

**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 5**

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1 about 12:45 or so, it would have said
2 "Ultrasound, Toco" and -- it literally
3 tells you, periodically, what is it.

4 The significance is that at this very
5 point that we have the fetal electrode in
6 and the pressure monitor on doing the
7 contractions.

8 Over here it says ECG Out. That means
9 that it is gone, it's taken off. You can
10 see right here clearly the break in this
11 electrode and then it tells you over here
12 that's it's got the Toco in, Ultrasound.
13 So they have put the ultrasound on. This
14 part right here in the ultrasound. Then it
15 tells you right that the Toco was out and
16 the ultrasound was out. So there's nothing
17 recording at this point.

18 Q. So, Dr. Oakes, a witness earlier
19 indicated that the fetal scalp electrode
20 was off at this point ---

21 CHILTON SIMMONS: Objection, Your
22 Honor, pitting witnesses.

23 THE COURT: Just a moment.

24 EDWARD GRAHAM: I haven't even
25 asked my question.

1 THE COURT: Let me hear your
2 question so that I can better gauge.

3 EDWARD GRAHAM: Thank you, Your
4 Honor.

5 DIRECT EXAMINATION CONTINUED

6 BY EDWARD GRAHAM:

7 Q. Doctor, do you have an opinion to a
8 reasonable degree of medical certainty as
9 to where on this tracing the fetal scalp
10 electrode was truly removed from the head
11 of Jayden Washington?

12 A. I do.

13 Q. Where is that, please, sir?

14 A. Right here.

15 Q. Could you mark that with this marker,
16 please?

17 A. (Complies).

18 Q. Label it, if you would, and please
19 circle the words from the equipment that
20 tell you that.

21 A. (Complies).

22 Q. Now, there appears to be a pretty solid
23 line of tracing up until this point and
24 some faint some disconnected lines after
25 that point. Do you have an opinion to a

1 reasonable degree of medical certainty as
2 to what those disconnected lines mean after
3 the electrode came out?

4 A. I do.

5 Q. What is that?

6 A. This is the attempt to get the baby's
7 heart rate by ultrasound, what it says
8 here. So, again, this is not a monitor
9 that is applied. It's focusing on the
10 heart from the external, from the outside
11 here. It -- in a mother who is moving
12 around, having delivery, it is very
13 difficult to get a tracing. You can see
14 that there is hardly any tracing here.

15 Whereas this part here is coming off
16 the scalp electrode, it is literally taking
17 the electrocardiogram, just like you would
18 if they put an electrode on you and it's
19 going to pick up virtually all kinds --
20 it records each monitor -- records each
21 interval between every single beat. So
22 they are not actually recording the beat,
23 they are recording the interval of time
24 translated into a rate, every single beat.
25 That's why we get so much jitter in here.

1 Q. Show in the circle how you know the
2 ultrasound, the external ultrasound has
3 been placed.

4 A. (Complies).

5 Q. All right, and is that -- what is this
6 reference in here?

7 A. That says the external OB is in, that
8 still means that we are doing the pressure
9 plate. Sorry. That says "External,
10 Ultrasound In" -- so they have applied --
11 they have applied the external ultrasound
12 right at that point, which is where we see
13 the electrode comes on. That is what it is
14 recording here.

15 Q. Was the vacuum placed before after the
16 electrode was taken out?

17 A. As we just saw, the electrode comes off
18 and then the vacuum is applied. I mean,
19 what -- what these strips are showing is,
20 at different times, which is -- which is
21 not surprising. There are clocks on the
22 monitor and there's are clocks up here and
23 they aren't necessarily exactly the same
24 clock. But the nurse who was doing this
25 wanted to reconstruct this record to look

1 at the times that she had taken off the
2 wall, so that's why she comes back in and
3 enters -- she enters that the vacuum is
4 placed and that there is a vacuum-assisted
5 delivery right here.

6 But, in fact, we've still got -- this
7 is not maternal heart beat, this is fetal
8 heart rate and it's still going here.

9 The delivery is here.

10 Q. Can you please mark that.

11 A. (Complies). We know that because we
12 know the electrode comes off, the vacuum is
13 applied, they put the ultrasound on the
14 baby and we have about three minutes of
15 time and then we have delivery.

16 Q. Thank you, sir. You may take your
17 seat.

18 A. (Complies).

19 Q. There's been testimony about Apgars and
20 in particular a reference to the score of
21 the color of this child being zero after
22 one minute of birth. Would you please
23 describe the five characteristics that go
24 into the measurement of an Apgar score?

25 A. There are five things that are

1 measured. The first is color, heart rate,
2 tone -- muscle tone, reflex irritability --
3 whether the baby is reacting or not, and
4 respiration, breathing.

5 So five features. We go through and
6 give two points, maximum two points, apiece
7 of each of these five. The maximum score
8 of ten. Anything that is seven or above is
9 normal.

10 Q. So we've heard testimony this afternoon
11 that the reason this baby scored at seven
12 after one minute is because two points were
13 taken off of color and one point was taken
14 off for tone. Tell us what that means to
15 you in terms of the health of the baby,
16 give the scores on the other areas.

17 A. I think that it is the -- that the
18 important thing is what the overall score
19 is, not so much what the components of the
20 score are. That's why there are these five
21 factors, why Virginia Apgar made up this
22 scale, uh, was to look at overall well-being
23 of the baby and the need for resuscitation.
24 So if one has a score of seven, this baby
25 needs minimal or no resuscitation. This is

1 a normal Apgar. And as we remember from
2 the video, this baby was screaming before
3 -- before, uh, it leaves the delivery area.

4 Q. Do you have an opinion to a reasonable
5 degree of medical certainty as to whether
6 or not a baby on the verge of brain damage
7 or being choked with a hangman's noose
8 would be scored at two for heart beat at
9 one minute?

10 A. If the baby was in extremis it would
11 not have an Apgar, a total score of seven.
12 So we're talking about that being normal.

13 When a baby is really depressed, we are
14 talking about Apgars that are three or
15 less.

16 Q. Do you have an opinion as to whether or
17 not a baby who was on the verge of brain
18 damage from the lack of oxygen from a
19 hangman's noose would score a reflex
20 irritability of two?

21 CHILTON SIMMONS: Objection, Your
22 Honor. Leading.

23 THE COURT: Sustained. Counsel,
24 that's -- sustained.

25 DIRECT EXAMINATION CONTINUED

1 BY EDWARD GRAHAM:

2 Q. Doctor, do you have an opinion to a
3 reasonable degree of medical certainty as
4 to whether the scores of this child at the
5 one-minute and five-minute Apgar indicate
6 about whether -- to what extent this baby
7 was in trouble at the time that it was
8 delivered?

9 A. I think very clearly the scores of
10 seven and nine indicate that this baby was
11 not in trouble. In fact, they are absolute
12 normal scores.

13 Q. Let me move on to something that we
14 heard about earlier this afternoon about
15 the vacuum pump being like a cap and
16 something about an obstetrician digging
17 down deep into the pelvis and coming back
18 up to apply -- first of all, Doctor, do you
19 have an opinion to a reasonable degree of
20 medical certainty as to whether that can
21 occur with a different type vacuum?

22 A. I do.

23 Q. What is your opinion?

24 A. Well, first of all, we recognize that
25 one is trying to apply this vacuum to the

1 baby's occiput, this part of the baby's
2 head. So it depends on where this part of
3 the baby's head is.

4 If in fact the baby is in a posterior
5 position, what is with the face looking up
6 towards the ceiling, then it's occiput is
7 way down posterior and, yes, you'd want to
8 try to place this down way posterior.

9 But this baby wasn't in a posterior
10 presentation. This baby was in anterior
11 presentation. That means that its face is
12 looking at the floor. So this baby's --
13 the back of its head is up underneath the
14 pubic synthesis. So you've not going to
15 go way down posterior to get this, because
16 in fact you could put it on the front of
17 the head and that would be the wrong thing
18 to do. That's the first thing.

19 The second point is -- that we talked
20 about. This vacuum is not supposed to be
21 used in mid-pelvic deliveries because it
22 doesn't flex. That's its real problem.

23 CHILTON SIMMONS: Objection, Your
24 Honor. This is not new testimony. It's
25 beyond the scope of rebuttal.

1 EDWARD GRAHAM: It deals with
2 that deep entry into the pelvis.

3 THE COURT: I am going to
4 overrule the objection, allow the testimony
5 and give you freedom on cross if you wish,
6 Counsel.

7 CHILTON SIMMONS: Yes, sir.

8 EDWARD GRAHAM: Thank you, Your
9 Honor.

10 DIRECT EXAMINATION CONTINUED

11 BY EDWARD GRAHAM:

12 Q. Continue.

13 A. If one is trying to apply this, you --
14 you -- you literally have to -- you're
15 going down, remember that you're fixed by
16 the vaginal here. Now you have to turn
17 this back up. This doesn't -- this doesn't
18 -- this doesn't turn. This is not a good
19 piece of equipment -- that's why the
20 manufacturer says don't use it for that
21 because it's not made. Now, there are
22 vacuum cups that don't have this kind of
23 length on them, they have -- they are made
24 like mushrooms and they are thinner. They
25 are used for that, because in fact they are

1 very flexible, you can apply them by
2 sliding them. But you would not on an
3 anterior presentation, this baby, you would
4 never been trying to put this down way
5 posterior.

6 Q. Doctor, I want to ask you about a
7 picture on the cover of the Instructional
8 Booklet, Exhibit 73. Why don't you step
9 down, Doctor?

10 A. (Complies).

11 Q. There was a question earlier today
12 about whether or not the cover photo on the
13 Utah Medical Products instruction booklet
14 of their vacuum delivery systems, shows a
15 vacuum cup completely inside the birth
16 canal. Would you please explain to the
17 jury what that diagram means to you?

18 A. When you look at this diagram, this is
19 a cross-section right through the midline.

20 This -- this is the bladder, see this
21 dark space here.

22 This the urethra coming out.

23 This white edge right here in the
24 vaginal introitus.

25 This is where the urethra comes out,

1 this is the vaginal introitus. It's not
2 this line coming over here.

3 You can see that the baby's head is --
4 as I talked about, the baby's head is
5 anterior. This cup is not the posterior,
6 it's the anterior. This one is right on
7 and it's -- it's coming through about the
8 midpart of the -- the midpart of that cup.
9 This would be -- this baby's head -- you
10 can see where it is coming around here is
11 not down at the introitus. So this is not
12 a crowned baby, which is -- it's okay to
13 use this vacuum. This vacuum can be used
14 at a plus two, plus three, plus four, plus
15 station. It just can't be used at plus two
16 (sic).

17 Q. So, Doctor, what type of presentation
18 is shown by that baby in that photo?

19 A. This is the occiput anterior, so the
20 back of the baby's head is towards the
21 ceiling, the mother's stomach.

22 Q. At what station is it depicted in that
23 photo?

24 CHILTON SIMMONS: Objection, Your
25 Honor. This isn't new.

1 THE COURT: Overruled.

2 THE WITNESS: In my view this
3 is a plus three.

4 EDWARD GRAHAM: Thank you, sir.

5 THE WITNESS: If you remember
6 from the pictures that we had, that we
7 showed, the station after ---

8 EDWARD GRAHAM: Thank you, sir.

9 DIRECT EXAMINATION CONTINUED

10 BY EDWARD GRAHAM:

11 Q. While you were out of the courtroom,
12 there was a demonstration through one of
13 the defendant's witnesses using the vacuum
14 cup and the pump to apply on this surface
15 right here (wooden jury rail) and movements
16 were made to the left and the right,
17 resulting in a pop-off.

18 Let me ask you, sir, what if anything
19 does that demonstration, that type of
20 demonstration, have to do with the delivery
21 of a baby with a vacuum?

22 A. It has no relationship because what one
23 is doing is applying the vacuum to a flat
24 surface. That -- the whole purpose of this
25 instrument is to have the scalp in this,

1 it's not to be flat. So it is going to
2 much more easily pop off of a flat surface
3 than it is than a concave one or a convex
4 one.

5 Q. Thank you, sir. And do you have an
6 opinion to a reasonable degree of medical
7 certainty as to whether or not the
8 movements to the left and the right that we
9 saw with the vacuum on the birth video
10 would have popped off like was shown in
11 that demonstration?

12 A. If it was on a flat surface, the answer
13 is yes. But this wasn't on a flat surface.

14 Q. What is the danger of using those right
15 to let movements on a true baby's round
16 surface of the head?

17 A. That's called rocking and that's what
18 is dangerous because in fact if ---

19 CHILTON SIMMONS: Objection, Your
20 Honor, this is not new.

21 THE COURT: Sustained, Counsel.
22 We got into rocking in your initial case,
23 as well as with the defense. It is not a
24 new area.

25 DIRECT EXAMINATION CONTINUED

1 BY EDWARD GRAHAM:

2 Q. Dr. Oakes, there has been testimony and
3 reference made to an article that was cited
4 in the ACOG Practice Bulletin Number 17
5 that specifically referenced a New England
6 Journal of Medicine article, and it has to
7 do with relative risk of brain bloods from
8 different types of delivery. Are you
9 familiar with what I am talking about?

10 A. I am.

11 Q. All right. Let me ask you, sir, what
12 deficiencies, if any, did you see in that
13 study?

14 CHILTON SIMMONS: Objection, Your
15 Honor.

16 THE COURT: That's leading,
17 Counsel.

18 DIRECT EXAMINATION CONTINUED

19 BY EDWARD GRAHAM:

20 Q. Doctor, do you have an opinion to
21 reasonable degree of medical certainty as
22 to whether or not the methodology used in
23 that study accurately reflects the relative
24 risk of a vacuum delivery and a normal
25 spontaneous vaginal delivery and a C-

1 section after labor?

2 THE COURT: Before you answer,
3 is there an objection?

4 CHILTON SIMMONS: Yes, sir.

5 THE COURT: Counsel, I am going
6 to sustain that. Earlier the New England
7 Journal was put forth as a learned treatise
8 and now being attacked, and that would not
9 be an appropriate followup in reply. The
10 Court sustains the objection.

11 Are there any other areas which
12 you believe are new for this witness.

13 EDWARD GRAHAM: If Your Honor
14 please, I do have a question that I think
15 would be proper about the article.

16 THE COURT: If you will phrase
17 the question, then the Court will rule.

18 EDWARD GRAHAM: Thank you, Your
19 Honor.

20 DIRECT EXAMINATION CONTINUED

21 BY EDWARD GRAHAM:

22 Q. Dr. Oakes, reference has been made to a
23 table that appears, Table 1, in Practice
24 Bulletin Number 17, that reflects certain
25 degrees of risk of intracranial hemorrhage

1 from different modes of delivery. Could
2 you please tell us -- do you have an
3 opinion to a reasonable degree of medical
4 certainty as to whether or not the approach
5 used in the article had an influence on the
6 relative degrees of risk set forth in this
7 table. If so, please explain.

8 CHILTON SIMMONS: Objection, Your
9 Honor.

10 THE COURT: Your objection?

11 CHILTON SIMMONS: Leading and not
12 new. We've got through the ACOG article --
13 he went through it for six days in his
14 case.

15 THE COURT: How is it new,
16 Counsel?

17 EDWARD GRAHAM: What's new, if
18 Your Honor please, is that Dr. Van Dorsten
19 talked about it and he said, based on the
20 New England study, these statistics are
21 applicable to all deliveries. I would just
22 like to explain the parameters of the
23 study, just to explain what it really
24 shows.

25 THE COURT: All right. I will

1 give you the opportunity for a speaking
2 objection. Now, do you want to rely?

3 CHILTON SIMMONS: Yes, sir.

4 Mr. Graham had his chance to cross-examine
5 Dr. Van Dorsten on that article. He was
6 the one that interjected the article in the
7 middle of the case and he never brought it
8 up. So we thin it's beyond the scope of
9 rebuttal.

10 JAY DAVIS: I join that
11 objection.

12 THE COURT: I sustain that
13 objection, counsel, and direct you to move
14 on to -- anything further?

15 EDWARD GRAHAM: Your Honor, in
16 the interest of time, I have no further
17 questions.

18 THE COURT: Very good. Now, is
19 there cross?

20 CHILTON SIMMONS: Yes, sir, very
21 briefly.

22 THE COURT: Do you wish to play
23 the video?

24 CHILTON SIMMONS: No, sir, I do
25 not.

1 THE COURT: You may proceed to
2 cross.

3 CROSS EXAMINATION

4 BY CHILTON SIMMONS:

5 Q. Dr. Oakes, we meet again.

6 A. We do.

7 Q. You had time to come back from Savannah
8 and see us again?

9 A. I did.

10 Q. Your work schedule is not too busy this
11 week?

12 A. No, in fact it was -- it was very tied
13 up. My wife is having surgery tomorrow, so
14 I have a very limited amount of time to be
15 here.

16 Q. I am sorry to hear that, Dr. Oakes. I
17 hope that she does just fine.

18 A. I hope so, too.

19 Q. Doctor, you have never worked at East
20 Cooper Hospital?

21 A. Correct.

22 Q. You have never seen a fetal heart
23 monitor machine at that hospital?

24 A. Correct.

25 Q. You don't even know what kind of

1 machine that it is, do you?

2 EDWARD GRAHAM: Your Honor, may
3 he finish his last answer.

4 CHILTON SIMMONS: Certainly.

5 THE WITNESS: I don't but
6 these are standard equipment made by
7 several manufacturers. Do I know exactly
8 which one that they have, no, I do not.

9 CROSS EXAMINATION CONTINUED

10 BY CHILTON SIMMONS:

11 Q. So you admit that nurses can document
12 portions of the strip but it's your
13 testimony that for some reason also this
14 monitor just automatically puts other words
15 on here.

16 Q. It does. If you go through this strip,
17 it has done that throughout this strip.
18 Yes.

19 Q. And you don't know the nurses at the
20 hospital?

21 A. I do not.

22 Q. You've never worked with them?

23 A. I have not.

24 Q. There's been no testimony from any
25 nurse in this trial that the fetal heart

1 monitor strip automatically documents

2 anything on there, has there?

3 A. I'm sorry, I haven't heard any of the
4 nurses' testimony in this case. I haven't
5 seen that asked in any of the depositions
6 that I reviewed.

7 Q. Exactly. And, Doctor, you admit that
8 an internal fetal electrode was used in
9 this case, correct?

10 A. Correct.

11 Q. And when the internal fetal electrode
12 is attached to the baby's scalp, it is
13 measuring the baby's heart rate as
14 accurately as possible; is that true?

15 A. As I have already said, it is actually
16 recording the interval of time between
17 beats and then translating those as a rate.

18 Q. And the internal electrode is more
19 reliable than the external, isn't it?

20 A. It is.

21 Q. Because the external can pick up mom's
22 heart rate as to where the internal is
23 attached to the baby's head, so it only
24 picks up the baby's heart rate. Correct?

25 A. Well, you can get artifact with the

1 fetal electrode, too, if it gets wet or
2 contaminated. The ultrasound is focusing
3 on all types of movement, so -- maternal
4 movement, fetal movement, maternal heart
5 rate. Sure, any of those things can be
6 picked up, yes.

7 Q. And whether this baby was born at 1937
8 or 1939 or even at 1943, you would contend
9 and you admit that that fetal strip shows
10 the baby's heart rate all the way through
11 the 1920s into the 1930s. Do you agree?

12 A. I do.

13 Q. Thank you, Doctor. And you agree that
14 on this strip if the baby was still --
15 connected to the internal fetal monitor at
16 this point, well being 1939, the baby's
17 heart rate would have dropped down to
18 sixty. Do you agree with that?

19 A. It's not quite down to sixty but, yes,
20 on that blip it is. The overall rate is
21 about eighty to ninety.

22 Q. And sixty is not normal for a fetus
23 heart rate, is it, Doctor?

24 A. It is not.

25 Q. And you have no reason to question, no

1 evidence to question, that indeed that
2 strip shows the baby's heart rate drips
3 down very close to sixty at that point.

4 Do you agree?

5 A. I am not following your question.

6 Q. In other words, you have no reason --
7 it is your testimony that the fetal scalp
8 electrode was applied at this point.

9 Correct?

10 A. It is still connected at that point,
11 yes.

12 Q. So that is the baby's heart rate that
13 dipped down to sixty, not mama's; is that
14 correct?

15 A. Correct.

16 Q. Thank you. Doctor, if the baby was not
17 delivered until the 1940s, as you alleged
18 for the first time today, you would agree
19 that there is an even longer period of
20 decelerations and bradycardia on that
21 strip?

22 A. I think that I have already said that
23 in the second stage of labor that there are
24 frequently decelerations of the baby's
25 heart rate when the mother is pushing.

1 That is a very common occurrence and that
2 is, in my view, the situation here.

3 If you look at where you were just
4 showing me before, at about sixty, you can
5 see that that baby's heart, which in this
6 case was in the middle of examination, goes
7 up to a hundred fifty. It accelerates.

8 That is the part that is reassuring.

9 Q. And you're talking about (indicating)

10 ---

11 A. No.

12 Q. You're talking about that part --
13 (indicating).

14 A. No, the one you just had.

15 Q. This part, that could be mama's heart
16 rate; correct?

17 A. No.

18 Q. So your opinion today is that that is
19 not the mama's heart rate?

20 A. It absolutely is my opinion.

21 Q. If this baby was delivered beyond 1937,
22 in to the 1940s, then mom would have pushed
23 more than eleven minutes in her second
24 stage of labor?

25 A. No. And the reason is not no -- the

1 nurse who was doing the recording is
2 looking at a wall clock, she's not looking
3 at the clock here, so she is recording the
4 1924 as the time as complete dilatation off
5 the same wall clock that she is doing the
6 delivery. The wall clock is saying the
7 delivery is 1937. I don't dispute that.
8 It's just that this monitor is not -- is
9 not coordinated with her wall clock.

10 Q. And you have never talked with or
11 worked with any of those nurses that
12 documented these records?

13 A. I have not. I don't see that has any
14 point.

15 Q. Let's talk about the pelvis. You
16 agree that women have different anatomy?

17 A. Different anatomy from each other or
18 from ---

19 Q. Yes, from each other. That's a good
20 clarification. Thank you.

21 A. Sure, there's individual variation.

22 Q. And the distance between the ischial
23 spines is not the same in every woman?

24 A. Correct.

25 Q. You agree that you could not measure

1 the number of centimeters the vacuum was in
2 Ms. Washington just by looking at how far
3 the vacuum was inserted; correct.

4 A. I don't agree with that.

5 Q. So you would dispute your deposition
6 testimony where you clearly testified to
7 that?

8 A. I think that you have to, uh, go back
9 to that and show me. I testified here in
10 direct and in direct that in fact the six
11 centimeters of this vacuum are completely
12 in, and in my view that's what makes it be
13 at a higher station than is alleged by Dr.
14 Rhett. Because, this is six centimeters
15 from there to the point of this cup and
16 this entire cup was inside.

17 Q. Doctor, you did not testify previously
18 in your deposition or even during the two
19 days that you were in this courtroom that
20 there was any issue at all regarding
21 screwing or unscrewing the fetal monitoring
22 electrode; did you?

23 A. I don't think that anybody asked me
24 that. What was asked me was -- and what
25 was shown in Dr. Rhett's deposition, was he

1 said the electrode was on during the
2 delivery and wasn't taken off. He
3 testified that in fact it was taken off and
4 we showed them that it was taken off. I
5 wasn't asked how it was taken off.

6 Q. With regard to the Apgars, Dr. Oakes,
7 you had no reason or no evidence to
8 question the Apgars as decided by Nurse
9 Eileen Stevens in this case. Is that true?

10 A. I wouldn't say that's entirely true.
11 The reason that I saw that is because I --
12 you know, this one-minute Apgar is taken at
13 one minute. This baby is crying lustily.
14 It's very, very difficult to concede that a
15 baby is going to have to have normal reflex
16 irritability and has a zero -- and normal
17 respirations but in fact is said to be
18 completely blue.

19 Q. You were not there?

20 A. I was not.

21 Q. And you did not have a reason to
22 dispute Nurse Eileen Stevens' assessment
23 that Jayden's color at one minute received
24 a zero score out of zero-to-two?

25 A. That's what she chose to record. And

1 that's the purpose of assigning Apgars and
2 having somebody assign them who in fact is
3 not necessarily related to the case. But
4 it's the overall number that is important,
5 it's not the individual number.

6 Q. Doctor, if you would look at your
7 deposition. Do you have it in front of
8 you?

9 A. I don't.

10 Q. Page 41, Line 18, I will ask you the
11 question and you can read the answer --
12 I'll hand you my copy right here. My
13 question was ---

14 EDWARD GRAHAM: Your Honor, may
15 we ask that he be allowed to use it to
16 refresh his recollection.

17 THE COURT: Well, she is going
18 to read the question and then let him do
19 that. This is superfluous. Go ahead.

20 CHILTON SIMMONS: Thank you, Your
21 Honor.

22 CROSS EXAMINATION CONTINUED

23 BY CHILTON SIMMONS:

24 Q. Page 42, Line 18, my question was:

25 Q. So you have no reason to

1 question those Apgars.

2 If you would, please read your

3 response?

4 A. I'm sorry, what line are you asking me?

5 Q. Line 19. My question was,

6 Q. Doctor, so you have no reason
7 to question those Apgars.

8 Your response in your deposition was?

9 A. My answer was, (reading):

10 A. That is correct.

11 You know, at the top of that page you asked
12 me if I thought Jayden's Apgars of seven at
13 one minute and nine at five minutes are
14 acceptable and I said that I did. I do.

15 Q. Doctor, let's talk about pop-offs. You
16 agree that if too much pressure is applied
17 to the vacuum that the vacuum will pop off?

18 A. I do.

19 Q. And you agree that the evidence by the
20 birth video that you have seen, that we
21 have all seen, that there were no pop-offs
22 when Dr. Rhett used this vacuum?

23 A. I agree.

24 Q. And you even have to agree that no pop
25 off is a positive finding when a vacuum is

1 used to assist in a delivery. Would you
2 agree?

3 A. I think that is is good that there were
4 popoffs, yes.

5 Q. And, Doctor, you have not practiced
6 ob-gyn in twelve years. Correct?

7 A. I have not practiced obstetrics in
8 twelve years, that's correct.

9 Q. And you have no read a fetal heart
10 monitor in conjunction with delivering a
11 baby in twelve years, is that correct?

12 A. That's correct.

13 CHILTON SIMMONS: I think those
14 are all my questions at this time. Thank
15 you.

16 THE COURT: Redirect?

17 EDWARD GRAHAM: Very briefly,
18 Your Honor.

19 THE COURT: This would be only
20 on something new.

21 REDIRECT EXAMINATION.

22 BY EDWARD GRAHAM:

23 Q. Dr. Oakes, Ms. Simmons asked you a
24 question about the baby's heart rate going
25 down to sixty and about some other levels.

1 My question is, sir, do you have an opinion
2 to a reasonable degree of medical certainty
3 as to whether or not those decelerations of
4 the baby's heart rate that she referred you
5 to justified use of a vacuum to deliver
6 this baby from the station that it was
7 located at the time that the vacuum was
8 applied?

9 CHILTON SIMMONS: Objection, Your
10 Honor, leading and has already been
11 rehashed.

12 THE COURT: Just a moment --
13 overruled, you may answer.

14 THE WITNESS: I have an
15 opinion.

16 REDIRECT EXAMINATION CONTINUED

17 BY EDWARD GRAHAM:

18 Q. What is that opinion, sir?

19 A. My opinion is that these decels -- I
20 agree that there are decelerations of this
21 baby's heart rate. Decelerations in the
22 second stage of labor are very common, as
23 talked about. It does not demand delivery.
24 It, in fact, needs to have repositioning,
25 administration of oxygen, shutting off of

1 the Pitocin, etc. Having the mother push
2 on her side. She doesn't need to be
3 pushing on her back. Which -- as we went
4 through before, when you are on your back
5 as a pregnant woman, you are in fact
6 compromising the profusion of the placenta.
7 Something has to change and position is one
8 of the major things that can happen to do
9 that.

10

11 EDWARD GRAHAM: Thank you, sir.

12 That's all.

13 THE COURT: Then, sir, you may
14 step down and are free to leave if you so
15 wish.

16 THE WITNESS: Thank you, sir.

17 (WITNESS STEPS DOWN)

18 THE COURT: Anything further in
19 reply?

20 EDWARD GRAHAM: No, Your Honor.

21 THE COURT: Very good. Counsel,
22 let's come up and talk a moment about the
23 scheduling.

24 (OFF RECORD BENCH CONFERENCE)

25 THE COURT: This is the end of

1 the day for the jury. We have some issues
2 that we need to resolve, to have what we
3 call a "charge conference" as we prepare
4 for the closings. We cannot go into that
5 this afternoon, it's too late in the day.

6 So what we will do is we will come
7 back tomorrow morning at 9:00 and we will
8 argue and charge. The testimony in this
9 case is over and tomorrow we will hear from
10 the lawyers in closing, then I will give
11 you the charge on the law. Hopefully we
12 will schedule it such that lunch will occur
13 and then you'll retire to deliberate. That
14 is how I expect the morning and the day
15 will do.

16 Please tell your loved ones at
17 home that it is still not appropriate to
18 discuss the case tonight, nor appropriate
19 among yourselves to discuss it.

20 I can't exactly tell you to tell
21 them what time you will be home tomorrow
22 evening. Just tell them that you may be
23 late tomorrow -- we are going to reverse
24 roles, but after we give it to you for
25 deliberation, we are basically here subject

1 to you call as opposed to the other way
2 around as it has been. Just tell your
3 loved ones that you may be late tomorrow.
4 We don't know that at this time. Just be
5 aware that that you may be late.

6 Get a good night's rest and be
7 back at 9:00 o'clock tomorrow morning when
8 we will begin closings and arguments. Any
9 questions now from the jury about
10 scheduling? (No response). Have a nice
11 evening, Ladies and Gentlemen, we will see
12 you tomorrow. We will all remain seated
13 out of respect for you as you depart the
14 courtroom.

15 (JURY OUT @ 4:20 P.M.)

16 THE COURT: Counsel, do you need
17 a break before we take up Motions or are
18 you ready to go?

19 MOLLY CRAIG: We're ready.

20 THE COURT: We deferred what
21 Motions would have been made at the close
22 of the defendants' case and went directly
23 into reply. Are there any Motions at this
24 time?

25 EDWARD GRAHAM: Your Honor, I

1 have a Motion for a directed verdict -- a
2 limited directed verdict to the extent that
3 the general consent document signed at the
4 outset, which is Exhibit 2004 is not an
5 informed consent.

6 If Your Honor please, we also have
7 a Motion for a limited directed verdict
8 that if Dr. Rhett is held to be liable for
9 damages, causing damages to the plaintiff,
10 then we believe that the defendant's P.A.'s
11 liability would rise or fall. In other
12 words, there's really no fact issue for the
13 jury about whether or not Dr. Rhett was an
14 employee at the time or whether he was
15 acting within the scope of his employment.
16 So we think that it unduly confuses the
17 role of the jury to submit liability for
18 the P.A. We think that is really a matter
19 of law. Dr. Rhett is liable the P.A. is
20 liable. If Dr. Rhett is not, the P.A. is
21 not. If Your Honor please, if we could get
22 a ruling from you in that regard it would
23 facilitate further negotiations with that
24 particular party.

25 THE COURT: All right, let's go

1 back to the issue of informed consent.

2 Tell me exactly what you're asking. You're
3 asking that that document be declared to be
4 a lack of informed consent?

5 EDWARD GRAHAM: No, sir, I am
6 just asking that the jury be instructed
7 that as a matter of law that that document,
8 the general consent form, does not
9 represent informed consent.

10 Everyone agrees that there has
11 been no discussion of risks, alternatives,
12 etc. At least one of the defense experts
13 admitted that.

14 I am not asking for a directed verdict
15 on the informed consent issue across the
16 board, just that that document is does not
17 represent informed consent and defense
18 counsel should be precluded from so
19 arguing.

20 THE COURT: Just a moment, let
21 me think that through. From the plain-
22 tiff's perspective, how would you present
23 that in the verdict form? Is it that the
24 Court has -- assuming that you are correct,
25 that the Court has ruled that Document X

1 does not constitute informed consent, was
2 there an emergency which alleviated the
3 necessity of discussing ---

4 EDWARD GRAHAM: I don't think
5 that would affect the verdict form. I
6 think you've still got the general verdict.
7 But in Your Honor's charge about informed
8 consent, I think you could simply add a
9 sentence that says "as a matter of law,
10 this is not informed consent."

11 THE COURT: Well, -- very good.
12 Well, let's talk first about informed
13 consent. Who argued that?

14 MOLLY CRAIG: Your Honor,
15 there is ample evidence in the record that
16 this is adequate informed consent. There
17 has been testimony from witness after
18 witness after witness that this was the
19 only form that any woman that comes into
20 East Cooper Hospital, St. Francis Hospital,
21 Roper Hospital or the Medical University of
22 South Carolina, that this is the only type
23 of informed consent form that they said;
24 that any other additional informed consent
25 in this situation, based on the emergent

1 nature of the situation, the standard of
2 care did not require additional informed
3 consent.

4 There was no other option when
5 confronted with this situation. The baby
6 had to be delivered. That has been
7 consistent testimony all throughout and
8 there's been testimony from all of the
9 nurses, all of the doctors who practice in
10 all of the hospitals here in the Charleston
11 area, that there is no separate informed
12 consent for a vacuum, forceps or for --
13 vacuum or forceps.

14 THE COURT: Well, let's talk
15 about that, Ms. Craig. I am concerned that
16 the defense on this has basically been
17 'well, we are all doing it this way' when
18 there is no informed consent in this case.
19 The document that purports to be a consent
20 for care form, I suppose, or a consent for
21 you to be my doctor form, clearly is not an
22 informed consent document pursuant to the
23 South Carolina law, which is very clearly
24 set out in the charge which I gave you --
25 on pages eighteen and nineteen. There are

1 at least six particulars which a person has
2 the right to be informed of.

3 The court has viewed the testimony
4 that has come before it in, uh, Dr. Rhett's
5 position, it simply seems to me that the
6 entire hospital system down here in
7 Charleston is not complying with South
8 Carolina informed consent laws.

9 MOLLY CRAIG: Well, why that
10 is important, Your Honor, is because the
11 standard of care is what other reasonable,
12 prudent physicians would have done under
13 the same or similar circumstances and that
14 is what they would have done under the same
15 or similar circumstances.

16 THE COURT: Not if it violates
17 the patient's rights. The basic right to
18 control the decisions with regard to his or
19 her own body is vested with the patient.
20 For a physician to say -- and I recall Dr.
21 Rhett testifying that because the consent
22 for ob-gyn services was signed, the doctor
23 was -- that he made the decision that he
24 needed to make. That is the not the law in
25 South Carolina and that is not in

1 compliance with the informed consent
2 requirements of South Carolina.

3 Now, to me the real question is
4 whether or not there was an emergency which
5 would have obviate the need to stop right
6 then and discuss this with Ms. Washington.

7 Now, this still doesn't get beyond
8 the issue that the plaintiff has to
9 overcome, proximate causation as well as
10 whether or not the plaintiff in that
11 position would have opted in or out. So
12 the plaintiff still has many hurdles.

13 But I am very much concerned that
14 there is a complete and total lack of
15 informed consent in this case. To me it is
16 -- the question to go to the jury is, and
17 we will have to work this out, is was there
18 an emergency such that necessitated an
19 informed consent was not be required at the
20 moment that the vacuum applied.

21 Of course, I am just speaking to
22 both sides. The plaintiff says, 'Well,
23 about during the first stages of labor when
24 they had several hours sitting around
25 there, to discuss this issue?' You would

1 think with the vacuum rate that is in
2 evidence, that is is used by Dr. Rhett,
3 that that would be a standard procedure to
4 have that discussion before you ever get
5 into a situation.

6 The Court is inclined to grant the
7 relief that Mr. Graham asks but I am not
8 certain how that impacts the deliberations
9 and how the question should be put to the
10 jury.

11 MOLLY CRAIG: Your Honor, may
12 I respond?

13 THE COURT: Please do.

14 MOLLY CRAIG: In their case,
15 they brought in no testimony whatsoever
16 about discussing this during -- why Dr.
17 Osborne, Dr. Joseph or other doctor
18 discussed this when she was in the early
19 stages of labor. In all candor, you don't
20 care a woman who is in labor to death by
21 saying, 'Okay, everything is going fine
22 now. But if it doesn't go -- here are
23 these forceps, I might have to use them.'
24 That is not how doctors deliver babies.
25 There has been no testimony at all from the

1 plaintiff, who has the burden of proof that
2 that should have been done in this case,
3 none whatsoever.

4 So I -- I understand Your Honor's
5 your tendency with regard to the informed
6 consent. I still do contest that the
7 standard of care is what other physicians
8 would have done in the same or similar
9 circumstances. This was an emergency.
10 This baby wasn't coming out. The options
11 were limited. It was either a vacuum, it
12 was either forceps or it was either a C-
13 section.

14 So regardless of what was said or
15 the warnings here or there, I mean it
16 wasn't an option. The baby had to come
17 out. That's what these doctors have
18 testified to, the baby had to come out.
19 Those are the only options if you can't
20 push the baby out. So it was an emergency,
21 it was a medical emergency.

22 THE COURT: But all of this
23 didn't happen on July 16th or the 17th,
24 2002. I mean, there was a course of
25 treatment. Although the defendant's

1 position is that the plaintiff came late to
2 prenatal care, there would have been ample
3 time to have had some discussion before you
4 get into the situation that occurred at the
5 hospital -- if you accept the defendant's
6 position that it was an emergency evolved.

7 MOLLY CRAIG: Dr. Rhett wasn't
8 on call on the 15th.

9 THE COURT: I know but ---

10 MOLLY CRAIG: He came on-call
11 on the 16th and the emergency didn't arise
12 until approximately 7:24. If you look at
13 that strip, you see the bradycardia. The
14 decelerations are -- but that doesn't mean
15 that a doctor throws up his hands and say,
16 'we've have to get this baby out.'

17 THE COURT: Very good. By that
18 argument, then, you raise an issue with
19 regard to that if Ms. Washington is a
20 patient of Lowcountry Ob-Gyn and Dr. Rhett
21 walked in in an emergency, then someone
22 before, whether it was an in-take nurse or
23 a nurse, when she started having prenatal
24 care or somewhere along the process would
25 have had the responsibility to discuss with

1 the patient the particular issues that may
2 occur and what decisions would have to be
3 made.

4 MOLLY CRAIG: If this issue
5 had been raised properly by the plaintiff
6 in their case, we would have had ever
7 single obstetrician testify as to the
8 custom and practice about what is discussed
9 when a woman is in labor. You don't care a
10 woman to death who is in labor by going
11 through and talking to her about forceps or
12 vacuum. You would send that woman into
13 orbit, who is already scared to death.

14 THE COURT: Ms. Craig, your
15 argument just flies in the face of the
16 basic tenants of South Carolina informed
17 consent law. It's the patient's decision.
18 It's the patient's decision, after being
19 advised of the risk of the procedure as
20 well as the benefits.

21 It's the same thing as with our
22 law practice. They may make a foolish
23 decision, they may decide what they want to
24 do is against our advice, but nevertheless
25 we advice them of the risks and benefits.

1 While they may not be sitting there in a
2 life-or-death situation, as they do in
3 medicine, the analyses are the same. The
4 patient's right, the client's right to self
5 determine the issue.

6 Thus the fact that everyone in
7 Charleston doesn't do it a particular way
8 -- I was surprised as I listened to that
9 testimony, because what I'm hearing is that
10 there is a systemic issue with informed
11 consent with regard to this procedure down
12 here in the Charleston area.

13 So what the Court is going to do.
14 I am going to -- I have to figure out
15 exactly how to charge the jury with regard
16 to this, but I am going to grant Mr.
17 Graham's motion.

18 You'all can still battle it out as
19 to whether there was an emergency or
20 whether there wasn't. That's one of the
21 battlegrounds of this case.

22 The Court is going to direct a
23 verdict that the Exhibit X, whatever the
24 number is, does not represent informed
25 consent under South Carolina law. I am

1 going to grant the plaintiff's motion. I
2 am going to have to figure out whether
3 that's in the verdict for or whether that
4 is in part of the charge. Very good.

5 Now, the next issue is vicarious
6 liability. Do you wish to be heard on
7 that, Mr. Davis?

8 JAY DAVIS: Yes, sir. I would
9 prefer at this point that it has not bee
10 satisfied at this point. With respect to
11 the issue of agency, I agree that as a
12 principle of law that we are in fact
13 responsibility for the actions of Dr.
14 Rhett, assuming a act of negligence,
15 assuming the jury agrees with that. That's
16 the first question. The second question is
17 that ---

18 THE COURT: Well, his Motion was
19 not for a directed verdict on liability
20 against you, it was or a directed verdict
21 on the issue that if Dr. Rhett is liable
22 that you're liable, that if Dr. Rhett is
23 not liable that you're not liable. In
24 other words, whether your defendant rises
25 and falls the position is same depending on

1 what the jury does with Dr. Rhett's issue.

2 JAY DAVIS: I don't disagree so
3 along as it's not the directed verdict that
4 he is seeking on my liability of the fact
5 that he falls, Dr. Rhett. I still think
6 that it is a jury issue, ultimately, not an
7 issue -- for them to determine -- for
8 instance, I don't think that there's been
9 any evidence at all that we're a
10 professional association. I agree with the
11 principle of law that he is stating, and I
12 agree totally -- I am going to say that to
13 the jury, that we rise or fall with Dr.
14 Rhett. But to direct a verdict on that
15 issue, I don't think would be proper.

16 THE COURT: Do you want to be
17 heard on this for Dr. Rhett, Mr. Hood, Ms.
18 Craig?

19 MOLLY CRAIG: I don't. I
20 agree with Jay's ---

21 THE COURT: All right, then the
22 Court is prepared to rule. Again, South
23 Carolina law is clear on this issues --
24 whether you want to call it agency,
25 *respondeat superior* or however you want to

1 wish to term it. The decision of the jury
2 with regard to Dr. Rhett, because at the
3 time he was performing services for Ms.
4 Washington, he was acting in furtherance of
5 his duties as a partner or as an employee
6 of Lowcountry Ob-Gyn. Thus, the Court
7 rules -- and again we will have to
8 determine how this will be advised to the
9 jury, but that the decision with regard to
10 one defendant, that is Dr. Rhett, will
11 control the decision with regard to
12 Lowcountry Ob-Gyn. I grant your Motion.

13 EDWARD GRAHAM: Thank you.

14 JAY DAVIS: And you grant my
15 Motion to the counter-argument, I guess
16 Your Honor, so that it would apply equally?

17 THE COURT: Win or lose, it's
18 the same.

19 JAY DAVIS: Thank you.

20 THE COURT: Any other issues
21 from the plaintiff at this juncture?

22 EDWARD GRAHAM: No Motion, if
23 that's what you mean.

24 THE COURT: Well, we left it
25 deferred. The Court has not heard any

1 evidence which would require a submission
2 of punitives to the jury. What is your
3 position with regard to punitives?

4 EDWARD GRAHAM: Your Honor, I am
5 not to argue for punitives.

6 THE COURT: Very good. Then
7 that is not an issue and we will not go to
8 the jury on punitives. The jury will be
9 charged only on actual damages.

10 Anything further from the
11 plaintiff at this juncture?

12 EDWARD GRAHAM: Your Honor, we
13 have some deposition transcripts that we
14 would like to get in and double-check
15 exhibits, all that. I don't know if that
16 is what you're talking about.

17 THE COURT: You will have time
18 to do that.

19 EDWARD GRAHAM: Thank you, Your
20 Honor.

21 THE COURT: Let's go to the
22 defendant, Dr. Rhett. Are there any
23 motions at this time from the defendant?

24 MOLLY CRAIG: Yes, sir, at
25 this time we would renew our Motion for a

1 directed verdict. The only reasonable
2 inference from the testimony in the
3 plaintiff's case is that the plaintiff has
4 not been able to prove the case against the
5 defendant.

6 The overwhelming evidence
7 presented by the defense is that Dr. Rhett
8 did comply with the standard of care and
9 did not cause any injury to this child.

10 Dr. Milunsky clearly testified
11 with regard to the child's physical
12 abnormalities, the problems with the
13 child's blood vessels, weak vessels which
14 are the cause the bleed in this case. We
15 would renew our Motion for directed verdict
16 on those grounds.

17 THE COURT: Mr. Davis, do you
18 want to be heard?

19 JAY DAVIS: No, sir, Your Honor.
20 I just want to join on those Motion and,
21 further, ask that the Motion on informed
22 consent be denied.

23 THE COURT: I am going to
24 respectfully deny that Motion. That is
25 really one of the battleground of the case,

1 is -- goes directly to the heart of the
2 case. There is evidence on both sides of
3 the issue, thus is clearly is probative.
4 It's not for the Court to determine or
5 weigh the credibility, this is for the jury
6 and I must respectfully deny your Motion,
7 Ms. Craig.

8 Is there anything further with
9 regard to Defendant Rhett's case?

10 MOLLY CRAIG: No, sir.

11 THE COURT: Nothing further from
12 Mr. Davis, as well.

13 JAY DAVIS: No, sir.

14 THE COURT: What I would suggest
15 that we do is let you'all stand down and
16 while it is fresh in your minds go over the
17 evidence with our court reporter, so that
18 tomorrow we won't come in here and have a
19 catastrophic event where there is no
20 decision about what is in and what's all.
21 Today I would like your agreement on that.

22 After you finish, I'll be in th
23 back and we will then have a charge
24 conference. Anything further before we
25 close the record for today? Well, I do

1 have something further. Tell me about the
2 closing argument tomorrow. Mr. Graham, do
3 you want to open in full and then close?

4 EDWARD GRAHAM: Open full, then
5 close.

6 THE COURT: How long in the
7 aggregate do you believe that your argument
8 would be?

9 EDWARD GRAHAM: Your Honor, just
10 as in opening, I don't want to straight-
11 jacket myself. I believe that I said no
12 more than an hour and I kept it well under
13 that in opening. I would like to have up
14 to an hour and fifteen minutes. I don't
15 think that I will need all that but I hate
16 to straightjacket myself.

17 THE COURT: Before I respond to
18 that, let's hear from the defendants.
19 Defendant Dr. Rhett, how long do you
20 believe that you closing will be?

21 ROBERT HOOD: It won't be any
22 longer than the plaintiff, it tees off of
23 how long he takes. If he is talking about
24 an hour and fifteen minutes, that's longer
25 than I like to argue but if I think he's

1 covered things that need to be covered and
2 it takes me an hour and fifteen minutes to
3 do it, I will do that. I don't expect that
4 to happen. But, Your Honor, what about
5 allowing us to divide our argument so that
6 Molly can also talk to the jury.

7 THE COURT: What says the
8 plaintiff about that? Do you have an
9 objection to that?

10 EDWARD GRAHAM: We do, Your
11 Honor.

12 THE COURT: Why?

13 EDWARD GRAHAM: I haven't
14 refreshed my memory about the Rules, but I
15 don't think the rules apply on that.

16 ROBERT HOOD: It is totally
17 discretionary.

18 THE COURT: Counsel, respectfully,
19 I am not aware of a rule that allows that.
20 I know that you say it is discretionary.
21 I've never seen that done before, thus I am
22 going to respectfully deny that request and
23 ask that plaintiffs have one lawyer, that
24 Dr. Rhett have one lawyer as well. Of
25 course, Defendant Lowcountry Ob-Gyn will

1 have their lawyer in addition.

2 Mr. Davis, do you have an
3 additional time needs from what we have
4 heard?

5 JAY DAVIS: No, sir.

6 THE COURT: I am not going to --
7 I will give each side an hour and fifteen
8 minutes. Remember, Mr. Graham, I am going
9 to require you to at least break that up,
10 so you have one hour for your initial
11 presentation and fifteen minutes in
12 rebuttal. It's one hour fifteen minutes in
13 the aggregate.

14 EDWARD GRAHAM: If I am shorter
15 than an hour on the original, does that add
16 to rebuttal?

17 THE COURT: Well, my intention
18 was to reduce not to let the arguments
19 grow. It's one hour fifteen for each, one
20 hour and then fifteen.

21 ROBERT HOOD: Thank you, Your
22 Honor.

23 THE COURT: Now, here's the plan
24 for tomorrow. We are going to have to have
25 a couple of breaks as well. It would be my

1 preference that when the jury leaves the
2 courtroom for the lunch room, that we're
3 done here -- with arguments as well as with
4 the charge so that the jury can, at their
5 own pace, have their lunch, clear lunch
6 from the jury room, then let them retire to
7 deliberate. That's the best laid plans
8 that I have at this juncture but that's my
9 intention. So if we give -- if we order
10 lunch tomorrow at one, that gives us four
11 hours in the morning to argue and charge.
12 I think we can do that.

13 Now, let's stand down and allow
14 the lawyers, along with our clerk and court
15 reporter, to review the evidence one last
16 time to make sure that we have everything
17 in order. Then I will be back in the back
18 and you can come back for a charge
19 conference.

20 Court is in recess until 9:00
21 o'clock tomorrow morning.

22 (REVIEW OF EXHIBITS)

23 (IN CHAMBERS CHARGE CONFERENCE)

24 (COURT IN RECESS)

25 (TRANSCRIPT CONTINUED NEXT PAGE)

1 defendants was the proximate cause." Seems
2 like we need to say "negligence" -- or that
3 the negligence of Defendant Dr. Rhett was
4 the proximate cause.

5 THE COURT: All right.

6 EDWARD GRAHAM: Then I have no
7 problem with number three.

8 THE COURT: All right. Very
9 good. I am going to adopt those changes.
10 Mr. Davis, do you want to weigh in on this?

11 JAY DAVIS: I am in agreement,
12 Your Honor. That's fine.

13 THE COURT: All right. We will
14 make those changes and that will be the
15 verdict form.

16 EDWARD GRAHAM: Will we have
17 that to show to the jury?

18 THE COURT: Yes. Carly is doing
19 a final version of the -- are you going to
20 do it in your rebuttal?

21 EDWARD GRAHAM: I was planning
22 on doing it in the opening part, just to
23 make sure that I got it done.

24 THE COURT: Well, why don't
25 you just take your written form that you

1 have -- take the form that you have, put
2 the writing on it that we just agreed to
3 and publish is as you wish.

4 Counsel also -- this does not
5 specifically mention informed consent. Do
6 you believe that's part of the deviation
7 from the standard of care?

8 EDWARD GRAHAM: That's my
9 understanding of South Carolina law.

10 THE COURT: So the verdict form
11 then is agreed upon. Is there anything
12 further with regard to evidence or
13 arguments that we need to resolve before we
14 bring in the jury?

15 MOLLY CRAIG: Good morning,
16 Your Honor.

17 THE COURT: Good morning.

18 MOLLY CRAIG: In chambers
19 during our charge conference last night,
20 indicating that we were talking about the
21 informed consent issue, I told Your Honor
22 that that is the first time that I'd
23 encountered that issue. We had some time
24 to research last time, and I've done so and
25 would just like to present to you what we

1 have found in research and ask that Your
2 Honor reconsider its ruling on the directed
3 verdict with regard to the informed consent
4 based upon *Hook v. Rothstein*.

5 THE COURT: Let me parse what
6 you said. I actually only directed a
7 verdict on one issue within the greater
8 issue of informed consent, which goes to
9 the document. But we're on the same
10 wavelength. I understand what you're
11 saying.

12 MOLLY CRAIG: In *Hook v.*
13 *Rothstein*, which is a leading case in South
14 Carolina on informed consent it states
15 that, and I quote, (reading):

16 "The general rule is that the
17 physician's duty to disclose is measured by
18 those communications a reasonable medical
19 practitioner in the same branch of medicine
20 would make under the same or similar
21 circumstances, and the plaintiff must
22 ordinarily establish the standard by expert
23 medical evidence. Where expert testimony
24 is in conflict, it creates a question of
25 fact for the jury."

1 In this case we brought in four
2 experts who said that the general consent
3 form was adequate and there is no separate
4 informed consent form that is required for
5 a vacuum extraction delivery. In fact, no
6 other informed consent form is required by
7 East Cooper Hospital, St. Francis, the
8 Medical University of South Carolina or
9 Roper Hospital.

10 If this conflicts with plaintiff's
11 experts, then it is a question of fact for
12 the jury to decide. The directed verdict,
13 Your Honor, we would respectfully say, must
14 be denied where there is conflicting
15 testimony as the Court does not have the
16 authority to decide credibility issues.

17 I am citing Burnett v. Family Kingdom,
18 691 S.E. 2nd 170. And I have a copy of
19 these cases for Your Honor to look at.

20 Again, I quote, (reading):

21 *"The trial Court must deny a*
22 *directed verdict Motion from evidence that*
23 *yields more than one inference, where its*
24 *inference is in doubt. When considering a*
25 *directed verdict Motion, neither the trial*

1 *court nor the appellate court has authority*
2 *to decide credibility issues or to resolve*
3 *conflicts in the testimony or evidence."*

4 We went to our states within the
5 Fourth Circuit to see if we could find any
6 case law regarding whether or not informed
7 consent was a question of fact or a
8 question of law.

9 In a North Carolina case, *Lander*
10 *v. Munn* (phonetic), 642 SE 2nd 540, a 2007
11 case, and that case -- in that case the
12 Court of Appeals denied the motion for
13 summary judgment and stated that it is a
14 genuine issue of material fact as to
15 whether or not there was informed consent.

16 Likewise, in Maryland, *Robinson*
17 *v. Hutchins*, 148 F2nd 488, a 2001 case,
18 that case held that disputed questions of
19 material fact exists and defendants have
20 conceded informed consent is one for the
21 jury.

22 I understood from Your Honor's
23 ruling yesterday that you believe that the
24 informed consent in this case is lacking
25 and does not comply with South Carolina

1 law. In reviewing South Carolina law,
2 under the doctrine of informed consent it
3 states, (reading): *"It is generally held*
4 *that a physician who preforms a diagnostic,*
5 *therapeutic or surgical procedure has a*
6 *duty to disclose to a patient of sound*
7 *mind, in the absence of an emergency that*
8 *warrants immediate medical treatment."*

9 It is our position that the use
10 of a vacuum, the use of forceps, an
11 episiotomy, all of these things that are
12 routine procedures that may be needed to
13 necessitate the delivery are not
14 diagnostic, therapeutic or surgical
15 procedures and so that portion of the
16 doctrine of informed consent would not
17 apply. That would be consistent with the
18 hospitals in our community that do not have
19 a separate informed consent form for vacuum
20 extraction delivery, because that is not
21 considered a diagnostic, therapeutic or
22 surgical procedure.

23 It's part of the routine
24 obstetrical care that a patient consents to
25 when she comes to the hospital to deliver a

1 baby. That case, Your Honor, is *Tisdale v.*
2 *Pruitt*, 394 SE 2nd 857, that's a Court of
3 Appeals case from 1990.

