end the case.

Additional Information for the Clerk: _____

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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

Circuit Court Judge

2138

8/28/2014

Judge Code

Date

For Clerk of Court Office Use Only

This judgment was entered on 9/2/14, and a copy mailed first class or placed in the appropriate attorney's box on 9/2/14 to attorneys of record or to parties (when appearing pro se) as follows:

Edward L. Graham, Esq.
P.O. Box 550
Florence, SC 29503

J. Ben Alexander, Esq.
ONE North Main, 2nd Floor
Greenville, SC 29601

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Court Reporter

Paul B. Wickensimer Greenville County Clerk Of
Court - Clerk of Court

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

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

STATE OF SOUTH CAROLINA)
 COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS
 THIRTEENTH JUDICIAL CIRCUIT
 C/A NO.:

Alana Mann, as Next Friend of
 J.B. a minor,

Plaintiff,

v.

Greenville Hospital System and
 Greenville Hospital System Partners
 in Health,

Defendants.

2011-CP-23-6665

COMPLAINT
 (Jury Trial Requested)

FILED
 2011 FEB 7 PM 3:00
 CLERK OF COURT

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

1. Plaintiff Alana Mann (hereinafter, "Alana") is a citizen and resident of Greenville County, South Carolina, and is the mother and Next Friend of J.B. hereinafter, J.B.).
2. Defendant Greenville Hospital System (hereinafter, "GHS") is, upon information and belief, a hospital corporation which owns and operates a regional hospital in Greenville County, South Carolina, and holds itself out to the public as having specialized facilities, equipment and staff for the provision of high quality obstetrical and neonatal care. Defendant GHS is named a party to this action by virtue of the acts and/or omissions of its residents, employees and agents, within the course and scope that that respective residency, employment and agency, including but not limited to obstetrical residents, Dr. William M. Merritt, (hereinafter, "Dr. Merritt"), Dr. Brandi Alt, (hereinafter, "Dr. Alt") and Dr. Ridner, (hereinafter, "Dr. Ridner") for which it bears *respondeat superior* liability.

3. Dr. Merritt, Dr. Alt and Dr. Ridner were upon information and belief, physicians duly licensed to practice medicine within the State of South Carolina, who at all relevant times held themselves out to the public as having specialized knowledge, training and experience for the provision of high quality medical care and were in training as obstetrical residents at GHS.

4. Defendant Greenville Hospital System Partners in Health, (hereinafter, GHS Physicians) is upon information and belief a 501(c) (3) subsidiary of GHS which at all relevant times employed Dr. Carrie Ann Twedt, (hereinafter, "Dr. Twedt") and Dr. John Dacus, (hereinafter, "Dr. Dacus") who were acting at all relevant times within the course and scope of their employment with GHS Physicians, such that this Defendant is therefore responsible for the torts of Dr. Twedt and Dr. Dacus under the doctrine of *respondeat superior*.

5. Dr. Twedt and Dr. Dacus are, upon information and belief, physicians duly licensed to practice medicine within the State of South Carolina, who at all relevant times held themselves out to the public as having specialized knowledge, training and experience for the provision of high quality obstetrical and gynecological care, who at all relevant times were citizens and residents of Greenville County, South Carolina, who maintained an office in Greenville, South Carolina, for practices of obstetrics and gynecology, and who served as attending physicians for the obstetrical residency program at GHS.

6. Prior to November 27, 2004, Alana became pregnant with her daughter,

J.B.

7. On November 27, 2004, Alana presented to GHS for delivery of her child.

8. Drs. Merritt, Alt and/or Ridner took charge of the labor of Alana and the delivery of J.B. at the GHS.

9. In exercising responsibility for the said labor and delivery, Drs. Merritt, Alt and Ridner were purportedly acting under the supervision of Dr. Twedt and/or Dacus; but it is unknown to Plaintiff whether or not Drs. Twedt and/or Dacus were physically present, and whether or not Dr. Twedt and/or Dacus actually supervised the labor and delivery.

10. Prior to delivery on November 27, 2004, Ja'Qulyne was a healthy baby.

11. Drs. Merritt, Alt, Ridner, Twedt and/or Dacus owed Alana and her daughter a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar situations.

12. Defendant GHS, its agent(s) and employee(s) owed Alana and her daughter a duty of providing obstetrical services, obstetrical nursing and support services, labor and delivery nursing and support services, and newborn care support services consistent with generally accepted standards of hospitals, obstetricians, nurses and support staff acting under similar situations.

13. Defendant GHS Physicians owed Alana and her daughter a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar circumstances.

14. Defendants, as well as Drs. Merritt, Alt, Ridner, Twedt and/or Dacus breached their duties of care to Alana and her daughter, J.B. and were negligent, reckless, willful, wanton, and/or otherwise wrongful in their care of them and attention to them, as a direct and proximate result of which J.B. sustained severe bodily injuries, losses and damages.

15. J.B. was born on November 27, 2004 by vaginal delivery performed, upon information and belief, by Drs. Merritt, Alt and/or Ridner.

16. In delivering **J.B.** Drs. Merritt, Alt and/or Ridner traumatically injured her brachial plexus nerves on the right, causing nerve damage to the entire right upper extremity.

17. Negligence and other wrongful conduct on the part of each Defendant and its employees joined and concurred with negligence and other wrongful conduct on the part of the other Defendant and its employees, to directly and proximately cause **J.B.** certain injuries, losses and damages.

18. Drs. Merritt, Alt and/or Ridner were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars:

(a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and complicated by shoulder dystocia delivery in particular, before attempting to deliver **J.B.**

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

(c) in failing and refusing to recognize the need for an experienced obstetrician to manage this delivery:

(d) in using improper delivery technique;

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

(f) in mismanagement of labor and delivery;

(g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and

(h) such other acts and omissions as may be determined during discovery or trial.

19. Drs. Twedt and/or Dacus were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars:

- (a) in failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patients' health;
- (b) in failing and refusing to recognize the need for an experienced obstetrician to manage delivery;
- (c) in failing to properly supervise a vaginal delivery complicated by shoulder dystocia and in allowing it to be mismanaged by one or more obstetrical residents;
- (d) in allowing J.B. to be delivered on their watch with inappropriate delivery techniques;
- (e) in allowing J.B. to be delivered on their watch with improper and excessive force, traction and/or torsion.
- (f) in allowing J.B. to be delivered on their watch with mismanagement of labor and delivery;
- (g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and
- (h) such other acts and omissions as may be determined during discovery or trial.

20. Defendant GHS, its employee(s) and agent(s), were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to the following particulars:

(a) in failing and refusing to require its employee(s), agent(s), resident(s), attending(s), and member(s) of its medical staff to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and shoulder dystocia in particular, before allowing inexperienced residents, without proper supervision to manage J.B.'s delivery;

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

(c) in failing and refusing to take proper steps to avoid J.B.'s severe and permanent brachial plexus injury;

(d) in failing and refusing to provide proper and timely labor and delivery nursing care and attention required by J.B.'s condition;

(e) in failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients; condition; and

(f) such other acts and omissions as may be determined during discovery or trial;

(g) In addition this Defendant has responsibility for the torts of its employees, including but not limited to Drs. Merritt, Alt and Ridner, under the doctrine of *respondeat superior*.

21. Defendant GHS Physicians, its employee(s) and agent(s), were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars:

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

(b) in failing and refusing to recognize the need for an experienced obstetrician to manage this delivery;

(c) in failing to properly supervise and manage or cause to be supervised and managed a vaginal delivery complicated by shoulder dystocia; and in allowing it to be mismanaged by one or more obstetric residents;

(d) in allowing J.B. to be delivered with inappropriate delivery technique;

(e) in allowing J.B. to be delivered with improper and excessive force, traction and/or torsion;

(f) in allowing J.B. to be delivered with mismanagement of labor and delivery;

(g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and

(h) such other acts and omissions as may be determined during discovery or trial;

(i) In addition this Defendant has responsibility for the torts of its employees, including but not limited to Drs. Twedt and Dacus, under the doctrine of *respondeat superior*.

22. As a direct and proximate result of the negligence and other wrongful conduct on the part of each Defendant, which joined and concurred with the negligence and other wrongful conduct on the part of the other defendants, J.B. suffered severe and permanent personal injuries, losses and damages as follows:

- (a) Physical injuries, disorders and dysfunction;
- (b) Permanent impairments and disabilities;
- (c) Medical expenses, including those to be incurred in the future;
- (d) Life care plan expenses;
- (e) Adverse effect on her career options, employability and earning capacity;
- (f) Pain and suffering;
- (g) Emotional and psychological damages;
- (h) Loss of enjoyment of life; and
- (i) Such other damages as may be determined during discovery or trial.

WHEREFORE, Plaintiff prays for judgment against the Defendants, jointly and severally, for actual and punitive damages, together with costs and such other and further relief as the Court may deem just and proper.

GRAHAM LAW FIRM, P.A.

By: 

Edward L. Graham
Mary H. Watters
383 W. Cheves St.
Florence, SC 29501

Attorneys for Plaintiff

STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT
C/A NO.:

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

Plaintiff,)

v.)

Greenville Hospital System and)
Greenville Hospital System Partners)
in Health,)

Defendants.)

SECOND AMENDED COMPLAINT
(Jury Trial Requested)

FILED
CLERK OF COURT
GREENVILLE CO. S.C.
2017 NOV 7 AM 10:25

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

1. Plaintiff Demetria Orange (hereinafter, "Demetria") is a citizen and resident of Greenville County, South Carolina, and is the legal guardian and Next Friend of J.B. J.B.).

2. Defendant Greenville Hospital System (hereinafter, "GHS") is, upon information and belief, a hospital corporation which owns and operates a regional hospital in Greenville County, South Carolina, and holds itself out to the public as having specialized facilities, equipment and staff for the provision of high quality obstetrical and neonatal care. Defendant GHS is named a party to this action by virtue of the acts and/or omissions of its residents, employees and agents, within the course and scope that that respective residency, employment and agency, including but not limited to obstetrical residents, Dr. William M. Merritt, (hereinafter, "Dr. Merritt"), Dr. Brandi Alt, (hereinafter, "Dr. Alt") and Dr. Ridner, (hereinafter, "Dr. Ridner") for which it bears *respondeat superior liability*.

3. Dr. Merritt, Dr. Alt and Dr. Ridner were upon information and belief, physicians duly licensed to practice medicine within the State of South Carolina, who at all relevant times held themselves out to the public as having specialized knowledge, training and experience for the provision of high quality medical care and were in training as obstetrical residents at GHS.

4. Defendant Greenville Hospital System Partners in Health, (hereinafter, GHS Physicians) is upon information and belief a 501(c) (3) subsidiary of GHS which at all relevant times employed Dr. Carrie Ann Twedt, (hereinafter, "Dr. Twedt") and Dr. John Dacus, (hereinafter, "Dr. Dacus") who were acting at all relevant times within the course and scope of their employment with GHS Physicians, such that this Defendant is therefore responsible for the torts of Dr. Twedt and Dr. Dacus under the doctrine of *respondeat superior*.

5. Dr. Twedt and Dr. Dacus are, upon information and belief, physicians duly licensed to practice medicine within the State of South Carolina, who at all relevant times held themselves out to the public as having specialized knowledge, training and experience for the provision of high quality obstetrical and gynecological care, who at all relevant times were citizens and residents of Greenville County, South Carolina, who maintained an office in Greenville, South Carolina, for practices of obstetrics and gynecology, and who served as attending physicians for the obstetrical residency program at GHS.

6. Prior to November 27, 2004, Alana Mann (hereinafter "Alana"), J.B. is biological mother, became pregnant with her daughter J.B.

7. On November 27, 2004, Alana presented to GHS for delivery of her child.

8. Drs. Merritt, Alt and/or Ridner took charge of the labor of Alana and the delivery of J.B. at the GHS.

9. In exercising responsibility for the said labor and delivery, Drs. Merritt, Alt and Ridner were purportedly acting under the supervision of Dr. Twedt and/or Dacus; but it is unknown to Plaintiff whether or not Drs. Twedt and/or Dacus were physically present, and whether or not Dr. Twedt and/or Dacus actually supervised the labor and delivery.

10. Prior to delivery on November 27, 2004, [REDACTED] J.B. [REDACTED] as a healthy baby.

11. Drs. Merritt, Alt, Ridner, Twedt and/or Dacus owed Alana and her daughter a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar situations.

12. Defendant GHS, its agent(s) and employee(s) owed Alana and her daughter a duty of providing obstetrical services, obstetrical nursing and support services, labor and delivery nursing and support services, and newborn care support services consistent with generally accepted standards of hospitals, obstetricians, nurses and support staff acting under similar situations.

13. Defendant GHS Physicians owed Alana and her daughter a duty of providing obstetrical care and attention consistent with generally accepted standards of obstetricians acting under similar circumstances.

14. Defendants, as well as Drs. Merritt, Alt, Ridner, Twedt and/or Dacus breached their duties of care to Alana and her daughter [REDACTED] J.B. [REDACTED] and were negligent, reckless, willful, wanton, and/or otherwise wrongful in their care of them and attention to them, as a direct and proximate result of which [REDACTED] J.B. [REDACTED] sustained severe bodily injuries, losses and damages.

15. [REDACTED] J.B. [REDACTED] was born on November 27, 2004, by vaginal delivery performed, upon information and belief, by Drs. Merritt, Alt and/or Ridner.

16. In delivering [REDACTED] J.B. [REDACTED] Drs. Merritt, Alt and/or Ridner traumatically injured her brachial plexus nerves on the right, causing nerve damage to the entire right upper extremity.

17. Negligence and other wrongful conduct on the part of each Defendant and its employees joined and concurred with negligence and other wrongful conduct on the part of the other Defendant and its employees, to directly and proximately cause [REDACTED] J.B. [REDACTED] certain injuries, losses and damages.

18. Drs. Merritt, Alt and/or Ridner were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars:

(a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and complicated by shoulder dystocia delivery in particular, before attempting to deliver [REDACTED] J.B. [REDACTED]

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

(c) in failing and refusing to recognize the need for an experienced obstetrician to manage this delivery:

(d) in using improper delivery technique;

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

(f) in mismanagement of labor and delivery;

(g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and

(h) such other acts and omissions as may be determined during discovery or trial.

19. Drs. Twedt and/or Dacus were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars;

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

(b) in failing and refusing to recognize the need for an experienced obstetrician to manage delivery;

(c) in failing to properly supervise a vaginal delivery complicated by shoulder dystocia and in allowing it to be mismanaged by one or more obstetrical residents;

(d) in allowing [REDACTED] J.B. [REDACTED] to be delivered on their watch with inappropriate delivery techniques;

(e) in allowing [REDACTED] J.B. [REDACTED] to be delivered on their watch with improper and excessive force, traction and/or torsion.

(f) in allowing [REDACTED] J.B. [REDACTED] to be delivered on their watch with mismanagement of labor and delivery;

(g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and

(h) such other acts and omissions as may be determined during discovery or trial.

20. Defendant GHS, its employee(s) and agent(s), were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to the following particulars:

(a) in failing and refusing to require its employee(s), agent(s), resident(s), attending(s), and member(s) of its medical staff to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and shoulder dystocia in particular, before allowing inexperienced residents, without proper supervision to manage [REDACTED] J.B. [REDACTED] s delivery;

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

(c) in failing and refusing to take proper steps to avoid [REDACTED] J.B. [REDACTED] s severe and permanent brachial plexus injury;

(d) in failing and refusing to provide proper and timely labor and delivery nursing care and attention required by [REDACTED] J.B. [REDACTED] s condition;

(e) in failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients; condition; and

(f) such other acts and omissions as may be determined during discovery or trial;

(g) in addition this Defendant has responsibility for the torts of its employees, including but not limited to Drs. Merritt, Alt and Ridner, under the doctrine of *respondeat superior*.

21. Defendant GHS Physicians, its employee(s) and agent(s), were negligent, reckless, willful, wanton and/or otherwise wrongful in one, more or all of, and including but not limited to, the following particulars:

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

(b) in failing and refusing to recognize the need for an experienced obstetrician to manage this delivery;

(c) in failing to properly supervise and manage or cause to be supervised and managed a vaginal delivery complicated by shoulder dystocia; and in allowing it to be mismanaged by one or more obstetric residents;

(d) in allowing J.B. to be delivered with inappropriate delivery technique;

(e) in allowing J.B. to be delivered with improper and excessive force, traction and/or torsion;

(f) in allowing J.B. to be delivered with mismanagement of labor and delivery;

(g) failing to timely and properly monitor, observe, record and/or have transcribed vital information about the patients' condition; and

(h) such other acts and omissions as may be determined during discovery or trial;

(i) In addition this Defendant has responsibility for the torts of its employees, including but not limited to Drs. Twedt and Dacus, under the doctrine of *respondeat superior*.

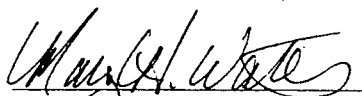
22. As a direct and proximate result of the negligence and other wrongful conduct on the part of each Defendant, which joined and concurred with the negligence and other wrongful conduct on the part of the other defendants, J.B. suffered severe and permanent personal injuries, losses and damages as follows:

- (a) Physical injuries, disorders and dysfunction;
- (b) Permanent impairments and disabilities;
- (c) Medical expenses, including those to be incurred in the future;
- (d) Life care plan expenses;
- (e) Adverse effect on her career options, employability and earning capacity;
- (f) Pain and suffering;
- (g) Emotional and psychological damages;
- (h) Loss of enjoyment of life; and
- (i) Such other damages as may be determined during discovery or trial.

WHEREFORE, Plaintiff prays for judgment against the Defendants, jointly and severally, for actual and punitive damages, together with costs and such other and further relief as the Court may deem just and proper.

GRAHAM LAW FIRM, P.A.

By:



Edward L. Graham

Mary H. Watters

383 W. Cheves St.

Florence, SC 29501

Attorneys for Plaintiff

October 30, 2012

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS

CASE NO.: 2011-CP-23-6665

Alana Mann, as Next Friend of
J.B. a minor,

Plaintiff,

v.

Greenville Hospital System and Greenville
Hospital System Partners In Health,

Defendants.

Answer of Defendants

FILED
CLERK OF COURT
GREENVILLE CO. SC
APR 5 2012

2012 APR -5 A 9:10

Defendants Greenville Hospital System and Greenville Hospital System Partners in Health ("these Defendants"), answering the Complaint of the Plaintiff, would respectfully show the Court:

FOR A FIRST DEFENSE

1. That these Defendants are without information and belief sufficient to form an opinion as to the allegations contained in Paragraph 1 of Plaintiff's Complaint and those allegations are therefore denied.

2. That in response to the allegations contained in Paragraph 2 of Plaintiff's Complaint, it is admitted that the Greenville Hospital System holds itself out as a facility that renders health care services in accordance with applicable standards of care. It is further admitted that this Defendant renders treatment and care by and through its agents and servants including obstetrical residents and their attendings.

3. That in response to the allegations contained in Paragraph 3 of Plaintiff's Complaint, it is admitted that Drs. Merritt, Alt and Ridner were obstetrical residents authorized and in fact practicing medicine in accordance with applicable standards of care.

4. That in response to the allegations contained in Paragraph 4 of Plaintiff's Complaint, it is admitted that Greenville Hospital System Partners in Health is a 501(c)3 subsidiary of the Greenville Hospital System and operated as an agent of the Greenville Hospital System for the purposes of delivering medical services. It is further admitted that at all times relevant to this Complaint, Dr. Twedt was employed by Greenville Hospital System Partners in Health. All other allegations contained in Paragraph 4 of Plaintiff's Complaint are denied.

5. The allegations contained in Paragraph 5 of Plaintiff's Complaint are admitted.

6. The allegations contained in Paragraph 6 of Plaintiff's Complaint are admitted, upon information and belief.

7. The allegations contained in Paragraph 7 of Plaintiff's Complaint are admitted, upon information and belief.

8. In response to the allegations contained in Paragraph 8 of Plaintiff's Complaint, it is admitted that the attending physicians of the Greenville Hospital System accepted Plaintiff for labor and delivery and assumed her medical care and treatment. All other allegations contained in Paragraph 8 are denied.

9. In response to the allegations contained in Paragraph 9 of Plaintiff's Complaint, it is admitted that the obstetrical residents involved in the treatment and care of Plaintiff were acting under the supervision of attending physicians employed by the Greenville Hospital System. All other allegations contained in or inconsistent with Paragraph 9 are denied.

10. This Defendant is without information and belief to form an opinion as to the allegations contained in Paragraph 10 of Plaintiff's Complaint and those allegations are therefore denied.

11. In response to the allegations contained in Paragraph 11 of Plaintiff's Complaint, it is admitted generally that agents and employees of the Greenville Hospital System involved in the treatment and care of Plaintiff owed to Plaintiff a duty to provide medical care in a manner consistent with accepted and applicable standards of care.

12. The allegations contained in Paragraph 12 of Plaintiff's Complaint are admitted.

13. The allegations contained in Paragraph 13 of Plaintiff's Complaint are admitted.

14. The allegations contained in Paragraph 14 are denied.

15. In response to the allegations contained in Paragraph 15, it is admitted that

J.B. was born on [REDACTED] by vaginal delivery assisted by agents and servants of this Defendant.

16. The allegations contained in Paragraph 16 of Plaintiff's Complaint are denied.

17. The allegations contained in Paragraph 17 of Plaintiff's Complaint are denied.

18. The allegations contained in Paragraph 18 of Plaintiff's Complaint are denied.

19. The allegations contained in Paragraph 19 of Plaintiff's Complaint are denied.

20. The allegations contained in Paragraph 20 of Plaintiff's Complaint are denied.

21. The allegations contained in Paragraph 21 of Plaintiff's Complaint are denied.

22. The allegations contained in Paragraph 22 of Plaintiff's Complaint are denied.

23. That any allegation not hereinabove admitted, modified or explained is hereby denied.

FOR A SECOND DEFENSE

24. That this Defendant realleges and incorporates herein by reference the relevant and consistent portions of its First Defense set forth above.

25. That this Defendant alleges and would show that Greenville Hospital System is a governmental entity and healthcare facility within the meaning of the South Carolina Tort Claims Act, S.C. Code Ann. § 15-78-10, et seq. (1976, as amended) and it and its agents and employees are, therefore, entitled to all rights, privileges, defenses, limitations, and immunities afforded by the Act and afforded by the doctrine of sovereign immunity, as is retained by the Act.

26. That this Defendant alleges that the Plaintiff's claims for actual damages are either governed or limited by the provisions of § 15-78-120(a).

27. That this Defendant alleges that the Plaintiff may not recover punitive damages in accordance with § 15-78-120(b).

28. That this Defendant specifically reserves, retains and does not waive any and all applicable and available rights, defenses, privileges, limitations and immunities afforded under the doctrine of sovereign immunity as is retained by the Act.

FOR A THIRD DEFENSE

29. That this Defendant realleges and incorporates herein by reference the relevant and consistent portions of its First and Second Defenses set forth above.

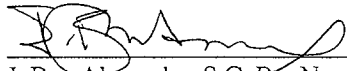
30. These Defendants affirmatively allege that GHS Partners in Health, Inc. is a "charitable organization" as that term is defined in *S.C. Code Ann.* § 33-56-170, and Carrie Ann Twedt, MD was and is an employee of said charitable organization during the time period set out in the Complaint. Accordingly, she is entitled to all rights, privileges, defenses, limitations and

immunities afforded by the statute and the doctrine of charitable immunity, as retained by the Charitable Immunity Statute, *S.C. Code Ann. § 33-56-180 et seq.*

31. These Defendant specifically reserve, retain and do not waive any and all applicable and available rights, defenses, privileges, limitations and immunities afforded under the doctrine of charitable immunity as is retained by the Act.

WHEREFORE, having fully answered, this Defendant prays that Plaintiff's Complaint be dismissed, with costs, and for such other and further relief as the Court may deem just and proper.

HAYNSWORTH SINKLER BOYD, P.A.



J. Ben Alexander, S.C. Bar No. 015323

PO Box 2048

Greenville, SC 29602

864-240-3323

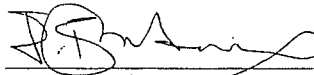
864-240-3391

jalexander@hsblawfirm.com

Attorneys for Defendants

Greenville, SC
Dated: April 3, 2012

These Defendants demand a jury trial.



J. Ben Alexander

STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT
C/A NO.: 2011-CP-23-6665

Demetria Orange, as Next Friend of)

J.B. a minor,)

Plaintiff,)

v.)

**PLAINTIFF'S MOTION FOR
NEW TRIAL ABSOLUTE**

Greenville Hospital System)
and Greenville Hospital System)
Partners in Health,)

Defendants.)

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

FACTS

Plaintiffs tried this case to verdict, which was rendered on November 5, 2013. The jury deliberated approximately seven hours over the course of two days. Ultimately, the jury found physician employees of Defendant Greenville Hospital System liable for negligence which proximately caused damages to Plaintiff. The jury did not find causally significant negligence on the part of nurse employees of Greenville Hospital System, or of any employee of Greenville Hospital Partners in Health. The damage award was only \$337,500.00.

The jury that rendered this verdict was not fair and impartial. This was actually the third jury picked, and the second trial in this matter. The first trial ended with a mistrial after the number of jurors dropped below twelve, and the Defendants refused to accept a jury of less than

twelve. One juror was dismissed for withholding his inability to attend the second week of trial because of undisclosed personal travel plans, and asserted inattention because of those plans; one juror was dismissed for intentionally withholding that Dr. Twedt delivered his child within four weeks before this trial started, and for mentioning to his wife during the delivery of his child that he "thought Dr. Twedt was pretty;" and a third juror was dismissed after asserting that he could not read or write in English, and did not speak English very well. The jury selected in the second trial had to be discharged and reselected after defense counsel impermissibly and unconstitutionally struck a juror based upon race.

With respect to the selection of the second jury during the second trial, Plaintiff sought to have the Court strike for cause a number of jurors based upon their business, financial and/or family employment relations with the Defendant Greenville Hospital System. Although the Court did strike for cause one or two direct employees of that Defendant, the Court declined to strike for cause one member of the venire whose wife was a nurse employed by the Defendant; another who was a paramedic or EMT with regular business ties with the Defendant; another who was a pharmacy executive whose employer has regular business relations with the Defendant, and whose pay is based in part on the volume of business with the Defendant; another whose sister is employed by the Defendant; and another whose work with BabyNet involves regular business relations with the Defendant, among others. Plaintiff did the best she could with her limited peremptory strikes, but was forced to leave three of these jurors on the final panel because Plaintiff did not have an adequate number of peremptory strikes to ensure that they were not seated. The man whose wife was a nurse employee of the Defendant not only sat on the jury, but was elected foreman. These three jurors were all allowed to serve despite their financial incentive to maintain good relations with the Defendant Hospital. Of course they

all proclaimed their ability to be fair and impartial, but few people recognize much less are willing to proclaim to a trial judge their biased views of issues related to their financial well-being. They may have sincerely proclaimed their willingness to be fair and impartial, but such is the nature of bias. Those who have lost impartiality may sincerely not recognize their partiality. The result dictated by their partiality may well seem to them to be a fair and impartial result. Of course such jurors also proclaimed their ability to follow the judge's charge on the law. However, to do so in a vacuum, without knowing what that charge will be, or how their partiality will affect their understanding of the charge, makes such a proclamation worthless. Upon information and belief, additional jurors who harbored biases and prejudices against Plaintiff or lawsuits in general, or in favor of Greenville Hospital System or health care providers in general, were also seated onto the jury; and this information went undiscovered because of the limited voir dire that was allowed.

The only evidence of record regarding causation established that the injury Plaintiff suffered was the result of greater than gentle traction to the neck and head of the Plaintiff applied by either Dr. Alt or Dr. Merritt. Both Dr. Alt and Dr. Merritt admitted that greater than gentle traction under these circumstances represents a breach of the obstetrical standard of care. Upon Dr. Merritt's own admission, greater than gentle traction most probably caused Plaintiff's injury in this case, applied by either him or Dr. Alt. The only testimony to suggest no breach in the standard of care is from defense expert Dr. Ernst, who assumes, routinely, and in this case, that doctors apply the correct amount of traction and are not negligent unless they admit negligence. Such testimony invades the province of the jury on credibility of witnesses, is neither reliable nor helpful to a jury, and should never have been allowed. Dr. Ernst was willing to stick with that assumption in this case despite the facts that Dr. Merritt did not record whether or not he used

forceful traction, nor how much traction he used; Dr. Merritt did not claim to recall whether or not he used forceful traction, nor how much traction he applied; Dr. Merritt admitted that excessive traction by he or Dr. Alt was the most probable cause of the child's injury; Dr. Alt had never before encountered a shoulder dystocia; Dr. Alt had never before seen a doctor use the proper amount of traction to safely resolve shoulder dystocia; Dr. Alt had never before seen a doctor resolve shoulder dystocia at all; Dr. Alt had never before even seen a video of how to safely resolve shoulder dystocia; Dr. Alt testified under oath that she thought it was permissible to use one's body weight to apply: "gentle" traction, which of course it is not; and Dr. Alt had violated her training by not making a contemporaneous entry in the medical records of her unsuccessful attempts to deliver the child and her use of downward lateral traction twice before a more senior resident arrived to take over responsibility to manage the delivery. To stick with such an assumption of no negligence in the face of such compelling evidence to the contrary, and with no factual basis other than defiant assumption is unworthy of a credible expert. Plaintiff respectfully submits such testimony was neither reliable nor helpful to the jury and that its admission represents reversible error. Without that erroneous admission of testimony, there would be no evidence to create a jury question of breach of standard of care or causation, entitling Plaintiff to a directed verdict on liability. Despite these considerations, Plaintiff's motions for directed verdict on the liability issues of breach of standard of care and causation were denied.

Plaintiff and Defense counsel made their closing statements and the case went to the jury. The jury deliberated for two days. During this time period, the jury requested a dictionary. Upon information and belief, the jury requested a dictionary in order to look up the word "intent" or "intentional" because a number of jurors believed, contrary to the law, that Plaintiff should not

be entitled to relief unless she proved the employees of Greenville Hospital System had intentionally harmed the child. The request for a dictionary was properly denied. Yet the request for a dictionary is telling about the unwillingness of biased, partial jurors to follow the Court's charge on the law. Nowhere in the jury charge was the word "intentional" used. Defense counsel, to his credit, never argued that liability required one to act with intent. Plaintiff counsel certainly did not make such a statement and did not acquiesce to any such statement made by anyone else. Upon information and belief, despite this Court's clear instruction on the definition of negligence and the level of proof required to find negligence, some of the jurors wished to require a higher level of culpability by the defendant(s) before finding liability. Inferentially, some biased, partial jurors disputed negligence because there was no showing of intent. Upon information and belief, because there was no effort by Plaintiff to prove intent to harm, some jurors held out from supporting a finding of negligence. Upon information and belief, their holdout resulted in an improper compromise verdict because of the improper, unlawful action of certain holdout jurors who refused to apply the law as given by the court. In order for these partial jurors to agree to a unanimous decision, they insisted on the other jurors' agreement to dramatically reduce the damages award substantially lower than what would otherwise have been allowed. In other words, they used as leverage their refusal to honor their oath to follow the law to secure a damages verdict far less than had been proven and far less than that which should have been allowed in accordance with law. Plaintiff is in the process of obtaining signatures on affidavits to support the representations made in this paragraph on information and belief, and proposes to serve them at least two days before the Court's hearing on this motion.

STANDARD OF REVIEW

In determining whether to grant a new trial absolute, our courts have stated:

If the amount of the verdict is grossly inadequate or excessive so as to be the result of passion, caprice, prejudice, or some other influence outside the evidence, the trial judge must grant a new trial absolute. The failure of the trial judge to grant a new trial absolute in this situation amounts to an abuse of discretion and on appeal this Court will grant a new trial absolute.

O'Neal, 314 S.C. at 527, 431 S.E.2d at 556 (citing *Mickle v. Blackmon*, 252 S.C. 202, 166 S.E.2d 173 (1969)).

Thus, "when the amount of the verdict is so grossly inadequate or excessive that it shocks the conscience of the court and clearly indicates the amount was the result of passion, caprice, prejudice, partiality, corruption or some other improper motives, the trial judge is required to grant a new trial absolute." *Waring v. Johnson*, 341 S.C. 248, 257, 533 S.E.2d 906, 911 (Ct. App. 2000).

DISCUSSION

A. This Court Should Either Grant a New Trial Absolute because of the Gross Inadequacy of the Jury Verdict.

Plaintiff argues that the amount awarded by the jury of \$337,500 is grossly inadequate in light of the evidence presented at trial. Accordingly, this court should grant Plaintiff a new trial absolute.

No evidence was presented to the jury regarding pre-majority medical expenses.¹ Nevertheless, evidence related to the harm and economic damages sustained by **J.B.**

¹ Plaintiff argues this was in error as well. To the extent the failure to submit pre-majority medical expenses should be argued in a motion for new trial absolute, Plaintiff incorporates the arguments made in the response motion on this matter by reference.

was presented to the jury through testimony from Dr. Vander Kolk, Dr. Grossman, Dr. Resnick, Karen Shelton, and Dr. Wood. Even though this court excluded all evidence related to medical expenses incurred or to-be-incurred prior to the child's eighteenth birthday, economic damages still exceeded \$360,000. This included minimal future needs of physical therapy, psychological and vocational counseling, prospective future surgery, and other long-term care needs, as well as the reduced earning capacity the child faces, all resulting from the child's impairment caused by Defendants. These numbers were reduced to present day value by economist Dr. Oliver Wood. These numbers are not in serious dispute. No testimony was offered by defense counsel to refute any of the economic loss numbers presented to the jury by Plaintiff.

The jury's verdict is grossly inadequate because it is less than the uncontested testimony of Plaintiff experts on economic damages, and it makes no award to the Plaintiff whatsoever for noneconomic damages. No testimony was presented by *anyone* on behalf of the defense to question any of the future treatment, care, or cost figures in the life care plan or reduction in earnings, set forth by Plaintiff's experts. Instead, Defendants sought to try their case by challenging liability and causation almost exclusively. Plaintiff's expert testimony regarding future economic damages went undisputed, except for brief cross-examination about no current therapies. There is no basis upon which to reliably assume the jury made any reduction in the economic damages. There is every reason to believe the low damages award was based not on any reasonable or logical discounting of damages for insufficient proof, but for reasons impermissible by law, related to the attempt by certain jurors to nullify the law by imposing an "intent to harm" requirement, and to ratchet down the allowance of damages proven as the price for giving up their refusal to follow the law on liability.

Additionally, such a de minimus award shocks the conscience, is grossly inadequate and reveals prejudice and partiality not only in light of the damages award being less than the economic damage, but also because the damages award fails to compensate for any of the significant and permanent human damages, permanent nerve damage, permanent loss of use of a baby's right shoulder and arm, two prior surgeries, future treatment needs, pain, suffering, emotional harm, humiliation and disfigurement suffered by **J.B.** A jury award which utterly fails to make any award for these damages where liability is found against the Defendants and where a child has lost the use her arm for the rest of her life is manifestly unreasonable and grossly inadequate as a matter of law. There is no question that these injuries actually occurred. The jury imposed liability. Defendants did not argue that the child's pain or humiliation experienced was not real. Defendants did not argue that the child was malingering or exaggerating. The child was introduced to the jury and the jury saw a child who cannot raise her right arm higher than her chest, cannot pronate her arm, cannot extend her right arm to the side, has a shorter and atrophied right arm and has an elbow contracture. The child will never be able to perform most two-handed tasks, or faces significant limitation in her ability to do so. Therefore, to award such an insubstantial amount to Plaintiff is grossly inadequate and a new trial absolute should be granted.

B. The Court's Refusal to Strike for Cause Certain Jurors with Business, Financial and/or Employment Ties to Defendant Greenville Hospital System, Combined with Plaintiff's Inability to Conduct a Thorough Voir Dire Resulted in Jurors Being Seated Who Exhibited Bias, Partiality and an Unwillingness to Apply the Appropriate Standard for Negligence That Was Instructed by This Court.

The man who was ultimately elected foreman of the jury was married to a nurse employed by Greenville Hospital System. Plaintiff requested that all members of the venire who were either employed by or who had relatives or spouses employed by Defendant hospital be stricken for cause. Plaintiff's request was denied with respect to those jurors not directly employed by Defendant, whose relatives were so employed. This ultimately resulted in a juror with a spouse employed by the Defendant being seated as a juror. This juror was ultimately selected to be the foreman.

A juror with such a patent conflict should have been stricken for cause. First, the juror had a direct financial interest in the case through his wife's employment. Concerns of adverse effects from a significant plaintiff's verdict on his wife's employment foreseeably impact any such person's ability to serve fairly and impartially. Any negative economic impact experienced by the hospital that trickled down to his spouse would have affected his wife's economic well-being, his economic well-being, and his family's economic well-being. The possibility that a large plaintiff verdict may negatively impact the well-being of a juror's family should have been a sufficient basis to have a juror stricken for cause. Would a circuit judge recuse himself in a comparable situation? If so, that raises serious questions about refusing to strike such a juror for cause.

Aside from the financial interest, there is other obvious bias in favor of the Defendant present in this situation. The jury foreman's spouse, a nurse, will have formed an opinion of Greenville Hospital System. As a healthcare provider, she likely had formed an opinion regarding medical malpractice suits in general, and in particular regarding litigation filed against GHS, or those who would bring suit against her employer. Even if the foreman followed this

court's instructions and did not discuss the case with his wife at home, it is all but certain that these topics had come up before this trial began.

Finally, even if one could argue the foreman did not believe a defense verdict would harm him financially, it is hard to imagine he did not understand how those who employ his wife would perceive his participation in a jury that rendered a multi-million dollar verdict against Greenville Hospital Systems. Any one of these three factors should have been sufficient reason to exclude this venireman for cause.

Given the limited number of peremptory strikes, Plaintiff was unable to remove this juror. All strikes were used and other members who exhibited a bias or prejudice as perceived by Plaintiff's counsel had to be stricken as well. Since Plaintiff used all available peremptory strikes, Plaintiff was unable to remove this venireman from the jury. Ultimately, a juror with a spouse employed by the Defendant sat on the jury, and this juror was elected foreman. Accordingly, Plaintiff was prejudiced by having a venireman with an interest in the outcome of this litigation seated.

To similar effect is the Court's refusal to strike other jurors for cause who had business, financial or employment relations with the defendant hospital, either directly or through immediate family. Those include the paramedic or EMT, the pharmacy executive, the man whose sister works for GHS, and the BabyNet supervisor, among others. The impartiality of a jury is too important to refuse to strike folks whose personal and financial interests make it even a little difficult to return a full verdict against a defendant.

Similarly, the court's limitation on voir dire, and the court's denial of Plaintiff's motion for attorney participation in voir dire unfairly harmed Plaintiff. As evidenced by some jurors'

desire to impose an "intentional" standard for a finding of negligence, certain jurors with preconceived ideas contrary to the law were seated on this jury. These jurors were either unaware of their own biases or inability to follow the law, or simply misrepresented their intentions in response to the judge's questions during voir dire. To avoid rehashing arguments made in limine, Plaintiff simply incorporates by reference its arguments in favor of attorney participation in voir dire. Plaintiff respectfully submits that, in retrospect, allowing attorney directed voir dire would have served the interests of judicial economy by improving the odds of a non-biased jury in this case. That would have avoided the need for the initial mistrial and for the new trial sought by this motion.

C. Certain Jurors Sought to Impose a Standard for Liability Contrary to This Court's Instructions, Which Caused a Compromised and Inadequate Verdict

As previously discussed jurors requested a dictionary in order to look up the word "intentional." Also as discussed upon information and belief, certain jurors sought to impose their own requirement of culpability for a finding of liability different from what the judge instructed. Whether these jurors willfully sought to violate this court's instructions or did so unintentionally is unclear, but it is not surprising given the number of partial jurors seated on this jury. The precise motivation for such jurors to refuse to honor their oath by refusing to follow the law is irrelevant. The fact remains that certain jurors in their minds required intent before they would award damages, and used that refusal as leverage to exact from the law-abiding jurors a damages award far below the amount proven in this case. As such, these partial jurors would not support a verdict based upon the evidence and the law as charged by the judge, and a new trial is the remedy.

Upon information and belief, these jurors would only support a finding of negligence pursuant to the court's instructions if the verdict was substantially less than the amount proven and requested by Plaintiff's counsel. Upon information and belief, because of these hold-out jurors, the jury ultimately reached a compromise verdict, which substantially under-compensated Plaintiff for *all* the injuries she suffered. The amount ultimately awarded was less than the amount of economic damages submitted to the jury.²

For the jury to apply any standard for liability but the standard charged by this court is fundamentally unfair to the Plaintiff.³ Moreover, it is misconduct by the jury. Any jurors who refuse to apply the law as charged deny a plaintiff of a fair procedure and a fair trial. Any compromise verdict reached because certain jurors did not assent to a Plaintiffs verdict because they wished to impose an intentionality requirement is a verdict reached as a result of juror misconduct and an inappropriate deliberation. An unwillingness of certain jurors to apply the law as charged evidences those jurors' partiality and imposed unfairness upon Plaintiff. The ultimate result of this misconduct was a compromised verdict substantially lower than what would have otherwise been awarded. For this reason, the court should grant a new trial absolute.⁴

D. This Court should have Granted Plaintiff's Motions for Directed Verdict on the Issues of Breach in the Standard of Care and Causation.

² "Juror testimony involving internal misconduct may be received only when necessary to ensure fundamental fairness." *Shumpert v. State*, 378 S.C. 62, 67, 661 S.E.2d 369, (2008).

³ "[C]onsiderations of 'fundamental fairness' are relevant to analyses of jury misconduct" *Vestry & Church Wardens of the Church of the Holy Cross v. Orkin Exterminating Co.*, 384 S.C. 441, 447, 682 S.E.2d 489, (2009)

⁴ See, e.g. *Youmans v. S.C. DOT*, 380 S.C. 263, 286, 670 S.E.2d 1, 12-13 (Ct. App. 2008) "We do not disagree with the proposition that a trial judge may grant a new trial where it is evident that the jury has not followed the law as instructed or has generally abrogated or failed to fulfill their functions according to law, but a jury verdict arrived at in a short period of time is not sufficient evidence to establish the fact that the jury failed to fulfill its function." (quoting *Park v. Belford Trucking Co.*, 165 So.2d 819 (Fla. Dist. Ct. App. 3rd Dist. 1964)).

In Plaintiff's case in chief, several experts took the stand and testified that the injury in this case resulted from forceful traction applied J.B.'s head. These included Dr. Yvonne Gomez-Carrion, Dr. Hall, Dr. Grossman, and Dr. Resnick. Dr. Gomez-Carrion and Dr. Hall for the Plaintiff also testified that the injury was caused by greater than gentle traction applied to the baby's head by either Dr. Alt or Dr. Merritt, in violation of the standard of care. Moreover, Dr. Merritt, an agent and employee of Greenville Hospital Systems at the time of the injury, admitted that this injury was caused by greater than gentle traction applied either by him or Dr. Alt during delivery.

Defense counsel offered no testimony to refute these conclusions. Dr. Ernst, Defendant's hired expert witness, provided no admissible causation testimony. His testimony was deemed unreliable and lacking in probative value by this Court, and the Court concluded that his testimony of other mere remote possibilities of the cause of the injury did not meet the standards of admissibility of expert testimony and would not aid the trier of fact. Accordingly, this expert offered no causation opinion.

As a result, the only offered opinions as to causation in this case were that the injury was caused by inappropriate traction applied to the head by either Dr. Alt or Dr. Merritt, employees of GHS. Therefore, there simply was no question for the jury to decide regarding causation in this case. For this reason, the court should have entered a directed verdict for Plaintiff on the issue of causation.

Similarly, the sole competent evidence on the issue of whether there was a breach in the standard of care was that there was in fact a breach. Dr. Gomez-Carrion and Dr. Hall both testified that either Dr. Alt or Dr. Merritt applied excessive traction to the Plaintiff's head, and that

the application of either greater than gentle traction or excessive traction is a breach in the standard of care. Similarly, Dr. Merritt, an agent and employee of one of the defendants at the time of the injury, admitted that either he caused this injury or Dr. Alt caused this injury. He admitted that the injury was caused by greater than gentle traction applied to the baby's head. Moreover, he admitted that it is a breach in the standard of care to apply greater than gentle traction to the baby's head. Dr. Alt concurred.

Dr. Ernst was permitted to opine on whether Defendants breached the standard of care. It was his opinion that Defendants did not. The asserted basis for his opinion is that he assumes, routinely, and in this case, that doctors apply the correct amount of traction and are not negligent unless they admit negligence. Such testimony invades the province of the jury on credibility of witnesses, is neither reliable nor helpful to a jury, and should never have been allowed. Dr. Ernst was willing to stick with that assumption in this case despite the facts that Dr. Merritt did not record whether or not he used forceful traction, nor how much traction he used; Dr. Merritt did not claim to recall whether or not he used forceful traction, nor how much traction he applied; Dr. Merritt admitted that excessive traction by he or Dr. Alt was the most probable cause of the child's injury; Dr. Alt had never before encountered a shoulder dystocia; Dr. Alt had never before seen a doctor use the proper amount of traction to safely resolve shoulder dystocia; Dr. Alt had never before seen a doctor resolve shoulder dystocia at all; Dr. Alt had never before even seen a video of how to safely resolve shoulder dystocia; Dr. Alt testified under oath that she thought it was permissible to use one's body weight to apply "gentle" traction, which of course it is not; and Dr. Alt had violated her training by not making a contemporaneous entry in the medical records of her unsuccessful attempts to deliver the child and her use of downward lateral traction twice before a more senior resident arrived to take over responsibility to manage the

delivery. To stick with such an assumption of no negligence in the face of such compelling evidence to the contrary, and with no factual basis other than defiant assumption is unworthy of a credible expert. Plaintiff respectfully submits such testimony was neither reliable nor helpful to the jury and that its admission represents reversible error.

Dr. Ernst also tried to confuse the jury about the proper standard of care relative to this case regarding the proper amount of traction that may be applied to a baby's head and neck. He claims that slightly more than gentle traction is within the standard of care as long as it is not unnecessarily forceful. There was no support in the literature for this assertion. Moreover, Dr. Ernst ultimately conceded that the standard of care permits only gentle traction, as more than that needlessly endangers the baby, which is never to be allowed.

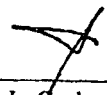
A reasonable jury could only have reached the conclusion that there was a causally significant breach in the standard of care. Accordingly, the only question the jury should have decided was damages. Submitting the issue of liability for jury determination with regard to Defendant Greenville Hospital System simply allowed for the unnecessary dispute of whether negligence required intent. Accordingly, had this Court granted Plaintiff's directed verdict on liability, including breach in the standard of care and causation, then the verdict would not have been as vulnerable to reduction due to certain jurors' improper belief that negligence required intent.

CONCLUSION

For the reasons stated, Plaintiff requests a new trial absolute.

Respectfully submitted,

GRAHAM LAW FIRM, P.A.



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Attorneys for the Plaintiff

Nov. 15, 2013

CERTIFICATE OF SERVICE

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

This 15th day of Nov., 2013.



STATE OF SOUTH CAROLINA)
COUNTY OF GREENVILLE)

IN THE COURT OF COMMON PLEAS
THIRTEENTH JUDICIAL CIRCUIT
C/A NO.: 2011-CP-23-6665

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

Plaintiff,)

v.)

**PLAINTIFF'S MOTION FOR
NEW TRIAL NISI ADDITUR**

Greenville Hospital System)
and Greenville Hospital System)
Partners in Health,)

Defendants.)

Plaintiff hereby moves before this court for an order granting Plaintiff a new trial *nisi additur*, for the reasons stated herein.

FACTS

For brevity's sake, Plaintiff incorporates herein by reference the facts set forth in her Motion for New Trial Absolute.

STANDARD OF REVIEW

"The trial judge *alone* has the power to grant a new trial *nisi* when he finds the amount of the verdict to be merely inadequate or excessive. *O'Neal v. Bowles*, 314 S.C. 525, 527, 431 S.E.2d 555, 556 (1993). "While the trial judge may not impose his will on a party by substituting his judgment for that of the jury, he may give the party an option in the way of additur or remittitur, or, in the alternative, a new trial." *Vinson v. Hartley*, 324 S.C. 389, 406, 477 S.E.2d 715, 723, (Ct. App. 1996). "The consideration of a motion for a new trial nisi additur requires the trial judge to consider the adequacy of the verdict in light of the evidence presented." *Id.* "Great deference is given to the trial judge." *Id.*

A new trial *nisi additur* may be ordered “when the verdict is merely insufficient based on the evidence. *Waring v. Johnson*, 341 S.C. 248, 257, 533 S.E.2d 906, 911, (Ct. App. 2000). “The import of a new trial nisi additur is a suggestion on the part of the judge of a settlement figure.” *Id.*

DISCUSSION

This Court Should Grant a New Trial *Nisi Additur* because of the Insufficiency of the Jury Verdict.

The amount awarded by the jury of \$337,500 is woefully insufficient based upon the evidence presented at trial. As grounds, the Plaintiff incorporates herein by reference the points and reasoning set forth in her Motion for New Trial Absolute. Accordingly, if the Court does not believe Plaintiff has proven entitlement to a new trial absolute, this Court should grant Plaintiff a new trial *nisi additur*, increasing the amount awarded to Plaintiff.

Ample precedent exists for granting a motion for a new trial *nisi additur* under these circumstances. For instance, in *Waring v. Johnson*, 341 S.C. 248, 533 S.E.2d 906 (Ct. App. 2000), the Court of Appeals affirmed the trial court’s grant of a new trial *nisi additur*, noting “The jury failed to consider Waring’s pain and suffering in reaching its verdict.” *Id.* at 960, 533 S.E.2d at 913. In *Waring*, the jury made an award to plaintiff of his medical bills. The trial court granted the plaintiff’s motion for new trial nisi additur and awarded nearly double what the jury awarded in its verdict, in addition to the jury award, for pain and suffering. The court of appeals noted that Waring “visited numerous doctors for years after the accident,” “underwent surgery for a condition . . . aggravated by the wreck,” and “found herself unable to continue her previous active lifestyle.” *Id.* The court ultimately concluded, “indubitably, Waring is entitled to an award for pain and suffering.” *Id.*

J.B. is no less entitled to an award of pain and suffering than the Plaintiff in *Warin*. J.B. has had to undergo several forms of treatment, surgery, and therapy. She has been in and out of doctors' offices her entire life. Moreover, in this case, there is not only physical pain and suffering but also permanent injury, loss of use of her right arm and shoulder, disfigurement and emotional pain and suffering by a child. For this reason, it would be inadequate for an additur award to be simply an approximation of the alleged economic damages. In this case, the non-economic harm suffered by this child should be a multiple of the economic harm suffered. Therefore, Plaintiff requests this court grant a new trial *nisi additur* in an amount in the range of at least \$800,000 to \$1,200,000.

Numerous other courts have ordered a new trial *nisi* on damages. In *Graham v. Whitaker*, 282 S.C. 393, 321 S.E.2d 40 (1984), the trial court ordered a new trial *nisi additur* of several times the jury verdict, increasing actual damages from \$10,000 to \$67,500. *Id.* Similarly, in *Stroud v. Stroud*, 299 S.C. 394, 385 S.E.2d 205 (Ct. App. 1989) the trial court's decision to grant a new trial *nisi additur*, recommending an additur that would nearly double the jury award was affirmed by the Court of Appeals. (This case was later reversed to the extent it held loss of enjoyment of life and pain and suffering were not separately compensable elements of damages. *Boan v. Blackwell*, 343 S.C. 498, 541 S.E.2d 242 (2001)). The court of appeals in *Jones v. Ingles Supermarkets, Inc.*, 293 S.C. 490, 361 S.E.2d 775 (Ct. App. 1987), (overruled on other grounds by *O'Neal v. Bowles*, 314 S.C. 525, 431 S.E.2d 555 (1993)), agreed with the trial court that the award made in this malicious prosecution action was insufficient in light of the damages, including "mental pain and suffering, fright, nervousness, indignity, humiliation, embarrassment, and insults to which she was subjected." *Id.* In *Chiappetta v. Orr*, 293 S.C. 250, 359 S.E.2d 530 (Ct. App. 1987), the trial court granted a motion for additur in the amount of \$12,500, bringing the award total to \$15,000, based

upon the judge's perceived inadequacy of the jury verdict. This case involved a breach of contract for sale of a home. The jury first returned a verdict that the plaintiffs had suffered no damages as a result of the breach. *Id.* The judge rejected this verdict and instructed the jury to determine an award for actual and special damages. The jury returned a verdict for \$2,500. *Id.* The judge then granted the plaintiffs' motion for new trial *nisi additur*. *Id.* The court of appeals found no abuse of discretion by the trial court in granting this motion. In *Patterson v. Reid*, 318 S.C. 183, 456 S.E.2d 436 (Ct. App. 1995) the court of appeals determined the trial court did not abuse its discretion in granting a new trial *nisi additur* which increased the jury verdict from \$500.54 to \$7,639.40. In this case, even though evidence related to pain and suffering conflicted, (including one finding that plaintiff's symptoms were psychosomatic), the trial judge noted that the treating physician "testified at trial that she diagnosed Patterson as having fibrositis" and that this "was 'most probably the result of her accident.'" *Id.* In this case, the jury made an award to the plaintiff that was less than economic damages. *Id.* Additionally, in *Thomas v. Seay*, 295 S.C. 455, 369 S.E.2d 660 (Ct. App. 1988) the plaintiff incurred medical bills of \$1,966.44, suffered a permanent impairment of around 10% to the spine, and suffered lost wages around \$646.85. The trial court granted a motion for new trial *nisi additur* for \$7,129.00, which brought the verdict total to \$7,500. The court of appeals determined the trial judge's decision was supported by the evidence. *Id.* In *Kalchthaler v. Workman*, 316 S.C. 499, 503, 450 S.E.2d 621, 623 (Ct. App. 1994), the Court of Appeals determined that the trial court did not abuse its discretion when it granted a new trial *nisi additur*, adding \$2,553.76 to the verdict of \$2,600.

Therefore, there is ample precedent for this court to make an award multiple times higher than the medical expenses and economic damages that were calculated in this case. Here the jury awarded damages just below projected economic loss. This is woefully insufficient both in light

of the economic damages this child has experienced, and will continue to experience into the future, and because of the human harms and losses past, present and future. Without minimal compensation of at least \$800,000, the tort system will have fai J.B. and the public at large, which needs a properly functioning tort system to serve societal needs of safety rule enforcement and deterrence of future medical negligence. For these reasons, Plaintiff requests this Court enter an order increasing the total award in this case to at least \$800,000 to \$1,200,000.

Respectfully submitted,

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Nov. 15, 2013

CERTIFICATE OF SERVICE

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

This 15th day of Nov., 2013



STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS

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

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

Plaintiff,

**Memorandum Opposing Plaintiff's
Motions for New Trial and New Trial *Nisi*
*Additur***

vs.

Greenville Hospital System and Greenville
Hospital System Partners in Health,

Defendants.

