

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178
Appellate Case No. 2017-002299

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SC Court of Appeals

Treva C. Flowers, Tristan
Flowers, and Ashley F., an
infant under the age of
fourteen (14) years, by and
through her next friends,
Treva C. Flowers and Tristan
Flowers,

Appellants,

v.

Bang N. Giep, M.D., and
Spartanburg & Pelham OB-
GYN, P.A. (formerly
Spartanburg OB-GYN, P.A.),

Respondents.

RECORD ON APPEAL

Volume II

Counsel of Record:

CHARLES L. HENSHAW, JR.
FURR & HENSHAW
1534 Blanding Street
Columbia, South Carolina 29201
Telephone (803)252-4050
Facsimile (803)254-7513
charles.henshaw@fholaw.com
Bar # 3068
ATTORNEY FOR APPELLANTS

C. MITCHELL BROWN
BRIAN P. CLOTTY
CAROLINA D. GIMENEZ
NELSON MULLINS RILEY & SCARBOROUGH, LLP
1320 Main Street, 17th Floor
Columbia, South Carolina 29201
Telephone (803)799-2000

D. GARY LOVELL, JR.
CARLOCK COPELAND & STAIR
40 Calhoun Street, Suite 400
Charleston, South Carolina 29401
Telephone (843)727-0307
glovell@carlockcopeland.com
ATTORNEYS FOR RESPONDENTS

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1 way to know there's a shoulder dystocia as far as doctor who
2 is standing here -- sorry. It could be a midwife too.
3 Clinician or doctor standing here has no idea what's going
4 on because, if you see this anterior shoulder or the top
5 shoulder, is not against that and right now head -- this is
6 what I would call crowning.

7 So, the head is visible to the doctor and anyone else
8 in the room but tried not -- everything is going fine. The
9 uterus has pushed the baby with the head just crowned.

10 Q Do some physicians sit on stools when they're doing
11 this kind of delivery?

12 A Yes, they do.

13 Q Okay. We see, doctor, some movement of that uterus.
14 What's that doing?

15 A So, this is the uterine contraction. So, this is the
16 uterine muscles all around and this is what's contracting,
17 and this is the hand of the clinician or doctor and they're
18 just checking as to what's going on and how far the head is.
19 They sometimes even stretch the perineum, but that's what it
20 is.

21 At this time, this is a Kiwi vacuum.

22 If you can just pause that for a second, sir?

23 So, this -- at this time, the decision is made and we
24 don't know anything about the shoulder is that the baby
25 needs to be delivered. This is the doctor's hand and a

1 vacuum or a Kiwi vacuum is placed on the visible portion to
2 assist with the delivery, for whatever reason, in this case,
3 abnormal fetal heart rate.

4 Q So, in this case, what was the reason that Doctor Giep
5 wanted to assist the delivery at this point?

6 A Because the fetal heart rate is looking normal at 120,
7 110, or up to 160 was -- had been down for several minutes
8 at 90 beats per minute.

9 Q And was it reasonable to proceed in this manner?
10 Was that within the standard of care?

11 A Yes, I would -- some -- had there been a damage, the
12 doctor -- the vacuum, people would have said why didn't you
13 put on the vacuum, because the head was visible, what were
14 you waiting for, the heart rate were down? So, not to put
15 it can lead to more mal -- alleged malpractice.

16 So, this is just assisting with the part of the vacuum.
17 I know -- this is painful to look at, but this is cutting
18 the episiotomy. So, this is the other hand of the doctor,
19 scissors, and this is what we call the perineum from the
20 edge, and this is the rectum. You cut the episiotomy to
21 help with the vacuum or forceps or even with some other
22 delivery. So, that's an episiotomy being cut.

23 Q And was that done in this case?

24 A Yes.

25 Now, this is -- if you freeze it?

1 Without knowing there's a shoulder dystocia because the
2 vacuum is still on, a lot of doctors put people in
3 McRoberts. So, this is the leg being pushed back. It
4 barely eases the -- in the delivery without even knowing
5 there's a shoulder dystocia. So, this, I would say, a lot
6 of us, if not majority of us, are doing this without knowing
7 anything about the shoulder impaction.

8 Now, the baby is turning, and with the help of the
9 vacuum, the head is coming out, and if you freeze it right
10 there?

11 So, now the head is out and the vacuum is about going
12 to be taken away, and now is when the shoulder dystocia is
13 apparent. So, you -- when the vacuum is on it, this minute,
14 because we haven't tried to deliver the rest of the body,
15 you do not deliver the whole baby with the vacuum attached.
16 In the second, mostly likely you'll see the vacuum come off,
17 and then when you try to deliver the rest of the baby is
18 when you will realize that this shoulder, anterior shoulder,
19 is stuck against the symphysis of the bladder bone.

20 So, that's contraction. The vacuum is moved or comes
21 off, and now this is attempt by doctor to try to deliver or
22 assess the babies. This is clearing the nose because it has
23 a lot of mucus, and then, in the second, the mouth and this
24 is normal part. At this moment, the doctor does not know
25 there's a shoulder dystocia.

1 Q Doctor, in a few seconds ago, before the bulbing was
2 done, we saw the hand of the physician go in.

3 What's he looking for at that point?

4 A So, you can have what we call nuchal cord. If they're
5 a hundred babies, anywhere from 15 to some studies say 25,
6 there will be cord wrapped around the neck. So, we want to
7 make sure there's no cord around the neck. So, we just feel
8 the neck to make sure there's no cord around the neck.

9 Now is the contractions and then the baby's not coming
10 out. So, this is the suprapubic. So, this is a clinician
11 or a nurse, most likely, pushing near the bladder bone to
12 get this shoulder to come down and underneath the bone.

13 This is the doctor in conjunction with the suprapubic
14 trying to deliver the head and the shoulder is still stuck
15 against the bone.

16 Q Now, at that point, doctor, what are the forces that
17 are being applied by the maternal -- the assistant doing the
18 suprapubic?

19 A So, this force is -- all it's doing is trying to push
20 the shoulder and it's not stretching the brachial plexus.
21 If anything, it will decrease it and the head is -- there's
22 a gentle traction here. So, right now, to the best of
23 everyone's knowledge, including the clinician, it's minimal
24 or the usual traditional traction.

25 So, this is the attempted Rubin's. So, the doctor's

1 hand is trying to dislodge or push that anterior shoulder
2 inward in trying to get the -- this shoulder to get
3 underneath it. So, that's Rubin maneuver or we call it
4 anterior post shoulder rotation.

5 Q Now, do physicians, at times in this part of the
6 process, attempt to grab the arm that we can see here to
7 facilitate the, the delivery?

8 A Depending on the clinician's preference, they can use
9 their hand to take the posterior arm and pull it out. If
10 that -- that's the more common. If even that's not working,
11 one of the last maneuver is trying to get the anterior arm
12 pulled downward, but we start with the posterior arm. This
13 is the posterior. This is anterior.

14 Q Can you always grab that posterior arm---

15 A No.

16 Q ---with your fingers?

17 A No, it sounds simple, but this is one of the hardest
18 thing cause a baby -- it's hard for most of our hand to go
19 where this hand is, and to try to bring that hand, the
20 sounds simple. It's not as easy as it's described in
21 textbook.

22 So, this is another attempt to dislodge the shoulder.
23 So, they -- see how the hand is curving?

24 So, what you've done is taken the one hand of the
25 doctor and the doctor, in this case, he has dislodged the

1 anterior shoulder against this while this pressure,
2 suprapubic, is being applied and McRoberts. So, you have
3 McRoberts, suprapubic, and Rubin maneuver all three working
4 together to dislodge the shoulder from this bone.

5 Q The last thing we saw with the hand going sort of
6 behind the baby's head and moving that, is that called the
7 Rubin II or Rubin maneuver?

8 A Rubin maneuver.

9 Q And at this -- at that point, has the dystocia been
10 resolved?

11 A Yes, you can feel or you can -- the baby descends, and
12 then when you apply gentle traction, the rest of the baby
13 comes out without any difficulty.

14 Q Thank you, doctor.

15 A Thank you, sir.

16 Q You can sit back up there.

17 Thank you for the lights.

18 Now, doctor, from what you saw with regard to what we
19 just saw on that, is that consistent with what you saw
20 described by Doctor Giep in the manner in which he completed
21 the delivery of this baby?

22 A Yes, in the records and in the deposition, that is the
23 description or the depiction is a good description of what's
24 in the record and in the deposition.

25 Q And you mentioned the traction that is applied by the

1 physicians. You described it, at the point the dystocia is
2 going on and they're doing whatever they're doing, as gentle
3 traction.

4 Is there a way that y'all measure that as you're doing
5 this stuff?

6 A No, I know -- there are some clinicians or researchers
7 who allegedly have measured it and they can tell it.
8 Believe it or not, with the device enlisted by medical
9 auxillary for the last two years, we are trying to duplicate
10 their work, and even though I have a Ph.D. and undergraduate
11 in OB-GYN, residents and a fellow, we can not duplicate
12 their work. We can not come up with a simple -- almost
13 like, you know, the thermometer or a speedometer or
14 something great which can objectively tell us. It is based
15 on our experience, knowledge, and the best judgment given
16 this -- what we have in front of us.

17 Q Same thing with regard to the ambulatory -- the baby's
18 head at your removing it, is there a certain direction y'all
19 are -- most doctors try to utilize in, in delivering the,
20 the baby once the dystocia is -- has been encountered?

21 A May I, may I come down, sir?

22 Q I'll show you, doctor. Maybe you can---

23 A I can just point from laser from here.

24 Q What I'm showing you is a, a -- what I marked as
25 Exhibit 8-D, as in Delta, for demonstrative purposes only.

1 Show us what we're talking about there.

2 A So, this is the baby's head and for the baby's crowning
3 right now, and what you see, this is the baby's spine. What
4 we try to do always is keep this in a straight-line, so when
5 we bring the baby out as at the end in the video, it is
6 almost in a straight-line with the spine.

7 Q But in the real word of delivering babies, is the spine
8 always in a -- is the body always in a direct straight-line?

9 A As you know, we are all different and we all come out
10 looking differently. No, this is a good ideal depiction of
11 what's suppose to happen.

12 Q And is -- when y'all -- when an obstetrics --
13 obstetricians acting within the standard of care do grab on
14 or attach their hands to the baby's head and guide it as
15 it's coming out, is there some degree of upward or downward
16 movement towards the ceiling or towards the floor that's --
17 that is employed?

18 A Even without shoulder dystocia, there's a -- so, when
19 the head comes out, there's a little bit of movement going
20 down and up. That is inevitable. For some head not to go
21 down, it would be a rare exception. They always movements.
22 Some up and down and that's just the normal part of delivery
23 process.

24 Q Now, doctor, I want to go to the idea of what it takes
25 to injure one of these nerves.

1 Is that something that you have studied?

2 A We are trying to study. There have been other
3 publications, which have been cited, but I personally, as of
4 today, not studied it though we're in the active process
5 with environmental engineer.

6 Q Are there reliable studies that you're aware of that
7 talk about the threshold for brachial plexus nerve injury to
8 occur in live babies born with or without shoulder dystocia?

9 A I personally am not convinced that this is reliable
10 threshold because one of my thing is, you know, the simplest
11 thing about science is what we call reproducible. If you
12 think this is it, then I, in a different hospital in a
13 totally different setting, should be able to redo the whole
14 thing and come to a similar measurements. So, it's almost
15 like, you know, if you take a sack of potato in one
16 hospital, another hospital, you put it on a weighing
17 machine, it should always come to 10-pounds at both center.

18 We have tried to duplicate what is alleged pressure and
19 all that. It is a good hypothesis but by some doctors done
20 in very unusual circumstances, but, as of today, if those
21 articles were to be published, and I'm an editor of OB
22 journals, I would not accept them as scientifically valid
23 anymore.

24 Q And, excuse me, doctor, is there, in the ACOG report
25 with which you are an author, are there statements about

1 whether there's a correlation between the fact that a
2 persistent or permanent brachial plexus injury occurs in the
3 delivery after a shoulder dystocia event means or implies
4 that excessive forces were used by the birth attendant or
5 the doctor?

6 A No, there is no force. One of the simplest number, and
7 no one denies it, if a matter can be literally calculated
8 when I was in the Spartanburg, if any doctor does a
9 thousands delivery, they will have one brachial plexus. So,
10 for just one brachial plexus, which can or can not result.

11 So, for me to study the force, I need to do at least
12 1,000 deliveries with the force meter. Whatever you want to
13 use to call it force. But most, as you know, brachial
14 plexus get better. The majority of the children get better
15 without any surgery. For it to last, I have to deliver
16 10,000 babies.

17 It's -- I don't care what country you are in, America
18 and in other countries across the globe, the likelihood that
19 the brachial plexus palsy could last for years is one in
20 10,000. I have to study 10,000 vaginal or 10,000 delivery
21 with this meter to find one case of brachial plexus.

22 Now, suppose I did get to it and I did find that one
23 case while imagining 10,000, that's only one case. As you
24 can imagine, you can't say much having had just one example
25 of adverse outcome.

1 Now I need at least ten. Now I need to measure a
2 hundred thousand deliveries to get ten cases of brachial
3 plexus which will persist. No one, no one has even come
4 close to doing that in America. All these ones alleged
5 pound needed to cause permanent is an educated guess by some
6 clinicians, and I think they're the right to their opinion,
7 but in terms of scientific, if you just think about the
8 simple number, they had to have at least 10,000 measurement
9 to find one.

10 No one has ever denied a persistent brachial plexus
11 happens one in 10,000 deliveries. Without getting to that
12 literally measurement of force of normal delivery, to say
13 anything is, at best -- what's the quick word?

14 It's a good guess, but it's no where compared to being
15 scientifically valid statement.

16 Q Do you agree, doctor, with the statement from the
17 Brachial Plexus Palsy Task Force report that no clinical, no
18 published clinical or experimental data exists to support
19 the condition---

20 MR. HENSHAW: Your Honor, I renew my earlier objection.
21 Since that was a motion in limine, I need to renew it.

22 THE COURT: All right, sir. Overruled.

23 Q I'll read -- I'll start over again, doctor.

24 No published clinical or experimental data exists to
25 support the contention that the presence of persistent, as

1 compared to transient, NBPP, neonatal brachial plexus palsy,
2 implies the application of excessive force by the birth
3 attendant?

4 Do you adhere to that?

5 A I absolutely a hundred percent agree as exemplified by
6 my simple math.

7 Q And, doctor, in terms of the degrees of force that
8 Doctor Giep described in his medical records, do you have a
9 recollection of what he described at roughly 9:00AM the
10 morning of the delivery as to the amount of force he used?

11 A Yes, I do.

12 Q And what was that?

13 A I'm sorry. I'd have to down where you can -- gentle---

14 Q Let me move it closer.

15 I'm showing you what has been previously admitted into
16 evidence. I've got it marked as Defendant's Exhibit, I
17 believe, No. 3.

18 A So, it's October 9th. It's gentle---

19 Q I'm sorry. I grabbed the wrong one. Pardon me. I got
20 things out of order.

21 Now, doctor, the one for October the 7th, '08, at
22 roughly 9:00AM in the morning, what did he describe was the
23 forces that he used at that point from your review of
24 everything?

25 A So, it says -- I'm just going to read the sentence.

1 Before EBL, estimated blood loss, 300 cc's, shoulder
2 dystocia, lasting, and those symbols are approximate one to
3 two minutes, minimal traction performed.

4 Q Okay. And the following day or day and a half later
5 when he was meeting with the family on the 9th at 8:00
6 something in the morning, again, what did he describe about
7 the forces and traction he used?

8 A So, a gentle and something traction supported --
9 support of head.

10 Q Okay.

11 A Internal McRoberts maneuver and suprapubic.

12 Q Gentle and constant traction applied to infant's head
13 at---

14 A Gentle and constant traction applied to fetal head
15 after McRoberts and suprapubic.

16 Q Is that a description of the type of forces that would
17 be used, or if used by an obstetrician in a scenario like
18 this one with this baby, that would be within the standard
19 of care?

20 A Yes, sir.

21 Q And did it appear, from what you saw, that the manner
22 in which Doctor Giep managed all of these issues revolved
23 the brachial -- the shoulder dystocia event?

24 A Yes, it did.

25 Q Did the baby suffer any type of a brain injury as a

1 result of the low heart rate combined with the shoulder
2 dystocia event prior to the time of the releasing of the
3 shoulder dystocia in the delivery?

4 A No, it did not.

5 Q Did it suffer any type of cerebral palsy?

6 A No, it did not.

7 Q Obviously we know it didn't pass away or die as a
8 result of that?

9 Is that fair?

10 A Yes, sir.

11 Q And are those the very risks that you, as
12 obstetricians, are worried about when shoulder
13 dystocia occurs, especially in a child where the heart rate
14 has dropped from the 130s down to the 90s?

15 A Yes, those are the risks we are concerned about.

16 Q Okay. Now, doctor, in terms of the direction of
17 traction, again I would like to go to the, the ACOG
18 publication that you've got, and ask you---

19 MR. HENSHAW: I would ask that my objection be
20 continuing, Your Honor, in regard to any of these exhibits
21 that are placed for the same reason---

22 THE COURT: They're from the treatise?

23 MR. HENSHAW: Yes, sir.

24 THE COURT: All right. Note your objection and it
25 shall continue.

1 Q Now, doctor, in your publication that was done with you
2 and the 20 odd other healthcare providers, did y'all look at
3 the issue of clinician applied traction and bending forces
4 and what relation that might have to the occurrence of
5 brachial plexus in babies?

6 A Yes, we did.

7 Q And the statement -- do you agree with this statement
8 that clinician applied traction and lateral bending of the
9 fetal neck have been implicated as causative factors in some
10 cases of neonatal brachial plexus palsy?

11 However, neonatal brachial plexus palsy also has been
12 shown to occur entirely unrelated to traction with studies
13 demonstrating cases of both transient and persistent
14 neonatal brachial plexus palsy in fetuses delivered by
15 cesarean without shoulder dystocia. Other studies have
16 reported neonatal brachial plexus palsy occurring in the
17 posterior shoulder in the presence of a delivery complicated
18 by anterior shoulder impaction.

19 Do you agree with that?

20 A Yes, I do.

21 Q What's all that mean?

22 A That means that you do not need excessive traction
23 because the fact that you can get brachial plexus, as I
24 said, initially just with cesarean delivery in the posterior
25 shoulder of the one which is not impacted with the bone up

1 front and without shoulder dystocia, they is ample evidence,
2 from those three examples, that one can have brachial plexus
3 without even the gentlest of traction. Combined with the
4 traction used with shoulder dystocia, that enough to explain
5 brachial plexus. We don't have to say that it had to be
6 excessive.

7 Q And, doctor, in terms of the nature of the tissue of
8 the babies, is every baby's tissue the same in their
9 brachial plexus?

10 A No, they are not.

11 Q From one baby to the other?

12 A They are not.

13 Q Even between babies, is every nerve the same in the
14 brachial plexus structures?

15 A As you can imagine, I don't think we are the same, no.

16 Q And when y'all are looking at those issues with our
17 Task Force, did you come to some conclusions about the
18 variations between individuals and what impact that had upon
19 the mechanical properties of that anatomy of the brachial
20 plexus?

21 A Yes.

22 Q Now, do you agree with the statement here that
23 significant variations exist between individuals both in
24 terms of mechanical properties in anatomy because of the
25 nonlinear behavior of tissues such as nerve tissue?

1 An estimate of the force needed to cause a nerve
2 rupture can not be directly established.

3 Is that what y'all wrote in the article we were talking
4 about?

5 A Yes, sir.

6 Q What does that mean?

7 A That means that you can not -- so, humans are
8 different. We all accept that. Same thing with newborns
9 fetuses. They're all different. And you can not take a
10 phenomena observed in one or two cases in some study and
11 apply to everyone and say it has to be like that because
12 there is a variation in the injury. I -- my best analogy is
13 because one kid gets the flu or even five kids gets the flu,
14 doesn't mean everyone gets the flu. Kids are different.
15 One day one kid may not get the flu. The next month, the
16 same kid will get flu. There is variation both in children,
17 adults, and newborns of how they're affected with anything.

18 Q And as far as that nerve tissue in there, did y'all
19 study the amount of forces it takes to cause some damage to
20 it to be permanent or otherwise?

21 A Yes, other authors have studied that.

22 Q And in your publication, the Task Force report, do you
23 agree with the statement the nerve tissue properties of the
24 newborn brachial plexus have not been adequately studied to
25 establish threshold for damage based upon either applied

1 force or resulting stretch?

2 A That is a corrected (sic) statement.

3 Q And what does that tell us?

4 A As I said, it's one in 10,000 phenomena for persistent
5 brachial plexus. So, they -- no one has studied the nerve
6 difference in that one case out of 10,000 to show that what
7 is the threshold damage though some doctors, pardon the
8 words, say yes, I know. But most of us, when you look at it
9 objectively, and even if you just think about it not being
10 an expert, the phenomena which happens once in 10,000 is so
11 difficult. I have to do 10,000 nerve study just to find the
12 one damage. So, this thing is a simple statement that we
13 don't know yet.

14 Q And is there any accepted threshold for these types of
15 injury?

16 A No.

17 Q Does the degree of this baby's injury, in your opinion,
18 tell us anything scientifically about how the injury
19 occurred, what caused the injury?

20 A So, the injury did occur during delivery, and during
21 the proper management of shoulder dystocia. That we and I
22 think we all agree. So, this injury did not happen before
23 the child or the birthing process began, which is very
24 uncommon.

25 So, yes, it did happen during the delivery process, but

1 not because of something was done abnormal. There is enough
2 evidence that, even when you manage shoulder dystocia
3 properly, in America and in other countries outside America,
4 you do get the same phenomena for persistent brachial plexus
5 injury.

6 Q And does that delivery process start pretty much from
7 the time that the contractions begin after the water has
8 broken?

9 A Yes. So, as you know, that the baby coming out starts
10 once the contractions pick up. So, it -- the whole process
11 of this "injury" started somewhere from regular contraction
12 to the actual delivery.

13 Q Now, we've heard some testimony about this idea of
14 maternal forces, and one of the witnesses earlier suggested
15 that maternal forces could never be strong enough to cause
16 any type of a brachial plexus injury. Much less one that's
17 permanent.

18 Do you have an opinion on the scientific validity of
19 that statement?

20 A I -- sure. While I respect clinicians who say that, as
21 a clinician and as human being, but this statement does not
22 have any validity because it does not explain the posterior
23 shoulder, why does that get injured. Why do persistent
24 brachial plexus with cesarean delivery. Why do you have
25 persistent brachial plexus without shoulder dystocia. You

1 can say well, these doctors in America, they just -- and the
2 fact that it's time -- the first report started in Libya, of
3 all the country, and even some other Africa -- other
4 countries in Africa and Europe have said the same thing over
5 and over again, and we just validated it by work with a
6 neurosurgeon in Michigan.

7 We have the largest series of brachial plexus in
8 English language and what happened in the labor and
9 delivery. 380 brachial plexus. Even when Michigan and
10 surrounding state the phenomena that you can have a brachial
11 plexus with C-section and without shoulder dystocia is
12 valid, and that that paper came out after the Task Force.
13 So, even after the Task Force publication, keep finding the
14 same phenomena, I think in about four out of ten brachial
15 plexus, there's no shoulder dystocia, yes, you can get it
16 with cesarean delivery.

17 Q And, doctor, we've heard some testimony yesterday from
18 other witnesses that this injury could of only occurred
19 because the doctor applied 35-pounds or greater of traction
20 at an excessive degree of 45-degrees of downward movement of
21 the head or combination of those two.

22 Do you have any opinion whether that has any scientific
23 validity based on all of the studies that you've done?

24 A This is our only -- because this is the first time I've
25 come in Spartanburg, I was literally in woodland in my house

1 when we realized, so looking at -- that persistent brachial
2 plexus is one in 10,000.

3 Okay. No one should deny that. Ten thousand -- one
4 between 10,000. Let's just accept that and I don't think
5 they're -- my colleagues on the other side are denying that.
6 They would need 10,000 measurement to say that I need that
7 35-pound. If you just think about it, without getting to
8 10,000 measurement, and the largest sample I know they have
9 is let's say a hundred or 200, and that's in what we call
10 artificial setting. They've -- doctors know what that was.
11 There's a special glove and, in medicine, there's a special
12 thing called Hawthorne Effect.

13 Hawthorne Effect is what you do when you know you are
14 being observed. The simple analogies of how you and I drive
15 when we know there's a cop behind us is totally different
16 than we do. So, we are, at our -- whatever you want to
17 call.

18 They only have 200 cases. There is no way,
19 mathematically, they have come to the correct conclusion by
20 measuring 200 or what happens in one in a 10,000 phenomena.

21 I've always said I will need to study at least a
22 hundred thousand measurement of angle and force before I
23 would publically say that it had to be this. Otherwise, it
24 is a -- literally stretching the truth beyond which it
25 should be. That would be my humble suggestion to their

1 opinion.

2 Q Now, doctor, in your education, training, and
3 experience, could the injuries to Ashley F have
4 occurred even if a delivering obstetric doctor does all the
5 maneuvers to relieve the shoulder dystocia perfectly and
6 barely applies any traction to the child?

7 A Yes, both in my personal experience. So, I've had two
8 brachial plexus injury. Even with normal traction, you can
9 have brachial plexus injury. Others have reported that,
10 even when doing everything properly to relieve the shoulder
11 dystocia, you can -- it's one of my simple things. Even
12 when we do everything right, sometimes things go wrong.

13 When we drive within the speed limit, obey all the
14 street laws, we can still get in an accident. That
15 phenomena exists in human life. That phenomena exists in
16 the management of shoulder dystocia. Even when you do the
17 very best, yes, we can have injury though it's exceedingly
18 rare.

19 Q Doctor, I want to circle back around to standard of
20 care and then we'll be done. Looking at -- from your review
21 of the medical records and everything, up until the time of
22 the -- when the nurses were doing all the maneuvers that
23 they did prior to the occurrence of shoulder dystocia, were
24 their actions all within the standard of care?

25 A Yes, they were.

1 Q When Doctor Giep got involved in the case and did the
2 things that he did with regard to the application of the
3 vacuum extractor, the maneuvers that he did and instituted,
4 the suprapubic pressure, the McRoberts maneuver, and then
5 backwards, the Rubin's II, those things, were those all
6 within the standard of care what most obstetricians would
7 have done when faced, when faced with a baby who presented
8 as did Ashley F on that October the 7th?

9 A I would say 95, 99 percent of us would have done the
10 same thing.

11 Q And was that all within the standard of care, what,
12 what he did?

13 A Yes, sir, absolutely within the standard of care.

14 Q And from your review of the records and his deposition
15 and his description of the forces that he used, the minimal
16 traction only or the gentle and constant traction and what
17 he described in his deposition, were -- was that within the
18 standard of care required of him as an obstetrician in the
19 delivery of this child?

20 A Yes, it was.

21 Q And the manner in which he described doing the delivery
22 and manipulation of the baby, was that also within the
23 standard of care required of him in the delivery of this
24 child?

25 A Yes, it was.

1 Q Sorry. Pardon me one moment.

2 (Pause.)

3 Q So, doctor, I guess the final question was if Doctor
4 Giep did not apply excessive and misdirected force as has
5 been previously claimed, how do you explain the injury that
6 occurred in this child?

7 A So, the injury is due to multiple things as you can
8 imagine. Nothing good or bad happens with just one thing
9 behind it. It's multiple factors coming together.

10 So, starting with regular contraction, the head coming
11 down, the head getting stuck behind the shoulder, and then
12 the gentle traction and maneuvers used to relieve it, it's
13 the, the combination of maternal pushing the baby or
14 maternal expulsive force, the compaction of this shoulder
15 behind the bone, and the gentle maneuver. It is the
16 combination of all together.

17 I couldn't dissect and say it was this or this. Those
18 three alone are sufficient to explain overwhelming majority
19 of persistent brachial plexus injury.

20 Q And in particular with Ashley F , did the fact
21 that her heart rate had dropped have any impact on the
22 occurrence of this injury in her?

23 A Other people have published that there -- if the baby
24 is not optimally or the best oxygenated or there's some
25 other concern, excuse me, then the threshold needed to have

1 that injury is lower. So, let's say needs this much. If
2 the baby is not getting oxygenation or some other things
3 going on, then it may take even less amount of traction to
4 cause a persistent injury.

5 Q And was there evidence you saw in the medical
6 records---

7 MR. HENSHAW: Objection, Your Honor, and move to
8 strike. That is not responsive to the question.

9 THE COURT: Well, I'll have to review the response.
10 I'll, I'll address that shortly.

11 Q Ask the question again.

12 Doctor, in terms of the heart rate having dropped in
13 this particular child from the 130s to the 90s, do you have
14 an opinion whether that also potentially contributed to the
15 cause of this neonatal brachial plexus injury that she
16 suffered in Ashley F ?

17 A Yes, I do.

18 Q And what is that?

19 A Because the threshold needed to injure is lower when
20 they's something going on else. So, in this case, the heart
21 rate, which is a very good suggestion of how the baby's
22 being oxygenated, so, the baby's getting less oxygenation
23 and less tone. That increases the likelihood of baby having
24 a brachial plexus.

25 Q Was their evidence, doctor, that you saw in the records

1 of the baby at the time, or after the delivery actually,
2 where there was evidence that she was in some distress in
3 terms of her muscle tone or oxygenation?

4 A So, the Apgars, which are assigned by the NICU team,
5 were low. The baby was noted to be blue, and the baby was
6 noted to have persistent low tone.

7 So, the baby had low Apgar, low -- or the color or
8 discoloration of blue, and low tone. They are all
9 suggestive that the baby had lower oxygen than what would be
10 optimum in the last minute.

11 Q And the tone that you're talking about, is that muscle
12 tone?

13 A Yes, sir.

14 Q And is that a measurement of the overall muscle tone of
15 the baby?

16 A That is a good approximation, yes.

17 Q And, in her case, did that low tone continue beyond
18 just the one minute after the birth?

19 A My recollection is it continued until five minutes.

20 Q Based on your education, training, your 27 years of
21 experience, do you have an opinion whether or not Doctor
22 Giep had breached the standard of care, committed
23 malpractice in his care of, of this mother and child?

24 A I would say two things. He did not breach the standard
25 of care considering how the heart rate was. Application of

1 forceps was wonderful because a lot of young OB-GYNs I
2 personally train don't know how to use the vacuum. He
3 appropriately did the vacuum application when needed in the
4 proper timing, encountered should dystocia, managed it
5 appropriately, and did a wonderful job of saving Ashley's
6 life.

7 Q Did the amount of time that the dystocia was lasting
8 from when it come -- when it started to when the baby was
9 delivered, are you saying that that was the reason that she
10 had the permanent injury?

11 A That could be. So, starting of low heart rate down to
12 one to two minute, that -- all that goes into the thought
13 process of what caused it.

14 Q And, doctor, in terms of the baby's health and
15 wellbeing with the depressed fetal heart rate, is the first
16 goal to deliver the baby as healthy as possible avoiding
17 brain injury and any other things that could eventually
18 happen?

19 A Yes.

20 Q And is there always a chance that's gonna happen in
21 every time y'all encounter a shoulder dystocia?

22 A No, I wish it was true.

23 Q Thank you, doctor. Please answer any questions
24 plaintiff's counsel may have.

25 THE COURT: All right. We're gonna take a short break

Suneet Chauhan - Direct examination
by Mr. Lovell

1 before we go forward with cross-examination. So, please go
2 to your jury room. Don't discuss the case.

3 (WHEREUPON, the following takes place outside the
4 presence of the jury.)

5 THE COURT: All right. You can step down.

6 THE WITNESS: Yes, sir.

7 THE COURT: But you're still on the witness stand. So,
8 you can't discuss your testimony during the break.

9 THE WITNESS: Yes, sir.

10 MR. HENSHAW: Your Honor, I can withdraw that last
11 question. He corrected it with the follow-up question.

12 THE COURT: Okay. Thank you.

13 All right. We'll be in recess for 15-minutes.

14 (WHEREUPON, a short recess was taken at this time.)

15 THE COURT: Any matters to address before the jury
16 comes back?

17 MR. LOVELL: No, sir.

18 THE COURT: Bring them in.

19 (WHEREUPON, the following takes place within the
20 presence of the jury.)

21 THE COURT: All right. The jury's back.

22 You may continue with your cross-examination.

23 MR. HENSHAW: Thank you, Your Honor.

24 CROSS-EXAMINATION

25 BY MR. HENSHAW:

1 Q It's, it's Doctor Chauhan?

2 Is that a correct pronunciation?

3 A That's close enough, sir.

4 Q All right, sir. Doctor Chauhan, do you agree that
5 axial traction is a pulling force applied in alignment with
6 the fetal cervicothoracic spine?

7 Sometimes this is referred to as downward axial
8 traction.

9 A I think that would be a reasonable statement though I
10 wouldn't use all those words in one sentence, but it sounds
11 reasonable, sir.

12 Q All right, sir. Would you agree that excessive
13 traction is a pulling force that is greater than the
14 inherent strength of the fetal brachial plexus?

15 A I could see why some would write that. I don't think
16 I've written that, but I could see why someone would write
17 that.

18 Q Well, it comes from your book.

19 You -- do you not know that?

20 A I, as you can imagine, there are, I'm going to guess, a
21 hundred pages. Let's say one page is at least 50 sentence.
22 So, 50 times a hundred. So, I can see why someone wrote
23 that, and I have no problem with that statement.

24 Q Do you have the book?

25 A I have a xeroxed copy, sir.

1 Q Well, turn to the glossary.

2 Do you have that?

3 It will be at Page 73.

4 A One second, sir.

5 (Pause.)

6 A My paging number may be different than yours. On my
7 Page 73, it's Table 5455.

8 Q Here.

9 The Inevitable Brachial Plexus, Brachial Plexus Palsy.

10 That's the book, right?

11 A Affirmative, sir.

12 Q And that's the one that you said was authority -- was
13 authoritative?

14 A Yes, sir.

15 Q All right. Page 73.

16 And, and, doctor, we can play with numbers all day
17 long. You're saying one page, but the glossary is intended
18 to be the definitional basis for all the terms used on every
19 page, isn't it?

20 A It is a simple summary or a definition of that word,
21 yes, sir.

22 Q And doesn't it says expressive traction is a pulling
23 force that is greater than the inherent strength of fetal
24 brachial plexus?

25 A Give me a --.

1 Q It's in black letters.

2 A Yes, sir.

3 Q Excessive traction.

4 A Yes, I see it, sir.

5 Q And you don't agree with that?

6 A No, I didn't say that I didn't.

7 Q Well, you do agree with that?

8 A Yeah, that statement is there. I agree with that, sir.

9 Q Okay. And you would agree that that is the
10 definitional term for excessive traction throughout this
11 entire book?

12 A In that glossary, yes, sir.

13 Q Every page. Not just out of five or two out of, two
14 out of 12. It's every page.

15 A Sir, I think you're making it somewhat disingenuous
16 statement. To make what -- the statement you just did, I---

17 Q Answer the question.

18 It's every page, isn't it?

19 MR. LOVELL: Your Honor, I object.

20 THE COURT: He's answering. Let him finish his
21 response.

22 MR. HENSHAW: Your Honor, may I?

23 THE COURT: You may.

24 (WHEREUPON, a bench conference was held out of the
25 hearing of jury at this time.)

1 THE COURT: You may continue.

2 Q Do you agree that lateral traction is a pulling force
3 that also bends a fetus's neck by moving the ear toward the
4 posterior shoulder thereby opening the contractural angle of
5 the neck and increasing strain on the brachial plexus.
6 Sometimes referred to as lateral bending, downward lateral
7 bending, or downward lateral traction.

8 Do you agree with that definition of lateral traction?

9 A Yes, sir, I've read that.

10 Q Do you agree that the standard of care in the United
11 States is that, in the management of shoulder dystocia,
12 among the things that should be done is that the woman
13 should be layed flat and any pillows should be removed from
14 under her back with one assistant on either side. The
15 woman's legs should be hyper-flexed.

16 If the woman is in the lithotomy position, that is in
17 stirrups, is that correct?

18 Lithotomy position?

19 A That is one way to get to the lithotomy position, sir.

20 Q Okay. Her legs will need to be removed from the
21 supports. Routine traction, the same degree of traction
22 applied during a normal delivery in an axial direction
23 should then be applied to the fetal head to assess whether
24 the shoulders have been released.

25 Do you agree that that is the standard of care in the

1 United States?

2 A That has been routine, yes, I agree with that.

3 Q All right, sir. And in terms of axial traction, we're
4 talking about pulling the baby in alignment with its spine
5 straight through the vagina.

6 Is that correct?

7 A As close to that, yes, sir.

8 Q All right. And do you agree that that needs to be done
9 with the same amount of traction?

10 Regardless of whether it's a shoulder dystocia or
11 whether it is a normal delivery, there is a routine amount
12 of traction that's suppose to be applied?

13 A That is a correct statement, sir.

14 Q Do you agree that, in the United States, it is the
15 standard of care that, when attempting to diagnose shoulder
16 dystocia, routine traction in an axial direction can be used
17 to diagnose shoulder dystocia, but any other traction should
18 be avoided?

19 A And that seems to be a reasonable statement, yes, sir.

20 Q All right, sir. So, if other types of traction include
21 lateral traction, as defined in the glossary of this book,
22 lateral traction is to be avoided as a standard of care in
23 the United States?

24 Would you agree with that?

25 A Yes, in an overwhelming majority of delivery, we do

1 avoid lateral fraction.

2 Q All right, sir. Now, allow me to further explore your
3 relationship with Doctor Giep, the father of the defendant
4 Doctor Giep.

5 You came to Spartanburg and you quickly identified with
6 him as a mentor.

7 Is that right?

8 A Yes, he was one of my mentors, yes, sir.

9 Q Okay. Well, he was not just a mentor to you. You have
10 described him as a professional father figure.

11 Is that right?

12 A I would agree with that statement.

13 Q And while you were in Spartanburg, you not only called
14 on him, but, for professional reasons, but you developed an
15 association with him so that you would seek out fatherly
16 advice from him.

17 Isn't that correct?

18 A I respected his advice, and, yes, I did seek it out,
19 yes, sir.

20 Q You sought advice from him on where to buy a house?

21 A Yes, I did, sir.

22 Q You sought advice from him as to where your kids should
23 go to school?

24 A Yes, I did.

25 Q And so he was -- and you have described him as your go

1 to person as a father figure?

2 A while in Spartanburg, yes. That is a true statement,
3 yes.

4 Q All right. And you continue to feel a great deal of
5 allegiance to Doctor Giep, the father of the defendant in
6 this case?

7 A I don't think I would use the words allegiance. I --
8 that's not a term I use from my culture. The better word I
9 would use is respect. I have a lot of respect for him and
10 his advice. And while I was in Spartanburg, I did seek it
11 out and I did try to listen to it, but I left Spartanburg
12 almost a decade ago, and, since I've left Spartanburg, I've
13 never sought his advice.

14 Q All right. I understand and thank you, doctor.

15 But would you agree that, in your culture, one word
16 would be to use respect, but another would be to use the
17 word honor?

18 A I'm more happy with respect, but I can see why someone
19 would interchange it, but that applies to the dad. Not the
20 sons.

21 Q Okay. And it doesn't apply to the family?

22 A Not to the sons. They're my age.

23 Q Now, in terms of the work that you do, among the work
24 that you do is, is that you have served as an expert witness
25 in at least 40 medical malpractice cases.

1 Is that right?

2 A Probably more, yes, sir, I have.

3 Q And probably more than that?

4 A Now. By now, yes, sir.

5 Q Okay. You charge \$800 an hour for trial testimony.

6 Is that right?

7 A That is correct, sir.

8 Q And in 70 percent of the cases that you have served as
9 an expert witness, you have been a defense expert?

10 A Lately, a little bit more, but that is a correct
11 statement, sir.

12 Q So, somewhat higher than 70 percent?

13 A Yes, sir.

14 Q And in this book that you helped write, and you were --
15 I take it you're considered -- you, you were one of the
16 members of the Task Force that actually put together or
17 compiled the information in this book?

18 A I actually wrote the complete -- did the whole Chapter
19 1. That's my chapter.

20 Q Okay.

21 A And then we edited everyone else's chapters. So,
22 Chapter 1 is authored by me. The rest I edited.

23 Q And the Task Force, the, the obstetricians that were on
24 the Task Force, included Doctor Robert Gherman?

25 A He's -- suggest -- I'm not trying to split hairs, but

1 he's in the maternal fetal medicine. I think he regards
2 himself---

3 Q All right.

4 A ---more as a maternal fetal medicine.

5 Q well, doesn't he hold a degree in obstetrics?

6 A Yes, he's both, but he's -- I guess we call him more
7 maternal fetal medicine.

8 Q All right. well, maternal fetal medicine means that
9 he's got an advanced degree in obstetrics, doesn't it?

10 A In high risk pregnancy, that is correct.

11 Q In high risk pregnancy?

12 A Yes, sir.

13 Q And, in fact, he worked here at least on some projects
14 with you when you were in Spartanburg.

15 Is that not right?

16 A That is correct statement, sir.

17 Q Okay. Doctor Gherman also is often a medical expert,
18 isn't he?

19 A You should ask him, sir.

20 Q well, don't you know?

21 I mean haven't you actually gotten to know him well
22 enough to know that he often is a medical expert for
23 defendant doctors?

24 A My relationship with Doctor Gherman is professional.
25 we talk but I know that he has been a defense expert in some

1 cases I've been involved in. But that's my -- extent of my
2 knowledge of his medical legal.

3 Q And that's all I'm asking is you know that he has
4 worked as a, as a expert for defendant doctors?

5 A Yes, but, by the same token, at least once he was on
6 the plaintiff's side and I was on the defense side.

7 Q Okay.

8 A So, we were on the opposite side at least in one case.

9 Q But, in this case, Doctor Gherman was named as---
10 MR. LOVELL: Objection, Your Honor.

11 May we approach on this question?

12 THE COURT: Okay.

13 (WHEREUPON, a bench conference was held out of the
14 hearing of the jury at this time.)

15 THE COURT: You may continue.

16 Q Okay. You knew that Doctor Gherman had been named as
17 an expert in this case, didn't you?

18 A I read some of his opinion in this case when I was
19 reviewing the thing, yes, sir.

20 Q Oh, you did read some of his opinions?

21 A In this case, yes, I believe so.

22 Q All right, sir. Doctor Steven Clark, another member of
23 the Task Force, do you know that he also is often a defense
24 expert in these cases?

25 A I have never interacted with him where he and I were on

1 the same case on either side. So, I do not know. He may
2 be.

3 Q You don't know---

4 A I accept that.

5 Q You don't know that he testifies in these cases?

6 A As -- he may, sir. I do not attribute to what all he
7 does.

8 Q Michele Grimm, she's not a obstetrician, but she's a
9 biomedical engineer?

10 A That is my understanding, yes, sir.

11 Q And do you know that she is often a defense expert?

12 A I -- not quibble, sir, I don't know about the word
13 often, but yes, in at least two cases she -- that I can
14 recall, at least two cases she and I have been on the same
15 side.

16 Q Doctor William Grobman, he's often a defense expert.
17 Do you know that?

18 A No, I do not know that for a fact.

19 Q Doctor Ouzounian is on the Task Force, defense expert.
20 Do you know that?

21 A I have interacted with him maybe in three cases where
22 he was on a shoulder dystocia case, brachial plexus, yes,
23 sir.

24 Q Okay. The term reasonable medical certainty, you
25 recognize that in the scientific context in which you work.

1 As a medical doctor that has no validity, does it?

2 A That's an interesting question. I hope it's not true,
3 sir.

4 Q Well, I understand.

5 But do you understand that the term reasonable medical
6 certainty is a legal term that we use in the Court system,
7 but it's not one that is routinely or even used for purposes
8 of validating scientific principles, is it?

9 A One more time, sir.

10 Reasonable what?

11 Q Reasonable medical certainty.

12 A It's -- so, in scientific writing, we do not use the
13 word reasonable medical certainty. We use -- we usually do
14 some statistical analysis to say something. That is a true
15 statement, sir.

16 Q All right, sir. And yet, this booklet that you wrote
17 with this Task Force, when we get to the executive summary
18 that was prepared, it says the Task Force recognizes that
19 knowledge about NBPP, that means neonatal brachial plexus
20 palsy, NBPP, right?

21 A That is correct, sir.

22 Q And that's the abbreviation used throughout the book
23 for neonatal brachial plexus palsy?

24 A That is correct, sir.

25 Q The Task Force recognizes that knowledge about NBPP is

1 continually evolving. what is known at this time, with
2 reasonable medical certainty, is that NBPP occurs
3 infrequently and can be caused by maternal (exogenous
4 forces) or clinician applied exogenous forces or a
5 combination of both.

6 why would you be using a term like reasonable medical
7 certainty to validate this document when it's not used
8 scientifically?

9 A That's a good question, sir, but that was the consensus
10 of the committee.

11 Q Is the consensus of the committee that this book needed
12 to be written for purposes of litigation rather than trying
13 to help doctors understand what happens when baby's face
14 shoulder dystocia?

15 A It was not written for the purpose of litigation. It
16 was to summarize the literature as it existed at that time.

17 Q Perhaps I did not understand you, doctor, when you
18 testified, on direct examination, about what you were trying
19 to say that you would need 10,000 patients to find one that
20 you could utilize for a nerve study.

21 A Sorry. Sorry if I was confusing. Let me elaborate.

22 So, the likelihood, and let's accept this, that, with
23 10,000 delivery, one child has permanent brachial plexus,
24 which is the question here. So, one would have to study
25 10,000 delivery to find that one case of persistent brachial

1 plexus palsy. So, there's no way to get around one will
2 need thousand of delivery to find that one case of nerve
3 which is damaged and has persistent damage for at least one
4 year.

5 Q Yet, in this book, Neonatal Brachial Plexus Palsy, you
6 cite to your own article, a 2005 article, and, and if we
7 break it down, one in 10,000, that's one-tenth of one
8 percent according to what you just said?

9 A And I don't have my cellphone or calculator. So, I
10 can't convert that into percentage rapidly, but the simple
11 way I remember is 10,000 delivery to find one case of
12 persistent brachial plexus.

13 Q All right. Well, in your 2005 article that you cite in
14 this book, you had a number of cases with NBPP, neonatal
15 brachial plexus palsy, with permanent NBPP 11.8 percent?

16 A No, I think you're confusing the two things, sir.
17 First of all, I would like to see that.

18 Q Well, I mean does that -- I'll show it to you, yes,
19 sir. There's the book.

20 A Yes, sir.

21 Q Why don't you open the book and it's at Page 16 and
22 it's a chart.

23 A One second, sir.

24 (Pause.)

25 A I'm there, sir.

1 Sir?

2 Q Yes, sir, you're there, and it's Table 2.1, various
3 risk factors and their association with neonatal brachial
4 plexus palsy.

5 A Yes, sir.

6 Q And there's Chauhan.

7 That's you?

8 A Yes, sir.

9 Q Second from the bottom.

10 A That is me, sir.

11 Q And it breaks down between number of cases with
12 birthweight greater than 4,000 grams. Number of cases with
13 birth weight greater than 4,500 grams. Number of cases with
14 diabetes. Number of cases with shoulder dystocia.

15 You had 46 cases with shoulder dystocia?

16 A Yes, sir.

17 Q Right?

18 A Yes, sir.

19 Q And then it has number of cases with NBPP, and then it
20 breaks it down, transient NBPP percentage, and permanent
21 NBPP percentage. The transient NBPP percentage was
22 75-percent and the permanent was 10-percent.

23 A Yes, sir.

24 Q Not .01. 10-percent.

25 A Sir, I appreciate your reading this out, but I think

1 you're making a simple mistake, and I think what it is, you
2 haven't read the original article. What it says is 11 --
3 so, if I had a hundred baby with brachial plexus, 11-percent
4 will have it persistent. So, that statement is true and
5 that's what that table says, but what I'm saying is
6 difference slightly. So, if you just hear me out, sir.

7 One in a thousand will get brachial plexus.

8 Okay?

9 Now, if I do 10,000 delivery, I would have ten brachial
10 plexus.

11 Okay?

12 One of them would be permanent, which is 11-percent,
13 one-tenth. So, the 11-percent refers to among children with
14 brachial plexus. Eleven percent will have persistent.
15 Not -- it does not negate my statement that one in 10,000
16 will have persistent brachial plexus. If you go to the
17 executive summary in the other, it clearly says the rate of
18 persistent brachial plexus is maybe one or two, but let's
19 say one to two per 10,000. The denominator that you need to
20 do 10,000 delivery to find one brachial plexus is the
21 statement true in America and other countries.

22 Q Well, I understand that, but, but what you said to this
23 jury was that we can't really know what's causing brachial
24 plexus injuries because the numbers that we would have to go
25 to in order to find the brachial plexus injuries is so

1 extraordinary, and you're the one that used 10,000, that you
2 just can't find enough to get a valid statement about what's
3 causing these brachial plexus injuries, and that's what you
4 told this jury.

5 A That is correct. So, when this was written, we had the
6 largest series of 85 cases of brachial plexus done over 23
7 years. It took us 22 years of experience at a teaching
8 hospital to find about 80 plus brachial plexus.

9 Q Well, you found -- it's says right here you found that
10 your total number of cases was 85, and the number with
11 transient NBPP was 75, and the number with permanent was
12 ten.

13 A That's my point. It took us 23 years, at a teaching
14 hospital, with almost 80,000 deliveries. Almost 80,000. I
15 don't have the original article. If you do, I'm happy to
16 show. But the simple number was yes, among brachial plexus,
17 ten percent are persistent, but, to get to that ten, I would
18 need 80,000 or a hundred thousand deliveries.

19 Q Well, Doctor Gherman, he found a 119 cases.

20 A But you're not looking at the number. We call it the
21 denominator. We can't -- see, I've not found 380, but for
22 me to get to 380, there had to be 380,000 deliveries.

23 Q But you didn't have to get to 10,000 is what my point
24 is.

25 A Yes, you do, sir. Approximately -- now, it could be

1 9,500, but no one, and if you like to give me two seconds, I
2 can you -- find you the executive summary where it says that
3 the persistent brachial plexus is about one in 10,000. Give
4 me one minute, sir.

5 (Pause.)

6 A So, if you look at Table 1.1, 16-million---

7 Q What page is that, doctor?

8 A Page 4, sir.

9 Q Page 4?

10 A Uh-huh. (Affirmative).

11 Q All right, sir.

12 A So, if we -- so, when we talliate 16-million birth, we
13 found rate of just brachial plexus is 1.5 at the bottom.

14 Okay?

15 Q All right, sir.

16 A If, if you take persistent, then---

17 Q That's per 1,000. That's not per 10,000.

18 A That's just total. Just total, sir. I'm not denying
19 that. So, if you -- for every thousand, you'll get one
20 brachial plexus and ten percent of them are permanent.
21 Therefore, you need 10,000. Just---

22 Q well---

23 A sir, if you would pause?

24 So, let's go to right there.

25 So, Chauhan, same article, 2005, in Table 12.

1 2005, from 1980 to 2002, it took us 22 years. There
2 were 89,978 delivery to find persistent of ten. I needed to
3 study 89,900 birth to get to ten persistent brachial plexus,
4 but you do the math. It's about 10,000. One -- ten
5 thousand, that's the article you're quoting, and that's the
6 complete denominator to -- for me to get to ten persistent,
7 I needed to study 89,978 deliveries and that's what I'm
8 saying.

9 Q Well, doctor, I guess what I'm really asking is, is
10 that if your numbers don't match up with your statement that
11 we need -- that we can only find one out of every 10,000,
12 and then that's not enough to get scientific validity, then
13 why are you writing this book because you don't have the
14 numbers?

15 A Sir, at that time, we had 89, and, since then, we have
16 now 380 brachial plexus. The conclusion with 380. So, we
17 went from 89 to 380. We just published this within last
18 year. Is still the same. That about 40, 45-percent happen
19 without brachial plexus. You can have it with cesarean
20 delivery.

21 Q The statements that you made, if you don't have the
22 numbers to develop a scientific valid -- scientifically
23 valid assumption about what is happening when these babies
24 are born, that means that you don't have a scientifically
25 valid number to support any conclusions you've got in this

1 book that says that maternal forces of labor are what's
2 causing these injuries, do you?

3 A No, sir. So, as I've said, maternal force alone aren't
4 only thing. So, maternal force is one of the contributing
5 or one of the things which increases the likelihood of
6 brachial plexus. Then they're others.

7 It is the sum totality, which I agree with, but the
8 simplistic no, it is only this -- to me, it's A, B, C, D.
9 Not just C or D. It's the combination, as with anything
10 else in life, it is the sum totality of what happens which
11 leads to the eventual outcome.

12 Q But what we do know, because doctors have generally
13 recognized and accepted that the standard of care should be
14 not to use any more traction than is necessary for a routine
15 birth, we know that's the standard of care, and that's what
16 doctors, all doctors who do obstetrics and delivery and who
17 are reasonably competent, have accepted that you do not use
18 anything but the same amount of traction as you would for a
19 routine birth, one that did not involve shoulder dystocia.
20 And so we know that, when you bend the baby's head too much,
21 when you pull too hard, we know, the reason we have that
22 standard of care, is to prevent brachial plexus injuries.

23 Isn't that true?

24 A That is one way to prevent it, but it doesn't prevent
25 all brachial plexus as you know.

1 Q But in terms of what is scientifically valid, in terms
2 of what is generally recognized and accepted, that is the
3 standard of care and that's the reason we have the standard
4 of care is to prevent these types of birth injuries.

5 Isn't that correct?

6 A That is one way. So, to do excessive traction will
7 increase it, but no one denies it, not only in publication
8 in America, but abroad, other countries, that even when you
9 do this routine maneuver or don't even have shoulder
10 dystocia, you can have persistent, and even when you do
11 everything right, you can have persistent brachial plexus.

12 Q In these 28 to 30 cases or more where you've defended
13 doctors in shoulder dystocia cases, how many of those
14 doctors admitted, admitted that they used anything other
15 than general traction?

16 None of them, did they?

17 A No, but I, as you know, plaintiff cases for sure.

18 Q Oh, I understand that.

19 So, you've had some cases where the doctors would admit
20 that they used more than general traction?

21 A I don't know if the -- in that case, when I was a
22 plaintiff's expert with shoulder dystocia, whether he did or
23 not. I do not recall.

24 Q But in cases where the, the -- where, where you have
25 been the defense expert, the doctors have never admitted

1 that they used anything more than general traction, did
2 they?

3 A That is correct, and that is how we are trained.

4 Q Because---

5 A Yes.

6 Q Because if they had, you wouldn't be defending that
7 doctor, would you?

8 A That would be a correct statement.

9 Q All right. So, for you to be in a case like this, the
10 doctor has to make the statement I did not use more than
11 general traction?

12 A That would be correct, and it has to be collaborated by
13 other clinicians who are in the room. That is correct.

14 Q Other clinicians, other doctors that are in the room?

15 A No, clinicians, to me, includes nurses in the room or
16 any other healthcare provider. It could be a resident. It
17 could be a colleague. So, yes, other clinicians.

18 Q Okay. But doctors?

19 A Not -- well, nurses, midwives.

20 Q Nurses.

21 Okay.

22 A Midwife.

23 Q Do you require that the doctors actually observed how
24 the doctor uses his hands when you make that decision?

25 A Sir?

1 Q When you say I want corroboration, do you require that
2 the other clinicians actually be able to observe what the
3 doctor was doing with his hands?

4 A So, the only way to say if doctor used excessive by
5 another person is for them to visualize it or see it some
6 way, yes.

7 Q Oh, you only required on the -- whether it's excessive
8 or not?

9 A Or even gentle traction if they see it, yes.

10 Q But, but do they have to be able to see it for the
11 corroboration that you want in order to be involved in the
12 case?

13 A Otherwise I don't see how one could corroborate that.

14 Q All right, sir. Where did you find a single witness in
15 this case who saw Doctor Giep's hands on this baby's head?

16 A I think the grandmother was there who had a view of it,
17 and none of the nurses have said it, and I'm having worked
18 in the Spartanburg. The nurses are very honest. If they
19 had seen it, they would have spoken up about it.

20 Q Well, wait, wait, wait, wait, wait, wait. No.

21 You said the corroboration requires that they either
22 say that there -- they could see the hands and that there
23 was gentle traction or that they could see that there was no
24 excessive force, but if they can't see the hands on the
25 baby's head, they can't corroborate that?

Suneet Chauhan - Cross-examination
by Mr. Henshaw

1 A That is true, sir. They're no nurses who have said it.
2 The note clearly says it, more than one occasion.

3 Q But that's Doctor Giep. That's just him saying that.

4 A I think I know him to be trustworthy human being and---

5 MR. HENSHAW: Objection, Your Honor. Move to strike.

6 He can't get into character.

7 THE COURT: Well, I understand, but that was in
8 response to the question.

9 Overruled.

10 Q One of the things that is recommended by your manual
11 that would allow for corroboration is a form that goes into
12 a great deal of documentation about what happened during a
13 shoulder dystocia case. You might turn to Page 99.

14 A One second, sir.

15 (Pause.)

16 A Ninety-nine?

17 Q Yes.

18 A Give me one second, sir.

19 Q Appendix C.

20 A Yes, I see that, sir.

21 Q All right, sir. And this is a patient safety checklist
22 recommended by the American College of Obstetricians and
23 Gynecologists?

24 A Starting in---

25 Q Is that right?

Suneet Chauhan - Cross-examination
by Mr. Henshaw

1 A ---August '12, 2012.

2 Q I understand.

3 Starting in August, 2012, that's when this form came
4 out?

5 A Yes, sir.

6 Q But the significance of a form like this is so that
7 there can be a complete statement about what types of
8 maneuvers the doctor utilized during the procedure.

9 Isn't that correct?

10 A That is one way to do it, sir.

11 Q All right, sir. And if we look at this form, one of
12 the things that is expected to be documented is Rubin
13 maneuver.

14 Isn't that correct?

15 A Starting 2012, yes, sir.

16 Q All right. Starting in 2012.

17 But before that, you didn't document the Rubin
18 maneuver?

19 A Sir, that varies from person to person, but I'm -- I
20 personally still do not use this form. So, before 2012,
21 whether it was applicable, I do not know as I sit here
22 today.

23 Q But if you used a Rubin maneuver, would you document
24 that?

25 A If I personally used it?

Suneet Chauhan - Cross-examination
by Mr. Henshaw

1 Q Yes, sir.

2 A Yes, I would document it.

3 Q You would definitely document it, even before 2012?

4 A That is a correct statement.

5 Q And you were here in what years in Spartanburg?

6 A If I remember correctly, I left in 2005.

7 Q And while you were here in Spartanburg, when you
8 delivered babies with shoulder dystocia and you used the
9 Rubin maneuver, you documented it then?

10 A Yes, sir, I would, sir.

11 MR. HENSHAW: Excuse me one minute, Your Honor, please.

12 (Pause.)

13 Q I'll move on.

14 Doctor, in the course of the events involving the birth
15 of Ashley F , the shoulder dystocia could not be
16 recognized until the baby's head had emerged and was between
17 the mother's legs.

18 Is that right?

19 A That is correct, sir. So, after the vacuum has been
20 removed, the head is come out. And when we -- this case,
21 Doctor Giep, is trying to deliver the baby, that's when you
22 would recognize the shoulder dystocia. That is correct,
23 sir.

24 Q And do you agree that was the point at which the doctor
25 was expected to use his experience, training, and knowledge

1 to recognize there was shoulder dystocia?

2 A And I think that's a reasonable statement, sir.

3 Q All right. And he was trained to do that?

4 A Yes, sir.

5 Q And I think that your -- would you agree that, in your
6 testimony here today, this situation where shoulder
7 dystocia will occur during the birth of a baby is not a one
8 in 10,000 event?

9 It happens, as you said, just last Sunday in your own
10 facility. It happens every day in a birthing facility.

11 Isn't that right?

12 A It happens in one in hundred delivery. That is correct
13 statement.

14 Q One percent.

15 One in every hundred deliveries?

16 A Approximately. That is correct, sir.

17 Q All right. So, it happens enough where doctors are
18 expected to be specially trained or, or start training and
19 understand that there is shoulder dystocia and how to
20 recognize it because it's not a rare event. It's one in a
21 hundred.

22 A That is correct, sir.

23 Q Okay. That is just as high as other medical events
24 that are occurring in our community such as heart attacks?

25 A I honestly don't know enough about heart attack---

Suneet Chauhan - Cross-examination
by Mr. Henshaw

1 Q Right.

2 A ---to comment on that.

3 Q But, statistically, it's enough where doctors are
4 expected to understand and appreciate it?

5 A I have made a point of never commenting on things I am
6 not expert on. Heart attack is not my specialty and I do
7 not comment on that.

8 Q And I apologize for that, doctor, and I don't, I don't
9 want you to do that if you don't feel comfortable with it.

10 All I'm saying, in shoulder dystocia, is something that
11 doctors are expected to be able to recognize and identify
12 and begin to treat?

13 A That is correct, but, nonetheless, it is an obstetrical
14 emergency.

15 Q Okay. And so, at the point that the baby's head comes
16 out, was Ashley F at risk for immediate death?

17 A And you -- so we know that the heart rate tracing has
18 already dropped from normal range to down to 90, which is a
19 major change.

20 Q Doctor, are you saying, based upon this record, that
21 she was at risk for immediately dying?

22 A So, you can let me finish the---

23 Q I'm sorry.

24 A Okay. So, what we know is there is already something
25 transpired before the shoulder dystocia. So, that alone, is

1 a risk factor for some kind of injury. So, no one should
2 deny that.

3 Once you encounter the shoulder dystocia, you have
4 another major risk factor. So, you have normal tracing is
5 one, and a shoulder dystocia. So now you have almost added
6 two emergency back to back.

7 So, yes, at that moment of recognition, any doctor who
8 says oh, this is nothing to worry about, baby will be fine,
9 I can take my time is fooling themselves. It -- the -- two
10 of them are there back to back, two obstetrics emergency,
11 which require prompt attention before there's a risk or
12 actual damage to the brain or death.