4 I have copies of all these copies
5 if Your Honor would like for me to pass
6 them up.

7 For all those reasons, we would
8 respectfully request that you reconsider
9 your ruling with regard to the directed
10 verdict Motion as to the document of
11 informed consent.

12 THE COURT: Very good. Mr.
13 Davis joins in the argument, obviously.

14 JAY DAVIS: Yes, sir.

15 THE COURT: You want to be heard
16 on this, Mr. Graham?

17 EDWARD GRAHAM: As to the last
18 point, about this not being surgery, it's
19 an operative vaginal delivery. Operative.
20 That means that it is an operation, it's a
21 surgical procedure. An instrument inserted
22 inside the body, that's what an operational
23 surgery is.

24 Even the defense experts conceded
25 that the form involved no disclosures of

1 risk, no disclosure of alternatives, no
2 indications provided, no risk benefits
3 analysis, no discussion whatsoever -- just
4 'sign here' if you want to come to our
5 hospital.

6 THE COURT: Let me see the
7 exhibit that was put forward as potentially
8 informed consent.

9 Our jurors are here now.

10 EDWARD GRAHAM: Your Honor, it
11 was here yesterday. I don't know where it
12 is now. It is contained in Exhibit 2, I
13 believe.

14 MOLLY CRAIG: We will give you
15 a copy of it. Would you like these cases?

16 THE COURT: Yes, please.

17 MOLLY CRAIG: (Tenders), Your
18 Honor, this is a redacted copy.

19 THE COURT: Thank you. (Upon
20 review), all right, the court is prepared
21 to rule.

22 MOLLY CRAIG: Your Honor, may
23 I add one more thing?

24 THE COURT: Go ahead.

25 MOLLY CRAIG: One of the

1 experts that we brought, Dr. Peter Van
2 Dorsten, from the Medical University of
3 South Carolina, which is of course our
4 teaching hospital, he teaches residents
5 that go throughout the state. He is a
6 regional authority, he is a national and
7 international authority and he has opined
8 that at MUSC, our teaching hospital, that
9 they don't have a separate informed consent
10 form. That in and of itself creates a
11 question of fact for the jury as to whether
12 or not the standard of care dictates that a
13 separate informed consent form has to be
14 signed before using a vacuum extraction.

15 THE COURT: Counsel, I think
16 you've misconstruing my ruling. I have
17 never said that a separate form needs to
18 be signed. I said that this form is not
19 informed consent as to procedure. I
20 reasoned that from the charge that the
21 Court gives on informed consent, which sets
22 forth the six things that physicians should
23 notify the patient of and then -- including
24 and pivotal to that are the risks and
25 benefits of the procedure, then the patient

1 makes a decision.

2 Now, there is an exception to that
3 which is the emergency exception. The
4 Court's ruling really has no impact on
5 whether there was some emergency.

6 Let's look at the facts of this
7 case and what the evidence has shown. Not
8 only was a document not signed -- and
9 that's really not a question, whether there
10 was a separate document for the vacuum, and
11 I am not saying that there has to be. But
12 the evidence is that Ms. Washington didn't
13 even know that they were using a vacuum.
14 That is just not informed consent.

15 All I am saying in my ruling is
16 that this general document that everybody
17 signs going into the hospital, if you take
18 the position that this is informed consent
19 for an operative procedure, well, I just
20 simply -- I think you're disputing that
21 this is some surgical or intervention for
22 which there would be additional consent
23 necessary.

24 Nevertheless, the plaintiff showed
25 in the case that there is a doubling of the

1 risk of a brain bleed when you use a vacuum
2 as opposed to spontaneous vaginal delivery.
3 That's a valid risk for which the Court
4 believes there should be some notice.

5 Even if there was a discussion
6 beforehand, even that vacuum being used,
7 one of the witnesses testified that later
8 on there would be a discussion about it.
9 I am not sure that the evidence in this
10 case shows that after the baby was born,
11 within the next few moments, that there was
12 a discussion but it all came out later when
13 the child had problems. At least that's my
14 understanding of it.

15 I just simply again say that this
16 form does not represent informed consent
17 for a vaginal delivery. Again, I am not
18 trying to eclipse your argument about other
19 standards or what happens in the community,
20 I am simply saying this form is not
21 sufficient and I decline to change that
22 ruling.

23 MOLLY CRAIG: May I respond
24 briefly?

25 THE COURT: Yes, ma'am.

1 MOLLY CRAIG: Respectfully,

2 Your Honor, our court experts have
3 testified that that is proper informed
4 consent regarding if there is a separate
5 one. Dr. Van Dorsten testified that that
6 is the informed consent that they sign at
7 -- not verbatim but very typical of what
8 they sign at the Medical University and
9 that that informed consent is adequate.

10 That fact is for the jury to
11 determine whether or not that informed
12 consent form is adequate for obstetrical
13 care, regardless of whether it was a vacuum
14 extraction.

15 THE COURT: But the Court's view
16 of that is that that argument, despite the
17 fact that it seems to be what everyone does
18 in the Charleston area, does not comport
19 with the rights of the plaintiff -- not the
20 plaintiff but the patient -- the patient
21 has the right to make decisions on their
22 medical care, not the doctors.

23 Now, if there is an emergency,
24 then that's -- that's an issue in this
25 case.

1 Except what the experts have
2 testified to, it runs or reverses what this
3 Court understand the patient's rights to be
4 in a doctor-patient relationship.

5 I well understand your position
6 and it is noted for the record. The Court
7 declines to change its ruling. Thank you.

8 All right, is there anything
9 further with regard to redactions -- Ms.
10 Simmons said something about an evidentiary
11 issue that needs to resolved before
12 closings?

13 CHILTON SIMMONS: Yes, sir, Your
14 Honor. There were two sets of records that
15 plaintiff's counsel gave yesterday to be
16 admitted as a complete set of the records
17 from Jayden's school, Oakland Elementary,
18 as well as Jayden's rehabilitation.

19 I spent yesterday afternoon going
20 through them to make sure that they were
21 redactions and I believe that there are.
22 There are about twenty documents, about
23 four inches, so not that many pages but
24 they say things like -- this is an
25 evaluation report at Charleston County

1 School District and it says, (reading):
2 "Review of records indicates complications
3 at birth included vacuum extraction,
4 causing intracranial hemorrhage."

5 No medical records say that, so
6 obviously the "review of records" would be,
7 Your Honor, what the mother reported.

8 For example, another record
9 states, (reading): "Jayden had birth
10 complications due to vacuum extraction,
11 per Mother." No medical diagnosis. They
12 don't exist in these records.

13 THE COURT: Let me ask you this,
14 are you going to argue from those records
15 and publish portion of that which would
16 otherwise be redacted during your closing?

17 CHILTON SIMMONS: No, sir.

18 THE COURT: Why don't we at a
19 break take that up? Have you had a chance
20 to talk to the plaintiff about this?

21 CHILTON SIMMONS: I did.

22 THE COURT: You could not reach
23 an agreement?

24 MARY WATERS: Tentatively,
25 Your Honor. I mean, it's replete

1 throughout the medical records and when it
2 says it's based on a review of the medical
3 records, that ---

4 THE COURT: Well, ---

5 MARY WATERS: They're school
6 records and therapy records. We thought
7 that Your Honor's rulings had put the onus
8 on the defendants to provide us copies and
9 we found out yesterday that those had not
10 been provided, though we provided ours and
11 -- from the very beginning there should be
12 redactions and ---

13 THE COURT: Okay. Well, let's
14 take it up at a break then rather than
15 delay the jury any further. Is there
16 anything else before closings?

17 EDWARD GRAHAM: Could I ask you
18 one thing, Your Honor?

19 THE COURT: All right.

20 EDWARD GRAHAM: Your Honor,
21 yesterday we used the third page of these
22 exhibits and I thought that all three had
23 been formally introduced. I thought that
24 we had an agreement that ---

25 ROBERT HOOD: We don't have

1 any objection.

2 THE COURT: Very good. Without
3 objection. What number is it?

4 COURT REPORTER: It would be
5 number 113.

6 (SO ENTERED AS EXHIBIT 113)

7 THE COURT: In evidence, without
8 objection. All right, anyone else?
9 Anything else for our record before we
10 bring in the jury?

11 MOLLY CRAIG: Your Honor, the
12 ruling with regard to informed consent, it
13 is not -- I assume that both sides,
14 considering your ruling that is not law,
15 that we are not permitted to argue or
16 discuss that in the closings. With regard
17 to the informed consent form?

18 THE COURT: Well, so that I can
19 understand that, tell us how you would
20 frame your argument, please.

21 MOLLY CRAIG: That this was an
22 emergency and just talk about that it was
23 an emergency, the evidence that has been in
24 this courtroom. What we would anticipate
25 is that plaintiffs would try to use that to

1 their advantage in closing, that Your Honor
2 has ruled as a matter of law that -- on the
3 informed consent form that you have already
4 made a ruling on, and that would be
5 improper. That should come from Your Honor
6 to the jury.

7 THE COURT: Just to make sure
8 that we are on the same wavelength. First
9 of all, I am not even sure that should be
10 called an informed consent. It talks about
11 payment, it talks about all sorts of things
12 and it is really not about informed consent
13 although the first paragraph does make
14 reference to giving permission for various
15 procedures.

16 But that document, whatever we
17 call it, is -- my ruling simply is that
18 that does not represent informed consent.

19 I am not saying that there was no
20 emergency. I don't in any way want the
21 defense to believe that I have curtailed
22 your argument about the necessity for an
23 emergent procedure with no time to discuss
24 it with the patient.

25 Really, that's what this case is

1 about, at least that issue in this case.

2 In making that ruling, I in no way
3 attempted to foreclose a decision about
4 whether informed consent was or was not
5 necessary prior to the procedure.

6 I hope that provides some light to
7 you. I would not limit your argument about
8 informed consent, except to the fact that I
9 am ruling that that particular document
10 does not represent an informed consent.

11 EDWARD GRAHAM: I don't intend
12 to dwell on it *ad nauseam*, but may I
13 address the jury about the fact that as a
14 matter of law that is not a true informed
15 consent.

16 THE COURT: That's in my charge.
17 You know, we talked about it yesterday and
18 I -- I am going to charge that and you may
19 -- there is nothing that would prevent you
20 from broaching that.

21 EDWARD GRAHAM: Thank you.

22 THE COURT: Now, when we bring
23 in the jury, do you want me to tell the
24 jury that the court has also made a ruling
25 with regard to the -- and I would ask you

1 to help me with the wording, but that the
2 court has ruled that the liability of the
3 Defendant Lowcountry Ob-Gyn rises or falls
4 with the liability of Dr. Rhett? Do you
5 wish me to tell the jury that before we
6 begin?

7 JAY DAVIS: No, sir, I will tell
8 them in my closing. I believe that it was
9 covered in the charge, will be covered in
10 the part of the charge that I saw, so that
11 will be automatically covered.

12 THE COURT: Very good. What do
13 you say to that, for Dr. Rhett?

14 MOLLY CRAIG: We believe it'll
15 be covered.

16 THE COURT: What does the
17 plaintiff say?

18 EDWARD GRAHAM: That's fine.

19 THE COURT: All right, I will
20 decide on that. It's in my charge and I
21 will not tell them that.

22 EDWARD GRAHAM: Will we have a
23 copy of the charge before we make our
24 closings?

25 THE COURT: It's a work in

1 progress right now, so I think the answer
2 to that is no. As soon as it arrives, we
3 will get it to you and but it is not ready
4 right now. You have what I had proposed
5 and you were with when I made the pencil
6 changes last night.

7 EDWARD GRAHAM: Yes, sir.

8 THE COURT: Finally I believe
9 that we are ready for the jury. Please
10 bring in the jury.

11 MOLLY CRAIG: The exceptions,
12 would you like those before or after your
13 charge?

14 THE COURT: Let's do that
15 afterwards. Thank you. What was the
16 exhibit number on that informed consent?

17 COURT REPORTER: Exhibit?

18 THE COURT: What is the evidence
19 number of that document that was the
20 alleged informed consent?

21 ROBERT HOOD: Your Honor, you
22 are not going to mention that before
23 closing arguments?

24 CHILTON SIMMONS: Do you need it
25 right now?

1 THE COURT: No, I just need it
2 at some point.

3 (JURY IN @ 9:35 A.M.)

4 THE COURT: Welcome back, Ladies
5 and Gentlemen. We are a little bit late
6 here this morning. Forgive me for that.
7 We had several issues that we needed to
8 resolve this morning before we could start.

9 We are now at the point in the
10 case where the lawyers will come before you
11 in closing statement. I trust that you had
12 a nice evening, had a good night's rest.
13 Let me ask you, is there anyone who has had
14 any discussion about the facts of this case
15 with any third party? If so, please raise
16 your hand. (No response). Let the record
17 reflect that no one raised their hand.
18 Thank you again for complying with the
19 court's request.

20 Now, let's talk a little bit about
21 closings. Remember I said to you when we
22 began this case some time ago that what the
23 lawyers argue to you is not evidence. The
24 evidence in the case is what the witnesses
25 say and what the exhibits in the record

1 show, as you determine them to be. So a
2 lawyer's argument is just that, argument.
3 Please understand that.

4 Secondly, the way that we
5 structure closing statements is that the
6 plaintiff, because the plaintiff has the
7 burden of proof, gets to go first and last.
8 Both sides have the same amount of time --
9 actually all three sides here have the same
10 amount of time, but the plaintiff is
11 allowed to open in full and then close in
12 rebuttal. Again, the reason for that is
13 because the plaintiff bears the burden of
14 proof in the case.

15 Now, with that understanding, the
16 court recognizes counsel for the plaintiff
17 for closing statements.

18 EDWARD GRAHAM: Thank you, Your
19 Honor. May it please the Court, Ladies and
20 Gentlemen.

21 Substandard medical care has
22 caused Jayden W. have lifelong
23 brain damage.

24 Substandard medical care poses a
25 danger to our community in many forms, in

1 many places. The best way to encourage
2 safe medical care in our community is to
3 award a large verdict in this case.

4 ROBERT HOOD: If the Court
5 please, I believe that Counsel's argument,
6 under *State v. Reece*, is a violation of the
7 parole rule argument.

8 THE COURT: Counsel, I am going
9 to sustain. This case is not about
10 punitive damages. It is about actual
11 damages, if the plaintiff is entitled to a
12 verdict of what the reasonable amount of
13 damages would be. With that understanding,
14 please proceed.

15 EDWARD GRAHAM: Good will come
16 from holding Dr. Rhett responsibility for
17 all the harms and losses experienced by
18 Jayden W .

19 The Greeks started this system of
20 trial by jury. In the Greek society, it
21 was about community service. That system
22 has come from the Greeks to our heritage,
23 England and other places.

24 Certainly as a member of the jury,
25 it's one of the most powerful jobs that a

1 private citizen can hold. How often do we
2 have a chance to do good in an important
3 case? Jury service gives you the power to
4 do right. Perhaps that's way most
5 countries don't have a jury system.

6 As I listened to Ms. Craig in her
7 opening remarks talk about truth, I found
8 myself responding in two very different
9 ways. One thing that I remember very
10 clearly that she said was that Dr. Rhett
11 wanted to come into the courtroom to tell
12 the truth. As we will see in my later
13 remarks, not so much. Ms. Craig also said
14 by the end of the trial the truth would be
15 obvious. On that, she and I can agree.

16 What is the ultimate truth in this
17 case? I submit to you that the ultimate
18 truth in this case is that the medical
19 establishment with excellent lawyering is
20 trying to keep the lid on a secret that we
21 have substandard care in our community that
22 causes danger to patients ---

23 ROBERT HOOD: Improper.

24 THE COURT: Counsel?

25 ROBERT HOOD: This case is

1 about the standard of care with one doctor.

2 It's not about the community, it's not

3 about "keeping the lid" on anything.

4 THE COURT: I am going to over-

5 rule the objection. Attorneys are allowed

6 to argue from the evidence and any

7 interference in the evidence. Ultimately

8 it's for you to determine whether an

9 argument is warranted. The Court overrules

10 that objection. You may proceed,

11 Counselor.

12 EDWARD GRAHAM: Thank you, Your

13 Honor. The medical establishment and the

14 excellent defense team are trying to keep

15 a lid on a secret. Our community has

16 substandard care in some pockets, that

17 causes tremendous danger to patients like

18 Jayden W.

19 Following on the lid thing, the

20 lid also involved a lack of knowledge,

21 which we have heard about in this case.

22 A lack of knowledge plus imposing the

23 doctor's will causes danger to the

24 patients, danger to people like Jayden

25 W.

1 Now, how is the medical establish-
2 ment able to try to keep a lid on these, on
3 this reality? In part by deception.

4 Remember, if you will, the trickery --
5 Dr. Rhett takes Exhibit 108, the centimeter
6 measure, and the pelvic model and somehow
7 measures seven centimeters. Well, you
8 heard that -- seven centimeters. We know
9 the reality is that there are five
10 centimeters from the ischial spine plane to
11 the outlet. Somehow he take a model that
12 is twenty percent smaller than normal and
13 comes up with seven centimeters by
14 measuring something different. 'Clearly,
15 clearly, seven centimeters. See how
16 clear?' Not so clear.

17 We've got trickery with the
18 electrode. You remember the electrode?
19 Dr. Rhett gets in front of you and says,
20 'I had to grab it by the tip and unscrew
21 it.' Well, if you unscrewed it, then why
22 did you pull these things apart and have it
23 pop out on it's on? Trickery. Deception.

24 We got the vacuum and the pump.
25 One of the witnesses put it on a flat,

1 wooden surface of the jury box -- as though
2 that has anything to do with what happens
3 to a baby's head when you move from left to
4 right. Trickery. Deception.

5 Trickery is that they parade in --
6 they parade in obstetrical witness after
7 obstetrical witness who says:

8 *Dr. Rhett is reasonable*

9 *Dr. Rhett is reasonable.*

10 *Is he reasonable?*

11 *Yes.*

12 *Is he reasonable about this?*

13 *Yes.*

14 *Is he reasonable about that?*

15 *Yes.*

16 Reasonable, reasonable, reason-
17 able. Well, what do you mean by
18 "reasonable"?

19 How substandard would care get for
20 you to tell the defense team you're not
21 willing to stand up and say that it was
22 reasonable? Dr. Van Dorsten, Chairman of
23 the OB Department at MUSC says that it
24 falls in the bottom four percent. I will
25 tell them privately that I can't say that's

1 reasonable. But give me a man who is
2 outside the bottom four percent and I'll
3 call it reasonable every time.

4 We deserve better in this
5 community.

6 Trickery in claiming that the baby
7 was delivered before the heart monitoring
8 was stopped.

9 Halfway through the trial, the
10 defense team realized what Dr. Rhett had
11 done. Dr. Rhett said if you've got an
12 emergency, we have to get this baby out.
13 Of course, he sees an "emergency" fifty
14 percent of the time or better.

15 Dr. Rhett said -- Dr. Rhett wrote
16 on here, "fetal scalp electrode off".

17 Another witness said, "vacuum on".

18 Dr. Rhett said, "Delivery", right
19 here. Right here. Okay?

20 And all of a sudden, halfway
21 through trial, the defense team thinks to
22 themselves, 'Oh, we've stepped in it now.
23 Dr. Rhett said that the baby is delivered
24 but the strip keeps going and going and
25 going.' How can we be monitoring the heart

1 beat of a baby in the birth canal that has
2 been delivered ten minutes ago? Eight
3 minutes ago? So they come up with another
4 explanation, 'Oh, starting here we've got
5 the mother's heart beat' -- hoping that you
6 will forget that Dr. Rhett said that the
7 baby was delivered way over here.

8 As Dr. Oakes pointed out
9 yesterday, the equipment itself tells you
10 that right here they took off the internal
11 monitor, put on the external monitor and
12 this bad tracing -- this disjointed faint
13 tracing -- is the external monitor after
14 the electrode was pulled out. The baby
15 wasn't delivered until here.

16 So they are just playing tricky
17 with you even about when the baby was born.

18 Trickery in calling this a low
19 station delivery when the vacuum cup was
20 completely inside the vaginal. This is
21 reality. That much is showing. That
22 matches up with a mid-pelvic delivery.

23 For them to say that a six
24 centimeter cup is completely inside the
25 vaginal but somehow was hidden in the deep

1 part of the pelvis just falls apart when
2 you realize that this baby's head is -- the
3 back of the head is to the front.

4 Remember Dr. Rhett thought that
5 there were two occiputs on the side? And
6 made up words for the lines in the middle?

7 But the occiput was like this. If
8 you go deep underneath, you'd put it on the
9 baby's forehead. There was no deep
10 underneath. You go like that (demonstrat-
11 ing). Six centimeters. That proves that
12 this was a mid-pelvic delivery. The
13 medical establishment engages in trickery,
14 trying to make you think you think your
15 eyes are lying to you.

16 There is also trickery by rehears-
17 ing trial testimony. I'm not suggesting
18 that Dr. Rhett is the first witness who has
19 practiced his testimony, rehearsed it. But
20 what is striking in this case ---

21 ROBERT HOOD: Your Honor, if
22 we could have a continuing objection.
23 You've ruled on that.

24 THE COURT: Overruled. Go
25 ahead.

1 EDWARD GRAHAM: What is striking
2 about this is that in the video it's -- I
3 know it got boring after a while but we
4 wanted to show you the opposite, just how
5 little this man knows about the
6 professional of obstetrics, how little he
7 knows about internal anatomy, birth canal
8 anatomy, dangers of the vacuum. So we
9 showed you that video just to show you how
10 lacking he was in knowledge.

11 When he comes into court, he's
12 been practicing and rehearsing for many,
13 many hours in front of a video camera to
14 try to get rid of that deer-in-the-
15 headlights looks.

16 You saw him on the video. Did
17 he look like a man who was in command of
18 obstetrical knowledge? Tried to fool you
19 into thinking that he was in command of
20 knowledge in July of '02 and somehow had
21 forgotten it by the time of the deposition.
22 That he'd quit delivering babies in '05 and
23 it's understandable for him to be lacking
24 in knowledge when the deposition was taken
25 in '08.

1 Let's think about that. Dr. Oakes
2 has not delivered babies since December of
3 '98. One of the reasons he was one of the
4 core witnesses in this case was not only
5 because of how smart he is, what a good
6 explainer that he is, but we wanted to show
7 you that if you have a guy who stops when
8 he knows what he is doing, it's ingrained.
9 It's ingrained. He's able to come in years
10 after the fact and explain these things --
11 not just flush his brain of all the
12 information that he's used as a
13 professional for thirty-some year.

14 I want to talk to you for a minute
15 about red herrings. Red herring is a word
16 that we hear in different contexts.
17 Sometimes in detective novels there will be
18 clues to make it look like somebody is the
19 guilty one and they're there just to throw
20 you off the track and then there is a
21 surprise at the end, when you figure out
22 that the real guilty one is not anyone who
23 you'd suspect.

24 There are all kinds of stories
25 about where the concept "red herring" came

1 from. I don't know how true any of these
2 are but there are kind of amusing:

3 A red herring is basically a
4 stinky fish and one of the stories is that
5 back in the olden days when there were
6 hunters trying to train their hounds how to
7 chase foxes and badgers through the woods,
8 they would start training them by giving
9 them an easy thing, a stinky fish, follow
10 the scent of the stinky fish. Later on
11 when they got used to following the scent,
12 they would give them a more complicated
13 scent, a more subtle scent, like a fox or a
14 badger or something like that and let them
15 learn how to follow something a little
16 harder. But to get the hounds to where
17 they were really topnotch, they would start
18 by letting them go after a fox and then
19 throw a Red Herring at them, a stinky fish,
20 to try to throw them off their scent, off
21 their path.

22 Another origin I've heard for
23 the phrase "red herring" has to do with
24 prisoners who escaped from jail and tried
25 to trick the hounds into not being able to

1 follow their trail, by throwing stinky fish
2 around to throw them off their scent.

3 Why am I talking about red
4 herrings. Because in this case that is
5 what the defense is all about. You're
6 going to hear, or you have heard, about
7 several red herrings. You've heard about
8 genetics. Genetics.

9 Genetics affects our individu-
10 ality, each and every one of us. Our
11 parent have a certain gene pool that they
12 pass down. In my case it led to a big nose
13 and a few other oddities which we won't
14 mention.

15 But genetics, genetics, uh,
16 genetics did not cause this baby's brain to
17 bleed. The vacuum caused the baby's brain
18 to bleed.

19 Alcohol. Alcohol is another red
20 herring thrown out by the defendants.
21 Alcohol doesn't make your baby's brain
22 bleed. If you have a glass of wine or a
23 beer or a mixed drink and then find out
24 that you're pregnant, you don't have to
25 worry that having a small amount of alcohol

1 in those early weeks is somehow going to
2 destroy and kill the brains of your baby.
3 That is just a red herring. Even the
4 defense witnesses acknowledge that -- they
5 can't even say that there is a one in a
6 million chance that alcohol had anything to
7 do with this brain bleed.

8 Late prenatal care. We've heard
9 about late prenatal care but the testimony
10 from Jamsetta is that she went to the
11 Health Department. You know, she tested
12 three weeks or so after she was pregnant,
13 she suspected that -- she missed a period,
14 so she tested and then she tested again
15 and she got counseling from the Health
16 Department.

17 She didn't have money, she was a
18 poor college student. She had no Medicaid,
19 even, to get health care. So she went to
20 the Health Department, asked for their help
21 in trying to figure out, 'How do I get set
22 up with an obstetrician. I've never done
23 this before. How do I pay for it? What
24 forms do I need to sign? What do I have
25 to do to qualify for a Medicaid program so

1 that I can get prenatal care?'

2 She was in the prenatal office,
3 the ob's office for her prenatal visit in
4 January. Now, she was pregnant in -- her
5 last period was at the end of September,
6 pregnant probably, according to Dr. Norton,
7 mid October. So within three months she is
8 getting medical care from an obstetrician.
9 Before then she is getting counseling and
10 assistance from the Health Department.

11 I personally wouldn't judge a poor
12 college student about when they started
13 prenatal care. We heard from the defense
14 about late prenatal care but have you heard
15 anybody say that late prenatal care caused
16 any problem? You don't have to worry.
17 Starting with a doctor's followup during
18 this time period is not going to cause your
19 baby to have brain bleeds.

20 Those are all red herrings by the
21 defense.

22 In the opening I told you that
23 there were seven reasons why we are suing,
24 why we are suing Dr. Rhett.

25 By the end of the defense case

1 they held up this form that everybody has
2 to sign when they come to the hospital and
3 they told you that this was an informed
4 consent form. Right? 'This is an informed
5 consent form.' Well, His Honor has ruled
6 that is not an informed consent form. That
7 is the form that you sign, that they make
8 you sign when they go into the hospital.
9 It's not informed consent because they
10 didn't tell you about the alternatives,
11 they didn't tell you what there would be
12 a vacuum, they didn't tell you about the
13 risks and danger of a vacuum; especially
14 from the mid-pelvis. That is not an
15 informed consent.

16 Informed consent in this case is
17 really an easy issue. It's part of Dr.
18 Rhett's negligence but, uh, he admits --
19 and this is the one part of his deposition
20 testimony that didn't change from
21 deposition to trial. He admitted both
22 times that he has never warned a vacuum-
23 delivered mother of the dangers of the
24 vacuum.

25 He has never told a mother on whom

1 he was about to use the vacuum why he
2 thought vacuum was appropriate.

3 He has never talked to a patient
4 about alternatives.

5 He imposes his will on the
6 patient. He's done so in over a thousand
7 vacuum deliveries.

8 His team is coming in today and
9 say that 'this was an emergency, cut him
10 slack, don't hold him to the informed
11 consent rule because we had an emergency.'

12 Guess what? He's going to say
13 that he had an emergency a thousand times.
14 You've got to consult with the client, with
15 the patient at some point. There's plenty
16 of time in a long first stage, there's
17 plenty of time when you say 'we need to get
18 this baby out, maybe we will do a C-
19 section.' In all that time there was ample
20 time for Dr. Rhett to explain the basic
21 reasons why he thought the vacuum should be
22 used, the alternatives and the risks --
23 especially for a high station, the risk to
24 a baby's brain.

25 Dr. Rhett needlessly endangered

1 Jayden. You've heard over and over that
2 doctors use vacuum in this country ten to
3 fifteen percent of the time. Decades ago
4 in the early days some doctors used vacuums
5 fifty percent. Dr. Van Dorsten said that
6 if a doctor stated in the olden days and
7 didn't keep up that he might still be using
8 it fifty percent of the time. Well, guess
9 what? That's what Dr. Rhett says.

10 With a high C-section rate of
11 forty percent, you'd expect Dr. Rhett to
12 have a below average vacuum rate. But his
13 vacuum rate is crazy high, over fifty
14 percent when the average is ten to fifteen
15 percent. That's needlessly endangering.
16 That's speeding up the delivery for reasons
17 that don't have to do with patient safety.

18 Dr. Rhett lacked knowledge of
19 maternal anatomy and safe vacuum
20 extraction. I am not going to play any of
21 his video deposition again. I'm sure that
22 you guys got the message with his wrong
23 words, with his deer-in-the-headlight look
24 that he lacked knowledge.

25 There was no indication in this

1 case for a vacuum. To try to concoct an
2 indication, the medical establishment came
3 in here, Dr. Rhett came in here and told me
4 that there was -- that the baby had to be
5 delivered eight or ten minutes before the
6 baby was actually delivered.

7 They chose the wrong vacuum cup.
8 This is the first case that I've ever been
9 involved in where a doctor came in and
10 said, 'it's fine for me to break the rules
11 of a manufacturer', the manufacturer's
12 rules. "Do not use our vacuum -- do not
13 use our vacuum, it's contraindicated to use
14 our for a mid-station vacuum extraction."
15 According to the medical establishment we
16 can break those rules when we feel like it,
17 we can break those rules when it is our
18 clinical judgment that it is okay.

19 If anybody tells you that it is
20 okay to use a vacuum at the mid-pelvis when
21 the manufacturer says 'don't use our
22 product for this purpose', just remind them
23 that misuse of a product that causes harm
24 plants responsibility right at the feet of
25 the misuser. If you misuse a product,

1 you're responsible for the harm.

2 And the dangerous vacuum
3 extraction technique, going left and right
4 and left and right. That pulls those
5 bridging veins away from the brain. You
6 heard Dr. Zimmerman and Dr. Adler and Dr.
7 Katz talk about that process. To say that
8 you need to move the vacuum to the side so
9 that you can reach in and check to see if
10 the mother's tissue is somehow caught in
11 the vacuum is just another effort to
12 confuse. When you first apply the vacuum,
13 you do need to make sure that the mother's
14 tissue is not caught. But once it's on
15 there, on the baby's head and you pump up
16 the vacuum, there's no way for the mother's
17 tissue to later get up under there. To say
18 that well into the delivery that we had to
19 move it to the side to see if the mother's
20 tissue was there -- that just doesn't make
21 good sense.

22 And, finally, Dr. Rhett refused to
23 accept responsibility. If he had a chance
24 to do this again, he would not do anything
25 different even though this delivery caused

1 this baby brain damage that will adversely
2 affect him for every day of the rest of his
3 life.

4 Now, I want to talk to you briefly
5 about the charge. His Honor is the judge
6 of the law and he is going to tell you --
7 after the lawyers, after we sit down, he's
8 going to tell you about the law in this
9 case. He's given us a preview of what that
10 is going to be and I want to just go over a
11 few things with you.

12 One of the key issues has to do
13 with the concept of negligence. Now,
14 negligence is basically a reasonable man,
15 reasonable woman, standard. If we are
16 judging an operator of a vehicle -- there
17 are rules of the road that we have to
18 follow. If it says Yield, we are supposed
19 to yield. If we run through the Yield sign
20 and hit somebody, we have a responsibility
21 for the harm that we cause. That's not
22 being as careful as a reasonably careful
23 driver would be. Similarly in a medical
24 negligence case, we're talking about a
25 doctor who fails to be reasonably careful

1 as others should be.

2 Now, you are going to hear His
3 Honor talk about this standard in several
4 ways. You will hear him talk about being
5 a reasonably careful physician. You'll
6 hear him talk about average competent
7 physicians. They all basically mean the
8 same thing.

9 We are not looking to excuse the
10 bottom of the barrel. We're not looking to
11 excuse substandard care. As a community,
12 as an agent -- in cases like this, we're
13 entitled, the patient is entitled to at
14 least average care that would be provided
15 by a reasonably careful doctor.

16 The testimony that, 'Oh, I am
17 going to say that it is reasonable if it is
18 not in the bottom four percent' doesn't
19 mean that it is a reasonably careful,
20 average, competent doctor. So look behind
21 the word "reasonable" from the defense
22 experts. They are talking a different kind
23 of reasonable.

24 They are talking -- sometimes I
25 find myself going into a restaurant that's

1 less expensive than some and I might say,
2 you know, at the end of the meal, 'The best
3 thing about this place is that that was
4 reasonable' meaning that was it was
5 inexpensive, that it was cheap. That's not
6 what we mean in the law by "reasonable."

7 In the law what we mean by reasonable is
8 care from a doctor that you can have a good
9 reason for. Average, at least average
10 competent care. Not cheap care, no
11 substandard care -- at least average,
12 competent care from a careful, a reasonably
13 careful doctor.

14 And you are going to hear "stand-
15 ard of care", standard of care. Standard
16 of care for a doctor is pretty much the
17 same thing as a reasonably careful driver.
18 You have to follow the rules of the roads.
19 An interesting thing about the medical
20 establishment is that they want to say that
21 there are no rules of the road for doctors.
22 What a scary world that would be, if that
23 were true, if doctors had no rules. They
24 would never be held accountable for
25 anything.

1 Doctors have a duty to keep
2 abreast of advances in their field.
3 Knowledge changes, they need to keep up.

4 Now, you've going to hear His
5 Honor say that negligence in a medical
6 negligence case is a failure to do that
7 which an ordinarily careful doctor would
8 have done under the same or similar
9 circumstances or doing something that an
10 ordinarily careful doctor would not have
11 done. So when you hear the other side say
12 "reasonable", you think careful. Not
13 reasonable in the sense of cheap or
14 inexpensive but reasonable in the sense of
15 careful.

16 There's all kinds of charges here
17 that you are going to hear that might throw
18 you out. You are going to hear that a
19 doctor is not an insurer of the care, that
20 a doctor does not guarantee a good result.
21 Well, that's true. I never guarantee
22 anything to my clients and I am sure a
23 sensible doctor wouldn't either. We can't
24 control the future. But the doctors have a
25 duty to follow the rules of an average

1 careful doctor.

2 A mistake alone does not
3 constitute negligence. But if the mistake
4 comes from not keeping up with the
5 knowledge or not providing ordinary careful
6 care, then it is negligence.

7 You are going to hear about
8 proximate cause. Proximate cause -- you're
9 going to hear His Honor's discussion about
10 proximate cause being the causation and
11 legal cause. I don't want to talk about
12 the legal terminology, you'll hear it
13 enough. But basically what we are talking
14 about is, what caused the brain damage?
15 What caused the brain damage?

16 If the doctors come in and say
17 that 'I can't even say that there is a one
18 in a million chance that alcohol caused the
19 brain damage', then you know that alcohol
20 is not the proximate cause. It's too
21 remote, it's too far fetched. The law
22 requires that you say more likely than not,
23 more probable than not this is what caused
24 it. In this case there is really only one
25 cause and that is trauma from the vacuum.

1 We've got -- one of the
2 interesting things in this case is, on the
3 plaintiff's side, on our side we put up
4 experts from several fields of medicine.
5 One to talk about the rules -- two to talk
6 about the rules of the road for
7 obstetricians, Dr. Oakes and Dr. Yvonne
8 Gomez-Carrion. We put up two pediatric
9 neurologists, Dr. Katz and Dr. Adler, to
10 talk about the causal relationship between
11 the vacuum trauma and the brain bleed. We
12 put Dr. Zimmerman -- he's the world's
13 leading authority on reading babies brain
14 MRI's, or certainly one of the top three.
15 Nothing else can cause this kind of damage.

16 Now, what did you hear from the
17 defense? We had four obstetricians and a
18 geneticist.

19 Think about this. If there was a
20 pediatric neurologist in the country who
21 was willing to say something caused this
22 brain damage other than the traumatic
23 vacuum, don't you think that these guys
24 would have brought them into court?

25 If there had been any other fair.

1 way ---

2 ROBERT HOOD: I object to
3 that.

4 THE COURT: Overruled. You may
5 address that, if you wish, in your closing
6 argument.

7 ROBERT HOOD: It goes back ---

8 THE COURT: So noted.

9 Overruled. Please proceed, Counsel.

10 EDWARD GRAHAM: Thank you, Your
11 Honor. We brought topnotch guys from the
12 Children's Hospital in Philadelphia to
13 explain the brain bleeds, to explain the
14 dead brain tissue that resulted from the
15 brain bleeds. Nothing can cause this
16 except a traumatic vacuum.

17 Now, if there was any other
18 qualified doctor on reading brain MRI's, to
19 say that there was any other cause, don't
20 you think that this defense team would have
21 brought such a person in to give you that
22 testimony?

23 THE COURT: The causation
24 testimony in this case is very one-sided.
25 It is all our experts. There is nothing

1 the other side can say about the cause of
2 this damage other than to claim, 'Oh, it
3 must have been bad genes' or something.
4 But even Dr. Milunsky, their geneticist,
5 comes in and says, 'Well, you know, I can
6 try to blame it on weak blood vessels but,
7 still, the blood vessels wouldn't have
8 sheared or ruptured if you hadn't had the
9 vacuum.'

10 Let's talk about damages. We're
11 heard a number of things in this case,
12 again, that fall in the red herring
13 category. We've heard a number of things
14 about Jayden that is if though we were
15 trying to say that he had some harms that
16 the defense was responsible for that had
17 nothing to do with the defense.

18 Well, we know that there are
19 unrelated harms. There is a coloboma in
20 this eye that doesn't require treatment,
21 that causes no functional problem. We are
22 not looking to them for that. That is
23 either a genetic issue or a birth defect, a
24 developmental problem, whatever it is, but
25 it causes no problem.

1 Hernia and related problems.

2 Surgery fixed the hernia, it fixed the
3 pockets of fluid that go along with a
4 hernia call hydroceles. It fixed the
5 testes that goes up and done. Surgery
6 fixed it. We are not asking them to pay
7 for that. We agree that was unrelated.

8 Strabismus, cross-eyed. It the
9 early days there was a finding that he had
10 some cross-eye. There is no continuing
11 problem with those

12 Those things are unrelated.

13 Now, we have heard some other
14 things. We've heard 'big ears', uh,
15 we've heard that maybe he has long arms.
16 We didn't have any measurement in the
17 record about the size of his arms. We
18 don't think that there is any other
19 significant problems in those individual
20 variations. He has a heart murmur, like
21 lots of children have, that hasn't required
22 treatment. There's all kinds of minor
23 things.

24 Just imagine having your past
25 checked with a microscope, as has been done

1 to Jayden W. Those aren't
2 related. We aren't asking for any damages
3 related to those.

4 But there are harms that were
5 caused by Dr. Rhett's negligence:

6 Brain bleeds,
7 balance problems,
8 frequent falls,
9 lack of coordination,
10 low muscle tone,
11 left side weakness,
12 cognitive impairment,
13 borderline or mild mental
14 retardation -- depending on his full-scale
15 IQ test, --
16 developmental delays,
17 speech and language problems,
18 feeding problems requiring stomach
19 surgery to keep him from throwing up all
20 the time,
21 brain and stomach surgery,
22 medical bills,
23 therapy bills,
24 loss of ability to live inde-
25 pendently -- which to me is one of the

1 biggest damages in this case, loss of
2 independence is like the loss of one's
3 humanity, loss of who one is.

4 Loss of earning capacity.

5 Those harms were caused by the
6 defendants and we are entitled to be
7 compensated for them. We are entitled to
8 get money to fix the ones that can be
9 fixed, we are entitled to get money to help
10 the ones that can be helped. There are
11 some that can't be fixed or helped, but you
12 can make up for those.

13 His Honor will tell you that
14 you're supposed to make up for those under
15 the law, to compensate for the things that
16 can't be fixed or helped.

17 The ones that can be fixed or
18 helped are easily addressed with
19 mathematical number. Past medical -- now,
20 you've heard the testimony that Medicaid,
21 through about five or so months ago
22 Medicaid had paid a total of \$99,000 for
23 this child's treatment. The doctors had
24 billed \$223,000. Now, His Honor is going
25 to tell you that what you're supposed to do

1 is award, if you find that an amount is due
2 for this category you award the reasonable
3 value of those services.

4 Now, you might think that the
5 reasonable value is what the doctors
6 charged, you might think the reasonable
7 value is what Medicaid paid. But His Honor
8 is also going to tell you that any money
9 that we get for bills paid by Medicaid, we
10 have to pay back. So don't think we're
11 taking a double dip by asking you for this
12 money.

13 The life care plan. There were
14 two options in there. Now, we have
15 actually -- these figures, I find out just
16 a minute ago that these figures actually
17 combine the life care plan and the economic
18 value that Dr. Wood talked about for the
19 loss for the extra services that the mother
20 had to provide. But we've taken out of
21 that -- we have taken out of that all of
22 the charges for the neurosurgery, like Dr.
23 Voight suggested that we do, and we also
24 taken out all charges for ophthalmology
25 since it wasn't clear to me if those

1 included anything for coloboma or
2 strabismus. So those are out.

3 As you go through the list, you'll
4 have the list in front of you from Dr. Wood
5 where he gives present value for these
6 various categories. If you don't like any
7 of these, if you don't think that it should
8 be paid to Jayden, take it off. If you
9 think it's too high, take it down. But
10 don't just say, 'oh, this number looks like
11 it's about a third too high.' When you're
12 looking at Dr. Voight's life care plan,
13 there are lots of things that are not
14 include in there. It's truly a minimal
15 life care plan. So if you're going to take
16 away from it, if somebody wants to take
17 away from it, ask why should we take that
18 off? Let's talk about it. Can we agree to
19 take that off? Can we agree to reduce
20 that? But don't just hack away at it, let
21 there be a reason for reducing it if you
22 deem that it should be further reduced.

23 Loss of earning capacity. The
24 defense put a witness up here that said
25 that he could get a job. The only thing

1 that I heard her say was a bagger in a
2 grocery store. We've got a mentally-
3 retarded bagger at the grocery store that
4 I go to and -- you know, he's a nice guy.
5 It is great that he has that employment,
6 but he doesn't fall down taking groceries
7 to the car. This child has not just mental
8 retardation. This child has not just
9 speech and language problems but he has
10 balance and coordination problems. You saw
11 him try to walk like this (demonstrating)
12 -- pretty hard for me. But who is going to
13 hire him? Who is going to hire him?

14 A subtotal for the harms and
15 losses that can be fixed or helped, if you
16 use this approach, is six million to seven
17 million dollars in round numbers.

18 Now, you come up with a different
19 total if you reduce the life care plan more
20 than it has already been reduced.

21 There are other parts of losses
22 that can't be fixed or helped. They can
23 only be compensated for:

24 Past physical pain.

25 Future physical pain.

1 Past mental and emotional

2 suffering.

3 Future mental and emotional

4 suffering.

5 Past loss of enjoyment of life.

6 Future loss of enjoyment of life.

7 I want to talk to you about ways

8 that you can come up with numbers for

9 these. First let me talk to you about a

10 couple of other points that you need to

11 understand.

12 One of the charges that you're

13 going to hear about is the burden that the

14 plaintiff has. Ms. Craig said that it was

15 a heavy burden. Actually it's not so

16 heavy. The law only requires that we prove

17 our case more likely than not. If you

18 imagine the scales of Justice equally

19 balanced, or tipping just every so slight

20 in favor of the defense, we lose. But if

21 you imagine the scale tipping ever so

22 slightly in our favor, even one fact in our

23 favor, we win.

24 Now, I am not saying that we only

25 have one fact more than the defense on our

1 side. I think we've proven our side
2 overwhelmingly. But all the law requires
3 is more like than not. You'll hear it
4 called the preponderance of the evidence,
5 the greater weight of the evidence, but
6 what it really means is more likely than
7 not. You can have all the doubts in the
8 world about this case and still find for
9 the plaintiff under the law if we have just
10 more likely than not. More likely than
11 not. That's the standard.

12 When you hear His Honor talk about
13 the greater weight of the evidence, let me
14 make sure that you don't misunderstand
15 that. That does not mean that you count
16 the OB experts on that side, the OB experts
17 on our side and say they outnumbered us
18 four to two, so that's more weight. Weight
19 means the power to convince you. What was
20 the quality of the evidence proved. How
21 did it convince you? What is the weight of
22 the evidence.

23 The other thing that I wanted to
24 talk to you about is the word "compensate".
25 Like many of our words it goes way back to

1 the ancient time when words had certain
2 meanings. "Com" basically means
3 "together", "pen" is -- if you remember
4 like a pendulum swinging, that root word
5 "pen" means to hang, so "compensate" means
6 to hang together, just like the scales of
7 justice.

8 But in this case when we are
9 talking about compensation, we're talking
10 about what goes in this scales on the
11 child's harms and losses and what goes in
12 this scale is the money necessary to
13 balance the harms and losses. That is all
14 that you're doing.

15 It's not like you're awarding
16 money. You are appraising how much money
17 balances this harms and losses.

18 If you had somebody who worked a
19 full forty hour week and the employer came
20 in at the end of the week and said, you
21 know, 'I appreciate your work here but I am
22 not sure that I need to be paying you what
23 you thought that you were going to get.

24 You know, you only have one child, uh, your
25 needs aren't that great, you've got other

1 good things going for you -- you've got
2 government benefits, -- there are all these
3 other reasons why I don't think you need
4 this much money, so I am going to pay you
5 less than you expect.' Well, is that fair?
6 No. That doesn't balance work with pay.

7 If you're paid too much, it's
8 unbalanced. If you're paid too little,
9 it's unbalanced. The same thing with the
10 harms and losses. All you can consider on
11 this side is harms and losses.

12 You can't consider any other
13 thoughts, any other reasons like Medicaid.

14 You can't consider -- this sounds
15 like an awful lot of money for that
16 youngster but you can't think the lawyer is
17 going to get a big fee if we give this kind
18 of money. You can't ---

19 ROBERT HOOD: Objection, that
20 is totally improper.

21 THE COURT: All right. Just a
22 moment. Ladies and Gentlemen, I am going
23 to sustain that objection. The issue is a
24 fair and just amount of damages if you find
25 that damages are recoverable, not fees or

1 anything of that nature with regard to
2 counsel's services. Sustained. Please
3 move forward.

4 EDWARD GRAHAM: Thank you, Your
5 Honor. That's what I was saying, no
6 improper reasons. Harms and losses, what
7 does it take to equalize that. What does
8 it take to hang together with that. That's
9 what you judge.

10 Now I want to talk to you quickly
11 about unit of time approach to damages like
12 these. You don't have to use this approach
13 but it's something that has been come up
14 with by people smarter than me to try to
15 figure out how you put a value on the loss
16 of enjoyment of life for a brain-damaged
17 eight-year-old.

18 THE COURT: Counsel, you have
19 ten minutes.

20 EDWARD GRAHAM: Thank you, Your
21 Honor. It seems to me that there are
22 several things that you have to take into
23 account:

24 Number one, over what time period
25 does the occur?

1 Number two, how bad is the harm?

2 Number three, how disruptive is
3 the harm? How much does it adversely
4 affect the patient's life?

5 And in going through these, what I
6 have done here is just quick math to help
7 you understand. The first eight years --
8 eight years, three hundred sixty-five days
9 a year, twenty-four hours a day is seven
10 thousand eighty hours. If you were to
11 value the past pain, mental and emotional
12 suffering and loss of enjoyment at life at
13 three dollars an hour, it would add up to
14 \$210,000. Five dollars an hour, \$350,00.
15 Ten dollars an hour, \$700,000.

16 If you were to do the same thing
17 for the future years, His Honor will tell
18 you that this child's life expectancy from
19 this day forward, not counting the past
20 eight years, but from this day forward, is
21 68.82 years. That equals this many hours
22 if you multiply it out, times three dollars
23 an hour \$1.8 Million, times five dollars an
24 hour, \$3 Million, times ten dollars an
25 hour, \$6 Million.

1 Now, I am not telling you that
2 this approach should be used. It can be
3 used. It's all up to you.

4 If you choose to use this
5 approach, I'm not telling you that three,
6 five or ten are the proper numbers to use.
7 It can be smaller, it can be larger. It's
8 up to you.

9 If we were to take the range that
10 I've used here of three to ten dollar per
11 hour, then the past sums add from \$210,000
12 to \$700,000.

13 Using a similar approach for all
14 these categories, physical pain, mental and
15 emotional loss of enjoyment of life, over
16 the future years it is \$1.8 Million to \$6
17 Million.

18 If you take the harms that can be
19 fixed or helped, \$6 Million to \$7 Million,
20 and add something in this range for --
21 we've got -- okay, these numbers here
22 represent the total of the past low-to-
23 high, the total of the future low-to-high.
24 If we take the low and the high of those,
25 we've got these. If we take the out-of-

1 pocket losses, we've got this. So the
2 total would be, roughly, \$8 Million to
3 \$13.7 Million if you use that approach.

4 Now, as I think about this case --
5 you know, as a lawyer, I am afraid to ask
6 you for too much money, frankly. Lots of
7 people think lawyers are greedy and try to
8 get money that is not deserved for their
9 clients. As a lawyer, I am afraid to ask
10 for too much money. As a parent, I would
11 ask for well into the middle of this range.
12 As a member of this community concerned
13 about the effects of dangerous healthcare
14 for people like Jayden in cases like this,
15 I would go with the high end of the range.

16 Let me talk to you briefly about
17 the jury verdict form. Number one,
18 (reading):

19 Did the Plaintiff prove by the
20 greater weight or the preponderance of the
21 evidence of the evidence that Dr. Rhett
22 deviated from the standard of care?

23 Yes or No.

24 If you believe that Dr. Rhett
25 should be held responsible for the harm to

1 this child, check yes.

2 Number two,

3 Did the Plaintiff prove by the
4 greater weight or preponderance of the
5 evidence that the negligence of Defendant
6 Dr. Rhett was the proximate cause of the
7 alleged injuries?

8 Again, if you believe that Dr.
9 Rhett should be responsible for is
10 negligence that caused harm, harm of any
11 kind in any amount, check "Yes."

12 The third question is where you
13 state the total amount of actual damages.
14 I am going to encourage you -- when you get
15 to this question, I am going to encourage
16 you to hold Dr. Rhett fully responsible for
17 all of Jayden's losses. It's good for you
18 and it carries out your legal duty as an
19 honorable member of this community ---

20 ROBERT HOOD: Objection, Your
21 Honor. That is improper argument.

22 THE COURT: Overruled, Counsel.
23 The Court does not find it to be improper.

24 EDWARD GRAHAM: Your role is one
25 of honor. You've been sworn to uphold the

1 law. No improper reason. Full losses.

2 That is what we are asking for. Thank you.

3 THE COURT: Ladies and
4 Gentlemen, let's do this. We've been here
5 almost an hour. So that you will be fresh
6 from a break when the defense begins their
7 closing, let's take a little break at this
8 time. We will take about a ten-minute
9 break. We will all remain where we are
10 while the jury returns to the jury room.

11 (JURY OUT @ 10:23 A.M.)

12 THE COURT: Court will be in
13 recess for about ten minutes.

14 (BRIEF RECESS)

15 THE COURT: Defendants ready?

16 ROBERT HOOD: I have a matter
17 of law for Your Honor.

18 THE COURT: Yes, sir?

19 ROBERT HOOD: The first time
20 that Mr. Graham mentioned it, he said
21 substandard medical care poses a danger to
22 our community. Then he referred to "our
23 community", he's from Florence and he's
24 referring to our community here in
25 Charleston, about five or six times. I've

1 read the same book that he read, that is
2 written by how Don Keenan on how to get a
3 jury churned out, mad at a defendant. Of
4 course, that's what he is asking them to
5 do. So I think that Your Honor should
6 grant a mistrial.

7 THE COURT: That's the sixth
8 mistrial Motion, Mr. Hood.

9 ROBERT HOOD: Yes, sir.

10 THE COURT: Way over the top,
11 sir.

12 ROBERT HOOD: It is, but this
13 has been a way over the top trial but Mr.
14 Graham.

15 Your Honor, you and I had a trial
16 with a very good plaintiff's lawyer from
17 Columbia and I didn't make any objections
18 of any significance and no Motion for a
19 mistrial. So it depends on my adversary
20 and the doing of my job.

21 THE COURT: Fair enough.

22 ROBERT HOOD: Thank you. So
23 what he's done is a violation of a case
24 that was on my desk last night, it's a
25 criminal case it cites The Golden Rule

1 argument. It says, in the *State v. Reese*,
2 cite 633 SE 2nd 898, an '06 by our Supreme
3 Court, I believe that it was the Supreme
4 Court case finding, "Improper golden rule
5 argument when the solicitor asked the jury
6 to speak for the victim through its
7 verdict." He is asking the jury to speak
8 for the community through its verdict and
9 to award a substantial amount of money to
10 the plaintiff. It's an indirect way to
11 violate the Golden Rule argument, to build
12 up emotion in the jury. Thank you.

13 THE COURT: Thank you. Do you
14 want to be heard on that briefly, Mr.
15 Graham, in response?

16 EDWARD GRAHAM: First of all, as
17 a person I've been accused of a lot of
18 things since this trial started but it's a
19 matter of record that even though my home
20 is currently in Florence I've purchased a
21 new home in Awendaw, Charleston County.
22 Once this trial is over I will be moving in
23 as my primary residence. So it is valid
24 for me ---

25 THE COURT: Congratulations.

1 Well, let me just say that Mr. Hood will
2 probably receive that information with less
3 than fervor. But, go ahead.

4 ROBERT HOOD: You ought to
5 learn to pronounce it if you're going to
6 live there.

7 EDWARD GRAHAM: Secondly, if
8 Your Honor please, in terms of The Golden
9 Rule, to me the golden rule is Biblical,
10 'Do unto others as you would have them do
11 unto you.' Never did I say, 'Ladies and
12 Gentlemen, put yourselves in the shoes of
13 Jamsetta, put yourself in the shoes of
14 Jayden.

15 They uphold the honor of the
16 community, it's in Your Honor's charge,
17 and that was the thrust of my comments
18 about the community. They are the repre-
19 sentatives of the community in determining
20 justice between these parties. I think
21 that's completely proper.

22 How can I zealously represent my
23 client without acting with some degree of
24 passion in trying to protect his interests?

25 THE COURT: Very good. Your

1 objection and your Motion for mistrial is
2 noted, Mr. Hood, and respectfully denied.
3 There are some parts of my charge that
4 tells the jury that we are acting for the
5 community here, seeing that every trial is
6 just and fair. Medical standards are often
7 referred to as standards within the
8 community, thus I don't find the argument
9 that the reference to our community to be
10 improper.