This case was tried to verdict the week of October 28, 2013. After six days of testimony and nearly two days of deliberation, the jury returned a verdict in Plaintiff's favor in the amount of \$337,500 against Greenville Hospital System ("GHS"). The jury returned a defense verdict as to the claims against Greenville Hospital System Partners in Health ("PIH"). Plaintiff now requests that this Court nullify the jury's damages award and grant a new trial or, in the alternative, invade the jury's province as fact finder and add to the jury's verdict. For the reasons discussed below, Plaintiff's motions should be denied. Plaintiff has not made any argument with respect to the defense verdict on behalf of PIH.

STANDARD OF REVIEW

I. NEW TRIAL ABSOLUTE

In order to warrant the grant of a new trial absolute, the Plaintiff must present compelling reasons to the Court to justify an order invading the jury's province. *Patterson v. Reed*, 318 S.C. 183, 456 S.E.2d 436 (Ct. App. 1995); *Vinson v. Hartley*, 324 S.C. 389, 477 S.E.2d 715 (Ct. App.

capacity based on testimony of a hired expert who opined that **J.B.** was not likely to graduate from college; and (4) non-economic damages. When these four categories are reviewed in turn, it is clear that the evidence in the record supports the jury's award.

A. The damages evidence supports the jury's verdict.

With regard to the first category of claimed damages – pre majority medical expenses – this Court properly ruled that those damages belonged to **J.B.**'s parents or custodial guardians and that no such claim was brought by them or on their behalf. Accordingly, the jury did not consider, and therefore did not award, any damages for this first category of claimed damages for pre majority medical expenses. This category should similarly not be considered by the Court in considering Plaintiff's post-trial motions.

With regard to the second category of damages – future treatment outlined by Plaintiff's expert, Karen Shelton – the testimony at trial established the following: (1) that many of the recommendations included in the life care plan came from a physiatrist who had never treated **J.B.** and, indeed, had only seen her once several years ago; (2) that **J.B.**'s biological mother and grandmother and, indeed, **J.B.** herself, opposed any future surgeries and even **J.B.**'s current custodial parent was unable to say whether **J.B.** would elect to have additional surgeries and the attendant physical therapy; (3) that from the date of **J.B.**'s birth in 2004 until the date of trial nearly 9 years later, neither the minor child nor her custodial guardians had availed themselves of many of the services (or accessories) included in the life care plan; and (4) that there was no testimony from any doctor currently treating the minor child suggesting that any of the treatment, care or accessories outlined in the life care plan were medically necessary. Accordingly, the evidence would allow the jury to conclude that Plaintiff had not availed herself of many of these treatments and accessories to date because they were not medically necessary

1996). The Court must consider the adequacy of the verdict in light of the evidence presented. *Hawkins v. Greenwood Dev. Corp.*, 328 S.C. 585, 493 S.E.2d 875 (Ct. App. 1977). It may not impose its will on a party by substituting its judgment for that of the jury. *Krepps v. Ausen*, 324 S.C. 597, 479 S.E.2d 290 (Ct. App. 1996). The Plaintiff has the burden of proving that the verdict was so grossly inadequate as to indicate caprice, prejudice, passion, or other improper considerations on the part of the jury. *Tool v. Tool*, 260 S.C. 235, 195 S.E.2d 389 (1973). Here, the verdict rendered by the jury represents a completely reasonable assessment of the credibility of the damages testimony presented at trial.

II. NEW TRIAL *NISI ADDITUR*

This Court may grant a new trial *nisi additur* if it finds the amount of the verdict to be inadequate. *Green v. Fritz*, 356 S.C. 566, 590 S.E.2d 39 (Ct. App. 2003). While the granting of such a motion rests within the sound discretion of the trial court, substantial deference must be afforded to the jury's determination of damages and the trial court must provide compelling reasons for invading the province of the jury. *Id.*

ARGUMENTS

I. THE JURY'S VERDICT IS SUPPORTED BY THE EVIDENCE, AND THERE IS NO REASON TO INVADE THE JURY'S DELIBERATIONS IN LIGHT OF THE VERDICT RENDERED.

In her motion, Plaintiff argues that the verdict in this case is so low as to be the result of passion, caprice, prejudice or some other influence outside the evidence. GHS disagrees and argues that the verdict is well-supported by the evidence at trial and shows that the jury followed the Court's instructions. Plaintiff's argument for damages at trial fell, broadly, into four categories: (1) pre majority medical expenses; (2) future treatment and care as outlined in a life care plan developed by Plaintiff's hired experts; (3) a diminution in **J.B.**'s earning

The same caution should be applied here where there was no evidence of any misconduct ascertained at the trial, particularly in light of the result reached.

C. The Court correctly denied Plaintiff's motion for a directed verdict.

Plaintiff's experts testified that "more than gentle" traction was a deviation from the standard of care. However, Plaintiff was never able to point to evidence of the application of more than gentle traction in this case other than the injury itself. This despite the fact that Plaintiff's experts conceded that some degree of physician applied traction is necessary in almost all vaginal deliveries and that they were unable to determine, in this case, who applied traction, when it was applied, how much was applied, for how long it was applied, or in what direction it was applied. Plaintiff's experts likewise were unable to say how much traction would be required to stretch a nerve, rupture a nerve, avulse a nerve or otherwise cause a permanent brachial plexus injury. Instead, Plaintiff and Plaintiff's experts relied largely on a res ipsa argument that because **J.B.** suffered a permanent brachial plexus injury, the injury must have been caused by negligently applied traction by the clinician.

Defendant's expert, Dr. Ernst, agreed that traction was required in most all vaginal deliveries. He testified that clinicians attempt to apply a normal amount of traction in a shoulder dystocia delivery, which, he too, characterized as gentle, but he also testified that greater than gentle traction was within the standard of care – even if that amount of traction ultimately proved sufficient to cause injury. Based on his review of the medical records, the testimony of eyewitnesses at the delivery, the depositions of multiple doctors and nurses involved in the delivery, and his education, training and experience as a practicing obstetrician for more than thirty years, Dr. Ernst testified that the medical providers in this case complied with the standard of care in their treatment and care of Alana Mann and her baby. This testimony was sufficient to

after the verdict was returned and no juror indicated there was anything amiss or that he or she disagreed with the result. Plaintiff did not file any affidavits in support of her motion for a new trial on this ground as required by Rule 59(c), SCRCP.¹ Supporting affidavits must be served with a motion for a new trial to be considered timely. *Baker v. Wolfe*, 333 S.C. 605, 510 S.E.2d 726 (Ct. App. 1998). In addition, “[t]he occurrence of a significant degree of jury misconduct calling for the admission of juror testimony has proved to be quite rare. For this reason, we think trial courts are justified in exercising a degree of caution before entertaining such evidence in an attack on a jury’s verdict.” *Shumpert v. State*, 378 S.C. 62, 661 S.E.2d 369 (2008) (citations omitted). As further elaborated in *Shumpert*:

But let it once be established that verdicts solemnly made and publicly returned into court can be attacked and set aside on the testimony of those who took part in their publication and all verdicts could be, and many would be, followed by an inquiry in the hope of discovering something which might vindicate the finding. Jurors would be harassed and beset by the defeated party in an effort to secure from them evidence of facts which might establish misconduct ... [and] the result would be to make what was intended to be a private deliberation the constant subject of public investigation.... [T]he argument in favor of receiving such evidence is not only very strong, but unanswerable- when looked at solely from the standpoint of the private party who has been wronged by such misconduct. The argument, however, has not been sufficiently convincing to induce legislatures generally to repeal or to modify the rule. For, while it may often exclude the only possible evidence of misconduct, a change in the rule would open the door to the most pernicious arts and tampering with jurors. The practice would be replete with dangerous consequences. It would lead to the grossest fraud and abuse and no verdict would be safe.

¹ GHS has not received any affidavits as of the filing of this memorandum. In the event affidavits are filed, GHS reserves the right to seek to strike the affidavits or, in the alternative, to file opposing affidavits as allowed by Rule 59(c).

swimming lessons and otherwise believes she can do most anything other children do. They also testified that, despite her injury, she was a happy, healthy, popular, and well-adjusted little girl. In light of this testimony and in recognition of **J.B.**'s injury, the jury awarded \$335,750 to compensate **J.B.** for her non-economic losses.

The verdict in this case was not inadequate and certainly was not such that would "shock the conscience of the court." Indeed, the verdict in this case was entirely reasonable and supported by the evidence. This jury listened attentively for six days and deliberated for nearly two more. This Court should not now second guess their judgments as to damages in this case. Plaintiff's motions for New Trial should be denied.

B. The conduct and makeup of the jury do not warrant the granting of a new trial.

With respect to the composition of the jury, that is a matter of discretion for the Court. *Hollins v. Wal-Mart Stores, Inc.*, 381 S.C. 245, 250, 672 S.E.2d 805, 807 (Ct. App. 2008). "On appeal, this court will rely on the judgment of the trial judge who is able to observe the character and demeanor of the jurors, unless the record firmly establishes an abuse of discretion." *Creighton v. Coligny Plaza Ltd. P'ship*, 334 S.C. 96, 109, 512 S.E.2d 510, 517 (Ct.App.1998). In this case, the jurors that Plaintiff questioned were statutorily qualified. The Court interviewed all of the jurors, excused a number of them for cause including several that otherwise would have been preferred by Defendant and likely stricken peremptorily by Plaintiff, allowed Plaintiff to question the jurors more extensively after which several more were disqualified for cause, and ultimately determined that the remaining jurors were able to serve in a fair and impartial manner. As such, the composition of this jury is not a basis for awarding a new trial.

There is no evidence supporting Plaintiff's arguments regarding improper motive of the jurors. As previously argued, the verdict is supported by the evidence. Plaintiff polled the jury

and that she was not likely to avail herself of them in the future for the same reason. Given that inference, the jury had every reason to discount Shelton's testimony.

The third category of damages – a diminution in **J.B.**'s lifetime earning capacity – was based on the extremely dubious testimony of Plaintiff's vocational rehabilitation expert, Dr. Charles Vander Kolk. Dr. Vander Kolk opined that **J.B.** would suffer a diminution in her lifetime earning capacity because of her birth injury. That opinion was based largely on his assumption that she would work in a manual labor job. His opinion that she would work in a manual labor job was based on his assumption that she would not graduate from college. His stated reason for assuming she would not graduate from college was based on: (1) a standardized test that **J.B.** took as a second grader and (2) the fact that **J.B.**'s custodial parents did not themselves graduate from college. It is entirely likely, and completely reasonable, that the jury found Dr. Vander Kolk's testimony completely unpersuasive. First, Dr. Vander Kolk's insinuation that **J.B.** lacks the cognitive ability to graduate from college is belied by the fact that she has been an above average student in every grade completed to date. The jury likely, and reasonably, may have found that her high achievement in school – as reflected in her grades – was a better indicator of her cognitive ability than a single standardized test score from the second grade. Second, Dr. Vander Kolk's assertion that **J.B.** would not graduate from college because her custodial parents never attended college ignores Dr. Vander Kolk's own personal narrative, that he managed to graduate from college and ultimately achieve a PhD despite his own parents never attending college. That the jury found Dr. Vander Kolk's testimony unpersuasive is not surprising.

This leaves that last category of damages – non economic damages. **J.B.**'s family testified that **J.B.** is an active little girl who rides her bike, plays soccer, throws a ball, takes

create an issue of fact and this case was, therefore, appropriately submitted to the jury for a verdict.

II. THE AMOUNT OF THE JURY'S VERDICT IS NOT INADEQUATE.

A. A new trial *nisi additur* is not warranted here because the verdict was supported by the evidence and was not inadequate.

As discussed above, the jury's verdict was adequate and supported by the record. The jury was not required to accept all of the damages submitted by Plaintiff's experts. As discussed above, there were many reasons to discount all or part of that testimony. For those reasons, a new trial *nisi additur* is not warranted in this case.

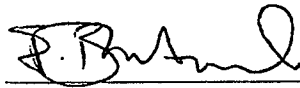
B. Under no circumstances should the Court award a new trial on damages only.

In addition, a new trial on damages only is not appropriate because the evidence supported submitting the issue of liability to the jury. In the event the Court orders a new trial as to GHS, the new trial should reflect both the damages and liability aspects of this case. *See Cartin v. Keller Bldg. Products of Charleston*, 299 S.C. 152, 382 S.E.2d 922 (1989) (finding new trial on damages alone improper where "the issue of damages is not so distinct and separable from the issue of liability in this case that a retrial on damages alone may be had without injustice.")

CONCLUSION

For the reasons stated above, Defendant would respectfully request that this Court issue denying Plaintiff's motions for New Trial Absolute, New Trial *Nisi Additur*.

HAYNSWORTH SINKLER BOYD, PA



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Attorneys for Defendant

Dated: December 4, 2013
Greenville, SC

STATE OF SOUTH CAROLINA
COUNTY OF GREENVILLE

IN THE COURT OF COMMON PLEAS
CASE NO: 2011-CP-23-6665

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

Plaintiff;

v.

MOTION TO ALTER OR AMEND

Greenville Hospital System and Greenville
Hospital System Partners In Health,

Defendants.

FILED IN THE COURT OF COMMON PLEAS
COUNTY OF GREENVILLE, S.C.
PAUL E. JACKSON, CLERK
2011 AUG 29 PM 9 09

Pursuant to Rule 59(c), SCRPC, Defendants Greenville Hospital System ("GHS") and Greenville Hospital System Partners In Health ("GHS-PIH") hereby move this Court for an order altering or amending its Order Granting New Trial *Nisi Additur* ("Order"). Defendants received the Court's order granting Plaintiff's post-trial motions on August 18, 2014.

Defendants seek a ruling on the following issues and incorporate herein by reference all supporting arguments made at the hearing and in its memorandum opposing Plaintiff's post-trial motions:

1. GHS-PIH was a defendant in this action by way of vicarious liability for its employee Dr. Carrie Anne Twedt, the attending physician supervising the labor and delivery of Alana Mann. Plaintiff made numerous allegations in her Complaint regarding care provided by Dr. Twedt, and Plaintiff argued at trial that Dr. Twedt deviated from the standard of care. The claim against GHS-PIH was then submitted to the jury, which returned a verdict in favor of GHS-PIH. Accordingly, there is no basis for *additur* with respect to GHS-PIH. GHS-PIH therefore seeks clarification that the defense verdict in its favor remains in place and the Order applies only to GHS and not GHS-PIH.
2. The Court's order grants a new trial *nisi additur* for a reason that was not expressly raised by the Plaintiff in her motion. In the Order, the Court found *nisi additur* was appropriate because "the jury failed to award Plaintiff noneconomic damages." (Order at 6, 11). Plaintiff's motion does not articulate this argument and Defendants refuted this argument by way of its memorandum in opposition. As argued by

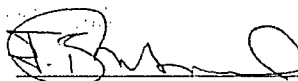
Defendants, the verdict here is supported by the evidence and the jury may well have included a measure of noneconomic damages. Therefore, the result here is in line with that in *Riley v. Ford Motor Co.*, 408 S.C. 1, 19-20, 757 S.E.2d 422, 432 (Ct. App. 2014) in which the trial court's grant of *nisi additur* was reversed because there was not a compelling reason to invade the province of the jury. As held by the Court of Appeals, "[i]n other words, the jury awarded noneconomic damages, but the trial court disagreed as to whether the amount was sufficient. We find this is not a compelling reason to invade the province of the jury. See *Krepps v. Ausen*, 324 S.C. 597, 608, 479 S.E.2d 290, 295 (Ct. App. 1996) (stating 'the trial court may not impose its will on a party by substituting its judgment for that of the jury')". *Id.* (footnote omitted).

3. Defendants refuted the evidence of Plaintiff's economic damages by cross-examining the Plaintiff's witnesses. As shown on cross, many of the included expenses are unlikely to be incurred and Plaintiff has not availed herself of the included services to date. For these reasons, the jury was not required to return a verdict that included all of the requested economic damages. In its Order, the Court improperly switched the burden of proof from the Plaintiff to the Defendant. Plaintiff has the burden of establishing damages beyond conjecture, guess, or speculation. See *Carlyle v. Tuomey Hospital*, 305 S.C. 187, 407 S.E.2d 630 (1999); *Gray v. S. Facilities, Inc.*, 256 S.C. 558, 570-71, 183 S.E.2d 438, 444 (1971). A defendant does not have any burden in challenging a plaintiff's damages theory or claimed damages. If the jury, in its wisdom, chose not to include some components of the Plaintiff's claim in its award, that was its prerogative. As noted by the Court, the general verdict makes it impossible to assess what was included in the jury's award. The Court has not provided compelling reasons for second-guessing the jury's verdict now.

4. The Court's Order does not explain the basis for the *additur* amount.

Respectfully submitted,

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Greenville Hospital System Partners in Health

August 27, 2014

STATE OF SOUTH CAROLINA	)	
	)	COURT OF COMMON PLEAS
COUNTY OF GREENVILLE	)	2011-CP-23-06665
	)	
	)	
	)	
	)	
DEMETRIA ORANGE, AS NEXT	)	
FRIEND OF J.B., A MINOR,	)	
PLAINTIFF,	)	
	)	
vs.	)	TRANSCRIPT OF RECORD
	)	
GREENVILLE HOSPITAL SYSTEM	)	VOLUME I
AND GREENVILLE HOSPITAL	)	
SYSTEM PARTNERS IN HEALTH,	)	
DEFENDANTS.	)	
	)	

October 28 and 29, 2013
Greenville, South Carolina

B E F O R E:

THE HONORABLE D. GARRISON HILL, JUDGE; and a jury.

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

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DIANE M. RODRIGUEZ, ESQ.
J. LAYTON RUFFIN, ESQ.
Attorneys for the Plaintiff

J. BEN ALEXANDER, ESQ.
Attorney for the Defendants

HOLLIE M. JENKINS
Circuit Court Reporter

1 There are a number of questions I'm going to ask you
2 to respond to, if you do need to respond to them. But
3 they're all designed to ensure that we can have a jury
4 that's going to be fair and impartial and can decide this
5 case without any kind of bias or prejudice. Some of the
6 questions are going to ask for personal information again.
7 And when we get to those questions, I will give you the
8 opportunity to come up and talk to us on the record up
9 here a little more privately, just as I did downstairs.

10 JURY QUALIFICATION

11 THE COURT: The first question is, is there anyone
12 who is related by blood or marriage, or kin to in any way
13 Demetria Orange or [REDACTED] J.B. ,

14 And, Ms. Orange, if you could just stand up, ma'am.
15 If so, please, stand.

16 (WHEREUPON, there was no response.)

17 THE COURT: Does anyone have any personal, social, or
18 business relationship with Ms. Orange or [REDACTED] J.B.
19 [REDACTED] J.B. ? If so, please, stand.

20 (WHEREUPON, there was no response.)

21 THE COURT: Is anyone employed by, or have you ever
22 been employed by, or has any member of your immediate
23 family been employed by Greenville Hospital System or
24 Greenville Hospital System Partners in Health? If so,
25 please, stand.

1 Okay. Starting to my left, the lady in the green.
2 Yes, ma'am.
3 JUROR #2, ANGELA ALFORD: Yes. I was employed with
4 GHS '80 to '87.
5 THE COURT: And in what capacity?
6 JUROR #2, ANGELA ALFORD: A nurse.
7 THE COURT: Thank you.
8 And your name?
9 JUROR #2, ANGELA ALFORD: Angie Alford.
10 THE COURT: Thank you.
11 Let's see. Over here, ma'am.
12 JUROR #86, VICKI MCMAKIN: Okay. I'm currently
13 employed by GHS in the -- medicine office.
14 THE COURT: And what is your --
15 JUROR #86, VICKI MCMAKIN: I'm an LPN and clinical
16 coordinator.
17 THE COURT: What's your name, ma'am?
18 JUROR #86, VICKI MCMAKIN: Vicki McMakin.
19 THE COURT: Thank you, Ms. McMakin.
20 Yes, sir.
21 JUROR #55, FRANKLIN HEATH: I have a sister that
22 works for --
23 THE COURT: I'm sorry. Can you speak up?
24 JUROR #55, FRANKLIN HEATH: I have a sister that
25 works for the Greenville Hospital System.

1 THE COURT: A sister that works for the Greenville
2 Hospital System?

3 JUROR #55, FRANKLIN HEATH: Yes, sir.

4 THE COURT: What's your name?

5 JUROR #55, FRANKLIN HEATH: Franklin Heath.

6 THE COURT: What does she do, Mr. Heath?

7 JUROR #55, FRANKLIN HEATH: I think it's clerical.
8 I'm not certain, specifically.

9 THE COURT: Okay, sir. Thank you.

10 Yes, sir.

11 JUROR #92, JOHN NEWCOMER: John Newcomer.

12 I'm a registered nurse at the Greenville Hospital
13 System.

14 THE COURT: Yes, sir.

15 JUROR #108, SAMUEL ROSS: My wife, Mary Ellen, works
16 for Interim Healthcare. And she's a registered nurse
17 through the Greenville Hospital System.

18 THE COURT: All right. And your name, sir?

19 JUROR #108, SAMUEL ROSS: Sam Ross, R-O-S-S.

20 THE COURT: Thank you.

21 Yes, sir.

22 JUROR #61, ERIC HUTCHINSON: My name is Eric
23 Hutchinson.

24 My wife was employed by Easley Baptist Hospital,
25 which is partly owned by GHS.

1 THE COURT: Mr. Hutchinson?

2 JUROR #361, ERIC HUTCHINSON: Yes, sir.

3 THE COURT: Thank you.

4 Now, those that just responded to that last question,
5 do you feel like you can be fair and impartial in this
6 case knowing that Greenville Hospital System is a party
7 given the connection that you have to them? If you do not
8 feel you can be fair and impartial, please, stand.

9 (WHEREUPON, there was no response.)

10 THE COURT: Do you feel like you can follow the
11 evidence and the law in this case? And let me ask that in
12 the reverse. Of anybody who just responded, do you
13 believe or do you have any reason to not believe you could
14 follow the evidence and the law in this case given your
15 connection to the Greenville Hospital System?

16 (WHEREUPON, there was no response.)

17 THE COURT: Okay. Is anyone a member of the board of
18 either Greenville Hospital System or Greenville Hospital
19 System Partners in Health, or have any other connection to
20 those two entities, or do you have any business
21 relationship with those entities whatsoever, other than
22 the people who have already responded?

23 JUROR #138, LEWIS WHITE: I do. I work for -- my
24 name is Lewis White.

25 I work for [inaudible] Pharmaceuticals. And

1 Greenville Hospital would be a client of ours.

2 THE COURT: And your name again?

3 JUROR #138, LEWIS WHITE: Lewis White..

4 THE COURT: Would that effect your ability to be fair
5 and impartial in this case, sir?

6 JUROR #138, LEWIS WHITE: No. It would not.

7 THE COURT: Could you base your decision in the case
8 on the evidence and the law, and put that aside?

9 JUROR #138, LEWIS WHITE: Yes, I could.

10 THE COURT: Thank you, sir.

11 I'm going to ask the lawyers in the case to introduce
12 themselves and the people at their table.

13 And, yes, sir, Mr. Graham.

14 MR. GRAHAM: Thank you, Your Honor.

15 May it please the Court.

16 I'm Ed Graham. With me is Diane Rodriguez. Also
17 with us is Rodney Pillsbury, who is here today just to
18 help us today. He will not be involved in the actual
19 trial this week.

20 You've already met Dee. This is Mike Hood, who is
21 going to be helping us at trial with technical blow-ups
22 and exhibits on the screen, and that sort of thing. Also,
23 Layton Ruffin is an attorney in our office.

24 Thank you.

25 THE COURT: Thank you.

1 Mr. Alexander.

2 MR. ALEXANDER: My name is Ben Alexander. I'm a
3 lawyer here in Greenville. And with me today is
4 Dr. Carrie Anne Twedt, who is an attending physician at the
5 Greenville Hospital System. Assisting me will be Elizabeth
6 Cowan. And, also, with me today is Lauren Spears.

7 THE COURT: All right. Is anyone related by blood or
8 marriage, or kin to either Mr. Graham, or Mr. Alexander,
9 or anyone they introduced? If so, please, stand.

10 (WHEREUPON, there was no response.)

11 THE COURT: Does anyone have any personal, or social,
12 or business connection with the -- any of the individuals
13 who introduced themselves, or others? If so, please,
14 stand.

15 (WHEREUPON, there was no response.)

16 THE COURT: Has anyone ever been represented by
17 Mr. Graham or his law firm, or Mr. Pillsbury, or
18 Mr. Alexander and his law firm, the Haynsworth Law Firm,
19 or the law firm of Hall, Booth, and Slover? If so,
20 please, stand.

21 (WHEREUPON, there was no response.)

22 THE COURT: Has anyone been involved in a dispute
23 where the other side was represented by one of these
24 lawyers or their law firms? If so, please, stand.

25 (WHEREUPON, there was no response.)

1 THE COURT: All right. I'm going to read off a list
2 of people who may testify as witnesses in this case. And
3 listen to this list very carefully. And if you have a
4 question about whether you may know some of these people
5 or the name rings a bell, please, let us know because it's
6 important information that the parties need to know about
7 and the Court needs to know about.

8 And the people who may testify include Demetria and
9 Samuel Orange; J.B.; Alana McClure; Robin
10 Dicks; Dr. John Grossman; Dr. Oliver Wood; Jacqueline
11 Johnson; Darlene Hutchinson; Kellie Williams; Karen
12 Shelton; Michelle Murray, who is a nurse; Dr. Trevor
13 Resnick; Dr. Suneet Chauhan; Dr. Joseph Ernest; Dr. Yvonne
14 Gomez-Carrion; Dr. Maureen Nelson; Dr. Michael Hall;
15 Dr. Brandi Alt; Dr. William Merritt; Dr. Jonathan Shepherd;
16 Tammy Nutt; Dr. Carrie Anne Twedt; Bethany Williams Russell.

17 Is anyone related by blood or marriage to any of
18 these potential witnesses? If so, please, stand.

19 (WHEREUPON, there was no response.)

20 THE COURT: Does anyone have any personal, social, or
21 business relationship with any of these potential
22 witnesses? If so, please, stand.

23 (WHEREUPON, there was no response.)

24 MR. GRAHAM: Your Honor, there were several of the
25 Defendant's witnesses on this list that may not have been

1 provided.

2 MR. ALEXANDER: I think there was only one, Dr. Kristin
3 McClanahan, Your Honor.

4 THE COURT: Okay. Dr. Kristin McClanahan; Mary
5 Katherine Kester. Is anyone related by blood or marriage
6 to those potential witnesses, or have any personal,
7 social, or business relationship with them? If so,
8 please, stand.

9 (WHEREUPON, there was no response.)

10 THE COURT: Has anyone ever been treated by any of
11 these doctors, or nurses, or health care professionals
12 that were just listed? If so, please, stand.

13 (WHEREUPON, there was no response.)

14 THE COURT: Has anyone ever been a patient of or
15 treated by the following: Mary Beck, Brandi Alt, L.
16 Kenneth Cook, Jr., Kimberly C. DuBose, Tamela Keller, R.
17 Montague Laffitte, Kristen McClanahan, Mark Moore, Valerie
18 Snyder? If so, please, stand.

19 Ms. McMakin.

20 JUROR #86, VICKI MCMAKIN: I have been treated by a
21 lot of those.

22 THE COURT: All right. Thank you.

23 Other than those of you who have already responded,
24 is there anyone who is currently employed by or been
25 previously employed by any hospital, doctor's office,

1 medical clinic, or other healthcare provider? If so,
2 please, stand.

3 All right. Yes, ma'am.

4 JUROR #2, ANGELA ALFORD: Children's Baptist Center.

5 THE COURT: And your name again?

6 JUROR #2, ANGELA ALFORD: Angie Alford.

7 THE COURT: Ms. Alford?

8 JUROR #2, ANGELA ALFORD: Uh-huh.

9 THE COURT: Okay. Thank you.

10 JUROR #67, CATHY JENSEN: I work for Blue Cross Blue
11 Shield. I don't know if that counts.

12 THE COURT: What's your name, ma'am?

13 JUROR #67, CATHY JENSEN: Cathy Jensen.

14 THE COURT: Ms. Jensen.

15 All right. Thank you.

16 JUROR #117, JARED STROUD: Greenville County EMS.

17 THE COURT: What's your name, sir?

18 JUROR #117, JARED STROUD: Jared Stroud.

19 THE COURT: Yes, sir.

20 Thank you.

21 Is anyone a member of any group or foundation that
22 supports Greenville Hospital System or Greenville Hospital
23 System Partners in Health? If so, please, stand.

24 (WHEREUPON, there was no response.)

25 THE COURT: Has anyone ever taken courses in medicine

1 or nursing, regardless of whether you've got a degree? If
2 so, please, stand.
3 Yes, ma'am.
4 JUROR #6, SONYA AUSBURN: I was a CNA when I
5 graduated high school. And I do oncoming general ed for a
6 dental office.
7 THE COURT: And your name is?
8 JUROR #6, SONYA AUSBURN: Actually, I will be going
9 to the hospital with my pediatric dentist.
10 Sonya Ausburn.
11 THE COURT: Ms. Ausburn, thank you.
12 JUROR #6, SONYA AUSBURN: Thank you.
13 THE COURT: Okay. Ms. McMakin, I think you told us
14 about your --
15 JUROR #86, VICKI MCMAKIN: I'm part of Partners with
16 Health.
17 THE COURT: Okay. Thank you.
18 JUROR #92, JOHN NEWCOMER: I'm a registered nurse.
19 John Newcomer.
20 THE COURT: Mr. Newcomer, yes, sir.
21 Yes, ma'am.
22 JUROR #106, LINDSEY RODGERS: I'm a CNA currently.
23 THE COURT: And your name?
24 JUROR #106, LINDSEY RODGERS: Lindsey Rodgers.
25 THE COURT: Where are you employed?

1 JUROR #106, LINDSEY RODGERS: It's a nursing home.

2 THE COURT: Oh, okay.

3 Thank you.

4 JUROR #117, JARED STROUD: I'm an EMT for Greenville
5 County.

6 THE COURT: Thank you, Mr. Stroud.

7 Other than anyone who may have already responded, is
8 anyone employed by or ever been employed by an insurance
9 company, or risk management association, or other related
10 entity? If so, please, stand.

11 (WHEREUPON, there was no response.)

12 THE COURT: All right. These next questions do ask
13 for some personal information. So I'm going to come down
14 here and ask it -- ask them. And if anybody needs to
15 respond, we'll take it that way.

16 Pay no attention to the man behind the curtain.

17 All right. These questions are as follows: Is there
18 anyone who believes they have received or had an immediate
19 family member receive inadequate treatment or care by a
20 physician, nurse, or a hospital?

21 Now, what am I meaning by immediate family member?
22 I'm just talking about a spouse, a child, or a parent, or
23 a sibling. So those are the immediate family members we
24 need to know about. So that's the first question.

25 Is there anyone who has such strong feelings about

1 doctors, or nurses, or the medical profession in general,
2 or the civil justice system, or the medical care system
3 that you do not feel you could be a fair and impartial
4 juror in a medical malpractice case where there are
5 allegations of medical negligence? That's the next
6 question.

7 Have you or any member of your immediate family
8 suffered an injury during childbirth, including shoulder
9 dystocia or brachial plexus?

10 Has anyone been administered or had a child delivered
11 where Pitocin was administered to the mother?

12 Okay. We're going to let you come up here and tell
13 us about that. You don't need to stand up. Just listen
14 to the questions. And then we'll go one by one. I'm
15 sorry if I was unclear about that.

16 Has anyone been a plaintiff or a defendant in a
17 lawsuit? I'm not talking about your immediate family.
18 I'm just talking about you.

19 Has anyone made a claim regarding what they perceived
20 as inadequate medical care from anyone, or any
21 organization, or business?

22 Does anyone have a special needs child?

23 Has anyone ever been employed by Rugged Warehouse, JC
24 Penney, Chilli's, Citgo, Eckerd's, South Carolina
25 Department of Social Services, BMW, the Salvation Army

1 Croc Center?

2 Has anyone been a member of or employee of Queen
3 Street Baptist Church, Palmetto High School, Southside
4 High School, Beck Middle School, Sarah Collins Elementary
5 School, or East Gantt Elementary School.

6 JUROR #112, CATHY SCHROER: Special needs child.

7 THE COURT: Yes.

8 So after I go through all of these questions, I'll be
9 glad to talk with you one by one up here.

10 Thank you.

11 Does anyone have such strong feelings, positive or
12 negative, about the Greenville Hospital System or the
13 Greenville Hospital System Partners in Health that they
14 don't believe they could be fair and impartial in this
15 case?

16 And does anybody know of any reason why they couldn't
17 be fair and impartial in this case, or is anyone aware of
18 any bias or prejudice they might have about anyone
19 involved in the case, or any issue that might be involved
20 in this case?

21 And, finally, does anybody know anything about this
22 case, other than what you've heard from me here this
23 morning?

24 All right. So those are the question. If anyone
25 needs to respond, I'll be glad to talk to you one at a

1 time up here in the front. We'll just form a short line
2 there in the center behind the bar, if you would.

3 (WHEREUPON, a sidebar was held with the Court, the
4 attorneys, and potential jurors.)

5 (WHEREUPON, Juror #6, Sonya Ausburn, came forward.)

6 JUROR #6, SONYA AUSBURN: During labor and delivery
7 of my daughter --

8 THE COURT: Okay.

9 JUROR #6, SONYA AUSBURN: Sorry about that.

10 THE COURT: She's got to be able to hear you.

11 JUROR #6, SONYA AUSBURN: Yeah. No problem.

12 THE COURT: But we don't need everybody else hearing
13 you.

14 Thank you.

15 JUROR #6, SONYA AUSBURN: I'm sorry. I work with
16 kids so I have to be loud all the time.

17 THE COURT: Right. Ms. Ausburn.

18 JUROR #6, SONYA AUSBURN: Uh-huh. During labor and
19 delivery with my daughter five years ago, I had to be
20 administered Pitocin because she wasn't coming down. She
21 does have a disorder. But it's nothing that -- it was
22 just from in utero. She has Turner Syndrome. But it's
23 nothing that's really a major disability, just a little
24 height issue.

25 THE COURT: Okay.

1 JUROR #6, SONYA AUSBURN: But other than that...

2 THE COURT: Okay. Would that effect your ability to
3 be fair and impartial in this case?

4 JUROR #6, SONYA AUSBURN: No.

5 THE COURT: You could decide the case on the evidence
6 and the law?

7 JUROR #6, SONYA AUSBURN: Absolutely.

8 THE COURT: All right. Thank you.

9 JUROR #6, SONYA AUSBURN: Thank you.

10 (WHEREUPON, Juror #6, Sonya Ausburn, was seated.)

11 (WHEREUPON, Juror #120, Travis Summerlin, came
12 forward.)

13 THE COURT: Yes, sir.

14 JUROR #120, TRAVIS SUMMERLIN: My name is Travis
15 Summerlin, #120.

16 Two questions. You asked -- my daughters, when they
17 were born, my wife was administered Pitocin.

18 THE COURT: Okay, sir.

19 JUROR #120, TRAVIS SUMMERLIN: No big deal.

20 And then I was a party to a lawsuit when I was very
21 young. I was injured in an industrial accident.

22 THE COURT: Would either of those effect your ability
23 to be fair and impartial in this case, sir?

24 JUROR #120, TRAVIS SUMMERLIN: I don't think so.

25 THE COURT: And you could decide this case based on

1 the evidence and the law?

2 JUROR #120, TRAVIS SUMMERLIN: Yes.

3 THE COURT: I'm sorry. Did you tell us your name?

4 JUROR #120, TRAVIS SUMMERLIN: Yes. Travis

5 Summerlin.

6 THE COURT: Yes, Mr. Summerlin.

7 All right. Thank you.

8 JUROR #120, TRAVIS SUMMERLIN: Sure.

9 (WHEREUPON, Juror #120, Travis Summerlin, was

10 seated.)

11 (WHEREUPON, Juror #94, Danielle Owens, came forward.)

12 THE COURT: Yes, ma'am.

13 JUROR #94, DANIELLE OWENS: Hi.

14 THE COURT: Tell me your name.

15 JUROR #94, DANIELLE OWENS: Danielle Owens.

16 THE COURT: Okay.

17 JUROR 394, DANIELLE OWENS: I don't believe I can

18 serve without bias. Three years ago, I was in a --

19 THE COURT: Just -- if you would, just keep your

20 voice down so she can hear you. But we don't want

21 everybody else hearing.

22 Thank you.

23 JUROR #94, DANIELLE OWENS: Several years ago, I was

24 admitted into the emergency room with severe abdominal

25 pain. I was refused any sort of treatment until I would

1 submit to a pregnancy test, despite telling them that I'd
2 not been sexually active in over a year.

3 It turned out that I had a ruptured appendix. And I
4 could have died from not having treatment in addition to
5 being refused anesthesia. When I was, finally, treated, I
6 woke up twice during surgery. And I just -- I don't feel
7 like I could serve.

8 THE COURT: Thank you, Ms. Owens.

9 JUROR #94, DANIELLE OWENS: Thank you.

10 (WHEREUPON, Juror #94, Danielle Owens, was seated.)

11 THE COURT: Okay. She's excused.

12 (WHEREUPON, Juror #117, Jared Stroud, came forward.)

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

14 JUROR #117, JARED STROUD: My wife was administered
15 Pitocin for induced labor for our daughter. I just
16 responded to that.

17 Didn't you ask if anybody had been administered
18 Pitocin?

19 THE COURT: Okay. Do you -- it's alleged in this
20 case that, you know, medical negligence occurred. Do you
21 think you can be fair and impartial given the fact that
22 you're an EMT?

23 JUROR #117, JARED STROUD: Yes, sir.

24 THE COURT: You could decide that fairly and
25 impartially and based on the evidence and the law?

1 JUROR #117, JARED STROUD: Yes, sir.

2 THE COURT: Okay. Why did you get a star on your
3 badge?

4 JUROR #117, JARRED STROUD: I'll just tell you --
5 just to be honest with you, I don't know. If you know,
6 let me know. I don't know if I'm marked out for something
7 special or not.

8 THE COURT: I don't know either. I've never seen
9 that.

10 Thank you.

11 (WHEREUPON, Juror #117, Jared Stroud, was seated.)

12 (WHEREUPON, Juror #61, Eric Hutchinson, came
13 forward.)

14 JUROR #61, ERIC HUTCHINSON: My name is Eric
15 Hutchinson.

16 And my wife gave birth seven weeks ago. And I
17 believe she was given Pitocin because of -- she was
18 running a temperature. And our son was having a rapid
19 heart rate.

20 THE COURT: All right. Would that effect your
21 ability to be fair and impartial in this case?

22 JUROR #61, ERIC HUTCHINSON: No, sir.

23 THE COURT: Was the delivery at Greenville Hospital
24 System?

25 JUROR #61, ERIC HUTCHINSON: Yes, it was.

1 THE COURT: Is there anything about your experience
2 that would effect your ability to be fair and impartial in
3 this case?

4 JUROR #61, ERIC HUTCHINSON: I don't believe so.

5 THE COURT: You could decide the case solely on the
6 evidence and the law?

7 JUROR #61, ERIC HUTCHINSON: Yes.

8 THE COURT: All right. Thank you, sir.

9 (WHEREUPON, Juror #61, Eric Hutchinson, was seated.)

10 (WHEREUPON, Juror #112, Cathy Schroer, came forward.)

11 JUROR #112, CATHY SCHROER: Cathy Schroer.

12 THE COURT: How are you doing today?

13 JUROR #112, CATHY SCHROER: Premature -- I have a
14 premature child, a special needs child with cerebral
15 palsy.

16 THE COURT: Would that effect your ability to be fair
17 and impartial in this case? This involves allegations of
18 medical negligence in the delivery process.

19 MR. GRAHAM: It does not involve CP.

20 JUROR #112, CATHY SCHROER: Okay. It doesn't involve
21 CP. Okay. Yes.

22 THE COURT: Okay. You could do that?

23 JUROR #112, CATHY SCHROER: Yeah. I could do that.

24 THE COURT: You could base your decision solely on
25 the evidence and the law?

1 JUROR #112, CATHY SCHROER: Yes.

2 THE COURT: All right. Thank you.

3 (WHEREUPON, Juror #112, Cathy Schroer, was seated.)

4 (WHEREUPON, Juror #111, Cheryl Schofield, came

5 forward.)

6 THE COURT: Good morning.

7 JUROR #111, CHERYL SCHOFIELD: You mentioned Pitocin?

8 THE COURT: Yes. Ms. Schofield?

9 JUROR #111, CHERYL SCHOFIELD: Schofield, uh-huh.

10 I've been administered Pitocin.

11 THE COURT: Would that effect your ability to be fair

12 and impartial in this case?

13 JUROR #111, CHERYL SCHOFIELD: Pardon me.

14 THE COURT: Would that effect your ability to be fair

15 and impartial in this case?

16 JUROR #111, CHERYL SCHOFIELD: No.

17 THE COURT: All right. Thank you.

18 JUROR #111, CHERYL SCHOFIELD: I just thought I had

19 to tell you.

20 (WHEREUPON, Juror #111, Cheryl Schofield, was

21 seated.)

22 (WHEREUPON, Juror #44, Shannon Grant, came forward.)

23 THE COURT: Good morning.

24 JUROR #44, SHANNON GRANT: Shannon Grant.

25 And I have given birth to a child with Pitocin.

1 And then, also, I have a working relationship with
2 GHS. And I work with families that have children with
3 special needs.

4 THE COURT: Would any of those effect your ability to
5 be fair and impartial in this case?

6 JUROR #44, SHANNON GRANT: No, sir. It would not.

7 THE COURT: You could decide the case solely on the
8 evidence and the law?

9 JUROR #44, SHANNON GRANT: Yes, sir.

10 THE COURT: Thank you, ma'am.

11 (WHEREUPON, Juror #44, Shannon Grant, was seated.)

12 (WHEREUPON, Juror #92, John Newcomer, came forward.)

13 THE COURT: #92.

14 JUROR #93, JOHN NEWCOMER: Hey.

15 THE COURT: Mr. Newcomb?

16 JUROR #93, JOHN NEWCOMER: John Newcomer, yes.

17 THE COURT: Newcomer, I'm sorry.

18 JUROR #93, JOHN NEWCOMER: That's okay.

19 My wife has had Pitocin during both pregnant
20 deliveries. And I think I possibly was involved with it
21 in '90 or '89 when I was in nursing school.

22 THE COURT: What part of the nursing are you in?

23 JUROR #93, JOHN NEWCOMER: Currently, I'm in bed
24 management.

25 THE COURT: And you work at the hospital system?

1 JUROR #93, JOHN NEWCOMER: Yes.

2 THE COURT: All right. Thank you, sir.

3 (WHEREUPON, Juror #93, John Newcomer, was seated.)

4 (WHEREUPON, Juror #18, Beverly Callaham, came

5 forward.)

6 THE COURT: Good morning.

7 JUROR #18, BEVERLY CALLAHAM: Good morning.

8 You mentioned companies, and you said Citgo.

9 THE COURT: Did I?

10 Yes, I did.

11 JUROR #18, BEVERLY CALLAHAM: I work in the home

12 office of Citgo.

13 THE COURT: Okay. Thank you.

14 (WHEREUPON, Juror #18, Beverly Callaham, was seated.)

15 (WHEREUPON, Juror #87, Charlene Meadows, came

16 forward.)

17 THE COURT: Good morning.

18 JUROR #87, CHARLENE MEADOWS: Charlene Meadows.

19 It occurred to me that I worked as a temp for Care

20 Partners of Asheville. And I was in hospice medical

21 records for about -- this has been about seven or eight

22 years ago.

23 THE COURT: Would that effect your ability to be fair

24 and impartial in this case, ma'am?

25 JUROR #87, CHARLENE MEADOWS: No.

1 THE COURT: All right. Thank you.
2 (WHEREUPON, Juror #87, Charlene Meadows, was seated.)
3 (WHEREUPON, Juror #90, Alan Myers, came forward.)
4 JUROR #90, ALAN MYERS: How are you doing?
5 THE COURT: Good morning, Mr. Myers.
6 JUROR #90, ALAN MYERS: I was -- on the medical
7 training, we are under the same umbrella medical training
8 wise that Greenville County is in conjunction with the
9 hospital system. So I just wanted to mention that it
10 shouldn't -- it's not going to bother me.
11 THE COURT: It's not going to effect your ability to
12 be fair and impartial?
13 JUROR #90, ALAN MYERS: No. It shouldn't be a
14 problem.
15 THE COURT: Thank you, sir.
16 JUROR #90, ALAN MYERS: Thank you.
17 (WHEREUPON, Juror #90, Alan Myers, was seated.)
18 (WHEREUPON, Juror #12, Valerie Baronkin, came
19 forward.)
20 JUROR #12, VALERIE BARONKIN: Hi.
21 I received Pitocin during childbirth many, many years
22 ago.
23 But I, also, have a bias against Greenville Hospital
24 System. My husband had -- was telling me about consumer
25 reports who had --

1 THE COURT: Well, I'll tell you what. We don't have
2 to get into the why.

3 JUROR #12, VALERIE BARONKIN: Okay.

4 THE COURT: Do you think you can be fair and
5 impartial?

6 JUROR #12, VALERIE BARONKIN: I think I'm a fair
7 person. But I just wanted to expose that I do have a bit
8 of a bias against --

9 THE COURT: Well, all right.

10 JUROR #12, VALERIE BARONKIN: Okay.

11 THE COURT: And you wouldn't be able to put that
12 aside?

13 JUROR #12, VALERIE BARONKIN: No. I think I could
14 after hearing the evidence. I just wanted you to know
15 before I go into this that I do have some preconceived
16 notions about Greenville Hospital System. But I think I
17 could put those aside.

18 THE COURT: All right. So when you're selected as a
19 juror, in order to serve, you have to take an oath that
20 you'll be able to base your decision on the evidence and
21 the law and not any other reasons.

22 Do you think you can do that?

23 JUROR #12, VALERIE BARONKIN: I think I can.

24 THE COURT: How confident are you that you can?

25 JUROR #12, VALERIE BARONKIN: If -- do you want a

1 scale?

2 THE COURT: Sure.

3 JUROR #12, VALERIE BARONKIN: I would say I -- you
4 know, I don't know. I guess I have -- like I said, if I
5 had to offer somebody advice about going to the hospital,
6 it would not be Greenville Hospital System. But in
7 hearing some evidence, I think I should be okay in
8 determining -- I mean, I'm a reasonable, logical person
9 and would be able to make a decision.

10 THE COURT: Thank you.

11 (WHEREUPON, Juror #12, Valerie Baronkin, was seated.)

12 (WHEREUPON, Juror #86, Vicki McMakin, came forward.)

13 JUROR #86, VICKI MCMAKIN: I don't know if you wanted
14 to hear from me again, but you asked the question about
15 the Pitocin. I've had Pitocin before.

16 And, also, Piedmont OB-GYN is my GYN group. And my
17 daughter is seeing them, too. So I feel like this might
18 be a conflict of interest, honestly.

19 THE COURT: Okay.

20 JUROR #86, VICKI MCMAKIN: But I do think I could be
21 fair. But still...

22 THE COURT: Thank you, ma'am.

23 (WHEREUPON, Juror #86, Vicki McMakin, was seated.)

24 (WHEREUPON, an off-the-record discussion was held
25 with the Court and the attorneys.)

1 THE COURT: Mr. White, if you could come up, sir.
2 (WHEREUPON, Juror #138, Lewis White, came forward.)
3 THE COURT: Hey. How are you doing?
4 JUROR #138, LEWIS WHITE: Good. How are you?
5 THE COURT: You mentioned that you had a business
6 relationship with THS [phonetic] Pharmaceutical sales.
7 JUROR #138, LEWIS WHITE: Uh-huh.
8 THE COURT: Tell me a little more about that, sir.
9 JUROR #138, LEWIS WHITE: I'm a sales manager for a
10 local team. And some of those -- some of those teammates
11 of mine would call on GHS and their customers, such as the
12 pharmacy physicians. I did not recognize the names that
13 you listed off. I haven't had direct contact with those
14 individuals, but some of my teammates could have.
15 THE COURT: What kind of pharmaceuticals are they?
16 JUROR #138, LEWIS WHITE: I'm in the pill side of the
17 business. So it's commonly prescribed by any type of
18 primary care physician. So Nexium would be one of the
19 products you're familiar with.
20 THE COURT: All right. So do you have other
21 customers other than GHS?
22 JUROR #138, LEWIS WHITE: Oh, yeah. I manage the
23 entire upstate. So it would be all hospital systems and
24 those physicians employed by them.
25 THE COURT: Do you know of any reason why you

1 couldn't be fair and impartial in this case with the
2 hospital system as a party?

3 JUROR #138, LEWIS WHITE: I don't think so. I think
4 I would be fine.

5 THE COURT: You could decide the case solely on the
6 evidence and the law?

7 JUROR #138, LEWIS WHITE: Yes.

8 THE COURT: Thank you.

9 (WHEREUPON, Juror #138, Lewis White, was seated.)

10 THE COURT: And Mr. Ross.

11 (WHEREUPON, Juror #108, Samuel Ross, came forward.)

12 THE COURT: How are you?

13 JUROR #108, SAMUEL ROSS: Doing great.

14 How are you?

15 THE COURT: Tell me again about your wife's
16 employment.

17 JUROR #108, SAMUEL ROSS: My wife, she's a registered
18 nurse. She works for Interim Healthcare and Med First.
19 And she's -- gets assigned to wherever they need an RN.

20 THE COURT: And do you know of -- what connection she
21 has with the Greenville Hospital System, if any?

22 JUROR #108, SAMUEL ROSS: She's a registered nurse
23 for the Greenville Hospital System.

24 THE COURT: All right. And how long has she been
25 doing that?

1 JUROR #108, SAMUEL ROSS: For eight years.

2 THE COURT: Was she ever employed directly by

3 Greenville Hospital System?

4 JUROR #108, SAMUEL ROSS: No.

5 She's, also, been on -- an as-needed nurse.

6 THE COURT: Do you have any other questions?

7 (WHEREUPON there was no response.)

8 THE COURT: Does she work in the OB-GYN --

9 JUROR #108, SAMUEL ROSS: No. She works at doctor's

10 offices primarily.

11 THE COURT: Okay. Got you.

12 MS. RODRIGUEZ: Does --

13 THE COURT REPORTER: Judge, I can't hear what she's

14 saying --

15 MS. RODRIGUEZ: -- your family --

16 THE COURT REPORTER: I can't hear --

17 JUROR #108, SAMUEL ROSS: Well, yes. Indirectly,

18 yes.

19 MR. GRAHAM: May I ask one more, Your Honor?

20 THE COURT: Sure.

21 MR. GRAHAM: If you sat on a jury that delivered a

22 verdict against Greenville Hospital System, would that

23 have -- what kind of repercussions would that have on you

24 and your family?

25 JUROR #108, SAMUEL ROSS: I don't believe it would

1 have any.

2 THE COURT: Do you know of any reason why you
3 couldn't be fair and impartial, sir?

4 JUROR #108, SAMUEL ROSS: No.

5 THE COURT: All right. Thank you.

6 JUROR #138, SAMUEL ROSS: Thanks.

7 (WHEREUPON, Juror #138, Samuel Ross, was seated.)

8 THE COURT: Mr. Newcomer.

9 (WHEREUPON, Juror #92, John Newcomer, came forward.)

10 THE COURT: Good to see you again.

11 JUROR #92, JOHN NEWCOMER: Thank you.

12 THE COURT: So GHS is a party to this case and you're
13 employed by them. So do you think you can decide the case
14 without any kind of preconceived ideas or any concern
15 about the outcome, given your status as an employee?

16 JUROR #92, JOHN NEWCOMER: I think I can act fairly
17 in the case.

18 THE COURT: You can decide the case based solely on
19 the evidence and the law, sir?

20 JUROR #93, JOHN NEWCOMER: That's correct.

21 THE COURT: Do you have any follow-up?

22 MR. GRAHAM: To what extent is your family dependent
23 on the Greenville Hospital System financially?

24 JUROR #93, JOHN NEWCOMER: It's entirely. I'm pretty
25 much the sole supporter.

1 MR. GRAHAM: And if you were on the jury that
2 rendered a verdict against Greenville Hospital System,
3 what type of repercussions might there be for you?

4 JUROR #93, JOHN NEWCOMER: I never considered that
5 until you asked it.

6 MR. GRAHAM: Where -- what kind of work were you
7 doing in '04? Were you at Greenville Hospital System in
8 '04?

9 JUROR #93, JOHN NEWCOMER: Yeah. I've been there
10 since 1990.

11 Let's see. I'm trying to think where I was in '04.
12 I was probably in the emergency room at that time.

13 MR. GRAHAM: Okay. Do you have friends and contacts
14 that work in the labor and delivery portion of the
15 hospital?

16 JUROR #93, JOHN NEWCOMER: No.

17 MR. GRAHAM: Does your wife work at Greenville
18 Hospital System, too?

19 JUROR #93, JOHN NEWCOMER: No. She works part-time
20 at --

21 MR. GRAHAM: If you were to serve on the jury against
22 your employer, would it give you even a little concern
23 about rendering a verdict against the company that signs
24 your paycheck?

25 JUROR #92, JOHN NEWCOMER: You know, I hadn't

1 considered it until you brought it up. But, as a citizen,
2 you know, I would have to do my duty.

3 THE COURT: Thank you, sir.

4 (WHEREUPON, Juror #93, John Newcomer, was seated.)

5 THE COURT: Ms. Grant.

6 (WHEREUPON, Juror #44, Shannon Grant, came forward.)

7 THE COURT: Hey. Tell me a little bit more about
8 your connection with the hospital system.

9 JUROR #44, SHANNON GRANT: I work with BabyNet. And
10 we work with children with possible developmental
11 handicaps and disabilities. So GHS refers children to our
12 organization.

13 THE COURT: And are you an owner of that business?

14 JUROR #44, SHANNON GRANT: I'm not an owner, no. I'm
15 a coordinator.

16 THE COURT: Do you have any questions?

17 MR. GRAHAM: She has a star, too.

18 THE COURT: Yeah.

19 MR. GRAHAM: Were you doing that in '04? 2004?

20 JUROR #44, SHANNON GRANT: No, since 2005.

21 MR. GRAHAM: Could I ask a couple of other questions?

22 THE COURT: Sure. Go ahead.

23 MR. GRAHAM: Do you know -- is it the OB's at GHS
24 that make the referrals?

25 JUROR #44, SHANNON GRANT: We get lots of referrals

1 from the NICU through --

2 THE COURT REPORTER: Judge, I can't hear --

3 JUROR #44, SHANNON GRANT: I'm sorry.

4 THE COURT: Go ahead.

5 JUROR #44, SHANNON GRANT: We get lots of referrals

6 from the NICU through the social department.

7 MR. GRAHAM: Do you have any working relationship

8 with any of the obstetricians at Greenville Hospital --

9 JUROR #44, SHANNON GRANT: None that were named, no,

10 not directly.

11 MR. GRAHAM: Do you consider that your financial

12 well-being is dependent on good relations with Greenville

13 Hospital System?

14 JUROR #44, SHANNON GRANT: No.

15 THE COURT: Thank --

16 MR. GRAHAM: Do you --

17 THE COURT: Go ahead.

18 MR. GRAHAM: I mean, would it have any personal

19 repercussions on you if you sat on the jury that gave a

20 verdict against Greenville Hospital System?

21 JUROR #44, SHANNON GRANT: No, sir.

22 THE COURT: Thank you.

23 (WHEREUPON, Juror #44, Shannon Grant, was seated.)

