

THE STATE OF SOUTH CAROLINA
In the Supreme Court

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SEP 14 2017

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

S.C. SUPREME COURT

Michael Nettles, Circuit Court Judge

Case No. 2013-CP-21-00587
Appellate Case No. 2015-001237

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

Appellants,

v

v.

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

Respondents.

APPENDIX
Vol 1 of 3

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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM FLORENCE COUNTY
Court of Common Pleas

The Honorable Michael Nettles, Circuit Court Judge

Appellate Case No. 2015-001237

RECEIVED

APR 14 2016

SC Court of Appeals

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

Appellants,

v

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

Respondents.

RECORD ON APPEAL
VOLUME 1 of 2

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FORM 4

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

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

Genesie Fulton	Bryson F	L William Goldstein	L William Goldstein
		Steven N Coker	Obgyn Drs Coker & Phillips
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: _____

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	Judge Code	Date 9/30/2014

For Clerk of Court Office Use Only

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

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

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

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel Shearin

Court Reporter

Connie Reel-Shearin - Clerk of Court

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

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

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

Genesie Fulton, individually, and as)
Next Friend of Bryson F , a Minor,)
Plaintiffs,)

-vs-

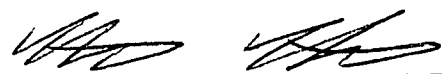
L. William Goldstein, M.D., individually)
and d/b/a L. William Goldstein OB-GYN,)
Steven N. Coker, M.D., and Drs. Coker)
& Phillips, P.A.,)
Defendants.)

IN THE COURT OF COMMON PLEAS)
CIVIL ACTION NO. 2013-CP-

STIPULATION OF DISMISSAL
(with prejudice)

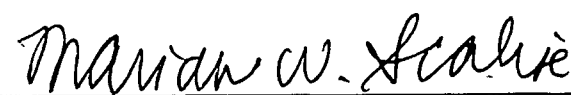
The Plaintiffs herein dismiss the above-entitled action against Steven N. Coker, M.D. and
Drs. Coker & Phillips, P.A. in its entirety with prejudice pursuant to Rule 41(a)(1)(B) of the
South Carolina Rules of Civil Procedure.

WE SO STIPULATE:


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

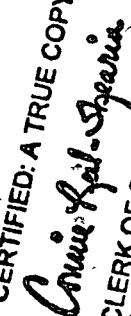
September 15, 2014

WE CONSENT:

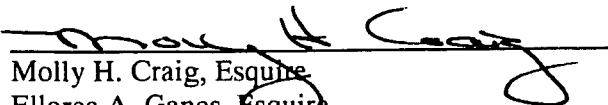

Marian Williams Scalise, Esquire
Lydia L. Magee, Esquire
Richardson, Plowden & Robinson, P.A.
P. O. Box 3646
Myrtle Beach, SC 29578
Attorneys for Defendants Steven N. Coker, M.D. and Drs. Coker & Phillips, P.A.

September 24, 2014

FILED
2014 SEP 29 PM 2:12
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

CERTIFIED: A TRUE COPY

CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

September ¹⁵, 2014



Molly H. Craig, Esquire
Elloree A. Ganes, Esquire
Hood Law Firm, LLC
172 Meeting Street
P.O. Box 1508
Charleston, SC 29401

Attorneys for Defendants L. William Goldstein, M.D., individually and d/b/a L. William Goldstein Ob-Gyn

FORM 4

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

FILED

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

Genesie Fulton

Bryson F

2015 MAY 19

William Goldstein

L William Goldstein
Obgyn

CLERK OF COURT
CCCP & GS
FLORENCE COUNTY, SC

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: _____

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)

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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

Judge Code

5/19/2015
Date

For Clerk of Court Office Use Only

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

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

ATTORNEY(S) FOR THE PLAINTIFF(S)

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

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel-Shearin

Connie Reel-Shearin - Clerk of Court

Court Reporter

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

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

Plaintiffs' Motion for a New Trial heard and denied.

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF FLORENCE
IN THE COURT OF COMMON PLEASJUDGMENT IN A CIVIL CASE
CASE NUMBER 2013CP2100587

Genesie Fulton Bryson F	Bryson F	L William Goldstein	L William Goldstein Obgyn
PLAINTIFF(S)		DEFENDANT(S)	
Submitted by:		Attorney for: ☐ Plaintiff ☐ Defendant ☐ Self-Represented Litigant	

DISPOSITION TYPE (CHECK ONE)

- ☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.
- ☐ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.
- ☐ **ACTION DISMISSED (CHECK REASON):** ☐ Rule 12(b), 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: _____

INFORMATION FOR THE JUDGMENT INDEX

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

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

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

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

Circuit Court Judge

Judge Code

Date

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

For Clerk of Court Office Use Only

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

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

ATTORNEY(S) FOR THE PLAINTIFF(S)

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

ATTORNEY(S) FOR THE DEFENDANT(S)

Connie Reel-Shearin

Connie Reel-Shearin - Clerk of Court

Court Reporter

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

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

Jury rendered a verdict in favor of the Defendant, L. William Goldstien, M.D.,
d/b/a L. William Goldstien OB-GYN, against the Plaintiff, Genesie Fulton and
Bryson F , no money damages.

Attorneys has 10 days to submit Post trial motions.

FILED

2015 MAY -8 PM 10:49

CLERK REEL-SHEARIN
CCCP & GS
FLORENCE COUNTY, SC

STATE OF SOUTH CAROLINA)

COUNTY OF FLORENCE)

Genesie Fulton, individually and as
Next Friend of Bryson F , a
minor)

Plaintiffs,)

Versus)

L. William Goldstien, M.D., individually
and d/b/a L. William Goldstien OB-GYN,)

Defendants.)

IN THE COURT OF COMMON PLEAS

TWELFTH JUDICIAL CIRCUIT

C/A No. 2013-CP-21-00587

VERDICT FORM

2015 MAY -8 PM 10:49
ONLINE REEL-TO-REEL
CCCP & GS
FLORENCE COUNTY, SC

FILED

I

Obstetrical Medical Emergency Exception

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

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

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

II

Breach of Standard of Care

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

☐ YES (if yes, proceed to Roman Numeral III)

☒ NO (if no, discontinue deliberation)

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

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

III
Proximate Cause

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

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

_____ NO (if no, discontinue deliberation)

IV
Actual Damages

If you find liability then calculate actual damages:

_____ (Numerical)

_____ (Cursive)

V
Punitive Damages

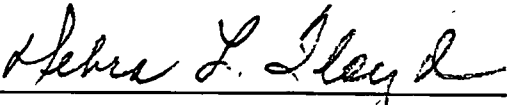
If you find actual damages you may consider an award of punitive damages. If you find that punitive damages are not warranted discontinue deliberation.

If you feel punitive damages are warranted assign the amount:

_____ (Numerical)

_____ (Cursive)

May 8, 2015
Florence, South Carolina



FOREPERSON

WHEN YOU HAVE COMPLETED THE QUESTIONS, NOTIFY THE BAILIFF.

VERDICT MUST BE UNANIMOUS.

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

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

Genesie Fulton, individually, and as)
Next Friend of Bryson F , a Minor,)

Plaintiff,)

vs.)

L. William Goldstein, M.D., individually)
and d/b/a L. William Goldstein OB-GYN,)
Steven N. Coker, M.D., and Drs. Coker)
& Phillips, P.A.,)

Defendants.)

IN THE COURT COMMON PLEAS
TWELFTH JUDICIAL CIRCUIT

C/A NO.: 2013 CP 21-587

COMPLAINT

FILED
2013 FEB 28 AM 9:43
CLERK OF COURT
COURT REPORTER
FLORENCE COUNTY, SC

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- (b) in choosing not to appreciate the heightened risk of shoulder dystocia in his delivery;
- (c) in causing Genesie to have excessive uterine activity;
- (d) in failing and refusing to timely recognize the signs and symptoms of shoulder dystocia;
- (e) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;
- (f) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;
- (g) in using improper delivery technique;
- (h) in using improper and excessive force, traction and/or torsion;
- (i) in mismanagement of labor and delivery;
- (j) in mismanagement of shoulder dystocia;
- (k) in ordering, requesting or permitting Dr. Coker to perform fundal pressure;
- (l) in failing and refusing to perform delivery by C-Section, or convert to a C-Section;
- (m) in failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health;

- (n) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition; and
- (o) such other failures and refusals as may be identified during discovery and the trial of his case.

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

- (a) in failing and refusing to acquire a reasonably safe level of knowledge, skill and training about obstetrics generally, and the recognition and management of shoulder dystocia in particular, before attempting to assist with the birthing process of Bryson;
- (b) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;
- (c) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;
- (d) in using improper delivery technique;
- (e) in using improper and excessive force, traction and/or torsion;
- (f) in mismanagement of labor and delivery;
- (g) in mismanagement of shoulder dystocia;
- (h) in performing fundal pressure;
- (i) in failing to communicate with fellow health care team workers on a timely and

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

- (j) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition; and
- (k) such other failures and refusals as may be identified during discovery and the trial of his case.

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

- (a) Direct violent and traumatic injuries to various bodily members of Bryson, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder and arm, commonly known as Erb's palsy;
- (b) Adverse effects on various other bodily members and/or functions, such as gait, balance and skeletal and muscular symmetry;
- (c) Past and future medical expenses;
- (d) Life care management plan expense;
- (e) Permanent impairments and disabilities;
- (f) Disfigurement;
- (g) Physical pain and suffering;

- (h) Mental, emotional and psychological harm;
 - (i) Adverse effect on the future career opportunities, employability, earnings and earning capacity;
 - (j) Loss of enjoyment of life; and
 - (k) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.
21. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein and Dr. Coker, Genesis has sustained certain losses and damages, including but not limited to:
- (a) Past and future medical expenses;
 - (b) Life Care Management expenses;
 - (c) Economic losses; and
 - (d) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.
22. Plaintiff names Defendant P.A. as a Defendant in this case because it has *respondeat superior* liability for Dr. Coker's torts as his employer.
23. Upon information and belief, Defendant Dr. Coker aided and abetted Defendant Dr. Goldstein in his failures, acts and omissions in that he:
- (a) Committed tortious acts in concert, or pursuant to a common design;

- (b) Knew, or should have known, that his conduct constituted a breach of duty, and gave substantial assistance or encouragement to Defendant Dr. Goldstein to conduct himself; and/or
- (c) Gave substantial assistance to Defendant Dr. Goldstein in accomplishing a tortious result, and Defendant Dr. Coker's own conduct, separately considered, constitutes a breach of duty.

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

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

GRAHAM LAW FIRM, P.A.



Edward L. Graham
Mary H. Watters

Florence, S.C. 29501
Attorney for Plaintiff

February 22, 2013

STATE OF MASSACHUSETTS)
)
COUNTY OF MIDDLESEX)

AFFIDAVIT

FILED
2012 AUG 17 AM 9:33
CLERK OF COURT
SUFFOLK COUNTY, MASS.

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

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

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

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

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

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

CERTIFIED TRUE
CLERK OF COURT
SUFFOLK COUNTY, MASS.

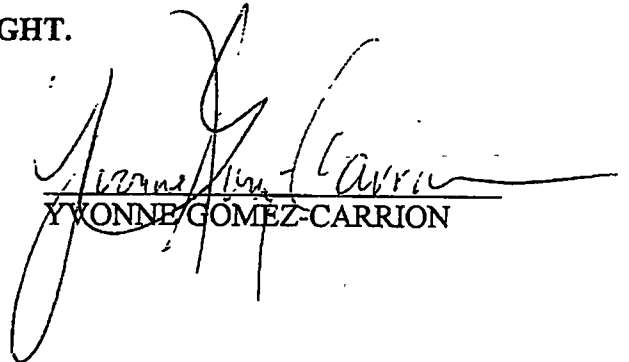
4. In this case, based on my review of the medical records noted above, Dr. L. William Goldstein committed at least two deviations from the generally accepted obstetrical standards of care during the delivery of Bryson F , on August 20, 2009. In my opinion, to a reasonable degree of medical certainty,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

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

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

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

FURTHER AFFIANT SAYETH NAUGHT.

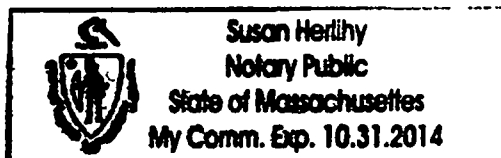

YVONNE GOMEZ-CARRION

SWORN TO BEFORE ME THIS

15 Day of August, 2012

Susan Herlihy (L.S.)
NOTARY PUBLIC FOR MASSACHUSETTS

My Commission Expires: 10/31/2014



STATE OF SOUTH CAROLINA)

COUNTY OF FLORENCE)

Genesie Fulton, individually, and as)
Next Friend of Bryson F , a Minor,)

Plaintiffs,)

-vs-)

L. William Goldstein, M.D., individually)
and d/b/a L. William Goldstein OB-GYN,)
Steven N. Coker, M.D., and Drs. Coker)
& Phillips, P.A.,)

Defendants.)

IN THE COURT OF COMMON PLEAS

CIVIL ACTION NO. 2013-CP-21-587

ANSWER ON BEHALF OF
STEVEN N. COKER, M.D. AND
DRS. COKER & PHILLIPS, P.A.

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

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

FOR A FIRST DEFENSE

- 2P R
1. These Defendants deny each and every allegation of Plaintiffs' Complaint not hereinafter specifically admitted, modified, or explained. Strict proof is demanded.
 2. These Defendants have insufficient information in which to admit or deny the allegations contained in paragraph one (1) of the Complaint; therefore, Defendants deny same and demand strict proof thereof.
 3. With regard to the allegations contained within paragraphs two (2), three (3), four (4), and five (5) of the Complaint, these Defendants would state that these allegations pertain to a Defendant other than these Defendants and require no admission or denial on behalf of these Defendants. However, if the allegations are directed to these Defendants, the allegations are denied, and strict proof is demanded.
 4. These Defendants admit the allegations of paragraphs six (6), seven (7), eight (8), nine (9), and ten (10) of the Complaint.

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

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

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

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

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

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

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

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

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

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

RPR
3
14. With regard to the allegations of paragraph twenty-two (22) of the Complaint, these Defendants state that these allegations call for a legal conclusion to which no admission or denial is required. These Defendants deny Dr. Coker committed any negligent acts and deny Defendant Coker breached any standard of care that proximately caused injury or damage to either Plaintiff. Strict proof is demanded.

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

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

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

FOR A SECOND DEFENSE

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

FOR A THIRD DEFENSE

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

FOR A FOURTH DEFENSE

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

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

FOR A FIFTH DEFENSE

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

FOR A SIXTH DEFENSE

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

FOR A SEVENTH DEFENSE

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

FOR AN EIGHTH DEFENSE

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

FOR A NINTH DEFENSE

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

FOR A TENTH DEFENSE

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

FOR AN ELEVENTH DEFENSE

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

FOR A TWELFTH DEFENSE

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

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

Respectfully submitted,

Marian W. Scalise

Marian Williams Scalise
Richardson, Plowden & Robinson, P.A.
2103 Farlow Street, P.O. Box 3646
Myrtle Beach, SC 29578
(843) 448-1008
mscalise@richardsonplowden.com

Lydia L. Magee by M. Scalise

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

PR
7
4-17

, 2013.

Myrtle Beach, South Carolina

STATE OF SOUTH CAROLINA) IN THE COURT OF COMMON PLEAS
COUNTY OF FLORENCE) TWELFTH JUDICIAL CIRCUIT

2013 APR 26 PM 1:27
Genesie Fulton, individually, and as) C/A No. 2013-CP-21-00587
Next Friend of Bryson F)
Plaintiff,)

Versus

L. William Goldstein, M.D., individually)
and d/b/a L. William Goldstein OB-GYN,)
Steven N. Coker, M.D., and Drs. Coker)
& Phillips, P.A.,)

Defendants.)

**DEFENDANT L. WILLIAM
GOLDSTEIN, M.D., INDIVIDUALLY
AND D/B/A L. WILLIAM GOLDSTEIN
OB-GYN'S ANSWER TO
PLAINTIFF'S COMPLAINT
(Jury Trial Requested)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HOOD LAW FIRM, LLC
172 Meeting Street
Post Office Box 1508
Charleston, SC 29402
Ph: (843) 577-4435 / Fax: (843) 722-1630
Email: Info@hoodlaw.com



Robert H. Hood (SC #2599)
Molly H. Craig (SC #6960)
Elloree A. Ganes (SC #70509)
Justin T. Bamberg (SC #100337)

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

4/24, 2013
Charleston, South Carolina

CERTIFICATE OF SERVICE

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

This 24 day of April, 2013.
Melanie D. Hall

FILED
2013 APR 26 PM 1:27
CLERK OF COURT
FLORENCE COUNTY, SC
CORRE REEL SHEET
CCCP & GS

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)
)
Genesie Prince, individually, and as)
Next Friend of Bryson F , a Minor,)
)
Plaintiff,)
)
vs.)
)
L. William Goldstein, M.D., individually)
and d/b/a L. William Goldstein OB-GYN,)
)
Defendants.)

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

**SECOND AMENDED
COMPLAINT**
(Jury Trial Requested)

FILED
2015 APR 30 PM 4:45
CLERK OF COURT C P & G S
FLORENCE COUNTY, SC

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

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

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

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

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

CERTIFIED A TRUE COPY

Amie R. Spivey

CLERK OF COURT C P & G S.
FLORENCE COUNTY, S C.

Appendix p. 40 of 1099

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

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

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

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

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

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

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

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

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

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

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

- (b) in choosing not to appreciate the heightened risk of shoulder dystocia in his delivery;
- (c) in causing Genesie to have excessive uterine activity;
- (d) in failing and refusing to timely recognize the signs and symptoms of shoulder dystocia;
- (e) in failing to respond properly and appropriately to the signs and symptoms of shoulder dystocia;
- (f) in failing and refusing to use the proper maneuvers to resolve shoulder dystocia without injury to Bryson ;
- (g) in using improper delivery technique;
- (h) in using improper and excessive force, traction and/or torsion;
- (i) in mismanagement of labor and delivery;
- (j) in mismanagement of shoulder dystocia;
- (k) in failing and refusing to perform delivery by C-Section, or convert to a C-Section;
- (l) in failing to communicate with fellow health care team workers on a timely and accurate basis about matters of critical importance to the patient's health;
- (m) in failing to timely and properly monitor, observe, record and/or transcribe vital information about the patient's status and condition;
- (n) in failing to advise and disclose to the patient that a circumstance had arisen that the physician believed indicated an operative delivery and use of a vacuum, in failing to

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

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

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

- (a) Direct violent and traumatic injuries to various bodily members of Bryson, including, but not limited to, permanent traumatic injury to the nerves which innervate his right shoulder and arm, commonly known as Erb's palsy;
- (b) Adverse effects on various other bodily members and/or functions, such as gait, balance and skeletal and muscular symmetry;
- (c) Past and future medical expenses;
- (d) Life care management plan expense;
- (e) Permanent impairments and disabilities;

- (f) Disfigurement;
- (g) Physical pain and suffering;
- (h) Mental, emotional and psychological harm;
- (i) Adverse effect on the future career opportunities, employability, earnings and earning capacity;
- (j) Loss of enjoyment of life; and
- (k) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

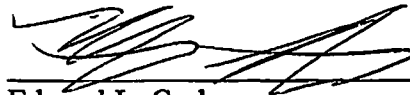
15. As a direct and proximate result of the negligence and other wrongful conduct on the part of Dr. Goldstein, Genesie has sustained certain losses and damages, including but not limited to:

- (a) Past and future medical expenses;
- (b) Life Care Management expenses;
- (c) Economic losses; and
- (d) Such further injuries, losses and damages as may be revealed through discovery and trial of this case.

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

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

GRAHAM LAW FIRM, P.A.



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

Attorney for Plaintiff

April 30, 2015

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

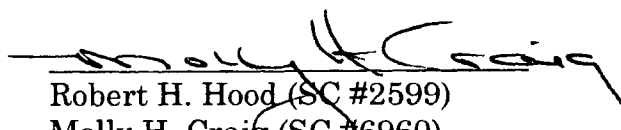
28. This Defendant would allege and show that the Plaintiffs had a duty to mitigate their damages and failed to do so.

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

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

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

HOOD LAW FIRM, LLC
172 Meeting Street
Post Office Box 1508
Charleston, SC 29402
Ph: (843) 577-4435 / Fax: (843) 722-1630
Email: Info@hoodlaw.com


Robert H. Hood (SC #2599)
Molly H. Craig (SC #6960)
Elloree A. Ganes (SC #70509)
Brian J. Kern (SC #79719)

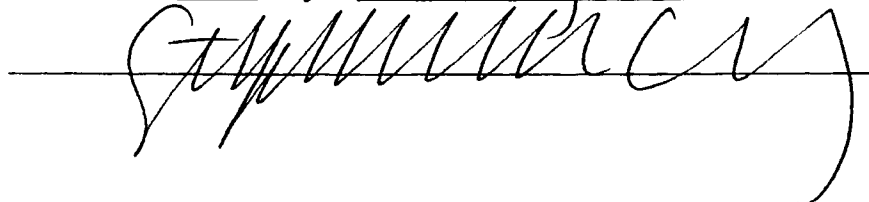
Attorneys for the Defendant
L. William Goldstein, M.D., individually and
d/b/a L. William Goldstein OB-GYN

May 1, 2015
Charleston, South Carolina

CERTIFICATE OF SERVICE

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

This 1 day of May, 2015.



 **COPY**

STATE OF SOUTH CAROLINA)

IN THE COURT OF COMMON PLEAS
TWELFTH JUDICIAL CIRCUIT

COUNTY OF FLORENCE)

CASE NO.: 2013-CP-21-0587

Genesie Fulton, individually and as Next
Friend of Bryson F , a minor,

MOTION AND ORDER INFORMATION

Plaintiff,)

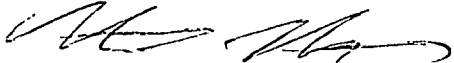
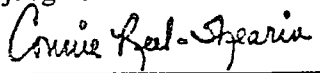
FORM AND COVERSHEET

vs.)

L. William Goldstein, M.D., individually and
d/b/a L. William Goldstein OB-GYN, Steven
N. Coker, M.D., and Drs. Coker & Phillips,
P.A.,

Defendant.)

FILED
2015 MAY 15 PM 1:20
CLERK OF COURT C.P. & G.S.
FLORENCE COUNTY, S.C.

Plaintiff's Attorney: J. Layton Ruffin, Bar No. 78267 Edward L. Graham, Bar No. 2483 Address: Graham Law Firm P.O. Box 550 Florence, SC 29503 Phone: 843.662.3281 Fax 1.800.859.7028 E-mail: jlruffin@grahamlawfirm.net Other: _____		Defendant's Attorney: Elloreë A. Ganes, Bar No. _____ Address: Hood Law Firm, LLC 172 Meeting St. Charleston, SC 29401 Phone: 843.577.1215 Fax 843.722.1630 E-mail: elloreë.ganes@hoodlaw.com Other: _____	
☒ MOTION HEARING REQUESTED (attach written motion and complete SECTIONS I and III) ☐ FORM MOTION, NO HEARING REQUESTED (complete SECTIONS II and III) ☐ PROPOSED ORDER/CONSENT ORDER (complete SECTIONS II and III)			
SECTION I: Hearing Information Nature of Motion: Motion For New Trial Absolute Estimated Time Needed: 30 mins Court Reporter Needed: ☒ YES / ☐ NO			
SECTION II: Motion/Order Type ☒ Written motion attached ☐ Form Motion/Order I hereby move for relief or action by the court as set forth in the attached proposed order.  _____ Signature of Attorney for ☒ Plaintiff / ☐ Defendant May 15, 2015 Date submitted			
SECTION III: Motion Fee ☒ PAID - AMOUNT: \$ _____ ☐ EXEMPT: (check reason) ☐ Rule to Show Cause in Child or Spousal Support ☐ Domestic Abuse or Abuse and Neglect ☐ Indigent Status ☐ State Agency v. Indigent Party ☐ Sexually Violent Predator Act ☐ Post-Conviction Relief ☐ Motion for Stay in Bankruptcy ☐ Motion for Publication ☐ Motion for Execution (Rule 69, SCRPC) ☐ Proposed order submitted at request of the court; or, reduced to writing from motion made in open court per judge's instructions Name of Court Reporter: _____ ☐ Other: _____ CERTIFIED: A TRUE COPY  CLERK OF COURT C.P. & G.S. FLORENCE COUNTY, S.C.			
JUDGE'S SECTION ☐ Motion Fee to be paid upon filing of the attached order. ☐ Other: _____		JUDGE CODE _____ Date: _____	

CLERK'S VERIFICATION

Collected by: DP Date Filed: 2/5
☐ MOTION FEE COLLECTED: \$ 25
☐ CONTESTED - AMOUNT DUE: \$

SCCA 233 (11/2003)

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

IN THE COURT OF COMMON PLEAS
TWELFTH JUDICIAL CIRCUIT
C/A NO.: 2013-CP-21-0587

Genesie Fulton, Individually and as)
Next Friend of Bryson F ,)
a minor,)

Plaintiffs,)

v.)

L. William Goldstein, M.D.,)
Individually and d/b/a L. William)
Goldstein OB-GYN,)

Defendants.)

**PLAINTIFFS' MOTION FOR
NEW TRIAL ABSOLUTE**

2015 MAY 15 PM 4:20
CLERK OF COURT
FLORENCE COUNTY, S.C.

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

FACTS

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

CERTIFIED: A TRUE COPY

Cornie Gal-Shearin

Appendix 56 of 1099
CLERK OF COURT
FLORENCE COUNTY, S.C.

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

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

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

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

STANDARD OF REVIEW

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

ARGUMENT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. Thirteenth Juror Doctrine

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

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

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

CONCLUSION

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

Respectfully submitted,

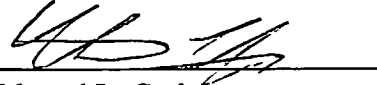
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_____, 2015

Respectfully submitted,

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Attorneys for the Plaintiff

May 15, 2015

STATE OF SOUTH CAROLINA)
COUNTY OF FLORENCE)

Genesie Fulton, individually, and as,)
Next Friend of Bryson F ,)
a minor)

Plaintiff,)

v.)
L. William Goldstein, M.D.,)
Individually and d/b/a L. William)
Goldstein OB-GYN,)

Defendants.)

IN THE COURT OF COMMON PLEAS
TWELFTH JUDICIAL CIRCUIT
C/A NO: 2003-CP-21-0587

CERTIFICATE OF SERVICE

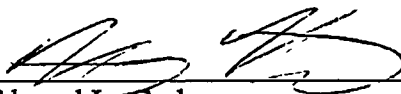
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FLORENCE COUNTY, SC

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

Ellore A. Ganes
Hood Law Firm, LLC
172 Meeting Street
Charleston, SC 29401

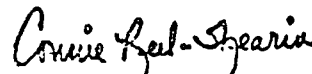
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May 15, 2015

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FLORENCE COUNTY, S.C.
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1 GOMEZ-CARRION, MD, testified as follows:)

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

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

9 THE COURT: Very good.

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

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

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

14 THE COURT: All right.

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

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

18 MR. GRAHAM: Thank you, Your Honor.

19 DIRECT EXAMINATION

20 BY EDWARD GRAHAM:

21 Q Good morning, Doctor.

22 A Good morning.

23 Q Tell us, please, where were you born.

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

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1 Q Where do you currently live?

2 A I live in Newton, Massachusetts. It's a suburb outside
3 of Boston.

4 Q Do you have children?

5 A I do.

6 Q How many?

7 A Five.

8 Q Tell us, please, about your education, starting with
9 college.

10 A I attended Princeton University. I graduated with a
11 degree in psychology and biology in 1979, then came back
12 across the bridge and attended Columbia College of
13 Physicians and Surgeons for my medical school training.
14 I stayed there for my residency training at the Columbia
15 Presbyterian Medical Center.

16 Q When you talk about Columbia, you are talking about
17 Columbia University in New York City?

18 A Correct, sir.

19 Q After medical school -- you finished medical school at
20 Columbia?

21 A I did.

22 Q And tell us about your residency training.

23 A So I started my residency training in 1983 and I did my
24 entire training at Columbia, which every now and then,
25 they shipped us to outside hospitals. I stayed a bit of

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

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

8 A Only one chief.

9 Q What is your specialty?

10 A Obstetrics and gynecology.

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

13 A Well, obstetrics deals with women who are pregnant, from
14 the very early parts of pregnancy, so; from the time of
15 pregnancy, their first missed period through their
16 prenatal period, through labor and delivery and three
17 months after that, so the postpartum period.

18 Obstetricians also deal with women who are not pregnant,
19 because often women are seeking advice in terms of how
20 to prepare for a pregnancy, something we call pre-
21 pregnancy counseling or pre-conceptual counseling.

22 Gynecology, however, deals mostly with women who are in
23 the non-pregnant state, with the exception of someone
24 who may be pregnant and the baby is not in the right
25 place. So that's called an atopic pregnancy. The baby

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

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

18 A Well, through my residency until today, 28 years after I
19 completed my residency training, in the beginning of my
20 career, I was delivering about 300 babies a year.
21 Towards the middle, more like 250, and last year, it was
22 more like 200. So I've delivered somewhere between 8000,
23 9000 babies. I also had the blessing of being at
24 Columbia and doing my core obstetrical rotation at
25 Harlem Hospital at a time where there was the beginnings

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

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

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

16 Q So the end of September of 2014?

17 A That is correct.

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

21 A I have.

22 Q Tell us about that.

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

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

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

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

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

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

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

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

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

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

25 A Absolutely.

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

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

14 Q Two dozen per year?

15 A Per year.

16 Q Over how many years?

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

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

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

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

7 Q What is traction?

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

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

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

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

1 attending?

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

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

12 A Plus or minus. Yes.

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

16 A Never.

17 Q Never?

18 A Never.

19 Q What do you attribute that to?

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

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

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

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

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

22 A Yes, I have.

23 Q How many times?

24 A I believe, two.

25 Q Okay.

1 A As an attending.

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

5 A Well, I am lucky in the sense of, again, in the practice
6 of medicine when you are doing something that you feel
7 is correct and then you go through the experience of, in
8 my case, I did a delivery, there was a shoulder
9 dystocia. I thought I was using appropriate traction for
10 delivering the baby. In retrospect, when the baby came
11 out, there was a difference in the movement of the
12 baby's arms and so I had to think back and remember how
13 much traction did I actually use. I realized at that
14 time that I actually used more traction than I should
15 have, but while I was doing it, I felt I was doing a
16 fine job. So this is where the experience comes into
17 play. I was able to, from those two deliveries, and
18 luckily those babies had what we call, transient
19 injuries, they were fine by the time they left the
20 hospital, but it really left a lasting impression on me
21 that I have to be very aware of how much traction --
22 first of all, I was an athlete in college. I have
23 amazing upper body strength and so I constantly when I
24 am faced with a shoulder dystocia, have to realize,
25 okay, Yvonne, my mantra is, "gentle, gentle, gentle" and
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1 the other mantra I have is, "you have time". And so, you
2 constantly have to resist that. It's an impulse. I don't
3 know if any of you have ever been scared, but that
4 impulse of, you just want to get it done and you have to
5 resist that "fright/flight" response. You don't want to
6 pull harder if you are faced with a situation that the
7 head is stuck.

8 Q Have you ever ruptured a nerve?

9 A I have not.

10 Q Have you ever repulsed a nerve?

11 A I have not.

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

14 A That is correct.

15 Q Okay. Just a few hours or days?

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

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

22 A Not any long-term harm. No.

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

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1 going forward?

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

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

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

22 Q Is that accurate and current?

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

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

13 Q When did you prepare this resume?

14 A April 3, 2015.

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

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

19 MR. GRAHAM: We do.

20 THE COURT: Have you seen it?

21 MS. CRAIG: I just received it.

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

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

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

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

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

12 THE COURT: Any query with regard to her qualifications?

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

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

1 opinions in that area.

2 MR. GRAHAM: Thank you, Your Honor,

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

5 A Since the late 1990s.

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

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

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

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

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

12 Q All right. And what does that mean?

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

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

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

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

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

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

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

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

12 A Sure.

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

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

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

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

24 (Jury out at 10:08 AM)

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

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

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

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

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

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

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

21 MR. GRAHAM: No, sir. These two.

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

24 MR. GRAHAM: Yes, sir.

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

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

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

9 THE COURT: Very good.

10 MR. GRAHAM: We will use this one instead.

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

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

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

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

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

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

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

24 (Brief break)

25 (Whereupon, 5 large blowups are marked as Court Exhibits

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1 #2-9. #2, Brachial plexus injury; #3, non-injured/injured
2 brachial plexus; #4 Rubin's maneuver; #5 Causes of injury; #6
3 Birth after delivery; #7 Suprapubic; #8 Rubin's maneuver; #9,
4 Posterior arm delivery.

5 THE COURT: We are ready for the jury.

6 (Jury in at 10:22 AM)

7 THE COURT: Mr. Graham, you are recognized.

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

10 CONTINUED DIRECT EXAMINATION OF DR. GOMEZ-CARRION

11 BY MR. GRAHAM

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

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

18 THE COURT: You may.

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

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

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

6 Q Thank you.

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

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

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

25 (Jurors indicated by nodding heads)

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

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

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

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

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

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

1 A A lateral.

2 Q Which is safer for the baby, axial traction or lateral
3 traction?

4 A Well, axial traction, again, is like you are trying to
5 extend your neck. Gentle lateral is also safe. Those two
6 are relatively safe. It's when you extend past that
7 angulation. On most of these, you have a 15, maybe 20,
8 30 degree max of deflection of the fetal head to be in
9 the safe range.

10 Q What happens if you go beyond that safe range?

11 A As we all experience, if you go beyond that certain
12 angle for the neck related to the shoulder, it's much
13 more of a chance of a stretch of the nerves coming from
14 the spinal cord. The nerves from C5 to T1 relate to the
15 brachial plexus.

16 Q What is greater than gentle traction?

17 A It's that amount of force, again, a learned amount of
18 traction. It's hard to explain and this is where the
19 experience I was talking about comes in. Experience,
20 once you go past that memory in your muscles, what
21 you're accustomed to using, gentle traction, and you
22 know it's gentle because you get feedback. As I
23 mentioned, you have a baby who moves his arms when you
24 are delivering and so you imagine that's in the safe
25 range of general traction. When you go beyond that, the

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

7 Q Thank you Doctor. You may take your seat.

8 (Witness returns it to the witness stand)

9 Q What is informed consent?

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

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

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

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

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

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

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

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1 applying traction?

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

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

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

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

10 A That's the McRoberts.

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

12 A The suprapubic pressure.

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

16 A Yes.

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

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

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

8 Q Excuse me. What does posteriorly mean?

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

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

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

17 (Witness complies)

18 Q Let's identify the Court Exhibit Number.

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

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1 shoulder.

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

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

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

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

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

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

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

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

23 Q So, the anterior is the top shoulder?

24 A Correct.

25 Q Posterior is the bottom shoulder?

1 A Correct.

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

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

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

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

14 (Mr. Graham adjusts easel)

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

1 often the baby comes out.

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

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

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

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

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

4 Q Thank you, Doctor.

5 A You're welcome.

6 Q What is induction of labor?

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

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

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

25 A I believe I have.

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

3 A I have.

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

11 A I have conclusions, yes.

12 Q What are those?

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

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

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1 here. So, Pitocin is not a benign medication. And then
2 you reach the point where mom is fully dilated and
3 pushing and according to Dr. Goldstein, he made the
4 decision to use the vacuum in order to deliver Bryson. I
5 didn't see any discussion -- in fact, in the doctor's
6 deposition, he said he really doesn't discuss putting on
7 a vacuum. He doesn't discuss the risks of the vacuum
8 delivery and the vacuum, although it's gotten safer.

9 This is a suction device that gets placed on a fetal
10 head and a certain amount of pressure is built up. That
11 carries risks. I mean, we think of it as a relatively
12 safe intervention, but there have been babies that have
13 had brain bleeds, have had brain damage, massive
14 swelling, lacerations, so moms and their support need to
15 know about these risks so they can say mom has the
16 opportunity and the right to say, "I'd rather continue
17 pushing or do something else other than have you put a
18 vacuum on my baby's head". You know, looking at the
19 tracing, and again, Dr. Goldstein said he intervened
20 because of the decelerations. Well, the type of
21 decelerations that I saw in the fetal heart rate tracing
22 are pretty standard at the end. There were no late --
23 There are so many different types of decelerations, but
24 the ones we look at that are of most concern to us are
25 what we call repetitive late decelerations. A baby has
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1 contraction -- sorry. The mom has a contraction, the
2 baby's heart rate goes down and has a hard time getting
3 back to its normal position. If you see that
4 repetitively, you know that there's decreased blood
5 flow, decreased oxygen, going to your baby. And in this
6 case, what the standard of care would've been in a woman
7 who is on Pitocin is, either turn it down or turn it
8 off. You want to do what we call a intrauterine
9 resuscitation. You can turn mom on her side, you can
10 give her bowls of fluid to make sure there's more fluid
11 and nutrients and oxygen getting to the baby rather than
12 coming and saying, I'm going to do a vacuum delivery
13 without any discussion of that risk, particularly, in a
14 woman who is diabetic and obese and in retrospect, we
15 knew this baby was quite large. The baby was 36 weeks
16 and weighed 8 lbs. 6 oz. That's a big baby. I didn't see
17 any documentation that Dr. Goldstein discussed with the
18 mom, "I think you're having a big baby. There may be a
19 risk if I put a vacuum on your baby's head that I will
20 pull your baby into shoulder dystocia and Dr. Goldstein
21 said in his deposition that he did not do those things
22 and so that is certainly a breach in the standard of
23 care in terms of consent.

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

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

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

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

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

19 THE COURT: Re-phrase the question.

20 MR. GRAHAM: Yes, sir.

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

25 A No, sir.

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

4 A That certainly fell below the standard of care.

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

10 A I did not.

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

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

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

19 A That is correct, sir.

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

24 A Fell below the standard of care.

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

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1 applied, was there a diagnosis yet of shoulder dystocia?

2 A No, sir.

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

6 A No, sir.

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

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

1 reduce that stressor to see how the baby responds and
2 most babies at term, well, most babies at term with
3 reserve do very well. Premature babies may not have as
4 much reserve so you may, instead of turning down the
5 Pitocin, you turn off the Pitocin until the baby can
6 regroup and while you're doing that, again, that term
7 "intrauterine resuscitation," you want to make sure you
8 maximize the uterine environment. So; relaxing the
9 uterus, possibly giving mother oxygen increases her
10 oxygen concentration which will potentially increase
11 baby's oxygenation, fluid bolus, changing mom's position
12 to increase blood flow to the uterus. So all those
13 things can be done because if you intervene prematurely
14 with the vacuum, it's not a benign procedure and it was
15 also my conclusion as I, you know, read through the
16 Doctor's deposition, I was very struck by the high rate
17 of induction and the incredibly high rate of what we
18 call "operative vaginal deliveries", his use of the
19 vacuum. I mean, he stated that he induces, I believe,
20 75% of his patients. He has a 25% caesarean section
21 rate, which is pretty standard in the United States. In
22 today's world, it's actually higher, so that didn't
23 strike me as much, but the fact that this physician
24 intervenes so often in terms of pushing a woman into
25 labor knowing what the risks of that intervention is and
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1 then once a woman is fully dilated, his use of the
2 vacuum. I believe he stated is 40 to 50% of his
3 deliveries, he does by vacuum delivery. Whereas,
4 national, if you look nationwide, depending on what part
5 of the country, it's more like 5%, maybe 10%, but
6 nowhere near 40 to 50%. So, you have a physician who is
7 intervening, trying to get someone into labor before the
8 uterus is ready or the body is ready and then trying to
9 shorten that second stage, that time between when a
10 woman is fully dilated to when the baby's head is out.

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

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

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1 Q What does an induction rate of 75% and a vacuum rate of
2 40 to 50% of vaginal deliveries tell you about Dr.
3 Goldstein's patients to let mother nature do her thing?
4 MS. CRAIG: Objection, Your Honor, speculative.

5 THE COURT: Sustained. Re-phrase your question.

6 Q Doctor, have you formed an opinion or a conclusion about
7 the significance of Dr. Goldstein's induction rate of
8 75% and vacuum rate of 40 to 50% in terms of his
9 patients, to let the natural course of labor proceed?

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

23 MS. CRAIG: Objection, Your Honor.

24 THE COURT: Sustained.

25 Q Don't tell us what she said. We were able to hear what
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1 she testified to, as you were, since you were in the
2 courtroom.

3 A Right.

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

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

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

19 MS. CRAIG: Objection, Your Honor. Leading.

20 THE COURT: Sustained.

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

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

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

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

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

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

13 THE COURT: Sustained.

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

19 MR. CRAIG: Objection. Leading.

20 THE COURT: Sustained.

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

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

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1 care.

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

7 A Falls.

8 Objection, Your Honor. Calls for speculation.

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

10 A It falls short of the standard of care.

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

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

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

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

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

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

3 MS. CRAIG: Objection, Your Honor.

4 THE COURT: That being?

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

7 THE COURT: I sustain.

8 ~~MR. GRAHAM: Your Honor,-- may we approach?~~

9 THE COURT: Yes.

10 (Brief bench conference off the record)

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

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

18 THE COURT: Sustained on both grounds.

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

24 MS. CRAIG: Objection. Asked and answered.

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

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

3 MR. GRAHAM: Thank you, Judge.

4 A It fell below the standard of care.

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

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

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

13 A Fell below the standard of care.

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

18 A Yes, I do.

19 Q And what is that, please?

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

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

25 A No, sir.

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

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

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

12 A No, sir.

13 MS. CRAIG: Objection. Leading.

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

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

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

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

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

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

4 A No significant factor there.

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

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

11 THE COURT: I'll sustain the objection.

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

14 THE COURT: Leading.

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

16 THE COURT: Yes.

17 MR. GRAHAM: Thank you.

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

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

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

4 A Yes, there is.

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

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

12 THE COURT: I'll sustain your objection.

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

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

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

23 A Yes, sir.

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

1 COURT REPORTER: Which exhibit is that?

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

3 A So, with gentle traction, when you have a shoulder
4 impacted under the pubic bone and you're using gentle
5 traction to try to clear the shoulder, you're putting
6 some stress on the brachial plexus. We don't know how
7 much stretch it takes to reach this area, but we know we
8 ~~are putting a baby at risk to go beyond gentle traction.~~

9 So, the more you exert traction and you are putting
10 downward traction, which the Doctor clearly did here --
11 there was a description that he was actually on his
12 knees while others in the room were up on stools trying
13 to do the other maneuvers so the bed appeared to be at
14 normal height and the Doctor was on his knees, so you
15 know that the angulation of the baby's head is certainly
16 off the axis of the spine and the more you exert
17 excessive traction, you are not only stretching these
18 areas, but then you go to rupture and possibly a
19 disruption of those areas and once you've severed the
20 nerves or made a disruption, there's no crossing over
21 signals and that's why you lose function of that arm
22 and the shoulder and that's what makes it a permanent
23 injury, because of the rigidity of the injury.

24 Q Thank you.

25 (Witness returns to the witness stand)

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

10 MS. CRAIG: Objection, Your Honor. Leading.

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

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

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

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

1 MS. CRAIG: Asked and answered, Your Honor.

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

4 A Would you repeat the question?

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

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

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

19 MR. GRAHAM: Thank you, Your Honor.

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

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1 with no justification puts patients at risk.

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

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

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

7 MR. GRAHAM: Thank you, Your Honor.

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

10 A I have.

11 Q Quite a few?

12 A Quite a few.

13 Q Do you charge for your time?

14 A I do, sir.

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

16 A No.

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

20 A I testify on behalf of doctors, as well.

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

22 THE COURT: Defense, you are recognized.

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

25 THE COURT: Yes.

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1 (Removes charts from in front of jury)

2 MS. CRAIG: May it please the Court?

3 THE COURT: Yes, ma'am.

4 CROSS EXAMINATION

5 by MS. CRAIG:

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

7 A I'm well, thank you.

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

12 A The same show?

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

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

23 Q How about the baby?

24 A Oh, the baby. Yes.

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

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1 and I can agree with. We've met each other before.

2 Shoulder dystocia is a risk to any pregnancy. Correct?

3 A Correct.

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

6 A Correct.

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

9 A I believe I stated that earlier. Correct.

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

13 A Correct.

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

20 A That's correct.

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

24 A That is.

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

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

3 A That's correct.

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

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

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

10 A That's correct.

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

15 A Absolutely.

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

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

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

5 A Yes. He did it twice, actually.

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

10 A That's correct.

11 Q Ma'am?

12 A That's correct.

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

22 A I am aware of that.

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

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

3 A I agree.

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

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

9 Q And she came pretty ---

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

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

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

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

16 THE COURT: Yes ---

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

19 THE COURT: Well, I ---

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

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

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

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1 confronted with the medical emergency of shoulder
2 dystocia. True?

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

5 Q And in this case, assistance came rather quickly.

6 A Three minutes into it.

7 Q But would you agree that it was rather quickly?

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

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

14 A Assistance came quickly. I would agree with you.

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

18 A That is correct

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

23 A I agree.

24 Q Is that correct?

25 A That is correct.

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

4 A That is absolutely correct.

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

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

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

12 A That's correct.

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

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

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

25 A That's correct.

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

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

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

8 A That is correct.

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

11 A Would you mind repeating that?

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

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

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

20 A Correct.

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

24 A Absolutely.

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

1 that there was excessive traction. Correct?

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

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

7 A I would agree with those statements.

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

10 A Yes, ma'am.

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

13 A Not based on the medical documentation I saw.

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

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

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

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

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

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

7 A That's a different question. No.

8 Q No?

9 A No.

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

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

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

18 A I am.

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

21 A Well, it is the professional society, yes.

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

24 A Yes.

25 Q And they issue various publications and medical

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

3 A Correct.

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

6 A I do.

7 Q And you review those, correct?

8 A Correct.

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

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

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

21 A Yes.

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

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

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

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

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

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

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

8 A No.

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

10 A Over a ten-year period, probably.

11 Q So, twenty cases and then in this case, you received a
12 \$1000 retainer from Mr. Graham to review these records?

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

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

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

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

19 Correct?

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

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

1 A That is correct.

2 Q So in the year 2013, Mr. Graham paid you \$51,370 to
3 testify and give opinions in cases. Is that right?

4 A I submitted my forms to you. I don't have those numbers
5 memorized, but that sounds about right.

6 Q Thank you, ma'am. You, at our request, gave your 2013
7 1099 form to the federal government and it indicated
8 that Mr. Graham had paid you \$51,370.

9 A That's correct.

10 Q And then, let's see, last year, 2014, Mr. Graham paid
11 you \$22,540.

12 A That sounds about right.

13 Q So, continuing on with your experience as a testifying
14 witness, let's go through the states. You've testified
15 in New Hampshire?

16 A Yes.

17 Q You testified in Vermont?

18 A Yes.

19 Q Massachusetts?

20 A Yes.

21 Q Pennsylvania?

22 A Yes.

23 Q District of Columbia?

24 A Yes.

25 Q South Carolina?

1 A Yes.

2 Q North Carolina?

3 A Yes.

4 Q Georgia?

5 A Yes.

6 Q Rhode Island?

7 A Yes,

8 Q New York?

9 A Yes.

10 Q And New Jersey?

11 A Yes.

12 Q All as a paid testifying expert. Did I miss any of those
13 states?

14 A I don't believe so.

15 Q All right. I'm looking at your CV. I believe it is in
16 evidence. It looks like there is a review -- in your CV,
17 you actually do mention that you are a member of ACOG,
18 The American Congress of Obstetrics and Gynecologists.

19 A Yes.

20 Q And then it looks as though the focus of your practices
21 changed over the past several years.

22 A Just since September of 2014.

23 Q Okay.

24 A So it hasn't been quite a year yet.

25 Q And that's when you stopped delivering babies. Right?

1 A Unfortunately, but true. Yes.

2 Q And it looks as though you have been focusing quite a
3 bit on minimally invasive hysterectomy for female to
4 male transitioning. Is that transgender?

5 A That is correct, but your statement is incorrect, as
6 well.

7 Q All right. Ma'am, I'm just looking at your CV.

8 A I know. You are on page -- you are looking at my
9 achievements and ---

10 A I'm looking at page six. I want to know what you are
11 doing nowadays since you are not delivering babies.

12 A Right.

13 Q And, actually, that was 2011. It says, workshop
14 presenter for minimally invasive hysterectomy for female
15 to male transitioning at a transgender conference.

16 A I presented, yes.

17 Q All right. And there is another transgender conference
18 in 2012.

19 A I'm invited to speak yearly at this conference.

20 Q Okay. Thank you. It looks like 2013, as well.

21 A And this year, as well.

22 Q And this year, as well, 2014.

23 A Yes. Every January. Yes ma'am.

24 Q And you indicate in your CV, you have a little narrative
25 report, you said that over the past three years I have

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

3 A Yes.

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

7 A That is incorrect.

8 Q So, you've always done transgender work?

9 A No. But I've not always just delivered babies. I've been
10 a true generalist in my entire practice until October
11 1st of last year. As a gynecologic surgeon, I mean,
12 that's why I said your first statement was incorrect.
13 The focus of my practice is not transgender surgeries.
14 It happens to be a group of people that have accessed
15 care and I'm one of the few gynecologists in Boston that
16 serves that patient population. A part of my fabric as a
17 physician and as the person that I am, I've always
18 prided myself in not turning anyone away from my
19 practice. So I've gotten many awards for compassionate
20 care. I just got an award for humanitarianism. I've
21 gotten an award for community service. I take care of
22 anyone who comes to my door. The reason you see so much
23 focus in terms of presentation around transgender work
24 is because in 2006 when I first got approached to take
25 care of a ill patient, one of my primary care doctors

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

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

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

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

5 Q Okay. Thank you.

6 A You're welcome.

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

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

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

18 A I do.

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

21 A Yes, ma'am.

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

25 A She seemed under reasonable care.

- 1 Q So talking about her prenatal care, Dr. Goldstein was on
2 it. He was managing her diabetes and she was reporting
3 her blood sugars every day to him. He was making sure
4 that her diabetes was well-controlled throughout her
5 pregnancy. Would you agree with that?
- 6 A She was reporting her blood sugars every day? I didn't
7 see that document.
- 8 Q You didn't see that?
- 9 A Every day? Reporting?
- 10 Q I'm just asking, did you see the document.
- 11 A No.
- 12 Q Okay.
- 13 A I saw documentation of her reporting her blood sugars,
14 but not every day.
- 15 Q Well, did you see that there are about 12 pages, 10
16 pages, of blood sugar documentation?
- 17 A Well, maybe I'm misunderstanding. There was a document
18 of her blood sugars on a daily basis, but she wasn't
19 reporting to the doctor every day, personally.
- 20 Q Did you see those in Dr. Goldstein's medical chart?
- 21 A Maybe I'm misunderstanding the question.
- 22 Q There are pages of documentation of various blood
23 sugar ---
- 24 A Yes. That, I saw.
- 25 Q Was that in Dr. Goldstein's chart?

1 A Yes.

2 Q Now, you were asked questions about informed consent,
3 but you weren't actually shown the informed consent form
4 in this case. Have you reviewed her chart?

5 A Yes.

6 Q Have you had an opportunity to review the informed
7 consent form?

8 ~~MR. GRAHAM: Your Honor, we object to the use of the~~
9 informed consent form. She is referring to the general
10 hospital consent form.

11 THE COURT: I think the document speaks for itself. Any
12 other objection?

13 MR. GRAHAM: No, Your Honor.

14 DR. GOMEZ-CARRION: (Looks at document) Okay.

15 MS. CRAIG: Let's mark that, please.

16 (Consent form is marked as Defendant's #1, without objection)

17 Q Now, at the top of this, it says Carolinas Hospital
18 Systems and it is a consent for operation and/or
19 procedure. You reviewed this document. Correct?

20 A Right.

21 Q And it says, "Acknowledgment. I received explanation
22 about the planned operation and/or procedure for my
23 attending physician and/or surgeons. No guarantees or
24 assurances have been made or given by anyone as to the
25 results that may be obtained. I understand." And I have

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1 that highlighted. Did I read that correctly? (Shows
2 document to witness)

3 A It appears that you did.

4 Q Okay. It also appears that Ms. Fulton signed that
5 informed consent form. Correct?

6 A Correct.

7 Q And just look at the date. What is the date on that?

8 A It says 8/20/09, which is the day of delivery.

9 Q Yes, ma'am. Thank you. So this is informed consent for
10 Carolinas Hospital Systems and ---

11 MR. GRAHAM: Your Honor, we continue to object to the
12 reference to this general consent form as an informed consent
13 document.

14 THE COURT: Your objection is overruled. The document
15 speaks for itself.

16 Q Under "Consent" on the document it says, "I give consent
17 for the following operation and/or procedure: Vaginal
18 delivery or cesarean section to deliver the infant
19 through the vagina or make an incision in the abdomen
20 and remove the infant." Correct?

