

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

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SC Court of Appeals

Samantha Jamison, as Personal Representative of the
Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

Ansley L. Hilton, MD, individually and as agent,
servant or employee of Rock Hill Gynecological
and Obstetrical Associates, PA; Christopher B.
Benson, MD, as agent, servant or employee of Rock
Hill Gynecological and Obstetrical Associates, PA;
and Rock Hill Gynecological and Obstetrical Associates,
PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

RECORD ON APPEAL
VOLUME II OF II

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1 MR. DAVIS - Thank you, Your Honor.

2 DIRECT EXAMINATION

3 BY MR. DAVIS -

4 Q Dr. Benson, would you introduce yourself to the jury
5 by sort of outlining briefly your training, your education
6 and your experience as an Ob-Gyn, sir?

7 A Yes, sir. I am a native of Western New York State,
8 born in Canton, Ohio. I went to college in St. Bonaventure
9 University in Western New York, degree in biology. From
10 there I went to Georgetown University to medical school.
11 That was from 1985 to 1989. I was on a military
12 scholarship, the Army, and I went -- did my residency in a
13 Army program, William Beaumont Army Medical Center. That's
14 in El Paso, Texas. That was a five-year program instead of
15 a four-year program. I was deployed to Desert Storm with a
16 U.S. Cavalry during that time during Desert Storm. I came
17 back in and finished my residency. After that I went to
18 Fort Knox; I paid back the Army three years of active duty
19 time, took my boards, became board certified in Ob-Gyn. I
20 practiced for three years there, and then I came to Rock
21 Hill, joined this group and I've been here practicing for
22 17 years, so I've been a Ob-Gyn physician practicing
23 outside of residency for approximately 20 years.

24 Q Dr. Benson, the Army scholarship, was that through
25 medical school?

1 A Yes, they -- they pay for medical school and then you
2 pay them back with active duty time taking care of soldiers
3 and military dependents.

4 Q What were the years you were on active duty in the
5 U.S. Army, sir?

6 A I was on active duty for eight years total. That
7 would've included all my residency time, my year in Desert
8 Storm, my payback three years afterwards.

9 Q What was your rank when you were discharged from the
10 military?

11 A I was a major.

12 Q Did you continue in any capacity, any reserve capacity
13 in -- Army or the military?

14 A No, I did not. I resigned my commission when I left.

15 Q Now, you're board certified in Ob-Gyn?

16 A Yes, sir.

17 Q Were you recertified?

18 A Yes, we recertify every year.

19 Q Dr. Benson, when did you first become involved on
20 September 5, 2008 with Samantha Jamison?

21 A When I was called by my nurses to come to evaluate her
22 on labor and delivery and they told me at that time that
23 they couldn't find the baby's heart rate, so that was a
24 pretty horrible meeting that we had. It was -- I was
25 expecting to hear that she was going to be there at any

1 moment. I was working on labor and delivery taking care of
2 five other families that were having babies that day, five
3 other women that were in labor, and we were having a busy
4 day on labor and delivery. I had done a delivery about
5 10:00 in the morning and finished up on that and I got this
6 phone call from Dr. Hilton around 11:00 o'clock, and she
7 was very clear that she was concerned about this baby, and
8 she told me about the testing and, of course, then I was
9 concerned, so I did what had to be done at that point. I
10 notified the anesthesia doctor. That's the most important
11 person for me to get the job done if I would've needed to
12 do a c-section, and that -- the anesthesia physician was
13 there on the unit. I notified my scrub tech and my nurse
14 that are right there on labor and delivery; they were there
15 and they were ready, and then it was important to take care
16 of and tuck in essentially those five laboring patients and
17 make sure that I was comfortable that they were doing okay
18 if I needed to immediately leave the unit and do a c-
19 section and be basically indisposed taking care of Samantha
20 Jamison for the next hour. So that involved quite a bit of
21 work to get everyone checked on and tucked in. I have a
22 back-up physician that can come from the office to take
23 care of my patients that are in labor while I'm doing a c-
24 section, and although our office is only five minutes away,
25 you still feel responsible; you want to make sure that

1 everyone is doing okay, that you're not going in to take
2 care of a patient and walking away from another patient
3 that's having a problem, but I was a little bit anxious
4 because of what I had heard about Samantha, knowing that I
5 might -- I might find a baby that had a heart rate tracing
6 that was not normal, and depending on what that looked
7 like, I might have to do something. Sometimes we put the
8 patient on oxygen, give her some IV fluids, turn her on her
9 side and that tracing looks better. That baby then can
10 continue to live and grow inside its mother. Sometimes if
11 you are worried and you weren't going to send that patient
12 home, you can give steroids, prolong the pregnancy, get
13 that baby to grow and do better, but sometimes you would
14 find a tracing that's so concerning that you would have to
15 do an emergency c-section, and basically with my team there
16 we could've done it in less than 10 minutes from the time
17 we decided to make that call.

18 Q You could've delivered the baby by cesarean section in
19 less than 10 minutes?

20 A If we thought that was the right thing to do, but
21 that's a very difficult decision to make. It's a very
22 important decision, because that baby's good health is at
23 stake either way. If you deliver a baby that's just before
24 32 weeks -- we heard from our neonatologist that that baby
25 has a 10 to 15 percent chance that it won't survive ---

1 Q What does that mean?

2 A Well, babies have complications from prematurity
3 sometimes, and I was concerned that how flippant the
4 discussion was about delivering a 32 week baby. It's a --
5 it's a weighty decision to have to have that
6 responsibility, because if you decide that that baby has to
7 be delivered, and then that baby has complications of
8 prematurity, then your -- your decision may lead to bad
9 things happening to that baby, possibly death, 10 to 15
10 percent chance of that baby not making it. So we do
11 deliver babies early when it's the right thing to do, but
12 we have a big responsibility to the mother and the baby
13 because it can hurt the baby, so it's risks and benefits.
14 There are risks of making that decision to do the c-
15 section, and there are risks to not making that decision,
16 so when you have a patient with an abnormal tracing, it's
17 not an easy situation, so I was -- let's just say I was
18 getting ready to rock and roll if it was necessary.

19 Q Explain to the jury -- you were on labor and delivery
20 duty. Is that the appropriate term to use?

21 A I was the on-call physician that day.

22 Q At the hospital.

23 A Yes. We take call 24 hours in-house. We might go out
24 and get something to eat for a very brief time period, but
25 we are in the hospital.

1 Q Do you know whether or not that's the national
2 standard of care to require Obs to be 24 hours like you
3 guys do?

4 A I don't know of any group in our area that does that.
5 We -- I think we basically have committed to do that,
6 partly because we take on the responsibility of taking care
7 of the indigent in our community. If someone comes in with
8 no care, we do that, plus we care for our patients, plus we
9 have an arrangement with North Central. North Central is a
10 federally funded clinic. There's an excellent mid-wife
11 there that provides prenatal care for patients, and they
12 take care of patients that are low socio-economic difficult
13 situations, and we take -- we supervise all the high risk
14 patients through that clinic and we have an arrangement
15 that when those patients come to the hospital we will
16 deliver them, so we are committed to do a lot of obstetric
17 work in our community and it -- several years ago it became
18 obvious that it would be best for us just to be in-house
19 and that's what we do, so we take on that responsibility.

20 Q When you are on duty at labor and delivery in-house,
21 describe for the jury the various responsibilities, the
22 various things that happen from time to time when you -- in
23 your experience when you have been the house duty officer
24 for labor and delivery?

1 A Well, we change over call at around 7:30, 8:00 o'clock
2 and there's some overlap, the physician coming off call is
3 working so ---

4 Q P.M. or A.M.?

5 A In the morning, 7:30 in the morning. And essentially
6 you sometimes help with rounds; you're making rounds on
7 labor and delivery; you're figuring out who's there on the
8 unit, who's going to have a baby that day, who's having
9 observation for complications in a pregnancy; you sometimes
10 might have a scheduled c-section or two that day, and
11 sometimes you may have inductions where you're helping
12 someone -- you're admitting them to the hospital and
13 helping them to go into labor, because it's an appropriate
14 time for them to have their baby. But managing labor and
15 delivery is your number one responsibility, but then
16 managing patients that may come through the emergency room,
17 obstetrics and gynecology, patients that are already
18 assigned to your practice, private patients of ours or
19 anyone who shows up without a doctor that needs obstetrical
20 or gynecological care. And then sometimes the doctor
21 coming off will handle all the rounds, occasionally you'll
22 help with that on an easy day, but generally you hit the
23 ground running and you're taking care of whatever needs to
24 be done on labor and delivery.

1 Q Typical day on labor and delivery is the house
2 officer, busy, slack? How do you describe that?

3 A It's an unpredictable place. You can come in and not
4 have any scheduled inductions and not have anyone in labor.
5 That doesn't happen very often in our group. Deliveries
6 per month by our group would put it at four to five
7 deliveries per day on average, probably closer to four per
8 day.

9 Q If this were an average day, how many patients would
10 you have been responsible for before you got the phone call
11 from your partner at around 11:00 a.m.?

12 A I would say on an average day I'd probably have three
13 to five patients that was I taking care of that morning.

14 Q These three to five ladies in the hospital?

15 A No, no, three to five on labor and delivery in labor
16 or being induced, but the rest of the hospital, you know,
17 usually we have probably on average 10 patients upstairs
18 that have had their baby already and we're caring for, some
19 Gyn patients there in the hospital, a few patients through
20 the ER each day, one consult per day maybe on average.

21 Q When you're on labor and delivery like you were that
22 morning around 11:00 o'clock or 1:00 o'clock just to use
23 that time-frame or even beginning at 8:00 or 9:00 o'clock
24 that morning, if you've got three to five patients in
25 various stages of labor that you're responsible for and a

1 nurse in room one says, Doctor, I need you to come and take
2 care of this patient, and the nurse in room two says,
3 Doctor, I need you to come and take care of this patient
4 about the same time, how do you decide where you go?
5 A Well, I already have those patients in my mind; I know
6 who I'm taking care of that day, and I know which ones I'm
7 worried about more and which ones I'm worried about less,
8 but it's all depending on the situation, and sometimes you
9 just go in a room and look at a strip for 30 seconds and
10 decide whether you like it or don't and just tell them
11 you're coming right back, go right to the other one look at
12 it, you know, decide where you need to spend more time
13 based on what the situation is, but you may walk back and
14 forth very quickly. You have to make notes when you do
15 something significant or something significant happens, so
16 if I was -- for instance, after I got the call about
17 Samantha I would go see those patients and make notes on
18 most of them, and so go in a room for a minute or two, make
19 sure the fetal heart rate tracing's okay, talk to the
20 patients, kind of make contact; patients just kind of want
21 to see their doctor every so often during the day, and I
22 knew that maybe I wasn't going to be there for an hour or
23 so, I needed to sort of check on people. Depends how far
24 back the last note I wrote was -- some of those patients I
25 would maybe need to write a note; maybe some of them I had

1 just written a note and I don't need to. I had one patient
2 I had delivered about 10:00 o'clock, so ---

3 Q Okay. What is clinical judgment, sir?

4 A Clinical judgment is being able to make decisions
5 based on your training and your life experience as a
6 doctor, all the prior care you've given. For me that's --
7 been a physician since 1989, but even during medical school
8 you're starting to pick that up. You're around physicians
9 that are your mentors; you're learning from them; you're
10 learning what's appropriate, what not to do, but you gain
11 experience over time and then it's on-going medical
12 education. Medicine today is not the same as it was when I
13 graduated from medical school. You have to stay up.
14 That's reading, going to conferences and just from
15 experience.

16 Q We looked a moment ago with Dr. Hilton at a nurse's
17 note, Betsy Peake. Was she a part of your team on labor
18 and delivery that day?

19 A Yes, I've had a long association with Betsy Peake.
20 She's a nurse that was on labor and delivery when I first
21 came to work here, so that was a long time ago, and Betsy
22 Peake still works in this community, but I know her very
23 well, extremely well.

1 Q Doctor, when Betsy Peake puts in her note that's in
2 evidence -- we just looked at it, you were here -- oligo,
3 IUGR, was that your diagnosis?

4 A No, it wasn't. I think she's just trying to summarize
5 what she thought was going on, and it's not written down in
6 our chart that she had that.

7 MR. JORDAN - Your Honor, I'm going to object to
8 anything that Betsy Peake may have thought. I think the
9 record speaks for itself.

10 THE COURT - Can't surmise what anybody else is
11 thinking.

12 DR. BENSON - Yes, sir.

13 Q What was your interpretation of Betsy Peake's note
14 when she notes oligo and IUGR on Ms. Jamison in late entry
15 dated -- at 1340 or whatever it was.

16 A Well, ---

17 Q What did you understand that to mean as her physician?

18 A I wouldn't have seen that note for a long time,
19 because that's not ---

20 Q I'm sorry?

21 A I wouldn't have seen that note for quite a long time.
22 That's not -- that's not in the realm of what I was doing
23 that day and what I was taking care of, so she wrote that
24 note after the care. What was important to me is I knew
25 certain details from the phone call I had, and then I had a

1 chart on labor and delivery to look at that would be a copy
2 of the chart that we had in our office. Nowhere on that
3 chart did it say that this patient had a fetus that was in
4 the 10th percentile or less which is how we define IUGR, so,
5 you know, clearly this was not a growth restricted fetus
6 when you reviewed the notes. There was no need to at that
7 time to do anything other than get ready to see the tracing
8 on that baby as soon as she got there.

9 Q The tracing from the office?

10 A No, the tracing that I was going to get on labor and
11 delivery as soon as she got there. That was the most
12 important item.

13 Q Why wasn't the most important thing to as soon as she
14 through the doors to rush her directly to the operating
15 room and have her perform -- have you perform an emergent
16 c-section and in 10 minutes from the time she walks in the
17 door to get that baby delivered, sir? Why wasn't that what
18 you needed to do?

19 A Well, the general recommendation for a biophysical
20 profile that's abnormal is to repeat the biophysical
21 profile maybe a couple hours later, so the only reason for
22 that is that many of those babies are sleeping or doing
23 better than what the study would've indicated, so if you
24 put the baby on the monitor and the heart rate doesn't look
25 too bad, even if you have some late decelerations, if you

1 put her on oxygen and give her some fluid and things perk
2 up, then that's the appropriate care, and then you would've
3 saved that baby from a c-section. If the -- if the risk
4 for fetal death prior to 32 weeks is 10 to 15 percent,
5 that's like rolling a dice with seven sides on it. If one
6 side comes up, that baby's dead, so that's not a -- that's
7 not a decision you make lightly, and we know that between
8 zero and four biophysical profiles, those are all
9 considered abnormal. Zero, two or four. Six is equivocal,
10 but four and down, those are abnormal biophysical profiles.
11 Forty percent of those babies will not show any problems
12 when you do your continued monitoring and following them;
13 they will not have difficulties. Forty percent of the time
14 -- so sixty percent of the time it is a serious issue, but
15 forty percent of the time it is not, and so it requires --
16 the standard of care requires further evaluation of that
17 baby.

18 Q Well, was your plan then, Doctor, to have her come in
19 when she got there, get her situated and monitor her for
20 another 30 or 40 minutes?

21 MR. JORDAN - I'm going to object to the leading.

22 MR. DAVIS - I'll restate it.

23 Q Can you -- let me restate the question subject to my
24 friend's objection. Doctor, can you state whether or not

1 your plan included putting her on a monitor for 30, 40
2 minutes after she got to the labor and delivery floor?

3 A That was possible. If I got some reassuring findings
4 when she got there, I would've monitored her like that and
5 maybe monitor her for days.

6 Q Hypothetically, if she had come in and she had gotten
7 the monitor and there was a heart rate -- assume that
8 hypothetical -- we know tragically there was not, but ---

9 A Yes.

10 Q --- assume that she had a heart rate.

11 A Yes, sir.

12 Q She'd come to the office and your partner said she's
13 got a two out of eight, possible late decelerations on an
14 NST in the office, I'm concerned, sending her over, and you
15 put her on the monitor and she's got a heart rate, but the
16 biophysical profile is still two out of eight, what do you
17 do?

18 A Just get more information, more monitoring, more time.

19 Q What if the heart rate is below normal and it's a two
20 out of eight, what do you do? I mean in two minutes you
21 see that. What do you do?

22 A Below normal is extremely vague but below what?

23 Q Well, a heart rate of 80 or 60 for a sustained period
24 of time, more than three minutes, two minutes, more than 60
25 seconds. What do you do?

1 A If we put it on and it's below 60 and it's not rising,
2 we don't have to watch it more than a minute, we're going
3 to the back.

4 Q And when you say going to the back, what do you mean?

5 A We're going to do a c-section.

6 Q And in 10 minutes from that time she's going to be
7 delivered.

8 A Less than.

9 Q Less than 10 minutes.

10 A My anesthesia physician met her when she first came
11 into the room. He was there and ready and I -- to do an
12 emergency c-section I do not have to have a perfect
13 situation. I have to have anesthesia, and I have to have a
14 knife; that is it. And it's been done without anesthesia
15 when it's a true emergency.

16 Q Really?

17 A That's not pretty, but that saves the baby's life
18 sometimes.

19 Q And you've done that?

20 A I haven't had to do it, but I've had to ---

21 Q Seen it done?

22 A --- I've had to help with that.

23 Q Okay. Would you look at Dr. Hilton's note, it's in
24 that chart, the original chart I hand it to you, that she

1 went over with us just a moment ago, and let me ask you a
2 couple questions about that, sir. Can you find it?

3 A Yes, I see it, the September 5th note?

4 Q Yes, sir. Let me ask you this, Dr. Benson. In your
5 opinion does the standard of care indicate or require an
6 Ob-Gyn office like yours in this country to even have an
7 ultrasound machine and train ultrasound technicians like
8 Jane McCain to perform those procedures?

9 A No, all those UN doctors do not have a trained
10 ultrasonographer in their office and ready to do
11 ultrasounds. Most do. Most do not have one that has the
12 same level of experience or skill that Jane McCain or Julie
13 Middleton have. We have very excellent ultrasonographers.

14 Q Dr. Benson, if a patient comes to an office that does
15 not have a ultrasonographer or ultrasound machine not being
16 below the standard of care and they need to have a BPP,
17 what does that reasonably prudent Ob-Gyn then do to follow
18 the standard of care?

19 A Usually send them to the hospital to get it or send
20 them to an imaging center to get it.

21 Q How long, in your opinion if you have an opinion,
22 would it take to send a patient from your office to
23 Piedmont Hospital, which is very close to your office, to
24 obtain a biophysical profile?

1 A Well, things -- it's a little bit like going to the
2 emergency room for something. Things may not happen very
3 quickly, but she would need to go to the radiology
4 department and get it done. It could take a long time.

5 Q Well, what do you mean, long time? What does that
6 mean to you?

7 A I think we'd be lucky to get it within an hour.

8 Q From the time this BPP was ordered, it was, according
9 to the records, completed within 30 minutes, 40 minutes?

10 A I think we were basically getting her in the room and
11 starting it within about 15 minutes and it was completed
12 within about 15 minutes.

13 Q Okay. A patient comes to your office with a
14 complaint of decreased fetal movement, in your opinion does
15 that constitute an obstetrical emergency, sir?

16 A No, that's one of the most common complaints that we
17 get. We definitely are concerned when a patient calls us
18 and -- any patient that calls us at night when we're on
19 call and says I feel my baby's moving a lot less than I
20 think it should. All she needs to do is indicate that she
21 thinks it's less than it should be, not that it's not
22 moving at all, not how many times was it moving, not how
23 many times it moved in the last hour. We don't really ask
24 those kind of details. If she has a gut feeling that her
25 baby's not moving as much as it should, she will be invited

1 to come immediately to labor and delivery. That's our
2 standard. And when someone comes to the office, we're
3 going to monitor them if they say that. When we're doing
4 regular Ob visits, you can see those blocks that we fill in
5 as you go across the chart, and ---

6 Q You've got the chart in front of you.

7 A So it's not -- it's not something we take lightly. A
8 baby moving is very important to us, and we put the date
9 down; we put the blood pressure down, the patients weight.
10 Early on in pregnancy we're asking about nausea, vomiting,
11 headache, edema, but also late -- those are indicators of
12 preeclampsia, something we're always watching for in our
13 prenatal care, but the next block over is activity. Even
14 before we, you know, put down data about how many weeks the
15 patient is, how large the fundal height is, things like
16 that, we very early on are asking the patient about
17 activity and we want to know that her baby's moving. And
18 early on, of course, mothers don't feel their babies
19 moving, so it becomes a bigger and bigger issue the further
20 along they get. Some mothers don't feel their baby move
21 til 20 weeks, but most of them starting at 17 weeks.
22 That's a big issue for us.

23 Q Ms. Jamison presented from North Central. You
24 mentioned that at history and arrangement with that office
25 and was referred to you from North Central at about

1 approximately what week of her pregnancy as best you can
2 tell?

3 A Well, our ultrasound -- that day that she came to our
4 office she had an ultrasound and at that moment that became
5 our best dating criteria.

6 Q Who interpreted that ultrasound on July 18?

7 A I did.

8 Q Would you look at that please in your chart and let's
9 ask you about that?

10 A Okay, I'm looking at that right now. It's from July
11 18th, 2008. That was the first date she was at our office.
12 She was there for a prenatal interview.

13 Q And an ultrasound was done?

14 A An ultrasound is not always done at that visit, but
15 the prenatal nurse asked whether that would be appropriate,
16 and I agreed that it would be appropriate, and the reason
17 for that is that we want the earliest ultrasound we can get
18 in any pregnancy where we're starting late.

19 Q What did the ultrasound that you interpreted on July
20 18 indicate as a due date?

21 A The due date from the ultrasound was the first of
22 November, 2008.

23 Q According to what the patient reports to you as her
24 last cycle, what was the date?

1 A The date given to the ultrasonographer -- she enters
2 the data in when she's doing an ultrasound -- was the 26th,
3 but we have in our obstetric record the 25th of December,
4 2007.

5 Q When there's a discrepancy between what mom tells you
6 as her last cycle and the ultrasound report, what is the
7 standard of care indicated or required of you as a
8 physician to determine an appropriate date -- due date?

9 A Well, we all get slightly different teaching as we go
10 through our residency. We learn to do ultrasound and we
11 learn how important it is to establish the best expected
12 date of confinement or expected delivery date that you can,
13 and it's -- you're making an estimate. You're trying to
14 determine which is going to be more accurate in each case.
15 We want at least one ultrasound on every pregnancy, because
16 it gives us a really valuable piece of information. It
17 tells us whether we should like the dates from the last
18 menstrual period or whether we should come up with a
19 different due date based on the ultrasound, and basically
20 when the last menstrual period due date and the ultrasound
21 due date are very close together and the mother states I'm
22 sure about the date of my last menstrual period, I also
23 have regular menstrual cycles, such that I have a menstrual
24 period approximately every 28 days. That's what our system
25 is based off of, that someone will ovulate on day 14, has a

1 menstrual period on day 28, and we also ask the patient,
2 was it a normal menstrual period, because sometimes the
3 patient has bleeding in pregnancy. If you bleed in a
4 pregnancy and you kind of thought that was your last
5 menstrual period, you may actually be off by a whole month,
6 and that does happen sometimes. So if it was a normal
7 menstrual period and it's a patient who's regular and she
8 was sure of the date and we're already liking that
9 information and the accuracy of it, and usually we're
10 seeing these patients before 10 weeks and we're getting
11 this information prior to 10 weeks. Now, we see the
12 patient for the first doctor's visit usually at 10 weeks,
13 and at that time we get an ultrasound on every single
14 patient, because that's in the time-frame that's super
15 accurate for determining the due date, and in most cases it
16 matches up nicely within two or three days. If it's off by
17 seven days, we probably still keep the last menstrual date.
18 If it's off by 11 days, some folks would consider going
19 with the ultrasound. If it's definitely off 13 to 14 days,
20 you're probably going with the ultrasound. Okay? So when
21 it starts getting further apart, you're going with an
22 ultrasound. Now, that's early on when it's very accurate.
23 As you get further along, the accuracy of the due date
24 based on an ultrasound becomes less sure, and the way to
25 explain that is that if a very large person who's six foot

1 four and is delivering a baby and the baby weighs 10
2 pounds, and a very small person that's five foot four is
3 delivering a baby that weighs five pounds, both of those
4 babies may have perfectly good health, and both may be
5 exactly 40 weeks and deliver right on their due date, but
6 they -- one will be twice as big as the other, but if you
7 ultrasounded both of those at 10 weeks, they would just be
8 about the same size, and therefore we like early
9 ultrasound. It's just called splay; your bigger babies,
10 they're destined to be bigger genetically or because too
11 much nutrition from diabetes. If they're destined to be
12 bigger, they'll be moving away from the average, and if
13 they're destined to be smaller, just because that's the
14 size baby that a mother makes, then they'll be moving away
15 from the growth curve simply because that's nature, but
16 early on they'll be very close to that average. And so
17 those are useful things -- useful dates when we get it from
18 an ultrasound that's early, and generally a very vague way
19 of saying this or a very -- a summary of it would be, you
20 get an ultrasound the first half of the pregnancy that's
21 prior to 20 weeks, it's probably going to be pretty
22 accurate. If you get it after 20 weeks, it's probably not.
23 Samantha when she came in to see us, her ultrasound showed
24 a baby that was 24 weeks and six days, so we could say

1 almost 25 weeks by our best estimate was when we first had
2 Samantha in our office and ---

3 Q Dr. Benson, do you have an opinion whether or not any
4 of the determinations as documented in your chart, things
5 you just talked about about establishing a due date was
6 done in any way below the standard of care of a reasonably
7 prudent office obstetrician trying to -- attempting to,
8 under these circumstances, determine an accurate or
9 appropriate due date?

10 A Well, even the standard in our office is not to get an
11 ultrasound when you come to see the nurse that day but
12 usually when your at you're new Ob visit with the doctor
13 getting it done, but our nurse that was doing the prenatal
14 interview had the wisdom and judgment to come to me and
15 say, shouldn't we get an ultrasound, and of course, I
16 agreed.

17 MR. JORDAN - Your Honor, we're going to object to
18 anything the nurse may have said.

19 THE COURT - You will need to rephrase your
20 question and see if -- state that in general -- used it in
21 his work on the patient.

22 Q July 18, 2008, you were asked to do an interpretation
23 or order an ultrasound?

24 A I was -- I did order an ultrasound ---

25 Q Okay.

1 A --- on Samantha Jamison that day and then I
2 interpreted it after it was done.

3 Q You ordered it and you interpreted.

4 A Yes, sir.

5 Q Did you see Ms. Jamison that day?

6 A I did not.

7 Q Okay. Did you ever see her in the office?

8 A I never did.

9 Q Before the c-section?

10 A I did not.

11 Q Have you had a chance to review the non-stress test
12 that was performed on July (sic) 5 in the office? Have you
13 looked at those?

14 A I've seen it many times.

15 Q You got in the file. If you want to locate it again,
16 please feel free to refer to it.

17 A I would like to.

18 Q Please, sir.

19 A So this is dated September 5, 2008.

20 Q Yes, sir.

21 A Whenever we interpret an NST we always start with the
22 baby's baseline and we want to know whether it's a normal
23 baseline or not. The baseline will decrease as the baby
24 matures.

25 Q Baseline of what?

1 A The baseline fetal heart rate.

2 Q Okay.

3 A And the baseline fetal heart rate here appeared to be

4 close to 140, maybe a little bit below 140, but

5 approximately 140 I would call the baseline. The next

6 thing you would want to determine is whether there's beat-

7 to-beat variability and we can rate that as minimal,

8 moderate or -- or excellent. I would call this moderate

9 variability, which is very good, meaning it's not flat. It

10 has a lot of jagged movement and just -- just indicates

11 variability and that's generally an indicator of fairly

12 good health of the baby, and I would say it's somewhere

13 between minimal and moderate, but there's definitely

14 variability present. Then you want to determine whether

15 you have accels present. Accels are where the fetal heart

16 increases off the baseline. She's got several accels here.

17 Sometimes you have the finding of an accel combined with a

18 decel. That's generally thought of more as a neutral, sort

19 of like a positive added to a negative, and it's a little

20 bit indeterminate. You wouldn't really give credit for a

21 positive, but you wouldn't really count it quite as a decel

22 either. It's a -- it could go a little either way. So she

23 has actually two of those that sort of fall into that

24 category, and so I would say those are somewhat -- somewhat

25 concerning, but I wouldn't call that the classic late

1 decel. The classic late decel is going along at its
2 baseline, you hit the contraction at its peak and then
3 sometimes after that peak of a contraction you see it start
4 to slide down. Now, if it drops down suddenly, that's a
5 variable decel, and it's kind of a different thing. They
6 can still be concerning if they're repetitive, but
7 generally a late decel tells us that -- it makes us
8 concerned about the baby when we see late decels
9 repetitively. When we see them intermittently it gets our
10 attention and it does what it did in this case, it -- it
11 convinces us that we should be getting some more
12 information, that this is -- this is not reassuring us;
13 we're not where we need to be in terms of happiness about
14 how the baby's doing.

