

STATE OF SOUTH CAROLINA
IN THE COURT OF APPEALS

APPEAL FROM CHARLESTON COUNTY
Court of Common Pleas

Michael J. Baxley, Circuit Court Judge

Case No.: 2007-CP-10-1553

Jamesetta Washington, as Guardian ad Litem for
Jayden W., a minor.....Appellants,

v.

Edmund Rhett, Jr., M.D., Low Country Obstetrics and Gynecology, P.A.; Tenant South
Carolina, Inc. d/b/a East Cooper Regional Medical Center and AMN Services, Inc. f/k/a
Nurses RX, Inc.....Defendants,

Of Whom Edmund Rhett, Jr., M.D. is.....Respondent.

RECORD ON APPEAL
VOLUME 4

Edward L. Graham
Mary H. Watters
J. Layton Ruffin
GRAHAM LAW FIRM, P.A.
383 W. Cheves St.
Florence, SC 29503
(843) 662-3281

Attorneys for Appellant

Robert H. Hood
Molly H. Craig
Chilton Grace Simmons
Deborah H. Sheffield, *Of Counsel*
HOOD LAW FIRM, LLC
172 Meeting St. ~ P.O. Box 1508
Charleston, SC 29402
(843) 577-4435

Attorneys for Respondents

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1 Q. You have never testified that a pH of
2 7.2 or 7.21 has been a contributing factor
3 for causing brain damage, have you, sir?

4 A. No.

5 Q. You have never written in any of your
6 books, all of your publications, you've
7 never written that a pH of 7.2 or 7.21 has
8 been even a contributing factor to brain
9 damage; have you?

10 A. No.

11 Q. Now, you told this jury that you
12 believe that this child may have partial
13 fetal alcohol syndrome.

14 A. I didn't say partial. I said
15 incomplete, which is what the literature
16 uses as the term.

17 Q. And you said that you believe that
18 Jayden has incomplete fetal alcohol
19 syndrome?

20 A. I did not. I did not say that.

21 Q. What ---

22 A. I said that he does not have fetal
23 alcohol syndrome, as point one. Point two,
24 that the features that he does have are
25 consistent with incomplete -- or that some

1 of the features are consistent with
2 incomplete fetal alcohol syndrome; for
3 which there is no proof.

4 Q. Do you disavow any claim that this
5 child has incomplete fetal alcohol
6 syndrome?

7 A. No. If I -- I have explained to the
8 jury, I am sure that they understand, that
9 we just don't know; that the alcohol sits
10 there as a question, that we can't go any
11 further with it, we just -- it just sits.

12 Q. Doctor, can you tell us today, do you
13 believe that there is even a one in ten
14 thousand chance that alcohol played any
15 role in causing the damage to Jayden?

16 A. I don't think that I can add to the
17 statement, that it simply would reiterate
18 it to the jury to hear it again.

19 Q. Can you say that there is even a one in
20 a million chance?

21 A. That's absurd statement to talk about
22 one in whatever number when there is no
23 scientific basis to account for such a
24 statement.

25 Q. Sir, please answer yes or no. Can you

1 tell these Ladies and Gentlemen whether
2 there is even a one in a million chance
3 that alcohol had any significance in this
4 brain damage?

5 A. No, the response -- that is not "yes"
6 or "no", the response is how do you come to
7 one in a million? That supports that there
8 is a statement, and there is no way for me
9 to come up with a rational, never mind
10 scientific, statement that could aid and
11 abet a statement of one in any number that
12 you might choose.

13 Q. You can't express an opinion with any
14 scientific reliability about any degree of
15 probability or possibility, can you?

16 A. About what?

17 Q. That alcohol played any significant
18 role in causing brain damage in this child?

19 A. You're like a dog with a bone. I mean,
20 the fact is that we made the statement here
21 that we don't know about the contribution
22 of alcohol taken, we don't know the volume,
23 the amount, the timing, and it sits there
24 as an item that cannot be resolved. It
25 sits there nevertheless because some of the

1 features are consistent with incomplete
2 fetal alcohol syndrome.

3 Q. Dr. Milunsky, please turn to Page 24 of
4 your deposition.

5 A. Okay.

6 Q. Starting at Line 7, I asked the
7 question, (reading):

8 Q. Would you be willing to
9 testify at trial that there is at least --
10 I mean, to a reasonable degree of medical
11 certainty, there's at least a one-in-a-
12 million chance that alcohol by the mom
13 caused any birth defect of Jayden
14 Washington?

15 A. There's no scientific basis
16 upon which to reach a statistical
17 likelihood for the alcohol role in Jayden's
18 birth defects.

19 Is that a correct reading of your
20 answer?

21 A. I even stated here again, multiple
22 times already.

23 Q. Let's talk about what geneticists know
24 and don't know. Geneticists know of two
25 thousand or so genetic syndromes. Correct?

1 A. No, that's not exactly right at all.
2 The -- you're misreading. We have computer
3 programs which are quite startling, really,
4 They encompass over two thousand birth
5 defect syndromes, things that just happen
6 in the development of the embryo and fetus.

7 When a number of features happen
8 together, we call it a syndrom -- like
9 missing ear, heart defect, mental
10 retardation, it might have somebody's name
11 attached to it as a syndrome. So we have
12 the Oxford Medicinal Database, the Oxford
13 Neurogenetics Database, the Australia
14 database, where you can put in the features
15 that you find and out comes a deferential
16 diagnose about what the possibilities are.

17 However, for genetic conditions they
18 are endless. They are seven thousand known
19 rare, r-a-r-e, genetic conditions. It
20 turns out that one in twelve of us have one
21 of those conditions. For almost all of
22 them there are no simple tests.

23 Q. You would agree with me, would you not,
24 that there are over two thousand genetic
25 syndromes that are well recognized with the

1 modern level of genetic knowledge?

2 Correct?

3 A. Well, you're doing that thing again.

4 You're confusing developmental defects and
5 syndromes and genetic conditions.

6 Q. Please turn to Page 25 of your
7 deposition, sir.

8 A. Yeah.

9 Q. Starting at Line 19, (reading):

10 Q. All right. There are many
11 genetic syndromes that are well recognized,
12 correct?

13 A. Yes, there are over two
14 thousand.

15 Did I read your testimony correctly?

16 A. Yes, and we're referring to birth
17 defect syndromes. If you look on Line 10
18 it says, "Yes, he has a syndrome." So we
19 are talking about syndromes.

20 Q. Well, my question on Line 19 was,
21 "...many genetic syndromes" ---

22 A. That may be but you're reading it out
23 of context.

24 Q. Jayden doesn't match any known genetic
25 syndrome, does he?

1 A. That's exactly right.

2 Q. You would agree?

3 A. I just said you're exactly right.

4 Q. And I realize that you can predict that
5 in the future geneticists will know more
6 about genetics than they currently know.

7 Correct?

8 A. Well, that's a reasonable statement.

9 Q. But that which geneticists will learn
10 in the future they don't know now, do they?

11 A. Well, you just rephrased your original
12 statement, so it's still correct.

13 Q. There is no scientifically reliable
14 basis to predict exactly what geneticists
15 will know in the future, is there?

16 A. Does that need an answer?

17 Q. I would like one, sir.

18 A. You're right.

19 Q. And there's no scientifically reliable
20 way to predict what tests will be available
21 in the future?

22 A. True.

23 Q. And there's no scientifically reliable
24 way to predict how Jayden would score on
25 any such speculative future tests. True?

1 A. I'm not quite sure where you're heading
2 with this, the intent of what you're trying
3 to say.

4 Q. There is no scientifically reliable way
5 to predict how Jayden would score on a test
6 that doesn't exist yet, is there?

7 A. Oh, -- that's right.

8 Q. You told these Ladies and Gentlemen
9 that you think Jayden has a connective
10 tissue disorder, right?

11 A. Yes.

12 Q. Have you ever diagnosed a connective
13 tissue disorder without doing an examina-
14 tion of the patient?

15 A. I explained earlier that I had not had
16 the opportunity to examine Jayden and the
17 information that I have is based on the
18 medical records and the photographs.

19 Q. Sir, my question is, have you ever
20 diagnosed a connective tissue disorder in
21 an individual without examining that
22 individual?

23 A. Well, when the medical records are that
24 explicit and that careful about the
25 features of the connective tissue disorder,

1 the answer is going to be yes.

2 Q. Well, before doing your work for the
3 defense team on Jayden W's case,
4 have you ever diagnosed connective tissue
5 disorder without examining the patient
6 first?

7 A. Well, the answer has to be yes. I've
8 seen thousands of patients in my career.

9 Q. Do you ---

10 A. Thousands. There are -- from time to
11 time when the records have been sent to me
12 ahead of the patient visit, it's become
13 completely clear that I'm going to be
14 seeing a patient with a connective tissue
15 disorder because of the absolute clear and
16 definitive diagnostic findings on the
17 examinations by others.

18 Q. With all this clear, precise
19 information, can you even come up with a
20 connective disorder, a specific disorder,
21 that you claim Jayden has?

22 A. Wait a second. I've stated that he has
23 a connective tissue disorder. We don't
24 have a definitive syndrome name to attach,
25 and that's no unusual, at all, especially

1 for connective tissue conditions.

2 Q. How many connective tissue disorders or
3 conditions are currently recognized under
4 reliable science and genetics?

5 A. I don't have a fixed number in my head
6 but there are some very clear recognized
7 conditions that even -- like Marfan Syn-
8 drome to name one; osteogenesis imperfecta,
9 brittle bone disease is another. It just
10 goes on and on. There are many.

11 Q. That's what I am asking. Are there
12 hundreds?

13 A. I've just stated that I don't know a
14 precise number and I don't believe that
15 someone has a precise number anywhere.

16 Q. Are there at least dozens?

17 A. Oh, there's more than dozens.

18 Q. And you can't tell us that Jayden fits
19 in any of them, can you, sir?

20 A. That's correct. That's not at all
21 surprising.

22 Q. In fact, what you call connective
23 tissue disorder could actually represent
24 poor muscle tone from an traumatic insult
25 to the brain. Correct?

1 A. No.

2 Q. Well, you talked about hyper-
3 extensibility. Hyperextensibility is a
4 reflection of poor muscle tone. Correct?

5 A. No, it may be a reflection purely of
6 ligamentous laxity, loose ligaments and
7 muscles. You see a patient with Marfan
8 Syndrome, for example, the muscles are
9 fine.

10 Q. Do you recognize Dr. Barbara Burton as
11 one of the leading geneticists?

12 A. I've known Barbara Burton for ---

13 ROBERT HOOD: Please note my
14 objection.

15 THE COURT: Overruled.

16 THE WITNESS: I have known
17 Barbara Burton for ---

18 ROBERT HOOD: My objection is
19 pitting.

20 THE WITNESS: Sorry.

21 THE COURT: The objection is
22 overruled because he hasn't yet pitted the
23 specific testimony, he's just asked about
24 whether he knows another witness. You may
25 answer that, sir. Please go ahead.

1 THE WITNESS: I've known her
2 for thirty years or something on that
3 order.

4 CROSS EXAMINATION CONTINUED

5 BY EDWARD GRAHAM:

6 Q. You have invited her to write chapters
7 for your books?

8 A. No. Sorry.

9 Q. Sir?

10 A. Sorry, -- no. She doesn't break into
11 the international league.

12 Q. Your testimony is that Barbara Burton
13 has never authored a chapter in any of your
14 books?

15 A. (Pause) -- she may have been a coauthor
16 somewhere long ago. There's twenty-three
17 books that's -- I say that I just don't
18 recall that, but I'm willing to be
19 corrected if that's the case. I don't
20 recall. She may have been a coauthor on a
21 chapter.

22 Q. Do you have confidence in the ability
23 of Barbara Burton to do a genetics
24 examination?

25 A. Do I have confidence?

1 Q. Yes, sir.

2 A. Uh, -- I am not sure what you mean by
3 "confidence".

4 Q. What does the word confidence mean to
5 you, sir?

6 A. Well, can I be sure about all the
7 findings that she observed? Is that the
8 question.

9 Q. My question is, would you have
10 confidence in a genetics evaluation done by
11 Barbara Burton?

12 A. I would have a reasonable confidence.

13 Q. Do you have any basis for questioning
14 anything about the genetics examination of
15 Jayden W. performed by Barbara
16 Burton in this case?

17 A. Well, my concerns in this case are
18 related to the fact that she's made
19 multiple errors in her deposition
20 testimony. So that's why I am sort of
21 hesitating about this word "confidence".

22 Q. Sir, I'm asking you -- I am not asking
23 you about any opinions that she stated
24 which you may disagree with. That would be
25 pitting, which there is an objection to.

1 I am asking about the examination of the
2 child that she performed.

3 A. Well, my -- my caution is because of
4 what she has basically stated erroneously
5 in her testimony. That's why I am
6 cautious.

7 Q. Do those alleged errors have anything
8 whatsoever to do with her examination of
9 this child?

10 A. Well, to an extent, yes.

11 Q. In what way?

12 A. Well, the -- I don't know to what
13 extent the jury is aware of the potential
14 condition called Charge. Has that been
15 discussed?

16 Q. Let me ask you, sir, do you content
17 that Jayden does or does not have Charge
18 Syndrome?

19 A. He may well have this condition and
20 that's one of the errors that she stated
21 absolutely in her deposition testimony,
22 that he does not have this condition
23 because sequencing of the Charge gene, uh,
24 revealed no mutation, no defect. However,
25 what she didn't say is that the figures

1 that are published and available range from
2 thirty-five percent to sixty percent, or
3 thereabouts, -- that still have the
4 condition but they don't have any affect on
5 this gene, implying that they maybe --
6 almost certainly, not maybe. That they are
7 at least one or more genes that cause this
8 condition.

9 Q. Dr. Milunsky, ---

10 A. Yes?

11 Q. --- you're under oath. Do you have an
12 opinion to a reasonable degree of medical
13 certainty as to whether or not Jayden

14 W. has Charge Syndrome?

15 A. I don't know but it is certainly
16 possible. The tests that have been done
17 has not ruled this out at all.

18 Q. I didn't ask about disagreement with
19 Dr. Burton's opinions, because that would
20 be improper pitting.

21 My question, sir, is, is there anything
22 about her hands-on examination of this
23 child that you lack confidence in?

24 A. There are a few things that are missing
25 from the report. For example, I didn't see

1 any measurement on the wingspan of Jayden.

2 Q. What significance, if any, do you
3 believe the wingspan measurement may have?

4 A. Well, my viewing of the photographs
5 suggested that he has rather long arms.

6 Long arms are, yet again, a feature of a
7 connective tissue disorder. So I would
8 have liked to have seen what his wingspan,
9 that is his arms stretched way out, what
10 those measurements were. There were no
11 such measurements.

12 Q. What would be healthy wingspan
13 measurements?

14 A. This are graphs with reference to age,
15 so ---

16 Q. Well, can you give us a percentile for
17 wingspan? For the wingspan measurement to
18 be significant to you, how much would it
19 need to vary from any average wingspan?

20 A. I say again that -- you just used the
21 word percentile, so it would depend upon
22 the percentile that he reaches. For
23 example, it could be eighty percent, ninety
24 percent, uh, -- that kind of percentile.
25 Fifty percent would be average. Eighty or

1 ninety percent would be rather long arms
2 and would be yet another factor that
3 implies that he has a connective tissue
4 disorder.

5 Q. Are you concerned that he has too-short
6 arms or only that he has too-long arms?

7 A. No, I am not concerned. I am just
8 indicating to you that from the photographs
9 I got to thinking that he had rather long
10 arms.

11 Q. Would you be better to assess that by
12 personal examination or by looking at
13 photograph?

14 A. Looking at-- of course a personal
15 examination, but that was not where we came
16 to this. We came to this about Dr.
17 Burton's examination ---

18 Q. You're right.

19 A. --- and that was absent.

20 Q. Do you lack confidence in Dr. Burton's
21 examination for any reason other than her
22 failure to record a wingspan measurement?

23 A. Well, I don't think that I have looked
24 at her examination findings with the kind
25 of detail that you're asking me, to pick

1 out any particular one item. So ---

2 Q. As you sit here today, do you lack

3 confidence in her examination for any

4 reason other than the wingspan issue?

5 A. We all make examination of children and

6 don't necessarily write down every single

7 item. So, for example, I didn't notice

8 whether or not she had seen or written down

9 whether he has high arched feet or whether

10 they collapse into a flat foot kind of

11 appearance, implying for example weaker --

12 flat feet imply a connective tissue

13 disorder. Those kinds of things.

14 So you're asking for a complete overall

15 statement about her examination and it's --

16 it neither makes sense, nor can I make any

17 sense of it.

18 Q. Doctor, would you agree that if Jayden

19 W 's brain bleeds truly relate to

20 vulnerable, weak blood vessels ---

21 A. It is more probable than not, in my

22 view, that that is the case.

23 Q. Please let me finish my question.

24 A. Yes, please. I apologize.

25 Q. If you truly believe that Jayden

1 W: 's brain bleed relate from
2 vulnerable, weak blood vessels, would you
3 expect him to have bleeding difficulties as
4 he goes through life?

5 A. Not necessarily, no.

6 Q. Would you expect him to have bleeding
7 difficulties when he submits himself for
8 brain surgery?

9 A. Not necessarily.

10 Q. Would you expect him to have bleeding
11 difficulties when he submits himself for
12 inguinal hernia surgery?

13 A. Not necessary.

14 Q. Or feeding tube surgery?

15 A. (Negative gesture), the same.

16 Q. It just happens when the vacuum is
17 applied?

18 A. No, because I think that's a multi-
19 factual set of things happening: there's
20 acidosis, there's a lack of oxygen. All of
21 these things affect the integrity of the
22 blood vessels. There are other things
23 happening at the same time, pressures and
24 forces, mechanical forces.

25 Q. You claimed that these blood vessels

1 were weak and vulnerable and that's what
2 caused the brain to bleed. But in fact
3 there is nothing in the world literature
4 to suggest a connective tissue disorder
5 causing a brain hemorrhage at birth, is
6 there?

7 A. There is clear evidence for example
8 of osteogenesis imperfecta, brittle bone
9 disease, where a bleed could occur that
10 could be fatal.

11 Q. Jayden has no brittle bone disease,
12 does he?

13 A. No, you asked me about connective
14 tissue disorder and that's one such
15 example.

16 Q. Can you give me other examples?

17 A. In the Ehler-Danlos Syndrome, where
18 blood vessels are -- the word we use is
19 "friable", they easily tear, in the brain
20 and elsewhere.

21 Q. In fact, when that happens it happens
22 in older individuals. Correct?

23 A. It may happen even in young infants.

24 Q. That is not reported in the literature;
25 at birth, is it, sir?

1 A. Erhles?

2 Q. Yes, sir.

3 A. I don't think so.

4 Q. Do you have any other theories about
5 connective tissue disorders that involve
6 brain bleeds during the birthing process?

7 A. No, not at the moment.

8 Q. So the only one that you can name today
9 is brittle bone disease, and you admit that
10 Jayden does not have that?

11 A. Jayden doesn't have that, no.

12 Q. There is no evidence in the world's
13 literature of genetics, pediatrics and
14 obstetrics or neurology of any brain
15 hemorrhage during the birthing process
16 caused by any type of connective tissue
17 disorder other than brittle.

18 A. Well, ---

19 Q. Right?

20 A. --- it turns out that named conditions
21 doesn't necessarily answer the question.

22 We know that babies that are born of normal
23 birth weight, or even premies, will
24 frequently have brain bleeds.

25 Q. Other than brittle bone, there is no

1 other reported incidence of brain
2 hemorrhage being associated at birth with
3 any connective tissue disorder. True?

4 A. I don't know if that is really true
5 without me looking at the entire
6 literature. I don't know that that's true.

7 Q. Well, as you sit here today, you can't
8 cite any literature to us, can you?

9 A. I'm not -- I cannot, no, not at this
10 moment.

11 Q. Now let's talk about brain damage.
12 Ultrasounds of the brain only look at a
13 certain part of the brain. Correct?

14 A. Yes.

15 Q. And where this child was having
16 bleeding is not something that's studied by
17 brain ultrasound; is it?

18 A. It is studied but it may not be
19 visualized in the way that it is normally
20 done.

21 Q. And when the CT scan was done the day
22 or so after birth it showed massive brain
23 bleeds, correct?

24 A. Yes.

25 Q. And when the MRI was done a couple of

1 days after birth it showed massive brain
2 bleeds; correct?

3 A. I don't see -- I don't recall the word
4 "massive" particularly. Do you have that
5 written somewhere?

6 Q. I used "massive" as a layman, Dr.
7 Milunsky.

8 A. Well, you ---

9 Q. What does the word "massive" mean to
10 you?

11 A. Huge.

12 Q. All right.

13 A. And this was not huge.

14 Q. This was not huge bleeding?

15 A. No, it was serious bleeding but I think
16 massive is rather sensationalized.

17 Q. What is the concept of mass effect in a
18 brain MRI?

19 A. It means in a very compressed space or
20 limited space within the brain. The brain
21 is sitting in a skull and there's not a lot
22 of space, so if there is a bleed it sorts
23 of pushes the brain out of the way.

24 Q. Was there enough bleeding in this
25 child's brain to have a mass effect, to

1 squish it's brain over to one side?

2 A. It's not "massive" but some mass
3 effect. That's the terminology that is
4 used.

5 Q. I understand. There was a mass effect,
6 correct?

7 A. Yes.

8 Q. And the mass effect squished the brain
9 over to one side, correct?

10 A. Not the entire brain, just the lesion
11 at the back of the brain.

12 Q. Just the cerebellum portion?

13 A. That's right.

14 Q. And that compression of the brain, the
15 mass effect of the brain was surely
16 powerful enough to cause compression of the
17 transverse sinus. True?

18 A. Possibly.

19 Q. When you told us earlier that absent
20 flow or reduced size of the transverse
21 sinus was a birth defect, in fact that's
22 what happens when your brain fills with
23 blood; isn't it?

24 A. Not necessarily. I was quoting
25 basically Dr. Zimmerman's testimony where

1 he indicated that it was possible that the
2 transverse sinus was hypoplastic, which is
3 the word that he used.

4 Q. In subsequent ---

5 A. Underdeveloped.

6 Q. --- studies, there's no defect in the
7 transverse sinus, is there?

8 A. That is what apparently is the case,
9 but nevertheless he's reading that this may
10 well be hypoplastic, underdeveloped. Of
11 course, continues to develop.

12 Q. By the way, you placed some
13 significance on the fact that the last
14 study that had been done of Jayden, of done
15 of his brain, was a CT rather than an MRI.
16 You admit that MRI's are more sensitive
17 than CT's, correct?

18 A. Yes, I do.

19 Q. And even though the CT didn't reveal
20 any residual dead brain tissue, you
21 recognize that MRI is better at showing
22 that than CT?

23 A. Of course, yes.

24 Q. And you indicated that you couldn't
25 rule out dead brain tissue without looking

1 at an MRI?

2 A. Yes.

3 Q. Several years after the birth?

4 A. Right.

5 Q. By the way, let me ask you about

6 Medicaid. Have you found that on occasion

7 an MRI is indicated for a patient but will

8 not be given to a patient on Medicaid, even

9 though it would be given to a private-pay

10 patient?

11 A. I've heard that kind of story, but I --

12 I work in the Boston Medical Center where

13 we served an underprivileged population and

14 that does not happen.

15 Q. Please turn to Page 68 of your

16 deposition.

17 A. Sixty-eight?

18 Q. Yes, sir.

19 A. I've got it.

20 Q. Starting at Line 19, my question,

21 (reading):

22 Q. Have you noticed that on

23 occasion Medicaid patients might not get an

24 MRI when one would be done for a privately

25 paying patient?

1 Please read your answer at Line 22?

2 A. I said yes, and I just said so again.

3 I read that.

4 THE COURT: Step up a moment and

5 let's talk about scheduling. Defense

6 counsel may join us.

7 (OFF RECORD BENCH CONFERENCE)

8 THE COURT: All right. If you

9 have further questions, please proceed.

10 EDWARD GRAHAM: Yes, sir. Thank

11 you, Your Honor.

12 CROSS EXAMINATION RESUMED

13 BY EDWARD GRAHAM:

14 Q. Dr. Milunsky, cognitive impairments can

15 be associated with brain bleeds; correct?

16 A. Brain bleeds.

17 Q. Yes, sir.

18 A. In theory or anywhere, or what?

19 Q. Can cognitive impairments be associated

20 with brain bleeds?

21 A. You'd have to be more specific about

22 that because they often -- they occur

23 without any cognitive anything.

24 Q. Please turn to Page 80 in your

25 deposition, sir.

1 A. Okay.

2 Q. Starting at Line 15, my question,
3 (reading):

4 Q. *Cognitive impairments and*
5 *speech delays can be associated with brain*
6 *bleeds, correct?*

7 A. Yes.

8 Please read your answer.

9 A. The answer is yes, and your question is
10 as vague as it was then.

11 Q. Then, I continue:

12 Q. *Motor delays can be associated*
13 *with brain bleeds, correct?*

14 What was your answer to that?

15 A. Same statement.

16 Q. "Yes", correct?

17 A. Yes. Equally vague.

18 Q. You claim that this child has
19 connective tissue disorder without doing a
20 physical examination. Correct?

21 A. Correct.

22 Q. And the only thing that this child has
23 in the way of individual variation or birth
24 defects of developmental defects or
25 whatever you want to call them are the

1 coloboma and cross-eyed. Correct?

2 Everything else is caused -- is either
3 associated with connective tissue or brain
4 bleeds. Correct?

5 A. You have that list of fifteen items
6 that we talked about. Many of those point
7 directly to connective tissue.

8 Q. All right. Please turn to Page 80 of
9 your deposition, Line 21, (reading):

10 Q. *So the only problems that this*
11 *child has that are not caused by brain*
12 *bleeds are coloboma and connective tissue*
13 *disorder?*

14 Your answer?

15 A. (Reading):

16 A. *And strabismus.*

17 Q. So apart from brain bleeds, we've got
18 connective tissue disorder, coloboma and
19 strabismus that are not caused by the brain
20 bleeds. True?

21 A. True.

22 Q. When you were evaluating this child,
23 you were under the impression that he did
24 not have serious balance problems, correct?

25 A. I wasn't aware of the extent of his

1 balance problems at the time.

2 Q. And when you evaluated this child, you
3 thought that he had an IQ of eighty-one,
4 correct?

5 A. Seventy-nine to eighty-one, right.

6 Q. You said eighty-one in your deposition,
7 correct?

8 A. Yes. I think that is recorded
9 somewhere in the records.

10 Q. All right. Assuming for the purposes
11 of this question that a baby in the birth
12 canal is vulnerable to blood vessel damage
13 from a vacuum, if that baby is not
14 traumatized by a vacuum he may go through
15 his entire life without any brain bleeds.
16 Correct?

17 A. Well, that's just a sweeping lengthy
18 statement that is impossible to answer.

19 Q. Really? Would you please turn to Page
20 109 of your deposition.

21 A. Okay.

22 Q. Line 13, (reading):

23 Q. Would you agree with me that
24 one with a vulnerability to blood vessel
25 damage from a vacuum, if not traumatized by

1 *a vacuum, may well go through life without*
2 *any brain bleeds?*

3 A. *Absolutely. We all live with*
4 *a bunch of harmful genes and we may never*
5 *know about them our entire life.*

6 Was that your answer?

7 A. Yes.

8 Q. You're not telling us that vacuum is
9 irrelevant to the brain damage, are you?

10 A. No -- uh, to the brain damage?

11 Q. Yes, to the brain bleeds?

12 A. Are we talking about the IQ? You're
13 sort of fuzzing over these things into sort
14 of ---

15 Q. Are you telling us today that the
16 vacuum is irrelevant to the brain bleeds?

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

18 Q. The vacuum is instrumental to the brain
19 bleeds, correct?

20 A. It's a factor. No question.

21 Q. And you indicated that you did not
22 think that there was focal injury to this
23 child's brain at the time that you formed
24 your opinions, correct?

25 A. Based on the imaging reports, that's

1 correct.

2 Q. And would you agree that if there is
3 focal damage to the brain that that makes
4 it far more likely that the brain bleeds
5 from the vacuum are what caused the brain
6 damage as opposed to any other kind of
7 theory, like genetics or alcohol?

8 A. You again are doing that same thing,
9 you are using the words "brain damage" as
10 sort of a collect all, that that is why he
11 has speech and language problems, and so
12 forth.

13 If he has balance problems and there is
14 damage to the cerebellum, the back of the
15 brain where balance and coordination are
16 focused, that's one item.

17 But there is no good explanation that
18 points to the bleed as causing his
19 learning, speech, language issues. As a
20 matter of fact, quite the opposite.

21 Subsequent MRI's have shown that his brain
22 is otherwise normal, and indeed that the
23 size of his head -- the size of his brain
24 has grown perfectly normally, in fact even
25 better than normal. So there's no

1 indications with reference to hypoxia, lack
2 of oxygen, or any other source like
3 bleeding that could have caused his
4 learning issues.

5 Q. Please turn to Page 112 of your
6 deposition.

7 A. Okay.

8 Q. Starting at Line 9, question,
9 (reading):

10 Q. If an MRI of the brain is
11 done which reveals evidence of nonfocal
12 residual brain damage, would your opinion
13 change about the most probable cause of
14 cognitive problems?

15 A. If the MRI shows a generalized
16 or global fit, then this will further
17 support a genetic and/or development basis
18 for his problem. Only if he shows a focal
19 injury can one ascribe the bleed as the
20 fundamental cause.

21 Q. So a focal area of damage by
22 MRI would change your opinion on that
23 point?

24 A. Yes.

25 Was that an accurate reading of my

1 questions and your answers?

2 A. Yes, so that it is clear in the jury's
3 mind, if we're talking about focal -- in
4 other words, precise localized injury to
5 one spot to the back of the brain, causing
6 balance issues, that's one item.

7 But you cannot use that information to
8 say that the rest of the brain, the cortex,
9 the cerebrum, etc. is involved, accordingly
10 his speech and language issues. That's
11 another whole issue.

12 THE COURT: Counsel, let me ask
13 you -- lunch has arrived -- how much longer
14 do you believe that your cross will be.

15 EDWARD GRAHAM: Just a couple of
16 minutes, Your Honor.

17 THE COURT: Thank you.

18 CROSS EXAMINATION CONTINUED

19 BY EDWARD GRAHAM:

20 Q. Doctor, on this MRI, do you see the
21 areas of dead brain tissue in blue?

22 A. I am not a radiologist. I will not
23 offer an opinion about the film.

24 Q. Okay. Do you believe Dr. Zimmerman is
25 one of the best or one of the top neuro-

1 radiologists in the world?

2 ROBERT HOOD: Objection.

3 THE COURT: I sustained because
4 we are -- sustained.

5 CROSS EXAMINATION CONTINUED

6 BY EDWARD GRAHAM:

7 Q. Focal brain damage is not consistent
8 with genetic damage, is it?

9 A. Well, it may be caused by an aneurysm
10 rupture and so forth, so that would be
11 genetic, yes, -- but not otherwise.

12 Q. In fact, you indicated in your
13 deposition that focal brain damage by MRI
14 would pose difficulties to the defense of
15 this case?

16 A. I don't know if I put it that way but
17 the focal damage implies damage at a
18 precise location due to a specific injury;
19 for example, a bleed. We're talking about
20 the back of the brain and the cerebellum
21 only.

22 Q. You offered no opinions about
23 obstetrics, correct?

24 A. Well, it depends on what you mean by
25 that. I am not a practicing obstetrician

1 and not prepared to comment on the standard
2 of expected care. But, you know, my major
3 textbook is exactly that, view in the field
4 of obstetrics and gynecology.

5 Q. But you don't express any opinions
6 today about whether or not Dr. Rhett broke
7 the rules or deviated from the standard of
8 care. Correct?

9 A. That's correct.

10 Q. By the way, Doctor, as one who attended
11 medical school and delivered seventy-five
12 babies, do you recall that there are
13 centimeters between zero station and plus
14 five?

15 A. I'm afraid that's too long ago?

16 EDWARD GRAHAM: Nothing further.

17 THE COURT: Is there redirect?

18 ROBERT HOOD: Thank you, Your
19 Honor.

20 REDIRECT EXAMINATION

21 BY ROBERT HOOD:

22 Q. The Charge Syndrome tested for by Dr.
23 Burton, ---

24 A. Yes.

25 Q. If this child's test was not positive,

1 does that rule it in or out?

2 A. It does not rule it out because
3 anywhere between thirty-five and almost
4 sixty percent, you don't find an
5 abnormality in their genes.

6 More importantly, the fact that --
7 sorry -- more importantly, from the jury's
8 perspective, Dr. Burton recognized that
9 this child had a series of abnormalities
10 that required a genetic study. She
11 recognized these abnormalities and that is
12 a critical realization, that Jayden was
13 born with a set of abnormalities that
14 required further investigation and
15 evaluation, which did not yield an actual
16 definitive named diagnosis but nevertheless
17 didn't remove the fact that he has these
18 abnormalities.

19 Q. She did four tests. How many tests are
20 there, genetic tests, are there?

21 A. Oh, there's and endless number of
22 genetic tests.

23 Q. Of those four tests that she did, what
24 percentage is there for error to normally
25 occur?

1 A. I'm sorry, I didn't understand you.

2 Q. Is there a percentage of error in the

3 four tests that she did?

4 A. No, no. This is highly accurate, the

5 tests that she ordered. The fact is that

6 when the charge gene is sequenced and it

7 comes back normal, it points to the fact

8 that there may be another gene involved.

9 That's the point.

10 There's multiple disorders, multiple

11 genetic conditions which come about from

12 different genes but they all look the same.

13 Q. Well, then are there genetic disorders

14 with no tests to diagnose them?

15 A. That's the majority, still.

16 ROBERT HOOD: Thank you for

17 coming.

18 THE COURT: All right -- what

19 new issue was brought up?

20 EDWARD GRAHAM: About the highly

21 accurate test results and the error rate.

22 Just one question, Your Honor.

23 THE COURT: Very good.

24 RECROSS EXAMINATION

25 BY EDWARD GRAHAM:

1 Q. Doctor, you indicted that Dr. Burton
2 only did four tests. Did she do all of the
3 ones that you indicated in your deposition
4 were indicated, plus an additional one?

5 A. I mentioned in my deposition that these
6 are four of the tests that I would be
7 recommending initially, right up front.

8 THE COURT: Anything further
9 now? This is your witness?

10 ROBERT HOOD: No questions.

11 THE COURT: Then you are free to
12 leave.

13 (WITNESS STEPS DOWN)

14 THE COURT: Ladies and
15 Gentlemen, we will take our lunch break at
16 this time. If you wish to take your lunch
17 outside, please do so. Have a good lunch.

18 (JURY OUT @ 12:46 P.M.)

19 THE COURT: Let me speak to
20 plaintiff's counsel up here.

21 (OFF RECORD BENCH CONFERENCE)

22 THE COURT: We be in recess
23 until 1:30.

24 (LUNCH RECESS)

25 THE COURT: All right. Ladies

1 and Gentlemen, please be at-ease everyone.

2 Bring in the jury.

3 EDWARD GRAHAM: Your Honor, we
4 would like to offer into evidence Exhibit
5 76 which was previously marked for ID by
6 Dr. Rhett, just to authenticate it as being
7 true and accurate.

8 THE COURT: Is there any
9 objection from the defendants?

10 ROBERT HOOD: No, Your Honor.

11 THE COURT: Exhibit 76 is in
12 evidence.

13 (SO ENTERED AS DEFENDANT'S EXHIBIT 76)

14 (OFF RECORD DISCUSSION RE: EXHIBITS)

15 THE COURT: We can take that up
16 later. The jury is ready. These may
17 already be in the record, those are --
18 these may not. We can take this up at the
19 end of the day.

20 ROBERT HOOD: And we wanted
21 the animation.

22 THE COURT: We will also talk
23 about the animation issue. Please bring in
24 the jury.

25 (JURY IN @ 1:40 P.M.)

1 THE COURT: Welcome back, Ladies
2 and Gentlemen, I trust that you had a good
3 lunch. We are in the defense case, as you
4 will recall. Please call your next
5 witness.

6 MOLLY CRAIG: Yes, sir, Your
7 Honor, the defense calls Dr. Richard
8 Winestein.

9 (WITNESS TAKES STAND)

10 RICHARD JOHN WEINSTEIN, being duly
11 sworn to tell the truth, the whole truth
12 and nothing but the truth, testified, as
13 follows:

14 DIRECT EXAMINATION

15 BY MOLLY CRAIG:

16 Q. Good afternoon, Dr. Weinstein. How are
17 you?

18 A. Fine.

19 Q. Please tell us a little bit about
20 yourself, where you live and where you
21 work.

22 A. I am in private practice. I work in
23 West Ashley at Roper and St. Francis
24 Hospitals in Charleston. That's about it.

25 Q. Tell us about your family, sir.

1 A. I am married, I have three children,
2 one stepchild and in about three or four
3 days I will be a new grandfather
4 (phonetic).

5 Q. Congratulations. Please tell us where
6 you went to college and medical school?

7 A. I went to Brown (phonetic) University,
8 graduated in 1973. I attended medical
9 school at the University of Cincinnati,
10 graduated in 1977. I did my internship at
11 the Metropolitan Hospital in New York City.
12 I did my residency in 1981. In 1981, I
13 moved to Charleston, South Carolina.

14 Q. Dr. Weinstein, where do you have
15 privileges? At which hospitals do you have
16 privileges to practice medicine?

17 A. At the present time I have privileges
18 at Roper and St. Francis and the Medical
19 University.

20 Q. What types of position have you held at
21 the St. Francis Hospital?

22 A. St. Francis, I've been Chairman of the
23 Department twice and -- maybe three times.

24 Q. How long have you been delivering
25 babies?

1 A. Since my residency began in 1976.

2 Q. And approximately how many babies have
3 you delivered, sir?

4 A. I don't know. Thousands.

5 MOLLY CRAIG: Your Honor, at
6 this time we would offer Dr. Weinstein as
7 an expert witness in the field of
8 obstetrics and gynecology.

9 THE COURT: Any objection?

10 MARY WATERS: No, sir.

11 JAY DAVIS: None, Your Honor.

12 THE COURT: All right, hearing
13 one, he is so admitted.

14 DIRECT EXAMINATION CONTINUED

15 BY MOLLY CRAIG:

16 Q. Dr. Weinstein, have you had the
17 opportunity to review the medical records
18 of Ms. Washington and the deposition taken
19 in this case?

20 A. Yes, ma'am.

21 Q. Have you also had the opportunity to
22 review the birth video?

23 A. Yes, I have.

24 Q. Based on your review of the medical
25 records and the birth video and the

1 deposition(s), do you have an opinion to
2 a reasonable degree of medical certainty
3 whether Dr. Rhett complied with the
4 applicable standard of care in the
5 treatment and delivery of Jayden
6 W. , Ms. Washington's baby?

7 A. Yes, I think he complied with the
8 standard of care from everything that I've
9 seen in my practice.

10 Q. What is your experience in using the
11 vacuum to assist a mom in delivering a
12 baby?

13 A. I actually trained with a vacuum
14 extractor back in the '70s. At that time
15 it was a hard cup, a metal cup that we used
16 then. Shortly after I came to Charleston
17 in the early '80s a soft cup called Mighty
18 Vac came out, uh, I ordered one of those
19 because I felt that there was some
20 advantage to using the vacuum. So in the
21 early eighties, as far as I am aware, I
22 believe that this was the first incidence
23 of a vacuum being used in Charleston. I
24 began using it at St. Francis and Roper
25 Hospitals.

1 Q. Who brought the vacuum to Charleston,
2 South Carolina?

3 A. To my knowledge, I did.

4 Q. And based upon your review of the birth
5 video in this case, do you have an opinion
6 as to whether or not the vacuum used to
7 help deliver Ms. Washington's baby was used
8 appropriately?

9 A. Yes, ma'am.

10 Q. What is that opinion?

11 A. That it was used appropriately.

12 Q. Have you listened to the monitoring
13 strips in this case?

14 A. I have.

15 Q. Are you relying on those fetal
16 monitoring strips to give your opinion in
17 this court?

18 A. Yes.

19 MOLLY CRAIG: I would like to
20 bring the doctor down, with the court's
21 permission, off the stand to go through the
22 previously marked two parts of the fetal
23 monitoring strip.

24 THE COURT: He may.

25 MOLLY CRAIG: Come on down,

1 Doctor.

2 DIRECT EXAMINATION CONTINUED

3 BY MOLLY CRAIG:

4 Q. For the record, these are Exhibits 104
5 and 105. You can see that there is some
6 handwriting already on there. This is Dr.
7 Rhett's handwriting. What I want you to
8 do, Dr. Winestein, if you will use this
9 pointer, (tendering). Tell us what you see
10 on this fetal monitoring strip, please.

11 What I would like for you to do is to
12 highlight anything that would concern you
13 as an obstetrician if you were delivering
14 this baby.

15 A. There are a couple of things. As you
16 look at the fetal monitoring strip, you
17 have to take this ---

18 COURT REPORTER: I'm sorry,
19 Doctor, could you speak a little louder for
20 me?

21 THE WITNESS: I'm sorry.

22 MOLLY CRAIG: Stand over here.

23 THE COURT: Yes, switch to the
24 far side so that he is facing back towards
25 the court reporter so that the court

1 reporter and jury can hear him.

2 MOLLY CRAIG: Move over here,
3 so that you're ---

4 THE WITNESS: Yes. The fetal
5 monitoring strips show the ongoing event
6 and you have -- it shows individual
7 activity that may be of concern or that may
8 not be. This shows the baby's heart rate
9 as it drops down, as it is being delivered.
10 But you really don't have to worry about
11 that. If the baby's heart rate drops way
12 down before that, you may or may not have
13 to be concerned or it may be a matter that
14 you can't wait.

15 This situation presented where the
16 baby's heart rate dropped down and so we
17 are looking at fetal heart baseline -- and
18 I can't go back any further than here but
19 -- between 120 and 150, very low
20 decelerations, which ---

21 DIRECT EXAMINATION CONTINUED

22 BY MOLLY CRAIG:

23 Q. Stop right there. What are decelera-
24 tions, Doctor?

25 A. A deceleration is a drop in the baby's

1 heart rate.

2 Q. Okay.

3 A. These decels are not of great concern
4 but they are showing a baseline that is
5 going down, then it comes back up and he
6 recovers. Okay? It goes a little bit
7 higher but then the baby's heart rate comes
8 back down, which means that he may need a
9 little bit of help. It drops down, it
10 dropped down significantly between this and
11 this. Here where it drops down and stays
12 down, it goes down to the ninety, this is
13 significant. The important thing in the
14 whole picture here is what are we going to
15 do about it. The heart stays down, it does
16 not come up, it's down here, ---

17 Q. The ---

18 A. Heart stays down, what is called
19 bradycardia, for a longer period of time.
20 At that time, Dr. Rhett made the decision
21 to delivery this baby, to get this baby
22 out.

23 As he is preparing to do that, he takes
24 the scalp electrode off the baby's head and
25 applied the vacuum suction cup. As he

1 prepares this, we see a lack of variability
2 in -- the baby's heart rate goes down and
3 stayed down.

4 Q. What significance is there to the fact
5 that the baby's heart rate is down and that
6 it stayed down?

7 A. Well, a baby needs to have a certain
8 heart rate to provide oxygen and nutrition
9 to its whole body and brain. If the heart
10 rate stays down long enough for a long
11 period of time it means the baby is oxygen
12 deprived, variable rates.

13 Q. Dr. Weinstein, you said bradycardia?
14 What is bradycardia?

15 A. That means -- when we have a baby's
16 heart rate that stays down -- a
17 deceleration where it goes down and then
18 comes up, generally that will last less
19 than a minute. When it goes down and stays
20 long for a period of time that's called
21 bradycardia, brady means slow, the
22 heartbeat is slow. So that starts here.

23 Q. Would you please mark and put
24 "bradycardia" where you see it on the
25 strip?

1 A. (Complies).

2 Q. Is there bradycardia on the other strip?

3 A. Yeah.

4 Q. If you would also mark it?

5 A. (Complies).

6 Q. Now, I didn't ask you about the fetal
7 monitoring strip before this because I am
8 trying to move things along, but based upon
9 your review of the fetal monitoring strip
10 up to this point do you have any concerns
11 about fetal distress?

12 A. Before this point here?

13 Q. Yes.

14 A. I would have to see that, I don't
15 remember without referencing that.

16 Q. Looking at these two exhibits, is there
17 anything on these two exhibits that concern
18 you, as a practicing obstetrician,
19 regarding the welfare of this baby?

20 A. Yes, the baby's heart rate has dropped
21 down and has not returned.

22 Q. What does a doctor do when a baby's
23 heart rate drops down and hasn't come back
24 up?

25 A. A decision has to be made to deliver

1 the baby. One of the choices is to a
2 vacuum-assisted delivery, one choice is to
3 use forceps -- (talking, inaudible) --
4 changing positions of the mother may help,
5 giving hydration/fluids may help but that
6 takes time, oxygen. At that point you have
7 to decide 'what can I do to relieve this
8 baby's distress?'

9 Q. If you had been the doctor who was
10 delivering this baby and you observed fetal
11 monitoring strips like we are seeing right
12 here, what would you have done?

13 A. I would delivered the baby, we needed
14 to take care of that baby outside, prevent
15 further distress for the baby.

16 Q. Dr. Winestein, please have a seat back
17 at the microphone. Thank you.

18 A. (Complies).

19 Q. Doctor, you mentioned the options for
20 delivery when faced with fetal monitoring
21 strips like those at-issue in this case.
22 Please tell us -- you gave us two, I think.
23 The option was to do nothing, right?

24 A. To -- well, I mean, doing nothing is
25 not a good option and I would not include

1 that. One is to do nothing. The baby
2 needs to be delivered. Yes, it's an option
3 but that is not a good option, not an
4 acceptable option.

5 Q. What are the acceptable options given
6 the signs of fetal distress?

7 A. One would be to instituting resus-
8 citative measures like we talked -- fluids,
9 oxygen, changing position.

10 As this was, at the point this labor
11 where the baby was not deliverable -- and
12 this is very important. Again, this is not
13 an adequate remedy, this was an ongoing
14 process with a patient that was four or
15 five centimeters dilated. You can't
16 deliver that baby vaginally. You'd have to
17 do either a C-section or -- so you try to
18 institute measures so that you can manage
19 the patient's process, so that she can
20 continue labor.

21 Q. Okay, so what ---

22 A. At this point the baby is deliverable.
23 The baby is down in the pelvic and it --
24 you have then at that point three choices
25 to get it out: you can use a vacuum, you

1 can let mom push but if that wasn't working
2 then you don't have time to do that, use
3 forceps. In my evaluation of where this
4 baby was, a C-section was not an option.

5 Q. Why was not an option?

6 A. It would have taken -- the baby is not
7 looking so good. We could try but -- now,
8 we're five or ten minutes down the road, he
9 baby's heart is still down and is in deeper
10 distress. So we don't want to -- we want
11 to get this baby born. C-section was not a
12 good option. Had the baby -- had there
13 been time, had the mom not been fully
14 dilated, C-section might have been an
15 option but in this situation a vaginal
16 birth was the way to go. The risk was far
17 greater to wait to arrange a -- there's two
18 patients that we're taking care of, we are
19 always taking care of two patients.

20 Q. Doctor, the option of giving fluids and
21 changing the position of the mother,
22 explain whether that was an option that you
23 would have pursued at this time in this
24 delivery?

25 A. No. It's the fact that she was ten

1 centimeters and the fact that the baby was
2 low enough in the pelvis that we could do a
3 relatively rapid and uneventful delivery.
4 Okay? So in that situation, let's not do
5 complicated surgery, let's do the easiest
6 thing. Let's get the baby out vaginally.
7 Forceps or vacuum.

8 Q. What would you have done?

9 A. In this situation -- I wasn't there but
10 I would have done one or the other and at
11 the time I was comfortable with both
12 instruments.

13 Q. When you say both instruments, which
14 instruments are you ---

15 A. Forceps or vacuum.

16 Q. Do you have an opinion as to the baby's
17 station when the vacuum was applied?

18 A. Absolutely.

19 Q. What is that opinion?

20 A. It was at the low station.

21 Q. We are going to come back to more
22 specifics on that in a minute but I want to
23 now keep going. The baby is delivered and
24 then what clinical signs are there after
25 delivery to confirm that the baby wasn't

1 getting enough oxygen?

2 A. The baby is a little slow to begin
3 with, they gave his some oxygen; there was
4 evidence of some term meconium; ---

5 Q. Stop there. Term meconium. Let's talk
6 about whether or not there really was
7 meconium. Specifically please tell us what
8 meconium is and whether or not from your
9 review of the charts it was actually
10 present?

11 A. Well, meconium is fetal stool. You can
12 see the meconium sometimes when the water
13 is broken, so we can say that the baby at
14 some point during the pregnancy and we
15 don't know when -- in this situation, it's
16 clear, I think on the delivery record that
17 was show, term meconium, which means that
18 the baby passed meconium in the last part
19 of labor, that it was not something that
20 was going on in the uterus. So it
21 indicates to me that the stress caused the
22 passage of meconium.

23 Q. What is the significance of the pH
24 being 7.21?

25 A. It's low. It is not abnormal but it's

1 low. It doesn't give you great comfort to
2 deliver a baby -- you say, 'Boy, am I glad
3 that I delivered this baby.' We like to
4 prevent that. We're talking about tenths
5 of hundreds of a point between a healthy
6 baby with a low pH of 7.21 and a baby that
7 is severely hypoxic at 7.0 or below.
8 That's not a lot of room. So back to 7.2,
9 yes, that's low normal but all it takes for
10 it to be 7.0 is a lack of oxygen. What
11 that means is that the baby retains CO₂ and
12 that's means you see acidosis. Now, the
13 nice thing about the oxygen is that he's
14 breathing at all. So what do you do? You
15 deliver the baby. He starts to breathe,
16 gets rid of the carbon dioxide and the pH
17 returns to normal.

18 Q. All right, now let's go back to the
19 numbering and stations that we were talking
20 about. There has been testimony that this
21 was a mid-pelvic delivery. What is your
22 opinion as to whether or not this was a
23 mid-pelvic delivery?

24 A. This was not a mid-pelvic delivery.

25 Q. Please explain why?

1 A. We had the definition -- there has to
2 be some sort of -- if the baby is plus
3 three, they don't want to -- and I -- I
4 believe the expert before me is a shorter
5 than I am, but we are all "normal".
6 There's a range. To say that this is the
7 ischial spines is five centimeters is
8 absurd. It doesn't really matter. The
9 number is not important. The difference
10 between a plus one station and a plus four
11 station is relative to where the baby is
12 and relevant ease of vaginal delivery. So
13 the fact that the station is not mentioned
14 -- it would be nice if it were --but when
15 we look at how this delivery was conducted,
16 we see Dr. Rhett taking the scalp electrode
17 off. You're reaching for ischial spines to
18 determine the station and -- you can see --
19 when he puts the cup on, again when the
20 baby comes down, the contraction comes and
21 he is pushed down, down and up, down and
22 up, it's a slow process. When I put that
23 cup on, the mother has to push the baby,
24 and it doesn't mean that the baby is at
25 zero station, it means that the cup pushes

1 the baby up and the baby -- it's the lowest
2 station that the baby comes down to, so if
3 that baby is not at plus four, yeah, I can
4 put the whole cup in the vagina but with
5 the next contraction it's going to go back
6 to where it was. So I am not concerned
7 that I see this cup inside the vagina,
8 because as soon as he starts pulling it is
9 right there. A mid-pelvic delivery means
10 that at the lowest tissue of the vagina,
11 the muscle, had not been separated by the
12 forces of labor.

13 The fact that the mom isn't pushing is
14 not a concern either. Sometimes in
15 obstetrics we call it laboring down. We
16 know that the mom is fully dilated but for
17 many reasons she is tired, she doesn't feel
18 like it, she is not a good pusher, but --
19 so what I see happening is that the cup is
20 attached, the doctor pulled and the baby
21 comes down and out. The way that it works
22 is not difficult.

23 Q. In this case what kind of delivery was
24 it?

25 A. A low vacuum delivery.

1 Q. Thank you. All right, there was a
2 blowup shown up earlier this morning, some
3 pictures of the various stages of delivery
4 that were shown to the jury earlier today.

5 Can you tell from a picture the
6 characteristics of the outlet.

7 A. Stop, I can't see the ---

8 Q. Can you tell from the blowup or
9 pictures whether or not it's a low, mid or
10 mid-pelvic -- outlet, low of mid-pelvic
11 delivery?

12 A. No. I tried to explain that you can't,
13 that it is a process. You can't look at
14 where the cup is at any particular time and
15 say whether this is a low, mid or outlet.

16 Q. You have had a chance to review the
17 birth video in this case?

18 A. I have.

19 Q. Based on your review of the birth
20 video, did that help you reach your
21 opinions in this case as to whether or not
22 this was a low pelvic delivery?

23 A. As I said, once Dr. Rhett used the
24 vacuum the baby came down rather quickly.

25 It was a low vacuum delivery.

1 Q. I want to show you one clip, a short
2 one and then ask a couple of questions.
3 (Video playing), -- you have seen that clip
4 before, right?

5 A. I have.

6 Q. Just tell us what your opinions are
7 based upon seeing that clip and based upon
8 whether or not you believe that Dr. Rhett
9 acted reasonably in this delivery.

10 A. At that point I am not really sure that
11 ---

12 Q. What can you say about his bedside
13 manner?

14 A. Well, Dr. Rhett enjoys what he does.

15 I've know Dr. Rhett for a long time. He's
16 an excellent physician in my opinion. He
17 enjoys what he does, being where he is,
18 interacting with the family.

19 He's maybe joking a little bit but he's
20 paying attention to how much fluid that the
21 patient has, making sure that she has got
22 adequate hydration. There wis something
23 about making sure that heart doesn't get
24 too long again because we might have to do
25 a C-section. He's thinking about the

1 process. But he's a happy guy, doing what
2 he likes to do.

3 Q. He's paying attention?

4 A. Yeah.

5 Q. All right, let's see the next clip --
6 (video playing) -- Chilton, let's play the
7 next one, too, please. It's short, (video
8 playing). Dr. Winestein, what do those two
9 clips show you?

10 A. Most of you enjoy what we do. It's a
11 pretty good specialty, it's a happy
12 specialty most of the time. Sometimes it
13 is real sad, but we enjoy it.
14 Unfortunately sometimes we are confronted
15 with situations where we need to make very
16 important decisions very quickly and we are
17 the only people who can make those
18 decisions. Dr. Rhett is serious, Dr. Rhett
19 has change his whole demeanor, he's a
20 different personality. He's, 'Let's see
21 what we can do to get this baby out.' You
22 can hear the baby's heart beat dropping
23 down while he is doing it. He's taking
24 care of his two patients. Different person
25 than you saw coming in the room and, if I

1 recall correctly, a different person --
2 happy -- when the baby was out.

3 The other thing that I think is very
4 important is that when you look and you see
5 him trying to unscrew that fetal scalp
6 electrode, the little thing you hold onto
7 at the end there is maybe a centimeter. He
8 didn't have to stick his fingers in to get
9 it, it was right there. This baby's head
10 was right there.

11 But important is the change in his
12 attitude, the way that he focused when
13 delivering this baby.

14 Q. Thank you. Now, the last clip that we
15 have is the actual delivery. Dr.
16 Winestein, I want you to stop us on the
17 video where it's your opinion, wherever we
18 are on the video, is proof that leads to
19 your opinion that this was a low pelvic
20 delivery. Okay?