21 A Yes.

22 Q And then, also, on this informed consent form it says,
23 "I understand that unexpected conditions may occur
24 during the operation and/or procedure and by signing
25 below, I give consent for additional or different

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1 procedures should the doctor named below decide it is
2 necessary or desirable." And then there is a section
3 where you can write "exception", and it says, what,
4 there? (Hands document to the witness)

5 A Where are you?

6 Q Sure. It says where you are supposed to note the
7 exceptions and what is written there.

8 A It says, "none".

9 Q Thank you. Vacuums. We talked about informed consent.
10 Now, let's talk about vacuums. You've used vacuums. I
11 know you're not delivering babies now, but when you used
12 to deliver babies, you used to use vacuums to deliver
13 babies.

14 A Absolutely.

15 Q The vacuums, in and of themselves, are helpful tools to
16 a doctor to help safely deliver a baby. Right?

17 A Yes.

18 Q And shoulder dystocia can happen even if a doctor does
19 not use a vacuum to help deliver a baby. Correct?

20 A Correct.

21 Q And I think you testified that some of the risk of using
22 a vacuum included brain damage, laceration, and
23 swelling. Did I state that correctly?

24 A Brain damage, cerebral bleed.

25 Q So, brain damage, cerebral bleed, laceration, and

1 swelling?

2 A And that -- if you have brain damage or bleed, that can
3 also lead to seizure activity and other issues that can
4 evolve in the neonatal course.

5 A Yes, ma'am. But we don't have any of that in this case,
6 do we?

7 A No. But you are asking the question and ---

8 Q Regardless of ---

9 A I'm trying to answer ---

10 Q Are you telling ---

11 MR. GRAHAM: Your Honor, I would ask that the witness be
12 allowed to finish her answer.

13 THE COURT: You may proceed.

14 MS. CRAIG: Thank you.

15 Q In this case, you'd agree that Bryson did not have brain
16 damage or -- what was the other thing you said? Brain
17 damage or what?

18 A Or bleed.

19 Q Or bleed. Hematoma?

20 A Hematoma or laceration.

21 Q And Bryson did not have a laceration. Right?

22 A As far as I know.

23 Q And he did not have swelling.

24 A Not sure on that. Most babies have swelling whether you
25 use a vacuum or not.

1 Q So, swelling, in and of itself, is not something that's
2 going to cause harm to a baby. Correct?

3 A Correct.

4 Q You testified about Dr. Goldstein's experience as a
5 physician. Remember those opinions and those questions
6 you answered?

7 A Yes.

8 Q Now, you don't know Dr. Goldstein, do you?

9 A I do not.

10 Q You didn't train with him.

11 A I did not.

12 Q You have never delivered a baby with Dr. Goldstein.

13 A I have not.

14 Q Do you know that he has delivered over 3000 babies in
15 his career?

16 A I saw that.

17 Q And he takes care of hundreds of patients here in
18 Florence. Were you aware of that?

19 A Yes, ma'am.

20 Q Dr. Goldstein's been practicing medicine for 37 years.
21 Did you see that in his deposition?

22 A I did.

23 Q And Dr. Goldstein is board certified in obstetrics and
24 gynecology.

25 A I saw that, as well.

1 Q In fact, board certification involves a day, or maybe
2 two days, I guess, of written tests and then a full day
3 of oral testing?

4 A No. One full day.

5 Q One full day.

6 A Written and oral.

7 Q Okay. But there is a written portion and then there is
8 an oral portion.

9 A And that happens, typically, not far after residency
10 training. Within the first five years, typically.

11 Q And so Dr. Goldstein is board certified in obstetrics
12 and gynecology. He passed that test. Did you know he
13 passed it on his first attempt?

14 A I did.

15 Q And are you aware that some doctors don't pass that test
16 on the first attempt?

17 A That's very true.

18 Q Dr. Goldstein teaches residents. Did you know that?

19 A Yes, ma'am.

20 Q He reads the medical literature. He reads the articles
21 from ACOG, The American Congress of Obstetrics and
22 Gynecology, to stay current on the medical literature.
23 Were you aware of that?

24 A I believe so.

25 Q And were you aware that Dr. Goldstein is a well-

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1 qualified member of the medical staff here in Florence?

2 Were you aware?

3 A He's on the medical staff in Florence? Yes, I'm aware of
4 that.

5 Q Yes, Florence, South Carolina.

6 A Yes, ma'am.

7 Q And Dr. Goldstein is a member of The American Congress
8 of Obstetrics and Gynecology. Did you know that?

9 A I did.

10 Q And based on your review of the medical literature and
11 The American College of Obstetrics and Gynecology that
12 you indicated was reliable, would you agree or disagree
13 with the publication that says there are multiple
14 reports in the peer-reviewed literature describing the
15 occurrence of a neonatal brachial plexus injury without
16 concomitant, clinically recognizable shoulder dystocia
17 at the time of a vaginal or caesarian delivery. Would
18 you agree with that statement from ACOG?

19 A I would.

20 Q You would also agree with the statement that neither
21 high quality nor consistent data exists to suggest that
22 a neonatal brachial plexus injury can be caused only by
23 a specific amount of applied force beyond that typically
24 used by health care providers during any delivery. Do
25 you agree or disagree with that statement?

1 A I would, overall, agree with that.

2 Q Ma'am?

3 A I'd agree.

4 Q Thank you.

5 Q Would you agree that mac -- what is macrosomia? What is
6 the definition of macrosomia? What is your definition of
7 it?

8 A Well, it's not my definition. It's the definition of
9 ACOG. Baby over 4000 grams, for example. There is also
10 that term, large gestational stage, for example. In this
11 case, you have a large gestational baby at 36 weeks near
12 4000 grams, but not macrosomic.

13 Q Okay. That's what I wanted to ask you about. You gave
14 testimony about the size of the baby and macrosomia or a
15 macrosomic baby is a big baby. Correct?

16 A Correct.

17 Q And ACOG actually defines macrosomia as growth beyond a
18 specific birth weight, usually 4000 grams, regardless of
19 the gestational age. Would you agree with the ACOG
20 definition of macrosomia?

21 A They use that standard cut-off of 4000 grams and beyond,
22 yes.

23 Q Okay. So 4000 grams, that's macrosomia, that's a baby
24 that is very big. In this case, Bryson was 3500 grams.
25 Did you know that?

1 A I did.

2 Q Would you agree with me that if somebody asked you how
3 you could, if you could quantify the miles per hour a
4 baby descends through the birth canal, that that's not a
5 fair question?

6 A No.

7 Q Would you agree or disagree with that?

8 A I would disagree. I mean, I would agree with that, that
9 that is not a fair question.

10 Q I'm sorry. My question wasn't very clear. That's not
11 what I'm asking. That's not a fair question for somebody
12 to quantify how many miles-per-hour a child descends
13 through the birth canal?

14 A No, ma'am.

15 Q Thank you. Quality nor consistent data exists to suggest
16 neonatal brachial plexus injury can be caused only by a
17 specific amount of applied force beyond that typically
18 used by healthcare providers or during any delivery.
19 Agree or disagree with that statement? Would agree with
20 that?

21 A I would agree.

22 Q A couple more questions on Dr. Goldstein's experience.
23 You are aware that he, as well as yourself, attends
24 continuing medical education programs?

25 A Well, that's the only way you can maintain membership in
GENESIE FULTON, et al. VERSUS L. WILLIAM GOLDSTEIN, MD, et al.

1 The Congress of OB/GYN.

2 Q Right. So, as lawyers, we have to attend legal
3 education, a certain amount of hours a year. So, do you
4 have to go through a certain amount of hours of
5 continuing medical education?

6 A Yes, ma'am.

7 Q And you are aware, of course, that Dr. Goldstein does
8 that. Correct?

9 A I am aware, yes.

10 Q And you made a comment earlier that you were chief
11 resident at one point in your residency.

12 A Yes, ma'am.

13 Q And are you aware that Dr. Goldstein was also a chief
14 resident?

15 A I was not aware of that, I don't think.

16 Q You weren't?

17 A I'm not sure if I was aware of that.

18 Q Now with regard to your opinion on lack of
19 documentation, we talked about lack of documentation
20 with regard to your opinion on informed consent. Would
21 you agree that lack of documentation does not cause an
22 injury?

23 A You are talking about writing on paper. Of course, it
24 would not.

25 Q You've testified a bunch. You know that you have to

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1 prove that there is a deviation and you have to prove
2 that it caused an injury. Correct?

3 A Correct.

4 Q What I'm asking you is, with regard to your opinion as
5 to lack of documentation, that doesn't prove that there
6 was any injury in this case. Documentation can't, do
7 that.

8 A A documentation reflects what was discussed with the
9 patient that may have changed the course of this
10 delivery.

11 Q Yes, ma'am. And I agree that's your opinion. You've done
12 this a lot. Right? You've testified a lot, right? You
13 know what standard of care is. Correct?

14 A I do.

15 Q You know that you have to prove not just that there was
16 a deviation, you also have to prove that that caused an
17 injury. Right?

18 A Right.

19 Q Okay. And I understand that it is your opinion, the lack
20 of documentation, is not within the standard of care. Is
21 that correct?

22 A That's correct.

23 Q But you agree that lack of documentation does not cause
24 an injury.

25 A I would agree with that.

1 Q Okay. And then, with regard to Pitocin, you can't say
2 that with or without Pitocin, the shoulder dystocia
3 could have been avoided, can you?

4 A I cannot.

5 Q So that's documentation, Pitocin. Traction, that was the
6 other one. To give your opinions in this case, have you
7 carefully reviewed the medical records and also the
8 depositions that have been taken in this case,
9 particularly the deposition testimony of the nurses, the
10 nurses who were involved in the care and treatment?

11 A I have.

12 Q And did you take into account, in reaching your
13 opinions, that an eyewitness to the delivery noted that
14 Dr. Goldstein didn't do anything differently in this
15 delivery than he does in any other delivery? Did you see
16 that testimony?

17 A I did.

18 Q And that nurse was physically present for the delivery,
19 was she not?

20 A I would assume so since she gave deposition testimony
21 that she was there.

22 Q Yes, ma'am. Thank you so much.

23 MS. CRAIG: Those are all the questions I have.

24 THE COURT: Any redirect?

25 MR. GRAHAM: Yes, sir, Your Honor.

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REDIRECT EXAMINATION

BY MR. GRAHAM:

Q I'LL try to be brief, Doctor. You were asked a question by Ms. Craig about whether shoulder dystocia is preventable and you said it's not preventable. My question is, is brachial plexus nerve damage preventable?

MS. CRAIG: Objection, Your Honor, to editorial comment and leading.

THE COURT: Sustained.

Q Doctor, have you formed a conclusion as to whether, to a reasonable degree of medical certainty, as to whether or not ruptures of four brachial plexus nerves, four or more nerves, is preventable?

A Yes, Sir.

MS. CRAIG: Objection, Your Honor. It is beyond the scope of cross and this is an area outside of her expertise. This is in the realm of pediatric knowledge.

THE COURT: Sustained.

MR. GRAHAM: May I respond?

THE COURT: Sustained.

Q You were asked questions about whether or not a baby can die if the doctor fails to deliver the baby safely with the various safety maneuvers to get the children unstuck. Is that why it is important for doctors to have

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1 knowledge about how to safely dissolve shoulder
2 dystocia?

3 A That is correct.

4 Q There was a question about whether or not Dr. Goldstein
5 delivered Bryson in four minutes. In fact, Bryson
6 delivered within four after Dr. Coker took over?

7 A Bryson delivered after Dr. Coker took over.

8 Q There were questions about suprapubic pressure and
9 McRoberts not working. Did you see any evidence in the
10 record that suprapubic pressure and McRoberts were used
11 at the same time before traction was in place?

12 A So, I did not see that in the medical record and that
13 was also substantiated in the depositions where it
14 constantly stated that mom remained in stirrups and if
15 you are in stirrups, that is not McRoberts.

16 Q There were questions whether or not permanent injury can
17 occur without the doctor being at fault or without the
18 doctor being negligent, et cetera. Do those situations
19 involve the kinds of things you talked about before,
20 like a tumor before birth growing into the nerves or
21 fibroids in the uterus, those kinds of things?

22 A That's correct.

23 MS. CRAIG: Leading.

24 THE COURT: Sustained.

25 Q Would you tell us whether or not any of those non-

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1 negligent causes of nerve damage were present in
2 Bryson's case?

3 MS. CRAIG: Objection, Your Honor. Beyond her
4 qualifications.

5 THE COURT: I'll allow her to answer that.

6 A Those conditions were not present as far as I've gleaned
7 from the medical records and depositions.

8 Q You were asked questions about the American Congress of
9 Obstetricians and Gynecologists. Does that group exist,
10 at least in part, to lobby Congress to advocate on
11 behalf of obstetricians?

12 MS. CRAIG: Objection, Your Honor. This has already been
13 ruled on at pre-trial.

14 MR. GRAHAM: I don't recall that.

15 THE COURT: Might counsel approach the bench?

16 (Bench conference held off the record)

17 Q Doctor, can you tell us whether or not one of the
18 purposes of ACOG is to lobby Congress?

19 A Yes, sir.

20 Q Can you tell us if one of the purposes of ACOG is to
21 lobby on or to advocate on behalf of the professional
22 and financial interests of obstetricians in this
23 country?

24 A Yes, sir.

25 Q Can you tell us whether or not publications that are

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1 published by this entity, this lobbying interest that
2 advocates for doctors, can you tell us whether or not
3 the articles they publish are always based on science?

4 A No, sir. They are not always based on science.

5 Q In particular, are there recent publications by ACOG and
6 its affiliates that relate to the area of shoulder
7 dystocia management and causation of permanent nerve
8 damage that are not based on science?

9 MS. CRAIG: Objection, Your Honor. It's beyond the scope
10 of cross. I asked about one publication from ACOG.

11 THE COURT: I will sustain your objection. Move on.

12 MR. GRAHAM: Very well.

13 Q What effect does the amount of money you get paid for
14 testifying have on your opinions?

15 A None, sir.

16 Q I understand the respect that you have for all your
17 patients, as you described. Are the transgender, is the
18 transgender community the only community that has
19 recognized you and honored you for your service?

20 A No, sir.

21 Q What percentage of your practice is related to
22 transgender populations? Is that a significant part or a
23 small part?

24 A It's a very small part, sir. It's just getting a lot of
25 recognition because, again, I'm one of the few people

1 who are involved with this patient population.

2 Q There were a lot of questions about informed consent.

3 Let me ask you first of all, this Defendant's Exhibit
4 #1, does that reflect informed consent about anything?

5 A Can you define anything?

6 Q Well, does that, is that, is that an informed consent to
7 an operative procedure that was involved in this case
8 that you talked about; induction of labor or vacuum?

9 A Well, first of all, as I pointed out, this informed
10 consent was dated the date of delivery, so again, that
11 brings up much concern to me. You're now asking a woman
12 who is presenting to deliver a baby to consent to things
13 you may or may not have talked about. We know as
14 providers that you don't consent someone in kind of the
15 heat of the moment. You want to, particularly in this
16 case with obesity, diabetes, risk of shoulder dystocia,
17 the fact that that Dr. Goldstein delivers 40 to 50% by
18 vacuum, this is something that should have been
19 discussed at some point during prenatal care. Also, in
20 Dr. Goldstein's deposition, he stated that he doesn't
21 get the consent, nurses get the consent. So, I'm not
22 sure how much a signature by a patient on the day she is
23 going in for induction, how much that reflects on her
24 knowledge, her understanding of benefits and risks, and
25 certainly, if you are going to intervene with an

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1 instrument that can cause harm, a general consent
2 doesn't generally address that.

3 MS. CRAIG: Your Honor, at this time we would ask for a
4 Rule 105 instruction.

5 THE COURT: Might counsel approach, again?

6 (Bench conference held off the record)

7 Q Doctor, what healthcare provider is identified at the
8 top left-hand corner of Defense Exhibit #1, a doctor or
9 a hospital?

10 A The hospital.

11 Q Carolinas Hospital System?

12 A Correct.

13 Q And what is the title of the document underneath the
14 name of Carolinas?

15 A Consent for Operation and/or Procedure.

16 Q Does the title contain anything about informed consent?

17 A No, sir.

18 Q All right. When you were talking about informed consent
19 not being given by Dr. Goldstein before he induced labor
20 and before he used the vacuum, were you in any way being
21 critical of the nurses at Carolinas Hospital or were you
22 being critical of someone else?

23 A Not the nurses, Dr. Goldstein.

24 MS. CRAIG: Objection, Your Honor.

25 THE COURT: I'll allow the question.

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1 Q You were being critical of who?

2 A Dr. Goldstein. Not the nurses.

3 Q Does that document say anything about informed consent?

4 A No, sir.

5 Q Did you read Dr. Goldstein's deposition to determine
6 whether or not he has ever provided informed consent for
7 vacuums?

8 MS. CRAIG: Objection. Asked and answered.

9 THE COURT: Sustained.

10 Q Does that document purport to give informed consent for
11 induction?

12 A No, sir.

13 Q Does that document purport to give informed consent for
14 vacuum?

15 A No, sir.

16 Q Does that document purport to discuss risks and
17 alternatives to induction or vacuum?

18 MS. CRAIG: Objection. Asked and answered.

19 THE COURT: Sustained.

20 Q Ms. Craig says that Dr. Goldstein is board certified.
21 Are you also?

22 A Yes, sir.

23 Q There were questions about whether reading from an ACOG
24 publication, there were questions from Ms. Craig about
25 whether you believed an injury to the nerves may occur

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1 without shoulder dystocia and you said, "Of course". Do
2 you believe that just because a chart doesn't document
3 the presence of shoulder dystocia that that means
4 shoulder dystocia was not present?

5 MS. CRAIG: Objection. Leading.

6 Q Do you have an opinion in that regard?

7 A I do.

8 Q And what is that, please?

9 A That shoulder dystocia can occur and it is not
10 documented in the delivering provider's notes, just as
11 you will never see in a chart that excessive traction
12 was used.

13 Q Can injurious traction, do you have an opinion to a
14 reasonable degree of certainty as to whether or not
15 injurious traction can be applied without shoulder
16 dystocia being ---

17 MS. CRAIG: Objection. Leading. Asked and answered.

18 THE COURT: Sustained, on both counts.

19 Q You were asked a question about whether to talk about
20 the speed of a baby through the birth canal in miles-
21 per-hour is fair. Would it be more fair to talk about
22 inches or feet per hour?

23 A Possibly.

24 Q There were questions about whether you knew if Dr.
25 Goldstein had attended medical education programs. Do

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1 you recall what his deposition said about whether or not
2 he had ever attended a continuing medical education
3 program about safe management of a stuck shoulder?

4 MS. CRAIG: Objection. Leading.

5 THE COURT: Sustained.

6 Q What recollection do you have, if any, about whether or
7 not Dr. Goldstein has ever attended a continuing
8 ~~education seminar about safe management of shoulder~~
9 dystocia?

10 A In his deposition, he stated that he has never attended
11 a continuing medical education focusing on the safe
12 delivery or the safe resolution of shoulder dystocia. He
13 also commented that he's never done a simulation, which
14 is what most institutions for quite some time now, is
15 how obstetricians do it. What a simulation is, is you
16 have a pelvis and a baby and you go through the process
17 of ---

18 MS. CRAIG: Your Honor, I object. This is not responsive.

19 THE COURT: It goes beyond the scope of the question. You
20 may proceed.

21 Q One final question, Doctor. You were asked if you knew
22 that Dr. Goldstein was a chief resident when he was in
23 medical school during his residency?

24 A Chief resident during his residency.

25 Q I'm sorry. Do you remember the question, whether he was

1 chief resident during his residency?

2 A Yes.

3 Q Do you know whether everybody in his residency class was
4 called "chief"?

5 A I don't know that.

6 Q Thank you.

7 MR. GRAHAM: No further questions.

8 THE COURT: You may step down. Thank you, ma'am. Madam
9 Forelady, ladies and gentlemen of the jury, each of y'all
10 have a lean and hungry look like y'all are ready for lunch.
11 We are going to do that. We are going to break until 2:00.
12 Once again, do not discuss the case, do not do any
13 independent investigation. I will ask that you return and be
14 here on time at 2:00, 2:00 sharp. Everyone remain seated as
15 the jury exits the courtroom.

16 (Jury out at 12:26 PM)

17 THE COURT: Anything from the Plaintiff?

18 MR. GRAHAM: No, Your Honor.

19 THE COURT: Anything from the Defense?

20 MS. CRAIG: No, sir, Your Honor.

21 THE COURT: We will stand at ease until 2:00.

22 (LUNCH BREAK)

23 THE COURT: Madam Forelady, ladies and gentlemen of the
24 jury, thank you for being here and being here on time. I am
25 going to ask that you pay very close attention. I notice we

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1 I went through their reports I'd already included it and
2 also enumerated it and I put it in the comments section.
3 I was right on point with Blackwell. It was almost like
4 we had both worked together.

5 Q So, at some point then, did you contact Ms. Blackwell
6 and write her and ask her for her input?

7 A I was not allowed to speak to her, but she was very kind
8 and she did fill out a form for me and it was very
9 helpful.

10 Q All right. I'm sorry. Go on.

11 A Basically, there is no occupational therapy after age
12 18. There is physical therapy to 18, none after that.
13 There is psycho-social until 18 and then, situationally,
14 anytime over his life. It's vocational assessment twice,
15 one for summer employment and one for when he graduates.
16 There is work site evaluation after he gets a job to
17 make sure they can accommodate him so he -- the criteria
18 is that the employer has to give him accommodation, but
19 with the accommodation, the employee has to do the job
20 ultimately the same as the non-disabled person does, the
21 same number, the same efficiency, but not necessarily
22 the same speed and the third evaluation is very simply
23 is, you want to put all the controls on the steering
24 wheel so that you can drive a car with one hand and
25 adjust the various items like the radio and not have to

1 worry about the other hand.

2 Q Next one.

3 A This is a recommendation for constructive procedures and
4 Dr. Grossman said one time and this one I did not
5 include at all. Then, I have orthopedic podiatrist only
6 to sixteen, one time a year as needed. No podiatrist,
7 only two or three times and then more times as needed,
8 which is not included. Serial casting, three or four
9 times, and as needed. Most of that came from Dr.
10 Grossman although it was mentioned in the deposition of
11 the occupational therapist, which is to say he might not
12 qualify independent to making a recommendation that
13 relies on the documents. This is the surgery and this is
14 what Dr. Grossman's office gave me and I validated it by
15 calling Cincinnati, Texas, and a couple others and I got
16 this from Dr. Grossman.

17 Q So, you have a range from 50 to 60 thousand dollars for
18 the surgeries.

19 A Well, at that time, it was not inclusive of the
20 hospital.

21 Q But what I want to verify, you did verify that with a
22 number of brachial plexus centers in terms of whether or
23 not that was an appropriate charge?

24 A If that was a reasonable rate, right.

25 Q And what did you determine?

1 A One hospital was 40,000, but most of them were between
2 50 and 60.

3 Q Thank you. Go on.

4 A Occupational Therapy, just till 18, a few times a week
5 and then from 19 to 21, just one time a week. Physical
6 therapy, till 18, two hours a week, 19-21, one hour a
7 week and that's during the transition and I'm dating
8 myself again, but in my office, I actually have a
9 typewriter on top of one of my bookshelves. People come
10 into the office and ask me what it is and so I had to be
11 re-trained to use a computer and afterwards, my kids got
12 frustrated with me, and I actually picked up the
13 knowledge and so we have to be aware of the fact that
14 our lifestyles change and it's usually between 19 and
15 21.

16 Q Now, Mr. Forman, before we go off this page, one thing
17 that I don't know the jury has heard yet is, you have
18 physical therapy and occupational therapy. Can you just
19 give them a very basic explanation of whether those are
20 the same or different?

21 A Physical therapy is strengthening and development of the
22 muscular and skeleton system to improve stamina,
23 endurance. Occupational therapy use effects stamina,
24 endurance, physical capacity and things like tie your
25 tie, put a belt on, comb your hair, shave, clean your

1 jury why we do a vocational analysis on a child like
2 Bryson.

3 A It's an earning capacity analysis, a job axis analogy.
4 It's not a pure vocational evaluation because we are
5 unfortunately unable to determine his aptitude, his
6 interests, all the other factors, but it is very
7 important to do it because it will help us gear him in
8 his further educational, explorations, activities that
9 he can succeed at.

10 Q And again, if you would just highlight a few things on
11 this issue and let's not go through every single item.

12 A Very simply, no difference in his intellect, no
13 difference in his vocational preparation, no difference
14 in his grade level. The first difference is in his
15 strength from heavy to light. The second difference is
16 climbing, from an occupational degree, limited. The next
17 one is crawling, limited. Reaching, handling, fingering
18 are limited. No more in that area. On the next page,
19 there is no limitations in environmental conditions
20 other than proximity to moving parts, explosives,
21 chemicals. There is no difference in his aptitudes until
22 we get to his motor coordination, finger dexterity,
23 manual dexterity and all that basically says is that out
24 of the jobs he could have done with the pre-injury
25 profile, he's lost access to a number of those jobs and

1 his earnings are reduced by about \$10,768.00 a year
2 because he can't do all the jobs that he used to be able
3 to do and I'm sorry if I went too fast or if I short
4 circuited it for you.

5 Q That's fine. Okay. In terms of, had Bryson not been
6 (injured, how would that have impacted him from a
7 vocational standpoint? What is the difference between
8 the pre and post injury?

9 A I'm going to use a bad example. Okay?

10 Q Okay.

11 A He could be a teacher of some sort. Could he be a Phys.
12 Ed. teacher? No. Okay? He could work in a jewelry store
13 selling jewelry. Can he repair the jewelry in the back?
14 No. He could possibly be a prime investigator, but he
15 can't be a policeman because you've got to be able to
16 shoot the gun with both hands. You know, there are
17 certain occupations that he can do and can't do all of
18 them, so his job axis is limited and his earning
19 capacity is diminished.

20 Q Mr. Forman, after your evaluation of Bryson and your
21 work-up of talking to his mother and all the work that
22 you did on this case, do you have an opinion to a
23 reasonable degree in the area of life care planning as
24 to whether or not those recommendations that you made
25 and that are reflected in your life care plan necessary

1 THE COURT: Very good.

2 MR. GRAHAM: Your Honor, we now have ---

3 THE COURT: And you don't have to say necessarily in
4 great detail. You can just say, "note my objection" and I
5 think that will preserve it.

6 MS. CRAIG: Thank you.

7 MR. GRAHAM: Your Honor, we now have the three-pound
8 weight we intend to use through Dr. Resnick and I believe
9 there was an objection. If you would rule on that.

10 THE COURT: I thought we had. I'm going to allow him to
11 do a demonstration. We decided that. We are ready for the
12 jury.

13 MR. GRAHAM: Thank you.

14 (Jury in at 9:14.AM)

15 THE COURT: Madam forelady, ladies and gentlemen of the
16 jury, thank you for being here and being here on time. We had
17 some legal matters to attend to and I apologize for the late
18 start. Plaintiff is recognized.

19 MR. GRAHAM: Your Honor, we would call Dr. Trevor
20 Resnick.

21 THE COURT: Dr. Resnick, please come forward. Dr.
22 Resnick, please come forward and place your left hand on the
23 Bible and raise your right hand as the Clerk administers the
24 oath.

25 (After being duly sworn by the Clerk of Court, DR.

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1 TREVOR RESNICK testified as follows:)

2 CLERK OF COURT: Please have a seat and state your name
3 for the record.

4 THE COURT: Have a seat in the witness chair. Pull up
5 real close to that microphone and speak loudly, clearly, and
6 slowly in order that we can hear everything you have to say
7 and let's start with your full name and let's spell that last
8 one for us.

9 DR. RESNICK: Trevor Jesse Resnick. R-E-S-N-I-C-K.

10 THE COURT: Thank you.

11 DIRECT EXAMINATION

12 BY MR. GRAHAM:

13 Q Dr. Resnick, good morning.

14 A Good morning.

15 Q Why don't you start off by telling us, please, where you
16 are from and where you are now.

17 A I'm in the courtroom. I'm originally from Cape Town,
18 South Africa. I went to medical school in Cape Town. I
19 spent a few years in London doing internal medicine. I
20 did my pediatric training at the University of
21 Connecticut, my neurology training at Albert Einstein
22 College of Medicine in New York. I did an epilepsy
23 fellowship and for the last thirty years have been in
24 Miami. I am chief of the neurology department at Miami
25 Children's Hospital and on the faculty at The University

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1 of Miami.

2 Q Thank you. And are you board certified?

3 A Yes.

4 Q In which fields?

5 A In pediatrics and neurology, with special competence in
6 child neurology.

7 Q Tell us what child neurology is.

8 A Child neurology is a specialty including diseases of the
9 brain, the spinal cord, the nervous system, including
10 the peripheral nerves and muscles. It involves disorders
11 such as headache, epilepsy, peripheral nerve disorders,
12 developmental disorders, and others.

13 Q Thank you. In your work, in your education, knowledge,
14 training and experience as a child neurologist, as a
15 pediatric neurologist, have you acquired expertise
16 related to the brachial plexus nerves and how they are
17 involved in child health?

18 A Yes.

19 Q Are you familiar with where the nerves start and where
20 they go in the child's body?

21 A Yes.

22 Q Do you have expertise about how those nerves can get
23 injured?

24 A Yes.

25 Q Have you, at my request, reviewed the medical records

1 involved with respect to Bryson F ?

2 A Yes.

3 Q Have you also reviewed, have you had an opportunity to
4 examine Bryson F ?

5 A Yes.

6 Q When is the first time you examined Bryson F ?

7 A In 2011.

8 ~~Q At that time, had he had surgery performed yet?~~

9 A No.

10 Q When is the next time you had an opportunity to see
11 Bryson F ?

12 A This morning.

13 Q Have you been qualified as an expert witness in various
14 states around the country to offer qualified opinions on
15 child neurology issues?

16 A Yes.

17 Q Let me hand you what has been pre-marked as Plaintiff's
18 Exhibit #15. Can you identify that, sir?

19 A Yes.

20 Q What is that?

21 A It is my curriculum vitae.

22 Q Thank you. Is it true and accurate?

23 A Yes.

24 Q How current is it?

25 A It's not current.

1 Q What would we need to do to bring it up to date?

2 A There are additional articles that I have written,
3 additional studies that I have been involved in since
4 the CV. None of those articles are pertinent to this
5 case.

6 Q Thank you, sir.

7 MR. GRAHAM: Your Honor, we offer this into evidence.

8 THE COURT: Any objection from Defense?

9 MS. CRAIG: Yes, sir, Your Honor. Just cumulative in
10 nature.

11 THE COURT: It's into evidence over objection. All CVs
12 will be in for everybody.

13 MR. GRAHAM: Thank you, Your Honor.

14 (Whereupon, Dr. Resnick's curriculum vitae is entered
15 into evidence as Plaintiff's Exhibit #15, over objection)

16 Q And you mentioned that you had seen the child back in
17 2011. Prior to examining the child, did you have the
18 opportunity to read certain pertinent records from his
19 birth and from his time in the nursery of Carolinas
20 Hospital here in Florence?

21 A Yes, I did.

22 Q And tell me, sir, are those types of records the types
23 of records that an expert in your field reasonably
24 relies upon in reaching conclusions and opinions about
25 the case?

1 A Yes.

2 Q All right. I'm going to hand you -- actually, I'm going
3 to hand you all of these documents and we can just go
4 through them one at a time. First of all, sir, the one
5 that is pre-marked Plaintiff's Exhibit #10. What is --
6 is that one of the documents that you reviewed?

7 A Yes.

8 Q All right. What is that document?

9 A It's a document that is a summary of the delivery.

10 Q Right. And what is the typed name at the bottom of the
11 note?

12 A William Goldstein.

13 Q Thank you.

14 MR. GRAHAM: Your Honor, we'd offer this into evidence as
15 Plaintiff's #10.

16 THE COURT: Any objection?

17 MS. CRAIG: No, Your Honor, no objection.

18 THE COURT: It's into evidence -- Plaintiff's #10 is into
19 evidence, without objection.

20 (Whereupon, a summary of the delivery from Carolinas
21 Hospital Systems is entered into evidence as Plaintiff's
22 Exhibit #10, without objection)

23 Q The next exhibit I handed you is Exhibit #11. Did you
24 review that as a part of your investigation in this
25 case?

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1 A Yes, I did.

2 Q And what is this?

3 A This is a summary of the examination of Bryson F
4 after delivery.

5 Q At the Carolinas nursery?

6 A Yes.

7 Q Thank you.

8 MR. GRAHAM: We'd offer that, Your Honor, as #11.

9 MS. CRAIG: No objection.

10 THE COURT: Number 11 is into evidence without objection
11 from Defense.

12 (Whereupon, a summary of Bryson F's examination
13 after birth is entered into evidence as Plaintiff's Exhibit
14 #11, without objection)

15 Q Next, let me ask you about Exhibit #12. Did you review
16 that in connection with your work in this case?

17 A Yes.

18 Q What is that document?

19 A It's the discharge summary from Carolinas Hospital
20 Systems.

21 MR. GRAHAM: We'd offer Exhibit #12 into evidence, Your
22 Honor.

23 MS. CRAIG: No objection, Your Honor.

24 THE COURT: Number 12 is into evidence without objection.

25 (Whereupon, a discharge summary for Bryson F is

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1 entered into evidence as Plaintiff's Exhibit #12, without
2 objection)

3 Q Next, is Exhibit #14. What is that document?

4 A This is a dictation of the electromyogram and nerve
5 conduction study that was done in 2010.

6 Q Thank you. And have you also had an opportunity to take
7 into account this particular document in reaching your
8 finalized opinions here today?

9 A Yes.

10 MR. GRAHAM: We offer that, Your Honor.

11 THE COURT: And that is Plaintiff's Exhibit number?

12 MR. GRAHAM: Fourteen.

13 DR. RESNICK: Thirteen.

14 MR. GRAHAM: I'm sorry. Thirteen.

15 THE COURT: Thirteen is into evidence.

16 (Whereupon, a dictation of the electromyogram and
17 nerve conduction study of Bryson F. is entered into
18 evidence as Plaintiff's Exhibit #13, without objection.

19 Q Now, let me get you to turn to #14. What is this
20 document?

21 A This is an interpretation of the MRI scan of the
22 cervical spine and the right brachial plexus that was
23 done in 2011.

24 Q Have you had an opportunity to review this document and
25 take it into account in terms of the finalized opinions

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1 you are offering here today?

2 A Yes.

3 MR. GRAHAM: We offer that, Your Honor.

4 MS. CRAIG: No objection.

5 THE COURT: Fourteen is into evidence.

6 (Whereupon, a 2011 interpretation of an MRI scan of
7 Bryson F is entered into evidence as Plaintiff's Exhibit
8 #14, without objection)

9 Q And finally, Exhibit #16, what is that, please, sir?

10 A That is a copy of my medical evaluation that was done in
11 June of 2011.

12 Q When you examined Bryson?

13 A Correct.

14 MR. GRAHAM: We offer that into evidence, Your Honor.
15 Sixteen.

16 MS. CRAIG: No objection.

17 THE COURT: Sixteen is into evidence.

18 (Whereupon, Dr. Resnick's medical evaluation of Bryson
19 F from 2011 is entered into evidence as Plaintiff's
20 Exhibit #16, without objection)

21 Q Doctor, let me get you to step down here if you don't
22 mind and I'd like to ask you some questions to get you
23 to explain to the jury what the brachial plexus nerves
24 are from the viewpoint of a child neurologist and why
25 don't you please stand on this side so our court

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1 reporter can hear you better. Will one of these assist
2 you as you explain brachial plexus to the jury?

3 (Mr. Graham places large chart on easel in front of the jury)

4 MS. CRAIG: Your Honor, may I have permission to move so
5 that I can see?

6 THE COURT: Certainly.

7 MS. CRAIG: Thank you.

8 Q Doctor, can you just tell us---just to get oriented. I
9 believe the healthy nerves are on the top left and the
10 injured are on the top right?

11 A The top right are the injured nerves and the top left is
12 just the normal brachial plexus.

13 Q Do you need a pointer?

14 A I do, yes.

15 Q Tell us if you would, first of all, about brachial
16 plexus nerves, generally. Where are they in the human
17 body and where are they on this diagram?

18 A Okay. If you will permit me to digress. So, this is a
19 diagram that looks at the body from the front. This is
20 where the head would be up around here. This is the neck
21 and these are the nerves coming out of the neck and
22 these are the nerves going to the arm. Where these
23 nerves come out of the neck, you can see where they join
24 together and they separate again and where they join
25 together and separate is called the brachial plexus.

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1 Q Thank you. What is the purpose of the brachial plexus
2 nerves in the human body?

3 A Well, the purpose of the nerves is, the nerves come from
4 the neck and they go down to the muscles of the arm and
5 will supply sensation to the arm. So, the purpose of the
6 brachial plexus and the nerves within the brachial
7 plexus is to allow the arm to work normally.

8 Q And we heard some discussion earlier that there are
9 three main branches of the brachial plexus. Which nerves
10 go into the top part of the brachial plexus bundle?

11 A So, if you can see, these are labeled C4, C5, C6, C7,
12 C8, and T1. Cervical is the name for the vertebrae and
13 the part of the spinal cord that is in the neck. T1
14 stands for thoracic, which is the beginning of the
15 thorax, which is the chest. So, these six nerves or
16 roots that come out of the spinal cord go up to make the
17 brachial plexus. So, the upper plexus is comprised of
18 these three roots. The middle plexus predominantly are
19 the C6 and C7 and then the C8 and T1 would be the lower
20 part of the plexus.

21 Q What muscles in the arm or what muscles in the body are
22 powered by C5 and C6?

23 A So, the easy way to think of it is, the upper part of
24 the plexus supplies the upper part of the arm. The
25 middle part of the plexus supplies the middle part of

1 the arm, around the elbow, and the lower part of the
2 plexus supplies the hand and wrist muscles.

3 Q Thank you. Now, let's talk about the various ways that
4 brachial plexus nerves might become injured or diseased
5 or something like that. Could you just tell us the
6 various ways in which a baby -- well, why don't we start
7 with an adult. Why don't you give us various ways an
8 adult's brachial plexus nerves might be injured.

9 A So, brachial plexus nerves or just nerves in general can
10 be injured. They can become inflamed, infected, or
11 there's trauma to the nerves or there is a stroke and
12 the blood vessels that supply the nerves are damaged.

13 Q And in a situation involving a baby who is born with
14 nerve paralysis in the brachial plexus, what are the
15 possible causes of that kind of injury?

16 A So, in a baby, things like inflammation or infection are
17 less with them and more likely causes of brachial plexus
18 injuries would be any type of trauma, such as stretching
19 or tearing of the nerves, any kind of compression of the
20 nerve or an abnormal formation of the brachial plexus
21 during intrauterine development and so in the same way
22 some babies are born without an arm or malformation, you
23 can also be born with a malformation in the area around
24 the brachial plexus and have a malformed chest or
25 shoulder and the brachial plexus will be abnormal and

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1 the arm function is minimal.

2 Q In medicine, is there a concept known as differential
3 diagnosis?

4 A Yes.

5 Q What is that?

6 A In medicine, patients come to us with a symptom. Often,
7 our jobs as physicians is to figure out what the cause
8 of that symptom is. So, for example, I have a cough. I
9 don't know if that cough is due to an infection or an
10 obstruction or asthma and a part of my history
11 evaluation, it's my job to figure out which one of those
12 three or four things it is. Now, those three or four
13 things are the differential diagnosis that I use to come
14 to a final conclusion.

15 Q And how do you go about coming to a final conclusion,
16 just in general?

17 A In general, you take a detailed history and do a
18 detailed examination and sometimes you have to do
19 additional testing in order to come to a final
20 diagnosis.

21 Q In reviewing the issue of what caused Bryson's brachial
22 plexus nerve damage -- well, before we get to that, let
23 me ask you, sir. Based on your investigation and your
24 examination of the child and your education, knowledge,
25 training and experience, have you been able to determine

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1 whether or not Bryson has damage to his brachial plexus
2 nerves and if so, what that damage is?

3 A Yes, he does have damage to his brachial plexus nerves.
4 The damage that Bryson has involves the attachment of
5 the entire brachial plexus and the examination that I
6 did shows that he has weakness in the muscles that are
7 related to all those nerves.

8 Q Thank you. Were you able to -- well, look at the top
9 right-hand corner. What does that represent to you?

10 A Well, the top right-hand corner represents, well, you
11 see these same nerves. Some of these nerves are now
12 colored red and based upon Bryson's examination and the
13 finding that he needed surgical intervention, this
14 demonstrates those nerves that were damaged in the
15 brachial plexus injury.

16 Q What is a neuroma?

17 A A -- when a nerve is torn, the part of the nerve that is
18 still attached to the spinal cord says I should be
19 attached. And what it does, it starts looking for the
20 other end of the nerve and the way it does that is by
21 growing a new nerve, but it can't find it and because it
22 can't find the nerve it extended from, it grows in
23 multiple different directions and so you get a ball of
24 nerves and that ball of nerves is called a neuroma.

25 Q Thank you. You mentioned several possible, you mentioned
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1 several possible causes of brachial plexus nerve damage
2 in a newborn baby. Which of those causes or potential
3 causes fits with Bryson's neuromas?

4 A Well, the only one, once you have neuromas, neuroma
5 means that the nerve was torn. So, the only potential or
6 only cause of Bryson's brachial plexus injury is the
7 fact that the nerves were torn and the nerves involved
8 in that injury were these nerves that you see in the top
9 right-hand side of the diagram. So, in his case, there
10 isn't a differential diagnosis that includes
11 inflammation or infection or compression. This is an
12 injury where the nerves are torn.

13 Q To get a -- well, sometimes can nerves in the neck just
14 be overstretched? And if so, how long might that type of
15 injury last?

16 A Yes, you can have stretching after the nerve has been
17 torn and under those circumstances, you may have what's
18 called ponzi weakness and the weakness can last from
19 days to weeks, but there is always a return to normal
20 function because the nerve is still attached and so even
21 if there might be micro tears, the nerves are adjacent.

22 Q If you've got a baby over eight pounds going through the
23 birth canal, what type of -- would the stretching that
24 you described be sufficient to tear these nerves in two,
25 be able to happen before the head delivers?

1 MS. CRAIG: Objection, Your Honor.

2 THE COURT: Sustained.

3 Q Doctor, can you describe please for us, what types of
4 activities would be involved in the type of stretch that
5 would be sufficient to cause this kind of harm.

6 A So, if we think of the brachial plexus as this is the
7 neck and here are the nerves coming out of the spinal
8 cord, the injury that occurs is an injury that stretches
9 the brachial plexus and stretches the nerves within the
10 brachial plexus and the only way you can stretch the
11 nerves in the brachial plexus is if you think of the
12 head, here is the neck and the shoulder, the only way
13 you can stretch the nerve in the brachial plexus is by
14 taking the head and tipping the head away from the
15 shoulder and so if you actually do that to yourself, you
16 can feel the stretch on your neck, so anything that will
17 result in deviating or taking the head and moving the
18 head away from the shoulder will cause stretching of the
19 brachial plexus and if that stretch is significant
20 enough, it will cause a tearing or stretching of those
21 nerves in the brachial plexus.

22 Q And to cause ripping and tearing of the nerves on the
23 right side, would the head need to be tilted towards the
24 right shoulder or the left shoulder?

25 A Towards the left shoulder.

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1 Q Were you able to determine whether or not Bryson has
2 neuromas and if so, in which nerves?

3 A Well, I wasn't able to determine that, but based upon
4 the MRI that I reviewed and based upon the operative
5 report where he had the surgery, the neuroma information
6 included C5, C6, C7, and C8, so there was this kind of
7 glove of neuroma and fibrous tissue formation around
8 those nerves.

9 Q Let me ask you about this point right here. As a non-
10 doctor, looking at that, it looks like C1 and C8 come
11 together. Would you explain that, please?

12 A Yes. On the brachial plexus, if you look throughout the
13 roots separating, you can see that they separate over
14 here, and then they join together again, so; separation,
15 coming together, separation, coming together. And down
16 at the bottom over here, we can see C8 and T1. We see
17 that C8, T1 and C8, join together. And where they join
18 together is where some of the damage was, so that T1 or
19 the root of T1 was actually intact, but when it became a
20 join between C8 and T1, there was damage.

21 Q What effect does that ball of nerves, the neuroma, have
22 on the ability of the nerve to function normally?

23 A Well, where you see the ball of nerve abnormality
24 indicates that there has been a tear within the nerve
25 and so the nerve is not working at that point. Now, it

1 doesn't matter whether the nerve is torn here or here or
2 here as long it's torn somewhere along the path, it
3 means that the message is not getting to the muscle for
4 the muscle to work normally.

5 Q So, if I decide I'm going to raise my hand, tell me what
6 just happened in terms of those nerves.

7 A So, when the brain decides that you want to move your
8 ~~arm and the message goes from the brain down the brain~~
9 stem to the spinal cord and the nerves responsible for
10 raising your arm then goes to those muscles and those
11 muscles elevate the arm.

12 Q It all happens just like that. (Snaps fingers)

13 A Just like that.

14 Q As long as the arm is working correctly.

15 A As long as the brain is working, as well.

16 Q All right. Doctor, are we done with this?

17 A Yes, unless you have other questions about it.

18 Q Let's move on. You talked about neuroma. Does this slide
19 or this blowup help you explain more about what neuroma
20 is and what effect it has?

21 A Yeah, well, it just gives you a visual picture of what a
22 neuroma looks like and we had shown the picture of what
23 the normal brachial plexus looks like and you see here
24 within the middle of the brachial plexus, you see a red
25 blob, which looks not dissimilar to what that red blob

1 looks like. This red blob is actually an accumulation of
2 blood products, scar tissue, nerve and neuroma tissue,
3 that has been formed around a nerve that's been torn or
4 stretched. And you can see within this diagram that
5 there is a nerve that runs along here and there are
6 nerves within this red blob that have been damaged and
7 torn and this is tissue forming around that region of
8 nerves that have been damaged.

9 COURT REPORTER: Could you identify that, please?

10 MR. GRAHAM: Sure. It's Court's Exhibit #2.

11 COURT REPORTER: Thank you.

12 Q Thank you, Doctor. Why don't we, why don't you re-take
13 your seat, please sir. I want to refer to some of these
14 exhibits we put into evidence earlier. Exhibits #11 and
15 #12 you've identified and #11 is the original nursery
16 notes from when Bryson was transferred from the delivery
17 room to the nursery. True?

18 A Yes.

19 Q All right. What relevance, if any, does that have in
20 forming your opinions?

21 A It just notes that he was unable to move his right arm
22 or his right hand indicating that something had happened
23 to the brachial plexus, but it doesn't really define the
24 extent to which that was the case.

25 Q Does it say anything about whether or not his arm at

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1 that point was the same size or different size as his
2 left arm?

3 A There is no notation that there is any difference in the
4 symmetry or the size of the arm.

5 Q Now, please turn to Exhibit #12. This is the one that
6 you identified as Bryson's discharge summary from the
7 nursery after his birth. What relevance does this have
8 in terms of forming your opinions?

9 A The same as the initial nursing notes. It, again,
10 demonstrates the fact that there is no movement in the
11 right arm and very little movement in the fingers of the
12 right hand, as well. So, from the standpoint of his
13 examination, it demonstrates the same thing.

14 Q Now, please turn to Plaintiff's Exhibit #13. I believe
15 you identified this as the EMG studies done by Dr.
16 Gilpin?

17 A Yes.

18 Q What is an EMG? What does that stand for?

19 A EMG means Electromyogram and what we do is, we put
20 very thin needles into the muscles and then measure
21 muscle activity. So, under normal circumstances, when
22 you put a needle into somebody's muscle, you see that
23 the muscles are quiet. When you ask them to move the
24 muscle, then you see an increase in muscle firing.
25 Somebody who has damage to their muscles, with a nerve

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1 going to the muscle that isn't working, the muscle
2 begins to fire abnormally by itself, because it's not
3 receiving direction or instructions from the nerve
4 telling it what to do, so when you do an EMG or
5 electromyogram on somebody when a nerve to the muscle
6 is abnormal, you see this abnormal firing in the muscle.

7 Q And what does that tell you? What does the EMG report on
8 Bryson F. tell you?

9 A Okay. So, if you look at Bryson's EMG, his EMG shows
10 that there has been, that there is abnormal function or
11 abnormal firing within multiple muscles involving
12 multiple areas within the entire brachial plexus.

13 Q Doctor, is this the exhibit that you were just referring
14 to?

15 A Yes.

16 Q All right. Let me see if we can magnify that so everyone
17 can see it. All right, could you direct this up or down
18 to the main part that you are referring to there?

19 A So, if you look at the middle section ---

20 Q Of the graph?

21 A Of the graph. You can see it says normal ---

22 Q Could you use your pointer to ---

23 A I think it's over there. (Mr. Graham hands laser pointer
24 to Dr. Resnick)

25 Q So, on the left -- I don't want to shine this into

1 anyone's eye. There you go -- these are the various
2 muscles. These muscles over here, like the infraspinatus
3 and deltoid, are the shoulder muscles. These muscles are
4 the triceps that straighten your elbow out and these
5 muscles over here are all the muscles of the fingers.
6 These are the muscles that open your fingers up. These
7 are muscles that extend your fingers and these are the
8 muscles that flex your fingers. And what you are looking
9 at here are various things that are done on the EMG that
10 look at function and you can see, for example, they are
11 looking for fibrillations and they say, "none". If you
12 look at amplitude, they say the amplitude is normal and
13 if you look all the way on the right-hand side of the
14 curve, the right-hand side of the graph which gives you
15 an idea of the recruitment pattern, which is the ability
16 for the muscle to work properly, you can see that they
17 are decreased to amps for all the muscle groups
18 excepting for biceps, which they say you can see one,
19 two, three units and the entire CI, where you see one to
20 three units, which is also not normal, but it just gives
21 you an idea that all those muscles are affected.

22 Q How many units is normal?

23 A You would get numbers of units. You'd see it firing up.
24 One to three and zero is not good.

25 Q What would be good just on the order of magnitude?

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1 A Ten times. Ten times more.

2 Q Ten times more. So, instead of one to three, like, ten
3 to thirty?

4 A Ten. Ten.

5 Q In the second column over, I see a bunch of "normals".
6 What does that mean?

7 A That's -- one of the tests that they do during the EMG,
8 which is insertional activity. INA means insertional
9 activity. So, when you put the needle in you look for
10 any activity you see there and for those muscles at the
11 time, the insertional activity was normal.

12 Q All right. So, what significance does that have in terms
13 of whether or not this child is really damaged?

14 A Well, this is just an indirect indicator of the child's
15 function. The most important indicator of the child's
16 function is how they use their muscles. This really
17 gives you an idea to some extent, electrically, the
18 difference between the different muscle groups.

19 Q Okay.

20 A Very frequently, you can get that information from the
21 examination, itself.

22 Q So, "normal" in that second column means the muscles,
23 themselves, have activity?

24 A No, it just means the insertional activity where it
25 says, IA, was normal when they put the needle in. It

1 doesn't mean to say the muscle is normal. The way you
2 tell whether the muscle is normal or not is by examining
3 the patient and this is the part that gives you the most
4 information over here and that's the recruitment
5 pattern. Recruitment means you tell the patient to
6 squeeze the muscle or move the muscle and normally you
7 should see a marked increase in the muscle firing and in
8 all those muscles, you can see there is a notation
9 saying there is a decrease, that the recruitment pattern
10 was decreased, meaning that muscle was not working
11 normally.

12 Q And which is worse, one to three units or decreased?

13 A Well, zero units is the worst.

14 Q Right.

15 A One to three is not good and decreased means it is not
16 normal.

17 Q Okay. So, let me just ask you to boil all this down so I
18 can understand it, so we can understand it. Are these
19 numbers consistent or inconsistent with multiple nerves
20 being ruptured after the baby's head was delivered?

21 A They are consistent.

22 Q Are these numbers consistent or inconsistent with some
23 pre-labor, pre-delivery kind of damage?

24 A It could be consistent with that, as well.

25 Q Okay. So, if they could be consistent with that, what

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1 other information do you need in order to make that
2 distinction?

3 A The EMG and nerve conduction just tells you how the
4 muscles are working at that time. That doesn't tell you
5 what the cause of the injury is. What tells you what the
6 cause of the injury is, is the presence of the neuroma,
7 because you can only get neuroma formation when you have
8 a stretch injury which tears the muscle. So, the EMG is
9 just telling you about function. It's not telling you
10 about cause.

11 Q Thank you. Now, let's turn to Exhibit #14, this, you
12 identified as the report from the Miami's Children's
13 Hospital?

14 A Yes.

15 Q By the way, we've heard about Miami Children's Hospital
16 and Nicklaus Children's Hospital. What is that all
17 about?