15 Q Following the interpretation of that non-stress, what
16 does a reasonably prudent physician or nurse practitioner -
17 - what should they do as far as further evaluation to
18 comply with the standard of care in an office setting?

19 A Well, we really like biophysical profile as a
20 reasonable test and that we think is the standard of care
21 and it certainly is in our office, in our area.

22 Q Did you review prior to today the films and studies
23 generated by Jane McCain of the biophysical profile
24 performed at 10 minutes in your office prior to 10:58?

25 A Yes, I did.

1 Q How would you characterize or explain to the jury your
2 interpretation of that study, sir?

3 A So it's a little bit confusing when we talk about
4 biophysical profile, whether we talk about out of eight or
5 out of 10, but I would prefer to talk about it out of 10,
6 so I'm referring to a potential score even numbers between
7 zero and 10, so already when this patient is being brought
8 to her biophysical profile, she has already lost two points
9 because we -- we didn't consider it a -- we didn't consider
10 it a bad NST, but we couldn't call it a good one. We would
11 have to call it a reactive NST. That's our word for a good
12 NST; it's a reactive, two accelerations lasting 20 seconds
13 going about 15 off the baseline and no decels. So because
14 there was at least one decel that was concerning on that
15 tracing, we couldn't give her any points for her NST, so
16 she was going into her biophysical losing two points, so
17 the best score she could've ever gotten if she did great
18 with that ultrasound would've been a eight out of 10. She
19 then got credit for her amniotic fluid value. She got a
20 two, and she did not score on the other three parameters.
21 Those parameters are dependent upon a baby that's mature
22 enough to do breathing movements which some 32 (sic)
23 fetuses will do them pretty often and some will not do them
24 very often; at 32 weeks is a pretty early time for a
25 biophysical; and biophysical can be limited by how mature

1 the baby is, and that's why all this discussion is about
2 looking for longer time periods. They may not do their
3 breathing movements that often, but also the baby just
4 looked like a baby that's asleep and did not have a lot of
5 tone. So we think of tone as contract -- are flexors, are
6 contractive a little bit, and then movement, of course, is
7 understandable, a baby moving its arms or legs or body or
8 head, so this baby got no credit for breathing movements,
9 which is pulling the water in and out. You can see the
10 chest move like so on the ultrasound. It's -- the
11 ultrasound's like a motion picture. We only see snapshots
12 from it, but our ultrasonographer sees and understands much
13 more about the ultrasound than the person looking at flat
14 pictures. And so we -- we really -- we need to rely and
15 trust our ultrasonographers, because their level of
16 information is higher than the level of information of
17 someone looking at a snapshot, a picture. Like the
18 difference between fluoroscopy where it's a motion picture
19 and x-ray where it's just a photograph essentially. So
20 when those breathing movements were not present, when the
21 baby wasn't moving, when we didn't see good tone, in that
22 first I would say about 10 minutes that we performed, the
23 score was a two, and then there was that decision point, do
24 you continue doing your biophysical or do you do something
25 different, and I think there was enough concern to get Dr.

1 Hilton involved, and I think that was the right decision to
2 get her to come look at it early. That would not always
3 happen, but she fortunately looked at that and was
4 concerned enough to say, if we would continue this -- I
5 shouldn't speak for her, but if I was in her shoes and if I
6 was sitting there, what I would've been thinking was, if we
7 sit here and continue this and it doesn't get any better,
8 we're just delaying getting her to the hospital where she
9 needs to be where we can do something if we had to deliver
10 the baby, so I -- I would've made the same decision she did.
11 thinking it's not useful to continue this study; it's
12 useful to get this patient to the hospital as quickly as
13 possible, so that's my understanding of what happened.

14 Q In your opinion, Doctor, after the NST you've just
15 gone over, in your opinion did that constitute an
16 emergency, the NST?

17 A No. I would say that many, many babies that have an
18 NST like that, we monitor them in a prolonged way, and over
19 a few hours we might see something that looks like a late
20 decel here or there, but you'll see some many reassuring
21 signs that we send them home and say just keep doing what
22 we're doing, routine prenatal care. You know, we feel
23 great about things now, because we've -- we've now looked
24 at you for a long extended time period, and we have much
25 more information to go on than a short NST.

1 Q Well, this NST was followed up with a BPP. We've
2 talked about that and discussed it. In your opinion at the
3 point where the BPP was done after that first 10 minutes,
4 with that NST you've just looked at, in your opinion did
5 that constitute an emergency?

6 A The biophysical profile and the ---

7 Q Yes, and the NST.

8 A --- the NST. No, I didn't think it constituted an
9 emergency. I think it's -- it's very easy to look in
10 hindsight knowing what happened and think, you know, you
11 must've thought that was an emergency, but you have to look
12 at the situation from where we were at that time and what
13 our experience has been when a baby has good amniotic fluid
14 and has some reactivity and a normal baseline, an NST, some
15 accels on an NST, this -- this is an absolute unheard of
16 outcome in that setting. So by no means did we feel that
17 there was an emergency at that time, not at all. But we
18 were concerned.

19 Q Okay. Any criticism of Dr. Hilton for stopping at 10
20 minutes and calling you and sending her over to the
21 hospital?

22 A I think stopping it was above the standard of care. I
23 don't think it met the standard of care. I think it was
24 above the standard of care. It would've been acceptable to
25 watch it further, but I think she made the smart decision.

1 Q I'm going to show you your operative note. It's
2 probably in the chart. If it is, you can look at that one.
3 If it's not, I'll hand this to you.

4 A I have the operative report here, the original.

5 Q All right, sir. Did you dictate and generate this
6 operate note after the cesarean section, sir?

7 A Yes, I did.

8 Q And that was done some time later that afternoon I
9 believe the record would reflect?

10 A Trying to see if there's a time that it was dictated.
11 I can't honestly tell you whether I dictated it at that
12 time or whether I dictated it the next day. There are
13 times when labor and delivery you should not take the time
14 to dictate it because you have to respond to the next
15 patient. I did a delivery not very long after this c-
16 section was done, and I can't say whether I dictated this
17 in the recovery room or whether I dictated it that evening
18 or the next day, but it was within a day or two of this
19 operation.

20 Q If you'll look at the second page of your operative
21 note on the bottom below your signature, left-hand side
22 there is a capital D, capital D colon, then there's a date
23 and a time.

24 A Okay, I see that.

1 Q Date dictated. Is that what that DD stands for?

2 9/5/2008? Was that the day you performed the surgery?

3 A Yes, it looks like I dictated in the recovery room,
4 because that was 7:25; DD would probably be date dictated.
5 I'm assuming that ---

6 Q Nineteen twenty-five -- you were in the Army eight
7 years. What time is that?

8 A Seven twenty-five.

9 Q And what's the 21 for? Seconds?

10 A Seconds.

11 Q Date dictated, DT. I mean date transcribed. Excuse
12 me.

13 A Yes, transcribed probably.

14 Q The next -- early the next morning?

15 A I think that's what that would be.

16 Q Okay. Going back to your first page and I want to
17 just pretty much focus if I could on the indications where
18 - I'll read part of this and just ask you about it. This
19 is your note. Indications for operation, this patient was
20 seen at Rock Hill Ob-Gyn today for her third visit. She
21 was thought to be approximately 32 weeks estimated
22 gestational age. Is that why you call it estimated,
23 because it's an estimate?

24 A Yes, sir. I mentioned two different dates here, but
25 basically what I was saying was that her dating was never

1 going to be very accurate because we started late on it,
2 but November 1 was what I would've told you was her
3 expected date of confinement or due date.

4 Q Okay. We have been seeing her every two weeks. She
5 was unsure -- she had unsure dating because of late
6 presentation, and it was unclear exactly which due date was
7 reliable. Her expected date of confinement was either
8 October 1 or November 1. November 1 was based on a 25 week
9 ultrasound, and the patient had a later ultrasound that
10 suggested additional due date. Have we talked about all
11 that now?

12 A Yes.

13 Q She had a history of uterine rupture, as repair of the
14 uterus after the rupture, the patient was thought to
15 possibly have chronic hypertension by notes of her history
16 and also a history of migraine headaches; no medical
17 problems. She smoked approximately four cigarettes a day.
18 She stated history of herpes, no known drug allergies.
19 This patient was evaluated at Rock Hill Gyn; noted to have
20 very concerning biophysical profile, as well as a non-
21 reactive NST which showed deceleration. She was told to go
22 directly to labor and delivery and when she arrived on
23 labor and delivery we could not obtain -- and there's a
24 blank line. What would you typically have dictated there?
25 I know you didn't transcribe this.

1 A Fetal heart tones, the heart beat essentially.

2 Q Fetal heart tones. We had made plans to perform the
3 c-section immediately upon her arrival to labor and
4 delivery. Here's my question. Was your plan to do an
5 emergency c-section as soon as she came through the door or
6 to evaluate her and then do it if needed? You tell me.
7 This is your note.

8 A The note is not very well written, but our plan was to
9 evaluate her.

10 Q Okay. Is that, in fact, what was done? Did you
11 evaluate her?

12 A Yes, it is what was done.

13 Q And when she was evaluated upon her presentation to
14 labor and delivery, it was determined what? On that
15 evaluation what was the determination that was made?

16 A It was determined that her baby had died.

17 Q All right. The note of Betsy Peake, 11:40, patient
18 admitted ambulatory from doctor's office and then you've
19 got that diagnosis of all the things, oligo and IUGR which
20 you've already told us in your opinion she didn't have. I
21 just want to be sure we covered that. You see that?

22 A Yes.

23 Q Okay, 11:40, patient admitted from doctor's office.
24 Let me show you this document which is in evidence. And
25 explain if you would how in your experience admissions is

1 notified when a patient comes directly to labor and
2 delivery, how do they know to come and do anything, if you
3 know. What's the routine?

4 A Well, patients come directly to labor and delivery;
5 they don't have any kind of check-in process. They come --
6 ring a doorbell essentially and it's a security system, so
7 they're allowed to come through the door, and then they're
8 met by the nursing staff that takes them to triage. So
9 anyone that knows the term triage, triage is figuring out
10 what to do -- what's appropriate to do with a group of
11 patients. Often you have multiple patients. Triage can be
12 used in the military or mass casualty situation. If you
13 have a number of injured people you have to determine who
14 needs the attention first basically, but in triage on labor
15 and delivery it's a little bit more who needs to stay and
16 who needs to go, so you're going to evaluate some patients
17 and release them, which happened a previous time when
18 Samantha came. She was evaluated ---

19 Q When Dr. Miller took care of her August 9th?

20 A She was able to be released home, so she never did get
21 admitted. And then you've got patients that are going to
22 be admitted. And so when a patient comes in and looks to
23 be possibly in labor, sometimes we'll say, well, she's not
24 changing in her cervix, but she's having regular
25 contractions, we need to give it some more time, so she

1 might walk and do some things, but once a doctor says,
2 okay, I think this patient's in labor, admit her, then
3 admissions comes to see the patient, so ---

4 Q They come up to the floor?

5 A They see the patient on labor and delivery.

6 Q Where the patient is.

7 A That's correct. They come to the patient.

8 Q Well, Samantha Jamison, hadn't she already been
9 essentially triaged in the office and sent directly to
10 labor and delivery for your evaluation?

11 A Yes.

12 Q All right, so she comes in; she's told to go change
13 clothes -- this is her testimony -- go to the bathroom,
14 change clothes, get in a bed, I guess, and they begin to
15 start looking for a fetal heart rate. Right?

16 A (No Response)

17 Q She comes through the doors at 11:40. I want to show
18 you this record, sir. It's in evidence. What time does
19 admissions on their hospital record document the time she
20 was admitted, sir?

21 A Eleven forty-three is the time.

22 Q Three minutes after she walked through the doors of
23 labor and delivery? Is that correct?

24 A Yes, sir.

1 Q Is that how it works in your experience, a few minutes
2 after they're coming through the doors at L&D, admissions
3 comes and they do the paperwork and get her admitted?

4 A I think the nurses probably called them because they
5 wanted to be ready to do a c-section?

6 MR. JORDAN - Your Honor, I'm going to object to
7 anything that the nurse may have done in this case; unless
8 he has a first-hand knowledge it would be hearsay.

9 THE COURT - You need to rephrase your question as
10 based upon his experience.

11 Q Based on your experience, is that how it's done?

12 A Yes, it is.

13 Q Thank you, Doctor. Have you ever, sir, in your career
14 at Rock Hill Gyn-Ob ever called the admissions office and
15 left a message on a voice machine about any patient that
16 you or your practice is sending to admissions, sir?

17 A I have never done that.

18 Q Okay. That same nurse's note -- we can look at again
19 -- documents at about 11:49 you're at the bedside with the
20 ultrasound. Fair?

21 A Yes.

22 Q The fetal monitor strips, and I apologize if I could
23 for the hospital, they don't have the originals of that
24 day. They've got copies. Okay?

25 A (No response)

1 Q I hand you a part of Joint Exhibit Number 3, which was
2 a copy of hospital records subpoenaed by our office from
3 the hospital, and that is what they brought to us, are the
4 fetal monitor strips. What is the time that first is
5 recorded on that fetal monitor strip, sir? Can you see
6 that?

7 A The time that I see is 11:47 on this strip.

8 Q And you were there in two minutes after that, 11:49,
9 according to the nurse's note, not your note. Is that
10 right?

11 A Yes, 11:49 I was there.

12 Q Would it be fair to say from these records that it
13 took you about two minutes to get to her bedside once
14 summoned by the nurses, sir?

15 A I can guarantee you it was less than two minutes.

16 Q How can you guarantee that to me?

17 A The unit's not that big, and I came immediately when
18 they told me that she was there and they couldn't get a
19 heartbeat. That's an emergency when your nurse tells you
20 that they can't get a heartbeat on a 32 week baby, and
21 that's a -- that's a -- that's a feeling of dread is what I
22 would say.

23 Q Was there anything in your operative note, and please
24 feel free to refer back to that if you need to, that tells
25 you as an operating surgeon performing the c-section later

1 that afternoon, that tells you anything or gave you any
2 clue about why, how or when Jayden passed away between
3 11:00 o'clock and 11:49, sir?

4 A Well, we always dictate the findings. Would you like
5 me to read by findings or do you want me to just go from my
6 memory?

7 Q Go from your memory.

8 A Okay. Obviously in that situation we would be
9 wondering what happened, and I did not find anything that
10 would explain why Jayden passed away, and that makes it
11 even harder when you don't have a reason.

12 Q Did you review at some point in time the placental
13 pathology report from the pathologist physician --
14 pathologist who examined the placenta?

15 A Yes, I did.

16 Q Did that give you any indication or clue as to why
17 this baby died?

18 A No, it basically described an opening in the fetal
19 membranes that we have to make to deliver the baby. It did
20 not show any of the obvious markers of abruption; there was
21 no blood in the amniotic fluid; there was no sign of
22 infection; there was no sign of an abnormal placenta
23 essentially, and we always hope placental pathology can
24 help explain things to us and helps give us answers even
25 when you don't have the ability to change the outcome, at

1 least to understand why it happened; it may be helpful to
2 you as the physician, especially helpful to the family to
3 have understanding and closure which is very difficult in a
4 situation like this, but it did not give us anything which
5 suggest the possibility of -- and there are other things
6 that suggest the possibility of something unusual, a baby
7 that had a fairly reactive tracing a short time before
8 their death, a baby that had normal amniotic fluid, a baby
9 that at c-section had no obvious signs, no sign of a cord
10 accident, because sometimes see a cord that's twisted in a
11 way that you could understand what happened, can sometimes
12 see a cord that's wrapped many times around a baby and it
13 could explain something. You can sometimes just get some
14 clues, but we really didn't have the ability to get any of
15 those clues, so we never had a karyotype analysis. A
16 karyotype would be a genetic analysis of the baby to see if
17 that baby had the same number of chromosomes that you and I
18 would have, 46 chromosomes, so we call that aneuploidy, a
19 baby that did not have a normal chromosomal component.
20 That could lead to fetal demise. Could've been a metabolic
21 type thing. Certain babies have metabolic disorders where
22 their genetics are different than your's or I; they can't
23 produce a certain enzyme that's needed for survival.
24 That's really fairly impossible to test for in most cases.
25 And then the last is congenital anomalies that are not

1 consistent or compatible with life. Any of those three
2 Jayden would not have survived if we'd performed a c-
3 section 24 hours earlier, so if we had learned any of those
4 things we might've had information, but it's very
5 understandable for a mother not to want her baby to have an
6 autopsy. That's a graphic and sort of difficult thing for
7 any mother to think about for their baby, so we understand
8 that, but we still don't have answers that maybe could've
9 explained what happened, but in most cases we don't -- in
10 many cases like this we don't get an explanation, and so
11 I'm certainly not saying that if we had an autopsy or
12 karyotype analysis that we would've known what happened,
13 but we possibly might've. That's all I would say.

14 Q Dr. Benson, do you have an opinion when this baby's
15 heart rate stopped from the time she left the office, let's
16 say 11:00 o'clock or 11:02, whatever it may have been, and
17 let's stretch it out to 11:47, any opinion about when in
18 that continuum this heart rate -- his heartbeat stopped?

19 A No, I don't have any opinion when it stopped. I don't
20 think there's any way of knowing that.

21 Q Could've happened at 11:03?

22 A It's possible.

23 Q Eleven o four?

24 A Yes.

25 Q Eleven o five?

1 A Any time between the two.

2 Q I could keep going to 11:47, can't I?

3 A Could've been anywhere in there. I don't think that -

4 - I don't think you could say when the baby died,

5 especially when you don't know why the baby died. Those

6 two things are both absolute question marks.

7 Q Doctor, do you have an opinion based on Ms. Jamison's

8 history, her care by your office or care of North Central -

9 - you had their records -- her NST that day, any

10 ultrasounds done prior to that day, her biophysical profile

11 done that day, whether or not that baby's unfortunate death

12 was reasonably foreseeable, sir?

13 A I don't think that it was foreseeable at all based on

14 any the evaluations that we did of this patient.

15 Q Same question, do you have an opinion whether or not -

16 -

17 DR. BENSON - I'm sorry, could I please have some

18 water.

19 THE COURT - Yes, absolutely. Mr. Bailiff, get

20 him some water, please. Just have a seat, sir. The

21 Bailiff will get it.

22 DR. BENSON - Thank you. Thank you.

23 THE COURT - Yes, sir.

24 Q Same question, sir. Do you have an opinion within a

25 reasonable degree of medical certainly more likely than not

1 whether or not based on all that you knew that day and what
2 you knew of the patient and what was knowable about that
3 patient at 11:00 o'clock or 11:02 all the way through 11:47
4 -- we'll assume that that's when the fetal heart tones were
5 determined to be absent in the hospital; just assume that -
6 - do you have an opinion, sir, whether that event was
7 predictable, reasonably predictable?

8 A No, I don't think it was predictable in any way, and I
9 think that's illustrated by our actions.

10 Q Doctor, you saw Ms. Jamison several times; your office
11 saw her several times after this sad day, September 5.

12 Correct?

13 A Yes, we did.

14 Q Still have the chart?

15 A Yes, I have it.

16 Q Let's look quickly as I finish at these records.

17 A Which date?

18 Q Let's look at your note of September 17, 2008. See
19 that?

20 A Yes, I'm looking at that.

21 A September 17, 2008 she came back to the office for
22 follow-up from your surgery. True?

23 A Yes.

24 Q Let me read this part of the note, and you can read
25 any part that you wish, but I want to particularly ask you

1 about this. And I've got it highlighted here, sir, the
2 last three lines up. Well, let me just get that whole last
3 paragraph if I can get to it. Patient will follow-up with
4 blood pressure check at 40 -- 48 -- what's that?

5 A Hours.

6 Q Hours. And then follow-up in one week for incision
7 check and to discuss her feelings. She is on Zoloft 25
8 daily, and we switched her to 50 today to see if this would
9 help her to do better with her sadness and grieving. Did
10 not know the cause of the fetal death. This patient had a
11 tragic experience of having a baby that was living in the
12 office and having concerning findings, but when she got to
13 the labor and delivery the baby no longer had a heartbeat.
14 Did I read that correctly?

15 A Yes.

16 Q Is that your note, sir?

17 A I wrote that note.

18 Q On October 2 you saw her again. True? You find that
19 note? And your -- other partners of your's saw her as
20 well, but I just want to look at your note.

21 A Yes, I see the note from October 2nd.

22 Q History of patient, has a fetal demise -- had a fetal
23 demise, continues to have hypertension. Is that high blood
24 pressure?

25 A Yes.

1 Q Were you treating her for that?

2 A Yes, we treated her for that during the pregnancy. We
3 also treated her for that after having the baby. At these
4 visits it's very hard to get an accurate assessment of what
5 her blood pressure would be like because in -- strong
6 emotion will drive your blood pressure through the roof,
7 and these were very high blood pressures, but we were
8 treating her. We added a second medicine after she had
9 left the hospital at one point.

10 Q Let me ask you this ---

11 A So it's hard to control.

12 Q Let me just ask you about blood pressure management of
13 this patient. You've reviewed this whole chart.

14 A Yes.

15 Q You've looked at every blood pressure recorded both on
16 the hospital records on August 9 and the hospital records
17 of your hospitalization and every one in the record in the
18 chart. Correct?

19 A Multiple times.

20 Q In your opinion, sir, based on your review of those
21 recorded blood pressures, do you have an opinion whether or
22 not your management, your office management of her
23 hypertension was appropriate or not?

24 A I think it was very appropriate management, and I
25 think one thing that has not been stated is that it's

1 important to understand that when a patient has blood
2 pressure problems and they come in and they're pregnant, if
3 you put them on a large dose of medicine and you try to
4 drive their blood pressure down into what would be a normal
5 range, you can decrease blood flow to the baby, and it can
6 be a negative. So it is not an automatic conclusion that
7 you are going to treat every hypertensive pregnant patient
8 with medicine. We classify hypertension in pregnancy or
9 outside of pregnancy into three ranges essentially, mild,
10 moderate and severe, and you can think -- if you can just
11 remember 140 over 90 would be the usual borderline for a
12 normal blood pressure hypertension and just take it up by
13 10 each time, that gives you those three categories; from
14 90 to 100 as a diastolic would be considered mild
15 hypertension.

16 Q And diastolic is the second number?

17 A Second number. If you take the top number, say from
18 140 to 150, that's mild. So take it up by 10; from 140 up
19 by 10 that's mild. Take it up 10 more; that's moderate.
20 Take it up 10 more; that's severe. So that puts severe at
21 above 110 and above 160. So severe -- and when -- when
22 doctor's do the best studies they can, they clearly see a
23 benefit in treating patients with medicine when they have
24 severe hypertension; the babies do better. It becomes a
25 softer call when you're seeing blood pressures in a lower

1 range, but many times when blood pressures are in the 90s
2 we will start patients on medicines, but some experts will
3 allow blood pressure up to 105 and not really recommend
4 even starting you on medicines, because all medicines have
5 side affects on babies, and they can be negative for
6 babies. Consequently, the medicine we use is a 40 year old
7 medicine maybe a 50 year old medicine, and the whole time
8 I've been doing it -- we haven't started using some new
9 medicines to treat babies for hypertension in pregnancies,
10 because we're very cautious. As Ob-Gyn doctors we don't
11 want to hurt a baby by placing a baby on medicine that we
12 don't have as much experience with or might have some
13 negative effects even though it brings down the blood
14 pressure, so we stick with Aldomet, which is Alfa
15 methyldopa, and that is usually our first line and
16 sometimes or maybe a second we us Labetalol, but we have
17 goals to manage blood pressure that are totally different
18 in pregnancy that what we have in a non-pregnant patient.
19 In a non-pregnant patient you -- you would like to keep it
20 below 140 over 90, and some people would even push it a
21 little lower that than. Pre-hypertension is the term for
22 130 over 80s, and some doctors would even try to get it
23 below that, but in pregnancy the goal should be to -- and
24 it is for most physicians. It's just a general thing, 150
25 over 100. And if your blood pressure is above 150, that's

1 concerning. And if it's above -- if it's above 100 that's
2 concerning, but generally when you have a patient on
3 medicine and their blood pressure is -- not just a one time
4 blood pressure, but the general trend you're seeing when
5 you see someone for a visit -- the night that Greg Miller
6 took care of the patient in the hospital, she had 13 blood
7 pressures. The first one was significantly elevated and we
8 often see that because the patient just walked in and sat
9 down and our blood pressure has to be higher when we're
10 walking around than when we're sitting and relaxing. But
11 then when we've got a series of blood pressures, by the end
12 we had only that first blood pressure and one other blood
13 pressure had a systolic of 160. All the other diastolics
14 were completely normal and systolics maybe in the 90s which
15 we think is perfectly acceptable in this situation, so it's
16 important to understand that when someone says, oh, she had
17 a blood pressure of 140 something over 70 something, isn't
18 that concerning, that is a blood pressure in beautiful
19 control and we think that is just excellent. So 90s don't
20 mean anything to us, and it's the trend. It's not just one
21 or two blood pressures. So if you look at the obstetric
22 record, the three visits we have, notice the blood pressure
23 is the very first thing that we look at, and her blood
24 pressures were all 140 over 82, 136 over 72, 120 over 70,
25 so we tend to see a trend. As someone goes deeper in the

1 pregnancy the blood pressures come down because of the
2 physiologic processes going on in the pregnant mother, lot
3 of blood flow's going to the placenta, so we will see this
4 trend of blood pressures coming down, but her blood
5 pressure control in this pregnancy was beautiful. If you
6 look at these notes after she had the baby, they were
7 terrible, and that's mostly because we were pretty much
8 talking about the loss of her baby and what a horrible
9 memory that was. Any patient that's lost a baby, if they
10 just walk into our office they're blood pressure through --
11 they have to walk past pregnant women to come see us. It's
12 really difficult for them, and their blood pressures are up
13 maybe because of their hypertension, but probably most of
14 time because of their emotions, so that's difficult to
15 really determine what their control really is at that time,
16 but we take it seriously and we had wanted her to get
17 attention for that blood pressure.

18 Q I'm going to close with this. Your note, October 2,
19 2008, patient is hoping to attend an Empty Arms visit as
20 she had an IUFD delivered by c-section. What is Open Arms?
21 Excuse me. Empty Arms. I apologize.

22 A Empty Arms is a program essentially that helps to
23 guide a nursing staff and a care team on how to best take
24 care of a patient that's going through a tragedy like the
25 loss of a baby. It's -- I would imagine that most people

1 in this room either have suffered a miscarriage or know
2 someone who has or, you know, at least has a friend who
3 has. It's common. We have -- one out of every five
4 pregnancies is a miscarriage, and so when people think
5 about Ob-Gyn doctors, they think what a cool job, it's so
6 happy and exciting when a baby comes into the world and we
7 -- we do really benefit from a really happy experience in
8 many, many cases, but we also have to take care of the
9 patients that are losing their babies. Many of us have
10 lived through that. My wife has lost a baby three times
11 and it stings and hurts, and it's something that is -- that
12 is hard to live through. They have -- Empty Arms also has
13 focus -- or essentially support groups where you can have a
14 meeting almost on a regular basis. There's a place where
15 Empty Arms meets, and mothers I think -- I think in a
16 situation where babies a little bit older or a baby -- a
17 child has been born, there's this formal process with a
18 funeral and it's -- there's more of a societal process to
19 help the family to grieve and go through it, but with
20 miscarriage or sometimes loss of the baby that wasn't yet
21 born, fortunately in this case there was a funeral and I
22 think that helps the family come together and can be
23 helpful, but we almost always talk to our patients about
24 Empty Arms because it's -- it's expected that this will
25 take a long time and I use the term to recover from. I

1 don't think -- I don't think people completely recover, but
2 they'll always be changed by the experience, but I think
3 that in many cases we can, you know, move on with our lives
4 and do what -- do what we need to do, but Empty Arms can be
5 helpful for that.

6 Q Doctor, you document again taking Zoloft, that's for
7 depression.

8 A Yes.

9 Q Okay. And is overall doing well with that, with the
10 medication, not the depression. Right?

11 A Yes. I think -- which note are you looking at?

12 Q October 2, 2008.

13 A So I said she's taking Zoloft 50, overall doing well
14 with that, and I might mean two different things by that.
15 I might mean that she's not having side effects from the
16 medicine, is not complaining about anything negative from
17 the medicine, and I might also mean she is starting to do
18 somewhat better emotionally. Can't honestly say which I
19 meant by that.

20 Q All right. All right, sir. Would like to continue;
21 refills are given; we will get her appointment with Dr. --
22 who is that?

23 A Valite or Dwivedi.

24 Q Who are they?

25 A They are psychiatrist in our community.

1 Q We will get her an appointment with Dr. Valite or Dr.
2 Dwivedi to be evaluated for her postpartum depression. Is
3 that something you offered to her?

4 A Yes.

5 Q Did she ever come back to your office after October 2,
6 2008?

7 A I'm just looking through the notes to be sure. I
8 think she saw Dr. Taylor on October 9th.

9 Q Okay.

10 A There's a note here from that.

11 Q How about after that? Any notes after that?

12 A October 8th and October 9th she was seen, and October
13 17th she was seen as well.

14 Q Any after October 17th?

15 A I think that represents the last time that we saw her.

16 Q All right.

17 A That's the last note in her chart. Those are all the
18 notes in her chart. Her obstetric record and those notes
19 we've just gone through.