21 A. Okay.

22 Q. You just tell us to stop when you ---

23 A. Can I come a little closer?

24 Q. Absolutely -- (video playing).

25 A. Right there.

1 COURT REPORTER: Doctor, I cannot
2 hear you.

3 DIRECT EXAMINATION CONTINUED

4 BY MOLLY CRAIG:

5 Q. (Video replaying).

6 A. (Indicating).

7 Q. Tell us what you see there, Doctor.

8 A. She's taken a deep breathe, she is
9 relaxing, she is not pushing down to where
10 the baby is going to go down as far as it
11 can. If you can get her to relax, you can
12 put that vacuum cup into the vagina.

13 Q. (Video playing), ---

14 A. You can see that he is moving the cup
15 around a little bit so that he can put his
16 fingers in there. One of the worst things
17 that you can do is to get the vagina caught
18 between the cup and the baby's head. Then
19 -- you'll get suction all right but in
20 bringing the baby down for delivery you'll
21 rip the vagina because it is stuck there.
22 The only way to get an indication of where
23 that cup is, to make sure that there is
24 nothing cup in it that doesn't belong
25 there, is to move the cup a little bit.

1 You've got to do that. That's not torque,
2 that's moving the cup to make sure that
3 this is a safe application. Go ahead.

4 Q. (Video playing) ---

5 A. So, now, -- go ahead.

6 Q. (Video playing ---

7 A. This is her first attempt at pushing
8 with the cup on. You can see that the top
9 of the cup is right there.

10 Again, this something that is
11 happening, it's not a still photograph,
12 it's not a snapshot, not picture. What is
13 more important, perhaps, than the station
14 of this baby -- whether it's high, mid or
15 low -- is how is it responding to what
16 we're doing.

17 If I've got a mom who has had a couple
18 of kids, especially if I know the last
19 delivery was rapid and the baby is ready,
20 when I tell her to push, sometimes she can
21 push that baby down three or four stations
22 in a couple of pushes.

23 That was not the situation here. This
24 was her first pregnancy. She'd never had a
25 baby before. With the first pregnancy --

1 with the first push, if you back up a
2 second, in the middle of this contraction,
3 this baby comes right down. It's not going
4 to do that if it's way up high. Even if it
5 is way up high, it's showing that there is
6 plenty of room for this baby to come out.

7 Watch, -- go ahead.

8 Q. (Video playing) -- you can see that as
9 you move this handle -- if we had a vacuum,
10 I could show you how this works. The
11 difference between moves what we try to do
12 is stretch the vacuum over, take our
13 fingers and put them into the vagina and we
14 go like this (illustrating with hand)
15 because if we can help stretch while the
16 baby is coming down, it makes it easier for
17 the baby to come through. In order to do
18 that, you've got to move things around a
19 little bit.

20 Q. If you ---

21 A. Again, if you want -- it this is the
22 baby's head here, I've got to reach in like
23 this, I've got to move around like this.
24 What we don't want to do is two things --
25 number one, and not necessarily the most

1 important, but twist back and forth like
2 this because this is not that sharp but
3 there is pressure on there and if you
4 rotate it back and forth you can injury the
5 skin..

6 Q. Do you see Dr. Rhett rotating it back
7 and forth on this video as you just
8 illustrated?

9 A. No. Let me continue.

10 Q. Sure.

11 A. The other one is that as the baby down,
12 it goes up this slight curvature -- as we
13 all know, the baby comes down and then as
14 we all saw in that model the -- the model's
15 head will come down like this, the baby's
16 head comes down, goes around a curve and
17 goes up. When the baby comes out, the
18 baby's head come up like this. So what you
19 don't want to be doing is rocking it back
20 and forth like this, trying to wiggle it
21 out, up and down, trying to wiggle it out.
22 But the movements are side to side so you
23 can feel what is going on in there, to feel
24 that baby's head coming down. There is an
25 acceptable practice.

1 Q. What is he doing?

2 A. He is just trying to feel what is going
3 on, and you can see him going like this
4 with one hand trying to stretch around,
5 stretch the vagina, to make more room for
6 the baby.

7 Q. Is it rocking it, torquing it, any of
8 those moves?

9 A. I can't -- no, no. He's doing this
10 (demonstrating). It's pulling it to one
11 side so that he can get his fingers in,
12 then pulling it to the other so that he can
13 -- I would call it maneuvering.

14 Q. Thank you. (Video playing) -- when I
15 tell mom to push, we want mom to give a
16 prolonged effort pushing -- (making sounds)
17 -- to push that baby down.

18 We say, "Mom take a deep breathe" -- or
19 whatever you want to do, "Bear down". Then
20 we count to ten: one, two, three, four,
21 five, six, seven, eight, nine, ten. Ten
22 seconds. Get the husbands to do it, some
23 husband sitting around there, helps them
24 get involved in the process. Okay?

25 But we want them to push for ten so

1 that that baby comes down for ten and --
2 and we tell them to take quick breathes
3 because it is going to come down when
4 you're pushing but the minute that you stop
5 pushing the baby is going to go back up.
6 This is the process, down and up.

7 She is not able to do that, for
8 whatever reason. She pushes two, three,
9 four seconds and then stops. It hurts. So
10 she is crying, screaming. When you're
11 making noises like that you can't be
12 pushing. So it was not as effective as it
13 might have been had we been able to get mom
14 to -- it's not her fault, okay? That's
15 just the way it is. But if we could have
16 gotten mom to give a prolonged push, -- and
17 this was a quick delivery but unfortunately
18 mom was not able to cooperate as well as we
19 would have like.

20 Q. (Video playing) ---

21 A. They are making slow progress, bringing
22 the baby down. You really can't really get
23 your hands around this baby's head by
24 moving this up and down, back and forth --
25 go ahead.

1 Q. (Video playing) ---

2 A. (Talking on top of screaming on video).

3 That man is focusing on what he's
4 doing. As you can see, slow and steady is
5 the way that it is supposed to be. It's
6 not supposed to a without the possibility
7 of pop-the-baby-out sort of thing. He
8 encouraged her to push, she did push, and
9 he got progress every time that he pulled.
10 This is a normal operative delivery.

11 Q. (Video playing) ---

12 A. He didn't do any quick pulling on the
13 baby's head.

14 Q. (Video playing) ---

15 A. Watch, as the baby starts crying he is
16 happy for them.

17 Q. Thank you, Dr. Winestein, for going
18 through that birth video with us. Based on
19 your review and your study of the birth
20 video, what is your opinion as to whether
21 or not Dr. Rhett used the appropriate
22 technique to help Ms. Washington delivery
23 the baby with the assistance of the vacuum?

24 A. It was appropriate.

25 Q. Have you had an opportunity to work

1 with Dr. Rhett?

2 A. Yes, many times.

3 Q. Have you done surgery together?

4 A. Yes.

5 Q. Have you and Dr. Rhett delivered babies
6 together?

7 A. Vaginal births, I know of at least one.
8 C-sections, yes.

9 Q. Have you worked with him a number of
10 times over your career?

11 A. Yeah, I mean especially in the
12 beginning part of the career in the old
13 practice downtown, we got to know everybody
14 pretty well.

15 Q. What are your observations about Dr.
16 Rhett's knowledge of obstetrics?

17 A. When I came, he was one of the people
18 who was already here and you kind of have
19 to look to people for guidance, and some
20 people are better than others, and Dr.
21 Rhett is one of those that I rely on for
22 some help. On at least two occasions that
23 I know of, I referred patient to him
24 because I felt that he could do things
25 better than I could. So I sent my patients

1 to him. I've always felt that he's an
2 excellent physician.

3 Q. Thank you, Dr. Winestein. Have you
4 looked at the informed consent that was
5 given in this case?

6 A. At some point, I'm sure.

7 Q. I show it to you. This is already in
8 evidence as Exhibit 2, Page 4. Have you
9 seen this document before?

10 A. Yes.

11 Q. Dr. Winestein, please explain whether
12 or not this is an adequate informed consent
13 for a mother to give when she comes into
14 the hospital to delivery a baby?

15 A. It's -- I can't speak to the exact
16 wording but it's similar to the type of
17 consent that I've seen at every hospital
18 that I've ever worked at. It's a standard
19 consent by a patient who is going to get
20 medical care at the hospital.

21 Q. Now, if you're delivering a baby and it
22 is an emergency situation, and you have
23 decided that you are going to use a vacuum
24 to assist in the delivery, do you stop
25 everything that you're doing to discuss the

1 FDA warnings and the manufacturer's
2 warnings with the mother before you help
3 her delivery the baby?

4 A. No.

5 Q. Explain why not?

6 A. Because there is not time. As I said
7 earlier, we have to make a decision. A
8 decision has been made to deliver this
9 baby. Some people may say more than others
10 but what we don't want to do is to waste
11 time trying to explain to somebody all of
12 the intricate details. What mom basically
13 does when she comes in is says, 'Okay, I
14 understand what you're doing, you're going
15 to try to take care of me and do the best
16 you can. Right?' There's a certain amount
17 of trust that has to exist there, and we
18 rely on that.

19 We can't take as much time as we might
20 like to get what perhaps some attorneys or
21 some hospital administrators would consider
22 perfect.

23 It's different when you're getting
24 someone ready, as I just did, and I thank
25 the court for their indulgence, for

1 surgery. The patient is awake, nothing is
2 going on, we can say 'Okay, here is what we
3 are doing to do. Here is what we can
4 expect to happen. Anything can go wrong.
5 These are your alternatives.' All right?

6 This baby is saying, 'Get me out of
7 here!' We've got to do something. We
8 don't have time to sit and talk about all
9 the possibilities that could happen.

10 If indeed we did -- it kind of depends
11 on how you present it. If we were to say,
12 'I am going to use a vacuum to help me get
13 your baby out as quickly as possible
14 because the baby is in trouble and there
15 might be a small instance of complication
16 or a C-section, which presents about the
17 same risk for the baby but all of a sudden
18 you're going to have bleeding, infections,
19 blood clot, hypoxia and all that sort of
20 stuff.' Well, the mom will go right
21 through the -- it wouldn't be safe for
22 everybody. We have two patients, we always
23 have two patients. So we don't have time
24 for that. If you went through all that
25 sort of stuff, people would say, 'Which do

1 you think is best?' because that's what
2 you're there for, you're the doctor. You
3 are the professional. Whether it is your
4 doctor or anyone else, we rely on people's
5 expertise.

6 Q. In your practice if you're delivering a
7 baby and the heart rate goes down and it
8 doesn't come back up and you need to use a
9 vacuum or forceps or even cut, an
10 episiotomy, do you have patient sign a
11 separate informed consent form?

12 A. No.

13 Q. What is your opinion, to a reasonable
14 degree of medical certainty, most probably
15 as to whether or not Dr. Rhett properly
16 provided informed consent based on the
17 informed consent form that Ms. Washington
18 signed when she came to the hospital?

19 A. This is the standard consent form that
20 we all get when people come into the
21 hospital. Like I said, any hospital that
22 I've ever worked at has a similar consent
23 form.

24 Q. You mentioned the nuchal cord or the
25 umbilical cord and I just want to ask you q

1 question about -- you can move back to the
2 microphone.

3 A. (Complies).

4 Q. Going back to when Dr. Rhett took the
5 umbilical cord from the baby's neck, please
6 explain to us the effect that umbilical
7 cord has around the baby's neck.

8 A. We can describe the cord as loose or
9 tight. If it is tight, sometimes you can't
10 even get it over the baby's head, you have
11 to clamp it and cut it and take it from
12 around the baby's neck. If it is loose,
13 you can tend to take it off.

14 The problem is that there is no real
15 association between the tightness and the
16 effects on the baby.

17 I've seen babies with cords wrapped
18 around their neck four times -- I'm shocked
19 when it comes out because the baby's heart
20 beat didn't show me anything.

21 And some times you've got a baby that
22 you can't figure out what is going on, you
23 deliver the baby and there's the cord and
24 you go, 'Ah-ha, that's the deal.'

25 The fact that it wasn't tight is

1 irrelevant. The fact that the cord is
2 being compressed and causing a deficiency
3 in the baby's blood flow, that was
4 important. Why some loose cords can affect
5 some babies one way and a tight cord is not
6 going to bother another baby, I don't have
7 an explanation for that. But there's no
8 question in my mind that this was an issue
9 here.

10 Q. In light of the fetal monitoring strips
11 that we have gone through already, should
12 Dr. Rhett have allowed Ms. Washington to
13 have just pushed longer?

14 A. No.

15 Q. Why not?

16 A. Well, again, no other experts -- you
17 know, they may say just let her push
18 longer, endure the pain, change the
19 position, provide fluids, all that stuff,
20 and that's great but -- so supposed that we
21 push a little bit longer and the -- she's
22 not a great pusher. She may become a
23 greater pusher if she learned and all that
24 stuff and perhaps could have done a little
25 bit better but what happens if you're seven

1 minutes down the road and we still have
2 baby whose heart rate is down in the
3 eighties ro the nineties. Now where are
4 we? We are truly up that creek without a
5 paddle, and you don't want to be there.
6 If this is a safe delivery in an expert
7 obstetrician's mind, delivery the baby,
8 take care of the problem, which is the
9 baby's heart's down.

10 Q. Dr. Winestein, what is your opinion as
11 to whether or not a bad out come is medical
12 malpractice?

13 A. My opinion is that I wish that there
14 were a way that everybody could understand
15 the difference. We all want an ideal
16 outcome, we all wish for the perfect world,
17 especially that's what we want for babies.
18 No matter what you do, no matter how
19 careful that you are, sometimes bad things
20 happen.

21 Medical malpractice is when you are
22 doing something that is considered outside
23 of what the average physician would do in a
24 similar situation.

25 And a bad outcome -- and we try to use

1 what is called, quote, "evidence-based
2 medicine', which means that you look at the
3 big numbers, you look at a lot of studies
4 and you say, 'Okay, this is a good way to
5 do something.'

6 Sometimes you do everything the way
7 that you're supposed to and something bad
8 happens. That doesn't mean that you don't
9 do the same thing the next time, because --
10 we've seen this over and over and over
11 again that this is a good way to do things.
12 But unfortunately some times bad things
13 happen, not because someone is doing
14 something that they shouldn't do but
15 because something happened even though they
16 are doing something that is correct. That
17 is a bad outcome, but a bad outcome is not
18 medical malpractice. There's a huge
19 difference, in my mind.

20 Q. Dr. Winestein, if you had been standing
21 in Dr. Rhett's shoes on July 15th, 2002,
22 delivering this baby in the face of fetal
23 distress as evidenced on the fetal
24 monitoring strips, how would you have
25 delivered this baby?

1 A. I probably would have used the vacuum.

2 Q. Are all of the opinions that you have
3 given today to a reasonable degree of
4 medical certainty most probably?

5 A. Yes.

6 MOLLY CRAIG: Thank you very
7 much, sir. Those are all the questions
8 that I have.

9 THE COURT: Cross examination?

10 MARY WATERS: Yes, Your Honor.
11 Briefly.

12 THE COURT: Ms. Waters, unless
13 you are going to use it, would you move the
14 tripod, please.

15 MARY WATERS: (Inaudible).

16 CROSS EXAMINATION

17 BY MARY WATERS:

18 Q. Dr. Winestein, my name is Mary Waters.
19 Thank you for being here today.

20 A. (No verbal response).

21 Q. Dr. Winestein, you've known Dr. Rhett
22 since 1981; is that true?

23 A. Yes.

24 Q. And you claim that you brought the
25 vacuum delivery system to Charleston?

1 A. To my knowledge, The Mighty Vac vacuum
2 system is what I brought in 1980-something.

3 Q. And do you claim that you taught Dr.
4 Rhett hold to use the vacuum system?

5 A. No. I know that I've used the vacuum
6 extraction system with him on one occasion,
7 that I recall. I don't know that I was the
8 one responsible for teaching him how to use
9 it.

10 Q. Do you recall whether or not that was
11 the first time Dr. Rhett used a vacuum
12 extraction?

13 A. I don't know that we discussed that.
14 I know that he knew that I had one and he
15 asked me if I could bring it for a
16 delivery.

17 Q. So at that time Dr. Rhett knew that you
18 had a vacuum extractor and asked you to
19 assist him in a delivery?

20 A. Correct.

21 Q. So would it be a reasonable assumption
22 that Dr. Rhett did not have a vacuum
23 extractor at that time?

24 A. Correct.

25 Q. You will agree that you do not, cannot

1 know the station of Jayden W. at
2 the time that Dr. Rhett placed the vacuum
3 on him.

4 A. I can't hear you.

5 Q. You will agree that you cannot know the
6 station of Jayden W. at the time
7 that Dr. Rhett placed the vacuum on Jayden
8 W.?

9 A. I couldn't give you a number, no.

10 Q. Would you agree that the lowest
11 recorded station in the medical records is
12 zero?

13 A. I believe that but I think it's
14 irrelevant.

15 Q. And you would agree that the entire cup
16 was placed in the vagina?

17 A. Again, that is not uncommon.

18 Q. And before you perform a vacuum
19 extraction delivery, you discuss the risks
20 and benefits of vacuum use with your
21 patients, don't you?

22 A. Not necessarily, no. But there's a
23 huge difference between using a vacuum
24 extraction delivery for the mom that has
25 been pushing two to three hours and is

1 exhausted, needs some help, where if she
2 had the capability she could push for
3 another period of time and maybe accomplish
4 delivery but to say, 'I can give you some
5 help if you'd like' versus 'we've got to
6 get this baby out, your baby is in
7 trouble.' We don't have time to talk about
8 risks and complications in that latter
9 situation.

10 Q. So as we sit here today, Doctor, you
11 would not agree that it is your practice to
12 discuss the risks and benefits of vacuum
13 use prior to using a vacuum on a delivering
14 mother?

15 A. Please give me an exact instance that
16 you're talking about. I just told you
17 that sometimes I do, sometimes I can't.

18 Q. Doctor, to you have a copy of your
19 deposition?

20 A. Not with me, no.

21 MARY WATERS: May I approach,
22 Your Honor?

23 THE COURT: You may.

24 MARY WATERS: (Tenders
25 deposition to witness).

1 CROSS EXAMINATION CONTINUED

2 BY MARY WATERS:

3 Q. I ask you to look at Page 69 of your
4 deposition.

5 A. Okay.

6 Q. Doctor, do you recall your deposition
7 being taken on May 29th, -- May 27th, 2009?

8 A. I know that I was deposed. I don't
9 recall the date or anything but -- go
10 ahead.

11 Q. Would you agree with me that your
12 deposition was taken at the Hood Law Firm?

13 A. I don't remember where it was taken.

14 Q. With reference to the front page of
15 that deposition, does it indicate that your
16 deposition was taken on May ---

17 A. Yes. It says the Hood Law Firm. Thank
18 you.

19 Q. --- 2009, at the Hood Law Firm? If I
20 could refer your attention to Page 69 of
21 the deposition.

22 A. Yes.

23 Q. I am going to read this and you let me
24 know if I read this correctly.

25 MOLLY CRAIG: Please tell us

1 the line.

2 MARY WATERS: Starting at Line
3 15.

4 MOLLY CRAIG: I would ask that
5 she would read the two questions before
6 that so as to put it in context.

7 THE COURT: Any objection to
8 that, Counsel?

9 MOLLY CRAIG: Starting at Line
10 17 on Page 68, that's three questions.

11 THE COURT: Any objection to
12 that, Ms. Waters?

13 MARY WATERS: No, sir, not at
14 all.

15 THE COURT: Go ahead and
16 publish, please.

17 CROSS EXAMINATION CONTINUED

18 BY MARY WATERS:

19 Q. (Reading):

20 Q. *What rights, if any, do you*
21 *believe that a laboring mother should have*
22 *about whether or not a vacuum should be*
23 *used to delivery her child?*

24 A. *That's a toughie. Mom, when*
25 *they came in, generally gives consent for*

1 obstetrician care. That's pretty global.
2 I think unfortunately sometimes there is
3 not a lot of time to discuss all the pluses
4 and minus, indications and contra-
5 indications of a situation, where time may
6 be of the essence. If a mom refused a
7 vacuum, then I would probably try to
8 explain to her why it was appropriate if I
9 felt that was she. And if she -- if I
10 didn't have time for that, then she would
11 have to be responsible for any final
12 outcome.

13 Q. What opportunity do your
14 patients have to refuse a vacuum?

15 A. They can always say 'I don't
16 want a vacuum.'

17 Q. Just out of the blue?

18 A. I have patients talk about
19 delivery in the office before they are even
20 in labor and say 'I don't want a vacuum.'

21 Q. In your practice, do you live
22 laboring women the right to be heard on
23 whether or not a vacuum should be used, if
24 you perform delivery with a vacuum during

1 the delivery process?

2 A. Do they have an opportunity?>

3 Q. Do you let them know before
4 you apply the vacuum that you've thinking
5 about applying it?

6 A. I generally say, for whatever
7 reason, 'this baby needs to come out and I
8 think the best way is to do a vacuum.'

9 Q. Why do you do that?

10 A. I think to let them know ...

11 A. I'm sorry, I'm lost here. Where are
12 you. Oh, you turned the page. Sorry.

13 Q. (Reading):

14 Q. Why do you do that?

15 A. I think to let them know what
16 I am doing and why I am doing it.

17 Q. Okay. Do you at least give
18 them some opportunity to be heard on
19 whether they consent to that decision or
20 not?

21 A. Well, there is always an
22 opportunity. They could say no.

23 Q. But they would only be able to
24 say no once you put them on notice that you

1 were getting ready to use a vacuum.

2 A. Yes.

3 Q. All right. Did Dr. Rhett do
4 that in this case?

5 A. I don't think so.

6 Q. Were you trained that it
7 should be done?

8 A. I think I was. I don't know
9 how I was, to be honest. When I was
10 trained, it was a while ago. 'What should
11 be done now', this is the way that I
12 practice.

13 Did I read that correctly?

14 A. Absolutely, except the word "unadorned"
15 I think was to be untoward ---

16 Q. There may be typographical errors but
17 the substance of what I read, was that
18 correct?

19 A. Correct.

20 Q. Doctor, can we agree that the standard
21 consent form that was shown to you earlier
22 does not mention anything about vacuum
23 delivery?

24 A. That's correct.

25 Q. Can we agree that there are no warnings

1 or risks about vacuum delivery, in any way
2 on that form?

3 A. Just as there are no warnings or risks
4 about what happens in normal vaginal birth.
5 No, there are no warnings or risks.

6 Q. Doctor, can we agree that when you
7 document in the medical record of a
8 delivery, the delivery note, that your
9 documentation is more detailed than the
10 documentation shown in Dr. Rhett's delivery
11 records?

12 A. Generally, yes.

13 Q. And do we agree that you generally
14 describe the type of vacuum, whether it was
15 an outlet, low, mid, and describe
16 indications and describe the delivery?

17 A. Some variation of that.

18 Q. Can we agree that Dr. Rhett failed to
19 record significant information such as that
20 the vacuum was used, the station and any
21 indication for the delivery or use of the
22 vacuum in the birth of Jayden W.
23 in his delivery notes?

24 A. He did not in his written delivery
25 notes, he did not say that it was a vacuum

1 delivery. I don't recall whether he or he
2 didn't. I think that he said that it was a
3 vacuum delivery. I just don't remember.
4 I'm sure you know.

5 Q. Do you recall anywhere in the medical
6 records where Dr. Rhett documented an
7 indication for using the vacuum in the
8 delivery of Jayden W. ?

9 A. I don't think that he did.

10 Q. So can we agree that it is your opinion
11 that the late deceleration in this case was
12 not an indication for delivery by vacuum
13 extraction?

14 A. No, these are not late decelerations,
15 this is a bradycardia. The baby's heart is
16 down, it's not coming up.

17 Q. Well, what would you -- how would you
18 interpret that indication on the fetal
19 heart monitor?

20 A. Bradycardia -- I'm not sure that I
21 understand the question.

22 Q. Doctor, you would agree that late
23 decels would not be an indication for this
24 delivery; is that true?

25 A. I believe that is correct. I only saw

1 a short period of the fetal heart tracing
2 and I've not memorized that in its
3 entirety. I think that it showed brady-
4 cardia, that the baby's heart rate was down
5 and was not coming up.

6 Q. Doctor, when you were referring to the
7 fetal heart monitor strips and you were
8 referring to Jayden's heart rate going down
9 and not coming up, was that after the
10 vacuum had been placed on Jayden's head?

11 A. It was -- I would need to look at it.
12 I think that it was as well as before.

13 MARY WATERS: Your Honor, may
14 I approach.

15 THE COURT: You may

16 CROSS EXAMINATION CONTINUED

17 BY MARY WATERS:

18 Q. Doctor, at what point was the vacuum
19 placed on Jayden's head?

20 A. (Upon review), it was sometime after
21 that.

22 Q. And you would agree that Jayden's heart
23 rate is increasing prior to the placement
24 of the Jayden (sic) -- on his head?

25 A. For a very short period of time.

1 Q. And when the vacuum is placed, it does
2 drop; is that true?

3 A. I don't know when the vacuum was
4 placed. All I know is that it does drop
5 and it stays down. This is not from the
6 vacuum. The vacuum doesn't cause a
7 bradycardia. The lack of -- if this is a
8 healthy baby, one of the things that we do
9 see whether a baby is -- if the baby's
10 heart rate comes up, it can be an
11 indication that things are okay. So
12 putting the vacuum on is not going to make
13 the baby's heart go down. The baby's heart
14 is going down because this baby is saying,
15 'get me out of here.'

16 Q. Is one way to stimulate the baby's
17 scalp is to place the vacuum?

18 A. No, the determination to deliver this
19 baby was made before the vacuum was placed.

20 Q. And the determination to deliver this
21 baby with a vacuum was made without any
22 other interventions; is that true?

23 A. That is correct. As I stated, you can
24 intervene but if it doesn't work then
25 things are a whole lot worse.

1 Q. Doctor, can we agree that meconium is
2 an indication of stress that the baby
3 underwent during delivery?

4 A. It's something that we frequently. I
5 don't know how that is actually
6 interpreted. But term meconium is, as I
7 said, something that we see frequently as
8 the baby comes out if there's been a
9 problem with the baby's heart. The
10 sphincter relaxes, it's just sort of the
11 physiological process.

12 Q. Can we agree that a vacuum extraction
13 delivery is a stressful event for a baby?

14 A. I think labor itself is stressful. I
15 don't know that a vacuum adds any stress to
16 this baby whatsoever. Same as a forceps
17 delivery, the same as Caesarean section.
18 It is a method of delivery.

19 You can't take the isolated situation.
20 You have to look at the alternative. The
21 alternative to not delivering a baby is
22 leaving it in a hostile environment. All
23 it could do is get worse, it doesn't get
24 better. So whether it's by vacuum,
25 forceps, Caesarean section, it just doesn't

1 matter. You've got to get this kid out,
2 you've got to get him to a place where he
3 can be resuscitated.

4 This is not something that you've got
5 time to say, 'Oh, this is stressful.' The
6 baby already is stressed. That's why we
7 have made the decision to put on the
8 vacuum.

9 Q. Doctor, can we agree that your opinion
10 with regard to the sense of urgency for
11 delivery of Jayden is different today than
12 it was the day of your deposition -- the
13 day your deposition was taken?

14 A. I think that this baby needed to be
15 delivered. I can't give you a sense of my
16 thoughts on urgency, etc., etc.

17 MARY WATERS: Thank you.

18 THE COURT: Is there redirect?

19 MOLLY CRAIG: Yes, sir.

20 REDIRECT EXAMINATION

21 BY MOLLY CRAIG:

22 Q. Doctor, you were asked about discussing
23 the vacuum with your patients while using
24 it during delivery. Please explain how
25 that situation changes in light of a fetal

1 heart rate that goes down and doesn't come
2 back up.

3 A. The difference is that -- I think that
4 I said that. If we have a situation that
5 is stable, where the baby is okay and
6 fatigue is becoming an issue, then we have
7 time to discuss options.

8 When you're confronted with an
9 emergency, when you're confronted with a
10 situation that if we don't do something,
11 something bad is going to happen.
12 Something bad may happen no matter what we
13 do, but at that time you don't have time to
14 discuss plus and minus. That's a time when
15 you're relying on the patient, who may not
16 know us, who has put their trust in our
17 hands, trusting us to make the decision
18 that is most appropriate. My comment at
19 that point was, 'we've got to get this baby
20 out, this is what I am going to use, let's
21 do it.' Sometimes we've just go to say
22 trust us.

23 Q. Dr. Winestein, you were asked questions
24 on cross examination about whether or not
25 it was the vacuum that caused the baby's

1 heart rate to go down. What is your
2 opinion as to what caused the baby's heart
3 rate to go down?

4 A. You've got it backwards, you're putting
5 the horse before the cart. The baby's
6 heart rate was down and that's why we used
7 the vacuum, the heart rate was down before
8 me -- the heart rate was down before the
9 scalp electrode was taken off. You don't
10 take the scalp electrode off until you put
11 the vacuum on. So we used the vacuum
12 because the heart rate was down. The
13 vacuum didn't cause the heart rate to go
14 down.

15 Q. Thank you, Doctor. Then you were also
16 asked questions about whether or not Dr.
17 Rhett documented in the medical chart that
18 this was a vacuum-assisted delivery.

19 MOLLY CRAIG: I am going to do
20 this very quickly, Your Honor, if I may
21 approach.

22 REDIRECT EXAMINATION CONTINUED

23 BY MOLLY CRAIG:

24 Q. We have gone through this but I am
25 going to show you what has been marked as

1 page two out of Exhibit 2, which is the
2 face sheet. Can you tell us where Dr.
3 Rhett documented that this was a vacuum
4 extraction delivery?

5 A. Yes, he put "vacuum-assisted vaginal
6 delivery."

7 Q. Then I am also going to show you
8 Exhibit 2, page seventeen, which is a labor
9 progress chart that has previously been
10 identified. Does it also identify that
11 this is a vacuum-assisted delivery?

12 A. "Vacuum-assisted delivery."

13 Q. Then also there is a two-page document,
14 pages twenty and twenty-one, Exhibit 2,
15 which is the record that goes with the baby
16 to the nursery. Can you please tell us ---

17 A. When I go through my own chart to try
18 to figure out what happened when I
19 delivered the baby, if I don't remember
20 something that I did years ago, this
21 happens to be green -- this says, "vacuum
22 extraction".

23 Q. So was this vacuum extraction delivery
24 documented in the medical charts?

25 A. Three times.

1 Q. Dr. Winestein, did Dr. Rhett deviate
2 from the standard of care?

3 A. No.

4 Q. Are all the opinions that you have
5 given today to a reasonable degree of
6 medical certainty, most probably?

7 A. Correct.

8 MOLLY CRAIG: Thank you, sir.

9 MARY WATERS: Your Honor, if I
10 may just briefly.

11 THE COURT: On what issue?

12 MARY WATERS: On the issue of
13 the documents shown to ---

14 THE COURT: Very well, you may.

15 RECROSS EXAMINATION

16 BY MARY WATERS:

17 Q. Doctor, of all the documents that were
18 given to you, were there any indications or
19 any documentation whatsoever of indications
20 for a vacuum delivery in this case?

21 A. I did not see that, but that's what we
22 have been talking about the whole time.

23 Q. Is it written on those papers, Doctor?

24 A. No, ma'am.

25 Q. Now, we have all seen this video a

1 number of times now?

2 A. We also looked at the fetal heart rate
3 and we've listened to the baby's heart rate
4 going whup, whup, whup, whup. We know what
5 the situation is, we know what the bottom
6 line is and we know what the solution
7 should be.

8 Q. With regard to your interpretation,
9 having seen this video again today, is it
10 your testimony that when Dr. Rhett told
11 Jamsetta to stop and during that time he
12 was waiting and then ultimately pulled out
13 the vacuum that there was no time for him
14 to tell her why he thought that the vacuum
15 needed to use and why he intended to use
16 the vacuum, to give her an opportunity to
17 either consent to or deny the use of the
18 vacuum in that case?

19 A. We all saw the video. Dr. Rhett said,
20 'Stop, stop.' What is going on is that mom
21 is in pain, he needs her cooperation, we
22 have family members who were all trying to
23 help, who were all doing a good job, doing
24 the best thing, but there's information
25 coming from all sorts of places to mom.

1 What Dr. Rhett is saying is, 'Stop, wait a
2 second. I am the one that has got to do
3 this delivery, you all have to listen to me
4 so that I can get cooperation to get this
5 baby out.'

6 That's not "stop, let me take a break,
7 let's talk about what we've got to do."
8 It's 'Wait a second, I'm focused here on
9 getting this baby out, getting this baby
10 out of distress. Let me run the show
11 because I'm the best qualified person to do
12 that.'

13 That's not the time to talk about
14 vacuum, risks, complications, Caesarean
15 sections or what could happen with that.
16 By the time that happens, this baby would
17 be in worse trouble.

18 Q. Doctor, do you agree that if Dr. Rhett
19 had time to say 'stop, let's get this baby
20 out', he also had time to give Jamsetta any
21 opportunity to consent to or refuse to use
22 the vacuum extractor.

23 A. Let's talk about informed consent. You
24 want to do an informed consent that would
25 make you happy as plaintiff's attorney.

1 It's not the same.

2 You can say, 'Would you like me to use
3 the vacuum?' You can say 'no'. But
4 that's not -- no, we'd have to talk about
5 risks, complications and alternatives.

6 In this situation there was no time for
7 that. So you are asking me a question and
8 the answer is 'no.' Maybe we had three
9 seconds. That's not appropriate, the
10 appropriate thing to do is to get this baby
11 out of trouble as soon as you can. I think
12 the question is not relevant.

13 MARY WATERS: Nothing further.

14 ROBERT HOOD: No other
15 questions, Your Honor.

16 THE COURT: Then you are free to
17 step down and free to leave.

18 THE WITNESS: Thank you and
19 the jury for your indulgence today so that
20 I didn't have to cancel my patient's
21 surgery.

22 (WITNESS STEPS DOWN)

23 THE COURT: Ladies and
24 Gentlemen, you may not be aware but the
25 defense changed their order of witnesses to

1 accommodate the doctor's medical
2 emergencies.

3 All right, counsel, let's take our
4 afternoon break at this time before going
5 on to our next witness.

6 We will take about a fifteen-minute
7 break. If you wish to go outside, we will
8 give you that opportunity. Everyone will
9 remain where we are while the jury is
10 excused.

11 (JURY OUT @ 2:55 P.M.)

12 THE COURT: We will be at-ease
13 for about fifteen minutes.

14 (BRIEF RECESS)

15 THE COURT: Anything before we
16 bring the jury in?

17 EDWARD GRAHAM: Your Honor,
18 there has been some speculation that the
19 plaintiff might have an extra large pelvis
20 or something to that effect. That is
21 absolute speculations. There is no
22 evidence in the record to suggest that
23 Jamsetta Washington has any abnormality in
24 her pelvis, at all, or any greater distance
25 than five centimeters.

1 I had made a Motion in limine at
2 the outset of the case, being concerned
3 about that issue, that speculative issue,
4 coming in. But when I raised it for Your
5 Honor to rule, Ms. Simmons stated on the
6 record that she had no idea what I was
7 talking about, that they were not going
8 there.

9 Now they've gone there in the
10 middle of presentation of Dr. Weinstein in
11 the jury's presence. We believe that it
12 violates the Motion in limine, it violates
13 the representation to the court that the
14 defense was not going there, it invites
15 speculation and we just believe that it
16 interferes with the process of a fair
17 trial.

18 The other thing that we want to go
19 back to, if Your Honor pleases, is Dr.
20 Milunsky's testimony. We have -- we had
21 asked for an opportunity to make a
22 challenge and you invited me to do that
23 later. We believe that his testimony about
24 alcohol is not based whatsoever on reliable
25 scientific evidence in terms of the facts.

1 of this case. He couldn't reach any level
2 of most probable, so it violates the *Payton*
3 v. *Kearse* standards about most probable for
4 the defense.

5 Also in terms of his testimony
6 about the diagnosis of a genetic tissue
7 disorder, that is not yet recognized, that
8 type of testimony about yet-unknown
9 conditions that will one day in the future
10 be recognized, he admitted that there is no
11 current reliable scientific evidence about
12 genetic knowledge yet to be discovered.
13 There is no reliable information about
14 tests yet to be created and no reliable
15 evidence that Jayden would test positive
16 for any of those conditions that are not
17 yet recognized by reliable science. We
18 believe that his testimony should be
19 stricken, either in its entirety or insofar
20 as it violates those concerns.

21 That concludes what we want to go
22 over.

23 THE COURT: Do you want to be
24 heard on those?

25 MOLLY CRAIG: Yes, sir. With

1 regard to this issue about Dr. Milunsky's
2 testimony, he didn't testify about Ms.
3 Washington's anatomy. His opinion, he was
4 talking about women in general, that
5 everybody is different. That's what he was
6 talking about, that you can't say that one
7 person is five centimeters or seven
8 centimeters. That's why he was saying --
9 not trying to get too personal here, but
10 Chilton's ischial spines is not in the same
11 place as my ischial spines are. That's all
12 that he was saying, he wasn't giving an
13 opinion on Ms. Washington's anatomy. That
14 wasn't prejudicial at all.

15 THE COURT: Let me ask you this,
16 his position was that somehow there had
17 been an agreement with counsel that that
18 was not going to be an issue in the case
19 and then was brought up by a witness, which
20 surprises him. He says that occurred here
21 on the record in this courtroom. Do you
22 have a response to that?

23 MOLLY CRAIG: Well, Your
24 Honor, as you know, I wasn't present for
25 that and -- I'll let Chilton speak to it,

1 but the -- I mean, his testimony was -- I
2 think what Mr. Graham is saying is that we
3 agreed that we weren't going to elicit
4 testimony that everybody's anatomy is
5 different. I don't think that's correct.
6 Chilton, is there anything else?

7 CHILTON SIMMONS: I think Mr.
8 Graham doesn't understand the testimony
9 from the witness.

10 What he was -- he was responding
11 to basically Dr. Oakes who at one said in
12 his deposition -- and I believe that he
13 said at trial, that based on how far he
14 could see the vacuum was in that he could
15 tell how many centimeters that the baby was
16 stationed.

17 Dr. Winestein's testimony is
18 simply that you can't tell from looking
19 from the outside to measure how far a
20 vacuum is inside of a person -- because you
21 don't know anatomy of that person.

22 Do you understand what I'm saying?

23 So when Mr. Graham said that it
24 was speculative, I simply said that I don't
25 think Mr. Graham understands the expert's

1 testimony and I don't understand what he's
2 talking about. I did not agree that that
3 testimony would never come in because I
4 think it's absolutely relevant.

5 THE COURT: Very good. Just
6 wanted the position to be protected on the
7 record.

8 EDWARD GRAHAM: May I just say
9 one more brief thing?

10 THE COURT: You may.

11 EDWARD GRAHAM: It arose in the
12 context of his narration of the birth video
13 where he says 'even though that cup is
14 completely inside the vagina, that doesn't
15 mean that it is five centimeters inside the
16 vagina because might have a seven
17 centimeter vagina.' It's highly
18 prejudicial.

19 THE COURT: Counsel, I --
20 counsel, it is not required but is there
21 anything that you wish to place on the
22 record? Again? At this point we are just
23 placing the position on the record for
24 whatever objection that you may wish to
25 have.

1 MOLLY CRAIG: I believe that
2 Dr. Milunsky complied with 702 without any
3 problem whatsoever and it definitely meets
4 the standard generally recognized. There
5 is no problem whatsoever with him meeting
6 the liability test. We've brought
7 everything that we need to meet the
8 liability test.

9 THE COURT: Very good. The
10 court is prepared to rule on both of those.
11 Your position is noted on the record but I
12 would decline to grant you any relief. It
13 would seem, to me, and again I am not
14 certain, uh, there seems to be some
15 difference of opinion about some promise of
16 what evidence would to would not come in,
17 but the testimony about variation in human
18 anatomy is certainly reasonably expected,
19 uh, in a case of this nature. While there
20 is no evidence of that applying
21 specifically to Ms. Washington, the
22 witness's comment about general anatomy
23 perhaps the situation was such with Ms.
24 Washington was not dispositive, but was
25 simply making a point about the

1 uncertainties of the profess and the female
2 anatomy. The court finds that appropriate.

3 Secondly, with regard to the
4 witness, Dr. Milunsky, the court finds that
5 it met the most probable standard.

6 His question -- his testimony,
7 there was not one particular component or
8 genetic findings that was dispositive but
9 that there was a constellation of things
10 that most probably resulted in the brain
11 bleed. I find that to be sufficient to
12 pass the test required by Rule 701, 702 and
13 also the *Daulbert* test.

14 For all those reasons, the court
15 offers no relief to the plaintiff at this
16 point on those issues. They've been
17 narrated to the jury adequately.

18 Are you ready to call your next
19 witness, Counsel?

20 MOLLY CRAIG: Yes, sir. Yes,
21 sir, we're ready.

22 THE COURT: Bring in the jury.

23 (JURY IN @ 3:17 P.M.)

24 THE COURT: Thank you, Ladies
25 and Gentlemen. I trust that you had a good

1 lunch. We are now in the defendant's case.

2 Counsel, you may call your next witness.

3 CHILTON SIMMONS: Your Honor, we
4 call Dr. Lynn Norton.

5 (WITNESS TAKES STAND)

6 LYNN NORTON, being duly sworn to
7 tell the truth, the whole truth and nothing
8 but the truth, testified, as follows:

9 DIRECT EXAMINATION

10 BY CHILTON SIMMONS:

11 Q. Good afternoon, Dr. Norton. Thank you
12 for coming to court today. Where did you
13 drive from today?

14 A. Beaufort, South Carolina.

15 Q. Is that where you live?

16 A. Yes.

17 Q. What do you do?

18 A. I am an obstetrician-gynecologist in
19 private practice.

20 Q. Do you have family?

21 A. I do.

22 Q. Who are they?

23 A. I am married and my husband and I have
24 six children.

25 Q. How many children?

1 A. Six children.

2 Q. And what does your husband do, what
3 kind of work?

4 A. He's an electrical contractor.

5 Q. How old are your children?

6 A. They range from four to eighteen.

7 Q. Congratulations, that's a
8 congratulations in itself.

9 A. Thank you.

10 Q. And your practice is located where?

11 A. Beaufort, South Carolina. Beaufort
12 Memorial Hospital.

13 Q. Is it a private practice or do you work
14 through a teaching hospital?

15 A. It's a private practice, a county
16 hospital, community hospital.

17 Q. How long have you been a doctor?

18 A. Twenty years.

19 Q. And if you would go just very briefly
20 with your medical school education?

21 A. Certainly. I was accepted out of high
22 school into a combined program at Brown
23 University in Rhode Island, so I was
24 accepted into college and medical school.
25 I completed my undergraduate work in '87,

1 my medical degree in 1990. Then I stayed
2 on at Brown for my residency in obstetrics
3 and gynecology and finished in 1995.

4 Q. Are you Board-certified?

5 A. I am.

6 Q. Did you pass the board on your ---

7 A. I did.

8 Q. And you're re-boarded every ten years
9 now?

10 A. (No verbal response).

11 Q. You are not grandfathered in?

12 A. Well, I have been taking the annual
13 Board certification that is voluntary, up
14 until I believe last year at which time it
15 became required. So I've been doing that
16 every year since I became Board-certified.

17 Q. How many babies have you delivered?

18 A. I don't know the exact number but it's
19 over five thousand.

20 Q. And you share call delivering babies
21 with how many partners?

22 A. One partner.

23 Q. So it is you and one other doctor that
24 shares calls for deliveries?

25 A. Right. We have another doctor that we

1 will sometimes share call with on the
2 nights and weekends, but there's just one
3 other partner.

4 Q. And ---

5 CHILTON SIMMONS: At this time I
6 would move to admit Dr. Norton as an expert
7 in Ob-Gyn?

8 THE COURT: Is there objection
9 from any party, or questions?

10 JAY DAVIS: No, sir, Your Honor.

11 THE COURT: Hearing none, then
12 she is so admitted and you may proceed,
13 Counsel.

14 Direct EXAMINATION CONTINUED

15 BY CHILTON SIMMONS:

16 Q. Dr. Norton, have you ever -- first of
17 all, do you use a vacuum to assist in your
18 deliveries?

19 A. I do when I feel it is necessary and
20 prudent.

21 Q. Do you have an opinion, after reviewing
22 the records in this case and the birth
23 video, as to whether Dr. Rhett complied
24 with the standard of care in this case?

25 A. I do.

1 Q. What is that opinion?

2 A. I believe that he absolutely complied
3 with the standard of care in that delivery.

4 Q./ Dr. Norton, let's talk about Dr.
5 Rhett's deposition testimony. Did you
6 review his deposition?

7 A. I did.

8 Q. And is it part of your job as a
9 clinical obstetrician to give definitions
10 of medical terms on the spot?

11 A. Certainly not.

12 Q. Were you bothered with Dr. Rhett's
13 inability to give some of the medical
14 definitions in his deposition?

15 A. I was not -- because I'd seen the
16 video, I -- I just met him today but I'd
17 seen the video of that delivery and it's
18 very clear how experienced that he is and
19 how competent he is, based on that video.
20 The only concern that I have with it, I
21 felt that he must have been extremely
22 nervous to -- to have some of the answers
23 that he gave.

24 Q. Have you been in a deposition before?

25 A. Yes, ma'am.

1 Q. Were you nervous?

2 A. Very.

3 Q. Are you nervous today?

4 A. A little. Yes, ma'am.

5 Q. Is this something that you normally do
6 in your practice, testify in court?

7 A. No.

8 Q. Are you normally asked question --
9 interrogated with questions as part of your
10 daily practice?

11 A. No, ma'am.

12 Q. Moving on to Dr. Rhett's documentation
13 in the chart of Jamsetta Washington and
14 Jayden W. , were you able to
15 accurately tell what happened in this
16 delivery based on your viewing of the
17 video, as well?

18 A. I could tell some of the details about
19 the delivery. Exactly where the head was
20 at the time of the vacuum application, I
21 couldn't tell from the delivery and I
22 didn't see that documented in the chart.
23 But the overall care, absolutely I thought
24 -- I saw that it was -- and the
25 documentation, I saw that was done at the

1 time of delivery.

2 Q. And was the vacuum usage documented in
3 the chart?

4 A. It was.

5 Q. There has been some talk, Dr. Norton,
6 that the vacuum usage, that somebody tried
7 to hide that or didn't properly document
8 it.

9 CHILTON SIMMONS: Your Honor, if I
10 may approach the witness.

11 THE COURT: You may .

12 DIRECT EXAMINATION CONTINUED

13 BY CHILTON SIMMONS:

14 Q. I am going to show you a document and
15 we've been through this, so I am going to
16 try to make this quick, but will you tell
17 me -- it's trial Exhibit 2-002. Does that
18 state that a vacuum was used anywhere on
19 that page?

20 A. (Upon review), it does.

21 Q. If you would, highlight that for me
22 please, Dr. Norton, with that highlighter.

23 A. Or is that a marker?

24 Q. It's sort of a marker.

25 A. (Complies).

1 Q. That's great.

2 CHILTON SIMMONS: Your Honor, this
3 has been admitted into evidence. If I may
4 publish it to the jury -- would it be all
5 right if I passed it around to the jury?

6 THE COURT: You may.

7 CHILTON SIMMONS: Thank you, Your
8 Honor.

9 DIRECT EXAMINATION CONTINUED

10 BY CHILTON SIMMONS:

11 Q. And also ---

12 EDWARD GRAHAM: Could we ask
13 what that is, by exhibit number?

14 CHILTON SIMMONS: Sure. I just
15 stated that it is Trial Exhibit 2-002.

16 DIRECT EXAMINATION CONTINUED

17 BY CHILTON SIMMONS:

18 Q. This next document is Exhibit 2-017.
19 Do you see where the vacuum is charted on
20 that document?

21 A. (Upon review), I do.

22 Q. If you would, please highlight that.

23 A. (Complies).

24 CHILTON SIMMONS: If I may publish
25 it to the jury, Your Honor.

1 THE COURT: You may.

2 DIRECT EXAMINATION CONTINUED

3 BY CHILTON SIMMONS:

4 Q. This next document, what is that
5 document?

6 A. This is standard form -- there are
7 several pages to it to the document, but it
8 documents the delivery and gives a number
9 of details about the prenatal care and when
10 certain things were done. The area that
11 applies to this discussion is the Method of
12 Delivery. It's on the document that the
13 delivery was assisted with vacuum
14 extraction.

15 Q. And on the second page of that
16 document, do you see Dr. Rhett's signature
17 -- if you flip the page over, Exhibit 2-
18 021?

19 A. (No verbal response).

20 Q. If you would, highlight that.

21 A. (Complies).

22 Q. Thank you, ma'am. Are you aware of the
23 labor and delivery summary chart, if a copy
24 of that goes with the baby to the nursery
25 at the hospital?

1 A. It does.

2 Q. Thank you. This next document is 2-
3 085. If you would, highlight if you see
4 where vacuum is documented on that page.

5 A. (Complies).

6 Q. Thank you. Would you tell me the title
7 of that document?

8 A. Yes, this is the MeduCare Infant
9 Transport form. It's the information sheet
10 that accompanied Jayden Washington when he
11 was transferred from East Cooper to Medical
12 University of South Carolina.

13 Q. So the treating physicians that would
14 receive him at MUSC would be notified that
15 he was delivered by what method?

16 A. Vaginally, vacuum extraction.

17 Q. Thank you. The next document is
18 Exhibit 2-090. Would you please highlight
19 where the vacuum is documented on that, we
20 well as the physician's name that signed
21 that document?

22 A. (Complies).

23 Q. Who was the physician in that case?

24 A. J Ward, which I believe is the
25 pediatrician, James Ward.

1 Q. So would that indicate that Jayden's
2 pediatrician at East Cooper was aware of
3 the vacuum delivery?

4 A. It does.

5 Q. Thank you, Doctor. The next form is
6 Exhibit 2-103. Would you please highlight
7 where the vacuum is charted.

8 A. (Complies).

9 Q. Are there initials there?

10 A. Yes, vacuum vaginal delivery -- VVD.

11 Q. Whose chart is that a part of, the
12 mother's or the baby's?

13 A. There is a stamp in the bottom right-
14 hand corner that says "Washington, Baby
15 Boy". So that's the baby's chart. It's a
16 description about the mother in the baby's
17 chart.

18 Q. Thank you. And the last document is
19 Exhibit 2-108. If you would, please
20 document where it states that a vacuum was
21 used on that document and who signed that
22 form?

23 A. It's in the nursing description and
24 it's signed ECN, that it was a "male
25 delivered with vacuum assist per Dr.

1 Rhett."

2 Q. Thank you, Dr. Norton. Do you recall

3 how many documents that was?

4 A. No.

5 Q. Ten maybe?

6 A. Seven, eight, ---

7 Q. Seven or eight?

8 A. (No verbal response).

9 Q. Is that sufficient documentation of the
10 vacuum use in the chart for the mother and
11 baby?

12 A. It seems to be absolutely that's
13 sufficient. It seems -- absolutely.

14 Q. Thank you. Dr. Norton, when you use a
15 vacuum in delivery, do you always document
16 the indication for the usage?

17 A. No, I don't. There's so many
18 situations in medicine in general and in
19 obstetrics in particular where we are
20 responding to taking care of an emergency
21 and focused on our patient and not on our
22 medical documentation. That -- because of
23 that, sometimes times are in shorthand or
24 initials, sometimes we leave things out,
25 sometimes we just don't go into detail

1 about it. I absolutely on numerous
2 occasions have not had detailed
3 descriptions of one of my deliveries.

4 Q. If it appears in Dr. Rhett's delivery
5 notes, on one of the pages that the vacuum
6 was not documented, does that matter as far
7 as what kind of care that Jayden was
8 getting?

9 A. Not at all, because when we saw the
10 video we saw Dr. Rhett responding in an
11 extremely appropriate and safe manner to
12 deliver Jayden as quickly as possible.
13 That was the focus, not the documentation
14 of the care of the mother and the baby.

15 Q. As far as Jayden is concerned, the
16 vacuum was documented in the appropriate
17 place?

18 A. Multiple times.

19 Q. Do you believe that Dr. Rhett complied
20 with the standard of care in documenting
21 this labor and delivery of Jayden
22 Washington?

23 A. I do because the -- the summary record
24 is very clear that it was a vacuum-assisted
25 delivery and that he signed that.

1 Now, our personal notes -- one of the
2 reasons that I understand why we have so
3 much charting with all of our medical care
4 now is for situations like this. It does
5 not have so much to do with caring for an
6 individual patient, helping them, as it
7 has to do with protecting institutions and
8 providers by trying to be as descriptive as
9 possible for potential situations.

10 So sometimes it's for the patient and
11 that's what the birth record notes and
12 summaries that go along with the baby are
13 -- and sometimes there is documentation
14 that is in shorthand that -- perhaps if it
15 were in more detail it would be more
16 helpful in a situation like this, but I
17 absolutely felt that it was adequately
18 documented.

19 Q. Thank you, Dr. Norton. Let's move on
20 to the day of Jayden Wa... i's delivery.
21 I am going to hand you a one-page document
22 that is the -- well, you tell me what it
23 is. It's marked Exhibit 2-024.

24 A. (Upon review) this is the progress
25 record from East Cooper on the mother,

1 Jamsetta Washington. It's the physician
2 notes and provider notes on the mother that
3 are handwritten.

4 Q. Who wrote that document?

5 A. Well, it's a combination of people.

6 Dr. Rhett wrote three entries and it
7 appears that two entries were written by
8 the nurse midwife, Ms. Stone.

9 Q. Okay. And you've reviewed the records
10 in this case, including the fetal heart
11 monitoring strips; is that right?

12 A. That's correct.

13 Q. Was there a time before Ms. Washington
14 started pushing that Jayden -- that you saw
15 on the fetal heart monitoring strips that
16 Jayden's heart rate declined or that he was
17 having distress in utero?

18 A. Multiple times.

19 Q. Okay. When is the first time that you
20 recall the medical providers and yourself
21 thinking that it was of some concern?

22 A. There's an episode around lunch time,
23 around 12:40, in the records where Jayden's
24 heart rate dropped down for a long stretch,
25 four minutes or more, and it's -- it is

1 called bradycardia when it goes that low
2 for that long. It happens spontaneously.
3 On exam, Ms. Washington was only five
4 centimeters but she was having a
5 spontaneous drop in the heart rate for the
6 baby.

7 Q. Do the records -- first of all, is that
8 episode noted in the records?

9 A. It is noted in multiple locations.
10 It's noted on the strip itself, the fetal
11 heart monitor strip; it's noted -- you can
12 see the drop in the heart rate but you can
13 also see the notes where the nurse has
14 written on the strip and then there's an
15 area -- another document that the nurses
16 use, uh, that talks about some of the
17 interventions that were done to address
18 that.

19 Then there is also a note that you've
20 handed me here that, that is Exhibit 2-024,
21 that has notes from Dr. Rhett describing
22 his interventions.