11 I decline at this time to grant a
12 motion for mistrial.

13 Are you asking for some sort of
14 curative instruction?

15 ROBERT HOOD: Yes, Your Honor.

16 I think the use of that word "community"
17 coupled with his again reference to Dr.
18 Rhett practicing with the videos, violating
19 the attorney work product and privilege
20 rules is extremely prejudicial in this
21 case. I think you should remind the jury
22 in your charge, very clearly, that argument
23 of counsel is just that. He's not a
24 witness, he's not under oath, and he's not
25 here representing anyone except one client

1 against one doctor and that's the only
2 issue in this courtroom.

3 THE COURT: I will include
4 something to that effect, though it will
5 not be in those words, in my charge to the
6 jury.

7 ROBERT HOOD: Thank you.

8 THE COURT: Thank you. Now
9 let's bring in the jury.

10 (JURY IN @ 10:40 A.M.)

11 (JURY IN @ 10:40 A.M.)

12 THE COURT: Welcome back, Ladies
13 and Gentlemen. Let me ask, Ladies and
14 Gentlemen of the jury, while I have not
15 actually discussed with you about choosing
16 a foreperson that it appears to me that the
17 jury has collectively chosen a foreperson,
18 and that is Mr. Sewell. Am I correct in
19 that?

20 JUROR NUMBER 336: Yes, sir.

21 THE COURT: Very good then.
22 Congratulations, Mr. Sewell.

23 JUROR: He pretty much nominated
24 himself.

25 THE COURT: Congratulations for

1 the confidence your colleagues have shown
2 in you. Later on in my charge I will talk
3 with you a little bit more about the role
4 of a foreperson but, again, in advance
5 thank you for your service in that
6 important role.

7 JUROR NUMBER 336: It's the
8 least I could do for vacation.

9 THE COURT: Very good. We are
10 now at the closing argument for the
11 Defendant Dr. Rhett. The court recognizes
12 counsel, Mr. Hood.

13 ROBERT HOOD: Thank you, Your
14 Honor. May it please the Court.

15 THE COURT: Yes, sir.

16 ROBERT HOOD: Good morning,
17 Ladies and Gentlemen. I hope everybody is
18 okay today. I've sorry you've been here
19 going on three weeks.

20 We've tried to move the case
21 along, only called the witnesses that
22 really answered the issues in this case.
23 We called four obstetrical experts, two
24 from other communities and two from right
25 here and we've advanced the case.

1 You know from at the outset that
2 His Honor told that the whole trial was
3 about was the plaintiff or doesn't the
4 plaintiff meet their burden of proof.

5 I submit to you that this
6 plaintiff has not met their burden of
7 proof. They have not shown by the greater
8 weight of the evidence that Dr. Edmund
9 Rhett deviated from acceptable stds of
10 medical care. That's why I am standing
11 tall. That's why he is standing tall.
12 That's why we are trying this case.
13 Because he is not negligent and he did not
14 do any harm to this child.

15 This is a wonderful country, we
16 all have wonderful freedoms and the jury
17 system is fantastic, and it works. Thank
18 each and every one of you for sitting here
19 enduring this trial and all of this back
20 and forth, hours of questions, all in a
21 search to get you to award them a lot of
22 money. To build up some emotion, they keep
23 talking about the community.

24 We're dealing with one person
25 against person for a claim that that child

1 has an injury because a doctor did
2 something wrong. The doctor didn't do
3 anything wrong. That's why he is trying
4 this case. That's why we are here, and
5 we're honored to be here representing him.

6 That's why we asked every nurse
7 that was called to the stand, 'Do you know
8 Edmund Rhett? What do you think of Dr.
9 Rhett?' They all love him. He's got a
10 great bedside manner, he's got seven
11 thousand children that are growing up in
12 this county, his home, that he brought into
13 this world without complications --
14 including this child.

15 One thousand uses of vacuum to
16 assist deliveries where the mother and her
17 pushing and needed assistance. So we want
18 to say, 'Dr. Rhett, thank you. You've had
19 a wonderful life, you've done a tremendous
20 job for our community, we are proud of you,
21 we're proud to get to know you in this
22 courtroom. We were proud to hear what
23 these nurses said about you, what the other
24 doctors said about you. What the chairman
25 of the department of the Medical University

1 of South Carolina said about you. What
2 Bobby Hood told me.

3 Peter Van Dorsten -- he's got,
4 what? Forty-five doctors that he is
5 training currently. He's the head guy for
6 this state at our teaching hospital in
7 Charleston. 'Dr. Rhett is a good doctor.
8 I've referred him patients and he's
9 referred to me. His care has always been
10 excellent'

11 Why shouldn't we be here? If he
12 hadn't done anything wrong and he did his
13 job properly, he should be here and be
14 defended. But we didn't overdo it. We
15 didn't spend three weeks talking about what
16 a great guy he was, talking in seven
17 thousand patient or five hundred or one
18 hundred or any. We brought in four ob-gyns
19 like him, Board-certified. The proof of
20 the pudding, when he was on the stand, I
21 said, 'Your Honor, I move to have the court
22 recognize Dr. Edmund Rhett as an expert in
23 the field of obstetrics.' The judge said,
24 'He is qualified as an expert and I so
25 recognize him as an expert.' Just like he

1 did for all the other experts in this case.

2 So we've got five Ob experts. We've got

3 Dr. Rhett himself -- and has counsel

4 forgotten Dr. Hobbs. My goodness, a viable

5 witness. A minister. His wife is in

6 charge of News in Chicago, one of the tv

7 stations, she's the anchor, she's the real

8 thing. What does he say? 'I never met

9 this man. I looked at the medical records

10 and he did a good job. He saved this

11 baby's brain from lack of oxygen.'

12 Now, there is no way that any

13 doctor can predict or prevent genetic

14 problems. The minister, he didn't say --

15 he used a phrase 'our Heavenly Father', it

16 was early on, only a minister would come up

17 with it. That's the proof of the pudding

18 in this case.

19 Dr. Milunsky, a world authority

20 says that that person they brought by video

21 doesn't even rise to the ability to be

22 quoted in any of his books, and he's got

23 twenty-some textbooks out there.

24 He says that these genetic

25 disorders, when you have them all together

1 add up to something real important, to
2 explain -- and I am going to show you a
3 picture in a minute that answers the whole
4 subject, that explains what happened here.
5 You've got a situation where the doctor
6 can't predict or prevent.

7 This child has small blood vessels
8 because of the way that he is drawn.
9 There's no way to know that. That's the
10 way God created that child, for whatever
11 reason.

12 He applies the vacuum, he helps
13 the mother deliver the baby, she is
14 exhausted, she's in labor for a whole day,
15 twenty-four hours. Isn't it a great
16 device? Isn't it wonderful that science
17 has developed something besides those awful
18 forceps? They scare me just to look at
19 them. If I was a lady, pregnant, I would
20 be running. But they used them for
21 centuries successfully, turning babies,
22 moving babies, helping babies. Now they've
23 got a vacuum. So doctors are gradually
24 going away from forceps and going to the
25 vacuum.

1 Now, I am going to try to put this
2 whole case in perspective for you: who we
3 have heard from, what they have said, what
4 we have answered and why we are here
5 standing tall.

6 As I am talking and as I am
7 explaining things, remember one thing,
8 that the word "verdict" comes from a Latin
9 phrase which means to speak the truth.
10 *Veredicto*, to speak the truth. That's why
11 Molly stood up in the opening and said that
12 we are here on a search for the truth and
13 we are going to show the truth. We've done
14 that.

15 How have we done it? Not by the
16 way they're talking, not by trying to
17 manipulate anything but by people who are
18 trained in delivering human beings, doing
19 wonderful things in their field of
20 medicine. You know, what a wonderful
21 rewarding occupation an obstetrician has,
22 that none of us have. They help a mama,
23 they bring into the world for a family a
24 new child. It's really a miracle, the
25 whole process from conception to delivery

1 is a miracle, created by God. Sometimes
2 bad things happen to good people. We have
3 all seen it. We don't know why. It's
4 awful. Bad things happened to this child.
5 We don't know why, but it did. He has
6 genetic problems.

7 So we got Dr. Milunsky to explain
8 to you that the kind of problems that he
9 has are not from blood in his brain but
10 that they are from his genetic disorders.

11 So we've got a picture from the
12 birth, we've got a photograph of his brain.
13 There is no blood in his brain, his
14 ventricles, this is from the Medical
15 University of South Carolina's ultrasound.
16 This is our Medical University treating
17 this child, doing an ultrasound that says
18 it is normal. A trained radiologist
19 looking at that picture, he doesn't see any
20 blood vessels that have been torn from a
21 vacuum causing a bleed in the brain. It
22 would be had it happened that way. Now,
23 you see why we're trying this case?

24 Then the next day they use another
25 test. They do an MRI, and it's in

1 evidence. Put it in the computer, pull it
2 up on the screen and you can see the
3 picture. You've going to see what Dr.
4 Milunsky is talking about. This child's
5 brain, the vessels in this brain are not
6 normal. One side is totally blocked and
7 not working. One side of his brain, the
8 day after he is born, doesn't have
9 bloodflow to it. It's the blood that goes
10 through the venous -- this is 7:18 in the
11 morning, absent of flow in the left
12 transverse sinus, suggested thrombosis or
13 compression. Not me talking. That's a
14 treating radiologist talking, his notes,
15 what he's looking at and he's telling it
16 and describing it to treating doctors so
17 that they will see it and understand what
18 they are seeing on this image.

19 They never showed you another
20 picture. Why? Because it proves
21 unequivocally in a photograph that there
22 was no tear from this vacuum at delivery;
23 i.e., there was no harm from the delivery
24 that caused this child any harm.

25 So we've got several reasons why

1 we are trying this case. Dr. Rhett
2 complied with the standard of care, Dr.
3 Rhett didn't cause any harm, and we've got
4 a picture to prove it.

5 How about this? This guy set up
6 and said that 'they called all these people
7 in here, basically circling the wagons, to
8 help out their buddy, Dr. Rhett.' He
9 didn't call one single treating person.
10 His experts are making \$20,000-plus a clip
11 to come in here to testify for the
12 plaintiff and not one of them recommended
13 any care for this child. All they wanted
14 was money to give you an opinion to get to
15 thinking you should give money. That's the
16 truth in this case. See why I'm here? See
17 why Mr. Rhett is here?

18 Let's talk at some of these
19 strips. We talked about this strips in
20 this trial but not one expert talked about
21 these strips. Hello. Not one. Now, what
22 is the truth here? He didn't want you to
23 see these strips. Why didn't he want you
24 to see these strips? Because they show
25 bradycardia, pending brain damage to a

1 child from lack of oxygen. That's the
2 truth of these strips.

3 So do did we bring in? A Board-
4 certified fetal monitoring, maternal
5 monitoring Chairman of the Department.

6 Do we have a crises here?

7 Yeah.

8 Why do you call it?

9 Bradycardia.

10 What do you do?

11 You get the baby out.

12 Do you sit down, talk to the mom?

13 No, you get the baby out.

14 What did Dr. Rhett do? He got the
15 baby out. The Apgar scores show that the
16 baby is good. Thank you, Dr. Rhett for the
17 appropriate care. Not a lawsuit.

18 Seven thousand patients thank you,
19 Dr. Rhett, for our new child, for your role
20 in helping to bring him or her in this
21 world.

22 This is a big deal. His entire
23 file has been sitting over there being
24 attacked, every minute of the day for two
25 and a half weeks. For two and a half

1 weeks, unmercifully, uncalled for,
2 infuriating. He's a great man, he's done
3 great things in this lifetime and he
4 doesn't deserve that kind of treatment.

5 He did a reasonable law, he did
6 the appropriate job, he did what he was
7 trained to do and he knows how to do --
8 it's second nature for him.

9 So before the case got done, in
10 the middle of it, the baby is at the wrong
11 station. 'He screwed up.' But then Dr.
12 Rhett says, or his experts Dr. Van Dorsten
13 and Dr. Hobbs said 'I can see his head.
14 He's got in his fingers, at the outlet
15 opening, the electronic fetal monitor
16 probe. That subject ends.

17 So we get back to all these other
18 things that have nothing to do with
19 anything, but they can't prove that mid
20 station, that the baby's head was down.
21 The fingers were right down at the opening,
22 not way in, the head is right there.

23 Dr. Rhett explains that I tried to
24 remove the probe, and you see it on the
25 video, the baby's hair was caught in the

1 wires, so I backed it off, twirled it. He
2 did. You see that. They're trying to make
3 it look like, well, because he is doing
4 that that the baby is way up in the birth
5 canal. But look at the beginning of that
6 series of films where his fingers are on
7 the probe and it's right there at the
8 outlet, plainly, at the opening of the
9 lady's vaginal.

10 So the baby is at the right
11 station, so they don't have a lawsuit.

12 Instead, we hear for days about things that
13 have nothing to do with anything -- and for
14 an hour this morning about the same things.

15 Do something for the community.

16 Well, Dr. Rhett has been doing a lot for
17 this community. Sleeping for years of his
18 life in hospitals for mother's who are
19 having babies. Thirty-three years he slept
20 in the hospital for one year, total.

21 That's pretty good dedication, particularly
22 considering what they get paid.

23 Let's talk a minute about the
24 case. On the verdict form, the very first
25 question is did Dr. Rhett deviate from the

1 standard of care. If you find that he did
2 not, you have found a verdict for Dr.
3 Rhett. He wins. That's the end of the
4 case. You don't go to the second, third or
5 fourth, any other questions.

6 Very first question, did he comply
7 with the standard of care? That's why we
8 brought four experts, like Dr. Hobbs -- my
9 goodness, what an impressive witness he
10 was. He got not two words on cross
11 examination out of him to prove any of this
12 stuff. That man is solid and strong. He
13 testifies for plaintiffs and defendants,
14 unlike their expert who hadn't delivered a
15 baby in twelve years, who only testified
16 for plaintiff and now testifying is how he
17 makes a living. So I drove from Savannah
18 -- I wonder, spent two weeks in Charleston
19 having a good time before he came back the
20 second time. At his hourly rate, I hope he
21 didn't.

22 And they say -- he's got to jump
23 over each of these hurdles without knocking
24 them down as his foot comes down. He
25 doesn't even get over the first one. The

1 second one, he doesn't get over it either.

2 This case is confusing but the
3 answer is genetics. Milunsky was the
4 answer. He basically didn't ask Milunsky
5 anything. We recognized him as the world's
6 authority on what he was talking about.

7 The sum total of all these things
8 add up to abnormalities that God created
9 that explains this child's disability, not
10 what -- bad obstetrics. You know, usually
11 we don't get into a fight over, they either
12 are or they aren't.

13 But in this case you're being
14 asked to pay for things that these doctors
15 told you don't relate to this case:
16 cardiac care for a heart murmur,
17 ophthalmology care for eye problems. It in
18 the life care plan, they want you to pay
19 for it for sixty-some years.

20 What is credible here? What is
21 the truth? What is real? Who is getting
22 hoodwinked.

23 The child is eight years old.
24 I've got several grandchildren, a couple of
25 them are about eight years old. I have on

1 idea of what eight-year-olds will be
2 capable of doing, nor does anyone else, in
3 their lifetime.

4 He asked one question of every
5 care person from that pediatric group, that
6 Medicaid is paying for, thank goodness, for
7 this child's life. They were really
8 sensitive, sweet people, they really care
9 about this child. And what did they say
10 that he is doing? Constantly improving.

11 Well, he's only eight and if he is
12 constantly improving, we have to reasonably
13 assume that he is going to continue to
14 improve. My god, we want him to have
15 gainful employment. That's only normal.
16 We want him to be able to live on his won,
17 certain when he grows up that he won't need
18 to have anyone to care for him around the
19 clock. That's why we brought a doctor that
20 specializes in this kinds of things to
21 explain that to you.

22 The whole point of the fetal heart
23 monitor is to detect the baby's distress,
24 so that the doctor can do something about
25 it. You're going to see in a minute every

1 witness has anything to do with his birth
2 is saying 'I'm worried about those strips'
3 -- the nurses, the midwives, labor and
4 delivery, even the nursery nurse. These
5 strips are a doctor's way of preventing a
6 child not getting oxygen, for whatever
7 reason, whether it was the cord, whether it
8 was the pain and pressure of twenty-four
9 hours of pushing in the birth canal
10 process, whatever.

11 We get to a point where it has
12 been totally explained to you,
13 unequivocally by Dr. Van Dorsten and Dr.
14 Hobbs where this child is at-risk and needs
15 to get out. Now, you don't stop in an
16 emergency. You put on your game face and
17 you do your job, just like I'm doing right
18 now. I'm doing my job, I hope well, like
19 Dr. Rhett did.

20 Undisputed fact: Vacuum is a
21 generally-accepted device used by
22 obstetricians to deliver babies. Yes, it
23 can cause hemorrhage. That doesn't mean
24 that it is medical malpractice.

25 This child, as mentioned, had

1 numerous congenital abnormalities. That
2 explains his condition to us. There was no
3 ripping or tearing of blood vessels,
4 because we've got a picture of his head
5 taken at the Medical University that says
6 there is not.

7 This piece of paper is Exhibit --
8 well, maybe the easiest way to say it is
9 Medical University of South Carolina 366.
10 Exhibit 27-459. The paper size of this is
11 in evidence, the ultrasound of his head.

12 All medical doctors in this case
13 agree you can't protect or prevent genetic
14 disorders.

15 A doctors should exercise his
16 clinical judgment -- and why do we talk
17 about clinical judgment? Because that's
18 what is going on here. You've got a
19 trained, Board-certified doctor that
20 deliveries babies and, all a sudden, the
21 picture changes and he takes over the
22 emergency in minutes. Now, if they had
23 been set up for a C-section maybe they
24 could have done that. But they weren't
25 they would have taken another twenty

1 minutes or so. What would have happened
2 to this child's brain without oxygen for
3 twenty minutes, forty minutes. Then we
4 really would be here. I wouldn't be able
5 to stand and talk.

6 His problems are unrelated to the
7 delivery. Even their star witness, from
8 Chicago, said that clearly if you are
9 concerned about the fetal heart rate
10 tracing that you want to get the baby out
11 as soon as you can, in the safest manner.
12 Is that what happened? Isn't that the
13 proof of the pudding? Isn't that what Dr.
14 Rhett did? Within two or three minutes the
15 baby was out. That was quick.

16 I believe that Dr. Van Dorsten
17 said that if the baby at been at midstation
18 that it would have been hours, or least an
19 hour.

20 I believe that you will hear, when
21 I sit down, from His Honor definitions of
22 phrases that are important to you in
23 understanding and in deciding this case.

24 You start with the standard of
25 care. The law doesn't require perfection.

1 God knows who could be held to perfection,
2 except the Almighty. It requires a doctor
3 to use the degree of knowledge, -- now,
4 remember these words -- care and skill
5 ordinarily used by doctors in goodstanding,
6 who have been recognized as experts by the
7 Court in this trial.

8 Goodstanding, that he's got.

9 That the doctor followed the
10 generally-accepted practices and procedures
11 in the profession. He did that. That's
12 why we brought Dr. Winestein, who practices
13 here. And -- how about Dr. Norton? That
14 little lady has six children. Wasn't she
15 reliable? She met Dr. Rhett when she
16 walked into the courtroom, as did Dr.
17 Hobbs. That's reliable by itself, isn't
18 it?

19 Another word that you need to
20 focus on is negligence. The failure to do
21 what an ordinary careful doctor would have
22 done under the same or similar circum-
23 stances. Dr. Rhett did what an ordinary
24 doctor would do under the same or similar
25 circumstances. Therefore, he is not

1 negligent. He did not deviate from the
2 standard of care.

3 You know, you don't have anybody
4 in this courtroom that you've got to
5 reward. There's no place for sympathy in
6 this case. You told an oath when we
7 started this trial to be fair, to be
8 impartial, to do justice for all parties.
9 You don't have anyone to reward here, you
10 don't have anyone to punish, you need to do
11 justice. You took an oath to be fair and
12 impartial to this judge, to this jury, to
13 each other. His Honor is going to tell you
14 that when you're deliberating that your
15 verdict has to be unanimous. Unanimous.

16 Don't compromise. If you agree
17 with me that Dr. Rhett was not negligent,
18 don't compromise one second. That first
19 question is was he negligent in providing
20 medical care -- I think the question is
21 worded another way, that he failed to
22 comply with it. Did the plaintiff prove by
23 the greater weight or the preponderance of
24 the evidence of the evidence that Dr. Rhett
25 deviated from the standard of care? If you

1 find "no", that's the end of the case. If
2 you agree with me on "no", stop right there
3 and don't let any pressure change your
4 mind. You've taken an oath to do what is
5 just and right and fair. Dr. Rhett would
6 rather have a mistrial than a misjustice.
7 We want a defense verdict.

8 We don't want a misjustice here
9 because someone's emotions are stirred up
10 by talking about a community that has
11 nothing to do with this case, five or six
12 times at closing. This case doesn't have
13 anything to do with the community. It's
14 got to do with a claim against an
15 individual that we've answered indepth,
16 in detail.

17 These are very well qualified
18 experts, they are not lawyers talking, they
19 are not guessing, they are not trying to
20 build up your emotion that gets you to do
21 something crazy.

22 A bad outcome, this child has
23 genetic problems, this child's current
24 condition, that doesn't add up to medical
25 negligence. It happens. Why it happens to

1 good people, I don't know. You know, to be
2 honest. It happens. And it's a shame when
3 it happens. We all hate it. But that
4 doesn't add up to negligence.

5 Undisputed by every witness who
6 got here, who testified from this witness
7 stand, the congenital abnormalities that
8 this child are not caused from the birth
9 process, were not caused by Dr. Rhett, but
10 by God. There they are.

11 Why do we show you those? Why do
12 we bring them to light? Because Dr.
13 Milunsky explained the totality of them,
14 what adds up to what is wrong with this
15 child. It is not just one of them, it's
16 not just that one of them is minor, one is
17 major. This is a laundry list of genetic
18 problems that add up to this child's
19 problems, to his competency problems that
20 this life care plan wants to give him all
21 this money for. See where the truth is
22 now? Don't forget Dr. Milunsky.

23 Absence of flow in the left
24 transverse sinus suggests thrombosis or
25 compression. There my picture, coming up.

1 That's the doctor writing the report saying
2 it. Not me. Here's the picture.

3 Now, this is proof positive of why
4 this case needed to be tried. Proof
5 positive of why this child's condition is
6 what it is. On the right is a normal
7 transverse sinus baby.

8 Now, the veins in the blood -- the
9 veins in the scalp and brains of the child,
10 the veins taken the used blood back to the
11 heart to get regenerated.

12 We're looking at the front of the
13 child, left side, they are normal. On the
14 right side they are not, they're little
15 teeny lines. There is a little teeny line
16 right there and that's it.

17 Why is it so key and so important
18 and why was this not answered by them?
19 Because they can't answer it. Because the
20 truth is that this child has congenital
21 birth defects that is -- it's like a toilet
22 that is stopped up. The veins are taking
23 the blood back to the heart on the right
24 side of his body and instead it's spilling
25 out into his brain and it's causing injury.

1 Two days after he was delivered, not at
2 delivery.

3 This same situation continues in
4 this child. The veins have gotten a little
5 better over the years but they are still
6 smaller now, they are still abnormal.

7 The reports are all in evidence,
8 thank goodness. This picture is in
9 evidence. I'll tell you where you can find
10 it, it's frame twelve in Exhibit 27, it's
11 the computer disk of the MRI done on 7-18-
12 02 at Medical University of South Carolina.
13 It's on a disk like this. You know, I may
14 have the wrong number, let me make sure.

15 I waited these two and a half
16 weeks for someone to answer this picture,
17 they never did. There it is. Right there,
18 abnormal. The whole right side, the blood
19 does not return to heart from the right
20 side of this child in the normal fashion;
21 which has caused him to have cognitive
22 problems. That ain't got nothing to do
23 with the labor, delivery or the vacuum.
24 Nothing to do with it.

25 This is the next day, at 8:48 in

1 the morning. There it is. Absolutely
2 proof of the pudding, absolutely proof in
3 this case that the vacuum did not cause a
4 tear or an injury to this child's brain.
5 There is no injury on the scalp from
6 "twisting" or turning the vacuum, there is
7 no -- nothing but the child's head has a
8 caput because the child has been coming
9 through the birth canal and there's a lot
10 of pressure but there's no physical sign of
11 any bleeding, tear or any blood at all.
12 The nurses don't note it. They note a
13 color probably, but then he perks up wit
14 oxygen and he's okay. He's okay.

15 I think the report must be the
16 number that I had, 27, but this disk -- I
17 will put it right here so if anybody wants
18 to look at it. It's 112. I've go in my
19 office, unplug the computer and bring it in
20 here, put that in the computer, pull it up
21 on the screen, it's good to play out.

22 There it is. It is much more effective on
23 the computer, more impressive than it is on
24 that. This should end your deliberations.

25 There it is.

1 I'm sorry that bad things happened
2 to this child. It's a shame, it is not
3 because of the birth process, the delivery,
4 or negligence. Dr. Rhett did not deviate
5 from the standard of care.

6 Because this show you, right
7 there. Because he's not getting oxygenated
8 -- because he's getting used blood back, a
9 lack of oxygen, back to the heart, it
10 doesn't have anywhere to go. That's why he
11 suffered a lack of oxygen.

12 Let's look at all of the
13 information available when you're deciding
14 a medical case. In this case, all they
15 have to prove their case is confusion,
16 trying to build up your emotion so that you
17 will want to do something from the
18 standpoint of sympathy, a motivation that
19 is not consistent with the oath that you
20 took as a juror.

21 That's why you heard in bits and
22 pieces that "we have no objection", we put
23 it all in. We want you, the jury, to see
24 the whole story. All of these images are
25 in because we put them in to make a full

1 and complete picture. We want you to have
2 the whole pictures. We wanted you to have
3 everything that is there so that you can
4 look at it.

5 They wanted to hold out this piece
6 of paper or that piece of paper and not put
7 in all the records.

8 Dr. Rhett, caring, kind,
9 compassionate, has delivered thousands of
10 babies. He saw a problem and he put on his
11 game face and, the main thing, he got this
12 baby out. The doctors who testified told
13 you that when you're delivering a child and
14 you realize that its oxygen is getting cut
15 off, that you've got to do something about
16 it. He did.

17 You know, everything that I've
18 said this morning is not evidence.
19 Everything that a lawyer says in closing
20 argument is not evidence. So if you hear
21 me say something that you disagree with,
22 throw that out the window. If you hear the
23 other side say something that you disagree
24 with, or a lot of things that you disagree
25 with, throw it all out a window.

1 But remember what was told to you
2 from this witness stand under oath by
3 witnesses, subject to cross-examination,
4 redirect. We can't prove by the way that
5 we ask our questions because His Honor runs
6 a tight ship. If I ask a leading question,
7 he'll tell me to stop and rephrase the
8 question and let the witness talk. I
9 would. Because this is a search for the
10 trial, as Molly told you at the beginning
11 of the trial.

12 Dr. Rhett was not negligent in the
13 delivery of Jayden W. and we ask
14 that you return a verdict for the defense.

15 THE COURT: All right, let's
16 take a break for a few minutes. Enjoy you
17 break, Ladies and Gentlemen.

18 (JURY OUT @ 12:01)

19 THE COURT: Counsel, let me just
20 tell you one thing about my charge. I had
21 to change one thing that we discussed
22 yesterday. We talked about *respondeat*
23 *superior*, up the point where I talk about
24 the fact that there are two defendants in
25 the case. I think that would be a little

1 bit better -- as we discussed yesterday,
2 the decision as to Dr. Rhett really
3 controls the decision as to both. So I
4 made that change.

5 All right. So we will be in
6 recess at approximately ten minutes.

7 (BRIEF RECESS)

8 THE COURT: At-ease everyone.

9 All right, Ladies and Gentlemen. We
10 are just confirming about lunch. Trying to
11 make sure that we end our arguments about
12 the time that lunch arrives. Bring in the
13 jury.

14 (JURY IN @ 12:14 P.M.)

15 THE COURT: Welcome back, Ladies
16 and Gentlemen. Now we will move to closing
17 argument for the Defendant Lowcountry Ob-
18 Gyn.

19 JAY DAVIS: May it please the
20 Court, Your Honor.

21 THE COURT: Mr. Davis.

22 JAY DAVIS: Ladies and
23 Gentlemen, I am not going to do anything to
24 delay this. One thing that I have to tell
25 you is that I was born and raised in

1 Charleston. My mama would tan my hide if I
2 didn't do this. I've got to thank you for
3 your service, thank you for your efforts,
4 for you time of listening to this case for
5 two and a half weeks. I've had a lot of
6 time to watch you and you've paid attention
7 during this case, and I appreciate that.

8 On behalf of Dr. Osborne and all
9 the folks at Lowcountry Ob-Gyn, the
10 doctors, the nurses, the folks that you saw
11 coming in and out of this courtroom, we
12 thank you.

13 Ladies and Gentlemen, I made you a
14 couple of promises at the beginning of this
15 case. One was that nobody would take the
16 stand and say that we did anything wrong.
17 No one did. The second promise that I made
18 was that I wouldn't stand up and ask a
19 bunch of question to which I already knew
20 the answer. I am going to do the same
21 thing in this closing argument, except to
22 tell you that I do join whole-heartedly in
23 the arguments of Mr. Hood on behalf of Dr.
24 Rhett in this case. We join in that. We
25 ask that, after you've had a chance to

1 deliberate, to make your decision and bring
2 a verdict back in favor of Dr. Rhett.
3 Thank you.

4 Because the answer to that
5 question is the only question controlling
6 now. We will rise and fall based on that
7 answer.

8 I know that you good folks will
9 consider the evidence, will consider the
10 law and respectfully ask that you bring
11 that verdict back.

12 THE COURT: Thank you. Then for
13 the plaintiff's rebuttal. Mr. Graham, you
14 have fifteen minutes remaining.

15 EDWARD GRAHAM: Thank you, Your
16 Honor, may it please the Court.

17 THE COURT: Certainly.

18 EDWARD GRAHAM: Ladies and
19 Gentlemen, you are about to start your
20 hardest work in this case. Sitting here
21 has not been easy. Listening as carefully
22 as you have is very impressive and we all
23 appreciate it.

24 But when you step back into the
25 jury room, you have two jobs -- two jobs:

1 One is to answer the questions on
2 the verdict form that His Honor gives to
3 you. It might surprise you that you have
4 second job, but you do.

5 Your second job is to tell the
6 other jurors why you feel the way that you
7 do about how to answer the judge's
8 questions on the verdict form.

9 Now, I want to take a few minutes
10 just to give you an idea, some ideas about
11 how to do that. If anybody says that --
12 you heard a parade of witnesses who said
13 that what Dr. Rhett did was reasonable.
14 If anybody says 'I think what he did was
15 reasonable because they said so', just
16 remind them that Dr. Van Dorsten let the
17 secret out. They say it is reasonable if
18 it is not in the bottom four percent.
19 That's not what the judge's charge is
20 asking you. We are not asking you if this
21 guy is in the bottom four percent. We are
22 asking if his treatment to Jayden was below
23 average, and that's fifty percent.

24 You will hear -- we heard that Dr.
25 Rhett saved this child's life, that he had

1 to intervene, that it was an emergency. If
2 anybody raises that, just remind them that
3 he jumped in with that vacuum after only
4 eleven minutes of pushing. With a first-
5 time mom, it takes an hour or two. He
6 jumped in with the vacuum because that's
7 what he does.

8 In terms of informed consent. You
9 heard Mr. Hood. They've got no time, this
10 was an emergency. Well, he never gets an
11 informed consent. It's always an emergency
12 to him. Over fifty percent of the time,
13 over a thousand vacuum deliveries, he has
14 never warned a patient, he has never
15 explained why he felt a vacuum was
16 appropriate. He has never talked about
17 alternatives. There is plenty of time.

18 For a guy that does this as much
19 as Dr. Rhett does, there is plenty of time
20 to talk about risks and dangers and
21 alternatives long before you get to that
22 place where you claim all of a sudden there
23 is an emergency and I've got to come ride
24 to the rescue.,

25 Medicine is not about rescue.

1 Medicine is about good care ahead of time,
2 to avoid having to act under stress.

3 So if anybody says 'but he didn't
4 have time to warn this patient', tell them.
5 These doctors in Charleston County need to
6 find time. It's the law in South Carolina.
7 Patients are entitled to be heard about why
8 a recommendation is made, what are the
9 risks of the recommendation and what are
10 the alternatives to the recommendation.
11 You'll hear His Honor charge you that is
12 the law. Doctors here need to receive a
13 message. They need to find time to follow
14 the law.

15 ROBERT HOOD: Objection, Your
16 Honor.

17 THE COURT: Counsel, I am going
18 to overrule the objection.

19 EDWARD GRAHAM: You may hear
20 that it is okay to not follow the
21 manufacturer's instruction about not using
22 a cup for a midpelvis extraction. Doctors
23 are allowed to break the rules, doctors are
24 allowed to call rules "guidelines" and said
25 that we can not do the guidelines if we

1 don't want to. But if anybody raises that,
2 tell them. If you misuse a product you're
3 responsible for the harm that you cause.

4 If anybody says alcohol has any
5 relevance to this case, just remind them
6 that alcohol doesn't make the baby's brain
7 bleed.

8 If anybody says anything about
9 weak blood vessels, ask them or remind them
10 that this baby had three surgeries and
11 never had a bleed from them. The only time
12 that he had a problem was when that vacuum
13 sucked him out from the mid-pelvic station.

14 Now, let me just -- oh, one more
15 about genetics. If you hear anything about
16 genetics from any of your fellow jurors,
17 just remind them that even Dr. Milunsky,
18 who came up with all this genetic stuff
19 about what he might have learned, even Dr.
20 Milunsky admits that it was the vacuum that
21 made the brain bleed.

22 This courtroom is funded by the
23 citizens of Charleston County in support of
24 a community justice. You sit here with an
25 honor to uphold the community justice.

1 Everything that happens in this courthouse
2 is public record. It is such an important
3 role that you serve here, to be a juror in
4 a large case with the ability to make a
5 true difference.

6 ROBERT HOOD: Objection,
7 that's not proper.

8 THE COURT: Again, I am going to
9 overrule the objection. I believe the jury
10 has an understanding of what the role of
11 the jury is and the Court overrules the
12 objection.

13 EDWARD GRAHAM: Thank you,
14 Your Honor. When you get home after your
15 service in this case, if any friend of
16 family member asks you why you gave so much
17 money in this case, remind them where there
18 is great harm it must be balanced by an
19 appropriate amount of money. The money
20 must balance the harm. If anybody asks you
21 why you gave such money, remind them that
22 this child is permanently brain damaged
23 because of the actions of Dr. Rhett.

24 Reference was made -- I want to
25 run through some of the things that Mr.

1 Hood talked about and I don't have much
2 time, so I am going to move as fast as I
3 can. He criticized me for taking too much
4 time. I'm sorry. I've got a solemn duty
5 to work as hard as I can for my client.

6 There are some medical issues in
7 this case that we wanted to make sure that
8 you understood so that you can see the
9 truth in this case. You can see that this
10 doctor delivered substandard care and
11 that's what caused the damage.

12 If I took too much time, -- I know
13 it dragged at times -- then I apologize for
14 that. It's hard to balance trying to move
15 and trying to cover all the bases. To the
16 extent that I took up more time than you
17 believe that I should have, I apologize.
18 Please don't hold that against Jayden.

19 One thing that we heard from Mr.
20 Hood is that this baby's brain was
21 defective, that it had small blood vessels.
22 But you heard from the witnesses, even Dr.
23 Milunksy admits, that when you've got this
24 much blood leaking into a baby's brain that
25 it scrunches the brain tissues and pushes

1 it to the side. It compresses the blood
2 vessels. Both sides didn't say that this
3 child has congenitally malformed blood
4 vessels. They said that there is no flow
5 of the blood through the transverse sinus.
6 That is because there was so much blood
7 clotting in there that it jammed up the
8 works.

9 Now, I am appalled at what this
10 man said during his closing argument. He
11 said that Jayden W. 's brain was
12 like a stopped up toilet.

13 ROBERT HOOD: If the court
14 please, I object to counsel's conduct in
15 this courtroom. It's not civil.

16 THE COURT: Overruled, Counsel.

17 EDWARD GRAHAM: Like a stopped
18 up toilet. It was stopped up, with blood
19 -- because of what this man (indicating Dr.
20 Rhett) did. But how insensitive, how mean-
21 spirited for that man to call Jayden's
22 brain a stopped up toilet.

23 When I think about the -- when I
24 think about the theme of this case that we
25 started with, that they are trying to get a

1 lid on this conspiracy, silence to cover up
2 for the low end medical care in our
3 community and the dangers that causes, Mr.
4 Hood gave me a new twist on that. I say
5 that we blow the lid off of that conspiracy
6 with a large verdict that is responsive to
7 what you heard in this courtroom, not only
8 from the witnesses but also from Mr. Hood.

9 In addition to his other
10 deceptions, he also said, by pulling out an
11 ultrasound -- may we have the ultrasound,
12 by the way, is that still in the courtroom,
13 that we can show the jury the truth about
14 the ultrasound. Do you have it?

15 ROBERT HOOD: If the Court
16 please, I would love to talk to Counsel but
17 it's improper and -- he knows it's in
18 evidence.

19 THE COURT: The Court declines
20 to rule one way or another. Mr. Graham, if
21 you have a document or evidence that you
22 wish to show, you may do so.

23 EDWARD GRAHAM: With my time,
24 Your Honor, I don't think I'll look for it.

25 THE COURT: Very good.

1 EDWARD GRAHAM: Thank you, Your
2 Honor. You will recall that the testimony
3 of one radiologist, and there was only one
4 radiologist that testified in this
5 courtroom, Dr. Robert Zimmerman, one of the
6 top guys in the world if not the top guy.
7 Who else did you hear from about radiology?
8 One man. One man. Lawyer Hood, on
9 radiology, he can't get a radiologist to
10 come into this courtroom to support his
11 position so he pretend to be a radiologist
12 by holding up an ultrasound and saying,
13 'Look, there is no blood.' But we heard
14 from the expert.

15 Why is there no blood? Because
16 the blood is not really what ultrasounds
17 look at. An ultrasound is a transducer.
18 It looks in certain parts of the brain and
19 the blood wasn't there.

20 A CT scan followed, within hours,
21 that showed the blood.

22 An MRI followed the next morning
23 and it showed the blood, it shows so much
24 blood that the surgeons had to go in and
25 "unclog" what he calls the stopped up

1 toilet. They had to go in an cut through
2 the back of this child's brain, pull out
3 the clots and give the compression a chance
4 to go back.

5 Unfortunately the brain tissue is
6 dead, as you saw in the brain slices that
7 Dr. Zimmerman talked about.

8 We really -- they talked a lot
9 about standard of care because they want
10 you to think standard of care is a low bar.
11 They want you to think that there is a four
12 percent bar for the standard of care.

13 We've got two standards of care:

14 We've got the standard of care that His
15 Honor is going to tell you about, which is
16 average competent area, fifty percent
17 level.

18 We've got a different standard of
19 care which has only one reason for
20 existence, not to protect patients but to
21 protect doctors who claim that there are no
22 rules, who claim that guidelines don't
23 apply to them, who claim that there is no
24 reliable literature, 'don't judge me by
25 anything in writing', 'just judge me by

1 what my cronies say.'

2 They say that Jayden is going to
3 have Medicare for life. Well, Jayden has
4 two futures and it's up to you, Ladies and
5 Gentlemen, to decide whether he's got a
6 future painted in gray tones as a ward of
7 the State, getting paid by Medicaid and
8 government handouts, taxpayer money, or
9 whether he's going to have his needs taken
10 care of by the man whose negligence created
11 the needs.

12 We've got two visions of the
13 future for Jayden that your verdict will
14 dictate.

15 We also have two versions of
16 healthcare in our community that your
17 verdict will dictate. Acting as honor as a
18 juror in this case, your verdict will -- if
19 it is large enough, your verdict will be
20 heard and it can improve the conspiracy of
21 silence, it can raise the level for doctors
22 in Charleston County above the four percent
23 bar. You have the power to do so much good
24 in this case.

25 We hear again over and over about

1 clinical judgment, but remind anybody that
2 is focused on that that you can't apply
3 judgment that they do not have.

4 We hear about sympathy, as though
5 we are asking for sympathy. The time for
6 sympathy, as far as Jamsetta and Jayden are
7 concerned the time for sympathy has long
8 passed. They get sympathy, lots and lots.
9 We are not here asking for sympathy. We're
10 here asking for justice and we're asking
11 for money.

12 THE COURT: You have one minute.

13 EDWARD GRAHAM: Thank you, Your
14 Honor. A large verdict that speaks the
15 truth about what you've witnessed in this
16 courtroom.

17 There was reference to -- Mr. Hood
18 was making a plea for a mistrial. If
19 somebody is not willing to go along with an
20 unanimous verdict, hang tough and we will
21 be happy with a mistrial. Well, I guess he
22 would be happy with a mistrial but if
23 anybody is opposing the will of the other
24 jurors because they are not following His
25 Honor's charge on the law, remind them that

1 you took an oath, you must follow the law.
2 You can't take improper considerations into
3 account. You have to follow the law. If
4 they still refuse to follow the law, knock
5 on the door and tell the bailiff that
6 you've got to talk to the judge, 'We've got
7 a juror here who doesn't want to follow the
8 law, who wants to introduce considerations
9 that are not proper.'

10 THE COURT: Please make your
11 final comment.

12 EDWARD GRAHAM: Thank you. The
13 image that we saw about file number twelve
14 or whatever it was, if that had any
15 significance, don't you think Mr. Hood and
16 the defense team would have put that up
17 originally instead of saving it for final
18 argument. What is means is what Dr.
19 Zimmerman said it means, you've got blood
20 in all parts of the brain, squeezing the
21 brain to one side and clotting up the works
22 because of the blood clot.

23 THE COURT: That's ---

24 EDWARD GRAHAM: Thank you for
25 your attention. Thank you for letting your

1 verdict speak the truth, and award full
2 justice, coordinate (sic) full
3 responsibility on Dr. Rhett. Thank you.

4 THE COURT: All right, just one
5 moment, Ladies and Gentlemen. I will check
6 on the status of your lunch.

7 Tara, I need to adjust the
8 position of this microphone. Ladies and
9 Gentlemen, I just want to make sure -- can
10 you hear me. (Affirmative response from
11 jurors). George, if you would kindly
12 moving that podium here to the side, so
13 that it is not between the jury and the
14 court. Thank you.

15 Ladies and Gentlemen, what my
16 intentions would be -- it was my hope that
17 I would be able to give you this charge
18 before lunch arrives, but I may not be able
19 to complete it. If that happens, we will
20 stop at the time that lunch arrives and
21 pick back up and conclude the charge. I
22 don't like to split the charge but we will
23 just see how it occurs. It has not yet
24 arrived, thus we have a few minutes and I
25 don't want to spend those waiting on lunch

1 to arrive.

2 You will recall that at the
3 beginning of the case that I told you that
4 at the end of the case the last person that
5 you would hear from before you retired to
6 deliberate would be the Court giving you
7 the charge on the law. That's where we
8 find ourselves now.

9 I want to say to you before I
10 begin these specific comments about the law
11 that, as counsel as said, I want to express
12 my gratitude for your service, which I
13 really believe has been above and beyond
14 the call of duty in this case.

15 I sit logistically in the
16 courtroom, where I can look beyond counsel
17 or beyond the witness and observe the jury.
18 I do that throughout the trial. I try to
19 not make you feel that you are being stared
20 at, but I do gauge your comfort level,
21 focus or interest.

22 Every time that I have talked with
23 you and looked at you, just as I am now,
24 just as you are at me now, you are looking
25 back at me with close purpose and what I

1 call rapt attention. I appreciate that
2 level of interest. I know the parties do,
3 too. Because when you retire to deliberate
4 in a few moments, you'll be in a position
5 to do so because you have set aside your
6 busy lives, as we talked about on that
7 Monday so long ago and fully engaged in the
8 issues of this case. That's not an easy
9 thing to do, and again I am grateful for
10 it.

11 Now you've heard the evidence,
12 you've heard the arguments of counsel.
13 You will have all the exhibits back with
14 you in the courtroom (sic) when you retire
15 to deliberate.

16 Now I want to explain to you the
17 law that applies to this action. The
18 plaintiff claims that her son was injured
19 by the actions of the defendants. In
20 bringing the lawsuit, the plaintiff claims
21 that the defendants should compensate her
22 and her son for those injuries and those
23 damages. As you know, both defendants deny
24 those claims.

25 Now, in this case there are two

1 defendants. I want to talk to you about
2 that for a moment. A physician and a
3 medical practice professional association.
4 Understanding South Carolina law, a
5 professional association is liable for the
6 acts of its agents, servants or employees
7 while those agents, servants or employees
8 are acting within the scope of their
9 authority and in furtherance of their
10 duties.

11 Therefore, under South Carolina
12 law an employer is liable for the negligent
13 acts or omissions of its employees that are
14 within the scope of their employment and
15 which proximately cause injury to another
16 person. That's because the relationship of
17 employer and employee is created by a
18 contract, either express or implied, which
19 provides that the employee will act for the
20 employer at the employers request and
21 direction for the employer's benefit and
22 under the employers control. Thus, the
23 corporate employer, or the professional
24 association as an employer is responsible
25 under South Carolina law for the negligence

1 of its employee(s) without any requirement
2 of independent fault or act of negligence
3 on the part of the employer.

4 So at the close of this case, the
5 Court ruled that the interest and the
6 position of the defendants in this case are
7 really the same. Thus, your decision as to
8 Dr. Rhett will control your decision as to
9 Lowcountry Ob-Gyn. So, thus the reference
10 to "defendants" throughout this charge is
11 actually a reference to the actions of Dr.
12 Rhett with regard to the standard of care.

13 Now, under our Constitution and
14 Code of Laws, only you can make the
15 decisions of the finding of the facts in
16 this case. I am not permitted to tell you
17 how I feel about the facts of the care and
18 throughout the trial I've tried to remain
19 independent and not in any way give you an
20 inference that I have a position on the
21 facts. I will tell you now, as I said in
22 the beginning, I don't have a position on
23 the facts. If I did, I would be invading
24 your province. You're sitting over there
25 in the jury box, I am not. Thus, it is not

1 for the Court to have a position on the
2 facts. I've tried to be fair and impartial
3 throughout this trial towards all the
4 parties in this case.

5 I would say again -- and I am
6 going to go into this because it may be of
7 pivotal importance, if you find it to be.
8 That is, that as the fact finders in this
9 case you are going to have to determine the
10 credibility, the believability of the
11 witnesses. If you have witness that say
12 things that seem inconsistent or mutually
13 exclusive, and this includes lay witnesses
14 and expert witnesses. Again, as we were
15 talking when we first began this case, this
16 is something that you do every day. Every
17 time that you talk to someone, you gauge
18 them for credibility and believability.
19 You should employ those same factors that
20 you employ in everyday life here in the
21 courtroom, but you also may wish to employ
22 the following factors:

23 What was the manner and appearance
24 of a witness while they testified?

25 How is it that they came to know

1 what it is that they're in here testifying
2 about?

3 Was the testimony of that witness
4 consistent, even with itself?

5 And, was it weakened or
6 strengthened by other evidence in the case?

7 Further, in light of the global
8 evidence in the case, as now you have heard
9 and as you have determined to be, how
10 reasonable is what that witness is saying.

11 And in light of an expert's
12 testimony, what is the basis of their
13 opinion? What is their ability to know
14 what they came in and gave any opinion
15 about?

16 Then, finally, is there some
17 reason that a witness would want to help or
18 hurt one side of the case by some bias or
19 prejudice?

20 In deciding the facts of the case,
21 I will tell you now that you, as the jury,
22 can believe as much or as little of any
23 witness' testimony that you think proper.
24 You can believe one witness against a whole
25 group of witnesses or you can do just the

1 opposite. You may believe part of what a
2 witness says and completely disbelieve the
3 rest.

4 I will anything to to you that
5 throughout the process that you have had
6 but one objective and that is to search for
7 and find the truth, regardless from which
8 witness or which side of this case it may
9 come.

10 Now, furthermore, when you are
11 considering the evidence, you must consider
12 as evidence any statement made by counsel
13 during the trial. This includes any
14 statement or opinion that may be contained
15 within a question that is directed to a
16 witness as well as a statement being
17 expressed in opening or closing arguments.

18 Now, I will say that if counsel
19 has stipulated to some fact during the
20 course of this trial that you should accept
21 that fact as being in evidence, as being a
22 fact. You should regard that fact as being
23 conclusively proved.

24 But as to any questions to which
25 there was an objection raised and

1 sustained, you must not speculate as to
2 what that answer might have been or the
3 reason for the objection. You must not
4 consider for any purpose any offer of
5 evidence that was rejected or any evidence
6 stricken by the court. The subject matter
7 is to be treated as though you'd never
8 known about it.

9 You must never speculate to be
10 true any insinuation that may be suggested
11 by a question asked the witness because a
12 question is not evidence and may be
13 considered only as it supplies the meaning
14 of an answer.

15 Now, I further charge you as the
16 jury that you must decide the issues in
17 this case solely upon the evidence that
18 you've heard during the course of this
19 trial. Your verdict must be without bias
20 and without prejudice to any party and
21 without comment by some third party.
22 That's why I've asked you every day about
23 whether you've had a discussion of the
24 facts. You cannot allow yourself, and this
25 Court cannot allow itself, to be governed

1 by sympathy, by prejudice, by passion,
2 public opinion or some other consideration
3 that has not been contained in the
4 evidence.

5 Now, you also heard the testimony
6 of several witnesses who have special
7 knowledge or skill, experience, training or
8 education in a particular field and they
9 came in and gave their opinion as an expert
10 witness about matters in which they are
11 skilled. In determining the weight to be
12 given any expert opinion, you should
13 consider the qualifications and the
14 credibility of the experts and the reasons
15 they give, the basis that they give for
16 their opinions. You are not bound by those
17 opinions. You should give them what
18 weight, if any, you deem that they are
19 entitled to.

20 In this case, if you find that
21 there has been a conflict in the testimony
22 of expert witnesses, then you must weigh
23 one opinion against the other. You must
24 consider the reasons given by one as
25 compared with those given by the other.

1 You should consider the relative
2 credibility and knowledge of the particular
3 expert who testified and therefore find in
4 favor of that expert testimony that, in
5 your opinion, is entitled to the greater
6 weight.

7 When a plaintiff relies upon
8 expert medical testimony to show a causal
9 connection between an incident of alleged
10 medical negligence and a subsequent result,
11 the medical expert must testify that it is
12 his or her professional opinion, based upon
13 a reasonable degree of certainty within his
14 or her profession that the result in
15 question most probably or most likely came
16 from the cause alleged.

17 It is not necessary that a medical
18 expert testify as to the exact cause of the
19 result, it is sufficient if the ultimate
20 outcome most probably or most likely
21 resulted from the alleged medical
22 negligence.

23 A plaintiff carries her burden of
24 proof when she shows that the defendant's
25 negligence most probably or most likely

1 caused her injuries or damages.

2 However, proof of causation cannot
3 rest in conjecture. The mere possibility
4 of such causation is not enough to sustain
5 a plaintiff's burden of proof. In that
6 case, you should find for the defendants.

7 I will tell you that in a medical
8 negligence claim, medical expert testimony
9 is necessary on the following issues:

10 One, to establish the generally
11 recognized and accepted practices and
12 procedures which would be followed by an
13 average competent practitioner in
14 defendant's field of medicine under the
15 same or similar circumstances.

16 Two, to establish that the
17 defendants departed from the recognized and
18 generally-accepted standard.

19 Three, to establish that the
20 defendant's departure from such generally
21 recognized practices and procedures, if
22 any, were a proximate cause of plaintiff's
23 alleged injuries and damages. That word
24 again was proximate, not approximate.
25 Proximate. We'll talk about that in just a

1 moment.

2 Certain testimony was presented in
3 this court by deposition. Deposition
4 testimony is taken under oath, outside the
5 courtroom, a proceeding before trial, and
6 preserved in writing or by mechanical
7 means, such a video or audio. You should
8 consider that testimony as if it were given
9 here in court as it is given under
10 circumstances and requirements that are the
11 same as they are here in the courtroom.

12 Now, there are two kinds of
13 evidences in cases such as these. Evidence
14 may be direct or it may be circumstantial.

15 Direct evidence is testimony of a
16 witness about what that witness personally
17 saw, heard or did; such as eyewitness
18 testimony.

19 Circumstantial evidence, on the
20 other hand, is indirect. It is proved by a
21 set or a chain of facts that indicate the
22 existence of yet another fact.

23 I tell you that in your delibera-
24 tions you're to consider all the evidence,
25 both direct and circumstantial. The law

1 permits you to give equal weight to both.
2 It is for you to decide how much weight to
3 give any of it. There is no greater degree
4 of one required over the other, you should
5 consider all the evidence in your
6 deliberations.

7 It is also a well recognized rule
8 in our court that an issue may be proved by
9 circumstantial evidence. But, for
10 circumstantial evidence to be sufficient to
11 warrant the finding of a fact, the
12 circumstances must lead to the conclusion
13 with reasonable certainty and must have
14 sufficient probative value to constitute
15 the basis for a legal inference and not
16 mere speculation.

17 The facts and circumstances shown
18 should be reckoned within the light of
19 ordinary experience and such conclusions
20 deduced therefore as common sense
21 indicates.

22 Tara, tell me when lunch arrives
23 please. It has not arrived yet?

24 CLERK: No, sir.

25 THE COURT: Very good. Now,

1 let's move forward and let's talk about the
2 law in this case.

3 Let me first of all say to you
4 that the same Constitution and laws that
5 make you the finders of the facts makes me
6 the judge of the law in the courtroom. As
7 I said to you when we began the case, you
8 decide the fact, I give you the law and,
9 working together, that's how we reach a
10 verdict.

11 Let me say to you that living in a
12 small town as I do, just being out on the
13 street, I know that there is a bad
14 information about what the law is on any
15 particular given subject out there on the
16 street. So I want you to set aside what
17 you may believe the law may be while we are
18 here in the courtroom and also to set aside
19 what you may believe may be a better idea.
20 It's not for you nor I to decide what might
21 be a better idea, it's simply our job to
22 decide -- to accept the law as I give it to
23 you and you apply it the facts that you
24 find. In doing that, you will reach a
25 verdict which is just and true.

1 Let's talk about that for a
2 moment. If I give you the law incorrectly
3 -- and let me just simply say about this
4 charge, that I have gone over it with the
5 attorneys and I am not giving it to you
6 incorrectly, but if I did, well, that error
7 would be preserved to be reviewed another
8 day an another time when that would be
9 considered and corrected, if necessary.
10 But I am not giving you the law
11 incorrectly. Accept it as I give it to you
12 here and apply it to the facts that you
13 find. If you do that, then you are going
14 to reach a verdict that is just and fair.