20 Q All right. Dr. Benson, do you have an opinion whether
21 or not you were negligent in any way or deviated in any way
22 from the standard of care of a reasonably prudent obstetric
23 gynecologist under the same or similar circumstances when
24 you cared for her on September 5, 2008, sir?

1 A I'm confident that our care was at the standard of
2 care. I think we met the standard of care or exceeded it
3 on that day.

4 MR. DAVIS - Thank you, sir.

5 THE COURT - Counsel, can y'all come and talk with
6 me, please.

7 (Bench conference was held in the presence of the
8 jury but out of the hearing of the jury which was not
9 reported.)

10 THE COURT - All right, Mr. Foreman and ladies and
11 gentlemen of the jury, I'm going to give this choice to
12 you. The cross-examination of the witness I think you can
13 fairly expect it to last an hour. It's about 25 after 5:00
14 right now. Our usual practice is not to split the direct
15 and the cross-examination, to have them together for your
16 evaluation, but again, I'm trying to be mindful of you
17 having lives outside of the courthouse and I'm going to let
18 y'all make this decision. Now, in doing this also, I want
19 to tell you, we will finish the evidentiary portion of this
20 case tomorrow, however long that takes. We're going to
21 finish it tomorrow. So, number one, I want y'all to plan
22 on being here tomorrow for whatever length of time it
23 takes. My hope is we not only finish the testimony in this
24 case, we hear the closing arguments of the attorneys, I
25 give you the law to apply to the facts and evidence in this

1 case and submit the case to you for your deliberations and
2 your unanimous decision in this matter. That is my hope
3 that we will do all that tomorrow and again with that, for
4 whatever length of time it takes. Now, understanding all
5 that, please retire to your jury room and let us know your
6 decision about staying and finishing the cross examination
7 or coming back tomorrow morning like we have, 9:15 and
8 continuing on expecting to happen what I just told you.
9 Okay? If y'all will go to the jury room and let us know
10 please as soon as possible.

11 (Jury exits the courtroom)

12 THE COURT - All right, gentlemen, we're going to
13 take a short break while the jury decides. Doctor, you can
14 certainly step down, but you can't talk to the lawyers.
15 Okay? Thank you very much.

16 MR. DAVIS - Thank you, Your Honor.

17 THE COURT - We'll just be at ease for a few
18 minutes while the jury decides.

19 (Recess taken)

20 THE COURT - You may be seated. Thank you very
21 much. All right, counsel, the jury has informed us that
22 they want to proceed and to have the witness subjected to
23 cross examination and finish this witness today. So we
24 will do that. Doctor, could you resume the witness stand,
25 please, sir.

1 (Witness re-takes the stand)

2 THE COURT - All right, ask the jury to come in,
3 please.

4 (Jury returns to the courtroom)

5 THE COURT - All right, sir, you may proceed.

6 MR. JORDAN - May it please the Court.

7 THE COURT - Yes, sir.

8 CROSS EXAMINATION

9 BY MR. JORDAN -

10 Q Dr. Benson, you testified a little bit ago about Empty
11 Arms and you made a statement that mothers probably don't
12 completely ever get over grieving over the loss of a child.
13 Correct?

14 A Maybe fathers as well.

15 Q Fathers as well. So it's perfectly normal that
16 Samantha Jamison would still be grieving over the loss of
17 her son.

18 A Well, I think that everyone is an individual and
19 they're going to react to everything in their own way, and
20 I -- I am not a psychiatrist and I -- I'm just -- in terms
21 of that I'm just another human being that's experienced a
22 loss and so I'm just -- have nothing but sadness for
23 Samantha in her situation and it obviously has been
24 difficult for her.

1 Q Now, Doctor, let's get into the care that she received
2 at Rock Hill Gyn-Ob. You didn't see her until September
3 5th, 2008. Isn't that true?

4 A That's correct.

5 Q But she came into your office -- she was referred to
6 your office. Is that correct? From North Central?

7 A Yes.

8 Q And she was a high risk pregnancy. Is that correct?

9 A Yes.

10 Q And as a high risk pregnancy, she comes in on July 18th
11 2008. Is that correct?

12 A July 18th was her first time in our office. That's
13 correct.

14 Q And she doesn't see the doctor then, does she?

15 A As our standard.

16 Q So your standard is you get a high risk person in and
17 they don't even get to see a doctor, do they?

18 A Our standard is for our nurse to interview the
19 patient, make up a chart, get her started in her care and
20 we try to get the patient scheduled to see a physician as
21 soon as possible.

22 Q And you knew that she had chronic hypertension on --
23 back on July 18th, 2008. Isn't that true?

24 A That's why we started her on blood pressure
25 medication, anti-hypertensive medication.

- 1 Q Right.
- 2 A We had identified that.
- 3 Q Even though you didn't see her, you wrote the
- 4 prescription.
- 5 A That's correct.
- 6 Q So you knew this patient, Samantha Jamison, had to be
- 7 followed as a high risk patient with chronic hypertension.
- 8 A (No response)
- 9 Q You knew that July 18th.
- 10 A Yes.
- 11 Q Now, Doctor, you first saw her when she came to the
- 12 hospital September 5th. Is that correct?
- 13 A Yes.
- 14 Q And I believe you testified that there was a note -- a
- 15 late note from Nurse Peake at 11:40 she was being
- 16 evaluated. Is that correct?
- 17 A Eleven forty is what Betsy's note said, that she was
- 18 seen at 11:40. That's correct.
- 19 Q And your testimony was that the ultrasound didn't even
- 20 start until 11:47. Is that correct?
- 21 A No, that's ---
- 22 Q Hospital note.
- 23 A No, that's incorrect. Eleven forty-seven was I.
- 24 believe when she said that they called me, basically ---
- 25 Q Well, you -- and I may be wrong ---

1 A Actually it's the time on the NST that did not show
2 fetal heart rate.

3 Q Okay. Can you look back? I may be wrong about the
4 time, but look back and see when there was a recording on
5 the ultrasound in the hospital. Is that record ---

6 A This is the record from the office.

7 Q Your record from the office.

8 A This is -- so 11:47 is the time on this strip?

9 Q I mean that's what I'm asking. Is that the correct
10 time? Did I remember that correctly?

11 A Yes, I think there's two pages of strip here, but the
12 first -- you know, there's not -- there's no fetal heart
13 rate on the strip whatsoever, then the second page is
14 blank.

15 Q So the first time would be what?

16 A Eleven forty-seven is the time on this.

17 Q And then you checked her at 11:49.

18 A That's correct.

19 Q Okay. So when she got there at 11:40, there wasn't an
20 ultrasound even started then, was it? It wasn't started
21 until 11:47. Is that correct?

22 A My understanding of what happened is that the patient
23 came to labor and delivery, was asked to take off her
24 clothes and put on a gown, was put in a bed and monitors

1 were put on her, and they didn't get the fetal heart rate
2 and they called me and I came immediately.

3 Q Okay. I'm asking about the time, Doctor. I
4 understand that. Eleven forty Nurse Peake says we're
5 checking her.

6 A Eleven forty's when she walks on to the unit; that's
7 not when we're checking her.

8 Q And the note will speak for itself and the jury will
9 have that, but 11:47 is the first time on that note. Is
10 that correct?

11 A Eleven forty seven is the time stamped on the strip
12 for listening to the baby's heart rate.

13 Q And then 11:49 is the first time the record shows that
14 you were present.

15 A That's correct.

16 Q Okay. So my question is, Doctor, when she got there,
17 the ultrasound wasn't going til 11:47 and you weren't there
18 til 11:49.

19 A Yes.

20 Q Looking back at the note, Doctor, from September 5th in
21 the office -- you've seen that note before -- if I can find
22 it -- do you recall, Doctor -- and I believe Dr. Hilton
23 testified -- there was no blood pressure on that record.

24 Is that correct? No blood pressure reading?

25 A I would need to look at that.

1 Q Okay.

2 A Which note do you want me to look at?

3 Q September 5th.

4 A Okay, I'm looking at that note right now.

5 Q Is there a blood pressure reading on September 5th in
6 your office?

7 A There's no blood pressure documented on the chart.

8 Q I want to get this straight, Doctor. We've got a
9 patient with a chronic hypertension that you prescribed a
10 drug for on July 18th, 2008; she's high risk; she comes in
11 on September 5th and you don't even check her blood pressure
12 at the office. Am I reading that correct? Is that what I
13 understand, Doctor?

14 A Yes. Looking back at the 25th her blood pressure's 128
15 over 70, so I think we already talked about how wonderful
16 her blood pressure control was during the pregnancy.

17 Q And we already know ---

18 A And we already talked about the fact that she came in
19 complaining of baby not moving as much as it had, so that's
20 what we would be addressing.

21 Q Okay. And we know that she was in the hospital August
22 the 9th and she had high blood pressure then, and your
23 testimony that there were two occasions ---

24 A Well, I -- I'm not agreeing with that.

1 Q Okay. You're not agreeing that on August the 9th she
2 had high blood pressure.

3 A I would say that that is simplifying -- that -- is a
4 very simple statement, but it's a very complex answer.
5 Would you like to hear the answer?

6 Q Well, I -- what I want to do, Doctor, is I want to ask
7 the question, and if it's a yes or no question, you can yes
8 and you can explain anything you want ---

9 THE COURT - Counsel, counsel.

10 MR. JORDAN - Yes, Your Honor?

11 THE COURT - If you have a problem with how the
12 witness is answering the question you address that matter
13 with the Court and I'll handle it.

14 MR. JORDAN - Yes, Your Honor. Sure. Thank you,
15 Your Honor. I apologize.

16 THE COURT - All right. All right, so let's just
17 -- so everybody's on the same page ---

18 Q Doctor, do you agree ---

19 THE COURT - Excuse me. So everybody's on the
20 same page, the attorney will ask the question, if it calls
21 for a yes or no answer, the witness will answer yes or no
22 and then they explain the answer fully as much as the
23 witness needs to explain the answer. Thank you very much.
24 Proceed on.

25 DR. BENSON - Yes, sir.

1 Q Doctor, do you agree or disagree on August the 9th when
2 she was at the emergency room and seen by Dr. Gregory
3 Miller that she had a high blood pressure?

4 A She had 13 blood pressures obtained during that time.
5 I've reviewed all those very carefully. The first one was
6 elevated outside the range that we would like to see her
7 blood pressure, but I've already explained that we
8 frequently see that on the first visit. It's all of the
9 blood pressures together that must be looked at. She had
10 one other blood pressure that had a diastolic of 160 which
11 is outside the range we would've like to have seen, and
12 every single other blood pressure either had a systolic in
13 the range we like which is under 150 -- okay -- for a
14 patient who has chronic hypertension on medicine -- 150
15 over 100, that would be the upper limits of our goal for
16 therapy. Okay? So of all those blood pressures she had,
17 she had one blood pressure that had two parameters elevated
18 outside the range we would like to have seen. She had one
19 blood pressure that had a systolic that was above the range
20 we'd like to see, and she had 11 blood pressures where the
21 systolic and diastolic were at or essentially below the
22 range that we were shooting for with our medication, so her
23 blood pressure was extremely well controlled would be my
24 estimate of what went on that night with regard to her
25 blood pressure.

1 Q Very long answer, but she did have high blood pressure
2 that was reported on August the 9th.

3 MR. DAVIS - Your Honor, I'm going to object to
4 his characterization of his answer. He's following
5 instructions of the Court.

6 THE COURT - Counsel, just ask the questions and
7 let him answer the questions. All right? Thank you..

8 Q Doctor, referring back to the record on September the
9 5th, 2008, does it indicate that her cervix was checked at
10 all September 5th?

11 A September 5th?

12 Q Yes.

13 A Let me just look at that. No, we did not check her
14 cervix.

15 Q She had blood in her urine at that point.

16 A She had one plus leukocytes and trace blood on the
17 urinalysis. That's on the urine dip. That's correct.

18 Q And the NST shows some contractions. Would you agree?

19 A Yes, definitely.

20 Q But cervix wasn't checked and she had blood in her
21 urine.

22 A (No response)

23 Q Doctor, don't you want to know if she's in labor?

24 A Well, I think that the most important thing is to know
25 that her baby's okay. That was our main concern. When

1 someone says I don't feel my baby moving as much as I think
2 should, there are a long list of things we may eventually
3 check, but making sure that baby's heart rate is okay is
4 the primary concern, so what I would say is examining her
5 cervix when she doesn't even feel the contractions, low
6 priority. When a woman is pregnant -- first of all, we've
7 been through this earlier that you don't catheterize her
8 for a urine specimen, so you do not have a pure urine
9 specimen that comes from within the bladder. You have a
10 urine specimen with urine that has passed essentially
11 through the vagina and vaginal secretions have a white
12 color for a very specific reason. They're full of white
13 blood cells. And we often do see a little bit of blood as
14 well, but it does get our attention, but let's just say
15 it's extremely common and most of those patients do not
16 have a bladder infection or any problem going on relating
17 to it, so we look at this all the time when we see patients
18 with regular Ob visits. When they're coming in they always
19 give us a urine, and when we see white cells and red cells
20 we'll have a little interview with them about it. We'll
21 say, have you had urinary frequency, going more often; have
22 you had urgency, sort of a strong urge to go; we ask them
23 about the signs and symptoms of bladder infections, which
24 is what that might indicate, and if they say -- if they
25 give us a strong sign that they've had bladder infections

1 in the past, we sometimes will start them on antibiotic and
2 then get a culture to really check to see whether they
3 really had one, because in many cases just the baby's head
4 being against the bladder and just being pregnant can kind
5 of make you feel like you have a bladder infection when you
6 don't, but that's a very common thing. It seemed to me
7 like your presentation of that fact was that that should be
8 something we're really worried about, and what I'm trying
9 to tell you is that we see that pretty often and it's
10 usually not anything serious.

11 Q Did this baby have any risk factors for intrauterine
12 growth retardation or restriction? Did Samantha?

13 A Yes.

14 Q And chronic hypertension is one of them.

15 A Yes, it is.

16 Q And, in fact, the abdominal circumference was lagging,
17 wasn't it?

18 A Well, lagging is an interesting term. What I would
19 say -- I would give you some more specific terms about
20 that. Are you referring to a specific day or a specific
21 ultrasound that you'd like me to talk about?

22 Q August 25th report, Doctor. Dr. Miller wrote in his
23 assessment possible lagging abdominal circumference. Isn't
24 that true?

25 A Yes, that's in his note.

1 Q Okay. And how much was it lagging?

2 A I'm trying to find that ultrasound so I can go over it
3 with you. The average for the measurements on that day
4 were for a fetus that was 28 weeks size, 28 weeks and one
5 day, and the abdominal circumference measurement was
6 consistent with the average fetus at 27 weeks and zero
7 days. That would be an eight day lag behind the rest of
8 the measurements, so about a week is what I would say.

9 Q Then was there an additional lag on September 5th,
10 2008?

11 A Yes.

12 Q And what was that finding?

13 A That finding was an abdominal circumference that was
14 essentially the same size as what we saw on this day, so
15 from the 25th to the 5th which is essentially 11 days maybe,
16 did not show growth. Now, on any ultrasound parameter when
17 we want to see if a baby has growth restriction, we never
18 get ultrasounds closer than two weeks, because ultrasounds
19 are just estimates and they can be off a little bit. We
20 guarantee ultrasounds within 10 percent. In other words,
21 if someone has an ultrasound the day before they're going
22 to deliver their baby and we say this is an eight pound
23 baby, when that baby is born it might be nine pounds or it
24 might be seven pounds. It's only good within about 10
25 percent, so these are estimates. Now, when a baby has

1 those breathing movements, if it has a breathing movement
2 that goes in at the time you shoot your picture, it'll be
3 different than two seconds later when the baby breathes
4 out. If the baby has a full bladder, that might affect the
5 abdominal circumference, and if the baby has just urinated,
6 that might make it smaller. So you usually want a two week
7 time period in between to reliably say that any ultrasound
8 parameter is significantly changing, but trust me, that was
9 concerning to us that it hadn't shown any growth over that
10 time period.

11 Q And, in fact, did the fundal height actually decrease
12 at some point during your care?

13 A Fundal height's the same kind of thing. When a baby
14 is in a transverse position, it's one thing. When a baby
15 is in a lengthwise position, it's in another. It's fairly
16 a rough figure. You put a tape measure -- a fundal height
17 is when you take a tape measure and hold it against the
18 patient's pubic symphysis. You roll it up over and you
19 kind of palpate and feel where the baby stops and where the
20 -- excuse me, where the uterus stops essentially, so you're
21 essentially measuring the amniotic fluid as well as the
22 size of the baby, but it's not a super accurate sort of
23 thing. What we had in terms of fundal height was 29, 28
24 and 28. Now, for a patient at 29 weeks, 28 centimeter.

1 fundal height is perfectly normal, so they were -- they
2 were normal every time we checked them.

3 Q Did the fundal height actually decrease from July 18th
4 down to August 25th?

5 A It was 29 and then it was 28, but, you know, if you
6 would've measured it twice on August the 11th or had 10
7 doctors come in and all write down their fundal height, it
8 could've varied by one to two centimeters just by a
9 different examiner doing it. It's like that question about
10 the ultrasound, you need to -- you're not talking about
11 precise things like me taking a ruler and measuring this
12 piece of paper. That's precision. This is a little
13 different than that and it's going to -- it's going to
14 change depending upon how much the woman's been drinking,
15 how much she's not, what the position the baby is and quite
16 a lot of different factors. I think we said that the
17 amniotic fluid is very dynamic, meaning it's changing all
18 the time, and so fundal height reflects that.

19 Q And fundal height dropped from 29 down to 28, so it
20 decreased a little.

21 A One centimeter.

22 Q That another piece of evidence of a potential
23 intrauterine growth restriction?

24 A Well, when you look at the fundal height on a day that
25 someone had an ultrasound, I guess what I would say is that

1 the ultrasound gave you a lot of detailed information and a
2 fundal height gave you a very sort of much less reliable
3 piece of information. We don't tend to think -- it doesn't
4 work out that when we get an ultrasound and then we get
5 concerned, we decide to do a fundal height. It's really
6 the opposite. When we're doing routine obstetrical visits,
7 we need to see a two centimeter or essentially a three
8 centimeter lag, two centimeters within the normal to decide
9 that we've got a size/date discrepancy. Let me go into
10 that with more detail. When you see someone for a Ob
11 visit, high risk person or standard obstetrical patient,
12 you measure their fundal height at each visit, from 20
13 weeks until they deliver the baby. When you do that fundal
14 height measurement you write it down and you write it down
15 -- notice the columns are right next to each other, the
16 column for how many weeks the patient is and the fundal
17 height. It's not any coincidence they're right next to
18 each other. We are trying to determine does this baby
19 measure about what we think it should for the gestational
20 age that this baby is, and essentially you've got to take
21 into consideration whether the patient weighs 100 pounds,
22 200 pounds or 300 pounds, because that will affect your
23 fundal height quite a bit. You've got to take into
24 consideration whether the patient's tall or short, and
25 you've got to -- just a lot of different things that go

1 into it. Also it's normal for the fundal height to
2 decrease when you get to the end, because it's measuring
3 from the pubic symphysis to the top of the baby. Well,
4 once the baby starts to engage in the pelvis, you're not
5 measuring the whole baby anymore, just really what's left
6 above the pubic symphysis so towards the end of the
7 pregnancy it does go down. It's normal to go down. We
8 expect it to go down. But it's a two centimeter variance I
9 would say that we look for between 20 weeks and about 34
10 weeks probably. We're looking for two centimeters to be in
11 the normal range. So if I measure someone's fundal height
12 when they're 30 weeks, I would consider it a normal fundal
13 height if they measured 29 or 28. I would consider it a
14 normal fundal height if they measured 31 or 32. So you've
15 got two centimeters above it and two centimeters below it
16 all considered normal. Then if you go outside of that, you
17 have three centimeters difference up or down that would
18 trigger me to do an ultrasound. On the most uncomplicated
19 patient I had I'd say we need to look at the amniotic
20 fluid; we need to look at the growth of this baby; we need
21 to baby sure the baby's growing the way it should, and then
22 most of the time those ultrasounds would show us amniotic
23 fluid's okay and the baby's growth's okay.

24 Q Doctor, when Samantha Jamison got to the hospital
25 September 5th, 2008, was her blood pressure elevated then?

1 A Which day?

2 Q September 5th, 2008.

3 A September 5th. I would have to look at the note from
4 the hospital to see whether -- what the blood pressure was
5 on that day.

6 Q Doctor, I've got a blowup here -- 191 over 77 at 12:37
7 on September 5th, 2008. Is that high?

8 A That's definitely high. I think we talked about the
9 emotion issue before. If someone told me they were worried
10 about my baby, you better believe it would be jacked up.

11 Q Doctor, she -- the biophysical profile -- well, first
12 of all, let me ask you, the fetal strips in and of
13 themselves -- I believe you heard Dr. Hilton testify; she
14 says that you want to continue monitoring even if you
15 hadn't had the biophysical profile with a category -- is it
16 two -- NST? Is that correct?

17 A You'd want to obtain more information, but the
18 biophysical might -- it just gives you a lot more detail,
19 so it would help you sort of decide how worried to be,
20 let's say.

21 Q And so basically with a non-reactive NST -- on the NST
22 that Samantha Jamison had, you would want to keep
23 monitoring, so you would want to send her to be observed
24 anyway even if you didn't have a bad biophysical profile.

1 A In most cases, yes, but we have the ability to
2 continue to monitor someone in the office, and many times
3 if we don't like the tracing, there are many times we'll
4 just say, let's just get more information here in the
5 office, keep her on the monitor for a while, let's get her
6 something to eat or drink so she's got a little more sugar
7 in her system for the baby, and maybe that baby's going to
8 start moving and doing a little better; let's position her
9 on her side, maybe the amniotic fluid goes up, it does
10 better, so we don't always send someone to the hospital
11 when they have a -- initially when they have a non-reactive
12 NST, but a biophysical we -- we get a really useful and
13 reliable piece of information from some very skilled
14 ultrasonographers when we get a biophysical in our office,
15 so we find that very useful, and so that's -- I think that
16 you could say that's standard of care for us because we
17 have that ability to do it. We're going to do it in the
18 office; we're going to get more information because we just
19 need to know what's going on.

20 Q And a two out of 10 is a very bad biophysical profile,
21 isn't it?

22 A We don't use the term very bad. We would say that
23 it's an abnormal. We use the term normal, equivocal or
24 abnormal. It was an abnormal biophysical profile and the
25 requirement for an abnormal biophysical profile is another

1 biophysical profile in a few hours or some other form of
2 monitoring and evaluation, because 40 percent of those
3 babies are going to do well and not really have problems
4 when you look at them later, and 60 percent are going to
5 have problems.

6 Q If you've got a biophysical profile of zero to two --
7 and I believe hers was two. Is that correct?

8 A Two.

9 Q If you've got a biophysical profile of zero to two,
10 you would strongly suspect chronic asphyxia, wouldn't you?

11 A After 10 minutes I wouldn't be sure. I wouldn't say
12 I'd strongly suspect. I would not use those terms.

13 Q What is asphyxia?

14 A Asphyxia? It's basically the result of the baby
15 getting less of what it needs. Usually oxygen is the main
16 term, main product it needs.

17 Q Do you have a copy of Gabby's book?

18 A Do I have a copy of that?

19 Q Yes.

20 A Yes, I do.

21 Q Not authoritative, you wouldn't say that, would you,
22 Doctor? Is it reliable?

23 A I wouldn't say that any textbook is authoritative.

24 Q Is it reliable if you reference it?

25 A I use it for some things.

1 Q So you find it reliable.

2 A Much of the information in there is useful to an Ob-
3 Gyn doctor. It sort of depends what edition you're looking
4 at too.

5 Q Suppose it's the edition 2007 which would've been -
6 come out about a year before the incident we're talking
7 about here.

8 A 2007 was a while ago now. A lot of new information
9 has come up and so the older a textbook is the less
10 reliable it is. A lot of times you use other sources for
11 information.

12 Q As of 2008 that would've been a reliable textbook?

13 A As soon as something comes out we consider it
14 outdated. You know, they basically print journals and
15 doctors share information, because it's changing all the
16 time, so I just -- I wouldn't have any textbook that you
17 could show me that I would just say everything in there
18 must be right.

19 Q Doctor, do you agree that even if you've got a score
20 of eight out of 10 or six out of 10 requires repeat
21 testing?

22 A It depends on what the situation is. You're not
23 giving me much detail on what the patient's situation is,
24 what her risk factors, what's the gestational age of the
25 pregnancy. Not giving me much ---

1 Q Well, 32 weeks gestational age, if you've got a score
2 eight out of 10, would you want to repeat that test?

3 A Usually if I had a patient that I was worried enough
4 to get a biophysical profile, then I have some concern for
5 that patient, so I might be getting a repeat test. It
6 depends.

7 Q And going down, if you've got a score of six out of
8 10, do you want to repeat that test maybe a little sooner.
9 Right?

10 A Definitely.

11 Q And if you've got a score of four out of 10, you would
12 want to repeat that test pretty quick, wouldn't you?

13 A Usually that patient would go to labor and delivery to
14 make sure everything's okay.

15 Q Okay. So a four out of 10, you're going to send her
16 on over to the hospital.

17 A Yes.

18 Q A two out of 10, that's even worse than a four out of
19 10, isn't it, Doctor?

20 A Neither one is considered normal. They're both
21 abnormal.

22 Q Both abnormal? Two out of 10 is more abnormal than
23 four out of 10. Would you agree?

24 A They're both abnormal.

25 Q Two is a less score.

1 A I ---

2 Q Two is less than ---

3 A I understand that two is lower than four.. They're
4 both abnormal. Zero is abnormal also.

5 Q And the lower the score gets on a biophysical profile,
6 the more you suspect asphyxia. Isn't that true?

7 A I would say that any score that's abnormal is
8 concerning to me;

9 Q And I understand that, and I agree with you. My
10 question is, the lower the score, the more you suspect
11 asphyxia. Isn't that true?

12 A I haven't read that anywhere. I haven't seen a study
13 that says if you have a zero that you have more asphyxia
14 than if you had a two, or if you had a two you had more
15 asphyxia than a four. I have not ---

16 Q Have you reviewed any of the charts in Gabby about
17 management based on biophysical profile?

18 A Not lately.

19 Q Would it surprise you if that -- they suggest actually
20 managing ---

21 MR. DAVIS - Objection, Your Honor. Objection,
22 Your Honor. He's going to the back door where he can't get
23 to the front door. Objection. Rule 803- ---

24 THE COURT - Sustained. Sustained.

25 MR. DAVIS - Thank you.

1 Q September 5th, 2008 was the only biophysical run on
2 Samantha Jamison.

3 A Was the only one indicated.

4 Q And the only one run.

5 A As far as I know. From looking at the chart that's
6 the only time we did a biophysical I know.

7 Q Is there any medical reason why a non-stress test or a
8 biophysical profile could not have been run on August 25th?

9 A It's hard question to understand.

10 Q Would a non-stress test or a biophysical profile cause
11 any harm to Samantha Jamison or unborn child, Jayden, on
12 August 25th, 2008?

13 A There's nothing about doing a biophysical profile that
14 would have injured her, but we do have strong feelings
15 about performing testing that's not indicated, not
16 appropriate. In fact, doctors are criticized quite a bit
17 for ordering things that are not appropriate. So we try to
18 be cautious about that and we try to weigh the risk and
19 benefits of each decision we make and each test we order,
20 but doing a biophysical -- doing a biophysical profile
21 doesn't injure anyone and doing an ultrasound doesn't
22 either.

23 Q And those tests don't take that long to run.

24 A We've talked about the timing of them.

25 Q So ---

1 A What do you mean by not that long?

2 Q Well, it doesn't harm -- it doesn't harm Samantha or
3 her baby, and you do them relatively quick.

4 A Was that a question?

5 Q Yes. We already established and you testified there's
6 nothing about those tests that would harm Samantha or her
7 baby, and those tests can be run quick in your office.

8 A (No response)

9 Q Can those tests be run quickly in your office?

10 A Well, a biophysical we talked about takes 30 or 40
11 minutes to run, and an NST takes often about a half hour.

12 Q So an hour of time and you could run those tests in
13 your office. Agreed?

14 A Sure.

15 Q What is a contractional stress test?

16 A A contractions stress test is often referred to as a
17 CST, and that's when you take a patient, start an IV, start
18 Pitocin, you make the patient contract and then you see if
19 they have decels. And then if they have repetitive late
20 decels, then you have some pretty serious concern for the
21 function of that placenta.

22 Q You have the ability to run that test in your office.

23 A The test is never run in the office, ever, at any
24 institution, because if you cause a problem for the baby by
25 causing those contractions, there's nothing you can do

1 about it like a c-section or delivery of that baby, so
2 that's not something -- that would probably be malpractice.

3 Q Would you agree, Doctor, that reduced fetal movement
4 or the lack of fetal movement, either one or both, are a
5 potential for emergency, one more so than the other?