23 Q. If you could, highlight that note from
24 Dr. Rhett, please, ma'am, and just read it,
25 if you would.

1 A. Certainly, ---

2 Q. And the time, as well.

3 A. (Reading): *July 16th, 1320 -- which*
4 *is 1:20 for most of us -- had an episode of*
5 *deceleration, about four minutes, which*
6 *resolved with 02 percent oxygen, IVF, --*
7 *which stands for intravenous fluids -- and*
8 *stopping Pit -- or Pitocin.*

9 Okay, so the baby looks good now.

10 (Reading): *Cervix 4-5/80-90/-1 with*
11 *some molding.*

12 Then there is a notation here prior
13 that looks to -- I am not familiar with
14 that one stop.

15 Q. Okay. So did Dr. Rhett document that
16 there was some concern earlier that day,
17 around lunch time, with the fetal heart
18 strip?

19 A. Absolutely.

20 Q. Thank you.

21 CHILTON SIMMONS: May I publish
22 this to the jury, Your Honor?

23 THE COURT: You may.

24 CHILTON SIMMONS: Thank you, sir.

25 DIRECT EXAMINATION CONTINUED

1 BY CHILTON SIMMONS:

2 Q. Now I would like to hand you the
3 correspondingly fetal heart strips. These
4 have already been admitted into evidence.
5 They are East Cooper Hospital 0258, 0259,
6 and 0260. If you would -- I don't have a
7 blowup of these, but if you could just
8 explain to the jury what see on those that
9 causes you concern at any -- and highlight
10 those areas of concern at that time.

11 A. All right. I know that you'all have
12 had a bit of education on this whole fetal
13 heart monitor strips. What we look at is
14 the -- may I stand?

15 CHILTON SIMMONS: Actually, Your
16 Honor, if she could come before the jury.

17 THE COURT: That's fine.

18 CHILTON SIMMONS: Come on down.

19 EDWARD GRAHAM: Could we get the
20 exhibit numbers, please?

21 CHILTON SIMMONS: You need the ECH
22 numbers or the -- ECH 0258, 0259 and 0260.

23 EDWARD GRAHAM: Thank you.

24 THE WITNESS: Can you still
25 hear me?

1 COURT REPORTER: Yes, I can.

2 DIRECT EXAMINATION CONTINUED

3 BY CHILTON SIMMONS:

4 Q. Okay. You come on this side.

5 A. On the top, ---

6 Q. Thank you.

7 A. The top part of the fetal monitoring
8 strips is the baby's heart rate and the
9 bottom pertains to the mom's uterine
10 activity. So the contractions.

11 There is normally a variation of normal
12 rate between 120 and 160 where the baby's
13 pulse is in that normal range. It's faster
14 than an adult's but it's normal for the
15 baby.

16 In this situation there is something
17 called a baseline, that's where Jayden is
18 most of the time whenever he is doing well.
19 That's in this -- strip is 130, between 120
20 and 150.

21 I should note that there are these
22 boxes here that tell how much time is going
23 by. In this particular strip, every three
24 boxes is one minute. That's gives you a
25 little bit of the sense of the time period.

1 The area that I am highlighting is the
2 spontaneous bradycardia, where the
3 decelerations happened around 12:40. What
4 I see is the heart rate going along
5 normally in the normal range and then it
6 starts to decline. It goes down, it stays
7 down for about four minutes before it comes
8 back up.

9 That's the area that Dr. Rhett talked
10 about in his notation and then what is
11 shown here on the strips.

12 Q. You may take your seat.

13 A. Thank you, (complies).

14 CHILTON SIMMONS: May I publish
15 these, Your Honor?

16 THE COURT: You may.

17 THE WITNESS: And this,
18 (tendering).

19 CHILTON SIMMONS: Is that part of
20 it?

21 THE WITNESS: It's a
22 continuation. This area is where it
23 continues normal and that's where Dr. Rhett
24 said to stop Pitocin.

25 DIRECT EXAMINATION CONTINUED

1 BY CHILTON SIMMONS:

2 Q. So you didn't highlight that because

3 ---

4 A. That's right. The baby is back in the
5 normal range, no bradycardia at that time.

6 CHILTON SIMMONS: May I publish
7 these, Your Honor?

8 THE COURT: You may.

9 DIRECT EXAMINATION CONTINUED

10 BY CHILTON SIMMONS:

11 Q. What was done for Ms. Washington when
12 the portion of those strips was concerning
13 at 12:40 that afternoon?

14 A. The intervention was to take her off
15 the Pit, try to improve oxygen to Jayden.
16 There are a number of things that can put
17 stress on the baby during labor, during the
18 natural course of labor. In this setting,
19 this was an induction, so Ms. Washington
20 wasn't in labor spontaneously and the
21 doctors were trying to help her go into
22 labor in order to deliver.

23 So one of the things that she got was a
24 medicine called Pitocin, which is a hormone
25 that helps the uterus contract. At that

1 point when the baby's heart rate dropped,
2 they turned off the Pitocin. So that was
3 the first thing.

4 As Dr. Winestein testified earlier
5 that that doesn't mean that it goes away
6 entirely because she was still having
7 contractions but there was not additional
8 medicine given to cause stronger
9 contractions. So the Pitocin was turned
10 off, she was repositioned.

11 Sometimes when we see that drop in the
12 heart rate, we're concerned that it is
13 related to blood flow, either to the uterus
14 or actually the placenta and the cord. A
15 cord compression is the most probable
16 cause. So moving the mom moves the baby.

17 So there was a position shift, the mom
18 was moved around in order to decrease cord
19 compression or improve blood flow to the
20 baby.

21 In addition, increased fluids were
22 given. Intravenous fluids. Bolus was
23 given. Oxygen was deliver.

24 Q. Were all those measures appropriate?

25 A. Absolutely.

1 Q. Now, if you continue reviewing the
2 fetal heart monitoring strip, as time went
3 on -- that would be 12:40 p.m.?

4 A. Yeah.

5 Q. And she obviously doesn't start pushing
6 until? 7:30 p.m.?

7 A. Delivery is at 7:37. She had a trial
8 pushing before the change of shift with one
9 of the nurses. It's on the monitoring
10 strip and it's also seen in the video.
11 That was around 6:45, I believe.

12 Then after the pushing, it happened
13 after 7:00.

14 Q. Okay. Then I am going to -- did you
15 see areas of concern before we get to 7:00
16 p.m.?

17 A. Absolutely.

18 Q. What did you see at various times?

19 A. Again, watching the baby's heart
20 strips, there were several other times that
21 the heart rate dropped. In fact, I think
22 you've seen from the video that Dr. Rhett
23 mentioned that if the baby does that again,
24 I may have to do a Caesarean section. That
25 was many hours prior to the actual

1 delivery. There was another deceleration
2 that was more prolonged and then there are
3 other episodes where the heart rate doesn't
4 go down and stay down but the timing of the
5 dip is concerning and that's what -- late
6 appearing decelerations.

7 Q. So you did see some late decelerations?

8 A. I did.

9 CHILTON SIMMONS: If Your Honor
10 would allow to step down from the stand.

11 THE WITNESS: Thank you,
12 (complies).

13 DIRECT EXAMINATION CONTINUED

14 BY CHILTON SIMMONS:

15 Q. If you would, explain what is a late
16 deceleration?

17 A. Certainly. Again we're looking --
18 the baby's heart rate is here, the mom's
19 contractions are here.

20 I believe that on this one is -- each
21 box is a minute, so -- so this is not --
22 this is just an example of what it would
23 look like.

24 So the yellow is the normal range for
25 the heart beat. We have normal heart,

1 normal heart, deceleration.

2 The interesting thing when you're
3 looking at the timing is that you're seeing
4 -- here is the start of a contraction and
5 here's the state of a deceleration. The
6 dip doesn't start until the contraction is
7 almost half over. That's why we call it
8 late, because it's later in the contraction
9 time.

10 So if it started here at the very
11 beginning and they went down together, we
12 think that is more a normal contraction and
13 the heart rate dropping in a nonworrisome
14 manner.

15 A late, we worry that it is a problem
16 with decreased oxygen to the brain of the
17 fetus, that the placenta is not getting
18 enough oxygen to the baby.

19 So late decelerations that are
20 persistent are more worrisome, potential
21 signs -- nonreassuring signs that the baby
22 is in trouble.

23 Q. Moving on -- I believe that you said
24 that you did see some late decelerations?

25 A. I did.

1 Q. Is that something -- what do you do if
2 you see those happening? Do you watch, do
3 you do something right away, or what
4 happens?

5 A. Well, it depends on what I see and when
6 I see them but I'm always watching. The
7 strip is a tool that helps me to stay as
8 safe as I can for the mother and the baby.

9 If I see an occasional late occurring
10 deceleration, then -- and if mom is in
11 labor, then I watch it.

12 If I see a prolonged bradycardic state,
13 if it stays down, the position has been
14 changed, we've pushed fluids, sometimes
15 turning off the Pitocin but it's still an
16 issue, then I respond and give instructions
17 to -- if it stays down too long and I no
18 longer feel comfortable with the baby's
19 status, then I have to make a decision as
20 to delivery.

21 Q. And you talk about the concern that Dr.
22 Rhett had at 12:40 p.m.

23 A. Right.

24 Q. And what was done as a result of that?

25 A. Right.

1 Q. Then there is some occasional
2 decelerations?

3 A. Right.

4 Q. Then what happens starting at 7:30, if
5 you could -- do you need these?

6 A. Could I ---

7 Q. Sure. You go ahead.

8 A. This is actually a copy of Ms.
9 Washington's cervix, blown up larger.
10 Again, this is the baby, Jayden.
11 We're seeing this 150, normal range.

12 Here's a contraction, a deceleration. It
13 appears to be that it started after the
14 contraction and then here again, starting
15 after the contraction, he's -- then down
16 here is where -- this circle in the red,
17 it's called bradycardia, which means slow
18 heart. It starts around 1929 and continues
19 for two minutes here and then on, continues
20 three more minutes here. So it's a brady-
21 cardia that goes on for five minutes right
22 around that 7:30 mark.

23 Q. Based on the fetal hear monitoring,
24 because this is a blowup of the actual
25 strip, how low did the heart beat drop in

1 this area?

2 A. On this strip it dropped down to ninety
3 beats per minute, with a baseline around
4 that -- whereas it was 150 or so prior to
5 this, in the 140-150 range.

6 Q. So it was one forty to one fifty and it
7 went down to ninety?

8 A. Then it went down to ninety.

9 Q. And what is it down to here?

10 A. Here it looks like it goes down as low
11 as probably eighty beats per minute, right
12 down in here.

13 Q. Eighty beats per minute, is that a
14 normal heart rate for a fetus?

15 A. No, it's a worrisome finding --
16 especially since it's persistent, because
17 it shows that the baby is not even able to
18 compensate. It shows -- for the heart to
19 work right, the baby has to get enough
20 oxygen during labor.

21 Q. Thank you very much. You can take your
22 seat now.

23 A. (Complies).

24 Q. Now, Dr. Norton, you told us earlier
25 that 12:30 was when the bradycardia

1 occurred, that the mother's Pitocin was
2 turned off, they changed positions and gave
3 her some fluids and the bradycardia
4 resolved. Were those things done at 7:35
5 when the bradycardia came back?

6 A. That's a great question. I think the
7 important thing for us to know is that --
8 doctors do different things at different
9 times. In that second scenario, that's
10 right at the time of delivery. So certain
11 things were done that -- the Pitocin was
12 turned off, actually, at that time but --
13 but, uh, when -- when -- at 12:30 she was
14 only five centimeters dilated. So in order
15 to have a vaginal delivery, you can't have
16 it at that moment.

17 So your options are to go ahead and
18 proceed with an emergency Caesarean section
19 or to see if you can resuscitate the baby
20 in utero, improve the blood flow to the
21 baby at the time and continue on with the
22 labor. Now, if you're completely dilated
23 and the baby is low enough that you think
24 that you can reach the baby and help the
25 mother to deliver, then the goal is of

1 course very different -- it is to get the
2 baby out of that environment, delivery as
3 soon as possible and not spending extra
4 time hoping that the baby will respond to
5 position changes, oxygen and other
6 maneuvers.

7 Q. Dr. Norton, do you believe -- well,
8 first of all, did Dr. Rhett turn off the
9 Pitocin at that point?

10 A. It was turned off, yes.

11 Q. Did he put mom in a different position
12 for delivery?

13 A. Well, he did position her differently,
14 moved her down to help with the delivery --
15 from the video.

16 Q. Do you believe that there was a
17 reasonable and appropriate decision for Dr.
18 Rhett to try to expedite Jayden's delivery
19 at that point, using the vacuum?

20 A. Absolutely.

21 Q. Was there anything after Jayden's birth
22 that helped you decide whether Dr. Rhett's
23 decision to use the vacuum to expedite
24 Jayden's delivery was appropriate?

25 A. There were several things. You know,

1 we're all playing guessing games. If you
2 were to go back and say, 'Oh, geez, did he
3 do the right thing?' But our goal as
4 obstetricians is to be as safe as possible
5 and -- to have a backup.

6 These are warnings on the heart monitor
7 strips that we're looking for as to there
8 being a potential problem. What I saw
9 after the delivery made me say, 'Well, look
10 at that.'

11 The baby was born on the video and
12 Jayden was limp. I don't know if you
13 remember seeing it but usually babies are
14 moving and crying right after delivery and
15 Jayden was not for the -- during the first
16 forty-nine seconds or a minute, the baby
17 was limp, was not crying, there was a
18 stimulation done by Dr. Rhett and suction
19 to try to get the baby to respond.

20 As a consequence of being limp at
21 delivery, the Apgar score at one minute was
22 lower.

23 In addition, after the baby was handed
24 off to the nurses there was oxygen given
25 and Dr. Rhett mentioned, and it shows in

1 the documents, that the baby had a bowel
2 movement at the end of delivery. It wasn't
3 that the meconium -- meconium is a baby's
4 first bowel movement and it can either be
5 in the fluid or it can be after the
6 delivery. In this case, the terminal
7 meconium is a sign that the baby's oxygen
8 was decreasing.

9 Q. Dr. Norton, would the application of a
10 vacuum cause a baby to have meconium?

11 A. No, the -- the application of the
12 vacuum itself is just a way to help the
13 baby come out. The other forces of labor
14 that necessitate the use of the vacuum
15 cause that terminal meconium.

16 Q. I understand. We've seen this form
17 before, the labor and delivery summary,
18 does it state that there was a nuchal cord?

19 A. It does.

20 Q. And that means what?

21 A. Nuchal is neck and the umbilical cord,
22 that means that the cord was wrapped around
23 Jayden's neck.

24 Q. Would -- do you need this document?

25 A. Yes. This is Exhibit 2-020.

1 Q. Great. This picture, is that an
2 accurate picture of what the baby looks
3 like in the uterus with the umbilical cord
4 wrapped around its neck?

5 A. Absolutely.

6 CHILTON SIMMONS: If I could show
7 that to the jury.

8 THE COURT: You may.

9 CHILTON SIMMONS: I believe
10 counsel has it.

11 EDWARD GRAHAM: Your Honor, are
12 we -- are they saying that it is an
13 accurate view in general or that is has
14 anything to do with this case?

15 CHILTON SIMMONS: I will be happy
16 to ask the doctor.

17 THE COURT: Go ahead.

18 CHILTON SIMMONS: Yes, sir.

19 DIRECT EXAMINATION CONTINUED

20 BY CHILTON SIMMONS:

21 Q. Dr. Norton, what do you think about
22 this picture? What does that portray to
23 you?

24 A. That shows a baby in the process of
25 delivery with the umbilical cord, that

1 feeds the baby, around the neck.

2 Q. Is this what you find in some

3 deliveries as an Ob-Gyn?

4 A. Yes.

5 CHILTON SIMMONS: If I could show

6 this to the jury, Your Honor.

7 THE COURT: You may.

8 DIRECT EXAMINATION CONTINUED

9 BY CHILTON SIMMONS:

10 Q. And, Dr. Norton, does the umbilical

11 cord have to be tight around the baby's

12 neck to affect the oxygen flow?

13 A. It does not. The cord itself, if it is

14 just pushed against it can decrease the

15 flow. There are several ways to have the

16 cord around the neck. One is that it can

17 push down on the cord and make it hard for

18 the blood and the oxygen to get through to

19 the whole baby. Also it can compress the

20 blood flow going up into the brain itself,

21 so that rest of the body may be getting

22 oxygen but the brain may be getting less.

23 Q. Thank you, Doctor. You've discussed

24 the nuchal cord that was documented, as

25 well as the meconium, I think, on the

1 second page?

2 A. Yes.

3 Q. If you would, highlight that.

4 A. (Complies), that is Exhibit 2-021.

5 CHILTON SIMMONS: If I could
6 publish that to the jury.

7 THE COURT: You may publish.

8 CHILTON SIMMONS: Thank you.

9 DIRECT EXAMINATION CONTINUED

10 BY CHILTON SIMMONS:

11 Q. Was it significant to you that Dr.

12 Rhett felt that the baby needed oxygen
13 after he was delivered?

14 A. Yes. Ideally, if everything is going
15 well, most obstetricians want to have the
16 baby admired by the family and the mother
17 and given directly to them. But this baby
18 was taken over to the warmer and
19 administered oxygen by the nurse and right
20 -- then shortly after that was taken to the
21 newborn nursery for further observation.

22 Q. Dr. Norton, do you have an opinion as
23 to what you believe likely would have
24 happened had Dr. Rhett not used the help of
25 the vacuum to delivery Jayden when he did?

1 A. I do. Just judging by the fact that
2 she was forty-one weeks, that we had
3 multiple episodes of decelerations, late-
4 appearing and then this terminal -- then
5 the heart rate goes down and stays down, I
6 don't know how long it is going to last but
7 the longer that it lasts the more at-risk
8 the baby is for permanent brain damage from
9 lack of oxygen to the brain.

10 Q. What condition can permanent brain
11 damage cause from lack of oxygen to the
12 brain of a baby that's in the uterus?

13 A. It can lead them to have permanent
14 handicaps, cerebral palsy and it can also
15 cause them not to survive the process of
16 the birth.

17 Q. Let's talk briefly about the baby's
18 station, Dr. Norton.

19 A. Certainly.

20 Q. Do you always know the exact station of
21 the baby when you are applying the vacuum?

22 A. We are supposed to know the area where
23 the baby is so that -- it's one of the
24 indications of delivery, is to know where
25 we are, know what we are doing and know

1 where we are. It's, uh, -- it's not
2 necessary ---

3 Q. My question wasn't very artful. Is the
4 measuring of centimeters in the station, is
5 that a subjective measurement? Are you
6 pulling out a measuring tape in the
7 mother's vagina when you're delivering that
8 baby or is it just a guesstimate?

9 A. There is no measurement tape used.
10 There's two different ways to describe this
11 coming down and -- the one that I use is
12 thirds -- so I am going from the middle of
13 the pelvis and then one-third down, two-
14 thirds down and all the way out is plus
15 three.

16 Q. There are two different ---

17 A. So I ---

18 Q. --- systems of measuring, as well?

19 A. Right. Obstetricians use one, two,
20 three or plus one, two, three, four, five
21 and that's supposed to be the centimeters,
22 but -- yes.

23 Q. And did you read the manufacturer's
24 warnings or actually the instructions
25 manual that is a part of this vacuum?

1 A. I have since the trial began, yes.

2 Q. Let me go back. Do you use this same
3 vacuum as part of your practice?

4 A. I do.

5 Q. It is what, the TenderTouch?

6 A. That's correct.

7 Q. Is this -- this is the vacuum that you
8 use?

9 A. (No verbal response).

10 Q. How often?

11 A. (No verbal response).

12 Q. Any time that you use a vacuum?

13 A. I prefer that one, yes. I occasionally
14 use another one but this is the one that I
15 prefer.

16 Q. When you're delivering a baby, where's
17 the vacuum -- where is it located?

18 A. It's in the delivery table -- we have,
19 in each room there's a nice looking table
20 covered with a sheet and it has all the
21 instruments on top and then it has
22 underneath all the things that we might
23 want in addition. So it has gloves,
24 sutures and it has the vacuum equipment --
25 right on that table.

1 Q. And is there ever an occasion where you
2 would chose a different kind of vacuum for
3 a delivery or do you always use that vacuum
4 that's on your delivery table?

5 A. You know, I personally use this one --
6 that's the one that I am comfortable with.
7 When -- as an obstetrician, it's my job to
8 take care of my patients and I want to do
9 something that I am comfortable with and
10 can use confidently.

11 I will tell you that occasionally, if
12 the situation warrants and I am presented
13 with another one that I will make do, of
14 course, and use whatever is available.

15 Q. And if the manufacturer's warning that
16 went with that said not to use it for a
17 mid-pelvic delivery, is that relevant here
18 when Dr. Rhett did a low pelvic delivery?

19 A. Not at all.

20 EDWARD GRAHAM: Your Honor, I
21 object. Leading.

22 THE COURT: That was a leading
23 question, Counsel.

24 CHILTON SIMMONS: I will rephrase
25 it, Your Honor.

1 THE COURT: Thank you.

2 DIRECT EXAMINATION CONTINUED

3 BY CHILTON SIMMONS:

4 Q. Dr. Norton, did you read the manu-
5 facturer's warning in this case?

6 A. I did.

7 Q. Had you ever read it before you became
8 involved in this lawsuit?

9 A. No, I had not.

10 Q. How long have you used that vacuum
11 without having read the manufacturer's
12 warning?

13 A. A number of years. I don't recall.
14 I think that I used or read another one
15 called Might Vac, but they are very
16 similar.

17 Q. Having been involved in this lawsuit,
18 are you aware that the manufacturer's
19 warning states that it should not be used
20 for a mid-pelvic delivery?

21 A. I am aware of that, yes.

22 Q. Was a mid-pelvic delivery done by Dr.
23 Rhett in this case?

24 EDWARD GRAHAM: Objection, Your
25 Honor.

1 THE COURT: No leading.

2 Overruled. You may answer.

3 THE WITNESS: May I answer?

4 THE COURT: Yes, ma'am.

5 THE WITNESS: I see no

6 evidence for a mid-pelvic delivery in this

7 case. Absolutely Dr. Rhett in his own

8 deposition has stated that it was low but I

9 watched the video and I see how long it

10 takes for the baby to come out, and I see

11 where his hands are, and I have no doubt

12 that this was a low delivery. I can't tell

13 from the video, can't see, but the scalp

14 with the hair -- it certainly is not up so

15 high that it would be a mid.

16 DIRECT EXAMINATION CONTINUED

17 BY CHILTON SIMMONS:

18 Q. And do you feel confident that this was

19 a low pelvic delivery based on your viewing

20 of the birth?

21 A. Absolutely.

22 Q. Now, Dr. Norton, did you bring a pump

23 with you today?

24 A. I did.

25 Q. I am going to hand this to you -- where

1 did you get this?

2 A. From my hospital, Beaufort Memorial
3 Hospital.

4 Q. This is what you use?

5 A. It's not the only one.

6 Q. You left some there?

7 A. I left some there.

8 Q. That's good. And if you would,
9 actually would it be easier to step down
10 again?

11 A. Certainly.

12 Q. If you would show us -- there's been
13 some talk about the -- is it hard to
14 operate this?

15 A. No, it is not.

16 Q. Show us what ---

17 A. All right. This is the handle and you
18 pump it up -- (demonstrating). If I can
19 attach -- this is the permanent part and
20 this is the disposal, so it attaches like
21 this. This part is sterilized, so when I
22 am doing a delivery this is the part that
23 is passed up to me sterile.

24 If I were to place the cup on the
25 baby's head -- I am just going to show you

1 for the sake of argument, if I bend this
2 up, I am creating a vacuum by pumping
3 (demonstrating), and you can all see that.
4 See the needle goes up? It's like a blood
5 pressure cuff, you pump it up and you can
6 see the numbers. This is pretty
7 straightforward.

8 Q. Okay. From the video, were you able to
9 see any portions that help you determine
10 whether this pump was in the right ---

11 A. There's a couple of shots where I can
12 see Dr. Rhett using the vacuum and the
13 nurse holding the pump and in that I can
14 see that -- I can't see the numbers, I
15 can't see the color, but I can see the
16 angle of the needle and I know that that
17 angle means the -- sorry ---

18 CHILTON SIMMONS: These are the
19 pictures, Your Honor. Plaintiff's counsel
20 has already seen them.

21 DIRECT EXAMINATION CONTINUED

22 BY CHILTON SIMMONS:

23 Q. Would it help you to hold the pictures
24 or do you want to hold them?

25 A. Pardon me -- it's Exhibit 95001.

1 Q. I'll hold them.

2 A. Great. Here is Dr. Rhett with the
3 vacuum in his hand during delivery. Over
4 here, you can't see the nurse but you can
5 see the gauge and I can see the needle,
6 that black line. I can't tell if the black
7 line is like this or if it is at zero, or
8 if it is, like I showed you earlier, with
9 the small part all the way in the green.
10 I can see the angle. Given the fact that
11 the vacuum didn't come off the baby's head,
12 I believe that this was in the green zone.

13 Q. Can you see the green in this picture?

14 A. I can't see the color. No, I can't.

15 Q. So what is important about that?

16 A. This thing has to be -- I can see the
17 needle's position and I can tell that the
18 needle is not -- there's like a little
19 clock, and it goes from about ten o'clock
20 to about four o'clock or so, which is in
21 that normal zone. If it were -- it was
22 still in the green zone. It would either
23 have to be a zero or be in the green zone
24 based on the angle of that needle.

25 (Demonstrating to jury), see the green

1 zone, the angle of that needle.

2 There is a question by a juror about what
3 pressure that it is, and there's different
4 ways to mark the pressure. This is about
5 six hundred millimeters of mercury.

6 Q. Doctor, does this picture help or is
7 the other picture better?

8 A. You can show that.

9 Q. That's marked as an exhibit.

10 A. Yes. Without pressure, the vacuum
11 would come off, so I believe that it was in
12 the green zone.

13 Q. Thank you. Shall I leave this up here?

14 A. Sure.

15 Q. Dr. Norton, were you able to tell from
16 the video how long the vacuum was used?

17 A. I was.

18 Q. Can you give me an estimate, if you
19 recall?

20 A. Slightly over three minutes.

21 Q. Do you have an opinion as to whether
22 that's an acceptable amount of time to use
23 the vacuum?

24 A. Absolutely. That's on the short side.

25 But -- the American College of

1 Obstetricians & Gynecology has recommenda-
2 tions and even in the manufacturer's
3 bulletin they talk about wanting to see
4 progress. Usually it's somewhere in the
5 twenty to thirty minutes range where you
6 wouldn't want to use the vacuum for
7 delivery, for longer than that period of
8 time. These are guidelines, they are not
9 an absolute, they are not an indication
10 where you would use it longer but -- in
11 general, you're going to use it for up to
12 fifteen to thirty minutes and this was only
13 for three. A very short amount of time.

14 Q. Were you able to tell the technique
15 that Dr. Rhett used from the video, when
16 using the vacuum?

17 A. I was.

18 Q. You are sworn to tell the truth, as you
19 know.

20 A. Yes.

21 Q. Do you have an opinion as to how he
22 used that vacuum?

23 A. I do. I believe that he used it
24 entirely appropriately. There's been some
25 question about turning the vacuum and one

1 of the things that -- we know that when you
2 use forceps that you're holding onto the
3 baby's skull, but when you're using a
4 vacuum you're holding onto the skin.

5 If you twist that vacuum, they call it
6 cookie cutter lacerations where you
7 actually take a circle from the baby's
8 scalp, it can be cut in a circle. You can
9 see Jayden's head after delivery and there
10 is no evidence of that laceration.

11 Just watching Dr. Rhett preform the
12 delivery, there's no -- there's no
13 twisting. Indeed, I think Dr. Winestein
14 described it very appropriately. What I
15 saw Dr. Rhett doing was trying to ease the
16 baby out with as little damage to Ms.
17 Washington's female area as possible. He
18 is easing it around that tissue, stretching
19 that tissue to try to minimize any harm to
20 her.

21 Q. Thank you, Dr. Norton. Moving on very
22 briefly to informed consent issues. There
23 has been a lot of talk about that. Do you
24 tell your delivering moms when you're about
25 to use the vacuum?

1 A. It depends on the situation. I have a
2 spectrum of patients involved in my care.
3 I have patients that come to me, uh, who
4 say 'take care of me however you feel is
5 best', and then I have a set of patients
6 that come to me with a five-page birth
7 plan.

8 I don't know if anyone has ever heard
9 of a birth plan but you can go on the
10 internet and look up different
11 recommendations as to how -- choices that
12 you want to be involved. You want to have
13 music on, you want to be able to walk and
14 deliver, you want to have your significant
15 other cut the cord. There's a whole bunch
16 of issues that can be involved in a birth
17 plan.

18 So I have that spectrum. I have
19 patients that come to me and say 'take care
20 of me' and I have patients who have a birth
21 plan.

22 What I want for all my patients -- I
23 think more information is better. I think
24 most of my patients watch those baby shows,
25 delivery shows now, because they have a

1 much better idea than back-in-the-day, than
2 I did.

3 But -- but the issue is that if they
4 come to me and they have -- say they have a
5 birth plan and it says that they will not
6 allow me to perform a Caesarean section,
7 for instance, then I tell them that they
8 need to find another doctor because I need
9 to have that as an option. My job is to
10 take care of both of my patients, the
11 mother and her baby or babies in the safest
12 way that I know how. If I don't have that
13 as an option, then I can't do that. Then
14 she needs to go to a different provider who
15 feels more comfortable with that. If I
16 don't have the options of, you know,
17 standard vaginal delivery, operative
18 vaginal delivery or Caesarean section, then
19 my hands are tied and I'm not able to care
20 for that patient properly.

21 Q. Thank you, Dr. Norton. Very briefly,
22 are you familiar with the general Ob-Gyn
23 literature regarding the risk of brain
24 bleeds from a vacuum?

25 A. I am.

1 Q. What does that literature say about the
2 number of brain bleeds caused by vacuum
3 compared to other modes of delivery?

4 A. Well, it is interesting because ---

5 EDWARD GRAHAM: Objection, Your
6 Honor.

7 THE COURT: Basis of your
8 objection?

9 EDWARD GRAHAM: We'd like a
10 reference to whatever literature that she
11 has ---

12 THE COURT: Counsel, what is
13 again the literature that you're asking?

14 CHILTON SIMMONS: I just asked the
15 Doctor her general medical literature that
16 she relies on.

17 THE COURT: We will give you
18 cross on that if you wish to be more
19 specific, Counsel. You may proceed.

20 CHILTON SIMMONS: Yes, sir.

21 DIRECT EXAMINATION CONTINUED

22 BY CHILTON SIMMONS:

23 Q. Dr. Norton, what documents have you
24 reviewed to keep updated on new information
25 from the medical field?

1 A. There's a number of different
2 resources: the American College of
3 Obstetricians & Gynecology sends out
4 regular bulletins and opinions to members.
5 We have journals that we subscribe to that
6 are specific to obstetrics and gynecology
7 and ones that are more broad -- like the
8 new ones, I have subscriptions to different
9 magazines.

10 I have the annual Board certification
11 that I mentioned earlier. Every year I
12 take and pass them, keep up with those.
13 Things that the American Board of Ob-Gyn
14 recommends. Things that we are instructed,
15 that are important to be aware of.

16 There's also lay press.

17 I learn things from my patients, as
18 well. As many of you may be aware, hormone
19 therapy became very, uh, unpopular about
20 2002 and so much of that information came
21 from the lay practice, from my patients.

22 There's a number of resources.

23 Q. Thank you, Dr. Norton.

24 CHILTON SIMMONS: This is in
25 evidence, Your Honor, the ACOG Practice

1 Bulletin Number 17, dated June 2000. If I
2 could approach.

3 DIRECT EXAMINATION CONTINUED

4 BY CHILTON SIMMONS:

5 Q. Have you seen this document?

6 A. Yes, I have.

7 Q. I believe that on the third or fourth
8 page, entitled Table 1, ---

9 A. This is Exhibit 31-001. I'm sorry,
10 table?

11 Q. On the fourth page, top right-hand
12 corner, Table 1.

13 A. Yes. Should I highlight that?

14 Q. Yeah, that would be great if you would
15 highlight Table 1. If you would, just
16 discuss what you find relevant about the
17 information on the number of brain bleeds
18 from vacuum versus other methods of
19 delivery such as Caesarean section delivery
20 or labor.

21 A. Certainly. This table was actually
22 devised from a study that was published in
23 the medical journals, the New England
24 Journal of Medicine in 1999. It looks at
25 babies born at term and what, if any,

1 bleeding that they had in their brains.
2 What is interesting is that every single --
3 whether it was delivering spontaneously,
4 having a C-section, not being in labor,
5 having a combination of forceps and vacuum,
6 all of them there is a chance for a baby to
7 have bleeding in the brain, every single
8 one.

9 So when you look at the difference that
10 -- vacuum alone versus forceps alone, you
11 get -- the risk is actually -- in this
12 study is actually less with vacuum alone
13 than it is with forceps alone. Caesarean
14 with no delivery (sic), there is fewer.

15 Q. What about Caesarean delivery during
16 labor? Intracranial hemorrhage is one out
17 of how many times?

18 A. 952.

19 Q. Versus vacuum alone, one of out of how
20 many times?

21 A. 860.

22 Q. Are those numbers similar in your
23 profession?

24 A. Yes, in my opinion clinically that's
25 very similar.

1 CHILTON SIMMONS: If I may publish
2 that to the jury?

3 THE COURT: You may.

4 DIRECT EXAMINATION CONTINUED

5 BY CHILTON SIMMONS:

6 Q. Dr. Norton, was the length and the
7 method of application of the vacuum in this
8 case that you saw on the video, was that
9 relevant to any opinions that you may have
10 as to whether the vacuum would have caused
11 the bleed in Jayden W. ?

12 A. I'm sorry. The length of time that it
13 was applied?

14 Q. And the method that Dr. Rhett used, the
15 vacuum?

16 A. I think that -- we talked about this
17 before. Shorter means better, of course.
18 It is not ethical for us to do studies on
19 pregnant women and their babies to find out
20 what this -- so we can't randomize my
21 patient number one from my patient number
22 two, on one of them I performed a vacuum
23 and one not. So, I mean, there's no way to
24 find out from the gold standard medical
25 literature the, uh, the -- randomized

1 control trial where you just say, where you
2 start off and you see where this
3 intervention goes. We can't do that with
4 medications in pregnancy. So -- but these
5 are all observations.

6 But what the observations show is that
7 these are associated, that there is an
8 increased chance of having a baby with a
9 bleed if you are in labor than if you're
10 not. But when they're associated, we don't
11 even know if it is a cause-and-effect or if
12 it is just that it happened.

13 If you're looking at a situation where
14 you are doing a Caesarean section or a
15 vacuum delivery or a forceps delivery,
16 there is something that is going on that's
17 making you want to do that, to help the
18 patient in that way. So it's more involved
19 because there is something going on. That
20 something going on may in itself increase
21 the chance for bleeding in the brain.

22 Q. Thank you. Wrapping up, Dr. Norton,
23 what is the whole purpose of the fetal
24 heart monitoring strip?

25 A. The purpose is that -- it just came out

1 as common use in the '70s but it was -- the
2 goal was to keep an eye on the baby all the
3 times, to protect the baby and be as safe
4 as you possibly can, to help the baby be
5 born healthy and -- for safety and
6 precautionary measures.

7 Q. Sitting here today, after reviewing
8 everything in this case, having the benefit
9 of hindsight, ---

10 A. Right.

11 Q. --- do you believe that Dr. Rhett
12 should have let Ms. Washington push longer?

13 A. I don't. You know, she did push but
14 she pushed with help and I think that it
15 was absolutely the right thing to do,
16 because -- again, we don't know how long it
17 takes for there to be permanent brain
18 damage. We know from animal studies that
19 if you have a health animal and then you
20 cut off the umbilical cord flow entirely
21 that it takes about ten minutes for that
22 baby to die. So we can't do these studies
23 on -- of course there would be absolutely
24 now way that it would ethical, but -- so we
25 don't know how long that drop would have

1 gone on, and we don't know if -- we had
2 already been, multiple times, worried about
3 the baby but -- the lunch time drop in the
4 heart rate, and then after that some late
5 decelerations and then we get to the very
6 end and it's heart rate went down and
7 stayed down. We don't know how much time
8 that we have, so in those situations I'd
9 have to make the decision. So I feel that
10 Dr. Rhett was very appropriate in getting
11 the baby out. Get the baby out as safely
12 as we can, as quickly as we can.

13 Q. Dr. Norton, was Dr. Rhett being
14 careless or unsafe by using the vacuum to
15 help get Jayden out?

16 A. No, in fact exactly the opposite. He
17 was being extremely careful and -- he did
18 not -- you can see from the video that he
19 is not rushing in there and doing
20 something. It's making a decision,
21 assessing the situation, trying to help
22 that mother and that baby, being as safe as
23 he possibly can.

24 Q. Did you find that there were proper
25 indications for Dr. Rhett to use the vacuum

1 here?

2 A. I did.

3 Q. I have another copy of that ACOG
4 committee opinion and in the top corner it
5 says "Indication for Using Vacuum". Do you
6 see any of those indications that were
7 applicable to Dr. Rhett in this delivery at
8 the time?

9 A. I do. This is Exhibit 31-002. There's
10 -- I will highlight the box. It talks
11 about when you would intervene and help a
12 baby out.

13 One of the indications is that there is
14 a problem with the baby's heart rate such
15 that you believe that the baby is already
16 not receiving enough oxygen or is assumed
17 to be in imminent danger of that.

18 Immediate or potential fetal
19 compromise. That, absolutely, I feel was
20 very -- there was an indication for helping
21 Ms. Washington deliver Jayden.

22 Q. Then, is there another indication below
23 that?

24 A. There is. There is -- right below that
25 it says, second stage for maternal

1 benefits. Maternal benefits if a pretty
2 broad term. One of the reasons that I will
3 use a vacuum is if I am trying to help
4 someone who isn't able to push effectively
5 to help me. So if they are exhausted,
6 maternal exhaustion, then that is another
7 reason to help with an operative -- with
8 some help from below.

9 Most women, even as young and as
10 healthy as Ms. Washington appeared to be,
11 if they've been going through a hospital
12 stay of twenty-four hours, with medicines,
13 being hooked up to monitors and beepers all
14 night long -- I believe that she said in
15 the video early on that she didn't sleep
16 the night before. Then here we are,
17 twenty-four hours later, and she's trying
18 to push, she's uncomfortable and everyone
19 is telling her -- she looked to me to be
20 exhausted. She's push and then lie back on
21 the bed. She was tired. That's another
22 reason I believe that Dr. Rhett chose the
23 vacuum.

24 CHILTON SIMMONS: May I publish,
25 Your Honor?

1 THE COURT: You may.

2 DIRECT EXAMINATION CONTINUED

3 BY CHILTON SIMMONS:

4 Q. Dr. Norton, do you believe that Dr.
5 Rhett complied with the standard of care
6 when treating Jamsetta Washington and her
7 baby, Jayden W. ?

8 A. I do.

9 Q. Do you hold your opinions to a
10 reasonable degree of medical certainty,
11 most probably?

12 A. Yes, I do.

13 CHILTON SIMMONS: Thank you, Dr.
14 Norton. Please answer any questions that
15 plaintiff's counsel might have.

16 THE WITNESS: Thank you.

17 THE COURT: Cross examination?

18 EDWARD GRAHAM: Thank you, Your
19 Honor.

20 CROSS EXAMINATION

21 BY EDWARD GRAHAM:

22 Q. You were saying that the incidence of
23 brain bleeds with a vacuum extraction was
24 one in 860, and you said something about
25 the Caesarean section but I don't recall

1 you telling us what the risk of brain
2 damage is in the babies in that study that
3 had a normal spontaneous vaginal delivery.
4 Do you recall that or do you need to see
5 the document?

6 A. I have two statements. I think you've
7 asked me several questions. I would like
8 to see the document to tell you the exact
9 number. I don't recall ever saying that
10 this was cause for brain damage. The
11 table, the study is intracranial bleeding.
12 It's about bleeding, it's not about damage.

13 Q. Does bleeding sometimes involve damage
14 or is that outside of your expertise?

15 A. Does bleeding sometimes -- that's a
16 very broad question.

17 Q. Is it outside of your expertise? If
18 so, I will ---

19 A. No, certainly not. Bleeding, I deal
20 with bleeding every day. Can you help me
21 understand what you'd like for me to answer
22 about that?

23 Q. Is it within your expertise, Doctor,
24 to address whether or not brain bleeds can
25 involve brain damage?

1 A. No, it is not outside of my expertise.

2 Q. Can brain bleeds cause brain damage?

3 A. Yes, they can.

4 Q. I believe that we have a blowup of that
5 part of -- it may be out of the courtroom.

6 At any rate, would you agree that in that
7 article the risk of brain damage from
8 normal, spontaneous vaginal delivery was
9 less than half of the brain bleeds --
10 brain bleeds was less than half the risk of
11 brain bleeds when a vacuum was applied?

12 A. I would have to see the actual one to
13 see the number but certainly in a
14 spontaneous vaginal delivery there's less
15 of an associated bleed than in intervention
16 with vacuum or a Caesarean birth process.

17 Q. Does this refresh your memory,
18 Spontaneous Vaginal Delivery, intracranial
19 hemorrhage one in one thousand nine
20 hundred?

21 A. (No verbal response).

22 Q. Can you see that?

23 A. Sir, I -- yes. Versus one in eight
24 sixty. Yes.

25 Q. So you would agree that even using all

1 the babies that were in this study that the
2 risk of brain bleeds from a vacuum was more
3 than twice the risk of brain bleeds from a
4 normal spontaneous vaginal delivery?

5 A. Again, I would not agree to that
6 statement. If I can explain, those are
7 both word associated. So, absolutely,
8 there is an association between brain
9 bleeding and intervention versus
10 spontaneous vaginal delivery. But I would
11 not agree that's what -- because it's
12 associated.

13 Q. Would you agree that Table 1 in ACOG
14 Practice Bulletin reflects, in terms of
15 effect of delivery on neonatal injury, the
16 title of the Table, spontaneous vaginal
17 delivery is one in nineteen hundred and
18 vacuum alone is one in eight hundred sixty?

19 A. I agree that's what it says.

20 Q. Would you agree that one in eight sixty
21 is less than half one in nineteen hundred?

22 A. I would.

23 Q. And that study for the New England
24 Journal doesn't even take into account
25 whether the vacuum application was at the

1 outlet, low or mid station. Correct?

2 A. I believe that's correct.

3 Q. And it takes into account not just term

4 babies but it takes into account babies

5 over a certain weight. Correct?

6 A. I am not sure about that. I thought

7 that it was term babies, but -- if you want

8 to clarify that for me, that's fine.

9 There's other information, too.

10 Q. As you sit here today, Doctor, do you

11 know whether or not that study involves

12 term babies?

13 A. That was my understanding, absolutely,

14 term babies.

15 Q. Is this the article to which you refer,

16 Doctor?

17 A. (Review).

18 Q. Is that the article to which you

19 referred?

20 A. Yes, it is.

21 Q. Please show me where it says the babies

22 in that study were term babies?

23 A. That's a great question. It's weight

24 related on the abstract method. It says

25 that they were born weighing between

1 twenty-five hundred and four thousand
2 grams.

3 Q. So twenty-five hundred grams takes into
4 account all kinds of premies, doesn't it?

5 A. Not all kinds of premies.

6 Q. Premies who weigh over twenty-five
7 hundred grams, correct?

8 A. That's correct.

9 Q. That involves many babies that are more
10 vulnerable to intracranial bleeds than term
11 babies, true?

12 A. I can't tell you the exact number that
13 it involves, but certainly they are using a
14 weight criteria.

15 Q. Now, you were going through a number of
16 exhibits where you talked about all the
17 document about vacuum being used -- and I
18 don't want to belabor this point, but we
19 never questioned that the nurses did their
20 job. But you never saw a single reference
21 of Dr. Rhett documenting that he used a
22 vacuum on the day that this child was born,
23 did you?

24 A. Can you repeat that question again?

25 I'm sorry.

1 Q. Yes, ma'am. Put aside the nurses'
2 entries about the vacuum. Did Dr. Rhett
3 ever make an entry in this delivery note
4 that he used a vacuum?

5 A. I did not see one of that handwritten
6 page that -- there is no description of the
7 actual type of delivery done.

8 Q. We know that he put it on the billing
9 doc, the face sheet; correct?

10 A. You know, I don't know whose hand-
11 writing that is.

12 Q. Well, he signed it and the date on it
13 is 7/17, correct?

14 A. If we are using it based on the
15 signature at the bottom as Dr. Rhett,
16 there's a signature at the bottom of the
17 delivery summary that's signed by the
18 nurses. I don't know how much of it he
19 filled out. But he signed this delivery
20 right here -- if I may, Exhibit 2-021, and
21 there's a signature at the bottom that says
22 "Dr. Rhett" and it is his initials. It was
23 passed around earlier as one of the
24 exhibits.

25 Q. And ---

1 A. This was filled out in part by the
2 nurses. I don't know how much he did. It
3 does say that it was a vacuum delivery.

4 Q. How is Dr. Rhett's name spelled on that
5 document?

6 A. Well, it may be a copy. It's hard for
7 me to see. Looks like there is an "R",
8 then another letter and two "T's".

9 Q. R-e-t-t?

10 A. Perhaps. Yes.

11 Q. And there is no date on any of that, is
12 there?

13 A. I'm sorry? There's all sorts of dates
14 on this.

15 Q. There is no date on the Rett nor on the
16 initials, is there?

17 A. Not right next to it; no, sir.

18 Q. Okay. Thank you. So you have no
19 evidence that Dr. Rhett documented the use
20 of a vacuum on the day of delivery, do you?

21 A. I don't know for sure when that was
22 signed. No, I do not.

23 Q. Fair enough, I will move on.

24 A. Thank you.

25 Q. We talked about Jayden recovering from

1 an episode of decelerations around
2 lunchtime. How long did it take Jayden to
3 recover?

4 A. How long did it take?

5 Q. Yes, ma'am.

6 A. The period of the drop in the heart
7 rate, where it was down to the bradycardia
8 was about four minutes. Then following
9 that, it took a little while for Jayden's
10 heart rate to move entirely to what I'd
11 call normal. On that third page there's a
12 little bit of an area where there's a
13 little bit of a dip. Looks like a late-
14 appearing deceleration. I didn't look at
15 it at that time. Dr. Rhett restarted the
16 Pitocin after it had been approximately one
17 hour from the time of the deceleration
18 until the time of the restart of the
19 intervention, continued intervention.

20 Q. The heart rate recovered just as you
21 would want it to. Correct?

22 A. (No verbal response).

23 Q. With changing the mother's position,
24 giving oxygen, fluids and stopping the Pit.

25 A. I would like for it to be faster but,

1 of course, -- yes, I was very pleased that
2 it did not continue on.

3 Q. It was a reassuring recovery, correct?

4 A. It was a recovery. When I see a
5 deceleration, I'm not reassured. I'm
6 concerned about that baby. I saw that this
7 was an -- somewhat out of the blue. That
8 episode made me be more concerned about the
9 baby, not less concerned.

10 Q. All right, let me ask you about a
11 couple of this diagrams that you brought to
12 court. Do these have anything to do with
13 this case?

14 A. Absolutely.

15 Q. I am holding up now the late decelera-
16 tion document. Does this strip come from
17 the Jayden W chart?

18 A. No, it does not.

19 EDWARD GRAHAM: We'd ask that be
20 marked as the next court exhibit, please.

21 COURT REPORTER: You want it
22 marked as a court exhibit?

23 EDWARD GRAHAM: Please.

24 CHILTON SIMMONS: No objection
25 from the defense, Your Honor.

1 COURT REPORTER: Court Exhibit

2 34.

3 (SO ENTERED AS COURT'S EXHIBIT 34).

4 CROSS EXAMINATION CONTINUED

5 BY EDWARD GRAHAM:

6 Q. Similarly, this document about nuchal
7 cord, you're to contending that this is
8 what Jayden W 's position in the
9 birth canal was, are you?

10 A. (No verbal response).

11 Q. This is just an illustration of what an
12 anonymous baby might look like with the
13 nuchal cord, is that correct?

14 A. I'm not sure -- you asked two
15 questions. First, was I contending that
16 this is what Jayden W looked like
17 in the birth canal. That was your first
18 question. Is that correct?

19 Q. Yes, ma'am.

20 A. Okay. And judging from the video, I
21 definitely -- we could see the head coming
22 down and partly coming out, then right
23 after that you could see that the cord was
24 taken from around the neck. So that -- as
25 far as that is concerned, absolutely that's

1 what it would look like.

2 Q. Do you ---

3 A. The head, the cord and then being able
4 to come back around to remove that cord.

5 Q. Do you contend that this diagram is a
6 true and accurate depiction of Jayden
7 Washington as his head emerged from the
8 birth canal?

9 A. This isn't Jayden W. This is
10 an example to understand what a nuchal cord
11 is.

12 Q. This is not a true and accurate
13 depiction of anything relating to Jayden
14 W., is it?

15 A. I am not sure I understand the legal
16 term for "true and accurate", this is an
17 example of the nuchal cord and that's
18 exactly what Jayden W. had, was the
19 cord wrapped around the neck.

20 EDWARD GRAHAM: Could we mark
21 this, please, as our next court exhibit.

22 CHILTON SIMMONS: Your Honor, we
23 would agree and would also be happy to mark
24 it as evidence if you wish.

25 COURT REPORTER: Court's Exhibit

1 35.

2 (SO ENTERED AS COURT'S EXHIBIT 35)

3 EDWARD GRAHAM: And while that
4 -- Your Honor, we would ask that this pump
5 also be marked as a court exhibit.

6 THE WITNESS: May I ask a
7 question?

8 EDWARD GRAHAM: Certainly.

9 CHILTON SIMMONS: We certainly
10 have no objection, Your Honor, but I
11 believe that belongs to Beaufort Memorial
12 Hospital.

13 THE WITNESS: I promised that
14 I would bring it back. I'll be in trouble
15 if it stays with the court. So I don't
16 know what that does.

17 EDWARD GRAHAM: Your Honor, we
18 would like an opportunity to use it in our
19 case. They chose to bring it into court,
20 we would like it as a court's exhibit.

21 THE COURT: If it is a court's
22 exhibit it wouldn't go to the jury, it
23 would just simply be preserved as evidence.

24 EDWARD GRAHAM: Yes, sir.

25 THE COURT: I am inclined -- we

1 will return it to the witness, the jury has
2 seen it. I don't believe that there is any
3 further benefit to retaining it among the
4 court's property.

5 EDWARD GRAHAM: Your Honor, we
6 would like to use it in the reply portion
7 of our case.

8 THE COURT: In what way?

9 EDWARD GRAHAM: To demonstrate
10 certain issues related to the power of this
11 vacuum.

12 THE COURT: Then what we would
13 have to do to return it through counsel at
14 the end of the case, back to the ---

15 EDWARD GRAHAM: I am not opposed
16 to that.

17 CHILTON SIMMONS: Your Honor, I do
18 believe that Dr. Norton has concerns with
19 that. We would have no objection to Mr.
20 Graham getting his own version of that.

21 THE COURT: Counsel, you brought
22 it in and he wants to use that one. I
23 think that's appropriate. The court will
24 retain it until the end of the case and
25 then return it to the hospital.

1 COURT REPORTER: Court's Exhibit

2 36.

3 (SO ENTERED AS COURT'S EXHIBIT 36)

4 THE WITNESS: May I ask a
5 question, Judge? Just so that I can let my
6 hospital know, do you have a sense of how
7 long that might be?

8 THE COURT: That's been an issue
9 in this case. I would suggest you tell
10 your hospital maybe next week. We will
11 make sure that it is kept secure here every
12 night and will be returned to you in good
13 working condition.

14 CROSS EXAMINATION CONTINUED

15 BY EDWARD GRAHAM:

16 Q. Dr. Norton, you were talking earlier
17 about this particular fetal heart monitor
18 strip which is marked 104. Where do you
19 contend in this tracing that the vacuum was
20 placed?

21 A. May I approach the jury? Is that all
22 right, sir?

23 Q. You may.

24 A. Okay. From the video, timing how long
25 the vacuum was applied, it was slightly

1 over three minutes. So -- (inaudible, back
2 to court, addressing jury). The fetal
3 scalp electrode was off and it was done
4 right after that.

5 Q. Please mark with this green marker
6 where you contend that the vacuum was
7 placed, just put "VAC".

8 A. Can I do it with an arrow where it was
9 placed?

10 Q. Sure.

11 A. I would say that it was about here,
12 (marking). I wasn't there but this is from
13 the information that I have.

14 Q. Okay. Thank you. You may take your
15 seat.

16 A. Thank you, (complies).

17 Q. You talked about meconium or a bowel
18 movement at the end of delivery. There is
19 no evidence of meconium before the pulls
20 with the vacuum, true?

21 A. Not that I saw in the video or in any
22 of the documentation. No, sir.

23 Q. You talked about nuchal cords. Would
24 you agree that thirty-five to forty percent
25 of babies have at least one nuchal cord?

1 A. I'm not aware of percentages that high,
2 but it's certainly common to have the cord
3 wrapped around the neck or to be pushed up
4 against the shoulder or to be in a number
5 of different places that can potentially
6 cause a problem for the baby.

7 Q. And it's not unusual for a baby to get
8 some oxygen after delivery, is it?

9 A. When you say that it is not unusual,
10 it's not standard. Babies don't get --
11 they have enough oxygen in the room for
12 them to get it. If there is no problem,
13 they don't get it. It's an additional
14 charge, there's equipment involved, it
15 means taking the baby away from the mom and
16 the rest of the family. I don't know what
17 you mean by it is not unusual.

18 Q. How frequently do you contend that
19 babies need supplemental oxygen after
20 birth?

21 A. I don't have that number, sir.

22 Q. You can't give us any number?

23 A. I can't give you a definite number; no,
24 sir.

25 Q. Now, did I understand you to say that

1 you don't use a plus five, minus five
2 system?

3 A. That's correct.

4 Q. When did ACOG start requiring or
5 recommending that its Board-certified
6 obstetricians use the plus-five, minus-five
7 system? Was it '84, '88? When was that
8 requirement imposed?

9 A. I'm -- may I respond? I don't believe
10 that there has ever been a requirement.
11 From the ACOG, American College of
12 Obstetricians & Gynecology, I don't know
13 how they could enforce such a requirement.
14 There is no law governing the description.
15 I think -- there are certain things that we
16 agree upon so that we can talk to each
17 other about things, but there are different
18 systems. But I -- when I was in training,
19 in the late '80s or early '90s, at that
20 time although I was taught the one, two,
21 three system, that's what all my tendency
22 was to talk about at that time, talking
23 about the American College in talking about
24 the centimeters.

25 Q. This vacuum is contraindicated for mid-

1 pelvic application. Correct?

2 A. No, sir.

3 Q. This vacuum cup, according to the
4 manufacturer's instructions, is not
5 designed nor indicated for mid-pelvic
6 deliveries, is it?

7 A. According to the manufacturer, that's
8 correct. They say not to use it in mid-
9 pelvic deliveries.

10 Q. Do you use it in mid-pelvics?

11 A. No, I do not.

12 Q. You do not?

13 A. (No verbal response).

14 Q. Tell us, please, if Dr. Rhett or any
15 other physician used this vacuum to deliver
16 a baby from the mid-pelvic position, would
17 that be a violation of reasonable care in
18 your opinion?

19 A. No, it would not.

20 Q. It's okay to violate the manufacturer's
21 instructions?

22 A. You know, I don't know to say that we
23 should ignore the manufacturer's
24 instructions because those guides. They
25 give information to people, they try to

1 help providers, but they are not
2 requirements. Every day I use something
3 that is not entirely as it was initially
4 designed.