24 THE COURT: I'll ask the thing about the Jehovah's

25 Witness. But, right now, I'm not -- I'm inclined to

1 strike Mr. Newcomer, but not the other -- I don't see a
2 basis for the other --

3 MR. GRAHAM: You didn't ask that first guy about any
4 follow-up questions about the financial aspects. Those
5 guys work and they get commissions.

6 THE COURT: I think based on his responses -- are you
7 talking about Mr. White?

8 MR. GRAHAM: Yes, sir, the drug guy.

9 THE COURT: Do you want me to bring him back up here
10 and ask him questions related about his employment with
11 Greenville Hospital System and -- you can go ahead and do
12 what you want to do.

13 (Pause.)

14 MR. GRAHAM: Yes, sir. We would like for you to call
15 Mr. White back.

16 THE COURT: Okay. Mr. White, one more question, sir.

17 (WHEREUPON, Juror #138, Lewis White, came forward.)

18 THE COURT: Yes, sir.

19 MR. GRAHAM: Thank you, Your Honor.

20 In terms of your business relationship with GHS, is
21 your compensation based in part upon how successful your
22 business relationship is with GHS?

23 JUROR #138, LEWIS WHITE: It's based on the
24 prescription volume that would come through the hospital
25 system.

1 MR. GRAHAM: All right. And your personal finances
2 would be based, at least, in part on contingent pay based
3 on the numbers of prescriptions, and that sort of thing.

4 JUROR #138, LEWIS WHITE: Such as bonuses? Is that
5 what you --

6 MR. GRAHAM: Bonuses, commissions --

7 JUROR #138, LEWIS WHITE: Yes.

8 MR. GRAHAM: -- any kind of variable pay like that.

9 JUROR #138, LEWIS WHITE: Yes.

10 MR. GRAHAM: Do you guys -- your company give some
11 kind of marketing promotions for goods or services of
12 value to Greenville Hospital System to try to curry their
13 favor?

14 JUROR #138, LEWIS WHITE: The only thing we're
15 allowed to do is give samples of the medicines so the
16 patients can try those.

17 MR. GRAHAM: Right.

18 Before those rules changed, did you guys do more of
19 that kind of marketing?

20 JUROR #138, LEWIS WHITE: Of course. It changed.

21 MR. GRAHAM: Okay. When did that change?

22 JUROR #138, LEWIS WHITE: It must have been around
23 2008.

24 MR. GRAHAM: So back in 2004, your company was giving
25 GHS and its doctors all kinds of goods and services to

1 promote a strong business relationship?

2 JUROR #138, LEWIS WHITE: It was just primarily in
3 the office, just pens, pads, that type of thing.

4 MR. GRAHAM: Have you hired some of the GHS doctors
5 to be -- to make presentations at conferences, and that
6 sort of thing?

7 JUROR #138, LEWIS WHITE: I'm sure that's occurred.
8 I haven't personally been involved in that, but I'm sure
9 that's happened.

10 MR. GRAHAM: Okay. Does that include -- you said
11 primary care and, of course, OB-GYN is primary care.

12 JUROR #138, LEWIS WHITE: I currently don't have any
13 OB customers. But they would be considered primary care.

14 MR. GRAHAM: Okay. And did you have OB customers at
15 anytime in 2004, or since then?

16 JUROR #138, LEWIS WHITE: I did not.

17 THE COURT: You personally did not?

18 JUROR #138, LEWIS WHITE: I did not.

19 THE COURT: What about those working on your team?

20 JUROR #138, LEWIS WHITE: I was not the manager at
21 that time.

22 MR. GRAHAM: Okay. Thank you.

23 THE COURT: Thank you.

24 (WHEREUPON, the sidebar was concluded.)

25 THE COURT: Is there anyone who is a member of the

1 Jehovah's Witness faith, or is there anyone who has moral
2 or religious feelings to such an extent that they do not
3 think they can be fair and impartial in a civil lawsuit?
4 If so, please, stand.

5 (WHEREUPON, there was no response.)

6 (WHEREUPON, a sidebar was held with the Court and
7 the attorneys.)

8 THE COURT: All right. Anything further?

9 MR. GRAHAM: Well, Your Honor, we would like to
10 strike all those for cause that we went over before,
11 including the drug rep.

12 THE COURT: Okay.

13 MR. GRAHAM: Because of all financial entanglements
14 he's had with them currently and in the past.

15 THE COURT: Okay.

16 MS. RODRIGUEZ: For the alternates, are we going to
17 do four, or two, or three?

18 THE COURT: We're going to have three alternates.

19 MR. GRAHAM: Even after last week?

20 THE COURT: Yes. Because we're going to be done by
21 Friday.

22 MR. GRAHAM: That wouldn't have done us any good last
23 week.

24 THE COURT: Maybe not.

25 All right. So I deny the motion to strike Mr. White

1 for cause.

2 We'll strike #92 Mr. Newcomer for cause.

3 So the first will be 1 through 21. And then 22
4 through 24, and then 26, 27, and 29 as the alternates.

5 MR. GRAHAM: Could you run through that one more
6 time?

7 THE COURT: Yes, sir.

8 One through 21. And then 22, 23, and 24 for an
9 alternate. And then 26, 27, and 29 for the second
10 alternate. I think number 28 is -- wait a minute.

11 Did I --

12 THE CLERK: We go with 28 --

13 THE COURT: 25, 26, and 27.

14 THE CLERK: Are you going to strike her?

15 THE COURT: Yes.

16 MR. ALEXANDER: I'm sorry. 25, 26, and 27 is the
17 second alternate?

18 THE COURT: Yes.

19 So we can get three alternates. We might as well.
20 What is -- 28 was stricken.

21 THE CLERK: That was the young girl?

22 THE COURT: Yes.

23 So 29, 30, and 31.

24 THE CLERK: Okay.

25 (Pause.)

1 MR. ALEXANDER: Are we doing two alternates or three?

2 THE COURT: We're going to do three.

3 (WHEREUPON, the sidebar was concluded.)

4 THE COURT: All right. Thank you for your patience.

5 We're going to proceed with the jury selection now.

6 And, yes, ma'am, Ms. Coker.

7 JURY SELECTION

8 THE CLERK: Plaintiff strikes first. Four strikes
9 each, 1 through 21 using the numbers on your left.

10 MR. GRAHAM: Plaintiff strikes #7.

11 THE CLERK: Plaintiff strikes #7.

12 MR. ALEXANDER: Defendant strikes #1.

13 THE CLERK: Defendant strikes #1.

14 MR. GRAHAM: Plaintiff strikes #17.

15 THE CLERK: Plaintiff strikes #17.

16 MR. ALEXANDER: Defendant strikes number #8.

17 THE CLERK: Defendant strikes #8.

18 MR. GRAHAM: Plaintiff strikes #14.

19 THE CLERK: Plaintiff strikes #14.

20 MR. ALEXANDER: Defendant strikes #6.

21 THE CLERK: Defendant strikes #6.

22 MR. GRAHAM: Plaintiff strikes #10.

23 THE CLERK: Plaintiff strikes #10.

24 MR. ALEXANDER: Plaintiff strikes #16.

25 THE CLERK: Plaintiff strikes #16.

1 Our first alternate will come from #22, #23, or #24.
2 MR. GRAHAM: The Plaintiff strikes #23.
3 THE CLERK: Plaintiff strikes #23.
4 MR. ALEXANDER: The Defendant strikes #24.
5 THE CLERK: Defendant strikes #24.
6 Our second alternate will come from #25, #26, and
7 #27.
8 MR. GRAHAM: The Plaintiff strikes #27.
9 THE CLERK: The Plaintiff strikes #27.
10 MR. ALEXANDER: The Defendant strikes #30.
11 THE CLERK: #25, #26, or #27.
12 MR. ALEXANDER: Oh, excuse me.
13 The Defendant strikes #25.
14 THE CLERK: The Defendant strikes #25.
15 Our third alternate will come from #29, #30, and 31.
16 MR. GRAHAM: The Plaintiff strikes #31.
17 THE CLERK: Plaintiff strikes #31.
18 MR. ALEXANDER: The Defendant strikes #30.
19 THE CLERK: Defendant strikes #30.
20 Gentlemen, I'll call these back to you. Plaintiff
21 strikes #7, #10, #14, #17, #23, #27, and #31.
22 MR. GRAHAM: Correct.
23 THE CLERK: The Defendant strikes #1, #6, #8, #16,
24 #24, #25, and #30.
25 MR. ALEXANDER: Correct.

1 THE CLERK: Ladies and gentlemen, when I call your
2 name, please, bring your things and have a seat in our
3 jury box.
4 Margaret Forrest.
5 (WHEREUPON, Margaret Forrest, a white female was
6 seated in the jury box.)
7 THE CLERK: Timothy Haughwout.
8 (WHEREUPON, Timothy Haughwout, a white male, was
9 seated in the jury box.)
10 THE CLERK: Cheryl Schofield.
11 (WHEREUPON, Cheryl Schofield, a white female, was
12 seated in the jury box.)
13 THE CLERK: Nancy Weatherford.
14 (WHEREUPON, Nancy Weatherford, a white female, was
15 seated in the jury box.)
16 THE CLERK: Cathy Schroer.
17 (WHEREUPON, Cathy Schroer, a white female, was seated
18 in the jury box.)
19 THE CLERK: Sonya Ausburn.
20 (WHEREUPON, Sonya Ausburn, a white female, was seated
21 in the jury box.)
22 THE CLERK: Samuel Ross.
23 (WHEREUPON, Samuel Ross, a white male, was seated in
24 the jury box.)
25 THE CLERK: Samuel Harris.

1. (WHEREUPON, Samuel Harris, a white male, was seated
2 in the jury box.)
3 THE CLERK: Calvin Bishop.
4 (WHEREUPON, Calvin Bishop, a black male, was seated
5 in the jury box.)
6 THE CLERK: Nancy Carter.
7 (WHEREUPON, Nancy Carter, a white female, was seated
8 in the jury box.)
9 THE CLERK: Travis Summerlin.
10 (WHEREUPON, Travis Summerlin, a white male, was
11 seated in the jury box.)
12 THE CLERK: Lindsey Rodgers.
13 (WHEREUPON, Lindsey Rodgers, a white female, was
14 seated in the jury box.)
15 THE CLERK: Our first alternate is Beverly Callaham.
16 (WHEREUPON, Beverly Callaham, a white female, was
17 seated in the jury box.)
18 THE CLERK: The second alternate is William Crawford.
19 (WHEREUPON, William Crawford, a white male, was
20 seated in the jury box.)
21 THE CLERK: The third alternate is Eric Hutchinson.
22 (WHEREUPON, Eric Hutchinson, a white male, was seated
23 in the jury box.)
24 THE COURT: Any matters or motions related to the
25 selection process or the composition of the jury from the

1 Plaintiff?

2 MR. GRAHAM: Yes, sir.

3 THE COURT: Let me see y'all up here real quick.

4 (WHEREUPON, a bench conference was held.)

5 THE COURT: All right. Ladies and gentlemen, I'm
6 just going to ask you to go with the other jurors, and
7 just go out in the hall for a little bit while we take
8 care of a legal matter in here. And don't talk about the
9 case. And we'll try to resolve this as quickly as we can.

10 So just go out in the hallway. And it will probably
11 take us, at least, 15 minutes to resolve this. So you can
12 consider it an extended break. But just be -- make sure
13 everybody is back out there at 12:45, though.

14 (WHEREUPON, the jury exited the courtroom.)

15 THE COURT: Okay. So that means everybody. I'm
16 sorry.

17 (WHEREUPON, the remaining jury panel members exited
18 the courtroom.)

19 BATSON MOTION

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

21 MR. GRAHAM: If Your Honor please, this panel did not
22 contain very many African-American jurors who, of course,
23 have every right to serve on a jury in this county. Of
24 his four strikes, Mr. Alexander used two to strike
25 African-American jurors. And he used one of his alternate

1 strikes to strike an African-American alternate as well.

2 There were I believe -- let me do a quick count.

3 Of a total of four African-American jurors, #1
4 through #35, Mr. Alexander struck 75 percent of them. We
5 believe that's disproportionate and makes a prima facie
6 case of impermissible -- Constitutionally impermissible
7 strikes under the Batson case.

8 THE COURT: Thank you, sir.

9 Yes, sir, Mr. Alexander.

10 MR. ALEXANDER: Your Honor, I believe I struck Juror
11 #16, Devario Wright. Mr. Wright was the gentleman that
12 stood up during jury qualification -- when he was asked
13 about the typical demographic information, including his
14 employer, he's the one that was unable to give us the
15 answer to who his employer was, or where he worked. And
16 my concern with Mr. Wright was that he was going to be
17 unable to understand the medical issues involved in this
18 case. And for that reason, I struck him.

19 Tabitha Belcher, Juror #8, was the second juror we
20 struck. And Ms. Belcher works for Classy Kids. And our
21 concern was the sympathy that may inure with regard to
22 this little girl, who has a birth injury. And so that is
23 the reason we struck her.

24 And the third juror was Carolyn Acker. And Ms. Acker
25 has a \$14,000 balance with the hospital that is being

1 pursued by collections. And that is the reason we struck
2 her.

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

4 MR. GRAHAM: If Your Honor please, I know
5 Mr. Alexander came armed into this courtroom with a list
6 of other jurors who owed money to the hospital. For us to
7 be able to pursue an inquiry as to whether or not that was
8 a mere pretextual reason for striking that witness [sic],
9 we would ask Mr. Alexander, as an officer of the Court,
10 whether or not there are other jurors he did not strike
11 who, also, owe money to the hospital.

12 THE COURT: Mr. Alexander.

13 MR. ALEXANDER: My assistant says yes.

14 MS. ELIZABETH COWAN: #15, Mr. Calvin Bishop, also,
15 owes money to the hospital.

16 MR. ALEXANDER: Was he struck?

17 MS. ELIZABETH COWAN: No. He's on the jury.

18 MR. ALEXANDER: Mr. Bishop is African American, by
19 the way. And he is on the jury.

20 Like I said, Caroline Acker is \$13,000.

21 MS. ELIZABETH COWAN: #21, also, owes money to the
22 hospital. And she's on the jury.

23 MR. ALEXANDER: I mean, there were two that I had
24 concerns about. Caroline Acker is \$13,000 -- almost
25 \$14,000. And Rhonda Thompson, who we did not get to, is

1 \$66,000. The remaining jurors either are none, or small.

2 I, also, had concerns about Sandra Haulter. And I
3 believe I struck her. And she has \$5,000 balance.

4 So, you know, if it was nominal -- I mean, literally,
5 everybody else is either \$129, \$299. I didn't strike
6 nominal amounts. And I, typically, don't strike nominal
7 amounts. Once they get up around, you know -- and Calvin
8 Bishop I didn't strike, an African American, who has a
9 \$1,700 balance.

10 But once they get up to \$5,000, \$10,000, \$15,000, I
11 have grave concerns. Because those people are usually
12 being pursued by collections and have ill will towards the
13 hospital.

14 So, again, Caroline Acker is almost \$14,000. She was
15 struck as was number -- who's not a subject of this Batson
16 motion, but she \$66,000. So I was, actually, perfectly
17 consistent with how we treated those who had outstanding
18 balances.

19 MR. GRAHAM: Your Honor, just so that we can make our
20 appellate record, we would ask Mr. Alexander to identify
21 all of the white jurors who owe money to the Greenville
22 Hospital System, according to the information that he has,
23 and how much each of those owes that he did not strike.

24 MR. ALEXANDER: Well, I'll read out the balances and
25 the individuals, if the Court will permit me.

1 Caroline Acker, Juror -- well \$13,961 --
2 THE COURT: Wait a minute. She is number --
3 MR. GRAHAM: #30.
4 THE COURT: On the left? Using the number on the
5 left?
6 MR. GRAHAM: #30 on the left, #1 on the right.
7 THE COURT: Okay.
8 MR. ALEXANDER: Calvin Bishop, who -- an African
9 American that we did not strike, has a \$1,719 balance.
10 Tabitha Belcher, she has a \$560 balance. That's not
11 the reason I struck her. I struck her because of her
12 association with Classy Kids.
13 THE COURT: She is #8 on the left?
14 MR. GRAHAM: Yes, sir.
15 THE COURT: Juror #13.
16 MR. ALEXANDER: And you're interested in those who
17 have balances; true?
18 THE COURT: Yes.
19 MR. ALEXANDER: Okay. Margaret Forrest has a \$134
20 balance.
21 THE COURT: Okay. Just make sure we've got the
22 numbers, so we can keep track of it.
23 MR. ALEXANDER: She was #2.
24 Sandra Haulter, who I did strike, Juror #24. She has
25 a \$5,000 balance.

1 Danielle Owens, Juror #28. She has a \$3,200 balance.
2 And, honestly, I don't remember if she was on the juror
3 list --

4 MS. ELIZABETH COWAN: No. She's not. She was
5 struck.

6 MR. ALEXANDER: Okay. And Daniel Phillips, who has a
7 \$299 balance.

8 Lindsey Rodgers has an \$1,800 balance.

9 THE COURT: She's #21?

10 MR. ALEXANDER: Yes, sir.

11 Eric Thomas has a \$100 balance.

12 THE COURT: What's his number? I don't see a Thomas.

13 MS. ELIZABETH COWAN: No. He's not on there.

14 MR. ALEXANDER: Okay. I'm sorry. I don't think he
15 made the cut.

16 And so -- and Rhonda Thompson has a \$66,000 balance.
17 I don't believe she's on the list either.

18 THE COURT: Okay.

19 MR. ALEXANDER: That's, actually, all the jurors.

20 MR. GRAHAM: And, if Your Honor please, with respect
21 to the Defendant's striking of Tabitha Belcher, #8 --

22 THE COURT: Yes, sir.

23 MR. GRAHAM: -- on the left. The reference to Classy
24 Kids doesn't particularly seem race neutral to me. I
25 mean, it's -- there's a number of other jurors on here who

1 have affiliations with some form of child care. This
2 particular one is child care for African American
3 children, I believe.

4 And to strike a juror because she's affiliated with
5 an entity that provides care for African American children
6 doesn't seem to me like a racially-neutral reason. But
7 even if the Court were inclined to accept it as such, we
8 believe it's merely pretextual.

9 THE COURT: Well, what basis do you have for saying
10 that Classy Kids is primarily African American and, also,
11 for saying that other jurors not stricken had similar
12 jobs?

13 MR. GRAHAM: I may have misspoke on that, Your Honor.
14 I misspoke on that. I saw some information on this
15 particular juror. And I, obviously, got confused on that
16 point for which I apologize.

17 THE COURT: Okay. So what other jurors have
18 connections with child care, or work at a child care, or
19 nursery, or...

20 MR. GRAHAM: Could you bear with me just one moment?

21 THE COURT: Sure.

22 (Pause.)

23 MR. GRAHAM: Your Honor --

24 THE COURT: Yes, sir.

25 MR. GRAHAM: -- perhaps the strongest example of

1 pretext is -- I'm sorry, Your Honor. We're still looking.

2 But one that they did not strike who, certainly, has
3 a similar relationship with youngsters is #11, Sonya
4 Ausburn. She's a pediatric dental hygienist, not a day
5 care, but she deals with children professionally.

6 THE COURT: Okay, sir.

7 MR. GRAHAM: And then on the juror that --
8 Mr. Wright, #16, Mr. Alexander said he was unable to
9 identify his employer. But he described what work he
10 does. He just had a momentarily slip of the mind about
11 the name of the company.

12 But the point about intelligence to follow the issues
13 in this case, I think -- I mean, I don't know that we can
14 glean from that mere slip of the mind about the exact name
15 of his corporate employer that he lacks the intelligence
16 to understand the issues in this case. So we believe that
17 sounds like it's not really a race-neutral explanation.
18 And if it is, we believe that would be merely pretextual
19 as well.

20 We, also, had #112 -- I'm sorry. That's the number
21 on the right. It's #9 on the left --

22 THE COURT: Yes, sir.

23 MR. GRAHAM: -- Cathy Schroer, who is a school
24 teacher that was not stricken. So she, also, deals with
25 children, not in a day care facility. But the logic of

1 the argument is dealing with youngsters, some of whom,
2 certainly, have special, unique issues as they would in a
3 day care center."

4 THE COURT: Okay. Yes, sir, Mr. Alexander.

5 What's the difference between the Classy Kids
6 employee, Ms. Belcher, and the other jurors that
7 Mr. Graham points to who work with children?

8 MR. ALEXANDER: Well, you know, someone who works
9 with children as a dentist is not what I was looking for
10 at all. So that is out.

11 And the same with the school teacher. I mean, the
12 issue was working with young children. Somebody who has a
13 passion for working with young children, I felt like was
14 going to be more inclined to sympathy and that kind of
15 persuasion than facts and evidence. And so I struck those
16 that I was concerned that that would be a problem.

17 I did not have that feeling with respect to someone
18 who is a dentist, because it's not similar medical issues,
19 nor a school teacher. Because I don't know, for instance,
20 on that juror whether she teaches 18-year-olds or
21 five-year-olds. And it's my understanding she's,
22 actually, retired, in any event.

23 MR. GRAHAM: Your Honor, I don't know of any evidence
24 in the record from which Mr. Alexander could draw a proper
25 inference about the level of passion being greater for the

1 African American juror he struck than for the dental --
2 the white dental hygienist and retired teacher, if she is
3 retired, that he allowed to serve on the juror.

4 We believe that if you start getting into feelings
5 about passion, that's the kind of subterfuge that would
6 allow every African American to be struck for any number
7 of spurious reasons whenever the defense lawyer can say I
8 thought they seemed to have passion. We believe that
9 would strike a very dangerous precedent if that were
10 deemed an appropriate reason to strike somebody in the
11 totality of the circumstances where 75 percent of every
12 African American in this draw, which is already a very low
13 number, four out of 35, 75 percent of those were stricken.

14 THE COURT: All right. Well, I find that, based on
15 the circumstances, the Plaintiff has met their burden as
16 to Juror #8. While there was a reason given by the
17 Defense as to striking her that was race neutral in terms
18 of her employment, I find that a similarly situated juror
19 of another race, Ms. Schroer, was seated. And there's no
20 race-neutral explanation for their inconsistent treatment
21 if teaching or care of children is the motivating factor
22 for the strike.

23 So we'll just have to reshuffle the list.

24 (Pause.)

25 THE COURT: She's going to have a new list generated.

1 I've instructed her I'm going to strike #32 and #35 for
2 cause. That's Ms. McMakin and Ms. Baronkin based on
3 their -- in the case of Ms. Baronkin, her expressly stated
4 bias against Greenville Hospital System. And Ms. McMakin
5 as having employment history, patient history, and other
6 insurmountable conflicts as to her impartiality.

7 MR. ALEXANDER: So, Judge, the folks that are coming
8 up are going to be the same folks on this list?

9 THE COURT: Right.

10 MR. ALEXANDER: Okay.

11 THE COURT: Except for Mr. Newcomer, Ms. McMakin, and
12 Ms. Baronkin.

13 THE CLERK: And Ms. Owens.

14 THE COURT: Ms. Owens?

15 THE CLERK: Danielle Owens.

16 THE COURT: That's right, yes. I'm sorry. I just
17 can't read my own handwriting.

18 Do y'all want to break for lunch and come back and do
19 it after lunch?

20 MR. GRAHAM: Whatever suits Your Honor.

21 THE COURT: Just tell that panel to come back up here
22 at 2:15.

23 THE CLERK: I think they sent them downstairs.

24 THE COURT: Oh, they did?

25 THE CLERK: Do you want her just to have the ones

1 that's going to be on our list come back at 2:15?

2 THE COURT: Yes, the ones on the list come back at
3 2:15.

4 And y'all get the list now and then y'all can be
5 studying over it at lunch.

6 Anything else for the record right now?

7 (WHEREUPON, there was no response.)

8 THE COURT: Thank you.

9 (WHEREUPON, a lunch break was taken.)

10 THE COURT: Anything before we bring the panel back
11 in?

12 MR. GRAHAM: No, Your Honor.

13 MR. ALEXANDER: Yes, sir.

14 May I be heard very briefly on the Batson issue?

15 THE COURT: Yes, sir.

16 MR. ALEXANDER: Your Honor, when I went back to the
17 office, some of my learned colleagues pointed me to a
18 recent appellate court case of which you may be aware, an
19 October 2nd, 2013, Court of Appeals decision. In this
20 case, the Defendant -- the criminal defendant in this
21 case, Mr. Scott, struck eight prospective white jurors.
22 The State then filed a Batson motion. And, ultimately, a
23 new -- well, the State filed a Batson motion.

24 What the Court has held in this opinion, it says,
25 Once the opponent of a preemptory challenge has made out a

1 prima facie case of racial discrimination, which is step
2 one, the burden of production then shifts to the
3 opponent -- proponent of the strike to come forward with a
4 race-neutral explanation, which is step two. If a
5 race-neutral explanation is tendered, the trial court must
6 then decide step three, whether the opponent of the strike
7 has proposed -- proved purposeful racial discrimination.

8 And the Court goes on to say that step two of this
9 process does not demand an explanation that is persuasive
10 or even plausible. In step two, the opponent of the
11 strike does not carry any burden of presenting reasonably
12 specific, legitimate explanations for the strike. And,
13 therefore, unless a discriminatory intent is inherent,
14 then the explanation provided by the proponent of the
15 strike, the reason offered will be deemed race neutral.
16 And the Court must proceed to the third step of that
17 Batson process.

18 At that step, this Court goes on to say the opponent
19 of the strike must show that the reason offered, though
20 facially neutral, was, actually, mere pretext to engage in
21 purposeful discrimination. And this burden is, generally,
22 established by showing similarly situated members of
23 another race were seated on the jury.

24 The facts of this case were that one of the jurors
25 that was struck was a school teacher. And one of the

1 ones -- the jurors that was struck was -- not struck was a
2 warehouse manager.

3 And the argument of the proponent of the Batson
4 motion was that both of these people -- the person doing
5 the strike came forward and said, I struck them -- this
6 person that's a warehouse manager because I didn't want
7 people with supervisory skills sitting on the jury. And
8 the opponent of the strike said, well, the other person is
9 a school teacher, who, also, has supervisory duties.

10 In any event, the holding of the Court was that
11 people don't have to be identical to survive -- to defeat
12 the Batson challenge. And so the distinction of those two
13 jurors in that case was the -- you know, that whether
14 supervising adults are similar to supervising children.
15 And the issue was that that was distinct enough to allow
16 the strikes. And then by ruling in that way on the Batson
17 motion that they denied the Defendant his Constitutional
18 right to a fair trial, et cetera.

19 I would just -- I just, for the record, would point
20 out that the argument we were making with respect to a
21 school teacher who -- we don't know what grade she
22 teaches, but she teaches children of all ages. And we
23 made the argument that Classy Kids we had struck on the
24 basis of being involved in working with small children was
25 part of our basis for striking that particular juror. And

1 we believe, under the facts of this recent appellate court
2 case, that would be sufficient to survive the Batson
3 challenge.

4 THE COURT: Thank you, Mr. Alexander.

5 MR. GRAHAM: Your Honor, as I understand the law, I
6 don't believe that case presented any new law. I don't
7 believe it made any new law. It applied long existing law
8 to a specific fact situation, just as Your Honor has done
9 here, and I think properly ruled that our argument that
10 striking the juror with the Classy Kids explanation was,
11 in fact, a pretext.

12 And so we believe Your Honor ruled correctly. And
13 unless Your Honor wants further argument, that's all we
14 have at this time.

15 THE COURT: Thank you, sir.

16 In my earlier ruling, I was relying on the State v.
17 Adams, which adopted the perfect factors which State v.
18 Scott, decided October 2nd, was bound to follow and, in
19 fact, cited and relied upon. And I don't --

20 While I appreciate your fine argument, Mr. Alexander,
21 I don't see anything that would cause me to change my
22 ruling. I find where I ruled before stands.

23 Anything else before we bring the jury in?

24 MR. GRAHAM: No, Your Honor.

25 MR. ALEXANDER: No, sir.

1 THE COURT: Is the panel on the way up or --
2 THE CLERK: I doubt it.
3 THE COURT: Can they come up now?
4 THE CLERK: Yes.
5 (Pause.)
6 THE CLERK: They're on their way.
7 THE COURT: Okay. Thank you.
8 (WHEREUPON, the jury panel entered the courtroom.)
9 THE COURT: Ladies and gentlemen, a matter arose that
10 is going to require us to -- for technical reasons, to do
11 the process over. I think the technical, legal term is
12 called a redo. That's what we're going to do.
13 So with that, we'll start the selection process.
14 Ms. Coker.
15 JURY SELECTION
16 THE CLERK: We'll strike #1 through #20 using the
17 numbers on the left.
18 MR. GRAHAM: The Plaintiff strikes #5.
19 THE CLERK: Plaintiff strikes #5.
20 MR. ALEXANDER: The Defendant strikes #3.
21 THE CLERK: Defendant strikes #3.
22 MR. GRAHAM: The Plaintiff strikes #9.
23 THE CLERK: Plaintiff strikes #9.
24 MR. ALEXANDER: The Defendant strikes #2.
25 THE CLERK: Defendant strikes #2.

1 MR. GRAHAM: The Plaintiff strikes #13.
2 THE CLERK: Plaintiff strikes #13.
3 MR. ALEXANDER: The Defendant strikes #6.
4 THE CLERK: Defendant strikes #6.
5 MR. GRAHAM: The Plaintiff strikes #8.
6 THE CLERK: Plaintiff strikes #8.
7 MR. ALEXANDER: The Defendant strikes #15.
8 THE CLERK: Defendant strikes #15.
9 Now, our first alternate will come from #21, #22, and
10 #23.
11 MR. GRAHAM: The Plaintiff strikes #23.
12 THE CLERK: Plaintiff strikes #23.
13 MR. ALEXANDER: The Defendant strikes #21.
14 THE CLERK: Defendant strikes #21.
15 Our second alternate will come from #24, #25, and
16 #26.
17 MR. GRAHAM: The Plaintiff strikes #25.
18 THE CLERK: Plaintiff strikes #25.
19 MR. ALEXANDER: The Defendant strikes #24.
20 THE CLERK: Defendant strikes #24.
21 Our third alternate will come from #27, #28, or #29.
22 MR. GRAHAM: The Plaintiff strikes #27.
23 THE CLERK: Plaintiff strikes #27.
24 MR. ALEXANDER: The Defendant strikes #29.
25 THE CLERK: Defendant strikes #29.

1 Gentlemen, I'll call these back to you.
2 Plaintiff strikes #5, #8, #9, #13, #23, #25, and #27.
3 MR. GRAHAM: Correct.
4 THE COURT: The Defendant strikes #2, #3, #6, #15,
5 #21, #24, and #29.
6 MR. ALEXANDER: Correct.
7 THE CLERK: Ladies and gentlemen, when I call your
8 name, please, bring your things and have a seat in our
9 juror box.
10 Franklin Heath.
11 (WHEREUPON, Franklin Heath, a white male, was seated
12 in the jury box.)
13 THE CLERK: Charlene Meadows.
14 (WHEREUPON, Charlene Meadows, a white female, was
15 seated in the jury box.)
16 THE CLERK: Margaret Forrest.
17 (WHEREUPON, Margaret Forrest, a white female, was
18 seated in the jury box.)
19 THE CLERK: Eric Hutchinson.
20 (WHEREUPON, Eric Hutchinson, a white male, was seated
21 in the jury box.)
22 THE CLERK: Angela Alford.
23 (WHEREUPON, Angela Alford, a white female, was seated
24 in the jury box.)
25 THE CLERK: Lindsey Rodgers.

1 (WHEREUPON, Lindsey Rodgers, a white female, was
 2 seated in the jury box.)
 3 THE CLERK: Samuel Ross.
 4 (WHEREUPON, Samuel Ross, a white male, was seated in
 5 the jury box.)
 6 THE CLERK: Tabitha Belcher.
 7 (WHEREUPON, Tabitha Belcher, a black female, was
 8 seated in the jury box.)
 9 THE CLERK: William Crawford.
 10 (WHEREUPON, William Crawford, a white male, was
 11 seated in the jury box.)
 12 THE COURT: Nancy Weatherford.
 13 (WHEREUPON, Nancy Weatherford, a white female, was
 14 seated in the jury box.)
 15 THE CLERK: Virginia Crews.
 16 (WHEREUPON, Virginia Crews, a white female, was
 17 seated in the jury box.)
 18 THE COURT: Shannon Grant.
 19 (WHEREUPON, Shannon Grant, a white female, was seated
 20 in the jury box.)
 21 THE CLERK: Our first alternate is Cheryl Schofield.
 22 (WHEREUPON, Cheryl Schofield, a white female, was
 23 seated in the jury box.)
 24 THE CLERK: And our second alternate is Travis
 25 Summerlin.

1 (WHEREUPON, Travis Summerlin, a white male, was
2 seated in the jury box.)

3 THE CLERK: And our third alternate is Calvin Bishop.
4 (WHEREUPON, Calvin Bishop, a black male, was seated
5 in the jury box.)

6 THE COURT: All right. Any matters or motions
7 related to the selection process or composition of the
8 jury from the Plaintiff?

9 MR. GRAHAM: Your Honor, may we approach?

10 THE COURT: Sure.

11 (WHEREUPON, a bench conference was held.)

12 THE COURT: All right. Ladies and gentlemen, just,
13 if you would, go to the jury room. Ms. Fryer is going to
14 escort you to it. And don't talk about the case. And we
15 will have you back in a few minutes.

16 (WHEREUPON, the jury was excused from open court at
17 approximately 2:34 p.m.)

18 THE COURT: Okay. And those of you who weren't
19 chosen, if you'll just return downstairs. And Ms. Olson
20 will give you further instructions down there.

21 Thank you very much for your patience.

22 (WHEREUPON, the remaining jury panel members exited
23 the courtroom.)

24 BATSON MOTION

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

1 MR. GRAHAM: Yes, sir.

2 As we noted up there at the bench just a moment ago,
3 Your Honor, we would like to renew our Batson motion.

4 This time, Mr. Alexander struck 50 percent of the
5 African-American jurors on the panel. He struck #3 and
6 #21. And -- but those two jurors were part of our last
7 Batson motion. And if I understood your prior ruling from
8 before, you didn't go so far as to expressly hold that you
9 were denying our motion as to those two strikes. But, by
10 inference, I think that might be what you intended.

11 So I don't want to take the Court's time unduly, but
12 we did want to make our Batson motion on the record. We
13 believe that it, certainly, on the face of it is a prima
14 facie statistical showing of disproportionate strikes of
15 African Americans. I assume Mr. Alexander has the same
16 explanations as before.

17 But we just believe, in the totality of
18 circumstances, striking 75 percent and striking 50 percent
19 in a case where the Plaintiff is an African-American child
20 and the Defendant is a hospital, and all the faces that
21 the jury will see on behalf of that corporation are
22 Caucasian. We believe that these issues are very
23 important. The African-American citizens in this county
24 have the right to serve as jurors.

25 So it's not just a matter of unfairness to the

1 Plaintiff, it's, also, a matter of safeguarding their
2 right to participate in our democracy.

3 Thank you.

4 THE COURT: Thank you, Mr. Graham.

5 Mr. Alexander, are your reasons for the strikes of
6 those two jurors -- do you want to amplify on that?

7 MR. ALEXANDER: I don't think so, Your Honor.

8 With respect to the statistical argument, I guess the
9 other way to look at that, there's 50 percent of African
10 Americans on this panel. I did not strike Mr. Bishop, nor
11 did I strike Tabitha Belcher.

12 And know -- Mr. Wright -- I know nothing about
13 Mr. Wright, because Mr. Wright didn't respond to hardly
14 anything on his juror questionnaire. So I knew very
15 little about him, other than he has a tenth-grade
16 education. So I was relying heavily on his
17 representations and his report during jury qualification.
18 And it was there that he was unable to tell us who he
19 worked for. And so that was the basis for that.

20 And, as I stated earlier, I had concerns about
21 Carolyn Acker, in part, because of the \$14,000 balance
22 with my client. I would add that Ms. Acker has -- as I
23 read her thing, she is the caretaker of a blind husband.
24 And so I have some misgivings about that as well.

25 MR. GRAHAM: Your Honor, could we inquire as to

1 whether there were any additional jurors on this draw that
2 owe money to the hospital that were excluded from the
3 prior draw?

4 MR. ALEXANDER: We've read into the record --

5 THE COURT: Well, I mean, just from my notes,
6 Mr. Bishop and Lindsey Rogers, #14 and #106 respectively,
7 both had balances of \$1,700 and \$1,800. And they were not
8 stricken, but Mr. Alexander is free to --

9 MR. ALEXANDER: As I stated earlier, it wasn't
10 everyone that had a balance. My concern was over a juror
11 that had a balance of almost \$14,000. Mr. Bishop is an
12 African American. I did not strike him. The amount of
13 his balance is \$1,700. Tabitha Belcher, also, owes money,
14 an African American. And she was not struck because it's
15 \$560.

16 MR. GRAHAM: I dare say, Your Honor, she was
17 probably, also, not struck because his striking her in the
18 last go round was deemed to be Constitutionally
19 impermissible.

20 THE COURT: My notes, also, indicate that Ms. Forrest
21 had a balance; is that right?

22 MR. ALEXANDER: \$134.

23 THE COURT: Okay. Anything further?

24 Mr. GRAHAM: No, Your Honor, just the same arguments
25 as before.

1 We believe it's pretextual to strike an African
2 American for having an outstanding balance if you're not
3 going to strike Caucasians that have a balance.

4 THE COURT: All right. Well, thank you, Mr. Graham.

5 I find that as to the Juror #142, the reason given
6 was not pretextual. It was non-discriminatory. It was
7 race neutral.

8 The gentleman during the qualification process, which
9 is not part of the record as far as being transcribed, but
10 my observation of him was he drew a complete blank as to
11 what he, actually, did every day for a living that was
12 prolonged and drawn out and, certainly, remarkable. So I
13 find that is a race-neutral reason.

14 And as to the striking of Ms. Acker, Juror #1, I find
15 that those reasons are, also, race neutral. There was a
16 distinction made clearly by Mr. Alexander between large
17 and small balances owed to the hospital. And they were
18 not similarly situated jurors of different races treated
19 differently by Mr. Alexander in that respect.

20 So I find the Plaintiff has not met their burden as
21 to showing purposeful discrimination.

22 I will say Mr. Wright's failure to recall his
23 employer's name, it wasn't necessarily what he did for a
24 living. I may have misspoke in that regard. But it was
25 remarkable. I don't think I've ever seen that. I've been

1 doing this almost 10 years.

2 Okay. Anything else before we bring the jury out?

3 MR. GRAHAM: No, Your Honor.

4 THE COURT: All right.

5 (WHEREUPON, the jury came into open court at
6 approximately 2:48 p.m.)

7 INTRODUCTORY REMARKS

8 THE COURT: Ladies and gentlemen, good afternoon.

9 We're going to start the trial now of Demetria
10 Orange, as Next Friend of J.B. v. The
11 Greenville Hospital System and Greenville Hospital System
12 Partners in Health.

13 And the first thing I want to do is thank you again
14 for your service this week. I know we're taking you away
15 from your jobs, and your families, and your other
16 important responsibilities and aspects of your life, and
17 asking you to come up here and spend time deciding issues
18 between your fellow citizens. But you are making it
19 possible for these parties to have their right to a jury
20 trial, which is guaranteed not only in our state and
21 federal Constitutions, but in three of the first Ten
22 Amendments, or the Bill of Rights, as a reality. So
23 you're making it possible for them to exercise that right.
24 And you've been called upon to resolve the dispute that
25 they have. So I know they're grateful to you.

1 THE CLERK: Thank you.
 2 Please be seated.
 3 DIRECT EXAMINATION
 4 BY MS. RODRIGUEZ:
 5 Q Demetria, can I get you to start out by introducing
 6 yourself to the jury? Tell them who you are.
 7 A Demetria Orange.
 8 Q And what's your date of birth, Demetria.
 9 A October 22nd, 1967.
 10 Q Can you tell the jury where you were born?
 11 A Newark, New Jersey.
 12 Q Were you raised in New Jersey?
 13 A For a few years, and then I moved here.
 14 Q Well, how is it that you came all the way to South
 15 Carolina? Explain to the jury how that came about.
 16 A My father -- my parents moved us here for a better
 17 life, more family oriented, just to have a better life
 18 than living in the north.
 19 Q And is your father still alive?
 20 A He is.
 21 Q Tell the jury how old is your father, and give them a
 22 little bit of information about how he chose South
 23 Carolina.
 24 A He's 72 years old now. And my mother is, originally,
 25 from South Carolina, but he's from Fayetteville, North

1 Carolina. And after her death, he moved back to
2 Fayetteville.

3 Q Is your dad still working today?

4 A He is.

5 Q Now, your mother, you said was deceased?

6 A Yes.

7 Q Tell the jury a little bit about your mother's work
8 history and how you -- what your involvement was with your
9 mom.

10 A My mother was a private care sitter. She did private
11 sitting with patients until she had her leg amputated when
12 she was 50.

13 Q And what did you do after your mom needed help?

14 A I stayed home and took care of her.

15 Q Now, did you attend schools here in South Carolina?

16 A I did, yes.

17 Q And tell the jury a little bit about where you went
18 to school.

19 A I went to Grove Elementary, Tanglewood Middle School.
20 And I graduated in 1985 from Southside High School.

21 Q Now, while you were in high school, did you take any
22 other types of courses?

23 A Yes, cosmetology.

24 Q Now, do you, also, have some other family here in
25 South Carolina?

1 A Yes, I do. I have cousins, aunts, uncles. My
2 grandfather is deceased now. And I have a sister and a
3 brother.

4 Q Okay. Just so that we can sort of understand the
5 relationship, explain to the jury the family relationship
6 between you and J.B.'s mother, Alana.

7 A She is my maternal cousin. Her grandmother and my
8 mother were sisters.

9 Q So did you know Alana growing up?

10 A Her whole life, yes.

11 Q Tell the jury a little bit about your relationship
12 with Alana when she was a child.

13 A She was my baby at first. She was -- I must have
14 been about 16 or 17 when she was born. So a new baby in
15 the family. And she was kind of like everybody's baby.
16 My aunt raised her, but we all helped and kind of chipped
17 in and raised her.

18 Q Now, tell the jury a little bit about your aunt and
19 how she felt children should be raised.

20 A Very strict. She raised her as a Jehovah's Witness.
21 But she is not -- Alana is not a baptized witness or
22 recognized as a Jehovah's Witness.

23 Q Now, when you said your aunt raised her, is that
24 Alana's mother who raised her?

25 A No. It's her -- another sister of her grandmother.

1 Q So it would have, actually, been Alana's aunt as
2 well?

3 A Yes.

4 Q Now, during the period of time your aunt was raising
5 her, did she give Alana a lot of freedom?

6 A No, not at all.

7 Q Well, tell the jury what happened when Alana became a
8 teenager, around 15, 16 years old.

9 A When she got around 16, she didn't want to listen.
10 She became unbearable to live with. So she went back to
11 live with her biological mother, who was more of a free
12 spirit. And she could kind of work around and do what she
13 wanted to with her.

14 Q Now, in that same time frame, did Alana, also, get
15 diagnosed with a medical condition?

16 A Yes, with diabetes.

17 Q Now, at some point, did she, also, get diagnosed with
18 a mental health problem?

19 A Yes.

20 Q Now, in terms of her diabetes, did Alana -- Alana, of
21 course, is still a diabetic today?

22 A She is.

23 Q And Alana took care of her own blood sugar, and
24 things like that?

25 A Yes.

1 Q Now, before her pregnancy with J.B., did she have
2 another child?

3 A She did. She had Brittany.

4 Q Okay. And tell the jury a little bit about Brittany
5 and Brittany's growing up, and your involvement there.

6 A Well, when J.B. was being born, Brittany came over
7 for a one-day visit and stayed three years. I had her for
8 three years, basically, while her mom was taking care of
9 J.B.

10 Q Now, during this period of time, had Alana become
11 involved with a gentleman -- a man?

12 A Yes.

13 Q And tell the jury a little bit about Alana's history
14 with men.

15 A She always chose older men, a lot older, dominant
16 men, and just made some real bad choices in choosing men.

17 Q Now, when she became pregnant with J.B., she was
18 diabetic during that pregnancy?

19 A Yes.

20 Q And she, also, had her mental health issues?

21 A Yes.

22 Q Now, at periods of time over the years when the
23 mental health would flare up, tell the jury what would
24 happen.

25 A I would have both girls. I would have J.B. and

1 Brittany because she would be hospitalized --
2 institutionalized or hospitalized for weeks, sometimes
3 months at a time. So I would have both girls.
4 Q Now, you had a chance, of course, during the periods
5 of time when Alana was doing okay to observe her with the
6 girls?
7 A Yes.
8 Q Tell the jury a little bit about what you saw in
9 terms of how she dealt with kids.
10 A She was always loving with **J.B.** especially when
11 she was, you know, an arm baby. She was loving and
12 nurturing with her. But the older she got, it shifted.
13 Q Now, when you say "it shifted," let's talk a little
14 bit about was -- **J.B.** had some medical problems as a
15 result of her injuries to her arm?
16 A Yes.
17 Q And tell the jury a little bit about that. I know
18 you were involved with taking -- or going with Alana to
19 some of the appointments. Kind of tell them a little bit
20 about what happened in terms of Alana's involvement in
21 **J.B.**'s medical care.
22 A Well, she had a couple surgeries. And with one, she
23 had to wear like a body cast, you know, for several
24 months, I think, she had to have the body cast on. And we
25 went to Atlanta for that surgery. But she was -- I think

1 it was overwhelming for her after a while just dealing
2 with a special-needs child.

3 Q Well, let's introduce the jury a little bit to **J.B.**
4 at this point.

5 MS. RODRIGUEZ: Can you pull up her two-year picture,
6 please?

7 BY MS. RODRIGUEZ:

8 Q We're going to go through some pictures here. And I
9 want you to tell the jury, now, who's that young lady?

10 A That's **J.B.** on her second birthday.

11 Q And tell the jury what her problem is from a physical
12 standpoint. Describe it to them, because it's kind of
13 hard to tell from that photo, although I think it will be
14 apparent from some more photos as we see them.

15 A Well, she had a right arm that didn't work, you know.
16 It was pretty -- I think it was still pretty limp at that
17 point. She couldn't bend it, or anything.

18 Q And tell the jury, now, when she was little like this
19 and, you know, she would try to get around, how did that
20 impact her?

21 A She was always carried. Alana would carry her. And,
22 finally, my great-aunt, finally, said, Put her down.

23 She'll never walk as long as you're holding her. And,
24 immediately, she started doing this -- she would never
25 crawl like the traditional crawl, but she just started to

1 scoot. And one day she got up and started walking, so.

2 Q Now, when she does walk, how are her balance issues

3 with that one arm that doesn't work?

4 A Sometimes, she's off balance. She falls down -- up

5 the steps a lot, instead of down the steps. I haven't

6 figured that one out yet, but she's a little off balance.

7 MS. RODRIGUEZ: Okay. I'm going to ask right here,

8 our assistant here, can you pull up the Shriners video,

9 the first one, the earliest one?

10 BY MS. RODRIGUEZ:

11 Q Now, around 2007, 05/16/2007, **J.B.** was seen at the

12 Shriners Children Hospital. Tell the jury a little bit

13 about -- tell the jury what's going on here.

14 A The doctors are asking her to do different things

15 with her arm. And she -- you can tell she kind of uses

16 that left arm to assist it, to make it do what she wants

17 it to do. It doesn't just do it on its own.

18 Q Now, I see she's having some difficulty there, it

19 looks like, putting that right arm behind her head?

20 A Yes.

21 Q Has that resolved?

22 A No. She still can't put her hand behind her head.

23 Q And she's, also, got a real cute bow on her head, who

24 did that?

25 A That's my signature hairdo, quick and easy.

1 Q She looks really thrilled here. We're going to --
2 you can tell the jury what you want about her as we're
3 going along here. It only runs for about a minute.

4 A She's just -- she -- as you can see, she just does
5 things in her own way. She doesn't necessarily do it like
6 it's supposed to be done, but she figures it out.

7 Q Now, which side is it here that -- oh, I think you
8 can see. Describe to the jury which is the side she's
9 having problems with there.

10 A Her right side.

11 Q Okay. She's trying there to put her right hand
12 behind her head?

13 A She cannot.

14 Q Okay. Now, we have another video here from 2009.
15 This one is really short. About how often was **J.B.**
16 going to Shriners?

17 A About every two years.

18 Q And she, also, had some of her surgery done there?

19 A Yes, her last one was there.

20 Q A little bit older here?

21 A Yes.

22 Q So this is 2009, she would have been how old?

23 A Close to five.

24 Q Close to five. Now, she really looks happy on this
25 day.

1 A Still not much difference.

2 Q Well, while she's doing the exercises here, tell the
3 jury about some of the things she has difficulty doing, as
4 well as some of the things she can do.

5 A She has difficulty like putting on jewelry, even
6 tying her shoes. She does it a little different than we
7 would tie our shoes. Getting on the school bus, you know,
8 it's for right-handed. So she pulls up with her left hand
9 to get on the school bus. Just everyday basic things that
10 we probably take for granted, she struggles with.

11 Q Now, I know she doesn't look very happy in this
12 video. But tell the jury, basically, how her demeanor is.
13 She's really a pretty happy kid, isn't she?

14 A Oh, yes, she definitely is. She's very witty.

15 Q Okay. Now, the jury heard a little bit in the
16 opening by Mr. Graham about the situation with DSS. And
17 we don't need to go into detail. But, at some point, DSS
18 did become involved in the children's lives?

19 A Yes.

20 Q And we've talked about **J.B.**. Does **J.B.** have
21 sibling?

22 A She does. Brittany is her older sister.

23 Q How much of an age difference is there between them?

24 A Brittany is 10 and a half, and Beans will be nine
25 next month.

1 Q Beans? Who's Beans?

2 A **J.B.** I'm sorry.

3 Q Tell the jury about that nickname.

4 A She always keeps wind in her jaw and just looks like
5 it's full of beans. So she's always been Beans to me, but

6 **J.B.**

7 Q You don't have to say you're sorry. You can call her
8 Beans, they'll understand.

9 Now, after DSS got involved, at some point -- and my
10 understanding from information is DSS, actually, has been
11 involved in their lives a couple of times?

12 A Yes.

13 Q The final time, tell jury a little bit -- the
14 children were taken away?

15 A Yes. DSS called me and asked if my husband and I
16 would consider taking permanent custody of the girls, that
17 they had been removed out of their mother's custody.

18 Q And --

19 A Mother and stepfather.

20 Q And Mr. Graham, again, mentioned this, but tell the
21 jury again how long y'all had been married.

22 A It was a couple weeks after our wedding.

23 Q And Sam is a pretty special guy, isn't he?

24 A Yes.

25 Q Now, he's not here today, but how does he get paid?

1 Tell the jury a little bit about why he can't be here the
2 whole time.

3 A Yes. Because if he's not at work -- he works for
4 BMW. And if he's not there, he doesn't get paid. And
5 he's our sole provider.

6 Q So the jury will be meeting Sam later during the
7 week; correct?

8 A Yes.

9 Q He is going to come and we're going to, actually,
10 have him testify a little bit. So how was Sam's reaction
11 to hear a request that he take in two kids?

12 A I think shocked is an understatement.

13 Q So once the kids got to be part of your marriage, how
14 did that change things?

15 A Well, needless to say, the girls were very -- their
16 lives had been altered. And they needed me to be a
17 consistency. Sam had to go to work. So I stayed home
18 with the girls. I take -- you know, send them to school
19 in the morning. I'm there when they get home, you know,
20 to give them that consistency. They just need needed it.
21 They just needed to be sure that somebody was going to be
22 there, and things wouldn't change again. They had been
23 through so much in such a short length of time that Sam
24 and I decided that I would stay home with the girls and
25 just give them that stability.

1 Q Now, when you and Sam first got married, did you
2 intend to stay home?
3 A Not at all.
4 Q Were you working at the time?
5 A Yes.
6 Q And in terms of the involvement Sam has had with the
7 girls, what's happened with his relationship with these
8 girls?
9 A They're spoiled rotten. He is -- they're just rotten
10 by him, not me.
11 Q Now, prior to the girls entering your lives, did you
12 have any of your own biological children?
13 A I did not.
14 Q And how about Sam, what's his prior --
15 A Sam has a 13-year-old and a 19-year-old.
16 Q Now, those are from a prior relationship?
17 A Yes.
18 Q Has Sam remained involved in those children's lives?
19 A Yes, definitely.
20 Q And have those kids, also, gotten involved with your
21 two girls now?
22 A Oh, yes.
23 Q Now, we're going to show some pictures here. And
24 what I'm going to do is I'm going to step over here and
25 I'm going to have you talk through. Let's start out with

1 daddy time. And I'm going to let you tell the jury a
2 little bit about the pictures so they kind of get a feel
3 of what life is like with the Oranges.

4 A That's what I mean by rotten. That's her having her
5 daddy time.

6 Q Now, let's go on to the Christmas picture. The first
7 year you had the girls, tell them a little bit about
8 Christmas with the girls.

9 A They were super, super excited. They had told us
10 prior to that they would wake up on Christmas morning and
11 not have gifts. So we kind of went a little overboard.
12 But they were super excited on Christmas morning. You can
13 tell by the missing teeth and that grin how happy she was.

14 Q Now, have the girls continued to have a relationship
15 with their biological mother, Alana?

16 A No, not at all.

17 Q Do they occasionally bring their mother up to you?

18 A It's not a topic that we discuss a lot in our home.
19 But if they -- the girls are both in therapy. And if they
20 have a question, they deal with it with their therapist.
21 And even if they do ask my husband and I something, we
22 deal with it and then we turn the page. We don't harbor
23 on it.

24 Q Now, do you and the children, also, attend a church?

25 A Yes.

1 Q And how have they been integrated into that?

2 A They enjoy it. They have not joined like the choir
3 or anything. I think they're just getting that safety
4 feeling first before they -- they enjoy it.

5 Q Now, there are some other activities, I think,
6 they've gotten involved with. Let's show the school
7 picture here. Let's start with this. Tell the jury what
8 that is.

9 A That is her first day at her new school when they
10 first came to live with us.

11 Q Okay. Let's go to the -- does she -- over the period
12 of time that they've kind of integrated into your and
13 Sam's marriage, have there been some issues like
14 nightmares, and things like that?

15 A Yes, definitely. Especially, at first, bed wetting
16 and the nightmares. And then they'd wake up and realize
17 their surroundings aren't the same and that they're okay.

18 Q Tell the jury what that is.

19 A That is Beans heading out to a play date. She's
20 going to the Peace Center to see Rapunzel with Lauren.

21 Q Now, I notice if you look at her and the young lady
22 next to her, her little friend there, although they hold
23 their arms -- both of them kind of have their arms relaxed
24 at their side. There is a little bit of a difference the
25 way that Beans is holding hers. Is that pretty much how

1 she always holds that arm?

2 A Yes, it is. The biggest difference is that Lauren
3 can straighten hers out, and Beans's arm stays in that
4 slant all the time.

5 Q Tell the jury about the family vacations here.

6 A That's just a photo op, a family photo op. That's,
7 actually, after Brittany's birthday party.

8 Q What did you do here with her?

9 A That's after a trip to Build A Bear. And, of course,
10 she had to take it to school the next day and show it for
11 show and tell.