6 A I would say that whenever someone talks to us about
7 decreased fetal movement, we would like them to have their
8 baby evaluated, and that's what we instruct them to do.

9 Q And, Doctor, even if you've got a normal amniotic
10 fluid, you can still have a cord compression or any other
11 amount of emergencies with a baby with a normal amniotic
12 fluid. Would you agree?

13 A I would agree that any pregnant woman at any time can
14 have any number of problems.

15 Q And you've -- we've talked a lot about the non-stress
16 test, and you've heard Dr. Hilton's testimony. You were
17 present in the courtroom. Correct?

18 A Dr. Hilton's testimony?

19 Q Yes, sir.

20 A Yes, I heard it.

21 Q And she testified that there were three, maybe four,
22 decelerations that were of concern.

23 A But I did not agree with that.

24 Q Okay. You said there were, what, only one?

1 A Only one that really concerned me, and I would say
2 there were several that weren't totally reassuring, but
3 they weren't classic late decelerations by my estimation.

4 Q How are the diagnosis made in a hospital when you have
5 a -- when it's charted?

6 A Excuse me?

7 Q Can you tell me how diagnosis are made when they're
8 charted in the hospital? When you have a -- I show you
9 this record. I think it's in evidence. Piedmont
10 Healthcare, intrauterine death, and one of the diagnosis
11 codes is insufficient prenatal care.

12 MR. DAVIS - May it please the Court, Your Honor.
13 May we please have that record identified.

14 THE COURT - All right. Go ahead.

15 MR. DAVIS - Thank you, sir.

16 THE COURT - Yes, sir.

17 MR. JORDAN - I'm sorry. Having a little
18 technical problem. PMC 41.

19 MR. DAVIS - Okay. Thank you, sir.

20 THE COURT - Go ahead.

21 Q Doctor, you see the diagnosis -- well, -- diagnosis
22 code on the left and then insufficient prenatal care.

23 That's one of the diagnoses from 9 --- September 5th, 2008.

24 A Yes, it is. Would you like my interpretation of that?

25 Q Well, you disagree with that. Correct?

1 A I don't disagree with that at all. I think -- I think
2 that what they're referring to is how many the visits the
3 mother had to an obstetrician and how early she presented
4 for care, and I think that's essentially how they come up
5 with -- often we have approximately 13 visits by the time
6 we're delivering the baby, and in this case we didn't have
7 a chance for that, and so I think that's what that's
8 referring to, but that's something -- a diagnosis made by a
9 records clerk who are skilled at what they do, but it's not
10 essentially a medical diagnosis. We say late prenatal care
11 to sort of indicate that -- we usually we'll place that on
12 our problem list as a indication that this is a patient
13 that's a little bit harder to take care of, because we
14 don't have that good early start, and we've gone through
15 the reasons that it's helpful to have someone in your
16 office earlier in terms of the expected date of confinement
17 and things like that, so we normally are starting prenatal
18 care earlier, and I think they're just simply referring to
19 the fact that Samantha started her care a little bit later
20 than usual.

21 Q Doctor, your plan, according to your dictated note,
22 was for an immediate c-section. Would you agree?

23 A Which note are you referring to?

24 Q It's PMC 133, and you've got history of present
25 illness.

1 A Can you show me the top of that note, please?

2 Q (Indicating)

3 A Keep going down so I can see the very top, please.

4 Q (Indicating)

5 A All right. And keep going up so I can see the whole
6 note and understand what it was.

7 Q (Indicating)

8 A It's a discharge summary of the patient.

9 Q Okay. And in that discharge summary ---

10 A Do we have on it the date when that was done?
11 Should be near the bottom.

12 Q Sorry. I'm losing some battery power. PMC 134. You
13 have it in the chart here. (Pause) Does that indicate
14 when it was dictated?

15 A Yes.

16 Q When was it dictated?

17 A The dictation date is the highlighted date and it's on
18 September the 7th.

19 THE COURT - You need to speak up, Doctor. I
20 don't think the jury nor the ---

21 A September 7th at noontime is when it was dictated.

22 THE COURT - Thank you.

23 DR. BENSON - Yes, sir.

24 Q And, Doctor, my question was -- (pause) -- Doctor, in
25 the dictated note, would you agree that it states, I was

1 contacted by Dr. Hilton and our plan was to perform a c-
2 section immediately upon the patient's arrival to labor and
3 delivery. Is that what the note says?

4 A Yes.

5 Q Okay.

6 A Although that's a summary of the patient's stay in the
7 hospital and I don't think it accurately reflects what we
8 did or what my intentions were on the day she came to the
9 hospital.

10 Q Doctor, you agree there's been testimony that Samantha
11 showed up at your office at 8:40, September 5th, 2008.

12 A Is that a question?

13 Q Yes. Did she show up at 8:40 September 5th?

14 A Yes, that's what it said on the sign-in sheet.

15 Q Okay. And would you agree that the testimony has been
16 from your staff is that the time is wrong on the NST sheet?

17 A Yes.

18 Q And their testimony is that the time is off by an hour
19 and 10 minutes on that NST sheet.

20 A That is correct.

21 Q Okay. And the time that the NST would've started
22 would've been around 10:00 o'clock if the time on that
23 machine is off.

24 A (No response)

1 Q We have an 8:40 sign-in, and then the NST was started
2 about 10:00 o'clock according to your staff's testimony.

3 Is that correct?

4 A Yes, that's -- that's my understanding. I wasn't
5 there at the time.

6 Q Okay. And then the non-stress test would end about
7 10:30.

8 A That's my understanding.

9 Q And we know the results of that. And then a
10 biophysical profile started at 10:48. Is that correct?

11 A Yes.

12 Q And would you agree that between 8:40 and 10:00
13 o'clock there's an hour and 20 minutes there? Just doing
14 the math.

15 A Yes, an hour and 20 minutes.

16 Q And would you agree that Samantha Jamison came in with
17 decreased fetal movement that day?

18 A Yes.

19 Q And would you agree, Doctor, that you -- your office
20 does not have a written -- you can have a seat; I'm sorry --

21 -

22 A Thank you.

23 Q --- does not have a written policy concerning patients
24 who walk in with a potential emergency?

1 A Yes, I would agree that we don't have a written policy
2 about patients coming in and complaining of decreased fetal
3 movement.

4 Q And would you, agree, Doctor, that you allowed the
5 nurses to make a call as to what needs to take place,
6 rather than seeing a physician immediately?

7 A They know that we want those patients to be seen and
8 worked in as soon as they can.

9 Q And would you agree, Doctor, that there's no written
10 policy with regard to when a patient needs to see a medical
11 doctor as opposed to a nurse? It's left up to the nurse's
12 judgment.

13 A We don't have any kind of protocol that list all the
14 possible complaints that someone could come in with, and it
15 is definitely a team effort in the hosp -- in the office,
16 and we trust our nurses to have good clinical judgment,
17 absolutely.

18 Q And I believe you prescribed Zoloft for Samantha after
19 the death of her son.

20 A Yes, I did.

21 Q That's for depression.

22 A Yes, sir.

23 Q Doctor, on September 5th, 2008 would you agree that the
24 record only shows decreased fetal movement and does not

1 indicate what type of movement there was, how many
2 movements per hour or anything else?

3 A What's your question?

4 Q September 5th, would you agree that the record does not
5 record the kick count or the number of kicks per minute --
6 or per hour, just indicates a decreased fetal movement?

7 A Absolutely. It's sort of like ordering a blood test.
8 You wouldn't order it unless it's going to change your
9 management, and you wouldn't ask that question and document
10 it unless it's going to change the test you're going to do.
11 As soon as she says, my baby is moving less than usual, we
12 know we're going to do an NST. The next step is -- well,
13 we're going to see her, talk to her, evaluate her, which we
14 did, and then usually we're going to get an NST, so it's
15 pretty -- pretty straightforward what's going to happen if
16 someone comes in and says I feel like my baby's moving less
17 than it is.

18 Q And you heard the testimony of Dr. Karotkin who was
19 here. Is that correct?

20 A I heard his testimony.

21 Q And I believe he testified that heartbeat that was
22 normal right before she -- she left the office, it wouldn't
23 just abruptly stop, that there would be sort of a tailing
24 off period of time. Would you agree with that?

25 A I heard him say that.

1 Q Okay. Do you agree with that statement?

2 A No, I don't agree with that statement. I think -- I
3 think he -- I think he could not tell us why this baby died
4 or when this baby died, so it's interesting that if he
5 can't say why the baby died, that he can kind of show us
6 how the heart rate pattern would've gone when he doesn't
7 even have an answer for why the baby died.

8 Q Well, do you agree that more likely than not Jayden
9 died from asphyxia, lack of oxygen?

10 A No, I do not think that that is straightforward at
11 all.

12 Q So you don't offer any reason.

13 A I spoke earlier about the fact that this was an
14 extremely unusual situation. That's -- and the way that
15 this happened was very unpredictable and very
16 unforeseeable, and when something happens that's very
17 unusual, it is sometimes caused by something that's very
18 unusual, which could be metabolic, which is very hard to
19 diagnose. The baby could've had a metabolic disorder that
20 no baby has ever even had before, and there isn't even a
21 test to test for it. The baby could've had a genetic
22 abnormality. No test was done for that. Chromosomal
23 things can lead to some of the things we saw and can lead
24 to a fetal death with no explanation, but we don't have a
25 karyotype that would explain that. We also could have had

1 a congenital anomaly that led to the death of a baby and
2 was inconsistent with life outside the womb. So those are
3 unusual things. We don't see those things all the time,
4 but this was a very unusual situation. We do not have a
5 diagnosis as to why this baby died, although it would be
6 nice to have some explanation, but for you to say that
7 asphyxia was the reason the baby died is something unknown
8 and unknowable. The baby was dead when she got to labor
9 and delivery and we don't know why, and we don't know when.

10 Q Do you agree or disagree, Doctor, that two out of 10
11 biophysical profile is consistent with chronic asphyxia?

12 A It can be.

13 Q And chronic asphyxia is something that you've got to
14 treat immediately. Would you agree?

15 A (No response)

16 Q Chronic asphyxia must be treated immediately.

17 A Chronic asphyxia requires placing the -- doing
18 something to improve the condition of the baby, putting the
19 baby on oxygen, turning the mother on the side, trying to
20 improve the situation, trying to decide what needs to be
21 done to try to protect the health of this baby, and
22 sometimes you might come to the conclusion that that baby
23 needs a delivery, but sometimes that would not be the right
24 answer.

25 Q You can't ignore suspected chronic asphyxia.

1 A You wouldn't ignore it.

2 Q Cannot ignore it. And if you do ignore it is a breach
3 of the standard of care. Would you agree? If it were
4 ignored, it would be a breach of the standard of care.

5 A Well, it wasn't ignored in this case.

6 Q My question is if it were, it would be a breach of the
7 standard of care.

8 A If you -- let me make sure I understand your question.
9 If you determined that a baby had chronic asphyxia -- do
10 you mean if the baby had an abnormal biophysical profile?

11 Q If a doctor who was treating a pregnant mother
12 suspects chronic asphyxia, can that doctor ignore it, fail
13 to intervene?

14 A No, it's important to do more testing.

15 Q Important to do some type of intervention.

16 A Yes.

17 Q And that may mean a c-section.

18 A If you come to that conclusion that that baby has
19 signs or symptoms that it's an impending fetal death, then
20 often we'll do a c-section as fast as we can.

21 MR. JORDAN - Doctor, thank you for your time. I
22 don't have any further questions at this time.

23 THE COURT - Any re-direct?

24 Mr. DAVIS - Two or three, Your Honor.

1 RE-DIRECT EXAMINATION

2 BY MR. DAVIS -

3 Q Doctor, let's start where we left off. I want you to
4 assume that a baby -- that somehow -- you as a reasonably
5 prudent obstetric gynecologist, I want you to assume that
6 the baby has asphyxia. You somehow know that or highly
7 suspect it, and that's on the top of your differential
8 diagnosis. Okay? Understand what I'm asking?

9 A Yes. Yes.

10 Q Do you do anything different than what was done in
11 this case, sir?

12 A No.

13 Q If you assume a baby has or may have asphyxia, does it
14 change your opinion today in this case, assuming the baby
15 had asphyxia, for the sake of my question, as to the
16 predictability for foreseeability of this death in about 45
17 minutes from the time the baby and mom got to the office,
18 sir?

19 A No, the way biophys -- the way the literature is
20 written about results of an abnormal biophysical profile
21 suggest that if the biophysical profile is abnormal,
22 meaning it's a four, a two or a zero, that that is a baby
23 that has a significant chance that something bad is going
24 to happen within a week, one week. That's how it's
25 written.

1 Q All right, sir. Doctor, is a non-stress test in your
2 opinion indicative of chronic asphyxia, sir?

3 A No.

4 Q He asked you to look at the -- your discharge summary,
5 and I want to look at a couple other lines or two of this
6 one and half page document. Okay? You can sit there.

7 Okay. And I'm going to do this; I want you to look at that
8 first page with me. All right, let me read it. I've got a
9 couple lines and I want you to -- if you can count down
10 with me. Oh, come on down here. I got it pink
11 highlighted. You see where I've got that pink highlight?

12 A Yes.

13 Q Let me read this and ask you a question. This is your
14 note. Right after he read to you, I was contacted by Dr.
15 Hilton and our plan was to perform a c-section immediately
16 upon the patients arrival to labor and delivery. When the
17 patient arrived on labor and delivery, no dot (sic) tones
18 were noted, no fetal heart tone was present. The
19 ultrasound was performed at that point at two different
20 times and no heart rate was noted. Is that the evaluation,
21 sir, that you did and the nurses did when she got to the
22 hospital, sir?

23 A Yes, it is.

24 Q Thank you. Next part I've got. Was that part -- is
25 that what you're trying to say about you had a plan, it

1 wasn't just to do a c-section as soon as she came in the
2 door?

3 A Yes.

4 Q And that's right there in the same paragraph?

5 A (No response)

6 Q Let's look down at the other sentence I've got
7 highlighted. This patient had a pregnancy complicated by
8 late care. On the note done by the billing clerk or
9 whoever it was at the hospital, they've got something about
10 care, prenatal care, insufficient.

11 A Insufficient, yes.

12 Q Insufficient. Is that what you were talking about?

13 A Yes, I think that -- that's -- when we say late care,
14 they probably have their own option to describe that. With
15 a code it's probably insufficient care. And I think that's
16 where they're lifting that from my discharge summary.

17 Q Please take a seat. I've got one more question and
18 I'm done. You have spent considerable amount of time
19 looking through the office chart, your office chart in the
20 care of this patient, not just your care, but your
21 partners, everybody. Right?

22 A Yes.

23 Q You've looked at the medical records in this case from
24 August 9th hospitalization and the hospitalization of yours
25 on September 5th. Correct?

1 A I've looked at both of them.

2 Q Spent a lot of time looking at those records before
3 today, haven't we, Doctor?

4 A Yes.

5 Q I want to ask you this question. Based on your review
6 of all those records, did you see any evidence, any
7 evidence, that Ms. Jamison when she came to your office on
8 September 5th was not seen as soon as possible that day,
9 sir?

10 A No.

11 Q Well, what if it was an hour and 20 minutes before she
12 was seen after she signed in at 8:40 with 19 other patients
13 signed in before her, was that an unnecessary delay?

14 A No, I think that -- although this was a tragic
15 outcome, we had a lot of patients we were taking care of
16 that day, and we got her in as quickly as we could. I
17 don't think that's unusual amount of time.

18 Q Any evidence that she wasn't seen as soon as possible
19 under these circumstances that day?

20 A No, I think we saw her as soon as possible.

21 MR. DAVIS - Nothing further. Thank you.

22 THE COURT - Questions on new matter.

23 MR. JORDAN - Just one.

1 RE-CROSS EXAMINATION

2 BY MR. JORDAN -

3 Q Doctor, I believe you testified that chronic asphyxia
4 is encountered that something bad will happen within a
5 week. Was that your testimony?

6 A When you read the literature about biophysical
7 profiles, they will say when you have an abnormal
8 biophysical profile of zero to four, that there is a 60
9 percent chance a negative event might happen within a
10 week's time.

11 Q Okay. And by negative event, you mean death.

12 A No, not death, just a baby not doing well, having
13 problems.

14 Q Death is one possibility?

15 A A rare possibility.

16 Q Well, if you've got a bad biophysical profile, you can
17 predict that within a week something bad is going to happen
18 to that baby.

19 A No, we already said that that was a certain
20 percentage, and in a large percentage of those babies will
21 be doing fine when you do further evaluation, because we
22 already talked about the fact that they may be asleep, or -
23 - you know, a biophysical is not a -- it's not drawing
24 blood from the baby. It's not a definite. It's a test
25 that reflects a certain situation at a certain moment, and

1 it makes us worry, because a certain percentage of those
2 babies are going to do badly and also a pretty large
3 percentage of them are going to do well.

4 Q Maybe I didn't ask correctly. If there's chronic
5 asphyxia present and that doesn't change, isn't it true
6 that you can predict that death will occur?

7 A No, you can't predict that death will occur. That is
8 wrong.

9 Q So is it your testimony that if an infant has chronic
10 asphyxia that you don't have to intervene; you can just let
11 it run its course?

12 A Your question wasn't about intervening.

13 Q Well, Doctor, is chronic asphyxia is that a bad thing?

14 A Yes.

15 Q And it can cause death?

16 A Yes, it can. If the situation progresses it can lead
17 to death. That's why ---

18 MR. JORDAN - That's all I have.

19 MR. DAVIS - Thank you, Your Honor.

20 THE COURT - All right you may step down, sir.

21 MR. BENSON - Thank you.

22 THE COURT - All right, ladies and gentlemen,
23 we're going to stop for today. We will resume tomorrow at
24 9:15. Be back in your jury room by that time. Remember,
25 don't talk about the case; don't allow anybody to talk to

1 you about it; don't do any research on your own; don't talk
2 to anybody at home or down the street about the case.
3 They're not jurors on this case. So I'll see you back
4 tomorrow morning, 9:15. Thank you very much. Everybody
5 else remain seated, please.

6 (Jury exits the courtroom)

7 THE COURT - All right, anything from the
8 plaintiff at this point in time?

9 MR. BOYD - No, Your Honor.

10 THE COURT - From defense?

11 MR. DAVIS - No, sir. I want to thank the Court
12 for allowing the jury to decide, and I appreciate the Court
13 letting us get through Dr. Benson's testimony. Thank you.

14 THE COURT - Yes, sir. All right, we'll see y'all
15 back -- we'll start again by 9:15, so y'all get here a
16 little bit before that, please. All right? Thank y'all.

17 MR. DAVIS - Thank you, sir.

18 THE COURT - Thank you.

19 (Court in recess at 6:40 p.m.)

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1 THE COURT - All right, is the plaintiff ready for
2 the jury to come in?

3 MR. BOYD - Your Honor, may we approach for a
4 second?

5 THE COURT - Sure.

6 (Bench conference was held which was not
7 reported.)

8 THE COURT - All right, ask the jury to come in,
9 please, sir.

10 (Jury returns to the courtroom)

11 THE COURT - All right, counsel, are you ready
12 with your next witness?

13 MR. WILLIFORD - Yes, Your Honor. May it please
14 the Court. We'd like to call Dr. Mark Moore.

15 THE COURT - All right. Please come around to be
16 sworn. If you would approach, please.

17 DR. MARK MOORE, AFTER BEING FIRST DULY SWORN,

18 TESTIFIES AS FOLLOWS:

19 DIRECT EXAMINATION

20 BY MR. WILLIFORD -

21 Q Doctor, please state your full name for the record.

22 A It's Mark Tillman Moore.

23 Q And where do you live?

24 A Greenville, South Carolina.

25 Q Okay. And where were you born and raised?

1 A Actually Spartanburg, outside Spartanburg, Roebuck.

2 Q If you could pull the mic just a little bit closer. I
3 think that would be helpful. And tell us a little bit
4 about your background and your training, but let's start
5 with college. Where'd you go college?

6 A I went to college at Wofford in Spartanburg. It's
7 interesting; I did that but I co-opted with Milliken,
8 Milliken Chemical. When I finished that I went to Medical
9 School at the Medical University of South Carolina in
10 Charleston, and then I did what's called a general
11 internship in Spartanburg and then went for residency for
12 obstetrics and gynecology in Medical College of Virginia in
13 Richmond.

14 Q And what is your current profession?

15 A I'm an obstetrician gynecologist.

16 Q Okay. How long have you been an Ob-Gyn?

17 A I started practice in 1991.

18 Q Doctor, do you have any -- are you married?

19 A Yes, I ---

20 Q Do you have any children?

21 A I have two children; my oldest son is 25 and he is in
22 Japan, and my youngest is at Clemson, and he's 20.

23 Q Are you board certified?

24 A Yes.

25 Q Are you re-certified?

1 A Yes. I just took -- like Dr. Benson said yesterday,
2 we generally re-certify yearly now, and -- but every six to
3 10 years you have to take a written exam, so I went and did
4 that this past month, passed that.

5 Q Pull the mic up just a little bit closer.

6 A The chair won't move. I'll try to speak up.

7 Q Okay, all right. That'd be great.

8 THE COURT - Thank you, sir.

9 MR. WILLIFORD - Thank you, Your Honor.

10 Q Yesterday we had heard a little bit about an attending
11 physician. Explain to the jury what an attending physician
12 is and what are you -- act in that role.

13 A Yes. They mentioned that yesterday. Attending
14 physician is a -- sort of a teaching physician. And when I
15 was hired in 1991 at Greenville, we have a residency
16 program to teach doctors how to become Ob-Gyns, and so I
17 was hired at that time to provide care for a private
18 practice, but I would also be on faculty to teach residents
19 how to deliver babies, interpret monitor strips, manage
20 high risk pregnancies, in-patient care and also teach them
21 some Gyn surgery. So I did that for about 15, maybe 18
22 years, just -- and I still do that on a -- on a less
23 intense basis, but I still teach residents. I taught
24 residents yesterday, so -- the -- so I still do that, so

1 I'm an attending physician to teach residents how to manage
2 obstetrics patients.

3 Q Tell the jury about kind of different aspect of your
4 practice, private practice, office practice. What do you
5 do day-in and day-out or week-in and week-out?

6 A Well, what we do is I have an eight-man practice. We
7 are like Dr. Benson's practice, we stay in the hospital;
8 one of us is there assigned generally 24 hours -- 24 to 30.
9 We have an overlap, and we take care of obstetrics
10 patients. We have in-patient Gyns; we have, you know,
11 surgery patients, and so we're in the hospital and we take
12 care of the labor and delivery unit, antepartum unit. We
13 also do Gyn surgery. We have a back-up physician as well.
14 And then when we're in the office, we see a combination of
15 gynecology patients as well obstetrics patients.

16 Q Are you a diplomat of the American Board of Ob-Gyns?

17 A Yes.

18 Q Are you a fellow of the American College of Ob-Gyns?

19 A Yes.

20 Q Are you a member of the South Carolina Medical

21 Association?

22 A Yes.

23 Q The Alpha Omega Alpha Honor Medical Society?

24 A Yes.

1 Q Dr. Moore, how many times in your career -- how often
2 do you manage pregnant patients doing Ob-Gyn versus --
3 doing Ob versus ---

4 A Well, our practice is a mix, so it's essentially every
5 day. We don't have assigned Gyn days or assigned
6 obstetrics days, so generally operate one day a week, maybe
7 two and then see office patients Mondays and Wednesdays,
8 Fridays.

9 Q How often do you in your experience see patients who
10 complain and come into your office with decreased fetal
11 movement?

12 A It's a very common complaint. In fact, the night --
13 the call before last I had a 28 week pregnant lady called
14 in said the baby wasn't moving, well, brought her in,
15 evaluated her that night and everything was fine. We see
16 it very commonly and, you know, our nurses, you know, they
17 know if somebody comes in to do that they generally just
18 triage them and automatically do an NST and we go through
19 that.

20 Q In this case have you reviewed materials such medical
21 records and depositions in this case?

22 A Yes.

23 Q Do you know what the standard of care is as it applies
24 to Ob-Gyns?

25 A Yes.

1 Q What's the standard of care?

2 A Well, when I look at something about management, I
3 look at -- different people have different definitions, but
4 I think of what is the plan of care, is it reasonable, is
5 what they're doing making sense, do they have a reason, a
6 basis for why they do something. Everybody does things
7 different. There's not a right or wrong to different
8 managements as long as you have an idea of why you're doing
9 it and it makes sense. So for me I look at it, does it
10 make sense, is it prudent, is it -- is it supported by the
11 literature, and that -- and I think that's what defines
12 standards.

13 Q Doctor, how often do you do medical legal reviews such
14 as what we're doing in this case?

15 A Well, I don't do it very often and the -- I think I've
16 maybe reviewed one or two cases -- out of my whole career
17 probably not even average two cases a year.

18 Q Now, how many times have you served as an expert
19 witness for my law firm?

20 A One -- one time in testimony and I believe one time in
21 deposition and then this case.

22 Q Would you consider reviewing a case on behalf of the
23 patient against a doctor?

24 A Yes.

1 Q Now, Doctor, you have been represented before by my
2 partner, Ashby Davis. Correct?

3 A Yes.

4 Q Okay. Tell the jury about that.

5 A When I got in practice in 1991 I had a -- I had a
6 delivery, I think, '92 where the lady got an infected
7 episiotomy from a vaginal delivery and had some
8 complications, and so I was sued during that -- for that
9 occurrence, and then --

10 MR. JORDAN - Your Honor, I just want to object.
11 Full details of the representation I don't think are
12 relevant in this case. The fact that he was represented I
13 think is.

14 THE COURT - All right, thank you. I think we've
15 explored it far enough. Thank you.

16 Q The fact that my partner Ashby Davis has represented
17 you, I think you said 15 or 20 years ago, does that have
18 anything to do with the evidence in this case or your
19 opinions in this case?

20 A No.

21 Q If you believe that Dr. Hilton, Dr. Benson or anyone
22 in their group fell below the standard of care as you
23 reviewed the case, would you have told me so?

24 A Oh, yes, I would -- I would not be here if I thought
25 it was below the standard of care.

1 Q Do you believe that you have reviewed sufficient
2 material to give an opinion as to the standard of care in
3 this case?

4 A Yes, I believe I have. The records I think are very
5 good and they're adequate to be able to say that.

6 MR. WILLIFORD - Your Honor, at this time I would
7 like to offer Dr. Moore as an expert in obstetrics and
8 gynecology.

9 THE COURT - Do you wish to voir dire the witness
10 as to his qualifications or challenge the offer by the
11 defense?

12 MR. JORDAN - No, Your Honor.

13 THE COURT - All right, sir, he is qualified to
14 give his opinion. You may proceed.

15 Q Dr. Moore, as an expert in this case, what did you
16 review?

17 A I reviewed the office records of Ms. Jamison, as well
18 as the hospital records and I reviewed the depositions of
19 the physicians, the office staff and the patient and her
20 family and the expert witnesses for the defense, as well as
21 for the plaintiff.

22 Q Without going through the list, do you believe you
23 reviewed all the depositions in the case?

24 A I believe so, yes.

25 Q You gave a deposition as well?

1 A Yes.

2 Q Throughout the course of your testimony today, would
3 it be fair to say that any opinions you give are to a
4 reasonable degree of medical certainty unless you tell me
5 otherwise?

6 A Yes, yes.

7 Q Dr. Moore, based on your review of the records and
8 depositions, all the evidence in this case -- and let me
9 add to that, including yesterday -- were you here for the
10 testimony of Dr. Hilton and Dr. Benson?

11 A Yes, I came yesterday and listened to their testimony,
12 yes, sir.

13 Q Based on everything that you know and have reviewed in
14 this case based on your training, experience and knowledge,
15 what is your opinion in this case?

16 A Well, I believe that their care that they gave Ms.
17 Jamison was not only standard of care, I believe was above
18 the standard of case. I deal with a lot of different
19 groups, physicians and I teach residency. This -- the care
20 they gave was phenomenal in my -- in my opinion.

21 Q Doctor, I don't want to go through all the details --
22 the jury saw a lot of that yesterday -- in terms of the
23 blood pressures at the hospital on August the 9th where Dr.
24 Miller treated Ms. Jamison -- I don't want to go through

1 all those details, but let me ask you this. Were you here
2 when Dr. Benson testified about that?

3 A Yes.

4 Q Okay. Based on the knowledge that we have of that
5 evidence and based on your training and experience; was her
6 blood pressure and was her admission to the hospital on
7 August 9th, 2008, was that appropriate care?

8 A Yes, it was -- it was interesting. She came -- based
9 on my review of the records she came because she was
10 uncomfortable, having contractions, and when she got there
11 her blood pressure was elevated, and I believe that Dr.
12 Miller admitted her to evaluate her, not so much for the
13 contractions but actually for the blood pressure to see if
14 it was a persistent and elevated issue, to see if it was
15 going to be something that he needed to deal with. On the
16 follow-up of those pressures, they returned to normal,
17 roughly acceptable range as Dr. Benson described yesterday,
18 and I think that was adequate care and did what needed to
19 be done.