5 The FDA has certain requirements to get
6 permission to launch a new device and in
7 order to do that, they have to do studies
8 and then they try to limit those studies.

9
10 I can't think of a good example but
11 just because the manufacturers says so,
12 that may be -- it may not be that's not a
13 good application but because that's not
14 what they tested it on.

15 It may be they want to protect
16 themselves and if they didn't test it, if
17 it exceeds the tests then they would want
18 to have on their booklet that that is not
19 what it is indicated for.

20 Q. Doctor, when a manufacturer of a vacuum
21 decides that it is not safe to be used for
22 a mid-pelvic vacuum extraction and a doctor
23 decides to do that anyway, to use that
24 vacuum for a mid-pelvic extraction, that's
25 dangerous to the baby; isn't it?

1 A. You know, you're telling me that the
2 manufacturer has decided that this is a
3 factual situation or are you telling me
4 that the manufacturer has decided that that
5 is not safe?

6 Q. The manufacturer instructs not to use
7 this vacuum to delivery from the mid-
8 pelvic; correct?

9 A. That's correct as a guideline, it's not
10 designed for that use. Again, I use things
11 everyday that weren't as originally
12 designed or originally.

13 Sometimes, you know, there is that new
14 shot that we've begun to give people for
15 cervical cancer prevention. It's not
16 designed to be used for men. The FDA did
17 not -- they tested men but they did not
18 allow that to continue. They said, 'Well,
19 we will have to have more evidence if you
20 want it proposed as good for men.'

21 That didn't mean that it was dangerous
22 to give it to men. In fact, they are now
23 in the process of getting FDA approval for
24 that shot to be given to men.

25 And they have an age range. It doesn't

1 mean that it is dangerous to give it to
2 someone above that age range, it just means
3 that they didn't get the FDA permission for
4 that.

5 So I don't know the manufacturer came
6 up with this booklet. I don't know that.
7 I don't know what animal studies they did
8 or people studies they did to decide that
9 they didn't want to it mid.

10 But I do know that all these forms,
11 these legal forms that come with devices
12 like an IUD or other kinds of birth
13 contraceptives, they have all kinds of
14 indications and contraindications, and
15 those are meant to be guidelines intended
16 to protect the manufacturer of those
17 devices from being held liable.

18 Q. Do you use drugs in your patients which
19 are contraindicated?

20 A. There is a relative and absolute number
21 of cases and I'm balancing a situation
22 where I have to -- in a situation like
23 chemotherapy, that's no indicated in
24 pregnant patients but if I have a patient
25 who has a breast cancer, sometimes I have

1 to decide does she need to continue the
2 pregnancy or end the pregnancy, is she
3 going to get the chemo even though she's
4 pregnant. Those are decisions that -- it
5 is contraindicated, absolutely, but yet the
6 medicine is given in certain situations.

7 Q. Do you give medicine to your patients
8 that is absolutely contraindicated?

9 A. Okay, contraindication is that it
10 causes a potential serious danger.
11 Chemotherapy is absolutely contraindicated
12 in pregnancy, if you look at the
13 description of it in the Physician's Desk
14 Reference, in it's category, Category X.
15 But that doesn't mean that I wouldn't use
16 it or have a patient receive it if that was
17 the only way to save her life.

18 Q. Is it dangerous to use a medical device
19 or drug that is contraindicated?

20 A. If there is a risk involved with
21 anything, absolutely. In any certain
22 situation, I would want to weigh my risks
23 and my benefits. The American College of
24 Obstetricians & Gynecology does not say
25 that doing a mid-pelvic delivery with a

1 vacuum is contraindicated. Their technical
2 bulletin that we passed away, that you have
3 two copies of, says the same indications
4 for forceps and for vacuum.

5 Mid-pelvic deliveries, the reason that
6 I said why I don't do them, I don't do mid-
7 pelvic deliveries because I am a little bit
8 younger than Dr. Rhett and the way the
9 training has gone over the years, we're
10 less experienced with operative vaginal
11 delivery. So I -- even though I've
12 performed some mid-pelvic deliveries as a
13 resident, I don't do it as part of standard
14 practice now.

15 Q. Do you consider that dangerous to your
16 patients?

17 A. In my hands it would be but that
18 doesn't mean that if I were in a certain
19 situation where I were -- if I were pushed
20 up against the wall, that would be the only
21 way to -- or the safest way to deliver the
22 mom and the baby, but I wouldn't do it.

23 I understand the concept, I've done it
24 before but I wouldn't do it routinely
25 because I'm not comfortable with it because

1 I am not proficient with that kind of
2 delivery.

3 Q. What is your understanding of how much
4 experience that Dr. Rhett has in delivering
5 babies from the mid-pelvis?

6 A. My understanding is that, because he
7 trained in the day when people did that all
8 the time, that he is experienced. He's an
9 experienced obstetrician who has practiced
10 for decades, practiced with all forms of
11 obstetrical deliveries.

12 Q. What is your understanding of how many
13 times that he has delivered a baby with a
14 vacuum from the mid-pelvis?

15 A. I don't know that number.

16 Q. But you believe that he is well-
17 experienced at delivering babies from the
18 mid-pelvis?

19 A. I believe that he is well experienced
20 in delivering babies from the pelvis based
21 on the fact of when he trained. In the
22 early '70s and '80s, training obstetrics,
23 you did a lots of more invasion, if you
24 will, deliveries, higher deliveries.

25 We don't deliver babies bottom first

1 because there are concerns about that but,
2 yet, Dr. Rhett, I'm sure, has delivered
3 many, many breeched babies. That's been a
4 relatively new change in delivering babies,
5 where they've said at the American College
6 that 'we don't recommend it.' Now if the
7 baby falls out breech, do we catch it?
8 Yes, we do. But it's no longer seem as
9 acceptable except in certain rare
10 situations, such as with twins.

11 Q. I don't mean to belabor this point but
12 I wasn't clear on a word that you used.
13 Did I understand you to say that you
14 believe that Dr. Rhett is well-experienced
15 at using a vacuum to deliver babies from
16 the mid-pelvis, yes or no?

17 A. I don't know. I believe that he is
18 well experienced with mid-pelvic deliveries
19 because of the time that he trained. But I
20 don't work with him. The doctors that I
21 have talked with, or whose deposition I
22 have read, they all say that back in the
23 day they did more with vacuums and forceps
24 at higher stations.

25 Q. May we agreed that an obstetrician

1 should never needlessly endanger a baby?

2 A. No, I don't think she should endanger
3 anyone needlessly.

4 Q. You don't consider yourself as having
5 any special expertise on the subject of
6 brain damage in babies, do you?

7 A. Well, because I am a Board-certified
8 obstetrician-gynecologist, and I take care
9 of moms and babies all the time, I feel
10 that I have more medical expertise, more
11 special expertise, than a person who didn't
12 have that background.

13 Q. Ma'am, do you have a copy of your
14 deposition?

15 A. Not with me.

16 EDWARD GRAHAM: Your Honor, to
17 speed things up, may I just read it and
18 hand it to her?

19 THE COURT: You may if there is
20 no objection.

21 CROSS EXAMINATION CONTINUED

22 BY EDWARD GRAHAM:

23 Q. On Page 48, Line 20, (reading):

24 Q. And do you consider yourself
25 to have special expertise on the subject of

1 *the cause of brain damage in newborns?*

2 A. No, sir.

3 I hand you this (deposition trans-
4 cript), is that the true question and
5 answer?

6 A. (Upon review), I think it's out of
7 context because you'd asked me a number of
8 questions about expertise in moms and
9 babies with medicines and alcohol use,
10 abuse, and other things. So I believe in
11 other points that I gave the answer that
12 because I take care of moms and babies and
13 I make recommendations that I have certain
14 expertise, moreso than someone who doesn't
15 have a background. Absolutely. Yes,
16 specifically on that page -- (pause).

17 Q. Thank you.

18 A. -- but no, sir. Thank you.

19 Q. Do you agree that Jamsetta got pregnant
20 approximately in the middle of October
21 2001?

22 A. Yes.

23 Q. Dr. Norton, you have no evidence that
24 Jayden W. 's brain bleed was caused
25 by anything other than trauma to his blood

1 vessels from the use of the vacuum from Dr.
2 Rhett; correct?

3 A. No, that is not correct.

4 Q. I am going to direct your attention to
5 Page 109 of your deposition, starting at
6 Line 3, (reading):

7 Q. Do you have any evidence that
8 Jayden W. 's brain bleed was caused
9 by anything other than trauma to his blood
10 vessels from the use of the vacuum by Dr.
11 Rhett?

12 A. No.

13 Is that what your testimony was at your
14 deposition? Did I read that accurately?

15 A. Yes, sir, you read it accurately but
16 again it's out of context where we talked
17 about -- this was a longer discussion where
18 I said that because of this ACOG article,
19 this article from The New England Journal
20 that we share, we see that babies can bleed
21 no matter how they are delivered. This was
22 a situation where this baby needed to be
23 delivered regardless and there's -- there's
24 going to be some babies that are going to
25 have brain bleeds regardless of how they

1 are delivered. There is increased
2 association with brain bleeds with
3 operative deliveries, vaginal or Caesarean
4 section and that can be an association and
5 not a cause.

6 Q. But that was an accurate reading of the
7 question and answer in ---

8 A. It was.

9 EDWARD GRAHAM: No further
10 questions, Your Honor.

11 THE COURT: Is there redirect?

12 CHILTON SIMMONS: Your Honor, just
13 a very quick response.

14 REDIRECT EXAMINATION

15 BY CHILTON SIMMONS:

16 Q. First of all, Dr. Norton, what do all
17 the questions that Mr. Graham asked your
18 about a mid-pelvic vacuum delivery have to
19 do with this case?

20 A. I don't know because this case -- what
21 I saw in the video, how quickly the baby
22 was delivered, this was a low delivery.
23 This was not a mid delivery, it was not
24 high up in the pelvis. This was within a
25 few centimeters of being delivered.

1 Q. Mr. Graham asked you some questions
2 from your deposition briefly, on Page 107,
3 Line 20. His question was -- first of all,
4 do you remember how long the deposition was
5 that Mr. Graham took of you?

6 A. We had two of them. I think the first
7 one was over four hours and the second one
8 was maybe over three. Several hours.

9 Q. Two depositions?

10 A. (Affirmative nod), two depositions.
11 That's correct.

12 Q. Page 107, Line 20:

13 Q. Well, what are you saying -
14 where -- what is the evidence in this case
15 of Jayden W. --'s hemorrhage being
16 caused by something other than trauma to
17 his blood vessels in his brain and the
18 vacuum used by Dr. Rhett?

19 Page 108, your answer was:

20 A. If I can go back to the
21 original question.

22 Mr. Graham repeated the question, then
23 your answer:

24 A. You said, did I have evidence
25 of anything -- that that was the only thing

1 that you know caused it. I said that yes,
2 I have evidence that that was -- that there
3 could be other things that could have
4 caused it. That there could have been
5 other things that could have caused it.

6 Was that your answer?

7 A. Yes, it was.

8 Q. The next question was, (reading):

9 Q. Okay.

10 A. And I did not have evidence
11 that this was the only thing that caused
12 the hemorrhage.

13 Is that consistent with your testimony?

14 A. Yes, it is.

15 Q. Did you see any evidence that the
16 vacuum did cause the hemorrhage?

17 A. No, I don't.

18 CHILTON SIMMONS: Thank you. I
19 have no further questions.

20 THE COURT: All right, then
21 ma'am you are free to step down and free to
22 leave if you wish. Have a good day.

23 (WITNESS STEPS DOWN)

24 THE COURT: Counsel, step up and
25 let's talk about scheduling a little bit.

1 (OFF RECORD BENCH CONFERENCE)

2 THE COURT: We will not stop for
3 the day. Let's be back at 9:00 tomorrow
4 morning. Have a nice evening, enjoy your
5 evening. We will all remain where we are
6 as you leave the courtroom. We will see
7 you tomorrow morning at 9:00 o'clock. Have
8 a nice evening.

9 JUROR: Will we be leaving around
10 3:00 tomorrow?

11 THE COURT: Yes, as we did last
12 week. Thank you for reminding me of that.
13 Have a good day.

14 (JURY OUT @ 5:10 P.M.)

15 THE COURT: Jury is clear. We
16 had some evidentiary issues to take up. Is
17 there anything further that counsel wishes
18 to do at this time, or Motions at this time
19 or anything that may have arisen in the
20 evidence today that we didn't take up
21 contemporaneously? Hearing none.

22 Mr. Hood, at the end of Dr.
23 Milunsky, you sought to put in the two
24 charts that you used that have
25 abnormalities.

1 ROBERT HOOD: I did.

2 THE COURT: And you first sought
3 to put in the blowup and the court
4 suggested that a page size would be better.
5 Let's hear your response on the 8.5x11.

6 EDWARD GRAHAM: We object, Your
7 Honor. It's demonstrative evidence. We
8 hadn't dreamed that we were going to mark
9 demonstrative evidence as court's exhibits.
10 If they are going to start putting them in,
11 we want to do the same thing -- but that
12 would just clutter the record.

13 THE COURT: I am going to --
14 this is cumulative. This is different in
15 that this was not a medical record or
16 something that was prepared or taken from
17 the evidence compiled at the time but has
18 been created really as a demonstrative
19 exhibit. I am going to return that and
20 sustain the objection to it.

21 If you want to mark this first
22 exhibit, you're welcome to.

23 ROBERT HOOD: Thank you, Your
24 Honor.

25 THE COURT: Very good.

1 JAY DAVIS: Your Honor, if I
2 could just add one thing to the record. It
3 would be proper under Rule 1006 to admit it
4 as evidence.

5 THE COURT: All right, let's
6 look at 1006.

7 MOLLY CRAIG: It would be
8 similar to medical bill summaries, which
9 are put in evidence frequently.

10 THE COURT: What do you say
11 about that, Mr. Graham?

12 EDWARD GRAHAM: Your Honor,
13 medical bills are evidence. Medical bills
14 are not demonstrative lists through an
15 expert of things that he cherry-picked.

16 THE COURT: I am going to leave
17 that in. You may mark it as you wish -- if
18 you want to make it a court's exhibit, I
19 will do that.

20 ROBERT HOOD: Yes.

21 THE COURT: Very good, let's
22 do that. What number are we up to now?

23 COURT REPORTER: Number 37.

24 (SO ENTERED AS COURT'S EXHIBIT 37)

25 THE COURT: Now, are there any

1 other -- seems to me that there were some
2 larger exhibits that perhaps there was some
3 objection to. If so, I will be happy to
4 take them up now before we end today.

5 ROBERT HOOD: There was the
6 animation.

7 THE COURT: The animation, yes.
8 What say you to the animation?

9 EDWARD GRAHAM: We object, Your
10 Honor. Again, it's demonstrative evidence.
11 If theirs goes in, we would like ours to go
12 in, the bleeding in the brain. Maybe we
13 should just let them both go in.

14 THE COURT: Do you want to talk
15 about that?

16 ROBERT HOOD: I think that
17 theirs was extremely prejudicial because
18 the witness didn't have any expertise about
19 delivering as a vacuum ---

20 THE COURT: I'll treat them the
21 same, Counsel. I'm going to let that be
22 demonstrative evidence as well and deny the
23 animation coming in as purely evidence.
24 Anything else?

25 ROBERT HOOD: We used a lot of

1 blowups which I believe are a matter of
2 record, but I would like to put the blowups
3 in evidence.

4 THE COURT: What do you say to
5 that?

6 EDWARD GRAHAM: Same objection,
7 Your Honor. We've got a lot of blowups,
8 too, and we agreed they would be
9 demonstrative. If his go in, ours go in.

10 THE COURT: I have not generally
11 allowed the blowups. If there are some
12 that are specifically marked by a witness,
13 I am going to let counsel discuss that
14 overnight, among yourselves, and we can
15 take a look at that again tomorrow morning
16 if we need to. If you reach an agreement,
17 of course that would resolve it. If you
18 can't, then we will take another look at it
19 in the morning.

20 Generally a blowup I will not
21 allow because, first of all, it's larger
22 than all the rest of the evidence and that
23 gives it greater weight than others.

24 In any event, that's the court's
25 ruling at this point. Now, will there be

1 anything in the morning that you're aware
2 of that I need to take up -- such as the
3 designation issues in the next deposition.

4 MOLLY CRAIG: I just talked to
5 Chilton and since we just received them,
6 Chilton is going to get with Mary tonight
7 and see if they can resolve -- see if we
8 can pare things down. There is no need to
9 read all that in.

10 THE COURT: I will be here a few
11 minutes earlier. I didn't have the courage
12 to tell the jury that the next witness was
13 by publication of a deposition. We will be
14 in recess until 9:00 o'clock, staff will be
15 here at 8:45.

16 (COURT IN RECESS @ 5:20 P.M.)

17 (TRANSCRIPT CONTINUED NEXT PAGE)

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1 we could take it up on break if you prefer.

2 THE COURT: Since we are a
3 little bit late, let's take it up on break.
4 Will our first witness take us to a break?

5 CHILTON SIMMONS: We have two
6 witnesses ready to go.

7 THE COURT: Let's take it up on
8 break. If you can, give me a written copy
9 of the deposition. That would be helpful,
10 let me review it while you're offering
11 testimony.

12 CHILTON SIMMONS: (Tendering).

13 THE COURT: Please bring in the
14 jury.

15 (JURY IN @ 9:10 A.M.)

16 THE COURT: Good morning, Ladies
17 and Gentlemen. Welcome back to the
18 courtroom. I trust that you had a nice
19 evening. Let me ask, since we were last
20 together has anyone -- is there any member
21 of the jury panel who has had a discussion
22 about the facts of this case with anyone?
23 If so, please raise your hand. (No
24 response). Please let the record reflect
25 that no one has raised their hand.

1 You will recall that we are in the
2 defense's case. Please call your next
3 witness.

4 ROBERT HOOD: Thank you very
5 much, Your Honor, we call Dr. Van Dorsten.

6 (WITNESS TAKES STAND)

7 PETER VAN DORSTEN, being duly
8 sworn to tell the truth, the whole truth
9 and nothing but the truth, testified, as
10 follows:

11 DIRECT EXAMINATION

12 BY ROBERT HOOD:

13 Q. You are the Chairman Ob-Gyn at the
14 Medical University of South Carolina; is
15 that right?

16 A. I am.

17 Q. Doctor, I want to introduce you to the
18 jury. You live here in Charleston?

19 A. I live on Johns Island.

20 Q. That's part of Charleston.

21 A. Yes, sir.

22 Q. You went to college where?

23 A. I went to Davidson College in Davidson,
24 North Carolina.

25 Q. And then to medical school where?

1 A. University of North Carolina, Chapel
2 Hill.

3 Q. Then trained where?

4 A. Came to Charleston in 1971, did a year
5 of Internal Medicine, then four years of
6 Obstetrics & Gynecology.

7 Q. How long have you been at the Medical
8 University, Doctor?

9 A. I was there almost thirty years, I was
10 there five years in the 1970s, six years in
11 the 1980s, and have been back since 1992.

12 Q. And what is your title at the Medical
13 University?

14 A. I am a tenured professor and Chair.

15 Q. Are you Board-certified in any field of
16 medicine?

17 A. Yes. I am Board-certified in general
18 Obstetrics & Gynecology, with a
19 subspecialty in Maternal Fetal Medicine.

20 Q. Have you received over your career any
21 awards or honors?

22 A. I have.

23 Q. I see a few pages here with your CV.
24 How about -- are you listed in the Best
25 Doctors in America?

1 A. Yes, that's a publication that -- about
2 twenty years old and I've been listed there
3 ever since.

4 Q. Were you given an award by your
5 students, called the Golden Apple Award for
6 being the best teacher?

7 A. Yes.

8 Q. Congratulations. Have you been listed
9 in the Top Doctors of America?

10 A. Yes, sir.

11 Q. Listed in the American Top Ob-Gyn ---

12 A. Yes, sir.

13 Q. Have been chairman of the steering
14 committee for maternal fetal medicine?

15 A. Yes, I've done that at NIH --

16 (inaudible recording).

17 Q. Doctor, have you had special appoint-
18 ments such as being a reviewer of medical
19 journals?

20 A. Yes, I've been a reviewer on a lot of
21 medical journals, lots of obstetrics
22 journals.

23 Q. Any organizations or societies that
24 you're a member of?

25 A. Yes.

1 Q. Are all of these listed on these two
2 pages national or international
3 organizations that deal with your
4 specialty, Ob-Gyn?

5 A. With the specialty and the subspecialty
6 of Fetal Maternal Medicine.

7 Q. Have you done public service here in
8 Charleston?

9 A. I have. I've been a Scout master for
10 fifteen years or so.

11 Q. Various civic clubs?

12 A. Yes.

13 Q. How many hundreds of publications have
14 you contributed to in the literature,
15 Doctor?

16 A. Well over a hundred.

17 Q. And if somebody wants to become board-
18 certified in Ob-Gyn, is there a test?

19 A. After we finish our residency, we take
20 a written examination. The pass rate is
21 around eighty-five percent for that. Then
22 two and a half years later, based on cases
23 during your first years of practice, you
24 take an oral exam where six different
25 examiners certify that you're qualified to

1 be certified in fetal maternal medicine and
2 in obstetrics as well.

3 Q. Are you one of those examiners that
4 test doctors?

5 A. I am an examiner since 1985 for general
6 boards and subspecialties.

7 Q. Have you been on programs, as Chairman
8 of programs, for ACOG?

9 A. I have. I've been -- and there are a
10 lot of publications that ACOG provides,
11 you've seen some of them, and I was on the
12 committee, have sat on various committees
13 that have published those. I was on the
14 technical bulletin committee, different
15 committees -- (inaudible recording).

16 Q. And have you been president of several
17 societies?

18 A. I have. I was president of the South
19 Carolina society, I was -- (inaudible
20 recording) -- and last year I was president
21 of the American Pathology Society
22 (phonetic).

23 Q. And all of this are invitational
24 societies, you don't just send them ten
25 dollars and you're a member?

1 A. You have to -- there are screening
2 committees to determine whether you're a
3 member.

4 ROBERT HOOD: Your Honor, I
5 would ask that the court recognize Dr. Van
6 Dorsten as an expert in obstetrics and
7 gynecology.

8 THE COURT: Are there questions
9 or objection?

10 EDWARD GRAHAM: No, sir.

11 THE COURT: Hearing none, then
12 it is so ordered. You may proceed,
13 Counsel.

14 ROBERT HOOD: Thank you, Your
15 Honor.

16 DIRECT EXAMINATION CONTINUED

17 BY ROBERT HOOD:

18 Q. Dr. Van Dorsten, I've asked the court
19 to recognize you in your field as an expert
20 in your field of medicine.

21 You know, we had a discussion here, I
22 guess that it has been six or seven days
23 ago, about a word called "reliable". Can
24 you expect to the jury what we mean when we
25 say that this book on obstetrics is a

1 reliable textbook.

2 A. It is not reliable in the sense that
3 the court uses -- they are generated by
4 people like me who look at the available
5 literature and grade the evidence and try
6 to make evaluations to help other
7 practitioners.

8 You can imagine that the literature
9 that we are using is already somewhat out
10 of date; before it is published, it is even
11 further out of date.

12 So textbooks are more of guideline than
13 they are absolute references.

14 We do because things change over time,
15 there's more evidence and better evidence
16 and things improve, evolution.

17 Q. Do they tell us what the standard of
18 care is?

19 A. No, they never tell that.

20 Q. We have heard some things in this case
21 also about package inserts that go with a
22 vacuum extractor from a manufacturer?

23 A. I am not aware of that.

24 Q. Sir?

25 A. I didn't know vacuums had package

1 inserts. It's like the medications that we
2 use, they all have package inserts but very
3 seldom do you look at them. We've so
4 familiar with this devices or these drugs
5 that we don't have to read the package
6 inserts. There are clearly well adhered
7 standards for using vacuums, but I don't
8 review the package insert before I use a
9 vacuum. There may be some exposure to
10 those in training but once you attain those
11 goals they are in constant practice.

12 Q. We've got three pieces of paper here
13 that we've heard a lot about, days of
14 testimony. One is the package insert,
15 Exhibit 73.

16 Are you aware of this ACOG bulletin,
17 Exhibit 31?

18 A. I've been on this committee and --
19 people sit around a table and we weigh the
20 various evidence and ultimately we come out
21 with these kinds of guidelines. They are
22 updated periodically as they get older or
23 as newer and better information becomes
24 available. Again, they are guidelines.
25 They certainly are not a mandate.

1 Q. We've heard about the FDA, Federal
2 whatever it is. What does FDA stand for?

3 A. Food & Drug.

4 Q. Food & Drug Administration. Exhibit
5 28.

6 A. Yes, sir.

7 Q. Again, does the FDA send out ---

8 A. Well, again, this was in 1998. It was
9 published because they were aware of
10 problems related to vacuum, so this --
11 (inaudible due to ELMO fan) -- much in the
12 national news, suggesting that these
13 devices were not totally -- so if you take
14 vacuums away, we wouldn't have anything
15 left but spontaneous vaginal delivery and
16 C-section, which the rate is already
17 approaching thirty percent. So these are
18 reminders to physicians that you need to be
19 mindful of technique and indications before
20 using forceps or vacuums. The American
21 College of Obstetricians & Gynecology
22 responded to, again, reinforce the fact
23 that, yes, these things are not without
24 some risk. But never was there a
25 suggestion that they be laid aside.

1 Q. Does the FDA establish a standard of
2 care for doctors who deliver babies?

3 A. Of course not.

4 Q. They do not?

5 A. (No verbal response).

6 Q. Does the FDA require that the delivery
7 of this child, uh, that something should
8 have been filed with the FDA about this
9 child's delivery?

10 A. No. What the FDA could do is to take
11 the instrument off the market, which they
12 have not done.

13 Q. The vacuum extractor that is right
14 there in front of you, let's -- we'll talk
15 about that a few minutes.

16 Doctor, Dr. Rhett testified, when
17 asked, are there any risks to the baby from
18 the use of a vacuum extractor -- Dr. Rhett
19 said, "The baby can get small subcutaneous
20 bruise, the baby could get an intracranial
21 bleed, but there's some question as to
22 whether that's from the vacuum or from the
23 vaginal delivery." Is that a doctor that
24 understand that you can have a hemorrhage,
25 have a complication?

1 A. Basically.

2 EDWARD GRAHAM: Objection.

3 THE COURT: Please rephrase.

4 DIRECT EXAMINATION CONTINUED

5 BY ROBERT HOOD:

6 Q. What does that tell you about Dr.
7 Rhett?

8 A. Tells me that he is aware of the
9 contraindications of a vacuum.

10 Q. Any doubt in your mind about that?

11 A. No.

12 Q. How about Dr. Rhett himself, have you
13 worked with him before? Referred patients
14 to him back and forth?

15 A. When I came back to Charleston in 1981,
16 Dr. Rhett was already practicing, had been
17 in Charleston since '77, and since that
18 time he has referred patients to me over
19 the years. In the last five years or so,
20 he doesn't practice obstetrics anymore but
21 before that we regularly got consultants
22 and referrals from Dr. Rhett. I respected
23 him then, as I do now.

24 Q. As far as you are concerned, he is a
25 good doctor?

1 A. He's a wonderful, respected physician.

2 Q. In this case, have you reviewed, at our
3 request, the medical records of the mother
4 and the child?

5 A. I have.

6 Q. And as an obstetrician, when you look
7 at the fetal monitoring strips records, do
8 you see things that are important?

9 A. I do. Routinely I did in this case.

10 ROBERT HOOD: Can we cut this
11 (ELMO fan) off? Does anybody know how to
12 cut it off. I can't hear the doctor.

13 THE COURT: Mr. Brown, step out
14 and see if you can bring Tara in.

15 Direct EXAMINATION CONTINUED

16 BY ROBERT HOOD:

17 Q. I will move to something else and then
18 come back once we get the noise cut off.
19 This thing makes noise -- okay, let's see
20 what we can talk about. Have you seen the
21 birth video?

22 A. I have.

23 Q. Was the vacuum placed at mid station?

24 A. It was not.

25 THE COURT: Counsel, that is

1 leading. Rephrase, 'where was the vacuum
2 placed?'

3 ROBERT HOOD: Yes, sir.

4 DIRECT EXAMINATION CONTINUED

5 BY ROBERT HOOD:

6 Q. Where was the vacuum placed?

7 A. In my estimation it was a low vacuum.
8 I am sure that you have looked at the --
9 can I show the jury on the pelvis.

10 Q. That would be great. We've got the
11 birth video and we could play it but we
12 need someone to come work on this (ELMO).

13 A. I can show it on the pelvis.

14 Q. That would be great.

15 A. The head enters the pelvis in this
16 space because it is the widest orientation
17 of the pelvis and the widest dimension of
18 the fetus, so this is side to side.

19 It sort of compresses so that it can
20 get into a more narrow birth canal.

21 These are the so-called ischial spines.

22 What we call the zero station is the
23 lowest part where the baby, where his head
24 gets. We call that the zero station.

25 For the purpose of this trial, we're

1 concerned about where his head was when the
2 vacuum was actually applied.

3 If when we are talking about applying
4 it around the ischial spines, we call that
5 the station. In general, we don't do that
6 anymore. It would be a longer pull,
7 generally an hour or two to get to that
8 point where you can actually see the head.

9 As the head starts to descend through
10 the birth canal, below the ischial spines,
11 we call that a plus station in centimeters.

12 So zero, you can see the head when you
13 separate the labia and we call that plus
14 five.

15 In my estimation this vacuum was
16 applied somewhere around plus four, which
17 is what we call a low vacuum.

18 We call it the outlet when you can
19 actually see the head without separating
20 the labia. You can see the head at that
21 point.

22 You can tell where Dr. Rhett took off
23 the scalp electrode when the baby was just
24 inside the introitus. The delivery that I
25 saw indicated that the baby's head was at a

1 low station. (Inaudible) -- and to be
2 honest, physicians don't do that anymore.
3 We have other ways to do deliveries -- like
4 C-section. In my estimation it wasn't done
5 in this case.

6 Q. Doctor, what is important to you that
7 you saw from the birth video about the
8 placement of the vacuum, about station of
9 the baby, etc.

10 A. It is important to know where the
11 vacuum is applied because the higher you
12 are up in the birth canal, the greater the
13 potential for injury. So it is important
14 to be able to know -- and I know that there
15 are others that disagree, but I think it's
16 very clear it was an outlet delivery and
17 that the vacuum was appropriate.

18 Q. With regard to the vacuum, was there
19 anything that you observed on the birth
20 video unfortold about the use of the
21 vacuum?

22 A. (No verbal response).

23 Q. Improper about the use of the vacuum?

24 A. Once it's applied -- there's a special
25 place where we apply the vacuum to the

1 fetal head such that when you pull it makes
2 the head tug and decreases the dimensions
3 of the head, makes it a better fit. It was
4 properly applied.

5 From that point on, they pumped up the
6 vacuum and you see the green zone, about
7 six hundred millimeters of mercury, and
8 this is standard on every -- the nurse in
9 this case was keeping it in the green zone,
10 it wasn't past twelve o'clock.

11 From that point on, it's a matter of
12 technique. There are things that you
13 should do with vacuums, there are things
14 that you should do before when you are
15 getting ready. I mean, you need some
16 indication for the vacuum; you need to make
17 sure that there isn't maternal soft tissue
18 before you start pumping it up; you make
19 sure that it is properly placed at the
20 right station in the right position, etc.

21 Then when you're actually doing the
22 delivery, you have to mimic the birth canal
23 -- it first goes down, then back up. You
24 don't want to rock it from side to side,
25 you want to rock up and down. When you

1 pull too hard, it pops off. A pop off is
2 likely to be more injurious than if you
3 don't pop off. If you start pulling at the
4 wrong angle, you know at the edge -- it is
5 like a tire, if it starts pulling loose
6 then at any point it could break off. It
7 is designed like that to ensure safety. If
8 you start pulling too hard or start pulling
9 in the wrong direction, they pop off. As
10 you saw in the video, there were not any
11 pop-offs in this particular case.

12 It was about three minutes of vacuum
13 application. That's a standard vacuum
14 delivery.

15 I thought Dr. Rhett was very cool
16 during the delivery. You could see his
17 demeanor change as the heart rate
18 deteriorated. He had his game face on at
19 the time. Earlier on there was a lot of
20 joviality and at that particular time you
21 could see his demeanor change as things got
22 more serious, which is likely after a
23 twenty-four hour labor.

24 Q. We have a still picture from the birth
25 video that is in evidence. Could you come

1 down and tell us ---

2 A. (Complies).

3 Q. This gauge and I'll hold this.

4 A. Basically as long as you keep it within

5 the green zone you haven't gone past six

6 hundred millimeters, which is where --

7 that's the zone you want to keep it within.

8 You can see that the needle here didn't go

9 beyond twelve o'clock, so it was within the

10 range.

11 (Inaudible due to ELMO fan) -- you can

12 see that as long as you are pulling

13 correctly that at first the head moves

14 down, like so, and then as he gets further

15 into the birth canal the last part is an

16 upward move. If you were to start torquing

17 it, it would create superficial injury to

18 the baby's head, so you don't do that.

19 Q. This picture is not that great. It's a

20 still picture that shows the gauge. I want

21 you to mark where you see the gauge.

22 A. (Complies).

23 Q. Twelve o'clock, in the green zone.

24 A. Right.

25 Q. That black line there, what is that?

1 A. That's the needle, twelve o'clock.

2 Q. Is there anything that concerns you
3 about that?

4 A. No.

5 ROBERT HOOD: May I publish
6 this to the jury, Your Honor?

7 THE COURT: You may.

8 DIRECT EXAMINATION CONTINUED

9 BY ROBERT HOOD:

10 Q. Now, this gadget is used by a nurse; is
11 that correct?

12 A. It is.

13 Q. As you looked at the birth video and as
14 you demonstrated the proper use of this
15 vacuum, please tell the jury whether or not
16 as you look at the birth video of this
17 delivery whether or not that is how the
18 vacuum was used, as you described it?

19 A. Yes.

20 Q. Did he rock it?

21 A. I never saw rocking in the video.

22 Q. Did he twist it?

23 A. I did not see that.

24 Q. Was there anything done that you
25 observed that would cause a rip and tearing

1 of the brain or of the blood vessels in the
2 brain?

3 A. Vacuums are associated with that but
4 there was nothing extraordinary about this
5 particular vacuum delivery that would
6 suggest that risk.

7 Q. Now let's talk about why the vacuum.
8 Let's look at this child's fetal monitoring
9 strips. There is a monitor inside the --
10 on the head of the child, is that correct?

11 A. Yes. One is where the scalp electrode
12 is actually -- it's a millimeter deep
13 spiral that actually attaches superficially
14 and the monitor read an EKG basically of
15 the baby, an electrocardiogram. Later,
16 after Dr. Rhett took it off the monitor --
17 they monitored the heart rate externally by
18 microphone on the abdomen. Most of the
19 tracing is done by the scalp electrode.

20 Q. Okay. So show yo -- Doctor, however
21 you are comfortable explaining it, starting
22 at 6:15 in the evening, the individual
23 tapes.

24 A. The tracings had been relatively normal
25 up to this point. She starts -- it looks

1 like she is actually pushing a little bit
2 here. You learn later that there was a
3 cord around the baby's neck.

4 These kinds of decelerations that we
5 see here, here and here, these are what we
6 call variable decelerations. They -- you
7 squeeze the baby's cord, it raises the
8 blood pressure of the baby and causes the
9 fetal heart rate to decelerate. It's a
10 reflex that baby's do. These are variable
11 decelerations suggesting that is going on.
12 They are seen late in labor, they are seen
13 more commonly when babies have a cord
14 around their neck. These are variables.

15 The tracings heretofore had been, in my
16 estimation, normal. By "normal", we mean
17 the rate was normal, the variability was
18 normal, there weren't any of these
19 decelerations going down. I thought the
20 tracing was normal and, therefore, the
21 fetus had normal oxygenation, normal base
22 status, frankly was healthy at that
23 particular time as best we can tell.

24 This is a little later, at 6:23. This
25 rate is pretty much back to what it was.

1 When we look at the heart rate, we look at
2 both the timing of the contractions and
3 inbetween -- called inbetween the baseline.
4 You can see that there is that "chatter"
5 that I was talking about, that variability.
6 This is normal variability in my estimation
7 in the decelerations that result.

8 Again looking a little later, at 6:30,

9 ---

10 Q. Is fetal monitoring strips and so forth
11 something that you're Board-certified in
12 and teach?

13 A. Yes. I trained at the Kelley Southern
14 California University program which is one
15 of the first places that fetal monitoring
16 was used, that's when I was first in
17 training and I feel very comfortable with
18 fetal monitoring.

19 A little later on, how we interpret
20 this is as normal. We don't see those
21 decelerations. We see the baseline heart
22 rate is normal at about 150 and you can see
23 that chatter in the baseline that we call
24 variability is normal.

25 This is about -- about a quarter of

1 7:00, you can see that there is variability
2 decelerations, quickly down, jagged,
3 they're back again, it's not surprising
4 that they are back. We don't know that
5 there is this cord around the neck but it
6 starts to worry an obstetrician because all
7 of a sudden the cord is being squeezed and
8 the baby could potentially suffer damage.

9 Q. Let me interrupt you, Doctor.

10 A. Go ahead.

11 Q. The testimony was that this cord was
12 loose around the neck. What's getting
13 squeezed?

14 A. The cord is being squeezed somewhere,
15 whether it is around the neck, whether it's
16 a kink. Remember, the waters that protect
17 a baby are not gone because they were
18 ruptured earlier that morning and so the
19 cushion that the baby normally enjoys is
20 gone. So you've got a fetus that is like
21 so (indicating), the umbilical cord is
22 about that long (indicating), you can
23 imagine that every time that there is a
24 contraction or that every time that she
25 pushes this is getting pinched. Whether it

1 at the neck or somewhere else doesn't
2 really matter. The potential ill effect
3 for the baby is -- we can see the
4 deceleration here at 1843, another one
5 later at 1848. Remember, the baseline
6 heart rate has been around one fifty, and
7 we're down to about a hundred. It takes it
8 a while to ---

9 Q. Stop right there, Doctor. In laymen's
10 language, right there where we have
11 something abnormal. Put an hour to it and
12 say what it is.

13 A. These are variable decelerations.

14 Q. Put it back on the screen just for a
15 second so that he can see it. This is at
16 6:47, ---

17 A. And the second one becomes what we call
18 a prolonged deceleration, some use ninety
19 seconds, some use two minutes. These are
20 minute signs in here, so you can see that
21 this deceleration wasn't a quick back like
22 we'd had here: quick down, quick back.
23 This one is down and prolonged. You can
24 see that it is not until the next tracing
25 that we get headed back to normal. We are

1 not back to normal until right here at
2 1855. So that was a prolonged
3 deceleration. You can see it kind of
4 working it's way back to where we were
5 before, which was around a hundred fifty.
6 We are back to a hundred fifty by the time
7 that we get here.

8 Q. We're talking about the fetal heart
9 rate, is that correct?

10 A. We are. This tracing -- this is the
11 next. You can see back to the one fifty,
12 and it's a pretty normal tracing.

13 To me, on this next tracing the
14 variability of that baseline chatter is
15 starting to be reduced. Anytime that it is
16 five or less, we call that kind of minimal
17 variability. To me the chatter is less
18 than I was seeing an hour earlier.

19 I would make the same commentary in
20 this 1920. You don't see the variability,
21 small variable here but really
22 inconsequential, certainly not prolonged,
23 based on the heart beat being around a
24 hundred fifty.

25 It is not until 1722, along in here,

1 that we get another variable deceleration.

2 Q. You mean 1922?

3 A. Sorry, 1922, 1923. You'll see that the
4 heart rate never gets back to normal. We
5 don't get back to that -- it's always an
6 exaggerated variability, all along the way.
7 This is problematic tracing for me.

8 Q. What does problematic to you mean?

9 A. Well, it potentially could be
10 unjurious. Babies breathe by virtue of the
11 cord. Right? Well, when the heart rate is
12 down like this and kinked, the baby may not
13 be circulating oxygen in or getting rid of
14 carbon dioxide out. So this potentially
15 can cause acidosis in the fetus,
16 potentially can be injurious.

17 Here at 1928-29, you see that we never
18 got back to the baseline, we never got back
19 to that one fifty and here comes around
20 one. This one goes down to ninety. You
21 can see down in here (indicating). It
22 stays down there for a substantial period
23 of time.

24 Q. So it is now 7:35?

25 A. (Affirmative nod).

1 Q. What are we looking at on this picture
2 here, Doctor?

3 A. This is a -- you've heard the term
4 bradycardia. I've seen it in various
5 depositions. By strict definition a
6 bradycardia goes on for ten minutes. I
7 wouldn't say that this ever does that.
8 But there are prolonged decelerations
9 where the cord is being kinked for extended
10 period of time, the baby is not getting
11 sufficient or not getting enough oxygen,
12 not putting off enough CO2, becoming
13 acidotic and being potentially damaged.

14 And this -- again, you'll notice that
15 we never get back to that normal baseline
16 that we had before. There's always this
17 jaggedness with ---

18 Q. Label that for us, Doctor, as to what
19 it is.

20 A. (Complies), and there's another
21 variable here.

22 Q. What do you mean when you say variable?

23 A. Variable deceleration. The baby never
24 recovers from that last variable
25 deceleration, he never came back to that

1 normal one fifty, normal baseline.

2 Q. Then the last two?

3 A. You can see that he never gets back to
4 that normal baseline, one fifty, so ---

5 Q. Did I switch these?

6 A. This is the earlier part.

7 Q. You've got the earlier, I've got the
8 latter.

9 A. This is the later one. You can see
10 that he never gets back to any sense of
11 normal, so the determination was made that
12 the baby would be better out than in and
13 the vacuum was applied. You can see that
14 he was delivered within three minutes,
15 which would be -- from the time that the
16 vacuum on, the baby began to recover from
17 the deceleration that I was talking about
18 earlier.

19 Q. The heart rate does not recover, what
20 does that mean?

21 A. It means that -- there was a time
22 around 1240, if you will remember, from
23 when we were looking at the tracings early
24 that they've turned the Pitocin off for a
25 period of time -- that's what stimulates

1 contractions -- and the baby recovered,
2 because likely the contractions were too
3 hard for this baby at that time.

4 In this case, the acidosis didn't start
5 until about 1931, so when Dr. Rhett got
6 there and saw the tracings -- and back here
7 we wouldn't have the medication causing any
8 more squeeze, so that was turned off -- not
9 turned down but was turned off -- and he
10 applied the vacuum.

11 Q. If you were there, would you have
12 delivered the baby?

13 A. I would have.

14 Q. How?

15 A. I would have done a vacuum delivery, it
16 was at a low station.

17 Q. Why?

18 A. Because I would have been concerned
19 about the fetal heart beat.

20 Q. Was there an objection for this patient
21 to continue pushing?

22 A. It was an option but we've now been in
23 labor for a long time, her pushing was
24 ineffective, we see these prolonged
25 decelerations and the recovery that didn't

1 happen. We'd turned the Pitocin off, moved
2 the mother, applied oxygen, all back here
3 and it still hadn't fully gotten back to
4 where we were before, so to me with the
5 head at low station after a long labor,
6 rather than hoping that it gets back -- not
7 knowing but suspecting that the cord may be
8 kinked, it may make sense to roll the
9 patient over with the hope of undoing the
10 kink but -- it obviously made sense to turn
11 the Pitocin off so that it's not squeezing
12 any more. You ask the patient not to push
13 anymore, but -- and you can add oxygen but
14 if that doesn't work because the cord is
15 kinked, you can give it all the oxygen in
16 the world and it's still not getting to the
17 baby through a kinked cord. So in my
18 estimation, a better alternate is delivery
19 especially considering the low heart rate.
20 Q. As to delivery, why not do a C-section
21 for this patient?
22 A. A C-section would take preparation of
23 fifteen, twenty, thirty minutes and so --
24 if the fetus is already at a low station,
25 you suspect a kink where no oxygen is going

1 in you start getting into a very precarious
2 situation where delivery is required.

3 In my estimation this was an easy low
4 vacuum delivery, that was certainly the
5 better action.

6 There isn't a shred of evidence in the
7 literature that a C-section reduces the
8 risk of hemorrhage or damage. The risks is
9 slight more with labor than it was vacuum
10 delivery, so -- (pause).

11 Q. What about those forceps up there, were
12 they an option?

13 A. They were (snapping forceps). When I
14 was in residency, forceps were a choice.
15 In about the late '80s the literature
16 starts to encourage that these were
17 slightly more injurious than vacuum --
18 they're steel, (inaudible due to snapping
19 forceps by microphone). So a vacuum would
20 be less injurious to the mother and no more
21 injurious to the babies, these were laid
22 aside. The females never liked hearing
23 all the clanking of the steel, most
24 preferred the vacuum. The technique of
25 delivery is the same. You can imagine that

1 this things might do some maternal damage.

2 Q. This vacuum here, this particular one,
3 Exhibit 72, is there anything wrong with
4 it?

5 A. They come in a lot of flavors. The
6 original vacuums were a little disk, a
7 little metal disk and I used those type,
8 the metal cups, then the Silastic. They
9 have evolved, a lot of different sizes.
10 I have used this one. The one that I use
11 know was developed by an Australian. They
12 all do the same thing, put pressure on the
13 scalp to mimic the natural forces of labor
14 and help to guide the baby out. They work
15 better now than they did -- they cause some
16 injuries to the fetus' scalp itself, called
17 hematomas. The literature suggests that
18 intracranial hemorrhage, injuries like
19 Jayden W. had are less commonly
20 seen -- slightly common but not
21 significantly so. There is some subgaleal
22 injuries. It can cause blood loss, some
23 fossa injury, but rarely doesn't cause
24 neurological injury because it doesn't get
25 into the brain itself. I've seen subdural,

1 I've seen subgaleal.

2 Q. You've seen those other two, the two
3 subs?

4 A. Subgaleal and subdural.

5 Q. Do they cause permanent injury?

6 A. Not usually. Subgaleal, certainly not.
7 Subdural, rarely.

8 Q. And the other one, the fossa, what is
9 that?

10 A. The back of the head.

11 Q. The back of the head. Have you ever
12 experience that one, on the back of the
13 head?

14 A. Yes, sir.

15 Q. There is an issue in this case about
16 informed consent. This is the form that
17 was filled out and signed the mother prior
18 to delivery. It's in evidence. This the
19 standard form used by the hospital. What
20 are the first two paragraphs?

21 A. (Inaudible reading)

22 Q. Is there any requirement or does the
23 standard of care require any further
24 informed consent by the obstetrician? For
25 example, as in this case, if a vacuum is to

1 be used?

2 A. No, because -- you could probably have
3 them sign an oxygen form, or we could do a
4 C-section or the baby's head is low and
5 that would make it safe to do a vacuum
6 delivery. I would tell them that there
7 are some risks but I believe that the
8 benefits outweigh the risks. There may be
9 a form specifically for the vacuum itself.
10 I maybe would do that in some
11 circumstances.

12 I mentioned earlier that Dr. Rhett had
13 his game face on, we saw his demeanor
14 change there at that end.

15 We don't get into the ins and outs of
16 risk and benefits. We're concerned with
17 the safety of the patient as things
18 develop.

19 Q. So the fact that Dr. Rhett didn't stop
20 everything and go to the bedside to explain
21 to the mother that he was going ---

22 EDWARD GRAHAM: Objection,
23 leading.

24 THE COURT: That's correct,
25 Counsel. You're leading.

1 DIRECT EXAMINATION CONTINUED

2 BY ROBERT HOOD:

3 Q. If Dr. Rhett did not explain to the
4 mother that he was going to use a vacuum
5 and that it could have complications, did
6 he deviate from the standard of care in the
7 delivery of this child?

8 A. He did not. It would be ridiculous to
9 place blame on an experienced obstetrician
10 for a heart rate that went down for a
11 prolonged period of time.

12 Q. Thank you very much. When you say that
13 it would be ridiculous, explain that to the
14 jury.

15 A. To add moments to Ms. Washington, who
16 is in the throes of making a decision, when
17 you believe that the correct decision is to
18 do a low vacuum delivery, I think is
19 ridiculous. Meantime the clock is running
20 which may mean that the baby is developing
21 acidosis, and I think it would be losing
22 precious seconds in medicine.

23 Q. Dr. Van Dorsten, at the obstetrical
24 department of the Medical University of
25 South Carolina here in Charleston, how many

1 attending doctors work under you?

2 A. Thirty-five, six Fellows, twenty-one
3 residents and five midwives.

4 Q. Are you in charge of all of them?

5 A. I am.

6 Q. Do you currently deliver babies?

7 A. A couple of years ago I stopped
8 delivering babies. To cover the
9 administrative labor and delivery, which
10 I'd done for thirty years, means getting
11 there at 7:00 and leaving at 6:00 or 7:00
12 at night. I have a lot of administrative
13 duties and it just wasn't productive for me
14 to be away from my office for an entire
15 day. So a couple of years ago I quit
16 delivering babies.

17 Q. Over the years, roughly how many babies
18 have you delivered?

19 A. You know we -- Mr. Graham and I may
20 have gotten into some of these
21 machinations. I've delivered thousands of
22 babies, maybe as many as five thousand.

23 Q. How many residents, that is doctors who
24 want to become obstetricians when the
25 finish medical school, have you trained to

1 become Ob-Gyns in this state?

2 A. One fifty to two hundred.

3 Q. Doctor, I want to ask you about your
4 opinions in this case. Your opinions need
5 to be to a reasonable degree of medical
6 certainty most probably. You've reviewed
7 depositions and medical records. Correct?

8 A. Yes.

9 Q. Do you have an opinion as to whether or
10 not Dr. Edmund Rhett complied with the
11 proper standard of care in this delivery?

12 A. Yes, I believe that he did.

13 Q. Explain that opinion to this jury.

14 A. Well, after the long late delays and
15 the protracted labor -- labor should
16 progress at one centimeter an hour and this
17 labor was not progressing at that speed.
18 There was a patient who was tired and
19 exhausted.

20 There was a heart rate pattern that was
21 concerning.

22 The criteria for a safe vacuum delivery
23 was met. I believe that it was appropriate
24 to do a vacuum delivery. In my estimation
25 the application was -- the indication was

1 appropriate, the application was
2 appropriate and the technique of vacuum
3 delivery was appropriate. In all instances
4 he met the standard of care.

5 Q. Have you read Dr. Rhett's deposition?

6 A. I did.

7 Q. Is there anything in his deposition
8 that changes that opinion?

9 A. There isn't.

10 Q. Did you compare what he said in the
11 deposition with the birth video?

12 A. I did.

13 Q. And what did you learn from the birth
14 video?

15 A. Basically that's where we get our
16 information in terms of application and
17 technique. I think the baby was at a low
18 station and I believe that his technique
19 was appropriate.

20 Q. Is that your opinion to a medical
21 degree of certainty, most probably?

22 A. It is.

23 Q. Why is it significance to an
24 obstetrician that this mother did not get
25 prenatal care until sixteen weeks of

1 pregnancy?

2 EDWARD GRAHAM: Objection, Your
3 Honor.

4 THE COURT: The question is, is
5 it significant?

6 DIRECT EXAMINATION CONTINUED

7 BY ROBERT HOOD:

8 Q. Is it significant?

9 A. Prenatal care is beneficial because
10 there are windows of opportunity that do
11 not get met if you see a patient linger
12 during the early days of pregnancy.

13 It's no longer just an issue of due
14 date but it is reassuring to know that the
15 dates are accurate. When we start dating
16 patient with later ultrasounds, the
17 accuracy diminishes.

18 There are lab tests when done early
19 that can diagnose anemia, we learn about
20 sickle cell disease, we learn about
21 infectious diseases that need treating like
22 gonorrhea, chlamydia trachomatis, sphyllis,
23 herpes.

24 We learn about blood types and whether
25 patients are at-risk for any issue related

1 to Rh.

2 So there are a lot of things -- there
3 are windows of opportunities that are
4 missed when the information comes later.

5 Patients that come later typically have
6 poor outcomes than those who come earlier.

7 That has to do also with socioeconomic
8 standards, people of lower socioeconomic
9 standards versus people of higher socio-
10 economic standards.

11 Q. Doctor, in this labor and delivery,
12 with twenty-four hours of labor, what is
13 the significance of that?

14 A. Well, obviously the mother becomes
15 fatigued.

16 The membranes were ruptured about 7:30
17 or 7:40 that morning. The membranes not
18 only cushion the baby but they are also the
19 barrier to keep infection from going -- any
20 bacteria from going into the vagina where
21 they normally reside up into the uterus,
22 where they normally don't. So the risk of
23 infection becomes greater. The fetus
24 is basically -- every time that there is a
25 contraction, the fetus is having to hold

1 its breath because blood doesn't come into
2 the intervillous space, the enervation
3 between the mother's circulation and the
4 fetus' circulation is called the
5 intervillous space. When the mother is
6 having a contraction, blood doesn't come in
7 there so the baby can't get oxygen.

8 If you and I could hold our breathe for
9 -- you know, I could probably hold my
10 breathe for a minute and a half if I had
11 to. If I rested fifteen minutes, I could
12 probably do it again. But when you start
13 doing it over and over again, you start
14 testing your ability to hold your breath.

15 The longer that the fetus has to hold
16 its breath with a contraction, the more
17 risky that it becomes in terms of
18 developing acidosis, not getting oxygen in
19 and not getting carbon dioxide out. When
20 the carbon dioxide goes up, the acid level
21 also goes up and that tends to become
22 injurious.

23 So all labor is problematic for mother
24 and fetus. When it is time to push, the
25 mother is totally exhausted from having

1 been there for twenty-four hours. So it is
2 problematic from both a fetal and a
3 maternal standpoint.

4 Q. In this case, does the application of
5 the vacuum cause the baby to release
6 meconium?

7 A. The much more likely cause of meconium
8 is that she was forty-one weeks.

9 Once babies get past their due date
10 there is a relaxation of the sphincter that
11 holds meconium in -- meconium is just fetal
12 bowel movement. As babies age, the
13 sphincter relaxes and that meconium is
14 passed.

15 When you look at this cord on
16 pathological evaluation, there was meconium
17 staining of the cord. That's a process
18 that takes not minutes, not a matter of
19 hours but likely days, so this baby had
20 already had a bowel movement inside.

21 When the head is wedged in the pelvis,
22 you don't generally see that meconium
23 because it prevents it from coming down on
24 the cord in the birth canal. But after the
25 baby is born, there is what we call

1 terminal meconium where, after the baby is
2 out, here comes the meconium. It was
3 always there, we just didn't see it because
4 the head was blocking egress of the
5 meconium.

6 Q. Doctor, were there indications there
7 for this delivery to be done in the way
8 that it was done, in your professional
9 opinion to a reasonable degree of medical
10 certainty most probably?

11 A. There were.

12 Q. The fetal monitoring strips, what did
13 they tell you?

14 A. They were non-reassuring to me.

15 Q. And when you have non-reassuring fetal
16 monitoring strips, what does that say to
17 you?

18 A. It suggests that the baby may be
19 developing toxemia, low oxygen, and
20 acidosis. That if continued, the baby
21 may be better served out than in.