13 Q All right. And thank you for that, doctor, but my
14 question is, at the point that her head came out and Doctor
15 Giep apparently recognized very -- almost immediately that
16 the head was out and that she was in a shoulder
17 dystocia situation, at that moment that he recognized that,
18 was she at risk of immediate death, that she was going to
19 die immediately?

20 A So, your definition of immediate may be different than
21 mine. But I would say yes, there was a risk that Ashley
22 could have died within minutes of recognizing the shoulder
23 dystocia.

24 Now, we -- you and I, and knowing in hindsight, can
25 quibble about it. But as a doctor having been there, if you

1 have two emergency, yes, you have to be concerned that, in
2 the near few minutes, in the next few minutes, that the baby
3 can have a brain damage or die is a real possibility.

4 Q Well, brain damage is not an immediate occurrence. It
5 occurs over a period of time because of depravation of
6 oxygen.

7 Isn't that correct?

8 A So, in a healthy with the -- let's say the heart rate
9 was normal, you have a shoulder dystocia, everything is
10 fine. Then the average, average is four to six minute. But
11 even among them, some can die sooner than four minutes. If
12 you add abnormal heart rate racing for several minute, I
13 would say that yes, you have to be concerned that there was
14 a real chance Ashley could have died in next few minutes,
15 yes.

16 Q And -- but at the moment that she appeared to have
17 shoulder dystocia, you would agree that she's not
18 immediately at threat of death?

19 A Sir, you use the word immediate. I'm going to go in
20 minutes. Yes, in next few minutes, was it two or was this
21 three or four, I think we have to allege -- you're arguing
22 about it, but at the moment of shoulder dystocia, as a
23 clinician, knowing the tracing had already been abnormal, if
24 I were in Doctor Giep's shoes, I would honestly think, if I
25 do not get the baby out in next few minutes, they's a real

1 chance the baby could have brain damage or death, yes.

2 Q And are you saying, aside from that threat of death,
3 that in terms of serious bodily injury, to a reasonable
4 degree of medical certainty, our legal term, not scientific
5 certainty, but legal term, to a reasonable degree of medical
6 certainty, that she had already had the injury to her
7 brachial plexus?

8 Is that what you're saying?

9 A Sorry. One more time, please. I, I honestly lost you
10 in that.

11 Q In terms, in terms of what you're telling us today, are
12 you saying that, in your opinion to a reasonable degree of
13 medical certainty, that she had already had the serious
14 bodily injury to her brachial plexus before her head emerged
15 and there was shoulder dystocia?

16 A No, I am not saying that the brachial plexus palsy
17 happened before the head emerging. So, there's a
18 stretching. So, some -- the process, it's not yes or no.
19 It's a process. As you can imagine in an injury, the
20 process began at the moment the head emerges, at that time,
21 more likely than not, probably there was no brachial. But
22 by the end of adequate management of shoulder dystocia, at
23 that end, yes, there was.

24 Q At the end of the management there was?

25 A Yes.

1 Q And when was the end of the management?

2 A When Ashley's totally delivered and the feet are out.

3 Q All right. So, that was -- so there was a period,
4 after the head, where the records indicate that she was
5 delivered. It took one to two minutes.

6 Is that right?

7 A That is my understanding, sir.

8 Q Doctor, did you see in the record where Doctor Giep
9 discontinued the Pitocin, which was being used to induce the
10 labor?

11 A I thought it was the nurses, but I know Oxytocin was
12 discontinued.

13 Q All right. Well, do you know whether that was just on
14 their own or whether that was because Doctor Giep wanted
15 them to?

16 Do you know?

17 A I do not know that as I sit here.

18 Q All right. And it, it was in response to her heart
19 rate being -- decelerating into the upper 80s and 90?

20 A That is correct that the Oxytocin or Pitocin was
21 discontinued because of that normal heart rate.

22 Q And there, there was a deceleration?

23 That's called a deceleration of the heartbeat.

24 Is that right?

25 A Yes, sir.

1 Q All right. And so is that the correct thing to do,
2 discontinue the Pitocin because the heart rate has gone
3 down?

4 A That is one of the correct thing to do, yes, sir.

5 Q And is that because, if you continue to infuse the
6 mother with Pitocin, it increases the contractions, the
7 increase in the contractions can, if the baby's not
8 responding appropriately in terms of its heartbeat, then
9 that can be devastating for the baby?

10 A That is one of the reasons is to resuscitate the baby
11 so the baby -- yes.

12 Q All right. Did you see in the record where, after they
13 had turned off the Pitocin, turned the mother on her side,
14 the heart rate appeared to go back up?

15 A It did, but, at the end, when the vacuum was applied,
16 the overall impression, which is accurate, that overall
17 fetal well being was not assured and to expedite the
18 delivery is the more prudent thing---

19 Q well---

20 A ---and I would agree.

21 Q It was assured enough where Doctor Giep ordered the
22 Pitocin to be restarted, didn't he?

23 A That may be, yes, sir.

24 Q well, not maybe. It -- did you read the record?
25 Did you see in the record where he reordered the

1 Pitocin to be restarted?

2 A I accept that, sir.

3 Q So, in his own mind, the baby's heart was strong enough
4 and the baby had been resuscitated enough where the baby,
5 the baby's mother could be restarted on Pitocin to help move
6 that baby down the birth canal.

7 Isn't that right?

8 A No, you're forgetting one thing, sir. So, you have
9 abnormal tracing. The baby's there. You have two options.
10 Either to deliver the baby vaginally and/or do a C-section.

11 So, one way to help the C-section would be probably one
12 of the worst thing one could have done considering how far
13 the baby's up.

14 So, the other way to deliver vaginally is to use vacuum
15 and Pitocin and mother's pushing. So, that's the way. So,
16 at that moment, the concern was what is the best way to get
17 the baby out considering the heart rate has been abnormal.
18 So, start the Pit, do the vacuum, have the mother push,
19 deliver with the push. Those were all reasonable thought
20 processes.

21 Q And aren't you leaving out something, doctor, that that
22 heart tone -- that fetal heart rate tracing had, in fact,
23 gone back up to about 120 to 125 before he -- when he
24 applied the Pitocin?

25 A Sir, as you know, no one should look at a second of the

1 delivery and say this is it, and I think we would not be a
2 good clinician if we did look at the whole picture. If you
3 look at the whole picture at the end, overall concern that
4 the baby was not doing well, needed to be delivered in the
5 best manner, in which case it was the Oxytocin and vacuum,
6 is a very reasonable process. And I think your own expert
7 have testified they do not have any problem with the use of
8 vacuum because of the tracings.

9 Q And, and that's absolutely correct. They have not said
10 that there was any problem with the use of the vacuum or the
11 reapplication of Pitocin, but that's not what my question
12 was, doctor.

13 My question was, when you gave an explanation just now
14 and tried to suggest that the only reason that the doctor
15 ordered Pitocin to be restarted was because he wanted to use
16 that in conjunction with the vacuum extractor, my point was
17 didn't you leave out the fact that the baby's heart rate had
18 gone back up to 120, 125?

19 A I will accept that as one of the reasons.

20 Q And that was reassuring because that's one reason you
21 turn the mother on her side is to try to alleviate whatever
22 condition might be occurring that has caused that heart rate
23 to go down.

24 Isn't that right?

25 A That is correct, but it's still when the baby's head is

1 almost out to do what Doctor Giep was absolutely
2 appropriate.

3 Q And that increase in the fetal heart was reassuring
4 that the baby was okay?

5 A At that minute, but it still needed to be delivered,
6 yes.

7 Q And one -- in fact, in the Apgars, didn't this baby get
8 a rating of two when she was born on her heart rate?

9 A At -- that is correct.

10 Q That means that her heart rate continued to stay above
11 100, which is what doctors strive for if they can, at the
12 time she was born?

13 A But one could also say it is because of Doctor Giep's
14 clinical judgment and management, even though it was 90 and
15 went back to normal, it was still a hundred because I -- you
16 can just turn this thing around. Had he not used vacuum,
17 had he not started the Pit, and the baby had the brain
18 damage, they all said doctor, why didn't you do something?
19 Didn't you see there was abnormal tracing?

20 His response was appropriate. In part, Ashley is as,
21 you said very nicely, one of the most intelligent girls in
22 her class is because of Doctor Giep's management. No one
23 should forget that.

24 Q All right, sir. And her heart rate was normal.

25 It was a two and it continued to be a two and her heart

1 did not have to be resuscitated, did it?

2 A In part because of what Doctor Giep did. That is
3 correct.

4 Q well, they didn't have to do chest compressions to get
5 her heart rate up. They didn't stop. She didn't have a
6 zero in terms of her heart rate. It went back up.

7 Isn't that right?

8 A That is correct and, in part, because of Doctor Giep.

9 Q Did she breathe spontaneously?

10 A I do not know that as I sit here right now.

11 Q what did she go to the other twos for?

12 A So, she was off her color and tone. So, she had
13 problems breathing, yes.

14 Q And -- well, I mean what did she get the twos for?

15 A I would have to see that, sir. I didn't memorize that,
16 her score.

17 Q Okay. well, what are the five things that you can --
18 that, that are scored?

19 A So, I do not do Apgar score. As in this case, most of
20 them was done by NICU. But it is color, tone, heart rate,
21 breathing, and reflexes is my understanding.

22 Q And reflexes?

23 A Yes, sir.

24 Q She got a two on reflexes?

25 A I don't know, sir. I'm sure you can pop that up in one

1 of your---

2 Q She -- crying, is that one of the things they get
3 scored on?

4 A Sir, I did not memorize that, her scores.

5 Q And within five minutes, without a great deal of
6 resuscitation, she was at a seven?

7 A That is correct, sir.

8 Q A -- you're familiar with the National Institutes of
9 Health studies on birth trauma, aren't you?

10 A Could be more specific please?

11 Q Well, aren't you familiar with what the National
12 Institutes of Health have said about what the requirements
13 are for birth trauma, for there to be some indication that
14 oxygen has been so insufficient that it caused a baby to be
15 brain damaged?

16 A I don't know if that comes under birth trauma, but I am
17 aware of ACOG and other national guideline on cerebral
18 palsy, yes, sir.

19 Q Are you aware that, in order to qualify for a birth
20 trauma, a baby has to be born with these scores, these Apgar
21 scores that we're talking about, named after Virginia Apgar?

22 You know that, right?

23 A Yes, sir.

24 Q Did you know Virginia Apgar?

25 A Yes, sir, he--

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by Mr. Henshaw

1 Q Okay. Right.

2 A She's the only woman clinician I know with a U.S.
3 Postage stamp.

4 Q All right.

5 A She was in Boston. She's a pediatrician neonatologist.

6 Q Right.

7 A Yes, sir.

8 Q So, you know Apgar scores?

9 A Yes, I do.

10 Q And you know that, in order for there to be considered
11 birth trauma under the NIH guidelines, is that scores have
12 to be zero or one, don't you, doctor?

13 A So -- and yes, but may I elaborate?

14 Q Certainly.

15 A So, first of all, it's not called birth trauma. I
16 think you're mixing and -- words and you're just all over
17 the place. To me, that's -- is there hypoxia, ischemic
18 encephalopathy, and, by the way, I was one of the coauthors
19 of that too, that workshop.

20 Q The 1984---

21 A Not that. Later one.

22 Q And that was the one that had the -- that was the one
23 that specifically resulted in the NIH determining what was
24 birth trauma?

25 A I don't---

1 Q Wasn't it?

2 A I don't recall in '98 and I don't think we called it
3 birth trauma. That being aside, your point is valid that,
4 to be called intrapartum brain damage, that Apgar has to be
5 three or less beyond five minute, but that is after the
6 fact. I would give the credit to Doctor Giep, his clinical
7 work, his clinical acumen-ship, his bedside manner, that
8 Ashley had Apgars of five to seven. To fall someone and not
9 give credit at the same time is just not the American thing
10 to do.

11 Q Well, my only point is, is that the, the issues
12 involving babies, and when we say they have been deprived of
13 oxygen sufficient to cause injury to the brain or another
14 organ, is -- requires that the Apgars, as you say, are less
15 than three. They have to be -- I thought they were zero and
16 one. You're suggesting they could go up to a two.

17 But the fact is is that, if that's the requirement for
18 oxygen insufficiency, Ashley never got there?

19 A That is correct, but there -- you're missing few
20 things. So, that is -- if you want to say if the baby has a
21 brain damage, the baby has to have a low Apgar, that is
22 correct. But one of the sentinel event for cerebral palsy,
23 believe it or not, is uterine rupture. The other one is
24 shoulder dystocia.

25 One of the biggest risk factor that you can have in

1 intrapartum brain damage is shoulder dystocia. It is
2 analogous to the uterus literally rupturing and the fetus
3 coming into the pelvic. That's how bad. They're almost
4 occurring. So, those are the two sentinel event in addition
5 to a rupture. So, either the placenta came apart, the
6 uterus ruptured, or shoulder dystocia. These are the three
7 major emergencies which are linked with intrapartum brain
8 damage.

9 In view of this absolute emergency, the fact that
10 Ashley has normal or let's say seven minute -- seven and not
11 zero to three at five minute is a credit to Doctor Giep's
12 excellent obstetric care and no one should forget that. Had
13 this baby been brain damaged with an Apgar of zero to three,
14 they would of said, well, my God, why didn't he do something
15 faster? why didn't he do something else?

16 It is to his credit that, in one of the absolute
17 emergency, which is a fluent rupture, abruption, cord
18 prolapse, and shoulder dystocia, this baby has Apgar of
19 seven.

20 Q well, first of all, there wasn't an abruption. There
21 wasn't a uterine abruption. There was no cord prolapse.
22 There was no indication that, as you say, these nurses would
23 of been able to document a prolapse and the doctor would of
24 been able to find an abruption if those two things had
25 occurred.

1 A That is a true statement, but what I'm trying to say is
2 shoulder dystocia, people are minimizing the emergency
3 nature. It is as bad. It has similar risk of brain damage
4 as prolapsing cord.

5 I am not saying there was a prolapse cord. I'm not
6 saying there's a uterine rupture, but to find an affluent
7 risk factor in labor and delivery, you have to go to other
8 things, which are -- everyone accept. My point is shoulder
9 dystocia is an emergency. Ashley is so intelligent in
10 school, in part, because of Doctor Giep.

11 Q All right. And let's give Doctor Giep credit for
12 getting the baby out.

13 Okay. Let's, for our purposes of my next questions, he
14 gets credit for that, but my question has to be, doctor,
15 isn't it true that he should have been able to get the baby
16 out by following the baby's head with axial traction, and
17 not lateral traction, and without excessive force?

18 A No, sir. As you know, both in the ACOG workshop and
19 other experience, people can have persistent brachial plexus
20 while doing the normal maneuvers for shoulder dystocia, and
21 minimizing the angle and the traction keeping it. Within
22 the normal for leaving shoulder dystocia, one in 10,000 will
23 have it. No one can deny that. You don't have to invoke
24 excessive traction as the only cause. It is the total
25 picture.

1 Q I, I under -- I understand that, doctor. I'm not -- I
2 understand that's what you've been telling us.

3 All I'm saying is, is that when Doctor Giep got the
4 baby out, under any circumstances, he was expected to get
5 the baby out by applying axial traction, that is keeping the
6 baby's head in line with the spinal column as the baby
7 delivered, and not having lateral traction so that he bent
8 the opposite ear toward the opposite shoulder of -- that was
9 hung up?

10 He was expected to be able to do that.

11 Isn't that correct?

12 Under any circumstances of this baby maybe having some
13 oxygen problem, even if that were the case, he got the baby
14 out in two minutes, and he was expected to be able to do
15 that without lateral traction, without excessive force.

16 Isn't that true?

17 A That is true, and even without lateral traction,
18 there's a perfect evidence from American studies and from
19 other countries, that even when you are not using lateral
20 traction or excessive traction, in normal management, you
21 can have persistent brachial plexus injury.

22 Q Okay. And you can have that, but what the studies have
23 also shown is that more times than not, when you do have
24 injury, permanent injury to the brachial plexus, it's more
25 likely than not the result of excessive traction, lateral

1 traction, failing to keep the baby's head in axial alignment
2 with the spinal column?

3 A I have not said that. I'm not aware of studies which
4 says that, if they're permanent brachial plexus, more likely
5 than not there was abnormal for excessive traction. I would
6 like to see where you are getting that.

7 Q Well, you're the one that said it only happens one in
8 what, 4,000 -- I'm not sure what your number was.

9 One in 10,000 cases where these injuries can occur
10 without excessive traction?

11 A That is correct. It is one in 10,000.

12 Q So, if only one in 10,000 has -- occurs when there's
13 not excessive traction, then it has to be, by logic,
14 excessive traction is causing all the rest.

15 Isn't that true?

16 A No, sir, I, I, I -- your logic and my logic may be a
17 little bit different. I spent a little bit more time than
18 you on this topic. So, I don't see your logic yet, sir.

19 Q All right, sir. That's all the questions I have.

20 A Thank you, sir.

21 MR. LOVELL: No redirect, Your Honor.

22 THE COURT: Okay. You may step down. Thank you.

23 THE WITNESS: Thank you, sir.

24 Thank you, ladies and gentlemen.

25 MR. LOVELL: May he be excused, Your Honor?

1 Mr. Lovell.

2 MR. LOVELL: Your Honor, we'll call Dr. Bang
3 Giep.

4 (Whereupon, witness comes forward.)

5 THE CLERK: Place your left hand on the bible and
6 raise your right. (Complies.)

7 Do you solemnly swear or affirm the testimony
8 you're about to give will be the whole truth and nothing
9 but the truth so help you God?

10 THE DEFENDANT: Yes, I do.

11 DR. BANG NGUYEN GIEP,
12 having been duly sworn, testified as follows:

13 DIRECT EXAMINATION

14 BY MR. LOVELL:

15 Q. Dr. Giep, if you can kind of scoot up to that
16 microphone so everybody could hear you.

17 A. Yes, sir.

18 THE COURT: And don't turn your back to the court
19 reporter, please.

20 BY MR. LOVELL:

21 Q. There you go. What's your full name?

22 A. First name is Bang, B-A-N-G, middle name is
23 Nguyen, N-G-U-Y-E-N, last name is Giep, G-I-E-P.

24 Q. You'll have to scoot up a little more. You're
25 soft spoken. Thank you.

1 How long -- do you live here in Spartanburg
2 County?

3 A. Yes, sir, I do.

4 Q. How long have you lived here?

5 A. I live here since 1975.

6 Q. All right. You're a doctor?

7 A. Yes, sir.

8 Q. What is your medical specialty?

9 A. I'm an OB-GYN.

10 Q. And with whom do you practice?

11 A. I'm practicing at Spartanburg OB-GYN.

12 Q. And when you say OB-GYN what does the OB mean and
13 what does the GYN mean?

14 A. OB means basically in simple terminology just
15 deliver babies. GYN is simply just taking care of
16 female issues.

17 Q. Obstetrics gynecology?

18 A. Yes, sir. Long-term obstetric gynecology.

19 Q. And in 2008 when Ms. Flowers was a patient of you
20 and your practice, were you involved in more than just
21 the delivery of her?

22 A. Yes, sir.

23 Q. And were -- how many other doctors were in your
24 practice back in '08 at the time when Mrs. Flowers was a
25 patient of the beginning of her pregnancy through the

1 delivery and afterwards?

2 A. At the time there was myself, there was my
3 brother, Dr. Hoang Giep. There is Dr. Bingham. There
4 was Dr. Pete Sereque and there was Dr. Ashley Fowler.

5 Q. Now we heard some testimony about how the doctors
6 would somehow rotate the patients through so they would
7 see different doctors at different times during the
8 pregnancy phase. Why do you all do that?

9 A. Well, we rotate through because we cannot be on
10 call 24 hours a day, seven days a week. So what we try
11 to do is try to see each patient and rotate them through
12 so that it just happens that we're not on call and the
13 patient is familiar with whoever is on so that at least
14 they get seen once.

15 Q. Talk to us about this call schedule. How did
16 that work back in the October 2008 timeframe for
17 patients that are in the hospital to deliver the babies?

18 A. What we usually do is that we usually take calls
19 12 hours at a time. So we have somebody cover early
20 from, let's say, 8 o'clock in the morning until about
21 5 o'clock in the afternoon. Then the next person will
22 come on and see patient or take care of the labor
23 patient from 5 o'clock in the evening until 8 o'clock
24 the next morning. So that way if you happen to be on
25 call all night long, you can get the next day, you can

1 rest the next day, so you're not working 24-hours a day.

2 Q. I kind of jumped ahead of myself, I apologize.

3 A. I'm sorry.

4 Q. How many years have you been delivering babies
5 and providing both obstetrics and gynecologic needs to
6 women in the Spartanburg area?

7 A. I started -- I was in medical school and started
8 doing OB-GYN basically in '91. So I did my residency
9 from '91 to '95 in which I specialize in obstetrics and
10 gynecology. After that, from '95 until now, I've been
11 an OB-GYN. So I guess up to now, you can say 22-plus
12 years.

13 Q. All right. And how many babies have you
14 delivered over that period of time that you've been a
15 doctor?

16 A. I think I would say probably, just a rough
17 estimate, just from private practice from 1995 until now
18 I would probably say at least probably over 2,000. If
19 you count my residency I'd probably say about 3,000.

20 Q. And if we go from residency up until 2008 when
21 you were involved with Ms. Flowers' delivery, about how
22 many?

23 A. I would probably say roughly probably about 2,000
24 or so.

25 Q. And are you board certified in any areas of

1 medicine?

2 A. Yes, sir. I'm board certified in obstetrics and
3 gynecology.

4 Q. And how long have you been board certified in
5 obstetrics and gynecology?

6 A. I've been board certified -- when we graduate
7 from residency in 1995, the first year you're board
8 eligible. You have to pass a written test. And after
9 that then you take what we call an oral board. And then
10 after oral board, then you are board certified. An oral
11 board can only be taken about a year or two after. So I
12 became board certified in 2007. I'm sorry, 1997. I've
13 been board certified ever since.

14 Q. Have you had to get recertified in obstetrics
15 gynecology boards?

16 A. Yes, sir. We have to recertify pretty much every
17 year.

18 Q. Have you done that every year?

19 A. Yes, sir, done that. You have to.

20 Q. In this board certification, do you take both a
21 written test and an oral test where somebody is asking
22 you questions realtime?

23 A. In the initial certification you do have to take
24 a written test, as well as an oral, oral board. And an
25 oral board consists of they look at you, how you

1 practice over the last two years before that. And then
2 you present your case and they question you. And after
3 that and every year you take a written test.

4 Q. Are you married?

5 A. Yes, sir.

6 Q. And what's your wife's name?

7 A. Her name is Julie.

8 Q. Do you have any kids?

9 A. Two kids.

10 Q. What are their ages?

11 A. My son, he's 17 years old. My daughter, she's
12 15.

13 Q. And where do they go to school?

14 A. They go to Dorman High School.

15 Q. Now, you mentioned a minute ago in your practice
16 two other Dr. Gieps, last name.

17 A. Yes, sir.

18 Q. Your brother and your father?

19 A. Yes, sir.

20 Q. How is it you came to be a doctor in practice
21 with your other -- your dad and your brother?

22 A. Well, I'll tell you honestly it was not
23 intentional because, you know, when I started out my
24 father's an OB-GYN, so that was not my first thought to
25 be an OB-GYN. But I ended up being an OB-GYN, decided

1 to come back to Spartanburg. And then later on my
2 brother, for some reason, also he followed the same
3 track. He wasn't gonna be in OB-GYN, ended up being
4 OB-GYN. He wasn't planning to come back to Spartanburg,
5 but he came back to Spartanburg. So we ended up
6 practicing together.

7 Q. Now, where were you born?

8 A. I was born in Philadelphia.

9 Q. How is it that you came to be in Philadelphia and
10 then end up in the Spartanburg area?

11 A. Well, when my father originally, my origine from
12 Vietnam. And so when he was in Vietnam he was a medical
13 student and medical resident, a doctor. And at the time
14 of the Vietnam war, the United States sponsored certain
15 physicians to go over to the United States and learn how
16 to practice medicine the way we do over here.

17 And so he's one of the chosen few to be
18 nominated. So he came over to Philadelphia to do his
19 residency. When he did his residency, my mother came
20 over and that's where I was born. So I was there until
21 he completed his residency in OB-GYN. After that we
22 went back to Vietnam. And, of course, you know that the
23 fall of Vietnam was in '75. And after '75 I came back
24 over with my parents and I've been in Spartanburg ever
25 since.

1 Q. So when your father came back here at the end of
2 the Vietnam war when the Saigon fell, did he come
3 straight to the Spartanburg area?

4 A. Initially he had an initial appointment at the
5 medical college in Georgia in obstetric gynecology, so
6 we spent about six months to a year down there. And
7 then afterwards we came back up. Then we came here to
8 Spartanburg.

9 Q. All right. So did you attend high school here in
10 the Spartanburg area?

11 A. Yes, sir, I did.

12 Q. Where?

13 A. I attended Spartanburg Day School.

14 Q. And did you go to college anywhere here in South
15 Carolina?

16 A. Yes, sir, I went to Wofford.

17 Q. And then medical, where was that?

18 A. As you can see, it's a common theme. I pretty
19 much stay in South Carolina. Medical University of
20 South Carolina, Charleston.

21 Q. How many years of medical training at -- between
22 when you start medical school and you finish the
23 residency and all of those things?

24 A. The normal obstetric gynecology residency is four
25 years and I did four years at the Medical College of

1 Georgia.

2 Q. And how about residency?

3 A. That is residency. Four years residency. Four
4 year medical school and then four years of residency.

5 Q. So eight total?

6 A. Eight total years after college.

7 Q. Now, we heard yesterday from an expert witness,
8 Dr. Chauhan. You obviously know him, right?

9 A. He was in Spartanburg, so the that's how I got to
10 know him.

11 Q. Was he big buddies with you?

12 A. No. We only dealt professionally, sir.

13 Q. When was the last time before yesterday that you
14 had seen Dr. Chauhan?

15 A. The last time I saw him was when he was here last
16 in private practice, I think I guess '90. I'm not sure.
17 Whenever he left, that was the last time I talked to
18 him.

19 Q. Are you in any professional medical organizations
20 or societies?

21 A. Yes, sir.

22 Q. Which ones?

23 A. I'm in the American College OB-GYN, which is a
24 society for the obstetric gynecology. I'm also a member
25 of the South Carolina Medical Association.

1 Q. And you mentioned board certification. Are all
2 doctors in OB-GYN board certified?

3 A. The majority are.

4 Q. Where do you have hospital privileges where you
5 go and deliver babies or do whatever you do as an OB-GYN
6 doctor?

7 A. Currently the only hospital I'm practicing at is
8 Spartanburg Regional.

9 Q. In the past have you had privileges in other
10 facilities?

11 A. I at one time had privilege at Mary Black
12 Hospital.

13 Q. How about when you were in training?

14 A. In training we had -- I had privileges at several
15 hospitals because it was a residency program, so we
16 rotate to three different hospitals.

17 Q. Which of those three were they?

18 A. At that time it was the Medical College of
19 Georgia, there was the University Hospital, and we
20 rotate to a military hospital.

21 Q. Where was that University Hospital?

22 A. This was in Augusta, Georgia.

23 Q. Got ya.

24 A. All three was located in Augusta, Georgia.

25 Q. Got ya. Now, as an OB-GYN, do you keep current

1 on the developments in the -- let's talk about the
2 obstetrics part -- about how to deliver babies, how to
3 deal with situations like shoulder dystocia when they
4 occur?

5 A. Yes, I do.

6 Q. And how do you do that?

7 A. Two ways. Number one, we try to keep up with the
8 bulletins and the literature that the American College
9 sends out. And then, secondly, we try to keep up the
10 date by taking the written test that are provided every
11 year.

12 Q. Do you also interact with other doctors that you
13 run into at the hospital or in your professional society
14 meetings about those issues of obstetrics and shoulder
15 dystocia, things of that sort?

16 A. Yes, I do.

17 Q. And you're licensed to practice medicine here in
18 South Carolina?

19 A. Yes, I am.

20 Q. From all of your residency training, your medical
21 education, your 20-odd, 22 years of practice, all of
22 your keeping up with medicine, do you feel that you are
23 familiar with how most obstetrical doctors do things
24 when it comes to managing shoulder dystocia and babies
25 who have depressed heart rates and the sort of

1 situations that Ashley F presented to you on
2 October the 7th, 2008?

3 A. Yes, I do.

4 Q. Are you familiar with the standard of care that's
5 required of you Ob, obstetrical doctors, in those types
6 of scenarios?

7 A. Yes, sir, I do.

8 MR. LOVELL: Your Honor, we would tender Dr. Giep
9 as an expert in the field of obstetrics and gynecology.

10 MR. HENSHAW: No objection.

11 THE COURT: He is so qualified.

12 BY MR. LOVELL:

13 Q. All right. Let's talk about your medical
14 training. In your training back in that eight years
15 that you were doing it, how were you -- well, first,
16 were you trained on how to recognize and manage shoulder
17 dystocia in the deliveries of babies?

18 A. Yes, sir.

19 Q. How were you trained in that regard?

20 A. Well, at residency what you do is that it's
21 basically residency is just four years and basically you
22 train the entire time. And so initially what you do is
23 that when you do your delivery, the first time you'll
24 have an attending there and you have a resident
25 overseeing you. And so they will observe you. They

1 will tell you what you're doing right, what you did
2 wrong and how you can improve it.

3 Q. Did any of that training during your residency
4 involve real deliveries where you were observing people
5 putting their hands on the baby or perhaps doing it
6 yourself?

7 A. They were all on real patients, real life at that
8 time.

9 Q. How about this issue of when the heart rate in a
10 baby begins to drop in that late second stage, you know,
11 when it's getting close to --

12 A. Yes, sir.

13 Q. -- the actual delivery. How were you trained in
14 learning to deal with those issues?

15 A. Well, in residency you would train in two
16 different ways. First of all, in real life experience
17 when you're watching it in real life time. And also
18 through didactics or through lectures. So we would
19 train on how to manage in those situations where the
20 heart rate drops.

21 Q. Now, did you ever have scenarios where when you
22 were training that you would put your hands on a baby
23 about to be delivered that was experiencing shoulder
24 dystocia?

25 A. Yes.

1 Q. And were people there with you, the trainers, I
2 guess the people doing the training, were they also
3 there with you at the point in time where you were
4 putting your hands on the baby and doing whatever it is
5 you guys do in that shoulder dystocia scenario?

6 A. Yes, sir.

7 Q. How do they do that?

8 A. What they do is that -- so let's say that you're
9 sitting here and you encounter shoulder dystocia, so you
10 have the hand on the baby's head. What they do is they
11 put their hand on your hand to make sure you apply the
12 correct traction, the correct angle, and that's, that's
13 what was done.

14 Q. And was that on more than one occasion where that
15 was done?

16 A. Yes, sir, that was more than one occasion.

17 Q. Is that one of the ways you learn about the
18 degree of force to use, the degree of traction, the
19 direction of traction was by handling, somebody
20 literally helping you do it while you're doing it?

21 A. Yes, sir.

22 Q. Now, prior to 2008, prior to this delivery, had
23 you in private practice from 1995 up until then,
24 13 years I guess, had you managed -- have you had the
25 scenarios where your patient had shoulder dystocia in a

1 delivery room?

2 A. Yes, sir.

3 Q. And about how many of those had you experienced
4 prior to 2008, either in your training part or in that
5 private practice part?

6 A. Probably prior to 2008 I probably encountered at
7 least probably a dozen shoulder dystocia case up until
8 2008. At least a dozen.

9 Q. So the Ashley F. delivery wasn't the first
10 time you had ever seen a shoulder dystocia?

11 A. No, sir.

12 Q. And had you also had scenarios where you had to
13 do different maneuvers to release those shoulder
14 dystocias where the baby's developed some type of a
15 brachial plexus injury after the delivery?

16 A. Yes, sir.

17 Q. And how many of those had you had before Ashley
18 F ?

19 A. Ashley F. is the first and the only
20 permanent injury I've had, sir.

21 Q. How about temporary injury?

22 A. I've had a few temporary injuries, sir.

23 Q. Before this event?

24 A. Yes, sir.

25 Q. Okay. And have some occurred afterwards?

1 A. Yes, sir.

2 Q. And in your experience with the other delivery
3 you participated in back in your training, did that
4 happen sometimes, even those when other folks were doing
5 the procedure?

6 A. Yes, sir.

7 Q. I want to go move now into sort of what you were
8 trained on how to do in preparing for shoulder dystocia
9 or what to do with it when you have it, okay?

10 A. Yes, sir.

11 Q. When you're doing a delivery like you did with
12 Ms. Flowers, kind of explain to us when you come into
13 the labor and delivery room first, what's the bed like
14 that the patient is sitting in?

15 A. Well the bed, most of the time the bed, to me,
16 the bed is already broken down. So the patient is lying
17 flat on her back. Her legs are in stirrups and the bed
18 is to the ground.

19 Q. When you say the bed is to the ground, what do
20 you mean?

21 A. Well, the delivery bed can be adjusted. It can
22 be up to this level or lower level, just like this
23 chair. And so what I like to do is for me, I like the
24 table to be all the way to the bottom or as low as
25 possible. (Indicating.)

1 Q. And why do you like the bed to be as low as
2 possible when you're gonna deliver a baby vaginally like
3 we're talking about with this case?

4 A. Yes, sir. The reason why I like to be lower is
5 just in case you have shoulder dystocia, instead of for
6 the nurse whose average height, you know, is like 5 or
7 5'5", they don't have to try to jump up and try to do
8 suprapubic pressure. So if the bed is lower and she's
9 on a standing stool, it's easier for her to get to where
10 she needs to be.

11 Q. And from your perspective when you got the bed
12 lowered down and you come in to do what you do on the
13 delivery in what we've been calling the business end of
14 it --

15 A. Yes, sir.

16 Q. -- where are you situated and how are you
17 situated there?

18 A. Well, if the bed is all the way to the ground or
19 as low as you can, then it makes me -- I have to sit on
20 the stool. And so I'm sitting on the stool between the
21 mom, between the mom's legs.

22 Q. When you say stool, describe what this stool
23 looks like.

24 A. The stool is not like this chair. It's probably
25 about a round circle about like that and it has four

1 wheels. (Indicating.)

2 Q. Does it roll?

3 A. Yes, sir, it rolls.

4 Q. And how close down to the ground are you when
5 you're sitting on that stool?

6 A. As low as I can so if -- part of the bed will
7 come down to about this height, a little bit lower. And
8 so my -- above my belly is where the business end, as
9 she put it, would be right here. (Indicating.)

10 Q. When you do deliveries like the one you did with
11 Ms. Flowers, do you stand at any point during the
12 delivery?

13 A. I will stand at the end of the delivery when the
14 baby's out so I can cut the umbilical cord.

15 Q. When you say the baby is out, do you mean when
16 the baby's body has been fully delivered?

17 A. Up to the belly. As the belly is coming out.

18 Q. And why do you stand up at that point from the
19 stool?

20 A. The reason I stand up at that time is so that
21 it's easier for me to hold the baby, turn around, cut
22 the cord and hand off to pediatrician, the NICU or
23 whatever in attendance.

24 Q. And do you do all of your deliveries of patients
25 like Ms. Flowers presented in the stool with the bed

1 lowered and standing only after the baby's body has been
2 delivered?

3 A. That's what I was trained to do, sir.

4 Q. But have you been doing it for 22 years?

5 A. Yes, sir.

6 Q. In 2008 -- first, were you at that time or even
7 now, what do you know about the predictability of
8 shoulder dystocia and delivery with patients like Ms.
9 Flowers?

10 A. Shoulder dystocia is unpredictable.

11 Q. In the occurrences where you had it occur before,
12 was that something you knew was going to happen in
13 advance?

14 A. No, sir, it's unpredictable.

15 Q. Now, in 2008 were you, with all your training and
16 knowledge and experience, aware of the different things
17 that doctors normally do, obstetrics and obstetricians
18 normally do when shoulder dystocia occurs, the maneuvers
19 and all of those things?

20 A. Yes, sir.

21 Q. Did you have a routine or a certain way you did
22 in a checklist form or whatever back then when shoulder
23 dystocia would occur?

24 A. Yes, sir, I do.

25 Q. Tell us how you were trained and how you -- what

1 you did do back in '08 when you would have a shoulder
2 dystocia, scenario.

3 A. Well, I'll be up front with you. I do the same
4 thing in residency as I did in 2008 as I do now. So
5 whenever, first of all, when I have a patient push she's
6 always in McRobert position. And I'm sure that was
7 explained to, to you yesterday numerous times, but
8 basically the leg is pulled back. So with that, as mom
9 pushed and shoulder dystocia is diagnosed, I would ask
10 the nurse, which I've already assigned, to distribute
11 pubic pressure. And suprapubic pressure, as you know
12 from yesterday, it's just a way for the nerves to push a
13 shoulder to rotate it away from the door, so to speak.
14 After that I would try to do, try to deliver a shoulder.
15 If I'm unable to deliver a shoulder, then you have to do
16 a second maneuver.

17 So with a second maneuver, what you usually like
18 to do ---

19 Q. I'm sorry, what did you call that?

20 A. A secondary maneuver.

21 Q. Secondary maneuver.

22 A. Secondary maneuver. I'm sorry, secondary
23 maneuver. So secondary maneuver is that would try to
24 put your hand in the vagina, trying to see if you can
25 deliver the bottom arm or the posterior arm. I'll tell

1 you up front that's very difficult and hard sometimes.
2 So if you could deliver that, that's fantastic. If you
3 can't do that then what I like to do is go back up,
4 reach behind the anterior shoulder or the shoulder
5 that's stuck, the upper part of the shoulder, rotate it
6 and collapse it this way. (Indicating.)

7 Q. Doctor, I'm gonna show you what I marked and
8 received from yesterday. And it's Defendant's Exhibit
9 12. Now, you mentioned this. Does this show this
10 McRoberts maneuver that you told us about a minute ago?

11 A. Yes, sir.

12 Q. And in a delivery like Mrs. Flowers, when do you
13 put her in this McRoberts position?

14 A. Well, on all my patients what I like to do is
15 when they push and ready to deliver, I always have them
16 in a McRoberts position. Not as exaggerated as that,
17 but their legs are up and pulled back.

18 Q. When the shoulder dystocia event is recognized,
19 can you modify the McRoberts at that time?

20 A. I ask them to push their legs back even further.

21 Q. So they start back at a certain level?

22 A. Yes, sir.

23 Q. And what do you tell them to do?

24 A. Bush em back further.

25 Q. So even more back towards the mom's head?

1 A. Yes, sir.

2 Q. And why are you doing that?

3 A. Basically the easiest way to explain it is kind
4 of like a, just to open up the pelvis, so you have an
5 extra just a few centimeters opening.

6 Q. And during that McRoberts maneuver, prior to the
7 shoulder dystocia discovery, are you applying any forces
8 to the baby at that point?

9 A. Can you repeat the question, sir? Sorry.

10 Q. When you have her in the McRoberts position --

11 A. Yeah.

12 Q. -- before you ever know about the shoulder
13 dystocia --

14 A. Yes, sir.

15 Q. -- before the head is delivered, are you doing
16 anything with the baby's head?

17 A. Well, I'm asking mom to push. And then with
18 general traction I'm trying to guide the shoulder
19 underneath the, the pubis, suprapubic bone.

20 Q. And is that before dystocia has occurred?

21 A. Yes, sir.

22 Q. Once we get into the scenario where the dystocia
23 has happened, how were you trained in terms of the
24 forces to apply at that point when you got her sort of
25 back in your more McRoberts position?

1 A. Well, at that time the traction has already been
2 applied. So if the traction had -- general traction had
3 been applied and the baby's not delivering, that's how
4 you diagnose shoulder dystocia. By that time you would
5 stop and you will ask the nurse to give suprapubic
6 pressure.

7 Q. So is the -- is there any difference in the
8 forces that you're applying in any of these points we've
9 just talked about as you were trained?

10 A. No, sir, same force.

11 Q. Now, we've seen the model yesterday -- excuse me.
12 The diagram yesterday on suprapubic maneuver. We
13 briefly put it up there. Doctor, in terms of the
14 suprapubic maneuver that you were trained on, does the
15 diagram that we've got here show sort of how best the
16 nurses could do that?

17 A. Yes, sir.

18 Q. And when they're doing this, is this done with a
19 contraction or were you trained to do it with or without
20 contraction?

21 A. At the time I was trained both. At the time if
22 you have a shoulder dystocia, that means mom is pushing
23 at the time and so you try to dislodge the shoulder.

24 Q. And what's the purpose of doing it when she's
25 pushing at the same time?

1 A. You're hoping that the natural maternal forces
2 will rotate that shoulder anyway. So when you kind of
3 push it -- the easiest example, the easiest way to think
4 about it is that if you have basically -- if -- I'll use
5 analogy of a door. So you have your shoulder -- this is
6 a door and you have the shoulder right here. And so
7 basically what you're doing is that you stand on this
8 side of the door and you're trying to push the shoulder
9 down.

10 So when you push the shoulder down, it doesn't go
11 underneath the door by itself. Something's gotta give
12 to go underneath the door by itself. And so when you
13 push, you also help mom to push so that shoulder will
14 slide underneath and come out also. (Indicating.)

15 Q. And are you having your hands on the baby's head
16 at this point in time?

17 A. When you're doing suprapubic pressure with the
18 contraction, I'm hoping to guide it out also because
19 with mom pushing and with the general traction, you
20 hopefully guide out underneath the pubic bone or the
21 door.

22 Q. And I forgot to ask you. How do you put your
23 hands on the baby's head at this point when you're
24 giving all these tractions and...

25 A. Put my hand -- I'm sitting right here. This

1 would be mom and the business opening. My hand would be
2 right here, and I'm guiding it down towards here.

3 (Indicating.)

4 Q. And when we look at this picture, are your hands
5 on the side of the baby's head, sort of around where the
6 ears are?

7 A. It would be like that. (Indicating.)

8 Q. Of course it would be the other direction, but...

9 A. Yeah. The other direction. I can't do my hands.
10 Yes, sir.

11 Q. And you're wearing gloves?

12 A. Of course.

13 Q. What's the baby's head like when you're
14 manipulating it in that position?

15 A. At a time -- I'm not sure who's been in
16 deliveries or not, but you can say delivery is not the
17 cleanest procedure in the world. And you've got blood
18 and you've got amniotic fluid, so the baby's head is
19 fairly slippery.

20 Q. And what type of forces were you trained to use
21 both from the McRoberts period with that maneuver or the
22 suprapubic maneuver that you're using there?

23 A. I would use the same gentle traction as I've
24 always been trained at residency.

25 Q. Is that the same traction that you use at any

1 normal delivery without a shoulder dystocia?

2 A. I use the same traction regardless of whatever is
3 going on.

4 Q. For any delivery?

5 A. Any deliveries.

6 Q. Now, let's assume the suprapubic pressure and the
7 general traction you applied hadn't then released the
8 shoulder dystocia, how were you trained to react next?

9 A. The next procedure is after McRoberts you would
10 try and do a secondary maneuver. And so what I've been
11 trained to do is put the hand in the vagina. And the
12 first thing you do is try and see if you can -- with the
13 shoulder, there's a top shoulder and a bottom shoulder.
14 So I will just use top and bottom instead of
15 interior/posterior.

16 You would try to take a look at the bottom
17 shoulder to see if it's easily moved. If it's not
18 easily moved, then you put your hand up in trying to
19 reach the arm vicinity. And what you're trying to do,
20 is you're trying to reach an arm underneath there, bring
21 it across the body and deliver outside the baby.

22 Q. I want to make sure I got that right. So when
23 you have -- and I'm putting up some excerpts from -- you
24 saw the video yesterday?

25 A. Yes, sir, I did.

1 Q. Was the video, in your opinion, a fairly accurate
2 depiction of the way you were trained and the way you
3 did the delivery in this particular case?

4 A. Yes, sir.

5 Q. And, Doctor, when you say that after you've done
6 the suprapubic and you reach in to try to pull the
7 shoulder and the arm, are you talking about the arm
8 that's on the top or the arm that's on the bottom, I
9 guess, left arm, right arm?

10 A. I'm gonna -- in this case I'm gonna say the arm
11 on the bottom because I don't want to sit there and say
12 right, left, but we know in this particular case the arm
13 on top is left.

14 Q. And when you say you're reaching in to try to
15 grab the baby's hand or arm, which of those are you
16 trying to grab?

17 A. What you try and do is the first thing when you
18 try and deliver an arm is try not to break it. And you
19 know that the baby's arm is very fragile. So what you
20 try to do is you try to reach an arm and you go all the
21 way down to the hands and you try to bend at the elbow.
22 Because if you grab right here or right here you're
23 gonna break the arm. So you have to go down to try and
24 grab the hand or wrist, to flex it like this. And then
25 gently then you have to pull it across the body to

1 deliver. (Indicating.)

2 Q. All right.

3 A. And you have to be very careful the entire time
4 because you can easily break the arm.

5 Q. Is that dependent on you being able to get your
6 hands inside enough to grab it?

7 A. Yes, sir. You're talking about a very tight
8 space. You're talking about a vaginal opening. With
9 your hand, you gotta put it all the way in there, far
10 enough in to grab.

11 Q. Does that happen every time you've tried it?

12 A. It's very difficult, sir.

13 Q. So let's assume you can't grab that arm, how are
14 you trained in terms of what to do next?

15 A. If I cannot grab the arm, then what I do is I put
16 my hand, I reach and I'm trying to find the back of the
17 shoulder or the back of the -- or the shoulder blade.
18 And so in this particular case I will find the shoulder
19 blade whose stuck on top and I'd go behind it, and I'd
20 rotate it. So basically rotating this, I will have my
21 hand on the shoulder like this. I would rotate the
22 shoulder. At the same time I'll try to collapse the
23 shoulder, so instead of being straight like this, it
24 will rotate and go that way. And so that way it
25 decreased. (Indicating.)

1 Q. Is your hand going behind the baby's back to get
2 that --

3 A. Yes, sir.

4 Q. -- shoulder blade? When we saw the video
5 yesterday and it showed the hand moving up in that area
6 and sort of moving forward, is that an accurate
7 depiction of how --

8 A. Yes, sir.

9 Q. -- you do that? And if you do that procedure,
10 and let's assume that wasn't successful and, you know,
11 the baby -- let me stop first.

12 When you throw the shoulder over, do you then go
13 put any -- are you trained to put any additional forces
14 from you on the baby?

15 A. Let me go back one thing. When you -- what I do
16 to clamp this, I always kind of cheat a little bit
17 because why? I ask the nurse to give suprapubic
18 pressure. So at the same time you could think about, if
19 you use the analogy of a door and you've got the
20 shoulder right here. So if I put my hand from the
21 outside to the inside and rotate the shoulder down, I'm
22 also gonna get the nurse, basically from this side, to
23 give me help to push that shoulder down.

24 So now I have two things kind of rotate that
25 shoulder down. Then with mom pushing, then with gentle

1 traction, I have to get that shoulder underneath the
2 door handle or underneath the bone. (Indicating.)

3 Q. Okay. When you're doing this traction, this
4 gentle traction, is it any different force than you
5 would apply on a regular non shoulder dystocia delivery?

6 A. It is not, sir.

7 Q. What about direction and force? I mean, any
8 point up until then from the minute shoulder dystocia is
9 discovered up until now, you've rotated the shoulder and
10 you're trying to help the baby, how do you -- how do you
11 guide the baby's head in what directions?

12 A. I would guide it gently down and I'll tell you
13 why. Okay, you ask me questions. You know, if you --
14 I'm sitting on a stool, a small stool about that
15 diameter. (Indicating.) I have wheels on a stool. So
16 if I put any traction unusual, I'll be rolling forward.
17 So that's how I know I'm using the same traction as I
18 always have been because, you know, if you start rolling
19 then you know you use more. And as far as traction,
20 you're sitting down so it really limits the angle that
21 you can put on the baby.

22 Q. In your training or in your practice in the way
23 you deliver babies, do you ever put traction in a
24 downward force that goes to the extreme of 20 or 30 or
25 35 or 45 degrees like we've heard testified to in the

1 courtroom?

2 A. No, sir. It would be very difficult for me to do
3 that.

4 Q. And why would you say it would be difficult?

5 A. To me, for me to do that I would fall off the
6 stool.

7 Q. Why is that?

8 A. The stool is on wheels. And so, you know, when
9 we were kids, you'd be sitting here. And we all know as
10 kids we're sitting here to pull the chairs can go
11 forward. And if you're sitting down here and you pull
12 down and you have wheels on what's gonna happen? You're
13 gonna fall forward and you'll fall off the chair.

14 Q. What about in terms of the amount of force as
15 you're pulling or -- pulling might not be the right word
16 -- guiding the baby out or whatever you want to call it.
17 If you were doing those degrees of forces, do you think
18 that you would ever, or in your training or in your
19 experience, ever get to the level of 30, 35 or greater
20 than 35 pounds in the position you're in when you're
21 delivering the baby with the hands the way you
22 described?

23 A. Sir, I don't think so because, I mean, if you're
24 sitting on a stool with wheels on it, if you generate
25 that much you're gonna be rolling.

1 Q. All right. If the Rubin II maneuver wouldn't.
2 work and you did the rotation and you had the suprapubic
3 applied by the nurse and the mom's pushing and the
4 contractions go and you're doing the general traction
5 and it just doesn't release the baby, what were you
6 trying to do next?

7 A. That, that's a very difficult situation. And
8 luckily I have not been in that situation, but in that
9 case then you think about either break the clavicle or
10 you have to do a procedure called a Zavanelli.
11 Basically it's a fancy word of saying push the head back
12 up to the birth canal and then do a c-section.

13 Q. What about this wood screw maneuver we heard
14 about, is that something you use or consider?

15 A. Yes, sir, that would be part of the second
16 maneuver.

17 Q. Of the Rubin II secondary thing you talked about?

18 A. Yes, sir.

19 Q. So would you do both of those, Rubin and then
20 wood screw, if the Rubin didn't work?

21 A. Yes, sir, I would.

22 Q. And then after if wood screw wouldn't work, the
23 next thing gets pretty ---

24 A. I mean, the things that -- I mean, you would try
25 to repeat. You know, if you cannot get the Rubin II to

1 go, you would -- you were trying to reach the arm, maybe
2 something happened during those couple seconds or a
3 minute to see if you can reach the arm. If you can't,
4 then you really try to put either, A, rotate the baby
5 this way or, B, rotate the baby that way. If that
6 doesn't work, then you would go to you break a clavicle
7 or whatever. (Indicating.)

8 Q. So you might repeat a secondary maneuver, the
9 Rubin II or wood screw if it was unsuccessful on the
10 first time to see if it would work if things had changed
11 a little?

12 A. Yes, sir.

13 Q. And then if it doesn't work on the second go
14 round?

15 A. You're really in trouble then.

16 Q. In this case did we ever get anywhere close?

17 A. No, sir.

18 Q. All right. Let's talk about this -- your
19 involvement in this patient's care. What time did you
20 come on duty at the hospital labor and delivery
21 department that day?

22 A. We usually turn over between five and six, so I
23 can't really tell you exactly what time I was there, but
24 I know we turn over between five and six.

25 Q. And -- I'm sorry, what happened when you came in?

1 You know, how did you become involved in the actual
2 delivery? Did you talk to Dr. Fowler about what had
3 occurred before you got there?

4 A. What we usually do is that at what we call
5 change, change shift or we take over, what we do is the
6 physician before me would just give me a call and give
7 me an update of what's going on. In this case, Dr.
8 Fowler was on call, so she called and said Ms. Flowers
9 was in the hospital and she was in labor and that her
10 labor was progressing well, no issue. Her pregnancy was
11 only complicated for diabetes that was well controlled
12 with sugar. And that was it.

13 Q. And did you go in and do a physical evaluation
14 after you talked to Dr. Fowler?

15 A. No, sir, I did not. Not at that time.

16 Q. Why not?

17 A. She's progressing well, she's doing well, and so
18 I was, I was gonna do what she needs to do.

19 Q. Now, we've looked at these fetal monitor strips
20 so far, but I want to ask you a question about how that
21 system works. How is the fetal monitor applied to the
22 mother?

23 A.. The simplest way to explain it is that basically
24 you have two monitors. One is on top and that's you use
25 an ultrasound wave, just bounce off sound wave to listen

1 to pick up the baby's heartbeat because ---

2 Q. Say that one more time, I didn't follow you.

3 A. I'm sorry. It's to bounce off sound waves to
4 pick up the baby heartbeat. So you would hear psh, psh,
5 psh and that's a sound wave. The second one is called a
6 tocum (phonetic), which you put also on the mom's belly
7 and that's to measure how often she's having
8 contractions.

9 Q. The one that measures the baby's heartbeat, are
10 you able to hear that sound in the, in the delivery
11 room?

12 A. Yes, sir. It's more accurate to listen because a
13 lot of time they have a program on the system, is that
14 sometimes if they can't pick up the heartbeat, they tend
15 to try to find something and a lot of time they find
16 maternal heartbeat and they'll double it to make it to,
17 to look like the baby's heartbeat.

18 Q. So are you able to look at the screen -- well, I
19 mean, the visual part we've got on our exhibits that
20 we'll talk about in a minute, what's that on, a computer
21 looking screen or...

22 A. Yes, sir. That is in the labor and delivery
23 there is a monitor that has an actual strip. And then
24 throughout labor and delivery they're monitored
25 throughout labor and delivery with the strip with all

1 the patients who's in the labor and deliveries unit.

2 Q. So if you're out at the, say, the nurse's station
3 in the labor and delivery area, are you able to look at
4 the picture of the fetal monitor strip that's going on
5 inside the delivery room?

6 A. They have all of the labor and delivery strips on
7 there. So, for instance, if you have 20 laboring
8 patients, then you have 20 strips up there on this big
9 monitor and all are indicated which room.

10 Q. And this thing that's on the mother's belly that
11 measures the contractions, how does it do that?

12 A. It just senses by the pressure tightening of the
13 mom's belly.

14 Q. Now, in terms of Mrs. Flowers, when did you get
15 notified or come to go into the room to see her?

16 A. Um, it was around probably 2011 I went to the
17 room. I was outside labor and delivery and doing other
18 things and I noticed heart tones are down, and so that's
19 why I came into the room to see what's going on.

20 Q. And when you say 2011, is that 8:11?

21 A. Yes, sir, that's 8:11 p.m.

22 Q. And at the point in time when you came in the
23 room, tell me what you did, what happened at that point,
24 this 8:11 time?

25 A. Well, the first thing when you come in is you

1 have to look at the strip to see what's going. You
2 cannot just look at the strip at that one point because
3 you have to see the overall situation, what they had
4 been doing and what it's doing now. And so what you do
5 as you walk in you look at the overall strip from the
6 past up until the present. You also look up the mom,
7 the vital signs, see her blood pressure and what the
8 nurse has done.

9 Q. Up until that time when you had been talking with
10 Dr. Fowler or when you came in and you were looking at
11 the strips, how had her labor been progressing?

12 A. Her labor had been progressing well.

13 Q. But how long had she been in this pushing or
14 contraction phase and all of that?

15 A. I think she had been complete since 7:30 to
16 8:00 p.m.

17 Q. And so at that point -- when you say complete,
18 what do you mean?

19 A. She was complete. In order for her to push, she
20 had to be dilated ten centimeters. So she was ten
21 centimeters at 7:32 p.m., and so I have to get her a
22 little situated and then start pushing after that.

23 Q. When you say dilated to ten centimeters first,
24 what has to be dilated?

25 A. Her cervix has to be dilated, sir.

1 Q. What does it -- where is the cervix and what does
2 it do?

3 A. The cervix is an opening of the uterus, and
4 basically it's the -- the cervix is what holds the
5 pregnancy in. So in order for you to start pushing or
6 for the baby to start coming out, the baby has to open
7 fully. And fully for us is ten centimeters.

8 Q. And I'm gonna show you, Doctor, a diagram and ask
9 if you wouldn't mind, does this show the cervix on it?

10 A. Yes, sir.

11 Q. All right. I'm gonna point and you tell me if
12 I'm in the right spot. Here? There? Maybe use that
13 laser thing. There you go.

14 A. The cervix is about right here, upper part, and
15 down here. (Indicating.)

16 Q. All right. And when you say it has to be ten
17 centimeters dilated, are you talking about the distance
< 18 between the two sides of it have to open up?

19 A. Yes, sir. Basically when we say complete or ten
20 centimeters, that when you check the patients, when you
21 check the mom, and you feel the head, you do not feel
22 the cervix anywhere at all around the baby's head.

23 Q. And at that point is that when you start -- or
24 the nurses and you start asking momma to start pushing?

25 A. Yes, sir.

1 Q. All right. And is that when the forces really --
2 let me stop.

3 Prior to that would contractions be going on?

4 A. Yes, sir, the entire time. That's how you get to
5 ten centimeters because with the contraction it caused
6 the cervix to dilate. So without contraction, the
7 cervix cannot dilate.

8 Q. And so when the pushing starts, is that force
9 that's added on to the forces of the mom's contractions?

10 A. Oh, yes, sir.

11 Q. All right. So -- and let me go back to this
12 fetal monitoring thing that we talked about so that we
13 understand. When we look at the fetal monitor strip
14 that I put up here, we've got bottom and top. These are
15 two strips that had been stacked on top of each other.
16 That's not how you all look at them, right?

17 A. No, sir, they're running continuously.

18 Q. But for purposes of my diagram, the one's that on
19 the top what's that showing? With the squiggly lines.

20 A. The one on top -- the one on top, the fetal heart
21 rate looks like it's about 130 beats, around 130.

22 Q. Let me stop. That's all I -- really what I was
23 asking was what does it show in general? Who is it
24 actually looking at?

25 A. I'm sorry, repeat again.

1 Q. Yeah. You said mom has got one thing on here and
2 the baby's got one. What is this?

3 A. Yes, sir. The top one is to monitor the baby's
4 heart rate.

5 Q. And the bottom?

6 A. The bottom is monitoring mom's contraction
7 pattern.

8 Q. And when we look at these squiggly lines on the
9 baby's one, what are they showing us in general? Not
10 the specific ones at that time, but just what does it
11 mean?

12 A. This shows, it just picks up the baby's heart
13 rate and what the baby's heart rate is doing at that
14 time.

15 Q. Okay. And the one at the bottom, what's it
16 showing us?

17 A. This is showing if mom is contracting or when mom
18 is pushing.

19 Q. When we have the lines here at the bottom, what
20 does that tell us in general?

21 A. Usually if mom is not doing anything, it should
22 be a flat line. If mom is doing something, is pushing,
23 then you'll see this up rise like this. Like this,
24 pushing. (Indicating.)

25 Q. So up is contraction, lower is probably resting?

1 A. It could be either. Well, I'm sorry. It could
2 be contraction or pushing. If it's lower then it's
3 resting.

4 Q. Okay, got ya. Now, you mentioned that you look
5 at the strips when you come in. When you came into the
6 labor and delivery you looked at them in totality. How
7 do you do that if it's only showing a certain amount on
8 the screen?

9 A. Well, you have -- the strip is in paper, so the
10 -- it's a recording of the entire event that she's been
11 in the hospital. So it'll probably be a stack about
12 this big. And so basically what's on a monitor is only
13 this and this combined. So you would look at the paper
14 strip to see what's going on before that. (Indicating.)

15 Q. Now when you went in and have been summoned to
16 see her or came in and saw her at about 8:11 and you
17 looked at the strips, what did they tell you about this
18 baby and what was going on?

19 A. Well, first of all, I cam in at 8:11.

20 Q. Yes, sir.

21 A. Nobody called me at 8:11.

22 Q. Okay.

23 A. But when I came in at 8:11 -- can you show me the
24 strip?

25 Q. Sure. Let me do one thing, Doctor. I might have

1 you come down and do it because I don't think we can
2 see.

3 Your Honor, can he step down?

4 THE COURT: (Nods head up and down.)

5 (Whereupon, witness leaves witness stand.)

6 BY MR. LOVELL:

7 Q. Now, what we gotta do is like we did with
8 Dr. Chauhan yesterday. You just stand where I'm
9 standing, Doc. Get this thing here. And can you see
10 her?

11 A. (Nods head up and down.)

12 Q. Okay. Talk so she can hear you. There's a
13 microphone there. You can kind of talk real loud. My
14 question is, when you came in at the 8:11 timeframe,
15 what did the strip tell you about the baby?

16 A. Well first of all, like I was saying, you have to
17 look at the strip in its entirety. You can't just look
18 at this part. So if I could have the other part real
19 quick. So before I came in, this -- you can see the
20 heart rate.

21 Q. Right.

22 A. And it's already dropping in the '90s.

23 Q. Why don't you highlight that where it's dropped
24 in the '90s with this yellow thing.

25 A. Now, you know the normal heart rate is supposed

1 to be at the bottom, it should be about 110, which would
2 be about right here. (Indicating.)

3 Q. What had been the range of this baby's heart rate
4 prior to these changes that are going on?

5 A. So if you look at the entire strip, this is the
6 first part, this is the second part. You can see it's
7 been about 130 and now the heart rate dropped to 90. So
8 there's about, about 40 beats dropped. So that's about
9 equivalent to a third of a heartbeat that's dropped.

10 Q. Is that concerning or was that concerning for
11 you?

12 A. Yes, sir, that's very concerning.

13 Q. Why?

14 THE COURT: Let me just mention, I don't think
15 the court reporter can see him.

16 MR. LOVELL: Back up a little more. I'm gonna
17 scoot this a little more.

18 THE COURT: Yeah.

19 MR. LOVELL: Is that good enough?

20 COURT REPORTER: Yes, sir.

21 BY MR. LOVELL:

22 Q. All right. Why was that concerning, Doctor?

23 A. Well, concerning because if you have a normal
24 rate, about 130, okay, and you cut it to about a third,
25 it's like -- the easiest analogy I can tell you is that

1 if you imagine holding your breath. Normally you would
2 breath like this. (Indicating.) But if you hold your
3 breath for a while, your heart rate is gonna go down
4 where you start getting tired. And so the only way the
5 baby gets oxygen from the mom is through the heart.

6 Okay, so the heart is beating, the option,
7 transport option are on the baby. The baby is not
8 breathing as a fetus, so the only way the baby is
9 getting oxygen is through the mom, through the heart
10 that the baby is beating. So normally right now the
11 baby is normal, beating heart rate 130, just like you
12 and I breath normally. But if you cut it down to 90,
13 that means she's cutting a third, a third of oxygen
14 supply of the baby. So that's why I think the baby is
15 in trouble because you and I, you know, I'm not sure how
16 long you can go with a third of oxygen supply cut off.