15 All right. Now, I think, Counsel,
16 because I am sort of at a stopping point
17 that this is a good time -- before I go
18 into the specifics of the law on medical
19 malpractice that we will stop, let you have
20 your lunch, come back, finish the charge
21 and then we will allow you to retire and
22 deliberation. Just enjoy your lunch. When
23 you are finished, we will come back in and
24 resume. I suspect probably about 1:30.

25 (JURY OUT @ 12:52 P.M.)

1 THE COURT: Ladies and
2 Gentlemen, we will be in recess until 1:30.

3 ROBERT HOOD: Your Honor,
4 since the jury is out. The oath of
5 civility that lawyers states, (reading):

6 *"To the opposing parties and their*
7 *counsel, I pledge fairness, integrity and*
8 *civility not only in court but also in all*
9 *written and oral communications."*

10 I move for a mistrial. Counsel
11 screamed at me, pointed his finger at me,
12 came across the courtroom, within a very
13 few feet of me screaming. Out of control,
14 I guess. I don't know what's wrong with
15 him. But it's not civil what he did. It
16 deserves a mistrial and the cost of my
17 witnesses coming to this trial and the
18 preparation of this trial should be borne
19 by him.

20 THE COURT: Mr. Hood, I am going
21 to respectfully deny your Motion for a
22 mistrial.

23 ROBERT HOOD: Thank you, Your
24 Honor.

25 THE COURT: I am going to do so

1 with the following comment. I felt that
2 you opened the door on that issue, Mr.
3 Hood. I am not saying that what came back
4 to you was responsive but in your closing
5 you challenged Mr. Graham, by looking
6 directly at him, about his conduct during
7 depositions and the way in which he
8 purported to quiz the physician, Dr. Rhett,
9 during depositions. Looking the entire
10 time at Mr. Graham.

11 I simply find that there's been a
12 lot of dynamics in this trial. While I
13 recognize that it is somewhat theatrics,
14 somewhat argument in tone as opposed to an
15 argument on the issues, uh, the court does
16 not find what happened to be warranting a
17 mistrial, and I would decline.

18 ROBERT HOOD: I do think the
19 Court, and Your Honor, knows that through-
20 out the discovery process that counsel
21 conducted himself in a noncivil fashion, to
22 the point that we finally had to come to
23 the Court. We got an Order from Judge
24 Dennis requiring counsel to conduct himself
25 civilly. That's what I was referring to.

1 His examination of Dr. Rhett for five hours
2 was intolerable and I think it stands on
3 its own for what he did. I think this jury
4 saw it and I think that they are just as
5 upset about it as I am.

6 THE COURT: Well, then,
7 ultimately -- and another reason that I
8 don't give you relief is this all goes into
9 the decision of the jury, with the posture
10 of the parties and the position of the
11 case, I think it goes to credibility and
12 believability. For all these reasons the
13 Court denies the Motion for a mistrial and
14 wishes the both of you, separately, a happy
15 and pleasant lunch.

16 EDWARD GRAHAM: Thank you, Your
17 Honor.

18
19 MARY WATERS: Your Honor, we
20 still have that matter of evidence for the
21 record whenever you ---

22 THE COURT: Why don't I came
23 back about five minutes early and we will
24 take that up then.

25 MARY WATERS: Yes, sir.

1 JAY DAVIS: Your Honor, one
2 matter. Dr. Osborne has a matter requiring
3 his ---

4 THE COURT: Absolutely. Good
5 luck to you, sir.

6 (LUNCH RECESS)

7 THE COURT: You needed to put
8 something the record? What is your
9 position?

10 MARY WATERS: Your Honor, I
11 think that it will just take a minute for
12 you to look at it.

13 THE COURT: All right -- we can
14 just go off the record.

15 (OFF RECORD DISCUSSION RE EXHIBITS)

16 THE COURT: There is an
17 objection from the defendants on the
18 Medicaid bill. That objection is noted
19 and I am going to overrule it.

20 MOLLY CRAIG: If I may put on
21 the record our objection to the Medicaid.
22 The basis was that since they've injected
23 Medicaid into this trial, they should only
24 consider the amount paid.

25 THE COURT: As we were

1 discussing yesterday, I believe that it was
2 the *Davis* case, that it's for the jury to
3 determine the amount, the reasonable value
4 of the bill which may be the Medicaid value
5 or it may be the value of the charges or
6 basically somewhere inbetween. So those
7 reasons, I am letting it in. Thank you.

8 (OFF RECORD DISCUSSION RE EXHIBITS)

9 THE COURT: Bring in the jury.

10 (JURY IN @ 1:48 P.M.)

11 THE COURT: Welcome back, Ladies
12 and Gentlemen. We were a little bit
13 delayed beyond 1:30 and the reason that we
14 were is that we spent a good portion of our
15 time here making sure that we have all the
16 exhibits in order, ready to go back to you.
17 They are somewhat voluminous, as you can
18 see sitting in front of you. So at the
19 conclusion of these remarks, we will send
20 that back to you.

21 All right, before the lunch hour
22 I had talked to you about some preliminary
23 issues. The final thing that I had
24 mentioned to you is that you should accept
25 the law as I give it to you and apply it to

1 the facts as you find them.

2 Now let's discuss the specifics
3 of the allegations in this case. The
4 plaintiff claims that the defendants
5 committed medical malpractice, or
6 professional negligence.

7 Malpractice is the failure to
8 treat a patient following good and accepted
9 medical practice, resulting in harm to the
10 patient. It is a form of carelessness or
11 negligence.

12 The defendants deny the plain-
13 tiff's claim, of course, as you are aware
14 from observing the trial, and assert that
15 they have complied with the standard of
16 care and, thus, the issues are joined for
17 trial.

18 Now, in order to recover for
19 medical malpractice, the plaintiff must
20 first shown by a preponderance or the
21 greater weight of the evidence what was the
22 standard of care that the defendants owed
23 the plaintiff in treating the plaintiff.

24 When a doctor treats a patient,
25 the law does not require absolutely

1 accuracy either in practice or in decision-
2 making. The law does not hold the doctor a
3 standard of perfection. It does not even
4 require the highest degree of care and
5 skill of which the human mind is capable.

6 The law does require that the
7 doctor use that degree or knowledge, care
8 and skill ordinarily used by doctors in
9 good standing under the same or similar
10 circumstances and that the doctor follow
11 the generally-accepted practices and
12 procedures in the profession.

13 The degree of skill and care that
14 a doctor must use is that which would be
15 used by a competent doctor in the
16 defendant's field of medicine and not that
17 which would be exercised by the profession
18 in general.

19 A doctor must use reasonable care
20 and diligence in using his skill and
21 applying his knowledge. What is reasonable
22 care, skill and diligence depends largely
23 on the circumstances of the particular case
24 taking into account the risks and dangers
25 to be apprehended and guarded against in

1 the particular case and, therefore, such
2 care and attention must be given as are
3 required by the circumstances of the
4 particular case.

5 The question of whether a
6 physician in making a diagnosis deviated
7 from the applicable standard of care either
8 by not employing a particular procedure or
9 by not ordering a particular test is to be
10 determined by what an ordinary, careful and
11 prudent physician would have done under the
12 same or similar circumstances.

13 A physician who holds himself out
14 to be a specialist is bound to bring to the
15 discharge of his professional duties as a
16 specialist that degree of skill, care and
17 learning ordinarily possessed by specialist
18 of a similar class under the same or
19 similar circumstances. Accordingly, one
20 who holds himself out as a specialist, who
21 undertakes a service in a special branch of
22 medical science, owes his patient the duty
23 of possessing that degree of learning and
24 skill ordinarily possessed by a specialist
25 of good standing.

1 Physicians have a duty to keep
2 reasonably abreast of current advances in
3 their field.

4 The law recognizes that medical
5 service is a progressive science. In
6 determining the degree of care and skill
7 which the law exacts of physicians, regard
8 must be had to the state of the advancement
9 of the profession at the time of the
10 treatment. Treatment is to be measured by the
11 standards existing at the time in question.

12 So first the plaintiff must prove
13 what is the standard of care and next the
14 plaintiff must prove that the defendant
15 negligently departed from the standard of
16 care in treating the plaintiff.

17 Negligence is the failure to do
18 what an ordinarily careful doctor who have
19 under the same or similar circumstances or
20 doing something that an ordinarily careful
21 doctor would not have done under the same
22 or similar circumstances, or both.

23 A doctor's duty in treating a
24 patient is to be measured by both the
25 doctor's skill and diligence. If by the

1 lack of required skill you find that the
2 defendant failed to properly treat the
3 patient so that the patient is injured or
4 damaged as a result, then the defendant
5 would be responsible for any injury
6 proximately caused to the patient.

7 Defendant would also be
8 responsible if, having the required skill,
9 the defendant negligently fails to use it
10 or is not as careful and diligent in the
11 treatment of the patient as he should be.

12 A doctor is not an insurer of a
13 cure or even of a positive result.
14 Therefore, the mere fact that a treatment
15 does not benefit a patient or that it even
16 harms the patient does not, in and of
17 itself, mean that the defendant doctor was
18 negligent. A bad result, injury or failure
19 to cure is not by itself enough to show
20 that the defendant was negligent.

21 If you find that the defendant
22 used due care and skill in treating the
23 patient and followed generally recognized
24 practices and procedures and, despite this,
25 the patient suffered damage, injuries or

1 death, you should return a verdict for the
2 defendant in those circumstances.

3 Now, similarly, a doctor's
4 mistaken or error in making a decision
5 alone does not constitute negligence.

6 If, however, a doctor failed
7 to gather information reasonably available
8 that a reasonable doctor would have
9 gathered before making a decision, the
10 doctor fails to comply with the recognized
11 standard of medical care that would be
12 exercised by a similar doctor under similar
13 circumstances.

14 The difficulties and uncertainties
15 in the practice of medicine and the
16 unpredictable variations in the response
17 to treatment are such that no doctor can
18 guarantee results.

19 Where there is more than one
20 recognized diagnosis or treatment and no
21 one of them is used exclusively and
22 uniformly by all doctors in good standing,
23 it is not negligence for a doctor, in
24 making a decision, to choose one of the
25 approved methods, even when the choice

1 later turns out to be a wrong selection.

2 Qualified doctors and experts may
3 differ as to what constitutes the best
4 course of treatment and these differences
5 do not amount to malpractice in and of
6 themselves. Where doctors in good standing
7 disagree or when medical authorities are
8 divided with regard to a specific course of
9 treatment or care, then the doctor is bound
10 only to exercise his best judgment in
11 determining which course on the whole is
12 best for the patient.

13 Just because another doctor might
14 have used a different course of treatment
15 does not make the defendant negligent.

16 However, if a doctor does not have
17 the degree of learning and skill required,
18 or if the doctor does not use the care
19 required, it is no defense to a charge of
20 negligence that the doctor did the best
21 that he or she could.

22 Now, in considering whether the
23 defendant made a reasonable decision, you
24 must consider the decision in relation to
25 the facts as they existed at the time and

1 not in light of what hindsight may reveal.

2 Now, let's talk about proximate
3 cause. Finally, the plaintiff must prove
4 what is the standard of care, that there
5 was a breach of a deviation of the
6 standard, and the plaintiff must prove what
7 we call "proximate cause".

8 Plaintiff must prove that the
9 defendant's negligence proximately caused
10 plaintiff damage. Again, that word is
11 proximate.

12 Proximate cause is something that
13 produces a natural chain of events that, in
14 the end, brings about injury. It is the
15 direct cause of the injury.

16 To prove that the defendant's
17 negligence proximately caused the
18 plaintiff's injuries the plaintiff must
19 first prove what we call causation in fact.
20 This is proven by showing that the injury
21 would not have occurred but for the
22 defendant's negligence.

23 The plaintiff must also prove what
24 we call legal cause. Legal cause is proven
25 by showing that the injury was foreseeable.

1 This means that the injury occurs as a
2 natural and probable consequence of the
3 defendant's negligence. The plaintiff must
4 prove that some injury from the defendant's
5 negligence was foreseeable, but does not
6 have to prove that the particular injury
7 that occurred was foreseeable. However,
8 the defendant cannot be held responsible
9 for something which could not be expected
10 to happen.

11 Sometimes a defendant's negligence
12 will combine with other forces, such as
13 acts of nature, to bring about a result.
14 The law does not require that a defendant's
15 negligence be the only cause or the sole
16 cause of an injury. A defendant must
17 compensate a plaintiff if one or more of
18 his negligent acts or omissions was an
19 efficient cause of the injury and, combined
20 with other efficient causes in such a way
21 that had there been no negligent act or
22 omissions the injury would not have
23 resulted or would not have been as severe.

24 Proximate cause does not mean the
25 only cause or the sole cause of a

1 condition. The defendant's act can be a
2 proximate cause of the plaintiff's injury
3 if it was at least one of the direct,
4 concurring causes of the injury.

5 Now, let's talk about informed
6 consent. A doctor has the duty to inform
7 a patient of the known risk or dangers of
8 the treatment or procedure that the doctor
9 proposes so that the patient will be able
10 to make an intelligent decision as to
11 whether to follow the doctor's proposed
12 treatment.

13 The basis of the doctrine of
14 informed consent is the patient's right to
15 exercise control over his or her own body
16 by deciding intelligently for herself
17 whether or not to submit to the particular
18 procedure.

19 In the absence of an emergency
20 that requires immediately treatment, the
21 doctor must tell the patient of

22 One, the diagnosis.

23 Two, the general nature of any
24 proposed procedure and the course of
25 treatment.

1 Three, the material risks involved
2 in the course of treatment.

3 Four, the probability of success
4 associated with the course of treatment.

5 Five, the prognosis if a
6 particular procedure is not done or course
7 of treatment not followed.

8 Six, the existence of any
9 alternatives to the procedure or course of
10 treatment.

11 The risks that a doctor has to
12 disclose are those risks that are material
13 to the proposed course of treatment. A
14 risk is "material" is a reasonable person
15 in the patient's position would find it
16 significant in deciding whether or not to
17 have the proposed treatment or procedure.

18 If the possible injury greatly
19 outweighs the possible benefit to be gained
20 from the procedure or course of treatment,
21 this might be a material and significant
22 factor that the patient would be entitled
23 to know before giving consent to the
24 procedure or course of treatment.

25 As the probability of severity of

1 the risks to the patient increase, the duty
2 of the doctor to tell the patient of the
3 risks increases.

4 The doctor must tell the patient
5 of those risks that an average competent
6 doctor with similar training in the same
7 branch of medicine would tell a patient of
8 under the same or similar circumstances.

9 In determining whether and how
10 much to tell the patient, the doctor must
11 consider what effect the information may
12 have on the patient considering the
13 patient's psychological, emotional and
14 physical condition.

15 Where the doctor reasonably
16 believes that a complete and truthful
17 disclosure of the possible risks might have
18 a detrimental effect on the physical or
19 psychological well-being of the patient,
20 the doctor is not required to disclose the
21 risks.

22 In addition, the doctor must
23 evaluate how great the risk is, how often
24 it happens and the feasibility of
25 alternative treatment. A doctor is not

1 ordinarily required to disclose a risk to a
2 patient where the risk is small and remote.

3 In order to prove that the
4 defendant's failure to inform was the
5 proximate cause of the patient's injury,
6 the plaintiff must prove that a reasonable
7 person in the patient's position would have
8 refused the course of treatment had the
9 doctor informed the person of the risks
10 that resulted in the patient's injury, not
11 simply that the patient would have refused
12 the treatment.

13 Now, let's talk about emergency
14 situations. However, informed consent is
15 not required in an emergency situation
16 because consent to a serious emergency
17 operation may be implied. Therefore, under
18 this ruling it is for you to decide whether
19 a medical emergency existed at the time of
20 the vacuum procedure requiring immediate
21 treatment and overriding the need to obtain
22 informed consent.

23 At the close of the evidence in
24 this case, the Court ruled that the
25 document entitled Consent for Admission and

1 Treatment, entered into evidence as Exhibit
2 2-004, does not provide informed consent
3 for a vacuum extraction delivery. This
4 does not mean that the issue of informed
5 consent in this case must be decided in
6 favor of the plaintiff, but simply means
7 that Exhibit 2-004, alone and by itself,
8 does not meet the requirements of South
9 Carolina law with regard to informed
10 consent and the vacuum extraction delivery
11 in this case.

12 We just talked about what the
13 plaintiff needs to prove. Now let's talk
14 about the defenses.

15 In their Answer to the plaintiff's
16 Complaint, the defendants have set forth
17 what are called defenses.

18 The defendants' first defense is
19 what is called a qualified general denial.

20 By this defense, defendants admit the
21 truthfulness of the fact that the
22 defendants treated Jamsetta and Jayden
23 We but deny all claims that would
24 make those defendants responsible for the
25 plaintiff's injuries and/or damages.

1 In this case, the defendants have
2 also alleged that the plaintiff had a
3 genetic condition that preexisted this
4 birth.

5 A person who has a physical or
6 mental condition or disability existing
7 at the time of injury is not entitled to
8 recover damages for such condition.
9 However, the person is entitled to recover
10 damages for an aggravation, enhancement or
11 making worse of such condition proximately
12 resulting from the injury caused by the
13 defendants. This is true even if the
14 person's condition or disability made him
15 more susceptible to injury and even if a
16 normally healthy person would not have
17 suffered any substantial injury. The
18 defendants take the plaintiff as they find
19 him, whether the plaintiff is in perfect
20 health, poor health or somewhere inbetween.
21 The liability of the defendants is
22 not lessened or affected in any way because
23 the injuries from the incident would not
24 have happened, or would to have been as
25 severe or would not have been as hard to

1 treat or care for if the plaintiff had been
2 in some other condition of health or in
3 better health at the time the incident
4 occurred.

5 In other words, if the presence
6 of a pre-existing injury or condition
7 aggravates or prolongs the injury and,
8 thus, increases the damages, the plaintiff
9 should be compensated for those increased
10 or additional damages.

11 Where a preexisting disability or
12 condition is so aggravated, the plaintiff
13 is entitled to recover and the defendant is
14 liable only for those injuries that were
15 caused by the aggravation and not for the
16 injuries that resulted from the original
17 condition. A defendant is only liable for
18 the worsening of the condition, not for the
19 condition itself or for the its natural
20 worsening.

21 The defendant cannot invoke a
22 preexisting condition of the person injured
23 for the purpose of escaping the
24 consequences of its own negligence or
25 reducing the damages for which it is

1 liable.

2 Let's talk a little bit about the
3 burden of proof. Ladies and Gentlemen of
4 the jury, the mere fact that a bad result
5 occurred, standing alone, does not permit
6 you, the jury, to automatically conclude
7 that plaintiff's claimed damages were
8 proximately caused by defendants' actions.

9 Negligence on the part of
10 physician is not presumed but must be
11 affirmatively proven. Thus, the plaintiffs
12 have the burden of proving the failure to
13 exercise due care and skill on the part of
14 the doctor. The plaintiffs must meet this
15 burden of proving their claims by what we
16 call the preponderance of the evidence or
17 the greater weight of the evidence.

18 Let's talk about that a little
19 bit. The preponderance of the evidence
20 means that the facts sought to be proved
21 are more likely so than not. Very simply.
22 The preponderance of the evidence means
23 that the facts sought to be proved as more
24 likely true than not.

25 So, what do we mean by the

1 greater weight of the evidence? Simply
2 this, in your mind's eye you can probably
3 see the statue of Justice. She is
4 blindfolded and in her hand she has a set
5 of scales.

6 When the case began, the scales were
7 even.

8 Now we are at the end of the case and
9 if after all the evidence has been
10 presented, if the scales should remain even
11 or if they should tip, ever so slightly, in
12 favor of a particular defendant, then the
13 plaintiffs will have failed to meet their
14 burden of proof and your verdict should be
15 for the defendant.

16 If, on the other hand, the scales
17 should tip ever so slightly in favor of the
18 plaintiff, then they will have met their
19 burden of proof as to that particular
20 defendant and your verdict should be for
21 the plaintiff in some extent for damages,
22 if you find that the plaintiff meets the
23 burden of proof on damages as well.

24 Of course, I've been back in your
25 jury room and there is not a set of scales

1 in there so weigh the evidence. I know you
2 know that, because there is no way to weigh
3 evidence except through the exercise of
4 your good common sense and judgment. It is
5 entirely a mental process. The evidence
6 you should give the most weight to is that
7 which convinces you of its truth, regard-
8 less of the source from which it comes.

9 Should you determine that the
10 plaintiff is entitled to recovery against
11 any of the defendants, your next step is to
12 determine the amount of that recovery. We
13 call that actual damages.

14 This case is not about punitive
15 damages. It is an actual damages case
16 only.

17 In this case the plaintiff has
18 requested actual damages. Actual damages
19 are intended to compensate the injured
20 party, that is to put them in as near as
21 possible the same position that they were
22 in before the injury occurred, as best as
23 this is possible through monetary damages.

24 In other words, actual damages
25 would be the actual losses, expenses and

1 harm that the plaintiff suffered because of
2 the defendant's actions.

3 In determining the amount of
4 compensation to be awarded for injuries
5 suffered by the plaintiff as a result of
6 the defendants actionable conduct, if you
7 find that the plaintiff is entitled to
8 damages, it is proper for you to consider,
9 should you find it applicable from the
10 facts the following areas of damages:

11 Medical expenses, including
12 physicians, hospital, medicines, physical
13 therapy expenses, rehabilitation expenses
14 and transportation expenses connected with
15 medical treatment.

16 Permanent disability and
17 impairment.

18 Loss or impairment of earning
19 capacity.

20 Out-of-pocket expenses.

21 Any future damages resulting from
22 permanent injuries.

23 Disfigurement.

24 Loss of family services.

25 Alteration of lifestyle.

1 Mental anguish.

2 Anxiety.

3 Emotional or psychological injury.

4 Pain and suffering.

5 Loss of enjoyment of life.

6 Those are in no particular order

7 but those are areas of damages that you may

8 consider if you find it appropriate from

9 the evidence.

10 As with all other claims in this

11 case, plaintiff must prove her actual

12 damages claim by the greater weight of the

13 evidence. We just discussed the burden of

14 proof.

15 An award of damages in this case

16 cannot be based upon sympathy, passion,

17 prejudice, emotion or some other

18 consideration not found in the evidence.

19 Now, let's talk about some of

20 these specific areas of damages.

21 Medical expenses. The measure of

22 damages for medical expenses consists of

23 all reasonable expenses necessarily

24 incurred for doctors and medical bills that

25 were proximately caused by defendant's

1 negligence. Recovery for medical expenses
2 is controlled by that services rendered
3 were reasonably and now what was actually
4 paid or contracted to be paid. While the
5 amount actually charged and incurred may
6 considered by you, you are not bound by
7 that amount. You must find only such sum
8 as is reasonable and necessary.

9 We have a discussion in this case
10 about Medicaid. Let's talk about that. A
11 person who is eligible for Medicaid may
12 have a portion of his medical bills paid
13 through Medicaid. You will note in this
14 case that the plaintiff has presented
15 medical bills, some of which had been paid.
16 This is because, under South Carolina law,
17 the defendant is not allowed to take
18 advantage -- let me back up. I probably
19 didn't say that right. You noted that the
20 plaintiff has presented medical bills, some
21 of which had been paid. The reason that
22 they are able to present them to you in
23 that fashion is because under South
24 Carolina law the defendant is not allowed
25 to take advantage of receive some benefit

1 from a collateral source if the plaintiff
2 was so fortunate as to have health
3 insurance or Medicaid coverage.

4 The reason for this rule is that
5 when a plaintiff is awarded monetary
6 damages for medical bills that had been
7 paid by some form of medical coverage, then
8 that coverage provider has a right to be
9 reimbursed for any payments it has made.
10 This is a legal process we call
11 subrogation, thus the jury is required to
12 treat those bills as if they have not been
13 paid. The value of those medical services
14 is for you to determine.

15 Let's talk about of loss of
16 earning capacity. The loss of impairment
17 of earning capacity caused by personal
18 injury is a proper element of compensation
19 if you find it appropriate.

20 Earning capacity refers to the
21 capacity of a person to sell his labor or
22 services in any hat is market reasonably
23 accessible to him, taking into
24 consideration his general physical
25 functional impairments resulting from acts

1 and conduct of the defendant.

2 Earning capacity does not
3 necessarily mean the actual earnings that
4 one who suffers an injury was making at the
5 time the injuries were sustained but refers
6 to that which, by virtue of the training,
7 experience and business acumen possessed an
8 individual is capable of earning.

9 Loss of earning capacity refers to
10 damage to one's ability to earn wages in
11 the future.

12 In determining the amount of
13 compensation due to the plaintiff for loss
14 or impairment of earning capacity, you
15 shall consider:

16 Loss of future earning power,
17 which requires a consideration of all
18 matters that relate to the issue of any
19 impairment.

20 The effect which the impairment
21 will have on the plaintiff's capacity to
22 work.

23 The extent to which the disability
24 will impair the plaintiff's earning
25 capacity.

1 The present value of all losses
2 due to plaintiff's impaired earning power
3 and such physical pain and suffering as
4 reasonably certainly will, of necessity,
5 result in the future from the injuries to
6 the plaintiff.

7 Evidence of what the plaintiff had
8 previously earned when employed in the past
9 is a factor upon which you may base any
10 loss or impairment of earning capacity. It
11 is not required that plaintiff be employed
12 at the time of the injury in order to
13 recover for a loss of earning capacity.
14 Remember, this is not lost wages but loss
15 of earning capacity.

16 In determining the amount to be
17 awarded for impaired earning capacity, you
18 should consider the health of the injured
19 party and his mental and physical ability
20 to maintain himself before the injury as
21 compared with his condition in these
22 respects afterward.

23 The extent of impairment of
24 earning capacity is to be arrived at by
25 comparing what an injured party was capable

1 of earning at or before the time of the
2 injury with what he was capable of earning
3 after it occurred.

4 If the plaintiff's injury or
5 impaired loss of earning capacity or
6 permanent, recovery for the lost or
7 impaired earning capacity should be granted
8 for the plaintiff's life expectancy.

9 In awarding damages for loss or
10 impairment of earning capacity, the law
11 provides that a person who is injured may
12 recover for the loss or diminution of his
13 earning capacity during his entire
14 expectancy of life and is entitled to such
15 amount as will compensated him for his
16 loss.

17 Therefore, if you determined the
18 plaintiff is entitled to damages for
19 impairment or loss of earning capacity,
20 then you shall calculate such damages using
21 the South Carolina life expectancy table as
22 a guide. I will talk to you about that in
23 just a moment.

24 Now, let's talk about future
25 damages. A plaintiff cannot recover

1 conjectural or speculative damages.

2 However if you find that plaintiff is
3 entitled to a verdict for actual damages,
4 your verdict should include an amount to
5 cover any damages that the evidence shows
6 will be reasonably certain to occur in the
7 future. Future damages need not be proved
8 to a mathematical certainty and often must
9 be approximated. These future damages must
10 be the result of the defendant's
11 negligence. Any future damages that you
12 award must be reduced to their present day
13 value.

14 The reason for allowing future
15 damages, if you find them appropriate, is
16 because the plaintiff may bring only one
17 claim, one cause of action, arising over
18 any one particular injury.

19 Now, about pain and suffering.
20 Pain and suffering is recognized by the
21 courts of this state as a material element
22 of damages on which a recovery may be
23 bottomed. Pain and suffering is recognized
24 as a separate kind of damage and is
25 separate and distinct from loss of

1 enjoyment of life, medical expenses or such
2 other applicable damages that I've just
3 talked to you about.

4 Damages for pain and suffering are
5 unliquidated and indeterminate in character
6 and the assessment of unliquidated damages
7 must rest in the sound discretion of you,
8 Ladies and Gentlemen, the jury.

9 Pain and suffering have no market
10 price. I know you know that. They are not
11 capable of being exactly and accurately
12 determined and there is no fixed rule or
13 standard whereby damages for them can be
14 measured. The amount of damages to be
15 awarded for pain and suffering must be left
16 to the judgment of the jury.

17 Remember, the universal principle
18 of actual damages is that an injured party
19 should receive compensation equal to his or
20 her loss, no more, no less.

21 Now, let's talk about loss of
22 enjoyment of life. Loss of the capacity to
23 enjoy life resulting from a personal injury
24 is a proper element of damages if you find
25 it applicable from the facts of this case.

1 Damages for loss of enjoyment of life
2 compensate for the limitations resulting
3 from the defendant's negligence on the
4 injured person's ability to participate
5 in and derive pleasure from the normal
6 activities of daily life or for the
7 individual's inability to pursue his
8 talents, recreational interests, hobbies,
9 or avocations.

10 Loss of enjoyment of life damages
11 compensate the plaintiff not only for the
12 subjective knowledge that one can no longer
13 enjoy all of life's pursuits, but also for
14 the objective loss of the ability to engage
15 in these activities.

16 Let's talk about mental suffering.
17 An injured party may recover for mental
18 anguish brought about by bodily injury and
19 suffering if you find that the injured
20 party is entitled to recover damages, you
21 may take into account anxiety and worry
22 about plaintiff's condition that he
23 suffered, if you find it applicable.

24 However, the plaintiff may only
25 recover for that mental anguish brought

1 about by bodily injury and suffering. In
2 the absence of such a connection, there
3 can be no recovery for mental pain and
4 suffering. Also, mental anguish must be
5 distinguished from mere annoyance, regret
6 or vexation. It is intense mental
7 suffering in order to be compensable.

8 Let's talk about permanent
9 impairment or disability and the mortality
10 table or the life expectancy table. In
11 this case plaintiff has requested damages
12 for permanent impairment of physical
13 condition and alleges such permanent
14 impairment.

15 In evaluating the plaintiff's
16 permanent disability or impairment, it is
17 up to you to determine, based upon the
18 evidence, the extent and degree of the
19 plaintiff's disability and impairment as
20 a result of these injuries. Permanent
21 disability or disability does not relate to
22 a workplace setting. In evaluating
23 permanent impairments and disabilities, you
24 should consider the effect on all aspects
25 of the plaintiff's life. This may include

1 such things as his ability to carry out
2 household chores or activities, enjoyment
3 or leisure time or recreational activities,
4 social functions, and the like.

5 There is no set measure of damages
6 for this type of loss. The law allows that
7 should you determined to award damages for
8 permanent impairment, you should only award
9 an amount that is fair, just and
10 reasonable.

11 Now, in deciding what amount, if
12 any, if you find it applicable, of money to
13 include in your award for future damages,
14 if you find such damages applicable, is is
15 necessary for you to decide the probable
16 life expectancy of the plaintiff. To aid
17 you in making this determination, you may
18 consider South Carolina Code Section 19-1-
19 150 which recognizes that a person at any
20 age has a particular life expectancy. We
21 call this our mortality table. The statute
22 recognizes that a boy who is eight years of
23 age, is currently Jayden's age, and you may
24 consider that it's not from the date of the
25 incident but from the date of the trial,

1 so a boy who is eight years of age has a
2 life expectancy in South Carolina of
3 approximately 68.84 years.

4 Life expectancy is merely an
5 estimate of the probable average remaining
6 length of life of all persons in our state
7 of a given age. That estimate is based on
8 a limited record of experience, so the
9 inference that may be drawn from this
10 statute is evidence bearing on the life
11 expectancy of the plaintiff, including his
12 state of health, habits and occupation.

13 On damages, remember about the
14 burden of proof. The plaintiff has the
15 burden of proving their actual damages by
16 the greater weight of the evidence. The
17 amount of damages cannot be left to
18 conjecture, guess or speculation. But this
19 does not mean that they must prove them to
20 a mathematical certainty, or produce
21 evidence of the precise amount of actual
22 damages they have suffered. Rather, the
23 evidence put forth by the plaintiffs should
24 be such as to enable you, Ladies and
25 Gentlemen of the jury, to determine what

1 amount of damages is fair, just and
2 reasonable under the circumstances.

3 Remember, one more time I am going
4 to say it, the universal principle of
5 actual damages is that an injured party is
6 entitled to be compensated in an amount to
7 put them in a position as near as possible
8 to the same position they were in prior to
9 the injury, as far as money damages can do
10 this. No more, no less.

11 Now, in conclusion, -- you are
12 probably glad to hear that.

13 Now, in conclusion, Ladies and
14 Gentlemen of the jury, in just a few
15 moments you are going to retire to begin
16 your deliberations. I wish to express to
17 you the hope that the Court has that each
18 of you will be mindful of the importance of
19 your responsibility. I know that you are.
20 You are not called upon to serve as jurors
21 very often -- I know some of you are
22 thinking 'thank goodness.'

23 You may recall that when we
24 qualified you as jurors we talked about the
25 fact that you cannot be required to serve

1 more than one time in three years, in the
2 same court. There is a reason for that.
3 The reason for that is that it is a
4 difficult task and it requires you and I of
5 freeing our minds of all outside or
6 improper influences. You and I are
7 fulfilling our civic duty to see to it that
8 the trial is fair and the verdict is just.

9 Now you have probably noticed
10 throughout the trial that the presiding
11 officer is called "Your Honor". I know you
12 know that's not some title that is given to
13 me as an individual. It's a title that is
14 assigned to the position that I am
15 privileged to hold. This court
16 is entrusted with the honor of this county,
17 this community, the honor of this state and
18 indeed this nation in seeing that every
19 case tried here receives fair and impartial
20 justice.

21 Now, you the jury, in just a
22 moment will take into your care the
23 preservation of the honor of this
24 community, the honor of this country and
25 the honor of this state. Now, do not get

1 the idea that I am trying to intimidate to
2 you how I might think you should decide
3 this case. That would be totally improper.
4 My point is simply that as the presiding
5 officer in this courtroom that it is of
6 vital importance to me that whatever
7 verdict that you reach will be the result
8 of your going back into the jury room,
9 considering the evidence put forth in this
10 courtroom, weighing it fairly, weighing it
11 impartially, and applying the law as I have
12 given it to you in this charge. I have
13 every confidence that is what you will do.
14 I say to you that everyone in this case is
15 about justice, nothing more, nothing less.

16 Everyone is entitled to justice in
17 this case, both the plaintiff and the
18 defendant. All are entitled to justice,
19 nothing more, nothing less. We have no
20 sympathy for either party, we have no
21 support for either party.

22 Again, I have confidence that
23 whatever verdict that you reach will be the
24 result of that process and will represent
25 truth and justice for all parties involved.

1 Remember, your verdict must be
2 unanimous and I will now explain the
3 verdict form and the possible verdicts.

4 You really can't see the verdict form from
5 here but you will have it with you.

6 It has three questions on it, and
7 the lawyers discussed it with you a little
8 bit in their closing.

9 The first question is simply, Did
10 the plaintiff prove by the greater weight
11 or the preponderance of the evidence that
12 the defendant, Dr. Rhett, deviated from the
13 standard of care? Then there are two
14 answers, two choices.

15 Now, when I've got two choices on
16 a piece of paper, I can't give them to you
17 at the same point. There is no priority of
18 preference of one, but there are simply two
19 blocks down here. One is yes. One is no.

20 I would say to you that whatever
21 decision that you reach of these three
22 questions must be unanimous.

23 One, if you answered that the
24 doctor deviated from the standard of care
25 then you would go on to the next question.

1 If you answered no, you determined
2 that the doctor did not deviate from the
3 standard of care, your verdict is for the
4 defendant and it tells you to end your
5 deliberations, sign the verdict form, knock
6 on the door and we will return you to the
7 courtroom.

8 I will tell you that the last
9 words on this form before your name, Mr.
10 Foreman, says, "I certify this decision is
11 a unanimous decision of the jury." So when
12 you sign here, returning this form to the
13 Court, then you are guaranteeing to the
14 court that this was a unanimous verdict.

15 I would simply say to you, and I
16 have been back there in the jury room and I
17 realize that there is a table, that some of
18 you may be sitting at the table, some of
19 you might be standing back against the
20 walls, but ask that if someone has a
21 position if they wish to state on a
22 particular issue, please make sure that
23 they have that opportunity so that the jury
24 verdict is not only unanimous, a consensus
25 verdict, but unanimous when the job is

1 done.

2 Now, just as I told you yesterday,
3 for the past three weeks you have waited on
4 our schedule and responded to our schedule,
5 now the roles have reversed and we will
6 respond to your schedule. You have no
7 compulsion for speed, or slowness. This is
8 your decision.

9 We are going to let you go to the
10 jury room but please do not begin your
11 deliberations yet. After I have talked to
12 lawyers then we will bring in all of the
13 exhibits and you may begin your
14 deliberations.

15 If you need to communicate with
16 the court during the course of your
17 deliberations, please knock on the door.
18 There will be someone there near the door,
19 not listening to your deliberations but
20 close by, listening for knock, they will
21 respond and you may communicate with the
22 court.

23
24 I do want to say a word or two to
25 our alternates. This is what we are going

1 to do. First of all, the alternates do not
2 go back and deliberate with the jury. You
3 might say, 'Well, my goodness I have wasted
4 my life for three weeks.' However, that is
5 not the case.

6 Under South Carolina law that we
7 are required to have twelve jurors and even
8 now at the end of the case if you were not
9 here and one of our jurors had an emergency
10 and said we would only have eleven, I would
11 have to declare a mistrial in this case and
12 it would have to be tried again. So you
13 can't imagine the cost and the damage that
14 would be done by simply not have been an
15 alternate juror. Your presence here has
16 prevented that from happening throughout
17 the trial. Of course, we did seat one
18 alternate.

19 I'm not going to be able to let
20 you go at this time but we will see that
21 you are put someplace comfortable, we won't
22 stick you in a closet but we will make you
23 comfortable in the event we have to seat
24 another alternate. If we had to
25 substitute, for whatever reason, a juror

1 then we would begin deliberations again and
2 seek an alternate juror. We will keep you
3 separate and apart from the other jurors.
4 In the event that we have to call for an
5 alternate juror. Thank you, again.

6 Ladies and Gentlemen, go to your
7 jury room but please do not begin your
8 deliberations for just a few moments until
9 we send all the exhibits in to you. I have
10 to have one more opportunity to talk to the
11 attorneys.

12 Best wishes to you now. We will
13 all remain where we are out of respect for
14 the jury as our jury exits.

15 FOREMAN: The charge on the
16 law. Will we get a copy of all that.

17 THE COURT: Let me discuss that
18 with the lawyers, as well, and we will
19 advise you of that shortly.

20 FOREMAN: Will we received the
21 video?

22 THE COURT: Yes. Tara, will you
23 go back and talk with our jurors about the
24 audio-visual aids that we are going to
25 provide you so that you'll see what you

1 have. We will make that available to you,
2 yes. Without the aid of outside people,
3 you will be able to review it.

4 FOREMAN: And if we have
5 questions, how do we get those to you?

6 THE COURT: That's an excellent
7 point. If you have a question, please
8 write it down on a piece of paper. Knock
9 on the door and give it to the bailiff.

10 Now, it may take me a moment to
11 respond to you because here is what
12 happens. When you send a question, I then
13 meet with the lawyers, we review the
14 question, see what the appropriate response
15 is and then get back to you. That process
16 doesn't always happen immediately so when
17 you're writing your question, you may want
18 to continue and consider something else
19 while that is being done.

20 Also, I didn't say this, but when
21 you have a verdict, when you reach a
22 verdict, please knock on the door and we
23 will be prepared to receive your verdict.
24 Any further questions?

25 JUROR: What about breaks?

1 THE COURT: Tara will be
2 prepared to meet whatever your needs are.
3 Let's all remain where we are while the
4 jury leave the courtroom. Thank you.

5 (JURY OUT @ 2:57 P.M.)

6 THE COURT: Let's take up the
7 issue, first of all, the jury is now clear,
8 about giving the charge to the jury. The
9 Court has a position on it but I will be
10 glad to hear from the lawyers. Does the
11 plaintiff have a position?

12 EDWARD GRAHAM: Your Honor, we
13 will abide by your discretion.

14 THE COURT: Very good. Do the
15 defendants have a position?

16 ROBERT HOOD: Yes, Your Honor.
17 I think it would be inappropriate.

18 THE COURT: I am going to follow
19 the example of my colleague, Judge Clifton
20 Newman, and I am going to send the charge
21 back to the jury.

22 I am going to do that for two
23 numbers. Number one, this is a complex
24 case with multiple issues and I just gave a
25 forty-page instruction, read it, to the

1 jury. I believe that it will assist them
2 in following the law in the discharge of
3 their duties to provide the charge to them
4 in written form. Secondly, this is
5 something that I have always done, is when
6 a juror asks for the charge or some
7 particular portion of the charge, I give it
8 to them out of respect to their request,
9 their importance to this process.

10 So over objection of the
11 defendant, I am going to give my charge to
12 the jury. This is what we are going to do.
13 I have asked Carly to come in and we are
14 going to take the charge -- there was one
15 part that I substituted and we're going to
16 fix it so that it is just as I read it and
17 give it to them without any marks. We will
18 let you review it, because I have pencil
19 notations in a margin or two here. I will
20 let you review it before it goes back, but
21 the court does intend to send it to the
22 jury.

23 Anything further on that point?

24 (No response).

25 Now, to the charge, uh, first to

1 the plaintiff, any objections or exceptions
2 to the charge as given by the Court?

3 EDWARD GRAHAM: Your Honor,
4 there was -- just very briefly there was
5 just one or -- hold on just a moment, I
6 think -- (sidebar with Ms. Waters).

7 Your Honor, on the medical
8 emergency exception to the informed
9 consent, you inserted a new portion of
10 that charge that wasn't in the draft that
11 we went over at the charge conference. It
12 just kind of caught me by surprise. In an
13 abundance of caution, I would like to take
14 exception to that part, it was right before
15 the comment about the form not being
16 informed consent as a matter of law. By
17 the time I realized that you were reading
18 something I didn't have a script for, I was
19 not certain that I heard all of it. It
20 seemed like it unduly emphasized the
21 exception without the other part of the
22 charge. That may have been the charge that
23 I requested but I didn't -- if so, I didn't
24 hear the part I'd requested.

25 THE COURT: What that is, Mr.

1 Graham, is a portion of the charge that you
2 requested but not all of it. So what
3 you're saying is that you got the part that
4 you didn't want and didn't get the part
5 that you did want.

6 EDWARD GRAHAM: Correct.

7 THE COURT: I will note the
8 objection. I felt that, though, I studied
9 our rules last night that my charge
10 complied with what South Carolina is on
11 implied (sic) consent and the emergency
12 exception. Your objection is noted for the
13 record but I decline to give any further
14 instruction.

15 EDWARD GRAHAM: Also, Your
16 Honor, our request -- I believe that it was
17 request number three about medical experts.
18 We ask that Your Honor would charge that.

19 THE COURT: I declined to charge
20 that. If you want to find that and make it
21 a Court's exhibit, I would be pleased for
22 you to do so. I felt like commenting on
23 whether an expert is paid, expects to be
24 paid, I am not sure that would be -- that
25 would be the case on both sides of this

1 wish for me to then I will.

2 EDWARD GRAHAM: She says that it
3 is not necessary. That's fine by me.

4 JAY DAVIS: We will of course
5 prepare the appropriate Order formalizing
6 the settlement.

7 THE COURT: Very good. That
8 settlement is entered and, thus, those
9 claims dismissed. We now find ourselves
10 with the claim against Dr. Rhett at this
11 juncture. Anything further?

12 EDWARD GRAHAM: If Your Honor
13 hand, may I hand up the request to charge
14 that we referenced earlier.

15 THE COURT: Yes, sir, those will
16 be court's exhibits.

17 EDWARD GRAHAM: I think I handed
18 up one yesterday so we just reprinted it.

19 THE COURT: Very good.

20 EDWARD GRAHAM: I put in
21 handwriting that it is Plaintiff's Request
22 to Charge Number 3, and I believe that's
23 the same number that it had yesterday.

24 THE COURT: All right, we will
25 just make that a Court's exhibit. We are

1 case, as well. The court declines to
2 charge that.

3 EDWARD GRAHAM: I don't have it
4 right in front of me but can we hand it up
5 while the jury is deliberating?

6 THE COURT: That's fine.

7 EDWARD GRAHAM: I think the
8 other ones that we requested, I think you
9 either covered or I understand why you
10 didn't. I don't have those in front of me
11 either but out of an abundance of caution I
12 would ask that we be ---

13 THE COURT: Please note it so --
14 our charge conference was in chambers, so
15 the record would be void of any reflection
16 of that. So if you have something that you
17 want to put on the record, once we get the
18 jury up and going, I will be glad to do
19 that.

20 EDWARD GRAHAM: Thank you.

21 THE COURT: Now, from the
22 defendants?

23 MOLLY CRAIG: Yes, sir. Your
24 Honor, we would except to the objections
25 and statements of counsel as an

1 insufficient curative instruction regarding
2 plaintiff's counsel's intentional violation
3 of Rule 26(4)(e) which states that a party
4 is not required to disclose or produce an
5 expert who was only consulted informally or
6 consulted but not retained, specially
7 employed.

8 As Your Honor will remember, Mr.
9 Graham asked Dr. Van Dorsten, 'you don't
10 know how many doctors the defense team took
11 this case to, and turned them down as
12 expert witnesses.' Something to that
13 effect.

14 I believe that it was Your Honor's
15 intention that opposed to giving a curative
16 instruction at the time to wait until your
17 charge to address this. Given the
18 prejudicial nature of the violation of Rule
19 26(4)(b) and our inability to respond to
20 the only inference that plaintiff's counsel
21 made with that statement is that there were
22 multiple experts that were consulted and
23 not retained. Not retained because they
24 could not be helpful but just not -- that
25 we were not able to respond to it and that

1 was a clearly violation of the Rules of
2 Civil Procedure.

3 THE COURT: The Court believes
4 that the charge given was sufficient and
5 also does not accept your belief that you
6 were damaged by that question. I told the
7 jury to disregard it and to continue to
8 question the witness. The Court doesn't
9 find any harm there and, therefore, no
10 further charge was indicated.

11 JAY DAVIS: Same objection, Your
12 Honor.

13 THE COURT: Mr. Davis joins in.

14 MOLLY CRAIG: Your Honor,
15 under the departure from the standard of
16 care, at the charge conference last night I
17 asked Your Honor under the negligence
18 paragraph is you would include the language
19 "at the end, the Court qualified Dr. Rhett
20 as an expert" and the plaintiff did not
21 object. Your Honor said that you would not
22 include that language in the charge, and we
23 would object to that language not being
24 included.

25 THE COURT: The Court declined

1 to charge that simply because I felt that
2 it would heighten the testimony of one
3 party over that of another. I didn't think
4 it was necessary and elected not to charge
5 it.

6 MOLLY CRAIG: On page sixteen
7 (sic) of the charge that you give, under
8 proximate cause, there is a paragraph that
9 starts, "Sometimes the defendant's
10 negligence will combine with other forces,
11 such as acts of nature, to bring about a
12 result."

13 Since the negligence here, the
14 only act at issue in this case is the
15 vacuum.

16 THE COURT: So?

17 MOLLY CRAIG: This is to the
18 "one or more negligent acts." The hospital
19 is no longer in the case and the only
20 negligent act that the plaintiff is
21 claiming in the case is the use of the
22 vacuum.

23 This is as to two persons in
24 concert. We discussed it yesterday.

25 THE COURT: We did discuss it

1 yesterday and it's my recollection of that
2 discussion is that part of your theme in
3 this case is comparative negligence,
4 although the Court did not give you a
5 charge on comparative negligence.

6 Thus, if the mother was negligent in
7 failing to properly take prenatal care of
8 her own child then that charge, I thought,
9 was irrelevant to that issue.

10 MOLLY CRAIG: Regarding
11 informed consent, Your Honor, I believe
12 that I addressed this when I asked if you
13 would reconsider your ruling on the Motion
14 for directed verdict. But you would except
15 to the charge of informed consent under the
16 doctrine of informed consent. "It is
17 generally held that physicians who perform
18 a diagnostic, therapeutic or surgical
19 procedure have a duty to disclose to a
20 patient of sound mind, in the absence of an
21 emergency that warrants immediate medical
22 treatment,..." -- and that this vacuum is
23 not a diagnostic, therapeutic or surgical
24 procedure any more than forceps, an
25 episiotomy, use a catheter, getting blood

1 work out, so the informed consent doctrine,
2 as set forth in *Tisdale v. Pruitt*, 394 SE
3 2nd 857, does not include vacuum delivery.

4 THE COURT: Objection noted.
5 The Court declines at this juncture to make
6 any changes in the charge concerning
7 informed consent.

8 MOLLY CRAIG: I also included
9 in the informed sentence charge, that there
10 is a sentence that states, "As the
11 probability or severity of the risks to the
12 patient increases, the duty of the doctor
13 to tell the patient of the risks
14 increases." We would object to that
15 language.

16 THE COURT: The Court find that
17 is common sense and I decline to change the
18 charge at this time.

19 MOLLY CRAIG: Your Honor, I
20 was trying to follow closely with your
21 charge and I am not certain whether or not
22 you charged feasibility of alternative
23 treatment, that paragraph.

24 THE COURT: It's in the printed
25 charge. I believe that -- are you talking

1 about within informed consent?

2 MOLLY CRAIG: Yes, sir.

3 THE COURT: I believe that I did
4 use those terms "feasibility of alternative
5 treatment." If you object to that, the
6 court would decline to change that. I
7 believe that is the law in South Carolina.

8 MOLLY CRAIG: With regard to
9 the listed damages, actual damages, an
10 actual damage set forth in there was a
11 charge on actual damages, and then each of
12 those damages -- there is a portion that
13 addresses each one of them in detail. We
14 would just object to the cumulative nature
15 of the damages that are set forth. It's
16 all written out in the actual damages.
17 Each one of those.

18 THE COURT: Overruled. That's a
19 standard procedure in all judges charges.

20 MOLLY CRAIG: Medicaid
21 suborgation. I brought this up previously.
22 Again, we except to the Medicaid
23 suborgation language as the damage limited
24 to what plaintiff paid. They interjected
25 Medicaid into this lawsuit and it should be

1 limited to what Medicaid paid as damages.

2 THE COURT: Very good. On that
3 point, I earlier mentioned the case of
4 *Haselden v. Davis*, 353 SC 481 or 581 SE 2nd
5 293, a 2003 decision by the Court.

6 MOLLY CRAIG: Your Honor,
7 under permanent impairment disability there
8 is a sentence that says, (reading:

9 "...may consider all aspects of
10 plaintiff's. This may include such things
11 as his ability to carry out household
12 chores or activities, enjoyment or leisure
13 time or recreational activities, social
14 functions, and the like."

15 We addressed those in chambers
16 last night and again we believe that this
17 is a comment on the facts.

18 THE COURT: The Court declines
19 to alter the charge at this time, does not
20 believe it to be a comment on the facts.

21 Let me ask you this, Counsel, and
22 I'll be glad to continue to go through but
23 are there any that you believe that the
24 Court will -- I realize that you are noting
25 this for the record but are there any that

1 you believe the Court would change? If so,
2 let's take those up. Otherwise, I feel
3 like the jury is sitting back there
4 wondering what we are doing.

5 MOLLY CRAIG: Yes, sir. I
6 will speed it up. The last one that I have
7 is Your Honor's charge with the use of the
8 word "community". Especially in light of
9 the plaintiff's violation of The Golden
10 Rule during this closing argument.

11 THE COURT: Again, that is the
12 charge -- gosh, how many hundreds of times
13 have I used it. I believe that I did
14 delete community at one place and said that
15 we were discharging our civic duty, but
16 then I used the community, county, state
17 and nation maybe twice but I just don't
18 believe that would have any negative affect
19 in any way.

20 MOLLY CRAIG: Your Honor, we
21 had asked to charge Defendant's Request to
22 Charge 12, 16, 19, 31, 35 and 36 be added
23 to your charge and they were not. We would
24 just ask that these be marked as a court's
25 exhibit at this time.

1 THE COURT: That's fine. You
2 may certainly mark them as a court's
3 exhibit. Let's go ahead and send our
4 exhibits to the jury, please.

5 MOLLY CRAIG: Your Honor, I
6 just have one more, the exception to
7 Plaintiff's Request to Charge Numbers 12
8 and 23, which we would also like to make
9 a Court's exhibit.

10 THE COURT: You may. Mr. Davis
11 joins in all those exceptions?

12 JAY DAVIS: Yes, sir.

13 THE COURT: Go ahead and take
14 our evidence into the jury. Remain in
15 session, Ladies and Gentlemen, I want to
16 speak to the parties and the lawyers before
17 we stand down.

18 (OFF RECORD DISCUSSION RE EXHIBITS)

19 THE COURT: The Court will allow
20 the photograph because it's pivotal
21 evidence but the Court declines to allow
22 the blowups as documentary evidence to go
23 to the jury. You can mark them as court's
24 exhibits if you wish.

25 (OFF RECORD REVIEW/DISCUSSION OF EXHIBITS)

1 THE COURT: Okay, we just
2 removed 98-A, B and C from the exhibits
3 that go the jury.

4 EDWARD GRAHAM: If Your Honor
5 please, earlier in the trial, before we
6 rested the first time, we had offered the
7 entire school records and Your Honor wanted
8 to give them a chance to move to exclude
9 certain individual ones. I understand that
10 has been and this is ready to go.

11 THE COURT: Those three boards,
12 are those fetal monitoring strips?

13 (OFF RECORD REVIEW/DISCUSSION OF EXHIBITS)

14 THE COURT: Okay, we will send
15 in redacted fourteen and twenty-one over
16 objection and we will send in the charge.

17 They have asked for an easel, so
18 can we get them an easel and -- did we send
19 a calculator to the jury? Do the
20 defendants have a position on that?

21 ROBERT HOOD: Did they ask for
22 one?

23 THE COURT: No, sir, they did
24 not ask for one.

25 ROBERT HOOD: Yes, it is our

1 position that if they did not ask for one
2 that we do not want them to have one.

3 THE COURT: Send a calculator
4 in.

5 ROBERT HOOD: I believe that
6 would be extremely prejudicial.

7 THE COURT: How so, Mr. Hood?

8 ROBERT HOOD: They didn't ask
9 for one, Your Honor.

10 THE COURT: I know they didn't.

11 ROBERT HOOD: Their job is to
12 analyze the facts of this case and render a
13 just verdict, not to suggestion that they
14 may need a calculator.

15 THE COURT: Please send a
16 calculator in over the objection of the
17 defendants. Thank you.

18 (EXHIBITS DELIVERED TO JURY)

19 (JURY IN DELIBERATIONS @ 3:40 P.M.)

20 THE COURT: Let me just say
21 this, it has been -- -- I think that there
22 are very few things that go more to the
23 core of our lives than for someone who has
24 a permanent impairment or disability that
25 is with them for their lifetime. On the

1 other side, I think for a professional who
2 has given his entire professional life to
3 do such a good cause as miracle birth. So
4 we bind ourselves with three sides of this
5 case who have strongly-held beliefs, core
6 belief, about what they represent and bring
7 here to court. The strength of our system
8 is that it's for the jury to decide.