18 A Jack Nicklaus gave a lot of money to the hospital and so
19 they named the hospital after him.

20 Q When did that happen?

21 A A few weeks ago.

22 Q So, back to Exhibit #14, the MRI report. What does this
23 tell you that you find relevant about determining the
24 cause of Bryson's nerve damage?

25 A Well, this is more important in determining the cause,

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1 because the MRI demonstrates that there is thickening of
2 the nerves that are consistent with what is called a
3 post-traumatic neuroma and it tells you that there is a
4 neuroma and it tells you what the neuroma involves and
5 so this study, in fact, is much more of a determinative
6 in telling you the cause of the injury and the nerves
7 that were involved.

8 Q Thank you. Now, turn to Exhibit #16. This, I believe you
9 identified as your report from the first time you saw
10 Bryson.

11 A Correct.

12 Q Tell us, please, what was the significance with your
13 interaction with Bryson that day. What did you do and
14 what did you learn?

15 A Well, I had reviewed the medical records and taken a
16 history and then I did my examination, which was normal
17 excepting as it pertained to his right arm. Now, with
18 the history, what I obtained was the fact that he had a
19 difficult delivery and there was a shoulder dystocia so
20 the head was stuck and there were different maneuvers
21 applied to get him delivered and then I described the
22 fact similar to what I mentioned previously, about the
23 fact that there was no movement in his right arm and
24 then there was the beginning of shoulder movement at
25 about nine months and then involving the thumb and the

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1 finger at about a year. I then note that there is
2 continued gradual improvement up to age three, which is
3 a typo, because when I saw him, he was only twenty-one
4 months. But the mother had noted that he had improved
5 through about one-and-a-half years and then he's, his
6 status had pretty much stabilized. He was receiving
7 physical therapy. At the time I saw him, he
8 predominantly used his left arm and the way he used his
9 right arm was a helper or stabilizer arm. What that
10 means is, if I have an object, I put it between my arm
11 and my chest to stabilize it and then I manipulate it
12 with my good arm and that's the way he was using his
13 right arm in terms of his functioning. He was able to
14 weakly grasp objects between the right thumb and the
15 index finger and then I mentioned what the EMG and the
16 nerve conduction showed, which is what we just
17 discussed. Other than that, he had some very mild
18 developmental language issues, but the major aspect of
19 his examination related to my examination of the right
20 arm and what the examination showed was the fact that he
21 had shrinkage of the right arm, which if you look just
22 where it says brachial plexus exam -- so, can you raise
23 it up higher? Just a little higher? Right there is just
24 perfect. (Magnified on the screen)

25 Q Before you go on, Doctor, let me ask just one question.

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1 A Yes.

2 Q You said something about shrinkage of the arm.

3 A Yes.

4 Q Is there any evidence of shrinkage of the arm at the
5 time of birth?

6 A No.

7 Q Okay. So, when you talk about shrinkage of the arm,
8 what's the time frame?

9 A Well, if you have damage to nerves, the atrophic or the
10 growth influence that nerves exert by using the arm and
11 from the nerve itself is what determines arm growth. If
12 you don't use your arm, what happens is, the muscles in
13 the arm shrink and the bones around the muscles also
14 shrink and that's called -- sorry, I'll try not to shine
15 this in anybody's eye -- atrophy. Can you see where it
16 says "atrophy" at the top left here? There, thank you.
17 And atrophy is another way, a medical way of saying
18 shrinkage of the arm. And so he had atrophy of his arm
19 and then after that, it says posture and that looks at
20 how he holds his arm and he held his arm in a flexed
21 position away from the side and his arm was turned
22 inward or pronated and his scapula was high riding and
23 so that was just a description of how he held his arm.
24 You can see also that there is a discrepancy in the
25 length of his arm in that is three centimeters shorter

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1 than his left arm. I didn't find any abnormalities of
2 sensation or temperature.

3 Q Let me stop you right there. You talked about abducted.
4 Well, you used a bunch of words that I want to make sure
5 I understand. First of all, flex.

6 A Flex is at the elbow, it would be extended. This is
7 flexion, so it's flexed like this. (Demonstrating)
8 Abduction would mean it's away from his chest, so he's
9 holding it away from his chest in a flexed position and
10 pronated.

11 Q Pronated, is what?

12 A That way. (Demonstrating)

13 Q Palm down to the floor?

14 A Correct.

15 Q What is the opposite of pronated?

16 A Supinated, which means palm up facing the ceiling.

17 Q And his was which way?

18 A Pronated down.

19 Q What are you saying about his ability to ---

20 A Nothing. That comes later. All I was doing was
21 describing what his posture was like when I saw him in a
22 normal position.

23 Q Thank you. And then you talked about the high-riding
24 scapula. First of all, what is a scapula?

25 A A scapula is the bone at the back that a lot of the

1 muscles of the shoulder are attached to.

2 Q Right.

3 A And if you have weakness of any of the muscles, the
4 scapula, instead of being low and flat against your
5 back, is high-riding, so it's raised up which ---

6 Q So, are you telling me that the brachial plexus nerves
7 that power the shoulder muscles get into these muscles,
8 then, around here? (Indicating on chart)

9 A No, higher up.

10 Q In here?

11 A Yes.

12 Q Okay. Thank you. Now, you said the arm length was three
13 centimeters shorter on the right. I'm used to dealing
14 with inches, so tell me about centimeters and how they
15 relate to inches.

16 A Well, two-and-a-half centimeters is an inch and so it's
17 about one-and-a-half inches shorter than the other.

18 Q Thank you. Excuse the interruption. Please continue.

19 A So, I didn't find any abnormalities in terms of
20 sensation temperature. There was no history of pain
21 and I couldn't elicit any pain when I examined him.
22 There is something called Horner's syndrome, which we
23 always look for in patients with brachial plexus
24 palsies, because the upper part of the plexus has a
25 nerve that goes up one side of the face and the eye and

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1 causes constriction of the pupil. He didn't have that,
2 and so it wasn't an abnormality ---

3 Q All right. On which ---

4 A --- on that part of the exam.

5 Q On which part of the nerves does Horner's relate to?

6 A C4. And you can see C4 was not involved when you look at
7 the brachial plexus. And then I examined his arm and you
8 can see it's broken into shoulder, further down, elbow,
9 and then further down, forearm, and probably on the next
10 page, the ---

11 Q Before we do that, past range of motion and active range
12 of motion. Can you tell me what that means?

13 A Yeah. I'm going to get there.

14 Q Oh, sorry. Sorry.

15 A So, I break it down into shoulder, elbow, forearm, wrist
16 and fingers and then what I do, with each one of the
17 muscle groups within each one of those sections, I first
18 make sure that by moving his arm myself, I'm getting an
19 idea of what the range of motion of the arm is and so I
20 lift his arm up and if I can lift it all the way up
21 without any problem, it means that there is no
22 restriction to that movement and so that's passive range
23 of motion. I am moving it and so it's a passive range of
24 motion for him. Active range of motion means that's what
25 he can do and so I check the movement and he shows me

1 what he can do with that group of muscles and then
2 reflex is just the reflexes that pertain to the group of
3 muscles that I'm testing.

4 Q All right. Tell us whether it's usual or unusual for a
5 child with brachial plexus nerve damage to have a
6 different ability to move the arm actively versus
7 passively.

8 A ~~Well, that's not just with brachial plexus. That's with~~
9 anybody, so we do passive range of motion with anybody
10 we are doing an exam with to make sure that there is no
11 restriction of movement say from a contracture or a
12 functional extraction and he didn't have any excepting
13 for two areas, which I will discuss in a while.

14 Q All right.

15 A But that allows me to then get a better assessment of
16 what his active range of motion is and what his actual
17 strength is.

18 Q All right. Just go through and tell us what limitations
19 he had in terms of what movements he could make.

20 A Okay. So, the first movement is abduction, which is the
21 ability to move your arm from its side and to lift your
22 arm up in the air to a vertical direction and I was able
23 to do that fully with him passively, and so there was no
24 obstruction to the movement, but when I asked him to do
25 it, you can see under active range of motion, it says

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1 60, which means he could do 60 degrees and so the best
2 he could do was this. (Demonstrating) He could get it
3 away from his chest up to about 60 degrees and so that
4 gives me an idea of the extent to which one of the
5 shoulder muscles, which is called the deltoid muscle, of
6 the extent of the weakness of that particular muscle.
7 The next thing that's important ---

8 Q Doctor, could you make that motion standing up? I want
9 to make sure everybody can see you.

10 A Yeah, sure. (Stands) Okay. So, normal motion would be up
11 like this and what he could do is, he could get it up to
12 about there. That was the extent of his weakness.

13 Q Thank you.

14 A The next thing that I did, was the ability -- also a
15 part of the shoulder function is something called
16 external rotation. So, normally, if we stand like this,
17 I'm externally rotating. I'm turning my arm out. I can
18 get it out to about 60 degrees. I'm doing it above my
19 left arm and that's the shoulder movement that's one of
20 the muscles that turns the arm out, so when you do
21 something, you may lift it up, but you may also want to
22 move it up in this direction, so any movement you do
23 when you do that, it's external rotation. It's a
24 shoulder movement. Now, you can see that because he was
25 so weak in his external rotator, that the action had the

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1 restriction of my ability to passively move his external
2 rotator and so when I moved his external rotator on the
3 good side I could go all the way up, just like that.
4 When I get to the bad side I could barely get it up to
5 30 degrees. There was a contractual disability to do
6 that. He couldn't do it. When I actively tested his
7 active range of motion, he had no movement, so on this
8 side he could do this. On this side, he couldn't, so he
9 has complete weakness to externally rotate that shoulder
10 muscle.

11 Q Okay. Let me ask you. Doctors in your field sometimes
12 use the word "weakness". How does the word "paralysis"
13 match up to the word choice of "weakness"?

14 A All right. You are more accurate than I'm being.
15 Paralysis means very severe weakness so that you cannot
16 move the arm and that's what he did have in that muscle.

17 Q Thank you. Please continue.

18 A (Sits down) Okay. External rotation means you hold your
19 arms in the same position, but then you move them in to
20 touch your chest. He had full ability for me to do it
21 passively, but actively he could only get it in about 60
22 degrees, so he did have some movement, but it was
23 restrictive. And then at the elbow, he had full ability
24 to extend, actually, and he was a little weak. So,
25 actually, he did pretty well at the elbow. He could flex

1 his elbow and extend his elbow with some mild weakness,
2 so that was a relative sparing of his function.

3 Q What does the five minus mean?

4 A Five minus means mild weakness.

5 Q Okay.

6 A And that's just when he extended his arm, he was unable
7 to extend it fully. He had a flexion contraction so if
8 you stretch your arm out, you can stretch it to 180
9 degrees and he had about a 30 degree contraction. Okay,
10 the next two are forearm, if we could actually move the
11 page up or turn it over. So, pronation. If you have your
12 elbow, again, pushed out as I had before, it's the
13 ability as if you are using a screwdriver to reverse or
14 this. That's supranation and pronation and you can see
15 that pronation and supranation, I had no problem doing
16 it passively, but he had no ability to pronate or
17 supranate, so when I asked him to turn his arm up, he
18 couldn't do it. If I asked him to turn his arm down, he
19 couldn't do it, but he could do it fully with his other
20 arm. In the wrist, I can't see that. There you go, thank
21 you. So, his wrist is your ability to flex the wrist
22 down or extend the wrist up and he couldn't either flex
23 or extend his wrist and then in the fingers, he had four
24 passive range of motion, but if you look at active range
25 of motion, he couldn't do anything with his fingers

1 except some minimal movement of his thumb and his pincer
2 finger and so he could put these two together, but
3 otherwise, he was very weak in the wrist, and the
4 fingers, as well. And then what I did was, other than
5 testing individual muscle groups which I just described
6 now, I got him to do some functional things. In other
7 words, taking your hand and putting your hand on your
8 forehead or your chin or behind your head and when I
9 tried to do those things with him, he was unable to do
10 that. The one thing that he could do is, he could get
11 his hand to his neck and his hand to his mouth, but you
12 can see in my examination, I have a little star next to
13 that and that star means he could do it, but he had to
14 do it with ancillary maneuvers. So, if I ask you to put
15 your hand to your chin, you would do this.

16 (Demonstrating) What he would have to do is, he would
17 have to raise his shoulder, because he's weak and then
18 put his hand on his chin and so he uses ancillary
19 maneuvers due to his weakness in order to do it and so
20 he can do it, but he can't do it in a normal fashion
21 that you all would do it. And then I tried something
22 called ADLs, which means Activities of Daily Living,
23 such as, lifting an object with both hands. Well,
24 obviously, he can't do that because he doesn't have
25 function in his right arm: Tucking in his shirt, combing

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1 his hair, putting on his shoes, taking off his shirt,
2 putting on his shirt. Now, remember, when I examined
3 him, he was only 21 months of age. So, kids don't do
4 that, but the major thing that he could not do that kids
5 do at that age is really lifting objects with both of
6 his hands and he couldn't do that because he didn't have
7 the use of his right arm. So, basically, my assessment
8 was that he had a severe brachial plexus palsy due to
9 the description of what I just went through with you and
10 that brachial plexus palsy involved the entire plexus,
11 but it wasn't equally involved, because he did have some
12 flexion and extension of an elbow, so it was patchy
13 involvement of the brachial plexus, but the entire
14 brachial plexus.

15 Q Except for about three years...

16 A Yes.

17 Q Does the rest of this report and the contents in there,
18 does that reflect you opinions and conclusions at that
19 time to a reasonable degree of medical certainty?

20 A Yes.

21 MS. CRAIG: Your Honor, could we approach, just briefly?

22 THE COURT: Yes.

23 (Bench conference off the record)

24 THE COURT: Exhibit #16 was previously offered into
25 evidence, but due to the fact that it's been published in

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1 great detail and gone over in great detail with the jury, I'm
2 not going to allow that into evidence as it is cumulative.

3 MR. GRAHAM: Yes, sir. Your Honor, we skipped over the
4 top of page two. Since it's not in evidence, can ---

5 THE COURT: You can ask him what you want to ask him.

6 MR. GRAHAM: Thank you.

7 Q Since this report is not going to be in evidence, Dr.

8 ~~Resnick, I'm going to go back to the part that we~~

9 skipped. Could you just go through this section here,
10 "Review of Symptoms and Neurological Examination," and
11 tell us the significance of your findings?

12 A Okay. There is one section before that, the
13 developmental history was, other than his right arm was,
14 motor milestones were completely normal. Now, anything
15 that I found was, at the time that I saw him, his
16 expressive language was delayed in that he was only
17 saying a few single words and at 20 months, he should be
18 doing more than that, but otherwise, there as nothing
19 developmentally ---

20 MS. CRAIG: Your Honor, I object. Beyond the scope of his
21 expertise.

22 THE COURT: I'll sustain the objection.

23 DR. RESNICK: I'm sorry? I couldn't hear the objection.

24 MR. GRAHAM: May we ask of his expertise?

25 THE COURT: I sustained the objection.

1 Q Please move on, Doctor.

2 A His reviewer systems which looks at other organ systems
3 was unremarkable. He was a healthy kid. Ear infections,
4 chest infections and so on and so forth in this specific
5 examination. I would then, as it pertains to his right
6 arm was completely normal as was his neurological
7 examination completely normal. The only additional thing
8 I found in his neurological examination was the fact
9 that his expressive language was mildly delayed.

10 Q Thank you, Doctor. Now, again, this report dates after
11 your visit with Bryson, on what date?

12 A I think it was June of 2011.

13 Q Thank you. Now, you next saw Bryson today.

14 A Yes.

15 Q After his surgery.

16 A Yes.

17 Q All right. He is actually available to come into the
18 courtroom. Would you be kind enough to show us with
19 Bryson in the courtroom, what you'd do to assess him
20 right now?

21 A Yes.

22 MS. CRAIG: Your Honor, we object to these new opinions.

23 THE COURT: Your objection is noted, but overruled.

24 MR. GRAHAM: Your Honor, I think he had to take a mother
25 nature call.

1 THE COURT: While we are waiting, let's have the jury
2 stand while we are waiting on the witness. (Jurors comply)

3 THE COURT: Mr. Graham, you are recognized. Y'all can
4 have a seat.

5 Q Doctor, can you --

6 MR. GRAHAM: Ladies and gentlemen, this is Bryson. Do you
7 remember Dr. Resnick?

8 ~~BRYSON F : (Nods head)~~

9 MR. GRAHAM: Why don't you listen to Dr. Resnick and do
10 what he asks you to do. Okay, son?

11 BRYSON F : (Nods head)

12 Q What I'm going to show you is -- and Bryson, can you say
13 hi to everybody? (He waves) So, what I'm going to show
14 you, and Bryson is very good at this, is I'm going to
15 show you the same kinds of functions that I described to
16 you in my original description on the examination. So,
17 Bryson, to start out, why don't you do this. I want you
18 to take this arm and I want you to lift that arm up, all
19 the way up to the -- (Bryson complies) Good job. Now,
20 put it down again. Very good. Now, I want you to keep
21 the shoulder where it is and I want you to do the same
22 thing with this arm here. Go up as high as you can.
23 Okay. Good job. Now, if you remember, I said to you that
24 when I originally examined him, he was able to get up to
25 60 degrees and what he's able to do now with ancillary

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1 maneuvers is get it up to about 90 degrees and so that
2 has been an improvement. So, now. Very good. Keep your
3 arms like that. Very good. Now, with this arm, I want
4 you to keep it against the side, but move it out as far
5 as you can and move it upwards, all the way up. Very
6 good. So, you can see that he is able to externally
7 rotate his arm. Move it out again? Now, this one. Very
8 good. Now, put that arm down. Now, I'm going to hold
9 this one up. Just try your best to see if you can get
10 that one out, as well. So, you see he flexes it, but
11 he's unable to externally rotate it. Now, let's do this
12 one. You've done this already for me Bryson. You did a
13 very good job. I want to see you turn it inwards like
14 that. I'm going to hold this front and you put it in.
15 Touch your tongue. Very good. Hold it out again? I'm
16 going to hold this one for you. Now, turn this one in.
17 Okay. He's not really using the rotator. He has some
18 function he gets a little bit of movement. With this arm
19 over here, I want you to go like this, straight and then
20 in. Okay. Now, do it with your good arm. Okay. Now, with
21 this arm. Very good. Now, you can see there is some
22 restricted movement. Now, he can do it. I've shown you
23 that he can do it. He does it a little more slowly than
24 anyone. Now, I want you to hold this and I know you are
25 a strong guy. Bend your arm. Good. Now, put your arm

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1 down again. Now, bend your arm. Excellent job. Now, lets
2 see if you can do it with this arm. Can you hold it?
3 Good. You've got it. Now, try to bend it up. Okay. You
4 can see that what he does there is uses his shoulder to
5 bend backwards, but he can't really flex the arm. He can
6 flex the arm reasonably well without a break, but shall
7 we do it with this arm? Good. Now, go down. Very good.

8 ~~Thank you very much. Now, so far you get an A+. Make~~
9 your arm into a fist. Very good. Now, what I want you to
10 do with this fist, straighten it. Very good. Now, I want
11 you to move it down and I want you to move it up, all
12 the way up. Good job. Okay. Let's put that arm down and
13 we are going to do this one, as well. Thank you very
14 much for closing the fist for me. Now, can you make it
15 go up? Now, can you make it go down? You can see that
16 he's unable to flex or extend with the wrist on that
17 side. Now, with this arm, make your hand like that. Make
18 a fist. First, I want you to turn the wrist up so it
19 faces the ceiling and then I want you to turn the wrist
20 down so it faces the floor. So, start like that. First,
21 go up so that it faces the ceiling. Good job. Now, put
22 it back again where it was. Good. Now, I want you to
23 turn it down so it faces the floor. Okay. Now, let's try
24 this one. Thank you. First, make it down so it faces the
25 floor. That's supranation and so it's a little bit of

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1 supranation. So, make it down so it faces the floor and
2 he's unable to rotate it down so that it faces the
3 floor. Now, let's see your fingers. Put your fingers out
4 like that. Now, close your fingers and open your
5 fingers. Make your fingers go out and then in. Very
6 good. Okay. Now, with this hand, we'll try to do the
7 same thing. Keep them up. Good. First, make your fingers
8 go down. Okay. Now, you have some extension, some
9 flexion with the fingers. Now, straighten them out. I'll
10 hold this one for you. Now, make them go down, bend them
11 down. Now, make them go up. So, you can see now he has
12 some flexion and some extension with his fingers, but it
13 is minimal. That was very good. I'm going to put this
14 under your chin like this. Can you take it off with this
15 hand? Okay. You see what he did, he just flexes the arm
16 and takes it off. Good job. We'll use the same one. Now,
17 I want you to do it with that arm. Do you see what he
18 does there? That whole arm comes up in order for him to
19 do it. He's still pretty good at doing it. Thank you,
20 Bryson. Now, see if you can get it off your forehead
21 like that. (Using a sticker) No problem. Now, use a new
22 one. Put this hand down. Same thing. He was not able to
23 do that before. Now he's able to do it, but again, using
24 an ancillary hand. Almost there. Very good job. Another
25 thing I want you to notice. Okay, hands down. You can

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1 see there is a difference in terms of the position that
2 he holds his hands and if you will look at the size.
3 Turn here. That's the atrophy we were talking about.
4 Good job. Okay.

5 Q Thank you, Doctor. You may take your seat. (Bryson
6 leaves) Doctor, you told us when you first saw Bryson
7 that his nerve damage was severe and permanent.

8 A Yes.

9 Q How do you describe his current situation?

10 MS. CRAIG: Objection, Your Honor.

11 Q Can you please -- have you formed ---

12 THE COURT: What is the objection?

13 MS. CRAIG: This is a new objection based on his
14 examination.

15 THE COURT: Oh, and your objection is noted.

16 MS. CRAIG: Thank you, sir.

17 Q Please continue, Doctor.

18 A So, my opinion is, essentially, the same. It has been
19 some minor improvement in his function in that he now
20 has better finger movements in that he is now better
21 able to extend and flex his fingers and there is also
22 some improved shoulder function, in that he was
23 previously only able to get it to 60 degrees. He can now
24 get it to 90 degrees and that has happened since the
25 surgery.

1 Q When you saw him before, did you know he was going to go
2 in for an attempt to reset his nerves at that age of
3 around two?

4 A No.

5 Q Can you tell us whether or not doing that kind of
6 surgery at age two is relatively common or is it
7 unusual?

8 A Oh, it is unusual.

9 Q Apart from Dr. Grossman, do you know anybody in the
10 world that would undertake that procedure at that time?

11 MS. CRAIG: Objection, Your Honor. Leading.

12 THE COURT: That's not really -- overruled.

13 A No.

14 Q If Bryson had not been evaluated and operated on by Dr.
15 Grossman, tell us whether or not he would have had the
16 improvement that you have seen and described today.

17 MS. CRAIG: Objection.

18 THE COURT: Sustained.

19 Q Can you tell us, sir, do you have an opinion or
20 conclusion to a reasonable degree of medical certainty
21 as to whether or not Bryson would have improved at all
22 since your first visit without the surgery?

23 MS. CRAIG: Objection, Your Honor. Speculative.

24 THE COURT: Sustained.

25 Q Ordinarily, Doctor, when a child -- do you have a

1 conclusion or an opinion to a reasonable degree of
2 medical certainty as to whether or not a child at age
3 two with severe ruptures and neuromas and total plexus
4 injury, like Bryson, is likely to improve at all after
5 age two through any form of treatment other than
6 surgery?

7 MS. CRAIG: Objection, Your Honor.

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

9 A So, generally, what we see is, you do see improvement
10 for the first six months to a year, maybe a year-and-a-
11 half. After that, any improvement that would have
12 occurred due to nerves that were stretched, not
13 permanently damaged, is done. So, generally, by the time
14 you've reached 18 months, whatever you see is what you
15 are going to see on a continuous basis, so to answer
16 your question, by 21 months, whatever I was seeing at
17 that time was reflective of a permanent injury without
18 any subsequent improvement under those circumstances.

19 Q And you told us in your report from your first visit
20 that Bryson's severe injury was permanent. Now you are
21 telling us there has now been some improvement after
22 surgery. How do you reconcile permanency with some
23 improvement?

24 MS. CRAIG: Objection. Asked and answered.

25 THE COURT: I'll allow him to answer it.

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1 MR. GRAHAM: Thank you, Your Honor.

2 A The answer is that, first of all, there has been some
3 improvement. It's not a huge improvement and the
4 improvement is that once you do neurolysis and you
5 separate the fibrosis and the scar tissue and you
6 interpose a nerve, you can get some return of function
7 for those with nerves that are now reattached and that's
8 what has happened to him. He has had some mild
9 improvement.

10 Q Doctor, I haven't asked you this question. Have you
11 formed a conclusion to a reasonable degree of medical
12 certainty as to the most probable cause of Bryson's
13 nerve damage?

14 A Yes.

15 Q What is that, sir?

16 A It was a stretch injury to the brachial plexus.

17 Q Involving stretch, involving movement of the head in
18 which direction?

19 A Away from the right shoulder towards the left shoulder.

20 Q So, like this?

21 A Yes.

22 Q You are not an obstetrician.

23 A Correct.

24 Q So, you are not pointing fingers at anybody about
25 whether the standard of care for obstetricians were met

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1 or violated.

2 A Correct.

3 Q But you can determine, but for the movement of this
4 child's head down towards his left shoulder, would any
5 permanent nerve damage have been caused?

6 MS. CRAIG: Objection. Asked and answered.

7 THE COURT: I'll allow him to answer.

8 A ~~Sir, could you ask the question again?~~

9 Q Yes, sir. But for the movement of this child's head of
10 the left ear down towards the left shoulder, would his
11 nerves have been ruptured, ripped, and torn?

12 A No.

13 Q Now, let me ask you about -- I expect that we are going
14 to hear later on in the trial about the role of this
15 child's poor body tone throughout his body at the time
16 he was born. What causal significance, if any, does that
17 have to causing this kind of injury?

18 MS. CRAIG: Objection, Your Honor. It is an editorial
19 comment.

20 THE COURT: Sustained.

21 Q Doctor, have you formed a conclusion to a reasonable
22 degree of medical certainty about whether or not this
23 child's tone at birth played any role in terms of
24 causing his brachial plexus nerve damage and, if so,
25 please explain your conclusions in that regard.

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1 A No, I don't believe that it had an effect and the reason
2 I don't believe it had an effect are for two reasons.
3 One, the actual tone of the muscles themselves is not
4 what is necessary to protect a child at the time of
5 delivery. It's the bulk and natural resistance of the
6 muscles. So, for example, if you have shrunken muscles
7 around the brachial plexus and you don't have that
8 natural resistance during delivery, that can actually
9 predispose to brachial plexus damage, but he had normal
10 formation of his muscles, so the actual bulk and
11 inherent resistance of the muscles were still there. The
12 decrease in the tone, if you think of examining or
13 holding a newborn baby, they don't have that much head
14 control and neck control when they are born and if in
15 the process of delivery there is a need to move the head
16 or the neck, whether they have tone or they don't have
17 tone is not going to make any difference to an adult who
18 is assisting in the delivery process.

19 Q Thank you. Have you formed an opinion and conclusion to
20 a reasonable degree of medical certainty about whether
21 or not the uterus contracting or the mother pushing
22 during the labor and delivery process played any role in
23 terms of causing the brachial plexus nerve damage?

24 A I don't believe it did.

25 Q All right. Can you explain it, please, sir?

1 A There have been various hypotheses on what are called
2 maternal uterine forces, which means the contraction of
3 the uterus pushing the baby out and that that
4 contraction of the uterus pushing the baby out when the
5 shoulder is stuck stretches the brachial plexus enough
6 to cause a brachial plexus palsy. A lot of bad data has
7 been evaluated and by many reputable physicians found
8 ~~not to be accurate. It wasn't actually proven it was a~~
9 mathematical model that was devised to calculate the
10 uterine forces and even under those circumstances, if
11 your head is in a straight position and you have your
12 shoulder where it is, it doesn't result in any
13 meaningful or significant stretching to the brachial
14 plexus enough to cause tearing or stretching of the
15 nerves. So, an example would be if I was standing under
16 a pole, a horizontal pole, and I was pushing out from
17 the pole and there was a pole here obstructing my
18 shoulder and I kept on going upwards it would hurt my
19 shoulder but it wouldn't cause a deviation in the
20 brachial plexus enough to stretch the brachial plexus
21 and tear the brachial plexus nerves.

22 Q And is there room for the baby's head to go like this
23 (indicating) before it comes out of the birth canal?

24 A Not that I'm aware of, but I would defer that to an
25 obstetrician.

1 Q Let me ask you, among the blowups, do we have a blowup
2 here that summarizes your views and opinions and
3 conclusions about the most probable cause of this
4 child's nerve damage?

5 A (Leaves the witness stand)

6 Q And before you say anything about it, let me read the
7 Court Exhibit number. Court Exhibit #5.

8 A So, this diagram shows a baby being delivered. It also
9 shows the vertebrae and the nerves coming out of the
10 neck that form the brachial plexus and the purpose of
11 this diagram is to evaluate what kind of structural
12 change can actually cause damage to the brachial plexus.
13 So, the one theory is that this is the synthesis or
14 pubic bone and if the shoulder gets stuck at the pubic
15 bone and the head continues straight up in this
16 direction, that you can get tearing or damage to the
17 brachial plexus and that would be the hypothesis of
18 uterine forces and the other would be, if this is the
19 cervical spine and this is the brachial plexus, if the
20 head is turned in this direction, in other words, away
21 from the shoulder, then you will then get stretching of
22 the brachial plexus and thereby cause stretching or
23 tearing of the nerves.

24 Q I notice that on this exhibit, greater than gentle
25 pulling on or twisting of the baby's head. Let me ask

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1 you about the twisting. What role, if any, do you
2 believe ---

3 A Only insofar as twisting or turning would increase the
4 stretching of the brachial plexus by getting it further
5 away from the shoulder. That's the only mechanism that
6 can result.

7 Q So, not only does twisting, but you need this kind of
8 traction, too, left ear towards left shoulder before you
9 get a permanent ---

10 A And when you turn, you also do get some degree, some
11 increased stretching, but it has to be contraction of
12 the head away from the shoulder.

13 Q Thank you, Doctor. Please answer any questions the
14 Defense may have for you.

15 THE COURT: Madam forelady, ladies and gentlemen of the
16 jury, we are going to allow y'all to take a morning break and
17 refresh yourselves. Once again, do not discuss the case.
18 Everyone remain seated as the jury exits the courtroom.

19 (Jury out at 10:38 AM)

20 THE COURT: You may be excused, as well, but you may not
21 discuss this matter with either attorney at this point.

22 DR. RESNICK: Thank you, sir.

23 THE COURT: We'll take about a ten minute recess.

24 (Break)

25 THE COURT: Ms. Craig, have you had enough time to gather

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1 your thoughts concerning the new opinion?

2 MS. CRAIG: Yes, sir. Thank you for the time.

3 THE COURT: It appears to me that that is not that
4 prejudicial in that the condition has improved, so I wanted
5 to mention that. So, anything more from the Plaintiff?

6 MR. GRAHAM: No, Your Honor.

7 THE COURT: Anything from the Defense?

8 MS. CRAIG: No, sir.

9 THE COURT: All right. We are ready for the jury.

10 (Jury in at 10:52 AM)

11 THE COURT: Madam forelady, ladies and gentlemen of the
12 jury, I know that listening to testimony sometimes is
13 certainly a sedentary activity and I'm going to ask all of
14 you to pay very close attention, because this is very
15 important stuff. It's important to everybody. So, everybody,
16 keep your eyes open, stay attentive and pay attention. Ms.
17 Craig, you are recognized.

18 MS. CRAIG: May it please the Court.

19 THE COURT: Yes.

20 CROSS EXAMINATION

21 BY MS. CRAIG:

22 Q Good morning.

23 A Good morning.

24 Q All right, Dr. Resnick, you started reviewing lawsuits
25 as a paid witness for Mrs. Fulton's lawyer about four

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1 years ago?

2 A Something like that.

3 Q 2011?

4 A I don't remember exactly, but, yes.

5 Q Well, you've reviewed quite a few cases for Mr. Graham.
6 Correct?

7 A Yes, I have.

8 Q In fact, you've seen approximately 15 patients that were
9 sent to you from South Carolina to Miami. Right?

10 A Yes.

11 Q To Miami. And those were all clients of Mr. Graham's.
12 Right?

13 A Yes.

14 Q And you've actually testified for Mr. Graham in South
15 Carolina before. Correct?

16 A Yes.

17 Q Two times?

18 A I think so.

19 Q And one of the times that you testified like you are
20 doing right here today, the court was in another trial
21 recently, in Greenville.

22 A Yes.

23 Q Is that right?

24 A Correct.

25 Q And you gave the same opinion in that trial, did you

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1 not?

2 A Yes.

3 Q And in that Greenville trial, the other experts that
4 were hired by Mr. Graham, who all you know, were Dr.
5 Grossman, Mr. Forman, Dr. Gomez-Carrion. Is that right?

6 A I don't remember.

7 Q You don't know if all those same experts and those same
8 opinions were in the Greenville trial as are in this
9 trial in Florence?

10 A No. I don't.

11 Q I believe you've been doing work and testifying in a
12 number of legal cases for 20 years?

13 A Yes.

14 Q And maybe eight to ten depositions a year?

15 A Correct.

16 Q You've been paid over \$10,000.00 by Mr. Graham's office
17 in this case?

18 A No.

19 Q How much money are you charging to be in court here
20 today?

21 A Seven-and-a-half thousand dollars.

22 Q Seven-and-a-half thousand dollars?

23 A Yes.

24 Q And you charged him more than \$10,000.00 for the case
25 that you testified in as a paid expert in Greenville.

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1 Correct?

2 A Are you talking about, in total, for the Greenville
3 case?

4 Q Yes, sir.

5 A Yes.

6 Q So, over ten grand there. Seventy-five for being here
7 and as you said, you've seen fifteen patients sent to
8 you by Mr. Graham. Correct?

9 A Yes.

10 Q Now, you refer patients to Dr. Grossman?

11 A Yes.

12 Q And Dr. Grossman refers patients to you?

13 A No.

14 Q Okay. So, you do the referring to Dr. Grossman.

15 A Well, Dr. Grossman is a surgeon, so I evaluate patients
16 and if I believe that they may be candidates for
17 surgery, I will send them to him.

18 Q Okay. So, you might send him some patients and then how
19 about Mr. Forman? You've worked with Mr. Forman. He's a
20 life care planner who creates plans for litigation
21 purposes. You've worked with Mr. Forman ---

22 A I have, rarely, in the past.

23 Q You were working with him in this case. Right?

24 A I don't remember working with him. I mean, I don't
25 remember reviewing anything of his in this case.

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1 Q Okay. So, you don't know about Dr. Forman being involved
2 in this case. Do you know if he was involved in the
3 Greenville case, too?

4 A I don't remember. If you tell me, yes. If that's true.

5 Q Now, you do not deliver babies. Correct?

6 A Correct.

7 Q And you can't say how much traction is used to deliver
8 any baby. Correct?

9 A Correct.

10 Q And you have no criticisms in this case regarding Dr.
11 Goldstein's care and treatment. Fair?

12 A Correct.

13 Q And, specifically, you are not here to testify that Dr.
14 Goldstein breached the standard of care in any way.

15 A Correct.

16 Q Now, I just want to make sure that we are clear. Mr.
17 Graham asked you a question about what's marked as
18 Court's Exhibit #2. Do you remember those pictures?

19 A Yes.

20 Q Okay. That picture of that neuroma, that's not the child
21 in this case. Correct?

22 A Correct.

23 Q That's just -- those are pictures out of a textbook of
24 some sort.

25 A Yes.

1 Q Okay. Now, your report that has been marked as a Court
2 Exhibit, now this report, you saw the child in this
3 case, you saw Bryson at Mr. Graham's request.

4 A Correct.

5 Q And that was back in 2011.

6 A Correct.

7 Q And then you documented your findings, which you call in
8 ~~your report an independent medical evaluation. Is that~~
9 what you call it?

10 A Yes.

11 Q Now, the Court did not ask you to do an evaluation.
12 Right?

13 A Correct.

14 Q And I didn't ask you to do an evaluation. Is that right?

15 A Correct.

16 Q So, the only person that asked you for an independent
17 medical evaluation was Mr. Graham?

18 A Correct.

19 Q And he has paid you for that evaluation. Right?

20 A Correct.

21 Q And it's actually his office that made the arrangements
22 with you so that Bryson could come down to Miami and be
23 seen by you. Correct?

24 A Correct.

25 Q Now, you did not communicate with any of the treating
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1 doctors, the doctors here in South Carolina that are
2 taking care of Bryson.

3 A Correct.

4 Q And you did not schedule a follow-up visit with Bryson
5 after this 2011 examination?

6 A Correct.

7 Q There's no treatment plan.

8 A Correct.

9 Q There's no prescriptions for therapy.

10 A Correct.

11 Q No medications were prescribed.

12 A Correct.

13 Q So, this independent medical evaluation was produced for
14 litigation purposes. Correct?

15 A Correct.

16 Q Now, during your one, your examination on this date in
17 2011, I believe you spent about an hour with the child?

18 A Correct.

19 Q And you'd agree that in your report, it's important to
20 document the details of your findings. Fair?

21 A Correct.

22 Q And you understand that you are asking the jury to rely
23 on your independent medical evaluation.

24 A Correct.

25 Q And in your report, you documented that there is gradual

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1 improvement up until Bryson was three years of age.

2 Correct?

3 A That was an error. Correct.

4 Q Okay. That's not right. We talked about he was not three
5 years old when you saw him. He was actually 21 months.

6 Correct?

7 A Correct.

8 Q Now, in your report under the developmental history, you
9 stated that his motor development milestones were age
10 appropriate.

11 A Correct.

12 Q And you found that he was medically healthy.

13 A Correct.

14 Q And you also found that Bryson did not have any
15 constitutional problems or problems with his vision.

16 A Correct.

17 Q He was alert and he was interactive?

18 A Yes.

19 Q And his social interaction and comprehension were age
20 appropriate.

21 A Correct.

22 Q And his motor examination was normal other than how it
23 pertains to his right arm.

24 A Correct.

25 Q And, of course, Bryson was in no pain.

1 A Correct.

2 Q Now, you offered the opinion that, when Mr. Graham was
3 asking you questions, that Dr. Grossman's surgery was
4 late in this case because the surgery was done when the
5 child was two years old. Correct?

6 A Correct.

7 Q Now, you are aware that Dr. Goldstein is an
8 obstetrician, he delivers babies for a living.

9 A Correct.

10 Q And so, of course, he doesn't treat babies after he
11 delivers them. Fair?

12 A I understand that.

13 Q And so your criticism that this surgery was too late is
14 not a criticism directed at Dr. Goldstein?

15 A It's not a criticism directed at anybody. The only
16 question, as I understood it from Mr. Graham, was that
17 the usual time to do that kind of surgery and the answer
18 is no, that surgery needs to be done at a much younger
19 age. I was not criticizing anybody.

20 Q I just want to make sure that we are clear, because Dr.
21 Grossman also said that two years was late.

22 A Yes.

23 Q Did you read his testimony in that regard?

24 A No.

25 Q Okay. Well, you are not criticizing Dr. Goldstein

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1 because Bryson had surgery at two years of age instead
2 of the recommend time frame, which is think you said,
3 six months to a year.

4 A Correct.

5 Q All right. Let's go through what you have marked as
6 Exhibit #10 and let's go through this. (Projects on
7 large screen) This is, at the top you will see,
8 Carolinas Hospital Systems and this is a medical record
9 of Dr. Goldstein's. This is a report that Dr. Goldstein
10 wrote regarding the delivery at issue in this case,
11 which was, of course, August 20th, 2009. Correct?

12 A Correct.

13 Q Now, I just want to go through what was going on in that
14 delivery. If you look at the highlighted section, it
15 says, "We had two pulls on the vacuum extractor."

16 A I'm sorry. Can we just get to the beginning of that,
17 because I don't have the lower figure.

18 Q Oh, I'm sorry.

19 A No, that's okay. As long as I'm -- I can't read that.

20 Q Take your time.

21 A Yeah, I've got it. Okay. I have it now. Vacuum extractor
22 was applied. We had two pulls on the vacuum extractor.

23 Q Right. Okay, so now, delivered the head at about 13:45.
24 That's the time. Correct?

25 A Yes.

1 Q And recognized that she had shoulder dystocia with the
2 right shoulder under the synthesis. Correct?

3 A Correct.

4 Q She also had a nuchal cord which was reduced over the
5 head. See that? She also had a nuchal cord ---

6 A Yes, I've got it.

7 Q --- that was reduced over the head.

8 A Yes.

9 Q Now, a nuchal cord, that's the umbilical cord. Right?

10 A Yes.

11 Q So, the umbilical cord, when it wraps around a baby's
12 neck, can strangulate a baby. Correct?

13 A It can.

14 Q So, what Dr. Goldstein is documenting on his chart is
15 that he noted that the nuchal cord was wrapped around the
16 baby's neck and so he took it and took it so it wouldn't
17 strangle the baby.

18 A Correct.

19 Q That was a reasonable and appropriate thing to do, of
20 course, wasn't it?

21 A It was. But you are asking a non-obstetric expert.

22 Q All right. Well, then, let's now move to the next page.
23 This is a document that your lawyer put into evidence.
24 Just want to make sure we can go through it all in
25 detail. We tried the McRoberts maneuver. Do you see

1 that?

2 A Yes.

3 Q Prior to that, a generous right mediolateral episiotomy
4 was cut.

5 A Yes.

6 Q Suprapubic pressure was applied.

7 A Yes.

8 Q The episiotomy was extended on two occasions. Correct?

9 A Yes.

10 Q Dr. Steve Coker was called to assist and Dr. Coker
11 applied suprapubic pressure and with that pressure, he
12 effected the delivery of the shoulders at 13:49. Is that
13 correct?

14 A Correct.

15 Q And from the time that the shoulder dystocia was noted,
16 it says 13:45 and the time the baby was delivered, four
17 minutes later, was at 13:49. Did I read that correctly?

18 A You did. At least from my math.

19 Q Thank you. Now, you are aware as a physician and
20 somebody who has reviewed the records in this case, that
21 when a shoulder becomes stuck under the mother's pubic
22 bone and the baby is unable to be delivered, that, sir,
23 is a medical emergency. Is it not?

24 A Yes.

25 MR. GRAHAM: Your Honor, I'm going to object at this

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1 point to questions about obstetrics to a pediatric
2 neurologist.

3 THE COURT: I'm going to allow her to ask, give her some
4 leeway. If he knows, he can testify.

5 MR. GRAHAM: Yes, sir.

6 THE COURT: He's a doctor.

7 MS. CRAIG: Thank you.

8 Q I have four questions left, okay? If the shoulder is not
9 dislodged, the baby can suffer brain damage.

10 A Correct.

11 Q Or the baby could die.

12 A Correct.

13 Q And in this case, sir, once the shoulder became stuck
14 and there was shoulder dystocia, Dr. Goldstein delivered
15 the baby in four minutes. Correct?

16 A Correct.

17 Q Thank you.

18 MS. CRAIG: Those are all the questions I have.

19 THE COURT: Redirect?

20 MR. GRAHAM: Redirect.

21 REDIRECT EXAMINATION

22 BY MR. GRAHAM:

23 Q Doctor, just very quickly, let me just run through a few
24 things. Ms. Craig asked you a few questions about
25 getting paid by me on the cases where we ask you to

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1 evaluate our child clients. What difference does it make
2 to you in terms of your opinions that you get paid for
3 the work that you do?

4 A It doesn't.

5 Q She's indicated that I have sent 15 or so child clients
6 to Miami Children's Hospital to be evaluated by you, but
7 let me ask you this, sir. In terms of the medical legal
8 ~~work that you've done as a testifying expert in the last~~

9 20 years or so, how do the percentages break down for
10 your work between representing injured children and
11 testifying on behalf of medical doctors?

12 A I testify on behalf of medical doctors about 60% of the
13 time and on behalf of patients about 40% of the time.

14 Q Thank you, sir. You were asked some questions about
15 obstetrical management of a delivery and I don't want to
16 step too far in that area because I know that you are
17 not an obstetrician, but if you had a child that was in
18 the process of being born whose shoulder got stuck,
19 would you want your doctor, your wife's obstetrician to
20 have the knowledge and skill ---

21 MS. CRAIG: Your Honor, objection---

22 Q --- to deliver that baby safely ---

23 THE COURT: Sustained.

24 Q --- without putting the ---

25 THE COURT: Sustained.

1 Q Doctor, Ms. Craig asked you questions about not getting
2 the baby out within six or seven minutes might put the
3 baby's brain and life at risk. My question to you, sir,
4 do you believe that obstetricians who are well-trained
5 and well-experienced should have the skill to get the
6 baby delivered without brain damage, without death, and
7 without brachial plexus nerves within the first few
8 minutes?

9 MS. CRAIG: Objection. Leading.

10 THE COURT: Sustained.

11 Q Do you have an opinion or a conclusion in that regard,
12 sir?

13 MS. CRAIG: Objection.

14 THE COURT: Sustained.

15 Q Do you have an opinion or conclusion, sir, whether or
16 not obstetricians should be held to at least the
17 standard of care required of other obstetricians in
18 their field?

19 A Yes.

20 Q Thank you, sir.

21 MR. GRAHAM: No further questions.

22 MS. CRAIG: Your Honor, one question?

23 THE COURT: The way it works, direct, cross and redirect.
24 You have an obligation to object any new material and so that
25 goes for all witnesses.

1 you are pleased with his motivation?

2 A I am pleased.

3 Q And are you pleased with his improvement?

4 A I am pleased.

5 Q He doesn't have any pain when he sees you on a regular
6 basis?

7 A I don't see that he ever has pain.

8 Q ~~Thank you very much.~~

9 THE COURT: Any redirect?

10 MS. RODRIGUEZ: No, sir.

11 THE COURT: You may step down. Thank you, ma'am. You may
12 call your next witness.

13 MS. RODRIGUEZ: Plaintiff calls Genesie Fulton.

14 THE COURT: All right. Why don't we stand and stretch a
15 little bit.

16 MS. CRAIG: Your Honor, may we approach while she's
17 walking up?

18 THE COURT: Certainly.

19 (Bench Conference off the record)

20 THE COURT: Yes, ma'am. Place your left hand on the Bible
21 and raise your right hand as the Clerk administers the oath.

22 (After being duly sworn by the Clerk of Court, GENESIE
23 FULTON PRINCE testified as follows:)

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

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1 THE COURT: Have a seat in the witness chair. Pull up
2 real close to that microphone and speak loudly, clearly and
3 slowly in order that we can hear everything that you've got
4 to say. Yes, ma'am.

5 MS. PRINCE: My name is Genesie Prince.

6 THE COURT: Thank you, Ms. Prince. Ms. Rodriguez, you are
7 recognized.

8 MS. RODRIGUEZ: Thank you, Your Honor.

9 DIRECT EXAMINATION

10 BY MS. RODRIGUEZ:

11 Q Genesie, I am going to try and get the jury to get a
12 little picture of who you are. They've heard a lot about
13 your family and a lot about Bryson up to this point and
14 I'm going to try and not make this repetitive, but I do
15 need to get you to give a little background information
16 so the jury knows who you are. Can you tell the jury
17 where you were born and raised?

18 A Clarendon County.

19 Q And who are your parents?

20 A Willie Mae Prince and James Prince.

21 Q Do you have any siblings in South Carolina?

22 A I do. I have three sisters and two brothers.

23 Q Tell the jury where you went to school, just to give
24 them a very quick little bit about your education.

25 A East Clarendon High School.

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1 Q Okay. And after you graduated from high school, what did
2 you do?

3 A I started working with a sewing factory called Kingstree
4 Knits and from there I went to The Department of
5 Corrections in '97 until present. I still am there.

6 Q And what do you do at the Department of Corrections?

7 A I'm a correctional officer.

8 Q At what facility?

9 A Turbeville.

10 Q And in that context did you meet a gentleman by the name
11 of Anton Hunter?

12 A I did.

13 Q And are you all currently living together?

14 A We are.

15 Q And how -- what has been his involvement in Bryson's
16 life?

17 A He's Bryson's father figure.

18 Q Tell the jury -- I know that back in January of this
19 year you had the privilege of having a luncheon
20 somewhere. Can you tell the jury ---

21 A I did.

22 Q --- about that?

23 A I had the privilege of going to eat lunch with Governor
24 Nikki Haley. I was involved in an arrest at the
25 institution that I work at. We had someone trying to

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1 introduce contraband into our facility and I -- I had
2 the privilege of going to eat lunch with her.

3 Q Tell the jury what's that picture?

4 A That's a picture of me standing in the Governor's
5 Mansion.

6 Q Genesie, in addition to Bryson do you have another
7 child?

8 A I do. I have Brittany Prince.

9 Q And how old is Brittany?

10 A Brittany is 25.

11 Q Now, tell the jury when Brittany was growing up what
12 your situation was.

13 A When Brittany was growing up it was just me and her at
14 one point and I eventually met this -- my ex-husband
15 which is Ernest Fulton and he had a son that was from
16 another relationship. I got him at a very young age and
17 I raised his son as -- like it was mine.

18 Q And where does he live today?

19 A He is currently living with me and Anton.

20 Q Okay. And just in case his name comes up, let's clarify.

21 A His name is Carlos Hickson.

22 Q But what do you call him?

23 A We call him Baldy.

24 Q Baldy. Okay. And so, in addition to Bryson and you and
25 Anton, Baldy is living with you?

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1 A Yes. At this time.

2 Q Do you know about how long you've been divorced?

3 A Since 2013.

4 Q And tell the jury a little bit about prior to your
5 pregnancy with Bryson, let's, we won't go through your
6 -- had you ever had any health problems before?

7 A I've got what's called diverticulitis. I was a diabetic.

8 ~~I had at one point a problem with,~~ something with my
9 kidneys. The creatinine in my kidneys was high. I think
10 I was also advised once with that but no major health
11 issues.

12 Q Now, at the time that you found out that you were
13 pregnant, right before that, who was your primary
14 doctor?

15 A Dr. Morris Brown.

16 Q And where is Dr. Brown located?

17 A In Lake City, South Carolina.

18 Q And did you -- had you at some point in time started
19 having problems with your ---

20 A I did.

21 Q --- menstruation?

22 A I did start having problems with missed menstrual cycles
23 for, like, maybe five months at the time or if I did, it
24 was very heavy, so he recommended that I go to a
25 gynecologist more in the area for females and he did

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1 recommend that I go to Dr. Goldstein at that time.

2 Q And was that on, oddly, August 20th of 2008, exactly ---

3 A Yes, ma'am. 2008.

4 Q --- a year ---

5 A Uh-huh.

6 Q Okay. Genesie, I'm going to ask you to try to let me
7 finish my question.

8 A Okay.

9 Q The court reporter next to you is taking everything down
10 and it's real hard for her if we talk over each other.

11 A Okay.

12 Q I know you're nervous ---

13 A Uh-huh.

14 Q --- but let's try and not talk over each other. Okay.

15 So, you were seeing Dr. Brown and then he referred you
16 to ---

17 A Dr. Goldstein.

18 Q Now, at the time that you went to see Dr. Goldstein, had
19 Dr. Brown put you on some medication for your diabetes?

20 A He did.

21 Q What were you taking?

22 A Glucotrol, like, five milligrams once a day.

23 Q Now, when you started seeing Dr. Goldstein, did he, at
24 some point, change your medications?

25 A He did when I went to see him and I don't know whether

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1 it was the first visit, second visit, but he did change
2 me over to a diabetic medicine called Metformin.

3 Q And after he had switched you over to the metformin, a
4 couple of months went by and what happened?

5 A I initially thought I had something with an achy body
6 associated with me. I thought it was the flu. I
7 eventually went to Dr. Brown thinking I had the flu, but
8 when they did the pregnancy test because of me having
9 nausea I found out I was pregnant.

10 Q And that was in January of 2009?

11 A Nine.

12 Q And at that point in time did you inform Dr. Brown about
13 your medication change?

14 A Well, he asked me who changed me to metformin and I told
15 him Dr. Goldstein did.

16 Q Now, prior to you getting changed to the metformin --
17 these are personal questions, but unfortunately, it's
18 the nature of what we do, were you using any method of
19 birth control?

20 A No, I wasn't.

21 Q And when you met with Dr. Brown, what did you learn
22 about metformin?

23 A That it was a medicine that can make women fertile, if
24 they're not ovulating, to get pregnant. This medicine
25 can make them fertile to get them pregnant.

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1 Q Now, when you saw Dr. Goldstein during those months when
2 you were -- he was working you up for the problems that
3 you were having with menstruation. Did he ever tell you
4 when he put you on the metformin that it could have side
5 effects such as to affect your fertility?