12 Q Now, in terms of her involvement in school, how has
13 her arm had an impact on that? Can you talk to the jury a
14 little bit about that?

15 A The older she gets, the more noticeable it is. And
16 then, of course, the other kids notice it, so they're
17 asking her questions now. When she first came, it really
18 wasn't an issue. And, now, she comes home and she goes,
19 Mom, you know, somebody's always asking me if it's broken.
20 She said, My teachers -- you know, she tells her teachers
21 that it was a birth injury, but she doesn't want to tell
22 the kids that. So she just shies away from that.

23 Q And what do y'all tell her when she's trying to do
24 things and she has -- she struggles with it because of
25 that arm? What do y'all tell her?

1 A That she has to try it once first before she can ask
2 anybody for any help, so.

3 Q Now, are there things in terms of taking care of
4 herself, like, you know, can she brush her teeth?

5 A She can brush her teeth. She does it her own way,
6 but she can brush her teeth, and stuff like that. She
7 can't comb her own hair or -- like she has a 10-year-old
8 sister that can do all of that stuff, and put her earrings
9 in. She can get one in, but not the other.

10 Q How about when she has to go to the bathroom?

11 A We're having issues with that. She's getting older,
12 so she's getting bigger. So we're having some issues with
13 that, with her being able to clean herself good.

14 Q And little other things like can she put on her own
15 boots and zip them up?

16 A She cannot. She can get one up, but not the other.

17 Q How about belts?

18 A She has a horrible time with belts.

19 Q Is that her with her friends again?

20 A Yes. That's at a presentation at her school.

21 Q Now, I understand y'all, also, have -- and I probably
22 shouldn't be showing this because it was a bad weekend for
23 football, but we're going to go ahead and take a chance
24 here. Tell them about your family situation with
25 football.

1 A Beans has decided to side with her daddy and be a San
2 Francisco 49er's fan. Brittany is a Steelers fan like her
3 mommy. But Beans is -- I'm working on it.

4 Q Okay. And how does she -- you know, you talked a
5 little bit about school. Let's show her math scores.
6 Tell the jury a little bit about what she does like in
7 school.

8 A She's very smart. And she's just -- nothing stops
9 her. She's a go-getter when it comes to her school work.
10 And you can see, she went past her goal.

11 Q Okay. And some of the sports that y'all have gotten
12 her involved in, tell the jury a little bit about that.
13 Let's hit the swimming picture first. Oh, we hit soccer.
14 Oh, there's swimming.

15 A Yes. She took swimming lessons this past summer.
16 She did good, but she doesn't swim like her peers do.
17 She does kind of like the dog paddle type thing.

18 Q Can she get that arm up to, actually, do the strokes?

19 A No, she cannot.

20 Q This is the soccer picture?

21 A That's her soccer picture. I tease her all the time.
22 She spent more time running across the field to get cold
23 water than she did playing soccer, but she tried real
24 hard.

25 Q Now, since she came to live with y'all, she's learned

1 to ride a bike?

2 A Yes, she did. That's one of her favorite things to

3 do.

4 Q And this is one of the photos that just cracks me up.

5 Tell the jury a little bit about this.

6 A This is Beans crying. I guess she was crying for her

7 sister because she hadn't gotten her shot yet. But she

8 was crying prior to getting the shot.

9 Q She was anticipating?

10 A I guess so.

11 Q And that's kind of interesting. She's been through a

12 lot from a medical standpoint?

13 A She has.

14 Q How does she react? Tell the jury a little about

15 that.

16 A She's a handful when it comes to anything that has --

17 now, this is just her regular pediatrician. But she wants

18 no part of anything that has to do with needles, or

19 anything like that.

20 Q Well, and that sort of -- even though we're jumping

21 ahead a little bit, but let's address right now the issue

22 of -- I know there's been a conversation with y'all about

23 her medical care providers, about the possibility of some

24 additional surgery to help the deformity in her arm?

25 A Yes.

1 Q Tell the jury about that issue, and what your
2 thoughts are, and what you and Sam are discussing.

3 A Well, we want her to be a little older so she can be
4 a part of the decision making. I think our biggest
5 mistake was the doctor said, Saw the bone in half. And
6 she was done with it at that point. You know the word
7 "saw" just -- so every time we talk about it, she's not --
8 but I think the older she gets and she knows it will help
9 correct the deformity of the arm, she'll be more willing.

10 Q So you are going to have her evaluated or consider
11 that at some point. But, right now, that's not on your
12 agenda?

13 A It is. We're going to go on December the 2nd to talk
14 to one of the doctors at the Shriners Club.

15 Q Let's go -- actually, let me ask one other thing at
16 this point. Tell me a little bit about what your concerns
17 are for J.B. related to how she's coping with these
18 issues with her arm.

19 A I worry about everything about her. She's my child.
20 So, you know, I worry about her driving, dating, defending
21 herself even, you know, with bullies being so popular now
22 in school. I worry about her -- you know, will she ever
23 live on her own. It's just everything.

24 Q Can you remember -- tell me what you told me about
25 cooking.

1 A Yes. I was saying that when I'm cooking, I'm using
2 both hands. I'm holding pots and pulling stuff. And she
3 talks -- the other day, she said she was thinking about
4 being a chef. Of course, every other day she wants to be
5 something different.

6 But it crossed my mind, will she ever be able to --
7 you know, that arm doesn't have strength in it like the
8 other arm. So will she be able to pick up a pot? Or will
9 she ever be able to cook a meal if she ever has her own
10 family.

11 Q Now, I think you've already addressed this, but do
12 you think **J.B.** is a happy child now?

13 A She is.

14 MS. RODRIGUEZ: Answer any questions the Defense has.

15 THE WITNESS: Thank you.

16 CROSS-EXAMINATION

17 BY MR. ALEXANDER:

18 Q Mrs. Orange, what date did you obtain custody of the
19 girls?

20 A February the 7th, 2012.

21 Q Okay. And, at that point, **J.B.** had already had two
22 surgeries?

23 A She had.

24 Q And those surgeries were done when she was in the
25 custody of her mom?

1 A Yes.

2 Q And her mom had the financial responsibility for her

3 at that time?

4 A As far as I know, yes.

5 Q Okay. And she has not had any additional surgeries

6 done since she's been in your custody?

7 A No.

8 Q All right. But we heard talk of a possible surgery

9 in the future; right?

10 A Yes.

11 Q But, at this point, at nine years of age, she's not

12 elected to have that future surgery?

13 A No, not yet.

14 Q Okay. And, as I understand it, when that surgery was

15 discussed, Alana said, no, that she was not going to do

16 that. Is that your understanding?

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

18 Q And J.B. said no; right, because she was scared?

19 A Yes. J.B. says no to a flu shot, so.

20 Q And you said maybe?

21 A I definitely -- it's definitely open.

22 Q Okay. And with respect to the services that J.B.

23 is receiving, is she going to physical therapy now?

24 A No, she isn't.

25 Q Is she going to occupational therapy?

- 1 A No.
- 2 Q Is she going to any kind of fitness therapy?
- 3 A No.
- 4 Q Has she availed herself for any services offered by
- 5 her school?
- 6 A No, she doesn't.
- 7 Q Okay. And the surgery that you contemplate for the
- 8 future, that's a surgery to be performed at Shriners
- 9 Hospital?
- 10 A Yes.
- 11 Q Okay. You mentioned that **J.B.** is now -- where is
- 12 she attending school?
- 13 A Augusta Circle.
- 14 Q And you showed -- was that a report card or --
- 15 A That was her math scores.
- 16 Q And what is that?
- 17 A It's like a standardized test they take that kind of
- 18 sets the child where they are.
- 19 Q So on standardized tests, she's done very well;
- 20 right?
- 21 A Yes.
- 22 Q And tell us about grades. How does she do in terms
- 23 of grades?
- 24 A She's a great student.
- 25 Q All A's and B's?

- 1 A Most of the time, yes.
- 2 Q She works hard in school?
- 3 A She does.
- 4 Q And you all impress upon her the importance of
- 5 education?
- 6 A Definitely, yes.
- 7 Q And you're not letting her off the hook on her
- 8 grades, are you?
- 9 A No.
- 10 Q And you're going to encourage her to go to college?
- 11 A Yes.
- 12 Q And we saw the pictures of a beautiful girl, and it
- 13 appears that she is happy?
- 14 A She is.
- 15 Q Witty?
- 16 A She is.
- 17 Q You told me she was sassy?
- 18 A Sometimes.
- 19 Q Is she popular?
- 20 A She is.
- 21 Q Well adjusted?
- 22 A Most of the time.
- 23 Q She plays soccer?
- 24 A Yes.
- 25 Q She plays basketball?

1 A She attempts to play basketball. She bounces the
2 ball.

3 Q She rides her bike?

4 A She does.

5 Q And you mentioned to me when I had a chance to take
6 your deposition that she wanted to do karate?

7 A Yes.

8 Q And you said, I don't think so?

9 A That's what I said.

10 Q And you said, I think she already knows how to defend
11 herself plenty well?

12 A Well, I don't remember saying that, but okay.

13 MR. ALEXANDER: Thank you, ma'am.

14 MS. RODRIGUEZ: That's all I have, Your Honor.

15 THE COURT: Thank you.

16 You may step down.

17 MS. RODRIGUEZ: May we approach?

18 THE COURT: Sure.

19 (WHEREUPON, a bench conference was held.)

20 MS. RODRIGUEZ: Your Honor, we have a video
21 deposition that we'd like to play of Dr. Grossman, who is
22 the orthopedist.

23 THE COURT: All right. Ladies and gentlemen, a
24 deposition is simply a record of questions that were asked
25 of a witness, under oath, before trial and answers to

1 those questions where the lawyers did it ahead of time.
2 And it was taken down, obviously, by video and by
3 transcript.

4 And, often times, witnesses cannot be in court live.
5 But the deposition testimony that is sworn is entitled to
6 the same consideration by you as a live witness's
7 testimony is.

8 You, also, are the sole judge of the witness's
9 credibility.

10 All right. Yes, ma'am.

11 MS. RODRIGUEZ: Thank you, Your Honor.

12 And I apologize, I misspoke. I said he was an
13 orthopedist. He's, actually, a plastic surgeon who deals
14 with these types of injuries.

15 THE COURT: Okay.

16 (WHEREUPON, a portion of Court's Exhibit No. 2 was
17 played in open court.)

18 THE COURT: Okay. Let's break right here.

19 Ladies and gentlemen, just be back in the morning at
20 9:00 to the jury room.

21 Don't talk about the case. Continue to keep an open
22 mind. Don't do any kind of outside research. In the age
23 of the Internet, we get curious and want to explore, but
24 it would not be in keeping with your oath to consider
25 anything outside of the record in this case. So don't try

1 to do any outside investigation.

2 Have a good evening.

3 Thank you very much.

4 (WHEREUPON, the jury was excused from open court at
5 approximately 5:27 p.m.)

6 THE COURT: Anything before we break for the night?

7 MR. ALEXANDER: No, Your Honor.

8 MR. GRAHAM: No -- well, just my crystal ball is
9 changing about how long this trial might last. I thought
10 we were going to get three witnesses done today.

11 THE COURT: Well, I thought your opening statement
12 was only going to be 30 minutes.

13 MR. GRAHAM: Sorry, Your Honor.

14 Thank you for your indulgence on that.

15 THE COURT: Well, we're going to push on. Y'all are
16 going to have to be efficient.

17 Thank you.

18 (WHEREUPON, Court's Exhibit No. 2 was marked for
19 identification and admitted into evidence.)

20 (WHEREUPON, the proceedings were concluded at
21 approximately 5:28 p.m., to be reconvened on
22 Tuesday, October 29, 2013.)
23
24
25

1 TUESDAY, OCTOBER 29, 2013

2 (WHEREUPON, Plaintiff's Exhibit No. 1 was marked for
3 identification only.)

4 THE COURT: Anything before we bring the jury in.

5 MR. ALEXANDER: No, sir.

6 MS. RODRIGUEZ: No, sir, Your Honor.

7 THE COURT: Bring them in.

8 (WHEREUPON, the jury came into open court at
9 approximately 9:17 a.m.)

10 THE COURT: Good morning, ladies and gentlemen.

11 We're getting a little bit of a late start, and
12 that's my fault.

13 Someone asked through the bailiff if you could take
14 notes. I, certainly, encourage you to take notes. I just
15 want to caution you, though, that notes, as we all
16 remember from school, that they can be wrong. They can be
17 incomplete. They can be misleading. And you're,
18 certainly, free to take them if you want to, but they're
19 for your own personal use. They'll be destroyed after the
20 trial. And they're not to be used in precedence over
21 someone else's memory.

22 Also, remember I told you that you are the judge of
23 the credibility of the witnesses. So it's important for
24 you to pay attention to the witnesses while they're on the
25 stand. So don't become so engrossed in taking notes that

1 you don't do that.

2 So, with that, we'll resume playing of the video.

3 (WHEREUPON, the remaining portion of Court's Exhibit
4 No. 2 was played in open court.)

5 MR. GRAHAM: Are you ready for our next witness?

6 THE COURT: Yes, sir.

7 MR. GRAHAM: If Your Honor please, our next witness
8 is Michelle Murray.

9 THE COURT: All right.

10 MR. GRAHAM: Let me step out.

11 MS. RODRIGUEZ: The Plaintiff calls Michelle Murray.

12 THE CLERK: Place your left hand on the Bible and
13 raise your right hand.

14 WHEREUPON,

15 MICHELLE LINDA MURRAY,

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

17 THE CLERK: State your name, please.

18 THE WITNESS: Michelle Linda Murray.

19 THE CLERK: Thank you.

20 Please be seated.

21 DIRECT EXAMINATION

22 BY MS. RODRIGUEZ:

23 Q Ms. Murray, could you, please, introduce yourself to
24 the jury?

25 A My name is Michelle Linda Murray. I'm a registered

1 nurse. I became a nurse in 1975.

2 Q And, if you could, just go through your educational
3 background for the jury.

4 A I graduated from UCLA in 1975. I received a Master's
5 of Science in Nursing in 1981. And I received a PhD in
6 Education in 1992.

7 Q If you have a PhD, do you go by the title "doctor"?

8 A My students -- I teach at a community college. And
9 my nursing students call me "doctor" when I'm on the unit.

10 Q In an area like this, do I call you "doctor" or do I
11 call you Nurse Murray?

12 A I think to make it clear I'm a nurse. We'll just say
13 Nurse Murray.

14 Q Now, you are a registered nurse; correct?

15 A Yes.

16 Q Do you, also, hold some national certifications?

17 A Yes. I sat for a four-hour examination on what's
18 called inpatient obstetrics. So my certification is in
19 obstetric nursing.

20 Q And have you worked in the labor and delivery area?

21 A Yes, I have.

22 Q If you could, just give the jury the benefit of what
23 your experience in labor and delivery has been.

24 A As a nursing student, I was what's called a tech,
25 where I washed the instruments after the birth. And I

1 helped the nurses. And that was back in 1974.

2 And then I became an actual bedside labor and
3 delivery nurse in the U.S. Air Force Nurse Corp. in 1977,
4 approximately January of 1977. So it was decades ago.

5 Q And then what have you done since then? Sort of
6 bring them up to date on what you're currently doing and
7 what your background has been.

8 A So I've worked as a baby and delivery nurse and
9 mother/baby like postpartum after delivery and with the
10 newborn babies in the Air Force. And I served my two-year
11 commission.

12 Then I became a civilian and moved to Colorado where
13 I worked full-time as a labor and delivery nurse for about
14 nine months. And then I got married during that time and
15 moved to Albuquerque, New Mexico, where I worked in a
16 newborn nursery. But then I, also, moved to what's called
17 a birthing unit. And I worked in labor and delivery.

18 At the same time, I got my Master's back in 1981. So
19 I taught nursing and I taught obstetric nursing at the
20 University of Albuquerque. And I, also, worked part-time
21 as a labor and delivery nurse. Up until January of 2005,
22 I was a nurse part-time in labor and delivery. And, now,
23 I'm teaching nursing. And I've taught with my students at
24 the bedside since August of 2011.

25 And between January of 2005 and August of 2011, I

1 wasn't at the bedside because I became allergic to latex
2 where it affected my breathing and the doctor said I can't
3 work in the hospital anymore. But I found a hospital that
4 didn't have latex. It was called latex safe. And that's
5 where I teach.

6 Q And, in addition, have you, also, had an opportunity
7 to publish?

8 A Yes. I brought some of my books here.

9 Q Can you show the jury what you brought with you?

10 A This is one of my books on -- it's called Essentials
11 of Fetal Monitoring. It's a workbook and a textbook to
12 teach some of the basic and intermediate concepts in terms
13 of a baby's heart rate analysis and contraction analysis.

14 Q And, Nurse Murray, if you would, just explain to the
15 jury, on textbooks, they're published at various times;
16 correct?

17 A Right. This is not the first edition. This is the
18 2000 edition. And there's been four editions of this
19 book.

20 Q But why did we have you bring the 2000 edition?

21 A Because what happened in this case happened in 2004.
22 So this book applied to that time frame.

23 Q Okay. And, if you could, just show them what else
24 you brought with you.

25 A I wrote this book with a coauthor on labor and

1 delivery nursing. And this is a 2009 book. But it shows
2 even though I wasn't at the bedside, I was writing this
3 book on labor and delivery nursing.

4 Oh, and I was teaching. I taught here in South
5 Carolina. I was teaching all over the country. Even
6 though I wasn't at the bedside, I was teaching labor and
7 delivery nursing all over the country providing continuing
8 education to registered nurses who work in labor and
9 delivery. So I didn't stop working. I just was teaching
10 because I couldn't be around the latex.

11 Q And, in fact, you've taught courses here in South
12 Carolina?

13 A Three times in South Carolina.

14 Q Now, do you get paid for your work in terms of doing
15 medical legal consultations?

16 A Yes, I do.

17 Q And, if you could, just tell the jury, how much are
18 you paid per hour?

19 A When I'm in trial, it's \$73 an hour. But it's
20 calculated based on when I left Albuquerque until I get
21 home. And when I review cases, it's \$375 an hour.

22 Q And I apologize. I got ahead of myself. Can you
23 just tell the jury your experience in reviewing articles
24 for journals?

25 A Right now, we have a professional organization. It's

1 pronounced A-1, which is the Association of Women's Health
2 Obstetric and Neonatal Nurses. And I've been reviewing
3 articles to decide if they should be published since 2008.

4 So I'm what they call a reviewer. And that's what we
5 call peer reviewed. So I'm one of the peer reviewers.
6 And I decide if I think the article is ready for
7 publication, or should be revised, or rejected.

8 Q Could you, also, explain to the jury a little bit
9 about what evidence-based nursing or evidence-based
10 medicine is and, I believe, reference your textbook while
11 you're doing that?

12 A We call this book, Labor and Delivery Nursing, a
13 Guide to Evidence-Based Practice. And what evidence is,
14 basically, research findings that are credible. In other
15 words, because I have the PhD, I can filter different
16 things I read and say that is credible, and this is just
17 someone's opinion, but it lacks a scientific basis. So
18 evidence is science, essentially, good science.

19 Q And explain to the jury what the movement has been
20 over the years to get to evidence-based nursing or
21 evidence-based medicine?

22 A Well, our professional organization has published,
23 for example, outlines that labor and delivery nurses
24 should know certain topics. And they have a paragraph in
25 that, basically, saying what we do should be based on

1 science and evidence, not just habits or routines.

2 Q Now, when a case is -- you're consulted for a medical
3 legal review such as this and a case is sent to you, can
4 you just explain to the jury the basis of how you process
5 that review, what you do?

6 A I do cases for both defense and plaintiff. I do both
7 sides. And I do the same process. I, first, want to see
8 the fetal monitor strip without knowing the facts. And I
9 start with the first page of the strip. I don't -- I --
10 it's kind of practice. I've been doing this for 26 years.
11 I start at the first page. I don't look at the back and
12 go, oh, that's what happened, because I don't want to bias
13 myself.

14 So I just take it one page at a time. And I write
15 notes about what I'm seeing, and what I'm thinking, and
16 what I think a reasonable prudent nurse would do if they
17 saw that, too. And then I get to the end. And then I sit
18 back and I think, well, did this baby have adequate oxygen
19 on the first page, and how is the baby at the end? And
20 why did the baby get to the end, if it's bad and something
21 happened in there.

22 And, sometimes, I call the lawyers. It doesn't
23 matter which side, I will call them. And I'll say, I
24 can't help you. Either the nurses did nothing wrong -- if
25 it's defense, I'll say, I'm going to speak for that nurse.

1 Send me into that courtroom. I'll support that nurse.
2 They did nothing wrong.

3 And I've had cases that plaintiff lawyers have given
4 me where they did nothing wrong and I tell them, and vice
5 versa. So I tell them the truth about what my opinion is
6 based on my review.

7 Q Now, in addition to reviewing the fetal monitoring
8 strips, do you, also, review the medical records?

9 A Yes. And I did in this case.

10 Q And do you review just the mother's medical records
11 or -- give the jury an idea of what you normally look at.

12 A So when I get a call, would you, please, review some
13 records, I ask for the fetal monitoring strip. I ask for
14 the mother's chart, prenatal records and the hospital
15 records. And I ask for the immediate baby's chart. In
16 other words, at the hospital delivery. And then,
17 sometimes, they'll send more. But that's the minimum of
18 what I want.

19 And after I've reviewed the monitor strips where I
20 see the baby's heart rate and the contractions, then I
21 will go to the mother's records to learn about her. And
22 then I'll go to the baby's records to learn about the
23 baby. And I'm looking for certain things.

24 Once I've reviewed the monitor strips, then I'm
25 looking for placental pathology, is the baby's head

1 squished, bruised, battered, whatever. I'm looking to see
2 if my notions from the tracing of the fetal heart rate and
3 the contractions fit. And then I make the call to the law
4 firm and tell them what I think.

5 Q Now, will you, also, just explain or differentiate
6 for the jury a little bit between what opinions you would
7 come to or what you would do as a nurse versus what a
8 physician would do? For instance, would you order a
9 Caesarian section?

10 A No. But as a bedside nurse, you have to be thinking
11 is this normal or not normal. And when you think, well,
12 this is normal and we're moving towards a vaginal birth,
13 I'm not going to bother them. But if there's something in
14 the baby's heart rate or the labor itself, the baby's not
15 coming in the pelvis, I think there's what is called a fit
16 problem, the baby is not fitting right. I'm going to call
17 them. And I'm going to call the right doctor, the one
18 that can do a C-section, if I think in my nursing mind
19 this baby is not coming out natural.

20 Q Explain to the jury a little bit about the concept of
21 chain of command from a nursing perspective.

22 A Some people call it a chain of communication where we
23 have to go up our leadership. So, as a staff nurse, I
24 would go to the charge nurse. I might ask the charge
25 nurse, could you call the attending doctor? But we're

1 going to go up this communication chain in terms of
2 leadership and levels in the nursing and the medical
3 chain, because there's two, to get the care for the
4 patient so they're safe and we prevent injury. That's our
5 duty as nurses, to prevent someone from getting hurt.

6 Q Well, as a labor and delivery room nurse, if you're
7 working in a facility that trains doctors, that is a
8 hospital that has a resident program, does the nurse need
9 to know the different levels of ability and practice of
10 the different level of residents?

11 A We have to know because certain levels can't do
12 C-sections. And we -- as a good nurse, we have to
13 anticipate. Because about a third of all patients these
14 days get C-sections.

15 So we have to anticipate what -- and even when I took
16 a report, I'd say where are they, what's their phone
17 number, how do I reach them and report. So if I need
18 someone right away, I can make that call.

19 So we have to know who can do what. Because we don't
20 want to call the wrong person, especially if there's an
21 emergency.

22 Q Well, are there standards of care for nursing in
23 terms of communication between nurses and the physicians?

24 A Yes, there are.

25 Q And what is your responsibility -- or what is the

1 responsibility of the nurse in that communication process?
2 A Well, right now, where I teach, for example, there
3 are residents. But you have to decide as a bedside nurse,
4 do I bypass the resident and go right to the attending,
5 depending on the situation. If it's not an emergency or
6 not something where you might need a C-section, I can just
7 ask the doctor who's a resident, whether that's an intern
8 or -- they have levels, first year, second year, third
9 year, fourth year.

10 So you have to think what are they capable of. And I
11 can, also, ask them if they want to call the attending or
12 should I. So they're there, the residents are around
13 24/7.

14 Q Nurse Murray, I forgot to hand you this. If I could
15 just hand you this document and have you identify what
16 this is for us.

17 A Well, this is what we call like my resumé or
18 curriculum vitae.

19 Q And is that current and up-to-date?

20 A Yes.

21 Q That outlines both your training and experience in
22 the fields?

23 A Yes.

24 MS. RODRIGUEZ: I'd like to mark this as a
25 Plaintiff's Exhibit.

1 (WHEREUPON, Plaintiff's Exhibit No. 2 was marked for
2 identification only.)

3 MS. RODRIGUES: At this point, we'd like to proffer
4 Nurse Murray as an expert in nursing, and labor and
5 delivery, and fetal monitoring strips.

6 THE COURT: Voir dire?

7 MR. ALEXANDER: No, sir.

8 I have no objection to her testifying on the nursing
9 standard of care. I would, obviously, object to any
10 testimony regarding physician standards.

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

12 Ladies and gentlemen, typically, witnesses may only
13 testify about things they've observed personally through
14 their senses. There is an exception, however, for people
15 who are qualified by reason of their training,
16 education, or experience and become experts in their given
17 field.

18 Expert witnesses, unlike other witnesses, may give
19 their opinions about things they've observed. So that's the
20 difference. All witnesses, whether they're expert witnesses
21 or not, have this in common, however, and that is that you,
22 the jury, are the sole and exclusive judge of their
23 credibility.

24 So, yes, ma'am, you may continue.

25 MS. RODRIGUEZ: Thank you, Your Honor.

1 BY MS. RODRIGUEZ:

2 Q Nurse Murray, you have documents in this case that
3 you brought with you?

4 A Yes.

5 Q As we're going along, if at any point you need to
6 refer to a medical record, a monitoring strip, or any of
7 the documents, please, feel free to do so. I think most
8 of the questions that I'm going to ask you, I anticipated
9 what records we're going to need, but if there's something
10 else, feel free to tell me what you need to see --

11 A Sure.

12 Q -- or if you just need to look at something.

13 What I'd like to do is start out with a few basic
14 principles before we get into the specifics of this case.
15 If you could, just explain to the jury -- they've heard a
16 little bit about this in opening, but sort of explain the
17 principles of the three P's.

18 A Labor and delivery nurses, we have, actually, many
19 P's. But the three main P's -- the letter P are the
20 power, which is the uterine contractions, the passenger,
21 which is the baby in the uterus, and the passageway or
22 pelvis. So passenger, passageway or pelvis, and powers.
23 And those have to come together to help make the baby come
24 out naturally.

25 Q And are there factors, as a nurse, that you have to

1 be aware of or take into consideration that can impact the
2 babies fitting into that pelvis and getting out?

3 A Right. So, of course, if there's not enough power to
4 push the baby down and out -- which that is very rare
5 because women have natural hormones and were built to make
6 babies and push them out. But that can happen, a power
7 issue. We call it hypotonic contractions.

8 And then there's the passenger, the baby. If
9 they're, we say too fat to fit, I mean, they're big or
10 they're angled in a certain way, which we would call
11 malpositioned, they're not going to come through, or if
12 the pelvis for that baby is contracted or just not the
13 right side for that baby to fit.

14 Q Now, when a woman arrives in labor and delivery, do
15 you look at the history to make a determination as to
16 whether or not there are any factors in that woman's
17 history that may impact those issues?

18 A Yes. And one of our jobs, as a labor nurse, is to
19 look at the prenatal record. And we keep them on file at
20 the labor unit, or in what's called triage.

21 So we're supposed to read them and recognize the
22 factors that could affect progress like the baby fitting,
23 what her history is with other babies if she's had them
24 before, what problems she had with bleeding, and other
25 issues. So we look at the risk factors, they're called.

1 Q And what are the risk factors that you would take
2 into consideration that would be most applicable if you
3 were worrying about the size of the baby fitting through
4 the pelvis?

5 A Well, there's an acronym DOPES, D-O-P-E-S. The first
6 D is diabetes. These are babies at risk for not fitting
7 and having shoulder dystocia. DOPES, diabetes.

8 Q Is that diabetes in the baby or the mother?

9 A The mother.

10 Q Okay.

11 A The mother, does she have diabetes. That's a risk
12 factor for shoulder dystocia. O is obesity. So we look
13 at her weight and her height.

14 P is for is the baby overdue. Because they get
15 bigger. And related to bigger could be just what we call
16 large for gestational age. Is this a big baby, too big to
17 fit.

18 And then E is excessive weight gain. We look to see
19 how much weight the mother gained during the pregnancy.
20 Where did she start, and where did she end.

21 And then S is short statute. And in the medical
22 literature, the nursing literature and what I've
23 published, 5'5" is the border of short, so less than 5'5".

24 So DOPES, we look at that. And those would be risk
25 factors for shoulder dystocia.

1 Q Now, in this particular case, you've had an
2 opportunity to review the medical records of Alana Mann
3 and [REDACTED] J.B. [REDACTED]; is that correct?

4 A Yes.

5 Q And what I want to do is let's talk, specifically,
6 about this case. Did you review the mother's prenatal
7 records?

8 A Yes.

9 Q And you, also, reviewed the delivery records?

10 A Yes.

11 Q Did you, also, have an opportunity to review the
12 initial newborn nursery assessments?

13 A Yes.

14 Q And based upon the information that was available in
15 this instance when this -- when Alana Mann was admitted to
16 the hospital, was there any indication that this was a
17 high risk pregnancy?

18 A Yes, high risk for shoulder dystocia. Because she
19 had short stature, 5'2-1/2", 5'2", or 5'3", those are all
20 in the records. She was a diabetic, insulin-dependent
21 diabetic. DOPES, she was a diabetic.

22 She was obese. She, actually, weighted 241.8 pounds
23 at the time she was admitted for labor. She wasn't
24 postdate. The baby was, actually, not even quite
25 36 weeks, but it was in the 97th percentile in weight,

1 large for gestational age and growing. Because that was
2 three weeks before she came in. 97th percentile. So
3 that's large. And then excessive weight gain.

4 Frankly, I haven't memorized where she started and
5 where she ended, but she had short stature, 5'2", 5'3".
6 So she had clear risk factors for shoulder dystocia that a
7 nurse would know if they were properly trained to know.

8 Q And that information would have been available to the
9 nurses in reviewing the records, the prenatal records?

10 A Yes.

11 Q And, as a general rule, do the prenatal records go to
12 the hospital when the patient is admitted into labor and
13 delivery?

14 A Not the final records. However, based on the notes
15 from labor and delivery, they knew her weight, and they
16 had her height, and they would have known her gestational
17 age. They knew things about her. They knew she was a
18 diabetic. They could see how big she was, just visibly
19 see how big she was. So they knew or they should have
20 known.

21 Q Now, in this particular case, there's been some
22 information that Alana Mann, also, had a diagnosis of a
23 mental illness. Is that a risk factor for shoulder
24 dystocia?

25 A No, ma'am.

1 Q She, also, had a history of being a Jehovah's
2 Witness. Is that -- does that have any impact on the
3 issues?

4 A No, ma'am.

5 Q Now, when the nurses evaluate a patient -- I'm sorry.
6 Let me back up. Initially, what unit was she admitted to?

7 A So she was admitted to what's called a high risk
8 unit, which is not a labor unit. Because her cervix,
9 which is the opening of her womb, was long, and closed,
10 and thick. And they wanted to induce her labor. So
11 they've got to soften that and start it opening up.

12 So she wasn't in the labor unit. She was on a
13 separate unit called high risk.

14 Q And how long was she in the high risk unit?

15 A She came in the day before Thanksgiving on a
16 Wednesday, the 24th of November of 2004. And she stayed
17 there until after her water broke at 10:30 in the morning
18 on the 26th.

19 So she was on that unit from midday on the 24th until
20 around 11:30. She showed up in labor and delivery on the
21 26th, which was a Friday.

22 Q Now, during the period of time that she was in the
23 high risk unit, was she on fetal monitoring?

24 A Yes, she was.

25 Q Can you -- again, let's stick to the -- give a very

1 basic explanation about what fetal monitoring is and its
2 purpose in this setting.

3 A It's a computer that is by the bedside that has a
4 paper output.

5 Can I show the paper?

6 Q Sure.

7 A So this is called C-fold paper. And this paper comes
8 out of a place on this computer called a fetal monitor.
9 And it's supposed to come out what's called three
10 centimeters per minute. And we can tell -- there are
11 little boxes on here. And we can tell if it's coming out
12 the way it's supposed to come out. That six little boxes
13 is a minute.

14 So it just slowly comes out. And it's printing on
15 this side the baby's heart rate, and on this side the
16 contractions, what we call uterine activity. So it comes
17 out of this computer.

18 And we have belts that we put on the mom's tummy that
19 will tell us contractions, or the baby's heart rate, or --
20 I brought some internal monitors that can be put in once
21 the water breaks. Those can be put in to tell us the
22 baby's heart rate and about the contractions.

23 Q Nurse Murray, what I want to just explain to the jury
24 is when we have these records photocopied or when the
25 hospital does and provides them to us, obviously, we're

1 not getting that big long sheet. Explain -- because what
2 we're seeing up there doesn't exactly look like what you
3 have in front of you. Can you explain the difference here
4 and what happened?

5 A Sure. I have my own little pointer. Well, it's very
6 hard to see the printout of the baby's heart rate. This
7 is, actually, a printer -- let me -- I need to explain.

8 This paper is heat sensitive. We call it thermal
9 paper. And the printer is hot. And if the heat of the
10 dot matrix printer isn't hot enough -- now, they have
11 fancier machines they call ray printers. But if it isn't
12 hot enough, you get this very pale -- you can barely see
13 it -- heart rate here of the baby printing here. And
14 that's a printer problem.

15 But we have a grid here. It's this side here. And
16 this is 30 beats a minute on the bottom line, 30 beats per
17 minute of the heart beating. And every line is 10 beats.
18 So 40, 50, 60, 70, 80, 90, all the way up to the top line
19 would be 240 beats a minute. And that's called the fetal
20 heart rate channel, the top part.

21 Q So by looking where that little squiggly line is and
22 the number mark there, it tells you what the -- what is
23 that telling us?

24 A Well, this number is 140. Here's 150. So it's
25 telling me this baby's heart rate is between 140 and 150.

1 And it's fluctuating up and down in here.

2 Q Okay. And then explain the time frame on these
3 things and how that works.

4 A Sure. Well, now this was from the high risk unit.
5 And what happened there is they did not set their monitor
6 right. They didn't even know they were using the wrong
7 speed. There's a switch on the back of the fetal monitor
8 for one, two, or three centimeters a minute. And the
9 reason they do that is they sell them to Europe and all
10 over the place.

11 And, in America, we use three centimeters a minute.
12 And that's how we're taught to interpret the images that
13 this prints. They had set theirs and didn't recognize it
14 for two days at two centimeters per minute.

15 So this is from that high risk unit at 8:10 at night,
16 this is military time, 2010 at night. So on their unit, a
17 minute of time would be two centimeters. And two little
18 boxes is a centimeter. So four boxes would be a minute of
19 time.

20 Q And, if you could, just, basically, explain to the
21 jury how you were able to determine -- and make sure I
22 have the right strip up here that shows the numbers.

23 A Well, you know, it's funny, when you look at
24 something and you're not aware, you miss it. So I was
25 studying this closely. And I realized that here is 2001,

1 and here is 2010. And if we did three centimeters a
2 minute, which we're supposed to do, six boxes would be a
3 minute.

4 So I counted and I went one, two, three, four, five.
5 Well, that's not six full boxes. By boxes, I mean the
6 dark line to the dark line or six little boxes makes one
7 big box. And I went, wait a minute.

8 So then I went through the entire two days and
9 realized they never recognized they were using a monitor
10 that was set wrong. And they didn't recognize this
11 machine should have been in the biomedical repair to heat
12 up that printer. They have to do it, nurses can't do it.
13 They were using a machine that was set wrong without a
14 proper printer.

15 But I did the whole strip. And when I counted from
16 here, four boxes, 2002, 2003, 2004, 2005, 2006, 2007,
17 2008, and, actually, nine and then 10 would be about here.
18 Because the way they put the time is close, but not -- it
19 doesn't have a line going down. And then I went, oh, my
20 goodness.

21 So then I looked at the whole thing. Because you
22 don't see two times on each sheet. I got it in like the
23 notebook size sheet, 8-1/2 X 11. Sometimes, there's only
24 one time on a sheet. But when I then saw the two times on
25 the sheet, I went they've been using it wrong for two days

1 and didn't know it.

2 Q Now, how do we know that this problem isn't just
3 related to the fact that this strip was done in 2004, and
4 it's been sitting around for all these years?

5 A Do you mean in terms of fading?

6 Because it's heat sensitive. When you have this
7 paper -- you know, those old copies -- Xerox copies that
8 would fade after about seven years. And so the reason we
9 know it was their printer not being hot enough is because
10 the grid is so clean and clear. Look how dark the grid
11 is. It's totally dark. And it would be a copy from
12 something like this, which is kind of a red grid. And you
13 can see how dark the grid -- you can see the times, the
14 grid, the handwriting. It's all dark. And, yet, you can
15 barely see the printout of this baby's heart rate.

16 So how's a care provider supposed to really know what
17 the baby is trying to communicate through its heart rate,
18 let alone know that what you're seeing is the image is
19 compressed, because it's coming out slower. So the
20 decelerations or the changes in the heart rate are
21 reduced, but nobody knew it. So they're not going to
22 interpret the meaning of the baby's changes or
23 contractions right.

24 Q Now, do you see any evidence or were you able to find
25 any evidence in the entire medical record that it was ever

1 recognized during the course of time in which Ms. Mann was
2 a patient in the high risk unit that anybody realized that
3 the monitor had been set on the incorrect speed?

4 A They never did.

5 Q Now, she was then transferred out of the high risk
6 unit at some point. I think you've already testified --

7 A Well, about 11:10, there was a note that they had
8 called labor and delivery, because her water broke at
9 10:30 and there was a small amount of clear fluid. And
10 they sent her over to labor and delivery. And they put
11 her on a monitor over there at about 11:29 it started.

12 Q Now, when she was transferred to labor and delivery,
13 was she put on a different monitor?

14 A Different monitor, different unit at the right, paper
15 speed of three centimeters a minute.

16 Q Now, let's talk about what happened in the labor and
17 delivery unit for a little bit here. I believe -- well,
18 first let me ask you. Does the nurse in labor and
19 delivery have any responsibility to take care of the
20 fetus, as well as the mother, or does her responsibility
21 simply go to the mother?

22 A We're responsible for the safety of the baby and the
23 mom. And we, also, sometimes take care of the dads.
24 Because they sometimes don't eat and they get tired. And
25 we worry about them passing out. So we -- and the

1 grandma, and the little kids running around. But, mainly,
2 the mother and the baby inside of her, or babies, if they
3 have twins.

4 Q What I want to talk about is the medication or drug
5 Pitocin. And, again, the jury has heard some about that
6 already. But if you could just give them a very basic
7 explanation of what Pitocin is and what the responsibility
8 is of the nurse in administration of Pitocin.

9 A Well, basically a chemist in America discovered how
10 to make Oxytocin, which is the same hormone moms make to
11 have contractions, and was able to make it and put it in a
12 bottle or a vial with a preservative. So, basically, it's
13 called Pitocin. But it's the same chemical formula as if
14 they took our own Oxytocin. And they just make it so we
15 can add it to a bag of IV fluid and give it through the
16 main line IV. We call it piggy back.

17 Q Now, in your review of these records -- and the
18 records were quite large. Did you create a summary for
19 yourself of the administration of Pitocin?

20 A Yes, I did. Because it's charted in different places
21 and the doctors write about it, the nurses write about it.
22 So I wanted to see when it started, and how frequently it
23 was increased, and what the maximum they gave, and did
24 they ever turn it off.

25 Q Now, what is the nurse's role -- or the nurse's

1 responsibility when the doctor orders Pitocin at a certain
2 rate or how -- the method by which it's supposed to be
3 administered? What's the nurse's responsibility in,
4 actually, administering it?

5 A We cannot give it faster than they ordered it. We
6 might give it slower, or not at all. We have a right, if
7 you will, our training as nurses to do what's called
8 titrate up or down.

9 So they might order -- okay, you can -- as in this
10 case, you can increase the dose every 30 minutes. And we,
11 as nurses, may lower that dose every 30 minutes, or turn
12 it off. But we cannot increase it faster than every
13 30 minutes, unless we call them and say, I want to change
14 your order. But they'd have to write the new order.

15 And why would we? Because it takes about 30 minutes
16 for it to attach to the uterine receptors and work
17 effectively. And if you give too much too fast, you don't
18 get a good response.

19 Q And when you say "a good response," what are we
20 looking for?

21 A Well, we're looking for contractions. Our goal --
22 women can push a baby out if there are two to three
23 contractions every 10 minutes. And we have to have a full
24 minute or more between the contractions so the baby
25 catches its breath. That's the time the uterus is resting

1 so the baby can get replenished with its oxygen.

2 Because when the uterus squeezes it, it cuts off
3 oxygen to the baby, so the rest time is critical. So we
4 want to have two to three every 10 minutes. And we want
5 to have, at least, a minute to catch its breath. The baby
6 needs the oxygen.

7 So that's kind of our goal to push a baby out. And
8 we want them to get stronger over time. Because without
9 the umph, we can't push the baby out. Moderate to strong,
10 I'll say. They need to be moderate to strong.

11 Q Now, in this particular case, was there an order
12 written to administer Pitocin?

13 A There was at 4:00 by Dr. Shepherd, who was a
14 first-year resident.

15 Q I think we have that up here. And the jury has
16 already seen a sample of the handwriting, and we know it's
17 pretty difficult to read. But can you tell them what the
18 order was?

19 A Pitocin, start at --

20 Oh, thank you.

21 Start at two milliunits per minute, increase by two
22 milliunits every -- "q" means every 30 minutes to a
23 maximum of 20, which would mean 20 milliunits a minute.
24 The goal is 220 montevideo units, which is abbreviated
25 MVU.

1 Q Now, it's indicating to go up two milliunits q
2 30 minutes. So could the nurse increase it more quickly
3 than every 30 minutes?

4 A No, not within the standard of care. That would be a
5 violation of the standard of care if the nurse didn't
6 follow that order the way it's written in terms of
7 increasing it.

8 Q Could she go up more than two units?

9 A No, not without having a conversation with the doctor
10 and saying, I'd like to change this order. But that's
11 their order.

12 Q Okay. Now, in this instance, as you said, you did a
13 chart, a summary chart. And I think you have your copy of
14 it there with you. I don't know if it's easier to read
15 there or here. But is that a copy of what you put
16 together?

17 A Yes.

18 Q And I think -- let's -- can you read it, Nurse
19 Murray? I can't read it.

20 A Well, I can read it pretty much for an old woman. I
21 have glasses, but they're for reading.

22 Thank you.

23 That helps.

24 Q Yeah. Talk -- explain through what you did here.
25 And let's just orient them that you've got written time,

1 which is -- what does that represent?

2 A So military time is 1602 or 4:02 p.m. It was started
3 at two, as ordered, milliunits per minute. And this is
4 the page in the records where I found that information.
5 And then within 13 minutes, not 30, it was increased to
6 four. And that's the page.

7 And then -- now, we have, at least, a half hour or
8 more. It went to six. And then we have a half hour
9 exactly. I think that's still six. I'm looking at it
10 sideways. At three -- 1802 -- I'm sorry. Back up. That
11 was eight. I'm sorry. Six, eight and then at 1802, which
12 is 6:02 p.m., it was 10. But then not even a half hour
13 later, it was increased and --

14 Q Nurse Murray, hold on one second. What I'm going to
15 do is let's try one more -- there you go.

16 A Thank you.

17 Q I can even read that.

18 A Thank you.

19 It's like an eye test.

20 Q I'm sorry.

21 A So here is your 4:02 p.m. or 1602, two. 1617, too
22 short an interval increase. 1702, at least, 30 minutes
23 later six. 1732, exactly 30 minutes, eight. 1802, 30
24 minutes, 10. And then in 15 minutes, 12. And then it was
25 a good more than 30 minutes to 14. And then 14 minutes

1 later, it's 16. And 22 minutes later, it's 18. And then,
2 at least, 30 minutes, it became 20.

3 Q So each of the ones that you've done in red was to
4 illustrate what concept?

5 A They didn't follow -- the nurses did not follow the
6 doctor's order.

7 Q So give us one second here. I still can't read it.
8 It's so small. And I apologize. Technology is wonderful
9 when it works.

10 There we go. If you could pick up from there,
11 Nurse Murray.

12 A Well, the maximum ordered was 20. So I think 20
13 was -- we skipped a few doses there.

14 Q Okay. And then I think what we had over to the
15 right --

16 MS. RODRIGUEZ: I apologize, Mike. Can you just go
17 back to the big screen?

18 BY MS. RODRIGUEZ:

19 Q Was there another order?

20 A It wasn't an order. But there, clearly, was
21 communication between the resident and the nurse. Because
22 in the progress note of the physician, it said to go above
23 the 20. But the physician was a resident, not an
24 attending physician.

25 Q Okay. And just point out to the jury what we're

1 talking about. This, I think, is dated 12:15 a.m.?

2 A Right. Well, there were different progress notes on
3 one page. This happens to be the progress note by the
4 second-year resident, Dr. Alt, at 0015. It's military
5 time, or 15 minutes after midnight, whereby at that time
6 in this labor, she had written her own note. But she,
7 obviously, communicated to the nurse to increase the
8 Pitocin to a maximum of 40 milliunits.

9 Q Okay. And if we can go back to the sheet. Okay.
10 Continue on with the dosing. And this explains why we go
11 over the 20.

12 A Prior to the second-year resident, Dr. Alt,
13 Dr. Shepherd, the first-year resident, had written a
14 similar note to go above the 20. So 20 was the original
15 max. And then we see more than 30 minutes passed, it got
16 to 22. 16 minutes later, 24. 26 minutes later, 26. And,
17 at least, 30 minutes, right here 11:02 p.m. or 2302, 28.
18 2332, exactly 30 minutes, 30. 15 minutes later, 32. 15
19 minutes later, 34. 23 minutes later, 36. 15 minutes
20 later, 38, and then up to 40. And it never was
21 discontinued ever until -- and the baby got stuck.

22 Q Okay. What I need to back up, though, and talk to
23 you about is the second order that we looked at in the
24 progress note to increase to 40 did not have a time. It
25 didn't say how frequently to go up on it. The original

1 order that we pointed to up to the 20 indicated to go up
2 at 30-minute increments.

3 Does that order roll over onto the 40 or, you know,
4 how does the nurse make a determination of what to do on
5 that one that says to go up to 40 when there was no time
6 limit on that one?

7 A Okay. So the nurse would make the determination of
8 what to do because of the goal of not getting the
9 contractions too close. You need a minute or more to give
10 the baby enough oxygen during the rest time.

11 You, also, need, because they have the internal
12 pressure catheter, to not go above 20 in terms of the
13 resting pressure. That's 20 millimeters of mercury. Like
14 millimeters for blood pressure mercury, they use a
15 pressure catheter inside the uterus.

16 So you don't want to go too high on the pressure
17 because that can cut off oxygen to the baby. You don't
18 want to go too close on the interval between contractions
19 because that cuts off oxygen to the baby. And so
20 you're -- even if the doctor doesn't tell you every
21 30 minutes, which is reasonable to establish good blood
22 levels, you still have to think I have to have time for the
23 baby to catch its breath. And I don't want to exceed the
24 pressures or I'm just cutting off oxygen to the baby.

25 And they put oxygen on her at 12:10 in the afternoon

1 and kept it on. So they, clearly, had a concern about
2 oxygen. So we're going to pay attention to the baby. We
3 don't want to cut off oxygen to the baby.

4 Q Okay. In terms of the specific orders for the
5 administration of Pitocin, let's talk about that first and
6 then we'll go on down the line here. But the order to
7 give the Pitocin at up to 20 milliunits at a rate of 30
8 every -- up it every 30 minutes, did they follow that
9 order?

10 A No. And this was the night nurse.

11 Q Okay. And is that considered within the standard of
12 care for a nurse to administer the Pitocin at a frequency
13 higher than is ordered by the physician?

14 A No. And, again, you have to, also, say no. But it,
15 also, did bad things when we see the contractions.

16 Q Okay. But let's -- I need to stick with the order
17 first.

18 A Okay.

19 Q Can you tell the jury, was it a violation of the
20 standard of care in nursing to administer the Pitocin at a
21 rate that exceeded -- or to increase the Pitocin at a rate
22 that exceeded every 30 minutes, based upon the orders?

23 A Yes.

24 Q Now, you, also, talked about the issue of the baby
25 needing a rest period. In terms of the administration of

1 the Pitocin in this case, now that you've looked at all
2 the times, was the baby being given sufficient time to
3 rest in between the doses of Pitocin or the increase in
4 the doses?

5 A Not on the night shift. It was excessive. I would
6 call it an overdose.

7 Q And when you reviewed the fetal monitoring strips --
8 and we're not going to go to those because they're so
9 large. But, if you could, just summarize for the jury,
10 did you see corresponding information on the fetal
11 monitoring strips that indicated that the baby wasn't
12 getting sufficient rest periods?

13 A Oh, yes, many.

14 Q Okay. Now, there was, also, an order here to
15 increase the Pitocin to 40. And how long have you been in
16 nursing now?

17 A Over 38 years.

18 Q And have you ever administered Pitocin in the doses
19 that it was administered in this case?

20 A The most, I think, was a couple of times in my career
21 was 20, never above 20.

22 Q Now, in this particular instance, you, also, had an
23 opportunity to review all the nursing records; correct,
24 that corresponded to this?

25 A Yes.

1 Q Did you ever see any entry that indicated that any
2 nurse contacted an attending physician when the Pitocin
3 exceeded 20 milliunits?

4 A They never did. They never called the doctor above
5 the resident, the attending.

6 Q And what would the chain of command for nursing be to
7 administer Pitocin in the doses ordered in this case?

8 A I would either call myself or ask the charge nurse to
9 call the attending to come. And, in this case, there's
10 more to the story because the baby wasn't descending,
11 meaning it wasn't fitting the passenger passageway, even
12 though they maxed out the Pitocin to 20.

13 So I want the attending there to evaluate the fit and
14 make a decision about the route of delivery. Are we going
15 to pursue trying to force the baby down into the pelvis
16 when nothing is changing? We're maxed out here on the
17 Pitocin.

18 So we have a fit problem from a nursing perspective,
19 not a power problem. We had plenty of power. We were
20 maxed out. So we had a fit problem in my nursing opinion.
21 And I would have called them to evaluate that.

22 Q What I'm going to try and do is not have you expand
23 on opinions that I know we have a physician that's
24 scheduled to testify on. And I'm honestly just trying to
25 do that in order to try to get things done as efficiently

1 as we can.

2 So what I need to ask you is, from a nursing
3 perspective, if -- what was the standard of care? What
4 did the standard of care require in terms of a nurse
5 communicating with a physician regarding the dosing of
6 Pitocin in this case?

7 A When I hit the max, I want an attending to come to
8 the bedside.

9 Q Okay. Now, you're saying you want -- is that what
10 you would expect of any nurse, any reasonable nurse
11 functioning in a labor and delivery unit, or is that just
12 your policy?

13 A No. It's the standard in context. Because we, also,
14 know how her cervix is opening up and where the baby is at
15 in terms of what we call station. So it's taking in all
16 the facts.

17 Q So, in this particular case, did the communication
18 between the nurses administering the Pitocin and the
19 physicians comply with the standard of care in nursing?

20 A It did not.

21 Q Okay. And describe what should happen.

22 A The attending physician needed to come to the bedside
23 and the nurse would communicate all the facts that they
24 were aware of.

25 Q Okay. Now, we're going to switch tracks here for

1 just a second. And I want to talk about as we've
2 progressed through the day into the night shift on the
3 labor and delivery unit.

4 THE COURT: I'll tell you what, let's take a break
5 right now since we're switching.

6 Don't talk about the case, ladies and gentlemen.
7 Continue to keep an open mind. And we'll resume the trial
8 in about 10 to 15 minutes.

9 Thank you.

10 (WHEREUPON, the jury was excused from open court at
11 approximately 10:56 a.m.)

12 THE COURT: Okay. I need to let y'all know that
13 Ms. Olson, the jury coordinator, advised me that, evidently,
14 Mr. Crawford, Juror #25, approached her and indicated an
15 association his sister had with the Greenville Hospital
16 System through a group of psychiatrists she works with.

17 And Ms. Grant, #44, thinks she may have had some
18 contact with the child in the case through her work with
19 BabyNet. We'll bring both of those jurors out after the
20 break. But I just wanted to advise y'all.

21 MR. ALEXANDER: Excuse me, Judge. Crawford, tell me
22 again the concern.

23 THE COURT: It says, Mr. Crawford brought in a letter
24 for you about his sister's association with Greenville
25 Hospital System through a group of psychiatrists she works

1 with.

2 MR. ALEXANDER: Okay.

3 THE COURT: Ms. Grant thinks she may have had some
4 contact with the child in the case through her work with
5 BabyNet. That's all the information I have.

6 MR. ALEXANDER: Thank you.

7 THE COURT: Okay. We'll take a short break.

8 MS. RODRIGUEZ: Judge, just so you know, when we
9 talked to Ms. Grant up at the podium, she indicated she
10 was not involved with BabyNet at the time of this case.
11 So we may not be on the same page.

12 THE COURT: Maybe not. I don't know. We'll find
13 out.

14 (WHEREUPON, a break was taken.)

15 (WHEREUPON, Court's Exhibit No. 1 was marked for
16 identification and admitted into evidence.)

17 THE COURT: Let's see. Can you ask Mr. Graham to
18 come out, please?

19 MS. RODRIGUEZ: Crawford, for the record.

20 THE COURT: Oh, is it Crawford?

21 I don't know why I've got Graham on my mind.

22 Mr. Graham is already out here.

23 MR. GRAHAM: I'm sorry, sir?

24 THE COURT: Mr. Graham is already out here.

25 MR. GRAHAM: I'm here to answer any questions.

1 (WHEREUPON, Juror #25, William Crawford, entered the
2 courtroom.)

3 THE COURT: They've got to hear what you're saying,
4 sir. If you'd back up just a little bit. I'm sorry.

5 JUROR #25, WILLIAM CRAWFORD: Yes. That's all right.

6 THE COURT: You have a letter?

7 JUROR #25, WILLIAM CRAWFORD: I wrote you a letter.
8 There was a question yesterday as to whether any of our
9 relatives works for Greenville Hospital System.

10 THE COURT: Yes, sir.

11 JUROR #25, WILLIAM CRAWFORD: My sister is a
12 psychologist who works with a group of psychiatrists. She
13 tests brain injury patients to find out what areas of the
14 brain were affected.

15 THE COURT: Okay.

16 JUROR #25, WILLIAM CRAWFORD: I thought they worked
17 as an independent unit. I didn't they know they were
18 associated. But they are under the umbrella of Greenville
19 Hospital System. And I felt, just for disclosure, I
20 should to come to you. I didn't know it yesterday, but.