9 But this case could have easily
10 broken into a brawl -- although, at times
11 it seemed as though it was edging that way
12 with objections, arguments, fights between
13 witnesses, between counsel that really
14 didn't have to -- we've been three weeks in
15 this courtroom and some of those really
16 important issues that go to the core of our
17 system. The reason that it did not break
18 down into just a brawl, I contribute to the
19 professionalism of the attorneys and the
20 professionalism and demeanor of the
21 witnesses and parties who appeared in this
22 courtroom. So I commend you both --
23 including you, Mr. Davis -- for the way
24 that you have conducted yourself throughout
25 the trials, for the attorneys have you have

1 chosen to represent you, for the stellar
2 professional presentations that they've
3 made.

4 Whatever decision from this jury,
5 again that's the strength of our system.
6 Whatever is is, they have had the full
7 benefit of your positions, arguing cogently
8 and professional and well to them. This
9 will be their decision. Whatever the
10 decision of the jury is, you should feel
11 comfortable with it when we walk out of
12 this courtroom and close this chapter in
13 our lives. Your positions have been well-
14 represented here in this courtroom.

15 I am sure that you're not here
16 every day but I am here every day, this is
17 what I do every day, so I've had the
18 privilege of working with capable competent
19 lawyer and I commend you for the way that
20 this trial has been conducted.

21 Now we are going to stand down --
22 before we do that, we have a note from the
23 jury.

24 Anyway, we are going to stand
25 down. Who knows what is going to happen

1 here, but as we move forward in our lives I
2 wish every one well.

3 Well, (reading juror note): May
4 we have the following exhibits, 98-A, B and
5 C?

6 They are directly on point with
7 what we were discussing. What says -- mark
8 that as a Court's exhibits. What says the
9 plaintiff as to providing 98-A, B and C?

10 EDWARD GRAHAM: It suits us to
11 honor the jury's request, Your Honor.

12 THE COURT: What says the
13 defense?

14 ROBERT HOOD: We are trying to
15 figure out what they are?

16 THE COURT: Those are the three
17 exhibits that were used by Dr. Oakes that
18 we just had a discussion about. There was
19 a question about them.

20 ROBERT HOOD: The jury
21 question is to see them?

22 THE COURT: 98-A, B and C. They
23 called them by number. An objection? From
24 the plaintiff, from the defendant?

25 EDWARD GRAHAM: No objection.

1 ROBERT HOOD: We would
2 respectfully object to those three
3 documents going to the jury. They were,
4 like ours, used for demonstrative purposes.
5 They are not accurate. They were
6 misrepresentations, according to our
7 experts, of this delivery and I think to
8 allow those to go back to the jury would
9 confuse the jury and allow them to consider
10 something that is misleading.

11 THE COURT: The Court, over your
12 objection, is going to allow them in for
13 the following reasons:

14 First of all, they were marked as
15 exhibits. How that happened, I am not sure
16 but it was my understanding that they were
17 admitted as exhibits and went into
18 evidence. We could have taken them back.
19 Then there was a question and they were
20 brought back and we agreed among ourselves
21 that we would remove them from the exhibit
22 pool but now the jury has asked for them,
23 which tells me that the jury finds them
24 relevant and probative; thus, over
25 objection of both defendants, the Court is

1 going to allow 98-A, B and C to go to the
2 jury.

3 While we are talking about what
4 goes back to the jury, let me just discuss
5 with you about the calculator. This is my
6 reason for the calculator going back. I
7 just don't find that it is suggestive,
8 after sitting in here for three weeks, as
9 if it means that the argument over
10 liability, which is their domain, that is
11 means nothing. What it is, if we get a
12 notice or a knock or a note from the jury
13 about whether or not they can have a
14 calculator, that changes the entire, uh, --
15 it's a sea change where we find ourselves,
16 it may impact positions of the parties with
17 regard to settlement. I don't know. But
18 rather than have to worry about that, I'd
19 just send them everything that I believe
20 that they would need. Respectfully, your
21 objection is noted for the record.

22 ROBERT HOOD: The reason that
23 I excepted is because, just simply
24 explaining my thoughts, I think it sends a
25 message to the jury that they need to start

1 adding up numbers when that is not their
2 job. Their job is to first at the standard
3 of care issue.

4 THE COURT: Very good.

5 ROBERT HOOD: I really think
6 that it sends the wrong message, totally,
7 to this jury to just get on to money.

8 THE COURT: Respectfully, that's
9 notes. In this case, the plaintiff argued
10 \$8 Million is damage, if I recall
11 correctly, with all sorts of subsets of
12 damages. To require the jury to get into
13 that with pen and paper and try to resolve
14 those issues, I simply felt that the better
15 course was to send in a calculator.

16 All right, let's stand down,
17 Ladies and Gentlemen. Best wishes to
18 everyone. We will await the call of the
19 jury.

20 (OFF RECORD DISCUSSION)

21 THE COURT: Counsel, actually
22 before I stand down -- let's go back on the
23 record, Madame Court Reporter. I am told
24 that there is apparently a partial
25 settlement of this issues and I'll be glad

1 to hear from you. Mr. Graham?

2 EDWARD GRAHAM: Thank you, Your
3 Honor. Mr. Davis has represented to us in
4 Interrogatories and followup discussions
5 that policy limits -- or coverage of his
6 funds is limited to JUA coverage in the
7 amount of \$200,000 for an individual claim,
8 that they had no PCF coverage. In reliance
9 on those representations, we have agreed to
10 a settlement for the policy limits of
11 \$200,000, which we agree would be credited
12 against any verdict that might be
13 forthcoming.

14 THE COURT: Very good. Mr.
15 Davis, is that your understanding of
16 settlement?

17 JAY DAVIS: It is, Your Honor.

18 THE COURT: All right. I don't
19 believe that you have a representative here
20 for me to inquire about the settlement.

21 JAY DAVIS: No, sir.

22 THE COURT: Do you wish to talk
23 to Ms. Washington about this settlement or
24 is that not necessary, Counsel? It is not
25 necessary and I will not do it, but if you

1 wish for me to then I will.

2 EDWARD GRAHAM: She says that it
3 is not necessary. That's fine by me.

4 JAY DAVIS: We will of course
5 prepare the appropriate Order formalizing
6 the settlement.

7 THE COURT: Very good. That
8 settlement is entered and, thus, those
9 claims dismissed. We now find ourselves
10 with the claim against Dr. Rhett at this
11 juncture. Anything further?

12 EDWARD GRAHAM: If Your Honor
13 hand, may I hand up the request to charge
14 that we referenced earlier.

15 THE COURT: Yes, sir, those will
16 be court's exhibits.

17 EDWARD GRAHAM: I think I handed
18 up one yesterday so we just reprinted it.

19 THE COURT: Very good.

20 EDWARD GRAHAM: I put in
21 handwriting that it is Plaintiff's Request
22 to Charge Number 3, and I believe that's
23 the same number that it had yesterday.

24 THE COURT: All right, we will
25 just make that a Court's exhibit. We are

1 in recess awaiting the call of the jury.

2 COURT REPORTER: At this time

3 I marked:

4 Defendant's Request to Charges as

5 Court's 38;

6 Plaintiff's Request to Charge,

7 some of them as 39;

8 Plaintiff's Request to Charge

9 Number 3 as 40;

10 blowups of medical records as 41,

11 42 and 43; and

12 Court's 44, the jury note

13 requesting 98-A, B and C.

14 (RECESS)

15 THE COURT: All right, I think

16 we will bring the jury back in. Let me

17 tell you that they have opted to go home

18 and go back at 9:00 o'clock tomorrow

19 morning. We've got two alternates that are

20 sequestered. Let me ask again if there is

21 a change from the defense position about

22 the need for alternates, would you accept a

23 verdict of ten or more if somehow I let the

24 alternates go and we lost two jurors

25 overnight? Has your position changed?

1 ROBERT HOOD: No, sir.

2 THE COURT: All right.

3 ROBERT HOOD: Thank you very
4 much keeping them. We may well need them.

5 THE COURT: All right. My
6 inclination, though, would be to offer the
7 third alternate the opportunity to go home
8 and stay or an opportunity to come back.
9 In other words -- if you remember, she's a
10 teacher. She starts school Friday, she has
11 medical appointments on Thursday. Of
12 course, tomorrow is Wednesday, so she would
13 have a day. I am sure that there must be
14 many things that she needs to do. Thus, I
15 will -- I would give her the option -- let
16 me think that through a moment. I suppose
17 the best thing would be to, to make sure
18 that we don't have something happen, would
19 be to have her come back. I just hate to
20 inconvenience her further. Anyone want to
21 be heard on that? Does anyone have a
22 position or not? (No response). I will
23 have her come back, just out of an
24 abundance of caution.

25 Bring all our jurors back, the

1 twelve and the two please.

2 (JURY IN)

3 THE COURT: Welcome back, Ladies
4 and Gentlemen. You all have been working
5 hard this afternoon. You have not
6 requested a break. I meant to tell you
7 during the charge that if you want to take
8 a break during the proceedings, that you
9 are not in prison. So tomorrow when we
10 return, if you wish to take a break at some
11 point we will certainly do that. Just
12 knock on the door and we will make that
13 available to you.

14 Now, let's talk a little bit about
15 tonight. Before I do that, I want to
16 address our alternate jurors. You've been
17 sitting quietly in the back. I would ask
18 you to come back tomorrow morning at 9:00.
19 If you wish to bring some work with you or
20 a computer with you or something that would
21 assist you in getting some things done,
22 feel free to do. I am going to ask you to
23 return tomorrow and we will continue to
24 have you remain with us.

25 To our other jurors, please

1 overnight don't undertake any fact research
2 or any discussions among yourselves. That
3 would not be appropriate. Just get a good
4 night's rest, come back tomorrow morning at
5 9:00 o'clock.

6 Any questions from our jury about
7 scheduling? (No response). Okay.
8 Everybody doing okay? I see some long
9 faces over there. Is everybody okay? (No
10 response). We will see at 9:00 tomorrow
11 morning. We will remain where we are out
12 of respect for you as you leave the
13 courtroom. Have a nice evening and we will
14 see you at 9:00 o'clock tomorrow morning.

15 (JURY OUT @ 6:23 P.M.)

16 THE COURT: The jury is clear.
17 Anything for the record before we close
18 this record for the day? (No response).
19 Hearing none, we will be in recess until
20 9:00 o'clock tomorrow morning.

21 (COURT IN RECESS)

22 (TRANSCRIPT CONTINUED NEXT PAGE)

23

24

25

1 AUGUST 11, 2010 9:00 A.M.

2

3 (JURY IN DELIBERATION @ 9:00 A.M.)

4 (LUNCH RECESS 12:00 - 1:00 P.M.)

5 THE COURT: Please be seated,
6 Ladies and Gentlemen. All right. Counsel,
7 Ladies and Gentlemen who are here, we have
8 received a note from the jury that they are
9 unable to reach an unanimous verdict on the
10 question one. The court at this time would
11 propose of give an Allen charge. Any
12 objection from the plaintiff?

13 EDWARD GRAHAM: No, Your Honor.

14 THE COURT: From the defendant?

15 ROBERT HOOD: No, sir.

16 THE COURT: For your
17 information, those of you that may not be
18 familiar, an Allen charge is a charge where
19 I discuss with the jurors the fact that
20 they consult with one another, take a new
21 look at the issues, discuss their
22 differences with open minds because if they
23 cannot reach an unanimous verdict then the
24 Court must eventually declare a mistrial in
25 this case. Please bring in the jury with

1 the alternates. Thank you.

2 (JURY IN @ 3:22 P.M.)

3 THE COURT: Welcome back, Ladies
4 and Gentlemen. How are you'all doing over
5 there? Doing okay? I trust that you had a
6 good lunch. I really haven't even said
7 hello to you today. So I'll say good
8 morning and good afternoon all at the same
9 time.

10 I received a note from you, and
11 we've made it a court's exhibit here that
12 you have been unable to reach a unanimous
13 verdict on question on of the verdict form.

14 What I would like to do is just
15 talk with you about that. What you're
16 telling me is that you're unable to agree
17 on a verdict at this juncture of the case.

18 As I instructed you earlier, the
19 verdict has to be unanimous. We can't
20 amend that rule simply because we find
21 ourselves in a delicate situation.

22 If you think about it, when any
23 matter is in dispute, it isn't always easy
24 for even two people to agree. So when
25 twelve people must agree, it becomes even

1 more difficult. In most cases, absolute
2 certainty just cannot be reached or
3 expected. However, if life there are very
4 few things that we are absolutely certain
5 of.

6 However, you have any duty to make
7 every reasonable effort you can to reach a
8 unanimous verdict. In doing this, you
9 should consult with one another, express
10 their own views, and listen -- listen -- to
11 the opinions of your fellow jurors. Tell
12 each other how you feel and why you feel
13 that way. Discuss your differences with
14 open minds. I assume that you've done that
15 thus far.

16 Although the verdict of the jury
17 must be unanimous, every one of you have
18 the right to the your own opinion. The
19 verdict you agree to must be your own
20 verdict, not someone else's, and it must be
21 the result of your own convictions, and you
22 should not give up your firmly-held beliefs
23 merely to be in agreement with your fellow
24 jurors.

25 In that regard, the majority

1 should consider the minority's position,
2 and the minority should consider the
3 majority's position. You should carefully
4 consider and respect the opinions of each
5 other and reevaluate your position for
6 reasonableness, correctness and
7 impartiality. You must lay aside all
8 outside matters and re-examine the
9 questions before you based on the law and
10 evidence in this case.

11 Now, let's talk a little bit about
12 what happens if you can't agree. If you
13 cannot agree on a verdict in this case, I
14 must declare a mistrial. In that case, it
15 does not mean anybody wins. What it really
16 means that is some future time the Court
17 will try this case with some other jury
18 sitting where you now sit. The same
19 participants will come and the same lawyers
20 will bring in the same witnesses and will
21 ask basically the same questions and get
22 basically the same answers. We will go
23 through the whole process again.

24 You were selected from a larger
25 jury panel. You may remember that we had a

1 courtroom full of people here when we chose
2 you as jurors for this case. You were
3 selected because of your willingness to
4 serve, your dedication to the cause of
5 justice, your intelligence as jurors, the
6 response that you made during our jury
7 qualification.

8 You were selected in the same
9 manner and from the same source as any
10 future jury will be and there is no reason
11 for me to suppose that the case will ever
12 be submitted to twelve more intelligent,
13 impartial, conscientious and competent
14 jurors than you or that more or clearer
15 evidence will be produced to one side or
16 the other.

17 So what I am going to ask you to
18 do in line with these discussions to ask
19 you to return to your deliberations with
20 the hope that you can arrive at a verdict
21 within a reasonable time. I encourage that
22 you return with an effort to do so.

23 I am going to send our twelve
24 jurors back to the jury room, our two
25 alternates back to their room and we will

1 all remain where we are out of respect for
2 you as you leave the courtroom.

3 (JURY OUT @ 3:29 P.M.)

4 THE COURT: Is there any
5 objection to the Allen charge as given by
6 the Court, from the plaintiff?

7 EDWARD GRAHAM: None, Your
8 Honor.

9 THE COURT: From the defendant?

10 ROBERT HOOD: (No verbal
11 response).

12 THE COURT: Hearing none, we
13 will stand down and continue discussion
14 among the parties, if there is some utility
15 in that. Otherwise, we will await response
16 from the jury.

17 (IN CHAMBERS CONFERENCE)

18 (NOTIFIED OF VERDICT @ 4:46 P.M.)

19 THE COURT: Thank you, please
20 be seated. I am told that the jury has
21 reached a verdict. Out of respect for the
22 jury, I ask that you please not react
23 emotionally or with an outburst to the
24 jury's verdict, whatever it may be; again,
25 out of respect for a difficult decision

1 they've obviously been over a day in
2 reaching. With that understanding, please
3 maintain the decorum of the courtroom.
4 Please bring in the jury.

5 (JURY IN @ 4:46 P.M.)

6 THE COURT: Ladies and Gentle-
7 men, welcome back to the courtroom. I am
8 advised that you have reached a verdict.
9 Is that correct, Mr. Sewell?

10 FOREMAN: Yes, we have, Your
11 Honor.

12 THE COURT: Please give the
13 verdict form to our clerk, Mr. Michele?

14 FOREMAN: (Tenders to Clerk).

15 CLERK DON MICHELE: (Tenders to
16 Court)

17 THE COURT: Let the record
18 reflect that the verdict form is
19 appropriately filled out, signed by the
20 foreperson. Mr. Clerk, please publish the
21 verdict.

22 CLERK DON MICHELE: State of
23 South Carolina, County of Charleston, in
24 the Court of Common Pleas, 9th Judicial
25 Circuit, Jamsetta Washington as guardian ad

1 litem for Jayden W. a minor,
2 Plaintiff versus Edmund Rhett, Jr., M.D.,
3 Lowcountry Ob-Gyn, P.A., Defendants. Case
4 number 07-CP-10-1553.

5 Question number one, (reading:

6 "Did the Plaintiff prove the
7 greater weight or preponderance of the
8 evidence that Defendant Dr. Rhett deviated
9 from the standard of care?"

10 Answer: "No."

11 Signed, Phillip Swell, Foreperson
12 of the jury dated August 10(sic), 2010.

13 Mr. Foreman, I'd of the jury, if
14 this is your verdict, please signify by
15 raising your right hand. Please let the
16 record reflect that all jurors raised their
17 hand, Your Honor.

18 THE COURT: Very good. Now we
19 are still in the presence of the jury, are
20 there any Motions or issues for which a
21 jury response would be necessary, from the
22 Plaintiff?

23 EDWARD GRAHAM: Yes, Your Honor.

24 We would ask for a polling of the jury.

25 THE COURT: All right. The

1 plaintiff has requested that the jury be
2 polled. This is the procedure that we will
3 use. Each of you will be called by name --
4 our twelve jurors. When your name is
5 called, please stand and you will be asked
6 two questions. The first question is, Was
7 this your verdict? You will answer. Then
8 the next question will be, is this still
9 your verdict?

10 CLERK DON MICHELE: Juror
11 Number 336, Phillip Sewell. Is this your
12 verdict, sir?

13 JUROR NUMBER 336: Yes, it
14 was.

15 CLERK DON MICHELE: Is it still
16 your verdict?

17 JUROR NUMBER 336: Yes, it is.

18 THE COURT: Thank you, sir.

19 Juror Number 22, Diane Birds. Is this your
20 verdict?

21 JUROR NUMBER 22: Yes.

22 CLERK DON MICHELE: Is it still
23 your verdict?

24 JUROR NUMBER 22: Yes.

25 CLERK DON MICHELE: Juror

1 Number 135, Myrna Jimenez. Is this your
2 verdict?

3 JUROR NUMBER 135: Yes.

4 CLERK DON MICHELE: Is it still
5 your verdict?

6 JUROR NUMBER 135: Yes.

7 CLERK DON MICHELE: Juror

8 Number 312, Brenna Emerson. Is this your
9 verdict?

10 JUROR NUMBER 312: Yes.

11 CLERK DON MICHELE: Is it still
12 your verdict?

13 JUROR NUMBER 312: Yes.

14 CLERK DON MICHELE: Juror

15 Number 242, Ronald Simmons. Is this your
16 verdict?

17 JUROR NUMBER 242: Yes.

18 CLERK DON MICHELE: Is it still
19 your verdict?

20 JUROR NUMBER 242: Yes.

21 CLERK DON MICHELE: Thank you,

22 sir. Juror 287, Rachad Williams. Is this
23 your verdict?

24 JUROR NUMBER 287: Yes.

25 CLERK DON MICHELE: Is it still

1 your verdict?

2 JUROR NUMBER 287: Yes.

3 CLERK DON MICHELE: Juror

4 Number 44, Sherman Brown. Is this your
5 verdict?

6 JUROR NUMBER 44: Yeah.

7 CLERK DON MICHELE: Is it still
8 your verdict?

9 JUROR NUMBER 44: Yeah.

10 CLERK DON MICHELE: Juror

11 Number 316, David Hills. Is this your
12 verdict?

13 JUROR NUMBER 316: Yes.

14 CLERK DON MICHELE: Is it still
15 your verdict?

16 JUROR NUMBER 316: Yes.

17 CLERK DON MICHELE: Thank you,
18 sir. Juror Number 292, Jerilyn Woods. Is
19 this your verdict, ma'am?

20 JUROR NUMBER 292: Yes.

21 CLERK DON MICHELE: Is it still
22 your verdict?

23 JUROR NUMBER 292: Yes.

24 CLERK DON MICHELE: Thank you,
25 ma'am. Juror Number 17, was this your

1 verdict?

2 JUROR NUMBER 17: Yes.

3 CLERK DON MICHELE: Is it still
4 your verdict?

5 JUROR NUMBER 17: Yes.

6 CLERK DON MICHELE: Juror
7 Number 43, Reshonda Brown. Is this your
8 verdict?

9 JUROR NUMBER 43: Yes.

10 CLERK DON MICHELE: Is it still
11 your verdict?

12 JUROR NUMBER 43: Yes.

13 CLERK DON MICHELE: Thank you,
14 ma'am. Juror Number 304, Heather Benton.
15 Is this your verdict?

16 JUROR NUMBER 304: Yes.

17 CLERK DON MICHELE: Is it still
18 your verdict?

19 JUROR NUMBER 304: Yes.

20 CLERK DON MICHELE: Thank you,
21 ma'am. Your Honor, the jury has been
22 polled. The verdict stands.

23 THE COURT: Thank you. Very
24 good. While we remain in the presence of
25 the jury, are there still Motions or issues

1 from either side for which a jury response
2 would be necessary? (No response). From
3 the plaintiff?

4 EDWARD GRAHAM: No, Your Honor.

5 THE COURT: Hearing none, from
6 the defendants?

7 ROBERT HOOD: No, thank you,
8 Your Honor.

9 THE COURT: Defendant Dr. Rhett
10 says no. Lowcountry Ob-Gyn?

11 JAY DAVIS: No, sir.

12 THE COURT: Very good. Ladies
13 and Gentlemen, this brings then to a
14 conclusion your role in this case, a very
15 important, pivotal role in this case.

16 I want to thank you for your service.

17 This is not easy but it's what you were
18 called upon to do. The question put to you
19 was not one of sympathy or compassion but
20 it was whether or not the plaintiff met its
21 burden of proof. You made the decision
22 that you have based on the facts you heard
23 in this courtroom and you rendered a
24 verdict which is just and true as you
25 determine it to be. Ma'am, do you have a

1 question?

2 JUROR: I wanted to address you,
3 personally.

4 THE COURT: That is where I was
5 coming to next. I wanted to tell you that
6 if -- in a few days you're going to receive
7 a little check from the county. It's not
8 going to be large, but it's going to be the
9 county's expression of gratitude for your
10 service. But I'm going to come down as you
11 leave the jury box and I am going to shake
12 your hand as you leave as my expression of
13 gratitude. It's been a privilege to work
14 with you. Perhaps our paths will cross
15 again. I look forward to that, should it
16 happen.

17 Again I want to thank you for
18 putting aside your busy personal lives,
19 giving up vacations, giving up work
20 requirements and the other things that you
21 have in order to be here to make this
22 decision, which was a difficult one -- that
23 could not be agreed to between the parties.
24 Thus, the system is working. I thank you
25 for that.

1 Let me come around, give me just a
2 moment and I will be there at the door.

3 Counsel, let me ask so that we can
4 talk about this in the presence of the
5 jurors. What is the parties' position with
6 whether there is any objection to
7 subsequent contact between jurors and
8 counsel. Do you wish to have the
9 opportunity if the juror wishes to speak
10 with you at some later time about these
11 proceedings?

12 EDWARD GRAHAM: Yes, Your Honor.

13 THE COURT: The plaintiff says
14 yes. What says the defendant?

15 ROBERT HOOD: That would be
16 very nice, if it is okay with them.

17 THE COURT: Very good. What
18 says defendant?

19 JAY DAVIS: Thank you, Your
20 Honor.

21 THE COURT: What that means is
22 that at some later time after we get home
23 and your mind is clear and you move back to
24 your personal lives, you may be contacted
25 by the attorneys. There is nothing wrong

1 with that. You are not required to speak
2 with them but if you wish to and you want
3 to have some instructive dialogue -- or
4 destructive dialogue, whatever your choice
5 may be -- then please respond accordingly
6 as you feel inclined to do. I think the
7 lawyers would be appreciate, as would the
8 parties. Thank you for that further
9 involvement if you choose to be involved.
10 Just one moment and I will be at the door.

11 (JURY EXCUSED)

12 THE COURT: Now outside the
13 presence of the jury, here in the court-
14 room, are there any Motions for which a
15 court response would be necessary? From
16 plaintiff?

17 EDWARD GRAHAM: Yes, Your Honor.
18 We would ask for a new trial absolute on a
19 number of grounds. We'd ask for time to
20 enumerate those grounds.

21 THE COURT: All right, what the
22 Court will do -- it has been a lengthy
23 trial and I will give you ten days to make
24 any Motions that you wish to make, whether
25 it be something other than a new trial

1 absolute or a new trial absolute. The
2 court will give you leave within ten days
3 of today's date, by 5:00 o'clock, to make
4 such a Motion.

5 EDWARD GRAHAM: Thank you.

6 THE COURT: Anything from the
7 defendants?

8 ROBERT HOOD: No, thank you,
9 Your Honor.

10 THE COURT: All right, now we've
11 got some property that belongs -- at least
12 one item that we need to return to the
13 Beaufort Hospital. Is there anything else
14 among the exhibits which is a medical
15 device or something which may have some
16 value that's needed?

17 ROBERT HOOD: We got those
18 back by agreement.

19 THE COURT: Is there anything
20 else?

21 EDWARD GRAHAM: Your Honor, just
22 as matter of inquiry, have you spoken with
23 the juror that asked to speak to you?

24 THE COURT: I did.

25 EDWARD GRAHAM: May we know what

1 she said?

2 THE COURT: She told me that I
3 was a very nice man. Then she cried.
4 That's what she did.

5 EDWARD GRAHAM: I agree with
6 her, Your Honor.

7 THE COURT: That was very kind.
8 I am sure that it was overstated but that
9 was her comment, that's what she wanted to
10 say. It had nothing to do with the merits
11 of the case. It was just a comment to me.

12 Ladies and Gentlemen, again this a
13 hard case. I just wish everyone can move
14 forward in life. Perhaps our paths will
15 cross again. This court is now adjourned.

16 (COURT ADJOURNED)

17 (TRANSCRIPT CONCLUDED)

18

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21

22

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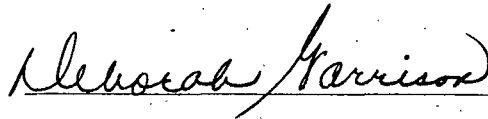
24

25

1 CERTIFICATE OF REPORTER

2
3 I, the undersigned, Deborah Garrison,
4 official court reporter for the 9th
5 Judicial Circuit of the State of South
6 Carolina, do hereby certify that the
7 foregoing transcript was prepared from the
8 audio tapes of Gayle Burns, presiding court
9 reporter assigned to capture the within
10 proceedings of July 26, 2010 through August
11 11, 2010, before The Honorable Michael
12 Baxley;

13 I further certify that I am
14 neither kin nor counsel to any of the
15 parties and have no interest in the outcome
16 of this action.

17
18 

19 Deborah Garrison

20 Circuit Court Reporter

21 9th Judicial Circuit

22
23
24 Charleston, South Carolina

25 February 19, 2011

Deposition of Yvonne Gomez-Carrion, M.D.

1 STATE OF SOUTH CAROLINA
2 COUNTY OF CHARLESTON

3 IN THE COURT OF COMMON PLEAS
4 NINTH JUDICIAL CIRCUIT
5 CASE NO: 2007-CP-10-1553

6 *****

7 Jamesetta Washington, as Guardian ad)
8 Litem, for Jayden W a minor,)
9 Plaintiff,)

10 vs.)

11 Edmund Rhett, Jr., M.D., Low Country)
12 Obstetrics & Gynecology, P.A., and)
13 East Cooper Community Hospital, Inc.,)

14 Defendants.)

15 *****

16 VIDEOTAPED DEPOSITION OF YVONNE

17 GOMEZ-CARRION, M.D., a witness called on
18 behalf of the Plaintiff, pursuant to the
19 South Carolina Rules of Civil Procedure,
20 before Kristin Kelley, a Registered
21 Professional Reporter and Notary Public in
22 and for the Commonwealth of Massachusetts,
23 at the offices of G&M Court Reporters, Ltd.,
24 42 Chauncy Street, Boston, Massachusetts, on
Thursday, July 22, 2010, commencing at
11:23 a.m.

Deposition of Yvonne Gomez-Carrion, M.D.

1
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31 & Gynecology, P.A.

32 ALSO PRESENT:

33 George Dobrentey, Videographer
34

Deposition of Yvonne Gomez-Carrion, M.D.

I N D E X

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4	Discharge Summary	101
5	Patient Information Facesheet	108

P R O C E E D I N G S

THE VIDEOGRAPHER: Good morning.

My name is George Dobrentey of G&M Court Reporters. Today's date is July 22, 2010, and the time is 11:23 a.m. This deposition is being held at the office of G&M Court Reporters in Boston, Massachusetts. The case caption is Washington versus Rhett, Jr., in the State of South Carolina, County of Charleston, Court of Common Pleas, Case number 2007-CP-10-1153. The name of the witness is Yvonne Gomez-Carrion.

At this time the attorneys will identify themselves and the parties they represent, after which our court reporter, Kristin Kelley of G&M Court Reporters, will swear in the witness and we can proceed.

MR. GRAHAM: Thank you. My name is Ed Graham. I represent the plaintiff.

MS. SIMMONS: Chilton Simmons for Dr. Rhett.

MR. SCOTT: Jim Scott for Low Country Obstetrics & Gynecology, P.A.

* * *

1 YVONNE GOMEZ-CARRION, M.D., a
2 witness called for examination by counsel
3 for the Plaintiff, having been
4 satisfactorily identified by the reporter,
5 being first sworn by the Notary Public, was
6 examined and testified as follows:

7 * * *

8 DIRECT EXAMINATION

9 BY MR. GRAHAM:

10 Q. Doctor, would you please state your full
11 name and address for the record.

12 A. My name is Yvonne Gomez-Carrion. My
13 business address is the Beth Israel
14 Deaconess Medical Center, 339 Brookline
15 Avenue, Boston, Massachusetts, 02215.

16 Q. Thank you. Dr. Gomez-Carrion, you are a
17 physician board certified in obstetrics and
18 gynecology. Is that correct?

19 A. That is correct.

20 Q. Before we get into your opinions with regard
21 to the labor and delivery of Jayden
22 W: let me just ask you some
23 personal background questions. Where were
24 you born, ma'am?

Deposition of Yvonne Gomez-Carrion, M.D.

1 A. I was born St. John's Hospital, Brooklyn,
2 New York.

3 Q. And in terms of your family situation, do
4 you have children, and if so, how many and
5 who are they?

6 A. Well, I definitely have family. I have five
7 children. Unfortunately, one is no longer
8 with us, but I have a 34-year-old stepson.
9 I have a 23-year-old biological son, and
10 17-year-old twin daughters.

11 Q. Thank you. Do you have connections with
12 South Carolina, and if so, please describe
13 those.

14 A. Well, I certainly do. My father's folks
15 originate from Sumter, South Carolina, and
16 most of the summers of my childhood I spent
17 in Orangeburg, South Carolina. And when I
18 had my children I pretty much had them spend
19 their summers in Orangeburg, South Carolina.
20 In case you have not noticed, I have quite
21 the golden tan because I just returned from
22 Charleston, so I have family in Orangeburg,
23 Columbia, Charleston, Sumter, and it's a
24 beautiful place.

1 Q. Thank you. Now, let's turn to your
2 professional qualifications. I have here a
3 trial exhibit marked number 46. Could you
4 identify that please, ma'am.

5 A. That's the curriculum vitae that I put
6 together in 2006.

7 Q. Thank you. As of the date it was prepared,
8 were the entries on here true and accurate?

9 A. They were.

10 Q. Has there been any significant change in
11 your professional status since that date?

12 A. I believe no. Nothing has significantly
13 changed in my academic status.

14 Q. Okay. Tell me first, please, about your
15 educational background starting with high
16 school.

17 A. Oh, my. All right. I attended Peter
18 Stuyvesant High School in New York City.
19 It's a science and math high school. It
20 still exists. I did quite well academically
21 and managed to get a full scholarship to
22 Princeton University, and I was there for
23 four years as a premedical student, and
24 majored in psychology and biology and

1 applied to medical school and decided that
2 although I loved New Jersey, I wanted to
3 return home, so I got into Columbia College
4 of Physicians and Surgeons and was a medical
5 student there for four years and stayed
6 there for my residency training at the
7 Columbia Presbyterian Medical Center.

8 Q. You referenced Columbia. Is that part of
9 the Columbia University in New York?

10 A. Yes, it is.

11 Q. When did you finish your, your medical
12 school training before the residency?

13 A. My medical school training ended in 1983.

14 Q. Okay. And after that did you intern and
15 serve as a resident, and if so, tell the
16 jury about that, please.

17 A. Well, I was an intern from 1983 to 1984, and
18 those were the days that residency work
19 hours were not protected, so it was common
20 to work anywhere from 120 hours a week doing
21 general obstetrics and gynecology, and also
22 rotating through medicine and general
23 surgery, going to outside hospitals.

24 I went to Overlook in New Jersey, and

1 then progressed to second year resident
2 where focus more on obstetrics and
3 gynecology, and as a third year resident did
4 more surgery and did more consultations to
5 the entire medical center.

6 My fourth year as resident oversaw a
7 major teaching of my junior residents, and
8 developed management plans for women and
9 dealt with a lot of high risk pregnancies
10 and complicated gynecologic patients, and
11 basically at Columbia at that time was
12 treated more like an attending, so gained
13 wonderful experiences.

14 Q. During your last year as a resident who
15 served as chief resident?

16 A. Well, we were -- the chief resident was
17 elected and they chose me to be chief
18 resident, so with chief residency not only
19 is it a nice title to have but it comes with
20 a lot of work, so not only are you as chief
21 resident in charge of schedules, but also
22 you have to do your own clinical work, so
23 it's sort of quite the increased workload to
24 be chief resident, but it's quite an honor,

1 because to be chief resident you have to be
2 incredibly efficient, have to know how to
3 bring people together and be a model for
4 your junior residents in terms of patient
5 care.

6 Q. You've told me early on that you were board
7 certified in obstetrics and gynecology.

8 What does it mean to be board certified?

9 A. Well, it's an exam that we take after our
10 residency training, and after collecting
11 cases for a year, the American College of
12 Obstetrics and Gynecology want to make sure
13 that all the practicing physicians are
14 competent and safe, so they want to make
15 sure you've had adequate cases in
16 obstetrics, high risk, routine, and
17 gynecologic surgeries.

18 And once your list is accepted after
19 collecting for a year, you then get invited,
20 and at that time it was to Texas, to have a
21 three-hour oral examination. And there were
22 three examiners and they just ask lots of
23 questions, some related to the case list
24 that's submitted and some related to just

1 various topics in obstetrics and gynecology,
2 and that was the experience.

3 Q. Thank you. Now, as I understand it, there
4 are certain subspecialties under obstetrics
5 and gynecologists, so some people might
6 specialize in one area or another and other
7 obstetricians do it all. How do you fit
8 into that situation?

9 A. Well, I'm a true generalist. I've had
10 training in high risk obstetrics, but I have
11 not done a maternal fetal medicine
12 fellowship. I've had excellent operative
13 training, but did not need to do an oncology
14 fellowship. I do a lot of fertility workup,
15 but did not do a reproductive endocrine and
16 fertility fellowship, so those are the three
17 main branches.

18 You know, 23 years ago when I became
19 an attending, the experience was much more
20 broader-based and because we didn't have the
21 strict need to have attendings always
22 present we had a lot more independence in
23 terms of patient management, and that's
24 certainly changed, and probably for the

1 better, over the last couple of decades.

2 It's become, I think, safer for
3 patients because all residents must always
4 have attending oversight, someone who's more
5 experienced making sure that the patient is
6 safe and the management plan is the most
7 positive.

8 Q. Let's move forward and talk about your
9 employment as a physician after you finished
10 your residency program.

11 A. Okay.

12 Q. Tell us. Tell the jury about that, please.

13 A. Well, I completed my residency training in
14 pretty much May of 1987. It should have
15 gone to the middle of June, but I had my
16 biological son at that time and was so very
17 pregnant at the end of my residency
18 training. Then I had six weeks to prepare
19 for my boards and move to Massachusetts for
20 my first job as an attending.

21 I gained employment at Roxbury
22 Comprehensive Community Health Center as a
23 payback. I was a National Health Service
24 Corps scholarship recipient and owed four

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1 years of service to the government.

2 At that time I also was an attending
3 at the Beth Israel Deaconess Medical Center,
4 but although my commitment was for four
5 years I enjoyed the work at Roxbury
6 Comprehensive so much I remained there for
7 11 years working with an incredibly
8 committed staff. And it was interesting as,
9 you know, a newly graduated resident. I
10 automatically inherited a staff of over 25
11 people, including three other attendings and
12 a couple of midwives and social workers, and
13 it was just a very comprehensive team
14 providing care to a very high risk and
15 fragile patient population.

16 So, after working at Roxbury
17 Comprehensive for 11 years I wanted to
18 spread my wings a little bit, and through
19 the hospital, through Beth Israel Deaconess
20 Medical Center and the chairman, who at that
21 time was Benjamin Sachs, encouraged me to do
22 more of a private practice, and actually, we
23 designed a clinic in Jamaica Plain, which is
24 part of Boston and 15 minutes from the

1 hospital proper.

2 I was there for five years and
3 realized that my practice was getting so
4 busy. Even though the distance was short,
5 it was taking a toll on me traveling back
6 and forth, so since 1997, I believe, I have
7 been at the Beth Israel Deaconess Medical
8 Center as an attending and have taken on a
9 more of a teaching role with the medical
10 students and the residents.

11 Q. You mentioned medical students. What does
12 Beth Israel Deaconess hospital have to do
13 with medical school?

14 A. Well, Beth Israel Deaconess Medical Center
15 is one of the Harvard teaching hospitals,
16 and we pretty much train a third of the
17 Harvard Medical students in obstetrics and
18 gynecology. They also rotate through the
19 other divisions, medicine, general surgery,
20 et cetera at the hospital, but I'm very
21 involved with the training of the medical
22 students.

23 I'm also involved with recruiting for
24 our program and involved with interviewing

1 and selecting residents for the residency
2 program itself.

3 Q. How much of your time actually involves
4 teaching medical students at Harvard?

5 A. Well, the days that I am in the operating
6 room and on call, which are usually 36 to
7 48 hours a week, I'm involved with medical
8 students. Periodically, a medical student
9 can also be assigned to my clinical
10 sections, which occur Monday through
11 Wednesday.

12 Q. Okay. When you talk about clinical
13 sessions, you're talking about actually
14 providing hands-on care to obstetrical
15 patients?

16 A. In an outpatient setting. That's when I see
17 the women who are coming for prenatal care,
18 antepartum testing, et cetera.

19 Q. Have you also been involved in any community
20 activities?

21 A. Lots. I do a lot of mentoring in the
22 community. As an African-American woman in
23 medicine, I have gained lots of experience
24 and I think it's important that I not only

1 pay back but also pay it forward, so I'm
2 often invited to churches and schools to
3 give motivational speeches. I also am
4 involved with lecturing on medical subjects
5 to particularly primary care physicians, so
6 I do a lot of community speaking.

7 Q. Thank you. You mentioned being board
8 certified. Have you continued your medical
9 education after you became board certified?
10 How does that work?

11 A. Well, for folks who are in my age range, we
12 are not what we call grandfathered in to
13 being board certified, so I've elected on a
14 yearly basis to read a number of articles
15 and take a written exam in order to keep my
16 certification active.

17 Q. Are you familiar with the generally accepted
18 standards of obstetrical practice with
19 regard to the use of a vacuum to assist in
20 the delivery of a baby?

21 A. Absolutely.

22 MR. GRAHAM: Okay. At this point I
23 would tender Dr. Gomez Carrion as an expert
24 qualified to address the jury on topics

1 related to obstetrics and the use of a
2 vacuum extractor.

3 MS. SIMMONS: No objection.

4 MR. SCOTT: No objection.

5 Q. Doctor, have you at my request reviewed the
6 medical records, depositions and other
7 materials related to this case and related
8 to the birth of Jayden W ?

9 A. Yes, I have.

10 Q. Okay. What did you consider your job
11 description to be as you reviewed those
12 materials?

13 A. Well, in reviewing the medical records and
14 the depositions, I believe it was my job to
15 get a good understanding as to
16 Miss Washington's prenatal course, her
17 clinical status when she presented in labor
18 and delivery, the course of her labor
19 process and then the events that occurred at
20 the delivery and subsequent status of her
21 child, Jayden, and to render an opinion on
22 whether there was a breach in standard of
23 care in various aspects of her care.

24 Q. What have you reviewed?

1 A. I've basically reviewed the three binders
2 that you've provided of medical records that
3 included her antepartum course, her labor
4 record, the fetal heart rate tracings. I
5 reviewed the depositions from Dr. Rhett, two
6 nurses and attendants. I don't recall their
7 names offhand. And I believe a doctor by
8 the name of Oatinger, and I also reviewed
9 the deposition that I had given previously.

10 Q. You mentioned several things there. Part of
11 what you mentioned was prenatal. What is
12 prenatal?

13 A. The prenatal course is when a woman realizes
14 she's pregnant and seeks care, so, you know,
15 various labs are checked, her medical status
16 is monitored during her pregnancy, the
17 baby's growth is monitored. We are
18 constantly looking for issues around, you
19 know, sugar issues ruling out gestational
20 diabetes, hypertension, which she had none,
21 and just making sure.

22 During that prenatal course one of the
23 jobs or the main jobs of the obstetrician is
24 to make sure the woman is prepared for

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1 delivery so there are no surprises when she
2 comes into labor and delivery. She is aware
3 of the potentials for various monitoring,
4 monitoring devices, use of Pitocin or
5 induction agents, in this case Cervidil and
6 Pitocin. She's aware of the nursing role,
7 what the physician's role is or are, and
8 what to expect when she becomes fully
9 dilated and, you know, talk a little bit
10 about how you know you're in labor. In this
11 case she was induced.

12 Q. What does it mean to induce labor?

13 A. A woman is induced when she's not in labor,
14 and the definition of labor is having
15 painful uterine contractions that cause
16 cervical change or cervical dilatation.

17 Q. So, if a woman is not in labor, how does a
18 doctor induce labor?

19 A. Well, in this case a cervical ripening agent
20 was given since this was her first baby.
21 And I believe that was Cervidil.

22 In a woman who has not had significant
23 contractions, the cervix tends to have
24 pretty significant consistency, so if you

1 just use Pitocin, the efficacy or the
2 ability of the Pitocin to work well is
3 decreased, so we tend to want the cervix to
4 be shortened, soft, hopefully even dilated,
5 so that was given and IV Pitocin was used as
6 well.

7 Q. You've used a lot of words I want to ask you
8 to define. What is a cervix?

9 A. Okay. The cervix is the -- in lay terms,
10 the mouth of the womb. It is the opening to
11 the uterus, and a cervix in a nonlaboring
12 person tends to be closed.

13 In terms of the labor process, a woman
14 has to have contractions to reach full
15 dilatation, which is also known as ten
16 centimeters. Some people call it full
17 dilatation. Some people use the term
18 complete. And that's when the fetal head
19 can descend further into the vaginal canal
20 past the uterus itself.

21 Q. Okay. Now, when you talk about cervical
22 dilatation, what are you talking about
23 exactly?

24 A. The cervix is part of the uterus. It's the

1 mouth of the womb and it's that part that
2 needs to open up in order to allow the baby
3 to come through.

4 Q. You also referred to Pitocin. What is
5 Pitocin?

6 A. Pitocin is also known as oxytocin. We make
7 Pitocin, as women, in our posterior
8 pituitary, which is part of the brain, but
9 we also realize that giving it through an
10 intravenous on a monitor, it has to be very
11 well monitored because some women are very
12 sensitive to Pitocin and you can cause
13 really strong contractions to come close
14 together and you can have changes in the
15 fetal heart rate tracing based on the
16 activity of the uterus.

17 So, if a provider, obstetrician or mid
18 wife is using Pitocin and contractions
19 become too close, you'll see decelerations
20 in the baby's heart rate, and we can
21 certainly turn Pitocin down or off to
22 correct that, so --

23 Q. All right. Excuse me. Go ahead.

24 A. So Pitocin is a hormone that we give. It's

1 exogenous, made outside of the body in the
2 cases where obstetricians use it to get
3 women in labor or to augment or increase
4 uterine contractions.

5 Q. All right. Now, these phrases you're using
6 are not as familiar to me as they are to
7 you, so I want to make sure you explain it
8 so I can understand it.

9 When you talk about giving Pitocin
10 intravenously, you're talking about like
11 through an IV tube?

12 A. Absolutely.

13 Q. Delivering medicine?

14 A. A plastic tubing that goes into the woman's
15 vein and then Pitocin is mixed in a bag with
16 IV fluid and a certain concentration and
17 then put on a pump so we know exactly how
18 much of this medication is being introduced
19 to the patient.

20 Q. When an obstetrician orders Pitocin for a
21 woman, a pregnant woman, what is the purpose
22 of ordering it?

23 A. Again, to help her have strong uterine
24 contractions in the goal of facilitating a

1 vaginal delivery.

2 Q. Now, was Pitocin used in this case?

3 A. Yes, it was.

4 Q. You talked about labor or is -- is there a
5 way to break down labor into different
6 stages, and if so, please explain that to
7 us.

8 A. All right. There's a part of labor we call
9 stage one or latent phase labor, part of
10 stage one, where you can have uterine
11 contractions but not a lot of cervical
12 change, and so latent phase labor, the early
13 part of labor, can last in a woman who's not
14 had a child before 12, 16 hours.

15 Once a woman theoretically is around
16 four centimeters, so she's moved from a
17 closed cervix to four after having uterine
18 contractions, she's now moving more into the
19 active phase of the first stage of labor, so
20 we consider the active phase four
21 centimeters to 10 centimeters.

22 And when a woman is ten centimeters
23 and she sometimes has the urge to push and
24 sometimes she doesn't, but the second stage

1 of labor is defined as when a woman is
2 complete or ten centimeters.

3 Q. That's when the first stage ends?

4 A. Correct.

5 Q. Could you show the video camera about what
6 ten centimeters looks like using your hands?

7 A. Ten centimeters is about like that
8 (indicating).

9 Q. Thank you. So once the cervix opens up to
10 ten centimeters, that's the end of the first
11 stage?

12 A. Well, that's the end of active phase of
13 labor.

14 Q. Okay. And does another stage start then?

15 A. Correct.

16 Q. What stage is that?

17 A. That's the second stage.

18 Q. Thank you.

19 A. That's the stage where mom starts pushing.

20 Q. Okay. And then a woman who is pregnant
21 delivering her first baby, what's the
22 significance of that second stage? What --
23 what's going on?

24 A. Well, the cervix now has disappeared

1 essentially. She is fully dilated. She's
2 complete. When you do an exam, you don't
3 feel any cervix. You're basically feeling
4 vagina, the pelvic anatomy and the fetal
5 head, the skull of the baby.

6 And as the second stage progresses --
7 again, I mentioned some women really don't
8 have a lot of pelvic pressure or the
9 sensation to push, and a lot of times that's
10 because women have epidurals. So, second
11 stage can be anywhere from two to
12 three hours in a woman who's never had a
13 baby or never pushed a baby out.

14 There's a learning curve, and
15 typically when a woman is in the second page
16 and she doesn't really have that urge to
17 push, that's a perfect opportunity to go
18 over how one pushes because it's not -- we
19 as women are not born knowing how to push.

20 Some lucky women have this incredible
21 sensation when the fetal head hits the
22 pelvic floor or the muscles of the pelvis
23 and it's uncontrollable. The baby comes
24 down and she pushes and it goes very well

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1 and very quickly often, but for the most
2 part, most first time moms average hour,
3 hour and a half, two hours of pushing well
4 in order to deliver a normal sized baby.

5 Q. Thank you. Let me ask you some other basics
6 about delivering a baby. Is there more than
7 one way to deliver a baby, and if so, what
8 are the different ways?

9 A. That's a great question. Clearly there are
10 more than one way to deliver a baby, more,
11 yes.

12 The first way is what we call a
13 spontaneous vaginal delivery, mom pushes,
14 the baby's -- the baby comes down the
15 vaginal vault, crowns, which means the
16 vagina is stretched around the baby's head,
17 and then with maternal effort, the baby
18 comes through, the obstetrician or midwife
19 does maneuvers to guide the baby out.
20 That's a spontaneous vaginal delivery.

21 There are times when the mom can also
22 deliver vaginally but needs a little
23 assistance from either the physician or the
24 midwife, and that assistance can come from

1 either a vacuum extractor, as used in this
2 case, or forceps.

3 And the other alternative is bypassing
4 the vaginal delivery, and that would be
5 called a cesarean section where you make an
6 incision on mom's abdomen, carrying it down
7 through the various layers, making an
8 incision into the uterus, also known as the
9 womb, and delivering the baby that way.

10 Q. Now, I've heard the phrase "operative
11 vaginal delivery". Is that the same as a
12 C-section, or what is an operative vaginal
13 delivery?

14 A. That is not the same as a cesarean section.
15 Operative vaginal delivery is exactly what
16 you said. It's a vaginal delivery but the
17 mom has had assistance and with an
18 instrument, so that's where the term
19 "operative" comes into play, and that
20 instrument can either be a vacuum extractor
21 or forceps. So, she's pushing and the
22 delivering physician is using an instrument
23 to provide more traction while mom is
24 pushing with her contractions.

1 Q. As a man, I've obviously never delivered a
2 baby. I think I've got a pretty good
3 understanding of what a birth canal is, but
4 probably not as good of an understanding as
5 you have. Could you help me understand
6 better what the birth canal really is.

7 A. Okay. Well, the birth canal -- some folks
8 call it the birth canal. Most physicians or
9 midwives, we think of it as the pelvis.

10 So, in the pelvis you have the bony
11 structures and on the top of the pelvis is
12 what we call the pelvic inlet. As the baby
13 comes down out of the upper part of the
14 uterus, it enters the pelvis, so it enters
15 the inlet, which is surrounded by the pelvic
16 brim, and the baby starts descending through
17 the cervix.

18 And then you'll hear terms. The term
19 or landmark we use to know whether baby's
20 head is engaged are these bony structures on
21 the side walls of the pelvis called the
22 ischial spines. Once the baby's head has
23 reached that point, we have a good
24 understanding that baby is in the proper

1 position and is following the path out.

2 So, the birth canal is the upper part
3 of the vagina, the middle part and lower
4 part. As the baby descends, it comes to the
5 lower part of the vagina. We think of that
6 more as the pelvic outlet.

7 And then the baby comes through that
8 area past the pubic bone, past the sacrum,
9 which are all bony structures of a woman's
10 pelvis, and then -- I'll use for the video
11 camera. You'll actually see the baby's head
12 pushing through the woman's vaginal opening.

13 When you see the head pushing through,
14 you can clearly see, often, hair, sometimes
15 no hair, but that's what we call crowning
16 because actually it looks like a crown that
17 the baby has on its head, so that's the
18 mom's perineum or vaginal opening stretching
19 to allow the delivery of her child.

20 Q. I'm going to hand you a document and ask you
21 if this would be helpful in explaining your
22 testimony to the jury about the birth canal.

23 A. It would be very helpful.

24 Q. Okay.

1 A. As I said, this is the bony structure of the
2 pelvis, and this area is the pelvic inlet as
3 the baby descends. You can see in this
4 picture the ischial spines, which is
5 actually marked here (indicating).

6 Q. May I help holding that for you.

7 A. Sure.

8 MR. GRAHAM: Would this be helpful,
9 Mr. Videographer?

10 THE VIDEOGRAPHER: Yes.

11 A. Here you have it labelled "the ischial
12 spine", and in this illustration you
13 actually see the fetal head, the top part at
14 the spine, so we would consider this baby
15 engaged.

16 So as the baby descends and has
17 internal rotation and flexion, the baby has
18 to go through all sorts of what we call
19 cardinal labor maneuvers in order to
20 negotiate the pelvis and the birth canal.
21 So it continues to come down the vagina and
22 pass the pubic symphysis, which is in this
23 area, and the vaginal opening would be more
24 here where it says plus five. And as the

1 baby's head comes to the plus five station,
2 it's basically crowning, just about out
3 (indicating).

4 Q. Okay. Now, let me ask you about these
5 numbers. On this image I see a minus five,
6 a zero and a plus five. What do those mean?

7 A. Okay. There is this numbering system that
8 we have so that when an exam is done by one
9 provider it's our way of communicating where
10 in the birth canal the baby is, is the baby
11 even in the birth canal.

12 That's when we use words like
13 engagement. If you're at minus five, that
14 means the baby's head is up in this area.
15 That is not an engaged head. A head is
16 engaged, again, when the top part is the
17 ischial spine or where the widest part of
18 the baby's head, also known as a biparietal
19 diameter, has passed the pelvic inlet.

20 When you're at zero station, you can
21 feel the spines and you can feel the top
22 part of the baby's head. As you progress
23 into the birth canal, you're more talking
24 positive numbers.

1 It gets a little tricky because some
2 babies as they come down the birth canal in
3 order to fit there are terms we use called
4 molding where the sutures and the skull
5 bones kind of shift. The baby's head is
6 very soft so you have this molding process.
7 The baby is trying to contour to mom's
8 pelvis.

9 The other term that you'll hear used
10 is caput where there's actually edema and
11 elongation of the baby's head. And these
12 are all normal processes, but sometimes when
13 a provider will examine a baby where a
14 little trick, sometimes because we think the
15 baby is actually lower than it is because of
16 the caput or the elongation of the head, and
17 if you feel up high, you realize the most
18 wide part of the head is still higher up in
19 the birth canal, so you have to be very
20 careful in terms of our descriptives where
21 the actual BPD or biparietal diameter is. I
22 hope I answered your question.

23 Q. Now -- yes, indeed. I'm going to come back
24 and ask you to explain some of those words

1 you used. But first let me ask you this,
2 there are certain lines between the minus
3 five and the zero in between the zero and
4 the plus five. What do those lines
5 represent?

6 A. Well, pretty much -- I believe this is why
7 we went to the five system as opposed to we
8 used to use the three system or some places
9 even used a four system.

10 Each line theoretically represents a
11 centimeter in distance, so in the typical
12 pelvis the distance from the ischial spine
13 to say the vaginal introitus or the perineum
14 even is about five centimeters.

15 So, when you examine mom and you've
16 determined that the fetal head is say at
17 plus three, you still have about two
18 centimeters before the baby's in the
19 crowning position or, as we say, the outlet
20 position.