20 Q Dr. Moore, you understand that Ms. Jamison had chronic
21 hypertension during her pregnancy.

22 A Yes.

23 Q Okay. Out of all the materials you have looked at and
24 reviewed, in your opinion, how was that managed?

1 A It was managed appropriately. She was placed on an
2 appropriate medication. Aldomet is a standard medicine.
3 It's been around like he said yesterday for 40 years. We
4 use it; it works; it's cheap and it's very safe and
5 effective.

6 Q Doctor, I want to move to talk about the August 25th
7 visit that Ms. Jamison had with Dr. Miller, and I'm handing
8 you the original records that are in evidence right here,
9 and here's a fetal monitor strip from the 5th, and we'll get
10 to that in a minute.

11 A Okay.

12 Q Doctor, what's your understanding of -- I believe your
13 copy has August 25th, 2008 at the top. Correct?

14 A Yes.

15 Q Okay. Mine's cut off a little bit, but -- we heard a
16 lot about this yesterday; I don't want to go into all the
17 details, but basically what is your understanding of what
18 occurred and what Dr. Miller's plan was?

19 A Well, it looks like to me that she came in and she --
20 as he said, came in for evaluation, had an ultrasound
21 performed. The ultrasound showed the baby to be in a
22 vertex or head-down position, had a amniotic fluid index of
23 nine. He described this as decreased, and as you heard
24 yesterday, that's a normal finding. A nine's normal.
25 Anything greater than five's normal, so I'm not sure where

1 I -- he thought it was decreased, but -- and then she had
2 normal doppler studies which means the placental function
3 appeared to be normal, and the abdominal circumference was
4 slightly behind at two weeks, and he thought that that
5 could be related to a diminished AFI which makes sense,
6 because sometimes if the fluid's different -- like Benson
7 said yesterday, it's really interesting, if you have full
8 bladder the measurement's are going to be different; if you
9 have an empty bladder, they're going to be different. If
10 the baby's taking a breath, it may be different, so there's
11 some differences here and he makes a note of why he thinks
12 that occurred, and then he did a physical exam on her
13 because she had some swelling of her leg, and obviously in
14 pregnancy we see swelling all the time. He was, it looks
15 like to me, concerned that she may have a -- you know, he -
16 - when you have unilateral swelling in a pregnant woman
17 they have a higher risk of a clot in their leg, and so I
18 think he examined her. The Homan's sign is to see if she
19 has a physical symptom related to a possible clot. It was
20 negative, so he gave her information regarding that. Since
21 there was a concern that there might be a lag in the
22 abdominal circumference, he began fetal movement counts
23 which is a reasonable way to monitor the baby, for the
24 mother to monitor the baby, because as you know, as you've
25 heard and as I tell my patients, an active baby -- a baby

1 that moves is a healthy baby, so if I get a mother that
2 comes in and says -- and the first thing I ask them, is the
3 baby moving; if they say, yes, I'm ecstatic, because that's
4 -- that means the baby's fine, so -- so he started her on a
5 way for her to monitor the baby at home without having to
6 be put on a monitor. One of the NSTs -- and I don't think
7 this was brought up, but I don't know if it was or wasn't,
8 but when you're put on a N -- a patient on a monitor for an
9 NST, you give them a button; they're on the monitor; when
10 they feel the baby kick, they're supposed to push the
11 button, and so years ago the -- the reading of an NST was
12 the movement associated with an acceleration of the
13 heartbeat, because if the baby moved -- it's like y'all, if
14 y'all walk up a flight of stairs your heart starts beating
15 faster. If the baby's kicking around, his heartbeat's
16 going to get faster. So that's the theory behind it. In a
17 baby who is -- everything's normal, if it goes up, that
18 means that the brain and the cardiovascular system, all of
19 those things are in tact and the baby should be healthy.
20 Okay, so you use that button. Well, at home -- she can do
21 that at home without the button without the monitor, and
22 then you get an idea of how the baby's doing by having to
23 do these fetal movement counts. So that's why you do that.

24 Q In reviewing the records and the testimony and looking
25 at this note and based on your training and experience and

1 knowledge, was his plan appropriate or reasonable at this
2 time?

3 A Oh, I think absolutely. I mean in this instance this
4 ultrasound is not worrisome. I mean it's normal fluid.
5 The doppler studies as you heard yesterday, they're normal,
6 so that means the placental function based on how we can
7 test it is normal. The fluid -- he -- he makes a note of
8 it being low. I don't consider that low and he makes a
9 plan to follow it up in two weeks and look for interval
10 growth, check the abdominal circumference and recheck the
11 fluid. As you heard from Dr. Benson yesterday, an interval
12 change, the minimum's two weeks; well, actually I think the
13 minimum's three weeks, because if you get -- if you're
14 beside the ultrasonographer doing the ultrasound and you
15 watch them put the calipers on and make those measurements,
16 there's errors between those measurements and the degree of
17 error is such that you really can't see an adequate
18 interval at two weeks. You can only really see it at three
19 weeks. All right. So not only did he do better, he had
20 her come back in two weeks for a repeat scan when I think
21 the standard would've probably been three weeks for a
22 growth scan. Now, if he wanted her to come back and bring
23 the scanner for the fluid, I think that's fine, but I think
24 the standard for a growth scan, interval growth is three

1 weeks, and so I think he even did above what you -- what
2 was required.

3 Q Doctor, why not do an NST that day or within a week,
4 or why not do a BPP that day or within a week?

5 A Well, there was no reason so. If you look at the
6 visit that day for the prenatal record, again, the whole
7 point was when you -- when a patient comes in for an
8 obstetrics visit the intake is how's the baby moving.
9 That's on the checkbox. Her checkbox that day was normal.
10 So the movement reported was normal based on the -- based
11 on the record, and if that movement's normal and you've got
12 an essentially normal ultrasound, why would you need
13 testing. That's my take on it. That's how I interpreted
14 that. So I didn't see any indication, but it could've been
15 done. But the baby's reported to be moving normal. You've
16 got an ultrasound that shows normal placental function;
17 you've got normal fluid, so it's like the old adage, you
18 put her back on the monitor, give her the finger (sic) --
19 push the button, she'd be pushing it because the baby's
20 been moving because she just reported it moving to the
21 nurse. So I don't see any indication to do it. I guess
22 you could do it. It's not going to hurt anything, but I
23 don't see a reason to do it; it wouldn't be needed. It
24 wouldn't add anything at that visit.

1 Q Okay. Now, in terms of what an NST might show versus
2 dopplers in reviewing this note where the doppler was
3 normal ---

4 A Yes.

5 Q What kind of information would an NST give you versus
6 doppler in the setting -- like for example, if the
7 doppler's normal, why would you do an NST if you will?

8 A Well, the doppler -- it's mostly looking at placental
9 function, and I don't know how much -- I wasn't here
10 yesterday for the discussion about doppler studies for
11 y'all, but essentially it's blood flow resistance through
12 the placenta, how much -- how the baby's blood is going to
13 the placenta and coming back to get nutrients. So a
14 doppler study looks at placental function, and an NST looks
15 at fetal function, which is also related to placental
16 function, so there are two different tests. Usually an
17 abnormal doppler occurs before an abnormal NST. That is,
18 the baby has enough reserve -- don't know how to explain
19 that. A healthy baby with normal dopplers has a lot of
20 ability to tolerate insults, contractions, whatever. If
21 the doppler studies were starting to become abnormal,
22 they're going to be abnormal before the heart rate tracing,
23 because there is a reserve there for the baby that it has,
24 so generally doppler abnormalities precede abnormalities in
25 the fetal heart rate because of that reserve.

1 Q Doctor, if you're going to do a BPP, what's kind of
2 the progression? You start with a doppler and go to NST
3 and then go to BPP ---

4 A Well, the doppler's not part of the -- a doppler
5 study's not part of the BPP. That's -- they did it, but it
6 -- definition of a biophysical profile is NST, fluid, fetal
7 breathing, fetal movement, fetal tone. It's not dopplers.
8 They added that to it, but that's not -- it's not
9 necessary.

10 Q Doctor, did the standard of care require Dr. Miller's
11 have Ms. Jamison come back within a week and do an NST and
12 a BPP?

13 A I don't see any indication for that. So the standard
14 of care -- I wouldn't know why he was doing it, so I -- I
15 don't see an indication for it, so, no, I don't think the
16 standard of care would've required that at all. Like I
17 said, I think the standard would've been a refuted growth
18 scan in three weeks for ultrasound. She's 20 -- I believe
19 28 weeks at that visit, so normally it would be a two week
20 visit -- a follow-up two week visit for a routine check
21 blood pressure, you know, just a routine Ob check and then
22 a three week check for an ultrasound. I think that
23 would've been within the standards, so he even went above
24 what I would've considered the standard.

1 Q Based on the information here at the time that Dr.
2 Greg Miller had, is there anything abnormal going on that
3 requires a follow-up in a week?

4 A Not -- not based on what I'm seeing here. Not based
5 on this note and not based on her intake on that visit. I
6 would say no.

7 Q I want to move to September 5th, and ask you some
8 questions about that. Ms. Jamison comes in at 8:40, didn't
9 have a scheduled visit, based on the evidence that you
10 looked at and you've read in the case and you were here
11 yesterday, did they work Ms. Jamison in as quickly as they
12 could?

13 A It appears so. I mean she got an appoint -- she got
14 the first visit that was available with the provider that
15 was -- had the -- I assume from Dr. Hilton's testimony
16 yesterday, that was the quickest appointment she could get
17 in. They worked her in to the person that found -- that
18 was there that had a time, so, yes, I think that it was
19 done in an appropriate way.

20 Q Doctor, there was a question yesterday about
21 protocols, written protocols in the office of when a
22 patient comes in and they have a complaint. You have an
23 office-based practice. Do you have written protocols in
24 your practice for that?

1 A No, I don't think -- we don't have written protocols
2 to my knowledge for that kind of stuff.

3 Q And why not?

4 A Well, we train our -- we have a triage nurse who takes
5 an intake -- you know, is a register that the nurse asked
6 them why they're there and we -- our nurses are trained.
7 They're Ob-Gyn nurses. I mean they're trained to triage
8 and so -- so that's what we do. So we don't really have a
9 protocol. I think we train them to do that. We don't
10 write it down. There's only certain many things that women
11 come in for; with obstetrics there's like a top 10 and so
12 it's really not -- there's only so many things and so we
13 teach them if this happens you do this, if this happens you
14 do that, this is what we expect you to do, this is what we
15 like you to do, this is what we need to be done. We teach
16 them that. We don't write it down.

17 Q Doctor, when Ms. Jamison came in on September 5th with
18 decreased fetal movement, was it an emergency at that time?

19 A No, it wasn't an emergency. And it's interesting,
20 when I was looking at his -- I don't know if anybody
21 noticed this, but in one of the depositions -- I think Ms.
22 Jamison was not the only woman that came in that morning
23 with decreased fetal movement, because there was a comment
24 that they were seeing a lot of that that day. I remember
25 that off of one of the depositions, and so I believe it was

1 -- you know, that's not generally an emergency. It's a
2 potential emergency. You heard that yesterday. You don't
3 know until you start the evaluation, but in general it's
4 not a -- a decreased fetal movement is not an emergency,
5 it's a potential emergency and it requires you to evaluate
6 it, but it's not -- doesn't have to be an emergent -- I
7 don't consider itself an emergency.

8 Q Doctor, looking at the case, was Robin Pruetto, the
9 nurse practitioner who first saw Ms. Jamison, was her care
10 appropriate?

11 A Yes.

12 Q Okay. And Ms. Pruetto, she ordered an NST?

13 A Yes.

14 Q And we've heard a lot about that. I do want to go
15 through this just a little bit. And you have provided to
16 me a tracing, and I've shared it with plaintiff's counsel,
17 a tracing to explain and compare this. I'd love for you to
18 come down if you will.

19 A Okay.

20 Q First, let's start with the tracing. In fact, let's
21 give you the original.

22 THE COURT - If you don't mind, can you have the
23 Doctor next to the court reporter, please, if you don't
24 mind.

25 MR. WILLIFORD - Yes, Your Honor.

1 THE COURT - So we can make sure that she can hear
2 and take it down.

3 Q Doctor, Judge John has asked you to be close to there,
4 so what I'm going to do is put it up here and if you want
5 to stand close to the wall over there and ---

6 THE COURT - Right there's fine.

7 Q Well, let's start with this first one, and I just want
8 you to tell the jury what we're seeing. We heard some of
9 this, but get you to kind of explain what we're looking at.

10 A Let me see if I can move this. Okay. Now, as Dr.
11 Benson said yesterday, there are things you look at with a
12 fetal heart rate, you look at the baseline heart rate.

13 THE COURT - You're going to have to speak up now.

14 A Okay. Oh, okay, I'm sorry.

15 THE COURT - You know, the court reporter's got to
16 make sure that she takes it down. Thank you, sir.

17 A All right. You look at the baseline heart rate, 110
18 to 160, and that's an average over a 10 minute window; you
19 look at the squigglyness of the line and that's essentially
20 a beat to beat variability. And then you look for what we
21 call periodic changes and that's what occurs as an accel or
22 decel. Accel is a jump in the heartbeat, again, like we
23 talked about; if you -- if you run up and down the hall,
24 the heartbeat's going to go up, and so an acceleration
25 shows everything -- generally it's a good thing. And then

1 the -- so on this tracing you've got a normal baseline;
2 you've got beat to beat, that's jumpiness to the thing that
3 what I consider moderate, and then let's see, as you go
4 down you've got a little drop in the heart rate here, but
5 it's not -- that just doesn't -- you don't mean anything to
6 that. And as you go into the second tracing, you've got a
7 variability here and you've got a normal heart rate
8 pattern, and then you've got this acceleration, and this
9 acceleration is a normal acceleration for this age child
10 would be as -- so this -- this is a reassuring kind, so you
11 see this -- just this window here, it's very reassuring for
12 us. So then you go back and you've still got some --
13 you've got your normal variability and you've got a normal
14 baseline. And then -- let's see -- this is the next -- and
15 then -- let me see if I can get this this way. In this
16 tracing, again you've got your normal baseline. Here you
17 have some contractions. You have a contraction I think
18 here, here and -- and this last one, this is an interesting
19 thing. So this last one she has a little contraction here
20 and it's along with the acceleration.

21 Q And what does that tell you, Doctor, when you have a
22 little contraction and acceleration?

23 A That just shows the baby at that point is oxygenated.
24 It's doing well at that point. So then you have
25 contraction here, here and here, and this contraction you

1 have no drop in the heartbeat; this contraction you have a
2 little drop and it's a pointed drop, so that's -- that's
3 what they're looking at. This is not the classic late
4 decelerations because there's more of a point. And then
5 you're coming down ---

6 Q What would be a late deceleration?

7 A Well, a late deceleration you would expect it to be
8 more of a curve and you have less of this interactivity
9 here. Some people would characterize -- everybody in --
10 everybody interprets fetal heart rate tracings different.
11 You get 10 doctors in a room and they'll interpret this
12 differently. And it's sort of a judgment call. There's
13 not a -- it's real interesting. As you're training -- when
14 you're training residents you put a -- you put a monitor
15 strip in a box and you pull the monitor strip out and you
16 teach them, okay, this -- this is a person -- give them a
17 scenario, and you pull it out and you say, okay, this is
18 what you do or this is what -- so you never know the
19 outcome, but you have to read it, and that's one of the
20 training ways to do this. But there are a lot of different
21 ways -- they'll be different doctors interpret them. I
22 interpret this as a variable type decelerations. Another
23 doctor may determine it as well so -- and then you -- so
24 then you go here, so this is -- and then you go down, this
25 is a more non-specific finding here because you've kept

1 your baseline. I don't really see much there. And this is
2 interesting, you get another contraction here, contraction
3 here, contraction here, and you maintain the heart rate
4 with those, and so when you have a contraction, the
5 contraction causes the blood flow to the placenta to be
6 diminished a little bit and that's -- that's what it's
7 supposed to -- but there's so much reserve with the
8 placenta it doesn't affect the baby usually. Okay, so you
9 see a contraction and you see a no response or no -- no
10 problem with the heartbeat there, no problem with the
11 heartbeat there, you're getting this little decelerations
12 here which is, again, a non-specific type because you've
13 got these contractions with nothing here. Okay.

14 Q So at this point -- out of all the ones we've gone
15 through, at this point how's the baby?

16 A Well, I think the baby right at this point -- I don't
17 see -- it's not reactive, the tracing, and we talked that
18 (sic) yesterday. The tracing's not reactive, but it's not
19 -- it's not worrisome; it just doesn't give us enough
20 information. You've got -- you've got some reassurance,
21 but you don't have adequate reassurance. Then you go to
22 the next step.

23 Q Is that what they -- this is the last one here, BPP and
24 I think that says MD ---

25 A Yes, BPP and MD.

1 Q --- Robin B. Pruette I believe is what it is.

2 A Right.

3 Q So would that have been appropriate?

4 A Yes. But you do the follow-up test; the follow-up
5 test is the BPP or CST but in pre-term child you got to go
6 the office to do a BPP. That's the worst.

7 Q Thank you, Doctor. Actually one more thing. I want
8 to compare different one. This is the one you have
9 provided to me.

10 A Yes, I ---

11 Q Explain this to the jury.

12 A Yes, this -- in this tracing I want you to take a look
13 at this. Now, this is the uterine activity in this
14 tracing. Okay. This is the fetal heart rate in this
15 tracing. You see how it's going up, down, up, down. As
16 you see how it's -- there's no variability within this
17 tracing. It's just essentially a line. There's not the
18 little squiglyness to it. There's these huge drops.
19 You've got tachycardia, so you've got decreased
20 variability.

21 Q And what's tachycardia just for the jury?

22 A Well, it's -- tachycardia is where the heart rate is
23 high. It's 160 or above is tachycardia, and so this --
24 this tracing shows tachycardia, decreased variability,
25 recurrent persistent decelerations. This is a -- this is a

1 nominal tracing. This tracing is one that you would have
2 to act on. This tracing is a pre- -- this is an acidotic
3 tracing. You have to deliver this child in this instance
4 immediately. This is what we call a category three. You
5 know, a category one -- I think about that category two;
6 this is a category three, and this is -- this is what you -
7 - this is a worrisome tracing. This is a bad tracing. So
8 you compare that to that and you see the difference, and
9 that's why I wanted to show that. I wanted to show there's
10 a difference, and that's a huge difference and that's why
11 there's a variability with that.

12 Q Doctor, did the standard of care require, after the
13 NST in this case, did it require an emergency c-section?

14 A After the NST?

15 Q After the NST.

16 A No.

17 Q Had an NST been run earlier in the office, let's say
18 it was even possible to do that, earlier in the office, in
19 your training and experience and looking at this strip,
20 what do you think it might've shown?

21 A Well, looking at all this and looking at this tracing
22 and ---

23 MR. JORDAN - Your Honor, could we ask the witness
24 to step back if he's not ---

25 THE COURT - Is it necessary?

1 MR. WILLIFORD - Thank you, Doctor.

2 A Now, I'm sorry, I forgot your question.

3 Q Sure, sure. If -- looking at this case, looking at
4 the tracing, based on what you see day-to-day, if it was
5 even possible to see Ms. Jamison earlier in the day on
6 September 5th, what to a reasonable degree of medical
7 certainty do you think that the NST might've shown based on
8 what we've seen already?

9 A Well, the part that I see, the beginning part was --
10 as I just showed -- was essentially reassuring. It wasn't
11 reassuring enough to consider it normal or reactive, but it
12 was reassuring. Now, if you move that back, it makes me
13 wonder if it wouldn't even been better earlier in the day.
14 It may not have been, but it might've been, because
15 something's happened here where you're getting a rapid
16 decline, and I still can't understand how a 32 week baby or
17 fetus goes from this tracing here to an abnormal
18 biophysical to a fetal death within that short period of
19 time. I just don't understand it. It just doesn't make
20 sense, so something happened rapidly I think, an acute --
21 something rapidly and acute; I don't know what it is, and
22 so my suspicion that testing earlier would've been more
23 reassuring, not less reassuring.

24 Q And, Doctor, if an NST occurs and it's reassuring
25 after a patient comes in with decreased fetal movement and

1 gets an NST and it's reassuring, what does the reasonable,
2 ordinary prudent Ob-Gyn or nurse practitioner do at that
3 point?

4 A Well, if the test is reassuring, then you know
5 hopefully that the baby's going to do well based on the
6 test and so then you would discharge the patient and give
7 her fetal movement counts.

8 Q So in this case had Ms. Jamison even been worked in
9 earlier if possible and an NST run, likely she would've
10 been sent home because all that ---

11 A Yes, potentially would've been better, because this --
12 something happened rapidly and you may have had a
13 reassuring tracing earlier in the day and she may have been
14 sent home because of that. I mean it is a possibility.

15 Q Doctor, backing it up a little bit, had Dr. Miller
16 ordered or asked Ms. Jamison to come back in the office
17 within a week after her August 25th visit and then had an
18 NST, do you have an opinion as to what an NST may have
19 shown even before September 5th?

20 A Well, again, a 30 week -- at that point she would've
21 been 30 -- I think 30 weeks. Thirty weeks you can have a
22 non-reactive NST and be normal, so -- because they're not
23 always reactive at that age, or the BPP if it was done. It
24 may not have been normal just because of the gestational
25 age. That's why you don't start testing that early

1 generally. Okay, but my feeling is, if you did test the
2 baby at that point, the test would've been normal; it
3 would've given you no information because it would've been
4 normal, because if you look at the studies on biophysical
5 profile NST, a low, zero to four, up to 60 percent of those
6 babies over a week's period of time will have a problem.
7 All right, so if you back this up, and we know the baby had
8 a problem on the 5th, but you back it up and do a test a
9 week earlier with a reassuring -- possible reassuring here,
10 then I believe the test if you did a week earlier would've
11 been normal, because other than that you would expected the
12 baby to come in with problems sooner than this, because
13 that test would've been -- that test would've been normal I
14 think.

15 Q Now, after the NST we know that she got a BPP started
16 at about 10:48. Correct?

17 A (Indicating yes)

18 Q Okay. Was the timeliness of what happened in the
19 office, getting seen, getting an NST, then going to the
20 BPP, was that appropriate and within the standard of care?

21 A Yes.

22 Q The BPP obviously was a two out of eight in 10
23 minutes.. Correct?

24 A Yes.

1 Q Okay. And at that point, as you know Dr. Hilton came
2 in, was what she did and what she said, is that appropriate
3 and within the standard of care?

4 A Absolutely.

5 Q If Dr. Hilton wanted to extend the BPP for a little
6 bit longer when there was a normal heart rate of 158,
7 dopplers weren't too concerning at all and normal AFI, had
8 Dr. Hilton wanted to extend it longer for maybe 30 more
9 minutes, would that have been appropriate based on the
10 knowledge that she had at the time?

11 A Absolutely. It would (sic) totally appropriately,
12 because that would've completed the test. I mean she --
13 she stopped the test early because she was concerned about
14 it, and as -- as you've heard yesterday and as we know as
15 obstetricians, if you're concerned you can't do anything in
16 the office. You have -- you have to have somebody
17 somewhere you can do something, so she made a great call.
18 She said, okay, I -- I'm not -- this is not reassuring me;
19 I'm going to send her somewhere where she can get checked,
20 and so -- and that's what she did.

21 Q Does the standard of care require Dr. Hilton to drive
22 or walk over with Ms. Jamison to the hospital?

23 A No.

1 Q Why not decide right then and there after 10 minutes
2 of this BPP why not do a c-section right there or
3 immediately go to the hospital to do a c-section?

4 A Well, I think that they were prepared to do that, but
5 the standard would've -- it would've been -- to deliver a
6 32 week baby where you don't have a indication at this
7 point -- all you have is a partial test, but you're going
8 to -- you're going to -- you wouldn't act on a partial test
9 -- that makes no sense -- and put the baby at risk for, you
10 know, complication of prematurity, because that baby -- it
11 could've easily gone over and retested and been normal, and
12 then you would've delivered a baby that didn't need to be
13 delivered and have all the concerns you'd have with that.
14 The -- the test wasn't completed, so you -- she sent her to
15 a place where the test could be re-established and re-
16 evaluated and then acted on if needed to be.

17 Q Doctor, we've heard some yesterday about chronic
18 asphyxia, whether the baby might've had chronic asphyxia.
19 What do you look for in a baby that might have chronic
20 asphyxia versus something acute?

21 A Well, chronic you would expect -- chronic asphyxia
22 generally is a placental problem, so you expect the doppler
23 studies to be abnormal, your placental pathology to be
24 abnormal, the amniotic fluid volume to be abnormal. I
25 don't know what you -- I didn't -- I wasn't here for some

1 of what y'all hear. When a baby's growing, you know, there
2 are certain things you look for. You look at interval
3 growth, which the child had, except for the abdominal lag,
4 and -- so you look at growth; you look at placental
5 function with dopplers and then -- those are the chronic
6 things -- and amniotic fluid volume and then the acute
7 things are the movements and stuff like that.

8 Q With the evidence in this case, did this baby have
9 chronic asphyxia?

10 A I don't see evidence of that. Normal doppler studies,
11 normal placental function, normal fluid, that does not go
12 with chronic asphyxia.

13 Q In your opinion, did this baby have a slow decline or
14 rapid one?

15 A I think it was rapid, and that's what bothers me. I
16 don't understand it. It was -- you just don't see -- this
17 just -- this is very uncommon. You don't see this kind of
18 tracing with a ultrasound, the growth and then a demise
19 that short. It's just -- you just don't see it.

20 Q In your opinion, Dr. Moore, did Dr. Miller deviate
21 from the standard of care?

22 A No.

23 Q Did Dr. Miller cause, directly or indirectly, this
24 baby to die?

25 A No.

- 1 Q What about Dr. Hilton?
- 2 A No.
- 3 Q Did she deviate from the standard of care?
- 4 A No, and again, she made a good call. I mean she
- 5 stopped the test early and she sent the patient to a place
- 6 that could be acted on if necessary.
- 7 Q Did Dr. Hilton directly or indirectly cause this baby
- 8 to die?
- 9 A No.
- 10 Q What about Robin Pruette in the office, did she
- 11 directly or indirectly cause this baby to die?
- 12 A No.
- 13 Q Did she deviate from the standard of care?
- 14 A No.
- 15 Q What about Dr. Benson? Did he deviate from the
- 16 standard of care in your opinion?
- 17 A No.
- 18 Q Did he directly or indirectly cause this baby to die?
- 19 A No.
- 20 Q What caused the baby to die?
- 21 A I have no idea. It bothers me. I don't understand
- 22 it. Makes no sense. It's tragic. We -- as obstetricians
- 23 our goal is to -- for this not to happen. It's like he
- 24 said yesterday, when a nurse calls you and says they can't
- 25 hear a heartbeat, you just get a sick feeling in your

1 stomach. It's the worst thing we got to do. Everybody
2 thinks, you know, we have a great job, and we do; we have
3 the best job ever. We're the lucky people, but that's the
4 worst thing we deal with, and so we try out best to prevent
5 it. Our goal is for that never to happen, but it happens.

6 Q Dr. Moore, in your opinion was the fetal demise in
7 this case, Ms. Jamison's baby, was it predictable?

8 A No. Absolutely not. That's what -- something
9 happened; it happened quickly and I think it was no way you
10 could predict this.

11 Q Was it foreseeable?

12 A No.

13 MR. WILLIFORD - Give me one moment.

14 Q Doctor, just ask you about clinical judgment. What is
15 clinical judgment and what does it mean to you as a
16 practicing obstetrician and gynecologist?

17 A Well, clinical judgment is deciding what to do and how
18 to manage something. You base that on how many -- you
19 know, you base it on your experience, how many people
20 you've seen, how you've taken care of it, your training,
21 who taught you, how they teach you, your reading, staying
22 up with literature, going to conferences. It's a
23 combination of all the knowledge that you can accumulate.

1 Q In your opinion, did Dr. Miller or Dr. Benson, Dr.
2 Hilton, Robin Pruette, did they exercise appropriate
3 clinical judgment in this case?

4 A Yes.

5 MR. WILLIFORD - Please answer any questions Mr.
6 Jordan or Mr. Boyd may have.

7 THE COURT - Cross examine.

8 MR. JORDAN - May it please the Court.

9 DR. MOORE - Can I get a tissue?

10 THE COURT - Yes, sir, absolutely.

11 MR. MOORE - These allergies are bothering me.

12 THE COURT - That's all right. Do we have some
13 tissues. Yes, the clerk ---

14 MR. MOORE - I'm sorry. I apologize.

15 THE COURT - That's all right. Not a problem.

16 CROSS EXAMINATION

17 BY MR. JORDAN -

18 Q Good morning, Dr. Moore.

19 A Good morning.

20 Q We met before when I took your deposition. Correct?

21 A Yes. (Indicating yes)

22 Q Doctor, let me ask you, before we start talking about
23 the care here, in your practice you've treated mothers who
24 have lost a child.

25 A Yes.

1 A I think it could've been. I mean -- I defer to her
2 like your expert did. I think she made a clinical
3 judgment. I wouldn't -- I don't know what I would've done
4 in the same situation. I think it was appropriate, yes.

5 Q Now, when someone comes into your office and have
6 decreased fetal movement, it's a potential emergency.
7 That's what you testified to earlier.