17 Q. And at this point in time, around 8:11-ish, when
18 you see that what do you decide to do?

19 A. Like I was saying, this is when she was doing
20 fine. This point you start noticing around 8:07. This
21 is the part -- no, this is the part that I arrive around
22 20:11 p.m., sorry. (Indicating.) 20:11 ---

23 Q. Draw it in and then talk so you can back up and
24 she can see you. Sorry about that.

25 A. What I did was I marked point 11, 8:11 p.m.,

1 that's when I arrived. I went ahead and marked that. I
2 went ahead and marked where 110 beats is. I went ahead
3 and marked where 110 beats is right here. So that's a
4 lower limit normal. As you can see here the heartbeat
5 is in the 90s.

6 So when you arrive there you have to look up the
7 entire strip, as I was telling you beforehand, and we
8 are seeing this strip. So when you look at it, you see
9 the majority up until 20:11, the heartbeat is below 120,
10 okay? She had some recovery up here. So when arrived
11 here the heartbeat had been down, a third of the oxygen
12 supply has been cutoff basically. She's been pushing,
13 she's contracting.

14 Q. And when you got there and you saw it, had it
15 been going on for some number of minutes before you got
16 in with this lower heart rate?

17 A. Yes, sir. Basically you break down, this is one
18 minute, two minute, three minute, four minute and then
19 you can count up to about five minutes, sir.

20 Q. And so what did you do upon coming in and seeing
21 this and having some concerns you just told us about?
22 What did you do about deciding on the delivery status of
23 Mrs. Flowers?

24 A. Well, first of all, when you come in here, you
25 have to take this in realtime because the problem is

1 that you can't look back and say what could have been
2 done, should have done, would have done. You have to
3 take realtime. So when I'd arrived, it was here.
4 (Indicating.) So upon arrival I notice the heart rate
5 has been down. I notice that the nurse has done a
6 couple things. She had decreased the Pitocin and shut
7 it off. She had put the patient on her right-hand side,
8 okay, to try to improve the oxygenation and to improve
9 blood supply to the uterus. And she also gave mom
10 oxygen. So at this time I went over ---

11 Q. Let me stop you right there. Why would the nurse
12 stop the Oxytocin or Pitocin and do the right-side turn
13 with the heart rate in that scenario?

14 A. What she's trying to do is called uterine
15 cessation, so she's not sure what's going on. And so
16 there's a protocol that we do. And the protocol
17 dictates, number one, shut off the Pitocin. Number two,
18 turn the mom on the side. And number three, give oxygen
19 to improve the oxygenation to the baby.

20 Q. And was that the -- I'm sorry, was that the right
21 thing for Mrs. Phillips to do?

22 A. Yes, sir.

23 Q. All right. Take us from what you were talking
24 about now, what you did forward and why you did it.

25 A. So 20:11 after evaluating that, now we come to

1 about 20:12. So about right here. (Indicating.) So it
2 took me that long to evaluate the script to be informed
3 of what's going on. And now I walk over and examine the
4 patient.

5 Q. All right. When you do that I want to ask, you
6 said you walk over from where to where?

7 A. Basically we're in the delivery room. So the
8 delivery room is probably from where I'm standing to
9 where Ms. Flowers is standing is probably --

10 Q. You mean me standing?

11 A. -- half a distance.

12 Q. And when you left and you went over to do the
13 examine (sic), where did you go?

14 A. What I did, about right here I went and examined
15 the patient and I wanted to see what's going on. I
16 wanted to check her. (Indicating.)

17 Q. Did you go on the business end?

18 A. Yes, sir, I'm on the business end.

19 Q. But on your stool?

20 A. At this time, the bed was not totally broken down
21 yet, so I was sitting on the bed.

22 Q. Did you have to lower the bed at some point?

23 A. The bed was already lowered, sir.

24 Q. Did you have them break it down?

25 A. Yes, sir.

1 Q. What did that mean? I'm sorry.

2 A. When the bed is -- there's two components there's
3 a front part, which the patient lies on there and if she
4 puts her feet down it's fine. And when it's time to
5 deliver you break the bottom part, which is this part
6 from here down, so that way you can stand or you can sit
7 between her legs in delivery. And that's what's going
8 on, that part was being broken down. (Indicating.)

9 Q. And so did you do an examination of her where you
10 were looking at the baby or trying to assess the baby?

11 A. Yes, sir, I was.

12 Q. What did you do?

13 A. Basically the first thing you do is you look at
14 the patient. And at that time I know that she was --
15 the baby's head was, you could see the top of the baby's
16 head.

17 Q. And what's that called?

18 A. That's called crowning or the top of the head is
19 the scalp. Or in this case you could say that she had a
20 plus three or crowning. Those terms are
21 interchangeable.

22 Q. Plus three means? What's the plus, the three in
23 the plus?

24 A. What we usually do is we divide to have an idea
25 of where the head is. So we use bone structure in the

1 pelvis. And we use what are called ischial spine, which
2 is a bone kind of pointing lateral in. And so we use
3 that as a landmark.

4 So the baby is at the ischial spine, we call that
5 zero. And we split zero to the outside opening by
6 one-third. So if that ischial spine is zero, a third of
7 the way down is plus one. Two-third of the way down is
8 plus two. Plus three is when it's outside. So plus
9 three is difficult. Plus two is that everybody's there.
10 How do you know that? Well, if you can see the head
11 without putting your hands in the vagina and opening up,
12 that's plus three. If you have to put your hand in the
13 vagina to feel a little bit, then that's plus two.

14 Q. And she was at what level?

15 A. She was at plus three or we call it crowning.

16 Q. So now you've done your evaluation, you've seen
17 that the head is at plus three. You're now down at the
18 business end. What did you do next with regard to the
19 labor and the delivery?

20 A. So right here -- so this is when I'll be
21 examining the patient.

22 Q. And why do you say that?

23 A. Well, this is when I came in. It takes about a
24 minute to examine the patient. And then what I was
25 trying to do with the heartbeat being down, what I was

1 trying to do is when I get a patient what we do is
2 called scalp stimulation. It's a pain to work, but
3 basically you're kind of touching the baby's head,
4 scratching a little bit to see if you can wake the baby
5 up to say hey, you know, breathe or in this case get
6 your heart rate up, and it did. Went up heart rate a
7 little bit.

8 So this situation I wasn't sure what's going on.
9 I know the baby's heart rate has been down for about
10 five minutes. So I went ahead and because you have a
11 plus three, I want to see how is she doing pushing, get
12 an estimate of how long it's gonna take her to push and
13 deliver this baby. So that's why you can see she
14 pushing, she pushing, she pushing.

15 Q. So did you let her do a couple, three pushes at
16 that point in time?

17 A. Yes, sir.

18 Q. All right. But what about your concerns over the
19 baby's heart rate?

20 A. Well, I was concerned because right here the
21 heart rate went up. So at that time I'm like, okay, I
22 may be okay. But then, as you can see here, it
23 disappeared. And then here, you can see here, it went
24 down to the 90s again. (Indicating.)

25 Q. All right. Now, when the heart rate went down to

1 the 90s again and you've allowed her to push a couple,
2 three times, what did you do next as far as the
3 delivery?

4 A. Well, the number one thing is that, you know,
5 according to our standard that when you have the heart
6 rate go down, you have about 30 minutes to try and
7 deliver the baby. That's -- it's the standard. You
8 need to deliver before 30, but if you deliver after 30
9 minutes, you're really not in the standards.

10 So upon arrival here, usually what I do is
11 evaluate the patient. I like to see if I can deliver in
12 the next 10, 15 minutes. Because why? Because then
13 I'll be under authority. It probably takes about 20
14 minutes from the time his heart rate has gone down
15 approximately.

16 So right here I asked her to push to see can she
17 deliver upon that option. If she's not able to deliver
18 in the next 10, 15 minutes, then I need to make a
19 determination to do, A, how am I gonna get this baby
20 out. With OB it's really simple. The only two
21 questions you have to ask yourself, does the baby need
22 to be delivered, yes or no. The second question, how do
23 you deliver the baby? Do you deliver by c-section or do
24 you deliver the baby naturally?

25 So to me the question is that when I approach

1 this right here, my answer is simple. Do I need to
2 deliver the baby? The heart rate has been down, a third
3 of the supply has been cut off. The answer is simple.
4 Yes, we need to deliver the baby.

5 So the next question comes in, how am I gonna
6 deliver the baby? Well, if the head is sitting right
7 there, okay, then you really don't want to take the
8 woman back for a c-section. Why? Because you take her
9 back for a c-section you have a risk of complications.
10 It's a major procedure. You have risk and complication,
11 as far as entering to the mom, entry into internal
12 organs. You predispose her to infection. Not only
13 that, you also predispose her when she's pregnant and
14 she may need to have another c-section. And multiple
15 surgery could cause problems later down the road.

16 That's just on the mom itself. On a baby, when
17 the baby's head is almost all the way out, you're gonna
18 do a lot of trauma reaching down there to push that
19 baby's head up, going up through the birth canal and go
20 through the incision.

21 Q. Why would you have to push the baby's head back
22 down?

23 A. Because if the head is at the opening outside and
24 you do a c-section, you have to reach your hand down the
25 birth canal to the top of the baby's head to pull the

1 baby up. And you have to do that on a c-section. So
2 with at the plus three station, the head is basically
3 you're seeing this much of the baby's head. It's the
4 quickest and easiest way to deliver by either vacuum or
5 forceps. (Indicating.)

6 Q. So your choices were to allow her to continue
7 with the vaginal delivery or somehow think about a
8 c-section?

9 A. No, sir. What I did was that at this time right
10 here, I made a decision. Seeing his heart rate is down
11 to 90, it's just not coming back up, I made a decision
12 we need to deliver Ms. Flowers. That's the first
13 decision. The second decision is what is the quickest
14 and safest way to do deliver for her and for the baby.
15 Then I decide we're going to deliver by vacuum.

16 Q. Okay. And is that a vaginal route?

17 A. Yes, sir, that's vaginal route.

18 Q. So at that point when you saw that the heart rate
19 was where it was, had it rebounded to a point where you
20 felt the baby had gotten back to its normal, you know,
21 pre-depressed heart rate level?

22 A. No, sir. That's a misconception. And I'll tell
23 you because you cannot take, like I told you before, you
24 cannot sit here and take a picture in time. So if I
25 showed you this picture by itself and asked how

1 everybody's doing, everybody's gonna say fantastic. If
2 I show you this picture, how is the baby doing,
3 everybody's gonna say bad. You have to look to see
4 what's going beforehand because you don't have 20/20,
5 you're not gonna be able to go well, you know, you could
6 have done this or should have done this. This is
7 realtime.

8 So at the time this is all you're seeing right
9 here. And I'm seeing heart rate's been down. Heart
10 rate's still down, I need to deliver this baby.

11 Q. So what did you do in terms of moving forward
12 with the delivery at that point and then now we're a few
13 minutes after you've been coming?

14 A. If I could mark this real quick. I'm sorry, ask
15 your question.

16 Q. Now, what did you do at that point when you had
17 decided that the safest thing to do is the vaginal
18 delivery to proceed onward, as you have been allowing
19 her to do?

20 A. I decided that we need to use a vacuum, because
21 based on these contractions here pushing I do not think
22 she was gonna be able to deliver this baby in the next
23 15 minutes or so.

24 Q. Did you restart the Pitocin?

25 A. I did.

1 Q. Why?

2 A. And the reason why I restarted the Pitocin is
3 that with the vacuum, basically what you're doing with
4 the vacuum is you're helping speed up the process.
5 You're helping mom out. You also need in order for the
6 baby to come out, two things must happen. You have to
7 have a contraction to push that baby out. So you don't
8 want to do a vacuum with no contraction. You want all
9 the help you can get. So that's why you start Pitocin
10 to get a contraction so that it'll help you out.

11 Q. Now this Pitocin medication, when it is
12 discontinued does the effect of it just immediately go
13 away like that? (Snaps fingers.)

14 A. No, sir. That's a good question. It does not.
15 It takes the half line of Pitocin about 30 minutes.

16 Q. All right. When you turn it back on is it an
17 immediate effect though?

18 A. It takes a couple minutes.

19 Q. So when you -- about what time did you restart
20 the Pitocin? And I'll direct you to Exhibit 2 if that
21 will help you on time.

22 A. That's something -- okay. About -- this is 18 at
23 17. About right here is when the Pitocin was restarted.
24 And it was restarted with 13 units, in which that's what
25 she was on before all this happened, given initially

1 when she started pushing. (Indicating.)

2 Q. Wait a minute. You restarted the Pitocin at this
3 point in time. Was that because you were feeling like
4 the heart rate had gotten back to assuring or normal
5 level?

6 A. No, sir. I restart the Pitocin because I know I
7 need to deliver this baby. I need all the help I can
8 get.

9 Q. And was the heart rate still in that concerning
10 level of the 90s at that point?

11 A. Yes, sir.

12 Q. All right. We restart Pitocin. What's next?

13 A. Well, one thing I need to point out is that, you
14 know, when you see a heartbeat in the 90s like this,
15 okay? You know there's a slope, what we recall
16 recovery. So if the baby has good reserves, okay? And
17 I'll give you an example. When you go swimming, you
18 first dive down the water, you come up no issue. You go
19 down for two more times, you come up, you're getting
20 real tired from lack of oxygen. You kind of go
21 (indicating). And so that's what's called slow
22 recovery.

23 So when the heart rate dropped down the first
24 time, if the heart rate goes up like this, we call that
25 quick recovery, would not worry too much. As you can

1 see, here at an angle getting slower, getting longer to
2 get back up to normal, get lower. So that's what's
3 telling me that if, like, you and I would go swimming is
4 when you go down in the water several times you're
5 getting tired and tired and this heartbeat is showing
6 it.

7 MR. HENSHAW: Your Honor, it is not appropriate
8 for him to use the word you and directly address the
9 jury in that way.

10 THE COURT: All right. Please do not.

11 THE WITNESS: Yes, sir. So as the heart rate
12 goes down, it's already dropped by a third. And it
13 showed that the recovery here is getting lower and
14 lower, so we're getting exhausted.

15 BY MR. LOVELL:

16 Q. And when you say reserve, what do you mean by
17 that term?

18 A. That the baby does not have enough oxygen to
19 bounce back up like it was beforehand.

20 Q. All right. So at this point in time after you've
21 started the Pitocin, walk us through the next step in
22 the delivery.

23 A. So the Pitocin started at 20:16. I made the
24 decision that I am going to go ahead and extract the
25 delivery using a vacuum.

1 Q. Expedite the delivery using a vacuum?

2 A. Yes. Yes, sir. And so I ---

3 Q. Tell us about this vacuum that you're using.

4 A. A vacuum, it's just an instrument that'll create
5 a little suction. You put it on the baby's head. And
6 the idea behind it is to speed up the process of parting
7 it as the head comes out. So as yesterday, before the
8 baby come out, the baby has to clear underneath the
9 bone. And then after that it has to extend up.

10 Q. Let me ask you, you said something about cardinal
11 maneuvers. Let me put this up. This is our exhibit
12 number 10, Doctor.

13 A. So the head right here, as you can see, the bone
14 right here, the head has cleared that bone.
15 (Indicating.)

16 Q. Underneath the bone?

17 A. Underneath the bone or the bladder bone and
18 suprapubic. And so that's what I mean by the head has
19 to flex, go underneath it, and then afterwards the head
20 comes up. As the head comes out, that's when the head
21 is being delivered right here. (Indicating.)

22 Q. And when you're putting this vacuum on the baby's
23 head, where do you stick it?

24 A. I'm sticking it in the middle of the head or so.
25 I'm sticking it at about right here.

1 Q. All right. And how does it assist you in helping
2 the mom deliver the baby?

3 A. As the mom is pushing by having the vacuum, you
4 help kind of keep the head down like this so it helps
5 clear the bone easier. (Indicating.)

6 Q. Are you using the vacuum to pull?

7 A. Just gentle traction.

8 Q. Are you still having your hands on the baby's
9 head at this -- or touching the baby at that point?

10 A. The hand is not touching the head. The hand is
11 on the vacuum and the vacuum is touching the head.

12 Q. Now, after you apply the vacuum, what happened
13 the next week with this delivery?

14 A. So the head comes out right here. (Indicating.)
15 And so through this process -- if you could put that
16 back up.

17 Q. (Puts up diagram.)

18 A. As you can see here, the vacuum is put at 20:18,
19 which is marked by right here. (Indicating.) What I
20 usually do ---

21 Q. And I'm just gonna -- when they typed this in,
22 somebody puts that in or is that automatic?

23 A. They put that in, but you can see they put it a
24 little bit afterward or, you know, a couple seconds
25 after. You cannot put it at the same time in realtime.

1 Q. Who's doing that?

2 A. This is the nurse. The nurse is putting it down
3 right there. (Indicating.)

4 Q. All right. Sorry I interrupted you. So after
5 you put the vacuum on, tell us what happened next.

6 A. What I usually do is that before, before I put
7 the vacuum on right here. (Indicating.) Before I
8 vacuum there's a couple of things I want to do. The
9 first thing I want to do is I make sure the head was
10 already all the way down. The second thing I want to do
11 is I want to make sure that I have the help that I need.
12 What I mean by help is that I usually assign the nurse,
13 in this case Ms. Phillips, to do suprapubic pressure if
14 I need it.

15 I have the CST or tech that's in there to hold up
16 the leg. I usually have the spouse or another nurse to
17 hold the other leg. So in this situation, um, I believe
18 that, um -- I'm not sure one of the nurse or Mr. Flowers
19 holding one leg. The nurse, Ms. Phillips, was on her
20 right side. So she was there just to monitor the baby.
21 And then the CST, which was Ms. Cindy White, was holding
22 the other leg.

23 Q. Okay.

24 A. So the bed is already down. I assign people what
25 to do in case of things going wrong. I also notify

1 NICU, which is Neonatal Care Unit. The reason why is
2 that with the heart rate going down, I'm not sure what
3 kind of baby I'm gonna be getting. So I want to make
4 sure I have all the help and everything I needed when
5 I'm adjusting things.

6 Q. Okay. And where are you situated at this point
7 in time?

8 A. Right here at this time I'm sitting between the
9 leg on a stool, a rolling stool. Bed all the way down.
10 Fully clothed, draped, ready to go.

11 Q. And vacuum was applied. Did it work?

12 A. Well, let me walk through. The vacuum was
13 applied. What I usually do is I like to apply the
14 vacuum through a contraction. What I mean by
15 contraction, I'm not sure if -- I'll just walk through.
16 With the contraction, I had to lead you in, we like the
17 mom to push at least about three times. So we like the
18 contraction to go up before we put the vacuum on. So in
19 this particular case she's having contractions. I like
20 to go up before I put on the vacuum, before I apply
21 traction for the vacuum.

22 So I usually like to apply two tractions. The
23 first traction -- the first traction I like to apply is
24 for the head. The head will come underneath the bone
25 here. (Indicating.) That's the first traction with the

1 first push. The second traction or through the second
2 push, that's how the head comes out. The reason why I
3 want to do that is I want this to come out at the
4 maximum peak of a contraction so she can push through,
5 so...

6 Q. Okay. And when you're doing that at the maximum
7 peak of the contraction, is the goal that perhaps the
8 contraction will let the baby go ahead and deliver on
9 out?

10 A. The goal -- yes, sir. And also for, for mom
11 pushing to rotate the shoulder internally also.

12 Q. Okay. Now, did the head deliver?

13 A. No, sir, it did not.

14 Q. The head did not deliver after the vacuum was
15 applied?

16 A. The head delivered, the body did not.

17 Q. All right. So what did you do at that point?
18 What did you do to figure out why this is happening?

19 A. Well, first of all, so the vacuum's at 20:18. We
20 know that the suprapubic pressure was put on 20:19,
21 according to the note there. So during this time with
22 the two traction I was able to deliver a head. After I
23 delivered the head, I went and checked to see if the
24 baby had nuchal cord.

25 Q. Now we saw the video yesterday. How do you do

1 that check for nuchal cord? How is it shown?

2 A. I put my hand, fingers and check around the neck
3 to see whether there's a cord, just like this.

4 (Indicating.) The reason why I do that is to make sure
5 was the cord compressing against the baby, was the cord
6 strangling the baby, therefore, may have cut off the
7 oxygen supply. In this case there was none.

8 Q. All right. And are you checking the position of
9 the shoulders while you're doing the nuchal cord check?

10 A. You kind of have an idea, but not really. You
11 kind of go -- you kind of put your hand in there in
12 trying to check the cord and that's pretty quick.

13 Q. And when you're checking for the cord do you know
14 whether or not a shoulder dystocia event has occurred?

15 A. No, sir, you don't.

16 Q. All right. What did you do next?

17 A. So after I checked the cord I bulb the baby.

18 Q. And is that what we saw on the video with the
19 blue thing up here?

20 A. Yes, sir, just bulb the baby.

21 Q. Why are you doing that?

22 A. Just to get any amniotic fluid out of the nose,
23 the throat so the baby doesn't swallow it or get it down
24 in the lungs.

25 Q. And at that point in time do you know that a

1 shoulder dystocia has occurred?

2 A. No, sir, I do not.

3 Q. What happened next?

4 A. Now, the mother, she was already in her legs
5 being pulled back. So I asked mom to push with gentle
6 traction, sitting on a stool, trying to guide the baby
7 down. The shoulder didn't come out. That's how you
8 diagnose shoulder dystocia.

9 Q. And when you were doing this guiding of the baby
10 down, were you moving the head in a downward position in
11 any 15, 20, 30, 35 or greater degrees of movement?

12 A. No, sir. Just like, just like you're just
13 sitting down like this, you basically guiding down just
14 like that. (Indicating.)

15 Q. And are you keeping the baby's head as closely
16 aligned to the spine direction as you could at that
17 point?

18 A. You try to but, you know, the baby's moving and
19 things of that, so you try your best.

20 Q. All right. What happened next?

21 A. So with that, with the first, first -- that was
22 the third push, dystocia was diagnosed. So after the
23 second push, I asked mom to stop. I asked Ms. Phillips,
24 right here, that's 20:19 ---

25 Q. Can I stop you before you move to that. How did

1 you diagnose that dystocia had occurred?

2 A. Because, number one, the shoulder did not
3 relieve, the shoulder didn't come out. So that's a
4 diagnosis of shoulder dystocia.

5 Q. Does the baby -- did the baby's head do anything
6 that you could see that gave you some inkling that there
7 was a problem?

8 A. Yes, sir. It contracted back a little bit.

9 Q. What's that called?

10 A. It's called a turtle sign.

11 Q. And when that occurs and you say it kind of goes
12 back, is the head out and then scoots back down towards
13 the mom's body?

14 A. Yes, sir.

15 Q. All right. What happened now? What did you do
16 next?

17 A. So bring up to 20:19. So this is -- that's when
18 it has Nurse Phillips here to put on suprapubic
19 pressure. As I've described beforehand, suprapubic
20 pressure is her trying to move that shoulder from this
21 position. This is the door handle. In this position to
22 that position. (Indicating.) And so that's what I was
23 hoping. That's what I asked her to do at 20:19, give
24 suprapubic pressure, at the same time increase my
25 McRoberts.

1 Q. And is mom trying to push as you're doing all of
2 that?

3 A. Initially I will ask her not to push just for a
4 second until we do the suprapubic pressure, then I ask
5 mom to push.

6 Q. All right. And is that what happened in this
7 case, according to our strip?

8 A. Yes, sir.

9 Q. All right. And what happened then?

10 A. So with suprapubic pressure, try and rotate this
11 leg, with McRoberts trying to get this down that way, I
12 want to see most of the time, about 50 percent of the
13 time, it should clear. (Indicating.) So I give gentle
14 traction straight and down. Gentle traction downward.
15 The shoulder did not clear.

16 Q. All right. When you say gentle traction
17 downward, are you again using the same degree of force
18 you'd use on any delivery?

19 A. Yes, sir.

20 Q. All right. And what about this angle of
21 downward, is it -- are you still keeping it as close as
22 you can to the spinal axis of the baby?

23 A. Yes, sir.

24 Q. All right. And if you had been pulling, I'll use
25 that term just loosely, guiding the baby or whatever,

1 your hands are on it, if you had been applying 20, 30,
2 35 or greater pounds, what would have happened to your
3 body as you're sitting there next to mom?

4 A. I think, number one, if I was pulling really
5 hard, then you know you're sitting on a stool, you pull
6 hard, the stool would be rolling towards the mom. And
7 that didn't happen. So, number one, I use the same
8 traction. The stool didn't move so, therefore, I know I
9 didn't, I did not pull hard.

10 Q. And at that point had you applied traction during
11 the McRoberts into the suprapubic pressure phases of
12 what we're looking at?

13 A. Well, with the initial right here, at the
14 delivery after the vacuum, I did put general traction
15 just for, you know, a few seconds, she didn't deliver.
16 That's how I diagnosed shoulder dystocia. Then I asked
17 mom to stop pushing. I did suprapubic pressure. Mom
18 pushed again. Again I gave general traction. But after
19 a second or two the shoulders are relieved and I stopped
20 contraction.

21 Q. Before you did the suprapubic, did you have her
22 do the way back leg?

23 A. Yes, sir, I did.

24 Q. And the ---

25 A. Well, she was already in McRobert beforehand.

1 Q. Did you do her even --

2 A. Yes, sir.

3 Q. -- further back than --

4 A. Right here, sir. (Indicating.)

5 Q. -- McRoberts?

6 A. Right here. (Indicating.)

7 Q. All right. And during that time are you hands on
8 the baby?

9 A. At this time right here, if you're talking about
10 right here, 20:19, I was doing suprapubic pressure. My
11 hand was on the head right here at this exact moment
12 right here. (Indicating.)

13 Q. Hands still in this position? (Indicating.)

14 A. Yes, sir.

15 Q. And baby's head wet at that point?

16 A. Yes, sir.

17 Q. And is it slippery?

18 A. Yes, sir.

19 Q. And what did you do next after the suprapubic
20 didn't work?

21 A. Well, now this is 20:19. So now I diagnosed
22 shoulder dystocia. My first maneuver hadn't worked. So
23 now I'm going through the second maneuver, as you recall
24 from the video yesterday. So I put my hand, because I'm
25 right handed, I put my hand inside the vagina on her

1 left. I try to feel for this shoulder if I can. Really
2 couldn't do a whole lot. Then I try and reach my hand
3 up there, trying to grab the arm. I was then able to
4 spend about 10, 20 seconds there trying to get the arm,
5 could not.

6 So I take my arm out. My hand out, I should say.
7 Not my arm, my hand out. I put my hand on the back of
8 the baby's back, move up to the shoulder that was stuck
9 on top. Then I try to find out this part right here.
10 At the same time, which all happened about right here, I
11 asked mom -- I mean, I asked Ms. Phillips to give me
12 suprapubic pressure. At the same time I'm rotating the
13 shoulder. So what's going on? If this is the door, I'm
14 using, I'm trying to reach in here, move this over like
15 this. At the same time I'm using the nurse to go up
16 here to push. So I'm doing two things at the same time,
17 trying to put my hand in, rotate it. Secondly, I'm
18 asking the nurse to give suprapubic pressure to push
19 that way. (Indicating.)

20 Q. All right. And when you're doing those maneuvers
21 with your hand in the baby, do you have your hand on the
22 baby's head?

23 A. No, sir.

24 Q. And I know it makes sense, but why not?

25 A. Well, I mean, you can't because if the baby's

1 head is right here, if you have your hand on the baby
2 head, it limits what you can do. So really when the
3 business end is open, it's very hard to put your entire
4 hand in it. So at most you get maybe two, maybe three
5 finger. Most of the time you only have two fingers in
6 you have to maneuver.

7 Q. All right. Now, after you did this Rubin II
8 maneuver what happened?

9 A. After the Rubin II maneuver, I was able to rotate
10 the shoulder a little bit. And also, with Nurse
11 Phillips giving suprapubic pressure, I thought there was
12 some movement. So all that took about, I don't know,
13 about right here. (Indicating.)

14 So at that time mom had a contraction. And so I
15 thought, you know, I thought I moved it a little bit.
16 Not a complete rotation. I thought there was some
17 movement. I'm gonna ask mom to push. And ask Nurse
18 Phillips to continue suprapubic pressure. At that time
19 I was able to deliver the baby.

20 Q. And at the point in time when you delivered the
21 baby, was that at about this 20:20 timeframe?

22 A. Yes, sir. Now, I need to let you -- I need to
23 stress this point, is that when you have a baby coming
24 out, any baby coming out, that's been in regardless of
25 whatever shoulder dystocia no dystocia, as soon as the

1 shoulder clears the bone, what I usually do is I stop
2 doing traction on the head. So I usually put my arm in
3 it. Not my arm, my two fingers in underneath the
4 armpit, pull the baby that way. The reason why I do
5 that is that there's no traction whatsoever on the head,
6 so that way.

7 Q. And is that what we saw on our video yesterday
8 that you did?

9 A. I think so, sir.

10 Q. All right. Now, Doctor, during this window of
11 time, really starting on the prior strip, but once you
12 got to the point where you had begun the delivery and
13 discovered the shoulder dystocia, given the things with
14 the baby's heart rate and the fact that you now have a
15 shoulder dystocia, was that baby medically stable?

16 A. No.

17 Q. And why not?

18 A. You had to take the total picture. Like I say,
19 the total picture, heart rate down to 90, a third of the
20 oxygen has been cut off, slow recovery. That's factor
21 one. Number two, you've got a shoulder dystocia. So
22 oxygen has already been cut off also, so you have two
23 things going on.

24 Q. In shoulder dystocia in the medical world that
25 you live in, is that recognized as an obstetrical

1 emergency?

2 A. Oh, yes, sir.

3 Q. Now, from that time when you recognized the
4 dystocia in the 20:18, 19, whatever the time was, up
5 until the time of the delivery, was the baby -- did the
6 baby ever become medically stable or was it still
7 medically unstable in that window of time?

8 A. Oh, unstable.

9 Q. All right. What about, in that window of time
10 from the shoulder dystocia through the actual full
11 delivery of the baby, was it at risk, imminent risk of
12 serious bodily injury or potentially dead?

13 A. Yes, sir.

14 Q. Tell us why.

15 A. Because when you have this situation here, we all
16 know in a dystocia case, normal dystocia, normal baby,
17 nothing wrong with the baby, you've got about four
18 minutes until you got some damage. That's a average.
19 Some babies have better reserve, some have low reserve.
20 That's standard or that's normal. And this baby is
21 already compromised, heart rate down. But all this
22 time, this is about three, six, nine, about ten minutes
23 now.

24 So when the heart rate's down, you've got a third
25 of oxygen supply and so the baby's already compromised.

1 And on top of that you've got dystocia, so you really
2 don't have an average of four minutes. You probably
3 have a lot less, but how much you don't know.

4 Q. And do you have the luxury, as the doctor would,
5 with things going on in that window of time, just to
6 wait and see if maybe the mom will deliver the baby
7 without you having to do the Rubin II or some other
8 maneuver after you've tried suprapubic and McRoberts?

9 A. No, sir, you don't because, you know, everybody
10 responds differently to the lack of oxygen. Some may
11 have a lack of oxygen or some could hold their breath a
12 lot longer, some can't. And at this time I don't know.
13 All I know is that the baby's been compromised, so I
14 don't know how much reserves they have and know the baby
15 has low reserves based on the slow recovery.

16 Q. Now, Doctor, we heard two days ago, I think, in
17 the testimony one of the experts that in her opinion you
18 performed the McRoberts after the dystocia, followed by
19 the suprapubic. And that at some point after the
20 suprapubic the baby just rotated on its own that
21 facilitated the delivery. Is that what happened in this
22 case?

23 A. No, sir. I rotated, I helped to turn that baby a
24 little bit.

25 Q. How do you know you did that?

1 A. Because I felt -- because if the baby rotated,
2 the baby would have come out with McRobert and
3 suprapubic. The baby not come out. I had my hand in
4 there to physically push that shoulder, rotate that
5 shoulder with the help of the nurse who did suprapubic.

6 Q. So you said if the baby had rotated on its own
7 with the suprapubic or the McRoberts -- and I got those
8 backward -- McRoberts or suprapubic, it would have come
9 out on its own without any assistance?

10 A. I was there. If the shoulder had rotated, it's
11 easy. Then I would not do any resistance. It would
12 just rotate, put my hand in there and just psh, out
13 already.

14 Q. Did you do this delivery using the same training
15 and techniques and sort of your routine as you do or
16 have done on all the prior shoulder dystocia event
17 deliveries you have had?

18 A. Yes, sir.

19 Q. Okay. Let's go back up there.

20 (Whereupon, witness resumes witness stand.)

21 Now, Doctor, you were pointing a minute ago to
22 Exhibit No. 2, the nurse's progress note. Who's writing
23 all of this?

24 A. This is the nurse in this case. I guess the
25 majority is Nurse Phillips.

1 Q. Okay. The stuff down at the end when we're
2 talking about the application is suprapubic and all
3 that, that's Natalie Phillips doing?

4 A. Yes, sir.

5 Q. All right. After the delivery of the child,
6 Doctor, and I'm talking about the actual body coming
7 out.

8 A. Yes, sir.

9 Q. At the point where you've got the body coming
10 out, and you've done your Rubin II, are you on the stool
11 at Rubin II time?

12 A. I'm always on the stool until the very end when
13 the body comes out.

14 Q. All right. What did you do when the body came
15 out? Did you get off the stool?

16 A. Like I was saying, so the shoulder has been
17 delivered, anterior shoulder has cleared, has cleared
18 the door handle, as you put it, on the door frame. Then
19 I put my hands in here. Then I will stand up to deliver
20 the baby like this, turn around, clamp the cord and hand
21 off. (Indicating.)

22 Q. We heard some testimony that the mom didn't
23 really get to hold the baby until after the NICU people
24 had dealt with it and all. Is that kind of normal when
25 you're dealing with a delivery with a problem like this

1 child had?

2 A. Normally I would love to hand the baby over, but
3 in this case the baby was in distress, the baby was kind
4 of limp with respiratory depression, so I want to get
5 the baby over to NICU team first to make sure the baby's
6 okay before doing anything else.

7 Q. Did you observe, did you look at baby Flowers
8 before you, you know, before she was out of that room?

9 A. I caught a quick glimpse and I got her over quick
10 to the NICU team.

11 Q. How did she look, the baby?

12 A. She looked like she'd been through a lot.

13 Q. Was she -- you mentioned the word limp, what do
14 you mean by that?

15 A. Very minimal, if any, no tone.

16 Q. Was the baby in distress at that point?

17 A. I know the baby was in distress but, you know,
18 once the baby come out, you know, I can't tell you.

19 Q. You heard some testimony earlier about the
20 possibility the baby may have had a fractured clavicle.
21 Did she have a fractured clavicle during your delivery?

22 A. Not I'm aware of, sir.

23 Q. Now, did you make a note about the delivery
24 shortly after it occurred?

25 A. Yes, sir. I, um, it was about 9:00 p.m., sir.

1 Q. All right. I'm gonna put up on our thing, and
2 you don't need to come down, Doctor.

3 A. Sir.

4 Q. Hopefully you'll be able to see. Is this the
5 note, this one I've got sort of highlighted on here?

6 A. Yes, sir, that would have been 9 p.m. on that
7 day, sir.

8 Q. And that's on Defendant's 11. I'm gonna ask you
9 because your handwriting is challenging, can you read it
10 for us? Let me give you a copy.

11 A. Yes, sir, I can read it. It's a typical doctor's
12 handwriting. Basically it says 10/7/2008, 9 p.m. I
13 used some abbreviation, so I'm just gonna read it out as
14 it's not abbreviated.

15 (Reading.) Fetal heart tones to the 90s. Fetus
16 at plus three station with head crowning, I control
17 this. Vacuum applied with tool pull noted. Shoulder
18 dystocia encounter with McRoberts maneuver and
19 suprapubic pressure. Viable female deliver, infant
20 handed to NICU. Midline episiotomy had been performed,
21 third-degree extension noted. Third degree repair.
22 Placenta delivered in tact with three vessel cord, as to
23 the blood loss, 300 cc, shoulder dystocia lasted one to
24 two minutes, minimal traction performed. (Ends
25 reading.)

1 Q. Now, Doctor, did you go back and look at the
2 strip to figure out how long the dystocia had lasted to
3 the second or tens of seconds?

4 A. No, sir. She delivered around, I guess around
5 8:20, and so I had to sew her up. So this is written
6 right afterwards. And so at the time the nurse would
7 have had the strip and I just, you know, wanted to go
8 ahead and write down my thoughts at the time at 9 p.m.

9 Q. Why did you make a note that minimum traction was
10 applied?

11 A. The number one thing you always do in dystocia
12 case or any deliveries, you want to make sure you use
13 the same traction regardless. And so I want to make
14 sure that, number one, I'm constant in the deliver.
15 And, number two, I want to make sure that I put down my
16 note to be aware that I'm still cognizant that minimal
17 traction was performed.

18 Q. At this point do you know if the baby has a
19 potential brachial plexus problem?

20 A. Well, you can tell that she has an injury. Her
21 arm was limp.

22 Q. And was that something you noted at the delivery?

23 A. After I handed off the baby.

24 Q. At the point when you're writing this note at
25 approximately 9 o'clock p.m., do you know it's going to

1 be a permanent injury?

2 A. No, sir. I've never had a permanent injury
3 before this.

4 Q. At this point did you know that you were going to
5 be sued over this delivery?

6 A. No, sir.

7 Q. I don't see written in here the Rubin II
8 maneuver. Why is that not in your notes?

9 A. The reason I didn't write Rubin II, that's a
10 standard protocol that I usually do. So because it's
11 standard I don't write it.

12 Q. But you did write the McRoberts and suprapubic.
13 Why did you include that?

14 A. Well, I write McRoberts and suprapubic pressure
15 because that's something that requires assistance. And
16 as you can see also there, I mean, I wrote that I put
17 the vacuum on. That's normal, but I didn't tell how I
18 put the vacuum on or what I did with the vacuum because
19 that's protocol.

20 Q. You write the McRoberts and suprapubic because
21 that is something you have to have assistance on?

22 A. Yes, sir. Have to have assistant on.

23 Q. All right. Now, did you -- we heard some
24 testimony from the Flowers that you talked to them that
25 night at some point.

1 A. Yes, sir.

2 Q. All right. If you have an in-depth discussion
3 with them that night about the circumstances of the
4 delivery and all the things that you had done and all
5 the things that had occurred?

6 A. From my experience, most of the time after I do
7 the delivery like this, I would go and check on the baby
8 and I would go talk to the parents afterwards and tell
9 them, you know, what happened, why I did the thing that
10 I did, and what's going on. But from my experience,
11 probably 99 percent of the time nobody remembers this
12 conversation. They remember bits and piece of it. So I
13 talked to them, but I usually try and come circle back
14 the next day or two after things settle down, after they
15 get through the process to explain a little bit more.

16 Q. Now, I want to show you what we marked earlier
17 and it's in one of those big exhibits, but it's marked
18 as Defendant's Exhibit Number 1. First, tell our jury
19 what that document is.

20 A. Basically this is a summary of delivery room
21 record.

22 Q. On that particular document, is that something
23 that you personally complete?

24 A. No, sir, I don't complete. Honestly, I don't
25 even look at it. That's by the nurse.

1 Q. What's the purpose of that record, though?

2 A. This is a record for the hospital.

3 Q. Now, is that something prior to today you've
4 looked at and studied it in preparation for our ---

5 A. Yes, sir, I, I -- yes.

6 Q. On that record is there anywhere for you to,
7 somebody to check off that a Rubin II maneuver was used?

8 A. No, sir, there is none.

9 Q. Anywhere for them to check off if, say, one of
10 these wood screw maneuvers had to be used?

11 A. No, sir.

12 Q. Or a Zavanelli had to be used?

13 A. No, sir.

14 Q. Or a fractured clavicle had to be used?

15 A. No, sir.

16 Q. I do see on there a box for rotation and a box
17 for forceps, what are those on -- what are those about?

18 A. Basically under that box it says vaginal delivery
19 and it has two options or three options. Vacuum
20 extraction, forceps or spontaneous. Rotation means
21 rotation by the forceps. So the baby is coming out
22 looking sideways, you would rotate the baby so either the
23 baby looking down or up to deliver. So that's implying
24 a rotational forceps.

25 Q. Did you have to do the forceps and a rotation in

1 this case that would be such checked on these boxes?

2 A. I don't do rotation forceps, sir.

3 Q. Okay. Now, let's go -- thank you, that's all
4 I've got on that one.

5 Did you then meet with Mrs. Flowers? Well,
6 first, you saw her the next day as well?

7 A. Yes, sir.

8 Q. The 8th?

9 A. Yes, sir.

10 Q. Sometime in the morning?

11 A. Yes, sir.

12 Q. Tell me what you wrote. Can you read that for
13 us, please?

14 A. Yes, sir. I said: (Reading) around 11 o'clock
15 doing well, routine care, infant moving hand, but not
16 arm yet. (Ends reading.)

17 Q. And did you see her again the next day?

18 A. Yes, sir.

19 Q. Read that one for us.

20 A. The first one I said, I probably round her in the
21 morning. (Reading.) Doing well, routine care, infant
22 still in NICU. Blood pressure 10/8 up. Will continue
23 to monitor. Prescription Darvocet times 30 on chart.
24 (Ends reading.)

25 Q. When you're talking about blood pressure up and

1 all that, is that mom or baby?

2 A. Mom.

3 Q. Okay. At this point are you really involved in
4 the baby's care?

5 A. No, sir.

6 Q. Is that something the intensive care and neonatal
7 people are doing?

8 A. Yes, sir.

9 Q. All right. And did you see the patient again on
10 that particular day?

11 A. Yes, sir. I ---

12 Q. Tell me, in your note here on Exhibit Number 5,
13 you wrote that?

14 A. Yes, sir. I probably round -- I probably circled
15 back with the family. That was around six-something
16 p.m. 6:30 p.m.

17 Q. All right. Tell us what happened there, what you
18 were doing.

19 A. I used some abbreviations, so I'll read without
20 it. (Reading.) Discussed with family, husband and
21 wife, concerning event. Explained to family reason for
22 vacuum extraction as outlet, secondary decreased fetal
23 heart tones. Gentle and constant traction applied of
24 infant head after McRoberts maneuver and suprapubic
25 pressure. Dystocia lasted one minute. Info on dystocia

1 and urged positive in the family. Will have patient
2 return in two weeks. (Ends reading.)

3 Q. Now, at the point in time when you're seeing them
4 on the ninth and that evening of the ninth, had you had
5 an opportunity to go back and look at the strips and
6 look at the notes that you and the nurses had made?

7 A. Yes, sir.

8 Q. All right. And is the reason you have a
9 different, a little bit of a different time on how long
10 the dystocia lasted?

11 A. Yes, sir.

12 Q. And, again, I don't see you having any writing in
13 here about doing the Rubin II maneuver. Why is that?

14 A. Again, sir, that's, you know, it's a standard
15 protocol that I usually do, so I don't, I don't write
16 down standard protocol. So I usually -- you know, I
17 know in my mind that there's shoulder dystocia. I know
18 these are things that I did.

19 Q. All right. Why did you write the gentle and
20 constant traction was applied?

21 A. Well, again, I want to make sure I reiterate that
22 that's the number one priority in my mind, that use the
23 same traction with every single delivery regardless of
24 whatever.

25 Q. So at this point, you knew the baby had a

1 brachial plexus?

2 A. At that time I thought it was temporary plexus.

3 Q. Did you have any idea this was a permanent
4 brachial plexus?

5 A. No, sir.

6 Q. Any idea that any lawyers were gonna be coming
7 after you because of this delivery when you wrote this
8 note at 6 o'clock, 6:30 10/9?

9 A. No, sir.

10 Q. Did you continue to see Mrs. Flowers while she
11 was in the hospital before she left three days into it?

12 A. If I did, I didn't write it down. So that was my
13 last note. I'm not sure. If I saw her the next day I
14 would have written a note.

15 Q. Okay. Were you in any way mistaken about the
16 degrees of traction you applied when you wrote the words
17 minimal traction performed or gentle and constant
18 traction applied?

19 A. No, sir.

20 Q. Were you in any way -- had you underestimated the
21 amount of those forces that you applied in this delivery
22 when you wrote those words minimal traction performed or
23 gentle and constant traction?

24 A. No, sir.

25 Q. Were you concerned about this baby?

1 A. Yes.

2 Q. While she was there in the hospital?

3 A. Yes. I mean, I try to take care of every patient
4 as they are my family members, so if you see a baby like
5 that you would be very concerned.

6 Q. Would you continue to follow Ms. Flowers
7 outpatient once she was out of the hospital?

8 A. Yes, sir.

9 Q. And did you have occasions to -- well, how long
10 did you all continue to follow her or did you continue
11 to follow her in doing office visits postdelivery?

12 A. I think I saw her one time for a postpartum check
13 and I'm not sure I saw her another time, but the last
14 note I have here was on April -- I guess for a complete
15 -- April 30th, 2009.

16 Q. And at that point in April 30th, were you still
17 having discussions with them about the injury that
18 Ashley had suffered, this brachial plexus problem?

19 A. Yes, sir. I want to make sure the baby is doing
20 okay and if the baby needs anything, the family needs
21 anything, I want to make sure I'm available. So I must
22 check on her, the baby, and making sure that she was
23 doing okay.

24 Q. And you're not a pediatrician, you weren't in
25 charge of the baby's care, were you?

1 A. No, sir, I was not.

2 Q. But had you connected them or referred them up to
3 a pediatrician to help with potentially this plexus,
4 brachial plexus injury?

5 A. I got some information and I gave it to them.
6 And I said I heard great things about this doctor, so I
7 said, you know, you could go ahead and check out this
8 physician.

9 Q. Had you referred any of the other patients to Dr.
10 I think it was, Newman was her name?

11 A. If there was any temporary brachial plexus
12 injury, I would say need some information. Go ahead and
13 start physical therapy. These are the people you may
14 want too see.

15 Q. In this visit on the 30th of April, 2009, did you
16 talk to Mr. and Mrs. Flowers about how the dystocia
17 might have occurred or what might have caused the baby
18 to get stuck?

19 A. Well, I wrote on my note that, you know, that I
20 recommended she was crying again to have a c-section
21 just because it is dystocia case. I wrote -- yeah..

22 Q. And what did you talk to them about as far as
23 what happened?

24 A. Well, let's see, in my note I, I said, again, I
25 discussed with patient concerning the shoulder dystocia,

1 that the pelvis was probably too small due to extensive
2 shoulder dystocia and amount of cap done on an infant.

3 Q. Now, was this your ability, and having been
4 through it all, to kind of figure out maybe why the baby
5 got stuck in the birth canal?

6 A. Well, I think, you know, when I wrote the pelvis
7 was too small, when I was -- really what I'm trying to
8 say is that on that day with the baby moving down, the
9 pelvis was not able to accommodate the baby and,
10 therefore, the shoulder was stuck. If it had been a
11 different day, it may be a different situation.

12 Q. If babies when they come down and the babies are
13 moving through the birth canal, do they always come down
14 the same way?

15 A. No, sir. They move, they move in different -- I
16 mean, kind of move like this in moving in different ways
17 moving down. (Indicating.)

18 Q. And is there the pelvis's ability to accommodate
19 the baby moving through it, sometimes depending on the
20 angulation of the baby as he was moving down?

21 A. Yes, sir.

22 Q. And sometimes does it just get in the wrong angle
23 for the side of that particular pelvic outlet?

24 A. Yes, sir. That's why sometime, you know, you
25 have a baby coming out looking head down. You have

1 sometime the baby coming out looking head up. It's the
2 way the baby moves and the way the baby rotates down
3 there.

4 Q. And is that why you ended up trying the
5 suprapubic McRoberts and the successful Rubin II to help
6 rotate the baby where it would go through the pelvic
7 outlet?

8 A. Yes, sir.

9 Q. And it did work obviously?

10 A. Yes, sir.

11 Q. Was -- in your understanding from the baby in the
12 hospital before everybody, she went home, did she have
13 any brain injury of any sort?

14 A. No, sir.

15 Q. Cerebral palsy of any sort?

16 A. No, sir.

17 Q. And you noted you delivered a live baby?

18 A. Yes, sir.

19 Q. I'm gonna show you one last thing. Exhibit 19.
20 Did your office continue to stay in touch with the
21 Flowers family to sort of check up on how things were
22 going?

23 A. Yes, sir.

24 Q. And this note I've given you, 19, what's the date
25 on that one?

1 A. 4/9/2010.

2 Q. Read what is written in that note for us.

3 A. (Reading.) Check on new call. Patient states
4 daughter is doing fine. Went to surgeon in March and
5 surgery is scheduled when two years of age. States she
6 can't raise arm. Can't read that part. Is to do other
7 normal activities. States she had her records sent to
8 Dr. Adams and she had her pap there last month.

9 Q. So ---

10 A. And then something about a nurse.

11 Q. And was that the practice's policy, your policy
12 with the practice? Do you all kind of keep up with your
13 patients and see how, especially in a scenario like
14 this, how the baby's doing?

15 A. That's my policy, sir.

16 Q. All right, Doctor. Did you apply any unusual
17 amount of traction or force to deliver this baby?

18 A. No, I did not.

19 Q. Would you have used the same forces in this
20 delivery that you use or had used in all prior
21 deliveries that you do?

22 A. Yes, sir.

23 Q. Did you apply any unusual direction of, of forces
24 or traction to deliver this baby?

25 A. No, sir.

1 Q. Did you use traction and forces that were
2 generally aligned with the axial spine of the baby as
3 best you could?

4 A. Yes, sir.

5 Q. Did you apply greater -- 35 pounds or greater
6 traction on this child?

7 A. It's hard -- I would not be able to. If I had
8 done that, the stool would have rolled over and fallen
9 down.

10 Q. Did you apply, 30, 45 degree angle of downward
11 traction on this baby during the delivery?

12 A. Again, no, sir.

13 Q. Did you comply, Doctor, with the standard of
14 care, that being what most competently trained doctors
15 would do when faced with a situation like Ashley F
16 faced with the condition she was in both before the
17 shoulder dystocia and from the time of shoulder dystocia
18 through the delivery of the baby in your care?

19 A. Yes, sir, I did everything an OB-GYN would have
20 done.

21 Q. You've been sued for malpractice. Do you have an
22 opinion whether you committed malpractice in your care
23 and treatment of Mrs. Flowers and her child?

24 A. I performed standard care. I did not perform
25 malpractice, sir.

1 THE COURT: We'll be in recess for 15 minutes.

2 MR. HENSHAW: Thank you, Your Honor.

3 (Whereupon, a recess was had from 11:15 a.m. -
4 11:31 a.m.)

5 THE COURT: Are we ready for the jury?

6 MR. HENSHAW: Yes, Your Honor.

7 THE COURT: Bring them in.

8 (Whereupon, jury enters the courtroom at 11:32
9 a.m.)

10 THE COURT: All right. We're going to continue
11 with the examination by Mr. Henshaw.

12 MR. HENSHAW: Thank you, Your Honor.

13 CROSS-EXAMINATION

14 BY MR. HENSHAW:

15 Q. Dr. Giep, do you agree that the definition of,
16 medical definition of axial traction as it applies to
17 circumstances of delivering a baby in shoulder dystocia
18 means that a pulling force applied in alignment with the
19 fetal suprathoracic spine, sometimes referred to as
20 downward axial traction?

21 A. I think from my interpretation of it, the
22 traction along the spine of the baby.

23 Q. All right. Do you agree that lateral traction is
24 a pulling force that bends a fetus' neck by moving the
25 ear toward the posterior shoulder, thereby opening the

1 posterior shoulder, thereby increasing strain on the
2 contralateral angle of the neck and increasing strain on
3 the brachial plexus, sometimes referred to as lateral
4 bending, downward lateral bending or downward lateral
5 traction?

6 A. The way I interpret that statement, so if you put
7 the head here, then that's mine.

8 Q. All right, sir. So axial traction, based upon
9 what you've told us, would be where the baby's head
10 stays in alignment with the spinal column as the baby
11 delivers?

12 A. In that picture -- in that picture it would be
13 along this plane.

14 Q. All right, sir. So this baby's head, if there
15 were traction to be applied, the hands here are not
16 shown by -- of the doctor, but if traction were to be
17 applied it would be in this straight direction all the
18 way down?

19 A. It would be a little bit angled down a little bit
20 to clear the shoulder, so...

21 Q. A little bit angled down?

22 A. Yes, a little bit.

23 Q. Maybe to here? (Indicating.)

24 A. I said a little bit of angle enough to clear the
25 shoulder --

1 Q. All right.

2 A. -- away from the bone.

3 Q. Okay. But this would be an illustration of
4 lateral traction as you defined it; is that correct?

5 A. That's what the picture depicts, so...

6 Q. Depicts lateral traction?

7 A. That's what the artist renders, yes, sir.

8 Q. All right, sir. Do you agree that the definition
9 of excessive traction in this context is a pulling force
10 that is greater than the inherit strength of the fetal
11 brachial plexus? Obsessive traction.

12 A. I mean, to me excessive traction is more traction
13 than you need to deliver the baby..

14 Q. All right. But do you agree that excessive
15 traction has an effect on the baby's brachial plexus?

16 A. There's a lot of other factors that can affect
17 it, sir.

18 Q. All right. Well, I understand that. But is
19 excessive traction one of those within your context of
20 what can affect brachial plexus?

21 A. Yes, sir.

22 Q. And the brachial plexus is the nerve system of
23 C-4, C-5, C-6, C-7, C-8 and T-1; is that right?

24 A. Yes, sir.

25 Q. And that comes out of the spinal cord in the area

1 of the neck and into the shoulder?

2 A. Yes, sir.

3 Q. Do you agree that the standard of care of a
4 reasonably competent obstetrician under the
5 circumstances of delivering a baby who has encountered
6 shoulder dystocia, is to apply routine traction, meaning
7 the same degree of traction that would be applied in a
8 normal delivery?

9 A. Yes, sir.

10 Q. And was that the standard of care on October 7,
11 2008?

12 A. Yes, sir.

13 Q. Do you agree that lateral traction should be
14 avoided?

15 A. That's a fair statement.

16 Q. And do you agree that excessive traction should
17 be avoided?

18 A. I can agree with that.

19 Q. And so do you agree that the standard of care on
20 October 7th, 2008, was to avoid both excessive traction
21 and lateral traction in the delivery of Ashley F ?

22 A. I agree.

23 Q. And this is -- is there a blow up on this thing?
24 I mean, can it be enlarged?

25 THE CLERK: Yeah.

1 MR. HENSHAW: Right here? It's not very
2 enlarged.

3 BY MR. HENSHAW:

4 Q. But this is your note that you entered shortly
5 after Ashley was born. She was born at 8:20 p.m.; is
6 that right?

7 A. Agreed.

8 Q. And you entered this note by your own time, by
9 the time that you -- you put down the time as 9:00 p.m.
10 as the time you entered this note; is that right?

11 A. Yes, sir.

12 Q. Now, you go through what you did here and it's in
13 evidence, both under Plaintiff's Exhibit 1 -- 2, I
14 believe, and all of those records and it's been
15 separated out by the defendant as Defendant's Exhibit 4,
16 and you go through that. And essentially what you did
17 here was to state what you did to get Ashley delivered;
18 is that right?

19 A. Yes, sir.

20 Q. And you stated in the order in which you did it,
21 except for the statement about minimal traction
22 performed.

23 A. I mean, I put down what was going through my
24 head, so I can't sit here and say these are the exact
25 chronological order because ---

1 Q. Well, let's go through what you say you did.

2 A. Yes, sir.

3 Q. So start at the very beginning. What is the
4 first thing that you put down?

5 A. Fetal heart tones to the 90s.

6 Q. All right. And you've explained to us how that
7 affected your decision process.

8 A. Yes, sir.

9 Q. What's the next thing you put down?

10 A. Fetus at plus three station.

11 Q. And would that have been in your order of looking
12 at the heart rate and then doing a vaginal examination
13 on your own to determine where the fetal head was?

14 A. Close.

15 Q. All right. And then so what's the next thing?

16 A. Plus three station, head crowning and shoulders.

17 Q. All right. And is that, so far are we staying
18 within the order of the way things probably occurred?

19 A. Probably but not absolute.

20 Q. All right. Well, then the next thing that you
21 have is that you placed the vacuum.

22 A. That's correct.

23 Q. And you've explained to us why you elected to use
24 the vacuum to help assist the mother deliver this baby.

25 A. That's correct.

1 Q. All right. So, so far are we still in order of
2 the sequence of the events?

3 A. Yes, sir.

4 Q. And then what's the next thing?

5 A. Vacuum applied with two pulls noted.

6 Q. All right. And then after that?

7 A. Shoulder dystocia encounter with McRoberts
8 maneuver and suprapubic pressure.

9 Q. And so that is still consistently within the
10 order of the events; is that right?

11 A. Yes, sir.

12 Q. And then what?

13 A. A viable female infant deliver.

14 Q. All right. And so that means you delivered the
15 baby. And the term viable means what, a live baby?

16 A. A live baby, yes, sir.

17 Q. A live baby who is -- who has enough features
18 about it that you expect it to continue to live within
19 the period -- within the neonatal period; is that right?

20 A. No. To me a viable infant is that the baby has a
21 heartbeat.

22 Q. All right. So you've got a live baby. So what's
23 the next thing you've got?

24 A. Infant headed to NICU.

25 Q. All right. So are we still in the order of the

1 events?

2 A. Close enough.

3 Q. Okay. And what do you have next?

4 A. Midline episiotomy. Had to perform with
5 third-degree extension noted.

6 Q. All right. So this is something that had
7 occurred before the baby was born; is that right?

8 A. Yes, sir.

9 Q. But it's something that after the baby was born
10 you were gonna have to deal with because you had to sew
11 it up?

12 A. Yes, sir.

13 Q. And so what's next?

14 A. Placenta delivery intact with three vessel cord.

15 Q. Okay. Now, did the placenta deliver before the
16 episiotomy was sewn up or did it deliver after?

17 A. In this instance it delivered after the
18 episiotomy, so...

19 Q. So we're still in the order of things.

20 A. Yes, sir.

21 Q. And so what do you have next?

22 A. Estimate loss 300 cc.

23 Q. This is where you're estimating the blood loss?

24 A. Yes, sir.

25 Q. By the mother?

1 A. Yes, sir.

2 Q. Not by the baby?

3 A. No, sir.

4 Q. And I take it this bleeding is from the
5 episiotomy that you cut?

6 A. No, sir. This is combination of the blood loss
7 after delivery as well as the cut and the repair.

8 Q. Okay. So both.

9 A. And the placenta separating, yes, sir.

10 Q. But that estimate would come -- in terms of that
11 estimate, that would come in the order of these events
12 where it is now; is that right?

13 A. Yes, sir.

14 Q. What do you have next?

15 A. Shoulder dystocia lasted one to two minute.

16 Q. All right. And so that's a line that is out of
17 order because the shoulder dystocia had occurred before
18 the delivery of the baby?

19 A. Yes, sir.

20 Q. And before the episiotomy?

21 A. No. It would have -- yeah, after the episiotomy.

22 Q. I'm sorry, before or after?

23 A. After the episiotomy.

24 Q. So even before you recognize that there was a
25 shoulder dystocia, you had already cut an episiotomy?

1 A. Yes, sir.

2 Q. And was that because you felt like -- well, tell
3 us why you, you cut the episiotomy in this particular
4 case?

5 A. Well, in this instance when you do a vacuum
6 extraction, you put the vacuum on the baby's head. As
7 the baby head comes out, being that this was a
8 first-time mom, she was gonna tear. And at that time I
9 thought that she was gonna tear so I just went ahead and
10 just did an episiotomy to make sure that the tear is
11 straight so it's easy to repair.

12 Q. All right. And did you do that before you
13 applied the vacuum or after you applied the vacuum?

14 A. This is -- I'm doing the episiotomy as the head
15 is about to come out after the vacuum was already
16 applied.

17 Q. All right. So you had -- and I take it that you
18 had, in fact, moved the baby down the birth canal with
19 the two pulls by the vacuum extractor?

20 A. Well, the head was already down at the vaginal
21 opening. What I did was flex the head and help the head
22 to come out --

23 Q. All right.

24 A. -- the opening.

25 Q. So that's the only reason that you used the

1 vacuum was to turn the head?

2 A. I did not turn the head, sir.

3 Q. What did you do with it?

4 A. As I've stated before, what happened was the
5 head, I flex the head so head go to chin so it can go
6 underneath the bone. And then I help it so it goes up
7 like that outside of that vaginal opening.

8 (Indicating.)

9 Q. All right. And that's what I'm trying to
10 understand is you put the vacuum on the baby's head.

11 A. Yes, sir.

12 Q. Engage it.

13 A. Yes, sir.

14 Q. And then did you use it to pull the baby's head
15 down or up?

16 A. There's two things, sir. What you do is you
17 guide the head, so put the chin to here so the head can
18 go underneath the pubis bone. And then the natural
19 progression for the baby's head is to (indicating). And
20 that's what would do that. And so the vacuum is just to
21 help assist to go up like that. (Indicating.)

22 Q. Well, the baby's head was crowning when you ---

23 A. Yes, sir. You see the top of the head.

24 Q. Before you did that?

25 A. Yes, sir.

1 Q. So what part of the baby's head needed to go
2 underneath the pubic bone?

3 A. The majority of the baby's head, sir.

4 Q. The majority of it. All right. And so you
5 lowered the baby's chin down, so that it could more
6 easily pass under the pubic bone?

7 A. The idea behind the vacuum is to decrease the
8 diameter going through the birth canal. So by doing
9 this, you decrease the diameter of the head so it goes
10 under easier.

11 Q. All right. And so you did two pulls with the
12 vacuum extractor in order to accomplish that; is that
13 right?

14 A. That's normal routine.

15 Q. Right.

16 A. Yes, sir.

17 Q. And that in and of itself would not have altered
18 the baby's alignment in regard to this axial traction
19 that, that ultimately should be applied; is that right?