22 If the mother is at eight centimeters,
23 that may be a different setting but if she
24 is at ten centimeters and the baby is low
25 in the birth canal -- if this occurred at

1 seven or eight centimeters, you could stop
2 the Pitocin and the heart rate tracing
3 doesn't turn, then we're kind of out of
4 tricks and you've got to do a C-section.
5 But in this particular case, the head was
6 what we call deliverable. It was at a
7 level where the vacuum could be safely
8 applied and delivery safely effected.

9 Q. Does this child have birth defects?

10 A. (No verbal response).

11 Q. Congenital birth defects?

12 A. I am not an expert in that. I'd yield
13 to others. I believe that there are people
14 who believe that this baby, that Jayden's
15 outcome was multifactoral and that there
16 were other issues, congenital issues, birth
17 defect issues if you will, that contribute
18 to his status today. I am not an expert on
19 that.

20 Q. In the delivery of a baby, should a
21 doctor exercise their clinical judgment?

22 A. Yes. That's what our training is all
23 about. It takes a while to develop that
24 acumen. Our residency is four years and
25 then we build on that thereafter, so it

1 isn't something that -- it's something that
2 is developed. It's not there for day one
3 residents, we have to -- we have interns
4 right now watching them stumble. Of
5 course, the chain of command is so rigid
6 that it doesn't hurt anybody but -- yes,
7 it's always about judgment.

8 Q. Do you have an opinion as to whether or
9 not the use of the vacuum was indicated in
10 this delivery?

11 A. It was.

12 Q. Do you have an opinion as to whether or
13 not the vacuum was appropriately used by
14 Dr. Rhett?

15 A. I have an opinion. It was.

16 Q. Do you have an opinion based on all the
17 evidence in this case, including the birth
18 video, of whether Dr. Rhett had the skill,
19 knowledge, judgment and experience to do
20 this delivery?

21 A. I have the opinion that he did.

22 Q. Do you have an opinion as to whether
23 Dr. Rhett met the standard of care during
24 the delivery of this child?

25 A. He did.

1 Q. Are those opinions that you have just
2 given to a reasonable degree of medical
3 certainty most probably, Dr. Van Dorsten?

4 A. (Affirmative nod), they are.

5 ROBERT HOOD: Thank you very
6 much for coming. I may have one or two
7 other questions. Hold on a second.

8 DIRECT EXAMINATION CONTINUED

9 BY ROBERT HOOD:

10 Q. Just so that there is no confusion, I
11 want to make sure that I've fully covered
12 these three exhibits:

13 ACOG, Exhibit 73.

14 Exhibit 31. Is there anything in that
15 bulletin that was required that Dr. Rhett
16 didn't do?

17 A. There is not.

18 Q. The package insert, anything about it
19 that Dr. Rhett didn't do correctly?

20 A. No. You asked me earlier if it was
21 required reading and I suggested that it
22 wasn't.

23 Q. And the FDA, Exhibit 28, is there
24 anything that Dr. Rhett did about the FDA
25 that was a deviation from the standard of

1 care?

2 A. There was not.

3 Q. Are those three things Red Herrings, in
4 your professional opinion?

5 THE COURT: That's leading,
6 Counsel.

7 DIRECT EXAMINATION CONTINUED

8 BY ROBERT HOOD:

9 Q. What are those three things in your
10 professional opinion, in this case?

11 A. They are guidelines to assist but
12 certainly they are not mandates nor
13 prescriptions for how one is to practice.

14 Q. Did Dr. Rhett practice, in the delivery
15 of this child, appropriately and reasonably
16 in your professional opinion?

17 A. He did.

18 ROBERT HOOD: Thank you very
19 much.

20 THE COURT: Mr. Hood, you have
21 been doing this a long time. I would ask
22 you to disregard the last question, Ladies
23 and Gentlemen.

24 ROBERT HOOD: I will reword
25 it. Yes, sir. Thank you. Just trying to

1 move along, Your Honor. Sorry.

2 DIRECT EXAMINATION CONTINUED

3 BY ROBERT HOOD:

4 Q. Tell us about Dr. Rhett and this
5 delivery, in your opinion?

6 A. I believe that Dr. Rhett conformed to
7 the standard of care.

8 ROBERT HOOD: Thank you.

9 THE COURT: Let go into cross-
10 examination now and we will take a break
11 when you conclude your cross-examination.

12 CROSS EXAMINATION

13 BY EDWARD GRAHAM:

14 Q. Good morning, Dr. Van Dorsten.

15 A. Mr. Graham.

16 Q. Sir, let me start off by asking you
17 about pay. Do you charge Dr. Rhett's
18 defense team for your time and work as a
19 professional?

20 A. I am compensated for my time to review
21 medical records, review depositions and
22 render opinions.

23 Q. Is that customary?

24 A. For me.

25 Q. Is it customary for a professional

1 witness?

2 A. They are generally compensated for
3 their time.

4 Q. For both the plaintiff's side and the
5 defense side?

6 A. Amazingly, yes.

7 Q. Really?

8 A. (No verbal response).

9 Q. Do you believe that your testimony
10 should be discounted because you bill for
11 your time and work?

12 A. No.

13 Q. Do you believe that any professional
14 witness' testimony should be discounted
15 because they bill for their time and work?

16 A. I do not.

17 Q. I don't either.

18 ROBERT HOOD: If the Court
19 please, I move to strike counsel's comment.

20 THE COURT: I will sustain that.
21 Please move on to your next question.

22 EDWARD GRAHAM: Yes, sir.

23 CROSS EXAMINATION CONTINUED

24 BY EDWARD GRAHAM:

25 Q. Doctor, for how long has ACOG requested

1 that obstetricians go to the uniform system
2 of stations, the five plus centimeter
3 system?

4 A. That system was introduced into play in
5 about 1988 when there was an attempt to
6 standardize the stations -- so we're
7 talking about apples and apples instead of
8 apples and oranges. Before that there was
9 this zero to plus five, ---

10 Q. You mean thirds?

11 A. I'm sorry. There were two systems on
12 going, one of which was centimeters, which
13 we talked about earlier, using the ischial
14 spines as zero, there were plus centimeters
15 below and minus centimeters above.

16 Some practitioners also divided it into
17 thirds, so you were plus one, plus two,
18 plus three instead of plus five.

19 Truthfully, it doesn't matter except that
20 we didn't know what the system was that
21 people were using. So in 1988 there was
22 some -- I think that it was '88. We were
23 trying to encourage people to use the plus
24 one to five, but it's truly just a matter
25 of semantics.

1 Q. Yes, sir. And ACOG Practice Bulletin
2 Number 17 published in June of 2000
3 confirms that in 1988 ACOG had redefined
4 the classification. Correct?

5 A. Yes, that's correct.

6 Q. Recommending that doctors use a zero to
7 five centimeters instead of the one-thirds;
8 correct?

9 A. That's what they were recommending,
10 correct.

11 Q. Doctors who continue to use one-thirds
12 instead of plus five after 1988 weren't
13 keeping up with ACOG's recommendations,
14 were they, sir?

15 A. They weren't keep up with the
16 recommendation but it doesn't really matter
17 because you could have divided it into
18 tenths. It doesn't really matter as long
19 as the obstetrician practiced some
20 measurement based on sound medicine.

21 Q. But ACOG is a national organization,
22 correct?

23 A. It is. It is our organization. It
24 doesn't certify anyone, its role is rather
25 educational.

1 Q. And it makes recommendations that
2 obstetricians throughout the country follow
3 the same guidelines and recommendations,
4 correct?

5 A. I don't know that all obstetricians
6 follow its recommendations.

7 Q. Oh, how true. I understand that. But
8 ACOG makes recommendations that doctors
9 should follow, correct?

10 A. They give guidelines for practice, they
11 don't mandate or prescribe particular
12 management schemes.

13 Q. You're telling us that there are no
14 rules for obstetricians, just guidelines?

15 A. You'd think that the rules are more
16 defined by the standard of care -- not as a
17 mean and two standard deviations, uh, it's
18 ever changing. It's influenced by
19 practice, it's influenced by more current
20 literature. These practice bulletins are
21 ever evolving. I've had my name on plenty
22 of bulletins that -- which I haven't had my
23 name on all because we all do things
24 differently, but -- no, they don't tell
25 people what to do. They try to help busy

1 obstetricians stay abreast of current
2 literature.

3 Q. How substandard would an obstetrician's
4 knowledge or conduct have to be for you to
5 testify publicly that he violated the
6 standard of care?

7 A. It would have to be more than the two
8 standard deviations that I was talking
9 about.

10 Q. Could you put that in percentages?

11 A. Two standard deviations is ninety-six
12 percent.

13 Q. Okay. So for you to testify publicly
14 that a doctor violates the standards of
15 care, he would have to be in the bottom
16 four percent?

17 A. That's correct.

18 Q. Anything about that, you're going to
19 give him the benefit of the doubt and tell
20 us that he is okay, that he's in compliance
21 with the standard of care. Correct?

22 A. If it is what competent physicians do,
23 then it's totally acceptable.

24 Q. Doing worse than ninety-five percent of
25 obstetricians out there is acceptable to

1 you?

2 A. Two standard deviations is within the
3 realm of reasonable.

4 Q. I just want to understand -- I want
5 everyone here to understand what you mean
6 by "reasonable".

7 A. It's doing what the majority of
8 obstetricians would do in similar
9 circumstances.

10 Q. Even though they are in the bottom four
11 percent. Doctor, let me ask you this, sir,
12 when -- can you see that, Doctor?

13 A. I can.

14 Q. Okay. In a plus-five system, the plane
15 between the ischial spines is zero station;
16 correct?

17 A. Correct.

18 Q. And a vaginal outlet is plus five
19 centimeters; correct?

20 A. In general, yes.

21 Q. From zero to plus five represents how
22 many centimeters?

23 A. Five.

24 Q. Thank you. Oh, let me ask you this,
25 sir, if one were to measure not from the

1 plane between the ischial spines to the
2 vaginal outlet but from the ischial spine
3 itself to the vaginal outlet, would this
4 line be longer than this line?

5 A. I think it would.

6 Q. Is the baby's head -- a mature baby in
7 a head-first delivery, is the leading part
8 of the baby's head ever over here in the
9 actual ischial spine?

10 A. Not the leading.

11 Q. It would be in the middle of the birth
12 canal. Right?

13 A. Yes.

14 Q. The proper measure of centimeters from
15 the leading part of a term baby in a head-
16 first delivery to the vaginal outlet, if
17 the baby is at zero station, is five
18 centimeters, zero to plus five; correct?

19 A. Correct.

20 Q. And this measure from the ischial
21 spines to the vaginal outlet has nothing to
22 do with anything, does it?

23 A. Not really, but as I said earlier we
24 draw kind of an imaginary line and -- it
25 takes some experience to actually determine

1 stations.

2 Q. If someone was to come into this
3 courtroom and measure seven centimeters
4 from the ischial spines to the vaginal
5 outlet, how is that helpful to the jury in
6 trying to figure out the station of the
7 baby?

8 A. It's very difficult to --- it's not a
9 reference that we use.

10 Q. It has nothing to do with the station
11 of a baby, does it?

12 A. The station -- it's easy to determine
13 the station when the baby's head is at the
14 -- when you can measure a line between the
15 ischial spine. As it starts to go past
16 that, you have to determine how far below
17 that imaginary line that you are, so you
18 still have to feel up laterally to see
19 where the ischial spines are. It takes
20 some doing, some experience.

21 Q. But from that line between the ischial
22 spines, that imaginary line in the center
23 of that birth canal, where the baby's head
24 is, down to the vaginal outlet in the plus
25 five position is five centimeters. True?

1 A. Yes, approximately. Obviously there's
2 biologic variation in female pelvis, but in
3 general that's correct.

4 Q. Let me ask you about the good 'ole boy
5 network. Are you part of the good 'ole boy
6 network in Charleston, among obstetricians?

7 A. No.

8 Q. You're not?

9 A. (No verbal response).

10 Q. Well, let me ask you about your
11 relationship with this particular
12 defendant, Dr. Rhett. How long have you
13 known him?

14 A. I came back to Charleston in 1981 and
15 Dr. Rhett had already been practicing for
16 some years in Charleston, so I've known him
17 for twenty-nine years.

18 Q. Would you consider yourself friends?

19 A. We have been professional friends.
20 We are actually in a large supper club
21 together. I consider him a friend. We are
22 not -- I believe that he may have been in
23 my house on some occasion, I've likely been
24 in his on some occasion. We are
25 professionally friendly and I enjoy seeing

1 Edmund. I probably see him ten or twelve
2 times a year.

3 Q. You've been in each other's homes
4 several times, correct?

5 A. I have been in his home a couple of
6 times. I move more than Edmund does, he
7 may have been in my home.

8 Q. Well, let me ask you this, sir. I
9 heard you say that you're willing to defend
10 a doctor that's being in compliance with
11 the standard of care if he's not in the
12 bottom four percent. Tell me, sir, since
13 you've been in South Carolina how many
14 times have you testified publicly that
15 doctors in the bottom four percent broke
16 the standards of care, violated the
17 standards of care? How many times?

18 A. Many, many times.

19 Q. Testified in court, under oath, how
20 many times?

21 A. I've been asked to look at cases but
22 perhaps in some of the case that I've
23 looked at I was unable to be of assistance
24 because some of those cases settled or --
25 other people are summoned -- but in terms

1 of testifying in South Carolina, we are
2 kind of the last bastion for referring
3 physicians. I think it would be
4 inappropriate to testify against physicians
5 that were referring patients to the Medical
6 University of South Carolina, so I wouldn't
7 testify against a South Carolina physician.
8 Although, I have deemed that the care that
9 they have rendered is below the standard
10 many, many times in South Carolina.

11 Q. You've done that secretly, correct?

12 A. I haven't done it secretly. I'm asked
13 if I can provide assistance in defending
14 the physician and I say that I can't.

15 Q. You either tell the defense team that
16 you can say that 'the guy is not in the
17 bottom four percent, so I will help you in
18 court' or 'this guy is in the bottom four
19 percent, I am not going to tell anybody
20 outside of the defense team.' Correct?

21 A. I'm sorry?

22 Q. Have you ever publicly, in a public
23 forum, criticized any South Carolina
24 obstetrician as being in the bottom four
25 percent of obstetricians?

1 A. I have not. I don't plan to ---

2 Q. By the way, how many -- do you have any
3 idea how many obstetricians told the
4 defense team that they couldn't help in
5 this case because they thought Dr. Rhett
6 was in the bottom four percent?

7 ROBERT HOOD: I move to strike
8 that, that's totally inappropriate.

9 JAY DAVIS: I join in that, Your
10 Honor.

11 THE COURT: Well, it assumes a
12 fact not in evidence. Counsel, I sustain
13 the objection. Strike that.

14 EDWARD GRAHAM: Respectfully,
15 Your Honor, may I rephrase it?

16 THE COURT: You may rephrase it.
17 Let's give the other side a chance to
18 object.

19 EDWARD GRAHAM: Absolutely.

20 CROSS EXAMINATION CONTINUED

21 BY EDWARD GRAHAM:

22 Q. Dr. Van Dorsten, do you know whether
23 any potential witnesses contacted by the
24 defense team have told the defense team
25 that they were not able to Dr. Rhett in

1 this case because they considered him to be
2 in the bottom four percent?

3 A. I don't know.

4 Q. Let me ask you, sir, was there ever a
5 time in your career when you were willing
6 to come into a courtroom and tell the truth
7 on behalf of a baby whose brain was damaged
8 by obstetrical negligence, that the
9 obstetrician violated the standard of care
10 and caused the brain damage?

11 A. I did do that.

12 Q. How many times have you done that in
13 your career?

14 A. Once.

15 Q. Once?

16 A. (No verbal response).

17 Q. How long has you been out of your
18 residency program when you did that?

19 A. In was in 1986. A physician asked --
20 I rendered an opinion and the next thing I
21 knew that I was back in South Carolina and
22 I was being asked to be deposed in a case
23 in North Carolina, where I grew up.
24 Because I agreed to do it, I did go to
25 trial and testified on behalf of the

1 plaintiff. In truth, the case settled
2 right after I testified against the
3 plaintiff (sic) because the care was in the
4 bottom four percent in that case, it was a
5 forceps delivery with a lot of rotation of
6 the head and, uh, in so doing the head was
7 elevated, the cord fell out, it became just
8 a really messy delivery, I think the baby
9 had a fractured skull. I thought that
10 obstetrician breached the standard of care
11 and I testified to such. It was very
12 difficult. I had to drive up to North
13 Carolina and to testify against a physician
14 in North Carolina. I haven't testified for
15 another plaintiff, haven't been asked to do
16 so.

17 Q. You consider obstetricians your flesh
18 and blood, right, if they practice in your
19 home state?

20 A. Well, I mean, I am paid by South
21 Carolina taxpayers to take care of
22 patients. South Carolina physicians, I
23 think to get into a situation where I would
24 be at-odds with a practitioner that would
25 potentially compromise the care of a

1 patient, I wouldn't do that.

2 Q. You were punished for telling the truth
3 on behalf of that brain-damaged baby, when
4 you did it that one time, true?

5 A. I wasn't punished. I received a number
6 of telephone calls, which made me uneasy.
7 I wouldn't want to do that again. If I
8 were testifying in South Dakota, it might
9 be easier for me because nobody from --
10 nobody has called me to testify on behalf
11 of a plaintiff.

12 Q. You felt a tremendous amount of peer
13 pressure after you testified on behalf of a
14 baby in the Carolinas that one time,
15 correct?

16 A. I did.

17 Q. You felt so much peer pressure, so many
18 unpleasant phone calls from doctors in the
19 bottom four percent that you made a vow
20 that you would never again testify on
21 behalf of an injured baby in the Carolinas.
22 True?

23 A. That's correct. The physicians that
24 have called me are not in the bottom four
25 percent.

1 Q. But the physicians that call you -- you
2 referred to them as your flesh and blood,
3 correct, even though they weren't blood
4 relatives?

5 A. Correct. These are colleagues of mine,
6 professional colleagues and close personal
7 friends.

8 Q. In the same sense, do you consider
9 South Carolina obstetricians your flesh and
10 blood?

11 A. For the reasons that I mentioned
12 earlier, yes. But you don't know anything
13 about -- nobody has ever called me.

14 Q. Let me ask you, sir, when you agreed --

15 ROBERT HOOD: (Stands)

16 THE COURT: Do you have a motion
17 in limine to make at this time?

18 ROBERT HOOD: Sir?

19 THE COURT: Do you have a motion
20 in limine?

21 ROBERT HOOD: I think counsel
22 has interjected something into this case
23 that is inappropriate and I would like to
24 talk with the Court about it.

25 THE COURT: Counsel, I am not

1 inclined to do that at this time because
2 we're in the middle of testimony. But ---

3 ROBERT HOOD: May I ask the
4 Court -- may I explain it to you?

5 THE COURT: Actually I know what
6 it is, but let's do this -- we will talk
7 about it at a later time rather than delay
8 the testimony. When the jury goes on
9 break, you can discuss it with the Court.
10 Very good.

11 ROBERT HOOD: Thank you.

12 THE COURT: Please proceed.

13 EDWARD GRAHAM: Thank you, Your
14 Honor.

15 CROSS EXAMINATION CONTINUED

16 BY EDWARD GRAHAM:

17 Q. By the way, when you're asked to defend
18 a doctor like Dr. Rhett by telling this
19 jury that he's not in the bottom four
20 percent, you make certain assumptions about
21 him before you even formulate your
22 opinions. True?

23 A. I didn't in this particular case. I
24 reserved my opinion based on the record,
25 developed my opinion based on the review of

1 the records and the video.

2 Q. You made no assumptions about Dr.

3 Rhett?

4 A. I didn't, I don't need to do that.

5 THE COURT: Counsel, I didn't

6 ask you, how long will you be on cross?

7 EDWARD GRAHAM: A while.

8 THE COURT: Let's take our

9 morning break at this point, Ladies and

10 Gentlemen. Enjoy your break and we will

11 return -- if you wish to go outside, we

12 will give you that opportunity. Mr. Brown,

13 please allow the jurors to go out if they

14 wish.

15 (JURY OUT @ 10:42 A.M.)

16 THE COURT: Doctor, you may

17 stand down and take a break as well but I

18 am going to ask you not to speak to either

19 side since you're a witness under

20 testimony. Feel free to stand down.

21 The jury is clear. Mr. Hood, did

22 you have something that you wished to put

23 on the record?

24 ROBERT HOOD: Thank you, Your

25 Honor. We respectfully move for a

1 mistrial. Counsel said, "Are you part of
2 the good 'ole boy network?" We observed
3 the African American jurors immediate
4 react. I did not immediately object
5 because I thought that it was over. He
6 went back into it a second time. They
7 reacted again. He is playing to the race
8 issue in this case a hundred percent. It
9 is totally improper, it has nothing to do
10 with this case. This gentleman is the
11 Chairman of the department that's trained
12 two hundred obstetricians in this state,
13 and it is not even civil to ask him that
14 question. But to try to inject race into
15 this courtroom is totally improper. That's
16 exactly what he did.

17 THE COURT: Do you want to
18 respond, Mr. Graham?

19 ROBERT HOOD: He asked for
20 sanctions against me yesterday. I've never
21 asked for sanctions against a lawyer. All
22 I want is just a mistrial so that we can
23 get a fair trial with the rules of the road
24 straight with this fellow before we have
25 another trial.

1 THE COURT: Mr. Graham?

2 EDWARD GRAHAM: Mr. Hood could
3 not be more wrong. Race had nothing do
4 with what I asked. There is an obvious
5 bias on the part of this man about
6 protecting doctors.

7 He will only tell the insurance
8 adjusters that he can't support them,
9 people who are in the bottom four percent,
10 and even then he won't say so publicly.

11 He considers other obstetricians
12 in this state his flesh and blood. He's
13 been intimidated by the medical
14 professionals that he testified against.
15 He made a vow that he would never testify
16 on behalf of a baby in South Carolina. If
17 that is not the good 'ole boy network, I
18 don't know what it is.

19 I never heard anybody, until this
20 very minute, contend that the good 'ole boy
21 network is somehow some kind of racial
22 concept.

23 THE COURT: The Court is
24 prepared to respond. First of all,
25 Counsel, I am going to deny your Motion

1 for a mistrial or for any further relief.
2 The Court did not perceive that to be a
3 racial statement, the Court did not
4 perceive the jury to take it as a racial
5 statement. I think in its general context
6 that "the good 'ole boy network" is a
7 reference to a system on cronyism where one
8 might take the side of one over another.

9 Now, plaintiff's counsel does this
10 at his own peril because the jury is
11 sitting here watching this. If this
12 witness seems to be a reasonable
13 professional dedicated to his profession
14 and colleagues with whom he works and is
15 attacked for that, that might -- the jury
16 will perceive what they believe to be
17 appropriate. I don't find anything -- or
18 I should say that the jury will determine
19 from that what they believe to be
20 appropriate and it may damage one side or
21 the other.

22 That is not for the Court to
23 decide. This does not warrant a mistrial.

24 ROBERT HOOD: Would Your Honor
25 instruct counsel not to use that phrase

1 again during this trial?

2 THE COURT: Well, actually I am
3 going to decline to do so because I don't
4 find it to be racial, but I believe that it
5 hurts the plaintiff. If he wants to drive
6 a train wreck, the court is not going to
7 stop him.

8 ROBERT HOOD: Your Honor, does
9 that mean that I can stand up and say,
10 'Dr. Van Dorsten, how many African American
11 babies have you delivered?' At the Medical
12 University, it's ninety percent.

13 THE COURT: Well, tell me why
14 you perceive the term "good old boys
15 network" to be a racial term.

16 ROBERT HOOD: Because I saw
17 three jurors react to it, Your Honor, in a
18 way that they haven't reacted to anything
19 else in this case. It really just steams
20 me. I really think that it was intentional
21 when it happened.

22 THE COURT: But my perception
23 is, just so our record will be clear, that
24 the jury doesn't perceive this fine
25 physician to be, quote, "a good 'old boy".

1 Not in a racial context but just someone
2 who would make a back room deal, like a
3 political crony that would protect other
4 political cronies. I just don't believe
5 that this witness comes out that way. I
6 think the plaintiff hurt himself by that.

7 But I am not going to argue about
8 that. I'm sitting over here. If he wants
9 to engage in a strategy or a tactic, well,
10 that's his call. But the Court does not
11 find it such that it would warrant a
12 mistrial.

13 JAY DAVIS: Out of an abundance
14 of caution, we would join in Mr. Hood's
15 Motion.

16 THE COURT: All right, Mr. Davis
17 joins in. You are free to step down. We
18 will be at-ease for about fifteen minutes.

19 (BRIEF RECESS)

20 THE COURT: We are still outside
21 the presence of the jury. How long do you
22 believe that your cross examination will
23 be, Mr. Graham?

24 EDWARD GRAHAM: Probably about
25 forty minutes.

1 THE COURT: All right.

2 EDWARD GRAHAM: I will try to
3 speed it up. I've got a lot to cover.

4 THE COURT: Very good.

5 JAY DAVIS: I have one minor
6 matter. Mr. Graham and I have conversa-
7 tions about which experts that we may or
8 may not call and he asked the doctor what
9 other experts would -- and Under Rule 26,
10 we would object to that ---

11 THE COURT: I sustain the
12 objection.

13 JAY DAVIS: I think the second
14 question was improper and that it creates
15 an inference that there was some out there
16 that we are hiding from this jury. Just
17 because he doesn't know about it, -- but
18 the inference is clearly brought into
19 court. It's prejudicial.

20 ROBERT HOOD: I join in that.
21 I thought that it was extremely
22 prejudicial. I could have asked that of
23 the plaintiff. I bet there's ten people
24 that he paid money who haven't come
25 testify, and that that is why they are not

1 here -- the ones that he paid money to
2 came. I mean, every one of them was here
3 at \$20,000.

4 THE COURT: Well, again, the
5 Court does not ---

6 EDWARD GRAHAM: May I be heard?

7 THE COURT: Yes, sir, go ahead.

8 EDWARD GRAHAM: It was in
9 response to his testimony that he refuses
10 to testify, in the Carolinas at least. He
11 readily comes to the support of
12 obstetricians in the Carolinas if they are
13 not in the bottom four percentile. If they
14 are in the bottom four percent, he tells
15 the defense team and they keep that a
16 secret. He's never testified publicly that
17 a doctor in the bottom four percent was
18 negligent. It was just a followup to that,
19 to put it into context of responding to his
20 testimony about -- if it is in the bottom
21 four percent that they just keep it under
22 wraps.

23 ROBERT HOOD: I would add one
24 thought for Your Honor's consideration.
25 Rule 26 says that if you hire a consultant,

1 the fact that you hire a consultant need
2 not be mentioned, that you do not have to
3 disclose a consultant, that they are not a
4 witness in the case, that they are not
5 deposed and no one can talk about it.

6 So I have never seen any lawyer
7 ask that question of a witness. I can
8 imagine what kind of Motion that he would
9 have made against me if I had asked his
10 experts that.

11 THE COURT: Counsel, so that our
12 record will be complete, what -- there is
13 an objection. What relief do you seek?

14 ROBERT HOOD: An instruction
15 from Your Honor to the jury that the
16 question was asked that is totally
17 irrelevant to these proceedings, that this
18 is a witness that is here and that's he is
19 the only thing -- that his testimony is the
20 only thing for them to consider, not some
21 statement by counsel which is not evidence.

22 JAY DAVIS: And that there is no
23 evidence in this record at all that we've
24 been turned down by anybody. The inference
25 from the question is that we have. There

1 is no evidence in this case that we've been
2 turned down by a single witness that we
3 contacted.

4 ROBERT HOOD: I can tell Your
5 Honor, as an officer of the court, that
6 when I go see Dr. Van Dorsten and he says,
7 'Bobby, I can't support you with this
8 case', that case settles. It's a very rare
9 event to have Dr. Van Dorsten in this
10 courtroom.

11 THE COURT: All right.
12 Gentlemen, the Court's response is that I
13 decline at this time to give the jury an
14 instruction. However, in the Court's
15 charge at the end of the case I am going to
16 include a statement that there should no be
17 inference taken from a question, there
18 should be no supposition of what an answer
19 might be if an objection is granted or the
20 answer not permitted, and that there should
21 be not inference taken from either counsel
22 because a question is not evidence. The
23 court will include that at that time as, in
24 part, a curative instruction with regard to
25 this issue.

1 Other relief, at this time the
2 Court declines to give further relief.
3 Because, number one, since it would
4 highlight it. Secondly, because it would
5 create delay unnecessarily. Thirdly, we
6 are going to move forward with cross
7 examination. Mr. Graham, I would recommend
8 to you, sir, that you move with all due
9 speed.

10 EDWARD GRAHAM: Yes, sir.

11 THE COURT: Please bring in the
12 jury.

13 ROBERT HOOD: I Googled the
14 words the "good 'ole boy network" and it
15 is "commonly thought of as being a system
16 which was used by white males to keep
17 others out." He did that. He made those
18 words -- he had a racial motivation to
19 seven jurors.

20 THE COURT: Again, I am going to
21 decline to give any relief. I do not
22 recognize Google as an expert, thus the
23 Court -- your position is well noted on the
24 record but the Court declines any further
25 relief. Bring in the jury.

1 (JURY IN @ 11:03 A.M.)

2 THE COURT: All right. Welcome
3 back, Ladies and Gentlemen. You will
4 recall that we were in cross-examination
5 when we took our break. You may proceed,
6 Mr. Graham.

7 EDWARD GRAHAM: Thank you, Your
8 Honor.

9 CROSS EXAMINATION RESUMED

10 BY EDWARD GRAHAM:

11 Q. Dr. Van Dorsten, before the break you
12 told me that you made no assumptions about
13 Dr. Rhett when you were making your
14 determination as to whether or not he was
15 in the bottom four percent?

16 A. That's the case. I've known Dr. Rhett
17 for a long time but that did not influence
18 my interpretation of the facts of the case.

19 Q. Specifically you testified that you
20 made no assumptions; correct?

21 A. That's correct.

22 Q. In fact, you assumed that the baby was
23 at the low or outlet station, didn't you,
24 sir?

25 A. I assumed that it was at a low station.

1 Yes, sir.

2 Q. May I give you the original deposition
3 transcript. If you would, sir, please open
4 that to Page 44.

5 A. It's hermetically sealed.

6 Q. Here you are, sir, (tendering
7 scissors).

8 A. (Complies).

9 Q. Page 44.

10 A. Okay.

11 Q. I am going to read a question and
12 answer. Please tell me if I read this
13 correctly, starting at Line 15, (reading):

14 Q. And in answering that
15 question, you are assuming that the baby is
16 either at the outlet or a low position?

17 A. I am.

18 Did I read that question and answer
19 correctly?

20 A. That's right.

21 Q. Please turn to Page 54, Line 17,
22 (reading):

23 Q. In forming your opinions in
24 this case, have you assumed that Dr. Rhett
25 provided truthful testimony at his

1 *deposition?*

2 A. *I have.*

3 Did I read that accurately?

4 A. That correct.

5 Q. Later on, Line 21 (reading):

6 Q. *In forming your opinions in*
7 *this case, have you assumed that Dr. Rhett*
8 *is a qualified birth attendant who uses*
9 *good clinical judgment?*

10 A. *I have.*

11 Did I read that accurately?

12 A. That's correct.

13 Q. Please turn to Page 75, starting at
14 Line 11, part of your answer says
15 (reading):

16 A. ... and, number two, Dr. Rhett
17 *deemed that the baby was safely delivered.*

18 Q. And you have assumed that to
19 *be true and accurate in reaching your*
20 *opinions in this case?*

21 A. Most assuredly.

22 Did I read that accurately?

23 A. That's correct.

24 Q. Please turn to Page 77, Line 3,
25 (reading):

1 Q. So as you sit here today, you
2 are prepared to accept that this was an
3 outlet delivery because Dr. Rhett said so?

4 A. Yes, I would.

5 Did I read that accurately?

6 A. That's correct.

7 Q. Please turn to Page 117, Line -- you
8 assumed that everything that Dr. Rhett said
9 was true with one exception. Correct?

10 A. I don't recall.

11 Q. Do you recall anything that you assumed
12 to be false about this deposition?

13 A. Could you please go to something and
14 I'll comment on it.

15 Q. Yes, sir, Page 117, Line 15, your
16 answer (reading):

17 A. Based on what the standard
18 of care is in current times, I would be
19 shocked if he had a fifty percent rate,
20 if he had a fifty percent rate in 2002.

21 For the context, that fifty percent
22 reference was to vacuum delivery rate.
23 Correct?

24 A. That's correct.

25 Q. Have you -- and you don't have any

1 personal knowledge that -- (reading):

2 Q. Have you assumed that that
3 testimony was false in reaching your
4 opinions in this case?

5 A. It didn't affect my opinions.
6 I assumed that it was inaccurate.

7 Did I read that accurately?

8 A. That's correct.

9 Q. Let's talk about the mid-pelvis.

10 A. Excuse me?

11 Q. Are you through with this?

12 A. Yes, sir.

13 Q. Let's talk about the mid-pelvis. You
14 were not there to examine this child in the
15 birth canal to determine to your own
16 personal satisfaction what the station was.
17 Correct?

18 A. I wasn't.

19 Q. Have you found in your experience that
20 when you determine what you believe the
21 station to be other practitioners can come
22 up with an erroneous station up to two
23 centimeters higher or lower than what you
24 believe the station to be?

25 A. Yes. An experienced clinician wouldn't

1 be a couple of centimeters off, likely a
2 centimeter if we're talking about comparing
3 me to a resident they might be two, three,
4 four centimeters off. With Dr. Rhett and
5 I, it wouldn't be two centimeters off on
6 the station.

7 Q. You don't know -- you have no personal
8 knowledge what this baby's station was at
9 the time that the cup was applied, correct?

10 A. I didn't examine her. No, sir.

11 Q. And you were prepared to accept that
12 this was an outlet position, the station,
13 the baby's head because that's what Dr.
14 Rhett testified to under oath at his
15 deposition. Correct?

16 A. We could go back and -- you know, I
17 thought that I said it was a low vacuum
18 (sic). I said so in the deposition and I
19 testified earlier today. Truthfully, it
20 doesn't matter to me whether it was an
21 outlet or low in terms of my opinions, but
22 I -- I can show you in this deposition, if
23 we want to take the time to go through it.
24 It was rather clear from my deposition that
25 I thought that it was low delivery, but I

1 can accept that it was an outlet -- again,
2 we're looking at an amateur photographer
3 and I wasn't there.

4 Q. You can accept that it was an outlet if
5 Dr. Rhett said that it was an outlet?

6 A. I can.

7 Q. In fact, tell us whether or not in
8 modern times, in the last twenty years,
9 whether or not you believe it would be a
10 violation of the standard of care for an
11 obstetrician to use a vacuum to extract a
12 baby from the mid-pelvic position at East
13 Cooper?

14 A. I don't think it's outside the standard
15 of care. It's not what people generally
16 do. There are circumstances where you
17 couldn't do a caesarean -- maybe because
18 the anesthesiologist wasn't there, they
19 couldn't get the OR person there. That
20 would be a better alternative than a fetal
21 death or fetal damage, in my estimation.

22 Q. The ---

23 A. In general, over the last twenty years
24 people have not done many mid-pelvic
25 deliveries because the literature supported

1 it then and continues to support it now.

2 Q. Let me make sure that we're talking on
3 the same wavelength here. Are you
4 criticizing East Cooper for not having the
5 ability to do a timely C-section?

6 A. The guidelines suggest that you should
7 be able to do a caesarean in thirty
8 minutes. If an anesthesiologist, in the
9 middle of the night, isn't physically there
10 -- I don't know the situation at East
11 Cooper. If the OR personnel were not there
12 or if there were other things going on that
13 tied them up, I would have no problem at
14 all with a mid-pelvic delivery. I think
15 it's a far better alternative.

16 Q. Did you testify at your deposition that
17 mid-pelvic application was dangerous and
18 against standards of care, except in remote
19 rural areas?

20 A. Yeah. It's -- yet there is literature
21 that still suggests that it is a reasonable
22 alternative.

23 Q. In remote rural areas, correct?

24 A. It is rarely done in Charleston, in my
25 opinion.

1 Q. Tell us, Doctor, do you believe that a
2 mid-, -- assuming that Jayden W.
3 was at a mid-pelvic station at the time
4 that Dr. Rhett applied that vacuum, do you
5 have an opinion as to whether or not that
6 was appropriate?

7 A. I am not saying that it was a mid-
8 pelvic delivery.

9 Q. For the purpose of this question, sir,
10 I am asking you to assume. Assume that the
11 jury finds it was a mid-pelvic delivery,
12 would that be appropriate or inappropriate
13 for baby Jayden?

14 A. I think it's inappropriate.

15 Q. Inappropriate?

16 A. She's had a protracted labor, she's
17 early in the second stage, has a concerning
18 heart rate tracing, I think that it would
19 be inappropriate -- if caesarean were a
20 reasonable alternative at East Cooper
21 Hospital, at that time on that day, I think
22 that it would be a -- I think it would be
23 an imprudent decision. Yes, sir.

24 Q. Imprudent?

25 A. Imprudent, not a wise decision. Not

1 proper. Not careful. A poor decision.

2 Q. By the way, this vacuum cup was
3 completely inside Jamsetta's vagina,
4 correct?

5 A. That's correct.

6 Q. The cup that you used most often in
7 modern times was how long, from the open
8 end to where the shaft starts?

9 A. It's just a couple of centimeters.

10 Q. A couple of centimeters?

11 A. Right.

12 Q. Nowhere near as tall as Exhibit 72.
13 Correct?

14 A. No, it would probably be half of that.

15 Q. Have you measured (Exhibit) 72?

16 A. No, I looked at it. Remember, the head
17 by this point is molded. You saw it when
18 it came out, it's quite molded after a long
19 labor. So the cup basically isn't perched
20 on the head, it rather engulfs the head
21 like a stocking cap. So when he was taking
22 the electrode off, clearly the scalp was at
23 a low station.

24 Q. How many centimeters does it appear to
25 be on this pink part of the shaft,

1 underneath the translucent base of the cup?

2 A. It's like a couple of centimeters.

3 Q. Two centimeters, from here to here?

4 A. Yeah.

5 Q. How far are you assuming that it is
6 from the top of the pink shaft to the open
7 end of the cup?

8 A. I'd say about four centimeters.

9 Q. Four centimeters?

10 A. Yeah.

11 Q. Would it surprise you that it is over
12 six?

13 A. Remember, when you are pushing this
14 thing, you're also pushing the head back up
15 in the pelvis such that you lose station.
16 But at the time that the decision was made
17 to use a vacuum, it was clearly at a low
18 station. But as you start pushing,
19 starting applying the vacuum, often you
20 lose station and you often between
21 contractions lose station as well.

22 Q. Doctor, do you recall ---

23 A. When she was pushing, the head was
24 clearly at a low station.

25 Q. Doctor, do you recall the question?

1 A. You were asking me about some
2 centimeters and I am more than willing to
3 measure, Mr. Graham. I don't see any need
4 in speculating. We can measure with our
5 centimeter rule.

6 Q. I asked you, sir, would you be
7 surprised to learn that from the top of the
8 pink shaft under the translucent cup base
9 to the open end is more than six
10 centimeters?

11 A. Well, why don't we just measure?

12 Q. Are you comfortable answering the
13 question, first?

14 A. I don't need to speculate about the
15 answer.

16 Q. I'm happy for you to measure it, sir.

17 A. Find me a centimeter rule and I'll be
18 happy to measure.

19 ROBERT HOOD: There's one
20 right there on the table. We put it in
21 evidence. May I hand it to the witness,
22 Your Honor?

23 EDWARD GRAHAM: I would like to
24 see it first, if Your Honor please. I
25 don't recall this being placed in evidence.

1 It's not marked as a court's exhibit or
2 anything.

3 ROBERT HOOD: Put it in
4 evidence.

5 THE COURT: It is not in
6 evidence, Counsel, I don't believe that it
7 is.

8 ROBERT HOOD: I asked for all
9 demonstrative evidence on that table, all
10 that is right there. Anything that he
11 wants to put in evidence, we have no
12 objection.

13 CROSS EXAMINATION CONTINUED

14 BY EDWARD GRAHAM:

15 Q. (Tenders rule to witness).

16 A. From the pink that you see there to the
17 bottom is about six centimeters.

18 Q. Thank you, sir. How long is the pink
19 shaft that's under the base of the cup?

20 A. The pink shaft under the base of the
21 cup looks to be a couple of centimeters.

22 EDWARD GRAHAM: Your Honor, we
23 would offer the tape measure in evidence at
24 this time.

25 THE COURT: What says the

1 defense?

2 JAY DAVIS: No objection.

3 ROBERT HOOD: No objection.

4 THE COURT: Without objection,

5 thus the jury will have it during

6 deliberation. What is the exhibit number,

7 Madame Court Reporter?

8 COURT REPORTER: Exhibit 108.

9 (SO ENTERED AS PLAINTIFF'S EXHIBIT 108)

10 CROSS EXAMINATION CONTINUED

11 BY EDWARD GRAHAM:

12 Q. Doctor, just to be clear for the

13 record, one side has inches; correct?

14 A. Correct.

15 Q. And the other side has centimeters?

16 A. That's correct.

17 Q. Not only would it have been

18 inappropriate for Dr. Rhett to delivery

19 this baby with a vacuum from the mid-pelvic

20 position, it would be a breach of standards

21 of care, correct?

22 A. I think under the circumstances --

23 under the circumstances that I outlined, if

24 a caesarean were immediately available,

25 operative personnel, an anesthesiologist,

1. all personnel were immediately available,
2. that would have been a superior choice.

3. Q. Would it be a deviation from generally-
4. accepted standards of obstetrical care,
5. under these facts and circumstances for Dr.
6. Rhett to use a vacuum if Jayden was at a
7. mid-pelvic position?

8. A. Except as I outlined.

9. Q. Do you have any reason to question the
10. availability of operating room and staff
11. for the performance of a caesarean section
12. at East Cooper on July 16th, 2002?

13. A. Do I have any reason to question?

14. Q. Yes, sir.

15. A. I have plenty of reason to question
16. because I don't know what it was.

17. Q. Do you have any evidence that East
18. Cooper was unable to meet the timely ---

19. A. I don't ---

20. Q. May I finish my question, please, sir?

21. A. Yes.

22. Q. Do you have any evidence to suggest
23. that East Cooper was unable to unwilling to
24. meet its obligation to provide timely C-
25. section services to a baby who needed one

1 in July of '02?

2 A. I don't.

3 Q. Let's talk about rate of vacuum. In
4 modern times what do you believe the
5 appropriate or average rate of vacuum
6 extraction is? About ten percent?

7 A. Certainly I wouldn't say appropriate
8 but the average has been around ten to
9 fifteen percent in the last decade or so.

10 Q. And ACOG Practice Bulletin Number 17
11 lists it as -- lists operative vaginal
12 delivery, including vacuum and forceps, of
13 ten to fifteen percent; correct?

14 A. That's what I just said.

15 Q. Usually when a doctor is high on his
16 C-section rate, he is relatively low on
17 vaginal, correct?

18 A. There is a relationship there, as I
19 pointed out earlier.

20 Q. Okay. And usually if a doctor is high
21 on vacuum rate, he's low on his C-section
22 rate. Correct?

23 A. There is a relationship, yes.

24 Q. Forty percent C-section rate for a
25 generalist, without a high-risk practice,

1 is generally higher than average. True?

2 A. I don't know what his rate was. I know
3 what he said in his deposition. I would be
4 surprised if he knew exactly what the rate
5 was.

6 Q. Well, you assume that he was telling
7 the truth about everything else, correct?

8 A. Yes, but he certainly didn't have a
9 rate in front of him.

10 Q. Well, if he testified truthfully, then
11 the C-section was forty percent for a
12 generalist, without a high-risk practice,
13 that would be quite high. Correct?

14 A. It would be higher than the
15 southeastern average. Yes, sir.

16 Q. And if a physician -- if an
17 obstetrician had a vacuum rate of over
18 fifty percent of his vaginal deliveries,
19 that would be extraordinarily high. True?

20 A. It would be higher than average, yes.

21 Q. It would be shockingly high. True?

22 A. I don't know about shockingly high.

23 There is abundant evidence that an outlet
24 vacuum delivery after normal labor is
25 analogous to a spontaneous delivery after

1 a normal labor.

2 Q. Please turn to Page 117, Line 15, your
3 answer was, (reading):

4 A. *Based on what the standard*
5 *of care is in current times, I would be*
6 *shocked if he had a fifty percent rate.*
7 *If he had a rate of fifty percent in 2002.*

8 Was that your testimony? Did I read it
9 accurately?

10 A. You did. I don't believe that it was
11 fifty percent.

12 Q. Sir, let me ask you about the
13 electrode. This was put into evidence as
14 an electrode. I am not sure where it came
15 from, but are there any parts missing to
16 this electrode?

17 A. There are not.

18 Q. No?

19 A. (No verbal response).

20 Q. Where do the leads go when one is using
21 an electrode for fetal monitoring?

22 A. The bottom part goes into an apparatus
23 taped to the mother's leg.

24 Q. And the top part?

25 A. The top part is that millimeter spiral

1 that I was talking about that attaches to
2 the fetal scalp.

3 Q. Now, let me ask you this, Doctor.
4 This top part is kind of like a screw when
5 you're putting it in. Correct?

6 A. That's correct.

7 Q. When you're putting it in, you need to
8 put your fingertips near the edge and ---

9 A. We have an inserter that puts it in, so
10 you don't have to physically do that with
11 your hands.

12 Q. Okay. So when you're putting it in,
13 how close are your hands to the actual
14 lead?

15 A. Not very far, because we have an
16 inserter that is about that long.

17 Q. And you put your hand on one end of the
18 inserter?

19 A. You put one hand on where you what to
20 put it, on the business end of that lead.
21 Obviously you want to put it in the right
22 place.

23 Q. When it is time to pull the electrode
24 out, you don't take it out the way that you
25 put it in. Do you?

1 A. There's several different ways. You
2 can clip that bottom lead and take the --
3 put it -- get it taut and pull the two
4 wires and it will unwind itself. Or you
5 can physically, as Dr. Rhett did, go in and
6 unscrew it, having your hands on the round
7 part, the business end of that.

8 Q. Your telling us today that Dr. Rhett
9 went in and unscrewed this?

10 A. Yeah.

11 Q. You're contending that he did not
12 unravel the wires?

13 A. I didn't see him unravel the wires. I
14 saw him undo the electrode.

15 Q. Normally you don't need to unscrew it,
16 correct?

17 A. Yeah, you must unscrew it.

18 Q. Normally you don't need to put your
19 fingers at the tip to unscrew it like a ---

20 A. Yeah, a lot of people do that.

21 Q. But the customary way and the most
22 common way is to unravel the wires.
23 Correct?

24 A. I have no idea. I am just telling the
25 jury what I do.

1 Q. What you do is unravel the wires.

2 Correct?

3 A. That's what I customarily did. Yes.

4 Q. And as you watched the birth video you
5 didn't note that Dr. Rhett unraveled the
6 wires?

7 A. I didn't.

8 Q. When one removes the screw by un-
9 raveling the wires, your fingertips don't
10 have to reach anywhere near the baby's
11 head, do that?

12 A. They don't.

13 Q. What would you say, about how far?

14 A. (No verbal response).

15 Q. Eight inches, six inches, four inches?

16 A. Depends on where you have the wire.

17 Q. Would you agree that typically your
18 hands are at least six inches away from the
19 baby's head as you unravel the lead?

20 A. I have no idea. I'm telling the jury
21 what I do. I don't know what Dr. Rhett
22 customarily does. There are different way
23 of getting it off.

24 Q. And when you do it, sir, is it at least
25 six inches away from your fingertips to the

1 baby's head?

2 A. If that's where I have the wire.

3 Q. Please turn to your at Page 50.

4 A. Page what?

5 Q. Fifty. Page 50, Line 12 (reading):

6 Q. When an obstetrician takes an
7 electrode off a baby's head, how does that
8 get done properly.

9 A. I mean, they are put on by
10 using a screwing device. They are taken
11 off by literally separating the wires and
12 pulling them against each other such that
13 in unravels and the scalp electrode, which
14 is a spiral electrode then goes counter-
15 clockwise to detach itself.

16 Q. And when you disentangle those
17 wires, the way that you described, I assume
18 that a doctor uses his hands?

19 A. Yeah, you're actually away
20 from the introitus when you're doing that
21 -- within, I mean, -- just watching the
22 electrode itself, it obviously wasn't up in
23 the pelvis when it came out, it was right
24 at the outlet. So you are asking me what

1 led me to believe that it was a low to
2 outlet delivery and that's one of the
3 things that I noticed.

4 Q. When you remove an electrode,
5 how close do your hands get to the baby's
6 head?

7 A. Well, sometimes the
8 disentanglement technique doesn't work and
9 you have to physically go to the electrode
10 itself and turn it counterclockwise; but in
11 most cases a simple way to do it, a quicker
12 way to do it is by taking the leads loose
13 from the maternal side and literally
14 pulling the against each other such that
15 there is a counter rotation.

16 Q. So the question is, ordinarily
17 how close do your hands get to the baby's
18 head?

19 A. Six inches or less.

20 Did I read those questions and answers
21 truthfully and accurately, Dr. Van Dorsten?

22 A. You did.

23 Q. Now, today you said something about
24 reduced variability. But in your
25 deposition you saw no problem with

1 variability. Correct?

2 A. For the most part the variability was
3 normal. That's what I ---

4 Q. Good variability is reassuring,
5 correct?

6 A. A feature of reassurance. Yes, sir.

7 Q. You never saw any loss of variability
8 that caused you any concern. True?

9 A. No, I did. I testified today that I
10 did see an area of decreased variability
11 towards the end.

12 Q. Well, you were talking about the
13 variability decelerations but you can't say
14 that it is sensible to consider loss of
15 variability during a decel, is it?

16 A. There was an episode that we looked at
17 earlier where I thought there was decreased
18 variability. By and large the phrase is
19 abnormal variability.

20 Q. When -- according to our study and your
21 knowledge about the safe delivery of babies
22 with a vacuum, when did it become well
23 known among obstetricians that the danger
24 of trauma to the mom and the baby was just
25 too great to use a vacuum from the mid-

1 pelvis?

2 A. I don't think -- I don't know
3 specifically with a vacuum. The forceps
4 certainly was a landmark study done by
5 Hankins, and colleagues, in about 1988.

6 Q. All right. And in your deposition, you
7 indicated that 1988 was the turning point
8 for not using vacuum for mid-pelvic, as
9 well. True?

10 A. Yes, but the date concerning vacuums
11 isn't as strong because the study was done
12 using forceps, but most people refrained
13 from doing mid-pelvic delivery with vacuum
14 about the same time.

15 Q. Let me ask you this, you indicated that
16 the rate is either ten percent or ten to
17 fifteen percent for use of a vacuum in
18 modern times. Correct?

19 A. That's -- I believe that's right.

20 Q. But if we go back several decades to
21 when you first did your learning and to
22 when Dr. Rhett first did his medical school
23 training, vacuums were in -- vacuums were a
24 lot more popular, were used a lot more
25 frequently. True?

1 A. Vacuums were rarely used when Dr. Rhett
2 and I were in training. The alternate
3 choice was forceps.

4 Q. All right. Well, I've forgotten
5 exactly when you were in school but if we
6 move forward from that date, there was a
7 time in the '70s or early '80s when vacuums
8 were used like fifty percent of the time or
9 something like that. Correct?

10 A. Certainly there was a time when
11 patients like Ms. Washington, who'd never
12 had a baby, would have what we called a
13 saddle block when they were fully dilated
14 and the head was crowning. We'd sit them
15 up, do a saddle block. At that point they
16 were unable to push any further, so the
17 rest of the delivery was completed by
18 forceps in those days. Then later I would
19 say that -- that forceps became the
20 instrument of choice in the '90s.

21 Q. At any rate, those who used vacuum in
22 the early days -- many of them used it as
23 much as fifty percent or more of the time
24 for deliveries. True?

25 A. Yeah, because of the reason that I

1 mentioned.

2 Q. But if an obstetrician kept up with
3 changes in knowledge, changes in dangers of
4 vacuum extraction, they would have gone
5 from fifty percent or more down to ten to
6 fifteen percent. True?

7 A. Yeah, -- well, I don't know. I never
8 had a fifty percent vacuum rate, so I don't
9 know what happened. I did have a fifty
10 percent C-section rate and with time I saw
11 a marked decrease.

12 Q. That was in a high-risk pregnancy.
13 True?

14 A. The majority of my practice has been in
15 a high-risk setting. Yes, sir.

16 Q. You would expect a higher C-section
17 rate in a high-risk practice than in a
18 generalist's practice. True?

19 A. Yeah, for different reasons. But
20 private practitioners often have high
21 section rates because they are managing
22 more patients who get to full term, whereas
23 my practice involves patients that are pre-
24 term. Obviously they can delivery
25 vaginally a lot easier because the babies

1 are smaller and their heads are smaller.

2 So section rates are often higher in
3 private practice where you are delivering
4 larger babies.

5 Q. If an obstetrician started using vacuum
6 more than fifty percent of the time, back
7 in the '70s and '80s and didn't keep us
8 with the knowledge about the dangers of
9 vacuum, then he is not keeping up with
10 advances in patient safety, is he?

11 A. I don't know the answer to that
12 question.

13 Q. If a doctor used to use vacuum -- had a
14 vacuum rate of fifty percent of more vacuum
15 deliveries back in the '70s and '80s, kept
16 using vacuum with that frequency until he
17 quit delivering babies, he would be
18 completely out of step with the modern
19 trend for vacuum use. True?

20 A. Yeah, because the bottom rate is ten to
21 fifteen percent. I am not aware of any
22 data that has looked at the rate of one's
23 vacuum practice and the rate of
24 intracranial hemorrhage such as Jayden had.

25 Q. Speaking intracranial hemorrhage, let

1 me ask you about the amount of that blood.

2 In the babies that you -- have you
3 delivered babies with a vacuum and had
4 brain bleeds?

5 A. Not intracranial. I've seen the
6 cephalohematoma that we talked about
7 earlier, the more superficial hematoma.
8 Those are seen in up to ten percent of
9 cases, so they are relatively common.

10 Q. Since you quit using a vacuum for mid-
11 pelvic deliveries, have you seen any
12 intracranial brain bleeds at all?

13 A. We have at the Medical University but I
14 haven't.

15 Q. Not on your watch?

16 A. Well, I haven't delivered babies in the
17 last three years, so -- (pause).

18 Q. When did you stop? Was it in 1988 or
19 thereabouts when you stopped using mid-
20 pelvic vacuums?

21 A. I wasn't doing mid-pelvic vacuums in
22 1988 or using forceps. I did stop them at
23 that point. The only mid-pelvic vacuum
24 deliveries that I've done has been on a set
25 of twins where after I delivered the first

1 twin sometimes you encounter a heart rate
2 problem with the second twin and I've used
3 a vacuum at a mid-pelvic position.

4 Q. Did you use vacuum to delivery a baby
5 from the mid-pelvis if it was a single baby
6 in uterus?

7 A. I didn't do that. I used forceps.

8 Q. Have you ever -- given that you don't
9 use a vacuum at the mid-pelvis, have you
10 ever had a baby delivered on your watch
11 with an intracranial bleed, delivered with
12 a vacuum?

13 A. Not that I am aware of.

14 Q. Did the amount of blood in Jayden's
15 head shock you?

16 A. I am not aware of the amount.

17 Q. Did the amount of blood in Jayden's
18 head surprise you?

19 A. Well, intracranial hemorrhages occur in
20 one out of every seven to eight hundred
21 patients; so, no, it's not shocking. It's
22 incredibly disappointing.