8 A Yes, potentially, yes.

9 Q And because it's a potential emergency, you have to
10 treat it as a potential emergency. Is that right?

11 A Yes.

12 Q Okay. Now, Doctor, you agree that Samantha Jamison
13 had chronic hypertension.

14 A Yes.

15 Q That's not a normal pregnancy, is it?

16 A No, not at all.

17 Q Now, do you treat a chronic hypertension patient the
18 same as you treat a normal patient?

19 A No.

20 Q And what you would have to do, Doctor, is you would
21 have to treat that chronic hypertension patient a little
22 bit different. Is that right?

23 A Yes.

24 Q Okay. Tell the jury how you would treat the chronic
25 hypertension patient a little different.

1 A Okay. Generally with hypertension the concern you
2 have are two-fold, one is the -- the hypertension, it's
3 just like if a -- if a person has hypertension, if it's
4 untreated they can have vascular problems, heart attack,
5 kidney failure, those kind of things. All right. So
6 you're looking at from a fetal standpoint that high
7 pressure head to the placenta can age the placenta, make
8 the placenta less sufficient, so it lead -- it can lead to
9 growth restriction; it can lead to problems with fluid and
10 -- so that's the concern of placental function. The other
11 is, if it's -- if the blood pressure's too high, it's
12 uncontrolled, then the placenta can separate and you'd get
13 an abruption. So those are the two common things you look
14 for with hypertension in pregnancy. So that's one reason
15 you treat it so it doesn't get to the severe range that Dr.
16 Benson talked about yesterday, but then again, you don't
17 want to drop it too low, because again, that vascular
18 supply to the pregnancy is -- it needs some pressure head
19 to it, because if you drop it too low, then the placenta
20 doesn't get enough blood flow. So you don't want to over-
21 treat, but you don't want to under-treat, so it's sort of a
22 fine line, and so that's why they put her on the blood
23 pressure medicine. And management during pregnancy for
24 chronic hypertension, everybody has a different protocol.
25 You can have -- it may be a written protocol. Some people

1 do it one way, some another, but in general, you look for
2 interval growth, so you do serial ultrasounds, and then
3 starting about 32 to 34 weeks you start fetal testing to
4 look for, you know, to make sure the baby's staying
5 healthy. Okay. And that's essentially what was done here,
6 but she delivered or had an outcome that was adverse, below
7 32 weeks, before the testing would normally start. And she
8 didn't have an indication to do anymore testing at this
9 point, because the baby was normally grown. It wasn't
10 growth restricted, so you generally don't start testing
11 unless you've got a growth restriction at hypertension
12 under 32 weeks. That's the standard I go by, and I think
13 most people do that, but there's probably some controversy
14 about that.

15 Q And when you say start testing, what -- what test are
16 you talking about?

17 A Well, you do the biophysical or NST. I mean a fetal
18 well-being test.

19 Q Fetal well-being. It's called fetal surveillance.

20 A Yes.

21 Q And fetal surveillance is how you manage someone with
22 chronic hypertension.

23 A Yes.

1 Q And looking back when Samantha Jamison came into the
2 office on September 5th, 2008, retrospectively that was an
3 emergency, wasn't it?

4 A Oh, absolutely. Retrospectively, yes, but the
5 hindsight, you know, is 20/20. We would love -- everybody
6 would love that. We -- I would be the best doctor ever if
7 I had that.

8 Q But you ---

9 A If you don't, you have to go based on what you have.

10 Q You got to see the patient and do the appropriate test
11 to know whether it's a potential emergency or a true
12 emergency.

13 A Yes.

14 Q Doctor, are your nurses trained to check a blood
15 pressure in chronic hypertension patients?

16 A Yes.

17 Q And do they do that every time?

18 A Depends on what they come in for. If they're coming
19 in for a visit, yes. If they come in for a standard visit
20 -- sometimes, like in this instance we would have --
21 sometimes a nurse would by-pass that and go straight and
22 put her on a monitor before doing a blood pressure, because
23 she's not worried about the blood pressure; she's worried
24 about fetal well-being, and then we'll deal with the blood

1 pressure later, so that's not a surprise that it wasn't
2 done here.

3 Q Typically you would want to do -- check the blood
4 pressure of someone who's chronic hypertensive.

5 A Yes.

6 Q And typically the standard of care would require that.

7 A I think if you're treating somebody with hypertension
8 with blood pressure medicine you'd need to keep an eye on
9 the blood pressure.

10 Q Now, you were here for Dr. Hilton's testimony.

11 A Yes.

12 Q And I believe you heard her testify. I think she said
13 there were three or four suspicious looking decels. Okay?

14 A (Indicating yes)

15 Q Would you agree with that?

16 A I think I just went through the tracing.

17 Q I agree ---

18 A I agree that she said that.

19 Q Okay. Now, Doctor, the category three, that's a
20 really bad strip.

21 A That's a really bad strip.

22 Q And we're not dealing with a really bad strip.

23 A No, that's -- I agree a 100 percent. That's why I
24 wanted to show that, because that is a really bad strip.

1 Q And it's a judgment call when you get down to a
2 category two is what you said. Is that correct?

3 A Absolutely, yes.

4 Q And we all make judgments every single day. Do you
5 agree?

6 A Yes.

7 Q When I'm out there driving on the highway I'm making a
8 judgment call if I pull out from a stop sign or if I'm make
9 a left-hand turn and if I pull out in front of someone it's
10 bad judgment though, isn't it?

11 A Yes, I would think so.

12 Q But we all make judgment calls every single day.

13 A Yes.

14 Q And when we make a bad judgment call, we're
15 responsible for that bad judgment call. Would you agree?

16 A Yes, I would agree with that.

17 Q And you don't want to see late decels on a strip, do
18 you?

19 A It depends on the whole scenario of the strip. If
20 you're just asking me in general do you want to see late
21 decels, I would say no, but it depends upon the whole
22 thing, that a woman -- sometimes we'll see late decels --
23 it's interesting, you'll put a woman in labor, get an
24 epidural and the blood pressure will drop and you'll get
25 late decelerations, and then you'll give them some

1 medicine, their blood pressure comes back up and they'll go
2 away. So you have to look at the whole scenario, but yes,
3 if you look in general -- repetitive, recurrent, a late
4 deceleration is something you don't want to see. I mean --
5 -

6 Q Doctor, when she was first transferred into care she
7 was seen by Robin Pruette on July 18th. You agree? You've
8 got the record here if you want to just glance at that.
9 The 18th note, does that say Robin Pruette?

10 A Yes.

11 Q Okay. And she's not a physician at that group?

12 A (No response)

13 Q She's not a physician.

14 A Nurse practitioner is what -- my understanding is
15 she's a nurse practitioner.

16 Q And she transferred in as a high risk pregnancy.

17 A Yes.

18 Q And we know from that note that Dr. Benson wrote a
19 prescription for her blood pressure.

20 A Yes.

21 Q So Dr. Benson knew at that time that she was high risk
22 because it's chronic hypertension.

23 A Yes.

24 Q Doctor, would you agree that decreased fetal movement
25 can mean that a baby's in trouble?

1 A Can mean, yes.

2 Q And obviously if a woman's got decreased fetal
3 movement, you don't want them waiting for a long period of
4 time before you check and see what's going on, because it's
5 a potential emergency.

6 A Yes, depends on what your definition of long is, but
7 yes, I agree with that.

8 Q Okay. And, Doctor, would you agree that if a baby is
9 in trouble, that an hour and 10 minutes or an hour and 20
10 minutes would be a long time?

11 A If you know the baby's in trouble, potentially, yes.

12 Q What is asphyxiation?

13 A Lack of oxygen -- in my -- in my definition of it, in
14 my understanding of it, asphyxia is just lack of oxygen.

15 Q Would you agree that Jayden died from a lack of oxygen
16 generally what caused it? Is that what ---

17 A Well, yes, I think -- just like I think I said in my
18 deposition, you know, over -- every death is essentially
19 asphyxiation at some point. The brain -- you know, brain
20 doesn't get oxygen you die.

21 Q Would you agree, Doctor, that when the NST was
22 performed, the decels would show that he -- Jayden was not
23 getting oxygen during those contractions, the late decels,
24 or not getting as much oxygen?

1 A I don't know if you can say that. I mean it's an
2 external monitor. I don't believe that -- I don't think
3 you can say that because they're not repetitive,
4 potentially, but I don't -- I don't think you can say that.

5 Q Isn't it true that from the tests that were run, the
6 non-stress test and the biophysical profile, there was an
7 indication that there may be concern for lack of oxygen for
8 this child?

9 A Yes.

10 Q And Dr. Hilton would've known that.

11 A I think she was concerned about that.

12 Q Doctor, if you have a total lack of oxygen with a
13 child, how long does it take before brain damage occurs?

14 A I think the general accepted rule for that is around
15 10 minutes. It's all individual. I mean it's -- it
16 depends on what you're starting with; if you've got a sick
17 back or not a sick baby, those kind of things, but I think
18 10 minutes is your general rule of thumb.

19 Q And if you've got a baby with a total lack of oxygen,
20 you've got to do something immediately.

21 A I believe that's correct.

22 Q And would you agree, Doctor, that this was not a good
23 biophysical profile?

24 A I would agree but with a caveat it wasn't a complete
25 biophysical profile.

1 Q But the results that were shown were not good.
2 A Yes, I agree with that.
3 Q And with a two out of 10, Doctor, would you agree that
4 that is consistent with asphyxiation?
5 A If you get a completed test and you get a two out of
6 10 I would agree with that, but this was not a completed
7 test.
8 Q Doctor, what if you get a four out of 10? Does that
9 require -- what does that require that you do?
10 A You have to find out why it's a four or repeat the
11 test. It's the same as a two. It's still bad.
12 Q Still bad. So even if her score had been doubled, you
13 still have to do something.
14 A Yes, I think -- well, I think -- I think everybody's
15 established that. I think y'all have heard that throughout
16 this week, so I don't disagree with that.
17 Q Doctor, suppose it would've been a six out of 10?
18 What do you have to do then?
19 A Well, a six out of 10 generally is you repeat every 24
20 hours, so, yes, you have to follow that up.
21 Q But you've got to follow that up.
22 A Yes.
23 Q Pretty quickly.
24 A No, I think 24 hours is the standard at six, but
25 that's not -- doesn't have to be quickly. I think you --

1 again you just have to repeat it. You have to follow it
2 up, find out why, yes.

3 Q And would you agree then though that with a
4 biophysical profile of two out of 10 that there is
5 possibility or a potential for asphyxiation?

6 A Potential, yes.

7 Q And you don't know if the baby's unconscious or not.
8 You just know the baby's not moving.

9 A Yes.

10 Q And Dr. Hilton referred her to the hospital and passed
11 off care to Dr. Benson. Is that right?

12 A Yes. (Indicating yes)

13 Q Okay. And for lack of a better analogy, Doctor, when
14 a quarterback hands the ball to the running back, you want
15 a good exchange.

16 A I would hope so.

17 Q Because in football game a fumble's not a good thing.

18 A I would agree with that.

19 Q And would, you agree, Doctor, that passing off care of
20 a chronically hypertensive woman, that you want to make
21 sure there's not a fumble?

22 A Well, yes, I believe so, but I don't think there was a
23 fumble here, so I don't know what you -- you stating about
24 this case or are you stating about in general?

25 Q Doctor, let me ask you another question.

1 A Okay.

2 Q When she comes in and is seen for the first time, is
3 it unnecessary to establish a true estimated date of
4 delivery?

5 A Well, you do the best you have, and I think that's
6 what was done here and it's really interesting that -- I
7 think that was the 18 where she came in for the visit. I
8 thought it was very prudent that they did an ultrasound
9 that day. That wouldn't be -- that wasn't their normal.
10 That's not our normal. You estab -- you starting to take
11 an intake, you talk to them, and then you schedule that.
12 They already -- they did it the same day, so -- and they
13 established a due date with the best criteria you can have,
14 which was the scan they had. It was all -- so I don't
15 understand what you want to do different. I mean you did
16 the best you could do with the information you had. You
17 established a due date.

18 Q Would you agree that the potential due date based on
19 the last menstrual period was about four weeks difference?

20 A I believe it -- I believe so. Yes, it was about four
21 weeks.

22 Q And that's a pretty significant period of time?

23 A Yes, I consider that a significant period of time.

24 Q And based on the ultrasound dating she was around 32
25 weeks on September 5th.

- 1 A Thirty-one weeks, six days I believe is what it is.
- 2 Q Right at 32 ---
- 3 A Right at 32 weeks, yes.
- 4 Q And if you'd gone by the last menstrual period, where
- 5 would she have been?
- 6 A I don't remember.
- 7 Q Approximately four weeks beyond that?
- 8 A Potentially, yes.
- 9 Q And how close to term would that be?
- 10 A Close.
- 11 Q That make a difference if you do a c-section or not
- 12 immediately?
- 13 A Well, yes, I -- well, yes, but you still wouldn't do
- 14 it at 36 weeks without getting the testing finished. But
- 15 that's a whole different scenario.
- 16 Q Are there some patients in your practice that you
- 17 would follow on a weekly or bi-weekly basis?
- 18 A Yes.
- 19 Q What would be the reasons that you would follow a
- 20 patient on a weekly or a bi-weekly basis?
- 21 A It depends on the gestational age but it -- and it
- 22 depends on the growth of the fetus, because you normally --
- 23 I do diabetics, hypertension, coagulopathy patients, let's
- 24 see, multiples -- there's -- high risk you can do those
- 25 things, but in generally it depends on the initial clinical

1 scenario. If you've got a hypertension that's poorly
2 controlled with a blood pressure and you've got to put them
3 on three blood pressure medicines, you're going to want to
4 check them more often because you've got to make sure their
5 blood pressure's under control. If you've got somebody
6 who's well-controlled with one agent and the blood
7 pressures have been normal, then you don't have to do it as
8 often. You look at growth, if the fetus is growing well,
9 well, then you don't need to test as often, and then when
10 you get toward the point where you want to do testing where
11 generally the blood pressure or the diabetes take effect or
12 becomes a problem, that's between generally, 32, 34, 36
13 weeks. That's why the testing protocols start there if
14 they don't sooner. And they start sooner if you identify a
15 problem sooner, so ---

16 Q And you would agree, doctor that on August the 9th
17 Samantha went into the emergency room complaining of
18 abdominal pain.

19 A August the 9th.

20 Q August the 9th.

21 A Yes.

22 Q And during that August the 9th visit she had high blood
23 pressure.

24 A Yes.

25 Q She was already on medication for blood pressure.

1 A Yes. But I think we already established initial blood
2 pressure was high, that the remainder of the pressures
3 during that time were within acceptable range, so it was
4 adequately treated.

5 Q Doctor, looking at this chart here, can you tell us on
6 -- looks like July 28th -- approximately what was the
7 gestational age of the baby written down?

8 A I don't see the dates.

9 Q I'm sorry. I need to move this over a little bit to
10 see if that will help.

11 A Okay, so July 28th?

12 Q Yes.

13 A Okay, what was your question?

14 Q Approximately how many weeks?

15 A July 28th -- I can't read that. I'm sorry. Can I get
16 the chart, because I can't read that.

17 Q Absolutely.

18 A What page is that?

19 Q (No response)

20 A I'm sorry, I can't find this.

21 THE COURT - Do y'all have a copy of it?

22 A Based on this form?

23 Q Yes.

1 A Well, they've given -- they've got two DVC, one at
2 10/1 and shows she had this visit, which should've been 20
3 -- around 28 weeks.

4 Q What's the first number there? Is that 30 ---

5 A Thirty ---

6 Q Thirty weeks, six days?

7 A Thirty weeks, six days.

8 Q And that's on July 28th?

9 A Yes.

10 Q Okay, and then the next entry, is that 33 weeks, and
11 then they mark through it and knock it back down to 28?

12 A Yes.

13 Q And then the next entry on August 25th is 29.

14 A Yes. Now the reason ---

15 Q Okay, so when she initially came in --

16 THE COURT - I'm sorry, it sounded like he needed
17 ---

18 A Yes, I'd like to go ahead and follow that up, because
19 this happens in obstetrics offices all the time. You --
20 you -- somebody who's doing an intake will look at the
21 menstrual EDC and do a wheel, figure out what (sic) many
22 weeks they are and they'll put it down, and then the
23 physician or the provider or the nurse practitioner or the
24 physical will review this and then somebody goes down in
25 this corner -- y'all can't see it on that -- but they have

1 circled the EDC change to the ultrasound, so the thirty
2 weeks six days at 7/28 is the menstrual dates not the
3 ultrasound dates -- is that's my interpretation of this,
4 and so that happens commonly, so this next one, they -- the
5 physician, whoever saw her here, marked through that and
6 corrected it, because the due date's not the menstrual
7 dates, it's the ultrasound sound dates, which is the
8 accepted standard at this point, and that's what Dr. Benson
9 I think tried to bring up yesterday, is you can only
10 establish a due date based on your best criteria, and your
11 best criteria at this point was the ultrasound done at 25
12 weeks.

13 Q Doctor, you would agree that Samantha Jamison had
14 several risk factors, the hypertension that we talked about
15 ---

16 A Yes.

17 Q --- prior uterine rupture, ---

18 A Yes.

19 Q --- and the abdominal circumference was lagging with
20 this baby.

21 A Yes.

22 Q And that's a potential to develop intrauterine growth
23 restriction ---

24 A That's a potential ---

25 Q --- or an indication that she may ---

1 A Possibility, yes.

2 Q Okay. What about the fundal height? That decreased
3 at all?

4 A Well, again, fundal height is a variable that's -- you
5 know, you get a pregnant woman and you get three different
6 doctors or four different doctors measuring, you're going
7 to get a difference, and I thought Dr. Benson did a good
8 job, because that's what I teach, is there's three
9 centimeters, one way or the other that's where you start
10 investigating, so I don't see that this is a pertinent or
11 this doesn't change anything.

12 Q Doctor, you would agree generally that a physician has
13 the duty to recognize an emergency and then make
14 appropriate decisions to protect the life of a child and
15 mother?

16 A Restate that again.

17 Q You would agree that a physician has a duty to
18 recognize an emergency and then to make appropriate
19 decisions to protect the life of a child and mother?

20 A Well, I think that's what you train to do. A
21 physician is trained to take care of the patient; the first
22 thing is do no harm and the second is to take care of the
23 patient and you do that to the best of your ability.

24 Q And does that mean, doctor, that you want to do the --
25 what's safest for the mother and the child?

1 A Well, you're -- sometimes the safest is not the --
2 it's like you driving down -- like you said, you get in
3 your car and you're driving down the road; well, the safest
4 thing for you to do is probably not drive down the road,
5 just walk down the road. So the same thing with medicine,
6 when you get -- you have to make choices and decisions on
7 what you're going to do; it may not be the safest thing,
8 but it's the choice you have to make. It's like the safest
9 thing is for a woman never to be pregnancy. Pregnancy's
10 not easy; it's not fun; it's hard; it's got risk factors;
11 there's problems. So the safest thing's for never to get
12 pregnant.

13 Q Doctor, would you agree that if there's a medical
14 condition that your patient has, that the patient has a
15 right to know about them?

16 A Yes.

17 Q And you've got a duty to tell your patient if there's
18 an emergency situation. You've got to convey that to the
19 patient.

20 A I would agree with that, yes.

21 Q And, Doctor, is it a breach of the standard of care
22 not to?

23 A I would think that if you don't convey an emergency
24 situation and it's an emergency, I think that that probably
25 is a decrease in the standard.

1 Q And, Doctor, would you agree that if a patient walks
2 into your office, not a scheduled appointment, they're
3 entitled to the same care and treatment and the same
4 standard of care applies as someone who has a scheduled
5 appointment?

6 A Well, I -- yes, I think that's been established
7 already, and I agree with that, yes.

8 Q Would you agree that -- we talked a little bit about
9 the hand-off. Would you agree that a doctor who's
10 referring a patient to another doctor has a duty to tell
11 the referring physician exactly what's going on?

12 A I think they need to convey the problems going on.
13 Yes, I agree with that.

14 Q Would you agree that the doctor referring the patient
15 to a hospital has a duty to tell a hospital what's going
16 on?

17 A Not sure about that. I think you -- I think you send
18 the patient to the hospital and you talk to the doctor
19 there. I'm not sure that you have to call. ---

20 Q Would it ever be appropriate to leave a voicemail
21 message, either a doctor leave a message or one of the
22 doctor's staff to leave a message with a hospital telling
23 them we need a baby out STAT?

24 A That -- I don't know of any -- I don't know of any
25 hospital that has that -- that occur or even has that

1 possibility. I don't know that. I've never heard that,
2 and I don't think based on my interpretation of privacy
3 laws, I don't believe that you'd do that anyway, because
4 that's not private.

5 Q But, Doctor, that wouldn't be a very good hand-off if
6 that occurred.

7 A Well, yes, I'd agree with that. I just -- yes, I find
8 that to be -- I just don't -- that doesn't make any sense
9 to me. I don't know about y'all, but that makes no sense
10 to me, why you'd leave a voicemail.

11 Q Doctor, are you family with an ACOD standard that
12 requires a c-section to be performed within 30 minutes?

13 A Yes.

14 Q And you would agree, Doctor, that if an emergency
15 situation exist a c-section has to be performed sooner than
16 30 minutes.

17 A I don't think the standards require you to do it
18 sooner than 30 minutes. The 30 minute rule -- I think you
19 can do it sooner than 30 minutes, and I think that you --
20 if you have the ability to do it, but I think there's a
21 standard there, because some hospitals don't have the
22 anesthesia, don't have the support to where, you know,
23 you're in a small hospital, you've got an anesthesia person
24 in, I think, you know, you're limited to what your options
25 are, so the standards in one place for time may be

1 different than the standards in another place, because just
2 the availability of healthcare providers.

3 Q Doctor, what's your understanding of what time she
4 finished up treatment at the office?

5 A I think around 11:00 o'clock.

6 Q Okay. And what is your understanding of when she was
7 first seen at the hospital?

8 A I believe based on what I've seen in records of 11:40.

9 Q And what is your understanding of the first time that
10 Dr. Benson was present and checking her?

11 A I think 11:47.

12 Q And, Doctor, you don't really have a reason why she
13 wasn't seen by Dr. Benson between 11:00 and 11:45, do you?

14 A Yes, I have no idea.

15 Q Doctor, would you agree that if an emergency situation
16 is occurring, that 49 minutes is a long time between one
17 exam -- when you end one exam and she's seen again?

18 A You talking about in general or in this case?

19 Q I'm asking in general. How long a time?

20 A In general if you have an emergency, it depends what
21 the emergency is. Forty-nine minutes could be a long time,
22 it could not. It depends on the emergency.

23 Q But generally if there's an emergency occurring and
24 you stop a test because of an emergency, 49 minutes is a
25 long time to wait to be seen again?

1 A It depends on the test. We've already testified with
2 Dr. Benson -- and it's not unusual -- they're lucky that
3 they -- y'all are -- or the health community here -- the
4 patients are lucky they have the ultrasound in their
5 office, because some places don't, and if they'd done the
6 test, the NST and had to send her to a referral center to
7 have the testing done, it could've been done two, three,
8 four hours later, so -- and that would've been -- that
9 would've been acceptable, so the 49 minute -- that's what
10 I'm saying, you have to look at the whole situation.

11 Q Doctor, do you remember if I asked you in your
12 deposition, would you agree if an emergency situation was
13 occurring that 49 minutes is a long time between one exam
14 that you end abruptly until she's seen again?

15 A Yes.

16 Q And if you tell me in that deposition, yes, I don't
17 argue that that's a long time.

18 A Yes.

19 Q Okay.

20 MR. WILLIFORD - Your Honor, I'd ask that he
21 reference the page number.

22 THE COURT - I'll allow you to reference the page
23 number ---

24 MR. JORDAN - Page number 52 beginning at line 9
25 through line 13.

1 Q And, Doctor, you agree that's a long time if emergency
2 situation is occurring.

3 A Let me look at my deposition. I want to see the
4 treating imposed just to make sure.

5 Q Certainly.

6 THE COURT - And again, ladies and gentlemen, a
7 deposition's a testimony of a particular witness taking at
8 a ---

9 A It was 58?

10 THE COURT - --- taken at a previous time.

11 Q Fifty-two.

12 A Fifty-two. (Pause)

13 Q Beginning with line 9, question and your answer on
14 line 13.

15 A Yes, I see. (Indicating yes)

16 Q Okay. Can you tell the jury what you responded?

17 A Yes. Yes, I don't argue that's a long time.

18 THE COURT - Just leave it right there be good.
19 Thank you, sir.

20 Q Doctor, are you aware that there was a late entry with
21 the hospital record that indicated that Samantha had a
22 diagnosis of oligohydramnios and IUGR?

23 A I did see that yesterday, and I saw it I believe in
24 somebody else's deposition in the records, yes.

25 Q She didn't have oligohydramnios, did she?

1 A No.

2 Q And the IUGR was a potential for developing that? Is
3 that your testimony?

4 A Yes, it's potential, but she didn't have a diagnosis
5 of IUGR.

6 Q You testified that tachycardia for a child is 160
7 beats a minute?

8 A Over 160 beats per minute.

9 Q Over 160. And 158 beats a minute, that would be
10 borderline tachycardia, wouldn't it?

11 A No.

12 Q No?

13 A No, be normal.

14 Q Was there any medical reason why an NST and
15 biophysical profile could not been run on August 25th, 2008?

16 A There's no reason it couldn't have been run.

17 Q Okay. And a non-stress test and biophysical profile
18 would not have caused any harm to Samantha Jamison or her
19 child.

20 A No.

21 Q And, in fact, a non-stress test and biophysical
22 profile is pretty much the gold standard for fetal
23 surveillance when you have a high risk pregnancy, isn't it?

24 A Depends on the gestational age.

1 Q Okay, but your answer be then, yes, depends on the
2 gestational age?

3 A Yes, it depends on the gestational age.

4 Q Okay, so the gold standards for following someone with
5 high risk is non-stress test and biophysical profile, and
6 you qualify that by saying it depends on the age.

7 A I think that's one of the tests. You can use several
8 tests, but those are tests we use.

9 Q Okay. And those are the tests that you use.

10 A Yes.

11 Q Okay. And you've got some women in your office that
12 you would follow on a weekly or bi-weekly basis.

13 A Yes.

14 Q Okay. Now when Samantha went in on August the 9th,
15 2008, she had a non-stress test then. Is that correct?

16 A I'm sorry?

17 Q When she went into the emergency room on August the
18 9th, 2008, she had a non-stress test then.

19 A She had a monitoring strip that was reactive.

20 Q But that wasn't a test that was scheduled by Rock Hill
21 Gyn-Ob.

22 A Oh, no. (Indicating no)

23 Q And when she went in on August the 11th and 25th, she
24 did not have a non-stress test or biophysical profile.

25 That was not ---

1 A There was no -- no, there was no reason to do that.

2 Q Okay. So those ---

3 A It's like we established before, she had normal fetal
4 movement at that time and normal growth, normal fluid,
5 normal doppler. There was no reason to do any surveillance
6 at that point. The blood pressure was well-controlled. So
7 I don't understand why you think that there should be a
8 test done.

9 Q My question, though, Doctor, is they were not
10 scheduled for those days, were they?

11 A No, I agree they weren't, because there was no reason
12 to do that.

13 Q And on September 5th, 2008, that was not a scheduled
14 appointment for Samantha.

15 A That's correct.

16 Q Okay. So no -- a non-stress test or biophysical
17 profile had been scheduled for September 5th.

18 A No.

19 Q And did you see anything in the record where a non-
20 stress test or biophysical profile had been scheduled after
21 September 5th if Samantha had not come in complaining of
22 decreased fetal movement on September 5th?

23 A No, I think that there were scheduling a follow-up
24 ultrasound which in that instance would be the appropriate
25 test to order instead of a biophysical profile and instead

1 you do the ultrasound, because you're trying to identify if
2 it is a growth restricted baby, which then you would have
3 to institute therapy or surveillance. Right now -- up to
4 that point it was no indication for it.

5 Q And depending on the gestational age, high risk
6 patients are seen more often than other normal pregnancies.

7 A Yes.

8 Q And you do that in your practice routinely.

9 A Yes.

10 Q And where a normal visit might be two or three weeks,
11 you would knock it down to weekly or twice a week.

12 A Depends on the gestational age, depends on the -- on
13 the medical condition that's occurred. And it depends on
14 your protocol. Some do one week; some do twice a week and
15 there's not a standard for that. You just have to decide
16 what you're going to do.

17 Q Would you agree, Doctor, that the lower the
18 biophysical profile score, the more of a potential for a
19 chronic asphyxia?

20 A Well, I don't know. I mean I think that a four is
21 abnormal, a two's abnormal, a zero's abnormal. I don't
22 know if there's a study that shows two's worse than four or
23 worse than zero. I think that -- I don't know of any study
24 that shows that. I think four or lower is abnormal.