20 A. That's the standard movement, the head coming
21 out. It goes underneath the bone and the head extend
22 out.

23 Q. I understand that, but that doesn't alter the
24 axial traction that should be applied after the baby's
25 head comes out.

1 A. I can't make that statement because I can't see
2 what's going on beyond this. But that's a normal state
3 -- normal maneuver.

4 Q. Well, do you have any reason to believe that it
5 altered that axial traction in this particular case?

6 A. I can't tell you one way or another. I don't
7 think so, but I can't sit here -- I don't have an x-ray.
8 I can't go in and tell you.

9 Q. Well, what about did you in any way pull the
10 baby's head so that the angle would have stretched the
11 brachial plexus?

12 A. The only thing I did was guide the head down,
13 guide the head up, normal as if she was delivering
14 without a vacuum.

15 Q. Did you take the vacuum extractor and move the
16 baby's head to the side, to the opposite -- toward its
17 shoulder, either way?

18 A. No, sir.

19 Q. Okay. So the vacuum extractor is not likely to
20 have caused the brachial plexus injury in this case, is
21 it?

22 A. The only thing is it guide the head down and it
23 guide the head up.

24 Q. My question, Doctor, is in terms of what you do
25 know it is not likely that the vacuum extractor that was

1 used in pulling the head two times had caused any injury
2 to this baby's brachial plexus?

3 A. I can't say that because I'm not sure what's
4 going on with the shoulder from the brachial plexus
5 behind the bone. The only thing I can tell you is what
6 was going on with the head. I can't tell you what's
7 going on with, with the nerve that was stuck behind the
8 bone.

9 Q. Did you pull so hard that you could rupture C-5,
10 C-6, C-7 with that vacuum extractor?

11 A. It's impossible to pull that hard with the
12 vacuum. It would have pop off.

13 Q. All right. Did you in any way angle the vacuum
14 extractor from side to side in terms of the baby's
15 shoulders?

16 A. No, sir.

17 Q. Okay. And then as your final comment, minimal
18 traction performed.

19 A. Yes, sir.

20 Q. Was that an afterthought or was -- why is that
21 the very last comment here rather than being indicated
22 up here when you were talking about the maneuvers and
23 the order in which they occurred?

24 A. Sir, when I'm writing that stuff it's 9 o'clock
25 that night. I just got through the delivery, a lot of

1 things running through my head, and so I'm doing the
2 best job I can writing things down.

3 Q. And minimal traction performed, that would be
4 your standard routine; is that right?

5 A. Yes, sir.

6 Q. That would be your standard protocol; is that
7 right?

8 A. Yes, sir.

9 Q. Just like the Rubins II that you say you did.

10 A. I think you're taking it out of context, sir.

11 Q. Well, you're the one who said I didn't write down
12 Rubins II even though I did it because that's my
13 standard protocol.

14 A. Right.

15 Q. So is it this -- if this is your standard
16 protocol why did you write this one and not write the
17 Rubins II?

18 A. This is important.

19 Q. And Rubins II wasn't?

20 A. Rubin II is one of the maneuver that you can do.

21 Q. Well, do you -- it's one of the maneuvers you can
22 do that you now say allowed this baby to deliver.
23 That's not important?

24 A. When you have a shoulder dystocia, there's
25 several maneuvers. The first maneuver is McRoberts

1 suprapubic. If that didn't deliver there's other
2 maneuvers you do. And I have a standard protocol that I
3 do.

4 Q. And some of the standard protocols you write down
5 and some of the standard protocols you don't. Is that
6 what you're saying?

7 A. No, sir, you're taking it out of context. I said
8 the ---

9 Q. I'm not taking it out of context if this is what
10 you've told us.

11 A. Well, I think you're playing words. I'm saying
12 that what I do is that if I need assistant or someone
13 participate in it I will write it down. If it's
14 standard protocol I don't write it down. For example, I
15 wrote here midline episiotomy performed, third-degree
16 repair. I didn't write down how I repair it because
17 it's standard protocol how I repair. Just because I
18 didn't write it down didn't mean I didn't repair her.

19 Q. I understand that. And that's what I'm trying to
20 find out. What do you write down, what do you don't?
21 Because you're the one who said I don't write down
22 standard protocols where I do it and don't need
23 assistance. And I'm just trying to understand why you
24 wrote down minimal traction performed because you did
25 that without any assistance and you're saying that's

1 your standard protocol, but didn't write down the Rubins
2 II, which you did without any assistance. And you say
3 that's your standard protocol.

4 A. Well, you're taking two different things. And
5 let me explain. First of all, let's take the shoulder
6 dystocia by itself. With the shoulder dystocia there's
7 protocol that I follow. If the protocol involved
8 assistant, such as McRoberts suprapubic, I write it
9 down. Rubin II, deliver posterior arm does not need
10 assistant, so I don't write it down.

11 Traction is important because I want to stress in
12 my mind, as I always do, use the same traction on every
13 delivery whether or not it's a regular delivery or
14 dystocia. It is more important in a dystocia case to
15 make sure you use the same traction. So I'm emphasizing
16 to myself beforehand and emphasize afterward I'm using
17 the same traction. No more than what I usually do.

18 Q. Okay. So what you're telling us is that what
19 people understand about your traction is important.
20 That's the reason you wrote it down.

21 A. This note is for me, so I just put down minimal
22 traction.

23 Q. This note is for you? This note is for the
24 entire hospital, isn't it?

25 A. Well, it's for me to recall what I did in this

1 situation.

2 Q. Well, that's one of the things, but when people
3 go and start looking at what you did in this situation,
4 that's what the note is for.

5 A. I guess you can say that.

6 Q. All right. Or is that not true? This note is
7 only for you?

8 A. No. It is part of the record, but the purpose of
9 the note is for you to know what you did.

10 Q. All right. And so when we look back, you wanted
11 to be sure that people knew that in your mind you only
12 applied minimal traction; is that right?

13 A. Well, when I wrote this note it's for me to
14 document I did minimal traction, for me to know that's
15 what I did.

16 Q. Okay. Doctor, do you know what the phrenic nerve
17 is?

18 A. I'm sorry, say it again, sir.

19 Q. Do you know what the phrenic nerve is?

20 A. It's a nerve in the diaphragm.

21 Q. And where does it start, do you know that?

22 A. I don't recall, sir.

23 Q. Is it in any way connected to C-4 and C-5?

24 A. I don't know, sir.

25 Q. You don't know that?

1 A. I don't remember that, sir.

2 Q. So you were earlier telling us about the baby's
3 oxygenation. You were explaining that when the baby is
4 in the womb it's a question about whether the heart is
5 getting adequate oxygen; is that right?

6 A. I didn't say that exactly, sir.

7 Q. All right. Well, my point is or what I really
8 want to get to is that you weren't trying to suggest
9 that the baby was breathing while in the mother's womb
10 before the baby delivered, are you?

11 A. No, sir.

12 Q. That's not what happens. What happens is that
13 oxygen comes from the mother and makes its way to the
14 placenta and then the oxygen passes through what is
15 called a membrane barrier and is then brought into the
16 baby by way of the umbilical cord which is attached to
17 that placenta; is that right?

18 A. That's a way to look at it. But basically what
19 it is, is that the baby does not actually breathe as an
20 action of take a deep breath in and out. The way the
21 baby gets its oxygen is from the mother. And the way it
22 gets oxygen through the baby's body is through the heart
23 beating and pushing that blood circulating the baby's
24 body.

25 Q. Well, for the oxygen to get to the heart it has

1 to come through the placenta through the baby's
2 umbilical cord; is that correct?

3 A. Yes, sir.

4 Q. And so one of the things that can explain why a
5 baby's heart rate will decrease is if the cord is
6 somehow compressed; is that right?

7 A. There's many factors, sir.

8 Q. But I -- but my question said that's one of the
9 ways. Do you agree that that is one of the ways that
10 the baby's heart rate will be decrease is because of
11 compression of the umbilical? Is that right?

12 A. If the baby's compressed the cord enough, yes, it
13 decreased the heart rate to the baby.

14 Q. And this notion that because that is one of the
15 ways when nurses see a lowering of the baby's heart
16 rate, like they saw in this case, they will move the
17 mother's position, as they did in this case, to see
18 whether that can relieve possible compression. They
19 can't know because they can't see it, but they can
20 suspect it and they can take action to try to relieve
21 any compression on the cord; is that right?

22 A. The movement of the mother is an increase of
23 blood supply to the uterus, to the placenta and there's
24 two scenario. If the cord is there and the baby is
25 laying on it, yes. It also be -- it could be that the

1 mom is not getting enough blood to the uterus. So by
2 moving mom it increase the blood supply to the uterus.

3 Q. Are you capable of just simply saying yes or no
4 to the question of don't nurses sometimes change the
5 mother's position in hopes of changing the problem
6 caused by cord compression?

7 A. Yes.

8 Q. All right, thank you. And that's what they did
9 in this case, isn't it?

10 A. They ---

11 Q. Before you got there. That's what the records
12 indicate.

13 A. They change the mother's position to increase the
14 blood supply to the uterus, to the placenta. Now, I
15 can't sit here and tell you whether they perceive as a
16 cord compression or anything, but it's a standard
17 protocol to increase the blood supply to the uterus.

18 Q. Are you able to just simply say yes or no to the
19 question of isn't that what the nurses did in this case
20 is that they changed the mother's position?

21 MR. LOVELL: Your Honor, I object. I think he's
22 argumentative with his question in not allowing the
23 witness to answer.

24 THE COURT: Overruled, continue.

25 MR. HENSHAW: Thank you, Your Honor.

1 BY MR. HENSHAW:

2 Q. Are you able to say simply yes or no to the
3 question of did they change the mother's position?

4 A. They did change the mother's position, yes.

5 Q. All right. They did that before you got there.

6 A. That's correct.

7 Q. So it was not on your instruction, it was
8 pursuant to a standard nursing protocol?

9 A. They would -- what they would do is, yes, they
10 can change position before I got there. They can also
11 change position when I got there and I instructed them
12 to change position because we will flip from one side to
13 the other.

14 Q. All right. And if we look at the -- I want to
15 look at the fetal heart monitor strips. Let's -- let me
16 just ask you to help us understand some things about
17 these fetal heart rate monitor strips.

18 A. That's upsidedown, sir.

19 Q. I've got it upside down?

20 A. Yes, sir.

21 Q. So this bottom section here, this is where the
22 electronic fetal heart tone monitor attempts to record
23 the mother's contractions; is that correct?

24 (Indicating.)

25 A. Yes, sir.

1 Q. And this top section here attempts to record the
2 baby's heart beat; is that right? (Indicating.)

3 A. Yes, sir.

4 Q. And on this particular strip, which is earlier,
5 but close to before you just arrived, we can see that it
6 is recording the baby's heart rate. And one of the
7 things that doctors and nurses want to look at is
8 generally what the heartbeat is so they can establish a
9 baseline; is that right?

10 A. Yes, sir.

11 Q. And in this case the baby's baseline was just
12 above 120, maybe 130, as shown by this strip?

13 A. On this strip I'd say baseline is about 130.

14 Q. All right. And although that might seem high for
15 an adult, that's about right for an unborn baby; is that
16 right?

17 A. Normal range is 110 to 160.

18 Q. All right. So there is a 50 point space that the
19 baby can fall into that's gonna be considered a normal
20 range; is that right?

21 A. Yes, sir.

22 Q. Okay. And so at about 1:30 she is at a normal
23 range at this particular point in time?

24 A. Yes, sir, compared to her baseline before, yes,
25 sir.

1 Q. All right. Now, we see these increases in the
2 heart rate. And one of the things that we do or you do
3 with the electronic fetal monitor strip is that that
4 tells you whether the baby is being responsive to
5 contractions?

6 A. That has nothing to do with baby's response to
7 contraction.

8 Q. A contraction won't cause a baby's heart rate to
9 go up and make a bump like this?

10 A. Not necessarily, sir.

11 Q. All right. So then what explains her heart rate
12 going up here?

13 A. Something caused her heart rate to go up.

14 Q. All right.

15 A. Could be she moved, she ---

16 Q. So you don't think it was the contractions?

17 A. It could be, but I can't say it's absolutely
18 hundred percent it is.

19 Q. But the fact that it went up here is not a
20 concern given this strip?

21 A. No, sir.

22 Q. Because even though it goes up, it comes back
23 down and stays relatively close to the baseline; is that
24 right?

25 A. Yes, sir.

1 Q. This is a continuation of the strip. Baby's
2 still close to the baseline but has this elevation here
3 that goes up to 160; is that right?

4 A. I believe so.

5 Q. All right. Nurses aren't calling you because
6 they're concerned about this increase in heart rate, are
7 they?

8 A. No, sir.

9 Q. And she comes back down and that strip continues
10 on relatively close to 130 or so or within the normal
11 range?

12 A. Yes, sir.

13 Q. Continuation of the strip. Baby's heart rate is
14 still at baseline?

15 A. Yes, sir. But you know this is not a lot of
16 movement up and down so it's stable.

17 Q. Not a lot of movement up and down. But as you
18 said, that's not necessarily -- I mean, you wouldn't
19 necessarily expect the baby's heart rate to go up and
20 down because of these contractions. These are
21 contractions every time you see on the lower panels,
22 that represents a contraction, that upward -- that
23 mountain looking thing; is that right?

24 A. Yes. What you pointed at is a contraction, yes,
25 sir.

1 Q. That's a contraction. That's a contraction.
2 That's a contraction. (Indicating.) There's three
3 contractions here?

4 A. That just monitor what the monitor perceive is
5 contraction. It could be mom, it could be a
6 contraction, it could be mom pushing, it could be mom
7 moving, getting up moving. It could be mom laying down
8 will cause that elevation.

9 Q. All right. And that's the reason I said earlier
10 this is where the electronic fetal heart tone monitor is
11 attempting to monitor the mother's contractions.

12 A. Yes, sir.

13 Q. I didn't say that it does, but it's attempting to
14 do that.

15 A. To its best ability, yes, sir.

16 Q. Okay.

17 A. Could I go back? With that, I mean you point out
18 130. You know, when you have a healthy baby, the heart
19 rate does not stay flat. It goes up, return baseline.
20 Goes up, return baseline.

21 Q. Well, let's continue on with these monitor
22 strips. And this is a continuation of that. And it's
23 pretty much the same as the one we just showed where
24 there's not a lot of change in the heart rate. It's
25 still right there about 130; is that right?

1 A. It is about 130. Not a lot of what we call
2 variability. So not a lot of movement.

3 Q. And you don't -- and you prefer to see
4 variability, but you don't always see it.

5 A. We would like to see variability in acceleration.

6 Q. Right. But you don't always see it.

7 A. It depends on the baby.

8 Q. Right.

9 A. The situation.

10 Q. Now, some other things that would be helpful to
11 understand, Doctor, is what these segments are that are
12 on the fetal heart tone monitor strip. Each of these
13 segments represent this column right here, if I just go
14 straight down inside the small rectangular blocks, that
15 represents ten seconds? (Indicating.)

16 A. Yes, sir.

17 Q. And so when you're actually looking at the strips
18 there is additional lines, and if you take each of these
19 segments they represent one minute?

20 A. Six of those blocks represent one minute.

21 Q. Six of those blocks represent one minute. And so
22 a little bit darker line if you can get close up to the
23 strip so that you can see one minute, the next minute,
24 the next minute. But six of these columns represents
25 one minute?

1 A. Yes, sir.

2 Q. Okay. And the same thing in regard to the
3 mother. We can see how many contractions she's having a
4 minute; is that right?

5 A. Yes, sir.

6 Q. Now, on this situation here where, as you said,
7 there does not appear to be much variability or hardly
8 any variability at all, were the nurses calling you?

9 A. It depends on the situation before that strip.
10 So I don't -- I mean, in this patient they did not call
11 me.

12 Q. That's all I'm asking you is did the nurses call
13 you in regard to what this lack of variability they were
14 seeing on the strip?

15 A. I don't know what time that was, sir, so I
16 couldn't tell you.

17 Q. Well, you know whether they called you or not in
18 regard to lack of variability, don't you?

19 A. I didn't get there until between five and six, so
20 I can't tell what time that was.

21 Q. Oh, I see. Okay. Well, I think we'll get to a
22 strip that helps us identify the time. But don't the
23 nurses usually note on these strips if a doctor is
24 responding or coming into the room?

25 A. They're supposed to put down a note. Sometimes

1 they may forget.

2 Q. Okay. So the two doctors that they could have
3 put down would either be you or Dr. Fowler. And there's
4 no note that Dr. Fowler was called in regards to this
5 situation, is there?

6 A. I don't know whether Dr. Fowler was called or
7 not. I don't know.

8 Q. Did Dr. Fowler when you say you communicated with
9 her before you took over coverage, did she tell you I'm
10 concerned about the lack of variability on these strips?

11 A. She may have already evaluated the patient and
12 deemed that was okay.

13 Q. I didn't ask that, Doctor. I asked you did she
14 tell you that she was concerned about the variability on
15 these strips?

16 A. At the time of checkout she said she was fine.

17 Q. Okay. This is the next strip and variability is
18 returning.

19 A. Somewhat. Still minimal, but somewhat.

20 Q. But it is returning; is that right?

21 A. I'd say somewhat.

22 Q. Okay. And the next strip, this is all in real
23 world a continuous strip that gets fed out of the
24 machine; is that right?

25 A. Yes, sir.

1 Q. Variability returning here?

2 A. Yes, sir.

3 Q. Baby is still at the baseline?

4 A. Yes, sir.

5 Q. And because the screen isn't so good I'll show
6 you, but there's a remark made by the nurse. Do you see
7 that here?

8 A. Patient to the left side.

9 Q. All right. So they turned the mother over to her
10 left side?

11 A. That's what it's saying.

12 Q. Do you know why they did that?

13 A. It could be for a number of reasons. It could be
14 that she had an epidural, they want to turn her on her
15 side make sure she's comfortable. And an epidural can
16 be on one side or the other.

17 Q. All right. And do you see a time on there yet,
18 Doctor?

19 A. (Witness shakes head back and forth.)

20 Q. No?

21 A. I do, but I can't read it.

22 Q. Okay. We just don't have good copies?

23 A. We don't have good eyes.

24 Q. Okay. I know I don't. But right here patient
25 turned to left side, right? (Indicating.) That's the

1 remark.

2 A. That's the remark that was made.

3 Q. And then the next strip is baby still at
4 baseline?

5 A. The front part, yes. I can't tell you about the
6 latter part of the strip.

7 Q. Now, this is -- is this a problem in terms of the
8 ability of the machine to monitor the heart when you get
9 an art -- well, is that just an artifact or is that a
10 true return of the baby's heart rate when it comes up
11 there like that?

12 A. Artifact.

13 Q. Artifact?

14 A. I guess. I'm not sure. I'd have to look at the
15 context to see.

16 Q. So somewhere or another the machine is not
17 getting a clear signal from the baby's heart here; is
18 that right?

19 A. You have to be there to listen to whether or not
20 the heartbeat really went up or a machine had trouble
21 picking it up.

22 Q. Okay.

23 A. It's trying to track the baby's heartbeat.

24 Q. But one of the things that can happen is that the
25 machine will lose it's signal for some reason.

1 A. Yes, it can.

2 Q. And there's a number of reasons why that can
3 occur.

4 A. Yes, sir.

5 Q. Now, was this an external monitor or an internal
6 monitor?

7 A. I believe this was external.

8 Q. All right. That means the mother was wearing a
9 belt around her abdomen?

10 A. I believe, yes, sir.

11 Q. And an internal monitor would actually put a
12 sensor on the baby's head if that could be done?

13 A. Yes, sir.

14 Q. But here mother's wearing a belt?

15 A. Yes, sir.

16 Q. And so the belt can move, that's one of the
17 things that can happen?

18 A. One of the possibilities that the monitor itself
19 could move.

20 Q. The baby can get in a position where the sensor's
21 not able to clearly pick up the baby's heartbeat. Is
22 that another way that you can end up losing the signal?

23 A. The baby can move position and shift, yes, sir.

24 Q. All right. And because -- and, as you say, you
25 have to be there. But if the nurses thought that this

1 was a serious problem with the baby, they should be
2 calling the doctors?

3 A. That's correct.

4 Q. And they didn't call the doctors here as far as
5 you know, did they?

6 A. I don't know.

7 Q. You don't have any reason to believe you got
8 called, do you?

9 A. I don't recall.

10 Q. And so here's the next continuation. Is the
11 machine having trouble picking up the baby's heartbeat?

12 A. Possibly.

13 Q. Okay. Here is the next strip. And somebody has
14 done us the favor of actually reading the time that is
15 on this strip. 1932 hundred hours military time, at
16 least that's what this purports to say; is that right?

17 A. If that's what's written there.

18 Q. That would be 7:32?

19 A. Yes, sir.

20 Q. And had you taken over for Dr. Fowler by
21 7:32 p.m.?

22 A. Yes, sir.

23 Q. And here is this a pretty reasonable strip in
24 terms of the collection of data by the fetal heart tone
25 monitor?

1 A. Yes, sir.

2 Q. Is the baby still at baseline?

3 A. 130s, yes, sir.

4 Q. And these are -- do you have reason to believe
5 that these are or are not contractions, these mountains
6 and hills that are in the lower graft?

7 A. It's hard to tell, but it's probably
8 contractions.

9 Q. Next continuation of that strip and baby is still
10 at baseline?

11 A. 130s, not a lot of variability.

12 Q. Not a lot of variability. Is this probably an
13 indication that mother's contractions are increasing?

14 A. Just telling that she's contracting.

15 Q. This indicates that right here the mother was
16 given lidocaine. Why is that? I can show you. I can
17 hand the strip to you, Doctor, if you need to look at
18 it.

19 A. It said something about two percent lidocaine.
20 I'm assuming that was for her epidural.

21 Q. Okay. And this is really just a matter of
22 minutes after the 1932 reading. And if that's correct,
23 this is somewhere between 7:32 and 7:50?

24 A. Without the two strip I can't confirm or deny it,
25 sir. I don't know. I will take your word on it.

1 Q. All right, sir. Here's the next strip. And,
2 again, someone has done us the favor of indicating the
3 time at 1955; is that right?

4 A. That's what the writing says, sir.

5 Q. That would be 7:55 p.m., correct?

6 A. Yes, sir.

7 Q. And this part of the strip the baby is still at
8 baseline?

9 A. Yes, sir. 130 with a little variability, yes,
10 sir.

11 Q. And there's variability in this particular part
12 of the strip; is that right?

13 A. Still not great but, yes, still some variability.

14 Q. So then we have this strip, which is the next
15 portion of the continuation. And the baby is continuing
16 at baseline in terms of its heart rate?

17 A. The first half of the strip, yes, sir.

18 Q. Okay. Well, what about the second half, are we
19 losing signal here?

20 A. Near the latter part of the strip you can see
21 right here somewhere in the 90s and this is decreasing
22 right here.

23 Q. Okay.

24 A. So this is down to 90.

25 Q. Okay. And then over here is that a signal that

1 gives an indication that the baby's heart rate is in the
2 160 area?

3 A. Not necessarily because when you have a heart
4 rate low, let's say, the machine sometime misperceive it
5 and double it to think that's the baby's heart rate. So
6 sometime if you have a true heart rate, let's say in the
7 60s, the machine can double it and think that it's at
8 120 until it can identify that's not correct.

9 Q. Okay. And if this is correct, this is around
10 8:04; is that right?

11 A. That's what it says, sir.

12 Q. So here a continuation of the strip at 8:07 p.m.,
13 we have the baby's heart rate again. According to the
14 machine it was signals in the range of, I think, that's
15 actually a 180?

16 A. I wasn't there, so I'm not sure that's a true 180
17 or that's a double of 90, times two that's 180.

18 Q. All right. Well, where's the 90? Is this the 90
19 right here? (Indicating.)

20 A. Yes, sir, there. (Indicating.)

21 Q. And so if we come across, the baby's heart rate
22 is at 90 for one, two, three, four, five, six minutes or
23 so, close to six minutes if you go by this?

24 A. I can't see the time, so I'm gonna take your word
25 you counted those right.

1 Q. And then it goes back up to around 211?

2 A. Well, 2011, this is when I arrived and so my hand
3 is inside the vagina doing the scalp stimulation. So
4 that's part creating it to go up.

5 Q. So are you saying then that the baby responded to
6 the stimulation of your hand while you're doing the
7 vaginal exam, most probably?

8 A. Most probably.

9 Q. And that's a good sign that the baby is
10 responding in that way; is that right?

11 A. It is a sign.

12 Q. Well, it's a good sign. I mean that's not
13 considered to be detrimental to the baby, that's
14 considered to be an indication that the baby has the
15 ability to respond to that type of stimulation.

16 A. You still have the tape. You can't just take
17 that one statement and say, okay, he respond to scalp
18 stimulation, you're fine, leave the baby alone like
19 that. You have to look at the entire picture. As I
20 stated before, you have to look at the entire picture.

21 Q. Right. And, Doctor, do you understand that there
22 is no criticism of you in this case of your
23 interpretation of the strips and what you needed to do?

24 A. Well, sir, I just want to make sure because
25 you're stating one event here. I want to make sure we

1 look at the entire picture.

2 Q. I understand. But do you understand that in
3 terms of this entire --

4 (Whereupon, there was a crash in the courtroom.)

5 MR. HENSHAW: Did somebody break? I guess we're
6 all right.

7 BY MR. HENSHAW:

8 Q. But really, seriously, back to my question,
9 because I think it's important to know whether you
10 understand that there has been no criticism of what you
11 did during this phase of the delivery.

12 A. Yes, sir.

13 Q. That you interpreted that there needed to be some
14 action taken in response to the lowering of this baby's
15 heart rate. Do you understand that there's no criticism
16 of that?

17 A. Yes, sir.

18 Q. Do you understand that there is no criticism of
19 your decision to apply the vacuum extractor and pull
20 twice in order to assist positioning the baby for
21 delivery?

22 A. Yes, sir. But you also -- I understand. But
23 like I said, you have to take this entire picture into
24 consideration for the latter part.

25 Q. Okay. And taking this entire picture, there is

1 no -- do you understand there is no criticism of what
2 was being done by either the nurses or by you during
3 this phase?

4 A. Yes, sir. But I was trying to explain it because
5 it's not as simple as one piece of domino. There are
6 multiple pieces that goes into the final picture.

7 Q. Okay. And so -- but looking at this, the baby
8 does respond apparently to your stimulation, but that
9 would be your interpretation of what's going on here?

10 A. Somewhat at this point, yes, sir.

11 Q. All right. And then the final strip that we have
12 is this strip. I believe this is the final strip. And
13 so the baby is -- and let me show you, Doctor, so you
14 can see it because this is hard to read. But if you
15 look at 2007 it says oxytocin. Is that -- oxytocin is
16 also called Pitocin, P-I-T, as opposed to oxy, so...

17 A. Yes, sir, it's the same thing.

18 Q. It's the same thing. And oxytocin or Pitocin is
19 used to induce contractions in an expectant mother?

20 A. It can be either used to induce it or augment the
21 string of contraction.

22 Q. All right. But it's a drug that has an effect on
23 the uterus?

24 A. Yes, sir.

25 Q. All right. And when it has an effect, if it's

1 being effective, one of the things that it's expected to
2 do is make the contractions more intense?

3 A. It can do that and also increase the frequency of
4 the contraction.

5 Q. All right.

6 A. So the idea of make you use contraction.

7 Q. So the nurses or somebody, if you were there at
8 2011 and this is 2007 -- I mean, if you were there at
9 8:11 and this is marked at 8:07, this is where the
10 nurses decided using their nursing judgment that they're
11 allowed to use, that the Pitocin should be cut off; is
12 that right?

13 A. Well, what's going on is the heart tone is down,
14 they're not sure what's causing it, so when that happens
15 they go ahead and do standard protocol.

16 Q. All right. And that standard protocol was to
17 stop the Pitocin?

18 A. That's one of the standard protocol.

19 Q. All right. So the answer to my question as to
20 whether or not that the nurses stopped the Pitocin at
21 8:07 is yes?

22 A. This nurse stopped the Pitocin at that time, yes,
23 sir.

24 Q. So the answer is yes?

25 A. Yes, sir.

1 Q. Thank you. They didn't think they needed to call
2 you at that point, did they?

3 A. I can't tell you what she's thinking.

4 Q. Well, do you recall getting a -- do you remember
5 getting a call from a nurse at any time and saying,
6 Doctor, we think you need to come in here and evaluate
7 this patient?

8 A. I don't remember.

9 Q. Well, you didn't document that, did you?

10 A. I said I don't remember if they called me.

11 Q. All right. Well, is the reason you don't
12 remember is because you did not document it?

13 A. I don't document every time a nurse calls me,
14 sir.

15 Q. Okay. I understand that.

16 A. Yes, sir.

17 Q. But if a nurse -- but you have no way of knowing
18 in terms of your recollection because you did not write
19 it down?

20 A. I know that when a patient -- whenever a patient
21 is completely pushing I am there at the hospital.

22 Q. Okay, I understand that. You are in the locality
23 so that you can come if a nurse calls you?

24 A. Yes, sir.

25 Q. But you're saying you don't remember?

1 A. Yes, sir.

2 Q. And don't you agree that the reason you cannot
3 remember is because there's no documentation indicating
4 that you were called at this time?

5 A. I don't think I was called.

6 Q. Okay. So the nurse discontinues the Pitocin.
7 You come in at 2000 -- at 8:11 and that is documented
8 that you arrived at 8:11?

9 A. Yes, sir.

10 Q. And do you recall that you were called at that
11 time because the nurse had determined that the cervix
12 was fully dilated and the baby was crowning?

13 A. No, sir.

14 Q. Why did you come at 8:11 then?

15 A. Well, you can see the strip, the heart tone is in
16 the 90s. So I'm on labor and delivery and you see a
17 monitor.

18 Q. So you were in the hospital where you could see
19 the monitor?

20 A. Yes, sir, I was in labor and delivery.

21 Q. Okay. And so you saw a monitor with Ms. Flowers
22 electronic monitoring system?

23 A. The monitor has pretty much every patient who's
24 on labor and delivery.

25 Q. Okay.

1 A. And so if there's an abnormality, they use a
2 little red bar that goes up near that strip.

3 Q. So you saw that and you responded to the monitor,
4 not a nurse?

5 A. That's correct, sir.

6 Q. And that's when you went to Ms. Flowers' room and
7 came in at 8:11?

8 A. Yes, sir. I can't tell you whether a nurse was
9 about to call me or not. I don't know. Only thing I
10 know is I arrived at 2011.

11 Q. And did you immediately go to make a vaginal
12 exam?

13 A. When you get there you have to see what's going
14 on, so you have to review the strip and what's going on
15 beforehand. You have to look at the vitals, is there a
16 blood pressure. You have to look what's going on, then
17 you go and examine the patient.

18 Q. All right. Before you went and did that, did you
19 go up to -- and I'm not saying you should have, I'm just
20 trying to find out the sequence of events. Did you go
21 up to Ms. Flowers and say anything like hello, I'm
22 Dr. Giep, I'm taking over for Dr. Fowler, or did you
23 immediately go to assessing the patient?

24 A. When the heart tone is in the 90s, in an
25 emergency situation like that, I will go in, look at the

1 strip, get the nurse to give me a quick what's going on,
2 then I will go and check the patient.

3 Q. All right. So there wasn't any friendly colloquy
4 between you and the family, it's let's go straight to
5 business here and deal with these issues that seem to be
6 on the strip?

7 A. Yes, sir.

8 Q. Okay. So that's something that you're trained to
9 do; is that right?

10 A. I don't understand the question.

11 Q. Well, I guess what I'm asking about is your
12 experience, training and knowledge. Now that you are --
13 you have this, what you call, an emergency, you're ready
14 for it because you've been trained to be ready for it;
15 is that right?

16 A. You've been trained for it, yes, sir.

17 Q. All right. Starting in medical school, followed
18 by residency, plus the fact that by 2008 this was not
19 your first time that you're dealing with a mother who
20 has a baby with a heart rate in the 90s.

21 A. I mean, whenever you're in an emergency
22 situation, regardless, I mean, you treat it as an
23 emergency. It never becomes routine.

24 Q. I understand that, Doctor. I'm just trying to
25 establish whether this was your first go round with a

1 patient having the issue of a baby in the 90 heart rate
2 range or whether this is something you had seen before.

3 A. Seen before, sir.

4 Q. Okay. And so you knew what decisions or options
5 you had available to you at that time?

6 A. Yes, sir.

7 Q. And you explained that to us. That in your
8 training you knew that you had two options. One was to
9 do a cesarian section or the other one was to vacuum
10 assist this delivery. But either way what you wanted to
11 do is get the baby out?

12 A. What I said beforehand is that in OB it's very
13 simple. You have two questions, does the baby need to
14 come out, yes or no? Second question, how do you get
15 the baby out, c-section or vaginal?

16 Q. All right. So the answer to my question is just,
17 yes, that those were your two options?

18 A. Yes, sir.

19 Q. All right. And you do understand there has been
20 no criticism of the decision you made to use the vacuum
21 extractor as one of your options?

22 A. Yes, sir.

23 Q. You understand that?

24 A. Yes, sir.

25 Q. And so -- and you've done this before. As you've

1 indicated, you've never had a baby before where you
2 exercised -- where you in a shoulder dystocia that has
3 had permanent brachial plexus injury. So I assume that
4 at any time that you've used the vacuum extractor you've
5 not had before this a baby that ended up with permanent
6 brachial plexus injury; is that right?

7 A. Yes, that's correct.

8 Q. And there are injuries that can occur with a
9 vacuum extractor if the doctor doesn't use it properly.
10 Do you understand that?

11 A. Yes, sir.

12 Q. But with your training and experience and the
13 knowledge that you brought there allowed you to use the
14 vacuum extractor and there's no reason, nobody has
15 suggested that that caused injury to this particular
16 baby. Do you understand that?

17 A. Yes, sir.

18 Q. The -- after the vacuum extractor -- and if this
19 is the last strip, this is the one that actually takes
20 us up to the baby's delivery at 8:20; is that right?

21 A. Yes, sir.

22 Q. So this is -- here's the time right here. Can't
23 read it on this screen, but it says 20/20. So right in
24 here is where the baby's actually delivered. And we
25 have tracings immediately before that. And are these

1 artifacts or are these actual signals from the baby's
2 heart indicating where the baby's at? (Indicating.)

3 A. That's part of the signals.

4 Q. That is probably signals or not?

5 A. Probably, sir.

6 Q. And if they are signals, then it indicates that
7 the baby's heart rate just before birth, if this is the
8 birth and we count back 10, 20, 30, 40, 50, and this
9 would be one minute before the baby's born, this would
10 mean that the baby's heart rate is 120 at that time?

11 A. Sir, I can't -- I mean, you're taking this one
12 spot right here so, yes, it's 120. But you have to take
13 a look at the overall picture. So if you ask me is this
14 120 at that exact spot I'd say yes. If you ask me
15 what's going on here, that's a different story.

16 Q. Well, I'm just trying to understand, you know, at
17 the various segments what the information or data that
18 we have available was, in fact, going on. And I
19 understand that you're saying that you felt like you
20 needed to move the delivery along because there were
21 segments where the baby's heart rate was down in the
22 90s. But one minute before the baby was born it was
23 back up to where it had been before that problem had
24 occurred.

25 A. I disagree with that statement because if I can

1 explain, is that as I explained before, you cannot take
2 this one picture in time and extrapolate, you can't.
3 You're doing this in live time. So first of all, you
4 don't know what's gonna happen after this. You don't
5 know if the heart rate is gonna go down. You don't know
6 what's going on. The only thing you can base it on is
7 what happened in the past. In the past, the last 10
8 minutes she didn't have a decent ratio. Her heart tone
9 has been down. So you can't really make a fair
10 statement and say, well, if you look at here it's at 120
11 she's gonna be fine. You can't do that.

12 Q. Okay. And, Doctor, we spent a lot of time on
13 this, but this is -- do you understand that it's not the
14 decision -- I mean, the reason that we're spending time
15 on this is not the decisions you made because the baby's
16 heart rate was at 90, it's because your lawyer is trying
17 to claim --

18 MR. LOVELL: Objection, Your Honor.

19 MR. HENSHAW: -- that the --

20 THE COURT: Just a minute. Just a minute.

21 MR. HENSHAW: That because the baby's heart rate
22 at times fell to 90, that this baby was so weak that for
23 some other unexplainable reason the baby had rupture of
24 C-5, C-6, C-7 and stretching of C-8 causing an aroma
25 that had to be operated on to release C-8. Do you

1 understand that it's about the causation of what
2 happened here that we're spending so much time on this
3 and not the decisions that you made?

4 THE COURT: Okay. That's the end of the
5 question. Now, what's your objection?

6 MR. LOVELL: My objection, Your Honor, one,
7 that's testimony from counsel that's not the evidence in
8 this case. Two, the issues he's talking about goes to
9 medical emergencies that existed at the time of these
10 strips and the standard of care that's required by my
11 doctor. So that's a misstatement of the scenario of
12 this case and it's improper for him to make that
13 argument to the jury because it's not right.

14 THE COURT: All right. Let's confine your
15 examination to questions as opposed to your view of
16 things.

17 MR. HENSHAW: All right, sir.

18 BY MR. HENSHAW:

19 Q. All right. Doctor, after the baby was born
20 assessments were done as to the baby's status and that's
21 done by way of an apgar scoring system; is that correct?

22 A. Yes, sir.

23 Q. And so you handed the baby off to the neonatal
24 team; is that right?

25 A. For this delivery, yes, sir.

1 Q. You did that immediately?

2 A. Yes, sir.

3 Q. And the neonatal team began to work on the baby
4 right there in the labor and delivery room; is that
5 right?

6 A. They would take care of the baby right then,
7 yeah.

8 Q. And then shortly after that they left to take the
9 baby down to the NIC unit?

10 A. I would assume so, yes, sir.

11 Q. All right. But while they were still there in
12 the labor and delivery room, they made an assessment
13 using the apgar scoring system; is that right?

14 A. I would assume so.

15 Q. You don't participate in that?

16 A. I was busy taking care of the mom, sir, so I am
17 not over it.

18 Q. Is the answer to the question you don't
19 participate in that no, I don't?

20 A. I don't participate in it.

21 Q. All right. But you could -- you immediately
22 realized that there was something wrong with the baby's
23 arm, didn't you?

24 A. Well, you know, when I deliver the baby, the baby
25 was basically no tone. So I can't sit here and say I

1 know 100 percent. I said, well, it looks like it but,
2 you know, the baby had no tone, no movement, the arm was
3 by its side like that, so I can't sit here and say yes,
4 no. I said it looks like it, but I can't say
5 definitively yes.

6 Q. Are you saying that the baby was flaccid?

7 A. Well, the baby came out, you know, with the hands
8 like this and not responding. (Indicating.) And so I
9 handed off the baby quick to NICU.

10 Q. When you say the baby had no tone are you saying
11 that the baby was flaccid?

12 A. I don't understand your definition of flaccid.
13 The only thing I can tell you is that the baby was like
14 this, no muscle tone. The arms are out, the legs are
15 out. (Indicating.)

16 Q. Doctor, this is the summary of the delivery room
17 records.

18 THE COURT: Be careful of the microphone, please.

19 THE WITNESS: Yes, sir, sorry.

20 BY MR. HENSHAW:

21 Q. And this is the apgar scoring system that was
22 used by the neonatal team to score what this baby looked
23 at. And what they do is they look at each of these
24 things first at one minute and then again at minutes.
25 Do you understand that?

1 A. Yes, sir.

2 Q. And if we look at the apgar scoring system
3 related to Ashley F. , this is the -- the first box
4 is the heart rate. And the options that they can score
5 on observing the baby are absent, slow, in the range of
6 100 or less, and then greater than 100. And if the baby
7 is greater than 100, the baby gets a two. If it's slow
8 the baby gets a one. And if there's no heart rate, then
9 it's a zero. And they scored this baby a two. Do you
10 understand that?

11 A. This is just a rough estimate of listing the
12 heart rate.

13 Q. Well, is there any reason to believe that it's
14 any less accurate than a fetal heart tone monitor strip
15 that's externally monitored by way of the mother wearing
16 a belt and trying to pick up heart tones while the
17 baby's still in utero?

18 A. This is done manually, so they listen and they
19 just estimate. So it's not hook up to a machine.

20 Q. Well, it's kind of like -- isn't it exactly like
21 when you go to the hospital emergency room and they say
22 we want to listen to your heart with a stethoscope or
23 they take your pulse and they count it. They have, they
24 have methods of trying to determine what the pulse rate
25 is.

1 A. But they have machines to record that.

2 Q. Well, they also do it manually, don't they?

3 A. Well, you have to have a watch to count it.

4 Q. Well, is there any reason that they didn't do all
5 that here?

6 A. I don't know.

7 Q. Well, for purposes of this baby's hospital
8 record, that hospital's neonatal team that you called in
9 to work on this baby said at one minute this baby had a
10 heart rate greater than 100; isn't that correct?

11 A. Yes, sir.

12 Q. And it stayed there until the five minute came.
13 And they did it again and it was still greater than 100;
14 isn't that right?

15 A. Yes, sir.

16 Q. So then the next part of the chart, again it's
17 difficult to read, is respiratory effort. And the
18 options were absent, slow or irregular, and good or
19 crying and the team gave the baby a one, which means
20 that they were slow or irregular in terms of the
21 breathing pattern. And at five minutes it was at two.
22 Do you understand that?

23 A. Yes, sir.

24 Q. And then we have next, muscle tone. And they
25 would give -- they had the option of giving the baby a

1 zero if the baby was flaccid. So you don't understand
2 what the term flaccid means even though that's one of
3 the ways that babies could score as soon as they're
4 born?

5 A. Well, sir, this is assigned by the NICU team. So
6 for me, as I hold a baby, I just didn't feel that the
7 baby, you know, it was kind of limp. So to me limp is
8 limp.

9 Q. My question is, Doctor, you said a few minutes
10 ago that you did not understand how to define the word
11 flaccid. That was not a word that you understood. And
12 so I'm asking you now, do you not understand the word
13 flaccid in the context in which apgar scores are made?

14 A. Sir, this is based on the judgment, the
15 observation of the NICU nurse. So you may have one
16 nurse who say the baby is score one. You may have a
17 nurse score the baby zero. I can't sit here and tell
18 you her thought process. The only thing I can tell you
19 is the baby was limp.

20 Q. I understand that process, Doctor. I'm asking
21 you about your knowledge. Do you understand the word
22 flaccid?

23 A. I mean, if you're talking about flaccid as in
24 limp, okay, I'll grant that to you.

25 Q. All right, sir. But they didn't score the baby

1 as being flaccid. Or if it means limp, they didn't
2 score the baby as limp. They gave it baby a one. And
3 one means some flexion of extremities. Do you
4 understand that?

5 A. I understand some flexion of extremity, yes, sir.

6 Q. Okay. And, of course, with a brachial plexus
7 injury that's not going to be, not going to move, is it?

8 A. But you have ---

9 Q. Not a severe one.

10 A. You have other extremities, sir.

11 Q. Okay. And those are the ones that could give you
12 some flexion; isn't that right?

13 A. Well, you know, I was not there to sit here and
14 define what that nurse meant by some flexion. So, you
15 know, if you take a baby and you put out, you have two
16 or three observers and it be close between flaccid and
17 some flexion, some would say flaccid, some would say
18 flexion. So the only thing I can go with what the
19 record said.

20 Q. Now, the next category that was scored was reflex
21 irritability. Do you know what that means, reflex
22 irritability?

23 A. They just checked the baby respond crying.

24 Q. And they could have scored no response or they
25 could have scored a grimace or they could have scored a

1 cry. And in this case they scored the baby as having a
2 grimace at one minute, but then a cry at two minutes; is
3 that right?

4 A. That's what they said.

5 Q. Okay. And then we get down to color. And the
6 possible scores are blue or pale or the body is pink and
7 the extremities are blue or the baby is entirely pink.
8 And on this scoring system they gave a zero at one
9 minute and a zero at five minutes. In other words,
10 they're saying the baby stayed blue; is that right? Is
11 that the way that should be interpreted?

12 A. That's what they're saying, yes, sir.

13 Q. And then they took the baby away.

14 A. Yes, sir.

15 Q. To go to the NICU?

16 A. Yes, sir.

17 Q. And so did Nurse Phillips fill this out? Is that
18 Natalie Phillips who is the R.N. who signed off on all
19 of this?

20 A. That's what it said, sir.

21 Q. So she took this down. And she was told these
22 things by the neonatal team and then she put them down?

23 A. I would assume so.

24 Q. Did you ever go to the NICU to see the baby
25 yourself?

1 A. Yes, sir.

2 Q. Did you talk to the doctors there?

3 A. Yes, sir.

4 Q. And is that where you learned about the clinic in
5 Charlotte that can treat brachial plexus injuries?

6 A. I believe either they told me or they said the
7 physical therapist or occupational therapist told me.

8 THE COURT: Mr. Hensahw, can I see you and Lovell
9 just a minute?

10 MR. HENSHAW: Yes, sir.

11 (Whereupon, an off-the-record bench conference
12 occurred.)

13 THE COURT: Ladies and gentlemen, there's going
14 to be some additional examination. I think it's a good
15 time to break for lunch so we can take that break. You
16 are gonna be excused right now. I'll ask you to please
17 report to your jury room at 2:15, 2:15 this afternoon.
18 Don't discuss the case in the meantime.

19 (Whereupon, the jury leaves the courtroom at
20 12:59 p.m.)

21 THE COURT: You may step down from the witness
22 stand, but do not discuss your testimony during the
23 lunch recess.

24 THE WITNESS: Yes, sir.

25 THE COURT: Court is in recess until 2:15 p.m.

1 (Whereupon, a lunch recess was had from 1:01 p.m.
2 - 2:16 p.m.)

3 THE COURT: Any matters to address before the
4 jury is brought in?

5 MR. HENSHAW: Not from the Plaintiff, Your Honor.

6 THE COURT: Bring them in.

7 (Whereupon, jury entered the courtroom at 2:17
8 p.m.)

9 Good afternoon. As you know, when we recessed
10 the witness was undergoing examination when we broke it
11 up, so we'll continue with that examination this
12 afternoon. Mr. Henshaw.

13 MR. HENSHAW: Thank you, Your Honor.

14 BY MR. HENSHAW:

15 Q. Dr. Giep, if you recall that when we broke we had
16 discussed that you did go see the baby in the NICU and
17 you spoke to people there and that's where you probably
18 learned about the doctors in Charlotte who could help
19 with brachial plexus. Is that ---

20 A. Yes, sir.

21 Q. Okay. Doctor, did you -- do you regularly talk
22 with members of the NICU team?

23 A. If there's something going on with the baby, I
24 always check on the baby and ask them what's going on.

25 Q. And is the NICU team the same as the neonatal

1 team that came in and did the resuscitation?

2 A. There's a lot of nurses and people in there, so I
3 can't tell you the exact team. But I talked to the
4 people in the NICU.

5 Q. All right. And did -- was the doctors that you
6 talked to, did they essentially take over the care of
7 the baby from that point on?

8 A. Yes, sir.

9 Q. And the baby stayed -- if the baby stayed in the
10 hospital for the next two-and-a-half weeks, they were
11 the ones that were responsible for managing the baby's
12 care during that time; is that right?

13 A. Yes, sir.

14 Q. Okay. But did you know that in addition to the
15 labor and delivery team's record, which includes the
16 apgar scoring that was signed by Natalie Phillips, in
17 terms of the apgar scoring, the neonatal team also had
18 its own form.

19 A. I would assume, sir. I didn't know that for
20 sure.

21 Q. And now Ms. Phillips she was part of the labor
22 and delivery team; is that right?

23 A. Yes, sir.

24 Q. Okay. And she would not have done the apgar
25 scoring herself, would she?

1 A. No, sir, not in this case.

2 Q. Okay. In this case it would have had to be
3 members of the neonatal resuscitation team?

4 A. Yes, sir.

5 Q. Okay. Doctor, let me show you what we put into
6 evidence as Plaintiff's Exhibit 9. Have you seen this
7 form before?

8 A. Not really, sir.

9 Q. All right. Well, do you realize that on this
10 form there is also scoring of the heart rate, of the
11 respiratory effort, the color, the muscle tone and
12 reflex for a combination of the apgar score? Do you see
13 that?

14 A. Yes, I see that.

15 Q. And if the first one was done, again, recalling
16 that the birth was at 8:20 p.m. and so the first scoring
17 was done one minute after birth, which is the standard
18 way that apgars are scored; is that right?

19 A. Yes, sir.

20 Q. And so the heart rate was checked. And if we go
21 down to the key, if there's a check that means normal,
22 doesn't it?

23 A. That's what it says, sir.

24 Q. And in this case it was checked both at one
25 minute after birth and at 8:26, which is five minutes

1 after birth, it was checked, right?

2 A. That's what they checked, sir.

3 Q. So the respiratory effort is marked down as a
4 minus one. And that is both at the one minute and
5 five-minute scoring periods; is that correct?

6 A. That's what it looks like, sir.

7 Q. And the color is marked down as minus two at both
8 the one-minute and five-minute scoring periods; is that
9 right?

10 A. Yes, sir.

11 Q. And muscle tone is minus two here, but it is
12 checked as being normal at five minutes; is that right?

13 A. That's what it said on this paper, sir.

14 Q. All right. And reflexes are checked as being
15 normal. And the total apgar score by the team that
16 resuscitated the baby is five and seven; is that right?

17 A. That's what it said here, sir.

18 Q. All right. So do you realize that there is a
19 difference in terms of the scoring and between what Ms.
20 Phillips put down, who did not actually do the scoring
21 but simply put down what she was told, and the team that
22 actually did the scoring?

23 A. I can't explain it. That's between Nurse
24 Phillips and the NICU.

25 Q. Okay. Now, a -- do you agree that a continuing

1 problem with the respiratory effort as indicated here,
2 as not being normal at one or at five minutes, can
3 contribute to the baby being blue in color both at one
4 and five minutes?

5 A. Sir, I'm not a neonatologist, I'm not a
6 pediatrician, so I mean I can't make that exact
7 statement.

8 Q. You can't make that statement?

9 A. I mean, I can tell you respiratory efforts minus
10 one and they got color as minus two, but I can't sit
11 here and tell you as an expert.

12 Q. All right. Were you aware that the resuscitating
13 team that the neonatal team that came in, within about
14 20 minutes after the baby was born sent the baby down
15 for x-rays of the left arm and the chest?

16 A. If that's what it said, then that's what they
17 did.

18 Q. Well, it's got 2140, so that's -- well, I've got
19 that wrong. That's about an hour and 20 minutes later,
20 I'm sorry. About an hour and 20 minutes after birth
21 sends the baby down; is that right?

22 A. I assume, yes, sir.

23 Q. And the word stat means they wanted it done
24 immediately after the order was entered; is that right?

25 A. That's my assumption.

1 Q. Do you know Dr. Brian Wood?

2 A. He's one of our neonatologists.

3 Q. And did you speak with him that evening after the
4 baby was born?

5 A. I'm not sure. Whoever -- if he was there I would
6 have spoke with him.

7 Q. So you don't recall whether you spoke with him or
8 not before you went to see the parents?

9 A. I don't.

10 Q. Were you aware of this injury that he made into
11 the baby's record that this infant had an elevated left
12 hemi-diaphragm on initial x-ray suggestive of paralysis
13 or eventration? What is the hemi-diaphragm, do you
14 know?

15 A. I would assume they're talking about the
16 diaphragm being elevated.

17 Q. All right. Well, what is the hemi-diaphragm?

18 A. Just a diaphragm separation the abdomen from the
19 chest.

20 Q. Is it related to breathing?

21 A. That's the separation between the abdomen and the
22 chest.

23 Q. All right. Is the diaphragm related to
24 breathing?

25 A. Yes, sir.

1 Q. And if the hemi-diaphragm is paralyzed in some
2 way, to some degree, does that mean that the baby is
3 having a problem breathing?

4 A. Again, I'm not an expert but if you ask me,
5 maybe.

6 Q. All right. He then goes on to write history of
7 shoulder dystocia with brachial plexus injury,
8 thorascopic evaluation to show paradoxical movement of
9 the hemi-diaphragm? Do you know what he means by
10 paradoxical?

11 A. I don't, sir.

12 Q. I consulted with Dr. Abrams from pediatric
13 surgery. Do you know Dr. Abrams?

14 A. No I do not, sir.

15 Q. Who concurs that this is not a diaphragmatic
16 hernia nor eventration. Do you know what the word
17 eventration means?

18 A. No, sir.

19 Q. But his findings are consistent with paralysis of
20 the left hemi-diaphragm. He suggests no surgical
21 intervention is required at this time. However, she
22 should require increase respiratory support. He would
23 consider mication or pacing but this reference would be
24 to avoid surgical intervention. His preference would be
25 to avoid surgical intervention and allow the diaphragm

1 to have ample opportunity to return to functioning
2 status.

3 And then he goes on to say: (Reading.) I spoke
4 with the infant's parents, they are in agreement with
5 the treatment plan at this time. (Ends reading.) Any
6 of that discussed with you when you met with anybody at
7 the NICU?

8 A. No, sir.

9 Q. This note is in exhibit. All of these are now
10 exhibits in evidence. And this note -- well, what did I
11 do with it? I walked off with it. It's in evidence as
12 Plaintiff's Exhibit 11. And it was entered on
13 November 1st, 2008, and it's a daily note. Do you know
14 what a daily note is in the NICU?

15 A. I assume that's what they write everyday.

16 Q. Okay. And so it says: (Reading.) Baby Girl
17 Flowers is a 3508 grand product of a 36-week gestation.
18 Delivery was complicated by shoulder dystocia. It was a
19 difficult delivery. The infant has a brachial plexus
20 injury, as well as left hemi-diaphragm paresis. (Ends
21 reading.) What does paresis mean?

22 A. It's not moving.

23 Q. (Reading.) Following admission, the infant was
24 in respiratory distress, had cardiomegaly with extra
25 cardio and chest x-ray. An echocardiogram was performed

1 which showed normal cardiac anatomy but the heart was
2 displaced to the right. Chest x-ray also revealed an
3 elevated left hemi-diaphragm. Lung fills were
4 relatively clear as sepsis evaluation was performed and
5 the infant was started on ampicillin and Gentamicin.
6 Thoracoscopy was performed which showed paradoxical
7 movement of the diaphragm consistent with paralysis of
8 the hemi-diaphragm.

9 I spoke with Dr. Abrams who reviewed the films
10 with me. He feels quite sure that this infant is not
11 suffering from diaphragmatic hernia, but it is in fact a
12 diaphragm paresis. He suggested no surgical
13 intervention. (Ends reading.)

14 No, Doctor, let me ask you this. Do you
15 understand as an obstetrician, as a doctor who's been --
16 as a doctor who's been trained as a medical doctor, that
17 the diaphragm does not come into play in terms of
18 breathing until the baby is born?

19 A. Yes, sir.

20 Q. I mean, we already discussed this. While the
21 baby is in the womb, in utero, the baby is getting
22 oxygen from the mother, through placenta, through the
23 umbilical cord to the heart?

24 A. Yes, sir.

25 Q. And you explained that?

1 A. Yes, sir.

2 Q. So this is a situation that in regard to the
3 hemi-diaphragm and the lack of performance by the
4 diaphragm that only could occur after the baby was born,
5 is that not right?

6 A. I can't say for sure yes or no.

7 Q. All right. Doctor, do you understand that the
8 diaphragm is controlled or innervated by the phrenic
9 nerve?

10 A. I assume so.

11 Q. And the phrenic nerve is innervated by C-4, nerve
12 roots C-4 and C-5 coming off the spinal cord?

13 A. If you tell me then -- that I'm not sure.

14 Q. You don't disagree with that, do you?

15 A. I don't have my manual with me, so I would
16 assume.

17 Q. Would you agree with this statement, Doctor?
18 Extreme lateral traction on the shoulder during delivery
19 can injure or transect the phrenic nerve and/or the
20 brachial plexus by stretching their cervical roots. The
21 traction occurs during delivery of the shoulder and
22 cephalic presentations and delivery of the head and
23 breach presentations. Cephalic presentations means head
24 first presentations; is that right?

25 A. Yes, sir.

1 Q. Do you agree with that statement, Doctor?

2 A. I mean, if the statement said that, then I mean
3 I'm not an expert so I can't sit here and tell you yes,
4 no. I don't have no literature research to deny or
5 agree to it.

6 Q. Would you agree with this statement? Involvement
7 of the third to fifth and specially the fourth cervical
8 roots results in diaphragmatic paralysis. Brachial
9 plexus palsy is associated in 80 to 90 percent of cases
10 while diaphragmatic paralysis occurs in approximately
11 five percent of brachial plexus injuries. Would you
12 agree with that?

13 A. Like I said, I'm not an expert in the area so I
14 can't sit here and tell you yes or no.

15 Q. Would you agree with this statement? Factors
16 associated with diaphragmatic paralysis are similar to
17 those of a brachial plexus injury?

18 A. Again, I'm not an expert in that area so I can't
19 sit here and tell you yes or no.

20 Q. Doctor, would you agree that based upon what the
21 neonatal team determined about Ashley F 's diaphragm
22 that that most probably is the reason that she had the
23 color blue?

24 A. I can't agree or disagree because I mean I don't
25 know. The only thing I can tell you that to me as an

1 obstetrician, one, when the baby comes out it's blue,
2 then it's probably due to what's going on before the
3 actual body comes out.

4 Q. And would you agree that if the combination with
5 rupture of C-5, C-6, C-7 nerve roots in her left
6 shoulder and scaring of C-8, along with an injury that
7 affected the phrenic nerve to such an extent that it
8 caused hemi-diaphragm paresis that that most probably
9 was the result of extreme stretching?

10 A. Again, sir, I'm not an expert. The only thing I
11 can tell you in this case is that gentle traction was
12 applied. So you'll have to ask the experts to that.

13 MR. HENSHAW: Just one moment, Your Honor.
14 That's all the questions I have. Thank you, Your Honor.

15 MR. LOVELL: Just very briefly, Your Honor.

16 REDIRECT EXAMINATION

17 BY MR. LOVELL:

18 Q. Doctor, you were asked a little while ago about a
19 note that you wrote that afternoon within half an hour
20 of the delivery. I'm just gonna hold it up. When you
21 see a baby who has fetal heart tones in the 90s and the
22 head is crowning, is it your normal procedure to
23 stimulate the head of the baby to see what happens?

24 A. Well, when I see a plus three station, I'm
25 examining the patient. And when I'm examining the

1 patient, my hand is inside the vagina. So, yes, I would
2 try to stimulate the head, see if it helps any.

3 Q. And when we looked at that fetal monitor strip,
4 when he was asking you questions on cross-exam, around
5 the time when you would have been doing that, did you
6 see a little bit of a response in the fetal heart rate?

7 A. Some response, yes, sir.

8 Q. Now, did you write that you did that in your
9 note?

10 A. No, sir, I did not.

11 Q. Okay. But that's part of your normal routine?

12 A. Yes, sir.

13 Q. And after the head was delivered, is it your
14 normal routine to check for that nuchal cord, especially
15 in a baby who's got decreased fetal heart tones?

16 A. Yes, sir, it is.

17 Q. And did you do that in this case?

18 A. I did, sir.

19 Q. Did you write that step that only you did in your
20 note as well?

21 A. No, sir, I did not.

22 Q. Is it your normal routine to bulb the baby, as we
23 saw in the video, in the nose and the mouth?

24 A. Always, sir.

25 Q. And why do you do that?

1 A. That's standard practice, protocol.

2 Q. Did you do it in this case?

3 A. Yes, sir.

4 Q. Did you write that in the note?

5 A. No, sir, I didn't.

6 Q. Is that something only you did and you didn't
7 have to ask somebody else to do?

8 A. That's correct, sir.

9 Q. The apgar scores that you were asked about,
10 whether it was one minute -- I'm sorry, whether -- those
11 are taken at one minute after delivery and then five
12 minutes after delivery, right?

13 A. Yes, sir.

14 Q. And in that period from when you see the baby at
15 zero minutes after delivery and you hand it over to
16 whoever else you hand it to, can some things change in
17 the baby in that minute?

18 A. Yes, sir.

19 Q. We heard testimony from both, I think, Mr. and
20 Mrs. Flowers that initially they heard, you know, no
21 baby cry and then some short time later they heard the
22 baby cry. Is that one of the changes that happens in
23 that minute or so?

24 A. Yes, sir.

25 Q. And whether that apgar muscle tone was a one or

1 minus two, are both of those not normal?

2 A. Yes, sir, not normal.

3 Q. Back to the last thing. I'm gonna talk about
4 this lateral traction. When you are delivering the
5 head, and you saw those diagrams, when the baby's head,
6 when you're trying to deliver this -- up the shoulder
7 that's on the top end towards the ceiling, do you have
8 to give the baby a little bit of downward movement to
9 facilitate that shoulder working?

10 A. Yes, sir, just very slightly.

11 Q. So in any delivery is there some degree of
12 downward lateral traction?

13 A. Yes, sir. A little bit down, that's it.

14 MR. LOVELL: Okay. Thank you, that's all I have.

15 THE COURT: You may step down.

16 (Whereupon, witness leaves witness stand.)

17 MR. LOVELL: Cindy White, Your Honor, would be
18 our next witness.

19 THE COURT: Okay.

20 (Whereupon, witness comes forward.)

21 THE CLERK: Do you solemnly swear or affirm the
22 testimony you're about to give is the truth, the whole
23 truth so help you God?

24 THE WITNESS: I do.

25 THE CLERK: Thank you, ma'am.

1 CINDY WHITE,
2 having been duly sworn, testified as follows:

3 DIRECT EXAMINATION

4 BY MR. LOVELL:

5 Q. Scoot up a little bit closer to that microphone,
6 Ms. White, so we can hear you. Thank you, ma'am.

7 What's your full name?

8 A. Cindy White.

9 Q. Where do you live?

10 A. Roebuck.

11 Q. What do you do for a living?

12 A. Right now I'm babysitting grand kids.

13 Q. Okay. In 2008 when Ashley F was a patient
14 -- was born and the mom was a patient, what were you
15 doing at that time?

16 A. I was working as a surgical tech at Spartanburg
17 Regional.

18 Q. Okay. And you've been in here listening to some
19 of the testimony, so I'm gonna kind of fast forward
20 through things. Were you involved in her delivery?