23 Q. Well, let me ask you this, sir. Please
24 turn to Page 123 of your deposition,
25 starting at Line 14, which is part of your

1 answer, (reading):

2 A. ... I think it is surprising
3 to have that degree of hemorrhage in the
4 delivery that I saw.

5 Q. Would it be less surprising if
6 Jayden was delivered from the mid-pelvis?

7 A. My assessment was that that
8 didn't occur.

9 Q. I realize that, but would it
10 be less surprising if it fact Jayden was
11 delivered from the mid-pelvis?

12 A. I think -- as I testified
13 earlier, I think that as you go up the
14 canal the risks become greater for the
15 neonate. So I guess it wouldn't surprise
16 me.

17 Did I read that truthfully and
18 accurately, my questions and your answer?

19 A. You did.

20 Q. In terms of the most probable cause of
21 this child's brain injuries, the vacuum was
22 part of that. Correct?

23 A. It's clear that the baby had intra-
24 cranial bleeds, it has subgaleal hemorrhage
25 and subdural hemorrhage. As to the cause

1 of hemorrhage, I think the labor and
2 delivery certainly impacted that. Then
3 circumstances of Jayden today may well be
4 related to that and it may be also related
5 to other issues that I am not qualified to
6 speak to.

7 Q. But when you say that the labor and
8 delivery caused the brain bleeds, the
9 delivery of that is by vacuum; correct?

10 A. I was telling the jury earlier that the
11 issue is probably more the labor, the
12 protracted labor, than it is the vacuum
13 itself.

14 Q. Please turn to Page 130 of your
15 deposition.

16 A. (Complies).

17 Q. Page 130, Line 9, question:

18 Q. So let me make sure that I
19 follow what you're telling me. When you
20 expressed an opinion that the most probable
21 cause is labor and delivery, you are
22 specifically talking about labor and
23 delivery with a vacuum?

24 A. Well, in this case obviously I
25 am.

1 Q. So the vacuum is part of that
2 opinion?

3 A. It is.

4 Q. You believe that the vacuum
5 does have causal significance?

6 A. No, I said that it may. I
7 don't know. We don't know where the
8 culprit is. I mean, whether this baby
9 already had bleeds before the vacuum was
10 placed, I don't know. I can tell you that
11 if you look at the literature that vacuum
12 has a modicum of risk, so I guess the
13 simply answer is that in combination it
14 probably is more dangerous than any one was
15 individually. But to tell you is sheer
16 speculation. Nobody knows when it
17 occurred.

18 Q. So you won't go to trial in
19 this case and say that labor, in and of
20 itself, caused this brain bleed?

21 A. Of course not.

22 Did I read that truthfully and
23 accurately?

24 A. Yeah. I am not sure what you were

1 getting at there. I think that I testified
2 here and today that labor clearly was part
3 of the combination of issues.

4 Q. Let me ask you, Doctor, you've taken
5 Charleston as your adopted home?

6 A. (No verbal response).

7 Q. In this community, do you believe that
8 we deserve obstetrical care that is safe as
9 that in other parts of the country?

10 A. I do.

11 Q. Do you believe that we deserve care
12 that is as safe as in Los Angeles?

13 A. I do. I've spent a large part of my
14 career insuring that is in fact the case.

15 Q. Do you believe that we deserve as safe
16 obstetrical care as in Boston and other
17 cities in our country?

18 A. I do.

19 Q. Do you believe that here in Charleston
20 that we deserve at least average safety in
21 obstetrical care?

22 A. You deserve the standard of care.

23 Q. Do we deserve at least average care?

24 A. You do.

25 Q. And are you testifying today that you

1 don't think that this man is in the bottom

2 four percent; isn't that true?

3 A. That's true.

4 Q. Let me ask you, sir, you've authored --

5 you are a coauthor of a book called

6 Operative Obstetrics; true?

7 A. I am.

8 Q. With Larry Gilstrap, Dr. Cunningham and

9 yourself?

10 A. That's correct.

11 Q. The second edition was published in

12 2002, shortly before this birth?

13 A. That's correct.

14 Q. And you didn't author the chapter on

15 Operative Delivery by Vacuum but you gave

16 it your blessing. True?

17 A. The way that this was done is that

18 various topics were parceled out to various

19 experts around the country and then we

20 divided up the various chapters and did the

21 editing on it, so I don't remember whether

22 I edited this particular chapter or not.

23 Q. The question, sir, did you give that

24 chapter your blessing?

25 A. I guess fundamentally that I did,

1 because my name is on the cover.

2 Q. All right. Let's turn to Page 11 of
3 your deposition.

4 A. (Complies).

5 Q. Starting at Line 13, (reading):

6 Q. So is it fair to say that even
7 though you did not author the chapter of
8 Williams Operative Obstetrics that deals
9 with vacuum extraction, you gave it your
10 blessing?

11 A. I did.

12 Did I read that truthfully and
13 accurately?

14 A. That's correct.

15 Q. And in this chapter you list principles
16 of safe vacuum extraction. True?

17 A. I didn't list them but someone did.

18 Q. With your blessing, true?

19 A. I guess so.

20 Q. All right. The first one is an
21 indication should exist for the procedure,
22 do you agree with that?

23 A. I do.

24 Q. And do you agree that that was true in
25 July of '02?

1 A. I do.

2 Q. Second, there should be informed

3 consent. Do you agree with that?

4 A. I do.

5 Q. Did you agree with that in July of '02?

6 A. I did.

7 Q. What does "informed" mean to you in the

8 context of informed consent? Does it mean

9 blanket consent like the one that Dr. Hood

10 showed on the board, or does it mean that

11 the patient has some say-so and should be

12 informed of the risks and alternatives and

13 reasons why the vacuum is even being

14 considered?

15 A. Yeah, we talked about that earlier.

16 Remember? In general, that would be our

17 preference, but in the heat of the battle

18 when fetal outcome is at-risk often we have

19 to dispense with that and go with our gut.

20 Q. Can you show me where in the list of

21 principles of safe vacuum extraction, to

22 which you gave your blessing, it gives

23 exceptions to informed consent?

24 A. It doesn't say that but I think that

25 the jury understands.

1 Q. Informed means aware of alternatives
2 and indications. True?

3 A. In general it does, yes, sir.

4 Q. Several bullet points down your book
5 indicates traction should be applied in the
6 direction of the pelvic axis, perpendicular
7 to the cuff. Do you believe that's true
8 now?

9 A. I did then and do now.

10 Q. And if the jury were to find that Dr.
11 Rhett, instead of pulling along the axis of
12 the birth canal went from side to side,
13 that would violate that rule in the
14 chapter. True?

15 A. That's correct.

16 Q. As you watched the birth video, it
17 appeared to you that Dr. Rhett applied
18 consistent traction to this baby's head.
19 True?

20 A. Well, it was intermittent.

21 Q. Intermittent?

22 A. Intermittent with pushing.

23 EDWARD GRAHAM: Excuse me just a
24 moment, Your Honor.

25 CROSS EXAMINATION CONTINUED

1 BY EDWARD GRAHAM:

2 Q. Please turn to Page 111 of your
3 deposition, starting at Line 9. This is
4 your answer, (reading):

5 A. Yes, it looked to me like - I
6 mean, I didn't see any -- he certainly
7 didn't, I don't think, let up on the
8 pressure. I don't think he ever totally
9 relaxed his traction.

10 A. What I was talking about there was the
11 -- there is a possibility of reliving the
12 vacuum between pulls. We talked about that
13 earlier. In this case, I didn't see that
14 the vacuum pressure was ever taken off.
15 The literature doesn't require that to be
16 done. So the pressure on the fetal scalp
17 was constantly. Obviously you saw on the
18 video that his traction was intermittent.

19 Q. Did I read your answer accurately?

20 A. Sir, I am telling you that we were
21 talking about the degree of vacuum. It was
22 constant in that it was never relieved.
23 It's clear from the video that he wasn't
24 pulling the entire time. There were
25 several times when he stopped and regrouped

1 and then pulled again, so that was clearly
2 intermittent. What I was referring to here
3 as that the traction stayed on the entire
4 time.

5 Q. My question, sir, did I read your
6 answer accurately?

7 A. Sir, I want the jury to hear accuracy.
8 I also want them to hear it in context.

9 Q. That's fine.

10 JAY DAVIS: Your Honor, could I
11 ask Mr. Graham, as he asked that last
12 question, to read the rest of the answer
13 which he left off.

14 THE COURT: Go ahead. Please
15 read the remainder of the answer, Mr.
16 Graham.

17 JAY DAVIS: Beginning with,
18 "...relaxed his traction."

19 EDWARD GRAHAM: Okay, (reading):

20 A. I can imagine that the degree of
21 traction may have varied relative to her
22 pushes but it looked to me like there was
23 traction on the head. A lot of people do
24 that so as to not lose stations that you
25 have gained. Is that all that you wanted

1 me to read?

2 JAY DAVIS: Thank you.

3 EDWARD GRAHAM: Is that it?

4 JAY DAVIS: Ye.

5 EDWARD GRAHAM: All right.

6 CROSS EXAMINATION CONTINUED

7 BY EDWARD GRAHAM:

8 Q. Doctor, I don't mean to belabor this
9 point but I think the Ladies and Gentlemen
10 are entitled to know, did I read your
11 answer truthfully and accurately?

12 A. You did.

13 Q. Thank you.

14 EDWARD GRAHAM: Beg your
15 indulgence, Your Honor.

16 THE COURT: Yes, sir.

17 EDWARD GRAHAM: In the interest
18 of time, Your Honor, I have no further
19 questions.

20 THE COURT: All right. Is there
21 redirect?

22 ROBERT HOOD: If I may, Your
23 Honor.

24 THE COURT: Please proceed.

25 REDIRECT EXAMINATION

1 BY ROBERT HOOD:

2 Q. Dr. Van Dorsten, are you a professional
3 witness?

4 A. Sir?

5 Q. Are you a professional witness?

6 A. Give me a hint.

7 Q. Do you make your living coming to the
8 courtroom, talking to jurors?

9 A. I don't.

10 Q. Do you make your living training
11 doctors?

12 A. I do.

13 Q. You have, what, forty-some doctors
14 working under you that you are responsible
15 for?

16 EDWARD GRAHAM: Leading, Your
17 Honor.

18 THE COURT: Sustained. That's
19 leading.

20 THE WITNESS: I have forty
21 faculty ---

22 EDWARD GRAHAM: It's also not
23 new material, Your Honor.

24 THE WITNESS: --- and twenty-
25 one residents.

1 THE COURT: Overruled.

2 REDIRECT EXAMINATION CONTINUED

3 BY ROBERT HOOD:

4 Q. You were shown something about mid-
5 station deliveries here, this thing. Does
6 that have anything to do with this
7 delivery?

8 A. It does not. I can't even -- I barely
9 can see it.

10 Q. Plaintiff asked you about this.

11 A. It is not pertinent to this case in my
12 estimation.

13 Q. This is not -- your answer, again?

14 A. That it is not pertinent to this case.

15 Q. Looking at Exhibit 98-C, is the birth
16 video pertinent to this case, Doctor?

17 A. It is.

18 Q. In that birth video, does Dr. Rhett
19 rock the ---

20 THE COURT: Leading.

21 REDIRECT EXAMINATION CONTINUED

22 BY ROBERT HOOD:

23 Q. Does Dr. Rhett do anything, with the
24 vacuum extractor, improperly?

25 A. He does not.

1 Q. When I asked about rocking, was there
2 any rocking?

3 A. He didn't rock.

4 Q. You were asked about popping off, the
5 pressure staying on it. Tell us about
6 that.

7 EDWARD GRAHAM: Your Honor, I
8 asked no such question.

9 ROBERT HOOD: I thought that
10 whole line of stuff that we just listened
11 to was about that.

12 THE COURT: Overruled. You may
13 proceed.

14 THE WITNESS: There was no pop
15 off.

16 REDIRECT EXAMINATION

17 BY ROBERT HOOD:

18 Q. Was Dr. Rhett pulling the entire time?

19 A. He maintained some traction. The major
20 pulling was done in concert with her
21 contractions, with her pushing.

22 Q. When we talk about Dr. Edmund Rhett,
23 his knowledge of anatomy, his knowledge of
24 obstetrics, his knowledge of the use of the
25 vacuum, what is your opinion?

1 A. Dr. Edmund Rhett is a skilled
2 physician. I have five women who practice
3 in the same hospital with him, who compete
4 with him, they hold him and his ---

5 EDWARD GRAHAM: Objection, Your
6 Honor.

7 ROBERT HOOD: He has gone into
8 this *ad nauseam*.

9 THE COURT: Go ahead.

10 EDWARD GRAHAM: He has no basis
11 for asking ---

12 THE COURT: Just a moment. How
13 is it responsive to an issue that he
14 brought up, Counsel?

15 ROBERT HOOD: He repeatedly
16 asked about Dr. Rhett and what category
17 that he was in, whether he was in the four
18 percentile or what percentile.

19 THE COURT: Objection overruled.
20 You may proceed.

21 THE WITNESS: Dr. Rhett is
22 held in high esteem by my colleagues that
23 practice alongside him. I have received
24 from him over the years. I find that his
25 management has been superb. His reputation

1 in the community at the Medical University
2 of South Carolina is that of an able
3 practitioner.

4 REDIRECT EXAMINATION

5 BY ROBERT HOOD:

6 Q. Is he a five percentile ob-gyn?

7 A. Of course not.

8 Q. You actually have people that practice
9 side by side. Explain that to the jury so
10 that they understand what the Medical
11 University is doing in the community?

12 A. I have five female practitioners that
13 practice at what is called the East Cooper
14 Women's Center, over in Mount Pleasant,
15 deliver at East Cooper Hospital.

16 At night when they need help or need to
17 do c-sections, they call persons from other
18 practices on call so as not to call one of
19 their own people that is not on call. So
20 they are intimately familiar with Edmund
21 and his style of medicine.

22 I've heard nothing but praise for
23 Edmund. I've never heard anything
24 derogatory or negative about Edmund Rhett
25 in the last thirty years that I've known

1 him, twenty-nine years.

2 Q. If you closed your eyes and you didn't
3 see the doctor during the delivery but you
4 were looking at the birth video, would your
5 opinions change in this case?

6 A. It would not.

7 Q. And when this vacuum was applied, what
8 was the station of this child as you see it
9 on the birth video?

10 A. It was a low vacuum (sic).

11 Q. Was it at an appropriate location when
12 the vacuum was applied?

13 A. It was.

14 Q. You were asked about your deposition.
15 I want to ask about -- I want to take where
16 you were asked question and then read the
17 next sentence or two. On Page 44, Line 2,
18 question in your deposition by Mr. Graham,
19 (reading):

20 Q. *At the time that Dr. Rhett*
21 *applied the vacuum, is there any reason for*
22 *you to disbelieve that a change in maternal*
23 *posture would have relieved the viable*
24 *decel?*

25 Your answer, Doctor? Please read it.

1 A. (Reading):

2 A. Well, as I stated, I don't
3 think that there is any scientific evidence
4 that that is an important part of one's
5 material.

6 I testified earlier today similarly.

7 Q. Are there risks and benefits to all
8 procedures in medicine, Doctor?

9 A. There are.

10 Q. Is that why a doctor goes to college,
11 to medical school, to residency, twelve
12 years to become a Board-certified Ob-Gyn?

13 EDWARD GRAHAM: Objection, Your
14 Honor.

15 REDIRECT EXAMINATION CONTINUED

16 BY ROBERT HOOD:

17 Q. To study the risks and benefits and to
18 apply them in a particular circumstance?

19 A. That's correct.

20 THE COURT: Overruled, as a
21 basic issue. Anything further, Mr. Hood?

22 ROBERT HOOD: Yes, sir, I've
23 just got a couple.

24 THE COURT: Go ahead.

25 REDIRECT EXAMINATION CONTINUED

1 BY ROBERT HOOD:

2 Q. Page 49, you were asked at your

3 deposition by Mr. Graham:

4 Q. Tell me on what basis you
5 contend that this child was at a low
6 station. You have said something about the
7 monitor. Can you explain that, please?

8 Your answer?

9 A. (Reading):

10 A. When he took off the scalp
11 electrode, it looked to me like he did so
12 with the fetal head at a very low station.
13 And when he applied the vacuum, it looked
14 like he got the head just inside the
15 introitus, just inside the birth canal.

16 Q. Is that what you said here today?

17 A. It is.

18 Q. Did you ever testify that this was a
19 mid-station delivery?

20 A. I never did.

21 Q. Was it?

22 A. It was not.

23 Q. Then, finally, Page 130, Line 17, you
24 were asked by Mr. Graham -- how many hours
25 was this deposition?

1 A. I don't remember. It seemed like an
2 eternity.

3 Q. You were asked this question,
4 (reading):

5 Q. Do you believe that the vacuum
6 does have causal significance?

7 Your answer?

8 A. (Reading):

9 A. No, I said that it may. We
10 don't know. We don't know where the
11 culprit is. This baby already had bleeds
12 before the vacuum was placed. I don't
13 know.

14 If the records at the hospital at the
15 time of this delivery, for a four-year
16 period show sixty-one vacuum deliveries of
17 the three hundred twelve deliveries, is
18 that an acceptable rate?

19 A. It is.

20 Q. Was Dr. Rhett's use of the vacuum in
21 this case appropriate in your professional
22 opinion, to a reasonable degree of medical
23 certainty most probably?

24 A. It was.

25 ROBERT HOOD: Thank you.

1 EDWARD GRAHAM: Just one
2 question, if the Court please.

3 THE COURT: What is the new
4 issue brought up in redirect?

5 EDWARD GRAHAM: It had to do
6 with brain bleeds.

7 THE COURT: All right.

8 RECROSS EXAMINATION

9 BY EDWARD GRAHAM:

10 Q. Dr. Van Dorsten, there is absolutely no
11 evidence in any of these records, on the
12 birth video or anywhere else, of Jayden's
13 brain bleeding before the vacuum was
14 applied. True?

15 A. That's correct. I've just suggested,
16 many times today, that labor may be in fact
17 be the culprit and not the vacuum itself.

18 Q. All right.

19 EDWARD GRAHAM: That's all.

20 THE COURT: Sir, you are free to
21 step down.

22 (WITNESS STEPS DOWN)

23 THE COURT: Counsel, come up and
24 let's talk about scheduling for a moment.

25 (OFF RECORD BENCH CONFERENCE)

1 him?

2 A. No, I don't remember working
3 with him other than what I saw in the
4 video.

5 Q. Do you recall how he treated
6 you as a nurse and any other nurses, that
7 you observed?

8 A. Yes, he was nice to the
9 patients.

10 CHILTON SIMMONS: That's it.

11 THE COURT: Ladies and
12 Gentlemen, we've been about an hour
13 publishing that deposition. Let's take a
14 quick break. We are going to let you go
15 back to the jury room for about ten minutes
16 or so and then we will reconvene for our
17 next witness. Let's all remain where we
18 are while our jury departs.

19 (JURY OUT @ 11:11 A.M.)

20 THE COURT: We will be in recess
21 for about ten minutes.

22 (BRIEF RECESS)

23 THE COURT: Are we ready for the
24 jury?

25 MOLLY CRAIG: Yes, sir.

1 THE COURT: Please bring in the
2 jury.

3 (JURY IN @ 11:22 A.M.)

4 THE COURT: Welcome back, Ladies
5 and Gentlemen. From time to time I have
6 law students from the law school join me,
7 to teach me some law. I have seated with
8 me today Miss Jennings, who is a rising
9 third-year student at the Charleston School
10 of Law, who will be working with my law
11 clerk for this next court session. Please
12 call your next witness.

13 MOLLY CRAIG: Yes, sir, we
14 call Dr. John Hobbs.

15 (WITNESS TAKES STAND)

16 JOHN HOBBS, being duly sworn to
17 tell the truth, the whole truth and nothing
18 but the truth, testified as follows:

19 DIRECT EXAMINATION

20 BY MOLLY CRAIG:

21 Q. Good morning, sir.

22 A. Good morning.

23 Q. Dr. Hobbs, please tell us where you and
24 your family live?

25 A. We live in Oak Park, Illinois, which is

1 right outside of Chicago.

2 Q. What do you do for a living?

3 A. I'm an obstetrician and I am an
4 assistant pastor of a church.

5 Q. You're an assistant pastor where?

6 A. On the south side of Chicago.

7 Q. What is the name of the church?

8 A. Progressive Community Center, The
9 People's Church.

10 Q. Doctor, if you could, put that
11 microphone a little bit closer to your
12 mouth. We're having a little bit of
13 trouble hearing you.

14 A. (Complies).

15 Q. Thank you. Please tell us, what does
16 your wife do for a living?

17 A. She's a news anchor with NBC, morning
18 anchor in Chicago, television station in
19 Chicago.

20 Q. A morning news anchor?

21 A. Yes.

22 Q. Mornings come early at your house?

23 A. Morning never ends.

24 Q. How many children do you and your wife
25 have?

1 A. I have four children, between my wife
2 and myself we have two.

3 Q. What is the name of your practice?

4 A. Female Health Care Associations.

5 Q. What is your role in that practice?

6 A. I'm the CEO, I'm the president and the
7 speaking physician of that practice.

8 Q. Please tell us about your education,
9 sir, where did you do to college, where did
10 you go to medical school?

11 A. I went to college in Montana, at the
12 University of Montana. I left there and
13 went to the University of Minnesota Medical
14 College in Minneapolis. I completed my
15 degree in Medicine at the University of
16 Minnesota and then I matriculated to
17 Chicago to do my residence at Rush
18 Presbyterian University, which at that time
19 was called Rush Presbyterian Medical
20 Center, where I did my residency.

21 Q. You indicated that you are also a
22 minister?

23 A. Correct.

24 Q. How much of your time do you give being
25 a minister?

1 A. It varies, it depends on what is going
2 on with the congregation. I do a lot of
3 grief counseling, what have you, and I also
4 preach quite a few Sundays.

5 Q. Are you Board-certified?

6 A. I am.

7 Q. In what areas?

8 A. Obstetrics and gynecology.

9 Q. Dr. Hobbs, are you involved in any
10 teaching of residents or any other type
11 students?

12 A. I am a clinical professor, which
13 basically means that all of my teaching is
14 to residents in training. All of my work
15 primarily at this time is based on clinical
16 training, in the operating room, in the
17 delivery room, in the labor and delivery
18 suite.

19 Q. How much are you paid for teaching
20 residents?

21 A. Zero.

22 Q. Please tell us about any awards that
23 you've received?

24 A. I am kind of humble about that. I have
25 received a number of awards in the past,

1 several of them have been related to the
2 practice of obstetrics. Some of my awards
3 have been related to my ministry as an
4 ordained minister.

5 Q. Who is in the Top 100 Doctors in
6 Chicago?

7 A. On an annual basis the television
8 networks and also a magazine called "The
9 Chicagoan" basically have used patients and
10 physician and ancillary personnel trying to
11 find out if you're sending your loved one
12 to a particular physician, who would you
13 send your loved one to. From that they
14 make an assessment of the more frequently
15 mentioned physicians, and that's how they
16 compile the number of the top physicians.

17 Q. Dr. Hobbs, have you received the award
18 as one of the Top 100 Doctors in Chicago?

19 A. I have.

20 Q. How many babies do you deliver a
21 month?

22 A. At present there are two people, two
23 physicians, in my practice, myself and my
24 association who has been in practice with
25 me now in excess of twenty-five years, and

1 we also have a midwife, and between the
2 three of us we delivery probably about
3 twenty, maximum twenty-five, babies a
4 month.

5 MOLLY CRAIG: Your Honor, at
6 this time we would offer Dr. John Hobbs as
7 an expert witness in the field of
8 Obstetrics and Gynecology.

9 THE COURT: Is there objections
10 or questions on the expertise of the
11 witness?

12 JAY DAVIS: No, sir.

13 EDWARD GRAHAM: No, Your Honor.

14 THE COURT: Hearing none, it is
15 so ordered.

16 MOLLY CRAIG: Thank you.

17 DIRECT EXAMINATION CONTINUED

18 BY MOLLY CRAIG:

19 Q. Dr. Hobbs, at my request have you had
20 the opportunity to review the medical
21 records related to Ms. Washington, her
22 prenatal course and her delivery?

23 A. Right.

24 Q. Have you also reviewed the birth video?

25 A. Right.

1 Q. Have you also reviewed depositions in
2 this case?

3 A. I have.

4 Q. Dr. Hobbs, tell us what the standard of
5 care is?

6 A. The standard of care basically is the
7 care that is provided by a physician in
8 similar circumstances as the issue one is
9 -- the issue is that one is discussing.

10 Q. What rules must an obstetrician follow
11 when delivering a baby?

12 A. I'm sorry.

13 Q. What rules must an obstetrician follow
14 when delivering a baby?

15 A. I'm not sure what you mean by rules.
16 There are no rules to the standard of care.

17 Q. What is the difference between rules
18 and standard of care?

19 A. I have rules in my house as to what my
20 children have to do.

21 I have rules at the church as to what
22 various ministers are to do.

23 But I don't know of any rules in
24 obstetrics and gynecology.

25 Q. In obstetrics and gynecology, what do

1 you operate under?

2 A. What is defined as the standard of
3 care.

4 Q. Do you have an opinion as to whether
5 Dr. Rhett acted reasonably in using the
6 vacuum in this case?

7 A. Considering the circumstances that he
8 was faced with, I agree with his approach
9 in delivering this baby.

10 Q. Dr. Hobbs, I have a checklist to make
11 sure that I've covered everything that --
12 (reviewing notes). I want to make sure
13 before I finish that we've covered all
14 these areas, this will keep me straight.

15 The first issue is standard of care.
16 Do you have an opinion as to whether or not
17 Dr. Rhett acted reasonably as to the
18 standard of care in this case?

19 A. Yes, I do.

20 Q. What is that opinion?

21 A. That he did act reasonably within the
22 standard of care.

23 Q. Dr. Hobbs, do you know Dr. Rhett?

24 A. I do not.

25 Q. When was the first time that you met

1 Dr. Rhett?

2 A. This morning.

3 Q. What is a mid-pelvic delivery, sir?

4 A. That is a delivery that occurs in the
5 area of the pelvis which we would define as
6 the mid pelvis.

7 Q. What is a low pelvic delivery?

8 A. That is the area that obviously we have
9 designated as being the lower aspect of the
10 pelvis.

11 Q. What type of delivery occurred in this
12 case?

13 A. I don't know exactly what type it was
14 but my feeling is that it was probably a
15 low delivery.

16 Q. Tell us what evidence that you base
17 your opinion on that it was a low pelvic
18 delivery?

19 A. Well, there is no absolute definitive
20 way for me to determine that it was however
21 I saw some points that made me suspicious
22 that it was. On the video, if you look at
23 it, Dr. Rhett removed the scalp electrode
24 from the video -- the scalp electrode is
25 actually screwed into the baby's scalp.

1 The purpose of it is establish contact
2 between the electrode and the baby's scalp,
3 which gives a good reading, an accurate
4 reading of the baby's heart rate.

5 As I remember from the video, Dr. Rhett
6 unscrewed the scalp electrode with his
7 fingers barely into the vaginal. You
8 cannot take that off without it being right
9 near the insert. So that was a sign to me
10 that the baby was reasonably low into the
11 pelvis, otherwise he would have had to have
12 put his whole hand up in there to get it
13 out.

14 The second thing is, and I think some
15 of the women on the jury who have had
16 vaginal births before can attest, is that
17 there is some time later that we as
18 physician use what we call a trigger point.
19 A trigger point makes us respond to examine
20 a patient. Usually what will happen is
21 that the patient will usually say 'I've got
22 the urge to push.' Many of you would
23 probably understand that nature -- if
24 you've ever been in a delivery room, you
25 would probably hearing everybody running

1 about saying 'don't push, don't push'
2 because they are not actually prepared for
3 it. So in essence when we hear a patient
4 say to us 'I got to push' or 'I need to
5 push' that means it's an effort that they
6 may sometimes try to control but they
7 really can't control because that baby has
8 now fallen down in the deep part of the
9 pelvis, triggering what we call the pelvic
10 floor. The muscle, the nerve is there and
11 your body gets that natural urge and you
12 can't stop it. That happens when the baby
13 is pretty low in the pelvis.

14 Q. How about the time that it takes to
15 deliver the baby, is that significant in
16 terms of determining where the baby is?

17 A. Well, the higher the baby is in the
18 birth canal, the more difficult to deliver
19 him. This was a relatively easy, smooth
20 delivery, so based on that I would think
21 that he must have been relatively low in
22 the pelvis.

23 Q. Other than where the scalp electrode
24 was, the ease of delivery and the need to
25 push, do you base your opinion that this

1 was a low pelvic delivery on any other
2 information?

3 A. The deposition of Dr. Rhett.

4 Q. Do you have an opinion whether Dr.
5 Rhett acted reasonably in using the vacuum
6 for this low pelvic delivery?

7 A. Considering what he was faced with,
8 yes.

9 Q. All right. Doctor, I want to make sure
10 about the need to push ---

11 MOLLY CRAIG: Your Honor, may
12 he come down off the stand and show us on
13 the fetal monitoring strips?

14 THE COURT: You may, please make
15 sure that you face our court reporter.

16 DIRECT EXAMINATION CONTINUED

17 BY MOLLY CRAIG:

18 Q. Dr. Hobbs, if you will, come right here
19 so that the court reporter can hear you.
20 You talked about the mother wanting to
21 push, was that on this page or another
22 page?

23 A. It's on this page.

24 Q. Show us where it is?

25 A. According to this diagram, 1931. So if

1 we go with three sections of this chart and
2 move down here the nurse opines that
3 (rapidly reading, voice getting quieter).

4 COURT REPORTER: I'm sorry,
5 Doctor, could you speak up.

6 THE WITNESS: We speak of
7 medical jargon and use abbreviations: C/O
8 is a standard one that we use to abbreviate
9 "complains of".

10 In this circumstance, a patient -- the
11 nurse charts that the "patient complains of
12 needing to push, VA complete."

13 DIRECT EXAMINATION CONTINUED

14 BY MOLLY CRAIG:

15 Q. What does that mean in terms of where
16 the baby's head is?

17 A. Well, as I said, in most circumstances
18 we know when we hear that that the baby is
19 low into pelvis, because the mother cannot
20 -- the mother would only say that -- when
21 she feels that pressure when it hits the
22 floor of the pelvis. If it doesn't hit the
23 floor of the pelvis, you'll not -- they
24 will not give you that response.

25 Q. Thank you, Dr. Hobbs. I want to go

1 straight to the second day of Ms.

2 Washington's labor, on July the 16th, 2002.

3 Have you had a chance to review the fetal

4 monitoring strips in this delivery?

5 A. Yes, I have.

6 Q. And starting at approximately 7:00

7 p.m., what did you see on the fetal

8 monitoring strips?

9 A. There were areas of decelerations,

10 which is a drop in the baby's heart beat,

11 and there were also areas of what we call

12 bradycardia. You differentiate the two

13 because of what we call the rebound or the

14 response to correct the problems.

15 In a deceleration, what generally will

16 happen is that the heart rate goes down and

17 stays down for a period of time -- usually

18 less than two minutes -- and then it

19 responds by coming straight back up. In

20 other words, the baby bounces right back.

21 As opposed to bradycardia, which is a

22 sustained decrease of the heart rate that

23 responds very, very slowly in coming back

24 to the baseline or it stays down.

25 Q. The decelerations that you just

1 referenced, when did those occur in
2 relation to the bradycardia?

3 A. The decelerations, as I remember, were
4 occurring prior to the bradycardia.

5 Q. The bradycardia that you're referring
6 to is bradycardia at what time?

7 A. There was one that occurred prior to
8 the delivery, prior to Dr. Rhett's
9 application of the vacuum, and then there
10 was one that occurred around the time that
11 he was in the process of trying to do the
12 delivery.

13 Q. Let's talk about the first bradycardia
14 at approximately 12:45 to 1:00 p.m. The
15 first bradycardia that you just referenced.
16 What was going on at that time, basically,
17 in your view of these records?

18 A. I'm sorry, what was going on?

19 Q. What was going on at approximately
20 12:45 or 1:00 o'clock when the first
21 bradycardia came about?

22 A. The patient was laboring.

23 Q. Did that cause you any concern in
24 reviewing the strips?

25 A. The bradycardia?

1 Q. Yes.

2 A. Of course. Bradycardia at any time is
3 a cause of concern for a physician.

4 Q. What was done at that time for the
5 mother?

6 A. I think that there was some indication
7 that the patient was turned or that someone
8 called -- I think that the one that we're
9 talking about -- let me clarify that.
10 There was one where the bradycardia
11 occurred and the nurse turned the patient
12 onto her side. That may have been much
13 earlier, I don't recall the time right now.

14 But then there was another one that
15 occurred later, at which time the nurse
16 called and Dr. Rhett came into the delivery
17 room.

18 Q. Now, the second brady--, -- I just want
19 to make sure that we have the timing right.
20 The decelerations that you just discussed,
21 when did those occur in relation to the
22 second bradycardia on the strip? Sorry
23 about making you get your exercise, do you
24 mind coming down again?

25 A. I'm from Chicago. I need it.

1 Q. You're used to walking, right?

2 A. You got it.

3 Q. All right. Let's walk through these,
4 I'll hold them for you. Just show us where
5 the bradycardia is on this strip.

6 A. These are called accelerations.

7 Sorry.

8 These are called decelerations. The
9 heart rate goes down and then it starts to
10 come back up.

11 This is a deceleration. The heart rate
12 goes down, comes right back up.

13 The difference in bradycardia, the
14 heart rate goes down, stays down, and
15 whatever is on the other side of 1931 is
16 what you see there.

17 Q. What does this tell you as a delivery
18 physician regarding the health and welfare
19 of the baby?

20 A. Well, it tells me that I need to do
21 something if this persists because of the
22 fact that the baby is in danger of being
23 hypoxic. If I cut your heart rate down for
24 some reason, the longer that it stays down
25 there is danger to you or to your baby.

1 Q. Than you. Looking at the next strip,
2 Doctor, tell us what is going on with the
3 baby in utero.

4 A. This appears to be a continuation of
5 what we're talking about in the previous
6 one with the bradycardia, where the heart
7 rate goes down. As you can see it, it's a
8 very, very slow incline trying to get back
9 up to its normal level. In essence, the
10 baby is still in the -- where the
11 bradycardia is having an adverse effect on
12 it.

13 Q. Doctor, looking at this strip, and in
14 looking at all the strips that you have
15 reviewed in this case, do you know what the
16 time of delivery was?

17 A. It is recorded as 1937.

18 Q. Who recorded it?

19 A. Looks like the nurse recorded it as
20 1937, but I am not totally convinced that
21 the delivery occurred at 1937.

22 Q. Explain that to us.

23 A. Well, if you look at this, the heart
24 rate comes back up. It starts to go down
25 again. There is continuity here, there is

1 no break in the -- see, this is the
2 legitimate heart rate that is going on
3 here. This is beyond what would be beyond
4 37, because 37 would be here but this
5 continuity of that heart rate persisted.

6 Under the circumstances, I am not totally
7 sure that baby was out at 37 -- although it
8 is recorded by the nurse as 37.

9 Q. Whether the nurse recorded the delivery
10 time as 1937 or 1939, how does that change
11 your opinion ---

12 A. Oh, no. You've still got to get the
13 baby out, so it doesn't make any
14 difference. You've got to get the baby
15 out.

16 Q. Explain why you've got to get the baby
17 out.

18 A. The baby is in danger, the baby is at-
19 risk and under the circumstances you need
20 to get that baby delivered.

21 Q. Dr. Hobbs, if you had been the
22 delivering physician for this child, what
23 would you have done?

24 A. I would have gotten the baby out.

25 Q. Don't go anywhere, I want to ask you

1 something else. If I could get you to
2 please come up to the -- the very next --
3 Dr. Hobbs, if you could look -- what am I
4 doing wrong? This always happens with me
5 (adjusting ELMO).

6 Explain, what is this document that we
7 are looking at? For the record, it is ECH
8 03. Tell us what -- there we go -- thank
9 you very much.

10 Is this a continuance of the blowup?
11 I just want to make sure that we know what
12 we are looking at here?

13 A. Counsel, I will admit to the jury that
14 my initial reaction when I saw this was
15 that I thought that this was a fetal heart
16 tracing. I thought that this was the
17 baby's heart beat continuing. But the
18 issue that came up was, there was a
19 question about the time of delivery and I
20 was never certain that 37 was the time of
21 delivery. At my deposition, I said that I
22 thought this was a continuing heart rate
23 but I'll admit that when I went back
24 through after questions were raised in
25 that, later reviewing the video and in also

1 looking at this, there is a distinct "gap",
2 if you will, right here -- here to here
3 (indicating), there is a distinct gap
4 there.

5 When I saw that, I then went -- that's
6 the gap that we are seeing right there.

7 When I saw that, I went back to the video
8 to try to establish whether this was actual
9 a fetal heart beat.

10 Well, it could not -- it was not the
11 electrode that was doing it and -- however
12 what I did notice is that when the external
13 monitor that was placed on the patient --
14 Dr. Rhett had asked for the external
15 monitor to be applied before he unscrewed
16 the electrode.

17 When that was placed, then they used
18 a handheld monitor which is basically the
19 monitor that reads -- we call it an
20 external monitor, a handheld monitor that
21 comes off the machine itself.

22 If you look at the video, what you see
23 is that when Dr. Rhett said 'use the
24 external video (sic)', you see the hand of
25 the nurse comes onto the patient with the

1 monitor. She places it approximately just
2 above the pubic bone. In that
3 circumstance, I deduced from that that as
4 that baby was delivered -- once that head
5 comes out, we as physicians listen for the
6 baby's heart beat on an external monitor
7 through the baby's back contrary to -- if
8 I listened to your heartbeat, I'd get a
9 stethoscope and I go to your front side and
10 listen for the heart beat. In order to do
11 that on a baby, you must go to the back.
12 That's how an external monitor works.

13 I noticed on the monitor after that
14 half of the baby was delivered that the
15 hand of the nurse remained in the same
16 position. What does that tell me? It
17 shows that the chest of the patient --
18 unless you make a gooseneck out of this
19 baby and stretch that neck way out -- which
20 is deadly to a baby because you'd break the
21 baby's neck -- once you stretch it out of
22 the lower part of the vaginal, it's no
23 longer up where the nurse originally had
24 the monitor.

25 On that basis, then, after the baby's

1 head was out, what she was getting was
2 probably the pulse of the mother. I looked
3 back at it and, lo and behold, the nurse
4 had charted that the mother's heart beat
5 was 96. That's charted on this fetal
6 tracing, that the mother's heart rate was
7 96.

8 Q. Show us that.

9 A. (Indicating) at approximately 1923-
10 plus, maybe 24, around 24, 1924, the nurse
11 indicates on here what the mother's heart
12 rate is. You will see a little tiny -- 96.

13 Q. Can you identify this document, please?
14 ECH009.

15 A. Right, 009.

16 Q. Hold on a minute. That's the mother's
17 heart rate. What was the heart rate.

18 A. 96.

19 Q. Then right here on this tracing, ---

20 A. When I went to this tracing, I noticed
21 that the mother's heart rate here was
22 vacillating around 96. Did it get more --
23 did it go up higher than that? Yes, it
24 did. It went up slightly higher than that,
25 but now she's at the termination of the

1 labor. Immediately upon delivery, if you
2 go back to the chart, her epidural is
3 turned off after the baby -- as soon as the
4 baby was delivered, which means that her
5 pain sensation also would have increased.

6 So under the circumstances, although I
7 said in my deposition originally that I
8 thought that this was the baby's heart
9 beat, when I actually looked back through
10 it because counsel brought my attention to
11 the fact that the delivery occurred at 37,
12 I said that's what is written but under the
13 circumstances I thought the baby was
14 delivered later.

15 Q. All right, just to be sure that I
16 understand, this tracing right here is
17 whose heart rate?

18 A. If you put an external monitor on the
19 mother and there is no baby, what the
20 monitor will pick up is the pulsation of
21 the aorta, the your blood supply, your
22 aorta, that carries blood to your body.

23 If you lay down at night and press
24 hard, you'll feel the pulsing. That is a
25 direct connection with your heart beat,

1 because your heart pumps -- blood goes
2 through, that's what pulsation is all
3 about.

4 Once that baby was down in the pelvis
5 and the vacuum (sic) was not longer
6 accessible to the nurse who was listening
7 to it, what she was listening to was the
8 pulsation of the aorta up against the back
9 of the uterus, which I believe was the
10 mother's heart rate.

11 Q. Okay, Doctor. That's the mother's
12 heart rate. Let's go back now to the time
13 of delivery. Have you reviewed this
14 document in your preparation as an expert
15 witness in this case?

16 A. I saw this document, yes.

17 Q. What is this document?

18 A. 1737; vacuum-assisted delivery.

19 Q. Whose document is it? The time of the
20 delivery was 1937?

21 A. I don't know exactly.

22 Q. What type of document is this?

23 A. It's called a fetal monitoring strip.

24 Q. Is it the type of information that you
25 need to determine the time of delivery?

1 A. Oh, certainly. If I were to dictate
2 something in regard to it, I'd go back to
3 the chart based on what is in here.

4 Q. Okay. That's ECH0017. What is this
5 document?

6 A. This is what we call the delivery data
7 or surgical data summary.

8 Q. Who prepares this document?

9 A. This is generally prepared by a nurse.

10 Q. What did the nurse document with regard
11 to the time of delivery?

12 A. Says delivery of infant "7/16 1937."

13 Q. Dr. Hobbs, can you now identify this
14 document, ECH0066? What does it say at the
15 top there, what is that? Could you read to
16 the jury the highlighted portion -- it's
17 hard to see on the ELMO.

18 A. (Reading):

19 Date: 7/16

20 Time: 1937

21 Type: Anot. Vac-assisted DEL,
22 viable male infant.

23 It says that it was entered by JCM.

24 Q. What is the time of delivery?

25 A. 1937.

1 Q. Who is the nurse who signed this flow
2 sheet?

3 A. The name is Judy -- looks like Mercer
4 but I won't hold myself to that because I
5 can't make it out but it looks like Mercer.

6 Q. Do you have an opinion as to whether
7 these nursing documents are documents that
8 delivering physician reasonably rely upon
9 with regard to timing delivery?

10 A. Well, I've never used this flow sheet
11 but I've certainly used the surgical data
12 sheet. I think most of my colleagues use a
13 surgical data sheet, delivery data sheet.

14 Q. Do you have any opinion whether Dr.
15 Rhett acted reasonably in believing that
16 the time of delivery was 1937, based upon
17 these records?

18 A. I think he did.

19 Q. What difference does it make, at all,
20 with regards to your opinion as to whether
21 or not the delivery was at 1937 or 1939?

22 A. The issue was that the baby needed to
23 delivered. Quite simply, the baby needed
24 to be delivered.

25 Q. Right. Can you show us definitively,

1 if you have been the doctor delivering this
2 baby, at which point this baby needed to be
3 delivered?

4 A. I would probably have intervened to
5 deliver this baby sometime inbetween this
6 bradycardia and the reoccurrence of the
7 second one.

8 Q. What time was that?

9 A. I can't tell you precisely at what time
10 I would have, but I said during the time --
11 from the time of this bradycardia until the
12 beginning of the next, I would have tried
13 to anticipate delivery.

14 Q. Well before 1937 or 1939?

15 A. Oh, absolutely.

16 Q. Thank you, Doctor. You may resume your
17 seat on the stand now.

18 A. (Complies).

19 Q. Dr. Hobbs, you talked about the
20 external transducer -- can we get the birth
21 video teed up, please. We are going to
22 just watch the very end of the delivery and
23 I want you to please explain to us where
24 the transducer is and how that affects your
25 opinion about the maternal heart beat being

1 shown on this monitor tracing -- (video
2 playing).

3 A. Back it up, back further, back further
4 -- here. Here, stop it. That hand is
5 screwing the electrode out. You can see
6 that his fingers are not completely in the
7 vagina. They are exposed. If that head
8 -- that electrode is attached to the baby's
9 head and you cannot remove it with your
10 fingers unless it is very close to the
11 outlet. It's a wired device and you can't
12 just pull it out. You have to unscrew it.

13 Q. Up here it says 7:40 p.m., we've got
14 another time here that we are looking at.
15 What significance does that have?

16 A. That's the video camera. It just
17 depends on what time that was set.

18 Q. Do any of these times affect your
19 opinion with regard to the need to delivery
20 this baby?

21 A. No.

22 Q. Please continue -- (video playing).

23 A. Stop. The right hand of the nurse --
24 if you look very closely that the device is
25 on the bellybutton right above the nurse's

1 hand. I don't have a pointer.

2 Q. Do we have a pointer?

3 A. I'll use my finger. That's what we
4 use in medicine. Here is the bellybutton
5 right here. The external monitor was
6 placed right underneath that, at the
7 mother's bellybutton.

8 Now, as the baby is descending down the
9 pelvis -- (video playing)-- that hand stays
10 there, the hand stays there and as you can
11 see as Dr. Rhett lifts the baby out the
12 hand is still in the same position.

13 (Video playing) -- as a matter of fact
14 you'll notice that the nurse is pushing
15 upward. She is not longer pushing downward
16 but pushing upward. Hand remains there.

17 (Video replaying) -- the hand remains
18 in the same place. With the advancing of
19 the vacuum, the baby is obviously coming
20 down. The hand remains in the same place.

21 Q. Please pause it. What is significance
22 about the nurse's hand. First of all, what
23 is she holding?

24 A. She is holding the external transducer,
25 a monitor.

1 Q. Transducer. What is significant about
2 the nurse holding the transducer on the
3 mother's stomach?

4 A. You are able to get a heart beat by
5 holding it to the mother's stomach.

6 Q. At this point whose heart rate is it
7 picking up?

8 A. Because the baby is not out yet, I
9 would accept that as the baby's heart beat.

10 Q. Keep going -- (video playing). Why
11 don't we stop right there? I see the
12 nurse's hand on the transducer?

13 A. On the transducer.

14 Q. What is your opinion with regard to Dr.
15 Rhett's technique in using the vacuum,
16 Doctor, based on this video?

17 A. I see no problem with it.

18 Q. Thank you. Please continue -- (video
19 playing) -- please stop. What is he doing
20 right there?

21 A. He is making sure that the muscles over
22 outside the perineum, so those muscles
23 don't affect the pull on the vacuum.

24 Q. Do you have an opinion whether that it
25 reasonable?

1 A. Oh, absolutely. We do that all the
2 time. Midwives move that all the time so
3 that we can avoid an episiotomy during
4 delivery, which is to cut to widen the
5 vaginal.

6 Q. Thank you, please continue -- (video
7 playing) -- stop right there. What is your
8 opinion regarding Dr. Rhett's technique at
9 that point?

10 A. He raised his hand because -- what he
11 is doing is guiding and allowing the force
12 of the labor once the baby's head goes
13 under the pubic bone, then the baby's head
14 extends and that is what it is doing.

15 Q. Do you have an opinion as to whether
16 that is reasonable?

17 A. That is certainly -- that is perfect.
18 I have no issue with that. That is very
19 reasonable.

20 Q. Do you have any issues whatsoever with
21 regard to this birth video?

22 A. Not at this time.

23 Q. Please continue -- (video playing) --

24 A. That's the head.

25 Q. (Video playing)

1 A. Stop. At this point in time the baby's
2 back and the baby's head is right there --
3 there is only so much room from the back of
4 the head, the shoulders to the back. In
5 order for that disk to be able to record
6 the heart beat of that baby, the back would
7 have to be arched up against that or you
8 would have had to stretch the baby and
9 that's not happening.

10 Q. Whose heart rate is that transducer
11 picking up?

12 A. At this point in time I would think
13 that it is not the baby's heart beat.

14 Q. Explain that, please, Doctor.

15 A. Because the baby's back, which is what
16 you listen to, is deep into the pelvis
17 right now and where she had the transducer
18 it wouldn't be picking the baby's heart
19 beat up. The only way that she could pick
20 up the baby's heart beat would be to bring
21 it down lower, but the problem with that is
22 that there's the bone and the ultrasound
23 does not work with bone, it works with soft
24 tissue.

25 Q. Is this is not the baby's heart rate

1 that is showing up on the tracing, whose
2 heart rate is it?

3 A. It would have to be the mother's.

4 Q. Thank you. Please continue -- (video
5 playing).

6 A. Now she takes it off. There's the
7 shoulders -- the shoulders could not be
8 there unless the baby was in the pelvis,
9 birth canal.

10 Q. (Video playing) -- anything else that
11 the jury needs to see with regard to the
12 birth video to understand the transducer
13 picking up the mother's heart rate?

14 A. No.

15 Q. Dr. Hobbs, with regard to that video,
16 please explain the vacuum cup around the
17 baby's head, please explain how if anything
18 it explains where the baby's head it in the
19 vaginal.

20 A. I'm sorry, Counselor?

21 Q. Sure. How did that vacuum cup fit
22 around the baby's head? Let me see if I
23 can find a photograph.

24 A. Well, it almost fits on like a cap.

25 Q. Like a what?

1 A. A cap.

2 Q. Okay. Can you explain how it fits like
3 a cap around the baby's head?

4 A. (Demonstrating), like so, press it
5 down.

6 Q. What significance, if any, if this is
7 six centimeters, does that have to do with
8 where the cup was in the mother's vaginal?

9 A. Well, in order to insert the vacuum the
10 mother's vaginal, you have to squeeze it
11 together -- and you can see that Dr. Rhett
12 did that -- the correct application is to
13 squeeze it together and place it into the
14 deep crevice of the mother's pelvis. In
15 other words, at the mother's sacrum, in
16 this area back here, in order to get it
17 onto the baby's head you must first put it
18 into the vagina, the back part of the
19 pelvis and then bring the cup onto the
20 baby's head. That's how the application
21 goes.

22 So you cannot make a deduction that
23 because this whole thing goes in -- all of
24 it literally goes in except -- there is
25 only time that it doesn't all go in and

1 that's when it's -- when you can see the
2 baby's head and you can see to put it on --
3 but, otherwise, you must put it and then
4 bring it up. That's how the application is
5 done.

6 Q. Did Dr. Rhett do that in this case?

7 A. Yes, he did.

8 Q. Was that reasonable?

9 A. That is the way that the vacuum is
10 done.

11 Q. All right, Dr. Hobbs, I want to make
12 sure that I get everything on my list
13 there. Next is the numbering system, Dr.
14 Hobbs, Please tell us just briefly what the
15 stages are.

16 Q. Well, there are two systems, if you
17 want to use that term.

18 There is one that is called the plus
19 one, plus two, plus three, minus one, minus
20 two, minus three. Basically what that is
21 is that you take a female pelvis and, in
22 your mind, arbitrarily or whatever, you
23 divide in your mind the pelvis into three
24 segments. One will be plus one, another
25 third would be plus two, another third

1 would be plus three.

2 A new system came out years ago
3 involving what we call a five-step -- five,
4 uh, plus one, plus two through plus five
5 system. Basically that's based on
6 centimeters of the pelvis. So from the
7 ischial spines you count one down -- and
8 that's plus one; you count two down and
9 that's plus two, you count three down,
10 etc., etc.

11 So there's two different systems that
12 of evaluation.

13 Q. What system do you use, Dr. Hobbs?

14 A. I use the plus one, plus two, plus
15 three.

16 Q. What system did Dr. Rhett use?

17 A. From his deposition, it sounds to me
18 like he uses the same measures.

19 Q. What system do you teach residents to
20 use when they're delivering babies?

21 A. Well, my -- to begin with I teach them
22 the plus one, plus two, plus three because
23 that's what I am most familiar with.

24 If they have any question with regard
25 to the plus one, plus two up to plus five,

1 then I can then discuss it with them. But
2 I don't routinely teach them the plus five
3 system.

4 Q. Do you have an opinion as to whether it
5 was reasonable for Dr. Rhett to use the
6 plus three system?

7 A. It's a very valid system. I mean, that
8 has not changed. People have used, it's
9 acceptable -- has been for many years.

10 Q. In fact, in the hospital record
11 ECH0014, what is the numbering system that
12 East Cooper Hospital uses?

13 A. The plus one, plus two, plus three;
14 minus one, minus two, minus three.

15 Q. Thank you. I asked you but I will ask
16 you again just to make sure that I can put
17 another check. Do you have an opinion
18 whether Dr. Rhett acted reasonably in using
19 the plus three numbering system?

20 A. He acted reasonably in using the plus
21 three numbering system.

22 Q. Thank you. Next are the various
23 options for delivery. What caused the
24 heart rate to drop and not come back up?

25 A. I believe that it was because of the

1 stretching of the umbilical cord that was
2 around the baby's neck.

3 Q. What caused Ms. Washington's inability
4 to push?

5 A. A couple of things. She had been in
6 labor for a long time. I think the biggest
7 thing that caused her not to be able to
8 push very well was the epidural.

9 Q. Explain now the epidural can affect a
10 woman's ability to push in labor.

11 A. Because the epidural locks down on the
12 nerve fibers going into the pelvic floor
13 and -- in an effort to relieve their pain
14 and labor, we also kind of take away their
15 sensation in the pelvis.

16 Q. Is that common?

17 A. Oh, absolutely.

18 Q. Whose fault was it that the fetal
19 heart rate had gone down and the mother
20 was unable to push?

21 A. It was no one's "fault". I am not
22 sure what you mean by whose fault. It was
23 no one's fault.

24 Q. Do you criticize Dr. Rhett for the
25 heart rate going down and the mother's

1 inability to push?

2 A. No.

3 Q. Explain that, sir.

4 A. Well, he didn't have anything to do
5 with making the heart rate go down. We
6 have -- we get patients who are in an --
7 labor and delivery is not a Joan Barr
8 (phonetic) Syndrome. Let's get that out
9 of the way. We tell the patient all the
10 time, 'You don't have to prove to me how
11 much pain you can take. I am not going to
12 fault you if you ask for something for pain
13 or if you don't ask for something. I am
14 not going to fault you for it. It doesn't
15 make any difference. What I want you to to
16 is to be as comfortable as possible.

17 We can give narcotics but narcotics
18 really does take away the pain of labor,
19 all it does is allow the patient to sleep
20 and resume contractions, the contractions
21 come back, but it does nothing for her
22 pain.

23 So what we in essence will do, and
24 it's across the board -- I think, at the
25 institutes where I am, probably about

1 ninety plus percent of the women will get
2 an epidural simply because labor is a haul
3 -- excuse my expression -- it's a long
4 haul. If you're doing that, you don't want
5 the patient struggling and agonizing
6 because labor is really not supposed to be
7 a determination of how much you can
8 tolerate. That is not what this is all
9 about.

10 Q. Given the clinical picture of the
11 baby's heart rate going down and not coming
12 back up and the mother's inability to push,
13 what options did the delivering physician
14 have at that point?

15 A. You have the option of forceps, you
16 have the option of vacuum and you have the
17 option of a caesarean section, and then you
18 have the option of potentially waiting and
19 hoping that it goes back up by infusing
20 fluids and all these other type things.
21 Those are, I guess, the four options that
22 you have.

23 Q. Let's take those, starting with the
24 last one. The one of waiting and hoping
25 that it comes back. In your opinion, based

1 on your review of these records, was that a
2 viable option?

3 A. I would not have done that because
4 simply under the circumstance -- if I lose,
5 meaning my gamble is wrong and it doesn't
6 come back up, I've lost valuable time for
7 this baby.