6 A He did not.

7 Q Now, in January then, of 2009, you ended up getting a
8 pregnancy test?

9 A Yes.

10 Q And what happened? Was it positive?

11 A It was positive.

12 Q Okay. And then, I think you went and saw Dr. Brown for
13 the pregnancy test?

14 A Yes, ma'am.

15 MS. GANES: Just object to the leading.

16 THE COURT: Sustained.

17 Q Where did Dr. Brown refer you for obstetrical care?

18 A He didn't refer me. He just said I needed to go to my
19 gynecologist.

20 Q Okay. And who did you go back to?

21 A Dr. Goldstein.

22 Q Now, when you went back to see Dr. Goldstein, did he
23 have any discussion with you about the fact that
24 metformin could cause, could impact fertility?

25 A No, he didn't.

1 Q And after you started -- or when you went back to Dr.
2 Goldstein after the positive pregnancy test, did he do
3 an ultrasound on you?

4 A He did.

5 Q Did he give you a copy of the printout from it?

6 A Yes.

7 Q Do you recognize that?

8 A Yes.

9 Q Who is that?

10 A That's Bryson.

11 Q Okay. And was that a picture you actually have kept?

12 A Yes, ma'am.

13 Q Okay. Now, I do want you to explain at this point
14 though, explain to the jury why a lot of the baby
15 pictures of Bryson no longer exist. Can you tell them
16 why?

17 A After separating from my husband and moving in with a
18 friend, which was Tameka at the time, she had a house
19 fire and a lot of me and Bryson's pictures, my
20 daughter's pictures, a lot of stuff got destroyed in her
21 house fire.

22 Q Now, during the period of time that Dr. Goldstein was
23 following you with the pregnancy with Bryson, did he
24 make a referral to a specialist at McLeod?

25 A Yes.

1 Q And why was that?

2 A It was for the -- because I was up in age, older, and
3 maybe some, some babies born to older mothers have some,
4 maybe, and I can't think of the -- Down Syndrome. Kids
5 can be born with Down Syndrome, so he think that I
6 should have that test done just to see if I may be set
7 to have a baby with Down Syndrome.

8 Q Did you go to that appointment?

9 A I did.

10 Q Now, you, your -- Bryson's father, did he have another
11 child?

12 A He did.

13 Q And did that child have any type of health condition?

14 A Yes, at that appointment I informed the -- I can't
15 remember her name, but that my previous husband had a
16 daughter that was born and had open heart surgery two
17 days after she was born, so she, she suggested that I go
18 see someone to have a echocardiogram done on the baby
19 while he was still in me to check his heart to see if
20 there was any need of a heart doctor at delivery or
21 anything, so if they did they would have it already on
22 site.

23 Q Did you keep that appointment?

24 A I did.

25 Q And was there anything wrong with Bryson --

1 A Nothing.

2 Q --- or were you told ---

3 A No.

4 Q Now, during the time that you went to see Dr. Goldstein
5 and he told you, confirmed that you were pregnant, did
6 they give you or did he give you any information about
7 pregnancy? You know, did they give you a packet or make
8 ~~you watch a video or something about pregnancy?~~

9 A No, ma'am.

10 Q At any point in time, did he talk to you about any
11 potential problems that could occur in your pregnancy
12 because of the fact that you were a diabetic?

13 A No, ma'am.

14 Q Did he ever tell you that you could have a big baby?

15 A No, ma'am.

16 Q During the, during the time that you were seeing him,
17 were you checking your blood sugars?

18 A I was.

19 Q Okay. I'm going to hand you a document here and ask you
20 if you recognize these. Is that your handwriting?

21 A Yes, ma'am, they are.

22 Q And what are those?

23 A Those are blood sugar records that I took fasting before
24 breakfast, two hours after breakfast, two hours after
25 lunch and two hours after dinner.

1 MS. RODRIGUEZ: I'd like to mark these.

2 THE COURT: Any objection?

3 MS. GANES: No objection, Your Honor.

4 THE COURT: Into evidence as Plaintiff's Exhibit #18.

5 (Whereupon, a blood sugar chart is entered into evidence
6 as Plaintiff's Exhibit #18, without objection.)

7 Q Genesie, I'm going to just put this up because I want
8 the jury to actually see what it is you were doing. So,
9 if you look at this, there's a date over here. Do you
10 see it? Right? And then next to that is -- what were
11 you, what were you writing down?

12 A That's the time that I checked -- did the check.

13 Q And I think you can read it from there. It says fasting
14 blood sugar on the next column.

15 A Yes, ma'am.

16 Q Tell the jury what is that.

17 A That's the -- my blood where I stick myself in the
18 morning and check my blood to see, the blood to see how
19 high is my blood sugar level before breakfast.

20 Q Okay. And then the next column says two hours after
21 breakfast.

22 A Uh-huh.

23 Q So, what were you doing then?

24 A I would check it two hours after breakfast.

25 Q Now, I, I see on there that there's some blanks.

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1 Throughout the pregnancy, were you always checking on
2 every day?

3 A No.

4 Q Okay. Now, was that your choice or were there different
5 times recommended to you?

6 A It was different times that he told me I could just pick
7 and, and I can't be sure that he said check it every
8 other day or check it every day. It was -- whatever he
9 told me to do, I did it.

10 Q Okay. And then in the next column, I think this one
11 says two hours after lunch?

12 A Right.

13 Q So, you would stick yourself and check your blood sugar
14 again?

15 A Yes, ma'am.

16 Q What happened when you were at work?

17 A I did it. I also took my meter to work and was allowed,
18 because I worked in a control room while I was pregnant,
19 so I could check my blood sugar level in the control
20 room where I worked.

21 Q Okay. And so then the next column says two hours after
22 dinner.

23 A Yes.

24 Q So, that's sometimes as much as four times a day you
25 were checking your blood sugar?

1 A Sometimes, it was.

2 Q Okay. And I'm just going to flip to the next page. This
3 is another month. I didn't pull them all out, but did
4 you do that throughout your pregnancy?

5 A Yes.

6 Q So, for each month that you were asked to do that, you
7 were keeping track of your blood sugars?

8 A Yes.

9 Q Now, at some point during your pregnancy, a couple of
10 months before Bryson was born, did your medication
11 change again from the, the pills that you were on? Did
12 Dr. Goldstein make a change in your medicine?

13 A Yes. He started me on the insulin.

14 Q And just, I think everybody knows, but just tell the
15 jury what is, what's the difference between the insulin
16 and what you were doing?

17 A That's where I give myself the shot with the needle
18 instead of by mouth.

19 Q Now, did there come a time after you were put on the
20 insulin that Dr. Goldstein was gone?

21 A Yes.

22 Q And you were, I think, about that time, it might have
23 been about June?

24 A Yes, ma'am.

25 Q So, you would have been about six-and-a-half months into

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1 the pregnancy and tell the jury what happened that sent
2 you to McLeod.

3 A I can't remember the date, but it was one night I know I
4 had a lot of pain so I called Dr. Goldstein's office and
5 spoke with the nurse and I asked her, I was, like, what
6 shall I do if I have gas pain? Can I take any medication
7 for gas pain? She said well, are you sure they was gas
8 pains and I said I think they were, because I'm okay
9 this morning. I said I'm dressed for work, but I just
10 wanted to call and ask you what to do because I had a
11 lot of pain last night, so she was, like, no, I think
12 you need to go to McLeod so as she instructed me to, I
13 went to McLeod to get checked to see if I was
14 contracting.

15 Q And when you went to McLeod did you see a different
16 doctor?

17 A I went to labor and delivery and the nurses checked me
18 and said, actually, I was contracting.

19 Q Okay. And did you have to stay in the hospital ---

20 A No, ma'am.

21 Q --- or what did they do?

22 A They gave me a shot and I stayed there and they
23 monitored me for a minute. They sent me home and asked
24 me to return the next day and I did exactly what they
25 said. I returned back to McLeod the next day to labor

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1 and delivery. They hooked me up again. After visiting
2 with them they told me I need to go see Dr. Dent,
3 because Dr. Goldstein was out of town. So, I did exactly
4 what they said. I went to Dr. Dent's office.

5 Q Now, when you went to McLeod, did the nurses or Dr. Dent
6 tell you anything about your activity level?

7 A When I got to his office he checked me and he informed
8 me that the cervix had widened and I need to be on
9 complete bed rest.

10 Q So, that would have been in June around the 15th or the
11 16th ---

12 A Yes.

13 Q --- of 2009?

14 A Yes, ma'am.

15 Q And as a result of that, what did you end up doing?

16 A I went to work and got the paperwork for Family Medical
17 Leave and that's what I did. I put in for it and was
18 approved for it and was put on bed rest.

19 Q Now, after the episode with the contractions and you
20 went home and stayed out, did you stay on bed rest?

21 A I did.

22 Q What, what kind of activities were you being permitted
23 to do?

24 A Nothing. Bed rest, shower, back to bed. No cooking, no
25 shopping. If I needed anything from the store or

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1 whatever, someone else had to do it.

2 Q And did you, did you do that?

3 A I did.

4 Q Then did you go back and see Dr. Goldstein after that,
5 after you had been seen by Dr. Dent?

6 A Yes, ma'am.

7 Q And was he aware that you had seen Dr. Dent?

8 A Yes, ma'am.

9 Q And did he actually complete the Family Medical Leave
10 Act paperwork for you?

11 A He did.

12 Q And then around the day before Bryson was born, what
13 happened?

14 A Well, it was the 18th. I started having pains and went
15 to McLeod and they said that I was contracting and the
16 baby would be here maybe the morning of the 19th. Well,
17 some time around about three, four o'clock, they sent me
18 home because the contractions had stopped. They said to
19 report to the doctor. I was informed to report to Dr.
20 Goldstein's office on the 19th, so that I did. I went on
21 the 19th and I arrived at his office and he just, he
22 told me that he will go ahead and induce me, to be
23 prepared to be induced in the morning, be at Carolinas
24 and I was, like, okay.

25 Q Now, when Dr. Goldstein told you that you were going to

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1 be induced, did he tell you that there were any
2 complications that could be associated with inducing you
3 at the gestational age of your pregnancy?

4 A No, ma'am.

5 Q Did he tell you that there -- did he have any discussion
6 with you about any alternatives to being induced the
7 next day?

8 A No, ma'am.

9 Q Did he have any discussion with you about anything that
10 he might do from a standpoint of using a vacuum during
11 the delivery?

12 A No, ma'am.

13 Q Did he talk to you about using forceps during your
14 delivery?

15 A No, ma'am.

16 Q Did he talk to you about the possibility of a Cesarean
17 section?

18 A No, ma'am.

19 Q Did he express anything to you that there was any
20 problem with the fetus or with Bryson at that point?

21 A No, ma'am, he just made, made a note to me that he think
22 his lungs was developed enough that he could go ahead
23 and induce me and he'd be okay, so I questioned because
24 I wanted to know about the weight. Would the baby's size
25 be affected and I was informed by him that, be prepared

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1 that the baby may stay in the hospital for a while to
2 gain weight, but he don't see that the baby would be
3 coming home with me because of the weight.

4 Q Now, did you go to the hospital the next day on August
5 20th?

6 A I did.

7 Q Okay. And who went with you?

8 A My husband, Ernest Fulton.

9 Q Now, when you got to the hospital was Dr. Goldstein
10 waiting for you?

11 A I didn't see him right then.

12 Q So, when you checked into the hospital, was there any
13 paperwork that they gave you to sign?

14 A Oh, yes, ma'am.

15 Q Okay. I'm actually going to look at an exhibit that
16 we've already marked. We're going to be looking at
17 Defendant's Exhibit #1. Genesie, this was admitted by
18 the Defense yesterday in some of the questioning and I
19 want to ask you about this form. I've actually got some,
20 some blow-ups of it to make it a little bit easier to
21 see what's on it. When you signed this form, was Dr.
22 Goldstein there?

23 A No, ma'am.

24 Q Did Dr. Goldstein tell you that you would be signing any
25 type of a consent form when you got to the hospital?

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1 A No, ma'am.

2 Q And did you actually sit down and read through this form
3 when they handed you the paperwork to sign?

4 A No, ma'am.

5 Q Is this the only document you signed that morning?

6 A No, ma'am.

7 Q What did you sign?

8 A You sign stuff like no smoking. You sign a lot of
9 paperwork when you're being admitted into the hospital.
10 Just general papers, like, if you was to go to the
11 emergency room they give you a stack of papers and ask
12 you to sign here, here, and here.

13 Q Okay. I'm going to show you, this is a blow-up of the
14 lower half of that document.

15 A Yes, ma'am.

16 Q And there's some writing on here.

17 A Yes, ma'am.

18 Q Just to orient, I'm in the middle of the document here
19 and I've just blown up this lower half and somebody's
20 handwritten in there the word, under "Exceptions", it
21 says "none". Did you write that in there?

22 A No, ma'am.

23 Q And then it says, "To be performed on myself". Is that
24 your handwriting?

25 A No, ma'am.

1 Q And it says, "by Dr. Goldstein". Is that your
2 handwriting?

3 A No, ma'am.

4 Q And then over on the right, the date 8/20/09, is that
5 your handwriting?

6 A No, ma'am.

7 Q And then under your name where it says relationship to
8 patient, "self", did you fill that out?

9 A No, ma'am.

10 Q There is an "X" there and then your signature appears
11 next to it. Did you make the "X"?

12 A I did not make that "X".

13 Q Okay. What was the "X" there for?

14 A That's where they said sign here.

15 Q Okay. Now, underneath it, it now appears that there's a
16 signature right under self. I believe we'll find out
17 later that that's Dr. Goldstein's signature. Was that
18 signed by Dr. Goldstein at the time you signed it?

19 A No, ma'am.

20 Q And at the time that that was signed, did anybody have
21 any discussion with you about any potential
22 complications or risks that could be associated with
23 inducing you?

24 A No, ma'am.

25 Q Did they have any discussion with you about the use of a
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1 vacuum?

2 A No, ma'am.

3 Q Any discussion with you about the use of forceps?

4 A No, ma'am.

5 Q Any discussion with you about any alternatives to being
6 induced?

7 A No, ma'am.

8 Q Now, you said that Bryson's dad was at the hospital with
9 you. Do you remember, was it, did you get there the
10 middle of the day, early morning?

11 A It was early in the morning before, I know it was before
12 six o'clock.

13 Q Okay. At some point did Dr. Goldstein come in and see
14 you?

15 A He did.

16 Q And at that point in time, was anybody present other
17 than your husband?

18 A No, ma'am.

19 Q Did Dr. Goldstein at that time go over for you, with
20 you, any complications or potential complications
21 associated with induction?

22 A No, ma'am.

23 Q Did he talk to you at all about whether or not any
24 testing should be actually done to check for the baby's
25 lung maturity?

1 A No, ma'am.

2 Q Did he talk to you about a vacuum or forceps or a
3 C-section?

4 A No, ma'am.

5 Q Okay. So you got admitted into the labor and delivery
6 suites?

7 A Yes.

8 Q ~~Did any other family members or friends come to stay~~
9 with you before you had the baby?

10 A They came later.

11 Q Okay. And we've already heard the testimony from
12 Brittany and Tamika. They were both present.

13 A Right.

14 Q Correct? And then also your aunt, I mean, your sister,
15 Geneva was present?

16 A Right.

17 Q Okay. Now, evidently at some point Bryson's dad decided
18 he did not want to watch the delivery?

19 A Yes, ma'am.

20 Q So, you chose to have Tamika and your daughter stay in
21 the delivery room with you.

22 A Yes, ma'am.

23 MS. GANES: Your Honor, object to the leading.

24 THE COURT: Sustained.

25 Q Who stayed in the delivery room with you?

1 A My sister and Tamika, which is Bryson's godmother.

2 Q Okay. And then when it came time to actually do the
3 delivery, do you remember when Dr. Goldstein came in?

4 A Yes, ma'am.

5 Q Okay. Had they hooked you up to a baby monitor?

6 A They did.

7 Q At any point during the morning, did anybody come in and
8 tell you there were any problems with anything going on
9 with the baby?

10 A No, ma'am.

11 Q When Dr. Goldstein got there did he tell you there were
12 any problems with the baby ---

13 A No, ma'am.

14 Q --- or the baby monitor?

15 A No, ma'am.

16 Q When it got, when Dr. Goldstein got there what did he
17 do?

18 A He talked to the nurse, asking her questions. I don't
19 know what that meant, whatever she answered. I don't
20 know what he was asking her, but he asked her and then
21 he looked at me and said, "Okay, it's time to get ready
22 to push".

23 Q Now, were there, was there primarily one nurse that
24 stayed in there with you?

25 A It was.

1 Q And was it Stephanie Collins?

2 A It was.

3 Q Is that Stephanie Collins' picture?

4 A That is.

5 Q Do you remember any of the other nurses, specifically,
6 that were in the room?

7 A No, not name-wise.

8 Q Okay. Was there more than one nurse?

9 A Yes, ma'am.

10 Q Okay. Tell me ---

11 MS. GANES: Your Honor, I just object to the leading with
12 the text on the pictures, if she's going to show pictures.

13 THE COURT: With regard to that picture of Stephanie,
14 I'll overrule the objection. Let's not lead her with
15 pictures. Ask her the questions and let them answer.

16 MS. RODRIGUEZ: Okay.

17 THE COURT: Let her answer and then if you want to show
18 her a picture you can do that.

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

20 Q Dr. Goldstein came in, was talking to the nurses. Did
21 you ever hear him have any discussion with them about
22 any concerns about the fetal monitor or what was going
23 on with the baby, the heart rate?

24 A No, ma'am.

25 Q Okay. Tell me what you remember from that point.

1 A They -- I was up on the bed getting ready to push when
2 he tell me push. Well, when they told me to push, I
3 pushed.

4 Q Okay. Were your legs, did your legs get put in the
5 stirrups?

6 A They were.

7 Q Do you ever remember any nurse before -- and I want to
8 be clear. Before Dr. Coker came in the room, do you ever
9 remember any nurse ever pushing your legs back up?

10 A No, ma'am.

11 Q Did any nurse ever push on your stomach?

12 A No, ma'am..

13 Q Okay. Then tell them what happened when you started
14 pushing.

15 A I pushed and Bryson's head came out. Brittany went and
16 looked. She came back and they told me to push again
17 very hard on the next one and I did that and all of a
18 sudden I heard Stephanie's voice got elevated, push,
19 push, push, push, just keep pushing, and then Tamika, I
20 could hear her encouraging me also to push, push, push
21 and at some point everything just got, they started
22 getting hysterical with it, so I was looking at facial
23 expressions, trying to figure out what's going on
24 because I'm pushing and the baby's head is out. Okay.
25 It should be easy now, but everybody still seemed like

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1 they getting hysterical and I hear Dr. Goldstein, like,
2 he was in a hysterical state at that time saying, "Get
3 someone in here, get someone in here. It doesn't matter.
4 Get a doctor, anybody. Get someone in here," and I could
5 hear that from him.

6 Q Now, could you see Dr. Goldstein, where his hands were
7 and ---

8 A No.

9 Q --- what he was doing?

10 A No.

11 Q Okay. And were you trying to look down and see what was
12 going on down there?

13 A Actually, I was just, like, in, like, what's going on
14 and I, like, was trying to get facial expressions. I
15 kept looking at my daughter and I could see her tears
16 like she was crying and I was, like, well, what's
17 happening, why is she crying? What's wrong? And so I
18 was, like, trying to get facial expressions but no one
19 would say anything. They was just saying to get help.

20 Q Do you ever remember them using, stating that the
21 shoulders were stuck?

22 A No, ma'am.

23 Q Did you ever hear anybody use the term, "shoulder
24 dystocia"?

25 A No, ma'am.

1 Q Did anybody ever tell you to stop pushing?

2 A No, ma'am.

3 Q Okay. And tell me after Dr. Goldstein called for help,
4 what happened? Did somebody else come in?

5 A A lot of people. The room was -- I can't even tell you
6 the number of people that came in the room, but I still
7 didn't know what was going on, but they said that the
8 doctor came in and helped ---

9 Q Did you know who that doctor was?

10 A I did not.

11 Q Okay. Do you remember, was he African American or
12 Caucasian?

13 A No, ma'am. Can't tell you nothing about him.

14 Q Okay. So, tell the jury what happened.

15 A And the baby was out and then I was looking to the side
16 over at the baby and his body was limp and I kept seeing
17 the nurses pick the baby up and his body just flopped
18 back down. They kept picking him up. His body flopped
19 back down and so I was crying and the anesthesiologist
20 came to me because I heard the nurse say, "Okay, guys,
21 that's it. Let's just say the time. Let's call the
22 time," and I started crying and then he came and he,
23 like, grabbed my hand. He said, "Look, we're not going
24 to stop working on him," and I was, like, well, you
25 know, only God can help us now and he was, like, they

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1 kept doing, I kept seeing them doing with the pump thing
2 across his face and I was just crying and looking over
3 to see if I was going to hear him cry or anything and
4 then all of a sudden I heard one of the nurses say we
5 got a pulse and the anesthesiologist said to me, "We've
6 got to get him out of here. We've got to get him to
7 neonatal. It's going to be all right," and they took the
8 baby out of the room.

9 Q Okay. And did -- after Bryson was removed from the room,
10 did Dr. Goldstein have any conversation with you about
11 what had happened?

12 A He didn't.

13 Q Did Dr. Coker have any conversation with you about what
14 happened?

15 A No, ma'am.

16 Q Do you actually remember Dr. Coker leaving the room?

17 A No, ma'am.

18 Q Do you actually remember him coming into the room?

19 A I don't.

20 Q Okay. Did any of the nurses tell you what had happened?

21 A No, Dr. Goldstein, I think, came back after and said
22 about the baby's arm.

23 Q And what were you told about the baby? Had you seen the
24 baby yet?

25 A I had not.

1 Q Okay. But what were you told?

2 A I was told that it was his right arm that was injured
3 but he, I don't think he exactly told me what was wrong
4 with it at that time.

5 Q Okay. At some point, did you get, hear the term
6 "shoulder dystocia" or there was a problem with the
7 shoulders?

8 A Yes.

9 Q And who told you that?

10 A One of the pediatric doctors came in and spoke with me
11 about what happened.

12 Q Okay. When you finally did get to see Bryson, what did
13 you notice?

14 A His arm was just, the right arm was just, like, laying,
15 but they had him, you know, I looked at his arm. It
16 looked a little bit longer than the other arm and it was
17 just, it was no movement in that arm, in his right arm.

18 Q Okay. Now, before you left the hospital with Bryson, did
19 the, do you know if the physical therapist or the
20 occupational therapist did their first evaluation on
21 Bryson?

22 A They did.

23 Q And did they have any conversation with you about
24 Bryson's arm and shoulder?

25 A Yes, he called it brachial plexus.

1 Q Okay. Hold on there. I want to show you another
2 document. This is the hospital record from Carolinas for
3 Bryson and I'm going to show you some -- starting at
4 page 96 here and I'm going to put it up over here so the
5 jury can see what we're looking at. Were you given a
6 pamphlet or some papers, these papers, at the hospital
7 when you went to check out?

8 A Yes, ma'am.

9 Q Okay. And do you remember what they told you that was?

10 A Yes, ma'am.

11 Q Explain to the jury what you were told.

12 A He said this is, was a injury that some time is, happens
13 at birth and it was an injury to the nerves. He said
14 sometimes it's, it's like a stretch and sometime it's
15 more severe, more than a stretch.

16 Q Okay. And if you'll go to the next page, page 97. Did
17 they go over or explain to you where the brachial plexus
18 nerves were?

19 A He did.

20 Q Okay. And is this where he was demonstrating when they
21 were showing you this is what the brachial plexus looked
22 like?

23 A Yes, ma'am.

24 Q And then I think on the next page there's some, sort of,
25 instructions. Tell the jury -- let's start out with

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1 while he was in the hospital, how you had to handle
2 Bryson with that arm.

3 A The nurses kept it -- when he came to the room with me,
4 we had to fold it up across him like this and swaddle
5 him with the blanket to hold it close to his body so it
6 would just linger to the side or just linger and pull.

7 Q And then when you -- go to the bottom. I think they gave
8 you some specific directions about not to flex or abduct
9 shoulder more than 90 degrees until physician tells you
10 it is okay to do so.

11 A Yes, ma'am.

12 Q Did you do that?

13 A I did.

14 Q When other people -- when you got Bryson home from the
15 hospital and you had to have other people taking care of
16 him, or helping you with him, did you have to show them
17 how to do these things?

18 A I did.

19 Q Okay. And I'm not going to go through the whole document
20 here, but it's several pages long and did it give you
21 directions on, like, directions on how to pick him up?

22 A Yes, ma'am.

23 Q Was there a special way that you needed to dress him?

24 A Yes, ma'am.

25 Q And were there some specific exercises that they gave

1 you that the pamphlet included on what you were supposed
2 to do ---

3 A Yes, ma'am.

4 Q --- with his arm and shoulder?

5 A Yes, ma'am.

6 Q Did you do all those?

7 A We did.

8 MS. RODRIGUEZ: I'm just going to go ahead and admit
9 just the -- the -- I'd like to just mark and admit just the
10 pages we referred to.

11 THE COURT: Have y'all seen the documents? Do you have
12 an objection?

13 MS. GANES: No objection, Your Honor.

14 THE COURT: They're into evidence as Plaintiff's Exhibit
15 #19.

16 (Whereupon, a hospital document is entered into
17 evidence as Plaintiff's Exhibit #19, without objection)

18 Q Genesie, when you were ready to go home from the
19 hospital, who went home first, you or Bryson, or did you
20 get to go home together?

21 A I was released first.

22 Q And did you go home?

23 A No, ma'am.

24 Q What did you do?

25 A They -- the hospital allowed me to stay in one of the

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1 empty rooms that wasn't being occupied by no patients
2 and they let me stay there as long as they didn't need
3 that room.

4 Q Now, after you took Bryson home from the hospital -- I'm
5 sorry. Let me back up. Did you have any other
6 conversations with Dr. Goldstein about what had happened
7 that day?

8 A He performed my tubal ligation and I remember, because I
9 was still -- I had, you know, I was put to sleep that
10 morning to do that, so I was still drowsy but I know he
11 was briefly talking to me about what happened to Bryson,
12 but I know I was very emotional during that time and I
13 was, like, crying when he was talking to me, but I was
14 hurt because I knew something -- my baby was different.
15 I wanted a healthy baby and he was alive. I thank God
16 that he's alive and I said that to Dr. Goldstein. I just
17 thank God he's alive.

18 Q Now, did Dr. Goldstein ever tell you that there had been
19 a problem with Bryson's heart rate or Bryson on the
20 fetal monitor?

21 A No, ma'am.

22 Q After you got out of the hospital, did you take Bryson
23 back to your pediatrician? Did he see the pediatrician?

24 A We went to Dr. Morris Brown but, you know, he's not a
25 pediatrician, he's just a family practitioner doctor.

1 Q Family practitioner?

2 A Yeah.

3 Q But he also sees babies?

4 A Yeah.

5 Q And did you get referred to a specialist to, for Bryson?

6 A Dr. Gilpin, and I'm thinking that that was the
7 appointment that was made through the hospital before we
8 left.

9 Q Okay. And do you have an understanding of what kind of
10 doctor Dr. Gilpin is?

11 A He's a bone doctor.

12 Q Okay. And did you, you kept your appointment with Dr.
13 Gilpin?

14 A I did.

15 Q Did you actually see him several times over the next
16 year?

17 A Yes, ma'am.

18 Q And did Dr. Gilpin ever suggest to you or refer you to a
19 brachial plexus clinic?

20 A He did not.

21 Q Did Dr. Gilpin ever tell you whether or not -- what did
22 he tell you or what was your understanding of whether or
23 not this was going to resolve?

24 A He -- his opinion and what he said to me was that it was
25 just a stretched nerve and then eventually he would be

1 able to move his arm, move his fingers and everything
2 else. It wasn't a severe injury. Brachial -- he said it
3 wasn't a severe brachial plexus injury.

4 Q Now, at some point did Dr. Gilpin refer you to Dr.
5 Walsh?

6 A Yes, after asking him to speak to someone else because I
7 wasn't seeing the improvement that he said that I should
8 be seeing, so I asked him can he please send me
9 somewhere else to let someone else get a, to get a
10 second opinion.

11 Q Okay. Now, when you asked or inquired about getting a
12 second opinion, by that time do you remember Bryson
13 would have been about nine months old?

14 A Maybe.

15 Q Okay. And you got to see a doctor in -- where was he at?

16 A Dr. Walsh at MUSC in Columbia.

17 Q At USC in Columbia?

18 A Yeah, USC in Columbia.

19 Q Did you find out what kind of doctor Dr. Walsh is?

20 A He's also a bone doctor.

21 Q And did Dr. Walsh ever refer you to a brachial plexus
22 clinic?

23 A He did not.

24 Q Now, during that period of time were you also taking
25 Bryson to see Ms. Joyce?

1 A Yes. Well, my sister was, like she said, was taking him
2 to see her.

3 Q Why was your sister taking him?

4 A Because I was back to work and I work 12-hour shifts so
5 some of the days that, that I was -- no, at that time I
6 was on eight hours, so I worked every day during the
7 week so I wasn't off any time, only on Saturdays and
8 Sundays, so my sister would take him then.

9 Q Now, when Dr. -- excuse me. When the physical therapy
10 appointments were -- were they occurring during daytime
11 hours?

12 A It was during the week, and it's occupational, and it
13 was Monday through Fridays.

14 Q Why were you living with your aunt at that time?

15 A I had separated from my husband.

16 Q Okay. And after you saw Dr. Walsh, did you go back to
17 see, did you continue to see Dr. Gilpin?

18 A I did.

19 Q And during that period of time, did Ms. Blackwell ever
20 make a suggestion to you?

21 A Yes, that I may need to see someone with nerves
22 something, a surgeon, a neurologist, or something.

23 Q And did you ask Dr. -- after he had sent you to Dr.
24 Walsh, did you ask Dr. Gilpin for another referral?

25 A I did.

1 Q And where was that to?

2 A He set up an appointment for me to go to the Shriners in
3 Greenville.

4 Q Okay. Did you take Bryson to that appointment?

5 A I did.

6 Q And at that point in time, Bryson was about a year old?

7 A Yes, ma'am.

8 Q And did you find out what kind of doctor it was at the
9 Shriners Hospital?

10 A It was a bone doctor.

11 Q Did that doctor refer you to a brachial plexus clinic?

12 A No, ma'am.

13 Q Now, was Bryson also being seen by Baby Net or First
14 Steps?

15 A Yes, ma'am.

16 Q And what services did they provide to Bryson?

17 A Also occupational, like, worked with him on day to day
18 movement, living.

19 Q Who was that? Who was the lady who did that?

20 A Ms. Patricia.

21 Q Okay. And did Bryson, did Bryson see -- let me show you
22 this picture and ask you if you can tell me what that
23 is.

24 MS. GANES: Your Honor, if I could just see the picture?

25

1 Thank you.

2 Q Who is that?

3 A That's, that's a picture of Bryson and Ms. Patricia
4 sitting on our living room floor.

5 Q Okay. And what was she doing with Bryson?

6 A Teaching him and she actually was instructing him to try
7 to pick up the puzzle pieces with his right hand.

8 Q Okay. And that's at your home?

9 A It is.

10 Q Did she see Bryson for some period of time, as well?

11 A Yes, ma'am.

12 Q Now, at some point did you also see a doctor at Levine
13 Children's Hospital in Charlotte?

14 A Yes, ma'am.

15 Q And do you remember who that doctor was?

16 A I don't know the name.

17 Q Okay. How did you end up seeing that doctor?

18 A Through the Graham Law Firm.

19 Q Okay. And did that doctor suggest to you that you see
20 somebody at a brachial plexus clinic?

21 A Yes, ma'am.

22 Q And as -- after that appointment did you get an
23 appointment to see Dr. Grossman?

24 A I did.

25 Q And we know from the prior testimony that on June 7th of

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1 2011, you had your first appointment with Dr. Grossman
2 in Miami?

3 A Yes, ma'am.

4 Q After you met with Dr. Grossman, he evaluated Bryson?

5 A Yes, ma'am.

6 Q Did he make any recommendations to you?

7 A Yes, ma'am, he recommended that he thinks that, that
8 surgery for his age is late. He should have gotten
9 Bryson before he turned, before he turned one, but he
10 said with some, with the surgery, he may get some better
11 and so after going home and I talked about it with Anton
12 and everything and I said well, a little more to help
13 him then I'll do it, and so we decided that yeah, we
14 want him to get the surgery.

15 Q And you went back to Miami Children's Hospital?

16 A Yes.

17 Q Okay. And ---

18 MS. RODRIGUEZ: Judge, may we approach the bench?

19 THE COURT: Yes.

20 (Bench conference off the record)

21 MS. RODRIGUEZ: Thank you, Your Honor. The Court's
22 indulgence. (Brief delay) Thank you, Your Honor.

23 Q Genesie, I'm going to hand you some pictures and ask you
24 if you can tell me what that is. What is that picture?

25 A It's pictures of him pre-opinion, before surgery.

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1 Q And where was he at this time?

2 A At Miami Children's Hospital.

3 Q And then what was this picture?

4 A This a picture of him after surgery.

5 Q Tell the jury what that picture is.

6 A This is a picture of him -- someone donated Pillow Pets
7 to all the kids in the hospital in Miami.

8 Q What's the bars he's behind?

9 A That's the crib that they keep the kids in after
10 surgery. That's their crib.

11 Q Okay. And what is this picture?

12 A This a picture of him standing up in the crib and me or
13 either the nurse pulling him through the hospital at
14 Miami Children's Hospital.

15 Q Now, there appears to be something around -- on the
16 picture to our right there appears to be something
17 around his neck.

18 A Yes.

19 Q What is that?

20 A That's the neck brace that Dr. Grossman put around his
21 neck to keep his neck still to keep him from moving it
22 or breaking the nerves back that they glued together.
23 He didn't want him to pop them loose, so that's the
24 brace on his neck to keep his neck still.

25 Q And I think if you look at his right arm ---

1 A Yes.

2 Q What's that?

3 A And that's a body cast. They called it an airplane cast
4 and it's a whole cast.

5 Q Stand up and show the jury how that -- just, sort of,
6 demonstrate on your own body what that looked like.

7 A It's a cast from, like, his chest all the way around and
8 he had a tube that extended with his arm up like this to
9 his hand.

10 Q Now, could his neck brace come off?

11 A It can.

12 Q And how about the chest cast?

13 A No.

14 Q And when the neck brace would come off ---

15 A Well, it had to stay on there for so many weeks.

16 Q And then tell the jury what that picture is.

17 A This is a picture of him at the hotel before we left.
18 He put the pillow in the dresser drawer at the hotel and
19 laid in it.

20 Q And what's that picture?

21 A This is a picture after we got home and he went in the
22 cabinets under the sink and got a bowl to put on top his
23 head.

24 MS. RODRIGUEZ: Okay. Can we just mark these all as one
25 exhibit?

1 THE COURT: Any objection from Defense?

2 MS. GANES: No objection.

3 THE COURT: They're into evidence without objection from
4 defense.

5 (Whereupon, 8x10 photocopies of Bryson are entered into
6 evidence as Plaintiff's Exhibit #20, without objection)

7 Q Now, in addition to Dr. Grossman, was there anybody else
8 who participated in Bryson's surgery while he was down
9 at Miami Children's Hospital, now Nicklaus Hospital?

10 A Yes, ma'am. Dr. Price.

11 Q And did -- was there a charge for Dr. Grossman's
12 surgery?

13 A Yes.

14 Q And the jury has heard a lot about it. Did you
15 understand that there would be a charge for that
16 surgery?

17 A I did.

18 Q How long did that surgery take?

19 A That surgery was over five hours.

20 Q And did you also have a bill from Dr. Price for that
21 surgery?

22 A I did.

23 Q And a charge from the hospital as well?

24 A I did.

25 Q And a charge for the anesthesia?

1 A I did.

2 Q I think ---

3 MS. GANES: Your Honor, we would object to the summary
4 and the bills going into evidence as cumulative. One or the
5 other.

6 MS. RODRIGUEZ: I'd like to use both, Judge.

7 THE COURT: I'm going to allow, I'm going to allow the --
8 for brevity's sake, use the summary and you can introduce, if
9 there are otherwise no objections with regard to material in
10 the bills, then I'm going to allow both of them to go in.

11 MS. GANES: Your Honor, may we approach?

12 THE COURT: Yes.

13 (Bench conference off the record)

14 MS. RODRIGUEZ: If we could go ahead and mark this then,
15 Your Honor.

16 (Whereupon, medical bills/hospital summary are entered
17 into evidence as Plaintiff's Exhibit #21, over objection)

18 Q Genesie, I'm going to hand you a document that we have,
19 it's called up at the top, Medical Bills for Bryson, and
20 ask you to take a look at that. Now, prior to your
21 testimony today have you had a chance to look through,
22 or have you received the bills from Miami Children's
23 Hospital?

24 A Yes, ma'am.

25 Q From Dr. Grossman's office?

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1 A Yes, ma'am.

2 Q From Dr. Price's office?

3 A Yes, ma'am.

4 Q From anesthesia?

5 A Yes, ma'am.

6 Q From McLeod Regional Medical Center?

7 A Yes, ma'am.

8 Q And from Lake City Occupational Therapy?

9 A Yes, ma'am.

10 Q Okay. If you could, looking at that list of bills there,
11 just tell the jury how much was the charge from Miami
12 Children's Hospital?

13 A It was over \$78,000.

14 Q And how much was the next bill on there?

15 A Over 55,000.

16 Q And that was from Dr. Grossman?

17 A Grossman.

18 Q Okay. And then how much was the bill from McLeod for
19 occupational therapy?

20 A Over 56 ---

21 Q 56,000?

22 A --- thousand dollars.

23 Q Okay. And then there's also a bill, I think, on there
24 from Dr. Price?

25 A Yes, ma'am.

1 Q And that's for how much?

2 A Over \$7,000.

3 Q And how much for the anesthesia?

4 A It's over \$12,000.

5 Q And then how much, was there also a bill on there from
6 Lake City Occupational Therapy?

7 A Yes, ma'am. It was over \$1,000.

8 Q Okay. I apologize, but let me just glance at that. I
9 handed it to you before I made sure I covered them all.
10 There's also a bill on here from, one from Dr. Walsh and
11 one from Dr. Gilpin. If you can tell the jury how much
12 those were?

13 A The one from Dr. Walsh was right at \$200. The one from
14 Dr. Gilpin is right at \$1,000.

15 Q Now, were all of those bills related to Bryson's
16 treatment for his brachial plexus problems?

17 A They were.

18 Q How do you think Bryson has done since his surgery at
19 Miami Children's Hospital?

20 A He has improved.

21 Q Do you think that he did have a benefit from that
22 surgery?

23 A I do.

24 Q If you had to do it over again, would you have that
25 surgery again?

1 A Yes, ma'am.

2 Q Now, at the time that you had that surgery by Dr.
3 Grossman, did you also meet with Dr. Price?

4 A Yes.

5 Q And what was your understanding of their plan?

6 A To go in and -- because they wasn't sure at first what
7 they could do to help improve him but they went in, is
8 ~~what they did, and removed the scar tissues that he had,~~
9 glued the nerves back. Dr. Price went in after that and
10 did some, something with his shoulder. His shoulder
11 blade was, it looked like it was protruding out and it
12 was very noticeable that his shoulder blade was sticking
13 out into his back, so he went in and he did replacement
14 of that and you don't see it as much. You can see it a
15 little but not as much as it was, because you could see
16 the blade of his shoulder just protruding out in his
17 shirts. If he had them on or anything you could see it,
18 but now it's not that noticeable.

19 Q Now, when they talked to you at that first surgery, what
20 was your understanding as to whether or not that would
21 be the only surgery he would need?

22 A It wasn't. Dr. Grossman came and, because he was the
23 first one out of the surgery and Bryson was still in
24 surgery with Dr. Price and he explained to me everything
25 went well and what he removed and what he did and what

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1 was Dr. Price in there doing at that time and he said
2 well, I think we did good. He said but at this time I
3 won't say, but I think he will, he may need more
4 surgeries at a later time. He didn't say what surgeries
5 but he did say at that day that he think that he would
6 need more surgery.

7 Q Now, did you take Bryson back down there for ---

8 A I did.

9 Q --- his follow-ups? Okay.

10 A Yes, ma'am.

11 Q And you actually saw Dr. Grossman again right before he
12 did his deposition for this case?

13 A Yes, ma'am.

14 Q And did he evaluate Bryson at that time, as well?

15 A Yes, ma'am.

16 Q Did he tell you the same thing?

17 A Yes, ma'am, the same thing he did right after surgery,
18 at the visit after surgery and the visit not long ago.

19 Q Now, do you plan to, when Bryson is ready to look at
20 additional surgery?

21 A Yes, ma'am.

22 Q Tell the jury from your perspective as a mom what are
23 your concerns for Bryson?

24 A My concern is, I always wanted a little boy, always. Now
25 that he's here and I thank God for him every day. No one

1 can pay me enough money to take him away from me, but my
2 concerns with Bryson is him growing up and becoming a
3 teenager and that is coming soon. It seems like it was,
4 like, yesterday he was just a baby. He's going to have
5 challenges. I have had to go to counseling to deal with
6 some of the stuff that I have went through with him and
7 other life issues, but more so, I'm constantly thinking
8 about him and it's very stressful. I'm constantly

9 thinking what is he, what's going on with him now.
10 What's going on so when he become a teenager, of course,
11 he's going to be away from me. He's always now with me
12 or either Anton or with one of the teachers at school or
13 with someone that I trust at a daycare, so I know we're
14 looking out for him. Eventually, Bryson is going to be
15 out in the community by himself with other kids his age,
16 a teenager. He's going to be a teenager. What is going
17 to happen to my son when we've got these other boys and
18 they're going to say certain things to him and they're
19 going to tease him? Maybe not, because I don't know.

20 It's just a possibility, like ---

21 MS. GANES: Objection, Your Honor, to the speculation.

22 THE COURT: I'll allow her to ---

23 A He -- we all know, like the Judge said yesterday, we
24 know kids can pick, bully or whatever. We all know that.
25 We're human. But as a mother with a child with this

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1 disability and physical appearance, it's going to be
2 hard. I don't want him to feel as though I'm going to do
3 this and I'm going to lash out. I don't want him lashing
4 out at people because they say something about him,
5 because I encourage him. It doesn't matter what nobody
6 else say about you. If they say you're different, you
7 are different. You are, but don't, I don't want him to
8 be angered by them. When he starts dating or the age
9 will come he's going to start dating, women, we can look
10 at a person's physical appearance because people are
11 human, instead of looking at his heart or his
12 intelligence or anything and they may say, "Well, I
13 don't want to date him. His arm look funny or his, he
14 got a disability." They may not want to date someone
15 with that, not looking at what type of person his
16 character he is. They may not look at that. I'm not
17 sure. He may not have no problems, but he could. I don't
18 know.

19 MS. RODRIGUEZ: The Court's indulgence.

20 Q Please answer any questions that the defense may have.

21 THE COURT: Madam Forelady, ladies and gentlemen of the
22 jury, it's time for a mid afternoon break. I'm going to ask
23 that you go back to the jury room and refresh yourselves. Do
24 not discuss the case with anyone. Everyone remain seated as
25 the jury exits the courtroom.

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1 (Jury out at 3:20 PM)

2 THE COURT: Anything from the Plaintiff before we recess?

3 MS. RODRIGUEZ: Your Honor, I'd just like an opportunity
4 to redact those bills while we're in recess.

5 MS. GANES: Your Honor, there's a lot. There's probably
6 50 pages in here. All of them are stamped insurance benefits
7 assigned and so I need -- that has to come off those pages.

8 THE COURT: All right. Y'all can work on that together.
9 Otherwise, you can go with the compilation. There will be no
10 discussion about insurance.

11 MS. CRAIG: Your Honor, would you like me to put that 105
12 motion on the record now or at the break?

13 THE COURT: You can do it right now if you want.

14 MS. CRAIG: Okay. At the sidebar I'd requested a 105
15 instruction to the jury based on the Plaintiff eliciting
16 testimony from three witnesses; Dr. Grossman, Dr. Resnick and
17 Nurse Blackwell, that the surgery in this case was done at
18 two years and that it was done late and I thought it was
19 confusing to the jury that that criticism, that I call a
20 criticism, was elicited from the witnesses on direct
21 examination when, of course, Dr. Goldstein has no involvement
22 whatsoever in the treatment of the baby after the baby is
23 delivered. I don't know why that was elicited and I think
24 it's confusing to the jury to the extent that they think that
25 somebody is at fault for not getting the child to surgery

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1 between the six-month and 12-month window. We respectfully
2 request an instruction that that evidence does not apply to
3 Dr. Goldstein.

4 THE COURT: I would anticipate -- anticipating
5 argument, there is a duty to mitigate damages and I can't
6 anticipate that anybody would think that it was Dr.
7 Goldberg's (verbatim) fault that they didn't get a surgery.
8 I can't -- but I'll hear what the Plaintiff's got to say
9 about it, but I just don't think that a 105 curative
10 instruction or instruction would be appropriate, but I'll be
11 glad to hear from the Plaintiff.

12 MR. RUFFIN: Your Honor, all I was going to say was we
13 were mitigating damages. That was our intent. They amended
14 their answer to include it as an affirmative defense which is
15 why we thought it was a necessity.

16 THE COURT: I think if that's the case and if anybody is
17 going to be, if it's going to be held against anybody, the
18 only logical inference would be that the parents and/or the
19 child should be held responsible because they didn't get
20 appropriate treatment. It's certainly not Dr. Goldberg's
21 fault, nor do I believe that a reasonable juror would say
22 that. I think that's just their preemptive attempt to address
23 the issue of mitigation of damages for failure to seek
24 treatment. So, you're protected on the record in that regard
25 and that's the reason why I think it's inappropriate. I don't

1 think it applies.

2 MS. CRAIG: Thank you, Your Honor.

3 THE COURT: We'll stand at ease.

4 (Brief break)

5 THE COURT: Please be seated. Anything from the
6 Plaintiff?

7 MS. RODRIGUEZ: We redacted the medical bills, Your
8 Honor.

9 THE COURT: We can tend -- let's go ahead and get
10 started. As far as the medical bills, we'll get that later.

11 MS. RODRIGUEZ: Okay.

12 THE COURT: Anything else?

13 MS. RODRIGUEZ: No, sir, Your Honor.

14 MS. GANES: No, sir, Your Honor.

15 THE COURT: All right. We're ready for the jury.

16 (JURY IN AT 3:37 PM)

17 THE COURT: Defense, you're recognized, cross
18 examination.

19 MS. GANES: Thank you, Your Honor.

20 CROSS EXAMINATION

21 BY MS. GANES:

22 Q Good afternoon, Ms. Fulton.

23 A Good afternoon.

24 Q Ms. Fulton, I'm going to show you this.

25 MS. GANES: May I approach, Your Honor?

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1 THE COURT: Yes.

2 Q I'm going to show you this document that's been marked
3 Defendant's Exhibit #1 and this is the document that you
4 signed when you came to the hospital on August the 20th
5 and I just wanted to be clear, Ms. Fulton. This is your
6 signature on this document. Is that correct?

7 A That is my signature.

8 Q And Ms. Fulton, do you know if you signed a document
9 like this when you had your first daughter?

10 A If you -- when you go into the hospital, I can't say
11 it's the same document but any time you go into the
12 hospital, even to the emergency room, they give you a
13 bunch of papers to sign.

14 Q Okay. And you've done that before when you've been to
15 the hospital for treatment?

16 A Right.

17 Q Ms. Fulton, when Dr. Goldstein came in -- I'm sorry.
18 When you came to the hospital on August 20th, 2009, Dr.
19 Goldstein came in that morning and checked you. Is that
20 correct?

21 A Yes, ma'am, at some point.

22 Q And then he came back when it was time to push?

23 A Yes, ma'am.

24 Q And he told you when to push and you had no trouble
25 pushing, initially.

1 A No problem.

2 Q And Dr. Goldstein never left the room while you were
3 delivering Bryson. Correct?

4 A No, ma'am.

5 Q When you started pushing, Stephanie was on your right
6 side. Is that correct?

7 A I think so. I'm not sure but I think so.

8 Q And you pushed as hard as you could when you were
9 instructed to. Correct?

10 A Yes, ma'am.

11 Q And you were even bearing down and pushing as hard as
12 you could when the delivery team asked you to do that.
13 Correct?

14 A Correct.

15 Q And do you recall that within 10 to 15 minutes of Bryson
16 being born, someone came into the room, and I think your
17 testimony in your deposition was that you didn't
18 remember if it was Dr. Goldstein or Stephanie, the
19 nurse, but someone came in and explained Bryson's injury
20 and told you about shoulder dystocia. Do you remember
21 that?

22 A I remember, I remember someone telling me and I know Dr.
23 Goldstein came back and said something happened, but I
24 don't think he said shoulder dystocia.

25 Q Do you remember that that was within 10 or 15 minutes of
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1 Bryson being born?

2 A After he was born?

3 Q Yes, ma'am.

4 A Yes, ma'am, it wasn't long.

5 Q Now, after Bryson was born you returned to see Dr.
6 Goldstein in his office on two occasions. Do you
7 remember that?

8 A Yes, ma'am.

9 Q And you appreciated all that Dr. Goldstein did in the
10 delivery room to get Bryson delivered, didn't you?

11 A I'm glad he was delivered.

12 Q Do you remember telling us in your deposition that you
13 appreciated all that he did in the delivery room to get
14 Bryson delivered?

15 A Yes, ma'am.

16 Q You respected Dr. Goldstein as a professional, didn't
17 you?

18 A I did.

19 Q Dr. Goldstein was never unkind to you, was he?

20 A I wouldn't say unkind. Like I told you in my deposition,
21 I feel as though that his bedside manners could have
22 been better and some of the, like, questions, like, a
23 patient asks their doctor, if I ask okay, is my fever --
24 do I have a fever today, I would like for him to say yes
25 or no, not just walk out like he didn't hear me. You.

1 know, answer my questions.

2 Q Dr. Goldstein never did anything to offend you or
3 treated you ugly, did he?

4 A I feel as though he did at one point.

5 Q Well, when I took your deposition do you remember
6 telling me that Dr. Goldstein never did anything to
7 offend you or treated you ugly?

8 A I don't know if that was your question, too, because at
9 that time I would have explained to you it was a meeting
10 that we had in his office at one point that I asked him
11 a question about some of my treatment and I could tell
12 you exactly today what he said that day and if you would
13 have asked me in my deposition that exact question I
14 would have explained to you then.

15 Q Well, let me ask you this with respect to Bryson's
16 delivery on the day he was born: Dr. Goldstein was never
17 unkind to you, was he?

18 A He was not.

19 Q And he wasn't unkind to you in those office visits when
20 you came to him on two occasions after Bryson was
21 delivered.

22 A He was not.

23 Q And in one of those office visits with Dr. Goldstein
24 when you all were talking about Bryson's injury, you
25 told him that you just thank God Bryson's alive and

1 here, didn't you?

2 A I did the same thing at the hospital at my tubal
3 ligation that morning. I just thank God that he's alive.

4 Q And Bryson's a delightful boy in your life, isn't he?

5 A He is.

6 Q Thank you, Ms. Fulton. I have no further questions.

7 THE COURT: Any redirect?

8 MS. RODRIGUEZ: Yes, sir, minimal. I'd like to mark this
9 exhibit. This is Carolinas Hospital System for Fulton Baby
10 Boy.

11 (Whereupon, a Carolinas Hospital document is marked for
12 identification as Plaintiff's Exhibit #22)

13 REDIRECT EXAMINATION

14 BY MS. RODRIGUEZ:

15 Q Genesie, see that document? I'm going to put it up so
16 the jury can see it as well. Okay?

17 A Okay.

18 Q This is from J- according to the medical record it was
19 in the medical record for Fulton Baby Boy and it says
20 Genesie next to it. The date is 8/20/09. Would that be
21 Bryson's delivery?

22 A It would be.

23 MS. GANES: Objection, Your Honor. Outside the scope.

24 THE COURT: Counsel, approach the bench.

25 (Brief bench conference off the record)

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1 THE COURT: I think it was addressed in cross-
2 examination ---

3 MS. RODRIGUEZ: Thank you, Your Honor.

4 THE COURT: --- and I'll allow you to address it.

5 Q Genesie, you were asked questions about the consent that
6 you signed when you got, went into the hospital for your
7 treatment with Dr. Goldstein. Correct?

8 A Correct.

9 Q Okay. This is the same consent, the identical consent,
10 only this time it is for Fulton Baby Boy and you'll see
11 over here it says the name. What is that name?

12 A Goldstein.

13 Q And it says, "Exceptions," exactly the same as the one
14 you signed, "none".

15 A None.

16 Q Okay. And did Dr. Goldstein ever talk to you about any
17 operation or procedure he planned to do on Bryson?

18 A No.

19 Q This is signed on what date here?

20 A The 23rd.

21 Q Now, my question to you is did you read this consent and
22 have -- before you signed it?

23 A I didn't read it.

24 Q How did you come to sign it?

25 A I was asked that Bryson needed to have his, what do you

1 call it? When they do the little baby boys? They do the
2 surgery on the penis, circumcise the baby. And I was
3 asked at the time they said Dr. Goldstein was in the
4 hospital, did I want him to perform that and I said
5 well, yes, because I couldn't leave the hospital with
6 the baby before he do it. Is it okay, and I said yes.