21 A. Yes.

22 Q. All right. How many years had you been a
23 surgical tech doing labor and delivery at that time in
24 2008?

25 A. Since 1990. Well, I went to school in '94. I

1 finished school in '94. I actually started in '94, but
2 I started as a student, so I was actually full time in
3 '95.

4 Q. All right. And in that period of '95 up until
5 around 2008 when Mrs. Flowers was in with her delivery,
6 about how many deliveries had you observed as a surgical
7 tech?

8 A. Hundreds.

9 Q. And were you working at Spartanburg Regional the
10 whole time?

11 A. I went to work in '95 as full time in '95, and I
12 worked a while. And then I stopped because my children
13 had a lot going on. And then I went back to work in
14 2001.

15 Q. And so from '01 to '08 full time doing that?

16 A. Full time, third shift.

17 Q. And did you have occasion in that role to be in
18 the delivery room when doctors other than Dr. Giep were
19 delivering babies?

20 A. Yes.

21 Q. Delivering babies vaginally, the natural
22 childbirth?

23 A. Yes.

24 Q. And did you have an occasion in that window of
25 time when you first started at Spartanburg Regional up

1 until the time of 2008 to be in the delivery room when
2 Dr. Giep was delivering babies?

3 A. Yes.

4 Q. Now, in the deliveries you saw with other
5 physicians, did you also see occasions where the
6 deliveries were complicated either by decrease of fetal
7 heart tones or shoulder dystocia?

8 A. Yes.

9 Q. All right. Had you observed how other doctors
10 dealt with those conditions?

11 A. Yes.

12 Q. In your role as a surgical tech, what exactly are
13 you doing in the room during a delivery?

14 A. I'm assisting the doctor.

15 Q. So if he's down on the business end, are you
16 relatively close to him?

17 A. I'm right beside him.

18 Q. Able to see everything that's going on?

19 A. I do.

20 Q. Do you have any role in terms of making all the
21 entries in the chart that we've been looking at for the
22 last ---

23 A. No.

24 Q. All right. And who's doing that?

25 A. The nurse does the charting.

1 Q. And in this case with this delivery was that Mrs.
2 Phillips?

3 A. Yes.

4 Q. Now, do you know Dr. Giep outside of work or did
5 you after you were in the hospital?

6 A. No, I just know him at work.

7 Q. As a surgical tech have you been trained on how
8 to help in assisting the team there in the labor and
9 delivery on responding to shoulder dystocia?

10 A. Yes.

11 Q. And have you done that --

12 A. Yes.

13 Q. -- over the course of all these years prior to
14 2008?

15 A. Yes.

16 Q. Do you do training at Spartanburg Regional --

17 A. Yes.

18 Q. -- or did you back then?

19 A. We did.

20 Q. How often did you all do that?

21 A. Once a year.

22 Q. Were you trained on how to put people in this
23 McRoberts maneuver we've heard about?

24 A. We do.

25 Q. How about the suprapubic pressure part?

1 A. Yes.

2 Q. Now in 2008, at what point with Ms. Flowers'
3 delivery, at what point would you have been in the labor
4 and delivery room with them?

5 A. You mean when I came into the room?

6 Q. Yeah. When would you have been involved? Were
7 you there the whole day or part of the day or how did
8 that work?

9 A. Well, I came into the room beforehand to set up
10 the room for her delivery, and then I went back out and
11 waited until they called me.

12 Q. And about what time do they normally call you or
13 did they call you to come in with her?

14 A. They call me when they call the doctor.

15 Q. And so throughout the -- I'm trying to remember
16 the time. So it was about 20 minutes before the actual
17 delivery, plus or minus, whatever the ---

18 A. Whatever time he goes in is usually I go in with
19 him.

20 Q. In terms of the delivery room and the bed, was it
21 set up as Dr. Giep told us a little while where the
22 mom's -- the business end of the bed is fairly close to
23 the floor?

24 A. Yes.

25 Q. And did he, from your observation, did he use the

1 stool, as he described using, to sit on while he's doing
2 the things he does?

3 A. He always did. He always sat on the stool.

4 Q. And was the only time he stood up is when he's
5 got the baby out and handed it off, from your
6 observations over the years?

7 A. Yes.

8 Q. And are you involved in that NICU part at all?

9 A. No, I'm still helping him.

10 Q. Now, in this case when Dr. Giep recognized that
11 there was a shoulder dystocia condition on Mrs. Flowers,
12 what did he ask you?

13 A. Get her legs back.

14 Q. Was that the McRoberts type position?

15 A. Yes.

16 Q. Were her legs already somewhat back for the just
17 regular labor?

18 A. They were in the stirrups, so we take them out of
19 the stirrups and push them back as far as we can.

20 Q. And then when you all are -- were you one of the
21 people that was applying that pushing back?

22 A. Yes.

23 Q. Do you remember who the other folks were that
24 were doing that?

25 A. I'm not -- sometimes the dad will actually hold

1 the other leg back. Sometimes the nurse will. It's
2 just according. I don't remember who was holding her
3 leg at that time.

4 Q. And do you have recollection of Nurse Natalie
5 Phillips doing the suprapubic pressure or did you do it?

6 A. She did.

7 Q. Okay. Did Dr. Giep, from your recollection, ever
8 panic when this shoulder dystocia occurred?

9 A. No.

10 Q. Did you ever observe or have a recollection of
11 seeing him panic at all during deliveries?

12 A. No.

13 Q. Did you have any recollection of seeing Dr. Giep
14 pulling any harder than you had seen the other doctors
15 pull in a delivery as it relates to Mrs. Flowers?

16 A. No.

17 Q. How about, was his arm straining? Was he
18 grunting, groaning, making any noise to suggest he was
19 struggling?

20 A. It was ordinary.

21 Q. Did the stool slide forward into the mother as he
22 was doing whatever it is he did on the business end
23 there during the delivery?

24 A. No.

25 Q. Did you ever see him have to brace and pull

1 himself back to try and deliver this baby?

2 A. No.

3 Q. If you had seen any of those -- well, and did you
4 see him making any movements way down towards the floor
5 when he was doing the delivery of this child?

6 A. Now, once I got the legs back I was sort of out
7 of the view of seeing what he was actually doing there
8 anyway, but I didn't see nothing that was not normal.

9 Q. Could you observe him, though, from how he looked
10 and how he sounded and ---

11 A. Yes.

12 Q. Did you observe anything about what you observed
13 and out of the ordinary of what you had seen either with
14 him or with all of the other doctors you observed?

15 A. No.

16 Q. If you had seen something unusual in that regard,
17 would you have made a note of it in that chart or ask
18 Nurse Phillips to make a note of it?

19 A. No, I probably wouldn't. I didn't make any kind
20 of notes of any kind in the chart. But I'm sure it
21 would have been discussed between me and probably my
22 charge nurse or my supervisor or somebody.

23 Q. Natalie Phillips as well?

24 A. Oh, yes.

25 Q. And would Natalie, from your dealings with her,

1 would that be something she would chart in it -- chart
2 if there was something unusual that she observed or that
3 you reported to?

4 A. If -- me and Natalie probably would have went to
5 my supervisor together.

6 Q. After the baby was born did you stay with the
7 mother while Dr. Giep was delivering the placenta and
8 sewing up --

9 A. Yes.

10 Q. -- the episiotomy? So did you go with the infant
11 at any point to the NIC unit?

12 A. No.

13 MR. LOVELL: Thank you, Ms. White. That's all
14 the questions I have. Please answer any from the
15 Plaintiff.

16 CROSS-EXAMINATION

17 BY MR. HENSHAW:

18 Q. The only reason you have any recollection of this
19 case at all is because after the lawsuit was brought you
20 went back and reviewed the record and then you talked
21 with Natalie Phillips; isn't that right?

22 A. No, it's not.

23 Q. Well, isn't that what you testified in your
24 deposition?

25 A. No, I did not. I never reviewed the record.

1 Q. Oh, you never reviewed the record?

2 A. No, I didn't.

3 Q. But you did talk to Natalie Phillips?

4 A. I asked Natalie when I found out this was going
5 to be a lawsuit, I asked her to refresh my memory on who
6 the family was. I didn't recognize the name.

7 Q. In your deposition didn't you say that you asked
8 Natalie to refresh your recollection about what happened
9 that day because that's when you came up with the
10 statement that she was a pretty -- that Ms. Flowers was
11 almost too pretty to be having a baby; isn't that right?

12 A. No, none of that's right. I asked Natalie to
13 refresh my memory on which family it was and that's when
14 she told me who they were. And I automatically
15 remembered it because I remembered the patient.

16 Q. And when you say you don't have any -- had not
17 had any involvement with Dr. Giep, you used to go to his
18 office, or at least on one occasion you went to his
19 office; isn't that right?

20 A. I did stop by his office to speak to his
21 receptionist one time. I did not see him.

22 Q. And the receptionist was your daughter?

23 A. That's right.

24 MR. HENSHAW: That's all the questions I have,
25 thank you.

1 REDIRECT EXAMINATION

2 BY MR. LOVELL:

3 Q. The fact that your daughter worked for Dr. Giep,
4 did that make you come in here and change any truth of
5 what you're saying here?

6 A. Absolutely not.

7 Q. Thank you, ma'am.

8 THE COURT: You may step down.

9 MR. LOVELL: May she be excused, Your Honor?

10 THE COURT: She may be.

11 (Whereupon, witness leaves witness stand, stays
12 in courtroom.)

13 MR. LOVELL: Ready, Your Honor?

14 THE COURT: Yes.

15 MR. LOVELL: We call Dr. Roger Gower.

16 THE CLERK: Do you solemnly swear or affirm the
17 testimony you're about to give is the whole truth,
18 nothing but the truth so help you God?

19 THE WITNESS: I do.

20 THE COURT: Thank you, sir.

21 THE WITNESS: Can I get some water?

22 THE COURT: Sure.

23 MR. LOVELL: Did you spill it back there?

24 THE WITNESS: Not too much. It'll evaporate.

25 MR. LOVELL: It'll dry.

1 THE COURT: It won't hurt this courthouse any.

2 DR. ROGER HUNTINGTON GOWER,

3 Having been duly sworn, testified as follows:

4 DIRECT EXAMINATION

5 BY MR. LOVELL:

6 Q. Scoot a little bit this way, Doc, so we can hear
7 you.

8 A. Okay.

9 Q. Tell us your full name, please.

10 A. Roger Huntington Gower.

11 Q. And, Doctor, where do you live?

12 A. In Greenville.

13 Q. Okay. And I'm calling you doctor. I assume
14 you're a doctor practicing in medicine.

15 A. Right. Correct.

16 Q. Tell us what kind of medicine you practice over
17 in Greenville.

18 A. I'm a general OB-GYN doctor.

19 Q. When you say general OB-GYN, what does that mean?

20 A. It just means four years of residency after
21 medical school.

22 Q. And do you deliver babies on a regular basis?

23 A. I do.

24 Q. How many years have you been delivering babies?

25 A. Since 1982, so 35.

1 Q. Now, tell us about your education. Give me
2 college, medical school that led you to become an OB-GYN
3 doctor.

4 A. Right. So went to college at Emory in Atlanta.
5 Then medical school in Charleston. Did a year of
6 internal medicine in Jacksonville and then back to
7 Charleston for OB-GYN.

8 Q. When did you complete that medical training,
9 Doctor?

10 A. So in '82 I finished the residency, moved to
11 Greenville, took my boards, all that stuff. Been in the
12 same practice ever since.

13 Q. And what's the name of your practice?

14 A. It's Greenville OB-GYN.

15 Q. How many doctors practice in that practice with
16 you?

17 A. We have nine, nine physicians.

18 Q. And what hospitals do you do your services and
19 delivery services?

20 A. Greenville Memorial and recently Patewood
21 Hospital.

22 Q. Do you have any positions at the hospital or have
23 you had any in your years of practice?

24 A. I've been involved in a lot of medical staff
25 stuff. The president of the medical staff, credentials

1 committee. Practice manager for our group. And now I'm
2 serving as vice chairman of our department for medical
3 affairs quality and safety.

4 Q. When you say our department, what department are
5 you talking about?

6 A. That's the OB-GYN department in Greenville.

7 Q. Have you been involved in teaching the medical
8 students in the field of obstetrics ever in your career?

9 A. Yes. Yeah, we have medical students in
10 Greenville.

11 Q. Do you hold any title associated with that?

12 A. Well, it's probably assistant or associate
13 professor for Greenville, USC School of Medicine
14 Greenville.

15 Q. How about professional organizations in the
16 medical field, which ones do you belong to?

17 A. County Medical Society, State Medical Society,
18 AMA, American College of OB-GYN, South Atlantic
19 Association of OB-GYN.

20 Q. American College, is that what we've been calling
21 ACOG?

22 A. That's ACOG. That's our --

23 Q. And are you board certified?

24 A. -- national. Board certified, yes.

25 Q. In what?

1 A. In OB-GYN.

2 Q. And how many years have you been board certified?

3 A. You take the exam two years into practice, so I
4 was certified in '84, so that would be 33 years this
5 December.

6 Q. So in your years of delivering children how many
7 approximately have you delivered?

8 A. You asked me that in the deposition. I said it's
9 about 150 a year since then, so that's like 4 or 5,000
10 maybe.

11 Q. And have you had experience with babies who
12 develop fetal heart tones similar to what you saw in
13 this case with this child?

14 A. Yes.

15 Q. How about shoulder dystocia?

16 A. Yeah. Shoulder dystocia that will come up, you
17 know, a couple times a year.

18 Q. And is that something that in your personal
19 deliveries you had children that ended up having a
20 brachial plexus palsy from the shoulder dystocia?

21 A. I have. I have.

22 Q. Any of them been permanent?

23 A. Not to my knowledge, not a permanent one.

24 Q. But you've had some with temporary issues --

25 A. Temporary as well.

1 Q. -- of brachial plexus?

2 A. Yeah, temporary. And also, you know, just to
3 expand. So I do also serve as the attending for the
4 resident. We have a residency program. And so the
5 residents are in house, so they have an attending. So
6 they do the deliveries, but I'm there for the deliveries
7 so I've been in a situation where they got stuck and you
8 have to, much as you were talking about in the teaching
9 this morning, the -- where you have to sort of step in
10 and, you know, each level resident sort of has their go
11 at it and sometimes you have to be the one to actually
12 come in and to the maneuver that works.

13 Q. When you say they get stuck, you mean the
14 residents --

15 A. The residents.

16 Q. -- get to a point where they're no longer able to
17 do anything to facilitate the ---

18 A. Either that or I run out of patience.

19 Q. Okay. Speaking of the training, we heard from
20 Dr. Giep earlier that when he was coming up, one way
21 they trained him on how much force to use as he had his
22 hands on a baby in a live birth and a teacher would be
23 there with him, sometimes with their hands on them. Is
24 that how you all do it as well sometimes?

25 A. Right. Yeah, that's what we did in residency. I

1 don't usually -- that would be a first year resident, so
2 I don't usually teach them anymore, so I haven't done
3 that in a while. But that's sort of the way we did it.

4 Q. Now, you're here today serving as an expert,
5 right?

6 A. Yes, sir.

7 Q. Have you done this before as a potential expert?

8 A. I have.

9 Q. How many times?

10 A. I've reviewed quite a few cases, maybe 10 or 12
11 cases. I've testified in court maybe four or five
12 times.

13 Q. And when you do this are you compensated for your
14 time away from your medical practice?

15 A. I am.

16 Q. And at what rate?

17 A. For the depositions I think it's \$200, maybe 300
18 for the chart review, 300 for the depositions. And then
19 I really don't have one for testifying.

20 MR. LOVELL: And, Your Honor, at this time we
21 tender Dr. Gower as an expert in the field of obstetrics
22 and gynecologists -- gynecology and the encounter of
23 shoulder dystocia and delivered babies with shoulder
24 dystocia and fetal distress and others.

25 MR. HENSHAW: No objection to his being deemed

1 qualified as an expert as an obstetrician. I'm not sure
2 that -- I don't agree that a sufficient foundation has
3 been laid as to the treatment of babies who encounter
4 shoulder dystocia following the birth. No foundation
5 has been laid for that.

6 MR. LOVELL: I'm not tendering him for after
7 birth. I'm talking about through labor and delivery.

8 THE COURT: Condition during birth and delivery?

9 MR. LOVELL: Yes, Your Honor.

10 MR. HENSHAW: No objection.

11 THE COURT: All right. He is so qualified.

12 BY MR. LOVELL:

13 Q. Just so we're clear, Doctor, when the baby is
14 delivered even with shoulder dystocia or not and there's
15 been some problem with the baby and it needs to be
16 handled by the NICU, you're not involved in the NICU
17 side of things, are you?

18 A. Correct, I'm not.

19 Q. You just do the deliveries and the labor and hand
20 the baby off?

21 A. We're very fortunate to have them close by.

22 Q. In your action or work on this case, have you
23 reviewed all of the medical records from Spartanburg
24 Regional relating to this child's birth?

25 A. I have.

1 Q. And prenatal records, did you review those?

2 A. I have.

3 Q. Did you also review the records that related to
4 the baby's time in the hospital after the birth? Not
5 necessarily -- did you review the documents?

6 A. I did briefly go through those, but didn't in not
7 much detail.

8 Q. Did you hear -- excuse me. Did you read the
9 depositions of both the Plaintiff, Mr. and Mrs. Flowers,
10 the grandmother, I think Mrs. Bowen, Dr. Giep, Mrs.
11 Phillips, Nurse Phillips, Mrs. White, who just
12 testified, along with the various other experts involved
13 in this? Did you review all of those?

14 A. I did review them in the past.

15 Q. And all that information you reviewed, did it
16 give you a good understanding of what occurred during
17 the course of this delivery unit and what the witnesses
18 to the delivery observed about what was going on at the
19 time?

20 A. Yes.

21 Q. Do you feel that you have enough information upon
22 which to base an opinion on whether or not Dr. Giep
23 exercised the standard of care required of him as an
24 obstetrician and his management of this labor and
25 delivery on the delivery of this child when the shoulder

1 dystocia occurred?

2 A. Yes, I did.

3 Q. What's your opinion in that regard?

4 A. I didn't see anything in the care of this patient
5 that was below the standard of care.

6 Q. Now, when you use the term standard of care, how
7 are you defining that?

8 A. That would be the care that any well trained,
9 competent OB-GYN would exercise in their medical care of
10 a patient.

11 Q. Okay. Now I want to back up. Before the
12 delivery, did you observe those fetal monitor strips
13 that we've been all looking at now for a day,
14 day-and-a-half?

15 A. Yes.

16 Q. Now, you've been in the courtroom during Dr.
17 Giep's testimony, so did you see the ones that were
18 displayed here in the court?

19 A. I did.

20 Q. From your review of the fetal monitor strips, as
21 we get within the, say, ten minutes prior to the head
22 being delivered in this child in roughly 2000 -- 8:04,
23 2004, up until about 2011, 12, 13, in your opinion was
24 there a problem with the baby's heart rate that would
25 make most OB-GYNs a bit concerned about the baby's

1 health and wellbeing?

2 A. So, yeah, the end of the fetal monitor strip,
3 when the heart rate decelerated and was in the 90 range
4 for like five to seven-minute range, so that was, that
5 was certainly a concern.

6 Q. Now, Plaintiff's counsel asked some questions,
7 and you may have seen where the heart rate went up a
8 little for a time and then sort of comes back down.
9 Tell us what that means as an OB-GYN under those total
10 circumstances.

11 A. Right. So the, you know the baby's probably been
12 deprived of oxygen for five to seven minutes at that
13 point. You've -- the patient -- and it is in a clinical
14 situation. You can see the head, it's crowning.
15 Probably the nursing staff all knew. Dr. Giep probably
16 knew that they could deliver the baby fairly
17 expeditiously, so they made the decision. And in the
18 course of that, the heart rate did come up briefly, but
19 it went right back down.

20 Q. And when you ---

21 A. So they just sort of ended back to whatever
22 caused the problem with the baby's heart rate in the
23 first place was still present, even though it did come
24 up.

25 Q. And when you all are at that point before the

1 baby has delivered, do you really know what's causing
2 that depression of the heart rate?

3 A. No.

4 Q. And all the ---

5 A. It is a very indirect measure of how -- of sort
6 of the fetal wellbeing. It could be any number of
7 reasons.

8 Q. Do you all rely upon any direct measure to make
9 the decision on what we're gonna do next?

10 A. Sure. You know that after a period of time that
11 the baby's gonna start to get acidotic, that the oxygen
12 level for the baby's gonna go down. It runs the risk of
13 brain injury and, you know, you're talking some serious,
14 serious problems.

15 Q. And is there any way of knowing how long it would
16 take for any of those things, the acidosis, the brain
17 injury or even death to occur once the fetal problems
18 start?

19 A. No, but it is time related. The longer it goes
20 on the more risk you have.

21 Q. So when Dr. Giep made the decision to go ahead
22 and restart the Pitocin, have the patient do a couple of
23 pushes and then apply the vacuum, was that all in your
24 opinion within the standard of care?

25 A. Yes.

1 Q. Once the baby's head delivered, when Dr. Giep
2 decided at that point that he was going to check for the
3 neutral porters, is that within the standard of care?

4 A. Sure.

5 Q. Is that what most doctors normally do as the
6 first step once the head's out, especially in a baby
7 like this one?

8 A. Absolutely.

9 Q. Why is that?

10 A. Well, because one of the causes of the heart rate
11 dropping is cord compression or a nuchal cord can be
12 associated with a heart rate dropping like that. So you
13 want to check because you can't really deliver a baby
14 with the cord still, still around the neck. You've got
15 to reduce it. So that would be an impediment to
16 deliver, a further impediment to deliver.

17 Q. And the bulbing out of the baby's nose and mouth,
18 that's something that is in the routine or it has to be
19 done at that point once the head is delivered?

20 A. Yeah. It's actually -- yeah, it's -- you know,
21 it's what we have always done. It's becoming a little
22 more optional for some reason, but that's another story.

23 Q. Why did you all -- why do you all do it?

24 A. Just to clear the airway because as soon as the
25 baby comes out and takes that first breath you want the

1 -- you don't want the baby with any amniotic fluid or
2 whatever else is there.

3 Q. And that's a question I want to ask you just from
4 an obstetrician standpoint. When the baby is inside
5 momma's body, is it breathing as we breathe now, you
6 know, in and out where your diaphragm is helping you do
7 all of that?

8 A. Well, you know, actually, you know, I don't think
9 -- I don't know that it's been discussed yet, but one of
10 the assessments that we do for food and wellbeing has to
11 do with looking for breathing motions on ultrasound.
12 Maybe you've discussed that elsewhere. So that does
13 happen. The diaphragm is working, so the baby's
14 working. That's a sign of fetal wellbeing as well.
15 But, and maybe that wasn't exactly the question you were
16 asking. The baby's not moving air obviously.

17 Q. Right. Because their head is inside the body?

18 A. Yeah, there's no, no oxygen.

19 Q. If there has been some entry to that nerve,
20 whatever one that rise the diaphragm is --

21 A. Right.

22 Q. -- as the baby is coming down the birth canal
23 before the head ever comes out, would you know that?

24 A. No.

25 Q. Now moving forward, once the head was delivered

1 in this case and Dr. Giep had done the blow thing and
2 the nose and mouth thing, when he moved forward to the
3 McRoberts type maneuver, was that, in your opinion,
4 something that was within the standard of care, as he
5 described it? I think you were in here when we talked
6 about it.

7 A. Yes.

8 Q. All right. Help us understand why.

9 A. Yeah. So, yeah, we've been doing McRoberts for a
10 long time and discovered that when you rotate the legs
11 back, a lot of babies that aren't coming out, shoulders
12 that sort of seem impacted, loosen up and will deliver
13 pretty easily. In fact, it works most of the time.
14 McRoberts alone without anything else.

15 Q. And does the doctor always have hands providing
16 traction during the McRoberts thing maneuver?

17 A. Yeah. So you do the McRoberts and then hopefully
18 that disimpacts the shoulder and then you pull the baby.
19 But you wouldn't probably necessarily -- you know, it's
20 all sort of all simultaneous.

21 Q. Okay. Let me ask a question that probably sounds
22 stupid. But when you're the doctor and you're down on
23 the stool, like Dr. Giep described, and you've got your
24 hands in that position, when all of these things are
25 going on do you tend to keep your hands on the baby's

1 head to some extent to protect it from I guess if it
2 were to become lucid or were to deliver suddenly?

3 A. Oh, yeah. Yeah, yeah, because a precipitous
4 delivery is not good for the baby. And even a
5 precipitous delivery can cause brachial plexus injury as
6 well. Plus there's a maternal result of a rapid
7 delivery is much more likely to cause trauma to the, to
8 the mom.

9 Q. When you say maternal, that's something that
10 might hurt the mother herself?

11 A. Right. Just much more likely to get a vaginal
12 tear that's problematic.

13 Q. Now, when Dr. Giep, you heard his testimony about
14 how he described the forceps that he was using during
15 the McRoberts and the suprapubic, you know, after the
16 head had delivered. Minimum traction and gentle
17 constant forces, are those the types of forces that can
18 be expected to use under the standard of care?

19 A. Yes.

20 Q. Help us understand why.

21 A. Yeah. So, yeah, as has been well discussed
22 already, the -- you want to keep sort of general
23 constant pressure. You don't want the kind of jerking
24 movements. You don't want anything to jerk. Much more
25 likely to, A, get the baby stuck or, B, cause an injury.

1 And, you know, excessive force has a potential to cause
2 problems.

3 Q. In your review of the information, including the
4 depositions of the family members of Mr. and Mrs.
5 Flowers and Mrs. Bowen, the grandmother, did you see any
6 information that led you to conclude about how Dr. Giep
7 was moving the baby or handling the baby's head as the
8 baby was going through all these things?

9 A. Well, yeah, in listening to the -- in reading
10 over the depositions and so on, you know, it sounded as
11 if you could sort of get a sense of the maneuvers that
12 occurred and sort of the step-wise process. And, you
13 know, escalating what he had to do to deliver the baby.

14 Q. How about in terms of the angle for traction that
15 was being applied? Did you see in the grandmother's
16 deposition where she described that he was pulling it
17 straight out?

18 A. I did read that.

19 Q. And is that what is the general direction you all
20 pull when you're doing these things?

21 A. Right. Right.

22 Q. Now, we've heard some testimony earlier, some, I
23 guess, questions earlier about this idea of the axial
24 spine that the forces are always on the axial spine.
25 And the baby's outside of the mother's body but the body

1 is still inside, are you able to see what the spinal
2 angle is?

3 A. No. You just have to sort of infer from the,
4 sort of, the normal direction of the pelvis and then the
5 further away it would be.

6 Q. And is there, as you're maneuvering the baby,
7 assisting it and guiding it out, is there some degree of
8 movement of the head and the body as it's coming out?

9 A. Well, yeah. Yeah, to get the shoulder down,
10 yeah, there is a slight amount of downward traction.

11 Q. Is that acceptable within the standard of care?

12 A. It's a routine. Yeah, so it is in the standard
13 of care and it's routine.

14 Q. Why do you have to apply that slight amount of
15 downward movement?

16 A. Well, just to -- yeah, you know, if you're there
17 you can kind of see, but the shoulder still does have to
18 come under the pubic bone and to come under the pubic
19 bone it'll get pushed down a little bit, so you just
20 assist in the direction that the baby will already be
21 going.

22 Q. And were all those descriptions that you saw
23 about manner in which you saw and were available or the
24 manner in which Dr. Giep applied the forces outward and
25 downward, were all of those in your opinion within the

1 standard of care of what most obstetricians would have
2 done when faced with a patient like this in this
3 scenario?

4 A. I thought they were.

5 Q. Now, moving to one other topic. When the baby's
6 head was out and the shoulder dystocia was identified,
7 based on everything you reviewed was that baby medically
8 stable at that point?

9 A. At the time of delivery?

10 Q. At the time that the head had delivered.

11 A. Well, the head, is the baby stable? Well, you
12 don't really know. I mean, you've got, you've got the
13 heart rate down for a period of time. You've got a
14 shoulder dystocia diagnosis so, yeah, the baby's in
15 pretty significant jeopardy at that point.

16 Q. And with the heart rate having dropped and then
17 rebound and then drop back again, is that an area of
18 stability of that medical conditional of whatever is
19 causing the heart to do that?

20 A. I wouldn't think so.

21 Q. Now, at the point the head was delivered and up
22 until the remainder of the baby's body was delivered,
23 was that baby at some imminent risk of some serious
24 bodily injury or even potentially dead?

25 A. Sure.

1 Q. Can you explain why you say that?

2 A. Sure. I mean, you know, we've -- I have never
3 experienced a shoulder dystocia that you couldn't
4 resolve, but you do read about that from time to time.
5 You all heard a little bit about that Zavanelli maneuver
6 that's just sort of life saving where you push the baby
7 back and do an emergency C-section and the outcome from
8 that is terrible, the statistics on that.

9 So you don't get the shoulder delivered, you're
10 -- the baby's gonna be hypoxic and probably a
11 significant brain injury and that sort of thing. So
12 that, that's what you're facing at this point once you
13 get the shoulder dystocia.

14 Q. And during that window of a minute to two minutes
15 that this child was experiencing the shoulder dystocia
16 before the body was, you know, the rest of the body was
17 delivered, was it at risk during that entire window of a
18 couple minutes or whatever?

19 A. Sure.

20 Q. And is there any way Dr. Giep or any doctor in
21 that scenario knows how long they got to sit there and
22 do whatever ---

23 A. You don't know how long the shoulder dystocia is
24 gonna take.

25 Q. And do you know how long the reserve of the baby

1 is gonna be able to hold up for whatever else?

2 A. No. No. We had one, we had one about seven
3 minutes about two weeks ago and it was pretty, pretty
4 stressful. Fortunately the baby didn't have any damage.

5 MR. LOVELL: Thank you, Doctor, please answer any
6 questions the Plaintiff has.

7 CROSS-EXAMINATION

8 BY MR. HENSHAW:

9 Q. You've been an expert witness before?

10 A. I have.

11 Q. And reviewing the materials of various witnesses
12 is part of the job of the expert; is that right?

13 A. Yes.

14 Q. You're charging, you said you couldn't -- well,
15 you didn't know what you were charging here, but
16 previously in your deposition in this case you indicated
17 you're charging \$3,000 per day for trial work.

18 A. Okay.

19 Q. Is that right?

20 A. Sounds good. Yeah.

21 Q. Sounds okay?

22 A. I'll do it.

23 Q. And you have reviewed these materials and so you
24 are relying in part, but you're relying upon what
25 Barbara Bowen, the grandmother, said about Dr. Giep

1 pulling the baby straight.

2 A. Well, I answered that question. That didn't
3 really fit -- that wasn't really part of my original
4 review of the case and my reasons to think that, that
5 this case was within their standard of care.

6 Q. Well, you didn't give that qualification when you
7 were just asked about it. You just said, yeah, I
8 understood that it was being pulled straight and
9 indicated that that was ---

10 A. I said that I had read it.

11 Q. All right. Well you also read, then, that she
12 said that: (Reading.) And she was pushing and all of a
13 sudden the baby's head came out and the doctor was
14 pulling. The nurse that was standing to the side of her
15 was pushing on her stomach. And then when the doctor
16 was pulling her head, all of a sudden he stood up. That
17 scared me. He stood up and he was still pulling. (Ends
18 reading.) Did you rely on that too?

19 A. No, I wouldn't probably rely on that.

20 Q. So you rely on some things in a witness's
21 deposition if it suits you but you don't rely on the
22 others?

23 A. Well, I wouldn't qualify if it suits me. I think
24 you, you know, I would agree I rely on some parts more
25 than others. Just like when you're interviewing a

1 patient, they tell you some things that sort of make
2 sense medically and some other things that sort of don't
3 exactly make sense, so...

4 Q. I mean, you ---

5 A. But I didn't rely on her, her deposition to form
6 my opinion, so I just answered the question that I did
7 read it.

8 Q. You don't even know what she meant by the term
9 straight, do you?

10 A. No.

11 Q. Because if Ms. Flowers was in a McRoberts
12 position but essentially prone on the bed and the doctor
13 pulled straight, that wouldn't be right, would it?

14 A. Well, the ---

15 Q. Because that would be lifting the baby's head up.

16 A. Well supine, not -- prone would be face up.

17 Q. Well, supine. I should have said supine, I
18 apologize.

19 A. So that threw me off to start it off.

20 Q. All right. Let me start over then. If she was
21 supine in McRoberts position and the doctor, I mean, one
22 view of straight would be to pull straight out from
23 that, that would not be appropriate because that would
24 not keep the baby's head in alignment with the spinal
25 column, would it?

1 A. Right.

2 Q. So if you rely upon Ms. Bowen's testimony that he
3 pulled out straight, well that's the same as saying that
4 Dr. Giep was negligent, aren't you?

5 A. Well, I didn't -- I'm not relying on her
6 testimony.

7 Q. Okay.

8 A. I wouldn't. I read it.

9 Q. But you are relying upon Dr. Giep's testimony
10 when he says I just used mild traction?

11 A. Yeah, Dr. Giep.

12 Q. Dr. Giep. You're relying on that when he just
13 says I used mild traction?

14 A. I am.

15 Q. All right. And as far as the nurses are
16 concerned, you didn't find anything in there to
17 corroborate Dr. Giep whether he used mild traction or
18 not because they all say they didn't see it; isn't that
19 right?

20 A. Can you repeat the question.

21 Q. I said, in terms of corroborating Dr. Giep's
22 statement that he used mild traction, the nurses weren't
23 in a position to corroborate that because they all said
24 they didn't see it, right?

25 A. Yeah, possibly so. Yeah.

1 Q. And what we do know, though, is that this baby
2 has injury ruptures to C-5, C-6, C-7 and C-8.

3 A. Right.

4 Q. That's a pretty severe injury, isn't it?

5 A. Well, I would think so. I'm not gonna testify
6 about the, about the neurological part of it, but yeah.

7 Q. Well, you can testify to your own experience,
8 which is you've been delivering babies since the 1990s,
9 and you have had about three cases a year that involved
10 shoulder dystocia; is that right?

11 A. Of some degree, sure.

12 Q. And you've never had a permanent injury, have
13 you?

14 A. I don't believe so. Not aware of it.

15 MR. HENSHAW: That's all the questions I have,
16 thank you.

17 MR. LOVELL: Very briefly, Your Honor.

18 REDIRECT EXAMINATION

19 BY MR. LOVELL:

20 Q. Doctor, I want to make sure we're clear on the
21 testimony of Ms. Bowen about the straight. To clear my
22 mind I had to read it over. I'm looking at Page 31,
23 Line 12. The question that was asked and the context of
24 the answer was: (Reading.) When the doctor was, as you
25 say, pulling your grandchild, was he pulling him

1 straight or was he pulling him up or was he pulling him
2 down and the answer was straight. (Ends reading.)

3 Right?

4 A. Straight.

5 Q. Is that what you read in the deposition?

6 A. That's what I read.

7 MR. LOVELL: Thank you, Your Honor.

8 THE COURT: You may step down. Thank you.

9 MR. LOVELL: Your Honor, may he be excused?

10 THE COURT: He may be.

11 THE WITNESS: Okay, thank you.

12 (Whereupon, witness leaves witness stand and
13 courtroom.)

14 MR. LOVELL: Your Honor, at this time we'd call
15 Dr. Robert Arnett.

16 THE CLERK: Do you swear or affirm the testimony
17 you're about to give is the whole truth, nothing but the
18 truth so help you God?

19 THE WITNESS: Yes, ma'am.

20 THE CLERK: Thank you, sir.

21 DR. ROBERT ARNETT,

22 having been duly sworn, testified as follows:

23 DIRECT EXAMINATION

24 BY MR. LOVELL:

25 Q. Dr. Arnett, would you give us your full name for

1 the record, please.

2 A. Robert Michael Arnett.

3 Q. Where do you live, Doctor?

4 A. I live here in Spartanburg.

5 Q. And what do you do for a living?

6 A. I'm now a -- I used to be an OB-GYN. I guess I'm
7 doing just gynecology now with the women's clinic in
8 Spartanburg.

9 Q. Women's clinic here in town?

10 A. In town, yes.

11 Q. Where's your office located?

12 A. Our office is at 475 Haywood.

13 Q. How many years have you been practicing here in
14 Spartanburg as a doctor?

15 A. Since 1991, so that would mean that is 26.

16 Q. You mentioned that you're no longer doing
17 obstetrics. When did you quit doing that?

18 A. I stopped doing it at the end of 2009.

19 Q. So back in 2008 were you actively delivering
20 babies?

21 A. Yes.

22 Q. And how many years at that point had you been
23 actively been delivering babies?

24 A. Eighteen. Well, not counting residency. I
25 guess, you know, you always don't know when you count

1 that or not, so that would be another four.

2 Q. All right. Tell us about your training to become
3 a doctor.

4 A. I went to the Medical University of South
5 Carolina, did four years there. And then I did my
6 residency training at the Medical University of South
7 Carolina as well.

8 Q. All right. And college before medical school?

9 A. I went to the United States Air Force Academy for
10 four years and then flew airplanes with the Air Force
11 for a little bit before I started medical school.

12 Q. How many years were you in the military total?

13 A. Well, I was in seven before I started medical
14 school and then I did reserves afterwards for a total of
15 22.

16 Q. And what was your highest rank in the military?

17 A. Lieutenant Colonel.

18 Q. Honorably discharged?

19 A. I just retired, so I guess that's honorable.

20 Q. They invite you to retire if you do it on your
21 own.

22 A. There you go.

23 Q. Did you belong to any professional organizations
24 in the field of medicine, Doctor?

25 A. Yes. The county Medical Society, the State

1 OB-GYN Society, ACOG, which is the American College of
2 Obstetrics and Gynecology. The South Atlantic, which
3 was also mentioned.

4 Q. How about hospitals, which ones when you were
5 delivering babies, where did you deliver your babies?

6 A. Originally I started both at the Regional and at
7 Mary Black. And then after about five years we went
8 exclusively to Spartanburg Regional.

9 Q. When you say we, how many other doctors are in
10 your practice?

11 A. At one time we had -- back then we had eight and
12 now we have seven.

13 Q. And are you board certified in your field and if
14 so, which one?

15 A. Yes. I'm board certified in OB-GYN still.

16 Q. And how many babies, when you were delivering
17 babies, let's take it up to about 2008, how many babies
18 do you think you delivered?

19 A. Probably about a little under 3,000 in residency
20 and maybe another 3,000 after that.

21 Q. And were you familiar from your educational
22 training and all the babies you delivered on how
23 obstetricians in general would deal with issues such as
24 fetal distress, like in this case, or shoulder dystocia
25 like in this case?

1 A. Yes.

2 Q. And are you familiar with the standard care
3 required of you guys as obstetricians in doing those
4 types of deliveries with those types problems?

5 A. Yes.

6 Q. And under the standard of care that existed in
7 2008?

8 A. Yes.

9 Q. And how did you keep up with all of the nuances
10 of doing those deliveries back when you were doing them?

11 A. Well, we all went to meetings to get certain
12 courses that we would take. The board certification
13 requires you to take a test periodically, and then every
14 year you have to also read articles that keep you up to
15 date. And, you know, general reading. You know, you're
16 gonna read different, different things periodically to
17 keep up to date with getting magazines to read and see
18 some of the articles.

19 MR. LOVELL: Your Honor, we tender Dr. Arnett as
20 an expert in the field of obstetrics and gynecology and
21 the recognition and management of shoulder dystocia in
22 delivering babies with that or with the fetal distress
23 condition.

24 MR. HENSHAW: May I voir dire?

25 THE COURT: You may.

1 VOIR DIRE EXAMINATION

2 BY MR. HENSHAW:

3 Q. Just a couple of questions. When was the last
4 time you delivered a baby?

5 A. In December of 2009.

6 Q. 2009?

7 A. Yes, sir.

8 Q. All right. And not since then?

9 A. No.

10 Q. You only work in the field of gynecology?

11 A. Yes, since 2009.

12 Q. All right, thank you.

13 MR. HENSHAW: No objection, Your Honor.

14 THE COURT: He is so qualified.

15 CONTINUED DIRECT EXAMINATION

16 BY MR. LOVELL:

17 Q. And I forgot to ask, Doctor, in your experience
18 do you all have medical students that you've trained or
19 been involved in teaching over the years?20 A. We have some medical students that come from the
21 local college, the osteopathic school here, but I
22 haven't been involved with them with obstetrics. More
23 with the family medicine residents and the GYN residents
24 that are at the Regional Hospital that we will
25 occasionally supervise.

1 Q. Now, do you know Dr. Giep on a personal level?

2 A. Yes.

3 Q. All right. How do you know him?

4 A. We interact at the office -- or at the hospital
5 is where we generally see each other. I think I've seen
6 him one time at some meetings. I knew his father. His
7 father helped train me earlier in my, my area.

8 Q. Do you out go out to dinner and socialize with
9 Dr. Giep?

10 A. I have not been out to dinner that I -- probably
11 maybe 15, 18 years ago we were at the same meeting and I
12 think he and his wife and I may have eaten dinner
13 together once.

14 Q. Is his group a competitor with your group when it
15 comes to obstetrics and gynecology?

16 A. Well, we would all prefer that the other patients
17 come to me instead of him, yes.

18 Q. Have you served as an expert witness previous to
19 today?

20 A. Yes.

21 Q. How many times?

22 A. Testifying probably five or six. Total cases
23 probably 15.

24 Q. Cases you might have reviewed, but only five or
25 six you testified and gave a deposition in?

1 A. Well, no, the depositions I probably gave more of
2 those. I might have given seven or eight depositions.
3 You don't always go to trial with a deposition. You
4 might give one and then have to come to trial.

5 Q. And are you paid, compensated for your time away
6 from your practice?

7 A. Yes, I am.

8 Q. And at what rate?

9 A. I review the records for \$300. The depositions I
10 do for, I want to say, 1500. I can't -- I haven't
11 looked at my scale in a while. And then the trial is
12 3500.

13 Q. Let's talk about your experience with shoulder
14 dystocia. In your thousands and thousands, I forget
15 what number you said of deliveries, have you had
16 experiences where your patients developed shoulder
17 dystocia with the baby?

18 A. Yes, I wouldn't think any obstetrician hadn't had
19 that.

20 Q. About how many times?

21 A. I probably over estimate my shoulder dystocias.
22 I would say probably 200 times that I've had an actual
23 shoulder dystocia. But out of those most of them were
24 mild and resolved very easily and with just the first
25 McRoberts maneuver. Then maybe I'd say 50 to 60 that

1 I've had that are -- that required more and that would
2 be more moderate or severe.

3 Q. Have you had a scenario with a brachial plexus
4 injury after a shoulder dystocia event?

5 A. I have had, yes.

6 Q. And how many times has that occurred?

7 A. I think I've had five.

8 Q. Have you ever had that occur on what you consider
9 to be an easy shoulder dystocia delivery?

10 A. Yes. I actually had one where I would say it
11 would have been very easy. We hardly had any traction
12 at all.

13 Q. Explain that. What do you mean by all of that?

14 A. Basically where we're only -- the way I look at
15 the severity is how many -- how long it takes, how many
16 maneuvers you use, how much trouble or things that you
17 have to do to get the baby out. And so the mild ones
18 generally just resolve when they do this McRoberts that
19 you guys approved I don't know how many times.

20 And McRoberts is basically just opening -- the
21 pelvis is not solid, it's -- it moves. And when you do
22 McRoberts it helps open up this part of the pelvis so
23 that you have more room to get the baby out with the
24 shoulders. (Indicating.) And in the particular case
25 that I had that I had a shoulder dystocia with a

1 brachial plexus injury where literally I think they just
2 did McRoberts, I didn't do any traction in it then.

3 Q. And have you had occasions with shoulder dystocia
4 injury, you've had a brachial plexus injury that did not
5 resolve?

6 A. I had one case that the last time I talked to the
7 patient's mother there was still some sort of deficit,
8 which was about six years afterwards. So I don't know
9 if it resolved. I would tend to think not.

10 Q. And in that scenario was that an easy delivery,
11 an easy shoulder dystocia? How would you qualify it?

12 A. I would say that one was probably easy to
13 moderate, something like that.

14 Q. Did you apply what in your mind was excessive
15 traction?

16 A. No. We did McRoberts and did the suprapubic
17 pressure and that got the baby out. And it didn't take
18 long. So, again, if you use time as a severity it was a
19 very short one.

20 Q. All right. In terms of long, was it one minute
21 to two minutes? How do you quality that?

22 A. To me, you know, a minute to two minutes is a
23 fairly short shoulder dystocia.

24 Q. Now, Doctor, from all -- I'm gonna ask you to
25 sort of set the foundation. Have you reviewed all the

1 medical records related to this child's, the prenatal
2 records with Mrs. Flowers, Mrs. Flowers in the hospital
3 records, the records of the delivery and the records of
4 before and up until when everybody went home?

5 A. Yes. And I looked at all the depositions as
6 well.

7 Q. Including mom, dad, grandma, Dr. Giep, all the
8 other folks --

9 A. Yes.

10 Q. -- we've previously testified about? With all of
11 that did you arrive at an opinion on whether or not Dr.
12 Giep and his management of this labor and delivery and
13 in the delivery itself exercise the standard of care
14 required of him as an obstetrician in those
15 circumstances that were faced with this baby?

16 A. And I think the way I always look at it is the
17 standard of care is what would your -- is a reasonable
18 prudent doctor do in similar situations with similar
19 training, and I feel like I'm just where Dr. Giep is,
20 just where Dr. Gower is, I've done general training, and
21 in my mind I didn't see anything in the records that
22 would reflect that he went below the standard of care.

23 Q. And from his testimony and what you heard in the
24 courtroom and what you read in the other depositions,
25 was there anything that led you to think that Dr. Giep

1 applied forces or direction of forces that was outside
2 of what most obstetricians would do in a scenario like
3 this with this case?

4 A. No, I didn't see that.

5 Q. And we just talked about it here and you heard
6 the testimony of Ms. Bowen. Did you read her testimony?

7 A. Yes, I did.

8 Q. And did you see the testimony of the parents and
9 the nurses about the demeanor of Dr. Giep in the
10 delivery room at the time he was at the business end
11 doing whatever he was doing?

12 A. I did.

13 Q. Did any of that suggest to you that he was acting
14 outside of the standard of care with the forces he
15 applied or the manner or direction that he applied with
16 it?

17 A. You know, and I tend to think that the parents
18 and the in-laws and all those definitely are saying what
19 they saw and remembered. Sometimes if you're not in
20 that field you don't know exactly. Things that look
21 awful to somebody that doesn't see them everyday can
22 look -- can be very normal. Any time you're reaching
23 inside somebody, that doesn't look normal. And it's, I
24 think, can be -- can look like there's something more
25 going on than may be. In their testimony I didn't see

1 anything that was outside of the area of normal.

2 Q. Now, Mrs. White, who just testified, and Mrs.
3 Phillips, who we'll play by video in a little bit, do
4 you know them from your years in the hospital?

5 A. Yes, I do.

6 Q. And have delivered babies where they were there
7 assisting you as either the surgical tech or the RN
8 nurse?

9 A. I've delivered babies with shoulder dystocias
10 with both of them.

11 Q. And are they good and competent nurses?

12 A. They are excellent. Natalie and ---

13 MR. HENSHAW: Objection, Your Honor, that's not
14 relevant for this case and it goes into areas of
15 reputation.

16 THE COURT: Sustained.

17 BY MR. LOVELL:

18 Q. In terms of their actions as nurses in
19 delivering, as you've heard Ms. White describe it and
20 you read in Mrs. Phillips deposition testimony, do they
21 have -- are they in a position to observe what the
22 doctors enumerated in the courtroom as you saw it?

23 A. Yes.

24 Q. And did you see anything in what they described
25 in how they observed it that suggested that what Dr.

1 Giep was doing on that particular day was any different
2 than what any other obstetrical doctor acting within a
3 standard of care would have done under those
4 circumstances?

5 A. No. I didn't see where they said anything like
6 that. And if they had seen something like that I would
7 have thought they would have put it down or told their
8 supervisor.

9 Q. Dr. Giep went through the maneuvers that he uses
10 as a routine, including the nuchal cord, the bulbing of
11 the baby, the suprapubic pressure and the McRoberts
12 maneuver, I got those backwards again, and the other
13 things he described, the Rubin II, are those the
14 maneuvers in that order that most obstetricians use when
15 faced with a dystocia event?

16 A. I would think that most -- when you start getting
17 down to the secondary maneuvers everybody does something
18 a hair different. McRoberts probably, I would say, 100
19 percent of people do that first. Suprapubic pressure
20 probably 99.5 percent of people do that second. And
21 then after that there's either gonna be somebody trying
22 to get the posterior arm, is what Dr. Giep tried to --
23 I'm sorry, Dr. Giep tried to describe, which it is very
24 difficult and used to be my go to.

25 But it's so hard. And I found that rotational

1 maneuvers work so much better that I went to a
2 rotational movement before I would actually try doing
3 the posterior arm. And I generally use the wood screw,
4 which is a little different. Dr. Giep uses Rubin, which
5 pushes in the wood screw. It's more of a pushing
6 motion.

7 But they all are trying to rotate the shoulders
8 to that they're, instead of being up and down, they're a
9 little off to the side. And typically when you do a
10 wood screw maneuver, or I haven't really seen a lot of
11 Rubins, but once it gets going and the patient's
12 pushing, the baby will literally spin around as it comes
13 out. And that's what I have used, you know, the most as
14 a secondary maneuver.

15 And then after that you're looking at possible
16 fracture of a clavicle to try and bring the shoulders in
17 to make less room. Then you're looking at -- I never
18 even thought about doing a Zavarelli maneuver.

19 Q. The wood screw and the Rubin, those secondary
20 maneuvers, is it within the standard of care to use a
21 Rubins first as opposed to the wood screw first?

22 A. Yes. And most people are -- what I used to teach
23 the residents is you should have the things you do boom,
24 boom, boom in your mind before we ever walk in there
25 because shoulder dystocia is you just don't know when

1 they're gonna happen. And so you have to have what
2 you're gonna do and how you're gonna do it in your mind
3 so you're not panicking when all that happens.

4 Q. Now, Doctor, I want to shift gears just a second
5 and ask you this. When the baby had the drop in the
6 fetal heart rate, was it at a risk of injury or was it
7 in trouble?

8 A. It was. It was in trouble as far as we can tell
9 at that time. I would have been concerned and done the
10 exact same thing that Dr. Giep did.

11 Q. When the baby's head had delivered and the
12 shoulder dystocia was discovered, at that point in time
13 was the baby medically stable with its heart rate and
14 what was going on?

15 A. No. Once you're in a shoulder dystocia, you
16 don't -- that's the definite or it's one of our few --
17 that's one of our obstetric emergencies and you don't
18 know how the baby is going to do at any one time during
19 that process. And so I would say -- and there's a
20 possibility of fractures. There's a possibility of
21 fetal death at that point from a shoulder dystocia.

22 Q. And is that in that window from the time of
23 dystocia recognition in the next minute and a half, two
24 minutes, whatever it was, is the baby at risk of
25 immediate serious bodily injury or even --

1 A. During --

2 Q. -- death?

3 A. During that whole time the baby is at risk. Now,
4 the -- I think most of us would agree that the longer it
5 goes, the more that we're gonna worry about injuries
6 because then you're starting to look at procedures that
7 may injure the baby.

8 Q. So during that window of time is baby medically
9 unstable, baby at imminent risk of serious bodily injury
10 or even death?

11 A. Yes.

12 Q. And does the doctor have unlimited time to get
13 the baby out?

14 A. No. And to go along with that, because the heart
15 rate was down a little bit beforehand in that period of
16 five to seven minutes, then it's -- I would normally say
17 if you have none of that, you probably have five to six
18 minutes that you're working on. In that case probably
19 three or four minutes.

20 Q. Now, Doctor, you've heard some testimony earlier
21 in the week about the degree of forces that those folks
22 thought would apply. Dr. Gurewitsch, she testified she
23 thought Dr. Giep used greater than I think 35 pounds of
24 pressure in his traction of force or whatever the word
25 is. In your opinion in a position where a physician is

1 on the stool sitting low with his hands over the baby's
2 ears or side of the face is that possible?

3 A. In my opinion no. If you're sitting on a stool
4 and you're trying to pull, that's the whole reason you
5 sit on a stool with a forceps delivery is so that -- or
6 a vacuum delivery or a shoulder dystocia, is so that you
7 wont put more pressure because if you're, you know, if
8 you're standing you can put the weight of your body
9 along with that. When you're sitting, that takes the
10 weight of your body out. And then I'd never really seen
11 forces or pounds put to this particular question. I
12 never looked at it until I saw her testimony.

13 And when I saw her testimony I just said, gosh,
14 35 pounds is a lot of pounds. And I started looking at
15 it and I said how much? I'd never done a simulator and
16 so I didn't know -- I really didn't know how many pounds
17 I might pull with a normal delivery. And so I tried to
18 sort of figure it out a little bit at home. I had a
19 scale that could tell me.

20 MR. HENSHAW: Your Honor, this is beyond the
21 qualifications of what he was allowed to testify to as
22 an expert. He's now getting into biomechanics.

23 MR. LOVELL: I think he's talking about his
24 experience in trying to determine if 35 pounds was
25 doable.

1 (Whereupon a bench conference was held off the
2 record.)

3 THE COURT: Overrule the objection.

4 BY MR. LOVELL:

5 Q. Doctor, I was asking you questions about
6 35 pounds of pressure. Continue on where you were on
7 what you were doing to figure out if you can do that.

8 A. Well, it just seemed like a lot of pounds to do
9 this way, and so I just tried to figure out how much
10 that might be. And I used a scale that you can pull
11 this way. (Indicating.) And you really had to strain
12 and pull to get up to 30 pounds. I couldn't get over 30
13 pounds.

14 And so I'm not -- that's why I say, when I did
15 moderate or when I did just normal pressure, I did about
16 a little under ten. When I did at -- when I did what I
17 thought was more than that where I might be at the five
18 or six-minute point of a dystocia, I probably did 15,
19 20. And I literally was shaking to get it up to 30.

20 Q. And when doctors are doing deliveries like we've
21 heard in this one and you've got the gloves on, either
22 latex or whatever, is the baby's head slick?

23 A. Yes.

24 Q. And when you're applying your hands in this
25 direction and you're trying to bring it towards coming

1 out, is that different even when you were doing your
2 little experiment with a dry area? (Indicating.)

3 A. Well, even different. Yeah, because a baby's
4 head is very gentle or, you know, it's very delicate and
5 so you couldn't, you know, you just can't squeeze very
6 hard to do that. So it would be hard to, hard to...

7 Q. When a physician is down in this position, and as
8 Dr. Giep has described, moving downward towards the
9 floor, in your opinion would it be 35, 45 degree of
10 ability there under that position?

11 A. I would think he could get maybe 20, 25. I don't
12 think he could get 35 or 40. But I don't -- I've never
13 looked at that.

14 Q. Sure. When you all are delivering, by you all I
15 mean obstetricians in general, are ---

16 MR. HENSHAW: Your Honor, I would object and move
17 to strike that last testimony. He gives the answer and
18 says I don't know I've never really looked at it. I
19 think it should be struck and ---

20 THE WITNESS: Well, I've never measured it.

21 MR. LOVELL: Hold on a second, Doctor. Judge, I
22 think he's giving his opinion. He's telling his basis.
23 I'll followup with how does he know this.

24 THE COURT: Overruled. You'll be able to examine
25 him.

1 MR. HENSHAW: All right, thank you.

2 BY MR. LOVELL:

3 Q. Have you ever measured it, Doctor?

4 A. No.

5 Q. When you were delivering, when obstetricians are
6 delivering a baby, we've heard a lot about axial spine,
7 is it necessary in order to facilitate the baby coming
8 out to move some degrees up, down, left or right as
9 you're moving and helping the baby in the delivery
10 process?

11 A. Yes.

12 Q. All right. Explain why that is.

13 A. Well, depending on where, you know, it depends on
14 whether you're talking about when the head's out or in.
15 When the head's in, the head's in a different position,
16 sometimes you're trying to, trying to get to see where
17 it's gonna go. And then once it comes out, you're
18 trying, especially if you have a dystocia, you're trying
19 to move the shoulders out of the straight up and down
20 line, so you're trying to get things to push and you're
21 trying to move them around.

22 And then once you do that, you're trying to get
23 them underneath the symphysis, the pelvic bone that's
24 right there that everybody keeps talking about. We're
25 trying to get the shoulder underneath that, and you're

1 gonna have to take just a little bit of downward
2 pressure to get there.

3 MR. LOVELL: Please answer any questions the
4 Plaintiff may have. Thank you, Doctor.

5 THE WITNESS: Okay.

6 CROSS-EXAMINATION

7 BY MR. HENSHAW:

8 Q. Please indulge me, Dr. Arnett.

9 A. Sure.

10 Q. I just need to see if I can find something here.

11 A. You all have a lot of things.

12 Q. Just to -- I may be covering some things you've
13 already answered.

14 A. Okay.

15 Q. So just indulge me in that too, okay?

16 A. Sure.

17 Q. You're being paid about \$3,000 today to be here?

18 A. 3500.

19 Q. 35, okay. And are you still working for
20 Spartanburg Regional Medical Center?

21 A. Yes, sir.

22 Q. Are you still working for the Medical University
23 of South Carolina?

24 A. I never worked for them. I was a clinical
25 instructor, so I helped instruct. I didn't get paid for

1 it.

2 Q. Were you somehow involved in the residency
3 program?

4 A. Yes.

5 Q. And you weren't paid for that?

6 A. No.

7 Q. Okay. But you were involved in the residency
8 program?

9 A. Both here and down at M -- with the MUSC resident
10 that came up.

11 Q. And you first got to know Dr. Giep, in fact, when
12 you were at MUSC in Charleston; is that right?

13 A. Um, I'm not sure if I didn't meet him before that
14 with his dad up here.

15 Q. Okay.

16 A. I can't remember.

17 Q. But, but you all were -- he was in medical
18 school, maybe a fourth year, and you were a resident
19 when you all were --

20 A. He was -- yes.

21 Q. -- beginning to become doctors?

22 A. He was either a third or a fourth-year resident
23 when I was down there doing OB and GYN.

24 Q. I mean, I hate to say baby doctors, but --

25 A. I understand what you're saying.

1 Q. -- that applies in both ways?

2 A. Sure.

3 Q. You all were baby doctors and you were becoming
4 baby doctors; is that right?

5 A. Well, yeah. I see where you're going, yes, sir.

6 Q. So you've known Dr. Giep for a long time. And
7 then you came back home to Spartanburg and so did he?

8 A. Yes, sir.

9 Q. And you don't mean in any way to suggest that
10 because you're competitors you would ever undertake to
11 use a trial to undermine a competitor, are you?

12 A. No, I'm not saying that at all.

13 Q. That was -- that's just the sort of off-handed
14 way of saying we know each?

15 A. Right.

16 Q. And you've both been in the same community for a
17 long time?

18 A. I guess it's a way of saying that, you know, that
19 we're not necessarily close.

20 Q. And you would look out for him if ---

21 A. I have. I think if there was something that I
22 needed to tell him I would.

23 Q. Okay. The -- had you said that before 2009 when
24 you stopped delivering babies you had delivered up to,
25 what, 3,000 babies?

1 A. Delivered probably 3,000. A little under that in
2 residency. Maybe a hair over that or somewhere in that
3 range.

4 Q. And maybe had as many as, what did you say, 80?

5 A. No I said 200.

6 Q. 200?

7 A. 200 very, you know, but probably 50 to 70, 80
8 more that other people may be more inclined to call them
9 more severe dystocia. In residence or somewhere in that
10 range.

11 Q. Do you know Dr. Chauhan?

12 A. Chauhan, yes.

13 Q. Chauhan?

14 A. Yes.

15 Q. And he also worked here in Spartanburg; is that
16 right?

17 A. Yes, sir.

18 Q. And when he was here he was doing research?

19 A. Yes.

20 Q. Were you contributing to his research?

21 A. No, not that I know. Now, I don't know if he
22 took numbers from my deliveries and somehow that may be
23 a contribution, but I wasn't actively giving him
24 anything.

25 Q. Were you here yesterday when he testified?

1 A. No, I was not.

2 Q. He was -- he indicated that he's been looking for
3 shoulder dystocia cases ever since he became a baby
4 doctor and was having a hard time finding them. And he
5 only could come up with like 90 over a period of 20 or
6 30 years and that you've got 200.

7 A. And, again, I probably -- if I have any kind of,
8 any kind of difficulty with the shoulder that I have to
9 use a maneuver, then generally I call that a shoulder
10 dystocia. And there's -- some people may not call it
11 that. Again, probably more on the lines of what he's
12 thinking may be closer to 50 to 60.

13 Q. Okay. But you've never offered him your series
14 of cases to look at?

15 A. I don't have a series that I could offer him.

16 Q. Okay. Now, and of that you've had one case that
17 you've identified as potential or permanent brachial
18 plexus injuries?

19 A. One that I can remember, yes, sir.

20 Q. All right. And you only know about that because
21 you had occasion to speak with the mother about six
22 years out?

23 A. Yes, but that was a ways back.

24 Q. All right. Did you know what nerve roots had
25 been affected in that child?

1 A. I did not.

2 Q. You don't know whether they had been ruptured?

3 A. I, I don't know.

4 Q. You don't know whether they had been avulsed?

5 A. No, sir.

6 Q. You really don't know anything about the
7 circumstances of that child's injury other than mother's
8 told you he's still having problems?

9 A. Still having problems with his arm, yes, sir.

10 Q. All right.

11 A. But it had improved over time, is what she said.

12 Q. Okay. Don't know the way that it looked?

13 A. No, not at all.

14 Q. Whether the wrist was turned in or the hand was
15 turned under?

16 A. No.

17 Q. None of that?

18 A. No, sir.

19 Q. Okay. Doctor, what is Erb's palsy? Do you know
20 that term?

21 A. Erb's palsy is a palsy from the shoulder dys --
22 or from the brachial plexus injury where you have a
23 problem with the wrist.

24 Q. Okay. And it's a problem with the wrist?

25 A. (Witness nods head up and down.)

1 Q. Does it ever --

2 A. Well, I mean ---

3 Q. -- create facial problems?

4 A. Um, I'm not sure that I know enough to make a
5 competent, or to give a clinical opinion on that.

6 Q. All right. Are you familiar with whether an
7 injury to C-4, C-5, as a result of shoulder dystocia
8 causing brachial plexus injury can cause respiratory
9 problems in a child?