8 Q. Let's go to the next one, a caesarean
9 section. Do you have an opinion as to
10 whether that was the best option under
11 these circumstances with this clinical
12 picture?

13 A. No, not if you're skilled experienced
14 person who can do a vaginal delivery of
15 this baby.

16 An operation to get this baby out is
17 not the better option because of the risks
18 and complications associated with caesarean
19 section while the baby is down in the
20 pelvis like that -- not only to the baby
21 but there's also great risks to the mother.

22 If you do a caesarean section on a
23 woman with a baby well down to the pelvis,
24 one of the biggest dangers that we all fear
25 as obstetricians, even to this day feared,

1 is that you have to reach way down to the
2 pelvis and pull the baby back up.

3 That can allow or cause extension of
4 your incision laterally -- if you get into
5 the lateral spaces of the pelvis, meaning
6 away from the uterus, out into the area of
7 the pelvis wall, the vasculature, you could
8 have a massive bleed.

9 The problem with it in a massive bleed
10 situation is several things that are going
11 to happen. She is going to have to be
12 transfused, number one, in order to
13 stabilize her. But the other part of this,
14 she could end up having to have a
15 hysterectomy. With a hysterectomy, the
16 chance of bearing another child is zero.

17 Q. Would you have done a caesarean
18 section?

19 A. No.

20 Q. The next one in reverse order was
21 forceps. Was that the best option in this
22 clinical picture?

23 A. Both -- I guess that you have to talk
24 about forceps and vacuum as to what you're
25 most comfortable with. I'm very

1 comfortable with forceps. Would I have
2 considered forceps in this circumstance?
3 Probably. Because I'm just a forceps
4 person. But I do vacuum extraction, too.
5 I think those two options are -- they are
6 not -- they are options but they are
7 options in and of themselves.

8 Q. So, Doctor, do you have an opinion
9 whether Dr. Rhett acted reasonably in
10 choosing the option for delivery in this
11 case to use the assistance of a vacuum?

12 A. From what I understand, Dr. Rhett was
13 very skilled in using a vacuum, he was very
14 experienced in using it. So you use the
15 best option that in your mind dictates what
16 is the safest and best way to go.

17 Q. Was a vacuum reasonable in this
18 scenario?

19 A. Absolutely.

20 Q. Risk of a vacuum. Doctor, please tell
21 us what the risks of the vacuum are.

22 A. There are fetal risks which are
23 associated with intracerebral bleeds.
24 There is a risk associated with bringing
25 the baby down and the baby getting stuck

1 with a shoulder dystocia where you get the
2 head up but then the shoulders are stuck
3 and you can't get those out or you have
4 great difficulty in getting them out.

5 From a maternal standpoint, if indeed
6 the vacuum is on the maternal tissue it can
7 tear the maternal tissue.

8 Q. Would you please explain to us how a
9 doctor uses a risk/benefit analysis to
10 determine the best course for the delivery
11 of a baby?

12 A. Well, if you have time, meaning that
13 time is not a limiting situation, you could
14 weigh all possibilities in their totality
15 and make a decision as to which way you're
16 going to delivery the baby.

17 If you don't have time, you've got to
18 pull -- what I refer to, to my residents a
19 lot of times, as the Sully technique. The
20 Sully technique basically, in my mind, is
21 that you had an airplane that's been hit,
22 you've got to make a decision do you go
23 back to the airport, do you go to the
24 nearest airport, or do you put it into the
25 water.

1 A physician has the same problem in an
2 emergency situation. You've got to flip
3 that card in your head, you've got to flip
4 it as fast as you possible can to make a
5 decision. I think under different
6 circumstances we're all going to -- we all
7 get caught in that predicament and we flip
8 the card as fast as we can, make the
9 decision based on the risks and benefits,
10 what have you, and whatever your decision
11 is, you go with it.

12 Q. What type of technique did you call
13 that? Sully.

14 A. It's just my little moniker that I
15 teach residents by because there was --
16 when the airplane pilot had the issue where
17 he was hit by birds and he put it into the
18 harbor, New York central (sic), because --
19 the first recommendation was to return to
20 the airport and he, in his own judgement
21 realized 'if I do that, I am not going to
22 make it because I am losing altitude.'
23 The second was to go to the nearest
24 airport, Newark, New Jersey I think was the
25 nearest, and he looked at that but his

1 feeling was that 'even if I get close and I
2 fall out, I am going to not only hurt the
3 individuals on the plane but it's very
4 congested area so some folks on the ground
5 are probably going to be killed to.'

6 His third option was, 'there's not very
7 much going on out here in the bay, I'm
8 going to put this plane into the bay. Lo
9 and behold, if based on my experience
10 having used a simulator where I've landed
11 on water, if I can keep the nose of the
12 plane up once I am into the water, then we
13 are all good.'

14 From a physician's standpoint I use
15 that in order to teach residents, to give
16 them a perspective of what I am talking
17 about.

18 Q. Let's take that analogy, the Sully
19 technique. In applying the Sully technique
20 to this case, do you have an opinion as to
21 whether or not Dr. Rhett acted reasonably
22 to use the vacuum in light of the risks
23 associated with the vacuum?

24 A. Yes, I think he did because the -- the
25 biggest risk to the patient, to the baby,

1 was going to be the potential of a bleed.

2 But that's a very, very small risk.

3 But at the same time there is
4 definitive and clear data in the medical
5 literature, which I remember from years
6 gone by, that the risk of doing a caesarean
7 section after labor also had a risk of
8 intracerebral hemorrhage. The numbers were
9 very close, the best that I remember from
10 it, was there was not a lot statistically
11 different between doing the vacuum
12 extraction, the vacuum assisted and doing a
13 caesarean section.

14 However, that circumstance of caesarean
15 section would have been, in my Sully
16 technique, my Sully nemonic, that would
17 have been trying to go to the airport in
18 New Jersey, because now not only are you
19 going to lose your people onboard but now
20 somebody else is going to get hurt who is
21 on the ground. In a caesarean section of
22 that nature which you're talking about, you
23 do the caesarean section, yes, the baby
24 could be harmed but now you've got another
25 person who has a great possibility of being

1 harmed, which is the mother.

2 Q. The indications for using a vacuum in
3 this case, what were the medical
4 indications for using the vacuum in Ms.
5 Washington case?

6 A. Baby was in distress. The baby is in
7 distress.

8 Q. I am going to show you what is already
9 in evidence, the ACOG Practice Bulletin No.
10 31 (sic), (tendering). Doctor, could you
11 identify this document, please?

12 A. This is ACOG Practice Bulletin Number
13 17 from June of 2000.

14 Q. Does this medical literature support
15 the use of the vacuum -- for what
16 indications? And I have turned to page two
17 of this document.

18 A. The document says under Indications for
19 Operative Vaginal Delivery, (reading):

20 *No indication for operative*
21 *vaginal delivery is absolute. The*
22 *following indications apply when the fetal*
23 *head is engaged and the cervix is fully*
24 *dilated.*

25 *Number one, it lists prolonged*

1 *second stage in a nulliparous woman, which*
2 *basically means that the woman was pregnant*
3 *for the first time.*

4 *Lacking of continuing progress for*
5 *three hours with regional anesthesia or two*
6 *hours without regional anesthesia.*

7 Which in essence we're talking --
8 regional anesthesia is basically the
9 epidural that we talked about.

10 The second indication they said was
11 (reading):

12 *Suspicion of immediate or*
13 *potential fetal compromise....*

14 Q. Okay, I want to stop there, please.

15 This is on page two of the ACOG Bulletin
16 which is marked as Exhibit 1 and there's a
17 chart in the left-hand corner that says
18 "Indications for Operative Vaginal
19 Delivery." What is the indication for
20 operative vaginal delivery that you just
21 read?

22 A. Suspicion of immediate or potential
23 fetal compromise.

24 Q. What indication was there in this case
25 for use of the vacuum?

1 A. Bradycardia.

2 Q. And is bradycardia a suspicion of
3 immediate or potential fetal compromise?

4 A. You bet it, you better believe.

5 Q. Doctor, do you have an opinion whether
6 or not Dr. Rhett acted reasonably with
7 regard to the indications for the vacuum
8 given the fetal compromise in this case?

9 A. Yes.

10 Q. What is that opinion?

11 A. That he reacted within the standard of
12 care.

13 Q. Do you have an opinion whether Dr.
14 Rhett complied with the guidelines in this
15 ACOG article?

16 A. Well, I am not sure that I understand
17 when you say "guidelines" because the
18 indication necessarily is not the
19 guideline.

20 Q. Why don't you tell us what guidelines
21 mean in terms of the ACOG Practice
22 Bulletin?

23 A. How something done, how the procedure
24 is done.

25 Q. Based on your view of this ACOG

1 Practice Bulletin, marked as Exhibit 31,
2 did Dr. Rhett comply with the indications
3 for operative vaginal delivery?

4 A. Yes, he did.

5 Q. Thank you. Before I get to application
6 of the vacuum, the type of vacuum used in
7 this case, do you have any criticisms with
8 regard to the type of vacuum used in this
9 case?

10 A. No.

11 Q. Okay, let's now go to the applications
12 of the vacuum. What are your opinions
13 regarding the application of the vacuum in
14 this case?

15 A. From the video, I believe that he did
16 it appropriately.

17 Q. According to the video, did you have an
18 opportunity to watch Dr. Rhett's technique
19 in using the vacuum to help in the delivery
20 of this baby?

21 A. Yes. In order to apply the vacuum, I
22 think I said before, you must put the
23 vacuum first of all into the curvature of
24 the pelvis, which is the widest and deepest
25 area of the pelvis in order to get it in.

1 You then bring the vacuum up to the baby's
2 head. So the application was appropriate,
3 the way that he did it. His actual
4 delivery process or the sequence of how he
5 did the delivery was within the standard of
6 care for a vacuum extraction, for a vacuum-
7 assisted delivery to be accomplished.

8 Q. Based on your review of the birth
9 video, what problems did Dr. Rhett
10 encounter when he was placing the vacuum,
11 the cup, on the baby's head?

12 A. What problems did he encounter?

13 Q. Yes, sir.

14 A. I didn't see any problems that he
15 encounter.

16 Q. What are pop-offs?

17 A. That is basically when you put the
18 vacuum on and you start to traction and the
19 vacuum comes off.

20 Q. Did we see any of that in the birth
21 video?

22 A. We did not.

23 Q. Is that good or not?

24 A. Well, the fact that we didn't see any
25 is good.

1 Q. How long did it take Dr. Rhett to
2 deliver the baby after the vacuum was
3 applied?

4 A. I think about -- I think about two and
5 a half to three minutes, somewhere in that
6 range.

7 Q. What is the recommended length of time
8 ACOG, the American College of Obstetricians
9 & Gynecology, what is the recommended
10 length of time for the application of the
11 vacuum?

12 A. Well, they don't say how much time to
13 apply the vacuum. We don't have any
14 guidelines about how long it takes you to
15 put the vacuum on. The recommendation is
16 based on how long you continue to apply
17 traction, trying to bring the baby out, how
18 long you should proceed in trying to get
19 the baby delivered.

20 Q. What does the fact that it took two and
21 a half to three minutes to deliver the baby
22 after the vacuum was applied tell you as an
23 obstetrician?

24 A. That was a pretty quick delivery

25 Q. What does it tell you about where the

1 baby's head is in the pelvis?

2 A. Well, it doesn't tell me exactly where
3 it is but, as I said before, the higher
4 that the baby is in the birth canal the
5 more difficult that it is to deliver. The
6 lower the baby is in the birth canal, the
7 easier that it is to deliver.

8 Q. So, Doctor, with regard to our
9 checklist here, did Dr. Rhett act
10 reasonably in the application of the vacuum
11 with regard to Ms. Washington's delivery?

12 A. He acted reasonably in applying the
13 vacuum. Yes.

14 Q. And the technique, which is the actual
15 -- you tell me what the technique is.

16 A. That's the traction that you apply to
17 bring the baby out.

18 Q. The traction that you're applying to
19 get the baby out. Based on your review of
20 the birth video, do you have an opinion
21 whether Dr. Rhett acted reasonably with
22 applying traction to get the baby out?

23 A. He did it in an appropriate fashion. I
24 have no problem with the way that he did
25 it.

1 Q. Thank you. The next one on the
2 checklist is one that we've heard quite a
3 bit about in this case, informed consent.
4 I am not going to go back through the
5 actual informed consent that signed in this
6 case. What I would like to ask you is,
7 what is involved in getting informed
8 consent from a patient?

9 A. There are three basic things and there
10 may be some other things that you can call
11 -- but the basic thing that's applied, that
12 is necessary in informed consent is the
13 risk and benefit of whatever you're
14 suggesting to be done, but also you must
15 explain to them what the alternatives are.
16 So the three things are: risk, benefit and
17 alternatives. The patient can then, in a
18 setting where it is feasible to do so, make
19 a decision whether they agree with going
20 along what you want to do or not.

21 Q. What occurred in this case, Dr. Hobbs?

22 A. I didn't see any informed consent
23 because the basic things is that there was
24 not time to do so.

25 Q. I would like for you to explain that in

1 more detail.

2 A. Well, it's common sense. You've got to
3 get the baby out. You don't have time for
4 a long extended discussion.

5 If you're going to do an informed
6 consent, you have to do it based on what an
7 informed consent entails. So not only do
8 you have to explain the vacuum but you also
9 have to explain a C-section, you also have
10 to explain forceps.

11 So the discussion one has -- if the
12 patient is going to make the decision, she
13 has to have all the information in order to
14 make that decision.

15 Q. If you had been confronted with this
16 clinical picture, what informed consent,
17 if any additional informed consent, if any,
18 would you have done in this situation?

19 A. I probably would not have done a whole
20 lot of informed consent because I needed to
21 get this baby out.

22 Q. Again, in this case, if Ms. Washington
23 had said that she would not have agreed to
24 using a vacuum, what is your perception of
25 the alternatives at that point?

1 A. I would think -- I don't know Ms.
2 Washington from anyone else in this case
3 but I would think that if I was then told
4 that my alternative was a c-section, where
5 I had the potential to lose my uterus and
6 also have my baby cut out and he could be
7 harmed, I think under the circumstances I
8 would -- I would hope the decision would
9 be, 'well, let's go with the less risky.'

10 Q. So under these circumstances, these
11 emergent circumstances, do you have an
12 opinion whether or not Dr. Rhett acted
13 reasonably with regard to the informed
14 consent.

15 A. Dr. Rhett did not get informed consent
16 because Dr. Rhett had a circumstance before
17 him that he needed to resolve. I instruct
18 my own students and my own residents, and I
19 really don't have much contact with
20 student, I have more contract with
21 residents who are in training for the
22 speciality, I tell, 'Doctor, do what you've
23 got to do and deal with the informed
24 consent afterwards. If the baby is in
25 trouble, get that baby out and then we'll

1 talk about informed consent.

2 Q. Dr. Hobbs, you mentioned informed
3 consent. Did you see any informed consent
4 actually signed in this case?

5 A. I did not.

6 Q. Let me show it to you, (tendering).
7 ECH004, signed by Ms. Washington when she
8 came into the hospital, is a consent for
9 admission and treatment. Have you seen
10 this in your review of the chart?

11 A. I saw this.

12 Q. So the additional informed consent that
13 you're referring to with regard to the use
14 of the vacuum, given the clinical
15 situation, the heart beat going down and
16 not coming back up and the mother's
17 inability to push, do you have an opinion
18 whether Dr. Rhett acted reasonably with
19 regard to informed consent at that point?

20 A. Well, I think this is a consent for
21 service, for care. It is not specific to
22 what he was faced with as far as what we
23 would classify as informed consent, but he
24 did not -- with what he had facing him, he
25 did not have time to deal with a sit-down.

1 formal informed consent, not even a stand
2 up informed consent. You need to get the
3 baby out, bottom line.

4 Q. Did Dr. Rhett comply with the standard
5 of care?

6 A. Yes, he did.

7 Q. The umbilical cord that was wrapped
8 around the baby's neck. Please come down,
9 if you will, again, and explain how and why
10 the umbilical cord, or the nuchal cord,
11 around the baby's neck is significant in
12 this case.

13 A. During the process of labor, if you
14 have an umbilical cord that is wrapped
15 around the baby's neck -- the purpose of
16 labor is to push the baby down the birth
17 canal so that the baby can be delivered.

18 If the cord is around the neck, this is
19 the same -- first of all, the cord is not
20 going to come from where it is inserted.
21 It is inserted in the uterus in the area
22 that we call the placenta.

23 Second of all, the cord is attached to
24 the baby's umbilicus, so it's not going to
25 move.

1 Where it inserts on both ends, that's
2 not going to change. What does change,
3 though, is when you're pushing that baby
4 down the birth canal with uterine
5 contractions, you're pushing that baby down
6 and that cord will become stretched.

7 Now, the further that it goes down --
8 it's the same as a hangman's noose, you put
9 it around the neck, you pull on it and if
10 you kick the bucket from underneath that
11 person -- and I don't mean to use such a
12 graphic thing as a suicide attempt or
13 whatever, so please forgive me for that.
14 But that's the best indication that I can
15 give you -- where now you have a cord that
16 is pulled around the baby's neck.

17 Whether it is super tight doesn't
18 matter. If the tracing is telling you that
19 the blood flow to that baby is being
20 comprised and -- most times we discover
21 this after the delivery. We don't know
22 that in advance but we have a suspicion
23 that that cord is somewhere where it should
24 not be. So on the circumstance when that
25 cord is stretched such that there is

1 decreased blood flow to the baby, that's
2 the same as a decrease of blood flow from
3 your heart to your brain. That's
4 dangerous. That's very dangerous.

5 Q. Thank you, Dr. Hobbs.

6 THE COURT: Ms. Craig, we are
7 going to stop the direct at this time.
8 Our lunch is here.

9 MOLLY CRAIG: Yes, sir.

10 THE COURT: All right, Ladies
11 and Gentlemen, I am advised that the jury's
12 lunch has arrived, so we will take a break
13 for lunch at this time. I suspect that we
14 will probably be in recess approximately
15 forty-five minutes or so. We will give you
16 an opportunity to take your lunch outside,
17 if you wish.

18 Doctor, I am going to ask you now
19 -- you are certainly welcome to stand down,
20 have some lunch if you will, but please
21 don't speak to lawyers on either side of
22 the case because you're a witness under
23 testimony.

24 THE WITNESS: Judge, I always
25 just love to sit in one of those seats

1 (jury box), I'll just sit up there.

2 THE COURT: Ladies and
3 Gentlemen, we will in recess now for the
4 court to have a recess. Ladies and
5 Gentlemen, enjoy your lunch.

6 (JURY OUT @ 12:33 P.M.)

7 THE COURT: We will be in
8 recess.

9 (LUNCH RECESS)

10 THE COURT: Dr. Hobbs, do you
11 want to return to the stand.

12 (WITNESS TAKES STAND)

13 THE COURT: Is there anything
14 for the record before we bring in the jury
15 in? (No response). Hearing nothing,
16 please bring the jury in.

17 (JURY IN @ 1:24 P.M.)

18 THE COURT: Welcome back, Ladies
19 and Gentlemen. I hope that you enjoyed
20 your lunch. We will recall that before
21 the break we were in the direct examination
22 of Dr. Hobbs. Ms. Craig, you may continue
23 your examination.

24 MOLLY CRAIG: Thank you, Your
25 Honor.

1 DIRECT EXAMINATION CONTINUED

2 BY MOLLY CRAIG:

3 Q. Dr. Hobbs, before the lunch break we
4 were talking about the condition of the
5 baby in utero and we were talking about
6 this pictures with the nuchal cord or the
7 umbilical cord wrapped around the baby's
8 neck. I had one more question with regard
9 to the baby in utero.

10 If the bradycardia that was on the
11 fetal monitoring strips was not from the
12 umbilical cord being wrapped around the
13 baby's neck, would that make any difference
14 in your opinions in this case?

15 A. You mean if we still had bradycardia?

16 Q. Yes, sir.

17 A. If you still have bradycardia you have
18 to get the baby out, you still have to
19 respond regardless of what the problem is.

20 Q. Okay, let's go now to -- the baby is
21 delivered and I would now like to address
22 the condition of the baby after delivery.
23 Okay?

24 A. Okay.

25 Q. What are Apgar scores?

1 A. An assessment that generally either the
2 pediatrician or the nurses make by
3 examining the baby and -- there's a scoring
4 mechanism where points are given for tone,
5 color, heart beat, reaction to stimuli, and
6 -- one other that I can't recall right now.

7 Q. All right. What does the first set of
8 Apgar scores tell you about the baby's
9 conditions in utero?

10 A. Well, it basically tells me that when
11 you've got this baby in your hand,
12 immediately upon delivery, what state it is
13 that the baby is. It gives you some idea
14 of the baby's condition at the time of
15 delivery.

16 Q. All right. Now, the baby's Apgar
17 scores -- the first set of Apgar scores, do
18 you have any opinions regarding that first
19 set of Apgar scores?

20 A. The first set of scores was a seven.
21 From my perspective, I -- two points were
22 taken off for color. I would think that
23 basically if you have a zero for the color
24 of an African American baby's skin, that
25 baby is probably not having very good

1 circulation.

2 Q. I'm sorry.

3 A. That baby is probably not getting good
4 circulation at a period of time -- I can't
5 tell you the exact period of time, but it's
6 not getting good circulation.

7 Q. Based on those first Apgar scores?

8 A. Yeah. Basically the bottom line is
9 what happens when a baby, or you, or me, is
10 distress, the distress meaning that there
11 is a decreased blood flow, going on for
12 some different reason, uh, what the human
13 body does -- having been beautifully
14 designed by our Heavenly Father -- has been
15 designed to do is to shift the blood flow
16 to the vital organs so that you keep the
17 individual alive first. That means then
18 that blood is shunted to the brain and is
19 shunted to the heart, number one.

20 There are other organs of the body,
21 including the dermatological system,
22 meaning our skin, our kidneys and
23 everything else, where the blood is shifted
24 away from that because are not vital --
25 that's not vital to the survival of the

1 individual at that moment.

2 So if you have a baby who is a zero
3 with no color, that means that somewhere
4 along the line that the heart shifted or
5 the blood flow shifted to the vital organs
6 in that circumstances. For me, that would
7 mean that there is some degree of decreased
8 profusion going on with that baby.

9 Q. What does decreased profusion mean?

10 A. Not getting blood. Anytime that you
11 don't get a blood to any organ, whether it
12 be the kidneys, the skin or whatever, there
13 is a possibility that you then -- and I am
14 not going to go very far with that, but
15 basically you start acidosis. In other
16 words, the tissue are not getting
17 circulation, so therefore acidosis forms.
18 Acidosis is deadly, which is nothing a lot
19 of acid buildup in your system. That's
20 deadly to the human body.

21 Q. You brought up acidosis, so let's talk
22 about acidosis. Just briefly, what is the
23 test that is done to determine whether or
24 not there is acidosis?

25 A. Fetal blood gases.

1 Q. Was that done in this case?

2 A. Correct.

3 Q. What was the pH based on that blood
4 gas?

5 A. I think that it was a pH of 7.208.

6 Q. A blood gas of 7.028 or 7.21, what does
7 that tell you?

8 A. Well, the blood gas, I think you said
9 7.0, but let me just -- based on what the
10 reading was, 7.208, basically tells me --
11 the normal range is about 7.28 up to about
12 7.4. It tells me that you can say that the
13 baby was either very close going into an
14 acidosis or it was on the very lower end of
15 normal, which means that it was probably on
16 its way.

17 Q. What does it mean going into an
18 acidosis, what does that mean about what's
19 going on with the baby?

20 A. You're not getting perfusion to a
21 number of organs, so those organs go
22 through a process that we call anaerobic
23 metabolism. You're pushing me, Counselor,
24 to things that I don't think the jurors --
25 because this is medical stuff. But let me

1 try to explain it to you.

2 If you're not getting the -- you know,
3 if you're running on the sidewalk and
4 you're perspiring like crazy, you tend to
5 sweat. If you are not well-oxygenated,
6 will pass out. You can't run because your
7 muscles go into what we call anaerobic
8 metabolism. In other words, you're not
9 breathing very well, not getting enough
10 oxygen.

11 The tissue then goes into what we call
12 anaerobic metabolism. The body has got to
13 give you -- so what the body automatically
14 does, again as it is designed, is to start
15 breaking down tissues to give you that
16 needed supply. Unfortunately that's called
17 lactic acid and that is not good, however
18 it's going to -- it is what it is. As that
19 starts to accumulate, then you in essence
20 have destruction of tissue and you
21 basically -- it can lead to a circumstance
22 where you, as an individual, can die.

23 Q. All right. So we have talked about
24 Apgars, we've talked about acidosis. I now
25 would like to ask you about meconium. I

1 will show you what has been previously
2 marked in evidence as Exhibit 27, Page 183.
3 This is a document from the Medical
4 University of South Carolina. Doctor, I
5 would like to direct your attention -- let
6 me get you a copy. It's so hard to read
7 this. If you could, please tell us what is
8 highlighted on the screen.

9 Q. There is a check mark beside the term
10 "meconium stain" and someone wrote in, with
11 pen or pencil or something "umbilical
12 cord."

13 Q. What is the significance of "meconium
14 stain, umbilical cord." What does that
15 mean?

16 A. Well, meconium is basically a response
17 that every one of us, I think at some point
18 in time, -- if you ride on an airplane and
19 they start bumping up and down, up and
20 down, up and down, you feel like your
21 bottom is going to fall out and you can
22 become nauseous because now the oxygen
23 supply in the cabin is decreased, assuming
24 that your body responds to that. One of
25 the things that you can do is reach up and

1 turn that little ventilator on above which
2 blows air on you and cools you off. If you
3 don't do that, then if you continue to
4 suffer with the way you're perspiring and
5 everything else, sometimes you lose control
6 of your bowels. That is because you're in
7 a period of distress -- if I can use that
8 term.

9 A fetus does the same thing. When a
10 fetus is in a period of distress, a baby
11 basically in utero or during delivery can
12 poop. That poop is basically because of
13 the fact that he had a response to distress
14 just like you and I would. When we get
15 stressed out, our GI tract gets a little
16 upset. When it gets upset we can certainly
17 feel like 'I've got stomach cramps.'
18 That's a natural process that goes on with
19 human beings.

20 Q. So the Apgar scores, the acidosis and
21 the meconium, what does that tell you about
22 the condition of the baby in the uterus?

23 A. Well, I -- there was one of the Apgars
24 taken off -- there's another Apgar that was
25 taken off that is a lot more -- that is

1 very, very important to us as obstetricians
2 because when we're dealing with the mother
3 in the antenatal, versus the prenatal,
4 period, we look for on an ultrasound the
5 tone of the baby, meaning does it flex,
6 does is plump or is it flat.

7 When this baby was born, it had one
8 point taken off for -- I think a nurse
9 explained that it meant that the baby was
10 not, that the tone was not ideal and so she
11 took one point off.

12 Tone is a great indication of one --
13 one being a near hypoxic state, where the
14 tissue is suffering, because if you
15 decrease the circulation, all of a sudden
16 the muscles start to break down, form this
17 lactic acid, and then your muscles get weak
18 -- if you happen to go into a high altitude
19 it'll happen to you, where you muscles get
20 weak because they are not producing enough
21 oxygen in that circumstance.

22 So I would accept the fact that the
23 Apgar scores showed no -- showed zero
24 color, the tone being decreased one point.
25 I would think under the circumstances that

1 sort of speaks to the fact of the baby
2 having some elements of stress. But then
3 with meconium passage, that tells me that
4 the baby was having some element of
5 distress.

6 Q. So do you have n opinion whether or not
7 the Apgars, the meconium and the acidosis
8 is consistent with what you see on this
9 fetal monitoring strips?

10 A. Well, and having bradycardia would make
11 me think that would answer as far as these
12 other issues that we're talking about.

13 Q. Now, with regard to the fetal
14 monitoring strips, I would like to make
15 sure that we get that in evidence and I
16 don't think that I did that before the
17 break. I think you can see it from there,
18 Doctor, if I put it up on this ELMO.

19 Starting at Page 309, 310 and 311,

20 ---

21 MOLLY CRAIG: First of all,
22 Your Honor, I offer these three pages of
23 the fetal monitoring strips in evidence at
24 this time.

25 THE COURT: Is there objection?

1 MARY WATERS: Your Honor, I
2 believe that they are already in.

3 THE COURT: Do you wish to put
4 them in again, Counsel?

5 MOLLY CRAIG: These three
6 specifically; yes, sir.

7 THE COURT: Is there any
8 objection?

9 EDWARD GRAHAM: (No verbal
10 response).

11 THE COURT: Hearing none, you
12 may mark them.

13 COURT REPORTER: Those are
14 exhibits 2-310, 2-311 and 2-312.

15 (SO ENTERED AS DEFENSE EXHIBITS)

16 MOLLY CRAIG: Thank you,
17 Gayle.

18 THE COURT: Without objection,
19 they are in evidence.

20 DIRECT EXAMINATION CONTINUED

21 BY MOLLY CRAIG:

22 Q. Looking at the first one, ECH309,
23 Doctor, we have gone through these but I
24 want to make sure that these are in
25 evidence and that we understand.

1 Based on this strip, up to the time
2 that the fetal scalp electrode was taken
3 off, whose heart rate was being monitored?

4 A. The fetus'.

5 Q. How do you know that the fetal
6 electrode was doing the monitoring of the
7 baby?

8 A. Because you had -- that is the purpose
9 of putting an electrode on, because that's
10 -- it's attached to the fetus' scalp and
11 then you connect it to the monitor.

12 Q. I don't see the electrode over here,
13 but can you just describe what that little
14 fetal electrode looks like?

15 A. It's a little wire, loop basically
16 that's screwed into the scalp of the fetus.

17 Q. What is this (displaying)?

18 A. That's a fetal scalp electrode.

19 Q. Thank you. Is there any question in
20 your mind that that is the baby's heart
21 rate that is being documented until ---

22 EDWARD GRAHAM: Objection,
23 leading.

24 THE COURT: Sustained, please
25 don't lead your witness.

1 MOLLY CRAIG: Yes, sir.

2 DIRECT EXAMINATION CONTINUED

3 BY MOLLY CRAIG:

4 Q. That was 309. Now going to 310, whose
5 heart rate is being monitored at that
6 point?

7 A. That looks like the fetus' heart rate.

8 Q. But then it was at 1939, whose heart
9 rate is being monitored at that point?

10 A. As I said, because there is a break in
11 the heart rate, which I -- I would think is
12 -- and because the baby is supposed to be
13 out at this point in time, I would think
14 that's the maternal heart rate.

15 Q. Thank you. In your opinion does it
16 matter or not whether the delivery was at
17 1937 or 1939, with regard to your opinions
18 in this case?

19 A. From my standpoint, the baby needs to
20 be delivered.

21 Q. Moving right along on our checklist
22 there, sir, the next one is documented.
23 There has been some question of whether or
24 not the vacuum delivery was documented in
25 this case. Do you have an opinion based on

1 your review of the records in this case
2 whether or not the vacuum was documented in
3 the medical chart?

4 A. Period?

5 Q. Yes, sir.

6 A. It was documented in the chart.

7 Q. I am going to show you collectively
8 Exhibits 107, -- and we have been through
9 this before so I would just like to do it
10 quickly -- please tell us where it says the
11 vacuum was used in the delivery?

12 A. This is the information face sheet and
13 it says -- one, two, three, four, five, six
14 -- six lines down, seven lines down, VEVD,
15 which is vacuum extraction vaginal
16 delivery.

17 Q. So does this document tell you that
18 there was a vacuum delivery in this case?

19 A. Yes.

20 Q. Next one, ---

21 A. Yes, those abbreviations are the ones
22 that I am accustomed to seeing.

23 Q. If those are the right abbreviations,
24 is it documented?

25 A. Yes.

1 Q. Showing you now Exhibit 2, 0017, the
2 labor progress chart, what does it document
3 with regard to what the delivery was in
4 this case?

5 A. This is the labor progress sheet, it
6 says "1937 vacuum-assisted delivery."

7 Q. Exhibit 2, Page 108, the nurses notes
8 from the hospital, what does it say with
9 regard to the delivery of this baby?

10 A. Nurses notes continued, East Cooper
11 Regional Medical Center, "One viable male
12 delivered with vacuum-assist, per Dr.
13 Rhett."

14 Q. Dr. Hobbs, Exhibit 2, Page 103, I show
15 you the Newborn Admission Assessment.

16 Where -- is there any documentation there
17 that the vacuum was used to help delivery?

18 A. If the abbreviation VVD is vacuum
19 vaginal delivery, is that what that is,
20 what that represents.

21 Q. Exhibit 2, Page 90, again out of East
22 Cooper Regional Medical Center's chart, is
23 there any documentation about the vacuum
24 used in this case?

25 A. There are check marks for spontaneous,

1 forceps, so forth -- under the heading of
2 Delivery "vacuum" is checked.

3 Q. Exhibit 2, Page 020, another record of
4 East Cooper Regional Medical Center, if you
5 would tell us whether or not there is an
6 documentation about the mode of delivery.

7 A. This is a labor summary and it says
8 "method of delivery, vaginal assisted
9 vacuum extraction."

10 Q. Thank you, Doctor. Now, Exhibit 2,
11 Page 85, this is the Meducare Infant
12 Transport form. Is there any documentation
13 about the use of a vacuum?

14 A. It says type of delivery is vacuum,
15 vaginal

16 MOLLY CRAIG: Your Honor, at
17 this time we would offer these documents
18 collectively into evidence.

19 THE COURT: Any objection?

20 EDWARD GRAHAM: They are in,
21 Your Honor. They're in multiple times.
22 I don't know why they need to go in again.

23 THE COURT: This is cumulative,
24 Counsel. Why is it ---

25 MOLLY CRAIG: These are the

1 specific records that document the vaginal
2 delivery. They respond to the plaintiff's
3 claim that it wasn't documented, that we
4 were trying to hide that it was a vacuum
5 delivery.

6 THE COURT: Counsel, I -- are
7 they highlighted or are they marked in any
8 way?

9 MOLLY CRAIG: Your Honor,
10 these are highlighted but we would be happy
11 to replace them with nonhighlighted copies.

12 THE COURT: Very good. Out of
13 fairness to them, the Court will ask that
14 you replace them with nonhighlighted
15 copies. We will mark them as a separate
16 exhibit. Let's mark them as one exhibit,
17 please, Madame Court Reporter.

18 COURT REPORTER: Exhibit 110.

19 THE COURT: Over objection, in
20 evidence for the defendants.

21 (SO ENTERED AS DEFENSE EXHIBIT 110)

22 DIRECT EXAMINATION CONTINUED

23 BY MOLLY CRAIG:

24 Q. Dr. Hobbs, do you have an opinion
25 whether or not the vacuum delivery is

1 adequately documented in the medical
2 records?

3 A. It certainly is in the medical records
4 for this patient.

5 Q. Now, ACOG. I believe that we went
6 through the ACOG earlier, though I didn't
7 do it on my checklist. Do you still have
8 that ACOG Bulletin Number 17 in front of
9 you?

10 A. I do.

11 Q. All right. Let me get a copy
12 (displaying on ELMO). Right here, Doctor,
13 if you could read to us what is in this
14 bold section right here of the practice
15 bulletin. Just read that to the jury.

16 A. (Reading):

17 The practice bulletin was
18 developed by the ACOG Committee on Practice
19 Bulletins - Obstetrician with the
20 assistance of Michael Belkco (phonetic),
21 M.D. The information is designed to aid
22 practitioners in making decisions about
23 appropriate obstetrical and gynecologic
24 care. These guidelines should not be
25 construed as dictating an exclusive course

1 of treatment or procedure. Variations in
2 practice may be warranted based on the
3 needs of the individual patient, resources
4 and limitations unique to the institution
5 or type of practice.

6 Q. My question to you is, what is the
7 difference between guidelines and the
8 standard of care?

9 A. Guidelines are what we basically use to
10 sort of guide us in our practice. The
11 standard of care is that which is accepted
12 method or the accepted level of care of
13 physicians in the same circumstance(s).

14 Q. Thank you. Do you have an opinion
15 whether Dr. Rhett complied with the
16 guidelines as outlined in ACOG Bulletin
17 Number 17?

18 A. I think that he did. Yes.

19 Q. His conduct was reasonable?

20 A. Reasonable.

21 Q. One moment -- the instruction booklet,
22 do you have a copy of the instruction
23 booklet up there?

24 A. I beg your pardon?

25 Q. Do you have a copy of the instruction

1 booklet, the manufacturer's instruction

2 booklet up there?

3 A. No, I don't.

4 Q. Actually before we get to the instruc-
5 tion booklet, let me ask you something that
6 should be on that list, and I want to add
7 it on there, FDA Warnings. What is your
8 understanding of the purpose of the public
9 health advisories?

10 A. Which are we talking about, Counsel?

11 Q. Was there an FDA warning that was
12 issued with regard to (use of) the vacuum?

13 A. Yes.

14 Q. Then -- I am going to show you -- I
15 don't believe that it's in evidence yet,
16 it's by agreement Exhibit 97. Could you
17 identify this document?

18 A. This is the Committee Opinion of the
19 American College of Obstetricians &
20 Gynecology regarding vacuum deliveries.

21 Q. Why was that advisory opinion, why was
22 that issued?

23 A. Well, in early 1998 or thereabouts the
24 Food & Drug Administration issued a warning
25 in regard to the uses of their vacuum

1 extractor when one was used in delivery.

2 The Warning was based on the fact that
3 after looking at the data over a four-year
4 time frame that there were approximately
5 nineteen adverse consequences of using a
6 vacuum.

7 That was based on the -- as I remember
8 the article, it said that there were two
9 hundred twenty-five thousand deliveries, so
10 I can only extrapolate that they're talking
11 about close to -- if you want to use that
12 as an average, I think about eight hundred-
13 some thousand deliveries. Out of those
14 eight hundred thousand deliveries, it
15 appears that they had a total of nineteen
16 adverse reactions.

17 So what the Food & Drug Administration
18 did was to send out a directive or a
19 Warning to us as physician, not just
20 obstetricians but to anyone taking care of
21 a newborn, that one should be aware of the
22 fact that these things can happen, these
23 adverse reactions.

24 What we then -- the purpose of it,
25 according to the advisory was that we are

1 to warn our receiving physician, that takes
2 out baby, whether it be a Family
3 practitioner, because Family practitioners
4 take care of babies, or a pediatrician --
5 we have to make sure that the communication
6 is transferred from the delivery room to
7 the nursery that the child was a vacuum
8 delivery.

9 Why did they want to do that? Well,
10 if you have a baby that is acting "funny"
11 after delivery, and I don't funny from the
12 standpoint of laughter, but if a baby is
13 not acting quite right -- in other words if
14 the baby is a little startled, if the baby
15 is a little irritable, what have you, the
16 general tendency in most circumstances the
17 pediatrician will test the baby's blood
18 sugar and they will also look for signs of
19 infection.

20 What the advisory was telling us as
21 physicians was, 'make it known to the
22 receiving physician or caretaker', let them
23 know that the baby had a vacuum done so
24 that in their workup they don't focus so
25 much on blood sugar or infection and

1 disregard the fact that potentially this
2 baby may have had a cerebral bleed after
3 the vacuum was done.

4 So the purpose of it was to have
5 everybody alert and aware of the fact that
6 the delivery was done so that if there is
7 an adverse reaction that one can then
8 respond accordingly.

9 Q. Now, first of all we talked about the
10 ACOG. Now, the FDA Warning, is that --
11 does that create a standard of care for
12 obstetricians?

13 A. No. Not the Warning. Counsel, we must
14 make sure that we understand. This was not
15 a withdrawal or a recall. This was a
16 Warning. There is a difference between a
17 recall and -- a recall is basically where
18 the device is taken off the market or taken
19 away from us so that we cannot use it.
20 This was a Warning.

21 Q. What response did ACOG make to the FDA
22 warning?

23 A. The article that you just gave me, the
24 Committee Opinion, was that -- I can read
25 it for you, if I may?

1 Q. Yes. Just a minute ---

2 MOLLY CRAIG: May I offer this
3 document into evidence so that he can
4 publish it.

5 THE COURT: What says the
6 defense -- what says the plaintiff?

7 EDWARD GRAHAM: No objection.

8 THE COURT: Without objection,
9 you may.

10 COURT REPORTER: It is Exhibit
11 97, already in evidence.

12 MOLLY CRAIG: Thank you.

13 DIRECT EXAMINATION CONTINUED

14 BY MOLLY CRAIG:

15 Q. Now, that Exhibit 97 is in evidence,
16 Dr. Hobbs, would you please publish the
17 portion that you deem relevant?

18 A. The last paragraph -- and I think, in
19 all fairness that the jury will understand,
20 I will read the entire thing. It's not
21 long, (reading):

22 *The Committee on Obstetric*
23 *Practice is aware of the recent Food and*
24 *Drug Administration Public Health Advisory*
25 *on the "Need for Caution When Using Vacuum-*

1 *Assisted Delivery Devices.*" Although the
2 Committee on Obstetric Practice supports
3 the FDA's role in informing physicians and
4 the public of potential risks of
5 therapeutic devices, the Committee also has
6 concerns regarding the implications of the
7 recent FDA Advisory on vacuum-assisted
8 delivery devices. Specifically:

9 The FDA basis its concern on
10 report of twelve deaths and nine serious
11 injuries occurring over four years, among
12 newborns on whom vacuum-assisted delivery
13 devices were used (i.e., five events per
14 228,354 vacuum deliveries per year, or one
15 in 45,455 vacuum extractions per year).
16 Clearly this is an extraordinarily low risk
17 of adverse event, even in the face of
18 possible under-reporting.

19 Given the decline in forceps
20 in the United States over the past ten
21 years any decrease in the use of vacuum-
22 assisted delivery devices resulting from
23 the FDA Advisory is likely to result in a
24 higher cesarean delivery rate or the

1 increased use of forceps in some cases by
2 practitioners who have inadequate training
3 in their use.

4 The Committee on Obstetric
5 Practice believes that, as with any other
6 obstetric procedure, obstetric care
7 clinicians using vacuum-assisted delivery
8 devices to effect operative vaginal
9 deliveries should be appropriately trained
10 and familiar with the indications and
11 contraindications for the use of the
12 device, as well as with its proper
13 application and traction procedure. The
14 Committee on Obstetric Practice strongly
15 recommends the continued use of vacuum-
16 assisted delivery devices in appropriate
17 clinical settings.

18 That's basically the crux of it.

19 Q. ACOG, that bulletin recommends
20 continuing use of the vacuum? Is that what
21 you said?

22 A. Correct.

23 Q. Do you agree with that guideline?

24 A. I still use it.

25 Q. Do you have an opinion, as the ACOG

1 Bulletin says, that the physician should be
2 properly trained in the use of the vacuum?

3 A. (No verbal response).

4 Q. Do you have an opinion whether Dr.
5 Rhett was properly trained in the use of
6 the vacuum?

7 A. By viewing the video, his way of doing
8 the procedure, of the delivery, is very
9 much consistent with what I am aware of way
10 to use a vacuum and to the way that I use
11 it.

12 Q. Doctor, now let's get to this
13 instruction booklet. This is in evidence
14 already as Exhibit 73. Would you please
15 identify that document?

16 A. It says *Instruction Booklet for Vacuum*
17 *Delivery Systems*.

18 Q. Where do you get one of these?

19 A. I don't know.

20 Q. Have you seen it before today?

21 A. You seen me a copy of it, but I had not
22 seen it before you sent me the copy of it.

23 Q. Let me ask you -- I'd like for you to
24 look at the front page of this instruction
25 booklet for vacuum delivery systems. It's

1 a Utah Medical. See the picture on the
2 front page that looks like the cup of the
3 vacuum is inside a woman's vaginal, do you
4 see that?

5 A. Looks like it is.

6 Q. Do you have an opinion whether or not
7 the picture on the front of the instruction
8 booklet with the cup inside the woman's
9 vaginal is a proper placement of the cup?

10 A. It looks like it is a proper placement
11 but it's a reproduction -- so, Counsel, I
12 would rather not say absolutely because
13 it's a reproduction and I can't see it as
14 clear as I would like to.

15 Q. We don't have the original, that's a
16 copy in front of you?

17 A. Correct.

18 Q. Okay. If you would look, please, turn
19 with me to page four of this document.
20 What is outlined on page four?

21 A. It says, "Vacuum-Assisted Delivery,
22 Indications for Use and Contraindications
23 for Use."

24 Q. Based upon your review of Dr. Rhett's
25 deposition testimony in this case, do you

1 have an opinion whether Dr. Rhett was aware
2 of the indications for use for a vacuum-
3 assisted delivery?

4 A. According to what they're listing here,
5 the patient was greater than thirty-six
6 weeks, there was no obvious evidence of
7 cephalologic disproportion. All that really
8 means is that the baby is too big to fit
9 through. Full effacement of the cervix,
10 which was the case here. Ruptured
11 membranes, which was the case here.
12 Engaged fetal head at the outlet or low
13 station.

14 Q. Do you have an opinion whether Dr.
15 Rhett was reasonable to use the vacuum in
16 light of the indications as outlined on the
17 instruction booklet?

18 A. Using all signs that suggest to me that
19 that this was a low station, his procedure
20 followed the indications for its use.

21 Q. Now looking at the contraindications.
22 You've read Dr. Rhett's deposition, is that
23 right?

24 A. Yes, I have.

25 Q. Based on your review of Dr. Rhett's

1 deposition testimony, do you have an
2 opinion whether or not he was aware of the
3 contraindications for vacuum-assisted
4 delivery?

5 A. He said that he was.

6 Q. So in light of the fact that Dr. Rhett
7 knew the indications and the contra-
8 indications, do you have an opinion as to
9 whether or not he acted reasonably with
10 what is outlined in the instruction booklet
11 which is marked as Exhibit 73?

12 A. Correct. Yes.

13 Q. I've got blue, the wrong color here --
14 I meant to do red.

15 One more question on the technique
16 of using the vacuum, Dr. Hobbs, is it
17 significant to you that the baby didn't
18 have any lacerations on his head?

19 A. Well, you -- in doing the delivery you
20 don't want to twist the device, in other
21 words twist on the scalp because that
22 injures the scalp resulting in scalp
23 lacerations.

24 Q. What evidence did you see on the birth
25 video or in the medical records that there

1 were any lacerations on the baby's head?

2 A. I don't recall see those. I don't
3 recall any.

4 Q. Dr. Hobbs, what opinions do you have
5 about Dr. Rhett's bedside manner during
6 Jayden's delivery?

7 A. Well, he certainly was in control of
8 the situation. Obviously, as with any
9 mother who is about to delivery a baby,
10 there's pain, discomfort and there's often
11 times a little increase in the increase in
12 the volume of one's voice box. But under
13 the circumstance there did not seem to be
14 panic and it seemed that during the
15 delivery process that he was trying to work
16 with her to control the situation,
17 encouraging her.

18 Q. Do you have an opinion as to whether
19 Dr. Rhett was safe during the delivery of
20 Ms. Washington's baby?

21 A. Do you mean was he performing in what
22 I'd consider a -- tell me what you're
23 talking about when you use the term "safe".
24 Was he safe? I don't know what you mean
25 when you ask was he safe?

1 Q. If we define "safe" as being within the
2 standard of care, in your professional
3 opinion was Dr. Rhett within the standard
4 of care during the delivery of Jayden
5 Washington?

6 A. Yes.

7 Q. Dr. Hobbs, can an obstetrician prevent
8 a child's genetic disorder?

9 A. Can they prevent it? Counsel, I will
10 answer this way: we can offer to them
11 genetic counseling and the decision where
12 they proceed with impregnation and creating
13 a new entity is the choice and decision of
14 the parties involved. So the physician
15 cannot prevent it but he can certainly make
16 the information available.

17 Q. In your professional opinion, did Dr.
18 Rhett deviate from the standard of care?

19 A. In?

20 Q. In this delivery?

21 A. No.

22 Q. Are all the opinions that you have
23 given today to a reasonable degree of
24 medical certainty, most probably?

25 A. Correct.

1 Q. Based on the documentation in the
2 medical chart that we went through, which
3 we have previously marked collectively as
4 an exhibit, was the East Cooper Hospital
5 nursery aware that the vacuum was used to
6 assist in this delivery?

7 A. It appears that they were informed.
8 As matter of fact, I think someone from the
9 nursery was there at the time of delivery.

10 Q. Dr. Hobbs, after your -- your
11 deposition was taken in December of 2009.
12 After December 2009, have you had an
13 opportunity to see Mr. Graham?

14 A. Yes.

15 Q. Why don't you tell us where you saw Mr.
16 Graham?

17 A. We were at a conference in Cabo San
18 Lucas?

19 Q. Whose conference room was that in Cabo
20 San Lucas?

21 A. The coordinator of the conference with
22 Dr. Aubrey Milunsky out of Boston.

23 Q. Dr. Milunsky?

24 A. Out of Boston. Yes, ma'am.

25 MOLLY CRAIG: Thank you,

1 Doctor. Those are all the questions that I
2 have. Thank you very much.

3 THE COURT: Cross-examination.

4 EDWARD GRAHAM: Thank you, Your
5 Honor.

6 THE COURT: Mr. Graham, do you
7 intend to use the projector?

8 MOLLY CRAIG: Your Honor, I
9 have one more question. I'm sorry. May I,
10 or would you like for me to wait?

11 THE COURT: Go ahead before we
12 cross over to cross-examination, go ahead
13 and ask him your question.

14 MOLLY CRAIG: Thank you.

15 THE COURT: Do you need the
16 projector?

17 MOLLY CRAIG: No, sir.

18 THE COURT: Are you going to use
19 it?

20 EDWARD GRAHAM: I don't believe
21 so, Your Honor.

22 THE COURT: Then let's cut that
23 off. Go ahead, Ms. Craig.

24 DIRECT EXAMINATION CONTINUED

25 BY MOLLY CRAIG:

1 Q. Dr. Hobbs, have you reviewed cases as
2 an expert witness before?

3 A. Yes, I have.

4 Q. Do you review cases only for defendant
5 doctors?

6 A. No, I do plaintiff and defendants.

7 Q. You do what?

8 A. Plaintiff and defendants.

9 MOLLY CRAIG: Thank you very
10 much.

11 THE COURT: Now, cross-
12 examination.

13 EDWARD GRAHAM: Thank you, Your
14 Honor.

15 CROSS EXAMINATION

16 BY EDWARD GRAHAM:

17 Q. Good afternoon, Dr. Hobbs. It's good
18 to see you again.

19 A. How are you?

20 Q. Let me ask you, sir, first of all, the
21 time issue -- I was confused about your
22 testimony about the time of this birth.
23 You aren't accusing the nurses of putting a
24 false time of birth on the medical records,
25 were you?

1 A. No.

2 Q. Sometimes nurses use their own personal
3 watch, true?

4 A. Correct.

5 Q. Sometimes they use the clock on the
6 wall, true?

7 A. True.

8 Q. Sometimes they use the time on the
9 strips, true?

10 A. True.

11 Q. But it is not at all unusual for the
12 time that the nurse enters on the chart to
13 be different from the time internally to
14 the strip, is it?

15 A. No.

16 Q. Speaking of the strips, many of the
17 word entries on the strips, the annotations
18 on the strips are entered manually by the
19 healthcare providers, true?

20 A. By the healthcare providers?

21 Q. Yes, sir.

22 A. Well, I mean -- when you say "manually"
23 placed, I'm not following.

24 Q. Well, for example, if a nurse sees that
25 a mother had a -- a laboring mother has an

1 urge to push, she has the ability to enter
2 manually on that equipment, at a certain
3 time of her choosing, "mother has urge to
4 push". True?

5 A. Yes.

6 Q. And if a doctor uses a vacuum, she has
7 the ability to type in or input "doctor
8 applies vacuum". True?

9 A. True.

10 Q. And when the baby is delivered, the
11 nurse has the ability, the nurse or the
12 doctor has the ability to write "baby
13 delivered, normal viable male delivery" or
14 words to that effect. True?

15 A. (No verbal response).

16 Q. Are there any annotations or word
17 entries on the strips that are put there
18 automatically by the monitoring equipment,
19 by the fetal heart monitor strip equipment
20 itself, without human involvement?

21 A. Counsel, I can't answer that because I
22 don't -- I don't recall -- I've never
23 actually done that myself. I don't pay
24 attention to it because I don't generally
25 do any annotation on the monitoring strips.

1 Q. Well, it wouldn't surprise you to learn
2 that the equipment itself records when an
3 electrode is pulled out; that wouldn't
4 surprise you, would it?

5 A. I don't know, I don't know anything
6 about it.

7 Q. Have you ever recorded or directed a
8 nurse to record on a strip that the
9 electrode was taking out?

10 A. I don't recall telling a nurse to
11 record it on the strip. I have said 'the
12 electrode is off'.

13 Q. And when the switch goes from the
14 internal electrode to the out -- the
15 external monitor, the equipment itself is
16 aware of that. You don't have to put that
17 in manually, do you? Or do you know?

18 A. I don't know.

19 Q. I will move on. Let's talk about the
20 electrode. You indicated -- do you have
21 the electrode up there now?

22 A. (No verbal response).

23 Q. Do you use an electrode somewhat like
24 this in your own practice?

25 A. Yes.

1 Q. When it is time for you to put the
2 electrode in, you use a device to insert
3 it, to screw it in?

4 A. There is a stylus that you use to put
5 it in, yes. The stylus is just to keep
6 from injuring the side walls of the
7 vaginal.

8 Q. You use it to put this in, you don't
9 manually screw it in with your fingertips
10 like that (indicating), do you?

11 A. No, you actually twist it so that it
12 goes in.

13 Q. You twist the -- and when it is time to
14 take this out, you don't routinely and
15 ordinarily unscrew it with your fingertips,
16 do you?

17 A. I do.

18 Q. Well, do you realize that many
19 obstetricians are trained to simply unravel
20 the cord?

21 A. I don't do it that way. If you're
22 saying that's true, I have to -- I don't.

23 Q. Have you ever heard of doctors pulling
24 out an electrode by unraveling the two
25 cords, the green and red or orange cord

1 that are woven together? Have you ever
2 heard of that?

3 A. No, I haven't seen it.

4 Q. In reaching your opinions today, have
5 you assumed that Dr. Rhett actually un-
6 screwed the tip of this with his
7 fingertips?

8 A. From where I saw his fingers, yes.

9 Q. You assumed that he unscrewed it?

10 A. Yes.

11 Q. Let me ask you about the Sully
12 technique. I was actually in New York at
13 the time of that flight and the lawyer with
14 me was on that plane, so I remember that
15 very vividly. But let me ask you, sir,
16 when Captain Sully took command of that
17 ship and heroically landed it, preventing
18 any harm -- any significant harm to any
19 passenger, -- he had command of the
20 relevant knowledge that he needed and he
21 was able to apply that knowledge to get
22 people out of that situation safely. True?

23 A. Yes.

24 Q. He would not be able to apply knowledge
25 that he did not have. True?

1 A. Well, Counsel, let me answer your
2 question by saying that is analogy. It's
3 not a technique, it's an analogy that I
4 used in order to compare when I am teaching
5 my residents.

6 Q. But when -- whether it is a pilot of an
7 obstetrician, if the issue is using one's
8 best clinical judgment to apply knowledge
9 to a given situation, a professional cannot
10 apply knowledge if he doesn't have that
11 knowledge. True?