1 Q And if someone has or a child has chronic asphyxia,
2 you can't ignore that.

3 A I don't think so. You talking about in general?

4 Q Yes.

5 A Yes, I think that in general, yes.

6 Q If you recognize chronic asphyxia, it can't be ignored
7 and you have to intervene.

8 A Well, -- I don't think you have to intervene. You
9 would have to decide -- again, you have to look at the
10 gestational age, what the effects of whatever that chronic
11 condition is and try to modify the factors you can modify
12 to make that better. It's like Dr. Benson said, -- I
13 thought it was pretty interesting -- you know, your fluids,
14 oxygen, you know, some resuscitative events, and you do
15 those things. You know, it's not -- you don't deliver
16 based on that. You potentially do, but ---

17 Q Potentially do.

18 A Yes.

19 Q And ---

20 A But again, this does not show anything chronic.
21 Placental function's normal; doppler stuff is normal;
22 growth was adequate. It doesn't show anything chronic.
23 That's the whole issue. It doesn't show chronic. It shows
24 something acute has happened. Something happened quickly
25 that was unforeseen; you can't predict it; it's unusual.

1 The test up to this point had not shown anything that
2 explains this.

3 Q Doctor, if an unborn child has chronic asphyxia and
4 you do nothing about it, you can predict that that child's
5 going to die.

6 A I don't think you can predict that. It can have
7 problems potentially. A chronic -- a baby gets an adapt --
8 it's an adaptive process occurs where the baby restricts
9 its blood flow to the kidneys, its stomach -- I mean
10 kidneys, the abdomen, the growth, redistributes blood flow
11 to the brain; it's an adaptive process, and that's why you
12 look for growth restriction. It doesn't show that here.

13 Q And I would agree with you; it's a process where
14 there's signs and symptoms of a baby not doing well.

15 A Yes.

16 Q Would you agree?

17 A There are signs of that.

18 Q And ---

19 A There are -- in conditions there's signs of that; up
20 until the day she came in there was not any signs of that.

21 Q Well, lagging abdominal circumference. You've already
22 testified that's a potential for intrauterine growth
23 restriction.

24 A But she didn't have; it was a potential. It wasn't
25 diagnosed. I mean I've had patients, I measure them and I

1 -- want a doppler study, get another scan the same day and
2 the abdominal measurements are two weeks different the same
3 day, so I -- you know, it's -- these are not accurate
4 measurements. You do the best you can do. They're
5 estimates.

6 Q Doctor, you're not a neonatologist.

7 A No.

8 Q You're not a maternal fetal medicine specialist.

9 A No.

10 Q And you testified about what strips might've shown and
11 for -- really, Doctor, that's -- you don't know what the
12 strips would've shown if they'd monitored earlier or if
13 she'd had a biophysical profile run earlier, do you?

14 A No, I don't, but if you -- if you're trying to look at
15 studies -- you know, if -- a biophysical four or lower if
16 you do nothing, 100, -- take 1,000 women, and if you do a
17 biophysical profile and it's abnormal, zero, two, four, and
18 you wait a week to retest, anywhere from 100 to 600 of
19 those babies will die.

20 Q And, Doctor, with high risk pregnancies, the reason
21 you test is because you don't know what's going to happen.
22 That's the reason you do fetal surveillance. Correct?

23 A I'm sorry?

24 Q Why do you do fetal surveillance on high risk
25 patients?

1 A Well, you want to make sure the baby's healthy.

2 Q Okay. That's the reason you do fetal surveillance ---

3 A Yes.

4 Q --- is because you want to make sure that baby is
5 doing well.

6 A Absolutely, yes.

7 Q Because if you don't do fetal surveillance, you don't
8 know. Would you agree?

9 A That's true, but they did fetal surveillance. They
10 did fetal kick counts. That's fetal surveillance. They
11 did serial ultrasounds. That's fetal -- that's part of
12 fetal surveillance.

13 Q And the other two tests for fetal surveillance are
14 non-stress test and biophysical profile.

15 A And CST.

16 Q CST.

17 A Yes.

18 MR. JORDAN - Thank you, Doctor. That's all I
19 have at this time.

20 THE COURT - Re-Direct.

21 MR. WILLIFORD - Yes, Your Honor.

22 RE-DIRECT EXAMINATION

23 BY MR. WILLIFORD -

24 Q Doctor, if -- I'm saying if -- the baby had asphyxia,
25 what caused the asphyxia in this case?

1 THE COURT - Understand.

2 MR. WILLIFORD - Other than that -

3 THE COURT - Four, five and nine I'm still
4 considering, but I believe those or some variation of those
5 -- I'll let you know. Have not yet made the decision on
6 those, but I understand your objection. Okay? All right,
7 so verdict form. Y'all want to suggest some suggestions to
8 it on behalf of the plaintiff?

9 MR. BOYD - Yes, sir, Your Honor. Your Honor, as
10 far as the first set, number one, we believe the jury
11 should be given a choice of -- or a finding against each
12 defendant. There's basically three defendants, Dr. Hilton,
13 Dr. Benson and the practice, and I think -- I mean
14 certainly the jury in looking at the case could find that
15 Dr. Hilton didn't depart from the standard of care but Dr.
16 Benson did or vice versa or that neither of them did and
17 the practice did through Dr. Miller or through some other
18 agents or servants of the practice.

19 THE COURT - Defense object to that?

20 MR. DAVIS - No, I -- I understand his point. The
21 only thing I would suggest as an amendment to that would be
22 adding the words where you have, do you find that, I would
23 say, any of the defendants. I think that would take care
24 of his suggestion.

1 THE COURT - Rather than specifically pointing to
2 a particular ---

3 MR. DAVIS - It doesn't matter.

4 THE COURT - --- person or entity.

5 MR. DAVIS - It really wouldn't matter.

6 THE COURT - So do you have an objection to that
7 where it would be, do you find that any of the named
8 defendants, any of the named defendants negligently
9 departed from the standard of care in treating the
10 plaintiff, and then -- and that this negligence departed
11 from the standard of care and proximately caused the
12 plaintiff's injuries?

13 MR. BOYD - Your Honor, I still think because of
14 the way the jury may deliberate, that each needs to be
15 named.

16 THE COURT - So you want a separate question for
17 each defendant?

18 MR. BOYD - Or - yes, sir. Yes, sir.

19 THE COURT - So, so do you find that the
20 defendant, Ansley L. Hilton, M.D. negligently departed from
21 the standard of care; do you find that -- and then the
22 separate -- you know, yes, no, then a separate question, do
23 you find that the defendant, Christopher B. Benson, M.D.
24 negligently departed from the standard of care; do you find
25 that the defendant, Rock Hill Gynecological and Obstetrical

1 Associates negligently departed from the standard of care?
2 You want -- you want that separate question for all three
3 of them.

4 MR. BOYD - (Indicating yes)

5 THE COURT - All right, and if they answer -- then
6 would say, if you answer yes to any of the above, then you
7 would go on to question two.

8 MR. BOYD - That's correct.

9 THE COURT - All right, now -- and if you answer
10 no to all three of them, then you stop and you deliberate
11 no further and that's the end of the case.

12 MR. BOYD - That's correct.

13 MR. DAVIS - I object on the complexity grounds.
14 It sounds more like the 1040 long form, and I would
15 respectfully suggest that we could have this resolved by
16 having question one, do you find that any of the named
17 defendants, and everything else the same, and then yes, if
18 yes, go to question two, and therein question two could be,
19 which of the following named defendants do you find was
20 negligent and then check, Dr. Benson, Dr. Hilton, Rock Hill
21 Gyn-Ob. Isn't that more simple?

22 THE COURT - I -- I don't know.

23 MR. DAVIS - I think it is.

24 THE COURT - I appreciate that. I appreciate
25 that. I think what's more simple is that if you find that

1 any of the named defendants negligently departed and don't
2 separate them out, but if we're going to separate them out,
3 what I'm going to do then -- I'm going to separate them out
4 and I'm just going to have, basically, question one, for
5 each one of the named defendants, Dr. Hilton, Dr. Benson
6 and Rock Hill Gynecological and Obstetrical Associates, and
7 then down below it says, if you've answered yes to any of
8 the named defendants you go on to question two, if not, you
9 stop and you don't deliberate anymore and that's the end of
10 the case. All right?

11 MR. DAVIS - That's fine.

12 THE COURT - So that's what I'm going to do.

13 MR. DAVIS - Okay. Sounds good.

14 THE COURT - All right, before we give it to the
15 jury then, we'll reformulate that and I'll give it to you
16 one more time for y'all to look at just so that we make
17 sure we've spelled everything correctly and y'all have any
18 further objections to it. All right?

19 MR. DAVIS - Thank you.

20 THE COURT - All right, with that anything else
21 that we need to cover from the plaintiff's perspective at
22 this point in time?

23 MR. BOYD - No, sir.

24 THE COURT - All right, from the defense?

25 MR. DAVIS - No, sir.

1 facts and circumstances of the case. All right, we'll use
2 that one. And number nine I'm not going to use. I believe
3 it's duplicative and will not use number nine. All right.
4 Ask the jury to come in, please, sir.

5 (Jury enters the courtroom)

6 THE COURT - All right, sir, if you want to call
7 your witness, please, sir.

8 MR. DAVIS - Your Honor, we'd like to call Dr.
9 Roger Newman.

10 THE COURT - All right, come around and be sworn.
11 If you would meet the clerk right here at the corner first.

12 DR. ROGER NEWMAN, AFTER BEING FIRST DULY SWORN,
13 TESTIFIES AS FOLLOWS -

14 THE COURT - State your full name for the record,
15 please, sir.

16 DR. NEWMAN - Roger Bemar Newman. B-e-m-a-r N-e-
17 w-m-a-n.

18 DIRECT EXAMINATION

19 BY MR. DAVIS -

20 Q Dr. Newman, are you a medical doctor?

21 A Yes, sir.

22 Q Tell the jury a bit about your educational background
23 and experience and training to become a physician and your
24 specialties in which you practice, sir?

1 A I went to Spring Valley High School in Columbia. From
2 there I went to Seton Hall University in New Jersey for
3 undergraduate and then I came to the Medical University of
4 South Carolina and did medical school and my residency
5 training at the Medical University in Charleston, then went
6 to San Francisco for two years to do a fellowship in
7 maternal fetal medicine, and after completing that I came
8 back to Charleston, and I've been on the faculty at the
9 Medical University since 1986.

10 Q Dr. Newman, what is the subspecialty, if I'm saying
11 that correctly, of internal fetal medicine? What is that?

12 A It's one of the three subspecialties in obstetrics and
13 gynecology. Basically I focus my time on caring for high
14 risk obstetrical patients, maybe a high risk based on
15 either maternal medical conditions that make them high risk
16 or we also take care of women who are carrying pregnancies
17 that are complicated either because of fetal abnormalities
18 or because of complications like pre-term labor or
19 preeclampsia or growth restriction, things like that.

20 Q Doctor, are you ---

21 A I do very little gynecology.

22 Q Okay. Doctor, are you board certified in your
23 specialty?

24 A I am board certified and re-certified in both Ob-Gyn
25 and maternal fetal medicine.

1 Q What is the American Board of Obstetrics and
2 Gynecology? What is that?

3 A It's an organization -- I don't know exactly how
4 they're -- how they are created or what their official
5 recognition is, but it is a educational certification board
6 in obstetrics and gynecology that is responsible for the
7 oral -- the written and oral board examinations of Ob-Gyn
8 specialist.

9 Q On your CV it stays that you're a board examiner for
10 the American Board of Obstetrics and Gynecology. What's
11 that about?

12 A To become -- to become certified in obstetrics and
13 gynecology or in the subspecialties, following your
14 training, you have to take a written examination and then
15 once you've passed the written examination after practicing
16 usually for about two years, you have to go to Dallas,
17 Texas -- and I was just there Monday, Tuesday, just got
18 back last night -- you go to Dallas, Texas and you have an
19 oral examination where you basically sit down with some
20 examiners and you're asked a series of structured questions
21 and they present a case list of their cases over the
22 previous year, and you review their case list and they have
23 to pass the oral examination in order to be completely
24 certified as a -- either a Ob-Gyn -- board certified Ob-Gyn

1 or as a board certified maternal fetal medicine specialist
2 or a Gyn oncologist or reproductive infertility specialist.

3 Q And you're one of the guys that examines them.

4 A I did the general examination probably for about 10
5 years, and then I've been doing the maternal fetal medicine
6 examinations for the last seven years.

7 Q Have you had the occasion to publish articles either
8 in textbooks or in peer review journal articles within your
9 specialty, sir?

10 A Yes, sir.

11 Q I'm not going to count them. Hundreds?

12 A Over a hundred peer reviewed articles, about 20
13 different book chapters, and I co-authored with another
14 woman one book on the care of multiple gestations.

15 Q Dr. Newman, are you familiar then with the standard of
16 care in obstetrics?

17 A Yes, sir.

18 Q Dr. Newman, have you had occasion to review cases in
19 the past other than this one as a potential expert witness?

20 A Yes, sir.

21 Q In this particular case can you tell the jury what
22 you've had the occasion to review that helps to form the
23 basis of your opinion in addition to your training,
24 knowledge and experience?

25 A In this case?

1 Q Yes, sir. As a witness.

2 A Pardon me?

3 Q Did you review medical records?

4 A Yes, I've been provided with what I believe are
5 comprehensive set of medical records involving this case as
6 well as multiple depositions.

7 Q Would that include the medical records from the office
8 of Rock Hill Gyn-Ob for Samantha Jamison?

9 A Yes, sir.

10 Q Do they include the hospital records from Piedmont
11 Hospital for a brief admission on August 9 as well as
12 admission on September 5, which is more the subject of this
13 litigation?

14 A Yes, sir.

15 Q Did it include the depositions of Dr. Hilton, Dr.
16 Benson?

17 A Yes, sir.

18 Q Wendy Knox, Jane McCain?

19 A Yes, sir.

20 Q Dr. Karotkin, Dr. Phillips?

21 A Yes, sir.

22 Q Samantha Jamison?

23 A Yes, sir.

24 Q Her family?

25 A Yes, sir.

- 1 Q Mom?
- 2 A Yes, sir.
- 3 Q Dr. Newman, you've had the occasion to review medical
4 malpractice cases for me or my firm in the past. Correct?
- 5 A Yes, sir.
- 6 Q About how many?
- 7 A Two I believe.
- 8 Q Okay. Have you ever told me that a case that I sent
9 to you to review you could not defend because you felt like
10 the doctor was negligent?
- 11 A Yes, sir.
- 12 Q Do you also review cases for other attorneys and other
13 law firms in South Carolina?
- 14 A I have.
- 15 Q Have you ever reviewed a case for a plaintiff, a
16 patient like Ms. Jamison in a medical malpractice case?
- 17 A I have.
- 18 Q Have you ever testified under oath that in your
19 opinion a doctor fell below the standard of care in your
20 opinion?
- 21 A Would that -- would a deposition be considered?
- 22 Q That's under oath.
- 23 A Yes, I have.

1 Q The time that you charge includes a \$350 an hour fee
2 for your review of this case, \$400 an hour fee for your
3 deposition in trial today. Correct?

4 A Yes, sir.

5 Q And you got up this morning and drove here from
6 Charleston?

7 A Yes, sir.

8 Q Okay. Do you know Dr. Joe Robinson, one of the
9 partners of Rock Hill Gyn-Ob?

10 A Yes, sir.

11 Q Where did you know Dr. Robinson from?

12 A When I was -- started my residency at the Medical
13 University in Ob-Gyn as a first year resident, Dr. Robinson
14 was a fourth year resident, so our residency training
15 overlapped by one year. He also happened to live in the
16 neighborhood where I lived.

17 Q Consider him a good friend?

18 A I do.

19 Q Do you see him very often?

20 A No.

21 Q Do you know Dr. Greg Miller?

22 A No, sir.

23 Q Do you know Dr. Chris Benson?

24 A No, sir.

25 Q Do you know Dr. Ansley Hilton?

1 A No, sir.

2 Q Ever met them?

3 A I might have met them at a South Carolina State Ob-Gyn
4 meeting or some other meeting just to say hello, but other
5 than that I don't know them.

6 Q Okay. Is the fact that you know Dr. Robinson, a
7 partner in this group, some 29 or 30 years ago while y'all
8 were training together have, in your opinion, any influence
9 on any of the opinions that you render or will render in
10 this case?

11 A No, sir.

12 Q When was the last time you delivered a baby?

13 A Well, as I said, I was out on Monday, Tuesday and
14 Wednesday, but I was on-call last Thursday, so it was
15 either Thursday night or early Friday morning.

16 Q At the Medical University of South Carolina what role
17 do you have as far as teaching? Who do you teach? Who are
18 your students?

19 A Really three different levels of students. We have
20 the medical students who rotate through on their Ob-Gyn
21 rotation, and we teach them on a daily basis, and we also
22 have our residents and we work with them and interact with
23 them also on a daily basis. And then we also have -- we
24 have what's referred to as a fellowship program, so that's

1 in maternal fetal medicine, so we have one fellow at each
2 year that we also work with and teach.

3 MR. DAVIS - Your Honor, at this time ---

4 Q Well, let me ask you this first. Does this appear to
5 be a copy of your current CV?

6 A Yes, sir.

7 Q All right.

8 MR. DAVIS - Your Honor, I'd ask this be marked
9 and introduced into evidence.

10 THE COURT - Any objection?

11 MR. JORDAN - No, Your Honor.

12 (Document marked into evidence as Defendant's
13 Exhibit 6.)

14 MR. DAVIS - Your Honor, introducing into evidence
15 a curriculum vitae of Dr. Roger Newman as Defendant's
16 Exhibit Number 6.

17 THE COURT - All right, it's in evidence without
18 objection.

19 MR. DAVIS - Your Honor, just a parenthetical
20 housekeeping, I failed to introduce into evidence
21 Defendant's Exhibit 5 which is -- which is just simply the
22 video-tape -- original video-tape of Michelle Sharpe. It's
23 been marked.

24 THE COURT - Any objection to that?

25 MR. BOYD - No objection.

1 THE COURT - It's in evidence without objection.

2 MR. DAVIS - Thank you, sir.

3 (Video-tape is marked into evidence as
4 Defendant's Exhibit Number 5.)

5 MR. DAVIS - Your Honor, at this time I'd offer
6 Dr. Newman as an expert in the area of obstetrics and
7 gynecology, specifically obstetrics and maternal fetal
8 medicine.

9 THE COURT - Do you wish to voir dire the witness
10 as to his qualifications or challenge the offer by the
11 defense?

12 MR. JORDAN - No, Your Honor.

13 THE COURT - All right, sir, he's qualified to
14 give his opinion. You may proceed.

15 Q Dr. Newman, I'm going to ask you a series of questions
16 about your opinions in this case, and I'm also going to ask
17 you the basis -- or the basis of those opinions. In that
18 regard if I could -- if we could have this agreement ahead
19 of time, any opinions that you are going to render to this
20 jury in this case today, would you agree that they will be
21 within a reasonable degree of medical certainty unless you
22 tell me otherwise?

23 A Yes, sir.

24 Q All right, sir. Dr. Newman, what are your opinions
25 regarding the care provided by Dr. Greg Miller, Dr. Ansley

1 Hilton and Dr. Chris Benson of Samantha Jamison throughout
2 the chart of their care and including and through the last
3 time she was seen in the office weeks after this day?

4 A I found nothing in the review of the medical records
5 or from reading the depositions that led me to believe that
6 anything they did fell below the standard of care.

7 Q Doctor, have you ever had occasion in the past to
8 review a medical malpractice case where you did feel that a
9 doctor should've acted more aggressively to prevent the
10 injury or death of an unborn child?

11 A Yes, sir.

12 Q I want to first ask you just very briefly about what
13 I'm going to call the due date issue in this case. Do you
14 have an opinion, sir, whether this -- there was an attempt
15 to establish in an appropriate manner an appropriate due
16 date for Ms. Jamison?

17 A Yes, sir, there at her initial presentation or initial
18 ultrasound, which I believe was in July, that ultrasound
19 differed from her last menstrual period dating by a month.
20 And in the mid-gestation of pregnancy, that's too much of a
21 discrepancy to accept in ultrasound measurements. So it
22 would standard of care to re-date -- to assume that the
23 menstrual dating criteria are mistaken and to re-date the
24 pregnancy based on the composite of the ultrasound
25 measurements, and those ultrasound measurements placed her

1 at about 34 and a half -- excuse me -- 24 and a half weeks,
2 maybe 24 and five days and dated her pregnancy as being
3 due, I believe November 1st as opposed to October 1st.

4 Q I want to now move to the hospitalization of August 9,
5 2008 where Dr. Miller was -- I'll ask you to assume for the
6 sake of the question was the labor and delivery -- excuse
7 me -- was the Ob-Gyn on call in-house, 24 hour in-house on
8 call at the hospital labor and delivery when Ms. Jamison
9 came through either the emergency room or the hospital or
10 the emergency triage area of the labor and delivery, either
11 way, and was subsequently admitted and evaluated. You've
12 seen those records.

13 A Yes, sir.

14 Q Was the admission for abdominal pain and the
15 evaluation that followed appropriate?

16 A It was reasonable and appropriate.

17 Q Did you have occasion to review -- and I've got the
18 originals here from the hospital -- the fetal monitor
19 strips during the time she was being monitored?

20 A Yes, sir.

21 Q Anything there on those strips that caused you any
22 concern for the fetal well-being, sir?)

23 A No, I thought those fetal heart rate tracings were
24 reassuring and would not raise any suspicion or concern.

1 Q You knew that this lady was -- came to the practice
2 with a history of hypertension.

3 A Yes, sir.

4 Q Do you have an opinion whether or not that and any
5 other factor, prior uterine rupture for example, anything
6 else put her in a category of a high risk pregnancy?

7 A She would've been considered a high risk pregnancy.

8 Q Were there efforts to control and manage her blood
9 pressure?

10 A Yes, sir. I believe she was -- she was on an anti-
11 hypertensive and for the records I saw it looked like it
12 was successful. And I would add it was an appropriate
13 anti-hypertensive for use in pregnancy as well. Aldomet is
14 most commonly used in a hypertensive in pregnancy.

15 Q So if the jury sees in evidence from the hospital
16 records an order by Dr. Miller on August 9th for Aldomet,
17 was that appropriate?

18 A Yes.

19 Q Okay. I want to move to the office visit of August 25
20 where Dr. Miller saw her and I want to put the original in
21 your hand. I know you've seen a copy. (Pause) Dr.
22 Newman, this has been marked Joint Exhibit Number 2. It's
23 original record from the office of Rock Hill Gyn-Ob and
24 includes flow sheet and handing the flow sheet as it may
25 have information we need to talk about, and I'll hand you

1 the office note, particularly of August 25 -- as soon as I
2 can find it. (Pause) Sorry, Doc. Here we go. I know
3 you've seen that before, but let me ask you some questions
4 about it. Let me also hand this to you while we're talking
5 about August 25. This is my copy of what's already in
6 evidence, the ultrasound, photographs and adjoining
7 reports. All this is in evidence. If you need to look at
8 that at any point, please feel free to do so. I will ask
9 you questions about it. Dr. Newman, on August 25 when Dr.
10 Miller saw her, what was the -- was that a regular
11 scheduled visit?

12 A I believe -- I could be wrong, but I believe it was.

13 Q All right. And what is your understanding as per Dr.
14 Miller's note, what was going on with the patient at that
15 time?

16 A Her complaint had to do with swelling of her ankle.
17 There was also an ultrasound that day. I think that
18 ultrasound was a scheduled anticipated evaluation, so in
19 terms of what the -- what was known that day in terms of
20 complaint, I think it was the concern of her ankle
21 swelling.

22 Q Okay. Was it one ankle or two?

23 A It was left ankle.

24 Q Is that a result -- do you have an opinion of whether
25 or not that was a result of high blood pressure?

1 A I don't think so because of it being unilateral
2 instead of bilateral and Dr. ---

3 Q What does unilateral mean?

4 A It just involved one side.

5 Q Okay.

6 A And, Doctor -- that was the same as Dr. Miller's
7 impression.

8 Q All right. Was there any notation on Dr. Miller's
9 detailed note of any decreased fetal movement on August 25?

10 A There is no mention of that.

11 Q But he -- but he plans and instructs the patient
12 apparently from his note about doing kick counts. Why?

13 A My assumption would be that it was because -- either
14 because it's routine. I instruct all my patients to do
15 fetal kick counts, low risk or high risk, or more possibly
16 it was because of her being a high risk pregnancy with
17 history of hypertension.

18 Q About what was her gestational age -- the baby's
19 gestational age on August 25th? Can you discern that from
20 the record?

21 A August 25th -- was probably about 30 weeks, 29 to 30
22 weeks I'm thinking.

23 Q Doctor, does the standard of care in your opinion
24 require weekly fetal monitoring, fetal surveillance of a

1 high risk patient like Ms. Jamison at 30 weeks and then
2 every week thereafter?

3 A For a patient with chronic hypertension the standard
4 of care would recommend -- would designate that patient
5 should have non-stress testing started probably somewhere
6 between 32 and 34 weeks unless there was some other acute -
7 - acute indication to start it -- to start evaluation
8 sooner which didn't exist in this case.

9 Q Doctor Miller -- what tests, if any, did Dr. Miller
10 order or do or have performed on August 25?

11 A He performed an ultrasound.

12 Q Okay. You've got a copy of the report and photographs
13 in front of you. They're in evidence.

14 A Yes, let me just turn to the ---

15 Q Yes, sir.

16 A He did an ultrasound evaluation of the baby to look at
17 the fetal weight and evaluate fetal growth. He did -- as
18 part of that there's an evaluation of the amniotic fluid
19 volume, and he also did umbilical artery doppler studies to
20 evaluate to the adequacy of the uteroplacental circulation.

21 Q Were those tests appropriate at that time?

22 A Those would be what you would expect, yes.

23 Q Did they show any abnormalities?

24 A No, they really don't. The growth was appropriate for
25 gestational age. The AFI of nine is within the normal

1 range. Normal range for AFI is somewhere between five and
2 25 centimeters of measured fluid, measuring -- adding up
3 each of four quadrants that you look at on the uterus. So
4 a AFI of nine would be considered normal. Someone might
5 want to call that low normal. Dr. Miller, did you say?

6 Q Yes, sir.

7 A Dr. Miller considered it low normal, but it's actually
8 normal, and the doppler studies were also normal.

9 Q Did the standard of care indicate or require in your
10 opinion on August 25 that Dr. Miller order and have
11 performed a non-stress test that day?

12 A No, there was no indication to start non-stress
13 testing with normal growth and normal dopplers and normal
14 amniotic fluid. The appropriate or what I would do and
15 what I think would be the appropriate management would
16 simply be schedule follow-up ultrasound and anticipating
17 starting non-stress test as I said somewhere between 32 and
18 34 weeks.

19 Q Did the standard of care indicate or require in your
20 opinion, Dr. Newman, for Dr. Miller or anybody else in the
21 practice to have her come back a week after August 25 and
22 have a non-stress test and a biophysical profile performed,
23 sir?

24 A No.

25 Q Why not? Why not?

1 A Well, first of all it'd be too soon to repeat another
2 ultrasound.

3 Q Why? Why too soon?

4 A Well, I actually -- let me rephrase that.

5 Q Okay.

6 A It's -- it would be too soon to reassess growth.
7 Usually need at least two weeks. Most people prefer three
8 weeks as an interval period of time to be able to tell if a
9 baby's truly growing or demonstrating an absence of growth.
10 In terms of following up the amniotic fluid volume,
11 following up the doppler studies with them having been
12 normal on the 25th of August, there would be no indication
13 to follow those up again in anything sooner than at least
14 probably two weeks. It would've not been unreasonable to
15 decide you're not going to do any of those tests again for
16 four weeks. So somewhere between two and four weeks you
17 could follow those tests up. Anything earlier than that
18 would've not been indicated.

19 Q What about the notation about some possible -- I think
20 Dr. Miller documents it in his note as a possible lag in
21 abdominal circumference on the ultrasound. What about
22 that?

23 A Of the measurements that were done on the 25th, the
24 abdominal circumference measurements are the smallest of
25 all of the different measurements they do which are the

1 composite of the ultrasound measurements. Some people feel
2 that the abdominal circumference is the first -- one of the
3 first things to change in a baby that is developing growth
4 restriction. So he was probably looking at that and just
5 noting the concern that the abdominal circumference was the
6 smallest of all their composite measurements and basically
7 emphasizing the need to follow up this baby's growth at
8 some point in the future, but that single measurement in
9 and of itself was not an indication in the -- together with
10 the other information that he has from this ultrasound
11 which is that overall the growth is adequate, that the
12 fluid's adequate, that the doppler studies are adequate.
13 That one measurement in and of itself is not an indication
14 to do anything different other than to plan to follow up
15 these tests at a later gestational age.

16 Q And any time as you reviewed all these records -- the
17 next thing we're going to talk about is obviously September
18 5 -- will go in some detail here -- but, Doctor, as a
19 result of your review of all the records in this case, did
20 you form an opinion within a reasonable degree of medical
21 certainty whether or not this child, this fetus, had IUGR,
22 intrauterine growth restriction?

23 A None of the three ultrasounds that she had did the
24 fetus measure less than the 10th percentile for the
25 gestational age at which that ultrasound was done.