21 Q. Thank you.

22 MR. GRAHAM: I'm going to ask you
23 to mark this please as deposition Exhibit 1.

24 (Illustration marked Exhibit No. 1

1 for Identification.)

2 MR. GRAHAM: Thank you.

3 Q. Dr. Gomez-Carrion, let me go back and get
4 you to define some of the phrases and words
5 that you used. You -- you talked about
6 engagement. As a baby's head moves into the
7 birth canal and moved down toward the
8 opening, at what point is the baby's head
9 first engaged? How do you tell that?

10 A. Well, the definition of engagement, again,
11 is when the top of the baby's head in a
12 non-molded head, a baby without caput, is at
13 zero station or the ischial spines and --
14 but, you know, it varies because there's
15 some readings that define it as when the
16 widest part of the baby's head is the
17 ischial spine, but most providers will use
18 the former definition, and what that just
19 states is that the widest diameter has come
20 through the pelvic inlet.

21 Q. Right.

22 A. So the baby -- on examining the baby, you
23 cannot really ungage it. It's kind of fixed
24 in the pelvis. If you were to examine it,

1 you can't blot it and push it back up into
2 the uterus that easily.

3 Q. Okay. So when you talk about the lowest
4 part of the baby's head not counting the
5 caput, are you saying basically the leading
6 part of the bony skull?

7 A. Exactly.

8 Q. Okay. And -- and in terms of caput, I want
9 to make sure we all understand that. Is --
10 what is a caput made of? Is it bony, or
11 what is it?

12 A. Well, it's -- it's the tissue of the scalp
13 over the bony structure, and due to the
14 forces of labor, sometimes that skin can
15 retain fluid. It can get -- the word we use
16 is edenamous (phonetic), so it gets kind of
17 spongy and it elongates and it contours to
18 the shape of the mom's pelvis, so there's no
19 bone in caput. It's basically soft tissue
20 and fluid.

21 Q. Okay. So when you're determining a baby's
22 station, you ignore the caput?

23 A. No, but you have to realize that the baby's
24 head is elongating, so you take that into

1 consideration. They -- you know, you may
2 think a baby is lower than it actually is in
3 terms of where the widest part of the head
4 is because of the elongation process.

5 Q. Okay. And if the top of the baby's bony
6 head is the lowest part as it comes down
7 head first, if that is above zero station,
8 is the baby's head engaged?

9 A. If that bony structure, if you have this
10 part of the head is above zero station, that
11 is not an engaged fetus.

12 Q. Right. And when it gets to zero, it is
13 engaged?

14 A. Correct.

15 Q. And then eventually it works from zero to
16 plus five?

17 A. That's what you'd like to do, yes. Yes.

18 Q. Okay. And then it comes out?

19 A. Yes.

20 Q. Thank you. Do obstetricians have standard
21 barriers to describe different parts of the
22 birth canal once the baby's head is engaged,
23 and if so, what are those?

24 For example, I've seen phrases like

1 outlet, low, mid, high. Are those
2 meaningful words to you, and if so, what do
3 they mean?

4 A. Well, those are terms usually used when
5 we've done an operative vaginal delivery.
6 So, for example, if you're using forceps or
7 a vacuum, if the baby's head is crowning,
8 that is a true outlet delivery.

9 Q. And how do you --

10 A. Because it's plus five station.

11 Q. And, again, how do you know if a baby's head
12 is crowning?

13 A. You can see it. It's right there. Mom is
14 usually in dorsal lithotomy, so her thighs
15 are to the sides, and you look at the
16 perineum and the head is there and the
17 vaginal vault is just sort of -- it looks
18 like a turtleneck being pulled back and it's
19 called crowning because the vagina is around
20 the baby's head.

21 Q. Okay. You used a phrase there I want you to
22 define, dorsal lithotomy. What is that?

23 A. That means mom is on her back with her legs
24 pulled back. I know, medical language.

1 Yes.

2 Q. All right. So you've told us that an outlet
3 is when the head is crowning and you can see
4 it?

5 A. Uh-hum. Then you have the descriptive of a
6 low, which is usually when the fetal head is
7 plus two station or lower. If it's above
8 plus two station, that's more of a mid. If
9 it's at zero or above that, it's high.

10 Q. Okay. Now, you -- you used the word
11 "station". Let me make sure we all
12 understand what station means in this
13 context. Would you explain that, please.

14 A. Again, looking at your diagram here --

15 Q. Let me hold it for you.

16 A. Great. And the various lines, each line is
17 considered a station. So where you have the
18 bony protuberances, the ischial spine, we
19 have defined that as zero station. A
20 centimeter above that or the first line
21 above zero would be minus one station as the
22 baby descends, each centimeter or each line
23 as you have on your diagram is an additional
24 station.

1 So each centimeter the baby comes down
2 is plus one station. Another descent of a
3 centimeter, plus two station. Another
4 descent of a centimeter, plus three station,
5 and so on.

6 Q. Thank you.

7 A. You're welcome.

8 Q. Let me get you to define just a few more
9 words that I think are coming up. One is
10 indication. To a doctor, what does the word
11 "indication" mean?

12 A. Well, to a physician and any health care
13 provider, an indication usually means you
14 have a clinical issue and you want to act on
15 that, but what it -- what's the reason for
16 your action or your proposed action, and
17 that reason we call indication.

18 Q. What is a contraindication?

19 A. A contraindication is often a reason not to
20 do something. You can have a clinical
21 entity, a clinical presentation and there
22 can be reasons to do something. That's an
23 indication, but there are also reasons not
24 to do something, and those are called

Deposition of Yvonne Gomez-Carrion, M.D.

1 contraindications.

2 Q. What does the phrase "informed consent"
3 mean?

4 A. Very important phrase. Any time a health
5 care provider makes a recommendation,
6 particularly if it's an intervention, for
7 example, an operative vaginal delivery,
8 cesarean section, we must go through step
9 wise what those procedures mean in terms of
10 exactly what are you talking about as a
11 health care provider, what does applying a
12 vacuum or forceps, what does that mean in
13 terms of what you're doing the technique,
14 what are the potential risks of those
15 procedures as oppose -- as related to what
16 the benefits are.

17 So when you're making a
18 recommendation, the patient has to be on
19 board as to what your proposal is and she
20 has to be an integral part of the
21 decision-making in terms of what then
22 happens, so we consider that patient
23 informed and able to consent or give
24 agreement to what you have recommended

Deposition of Yvonne Gomez-Carrion, M.D.

1 because you've given her the facts as best
2 as you know them from your education,
3 personal experience or medical literature.

4 Q. Well, the patient is not the doctor. The
5 doctor's the one with the medical school and
6 the experience and so forth. What do you --
7 what are you saying? Who -- who has the
8 right to make the final decision about
9 whether or not to use an intervention? Is
10 that something the doctor can do on his or
11 her own, or is that something that the
12 patient has a say so in?

13 MS. SIMMONS: Object to the form.

14 A. The physician or health care provider
15 clearly has additional knowledge and it's on
16 us, and that's why prenatal care is so
17 important, to help our patients understand
18 the potentials that might occur when she
19 goes to labor and delivery.

20 When a health care provider, whether
21 it be obstetrician or midwife, is concerned
22 about something and wants to intervene, it's
23 on us to help our patient understand why
24 we're concerned, what the options for

1 treatment are, what the benefits and risks
2 are.

3 Clearly our patients, most of them
4 haven't gone to medical school or done a
5 residency training, but women, we know our
6 bodies and we -- most women are incredibly
7 knowledgeable when we as health care
8 providers, do a good job in explaining the
9 rationale for an intervention, so it's --
10 you have to have consent from your patient
11 in order to do an intervention, otherwise
12 it's --

13 It's called other things if you decide
14 to say do surgery on someone and they're not
15 totally aware of why you're doing it and
16 what the risks are, because if there's an
17 untoward effect or there's a complication,
18 the discussion after that can be very
19 different depending on what dialogue you had
20 up front with your patient.

21 Q. Well, let's talk about use of a vacuum
22 extractor. Are there benefits and risks
23 involved in the decision whether or not to
24 use a vacuum, and if so, please describe

1 those?

2 A. Well, there are benefits and risks in the
3 use of a vacuum extractor. I mean, clearly
4 the indications for a vacuum is to
5 facilitate a safe vaginal delivery.

6 The indication for a vacuum delivery
7 can be maternal exhaustion, you're concerned
8 about the baby's heart rate. There may be
9 some medical issues with your patient where
10 the patient shouldn't have a prolonged
11 pushing. She could have some type of heart
12 disease. She could have some type of brain
13 issue where it's medically contraindicated
14 or she should not push where a vacuum is
15 helpful, but using a vacuum comes with
16 risks.

17 There's risk of -- the word, another
18 big medical term, cephalohematoma, where
19 there's a bleed into kind of the soft
20 tissue. Those tend to resolve.

21 You can lacerate or cut a fetal scalp.
22 It may be something superficial or could
23 require suturing. It could get infected.

24 Or you could have something more

1 serious, as in this case where you get a
2 subgaleal bleed or intracranial bleed, which
3 can have negative implications in terms of
4 the baby's development, cognitive
5 functioning, et cetera, et cetera.

6 So when you're recommending to
7 intervene and there can be complications, I
8 personally feel, as is I believe the
9 standard of care, that the mom is informed
10 so she can tell you, because again, there
11 are options here. You don't have to do a
12 vaginal or operative vaginal delivery. You
13 can do a cesarean section if you're
14 concerned about baby but also concerned that
15 you as a provider can't really facilitate a
16 safe delivery. The benefits must outweigh
17 the risks.

18 Q. If a vacuum is not always appropriate, when
19 is it appropriate?

20 A. Well, it's appropriate again if you believe
21 there's no cephalopelvic disproportion,
22 which is another medical term for you.
23 Truly believe this baby should fit through
24 the vaginal canal, so you're not going to

1 deliver the head and then have problems with
2 the shoulder. You, as the delivering
3 provider, feel it's a safe way to deliver a
4 baby, and then you have the indications that
5 I spoke of before.

6 If you have concerns about the baby's
7 heart rate, if you feel mom has pushed, like
8 I said earlier, she's now into the second or
9 third hour of pushing and she just can't do
10 it anymore, you can help her by using a
11 vacuum, but again, a conversation has to
12 happen because the provider's not just going
13 to put the vacuum on and exert so much
14 traction and pull the baby out.

15 You need mom's cooperation because
16 you're just helping. You're not doing the
17 delivery. So she has to be part of the game
18 plan. She has to be on board and accepting.

19 Q. In this case, do you have an opinion to a
20 reasonable degree of medical certainty as to
21 whether or not there was an indication for
22 Dr. Rhett to use a vacuum in the delivery of
23 Jayden W ?

24 A. I did not see, at the time the vacuum was

1. used, an indication for the vacuum.

2. Q. Okay. Now, if -- if Dr. Rhett were to say
3. that a vacuum was appropriate because the
4. mother was exhausted, what are your thoughts
5. on the subject of potential maternal
6. exhaustion?

7. MS. SIMMONS: Object to the form.

8. A. We typically see maternal exhaustion in a
9. woman who's been pushing for quite some
10. time. Labor -- there's a reason we call it
11. labor.

12. The process, the first stage of labor,
13. the latent phase, active phase, getting a
14. woman to the place where she can push, it's
15. work, so yeah. There's a fatigue factor
16. there.

17. But, again, usually when a woman
18. becomes complete or fully dilated and you
19. and -- you know, you have the discussion on
20. how to push efficiently. Particularly in
21. this mom's case, she's never pushed before.
22. So you want to first give her instructions
23. on how to push, what the expectations should
24. be in terms of how long she's going to push.

1 If you have concerns about the fetal
2 heart rate tracing, explain to her, you
3 know, what's normal with pushing because
4 it's common to see decelerations during
5 contractions when a mom is pushing. You
6 know, you want to set that stage so she has
7 understanding in case something does happen
8 that you need to act quickly she's not
9 surprised. But you have to go through that
10 up front kind of quick education so she
11 knows how to push efficiently, she knows
12 when to push.

13 That all has to be laid out, and
14 again, in this case, she pushed -- I mean,
15 the time she was diagnosed as fully dilated
16 to the time the vacuum was applied was
17 11 minutes, so in terms of fatigue, and I
18 looked at the video, she didn't seem out of
19 it. She didn't seem overly fatigued.

20 And even if a woman appears fatigued
21 to you, when she starts pushing, it's
22 amazing the power of women. We find the
23 strength to push, but she was never
24 adequately given that opportunity to do

1 that.

2 Q. You said the vacuum was applied in this case
3 after 11 minutes of -- of the second stage
4 part?

5 A. Well, according to the documents you
6 provided to me, I believe it was 11 minutes.

7 Q. Okay. I thought you said that normally in a
8 first time mother the second stage lasts an
9 hour or two?

10 A. At least. Average an hour and a half to two
11 hours.

12 Q. What significance do you place on Dr. Rhett
13 using a vacuum after only 11 minutes of
14 second stage?

15 A. Well, that's one of the questions in terms
16 of what was the indication for applying the
17 vacuum, and in Dr. Rhett's deposition he
18 described the fetal heart rate tracing as
19 ominous, which I definitely disagree with.

20 Q. You mentioned that the baby's heart rate can
21 sometimes be an indication for use of a
22 vacuum?

23 A. Absolutely.

24 Q. Was there anything going on with Jayden

1 W 's heart rate that would have
2 justified the use of a vacuum as used by
3 Dr. Rhett?

4 A. I think not. In this particular case, and
5 if you look at all the fetal heart rate
6 tracings, earlier in mom's labor there were
7 some decelerations and they went away very
8 appropriately with change in position and
9 hydration, and that's typically what we do.

10 Now, this is a woman who had just been
11 diagnosed as being fully dilated and she was
12 instructed to push without any real
13 instructions and you had decrease in the
14 baby's heart rate. It was a deceleration,
15 not a bradycardia, so you don't have a
16 prolonged deceleration. And if you look at
17 the tracing, it drops off at its baseline
18 but there's excellent variability, so it
19 would have been appropriate in this case to
20 have mom just stop pushing, possibly put her
21 on her left or right side, maybe give her
22 fluid bolus, give her oxygen and see if the
23 baby responds.

24 Clearly if the baby continues to have

1 decelerations or if that deceleration
2 pattern worsened, then certainly you need to
3 have a conversation about I'm worried about
4 your baby's well-being and these are the
5 options for delivery. We can -- I can
6 either do a vacuum, forceps or cesarean
7 section. Very quick conversation.

8 Q. Thank you. But let me go back and ask you
9 to define some of those words you just used.
10 You referred to -- I believe you referred to
11 a strip. What is -- or a tracing? What is
12 a tracing in this context?

13 A. Well, mom was being monitored so there is a
14 monitor on the fetal head. It's called the
15 fetal scalp electrode. That allows you to
16 closely monitor the baby's heartbeat, so
17 each beat is kind of projected on to a strip
18 and it's a strip that keeps moving so you
19 can see the pattern of the baby's heart.

20 Now, we use fetal heart rates as a way
21 to kind of judge baby well-being. I mean,
22 it's limiting because it's only one
23 parameter in a little human being, but it's
24 the best thing that we have.

1 So we're looking for baseline. We're
2 looking to make sure the fetal heart rate is
3 somewhere in the range of 110 to 160 beats
4 per minute, but in second stage when mom is
5 pushing, you certainly can see the fetal
6 heart rate drop off the baseline. It can go
7 down to 90's, 60's.

8 Babies have reserve, so we, as
9 obstetricians, you don't panic when you see
10 that, but you are, you know, your little
11 antennas should go up and you reevaluate how
12 close is this first time mom to delivering,
13 how much reserve does this baby have and
14 does the baby look better when you do all
15 the things that we call -- and you'll love
16 this term -- intrauterine resuscitation.

17 When you turn mom on one side or the
18 other you're increasing blood flow to the
19 baby, the nutrition to the baby. That with
20 increasing mom's fluid or hydration and
21 mom's oxygen concentration should have a
22 positive impact on the fetal heart rate
23 tracing. So you're actually looking at this
24 heart rate march along the strip.

1 Q. Thank you. One of the words you used
2 recently was deceleration. What does that
3 mean in this context?

4 A. So, again, going back, there's a baseline
5 heartbeat. We all have baseline heartbeats,
6 and when we get excited our hearts go up
7 sometimes depending on what we're doing our
8 hearts can go down.

9 Same thing happens in a baby. If a
10 baby is being stressed, and I use that word
11 carefully, with uterine contractions, that
12 can be a stressor to baby, because as the
13 uterus contracts, blood is decreased to the
14 baby, the umbilical cord can be compressed.
15 So baby is not seeing a lot of flow, so you
16 have classic decelerations or the baby's
17 heart rate drops off of its standard
18 baseline. It can drop down, but you'll see
19 it come back up. It may go back down, but
20 you'll have fast decells or fast decreases,
21 but fast returns to baseline, and we know
22 that that's reassuring.

23 It's the baby that drops off its
24 baseline, slurs down. You don't have the up

1 and down lines. You just have these very
2 straight lines. Those kind of changes in
3 the baby's heart rate is much more
4 concerning.

5 Q. Okay. And I believe you indicated that in
6 this case, Jayden's tracing was showing a
7 deceleration but not a bradycardia. What is
8 bradycardia?

9 A. A bradycardia is a prolonged or longer
10 deceleration, and depending on who you read,
11 people define bradycardia as greater than
12 six minutes. Some folks say it's greater
13 than ten minutes.

14 So, that did not occur in this case.
15 You had decelerations that were recovering,
16 had good variability, so clearly the
17 delivering physician is noting this and
18 thinking about okay, this mom needs to be
19 delivered, but can we get the baby on, back
20 on its more reassuring heart rate track.

21 The other thing we have to realize,
22 she's still on Pitocin, so that's another
23 stressor because again, the more strength
24 the uterus contracts, the more the baby can

1 respond to that.

2 I forgot to mention one of the things
3 you do when you have decelerations in a baby
4 on Pitocin, you turn the Pitocin off and
5 give the baby a chance to recover. It
6 allows everyone to regroup. Then you can
7 instruct mom on what she needs to do to
8 deliver her baby, let her know what you're
9 concerned about, let the baby recover. And
10 sometimes we'll let mom not push for ten,
11 15 minutes and then start the process over
12 again.

13 Now, if the baby does this again, it's
14 on the obstetrician to determine which route
15 is the safest route for delivery. Do you do
16 an operative vaginal delivery or do you
17 recommend a cesarean section?

18 Q. One word that you've used several times is
19 variability. I want to make sure we get a
20 good understanding of what that means. Can
21 you help me with that?

22 A. Okay. You want to see change in the baby's
23 heart rate. You don't want to see what is,
24 I call the definition of a straight line.

1 You have two points and you draw a line.
2 That is not good to see in a fetal heart
3 rate tracing. You want to see change
4 because that lets you know that the central
5 nervous system is in tact.

6 So, even the baseline, you can see
7 these wiggly lines going 120's, 130's, you'd
8 love to see go up to the 140's, 150's, back
9 to the baseline. You want to see
10 fluctuation. That let's you know that baby
11 is responding to its environment, its
12 signaling is in tact, because if baby's
13 oxygen decreases, if mom has been on
14 medication during her labor, those are
15 things that can affect the variability in
16 the fetal heart rate tracing.

17 Q. As you reviewed the tracings from the fetal
18 heart monitoring in this case, did you see
19 good variability or not?

20 A. Jayden had good variability, yes.

21 Q. Did you see bradycardia or not?

22 A. I did not see bradycardia.

23 Q. Did you see any decelerations or not?

24 A. I saw decelerations.

1 Q. Did the decelerations that you saw give you
2 concern?

3 A. Well, that's a hard question to answer
4 because any deceleration makes an
5 obstetrician pay closer attention.

6 Now, concern, I mean, again, where
7 Jayden was and Jayden's mom were in the
8 stage of labor, you expect decelerations at
9 this time. This is a very common finding
10 when a mom starts to push and she's flat on
11 her back.

12 Q. Was there anything that you saw on the
13 strips that would justify the use of a
14 vacuum or give an indication for use of a
15 vacuum as Dr. Rhett did?

16 A. Not at this time.

17 Q. Do you have an opinion to a reasonable
18 degree of medical certainty as to whether or
19 not Dr. Rhett's choice to use a vacuum
20 without an indication represents conforming
21 to the generally accepted standards of
22 obstetrical practice or violating those
23 standards?

24 A. That is a breach of standard of care.

1 Q. Now, let me ask you about the station. You
2 mentioned a videotape. Have you viewed the
3 birth videotape taken by Jamesetta's sister?

4 A. Yes, I have.

5 Q. Have you also had an opportunity to review
6 the entries on the medical chart about the
7 baby's station?

8 A. Yes, I have.

9 Q. I'm going to hand you a document which comes
10 from trial Exhibit 2, which we will mark as
11 deposition, plaintiff's deposition
12 Exhibit 2.

13 (Labor Progress Chart marked
14 Exhibit No. 2 for Identification.)

15 Q. Now, this comes from the mother's hospital
16 records, Denise Cooper, where James -- where
17 Jayden was delivered. What is this
18 document?

19 A. This is a chart of the classic Friedman's
20 curve and -- I'm impressed. This was 2002.
21 So many of us were plotting labors on the
22 Friedman curve. So each exam that's done to
23 mom you plot the cervical dilatation or the
24 cervical opening in relationship to the baby

1 coming through the birth canal, and you want
2 to make sure that she is progressing in a
3 normal sense, and Friedman had all sorts of
4 rules about what's adequate and what's
5 inadequate.

6 Q. Okay. Who makes entries on that chart
7 typically?

8 A. Well, I'm going to date myself, but when I
9 was a resident it was mandated that
10 residents fill these out, but I know in many
11 institutions the nurses will fill these out.

12 Q. Okay. At any rate, whether it was the nurse
13 or someone else who filled out this chart,
14 what is the lowest in the birth canal that
15 the baby's station was ever recorded to be
16 on this document?

17 A. On this document, the lowest station was a
18 minus one.

19 Q. Does that mean the head was engaged or not
20 engaged?

21 A. That means the head's not engaged at this
22 point.

23 Q. From your review of other medical entries
24 did you ever see any documentation of the

1 head at a lower station than minus one?

2 A. Repeat that question, please.

3 Q. From your review of other documents in the
4 hospital chart did you see anything that
5 showed or documented that the baby's head
6 was lower than minus one?

7 A. I believe, and I can't tell you exactly
8 where this was, but Dr. Rhett noted the baby
9 was at zero station at some point.

10 Q. Did you see anywhere on the chart that the
11 baby's head was lower than zero station?

12 A. Not written in the record.

13 Q. If the baby's head was between zero and plus
14 two, what would that position in the birth
15 canal be called?

16 A. Mid position.

17 Q. From your review of the records and your
18 viewing of the videotape, do you have an
19 opinion to a reasonable degree of medical
20 certainty as to Jayden W 's station
21 at the time the vacuum was applied by
22 Dr. Rhett?

23 A. Well, there clearly was not an outlet. It
24 didn't appear to be low, so I would think

1 based on the documentation and the medical
2 records and the viewing of the video, it was
3 probably more of a mid application.

4 Q. Is that an opinion that you hold to a
5 reasonable degree of medical certainty, most
6 probably?

7 A. I would say a reasonable degree of medical
8 certainty.

9 Q. You've already indicated that you believe it
10 would be a breach of generally accepted
11 standards of obstetrical practice for
12 Dr. Rhett to have used a vacuum at all, but
13 given that the baby's station was in the mid
14 pelvic position, do you have an opinion to a
15 reasonable degree of medical certainty as to
16 whether the use of a vacuum in this case
17 under these facts and circumstances with the
18 baby in the mid pelvic position would be an
19 additional breach or not?

20 A. If this baby was in the mid position or
21 higher, I would consider that a breach of
22 standard of care in this case.

23 Q. What role does obstetrical knowledge have --
24 what role does obstetrical knowledge play

1 with regard to the proper management of
2 labor and delivery by an obstetrician?

3 A. It plays a huge role. As the obstetrician,
4 you are the director of the team and based
5 on experience and education and readings and
6 keeping up with the medical literature, our
7 first job is to make sure our patients are
8 safe, and as an obstetrician you have at
9 least two patients. In this case there's a
10 mom and a baby, so the -- the experience and
11 judgement of the obstetrician and knowledge
12 is huge.

13 Q. Do you have an opinion to a reasonable
14 degree of medical certainty as to whether or
15 not Dr. Rhett had sufficient obstetrical
16 knowledge to properly manage the labor and
17 delivery involving Jayden W. ?

18 MS. SIMMONS: Object to the form.

19 A. Well, clearly I don't know Dr. Rhett
20 personally, but based on the documentation
21 in the medical record, the contradictory
22 documentation and a delivering physician not
23 completing certain things in an accurate
24 method or following up with, for example,

1 the midwife who dictated the discharge
2 summary saying it was a vaginal delivery
3 without mention of it being a vacuum
4 delivery makes me question the thoroughness
5 or the knowledge.

6 But certainly when I read the
7 deposition of Dr. Rhett, in someone who
8 states that he in doing vaginal deliveries,
9 over 50 percent of his vaginal deliveries
10 are vacuum assisted deliveries, so that
11 makes me think if he's doing 200, 250
12 deliveries a year and half of his vaginal
13 deliveries are by this method, then he
14 should be the true expert in terms of how to
15 use a vacuum, the indications for the vacuum
16 and the -- and the whole labor process in
17 terms of once a woman is about to push.

18 And all those basic trainings we, as
19 obstetricians, have to be aware of and
20 knowing the definitions for engagement,
21 knowing about stations, knowing about the
22 anatomy of the baby's head, knowing what a
23 biparietal diameter is, all those things are
24 basic for a delivering obstetrician. So I

1 was very concerned when I read the
2 deposition, and that was not coming forth.

3 Q. So, as you read the deposition of Dr. Rhett
4 and gleaned from that his degree of
5 knowledge or lack thereof, what conclusions,
6 if any, did you draw about his degree of
7 obstetrical knowledge related to the vacuum
8 delivery, such as in this case?

9 MS. SIMMONS: Object to the form.

10 A. Again, very concerned. He describes this
11 delivery as an outlet and he also described
12 zero station as the baby's being right
13 there, so those --

14 Based on the video, it didn't appear
15 that the baby was right there. If you view
16 the video and you see that the entire vacuum
17 cup is in the vaginal vault, and we know,
18 and based on the illustration that you
19 provided today, that zero station the baby's
20 head isn't right there. That's not outlet.
21 That's not low. It's zero station. It's
22 five centimeters above the vaginal opening.

23 And he stated that in his deposition.
24 Those were his definitions of zero station

1 and an outlet forceps. I'm sorry. An
2 outlet vacuum.

3 Q. Were his -- were his definitions correct or
4 incorrect?

5 A. Mostly incorrect.

6 Q. Do you have an opinion as to a reasonable
7 degree of medical certainty as to whether or
8 not Dr. Rhett's level of obstetrical
9 knowledge or lack thereof conforms with the
10 generally accepted standards of obstetrical
11 practice required for an obstetrician to
12 properly manage a vacuum extraction
13 delivery?

14 MS. SIMMONS: Object to the form.

15 Q. Under circumstances such as those in this
16 case?

17 MS. SIMMONS: Objection.

18 A. He did not conform to the standard of care.

19 Q. Let me turn to another aspect of this case,
20 and that is can you tell us, please, what is
21 the proper technique for performing a vacuum
22 extraction in those circumstances where it's
23 proper to use a vacuum at all.

24 A. All right. Well, again, you want to make

1 sure that you have a good understanding of
2 your patient's pelvic anatomy. You want to
3 really evaluate the baby, how is the baby
4 coming down the birth canal, the fetal
5 weight, do you truly believe you can do a
6 safe vacuum delivery. That's the primary
7 evaluation that needs to be done.

8 Then you assess where is the head, is
9 it safe to apply the vacuum. You want to
10 make sure her bladder's empty. In this
11 case, she had a Foley catheter, so that
12 wasn't an issue. Her bladder was empty.

13 You want to again make sure there is
14 no cervix left because the vacuum needs to
15 be placed on the flexion point of the baby's
16 skull which is -- in this case the baby was
17 occiput anterior so, you know, there's the
18 posterior fontanel, the soft spot in the
19 back.

20 You want to go about three centimeters
21 anterior to that so you're not over the soft
22 spot. And you place the vacuum, make sure
23 there's no cervical tissue. The vacuum is
24 then pumped up. And in this case a nurse

Deposition of Yvonne Gomez-Carrion, M.D.

1 did the pumping. And you want to make sure
2 that it's pumped into the green zone, in
3 this case, or the safe zone, because using
4 too much pressure also can cause fetal
5 injury.

6 And then once you've made your
7 assessment, the vacuum is properly placed
8 and patient has a contraction, she's
9 instructed to push as you exert steady
10 traction. There's no rocking back and
11 forth. There's no torquing. It's downward
12 traction until you reach the pubic bone and
13 then you have upward traction to deliver the
14 fetal head. Then you release the vacuum.

15 THE VIDEOGRAPHER: Excuse me.

16 MR. GRAHAM: Let's go off the
17 record.

18 THE VIDEOGRAPHER: The time is
19 12:35 p.m. This is the end of tape one and
20 we are off the record.

21 (Recess.)

22 THE VIDEOGRAPHER: The time is
23 12:46 p.m. This is the beginning of tape
24 two and we are back on the record.

1 Q. Doctor, before the break you were talking
2 about the proper technique for use of a
3 vacuum. Do you have an opinion to a
4 reasonable degree of medical certainty as to
5 whether or not Dr. Rhett's technique of
6 using the vacuum in this case conformed to
7 the generally accepted standards of
8 obstetrical practice?

9 A. No, I don't. In reviewing the video of the
10 vaginal assisted or vacuum assisted vaginal
11 delivery, you can see where Dr. Rhett would
12 stop and actually push the vacuum handle
13 from one side to the next, and that's really
14 a contraindicated maneuver.

15 You want to stay in one plane with
16 traction, steady traction, no jerkiness, no
17 side to side action, so that was certainly a
18 breach in the accepted technique on
19 delivering a baby by vacuum.

20 Q. What about moving a vacuum -- I believe you
21 said the correct direction of pull is in
22 which direction?

23 A. Well, at the station this vacuum was applied
24 you have to have more downward traction

1 because you have to clear the symphysis
2 pubis. And once you've done that, you start
3 off at an angle, and once you've cleared the
4 bone, you then come up. And you can see it
5 sort of -- you're mimicking the natural
6 maneuvers of the labor.

7 As the baby comes down and then it,
8 rather than flexing its head it's now doing
9 an external rotation and extending, so
10 that's the motion with the vacuum, down and
11 then up, not side to side.

12 Q. I believe you indicated that part of the
13 proper technique is to avoid using any
14 rocking motions or torque. Do you have an
15 opinion to a reasonable degree of medical
16 certainty as to whether or not Dr. Rhett
17 refrained from using rocking and torque
18 maneuvers?

19 A. Again, I'll refer again to the video. There
20 was certainly deviation off the downward
21 traction. There were times when he did rock
22 from one side to the next with the handle of
23 the vacuum.

24 Q. What -- what risk of danger, if any, is

1 there to those type of movements?

2 A. Well, you can have a sheering effect on the
3 baby's soft tissue and it can change
4 pressure directions and cause head bleeds.

5 Q. Okay. When you say head bleeds, are you
6 talking about bleeds on the outside of the
7 head or somewhere else?

8 A. All of the above. It also depends on the
9 amount of pressure that's being introduced
10 to the fetal scalp. In this case we don't
11 know what that pressure was.

12 For example, if it was above the
13 normal pressure that's recommended with this
14 particular device, that certainly would have
15 been a breach as well.

16 If you have increased pressure and
17 then you're going off the recommended
18 downward traction and in upward traction
19 you're going side to side, that certainly
20 can increase your risk of a bleed, but we
21 know that risk of whether it be
22 cephalohematoma or subgaleal bleed, that's a
23 risk of the vacuum device, and depending on
24 who you read, that risk can be as high as

1 five percent, so it is significant.

2 Q. And one thing that we're going to hear about
3 in this case is clinical judgement. Can you
4 give us a definition of what clinical
5 judgement means?

6 A. Well, that's the process that health care
7 providers use in order to come up with a
8 management plan. You have the data
9 presented. You have your patient. You make
10 an assessment and based on the information
11 that you have. You make a judgement or an
12 action plan as to how to proceed from the
13 information that you've gathered and based
14 on your experience and education.

15 Q. What role does good clinical judgement play
16 in the proper management of labor and
17 delivery by an obstetrician?

18 A. Again, it's huge. It's key. You're -- you
19 would not be an obstetrician very long if
20 you often displayed non-reasonable clinical
21 judgement. I would hope that if a provider
22 was showing judgement that did not meet
23 standard of care that colleagues would
24 intervene and make recommendations, nursing

1 staff would take it to another level so
2 there can be a corrective action.

3 Q. Do you have an opinion to a reasonable
4 degree of medical certainty as to whether an
5 obstetrician is capable of exercising good
6 proper clinical judgement about vacuum
7 extractions without having sufficient
8 command of the obstetrical knowledge
9 regarding the proper use of a vacuum?

10 MS. SIMMONS: Object to the form.

11 A. Well, if you don't have the tools to
12 correctly evaluate your patient, if you're
13 not aware of the proper indications and you
14 have not done the proper preintervention
15 evaluation, then I would say you're in a
16 dangerous zone intervening with a device
17 that has risks without doing a complete
18 evaluation.

19 Again, the purpose here is to make
20 sure that any intervention you're pretty
21 certain that you're not causing harm to mom
22 or to baby.

23 Q. Do you have an opinion to a reasonable
24 degree of medical certainty concerning

1 whether or not Dr. Rhett was capable of
2 exercising good proper clinical judgement in
3 this delivery given his level of knowledge
4 regarding obstetrical and vacuum matters?

5 MS. SIMMONS: Object to the form.

6 A. Again, my opinion is based on the events of
7 this case and his deposition, and I have
8 concern that he did not have the proper fund
9 of knowledge which led to an inappropriate
10 usage of this particular vacuum.

11 Q. Speaking of this particular vacuum, I hand
12 you trial Exhibit 72, which is in a folder,
13 but the vacuum cup and tubing is inside.

14 A. May I take it out?

15 Q. Pull it out. Yes, ma'am. And would you
16 please hold that vacuum cup up so the camera
17 can see. Is this the cup that you use?

18 A. We -- I'm used to more of a flat cup with a
19 wider diameter and also is a more soft
20 silastic, so this is a different -- Tender
21 Touch it's called. A different vacuum that
22 I'm used to using, and we also now are
23 moving towards a smaller very flat
24 instrument called the Kiwi vacuum extractor,

1 so at my institution we use a device like
2 this, but again, shorter and softer and the
3 key wee device.

4 Q. Looking at the measure from the opening of
5 the cup to the -- to the section where the
6 cup narrows down and eventually meets the
7 shaft from say the open end to the foot of
8 the cup, how does that dimension compare
9 with the cup that you use?

10 A. It's almost, almost double the vertical
11 distance. This looks, and I don't have a
12 correct meter ruler here, but this looks to
13 be about six, seven centimeters, and it's
14 not flexible because the cup I use is a
15 bigger diameter, so when you put it on this
16 part of the baby's head it's kind of like
17 putting on a skull cap and it contours with
18 the head. This is very inflexible.

19 Q. I now hand you trial Exhibit 73, which is an
20 instruction booklet for that particular
21 vacuum. Have you had an opportunity to
22 review the indications and contraindications
23 for the use of this particular vacuum?

24 A. Yes, I have.

Deposition of Yvonne Gomez-Carrion, M.D.

1 Q. On which page of Exhibit 73 are the
2 indications and contraindications listed?

3 A. On page four. We have the vacuum assisted
4 delivery, also known as VAD indications for
5 usage. There are five indications, and
6 there are 11 contraindications for use.

7 Q. Okay. What is indication number five?

8 A. Indication number five is an engaged fetal
9 head at outlet or low station.

10 Q. And what is contraindication number two?

11 A. Unengaged or mid station fetal head.

12 Q. Okay. If the instruction booklet for this
13 vacuum indicates that mid station fetal head
14 is a contraindication for the use of this
15 vacuum, can you tell us whether or not this
16 vacuum should be used to deliver a baby from
17 the mid pelvic station?

18 A. It clearly states that that would be a
19 contraindication.

20 Q. Okay.

21 A. So if a baby is above the plus two station,
22 this device should not be used.

23 Q. By the way, I'm not sure if we really got
24 into the, the specific rules about

1 performing vacuum extractions from different
2 stations. This -- these instructions
3 indicate that this cup is indicated for
4 outlet and low deliveries. How does that
5 compare with your experience and your
6 training?

7 A. Well, at the time I was a resident, the
8 vacuum extractor really wasn't being used
9 all that much and basically, we were
10 trained, as most obstetricians of that era,
11 to use forceps, and at that time we would do
12 high forceps deliveries. We'd actually use
13 forceps to rotate the baby, change forceps
14 and use a pair of forceps to actually bring
15 the baby down through the vaginal or the
16 birth canal.

17 We realized over time that we were not
18 only causing damage to the baby but damage
19 to mom. And that's one of the reasons why
20 the vacuum assisted vaginal delivery came
21 about because it's not metal, because most
22 of these are very flexible. The damage to
23 mom in terms of vaginal tears, rectal
24 sphincter damage, damage to the bladder is

1 certainly reduced. But also in the baby and
2 using forceps we'd have damage or, you know,
3 nerve damage to the facial area. You'd have
4 babies with the forceps marks or actually
5 lacerations. We had severed ears.

6 So it just wasn't a great instrument
7 to use, so many of us moved to the vacuum,
8 but it's interesting that the indication for
9 forceps and vacuum is the same. You still
10 need to assess the mom's pelvis to make sure
11 that it's safe, that this baby has a high
12 likelihood of a safe vaginal delivery. You
13 must make sure the cervix is fully dilated,
14 again bladder empty, because you don't want
15 to cause any trauma to the bladder, but also
16 you want to be very judicious in how you
17 place the vacuum.

18 And we know that if a vacuum is placed
19 at a higher station, first of all, you're
20 leaving the vacuum on longer because there's
21 a greater distance to come, theoretically
22 more traction which can increase the chance
23 of intracranial or cephalohematoma or scalp
24 laceration, so all of those risks can be

1 increased the higher station the vacuum is
2 applied, and that's why most providers will
3 err on the side of safety and do more outlet
4 or low vacuum assisted deliveries.

5 And if you're really concerned about a
6 baby and want a fast delivery and the baby's
7 above plus two station, we would more
8 entertain doing a cesarean section just for
9 safety of baby.

10 Q. Speaking of safety of baby, again referring
11 to the trial exhibit that you just referred
12 to with indications and contraindications,
13 that is the instruction booklet. On page
14 four, does the manufacturer list certain
15 risks or adverse reactions that can be
16 associated with the use of this vacuum?

17 A. Yes. The manufacturer's very clear on that.

18 Q. Okay. Are brain bleeds among those adverse
19 reactions warned about?

20 A. Yes.

21 Q. Were you -- do you recall Dr. Rhett's
22 testimony about whether or not he was aware
23 of the manufacturer's warnings about brain
24 bleeds from the use of this vacuum?

Deposition of Yvonne Gomez-Carrion, M.D.

1 MS. SIMMONS: Object to the form.

2 A. I believe Dr. Rhett stated he was not aware
3 of these possible adverse reactions.

4 Q. What significance, if any, do you place on
5 an obstetrician using a vacuum that
6 indicates it's contraindicated for mid
7 pelvic application with a warning of brain
8 bleeds by a doctor who is unaware of those
9 warnings?

10 A. Well, it's very concerning. I mean, the
11 Academy of Ob/Gyn in the 90's sent out
12 basically a warning to all Ob/Gyn's who were
13 using vacuums to just reenforce. It's an
14 acceptable tool in which to facilitate a
15 vaginal delivery, but must be aware that
16 there are risks, and the risks are quite
17 serious, as stated here. So this went out
18 to all Ob/Gyn physicians.

19 So I find it very worrisome that a
20 physician in 2002 stated that he was unaware
21 of these possible adverse reactions when
22 using a vacuum that could cause hemorrhage,
23 lacerations of mom, pelvic anatomy as well
24 as the baby's scalp, intracranial

1 hemorrhage, et cetera.

2 Q. Do you have an opinion to a reasonable
3 degree of medical certainty as to whether or
4 not Dr. Rhett conformed to the instruction
5 booklet in terms of its indications and
6 contraindications or violated that
7 information?

8 A. Again, in viewing the video and actually
9 looking at this instrument up close, in the
10 video this entire cup is in the mom's
11 vaginal vault so it would seem that this
12 baby was higher than plus two station, so
13 that would be, as stated clearly on this
14 sheet from this manufacturer, that would be
15 a contraindication to the use of this device
16 and breach of standard of care.

17 Q. Is a mid pelvic vacuum extraction always
18 improper?

19 A. No. Just as a mid forceps delivery is not
20 always improper. I try to be very careful
21 about using the term always and never. I
22 mean, in the hands of an experienced
23 delivering obstetrician do people do mid
24 deliveries with the vacuum and forceps,

1 probably so, but again, you really have to
2 have a serious conversation with mom so you
3 make sure that she's aware of the increased
4 risk for all the things that we've been
5 talking about.

6 Q. If a particular obstetrician thought that
7 there was such an emergency situation
8 requiring that the baby come out quickly
9 from a mid pelvic station and if that
10 obstetrician decided to use a vacuum to make
11 that happen, do you have an opinion whether
12 or not this is the correct vacuum to use for
13 a mid pelvic vacuum delivery?

14 MS. SIMMONS: Object to the form.

15 Q. Do you have an opinion to a reasonable
16 degree of medical certainty as to whether or
17 not this vacuum is the appropriate one to
18 use for a mid pelvic vacuum extraction?

19 A. Well, it is my opinion to a reasonable
20 degree of medical certainty based on this
21 device, based on the company's warnings,
22 that this would not be the vacuum of choice.

23 Q. I'm going to hand you trial Exhibit 28.
24 What is that, please, ma'am? Let me get

1 this vacuum out of your way.

2 A. This is from the U.S. Food and Drug
3 Administration. It's entitled FDA Public
4 Health Advisory, need for caution when using
5 vacuum assisted delivery devices. And this
6 went out May 21, 1998.

7 And, again, it's a document I was
8 referring to. At least this one came out.
9 There are probably others as well. But it
10 went out to obstetricians, birthing centers,
11 nurse midwives, pediatricians,
12 ultrasonographers, Ob/Gyn nurses, family
13 practitioners, radiologists, hospital risk
14 managers, hospital Ob/Gyn departments. And
15 basically outlined if you choose to use the
16 vacuum what the types of complications that
17 can occur. And the serious complications of
18 the subgaleal hematoma and intracranial
19 hemorrhage are the first two complications
20 they list.

21 Q. On page two of this exhibit, what were the
22 recommendations that the government made to
23 those health care providers involved in
24 delivery of babies with a vacuum?

1 A. "Use these devices", and in bold, "only when
2 a specific obstetric indication is present".

3 Q. Was there one in this case?

4 A. It's my opinion that there was not.

5 Q. Okay. And what's the next recommendation?

6 A. There are a number of bullets that follow.

7 "Be sure that persons who use vacuum devices
8 for assisted delivery are versed in their
9 use and that they are aware of the
10 indications, contraindications and
11 precautions as supported in the accepted
12 literature and current device labeling".

13 You want me to proceed?

14 Q. Well, let me stop you right there. Was
15 Dr. Rhett versed in the proper use of a
16 vacuum and wear of the indications,
17 contraindications and precautions?

18 MS. SIMMONS: Object to the form.

19 Q. In your opinion to a reasonable degree of
20 medical certainty?

21 MS. SIMMONS: Objection noted.

22 A. Based on the documentation supplied to me, I
23 would say that he was not.

24 Q. Okay. And what is the next bullet point in

1 the recommendations section?

2 A. "Before using a vacuum assisted delivery
3 device, read and understand the device's
4 instructions. Pay particular attention to
5 the manufacturer's instructions regarding
6 cup placement, vacuum strength to be used,
7 cumulative duration of applications and
8 number of recommended extraction attempts.

9 The recommended use for all these
10 products is to apply steady traction in line
11 with the birth canal. Rocking movements or
12 applying torque to the device may be
13 dangerous".

14 And then going on, it says "the
15 instruction may be different for each
16 device, type or style. It is important to
17 use the instructions provided by the
18 manufacturer of the particular product being
19 used".

20 Q. Okay. That recommendation consisted several
21 -- of several parts. The first one
22 indicates that "the health care provider
23 using a particular vacuum should read and
24 understand the instructions for proper use

1 of that vacuum".

2 Do you have an opinion to a reasonable
3 degree of medical certainty as to whether or
4 not Dr. Rhett did that?

5 A. Well, again, if the application of this
6 particular device was applied at plus two or
7 higher, then that was a violation of this
8 manufacturer's instructions.

9 Q. And this recommendation is to use steady
10 traction in the line of the birth canal and
11 to avoid rocking movements or applying
12 torque.

13 Do you have an opinion to a reasonable
14 degree of medical certainty as to whether or
15 not Dr. Rhett complied with that
16 recommendation or violated it?

17 A. Well, based on viewing the video, there
18 clearly was violation of that recommendation
19 as you see Dr. Rhett pulling in the line of
20 the birth canal but then deviating laterally
21 both to the right and the left at particular
22 points of the delivery process.

23 Q. And then the next recommendation please
24 read.

1 A. "Alert those who will be responsible for the
2 infant's care that a vacuum assisted
3 delivery device has been used so that they
4 can monitor the infant for signs of
5 complications".

6 Q. Do you have an opinion to a reasonable
7 degree of medical certainty as to whether or
8 not Dr. Rhett did that?

9 A. Well, in both his delivery note and the
10 discharge summary it said vaginal delivery.
11 I'm not clear as to what was communicated
12 verbally, but it certainly wasn't documented
13 at the time of the delivery.

14 It was documented in the sheet where
15 you put down all the maneuvers, so he
16 documented the Cervidil, the Pitocin, that
17 type of stuff, and that is where he
18 documented the vaginal assisted vaginal
19 delivery, the vacuum assisted vaginal
20 delivery, and that sheet is for purposes of
21 billing, I believe.

22 Q. Did Dr. Rhett document that he used a vacuum
23 to deliver Jayden W. on the day of
24 delivery?

Deposition of Yvonne Gomez-Carrion, M.D.

1 A. No, he did not.

2 Q. Do you recall -- now, you indicated this
3 trial Exhibit 28 that you have in front of
4 you, this came from the FDA?

5 A. That's the header of it. Center for Devices
6 and Radiologic Health.

7 Q. Part of the U.S. Food and Drug
8 Administration?

9 A. Health & Human Services, yes.

10 Q. Commonly referred to as the FDA?

11 A. Correct.

12 Q. Do you recall Dr. Rhett's testimony about
13 whether he was aware of any government
14 warnings about the use of vacuum and how
15 they could be implicated as a cause of brain
16 bleeds in babies?

17 A. I believe Dr. Rhett stated he was unaware of
18 these potential adverse actions.

19 Q. When this FDA warning came out, how would
20 you describe the level of attention to this
21 warning that was given by ACOG, the American
22 College of Obstetricians and Gynecologists,
23 and the obstetricians that you're familiar
24 with?

1 A. I have quite impressive memories from this
2 period of time. Now, I was an attending for
3 11 years when this all started, and it was
4 because folks were transitioning from
5 forceps to vacuums and were noticing the
6 increased complication rate.

7 So, when this came out from the FDA
8 and ACOG put out their warnings, it was at
9 grand rounds. It was at conferences because
10 of the fear of putting forth a management --
11 what's the word? An intervention and
12 causing harm, so -- you know, this was also
13 a time when we were looking at cesarean
14 section rates and trying to figure out how
15 to reduce those rates and we were encouraged
16 to do more operated vaginal deliveries, but
17 do it safely. So there was a lot of
18 discussion around the potential harm or
19 nature of vacuum assisted vaginal delivery.

20 Q. Well -- I'm sorry. Were you finished?

21 A. Yeah.

22 Q. Until you read Dr. Rhett's deposition, have
23 you ever known of a doctor, an obstetrician,
24 who was unaware or claimed to be unaware of

1 the FDA warnings about brain damage from
2 vacuum extraction?

3 A. I would be very surprised if at that time,
4 particularly when Jayden W was
5 born, that an obstetrician at that time
6 would be unaware.

7 I mean, this was discussed ad nauseam
8 and it was clearly engrained that if you
9 even think about using a vacuum at the
10 delivery, you need to alert the
11 pediatricians, just because babies would
12 come out looking fine, and particularly if
13 there's a bleed, that evolves over time so
14 that whoever is monitoring the baby in the
15 nursery definitely has to have that
16 information in order to know how to monitor
17 these children.

18 So, again, these warnings came out
19 four, five years prior to Jayden
20 W's delivery, so it surprised me
21 that Dr. Rhett said that he was unaware of,
22 not only from our federal government but
23 also our College of Obstetrics and
24 Gynecology, and he was board certified so

1 you would imagine this information came to
2 him.

3 When you're a member of ACOG, you get
4 the bulletins, you get the guidelines, you
5 get the updated, you know, protocols and
6 manuals. And I'm sure that he's gone to
7 conferences as well. So it's hard to
8 imagine that this information was missed.

9 Q. Earlier you mentioned the concept of
10 informed consent. Before using a vacuum,
11 whether it's -- whether it's proper to use
12 the vacuum or not -- let's say even if it is
13 proper to use a vacuum, what should the
14 obstetrician who is thinking or planning
15 about using a vacuum talk to the patient
16 about in order to gain informed consent?

17 A. Well, you want to speak to the patient in
18 terms of what your concerns are, what are
19 your indications for making the
20 recommendation to use a vacuum in promoting
21 her vaginal delivery.

22 And then once that's discussed, make
23 sure she has no questions, and once you've
24 answered her questions, then you go into

1 what the potential risks are because it is
2 an intervention, and with that come risks.
3 And as long as she accepts the risks, then
4 you can proceed with that delivery.

5 Some women get overwhelmed and they
6 want you to really go over and over the
7 risks, and if you're very concerned about a
8 fetal heart rate tracing and you feel that
9 mom is just not capable of understanding or
10 agreeing to taking on that risk because
11 she's so caught up in all the emotionality
12 of what's happening, then you kind of are --

13 It's recommended you really entertain
14 cesarean section because if she can't give
15 you a consent and there is anywhere from a
16 two to five percent chance of this baby
17 having a significant bleed, and we know that
18 is a decreased risk at cesarean section,
19 that needs to be entertained as well.

20 Q. So, you mentioned the doctor must discuss
21 risks of a vacuum extraction with a patient.
22 Do those risks that should be discussed
23 include brain bleeds of the baby?

24 A. Absolutely. Obstetricians have, including

1 myself, have gone over risks and mom will
2 clearly say I don't want that, I don't want
3 any additional risk to my baby. And if
4 you're concerned about a tracing and if
5 you've done the maneuvers to try to improve
6 the fetal heart rate or the baby's heart
7 rate settles out because you've turned the
8 Pitocin off and you've done all the
9 maneuvers we spoke about earlier, then you
10 can wait and mom can resume pushing.

11 But if you're truly concerned that
12 this baby is in jeopardy, then you move
13 cesarean section.

14 Q. How do the risks to the baby compare when a
15 baby's at a mid pelvic position compared to
16 a low or outlet station?

17 A. Well, theoretically the risks would be
18 reduced the lower the station because
19 theoretically the pull is shorter as long as
20 the pressure is in the proper place, and
21 because the pull is shorter, there's a
22 reduced risk of rocking and torquing.

23 Q. Should the discussion of risks include a
24 discussion of, of the extra risks from the

1 baby's station if the baby is at a mid
2 pelvic position?

3 A. Absolutely.

4 Q. Do you have an opinion to a reasonable
5 degree of medical certainty as to whether or
6 not Dr. Rhett conformed to the generally
7 accepted standards of practice or breached
8 those standards with regard to the informed
9 consent issue?

10 MS. SIMMONS: Object to the form.

11 A. He -- he certainly breached the standard of
12 practice in that respect. There was no
13 discussion.

14 In fact, I was really taken aback when
15 I was looking at the video when he examined
16 Miss Washington. It was very little
17 exchange of information. Basically, a
18 vacuum appeared and it was placed, and I was
19 even questioning did she even realize that a
20 vacuum was being used at that time.

21 Q. If Dr. Rhett had done proper counseling and
22 discussion with Jamesetta about the risks
23 and alternatives and so forth, and if she
24 decided she did not want her baby to be

1 delivered with a vacuum, would it be
2 reasonable for a patient under these
3 circumstances to refuse vacuum extraction?

4 MS. SIMMONS: Object to the form.

5 A. Absolutely.

6 Q. Okay. Because there's been an objection,
7 let me rephrase that question.

8 A. All right.

9 Q. All right. Assuming for the moment that
10 Dr. Rhett had done a proper counseling and
11 discussion with the patient about
12 alternatives and risks of using a vacuum in
13 this situation under these facts and
14 circumstances and assuming further that the
15 mother did not want a vacuum extraction, do
16 you have an opinion to a reasonable degree
17 of medical certainty as to whether or not it
18 would be reasonable for the mother to refuse
19 a vacuum delivery?

20 MS. SIMMONS: Object to the form.

21 A. Yes. If mom stated that she did not want
22 any increased risk based on what the
23 obstetrician or delivering provider, what
24 risks were presented, she certainly has the

1 right to refuse.

2 And the fact that clearly Dr. Rhett is
3 very versed at performing cesarean section
4 given his cesarean section rate, if Miss
5 Washington said no, then it would have been
6 quite acceptable to move on to cesarean
7 section if that was even indicated.

8 Q. Let me ask you about documentation by a
9 doctor in the medical records. When a
10 doctor decides to pull a baby out with a
11 vacuum, what should he or she document in
12 the medical records about the use of a
13 vacuum?

14 A. All right. This kind of ties into the whole
15 FDA American College warning, because when
16 all this information and warnings came out
17 the culture changed in obstetrics. We then
18 changed the way we documented these
19 deliveries.

20 When you had concerns about a fetal
21 heart rate, concerns about a baby and you
22 decide that I need to expedite this
23 delivery, I need to make this happen faster
24 for -- you thought as a provider you thought

1 this would be better. Again, you have to
2 explain this to the patient, get her
3 consent, and you also have to write a note
4 in the patient's chart, your concerns,
5 indication for the vacuum assisted vaginal
6 delivery and the patient agreeing.

7 Then once the delivery was completed,
8 at the time of delivery or in a timely
9 fashion, document the events of the
10 delivery, that you prepped and draped her,
11 again, inform consent was gotten, verbal is
12 quite fine, and the maneuvers used and what
13 you did to prepare to do a safe vacuum
14 assisted vaginal delivery, the vacuum is
15 placed, did you pull during contractions,
16 did you pull continuously, were there
17 popoffs.