7 Q And the consent that they had you sign here, though, is
8 identical to the one you signed when you were admitted
9 to the hospital?

10 A Yes.

11 MS. RODRIGUEZ: Thank you. That's all I have.

12 THE COURT: You may step down. You may call your next
13 witness.

14 MS. RODRIGUEZ: Judge, we have a couple of matters that
15 we need to take up outside the presence of the jury and I
16 believe that will be our last witness.

17 THE COURT: Okay. Madam Forelady, ladies and gentlemen of
18 the jury, we have some matters of law to take up outside of
19 your presence. Return to the jury room, but do not discuss
20 the case.

21 (Jury out at 3:47 PM)

22 THE COURT: I'll be glad to hear any motions.

23 MR. GRAHAM: Your Honor, we -- before we get to motions
24 and before we rest, we want to make sure that certain
25 exhibits were actually offered into evidence. I know they

1 THE COURT: Be happy to entertain any further motion.

2 MR. GRAHAM: Yes, sir. Your Honor, subject to Your
3 Honor's permission to put that edited DVD in tomorrow
4 morning, we're prepared to rest.

5 THE COURT: Very good. Yes, ma'am.

6 DIRECTED VERDICT MOTION

7 MS. CRAIG: Your Honor, at this time on behalf of the
8 Defendants, Dr. Goldstein and his practice, we would move for
9 directed verdict as to all claims that have been asserted by
10 Ms. Fulton. The Plaintiffs have not met their burden as to
11 liability, causation or damages and we're moving for directed
12 verdict pursuant to Rule 50.

13 The only reasonable inference from the testimony in the
14 Plaintiff's case is that Plaintiff has not met her burden of
15 proof. Your Honor, starting with -- as you know, Your Honor,
16 the Plaintiff must prove what the standard of care is, that
17 there is a deviation from the standard of care, proximate
18 cause and damages.

19 So, starting with the standard of care, the only
20 standard of care expert that was brought by the Plaintiff was
21 Dr. Gomez-Carrion and she mentioned various deviations from
22 the standard of care like Pitocin, vacuum, but these
23 deviations did not cause any injury. That's why I asked her
24 about the informed consent. She said it was a deviation not
25 to have a specific informed consent for the vacuum and that's

1 why I asked her, because she's a professional witness, that
2 you know that not only do you have to prove there's a
3 deviation, but it actually has to cause the injury, and she
4 agreed that lack of documentation does not cause an injury,
5 so that was -- that was her opinion with regard to
6 documentation.

7 Then the Pitocin, she said that was a deviation to
8 administer Pitocin and I asked her on cross examination and
9 she agreed that she can't say with or without the Pitocin the
10 shoulder dystocia could have been avoided, so again they're
11 not meeting their burden of proof. They've got a deviation,
12 but they can't prove causation.

13 And then her final opinion was traction and she -- it is
14 her opinion that too much traction was used in this case, but
15 I asked her, I said, you can't say how much traction was
16 used. She said that is correct. There is no way to quantify.
17 And all of the experts will testify that there's no way to
18 quantify the amount of traction. It's based on a physician's
19 experience in delivering babies and so she says that.

20 So, we're left really with one argument with her that
21 even gets to the, to the, past probable cause and that's
22 traction, and so her opinion is really a res ipsa loquitur
23 opinion that because there was a brachial plexus injury, it
24 must have been caused by the traction. She said on cross
25 examination not only could she not say how much traction was

1 used, but she also, she said that she can't tell based on the
2 medical records, that there was no documentation anywhere in
3 the medical chart that there was evidence of too much
4 traction and she didn't rely on the testimony of any of the
5 eye witnesses, so her one opinion that gets to probable cause
6 is really a res ipsa argument, and of course, as Your Honor
7 knows, the res ipsa is not a doctrine that's followed in
8 South Carolina.

9 In the absence of any admissible evidence in the record
10 to support their claim, the jury would simply be speculating
11 as to the cause of the injury and I'm relying on the Watson
12 case, Watson versus ---

13 THE COURT: Isn't res ipsa loquitur, or whatever the
14 Latin term is, isn't that something where someone comes into
15 Court and says that just by virtue of the fact it happened it
16 had to be so and it really addresses a situation where you
17 don't have an expert? In this case, we've got an expert who
18 says that there was excessive traction, although she can't
19 quantify it in pounds or however you measure traction, she
20 says it was too much, which I think takes it out of the
21 concept of res ipsa loquitur but I don't know. What do you
22 think?

23 MS. CRAIG: Well, in reviewing the Ford versus Watson
24 case, there is a statement about res ipsa and there is
25 another earlier case that I can pull up.

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1 THE COURT: That Ford case, isn't that about the cruise
2 control?

3 MS. CRAIG: Yes, sir. That's the product liability case.

4 THE COURT: Yeah, that was kind of voodoo science they
5 had. That was one of Mr. Bell's experts he got from somewhere
6 that said something about radio frequency interference
7 affecting cruise control. That ain't what we got here. We've
8 got doctors talking about how to deliver a baby which I think
9 is a lot different than the Ford case.

10 MS. CRAIG: But in that case, what the Court did say, and
11 I, I don't think this is the exact quote, but it's close to
12 it. It says that in the absence of any admissible evidence,
13 which is what we have, there is no admissible evidence other
14 than her saying that traction caused the injury because we
15 have an injury, and that's the res ipsa. But in the absence
16 of any admissible evidence in the record to support the
17 claim, the jury would be speculating as to the cause of the
18 injury. That's exactly what we're arguing here. She makes a
19 statement, makes a, has an opinion that's based on the fact
20 that we have an injury but she can't support it with any
21 admissible evidence, so it's pure speculation on the part of
22 the jury to connect that deviation to causation in this case.

23 Now, that's the first basis for our directed verdict.
24 We'd also like to address the informed consent. The informed
25 consent that was signed in this case by Ms. Fulton is a

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1 standard informed consent that is signed by every woman in
2 Florence County that goes to one of these hospitals to
3 deliver a baby. It is the, it is the standard informed
4 consent form that is signed, same type of, anywhere in the
5 state at any hospital. You've got to sign the informed
6 consent before you're allowed to, before having the baby.
7 And that form clearly states the risk and gives the doctor
8 permission to do a vaginal delivery and a C-section so that
9 the child can be delivered, and in this case it is our
10 position that informed consent was clear and that the facts
11 are in compliance with the holding in the Hook versus
12 Rothstein case.

13 Also, Your Honor, we would ask for a directed verdict
14 based on the emergency medical and obstetrical care
15 exception. It's §15-32-230 and in this statute it says in an
16 action involving a medical malpractice claim arising out of
17 care rendered in a genuine emergency situation involving an
18 immediate threat of death or serious bodily injury to the
19 patient receiving care in an emergency department or in an
20 obstetrical or surgical suite, no physician may be held
21 liable unless it is proven that the physician was grossly
22 negligent. And in this case it was definitely a life or death
23 situation. It was an obstetrical emergency. I think that's
24 undisputed in this case. We were in an obstetrical suite and
25 the Plaintiff has not proved gross negligence in this case.

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1 The Plaintiff, in order to prove gross negligence and to
2 pursue a punitive damages claim, as Your Honor knows, the
3 standard is clear and convincing evidence, and we would move
4 to strike the claim for punitive damages. The questions that
5 were posed to Dr. Gomez-Carrion, I think it took three or
6 four times being asked the question before she answered it
7 and she did say that it was reckless but she did not come
8 forth with any evidence to support that there was willful,
9 wanton or reckless behavior, and that certainly doesn't meet
10 the clear and convincing standard that is required for
11 punitive damages or for gross negligence.

12 THE COURT: Well, that's, kind of -- that's very
13 interesting, but really what I've got to do at this juncture
14 is not clear and convincing, but a scintilla, a scintilla
15 towards convincing, clear and convincing. Do you understand
16 where I'm at as far as directed verdict? The standard is a
17 scintilla of evidence of egregiousness. Is that right?

18 MS. CRAIG: Your Honor, we maintain that there isn't even
19 a scintilla. There was no ---

20 THE COURT: Well, you do agree that she did reluctantly
21 say egregious, didn't she?

22 MS. CRAIG: I do agree that she reluctantly said ---

23 THE COURT: It might be a scintilla, barely. Don't you
24 think?

25 MS. CRAIG: I've been struggling with that scintilla

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1 standard for a long time.

2 THE COURT: All right. I understand your point.

3 MS. CRAIG: So on those reasons, the Defendants move for
4 a directed verdict on behalf of Dr. Goldstein and his
5 practice. Thank you, Your Honor.

6 THE COURT: Very good. Be glad to hear from the
7 Plaintiff.

8 MR. GRAHAM: Thank you, Your Honor. I don't believe this
9 will take much time. First of all, they were talking about no
10 testimony of how much traction. There's no testimony of how
11 much traction in terms of Newton's, which is what physicians,
12 what physicists may talk about or what engineers may talk
13 about, nor was there any discussion about pounds of force,
14 which is what engineers and physicists may talk about, but
15 there was certainly ample testimony from a highly qualified
16 obstetrician who's delivered eight or 9,000 babies without a
17 single permanent injury that greater than gentle traction is
18 below the standard. Greater than gentle traction was applied
19 here. Lateral traction to the side is below the standard.
20 Lateral downward traction was applied here, et cetera.

21 So, and the business about res ipsa, as I understand it,
22 res ipsa means the ---

23 THE COURT: It speaks for itself.

24 MR. GRAHAM: --- the injury proves negligence. Dr. Gomez-
25 Carrion did not in any way say negligence proves -- I mean

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1 injury proves negligence. She did say an injury that includes
2 four or five of the nerves being ripped and torn in two that
3 grow back with a neuroma is something that happens during the
4 birth process when too much traction in this is applied. She
5 didn't say every time there's neuromas that the excessive
6 lateral bending of the neck is negligence. Whether that's
7 negligence or not depends upon a host of other factors; how
8 long has the head been out, if it's more than six or seven
9 minutes, maybe you tell the patient you're going to wrench
10 that neck as hard as it takes to save the baby's brain and
11 life, but that's not the situation we're in.

12 Also, if a doctor has used all the various safety
13 maneuvers unsuccessfully and gone back and tried to perfect
14 those, then if you get to six or seven minutes maybe it's not
15 negligence to choose life and brain over nerves, but that's
16 not this case. In this case we have a man who performed --
17 the evidence shows McRoberts after Coker arrives, suprapubic
18 pressure by three different providers, and the one by Dr.
19 Coker is the one that delivered the baby. No internal
20 maneuvers; not Woods, not Rubin's, not posterior arm delivery
21 method, and no attempt. Then Dr. Coker, the former boss, is
22 called to bail Dr. Goldstein out. He comes in and in -- I
23 mean, he's told Dr. Goldstein is on the floor. Being on the
24 floor pulling down on the head is also a breach of the
25 standard under these circumstances. So, Dr. Coker gets the

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1 message Dr. Goldstein's on the floor, we need your help
2 immediately. He rushes in expecting to see Dr. Goldstein
3 having a heart attack on the floor but instead he sees Dr.
4 Goldstein on his knees pulling down on the head and neck. He
5 sizes the situation up, leaps up and gets the baby delivered
6 all in less than a minute and this man was there for four
7 minutes according to part of the records. He was there for
8 five minutes after the head delivered and he just, he wasn't
9 properly trained. He wasn't properly calm to do the maneuvers
10 that are necessary to protect the baby's brain, life, and the
11 brachial plexus nerves.

12 Also if Your Honor please, there was a reference about
13 vacuum not being a direct cause of a brachial plexus nerve
14 injury. That's true enough but there is testimony that vacuum
15 is -- is a -- an increased risk factor for the shoulder
16 getting stuck and if a doctor who doesn't know how to get a
17 shoulder unstuck safely increases the risk of the shoulder
18 getting stuck, that's additional negligence.

19 We've also got -- and Dr. -- in terms of causation, Dr.
20 Gomez-Carrion went through a differential diagnosis which is
21 what doctors do. The Supreme Court of this state has approved
22 that differential diagnosis approach. She had very good
23 reasons for why she ruled out other causes and counsel didn't
24 even mention Dr. Resnick or Dr. Grossman. They testified
25 about causation issues, not standard of care, but their

1 causation testimony dovetails with Dr. Gomez-Carrion's
2 standard of care testimony.

3 THE COURT: Very good.

4 MR. GRAHAM: Thank you.

5 THE COURT: All right. I believe that the only thing that
6 you did not address was the punitive damages.

7 MR. GRAHAM: Yes, sir. On punitive damages, if Your Honor
8 please, I've heard comments about hesitation from Dr. Gomez-
9 Carrion, about testifying truthfully to her genuine belief
10 that this man was -- this man did, in fact, recklessly
11 endanger Bryson F and her hesitation should not be
12 viewed in terms of a lack of confidence but in terms of a
13 recognition that she was about to make a very serious
14 accusation and I -- I saw her taking a deep breath, because
15 it's a courageous thing for one physician to say that about
16 another physician. She's not one to lightly utter those
17 words.

18 THE COURT: Very good.

19 MR. GRAHAM: Thank you.

20 THE COURT: All right. Very good. I'm going to deny all
21 motions for directed verdict. However, I am going to take the
22 issue of punitive damages under advisement. Anything else
23 before we bring the jury out?

24 MS. CRAIG: No, sir, Your Honor, if we could just have a
25 second to get set up?

1 THE COURT: And while we're doing that have we reached an
2 agreement with regard to the medical records?

3 MS. GANES: She's just handing them to me, Your Honor.

4 THE COURT: Take a look at them and by the time --
5 before we bring the jury out, we'll see if we've gotten it
6 done.

7 (Brief break)

8 THE COURT: We are going to proceed. If y'all could have
9 a seat. There's going to be some time when we conclude today
10 to, kind of, get everything straight for tomorrow, but you're
11 prepared with regard to your first witness?

12 MS. CRAIG: Yes, sir, we are.

13 THE COURT: Very good. We'll start right now. We'll keep
14 going until -- do you anticipate how long this will take?

15 MS. CRAIG: I would bet an hour-and-a-half, at least,
16 maybe more. Maybe two.

17 THE COURT: Okay. We'll probably break some time in the
18 middle of testimony, but let's just go and get as much as we
19 can get done. We aren't in a terrible hurry so we'll just see
20 how far we can get. We're ready for the jury.

21 (Jury in at 4:16 PM)

22 THE COURT: Ms. Craig, you're recognized.

23 MS. CRAIG: Thank you, Your Honor.

24 THE COURT: Excuse me.

25 MS. CRAIG: Yes, sir.

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1 THE COURT: Madam Forelady, ladies and gentlemen of the
2 jury, the Plaintiff has rested. They have completed their
3 case in chief. At this point in time, the Defense will move
4 forward. At the conclusion of their presentation, Plaintiff
5 will be given an opportunity for reply. Ms. Craig, you're
6 recognized. I'm sorry.

7 MS. CRAIG: Thank you, Your Honor. May it please the
8 Court.

9 THE COURT: Yes.

10 MS. CRAIG: The Defendants call Dr. Bill Goldstein.

11 THE COURT: Dr. Goldstein, if you could come forward and
12 place your left hand on the Bible and raise your right hand
13 as the Clerk administers the oath.

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

16 THE CLERK: Please be seated and state your name for the
17 record.

18 THE WITNESS: L. William Goldstein, M.D.

19 THE COURT: Dr. Goldstein, make yourself comfortable.
20 Have a seat in that witness chair. Pull up real close to that
21 microphone. Speak loudly, clearly and slowly and let's start
22 with your full name once again.

23 DR. GOLDSTEIN: L. William Goldstein, M.D.

24 THE COURT: Thank you. Ms. Craig.

25 MS. CRAIG: Thank you.

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DIRECT EXAMINATIONBY MS. CRAIG:

Q Dr. Goldstein, I'd like to introduce you to this jury.
Tell us where you live, sir.

A I live in Florence, South Carolina. I live on Cherokee Drive.

Q And are you married?

A I am.

Q Is your wife here?

A My lovely bride is sitting right back there.

Q Okay. And how long have you and Sara been married?

A Forty-seven years.

Q Good thing you got that right.

A Yeah. I had to fact-check that before.

Q Dr. Goldstein, do you have any children?

A We have three.

Q And how about grandchildren? Any grandchildren?

A Five.

Q Tell us what you and your wife like to do in your spare time.

A Well, we enjoy -- we have dogs. We have Labrador retrievers and I enjoy training them and we enjoy competing with them in field trials. We've been doing this ever since I got out of my residency and I've had the pleasure of running in the national amateur several

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1 times and my dogs have competed in the national open
2 several times. I think on three occasions my dogs have
3 been finalists in these national events. I've been the
4 president of the National Open Club.

5 Q Is this something that you and your wife enjoy doing
6 together?

7 A Indeed.

8 Q I saw you in that big old truck of yours coming to the
9 courthouse. What's that thing on the back of your truck?
10 What is that for?

11 A It's called a topper dog box. It's a topper that fits on
12 top of the pickup. A lot of people have accused me of,
13 is that an ice cream truck, so I've had to tell them I
14 don't have any Eskimo Pies in the back.

15 Q All right. Dr. Goldstein, tell us where did you grow up?

16 A I was born and raised in Spartanburg, South Carolina.

17 Q Where did you go to college?

18 A I attended Clemson University.

19 Q And how about schooling after Clemson? Where did you go
20 to graduate school?

21 A Well, after I graduated from Clemson I did two years in
22 the Army and then I attended graduate school at the
23 University of South Carolina in Columbia and from there
24 I went to medical school at the Medical University of
25 South Carolina.

1 Q How long was graduate school? How many years?

2 A Two years.

3 Q Two years of graduate school. How many years was medical
4 school?

5 A Four.

6 Q Four years of medical school. How many years of
7 residency?

8 A Four.

9 Q Tell us why you wanted to be a doctor.

10 A I always wanted to be a doctor. It's just something that
11 I, an aspiration that I had all my life. When I was in
12 high school I worked as a surgical tech at Spartanburg
13 General. During college, I worked as a tech in the
14 urology clinic at Grady Memorial and then, you know,
15 just followed my dream.

16 Q Dr. Goldstein, are you board certified by the American
17 Board of OB/GYN?

18 A Yes, ma'am.

19 Q Explain to us what it means to be board certified.

20 A That means that you've taken a test to assure that your
21 training is adequate and it's -- it involves case
22 presentations of patients that you see during the first
23 two years of private practice, as well as a written test
24 and an oral board exam.

25 Q Let's start with the written test. How many days is

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1 that?

2 A I think -- it's hard to remember, but I think it was
3 over one day.

4 Q And -- okay. So, that's just for the written portion?

5 A Right.

6 Q All right. How long for the oral portion?

7 A For the oral portion you presented your cases and
8 discussed cases and then they have the oral boards
9 afterwards.

10 Q Did you pass your board certification, your written and
11 orals, on the first attempt?

12 A Yes, ma'am.

13 Q Does everyone pass on the first attempt?

14 A Not usually.

15 Q Dr. Goldstein, how long have you been practicing in the
16 field of obstetrics and gynecology?

17 A I'm going to have to add in my head. Let's see.
18 Thirty-seven years.

19 Q And in the 37 years, approximately how many babies have
20 you delivered?

21 A I'm guess-timating it's somewhere between 3000 and 3500.

22 Q Tell us where you currently practice.

23 A I practice here in Florence. My office is on Coit
24 Street. I'm on the staff at Carolinas Hospital and
25 McLeod Regional Medical Center.

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1 Q Do you work with anyone else?

2 A Only in that we have a call group and we share calls and
3 so, generally, I see my patients all during the week and
4 then on the weekend we switch out being on call and
5 cover for the other doctors.

6 Q With whom do you share call?

7 A Dr. Brent Baroody, Dr. Ami Chaudhry and Dr. Sue Fran.

8 Q So, before going out and establishing your own practice,
9 where did you work?

10 A I worked a year with Coker and Phillips and prior to
11 that I was in Camden, South Carolina, with John Moore.

12 Q So, why did you leave Camden and come to Florence?

13 A Basically, we had a disagreement so I decided to move on
14 and came to Florence, because it was a good opportunity.

15 Q And then when you started working with Dr. Coker and Dr.
16 Phillips, tell us why you decided to leave that practice
17 and open your own.

18 A It became evident that this wasn't going to lead to a
19 partnership in the near future, so I decided to go out
20 on my own.

21 Q All right. Let's move now to teaching opportunities that
22 you've had. Tell us about your involvement with teaching
23 medical residents.

24 A Well, of course, while I was in residency, we taught the
25 medical students as well as the residents. When I

1 graduated and went into private practice, I don't think
2 we had any in Camden, but in Florence I've had a number
3 of PA students from the Medical University that have
4 done one-month rotations with me at my office. I had one
5 osteopath third-year medical student from Virginia Tech
6 School of Osteopathic Medicine in Spartanburg that came
7 down and did about a month's rotation with me.

8 Q Where do you have hospital privileges?

9 A McLeod and Carolinas.

10 Q What does it mean to have hospital privileges?

11 A It means that you have privileges, you've been approved
12 by the board and they renew your privileges about every
13 two years, check your credentials and make sure that,
14 you know, everything is going okay at the hospital with
15 your patients and with your practice.

16 Q Were you Chair of the Department of Obstetrics?

17 A I was Chair of the Department of OB at McLeod. I think
18 that was a two-year appointment and then I did two
19 two-year stretches.

20 Q Dr. Goldstein, are you a member of any professional
21 organizations for your medical specialty?

22 A Yes. I'm a member of American College of OB/GYN or the
23 American Congress of OB/GYN, as it's now referred to.

24 Q Tell us what the American Congress of OB/GYN is.

25 A It's a professional organization for all OB doctors that

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1 deals with issues that affect the OB/GYNs, educational.
2 I'm sure they do a collection of funds. They send out
3 educational materials and are also involved in the
4 political aspect of it.

5 Q Now, Dr. Goldstein, as a member of the American Congress
6 of Obstetrics and Gynecologists, I'll just call it ACOG,
7 what publications do you receive from that professional
8 organization?

9 A Well, they have a compendium that has committee opinion
10 reports as well as articles on various topics of
11 interest in OB/GYN. They also put out some other, other
12 issues. They have precise -- there is a handbook that, a
13 monograph that they publish and this has to do with, the
14 latest one I've seen was anemia, they have one
15 concerning hypertension, others concerning elevated
16 cholesterol. These are just general topics and they give
17 CME credits for these.

18 Q Do you read these publications from ACOG and from other
19 medical professional organizations?

20 A Yes, ma'am.

21 Q Are you a member of the Florence Medical Society?

22 A I am indeed.

23 MS. CRAIG: Your Honor, at this time we would offer Dr.
24 Goldstein as an expert witness in the field of Obstetrics and
25 Gynecology.

1 THE COURT: Any query with regard to his qualifications?

2 MR. GRAHAM: None as to his status as an OB/GYN but ---

3 THE COURT: That's what my question is. Do you have any
4 query or any questions of him about his qualifications?

5 MR. GRAHAM: Not at this time, but we reserve the right
6 to do that before he gets into certain opinions.

7 THE COURT: Well, that's not what I'm asking. I'm just,
8 we're wanting to know whether you feel you need to ask him
9 questions about whether he's qualified as an expert.

10 MR. GRAHAM: No, sir, Your Honor.

11 THE COURT: If you have questions or concerns concerning
12 scope, you can object at a later date and time.

13 MR. GRAHAM: Thank you, Your Honor.

14 THE COURT: But my question to you is, do you have any
15 query with regard to his qualifications?

16 MR. GRAHAM: No, sir.

17 THE COURT: All right. He is indeed qualified as an
18 expert in the area of Obstetrics and Gynecology and allowed
19 to render his opinion in that field. Ms. Craig.

20 MS. CRAIG: Thank you, Your Honor.

21 Q Dr. Goldstein, did you comply with the standard of care
22 in your care and treatment of Ms. Fulton and her son?

23 MR. GRAHAM: Objection, Your Honor.

24 THE COURT: That being?

25 MR. GRAHAM: In his deposition ---

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1 THE COURT: You know, state your grounds for it. We
2 aren't going to argue it.

3 MR. GRAHAM: Lack of knowledge, if Your Honor please.

4 THE COURT: Overruled.

5 Q Dr. Goldstein, did you comply with the standard of care
6 in your care and treatment of Ms. Fulton and her son?

7 A Yes, ma'am.

8 Q Did you cause the injuries that are alleged in this
9 case?

10 A No, ma'am.

11 MR. GRAHAM: Objection, Your Honor. Lack of knowledge;
12 lack of expertise.

13 THE COURT: He has knowledge. He was there and he's an
14 expert and if he feels as though he didn't cause it, he's an
15 expert. He can do that.

16 MR. GRAHAM: Well, if Your Honor please, if I may
17 respectfully -- may we approach?

18 THE COURT: Yes.

19 (Bench conference off the record)

20 THE COURT: Ms. Craig, you're recognized.

21 MS. CRAIG: Thank you, sir.

22 Q Dr. Goldstein, what is shoulder dystocia?

23 A Well, shoulder dystocia, in essence, is where the
24 shoulder becomes stuck under the pubic symphysis and
25 the opposite shoulder is stuck under, behind the sacral

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1 promontory. It's also defined by -- it takes ancillary
2 maneuvers to deliver the baby's shoulders after failure
3 of gentle downward traction.

4 Q Tell us what training you received during your residency
5 about how to manage the medical emergency of shoulder
6 dystocia.

7 A First of all, didactic instruction ---

8 Q What does that mean?

9 A That means reading it in the textbook and in the
10 literature and I'm sure we discussed it at the board.
11 We had one case in my residency in which a private
12 attending had a baby that had got stuck and the baby
13 ultimately died, so we usually talked about these cases
14 at the board in the morning as we, you know, did rounds.

15 Q I want to follow up on that. If you are confronted with
16 a shoulder dystocia and you're unable to get the baby
17 out, you indicated you had an experience or someone in
18 your residency that the baby died. What are some other
19 problems that can result because of shoulder dystocia if
20 you're not able to get the baby delivered within six or
21 seven minutes?

22 A Well, ultimately the worse thing that can happen is that
23 the baby can die and that happened in this case in my
24 residency. Another thing is that you can get what they
25 call, hypoxic ischemic encephalopathy, which ---

1 Q What does that mean?

2 A Which basically means that the blood supplied to the
3 baby and to the baby's brain has been cut off so that
4 they get damage to the brain because of lack of oxygen,
5 lack of blood supply.

6 Q Do you know what McRoberts is?

7 A I do.

8 Q Tell us what McRoberts is.

9 A It's hyperextension and flexion -- I mean, excuse me.
10 Hyperextension of the thighs so that the thighs go
11 towards the patient's armpits and abduction of the
12 thighs is outward.

13 Q So, the woman's legs are pulled all the way back.
14 Correct?

15 A Correct.

16 Q And what does that do when you're confronted with
17 shoulder dystocia? If the legs are all the way back,
18 what's going on with the pelvis?

19 A Well, say, if the patient is sitting -- I mean, on the
20 supine -- I mean, supine on a surface ---

21 Q Supine, you mean on your back ---

22 A --- on your back.

23 Q --- having a baby.

24 A Yeah. Then when you extend the thighs back it opens up
25 the pelvis. Normally the pelvis is, kind of, pointing

1 down a little bit off the plane of the floor so it, kind
2 of opens up the pelvis.

3 Q Do you know what suprapubic pressure is?

4 A Yes.

5 Q Tell us what it is.

6 A It's pressure applied in the suprapubic area generally
7 in reference to helping dislodge the entrapped shoulder
8 from under the symphysis pubis.

9 Q Were you taught McRoberts and suprapubic pressure when
10 you were in your residency?

11 A Yes, ma'am.

12 Q Were you also taught rotational maneuvers?

13 A Yes, ma'am.

14 MR. GRAHAM: Your Honor, at his point I object to the
15 leading.

16 THE COURT: I'll allow her some leeway in that regard.
17 Go ahead.

18 Q What training on all of these types of maneuvers in your
19 residency to resolve a shoulder dystocia situation, did
20 you receive?

21 A Well, again, didactic instruction, discussion on rounds,
22 and I'm sure since then I've, you know, read some
23 articles about it.

24 Q Dr. Goldstein, do you know how to manage a shoulder
25 dystocia emergency?

1 A I do.

2 Q And did you do that in this case?

3 A I did.

4 Q All right. We're going to go through the records. I'm
5 going to give you a copy of your original chart as well
6 as a copy of the hospital chart.

7 (Ms. Craig hands a document to Dr. Goldstein and a
8 document to Mr. Graham)

9 MR. GRAHAM: No objection, Your Honor, to this.

10 MS. CRAIG: All right. So, we'd like to mark your
11 original chart as a Defendant's Exhibit as well as a copy of
12 the hospital chart from this delivery as a Defendant's
13 Exhibit. Your Honor, we would move into evidence Defendant's
14 #2 and Defendant's #3.

15 THE COURT: They're into evidence without objection from
16 the Plaintiff.

17 (Whereupon, Dr. Goldstein's medical records are entered
18 into evidence as Defense Exhibit #2 and hospital records are
19 entered into evidence as Defendant's #3, without objection)

20 Q So, Dr. Goldstein, we're going to walk through ---

21 THE COURT: Just one second.

22 MS. CRAIG: Oh, I'm sorry.

23 MR. GRAHAM: The Court's indulgence. Your Honor, as we
24 discussed earlier we have no objection to any page of the
25 records that is actually discussed by a witness, but we don't

1 believe any other pages that are not addressed in the
2 courtroom by a qualified witness should be admitted.

3 THE COURT: What does the defense have to say about that?

4 MS. CRAIG: Your Honor, these are the -- this is the
5 complete chart of the hospital delivery as well as the
6 complete chart, Dr. Goldstein's complete chart for Ms.
7 Fulton. He's reviewed these documents, relied on them, and we
8 would like him to have all of the information. We believe
9 it's all relevant to this case.

10 THE COURT: Under the business records exception and
11 you're going to be -- anything that's not talked about, if
12 she doesn't talk about it, you can talk about it, as well as
13 your objection is overruled. The medical records are in
14 evidence.

15 Q As we're going through, Dr. Goldstein, we're going to
16 start -- we're going to go in chronological order.
17 We're going to start with prenatal and then we're going
18 to go through the delivery. At any time, if you need to
19 review the actual medical records, please feel free to
20 do so and I'll try to reference certain pages to help
21 you. Okay?

22 A Yes, ma'am.

23 Q Do you have an opinion whether shoulder dystocia is
24 unpredictable and unpreventable?

25 A Yes, I do. Pretty much the literature states that

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1 shoulder dystocia is unpredictable and unpreventable. I
2 think there are a couple of exceptions, one being the
3 patient has had a previous shoulder dystocia with a bad
4 outcome. They suggest on those cases, maybe considering
5 operative vaginal -- I mean, C-section delivery.

6 Q Did Ms. Fulton have a previous shoulder dystocia with
7 her first child?

8 A No, ma'am.

9 Q First delivery?

10 A No.

11 Q When the shoulder dystocia occurred in this delivery,
12 did you immediately recognize it?

13 A Yes, ma'am. She demonstrated the turtle sign. That is,
14 the head delivers but then retracts back into the
15 perineum, you know, with the chin against the side wall
16 of the vagina and the back of the head against the other
17 side.

18 Q Okay. Let's start with your chart. You've got your
19 original chart up there.

20 A Yes, ma'am.

21 Q If you will tell us how Ms. Fulton became your patient.

22 A She was referred by Dr. Morris Brown from Lake City.

23 Q And who's Dr. Brown?

24 A He is a family practitioner in Lake City, very nice guy.

25 Q All right. So, Dr. Brown referred the patient to you.

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1 When is the first time you saw Ms. Fulton as a patient?

2 A 8/20/08.

3 Q All right. And it's in your record, page 69. We're going
4 to pull it up for you (on screen) and while we're
5 waiting for it to come up, if you can -- this is -- how
6 many pages is this note, this office visit on this one
7 day?

8 A Two pages.

9 Q All right. Tell us about your evaluation of Ms. Fulton
10 at this time.

11 A At that time, she was referred by Dr. Brown with
12 excessive menstrual bleeding and the suggestion from
13 them was that she had fibroids and this was causing her
14 excessive bleeding. She also had secondary infertility.
15 She'd had one pregnancy in 1989 and had been unable to
16 conceive since that time.

17 Q Doctor, if you'd speak up a little bit just so that we
18 can hear you. I think you were referring to number three
19 on your actual office chart and you're talking about
20 infertility. Why did you document that she had secondary
21 infertility?

22 A Because we discussed her being unable to conceive and
23 she desired to conceive.

24 Q Okay. And then you go through and it looks like there's
25 a past medical history. Correct?

1 A Diabetes mellitus, type two.

2 Q So, she had diabetes before her pregnancy?

3 A Right. She was on Glucotrol, five milligrams, once a
4 day.

5 Q Okay.

6 A She had elevated cholesterol. She had complained of some
7 back pain, back spasms, was being treated with Flexeril
8 and she had a prescription for nausea, but her biggest
9 complaint when she came in was the heavy, prolonged,
10 irregular bleeding.

11 Q It looks like you obtained her past surgical history,
12 her OB history, her family history, her social history
13 and then pertinent physical findings of your exam.
14 Correct?

15 A Yes, ma'am.

16 Q What kind of exam was that?

17 A Complete exam including vital signs. Generally, I check
18 their neck and feel for thyromegaly or lymph nodes, I
19 listened to her lungs, listened to her heart, checked
20 her breasts, palpated her abdomen, and then did a pelvic
21 exam with a Pap smear and I did a STANDARD check also.

22 Q Okay. Then if you look on the second page, it says GYN
23 endovaginal probe ultrasound. Did you actually do an
24 ultrasound on that visit?

25 A Yes, I did. I did an ultrasound at that time because

1 number one, she was referred for fibroids but number
2 two, I was suspecting that she had polycystic ovary
3 disease so we did an ultrasound and revealed the uterus
4 to be fairly normal size, 8.7, about 4.5 by 5.0, and it
5 was a small fibroid. I think it was 1.9 centimeters in
6 the fundus so that's, you know, less than two
7 centimeters, maybe that big. But I did notice that she
8 had typical polycystic ovaries.

9 Q What does that mean?

10 A Well, for example, the right ovary was enlarged 5.1 by
11 2.6 by 4.1 and it had what we refer to as the typical
12 chain of pearls appearance in the periphery of the
13 ovary, so generally with polycystic ovary disease the --
14 when you look at it on ultrasound you can see that the
15 capsule is thickened and then under the, under the
16 capsule are a lot of small follicular cysts that looks
17 like a chain of pearls under the capsule so that's, kind
18 of, it's not a sine qua non diagnosis of polycystic
19 ovary disease, but it's one of the things that helps in
20 your differential -- I mean, in your diagnosis of
21 polycystic ovary disease.

22 Q Okay. So, the ultrasound was done in your office?

23 A By me.

24 Q By you. All right. Then going down, next, is your
25 assessment on this record ---

1 A Right.

2 Q --- and it says that polycystic ovary disease. That was
3 a diagnosis that you made. Correct?

4 A That's right. No, I mean, these assessments, the
5 hirsutism, secondary infertility, irregular menses,
6 obesity, these are all part of the thing that you add up
7 to get the diagnosis of polycystic ovary disease. You
8 can have signs of excess androgen, which would be the
9 hirsutism, or you could have chemical or laboratory
10 proven excess androgen, but she had all the biggies,
11 including an ultrasound picture that was consistent with
12 polycystic ovaries.

13 Q So, under assessment, you state what? What is written
14 there in your chart?

15 A Polycystic ovary disease based on hirsutism, secondary
16 infertility, irregular menses, obesity.

17 Q And then continue please.

18 A I suspected most of her problems with irregular
19 bleeding, heavy bleeding were a result of PCO disease.
20 I also suspected that her diabetes was related to the
21 PCO disease as well as her infertility.

22 Q All right. So, with regard to the plan, it says you
23 discussed with her the treatment options and you changed
24 medication. Explain the change in the medication,
25 please.

1 A Well, we discussed the various options. I mean, and some
2 of the options are just simply to be on birth control
3 pills to regulate your cycles, but she was more desirous
4 of pregnancy so we simply changed her diabetic regimen
5 to Metformin because Metformin is the type of, it is an
6 agent used to treat diabetes, but it's also usable in
7 patients with polycystic ovary disease in helping them
8 achieve pregnancy.

9 Q Thank you, sir. All right. So, that was August 20th,
10 2008, first visit. Correct?

11 A Yes. Yes, ma'am.

12 Q I've got a time line that might help us stay on track.
13 When was the second visit?

14 A Well, she had a colposcopic exam on 9/4/08 for -- her
15 Pap smear was atypical squamous cells of undetermined
16 significance.

17 Q Are you looking at page 57?

18 A I'm looking at page 66.

19 Q All right.

20 A And the colpo picture is on page 63.

21 Q All right. What does that mean?

22 A The colpo picture?

23 Q Yes, sir.

24 A Basically it just -- just shows some areas of white
25 epithelium and I biopsied the areas at, it looks like 12

1 o'clock, four o'clock and eight o'clock, and I sent
2 those for pathological evaluation and the pathology said
3 eight o'clock benign into cervix, five o'clock focal
4 cytopathic effect consistent with HPV infection, low
5 grade squamous intraepithelial lesion CIN 1. I'll
6 explain that if you want but ---

7 Q So this ---

8 A --- basically ---

9 Q --- this is a test that you'd ordered after her first
10 visit. Correct?

11 A Well, see, her Pap ---

12 Q These are the results?

13 A Yeah, her Pap smear came back as abnormal so generally
14 if we get an abnormal Pap smear, the way we follow that
15 is by doing a colposcopic exam and a colposcopic exam is
16 simply taking a lighted microscope so you can look at
17 the cervix under magnification with light and then we
18 stain the cervix and abnormal areas that we see on the
19 colposcopic evaluation. We can evaluate those, but
20 generally, you know, we take biopsies of the areas
21 suggested by the colposcopic exam and send those to the
22 pathologist and then they give us a pathologic diagnosis
23 of what's going on with her cervix.

24 Q And you did all that?

25 A Yes, ma'am.

1 Q Then Ms. Fulton comes back for her second visit with you
2 and I think that's January 29, 2009, on page 57.

3 A I think ---

4 Q If I missed something tell me.

5 A Nine four, that's page 61, so we discussed her diabetes
6 at that visit.

7 Q Which visit are you talking about?

8 A Well, this is -- I guess this is on 9/4, too. So I
9 dictated a note about the colposcopic exam.

10 Q Okay. That was the finding after the abnormal Pap smear.

11 A Right.

12 Q All right. So ---

13 A So, I mean, you know, we talked about the abnormal Pap
14 smear, but then we talked about her diabetes and her --
15 I mean, her irregular periods and discussed those things
16 while we, at the same visit, went over the colposcopic
17 exam.

18 Q Okay. You're evaluating your patient. You're monitoring
19 your patient. Correct?

20 A Right. Yes, ma'am.

21 Q All right. Let's go to the second visit and it's page 57
22 and the date is January 29, 2009.

23 A Page 57?

24 Q Yes, sir.

25 A I've got 56 and I've got 58.

1 Q I've got a copy.

2 A I think it's out of order in my chart. I'm looking.

3 Q So we can keep moving, do you want to look at my copy?

4 A Yeah.

5 Q All right. Just tell us what her condition was on this
6 date and tell us what you did for her.

7 A This is, this is her history and physical from when she
8 came in for her first pregnancy evaluation and I've got
9 that here, so.

10 Q Okay. So, she was able to get pregnant. Correct?

11 A That's correct.

12 Q All right. So, tell us what her condition was on January
13 29, 2009, as documented in your medical record.

14 A She was certain that her last menstrual period was
15 11/06/08. That gave her a due date of 8/13/09 and that
16 made her estimated gestational age or her ETA 12 weeks
17 and we did an ultrasound that day that the measurement
18 of the crown/rump length, you know, how, the distance
19 from the baby's, top of the baby's head to the bottom of
20 the baby's bottom was consistent with seven weeks and
21 two days.

22 Q Did you do that on ultrasound?

23 A Yes, ma'am.

24 Q Okay.

25 A So, that would make her due date by ultrasound, 9/16/09,

1 and that was later confirmed by the physicians at McLeod
2 Maternal Fetal Medicine.

3 Q All right. So, she comes in on January 29, 2009, and she
4 is pregnant. So, do you take care of her for her
5 prenatal course?

6 A Yes, ma'am.

7 Q So, I think it's a few weeks later you see her on
8 February 12th, 2009, at page 39. Is that right?

9 A Yes, and she's nine weeks pregnant.

10 Q So, she's nine weeks pregnant. How is she doing?

11 A She'd been to the emergency room for abdominal and back
12 pain.

13 Q And what do you do?

14 A And she was having nausea. So, the pain was better at
15 that time. She was having morning sickness or AM nausea,
16 and then we adjusted her diabetic medicine. We increased
17 her Glipizide to five milligrams twice a day and her
18 blood sugars were relatively good at the time so we
19 decreased the requirement for her checking her blood
20 sugars to twice a day.

21 Q Did you carefully monitor her blood sugar, her diabetes,
22 throughout the pregnancy?

23 A Yes, ma'am. I've got, I've got a bunch of blood sugar
24 sheets here and --

25 Q Yeah --

1 A --- you know, we ---

2 Q --- we saw that earlier. The Plaintiff's attorney put, I
3 think they showed one of those blood sugar records. Is
4 this what the blood sugar record looks like?

5 A That's it.

6 Q Okay. How many pages of these blood sugar records do you
7 have in your chart monitoring ---

8 A Well, I was counting, but I got lost.

9 Q I'm sorry.

10 A Let's see. One, two, three, four, five, six, seven,
11 eight, nine, ten, eleven, twelve, thirteen. But some of
12 these sheets overlap. I mean, you know, I've got one
13 printed from 7/28 to 8/4 and then I have a 7/28 to 8/11,
14 so basically when they come in, we Xerox the blood sugar
15 sheet and put it in the chart.

16 Q Were you monitoring her blood sugar?

17 A I was, indeed.

18 Q And it looks from these records that there's a fasting
19 blood sugar. Correct?

20 A That's right.

21 Q Two hours after breakfast, two hours after lunch, two
22 hours after dinner.

23 A Yeah, and that's how we ask them to check their blood
24 sugar so, you know with meals what their blood sugar
25 goes up to.

1 Q All right. Continuing along our time line. You saw her
2 at nine weeks and then you again saw her at 11 weeks. Is
3 that correct? That's February 26th, 2009.

4 A Yes, ma'am.

5 Q You do a random blood sugar. Did you modify the diabetic
6 medication?

7 A That's on 2/26?

8 Q Yes, sir.

9 A Let's see. We increased her Glipizide or Glucotrol to
10 three times a day. She had a hemaglobin A1C that we
11 checked the week before that was elevated at 7.0 so
12 optimally we -- you know, to reduce the risk of heart
13 disease you want it below 6.9 but, you know, in
14 pregnancy we like to achieve tighter control so we'd
15 like to see it below 6.5.

16 Q So, after this visit you see her again three weeks
17 later. Now, she's 14 weeks pregnant and that date is
18 March 24, 2009. Do you see that in your record? We don't
19 have to go through all of them. We just want to
20 establish how many times you saw Ms. Fulton for prenatal
21 care.

22 A I think that time she was complaining of symptoms of a
23 urinary tract infection, however we looked at her urine
24 and it was clear and, you know, we evaluated her and it
25 seemed to be that her uterus was tender so we gave her

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1 some Vittaria to take whenever she had discomfort.

2 Q And then after that visit, I assume maybe because of the
3 discomfort, you saw her just one week later at 15 weeks?

4 A No, that time was -- this was, that's 15, 15 and 5/7ths.
5 She had an abnormal AFP.

6 Q What does that mean?

7 A It was elevated slightly. I mean, the risk of Down
8 Syndrome was given as 1/181 so admittedly, you know,
9 this wasn't a real high elevation but anything over
10 1/180 is considered elevated and with her maternal age
11 being 37, we gave her the option of what to do and ended
12 up referring her to McLeod Maternal Fetal Medicine for a
13 consult concerning her risk of Down Syndrome.

14 Q Did you discuss with Ms. Fulton the abnormal AFP?

15 A Indeed.

16 Q Based on your observations did she understand what you
17 were relaying to her regarding that abnormal finding?

18 A Yes, ma'am.

19 Q And then you said you actually referred to her high
20 risk?

21 A To, yeah, to the maternal fetal medicine doctors at
22 McLeod. The maternal fetal medicine doctors from
23 Charleston come up to McLeod and do a clinic. I think it
24 generally has been on Tuesdays but they see patients, do
25 ultrasounds, consult and also consult in the hospital.

1 Q And who made that referral?

2 A I did.

3 Q And it's actually documented in your chart on April 6,
4 2009, that the AFP was discussed with Ms. Fulton. Is
5 that what you just testified to?

6 A Yes, ma'am.

7 Q All right. And it says that you set up an appointment at
8 a perineonatologist?

9 A That's right.

10 Q Who did that?

11 A I'm looking for that. Here it is. That's on page 42 and
12 the ultrasound is page 95 and then 96 is the comment.
13 Patient was seen by one of our genetic counselors. The
14 risk of fetal chromosome abnormalities was reviewed with
15 options for prenatal diagnosis. A letter detailing that
16 encounter will follow under separate cover. Patient
17 declined amniocentesis for karyotype.

18 Q Okay.

19 A And that was Donna Johnson, Dr. Donna Johnson from
20 Charleston, who saw her.

21 Q That's Dr. Johnson that works at the Medical University?

22 A That's right.

23 Q Okay. So, that was at 16 weeks. Looks like you see her
24 three weeks later at 19 weeks and the date is April
25 28th, 2009. Based on your review of the record, what

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1 were you concerned about at this time?

2 A April the 28th?

3 Q Yes, sir.

4 A Again, about her diabetic control. I noted that her
5 blood sugars were out of control, so we increased her
6 Glipizide to 7.5 milligrams three times a day with
7 meals.

8 Q Who's making these changes to her medication?

9 A Me.

10 Q Who's following this patient who's pregnant?

11 A Me.

12 Q Who's monitoring Ms. Fulton?

13 A I was.

14 Q All right. Next time you see her it looks like it's 22
15 weeks. This is three weeks later.

16 A Well, another point was the perinatologist had
17 recommended that because of her diabetes that she get a
18 fetal, I mean, a fetal echo so we referred her to Dr.
19 Dent in town for the echocardiogram on the baby.

20 Q So, did you make that referral?

21 A I think so.

22 Q All right. Now, going to May 13th, 2009, 22 weeks
23 pregnant. It looks like there was another visit and you
24 were a little, you were happier with the blood sugar.

25 A Yeah. I made the comment that the blood sugars after

1 dinner were a little bit high at 167 to 177 and we
2 discussed decreasing her carbs at dinner time but, you
3 know, they were good enough that we told her to decrease
4 her blood sugars to twice a day.

5 Q Who -- when you say "we" discussed, who discussed with
6 Ms. Fulton about monitoring her carbs and keeping her
7 diabetes in check?

8 A I did.

9 Q You had those conversations?

10 A Yes, ma'am. And usually I give them a, I have a diabetic
11 diet handout that I give them and I may have given it to
12 her at that visit or earlier.

13 Q Next, you mentioned the fetal echo. The date appears to
14 be May 22, 2009. Who ordered that? Was that ordered by
15 you or Dr. Johnson from MUSC?

16 A I think she suggested it and I think we followed up and
17 ordered it. Here's the...

18 Q When you would receive these reports, like, we've
19 already gone through the AFP that was abnormal, but when
20 you would receive the report from the doctor who
21 performed the fetal echo, who would relay the results to
22 Ms. Fulton?

23 A I would.

24 Q You would?

25 A Yes, ma'am.

1 Q Who was updating Ms. Fulton throughout her prenatal
2 course regarding any of the issues or problems that she
3 had and treatment that she needed? Who was educating
4 her and giving her that information?

5 A Me.

6 Q All right. After the echo it looks like at 25 weeks, she
7 came in for another office visit and that date was June
8 3, 2009, and it's on page 36. Tell us what you did for
9 this visit.

10 A June the 3rd, 2009. Her random blood sugar in the office
11 was 111. Evidently, blood sugars on the sheet were
12 elevated, so at that point in time we decided to convert
13 her from oral hypoglycemic agents to insulin, so we
14 started her out on NPH 20 units twice a day.

15 Q Who made that modification?

16 A I did.

17 Q Did you explain that to Ms. Fulton?

18 A Yes, I did.

19 Q Why would you explain all of these changes in the
20 medication? Why would you explain the results of the
21 tests that you were ordering? Why were you explaining
22 this to Ms. Fulton?

23 A It was part of her prenatal care.

24 Q And it looks like she missed an appointment on June 5,
25 2009, but she came in for the next visit, which was June

1 15, 2009.

2 A That was just a note in the chart by the nurse.

3 Q Okay. And what does that note say?

4 A Patient called with pain, with cramps, lower abdomen and
5 back. Spoke with Cindy at Dr. Dent's office on call and
6 she advised to send her MPMC. We faxed the records
7 over.

8 Q What is MPMC?

9 A That's McLeod Regional Medical Center. We also ordered
10 her RhoGAM at that time too, since she was RH negative.
11 I'm sorry.

12 Q Excuse me?

13 A She also had the order for RhoGAM. The mother's blood
14 type was O negative, or RH negative, and so in order to
15 prevent a possibility of developing an antibody to the
16 baby's blood they get RhoGAM.

17 Q Who made that order?

18 A That's kind of a standard. We usually do that about 28
19 weeks and then, you know, we check the baby after the
20 baby's born to, if the baby is RH positive, then we give
21 them another RhoGAM shot at the end of the pregnancy.

22 Q All right. Now, 27 weeks, it appears like the next
23 office visit was on June 22, 2009, and it's in your
24 records on page 36.

25 A Right.

1 Q What's happening?

2 A This is, you know, when I saw her in the office she'd
3 gone into McLeod as per Dr. Dent and evidently was
4 having some contractions, so Dr. Dent treated her with
5 some terbutaline and stopped her contractions.

6 Q What's terbutaline?

7 A Terbutaline is, it's actually an agent that they use for
8 diabetes. It's a bronchodilator, but it's been shown,
9 you know, to be very effective at stopping uterine
10 contractions. We used to use it in a terbutaline pump in
11 days gone by but, you know, it has some side effects so
12 we switched to other things, other agents.

13 Q Okay. After she was given the terbutaline for early
14 contractions, what happened?

15 A Well, Dr. Dent put her on Nifedipine which is, it's an
16 oral anti-hypertensive, but it also has an off-label use
17 as stopping or preventing pre-term contractions.

18 Q Did you discuss these medications with Ms. Fulton on her
19 next office visit?

20 A Yes.

21 Q Okay.

22 A As a matter of fact we -- you know, she was having to
23 take it three times a day so we put her on an extended
24 release tablet that she only had to take once a day.

25 Q That was June 22, 2009. Moving on to -- let me ask you,

1 based on those pre-term contractions that she was
2 having, did you put her on bed rest?

3 A Yes, she was.

4 Q Who made that decision?

5 A I think that was me. I've got bed rest here in the
6 chart, but I'm not sure if I was the one that ordered
7 it. You know, on the 22nd, I said continue bed rest.

8 Q Did you communicate to Ms. Fulton the importance of bed
9 rest and staying off of your feet because of the
10 pre-term contractions?

11 A Right.

12 Q Did you have that conversation with Ms. Fulton?

13 A Well, you know, it hasn't been proven, but it certainly
14 does seem to help and so it's better to err on the side
15 of too much than too little.

16 Q During all these conversations that you would have
17 during these various office visits and the tests that
18 you were ordering, did you have any concern that Ms.
19 Fulton did not understand what you were communicating to
20 her?

21 A No, she was a very compliant patient.

22 Q Now, on page 35, you saw Ms. Fulton again on June 29,
23 2009. She's now 28 weeks pregnant.

24 A Yeah.

25 Q Looks like you measured her uterus.

1 A Well, that's the same -- same day. I dictated a note on
2 that day because there was a lot going on so I dictated
3 a note.

4 Q Okay. Got it. So, let's go two weeks later. Looks like
5 30 weeks.

6 A Well, also one thing ---

7 Q Yes, sir.

8 A --- on that note, you know, she'd gone to McLeod and her
9 labor was stopped, but Dr. Dent sent her in for a
10 Celestone series.

11 Q What does that mean?

12 A That's -- we give them steroids to help mature the
13 baby's lungs, so they get a shot of 12 milligrams of
14 Celestone 24 hours apart so she'd gone in for a
15 Celestone series, or a steroid series.