10 A. That wouldn't be my area of expertise. I don't
11 think I can give you a comment on that.

12 Q. So you don't know whether the phrenic nerve could
13 be affected by this type of injury?

14 A. I've heard that phrenic nerves are affected, but
15 I couldn't give you even a how that happens or where it
16 is or -- it's just not part of my, my training.

17 Q. Do you, do you generally understand as a medical
18 doctor who's been given some anatomical training in
19 medical school that the phrenic nerve relates to the
20 diaphragm?

21 A. Yes.

22 Q. It's that much that we can --

23 A. Yes.

24 Q. -- establish --

25 A. Uh-huh.

1 Q. -- with you? Okay. Now, you're not a biomedical
2 engineer, are you?

3 A. I've had some engineering, but I'm not a
4 biomedical engineer.

5 Q. We've heard some testimony from the experts, not
6 just the plaintiff's experts, about use of dummies or
7 synthetic models that doctors use to try to test how
8 much pressure they're applying. Have you ever done
9 that?

10 A. No.

11 Q. So instead of going to your bathroom scale, was
12 there a model or dummy that you could have gone to and
13 tested how much 35 pounds is?

14 A. There's not one around here that I know of, but I
15 haven't actually looked. I, I didn't even think about
16 pounds until the other day.

17 Q. I understand.

18 A. And I got a -- not really a bathroom scale, it's
19 a luggage scale, if you want to know.

20 Q. Oh, okay. All right. And were you in any way in
21 terms ever using the scale actually trying to reproduce
22 some of the things that have been discussed here, such
23 as lateral traction where there's a bending?

24 A. This would have been more a straight axial type
25 because you can't -- I mean, you can pull it down that

1 way, but it's not gonna tell you.

2 Q. Okay.

3 A. You know, it's always gonna be the same amount of
4 pull when you bring it.

5 Q. All right. So would you agree, Doctor, that you
6 certainly would not want to publish your results?

7 A. No, sir, you're correct.

8 Q. Because really it's not scientifically valid at
9 all, is it?

10 A. It just gives me an idea probably how much I was
11 giving the forces that I might use just in my own mind.

12 Q. Okay. And, Doctor, I hate to bring this up.

13 A. Uh-huh.

14 Q. But this one baby that you know of that where the
15 mother came and said my baby is -- my child is still
16 having problems and you're thinking that that might be a
17 permanent injury, you don't recognize or acknowledge
18 that you used too much traction in that baby's case, do
19 you?

20 A. No.

21 Q. And, in fact, you've been involved in other cases
22 where you defended the actions of doctors and none of
23 them have ever acknowledged that they used too much
24 traction, have they?

25 A. I've only been in one case.

1 Q. Okay. But in that case the doctor ---

2 A. The doctor said he didn't touch the baby's head.

3 Q. Didn't even touch the baby's head?

4 A. Or do any kind of traction and let it rotate.

5 Q. Okay. Have you been involved in any peer review
6 proceedings at the hospital where you had to go in and
7 look at the conduct of obstetricians who delivered
8 babies under these circumstances?

9 A. I was the department chairman in the '90s. I'm
10 sure we might -- we probably -- we all look at our
11 shoulder dystocias to see what happens and what went on,
12 but I don't remember anything specific.

13 Q. Did any of the doctors that were interviewed as
14 part of those processes ever acknowledge that they had
15 used excessive traction?

16 A. None that I can remember. Now, I'm gonna tell
17 you I have written it on a document on my, on two of my
18 deliveries where I used more than what I would consider
19 minimal traction.

20 Q. Did you feel like you had a reason to --

21 A. Yes.

22 Q. -- use excessive traction?

23 A. We were into six, seven minutes of it.

24 Q. Okay. So in other words, you were faced with a
25 situation where you either -- you had to sacrifice the

1 arm in order to spare the baby?

2 A. Well, I ---

3 Q. Or at least took that risk?

4 A. I was, I was running out of ideas and I've never
5 done a Zavanelli maneuver, don't think I ever will.

6 Q. And that's where you actually push the baby back
7 up into the uterus?

8 A. I figured that's gotta be worse than what I was
9 gonna do, so... And I didn't have an injury with either
10 one of those, so...

11 Q. But in that situation where you are six to seven
12 minutes down the path with the baby's head out and the
13 baby's still not coming, that's when a doctor is faced
14 with probably the most dreaded, one of the most dreaded
15 decisions he can make.

16 A. Yes, sir.

17 Q. Which is I either take the risk of sacrificing
18 the arm to spare the baby or I don't and the baby is
19 likely to die.

20 A. Yes, sir.

21 Q. Okay. And so when you say you've actually
22 written that and you've faced that decision, that
23 dilemma, you've written it and explained why you did
24 what you did?

25 A. Yeah. Well, I mean, I, I put it in. Typically

1 I'll put it in at the bottom of my note if I have a
2 shoulder dystocia how much traction I use.

3 Q. But in this particular case that we have here in
4 this court, there's no indication that Dr. Giep was at
5 the point where he was faced with that dilemma?

6 A. No. No.

7 Q. There's no indication that he was intentionally
8 sacrificing the arm in order to spare the baby.

9 A. There was no -- this wouldn't have been the time
10 where I would have thought he would have tried more than
11 just what he'd described, which was general traction or
12 mild traction.

13 Q. And did you find in the records that there is
14 some difference but, regardless, the time that it took
15 him to use the maneuvers and get the baby out was
16 between one and two minutes?

17 A. No, that's what I saw.

18 Q. All right.

19 MR. HENSHAW: Just one moment, please, Your
20 Honor.

21 BY MR. HENSHAW:

22 Q. Do you agree, Doctor, that under the
23 circumstances that exist in this case that lateral
24 traction would be a deviation from standard medical
25 care? -

1 A. No.

2 Q. Pulling the baby's head away from the impacted
3 shoulder?

4 A. No. I think you can still use some downward
5 traction to ---

6 Q. And ---

7 A. Most people would call it minimal downward
8 traction.

9 Q. Okay. But is there a limit on what is allowed
10 within that standard that you're trying to tell us
11 about?

12 A. I would think if you went -- and, again, I don't
13 know if the baby's head is coming down, I mean, I'd
14 almost have to see what -- to me minimal traction means
15 you bring it down slightly. And probably anything much
16 past that I think would not -- would be more than we
17 would recommend at one to two minutes. Now at four to
18 five minutes then, yeah, you might want to pull down a
19 little bit more in that direction.

20 MR. HENSHAW: All right. That's all the
21 questions I have. Thank you, Doctor.

22 MR. LOVELL: Very briefly, Your Honor.

23 REDIRECT EXAMINATION

24 BY MR. LOVELL:

25 Q. Doctor, did I hear you say that when you write

1 the amount of traction you use in a shoulder dystocia
2 delivery, you write it at the end of your note, like
3 this? (Indicating.)

4 A. Generally I put the standard stuff and then I do
5 the shoulder dystocia at the bottom.

6 MR. LOVELL: That's all I have.

7 THE COURT: You may step down.

8 MR. LOVELL: May he be excused?

9 THE COURT: You may also be excused.

10 (Whereupon, witness leaves the witness stand.)

11 THE COURT: We're gonna take a short break. I'll
12 ask the jury to please go to the jury room and I'll
13 bring you back after that break. Don't talk about the
14 case.

15 (Whereupon, jury leaves courtroom at 4:01 p.m.)

16 THE COURT: Court's in recess for 15 minutes.
17 Mr. Henshaw, Mr. Lovell, let me see you all just before
18 we break.

19 (Whereupon, a bench conference was held off the
20 record.)

21 (Whereupon, a recess was had from 4:03 to 4:15
22 p.m.)

23 THE COURT: Mr. Henshaw, did you give the court
24 reporter some exhibits?

25 MR. HENSHAW: Yes, sir. I need to give them back

1 THE COURT: Bring them in.

2 (Whereupon, jury enters the courtroom at 4:18
3 p.m.)

4 THE COURT: All right. Mr. Lovell.

5 MR. LOVELL: Your Honor, we call Natalie Phillips
6 by video taken on 9/17/2017 in Knoxville.

7 (Whereupon, plays video of deposition of Natalie
8 Phillips.)

9 MR. LOVELL: You're Honor, that's the conclusion.

10 THE COURT: I understand we have one final
11 witness. That witness will probably take maybe
12 45 minutes to conclude and we can do it now or we can do
13 it in the morning. I'll leave it up to the jury. If
14 you need to talk about it, you can go back to the jury
15 room and talk about it. If we do it tonight, then that
16 means all of the evidence will be in and what will
17 remain to be done will be the lawyers final summations
18 and the instruction on the law and your deliberations.

19 If we do it in the morning, obviously we'll have
20 to complete the testimony and evidence before we
21 conclude. Go back to the jury room and talk about it
22 for a minute and come back and let me know.

23 (Whereupon, jury leaves the courtroom at 5:42
24 p.m.)

25 MR. LOVELL: Do I have time to be excused for a

(On the Record at 10:45 a.m.)

VIDEOGRAPHER: Okay. Today is September 19, 2017. This is the deposition of Ms. Natalie Phillips. At this time the attorneys may identify themselves on the record and for whom they represent.

MR. WEATHERLY: My name is Lee Weatherly, and I represent Dr. Bang Giep and Spartanburg & Pelham OB/GYN.

MR. HENSHAW: My name is Charles Henshaw. I represent the Flowers family, specifically Ashley F and her parents as Plaintiffs in this action.

NATALIE PHILIPS,
having first been duly sworn, was examined and deposed as follows:

DIRECT EXAMINATION BY MR. WEATHERLY:

Q. Good morning, my name's Lee Weatherly, and I represent Spartanburg & Pelham OB/GYN. And we're here today to take your deposition on video, we have a camera here, to be played in front of a jury at the trial of this case happening the week of October 9th. Could you start by telling the jury who you are and where you live right now?

A. My name's ~~ROA 795~~ Phillips, and I live in

1 Knoxville, Tennessee.

2 Q. And why do you currently live in
3 Knoxville?

4 A. We moved here about three years ago from
5 Spartanburg.

6 Q. Okay. And when you say "we," who is
7 that?

8 A. My family, my husband and my two kids.

9 Q. All right. So you have two children now.
10 Are you expecting again?

11 A. Yes. Third coming in January.

12 Q. Congratulations. What does -- let me ask
13 a couple of questions about your husband first. What
14 does your husband do for a living?

15 A. He's a worship pastor at a church here.

16 Q. And where was he born and raised?

17 A. He was born in Texas, but he was raised
18 in Spartanburg.

19 Q. Back in October of 2008, did you live
20 near Spartanburg?

21 A. Yes.

22 Q. And where did you live?

23 A. Boiling Springs.

24 Q. And was your husband working for a church
25 there around Spartanburg **ROA 796** at time?

1 A. Yes.

2 Q. What was he doing there?

3 A. At that time he was a junior-high pastor.

4 Q. And where were you born and raised?

5 A. Spartanburg.

6 Q. And where did you go to high school?

7 A. Boiling Springs.

8 Q. Were you a labor and delivery nurse who
9 was present for the delivery of Ashley F. back in
10 the October 2008?

11 A. Yes.

12 Q. Was there also what's called a scrub tech
13 named Cindy White who was involved in the delivery of
14 Ashley F. ?

15 A. Yes, to my knowledge, yes.

16 Q. Other than today, here in this
17 deposition, the only other time we've met is when
18 Mr. Henshaw took your deposition about a year ago?

19 A. Correct.

20 Q. Do you remember the Ashley F.
21 delivery?

22 A. Vaguely, yes. Somewhat. A little.

23 Q. And why does that delivery stick out in
24 your mind as opposed to some others?

25 A. In initial **RQA 797** production I found he worked

1 at the hospital, and it was one of my first shoulder
2 dystocias. I had been working there about a year.

3 Q. And when you say "he," who do you mean?

4 A. The father.

5 Q. Okay. So Ashley F father -- what
6 did you say? He worked where?

7 A. At the hospital.

8 Q. Okay. Describe for the jury back in
9 2008, were you what's called a labor and delivery
10 nurse?

11 A. Yes.

12 Q. And what does that mean?

13 A. That means I took care of the patients
14 and the babies or soon to become or delivered babies,
15 yeah. I was the primary nurse for those patients.

16 Q. All right. So when --

17 A. Laboring patients.

18 Q. So when moms were in the hospital to
19 deliver babies, you were sort of the nurse who was in
20 charge of that patient while they were delivering and
21 before they were delivering?

22 A. Correct.

23 Q. All right. Did you go to school to be
24 able to do that?

25 A. Yes. I went to school to be a nurse, a

1 registered nurse.

2 Q. All right. Describe for the jury kind of
3 what education and training you had to go through to
4 become a labor and delivery nurse?

5 A. Well, I went to USC Upstate for my
6 prerequisites, and I transferred to Spartanburg
7 Community College to have my associate's degree in
8 nursing. And, of course, we all have to take our
9 boards, NPLEX, and then I was hired at Spartanburg
10 Regional as a labor and delivery nurse right out of
11 school.

12 Q. And how long were you a nurse -- or let
13 me ask you, right now, what do you do now?

14 A. I'm a stay-at-home mom.

15 Q. How long were you a labor and delivery
16 nurse before you decided to stay home and be a mom to
17 your children?

18 A. Seven years.

19 Q. And was the last time you were a nurse, I
20 guess, about 2014?

21 A. Uh-huh.

22 Q. So would that make it from 2007 to about
23 2014 you were an actively practicing labor and delivery
24 nurse?

25 A. Correct. **ROA 799**

1 Q. And where did you start your career as a
2 labor and delivery nurse?

3 A. At Spartanburg Regional.

4 Q. And did you do that the whole time you
5 were there?

6 A. Yes.

7 Q. Do you still hold a nursing license?

8 A. Yes.

9 Q. Where do you hold that?

10 A. Tennessee.

11 Q. Do you have to do continuing education to
12 keep that nursing license active?

13 A. Yes.

14 Q. How many babies do you think you
15 participated in the delivery of during that seven-year
16 period?

17 A. Hard to say. We would usually do about
18 two a shift every, you know, 12 hours usually, so I
19 worked for seven years, so hundreds, I don't know.

20 Q. So you participated in the birth as a
21 labor and delivery nurse of hundreds of children?

22 A. Yes, I would say, yeah.

23 Q. Have you seen or worked with a number of
24 different obstetricians other than Dr. Giep?

25 A. Yes. **ROA 800**

1 Q. And before the delivery, before the birth
2 of Ashley F , had you been involved in deliveries
3 where a shoulder dystocia occurred?

4 A. Before Ashley?

5 Q. Yes.

6 A. Yeah.

7 Q. And after Ashley F birth, were you
8 involved in deliveries that involved shoulder
9 dystocias?

10 A. Yes.

11 Q. And have you witnessed other doctors,
12 other than Dr. Giep, in how they handle and treat and
13 react to a shoulder dystocia occurring?

14 A. Yes.

15 Q. Have you been trained as a nurse on how
16 to respond to a shoulder dystocia?

17 A. Yes.

18 Q. Tell me a little bit about the training
19 that you underwent during your seven years as a nurse
20 as to how to respond to a shoulder dystocia?

21 A. We would -- our unit educator would go
22 over, at least one or twice a year, a mock drill. We
23 would deal with a manikin and a fetal monitoring strip
24 and also have to take a test.

25 Q. And tell me **ROA 891** that was like when you

1 had a monitor, a fetal monitoring strip. Explain that
2 a little more to me and the jury.

3 A. We would just go through a scenario, and
4 we would go through the steps and interventions that we
5 would need to have to go through of doing a shoulder
6 dystocia when it occurred.

7 Q. And you would do that every year?

8 A. At least, uh-huh.

9 Q. Have you been trained in how to put a
10 patient in what's called the McRoberts' position?

11 A. Yes.

12 Q. And have you been trained on how to
13 correctly apply what's called suprapubic pressure?

14 A. Yes.

15 Q. Let me shift gears, ma'am, and talk a
16 little bit about the delivery of Ashley F . Were
17 you in the deliver room for the birth of
18 Ashley F ?

19 A. Yes.

20 Q. And what was your role in that delivery?

21 A. I was a primary nurse.

22 Q. And what does that mean being the primary
23 nurse?

24 A. I was the one -- I was the nurse
25 responsible for her. **ROA 802**

1 Q. All right. And were you there from when
2 you started your shift at around 7:00 p.m. until Ashley
3 was born until 8:20 p.m.?

4 A. Yes, I was her nurse there.

5 Q. I'm going to hand you what I have marked
6 as Defendants Exhibit 2.

7 A. Uh-huh.

8 Q. And ask you to take a look at that and
9 tell me if after 19:00, and that means 7:00 p.m.; is
10 that accurate?

11 A. Uh-huh.

12 Q. Okay. Starting at 7:00 p.m., if that's
13 your handwriting on that medical record?

14 A. After 7:00 p.m., yes.

15 Q. And did you take, I guess, what's a
16 handoff from another nurse at 7:00 p.m. who had been
17 treating Ms. Flowers before your shift started?

18 A. Yes, it looks like it, uh-huh.

19 Q. And these recordings that you made on
20 Exhibit 2 in this medical record, were those made on
21 the night of Ashley F birth?

22 A. Uh-huh.

23 Q. And you have to say --

24 A. Yes.

25 Q. -- "yes" **RQA 803** Court Reporter here?

1 A. Yes.

2 MR. WEATHERLY: Thank you. At this time
3 I would like to admit Defendants Exhibit 2 into
4 evidence, please.

5 MR. HENSHAW: No objection.

6 (Defendants Exhibit 2 - Nurse's Progress
7 Record.)

8 BY MR. WEATHERLY:

9 Q. All right. Could you hold that record up
10 for the camera to show the jury sort of where your
11 writing on this document is? You can just point to it.

12 A. Yes, 19:00, to 20:20.

13 Q. All right. Thank you. And feel free to
14 refer to that record whenever you need to. Starting at
15 7:12 p.m., did you have to give Ms. Flowers some
16 medications?

17 A. Yes, looks like ampicillin.

18 Q. Why did you have to do that?

19 A. It was a doctor's order he wrote.

20 Q. All right. And then at 7:32 or 19:32,
21 did you do an exam of Ms. Flowers?

22 A. It looks like it, yes, sir.

23 Q. And what did that exam show?

24 A. It says SVE, sterile vaginal exam, with
25 the mom being completely ~~ROA 804~~ed, completely effacing

1 at zero station.

2 Q. Tell me what those three things mean?
3 Completely dilated and completely effaced and at zero
4 station?

5 A. Completely dilated, she was 10
6 centimeters. Completely effaced means her cervix was
7 thinned out completely, and zero station is where the
8 baby's head was in relation to the pelvis.

9 Q. Does this mean that Ms. Flowers is, for
10 lack of a medical term, ready to push?

11 A. Yes. Correct.

12 Q. I'm going to hand you what's been marked
13 as Defendants Exhibit 1 and ask you if some of your
14 handwriting is on this medical record?

15 A. It is.

16 Q. Could you'll show the jury on the camera
17 there where on that document your handwriting is?

18 A. Okay. "Dr. Giep" here. Let's see.
19 "Completely dilated," the hours and minutes of each
20 stage. "Ampicillin" here I administered at 19:12. And
21 the date of time of delivery. Those are my initials
22 and the time I put the Pitocin gave after delivery.

23 Let's see. Episiotomy, the first degree
24 midline there, and the laceration, third degree
25 midline, that's me. The **RQA 805** penta, 20:51, and estimated

1 blood loss within normal, that's me. Core vessels,
2 three, that's me.

3 Complications, shoulder dystocia and
4 vacuum, that's me. Apgars, the one minute, five
5 minute, that's me. And the weight, 7 pounds,
6 11 ounces, is me. Let's see. Oh, guarded condition at
7 NICU, that's me. And then the sponges and needles
8 accounts there, that's me. And the Apgar scores down
9 there is me, and the signature, R.N., Natalie Phillips.
10 And I said that Cindy White was there as well.

11 Q. Okay. Did you write all of this
12 documentation on the medical record that's Exhibit 1 on
13 the night of Ashley F. birth?

14 A. Yes.

15 MR. WEATHERLY: At this point I would
16 like to move Exhibit 1 into evidence, please.

17 MR. HENSHAW: No objection.

18 (Defendants Exhibit 1 - Spartanburg Regional
19 Healthcare System record.)

20 BY MR. WEATHERLY:

21 Q. Did you record on this Defendants
22 Exhibit 1 the time that Ms. Flowers was completely
23 dilated?

24 A. Yes, I recorded that, uh-huh.

25 Q. And I'm going to hand you now what's been

1 marked as Defendants Exhibit 3, and could you tell the
2 jury what that is?

3 A. That is a fetal monitoring strip.

4 Q. And explain to the jury how that record
5 is made, to the best of your knowledge?

6 A. It's just a strip that prints out on the
7 monitor of the baby's heart rate and mom's
8 contractions.

9 Q. If you could show the jury, hold it up --

10 A. Yeah.

11 Q. -- and show sort of what that top grid is
12 and explain to them what that is and then explain to
13 them what the bottom grid is.

14 A. The top is the baby's heartbeat, the rate
15 is the 130s.

16 Q. And how is that measured? How do you get
17 that reading?

18 A. You see the "120" there and it goes up by
19 tens, so that's 20, that's 30, and that's about where
20 the baby's heart rate is.

21 Q. I guess my question is, how does the
22 computer get the information to print that out?

23 A. Oh, we have monitors on the mother's
24 stomach --

25 Q. Okay. **ROA 807**

1 A. -- that relays us to the --

2 Q. All right. Now, what's the bottom grid?

3 A. That's the mom's contractions. And this
4 is kind of hard to read here, but these kind of hills
5 are the mom's contractions.

6 Q. Okay. Now, is there some writing in
7 between those two grids? Some typed in information?

8 A. Yes, yes. Blood pressure that prints
9 out -- once it takes from the monitor, it prints out
10 from an actual strip that's coming from the monitor,
11 and then there's also a type -- a thing we can type in
12 messages that prints out on the strip, which I did.

13 Q. And that area that's typed in, for
14 instance, the first page, I think it says, "SVE" --

15 A. Uh-huh.

16 Q. -- "C/C/O NP, R.N."

17 A. Uh-huh.

18 Q. Is that information that you would have
19 typed in this record?

20 A. Yes.

21 Q. And is there other information in the
22 subsequent pages that you would have typed into that
23 record?

24 A. Yes.

25 Q. And would you have been typing that in at

1 the same time as these events were occurring?

2 A. Around about, yes.

3 MR. WEATHERLY: At this time I would like
4 to move Exhibit 3 into evidence as well.

5 MR. HENSHAW: No objection.

6 (Defendants Exhibit 3 - Printout of fetal
7 monitoring strip.)

8 BY MR. WEATHERLY:

9 Q. Okay. Let's go back to 7:32. You just
10 told us that Ms. Flowers at this point was ready to
11 start pushing. At 7:42, about ten minutes later, did
12 she have some complaints?

13 A. It looks like it, yes.

14 Q. And describe for me what her complaints
15 were at 7:42?

16 A. It looks like on my notes, it says,
17 "Patient complains of pain and cramping," and then I
18 notified anesthesia.

19 Q. And you already answered my next question
20 is, what did you do about that?

21 A. Notified anesthesia.

22 Q. And did an anesthesiologist come then to
23 the room?

24 A. It looms like it 19:44.

25 Q. And what ~~ROA 809~~ anesthesiologist do,

1 according to your record?

2 A. It says, "Anesthesia at bedside, five cc
3 of two percent lidocaine administered."

4 Q. Is that pain medication?

5 A. Yes. They give it through the epidural
6 catheter that's in her back.

7 Q. And was that effective in alleviating
8 Ms. Flowers' complaints.

9 A. It looks like it. It looks like they
10 gave a little bit more of it at 19:46, but, yes, as far
11 as my notes, yes.

12 Q. And then what did you do after her pains
13 or complaints of pain were alleviated? What did you do
14 at 7:47?

15 A. Removed her Foley catheter.

16 Q. Now, why is it important to do that when
17 she's getting ready to start pushing?

18 A. When you put a Foley catheter in, there
19 is a balloon that's inflated with saline, so we have to
20 deflate that so it doesn't prevent the baby's head from
21 coming down the birth canal.

22 Q. And were you able to remove that Foley
23 catheter?

24 A. Yes, it looks like it.

25 Q. And did Ms. ~~ROA 810~~ Flowers start pushing after

1 that?

2 A. Yes, it looks like it at 19:55, yes.

3 Q. Based on your records and the fetal
4 monitoring strip that's Exhibit 3, what was
5 Ashley F baby's normal baseline heart rate
6 during labor, approximately?

7 A. It looks to be about 130. Yeah. Yes,
8 uh-huh.

9 Q. At about 8:07 or 20:07, did the fetal
10 monitoring strip show that the baby's heart rate had
11 dropped?

12 A. Yes.

13 Q. And what had it dropped to?

14 A. Like, the nineties. It's kind of broken
15 up, but, yes, going into the nineties.

16 Q. And did you document that on Exhibit 2?

17 A. Yes.

18 Q. And what did you do in response to the
19 baby's heart rate dropping into the nineties?

20 A. I turned the Pitocin off.

21 Q. What are you -- as a nurse, what are you
22 concerned about there with the baby's heart rate being
23 in the nineties?

24 A. I mean, we just didn't want -- I just
25 didn't want the heart rate **ROA 811** stay there in the

1 nineties. I went to shut off the Pitocin so it's less
2 stimulus on the baby, the contractions.

3 Q. Other than turning off the oxytocin, what
4 else did you do in response to the heart rate being in
5 the nineties?

6 A. It looks like at 20:11 I put the patient
7 on the right side.

8 Q. And what are you trying to accomplish by
9 doing that?

10 A. Sometimes position changes helps with
11 maybe the baby's head is compressing on the umbilical
12 cord, and it alleviates that.

13 Q. And does the shifting of the patient, are
14 you hoping that that pulls the baby -- sort of using
15 gravity to pull the baby's off of the umbilical cord?

16 A. Yes.

17 Q. And why would you be concerned about the
18 baby's head being on the umbilical cord? What can that
19 cause?

20 A. Just decreased heart rate and cut off the
21 blood flow to the baby.

22 Q. Did you also give the mom oxygen at that
23 time?

24 A. Yes, it looks like 20:08.

25 Q. And why are you giving the mom oxygen at

1 8:08 p.m.?

2 A. To increase the oxygen to mom and to baby
3 to help with the heart rate.

4 Q. Do you have some concern during this
5 period that the baby is not getting enough oxygen?

6 A. Yes. To some degree because it wasn't
7 recovering, the heart rate wasn't recovering.

8 Q. And how long was the baby's heart rate in
9 the nineties while all this was going on?

10 A. Let's see. About five minutes, four or
11 five minutes.

12 Q. And did Dr. Giep arrive in the delivery
13 room at 8:11 p.m.?

14 A. It looks like it, yes, sir. Yeah.

15 Q. And what did you chart on Exhibit 2 and
16 Exhibit 3 that he did shortly after he arrived?

17 A. It says patient to right side at 20:11,
18 Dr. Giep at bedside. And at 20:16 it says Dr. Giep,
19 it's a verbal order to restart Pitocin at 13
20 milliunits.

21 Q. All right. Is some of the tracing after
22 Dr. Giep arrived at 20:14, 20:15 and 20:16, is it
23 somewhat hard to follow?

24 A. Yes. It's broken up because we're doing
25 position changes. And ~~ROA 813~~ at that point it's still

1 in external -- it's on the mom's tummy, so we're doing
2 position changes and pushing.

3 Q. Even though you don't have a consistent
4 line on this strip, are you still able to hear the beat
5 of the heart there in the room?

6 A. Yes.

7 Q. And are you trained to be able to tell
8 the difference between a heart rate in the 130s and a
9 heart rate in the nineties?

10 A. Yes.

11 Q. Did you next document that Dr. Giep used
12 a Kiwi to help deliver the head of Ashley F. ?

13 A. It looks like vacuum. Yeah, vacuum
14 applied.

15 Q. And is Kiwi a type of a vacuum?

16 A. Yes.

17 Q. Is it sort of a small handheld pump-type
18 thing?

19 A. Yes.

20 Q. Did you note that he pulled twice on the
21 vacuum or the Kiwi to deliver the head?

22 A. It looks like it, yes, sir.

23 Q. And how could you tell that he pulled
24 twice during this delivery?

25 A. Well, there ~~ROA 814~~ drapes up, but I can

1 still see from his upper to lower arms up to his head.

2 Q. So were you able to see the movement of
3 his arms twice?

4 A. Yes.

5 Q. Did you document the use of the Kiwi both
6 on the fetal monitoring strip and on Exhibit 2?

7 A. Yes, sir, it looks like it, yes.

8 Q. Now, did that vacuum ever pop off of
9 Ashley F head because he was pulling too hard on
10 it?

11 A. Not that I can remember.

12 MR. HENSHAW: Objection. Calls for
13 speculation.

14 BY MR. WEATHERLY:

15 Q. Let me rephrase that question. When
16 Dr. Giep was using the Kiwi, to your knowledge did it
17 ever pop off of Ashley F head?

18 A. Not that I can remember. I don't recall.

19 Q. Is that something that, if there was
20 what's called a "popoff," you would ordinarily
21 document?

22 A. Yes.

23 Q. All right. When Dr. Giep began using the
24 Kiwi, did you then call for the NICU team?

25 A. Yes. There ~~was~~ **ROA 815** an intercom system in the

1 room right beside the patient's beside. I can call and
2 the secretary comes over the speaker. And I called for
3 NICU at that point, yes.

4 Q. And would that be before the shoulder
5 dystocia ever occurred?

6 A. Yes.

7 Q. Okay. All right. Now, when Dr. Giep
8 determined that Ashley F was experiencing a
9 shoulder dystocia, did he then instruct the nurses to
10 have the mom in McRoberts' position and for someone to
11 apply suprapubic pressure?

12 A. Yes.

13 Q. And were you the person that applied
14 suprapubic pressure in this case?

15 A. Yes.

16 Q. And that's something that you were
17 trained to do?

18 A. Yes, sir. Uh-huh.

19 Q. Could you demonstrate for the jury
20 because we have a have video here --

21 MR. WEATHERLY: And if the Videographer
22 could pan back a little bit.

23 BY MR. WEATHERLY:

24 Q. If you could sort of show the jury what
25 suprapubic pressure is ~~ROA 816~~ describe how you apply it?

1 A. I just take my hand, usually my dominant
2 hand, usually in a fist and usually take it right to
3 where her pubic bone is right near her pubic bone and
4 apply pressure at an angle to kind of dislodge the
5 baby's shoulder as the mom is pushing.

6 Q. Now, are you standing on the ground while
7 you're doing this?

8 A. No. I'm usually -- the bed's elevated so
9 we have a stool, so it helps us get closer to the mom.
10 And in the bed, sometimes in the bed, sometimes at the
11 bedside.

12 Q. Okay. Now, did you document that you did
13 suprapubic pressure there on Exhibit 2?

14 A. Yes.

15 Q. And did you also document that on
16 Exhibit 3?

17 A. Is that the fetal monitoring --

18 Q. Yes, ma'am.

19 A. -- strip? Yes, this -- yeah, at 20:20.

20 Q. It says "supper," but --

21 A. Yeah.

22 Q. -- did you mean to write "supra" there?

23 A. Yes, it was really fast, yeah.

24 Q. Okay. And were you looking at Dr. Giep
25 while you were applying **ROA 817** suprapubic pressure?

1 A. My -- it was -- my vantage point was
2 either the mom or his -- yes, at him.

3 Q. All right. Did you ever feel like this
4 suprapubic pressure was releasing the shoulder? It was
5 being effective?

6 A. I couldn't tell. He'd instruct to me,
7 "yes, that's good," or, "no, it's not helping," because
8 I couldn't see the baby's head.

9 Q. Did you apply that suprapubic pressure
10 until Dr. Giep told you to stop?

11 A. Yes.

12 Q. Did the NICU team arrive shortly after
13 the shoulder dystocia was diagnosed by Dr. Giep,
14 according to your records on Exhibit 2?

15 A. Yes.

16 Q. And could you see what Dr. Giep was doing
17 with his hands, either while you were applying
18 suprapubic pressure or immediately afterwards?

19 A. No. I could just see a little bit of his
20 forearm and his arms.

21 Q. If he put his hands into Ms. Flowers'
22 vagina to try to do any sort of maneuvers or anything
23 to release that shoulder, would you have been able to
24 see that?

25 A. No. **ROA 818**

1 Q. And if you weren't -- well, excuse me,
2 let me -- after the child was delivered, were you
3 involved in the resuscitation efforts, or was that left
4 to the NICU team?

5 A. That was the NICU team.

6 Q. Who, to your recollection, was involved
7 in attempting to resuscitate Ashley F ?

8 A. It was just the NICU team. And at that
9 point I didn't know who was there, the nurses
10 specifically.

11 Q. Were you responsible for determining what
12 is called the "Apgar scores" for Ashley that are listed
13 on Exhibit 1?

14 A. No, I did not assign that.

15 Q. Was that something done by the NICU team
16 and then called in to you to put on this record?

17 A. Yes.

18 Q. All right. Ms. Phillips, just a couple
19 of more questions for you. To your knowledge, did
20 Dr. Giep ever use any level of traction on
21 Ashley F head at any time during this delivery
22 that was different from what you've seen other
23 physicians do, either before or after this shoulder
24 dystocia?

25 A. No, not to my knowledge. I couldn't see

1 where his hands were.

2 Q. Did you see any signs from Dr. Giep such
3 as flexed biceps or flexed shoulders or grimacing on
4 his faces or anything like that that would indicate to
5 you that he was straining to do anything during the
6 shoulder dystocia?

7 A. No.

8 MR. HENSHAW: Objection. Leading.

9 BY MR. WEATHERLY:

10 Q. Did you notice anything about Dr. Giep's,
11 either his physical presentation or his -- how he was
12 acting during the shoulder dystocia that would indicate
13 to you that he was straining and pulling on
14 Ashley F head?

15 A. No.

16 Q. Did you ever during this delivery see
17 Dr. Giep pulling Ashley F towards the floor?

18 A. I couldn't see the baby's head. I
19 couldn't tell you.

20 Q. In your seven years, I guess, of
21 participating in delivering babies, did you see
22 Dr. Giep in this case do exactly what you've seen other
23 obstetricians do when confronted with this emergency?

24 A. I'm sorry. Can you --

25 Q. Sure. In ~~ROA 829~~ even years of being a

1 labor and delivery nurse, did you see Dr. Giep do
2 exactly what you've seen other obstetricians do when
3 confronted with this emergency?

4 A. Yes.

5 Q. When the shoulder dystocia occurred, did
6 you or Cindy White, the scrub tech, or Amber Dallas,
7 the NICU nurse, did any of you ever panic?

8 A. Not to my knowledge, no.

9 Q. When the shoulder dystocia occurred, did
10 Dr. Giep ever panic?

11 A. No, not that I can recall.

12 MR. HENSHAW: Objection. Calls for
13 speculation.

14 BY MR. WEATHERLY:

15 Q. Did you see any signs or did you see any
16 actions or statements by Dr. Giep during this delivery
17 that would indicate to you that he had panicked?

18 A. No, not that I can remember.

19 Q. If you had seen something unusual, such
20 as Dr. Giep pulling hard on this -- on Ashley F
21 head, would you have -- what would you have done?

22 A. Documented it.

23 Q. And anywhere in the records that you've
24 seen in this case, is there anywhere that you
25 documented that that happened?

ROA 821

1 A. No, not that I can see, no.

2 MR. WEATHERLY: Ma'am, I don't have any
3 further questions for you. I'm sure Mr. Henshaw
4 will have a few questions for you.

5 THE WITNESS: Okay.

6 MR. HENSHAW: Let's take a break.

7 VIDEOGRAPHER: The time is 11:14. We're
8 going off the record.

9 (Whereupon, the deposition was in recess.)

10 VIDEOGRAPHER: The time is 11:23. We're
11 back on the record.

12 CROSS-EXAMINATION BY MR. HENSHAW:

13 Q. Ms. Phillips, we have talked before. I
14 think I took your deposition sometime ago in this case;
15 is that right?

16 A. Yes, sir.

17 Q. And at the time that I took your
18 deposition before, you were a little bit undecided
19 about whether you would go back into nursing; is that
20 right?

21 A. Yes.

22 Q. Have you decided now that you're not
23 going back into nursing, that you're going to be a
24 full-time mom?

25 A. For now, **ROA 822**

1 Q. Okay. So, in terms of your plans of
2 going back into nursing, you don't know whether that
3 will ever happen or when it will happen; is that right?

4 A. Yes, I don't know when. I'd like to, but
5 right now, no.

6 Q. All right. Now, but you were a full-time
7 nurse at Spartanburg Regional Healthcare System on
8 October 7, 2008; is that right?

9 A. Correct.

10 Q. You had been a nurse for approximately
11 one year at that hospital; is that right?

12 A. Yes.

13 Q. And it was -- when I say you had been a
14 nurse for approximately one year at that hospital, that
15 was the full extent of your experience working as a
16 nurse was that one year at the time that this delivery
17 occurred?

18 A. Yes.

19 Q. Now, the system that was in place in
20 October 2008, called for you to be Ms. Flowers' primary
21 nurse beginning at 7:00 p.m. on October 7th; is that
22 right?

23 A. Yes.

24 Q. You also were assigned to be the primary
25 nurse of another expectant mother that same evening

1 beginning at 7:00 p.m. Am I correct about that?

2 A. More than likely, yes.

3 Q. All right. Tell me about that other
4 patient. What happened with her?

5 A. I don't remember.

6 Q. Okay. So you don't remember that case at
7 all?

8 A. No, sir.

9 Q. And the reason that you remember the
10 Flowers case is because you had seen Mr. Flowers
11 working at the hospital?

12 A. No, had not -- I had not seen him. We --
13 on our initial introduction, I'd -- he said that he
14 worked at the hospital, so we had that in common.

15 Q. Okay. And that's the reason that you
16 remember this case at all?

17 A. Well, no. That and it was one of my
18 first shoulder dystocias.

19 Q. Was it one of your first shoulder
20 dystocia cases or your first shoulder dystocia case?

21 A. To my knowledge, one of the first.

22 Q. Okay. How many had you had by that time?

23 A. I don't know.

24 Q. Okay. But you recognize that shoulder
25 dystocia was something **ROA 824** you could expect to

1 experience as a labor and delivery nurse; is that
2 right?

3 A. Yes, sir.

4 Q. You had been trained in nursing school
5 that that was an expected complication of a delivery;
6 is that right?

7 A. Yes, sir.

8 Q. And you had even had training in how to
9 follow specific instructions from a doctor delivering a
10 shoulder dystocia baby; is that right?

11 A. Yes.

12 Q. So, while this is an unfortunate
13 complication that can occur, it's something that you
14 and other nurses were trained to deal with?

15 A. Yes, sir.

16 Q. And did you realize as a trained nurse
17 that the doctors who delivered these babies were also
18 trained to deal with shoulder dystocias?

19 A. Yes.

20 Q. And that there were -- and that shoulder
21 dystocia was not a hopeless situation. It was one that
22 could be managed and the baby could be delivered
23 without any permanent damage or harm; is that right?

24 MR. WEATHERLY: Objection to the form.

25 Speculation. **ROA 825**

1 BY MR. HENSHAW:

2 Q. Well, you were trained that there were
3 methods that were known and utilized by trained doctors
4 to deliver these babies so that they didn't have
5 permanent injury; is that right?

6 MR. WEATHERLY: Objection to the form.
7 Speculation.

8 THE WITNESS: Yes, they --

9 BY MR. HENSHAW:

10 Q. Go ahead and answer the question.

11 A. Yes, yes.

12 Q. So, in this case, when you came on at
13 7 o'clock, did everything appear to be going as
14 expected for Ms. Flowers' delivery of her baby?

15 A. Yes, sir.

16 Q. She -- was she in for a planned delivery
17 on that date? In other words, was she scheduled to
18 come in and deliver on that date that she was at term?

19 A. I can't -- I don't recall. I don't
20 remember if it was.

21 Q. Well, you would have known that when you
22 took report --

23 A. Right.

24 Q. -- from the nurse who went off at
25 7 o'clock; is that right?

ROA 826

1 A. Right. But I can't remember
2 specifically. I don't know if it was an induction or
3 if she --

4 Q. And had she come in and been induced to
5 cause her to have contractions so that she could
6 deliver the baby vaginally?

7 A. Yes, it looks like it. We gave Pitocin.

8 Q. And as far as you knew when you came on
9 at 7 o'clock, she had proceeded through the labor
10 according to plan? In other words, there had not been
11 anything unexpected; had there?

12 A. No, sir.

13 Q. There was no reason to believe that the
14 baby was damaged during the development of pregnancy;
15 was there?

16 A. No. No, sir.

17 Q. And there are stages of labor, and
18 Ms. Flowers had proceeded through those stages of labor
19 as expected by the time you had arrived?

20 A. Yes, sir.

21 Q. Okay. When you came in at 7 o'clock,
22 based upon what you can remember and based upon the
23 records, there was nothing particularly unusual about
24 the way that she was proceeding toward delivery; was
25 there?

ROA 827

1 A. Not that I can remember, no, sir.

2 Q. All right. Now, who were the family
3 members that were with Ms. Flowers in her room? Do you
4 remember that?

5 A. I just remember her husband and the
6 patient.

7 Q. All right. Do you remember any other
8 family members being present?

9 A. I don't.

10 Q. All right. You came in at 7 o'clock.
11 How many times did you go in and out of Ms. Flowers'
12 room?

13 A. Several. I don't know a specific number.
14 I'm sorry.

15 Q. All right. Now, Dr. Giep, were you aware
16 that he was her attending physician for purposes of
17 delivery that day?

18 A. Yes, sir.

19 Q. What group was he working with?

20 A. Spartanburg OB, I believe.

21 Q. I'm sorry. What was that?

22 A. Spartanburg OB.

23 Q. And did you understand that Spartanburg
24 OB and Dr. Giep had been imagining Ms. Flowers'
25 pregnancy for most of the **ROA 828**tion of her pregnancy?

1 A. Yes. I would have seen those on those
2 records, yes.

3 Q. All right. He wasn't be called in
4 because she didn't have a doctor; was he?

5 A. No.

6 Q. He was expected to be there for the
7 delivery of this baby that was planned; is that right?

8 A. Yes, sir.

9 Q. He was not being called in because of any
10 emergency; was he?

11 A. No, that was -- no, no.

12 Q. All right. So you were there at
13 7 o'clock, you went in and out of her room on a number
14 of occasions. During -- from 7 o'clock up until the
15 point that Dr. Giep came in are, what was it -- what
16 time did he come in for the delivery?

17 A. It looks like Dr. Giep at bedside at
18 20:11.

19 Q. 20:11, and that would be 8:11 p.m.; is
20 that right?

21 A. Yes.

22 Q. From 7:00 p.m., when you came on duty,
23 until 8:11 p.m., how many times did Dr. Giep come into
24 the room?

25 A. I don't remember. I'm sorry. I don't

1 recall.

2 Q. Would you normally have documented each
3 time that he had come into the room to be at the
4 patient's bedside?

5 A. Usually, yes, sir.

6 Q. And in this record which we've put into
7 evidence, do you find that the only time documented
8 that Dr. Giep came into the room after you arrived was
9 at 8:11 p.m.?

10 A. Yes. As far as my notes, yes.

11 Q. And did he go back out of the room, or
12 did he stay there through the delivery?

13 A. I'm pretty sure he stayed from 8:11 to
14 delivery, yes, sir.

15 Q. And the baby was delivered at 8:20 p.m.;
16 is that right?

17 A. Yes, it looks like it.

18 Q. So the course of events involving
19 Dr. Giep's delivery of this baby are reflected by
20 records from 8:11 p.m. until 8:20 p.m. a period of nine
21 minutes; is that right?

22 A. Yes, sir.

23 Q. Now, so he was there at 8:11. And up
24 until 8:11, had everything gone, in terms of this labor
25 and delivery, as planned up until 8:11?

ROA 839

1 A. Yes. I mean, yes.

2 Q. There was a point where the baby's heart
3 rate decelerated; is that right?

4 A. Correct, yes.

5 Q. The baby had a baseline heart rate of
6 about what?

7 A. Let's see. It looked to be about like
8 120s -- or, no, I'm sorry, 130s to 125, something like
9 that.

10 Q. Now, that's during the period of time
11 that you were there. You don't know what the baseline
12 was earlier in the day; do you?

13 A. No, sir, not that I -- no, not that I
14 know.

15 Q. But 125 to 130 is a normal heart rate for
16 an unborn baby waiting to be delivered; is that right?

17 A. Yes.

18 Q. And some of the things that you look at
19 as a nurse include, in terms of how the baby is doing,
20 is whether or not there has been any unusual discharges
21 by the baby during the later stages of the delivery; is
22 that right?

23 A. Yes. According to --

24 Q. In other words, you looked for meconium?

25 A. Yes. But **ROA 831** I mean we usually don't

1 see that until -- yeah, that, we see that when they
2 rupture the membranes, we can see meconium at that
3 point or after delivery.

4 Q. And meconium can be significant to a
5 nurse and a doctor, because it's not a usual finding in
6 a normal delivery; is that right?

7 A. Not normally, no.

8 Q. It indicates that the baby has been under
9 some sort of abnormal stress that may be causing the
10 baby to be harmed; is that right?

11 A. Yes, or if they're -- but sometimes if
12 they're over due date, sometimes that plays into factor
13 too if they have meconium.

14 Q. But this baby was not over due date?

15 A. Yes, not that I can remember, yes, sir.

16 Q. And what meconium is is actually fecal
17 material expressed by the baby's bowels?

18 A. Correct.

19 Q. In this case, this baby has no meconium;
20 is that right?

21 A. Not that I can remember. Not from the
22 notes. It says that the ruptured membranes, it says
23 clear. It was clear. No meconium.

24 Q. Meconium is significant enough to have
25 part of the summary of ~~ROA 832~~ delivery room record. The

1 hospital specifically has a place for you to check
2 whether meconium was present at any time during the
3 delivery; is that right?

4 A. Yes, sir.

5 Q. And in this case nothing was checked in
6 regard to meconium; was there?

7 A. No, not that I can see, no.

8 Q. And so if meconium is a sign of unusual
9 stress on the baby during the delivery, that was not a
10 sign present in this case; was it?

11 A. No, not that I can remember, no, sir.

12 Q. All right. Now, another feature of a
13 delivery that nurses pay attention to is how well a
14 baby's heart responds to a mother having contractions;
15 is that right?

16 A. Yes.

17 Q. What you want to see is that every time
18 that the mother has a contraction, the baby's heart
19 rate goes up; is that right?

20 A. Yes, that's shows good viability, yes.

21 Q. Generally speaking?

22 A. Yes.

23 Q. So if the baby's heart rate, baseline
24 heart rate is 125 to 130, you would like to see it go
25 up at least 15 beats per ~~minute~~ **ROA 833**?

1 A. Yes.

2 Q. Now, in this particular case, from what
3 you've seen in terms of the fetal heart tone monitoring
4 strip, this baby's heart rate is exactly that. Every
5 time the mother has contractions, the baby's heart rate
6 would go up, with the exception of that one time it
7 decelerated to nine; is that right?

8 A. To 90, yes, sir.

9 Q. To 90, that's what I meant to say.

10 A. Yes.

11 Q. So and that should be because, at that
12 particular point in time, the baby has -- I mean, the
13 possibility is -- and that's all we can say --

14 A. Right.

15 Q. -- isn't it, is that for that one time
16 the baby had rolled over and compressed the umbilical
17 cord?

18 MR. WEATHERLY: Objection. Calls for
19 speculation.

20 THE WITNESS: Possibly. But there are
21 times too when the baby's heart rate goes down,
22 we're pushing because there's head compression.

23 BY MR. HENSHAW:

24 Q. Just from pushing?

25 A. Yes, sir. **ROA 834**'s --

1 Q. So a onetime deceleration is not
2 particularly concerning to an experienced labor and
3 delivery nurse such as yourself; is it?

4 A. No.

5 Q. It was not concerning enough where you
6 felt like you needed to call Dr. Giep and tell him
7 about that; was it?

8 A. No, but usually -- well, go ahead. I'm
9 sorry.

10 Q. Sorry. Go ahead.

11 A. Well, I don't know for sure in this case
12 particularly, but a lot of times the doctors would sit
13 at the -- outside -- in the nurse's station there's
14 monitors there, a big screen with everyone's -- the
15 strips printed on the screen so they can see what's
16 going on.

17 Q. I understand. But it was not something
18 that you felt like you needed to call him or go to him
19 and discuss with him when it occurred that one time?

20 A. Yes.

21 Q. You did or did not go?

22 A. No. I'm sorry. No, I didn't. I was in
23 the room with the patient. No, so I didn't, no.

24 Q. And, in fact, it was the kind of
25 situation that nurses are allowed to take a nursing

ROA 835

1 action in order to correct it; is that right?

2 A. Yes. We have interventions that we do,
3 you know.

4 Q. Nursing interventions?

5 A. Yes.

6 Q. And in this case the nursing intervention
7 was to roll the mother over on one of her sides?

8 A. Correct.

9 Q. Is that right? Sorry?

10 A. Correct. Yes, yes.

11 Q. And you got a positive response from
12 that; didn't you?

13 A. Yes.

14 Q. The babies heart rate began responding
15 again to mother's contractions just the way she was
16 supposed to; is that right?

17 A. Correct. Yes.

18 Q. Now, Dr. Giep was not in the room yet
19 when all of that happened; was he?

20 A. It doesn't look like it, not when I was
21 doing the interventions, no.

22 Q. Okay. And the -- you took the
23 interventions, and by the time he arrived the baby's
24 heart was back to doing what was considered to be
25 helping; is that right? **ROA 836**

1 A. Yes, it looks like he came in at -- yeah,
2 the 2011 and it came up for a couple of minutes, yes.

3 Q. All right. So he's there and does it
4 appear to you that he's there because the mother is
5 ready to deliver, that her cervix has expanded to the
6 maximum point. The baby is crowning; that is, the baby
7 at least a portion of the baby's head is beginning to
8 show. And the expectation is that with a few pushes by
9 the mother, in combination with her contractions, the
10 baby should deliver. Is that right?

11 A. Yes.

12 Q. And that's when the doctor gets called
13 because he needs to be the one who's going to catch the
14 baby; is that right?

15 A. Right. We wouldn't want the head to be
16 too -- I didn't like the head to be too much crowning
17 before they come in because I didn't want to deliver
18 the baby, right.

19 Q. Because some babies will just slip
20 through. And if the doctor or somebody's not there to
21 catch it, the baby could fall to the floor.

22 A. Right. But I don't remember specifically
23 where the baby's head was, if it was crowning or what
24 at this point. I don't remember.

25 Q. But Dr. G ~~QA 837~~ there. And under normal

1 circumstances, do you remember in this case whether he
2 began to move the mother into a position where he could
3 stand between her leg and catch the baby?

4 A. Yes. Usually that's the sequence of
5 events, yes.

6 Q. All right. Did that entail putting the
7 mother's legs up into stirrups?

8 A. Yes.

9 Q. And you had to convert the bed in order
10 to put the stirrups onto the bed so she could do that;
11 is that right?

12 A. Yes. Usually the lower part of the bed
13 would drop down, it would be removed and then we would
14 put her legs in the stirrups.

15 Q. And while some of that was being done,
16 Dr. Giep would have gloved and gowned himself so that
17 he could be more sterile as he caught the baby?

18 A. Correct.

19 Q. So he was in place and then something
20 happened where he realized that the baby was not coming
21 out as expected; is that right?

22 A. Yes.

23 Q. Do you know whether he actually declared
24 during that that he had recognized shoulder dystocia?

25 A. I can't remember specifically, but

1 usually they say, you know, "Prepare for a shoulder
2 dystocia."

3 Q. All right. Now, had he applied the
4 vacuum extractor at that point?

5 A. Not that I can remember. I just --

6 Q. So did he apply the vacuum extractor
7 after he identified shoulder dystocia?

8 A. I don't remember. Usually they say,
9 "Prepare for a shoulder dystocia," and then that's when
10 they -- we get the patient in position, and they apply
11 the vacuum.

12 Q. All right. So if he identified that
13 there had been shoulder dystocia, do you understand
14 that that means that the baby's head was all the way
15 out and up to the neck?

16 A. I couldn't see the baby's head at that
17 point. I don't remember.

18 Q. All right. But do you understand that
19 the definition of shoulder dystocia means that the
20 baby's head was out?

21 A. Not -- I mean not necessarily they can
22 see signs of turtling.

23 Q. Well, the baby's head comes out, and then
24 kind of retracts back in, but the baby's head had come
25 out?

ROA 839

1 A. Yeah, I guess. I don't know. I didn't
2 see it. Sorry.

3 Q. But, as a nurse, is that what you usually
4 understand is that the baby's head has come out, but
5 the body is not coming out?

6 A. Yes.

7 Q. So Dr. Giep applies the vacuum extractor
8 to the baby's head, and you've got that noted in your
9 Nurse's Progress Record of Exhibit 2; is that right?

10 A. That the vacuum was applied?

11 Q. Yes.

12 A. Yes, at 20:18.

13 Q. All right. Now, you have and what you
14 wrote there, that's in your handwriting and signed by
15 you?

16 A. Yes, sir. It looks like it, yes, sir.

17 Q. "Vacuum applied by Dr. Giep." Is that
18 what you said?

19 A. Yes.

20 Q. And then you wrote "two pulls?"

21 A. "Times two pulls," yes. It looks like
22 it, yes, sir.

23 Q. "Times two pulls?"

24 A. Yes, sir.

25 Q. And then ~~you~~ **ROA 840** signature?

1 A. Yes, sir.

2 Q. And then is it correct that when you
3 wrote two pulls, that means that the vacuum extractor
4 popped off at least one time?

5 A. No. It's pulls, so he's pulling with his
6 arms, so I don't remember a popoff. That's not what
7 that is.

8 Q. Well, in your deposition, do you have
9 that?

10 A. Yes.

11 MR. WEATHERLY: Charles, she doesn't have
12 it in front of her. We don't --

13 MR. HENSHAW: Do you have a copy that you
14 can put in front of her?

15 THE WITNESS: Okay. I have one, yes,
16 sir.

17 BY MR. HENSHAW:

18 Q. All right. Just one minute. Let me find
19 the page. Now, you actually don't recollect -- you
20 stated earlier that the vacuum extractor did not pop
21 off or that you did not write that it popped off, but
22 you don't really have a recollection as to whether it
23 popped off or not; do you?

24 A. I don't remember, no. I'm sorry.

25 Q. Okay. And ~~ROA 841~~ the vacuum extractor did

1 come off, would you normally indicate "vacuum twice" on
2 this record?

3 A. If it had popped off?

4 Q. Well, no, just if it had come off?

5 A. Well, I can't really -- you can usually
6 hear a popoff, that's when I would usually document it.
7 But if it had come off and I didn't hear it, I wouldn't
8 have known because I can't see his hands.

9 Q. Well, turn to page 81 of your deposition?

10 A. Okay. Okay.

11 Q. And did I ask you, "If it had come off
12 and had to be reapplied, would you normally indicate
13 'vacuum twice' on this record?" And didn't you say,
14 "Usually or a popoff, yes, usually?"

15 A. Okay. So the question was, "If it'd come
16 off and had been reapplied, you would normally indicate
17 'vacuum twice' on the record?" Yes. Or -- yes.

18 Q. And you were under oath when you gave
19 this testimony at least a year ago?

20 A. Yes, sir.

21 Q. Now, in addition to indicating that --
22 well, in this case where you put two pulls, does that
23 mean you saw Dr. Giep with the vacuum extractor in
24 place, and he pulled twice using the vacuum extractor?

25 A. Yes, that **ROA 842** remember or what's in the

1 notes. Yes. I'm going by what the notes says, yes.

2 Q. All right. So there was some pulling
3 force with the vacuum extractor itself; is that right?

4 A. Yes.

5 Q. And he was unsuccessful in delivering the
6 baby using the vacuum extractor and pulling twice on
7 the baby's head; is that right?

8 A. I don't remember. I don't recall.

9 Q. Well, is that the way the notes read,
10 that he was unsuccessful with his two pulls by the
11 vacuum extractor?

12 A. It doesn't say that in my notes.

13 Q. All right. Well, after the 20:18 note --

14 A. Yes, sir.

15 Q. -- you wrote a note "suprapubic pressure
16 applied for shoulder dystocia?"

17 A. Okay. Right.

18 Q. Is that right?

19 A. Yes.

20 Q. You would not have done that if he had
21 been successful in pulling the baby out with the vacuum
22 extractor; would you?

23 A. Okay. No.

24 Q. So, by circumstance, at least as an
25 experienced nurse, you ~~ROA 843~~ have to say these notes

1 indicate that he pulls once with the vacuum extractor,
2 but was not successful in delivering the baby; is that
3 right?

4 A. I would assume, so.

5 Q. That's most likely what happened?

6 A. Yes.

7 Q. And you were the nurse who applied the
8 suprapubic pressure; is that right?

9 A. Yes, sir. It looks like it, yes.

10 Q. And, by doing that, you took your hand
11 and placed it down on through the pubic -- to the
12 mother's pubic bone underneath the drapes that were
13 across her legs and abdomen?

14 A. Yes.

15 Q. And pressed down when Dr. Giep told you
16 to press down; is that right?

17 A. Yes.

18 Q. And did you understand as a nurse that
19 what was hoped would happen would be that you would be
20 able to compress the baby's shoulder so much that it
21 would release the baby and allow for the delivery?

22 A. Yes, that was what was hoped, yes, sir.

23 Q. Okay. You were not pressing down to try
24 to push on the baby's head. You were pushing down to
25 press on the baby's shoulder, is that right?

ROA 844

1 A. Yes.

2 Q. And do you know whether or not your
3 application of suprapubic pressure released the baby or
4 not?

5 A. I don't know. They usually say "stop,"
6 you know, with the suprapubic pressure when it's
7 released, the shoulder is released.

8 Q. Okay. So, well, do you know whether or
9 not your application of suprapubic pressure did
10 compress the shoulder enough to release the baby?

11 A. I couldn't tell you. I wasn't at that
12 vantage point. I don't know. I couldn't see the
13 baby's head.

14 Q. All right. Now, while you were applying
15 suprapubic pressure -- well, first of all, is that a
16 situation where you have to apply a considerable amount
17 of force downward to try to release the shoulder?

18 A. Yes.

19 Q. In some situations you actually will get
20 in bed with the mother on top in order to apply enough
21 pressure; is that right?

22 A. In some situations, yes, on the mother's
23 side, yes.

24 Q. Okay. And in some situations you'll get
25 up on a stool --

ROA 845

1 A. (Nods head affirmatively.)

2 Q. -- to be able to get enough leverage to
3 apply that kind of pressure --

4 A. (Nods head affirmatively.)

5 Q. -- to try the release the shoulder; is
6 that right?

7 A. Yes, sir.

8 Q. Okay. And in this case you used the
9 stool; is that right?

10 A. I would assume so, yes.

11 Q. Okay. Now, during your application of
12 the pressure, are you concentrating to be able to get
13 your hand in the right place and be able to apply the
14 pressure in a considerable way?

15 A. Yes. That's my main job so I'm trying
16 to --

17 Q. Okay.

18 A. -- yeah, right at that moment.

19 Q. While you're doing that, Dr. Giep is --
20 has his hands -- or had his hands around the baby's
21 head; is that right?

22 A. I don't -- I would assume so, but I don't
23 know. I couldn't see his hands.

24 Q. Okay. So whether he was -- had his hands
25 around the baby's head, **ROA 846** you don't know whether that's

1 the case?

2 A. Not in this particular moment, no. I'm
3 sorry. No.

4 Q. Whether he bent the baby's head downward,
5 you don't know because you couldn't see that; is that
6 right?

7 A. Right. I was concentrating on putting
8 suprapubic pressure down towards the mother's --

9 Q. Right.

10 A. -- pubic bone.

11 Q. Whether or not he bent the baby's head
12 upwards, you don't know that either; do you?

13 A. No, sir.

14 Q. All right. And whether or not he was
15 applying traction to the baby's head, you don't know
16 that either?

17 A. I couldn't tell you, no, sir.

18 Q. I'm sorry?

19 A. No, sir.

20 Q. Because you are concentrating on your
21 main job, which is to apply pressure to the baby's
22 shoulder; is that right?

23 A. Yes, sir.

24 Q. The baby did come out. Do you know
25 whether Dr. Giep used any type of turning motions or

1 sweeping motions inside the mother's birth canal with
2 his hands?

3 A. No, I don't know.

4 Q. What you do know is that the procedures
5 that are utilized by doctors to release a baby from
6 shoulder dystocia is that he did use the McRoberts'
7 procedure, which is the pull the mother's legs back up
8 toward her head?

9 A. Yes, that's part of the protocol.

10 Q. And he directed you to apply suprapubic
11 pressure; is that right?

12 A. Yes, sir.

13 Q. That's a yes?

14 A. Yes.

15 Q. Whether or not he used a procedure called
16 the Rubin's procedure or any other, the corkscrew
17 maneuver, you don't know whether he did that or not; do
18 you?

19 A. No.

20 Q. And it's not noted in your record as to
21 whether he did those other procedures?

22 A. No, it's not noted.

23 Q. Okay. The baby delivered at 8:20 p.m.;
24 is that right?

25 A. Yes, sir, ~~ROA 848~~ks like it.

1 Q. And you noted that there had been vacuum
2 extraction on the Summary of Delivery Room Record,
3 which is Exhibit 1, Defendants Exhibit 1; is that
4 right?