12 A. That's correct. Yes.

13 Q. In terms of the need to warn, you train
14 your residents to warn moms about the
15 dangers of brain bleeds from the use of a
16 vacuum. True?

17 A. Yes.

18 Q. You warn patients yourself about the
19 dangers of a brain bleeds from the use of
20 a vacuum, true?

21 A. If the circumstances present it, yes.
22 If there is time to do so, yes.

23 Q. All right. Well, let me ask you this,
24 this is a long, slow first stage. True?

25 A. Yes.

1 Q. When there is a long, slow first stage
2 the doctor has reason to start thinking
3 'what might we run into in the second
4 stage?' True?

5 A. You think, in general.

6 Q. During that first slow stage there was
7 plenty of time for Dr. Rhett to talk to
8 this mama about various modes of delivery.
9 True?

10 A. Well, there was time for him to do that
11 but I think his expectation was for a
12 normal delivery. Most of us have that as
13 our expectation.

14 Q. And there was plenty of time for him to
15 give the alternatives if anything bad
16 developed, to tell the mom about the
17 alternatives? Tell her about the options?
18 To tell her about the pros and cons of each
19 option? True?

20 A. Yes, he could have done that.

21 Q. He could have given her the warnings,
22 the FDA suggestion about brain bleeds being
23 made known to the mom before a decision is
24 made about whether to use a vacuum. True?

25 A. Correct.

1 Q. He could have given the warnings that
2 ACOG recommends to be given to the mom
3 before the decision to use a vacuum? True?

4 A. In the circumstances he was in at the
5 time the vacuum was applied, no, he would
6 not have had time to do it -- as far as I
7 am concerned.

8 Q. Not have time to give warnings?

9 A. At the time that he was trying to get
10 the baby out, he did not have a lot of
11 time.

12 Q. He had time to give warnings during the
13 first stage when he was talking about --
14 when he should have been talking about
15 alternatives. True?

16 A. During the first stage of labor, he
17 could have talked about a lot of thing
18 involving obstetrics?

19 Q. Including warnings of brain bleeds from
20 vacuum. True?

21 A. Including warnings of brain bleeds from
22 C-section, including warnings of brain
23 bleeds from a normal vaginal delivery.

24 Q. Let's turn back to ACOG Bulletin Number
25 17. You are very familiar with this.

1 True?

2 A. Yes, I saw this.

3 Q. Let me ask you to read the first
4 sentence on Page 1001, starting with the
5 word "given". Would you please read that
6 to the jury?

7 A. (Reading): *Given the maternal and*
8 *neonatal risks associated with operative*
9 *vaginal delivery, it is important that the*
10 *patient be made aware of potential*
11 *complications of the proposed procedure.*

12 Q. I am going to highlight, Dr. Hobbs.
13 While I am highlighting it, let me ask you,
14 sir, why did you tell these Ladies and
15 Gentlemen that this man matched up -- that
16 he acted in accordance with ACOG if he
17 didn't do what ACOG says?

18 A. He did not do as ACOG said because ACOG
19 did not include in that information the
20 time frame and/or the urgency of the
21 delivery, of the intervention.

22 Q. Doctor, do you think that it is fair
23 and honest to put a red checkmark by ACOG
24 on this list?

25 A. I don't know -- I'd have to --

1 reasonable, yes, I think it is very
2 reasonable.

3 Q. You think that it is reasonable to say
4 that this doctor, Dr. Rhett, followed the
5 rules of ACOG about warning the patient of
6 the dangers of brain bleeds?

7 A. I think the question was in relation-
8 ship to the indications and contraindica-
9 tions.

10 Q. Brain bleed is what the FDA and ACOG
11 said to warn about. True?

12 A. Right.

13 Q. Potential complications. That
14 specifically includes brain bleeds?

15 A. Correct.

16 Q. Do you think that it would be fair for
17 you to take off this red "X" mark or do you
18 want to leave that on ---

19 A. I'd leave it on.

20 Q. You want to leave that on?

21 A. Leave it on.

22 Q. All right. Now let's talk about this
23 general consent form. I was very confused,
24 very confused. You said this form,
25 Exhibit 2004, you -- which the defense

1 keeps calling an informed consent form.

2 Doctor, please tell us all, is this an
3 informed consent form?

4 A. No, I said that before in my testimony.

5 Q. It is not?

6 A. It is not.

7 Q. And this doctor never gave the patient
8 and never obtained from the patient an
9 informed consent; did he?

10 A. No, he did not.

11 Q. Can you please explain to me, sir, do
12 you believe that it is fair and reasonable
13 to put a red checkmark by "Informed
14 Consent" when you have told us that this
15 is not informed consent and there was no
16 informed consent? Is it fair and
17 reasonable to put a red checkmark by
18 "Informed Consent"?

19 A. There was not informed consent.

20 Q. Is it fair and reasonable for you to
21 allow Ms. Craig to put a red check mark
22 there?

23 A. I didn't really put the check mark
24 there.

25 Q. Is it ---

1 A. There was not informed consent.

2 Q. That red check mark doesn't believe
3 there, does it?

4 A. It belongs there from the standpoint
5 that there was not time to do it.

6 Q. It was not obtained?

7 A. It was not obtained.

8 Q. No informed consent was obtained?

9 A. There was not.

10 Q. Shall we take this check mark off or do
11 you ---

12 A. No.

13 Q. You want to leave it on there?

14 A. I want to leave it on there.

15 Q. Speaking of ACOG, I just want to make
16 clear, you recognize that ACOG has been
17 using a plus-five, minus-five centimeter
18 system since 1988. Correct?

19 A. Correct.

20 Q. Let's see if we can agree on this:

21 If an obstetrician does not know a baby's
22 station, would it be a violation of
23 standards of care for that doctor to use a
24 vacuum?

25 A. Are we asking a hypothetical?

1 Q. I am asking the question applicable to
2 any and every situation that fits these
3 facts. If the doctor does not know the
4 baby's station, is it improper and against
5 the standards of care for that doctor to
6 use a vacuum?

7 A. Then it is improper, yes, if he does
8 not know the station.

9 Q. Not only is it improper but it is also
10 a violation of the standard of care. True?

11 A. If he does not know the station, that's
12 a violation of the standard of care.

13 Q. So if we -- if the jury decides that
14 Dr. Rhett did not know this baby's station
15 at the time that he applied that vacuum,
16 that would be inappropriate?

17 A. Correct.

18 Q. And against the standards of care?

19 A. Correct.

20 Q. We were talking earlier -- or you were
21 talking earlier about Apgars. Apgars of
22 seven and nine are pretty good, right?

23 A. Reasonable.

24 Q. They have -- the brain bleeds caused by
25 the vacuum had not bled out enough for the

1 vital signs to show that the brain was
2 bleeding, true?

3 A. I can't answer that. That's more
4 pediatric.

5 Q. So you don't know how long it takes for
6 a -- when a scalp shears the bridging veins
7 in the baby's brain, you don't know how
8 long it takes for those veins to empty of
9 the blood and collect into a clot in
10 various portions of the brain?

11 A. I don't.

12 Q. But surely you know that when the brain
13 bleeds that it affects the baby's circulat-
14 ing volume of blood?

15 A. Correct.

16 Q. So if there's not a -- if blood is
17 going out into the spaces of the brain
18 rather than to their intended locations
19 through the blood vessels, the baby's
20 circulating suffers?

21 A. Yes.

22 Q. Let's go to what you read in evidence,
23 the first ACOG Committee Opinion, the one
24 back in September of '98, Exhibit 97. This
25 was followed within two years or so by ACOG

1 Technical Bulletin Number 17, correct?

2 A. I believe that's correct.

3 Q. So when Technical Bulletin Number 17
4 came out in 2000, June of 2000, that
5 replaced this Committee Opinion. Correct?

6 A. The one that came out in 2000 said that
7 it replaces Technical Bulletin 196 of
8 August 1994, is what I am reading here,
9 unless you have something to contrary.

10 Q. But it talks about operative vaginal
11 delivery, it talks about the FDA Warnings
12 and it is the latest word from ACOG; true?

13 A. Well, I don't -- yes, it is. The 1998
14 Food & Drug Administration. Yes.

15 Q. But even going back to Exhibit 97,
16 which has been replaced or superceded, if
17 you will, by the June 2000 technical
18 bulletin, this first reaction from ACOG to
19 the FDA warnings indicates in that last
20 paragraph ---

21 A. Excuse me, Counsel.

22 Q. Yes, sir?

23 A. You are saying that this June of 2000
24 is replacing the Committee Opinion on
25 September 19, 1998. That's not true, it's

1 not replacing it. It does not say anywhere
2 that it is replacing it.

3 Q. Well, ---

4 A. This Committee Opinion was a one sheet
5 statement. This is an operative vaginal
6 delivery and the discussion of operative
7 vaginal deliveries.

8 Q. September of '98 was the first ACOG
9 Committee Opinion about the FDA Warnings,
10 true?

11 A. Yes.

12 Q. And the latest ACOG literature on the
13 FDA warnings is contained in this technical
14 bulletin, number seventeen?

15 A. Part of the discussion of the FDA is
16 included in this but that is not the
17 essence, total, of this that you're talking
18 about in June of 2000. So it did not -- it
19 did not replace the Committee Opinion of
20 September of 1998 is what I'm saying.

21 Q. But you'd admit that Technical Bulletin
22 Number 17 is dated almost two full years
23 later?

24 A. Well, one was written in September of
25 1998 and the other was written in June

1 2000.

2 Q. Technical Bulletin Number 17 was
3 written almost two years later. True?

4 A. Yes, that's -- the committee opinion
5 was done in September of 1998 and the ACOG
6 bulletin was done in June of 2000.

7 Q. Let's turn back to (Exhibit) 97, the
8 Committee Opinion, the last paragraph.

9 A. Ninety-seven. I'm not with you. Where
10 are we in '97?

11 Q. The Committee Opinion.

12 A. That was in '98, sir. Sorry.

13 Q. (Indicating).

14 A. Oh, this marking?

15 Q. I am not talking about the year now,
16 I'm talking about an exhibit number.

17 A. Okay.

18 Q. You see the exhibit number in the
19 bottom right-hand corner, Exhibit 97?

20 A. Right.

21 Q. In the last paragraph, it indicates
22 that the Committee on Obstetric Practices
23 believes that vacuums are still
24 appropriate. Then it lists certain
25 provisions. Correct?

1 A. No, it doesn't list it in here. No.

2 The statement says, (reading):

3 *The Committee on Obstetric*
4 *Practice believes that, as with any other*
5 *obstetric procedure, obstetric care*
6 *clinicians using vacuum-assisted delivery*
7 *devices to effect operative vaginal*
8 *deliveries should be appropriately trained*
9 *and familiar with the indications and*
10 *contraindications for the use of the*
11 *device, as well as with its proper*
12 *application and traction procedure.*

13 Is that what you're referring to?

14 Q. Yes.

15 A. That does not list anything at all.

16 It says that you should be familiar with
17 the indications and contraindications.

18 Q. It says obstetricians who continue to
19 use a vacuum after FDA warnings should be
20 familiar with the contraindications for use
21 of a vacuum. True?

22 A. Correct, that's what it says.

23 Q. And it goes on to say obstetrician who
24 continue to use a vacuum after the FDA
25 warnings should be familiar with proper

1 traction procedure. True

2 A. Correct.

3 Q. Let me ask you, sir, about the
4 instruction bulletin, Exhibit 73, referred
5 to earlier.

6 A. Yes.

7 Q. It was very curious to me that Ms.
8 Craig asked you some questions where she
9 asked you to list the indications for use
10 but she didn't ask you to list the
11 contraindications for use. She just asked
12 you a totally different question about
13 whether you thought Dr. Rhett knew about
14 contraindications from what you read in his
15 deposition. I ask you, sir, please read
16 contraindications for use number two.

17 A. (Reading): *Unengaged Mid-Station*
18 *Delivery.*

19 Q. If this jury finds that the vacuum was
20 applied to Jayden W 's head when it
21 was in the mid pelvis, that would be in
22 violation of the contraindications listed
23 by the manufacturer on this instruction ---

24 A. But not in violation of the standard of
25 care for obstetrics and gynecology. False.

1 Q. It would violate the manufacturer's
2 instructions, true?

3 A. The manufacturer does not determine or
4 dictate the standard of care for obstetrics
5 and gynecology.

6 Q. But it would be in violation of the
7 instructions?

8 A. What the manufacturer says.

9 Q. And ACOG indicates in its Committee
10 Opinion that if you're still going to use
11 a vacuum after the FDA Warnings about all
12 these brain bleeds, you as an obstetrician
13 better be familiar with the contra-
14 indications for the use of the device.
15 True?

16 A. But the contraindications, based on
17 the American College of Obstetricians &
18 Gynecology for obstetrics and gynecology,
19 not the booklet itself.

20 Q. So you're telling us here today that it
21 is A-okay to violate the manufacturer's
22 instructions?

23 A. I am saying to you that in that same
24 document from which you were reading -- I
25 would also like to clarify my point, if you

1 don't mind. As an alternative -- midway
2 down through the second paragraph of the
3 introduction, it says, (reading):

4 *At midstation and higher in the*
5 *birth canal operative vaginal delivery*
6 *techniques are contraindicated, requiring*
7 *caesarean section when fetal descent has*
8 *become arrested or indications of fetal*
9 *distress.*

10 This is untrue. That only had one
11 application here, if it is higher than the
12 mid-station. In the standard of care for
13 obstetrics and gynecology, a mid-station
14 vaginal delivery, vacuum-assisted or
15 forceps, can be performed. It is within
16 the standard of care as long as you have an
17 experienced physician who is skilled and
18 trained in doing so.

19 So my point is that the contra-
20 indications that are necessarily written by
21 manufacturer does not necessarily apply to
22 the standard of care of the American
23 College of Obstetricians & Gynecology.

24 Q. Which document are you referring to?

25 A. The one that you gave me.

1 Q. Which one?

2 A. This is the instructional booklet of
3 the vacuum delivery system.

4 Q. Does that instruction booklet say that
5 it is acceptable for obstetricians to use
6 this particular vacuum cup to delivery a
7 baby from the mid pelvis?

8 A. I don't know if it is speaking of this
9 particular one or not. This says -- the
10 heading says "Vacuum Delivery Systems". I
11 don't know if they are talking about just
12 their cup or if they're talking about
13 others. I see it listed, yes.

14 Q. The contraindications?

15 A. There is ---

16 Q. "Do not use this cup for a mid-
17 pelvic..." -- that doesn't give you a clue?

18 A. Counsel. Counsel, please. Allow me to
19 finish my answer. "Instruction Booklet for
20 CMI Vacuum-Assisted Delivery System".

21 There is a disposable cup and this is a
22 listing of eleven different cups. There-
23 fore, I do not know if they were speaking
24 of a specific cup, as you want to imply to
25 the jury, and I think that is not true.

1 That is a listing of eleven different cups.

2 Q. Is Vacuum Cup 404TT in that list?

3 A. (Upon review), it is.

4 Q. And the contraindication about mid-
5 pelvic application applies to Vacuum 404TT.

6 True?

7 A. According to the manufacturer, but not
8 according to the standard of care of
9 American College of Obstetricians &
10 Gynecology or the standard of care for a
11 physician practicing the specialty of
12 obstetrics and gynecology.

13 Q. If a doctor violated the ACOG Committee
14 Opinion where it says 'don't use vacuums
15 unless you're familiar with the
16 contraindications for the use of the
17 device', if the jury finds that Dr. Rhett
18 violated that, would you recognize that as
19 a violation of the standard of care?

20 A. I'm sorry, the last part of that I
21 didn't quite catch. If the jury find?

22 Q. Referring to your committee opinion
23 from ACOG, Exhibit 97, if the jury were to
24 find that Dr. Rhett used a vacuum without
25 being familiar with the contraindications (

1 of use, would you agree that that be,
2 number one, dangerous to the baby?

3 A. Yes.

4 Q. Would you agree that that would
5 improper obstetrical care?

6 A. Before I answer the question, are we
7 taking the assumption that Dr. Rhett does
8 not know. Is that what you're asking me?

9 Q. I am asking you, sir, assuming that the
10 jury finds that Dr. Rhett used the vacuum
11 without being familiar with contraindica-
12 tions, do you recognize that that would be
13 dangerous for the baby?

14 A. Yes.

15 Q. Do you recognize that would be improper
16 obstetric care?

17 A. Yes.

18 Q. Do you recognize that would be a
19 violation of generally-accepted standards
20 of care for obstetricians under these facts
21 and circumstances?

22 A. If the jury finds that to be the case,
23 yes.

24 Q. And if the jury find that Dr. Rhett was
25 not familiar with proper traction

1 procedure, would you agree that that would
2 be dangerous to the baby?

3 A. My problem is that the determination
4 that the jury makes is the determination
5 that they as a group -- and we yield to
6 their decision. But as to whether that
7 indeed, based on what they're drawing the
8 conclusion, that the traction technique was
9 not proper, according to the standard of
10 care, of which I'm very, very familiar and
11 application and delivery, Dr. Rhett did
12 follow the standard of care. So if the
13 jury finds it, then that is actually the
14 jury's decision and I cannot argue with the
15 decision of the jury.

16 Q. Would you agree that obstetricians, in
17 using a vacuum, should pull smoothly along
18 the axis of the birth canal?

19 A. Along the lines of the birth canal.

20 Q. Yes, sir. Would you agree that it is
21 dangerous to the baby to move or to pull
22 the vacuum shaft to the left or the right?

23 A. No.

24 Q. You disagree?

25 A. I disagree with that.

1 Q. And in formulating your opinions in
2 this case, you've assumed that it is
3 acceptable for a doctor to move -- to pull
4 the vacuum to the right and the left?

5 A. In is unacceptable to rock with it but
6 to move your hand to the right or the left
7 is not a contraindication to its usage.

8 There is a difference between moving
9 your hand and rocking, Counsel.

10 The direction for the contraindication
11 have been explained, that you are not to
12 rock nor are you to torque, which is
13 twisting of the baby's head.

14 Q. Doctor, as you formulated your opinions
15 in this case, you've assumed that it's
16 acceptable for an obstetrician to pull to
17 the right and the left as long as he
18 doesn't so-call "rock"?

19 A. That's correct.

20 Q. True?

21 A. That is correct.

22 Q. Just a few more areas that I'd like to
23 move through very quickly, Dr. Hobbs.

24 First of all -- but before we get to that,
25 let me ask you, on the risks of vacuum --

1 you put a red check by "risk of vacuum".

2 You're not telling us, are you, that Dr.

3 Rhett told the mother about the risks of a

4 vacuum. Are you?

5 A. No, I am stating that I understand that

6 Dr. Rhett knew the risks of vacuum.

7 Q. All right. Do you want to leave that

8 red check mark on risk of vacuum?

9 A. Based on the application of it that I

10 am associating, yes.

11 Q. You're admitting that he kept any

12 knowledge that he might have had to

13 himself, true?

14 A. Correct.

15 Q. Also you put a red mark by documenta-

16 tion. Now, if I remember correctly, Ms.

17 Craig showed you a bunch of record entries

18 from the nurses saying that they had

19 documented the vacuum. True?

20 A. Correct.

21 Q. One lists on the face sheet for billing

22 and coding purposes saying about the

23 vacuum. True?

24 A. Correct.

25 Q. She didn't show you the delivery notes,

1 did she?

2 A. No.

3 Q. In your delivery notes, Doctor, do you
4 document that you actually used a vacuum if
5 you did?

6 A. Yes.

7 Q. Do you also consider it proper to
8 document the reason or indication of why
9 you used a vacuum?

10 A. Right.

11 Q. Do you also document the station of the
12 baby's head when you applied the vacuum?

13 A. Correct.

14 Q. Do you train your residents to document
15 use of vacuum in the delivery notes?

16 A. Yes.

17 Q. Do you train them to document the
18 reason or indication in the delivery notes
19 of why the vacuum was used?

20 A. Correct.

21 Q. Do you teach them and train them that
22 they use -- that they should also document
23 the baby's station at the time that the
24 vacuum was applied?

25 A. Correct.

1 Q. What Dr. Rhett did in his delivery note
2 violates your individual training when you
3 were a resident, true?

4 A. Yes.

5 Q. It violates the training that you give
6 to your residents, true?

7 A. Correct.

8 Q. It also violated the rules that you
9 have learned to apply in your own practice,
10 true?

11 A. Correct.

12 Q. Yet Ms. Craig, with your permission,
13 put a red check under documentation.

14 A. The basis of the discussion with me on
15 documentation was, was it documented in the
16 chart? It did not say 'did Dr. Rhett
17 document it?' It said is it documented in
18 the chart. So, yes, the red mark is
19 because it is in the chart that a vacuum
20 delivery was done. Correct.

21 Q. The proper documentation is not in the
22 chart, is it?

23 A. Well, that depends on who you're
24 talking about. The proper documentation
25 from the nursing staff is there. The

1 proper documentation in the chart, I don't
2 recall right offhand whether or not Dr.
3 Rhett indicated it was a vacuum delivery in
4 the chart.

5 Q. You don't?

6 A. I would have to go back and look at it
7 to see.

8 Q. Well, do you remember whether or not he
9 put an indication in the chart?

10 A. No, there was no indication in the
11 chart.

12 Q. Do you whether or not he put anything
13 about the station of the baby, where he
14 applied the vacuum?

15 A. No.

16 Q. Do you believe that it is fair and
17 reasonable for you to leave this red check
18 mark under documentation?

19 A. Based on my discussion with counsel,
20 yes, I would leave it there.

21 Q. You don't think that it would be more
22 appropriate to "X" through that one either?

23 A. Counsel, based on my discussion with
24 counsel I will leave the documentation red
25 "x" there because what we discussed is

1 based on -- that check mark is based on
2 what we discussed.

3 Q. Now, in our testimony today you told us
4 -- you've told us that you believe that
5 this was a low vacuum delivery. True?

6 A. Yes.

7 Q. That's not what you said in your
8 deposition, is it, sir?

9 A. I don't know.

10 EDWARD GRAHAM: Your Honor, may
11 I present the original?

12 THE COURT: You may.

13 CROSS EXAMINATION CONTINUED

14 BY EDWARD GRAHAM:

15 Q. (Tenders), let me get you to please
16 turn to Page 83, starting at Line 16.
17 Let me know when you are there.

18 A. Okay.

19 Q. Starting at Line 16, I am going to read
20 the question and answer and then I will ask
21 you if I read it correctly:

22 Q. What was the baby's station at
23 the time the vacuum was applied?

24 A. I don't know.

25 Q. Do you contend that this was

1 an outlet vacuum extraction?

2 A. No. I contend that it is a
3 vacuum-assisted delivery.

4 Q. Do you contend that this is a
5 low vacuum extraction?

6 A. I don't know.

7 Q. Do you contend that this is a
8 mid-pelvic vacuum extraction?

9 A. I don't know.

10 Did I read that accurately, sir, the
11 questions and answers?

12 A. Correct. So, -- what is your question?

13 Q. You have answered my question, sir.

14 A. Oh, -- okay.

15 MOLLY CRAIG: Your Honor,
16 that's an improper use of the deposition.

17 THE COURT: Counsel, I am going
18 to sustain that although throughout the
19 trial we have been publishing that the
20 proper use is to allow the witness to see
21 it to refresh his memory. The objection is
22 sustained. Use it -- in the future, please
23 use it for that purpose.

24 EDWARD GRAHAM: Yes, sir.

25 CROSS EXAMINATION- CONTINUED

1 BY EDWARD GRAHAM:

2 Q. Doctor, you've indicated that even
3 though there was plenty of time to give the
4 mother warnings, alternatives, indications
5 and so forth during the first stage of
6 labor, that in your opinion once there was
7 some decelerations you had to get the baby
8 out right away and there wasn't time to
9 obtain informed consent?

10 A. That was not my testimony. I said that
11 during the time that once bradycardia
12 began, persistent bradycardia. I did not
13 say that during time of other decelerations
14 that there was an emergency to get the baby
15 out.

16 Q. Well, in your practice, Doctor, even if
17 you're in a situation where you believe
18 that there is a bonafide medical emergency
19 and you have to use a vacuum, not matter
20 what the mom thinks, you at least tell her
21 you're getting ready to use a vacuum.
22 True?

23 A. Yes, I may say that I going to use a
24 vacuum. Yes.

25 Q. That only takes a split second, true?

1 A. Right.

2 Q. There was plenty of time for at least
3 that even under your emergency theory,
4 true?

5 A. Yes.

6 Q. Now, you used the phrase "hangman's
7 noose" before this jury today. As you
8 approached your work on this case, were you
9 assuming that this was a tight nuchal cord?

10 A. I didn't assume anything. I assumed
11 that there was a compromise of the blood
12 flow regardless of whether it was tight or
13 whether it not.

14 Q. Well, as you sit here today, are you
15 contending that this cord was tight?

16 A. No, I am contending that this cord
17 caused compromise of blood flow.

18 Q. You gave your deposition in late
19 December of last year. Correct?

20 A. Yes.

21 Q. You were pretty late to this case.
22 Other depositions that you read were mostly
23 from 2008 and that time period, true?

24 A. I don't remember. I don't recall.

25 Q. But you were not brought into this case

1 until just a few months before the end of
2 last year. True?

3 A. I'd have to go back and look at my
4 correspondence. I don't remember.

5 Q. Well, please turn to page eleven of
6 your deposition.

7 A. (Complies).

8 Q. Actually start on Page 10, Line 22
9 through (Page) 11, Line 4.

10 A. Okay.

11 Q. Does that refresh your recollection
12 about how long you have been involved in
13 this case?

14 A. Counsel, please read it to the jury so
15 that they will understand what your
16 question is because I'm not quite sure I
17 understand what your question is. Please
18 read it.

19 Q. Certainly. I will go back to the old
20 mode and I'll read the question and answer
21 and then you tell if I read it correctly.
22 Starting on Page 10, Line 22, (reading):

23 Q. Well, when did you first get
24 contacted about serving a role in this
25 particular case?

1 A. I can't be absolutely specific
2 because I couldn't find the letter but I
3 would imagine that if I could, just --
4 primarily guessing, it's probably been
5 about three, three and a half months ago,
6 would be my guess.

7 Did I read that accurately?

8 A. Correct. So what's your question?

9 Q. And this deposition was taken on
10 December 19, 2009. True?

11 A. And the answer said I was only
12 guessing, that I did not know. Yes, true.

13 EDWARD GRAHAM: Sir, thank you
14 for answering my questions. My best to you
15 and your family.

16 THE COURT: Is there redirect?

17 MOLLY CRAIG: Yes, sir.

18 REDIRECT EXAMINATION

19 BY MOLLY CRAIG:

20 Q. Dr. Hobbs, do you still have that
21 deposition in front of you?

22 A. I do.

23 Q. Let's go back to Page 83. Mr. Graham
24 read in, starting down at Line 16, but I
25 would like to read the question and answer

1 right before that. Are you on Page 83?

2 A. I am.

3 Q. The question before that, Line 4:

4 Q. My question is, what is your
5 understanding or assumption about what the
6 facts of the labor and delivery are and Dr.
7 Rhett's conduct that leads you to the
8 opinion that he did not deviate from the
9 standard of obstetrical care.

10 What was your answer?

11 A. (Reading):

12 A. The baby needed to be
13 delivered. The fetal heart rate was down
14 and the patient needed to be delivered.
15 So Dr. Rhett felt that he could delivery
16 the baby vaginally with the vacuum. And,
17 so, that is not a deviation of the standard
18 of care given an experienced physician
19 feels that they can get that baby
20 delivered.

21 Q. Is that deposition testimony consistent
22 with your testimony today?

23 A. Yes, it is.

24 Q. Thank you. All right, Mr. Graham asked
25 you some questions about the scalp

1 electrode.

2 A. Right.

3 Q. Based on your review of the birth
4 video, do you have an opinion whether Dr.
5 Rhett properly took off the fetal scalp
6 electrode?

7 A. I believe that he did. I can ---

8 EDWARD GRAHAM: If Your Honor
9 please, this is not ---

10 THE COURT: Sustained, Counsel.
11 That is something that you covered in your
12 direct, so -- redirect is only for new
13 issues brought up in cross. Anything
14 further?

15 MOLLY CRAIG: Yes, sir.

16 REDIRECT EXAMINATION CONTINUED

17 BY MOLLY CRAIG:

18 Q. Plaintiff's counsel asked you questions
19 about documentation. My question to you
20 is, please tell the jury what the standard
21 of care required a doctor to document, if
22 anything?

23 A. The standard of care is related to the
24 preformation of the execution of medical
25 care and treatment. I do not know of

1 anywhere where the standard of care writes
2 about how documentation is to be written.

3 Do we train individuals, especially our
4 residents, to document everything? In this
5 medical/legal environment, yes, we do. But
6 as far as the standard of care, the
7 obstetrical -- the standard of care for
8 obstetrics and gynecology is related to the
9 performance of or the execution of medical
10 care and treatment, not documentation.

11 Q. Dr. Hobbs, do any of the questions
12 asked of you by plaintiff's counsel change
13 your opinion that Dr. Rhett acted
14 reasonably in all of these respects?

15 A. No.

16 Q. Are all of those your opinions to a
17 reasonable degree of medical certainty most
18 probably?

19 A. Yes, it is.

20 MOLLY CRAIG: Thank you, sir.

21 THE COURT: You are free to step
22 down and free to leave if you wish.

23 (WITNESS STEPS DOWN)

24 THE COURT: Ladies and
25 Gentlemen, let's take our afternoon break.

1 at this time. We will let you go back to
2 the jury room. If you wish to go outside,
3 we will make that available to you. Let's
4 all remain where we are while our jury
5 departs the courtroom.

6 (JURY OUT @ 2:47 P.M.)

7 THE COURT: We will be recess
8 now approximately fifteen minutes, subject
9 to the return of the jury from their break.

10 (BRIEF RECESS)

11 THE COURT: Let me talk to the
12 defendant, talk a little bit about where
13 you are in the case.

14 (OFF RECORD BENCH CONFERENCE)

15 THE COURT: Before we bring the
16 jury in, the defense tells me that they are
17 prepared to rest. I didn't know whether
18 you were aware of that or not, if you'all
19 had had any communication about that. But
20 let me ask, is there anything for the
21 record that you want to take up at this
22 time regarding that?

23 MOLLY CRAIG: Your Honor, we
24 are aware that the MRI and the CT films
25 were not offered into evidence and we ask

1 that that be in evidence before we rest.
2 And if we could just have -- we don't mind
3 going ahead and officially resting but if
4 we could just double check the exhibits as
5 a housekeeping matter afterwards.

6 THE COURT: My response to that
7 would be that because of the multiple
8 exhibits that we've had in this case, is
9 that after we get all the testimony
10 finished -- we're going to let the lawyers
11 on both sides revisit the evidence, see
12 where we are. So without prejudice to your
13 desire to put something in a later time,
14 you can go ahead and rest when the jury
15 comes back.

16 MOLLY CRAIG: So the films are
17 in at this point.

18 THE COURT: Is there an
19 objection to the films?

20 EDWARD GRAHAM: I thought we put
21 them in. Apparently we -- we certainly
22 have no objection to the actual films as
23 well as the electronic versions.

24 THE COURT: Then hearing no
25 objection, Madame Court Reporter, let's

1 count those as being in.

2 COURT REPORTER: Which number
3 would they -- do you have any idea?

4 MOLLY CRAIG: They are --
5 these are the two disks and think that it
6 was marked on the Trial Exhibit List as 87
7 through 94, but those are the only two
8 disks so I don't know how you want to mark
9 that.

10 COURT REPORTER: I will put the
11 disks in as new numbers.

12 THE COURT: Now, Mr. Davis, will
13 there be witnesses testifying for your side
14 of the case?

15 JAY DAVIS: No, sir, there will
16 -- we will not be calling any witnesses.

17 THE COURT: Do you want to rest
18 in front of the jury?

19 ROBERT HOOD: Yes, sir.

20 THE COURT: All right. So when
21 the jury comes back in we will rest, rest.
22 Now, let's talk about reply. Apparently
23 the plaintiff intends to offer reply?

24 EDWARD GRAHAM: We do, Your
25 Honor. We've narrowed it down to one.

1 THE COURT: What new issues were
2 brought up in the defendants' case that
3 would warrant reply.

4 EDWARD GRAHAM: Your Honor, I
5 will run through them real quickly.

6 One has to do with the pH of 7.21
7 and the significance of that.

8 One has to do with movements from
9 side to side in order for Dr. Rhett to get
10 his fingers in.

11 One has to do with the New England
12 Journal of Medicine article. Now, that
13 came in ever so slightly in our direct case
14 but Your Honor precluded our getting into
15 it to the extent that we wanted to.

16 The pop-off exercise with the
17 vacuum on the flat wood in front of the
18 jury's area.

19 The terminal meconium issues.

20 The business about the electrode.

21 The business about the pelvic
22 model.

23 The business about the strips,
24 those blowups of the strips and the
25 markings on the strips telling when the

1 baby was delivered and all that stuff,
2 please what Dr. Hobbs said about the
3 mother's heart rate.

4 The long first stage.

5 These are all very quick points,
6 if Your Honor please.

7 The business about the Apgars, the
8 zero for color.

9 The business about the time for
10 delivery was to fast to be from mid-pelvis.

11 The business about the trigger
12 point and the need to push.

13 THE COURT: Anything further?

14 EDWARD GRAHAM: The business
15 about the cup around the head like a cap,
16 going deep into the pelvis and back up.

17 THE COURT: Anything further?
18 Is that it?

19 EDWARD GRAHAM: The business
20 about the photo on the cover of the
21 instructional manual.

22 THE COURT: That's sufficient.

23 Let me hear from the defense as to what
24 your position is about whether or not this
25 is ---

1 CHILTON SIMMONS: Thank you, Your
2 Honor. All of these issues that Mr. Graham
3 brings up were addressed in his case. We
4 were simply addressing what he brought up.
5 None of these are new issues.

6 He had Dr. Oakes on the stand for
7 a day, and entire and then the following
8 morning.

9 I don't see one thing on this
10 entire list that's he's rattled off that
11 is a new issue. We have responded to
12 everything that his experts testified for
13 six full days of court. In fact, we were
14 making a Motion against his expert for
15 pitting testimony. It would be -- and we
16 understand that was overruled but we were
17 simply responding to the new allegations
18 that he brought in his direct case.

19 Your Honor, I feel that we have
20 been through these issue *ad nauseam*.

21 JAY DAVIS: I would join in,
22 Your Honor with "what is good for the goose
23 is good for the gander" argument. Mr.
24 Graham sat over there and said, 'Well, you
25 took his deposition, you could have asked

1 all the questions that you wanted.' If his
2 position is that this is somehow new, he
3 had opportunity to discover all these
4 things -- if in fact they are new -- in his
5 deposition and he didn't do it.

6 CHILTON SIMMONS: I join in that,
7 Your Honor.

8 THE COURT: All right, let me
9 think about this just a moment, please.

10 CHILTON SIMMONS: Your Honor, if I
11 may add one thing. Some of those subjects
12 as well were also addressed by Dr. Gomez-
13 Carrion. She specifically testified as to
14 meconium as well as other subjects, so
15 that's been addressed by two of his
16 witnesses.

17 THE COURT: Very good. Counsel,
18 what is different about the New England
19 Journal? You had a -- you said something
20 about the New England Journal, which was
21 your third point.

22 EDWARD GRAHAM: Yes, sir. They
23 asked about a table and in redirect I tried
24 -- I asked question about the table, which
25 you allowed. But then when I tried to go

1 into the article from which the table was
2 taken, you stopped me. Let me rephrase
3 that. We started with ACOG 17, which cites
4 the New England Journal. The table in ACOG
5 17 is what we got in, but you stopped me
6 from getting into the New England Journal
7 of Medicine article on which that was
8 based.

9 THE COURT: Did you want ---

10 CHILTON SIMMONS: Your Honor,
11 just briefly, that same article in the New
12 England Journal of Medicine was in the ACOG
13 article, so we had been talking about
14 throughout this litigation. We never
15 brought up the New England Journal article.
16 Plaintiff's counsel asked Dr. Rhett about
17 that article on the stand.

18 THE COURT: All right. Here are
19 the issues that I found would be appropri-
20 ate in reply. First of all there was some
21 new testimony about the electrode, the use
22 of the pelvic model, the blowup strips, the
23 colors of the Apgars, the trigger point on
24 the pelvic floor, the way that the -- Dr.
25 Hobbs testified about putting on the cap by

1 going deep into the pelvis and then the
2 photo on the cover of the manual.

3 That's seven issues that the court
4 seems that are new, those are the ones --
5 make sure that I counted them correctly --
6 those are the ones that I see as being new,
7 responsive, where something could have been
8 brought up in -- those are responsive to
9 what the defendant brought up which was in
10 response to what you started -- such as
11 rocking, pH, pop-off.

12 Then, finally, the -- again, there
13 are several things that you initiated and
14 then other that may not have been initiated
15 by you but which are certainly not new to
16 the case.

17 EDWARD GRAHAM: May I ask
18 specifically on a couple of them, Your
19 Honor?

20 THE COURT: Go ahead.

21 EDWARD GRAHAM: All right. Do
22 you have the New England Journal of -- may
23 I get into that?

24 THE COURT: Tell me what's new
25 about the New England Journal.

1 EDWARD GRAHAM: If Your Honor
2 please, the New England Journal studies all
3 vacuum deliveries and all certain other
4 types of deliveries of babies that are
5 twenty-five hundred grams or larger. Then
6 it purports to draw conclusions about the
7 relative degree of risk from brain bleeds
8 from different modes of delivery.

9 The last paragraph in there says
10 that it should not be used for the purpose
11 that they are trying to use it for.

12 I also -- I would like to bring
13 out that it doesn't make any distinction
14 between outlet, low and mid-pelvic vacuums,
15 which makes all the difference in the world
16 to the relative degree of risk of vacuum
17 deliveries. In terms of C-section and that
18 sort of thing, it includes babies who were
19 just very small -- twenty-five hundred
20 grams is very small, many pre-term babies
21 would fall into that category with
22 increased risk of brain bleeds.

23 THE COURT: And what other
24 issues do you ---

25 EDWARD GRAHAM: They did that

1 little trick, if Your Honor please, with
2 the vacuum and the pump through -- I think
3 it was Dr. Norton who brought the pump with
4 her. They put it on the flat surface of
5 the jury box, pumped it up and tried to
6 show that ---

7 THE COURT: What else?

8 EDWARD GRAHAM: (No verbal
9 response).

10 EDWARD GRAHAM: Counsel, I
11 actually am going to stop you with those
12 two additions. I will give you followup on
13 the New England Journal as well as the pop-
14 off exercise, because there was a
15 discussion about whether the pump itself
16 should be retained here as evidence solely
17 for the purpose of reply. Now, again, this
18 is not issues that -- these are very
19 specific issues that we'd talked about, not
20 to spill over or rehash what is already
21 been over.

22 EDWARD GRAHAM: If you would
23 permit one more, there is one that I
24 neglected to mention.

25 THE COURT: Go ahead.

1 EDWARD GRAHAM: It is the pH,
2 they've started talking about that. There
3 is not a lot of room to go from 7.21 to the
4 "dangerously acidotic 7.0 or below" and all
5 that kind of stuff, that came in through
6 defense experts. We would like a chance to
7 respond to that. We went into nothing
8 about pH in our direct.

9 THE COURT: Do you want to be
10 heard?

11 CHILTON SIMMONS: Your Honor, that
12 was brought up in their original deposition
13 -- throughout this case.

14 THE COURT: I am going to -- I
15 believe that you did do something about pH,
16 because I recall the discussion in your
17 case about the 7.2 figure. I'm not going
18 to permit the pH discussion.

19 The others, I will allow over
20 defendants' objections. And ---

21 EDWARD GRAHAM: Thank you, Your
22 Honor. We do have some Motions when they
23 rest.

24 THE COURT: Let's do this. What
25 I would like to do, out of courtesy to the

1 jury. Let's bring the jury back. Rest.
2 We will defer any Motions that you would
3 make at that time, you'll be protected for
4 the record to make them at the close of all
5 the evidence, so that we don't delay the
6 jury while we hash out whatever results.

7 EDWARD GRAHAM: May I have a
8 chance -- just an ever so brief chance, to
9 tell Dr. Oakes not to talk about things
10 that you ---

11 THE COURT: Why don't you do
12 that while we bring in the jury.

13 EDWARD GRAHAM: Thank you.

14 CHILTON SIMMONS: Your Honor, if
15 I may, one final point on the New England
16 Journal, we did not bring that up. Mr.
17 Graham brought that up in Dr. Rhett's
18 cross-examination. We never asked a
19 question about that. We've never had any
20 testimony on that.

21 THE COURT: All right. Now, Mr.
22 Graham, you tell me that they used it for
23 an improper purpose. Now they tell me that
24 they didn't use it, didn't ask any
25 questions about it. I honestly do not

1 remember.

2 EDWARD GRAHAM: Dr. Rhett asked
3 me for the article. He said 'I read
4 somewhere.' I said, 'Where did you read
5 it?' He said, 'I am not sure.' I said,
6 'Was it the New England Journal?' And he
7 said, 'I don't know, do you have one that
8 can read?' So I just responded to his
9 request. Plus, I'm quite sure there were
10 questions that they asked Dr. Van Dorsten.

11 THE COURT: Well, out of an
12 abundance of -- well, let's do it this way.
13 Giving the plaintiff the benefit of the
14 doubt, I will let him go into it. If there
15 is something that you perceive to be new
16 and you want to recall someone in what
17 would be a -- I guess that would be -- I am
18 not sure what you would call that. But, in
19 any event, we will just take it up at that
20 time. Please tell your witness that he is
21 limited to these issues.

22 EDWARD GRAHAM: Thank you.

23 THE COURT: Bring in the jury.
24 If you believe that the plaintiff strays
25 beyond, please objection contemporaneously.

1 (JURY IN @ 3:06 P.M.)

2 THE COURT: Welcome back, Ladies
3 and Gentlemen. You will recall that we
4 were in the defendant's case for Dr. Rhett.
5 Please call your next witness.

6 MOLLY CRAIG: On behalf of Dr.
7 Edmund Rhett, we rest.

8 THE COURT: Defense for Dr.
9 Rhett rests. Are there witnesses for the
10 Defendant Lowcountry Ob-Gyn?

11 JAY DAVIS: Thankfully, no, Your
12 Honor. We will rest as well.

13 THE COURT: Defendant rests as
14 well. All right, Ladies and Gentlemen,
15 in the presentation of the case you have
16 the plaintiff's case, the defendant's case
17 and then just like the presentation of a
18 witness: direct, cross. Then you are
19 allowed what we call reply on any new
20 issues that may be brought up during the
21 course of the defendants' case. Plaintiff
22 tells us that they wish to call a reply
23 witness.

24 We have permitted them the
25 opportunity to call one -- counsel (Graham)

1 has actually stepped outside to advise the
2 witness that is getting ready to be called,
3 so we will wait just a moment until they
4 return to the courtroom. Please tell Mr.
5 Graham that we are assembled and waiting.
6 Thank you.

7 (MR. GRAHAM ENTERS COURTROOM)

8 THE COURT: Counsel, the Court
9 is advised that you wish to call a replay
10 witness. Please call your witness.

11 EDWARD GRAHAM: The plaintiff
12 recalls Dr. Gary Oakes.

13 (WITNESS TAKES STAND)

14 GARY K. OAKES, M.D., having been
15 previously sworn, testified, as follows:

16 DIRECT EXAMINATION

17 BY EDWARD GRAHAM:

18 Q. Dr. Oakes, good afternoon.

19 A. Good afternoon.

20 Q. Thank you for coming back. Let me just
21 run through a few areas that have come up
22 since you last testified in this case and
23 for your comments.

24 First of all, there was an electrode --
25 there was an electrode in this case that

1 was introduced as a Court's exhibit, -- I
2 am going to let you look at this, sir. Is
3 this similar to electrodes that you are
4 familiar with?

5 A. Yes, this is a spiral electrode, so it
6 literally screws into the baby's scalp and
7 then it hooked up to a plate on the
8 mother's leg so that it picks up the
9 recording from the heart rate of the baby.

10 Q. Let's talk about how obstetricians
11 customarily apply that to the baby's scalp,
12 just very briefly.

13 A. This comes with an introducer so that
14 you can in fact place it, then you twist it
15 in so you're literally screwing it in a
16 couple turns and that's what holds it. I
17 don't know if anybody can really see that
18 very thin little tip of the white -- that's
19 what actually, clearly is a screw that goes
20 in. It only goes in about three
21 millimeters.

22 Q. Can you show three millimeters with
23 your finger?

24 A. Yeah, but -- (indicating).

25 Q. When it is time to get the electrodes

1 out of the baby's head, how do most
2 obstetricians do that?

3 A. Again, it has to be unscrewed. Very
4 often the easiest way to do that is to cut
5 the wire, undo a little of the wire and
6 just pull it so that reverses the coiled
7 line so it -- you know, so it's undone.
8 As it sits right now, if you leave it just
9 like this, you have to unscrew it. So
10 using your fingers, turn it the opposite
11 direction from where you began.

12 Q. Is it necessary for a doctor to put his
13 fingertips on the edge of that electrode,
14 up next to the baby's head and unscrew it
15 like you would a wood screw?

16 A. It's not necessary, no. In fact, if
17 you look at the video we can see that in
18 fact Dr. Rhett uses his fingers to twirl
19 it, just like I am twirling it
20 (demonstrating).

21 Q. Could we please show that ---

22 CHILTON SIMMONS: Your Honor,
23 objection. It's not reply to show the
24 video all over again.

25 THE COURT: Well, the Court will

1 allow it to be demonstrative of the point
2 brought up. The fact that it has been
3 shown doesn't mean -- that it was
4 previously shown doesn't mean that some
5 portion of it can't be used in reply.
6 Overruled. Are you able to play a portion
7 of it.

8 EDWARD GRAHAM: Your Honor, let
9 me move on to another point while he
10 (technician) is figuring that out.

11 THE COURT: That will be fine.

12 EDWARD GRAHAM: Thank you, Your
13 Honor.

14 EXAMINATION CONTINUED

15 BY EDWARD GRAHAM:

16 Q. Doctor, let me ask you about the pelvic
17 model that Dr. Rhett talked about. Right
18 before the jury came in, have you had a
19 brief opportunity to glance at this model?

20 A. I did, yes.

21 Q. Is that model to scale?

22 A. It is not.

23 Q. All right. Is it large or smaller than
24 an average woman's pelvis?

25 A. It's smaller than an average woman's

1 pelvis. I did a couple of measurements on
2 it. A couple of key measurements as you
3 look at this -- this diameter from here to
4 here is, uh, in an average woman's pelvis
5 is thirteen and a half centimeters. This
6 one is eleven. Between the ischial spines,
7 which are these prominent little spines
8 back here, in an average woman's pelvis
9 those are ten centimeters, this is eight.
10 So this is about twenty percent below
11 normal.

12 Q. Despite that, could you tell us --
13 using the pelvic model that the defense
14 introduced through Dr. Rhett, can you tell
15 us what the measure is from the plane of
16 the ischial spines to the vaginal outlet?

17 A. On this particular model?

18 Q. Yes.

19 A. On this model it's about four and a
20 half centimeters.

21 Q. In the real world, how many centimeters
22 is it from the ischial spines to the
23 vaginal outlet?

24 A. As we went through in my previous
25 testimony, it is five.

1 Q. Now, if one were to measure from the
2 ischial spines itself, in the bony part of
3 the pelvis to the side of the vaginal
4 outlet, how far would that measure be?

5 A. Well, that would not be accurate
6 because that is not the mid-plane of the
7 pelvis. It's in fact the posterior part of
8 the mid-plane. One really has to go
9 through what is the plane between the pubic
10 synthesis and the ischial spines; i.e., in
11 the center here of the pelvis going down
12 towards the vagina. That's the axis that
13 we're talking about, not from the spine
14 itself.

15 Q. What significance, if any, would it
16 have to measure from the ischial spines to
17 the vaginal outlet?

18 A. You would get an artificially elevated
19 number.

20 Q. Nevertheless, would you please do that
21 just so that we can see what the measure is
22 on that model?

23 A. (Complies), I get about six and a half
24 centimeters.

25 Q. Do you see any way that someone

1 measuring from the ischial spines or the
2 plane of the ischial spines, trying to
3 present the information in a fair, honest
4 way to the jury, could come up with seven
5 centimeters?

6 CHILTON SIMMONS: Objection, Your
7 Honor. Leading.

8 THE COURT: Leading -- that is,
9 Counsel. Sustained.

10 DIRECT EXAMINATION CONTINUED

11 BY EDWARD GRAHAM:

12 Q. Doctor, do you have an opinion to
13 reasonable degree of medical certainty as
14 to whether or not, using that model, one
15 could fairly and honestly come up with
16 seven centimeters from the ischial spines
17 to the outlet?

18 CHILTON SIMMONS: Objection.

19 THE COURT: Sustained.

20 DIRECT EXAMINATION CONTINUED

21 BY EDWARD GRAHAM:

22 Q. Dr. Oakes, do you have an opinion to
23 reasonable degree of medical certainty as
24 to whether or not one wanted to give an
25 accurate measure from the ischial spines to

1 the outlet, using the model, what the
2 measure would be?

3 A. From the mid-plane?

4 Q. Yes, sir.

5 A. I think I have given you what I think
6 is an accurate measurement, and that's four
7 and a half centimeters.

8 Q. Thank you, sir. I believe that we have
9 the electrode part of the video back. If
10 you would, just give directions to the ---

11 A. Do you still have that laser pointer?

12 Q. Well, we are looking for the laser
13 point, let me ask you about a couple other
14 things, if I may. There was testimony this
15 afternoon about trigger points. What is a
16 trigger point?

17 A. It can be lots of different things.
18 You know, some people would describe this
19 as point of pain, some would describe this
20 as a point at which the patient would have
21 an urge to push. "Trigger point" is really
22 not an obstetric expression.

23 Q. Do you have an opinion to a reasonable
24 degree of medical certainty as to what the
25 baby's station would be based on when the

- 1 mother says that she has an urge to push?
- 2 A. Remember that the protrusion is of the
- 3 bony part of the head, it's not the soft
- 4 tissue, it's not the molding, it is not the
- 5 cap formation. So in fact if there is
- 6 molding and there is caput formation, that
- 7 -- that protrusion is further down and, in
- 8 fact, can be -- the mother's, uh, perineum
- 9 and rectum, that's what really get's you
- 10 the urge to push. So usually if you don't
- 11 have molding one is going to be at a plus
- 12 three or plus four station in order to have
- 13 that kind of sensation.
- 14 Q. If it is true that the mother
- 15 complained of an urge to push before the
- 16 vacuum was applied, what effect, if any,
- 17 does that have on your opinion that the
- 18 baby was at the mid-pelvic position when
- 19 the vacuum was applied?
- 20 A. I think that we already know that there
- 21 was molding and caput formation. So that
- 22 says that there is -- that there is soft
- 23 tissue leading the way, not the true skull
- 24 of the baby.
- 25 Q. Thank you, sir. Do you have the laser

1 pointer now?

2 A. I do.

3 Q. Let's proceed with the portion of the
4 video tape that shows the ---

5 A. Now, again, what we want to do is to
6 follow this -- the doctor's left hand here.
7 What I want you to know is that when -- go
8 ahead and start it.

9 Q. (Video playing).

10 A. Dr. Rhett has his left hand on the
11 electrode. Now you can see -- right now he
12 is twisting it, he is twisting it in the
13 opposite direction, just like I was talking
14 about, to the left.

15 CHILTON SIMMONS: Your Honor, the
16 cut of the video leaves off the part where
17 Dr. Rhett exams the patient, where you can
18 clearly see how low the baby's head is in
19 the station.

20 MOLLY CRAIG: We have a copy
21 of the complete uncut video if you would
22 like that.

23 THE COURT: All right.

24 THE WITNESS: This is just
25 going in slow motion.

1 THE COURT: This is -- we've
2 heard the answer. Apparently it is slow
3 motion. That's the first time that we've
4 seen that. If you wish to come back and --
5 well, this would be cross to reply -- play
6 the entire video, you may do so.

7 CHILTON SIMMONS: Thank you, Your
8 Honor.

9 THE COURT: Very good.

10 DIRECT EXAMINATION CONTINUED

11 BY EDWARD GRAHAM:

12 Q. Please continue, Dr. Oakes.

13 A. Keep running the video.

14 Q. (Video playing) -- now you can see Dr.
15 Rhett is twisting this to the side, going
16 away, going to the left, which is -- now he
17 trips it back, he's got the electrode in
18 his right hand and now he tugs on it just a
19 bit. Right there he's tugging. Now it
20 comes out. Now, this is the electrode
21 right here. See this white? And you can
22 see how much -- how much of that electrode
23 is inside. It's not just -- it's not just
24 right inside the vaginal, there is this
25 much electrode there.

1 Q. Doctor, if Dr. Rhett had in fact put
2 his fingertips on the end of the electrode
3 and reached up and unscrewed it, like you
4 would a wood screw, directly on the head,
5 what need would there be to unravel the
6 leads on the electrode?

7 A. There wouldn't. That's what I am
8 talking about. His movement, you can
9 clearly see that he is unscrewing it. He
10 is even tugging on it, so it hasn't been
11 released. He's releasing it there from the
12 exterior. Then if somebody did unscrew it
13 at the scalp, you've have it in your hand.

14 Q. Anything else that you want to tell us
15 about the leads?

16 A. No.

17 Q. Thank you. Doctor, I am going to ask
18 you to please step down here, if you would.
19 I have some questions about these blowups
20 of some strips.

21 Let me makes sure that I've got the
22 times right. On the left we have 1931,
23 1939 and 1947. Do those appear to be in
24 the right order.

25 Q. Let me ask you, Doctor, first of all

1 with regard to the strip equipment, the
2 strip that creates the mother's uterine
3 contractions and the baby's heart rate, if
4 a healthcare provider such as a nurse
5 wanted to make an entry onto this strip
6 about 'Mother has urge to push' or
7 'cervical dilatation complete' or words to
8 that effect, how would the healthcare
9 provider do that?

10 A. She has a keypad, a monitor that she
11 has that she can type it in and enter. She
12 can type it in so that it is coming
13 simultaneously or put it in back in
14 retrospect.

15 Q. If there any information, any words
16 that are put on these strips by the
17 equipment without human intervention?

18 A. Yes, this -- this equipment tells you
19 what is important.

20 Q. I'm sorry, Doctor. Would you stand and
21 face that way, please.

22 A. It's telling you what it is recording
23 and it is telling you what it is recording
24 and it is telling you how fast it is
25 running. Obviously if it is running at

1 different speeds, it could be interpreted
2 differently.

3 For example, what's important here that
4 this is running -- let me just see what it
5 says here for a minute. Here, this is
6 being entered. It's three centimeters a
7 minute. That's what it is telling you.

8 The reason that's important is because
9 that makes -- that makes each of these
10 lines twenty seconds, so this is a minute.
11 One knows that based upon how fast it is
12 running but also then it tells me what kind
13 of equipment is recorded.

14 In this case right here it says --
15 sorry, over here -- three centimeters a
16 minute and it says that it's got an
17 external Toco, that means a pressure device
18 that is measuring the contractions. The
19 contractions, and that's this channel

20 Then it says that it has "F" and then
21 on this one "ECG", so that's the fetal ECG,
22 electrocardiogram. That's what is being
23 recorded in this channel.

24 If we had the -- we had the earlier
25 strips, before they put ECG on, which was