16 Q So, the steroid series, the purpose is what?

17 A To mature the baby's lungs.

18 Q Did you communicate that to Ms. Fulton?

19 A Yes, ma'am.

20 Q Did you have any concern that she didn't understand why
21 she was receiving steroid shots?

22 A No. Another thing, you know, Dr. Dent had done an
23 ultrasound to measure her cervical length and then I did
24 a cervical length measurement and it was, it was okay.
25 It was 2.94.

1 Q Now, when, when Ms. Fulton went to see Dr. Dent and he
2 checked Ms. Fulton and his findings, were those findings
3 relayed to you?

4 A Yes, ma'am.

5 Q Do doctors communicate with each other when they share a
6 common patient?

7 A Yes.

8 Q Did that happen in this case?

9 A Yes. I've got a copy of his note and I think we have a
10 copy of his ultrasound.

11 Q All right. Now, moving to, I think, the next one is July
12 13th, 2009.

13 A Right.

14 Q That's page 34 in your record.

15 A Right.

16 Q Looks like she's still on bed rest and her blood sugars
17 look good.

18 A Random blood sugar was 121, a teeny bit high, but she
19 could have had something to eat on the way but evidently
20 from the blood sugar she -- they were all good, all less
21 -- I mean, the postprandials or after meals were less
22 than 140, which is where we like to keep them.

23 Q Any concern on this day at 30 weeks, July 13, 2009?

24 A Well, she's on Nifedipine, 30XR to prevent pre-term
25 labor, but the cervical exam or cervix was two to three

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1 centimeters, 50 percent, but minus three.

2 Q Now, it looks like from your records that you now see
3 her once a week. Why is that?

4 A Just following her blood sugars. We're doing -- we did a
5 non-stress test to check on the baby's well-being.

6 Q Okay. What was the non-stress test finding?

7 A It's kind of -- you know, it's either positive or
8 negative or somewhere in between but if it's a reactive
9 test, that means they have 10 to 15 beat acceleration
10 for 10 seconds during a strip of 20 minutes.

11 Q Was the results of the nonstress test relayed to Ms.
12 Fulton?

13 A Generally, you know, we go -- I mean, they're on the
14 monitor in our office and, you know, usually we put them
15 on the monitor and pop in and out and look at the strip
16 and, you know, once it's reactive then we take them off
17 the monitor and let them go home and generally tell them
18 your strip is reactive.

19 Q Who is doing that?

20 A The nurse puts them on and then I check the strip.

21 Q Okay. So now we're on a one-week follow up. You see
22 her next at July -- I think the next one is July 20th,
23 2009. She's 31 weeks; correct?

24 A Yeah.

25 Q Was she still on bed rest?

1 A Yeah.

2 Q All right. Next week, July 27th, 2009, 32 weeks.

3 What's going on with her pregnancy?

4 A Blood sugar -- random blood sugar was okay, cervix 4 to
5 5. Now she's more effaced. We did a non-stress test and
6 it was reactive.

7 Q What does it mean to be more effaced?

8 A It's thinned out. The cervix is thinned out. Typically,
9 when the head, the fetal head comes down and is applied
10 to the cervix, generally the cervix is, you know, two,
11 maybe three centimeters but, you know, as they approach
12 term not only does the cervix dilate or open up, but it
13 effaces and it thins out.

14 Q Is that normal or abnormal?

15 A That's normal.

16 Q It means the baby's coming?

17 A Yeah.

18 Q All right.

19 A But, you know, it's abnormal in the fact that she's 32
20 weeks here.

21 Q All right. That is July 27th, 2009. Is that right?

22 A Yeah.

23 Q All right. Next one, one week later, July 30th, 2009.
24 What's going on at this visit?

25 A July 30th, checked her cervix. It was unchanged. She

1 complained of contractions every 10 minutes. Blood
2 sugars were good.

3 Q Then the next one is at page 33 in your record. She's
4 33 weeks.

5 A Closer to 34.

6 Q Okay. What about her uterus? It looks like you measured
7 it. What was the significance of the measurement?

8 A There I think -- her fundal height on that day was 43.
9 That's just the height of the top of the uterus, you
10 know, when measuring from the symphysis pubis to the
11 top.

12 Q Why did you document on this day that the head -- it
13 says head out of pelvis. What does that mean?

14 A Well, just when I do a cervical exam that means the head
15 is still high. It's not slammed against the cervix and
16 down in the pelvis.

17 Q All right. Let's go to the next week. We see her at 34
18 weeks. That's August 11, 2009.

19 A That's -- she's close to 35 there.

20 Q Close to 35. Okay.

21 A She's 34 6/7ths, so that's 35.

22 Q Yes, sir. How is she doing?

23 A Her cervix was soft and maybe two centimeters, 25
24 percent so, you know, generally we discontinue the
25 Nifedipine after 35 weeks, so I discontinued her

1 Nifedipine the following week.

2 Q Did you communicate that to Ms. Fulton?

3 A Yes.

4 Q Did she appear based on your observations to understand?

5 A Yes.

6 Q All right. One week, next week, it looks like August
7 17th, 2009.

8 A Right.

9 Q What do you document about this visit?

10 A She complained of pressure. She complained of swelling
11 in her ankles. Complaints of body aches all over. Blood
12 sugars were good. Her cervix was four, 50 percent minus
13 two. We discontinued the Nifedipine. She's close to 36
14 weeks.

15 Q What is causing the pressure in the pelvis that you
16 mentioned?

17 A That's the baby's head.

18 Q The next week the uterus is measuring 44 weeks and the
19 date of this is August 19, 2009. What significant
20 findings are documented on this office visit?

21 A Well, basically she'd been to McLeod the previous night
22 and was evaluated in labor and delivery and was having
23 some uterine contractions.

24 Q Can I stop you right there? You said that she was at
25 McLeod the night before.

1 A Right.

2 Q Why did she go to McLeod?

3 A I'm not sure.

4 Q But she was having some ---

5 A She was having ---

6 MR. GRAHAM: Objection, Your Honor. I've been trying not
7 to object to the leading but at this point, I must ---

8 THE COURT: I'll sustain the objection, but just one
9 moment. Let's let the jury stand up and stretch for just one
10 moment. Madam Forelady, ladies and gentlemen of the jury,
11 we're going to allow you to retire to the jury room and
12 refresh yourselves and we'll be back in, momentarily. Do not
13 discuss the case.

14 (Jury out at 5:17 PM)

15 THE COURT: We'll stand at ease for about five minutes.
16 We had some of the jurors wanting to use the restroom.

17 MS. Craig: Your Honor.

18 THE COURT: Yes, ma'am.

19 MS. Craig: I know Mr. Graham didn't care about juror
20 number 21 sleeping in his case, but he is, he is sleeping
21 still, and I just want to bring it to the Court's attention.

22 THE COURT: What is the Plaintiff's position?

23 MR. GRAHAM: I haven't noticed any significant difference
24 from the last time.

25 THE COURT: It's kind of odd that Mr. Graham did not

1 object to him sleeping during his presentation, which would
2 have been most important to him, and you objected when he was
3 sleeping during his presentation. Seems like, it seems kind
4 of odd, but at any rate, I think that he is doing fine. I've
5 watched him consistently. His head is not nodding. He just
6 looks downward or closes his eyes and we'll continue to
7 monitor him. We do have two alternate jurors and we'll
8 monitor his activity for the balance of the trial. We'll
9 stand at ease for five minutes.

10 (Brief break)

11 (Jury in at 5:24 PM)

12 THE COURT: Ms. Craig, you're recognized.

13 MS. CRAIG: Thank you, Your Honor. May it please the
14 Court.

15 CONTINUED DIRECT EXAMINATION

16 BY MS. CRAIG:

17 Q August 19, 2009, that's where we left off and actually a
18 'good place to leave off, because it's looks like it was
19 the last prenatal visit.

20 A That's correct.

21 Q Okay. How many weeks pregnant was Ms. Fulton on this
22 visit?

23 A Thirty-six and 07ths.

24 Q Okay. And tell us what your findings were based on your
25 medical record on this last prenatal visit.

1 A She was five centimeters dilated.

2 Q Okay. What does it mean to be five centimeters dilated?

3 A That's, kind of halfway there.

4 Q That's pretty dilated.

5 A Ten centimeters is complete cervical dilation ---

6 Q Okay.

7 A --- so she was over -- I mean, she was five centimeters
8 dilated. She'd been having uterine contractions. We had
9 stopped the Nifedipine. She, you know, when they're over
10 35 weeks and they've had pre-term labor then, you know,
11 the tradition is to stop the Nifedipine or whatever
12 you're using to inhibit labor at that time.

13 Q And how did you determine that Ms. Fulton was five
14 centimeters dilated on August 19, 2009?

15 A I did a cervical exam on her, as I did with each
16 previous exam.

17 Q What's the difference between a cervical exam and a
18 vaginal exam?

19 A Well, the same thing essentially. Yeah. I mean, you
20 could do a -- well, if you did a vaginal exam you'd be
21 checking the cervix too. I was, kind of, thinking maybe
22 there was a difference between a gynecology patient and
23 an obstetrics patient, but in gynecology you check the
24 cervix too.

25 Q Based on the fact that Ms. Fulton was five centimeters

1 dilated on August 19th, 2009, do you have an opinion
2 whether induction was reasonable?

3 A Yes, and we discussed that. I mean, she lived in Olanta,
4 I think, and, you know, a fair distance from the
5 hospital so if you're walking around and you're five
6 centimeters dilated and all of a sudden you decide to go
7 into labor at two o'clock in the morning and it takes a
8 while to get to the hospital, you might be having the
9 baby in Scranton or some place on the way to the
10 hospital.

11 Q All right. What discussions, Dr. Goldstein, do you have
12 with your patients to provide informed consent regarding
13 the delivery of their babies?

14 A Usually when -- you know, as we approach term we
15 discuss, you know, various things that they are to
16 expect when they go into labor. You know, they're going
17 to go into labor some time so, I mean, we discuss these
18 things. You know, I noted on the chart that we had
19 discussed tubal ligation at some time in the past. We
20 discussed anesthesia. I generally ask them if they, you
21 know, if they want an epidural or not and generally, you
22 know, there's a discussion about vaginal delivery versus
23 C-section delivery and I generally tell them that, you
24 know, you've had a baby before so the probability is
25 high that you'll have another vaginal delivery.

1 Q Why do you have these conversations with your patients
2 during the 19 plus prenatal visits that you may have
3 with any patient?

4 A Well, it's just a part of the, a part of the care that
5 we provide.

6 Q And how do you know that you provided informed consent
7 to Ms. Fulton?

8 A We -- like my other patients, we discuss these issues
9 when they come in, you know, especially when, you know,
10 they get above 32, 34, 36 weeks.

11 Q And did you relay all medical information to Ms. Fulton
12 regarding the tests that you ordered, the tests other
13 doctors ordered, the treatment, the changing in
14 medication, the bed rest and the delivery ---

15 MR. GRAHAM: Objection, Your Honor.

16 THE COURT: I'll overrule. I'll allow her some leeway in
17 that regard.

18 MS. CRAIG: Thank you.

19 Q Dr. Goldstein, did you relay the medical information to
20 Ms. Fulton related to the medication, the treatment
21 changes that you made, the tests and the results of
22 those tests that you ordered? Did you relay that
23 information to Ms. Fulton?

24 A Yes.

25 Q And did you also relay to her adequate informed consent

1 for delivering this baby?

2 MR. GRAHAM: Objection, Your Honor. Leading.

3 A Yes.

4 THE COURT: Overruled.

5 MS. CRAIG: Your Honor, may I have permission to have
6 Dr. Goldstein come down and explain a couple of medical
7 illustrations?

8 THE COURT: Certainly.

9 MS. CRAIG: Thank you.

10 Q So Dr. Goldstein, if you will come down. Let's start
11 with this one.

12 COURT REPORTER: Could he stand on the other side,
13 please?

14 MS. CRAIG: Yes, certainly.

15 COURT REPORTER: Thank you.

16 MS. CRAIG: Dr. Goldstein, if you'll stand right here and
17 I need you to speak loudly.

18 DR. GOLDSTEIN: Okay.

19 MS. CRAIG: Let me mark this as a Court exhibit.

20 (Whereupon, a large medical illustration of a normal
21 delivery/shoulder dystocia is marked as Court's Exhibit #11)

22 Q All right. We've marked as a Court's Exhibit,
23 Defendant's #1. Explain to us, we've got a normal
24 delivery on the left side and a shoulder dystocia on the
25 other, so explain to us what we're seeing on a normal

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1 delivery and then I want you to show us what's going on
2 when shoulder dystocia is encountered.

3 A Well, this is a normal vaginal ---

4 Q You have to speak up.

5 A --- normal vaginal delivery and the uterus is
6 contracted. There's not that much free space here
7 between ---

8 Q Doctor, you've got to come back here so everybody can
9 see. That's okay.

10 A I can't see ---

11 Q Okay. I know. You've just got to lean over. Just do
12 that.

13 A All right. Here's the baby's bottom and there's the
14 uterus. This looks like the placenta there and so the
15 baby's head is delivered here. The head is out and so
16 in this, the shoulders are kind of rotated to the side
17 so the anterior shoulder has slipped under the symphysis
18 pubis right there. Here's the ---

19 Q What's the symphysis pubis? We've heard that a lot.
20 Show us.

21 A That's the pubic bone ---

22 Q Okay.

23 A --- right there.

24 Q Got it.

25 A Okay. And here's the sacral promontory. So, the

1 posterior shoulder is, you know, the baby's shoulders
2 are kind of twisted and so it slid out between this
3 obstruction, if you will.

4 Q All right. Now, you come over here and tell us what you
5 see on this side of the Defendant's #1.

6 A All right. And this depicts the shoulder dystocia. So,
7 here the head is delivered. This is the, I guess the
8 cervix right there but, you know, again, here's the
9 placenta and here's the baby's bottom and here's the
10 anterior shoulder and it's more of in a straight up and
11 down plane, so the anterior shoulder is stuck under the
12 symphysis pubis right here and the posterior shoulder is
13 stuck against the sacral promontory right there.

14 Q Okay. Thank you. Stay right there. All right. I've got
15 another one.

16 MS. CRAIG: We'll mark it as #2.

17 COURT REPORTER: Will this be a court's exhibit?

18 MS. CRAIG: Yes.

19 COURT REPORTER: Okay. This will be Court's #12.

20 (Whereupon, a large medical illustration of the crowning
21 of a baby's head is marked as Court's Exhibit #12)

22 MS. CRAIG: I'm sorry. So, the first one was Court's
23 Exhibit #11 that we just went through and this one is Court's
24 Exhibit #12.

25 Q So, tell us what we are seeing in this medical

1 illustration.

2 A Well, this is virtually the same as the last exhibit
3 here. Here's the baby's shoulder. Basically, the baby's
4 at a higher station. Here's the cervix right here and so
5 the baby's crowning. The head is just presenting at the
6 vaginal opening there, so ---

7 Q Now, explain to us, in this situation, is the baby
8 getting oxygen?

9 A The baby should be getting oxygen. I mean, here's the
10 placenta, but you can't see the cord here so, you know,
11 the cord could be, you know, trapped between the back of
12 the head, or the cord could be wrapped around the neck.
13 I've seen as many as three wraps around the neck. I've
14 seen true knots, double true knots in the cord, but, you
15 know, we can't see the cord so, you know, the baby
16 should be getting adequate oxygen.

17 Q When you say it's wrapped around the neck, what are you
18 talking about?

19 A I mean some babies have long umbilical cords and during
20 the process of growth and development the cord becomes
21 looped around the neck and, you know, sometimes it can
22 be real tight and that can -- you know, when the baby
23 has a contraction, or when the mother has a contraction
24 and pushes on the baby and pushes the baby down, the
25 cord can constrict around the neck and it doesn't cut

1 off the breathing of the baby, but it cuts off the blood
2 supply to the baby which is where the baby gets the
3 oxygen.

4 Q All right. One more?

5 A This next one is pretty much the same one that we talked
6 about before. Here's the anterior shoulder stuck behind
7 the symphysis pubis. The posterior shoulder. You can see
8 the head is delivered and rotated.

9 (Whereupon, a large medical illustration of McRoberts
10 maneuver is marked as Court's Exhibit #13)

11 Q Okay. Thank you. This is Court Exhibit #13. Tell us what
12 we are seeing on this medical illustration.

13 A Well, this is shoulder dystocia during delivery,
14 McRoberts maneuver with simultaneous suprapubic
15 pressure.

16 Q Would you like to use this? (Referring to laser)

17 A Does it work?

18 Q That's a good question. There you go.

19 A Here's -- here's the mother's feet and so there -- I
20 can't remember if this is extended or flexed, but the
21 knee goes up towards the armpit.

22 Q And that's what I want -- so what is this?

23 A That's the knee.

24 Q So that's the -- that's the mama's knee is all the way
25 back.

1 A Right.

2 Q Now, keep going, please.

3 A So, I assume the other leg is back, so they're extended
4 and abducted, so the knee goes out and so that's the
5 McRoberts.

6 Q Okay.

7 A And the same guy that looks like he's holding the foot
8 is doing suprapubic pressure, so here's the symphysis
9 pubis right there. He's pushing down with the ball of
10 his hand and trying to dislodge the anterior stuck
11 shoulder from behind the symphysis pubis and basically
12 that just, you know, it can dislodge it under there or
13 it could rotate the shoulders posteriorly towards the
14 baby's back or anteriorly and that changing the position
15 tends to free up the action.

16 Q Explain -- this looks like a fist. What is this? What's
17 going on here?

18 A That's the suprapubic pressure. That's the attendant, or
19 whoever, putting pressure just above the pubic symphysis
20 in conjunction with McRoberts.

21 Q Okay. Thank you, sir. You can go back to the stand
22 please.

23 Q Dr. Goldstein, what is gentle downward traction?

24 A I guess gentle downward pulling on the baby or guidance.
25 It's a term that's difficult to quantitate but, you

1 know, in medical school and residency we learn what
2 gentle downward traction is.

3 Q Explain why during every delivery, not just in shoulder
4 dystocia, but why in every delivery some traction is
5 needed to help deliver the baby. Explain that.

6 A Well, basically, you're guiding the baby out of the
7 birth canal and some degree of pulling or guidance or
8 traction is necessary to get the shoulders delivered out
9 of the pubis. I mean, generally, the head delivers and
10 then you still need to get the anterior shoulder
11 delivered and then the posterior shoulder and once you
12 get the two shoulders delivered, basically it's a matter
13 of catching the baby as the baby falls out by gravity.

14 Q Explain how you and an obstetrician knows how -- what
15 the appropriate amount of traction is to use during a
16 delivery. How do you know that?

17 A Well, I guess we were -- I mean, we started out in
18 medical school when we did our OB rotation and did our
19 first deliveries and then when we were residents, you
20 know, we generally did, even as interns, you know, our
21 upper residents did deliveries with us and our
22 attendings did deliveries with us and they instilled on
23 us the proper traction to deliver a baby.

24 Q And how do you know that you used gentle downward
25 traction during this delivery?

1 MR. GRAHAM: Objection, Your Honor. Leading.

2 THE COURT: I'll overrule the objection.

3 A Because that's what I do in all my deliveries. I've done
4 over 3,000 deliveries in my lifetime and, you know, I do
5 them pretty much all the same.

6 Q How many times have you ever used excessive traction in
7 a delivery?

8 A None, that I know of.

9 Q Did you do it in this case?

10 A No.

11 Q How many other shoulder dystocias have you encountered
12 throughout your practice, that you can recall?

13 A About five or six.

14 Q And tell us how you -- did you resolve those shoulder
15 dystocias?

16 A Yes.

17 Q Okay. How did you do it?

18 A Generally, all of them resolved with McRoberts and
19 suprapubic pressure.

20 Q And how many times have you had to use a rotational
21 maneuver?

22 A I don't think I've ever had to use a rotational
23 maneuver.

24 Q Does that mean you don't know how to use -- do one?

25 A No, ma'am.

1 Q Tell us about that.

2 A We -- like, in residency we've been instructed in the
3 proper performance of Rubin's and Woods and posterior
4 arm. We study it in our textbooks. There's also review
5 articles that come out and update precise, those kind of
6 things, that go over this.

7 Q You've been sitting here as well as everybody else for
8 the past several days. There's been testimony about your
9 knowledge and experience. My question to you is, Dr.
10 Goldstein, do you have the knowledge and experience to
11 manage the obstetrical emergency of a shoulder dystocia?

12 A Yes, ma'am.

13 Q Did you do that in this case?

14 A Yes, ma'am.

15 Q And how long did it take to deliver the baby?

16 A About, less than five minutes.

17 Q Let's walk through, now, the delivery. We've gone
18 through the prenatal care and treatment that you
19 provided to Ms. Fulton. Now, I'd like to move to the
20 delivery and I've got a blow-up of your history and
21 physical. Just one second and I will get that for you.
22 Let's pull it up. Doesn't look like we have a blow-up of
23 it right here, but let's pull it up on the screen and
24 doctor, we will now be moving to the hospital chart
25 that's in evidence. Back when I asked you if you had the

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1 knowledge and the experience how to handle the
2 obstetrical emergency of a shoulder dystocia, what was
3 your answer?

4 A Yes, ma'am.

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

7 A Yes, ma'am.

8 Q Now, let's move on to the actual delivery. Looking at
9 the history and physical and it's page 22 and 23.

10 A Is that on the hospital record?

11 Q Yes, it looks like it was on the hospital record. Let me
12 see if I ---

13 A No, it's not on mine.

14 Q All right. Well, they are pulling up the H and P. What
15 number is it? Oh, excuse me. I'm sorry. It's your
16 record. I told you to go to the hospital records.
17 Actually, do you, as the delivering physician, does the
18 hospital send you the records of the delivery?

19 A Yes, ma'am.

20 Q Okay. Do you keep those in ---

21 A Yes.

22 Q --- the chart of your patient?

23 A Yeah. I have it.

24 Q Let's go back. Sorry about that If you want the
25 hospital record, it's here, but we think we can, do it

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1 all through your chart.

2 A It'll be easier.

3 Q All right. Just let me know when you're there.

4 A I'm there.

5 Q Okay. All right. Let's start from the beginning. It
6 looks like the date of admission is August 20th, 2009.
7 Is that correct?

8 A That's correct.

9 Q What was the purpose of the admission to the hospital?

10 A Admitted for induction.

11 Q All right. Tell us about the present illness and it's
12 going to be blown up on the screen.

13 A Simply read it or ---

14 Q Yeah, let's first read it so that we all know exactly
15 what you documented and then we'll ask you some
16 questions.

17 A Ms. Fulton is 38 years old ---

18 Q Speak up please, doctor.

19 A Ms. Fulton is 38 years old, AAF G2, P1, 001. That means
20 she's been pregnant twice, she's delivered a full-term
21 once, she's had no pre-terms and no miscarriages or
22 abortions and one living child.

23 Q All right. Please continue.

24 A LMP, last menstrual period November 6th, 2008, making
25 EDC by dates August 13th, 2009. Ultrasound gave an EDC

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1 of August 16th. That's a mistake. It should have been
2 September the 16th.

3 Q Okay.

4 A ETA by ultrasound is 36 weeks. She admitted at this time
5 for induction of labor secondary to gestational diabetes
6 and pre-term labor with cervix dilated to five, 75
7 percent effaced. Five centimeters dilated, 75 percent
8 effaced.

9 Q Doctor, let me stop you right there. So, is this history
10 and physical, is the five centimeters dilated, is that
11 consistent with your office note that we've already gone
12 through?

13 A Yes, ma'am.

14 Q Okay. All right. Please continue. She has repeated
15 complaints of...

16 A She has been to McLeod a number of times complaining of
17 contractions, most recently on August the 18th, where
18 she was evaluated for regular uterine contractions.
19 Most recently when she -- her cervix did not progress
20 beyond five centimeter, dilated state. She has had
21 repeated complaints of pelvic pressure, pelvic pain, et
22 cetera. She has other problems with type two diabetes
23 mellitus. Initially, on her first exam she had a history
24 of being diabetic and, and was being treated with
25 Glucotrol XL 2.5.

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1 Q What is that? Is that the diabetic ---

2 A Yeah.

3 Q Sir?

4 A That is. Glucotrol is Glipizide with Metformin.

5 Q Okay. For what condition?

6 A For her diabetes.

7 Q Okay.

8 A However, her random blood sugar at that time was 216 and

9 hemoglobin A1C on admission was 8.1. Patient was

10 instructed on four-times-a-day blood sugar monitoring

11 and eventually we switched her over to dosing with NPH

12 insulin 20 units twice a day.

13 Q Did she do that? Did she do the blood sugar monitoring
14 as you suggested?

15 A Yes.

16 Q Okay.

17 A She was very, very good with that.

18 Q Okay.

19 A Her two-hour postprandials have been less than 130.

20 Q What does that mean, postprandials?

21 A That's the blood sugars that we check after breakfast,
22 lunch and dinner.

23 Q All right.

24 A After meals.

25 Q Finish this up?

1 A Yeah. She's thought to have PTO-type pitcher. She also
2 has a history of diverticular disease and kidney
3 infection in the past. In March of 2008, she was
4 hospitalized at Lake City diagnosed with diverticular
5 disease.

6 Q Okay. So, that's the present illness. Whose document is
7 this? Who dictated this note?

8 A I did.

9 Q And then you have allergies and then let's not go
10 through everything. This is a very detailed note so
11 under allergies, what's the next? It says -- what's the
12 next big topic?

13 A Well, about her past history and then pertinent physical
14 findings, pelvic five centimeters, 50 percent minus two.
15 Membranes were artificially ruptured. Scalp electrode
16 placed. Pit is running and uterine contractions about
17 every three to four minutes.

18 Q All right. Why do you put a fetal electrode, the scalp
19 electrode on the baby? Why do you do that?

20 A Because it maintains the baby's fetal heart tracing a
21 lot better than the ultrasound external monitor because,
22 you know, when the uterine contracts, when the baby
23 moves, it moves the heart rate off the signal so with
24 the scalp electrode which is just a little, a little
25 wire in a screw-type fashion, we screw that into the

1 baby's scalp and it records their fetal heart rate
2 tracing more effectively.

3 Q Is that internal of external?

4 A It's internal.

5 Q And externally, where is the fetal monitor?

6 A Externally, there's a contraction monitor which is more
7 towards the fundus of the uterus and then there's a
8 fetal heart tone monitor which is an ultrasound monitor
9 and it's more where the baby's heartbeat is best picked
10 up on the mother's abdomen and generally that's over the
11 back.

12 Q Okay. And then if we go to the second page of your
13 history and physical, and again we're not going to go
14 through all of this detail, but at the top it looks like
15 cardiovascular abdomen extremities pelvic and then you
16 do a full assessment. There are nine points to your
17 assessment. Is that correct?

18 A I guess, yeah.

19 Q Okay. And down at the bottom that's your -- you dictated
20 this and then is that your signature, your electronic
21 signature?

22 A No.

23 Q Okay.

24 A That's where my signature should be but, you know, the
25 ones we send to the office I don't sign them. I do sign

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1 them when I read them.

2 Q Does this appear to be an accurate history and physical
3 of Ms. Fulton when she came in to deliver her baby on
4 August 20th, 2009?

5 A Yes, 'ma'am.

6 Q These were the findings based on your evaluation of her
7 at that time?

8 A Yes, ma'am.

9 Q All right. Now, let's walk through, I want to go through
10 the delivery and so let's start with going through the
11 nurses' notes and then we're going to go through your
12 handwritten notes and we're going to go through your
13 dictated notes, but first of all, explain to us what the
14 nurses are documenting during a delivery.

15 A Well, let me have an example of what page we're talking
16 about.

17 Q Sure. If you look at the nursing notes, and this is in
18 the hospital chart, looking at page, starting at page
19 155. Just generally, if you can tell, tell us -- explain
20 the nurse's document throughout labor and delivery.

21 A Well, the one I'm looking at is -- did you say 1...

22 Q 155.

23 A Okay. Okay. Yeah, these are actually postpartum notes.

24 Q Okay.

25 A The mother's already delivered.

1 Q All right. I don't want postpartum. I want the notes
2 from during the delivery.

3 A Uh-huh.

4 Q And I want to start -- the first note from the delivery
5 from the nurse was at six o'clock when the Pitocin was
6 started.

7 A Do you have a page reference?

8 Q Yeah, I'm going to look for that. I'll let them look for
9 that. If you'd look for that for me while we keep
10 moving.

11 A This is, kind of, what I was looking through before when
12 we flipped through earlier or when I flipped through
13 earlier.

14 Q So, let's start with page 140.

15 A Uh-huh. There you go.

16 Q All right. Are we on the right page now?

17 A Yes.

18 Q All right. Let's just back up ---

19 A This is a labor progress chart so this is while she's in
20 labor. This is what the nurses are recording while she's
21 in labor.

22 Q And that's my question. Is that common? Is that -- do
23 the nurses document ---

24 A Yes.

25 Q --- during labor and delivery? Okay.

1 A So, their first note was, like, at 6:15.

2 Q All right. So, at 6:15, what's going on?

3 A Well, there are two sides to this, but their first note
4 was, admitted to unit for induction. Consents explained
5 and signed. Admission paperwork done. IV started times,
6 one attempt.

7 Q Let's -- let's highlight that right there. On the first
8 line it says admitted to unit for induction. Consents
9 explained and signed. What, what consent is that
10 referencing?

11 A I imagine that's the standard consent.

12 Q Okay. Consent for what?

13 A Consent for delivery.

14 Q Okay. So, based on these nursing notes, was Pitocin
15 started?

16 A Let's see. They started her IV. It was infusing well.

17 Q Let's talk about Pitocin.

18 A All right.

19 Q What is Pitocin?

20 A It's oxytocin. It's a hormone that's secreted by the
21 posterior pituitary, I think it is, and it helps the
22 milk let down and helps stimulate uterine contractions.

23 Q In this case for Ms. Fulton, do you have an opinion
24 whether it was appropriate to give her Pitocin to start
25 her labor?

1 A Yes.

2 Q And what is that opinion?

3 A That it was appropriate. We did an amniotomy and we also
4 added dilute Pitocin to her IV fluids. This is given
5 with a pump and it's very regulated and generally we
6 start out at one or two milliunits per minute and
7 gradually increase it to, until we get a good adequate
8 contraction pattern.

9 Q Okay. At any point during the delivery, did you actually
10 reduce the Pitocin?

11 A I did and I think that was -- let me see. I'm looking in
12 the nurse's notes here. Oh, yeah, here it is. 11:50, Dr.
13 Goldstein at bedside. Vaginal exam. Eight, 100 percent,
14 minus one, pit decreased to 10 milliunits, straight
15 cath, 450 CCs of urine.

16 Q Okay. Hold on. That's a lot of information. When you say
17 that pit is decreased, what does that mean?

18 A Well, basically, I mean, I looked at her tracing and she
19 was having a little bit more than -- you know, she was
20 having more frequent contractions than we like to see
21 and there was a slight change in the, what we call the
22 beat to beat variability of the baby's heart rate, so
23 you have long term variability and you have short term
24 variability, you know, so, you know, if you can imagine
25 an EKG going across the page, you know, if the -- the

1 QRS complex, kind of, comes down like that then, you
2 know, that would be decreasing their beat to beat
3 variability. So, I mean, she wasn't having decelerations
4 but she had, you know, these subtle changes so we felt
5 like, you know, I think she was at 16 milliunits then,
6 you know, so we decreased her Pitocin and slowed the
7 contractions down and I think her, the fetal heart
8 tracing improved.

9 Q Were you monitoring the Pitocin?

10 A Yes.

11 Q How about the nurses? Did they assist in the monitoring
12 of the Pitocin?

13 A Yes, and they let us know if something doesn't seem to
14 be going right with the Pitocin.

15 Q Did that happen in this case?

16 A I think I noticed it. I mean, you know, but, you know,
17 if the baby's having variable decelerations or late
18 decelerations, which are long term decels then, you
19 know, the nurses are supposed to turn the pit off.

20 THE COURT: Counsel approach the bench.

21 (Bench Conference off the record)

22 THE COURT: Madam Forelady, ladies and gentlemen of the
23 jury, y'all have worked hard today. Y'all have paid very
24 close attention. Thank you for that. We're going to recess
25 for the evening. Once again, do not do any independent

1 investigation and do not discuss the case amongst yourselves
2 or with anyone else. We'll see you bright and early at nine
3 o'clock in the morning. Nine o'clock sharp here. Nine o'clock
4 sharp. Everyone remain seated as the jury exits the
5 courtroom.

6 (Jury out at 5:59 PM)

7 THE COURT: Anything from the Plaintiff before we recess
8 for the evening?

9 MR. GRAHAM: None, but we would just ask that you
10 admonish Dr. Goldstein that he's not supposed to talk with
11 anyone about his ---

12 THE COURT: I will. Have y'all gotten the medical records
13 straight yet? Now would probably be a good time to do that.
14 I know y'all are tired, but I think now is the time to do
15 that. You can't take them out of the courtroom, so I'll let
16 y'all do that. Ms. Rodriguez, it might be a good idea for you
17 to do that and you can check behind her tonight or check in
18 the morning.

19 MS. GANES: I'd like to check in the morning, Your Honor.
20 I think the biggest problem was the pen that she had to
21 redact it. It's not her fault, but it just wasn't the same
22 redaction ink that had been used on the others and you could
23 read through it, and then there were ones that weren't
24 redacted at all.

25 THE COURT: Anything from the Defense?

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1 MS. Craig: No, sir, Your Honor.

2 THE COURT: All right. We'll stand at ease until nine
3 o'clock in the morning. Nine o'clock sharp.

4 MR. GRAHAM: Could you admonish him not to talk ---

5 THE COURT: I will.

6 MR. GRAHAM: Oh, thank you.

7 THE COURT: Very good. Under the rules of the Court, you
8 can't discuss the case with any of the lawyers, Mr. Graham,
9 nor any of the team of defense lawyers. You can't talk to
10 them about it while you're still on the stand.

11 DR. GOLDSTEIN: Okay.

12 THE COURT: Okay? Does that sound fair enough?

13 DR. GOLDSTEIN: That's fair enough.

14 THE COURT: All right. We'll see you at nine o'clock in
15 the morning.

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17 THE COURT: Good morning, everybody. Please be seated.
18 Anything from the Plaintiff before we proceed?

19 MR. GRAHAM: Yes, sir, Your Honor, I thought now might be
20 an opportune time for me to mention that in the event we need
21 to do any impeachment of Dr. Goldstein with his deposition we
22 would ask Your Honor's indulgence to be allowed to do that
23 with video clips. They are, they are critically important to
24 our case because they show Dr. Goldstein's demeanor. They
25 show his body language. They show his facial expressions.

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1 They show lengthy pauses between the answers and a number of
2 things that really affect the credibility and we've gone to a
3 lot of expense to do that and we believe, we would ask Your
4 Honor to allow us to do that.

5 THE COURT: Let's hear from ---

6 MR. GRAHAM: We've got them ready to do it.

7 THE COURT: Let's hear from the Defense with regard to
8 that.

9 MS. CRAIG: Thank you, Your Honor. Good morning.

10 THE COURT: Good morning.

11 MS. CRAIG: With regard to the video clips, I anticipate
12 what we're going to have are little snippets that are taken
13 out of context or the same sound bites that he tried to use
14 with Dr. Gomez-Carrion, and so they're going to be out of
15 context and I would object because I think it's easier and
16 quicker just to use the deposition like we've been using it
17 in the written form, but if he's going to be going through
18 video clips we would ask that we stop, we review it, and I
19 have an opportunity if he's going to show a video clip that
20 it be put in context. It's not a sound bite. It's not one
21 line out of an answer and that's what those little clips were
22 with Dr. Gomez-Carrion, so I ask that we stop it and do that
23 and make sure it's in context so -- because otherwise I can't
24 undo the harm that that taking something out of context like
25 that would do. It would be extremely prejudicial to the

1 defense.

2 MR. GRAHAM: Your Honor, this is cross examination we're
3 talking about. They tried to impeach our folks by pulling
4 snippets out of context out of the deposition. They just,
5 they want to prejudice us by not allowing the jury to see the
6 demeanor and body language and pauses that are so
7 significant.

8 THE COURT: What about just playing the whole video? How
9 long is it?

10 MR. GRAHAM: Oh, it's very long.

11 MS. CRAIG: Oh, my word, it was eight hours.

12 MR. GRAHAM: A lot ---

13 THE COURT: Oh.

14 MR. GRAHAM: A lot of it ---

15 MS. CRAIG: It was excruciating.

16 MR. GRAHAM: A lot of it -- I mean, we've got it --
17 we've got it culled down to clips that we can play.

18 THE COURT: Well, we don't need to address that now. The
19 jury is here ready to go.

20 MR. GRAHAM: Yes, sir.

21 THE COURT: We're going to -- we'll talk about that
22 later. We're ready for the jury.

23 MS. CRAIG: Would you like Dr. Goldstein to take the
24 stand?

25 THE COURT: Yes.

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(Jury in at 9:06 AM)

THE COURT: Madam Forelady, ladies and gentlemen of the jury, everybody looks well rested and happy to be here. Thank you for being here and being here on time. We're going to proceed forward with the testimony of Dr. Goldstein. Dr. Goldstein, good morning.

DR. GOLDSTEIN: Good morning.

THE COURT: I want to remind you that you're still under oath. Very good. Yes, ma'am.

MS. CRAIG: Thank you, Your Honor.

THE COURT: Ms. Craig.

CONTINUED DIRECT EXAMINATION

BY MS. CRAIG:

Q Good morning, Dr. Goldstein.

A Morning.

Q Did you get some rest last night?

A A little.

Q Okay. All right. Let's finish up with yesterday before we broke for the evening. We had gone through all of the prenatal visits, 19 prenatal visits that Ms. Fulton had with you, so now where we are at the actual delivery. Okay? We're not going to go back through that. All right. Now, I was asking about -- we had just started the nurses' notes and Brian will pull that up on the screen, but you have -- let me show you. It's in the

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1 mother's chart. It's page 140.

2 MS. CRAIG: May I approach, Your Honor?

3 THE COURT: Yes.

4 MS. CRAIG: Thank you.

5 Q There you go. All right. So, you're at 140?

6 A Well, I think it's out of order here but ...

7 Q Here. I'll give you my copy. Here you go, doctor.

8 A Here it is.

9 Q Okay.

10 A It's on the back.

11 Q Yeah, we were trying to save some paper, so front and
12 back. All right. Dr. Goldstein, first, let's identify
13 what we have into evidence which is out of Ms. Fulton's
14 chart. Whose chart is this? Who keeps this chart?

15 A This is the hospital chart.

16 Q Okay. Tell us whose handwriting is on this document.

17 A That's the nurse's handwriting. I can't read the
18 signature but I assume it's ...

19 Q Well, that's, and that's my question. We'll get to the
20 nurses that are involved in the delivery, but who -- in
21 just general, who documents a labor progress chart?

22 A That would be the nurses.

23 Q Okay. And in the context of the delivery?

24 A We also have a progress chart that we keep on the
25 patient during delivery.

- 1 Q All right. When you say "we" who are you talking about?
- 2 A The physicians.
- 3 Q Okay. The doctors.
- 4 A Yeah.
- 5 Q We're going to go through that, but right now we're
- 6 going to go through what the nurses documented. Tell me,
- 7 when is this nursing documentation done?
- 8 A At the time that the event occurs.
- 9 Q Okay. Contemporaneous with the care?
- 10 A Contemporaneous with the care.
- 11 Q Do you document anything in the labor progress chart
- 12 that we have up on the screen?
- 13 A The nurses' progress, no.
- 14 Q All right. So, let's go through the nurses' notes. We'll
- 15 start at the very first one. It's a little difficult to
- 16 read so just let us know if you have any trouble.
- 17 There's that first one and it says admitted to unit for
- 18 induction. Consents explained and signed. Admission
- 19 paperwork done. IV started. What does that say? One or
- 20 two attempts ---
- 21 A One time, two attempts.
- 22 Q Okay. Infusing -- what else does that say?
- 23 A With number 18 jelco. That's the size of the needle that
- 24 they use.
- 25 Q Okay. That's at six o'clock, and who started the

1 Pitocin?

2 A The nurses did.

3 Q All right. And we talked about Pitocin, but one more
4 question on Pitocin. How often, in your experience, do
5 doctors use Pitocin to start a mama's labor?

6 A Ninety percent of the time.

7 Q Was it appropriate to use Pitocin?

8 A Yes.

9 Q All right. Let's go to the next entry that the nurses
10 have. I believe it's at 6:20 and this is bright and
11 early in the morning. Right?

12 A Yeah.

13 Q 6:20 AM?

14 A Yes.

15 Q Okay. Why was penicillin given via IV?

16 A Ms. Fulton was group B strep positive.

17 Q What does that mean?

18 A That means we did a culture of her vagina and there was
19 a colonization of group B strep, so we prophylactically
20 give penicillin during labor to those that are not
21 penicillin-allergic to prevent the possible infection of
22 the fetus when he passes through the birth canal.

23 Q Who issues that order? Who gives the order for the
24 penicillin?

25 A I do.

1 Q Is that ---

2 A The physician does.

3 Q Is that reasonable?

4 A That's reasonable.

5 Q Okay. After you gave the order for the penicillin
6 course, nurses gave the penicillin. Right?

7 A Correct.

8 Q All right. Now, let's look at the next entry by the
9 nurses. I think it's 6:55 a.m. It says BS 80. What does
10 that mean?

11 A Blood sugar 80.

12 Q Okay. What are you checking here?

13 A We're checking her blood sugars to make sure that she
14 doesn't have a real deviation in her blood sugars, that
15 she's not either hypoglycemic or hyperglycemic.

16 Q Okay. And the next ---

17 A This is ---

18 Q --- documentation from the nurses is 7:18. It says Dr.
19 Goldstein AROM. What does that mean?

20 A Artificial rupture of membranes.

21 Q What does that mean in terms of where were you
22 physically at 7:18 AM?

23 A I was at the bedside.

24 Q Is the first time you saw Ms. Fulton for this delivery
25 when it was time to push?

1 A No. I saw her throughout the morning.

2 Q So, at 7:18 -- and just quickly, what does it mean to
3 rupture the membranes? What does that mean?

4 A That means that we break her bag of waters and this also
5 helps stimulate her labor.

6 Q Now, it also says the fetal scalp electrode is
7 attempted. Is that correct?

8 A Yes.

9 Q I think we might have talked about this yesterday.
10 What's the purpose of that?

11 A That's an electrode that we apply to the baby's scalp
12 and it enables us to monitor the baby's heart rate much
13 better than an external monitor.

14 Q All right. Next time that the nurses document is at --
15 about 20 minutes later, 30 minutes later, 7:50.

16 A Yes.

17 Q It says Dr. Goldstein at bedside. What does that mean?

18 A That means I was there checking the patient and at 7:18
19 I attempted a fetal scalp electrode, but was not
20 successful and then I came back later and applied it.

21 Q Next documentation is 8:32. It states test dosed for
22 epidural. What's going on now?

23 A The anesthesiologists are there and they've placed the
24 epidural catheter and they give a test dose first to
25 make sure that the catheter is not in the subarachnoid

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1 space and, you know, if they gave too much of a dose and
2 it was a spinal instead of an epidural, then they get
3 complete paralysis so they do a test dose initially.

4 Q All right. And that was done by whom?

5 A I can't read the signature, but I did -- it's the
6 nurse's note, but she's noting that the anesthesia
7 department placed the epidural and gave the test dose.

8 Q Okay. All right. Moving down our delivery time line.
9 The next notation from our nurses is, it says VE. What
10 does that mean?

11 A Vaginal exam.

12 Q Okay. And in a vaginal exam you are checking on how far
13 the mama's dilated?

14 A Yes.

15 Q Okay. And what is documented?

16 A She's six centimeters, 80 percent effaced, minus two
17 station.

18 Q Is the delivery progressing?

19 A The labor is progressing.

20 Q Thank you. All right. Five minutes later the nurses
21 document 10:45 penicillin given via IV. Why is that
22 being done?

23 A I don't see that, but I guess that's the second dose of
24 penicillin.

25 Q Okay. And that was group B strep positive?

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- 1 A Right.
- 2 Q Next time -- next documentation looks like 11 o'clock
- 3 FSBS 67. What does that mean?
- 4 A Finger stick blood sugar is 67.
- 5 Q Why are you monitoring her blood sugar so carefully
- 6 during this labor?
- 7 A She has diabetes, insulin-dependent diabetes, and we
- 8 hold the dose of insulin on the morning of labor and
- 9 we're monitoring here blood sugars to make sure her
- 10 blood sugars are within optimal limits.
- 11 Q All right. Next, it looks like 20 minutes later. The
- 12 nurses document at 11:20. What is documented here?
- 13 A I think that the next notation is Dr. Goldstein at
- 14 bedside, vaginal exam, 800 percent minus one. Pitocin
- 15 decreased to 10 milliunits. Straight catheter for 150
- 16 ccs of urine.
- 17 Q All right. Who is at bedside?
- 18 A Dr. Goldstein.
- 19 Q Next notation that the nurses make is 10 minutes later.
- 20 What's going on now?
- 21 A Dr. Goldstein here, strip viewed, vaginal exam, 800
- 22 percent, zero station.
- 23 Q First of all, who reviewed the fetal monitor strip ---
- 24 A I did.
- 25 Q --- based on this note?

- 1 A I guess me and the nurse together.
- 2 Q Is that what you usually do ---
- 3 A Right.
- 4 Q --- during the ---
- 5 A Yeah.
- 6 Q --- labor? And then tell us what significance it is with
7 regard to the vaginal exam, your findings there.
- 8 A Well, she's still eight centimeters. She's 100 percent
9 effaced, but she's coming down through the pelvis.
10 She's now at a zero station. That's the head at the
11 level of the ischial spine and the pelvis.
- 12 Q Okay. Ten minutes later what did the nurses document?
13 The next ---
- 14 A Straight cath for 120 ccs. Fetal heart rate 140 with
15 spontaneous accels. Peri care done. Vaginal exam
16 complete, 100 percent plus two. Oh, I'm sorry. I
17 skipped down too far.
- 18 Q Yeah, I think you missed one.
- 19 A Yeah.
- 20 Q Let's go back up to the one before it.
- 21 A 12:05?
- 22 Q Yes, sir.
- 23 A Dr. Goldstein here. Strip reviewed. Vaginal exam, eight,
24 100, zero station.
- 25 Q What time based on the notes was Ms. Fulton complete?

1 A Based on the notes she was complete, I think that's
2 13:05.

3 Q And what does it mean to be complete?

4 A She's completely dilated, completely effaced, plus two
5 station.

6 Q And when a pregnant woman is completely dilated, it's
7 time to do what?

8 A Time to begin pushing.

9 Q Now, when it was time to push who was in the -- what
10 other medical professionals were in the room with you?

11 A Pushing. The next note says pushing with patient, family
12 at bedside, Stephanie Collins.

13 Q Okay. And who's Stephanie Collins?

14 A She's the nurse that was in charge of that patient that
15 day.

16 Q And do you have the pleasure of working with Nurse
17 Collins from time to time?

18 A I do.

19 Q She's a labor and delivery nurse?

20 A Yes. She's a labor and delivery nurse.

21 Q All right. Let's go through. It appears, then, that the
22 nurses next document is at 13:40. What time is that?

23 A That's 1:40 PM.

24 Q All right. So, we're at 1:40 PM and what is, what's,
25 please tell us what the nurse is documenting.

1 A Dr. Goldstein at bedside, vaginal exam, plus three
2 station. Patient placed in stirrups. Perineum prepped
3 and patient draped. Newborn nursery present. Stephanie
4 Collins.

5 Q Okay. Then at 13:44 what does the -- so what's going on
6 at 13:44? That's 1:44 in the afternoon, Right?

7 A Yeah, 1:44.

8 Q So, we're at 1:44 p.m. What's documented in the note
9 here?

10 A I think that says Mityvac placed here, Dr. Goldstein,
11 with contractions. Pressure 250 centimeters, murphy
12 pressure times 30 second, head delivered with two pulls.
13 Shoulder dystocia recognized. Rebecca Lawrimore, RN, on
14 stool on patient's left. I'm sorry. I just can't...

15 Q That looks like writer.

16 A Yeah. Left writer. I'm not sure what that means.

17 Q Okay. Keep going.

18 A On stool on patient's right side. Episiotomy per MD.
19 McRoberts maneuver performed. Episiotomy extended per
20 MD. Suprapubic performed per Rebecca Lawrimore. Dr.
21 Coker called to delivery. Delivery of infant post
22 suprapubic pressure per MD at 13:49. Anesthesiologist
23 present to assist newborn nursery. Stephanie Collins.

24 Q Okay. Doctor, let's -- now, I need you to speak up a
25 little bit. Is this your first time in a witness chair?

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1 A Yes, ma'am.

2 Q Okay. So, you need to speak up so that we can hear you.
3 This is an important note and I want to go through it
4 with you. Who documented and who, based on our review of
5 these records, who wrote this note?

6 A It says S-C at the end, so I assume that's Stephanie
7 Collins.

8 Q Okay. All right. In those notes it says that -- I want
9 you to explain what is documented contemporaneous with
10 the delivery. Okay? So, I want you to explain that
11 first, that first sentence. It says something is placed
12 per Dr. Goldstein. What is that?

13 A I think that's mother or mom placed per Dr. Goldstein
14 with ---

15 Q Okay. And then what do you ---

16 A Oh, no, no. I think that was the Mityvac.

17 Q All right. Let's talk about -- okay. What is the
18 Mityvac?

19 A That's a type of vacuum extractor.

20 Q Okay. Why did you use the vacuum to help deliver Ms.
21 Fulton's baby?

22 A She was not -- she had an epidural and the head was at a
23 plus three station and basically we used it as an outlet
24 instead of forceps to help the baby over the perineum.

25 Q What does it mean when a baby is at a plus three

1 station?

2 A The baby's right at the -- the head is at the vaginal
3 introitus so that you can see the head.

4 Q When a baby is at a plus three station, is it reasonable
5 to use a vacuum?

6 A Yes.

7 Q Did you have any problems using the vacuum to help
8 deliver the baby?

9 A No.

10 Q Was there any harm to the baby based on your use of the
11 vacuum?

12 A No.

13 Q All right. That's it on the vacuum. Let's move now to
14 the, to the second line here. It says; head delivered at
15 two pulls and then right here it says shoulder dystocia
16 recognized. Correct?

17 A Correct.

18 Q Dr. Goldstein, did you and the nurses involved in this
19 delivery know exactly what you were confronted with as
20 documented by the nurse?

21 A Yes, ma'am.

22 Q And when you were confronted with a shoulder dystocia,
23 were you confident in your previous experience working
24 with the nurses that they knew what to do?

25 A Yes.

1 Q And did you and the nurses, as a team, do everything
2 that you could to help relieve the shoulder dystocia and
3 dislodge the shoulder?

4 A Yes, ma'am. You know, they -- I mean, you know,
5 routinely we'll start out with McRoberts, you know, when
6 a problem occurs like this so they pretty much grab the
7 legs and flex the legs, hyperflex the legs and abduct
8 the thighs for McRoberts so that was, that was one of
9 the first things they did.

10 Q Did those nurses do a good job?

11 A They did an excellent job.

12 Q All right. After shoulder dystocia was recognized, it
13 says Rebecca Lawrimore, RN -- who is that?

14 A That's one of the other labor and delivery nurses.

15 Q How many labor and delivery nurses do we have in the, in
16 the, helping with the delivery?

17 A Well, there were at least two.

18 Q Okay. So, we have Nurse Lawrimore and she's on a, it
19 says, a stool.

20 A Right.

21 Q Where?

22 A It says on patient's left. Stool on patient's left.

23 Q Okay. Now, why would Ms., Nurse Lawrimore be on a stool?

24 A Oh, I'm sorry. Lawrimore, RN, on stool on patient's left
25 and then there's slash writer. I'm not sure what that is

1 on stool on patient's right side.

2 Q Okay. And we'll have the nurses look at -- she'll read
3 her handwriting later, but what I want you to explain is
4 why would the nurses need to get on a stool once you and
5 the nurses recognized this medical emergency?

6 A To apply -- they keep a stool in most delivery rooms in
7 order to get elevation so that they can apply suprapubic
8 pressure.

9 Q Was that the appropriate thing to do?

10 A Yes.

11 Q All right. So, the nurses are applying suprapubic
12 pressure and then it says episiotomy per MD. Right?

13 A Yeah.

14 Q That's hard to see up there.

15 A Yeah.

16 Q But right there ---

17 A They kind of jam it together.

18 Q --- highlighted. Okay. What's going on here? Who's doing
19 this episiotomy, per MD?

20 A That would be me.

21 Q And why are you doing that?

22 A To get more room to attempt the rotational maneuvers.

23 Q All right. Then the nurses say McRoberts maneuver
24 performed.

25 A Right.

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1 Q Did that happen?

2 A Yes.

3 Q Based upon your notes, the nurses' notes that you
4 reviewed, do you have an opinion whether McRoberts was
5 used before Dr. Coker came into the labor and delivery
6 room?