5 A. Right. "Complications: Shoulder
6 dystocia and vacuum."

7 Q. But when it comes to other methods, such
8 as rotation, you don't have that checked; do you?

9 A. On this particular record, they don't
10 have those itemized things that you can check.

11 Q. Well, look at in the middle of the
12 page --

13 A. Yes, sir.

14 Q. -- under "vaginal delivery?"

15 A. Yes, sir.

16 Q. And it has a checkmark in one, and you've
17 checked "vacuum extraction?"

18 A. Let's see. Vaginal delivery.

19 Q. Right in the middle of the page --

20 A. Yes. Forceps, yes.

21 Q. -- on the right-hand side.

22 A. Yes. Rotation, yes. Okay. Yes. I see,
23 yes.

24 Q. All right.

25 A. And "rotation" **ROA 849** yeah.

1 Q. So rotation --

2 A. Yes.

3 Q. -- is on this page?

4 A. Okay. You're right.

5 Q. And you did not check it?

6 A. No.

7 Q. So you neither observed rotation and
8 apparently Dr. Giep did not tell you that he had used
9 rotation?

10 A. Right.

11 Q. Forceps is not checked, so you neither
12 observed the use of forceps and Dr. Giep did not tell
13 you that he used forceps?

14 A. Right.

15 Q. And, of course, this would not be
16 considered a spontaneous delivery because of the
17 complication of the shoulder dystocia; right?

18 A. Right.

19 Q. You noted that under "Anesthesia" that
20 there had been an epidural, but that had been done
21 considerably before the delivery and the shoulder
22 dystocia; is that right?

23 A. Right.

24 Q. You noted that an episiotomy was cut by
25 Dr. Giep?

ROA 850

1 A. Right. And that's something he would
2 have told me.

3 Q. He did it one degree off the midline
4 or -- well, he did -- well, explain to me what he did
5 in terms of an episiotomy?

6 A. Like I said, that's something he would
7 have told me. I wouldn't have seen it.

8 Q. Okay. And episiotomy is where he makes a
9 cut in order to give more expansion of the birth canal;
10 is that right?

11 A. Correct, yes.

12 Q. This baby, once it's delivered, the cord
13 had to be cut. And one of the things, if a baby -- if
14 a baby appears to have suffered from lack of oxygen,
15 one of the things that normally will be ordered is a
16 cord blood gas; is that right?

17 A. Normally, yes.

18 Q. But in this case there was no cord blood
19 gas ordered; is that right?

20 A. From what I'm looking at in the
21 documentation, no.

22 Q. Okay. So apparently nobody felt like
23 that this baby was suffering from a deprivation of
24 oxygen such that it needed to be tested to determine
25 whether the baby was adequately oxygenated?

1 MR. WEATHERLY: Objection. Speculation.

2 BY MR. HENSHAW:

3 Q. Well, go ahead and answer.

4 A. Okay. I'm sorry. Could you re-ask the
5 question? I'm sorry.

6 Q. I'll try to rephrase it or repeat it.
7 From the circumstances of this record, it does not
8 appear that anybody was concerned enough about the
9 baby's oxygenation that a cord blood gas was ordered?

10 A. Right. That would have come from the
11 doctor, yes.

12 Q. All right. So the doctors didn't do
13 that?

14 A. No, not to my knowledge.

15 Q. And that could have come from either
16 Dr. Giep or it could have come from the doctor who was
17 on the resuscitation team; is that right?

18 A. Yes.

19 Q. And do you recall the resuscitation team
20 being present at the point that this baby delivered?

21 A. Yes.

22 Q. And was the baby handed over immediately
23 to the resuscitation team?

24 A. Yes.

25 Q. And in terms of what the resuscitation

1 team did, is it indicated that, in terms of
2 oxygenation, they simply bolt-suctioned the baby's
3 mouth?

4 A. Where would that -- yes. Resuscitation,
5 yes, sir.

6 Q. Now, other things that were -- that could
7 have been done if they felt it necessary would have
8 been to actually put an oxygen mask over the baby to be
9 able to feed it oxygen; isn't that right?

10 A. Right. But I don't remember what they
11 did. I wasn't -- the NICU team was around the baby
12 doing the resuscitation.

13 Q. Well, I understand that, but if you go
14 down to your Summary of Delivery Room Record, in which
15 you are gathering information about what happened,
16 there is a place for what type of resuscitation is
17 done; isn't --

18 A. Right.

19 Q. -- that right?

20 A. Correct. Because that's -- yeah, because
21 I saw the doctor had the baby and he was bulb
22 suctioning, and that's all I saw or would remember.

23 Q. All right. So, you know, if they needed
24 to inform you that they needed to put a mask over the
25 baby and resuscitate it **ROA 853** didn't do that because

1 you didn't check "Bag & Mask." Did you?

2 A. Right. Because I didn't see it and they
3 didn't relay that message to me to document it.

4 Q. Right. One of the things that can be
5 done in order to oxygenate a newborn baby is to
6 actually put an airway tube or intubate the baby with
7 an airway tube?

8 A. Right.

9 Q. And you didn't check that either; did
10 you?

11 A. No.

12 Q. And, in fact, you don't even have --
13 where you could have checked "oxygen," which would have
14 just simply been putting blow-by oxygen near the baby's
15 face, that's not checked neither; is it?

16 A. No.

17 Q. Now, you saw the baby because you walked
18 by the bassinet where they had done the resuscitation;
19 is that right?

20 A. Yes, very briefly.

21 Q. But in passing by the baby's bassinet,
22 you did not note anything wrong the baby's arm or any
23 particular abnormalities about the baby following the
24 delivery?

25 A. No, sir, ~~because~~ **ROA 854** the NICU team was taking

1 care of the infant. At that point, I was focussed on
2 the mom.

3 Q. Right. And, in fact, were the
4 circumstances such that you would not want to be
5 hanging around the bassinet admiring the baby, looking
6 at the baby, inspecting the baby, because that was not
7 your job; that was the job of the resuscitation team
8 and you basically needed to get out of their way.

9 A. Right.

10 Q. So if the baby did have a problem with
11 its arm, it's not unusual that you would not have
12 noticed it under the circumstances that you were
13 involved with the baby's delivery; is that right?

14 A. Would I have noticed it?

15 Q. Yeah.

16 A. Usually, but I don't recall in this -- I
17 don't recall in this circumstance. I don't remember.

18 MR. HENSHAW: Okay. I believe that's all
19 the questions that I have for you, Ms. Phillips.
20 Thank you very much.

21 THE WITNESS: Okay. You're welcome.

22 REDIRECT EXAMINATION BY MR. WEATHERLY:

23 Q. Ms. Phillips, I have a couple of
24 follow-up questions --

25 A. Yes. **ROA 855**

1 Q. -- for you. Mr. Henshaw had asked you a
2 series of questions about the vacuum and whether or not
3 you remembered a popoff, and he pointed you to one
4 section of your deposition. I would like for you to
5 turn to another section of your deposition. If you
6 could turn to page 102, please.

7 A. Okay.

8 Q. Okay. And this is the same deposition
9 where you were under oath back in January 2016; is that
10 right?

11 A. Yes.

12 Q. Okay. I'm going to start on line eight,
13 and I'm going to read a question that you were asked
14 and ask you to give the response that you gave then.
15 And you were first asked, "I had a question about the
16 two pulls that is marked at 20:18." And what was your
17 response?

18 A. "Yes."

19 Q. And was that the same pulls that
20 Mr. Henshaw was asking you about?

21 A. Yes.

22 Q. Okay. And then you were asked, "And tell
23 me if I understood this correctly, is a popoff where
24 you apply the pressure of the vacuum, you pull on the
25 vacuum, and the suction pump at the end of the vacuum

1 actually pops off the child's head. Is that different
2 than a 'pull.'" What was your response?

3 A. "Yes."

4 Q. And is that the same testimony you gave
5 here testimony?

6 A. Yes.

7 Q. And then you were asked, "Tell me what
8 the difference is," and what did you say in your
9 testimony then?

10 A. It says, "A pull is the vacuum. It's
11 still applied to the baby's head and is not relieve --
12 doesn't relieve the suction, that I remember. I don't
13 remember a popoff."

14 Q. And is that the same testimony you gave
15 here today?

16 A. Yes.

17 Q. And then you were asked, "Did I
18 understand correctly that your documentation of two
19 pulls was based on you viewing Dr. Giep?" Now, what
20 was your response?

21 A. I said, "His arm movement."

22 Q. And is that the same testimony you've
23 given here today?

24 A. Yes.

25 Q. And then ~~you~~ **ROA 857** asked, "His arm

1 movement, did you ever hear a popoff during his
2 application of the vacuum?" And what was your
3 response?

4 A. "Not that I can remember."

5 Q. And that is -- is that the same testimony
6 that you've given here today?

7 A. Yes.

8 Q. I have two more questions for you. You
9 were asked some questions about the training that
10 physicians undergo to treat a shoulder dystocia and
11 whether or not that can avoid injuries to the child.

12 Have you done any research into brachial
13 plexus injuries, both with or without a shoulder
14 dystocia?

15 A. Not really, no.

16 Q. Do you have any personal knowledge as to
17 whether or not brachial plexus injuries are avoidable
18 in every case, even if the doctor does everything
19 within the standard of care?

20 A. It's -- yeah, sometimes it's not
21 avoidable.

22 MR. WEATHERLY: I don't have any further
23 questions, ma'am. Thank you.

24 MR. HENSHAW: Thank you, Ms. Phillips.

25 VIDEOGRAPH **ROA 858**his concludes our

1 moment, Your Honor?

2 THE COURT: You do.

3 MR. LOVELL: Thank you.

4 (Whereupon, a recess was had from 5:43 p.m. -
5 5:51 p.m.)

6 THE COURT: Okay. The jury has indicated they
7 wish to stay, so bring them in. And I recommend concise
8 examinations.

9 (Whereupon, jury enters the courtroom at 5:52
10 p.m.)

11 THE COURT: All right. The jury is seated. You
12 may continue.

13 MR. LOVELL: Your Honor, we call our final
14 witness, Dr. Joseph Ernest.

15 THE CLERK: Do you solemnly swear or affirm your
16 testimony will be the truth, nothing but the truth so
17 help you God?

18 THE WITNESS: Yes.

19 DR. JOSEPH M. ERNEST, III

20 having been duly sworn, testified as follows:

21 DIRECT EXAMINATION

22 BY MR. LOVELL:

23 Q. Dr. Ernest, tell us your name, please.

24 A. My name is Joseph McDonald Ernest, III. I go by
25 Mack.

1 Q. Scoot up just a little bit there so we can hear
2 you. Tell us where you went to school to become a
3 doctor.

4 A. I went to school at William Carey College in
5 Hattiesburg, Mississippi. I went to medical school at
6 the University of Mississippi. When I finished medical
7 school I came to Charlotte, did residency at Carolina's
8 Medical Center. When I finished there, I went to Wake
9 Forest University, which was then called Bowman Gray
10 School of Medicine.

11 In Winston/Salem did a fellowship in maternal
12 fetal medicine. I stayed on the faculty there for 26
13 years. I then went back to Charlotte to be the chairman
14 of the department at Carolinas for six years and retired
15 in 2014.

16 Q. And, Doctor, you mentioned maternal fetal. Is
17 that your area of specialty?

18 A. Yes.

19 Q. And are you board certified in that area?

20 A. I'm board certified in obstetrics and gynecology
21 and maternal fetal medicine.

22 Q. In your experience and all, do you teach doctors
23 to do what obstetricians and gynecologists do when
24 delivering babies?

25 A. I teach medical students, residents and

1 practicing physicians, yes.

2 Q. And have you in that teaching also used any
3 devices to help kind of figure out the forces that are
4 applied when doing deliveries, whether they're shoulder
5 dystocia or otherwise?

6 A. We teach by feel, so in the beginning doctors
7 learn how to feel with their hands on the baby's head
8 and my hands around them to help them understand how
9 much traction is appropriate. I then observe them. We
10 also have simulators. We have those in Winston/Salem.
11 We have very advanced simulation there in Charlotte
12 where we had a full manacan that we would do delivery --
13 would teach deliveries.

14 And we actually had a device that we can measure
15 the traction of the force that was being applied by the
16 physician. We could set it so it could be a normal
17 delivery or a shoulder dystocia type delivery and you
18 can monitor and measure the force. And we would use
19 that to teach how much force is appropriate.

20 Q. And, Doctor, were you involved yourself in the
21 use of that device that you just -- this manacan thing
22 you talked about and using it and making it work and
23 measuring forces and studying the amount of forces that
24 you applied?

25 A. Yeah. We used it for resident teaching and we

1 had courses that we would have practicing physicians
2 come in to give them ideas about how much traction they
3 were applying. We have a resident that did a research
4 project with it, looking at different types of traction
5 forces.

6 Q. Now, you gave us your educational background.
7 Have you ever been on -- we've heard about board
8 certification, I assume you are.

9 A. Yes.

10 Q. And you're board certified in what?

11 A. In obstetrics, gynecology and maternal fetal
12 medicine.

13 Q. Have you ever been involved in being the person
14 who gives the test for those, any of those?

15 A. Yes. I was a board examiner for between 15 and
16 20 years, which meant that I was on the team that was
17 the final decision about whether a person became board
18 certified. Those were done in Chicago and in Dallas.
19 And we would go for a week. Several hundred of us would
20 go for a week and we would examine 20 or 30 doctors that
21 wanted to be board certified.

22 Q. Fair to say you delivered some babies in your
23 day?

24 A. Yes.

25 Q. How many?

1 A. Several thousand. I delivered probably one to
2 2,000 myself. And then I observed or assisted with
3 several thousand more.

4 Q. And in your teaching of doctors, learning how
5 people do it, delivering of babies, are you familiar
6 with the standard of care of what most obstetricians do
7 when they're faced with a shoulder dystocia event or
8 fetal distress or just in general when delivering
9 babies?

10 A. Yes.

11 Q. Have you had occasion in your experience to
12 encounter this shoulder dystocia condition?

13 A. Yes.

14 Q. Tell us about that.

15 A. Well, we -- one of the first things we teach and
16 one of the first things I learned when I was a resident
17 was how to manage a shoulder dystocia. That's -- that's
18 generally the thing -- one of the first things you do
19 the first week you start residency. And, actually, some
20 of us got that as students.

21 And so you experience it. It's unpredictable.
22 And so you have to learn it from the very beginning so
23 that if you're the highest level of person in the
24 delivery room at the time the shoulder dystocia occurs,
25 you know how to handle it.

1 So I had those all through residency, and then I
2 had them as a practicing physician in Winston/Salem. I
3 had those in Charlotte. And I taught and observed
4 residents managing those and taught them how to manage
5 them as well.

6 Q. How many have you seen in your career, either
7 directly when you're doing the primary delivery and the
8 watching other folks?

9 A. Dozens, maybe hundreds.

10 Q. Did some of those involve permanent injuries?

11 A. Yes.

12 Q. And the ones that involved permanent injury, were
13 you the one that was the primary delivery doctor?

14 A. There were two that I recall. One was as a
15 resident. And as a resident you don't get a chance to
16 follow the patient for months and months after they go
17 home. The extent of the injury I think was probably
18 permanent but I didn't have a one-year followup to know.
19 I had a second patient when I was practicing that I
20 delivered myself that had an injury that lasted several
21 months and I think was permanent but I'm not sure
22 because, again, I didn't have the, the full of range to
23 follow that one up either.

24 MR. LOVELL: Your Honor, we would tender Dr.
25 Ernest as an expert in the field of obstetrics and the

1 labor and delivery of babies with and without shoulder
2 dystocia. Also, in the area of, I guess it would be,
3 biomechanics of the forces involved in labor and
4 delivery, as well as his experience in measuring the
5 forces applied by physicians in general.

6 MR. HENSHAW: No objection to his qualifications
7 as an expert in obstetrics. I would object to his
8 qualifications as a -- in biomechanics. He hasn't laid
9 any foundation indicating that he has that.

10 THE COURT: All right. Lay some foundation.

11 BY MR. LOVELL:

12 Q. Let's talk about the biomechanics of delivery.
13 Have you through your study in engineering, edu -- I
14 mean, study, education and experience learned about the
15 forces that are applied by the mom, the maternal forces
16 during the labor process when the baby starts moving
17 down those cardinal stages of labor?

18 A. Yes, I have. We, in many deliveries, insert a
19 catheter into the uterus that measures the intrauterine
20 pressure. And the pressure that's generated by the
21 uterus and by the contractions and by McRoberts, which
22 also generates pressure or force, are the endogenous
23 forces which are the maternal forces that happen on the
24 baby. It pushed the baby down the birth canal. So we,
25 we use those to determine how to proceed with the

1 delivery.

2 And then the exogenous forces, which are the ones
3 that the delivering person applies, I've done again by
4 my experience. I taught it and I observed it and then
5 we measured it in our simulation lab, both in
6 Winston/Salem and in Charlotte.

7 Q. And you used the term we, Doctor. Does that
8 include you, along with other people that are working
9 with you in all these studies with both the endogenous
10 and the exogenous ones?

11 A. Right.

12 MR. LOVELL: Your Honor, we would again tender
13 him as an expert in biomechanics.

14 MR. HENSHAW: If I may, Your Honor?

15 THE COURT: All right.

16 VOIR DIRE EXAMINATION

17 BY MR. HENSHAW:

18 Q. Doctor, have you published any of these studies?

19 A. We had one, one study that was presented at a
20 state medical meeting that the resident chose not to
21 publish that.

22 Q. And that was a resident study, not your study?

23 A. That was a resident study that I helped with,
24 yes.

25 Q. All right. And what was the specifics of that

1 study?

2 A. The specifics were that we measured the different
3 traction forces by physicians to see if they could gage
4 when they were getting up to a level that would be
5 excessive. And that's what we -- that's what she
6 presented at that meeting.

7 Q. So you have not had a study that's been peer
8 reviewed?

9 A. That's correct.

10 Q. And so the methodologies that you've chosen to
11 use have not been subjected to peer reviewers who
12 determine by way of publication or for purposes of
13 publication whether or not it's scientifically valid?

14 A. It was reviewed by the people that decided to
15 invite her to speak at the meeting. It was not peer
16 reviewed in the sense that it was published. So it had
17 a review, but not the type of peer review for
18 publication.

19 MR. HENSHAW: Same objection, Your Honor.

20 THE COURT: All right. Mr. Lovell, let me ask
21 you this. Do you intend to ask him about these
22 pressures and forces or is this going to be based on his
23 own training and experience or somebody else's?

24 MR. LOVELL: Well, I'm gonna ask him some
25 questions about the pressures and forces in his

1 experience on the mother's maternal forces. And he told
2 us about the study he has participated in and live body
3 deliveries with that, so that comes with his experience
4 and training. The others come from his experience and
5 training in the study he assisted the resident on that.

6 THE COURT: All right. Well, I'm gonna, I'm
7 gonna permit him to testify about those matters if he
8 can testify to it of his own personal training and
9 experience.

10 MR. LOVELL: Sure. Thank you, Your Honor.

11 CONTINUED DIRECT EXAMINATION

12 BY MR. LOVELL:

13 Q. Doctor, have you served as an expert before
14 today?

15 A. Yes, sir.

16 Q. How many times?

17 A. I've reviewed probably 3 or 400 cases. I've been
18 in court two or three dozen times. And I've probably
19 given 40 or 50 depositions.

20 Q. And do you always do it just for lawyers like me
21 representing the physician?

22 A. I do it on behalf -- I've reviewed cases for both
23 defense and plaintiffs.

24 Q. And are compensated for your time when doing so?

25 A. Yes.

1 Q. What percentage of your total income do you make
2 doing this expert witness testimony?

3 A. It varies from year to year. I don't know what
4 it will be this year. I have other income from
5 retirement. I have income from presentations with a
6 pharmaceutical company, so it varies from year to year.

7 Q. When you were practicing medicine actively before
8 you retired, how much of your income was from expert
9 income?

10 A. Probably 10 to 15 percent.

11 Q. We hired you in this case. Have you reviewed the
12 medical records from Spartanburg related to her labor
13 and delivery, prenatal course, the depositions of all
14 the family members, including mom, dad, grandmother, the
15 deposition of Dr. Giep, all the other expert
16 depositions?

17 A. Yes.

18 Q. And were you here in court hearing the testimony
19 all day today I take it?

20 A. Yes.

21 Q. From all of the information you gathered, do you
22 have enough information to where you feel comfortable
23 giving an opinion about the standard of care and
24 potentially the cause or the contributing factors to the
25 injury in the child?

1 A. Yes.

2 Q. And can you give us all of those opinions to the
3 reasonable degree of medical certainty or probability?

4 A. Yes.

5 Q. All right. Doctor, I want to show you very, very
6 briefly the board that has been in evidence and the jury
7 has seen it. It is this one here. Are you familiar
8 with this board? (Indicating.)

9 A. Yes.

10 Q. In fairness, is this something that you provided
11 me as an example of the cardinal movements of labor?

12 A. Yes.

13 Q. In this movements of labor, we've heard testimony
14 already about what happens to the baby, but describe for
15 us from your experience and training and the things that
16 you've done studying the degree of forces that apply to
17 the baby during the time it's moving down towards the
18 baby down towards the outlet.

19 A. Can I come up there and point it out?

20 Q. Yeah. I'm gonna get a thing to put it on. So,
21 Doctor, when we do this you gotta -- you saw how Dr.
22 Giep had to stand. I'll put this here and you stand
23 where I'm standing. And talk so the court reporter can
24 see your face. And I'll give you a pointer.

25 (Whereupon, witness leaves witness stand.)

1 A. Okay. When the baby comes down the birth canal,
2 it has to twist and turn and move his head and rotate to
3 fit. It's not a straight tube because there are
4 obstructions that the baby has to pass. And the
5 cardinal movements of labor are what we use to teach
6 medical students and residents and juries about how
7 babies get from inside to outside.

8 And the things I wanted to show you were one of
9 the positions right here. This little area here is the
10 pubic bone. And it actually is an arch. It looks like
11 this. But if you look at it in cross section, it's just
12 a round circle. So if you think about that as an arch
13 or an upside down V, the baby has to get under that.

14 And in order to get under that, if the shoulders
15 come down straight, they don't fit because the shoulders
16 will get caught behind it. You can see right here the
17 shoulder is behind it. And so if the baby continued to
18 go straight down, that shoulder would be caught there.
19 And that's what happens with the shoulder dystocia.

20 So what the baby has to do is it has to rotate.
21 And you can see in this picture, that's what that baby's
22 done. You see the shoulder has rotated around. So what
23 you've been hearing today is the different maneuvers
24 that you use when we recognize that the shoulder has
25 been caught behind the pubic bone, but the head

1 continues to come down. (Indicating.)

2 It's a little bit of a different concept. If you
3 think about going to get your haircut. When you're in
4 that chair that the stylist or the barber pushes up,
5 because it pushes on your spine, you start going up in
6 the chair. And if there were something on your shoulder
7 that kept you from going up ---

8 MR. HENSHAW: Your Honor, he used the word your
9 and to speak in that way directly to the jury is
10 inappropriate.

11 THE COURT: All right. Don't inject the jury
12 into your statement, please.

13 THE WITNESS: When I am in the chair and the
14 woman who cuts my hair pumps that chair, I move up. If
15 there was something on my shoulder that kept my shoulder
16 from moving with my body, my spine, my neck, and my
17 head, the nerves in my shoulder, my brachial plexus
18 would continue to go up, but my shoulder would stay put.
19 And that's what happens in a shoulder dystocia.

20 And that's what happens when you see what you've
21 heard about in the turtle spine. The baby is being
22 pushed up and the spine and the body and the nerves and
23 the head are all moving at different rates than the
24 shoulder because the shoulder has been stuck behind the
25 pubic bone. So the brachial plexus can get stretched at

1 that time. So what we need to do when we recognize
2 that, when we recognize that the head is retracting back
3 and we apply gentle traction and there's no movement of
4 the baby's shoulders after the head comes out, we do
5 maneuvers to try to rotate and get that shoulder, which
6 is here into this position. (Indicating.)

7 Some other things we do is McRoberts. We pull
8 the legs back. That not only opens up the pelvis a bit
9 and also put pressure inside the mother's abdomen to
10 help push the baby down a little bit more. We do
11 suprapubic pressure by pushing -- and I'm gonna have to
12 come over here. We push our fists -- and Ms. Phillips
13 was saying that on her video. We put our fists right
14 here on the abdomen and we push to try to get that
15 shoulder to rotate. That's what suprapubic is.

16 Sometimes we try to reach in and we try to reach
17 in to get the posterior arm because if you can get the
18 arm out, then the shoulders are narrower and they can
19 get in better. Sometimes then if we can't do that, we
20 do the rotational maneuver. And the Rubin maneuver is
21 one where we push on the back of the shoulder to try to
22 collapse or reduce the width of the shoulders to get
23 them to come out.

24 Sometimes we push forward. That's the wood screw
25 maneuver. We try to rotate the baby. And by rotating

1 the baby, we're again turning the baby to get it in this
2 position. So as long as the shoulder is here, it
3 doesn't tend to come out. And our goal is to do
4 maneuvers to get the baby into this position so the baby
5 can come out. (Indicating.)

6 BY MR. LOVELL:

7 Q. Have you, Doctor, done studies where you all have
8 measured the amount of forces that the contractions from
9 the mother's uterus create on the baby, and this is
10 before the head ever gets down, or when she's doing the
11 pushing, pushing that the nurses are telling, or let's
12 say even up until the time of maybe that initial
13 McRoberts thing when they're lifting the leg back? Have
14 you all studied that?

15 A. Those studies have been done. I have done
16 pressure measurements inside the uterus. People have
17 taken those measurements further and they've actually
18 measured the pressure of the contractions and they've
19 measured the pressure as the mother pushes down called
20 Valsalva. And they're measurements where the McRoberts
21 is done.

22 Q. How is this measurement done on the inside of a
23 person? First let me ask, is it a live person who's
24 pregnant and about to have a baby?

25 A. Right. We routinely put a pressure catheter in

1 when we're not sure labor is adequate. It's just a
2 little tube that slides up next to the baby's head in
3 the uterus and it measures the pressure inside when
4 women have contractions. That tells us how much Pitocin
5 to give, if we're giving Pitocin, or whether the labor's
6 adequate. Studies have taken it a bit further and used
7 a different type of sensor and they measure the pressure
8 and the contractions and with the mother pushing down
9 and with the McRoberts.

10 Q. In your experience from what you've done and
11 you've learned in doing those things, how much pressure
12 can the mom's forces of either the involuntarily
13 contractions or the push, push, push or the McRoberts,
14 how much force can that put on a baby as it's coming
15 down before it ever gets to the point where we've got a
16 hung up shoulder?

17 A. The easiest way is to write that down. Can I use
18 the flip chart?

19 Q. Let me get it. Let's move it where folks can
20 see. And again, Doctor, I'm gonna scoot this one down a
21 little bit. If you could stand where the court reporter
22 can hear you.

23 A. Force is measured in different ways. Force can
24 be measured in pounds, which we can relate to. Force is
25 also measured in Newtons.

1 THE COURT: I'm sorry, but we're not hearing over
2 here.

3 THE WITNESS: Oh, I'm sorry. Force can be
4 measured in pounds or it can be measured in Newtons.
5 And some studies give it -- give the force in Newtons
6 and some in pounds. Just for reference, if you hear me
7 say Newtons, one pound equals four Newtons. And so
8 sometimes we talk about Newtons in pounds, but when
9 people -- when studies have been done measuring the
10 internal force before the doctor ever gets their hands
11 on the baby, they found that there are about 160
12 Newtons. These are the endogenous forces. These are
13 the ones inside that the mother and the uterus and the
14 McRoberts generate. 160 Newtons. That equals about 40
15 pounds.

16 So before anybody gets to touch the baby, that's
17 how much force has been generated on the baby or the
18 head or the shoulder, if the shoulder's impacted.
19 That's the force that we know is happening before the
20 baby gets out.

21 Now, people have also measured exogenous forces.
22 And there are a lot of studies. Dr. Allen has done
23 studies with these that you heard, I think, testify.
24 Dr. Gherman has done these studies. But there have been
25 very few that have measured how much we actually pull on

1 babies. The most I have found in the literature on a
2 real live human that anybody's pull is 135 Newtons. And
3 that was a paper published in 2010.

4 So this is what we know is internal. The most
5 I've seen reported is 135. That equates to about 35 or
6 so pounds. The one other number that I think -- well,
7 that's plenty of that. But this is internal forces.
8 The most I've seen reported is that, and that's external
9 forces that the doctor would generate. (Indicating.)

10 Q. Now, Doctor, if this amount of forces is being
11 generated as 1600 -- 160 Newtons or 40 pounds by mom and
12 the contractions and the McRoberts lifting of the leg,
13 do you have an opinion where there is a threshold that
14 you accept as a threshold for an injury to nerves in a
15 baby's brachial plexus?

16 A. Well, it's not my opinion. There have been very
17 few studies on humans to know what type of force can
18 actually injure a baby. We know that stretch can injure
19 the nerve and we know compression can injure a nerve.
20 And so it's impossible to measure that, that level on
21 live humans. They get it done on cadavers, on stillborn
22 babies.

23 The number that I've seen, and really the only
24 number I've seen in humans, and these were, these were
25 babies that had died either during labor or after birth

1 was about 190 Newtons. So this is a -- again, this is a
2 study with humans, but it's not a study with live
3 humans. We can't measure that with live humans.

4 Q. Okay. And what's this in pounds, roughly?

5 A. Well, we divide that by four, so that would be
6 about 45.

7 Q. So, Doctor, if a baby is subjected to this degree
8 of pounds with the contractions and the push, push and
9 the McRoberts and the threshold is this, the doctor is
10 applying normal gentle traction, as you've studied and
11 understood it, is there a lot of room for potential
12 pressure that can create this injury?

13 A. There's not. And that's why I think it's -- for
14 years we couldn't figure out why somebody who's had
15 injury that didn't seem to have excessive traction and
16 others did. And as we study more about what's going on
17 inside, it makes more sense. If this is going on before
18 we ever get to the baby and this is the level that we
19 may start seeing injury, it doesn't take a lot of
20 traction, and as a matter of fact, well within the
21 normal range of traction for some babies to be injured.

22 Different babies have different levels of
23 susceptibility to injury. We know that. And so, if
24 this is the level that we have to use as a potential
25 injury, this is what's already going on if you just

1 generate five or ten pounds more, which is well within
2 the normal range for a delivery, then some babies are
3 gonna be injured.

4 Q. And, Doctor, can the condition of the baby while
5 it's in the mom with low muscle tone, can that affect
6 that threshold for injury that we've got here?

7 A. Yes. That's been shown in studies that if babies
8 are depressed at birth, measured in different ways, and
9 they don't have the muscle tone to protect their nerves,
10 they're more susceptible to injury.

11 Q. And from your review of all this stuff that we
12 sent you on this and what you've seen, was Ashley
13 F suffering from some degree of not normal muscle
14 tone?

15 A. She was either limp or flaccid, depending on your
16 definition. And that was based on what Dr. Giep saw
17 when he delivered her and that's what the neonatology
18 team said when they did their apgar scores.

19 Q. So we heard earlier in this trial a statement
20 that when an injury that's permanent occurs in a baby,
21 that it has to be because the doctor either applied
22 greater than 35 pounds of traction and/or in combination
23 with an angulation of delivery downward of more than, I
24 think, it's 40, 45 degrees. Do you agree with that as a
25 valid statement?

1 A. That is not a valid statement.

2 Q. Explain to us why or why not.

3 A. It's just not true. There is no evidence,
4 there's no scientific evidence that an injury by itself
5 tells you that there is an excessive force generated by
6 the doctor. That just -- it just doesn't exist.

7 Q. Is the extent of the injury, the number of nerves
8 that might be damaged or the residual deficit that the
9 child might have as a result of a brachial plexus event,
10 is that indicative of the amount of forces that the
11 doctor applied or the direction in which the doctor
12 applies it?

13 A. No.

14 Q. And why do you say that?

15 A. There is no evidence that the extent of the
16 injury reflects the degree of traction or the angle at
17 which the traction was applied.

18 Q. Let's talk about Dr. Giep's -- actually, thank
19 you, Doctor, you can go back.

20 A. Thank you.

21 (Whereupon, witness returned to witness stand.)

22 Q. Actions when delivering this child. First I'll
23 ask, do you have an opinion whether or not Dr. Giep, his
24 actions in delivering the child and the forces that he
25 used and the direction of the application of those

1 forces was within the standard of care of what most
2 obstetricians would have done under the circumstances he
3 was presented with in this delivery?

4 A. Yes.

5 Q. What are your opinions?

6 A. That he acted well within the standard of care
7 and used very good judgment to deliver this baby.

8 Q. And from what you saw on all the evidence you
9 reviewed, was there any evidence to suggest that he used
10 excessive downward angle of lateral traction when
11 delivering the child?

12 A. I see nothing to indicate he used lateral
13 traction. You used two different terms there and I
14 think that may be a little more confusing. We normally
15 apply downward traction, but we don't apply lateral
16 traction. If we're delivering a baby and we're pulling
17 like this, it's normal to pull down but you don't flex.
18 You pull down at an angle, but you don't bend the head
19 because if you bend the head and have the ear go towards
20 the shoulder, that stretches this brachial plexus.

21 So it's okay to pull this way and it's okay to
22 pull this way, but it's not okay to pull this way. And
23 I don't see anything in what I read or what he said or
24 what he understands he's supposed to do or what others
25 saw, that he did anything but pull in the right

1 direction. (Indicating.)

2 Q. You see in his notes both on the day of delivery
3 and a day and a half later where he indicated minimal
4 traction applied on the day -- he wrote the note on the
5 day of the delivery. Gentle constant on the other one.
6 Is that the description of forces that are within the
7 standard of care?

8 A. Yes.

9 Q. Now, there was some questions asked of Nurse
10 Phillips about this exhibit, this summary of delivery
11 room record, I think it was. Are there, Doctor, are you
12 familiar with those types of forms?

13 A. Yes.

14 Q. And on there it lists several checked boxes.
15 First, is there a check box on there for doing a Rubin
16 II maneuver?

17 A. No.

18 Q. Or a wood screw maneuver?

19 A. No.

20 Q. It has on there forceps rotation and some other
21 checks -- boxes that are not checked. Does, in your
22 opinion, do those apply to the -- a notation of a
23 rotation maneuver such as a Rubin II or a wood screw?

24 A. No. This, this box rotation refers to a
25 procedure where we can put forceps around a baby's head

1 and rotate the head. It has nothing to do with the
2 Rubins or a shoulder dystocia at all.

3 Q. Doctor, do you have an opinion as to what was the
4 cause of Ashley F. brachial plexus injury that she
5 suffered or has suffered from after this delivery?

6 A. Yes.

7 Q. All right. Tell us about that.

8 A. I think it's most likely a stretch and/or
9 compression injury during the process of the labor and
10 delivery. I see nothing to indicate that Dr. Giep was
11 the reason for that injury, and so I think it was a
12 labor and delivery issue.

13 Q. And is that a combination of the maternal forces
14 of contraction and push, push and the McRoberts and
15 everything else that sort of occurred, and did that
16 contribute to this injury?

17 A. It could have been strictly the endogenous forces
18 or it could have been a combination. I see nothing to
19 indicate that it was because Dr. Giep did anything
20 wrong.

21 Q. Thank you, Doctor. Please answer any questions
22 the Plaintiffs may have.

23 CROSS-EXAMINATION

24 BY MR. HENSHAW:

25 Q. Doctor, did you bring the data with you today?

1 A. What data is that?

2 Q. Huh?

3 A. What data is that?

4 Q. The data of the endogenous forces that you say
5 that you've compiled.

6 A. No, sir. I didn't compile those. Those are
7 articles that were published in the peer review
8 literature.

9 Q. What articles?

10 A. Where are they?

11 Q. What are they?

12 A. The article that I'm referring to there for the
13 160 is an article about Bhumichi (phonetic).

14 Q. Where is it? Did you bring it today?

15 A. It's on my computer.

16 Q. Okay. On your computer?

17 A. Yes, sir.

18 Q. And when was it written?

19 A. When was it written? I don't remember the exact
20 date of publication.

21 Q. That was not your study?

22 A. No, sir. It was published in the peer review
23 literature.

24 Q. You don't have a study?

25 A. I don't have a study, no, sir.

1 Q. You're not a biomedical engineer?

2 A. No, sir. I'm a medical physician that delivers
3 babies.

4 Q. Have you worked with a biomedical engineer?

5 A. I have read many of the biomedical engineer
6 literature, but I've not worked with one personally.

7 Q. Have you ---

8 A. No.

9 Q. You have not worked with one personally?

10 A. No, sir.

11 Q. You testify quite often; is that right? You've
12 had about, what, how many cases?

13 A. I've reviewed 300 to 400. And I probably on
14 court two or three dozen times.

15 Q. And your rate for services?

16 A. Is \$400 an hour.

17 Q. How many hours have you had in this?

18 A. I have not added them up. I don't know.

19 Q. When we took your deposition you didn't mention
20 any of these articles, did you?

21 A. I don't know that we discussed those then.

22 Q. Well, so you came into this case, you had
23 opinions, you were named as an expert, but you did not
24 have these opinions at the time we took your deposition;
25 is that right?

1 A. Well, I had these opinions. I've -- this is
2 published well known literature.

3 Q. But you did not state any of these opinions in
4 your deposition, did you?

5 A. The opinions about the endogenous forces?

6 Q. Yes.

7 A. I don't remember specifically whether we talked
8 about endogenous or not.

9 Q. And you were asked what you were gonna talk about
10 in this case and you said I'm gonna talk about standards
11 of care and causation.

12 A. That's correct. And this is part of the
13 causation issue, yes.

14 Q. I understand. And you understood when we took
15 your deposition that when you were asked about what you
16 were going to say you were expected to tell us
17 truthfully what you were gonna test -- in completeness
18 what you were going to say. And you didn't say anything
19 about this, did you?

20 A. I'm not sure you asked me about this.

21 Q. I did ask you about what you were going to say,
22 didn't I?

23 A. I don't know that I could have told you every
24 single thing I was going to say because I'm not sure
25 what you or Mr. Lovell would ask me. We talked about

1 standard of care. We talked about causation. This is
2 part of that.

3 Q. Any other articles?

4 A. If you ask a question -- well, there's another
5 article referred to there about the exogenous forces.

6 Q. Not your article though?

7 A. No, sir. That was published in a journal, but I
8 did not write that one, no, sir.

9 Q. And you told the jury earlier that you have
10 actually studied this yourself by placing some type of
11 sensor device inside the uterus that would give you some
12 idea about the maternal forces.

13 A. No, sir. What I said was I have used entry and
14 pressure catheters which are the same methodology to
15 measure the intrauterine pressure which was part of the
16 study that I mentioned by Bhumichi which measured the
17 intrauterine pressure as part of this study that came up
18 with 160 Newtons.

19 Q. And you did that with a resident when you put
20 these intrauterine devices in?

21 A. No. We do that with a lot of deliveries when we
22 are inducing labor or we're measuring the adequacy of
23 labor.

24 Q. And you collected the data and attempted to
25 publish it or not?

1 A. No. There's no publication in this. This is a
2 clinical process that we do to measure the intrauterine
3 pressure.

4 Q. Now, do you have that data with you today?

5 A. I can tell you what it shows, but I don't have
6 any data because it's a clinical experience over a
7 number of years.

8 Q. You can tell us what it shows, but you're not
9 able to actually let us verify it by looking at the
10 data?

11 A. The data comes from probably 2 to 3,000
12 deliveries and my experience that the intrauterine
13 pressure is similar to what was measured in the article,
14 so I can validate it myself that the pressure that they
15 generated in these 22 patients was what I would have
16 expected so that when I look to see what the endogenous
17 forces are I can believe that article.

18 Q. Now, one of the things that's different between
19 endogenous and exogenous is the head does not appear; is
20 that right?

21 A. The endogenous is before the head comes out, yes.
22 And the exogenous is after, yes.

23 Q. Which means that the birth canal is aligning the
24 head with the spine in those cases; isn't that correct?

25 A. It usually does that. Not always, but it does

1 that most of the time.

2 Q. All right. And by doing that, if there are
3 maternal forces from the uterus on the baby, by aligning
4 the head with the spine it is evenly placing those
5 forces on the various parts of the baby's body that can
6 be compressed?

7 A. No.

8 Q. It is spreading out. It is distributing the
9 pressures?

10 A. Well, they're uneven because the baby's head is
11 rotating and it's flexing, so there are differential
12 forces on the brachial plexus depending on where the
13 baby is in the delivery process.

14 Q. From a biomechanical standpoint, it would be
15 expected that the pressures would be even on the
16 shoulders and on the crown of the head, is that not
17 correct?

18 A. It ---

19 Q. It's a dispersement of -- it's a dispersement of
20 force.

21 A. It depends on where the baby's head is. Before
22 the baby's head descends that would be correct. As the
23 baby's head descends and turns and flexes, then those
24 forces are probably gonna be somewhat different.

25 Q. And so when the baby's head comes out and the

1 doctor places his hands on the baby's head, then he at
2 that point is in a position to control the forces that
3 can be applied to the shoulders, is that not correct?

4 A. Not all of them, but some of them, yes.

5 Q. All right.

6 A. Because the mother is still pushing and the
7 Valsalva is affecting the force on that shoulder. And
8 there's compression going on. There's McRoberts going
9 on. But some of the force will be directed by the
10 delivering doctor, yes.

11 Q. And he can displace these forces that will affect
12 the nerve roots that are in the shoulder whether he
13 keeps the head straight or whether he turns the head;
14 isn't that correct?

15 A. No.

16 Q. If he applies lateral traction, you don't believe
17 that that can displace the forces and damage one
18 shoulder and protect the other?

19 A. Those are -- there were two different questions
20 there. The lateral traction, the lateral deviation
21 increases the stretch on the brachial plexus and can
22 cause injury, but it doesn't displace the forces that
23 are already there because those forces are gonna be
24 there whether he does lateral traction or not. So he
25 doesn't do anything to displace the forces that are

1 already being present.

2 Those endogenous forces, the maternal forces,
3 what he's doing is changing the direction of the force,
4 bringing the shoulder under the pubic bone to minimize
5 the force that the mother and the uterus and the
6 McRoberts are generating, but he's not really displacing
7 them.

8 Q. Well, Doctor, can we just -- don't you agree that
9 it's just common sense that if you position the head
10 down so that it stretches the nerves on one shoulder,
11 the nerves on the other shoulder are not under that same
12 type of pressure? They're not under any -- they're
13 under either no pressure or very little pressure. Do
14 you not agree with that?

15 A. That's a different question but, yes, that is
16 correct.

17 Q. All right. So the doctor is controlling where
18 the forces will be applied and where they will be
19 directed and he can create, by how he positions the
20 head, he can create forces that can do damage in one
21 shoulder and not the other?

22 A. He's not displacing the forces coming from
23 inside.

24 Q. I understand that, Doctor.

25 A. He is directing the forces that are being

1 generated on the outside, yes.

2 Q. But he is creating forces that will cause damage
3 to one shoulder and not the other?

4 A. If he applies lateral traction or pulls too hard,
5 he can create traction that can cause injury, that's
6 correct. That didn't happen here, but that's possible.

7 Q. Well, you don't know whether it happened here
8 because you don't do any studies of the cervical nerves
9 yourself. You've not ever done an examination of those
10 nerves, have you?

11 A. I don't think anybody's ever studied the cervical
12 nerves to see what kind of traction causes injury on
13 live humans. But, no, I haven't done that.

14 Q. Not live humans, but they've done it in cadavers.

15 A. That was -- there have been very few studies in
16 baby cadavers, yes.

17 Q. And they've -- and there's a study out of Sweden
18 that involved, what, 100,000 births that --

19 A. You'd have to be more specific about that.

20 Q. -- validated or documented what can happen when
21 lateral traction is applied.

22 A. Are you referring to the Malburg study?

23 Q. I just know it's out of Sweden. Is that a -- are
24 you familiar with that?

25 A. There are many, many studies out of Sweden, so

1 I'm not sure to which one you refer. But there is one
2 by a doctor named Malburg. It was not a study looking
3 at nerves. It was a study in which they asked the
4 delivering midwife or doctor to estimate how much force
5 they generated and they tried to come up with some
6 connection with whether the traction would cause an
7 injury. They had different delivery processes there,
8 but if that's the Malburg study, then that was a Swedish
9 study that looked at deliveries, but not in nerves per
10 se.

11 Q. Now, Doctor, do you agree that the standard of
12 care in the United States in October of 2008 was not to
13 apply excessive force during the delivery of a shoulder
14 dystocia?

15 A. That's correct.

16 Q. Do you agree that the standard of care in the
17 United States was not to apply excessive -- excuse me,
18 lateral traction during the delivery of a shoulder
19 dystocia?

20 A. Lateral flexion, yes. Flexion is the key. Not
21 -- I think traction and flexion can be confusing
22 because, again, downward does not mean lateral. So what
23 you don't want to do is bend the head so that the ear
24 goes towards the shoulder, but you do pull down. So
25 lateral flexion is what we want to avoid.

1 Q. Well, Doctor, you're familiar with natal brachial
2 plexus palsy?

3 A. Uh-huh, yes.

4 Q. And published by the American College of
5 Obstetrics and Gynecology?

6 A. Yes.

7 Q. And are you familiar with the glossary?

8 A. Yes.

9 Q. And do you agree with this statement: Lateral
10 traction, a pulling force that also bends the fetus'
11 neck by moving the ear toward the posterior shoulder,
12 thereby opening the contract -- contralateral angle of
13 the neck increasing strain on the brachial plexus,
14 sometimes referred to as lateral bending, downward
15 lateral bending or downward lateral traction. Do you
16 accept that as the definition of lateral traction?

17 A. That is a definition of lateral traction. But I
18 want to make sure it's clear that what we're talking
19 about is bending. The bending is the key. The flexion
20 is the key. Not the fact that the traction is downward.
21 It's the fact that it's the bending that can cause the
22 injury.

23 Q. Because it creates more stretch in the opposite
24 shoulder, the one's that's hung on the, in this case, on
25 the suprapubic bone.

1 A. Yes.

2 Q. Is that correct?

3 A. Yes.

4 Q. And do you agree with the glossary definition of
5 this manual that excessive traction is a pulling force
6 that is greater than the inherent strength of the fetal
7 brachial plexus?

8 A. That's a good definition. In relation to the
9 nerves, there are other definitions that excessive
10 traction in relation to how much the doctor generates,
11 but that is a definition that is specific to the nerves
12 and how much they can tolerate because we know that some
13 nerves can tolerate more traction than others.

14 Q. And do you agree that axial traction shall be
15 defined as a pulling force applied in alignment with the
16 fetal cervicothoracic spine, sometimes referred to as a
17 downward axial traction?

18 A. Yes, that's a good definition.

19 Q. And so if we were to incorporate these terms into
20 the standards of care, it would be acceptable care for a
21 doctor to utilize axial traction; that is, keep the
22 baby's head in alignment with the spine during the
23 delivery?

24 A. That would be pulling straight, yes, rather than
25 bending.

1 Q. Well, straight depends upon when you mean -- when
2 you say straight, that means in alignment with the
3 spine?

4 A. That's correct.

5 Q. Because if you really pull straight out, you
6 would have elevated the baby's head in a way that was
7 inappropriate; isn't that correct?

8 A. Not necessarily. That would be horizontal.
9 Straight would be in relation to the actual spine.

10 Q. Okay.

11 A. And bending would be bending the head so that the
12 ear is next to the shoulder.

13 Q. And that, again, lateral traction would be a
14 deviation from standard medical care in 2008 during
15 delivery of a shoulder dystocia.

16 A. Uh-huh. That's correct.

17 Q. Correct?

18 A. Yes.

19 Q. All right. And the standard of care is more --
20 it even goes further than that and requires that the
21 amount of traction should be no more than what would be
22 done in a routine normal delivery; is that correct?

23 A. Well, there are different levels of traction that
24 would be applied in a routine normal delivery. So what
25 we would -- what would be a better way to look at that

1 would be to say don't use more than you need, but try to
2 stay within the range that you have used for the other
3 3,000, 5,000 deliveries that you've performed.

4 Q. Well, in Britain do they not say that routine
5 traction is the same degree of traction applied during a
6 normal delivery?

7 A. They may say that in Britain and that may be a
8 good definition in Britain. I think that the key in the
9 standard of care is not to use more than you need and
10 excessively be more than you need. Sometimes you need
11 just enough to keep the baby from dropping on the floor.
12 Sometimes you need enough to apply to help the baby out.
13 Sometimes you need enough to save the baby's life.
14 There are different levels of that, all of which could
15 be in a standard delivery.

16 Q. Now, and so one of the things that has to be
17 considered are the circumstances of that delivery. And
18 in this particular case, did you see any need where Dr.
19 Giep needed to sacrifice the arm in order to spare the
20 baby?

21 A. I did not.

22 Q. And so he would not need to apply, and it would
23 be outside the standard of care if he applied traction
24 to such a degree that he sacrificed the arm in this
25 case; isn't that correct?

1 A. That's correct.

2 Q. Do you agree with that?

3 A. I would agree with that, yes.

4 Q. Doctor, do you agree that in this case there were
5 ruptures of C-5, C-6 and C-7?

6 A. They did not see them, but they suspected that
7 from the neuroma that they took out.

8 Q. Doctor, do you agree that there was significant
9 stretching of C-8 to the point that it caused scarring
10 formation around the C-8 nerve root?

11 A. I don't know that the neurosurgeon said there was
12 stretching. I think what he said was that the C-8 was
13 encased in that scar, which is called a neuroma, and it
14 was not working until they removed the scar and it began
15 working again.

16 Q. Did you ---

17 A. So I don't know that he had any comment about the
18 stretching of it.

19 Q. Did you not read his deposition where he
20 specifically stated that it was because of stretching?

21 A. I read the operative note. And I don't remember
22 what he said in his deposition, but in the operative
23 note they said that when they dissected out the neuroma,
24 that the nerve C-8 began working. But I don't remember
25 specifically what he said in his deposition.

1 Q. And, Doctor, in terms of -- or do you recognize
2 that respiratory efforts can be affected by damage
3 caused by injury to C-3, C-4, C-5?

4 A. Yes. That's the phrenic. Those are components
5 of the phrenic nerve.

6 Q. And did you find in this record that there was a
7 problem with Ashley's phrenic nerve, most probable?

8 A. Yes.

9 Q. And is that most probably the result of whatever
10 forces were causing injury to these nerves?

11 A. Since it is a nerve next to those, probably the
12 same force affected C-4, which is usually the phrenic
13 nerve. And then five, six and seven.

14 Q. Okay. So you would agree that most probably that
15 whatever was causing injury to these other nerves was
16 causing her respiratory difficulties after birth?

17 A. That would be my suspicion because that is
18 something that we see from time to time with a shoulder
19 dystocia on a brachial plexus injury.

20 Q. So in effect, as a result of this birth, she had
21 injuries to C-4, C-5, C-6, C-7 and C-8, five of the
22 cervical nerves in the brachial plexus?

23 A. I think three of those were permanent, five, six
24 and seven. I think four I don't think was permanent.
25 And I think eight was not permanent, but they were all

1 affected by the delivery, yes.

2 Q. That's all the questions I have, thank you.

3 A. You're welcome.

4 REDIRECT EXAMINATION

5 BY MR. LOVELL:

6 Q. All of the nerves in the brachial plexus, are
7 they affected by the maternal forces of either momma
8 pushing, which I think you called Valvulva (sic)?

9 A. Valsalva.

10 Q. The contractions, and then the McRoberts?

11 A. Yes. Yes, they are.

12 Q. So whether it's C-3, C-4, C-5 or whatever,
13 they're all affected by those forces?

14 A. They can be affected by those forces, by the
15 endogenous forces, yes.

16 Q. And the nerves at the phrenic level and the C-8
17 level, just like the four -- I mean, the five, the six
18 or the seven, would be protected if the muscle tone was
19 normal, but if the muscle tone is less or if the baby is
20 in distress, those likewise can be more susceptible to
21 injury, that whole bunch?

22 A. Yes.

23 MR. LOVELL: That's all the questions I have.

24 THE COURT: You may step down.

25 MR. LOVELL: May he be excused, Your Honor?

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2
3 THE COURT: All right, gentlemen. Let's readdress the
4 directed verdict motions.

5 MR. LOVELL: Thank you, Your Honor.

6 On behalf of Doctor Giep and Spartanburg Pelham OB-GYN,
7 we would renew the directed verdict motions we made at the
8 close of the plaintiff's case, and just to summarize those,
9 Your Honor, in general, they were first that the defendants
10 are entitled to directed verdict under 15-32-230, emergency
11 statute.

12 We think the evidence has shown that occurred in this
13 case, and that there's no evidence to support that this was
14 an -- to suggest this was not a medical emergency as defined
15 under the statute or that the doctor acted in gross
16 negligence as we've argued earlier.

17 THE COURT: All right. That motion is denied. I think
18 it's a question of fact.

19 MR. LOVELL: Secondly, Your Honor, on the issue of
20 punitive damages, we renew our motion in regard for the same
21 reasons we state.

22 THE COURT: What's the position of the plaintiff?
23 Punitive damages, are you withdrawing?

24 MR. HENSHAW: Your Honor, we will be withdrawing
25 punitive damages.

1 THE COURT: All right. That's granted.

2 MR. LOVELL: On the issues of the gross negligence
3 allegations, we move for a directed verdict on that as well.

4 THE COURT: What's the plaintiff's position?

5 MR. HENSHAW: Your Honor, we will also be withdrawing
6 our allegations of gross negligence.

7 THE COURT: That motion is granted.

8 MR. LOVELL: Your Honor, we had made motions on certain
9 of the damage elements, future medical expenses. We don't
10 think sufficient testimony has been introduced as to the
11 amount or cost of any of those for a jury to be able to
12 reasonably conclude what those might be.

13 THE COURT: All right. What's the plaintiff's
14 position?

15 MR. HENSHAW: In regard to future economic damages,
16 Your Honor, we acknowledge that the evidence, at this point,
17 is too speculative in order for the jury to take into---

18 THE COURT: All right. That motion is granted.

19 MR. HENSHAW: ---consideration.

20 MR. LOVELL: Your Honor, on the potential loss of
21 future income of the child, we think there's been inadequate
22 evidence in that regard as well.

23 MR. HENSHAW: The same thing---

24 THE COURT: Well, that's economic.

25 MR. HENSHAW: ---there, Your Honor.

1 THE COURT: That's economic. That's granted.

2 MR. LOVELL: And the final one, Your Honor, was on --
3 there was an allegation in the complaint of loss of income
4 of the parents. There's no evidence to support that.

5 THE COURT: That's economic too. That's granted.

6 MR. HENSHAW: That -- well, we, we do think that there
7 was economic loss by the parents as reflected by the billing
8 summary, but that's the only factual evidence that's in --
9 the only facts that are in evidence at this time.

10 THE COURT: All right.

11 MR. LOVELL: And, Your Honor, one final point.

12 On the issue of the applicability of the medical
13 emergency statute, 15-23 -- I think 15-32-230, we believe
14 though that is a defense that has been raised in this case,
15 both through the evidence pretrial, and then because,
16 obviously, you've heard the evidence we've heard all week.

17 So, we would ask that the Court allow an amendment of
18 our answer to incorporate that as an affirmative defense
19 understanding that we do have the burden on that.

20 THE COURT: What's the plaintiff's position?

21 MR. HENSHAW: Your Honor, we agree that it has been --
22 that it has been litigated, that is through discovery and
23 through this trial, and that it is---

24 THE COURT: No, no prejudice?

25 MR. HENSHAW: Sir?

1 THE COURT: No prejudice to the plaintiff?

2 MR. HENSHAW: No prejudice that it -- that it is being
3 added as an affirmative defense. However, we do have a
4 motion to strike it as an affirmative defense at the
5 appropriate time.

6 THE COURT: All right. Motion to amend is granted.

7 MR. LOVELL: That's all from the defense, Your Honor.

8 THE COURT: All right. Mr. Henshaw.

9 MR. HENSHAW: Your Honor, we would now turn to exactly
10 that and move to strike the affirmative defense as to the
11 emergency medical statute. We do not believe, for several
12 reasons, that it is applicable as a matter of law.

13 Number one, we believe that the section that provides
14 that it is not to be applied in situations where there has
15 been an ongoing physician/patient relationship is inclusive
16 of all the other provisions of that statute. And since
17 there was a -- it's been established, without any evidence
18 to the contrary, that there was an ongoing relationship
19 between Mrs. Flowers and the practice, we think that, for
20 that reason, the statute is not applicable and that that
21 affirmative defense should be struck.

22 In addition to that, Your Honor, we do not believe that
23 it is applicable under subsection -- because of subsection
24 C, which says the, the immunity shall not apply unless it is
25 shown that there was an immediate risk of death or an

1 immediate risk of serious bodily injury. While we realize
2 that one of the experts that was proffered by defense said
3 that it should be applicable, and it was immediate, it was
4 immediate, it -- there was no basis for that statement under
5 the circumstances that the, the only -- there was no death
6 that would of occurred within four to six minutes after the
7 dystocia was recognized, and no serious bodily injury, which
8 was, in this case, would have been brain injury that would
9 have occurred within four to six minutes after the shoulder
10 dystocia was recognized.

11 And, for that reason, we do not believe it's applicable
12 as a matter of law. That is the overwhelming evidence in
13 this case. And, for that reason, we would move to strike.

14 THE COURT: All right. Mr. Lovell.

15 MR. LOVELL: Your Honor, we believe that both Sections
16 A and C of 15-32-230 are applicable under the facts of this
17 case, and we prevented -- presented evidence from both
18 Doctor Giep, Doctor Chauhan, Doctor Gower, and Doctor Arnett
19 that it was a medically unstable scenario with a baby that
20 was at immanent risk of serious bodily injury and/or death
21 from the time of the dystocia through the time of the
22 delivery with full body impairment.

23 MR. HENSHAW: Your Honor, I, I failed to also raise the
24 constitutional issues that we want to raise in regard to
25 that statute. It is a new statute. It came in under the

1 Medical Malpractice Reform Act of 2005. It has not been
2 tested, to my knowledge, on a constitutional basis.

3 It clearly sets up categories of, of doctors and
4 patients that are treated differently than other doctors and
5 patients in the medical malpractice context. We believe
6 that it denies equal protection to the categories that are
7 raised without a rational basis, and we would ask the Court
8 to declare the statute unconstitutional.

9 MR. LOVELL: Your Honor, we believe the statute is
10 constitutional. It does establish a rational basis for
11 legitimate governmental interest or community interest, and
12 we think it's constitutional.

13 THE COURT: Well, I'll say this is my first encounter
14 of a trial with this particular statute, and I've read it
15 several times. And while I think, in some respects, it's
16 somewhat confusing, it does appear to be addressing two
17 of -- the Legislature appears, from the language, to be
18 addressing two, what they consider, to be two separate and
19 distinct situations. And the language would indicate that
20 both in A, B, and in C when it says further the limitations
21 on liability established under Sections A and B shall only
22 apply where care is rendered prior to a patient's discharge.

23 So, they appear to be looking at it like it's two
24 separate and distinct situations. B, obviously, relating to
25 a physician with no previous doctor/patient relationship

1 with a patient. But Subsection A, which the defense
2 contends is applicable, does say that, in an action
3 involving medical malpractice arising out of care rendered
4 in a genuine emergency situation, which is described in the
5 statute, is immune from a medical malpractice claim unless
6 gross negligence is shown, and it says no physician may be
7 held liable unless under the circumstances as set forth in
8 Subsection A.

9 So, based upon my reading of the statute, I think it's
10 applicable. I do think that it, it is an affirmative
11 defense. It has to be established by the defense, and,
12 therefore, the motion to strike, it is denied.

13 Also, I don't see any constitutional depravation.
14 Therefore, your motion to declare it unconstitutional is
15 also denied.

16 All right. Anything else?

17 MR. HENSHAW: Not from the plaintiff, Your Honor.

18 MR. LOVELL: No, sir, Your Honor.

19 THE COURT: All right. Now, each of you have a copy of
20 my proposed verdict form.

21 MR. LOVELL: Yes, sir.

22 MR. HENSHAW: Yes, we do.

23 THE COURT: Now that we've addressed the, the issues
24 and narrowed those somewhat, is that form acceptable to
25 both?

1 MR. LOVELL: It is acceptable to the defense, Your
2 Honor.

3 MR. HENSHAW: Yes, Your Honor.

4 THE COURT: Okay. All right. Y'all ready for the
5 jury?

6 MR. LOVELL: Yes, Your Honor.

7 THE COURT: Okay. Bring them in please.

8 MR. LOVELL: Your Honor, one point.

9 On your draft charge, it has an italicized gross
10 negligence charge.

11 I assume those are not gonna be---

12 THE COURT: Obviously, that's a standard charge. And
13 when I think it's not gonna be applicable, rather than erase
14 it, I just reduce the font, italicize it. That way I can
15 use it next time if it's applicable.

16 MR. LOVELL: I kind of figured. That's a good idea.

17 (WHEREUPON, the following takes place within the
18 presence of the jury.)

19 THE COURT: Good morning, ladies and gentlemen.

20 As you know, when we recessed yesterday, all of the
21 testimony and other evidence to be introduced in this case
22 had been received, and, therefore, what remains to be done
23 are the lawyer's final summations, after which I'll instruct
24 you on the law, and then you'll begin with your
25 deliberations in the case.

1 Now, the way that is accomplished, the plaintiff has
2 the burden of proof. So, the plaintiff goes first in the
3 final argument. After the plaintiff concludes, the defense
4 has the opportunity to respond and to present argument as to
5 the defense's position. And then the plaintiff is permitted
6 a brief reply response to those matters brought out by the
7 defendant. That way everybody has a chance to talk about
8 the other's position and address it with the jury.

9 So, please give the lawyers your attention as they give
10 you their final summations.

11 MR. HENSHAW: May it please the Court?

12 THE COURT: Mr. Henshaw.

13 MR. HENSHAW: Ladies and gentlemen, much of obstetrical
14 medicine is about managing complications of pregnancy. When
15 Treva Flowers became pregnant with Ashley in 2008, she
16 encountered two of those complications, gestational diabetes
17 and shoulder dystocia.

18 Gestational diabetes was properly managed by the
19 doctors at Spartanburg & Pelham OB-GYN. The shoulder
20 dystocia was not.

21 As a result, Ashley F has permanent disfigurement
22 and physical impairment of her left shoulder, arm, wrist,
23 and hand. You, the jury, will now be deciding whether
24 Doctor Bang Giep was negligent and committed malpractice on
25 October 7th, 2008, at Spartanburg Regional Medical Center

1 when he delivered Ashley.