21 THE COURT: Okay. Mr. Crawford, would that affect
22 your ability to be fair and impartial?

23 JUROR #25, WILLIAM CRAWFORD: No, not at all.

24 THE COURT: Could you decide the case solely on the
25 evidence and the law?

1 JUROR #25, WILLIAM CRAWFORD: Certainly.
2 THE COURT: I haven't seen the letter.
3 JUROR #25, WILLIAM CRAWFORD: Well, I gave it -- they
4 said -- it's just explaining the same thing. You're
5 welcome to it.
6 THE COURT: Okay. We'll just make this part of the
7 record.
8 Does anybody have any further questions of Mr. Crawford?
9 MR. ALEXANDER: No, sir.
10 THE COURT: All right.
11 MR. GRAHAM: No, Your Honor.
12 THE COURT: Thank you, sir.
13 JUROR #25, WILLIAM CRAWFORD: Okay. Sorry for that.
14 (WHEREUPON, Juror #25, William Crawford, exited the
15 courtroom.)
16 THE COURT: Y'all are, certainly, welcome to look at
17 the letter, but it is consistent with what he said.
18 MS. RODRIGUEZ: Grant.
19 THE COURT: I'm sorry.
20 MR. GRAHAM: Are you asking me, Your Honor?
21 THE COURT: Ms. Grant. Could you get Ms. Grant?
22 (WHEREUPON, Juror #44, Shannon Grant, entered the
23 courtroom.)
24 THE COURT: Good morning.
25 JUROR #44, SHANNON GRANT: Good morning.

1 THE COURT: Ms. Olson said that you had approached
2 her about you thought that you may have had some contact
3 with the child, [REDACTED] J.B. ?

4 JUROR #44, SHANNON GRANT: Well, not --

5 THE COURT: Tell us about that.

6 JUROR #44, SHANNON GRANT: Not direct contact. But
7 she was, in fact, referred to the program with which I
8 work. And my name could -- although I was not the intake
9 or service coordinator for her, my name could, in fact, be
10 on her eligibility determination for our services.

11 THE COURT: Do you have any independent recollection
12 of the child?

13 JUROR #44, SHANNON GRANT: No, sir. I do not.

14 THE COURT: Okay. Is there anything about that that
15 would affect your ability to be fair and impartial in this
16 case?

17 JUROR #44, SHANNON GRANT: No, sir, it should not.

18 THE COURT: Do you believe you could decide the case
19 based solely on the evidence and the law?

20 JUROR #44, SHANNON GRANT: Yes, sir.

21 THE COURT: And does anybody have any questions?

22 MR. GRAHAM: No, Your Honor.

23 MR. ALEXANDER: No, sir.

24 THE COURT: All right. Thank you, ma'am.

25 I appreciate you telling us about that.

1 (WHEREUPON, Juror #44, Shannon Grant, exited the
2 courtroom.)

3 THE COURT: Okay. Anything else before we bring the
4 jury back in?

5 MR. ALEXANDER: No, sir.

6 THE COURT: You may resume the stand, Ms. Murray.

7 THE WITNESS: Thank you.

8 (WHEREUPON, the jury came into open court at
9 approximately 11:16 a.m.)

10 THE COURT: Yes, ma'am. You may resume your
11 questions, Ms. Rodriguez.

12 MS. RODRIGUEZ: Thank you, Your Honor.

13 CONTINUED DIRECT EXAMINATION

14 BY MS. RODRIGUEZ:

15 Q I want to talk now about the labor and delivery, and
16 what went on in the labor and delivery unit, and what
17 occurred during the nightshift there. Nurse Murray, when
18 a patient with high risk issues is admitted to a unit such
19 as Ms. Mann was, what -- from a nursing perspective, just
20 explain to the jury a little bit about patient assignments
21 and how things are generally -- or should be handled
22 within nursing.

23 A We try -- well, charge nurses try, I think, to make
24 sure that the nurse who's going to take care of the
25 patient is capable based on their knowledge and

1 experience. And, if not, then who is helping that new
2 graduate, for example, to not hurt somebody and overseeing
3 them and helping them. Because sometimes you're stuck
4 with the staff you have. But you try to have the best fit
5 so that the patient gets the best care with the staff you
6 have.

7 So if they're complex, you want someone who can
8 handle the complexities. If they're just a natural birth
9 and no issues, a new grad can do that because women had
10 babies before there were nurses. So you try to make a
11 good fit so to keep the patient safe.

12 Q But what happens in a circumstance where you admit a
13 patient and they, initially, start out as a normal labor
14 and complications develop, and you are assigned the new
15 grad, the most inexperienced nurse to that patient? What
16 happens?

17 A The charge nurse is supposed to know, because we
18 communicate with them. Things change and either pull you
19 out and put an experienced nurse in and maybe give the new
20 grad the normal labor, normal patient, but move people
21 around. So it's a dynamic to keep patients safe. That's
22 the bottom line.

23 Q In this particular instance, would you just orient
24 the jury as to who two of the nurses that were involved in
25 this case were? And I'm going to, specifically, reference

1 to the nightshift, Nurses Nutt and Russell Williams, if
2 you could orient the jury.

3 A The charge nurse was named Tammy Nutt. And she's in
4 the room. I've been told she's here. And the staff nurse
5 was named Bethany Russell Williams. And Bethany had
6 graduated that same year in the summer. She had a month
7 of orientation, and was a labor nurse for less than six
8 months total counting that orientation. So not even a
9 half year of experience.

10 Q Now, based upon the information that was available to
11 you, what information were you able to get from Ms. Nutt's
12 deposition regarding her practice for assigning nurses to
13 complex patients in this case?

14 A There was no effort made to look at the complexity of
15 the patient, and the skill level, and knowledge base of
16 the nurse. They were assigned rooms, like room one and
17 two.

18 Q Okay. I'm going to show you an excerpt from the
19 deposition of Ms. Nutt. And have you read this
20 deposition?

21 A Yes, I did.

22 Q And is this what you were referencing?

23 A Yes.

24 Q And, if you would, let's just -- if you would, read
25 to the jury, the question was, So it would have been your

1 decision to assign Bethany Williams -- who we know now has
2 been married, her last name, I think, has changed -- to
3 manage Alana Mann's delivery?

4 And her answer was?

5 A I did not, specifically, pick Bethany Williams to
6 labor Ms. Mann.

7 Q Okay. How is that determination made?

8 A Nurses are given patients just by the mere fact that
9 we do labor and delivery. We don't look at a nurse or a
10 patient and make an assignment. We just say you have
11 rooms one and two. You have rooms three and four. We all
12 have the same responsibilities. We all have the same
13 training. Now, some of us may be more advanced than
14 others, but we're there to help and assist each other.

15 Q Does that policy of assigning nurses in that manner,
16 assigning them to a room, rather than looking at their
17 qualifications and the needs of the specific patient
18 comply with the standard of care for nursing?

19 A No.

20 Q And why not?

21 A Because it's dangerous.

22 Q And, in this particular instance, after your review
23 of the medical records and the involvement of this nurse
24 and this patient's care, were there any issues?

25 A Yes.

1 Q And just summarize for the jury.

2 A Based on the deposition of Nurse Bethany Russell
3 Williams, she only became first concerned about this baby
4 when the baby's heart rate bottomed out a minute before
5 birth. She did not have any concerns whatsoever. Because
6 she didn't, in my opinion, have the knowledge to filter
7 the information coming into her brain because she wasn't
8 experienced or educated. She didn't have the core
9 knowledge.

10 And so, basically, the contractions got closer, and
11 closer, and closer. And the resting tone of the uterus
12 got higher and higher. And she went all the way up to 40
13 and never turned it off, never turned the Pitocin off.

14 She didn't understand the implications of her
15 behavior for that baby, pushing the baby down into the
16 pelvis and jamming it up against the pubic bone. She
17 didn't understand. She didn't understand her role. She
18 didn't know what she was doing, basically. She was put in
19 a situation she wasn't capable of handling properly.

20 Q Now, Nurse Murray, one of the things you mentioned is
21 the baby getting jammed and hitting the pubic bone. What
22 evidence do you have that that, actually, happened in this
23 case?

24 A There's two parts of the evidence of this baby --
25 well, there's more than two, but, basically, the baby

1 itself. Because the baby's head came out what's called
2 molded. Some people say cone head, but I don't like to
3 say that, but molded and swollen, which we call caput.

4 So the head itself got pushed in, and stretched, and
5 swollen. And, of course, the shoulder got jammed up
6 against the pubic bone. And the Pitocin is causing force
7 of the uterus. And so the baby -- but, also, the baby's
8 heart rate changed.

9 So the cord was being compressed. The placenta was
10 being compressed. Everything got compressed by the uterus
11 with not enough rest in between. So the baby, actually,
12 changed her heart rate, and it went up until it came down.

13 Q Okay. Now, the next issue I want to talk to you
14 about is latex allergies. If you would, just explain to
15 the jury a little about what a latex allergy is and the
16 significance. I know you've talked about it in your own
17 experience, and we know you have some experience. But in
18 the context -- explain to them when you have a patient
19 that comes in with a latex allergy.

20 A Well, it's basic nursing knowledge that you do not
21 use latex products near them, not even in their room, not
22 even latex gloves. If they have hyper-one type
23 sensitivity, they could stop breathing. For me, I get
24 asthma and then I could stop breathing.

25 But, also, the hands, if you wear latex gloves, you

1 get inflammation so the tissue swells up. And you can
2 break out and swell up. So that's called type-four latex.
3 Type one is when you can't breath. So there's type one,
4 and type four, or both.

5 Q And I'm going to refer you to Page 42 of the medical
6 record.

7 MS. RODRIGUEZ: And, Mike, if you would, do the top
8 part so we can, actually, read it.

9 All right. I give up.

10 THE WITNESS: I can read it.

11 BY MS. RODRIGUEZ:

12 Q Can you read it? I'm sorry. There you go.

13 A It says, Patient allergy information. And have you
14 ever been told you have an allergy to latex products? If
15 yes, patient voiced only allergic to condoms and Foley
16 caths, meaning the Foley catheter that goes to make the
17 urine come out.

18 Oh, and wait. Could I just say that the result is
19 swelling and itching?

20 Q Okay. The bottom right.

21 A Again, it's, actually, in the medical record, in the
22 computer printout of the record, the same story. And
23 here's the Foley caths, meaning the catheters for the
24 urine to come out.

25 Q If you'd tell the jury, what happened here at 1557?

1 A So this is Friday, the day after Thanksgiving, when
2 her water broke at 10:30 and she came to labor and
3 delivery. So now, they're in labor and delivery. And at
4 3:57 p.m., or 1557 p.m., the nurse entered the
5 information. And this was Nurse Robin Dicks. Patient
6 indicates latex allergy to Foley catheter, number 16
7 French Foley latex catheter placed. Clear urine noted.

8 So she knew she was allergic and put a catheter in
9 that she was allergic to.

10 Q Does that comply with the standard of care in nursing
11 to put a latex catheter in a patient who has a documented
12 allergy to latex in the medical record?

13 A No, ma'am.

14 MS. RODRIGUEZ: If you'd go to Page 84 of the medical
15 record, please.

16 BY MS. RODRIGUEZ:

17 Q Can you read -- I can't read it from here. Can you
18 point out what we need to -- I believe down at the bottom,
19 does it indicate the actions?

20 A Well, the Foley catheter was still in her at
21 10:25 p.m. So they put it in almost at 4:00 p.m., and
22 it's still in her at 10:25 p.m., or 2225. Because what
23 happened is there wasn't urine coming out in the amount
24 that we'd expect.

25 Q Why would that happen?

1 A Because she told them she swells up. So if
2 everything swells up around that thing she's allergic to,
3 how is the pee-pee going to get out? I mean, that was an
4 advanced word. But how is the urine going to get out? So
5 she had a uterine output problem. And they did pull that
6 catheter at 11:00 p.m.

7 Q Okay. Well, we won't go to that medical record. Do
8 you have an opinion to a reasonable degree of certainty of
9 nursing as to whether or not it was a violation of the
10 standard of care for a nurse to insert a latex Foley
11 catheter in a patient with a documented allergy?

12 A It violated the standard of care.

13 Q Now, ultimately, did that have anything to do with
14 the shoulder dystocia in this case?

15 A Not that I've testified to. I was thinking about if
16 the bladder is full because the urine can't get out, it
17 can, also, make a little blockage for the baby to come
18 out, but not that I'm sure of, so.

19 Q Okay. But in terms of the big picture here, what
20 concern do these issues raise in terms of the system here
21 at Greenville Hospital System?

22 A From the beginning when they used the fetal monitor
23 that wasn't -- the printer wasn't working properly, and
24 the paper speed was wrong until the delivery, where they
25 never turned off the Pitocin that was at a max of 40 and

1 made excessive contractions, and too little resting time,
2 too much power. And, also, there were issues of just the
3 labor itself being abnormal in terms of fit. It was a
4 system failure. It was a total system failure.

5 MS. RODRIGUEZ: Thank you.

6 Please answer any questions the Defense may have.

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

8 CROSS-EXAMINATION

9 BY MR. ALEXANDER:

10 Q Good morning.

11 How are you?

12 A Good morning.

13 Fine.

14 Q Let's confine the scope of your opinions and the
15 scope of your expertise for this jury. You are not a
16 physician?

17 A Correct.

18 Q You have not ever participated in any residency
19 program of any kind?

20 A Correct.

21 Q You have not attended medical school?

22 A That's correct.

23 Q You are not board certified in obstetrics and
24 gynecology?

25 A True.

1 Q No training as a maternal fetal medicine specialist?

2 A That's correct.

3 Q You are not qualified to tell this jury what the

4 standard of care is for an obstetrician or gynecologist?

5 A Well, as a practicing nurse, I know what I'd expect.

6 But not today -- that's something I think a physician

7 would best do today.

8 Q You are not ever qualified to tell this jury what

9 a -- what the standard of care is for an obstetrician or

10 gynecologist; true?

11 A Not in the courtroom.

12 Q You are not qualified to make a medical diagnosis;

13 true?

14 A True.

15 Q You are not qualified to make a diagnosis of shoulder

16 dystocia; true?

17 A That would be a physician.

18 Q You are not qualified to diagnose medical conditions

19 like cephalopelvic disproportion; true?

20 A Correct.

21 Q You are not qualified to make a medical diagnosis

22 like failure to progress; true?

23 A That's right. That's what the doctor would do.

24 Q And you are not an expert in the causes of brachial

25 plexus injury; true?

1 A I would never be qualified as an expert in the
2 courtroom, correct.

3 Q All right. Now, you discussed the risk factors for
4 shoulder dystocia. Do you recall that?

5 A Yes.

6 Q All right. You discussed some of them; true?

7 A Well, those are the main ones nurses are taught in
8 our nursing classes.

9 Q Okay. You did not discuss the fact that this mother
10 did not have a history of macrosomia; true?

11 A I'm confused by your question. You asked about the
12 mother and her history.

13 Q Sure. This mother has never had another pregnancy
14 that was complicated by macrosomia; true?

15 A Right. She had one other baby that weighed six
16 pounds and 13 ounces.

17 Q That's right.

18 A And we wouldn't -- once you weigh the baby in the
19 nursery, then you look at the newborn's weight to decide
20 if they fit that criteria.

21 Q History of macrosomia is a risk factor for shoulder
22 dystocia; true?

23 A No, not exactly for that pregnancy. You're looking
24 at what's happening here and now, not what happened
25 before. And so we're looking at the pregnancy right now.

1 Plus, there are other factors like the height of the
2 father of the baby, and things like that. But the ones
3 that nurses know are the DOPES.

4 Q Right. So it is your testimony that history of
5 macrosomia is not a risk factor for shoulder dystocia?

6 A It would depend on many things. But that's not the
7 one nurses would think of at the bedside for that labor.

8 Q Certainly, not --

9 A Because we're dealing with that patient in that
10 labor.

11 Q Certainly, not one that you would think of?

12 A Well, it wouldn't matter except in the back of your
13 mind. Because you're going to pay attention to what's
14 happening here and now today with this patient.

15 Q Sure. Is history of shoulder dystocia a risk factor
16 for shoulder dystocia?

17 A Well, sure. About 12 percent of women would have
18 another shoulder dystocia. But, again, we're looking at
19 here and now.

20 Q Okay. And you would agree this mom did not have a
21 history of prior shoulder dystocia?

22 A No. Again, she had a six-pound, 13-ounce baby at
23 35 weeks.

24 Q And is postdates a risk factor for shoulder dystocia?

25 A Yes. I mentioned it today.

1 Q And this mom -- this baby was not postdate; true?

2 A True.

3 Q Indeed, this baby was preterm?

4 A Yes.

5 Q Okay. And is excessive weight gain a risk factor for

6 shoulder dystocia?

7 A It's in that DOPES, yes.

8 Q Right. And this mom's weight gain was about

9 12 pounds?

10 A I don't remember. I just know she weighed 241.8

11 pounds on the day of admission.

12 Q You just know excessive weight gain was not a risk

13 factor in this case?

14 A No. But you don't have to have all five of the DOPES

15 to have a risk of shoulder dystocia.

16 Q Right. But --

17 A If you have all five, it would be like wow, now,

18 you've really got to be on your toes as a nurse.

19 Q Right. And what we, also, have to do in addition to

20 examining the passenger, which you and I just did, a

21 practitioner, also, has to examine what they know about

22 the passage. Would you agree with that?

23 A Right. And we knew her history of a six-pound,

24 13-ounce baby, 35 weeks. The prenatal record, gynecoid

25 pelvis, meaning a female pelvis.

- 1 Q Okay. She had had a vaginal delivery before; true?
- 2 A Yes.
- 3 Q She had proven herself to six pounds, 13 ounces in
- 4 that prior vaginal delivery; true?
- 5 A Yes.
- 6 Q There was a physical exam done of her that showed
- 7 that she had a normal gynecoid pelvis?
- 8 A Yes.
- 9 Q Right. And in that same physical exam, it was shown
- 10 that they could not reach the diagonal conjugate. Do you
- 11 recall that?
- 12 A Well, now, you're asking for a doctor's opinion about
- 13 how they do pelvic exams.
- 14 So do you want me to provide a medical opinion?
- 15 Q I want to examine with you all the things that you
- 16 looked at so you could inform this jury about the risk
- 17 factors for shoulder dystocia.
- 18 Did you look at the fact that in the physical exam
- 19 where a doctor would be examining the passageway that she
- 20 could not reach the diagonal conjugate?
- 21 A It's on the prenatal record.
- 22 Q And after examining the passenger and examining the
- 23 passageway, we can, also, take a closer look at this
- 24 particular baby; true?
- 25 A Do you mean the baby outside the uterus or inside?

1 Q Inside the uterus.

2 A Yes.

3 Q And we do that, in part, by ultrasound; true?

4 A Well, doctors do that through their techs, or they do
5 the ultrasound themselves. But doctors do that, yes,
6 that's true.

7 Q And you're aware that this patient had an ultrasound
8 done nine days before delivery?

9 A Yes, on November 18th, right.

10 Q And you're aware that that ultrasound showed that the
11 baby, at that time, was about 3580 grams?

12 A Yes.

13 Q And that is about 7.9 pounds; true?

14 A Whatever it said. But, yes, it was not eight pounds,
15 but more than plain old seven pounds.

16 Q And you know, as a nurse, that we would anticipate
17 about a half pound a week?

18 A Yes, the average is. But she's a diabetic. So in --
19 just, in general, we say every week of the pregnancy at
20 that point forward, we expect the baby to gain a half
21 pound. But she's a diabetic with sugar. So, now, there's
22 a risk of an even bigger baby because she has that sugar
23 that's higher.

24 Q All right. And if she was 7.9 pounds nine days
25 before delivery, then we would estimate roughly eight and

1 a half pounds at delivery; true?

2 A Yes.

3 Q And, in fact, this baby was eight and a half pounds
4 at delivery; true?

5 A Yes.

6 Q All right. So, now, we've taken a look at the
7 passenger. We've examined all the risk factors. We've
8 got an estimated fetal weight. We've determined this baby
9 is likely to be 8.5 pounds. And, today, we know that,
10 indeed, this baby was 8.5 pounds. Would you agree, ma'am,
11 that that is not macrosomic?

12 A Based on a book. But we're missing one important
13 point about that ultrasound. And it's not just about the
14 weight. It's about the baby's belly, which reflects the
15 size of the shoulders was off the charts. And I did talk
16 about that in my deposition.

17 Q All right. And would you agree, ma'am, that there is
18 actual guidance from organizations about when we consider
19 C-sections under these circumstances? Are you aware of
20 that?

21 A I'm confused by your question. I don't mean -- I
22 don't know what you're saying.

23 Q Sure. That's no problem.

24 You are aware that organizations like ACOG, for
25 instance, provide us guidance on when we would consider

1 C-sections for patients like Alana Mann. Are you aware of
2 that?

3 A I think you're asking a medical doctor's opinion,
4 sir. And that organization is medical doctors.

5 Q And so you would be unaware that that organization
6 says that we would not consider C-sections in this
7 circumstance --

8 MS. RODRIGUEZ: Objection.

9 BY MR. ALEXANDER:

10 Q -- unless the estimated fetal weight is over
11 4500 grams?

12 A I --

13 MS. RODRIGUEZ: Objection, Your Honor. I'm not
14 sure -- she said she wasn't familiar with the guidelines.
15 She's not a physician.

16 THE COURT: Overruled.

17 THE WITNESS: If you would show me a document to
18 refresh my memory, I may or may not be able to answer your
19 question. But, off the top of my head, I'm not sure what
20 you're talking about.

21 BY MR. ALEXANDER:

22 Q Okay. This baby was set for induction preterm; true?

23 A Yes. She was admitted to induce the labor and soften
24 the cervix, and induce.

25 Q And that was, in part, because this mom was diabetic;

1 right?

2 A I don't know the thinking of the doctor's mind. I
3 don't know what they were thinking, so I can't speak to
4 why. But she was brought in. And she was being induced
5 before -- my -- I could talk about my experience with
6 diabetics. They often do come in before they're due
7 because there's a high rate of still birth. And so they
8 want to get them in when the baby's alive and not wait.

9 Q All right. Is it your testimony that whether or not
10 this induction is appropriate is beyond the scope of your
11 expertise?

12 A I would defer to a physician.

13 Q All right. Would you agree with me that the latent
14 phase of labor begins with regular contractions?

15 A In part. But you, also, have to have a change in the
16 cervix so it's opening and thinning.

17 Q Would you agree that the latent phase of labor is
18 often characterized by no cervical change, or very slow
19 cervical change?

20 A You have to have change. I mean, labor itself
21 involves contractions with change in the cervix. It's a
22 two-part definition for labor.

23 Q Would you agree with me that the latent phase of
24 labor can be as long as 20 hours in a first-time mom?

25 A It can be longer. Some women are in that early part

1 of labor for days. So it depends on the mom.

2 Q Would you agree that the latent phase can be greater
3 than 14 hours or more for a second-time mom?

4 A Yes. We would call it abnormal if it were more than
5 14 hours. But, sure, I mean, there are abnormal labors.

6 Q But you would agree this latent phase was not
7 abnormally long. Is that what you told me at your
8 deposition?

9 A Well, I can just look again at one of my exhibits
10 from my deposition, which is the labor curve I created.
11 Right, it was not abnormally long, the latent phase.

12 Q Okay. And when we induce women, they are not yet
13 having contractions; true?

14 A Some are, but they're not changing the cervix.

15 Q And in order to get their cervix more favorable, we
16 use drugs like Cervidil or Cytotec; true?

17 A Yes.

18 Q And in order to stimulate contractions, we use a drug
19 called Pitocin; true?

20 A Yes.

21 Q And that is commonly used in laboring patients that
22 are being induced; true?

23 A That are being induced, yes, true.

24 Q And the purpose of Pitocin is to strengthen
25 contractions; true?

1 A In part. It's for hypotonic contractions, so not
2 only to strengthen, but to cause them to be more often and
3 frequent.

4 Q Okay. Because we want to see if we can get mom to
5 sufficient power to deliver a baby?

6 A If they have hypotonic contractions, they need more
7 power, because you want to strengthen the contractions.

8 Q And the way we monitor the strength of those
9 contractions is with a device called an IUPC; true?

10 A That's one way. I brought an example of one here.

11 Q That is the standard of care for patients on Pitocin,
12 is it not?

13 A It's very reasonable, yes, to do that. It doesn't
14 always happen, but it, certainly, would not be below the
15 standard of care.

16 Q Certainly not. And IUPC's measure the intensity of
17 contractions in montevideo units, do they not?

18 A Not exactly. It measures the force of the uterus.
19 And then the montevideo is a calculation that a nurse can
20 make by looking at the wave form and -- I didn't show
21 that, but I could, if you like.

22 Q Right. We are measuring the power of those
23 contractions. And we get the power of those contractions
24 in a unit called montevideo units?

25 A Yes. I'd say that's reasonable.

1 Q That's right. And adequate montevideo units would be
2 somewhere in the neighborhood of 220 montevideo units;
3 true?

4 A No, sir. That's the power you need to push the baby
5 out. 95 montevideo units would be adequate labor, 95.
6 And when you get up to the 200, that's enough force if the
7 baby fits to push him out.

8 So 95 is the low. And some women, actually, go into
9 the 300s when they're pushing their baby out. And that's,
10 I think, why Dr. Shepherd said the goal is 220. Because
11 your goal, if the baby fits, is to get the power to push
12 the baby out. But that's not adequate labor. 95 is fine.

13 Q Okay. Did you see anywhere in this record where this
14 mom reached 200 montevideo units?

15 A No. And I can explain why.

16 Would you like me to explain?

17 Q Sure.

18 A Because Nurse Russell -- I'll do it with this
19 analogy. If I flex my muscle a lot, I can never get the
20 strength as if I'm lifting weight slowly, then you get
21 some power. But because she was given so much -- such a
22 high dose and the uterus was contracting so frequently,
23 they lost power. In fact, it created weaker contractions.
24 But they were close, so the baby still couldn't get enough
25 oxygen.

1 So, no, they weren't ever going to get there because
2 the nurse violated the standard of care.

3 Q Did you see anywhere in this medical record where
4 this mom was -- had a contraction pattern of 200
5 montevideo units for two consecutive hours without
6 cervical change?

7 A No, because of the violation of the standard of care.

8 Q If there was a safety rule that said that an arrest
9 disorder should not be declared unless there's been a
10 contraction pattern of 200 MVU's for two consecutive hours
11 without cervical change, do you think a provider should
12 follow that rule?

13 A Not necessarily. You have to look at the
14 circumstances that you're dealing with and who your
15 patient is. We don't just -- it's not a cookbook. You
16 take care of the patient.

17 Q Doctor [sic], what is a normal blood gas in a baby?

18 A Are you talking about from the umbilical cord or the
19 babies in the nursery?

20 Q Either one. Tell us about umbilical cord.

21 A Okay. So I teach nursing. And I've taught thousands
22 of labor nurses. And there are two vessels we would pull
23 from the cord with our syringe. And the color of the
24 blood is the only way you know you've got each one. One's
25 called the umbilical vein, and one is called the umbilical

1 artery. It's kind of opposite our bodies.

2 But the placenta delivers blood through the umbilical
3 vein to the baby. And the baby's blood goes back to the
4 placenta through -- there are, usually, two arteries. So
5 you have the oxygenated blood coming in and deoxygenated
6 blood going out.

7 So for the baby's blood -- see, if they pull it, then
8 depending on the study you look at -- but the PH should be
9 about 7.1 or higher. And the PCO2, which is the carbon
10 dioxide, we don't want to see it above 50. And the oxygen
11 is normally between 10 and 16 for the baby's blood, 10 and
12 16. And the base excess is zero to a minus 10. So
13 that's, more or less, what I've taught.

14 But the venous blood has different values. And so
15 you have to be sure you drew from each one. If you only
16 draw one sample, there's research that shows people make
17 mistakes because they didn't compare the color. And they,
18 more than likely, will draw from the vein and get the
19 placental function and not the baby. And they have to
20 compare the color.

21 Q All right. What was the cord blood gas that was
22 drawn in this case?

23 A Oh, I told you in my deposition, I don't memorize all
24 these records. So if you want to show me that, I can talk
25 about it.

1 Q Is it not important to your opinions what this baby's
2 status was at the time of delivery?

3 A Well, everything is important to forming my opinion.
4 This baby came out and had to be resuscitated, so -- and
5 the monitor strip predicted this baby would come out and
6 need to be resuscitated. Because, as I said, the baby's
7 heart rate rose up, up, tachycardic, abnormal, and then
8 fell down.

9 And the baby came out in a bradycardia and had to be
10 resuscitated. And the neonatal intensive care team came
11 in after the birth to resuscitate the baby. So, of
12 course, that's important.

13 Q Would you agree that babies heart rates decelerate at
14 the point of most vaginal deliveries?

15 A No, not in my experience. They come out screaming,
16 and I would expect that.

17 Q I'm talking about the heart rate on a fetal
18 monitoring strip. Would you agree that, typically,
19 there's a deceleration in the heart rate as the baby's
20 head and cord are depressed at the point of a vaginal
21 delivery?

22 A Possibly. It depends on the baby. Again, it depends
23 on the situation.

24 Q Okay. You --

25 A But oftentimes not. And they come out screaming.

1 Q And would you agree in a case like this where there
2 is shoulder dystocia that the interval in which this baby
3 was being deprived of oxygen was extended because of
4 shoulder dystocia?

5 A Well, it was about a minute and a half, based on
6 nursing notes, and a minute and 45 seconds, based on
7 doctor notes. So that in and of itself -- you know, if
8 the baby had come into that full of oxygen, which it
9 didn't, because Bethany didn't meet the standard of care,
10 then I'd expect that to be nothing. The baby would be
11 like holding its breath a little bit, come out and scream.

12 But there was this prolonged period of time due to
13 her violation of the standard of care where the baby was
14 cut off of its normal oxygen. Even though the mother had
15 oxygen on her face, it wasn't getting to the baby.

16 Q You would not have expected any deceleration in the
17 heart rate, despite the fact that the baby's head was
18 delivered for about a minute and a half and deprived of
19 oxygen during that time? Is that your testimony?

20 A No. It depends on the baby. This baby bottomed out,
21 I think, because she was so deprived. She was born with
22 acid in her blood, lactic acid.

23 Q And despite the fact that this baby had a prolonged
24 interval of the head delivering and the body did with cord
25 and head compression and deprivation of oxygen for, at

1 least, that minute to a minute and a half, the cord blood
2 gas was about 7.15, which you have described as,
3 essentially, normal; true?

4 A Sir, it's my opinion that they only had the one
5 sample. And it was probably as common in the mistakes
6 people make when they only draw one and don't compare the
7 color. It was probably venous. And we can't even say
8 with any scientific reliability that it was arterial,
9 because they didn't draw two samples.

10 Q Right. Because if that cord blood gas is true, then
11 the idea that this baby was hypoxic would be impossible?

12 A I'm totally confused by your question.

13 Q Ma'am, if that cord blood gas is true, ma'am, then
14 the idea that this baby was hypoxic for hours, and hours,
15 and hours prior to the delivery of the head would be
16 impossible?

17 A I'm totally confused by your question.

18 Q Ma'am, if this blood gas is correct, it is 7.15,
19 which is, essentially, normal, you would agree with me
20 that it is impossible that this baby was hypoxic for
21 hours, and hours, and hours before delivery?

22 A There are two different concepts. Hypoxia is about
23 oxygen and 7.15 PH, which is about hydrogen. So it's
24 apples and oranges.

25 Q Now, ma'am, you talked about risk factors for

1 shoulder dystocia. You would agree with me that
2 there are, also, risk factors for cesarean delivery;
3 true?

4 A I'll defer to a physician to talk about risks of
5 cesarean. That's a medical opinion, I think.

6 Q And I assume then you would never dare advocate for a
7 C-section delivery when you don't fully understand the
8 risks posed by a C-section?

9 A Nurses advocate for C-section delivery when there's
10 clear evidence to them that the baby is not fitting, or
11 the baby's heart rate is suggesting it's not going to get
12 any better, that is the baby is oxygen deprived. We're
13 going to advocate to the physician. But, ultimately, the
14 doctor has to decide are they going to do a C-section or
15 not. But we have to do what we can, as nurses, to protect
16 the patient.

17 Q And you're going to do that advocating without fully
18 understanding the risks of a C-section?

19 A We know that it's a surgery. It's major abdominal
20 surgery. And we participate in it and we circulate in it.
21 And, certainly, there are risks. But that's really the
22 doctor who decides.

23 Q You just advocate?

24 A We have to advocate. It's our duty to prevent injury
25 in the ways we can, and that's communication.

1 MR. ALEXANDER: Thank you, ma'am.
2 THE WITNESS: Thank you.
3 THE COURT: Redirect.
4 MS. RODRIGUEZ: The Court's indulgence.
5 (Pause.)
6 MS. RODRIGUEZ: No further questions.
7 THE COURT: Thank you.
8 You may step down, ma'am.
9 MS. RODRIGUEZ: May the witness be excused, Your
10 Honor?
11 THE COURT: Yes.
12 All witnesses are excused, unless there is an
13 objection made.
14 You may call your next witness.
15 MR. GRAHAM: Thank you, Your Honor.
16 The Plaintiff calls Dr. Yvonne Gomez-Carrion.
17 THE CLERK: Place your left hand on the Bible and
18 raise your right hand.
19 WHEREUPON,
20 YVONNE GOMEZ-CARRION, M.D.,
21 after first having been duly sworn, testified as follows:
22 THE CLERK: State your name, please.
23 THE WITNESS: Yvonne Gomez-Carrion.
24 THE CLERK: Thank you.
25 Please be seated.

DIRECT EXAMINATION

BY MR. GRAHAM:

Q Good morning, Doctor.

A Good morning.

Q Tell us, please, a little bit about your personal background. Where were you born?

A Saint Johns Hospital, Atlantic Avenue in Brooklyn, New York.

Q And where do you live now?

A Newton, Massachusetts, which is outside of Boston.

Q Do you have children?

A I do.

Q Tell us about your education and professional training, please, ma'am, starting with college.

A I attended Princeton University and got a degree in psychology. I graduated from Princeton in 1979. Then being from New York, I decided to go back across the bridge. And I did my medical school training at Columbia College of Physicians and Surgeons. I graduated from there in 1983. I was lucky enough to be matched and remain at Columbia Presbyterian Medical Center until I completed my residency training in four years in 1987.

Q Thank you.

What have you done since 1987?

A A lot. My medical school training was, actually,

1 paid for by the Government. I was in the National Health
2 Service Corp. So after completing my residency training,
3 I had to go to a physician site where there was a
4 shortage. And I was told that I could go to Alaska, a
5 prison in upstate New York, and some place in the rural
6 south. And none of those -- being an only child, my mom
7 and I had a pretty close relationship. I needed to be
8 more accessible.

9 So with the help of Senator Edward Kennedy, may he
10 rest in peace, I kept plotting where infant mortality was
11 highest at that time. Again, this is 1987. And Newark,
12 New Jersey, Roxbury, Massachusetts, came up. And I
13 thought, um, Roxbury, Massachusetts. I had heard a lot
14 about Boston and its history and was very curious. So I
15 thought three hours from New York, I could do this.

16 So I took a job at the Roxbury Comprehensive
17 Community Health Center. And I owed them four years. I
18 was accepted at the Beth Israel Deaconess for a place to
19 deliver my babies and do all my surgeries. But I loved
20 the work at Roxbury Comprehensive so much that my
21 four-year commitment -- I was there for 11 years.

22 After 11 years, my practice grew to the extent that I
23 was asked to serve not just patients coming to the health
24 center -- and those are mostly poor women, women of
25 color -- but folks from the suburbs wanted to receive my

1 care as well. So the hospital, actually, moved my
2 practice to a place called Jamaica Plain, which is between
3 Roxbury and where I am now, so I would have -- more
4 patients would have access to my care.

5 So I was in Jamaica Plain from 1998 to 2003. And,
6 again, my practice did another growth and became too busy
7 for that practice. So then I was shipped -- or, actually,
8 recruited to -- I call it the mother ship. I'm, actually,
9 housed at the Beth Israel Deaconess Medical Center
10 presently.

11 Q Okay. And what relationship, if any, is there
12 between Beth Israel Deaconess Hospital in Boston and the
13 Harvard University School of Medicine?

14 A Well, we're a teaching hospital for Harvard Medical
15 School. And that's one of the reasons why I, actually,
16 stayed as an attending at Beth Israel Deaconess. I've
17 been there now 26 years. Because one of the things that
18 really jazzes me is not only learning myself and my
19 personal growth, but teaching others, teaching the medical
20 students that come through, and teaching residents.

21 And, now, I'm considered a senior attending. So I
22 have the opportunity to teach younger attendings as well.
23 So I'm able now to pay forward what I received. And that
24 just brings me lots of professional satisfaction.

25 Q In terms of your work as an attending, is that in a

1 traditional classroom setting with the teacher giving
2 lectures, or is that a different type of instruction?

3 A In the earlier years, I would, actually, go to
4 Harvard Medical School and teach. But I am the type of
5 person who likes teaching hands on. So I teach in labor
6 and delivery.

7 There's a room we go into to talk about the various
8 emergency obstetrics, including, you know, preeclampsia
9 that can lead to eclampsia where a woman, actually,
10 seizes, or dealing with how you safely deliver a baby
11 whose mom has been diagnosed with shoulder dystocia,
12 because that is an obstetrical emergency, or how you deal
13 with a woman who has a postpartum hemorrhage. All these
14 things you have to really think about quickly on your feet
15 to maintain safety of mom, baby, or babies. So I do a lot
16 of hands-on teaching there.

17 Also, I am probably the busiest benign gynecologic
18 surgeon. So I do a lot of teaching in the operating room
19 as well, and teaching in the clinic.

20 Q Are you board certified?

21 A I am, sir.

22 Q In what field?

23 A Obstetrics and gynecology.

24 Q As of what date?

25 A I was officially inducted, I guess, in 1990.

1 Q What does it take to become board certified as an
2 obstetrician?

3 A A lot of blood, sweat, and tears. So, basically,
4 after completing a residency training, you are out and
5 practicing. And you are instructed to collect cases for a
6 year, so every patient you've come in contact with. You
7 have to have a certain number of outpatient, including
8 normal and high risk pregnancies, and surgical cases.

9 So you collect these cases for a year. You then
10 submit it to the college and reviewers to look at your
11 case list. And they decide whether you have done enough
12 work to, actually, be able to sit for your three-hour oral
13 exam.

14 So I submitted my case list. It was accepted the
15 first time around. And I got to go to Chicago in 1990 to
16 have my three-hour oral exam with three different
17 examiners. And passing that on the first time, I then was
18 deemed board certified.

19 Q Where do you, currently, hold a medical license?

20 A In Massachusetts.

21 Q And what -- do you have privileges at a local
22 hospital there?

23 A Just at Beth Israel Deaconess Medical Center.

24 Q Over how many years have you been involved with
25 teaching obstetrical residents?

1 A Well, I, actually, was involved with teaching
2 residents when I was a resident. I happen to have been
3 chief resident in 1987. And chief resident in 1987 is a
4 little different from now. Now, everyone gets to rotate
5 through that responsibility. In 1987, when I was chief,
6 your other residents had to elect you to become chief
7 resident.

8 So I did a lot of teaching when I was a chief
9 resident.

10 Q Have you received awards with respect to your
11 practice of obstetrics, and your teaching activities?

12 A I've received many awards. Pretty much over the last
13 three years, I've received teaching awards from the
14 residents.

15 Q Do you have experience with work involving quality
16 assurance of hospitals and obstetricians?

17 A I do. I, actually, sat on the Maternal Morbidity and
18 Mortality Committee of Massachusetts for a number of years
19 looking over all the ways to improve access to care in
20 Massachusetts and, also, looking at all the maternal
21 deaths, unfortunately, that occurred in the years that I
22 served. And we, actually, had a paper come out of that
23 work in terms of the safety of vaginal birth and for
24 cesarean delivery, and all the other challenging cases
25 obstetricians face.

1 I've, also, multiple times, been a member of the
2 quality assurance committees. There are triggers that we
3 look for to make sure that a woman is getting safe care in
4 the hospital.

5 In obstetrics, we look at things -- like you'll hear
6 us say we cut an episiotomy, which is when the baby's head
7 is coming out and you, actually, take a pair of scissors
8 and cut the perineum to make the opening of the vagina
9 wider. Well, when that extends to more than what you've
10 cut, for example, a fourth-degree extension, that means
11 what you've cut has gone into a woman's rectum. So that's
12 a trigger that will make us look at a chart.

13 Or if someone has been discharged home and are called
14 back for an admission, what brought this woman back? Was
15 there a way we could have provided safer care? Or someone
16 has had so much blood loss during a delivery that she
17 required a transfusion.

18 Another trigger to -- you know, we just gather all of
19 these charts to look at. There may not have been anything
20 in terms of breaching a standard of care. But if there is
21 an area that we identify, then hospital policy can get
22 changed. And it has changed in our institution.

23 I now, over the last decade, have, actually, sat on
24 the executive committee. So that's a step above the
25 quality assurance.

1 On the executive committee, you, actually, review the
2 charts where there was a breach of the standard of care.
3 And when there was a breach, our challenge or charge is to
4 come up with how to help the physician. If there's a
5 trend in a particular physician's practice, not only
6 addressing the ramifications to the patient, but, also,
7 trying to help the physician to whether it's additional
8 education, training, how do you make this physician better
9 and safer.

10 Q Doctor, I'm going to hand you your curriculum vitae.
11 Can you identify that document?

12 A It's an older curriculum vitae of myself.

13 Q Okay.

14 A It's dated January of 2011.

15 Q I saw that. And that's the one I was handed. So
16 here I am with this one.

17 A No problem.

18 Q But let me ask you, Doctor. What needs to be added
19 to this to make it current and accurate, as of today's
20 date?

21 A Just a number of awards.

22 MR. GRAHAM: We offer that, Your Honor.

23 THE COURT: Okay. It's in evidence.

24 (WHEREUPON, Plaintiff's Exhibit No. 3 was marked for
25 identification and admitted into evidence.)

1 BY MR. GRAHAM:

2 Q Let me ask you a specific question or two about your
3 background. With regard to the practice of medicine,
4 generally, how long have you been an M.D.?

5 A Well, that includes being a resident. So I've been
6 an M.D. for 30 years.

7 Q And how long have you been engaged in practicing the
8 specialty of obstetrics and gynecology?

9 A Well, if you're including my four years of residency,
10 still 30 years.

11 Q How would you describe your knowledge and familiarity
12 with the generally-accepted obstetrical standards of care
13 with regard to risks of a pregnant woman encountering
14 shoulder dystocia?

15 A Very familiar.

16 Q How -- please describe your knowledge and familiarity
17 with generally-accepted obstetric standards of care about
18 the safe management and resolution of shoulder dystocia.

19 A Very familiar.

20 Q Describe your knowledge and experience in terms of
21 the available safety maneuvers to resolve shoulder
22 dystocia without injury to the baby.

23 A Very familiar.

24 Q What role does safe management of shoulder dystocia
25 have in terms of your teaching activity?

1 A I spend a lot of time teaching residents and medical
2 students risk factors for shoulder dystocia. Once you
3 encounter shoulder dystocia, how to safely resolve it and,
4 also, improving ways to communicate. And that starts
5 before you encounter the delivery, particularly, if we're
6 going to talk about Ms. Mann. She had several risks for
7 having shoulder dystocia. So the communicative process
8 would have happened before she even got to the pushing
9 stage.

10 Once she was pushing and you thought, oh, delivery is
11 going to happen between five minutes and 120 minutes,
12 probably, you want to make sure your team is all on the
13 same page. You want to make sure that everyone is sharing
14 that same mental model that this is a patient who is at
15 high risk for a shoulder dystocia. When the baby's head
16 comes out, we need to all be there to support.

17 Particularly, a resident who had never resolved a
18 shoulder dystocia, you want to support your resident. You
19 never want to have a resident feel that, in this case, she
20 is out there on a limb. You want the attending there,
21 possibly, the chief resident. But, certainly, you want
22 someone at the delivery with the resident teaching, and
23 guiding, and making sure that, you know, she is learning,
24 but, also, you have a patient -- two patients that you
25 want to keep safe.

1 You, also, don't know how this baby is going to come
2 out. So you don't want to have to call the NICU once the
3 baby is delivered. You want the NICU present. You want
4 an additional nurse present. It's like all hands-on deck
5 when you have a woman who has such high risks for shoulder
6 dystocia and possible difficult delivery.

7 Q Doctor, in your career, how many babies have you
8 delivered hands on?

9 A I haven't really counted. But if you multiply 30 by
10 250 a year, it's over 8,000 babies.

11 Q And how many babies' births have you supervised?

12 A Not as many. But I do a lot of -- I'm at a teaching
13 hospital. So the residents are with me often because they
14 say I'm a good teacher. So I do hands on with them,
15 particularly, if they're a first- or second-year resident.

16 But, as an attending, you get to know the skill set
17 of the resident you're with. So as I do more and more
18 deliveries with my residents, I know when to pull back and
19 just have -- in my hospital, there are only female
20 residents. So I know when to pull back to allow her to
21 kind of manage the delivery.

22 But if I have any inkling -- you know, if we have a
23 shoulder dystocia and she's recognized it, or maybe she
24 hasn't, I'm there to make sure that the patients remain
25 safe. And if it is a shoulder dystocia, we'll go through

1 maneuvers together, depending on whether this is the first
2 time or maybe this is the hundredth time this resident has
3 been with me in trying to resolve a shoulder dystocia.

4 If the resident -- for example, a chief resident has
5 seen a number of shoulder dystocias. If I feel that
6 person has skills to facilitate a safe delivery, I will
7 just stand there. But, again, if there's any sign that
8 excessive traction is being used that could potentially
9 harm the nerves coming out of the spinal cord controlling
10 the shoulder, hands off, take a deep breath, and let's do
11 the maneuver safely.

12 So there's constantly a check and balance there. You
13 have time. So there's no need to rush to resolve a
14 shoulder dystocia.

15 Q In your thousands of deliveries, how many times have
16 you encountered shoulder dystocia?

17 A Many. Because I deal with a patient population that
18 is obese, diabetic. I probably deal with more shoulder
19 dystocias than you hear in the quotes from the national
20 statistics. Anywhere from three to five percent in my
21 practice, I've encountered shoulder dystocia. So that's
22 hundreds of babies over the last 30 years.

23 Q With that many encounters of shoulder dystocia, how
24 many times have you delivered a baby with a permanent
25 brachial plexus injury?

1 A Never.

2 Q What do you attribute that to?

3 A I attribute that to the practice of good medicine. I
4 attribute that to being able to listen to the signals that
5 a woman's body and a patient is giving me. I attribute
6 that to knowing when to ask for help. There's so many
7 factors.

8 Safety is paramount in what we do as physicians.
9 That's why we do have standards of care. And that's why
10 it is so important that if you are at the beginning of
11 your learning curve that you have someone there that can
12 support you and make sure you're safe, and that the care
13 you're delivering is safe.

14 Q No permanent injuries, but what about temporary
15 injuries? Have you ever had a baby with a temporary
16 brachial plexus injury, even if for a very short period of
17 time?

18 A I have.

19 Q How many times?

20 A A couple of times when I was a young attending. And,
21 again, I was there -- I'm the attending. The buck stops
22 with me. And I was there alone.

23 And, at the time, I did not appreciate the fact that
24 I was using more than my standard amount of traction. And
25 when I was delivering this baby, I kind of had an idea,

1 but I thought it was safe to apply more traction. And
2 when I delivered, it was two, three babies in the first
3 couple of years of being an attending. These babies came
4 out, and I could tell there was a difference in the way
5 the shoulders were moving. Luckily for me, and thank God
6 for the baby, that temporary discordance in strength of
7 the babies' arms resolved very quickly. It resolved
8 pretty much before the babies -- the labor and delivery.

9 But I learned a lot from those experiences that made
10 me think, okay, how much traction did I use. And, now, I
11 am setting up this framework that I know when I'm
12 delivering a baby, if I feel resistance, I now know from
13 those babies, who taught me a lot, not to go beyond that
14 point. And I have to be careful because I have incredible
15 upper body strength.

16 So I always have to be cognizant when I'm just
17 assisting a baby and I feel resistance that I must stop.

18 Q Well, interesting point, you're a petite lady.

19 A Oh, yeah, but I'm strong.

20 Q What do you do to stay fit?

21 A I lift weights. I am not able to do exercise that
22 most folks do because I played pretty high-level
23 volleyball when there weren't appropriate pads. So I now
24 have pretty bad arthritis in my knees. So I can't do the
25 standard walking and jogging. So I do a lot of chair

1 exercises and lifting weights. So my upper body is much
2 stronger than my lower body, unfortunately.

3 Q What about Pitocin? What's your familiarity with the
4 safety rules and standards of care about safe use of
5 Pitocin?

6 A I'm very familiar.

7 Q What about the need for a doctor to change the plan
8 of delivery from vaginal birth to caesarian section? Are
9 you familiar with those safety rules?

10 A Very familiar.

11 Q Let me ask you about the roles of a labor and
12 delivery nurse, residents one, two, three, four-year
13 residents, and the attending in a teaching hospital. Are
14 you familiar with those roles, and how there's a chain of
15 command, and different responsibilities for each member of
16 the team?

17 A Yes.

18 Q Let me ask you about your experience as an expert
19 witness. Have you from time to time before this case
20 agreed to review issues in a medical legal case involving
21 birth injuries?

22 A Yes.

23 Q Okay. When did you start doing that?

24 A I started very slowly back at the end of the 1990's.

25 Q Have you previously been qualified to serve as a

1 testifying expert witness in court?

2 A Yes.

3 Q In which states?

4 A In Connecticut, Massachusetts, New Hampshire. I

5 believe that's it.

6 Q Okay. North Carolina?

7 A I'm sorry. North Carolina, yes.

8 Thank you.

9 Q South Carolina by videotaped deposition?

10 A Right, yes.

11 Q Have you ever been found by a court to not be

12 qualified to testify as an expert witness?

13 A No, I have not.

14 Q Have you reviewed the medical records in this case

15 relating to the prenatal care, and the labor and delivery

16 of **J.B.**?

17 A Yes, I have.

18 Q Have you read the depositions of the labor and

19 delivery nurse, the residents, the attending?

20 A Yes, I have.

21 MR. GRAHAM: Your Honor, at this point, I would

22 proffer Dr. Gomez-Carrion as an expert witness about the

23 various subjects mentioned above, medicine, obstetrics,

24 and the related areas of obstetrics.

25 THE COURT: Any voir dire?

1 MR. ALEXANDER: No, sir. No objection.

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

3 Yes, sir.

4 MR. GRAHAM: Thank you, Your Honor.

5 BY MR. GRAHAM:

6 Q Dr. Gomez-Carrion, please, tell us what you consider
7 to be the proper ethical approach to serving as an expert
8 witness on a case like this.

9 A Well, the proper ethical approach would be to receive
10 the necessary documents in order to form an opinion. So
11 you want to receive the medical records that are pertinent
12 to forming your opinion, and any pertinent depositions.
13 You want to read them in a very objective manner with no
14 preconceived notions. And you request any information
15 that may be lacking in order for you to come up with an
16 objective opinion.

17 Q And what state of mind do you believe you should
18 bring to the case before you review any of those records?

19 A An objective state of mind, non-biased.

20 Q Have you from time to time reached opinions in favor
21 of the company or attorney who hired you, and other times
22 against the interest of the company or attorney who hired
23 you?

24 A Yes. I've testified for both plaintiff and defense.

25 Q Have you -- have I from time to time sent you files

1 and asked for your objective candid opinion?

2 A Yes, you have, sir. And I've said there was no
3 breach of the standard of care in a number of the cases
4 that you've sent me.

5 Q When is it acceptable for a medical doctor to
6 needlessly endanger a patient?

7 A It's never acceptable.

8 Q Is that a voluntary guideline, or a mandatory rule?

9 A It's both, but it's a rule. I mean, we took the
10 Hippocratic oath as physicians to do no harm. And I
11 believe most physicians take that very seriously. I know
12 I do.

13 Q How long have you known that?

14 A I knew that while I was a medical student. Actually,
15 I knew that in college. I studied -- some of my courses
16 went into why we have to take the Hippocratic oath.

17 Q Do you consider the principle about never needlessly
18 endangering a patient to be important?

19 A Very.

20 Q Why is that?

21 A Again, you don't want to do harm. I can't -- you
22 know, I'm finding it difficult to even answer your
23 question because as a health care provider, as a healer,
24 people who are in various states of vulnerabilities come
25 to us to guide, to deliver the most -- upmost safe and

1 excellent care. And if we don't take that seriously, we
2 can do harm. And that's why there are safety rules.

3 Q What types of dangers would folks in our community --
4 patients in our communities in this state face if medical
5 doctors could needlessly endanger patients and cause harm
6 without being held accountable for the harm they caused
7 from needless endangerment?

8 A Well, I think we would be in a true state of chaos.
9 That's not to say that the medical system is a hundred
10 percent safe. We know all the issues. Because if you're
11 listening to the news today, Obamacare and all that, and
12 trying to increase access to care.

13 But just imagine you're going to your healthcare
14 provider with a bleeding ulcer and they go, oh, you'll be
15 fine, and you bleed out and die. Or you go to a
16 gynecologist with an atopic pregnancy, a pregnancy that's
17 in your fallopian tube, and it causes the tube to rupture,
18 you now bleed internally and you die --

19 MR. ALEXANDER: Judge, could I make an objection on
20 the basis of relevance, please?

21 THE COURT: Sustained.

22 BY MR. GRAHAM:

23 Q Doctor, if a medical professional -- medical doctor
24 has two possible courses of conduct available to him or
25 her, both readily available, and one of them is safe, but

1 the other one involves some risk of harm to the patient,
2 which course of conduct must the doctor follow?

3 MR. ALEXANDER: Same objection, without foundation.

4 THE COURT: Overruled.

5 THE WITNESS: You must choose a safe course.

6 BY MR. GRAHAM:

7 Q Why is that?

8 A You want the best outcome for your patient with the
9 least risks.

10 Q If a doctor chose a course of action that involved a
11 risk to the patient when there was a safe alternative,
12 would that needlessly endanger the patient?

13 A Yes, sir.

14 Q I know -- I'm anxious to get ahead and ask for your
15 opinions. But before we do that, Doctor, let me make sure
16 we have a basic understanding of certain medical words and
17 phrases.

18 First of all, in an OB teaching hospital, what is the
19 role of the labor and delivery nurse?

20 A Well, that is an incredibly important role. A nurse
21 is the person who is at the patient's bedside most of the
22 time. And, particularly, in labor and delivery, the nurse
23 is the patient's advocate.

24 The nurse has a relationship with the physician and
25 takes the orders from the physician. And if she has any

1 questions, a nurse has a voice. The nurse has the ability
2 to question any order that is presented to her. And it's
3 her charge to make sure that the care she is involved with
4 in rendering to the patient is safe.

5 And her job, also, is to make sure that the patient
6 understands the reason for doing certain things. You
7 know, why are we increasing your Pitocin? Why aren't we
8 doing other things?

9 So often, a patient who may not understand the
10 actions of the physician, or physician assistant, or
11 resident, the nurse is kind of the in-between to make sure
12 the patient understands, but, also, carrying out her job
13 or his job, although labor and delivery is mostly her --
14 her job in terms of following through with the orders from
15 the caring physician.