7 A Yes, the McRoberts maneuver was the first thing we, we
8 did.

9 Q Is this a medical demonstration, a medical illustration
10 showing the McRoberts that you and the nurses did after
11 the shoulder dystocia was recognized?

12 A That's actually showing McRoberts plus suprapubic
13 pressure.

14 Q Okay. So, let me change my question as to both. Is this
15 a medical illustration that shows the McRoberts and the
16 suprapubic pressure that you and the nurses were doing
17 prior to Dr. Coker coming into the labor and delivery
18 room?

19 A Right. Yes. I think Ms. Collins, I mean, Rebecca
20 Lawrimore ---

21 Q Speak up.

22 A --- Rebecca Lawrimore was doing the suprapubic pressure
23 and I assume Stephanie was holding one leg and somebody
24 else was holding the other leg for the McRoberts.

25 Q And when you describe the legs, what are you describing

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1 or what is that maneuver? When you said holding the
2 legs, what is that called?

3 A The legs are hyperflexed and abducted, so the knees go
4 up towards the -- I mean, towards the shoulders.

5 Q Yes, sir.

6 A And they're extended out as much as they can go.

7 Q And what is that maneuver called?

8 A McRoberts.

9 COURT REPORTER: Could you identify that exhibit please?

10 MS. CRAIG: Yes, ma'am. Court's, madam clerk, it is #13.

11 Q All right. So, after McRoberts maneuver is performed,
12 why did you extend the episiotomy a second time?

13 A To get more room, basically.

14 Q And then suprapubic is performed per Rebecca Lawrimore?

15 A Correct.

16 Q Doctor ---

17 A And I think at that point, you know, we dropped the
18 table down as far as we could get it to go. Usually when
19 I do a delivery, I bring the table up as high as I can
20 because I usually stand when I do my deliveries but, you
21 know, with the table up high she wasn't able to give
22 effective suprapubic pressure so we dropped the table
23 down as low as we could for her to be able to apply
24 suprapubic pressure.

25 Q Okay. I'm glad you brought that up. So, tell us, when

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1 you say that you dropped the bed down or you lowered the
2 bed, what part of the bed was lowered? Thank you.

3 A The whole bed. It's an electric bed so it goes up and
4 down and it, you know ---

5 Q Okay. So I'm going to ---

6 A --- we lowered the bed towards the floor.

7 Q Tell me about how far the bed went down. Just estimate,
8 about how far did you put that bed?

9 A Well, usually ---

10 Q Do you want to stand up and just show us just so we have
11 an idea?

12 A (Complies) Usually, you know, we have the bed about
13 there, you know, parallel to the floor and then so it'll
14 go down to about there.

15 Q Okay. So, this is where the bed is. This is where Ms.
16 Fulton's body is.

17 A Right.

18 Q Okay. Thank you. All right. Given that the bed was that
19 far down to help with the suprapubic pressure, what was
20 your positioning at, at the bottom of the bed to try to
21 help deliver the baby?

22 A Well, at that point, I mean, since the bed was so low
23 and I'm kind of tall, so I had to kind of get down on my
24 knees to apply pressure in the axial ---

25 Q What is odd or strange to you about having to get down

1 on your knees when the bed is low to help deliver a
2 baby?

3 MR. GRAHAM: Objection, Your Honor. I've been holding
4 back, but I object to the leading.

5 THE COURT: I don't think that's a leading question.
6 What is odd about -- repeat the question.

7 MS. CRAIG: What is odd or strange about you having to
8 get on your knees to deliver a baby when the bed is ---

9 THE COURT: Certainly not a leading question. I think
10 that's an appropriate question.

11 A Well, it's -- I mean, it's not the usual thing that we
12 do because normally, you know, in a delivery, a normal
13 delivery, I have the bed up and, you know, I can stand
14 there and deliver the baby at arm level, but with the
15 bed down so that Ms. Lawrimore could apply suprapubic
16 pressure, I had to get down closer to the floor to
17 manipulate the baby to effect delivery.

18 Q Okay. Thank you. All right. Let's keep going. We're
19 almost through with the nurses' notes. It says Dr. Coker
20 called to delivery. Is that accurate?

21 A Let me get to the back of my page.

22 Q Sure. We've got it, actually, you can come see this
23 part up here, Dr. Goldstein.

24 A Let me look here.

25 Q Okay.

1 A All right. Let's see. We're in that same note.
2 Episiotomy. Dr. Coker called to delivery. Delivery of
3 infant post suprapubic pressure per MD at 13:49.

4 Q Okay. Let's stop right there. What does this note say
5 occurred after Dr. Coker came in?

6 A Dr. Coker came in, he assessed the situation. I think he
7 examined, I mean, visually examined the patient and then
8 he got up on the stool. We raised the bed back up and he
9 applied suprapubic pressure that manipulated the
10 shoulders under the pubic symphysis and the shoulders
11 delivered.

12 Q And where were you, physically, when Dr. Coker was at
13 bedside at the side of Ms. Fulton? Where were you?

14 A I was between the patient's legs delivering the baby.

15 Q When Dr. Coker came in, did he take over the delivery?

16 A No, he assessed what the problem was. We discussed what
17 the problem was. He looked at the patient and, you know,
18 said let's try suprapubic pressure so he was more --
19 he's a tall guy and he was better able, capable of
20 applying suprapubic pressure and when he applied
21 suprapubic pressure, then the anterior shoulder came
22 under the pubic symphysis and the shoulders delivered,
23 the baby delivered.

24 Q So, who was in the team of medical professionals that
25 helped deliver this baby within four to five minutes

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1 after the shoulder dystocia was recognized? Who were
2 those individuals?

3 A Well, one of the first things, you know, when you have a
4 shoulder dystocia is to call for adequate help and so
5 one of the first things I did is tell one of the
6 ancillary personnel there to go down to Dr. Coker's
7 office or, you know, Dr. Phillips and Coker's office,
8 because they're in the building, and to obtain more help
9 for us but, you know, when we called this shoulder
10 dystocia emergency then Dr. Phillips, the son of Dr.
11 Phillips who is the anesthesiologist who was on call
12 that day, came in. The newborn nursery nurses were
13 already there and a lot of other personnel came into the
14 room to assist in the delivery.

15 Q And as far as how many nurses, I'm talking labor and
16 delivery nurses. How many labor and delivery nurses
17 assisted you and Dr. Coker?

18 A Well, at least Rebecca Lawrimore and Stephanie Collins,
19 but I'm not sure who else was in the room but the room
20 was fairly crowded with personnel there.

21 Q Now, it says the baby was delivered at what time?

22 A 13:49.

23 Q What time is that?

24 A That would be 1:49 PM.

25 Q And where was the baby? Where did the baby go after the

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1 delivery?

2 A After the delivery, the baby was fairly obtunded from
3 the delivery and so once the cord was cut and clamped
4 and cut, we handed the baby off to the pediatric staff.
5 I'm not sure if one of the perinatologists or
6 pediatricians were there, but I think Dr. Phillips was
7 there and that's Dr. Phillips, the anesthesiologist, was
8 there, and he intubated the baby so that they could
9 effectively oxygenate or effectively breathe for the
10 baby to help revive the baby.

11 Q Okay. Based on this labor progress chart, and we've gone
12 through every single entry in here, based on these
13 nursing notes which were documented at the time that the
14 care was given, do you have an opinion whether you were
15 monitoring, evaluating, and assessing Ms. Fulton
16 throughout her delivery?

17 A Indeed, I was.

18 Q And is that your opinion to a reasonable degree of
19 certainty, most probably?

20 A That's my opinion to a reasonable degree of medical
21 certainty.

22 Q All right. Now, we've gone through the nurses' notes.
23 Now, I want to go through your notes. Okay?

24 A Okay.

25 Q I've got another blow-up of your handwritten delivery

1 note and before I ask Your Honor if you can get off the
2 stand and tell us, and read through your notes, explain
3 to us why a doctor has a handwritten note from a
4 delivery as well as -- just a minute. Tell me why a
5 doctor has a handwritten note and a dictated delivery
6 note.

7 A Well, I traditionally do both because the dictated note
8 doesn't get to the chart until the dictation staff types
9 it up and sends it out, so I traditionally dictate a
10 note and then write a note as a summary note on the
11 chart so that it's concurrent with the patient's
12 hospitalization. The dictated note may not get to the
13 chart for two or three days.

14 Q Is that a common practice?

15 A Well, it was back then. I mean, they're getting them
16 there pretty quick now. It's within a day.

17 Q When you say they are getting them pretty quick now ---

18 A Well, back at that time they had a, a staff of typists,
19 I guess, that would listen to the dictation that we gave
20 and type them up and send them over in hard copy to the
21 chart.

22 Q Okay. Is technology different now?

23 A Technology is different now. They've gone to computer
24 charts and electronic medical records.

25 MS. CRAIG: Now, Your Honor, may Dr. Goldstein get off

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1 the stand to review his handwritten note?

2 THE COURT: Yes, ma'am.

3 MS. CRAIG: Thank you.

4 Q All right. Dr. Goldstein, come on down and let's go
5 through this. All right. So, I got you something really
6 high tech last night, so you can stand right here so the
7 court reporter can hear you and I want you to identify
8 this document which, for the record, is "Mother 126" out
9 of the mother's chart. All right. Now, tell us, first of
10 all, identify what this document is.

11 A This looks like my delivery note. My see dictation note.

12 Q Okay. And we're going to go through the dictated note in
13 just a minute, but whose signature is this at the
14 bottom?

15 A That's mine.

16 Q Okay. And when do you write this, these handwritten
17 notes? When is this written?

18 A Usually immediate, I mean, not immediately, but very
19 shortly after the delivery.

20 Q Okay. I need you to just move back a little back. All
21 right. Just tell us exactly -- and it's up on the screen
22 as well. Tell us what you documented. Just start at the
23 top.

24 A A complete, complete plus three. Epidural in place.
25 Pushed well. Vacuum extractor with two pulls.

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1 Q Okay. Hold on just a second. Now, we went through with
2 the nurse's note on vacuum extractor. How many, how many
3 pulls did the nurse's document?

4 A Two pulls.

5 Q How many pulls did you document?

6 A Two pulls.

7 Q Okay.

8 A And these pulls are, you know, we wait until the mother
9 is having a contraction so that we can use the force of
10 her pushing along with us pulling to effect delivery.

11 Q Okay. What is, what are these? What does this stand for,
12 R-M-L-E?

13 A Right medial lateral episiotomy. That's -- traditionally
14 we cut down to the right. This avoids fourth degree
15 lacerations where the episiotomy -- you know, with a
16 large head or something the episiotomy can extend into
17 the rectum so that's a problem, so with the right medial
18 lateral episiotomy, that doesn't occur.

19 Q Okay. Then what is 14:30? And again, speak up so
20 everybody on our jury can hear you. You've got to speak
21 up a little bit, so let's do this. Why don't we go over
22 here so I can make sure everybody can hear you and they
23 can also see it, so let's just walk over here and if
24 you'll just tell us.

25 A On this?

1 Q Yeah, and speak up.

2 A Okay. Delivered head about 13:44. Shoulder dystocia.
3 Nursing staff in place.

4 Q All right. I'm going to stop you right there. When the
5 nurses document -- what time did the nurses document
6 list the shoulder dystocia, based on their note?

7 A 13:44, I think.

8 Q What time did you document shoulder dystocia?

9 A 13:44.

10 Q Okay. All right. Now, so, it's nursing staff. Please
11 continue.

12 A She had a nuchal cord and fortunately we were able to
13 reduce the cord over the baby's head.

14 Q Okay. Now, I want you to stop right there and in your
15 delivery note, I want you to explain the medical
16 significance of where the nuchal cord was.

17 A The cord is looped around the baby's neck so, you know,
18 sometimes these are tight nuchal cords and when they're
19 tight then they, they compress the umbilical cord and
20 that compresses the blood flow to the baby and reduces
21 the baby's oxygenation during labor and during pushing.

22 Q Okay. And when you saw that the nuchal cord was wrapped
23 around the baby's neck, what did you do?

24 A Well, fortunately, in this case, we were able to slip it
25 over the head.

1 Q Okay. What I'm trying to find out is what does it mean
2 when you say nuchal cord reduced.

3 A That means that we slipped the cord over the baby's head
4 and reduced it from being around the baby's neck.

5 Q Okay. Got it. All right. Let's move on to the next
6 portion.

7 A All right.

8 Q What does that say?

9 A Extended the episiotomy times two.

10 Q All right. What does that mean?

11 A That we extended the episiotomy or we made the
12 episiotomy wider or deeper.

13 Q How many times, based on the nurses' note, was it
14 documented that the episiotomy was extended?

15 A Twice.

16 Q Is that consistent with your note?

17 A Yes, ma'am.

18 Q Okay. Keep going, sir.

19 A Dr. Coker was called and assisted with suprapubic
20 pressure. Head delivered at 13:49. Eight pound, six
21 ounce male. Infant APGARs one, four, five. The APGAR at
22 one minute was one, at five minutes was four, and I
23 think the next one was five at ten minutes.

24 Q And what does that say about the baby's condition, that
25 the APGAR score got higher?

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1 A Well, the baby was improving with -- uh-oh.

2 Q I told you it was high tech.

3 A It is. I'll just use -- so the baby was being,
4 resuscitated by the pediatric staff and Dr. Phillips was
5 assisting with the respirations and the baby and the
6 baby was improving.

7 Q Okay.

8 A But the baby was obtunded -- you know, fairly obtunded
9 when he delivered.

10 Q All right. So keep going. Tell us what else is in this
11 note.

12 A Cord gasses sent and then down here at the bottom we
13 have the poor pH at 7.19.

14 Q Okay. What does that mean?

15 A That shows that the pH was a little bit low. We like to
16 see them above 7.2.

17 Q All right.

18 A So ---

19 Q All right. Stay right there, Dr. Goldstein. Now, we've
20 mentioned your dictated delivery note. All right. And
21 for the record, it looks like your delivery note is
22 Goldstein 21. It's out of your chart. All right. So
23 let's -- let's walk through again. Identify the document
24 and the time, the date on the document.

25 A Let's see. The date is 8/20 at about 13:45.

1 Q Okay. And I'm going to -- excuse me. I'm going to go
2 through each thing that you did on this date, so let's
3 talk about the, what time was the delivery, by the way?

4 A I think we said the baby's head delivered at 13:49.

5 Q But at the top it says date of delivery, 8/20/2009 at
6 about 13:45. Why is that?

7 A The date, on the date of delivery, I guesstimated the
8 time. I

9 Q Okay. All right. Let's walk through your dictated note.
10 Starting at the top, what did you document?

11 A In review, the ---

12 Q Got to speak up, doctor.

13 A In review, the patient was admitted this morning for
14 induction into labor at 36 weeks. Has gestational onset
15 diabetes. She was admitted this morning. Cervix was
16 about five centimeters but minus two, minus three.
17 Membranes were artificially ruptured. She was given
18 dilute Pitocin. Scalp electrode was placed. She
19 progressed well through the active phase of labor before
20 she gets to complete.

21 Q Okay.

22 A She progressed well through the active phase of labor.
23 Epidural catheter was placed and dosed. She was eight,
24 complete, minus one at 11:30 and complete, complete,
25 plus one to plus two and pushing at 1 PM. She brought

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1 the head down to plus two to plus three position. She
2 pushed to the perineum and vacuum extractor was applied.
3 We had two pulls on the vacuum extractor. Delivered the
4 head about 13:45 and recognized that she had a shoulder
5 dystocia with the right shoulder under the symphysis.

6 Q Okay. Let's stop right there. Now, the information that
7 you've gone through so far on your dictated delivery
8 note, is that, is that consistent with the documentation
9 from the labor and progress chart from the nurses?

10 A Yes.

11 Q Is that consistent with your handwritten delivery note?

12 A Yes.

13 Q Okay. Keep -- continue please.

14 A It said she had a nuchal cord we reduced over the head.
15 We tried the McRoberts maneuver. Prior to that, a
16 generous right mediolateral episiotomy was cut.
17 Suprapubic pressure was applied. The episiotomy was
18 extended on two occasions.

19 Q Okay. Hold on just a second please. All right. So, in
20 your dictated delivery note you say -- do you want to
21 hold that for a second? You say we tried the McRoberts
22 maneuver. Is that correct?

23 A That's correct.

24 Q When did you try the McRoberts maneuver?

25 A Shortly after the shoulder dystocia was recognized.

1 Q Was that before or after Dr. Coker came in?

2 A That was before.

3 Q Okay. And then I think you already talked about the
4 generous right medial lateral episiotomy. Let's go to
5 suprapubic pressure.

6 A Suprapubic pressure was applied.

7 Q Okay. When was suprapubic pressure applied?

8 A Probably after we applied -- after we did the McRoberts
9 maneuver.

10 Q All right. Was suprapubic pressure applied before or
11 after or/and after Dr. Coker arrived?

12 A Before and after.

13 Q All right. Please continue.

14 A The episiotomy was extended on two occasions. Next, it
15 says Dr. Steve Coker was called to assist and Dr. Coker
16 applied suprapubic pressure and with that pressure we
17 effected delivery of the shoulder at 13:49. The baby had
18 one cry. The pediatric staff was, was in attendance.
19 The baby was floppy on delivery which means the baby
20 didn't have a lot of tone.

21 Q Okay. What does that mean? If a baby does not have a lot
22 of tone, what does that mean?

23 A It just means that the baby is obtunded from the
24 delivery, you know.

25 Q All right. Keep going.

1 A Baby was floppy on delivery. Dr. Phillips was in
2 attendance and intubated the baby. It was a viable male
3 infant, eight pounds and six ounces. APGARs were one at
4 one minute, four at five minutes, five at 10 minutes,
5 seven at 15 minutes.

6 Q Okay. Let's go through and see the rest of it. I can
7 pull the rest of it up for us.

8 A Cord blood was sent. Cord blood was sent for pH. The
9 placenta sent to pathology. The right medial lateral
10 episiotomy was repaired in multiple layers using 2/0
11 chromic and 3/0 chromic. Estimated blood loss is less
12 than 400 milliliters. Patient tolerated delivery without
13 problem.

14 Q Okay. Thank you, Dr. Goldstein. All right. So, hold on.
15 So, after -- you did the handwritten delivery note and
16 then you did the dictated delivery note. We just went
17 through that. Correct?

18 A Yes.

19 Q What is a discharge note?

20 A When we send patients home from the hospital we
21 frequently dictate a discharge summary.

22 Q Okay. And did you do that in this case?

23 A Yes.

24 Q Let's pull that up.

25 MS. CRAIG: And the discharge summary is Exhibit #9,

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1 Brian.

2 Q All right, doctor, again let's go from the top and we're
3 not going to go read the -- this is a long document. Is
4 this actually two pages long?

5 A No, it's -- well, I think it's not a whole lot on the
6 second page.

7 Q Okay.

8 A But it is two pages.

9 Q All right. So, identify the document at the top.

10 A Discharge Summary.

11 Q Okay. And who wrote the Discharge Summary?

12 A I dictated the Discharge Summary.

13 Q All right. Let's start from the top. What -- let's start
14 with that first paragraph. What does it say?

15 A Dictated H and P and details of admission history and
16 physical. Briefly, 38 years old. A-A-I, G2, P1, 001.
17 That means she's been pregnant twice and delivered one
18 previously. EDC by ultrasound 9/16.

19 Q What does EDC mean?

20 A Estimated date of confinement. That's the due date.

21 Q All right.

22 A I'm sorry. That's by her ultrasound, 9/16, but her date
23 said 8/13.

24 Q All right.

25 A So, we relied on the ultrasound date. EGA ultrasound

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1 estimated gestational age by ultrasound 36 weeks. She's
2 had problems with gestational diabetes and pre-term
3 labor since about 28 weeks. At 28 weeks she was admitted
4 to McLeod, treated with Celestone and treated with
5 Terbutaline and was maintained on Nifedipine until
6 earlier this week. She has been to McLeod within the
7 past 24 hours complaining of contractions. Cervix today
8 in the office was five centimeters dilated and the head
9 had come down and pressing on the cervix. She was
10 therefore admitted for induction.

11 Q Okay. Is that note -- is that consistent with other
12 documentation that we've already gone through?

13 A Yes, ma'am.

14 Q Next, you document the laboratory data on admission and
15 without going through all of this, what's the importance
16 of the hemoglobin and the hematocrit?

17 A Her -- I mean, this is okay. I mean, it's a little bit
18 lower than we like to see but, you know, with pregnancy
19 there's hemo dilution and so, you know, we weren't
20 thinking about transfusing this lady but just watching
21 her blood counts.

22 Q All right. And then so -- and who's watching those blood
23 counts?

24 A That would be me.

25 Q All right. How about platelets? Were you watching those?

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1 A Yes, and the platelets are important because, you know,
2 if they have low platelet count then the anesthesiology
3 department is reluctant to put an epidural in.

4 Q Who's the one that's ordering these tests and following
5 this patient?

6 A Me.

7 Q All right. Let's go to hospital notes and again, this is
8 a very detailed note. I'd like to direct your attention
9 to a few lines down where it says when she was complete
10 subsequently at 2:30 we effected delivery with a vacuum
11 with about two pulls of vacuum, deliver the head, but
12 there was shoulder dystocia so let's start right there
13 after you recognize shoulder dystocia. Now, what does
14 that say?

15 A This is a little behind there but this says she advanced
16 through the active phase of labor about 11:20. She was
17 eight, complete, minus one. She was having
18 hyperstimulation. We cut back on the Pitocin level. The
19 hyperstim resolved. Reactivity improved. About one p.m.
20 she was pushing when she was complete, complete plus
21 one. Subsequently, about 2:30 -- that's kind of a
22 mistake on the time there.

23 Q Okay. Because we know based on the nurses' notes and
24 your delivery note and the dictated delivery note, what
25 time was the baby delivered?

1 A The shoulders delivered at 13:49.

2 Q That's military time. What's that regular time?

3 A 1:49 p.m.

4 Q Okay. Let's go to -- see where it says Dr. Coker, and
5 Brian can pull up that sentence.

6 A Dr. Coker came and added suprapubic ---

7 Q Hold on just a second.

8 A Dr. Coker came and added suprapubic pressure to the
9 already applied McRoberts maneuver and other measures
10 in an attempt to get the anterior shoulder delivered
11 under -- it says this pubis, but it should have been
12 the pubis ---

13 Q Okay. Let's stop right there. It says Dr. Coker came
14 and added suprapubic pressure to the already applied
15 McRoberts maneuvers. What does that mean when you
16 document already applied McRoberts maneuvers?

17 A That we'd already applied McRoberts to the patient
18 before he got there.

19 Q Okay. And when you documented after the already applied
20 McRoberts maneuvers, you documented other maneuvers.
21 What did you mean when you documented other maneuvers?

22 A That would be suprapubic pressure and we attempted to
23 get our hand in the birth canal to effect some of the
24 rotational maneuvers, but were unable to do so because
25 the head cheeks were pulled up against the perineum and

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1 limited the room to place our hand in the vaginal ---

2 Q Okay. Doctor, that's an important point. Why don't you
3 come back to the witness stand so we can make sure
4 everybody can hear you.

5 MS. CRAIG: And let's keep this up please, Brian.

6 A Do I get to keep my stick or do you want that?

7 Q All right. You mentioned -- when I asked you what other
8 maneuvers was or what you mean by that, you said about
9 your hand and trying to do the maneuvers. I want you to
10 explain in detail what happened when you tried to do the
11 other maneuvers.

12 A Well, this is -- this wasn't just one point in time. I
13 mean, while -- I mean, after we recognized that the
14 patient had a shoulder dystocia, I think the first thing
15 we did is McRoberts and then when we were not able to
16 effect delivery with McRoberts alone, I think it was
17 Rebecca that was asked to apply suprapubic pressure. We
18 lowered the bed so she could apply suprapubic pressure
19 more effectively and when the shoulder did not deliver,
20 we -- we did an -- we had an episiotomy. We extended the
21 episiotomy. I tried to get my hand into the birth canal
22 to effect some of the rotational maneuvers and was
23 unable to get my hand in, so ---

24 Q Why couldn't you get your hand in? Explain that to us.

25 A Well, with shoulder dystocia, you know, the shoulders

1 are stuck under, the anterior shoulder is stuck under
2 the pubic symphysis and the posterior shoulder is wedged
3 into the sacral promontory and frequently the head
4 delivers, but it retracts back up against the perineum,
5 the tissue surrounding the vagina, so this is a baby's
6 head that's in the way so, you know, you're trying to
7 work your hand in there but there was just no room to
8 get my hand in there, so I extended the episiotomy and
9 tried again and when that didn't, when I couldn't get my
10 hand in again, I extended the episiotomy a second time
11 and so this -- you know, the head delivered at 13:44 and
12 I think the shoulders delivered at what, 13:49. While
13 we were attempting these things I think we re-attempted,
14 I mean, she was in McRoberts and we re-attempted
15 suprapubic pressure with the nurses and in the interim
16 Dr. Coker came down. I think he ran all the way from his
17 office and he assessed the baby or he assessed the
18 situation, took a look at the mom and where the baby's
19 head was and he suggested that we try suprapubic
20 pressure, so he got up on the stool and pushed on the
21 suprapubic pressure region and was able to dislodge the
22 baby's shoulder from behind the pubic symphysis.

23 Q Why were you, the nurses and Dr. Coker, why were you
24 using McRoberts, using suprapubic pressure and
25 attempting other maneuvers? Why were you doing all that?

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1 A Trying to effect the delivery of the anterior shoulder
2 or trying to resolve or take care of the shoulder
3 dystocia, get the baby delivered. We wanted to deliver
4 the baby before, you know, a prolonged period of time
5 occurred because these babies, if they stay in the birth
6 canal for a prolonged of time, they can get what's
7 called hypoxic-ischemic encephalopathy which means brain
8 damage due to lack of oxygen.

9 Q What else can happen to the baby?

10 A Babies can die.

11 Q Were you successful in delivering this baby?

12 A Yes, ma'am.

13 Q All right. You mentioned one thing I wanted to follow up
14 about. When the baby's head was delivered you said it
15 went back into the vagina.

16 A It retracted.

17 Q Retracted.

18 A Yeah.

19 Q That's what you said.

20 A Yeah. I mean ---

21 Q What -- what is that called?

22 A --- the head delivers, but the shoulders don't come
23 under the pubic symphysis so the head retracts and this
24 is known in obstetrics circles as the turtle sign.

25 Q All right. Just make sure I've got, that I've checked

1 off all of these. With regard to the vacuum, I've asked
2 you some questions. What was concerning to you regarding
3 the fetal heart tracing that you saw during the
4 delivery?

5 A Well, during the late second stage she started having
6 some variable decelerations, variables with late return,
7 and then there was an episode in there when she had some
8 bradycardia too, prolonged decelerations.

9 Q Is that why you used the vacuum?

10 A Well, one of the reasons.

11 Q We've gone through vacuum, Pitocin, the bed was down.
12 Was all that reasonable?

13 A It was, yes.

14 Q Now, when Mr. Graham held up the baby doll, when we had
15 the baby doll demonstration, and he was jerking the
16 baby's head around and jerking the arms and the legs, is
17 that what you did in this delivery?

18 A No, ma'am.

19 Q How do you know that you used downward gentle traction
20 to deliver this baby?

21 MR. GRAHAM: Objection, Your Honor. Leading and assuming
22 facts not in evidence.

23 THE COURT: That's not leading. It's an open-ended
24 question by it's very nature and I think it's an appropriate
25 question. He's an expert. He was there. I think it was an

1 appropriate question at this point.

2 Q So, Dr. Goldstein, how do you know that you used
3 downward gentle traction?

4 A Because that's what I've used for all these 37 years
5 that I've been practicing obstetrics.

6 Q And what did you do in this case? What kind of traction
7 did you use, sir?

8 A Gentle downward axial traction.

9 Q And is that your opinion to a reasonable degree of
10 medical certainty, most probably?

11 A Yes.

12 Q All right. We've gone through all the prenatal. We're
13 wrapping up here. We've gone through all of the
14 delivery. I believe that Ms. Fulton came to see you
15 after the delivery for some postpartum visits. Correct?

16 A Yes.

17 Q Okay. So, the first one was approximately a week after
18 the delivery.

19 A Right.

20 Q Who saw Ms. Fulton on the first postpartum visit?

21 A That would be me.

22 Q Okay. And how was she doing?

23 A Can I refer to my notes?

24 Q Of course.

25 A She was doing well.

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1 Q I'd like for you to -- what date is that?

2 A Let's see. Well, I have it in my chart. I can find it.

3 Q I would like to get the ---

4 A That was on 9/1/09.

5 Q Okay. Great. 9/1/09. That's the first postpartum visit.

6 A Right.

7 Q And what did -- what did you and Ms. Fulton discuss
8 regarding the delivery?

9 A As indicated on my notes or...

10 Q Well, is it your notes or your recollection, sir?

11 A We discussed the baby and the fact that the baby had had
12 a shoulder dystocia. I noted in my note that the baby
13 has no movement on the right arm secondary to brachial
14 plexus injury. I also noted she was taking the baby to
15 an orthopedic PT specialist, a physical therapy
16 specialist, and is going to be seen there and I reminded
17 her about exercises with the baby and said hopefully the
18 baby will start moving the right arm soon, and then we
19 discussed her diabetes and anemia, blood pressure and
20 her episiotomy.

21 Q And what did you and Ms. Fulton discuss regarding the
22 baby?

23 A About the shoulder dystocia and the injury to the right
24 arm. We just discussed what was going on and what her
25 plans were with the orthopedic physicians and the PT

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1 specialist.

2 Q And did you, did you give her advice at this visit? Did
3 you consult with her?

4 A Yes, ma'am.

5 Q And did you answer her questions?

6 A Yes, ma'am.

7 Q And what did Ms. Fulton say regarding the birth of the
8 baby?

9 A She told me she was just happy that she had a live,
10 healthy baby and thanked me for delivering her baby.

11 Q Okay. Dr. Goldstein, Ms. Fulton came back to you a
12 second time. Now, this is for a six-week postpartum
13 visit. Is that correct?

14 A Right.

15 Q And on this visit did you evaluate her?

16 A Yes, ma'am.

17 Q Did you answer her questions?

18 A Yes, ma'am.

19 Q Dr. Goldstein, did you provide appropriate and
20 reasonable care to Ms. Fulton and her child?

21 A Yes, ma'am.

22 Q Do you care about your patients?

23 A Always.

24 Q Did you care and do you care about Ms. Fulton?

25 A Yes, ma'am. I hope for the very best for both of them.

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1 Q Do you have the knowledge and the experience to deliver
2 a baby when confronted with the medical emergency of
3 shoulder dystocia?

4 A Yes, ma'am.

5 Q And based on that knowledge and that experience of 37
6 years, how long did it take you to deliver the baby
7 after the shoulder dystocia was recognized?

8 A Five minutes or less.

9 Q And if you and Nurse Lawrimore, Nurse Collins, and Dr.
10 Coker had been unable to dislodge the shoulder what
11 could have happened to the baby?

12 A Well, one thing is the baby could have hypoxic-ischemic
13 encephalopathy or brain injury. The other thing is fetal
14 death.

15 Q Now, we did this yesterday, but I want to wrap
16 everything up. Going back to the prenatal visits, based
17 upon your review and your recollection of the 19
18 prenatal visits that Ms. Fulton had with you, what is
19 your opinion as to whether you were carefully monitoring
20 and following Ms. Fulton throughout her pregnancy?

21 A I was. She had more prenatal visits than most people,
22 but she had more problems so we addressed those problems
23 and took care of them. I thought we managed her diabetes
24 very well. We addressed all of the issues.

25 Q And do you have an opinion whether you were carefully

1 monitoring and following her throughout her ---

2 A Oh, yes.

3 Q --- pregnancy?

4 A I was carefully monitoring her.

5 Q Now, moving to the delivery, based on the nursing notes,
6 the, your handwritten note, your dictated delivery note,
7 your discharge summary, do you have an opinion whether
8 you were carefully monitoring, evaluating and taking
9 care of Ms. Fulton throughout her labor and delivery?

10 A Yes, ma'am, I was very careful in taking care of Ms.
11 Fulton.

12 Q And are all of those opinions that you've given to a
13 reasonable degree of medical certainty, most probably?

14 A Yes, ma'am.

15 MS. CRAIG: Court's indulgence.

16 Q This is the best part of working with your dad. A few
17 more questions, then I'll sit down. Dr. Goldstein, did
18 you twist or turn the baby in any inappropriate way that
19 would cause the injury in this case?

20 A No, ma'am.

21 Q And please tell the jury how much pressure or traction
22 you used in the delivery of this baby.

23 A Well, it's hard to quantitate, but I used the same
24 downward traction that I use to effect delivery in all
25 of my OB patients.

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1 Q And we do need to explain that a bit. When you say it's
2 hard to quantitate or it's hard to -- to quantify the
3 amount of pressure or traction, you need to explain why
4 that is.

5 A Well, it's hard to take a series of 100 women and put
6 pressure on the baby's head to effect delivery and
7 quantitate how much pressure is being applied.

8 Q Did you do anything to cause harm to Ms. Fulton or her
9 baby?

10 A No, ma'am.

11 Q And were you ---

12 A I did the best I could to deliver her baby safely and
13 effectively.

14 Q Were you negligent in this delivery?

15 A No, ma'am.

16 Q And Dr. Goldstein, were you reckless in delivering this
17 baby within four minutes of recognizing the shoulder
18 dystocia?

19 A No, ma'am, I did the very best I could for Ms. Fulton
20 and her baby.

21 Q Are all of the opinions that you've given today and
22 yesterday are to a reasonable degree of medical
23 certainty, most probably?

24 A Yes, ma'am.

25 MS. CRAIG: I got the nod, so those are all the questions

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1 I have.

2 THE COURT: Madam forelady, ladies and gentlemen of the
3 jury, I'm going to ask if you could retire to the jury room
4 for one moment. Do not discuss the case in any way, shape or
5 form. Everyone remain seated.

6 (Jury out at 10:11 AM)

7 THE COURT: Madam bailiff, I'd like to see the juror out
8 with the white shirt and red collar. He sits about midway in
9 the front row and he wears glasses, sometimes. White shirt,
10 red collar.

11 (The juror enters the courtroom.)

12 THE COURT: Yes, sir, how are you doing? Come on up right
13 here. Counsel, feel free to come up here. I just want to
14 speak with him on the record up here at the bench. How are
15 you doing this morning? Well, let's wait until these lawyers
16 get up here.

17 First of all, I want to thank you for being here. I know
18 that it's a long, arduous process. The wheels of justice
19 grind, kind of, slowly and you're certainly not being paid
20 for your services, legitimately. One of the things I've
21 noticed throughout the trial is that sometimes you shut your
22 eyes and I need to make a determination as a trial judge as
23 to whether or not you're asleep or simply just closing your
24 eyes and listening. We quite often do that. I need to make
25 that determination to determine whether or not you've been

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1 paying attention. Have you been paying attention?

2 JUROR: Yes, sir, I have.

3 THE COURT: I thought so. When I was looking at you, you
4 know, your head wouldn't nod. It's just, some people listen
5 better with their eyes shut. Have you been paying attention?

6 JUROR: Yes, sir.

7 THE COURT: Okay. Very good. And thank you. That's what I
8 wanted to ask you and I want to thank you for your service.
9 Very good. Thank you so much. You may return to the jury
10 room.

11 (The juror exits the courtroom.)

12 THE COURT: I wanted to do that. Of course, the case law
13 in South Carolina kind of encourages you to, in fact, do
14 that, to ask them whether or not they have been paying
15 attention and it appears to me as if he has and one of the
16 things I've noticed, I quite often will go to the picture
17 show and I always get Raisinettes and a big old soda and it
18 makes me, when they turn off the lights, I usually last about
19 10 minutes in a picture show. When I do, my head always falls
20 backwards and falls forward. In this case, he has not done
21 any of that. I've watched him closely. His eyes are shut, but
22 I don't believe he's fallen asleep. I've asked him and he
23 says that he's paying attention. The predicament that puts me
24 in is, you know, if there's ever an accusation that somebody
25 has fallen asleep, you know, if someone shuts their eyes and

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1 I just automatically just take them off, I think that's
2 unfair to perhaps the other party. It's unfair to everyone.
3 They have a right to serve and the law seems to indicate that
4 it's incumbent upon the person moving to have the juror
5 excluded to determine -- or to show prejudice and Ms. Craig,
6 you're recognized as to how you've been prejudiced.

7 MS. CRAIG: Yes, sir, and just so it's clear, I've
8 noticed him with his eyes closed since Monday.

9 THE COURT: Right.

10 MS. CRAIG: And I know that we were in -- you know, in
11 jest, teasing that it's okay for him to sleep during, you
12 know, Mr. Graham's case or when Mr. Graham was questioning
13 witnesses, but it really isn't, because he's not getting all
14 of the information or the education and so when I -- so I saw
15 him with his eyes closed on Tuesday off and on and I clearly
16 saw him today. I mean, I kept raising my voice a little bit
17 and moving around, trying to wake him up and he had his eyes
18 closed during the examination of Dr. Goldstein. I noticed
19 yesterday that he did have his hand up on his, on his cheek
20 and I don't know if that was helping him from bobbing his
21 head back and forth. But given, regardless of whose case he's
22 sleeping in, now he's sleeping in our case. He slept on and
23 off throughout Mr. Graham's case.

24 This is a very complex medical malpractice case that
25 needs the attention of every single one of those jurors and

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1 the two -- the easy fix here is just to seat one of the
2 alternates, because they have been very attentive and I
3 haven't seen them fall asleep at all and they are listening
4 intently to all of the evidence and it's just my concern that
5 regardless of when he is closing his eyes, that it's been in
6 both Mr. Graham's case and in our case now, but regardless of
7 when he's doing that, he's just not getting all of the
8 information and this is a lot of information about a
9 complicated medical obstetrical emergency and I just, I'm
10 concerned that he's getting bits and pieces and, and there's
11 such an easy fix for this and that we don't have to worry
12 about whether or not he's really sleeping when he closes his
13 eyes or if he's thinking when he's closing his eyes.

14 THE COURT: Thank you.

15 MS. CRAIG: And another point is with regard to this
16 morning, I had several Court exhibits, blow-ups, and
17 yesterday used the medical illustrations, so to the extent
18 that he not only needs to hear what we're saying, he needs to
19 see what we're showing him and the educational piece of this
20 and to the extent that he is closing his eyes, I'm not only
21 worried about him sleeping, but he's not clearly seeing the
22 evidence that we're trying to explain and present to the
23 jury.

24 THE COURT: All right. You know, in looking at the cases
25 that deal with sleeping jurors, one of the things that's

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1 clear is it's treated differently in a criminal case than a
2 civil case. One of the things -- this is what the state of
3 the law is and in South Carolina says indeed the great
4 majority of courts in other states considering the sleeping
5 juror have utilized this approach and South Carolina assumes
6 this approach. It says to cause harm to a defendant does not
7 automatically follow a determination that a juror is
8 sleeping. Most states require a defendant to show prejudice
9 such as the juror failed to follow some essential part of the
10 proceeding.

11 MS. CRAIG: Your Honor, that's what we've got. He's not
12 reading any of the evidence that's been up on the screen,
13 that I've got blow-ups on. That's the problem we've got. His
14 eyes, we all -- nobody disputes his eyes are closed so he
15 can't see the evidence. I do have to say that I'm slightly
16 worried that, that he would now blame us for coming in and
17 being asked questions. I understand why Your Honor did that
18 and that's not my issue, but I think that since he was called
19 in now and I was the one doing the presentation, it's pretty
20 obvious that we all saw him sleeping and that I would
21 probably be the one to complain about it.

22 THE COURT: Mr. Graham, what do you have to say about it?

23 MR. GRAHAM: A few things, Your Honor. First of all,
24 there's absolutely not a shred of evidence that this man has
25 fallen asleep, once. He's had his eyes closed from time to

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1 time. I've had my eyes closed from time to time. Looking
2 around the courtroom, several jurors have had their eyes
3 closed from time to time. Several lawyers have had their eyes
4 closed from time to time. That's just human behavior and
5 from, from an outward appearance you can't tell if eyes
6 closed equate to sleeping or not. From all indicia, all
7 objective indicia, the man has been awake. As Your Honor
8 noted, his head hasn't been nodding back or forward. He
9 testified in front of Your Honor that he has been listening.
10 He has not fallen asleep. It's as though the defense wants
11 to have a fifth peremptory strike. And, Your Honor, every
12 single exhibit put up by the defense has either been read
13 verbatim, or substantially verbatim, and even with my poor
14 eyesight standing back there, I didn't feel the need to
15 actually read what was up here because they were reading it
16 for me.

17 MS. CRAIG: Briefly, Your Honor. Whether other people
18 have been nodding off is completely irrelevant. What ---

19 THE COURT: Say that again now?

20 MS. CRAIG: Whether or not other people have been
21 nodding off is completely irrelevant. What's important is
22 that this jury is listening to the evidence and Mr. Graham
23 just admitted that he has had his eyes closed. I mean,
24 there's no way anyone can say, that's been in this trial,
25 that this man hasn't had his eyes closed.

1 THE COURT: Well, these cases -- you know, he says his
2 eyes are closed but he hasn't been asleep. These cases
3 contemplate somebody actually going to sleep and it being
4 appropriate to keep them on the jury under certain
5 circumstances.

6 MS. CRAIG: In a highly complex medical malpractice case
7 where something as serious as this, when we have -- we have
8 two alternates who have been paying attention the whole time.
9 I just ask in your discretion and it's such an easy way to
10 fix this problem. Then, we know that we have 12 jurors who
11 have been attentive to the evidence.

12 THE COURT: Well, how do I deal with the fact that he's
13 testified here in Court that, that he was awake and paying
14 attention?

15 MS. CRAIG: Because I think that if you're called in
16 front of the Judge and asked questions in front of the Judge
17 in Court, he's going to, he's going to be nervous, possibly
18 intimidated and with all due respect, he's going to say he's
19 paying attention. He's not going to admit to you and to this
20 courtroom full of people that he's sleeping and not listening
21 to the evidence.

22 MR. GRAHAM: Your Honor, I would just remind Your Honor
23 that during voir dire, Ms. Craig asserted the exact opposite:
24 That whatever a juror stated to Your Honor should be accepted
25 as the truth. I don't believe it's proper for Defense counsel

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1 to be the judge of the credibility of a juror who testifies
2 before Your Honor that he's been listening and has not been
3 asleep. There is absolutely not a shred of evidence to
4 suggest that that is anything but the truth.

5 MS. CRAIG: You know, that's completely different than
6 when you brought up all the different jurors to ask them
7 specific questions about their qualifications. I mean, there
8 are a lot of people coming up. There's a lot of discussion.
9 I mean, he's the only juror, other than the CNA the other
10 day, that's been asked to come out and been asked, are you
11 sleeping. I mean, what is he supposed to say with a courtroom
12 full of people with a judge? If he says yes, I'm sleeping ---

13 THE COURT: And he might say ---

14 MS. CRAIG: --- and he's scared he's going to get in
15 trouble.

16 THE COURT: --- that you and Mr. Graham are very boring
17 and I did go to sleep. That's what he might say. I don't
18 know. But one of the -- the beauty of it is that there's been
19 a lot of repetition in this trial, as well. Even if you
20 assume there was a little bit of sleeping, we've heard it at
21 least twice, a lot of everything, so I'm going to -- you
22 know, we don't have to make a decision right now, but I'm
23 going to take it under advisement. We still have two
24 alternate jurors, so I just want to put that on the record
25 and hear what you had to say about it.

1 MS. CRAIG: Thank you, Your Honor.

2 THE COURT: All right. With regard to Ms. Craig
3 concerning the playing of video snippets as a part of cross
4 examination, have you had an opportunity to prepare reply
5 video snippets?

6 MS. CRAIG: No, Your Honor, he hasn't -- the only video
7 snippets that we received were for the use with Gomez-Carrion
8 so, I mean, I don't know if he was going to use the same
9 snippets, but as far as specific snippets that he plans to
10 use for Dr. Goldstein, those have not been identified at all.

11 THE COURT: So you don't even know what ---

12 MS. CRAIG: I have no clue, Your Honor.

13 THE COURT: All right. Based on that, I'm not -- I'll be
14 glad to hear from you. Yes, sir.

15 MR. GRAHAM: Yes, Your Honor. First of all, Your Honor,
16 for me to, to -- I don't know of any rule in the civil
17 procedure rules that requires me to share with Defense
18 counsel my cross examination questions ahead of time.

19 THE COURT: If it deals with a deposition you do.

20 MR. GRAHAM: Well, they -- excuse me?

21 THE COURT: If it deals with a deposition, don't you have
22 to designate it?

23 MR. GRAHAM: No, sir. If we're doing a de bene esse ---

24 THE COURT: Right.

25 MR. GRAHAM: --- but if, but this is impeachment. I have

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1 no idea until I hear his testimony when he's going to testify
2 consistently with his deposition and when he's going to say
3 things that are the total opposite of what he said under oath
4 at his deposition. We'd like the right when he testifies at a
5 totally opposite position today compared with deposition it
6 prejudices our case if we're limited to the cold words in the
7 transcript. We need to be able for the jury to see ---

8 THE COURT: Well, I understand. I understand your
9 position.

10 MR. GRAHAM: --- and if Your Honor please, in terms of,
11 in terms of giving advance notice, certainly the impeachment
12 that we received from our witnesses, we had no prior notice
13 of and I didn't expect it because I've never gotten that and
14 I've never given that and nobody's ever complained about it.

15 THE COURT: What do you have to say about that, Ms.
16 Craig?

17 MS. CRAIG: Your Honor, first of all, we're not
18 preventing him from -- if he thinks he's got proper
19 impeachment, he knows how to do it with a deposition. The
20 same way I did it with his witnesses, but the Rule of
21 Completeness is very clear. This is Rule 32.4 and it says if
22 only part of a deposition is offered in evidence by a party
23 an adverse party may require him to introduce any other part
24 which ought, in fairness, to be considered with the part
25 introduced and any party may introduce any other parts. So,

1 if he wants -- first of all, there was no notice on this.
2 Second of all, if he wants to do this, we're going to need to
3 stop and set a -- and we're going to have to go through and
4 then put it into context with the Rule of Completeness to
5 make sure because I -- I have a pretty good feeling based on
6 some designations I saw for Gomez-Carrion, that they're out
7 of context. They're little snippets. They're parts of
8 answers. It's not the whole thing and it's so confusing and
9 prejudicial.

10 THE COURT: I understand your position in great detail.
11 You articulated it very well, but under these circumstances
12 I'm not going to allow cross examination with video. However,
13 you can have ample opportunity to use the deposition in any
14 way in written form. That's my ruling and you're protected on
15 the record. We're ready for ---

16 MR. GRAHAM: Your Honor, may we have a short break before
17 we bring the jury back?

18 THE COURT: Just one moment. All right. We're going to
19 take about a five-minute recess.

20 (Brief break)

21 THE COURT: Are y'all ready to proceed?

22 MR. GRAHAM: Yes, sir, Your Honor.

23 THE COURT: Anything from the Plaintiff before we
24 proceed?

25 MR. GRAHAM: No, Your Honor.

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1 THE COURT: Anything from the Defense?

2 MS. CRAIG: No, sir, Your Honor.

3 THE COURT: We're ready for the jury.

4 (Jury in at 10:36 AM)

5 THE COURT: Mr. Graham, you're recognized for cross
6 examination.

7 MR. GRAHAM: Thank you. Thank you, Your Honor. May it
8 please the Court.

9 CROSS EXAMINATION

10 BY MR. GRAHAM:

11 Q Dr. Goldstein, good afternoon.

12 A Good afternoon or good morning.

13 Q That's right. It's been a long morning. Sir, let me ask
14 you, with respect to what you and your lawyer have been
15 calling an informed consent document, that's really just
16 the hospital admission consent form. That's the only
17 consent form that was ever signed by Genesie. True?

18 A True.

19 Q With respect to that consent form, you don't have any
20 personal involvement until much later, do you?

21 A In signing the consent?

22 Q Yes, sir.

23 A No. They sign the consent when they come into the
24 hospital.

25 Q Okay. But you don't have any personal involvement in

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1 that process, do you?

2 A No. I sign the consent after, after the fact.

3 Q Yes, sir, and, in fact, in this case what was the date
4 of this child's birth?

5 A 8/20/09.

6 Q Okay. And is that your signature on the bottom right
7 where it says physician signature?

8 A Correct.

9 Q Is that the date to the left?

10 A Yes.

11 Q Is that your handwriting?

12 A No.

13 Q Do you have any reason to question the accuracy of the
14 date to the left of your signature?

15 A No. That's the date that I signed it, date and time.

16 Q That was on October the 5th?

17 A Right.

18 Q Some month-and-a-half after this child was delivered?

19 A That's probably when the chart appeared in my box.

20 Q Yes, sir, and when it comes to -- when it comes to
21 talking to a patient about giving consent to enter the
22 hospital and delivery a baby, you don't have any
23 involvement with talking to the patient about the risks
24 of induction or vacuum and the alternatives, do you?

25 A Well, those are things that we discuss in the prenatal

1 course.

2 Q Sir, have you ever obtained a specific informed consent
3 for the use of a vacuum?

4 A Not specifically for the vacuum.

5 Q Have you ever obtained a specific informed consent for
6 induction of labor with Pitocin?

7 A Not specifically.

8 Q And do you know how many -- do you know what an average
9 obstetrician, the percentages that an average
10 obstetrician induces labor in?

11 A No, I don't know the average.

12 Q All right. But your personal rate is 75%. Correct?

13 A Not sure if that's exactly correct, but somewhere in
14 that range.

15 Q Well, that's the figure you gave us in your deposition.
16 Right?

17 A That's, approximately.

18 Q And of all those 75% or so times you decided to induce a
19 pregnant lady's labor and delivery with drugs, with the
20 drug Pitocin, how many of those times did you talk to
21 her and inform her about the risks of inducing her labor
22 with a drug like Pitocin?

23 A We discuss the process during the prenatal period,
24 especially beginning at 32, 34 weeks, 36 weeks, when
25 they're getting close to term. We discuss this and what

1 the plans for delivery are and what their plans for
2 anesthesia are.

3 Q Sir, you've never asked -- you've never informed a
4 patient and obtained her informed consent about the
5 risks of induced labor, have you?

6 A No.

7 Q And do you know how many obstetricians, or what the
8 average percentage is of vacuum extraction deliveries by
9 a typical obstetrician in this country?

10 A No.

11 Q You deliver at least 25 percent of your babies by
12 C-section. True?

13 A Correct.

14 Q And of the, of the vaginal deliveries you deliver 40 to
15 50% of those women with a vacuum extractor. True?

16 A True, but it's used as, what we used to refer to as an
17 outlet forceps, almost 90% of my patients have epidurals
18 and a lot of times when it gets to the time to push they
19 are unable to generate enough force to deliver the
20 baby's head, so we apply the vacuum and assist and as I
21 tell them, you push and I'll pull. So, it's basically
22 just to help the baby over the perineum.

23 Q You push and I'll pull. Before the doctor puts his hands
24 on the baby's head, either directly with his hands or
25 indirectly with forceps or a vacuum suction device,

1 mother nature is pushing the baby from behind. True?

2 A That is correct.

3 Q It's -- this business about you push and I'll pull, that
4 only happens when the doctor decides he's going to
5 intervene into the natural delivery process. True?

6 A Well, the natural delivery process sometimes is not
7 effective at getting the baby out that last little bit
8 and it depends on the mother's ability to push and how
9 well and effectively she does push, so frequently, it's
10 simply to help the mother out.

11 Q And when you induce labor that's to help the mother out
12 with her schedule planning, not to help yourself out.
13 True?

14 A Well, some of these patients live in Lake City and
15 Johnsonville and other parts out. It's difficult for
16 them to get into the hospital at night, so frequently,
17 you know, we set up a time where it's convenient for
18 them to be there and it progresses well.

19 Q Inducing labor is convenient for you, isn't it, Dr.
20 Goldstein?

21 A It's convenient for me and the patient.

22 Q Yes, sir, and when you deliver a baby by induction you
23 can make sure you have a nine-to-five type job in terms
24 of delivering that baby. True?

25 A Well, it doesn't always work out that way.

- 1 Q But that's what you intend to happen.
- 2 A Not necessarily.
- 3 Q You intend ---
- 4 A I intend to be there when they have their delivery.
- 5 Q Yes, sir, and you intend to influence the time of day
- 6 during which they have their delivery. True?
- 7 A Well, when we have them come in at that hour of the
- 8 morning, it certainly does occur during the daylight
- 9 hours, but sometimes these deliveries occur in the
- 10 night. Frequently, they come in on their own.
- 11 Q And despite, despite, despite your intervention with
- 12 mother nature with induction and vacuum, you have never
- 13 obtained an informed consent for either one. True?
- 14 A Despite my intervention with mother nature.
- 15 Q Yes, sir.
- 16 A What was the rest of the question?
- 17 Q You've never, ever, obtained an informed consent from
- 18 any of your patients for induction or labor or use of a
- 19 vacuum. True?
- 20 A Well, other than the standard consent that they sign
- 21 when they come into the hospital.
- 22 Q That you have nothing to do with.
- 23 A That I have nothing to do with.
- 24 Q The Mityvac is what you said today that you used to
- 25 deliver this child?