18 All that pretty much was stated to be
19 written in a note, and clearly in this
20 medical record none of that was done.

21 MR. GRAHAM: Could we please mark
22 this as our next numbered deposition
23 exhibit.

24 (Handwritten notes marked Exhibit

Deposition of Yvonne Gomez-Carrion, M.D.

1 No. 3 for Identification.)

2 Q. Dr. Gomez Carrion, I hand you now a document
3 that has been marked as deposition
4 Exhibit 3, and I will tell you it's taken
5 from trial Exhibit Number 2. This
6 particular page is marked at the bottom
7 right-hand corner ECH0024.

8 Directing your attention to the entry
9 in the bottom half at -- on 7/17/02 --
10 excuse me.

11 Directing your attention to the entry
12 in the middle of the page with the time of
13 20:00 on 7/16/02, what is that, please?

14 A. You'd like me to read that?

15 Q. Well, tell me, first of all, what it is.

16 A. It looks like the delivery note.

17 Q. Okay. And, in fact, in his deposition did
18 Dr. Rhett identify this as his delivery
19 note?

20 A. Yes, he did.

21 Q. Okay. What time did -- did he indicate --
22 apart from the time of the entry at 20:00,
23 did he indicate the time of the delivery?

24 A. No, he did not.

Deposition of Yvonne Gomez-Carrion, M.D.

1 Q. Okay. What did he say about the indication
2 for using a vacuum?

3 A. I mean, there are few words that I can't
4 make out here, but from what I glean, there
5 is no indication written in his delivery
6 note. He has a note before that at 15:45
7 where it says, gives a cervical exam and
8 comments fetal heart tones okay.

9 Q. All right. And in the delivery note at
10 20:00?

11 A. It says something over in tact perineum,
12 which means he did not cut an episiotomy.
13 Under CLE, I think that might refer to the
14 anesthetic, but not sure. That doesn't
15 appear to be a standard obstetric
16 abbreviation. 7-pound 10-ounce male.
17 Apgar's six slash nine, which means at one
18 minute the Apgar score was six, at five
19 minutes, nine. Placenta, spontaneous in
20 tact. Nuchal cord times one. Second degree
21 laceration at introitus repaired with 4-0
22 VICRYL. M and B, which I would imagine says
23 mom and baby, tolerated well. Arterial
24 blood gas 7.21. And signed.

Deposition of Yvonne Gomez-Carrion, M.D.

1 Q. Now, the reference to Apgar of six and nine,
2 what does that tell you, if anything, about
3 whether the vacuum has torn the blood
4 vessels in Jayden's brain?

5 A. This doesn't really tell us much. It shows
6 with the blood gas that Jayden had at
7 delivery was well.

8 Q. What does Dr. Rhett say in his note about
9 the station of Jayden's head at the time the
10 vacuum was applied?

11 A. Well, in his delivery note he doesn't state
12 that. In the note above it when she was
13 seven centimeters he notes the station was
14 minus one, but there is no documented
15 station at time of delivery, unless one of
16 those squiggles that I can't interpret is
17 one of the stations, but it doesn't appear
18 to be.

19 Q. What does Dr. Rhett say about -- in the
20 delivery note about how much pressure was
21 used to apply suction on this vacuum to the
22 head of the baby?

23 A. Well, there's no mention of a vacuum in this
24 delivery note, therefore there's no mention

1 of what pressure is used on the fetal head.

2 Q. How does this delivery note involving a
3 vacuum extraction of a baby from a mid
4 pelvic position who was diagnosed with brain
5 bleeds soon after birth compare with other
6 delivery notes that you've read in your
7 career?

8 A. It's an inadequate note. It doesn't really
9 give you any information. Again, there's no
10 indication. There's no descriptive as to
11 what was done with the vacuum in terms of
12 where it was applied, pressure. It states
13 nothing.

14 Q. Before reading this note, have you ever seen
15 a delivery note of a vacuum extraction as
16 inadequate as this one?

17 A. No.

18 MS. SIMMONS: Object to the form.

19 A. No, I have not.

20 Q. Assuming that the nurses in the nursery had
21 only the delivery note to go by to figure
22 out facts about the delivery, is there any
23 way the nurses would be able to know that
24 this child had been extracted with use of a

Deposition of Yvonne Gomez-Carrion, M.D.

1 vacuum?

2 MS. SIMMONS: Object to the form.

3 A. No.

4 Q. Let me rephrase that because of the
5 objection.

6 Assuming that the nurses in the
7 nursery had no knowledge about the mode of
8 delivery of Jayden W. other than
9 what Dr. Rhett wrote in his delivery note,
10 do you have an opinion to a reasonable
11 degree of medical certainty as to whether or
12 not those nurses would know that he had been
13 delivered by use of a vacuum?

14 MS. SIMMONS: Object to the form.

15 A. Well, based on the documentation around this
16 delivery, they would not know.

17 Q. And with the same assumption, do you have an
18 opinion to a reasonable degree of medical
19 certainty as to whether those nurses would
20 know that Jayden had been extracted from a
21 mid pelvic position with a vacuum with no
22 indication?

23 MS. SIMMONS: Objection.

24 A. They would have no idea. It's not

1 documented again that a vacuum was even
2 used, not to mention the criteria for which
3 the vacuum was used or indications or how it
4 was applied.

5 Q. Assuming that health care providers working
6 in conjunction with Dr. Rhett had no
7 information about the birth of delivery --

8 MR. GRAHAM: Strike that.

9 Q. Assuming that the health care providers who
10 worked in conjunction with Dr. Rhett had no
11 source of knowledge about the mode of
12 delivery in this case other than what
13 Dr. Rhett put in his delivery note, do you
14 have an opinion to a reasonable degree of
15 medical certainty as to whether or not those
16 colleagues of Dr. Rhett would know that a
17 vacuum was used to pull this baby out?

18 MS. SIMMONS: Objection.

19 A. They would not know unless there was some
20 other mode of communication used.

21 MR. GRAHAM: Could you please mark
22 this as our next exhibit.

23 (DischARGE Summary marked Exhibit
24 No. 4 for Identification.)

1 Q. What is the risk to a baby that's been
2 delivered by use of a vacuum for the
3 obstetrician to keep secret in the medical
4 records that he used a vacuum?

5 A. Could you restate that question, please.

6 Q. Yes. You've told me that Dr. Rhett's
7 delivery note doesn't even indicate that a
8 vacuum was used at all in this delivery. Is
9 there any risk to a baby from an
10 obstetrician's failure to document use of a
11 vacuum in delivering a baby, and if so, what
12 is that risk?

13 A. Well, first of all, that's a breach of
14 standard of care, but it's most important if
15 the health care providers who are monitoring
16 the baby, and there's a lot the baby has to
17 transition to, particularly the first 24
18 hours, but we also know that the risk of a
19 brain bleed is significant and it evolves,
20 and that's why in this case babies who are
21 born by vacuum delivery can look fine and in
22 12, 24, 36 hours they can really deteriorate
23 clinically because the brain bleed is
24 evolving.

Deposition of Yvonne Gomez-Carrion, M.D.

1 So, it's really important that the
2 people in the nursery, the nurses and the
3 pediatricians, are aware of that because
4 there's certain signs that a baby will show
5 to heighten their awareness that something
6 not good is happening.

7 Q. What does the phrase or the acronym NSVD
8 mean?

9 A. That means a normal spontaneous vaginal
10 delivery, which means mom pushed the baby
11 out all by herself. No one helped her with
12 a vacuum, with forceps. She did all the
13 work herself.

14 Q. I hand you a document that's been marked
15 deposition Exhibit 4. In the bottom
16 right-hand corner it has a bates number
17 ECH0008, and it's part of trial Exhibit 2.
18 What is that document?

19 A. It's called the East Cooper Regional Medical
20 Center Discharge Summary, dated -- dictated
21 7/17/02.

22 Q. And who prepared this report?

23 A. It looks like Barbara Stone, certified nurse
24 midwife, although it says attending

1 physician, but it appears that the midwife
2 in Dr. Rhett's practice prepared this
3 discharge summary.

4 Q. Okay. Do you know from Dr. Rhett's
5 deposition testimony whether or not that was
6 customary to get the midwives to discharge
7 the patients and do the discharge summary?

8 A. It seemed like that was common practice for
9 him.

10 Q. Please turn to page one of this exhibit in
11 the last paragraph in line seven.

12 A. Oh. That's what the C means. Okay. In his
13 delivery note it says C, and here it says
14 complete.

15 Q. Okay. Tell me -- please read that sentence
16 into the record.

17 A. So, "complete 20:00", which is the time,
18 "NSVD", which stands for normal spontaneous
19 vaginal delivery, "over an in tact perineum
20 under epidural anesthesia, 7-pounds,
21 10-ounce, Apgar's six and nine, placenta
22 spontaneous and in tact".

23 Q. Okay. You can stop. What I really want you
24 to cover was the NSVD. What does NSVD mean?

1 A. Again, it's normal spontaneous vaginal
2 delivery.

3 Q. All right. And Barbara Stone, the certified
4 nurse midwife who works in conjunction with
5 Dr. Rhett, stated in the discharge summary
6 for this patient that the baby was born with
7 a normal spontaneous vaginal delivery?

8 A. That is correct.

9 Q. Was Jayden born with a normal spontaneous
10 vaginal delivery?

11 A. No, he would not.

12 Q. If Barbara Stone had as a source of
13 information about this delivery the delivery
14 notes entered on the official hospital chart
15 written by Dr. Rhett, would she have any way
16 of knowing that a vacuum was in fact used?

17 MS. SIMMONS: Object to the form.

18 A. No, she would not.

19 Q. Let me ask you to turn to page two. Just to
20 the right of the signature line for Barbara
21 Stone there appears to be some initials. Do
22 you recall from Dr. Rhett's deposition
23 testimony that those are his initials?

24 A. Yes. I do believe he said that, he signs

1 off on the dictated discharge summaries that
2 the midwife does.

3 Q. So he agreed with what the midwife wrote on
4 this discharge summary?

5 A. Apparently at this time, he did.

6 Q. Was that true or false?

7 MS. SIMMONS: Objection.

8 A. What's the question?

9 Q. When Dr. Rhett signed off on this discharge
10 summary -- what is your understanding of, as
11 an obstetrician, what is the customary
12 significance of a physician signing off on
13 the entry of another health care provider?

14 A. Your signing off basically suggests
15 documents that you've read the discharge
16 summary, you agree with what's in the
17 discharge summary, because your signature is
18 -- you're stating that you agree with what's
19 dictated here, because if you did not agree,
20 you would either write an addendum or you
21 would strike a line through what was
22 inaccurate and correct it and initial it in
23 the body of this particular document, and
24 none of that was done.

1 So, the initials representing the
2 signature of Dr. Rhett suggest that he read
3 it, agreed with it and made them part of the
4 patient's permanent medical record.

5 Q. Saying that there was no vacuum used?

6 A. Correct.

7 MS. SIMMONS: Object to the form.

8 A. Correct. That she underwent a NSVD, a
9 normal spontaneous vaginal delivery, which
10 means there was no operative delivery in the
11 case of this patient.

12 Q. Because of that objection I'm going to run
13 through that again.

14 A. Okay.

15 Q. As I understand it, Dr. Rhett signed off on
16 the discharge summary dictated by Barbara
17 Stone, certified nurse midwife, in which it
18 is asserted that Jayden W was born
19 NSVD. In signing off on this discharge
20 summary and in agreeing with its contents
21 did Dr. Rhett provide truthful information
22 about the mode of delivery of this baby?

23 MS. SIMMONS: Object to the form.

24 Q. Please tell the jury whether or not

1 Dr. Rhett provided by signing off on the
2 discharge summary a truthful description of
3 the mode of delivery of Jayden W ?

4 MS. SIMMONS: Object to the form.

5 A. I'd have to say it's not truthful, but
6 certainly is not accurate in terms of what
7 happened at the delivery.

8 MR. GRAHAM: Could you please mark
9 this as our next numbered deposition
10 exhibit.

11 (Patient Information Facesheet
12 marked Exhibit No. 5 for Identification.)

13 MR. GRAHAM: We can let the video
14 run, but I'd like to go off the record for a
15 moment.

16 (Discussion off the record.)

17 MR. GRAHAM: Chilton and I have
18 just agreed that deposition Exhibit 5, which
19 I'm about to ask the witness about, contains
20 a secondary diagnosis, quote, history herpes
21 simplex virus, end quote.

22 We have made a motion in limine to
23 keep out of evidence any reference to herpes
24 in the testimony and documents of this case.

1 The judge has not yet ruled on that motion
2 so by asking a question about this document
3 I'm reserving our right to redact out that
4 reference to herpes.

5 MS. SIMMONS: By agreement.

6 MR. GRAHAM: Depending on the
7 judge's ruling.

8 Q. Doctor, I hand you what's been marked as
9 plaintiff's deposition Exhibit Number 5.
10 Can you tell me what this document is?

11 A. Again, it says East Cooper Regional Medical
12 Center Patient Information Facesheet.

13 Q. In the bottom half of this page where it
14 lists operative slash nonoperative
15 procedures, a number of items are listed,
16 about eight items, correct?

17 A. That's correct.

18 Q. What is your understanding of the purpose
19 for listing procedures on this form?

20 A. Well, with most institutions once you have
21 taken care of a patient the charges must be
22 gathered and the medical billers it would be
23 quite an incredible task for them to go
24 through the medical record, so the provider

Deposition of Yvonne Gomez-Carrion, M.D.

1 who knows what occurred during the patient's
2 hospital stay will list the billable items
3 for that particular hospitalization.

4 Q. And do you recall from Dr. Rhett's
5 deposition whether or not this initial to
6 the left of B. Stone is his initial?

7 A. Correct.

8 Q. Okay. And the date on this document is
9 what?

10 A. 7/17/02, date of discharge of the patient.

11 Q. Okay. So that's the day after delivery?

12 A. Correct.

13 Q. Look at the seventh item on this list, the
14 next to the last one. What is that acronym?

15 A. It's a little different. It says VEVD,
16 which I believe he is saying a vacuum
17 effected vaginal delivery. Usually it's
18 called a vacuum assisted vaginal delivery.

19 Q. Okay. Or perhaps vacuum extraction vaginal
20 delivery?

21 A. Possibly that too as well. It was not a
22 normal spontaneous vaginal delivery.

23 Q. Does this particular document go to the
24 nursery ordinarily?

1 MS. SIMMONS: Object to the form.

2 A. No. This stays in the mom's chart if this
3 institution is similar to most.

4 Q. All right. Let me rephrase the question
5 because of that objection.

6 A. All right.

7 Q. Do you have an opinion to a reasonable
8 degree of medical certainty as to whether or
9 not this document, deposition Exhibit 5, is
10 for the purpose of patient care or for some
11 other purpose?

12 A. Well, it's basically a document that lists
13 what occurred to the patient in the
14 hospital, so it's typically in the mother's
15 record, so in terms of patient care, one
16 could look at it and say oh, this is what
17 occurred, but usually it's for purposes of
18 billing.

19 Q. Does -- do the contents of deposition
20 Exhibit 5 --

21 MR. GRAHAM: Strike that.

22 Q. Do you have an opinion to a reasonable
23 degree of medical certainty as to whether or
24 not the contents of Exhibit 5 relate in any

1 way to patient safety?

2 MS. SIMMONS: Object to the form.

3 A. That's a very broad question as well.

4 Q. Okay.

5 MR. GRAHAM: I'll withdraw it.

6 Q. If I understand your testimony, Dr. Gomez
7 Carrion, you've indicated that neither
8 Dr. Rhett in his delivery note, nor the
9 midwife in her discharge summary signed off
10 on by Dr. Rhett make any mention of vacuum
11 extraction, correct?

12 A. That's correct.

13 Q. But deposition Exhibit 5 for billing
14 purposes makes reference to vacuum
15 extraction vaginal delivery or vacuum
16 effected vaginal delivery.

17 What significance, if any, do you
18 place on the fact that the discharge summary
19 and the delivery note make no reference to
20 vacuum, but the billing list of procedures
21 does?

22 A. Well, what's most important in terms of
23 patient safety is the documentation in the
24 medical record being the delivery note and

Deposition of Yvonne Gomez-Carrion, M.D.

1 the discharge summary, and the fact that an
2 intervention happened and there was no
3 documentation of that in that portion of the
4 medical record that's often read by other
5 providers is alarming.

6 Q. Doctor, do you have an opinion to a
7 reasonable degree of medical certainty
8 regarding the most probable cause of Jayden
9 W's brain bleeds diagnosed shortly
10 after his birth?

11 MS. SIMMONS: Object to the form.

12 A. Well, clearly the risk of a vacuum assisted
13 vaginal delivery is brain hemorrhage. The
14 fact that Jayden underwent that type of
15 delivery and had a brain hemorrhage it's a
16 reasonable deduction to state that the brain
17 bleed was directly related to the mode of
18 delivery.

19 Q. And do you hold that opinion to a reasonable
20 degree of medical certainty most probably?

21 A. Absolutely.

22 Q. Were Jayden W's brain bleeds
23 preventable?

24 A. Yes, they were.

1 Q. How?

2 A. If he had not been delivered by a vacuum
3 delivery in this manner, the likelihood of
4 him having had this complication would be
5 not there.

6 Q. You've mentioned statistics earlier about
7 frequency of use of C-sections, frequency of
8 use of operative vaginal delivery with
9 forceps or vacuum. Let me ask you, what is
10 the range of frequency in this country of
11 cesarean section delivery rates?

12 A. At the time of the case or now or both?

13 Q. Well, let's focus on the time of the case.

14 A. Yeah. I believe back then, as I stated
15 earlier, there was a push to reduce cesarean
16 section rate. So the rates were probably
17 around anywhere 15, which was what most
18 institutions wanted the docs to be at, but
19 could be as high as 25 percent.

20 Q. Do you recall Dr. Rhett's testimony about
21 his cesarean section rate?

22 A. I sure do.

23 Q. And what was that?

24 A. 40 percent.

1 Q. How does that compare with the average range
2 of frequency of cesarean section rates back
3 in 2002?

4 A. Well, back in 2002 and 2010 that's a high
5 rate, particularly for a generalist. If
6 you're talking about being a maternal fetal
7 medicine doctor with different types of
8 patients, the quads, quintuplets, all the
9 high risk pregnancies, you would expect a
10 fetal medicine doctor to have a caesarean
11 section rate 40 to 50 percent, but for a
12 generalist it should be much lower.

13 Q. What is the range of frequency of the rate
14 of operative vaginal deliveries, and what
15 I'm really asking is focusing on --
16 forgetting for a moment about C-section
17 rate, C-section deliveries.

18 Of the remaining deliveries that are
19 vaginal, what is the range of frequency of
20 operative vaginal deliveries back in 2002?

21 A. Again, it varied, but it could be anywhere
22 from five, ten period of time.

23 Q. Okay. And do you recall Dr. Rhett's sworn
24 testimony about his frequency of vacuum

1 extractions?

2 A. Yes, I do.

3 Q. What was that?

4 A. Well, he stated that over half of his
5 vaginal deliveries were done by vacuum
6 assisted vaginal delivery, which definitely
7 caught my attention because that was --
8 that's an incredibly high statistic.

9 Q. Is there a relationship between how an
10 individual obstetrician compares to the
11 averages on C-section rates and how that
12 same doctor compares to the average on
13 operative vaginal delivery rates, and if so,
14 what is that?

15 A. Well, typically, particularly during this
16 period, the push was to decrease the
17 cesarean section rate, therefore the
18 operative vaginal delivery rate was slightly
19 higher. You typically don't see someone who
20 has a high cesarean section and a high
21 operative vaginal delivery rate. I mean,
22 you're doing very few spontaneous vaginal
23 deliveries.

24 Q. Do you have an opinion to a reasonable

1 degree of medical certainty as to what the
2 typical range of frequency would be for
3 operative vaginal deliveries of a particular
4 provider who is relatively high in his
5 C-section rate?

6 A. Then operative vaginal delivery rates would
7 be pretty low --

8 Q. And --

9 A. For the most part.

10 Q. The flip side of that, do you have an
11 opinion to a reasonable degree of medical
12 certainty as to what the relative frequency
13 of C-section rate would be for a provider
14 who has a relatively high operative vaginal
15 delivery rate?

16 A. Then that provider typically would have a
17 lower cesarean section rate.

18 Q. Before reading Dr. Rhett's deposition have
19 you ever encountered a situation where an
20 obstetrician is high on both?

21 MS. SIMMONS: Object to the form.

22 Q. Let me rephrase. Doctor, in your career,
23 have you had an opportunity to be familiar
24 with the C-section rates and operative

1 vaginal delivery rates of various
2 obstetricians?

3 A. Absolutely.

4 Q. Okay. Do you have an opinion as to how
5 frequently or infrequently it would be for a
6 particular provider to have an above average
7 rate for C-sections and also have an above
8 average rate for operative vaginal
9 deliveries?

10 A. I've never seen that, but I also have never
11 seen anyone with an operative vaginal
12 delivery rate this high and.

13 Q. What --

14 A. Sorry. And I've overseen a lot of
15 obstetricians statistics being on various
16 quality assurance quality improvement
17 committees that I'm on.

18 Q. What significance do you place on that?

19 A. Well, if I worked with this particular
20 physician, as I alluded to earlier, there
21 has to be some type of peer review as to why
22 this particular provider has such a high
23 incidence of operative vaginal deliveries.
24 I would imagine that --

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1 I mean, there's so many factors. I
2 would be interested in the length of his
3 call. Is he busy in office? Does he have
4 other commitments where he doesn't have the
5 time to be with a patient who would push for
6 an hour and a half to two hours?

7 So are there other pressures on this
8 physician to fulfill other commitments while
9 on call or is there something else going on.
10 It just -- it raises a red flag why
11 someone's operative vaginal delivery rate
12 would be above 20 percent, and that's being
13 very generous.

14 Q. What effect does it have on patient safety
15 if an obstetrician resorts to use of a
16 vacuum quicker and more frequently than
17 other obstetricians?

18 A. Well, your complication rate goes up,
19 complications to not only mom but clearly to
20 the babies that you're delivering. You're
21 putting them at higher risk.

22 Q. We've been going for a while now, Dr. Gomez
23 Carrion. Have all of the opinions that
24 you've expressed today been opinions that

Deposition of Yvonne Gomez-Carrion, M.D.

1 you hold to at least a reasonable degree of
2 medical certainty, most probably?

3 A. Yes, sir.

4 MR. GRAHAM: Please answer any
5 questions that Miss Simmons may have.

6 MR. SCOTT: Can we take a quick
7 break?

8 MS. SIMMONS: Sure.

9 THE VIDEOGRAPHER: The time is 1:57
10 p.m. This is the end of tape two and we are
11 off the record.

12 (Recess.)

13 THE VIDEOGRAPHER: The time is 2:09
14 p.m. This is the beginning of tape three,
15 and we are back on the record.

16 CROSS-EXAMINATION

17 BY MS. SIMMONS:

18 Q. Dr. Gomez-Carrion, I'm Chilton Simmons. I
19 represent Dr. Rhett, and I have some
20 questions for you this afternoon. We've met
21 before?

22 A. Yes, we have.

23 Q. We met when I took your deposition in this
24 case approximately six months ago?

Deposition of Yvonne Gomez-Carrion, M.D.

1 A. Was it that long? Okay. Seems like longer.
2 All right.

3 Q. Okay. The purpose of that deposition was
4 for me to get an understanding of your
5 opinions in this case, correct?

6 A. Correct.

7 Q. And you did swear to take an oath of truth
8 in that deposition?

9 A. Correct.

10 Q. Just as you've sworn to told the truth this
11 in this deposition?

12 A. Correct.

13 Q. And, Doctor, you had reviewed about 12 legal
14 cases a year for the last five years. Is
15 that true?

16 A. With the exception of this year. I've
17 gotten more cases this year, yes.

18 Q. Okay. And this year how many?

19 A. Well, already I've gotten 12 and it's July,
20 so.

21 Q. And you've reviewed about a dozen or so
22 cases just for this plaintiff's attorney,
23 Mr. Ed Graham. Is that true?

24 A. More than that at this point in time as

Deposition of Yvonne Gomez-Carrion, M.D.

1 well.

2 Q. That's a lot of cases for one lawyer, isn't
3 it?

4 A. I don't know. I don't know what the
5 standard is.

6 Q. And as of February of this year, just five
7 months ago, about four to six of those cases
8 of Mr. Graham's are still active. Is that
9 right?

10 A. Correct.

11 Q. You've testified about three or four times
12 at trial?

13 A. I believe four times at trial, yes.

14 Q. And most of your cases, most of your legal
15 cases are for plaintiffs suing doctors. Is
16 that true?

17 A. That's what's sent to me, yes. I get much,
18 many more plaintiff cases and the defense
19 cases I get seem -- on both sides no breach
20 of standard of care, so it can go either
21 way.

22 Q. Doctor, you testified today that it was a
23 breach of the standard of care for
24 Dr. Rhett to have used the vacuum in this

Deposition of Yvonne Gomez-Carrion, M.D.

1 case. Is that true?

2 A. Based on the information that I have
3 reviewed, yes. Yes.

4 Q. And it's pretty serious to accuse a doctor
5 of a breach of the standard of care, isn't
6 it?

7 A. I take that very seriously.

8 Q. Doctor, I'm going to hand you your original
9 deposition, and this is the transcript from
10 which I took your deposition in this case,
11 January 30th of 2009.

12 A. 2009.

13 Q. So that was a year and a half ago?

14 A. Right. Yeah. You said six months.

15 Q. I'm sorry. I misread the date.

16 A. Okay.

17 Q. And if you would please turn to page 27,
18 line 19.

19 A. Uh-hum.

20 Q. Are you there?

21 A. Uh-hum.

22 Q. At line 19 -- I'll read the question to you,
23 and if you would read your answer. The
24 question asked you on that date was, quote,

1 "is it your opinion that it was a breach of
2 the standard of care for Dr. Rhett to have
3 used or done an operative delivery at the
4 point that he did based on the strips, or is
5 it your opinion that that portion is a
6 judgement call by him".

7 And your answer at line three was?

8 MR. GRAHAM: Just for the record, I
9 objected to the form and I preserve my
10 objection and repeat it now.

11 Q. And, Doctor, your answer for the record was,
12 line three?

13 A. Oh, yes. My turn. "That portion would be a
14 judgement call, right".

15 Q. Okay. And, also, if you turn to page 26,
16 line nine. And I'll read my question to
17 you, quote, "Well, at one point Dr. Rhett,
18 because the fetal monitor strip becomes what
19 he deems nonreassuring, he obviously used
20 intervention. He used the vacuum to get the
21 baby out. Do you think that that was an
22 inappropriate decision?" And your answer at
23 line 16, please, ma'am.

24 A. "That with the patient because the patient

1 in today's world had some input and that was
2 not done".

3 Q. Sorry. I think you're on the wrong page.

4 A. Page?

5 Q. 26.

6 A. Sorry.

7 Q. It's okay. And let me repeat the question
8 for you.

9 A. Okay.

10 Q. Page 26, line nine. "Well, at one point
11 Dr. Rhett, because the fetal monitor strip
12 becomes what he deems nonreassuring, he
13 obviously used intervention. He used the
14 vacuum to get the baby out. Did you think
15 that that was an inappropriate decision?"
16 And your answer was?

17 A. "It's a judgement call. Again, he looked at
18 the tracing and deemed it ominous. I did
19 not agree with that assessment, however, you
20 are the delivering physician so you have to
21 act on what your assessment is at that
22 time". You want me to continue?

23 Q. Yes, ma'am.

24 A. "In the video, you can hear the baby's heart

1 rate because he had taken of the fetal scalp
2 electrode in order to apply the vacuum, but
3 prior to that you could hear the baby had
4 recovered, but again, it's the delivering
5 provider who makes the decision of when to
6 deliver the baby.

7 The question is what mode of delivery
8 is safest. If you have a baby that you
9 think has an ominous pattern whose fetal
10 head is above plus two station who's never
11 had a baby, well, that kind of cuts down on
12 mom's ability to push the baby out in a
13 timely fashion.

14 And the question is do you do an
15 operative vaginal delivery or do you move to
16 cesarean section. It's on the physician to
17 make that judgement that's safest for the
18 patient".

19 Q. And, Doctor, you were asked on two occasions
20 if it was a breach of the standard of care
21 for Dr. Rhett to have used the vacuum at
22 that time, and on both of those occasions
23 you said it was clearly within his judgement
24 to do so?

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1 MR. GRAHAM: Objection.

2 Mischaracterizes the testimony.

3 A. Okay. I think what I was referring to there
4 is based on a physician's assessment of
5 what's going on in this particular case,
6 that Dr. Rhett thought it was an ominous
7 pattern, that it was his judgement, but I
8 disagree with his interpretation of that
9 fetal heart rate tracing, therefore based on
10 if my interpretation is different and I deem
11 that it was not an ominous pattern, it would
12 have been breach of standard of care to do
13 an operative vaginal delivery in that
14 scenario, and I think I clarified that later
15 in this deposition.

16 Q. Doctor, looking at line, at page 27, line
17 five, you clearly state, quote, "if you have
18 a baby that you think has an ominous pattern
19 whose fetal head is above plus two station,
20 who's never had a baby, that kind of cuts
21 down on mom's ability to push the baby out.
22 And the question is do you do an operative
23 vaginal delivery or do you move to do a
24 cesarean section. It's on the physician to

1 make the judgement that's safest for the
2 patient", end of your quote.

3 MR. GRAHAM: No. It's not the end
4 of her quote. I object to you leaving off
5 the next sentence.

6 Q. You're welcome to read the next sentence but
7 it doesn't have anything to do with the
8 actual reason for the vacuum.

9 MR. GRAHAM: Well, I object to your
10 false statement that that's the end of her
11 quote. It's not the end of her quote. You
12 stopped in mid answer, and that should be on
13 the record.

14 Q. Dr. Gomez-Carrion, you are welcome to read
15 the other sentence as part of that quote,
16 but it's on a different subject, but
17 certainly go ahead.

18 A. It certainly ties into the decision-making
19 process. In addition, you have time to
20 discuss that, which I've stated above, with
21 the patient, because the patient in today's
22 world has some input and that was not done.

23 So, you know, if his interpretation of
24 a pattern that this was ominous and this

1 baby needed to be delivered right then, you
2 then have to use good judgement in
3 determining what's safest for the baby,
4 whether it be a mid forceps or mid vacuum
5 delivery or cesarean section.

6 I was just stating what the judgement
7 and thinking should be. And this was a year
8 and a half ago, and the more I think about
9 this tracing and looked at the tracing and
10 thought about, you know, Dr. Rhett's
11 deposition and his statistics, it become
12 more bothersome to be, and I think at the
13 end of my deposition I clarified what I
14 thought was breach of standard of care based
15 on his in -- his wrong reading or inadequate
16 reading of the tracing and that he also had
17 other options.

18 Rather than going straight to a
19 delivery of this baby he had the option to
20 do other things to allow the baby to
21 recover, because, again, babies have
22 reserve. This baby did not show, up until
23 this point, any signs of compromise. There
24 was no meconium, beautifully reactive

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1 tracing until she pushed, and that's a
2 change in the environment.

3 Q. And, Doctor, I understand that you do not
4 think there was an ominous pattern on the
5 fetal heart rate.

6 A. Correct.

7 Q. But you understand from Dr. Rhett's
8 testimony and Nurse Judy Mercer's testimony
9 that they both did at that time think that
10 there was an ominous pattern? Do you agree
11 with that, that they had a different opinion
12 than you do?

13 A. They have a different opinion, but ominous
14 means you think the baby is going to die.

15 Q. Okay. And therefore you would agree that
16 Nurse Mercer and Dr. Rhett thought there was
17 an ominous pattern, though I understand you
18 disagree?

19 A. Correct.

20 Q. And it's your opinion that the fetal head
21 was above plus two station?

22 A. Based on the documentation I was provided,
23 correct.

24 Q. And this mother had never had a baby?

1 A. As stated in the record, correct.

2 Q. Okay. And those are your criteria in your
3 own quote on page 27 that states that that
4 is a reason for the physician to make the
5 judgement as to whether to use the vacuum or
6 not. Would you agree?

7 A. That is correct.

8 Q. Okay. Thank you.

9 It's your opinion that first time
10 mothers in labor and delivery don't push
11 very well. Is that right?

12 A. For the most part. It's a learning process,
13 yes.

14 Q. And the mother getting tired and not pushing
15 well is an indication or a reason to use the
16 vacuum. Is that true?

17 A. Typically after mother's been pushing for
18 hour, two hours, three hours even. That is
19 work and those women do get tired, and if
20 you feel that the baby will fit and it would
21 be safe to help mom deliver this baby
22 vaginally, then that is certainly an
23 indication to place the vacuum or forceps.

24 Q. And you did not get the sense from the video

1 that Miss Washington really reached down and
2 gave pushing her all, did you?

3 A. Well, she didn't really get a chance to
4 push. She became fully and 11 minutes later
5 a vacuum was placed on her baby's head. You
6 know, ten minutes is not enough time for a
7 first time mom to get instruction and to
8 have some trial pushing to see if she's
9 going to be a good pusher or not or if
10 baby's going to descend in a quick fashion
11 or not.

12 Q. And the vacuum was placed on the baby's head
13 after his fetal heart tones had moved from
14 the 120's to 160's range down to the 90's
15 range. Is that true?

16 A. And that's typically seen when mom is
17 pushing, yes. True.

18 Q. But is that true?

19 A. Absolutely.

20 Q. And you felt that she really wasn't pushing
21 very well or very hard because she could
22 easily breathe during her contractions which
23 reenforced the fact that she wasn't having
24 great effort or urge to push. Would you

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1 agree with that?

2 A. It's hard to answer that question because I
3 don't know what her urge to push was.

4 Again, I didn't have a lot to look at
5 in terms of the pushing effort, but I would
6 say she was pretty typical of someone who is
7 initially instructed to push. The first
8 instinct is this hurts and you'll hear
9 yelling and see fidgeting because it's a new
10 experience and it is painful, even when
11 women have epidurals.

12 Q. And if you would turn to page 49 of your
13 deposition, please, ma'am.

14 MR. GRAHAM: Which page, please?

15 MS. SIMMONS: Page 49.

16 Q. At line 22, my question was "but when you
17 have an epidural, sometimes you don't even
18 feel that rectal pressure, true", and your
19 answer was?

20 MR. GRAHAM: Objection. I don't
21 think this is a proper use for a deposition.

22 MS. SIMMONS: I'm placing it in
23 context based on your last objection. We'll
24 get down to the next question which is

1 exactly on point for the mother's pushing.

2 This is my cross-examination.

3 Q. At line 22, question, "but when you have an
4 epidural, sometimes you don't even feel that
5 rectal pressure, true"?

6 MR. GRAHAM: Same objection.

7 MS. SIMMONS: Thank you.

8 Q. What was your answer, Doctor?

9 A. "Most of the time you do and the thing is if
10 you have an epidural that's blocking that
11 infurious sensation, you can turn the
12 epidural down".

13 Q. And my next question line four, "but that
14 takes at least several likely more minutes".
15 And your answer was?

16 MR. GRAHAM: Objection.

17 A. "Right, but again, backing up again, we
18 don't have a crystal ball. In this case,
19 given the fact that this baby's tracing was
20 so reassuring for so many, many, many, many
21 hours when she started to push, you had the
22 decelerations. There is a great possibility
23 with increasing her fluids, giving her
24 oxygen and continuing her on her side

1 without pushing that this baby would have
2 recovered.

3 Because she could easily breathe
4 through her contractions sort of reenforces
5 the fact that she wasn't having a great
6 effort or urge to push so you can let her be
7 there until baby really is happy and then
8 start again, and that was not done so we
9 don't know the answer".

10 Q. And your testimony again was that "the
11 mother could breathe easily and it
12 reenforces the fact that she wasn't having a
13 great effort or urge to push". Do you
14 agree?

15 A. Correct.

16 Q. Thank you. Doctor, when a baby needs help
17 getting down the birth canal to be delivered
18 there aren't many methods a doctor has to
19 use to help the baby. Is that true?

20 A. Well, there are more efforts than we
21 discussed today. There are other things you
22 can do with a patient and with your
23 directions so you're still helping the
24 mother encourage the baby to come down.

1 We have bars, squatting bars we use.

2 We have birthing balls. Changing maternal
3 position can often help the descent of the
4 baby as well.

5 Q. But as far as having some kind of concern or
6 indication that the baby needs help coming
7 out, would you say that basically the
8 devices used are a vacuum or a forceps or
9 the doctor can do a C-section depending on
10 the circumstances?

11 A. Correct.

12 Q. Okay. And you use a vacuum to help you
13 deliver babies?

14 A. Absolutely.

15 Q. And you use them in about 15 percent of your
16 deliveries?

17 A. About.

18 Q. That's the only kind of operative vaginal
19 deliveries you do since you don't use
20 forceps?

21 A. I still use forceps but not as frequently,
22 nowhere as frequently as I used to.

23 Q. And you feel that the vacuum is safer than
24 the forceps. Is that true?

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1 A. In terms of the potential risks, yes. I do.

2 Q. Vacuum has a less than five percent chance
3 of causing complications. Is that true?

4 A. Overall speaking?

5 Q. Yes.

6 A. Depends -- well, depends on what institution
7 you're at and the delivering provider, but
8 five percent seems reasonable.

9 Q. And it has less than a three percent chance
10 of causing a subgaleal hemorrhage?

11 A. Again, that depends on who you read. I've
12 seen it as high as five percent.

13 Q. And subgaleal hemorrhages are rare. Would
14 you agree?

15 A. Five percent.

16 Q. And there are certainly risks in using
17 forceps?

18 A. Absolutely.

19 Q. And there are certainly risks in doing a
20 C-section?

21 A. There are risks in any intervention.

22 Q. And the lower the baby is in the birth
23 canal, such as when the baby is at the
24 perineum, the riskier it is for mom and baby

1 to do a C-section. Would you agree?

2 A. No, I would not.

3 Q. If you turn to page 39 of your deposition,
4 please. At line one, the question was "but
5 there is a point at which the baby surpasses
6 that makes a C-section dangerous, true, or
7 more risky"?

8 MR. GRAHAM: Again, I objected to
9 the form of that question and I preserve
10 that objection and will repeat it now.

11 MS. SIMMONS: Noted.

12 Q. And, Doctor, your answer at line seven is
13 what?

14 A. "Well, if you have a baby that you've
15 managed to deliver to the perineum, so my --
16 at crowning position, which is different
17 from what you just asked me, that would be
18 more risky because you would have to elevate
19 the baby back in to the upper pelvis, which
20 we do.

21 I mean, there are many babies who
22 actually moms push it down to that level,
23 you realize it's not going any further and
24 due to the size of the baby you're not going

1. to put, put on a vacuum or forceps for fear
2. of shoulder dystocia.

3. So you can do a cesarean section
4. pretty much at any stage, but it does, as
5. you say, it can result in increased
6. morbidity for mom with the vaginal cervical
7. lacerations and hemorrhage".

8. Q. Again, when you talk about increased
9. morbidity for mom. That means increased
10. chances that mom would die. Is that true?

11. A. No. Not necessarily. Increase the chance
12. of causing lacerations in the vagina. You
13. can also -- that's pretty much the most
14. risk. We're not talking about the Zavanelli
15. maneuver where the baby's head is out and
16. you have to flex and use a lot of pressure.
17. Those women have certainly an increased
18. chance of dying.

19. Q. And, Doctor, when you decide that a baby
20. needs to come out because his heart rate has
21. declined and you think that he may be in
22. distress, you would agree that there are
23. serious risks to the baby the longer it
24. takes for the baby to come out. Is that

1 true?

2 A. Could you restate that question.

3 Q. I certainly can. When you, as a delivering
4 OB, decide that a baby needs to come out
5 because you're concerned about the baby's
6 fetal heart rate --

7 A. Yeah.

8 Q. -- if you think that baby is in distress,
9 there are risks to the baby the longer the
10 baby is in the uterus. Is that true?

11 A. Often, but, I mean, there are different
12 types of decelerations and different levels
13 of worry. There's the nonreassuring and
14 then there's the ominous patterns, so
15 depending -- again, on the whole picture,
16 does your baby have reserve, is this
17 something that's just starting, can you
18 entertain allowing mom to push to a lower
19 level, or is it something that you need to
20 act on immediately because something
21 potentially catastrophic is happening, like
22 a placental abruption or, you know,
23 something, total compression of the cord,
24 the cord comes out, you know.

1 So there are different scenarios that
2 can be entertained, so that would direct
3 what method you think is safest as the
4 delivering physician, whether you do a
5 vaginal approach or an vaginal bypass
6 approach.

7 Q. And the bottom line is if for whatever
8 reason you come to the conclusion that you
9 think the baby may well be in distress in
10 utero, that the fetal heart monitor strips
11 are concerning to you, that they are
12 nonreassuring to you, would you agree that
13 there are serious risks to the baby the
14 longer the baby is in the uterus?

15 A. Again, it depends on the reserve and what
16 kind of decelerations you have. But clearly
17 if you're concerned about a fetal heart rate
18 tracing, you want to get the baby out as
19 soon as you can in the safest manner.

20 Q. Thank you.

21 A. You're welcome.

22 Q. And the risk that that baby has while
23 staying in the uterus would be getting
24 acidosis is that --

1 A. Potentially. But you can have a baby that
2 if there's a reason for decelerations, for
3 example, someone on Pitocin who starts
4 contracting a lot. We call it tachysystole.
5 We used to call it uterine hyperstimulation.
6 You take away that stressor, you can then
7 have the intrauterine resuscitation so
8 there's no need to immediately deliver that
9 baby.

10 In fact, it's better if you relax the
11 uterus, change mom's position, hydrate her,
12 give her O2. You'll see the baby recover in
13 utero. And sometimes that is actually more
14 beneficial because the baby has not had any
15 so-called permanent damage done. It's sort
16 of your baby's transitioning was in a place
17 where it says I don't like this. You take
18 away those stressors and baby's happy again.

19 Q. And you would agree that acidosis means --
20 that's a fancy term that basically means the
21 baby is not getting enough oxygen?

22 A. Correct.

23 Q. And decreased oxygen to the baby puts that
24 baby at risk for brain damage. Is that

-1 true?

2 A. That is potentially correct, yes.

3 Q. Doctor, you testified today that you believe
4 this is a mid vacuum delivery?

5 A. Well, based on the documentation, it's hard
6 to -- I wasn't there. But looking at the
7 vacuum apparatus, looking at the video, the
8 fact that that entire cup was in the vaginal
9 vault, including some of the shaft, if you
10 look at the stations in the mother's pelvis,
11 the documentation in the medical record that
12 minus one, zero station, it suggests that it
13 was not a low or outlet delivery.

14 Q. Would you please turn to page 31 of your
15 deposition. At line eight, my question is
16 "how are you defining traumatic". I'm
17 sorry. That was your answer.

18 A. That was my answer.

19 Q. Sorry.

20 A. No problem.

21 Q. At line nine, I state "you can define it
22 however way you see fit", talking about
23 traumatic.

24 A. Okay. Well, again --

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1 MR. GRAHAM: Excuse me. I'm going
2 to object to this. It's not a proper use
3 for a deposition.

4 Q. Okay. Let's start at line five, Doctor. My
5 question was "would you define Jayden's
6 delivery as traumatic", and your answer was
7 what?

8 A. "How are you defining" --

9 MR. GRAHAM: Excuse me. Excuse me,
10 Doctor. I object to this as an improper use
11 of the deposition. Also, I had objected to
12 the form of that question in the original
13 deposition, which I now repeat.

14 MS. SIMMONS: Okay. Your objection
15 is noted, but I'm going to start over hoping
16 to get a clean record.

17 Q. At line five, Dr. Gomez Carrion, my question
18 was "would you define Jayden's delivery as
19 traumatic?"

20 A. "How are you defining traumatic?"

21 Q. My next question was "you can define it
22 however way you see fit", and your answer
23 was what?

24 A. "Okay. Well, again, I think I answered this

1 question. If you look at the way the vacuum
2 was applied, high station, more than normal
3 continuous traction, added pressure, I don't
4 know where, whether it was in the red zone,
5 green zone, so I would have to say yes".

6 Q. Doctor, would you agree sitting here today
7 that your testimony is different today than
8 it was in your deposition a year and a half
9 ago when you said that this was a high
10 station delivery?

11 A. I think my --

12 MR. GRAHAM: Excuse me. Let me
13 object to that. It's again an improper use
14 of her deposition and it also takes things
15 out of context in a misleading manner.

16 A. I believe what I was thinking a year and a
17 half ago is that it's typical when you're
18 doing a vaginal delivery that the safest
19 levels to do a vaginal -- a vacuum assisted
20 vaginal delivery, be outlet, low. When you
21 start getting into above the plus two
22 station, even though that's called medium or
23 mid, you know, I consider -- I may have used
24 the term "high" because it's higher than

1 what's standardly used. So I think my
2 deposition then and testimony today is
3 consistent, because based on the
4 documentation in the medical record and
5 Dr. Rhett's deposition, he mentioned that
6 zero station was baby is pretty much out and
7 that's incorrect. And then he also stated
8 this was an outlet vacuum assisted vaginal
9 delivery, and from all that I have been
10 presented I don't see where that's true.

11 Q. You would agree that mid station or high
12 station both are terms of art in the medical
13 world? They have significance?

14 A. Terms of art?

15 Q. Well, I mean, you don't just use them
16 loosely, do you? They mean the baby's at
17 different stations, right?

18 A. Well, we're usually very specific in terms
19 of numbers and that's why sometimes these
20 words can get interchanged and that's why we
21 have the numbered stations that we have,
22 because though words do mean different
23 things to different people. And high can
24 mean not necessarily zero station but higher

1 than plus two.

2 Q. Okay. And in fact, aren't there two
3 different ways to keep the numbering system
4 for the plus and minus stations? Some
5 doctors use a scale of five centimeters plus
6 and minus and other doctors use a scale of
7 plus or minus three stations?

8 A. I think I presented that earlier in today's
9 deposition, that there are three different
10 systems. We're now using the five system.
11 In this time I believe we were using a three
12 system, and I know there are folks who use
13 the four system, so it really -- we're
14 trying to get more consistent in terms of
15 what those numbers mean.

16 Q. But that's confusing, right?

17 A. There's a lot of things in medicine that are
18 confusing.

19 Q. And, Doctor, you testified today that doing
20 a mid station vacuum delivery is a breach of
21 the standard of care. Is that true?

22 A. In terms of the use of this particular
23 vacuum. It's a breach in -- it was Tender
24 Touch? It clearly states in their specs

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1 that it should not be used.

2 Now, I do know physicians -- I used to
3 do mid vacuum mid forceps deliveries. Very
4 few people do that now and probably fewer
5 were doing it back then because we were
6 beginning to appreciate the risks involved.

7 Do people still do it, absolutely, but
8 again, as a delivering provider, you really
9 have to think through what the potential
10 risks are and have mom on board.

11 As long as everyone's clear that you
12 might be pushing the recommendation or, you
13 know, going outside of guidelines, and we do
14 that all the time in medicine, but you have
15 to weigh the benefits and the risks.

16 Q. And you would agree that mid station vacuum
17 deliveries are within the standard of care
18 in certain circumstances?

19 A. Yes.

20 Q. Okay. And, Doctor, have you read the
21 manufacturer's warning on all the products
22 that you use in the hospital?

23 A. Yes.

24 Q. On all of them?

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1 A. Yes.

2 Q. Vacuum? Forceps?

3 A. Yeah. Endometrial ablation techniques,
4 amnio instruments. Yeah. Absolutely.

5 Q. The manufacturers' warnings?

6 A. Absolutely.

7 Q. You agreed that had Dr. Rhett chosen to do a
8 C-section on Miss Washington, it would have
9 taken more than the three minutes of the
10 vacuum usage to get Jayden out?

11 A. Yes.

12 Q. In fact, doing a C-section would have taken
13 20 to 30 minutes longer. Is that true?

14 A. Possibly.

15 Q. And a lot can happen in 20 to 30 minutes
16 while the baby's in the uterus waiting to be
17 delivered. True?

18 A. The baby could have recovered and gone back
19 to its reactive tracing, correct.

20 Q. And this baby also could have been suffering
21 from acidosis. True?

22 MR. GRAHAM: Objection.

23 A. Clearly the tracing did not support that and
24 clearly the fact that blood gases

1 immediately after delivery did not support
2 that.

3 Q. Doctor, if in fact Jayden was suffering from
4 acidosis while in the uterus, that extra
5 time waiting for the C-section would have
6 put him at risk for brain damage. Is that
7 true?

8 MR. GRAHAM: Objection. There's no
9 foundation.

10 A. There's no indication on that in this case.

11 Q. If Jayden was suffering from acidosis while
12 in the uterus, the extra time in the uterus
13 put him at risk, would have put him at risk
14 for brain damage. Is that true?

15 MR. GRAHAM: Same objection.

16 A. Are we talking hypothetical now or?

17 Q. Yes.

18 A. Because that does not represent what's
19 happening here, but in a hypothetical case,
20 anything's possible. But in this case,
21 again, you have to look at the whole
22 picture. You have a baby who has been
23 perfectly fine during the stress of labor.
24 There's one time that he did have

1 decelerations. That resolved with the
2 positioning and all the things we've talked
3 about ad nauseam today.

4 There's no reason to think that with
5 the initiation of pushing with a different
6 stressor if you stopped the Pitocin, stopped
7 the pushing, if you were thinking at that
8 time okay, let's deliver him by cesarean
9 section, most likely his tracing would have
10 returned to pretty normal.

11 That's typically what happens in these
12 cases, because there's no other indication
13 that Baby Jayden was in distress. There was
14 no meconium, and that's one of the first
15 stressors. I mean, when a baby is getting
16 more acidotic, there's relaxation of the
17 rectal sphincter and the baby's stools.
18 According to the documentation I've seen,
19 that was not an issue here. And again, the
20 blood gases immediately after delivery were
21 normal.

22 Q. The blood gases were 7.21?

23 A. Correct.

24 Q. That's on the low side of normal? Would you

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1 agree?

2 A. It's normal. It's normal.

3 Q. And when you mention the meconium, meconium
4 is the baby's, the fetus's bowel movement.
5 Is that true?

6 A. That's correct.

7 Q. And when that's present at delivery, that
8 means the baby is in distress. Is that
9 true?

10 A. Or that some stressor has occurred that
11 caused the baby to, yes, release its stool.
12 Adults do that as well.

13 Q. And we'll never know, Doctor, what damage
14 could have or would have occurred to Jayden
15 had he remained in the birth canal while his
16 heart rate declined because Dr. Rhett acted
17 to get him out. Is that true?

18 MR. GRAHAM: Objection.

19 A. Repeat that question, please.

20 Q. Yes, ma'am. We'll never know what damage
21 could or would have occurred to Jayden had
22 he remained in the birth canal while his
23 heart rate declined because Dr. Rhett acted
24 to get him out?

1 MR. GRAHAM: Objection. It
2 violates the most probable rule.

3 A. We don't know that, but again, based on baby
4 Jayden's presentation, condition at birth,
5 Apgar scores and blood gas, most likely my
6 opinion is, within a reasonable degree of
7 medical certainty, he would have been
8 stable.

9 Q. Are you aware that Jayden's umbilical cord
10 was wrapped around his neck when he was
11 born?

12 A. I'm quite aware of that.

13 Q. And would you agree that Dr. Rhett's Pitocin
14 usage was appropriate?

15 A. That's correct.

16 Q. And you would agree that the Cervidil
17 administration was appropriate in this case?

18 A. Absolutely.

19 Q. There is no way to know that had
20 Miss Washington pushed longer that she would
21 have delivered Jayden successfully without
22 the help of the vacuum, is there?

23 MR. GRAHAM: Objection. Violates
24 the most probable rule.

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1 A. We'll never know that. Sorry.

2 Q. And I'll ask the question again, Doctor, and
3 counsel, your objection is noted.

4 There is no way to know had Miss
5 Washington pushed longer that she would have
6 delivered Jayden successfully without the
7 help of the vacuum?

8 A. That's true for any vacuum delivery. You
9 never know it's going be a successful
10 vaginal delivery until the baby is out.

11 Q. Doctors don't have a crystal ball to see
12 inside into the future to guide them in the
13 present, do they?

14 A. No, but that would make life a lot easier.

15 Q. That would be nice.

16 A. Yes, it would.

17 Q. You agree it was not a breach of the
18 standard of care for Dr. Rhett not to have
19 let Miss Washington push longer?

20 A. Repeat that question.

21 Q. Do you believe that it was a breach of the
22 standard of care for Dr. Rhett not to have
23 let Miss Washington push longer?

24 A. I think it was a breach of standard of care

1 to move to the vacuum delivery at that time.
2 Again, and I keep repeating myself, I
3 believe based on the baby, the tracing, with
4 the standard customary decelerations that
5 occur when a mom starts pushing, you need to
6 allow her body to adjust to the new stress
7 and do all those things I've said before.

8 If the baby continues to have
9 decelerations, then certainly you need to
10 entertain possible faster delivery, but if
11 baby recovers, it's quite fine to allow mom
12 to push after you have your intrauterine
13 resuscitation.

14 Q. And you agree that if the doctor believes
15 that a baby has an ominous fetal heart
16 pattern, that is an indication to use the
17 vacuum. True?

18 A. If a physician thinks there is an ominous
19 pattern, a vacuum is one of the modes of
20 delivery, yes.

21 Q. You agree if a doctor has a 50 percent
22 vacuum rate it is not a breach of the
23 standard of care?

24 A. There's nowhere that says what the right

Deposition of Yvonne Gomez-Carrion, M.D.

1 rate is for anything that we do, but that is
2 certainly out of the norm.

3 Q. And you have no idea what pressure was used
4 with respect to the vacuum?

5 A. That is correct.

6 Q. The vacuum pump is worked by the nurse, is
7 that right, the doctor and the nurse?

8 A. In this case, it was the nurse. That can
9 vary depending on your institution.

10 Q. And that's acceptable for the doctor and
11 nurse to work as a team?

12 A. As long as there's communication, yes.

13 Q. You don't have any knowledge of the
14 relationship between Dr. Rhett and the
15 delivery nurses in this case, do you?

16 A. What do you mean by relationship?

17 Q. As far as how long they'd worked together,
18 how well they knew each other, how many
19 deliveries they'd done together?

20 A. No, but clearly there was some familiarity
21 because I've tried to really listen to the
22 communication that occurred on the video and
23 there was very little discussion. The
24 vacuum appeared. It was placed. So I would

1 imagine -- and again, if they worked
2 together and his vacuum rate is greater than
3 50 percent, that most of the nurses that
4 work with him are very ready to assume that
5 position and pump the vacuum.