16 Q What about -- the residents years one through four,
17 what are their roles?

18 A Well, residents are physicians. Residents, depending
19 on their level, though, require supervision. And that's
20 in any teaching hospital, even a chief resident.

21 Because the purpose of a residency training program
22 is that you're being trained. And the person who is in
23 the best position to train you is the person who's
24 completed the residency program, and that's the attending.
25 But the resident, often, is the person who's constantly

1 looking at the monitor, constantly examining a patient.
2 But that resident, if the attending is not physically
3 present, needs to be in a very thorough objective way
4 presenting the data of what's going on with the patient.
5 And the attending, particularly if it's an intern, or
6 family practice, or even a second-year who's not had a lot
7 of experience in simple situations, it's the attendings
8 responsibility to be there.

9 And I know we're going to talk about the specifics of
10 this case. But depending on the risk of the patient, you
11 shouldn't have to call the attending to oversee. The
12 attending in a teaching position has to not miss the
13 opportunity to teach. But if you're not present, you
14 can't teach. You can't guide. You can't assure that the
15 environment is safe for not only your patients, but for
16 your residents.

17 Q Doctor, can you explain what is a normal spontaneous
18 vaginal delivery without complications -- or, actually,
19 have you -- do you have available for us to show --

20 A I think there -- yeah. There's a video clip that
21 beautifully illustrates a normal spontaneous vaginal
22 delivery.

23 Also, we have a pelvis and a baby that I can show you
24 the maneuvers in order to facilitate a safe and normal
25 vaginal delivery.

1 Q As we watch this, feel free to comment.

2 A Of course, the pelvis. The uterus or womb, the house
3 of the baby. The amniotic sac, in this case, the
4 membranes are still around the baby with amniotic fluid.
5 That's the pubic bone, also, known as the pubic symphysis.
6 That's the tailbone, also, known as the coccyx.

7 So there's a lot in the pelvis. The baby has to
8 undergo internal rotation, expulsion, external rotation.
9 And you see it didn't get caught up anyway -- anywhere.
10 It kind of very naturally gradually was expelled from the
11 house.

12 Q Now, let me ask you about shoulder dystocia. You,
13 also, have --

14 A I do. There's a video clip.

15 Q -- a still image of shoulder dystocia?

16 A So -- and there wasn't --

17 Q Let me give you this pointer. I'm sorry about that.

18 A No problem. I'm not sure I know how to use it.

19 Q It's the green --

20 A But I don't see anything.

21 Q I'm sorry. Let me see.

22 A Technical problems this morning.

23 Q Let's try the red one.

24 A Thank you.

25 Okay. So you have a fetal head, the baby's head.

1 And just as you saw in the normal vaginal delivery, this
2 is the womb. You see the placenta and the cord coming to
3 the baby, the coccyx or tailbone. This is the pubic bone.

4 So if you touch right in front, it's a pretty hard
5 bone. And you can see in this picture, the baby should
6 have had internal rotation. And it's becoming -- the
7 expulsion process is happening. But, in this depiction,
8 you can see where the shoulder is caught up on the pubic
9 symphysis. And at the time of delivery, you have your
10 hands on the baby's head.

11 And then, at this point, you do feel that resistance.
12 And it's up to the delivery provider to diagnose that you
13 have a shoulder dystocia.

14 Q Is shoulder dystocia a true medical emergency?

15 A Absolutely. Because you have a limited amount of
16 time in order to get this baby out. Most babies, when
17 they're being expelled from the womb, there is cord
18 compression. And once you have compression of the cord,
19 you have either decrease in blood flow taking oxygen to
20 the baby, or you could have a total cut off.

21 And depending on where your baby is reserve-wise
22 prior to this point will determine how much time you have.
23 But, typically, in a baby that has a reasonable fetal
24 heart rate tracing, no meconium, you have a number of
25 minutes to get the baby out safely.

1 Q Are obstetricians expected to handle such emergencies
2 without injury to the baby?

3 A Yes, sir. That's part of the residency training
4 program.

5 Q All right. Does that apply to the attending?

6 A Well, the attending went through the residency
7 training program. And this is one of the areas that we're
8 constantly going over. Because, as we know, women can
9 have risk factors.

10 So you have a high -- you appreciate that this
11 patient in front of you may have a shoulder dystocia. But
12 you can have a woman having a five-pound baby and
13 depending on how the baby is coming down or the anatomy of
14 a woman's pelvis, she, too, can have a shoulder dystocia.
15 So it's an obstetrical emergency.

16 But often, it's unpredictable. So it's always on our
17 radar. Every time we do a vaginal delivery, you know that
18 the baby's shoulder can get stuck. So you have to always
19 be ready for action, so to speak.

20 Q When a resident is in a situation to deliver a baby
21 where there's shoulder dystocia encountered, is the
22 resident held to the same safety rules and the same
23 standards of care as an obstetrician?

24 A Well, the resident is an obstetrician. And the
25 answer to your question is yes.

1 Q Okay. Does a resident -- does a relatively new
2 resident like a second-year resident get a pass from being
3 held accountable for harm caused when a shoulder dystocia
4 management is mishandled?

5 A No, sir.

6 Q Okay. What about any experienced level resident?

7 A Again, as in my case, if I had had a permanent injury
8 with those couple of babies I delivered because I exerted
9 excessive traction, I would have been held responsible for
10 that if they had a permanent injury.

11 It doesn't matter where you in your training are.
12 You can be a chief of the department and, for whatever
13 reason, pull too hard and get an injury. You are held
14 responsible for that injury.

15 Q What if it's a resident who causes the injury by too
16 much traction down on the baby's head toward the left
17 shoulder and the attending is not in attendance? What
18 responsibility, if any, does the attending have in that
19 situation for the harm done?

20 A Well, the attending is responsible. The attending is
21 the person responsible for the safe care of the patient
22 that's admitted under him or her. And if an attending was
23 not present, particularly in a case like this when you
24 know you have a high risk patient, you know she's at high
25 risk for shoulder dystocia, you know she's had a prolonged

1 labor, you know that she's now pushing, and the only
2 person available at her delivery is a new second-year
3 who's never dealt with a shoulder dystocia, that's a
4 breach of the standard of care. That attending is
5 responsible.

6 Q Are there some normal spontaneous vaginal deliveries
7 without any complications and without any emergencies that
8 you really don't need a doctor to handle?

9 A Well, as a physician, of course, you need a doctor to
10 handle it. But in my 30 years, I've had patients on labor
11 and delivery having their second baby. And I go in the
12 room and I examine the patient. She's eight centimeters.
13 I say, okay, I'll be right back, I need to get a little
14 glass of water. I go back in and the baby is out, you
15 know.

16 So our job, as a physician, is to try to be readily
17 available. But babies have a mind of their own. They
18 sometimes don't follow what's written in our textbooks.
19 And that's why nurses are important.

20 Because the nurse was at the bedside, baby pops out.
21 And the nurse prevented the baby from rolling off the bed.
22 But those things -- you try not to experience that, but
23 there are things that are beyond our control. But you
24 have to be really in tune to what your patient is doing at
25 the time.

1 Q When is an obstetrician truly needed? In all
2 deliveries, or when there's an emergency?

3 A In all deliveries. Because, luckily, most deliveries
4 go just fine without complications. But in obstetrics --
5 and that's why many of us are on anti-hypertensive
6 medications or anti-anxiety medications.

7 In obstetrics, things can be going just fine and
8 within seconds, not so fine. You can have a placenta that
9 shears from the wall of the uterus. You can have a baby
10 who has a shoulder dystocia.

11 So you always -- that senior person has to always be
12 around in an event that something unexpected is going to
13 happen. Because, again, your charge is, particularly an
14 obstetrician, to make sure your patients are all safe.

15 Q Let's talk about the risks of shoulder dystocia that
16 present to the healthcare providers in the prenatal
17 period, before the hospital admission for actual labor and
18 delivery. What are some of those risks factors?

19 A Well, I'll -- just, generally, having a history of a
20 prior shoulder dystocia puts you at risk. Having a big
21 baby puts you at risk.

22 So, therefore, if you're a diabetic mom, most
23 diabetic mothers have big babies. If you've gone past
24 your due date, again, as the weeks go by in the woman's
25 pregnancy, the baby is gaining, normally, a half to

1 three-quarters of a pound a week. In a diabetic mom, that
2 can be more.

3 Q What about -- after the mom is admitted to the
4 hospital for labor and delivery, are there any additional
5 warning signs or risks factors that can occur during
6 labor?

7 A Sure. But another big risk factor for shoulder
8 dystocia is maternal obesity, excessive weight gain, as
9 was discussed earlier.

10 Once a woman is in labor, then you're now looking at
11 the progress, what the muscle is doing, the force of the
12 uterus, and how is the baby and cervix dealing with the
13 contractions of the uterus.

14 So, particularly, in this case, you had hours and
15 hours of Pitocin with no significant change in a woman
16 who's already had a baby. Granted, that baby was smaller.
17 But the expectation for someone who's had a baby before is
18 that she's going to progress normally. At least, when
19 she's in active phase labor, you expect her to dilate one
20 centimeter an hour.

21 And I know we have this chart where it showed that
22 she was on -- this patient was on Pitocin. And, at 12:10,
23 both examined by nurse and physician. This mom was
24 anywhere between five and six centimeters --

25 Q Excuse me, Doctor. Let me interrupt you just a

1 moment. You're referring to a chart none of us can see.
2 Is this that chart?
3 A That is the chart.
4 Q Let me get you, if you would, to step down here and
5 explain to the ladies and gentlemen what you're talking
6 about.
7 A (Witness complied.)
8 Q Okay. Or which is easier for you?
9 A To sit. Now, I have my pointer, it's easier.
10 Okay. So this is a chart that shows the nurse's
11 progress notes, and the doctor's progress notes, the times
12 of the exams, the dilation by the nurse, dilation by the
13 doctor. The station is where the baby's head is in
14 relation to bony landmarks in the pelvis. We call
15 engagement at zero station. So this baby was high in the
16 pelvis -- and who the notes were written by.
17 And if you look at this, at 12:10, 12:15, both nurse
18 and physician stated this patient was somewhere between
19 five and six centimeters. Typically, that's active phase
20 labor.
21 But, as time goes on, she's now two hours later, four
22 hours later, six hours later, eight hours later, 10 hours
23 later. And in someone who's had a baby before, she's gone
24 one and a half centimeters in 10 hours. That is an
25 abnormal labor curve.

1 Q All right. Let me ask you about this one, Doctor.
2 The green spot right there, five to six at 1:45. This is
3 Dr. Merritt. If I remember, he's the chief resident. And
4 Dr. Shepherd, who had gone before him, was the first-year
5 resident. What significance do you place on Dr. Merritt
6 saying five to six after Dr. Shepherd had been saying six
7 to seven?

8 A Well, there is interexaminer variation. We know that
9 my five centimeters -- if you were an obstetrician, your
10 four centimeters could be my five centimeters. So we
11 allow for a little difference in exams.

12 But it's interesting that -- now that you pointed
13 that out, if you go by Dr. Merritt's exam, who is a more
14 senior resident, this woman has not changed her cervical
15 dilation at all in eight hours. So that's a true
16 definition of arrest of cervical dilation. And when a
17 woman stops dilating, you, as the obstetrician, have to
18 ask why is that. She's not dilating and the baby is not
19 coming down.

20 It's interesting the baby, according to Dr. Floyd,
21 who I believe was a family practice residence, stated that
22 the baby was at minus two. And then when the OB residents
23 took over the exam, the baby, actually, went up higher.

24 So, now, not only do you have a cervix that's not
25 opening, you have a baby that's not coming down on lots of

1 Pitocin with mom having lots of contractions. So you, as
2 the obstetrician, have to step back from this picture and
3 go, okay, is there a problem here? Is there not enough
4 force? And why isn't there enough force? Because I'm
5 giving this woman all this Pitocin.

6 If there's no significant change in someone who's had
7 a baby before, something is not quite right. Either the
8 baby is too big, mom's pelvis is not large enough. You
9 have that cephalic head pelvic disproportioned.

10 And, at some point, you have to recognize that this
11 is not working. And although she's a Jehovah's Witness --
12 and we're talking about the patient, Jehovah's Witness,
13 she's obese, she's diabetic. We know there are risks to
14 surgery. But if you keep on this track, not only are you
15 putting mom at risk, you're putting baby at risk. So, at
16 some point, you, as an obstetrician, need to make the
17 call. We need to end this.

18 But the problem here, if you look at the far right
19 column, none of these folks have the ability to call a
20 cesarean section. They're all residents and nurses.

21 So where is the attending? I looked in the chart,
22 looking at the documentation, the attending was talking to
23 the patient about increasing the Pitocin. The attending
24 was talking to the patient about why she wasn't dilating
25 in the fashion that she should have been. And I didn't

1 see any of those notes. I didn't see any documentation
2 that the attending was involved in this high risk patient
3 at all.

4 Q Throughout this period of time, from 128 through
5 160 --

6 A Well, the times are here.

7 Q I'm sorry. Those are the page numbers.

8 A That's why I looked there.

9 Q From 12:10 p.m. to 12:15 a.m., approximately 12 hours
10 later, did you see any indication in any record or
11 deposition that the attending was in attendance?

12 A No, sir.

13 Q Throughout any period of time from the initial
14 administration of Cytotec and Pitocin, through the
15 delivery of this baby and the injury to the nerves, did
16 you see any indication in the medical records or the
17 depositions that the attending was ever in attendance?

18 A No, sir.

19 Q Show us, please -- you mentioned about dilation.
20 Show us, please, what five to six centimeters of dilation
21 looks like.

22 A Probably about like that.

23 Q Okay. And show us what complete dilation is.

24 A Probably more like that.

25 Q And, again, what is the significance of the cervix

1 not opening up?

2 A Well, if the cervix is not opening up in someone
3 who's had a baby before and is theoretically in active
4 labor, you're giving her large amounts of Pitocin, that
5 speaks to cephalopelvic disproportion. That's speaks to
6 the point that this baby is telling you I'm having
7 problems negotiating my mom's pelvis, I need help getting
8 out. Right -- you know, you want to intervene while your
9 baby is safe and well, as mom is safe and well.

10 Q All right. Let me switch gears and ask you, when
11 there is shoulder dystocia, what are the risks to the
12 patient if that shoulder dystocia is not resolved in
13 accordance with the safety rules?

14 A Risks to the patient -- mom, you mean, or baby?

15 Q Well, the patients, I should say.

16 A Well, the risk to the baby is that you don't deliver
17 safely in a timely manner. So you run the risk of death,
18 or you run the risk of having the oxygen supply cut off
19 for such a long period of time that the baby is delivered
20 alive, but has significant brain damage. Or you do
21 maneuvers in a way that aren't safe and you put excessive
22 traction on the brachial plexus, as in this case, and you
23 have a permanent brachial plexus injury from severing of
24 nerves. So that's baby.

25 With mom, particularly in this case, some of the

1 potential risks are given the long amount of time she was
2 in labor, the multiple exams, it's shocking to me that she
3 didn't get a serious infection. Also, a woman who's been
4 on such a long period of high dose Pitocin, you run the
5 risk of once the baby is out -- we, as women, are built
6 magnificently. But sometimes our bodies need a little
7 help.

8 An if you've been on Pitocin, which is, also, the
9 hormone that's still present when the baby is delivered,
10 that Pitocin allows the uterus to contract down. And if
11 you've been on such long amounts of Pitocin, the uterus
12 becomes insensitive. And when the baby comes out, the
13 uterus is more floppy and puts the woman at risk for
14 increased blood loss.

15 There's a chance of, actually, damaging mom's
16 perineum. You know, in this case, a larger episiotomy had
17 to be cut, which is standard, but do you not put mom at
18 risk for pain, chronic pelvic pain. Mom has a risk of
19 having deep lacerations, so there's extensive repairs that
20 need to be done.

21 In this case, mom was pushing before she was totally
22 dilated. She was not completely dilated. She could have
23 had cervical tears, again, leading to hemorrhage. I mean,
24 the potential harm to mom and baby, it's a long list.

25 Q Before we go on, let me jump in and ask you about

1 that point. You said that mom started pushing at nine and
2 a half centimeters before she was complete. Whose
3 decision was that?

4 A Well, it said she was encouraged to push. The nurse
5 was there encouraging her. And the second-year resident
6 noted that she was nine and a half centimeters. So that's
7 a breach in the standard of care, particularly in a woman
8 who's had such a dysfunctional labor pattern. You don't
9 want to put her at more risk for damage to her internal
10 organs. And we don't encourage women to push before
11 they're completely dilated.

12 Q There are a lot of issues to cover here. Right now,
13 I want to focus on the safety rules for solving the
14 shoulder dystocia problem without injury to the mom or
15 baby. Are there any safety maneuvers that a competent
16 obstetrician or resident would use to avoid damage to the
17 baby or the mom?

18 A Certainly. I mean, that's what we learn in our
19 residency training, how to safely deliver a baby whose mom
20 has been diagnosed with a shoulder dystocia.

21 Q Would you, please, step down, ma'am?

22 A (Witness complied.)

23 Q And using the baby doll and the pelvis, could you
24 explain to this jury what those maneuvers are?

25 A If you will hold the pelvis.

1 Q I will hold the pelvis however you tell me to hold
2 it.

3 A You might have to hold it up.

4 Q Should I have it flat or slightly --

5 A So babies come down, internal rotation, the head
6 comes out, and this shoulder now is on the pubic bone. If
7 mom is up like this, one of the first things you want to
8 do is flatten mom. So you lower the bed. You take her
9 hips and you hyperflex because that opens up her pelvic
10 floor.

11 Q What do you mean hyperflex?

12 A Mom's legs -- typically, mom's legs may be in
13 stirrups, two people may be holding them so the legs are
14 more down. And I can't demonstrate it. So the legs are
15 more down like.

16 So when you diagnose the shoulder dystocia, you want
17 mom's legs all the way back pretty much at her ears. And
18 you need someone professional who knows how to do -- it's
19 called the McRoberts maneuver, to make sure you hyperflex
20 mom's legs. Because when you do that, you're opening up
21 the pelvic floor. And you're, also, flattening that
22 tailbone we talked about. So, theoretically, you have
23 more room to do that.

24 If with normal traction -- and you have mom stop
25 pushing because the more she pushes, she's just pushing.

1 the shoulder against the bone. Her legs are back and you
2 have your hands on. You're gently checking to see did
3 that maneuver release the shoulder? And the answer is no.

4 So then you have someone come and give what we call
5 suprapubic pressure. And, unfortunately, you, as the
6 delivery provider, have to really watch. You are the
7 commander of the ship now. Watch to make sure that the
8 nurse or whoever's giving the suprapubic pressure is
9 pushing in the right way.

10 Because I've seen nurses, actually, push on the pubic
11 bone. And pushing on mom's pubic bone is not going to
12 help the shoulder dislodge. So you want the assistant to,
13 actually, push on above the pubic bone in that manner,
14 legs are still back, pushing here to, hopefully, release
15 that shoulder.

16 Q And let me jump in again. We've got a cut away
17 pelvis here that I'm holding. And, of course, we don't
18 show the mom's outer skin. When you had the nurse pushing
19 down on the baby's shoulder, what is her fist, actually,
20 touching?

21 A It's touching above the pubic bone.

22 Q So is it touching on the mom's body or reaching
23 inside the birth canal?

24 A Oh, it's on mom's abdomen, lower abdomen above the
25 pubic bone. So if I were mom, you would push somewhere in

1 here.

2 Q You've told us about the McRoberts and suprapubic
3 pressure --

4 A Okay. That didn't release the shoulder.

5 Q Let me get you to stand where everybody can see on
6 the jury. I'm sorry.

7 A All right. So McRoberts and suprapubic, those are
8 pretty much the standard or easiest maneuvers to do. And,
9 typically, 60 to 70 percent of the shoulder dystocias are
10 resolved with that. You know, there's no specific -- you
11 know, kind of you don't have to do a specific maneuver in
12 a certain order.

13 There's some of us who now realize after years of
14 practice that you can, actually, reach in. And that's the
15 purpose for cutting the episiotomy. Cutting the
16 episiotomy is not a maneuver, but it allows you to put
17 your hand in and potentially swing the posterior arm.
18 Let's pull it out a little bit. I wish we could do that
19 with shoulder dystocia, but we can't. To dislodge a
20 posterior arm, if you pull the posterior arm out, you are
21 the diameter.

22 And there are other maneuvers used to decrease the
23 diameter. You call those rotational maneuvers. There's a
24 Rubin maneuver where you're pretty much collapsing the
25 shoulders. And you take your fingers and you push on the

1 shoulder. So you're pushing the shoulder towards the
2 baby's chest. There's, also, a Woods Corkscrew, where you
3 totally change the orientation of the baby 180 degrees.

4 So all of those maneuvers are safe. Sometimes they
5 don't work. And you don't panic. Again, it seems like
6 forever when you have to do these maneuvers. You can
7 repeat them all again. And, typically, it's been my
8 experience that the shoulder gets dislodged in a safe
9 fashion.

10 Q Thank you.

11 Now, you've told us about --

12 A Can I sit back down?

13 Q Oh, please.

14 THE COURT: I'll tell you what. Let's go ahead and
15 break for lunch while we're at a good place to stop.

16 Ladies and gentlemen, don't talk about the case.
17 Continue to keep an open mind. Be back in the jury room
18 at 2:15 to give everybody time to get out and have lunch.

19 (WHEREUPON, the jury was excused from open court at
20 approximately 12:52 p.m.)

21 THE COURT: All right. See everybody back at 2:15.
22 Thank you.

23 (WHEREUPON, a lunch break was taken.)

24 THE COURT: Anything before we bring the jury out?

25 MR. GRAHAM: Yes, sir, Your Honor.

1 I wanted to offer into the Court's record the
2 original transcript of Dr. Grossman and the original video
3 deposition CD.

4 (WHEREUPON, Court's Exhibit No. 2 was marked for
5 identification and admitted into evidence.)

6 MR. GRAHAM: Also, Your Honor, we have -- the medical
7 records from last week have been compiled as Plaintiff's
8 Exhibit 1 for this week.

9 THE COURT: Okay.

10 MR. GRAHAM: Which we'd like to offer at this time.

11 Also, we have one of the documents referred to
12 earlier, the Pitocin used chronology, that we would offer
13 in the compilation. We went over that issue last week
14 about introduction of a compilation of medical records.
15 So we would offer that. And I'm not sure if there's an
16 objection to that one.

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

18 MR. ALEXANDER: I do have -- but if you want to go to
19 the last one as well, and I'll just address all of them.

20 MR. GRAHAM: Yes, sir.

21 And, finally, the phase of active labor compilation.

22 THE COURT: Yes, sir.

23 MR. GRAHAM: It's really the same issue. We believe
24 they should be admissible as evidence pursuant to that
25 compilation rule that we went over last week.

1 THE COURT: Okay.

2 MR. GRAHAM: I'll be happy to cite the number for
3 you.

4 THE COURT: Yes, sir, Mr. Alexander.

5 MR. ALEXANDER: Judge, I have no objection to the
6 first two items, Dr. Grossman's deposition and, I believe,
7 his CV. I have no objection to those two things.

8 My objection would be to the document that has active
9 phase of labor. One of the disputed issues in this case
10 is when the active phase of labor began. If that
11 editorial part of the compilation is taken off so we just
12 have the compilation of data, then I would withdraw my
13 objection.

14 And then on the Pitocin, I don't have an objection to
15 the compilation of data of the Pitocin administration
16 provided the right-hand side of the document that has
17 orders or progress notes is taken off. Because the orders
18 and progress notes are not complete. There were multiple
19 orders during that time frame related to Pitocin
20 administration. So if we could modify those two
21 documents, then I would be okay with the actual
22 compilation of evidence.

23 MR. GRAHAM: Your Honor, it's a compilation of
24 selective portions of massive medical records. We have
25 the entirety of the records in evidence. But we're just

1 trying to compile those parts that are relevant to a
2 certain point. And that's what I think that rule refers
3 to. 1006 is the rule number.

4 There's been testimony explaining Dr. Gomez-Carrion's
5 explanation about the active phase of labor. There's some
6 controversy about exactly when it's deemed to have
7 started. But this is a summary of those significant
8 measures during a period of time when there was no
9 question of active phase of labor.

10 Frankly, we're not contending that that is a complete
11 representation of all important measures during the active
12 phase of labor. That's a snapshot of that portion of the
13 active phase of labor. And I believe we've set the
14 foundation through her testimony. If not, I can revisit
15 that, if Your Honor deems necessary.

16 MR. ALEXANDER: I think it's more confusing than it
17 is probative to the jury. If we're going to submit that
18 that purports to be a compilation of data, but omit
19 certain parts of it, I think that is not helpful for the
20 jury and would be inappropriate under 403 just because
21 it's going to be confusing and misleading to them.

22 MR. GRAHAM: It's complete with respect to that
23 12-hour window of time, which is the window of time she
24 was compiling the important data about. It omits data
25 before and after. But it contains the relevant data for

1 that 12-hour period when there was an arrest of cervical
2 dilation. The only real provision under Rule 1006 is that
3 the underlying data are admissible into evidence. They're
4 not only admissible, they're in evidence.

5 MR. ALEXANDER: That's why my objection is under 403.
6 The Pitocin thing, particularly, if you show orders on one
7 side, I think if it's a compilation of evidence, it ought
8 to include all of them and, otherwise, would be
9 misleading.

10 THE COURT: You don't need a ruling on this right
11 now, do you? I mean, your witness is still testifying.

12 MR. GRAHAM: Only if Your Honor were to rule based on
13 some foundational defect. I think we've covered the
14 foundation.

15 THE COURT: Right.

16 MR. GRAHAM: But if that might be an issue, we'd like
17 to correct that now.

18 THE COURT: I don't think --

19 MR. GRAHAM: I don't believe that's an issue.

20 THE COURT: Yes. I just need to look at a couple of
21 things. And I don't want to hold everybody up.

22 MR. ALEXANDER: That's fine, Your Honor.

23 THE COURT: All right. So are y'all ready for the
24 jury?

25 MR. GRAHAM: Well, may I ask you one more question?

1 THE COURT: Sure.

2 MR. GRAHAM: Just in terms of trying to plan the rest
3 of the day as efficiently as possible. Does Your Honor
4 have a set time in mind for quitting today?

5 THE COURT: I don't -- I know last night there were
6 some -- according to the bailiffs, several jurors were
7 concerned. They needed to get somewhere by 6:00. I don't
8 know if that's still an issue tonight or not.

9 Nobody has said anything?

10 THE BAILIFF: No.

11 THE COURT: So no -- as far as I'm concerned, we can
12 go late. But I don't know.

13 MR. GRAHAM: Past 6:00?

14 THE COURT: Sir?

15 MR. GRAHAM: Past 6:00?

16 THE COURT: If we need to. If you've got issues that
17 need to be --

18 MR. GRAHAM: We'll be putting up one expert. I mean,
19 it's guesswork at this time, Your Honor, but we'll be
20 putting up Dr. Vanderkolk today. We'd, certainly, like to
21 finish him. I don't think it would run that late.

22 THE COURT: Okay.

23 MR. GRAHAM: If we were to put another witness up
24 before, we would never finish with her at a reasonable
25 time.

1 THE COURT: Well, we'll just play it by ear.

2 MR. GRAHAM: Thank you.

3 THE COURT: Okay. You can bring the jury back in.

4 Ma'am, you can come back up or you can -- I don't
5 know if you were planning on staying down there or not.

6 THE WITNESS: I'm going with the flow, sir.

7 (WHEREUPON, Plaintiff's Exhibit No. 1 was admitted into
8 evidence.)

9 (WHEREUPON, Plaintiff's Exhibit No. 4 was marked for
10 identification and admitted into evidence by agreement
11 of counsel.)

12 (WHEREUPON, the jury came into open court at
13 approximately 2:37 p.m.)

14 THE COURT: All right. Yes, sir, Mr. Graham.

15 MR. GRAHAM: Thank you, Your Honor.

16 CONTINUED DIRECT EXAMINATION

17 BY MR. GRAHAM:

18 Q Doctor --

19 A Yes, sir.

20 Q -- let me take this baby doll up there for you.

21 Using this baby doll, Doctor, please, explain to the jury
22 what torsion is in the context of shoulder dystocia and
23 brachial plexus injury.

24 A Well, if you have a baby whose shoulder is stuck
25 under that pubic bone, what you don't want to do is a

1 twisting motion of the head. That would be called
2 torsion.

3 Q Thank you.

4 And explain what traction is.

5 A Well, traction -- there, usually, is a certain amount
6 of traction that you have to put on a baby's head in order
7 to naturally clear the bone. So it's, usually, a downward
8 lateral traction of a gentle nature that you have to do.
9 Some babies do come flying out and you don't need any
10 traction. You, actually, need obstruction so they don't
11 go too far. But most babies do need a little guidance in
12 terms of being delivered.

13 Q So gentle traction is acceptable?

14 A Absolutely.

15 Q What about greater than gentle traction?

16 A No, sir.

17 Q What is gentle traction?

18 A I mean, that's -- gentle traction -- it's hard to put
19 it into words, because it really comes from experience.
20 You figure out as you deliver babies what is an acceptable
21 amount of traction in order to safely deliver a baby
22 without injury. So we're taught to do minimal gentle
23 traction.

24 I know that probably didn't answer your question very
25 well. But it's an art form. Medicine is an art. Over

1 time and with guidance -- that's why we do a four-year
2 residency training, to learn what these things are. And
3 you develop your own sense of, for you, how much is gentle
4 traction when you're delivering a baby.

5 Q How does gentle traction compare with a handshake?

6 A It would be a limp handshake, not something very
7 forceful and strong, but more of a -- you know what I
8 mean? You shake somebody's hand and they're barely
9 touching you.

10 Q What is the danger if a doctor applies more than that
11 gentle amount of downward traction when the upper shoulder
12 is stuck behind the bone?

13 A Well, as we saw this morning, a plexus of nerves
14 exits from the spinal cord. And if you do too much
15 traction, you're, actually, stretching that plexus of
16 nerves. And you could either have a stretch injury, or
17 you could have a total snapping of the nerves called
18 avulsion where you break the nerves. But you could have
19 injury whether you do that or have a serious stretch
20 injury.

21 I kind of equate it to all the technology we use
22 with -- for example, your iPhone charger. It looks
23 intact. But if you pull that cord too much, you could
24 interfere with the integrity of all those fibers coming
25 through that allows you to plug into your phone and for

1 that battery to get recharged. You don't have to break
2 the cord totally. But if you pull on it too much, it's
3 not going to work. So the same thing can happen to this
4 conduit of nerves that transmits the impulses from muscles
5 to the brain and back in terms of functioning.

6 Q Thank you.

7 A You're welcome.

8 Q When you're teaching residents -- when you or any
9 attending obstetrician in a teaching hospital -- in
10 teaching obstretical residents how to apply the correct
11 amount of gentle traction, do you just teach with words,
12 or do you, also, teach with hands-on training?

13 A Starting out -- well, prior to even entering the
14 delivery room, you're using your words. You're going
15 through the cardinal movements of labor, what happens when
16 the head comes out, what you would like to happen once
17 that happens. You know, the head is delivered, the
18 shoulders, the rest of the body. But if that does not
19 happen, you want to articulate that with your residents.

20 But in the delivery room, it has to be hands on until
21 you as the attending, as the teaching person, the person
22 in charge, the person who is responsible, you have to
23 convince yourself that you are okay with the safe
24 maneuvering that your resident is doing.

25 And, in the beginning -- I mean, I've had residents

1 who midpoint through their second year, I had hands on
2 because I just didn't quite feel confident that they knew
3 the difference. There were some interns after the fifth
4 delivery, I knew they got it. So everyone has their own
5 learning curve.

6 But until I'm convinced -- like most teaching
7 attendings, until you know someone is applying that safe
8 level of gentle traction, you put your hands on top of
9 theirs so you, actually, have that tactile. You can feel
10 how much force they're exerting.

11 Q What about body weight? What role does body weight
12 play in terms of gentle traction?

13 A None. You should not be putting your body into
14 adding to the amount of force that you're using to try to
15 deliver a head. And, again, I'm particularly in tuned to
16 that since I have such a strong and somewhat large body
17 that I'm very aware.

18 And I make sure my residents are aware. You do not
19 push into it when you're doing a delivery. It's really
20 just using your hands, and guiding, and being very -- the
21 word we keep using is gentle. You don't want to go beyond
22 that point. Because we don't know how much above gentle
23 is going to cause injury. And you really don't want to
24 test that.

25 Q What is excessive traction?

1 A Traction that is beyond gentle. And, again, you
2 don't want to test that. So it can be -- you know,
3 there's a clear excessive traction. I've walked into
4 deliveries where someone -- they, essentially, should have
5 had their foot up on the table pulling down on a baby.
6 You never want to see that as an obstetrician or a
7 midwife. But you can tell excessive traction. You can
8 see because you're seeing the stretch. Or if you have
9 your hands on, you can, actually, feel that someone is
10 putting much more traction than you believe is safe.

11 And one of my favorites mantras to my residents is
12 gentle, gentle. They hear that all the time when we're
13 delivering together. Gentle. And if they're not being
14 gentle, I say hands off. And they know -- that's when I
15 go to my momma voice. You take your hands off.

16 Q Would a lay observer or an inexperienced observer
17 always recognize greater than gentle traction?

18 A No.

19 Q Is it that dramatic?

20 A No. It doesn't have to be. Plus, it, also, depends
21 on the angle in which the person is observing. Unless
22 you're right on top and seeing what's happening right here
23 on the neck, sometimes you cannot appreciate the amount of
24 stretch that's happening. You can't really see how the
25 shoulder is caught up behind the bone and the way the neck

1 and the head is stretching away from that point that's not
2 flexible.

3 Q Please explain the difference between axial traction
4 and lateral traction. First of all, what is axial
5 traction?

6 A Well, axial is in the same plane, so that's more
7 pulling out. Whereas lateral -- we often call it lateral
8 downward traction is coming off of the plane itself. So
9 you're, actually, coming off of your straight line, where
10 axial is going more towards the straight line.

11 Q If a doctor applies axial traction, does that put a
12 stretch force -- an injury causing stretch force on the
13 nerves.

14 A Typically not. You'd have to pull pretty darn hard
15 to stretch this area pulling straight out. I mean,
16 anything is possible. But you'd have to pull really hard
17 in the axial direction. It's much easier to cause damage
18 pulling down.

19 Q If you pulled hard enough in the axial direction to
20 cause damage, would you just as likely injure the spinal
21 cord as the peripheral nerves like the brachial plexus?

22 A Yeah. You could break a baby's neck doing that.

23 Q And you mentioned downward lateral traction. If the
24 baby's right shoulder is the top shoulder stuck behind the
25 mother's pubic bone, in which direction would downward --

1 in which direction would lateral traction be applied to
2 put the baby at risk of nerve damage to the right brachial
3 plexus?

4 A So the baby would be in this position, right shoulder
5 up. And you'd be pulling downward in that direction, or
6 even in that direction, or that direction. But it's still
7 you're lateral off the plane.

8 Q This issue is going to come up later in the case, so
9 I want to ask you about it now. Can you talk about the
10 difference between lateral traction from the -- excuse me,
11 lateral traction from the doctor's point of view side to
12 side and traction from the baby's point of view side to
13 side? Which one puts the brachial plexus nerves at risk?

14 A It's what you, as the delivery provider, are doing.
15 Your baby is like so. And you're usually directly
16 opposite. And it's what you're doing with your hands,
17 because the baby is not really moving around. The baby's
18 head is out.

19 So it depends on what you do with that nerve plexus
20 that could potentially cause damage. This is stuck -- or
21 in a normal delivery, it's not. So you're just doing your
22 gentle traction to release that shoulder.

23 Q If the baby has the right shoulder stuck behind the
24 pubic bone?

25 A Correct.

1 Q Then after the head comes out, if the restitute --
2 what is restitution?

3 A Well, a number of babies will come out -- they do
4 this external rotation. They may come out a little, what
5 we call, occiput anterior, the back of the head is
6 pointing up. And they'll, actually, turn their head one
7 way or the other. So you know which way to put your hands
8 and which way to pull.

9 Q So if the baby's right shoulder is on top stuck under
10 the pubic bone?

11 A Correct.

12 Q And the head comes out, like you say, the back of the
13 head occiput, up. And if the baby's head restitutes, does
14 that mean it's turned back to a normal orientation toward
15 the front of the body?

16 A Sure. It might be helpful if you came and held the
17 baby and I could show you that.

18 Q Sure.

19 A So the baby is coming down. It comes out. The head
20 is sort of like that. You, as the obstetrician, don't
21 want to do this and decide -- you don't want to decide
22 which way the baby's head should turn. Most babies are
23 very smart. And this baby will turn its head slightly, so
24 you know how to guide the baby.

25 If you don't wait or if the baby doesn't, then you

1 can, actually, feel the orientation of the baby so you
2 know not to do that because that's torsion or torquing.
3 And that can, also, put a stretch on the brachial plexus.
4 So you want to wait and get your guidance from the baby.
5 Q So if the baby's right shoulder is stuck behind the
6 pubic bone and after they reconstitute so that it's in normal
7 alignment, facing the front, would side to side traction
8 by the doctor put any stretch on the brachial plexus
9 nerves?
10 A Not a whole lot, no.
11 Q Okay. It's the downward traction?
12 A Yes.
13 Q What about upward traction?
14 A Well, you could damage the other brachial plexus if
15 you put too much traction on the opposite.
16 Q So with the right shoulder on top, upward traction
17 would put a stretch on the left side?
18 A Correct.
19 Q And a downward stretch would put a stretch on the
20 right side?
21 A Correct.
22 Q Thank you.
23 A You're welcome.
24 Q Let's talk about permanent versus temporary brachial
25 plexus nerve injury. How do you define permanent injury?

1 A It's an injury that does not resolve. And, you know,
2 most of the literature will state after 18 months
3 following the delivery of the baby. So you can have an
4 injury that with physical therapy and different treatments
5 can resolve, say, by 15 months. That would be classified
6 as a temporary brachial plexus injury.

7 Q Okay. You mentioned having a couple of temporary
8 injuries, how long --

9 A Transient.

10 Q -- did yours last?

11 A Hours. I think my deliveries were more, we call it
12 shock nerve, where you have the stunning of the nerves.
13 It's sort of like when you go to sleep and you sleep on
14 one side too much and you wake up and one arm isn't moving
15 as well. I think when I exerted my increased traction, I
16 may have done that. So it recovered very quickly. And
17 I'm very thankful for that.

18 Q What is a neuroma?

19 A A neuroma is that scar tissue that forms after a
20 traumatic nerve injury. In this case, we had damage to
21 C5, C6, and C7. When you have kind of the avulsion of the
22 nerve, the breaking of the nerves, you have the scar
23 tissue over time that forms trying to rejoin that area.

24 Q Let's talk about contractions. How many contractions
25 do you, as an obstetrician, want a pregnant lady to have

1 during labor? What's a healthy number of contractions?

2 A Well, you want someone to contract, say, every two to
3 three minutes. Exactly how many contractions during the
4 labor process, I'd have to sit and do some high level
5 mathematics.

6 Q Let's just take a 10-minute window. During 10
7 minutes, how many contractions would you want to see?

8 A Three to four.

9 Q Is there a number of contractions that obstetricians
10 recognize as being too many? And, if so, what number is
11 that?

12 A Typically, five and above. Because, again, as
13 discussed earlier, when the uterus contracts, there's
14 decreased blood flow to the baby. So babies with reserve
15 can sustain that. But if you go beyond that point, you're
16 now allowing the baby to recover from the stress of the
17 contraction. And we call that tachysystole.

18 It's the same thing with the heart. Systole is when
19 the heart contracts, diastole is when it relaxes. And if
20 our hearts stayed contracted all the time, we wouldn't be
21 here. And the opposite is true as well.

22 So when the uterus contracts -- the uterus is a
23 magnificent muscle. It's able to cause cervical dilation,
24 baby to come down. But if it stays in that state too
25 much, it can, certainly, potentially cause harm to a baby.

1 Q Two questions. First of all, what's the relationship
2 between the head coming down and the cervix opening up?

3 A It's interrelated.

4 Q Please explain.

5 A Well, it's very woman dependent. Most women having
6 their first baby, you'll get what we call fetal descent.
7 So the head is, actually, pressing on the cervix. And
8 that, also, helps -- when you have this pressure against
9 this tissue, it helps with the contraction process, the
10 cervix to shorten, that term we call effacement, and to,
11 also, dilate. So the head is, actually, helping that
12 process.

13 Women having their second and third babies, as in
14 this case, the baby may hang high. And the forces of the
15 uterus can soften the cervix and cause contractions, and
16 the head's not quite well applied. But you can still see
17 the normal changes occur in the cervical tissue.

18 Q Thanks.

19 Now, a minute ago, you used one of those highfalutin
20 medical words, tachysystole.

21 A I apologize. I thought I tried to define it.

22 Q Back in 2004, what were obstetricians allowed to call
23 that condition where there's more than five contractions
24 in 10 minutes?

25 A It's called hyperstimulation.

1 Q Hyperstimulation of the --

2 A Of the uterus.

3 Q When did -- who changed that word? And when did that
4 happen?

5 A I'm really bad at years. But a number of years ago,
6 maybe five or so, I think some folks from the American
7 College got together and decided hyperstimulation maybe
8 had negative connotations, and that tachysystole more
9 represented what was, actually, happening to the uterine
10 muscle.

11 Q When there's tachysystole in the medical phrase, the
12 medical jargon, does that mean the same thing as a uterus
13 that is being hyper stimulated?

14 A Yes.

15 Q Are we allowed to call it hyperstimulation since it
16 happened back in 2004?

17 A Absolutely. I much rather the term hyperstimulation.
18 I struggle with tachysystole because -- you know, to refer
19 to a uterus as being tachy, as a woman, that's offensive
20 to me.

21 So, yes, hyperstimulation is a much kinder word.

22 Q Thank you.

23 In this case, did you see examples of hyperstimulation?

24 A Yes, I did.

25 MR. GRAHAM: I'm going to ask Mike to pull up medical

1 record page numbers 523 and 524.

2 BY MR. GRAHAM:

3 Q Okay. This is 523. And now let's go to 524.

4 A You can see the repetitive there. The uterus is not
5 quite getting back to its resting point of a contraction,
6 trying to get back, contraction, contraction. And each of
7 these dark boxes marks off a minute.

8 So you have one, two, three, four, five, six, seven,
9 eight, almost nine minutes. And in that nine-minute
10 period, you have one, two, three, four, fix, six
11 contractions in a nine-minute period. So that is
12 hyperstimulation.

13 Thank goodness the baby has reserve. So the baby's
14 heart rate is normal and has variability. But you don't
15 want to keep allowing this to happen. Because, at some
16 point, the baby is going to use its reserve, and then, as
17 we saw in this case, crash at the end. You don't want to
18 push a baby to that point.

19 Q In the phase of hyperstimulation, does the uterus
20 function effectively?

21 A No.

22 Q In the phase of hyperstimulation, if a baby is
23 getting Cytotec, is there any way to undo the Cytotec
24 effect?

25 A No.

1 Q In a case where the baby is getting Pitocin, is there
2 a way to remove the hyperstimulation effect of the
3 Pitocin?

4 A Absolutely.

5 Q And how would one go about that?

6 A Well, in this case, being that the baby, at this
7 point in time, looked fine, you would turn down the
8 Pitocin. If you've gone too far and the baby is showing
9 negative reaction to the Pitocin, you turn the Pitocin
10 off.

11 And then you, also, do your other resuscitative
12 moves. We call it intrauterine resuscitation.

13 Because what has happened is you've decreased the flow,
14 again, of blood which carries the oxygen to your baby.

15 So not only are you turning the Pitocin off, if mom
16 is on her back, which, also, decreased the blood supply,
17 you're now turning mom to her side, you're giving mom
18 extra oxygen via mask. You're doing all of those things,
19 increasing the IV fluid, to try to get more flow to your
20 baby.

21 Q In this case, how many times did the folks at
22 Greenville Hospital System turn off the Pitocin?

23 A They did not.

24 Q How many times did the folks at Greenville Hospital
25 System reduce the amount of Pitocin?

1 A In the documentation I saw, they did not.

2 Q Let's talk for a moment about the rate of cervical
3 dilation. Actually, we may have -- I think we touched on
4 that earlier. You were showing us the compilation of
5 measures over a 12-hour period?

6 A Correct.

7 Q What does that tell you? When you see heavy doses of
8 Pitocin, hyperstimulation, but the cervix is not opening
9 up, what does that combination tell you?

10 A That you, most likely, have a problem with the
11 passenger in the passage, also, known as cephalopelvic
12 disproportion. You have many, many contractions. You
13 have an intrauterine pressure catheter documenting the
14 frequency of contractions and now intensity of
15 contractions. You don't quite meet -- I mean, there was a
16 discussion earlier about adequacy of contractions. We,
17 typically, use 200 montevideo units, and didn't quite get
18 there.

19 So, as an obstetrician, you have to ask yourself,
20 she's on high levels of Pitocin, hours of no change in her
21 cervix, baby is not descending. We have a problem here.
22 And to keep kind of going along that course, you're asking
23 for potential trauma to mom and/or baby.

24 Q How does the station of the baby factor in?

25 A Again, this is her second baby. And it's not

1 uncommon for second babies to do what I call the drop
2 zone. They'll stay up high. And then they'll all of a
3 sudden rotate and come down quickly into the pelvis.

4 So station -- I mean, we always think about it, but
5 dilation or lack of dilation, plus lack of decent in a mom
6 with, you know, a big baby, big abdomen, large shoulders,
7 mom is obese, diabetic, I mean, it's a perfect set up for
8 shoulder dystocia.

9 Q Doctor, as you know, we have available a couple of
10 blow-ups. Do you want to choose one of these to explain
11 fetal station?

12 A I think this one is better.

13 Q Okay. Are you able to -- well --

14 A Can y'all see?

15 Q Yes.

16 A So you have the baby in the pelvis. And that bony
17 structure I was talking about, the landmark, as we have
18 here, is at zero station. So when you're doing an exam,
19 you're, actually, feeling mom's sidewalls and you can feel
20 that bony landmark. So you're feeling for dilation. And
21 you're, also, feeling where the head is in the pelvis.

22 So an unengaged head is up here around minus five,
23 minus four, minus three, minus two. When it gets to this
24 area, we -- the term we use is the head is engaged. It's
25 not going anywhere. You're not going to push it out of

1 the pelvis unless you use massive strength. And as the
2 baby gets more into the delivery position, it goes from a
3 minus number to a plus numbers.

4 So this baby -- as we saw in that previous slide, the
5 baby was hanging up around minus three, minus two,
6 depending on who did the assessment of the position of the
7 baby. And, certainly, over a 12-hour period, there was no
8 significant change in cervical dilation.

9 So that meets the classic definition for arrest of
10 dilation and arrest of descent. And when you get those
11 things over so many hours, you have to think about an
12 alternative way of delivering that baby safely.

13 Q And what alternative way should you think about?

14 A Cesarean delivery.

15 Q In this -- well, let me ask you this. Let's talk
16 about informed consent. When there's a good reason for a
17 doctor to consider switching from vaginal delivery to
18 C-section, what duty is there for a doctor to talk to the
19 patient about the risks and benefits of vaginal labor
20 versus cesarean section?

21 A Well, I'm hoping that conversation happened before
22 the patient even entered labor and delivery. The
23 important part of the prenatal process is to make sure you
24 are preparing your patient for what could happen in labor
25 and delivery.

1 When a woman is uncomfortable and in labor of some
2 sort, that's not the time to start talking about the
3 different ways we might be able to deliver your baby.
4 That's not the time to talk about what could potentially
5 happen to a fetal heart rate. That's not the time to talk
6 about I'm going to monitor your uterine contractions with
7 external versus internal. You really want to make sure
8 that your patient understands all of that before being
9 induced. So you've already had that conversation.

10 Now, you're in a position -- you, and your patient,
11 and the baby are in a position where the cervix is not
12 dilating, the head is not coming down. You know she's a
13 high risk operative patient. She's a Jehovah's Witness,
14 which means she wants blood-free therapy, whatever that
15 means. Because we, also, have other alternatives when
16 someone bleeds. We don't need to give you blood. There
17 are different things that can expand your volume.

18 And having taken care of a number of Jehovah's
19 Witnesses, as we know, one size doesn't fit all. You can
20 have a Jehovah's Witness who will accept certain products,
21 and a Jehovah's Witness who may not.

22 So that is an opportunity to not only educate
23 yourself, but your patient and have a prelabor delivery
24 consultation with someone like your anesthesiologist.
25 Because they will get involved if you have massive

1 bleeding.

2 And, again, you don't want to wait until someone
3 starts bleeding to figure out, well, what am I going to
4 do? You want to have that clear in your mind before you
5 intervene. And they intervened here because they induced
6 the station. So you want to talk about the risk of
7 hemorrhage, risk of death with a Jehovah's Witness. And
8 someone who has an elevated BMI or is classified as obese
9 and hypertensive, she's an operative risk.

10 But you always weigh benefits to risks as an
11 obstetrician. Because the patient needs to be aware that
12 you are concerned about she and her baby. And, as I
13 always say, it's healthy mommy, healthy baby, happy
14 family, and partner. You want to make sure you're keeping
15 your first two folks in the safest place possible.

16 And if in this case and if I were the obstetrician,
17 I, certainly, would have had the conversation you're not
18 dilating, your baby is not descending. Before baby gets
19 sick or you get sick, I would recommend a cesarean
20 delivery. And let me once again review the risks of that.
21 There's a risk of hemorrhage, infection, your death.
22 There's a risk to the baby. We could injure the baby, cut
23 the baby coming out, which is incredibly rare.

24 So you go through all of that. But the safest
25 delivery in this sense where we are right now is a

1 cesarean delivery. And, of course, you need mom's
2 permission because you can't just do a cesarean without
3 mom's permission.

4 Q Do you believe a pregnant lady has the right to be
5 informed of the risks and benefits of different ways of
6 delivering that baby so that she can participate in an
7 intelligent way in medical decisions that affect the
8 well-being of herself and her child?

9 A Absolutely.

10 Q Was that done in this case?

11 A I didn't see any documentation of that.

12 Q What about this, when there's -- what do you mean by
13 the phrase medical indication, just in general?

14 A You have to have a reason for an intervention.

15 Q Okay. If there's a medical indication that gives you
16 a reason to recommend a C-section in a teaching hospital
17 setting, who should be involved in that decision? I mean,
18 is that something a labor and delivery nurse can do?

19 A No.

20 Q Is it something a resident can do?

21 A A resident can participate in the discussion, and we
22 encourage that, but it's the attending who makes the
23 decision. It's the attending who should be talking to the
24 patient about options for safe delivery.

25 Q And to the extent that there is a potential risk of

1 enough bleeding during a C-section to cause trouble --
2 what percentage of C-section patients, ultimately, need a
3 blood transfusion?

4 A It's a rare event. But, again, now, we wish we could
5 predict the future. So you always wants to be prepared.
6 And, in this patient, knowing that she wants blood-free
7 therapy, you want to make sure you don't put yourself in a
8 situation where you're going to increase her risks for
9 bleeding and, in this case, prolonged labor, high levels
10 of Pitocin.

11 I mean, if you cause a muscle to work so much, so
12 long, so hard, it fatigues. And when the baby comes
13 out -- luckily, it didn't happen in this case. When a
14 baby comes out, you can just have a floppy uterus, what we
15 call an atonic uterus. And then you have to use various
16 medications and you have to do it very quickly, or you run
17 the risk of now needing to do more surgery, removing her
18 uterus to prevent loss of life from hemorrhage.

19 Q What about the mom's mental health problems in this
20 case? What role does that play in terms of the doctor's
21 duty, the attending's duty to have a discussion, an
22 informed consent discussion with the mother about whether
23 C-section should be the chosen delivery route?

24 A I mean, it's important to have that discussion in a
25 language where the patient can understand. So you don't

1 want to use the highfalutin language that we physicians
2 tend to use. You really want to break it down in a way
3 that she can understand it, and whoever is there with her.
4 You encourage your patient to ask questions. You want to
5 make sure that -- again, this conversation should not be
6 happening for the first time when you're in an urgent
7 situation. And it's important she understands.

8 And the mental place where she is -- I mean, I deal
9 with a lot of depressed women. I deal with a lot of
10 anxious women. I have -- and most of us, we deal with
11 women who have all sorts of psychiatric diagnoses. It's
12 even more important in that patient population that they
13 feel relaxed and safe, and they trust who's taking care of
14 them.

15 So you don't want to come at them all of a sudden
16 with things they've never heard of before. And you have
17 to lay that foundation before they come into the labor and
18 delivery suite. Because the more you prepare your
19 patient, the less there's going to be that anxiety or that
20 feeling of I'm out of control in that particular
21 situation.

22 Q Thank you.

23 Doctor, I've been asking you a lot of specific
24 questions. And I think it might be more interesting if
25 you just summarized for us what you consider to be

1 significant actions, omissions, observations about the
2 prenatal period in this pregnancy. What do you believe
3 are the key components of this prenatal period, with
4 particular focus on any criticisms you have of the
5 prenatal care that this lady received?

6 A So before she entered the hospital or --

7 Q Before -- yeah, before she entered for the -- before
8 she entered on Wednesday for the Saturday morning
9 delivery.

10 A Again, in reading the medical records, I did not get
11 the impression that this patient was prepared. And I
12 didn't get the impression that folks realized the risks
13 involved with a vaginal delivery, or the potential risks
14 of shoulder dystocia.

15 Again, you have someone who is obese, who is
16 diabetic, has been diabetic since she was 15 years old,
17 and you have a large gestational-age baby. The ultrasound
18 you had -- and, remember, this baby is not even 36 weeks
19 and they were estimating -- at that time, baby was 35ish,
20 and they were estimating the baby would be over seven
21 pounds. That's a big baby. And the percentile that went
22 with that is that baby is above the 97th percentile in
23 terms of growth in certain areas of the body.

24 Now, we're talking about nine days later, you know,
25 you're dealing with a baby. And they got it right on --

1 which I was very impressed about. This baby is eight and
2 a half pounds and not 36 weeks yet. If this baby had gone
3 to 40 weeks, this would have been a massive baby. It
4 would have been one of those babies you read about or hear
5 about in the news.

6 So I don't think there was a good enough appreciation
7 for the risks. And, now, I'm kind of melting into what
8 happened in labor and delivery.

9 Q Well, let's talk about certain aspects of the
10 prenatal care. Do you believe that the folks at
11 Greenville Hospital System planned appropriately given the
12 risks of shoulder dystocia that were revealed during the
13 prenatal period?

14 A No.

15 Q What should they have done differently?

16 A Now, I'm going to start talking about labor and
17 delivery when you ask the question.

18 Q What should they have done differently in terms of
19 planning for labor and delivery?

20 A Well, having the discussion with the patient, you
21 know, what could possibly happen in labor and delivery
22 because of the shoulder dystocia, who would be at delivery
23 ahead of time say, you know, if your baby's shoulders get
24 stuck, we're going to have an additional medical
25 personnel, the pediatricians are going to be there, an

1 anesthesiologist may be there.

2 I, as the attending taking care of you, may call in
3 another attending to help me. In case I do all my
4 maneuvers and they don't work, it's always good to have
5 another set of hands to repeat the maneuvers and, also, to
6 help keep me calm.