1 A I think that's the name of it. It's the, the cup that is
2 a bell-shaped cup.

3 Q Have you read the product description about the dangers
4 of using Mityvac?

5 A At some time in the past.

6 Q Yes, sir, then you would be familiar that one of the
7 contraindications is when there's a suspected risk of
8 shoulder dystocia, you're not supposed to use a Mityvac.
9 You knew that, didn't you, doctor?

10 A I think the operative delivery that is a risk that's
11 associated with shoulder dystocia is in the, in that
12 this occurs in some patients, but it's not a predictive
13 risk.

14 Q All right. But you admit that the contraindications for
15 the Mityvac product warning sheet says, and I quote, do
16 not initiate vacuum if any of the following conditions
17 exist, and I'm going to skip down to number four, the
18 second part of which is risk of shoulder dystocia.

19 A That's correct.

20 Q You're not supposed ---

21 A I mean, you're reading it. I'm assuming that that's
22 correct.

23 Q Would you like to see it, sir?

24 A So, number four says suspected macrosomia or risk of
25 shoulder dystocia.

1 Q Yes, sir.

2 A So, we didn't suspect that there was macrosomia in this
3 patient.

4 Q Okay. But you knew there were risks for shoulder
5 dystocia. True?

6 A It's a risk, but it's not a predictive risk. It doesn't
7 predict.

8 Q When you say "it" doesn't predict, what is "it"?

9 A Macrosomia or operative delivery.

10 Q All right. Well, this says do not initiate vacuum if any
11 of the following conditions exist: number four,
12 suspected macrosomia or risk of shoulder dystocia. True?

13 A Well, there wasn't a risk of shoulder dystocia in this
14 patient. We didn't -- I mean, shoulder dystocia was not
15 diagnosed until after the head was delivered and it was
16 the anterior shoulder that was stuck under the symphysis
17 pubis.

18 Q In fact, doctor, you've known since you were a resident
19 that diabetes in a woman is a risk factor for shoulder
20 dystocia. True?

21 A Diabetes is a risk factor in that it's associated with
22 macrosomia.

23 Q It's a risk factor for a shoulder getting stuck. True?

24 A No, it's a risk factor for macrosomia and again, like
25 the other things, it's not predictive. There's no way of

1 predicting or preventing shoulder dystocia.

2 Q But when there's a risk of shoulder dystocia, a vacuum
3 extraction is contraindicated according to the
4 manufacturer of the device you chose to use without
5 informed consent. True?

6 A According to that sheet, yes.

7 Q Yes, sir. And according to this sheet, there are risks
8 of numerous adverse events to the baby and the mama.
9 True?

10 A Where are you? Adverse events?

11 Q Yes, sir.

12 A All right. So, head trauma, bruises, contusions,
13 lacerations, scalp edema and so how, how significant do
14 you think those are.

15 Q Do you think they're significant enough to talk to the
16 patient about?

17 A Well, these, these are things that, you know, that are
18 very minor. They have fractures, cephalohematoma,
19 subgaleal hematoma and that's a possibility, but it's
20 very rare. It's less than .1%.

21 Q The manufacturer of the Mityvac vacuum device that you
22 chose to use in this case without warning to the mother
23 provides you with warnings that adverse events include
24 the following for the mom: vaginal, cervical, uterine,
25 bladder and rectal tissue tears. Did you tell Genesie

1 about any of those risks?

2 A No.

3 Q It -- this form from the manufacturer indicates fetal
4 injuries that include; head trauma, bruises, contusions,
5 lacerations, scalp edema. That's swelling of the head.
6 Right?

7 MS. CRAIG: Objection, Your Honor. Relevance. These
8 are none of the, none of the issues involved in this case.

9 MR. GRAHAM: It goes to informed consent, if Your Honor
10 please.

11 THE COURT: I'll allow him some leeway.

12 Q Scalp edema, that's swelling of the head. Right?

13 A That's swelling at the site at which the Mityvac is
14 applied.

15 Q Skull fracture, cephalohematoma. That's a, that's a ---

16 A Edema of the scalp in which there's some blood collected
17 under the skin.

18 Q Subgaleal hematoma. That's a blood clot in the brain.
19 True?

20 A That's correct.

21 Q Subdural hemorrhage. That's bleeding inside the brain.
22 True?

23 A That is true, but it's an awful rare occurrence.

24 Q Parenchymal hemorrhage. That's another form of bleeding
25 inside of the baby's brain. True?

1 A I'd, I'd have to refer to the literature for that.

2 Q Yes, sir.

3 A But I think if you Google these things you'll find out
4 that they're extremely rare.

5 Q They're important enough for the manufacturer to warn
6 you that you should warn the patient. True?

7 MS. CRAIG: Objection, Your Honor. Standard of care is
8 not what the manufacturer says.

9 THE COURT: I'll -- might counsel approach the bench?

10 (Bench conference off the record)

11 MS. CRAIG: Your Honor, just object if they don't have
12 another copy. I haven't seen this or this is the first I've
13 been made aware of this.

14 MR. GRAHAM: Your Honor, during direct exam they
15 identified the Mityvac.

16 (Bench conference resumes)

17 MR. GRAHAM: Thank you. May it please the Court.

18 Q Doctor, before that break in my questioning, we were
19 going through various fetal injuries, some of which are
20 relatively minor like bruises and cuts, but others are
21 quite serious like head trauma, skull fracture, brain
22 bleeding in different parts of the brain, blood clots.
23 How many times have you ever warned any of your
24 maternity patients that you delivered, whose children
25 you delivered with a vacuum, that there were these

1 dangers involved in your choice to use a vacuum?

2 A Probably, not very many.

3 Q In fact, you've never done that, have you, doctor?

4 A No, that's, that's not one of the things I do.

5 Q You've never warned a patient about any of the risks of
6 vacuum extraction. True?

7 A Well, I've never had any of the risks occur other than
8 maybe an edema of the scalp.

9 Q In terms of informing the patient so she can participate
10 in important decisions about her health and her baby's
11 health, you've never provided those warnings to the
12 patient, have you?

13 A No.

14 Q That was no?

15 A No.

16 Q Thank you. Let's talk about standard of care. Sir, do
17 you believe that there exists certain standards of care
18 for obstetricians that all obstetricians are supposed to
19 meet or exceed, not fall short of? Do you believe that
20 there are standards of care that place a limit on how
21 much traction can be used on a baby's head and neck
22 during shoulder dystocia?

23 A I believe there are standards of care but the standards
24 of care are legal terms and I think the legal term is
25 what a corresponding physician under similar

1 circumstances in a similar position would do prudently.

2 Q Yes, sir, and despite your testimony here today you gave
3 deposition testimony before. Do you recall that?

4 A I do.

5 Q All right. We videotaped it?

6 A Yes.

7 Q You had at least two lawyers present with you?

8 A Yes.

9 Q You were sworn to tell the truth?

10 A Yes.

11 Q And at that time ---

12 MS. CRAIG: Your Honor, this is improper use of
13 deposition. If he has a question he needs to ask it.

14 THE COURT: That is correct. You need to ask whatever
15 information was asked in the deposition and if he agrees with
16 it you don't have to talk about the deposition, but if he
17 says something different you can cross examination him and
18 impeach him with it.

19 MR. GRAHAM: Yes, sir. All right.

20 THE COURT: So ask him the question first and see what
21 his response ---

22 MR. GRAHAM: Well, I already did, Your Honor. I asked him
23 if he believed there were certain standards of care placing
24 limits on traction.

25 THE COURT: Okay. All right. I assume he said something

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1 different in his deposition. If so ---

2 MR. GRAHAM: Absolutely, Your Honor.

3 THE COURT: --- you can ask him about it.

4 DR. GOLDSTEIN: No, you asked me about standard of care
5 and I told you that there is a standard of care and it's a
6 legal term and it has to do what a physician or physicians
7 under certain or similar circumstances would do.

8 MR. GRAHAM: Yes, sir, I understand that definition.

9 Q My question, sir, is, do you believe there exists a
10 standard of care that puts a limit on how much traction
11 a doctor is allowed to put on a baby's head and neck
12 during shoulder dystocia?

13 A I don't think that -- I mean, the standard of care is
14 something that particularly, I mean, we don't have a
15 standard of care for each and everything that we do. We
16 don't have standard of care for placing the IV. We don't
17 have a standard of care for tubal ligation or removing
18 the tube or, you know, any of the procedures that we do.

19 MR. GRAHAM: Your Honor, may I ---

20 A It's a -- it's a legal term.

21 MR. GRAHAM: Your Honor, may I unseal the deposition?

22 THE COURT: Yes, you may.

23 MR. GRAHAM: And, if Your Honor please, we have video
24 discs as well as the original deposition.

25 Q Please, sir, turn to page 109 of your deposition.

1 Starting at line 17 through 25.

2 MS. CRAIG: I'm sorry. Seventeen...

3 MR. GRAHAM: Page 109, lines 17 through 25.

4 MS. CRAIG: Okay. Thank you.

5 MR. GRAHAM: Sure.

6 Q Was this my question and your answer, sir?

7 Q Sir, do you believe that there exists certain
8 standards of care for obstetricians that place a
9 limit on how much traction can be used on the
10 baby's head and neck in the context of managing a
11 shoulder dystocia complication? And your answer
12 was:

13 A Well, once again it's, it's hard to quantitate
14 traction, if not impossible, and I don't think that
15 there's a standard of care for traction.

16 Q Was that my question and your answer?

17 A That was my -- that's true. That was the answer, but
18 also above that on line four you asked the same question
19 and I answered that I didn't understand.

20 MS. CRAIG: And, Your Honor, under the Rule of
21 Completeness, we'd ask that the next question be asked and
22 the next answer given.

23 THE COURT: I think that would probably be more
24 appropriate for redirect.

25 MS. CRAIG: Yes, sir. Thank you.

1 THE COURT: Just make a note of it and you'll be given
2 ample opportunity to address all those issues.

3 MS. CRAIG: Thank you.

4 Q Doctor, are there any safety rules in medicine that
5 place limits on how much traction can be used by an
6 obstetrician trying to deliver an anterior shoulder that
7 is lodged behind the mother's pubic bone?

8 A I don't think ---

9 MS. CRAIG: Objection, Your Honor. We don't -- we don't
10 operate under rules. We dealt with this in pre-trial. It's
11 what the standard of care is.

12 MR. GRAHAM: And if Your Honor please, Dr. Gomez-Carrion
13 has already indicated that the purpose of standards of care
14 are to...

15 Q Doctor, do you believe that it would ever be
16 inappropriate to give more than gentle traction and if
17 so, under what circumstances?

18 A Are you reading from the deposition again, or is that a
19 question?

20 Q I'm asking you a question, sir.

21 A Could you repeat please?

22 Q Sure. Doctor, do you believe that it would ever be
23 inappropriate to give more than gentle traction and if
24 so, under what circumstances?

25 A Well, generally in our practice of obstetrics we learn

1 gentle downward traction and that's generally what we
2 use and that's what I used in this case.

3 Q Sir, please turn to your deposition at page 130, lines
4 one through seven. Did I ask the following question and
5 you give the following answer?

6 Q Do you believe that it would ever be
7 inappropriate to give more than gentle
8 traction and if so, under what circumstances?
9 And your answer.

10 A Inappropriate to give more than gentle
11 traction? So, well, I guess I'd have to say I
12 don't know. I'm trying to help you out here
13 but I'm, I'm, I'm not certain of these.

14 Q Was that my question and your answer?

15 A Evidently, so.

16 Q Yes, sir. Doctor, do you believe there are any
17 circumstances under which you believe an obstetrician
18 must refrain from using greater than gentle traction on
19 the baby's head and neck and if so, what are they?

20 A Refrain?

21 Q Yes, sir.

22 A Well, I think that in our practice we refrain from
23 giving more than gentle downward traction traditionally.
24 That's what we learn in our medical school. That's what
25 we learn in residency and that's what we practice in, in

1 our practice.

2 Q Page 128 please, line 23, through page 129, line 6.

3 Doctor, at your deposition did I ask the following
4 question and you give the following answer?

5 Q Are there any circumstances under which you believe
6 an obstetrician must refrain from using greater
7 than gentle traction on the baby's head and neck
8 and if so, what are they?

9 A Are there any circumstances? Now, this is the other
10 way. Are there any circumstances in which the
11 doctor must refrain.

12 Q Yes, sir.

13 A I don't know.

14 Q Was that your answer under oath to my questions on those
15 subjects at your deposition?

16 A Yes, sir, but again, I don't -- you know, I'm not sure
17 if I could explain in what context. You know, practicing
18 medicine is not an exact art. It's the art of taking
19 care of the mother and infant as the mother and the
20 infant pair, doing the best we can for the babies, doing
21 the best we can for the mother and in this case that's
22 what I did for the patient, Ms. Fulton.

23 Q Sir, do you claim to have any experience dealing with
24 shoulder dystocias in medical school or residency with,
25 in a hands-on way?

1 A Resident? No, not in a hands-on way.

2 Q Yes, sir, and then when you started practicing, doctor,
3 in Camden before you moved to Florence, did you have any
4 experience with shoulder dystocias there?

5 A Yes, during my years of practice I maybe had five or so
6 shoulder dystocias.

7 Q Okay. I'm asking about Camden, not Florence.

8 A Well, I can't separate them out specifically and I can't
9 remember them individually, but I know I've had cases of
10 shoulder dystocia.

11 Q And then you left ---

12 A And fortunately, fortunately, most of these resolved
13 with suprapubic pressure and McRoberts.

14 Q In fact, you've never successfully performed any
15 internal maneuver ever. True?

16 A I've never had to.

17 Q You've never -- how many -- you claim that you've only
18 attempted any internal maneuver one time. True?

19 A That was in Ms. Fulton's case.

20 Q Yes, sir.

21 A The other cases resolved with suprapubic pressure and
22 McRoberts.

23 Q The point, sir, you've, you've had zero experience
24 performing a Wood's maneuver ---

25 A But that doesn't mean I don't know how to do them.

1 Q Well let me finish my question, sir.

2 A Okay.

3 Q Before Genesie was induced and her baby's head delivered
4 with a vacuum, you had never even attempted to perform a
5 Woodscrew maneuver. True?

6 A No, I hadn't but I hadn't needed to ---

7 Q So ---

8 A --- but that doesn't mean that I do not know how to do
9 them. I've studied in the text, in the literature. I've
10 had residency training and, all of which, you know,
11 instructed me how to do these things.

12 Q And until you induced Genesie and pulled Bryson's head
13 with a vacuum that day, you had never even attempted a
14 Rubin's maneuver. True?

15 A I've not attempted the, I've not had to do the
16 rotational maneuvers and in Ms. Fulton's case, I was
17 unable to get my hand in there to do the rotational
18 maneuver, but that doesn't mean that I wasn't fully
19 capable of doing it if I had the opportunity.

20 Q It does mean you were completely inexperienced. True?

21 A It doesn't mean I was completely inexperienced, no. I
22 had the knowledge and the skills but I've never had to
23 do it in real life.

24 Q How many experiences in real life or pretend life have
25 you had where you performed a Wood's maneuver? Is it

1 more than zero?

2 A How many -- please, repeat.

3 Q Yes, sir. You said something about real life. Whether
4 real life or some other kind of life, how many
5 experiences do you claim you've ever had attempting a
6 rotational maneuver before Genesisie?

7 A I've never had to do one.

8 Q Zero experience?

9 A I could -- you could call that zero experience ---

10 Q Before Genesisie ---

11 A --- but that doesn't mean that I don't know what to do
12 given the opportunity or the circumstances in which it's
13 required.

14 Q And when it was required you couldn't even get your hand
15 in. True?

16 A When it was required, the head was in the way and I
17 attempted or I did extend the episiotomy in an attempt
18 to get the rotational maneuvers performed, but was
19 unsuccessful in being able to jam my hand into the
20 vaginal canal around the baby's head so that I could do
21 the rotational maneuvers.

22 Q So, you were unsuccessful in trying to jam your hand in
23 there?

24 A Exactly.

25 Q How much experience had you had, trying to jam your hand

1 in there before, in a shoulder dystocia situation?

2 A I'm sorry? I've not had to do the rotational maneuvers
3 before. Fortunately, these other cases resolved with
4 simply McRoberts or McRoberts plus suprapubic.

5 Q Yes, sir. How much ---

6 A And those, I mean, most of the literature calls to
7 perform McRoberts and suprapubic first before you have
8 to attempt rotational maneuvers or posterior arm
9 delivery.

10 Q And when you were unable to get Bryson's head out before
11 Dr. Coker came to the rescue, how many -- you, in fact,
12 tried to jam your hand into Genesie's vagina. True?

13 MS. CRAIG: Your Honor, asked and answered.

14 A The head was delivered.

15 THE COURT: I'm -- we'll move on. You've asked that at
16 least twice.

17 Q And with respect to the posterior arm delivery method,
18 you had zero experience even attempting that before
19 Genesie's delivery. True?

20 A Well, the same situation. In this case, I couldn't get
21 my hand in to sweep the arm but I certainly know how to,
22 how the maneuver is done and what, what to do. You put
23 your hand in the vagina, you flex the elbow by pressure
24 on the antecubital fossa, you sweep the arm over the
25 chest and grab the arm and deliver the posterior arm.

1 So, I know how to do it.

2 Q You've never done it successfully.

3 A That doesn't mean I don't know how to do it.

4 Q How many years had you been practicing when you jammed
5 your hand in with Genesie?

6 A How many years?

7 Q Yes, sir.

8 A This was in 2008, so, 30 years.

9 Q Okay. In fact, it was '09. True?

10 A Oh, 31 years.

11 Q In 31 years you've had, according to your testimony
12 you've had five or six ---

13 A Shoulder dystocias.

14 Q --- shoulder dystocias.

15 A Yeah.

16 Q All right. So, you are telling us that you've had the
17 experience of dealing with this emergency one time every
18 six years or so?

19 A I guess you could boil it down to that.

20 Q Let's talk about your personal knowledge. You told us
21 that you read books and you learned how to do these
22 special maneuvers that you've never attempted
23 successfully in over 30 years of practice and we heard
24 in opening, or maybe your direct testimony, that you go
25 to CME courses, continuing medical education courses?

1 A Uh-huh.

2 Q You've never once gone to a CME course to learn how to
3 safely manage shoulder dystocia, have you?

4 A I don't think specifically that was the topic but there
5 were -- I've been to a lot of, I mean, to review courses
6 in which there were complications of obstetrics
7 discussed and ...

8 Q Have you had any CME courses that dealt with safe
9 management of shoulder dystocia complications?

10 A CME specifically to that, shoulder dystocia?

11 Q Yes, sir.

12 A No.

13 Q A moment ago you said something about never successfully
14 doing an internal maneuver in the real world. How many
15 times have you participated in shoulder dystocia
16 simulations?

17 A None.

18 Q How many times have you participated in shoulder
19 dystocia drills at the hospital?

20 A None.

21 Q How many times have you had measured the amount of
22 traction that you apply pulling down on a baby's head
23 and neck?

24 A How many times have I had that measured?

25 Q Yes, sir.

1 A None.

2 Q Sir, are you aware of the simulation studies that show
3 when obstetricians pay attention to CME courses and
4 measurement of their traction and use/practice on
5 simulation equipment and drills in the hospital that the
6 safety of babies goes up?

7 A I'm aware of studies.

8 Q All right, sir. And you're aware of the studies that
9 conclude shoulder dystocia drills and simulation, if
10 participated in by doctors as well as nurses ---

11 MS. CRAIG: Objection, Your Honor.

12 Q --- facilitates patient safety?

13 MS. CRAIG: If there is such a study I would ask ---

14 THE COURT: Your objection being?

15 MS. CRAIG: That he's being asked about a study and I
16 would -- my objection is he doesn't have whatever study he's
17 referring to, if there is one.

18 THE COURT: All right. I think he's asking in a general
19 way. I'll allow him to ask the question.

20 Q Are you aware, sir?

21 A Aware of the studies?

22 Q That, that have concluded that ---

23 A I'm aware of the studies, but I'm not aware of their
24 conclusion.

25 Q So, you heard about the studies but didn't bother to

1 find out what the conclusion was?

2 A No, I just can't remember what the conclusions were, but
3 if you have a specific study I'll be glad to review it
4 and give you my thoughts on it.

5 Q Yes, sir. You've told us a few times in this trial that
6 you were trained in residency that obstetricians should
7 avoid using more than gentle traction on a baby's head
8 and neck. Do you remember that?

9 A I think I told you that in residency we learned the
10 appropriate amount of traction and downward force that
11 we apply to babies and it was, kind of, a learned thing
12 over the years, medical school, residency, that we -- it
13 comes to muscle memory.

14 Q Sir, were you trained in residency that obstetricians
15 should avoid using more than gentle traction in the
16 course of managing shoulder dystocia?

17 A Wasn't this a question that you asked me before?

18 Q Yes, sir.

19 A I'm not sure what I said then.

20 Q Could you please -- page 113, lines nine through 14.
21 Was this was my question and your answer.

22 Q Okay, were you trained in residency that
23 obstetricians should avoid using more than gentle
24 traction in the course of managing shoulder
25 dystocia?

1 A I don't remember specifically. That was a long time
2 ago.

3 Q Was that my question and your answer, sir?

4 A That, indeed it was.

5 Q As you sit here today, sir, in this courtroom, do you
6 believe it's appropriate for an obstetrician managing a
7 shoulder dystocia complication to use greater than
8 gentle downward traction to deliver the anterior
9 shoulder?

10 A Could you repeat?

11 Q Yes, sir. As you sit here today, do you believe it's
12 appropriate for an obstetrician who is managing a
13 shoulder dystocia complication to use greater than
14 gentle downward traction to try to deliver the anterior
15 shoulder?

16 A And -- no, I don't believe it's appropriate and that's
17 not what occurred in this case. We used gentle downward
18 traction.

19 Q Page 114, lines 13 through 21 please. Doctor, at your
20 deposition did I ask the following question and you give
21 the following answer?

22 A What line was that?

23 Q Line 13 through 21, page 114.

24 A Thirteen through 21?

25 Q Yes, sir. On page 114.

1 MS. CRAIG: Your Honor, this is improper.

2 THE COURT: You may approach.

3 (Bench conference off the record)

4 Q Doctor, before we read this question and answer up
5 here ---

6 MS. CRAIG: Your Honor, he's going back several pages.

7 THE COURT: Well ---

8 MS. CRAIG: All he needs to do is tell him what kind of
9 question it is.

10 THE COURT: Right.

11 Q Doctor ---

12 THE COURT: If the response in the deposition was in
13 response to a hypothetical, you need to ask him the same
14 hypothetical question here today.

15 MR. GRAHAM: It wasn't, Your Honor. The hypothetical was
16 several pages before. I had changed subjects several times.

17 THE COURT: All right. Put up on the screen what you're
18 going to be asking. That's the same question. It says -- look
19 at -- you've got it starting on 13. Start on 12. If you're
20 going to ask him that question here today, you need to ask
21 him the hypothetical here in Court. Start at 12.

22 MR. GRAHAM: She's talking about several pages earlier.

23 THE COURT: Let me see that. That's not what's up there.
24 Look at number 12 up there. Yeah, ask him a hypothetical if
25 you want to talk to him about that response or move on.

1 MR. GRAHAM: Could you please back up to page
2 113, line nine, so we can get the full context? And, Your
3 Honor, I apologize. This -- this goes back over the question
4 I just went through, but just to get the full context.

5 Q Starting on page 113, line nine.

6 Q And doctor, I'm going to ask you a series of
7 questions and -- I'm going to read a series of
8 questions and answers and ask you if that
9 accurately reflects ---

10 THE COURT: You can't do that. You can ask him the
11 questions and ask what his response is here today. We aren't
12 publishing depositions.

13 MR. GRAHAM: Yes, sir.

14 THE COURT: Ask him the question and what his response is
15 here today and if it's different than what's in the
16 deposition you can ask him. You can impeach him. We just
17 aren't going to read depositions.

18 MR. GRAHAM: Yes, sir, but I thought you asked me to give
19 the context leading up to what I already asked him about.

20 THE COURT: Well, that's absolutely correct but you need
21 to ask him the question here today. If it's different in the
22 deposition, then you can talk about it.

23 MR. GRAHAM: May we approach?

24 THE COURT: Yes.

25 (Bench conference off the record)

1 MR. GRAHAM: Thank you, Your Honor.

2 Q Sorry about that. Doctor, hypothetically, any time a
3 doctor who is delivering a baby, managing the labor,
4 encounters a shoulder dystocia situation, do you believe
5 it is appropriate for the obstetrician to use greater
6 than gentle downward traction to try to deliver the
7 anterior shoulder?

8 A I think in those same studies that you referred to
9 earlier about doing the mechanical studies to determine
10 pressure, I think they found that, you know, detraction
11 in shoulder dystocia was a little bit higher than that
12 used in a regular vaginal delivery, but I don't think
13 normally we use gentle downward traction and that's what
14 we use in shoulder dystocia as well as vaginal
15 deliveries uncomplicated by shoulder dystocias.

16 Q Doctor, I'm going to read the following question and
17 answer and tell me if I read it correctly, please.

18 A Hypothetically?

19 Q Tell me if I read the question and answer ---

20 A Oh.

21 Q --- accurately, please, sir. Starting at line ---

22 A What page are you on?

23 Q Page 114, line 11.

24 A All right.

25 Q All right, sir, when -- when you -- Then you

1 interrupt with answer:

2 A Hypothetically.

3 Q Okay, when -- when do you -- as you sit here today,
4 do you believe it's appropriate for an obstetrician
5 who is managing a shoulder dystocia complication to
6 use greater than gentle downward traction to try to
7 deliver the anterior shoulder?

8 A I think they have to use the traction that's
9 necessary to get the baby delivered -- to deliver.
10 These are emergency situations here.

11 Q Did I read my questions and your answers correctly?

12 A Yes, sir. And then I go on to say all right, is that
13 what you do in your practice when you encounter shoulder
14 dystocia and then I answered, fortunately, I haven't
15 encountered that many and I couldn't recall,
16 specifically.

17 Q Yes, sir, in fact, not recalling specifically was a
18 recurrent theme in your deposition. True, sir?

19 A Well, these things are hard to quantitate and they're --
20 you know, you're talking about events that occurred over
21 maybe a 37-year period of time.

22 Q Yes, sir. Do you claim to have a better memory today
23 about this August of 2009 delivery than you had back
24 when this deposition was taken on December the 12th,
25 2013?

1 A Well, I have read over my hospital records and my
2 prenatal records, so that's probably helped to jog my
3 memory.

4 Q Yes, sir. And you had read those over before your
5 deposition. True?

6 A Well, not as, not as much, but yes, I've, you know, read
7 more in depth since then.

8 Q And you had prepared for that deposition with your
9 lawyers in advance. True?

10 A Probably to some degree, but I don't think I read the
11 records as much and as frequently as I have since then.

12 Q All right. Have you prepared with your lawyers for your
13 trial testimony more than or less than you prepared for
14 your deposition?

15 MS. CRAIG: Your Honor, to the extent he's getting into
16 attorney/client privilege ---

17 DR. GOLDSTEIN: Yeah, I think that ---

18 MR. GRAHAM: I'm not.

19 DR. GOLDSTEIN: --- that was going to be my answer.

20 THE COURT: We'll move on.

21 MR. GRAHAM: Yes, sir.

22 Q Doctor, do you have a specific memory of the downward
23 traction in this case?

24 A In this case?

25 Q Yes, sir.

1 A Not specifically. I mean, I can't tell you how many
2 Newtons of pressure I applied, but I know it was the,
3 you know, my standard for doing a delivery.

4 Q You don't remember how much traction you used at any
5 point during this delivery. Is that fair? Is that fair?

6 A Is that fair?

7 Q Yes, sir.

8 A I don't remember specifically how many Newtons it was,
9 but I know that it was no more than my usual traction
10 that I used in 3,000 or so other deliveries.

11 Q Page 179, line 25, through page 180, line 6.

12 A 179?

13 Q Yes, sir. 179, line 25, through 180, line 6.

14 A 179, line what?

15 Q 179, line 25, through page 180, line 6. Please tell me
16 if I read this, these two questions and answers
17 correctly.

18 Q Do you have a specific memory of the downward
19 traction?

20 A No, not specifically.

21 Q So, you don't remember how much traction you used
22 at any point during this delivery? Is that fair?

23 A No, I don't remember.

24 Q Did I read that accurately?

25 A You read it accurately and that's basically what I

1 responded to you before. I mean, you can't quantitate,
2 but it was the same that I used for my other deliveries.

3 Q Sir, do you claim to recall how much traction you've
4 used on any of your shoulder dystocia complications?

5 A Not in Newtons. I mean, it's the same that I use. It's
6 what we were taught in our residency. It's more muscle
7 memory and experience.

8 Q Page 115, lines 1 through 4 please. Tell me if I read
9 this question and answer correctly.

10 Q Do you claim to recall how much traction you used
11 on any of your shoulder dystocia complications?

12 A No.

13 Q Was that a correct reading of your testimony?

14 A That was correct, word for word.

15 Q You told me earlier that you have no memory of how much
16 traction you applied at any time during this delivery.
17 True?

18 A True, but the standard amount that I've used on all of
19 my deliveries.

20 Q You believe that the proper way to do suprapubic
21 pressure is to, for the doctor or nurse to feel above
22 the pubic bone and push straight down toward the floor.
23 True?

24 A Above the pubic bone.

25 Q Straight down toward the floor. True?

1 A True, but you can also push one way or the other,
2 whatever dislodges the anterior shoulder from under the
3 pubic symphysis.

4 Q And do you believe that's how a properly trained labor
5 and delivery nurse should correctly perform suprapubic
6 pressure?

7 A I think that's how anybody should perform suprapubic
8 pressure.

9 Q Page 31, lines 2 through 18, please.

10 A What lines?

11 Q Page 31, line 2 through 18.

12 MS. CRAIG: Objection, Your Honor.

13 THE COURT: Objection being?

14 MS. CRAIG: The nurses aren't involved in the
15 suit. Hospitals aren't involved in the suit.

16 MR. GRAHAM: Goes to his knowledge.

17 THE COURT: Might -- might counsel approach
18 the bench?

19 (Bench conference off the record)

20 Q Did I ask the following questions and answers starting
21 on page 31 at line 2:

22 Q Do you know how a properly trained labor and
23 delivery nurse should correctly perform suprapubic
24 pressure?

25 A Yes.

1 Q How should they?

2 A Pressure in the suprapubic, downward pressure,
3 straight downward pressure in the suprapubic area.

4 Q All right. Now, in the context of a mom who is
5 somewhat on her back, either on her back or someone
6 on her back, when you talk about downward pressure,
7 are you talking about downward toward the floor?

8 A Toward the floor.

9 Q Okay. All right. Not toward either side, but
10 directly toward the floor. Is that right?

11 A Yes.

12 Q Did I read that accurately?

13 A You certainly did.

14 Q Let's turn to the topic of causation please, sir. You
15 don't consider yourself to be an expert about the cause
16 of brachial plexus birth injuries, do you?

17 A No, I wouldn't think so.

18 MR. GRAHAM: Your Honor, at this time we would
19 move to strike his earlier opinions about causation that he
20 expressed.

21 THE COURT: Glad to hear from you.

22 MS. CRAIG: Sure, Your Honor. He's not -- he wasn't ---

23 THE COURT: If you could approach the bench.

24 MS. CRAIG: Yes, of course.

25 (Bench conference held off the record)

1 Q And, sir, you do not claim to have an opinion about the
2 most probable cause of Bryson's injury, do you?

3 A Could you repeat please?

4 Q Yes, sir. You do not claim to have an opinion as to the
5 most probable cause of Bryson F. 's brachial plexus
6 birth injury, do you?

7 A I probably have an opinion.

8 Q Could you please turn to 86, lines 17 to 20?

9 A Eighty-six?

10 Q Yes, sir.

11 A Line what?

12 Q Seventeen to 20.

13 A Eighty-six, line?

14 Q Seventeen to 20.

15 A Okay.

16 Q Did I ask the following question and you give the
17 following answer?

18 A Yes.

19 Q Fair enough.

20 Q Do you claim to have an opinion as to the most
21 probable cause of Bryson F. 's branchial plexus
22 birth injury?

23 A No.

24 Q Did I read that accurately, sir?

25 A You did, indeed.

1 Q Doctor, you don't believe that an obstetrician can
2 become an expert on causation of brachial plexus birth
3 injuries by reading medical literature on that subject,
4 do you?

5 A Depends on how extensively he reads.

6 Q Please turn to page 147, lines 21 to 24. See if I read
7 this question and answer accurately, sir.

8 Q Do you believe that one can become an expert by ---

9 A I'm sorry. I must have the wrong page.

10 Q Oh, I'm sorry. Page 147, lines 21 through 24. Ready?

11 A Yes.

12 Q Do you believe that one can become an expert by
13 reading certain medical literature on that subject?

14 A I don't think they'd be an expert.

15 Q Did I read that accurately?

16 A Yes, and I stated that it depends on how much they read.
17 It doesn't necessarily depend on how many cases of
18 shoulder dystocia they've managed.

19 Q Yes, sir, but with the amount of reading that you've
20 done on the topic, you agree you're not an expert. True?

21 A I don't purport to be an expert.

22 Q Right. In your direct testimony when Ms. Craig was
23 asking you questions, one of the questions was about
24 nurse Lawrimore, I believe, doing suprapubic pressure
25 while climbing up on the stool and then climbing up on

1 the bed and pushing down on the mother above her pubic
2 area, and you testified that you assumed people were
3 holding her legs as Rebecca Lawrimore was doing
4 suprapubic pressure. In fact, you don't have any memory
5 of McRoberts and suprapubic pressure ever being
6 performed at the same time, do you?

7 A I have a memory that they were done, but this is a
8 complex situation where there's a lot of things going on
9 and ---

10 Q Yes, sir.

11 A --- so the particular point in time between 13:44 and
12 13:49 in which these things occurred escapes me ---

13 Q Yes, sir.

14 A --- but I know that suprapubic pressure was applied
15 while McRoberts was in place.

16 Q After Dr. Coker arrived to the rescue. True?

17 A No, that's a complete misrepresentation. Dr. Coker came
18 in after we'd already attempted these maneuvers.

19 Q If a -- if a maternity patient's legs were in McRoberts
20 they're way up here in the air. True?

21 A That's correct.

22 Q If her legs are in stirrups, they're over here in front
23 of her. True?

24 A That's true. So, at some point her legs were in the
25 stirrups, but then when McRoberts is applied then we

1 take her legs out of the stirrups, we hyperflex them and
2 abduct them so they're not in the stirrups anymore.

3 Q Not during McRoberts.

4 A Not during -- you know ---

5 Q But Genesie's legs were in the stirrups when Rebecca
6 Lawrimore was applying suprapubic pressure. True?

7 A I'm not sure that that's documented in the record.

8 Q All right, sir. Do you deny that Genesie's legs were in
9 the stirrups ---

10 A No, her legs were in the stirrups.

11 Q Let me finish please, sir. Do you deny that Genesie's
12 legs were in the stirrups at the time that Rebecca
13 Lawrimore and the nurses in that room, I believe it was
14 Rebecca, were applying suprapubic pressure? Do you deny
15 that?

16 A I don't -- I can't deny it because I have no specific
17 knowledge that her legs were in the stirrups.

18 Q In fact, you don't have any memory of legs being in
19 McRoberts when suprapubic pressure was ---

20 A Yes, I have ---

21 Q --- until ---

22 A --- some memory, yes.

23 Q --- until Dr. Coker was there. True?

24 A No.

25 Q But you can't deny that the legs were in the stirrups at

1 that time. True?

2 A I certainly admit that the legs were in the stirrups,
3 but that may be, may have been at 13:40, 13:41, 13:42,
4 but once the shoulder dystocia was recognized, the first
5 thing they do is take the legs out of the stirrups and
6 apply McRoberts.

7 Q And if you're going to deliver a baby safely, you do
8 suprapubic pressure with the legs still in McRoberts.
9 True?

10 A Generally, but you can do them separately.

11 Q Of course you can do them separately, but it's best to
12 do them at the same time if you want to get the baby out
13 safely without brachial plexus nerve injury. True?

14 A That's -- it says in the literature you can do McRoberts
15 and then move to suprapubic and then a combination of
16 the two.

17 Q Besides yourself, do you know any obstetrician who is
18 board certified who would apply traction on a baby's
19 neck before attempting suprapubic and McRoberts at the
20 same time?

21 A Well, since the diagnosis of shoulder dystocia is that,
22 that the head does not, I mean, the shoulders do not
23 deliver with gentle downward traction and the
24 application of accessory maneuvers, then there's got to
25 be some downward traction applied somewhere at some

1 time.

2 Q Yes, sir, you lost me there ---

3 A Well, you lost me several times.

4 Q Let's refocus. Okay? Can you tell us where Genesie's
5 legs were when Rebecca Lawrimore was applying suprapubic
6 pressure?

7 A I can't tell you specifically at -- you know, this is a
8 continuum of care.

9 Q You cannot?

10 A I cannot.

11 Q How long was it that you had been working with Dr. Coker
12 and Phillips before you realized that they didn't want
13 you to be their partner?

14 A Towards the end of my year's contract.

15 Q Toward the end of year number one?

16 A Yeah.

17 Q Good thing Dr. Coker was around that day. True?

18 A It would have been a good thing if anybody was around
19 that day. Dr. Coker, Dr. Clary, Dr. Phillips, Dr.
20 Sufrant or Dr. Jackson, at that time.

21 Q Yes, sir, and it would have been a good thing if you
22 called for help before you couldn't get your hand into
23 Genesie's vagina. True?

24 A No, I called for help as soon as we recognized shoulder
25 dystocia.

1 Q There's nothing in the records about that, is it, sir?
2 ANo, that's not something that we typically, you know, at
3 13:33, we recognized shoulder dystocia and at 13:33-and-a-
4 half we called for Dr. Coker, for assistance. That was one of
5 the first things that occurred after we recognized shoulder
6 dystocia.

7 Q After ---

8 A There's some distance between the delivery room and Dr.
9 Coker's office. One of the ancillary personnel ran down
10 there to get him and I don't think he showed up for
11 maybe two or three minutes, possibly.

12 Q In fact, you didn't call for help until you had been
13 unsuccessful with getting the head out or the shoulder
14 out safely with McRoberts and suprapubic pressure. True?

15 A That's not true. That's completely not true.

16 Q So, now you claim to know the timing of all these
17 events?

18 A No, but I remember as soon as we recognized that there
19 was a shoulder dystocia, then we called for help which
20 is the standard thing to do.

21 Q It is standard, yes, sir, but are you claiming -- are
22 you telling us here today that you called for help as
23 soon as you saw that turtle sign?

24 A Maybe not as soon as I saw the turtle sign, but as soon
25 as we recognized that we had a problem we called for

1 help ---

2 Q As soon ---

3 A --- and that was not only Dr. Coker, but additional
4 nursery staff, Dr. Phillips, the anesthesiologist was
5 there, additional nursing staff came in.

6 Q Yes, sir, but the nurses didn't get there when Rebecca
7 was having to push on the suprapubic area without a
8 nurse to hold the legs. True?

9 A I'm not sure. I mean, there -- I mean, McRoberts was
10 applied and I'm not sure exactly of the timing of the
11 event, but Rebecca certainly applied suprapubic pressure
12 at some point during the, the delivery process and
13 McRoberts was certainly applied at some point.

14 Q Yes, sir. Do you remember -- do you claim it was four
15 minutes or five minutes between the head coming out and
16 the shoulders coming out?

17 A I think the shoulder dystocia was recognized at 13:45
18 and shoulder delivered at 13:49, so that's four minutes.

19 Q Yes, sir, I saw that in one of your records. I saw a
20 different time in the other, so just to be clear in this
21 courtroom during this trial, there was four minutes
22 between the delivery of the head and delivery of the
23 baby's body. Is that true?

24 A That's true ---

25 Q Yes, sir.

1 A --- as far as I know.

2 Q Yes, sir. And during that four minutes, except for when
3 you were cutting an episiotomy, you were pulling down on
4 the baby's head. True?

5 A No, not all during the four minutes.

6 Q Do you claim to remember stopping traction?

7 A Yes, I had to stop to cut the episiotomy. We had to stop
8 to put McRoberts in place. We had to pause to get the
9 suprapubic in place.

10 Q All right. You might reason it out now, but in fact, you
11 don't claim to remember stopping traction, do you?

12 A I reasoned that out.

13 Q Yes, sir. And while Dr. Coker was there saving the day,
14 you were still pulling on the baby's head, down on your
15 knees. Right?

16 A No, no. Dr. Coker came down. We talked about what was
17 going on. He looked at the patient, looked at the baby
18 and said let's, let's try suprapubic again, so Dr. Coker
19 is 6'4" or so. He's a tall guy. He got up on the stool
20 and he applied suprapubic pressure while I did downward
21 traction on the baby's head and we effected delivery of
22 the anterior shoulder.

23 Q Yes, sir, he's tall, well over six feet, but he still
24 had to climb on the stool as a stepping stone before he
25 was able to climb higher up onto the bed. True?

1 A He didn't climb on the bed. He did suprapubic from the
2 stool.

3 Q You deny that Dr. Coker climbed up on the bed?

4 A I don't know, specifically but no, I don't remember him
5 being on the bed. I remember nurse Lawrimore getting up
6 on the bed and that's when we dropped the bed down.

7 Q And the reason you don't remember Dr. Coker being on the
8 bed is because you were down there on your knees pulling
9 on this baby's head.

10 A No, I wasn't ---

11 Q --- Right?

12 A --- on my knees at that time.

13 Q You weren't on your knees?

14 A No, I wasn't.

15 Q You deny ---

16 A We raised the bed ---

17 Q --- you were on ---

18 A We -- no, I -- we were down on our knees at some point
19 in time, but not the whole time.

20 Q Do you deny being on your knees ---

21 A No, I do ---

22 Q --- when Dr. Coker came into the room to get the
23 shoulder unstuck?

24 A I'm not sure when I got off my knees, but I know we
25 raised the table back up because he was taller and could

1 give more forceful suprapubic pressure.

2 Q I hear you say you raised the table up and you stayed on
3 your knees. Didn't you, doctor?

4 A No.

5 Q You stayed on your knees pulling down on that baby's
6 head ---

7 A No.

8 Q --- and neck.

9 A No, I ---

10 Q You deny that?

11 A I deny that.

12 Q Tell me every -- how would you summarize Dr. Coker's
13 involvement in delivering Bryson?

14 A Do you want what's in the record here?

15 Q No, sir. Do you remember telling me at the deposition---

16 Q All right.

17 A --- he came, he saw, he conquered?

18 Q And then he left.

19 A Right.

20 Q He was there for less than one minute.

21 A Approximately, a minute. I didn't have the stopwatch on.

22 Q He came, he saw ---

23 A Uh-huh.

24 Q --- he conquered.

25 A He applied sufficient suprapubic pressure to manipulate

1 the anterior shoulder from out, out from under the pubic
2 symphysis.

3 Q He came, he saw, he conquered, he left.

4 A Right. That's just to say that he came down to the
5 delivery room. We conferred. He looked at the patient
6 and then we decided, between us, to apply suprapubic
7 pressure and he applied sufficient suprapubic pressure
8 to effect delivery of the anterior shoulder.

9 Q Doctor, you're not telling us here today that it's
10 appropriate for a doctor to needlessly endanger a baby's
11 brachial plexus nerves, are you?

12 MS. CRAIG: Objection, Your Honor. To needlessly
13 endanger?

14 THE COURT: It's argumentative. Sustained.

15 Q When do you believe it's appropriate for a doctor to
16 needlessly endanger a baby's brachial plexus nerve?

17 MS. CRAIG: Same objection.

18 THE COURT: Argumentative. Re-phrase the question.

19 Q When do you believe it's appropriate for a doctor
20 managing a shoulder dystocia delivery to apply greater
21 than gentle downward traction on a baby's head and neck?

22 A When do I believe it's appropriate?

23 Q If ever.

24 A I don't believe it's, you know, appropriate but, you
25 know, you're bending the baby's head down. What we're

1 talking about is downward axial traction.

2 Q Right.

3 A And we're not ---

4 Q To be clear, you admit it is never appropriate to apply
5 greater than gentle downward traction on a baby's head.
6 True?

7 A True, and that's not, I mean, that's not what we did in
8 this case.

9 Q We've heard a lot from Ms. Craig asking you questions.
10 We've heard a lot about how dangerous shoulder dystocia
11 can be for a baby's brain and indeed for a baby's life.
12 Do you agree that it can be dangerous to a baby's brain
13 and a baby's life if an obstetrician does not have the
14 knowledge and the experience and the skill to
15 effectively and safely manage shoulder dystocia?

16 A Could you repeat that? That was a pretty long question
17 and ---

18 Q It was. It was. I plead guilty, sir. Let me try to break
19 it down. We heard you talk about risk of brain damage.
20 All right? You're not claiming there was any imminent
21 risk of brain damage that justified you in using too
22 much traction, are you?

23 A No, I'm not implying that I used too much traction ---

24 Q All right.

25 A --- but from the literature there's been episodes of

1 hypoxic ischemic encephalopathy that occurred within two
2 minutes of the head to shoulder interval.

3 Q Only if there's a placental abruption or some other
4 emergency superimposed ---

5 A Or maybe a cord, a nuchal cord or other things like
6 that.

7 Q All right. Let's talk about the nuchal cord. This nuchal
8 cord was not tied in a knot. True?

9 A No, no.

10 Q It was not so tight that you had to doubly clamp it and
11 cut it. True?

12 A Fortunate.

13 Q It's just like taking a big necklace off of a woman's
14 neck.

15 A No, no.

16 Q You just lifted it up and over. True?

17 A I slid it over the head but, still, with the
18 contractions, the downward momentum of the baby can
19 tighten that cord and cause reduction in the blood flow
20 through the umbilical cord.

21 Q Literature shows that you should never think about using
22 greater than gentle traction until six or seven minutes
23 have passed and then only if you have fear that the baby
24 is in imminent danger of brain damage or death. True?

25 MS. CRAIG: Objection, Your Honor. He's referencing

1 literature that we haven't seen.

2 THE COURT: Sustain the objection. Move on.

3 Q This baby was delivered well before the six to seven
4 minute mark. True?

5 A That's true and I'm proud of that fact.

6 Q Yes, sir. Are you proud, sir, of your skill set and
7 experience for getting baby's shoulders unstuck?

8 A Yes, sir.

9 Q You're proud of that, too?

10 A Yes, sir.

11 Q Doctor, you...

12 MR. GRAHAM: Court's indulgence, please.

13 Q Doctor, we started off your testimony yesterday with
14 your lawyer presenting you as an expert witness to
15 testify in this case to defend your own actions. True?

16 Q Yes, sir.

17 A You've told us today that, in fact, you don't even claim
18 to be an expert about what causes brachial plexus nerve
19 damage. True?

20 MS. CRAIG: Your Honor, objection. Qualifications were
21 addressed yesterday. There was no objection and Your Honor
22 qualified ---

23 MR. GRAHAM: I ---

24 THE COURT: I think he's allowed. I'm going to give him
25 some leeway with regard to talking about the scope of his

1 expertise.

2 MR. GRAHAM: Thank you.

3 MS. CRAIG: Yes, sir.

4 Q You don't even claim to be an expert on what causes
5 brachial plexus nerve damages in babies, do you?

6 A That's a little bit out of my field but ---

7 Q Yes, sir.

8 A --- I'm not an expert, but I'm well versed in the
9 subject.

10 Q Yes, sir, and can you tell me, sir, I know you still
11 claim to be an expert on standards of care. Right?

12 A I guess.

13 Q All right. A standard of care is that degree of
14 knowledge, skill and attention and care to the patient
15 that would be, that would be brought to the
16 doctor/patient relationship by obstetricians who are
17 careful and prudent in same or similar circumstances.
18 True?

19 A Could you break that down? That was a lot ---

20 Q Yes.

21 A --- in one statement and I'm not sure that I agree with
22 every single thing you said.

23 Q Do you believe that a standard of care requires of all
24 obstetricians in this country to conform or comply or
25 honor that level of knowledge, skill, and care that

1 reasonably careful, reasonably prudent, obstetricians
2 would apply in the same or similar circumstances?

3 A I think that's a fair representation of the legal term
4 of standard of care.

5 Q Thank you, sir. And as an expert on standard of care
6 issues, do you recognize that when an obstetrician falls
7 short of the standard of care and harm results to the
8 patient because of that, the doctor is held accountable
9 for all of the harm he causes by falling below the
10 standard of care? Are you aware of that, sir, as an
11 expert on these issues?

12 A Could you repeat the question and, kind of, simplify the
13 multiple ---

14 Q When a doctor ---

15 A --- components?

16 Q --- violates the standard of care and causes harm to a
17 baby, the doctor should be held liable in a court of law
18 for all the harm he causes. True?

19 MS. CRAIG: Your Honor, I believe you ruled on this.

20 THE COURT: Well, I sustain the objection. It calls for
21 a legal conclusion.

22 MR. GRAHAM: Yes, sir, but may we approach, Your Honor?

23 THE COURT: I sustained the objection.

24 MR. GRAHAM: I'll move on, Your Honor. Thank you.

25 Q As an expert on standard of care issues, sir, do you

1 believe it meets or violates the standard of care in
2 this case for an obstetrician to apply greater than
3 gentle downward traction on Bryson's head and neck?

4 A I'm sorry. Again, I got lost on that question. Could you
5 repeat it, please?

6 Q I'll be happy to, sir. As an expert on standard of care
7 issues for obstetricians, do you believe that if the
8 obstetrician who delivered Bryson F put more than
9 gentle downward traction on his head and neck, that
10 doing so would meet the standard of care or fall below?

11 A I think it would meet the standard of care, but it's a
12 relative thing. You know, I'm still not sure I
13 understand the question that you're posing to me.

14 Q Yes, sir. Do you consider it a breach of the standard of
15 care for a doctor managing a shoulder dystocia situation
16 within the first four minutes after the head comes out
17 to use greater than gentle downward traction on a baby's
18 head?

19 A Yes.

20 Q You believe it's acceptable or you believe it's a
21 violation?

22 A I believe it's a violation, but in this case we applied
23 gentle downward traction, so it doesn't apply to this
24 situation.

25 Q Sir, in fact, you don't remember how much traction you

1 applied in this delivery, do you?

2 A I remember it was my standard amount ---

3 MS. CRAIG: Your Honor, this has been asked and
4 answered.

5 A --- of ---

6 THE COURT: At least twice, so let's move on.

7 DR. GOLDSTEIN: Yeah. Fifteen during the deposition.

8 MR. GRAHAM: No further questions, Your Honor.

9 THE COURT: Ms. Craig, you're recognized.

10 MS. CRAIG: May it please the Court.

11 REDIRECT EXAMINATION

12 BY MS. CRAIG:

13 Q Dr. Goldstein, you were asked about informed consent.

14 A Yes.

15 Q I want to show you the informed consent form.

16 MR. GRAHAM: Objection, Your Honor, it's not new.

17 THE COURT: You did talk about informed consent.

18 MR. GRAHAM: Yes, sir, in response to what they did on
19 direct.

20 THE COURT: Well, if you talked about it, she can talk
21 about it. Go ahead.

22 Q Dr. Goldstein, just, can you tell us whether or not
23 that's your signature?

24 A Yes, ma'am.

25 Q Thank you. Dr. Goldstein, did you discuss with Ms.

1 Fulton her delivery during any of those 19 prenatal
2 visits that she had with you?

3 A Yes, ma'am.

4 Q And did you provide informed consent to Ms. Fulton?

5 A Not during our prenatal visits, but she had informed
6 consent when she came into the hospital.

7 Q And when I'm talking about informed consent, the various
8 risks that and the various modes of delivery that a
9 woman can have. Tell us what your custom and practice is
10 for telling your patients about that.

11 A Well, generally in the last few visits when we get close
12 to time for delivery we go over the proposed delivery
13 method, whether it be vaginal delivery or C-section and
14 the proposed anesthesia. We discuss about some of the
15 factors that occur with C-section as opposed to vaginal
16 delivery.

17 Q And when you are discussing the various modes of
18 delivery and the various risks, is that adequate
19 informed consent?

20 A Yes, I would suppose so. Yes.

21 Q Now, does the standard of care -- you were just asked a
22 bunch of questions on standard of care, but does the
23 standard of care require that there be a specific
24 document where you have the patient sign that you, in
25 fact, went through all the various modes of delivery, et

GENESIE FULTON, et al. VERSUS L. WILLIAM GOLDSTEIN, MD, et al.