6 Q. You have no opinion if there was a breach of
7 the standard of care with respect to the
8 amount of pressure used?

9 A. I have no idea how much pressure was used,
10 so that is correct.

11 Q. Thank you. Doctor, let's talk about
12 documentation for a moment.

13 You would agree that documentation or
14 lack of documentation by a doctor or a nurse
15 or midwife does not cause injury to a mother
16 or baby. Is that true?

17 A. Not necessarily. I mean, that's a very
18 broad question, but lack of documentation --
19 as in this case, if a following physician
20 doesn't have information that could lead to
21 delayed diagnosis which could lead to injury
22 potentially, but writing on a paper is not
23 going to physically cause an injury, so I'm
24 -- your question is a, yeah, a little

1 difficult to answer.

2 Q. Okay. And at page 35 of your deposition you
3 were able to answer that pretty easily.

4 MR. GRAHAM: Objection.

5 A. Oh, a year and a half ago.

6 Q. At page 35, line five, "but you would agree
7 that documentation or lack thereof does not
8 cause injury"?

9 A. And at that time I was clearly thinking just
10 writing words on paper.

11 Q. Okay. But your answer at that time was
12 what?

13 A. Right. "That's correct".

14 Q. Thank you. Are you aware that the nursery
15 at East Cooper Hospital was indeed notified
16 that a vacuum was used to help deliver
17 Jayden?

18 MR. GRAHAM: Objection. Assumes
19 facts not in evidence.

20 A. It wasn't documented in writing, but I
21 believe in depositions that it was verbally
22 communicated.

23 Q. And, Doctor, you discussed the discharge
24 summary in which nurse midwife Barbara Stone

1 documented it was a vaginal delivery?

2 A. Correct.

3 Q. What's the date of that discharge summary?

4 A. 7/17. I believe it's the day after the
5 delivery. So, yes. The delivery was 7/16,
6 so the discharge summary was 7/17.

7 Q. And are you aware that Jayden was already at
8 MUSC Hospital by this time?

9 A. Correct. Yes.

10 Q. So is it fair to say that the nurses in the
11 nursery would not be relying on that
12 discharge summary to tell them whether
13 Jayden was born by a vacuum or not?

14 A. Repeat that question.

15 Q. If Jayden was already at MUSC Hospital would
16 it be fair to say that the nursery nurses
17 would not be relying on a discharge summary
18 created after that time?

19 A. But it would impact on the care Jayden
20 received while still at East Cooper.

21 Q. And, Doctor, the discharge summary is for
22 who, mom or baby?

23 A. Both.

24 Q. That discharge summary, is that a part of

Deposition of Yvonne Gomez-Carrion, M.D.

1 Jayden's medical record?

2 A. No. Those are part of the maternal medical
3 record.

4 Q. And maternal is the mom?

5 A. Correct.

6 Q. Thank you. If you know the exact
7 measurements of the vacuum, it is not
8 possible to measure the station of the baby
9 by viewing its use on a video. Is that
10 true?

11 A. Exact? That's probably true.

12 Q. Okay. And that's because every pelvis is
13 different, right?

14 A. Pretty much.

15 Q. Okay. And one centimeter can make a
16 difference as to whether it's a low, mid or
17 high station. Is that fair?

18 A. Correct.

19 Q. Doctor, you did not review Jayden's CT's or
20 MRI's?

21 A. No, I did not.

22 Q. Doctor, are you aware that Jayden has been
23 diagnosed with bilateral hydroceles?

24 MR. GRAHAM: Objection.

Deposition of Yvonne Gomez-Carrion, M.D.

1 A. I believe I saw that documented in the
2 medical record, yes.

3 Q. And are you aware that he was diagnosed with
4 undescended testes?

5 A. Yes.

6 Q. Are you aware he was diagnosed with inguinal
7 hernia?

8 A. Inguinal, yes.

9 Q. Thank you.

10 A. No problem.

11 Q. I'm obviously not a doctor. I'm doing the
12 best that I can.

13 A. You're doing fabulous.

14 Q. Correct me where you need to on the
15 pronunciation. Are you aware he was
16 diagnosed with coloboma of the eye?

17 A. Yes.

18 Q. With congenital cholesteatoma?

19 A. I believe I read that somewhere.

20 Q. That's an abnormality of the ear?

21 A. Yes.

22 Q. Hyperextensibility the joints?

23 A. Yes.

24 Q. DIC?

1 A. Well, yes, because of the bleed in the
2 brain, yeah.

3 Q. Reflux and GERD?

4 A. Yes.

5 Q. A heart murmur?

6 A. Yes.

7 Q. Narrow or absent transverse sinus in his
8 brain?

9 MR. GRAHAM: Objection. Assumes
10 facts not in evidence.

11 A. I don't recall seeing that.

12 Q. Pulmonary artery branch stenosis?

13 A. I'd have to see the medical record too. I
14 don't. --

15 Q. You don't recall that?

16 A. No, I don't.

17 Q. Would you agree that pulmonary artery branch
18 stenosis is a weakening of the arteries?

19 A. A weakening of? It's narrowing of the
20 arteries, not weakening.

21 Q. Okay. And you would agree that Jayden's
22 delivery and birth process did not cause
23 those genetic or birth defects. Is that
24 true?

Deposition of Yvonne Gomez-Carrion, M.D.

1 MR. GRAHAM: Objection. Objection.

2 A. I would imagine that's true, yes.

3 Q. And a doctor doesn't cause genetic problems
4 or birth defects. Is that true?

5 MR. GRAHAM: Objection.

6 A. That's true.

7 Q. Genetic means the baby is born with those
8 problems. Is that true?

9 A. Problems that came from, yeah, family, DNA,
10 yeah.

11 Q. Okay. And genetic defects are present on
12 conception when the sperm meets the egg?

13 A. Well, there has not been development of
14 those organs yet so it takes a little time,
15 yeah.

16 Q. But it's nothing that happens because of the
17 environment basically or because of what
18 somebody does or doesn't do?

19 A. Well, I'd have to look at all of those
20 because medications can do it, can cause
21 certain congenital defects. We don't know
22 the role of stress. You know, there are so
23 many factors that can lead to some
24 congenital abnormalities. They don't all

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1 have to be kind of hereditary. They can be
2 a reaction to environment.

3 Q. And looking at the instruction booklet, I
4 believe there were some risks of the vacuum
5 listed in there, or was it on the warning?

6 A. It's definitely on the warning.

7 Q. Okay.

8 A. I'm sure it's here as well. The possible
9 adverse reaction?

10 Q. Sure. Yup.

11 A. Yes.

12 Q. And also on the FDA warning, where does it
13 state in those documents that any of those
14 genetic issues that we just discussed are
15 risks of vacuum usage?

16 MR. GRAHAM: Objection. It's vague
17 and ambiguous what you're referring to as
18 genetics or birth defects.

19 Q. Doctor, I'll restate that. Looking at the
20 instruction booklet made by the manufacturer
21 of the vacuum and looking at the FDA
22 warning, do either of those documents state
23 that any of these problems are caused by the
24 vacuum, hydroceles, undescended testes,

1 inguinal hernia, coloboma, cholesteatoma,
2 hyperextensibility joints, DIC, reflux and
3 GERD, heart murmur, narrow or absent
4 transverse sinus of the brain, and pulmonary
5 artery branch stenosis.

6 A. Well, all of those with the exception of
7 DIC, because DIC is the outcome if one has a
8 lot of bleeding because you're consuming
9 your coagulation products. So even though
10 it's not listed here, if you have a huge
11 cephalohematoma or large brain bleed, that
12 can certainly lead to DIC. The others I
13 would agree with you.

14 Q. Thank you. And does it state on either of
15 those two documents, the instruction booklet
16 or the FDA warnings, that the vacuum has a
17 risk of causing a posterior fossa bleed?

18 A. No. It just says intracranial hemorrhage
19 cephalohematoma. The posterior fossa is
20 part of the baby's head, so it could be
21 inferred that that's under the category of
22 the brain bleed.

23 Q. You have no opinions on whether Jayden's
24 hemorrhage caused his developmental delays

Deposition of Yvonne Gomez-Carrion, M.D.

1 or other problems, do you?

2 A. Do I have an opinion?

3 Q. Yes, ma'am. As an Ob/Gyn, you have no
4 opinions as to whether Jayden's hemorrhages
5 caused his current developmental delays or
6 other problems?

7 A. Well, I think I will restrict my opinion to
8 obstetrics, yes.

9 Q. Thank you. You would defer to a
10 specialists, such as a neonatologist for
11 that?

12 A. That would be a grand idea, yes.

13 Q. Doctor, looking at the fetal heart monitor
14 strips --

15 MS. SIMMONS: Strike that.

16 Q. As to the fetal heart monitor strips in this
17 case, Jayden's heart strips, you recall that
18 Nurse Judy Mercer had concerns about
19 Jayden's heart rate based on his fetal heart
20 monitor strips. Is that true?

21 A. That is correct.

22 Q. And you recall that she called for
23 Dr. Rhett's help at that point?

24 A. That's correct.

1 Q. And do you recall Dr. Rhett came right away?

2 A. It appeared so, yes.

3 Q. Responded to Nurse Mercer?

4 A. In a timely fashion, that's correct.

5 Q. Thank you. And it's appropriate for the
6 nurse to call the doctor when she's
7 concerned about the baby's heart rate, isn't
8 it?

9 A. If the doctor is not present already, that
10 is correct.

11 Q. And you didn't find Jayden's fetal heart
12 monitoring strip reassuring at all times,
13 did you?

14 A. That is correct.

15 Q. You agree it's a judgement call for the
16 delivering doctor to act on a fetal heart
17 monitor strip. Is that true?

18 A. True, but there are various actions one can
19 undertake, yes.

20 Q. And when I say "act on a fetal heart monitor
21 strip", I mean use a device, such as a
22 vacuum or forceps, to help get the baby out.
23 Is that fair?

24 A. If you're concerned about a tracing, I think

1 we've gone over this, the action doesn't
2 necessarily have to be using an instrument
3 unless you consider, you know, turning off a
4 Pitocin pump or increasing IV fluids or
5 placing an oxygen mask as an instrument, but
6 there are other things one can do depending
7 on your interpretation of the tracing.

8 Q. And it's your testimony that you believe
9 Dr. Rhett instead of using the vacuum should
10 have changed mom's position, turned off the
11 Pitocin and increased her IV rate. Is that
12 true?

13 A. That's probably one of the, yeah, easiest
14 things to do, and in a baby like this you
15 get a good result.

16 Q. Are you aware that he did turn off the
17 Pitocin?

18 A. I think at some point, yes. I'm not sure
19 exactly when, but yes.

20 Q. Because your opinion is that he handled the
21 Pitocin administration appropriately?

22 A. Yes.

23 Q. And, Doctor, if those things don't work,
24 Dr. Rhett's choice at that point, if the

Deposition of Yvonne Gomez-Carrion, M.D.

1 heart rate was still declining, was to use
2 the vacuum, use the forceps or do a
3 C-section that would have taken another 20
4 to 30 minutes. Would you agree?

5 MR. GRAHAM: Objection. Assumes
6 facts not in evidence. It's not a proper
7 hypothetical, and it violates the most
8 probable rule.

9 A. I am not sure how quickly a cesarean could
10 be done at his institution, but, you know,
11 according to ACOG, as long as it's done
12 within 30 minutes you are within standard of
13 care.

14 Again, in Jayden's case, you do have
15 time and it is my opinion that if those
16 things had been done without instrumentation
17 you would have had recovery. Now, if the
18 baby continued to have these variable
19 decelerations with good variability, you
20 have time, so it's not like you have to do a
21 stat cesarean section. Once you turn off
22 the Pitocin and do the position and do the
23 oxygen, these babies tend to recover, as
24 Jayden had done previously.

1 And if the baby doesn't, then you do
2 have to work quickly and use your clinical
3 judgement, and in this case no judgement was
4 rendered.

5 Q. And using one's clinical judgement at that
6 point would be to use the vacuum, the
7 forceps or to order a C-section. Is that
8 true?

9 MR. GRAHAM: Objection.

10 A. Those are your options.

11 Q. Is that true?

12 A. If you don't have recovery that's to your
13 satisfaction.

14 Q. And all three of those options have inherent
15 risks to them. Is that true?

16 A. That's true.

17 MS. SIMMONS: I'm going to take a
18 brief break and come back for maybe just a
19 few more questions and then I'll be
20 finished. Okay?

21 THE WITNESS: All right.

22 THE VIDEOGRAPHER: The time is 2:56
23 p.m., and we are off the record.

24 (Recess.)

1 THE VIDEOGRAPHER: The time is 3:03
2 p.m., and we are back on the record.

3 Q. Dr. Gomez-Carrion, you testified today that
4 at no point in the medical record did
5 Dr. Rhett document on the date of delivery
6 that a vacuum was used. Is that true?

7 A. Except in that document. The list of
8 procedures is where it was listed.

9 Q. Okay. ECH0002?

10 A. Yes.

11 Q. And that is a part of the mother's permanent
12 record. Is that right?

13 A. Yes, it is.

14 Q. Okay. Did you see ECH0020 and 0021?

15 A. Yes, I did.

16 Q. And you would note that on the first page it
17 states that the delivery was by a vacuum?

18 A. Vaginal assisted vacuum extraction, yes.

19 Q. Okay. And on the next page in the bottom
20 right-hand corner, do you see Dr. Rhett's
21 position, ER?

22 A. Yes.

23 Q. So, would you change your testimony and your
24 previous opinion that indeed Dr. Rhett did

Deposition of Yvonne Gomez-Carrion, M.D.

1 document the vacuum was used on the date of
2 the delivery?

3 A. Well, seeing this document, which is part of
4 the labor and delivery summary, I stand
5 corrected. But typically, again, when a
6 physician does delivery, an operative
7 delivery, most people would look towards the
8 delivery note for the information. These
9 forms are often -- we have various forms
10 that we fill out, but in terms of -- and
11 they're checkoffs -- in terms of getting the
12 true details of the delivery, it should be
13 in the written or dictated delivery note.

14 Q. But you would agree that the vacuum
15 extraction was documented on the date of
16 delivery in the permanent chart?

17 A. Correct.

18 MS. SIMMONS: Those are all my
19 questions at this time. Thank you.

20 THE WITNESS: Thank you. You're
21 welcome.

22 MS. SIMMONS: Jim?

23 MR. SCOTT: I apologize. No
24 questions.

1 REDIRECT EXAMINATION

2 BY MR. GRAHAM:

3 Q. Doctor, when Miss Simmons was asking you
4 questions, one of her early questions
5 focused on testimony about whether or not
6 you thought Dr. Rhett had exercised proper
7 clinical judgement in terms of his
8 intervention with a vacuum. She was calling
9 to your attention certain specific questions
10 and answers, and in that regard you told her
11 that you had clarified your testimony later
12 on, but she never got you -- gave you a
13 chance to express the clarification or point
14 to it in the record. Do you -- I'm going to
15 give you that opportunity at this point.

16 A. All right.

17 MS. SIMMONS: Object to the form.
18 And what page are you referring to?

19 THE WITNESS: I have to find it.

20 MR. GRAHAM: I haven't referred to
21 a page yet.

22 Q. Okay. Well, you mentioned page 74?

23 A. Yes.

24 Q. Let me -- let me read the question which was

Deposition of Yvonne Gomez-Carrion, M.D.

1 in the deposition. It was posed by Miss
2 Simmons. I'll read her question and ask for
3 you to read your answer.

4 A. Okay.

5 Q. It's on page 74 starting with line five.

6 Question, "do you think that it rose to a
7 breach of the standard of care for Dr. Rhett
8 to have acted on the strip".

9 A. "Again, it's judgement, judgement call".

10 Q. Question, "so you would not agree that was a
11 breach"?

12 A. "To act on the strip, now the act was, now
13 what that act was was a breach".

14 Q. "Okay. And just so I understand, I'm going
15 to repeat, and you tell me if you're correct
16 on your opinions".

17 A. "Okay".

18 Q. "You believe it was a judgement call to act
19 on the strip, so that was within the
20 standard of care"?

21 A. "Correct".

22 Q. "But you do not agree with how he acted on
23 the strip"?

24 A. "Correct".

1 Q. "Which was using the vacuum?"

2 A. "At the station that appeared high, the
3 technique of the vacuum, correct".

4 Q. "And I believe you did go into this, but if
5 you would tell me again how do you think it
6 would have been appropriate to act on the
7 strip?"

8 A. "I think I just went over that".

9 Q. "Which is to change the mother's position,
10 which they did?"

11 A. "Uh-huh".

12 Q. "And possibly give her oxygen?"

13 A. "Yes. Changing mom's position, which
14 occurred, if Pitocin was on at that point,
15 turning it off, increasing her IV rate to
16 make sure there's adequate flow through the
17 placenta to baby, from mom to baby, stopping
18 pushing, and you have a minute or two to see
19 is the baby going to continue, have a normal
20 baseline or not.

21 And in a baby that has shown you no
22 issues prior to that point of significance,
23 you can certainly wait to see if that is
24 going to occur unless you have other

1 clinical signs, which we did not have here,
2 that something catastrophic was happening".

3 Q. "Can you say to a reasonable degree of
4 medical certainty most probably that had
5 those things been done it would have most
6 likely changed the circumstances?"

7 A. "Yes".

8 Q. All right. And I'll just stop there. We
9 could keep going forever.

10 But let me ask you this, getting back
11 to the point of clinical judgement about
12 whether to intervene in some way, if a
13 doctor is in charge of a labor and delivery
14 and is pondering whether or not to use the
15 vacuum, to what extent does his knowledge or
16 lack of knowledge have on his ability to
17 exercise good clinical judgement?

18 A. Well, you're working with your knowledge
19 base and if that knowledge base is not
20 adequate or flawed, then the judgements you
21 make based on the interpretations of
22 particularly tracings could lead to not so
23 great an outcome.

24 Q. Was it a proper exercise of clinical

1 judgement for Dr. Rhett to intervene at the
2 point he did with a vacuum?

3 A. I believe not.

4 Q. Would it be within the appropriate standard
5 of care for him to have intervened in a
6 different way?

7 A. Correct.

8 Q. Now, there were questions about whether the
9 strip tracing was ominous or not. Is that a
10 matter of clinical judgement or can you --
11 do you have an opinion to a reasonable
12 degree of medical certainty as to whether or
13 not the strip ever revealed anything
14 ominous?

15 A. I believe based on my medical knowledge and
16 within a reasonable degree of medical
17 certainty at no point was anything on
18 Jayden's tracing ominous.

19 Q. Is there any better way for the baby to, the
20 baby in utero to speak to the health care
21 providers about his or her level of health
22 other than the tracings?

23 A. No. As I stated, you know, the color of the
24 amniotic fluid coming out of the uterus.

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1 This is constantly being produced and the
2 fact that there was no mention of meconium
3 is reassuring.

4 Q. Okay. Based on your review of the records,
5 the birth video and all the materials that
6 you've reviewed in this case, do you have an
7 opinion to a reasonable degree of medical
8 certainty as to the health of Jayden

9 W. Immediately prior to the
10 application of a vacuum by Dr. Rhett?

11 A. Baby Jayden seemed to be in good health.

12 Q. You were asked whether a risk of a vacuum is
13 lower than a risk of forceps, and I believe
14 you indicated that in your practice you do
15 consider use of a vacuum to be less risky
16 than forceps. Correct?

17 A. That's correct.

18 Q. What difference, if any, does it make about
19 the risk of vacuum when a vacuum is used by
20 an operator who lacks sufficient knowledge
21 of obstetrics and vacuum usage?

22 MS. SIMMONS: Objection. Asked and
23 answered and beyond the scope of cross.

24 MR. GRAHAM: Well, it's directly

1 responsive to your questions about risk of
2 vacuum being lower than forceps.

3 Q. But let me rephrase the question. Doctor,
4 do you have an opinion to a reasonable
5 degree of medical certainty --

6 MR. GRAHAM: I'm sorry. I thought
7 it was off.

8 (Discussion off the record.)

9 Q. Doctor, with respect to the relative risk of
10 vacuum versus other modes of delivery, do
11 you have an opinion to a reasonable degree
12 of medical certainty as to what effect, if
13 any, it has on the risk of harm to the baby
14 if the operator who chooses to use the
15 vacuum lacks appropriate knowledge
16 concerning obstetrics and vacuum usage?

17 MS. SIMMONS: My objection's noted.

18 A. The potential risk to mother and baby
19 certainly is increased.

20 Q. And do you have an opinion to a reasonable
21 degree of medical certainty as to the effect
22 on the risk of a vacuum if the vacuum is
23 applied to a baby at the mid pelvic station?

24 A. Risk to the baby and mom is increased.

1 Q. Do you have an opinion to a reasonable
2 degree of medical certainty as to the
3 relative -- the effect on the risk of a
4 vacuum if the operator chooses to use a
5 vacuum at the mid pelvic station that is
6 contraindicated for use at that station?

7 A. Clearly the risk to mother and baby is
8 increased.

9 Q. Do you have an opinion as to the effect on
10 the risk of a vacuum delivery if the vacuum
11 is used without an indication?

12 A. Restate that question, please.

13 Q. Do you have an opinion to a reasonable
14 degree of medical certainty as to what
15 effect, if any, it would have on the risk to
16 a baby of harm from a vacuum if there is no
17 indication for a vacuum to be used?

18 A. That's a more difficult question to answer
19 because it depends on the scenario. I mean,
20 you could do an outlet vacuum and certainly
21 you still have the risk of the vacuum, but
22 the risks are minimized.

23 If that station gets higher, then
24 certainly without an indication why would

1 you take risk or increase risk to mom and
2 baby.

3 Q. Miss Simmons asked you a question about
4 whether a C-section would be dangerous when
5 the head is at the perineum. Prior to
6 application of the vacuum by Dr. Rhett was
7 Jayden W 's head at the perineum?

8 A. No, it was not.

9 Q. When you made reference to the station in
10 this case being high or words to that
11 effect, what did you mean?

12 A. It seemed like the station was above the
13 plus two.

14 Q. Is that any different from what you've said
15 today about the mid pelvic station?

16 A. Same answer.

17 Q. Miss Simmons asked you a question about
18 whether or not an obstetrician has a crystal
19 ball to predict the future, and of course no
20 physician does.

21 My question is if a caring
22 obstetrician follows the rules and complies
23 with the standard of care is -- do you have
24 an opinion as to whether or not that

1 physician is able to influence the outcome
2 and thereby influence the future?

3 A. Clearly, if you have an indication and you
4 appropriately use your options for delivery
5 and with mom's consent, I feel and have
6 witnessed that you can reduce the risk
7 potential.

8 Q. And a question was posed to you if a doctor
9 thinks that a tracing is ominous is a vacuum
10 okay. What I'd like to ask you is if a
11 doctor is in error in interpreting a tracing
12 as being ominous, is there an indication for
13 a vacuum, everything else being equal?

14 A. Restate that question.

15 Q. The question was posed to you of whether a
16 vacuum is an acceptable choice if a doctor
17 believes that a tracing is ominous.

18 What effect, if any, would -- what
19 impact would it have if a doctor is in error
20 in believing that the tracing is ominous?

21 MS. SIMMONS: Object to the form.

22 A. Well -- well, you're now recommending an
23 intervention without a proper indication, so
24 again, without a proper indication, you're

1 increasing risk unnecessarily.

2 Q. Okay. Because of that objection I want to
3 revisit that question.

4 You were asked is a vacuum acceptable
5 if the doctor thinks a tracing is ominous.
6 My question is if the doctor is erroneous in
7 his belief that the tracing is ominous, do
8 you have an opinion as to a reasonable
9 degree of medical certainty as to what
10 effect, if any, that has on the
11 appropriateness of a vacuum?

12 A. Well, again, you're -- you have now decided
13 to intervene unnecessarily and any
14 intervention has risk, so the fact that
15 you're intervening without a reason puts mom
16 at unnecessary increased risk, mom and baby.

17 Q. Okay. You were asked if a 50 percent vacuum
18 rate in and of itself represented a breach
19 of the standard of care, and your answer was
20 --

21 A. In absolutes, no, but that certainly would
22 be looked upon, and in any institution I
23 would think that physician would be sat down
24 and would review the indications for the

1 vacuum.

2 Q. To determine whether there was a breach of
3 the standard of care by use of a vacuum in
4 those 50 percent of cases, would it be
5 necessary to look at the facts and
6 circumstances of each of those cases?

7 A. Yes.

8 Q. How many facts and circumstances of
9 Dr. Rhett's use of a vacuum have you
10 reviewed?

11 A. I mean, I've just reviewed this case and
12 noted his description of his practice style.

13 Q. Okay. And in using a vacuum in this case
14 did Dr. Rhett violate the generally accepted
15 standards of obstetrical care?

16 A. Yes.

17 Q. You were asked a question whether
18 measurements of the vacuum cup and viewing
19 the station in viewing the birth video would
20 allow you to precisely and exactly measure
21 the station, and your answer was no.

22 But let me ask you this, Doctor, from
23 reviewing the videotape and from examining
24 the vacuum cup used in this case and having

1 access to its size, are you able to
2 determine to a reasonable degree of medical
3 certainty whether it was an outlet station?

4 A. It was not an outlet station.

5 Q. Were you able to determine to a reasonable
6 degree of medical certainty whether the
7 vacuum -- whether the baby's head in this
8 case was at a low station?

9 MS. SIMMONS: Object to the form.
10 Asked and answered and beyond the scope of
11 cross.

12 MR. GRAHAM: Well, it is directly
13 responsive to your question about whether or
14 not you can get an exact measure of station.

15 Q. My question, Doctor, from reviewing the
16 videotape and having access to the cup used
17 in this case, do you have an opinion to a
18 reasonable degree of medical certainty as to
19 whether or not the baby's head was at a low
20 station at the time the vacuum was applied?

21 A. Based on all that I've seen and reviewed
22 within a reasonable degree of medical
23 certainty, I believe this was not at a low
24 station.

1 Q. Are you -- if we rule out outlet and low,
2 may we agree that this station was mid
3 pelvic at the time the vacuum was applied?

4 A. We can agree to that.

5 Q. Okay. Are you able to tell us exactly where
6 in the mid pelvis the baby's head was?

7 A. No, I cannot.

8 Q. Are you confident that it was in the mid
9 station?

10 A. Based on everything that I've reviewed, I am
11 confident.

12 Q. Okay. There were a number of questions
13 about genetics and birth defects and
14 individual variability and all that stuff.

15 In terms of whether an individual
16 variation is enough of an outlier to be a
17 birth defect, would you rely -- is that
18 something you have expertise to address or
19 would you have to rely on opinions of a
20 geneticist?

21 A. As an obstetrician, I would defer to the
22 geneticist.

23 Q. And you've indicated that in your opinion
24 the use of the vacuum in this case caused

1 brain bleeds.

2 Is it within your expertise to address
3 what harms follow from brain damage or would
4 you defer to someone like a pediatric
5 neurologist or another specialist?

6 A. As an obstetrician, I would defer to someone
7 who specializes in those fields.

8 Q. There was a question about pages ECH20 and
9 ECH21?

10 A. Correct.

11 Q. Which were part of trial Exhibit 2, I
12 believe. And specifically, the question had
13 to do with whether Dr. Rhett had documented
14 vacuum, usage of a vacuum on the day of
15 delivery. Page one of this document has a
16 check for vacuum extraction, correct?

17 A. Correct.

18 Q. Does it have Dr. Rhett's signature on it at
19 all?

20 A. On page one, no.

21 Q. Page two had originally for the signature
22 line for the doctor, the first words are
23 Doctor R-E-T-T, correct?

24 A. Correct.

Deposition of Yvonne Gomez-Carrion, M.D.

1 Q. Do you know if that's a correct spelling of
2 Dr. Rhett's name?

3 A. That's not the spelling on the documents
4 that have been provided to me. I believe
5 it's R-H-E-T-T.

6 Q. Okay. And assuming that the initials to the
7 right of Doctor R-E-T-T are initials of
8 Dr. Rhett, do you have any basis for
9 determining when Dr. Rhett initialled this
10 page?

11 A. No. I cannot answer that question.

12 Q. Okay. So can you tell from review of these
13 documents whether he did that on the day of
14 delivery or some other date?

15 A. I cannot answer that question. I don't
16 know.

17 Q. All right. And do you know whether he even
18 read page 0020 before he initialled page
19 0021?

20 A. Don't know.

21 Q. You were asked quite a few questions by Miss
22 Simmons. What affect, if any, has her
23 questions -- have her questions had on the
24 opinions that you have stated in my direct

1 examination of you earlier?

2 A. Restate.

3 Q. Let me rephrase. Let me rephrase.

4 Doctor, you've answered a number of
5 questions from Miss Simmons. Have your
6 opinions changed any?

7 A. No, they have not.

8 Q. Okay. Do you have an opinion to a
9 reasonable degree of medical certainty as to
10 whether or not Jayden W. would have
11 suffered bleeding in his brain if Dr. Rhett
12 had followed the rules?

13 MS. SIMMONS: Object to the form.

14 A. I believe that if a vacuum had not been
15 placed at the time it was placed we would
16 not be sitting here today.

17 Q. Thank you. Because of the objection, I'm
18 going to ask again.

19 MS. SIMMONS: They can cut out the
20 objection when they edit the video.

21 MR. GRAHAM: That's okay. I just
22 want to get around the objection.

23 Q. Doctor, do you have an opinion to a
24 reasonable degree of medical certainty as to

1 whether or not Jayden W would have
2 suffered bleeding in his brain if Dr. Rhett
3 had complied with the generally accepted
4 standards of care for obstetricians under
5 the facts and circumstances of this case?

6 MS. SIMMONS: Objection noted.

7 A. I believe that we would not be discussing a
8 brain bleed if he had followed the standard
9 of care.

10 MR. GRAHAM: Thank you. No further
11 questions.

12 MS. SIMMONS: I have two last
13 questions, Doctor.

14 THE WITNESS: Yes, ma'am.

15 RE CROSS EXAMINATION

16 BY MS. SIMMONS:

17 Q. Dr. Rhett's reason for intervention with the
18 vacuum was Jayden's declining fetal heart
19 rate tracing. Is that true?

20 MR. GRAHAM: Objection. Exceeds
21 the scope.

22 MS. SIMMONS: Objection noted.

23 Q. Doctor, my question is Dr. Rhett's reason
24 for intervention with the vacuum was

Deposition of Yvonne Gomez-Carrion, M.D.

1 Jayden's declining fetal heart strip. Is
2 that correct?

3 A. That's what the doctor stated.

4 Q. And you have no reason to think that
5 Dr. Rhett was not a caring physician, do
6 you?

7 MR. GRAHAM: Same objection.

8 A. I don't know Dr. Rhett so I can't answer
9 that question.

10 MS. SIMMONS: Okay. Thank you.
11 Those are all my questions.

12 REDIRECT EXAMINATION

13 BY MR. GRAHAM:

14 Q. Doctor, do caring obstetricians discuss
15 risks and benefits with their clients, with
16 their patients before they impose their own?

17 MS. SIMMONS: Objection noted.

18 Q. Treatment options?

19 A. Yes.

20 Q. Do caring doctors learn the medicine before
21 they intervene?

22 A. I would hope so, yes.

23 Q. Do caring doctors learn the risks and read
24 the literature to keep up to date about the

1 risks of vacuum usage?

2 A. Absolutely.

3 MR. SCOTT: I'm going to note an
4 objection to all these questions as beyond
5 the scope of. I think we're now in
6 reredirect which is outside the scope of
7 what's allowed.

8 MS. SIMMONS: I second that
9 objection for this whole line of
10 questioning.

11 Q. Does a caring doctor perform a vacuum
12 extraction delivery and create a delivery
13 note that doesn't even indicate he used a
14 vacuum to suck the baby out?

15 A. A caring doctor would not do that.

16 Q. Would a caring doctor having delivered a
17 baby with a vacuum with massive brain bleeds
18 diagnosed the next day choose not to report
19 the incident to the FDA?

20 A. No, sir.

21 MS. SIMMONS: Objection. Beyond
22 the scope.

23 MR. GRAHAM: No further questions.

24 THE VIDEOGRAPHER: The time is 3:31

Deposition of Yvonne Gomez-Carrion, M.D.

1 p.m. This is the end of tape three. The
2 deposition has concluded, and we are off the
3 record.

4 (Whereupon, the deposition was
5 concluded at 3:31 p.m.)
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Deposition of Yvonne Gomez-Carrion, M.D.

1 COMMONWEALTH OF MASSACHUSETTS

2 MIDDLESEX, ss.

3
4 I, Kristin Kelley, a Certified Shorthand
5 Reporter and Notary Public duly commissioned
6 and qualified within and for the
7 Commonwealth of Massachusetts, do hereby
8 certify:

9 That YVONNE GOMEZ-CARRION, M.D., the
10 witness whose deposition is hereinbefore set
11 forth, was duly sworn by me, and that such
12 deposition is a true record of the testimony
13 given by the witness to the best of my
14 skill, knowledge, and ability.

15 IN WITNESS WHEREOF, I have hereunto set my
16 hand and my affixed notarial seal this 23RD
17 day of July 2010.

18
19
20 Kristin Kelley
21 Notary Public

22 My Commission expires:
23 November 29, 2014
24

In The Matter Of:
JAMESETTA WASHINGTON v.
EDMUND RHETT, JR., M.D., ET AL.

BARBARA BURTON, M.D.
July 15, 2010

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www.amicusreporters.com

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STATE OF SOUTH CAROLINA)
) SS:
COUNTY OF CHARLESTON)

IN THE COURT OF COMMON PLEAS
NINTH JUDICIAL CIRCUIT

JAMESETTA WASHINGTON, as)
Guardian ad Litem for)
JAYDEN W , a minor,)
Plaintiff,)
-vs-) Case No. 2007-CP-1533
EDMUND RHETT, JR., M.D.,)
and LOW COUNTRY OBSTETRICS &)
GYNECOLOGY, P.A.,)
Defendants.)

The videotaped evidence deposition of
BARBARA BURTON, M.D., called for examination, taken
pursuant to the provisions of the Code of Civil
Procedure and the Rules of the Supreme Court of the
State of South Carolina pertaining to the taking of
evidence depositions for the purpose of discovery,
before ANDREW ROBERT PITTS, C.S.R. No. 84-4575, a
Certified Shorthand Reporter within and for the
County of Cook, State of Illinois at 300 West Adams
Street, Suite 800, Chicago, Illinois, on the 15th
day of July, A.D. 2010, at 2:33 p.m.

PRESENT:

GRAHAM LAW FIRM, P.A.,
(383 West Cheves Street, P.O. Box 550,
Florence, South Carolina 29503,
843-662-3281), by:
MR. EDWARD L. GRAHAM,
appeared on behalf of the Plaintiff;

HOOD LAW FIRM, LLC,
(172 Meeting Street, P.O. Box 1508,
Charleston, South Carolina 29401,
843-577-4435), by:
MS. CHILTON GRACE SIMMONS,
appeared on behalf of the Defendant
Edmund Rhett, Jr., M.D.;

YOUNG CLEMENT RIVERS, LLP,
(28 Broad Street,
Charleston, South Carolina 29401,
843-720-5402), by:
MR. JAMES E. SCOTT,
appeared telephonically on behalf of the
Defendant Low Country Obstetrics &
Gynecology, P.A.

ALSO PRESENT:

MR. JOSHUA URBAN, Videographer,
Legal Visual Services,
205 West Randolph Street, Suite 1150,
Chicago, Illinois 60606, 312-551-0595.

REPORTED BY: ANDREW R. PITTS, C.S.R. No. 84-4575.

I N D E X

BARBARA BURTON, M.D.

EXAMINATION

BY MR. GRAHAM

4, 85, 104

BY MS. SIMMONS

53, 94

E X H I B I T S

NUMBER

MARKED

FIRST REF'D TO

BURTON DEPOSITION EXHIBIT

No. 1

4

13

No. 2

4

19

No. 3

4

20

No. 4

4

21

No. 5

4

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No. 6

4

24

DEFENDANTS' EXHIBIT

No. 1

99

96

No. 2

101

101

No. 3

102

103

No. 4

104

104

(Burton Deposition Exhibits 1-6

sent to Mr. Graham.)

(Defendants' Exhibits 1-4

sent to Ms. Simmons.)

1 (WHEREUPON, certain documents were
2 marked Burton Deposition Exhibit
3 Nos. 1, 2, 3, 4, 5, and 6 for
4 identification, as of 7/15/10.)

5 THE VIDEOGRAPHER: This is Joshua Urban with
6 Legal Visual Services, 205 Randolph Street,
7 Chicago, Illinois. I am the operator of this
8 camera. We are on the record on July 15th, 2010.
9 The time is 2:33 p.m., as indicated on the video
10 screen.

11 This is the videotaped deposition of
12 Dr. Barbara Burton, and it is being taken pursuant
13 to South Carolina Rules of Civil Procedure on
14 behalf of the Plaintiff.

15 We are at 300 West Adams Street,
16 Chicago, Illinois. This case is captioned
17 Washington versus Rhett, Case No. 2007-CP-10-1553.

18 Will the attorneys please identify
19 themselves for the video record.

20 MR. GRAHAM: Ed Graham for the Plaintiff.

21 MS. SIMMONS: Chilton Simmons for Defendant
22 Dr. Rhett.

23 MR. SCOTT: Jim Scott for Low Country
24 Obstetrics & Gynecology, P.A.

1 THE VIDEOGRAPHER: The court reporter today is
2 Andrew Pitts from Amicus Court Reporting.

3 Please swear in the witness.

4 THE REPORTER: Please raise your right hand.

5 (WHEREUPON, the witness was duly
6 sworn.)

7 BARBARA BURTON,
8 called as a witness herein, having been first duly
9 sworn, was examined and testified as follows:

10 DIRECT EXAMINATION

11 BY MR. GRAHAM:

12 Q. Dr. Burton, good afternoon.

13 A. Good afternoon.

14 Q. We are here in Chicago to take your
15 deposition for use at trial, which is scheduled to
16 start on July 28th.

17 You are unable to come to South Carolina
18 for trial; is that correct?

19 A. That's correct. I'll be out of town,
20 unfortunately.

21 Q. Let me ask you in the beginning just a
22 few personal background questions.

23 Where were you born?

24 A. I was born in Minneapolis, Minnesota.

1 Q. Okay. And where do you currently live?

2 A. I live here in Chicago.

3 Q. And are you married?

4 A. Yes, I am.

5 Q. Do you have children?

6 A. I have two grown children, yes.

7 Q. Thank you.

8 Other than Minnesota and Chicago, where
9 else have you lived?

10 A. Well, I grew up in Tallahassee, Florida.
11 That's where I graduated from high school, and then
12 I came to Chicago for further education. And when
13 I finished my training here, I moved to
14 Winston-Salem, North Carolina where I was on the
15 faculty at Wake Forest University for 11 years, and
16 then I subsequently moved back to the Chicago
17 suburbs.

18 Q. And at present, you are a physician
19 specializing in genetics; is that correct?

20 A. Correct.

21 Q. All right. Let me get you to tell the
22 jury a bit about your educational background.

23 You mentioned college in Chicago, but
24 could you be more specific.

1 A. Sure. I graduated from Northwestern
2 University and then the Northwestern University
3 Medical School here in Chicago. I then did
4 training in pediatrics at Northwestern and
5 Children's Memorial Hospital followed by further
6 training in medical genetics at the same
7 institutions.

8 Q. What does it mean to be board certified?

9 A. Well, in any medical specialty, what
10 that means is that you've completed a training
11 program in that specialty, one that's accredited by
12 the group that accredits training programs in that
13 particular specialty, and that you've passed an
14 examination in that specialty.

15 Q. Do you have to be board certified to
16 practice as a pediatrician or a geneticist?

17 A. No.

18 Q. Are you board certified in any field,
19 and if so, which ones?

20 A. Yes, I'm board certified in pediatrics
21 and in clinical genetics.

22 Q. Since when have you been board certified
23 in pediatrics?

24 A. Since 1978.

1 Q. And genetics?

2 A. 1982.

3 Q. Okay. During your career, have you been
4 honored with certain awards, and if so, could you
5 please touch on some of those.

6 A. Sure. I received a research award in
7 pediatric research during my training that was
8 given by the Midwest Society for Pediatric
9 Research. I am a member of Alpha Omega Alpha,
10 which is the Medical Honorary Society.

11 I also received an award here in Chicago
12 from the Chicago pediatric society, one that I'm
13 particularly proud of. It's an award, the
14 Archibold Hoyne award, given to someone who's made
15 outstanding contributions to the field of
16 pediatrics in the Chicago area. One award is given
17 a year, and I received that several years ago.

18 Q. Okay. I notice on your CV there's a
19 reference to best doctors in America for various
20 years.

21 What's involved in that designation?

22 A. I think there's a commercial group that
23 puts together that list of best doctors based on
24 surveys from peers, in other words physicians in

1 the same specialty and other specialties, actually,
2 also, referring physicians across the country.

3 Q. Let me turn to your teaching activities.

4 Have you served as a professor at
5 various medical colleges and, if so, which ones?

6 A. Yes, I'm currently a professor at the
7 Northwestern University Feinberg School of
8 Medicine. I was previously a professor at the
9 University of Illinois College of Medicine here in
10 Chicago and before that at the Wake Forest
11 University Medical School.

12 Q. What hospital appointments do you have?

13 A. Well, my primary hospital appointment is
14 at Children's Memorial Hospital here in Chicago.
15 That's where I admit my patients and see most of my
16 patients.

17 I am also on the consulting of staff of
18 Northwestern Memorial Hospital, which is the major
19 teaching hospital associated with Northwestern
20 where we have newborns, but we don't have a general
21 pediatric service. So I do consultations there in
22 the nursery of infants who are either suspected of
23 having birth defects or genetic disorders or who,
24 in fact, have those kinds of problems.

1 Q. Who directs the genetics program at
2 Children's Memorial?

3 A. I am the director of the clinical
4 practice at Children's Memorial, the clinical
5 practice director. We have a separate academic
6 division head who is Dr. Joel Charrow, but I am
7 director of the clinical service.

8 Q. How long have you held that position?

9 A. I believe it's been, oh, about ten
10 years, since shortly after I arrived there in 1999.

11 Q. How much of your time is spent dealing
12 with patients in the clinical setting versus
13 teaching medical students or residents?

14 A. I spend about 80 percent of my time in
15 direct patient care activities, seeing the
16 patients, doing some clinical research as well and
17 follow-up of patient care, and then the other
18 20 percent is divided among academic activities
19 like teaching students and residents,
20 administrative responsibilities, things of that
21 nature.

22 Q. Among other activities, have you been
23 involved with research relating to drugs that were
24 in the development or testing phase?

1 A. I have. I am currently involved in
2 clinical trials related to drugs for certain
3 genetic disorders and have done that in the past.

4 Q. What are some of the pharmaceutical
5 companies or biotech companies that you have worked
6 for?

7 A. Well, I have worked on projects that
8 were sponsored by BioMarin Pharmaceutical, Shire
9 Human Genetic Therapies, and Genzyme Corporation.

10 Q. Have you received government grants to
11 support some of your research work?

12 A. Yes.

13 Q. Without going into detail, are you a
14 member of various professional organizations
15 relative to your career?

16 A. Yes. I am a member of the major
17 national and local organizations in both the field
18 of medical genetics and also pediatrics.

19 Q. Have you authored any books or textbooks
20 on the subject of genetics and particularly the
21 birth context?

22 A. Yes. I am co-editor of a textbook
23 called Congenital Malformations that relates to
24 birth defects, and I have authored chapters in a

1 number of other textbooks on similar subjects.

2 Q. All right. In reviewing your CV, I see
3 the name Aubrey Milunsky mentioned.

4 Is that the same Dr. Milunsky who is
5 serving as a defense expert witness in this case?

6 A. Yes, it is.

7 Q. All right. What -- what role have you
8 played in authoring materials, chapters, or
9 whatever in his textbooks?

10 A. I have written a chapter on, I think,
11 two occasions, as I recall, for his textbook
12 Genetic Disorders and the Fetus.

13 Q. Did he invite you to do that?

14 A. Yes, he did.

15 Q. I see a number of journal articles.
16 What would have been your primary
17 interest in terms of research and publication?

18 A. Oh, I've been interested in a number of
19 different areas, and my interests have shifted a
20 little bit during the course of my career.

21 I was very involved with prenatal
22 diagnosis of birth defects and genetic disorders
23 early in my career, particularly with a technology
24 called Alpha-Fetoprotein screening.

1 Over time, my interests have shifted
2 more toward pediatric diagnoses, so I'm interested
3 in genetic disorders that affect children. I have
4 some special interest in several groups of
5 inherited disorders of the body biochemistry
6 referred to as inborn errors of metabolism.

7 Q. Thank you. I hold in front of me, and I
8 will ask the court reporter to pass to you, a
9 document marked as Exhibit 1.

10 (WHEREUPON, the document was
11 tendered to the witness.)

12 BY MR. GRAHAM:

13 Q. Is this a true and correct copy of your
14 professional CV?

15 A. Yes, it is.

16 MR. GRAHAM: Thank you. We would offer that
17 at this time.

18 MS. SIMMONS: Into evidence?

19 MR. GRAHAM: Yes.

20 MS. SIMMONS: I would object on hearsay
21 grounds, and that CV was not produced in the
22 regular course of business, so --

23 BY MR. GRAHAM:

24 Q. Are the contents of that CV true and

1 accurate?

2 A. Yes, they are.

3 Q. Thank you.

4 MS. SIMMONS: My objection is still noted for
5 the record, please.

6 MR. GRAHAM: Sure. At this point, I will
7 proffer Dr. Burton as an expert in the field of
8 genetics and related issues.

9 MS. SIMMONS: No objections.

10 MR. SCOTT: No objections.

11 BY MR. GRAHAM:

12 Q. Dr. Burton, before we get into the
13 detailed opinions related to the Jayden W
14 case, let me ask you some background questions.

15 First of all, could you please explain
16 to the jury what is genetics.

17 A. Well, the term, the word "genetics" just
18 refers to anything relating to the genes that are
19 the hereditary information that lead to normal
20 characteristics when we talk about human genetics
21 in humans and also to abnormal characteristics or
22 problems, medical problems that would be related to
23 the genetic information or the genes.

24 Q. In this case, some of the defense

1 witnesses have talked some about genetics and birth
2 defects.

3 What is a birth defect?

4 A. A birth defect is an abnormality in the
5 structure of a baby that's present at birth,
6 whether it's genetic or nongenetic. It really
7 doesn't say anything about the cause of that birth
8 abnormality.

9 Q. When I look in the mirror every day, I
10 see a big nose. Is that a birth defect?

11 MS. SIMMONS: Object to the form.

12 BY THE WITNESS:

13 A. Generally, no. In other words, there's
14 a lot of human variability. There's variation in
15 human characteristics: Tall, short, big nose,
16 small nose, big ears, small ears. There's a lot of
17 variation that is not a birth defect, it simply
18 represents human differences. As we look around
19 any room, you see a lot of characteristics that
20 vary. So that's just an example of human
21 variation.

22 BY MR. GRAHAM:

23 Q. I'm curious about where individual
24 variation stops and birth defect arises. Can you

1 help the jury understand that.

2 A. Well, sometimes there can be some
3 subjectivity to that. It can be a little difficult
4 to define, but in general, we think about birth
5 defects in the sense of major and minor birth
6 defects, and a major birth defect would be one that
7 requires some sort of treatment or intervention or
8 significantly interferes with the function of the
9 individual or of an organ. So an example would be
10 a heart defect that requires surgery.

11 And then there are minor birth defects
12 which are distinctly different from what you would
13 see as normal human variation but yet don't have a
14 significant cosmetic or functional impact on the
15 individual. And an example of that would be what
16 we call ear pits, little tiny holes in the front of
17 the ears that we see as a minor birth defect. It
18 is certainly not normal. It is not within the
19 spectrum of normal.

20 You can look at lots of people that are
21 normal and they don't have that, but at the same
22 time, it doesn't really cause a functional problem,
23 it's not a serious medical issue, so we'd refer to
24 that as a minor birth defect.

1 Q. Thank you, Dr. Burton. Let's turn to
2 Jayden Washington.

3 A. At my request, did you accept
4 responsibility for reviewing certain materials and
5 formulating certain opinions about this case?

6 A. Yes, I did.

7 Q. What was your understanding of your job
8 description for your work in this case?

9 A. My understanding was that you were
10 asking me to look at the materials and then
11 subsequently the patient, actually, himself to
12 determine if there was any identifiable genetic
13 explanation for his neurologic disabilities,
14 handicaps.

15 Q. In that regard, what medical records and
16 depositions and other materials did you review?

17 A. I reviewed medical records on the
18 mother, Jamesetta Washington, and also medical
19 records on the patient, Jayden W , several
20 depositions. I reviewed the mother's deposition
21 and the grandmother and then depositions of several
22 experts in the case.

23 Q. Okay. Did you read Dr. Milunsky's
24 deposition?

1 A. I did. I read Dr. Milunsky's
2 deposition, Dr. Zimmerman's. I also initially saw
3 some photographs of the patient, and then later I
4 had the opportunity to actually examine the
5 patient.

6 Q. When did you examine the patient?

7 A. It was, I believe, late April of 2009.

8 Q. When Jayden came to your office for that
9 examination, what did you glean from your
10 interaction with him? What did you do and what did
11 you learn?

12 A. Well, I had previously reviewed the
13 medical records, so I had quite a bit of the
14 medical history that normally I would get during
15 the course of an evaluation, but I reviewed some of
16 that history with the mother and filled in some
17 gaps.

18 I obtained information about how he was
19 doing at the time, about his medications, other
20 medical problems that he had. I took a family
21 history from the mother, and then I did a physical
22 examination on him. Subsequently, I also ordered
23 some laboratory tests, which were performed after
24 the visit.

1 MR. GRAHAN: I hold in front of me what's been
2 marked as Plaintiff's Exhibit 2, and I will ask the
3 court reporter if he would kindly hand that to you.

4 (WHEREUPON, the document was
5 tendered to the witness.)

6 BY MR. GRAHAM:

7 Q. You mentioned ordering some tests. What
8 is Exhibit 2?

9 A. It's the report of a blood chromosome
10 analysis.

11 Q. Did you order this test, and, if so,
12 why?

13 A. I did order it. Chromosome
14 abnormalities are a relatively common cause of
15 developmental disabilities in birth defects. This
16 would be a test that would be commonly done on a
17 patient who had developmental disabilities,
18 particularly if there was no other obvious
19 explanation for them, and it's also one of the
20 tests that Dr. Milunsky had mentioned in his
21 deposition that he felt would be important for the
22 patient.

23 Q. What was the result of the test?

24 A. It was normal.

1 Q. Okay. I'm going to hand you a
2 highlighter and ask if you could please mark on
3 this exhibit where the finding of normal is.

4 A. Okay.

5 MR. GRAHAM: Thank you.

6 Could you please hand the witness
7 Exhibit 3.

8 (WHEREUPON, the document was
9 tendered to the witness.)

10 BY MR. GRAHAM:

11 Q. Dr. Burton, what is Exhibit 3?

12 A. It's a report of another blood test, a
13 test called microarray. It's sometimes also
14 referred to by the long name, comparative genomic
15 hybridization, or a CGH.

16 Q. Did you order this test?

17 A. Yes.

18 Q. Why?

19 A. Well, this test, it gives us a more
20 finely detailed look at the chromosomes and is able
21 to detect very small abnormalities that can't be
22 seen under the microscope on the previous test.

23 So little pieces of DNA or genetic
24 information missing or extra that could cause birth

1 defects or developmental disabilities would be
2 detected with this test, and it was, again, one of
3 the tests that Dr. Milunsky had mentioned he
4 thought would be appropriate for the patient.

5 Q. What was the result of the test?

6 A. It was normal.

7 Q. Would you please highlight where the
8 normal finding is located.

9 A. Okay.

10 MR. GRAHAM: Thank you.

11 Mr. Court Reporter, would you please
12 furnish the witness with Exhibit 4.

13 (WHEREUPON, the document was
14 tendered to the witness.)

15 BY MR. GRAHAM:

16 Q. Dr. Burton, what is Exhibit 4?

17 A. It's a report of another blood test
18 called Fragile X DNA analysis.

19 Q. Did you order this test?

20 A. Yes.

21 Q. Why?

22 A. Again, it was one of the tests that
23 Dr. Milunsky mentioned he felt was indicated. It
24 is a test for the most common genetic condition

1 that results in hereditary mental retardation or
2 developmental disability. So it's a test that
3 would be very commonly done in any patient who
4 presents with those findings without any other
5 obvious explanation.

6 Q. What was the result of this test?

7 A. It was normal.

8 Q. Would you please highlight where that
9 normal finding appears.

10 A. Okay.

11 Q. I note that in the "Result" section
12 after it says "normal male," it says "30 CGG
13 repeats identified."

14 Can you shed any light on that, please.

15 A. Sure. Well, the Fragile X gene is a
16 really complicated gene, and within the gene
17 there's a region where the little building blocks
18 of the gene which go by letters like A, T, C, or G,
19 where groups of three are repeated over and over
20 again, and normally they're repeated over and over
21 again about 30 times, as is true in this case.

22 The way that a patient gets the genetic
23 disorder called the Fragile X Syndrome is that that
24 area is expanded so that there's a whole bunch of

1 those repeats, and then the gene doesn't work
2 anymore. So in a patient who's got the Fragile X
3 syndrome, we see typically more than 200 of those
4 repeats.

5 MR. GRAHAM: Thank you.

6 Mr. Court Reporter, would you please
7 furnish the witness with Exhibit 5.

8 (WHEREUPON, the document was
9 tendered to the witness.)

10 THE WITNESS: Okay.

11 BY MR. GRAHAM:

12 Q. All right. What is this document?

13 A. It's a report of another blood test.
14 This time the test was a test of a gene called the
15 CHD7 gene, and the analysis that was done was
16 sequencing, which means that all of the building
17 blocks of that gene were studied to determine if
18 they were all there and in the right order, and
19 that test was normal.

20 This is a gene that is frequently
21 altered in a condition called CHARGE Syndrome, so
22 it's a test for CHARGE Syndrome, basically.

23 Q. And the result is what?

24 A. It was negative, or normal.

1 Q. Okay. Negative is the same as normal?

2 A. Exactly. Yes.

3 Q. Could you please highlight that finding.

4 A. Sure.

5 MR. GRAHAM: Sir, would you please furnish the
6 witness with Exhibit 6.

7 (WHEREUPON, the document was
8 tendered to the witness.)

9 THE WITNESS: Okay.

10 BY MR. GRAHAM:

11 Q. What is this document, Dr. Burton?

12 A. It is a report of another series of
13 blood tests on a blood sample. This time, this is
14 a group of tests having to do with blood clotting.
15 So there's a platelet count, and then there's a
16 series of other tests that have to do with what's
17 called coagulation, how the blood clots.

18 Q. Did you order this test?

19 A. I did.

20 Q. Why did you order it?

21 A. I ordered it because sometimes,
22 subsequent to my evaluation of the patient when I
23 had ordered the other tests we just discussed, you
24 indicated to me that another witness in the case