7 Again, the worst thing you want to do, as an
8 attending, is get so anxious. It's instinctual when a
9 baby gets stuck, you want to deliver that baby. So your
10 body, your mind says pull. And you have to override that.

11 So when you have a colleague next to you, it's a
12 calming effect. I know when I'm on labor and delivery, if
13 I hear shoulders, I go into the room. I may not do
14 anything. But I've heard time and time again just the
15 fact that I was there was calming to the room. And it's
16 so important to prepare ahead of time. It may not happen.
17 And that's great if it doesn't. But if it does, then
18 everyone is in place.

19 Q What criticisms, if any, do you have about the
20 planning at Greenville Hospital System during the prenatal
21 period about -- patient discussions about the potential
22 for delivery by C-section?

23 A Well, every patient has a potential delivery by
24 C-section, particularly, a patient with this history. And
25 if you're sending someone in for induction, I mean, you're

1 acting on, you're doing an intervention.

2 So whoever the sending person is to the receiving
3 persons, there should be a discussion, oh, by the way, she
4 has a big baby. She's diabetic. She's obese. And, you
5 know, you have to be careful in terms of the labor curve,
6 what happens. And be aware that she's at high risk for
7 shoulder dystocia. Make sure your nurse has a stool in
8 the room so she can get up high enough to do the
9 suprapubic.

10 There's all of these things, this communication
11 process that has to occur so everyone, again, is of the
12 same shared mental model. Everyone is aware of the
13 potential here, so that you don't have to wait a minute to
14 call people to the room. Everybody already knows. So
15 everyone is ready to go into action.

16 Q What criticisms, if any, do you have about the
17 planning that was or was not done at Greenville Hospital
18 System with regard to special requirements for a Jehovah's
19 Witness pregnant lady?

20 A I think I partially have answered that question.
21 Prenatally, you want to identify whether she be a
22 Jehovah's Witness or we're now getting a lot of patients
23 who just want blood-free therapy.

24 First of all, you need to sit down with the patient
25 and make sure you understand what her desires are. Does

1 she really want to die, rather than getting a blood
2 transfusion? Because I've had that conversation multiple
3 times. And when you get down to it, particularly in
4 someone who may be younger or studying the religion of
5 Jehovah, they're not quite ready when they realize, oh,
6 I'm going to die. Someone else has to take care of my
7 baby. Because we make them sign blood-free therapy. You
8 need to designate in your demise who's going to be
9 responsible for taking care of your child. And it gets
10 them to thinking this is very serious.

11 Now, folks who are versed in the religion of Jehovah,
12 being a Jehovah's Witness, they're fine. They come in
13 with their list of people who will take charge of their
14 children. They are so passionate about being in the
15 kingdom of Jehovah that they would rather not be here
16 physically because they feel that they're spiritually
17 dead.

18 You know, as healthcare providers, we struggle with
19 that because we are trained to save lives at whatever
20 cost. And, for me, I got sensitized to that early in my
21 training. As an intern, I had a Jehovah's Witness who
22 died because she did not receive a blood transfusion.
23 And, as the intern, I was sent in every day to try to
24 convince her to get a blood transfusion. And somewhere in
25 that month that I was with her every day, I got it, that

1 she truly believed that she would be dead on this earth if
2 she received a blood transfusion. So who am I to judge
3 that?

4 So you have to be clear in the prenatal period that
5 you understand what your patient's needs are. And if
6 she's very clear that this is what she wants, then you
7 need to think about what could potentially happen in labor
8 and delivery that could put her at more risk for death.

9 And that's why you want to get your anesthesiologist
10 involved, because they can talk to the patient. You may
11 start bleeding, but I can give you Albumin, I can give you
12 IV fluids, I can do other things. Do you want Self-Saver?
13 We can set up a system where you bleed, it circulates in a
14 tube and it goes back in. There's some Jehovah's
15 Witnesses that say, no, that blood has left my body so
16 that is unacceptable. But there's some Jehovah's
17 Witnesses that says if the connection is not truly broken,
18 I can receive that. So it makes them think about all the
19 things that would be acceptable from our point of view in
20 order to attempt to save their life in that situation.

21 So there has to be the up-front preparation, and
22 discussion, and understanding and, you know, the hope that
23 you don't have to face those decisions. But, if you do,
24 then everybody is better about it because it's been
25 addressed in a very thorough manner.

1 Q Do you believe that Greenville Hospital System
2 properly planned for the shoulder dystocia risks, the
3 potential for C-section, the need for a C-section
4 delivery, and the potential complications related to
5 Jehovah's Witness?

6 A No.

7 Q All right. Do you have an opinion to a reasonable
8 degree of medical certainty as to whether or not those
9 failures to plan represented a breach of the
10 generally-accepted standards of practice for obstetricians
11 under these facts and circumstances?

12 A Absolutely.

13 Q And what is that opinion?

14 A That opinion is that the health care providers in the
15 hospital were not ready for the safe delivery of this baby
16 whose mom had a shoulder dystocia. The fact that you had
17 the least experienced delivery provider, your new
18 second-year resident, without the support of her attending
19 delivering -- trying to deliver this baby by herself and
20 attempting to do that for, at least, a minute until the
21 chief resident came in and did additional maneuvers, and
22 the attending still was not present at the delivery. That
23 is a breach of the standard of care.

24 Q What difference would it have made in the outcome if
25 there had been a competent attending in attendance at

1 those critical times?

2 A Well, the fact that this was a traction injury
3 causing a permanent brachial plexus injury, if the
4 attending had been in attendance -- and it's my opinion to
5 a great degree of medical certainty as we all do -- as all
6 attendings do with new residents, particularly, a resident
7 who had never ever resolved a shoulder dystocia before,
8 her hand should have been in the field with her resident
9 showing her how to safely deliver this baby.

10 So this new second-year resident is trying her best
11 to deliver this baby, but did not have the fund of
12 knowledge nor the clinical skill to do that safely.

13 Q Thank you.

14 We're jumping around a little bit. But let me get
15 you to focus now on your general impressions about the
16 labor after admission to the hospital, the labor time
17 period prior to the actual delivery. Just, please, tell
18 us about what you recall from your review of the medical
19 records and depositions that you believe to be of
20 significance with respect to any criticisms you have of
21 Greenville Hospital System during that early labor, during
22 the labor before the head.

23 A Well, you're talking about -- the time that is
24 impressive to me is the almost 10 to 12 hours that this
25 patient did not change her cervical dilation with the

1 continuation of the increasing in the IV of Pitocin. So
2 you have a true arrest of dilation and arrest of descent.
3 And it just kept going. And my question is, at what point
4 was an attending, who is the captain of this team, going
5 to come and evaluate the patient?

6 There is no documentation at any point during that
7 10- to 12-hour period that the attending ever came into
8 the room. I didn't see it in the nursing notes. I didn't
9 see the attending write a note in the chart. There was a
10 note saying the attending was present by someone who
11 wasn't involved with the delivery.

12 And, according to the depositions from Dr. Alt and
13 the fourth-year resident, when the baby is being
14 delivered, the attending wasn't there. So, to me, as an
15 attending, taking care of a patient of such risk for a
16 severe shoulder dystocia, my big question was, where was
17 she? I mean, from the beginning to the end, again, not
18 only to promote safety in the delivery of this patient,
19 but education for her residents.

20 Q Was that a violation of the generally-accepted
21 standards of practice for attending obstetricians at a
22 teaching hospital under facts and circumstances like this?

23 A Yes, sir.

24 Q What about the -- you mentioned the 12 hours or so
25 when there was very little movement in the descent of the

1 head or opening of the cervix. Do you believe that it was
2 a breach of the standard of care to not have a discussion
3 with the patient in which the risks and benefits of
4 C-section were discussed?

5 A Correct. And I think I eluded to that earlier. Once
6 she reached 9.5 centimeters and, all of a sudden, she was
7 encouraged to push, she's not 10 centimeters, so you risk
8 damaging her cervix. And, again, where is the attending?
9 The resident may not have known any better. Okay. You
10 feel like pushing, push.

11 We've had patients who are two centimeters who feel
12 like pushing. But we discourage that and try to figure
13 out how we can get mom to change positions, or do you need
14 an epidural so you can take away that urge to push.
15 Because the more force that a mom and bearing down causes
16 with the cervix is swelling of the cervix.

17 And this is a patient who's had a baby before who now
18 is, at least, a two-hour second stage. So she was pushing
19 for a good period of time. And all of that transpired
20 without intervention from the attending.

21 Q What about the informed consent issue? Do you
22 believe that represents a violation of generally-accepted
23 standards of obstetrical care to fail to have that
24 discussion with the mom about the risks and benefits of
25 C-section and the failure to recommend C-section?

1 A At that -- yes, I do.

2 Q Let's talk about the period of time after delivery of
3 the head. What are your impressions and criticisms about
4 the folks at the teaching hospital during that period of
5 time?

6 A Again, this appeared to be a team that was caught off
7 guard. And as someone who read through this record, I was
8 dumbfounded by that. It's like, oh, my God, we have a
9 shoulder dystocia. We have a shoulder dystocia.
10 Everyone's in place and we're going to deliver this baby
11 safely.

12 But, now, you have, again, the early second-year
13 resident, along with the nurse delivering the baby
14 realizing, okay, I'm pulling, I'm putting my body into it,
15 traction, the baby is not being delivered. I need help.
16 But a minute has gone by, too late then. The attending
17 should have been there. The NICU should have been there.
18 The whole team should have been there to prevent such an
19 injury from occurring.

20 Q Now, Dr. Merritt, apparently, knew how to get J.B.
21 J.B. delivered with a rotational maneuver. Do you
22 remember that? He said after doing traction, he then did
23 a rotational maneuver and she delivered?

24 A Right. He enlarged the episiotomy and was able to do
25 the rotational maneuver, yes.

1 Q What good does it do **J.B.** for a safety maneuver to
2 be used to deliver her after too much traction has already
3 caused a permanent brachial plexus injury?

4 A It's done. It's too late. It doesn't take a long
5 time to cause a permanent injury. You don't have to do
6 excessive traction for a minute. It can be a very --
7 depending on how strong you are, it could take a couple of
8 seconds to cause breakage of nerves.

9 Q Now, how do we know that this baby could have been
10 delivered safely if traction had not been excessively
11 applied?

12 A Well, we know that statistic from the medical
13 literature.

14 Q Okay.

15 A You know, the incidents of brachial plexus injury is
16 very small. And the incidents of a permanent brachial
17 plexus injury is even smaller. So, clearly, most
18 obstetricians know how to deliver a large baby safely, or
19 make the decision to do the cesarean delivery to avoid
20 testing that theory.

21 Q And we know Dr. Merritt got the baby out with the
22 rotational maneuver. If traction had not been used before
23 then, if excessive traction had not been used before then,
24 do you believe the rotational maneuver would have worked
25 just as good as it did after the excessive traction caused

1 the injury?

2 A I believe if you used safe maneuvers, I would not be
3 sitting here today.

4 Q What is your response to the deposition testimony
5 from Dr. Alt about attempting a posterior arm delivery
6 method after cutting a one-degree episiotomy?

7 A Well, if you're going to cut an episiotomy -- and
8 that's when you, actually, take scissors -- the area
9 between the vagina and the rectum is called the perineum.
10 And sometimes in a woman, that area can be very tight.

11 And it makes it -- as I was struggling with the
12 non-forgiving model there, you don't have enough
13 elasticity, enough room to put your hand in until you,
14 actually, enlarge that space by cutting a significant size
15 episiotomy. Where I trained, they, actually, cut four
16 degrees. So just cutting a little bit into the vaginal
17 mucosa and the perineum is not going to do it.

18 And I would imagine that's why a more senior resident
19 came in and thought right away, that's not big enough, so
20 I'm going to enlarge that and, actually, cut a third
21 degree. And it enabled him to put his hand in and deliver
22 the baby.

23 Q What are your impressions about the level of
24 knowledge of the second-year resident, Dr. Alt, in terms
25 of recognition of shoulder dystocia and proper management

1 of it?

2 A Well, she herself admitted in the deposition she's
3 done four to five, but this was her first. So I would
4 imagine that there was a delayed diagnosis. Because
5 that's what you do when --

6 MR. ALEXANDER: Your Honor, she has -- I object.
7 There's no foundation for that.

8 THE COURT: Rephrase your question.

9 MR. GRAHAM: Thank you.

10 BY MR. GRAHAM:

11 Q Doctor, do you rely, in part, on some of the
12 deposition testimony of Dr. Alt in this case?

13 A Yes.

14 MR. GRAHAM: Mike, would you, please, refer to Alt?

15 BY MR. GRAHAM:

16 Q Question: Do you recall when your first time was
17 that you encountered shoulder dystocia?

18 Would you, please, read the answer?

19 A It would be this presumed case, yes, ma'am.

20 Q Question: So your first would have been the
21 delivery -- during the delivery of J.B. ?

22 A Uh-huh, early my second year of residency. Yes,
23 ma'am.

24 Q Had you ever observed a delivery where shoulder
25 dystocia was encountered prior to your involvement of

1 [REDACTED] J.B. 's delivery?

2 A No, ma'am.

3 Q Doctor, let me ask you, do you believe it is within
4 the standard of care for an attending physician to not be
5 in attendance when a second-year resident who has never
6 before seen, or witnessed, or resolved a shoulder dystocia
7 is the most senior resident in the room with the duty of
8 getting that baby out safely?

9 A That's a breach in the standard of care.

10 Q Doctor, let me ask you -- let's turn to causation for
11 a moment. Do you have an opinion to a reasonable degree
12 of medical certainty as to the most probable cause of

13 [REDACTED] J.B. 's ripped and torn brachial plexus nerves?

14 A Yes, sir.

15 Q What is that opinion?

16 A My opinion is that excessive traction was used in
17 trying to resolve the shoulder dystocia. Therefore,
18 leading to the evulsion of the nerve roots leading to her
19 permanent brachial plexus injury. And that opinion is to
20 a reasonable degree of medical certainty.

21 Q Thank you.

22 Doctor, could this permanent brachial plexus nerve
23 damage have most probably been avoided if a competent
24 attending was in attendance?

25 A Yes, sir.

1 Q Doctor, let me direct your attention to the following
2 clip from the deposition of Dr. Merritt starting on Page
3 78 and continuing on to 79.

4 Question: Okay. What types of injuries are
5 foreseeable following the application of excessive
6 pressure to a baby's head during a delivery?

7 A I suppose you could have a brachial plexus injury
8 would be one.

9 Q Question: It doesn't matter whether the baby is big
10 or little, you could still injure the baby if you pull
11 hard enough; is that fair?

12 A I think that's fair.

13 Q Question: Do you agree a doctor must not use greater
14 than gentle traction to resolve shoulder dystocia when
15 there's an available safety maneuver that they have not
16 yet tried?

17 A Yes.

18 Q Question: And, again, we're talking about a doctor
19 must not use greater than general traction to resolve
20 shoulder dystocia when there's an available safety
21 maneuver that they have not yet tried?

22 A Yes.

23 Q Can we agree that's the standard of care?

24 A Yes.

25 Q Let me ask you, Doctor, how good are new doctors, new

1 obstetricians, new residents, or even fourth-year
2 residents at recognizing how much traction they do use?

3 A Not very good.

4 Q Question -- this is Doctor Dr. Alt's deposition.
5 Would you agree with me that when an obstetrician is upset
6 that the doctor may use more traction than they realize
7 they're using?

8 A It could happen.

9 Q Question: Would you agree with me that when an
10 obstetrician is upset, the doctor may use more traction
11 than they realize they're using?

12 A I think that in pressure situations, it's likely hard
13 to determine exactly how much pressure you're using.

14 Q Given -- well, do you believe that a second-year
15 resident's first shoulder dystocia is a pressure
16 situation?

17 A Yes, sir.

18 Q Given the pressures involved, how important is it for
19 a competent attending to be in attendance as a teaching
20 influence and as a calming influence?

21 A It's very important. I mean, even the most mature
22 attending -- I mean, I've been doing this 30 years. When
23 I encounter a shoulder dystocia, I know my heart rate goes
24 up.

25 But the first thing I do is take my hands off, take a

1 deep breath and realize we have an emergency situation. I
2 have to be calm. Because I'm setting the tone in the
3 room. And I have to go through the maneuvers in a
4 methodical and safe manner because we have time.

5 Q Have there been studies in the literature that
6 address how frequently obstetricians -- even experienced
7 obstetricians underestimate the amount of forceful
8 traction they put on a baby's head?

9 A Absolutely. I mean, there's studies out of Europe.
10 And the Europeans are a little ahead of us. In fact,
11 we've done a number -- I believe it was -- again, I'm bad
12 with years, but in the early 200's [sic], we, actually,
13 had a physician from England come with a stimulator to
14 show us how hard we were pulling and what we thought was
15 gentle versus excessive traction. And we all
16 underestimated how much traction we were putting on a
17 baby's head.

18 So that is common when you're early in your training
19 or even a young attending.

20 Q I think you may have misspoke there, you said
21 something about the early 200's.

22 A Oh, yeah. I'm really old. 2000's.

23 Thank you.

24 I look good, don't I, for the early 200's?

25 Q Thank you.

1 And speaking of the folks from England, have there
2 been published studies about the benefits of that kind of
3 simulation with computer feedback about the amount of
4 traction --

5 A Absolutely.

6 Q -- being applied?

7 A And it's very beneficial. Because rather than
8 working your way through 10 years of delivering babies,
9 you, as an intern, can now do many simulations and get
10 that experience or knowledge without doing it in a live
11 patient.

12 So those days of see one, do one, teach one are over.
13 And doing a simulation gives you a lot of feedback as to
14 safe practice in labor and delivery. There's a lot of
15 literature confirming that.

16 Q Okay. Doctor, this is the one I was looking for. I
17 know you really -- this one resonated with you. You
18 mentioned it earlier.

19 Question -- this is Dr. Alt's deposition. Question:
20 How do you define gentle traction?

21 A Just -- I don't know exactly how you want me to
22 articulate. I mean, it's just a normal amount of
23 pressure. I mean, have I ever had to think about what
24 that measure -- what that would measure in terms of
25 Newton's or -- and the answer is no. I mean, just using

1 my own standard body weight in a downward fashion.

2 Q Let's focus on the last sentence.

3 Question: How do you define gentle traction?

4 I mean, just using my own standard body weight in a
5 downward fashion.

6 What's your response to that sworn testimony from the
7 second-year resident who was the first to apply traction
8 to J.B.'s head and neck?

9 A When I first read that, I gasped. Because, again,
10 you don't want to put your body -- if you think about it,
11 you're leaning your body into downward traction. That's
12 translating into a lot of force you're putting on the
13 baby's brachial plexus, and causing an incredible stretch
14 to that area.

15 You really want to just use your hands and, possibly,
16 a little bit of your arm. But you want to not put a lot
17 of pressure on a baby's head. Because you can, in this
18 case, cause a significant permanent injury.

19 Q Is one able to follow the safety rule about gentle
20 traction and only gentle traction if one, actually, uses
21 body weight to apply traction?

22 A No.

23 Q Is that gentle traction in any way, shape, or form?

24 A If you're using your body's weight, no, that's not
25 gentle traction.

1 Q What's the risk to the baby of a second-year resident
2 or any doctor using body weight to apply traction?

3 A Just what happened in this case, excessive traction
4 leads to nerve injury, leads to permanent injury.

5 Q Here is a clip from the deposition testimony of
6 Dr. Merritt, the chief resident, who was the second one to
7 apply traction to **J.B.**'s head and neck.

8 Question: Would you agree with me that the most
9 probable cause of permanent brachial plexus birth injury
10 is greater than gentle lateral traction applied to the
11 baby's head by the birth attendance?

12 A I'd have to say yeah.

13 Q Doctor, it seems to me from the testimony of Dr. Alt,
14 the second-year resident, and from Dr. Merritt, the
15 fourth-year resident, that they had some book learning
16 about these issues. How can you reconcile the fact that
17 you've expressed an opinion that they did apply -- one of
18 them, at least, applied excessive greater than gentle
19 lateral traction so forcibly as to rip and tear those
20 three brachial plexus nerves and, yet, they seem to know
21 you're not supposed to do that? Can you help us
22 understand how those could both be true?

23 A Because, intellectually, you know what you should not
24 do as a delivery provider. But when faced with an
25 emergency -- and this is an emergency -- your body kind of

1 takes over. And that's why it's important that you have
2 someone in the room who can say stop or gentle, gentle,
3 gentle to constantly remind you, oh, I can't follow what
4 my body is leading me to do. I need to listen to my
5 brain.

6 Because it's instinctual. Any time you're faced with
7 an emergent issue, you just want to act, and act in the
8 fullest and most forceful way you can. But when you're
9 dealing with a baby with a very vulnerable area of the
10 baby's body, you don't want to do that. And that's very
11 hard for us human beings to override that. That's not our
12 first instinct.

13 Q Doctor, I'm going to hand you this exhibit.

14 And do you want to keep your seat?

15 A I do.

16 Q Let me have you --

17 A Unless y'all need me to stand.

18 Q First of all, is this board exhibit a fair and
19 accurate representation of some of the key points you've
20 been trying to make in your deposition -- I mean, in your
21 trial testimony here today?

22 A Correct. I mean, this first circle, you'll see
23 normal anatomy. You have the nerves intact. And then you
24 have a stretch injury with the rupture of C5, C6, C7
25 nerves. In this area, as you see, the baby's head is

1 being deviated. And if you put in this area too much
2 stretch, you have the ripping, or what we call evulsion.
3 And over time, that area tries to repair. And that's when
4 you get the large neuroma of these upper and middle trunks
5 resulting in your permanent injury.

6 Q Are you aware of anything that can cause this type of
7 complete rupture, ripping, and tearing of C5, C6, and C7,
8 and the development of this traumatic neuroma over the
9 next few months other than forceful greater than gentle
10 traction by either Dr. Alt, or Dr. Merritt, or both?

11 A In this case, there's no other explanation for the
12 type of injury this baby sustained.

13 Q All right. Have you, also, participated in the
14 creation of an animation to show -- to depict visually to
15 the jury what you believe happened in this case?

16 A Yes, I did.

17 Q Okay. Does it fairly and accurately represent key
18 portions of your testimony?

19 A Yes, it does.

20 Q Is it helpful to you to be able to try to visually
21 explain your testimony?

22 A I think it would be helpful to show that, because
23 sometimes a picture is worth a million words.

24 Q All right.

25 A So you have fetal descent --

1 Can you see that?

2 MR. GRAHAM: Yes.

3 Your Honor, may we ask that the lights be dimmed?

4 THE COURT: Yes. Sure.

5 THE WITNESS: So, in this picture, you have fetal
6 descent. You have internal rotation. And now, you have
7 the baby clearing the cervix. And you see that shoulder
8 getting stuck on the pubic symphysis. And you have
9 external rotation.

10 So, at this point, you've now diagnosed the shoulder
11 dystocia. And whoever the delivering provider is needs to
12 go through the standard safe maneuvers, not just cause
13 traction. You know, these legs should be back, there
14 should be suprapubic pressure. Because if you just do the
15 traction, you have the ripping of the nerves that occurred
16 in this case.

17 BY MR. GRAHAM:

18 Q All right. And you mentioned not doing McRoberts and
19 suprapubic pressure. I believe --

20 A They did that in this case.

21 Q Well, let me --

22 A And then months later --

23 Q Continue. And I'll ask my question.

24 A Months later, you have the attempted repair of this
25 area by the body. But, unfortunately, it tends to be more

1 scar tissue. This is what we call a traumatic neuroma.

2 So you never get reconnection of the nerves. You
3 just get the scar tissue enveloping that whole area. And
4 that's why this is a permanent injury, as opposed to a
5 transient injury.

6 Q Now, Doctor, you mentioned that they did suprapubic
7 pressure and McRoberts. But let's break it down between
8 Dr. Alt, the second-year resident, and Dr. Merritt, the
9 chief, who came in next. In terms of Dr. Alt's
10 intervention, what of significance did you find in her
11 delivery note?

12 A Well, in actuality, there was no delivery note from
13 Dr. Alt. I looked and looked through the medical records.
14 And I didn't see any documentation of exactly what she did
15 at the delivery.

16 Q Dr. Alt did not do a delivery note?

17 A Unless you neglected to send it to me, I did not see
18 a delivery note.

19 Q Okay. Did you read her deposition testimony on that
20 point?

21 A Yes, I did.

22 Q All right. Did Dr. Alt have a duty to record
23 significant observations and events on her watch in this
24 medical record?

25 A Yes, she did.

1 Q Okay. Did she admit in her deposition that she
2 violated that duty?

3 A I don't recall if she admitted to violating that
4 duty. I believe she admitted to not writing a delivery
5 note.

6 Q Thank you.

7 Do you remember whether or not Dr. Alt claims to have
8 done McRoberts and suprapubic pressure?

9 A I believe she said she did -- or instructed -- she
10 didn't personally do it, but instructed the staff in the
11 room.

12 Q Well, actually, why don't we go to the delivery note
13 from Dr. Merritt and see if he's the one who, actually,
14 did McRoberts and suprapubic pressure. Well, actually,
15 we'll put this on the screen. It's really small and hard
16 to read.

17 A So this is PGY-4, Dr. Merritt, who's writing this
18 note. Unconventional abbreviation, but it says CTPR, so
19 called to patient's room for --

20 Q Delivery?

21 A Possibly delivery, something head at perineum. I
22 never did figure out what that said. But I knew from
23 reading other things that the head was on the perineum for
24 approximately a minute as Dr. Alt attempted to deliver the
25 baby.

1 Q Let me interrupt, Doctor. Do you recall whether or
2 not the discharge summary, actually, had a typed version
3 of this hard to read delivery note?

4 A Yes.

5 Q Why don't we go to the discharge summary starting
6 with Page 11.

7 By the way, who did the discharge summary? Was it
8 anyone who had anything to do with this delivery?

9 A No. I think it was someone pulling information from
10 either discussion with the delivery doctors or the chart.
11 That's reason for admission.

12 Do you want me to read that?

13 Q Well, just call our attention to anything you find
14 significant on these two paragraphs of the discharge
15 summary.

16 A Again, her risk factors, Class B diabetic, vaginal
17 delivery. It's, also, mentioned here it's a male child,
18 but it's, actually, a female child. A weight had not been
19 taken at that time.

20 The APGAR score is -- and that's an assessment of the
21 baby at birth. There's a scoring done at one minute, and
22 it's a score of four, which is low. A score at five
23 minutes, which did not change. So the baby was getting
24 resuscitated at this time.

25 And 10 minutes later, the baby achieved a score of

1 six. And the score is out of a range of 10. You,
2 basically, get points for reflexes, breathing, heart rate,
3 color. So the baby did not score very well after
4 delivery.

5 Again, to the discharge summary.

6 Q Okay. Let's --

7 MR. GRAHAM: Mike, can you go to the part of the
8 discharge summary that talks about the actual delivery?

9 THE WITNESS: Keep going. Next page.

10 So on 11/27/04 at 4:38 in the morning, spontaneous
11 delivery of a viable male infant -- it should be female --
12 was accomplished. APGAR scores four at one minute, four
13 at five minutes, six at 10 minutes. Weight was eight
14 pounds eight ounces.

15 There was initial distress present during the
16 delivery. Infant's head was at perineum for approximately
17 one minute with the midline episiotomy. \ McRoberts
18 maneuver was performed. Suprapubic pressure was applied
19 with downward traction and little movement of the
20 shoulder. Posterior shoulder and anterior shoulder were
21 rotated and this allowed delivery of the anterior
22 shoulder. Body was delivered with activity. Infant was
23 floppy and placed in warmer.

24 The neonatal intensive care unit personnel and
25 pediatricians were present. Fetal heart tones were in the

1 70's and 80's. Positive upon presentation times 1.5
2 minutes. Infant was given supplemental oxygen. NICU
3 present in the room. No movement of right arm. Left arm
4 movement is good. Dr. Twedt was present.

5 Episiotomy was cut with extension of a partial third
6 degree. Was repaired in the usual fashion with good
7 hemostasis. Placenta was delivered without difficulty and
8 intact. The fundus was firm. Mother is in stable
9 condition and transferred to postpartum ward.

10 Q Thank you.

11 Was Dr. Twedt, in fact, present before the baby was
12 put in the warmer?

13 A In reading through the documentation, I saw no
14 documentation that she was present during the delivery
15 itself.

16 Q Okay. So is this statement in the discharge summary
17 true or false?

18 A Well, the fact that she was present -- present where?
19 I mean, was she present on the floor. She could have been
20 present in the room during the repair of the episiotomy.
21 It's such a broad statement. It kind of says she's
22 present.

23 Q Do we know from Dr. Twedt's other notes in the record
24 and from her deposition testimony that, in fact, she did
25 not arrive in this delivery room until after the baby had

1 been delivered and placed in the warmer?

2 A That's correct. There were no notes from Dr. Twedt
3 during the labor process that I saw.

4 Q So since that was Dr. Merritt's note as dictated
5 again into the discharge summary, is it your understanding
6 it was Dr. Merritt who ordered suprapubic pressure and
7 McRoberts?

8 A Well, I know he did do that, yes.

9 Q Are you able to determine with absolute certainty
10 whether the damaging traction was applied by Dr. Alt, the
11 second-year resident, Dr. Merritt, the chief resident, or
12 both?

13 A I can't determine that.

14 Q Okay. This is a clip from Dr. Merritt's deposition.

15 Question: We agreed earlier that injury to **J.B.**
16 **J.B.**'s brachial plexus nerves most probably occurred
17 after delivery of the head. Are you able now to determine
18 at what point her brachial plexus nerves were injured in
19 the course of this delivery?

20 A The answer is, no.

21 Q Were you able to -- or are you able to determine
22 whether or not -- or whether it was during the time that
23 Dr. Alt was attempting delivery, or when you were
24 attempting the delivery?

25 A I thought this last -- this next response brought a

1 chuckle to me because this is Dr. Merritt's deposition.
2 And it's like he was talking about someone else. He says,
3 I can't tell if it was Dr. Alt or Dr. Merritt.
4 Q So Dr. Merritt was referring to himself as
5 Dr. Merritt?
6 A Yes.
7 Q Instead of me or somebody --
8 A Right. That's like me saying both Doctors Gomez and
9 Carrion are here and present. It's kind of an interesting
10 way of talking about self.
11 Q Were any safety maneuvers performed by Dr. Alt, or
12 Dr. Merritt, or by anybody else before Dr. Alt applied
13 traction with her body weight?
14 A I don't recall every answer that Dr. Alt gave in her
15 deposition. And there's, certainly, no delivery note that
16 states that she asks for suprapubic and McRoberts. So I
17 don't see any evidence that that was done prior to her
18 exerting her body in traction in order to dislodge the
19 shoulder.
20 Q And after applying body weight traction, does a
21 safety maneuver after that do you any good?
22 A No.
23 Q Does it do **J.B.** any good?
24 A Probably not. The damage was probably done, if that
25 was, indeed, how it happened.

1 Q All right. Let me ask you about some underlying
2 events that contributed to the cause. I know you believe
3 that greater than gentle forceful traction was the direct
4 immediate cause of the nerve damage; true?

5 A Yes, sir.

6 Q Were there underlying causes that you believe, also,
7 contributed? And, if so, what are they?

8 A Well, the lack of doing the safety maneuvers, that
9 could have released this baby's shoulder. I mean, not
10 done because the doctors described excessive traction.
11 They didn't put it in those words exactly, but that's the
12 descriptive.

13 Q What about the failure to plan with the risk factors,
14 and the cervical dilation, and the head descent being so
15 slow?

16 A That's one of my opinions that there was lack of --
17 the appreciation for the seriousness of the risks factors
18 for this patient. Therefore, if you don't appreciate the
19 seriousness of it, you're not going to prepare for it. It
20 wasn't prepared for. Therefore, you have an emergent
21 situation and you're caught totally off guard.

22 And, again, you have the least experienced person on
23 the team trying her best to resolve a situation when she
24 doesn't have the clinical tools to do that safely. So
25 there's no preparation.

1 Q She was just in over her head?

2 A Yes, sir.

3 Q No attending in attendance?

4 A Yes, sir.

5 Q What about the failure to do a C-section? Do you
6 believe that's a contributing cause? And, if so, what
7 difference would that have made?

8 A Again, based on all that we've talked about today,
9 you have a patient who stays at one exam [sic] for many,
10 many, many hours, risk factor for shoulder dystocia.
11 She's on high levels of Pitocin.

12 You're encouraging her to push before she's fully
13 dilated. You know, at that point, where you note she's --
14 she wants to push and you're encouraging her to push at
15 9.5. That's a pivotal point in my mind that you have the
16 discussion, you're not completely dilated, you have a rest
17 of dilation and descent, I recommend a C-section.

18 If mom says, you know what, I don't want a C-section,
19 well, then you make her comfortable and you give her more
20 time. You know, have an end point. In two hours, we're
21 still keeping you on 40 units of Pitocin. In two hours,
22 if you're not fully dilated, the safest thing to do for
23 you and your baby is to have a C-section.

24 And, in my 30 years of experience, when I've
25 recommended a C-section to protect the wellbeing of mom

1 and baby, I've never had a patient say no. So we, as
2 health care providers, have to know how to guide our
3 patients in the safest track to have the best outcome.

4 And if a C-section delivery had been done with an
5 adequate uterine incision -- because we know we can get a
6 brachial plexus injury at C-section if you make too slow
7 of an incision, because you have the same effect. But you
8 make a generous incision, deliver the baby, and we
9 wouldn't be sitting here today.

10 Q We've talked about so many different issues for the
11 last couple of hours, Doctor. You've expressed a number
12 of criticisms of various folks at the Greenville Hospital
13 System or the attending who works for the Greenville
14 Hospital System Partners in Health. Have all of those
15 criticisms -- do all of those criticisms represent a
16 violation of the safety rules?

17 A Yes, they do, sir.

18 Q Do all of those represent breaches of the
19 generally-accepted standards of care for doctors in those
20 circumstances?

21 A Yes, they do.

22 Q Do you hold all of those standard of care opinions
23 to, at least, a reasonable degree of medical certainty?

24 A Yes, sir.

25 Q Beyond that, how would you describe your level of

1 certainty about the breaches of care that you believe to
2 be causally significant, attending not in attendance,
3 failure to plan, failure to do a C-section, and greater
4 than gentle forceful traction on J.B.'s head and neck?

5 A All of my opinions that you just stated are to a
6 degree of medical certainty -- a reasonable degree of
7 medical certainty.

8 Q So they rise above that level?

9 A Yes, they do.

10 Q In terms of your -- and you've expressed a number of
11 opinions about causation, the direct immediate cause of
12 the traction, the underlying cause about attending not
13 being in attendance, failure to plan, failure to do a
14 C-section. Do you hold all of those opinions to, at
15 least, a reasonable degree of medical certainty?

16 A Yes, sir.

17 Q Beyond that, is your level of confidence in those
18 opinions even higher?

19 A Yes, sir.

20 Q What level of certainty do you hold?

21 A At a high level of certainty, based on the facts of
22 this case.

23 Q In fact, are you aware of any other possible cause
24 that makes any sense at all as the cause of this baby's
25 ripped and torn C5, C6, and C7 with the development of a

1 traumatic neuroma over the next few months?

2 A I can't think of any other medical condition that
3 would have caused such a significant injury.

4 Q Finally, just as I come to a close here. Let me ask
5 you, Doctor, do you -- on these issues about proper
6 management of shoulder dystocia and the causes of
7 permanent brachial plexus nerve injury, do you recognize
8 some reliable authorities in the literature?

9 A Well, there is lots of good literature out there
10 supporting the opinions that I have, the folks at Johns
11 Hopkins, the work that's been done even in Boston. I
12 mean, if you look at the body of OB medical literature,
13 there's a whole -- the body supports that an injury that's
14 this significant is a result of significant traction.

15 Q You mentioned the folks at Johns Hopkins. Do you,
16 specifically, reference Dr. Robert Allen and Dr. Edith --

17 MR. ALEXANDER: Your Honor, I'd object on the grounds
18 of hearsay. She's not an expert on this. And it's
19 statements made out of court.

20 THE COURT: Overruled.

21 MR. GRAHAM: Thank you, Your Honor.

22 THE WITNESS: Those are some of the folks at Johns
23 Hopkins, yes, sir.

24 BY MR. GRAHAM:

25 Q And you mentioned folks in Europe. Did you

1 specifically include Margaret Holberg from Sweden?

2 A Yes.

3 Q And you mentioned some simulation studies. Were you
4 making specific reference to the studies by Crofts and
5 Englis?

6 A That's one group. Again, I'm blanking on the
7 gentleman who came from England, the other gentlemen, who,
8 actually, came from a hospital. I'm blanking on the name.

9 There are a number of very reliable bodies of
10 information literature out there supporting the benefit of
11 simulation. And we see it every day. If you practice
12 something over and over -- and this is the practice of
13 medicine. You get better and better at it and become
14 safer and safer.

15 MR. GRAHAM: Please answer any questions
16 Mr. Alexander might have.

17 THE COURT: We're going to take a short recess.
18 Don't talk about the case. And continue to keep an open
19 mind.

20 Thank you.

21 (WHEREUPON, the jury was excused from open court at
22 approximately 4:10 p.m.)

23 THE COURT: Let's take about a 15-minute break.

24 (WHEREUPON, a break was taken.)

25 THE COURT: Anything before I bring the jury back in?

1 MR. GRAHAM: Your Honor, just for the record, Ben
2 just showed us an exhibit that he's getting ready to put
3 in that he represents to be the prenatal records. All the
4 records we've used before appear to be much slimmer than
5 this set. And ours have bates stamp numbers on them so we
6 can keep track of them. This set has no bates stamp
7 numbers on it.

8 So we've talked about it. Ben wants to -- Ben is
9 willing to hold off and give us a reasonable opportunity
10 tonight to see if we have any objections to any of these
11 pages. It would take us a long time right now to try to
12 figure out if any of these are documents we haven't seen
13 before.

14 But as long as any -- he questions this witness about
15 the ones we've seen before, we don't have a problem with
16 him asking questions about it. Then we can decide later
17 about what comes in.

18 THE COURT: All right. I understand.

19 MR. GRAHAM: But, also, Your Honor, we would ask that
20 Ben provide us with any pages he's basing a question on
21 before he asks it. Because we have bates stamp numbers to
22 use to find it in our set.

23 MR. ALEXANDER: Do you mean just describe the
24 document?

25 MR. GRAHAM: Or just show it to us.

1 MR. ALEXANDER: Okay.

2 THE COURT: Okay. You can bring the jury on in.

3 Thank you.

4 (WHEREUPON, the jury came into open court at
5 approximately 4:37 p.m.)

6 THE COURT: Yes, sir, Mr. Alexander.

7 CROSS-EXAMINATION

8 BY MR. ALEXANDER:

9 Q Dr. Gomez-Carrion, quite a while ago, you were asked
10 about gentle traction. And I think I wrote down that you
11 said it's hard to describe. Do you remember that?

12 A I do.

13 Q Okay. And, indeed, I asked you in your deposition
14 about gentle traction and you said it's hard to describe;
15 right?

16 A I'm consistent, yes.

17 Q Okay. You were asked about a comment that Dr. Alt
18 made about describing gentle traction. Do you remember
19 that?

20 A I'm not exactly sure what you're referencing, sir.

21 Q Do you remember when there was a -- you were asked
22 about Dr. Alt leaning her body weight into the patient?

23 A Yes, sir.

24 Q Do you remember that?

25 A Yes.

1 Q You read all of Dr. Alt's deposition?

2 A I did.

3 Q Okay. Do you remember her being asked, like you
4 were, to describe gentle downward traction several times
5 in her deposition? Do you recall that?

6 A I recall her being asked several times, yes.

7 Q Several times?

8 A Yes.

9 Q And -- if you would care to, let me reference that
10 portion of her deposition.

11 MR. GRAHAM: Page and line, please.

12 MR. ALEXANDER: All right. I'm going to be on Page
13 21, and 22, and 23.

14 BY MR. ALEXANDER:

15 Q Doctor, do you remember -- or if you will just look
16 at the deposition, she was asked about gentle traction a
17 number of times. And you see there on Page 21 starting on
18 Line 8 where it says, Or again -- can you read that for
19 us?

20 A Or again, just that with gentle downward axial
21 traction that the head and the anterior shoulder do not
22 deliver.

23 Q And so there, she's trying to describe to us what
24 gentle downward traction is; fair?

25 A (There was no response.)

1 Q She's describing what we do in these deliveries as
2 gentle downward axial traction. Do you see that?

3 A I do see that.

4 Q And then down a little bit further on Page 21,
5 starting with Line 23, can you read that sentence for us?

6 A Honestly, usually, head delivery at anterior fashion.
7 So I would either rotate head to the left or right and
8 then downward axial traction.

9 Q And that's, again, describing -- attempting to
10 describe what she means by gentle traction; right?

11 A I guess the reason I hesitated, you have -- downward
12 and axial is not making sense to me.

13 Q Okay. She's struggling to describe what she means by
14 gentle traction?

15 A Well, axial means staying in the axis of the same
16 line. Downward is off of that axis.

17 Q Okay. And then on Page 22 at Line 9, what does she
18 say there about gentle downward traction?

19 A We've talked about rotation and gentle downward
20 traction.

21 Q And then we get to what you were asked about on
22 Page -- I believe it's 23. And what is the question on
23 Line 5?

24 A How do you define gentle traction?

25 Q And what's her answer?

1 A Just -- I don't know exactly how you want me to
2 articulate. I mean, it's just a normal amount of
3 pressure. I mean, have I ever had to think about what
4 that would measure in terms of Newton's or -- and the
5 answer is no. I mean, just using my own standard body
6 weight in a downward fashion.

7 Q Is it your testimony to these folks that it's a fair
8 reading of all of those lines to suggest that what she
9 means is that she leans her body weight onto the patient's
10 head or neck?

11 A Well, she's saying just using my own standard body
12 weight in a downward fashion. That, to me, paints a
13 picture that she's using her body adding to the forces of
14 the traction she's using with her hands. She says --
15 that's what she states in her deposition.

16 Q And that's your interpretation of that struggle to
17 define gentle traction is that she is leaning her body
18 weight into the patient?

19 A She says, Just using my own standard body weight in a
20 downward fashion.

21 Q Okay. Doctor, you yourself have testified that you
22 use traction in most of your deliveries; true?

23 A Guidance or gentle traction, yes.

24 Q Okay. And you describe the traction in your
25 deliveries as gentle traction?

(

1 A I do.

2 Q All right. But you are unable to tell us how much
3 traction that is?

4 A There's no way of measuring exactly how much
5 traction. We don't have that technology yet.

6 Q Right. You don't know it; right?

7 A Correct. I know what my gentle downward traction is.
8 And it has been measured on a simulator.

9 Q Right. Practitioners like Brandi Alt or even
10 yourself find it difficult, if not impossible, to quantify
11 what they mean by gentle traction. Would you agree with
12 that?

13 A Well, it's difficult to quantify. It's difficult to
14 say to a person this is what gentle downward traction is.
15 And that's why we go through a residency training of four
16 years. That's why you have new attendings being mentored
17 by older attendings to make sure that those safety
18 measures are in place.

19 Because there are times when we don't know what the
20 right thing is. And that's why they call it the practice
21 of medicine. And that's why a second-year resident, who's
22 never seen or resolved a shoulder dystocia, needs someone
23 who's more experienced to make sure that her definition of
24 downward gentle traction is truly the correct definition.

25 Q Well, you have been unable to define gentle traction

1 in terms of quantity. You can't do that, can you? You've
2 told us that?

3 A Correct.

4 Q And you would agree that providers will vary from one
5 provider to the other as to what they consider to be
6 gentle traction. Would you agree with that?

7 A Of course, it's a range, yes.

8 Q And you use the handshake analogy. If someone
9 doesn't apply enough traction, is that gentle traction?

10 A I don't think I understand your question.

11 Q Well, if I were to shake your hand and I just give
12 you a limp handshake, is that enough traction in your
13 handshake analogy?

14 A It may be.

15 Q All right. And if I give you slightly more than a
16 handshake, is that excessive traction? Is that excessive
17 force?

18 A I'd have to feel your handshake, sir. I don't know
19 your limp handshake compared to my limp handshake.

20 Q Nor do you know Brandi's gentle traction as compared
21 to yours; true?

22 A That is correct.

23 Q And with respect to this delivery, you don't know how
24 much traction was applied?

25 A I know excessive traction was applied.

1 Q Well, you know -- you believe excessive traction was
2 applied because of the injury itself; true?

3 A And you have someone who's a novice at this. And we
4 know -- I think I've answered that question a number of
5 times in terms of what we, as healthcare providers, do in
6 training. And that's why we're in training with people
7 who have experience. Because we know what human beings
8 tend to do in certain situations. And that's why we have
9 simulations, and mentors, and all that.

10 Q You believe that the inexperience of a provider is
11 evidence of excessive traction. Is that what you're
12 telling us?

13 A That's part of it.

14 Q Do you believe that the experience of a provider is
15 evidence of non-negligent traction?

16 A Repeat that question.

17 Q If inexperience is evidence that someone applied
18 excessive traction, do you believe that the experience of
19 the provider is evidence that they did not?

20 A No. An experienced provider can, too, exert
21 excessive traction. I think I used myself as an example
22 of that.

23 Q You don't know the direction the traction was applied
24 in this case; true?

25 A Well, she said downward traction.

1 Q Do you know whether it was lateral or axial?

2 A She said axial.

3 Q And that's appropriate?

4 A Again, axial, in my mind, my definition of axial is

5 pulling straight out, so axial downward.

6 Q Okay. When you're describing to your residents how

7 to apply traction in delivery, do you tell them gentle

8 traction?

9 A Yes, sir.

10 Q All right. Are you able to tell us how much traction

11 would be required to stretch a nerve?

12 A Again, that has not been measured because that's

13 unethical. You don't want to put normal babies through

14 how much can I pull on your head before your nerves snap.

15 So that's not going to be done.

16 But we do have an appreciation for gentle traction

17 and when not to go past a certain level of gentle

18 traction, because you run the risk of causing injury.

19 Q You're unable --

20 A You --

21 Q Sorry.

22 A You don't want to test that gray zone, so to speak.

23 Q You're unable to tell us how much traction would be

24 required to rupture a nerve; true?

25 A Well, I could tell you how much traction could

1 rupture a nerve.

2 Q How many pounds?

3 A Well, the term we use is Newton's. And I would
4 imagine over 200 Newton's for most babies would rupture a
5 nerve.

6 Q Would you agree that whatever amount of traction
7 would be required to cause a traction-related injury that
8 it is likely to be variable from baby to baby?

9 A It can be, sir.

10 Q Like us, all babies are different; true?

11 A Correct.

12 Q And that would include their susceptibility to
13 traction-related injuries; true?

14 A True.

15 Q And you would agree that some babies are predisposed
16 to those injuries?

17 A Well, there are babies that have -- I mean, the other
18 reasons for predisposition to a brachial plexus injury, if
19 you have some genetic predisposition or if it's some
20 anatomical -- I mean, I saw nowhere in the evaluation of
21 this baby that there was an infection or underlying
22 neurologic condition. There, certainly, wasn't any
23 discrepancy in the baby's appearance in terms of babies
24 who have in-utero insults to nerves and muscles have what
25 we call withered arm. This baby did not have that.

1 So if you run down the differential list of what
2 could have caused such a significant injury, none of those
3 were present.

4 Q What we're talking about right now is whether a baby
5 is predisposed to having a traction-related injury. And
6 what you told me -- or what you've testified to is some
7 babies are predisposed to this injury; right?

8 A If they have a genetic predisposition and neurologic
9 predisposition, sure.

10 Q All right. Do you recall telling me in your
11 deposition that the nutritional status of the baby could
12 predispose the baby to traction-related injuries?

13 A Sure. If you have a baby that you know is in uterine
14 growth restricted, a baby that, clearly, has not gotten
15 sufficient nutrition, yeah, their nerve plexus might be a
16 little weak. But that, certainly, wasn't the case in this
17 eight-pound eight-ounce baby at 35 and six-sevenths weeks.

18 Q Do you remember telling me at your deposition that
19 oxygenation of the baby could predispose a baby to a
20 traction-related injury?

21 A Well, you have -- if you have hypoxia, running
22 hypoxia. There's nowhere on this baby's tracing that
23 showed that. And the fact that the baby's blood gases at
24 postdelivery were within the normal range --

25 Q Let's talk about that. Tell me what you mean.

1 A Well, there's nowhere on this tracing that I saw that
2 showed -- you have a baby, for example, as we speak now,
3 that had a category 3 tracing. There was variability.
4 There were no prolonged acceleration. There were no
5 bradycardia until the very end.

6 So, in looking at this tracing, the question to any
7 obstetrician would be, would you have intervened sooner
8 based on the baby's fetal heart rate tracing? I think we
9 discussed that at my deposition. I would not have
10 intervened necessarily on the baby's heart rate tracings.
11 I thought this baby was, actually, coping with labor well.
12 I would have intervened based on arrest of dilation and
13 arrest of descent.

14 Q Interesting.

15 A Did you say "interesting"?

16 Q Your evaluation of the fetal heart rate strips is
17 that this baby was overall stable; true?

18 A Yes.

19 Q That this baby was having accels?

20 A There were points where it had acceleration. Mostly,
21 it did not. I mean -- but, again, you had variability.

22 Q This baby had moderate variability; true?

23 A At points.

24 Q Right. And it was overall a reassuring strip?

25 A I saw no point that I would have said oh, we need to

1 do a cesarean section, based on the fetal heart rate
2 tracing.

3 Q Okay. And you saw on the fetal heart rate tracing
4 that at the point of delivery, there is a deceleration of
5 the heart rate?

6 A Yes.

7 Q And what do we call that? Is that bradycardia?

8 A Well, bradycardia is defined by the length of
9 deceleration.

10 Q What would you call the deceleration that we see on
11 the strip at the end of this --

12 A I'd have to look at that again.

13 Q Okay.

14 A Thank you.

15 Q Is that what you're referring to?

16 A Yes.

17 Q Okay. And let me ask you this. In a normal vaginal
18 delivery, does the baby's head and cord become depressed
19 as the baby is delivering?

20 A What do you mean by "depressed"?

21 Q Compressed, I should say.

22 A Okay.

23 Q In other words, is the baby being deprived of oxygen
24 to some degree or another in a normal vaginal delivery?

25 A It can be, sure.

1 Q Okay. And if that interval is prolonged, as it would
2 be in a shoulder dystocia delivery, is that interval of
3 lack of oxygen, also, prolonged?

4 A It can be.

5 Q Okay. And is that why we would see something like
6 this, that is a downward trend in the heart rate at the
7 end of the delivery?

8 A But if you look at this tracing up into the descent
9 and the fetal heart rate, they had a normal baseline. And
10 there's moderate variability. And even in -- and this is
11 a prolonged deceleration. There's variability. So, you
12 know, this baby had reserve. So it's not --

13 Q No. That's exactly right. So you've looked at the
14 strips before this and you've concluded that the baby had
15 moderate variability; true?

16 A At times.

17 Q It had a normal baseline?

18 A Yes.

19 Q And it was overall reassuring right before
20 delivery --

21 A Right.

22 Q -- fair? Okay. And then you see this period of
23 bradycardia; true?

24 A True.

25 Q And then you see a blood gas that is drawn that is,

1, essentially, within normal limits; true? A little low,
2 but, essentially, within normal limits?

3 A Yeah, low. Normal, true.

4 Q And you would agree that low to normal is,
5 essentially, explained by that strip right there?

6 A Absolutely.

7 Q Okay. Doctor, you've been delivering babies for a
8 long time; true?

9 A I would consider 30 years a long time.

10 Q All right. And I think you told me at your
11 deposition that you delivered babies in medical school?

12 A Yes, I did.

13 Q And that was before you were a doctor?

14 A That's correct.

15 Q And some of those were by yourself; true?

16 A Well, the first delivery I ever did was by myself,
17 and with the patient, and the nurse, of course. That was
18 the first day on my OB core rotation at Harlem Hospital.
19 And it was a time -- let me get my math correct. It was
20 1982. It was a time that HIV, AIDS was coming about, and
21 so was crack cocaine.

22 And, unfortunately, at Harlem Hospital, I worked with
23 a patient population that indulged. So a lot of the
24 attendings were addressing very sick patients. And this
25 particular night, there were a number of deliveries going

1 on. And I was looking for my preceptor.

2 And this woman who was having, I believe, her eighth
3 baby, the nurse said, Come. And I thought she was talking
4 to somebody behind me. She goes, No, you.

5 And I just started saying, I've never even seen a
6 delivery, any of that.

7 She said, All you need to do is prevent this baby
8 from hitting the floor. Mom will take care of everything
9 else. And mom did.

10 And so that was the first experience I had with
11 obstetrics.

12 Q Okay. And then you entered into a residency program
13 and you delivered babies during your first year of your
14 internship; true?

15 A Actually, at Columbia, the nice thing about that
16 program is that they were emphatic about teaching us what
17 normal is. So I, actually, had a lot of experience
18 delivering babies with the midwives.

19 Q All right. And in your residency program and even in
20 your internship year, you had occasions when you delivered
21 babies by yourself; true?

22 A Towards the end of my first year, yeah, when folks
23 deemed that I was capable.

24 Q Sure. And they had the opportunity to decide whether
25 you were capable. Because in the first year of residency,

1 you delivered hundreds of babies, didn't you?

2 A Yes.

3 Q And you would expect that Brandi Alt had probably
4 delivered hundreds of babies in her first year of
5 residency; true?

6 A I can't comment on that.

7 Q Well, any reason to believe she would not deliver
8 hundreds of babies in her first year of residency in a
9 busy residency program?

10 A I can't comment on that.

11 Some residents are busy doing, you know, all types of
12 other things without, actually, doing the delivery
13 themselves. We see that with our residents as well. You
14 know, they're busy taking care of patients, and rupturing
15 membranes, and doing exams. And when the baby is
16 delivering, someone else does the delivery.

17 Q But, in any event, when you did 100 to 200 deliveries
18 during your internship year, your attendings felt like
19 that was sufficient experience for them to know whether
20 you knew what you were doing when it came to delivering
21 babies?

22 A Well, I had a lot of experience before starting my
23 internship. So I had an edge up on my colleagues.
24 Because I had a very seasoned attending who I worked with
25 during my third year and fourth year of medical school. I

1 came in pretty experienced.

2 So it was very easy for a number of the attendings
3 for normal folk without risk factors for risky outcomes
4 felt comfortable having me do deliveries by myself, where
5 some of my colleagues did not get that treatment until
6 they proved, too, that they were capable of being alone.

7 Q Sure. And you know about Brandi's experience, don't
8 you?

9 A In terms of what, sir?

10 Q Well, you know that Brandi had a full year of
11 residency training before she came to the Greenville
12 Hospital System; right? Were you aware of that?

13 A Yes.

14 Q And some portion of that was labor and delivery. Do
15 you recall that?

16 A Yes.

17 Q And then she had a full year of being the primary
18 intern that would be delivering babies in that first year.
19 Do you remember that?