2 The law in South Carolina requires that every medical
3 practitioner act according to generally recognized and
4 accepted standards of care and do what would be expected of
5 a reasonably competent practitioner under the same or
6 similar circumstances.

7 Your verdict must be unanimous. You do not arrive at
8 your verdict by majority decision. Each of you must be
9 convinced, by a preponderance of the evidence, as to what
10 happened, and then come together for a verdict that speaks
11 the truth. Due deliberation and wisdom and judgment and
12 common sense are the hallmarks of a true and just verdict.
13 You have no friends to reward. You have no enemies to
14 punish. You are the jury.

15 Treva Flowers, her husband, Tristan, wanted a baby.
16 Tristan worked at Spartanburg Regional in the communications
17 and was recommended to Spartanburg OB-GYN. Treva met every
18 appointment, and did everything she was told. Tristan
19 usually went with her to the office visits.

20 As you heard, he was there that night when they went to
21 Spartanburg Regional Medical Center at 2:00 in the morning.
22 Treva circulated through the different doctors in the
23 practice. She mostly saw Doctor Ashley Fowler, but she saw
24 Doctor Giep in her office three times before she delivered.

25 In about her 32 week of pregnancy, standard testing

1 showed that she had gestational diabetes, a complication of
2 pregnancy that sometimes can cause babies to be large.
3 Treva's, Treva's gestational diabetes was managed by diet.
4 Otherwise, the pregnancy, the pregnancy went well and the
5 baby developed normally.

6 The baby was considered big at about the 85-percent in
7 size, but ultrasound showed there were no abnormalities.

8 Early on October 7, 2008, Treva's water broke at home.
9 As planned, Tristan took her to Spartanburg Regional where
10 she was admitted for her labor. She was admitted under the
11 care of Doctor Fowler, who managed her throughout the day
12 until about 7:00PM. Then Doctor Giep took over according to
13 the schedule of the medical practice.

14 Doctor Giep held himself out as a specialist in
15 obstetrics. He was trained to handle obstetrical
16 complications such as shoulder dystocia, which, according to
17 the evidence in this case, happens about one in every
18 hundred deliveries.

19 For him, as a board certified obstetrician, shoulder
20 dystocia was a foreseeable event. It wasn't gonna happen
21 with every delivery, but it was something that he began to
22 learn about in medical school and then in his residency and
23 had experience with in the years before 2008, and knew that
24 any pregnancy could result in shoulder dystocia.

25 He was trained in how to manage it, how to resolve it

1 so that a baby would not suffer injury as the result of his
2 maneuvers.

3 By October 7 or by the time that -- excuse me. By the
4 time that Doctor Giep arrived in the labor room, the baby's
5 head was crowning meaning that the baby's scalp was
6 beginning to appear between the mother's legs. Doctor Giep
7 arrived in the labor and delivery room about 8:11PM. Treva
8 had been laboring since about 2:00 in the morning. Her
9 labor had been augmented by a drug called Oxytocin or
10 Pitocin to promote her contractions.

11 At about 8:07PM, before Doctor Giep arrived, the
12 external electronic fetal heart monitor showed that the
13 baby's heart rate had decreased from a baseline of 125 beats
14 per minute to 90 beats per minute. The labor and delivery
15 nurse, Natalie, Natalie Phillips, stopped the Oxytocin.

16 When Doctor Giep arrived at 8:11PM, he had the mother
17 turn on her right side hoping that the baby's heart rate
18 would improve. He waited five minutes without doing
19 anything at that point. Not that that was wrong, but he
20 waited five minutes to see what would happen and then he
21 restarted the Oxytocin.

22 He waited some more and, at 8:18PM, he applied a vacuum
23 extractor to the baby's head. A vacuum extractor is
24 sometimes called a Kiwi extractor, and he applied it to the
25 baby's head and he pulled twice. At 8:19 -- at 8:19PM, the

1 baby's head was out of the birth canal.

2 This is all documented.

3 Is this on?

4 THE LAW CLERK: Press the power button.

5 MR. HENSHAW: There it goes.

6 what we have done, by agreement, is placed all of
7 Ashley's medical records into evidence, and y'all are
8 certainly welcome to go through it page by page if you'd
9 like. But what we have done, by agreement, is each of us,
10 each, when I say each, each lawyer has placed into evidence,
11 under separate exhibit stickers, pages from these records
12 that we think are the most important things for you to
13 consider. And so you will find what I'm about to show you
14 in these records. I believe it's Exhibit 9 or 10. And
15 you'll be able to look at this and the other records.

16 And this is the record of Natalie Phillips. It's the
17 nurse's progress note. And because of the way that evidence
18 has to be presented, it may have seemed out of order or not
19 necessarily in chronological fashion. But we, we -- when we
20 got to Mrs. Phillips deposition yesterday, this is the
21 record from which she testified, and this is the record
22 that's in the mother's hospital record as to what happened
23 that morning or that night on August 7th, 2008, and it's
24 very informative as to what happened because it tells us the
25 times of things, which, in this case, can become very

1 significant.

2 And so the part that, that I believe is most critical,
3 and, again, my opinion is not that important, but in terms
4 of me explaining what I think is most important, I think
5 that it begins around 7:55 when she notes that the patient
6 begins to push, and that means that the mother is entering
7 the second phase of her labor. She's been laboring since
8 about two o'clock in the morning, and now she has reached a
9 point where she is fully dilated. She is -- the baby is
10 head first down ready to come out, and the mother is
11 beginning to push and that's at 7:55PM.

12 It's 12-minutes after that, at 8:07PM, that the nurse
13 recognizes that the fetal heart tones have dropped into the
14 90s. Up until that point they had been around 125 beats per
15 minute, which is average for a baby in-utero. That, of
16 course, would not be a normal heart rate for an adult, but,
17 for a baby that's not yet born, 125 beats is the average.
18 And that was her baseline and she had maintained that for
19 most of the day up until 8:07.

20 So, Natalie Lee Phillips, as she testified and she
21 indicates in this record, made a nursing decision, which she
22 was allowed to do, to decrease or stop the Oxytocin or the
23 Pit drip and she did that because the babies -- and she
24 says, for fetal heart tones in the 90s.

25 A minute later, she puts an, an oxygen mask on the

1 mother to let her get some oxygen to see whether or not that
2 might improve the baby's heart rate and bring it back up
3 above a hundred because that's what they want to do. They
4 want to see the baby's heart rate above a hundred.

5 Then, at 2:10, she shuts down the Pit drip or the
6 Oxytocin completely. She previously had decreased it, but
7 now she -- now it is off. Again, because the fetal heart
8 rate has remained in the 90s. So, that's approximately
9 three minutes where the heart rate has been in the 90s.

10 Then, at 2:11, Doctor Giep comes into the room, and the
11 patient is turned in her right side. Doctor Giep testified
12 that he's the one that directed the patient be turned on her
13 right side. It's a maneuver that both doctors and nurses
14 can make in order to try to improve the baby's heart rate.
15 Sometimes the baby will get in a position where they begin
16 to compress the cord, and it makes the heart rate go down.
17 And by moving the mother onto one side or the other, it can
18 sometimes relieve that compression if that's what's going
19 on.

20 So then he waits because the next entry by
21 Mrs. Phillips is at 20:16, 8:16PM. Doctor Giep gives a
22 verbal order to restart the Pitocin. He is explained, in
23 this case, that he wants to move the baby. He wants to go
24 ahead and get the delivery done.

25 The birth, the baby's fetal heart monitor strips

1 indicate that there has been some recovery in the baby's
2 heartbeat by this time. And so apparently he feels that the
3 baby can tolerate the mother having Pitocin. Pitocin is
4 given to enhance the contractions. It's, it's given to
5 increase the number of contractions early on. It's given to
6 start the contractions. In this case, it's being given to
7 enhance the contractions to try to push the baby out.

8 Then, two minutes later, he applies the vacuum or the
9 Kiwi extractor to the baby's scalp and he pulls twice. That
10 says times two pulls. And he pulls twice. And the baby's
11 head comes out. And, under most circumstances, if there's
12 not gonna be a complication, the body immediately follows,
13 but it didn't in this case.

14 And so he's got the head out. And he realizes,
15 apparently some time around 20:18, that he's got shoulder
16 dystocia. And he realizes that because the body is not
17 delivering. I don't believe that the turtle sign was
18 documented, but there may have been what is called the
19 turtling sign where the baby's head comes out and then
20 recedes back. Not just up to the chin. Not completely.
21 But it goes backwards instead of continuing to come forward,
22 and that is good evidence, to a trained doctor like Doctor
23 Giep, that he is now encountering a baby whose, whose one
24 it -- whose shoulder, one of its shoulders, is being
25 obstructed by the mother's pelvis.

1 In this case, it's pretty apparent that he believed
2 that it was the left shoulder, the one that was highest up,
3 the one that was closest to the front of the pelvis, that
4 was being obstructed by the mother's pubic bone.

5 There's another form of shoulder dystocia where the
6 baby's shoulder can get blocked by the spine, the bony
7 spine, the prominences of the bony spine, but that's not
8 what he thought here and that's what was occurring here.
9 This was a shoulder dystocia where the baby's left shoulder
10 was being blocked by the pubic bone, and we know that that's
11 what he thought and because he then had Mrs. Phillips begin
12 to apply suprapubic pressure.

13 She climbed up on a stool. Well, first they put the
14 mother's legs into what is called the McRoberts position.
15 It's called the McRoberts maneuver. And her legs were
16 pulled back toward her chest. They were taken out of the
17 stirrups and pulled back toward her chest, and then
18 Mrs. Phillips climbed up on a stool, and with her hands,
19 began to apply pressure downward just at or near -- right
20 behind the pubic bone in order to release the shoulder, to
21 try to get it to move, to unblock it, and that occurred at
22 20:19.

23 Now, please understand, up until this point, we have no
24 criticism of what Doctor Giep did or what any of the doctors
25 did at Spartanburg & Pelham OB-GYN. You've heard a

1 cross-examination of Doctor Gurewitsch in which the defense
2 lawyer said let's go down everything they did right. And
3 they started early in the pregnancy and named off everything
4 that we had -- that we never said was done wrong, and it was
5 a long list.

6 If a person gets in a car and they drive a hundred
7 miles, and they stop at every light, and they yield at every
8 yield sign and they stop at every stop sign, and they never
9 go over the speed limit, they adhere to every rule, but
10 then, after a hundred miles, after they've done all of that,
11 they run a red light, are they responsible for the mistake?

12 The answer is yes.

13 They don't get to come in and say look at how many red
14 lights I stopped at. Look at how many stop signs I stopped
15 at. Look at how many yield signs I adhered to. Look at all
16 these things I did right. So, don't hold me responsible for
17 what I did wrong.

18 No, that's not the way it works. That's not the law,
19 and that's the situation here.

20 Yes, Doctor Giep, the other doctors, they did a lot
21 right. They don't -- unfortunately, they don't get credit
22 for that when they did something wrong as severely as what
23 happened next. They just don't.

24 And what happened next is this. Doctor Giep had his
25 hands on the baby's head. He may of been sitting. He may

1 have stood up. Either way, the circumstances of this case
2 are -- show that he pulled with excessive traction and
3 pulled the baby's head away from the shoulder that was
4 impacted by the pubic bone, and, by doing that, he ruptured
5 the nerve roots at C5, C6, and C7. He stretched the -- and
6 that was all my stretching, but then they ruptured. They
7 got stretched so much they ruptured, and then the stretching
8 was severe enough to damage C8, which then ultimately
9 developed scarring called a neuroma and was also injured.

10 There's also an indication that temporary injuries were
11 caused, those were all permanent, to the phrenic nerve,
12 which runs down and affects the diaphragm and affects the
13 baby's ability to breathe, and, for a considerable time and
14 for -- during the hospitalization, treatment had to be given
15 because Ashley had a paralyzed diaphragm and could not
16 breathe properly and could not get adequate oxygenation.

17 The judge will tell you that circumstantial evidence is
18 to be given the same weight and significance and can be
19 accepted in the same way as direct evidence. Direct
20 evidence is usually in the form of eye witness testimony.
21 There is one eye witness in this case to what Doctor Giep
22 did in regard to holding that baby's head, and,
23 unfortunately, he's the one eye witness.

24 Every doctor that took the stand, every doctor that
25 took the stand who said that they have ever, ever had an

1 opportunity to examine one of these cases and become
2 involved, either on the plaintiff's side, my side, the
3 patient's side, or on the defendant's side, Doctor Giep's
4 side, said no doctor has ever admitted, ever admitted to
5 applying too much traction or to applying what is called
6 lateral traction where they bend the head downward away from
7 the obstructed shoulder. They never do it.

8 So, in terms of direct evidence, it's, it's what it is.
9 It's a doctor who doesn't want to be blamed for causing a
10 permanent injury to a child and so they never admit it.
11 Maybe they don't recognize it. Maybe they just want to
12 cover it up. But, under any circumstances, direct -- the,
13 the doctor's statement when he writes in I only used gentle
14 traction, that's what you're gonna see every time that one
15 of these things happens. And if that's all it takes to
16 excuse what happened to my client or anybody else is for him
17 to write gentle traction and then sign his name in order to
18 escape responsibility for what happened, then we don't have
19 a system of justice cause our system of justice says that,
20 if you negligently injure someone, then you are responsible
21 for compensating them for their injuries, to make them whole
22 to the extent that compensation can make them whole. That's
23 what our justice system requires.

24 So, I'm not saying that you can't believe Doctor Giep
25 if that's what you conclude in your deliberations, if they

1 are good and complete deliberations. If that's what you
2 conclude, that he did not pull too hard, that he did not
3 bend that head away from the obstructed shoulder, you can
4 conclude that and that would be based upon the direct
5 evidence.

6 But I do suggest as well that the circumstantial
7 evidence where we know that what happened to Ashley is that
8 she ended up with these ruptured nerves, and that the arm
9 appeared to have a brachial plexus injury immediately after
10 birth, all of these circumstances indicate that something
11 more than general traction was applied. And we -- and
12 that -- and, in fact, the evidence preponderates in favor of
13 finding that Doctor Giep did not apply general traction,
14 that he applied excessive traction.

15 Now, you will recall that every witness who was an
16 expert in obstetrics told you that it is the standard of
17 care, generally recognized and accepted standard of care,
18 that a reasonably competent physician, under these
19 circumstances, should only apply the same amount of traction
20 that they would apply in a normal delivery. It should never
21 be more than that. That that is, in fact, the standard of
22 care.

23 And so if this was excessive traction, and also -- they
24 also told you that lateral traction, not the, the -- not to
25 apply lateral traction is the generally recognized and

1 accepted standard of care. So, if the circumstances say to
2 you, as a jury, that he did apply excessive force, that he
3 did apply lateral traction, then that would be a deviation
4 from standard medical care.

5 Just to refresh, this is the circumstances that amounts
6 to a deviation from standard medical care. This is where
7 lateral traction is on the head. Doctor Giep wants you to
8 believe that he, by, by staying in a sitting position when
9 he delivers the baby, he could not cause injury to the baby
10 because he wouldn't be able, by sitting there, to pull hard
11 enough. Really -- what he's really saying is to pull hard
12 enough while he is in a seated position.

13 There is nothing about -- and staying in a seated
14 position that prevents him from applying lateral traction
15 while he's in a seated position if that's what he did.
16 Again, that's his testimony that that -- he's the only one
17 who knows that and to testify to that, but the
18 circumstances, suggest whether he was seated or whether he
19 was standing, he applied lateral traction to this baby's
20 head, and that's what caused the brachial plexus injury when
21 the shoulder was up against the pubic bone as indicated and
22 shown by this illustration.

23 There are some circumstances where a doctor doesn't
24 have a choice. There are some circumstances where the
25 doctor is faced with the dilemma of either sacrificing the

1 arm or losing the baby. That was not one of these cases.

2 No expert found, when they looked at this situation,
3 that the baby was facing that. Every expert said that was
4 only going to happen if he got down the road four minutes or
5 five minutes or six minutes after the diagnosis of shoulder
6 dystocia, but the record indicates that it was only about a
7 minute because the testimony was -- is that the reason that
8 he had the nurse apply suprapubic pressure is cause that's
9 when he diagnosed shoulder dystocia. The baby's head was
10 out, the rest of the body would not come, and that occurred
11 at 20:19, and, a minute later, after the suprapubic pressure
12 was applied, he was able to deliver a viable infant.

13 So, he wasn't four minutes down the road or five
14 minutes down the road or six minutes down the road. He was
15 not in a place where he had to make that horrible decision
16 do I sacrifice the arm in order to spare the baby. That
17 wasn't what happened here. It wasn't that type of
18 situation.

19 Now, we agree that this is called, when shoulder
20 dystocia arises, and Doctor Gurewitsch testified to this,
21 that this is called a obstetrical emergency, but it's an
22 obstetrical emergency that does not pose immediate risk to
23 life or immediate risk of death or an immediate risk of
24 serious bodily injury. That would not happen until the baby
25 was -- until the shoulder dystocia had been in existence for

1 at least four minutes.

2 Despite that, one of the questions that you're going to
3 have and that you have to answer is was this a medical
4 emergency that posed the immediate risk of death or the
5 immediate risk of serious bodily injury because, in South
6 Carolina, we have a statute that says that, in a obstetrical
7 situation, in a labor and delivery suite, where there is a
8 medical emergency, then the doctor is immune from any type
9 of lawsuit like this that can hold him responsible.

10 And so, if you find that this baby was at immediate
11 risk of death or at immediate risk of serious bodily injury
12 because of the obstetrical emergency that occurred when she
13 had shoulder dystocia, then Doctor Giep will have the
14 burden. He'll be immune under those circumstances, and you
15 have to make that decision, but it wasn't that type of
16 emergency. It had not gotten to that far. He is not immune
17 from being responsible for what happened to Ashley F .

18 The defense has put up a lot of experts. People who
19 knew Doctor Giep, who knew Doctor Giep's father, some of
20 them. You're entitled to take into consideration the biases
21 and prejudices of every, of every witness.

22 what was their demeanor on the stand?

23 How did they answer the questions?

24 Did they try to avoid answering questions?

25 Did they try to change the question and give an answer

1 to something that was not asked?

2 You're entitled to take all of that into consideration
3 in your determination of whether or not the expert or the
4 witness is believable. You do not make a decision based
5 upon the number of witnesses that any side presents. This
6 is not a popularity contest. Whoever brings in the most
7 witnesses wins. That's not the way that it works.

8 You can believe part of a witness' testimony and
9 disregard the rest as not believable. You can believe
10 several witnesses and not believe one witness or you can
11 believe one witness over many witnesses, and the ultimate
12 goal is to arrive at the truth.

13 Your verdict must speak the truth, and you come to that
14 as a deliberative body. You don't go back into the jury
15 room and say let's take a vote and whoever has the most
16 votes by the jury wins. That's not the way it works.

17 Everybody on the -- on a jury must, themselves, come to
18 the belief of what is the truth, and then all 12 of you,
19 collectively, must come to that same belief, and that will
20 be your verdict. That will be your verdict and that takes
21 deliberation. That takes -- and the reason that we have 12
22 people is because, in our experience in the American system
23 of justice, we have found that bringing 12 people together
24 who work together to try to arrive at the truth is the best
25 way to arrive at the truth. We don't let one person make

1 that decision. We let 12 people make that decision. And it
2 is absolutely amazing what the collective wisdom of a jury
3 can do when they act in fairness, when they deliberate in
4 the appropriate way, when they use their common sense and
5 they come to a conclusion about what happened in a case like
6 this.

7 The damages that we seek are these. You, you saw
8 Ashley. We are convinced that Ashley will succeed in spite
9 of her injury. She is a special little girl. We don't
10 think that she will be hampered in a way that affects her
11 ability to make a living, and we're not seeking economic
12 damages for her working because we, frankly, believe that it
13 would just be speculative as to whether she will not be able
14 to make a living. If we could prove that, if she had the
15 kind of injury where she couldn't go out and do work at all,
16 we would be here asking you for economic damages for her
17 working life, but that's not what we're gonna seek here. We
18 don't seek that.

19 So, that will not be part of our damages in regard to
20 Ashley. We will not be seeking economic damages.

21 Moreover, Doctor Armenta was only able to speculate or
22 suggest, as a possibility, as to whether she will need
23 surgery in the future, and there was no indication that he
24 was able to give us indicating that. While he said there's
25 a good chance, but not a probable chance at this point where

1 he can say for sure that she's going to need surgery. Even
2 if he did, it would probably be when she is still a minor
3 child. Maybe around the age of 15.

4 So, that will not be her responsibility. So, we're not
5 seeking economic damages for her in regard to that surgery
6 or that possible surgery either.

7 But what he is saying is, and what we believe is that,
8 regardless of whether she has another surgery or not, she
9 will still be a -- left with a deformity, and she will still
10 be left with an impairment in terms of the every day, every
11 moment use of her left-hand, and she will have to live with
12 for the rest of her life.

13 And we have a mortality table that comes into play at
14 this point that indicates that her expected life is about
15 until age 80. And she's nine years old now. And she's 71
16 years from that. If she is dying at that time, she will
17 still be looking at a deformed wrist and a deformed hand
18 that bends upward that she will have lived with all of her
19 life.

20 Now, at nine years old, she's a sweet, cute, beautiful
21 little girl, and she'll grow into a sweet, beautiful young
22 woman.

23 But will she still be as appealing to a young teenage
24 boy when she has an arm like that?

25 we don't know, but human nature being what it is, is

1 that she will suffer some indignities, and she will still
2 have to live with it. She'll still have to face it.

3 will she still be coming home and saying why was I born
4 with this?

5 will she still be looking at her brother, who may grow
6 in to be an All American himself like his older brother, and
7 look at him and saying why am I the one?

8 And I think that your common sense tells you that,
9 that, in all fairness, if we are going to recognize that she
10 should be made whole, then those things should be
11 considered. Her disability, her disfigurement should all be
12 considered in terms of the damages that you seek. And I
13 can't tell you what you should award for something like that
14 because it's not, it's not economic. It's not where I can
15 say oh, I've got a bill for this, and I can tell you how
16 much this costs in the market place.

17 I don't know what 12 jurors -- I mean that's the reason
18 that you're 12 and you're the ones who make the decision.

19 Is it a, is it a verdict of \$500,000 that would make
20 her whole?

21 Is it a verdict of a million dollars, two million
22 dollars?

23 what is it, what is it worth not to suffer with that
24 type of deformity for the rest of your life, for the next 70
25 some odd years, for the time period that you've already

1 suffered because the damages take into consideration not
2 only the deformity itself, but the physical pain?

3 And she's had three surgeries. And every one of those
4 surgeries has involved some pain. And the mental anguish
5 and emotional distress. And we know to what extent that has
6 been. Not to be able to tie a ponytail in your hair. To
7 only be able to braid one side of your hair.

8 Is she gonna get asked to the prom?

9 And if she does, who's gonna dress her?

10 who's gonna set -- who's gonna set her hair?

11 We do seek economic damages for the parents. By law,
12 it is the responsibility of a parent to take care of their
13 child, and when there are special needs, our law rewards the
14 parents or awards the parents for what it has cost them,
15 economically, to pay for those special needs.

16 So, we have an extended hospital, hospitalization
17 immediately after birth. That's an economic damage. It's
18 listed on our summary of the bills. We have the
19 hospitalizations in Texas and this payment of the surgeons
20 for the three surgeries that she's already had.

21 We've had physical therapy. We've had occupational
22 therapy. We've had speech therapy related to the
23 respiratory problem that she had, and all of that is listed
24 and it comes to around \$610,000. And that has all been the
25 parent's responsibilities.

1 By law, we are not allowed to seek any award for the
2 parents for their emotional pain from watching their child
3 go through this. That's not what we're allowed to recover,
4 and we don't seek that, but we are allowed to recover for
5 that monetary expense and that's what those bills reflect.
6 And they're entitled to get that back, and that's an exact
7 number. And we seek every bit of that.

8 And, in fact, that billing summary was stipulated to as
9 to the bills. They're not stipulating that we should
10 recover it, but they are stipulating as to the amount that's
11 stated in that billing summary. And you will have to
12 consider that in deciding what your verdict should be.

13 You will have a verdict form and it will ask you
14 questions, and the first question in my summary is do you
15 find that Doctor Giep, on behalf of the defendants, was
16 negligent and caused injury -- unnecessary injury or caused
17 injury to Ashley F . If you answer no, then that's a
18 defense verdict. If you answer yes, you have other
19 questions that you'll need to answer because the next
20 question is whether or not this was an emergency situation
21 in which the -- in which Ashley faced immediate death or
22 immediate risk of death or immediate threat of death or
23 threat of serious bodily injury.

24 Now, if you answer yes, then that's the defense
25 verdict. If you answer no, then you go to the next

1 question, and the next question has to do with the damages.
2 And you're asked about the damages sustained by Ashley
3 F , and then -- and whether or not she has those
4 damages, and then you decide what that will be. And then
5 the fourth question is do you find that the parents, Treva
6 and Tristan Flowers, have sustained damages because of
7 Doctor Giep's negligence, and then you determine what that
8 is and you place that if you so find.

9 Doctor Giep and Spartanburg & Pelham OB-GYN will be
10 treated, for purposes of your verdict, as one party. The
11 law in South Carolina is, is that you have an employer and
12 you're -- and, during the course of your employment, you
13 commit an act of negligence, then the employer is liable
14 just as you are. And so we -- for purposes of your
15 consideration, you will consider Spartanburg & Pelham OB-GYN
16 and Doctor Giep to be the same party. And that's how you
17 arrive at your verdict.

18 I get to speak to you one more time in response to the
19 defense lawyer's closing argument. I want to thank you for
20 the attention that you have given to all of us during this
21 time. I hope that you recognize, and I'm sure Mr. Lovell
22 will repeat this, how important this is to both sides, to
23 both parties that whether one of the parties wins or loses,
24 we all want to leave here feeling as though justice was
25 done, that we got fairness from the jury, that we got due

1 consideration from the jury. And so we appeal to that and I
2 thank you for your consideration.

3 THE COURT: Mr. Lovell.

4 MR. LOVELL: May it please the Court?

5 Morning, ladies and gentlemen.

6 On behalf of Doctor Giep and Spartanburg & Pelham

7 OB-GYN, I want to thank you for the attention you've given

8 us all week. We've tried to move things along, but it's

9 been a long week. So, I want to thank you on their behalf.

10 Plaintiff's counsel is correct. In this case, you have
11 really two major questions to answer. The first being was
12 Doctor Giep negligent.

13 Did he commit a breach of the professional standard of
14 care?

15 Was he -- did he commit malpractice?

16 That's kind of what it boils down to.

17 The judge will tell you that the burden of proof on
18 that issue lies with the plaintiffs. They have to prove, to
19 your satisfaction by a greater weight of the evidence, that
20 Doctor Giep committed professional negligence.

21 The second question that you have to ask or answer and
22 that the judge will ask you to answer is was this birth in a
23 circumstance that is a medical emergency as the law in our
24 state defines it. And the judge will tell you what the law
25 is. He'll give you the definition of that, and that's a

1 question the judge will ask you to define.

2 What I want to do, very briefly, is kind of walk
3 through some of the legal concepts that the judge will tell
4 you in his charge, and then talk to you a little bit about
5 the way they interact with the case.

6 So, on this issue of negligence, the judge will define
7 for you that that requires that the plaintiff show that
8 Doctor Giep deviated from the standard of care that was
9 required of him as an obstetrician. The judge will tell you
10 that and he'll define that term and he says was there care
11 provided by my client, Doctor Giep, that didn't conform to
12 the standard of medical care of most obstetricians. He'll
13 tell you that a doctor like Doctor Giep only is required to
14 bring reasonable care, skill, and diligence in his care of a
15 patient under the circumstances he's faced with.

16 There's no magic formula that you plug in and the
17 standard of care is always like that regardless of the
18 circumstances, circumstances of the delivery or the labor.
19 The standard of care that has to be required is what was
20 Doctor Giep faced with on October the 7th of 2008.

21 The judge will also, I think, tell you that, when
22 you're trying to assess whether Doctor Giep was complying
23 with the standard of care, you can't use any hindsight.
24 He'll tell you this is not a judgment that's made in
25 hindsight after you know the, the results of what happened.

1 You can't look back and say oh, he should of done this,
2 should of done that. You got to put yourself in the shoes
3 of Doctor Giep at the time he's standing at the, at the
4 patient's bedside or delivering the baby herself.

5 I think the judge will define the standard of medical
6 care as applicable to be the generally recognized standards,
7 practices, and procedures that were exercised by the average
8 competent obstetrician under same or similar circumstances.
9 And an important thing I think the judge will tell you is
10 the standard of care can only be established through expert
11 testimony.

12 I can't come in, as a nonmedical doctor, and say here's
13 what the standard of care is. You have to have a medical
14 degree or be a medical expert to do that. And one other
15 thing the judge will tell you that you can not presume, from
16 the outcome of an event or the fact that an injury occurred,
17 that the doctor must have been negligent. It has to be
18 proven by competent medical evidence. You can not infer
19 that, solely because an injury occurred or there was an
20 occurrence that nobody expected or wanted or a bad
21 consequence of treatment, that the doctor was negligent.
22 The law doesn't permit that.

23 The mere fact that a complication occurs is not, in and
24 of itself the judge will tell you, sufficient to establish
25 the issue of negligence. That burden of proof lies with the

1 plaintiffs.

2 And why -- why is that allowed?

3 The judge will tell you that medicine is an exact
4 science. Some people call medicine an art, and, like
5 anything in art, there's no precise way that things can be
6 done. No precise way that it happens.

7 The judge will tell you that, because medicine is an
8 act -- inexact science, that physicians are not held to
9 absolute accuracy. They're not held to a standard of
10 infallibility. They're not held to being required to
11 provide the utmost perfect standard or perfect skill, and
12 they're certainly not someone who's an insurer of a
13 beneficial result in any scenario where they're involved in
14 providing care.

15 The judge will also, I believe, instruct you that the
16 law says a physician is not liable for an error or mistake
17 in judgment as long as he applies the ordinary and
18 reasonable care, ordinary and reasonable care that is
19 recognized and approved in the obstetrician field in
20 general, the types of methods and manner of treatment that
21 most obstetricians use.

22 So, I am gonna talk briefly now a little bit about the
23 knowledge, the training, and the experience that Doctor Giep
24 had, and it's important, ladies and gentlemen, from my
25 prospective, that you understand that, when Doctor Giep came

1 into this delivery, he brought all of the skills that he had
2 been trained on, the methods and manners that he had learned
3 from medical school, through residency, through his
4 practice, through his keeping up with medical literature,
5 and all of those things, what he knew to do in a scenario
6 when faced with medical emergencies, when faced with fetal
7 heart tones. I know y'all probably got sick of hearing me
8 ask about the depressed fetal heart tones and what could
9 happen when a shoulder dystocia occurred, but those are the
10 things that Doctor Giep was faced with.

11 So, the question is did Doctor Giep use the methods and
12 procedures that most doctors would use, the types that he
13 was trained on, when faced with the issues that arose during
14 this delivery?

15 So, let's talk about that very briefly.

16 What did he do?

17 Well, we know that plaintiff's counsel and even their
18 expert has agreed, when he came in, he assessed that fetal
19 monitor and looked and noted that the heart rate had gone
20 from about 120 down to about 90. Doctor Giep said that's
21 about a 30-percent reduction in the blood flow of oxygenated
22 blood to the body.

23 Did he do nothing about it?

24 Of course, not.

25 You saw that he exercised his skill, the training, and

1 knowledge, and did things to respond to that condition. He
2 was concerned about it. He told you, and you've heard all
3 the experts talk, and you'll have the fetal monitor strips.
4 It was at 130. It had dropped down to 90. Then did a few
5 things. It jumps up, but it drops back down, and it was
6 persistently low. On up until the minute or so prior to the
7 actual delivery, that fetal heart rate was not stable. It
8 was not reassuring, which is one of the medical terms they
9 use.

10 It was not something that felt -- that made the doctor
11 feel comfortable with just allowing Mrs. Flowers to continue
12 to push, push, and push until the baby was delivered,
13 because a low heart rate can mean a lot of things, but it
14 can end up in a scenario where a baby has got brain damage,
15 the baby's got cerebral palsy, or the baby can die. And
16 that's before shoulder dystocia ever occurs.

17 So, the doctor was concerned about it and did things
18 about that.

19 What did he do?

20 He proceeded to go ahead and expedite the delivery, and
21 you've heard every expert that got on this witness stand
22 says that's the right thing to do. When you think it's
23 gonna be a potential of time that the baby's gonna be in
24 distress, you can't just sit there and do nothing cause you
25 don't know how long that baby's reserve is gonna last. You

1 already know the reserve is weak because, for about eight
2 minutes, nine minutes, ten minutes, I don't know the exact
3 number, the heart rate's been kind of doing this, but it's
4 staying down and that tank is beginning to become empty.
5 The tank of reserve of the energy that the baby needs.

6 So, the doctor decides let's deliver this baby as
7 quickly as I can. C-section, not an option. Too unsafe for
8 you, mom. Too unsafe for baby. Takes too long to do it. I
9 think I can help her assist the delivery. I can do the
10 Pitocin, do the maneuvers, use the Kiwi, all of those
11 things.

12 So, he acted appropriately and every expert, including
13 Doctor Gurewitsch, plaintiff's expert, has come in and said
14 he handled that stuff correctly. That shows you the skill
15 and care and training and the knowledge base that Doctor
16 Giep had.

17 what did he do at the time the baby's head had
18 delivered?

19 well, you heard him testify. He checked for a nuchal
20 cord to see if that was the reason that this baby's heart
21 rate was down, the cord wrapped around it sort of choking a
22 little bit of the baby's blood flow. Nothing there.

23 I bulbed the baby's nose and mouth. He did that.
24 Recognized that the shoulder dystocia had occurred, as he's
25 observing the baby not coming out, and he's doing this test

1 traction, nothing's working, he's doing, as you heard every
2 expert say, include theirs, what's required under the
3 standard of care. What doctors who had been well trained
4 know to do he did.

5 He requested, as you've seen a bunch, the timely
6 application of the McRoberts maneuver, and you heard Nurse
7 Phillips and Ms. White testify about what they do with that
8 and the doctor talked -- and every witness said that's what
9 you do. That's the first thing in the routine that doctors
10 have been trained, let's go to McRoberts, let's see if that
11 works. Unfortunately, in this situation, it did not.

12 What did they do next?

13 Doctor Giep says let's try the suprapubic pressure and
14 he, with Nurse Phyllis, Phillips, assistance tried
15 suprapubic pressure. Didn't work. You saw on the video
16 that we showed the other with Doctor Chauhan how they do it.
17 You saw, from Nurse Phillips video when she described how it
18 worked, how they try to make it work and one is suppose to
19 do in sort of moving the shoulder down. It didn't work.

20 Both after McRoberts and suprapubic, the doctor
21 assessed the baby to see did it work, did it happen, did --
22 was it successful and no, it didn't occur.

23 So, he took his skills, he took his training, he took
24 his knowledge and went to the next step, and he went ahead
25 and decided that I will try to reach in and grab the baby's

1 arm and see if I can pull the shoulder myself. You saw it
2 on the video how that works, how they take their fingers and
3 kind of reach in. Didn't work. Couldn't grab it. I think
4 you heard from, I think it was Docker Arnett said hard as
5 heck to do it and it doesn't work a lot of times, that you
6 can't reach far enough in, and the doctor described --
7 Doctor Giep describe that he then went to the Rubin II, the
8 next maneuver in the list.

9 Now, you did hear from I think it was Doctor Arnett and
10 maybe Doctor Gower that, when you get to those secondary
11 maneuvers, there are several different ones you can use.
12 You can use the Rubin II. You can do this thing called the
13 Woods' Screw, either of which are acceptable. Doctor Giep
14 told you he's trained in using the Rubin II that was the
15 easiest for him to do. He can put his hand behind the baby
16 and gently turn.

17 No witness has come in and said it's beneath the
18 standard of care to try the Rubin II. Not even Doctor
19 Gurewitsch or the Woods' screw, using the one. Fortunately,
20 at this time, the Rubin II worked.

21 So, the doctor also showed you what else he did, and
22 that was -- I apologize. I want to use my boards.

23 Let's see. The other thing that the doctor testified
24 that he did do was use his skill and the way he was trained
25 to apply minimum traction performed.

1 Now, he told you that he uses and used the same degree
2 of force, the same degree of traction, whatever word you
3 want to call it, that he uses on every delivery, whether
4 it's the shoulder dystocia delivery or not, but he used
5 minimum traction. He also told you that he used the same
6 degree of manipulation of the head, this lateral traction or
7 force or whatever -- anything you want to call it, but he
8 always does.

9 You heard all of the doctors say, you know, babies
10 aren't static. They're not like a shoe where you just pull
11 things straight out. Babies usually move a little bit and
12 you got to move their heads a little bit to try to move them
13 down at the shoulder. You try to do everything to the
14 minimum. You keep that axial traction as close as you can
15 do it under the circumstances, but you can't see the whole
16 baby's body when the head is only out, but he described what
17 he did in the terms of the delivery itself and manipulation
18 of the baby's body.

19 And that as he's sitting down there, he can not apply
20 the 45-degrees of traction that Doctor Gurewitsch says she
21 thinks he applied to cause an injury, and he certainly can
22 not, as he's sitting on that wheeled stool, apply 35-pounds
23 or greater traction that Doctor Gurewitsch says because he
24 would be pulled into the mother, fall over off the stool,
25 and, if he was leaning trying to do the traction, the stool

1 would fall over and he says he never does that. That's for
2 y'all to decide if you believe what he's telling you.

3 We do know that, at the conclusion of all of his
4 activities, the one thing that happened with the baby is,
5 despite the fetal heart distress, the low heart rate,
6 despite the shoulder dystocia, despite a period of time that
7 the suprapubic and McRoberts didn't remove that, the baby
8 was delivered without brain injury, did not have cerebral
9 palsy from the low blood flow, did not have death.

10 And those are three things that can happen, and you
11 heard all of the doctors talk about how quickly it can
12 happen and how unpredictable it is. From the time a
13 dystocia occurs, you don't have a crystal ball. You don't
14 have the benefit of hindsight to say oh, she's gonna deliver
15 in two minutes. I don't got to worry about brain death or
16 injury. That that is a problem that you have to worry about
17 immediately right then because you don't know how long this
18 baby's gonna be able to withstand the forces of the
19 dystocia, the lack of blood flow that occurred before the
20 birth, about eight, or nine, or ten minutes, and certainly
21 at the time the head is stuck in the mom's vaginal opening
22 and compression there. You don't know how long this baby
23 can hold out, especially one whose been in the scenario of
24 six, seven, eight minutes. So, you got to do what you know
25 and what is necessary to deliver the child at that point.

1 Now, I want to talk briefly about this issue of direct
2 evidence and what the notes show. Excuse me.

3 Doctor Giep's note that I've got up here on the board,
4 and at nine o'clock, and he read all the, the handwriting on
5 it, he described using minimum traction. This is direct
6 evidence. It was written at a time 20 minutes after the
7 delivery of this child. Doctor Giep, probably it took some
8 time to deliver the placenta that comes out after the baby
9 and to do the episiotomies and do everything they do, but
10 within 20 to 30 minutes he's writing his note, and he wrote,
11 at that time, what he did.

12 The next day -- and all of these are in evidence.
13 You'll see it on Exhibit 4 when you go back to your
14 deliberations. The next, two days later he's meeting with
15 the Flowers family, with mom and dad, talking about what
16 happened.

17 He told them what he did, but he also wrote again
18 gentle and constant traction applied to the infant's head.
19 Again, that's direct evidence.

20 And you might ask well, maybe he's worried he's gonna
21 get sued. Maybe he's worried about the time. Maybe he's
22 just writing this as a CYA, but ask yourself this.

23 At the point in time when he's writing the first note,
24 and at the point in time when he's writing the second note,
25 10/7, 10/9, he doesn't know that this is a permanent injury.

1 You've heard the testimony of everybody, including
2 Doctor Gurewitsch, their expert, say that the majority of
3 brachial plexus injuries, from whatever cause, shoulder
4 dystocia or they can occur without shoulder dystocia, are
5 temporary. They resolve within a period of days, weeks,
6 months. Some of them might last a little longer, but all
7 physicians, including Doctor Giep know these things are
8 temporary. You don't worry about them because they're gonna
9 get better most of the time.

10 So, he would have no motivation or fear of lawsuit that
11 he's gonna be writing his CYA note. And I can promise you,
12 if Doctor Giep were writing a CYA note, it would be a heck
13 of a lot better than the two he wrote here.

14 Secondly, lady and -- ladies and gentlemen, you heard
15 the issues Doctor Giep -- I'm sorry.

16 At the time all this was done, Doctor Giep doesn't even
17 know the extent of the brachial plexus injury. You've heard
18 a lot of the testimony from their experts and Doctor
19 Armenta, who was sued three, four, five, six, seven,
20 whatever the numbers were, but how do you do that at that
21 point?

22 None of that was recognized until weeks and months
23 later. So, Doctor Giep doesn't know the extent of the
24 injury. He's writing this note because he's recording. As
25 you heard Doctor Arnett say, well, Doctor Arnett testified

1 we write our notes and not have a dystocia. The beginning
2 of my note I write the degree of traction or forces that I
3 used, and he said, one of his where he used moderate force,
4 he wrote moderate force in there, you can always write it at
5 the beginning of the note, and I specifically asked Doctor
6 Arnett, who's been practicing at that same hospital, where
7 do you write it?

8 At the end of the note. He said right there.

9 You heard earlier, some question about well, no doctor
10 ever writes that they use anything other than minimal
11 traction. Doctor Arnett testified that he does, did, and
12 that the scenario we have is permanent brachial plexus
13 injury.

14 Does he write in the report what he did?

15 And I tell you that that's what Doctor Giep did. He
16 recorded what he did in terms of applying the forces. He
17 wasn't worried about lawyers, wasn't worried about things.
18 Just writing what you did.

19 Now, back to these notes just briefly. Plaintiffs
20 allege that, because Doctor Giep did not write in the note
21 that he did a Rubin II maneuver, must not have happened.
22 Not written. Didn't do it.

23 well, let's take their same logic. If, if that's
24 right, if you don't write something, you don't do it. The
25 flip side is, I guess, is, if you wrote it down, that's what

1 you did.

2 So, we go with their logic. You got to write it down
3 to say what you did. Clearly, the doctor wrote, twice in
4 the note, I did apply minimum traction. I did apply a
5 gentle and constant traction.

6 The other thing in terms of eye witnesses and direct
7 testimony, the plaintiff's experts ignore, as has the
8 presentation to you on the plaintiff's side of the case,
9 direct testimony of people who were in the room.

10 I asked Doctor Allen, their witness, did you review the
11 sworn deposition testimony of Grandmother Bowen, who was
12 there seated and observing his delivery?

13 Yep.

14 Did you see the question that was asked, when you were
15 observing Doctor Giep with his hands on the baby, did it
16 appear that he was pulling the baby up towards the ceiling,
17 down towards the floor, or straight out?

18 Her testimony was straight out.

19 Direct evidence.

20 You heard the testimony of Ms. White and Nurse Phillips
21 yesterday, both of whom were in the room, admitted they're
22 not seeing the doctor's hands inside of the vagina, but you
23 heard them both say we could see his upper arms, his body.
24 We could see his face.

25 He did not appear to do anything differently than every

1 other doctor we've ever watched do regular delivers or
2 shoulder dystocia deliveries. He wasn't grimacing. He
3 wasn't grunting. He wasn't panting. He wasn't flexing his
4 arms. He was just doing what he's seen everybody else do,
5 what every obstetrical -- obstetrician does under similar
6 circumstances, circumstances, and situations. That's direct
7 evidence, ladies and gentlemen.

8 Doctor Giep told you how he delivers the children,
9 babies, when he's sitting on a stool. It's for you to
10 decide, using your judgment and common sense, whether he
11 would be able to apply 35 plus pounds of pressure or
12 traction on a baby sitting on the stool. You heard Doctor
13 Arnett said he's tried to do it. He can't do it.

14 It's for you to decide whether his position sitting on
15 a stool, and you heard both Nurse Phillips and Ms. White
16 say, he delivered the baby sitting on a stool. That's what
17 the doctor said. Nobody's come in here and said he's
18 standing up while he was doing all of these maneuvers.
19 Sure, he's sitting on the stool. Once the baby is
20 delivered, the whole body is out, he has to stand up to cut
21 the cord and hand it to the NICU people. He does stand at
22 that point, but everything else is done on the stool.

23 It's for you to decide would it be virtually impossible
24 for him to be in that position doing the 35 plus pounds of
25 traction that their expert said was where the cut-off line

1 for malpractice is or the greater than 45-degrees of
2 downward traction, which is the cut-off line for
3 malpractice. So, we've all decided that was reasonable and
4 could occur.

5 One other thing that the plaintiffs seem to want to
6 ignore about records and such, they read you a lot of
7 quotations out of the part of the, I forgot what you call
8 it, but part of -- the definitions part of that ACOG Task
9 Force bulletin, the glossary. That was it. And they say
10 oh, they went to every one of our experts, that I'm reading
11 this glossary, and it defines such and such and such and
12 such.

13 So, they want to rely on the glossary and what's
14 written in the ACOG report when it supports what they think
15 happened here, but they don't want to rely upon any portion
16 of the ACOG report that doesn't fit their version of events
17 about how these types of injuries occurred and what causes
18 them.

19 I asked Doctor Chauhan quite a few questions about
20 that. One of which I asked him, I said, doctor, do you --
21 is it published in this ACOG Task Force and do you agree
22 with the statement no published clinical or experimental
23 data exists to support their contention that the presence of
24 persistent, as compared to transient, neuro brachial plexus
25 palsy implies the application of excessive force by the

1 birth attendant. He said I agree with that.

2 There's no evidence, he explained it in a little less
3 complicated terms, there's no evidence that, because you got
4 a permanent -- you got an injury at all, much less a
5 permanent one, that it's the pulling force of the doctor
6 that caused it. No evidence of that. No scientific basis.

7 So, I went and asked him all right, let's go to the
8 next part.

9 Is it written in that report, that one that the
10 plaintiffs want to rely on bits and pieces of, that
11 significant variation exists between individuals both in
12 terms of the mechanical properties in anatomy because of the
13 nonlinear behavior of tissue such as nerve tissues, an
14 estimate of the force needed to cause a nerve rupture can
15 not be directly established.

16 And then I asked, the nerve tissue properties in
17 newborn brachial plexus has not been adequately studied to
18 establish the threshold for damage based on either the
19 applied force or resulting strategy?

20 Again, he explained all right. It's not scientifically
21 valid to come in, it's not credible, it's not competent to
22 come in and try to make the assumption that, because there's
23 an injury, it had to be because somebody pulled too hard or
24 went the wrong direction. That's what he said they studied
25 in all of that Task Force with the 20 odd authors and all

1 the people that were involved. That was one of the
2 conclusions they arrived at and published in this document
3 that was peer reviewed and all of the other things they
4 talked about.

5 And then, finally, I asked him all right. What about
6 clinician applied traction, the statement clinician applied
7 traction in lateral bending of the fetal neck have been
8 implicated as causative factors in some cases of neonatal
9 birth, brachial plexus palsy. However, neonatal brachial
10 plexus palsy also has been shown to occur entirely unrelated
11 to traction with studies demonstrating cases of both
12 transient and persistent brachial plexus palsy in fetuses
13 delivered by cesarean without shoulder dystocia. Other
14 studies have recorded brachial plexus palsy occurring in the
15 posterior shoulder in the presence of a delivery complicated
16 by anterior shoulder impaction.

17 And I said well, you know, what's all that mean?

18 He says it just means that it happens sometimes when
19 there's no shoulder dystocia. It happens sometimes when
20 cesarean sections are done, and you can't say that, because
21 you have a permanent injury, it was because of what the
22 doctor did in applying the traction after shoulder dystocia.

23 I brought experts in to testify about standard of care.
24 You may think they're biased because they knew Doctor Giep.
25 You may think they're biased because they knew his father.

1 They all practice in the Upstate. Some of them here in the
2 city. Some of them are competitors of his.

3 They all testified that, based upon everything they
4 saw, the totality of the chart, and Ms. Bowen's deposition,
5 Ms. Phillips' deposition, Ms. White's sworn testimony, the
6 parent's testimony, what they saw in the records, that, in
7 their opinion, Doctor Giep complied with the standard of
8 care, that he did what most competently trained
9 obstetricians would do under like circumstances, similar
10 surrounding conditions.

11 The plaintiffs brought you one expert witness to talk
12 about standard of care by videotape, Doctor Gurewitsch. I
13 guess she testified too busy to come live. She didn't come
14 down here. So, you saw her on videotape.

15 She repeatedly refused to answer a litany of questions.
16 I can't answer that question. I'm not gonna answer that
17 question. Over and over. It's for you to judge her
18 credibility, but I ask you this.

19 What bias does she have?

20 She gets paid a hundred and 50 -- a hundred to \$150,000
21 a year herself, half of her income, to come in and testify
22 against doctors like Doctor Giep and doctors around the
23 United States in these types of lawsuits arising out of
24 birth issues. Her husband also does the same thing. You
25 heard him, Doctor Allen. He makes a third of his income

1 doing this, going around the United States testifying in
2 cases against doctors. Between the two of them, and I think
3 they said it was a third or a quarter of their whole family
4 income.

5 They came up and told you about their opinions about
6 how things occurred, but I ask you were they using real
7 science or junk science?

8 That's for you to decide.

9 The judge is gonna tell you -- and backing up. Doctor,
10 excuse me, Gurewitsch said the only way this act -- incident
11 and injury could occur was Doctor Giep had to be applying
12 more than 35-pounds of traction or maybe 35-pounds and
13 greater, I can't remember exactly, and greater than
14 45-degrees of downward flexion, downward extension. That's
15 the only way it could occur. It's her opinion and she
16 talked to you about her basis of that.

17 Yet, she also said and agreed that every time there is
18 a permanent brachial plexus injury, in her condition, in her
19 opinion, every time that the doctor who was delivering the
20 baby had to have been negligent, had to have applied too
21 much force, too much downward force, but one exception to
22 that rule. Her rule, the Gurewitsch Rule, one exception is
23 in the case where she had a delivery that involved permanent
24 brachial plexus injury to a baby.

25 when she delivered the one that had that, she wasn't

1 negligent. She did everything appropriate. She's the only
2 doctor out of the hundreds that she has testified against
3 who had a permanent brachial plexus palsy injury that didn't
4 do it, wasn't negligent in the way they did it. Ask
5 yourself who's biased in that regard.

6 The judge will tell you that the burden of proof of
7 negligence lying on the plaintiffs, and they have to present
8 to you competent and credible evidence of what the standard
9 of care is, and that there was a breach of the standard of
10 care. They can't rely on what you think is not competent or
11 credible or is junk science. If that's all they rely on,
12 they haven't met their burden of proof.

13 The judge will instruct you, I believe, that in the
14 absence of the proof to your satisfaction of competent and
15 credible evidence to the contrary, it shall always be
16 presumed that the doctor has complied with the applicable
17 standard of care.

18 In this case, you don't have to presume that Doctor
19 Giep complied with the standard of care because I proved it
20 to you by bringing all of these witnesses in, by bringing
21 four obstetricians, two obstetricians, and two obstetrician
22 specialist with maternal fetal. Doctor Chauhan, Doctor
23 Arnett, Doctor Gower, Doctor Ernest, and I would tell you I
24 think Doctor Giep's as much of an expert as those guys.
25 Maybe not in the maternal fetal side, but in the obstetrical

1 side cause he's been delivering thousands and thousands of
2 babies himself.

3 We showed you, in the chart, where he wrote the degree
4 of forces. We have proven that he complied with the
5 standard of care even though that wasn't our burden.

6 So, you will have a verdict form when you go back. The
7 question one, it's kind of long, but I'll summarize it as
8 plaintiff's counsel did.

9 Do you think the plaintiffs have met their burden of
10 proving that Doctor Giep was negligent, yes or no?

11 If your answer to the question is no, they have not met
12 their burden of proof that he was professionally negligent,
13 committed malpractice, then your deliberations end.

14 Second question you have to answer. Have the
15 defendant's proven, my burden, our burden, that this care,
16 medical care rendered by Doctor Giep during the birth and
17 delivery of this child, was rendered in a genuine, medical
18 emergency situation where the child was not medically stable
19 and was in immediate threat of serious bodily injury or
20 death at the time?

21 Now, the judge will define all those terms for you. He
22 will define the term immediate. I think he's gonna define
23 it in terms similar to this. Current. Present. Actual.
24 Existing. Urgent. Sudden. Those are some of the terms the
25 judge tell you the law defines the word immanent, I'm sorry,

1 immediate, but also, ladies and gentlemen, we presented
2 evidence from which you can reach that conclusion sort of on
3 your own without any help from anybody else.

4 We showed you, on all these fetal monitor strips, and
5 you'll have them back there, they're, again, exhibits with
6 stickers from both of us, plaintiff's counsel alluded to it,
7 but Doctor Giep showed you that, even as far back as, you
8 know, eight, nine, ten minutes before, that baseline started
9 dropping and got low. Then, as he got closer to the time of
10 delivery, as the baby got closer, this is the board Doctor
11 Giep drew on. Still got this thing. Yeah, it rebounds, but
12 look at the trend. It's going back down. It's going up.
13 It's not medically stable. It's not gone back to that, you
14 know, wiggly line that you saw early on. It's kind of doing
15 this and the trend is not looking good.

16 Doctor Giep told you that that concerned him. He was
17 worried about the baby's well being. And plaintiff's
18 counsel mentioned that, in his opinion, there were two
19 complications in this pregnancy or in this birthing
20 experience. One, the gestational diabetes, and, secondly,
21 the shoulder dystocia.

22 I would present to you that perhaps there was a third,
23 and that was the fetal distress from when the strip changed
24 because clearly the nurses and the doctors were concerned
25 about it. They did things about it.

1 The shoulder dystocia itself created an obstetrical
2 emergency. Even Doctor Gurewitsch conceded shoulder
3 dystocia is an obstetrical emergency. The doctor has to do
4 something and he has to do it in a relatively short period
5 of time.

6 There's a debate amongst the experts.

7 Is it six minutes, is it four minutes that the serious
8 injury -- the brain injury can occur and the death can
9 occur?

10 Some said, you know, the average might be four to six,
11 but that's just the average. Some babies have bad things
12 happen within a minute or so. Some a little longer. It
13 depends on the reserve.

14 Well, we know, in the fetal monitor strip, this baby's
15 reserve, direct evidence, her fetal heart rate had declined
16 and was not steady and wasn't stable. We know, looking at
17 the records from the Apgar scores, scores you heard that her
18 muscle tone, and one of them was a minus one which two being
19 normal and minus one not being good one was a minus two.

20 But even the direct testimony of Doctor Giep, the
21 nurses, and even the family, the baby was blue. She was
22 limp, placid, whatever you want to call, she wasn't doing
23 anything for some period of time until they heard her cry.
24 That's evidence that, at the time, in the two minute window
25 following the dystocia event and beine recognized in the

1 delivery of the baby, this baby was in trouble. This baby's
2 muscle tone was in trouble. Her heart beats weren't normal.
3 She was in trouble. And, fortunately, because she was able
4 to be delivered in a couple, two minutes, she didn't suffer
5 the brain injury. She didn't suffer death, but we don't
6 know that at the time and she was at a risk of all of that.

7 It was a present risk. It was actual risk. It was an
8 immediate risk of serious bodily injury from the time of the
9 dystocia event until the time the entire body was delivered
10 or the cord was cut she was handed off to a NICU unit at
11 about 20:20, two minutes there, maybe less than two minutes.
12 Doctor Giep said that, if you look at the strip, the whole
13 thing is maybe a minute, a minute and a half.

14 So, there's no way for these doctors to present when
15 that serious bodily injury death can occur, but we all heard
16 testimony from every one of them it can happen within a
17 matter of a very, very, very, very short period of time.

18 We believe that we have met the burden of proving that
19 this was a genuine medical emergency. The baby was
20 medically unstable, that there was an immediate risk for
21 death or serious bodily injury. So, we believe, when you
22 get the jury verdict form and you see question two where
23 you're asked the question was this is a medical emergency
24 and was the baby in immediate risk of serious bodily injury
25 or death, you should circle yes. And when you circle yes,

1 if you've gotten to that point, then your deliberations will
2 end.

3 Now, at the -- you've heard some testimony earlier in
4 this trial and you saw young Ashley, and I will tell you the
5 one thing that comes into play, when you see a beautiful,
6 beautiful young lady like that, and you see parents who are
7 obviously very, very interested in their daughter and doing
8 magnificent and great things to help her develop despite the
9 problems that she suffers, and it sounds like a great
10 family, we all feel sympathy. And we all think gosh, you
11 know, it's so sad that it happened.

12 Well, the judge is gonna tell you sympathy is something
13 that you can not base your jury verdict on. You have to
14 base it on the evidence, competent medical evidence on the
15 standard of care, with evidence you saw in this courtroom.
16 And while we are -- our hearts all go out for this young
17 lady, that can not be the basis of your jury verdict.

18 We all wish this had never occurred. Doctor Giep,
19 everybody in this room, but that can't be the basis of your
20 verdict. You have to decide it based upon the evidence, and
21 whether the plaintiff met their burden of proof by
22 competent, credible medical evidence that Doctor Giep
23 breached the standard of care and did what most OB-GYN
24 doctors would normally do.

25 So, you probably ask yourself the question all right,

1 Gary, what in the world caused this problem?

2 I asked myself that.

3 Why does this child have the injury if it wasn't the
4 doctor pulling too hard, pulling down, or whatever, even as
5 Doctor Gurewitsch claims, 35-pounds of force or greater than
6 45-degrees?

7 So, I presented a good bit of evidence, direct
8 evidence, about that issue to you. We presented, through
9 all the various experts, the maternal fetal people, Doctor
10 Chauhan, Doctor Ernest, and Doctor Gower, even Doctor Giep,
11 and I think, if I heard correctly and remember correctly,
12 Doctor Allen who then conceded that a weakened motor area of
13 the nerve -- of the muscles in the area of the brachial
14 plexus, if those muscles were weak, the motor tone or motor
15 strength is not normal, then that provides less resistance
16 to the forces of coming down on the mama's birth canal,
17 coming down to the shoulder when the shoulder gets stuck.
18 That nerve is not as -- that muscle area is not as resistant
19 and, thus, those nerves are more susceptible to injury from
20 the normal forces that occur in any delivery.

21 We also heard testimony that, when the fetal heart rate
22 is decreased, that can cause that muscle tone to become
23 weak, and there's direct evidence in that chart in those
24 Apgar scores that her muscle tone was not normal. At a
25 minute after the delivery it was not normal. At five

1 minutes after delivery, it was still not normal.

2 The experts all told you that tells you that muscle
3 tone was not normal as this child was experiencing the fetal
4 heart rate depression and coming on down and coming on out.

5 I had Doctor Ernest spend some time yesterday talking
6 about what happens to the baby as it moves down the mother's
7 birth canal, and he showed you these diagrams and he
8 described babies move shoulders and the head turns in
9 various positions. And he told you that, as the movement of
10 the baby's head comes down, that places stresses on the
11 neck, on the shoulders, on the -- all parts of the baby's
12 body.

13 And then he talked about the forces that are involved
14 in those various times and movements and he wrote all this
15 up here, and I'll be honest, I'm not familiar with newtons
16 and all, but he said that the exogenous forces. He
17 described them as when the mom's uterus is contracting, and
18 that's sort of involuntary, it creates forces.

19 When the mom is asked to push, push, push, and he used
20 the term I think Valsalva, that creates forces that, when
21 they put the legs in just the standard type McRoberts,
22 before you ever have shoulder dystocia, just when the legs
23 are up, that creates forces, and he said all of the studies
24 where they have put pressure catheters inside women who are
25 pregnant at the same stage where they're measuring the

1 pressures, they have proven that those pressures are in the
2 range of 160 newtons for 40-pounds. And he said they also
3 have done those studies of the, the cadavers things on when
4 the nerves can become injured, and that's normally at about
5 190 newtons or 45-pounds.

6 So, it's pretty darn lots of forces going on while the
7 baby is coming down, and he said that, when you look at all
8 of these forces combined in a scenario that you have like
9 with, with Ashley, motor tone is low. The nerves aren't
10 being protected by the muscle that would normally be
11 tighter. You've got an area of fetal distress. You've got
12 the force of the mom. You've got a shoulder dystocia. You
13 do have forces applied by the doctor.

14 He said, you know, doesn't take much for doctor forces
15 to create the difference between those two, but you use the
16 normal forces you use and they apply various, five, ten,
17 whatever the pounds are, doesn't take much and it's a
18 constellation of all of that that leads to injury. It's not
19 just that the doctor pulled too hard or harder than most
20 doctors would do or at an angle that was excessive.

21 And I asked Doctor Chauhan, you know, all right. Talk
22 to me about some statistics about brachial plexus injury,
23 and what he told us was 46-percent of all neonatal brachial
24 plexus palsy injuries occur in the absence of documented
25 shoulder dystocia, but when there's no shoulder dystocia at

1 all, 46-percent of the brachial plexus injuries occur in
2 that scenario. And, in permanent brachial plexus injuries,
3 26-percent of them occur in the absence of documented
4 shoulder dystocia.

5 That supports the very theory of this maternal
6 exogenous forces there that can cause it.

7 Do we know why it happens in some babies and others?

8 Not a hundred percent. They have ideas about the
9 weakened muscle tone and just, you know, everybody's born
10 and built a little differently, but that's, in essence, sort
11 of an explanation of how the injury can occur without the
12 doctor having done something that was beneath the standard
13 of care or negligent or malpractice.

14 The judge will tell you that the occurrence of an
15 injury alone can not serve as the basis, the sole basis, for
16 the finding that doctor -- that a doctor committed
17 negligence.

18 So, ladies and gentlemen, I'm about to sit down. I
19 won't get to get up and he's gonna get up and talk about
20 what I've said. I don't get to come back again.

21 So, I'd ask that you remember the things that I've
22 talked about, and, as you're answering the questions on the
23 verdict form, when you get to question one, have the
24 plaintiffs proven that Doctor Giep committed malpractice,
25 was negligent in this case, you answer that no and that your