20 A Yes.

21 Q And, now, we're in the second year?

22 A Early part of the second year, yes.

23 Q All right. Now, Doctor, your -- you practice in --
24 are you still practicing in New York?

25 A No.

1 Q Why did I say --

2 A I'm in Massachusetts.

3 Q Massachusetts. I'm sorry. So this is a busy clinic
4 practice?

5 A No. I have a -- I'm faculty. I have my own
6 practice. I oversee the residents in their clinical
7 works.

8 Q Okay. The residents that you oversee, is that a
9 clinic practice that you're overseeing with the residents?

10 A Yes.

11 Q And is that a busy clinic practice?

12 A Define busy.

13 Q Well, you define it. I'm not grasping for a
14 particular -- is it a busy clinic practice?

15 A It depends on the level. They, actually, have
16 continuity clinics. So the intern would see a patient an
17 hour, where a second-year might get two patients an hour.
18 In my clinic, I get four to five patients an hour.

19 So as you go up the experience ladder, you tend to
20 have shorter periods of time slotted for you via the
21 computer to see patients.

22 Q Okay. And, in this clinic practice, do you commonly
23 see women who are obese?

24 A Yes.

25 Q What percentage?

1 A (There was no response.)
2 Q 40 percent?
3 A Probably around 30 to 40, yeah.
4 Q And do you frequently see women who are diabetic?
5 A Now, are you talking about the residents clinic or
6 mine?
7 Q The residents clinic.
8 A Yes, a good percentage.
9 Q 40 percent? 50 percent?
10 A Higher. We, actually --
11 Q Really?
12 A We, actually, are partnered with Joslin, which is the
13 diabetes center of not only Massachusetts, but people from
14 all over the country come to Joslin for diabetes control.
15 And a number of these women get pregnant.
16 So we, actually, see a higher percentage of diabetic
17 women who have achieved pregnancy.
18 Q So what percentage of women do you see in that clinic
19 that are both obese and diabetic?
20 A Again, I'm not the only attending overseeing there.
21 Q Sure.
22 A I might do that once a month. I do more GYN-wise
23 with the residents. Obese and diabetic, about 20 percent.
24 Q All right. Now, Doctor, in your clinic practice when
25 you're overseeing residents, tell us about that. How many

1 residents are on at any given time?

2 A Outpatient or inpatient?

3 Q Inpatient.

4 So I want to take you to a setting like this labor
5 and delivery --

6 A Okay.

7 Q -- in your clinic practice where you oversee
8 residents.

9 A So the residents do 12-hour shifts.

10 Q Okay.

11 A 7:30 a.m. to 7:30 p.m.

12 Q Okay.

13 A There's always a chief resident on. There's always
14 an attending covering the service. And, during the day,
15 there may be a first and second-year. At night,
16 typically, there isn't a first-year. Because they're
17 inexperienced and you want to have the most experienced
18 crew on at a time where things can happen and staffing may
19 be a little bit more tight.

20 Q Do you ever have third-year residents on?

21 A Third-year residents are more consult to the
22 hospital. So they do different rotations. They're
23 mostly -- to be a third-year resident is kind of the dream
24 year. They don't have a lot of responsibility. Yet, they
25 stay in the operating room doing lots of procedures.

1 They're consults to the emergency room. They come in for
2 difficult deliveries. So they're kind of more a float
3 resident. It's the first and second-year residents that
4 kind of run labor and delivery with the chief and the
5 attending.

6 Q So you've got a chief, an attending, and then the
7 first and second-year residents who are running the
8 clinic?

9 A Running labor and delivery.

10 Q Labor and delivery. All right.

11 Now, do you have computers at your clinic?

12 A You're talking labor and delivery?

13 Q Yes.

14 A Yes.

15 Q And, on these computers, can you access the patient
16 data?

17 A In 2013, yes. In 2004, not so much.

18 Q All right. You did not have the ability by computer
19 to access patient data in 2004?

20 A Not like the entire prenatal record. A lot of it was
21 on paper. So you'd, actually, bring the prenatal chart to
22 labor and delivery by 28 weeks. So if the patient
23 presented at 35 weeks, for example, you may not have had
24 all the information.

25 Q So tell me what information you did have in 2004 that

1 you could access by a computer monitor.

2 A We had laboratory. We had imaging studies, so
3 ultrasounds. Sometimes, there were notes printed in. You
4 had the ability to type notes in. But if a patient came
5 from -- the resident practice, most of the notes were in,
6 we really pushed that, depending on the level.

7 Q Could you access the fetal heart rate tracings in
8 2004?

9 A I'm a little confused by your question.

10 Q So could you go on to a computer monitor and see a
11 baby's heart rate?

12 A Yes.

13 Q So you could monitor the fetal heart rate tracings --

14 A Oh, yes.

15 Q -- on a computer?

16 A That was available in 1983 when I was a medical
17 student.

18 Q Okay. And how many monitors like that were there
19 throughout the labor and delivery suite?

20 A You had the capability of pulling that up on most of
21 the computer screens. But we had central monitoring. So
22 they were always up so that anyone could look at --

23 Q So everybody that's walking around labor and delivery
24 was looking at -- could look at those computer monitors;
25 true?

1 A True.

2 Q You could access it any time you wanted?

3 A Now. But not so much then.

4 Q And other residents, if they're looking up at their
5 computer monitors, they could see what was happening with
6 that baby; true?

7 A Sure.

8 Q And what about things like vaginal exams? Did -- was
9 that available to you on those monitors?

10 A No. We have a board that any time someone got
11 examined or ruptured a membrane, whether they had
12 spontaneous rupture or reruptured, you'd update the board.
13 It's a white board that you have a little Sharpie,
14 erasable, that you can update.

15 You put the time so people know when someone had been
16 examined last. And all the pertinent information is
17 there, meconium, do they have an epidural, are you using
18 Pitocin, antibiotics. All the pertinent information would
19 be in those little box.

20 Q And, actually, that's sort of a term of art, managing
21 the board; right?

22 A Correct.

23 Q Okay. And so --

24 A Or running the board.

25 Q I'm sorry?

1 A Running the board.

2 Q Running the board. All right. That is common in
3 labor and delivery suites in this country; true?

4 A Correct.

5 Q And so when you talk about the team, there was a
6 chief, there was an attending, there was a first-year, and
7 there was a second-year. And all of them are looking at
8 the data, managing the board; true?

9 A I don't know that.

10 Q Well, that's what you would have expected in your
11 labor and delivery suite; true?

12 A That's my expectation. But I don't know whether that
13 happened.

14 Q Well, you're the attending, you're the teacher?

15 A Yes.

16 Q You would ensure that that's happening?

17 A Well, I don't know whether the first or second-year
18 is out. They may be in a section. I don't know if
19 they're physically present to be able to look at the
20 board.

21 Q So they may not be -- they may be split in their
22 duties and not be looking at the board. But, in general,
23 that team is managing the board and looking at all that
24 data; true?

25 A That would be my expectation.

1 Q And, now, if you as an attending -- your folks, your
2 expectation is they're managing the board, that they're
3 looking at all that data, that they're following the fetal
4 heart rate tracings, that they are looking at vaginal
5 exams to see what the progress of labor is, they are
6 monitoring mom's vital signs and aware of all this
7 information. But, as an attending, what do you do to get
8 up to date on that information?

9 A Again, it depends on the level of the resident. It
10 depends on the situation of the patient. I often -- if
11 it's an intern or second-year, especially during the day,
12 I will go in the room and do an exam with them. We have
13 teaching at the bedside, if it's okay with the patient.

14 Again, we have to be very sensitive to increasing a
15 woman's anxiety in pregnancy. Some women welcome you
16 talking about her and her progress in front of her. Some
17 women say, I don't want to hear that. Just let me be in
18 my little Zen place, and you can talk outside the door.

19 But, as an attending -- as most attendings, we teach.
20 And when an intern or second-year has done an exam, we may
21 repeat the exam just to make sure that it's what we
22 consider accurate. If I'm off the floor and there's a
23 concern or our resident would like to do something, they
24 page me, they talk to me on the phone.

25 In a case like this, if a resident called me and said

1 there's a woman who's been at the same dilation for five
2 hours and they keep increasing Pitocin, I would have come
3 up and made sure I did an exam and not totally relied on
4 the reporting from the resident, just to make sure all the
5 data that I'm receiving is correct.

6 Q Okay. So your residents had -- you had a pager;
7 right?

8 A I do.

9 Q And they had pagers as well?

10 A Well, in labor and delivery, they don't usually
11 activate their pagers because they don't leave labor and
12 delivery.

13 Q So one way that you all communicated was that when
14 they wanted to update you, they would page you and tell
15 you?

16 A Typically, I'm the kind of attending that stays
17 around. But if I get called off the floor, I'm not hard
18 to find.

19 Q And the other option would be for you to go find
20 them, either by phone call, pager, or going physically to
21 see them?

22 A Right.

23 Q And that's how you all communicated as a team; fair?

24 A We, also, have team meetings.

25 Q Okay.

1 A So everyone -- everyone being an anesthesiologist,
2 fellow attendings, all the residents, sometimes even the
3 pediatrician will come to a team meeting. It usually
4 happens one time per shift. And we've been doing this a
5 long time. Again, I talk about that shared mental model.
6 So if I'm an attending and there's another attending
7 on the floor, I want to know if that other attending has a
8 potential situation that might need my assistance. So
9 I'll know when that patient is nearing to deliver. That's
10 not the time I'm going to walk to Starbucks and get my
11 coffee. I make sure I stay on the floor so everyone is
12 aware of when there's a high risk patient and what the
13 potentials may be.
14 Q And you told us 30 percent of your patients are both
15 obese and diabetic?
16 A No. You asked me a question about the residents
17 being obese and diabetic.
18 Q The residents?
19 A I didn't say my patients. You said the clinical
20 patients.
21 Q Sure. Right. That 30 percent of those folks are
22 both obese and diabetic?
23 A I said 20 or 30 percent, yes.
24 Q Okay. Now, in this case, you've reviewed the
25 prenatal records?

1 A Yes, sir.

2 Q And we've talked about some risk factors. Would you
3 agree that prior history of macrosomia is a risk factor?

4 A Yes, sir.

5 Q And she did not have that?

6 A That's correct.

7 Q You would agree with me that shoulder dystocia is a
8 risk factor?

9 A Yes, sir.

10 Q And she did not have that?

11 A That's correct.

12 Q You would agree that postdate is a risk factor for
13 shoulder dystocia and she did not have that?

14 A That's correct.

15 Q You would agree that excessive weight gain is a risk
16 for shoulder dystocia and she did not have that?

17 A She did not.

18 Q And this baby was delivered preterm; true?

19 A I believe it was 35 weeks and six-sevenths.

20 Q And would you agree that the ultimate weight of this
21 baby, eight-pounds and five ounces, was consistent with
22 the November 18th ultrasound that indicated 7.9 pounds
23 with nine weeks -- nine days prior to delivery?

24 A Again, it's 8. -- I'm sorry, 8.8-ounce baby. It was
25 large for gestational age being in the growth percentile

1 greater than 95 percent.

2 Q Right. So if you carried that baby to term, then, as

3 I think you said, we could have a 10-pound baby; right?

4 A That's correct.

5 Q But this baby was delivered nine days later; right?

6 A Correct. It's still a big baby. And mom's pelvis

7 had been tested to six pounds and 13 ounces, I think.

8 Q Almost seven pounds. She, also, had a physical

9 examination of her pelvis; true?

10 A Correct.

11 Q Normal gynecoid pelvis?

12 A That's what I saw documented.

13 Q Normal spines?

14 A Correct.

15 Q Could reach the diagonal conjugate?

16 A Correct.

17 Q Nothing about that suggests she doesn't have an

18 ordinary normal pelvis?

19 A Correct.

20 Q And you would agree that at 8.5 pounds, this baby was

21 not macrosomic?

22 A Correct.

23 Q And you would agree that ACOG would not support a

24 C-section of this baby under those circumstances?

25 A Correct. Not an outright recommendation for

1 C-section without a trial of possible vaginal delivery.
2 Q That's right. So this mom had a trial of vaginal
3 delivery; right?
4 A Yes, she did.
5 Q She was induced for a trial of labor?
6 A Correct.
7 Q And she was induced, in part, because she was
8 diabetic?
9 A Correct.
10 Q And she was induced, in part, because she was
11 hypertensive?
12 A Right. We call it superimposed preeclampsia.
13 Q And you would agree that induction of this patient,
14 under these circumstances, was appropriate?
15 A Absolutely.
16 Q And then prior to her, actually, being induced, she
17 went to maternal fetal medicine. Do you recall seeing
18 that?
19 A I'm sorry. Ask that question again.
20 Q So prior to being induced on the 24th of November,
21 she went to maternal fetal medicine and had an
22 amniocentesis. Do you recall that?
23 A Correct, to check the maturity of the baby's lungs.
24 Q All right. So we've decided that induction is
25 appropriate for this patient's return because of the

1 indications that we have discussed. And, now, they've
2 sent her to Maternal Fetal Medicine to make sure that
3 induction is safe for this baby; true?

4 A Correct.

5 Q All right. And at Maternal Fetal Medicine, in that
6 amniocentesis, they discovered that, indeed, the baby had
7 adequate fetal lung maturity for delivery; true?

8 A That's correct.

9 Q They, also, determined that the baby -- they did a
10 non-stress test -- is that what it's called?

11 A That's correct.

12 Q And that indicated that this delivery was safe for
13 this baby; true?

14 A Well, not -- indicated the initiation of the
15 induction was safe. You don't know whether induction is
16 safe until the baby is delivered.

17 Q That's right. And so what the NST proved to us is
18 that it was reactive and it was, therefore --

19 A Safe to start.

20 Q Exactly. And on the November 18th ultrasound, the
21 baby, also, had a biophysical profile at that time that
22 showed that it was eight out of eight. Do you recall
23 that?

24 A Yes, I do.

25 Q And that, also, indicated that this baby was healthy

1 and appropriate for induction at that time?

2 A Based on the clinical indicators, that is correct.

3 Q And the way we induce patients like this is that we

4 give them cervical ripening agents; true?

5 A When indicated.

6 Q Okay. And in this patient, this patient was given, I

7 believe, Cytotec; is that true?

8 A She was.

9 Q And is that appropriate in this case?

10 A Yes, sir.

11 Q And so what that does is it gets the cervix more

12 favorable for delivery?

13 A Well, you can initiate an induction with Cytotec,

14 which is a prostaglandin agent, which, actually, causes

15 the uterus to cramp. And that can cause cervical change.

16 Q Okay.

17 A Sometimes -- and we call it Cyto-blasting.

18 Sometimes, we'll give a woman one Cytotec and, all of a

19 sudden, she's in raging labor and that's all you need to

20 do. As opposed to this case where she, actually, got

21 three Cytotecs, I believe, and then transitioned to IV

22 Pitocin.

23 Q Right. And it's not unusual for a woman not to

24 immediately have contractions when she's being induced.

25 Would you agree with that?

1 A That's correct.

2 Q So one of the ways that we deal with that is that we
3 give them a drug called Pitocin; true?

4 A Correct.

5 Q And the idea behind Pitocin is to either stimulate
6 contractions or strengthen the contractions of the --
7 strengthen the contractions that we, actually, have?

8 A Correct.

9 Q And that's what was done in this case?

10 A Yes.

11 Q And you would agree that that was appropriate?

12 A Yes.

13 Q And when we use Pitocin, we use a device called an
14 IUPC; is that true?

15 A Not always. It depends on what's clinically going on
16 with the patient. The purpose of using an IUPC,
17 typically, is when you're using Pitocin and you're not
18 getting the effect that you think you should be getting.

19 Most patients don't get an IUPC. Because when you
20 use Pitocin, they dilate their cervix, the baby comes
21 down, and they deliver. But in patients where you're not
22 sure of the quality of the contractions and you want to
23 get more information, you'll use an intrauterine pressure
24 catheter because it gives you much more accurate data.

25 External monitoring will only tell you when a

1 contraction is happening. It doesn't tell you anything
2 about the intensity of the contraction.

3 Q Okay. So you do not believe the use of an IUPC is
4 required by the standard of care with a woman on Pitocin?

5 A No.

6 Q Okay. The IUPC is used to measure the adequacy of
7 contractions; true?

8 A It gives you more information, correct. It allows
9 you to use Pitocin more safely, yes.

10 Q And it does that by telling us about the strength of
11 contractions; true?

12 A And the frequency, yes.

13 Q And we do that -- that measurement is made in
14 montevideo units; true?

15 A That's correct.

16 Q And would you agree that adequate contractions --
17 adequate strength of contractions is 200 montevideo units?

18 A That is correct. That is the goal we try to achieve.

19 Q Would you agree that this woman never reached 200
20 montevideo units?

21 A That is correct.

22 Q Would you agree that she never reached two [sic]
23 montevideo units for two consecutive hours?

24 A I'm sorry.

25 Q Would you agree that she, obviously, never reached

1 200 montevideo units for two consecutive hours without
2 cervical change?

3 A That's correct.

4 Q All right. And, Doctor, you've discussed C-sections.
5 You would agree that a C-section is a major abdominal
6 surgery?

7 A It is, sir.

8 Q And you would agree that all major surgeries,
9 including a C-section, carry with it significant risks?

10 A I think we've chatted about that earlier today.

11 Q And those risks would include infection?

12 A Yes.

13 Q And that would be higher for a diabetic patient?

14 A Yes.

15 Q It would be higher for a patient with a history of
16 noncompliance. Would you agree with that?

17 A Restate your question.

18 Q Would you agree that the risk of infection from a
19 C-section would be greater in a patient with a history of
20 noncompliance?

21 A No, sir.

22 Q You would not agree with that?

23 A No.

24 Q You don't think wound infections are higher in
25 patients that are noncompliant?

- 1 A I don't see where -- first of all, what's your
2 definition of noncompliance?
- 3 But I don't see where a patient is in the hospital
4 and you assess clinically and you think there's an
5 infection, you'd give appropriate antibiotics. The
6 patient is there. There's -- noncompliance does not come
7 into that discussion.
- 8 Q Is the risk of infection not carried with the patient
9 after they leave the hospital?
- 10 A It depends on what's going on with the patient.
- 11 Q Okay. Would you agree that a major abdominal surgery
12 like a C-section carries with it the risk of pulmonary
13 complications?
- 14 A Absolutely.
- 15 Q And that would include things like atelectasis?
- 16 A Sure.
- 17 Q And that would include things like pulmonary
18 embolism?
- 19 A Sure.
- 20 Q And that, of course, can be fatal?
- 21 A Sure.
- 22 Q And that is a higher risk for obese patients. Would
23 you agree with that?
- 24 A Yes, sir.
- 25 Q Would you agree that C-sections carry with them the

- 1 risks of intraabdominal injury?
- 2 A Any surgery would carry that risk.
- 3 Q And any surgery would carry the risk of bleeding;
- 4 true?
- 5 A Correct.
- 6 Q And would you agree that that risk is greater in a
- 7 patient that is chronically anemic?
- 8 A No.
- 9 Q All right. If a -- all right.
- 10 A You don't increase risk of bleeding with --
- 11 Q No, no, no. What I'm suggesting is -- or asking you
- 12 is if a patient has a bleeding complication
- 13 intraoperatively or postoperatively, is that a risk to the
- 14 patient -- the risk of harm to the patient greater if they
- 15 are chronically anemic?
- 16 A Oh, yes.
- 17 Q Doctor, would you agree that, in this case, the
- 18 providers that were attending this patient and effecting
- 19 delivery used the McRoberts maneuver?
- 20 A It was documented in the record that that maneuver
- 21 was used.
- 22 Q And that's an appropriate safety maneuver for
- 23 shoulder dystocia?
- 24 A Yes, it is.
- 25 Q Would you agree that the providers involved in this

1 case used suprapubic pressure?

2 A Yes, sir.

3 Q And that is an appropriate safety maneuver?

4 A It is.

5 Q Would you agree that the providers, in this case,

6 used rotational maneuvers to deliver this baby?

7 A Yes.

8 Q And those are appropriate safety maneuvers?

9 A Yes.

10 Q And would you agree that this baby was born -- that

11 shoulder dystocia was resolved at approximately 90 seconds

12 in this case?

13 A That's what's documented in the medical record.

14 Q And that this baby was born without hypoxic injury?

15 A That's what I understood.

16 Q And this issue of shoulder dystocia that we've been

17 talking about, you would agree that it is an obstetrical

18 emergency?

19 A It is, sir.

20 Q And would you agree that if this obstetrical

21 emergency is not resolved expeditiously by the providers

22 that the child can suffer brain damage?

23 A It can.

24 Q And would you agree that the child, if the shoulder

25 dystocia is not resolved expeditiously, can suffer fetal

1 death?

2 A It can.

3 MR. ALEXANDER: Thank you, ma'am.

4 THE COURT: Redirect.

5 MR. GRAHAM: Thank you, Your Honor.

6 REDIRECT EXAMINATION

7 BY MR. GRAHAM:

8 Q Doctor, I just want to cover a few areas. First of
9 all, there was a comment -- or a question, rather, about
10 some children having special predisposition or
11 vulnerability to brachial plexus nerve injury. My
12 question, did you see anything at all in the records to
13 suggest that this child was missing any muscles in the
14 neck or anything like that before the nerve damage?

15 A There was nothing documented in any of the exams that
16 this baby, besides the extent of its injury, was
17 predisposed to this injury.

18 Q And there were a number of questions about the -- the
19 very last page of the strips that show that terminal
20 bradycardia. All right. And the question more recently
21 about 90 seconds to deliver the baby after the head
22 delivered. I believe the records show in some places a
23 minute and a half and in other places a minute and 45
24 seconds?

25 A That's correct.

1 Q At any rate, whether it's a minute and a half or a
2 minute and 45 seconds, was there a rush?

3 A No, sir.

4 Q To get this baby out that fast?

5 A No.

6 Q Is it important if you -- if you, as an obstetrician
7 or a resident, want to try to minimize the risk of ripping
8 and tearing the brachial plexus nerves, is speed a good
9 thing or a bad thing?

10 A Speed is not the intent. It should not be your goal.
11 The goal is for a safe delivery. And again, you want to
12 settle yourself before you exert pretty much any traction
13 of the baby's head once you have diagnosed the shoulder
14 dystocia.

15 And when you do appropriate maneuvers, the McRoberts,
16 suprapubic, like I said earlier, 60 to 70 percent of
17 babies come out just with those maneuvers. Clearly, the
18 rotational maneuvers helped as well in this case. That
19 helped resolve a shoulder dystocia. It doesn't take a lot
20 of time to do that.

21 So the intent of the delivery provider should not be
22 how fast I can get this baby out. Because then you run
23 the risk of exerting more than your normal gentle downward
24 traction.

25 Q Did you read the delivery notes of the attending -- I

1 mean, excuse me. Did you read the deposition of the
2 attending?

3 A Yes, I did.

4 Q All right. Do you recall her testimony about whether
5 or not there was any great rush or urgency to deliver this
6 baby?

7 A No.

8 MR. GRAHAM: All right. Please show on the screen
9 Twedt's Page 102.

10 BY MR. GRAHAM:

11 Q This is from Dr. Twedt's deposition.

12 Question: In looking at the strips, did you see any
13 reason to believe that this baby needed to be delivered
14 urgently?

15 A No. At the time of delivery, there was a terminal
16 bradycardia at the time that the shoulder dystocia was
17 encountered and during maneuvers. So we didn't have seven
18 minutes, we had five to seven minutes. But it was
19 resolved prior to that.

20 Q So despite the terminal bradycardia, despite all
21 those questions making it sound like there was some rush,
22 was there, in fact, any urgency to get this baby out
23 with -- in under two minutes?

24 A No, sir. The goal would be to deliver the baby
25 safely. And this baby, clearly, had reserve, as you saw

1 from the tracing prior to the terminal bradycardia. So
2 you do have time.

3 Q I want to go back to that interesting story you told
4 about yourself. I believe you said maybe an intern,
5 first-year resident, or maybe even a medical student.

6 A Which story? I've told so many stories about myself.

7 Q The one about looking for your --

8 A My preceptor.

9 Q Your preceptor when you get pulled in to deliver?

10 A Yes. I was a third-year medical student doing my
11 first OB core rotation.

12 Q My question for you, Doctor, is, despite the fact
13 that you hadn't even finished medical school yet, since
14 you were in a hospital, a teaching hospital, performing
15 the work of a baby delivery doctor, were you subject to
16 the same safety rules as obstetricians and attendings?

17 A Absolutely.

18 Q All right. If you had botched that delivery and
19 caused a brachial plexus injury or some other kind of
20 injury to that baby, would you and your hospital have had
21 the responsibility to be held accountable for the harm to
22 the baby?

23 A Absolutely.

24 Q All right.

25 A The question would have been why was I put in that

1 position. And, as I was experiencing that, I was asking
2 myself why is this happen to me. But, luckily, things
3 turned out all right because you had a very veteran mom
4 who knew what she was doing.

5 Q There were a number of questions about risk factors
6 that Alana Mann, J.B.'s mom, did not have. That's
7 confusing to me. Can you, please, tell us when you're
8 looking at risk factors for shoulder dystocia, which is
9 more important, risk factors that are there or ones that
10 aren't?

11 A The risk factors that are there. And the fact,
12 again, of obesity and diabetes. Because diabetic babies
13 have a different body structure. We know their abdomens
14 and shoulders are going to be larger.

15 And that's why it's such an urgent or, potentially,
16 emergency situation when the head comes out. You'll often
17 hear it described as a turtle sign. The head comes out
18 and then sucks back in. And then, you know, oh, oh,
19 there's a potential shoulder dystocia. You assert your
20 gentle traction. And then you go, again, oh, oh, this is
21 not coming.

22 So those two factors alone are paramount in being
23 alert to the fact that this could result in a shoulder
24 dystocia.

25 Q There was a question put to you about whether ACOG

1 requires a C-section at the weight of -- the estimated
2 fetal weight of J.B. without a trial of labor. And you
3 indicated that a trial of labor would be --

4 A Appropriate.

5 Q -- appropriate. What does all of your training and
6 experience tell you about when a doctor must stop a trial
7 of labor because to keep up with a trial of labor is to
8 needlessly endanger the baby?

9 A Right. Well, again, you have a patient that's high
10 risk for shoulder dystocia, who has hours, and hours, and
11 hours of high dose Pitocin not changing their cervix, baby
12 not coming down. So you, as the obstetrician in charge,
13 must evaluate the patient, must have a discussion, and
14 must recommend a C-section, particularly, at 9.5
15 centimeters when the patient is encouraged to push.
16 That's a setup for disaster.

17 So the initiation of the induction is absolutely
18 fine. But you have to know when to say this is no longer
19 safe.

20 Q And I can't remember whether we've talked -- really
21 talked about that starting to push at nine and a half
22 centimeters. Was that a breach of the generally-accepted
23 standards?

24 A Yes, we did. I think I did answer that question.

25 Q Is that a breach of safety rules?

1 A Yes, it is.

2 Q Did that contribute as a background factor for the
3 permanent nerve damage in this case?

4 A Well, again, you want to wait until the mom is fully
5 dilated. So to encourage her to push at 9.5 centimeters,
6 you've gotten yourself into this situation.

7 If you had given her the option of C-section, then
8 you bypass all of this. If you give her the option of
9 waiting, you may have never gotten to full dilation. And
10 you would have ended up with a C-section, and this would
11 not have happened.

12 Q But if you skip the C-section and keep on trying to
13 pound that baby's head down through the birth canal --

14 A Eventually, it will come out.

15 Q What should a teaching hospital do in terms of who
16 should be around to fix it if the baby's shoulder gets
17 stuck?

18 A The attending.

19 Q In that respect, Doctor, is looking at the board a
20 satisfactory way to meet one's duty to manage the risks of
21 labor and delivery with a second-year resident in the
22 actual delivery room?

23 A No, sir.

24 Q All right. So if the attending, who was not in
25 attendance in the delivery room, might have been in

1 attendance in front of a board somewhere else, does that
2 help the baby?

3 A That helps no one.

4 MR. GRAHAM: Thank you, Doctor.

5 MR. ALEXANDER: Very briefly.

6 THE COURT: Yes, sir.

7 RE CROSS-EXAMINATION

8 BY MR. ALEXANDER:

9 Q In fairness to whoever your preceptor was, when you
10 found yourself in a room by yourself delivering a baby in
11 medical school in your internship and during your
12 residency, would you agree with me that there are times
13 when an attending's duties are split?

14 A (There was no response.)

15 Q Have you had the circumstance of a precipitous
16 delivery?

17 A Absolutely. We all have.

18 Q And you were unable to get there in time?

19 A I think I related that story today.

20 Q Okay. And have you, also, had the experience of
21 simultaneous deliveries?

22 A Absolutely.

23 Q Have you had the experience where you're doing labor
24 and delivery, and there is an emergency in the emergency
25 room, that an obstetric patient has been called to the

1 emergency room and you're asked to consult?

2 A Well, that's why it's so important to communicate
3 with those that are on the floor. There's a rare
4 circumstance when there's no other attending around.

5 So you want to make sure if you feel you're going to
6 be pulled somewhere else that someone is apprised of what
7 you're concerned about so you have coverage.

8 Q But, earlier this morning, you told us that sometimes
9 by the time you get a drink of water, everything has
10 changed. You don't always know when you're going to be
11 needed; true?

12 A That's not true. If I'm called to an emergency in
13 the emergency room and I have to physically leave labor
14 and delivery, before I leave labor and delivery, I get
15 someone to cover me. If they're not on the floor, they
16 get paged, go up to labor and delivery.

17 You never, as an attending, want to leave yourself in
18 that vulnerable position. And you never want to leave
19 your resident in that vulnerable position.

20 Q That's right. And you know from the testimony in
21 this case -- the testimony is that when John Shepherd, the
22 intern, walked out of the room to get assistance, he saw a
23 chief resident heading towards him; true?

24 A Yes.

25 Q And by the time this baby's shoulder dystocia was

1 resolved in less than 90 seconds, Dr. Twedt was in the
2 room as the baby was being placed in the warmer; true?

3 A Okay. Yes.

4 Q Would you agree that Dr. Twedt was, obviously, on her
5 way to that delivery at the time of delivery?

6 A I don't know when Dr. Twedt got there. But, again,
7 this patient pushed for two hours. And there was no
8 documentation in the medical record that Dr. Twedt was
9 involved. And that's where I have my criticism that
10 pediatricians weren't there, Dr. Twedt wasn't there.

11 This woman is not like -- this was not a precipitous
12 delivery. This woman's baby took a long time to come down
13 and negotiate the pelvic anatomy. And she pushed for two
14 hours. So this is not a precipitous delivery.

15 Q Nor do you stand at the bedside for two hours while a
16 patient is pushing, do you?

17 A Oh, yes, I do.

18 Q Every time?

19 A No, depending on the circumstances.

20 MR. ALEXANDER: Okay.

21 MR. GRAHAM: Just very briefly, Doctor.

22 FURTHER EXAMINATION

23 BY MR. GRAHAM:

24 Q Which is better for the mother's health and for the
25 baby's health, an attending to come rushing in at the last

1 minute trying to rescue, or to come up with a plan early
2 on that assures the attending's involvement before there's
3 a need for rescue?

4 A I think I've answered that question. There was a
5 need for-preparedness in this case with all that we talked
6 about today, the risk factors of mom, her dysfunctional
7 labor, two hours of pushing with someone who had had a
8 baby before. She had a tested pelvis for six-plus pounds.

9 Why is the attending coming in after the baby is
10 delivered? This attending should be there evaluating the
11 patient and seeing how she's pushing with her new
12 second-year.

13 Q If, in fact, an attending fails to plan and if, in
14 fact, an attending claims to be doing some important work
15 somewhere else at the time when [REDACTED] J.B. [REDACTED] needed
16 help, should the fact that the attending was busy
17 somewhere else on important business be charted on the
18 records?

19 A That's a difficult question to answer. I would say
20 that usually doesn't get charted in the medical records.
21 Because what should happen is if the attending is that
22 busy and can't assume her duties or his duties, you make
23 arrangements so there's no need to write that in the
24 patient's medical record.

25 Q And if, in fact, an attending claims to be busy off

1 doing some other kind of important work so they don't get
2 there until after the baby's in the warmer, should the
3 folks at the hospital write on the chart that the
4 attending was present?

5 A Again, what does that mean? When did the presence
6 happen? The fact that you're in the room, you're present.

7 Q Should the attendings write on the chart that the --
8 I mean, should the hospital folks write on the chart, that
9 the attending was supervising the delivery if, in fact,
10 she was not in the room?

11 A No. That should not have happened.

12 MR. GRAHAM: Thank you.

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

14 THE WITNESS: You are so welcome.

15 THE COURT: Let me talk to the lawyers up here real
16 quick.

17 (WHEREUPON, a bench conference was held.)

18 MR. GRAHAM: Your Honor, the Plaintiff calls Alana
19 Mann.

20 THE COURT: All right.

21 THE CLERK: Place your left hand on the Bible and
22 raise your right hand.

23 WHEREUPON,

24 ALANA ANDREA MCCLURE,

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

1 THE CLERK: Thank you.

2 State your name, please.

3 THE WITNESS: Alana Andrea McClure.

4 THE CLERK: Thank you.

5 Please be seated.

6 DIRECT EXAMINATION

7 BY MR. GRAHAM:

8 Q Alana, good afternoon.

9 A Good afternoon.

10 Q Are you ready for this?

11 A Yes.

12 Q Okay. I'm going to ask you some terribly personal
13 questions. Do you understand that?

14 A Yes.

15 Q Okay. I want to be as sensitive as I can about these
16 issues, but we need to get these issues out because we all
17 need to understand what's going on in **J.B.**'s first nine
18 years. And, as her mom, we need to hear it from you. Do
19 you understand that?

20 A Yes.

21 Q Thank you.

22 Tell us a little bit about yourself. First of all,
23 where were you born?

24 A I was born in Greenville, South Carolina.

25 Q Okay. And when were you born?

1 A I was born January 31st, 1983.

2 Q And where did you grow up?

3 A I grew up in Greenville, South Carolina.

4 Q Okay. Tell us about your educational background.

5 The first go round, how far did you go in school?

6 A I got to the eleventh grade.

7 Q And then what happened?

8 A I dropped out. And then I went and got my GED. And

9 then I've done six months of college.

10 Q Okay. When did you get your GED?

11 A 2000. The year 2000.

12 Q And when did you go back to start some college work?

13 A 2008, 2009.

14 Q What college are you going to?

15 A I was going to Brown Mackey at that time.

16 Q And what is that exactly?

17 A Where is it?

18 Q Yes, ma'am.

19 A It's right over there right across the street from

20 the courthouse.

21 Q What are your intentions as far as future education

22 are concerned?

23 A I plan on going back to college to get a degree.

24 Q Do you have the ability to do that right now?

25 A Not at this point.

1 Q Tell us about the jobs that you have held.

2 A I have been a retail associate, a department head in
3 the -- retail associate. I've been a cashier. I've been
4 a host, a waitress, and to-go person for the last couple
5 of years off and on.

6 Q Thank you.

7 Have you ever held a job that you could do with one
8 strong arm and hand?

9 A No, I haven't.

10 Q Let's talk about some of your health problems. When
11 were you first diagnosed with diabetes?

12 A At age 15.

13 Q What kind of treatment did you get for that back in
14 those days?

15 A At that time, I was on a pill.

16 Q Okay. Was there a time when -- I know you had to
17 take insulin shots?

18 A Yes, when I got pregnant.

19 Q And, currently, how do you treat your diabetes?

20 A With the pill and, sometimes, insulin.

21 Q When did you first get diagnosed with mental health
22 problems?

23 A Around age 15.

24 Q How have you gotten treated for that?

25 A With pills.

1 Q What about high blood pressure? I remember seeing
2 that on some of your records. When were you diagnosed
3 with that?
4 A At age 15. And it's, also, treated with pills.
5 Q Let me ask you about the father of your babies.
6 We've heard about, of course, J.B. This is J.B.'s
7 case. We've, also, heard about Brittany. Are those all
8 of your children?
9 A Yes, it is.
10 Q Okay. Who is the biological father of your girls?
11 A His name is Bobby Ballenger.
12 Q How did you and Bobby meet?
13 A We met at a grocery store.
14 Q How long did you and Bobby have a relationship?
15 A For, I'd say, about six years.
16 Q When did you first get pregnant?
17 A In 2003 with Brittany.
18 Q Were there any problems with that pregnancy?
19 A No, there wasn't.
20 Q Was there any problems with that labor and delivery?
21 A No, there wasn't.
22 Q Were there any complications that made her birth
23 difficult?
24 A No, there wasn't.
25 Q Okay. Did you have to handle the problems with --

1 well, you were over 15 then; right?

2 A Yes.

3 Q All right. So you already had diabetes, and high
4 blood pressure, and mental health problems?

5 A Yes.

6 Q Did those present any problems with the first
7 pregnancy?

8 A No, they didn't.

9 Q Tell me about the second pregnancy. What did you do
10 from -- to keep from gaining too much weight?

11 A Limited what I ate. And just watched my diet. And I
12 tried to eat a lot of vegetables.

13 Q What did you do to monitor your blood sugar?

14 A I stuck myself three to four times a day.

15 Q And what did you do as -- did you have any other
16 health problems around that time, besides the mental
17 health, and the hypertension, and the diabetes?

18 A No, I didn't.

19 Q Okay. Did any healthcare provider ever tell you that
20 they wouldn't be able to treat you because of those
21 problems?

22 A No, they didn't.

23 Q Did any healthcare provider ever tell you that those
24 problems were going to cause you difficulty with your
25 pregnancy, or cause problems for your baby?

- 1 A No, they didn't.
- 2 Q Did any -- did you tell your healthcare providers
3 about your religious faith?
- 4 A Yes, I did.
- 5 Q Did you explain to them that, as a Jehovah's Witness,
6 it was against your faith to have a blood transfusion with
7 someone else's blood?
- 8 A Yes, at that time.
- 9 Q Did anyone ever discuss with you a refusal to treat
10 you because of your faith?
- 11 A No, they didn't.
- 12 Q Did anybody ever tell you your faith would cause
13 problems with your pregnancy or delivery?
- 14 A No, they didn't.
- 15 Q Did anyone ever tell you that would put your child at
16 risk?
- 17 A No, they didn't.
- 18 Q Did anyone ever discuss with you alternatives to
19 being -- to receiving a blood transfusion with someone
20 else's blood?
- 21 A No, they didn't.
- 22 Q Did they talk to you about taking high dosages of
23 iron for your blood?
- 24 A No, they didn't.
- 25 Q Did they talk to you about saving your blood so that

1 you could recycle it, take it out, and put it back in?

2 A No, they didn't.

3 Q Did they talk to you about medicine to help you
4 stimulate the growth of more blood to increase the volume
5 of your blood?

6 A No, they didn't.

7 Q Did they talk to you about the availability of
8 artificial blood?

9 A No, they didn't.

10 Q During that second pregnancy, did anyone ever talk to
11 you about the possibility you might need a C-section?

12 A No, they didn't.

13 Q Did they do that -- even after you got in the
14 hospital, was there any discussion with you about problems
15 with your baby being slow to go down the birth canal?

16 A No, there wasn't.

17 Q Did anybody talk to you about your cervix, the bottom
18 part of your uterus, being real slow to open up?

19 A I can't remember.

20 Q All right. But you would -- would you remember if
21 you had had a discussion at any time about whether or not
22 you should have a C-section?

23 A Yes.

24 Q Was there any such discussion?

25 A No, there wasn't.

1 Q Now, tell me what you remember about those early days
2 and months with J.B. after she was born with a limp arm.

3 A It was really hard because we had to dress her with
4 her right arm being first and then her left arm. And we
5 had to learn how to hold her a certain way, how to feed
6 her a certain way, how to carry her a certain way.

7 We couldn't leave her with just anybody. The person
8 had to be trained by me or her occupational therapist, at
9 that time, to learn how to hold her so they wouldn't
10 damage her arm, and how to carry her, and how to care for
11 her, and how to bathe her, and how to just, basically, do
12 what a -- you know, a normal baby-sitter would do. We
13 couldn't have a normal baby-sitter there.

14 Q How did she do in terms of learning to crawl?

15 A She did not crawl. She scooted on her rear-end
16 across the floor. She did not crawl.

17 Q Did she figure out how to walk?

18 A Yes. Eventually, she figured out how to walk,
19 eventually.

20 Q Now, we know -- we've heard there was a first surgery
21 on the nerves in Atlanta. Who took J.B. to Atlanta for
22 that surgery?

23 A Me and her father.

24 Q Okay. What do you remember around that period of
25 time? Just tell us, what you remember about the days

1 leading up to the surgery and the aftermath?

2 A The days leading up to the surgery, we were just --
3 had to go visit. And we were nervous and scared. And we
4 took her for the surgery. And we stayed down there a week
5 in the hospital.

6 And when she came out of surgery, she would not eat
7 anything but a grape popsicle. She -- at that time, she
8 was nursing. She wouldn't nurse. She wasn't feeding.
9 She wasn't gaining weight. We could not get her to eat.
10 And because of that, she had to have more therapy.

11 Q How many therapies were going on during those early
12 years?

13 A Three.

14 Q What types?

15 A Occupational, physical, and speech therapy. And not
16 speech therapy because she couldn't talk, speech therapy
17 because she wouldn't eat. She could not eat.

18 Q Let's talk about the second surgery. What do you
19 remember about that?

20 A It was at the hospital. I stayed with her through
21 the whole surgery, through the whole time she was in the
22 hospital. Family came to visit. Her father came to
23 visit. Several people came to visit.

24 And after she got out of there, we had to go back --
25 I had the choice of going back every day for physical

1 therapy, or I had a choice to stay in the hospital again.
2 So it was really hard because we had to learn how to dress
3 her again, how to carry her. I had to carry her
4 everywhere she had to go. It was just really hard.

5 Q And what position did she have to keep her right arm
6 in?

7 A In the Statute of Liberty pose, because there was a
8 bar holding up her arm.

9 Q All right. I need to switch to some unpleasant
10 subjects. When did you first learn that there was a
11 problem -- or how did you first learn that there was a
12 problem with some bad acts involving Bobby Ballenger and
13 Brittany?

14 A Brittany is a very intelligent child, a very, very
15 intelligent child. And she had some trouble with going to
16 school and seeing her father, who, at that time, was a
17 delivery driver for her school. And I thought maybe that
18 she had inherited some problems from me or through me.

19 So I took her to mental health. And when she went to
20 mental health, she revealed to the counselor that he had
21 abused her.

22 Q What was the upshot of all that?

23 A The girls were put with my mom for a while. And he
24 was found guilty in Family Court of abusing her.

25 Q Okay. And I don't want to go into too much detail

1 there. But did you, subsequently, get married?

2 A Yes, I did.

3 Q Okay. And what's your husband's name?

4 A Charles.

5 Q What kind of work does he do?

6 A He's a tow truck driver and an over-the-road driver,

7 transporter of cars, and different items.

8 Q Now, have there been -- has there been a report

9 involving bad acts on the part of your husband?

10 A Yes, there have.

11 Q Did the Department of Social Services get involved at

12 that point?

13 A Yes, they did.

14 Q Is he currently in jail?

15 A Yes, he is.

16 Q To the best of your knowledge, did any bad acts that

17 were committed by either of those two men in your life

18 involve **J.B.**

19 A No, they did not.

20 Q They were both limited to Brittany?

21 A Yes, they were.

22 Q Are both children in therapy?

23 A I do not know at this point.

24 Q Okay. And let's talk about that for a moment. Did

25 you have any knowledge whatsoever of any bad acts going on

1 at the time they were going on?

2 A No, I did not.

3 Q Did you -- after the Department of Social Services
4 got involved, did you lose the right to keep your precious
5 daughters with you?

6 A Yes, I did.

7 Q I know this must be terribly difficult, Alana. But
8 does your mom stay in touch with your children?

9 A Yes, she does.

10 Q Do you keep up with them?

11 A Yes, I do, through my mom.

12 Q Are you okay to keep going?

13 A Yes.

14 Q How are Dee and Sam doing as the adults -- as the
15 parents in the lives of your children?

16 A They're doing a wonderful, awesome job. And I'm so
17 proud to have them as the parents of my children to step
18 in and take care of my children.

19 Q Are they able to provide some things for your
20 children that you have never been able to?

21 A Yes, they are, yes.

22 Q How would you describe your present feelings about
23 **J.B.** and Brittany?

24 A I feel like they're young ladies that are thriving
25 very well, and do very awesome in school. And they're in

1 great care. I love them.

2 Q You love them from a distance?

3 A From a distance.

4 MR. GRAHAM: Thank you.

5 Please answer any questions Mr. Alexander might have.

6 CROSS-EXAMINATION

7 BY MR. ALEXANDER:

8 Q Ms. Mann, you received your prenatal care at the GHS
9 clinics during Brittany's pregnancy; true?

10 A Yes.

11 Q Back in 2003?

12 A Yes.

13 Q Had you been using the clinics prior to that?

14 A Yes.

15 Q How long?

16 A I'm not sure.

17 Q Years?

18 A Maybe since age 15.

19 Q Okay. So from age 15 until Brittany's pregnancy in
20 2003, you had used the Greenville Hospital System health
21 clinics?

22 A Yes, if not before.

23 Q Okay. And you used the Greenville Hospital System
24 health clinics in 2004 with J.B.'s pregnancy?

25 A Yes.

1 Q All right. And, in fact, after J.B. was delivered,
2 you continued to be treated at the GHS health clinics?

3 A Yes.

4 Q And are you still being treated at the GHS health
5 clinics?

6 A No.

7 Q When did you stop?

8 A Let me take that back. I see the endocrinologist
9 clinic at the Greenville Hospital System. And that's the
10 only thing I see. Other than that, I use Saint Francis.

11 Q But for years after J.B. was born, you continued to
12 use the GHS health clinic; true?

13 A Yes.

14 Q All right. You were diabetic with your pregnancy
15 with Brittany?

16 A Yes.

17 Q And you were diabetic with your pregnancy with
18 J.B.?

19 A Yes.

20 Q You were hypertensive with your pregnancy with
21 Brittany in 2003?

22 A Yes.

23 Q And you were hypertensive with your pregnancy with
24 J.B. in 2004?

25 A Yes.

1 Q You were 5'2", roughly, 220 pounds with your
2 pregnancy with Brittany?

3 A Yes.

4 Q And you were 5'2" and 220 pounds, roughly, with your
5 pregnancy with J.B.

6 A Yes. I guess the pounds are right. I'm not sure
7 about the pounds.

8 Q You were induced early for hypertension in 2003?

9 A Yes.

10 Q And you were induced early for hypertension in 2004?

11 A Yes.

12 Q You had a history of chronic anemia in 2003?

13 A Yes.

14 Q And you had a history of chronic anemia in 2004?

15 A Yes.

16 Q You were a Jehovah's Witness in 2003?

17 A Yes.

18 Q And you were a Jehovah's Witness with J.B.'s
19 pregnancy in 2004?

20 A Yes.

21 Q And you had a vaginal delivery both in 2003 and 2004?

22 A Yes.

23 Q You saw Dr. Alt many times in the clinic, did you
24 not?

25 A Yes.

- 1 Q Okay. And do you remember her?
- 2 A I remember the way she looked and the way she was.
- 3 Q Okay. You told me at your deposition that she was
- 4 very nice to you?
- 5 A Yes, she was.
- 6 Q That she seemed like she cared about you?
- 7 A Yes.
- 8 Q That she was very approachable?
- 9 A Yes.
- 10 Q That you were very comfortable talking to her?
- 11 A Yes.
- 12 Q You were comfortable asking her questions?
- 13 A Yes.
- 14 Q That she seemed very knowledgeable?
- 15 A Yes.
- 16 Q That she answered all your questions?
- 17 A Yes.
- 18 Q And that you were able to understand her answers?
- 19 A Yes.
- 20 Q All right. And you remember receiving counseling at
- 21 the GHS clinics?
- 22 A For what?
- 23 Q Do you recall, for instance, receiving nutritional
- 24 counseling?
- 25 A I think so.

1 Q Okay. Do you recall them talking to you about your
2 diet?

3 A I think so.

4 Q Do you recall them talking about the importance of a
5 good diet?

6 A Yes.

7 Q Do you recall them talking to you about the
8 importance of controlling your blood sugars?

9 A Yes.

10 Q Do you recall them talking to you about dietary
11 indiscretions, problems that you were having being
12 compliant with your diet?

13 A No. I don't remember that.

14 Q All right. Do you recall that counseling about
15 general instructions about your pregnancy, things like the
16 need for hygiene, exercise, the importance of prenatal
17 care, physical -- let's see, physical and sexual activity,
18 all of those kind of things? Do you recall them
19 counseling you about those kinds of things?

20 A Yes.

21 Q Do you recall them talking to you and counseling you
22 about fetal growth and development, that is the growth of
23 your baby?

24 A With Brittany or J.B.

25 Q J.B.

1 A I can't remember.

2 Q Do you recall them talking to you about fetal
3 development month by month, physical changes for you and
4 your baby?

5 A Yes.

6 Q All right. We've talked about nutrition. You do
7 recall them counseling you about that?

8 A Yes.

9 Q All right. Do you recall them counseling you about
10 your due date, that is understanding your due date?

11 A I remember them telling me my due date.

12 Q Okay. Do you remember them counseling you about
13 risky behaviors, things like smoking, alcohol, substance
14 abuse, sexual risks, and consequences to the baby, those
15 things?

16 A I cannot remember.

17 Q All right. Do you remember them counseling you about
18 cesarean section, discussion of what it is, what are the
19 usual indications?

20 A No, I do not.

21 Q The risk and benefits of cesarean section?

22 A No, I do not.

23 Q Vaginal birth after cesarean counseling?

24 A No, I do not.

25 Q Do you remember them counseling you about

1 breast-feeding?

2 A Yes.

3 Q And do you remember them counseling you about family
4 planning?

5 A Yes.

6 Q **J.B.** had her first surgery at 11 months of age?

7 A It was 10 or 11.

8 Q And she was in your custody at that time?

9 A Yes, she was.

10 Q You had legal custody of her?

11 A Yes, I did.

12 Q She was your financial responsibility at that time?

13 A Yes, she was.

14 Q She had her second surgery at, what, four years of
15 age?

16 A Three or four. I'm not sure.

17 Q Three or four. And she was in your custody at that
18 time?

19 A Yes, she was.

20 Q You had legal custody of her?

21 A Yes, I did.

22 Q You had financial responsibility for her?

23 A Yes, I did.

24 Q All right. And then, at some point, there was a
25 suggestion that she might need another surgery. Do you

1 recall that?

2 A Yes, I do.

3 Q And that was while she was in your custody?

4 A Yes.

5 Q While you had legal custody of her?

6 A Yes.

7 Q And financial custody of her?

8 A Yes.

9 Q And you were told, at that time, that the surgery

10 would be largely cosmetic. Do you recall that?

11 A Yes.

12 Q And that, though, she may make gains in a cosmetic

13 sense, she would lose some function that she currently

14 had?

15 A Yes.

16 Q And you said no. Do you recall that?

17 A Yes.

18 Q And your mom said no?

19 A Yes.

20 Q And that surgery was never done?

21 A No.

22 MR. ALEXANDER: Thank you.

23 MR. GRAHAM: No questions, Your Honor.

24 THE COURT: Thank you.

25 You may step down.

1 Did you say you had a short witness?
2 MR. GRAHAM: We do.
3 THE COURT: Okay.
4 MR. GRAHAM: We call Kelly Williams.
5 THE CLERK: Place your left hand on the Bible and
6 raise your right hand.
7 WHEREUPON,
8 KELLY WILLIAMS,
9 after first having been duly sworn, testified as follows:
10 THE CLERK: Thank you.
11 Please state your name.
12 THE WITNESS: Kelly Williams.
13 THE CLERK: Thank you.
14 Please be seated.
15 DIRECT EXAMINATION
16 BY MS. RODRIGUEZ:
17 Q Kelly, I know you told me you were very nervous.
18 They don't bite.
19 Can you tell them who you are?
20 A Kelly Williams.
21 Q And, Kelly, how old are you?
22 A 35.
23 Q And where do you work?
24 A Vista Care or Gentiva Hospice.
25 Q You're going to have to talk up louder. Okay.

1 A Gentiva Hospice. . .

2 Q And how long have you been with hospice -- worked

3 with hospice?

4 A It will be a year in December. But I've been doing

5 home health for like 13 years.

6 Q And where did you grow up?

7 A In Greenville.

8 Q And how do you know the Oranges?

9 A I met her about six years ago. She knew my family,

10 but I didn't know her. But we got online one time talking

11 about mother on Mother's Day. And we've been friends ever

12 since.

13 Q And you're talking about Dee?

14 A Dee.

15 Q And in your relationship with Dee, you knew her

16 before she got married and after she got married?

17 A Yes.

18 Q And did you have a chance to see her interact with

19 the girls?

20 A Oh, yeah.

21 Q Okay. Well, tell the jury a little bit about how

22 their lives changed when the girls came into their lives.

23 A Well, they used -- Sam and Dee, we used to always go

24 out and hang out all the time. Now, it's just their

25 focus -- main focus is the girls. They do family things

1 all the time. They leave [phonetic] me and my son. But
2 they still go out and do stuff, but it's more focused on
3 them.

4 Q How old is your son?

5 A Eight.

6 Q And is he friends with the girls?

7 A Oh, yeah, before they came, too.

8 Q Okay. Well, in terms of your observing Dee and Sam,
9 do you know if Dee intended to continue working?

10 A She can't. She's focused too much on them.

11 Q On the girls?

12 A Uh-huh.

13 Q Tell the jury just a little bit about the sleep over
14 you told me about at your house and what happened.

15 A Well, of course, I have two boys. One is 17 and one
16 is eight. But I had a sleep over with the sisters and
17 friends. And they ranged from age three all the way up to
18 like 15.

19 And we was doing different stuff. And it was time to
20 eat and everybody got their food and drink. And Beans
21 kept wasting her drink on my carpet. And I was like --
22 she did it three times -- well, two or three times. And I
23 said, Hey, you've got to eat over here with the smaller
24 kids. So instead of making her feel some type of way, I
25 made her think she was hosting the little kids versus the

1 big kids in the living room.

2 Q Tell the jury what Beans told you.

3 A She said she wished she was normal. And I told her

4 she was.

5 Q How did Dee and Sam treat her with her injury?

6 A They're really protective of her. And I guess they

7 want everybody to look at her normal, but, they just

8 don't. So they want to put her in a bubble, but they

9 can't.

10 Q And tell the jury what you told me about what you

11 fear about what's going to happen as Beans gets older.

12 A Her momma is not going to be there to protect her.

13 And she's just going to have to deal with it and harden up.

14 MS. RODRIGUEZ: Thank you, Kelly.

15 Answer any questions the Defense asks.

16 MR. ALEXANDER: I don't have any questions.

17 THE COURT: All right. Thank you, ma'am.

18 You may step down.

19 Ladies and gentlemen, thank you for your patience.

20 And we'll see you in the morning at 9:00. Don't talk

21 about the case or do any outside investigation. And,

22 please, continue to keep an open mind.

23 We'll see you back at 9:00.

24 (WHEREUPON, the jury was excused from open court at

25 approximately 6:07 p.m.)

1 THE COURT: Okay. Anything else before we break?
2 MR. GRAHAM: No, Your Honor.
3 MR. ALEXANDER: No, sir.
4 THE COURT: All right. Thank you all.
5 Well see you back in the morning at 9:00.
6 (WHEREUPON, the proceedings were concluded at
7 approximately 6:07 p.m., to be reconvened on
8 Wednesday, October 30, 2013)
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