1 Q So what does that mean? Is that a yes or no?

2 A It means -- I'm sorry -- means that the baby did not
3 have intrauterine growth restriction.

4 Q All right. What about -- and I never can pronounce
5 this. I'm going to call it oligo. You know the whole long
6 rest of that word.

7 A Oligohydramnios.

8 Q I knew you did. What does -- what is that, and did
9 this baby ever have it, ever?

10 A Oligohydramnios just simply means low fluid. The
11 assessment of fluid on ultrasound is subjective to some
12 degree, but in an effort to make it objective there are two
13 techniques used to define oligohydramnios. One is called
14 the amniotic fluid index or AFI, and that's where you kind
15 of divide the uterus up into four quadrants, upper and left
16 right -- right and left upper and right and left lower, and
17 you put the transducer ultrasound in that quadrant and
18 measure the depth of the deepest pocket, and then you add
19 the four together, and that measurement should be between
20 five and 25. Anything less than five would be considered
21 oligohydramnios. A simpler, and some people prefer,
22 although not everyone, is a simple measurement of what's
23 called the deepest vertical pocket, which means you just
24 look for the one pocket of amniotic fluid that looks the
25 largest or deepest, and as long as that pocket is more than

1 two by two centimeters, then that's considered -- if it's
2 more than it's normal; if it's less than that it's
3 oligohydramnios. At no point in time did she have
4 oligohydramnios. The two AFIs that I saw were nine and 14,
5 which are both within the normal range, and the biophysical
6 profile that she had on the 9th which was the day of her
7 admission to the hospital, she received two points for the
8 fluid volume, which means she had a least a two by two
9 centimeter pocket then.

10 Q You said the 9th. You meant September 5?

11 A I'm sorry, yes. September 5.

12 Q Nine five.

13 A Nine five.

14 Q Okay. Thank you, sir. Let's look at -- at the moment
15 at some of the issues on September 5, 2008 in the office
16 and then we'll get to the hospital right after that.

17 Assuming that Ms. Jamison came in as a walk-in that morning
18 and signed in at 8:40 a.m., and I'll refer to Defendant's
19 Exhibit Number 5, which is a multi-page sign-in sheet. She
20 signs in at the top of the second page. Do you see that?

21 A (No response)

22 Q Assuming she signs in at 8:40 a.m. with a single
23 complaint of decreased fetal movement. Based on that
24 alone, do you have an opinion whether that constitute an
25 obstetrical emergency?

1 A It's a -- that in and of itself is not an emergency,
2 but it is a -- it is a complaint that needs evaluation.

3 Q Well, she wasn't evaluated or begun to be seen for
4 about an hour and 20 minutes, from 8:40 til an hour --
5 let's call it an hour and 15, an hour and 20 minutes later,
6 do you have an opinion in the circumstances of her
7 situation, not knowing what's going to happen hours later,
8 but with a complaint with her history of decreased fetal
9 movement, walk-in, signed in at 8:40 in the morning, the
10 19th or 20th person to sign in the office that day, she's
11 seen an hour and 20 minutes later by a nurse practitioner
12 in the office for further evaluation, do you have an
13 opinion whether that was a timely being seen or untimely
14 being seen, negligent or within the standard of care?

15 A Well, there's a lot of pieces to that question.

16 Q There are. Want me to blow it down for you?

17 A No. I mean obviously we all have the abil -- you
18 know, -- well, it seems like a long time certainly. Nobody
19 likes sitting in the doctor's office; however, it was not
20 in my opinion untimely, nor did I feel like it was -- nor
21 it is negligent, nor is it a deviation from the standard of
22 care. As a unscheduled patient who shows up at 8:40 in the
23 morning, she has to be checked in through the office; she
24 has to be administratively checked in; I don't know how
25 smoothly that goes or what's involved, but that's going to

1 take a little bit of time. She then has to be seen by a
2 provider. The front desk clerk isn't going to make a plan
3 of action for the patient. She's going to need to be seen
4 by a provider. In this case it was a nurse practitioner.
5 That nurse practitioner has a docket or a schedule of
6 patients that she's seeing, so she has to finish or find a
7 break in time between the patients that she's seeing at
8 that point in time in order to see Ms. Jamison and then she
9 has to evaluate Ms. Jamison, find out what her complaint
10 is, what the nature of the decreased fetal movement, how
11 long, how much decreased fetal movement, any other signs or
12 symptoms, so she has to do an evaluation of Ms. Jamison and
13 then formulate a plan, and that plan is to -- and the
14 appropriate plan is to, let's evaluate fetal well-being by
15 doing a non-stress test. Again, this is something that we
16 do in our office every day. That patient, Ms. Jamison,
17 then has to be -- have that non-stress test performed. Our
18 office we have two non-stress test machines. I don't know
19 how many they have in Dr. Hilton's office, but those
20 machines are being used, and every patient that's getting a
21 non-stress test is a high risk patient. You don't do them
22 on low risk patients, so one of those machines have to
23 become available, and I wasn't there; none of us were
24 there; we don't know what was being done or -- but I'm sure
25 if they had two empty non-stress test or even one empty

1 non-stress test machines and beds to do a non-stress test,
2 I doubt that Ms. Jamison was sitting in the hallway while
3 the machine was not being used. So I'm sure that there was
4 a patient who was on the machine; they had to complete her
5 test, be taken off the machine. That test has to be
6 evaluated and cleared by a doctor, and then the patient has
7 to be taken off that machine before Ms. Jamison can then
8 move into that space or move into that room to have her
9 non-stress test done, so am I surprised that it might take
10 somebody an hour and a half to move from the front desk to
11 actually begin put on a machine for this complaint? No,
12 I'm really not. I wish it were quicker. Even if it had
13 been quicker, I don't think that the find -- the delay in
14 getting the non-stress test was done had any impact on the
15 outcome of the case or what happened, because the non-
16 stress test, while have it being suspicious and having some
17 concerning features that require Dr. Hilton to then order
18 the -- excuse me -- the biophysical profile was not an
19 ominous non-stress test in and of itself.

20 Q And you've look at that strip?

21 A I have.

22 Q Thirty-four minutes long, thirty -- thirty-four
23 minutes long, running some time between 9:50 and 10:20 or
24 10:00 o'clock and 10:30, 10:34..

25 A Yes, sir.

1 Q All right. I want you to assume for the sake -- well,
2 it's not an assumption; you've got the records; you've got
3 the films right in front of you. She was put on the
4 biophysical profile by 10:48 a.m. You understand that from
5 the records.

6 A Yes, sir.

7 Q What do you understand happened after that biophysical
8 profile began? What -- from the records and depositions,
9 things you've looked at in this case, tell the jury what
10 you understood took place -- happened?

11 A My understanding from the records are that at the
12 completion of the non-stress test, the nurse practitioner
13 took -- she thought that a biophysical profile was needed,
14 had taken the non-stress test to Dr. Hilton who agreed and
15 they moved her from the non-stress test room to the
16 ultrasound room where the ultrasound technician began doing
17 the biophysical profile. At some point after that testing
18 began, Dr. Hilton came into the ultrasound room and watched
19 over the technician's shoulder while she was doing the
20 biophysical profile. She and I assume probably the
21 technician were both concerned by the fact that the
22 biophysical profile -- that the baby was only scoring a
23 two, which means the baby was not moving, was not breathing
24 and -- don't want -- that sounds wrong or it doesn't sound
25 good. Babies go through the activity of breathing.

1 They're basically breathing amniotic fluid in and out; they
2 don't do it all the time. It's kind of a practicing thing,
3 but it is something they do when they're awake and alert.
4 They don't do it when they're sleeping, and they don't do
5 it when they're unconscious. So they did not see
6 breathing; they did not see movement, and they were
7 concerned about the body tone of the baby. What you look
8 for on a biophysical profile is active flexion and
9 extension, clenching of the fists, releasing of the hands,
10 flexion, extension of the arm; they did not see normal body
11 tone. So Dr. Hilton, knowing that the patient's complaint
12 had been decrease -- knowing that she was a high risk
13 patient, probably influenced by the fact that she had had a
14 prior uterine rupture, which is, you know, very -- a
15 concerning history, knowing that she had decreased fetal
16 movement and having seen the non-stress test that had some
17 suspicious areas on it, after seeing approximately about 10
18 minutes of the ultrasound decided that the patient should
19 go to labor and delivery for continuing evaluation because
20 of the possibility of needing a cesarean section.

21 Q At the conclusion of the non-stress test, which
22 believe me we've been over that a lot with other witnesses
23 -- again, be glad for you to do that, but it's - you've
24 seen it ---

25 A Yes, sir.

1 Q --- on that day. Based on that ---

2 A I'm sorry. Did you say non-stress test or
3 biophysical?

4 Q Non-stress test.

5 A Okay.

6 Q Based on that non-stress test done that day, 30, 34
7 minute run, looked at it, we've talked about it -- do you
8 have an opinion whether or not at the end of that NST based
9 on what you see on those strips, whether that constitutes
10 an obstetric emergency for Ms. Jamison with her high risk,
11 with her complaint of decreased fetal movement?

12 A The non-stress test did not represent -- or to my --
13 in my opinion constitute a fetal emergen -- an emergency.
14 Non-stress test can be interpreted in one of three ways.
15 The vast majority are what are referred to as category one
16 strips, which basically everything about the strip is
17 reassuring. The positive predictive value of that is 99.9
18 percent that the baby's fine. There are category three
19 strips. Category three strips are what would be referred
20 to as an ominous strip. There are specific features that
21 you look for, but required of almost all category three
22 strips is the absence of any fetal heart rate variability,
23 and those are the little up or down squiggles that you see
24 in the heart rate. That's the baby changing its heart rate
25 from moment to moment, and it's under central nervous

1 central control. Babies that are unconscious and are
2 asphyxiated lose that and the heart rate is flat. And
3 accompanying those flat heart rate are some sort of
4 decelerations. They could be repetitive late
5 decelerations; they could be repetitive variable
6 decelerations, which represent cord compression. Late
7 decelerations usually represent a response to contrac -- an
8 adverse response to uterine contractions, but those would
9 be an -- that would be an ominous strip and that would --
10 whether you'd want to call it an urgency or emergency, that
11 requires prompt evaluation, because that baby could
12 potentially be in trouble. Not all of them are. Some of
13 them are asleep; some of them are very premature; some of
14 them are on a medication that makes them -- makes the strip
15 look like that, but some of those babies are sick and in
16 trouble. There is a group in the middle, which are
17 category two strips. Category two strips are basically
18 indeterminate strips. They have something on them that's
19 suspicious. In this case there were some decelerations
20 that were suspicious as being late decelerations, but at
21 the same time this strip had normal baseline heart rate and
22 had normal variability, so from my looking at that fetal
23 heart rate strip, I would be certain that this baby was not
24 asphyxiated. It was not unconscious; it was not acidotic,
25 and I would almost certainly (sic) that it would be moving

1 around, however, those late decelerations made it a
2 category two strip, which means it requires further
3 evaluation to figure out what's going on.

4 Q At the end of the biophysical profile do you have an
5 opinion whether at that point -- and she stopped at 10
6 minutes into, what a 20, 30 minute process?

7 A Biophysical profile should be 30 -- actually I've
8 heard people say 30, but I think the actual requirement for
9 a biophysical profile is 40 minutes.

10 Q All right. Dr. Hilton ---

11 A That's what the -- that's what the sleep cycle is with
12 babies.

13 Q Okay.

14 A Babies sleep about every 40 minutes.

15 Q Dr. Hilton ordered it stopped at 10 minutes and Jane
16 McCain punched the print button at 10:58. It's on the
17 records. Was that within the standard of care for her to
18 do that at that point in time with a two out of eight given
19 those strips, given her complaint, given the situation?

20 A I think it's certainly within the standard of care for
21 Dr. Hilton to decide that she's no longer comfortable with
22 the way this baby looks and how the mother's symptoms,
23 signs and evaluation is going in the office, and she wants
24 to have that patient moved to the labor and delivery unit
25 in case there's an emergent situation that requires the

1 baby to be delivered. So I think it's well -- I think -- I
2 don't think it's a deviation from the standard of care for
3 her to decide that I want to stop this NST -- excuse me --
4 stop this biophysical profile early; I don't like the way
5 it looks; I looked at the NST a little while ago; I wasn't
6 pleased with how that looked; I'm not pleased with the fact
7 that she's got a complaint of decreased fetal movement, and
8 I don't want her here in our office anymore; I want to move
9 her to labor and delivery, have her re-evaluated and if
10 this testing continues -- if we continue to see a two out
11 of 10 biophysical profile, she's going to need to be
12 delivered. I think that's within the standard of care.

13 Q Doctor, would it include in the standard of care a
14 requirement that she notify her partner at labor and
15 delivery, in this case, Dr. Benson, of her findings, her
16 thoughts, her suggestions and discuss with him a plan?

17 A I think the standard of care requires that any time
18 you send a patient to the hospital that you call ahead and
19 notify the hospital of who's coming and why they're coming
20 and what the plan that you've made for them is, so, yes, I
21 think that's within the standard of care for her to do
22 that.

23 Q In this case when she called the hospital, she spoke
24 with, I think -- I'll ask you to assume for the sake of the
25 question, a nurse on the labor and delivery floor and then

1 requested to speak with Dr. Benson and spoke with Dr.
2 Benson -- assume that for the sake of the question -- would
3 that be appropriate?

4 A Yes, sir.

5 Q Would it also be appropriate in your opinion, sir, for
6 Dr. Hilton to advise the patient in the ultrasound room --
7 they're there together -- I'd ask you to assume -- that she
8 needs to go to labor and delivery right away, go directly
9 to labor and delivery, would those kind of words to convey
10 that to the patient be within the standard of care?

11 A Yes, sir.

12 Q Does the standard of care require Dr. Hilton under
13 those circumstances, knowing everything that she knew,
14 could have known at that time, to tell the patient, this is
15 an emergency? Was that required by the standard of care in
16 your opinion?

17 A I don't think the standard of care has any requirement
18 that certain words be used at any given time. I think the
19 expectation would be that the patient be informed that
20 there's a serious situation going on that needs further
21 evaluation on labor and delivery and that we want you to go
22 over there immediately for continued fetal evaluation. And
23 whether you call that an urgency or emergency, what -- what
24 word you attach to it I don't think is a standard of care
25 issue. It's the action of notifying the patient, letting

1 them know that it's a serious situation and your advice as
2 her physician is for her to go immediately to labor and
3 delivery for further continued fetal evaluation, but I'd
4 never say that a standard of care was violated because one
5 word was used and not another.

6 Q You had looked prior today I know at the films from
7 that biophysical profile and I want to ask you one question
8 about that. You can anything about them you wish and they
9 were before you, both the written report and the films.
10 There's an issue on the reports about a decrease in the
11 abdominal circumference growth lagging even more-so than
12 the July -- excuse me -- August 25 ultrasound. You know
13 that.

14 A I saw that, yes, sir.

15 Q Do you have an opinion, sir, as you look at those
16 films to make comment about the documented lag in abdominal
17 circumference?

18 A Well, I'd note a couple things about that. First of
19 all, and I'm sure the abdominal circumference was lagging,
20 because it had been lagging on all of her previous
21 ultrasounds as well. I do believe that in that particular
22 ultrasound, that looking at the images I think that
23 ultrasound was under-measured; I think the abdominal
24 circumference is probably better than what was measured.
25 It's not a great abdominal -- it's not a great image of the

1 abdominal circumference and when you look at the little
2 dots that are used to outline the abdominal circumference,
3 they don't go completely around the abdominal
4 circumference, so I think it probably underestimates what
5 the abdominal circumference really was, but I think the
6 more important thing about that growth evaluation is to
7 look at all the other measurements of the baby which
8 actually showed good growth from her previous ultrasound to
9 the ultrasound of September 5th. And, again, the estimated
10 fetal weight even given an under-measured abdominal
11 circumference still fell within the normal range, so even
12 as of September 5th, they weren't -- the diagnosis of fetal
13 growth restriction still hadn't been made and there was
14 normal amniotic fluid.

15 Q You mentioned something about that abdominal
16 circumference and I would just like to very briefly put
17 this -- on this overhead -- if I could ask you to please
18 step down. I'm going to bring all the 9/5/08 films that we
19 have and these are copies of what's in evidence. Would you
20 please down quickly, sir. I'm going to hand these back to
21 you since I don't really know what I'm looking at. Would
22 you find a film or the film or films that you were
23 referencing.

24 A Well, to be honest with you, I don't think this
25 probably projects very well, but this here is the -- is a

1 cross section of the baby's abdomen, and I think you can
2 see that there's -- where there's a loss -- there's a loss
3 of the image here. You can't really see the borders of the
4 abdomen like you can, you know, the rest of the way around
5 here, so I think this image didn't really show for whatever
6 reason this part of the abdominal measurement; the
7 abdominal wall here doesn't get imaged very well, and there
8 might be a little bit of concern back here not so much.
9 And the other thing is, as opposed to the other fetal
10 measurements where there's always bones to follow, humerus,
11 femur length, head circumference, all those things, you can
12 just put the little dots, the cursor dots and you can
13 follow a bone. There is no bone of the abdominal
14 circumference, so you're measuring soft tissue, so that the
15 standard for measuring abdominal circumference is that
16 these cursors are supposed to be outside the width of the
17 abdomen. So for instance in this area here, that's
18 probably liver, this right here, and that -- these dots
19 that represent the measurement cursors should be out here,
20 because this is the actual end of abdominal fat of the
21 baby, so the baby's being under-measured really through
22 here, probably being under-measured up here, a little bit
23 here. You can't say here, because you don't see the
24 abdominal wall very well. It looks like down here the
25 measurements are probably a little bit closer to the edge,

1 but I think that's the edge of the fetal skin here. I
2 think that's the edge of fetal skin. So again these
3 measurements probably should've all been pushed out a
4 little bit more. So in actuality -- and I think at this
5 point in time she's 31, about 31 and a half weeks. The
6 biparietal diameter which is ear to ear is measuring 31 and
7 two; the head circumference is 31 and two; the femur length
8 is 31 and four, so those are all right on target and all
9 have increased appropriately from the last ultrasound. The
10 abdominal circumference with the AC is measuring 26 and
11 four. Now, just -- from experience I can tell you if you
12 move these cursors and move it out a little bit, this
13 difference might -- might make a week, maybe a week and a
14 half. I'm just -- I'm guessing. It isn't going to make
15 this measurement 31 weeks, but I think the gestational age
16 measurement would've been better than 26 and four weeks and
17 probably would've still been consistent with the lagging
18 that you've seen in all the other ultrasounds.

19 Q Are you saying then that the ultrasonographer was
20 negligent when she measured the abdominal circumference on
21 this day?

22 A No, sir, I don't think it's negligence. The abdominal
23 circumference measurement is well known to be the most
24 difficult fetal biometric measurement to obtain for exactly
25 the reasons I just showed you. You don't have bony markers

1 to go by, and I -- I don't -- no, I just don't -- don't
2 think that falls into a level of negligence. It's just an
3 error -- in my opinion an error in measurement that
4 would've changed the estimated gestational age based on the
5 abdominal circumference by maybe a week to two.

6 Q In your opinion would it have changed anything that
7 was done in this case as far as sending her immediately to
8 labor and delivery?

9 A No, they would've still had the same impression that
10 the abdominal circumference was lagging as it had been and
11 that the biophysical profile wasn't good.

12 Q Okay. I've got to get through my questions a little
13 bit quicker. Bear with me, please. In your opinion does
14 the standard of care, did it require Dr. Hilton to take Ms.
15 Jamison by the hand and walk her over five, 10 minutes away
16 from her office to labor and delivery in a separate
17 building? Did it require that?

18 A No, sir.

19 Q Let's talk about Dr. Benson for a moment. And he was
20 the physician that was at labor and delivery and was called
21 by Dr. Hilton and did whatever he did and didn't do
22 whatever he didn't do that day. Based on all the
23 information conveyed to Dr. Benson from Dr. Hilton as you
24 understand it to have been and all that happened in the
25 office that day including Ms. Jamison's history, her prior

1 uterine rupture and history of hypertension and 32 week
2 gestation and decreased fetal movement, the NST and the BPP
3 that were done that day -- that was all the things known at
4 that time -- what did the standard of care upon receiving
5 that phone call from Dr. Hilton require of him, sir?

6 A Require of Dr. Benson?

7 Q Yes, sir, at the hospital. He's on labor and
8 delivery; he's on call for the service and he is there on
9 duty.

10 A I think it required of him to do the things that he
11 said he was going to do, which were to evalu -- that
12 recognizing that she was a high risk patient and had
13 concerning testing done in the office, to immediately
14 evaluate her upon her arrival there and if the abnormal
15 fetal biophysical profile persisted, be able to do a
16 cesarean section urgently.

17 Q Why -- why do any further testing? I mean don't we
18 have enough information by this time about this lady
19 needing to be delivered?

20 A I would -- I would say that first of all anybody in
21 this -- anybody in this circumstance you would need to re-
22 evaluate them upon their arrival.

23 Q Why?

24 A Well, the patient has to be evaluated to make sure
25 she's healthy and a candidate for surgery and there's not

1 anything acute going on with her. I would imagine that one
2 concern they might've had is that she was rupturing her
3 uterus. Rupturing the uterus could be a life-threatening
4 emergency for a mother, and so I'm sure the anesthesia
5 people want to assess -- want to assess the mother, make
6 sure she's stable and able to have surgery or doesn't need
7 anything else to assist them with surgery, such as emergent
8 blood or something like that. And you have to reassess the
9 baby, and that's particularly important in this case for a
10 couple of reasons. One is the non-stress test that I
11 looked and the biophysical -- and a biophysical profile of
12 two suggesting a baby that's completely unconscious,
13 acidotic, asphyxiated are incongruous. The non -- the non-
14 stress test doesn't match the biophysical profile. So --
15 and knowing that the biophysical profile had only been done
16 for 10 minutes, if I had no knowledge of what was going to
17 happen in this case, if I -- again, you were showing me
18 this information, I had no information as to outcome, I
19 would almost have guaranteed you that upon her arrival on
20 labor and delivery, they would've done a biophysical
21 profile that would've been much better, so I ---

22 Q Was that foreseeable?

23 A Pardon?

24 Q Was -- in your opinion based on everything you know
25 about this case and being a maternal fetal medicine

1 specialist and Ob-Gyn, was that foreseeable that more
2 likely than not she -- she would've improved when she got
3 to the hospital with a two of eight?

4 A No, I mean I don't think you would know that. You
5 don't know that it's going to happen, ---

6 Q Right.

7 A --- but I think the -- to me the standard of care
8 would've required re-evaluation of the patient upon --
9 excuse me -- the patient and her baby upon arrival at the
10 hospital, because to do a cesarean section based on a 10
11 minute biophysical profile would be inappropriate. That
12 would be outside the standard of care, because if you did
13 biophysical profiles on a 100 women at 32 weeks gestation
14 and did them only for 10 minutes, a large percentage of
15 them are going to have a score of only two, because the
16 baby's asleep, because the baby's premature, for some other
17 reason, and you're going to do a c-section on them and
18 deliver a baby unnecessarily at 32 weeks gestation, so I
19 think it was a requirement that he re-evaluate the status
20 of the baby and confirm what Dr. Hilton had seen in just a
21 10 minute window of time in her office.

22 Q If that was his plan, was that an appropriate plan?

23 A I believe that was the only appropriate plan.

24 Q All right. Did in your opinion the standard of care
25 require Dr. Benson after a 10, 15, 20 minutes when Ms.

1 Jamison had not yet gotten to the labor and delivery floor,
2 -- reason not important -- did the standard of care in your
3 opinion require him at that juncture, 10, 15, 20 minutes,
4 knowing it should only take about 10 minutes for her to get
5 here from the office, did it require him to try to find her
6 cell phone and call the office, call admissions, try to
7 find out -- get on the phone and try to make a search for
8 her and find out where she was?

9 A No, sir, I've never heard of standard of care that
10 would require that.

11 Q Do you have an opinion, sir, with your knowledge,
12 training and experience and your review of these records,
13 do you have an opinion what was going on with this baby
14 that would cause, first of all a decreased fetal movement?

15 A No, I don't.

16 Q Based on the non-stress test, do you have an opinion
17 whether or not the baby at that time was in any sort of
18 acute distress based on the NST?

19 A Based on the NST I would say no, there is not evidence
20 of acute distress based on the NST. There is -- there is a
21 suspicion of, I think, two late decelerations that would
22 necessitate further monitoring or evaluation of some sort.

23 Q Well, now let's add on what we've talked about, the 10
24 minutes of a 40 minute BPP, 10 minutes. We know what those

1 show, two out of eight. Now, do we have a baby that's in
2 acute distress based on what you now know?

3 A If the -- well, again, can you break that -- there's a
4 -- there's a lot of pieces, - I mean if by adding based on
5 what I now know.

6 Q Well, you're right. Let me back off of that. I want
7 you to assume that all you know is the NST, the history of
8 Ms. Jamison and the biophysical profile done on 9/5/08;
9 that's all you know. Based on that, do you have an opinion
10 whether or not her baby is in any sort of acute distress?

11 A Again, given the limitation of the fact that it's a 10
12 minute biophysical profile, which is an inadequate length
13 of time to evaluate a baby for a biophysical profile, the
14 fact that it's a two out of 10 and the fact that there were
15 two possible late -- two late decelerations on her NST and
16 her presenting complaint was decreased fetal movement, I
17 would have concern at that point that there's possible
18 distress going on. I would have concern that there could
19 be distress present at that point.

20 Q Your index of suspicion would be raised?

21 A Yes.

22 Q All right. I want you to assume as the records
23 reflect that her heart rate, the baby's heart rate at 10:55
24 a.m. on the ultrasound was 158 beats per minute. Is that
25 within the normal range?

1 A It is.

2 Q When you have reason to have on your index of
3 suspicion -- I think sometimes call it a differential
4 diagnosis -- when your index of suspicion is there's a
5 possibility or there's more of a likelihood this baby is or
6 may be in acute distress, under -- in this -- on these
7 facts and circumstances there's anything more that the
8 standard of care indicated or suggested or required Dr.
9 Hilton to do than she did?

10 A Anything more than she did?

11 Q Than she did, yes.

12 A No.

13 Q In your opinion would you reasonably expect, based on
14 all you knew through the biophysical profile 11:00 a.m.,
15 call it that, everything you knew just to that point, would
16 you, sir, be reasonably expecting this baby to die within
17 45 to 50 minutes?

18 A No, I would not.

19 Q Do you have an opinion, sir, what caused this baby to
20 die?

21 A I do not.

22 Q Do you have an opinion what caused any potential or
23 possible or likely placental insufficiency or asphyxia
24 would cause that?

1 A If the cause of death was placental insufficiency or
2 asphyxia?

3 Q Yes, sir.

4 A Possibilities ---

5 Q No. Do you have an opinion what caused it more likely
6 than not if you assume placental insufficiency and if you
7 assume asphyxia, what led to that?

8 A Specifically, no. She has risk factors which is her
9 hypertension and prior uterine rupture which interferes
10 with uterine blood supply, but other than those -- but what
11 caused her uteroplacental insufficient I don't know. If
12 that was the problem. I think there is question as to
13 whether or not there was chronic uteroplacental
14 insufficiency.

15 Q And I asked you to assume that as a hypothetical. Is
16 that fair?

17 A That's correct.

18 Q Do you have an opinion when this baby's heart stopped
19 beating after 11:00 a.m. and before -- we'll call it 11:47
20 a.m., sir?

21 A During that time period?

22 Q Yes, sir.

23 A No, I do not.

24 Q Could've been 11:01?

25 A Could've been any time during that time period.

- 1 Q Eleven o two?
- 2 A Yes, sir.
- 3 Q I can keep going, can't I, until 11:47, can't I?
- 4 A Yes, sir. No, you'd have to stop at 11:43.
- 5 Q Why's that?
- 6 A I think that's when the nurses evaluated her and
- 7 couldn't find heart tones.
- 8 Q Do you have an opinion about the overall care and
- 9 management of Ms. Jamison including all of her risk factors
- 10 by all of the physicians, nurses and nurse practitioners
- 11 that rendered care to her during her treatment at that
- 12 office? Was it within the standard of care? Was it below
- 13 the standard of care in any way?
- 14 A I think all the care that she received provided by
- 15 individuals you mentioned was within the standard of care.
- 16 Q Does that include the hospitalization of August 9?
- 17 A Yes, sir.
- 18 Q Does that include everything that happened on August
- 19 25th with Dr. Miller?
- 20 A Yes, sir.
- 21 Q Does it include everything that happened or didn't
- 22 happen on September 5th, sir?
- 23 A Yes, sir.

1 Q Do you have an opinion within a reasonable degree of
2 medical certainty whether this baby's death within 45
3 minutes of leaving the office was reasonably predictable?

4 A I don't think it was predictable at all.

5 Q Do you have an opinion whether it was reasonably
6 foreseeable based on all that you knew through 11:00, 11:15
7 that morning?

8 A Let me back up a moment.

9 Q Sure.

10 A Obviously, the fact that Dr. Hilton following their
11 assessment was sending her to the hospital for continued
12 evaluation and potential delivery at 32 weeks means that
13 they were -- that there was a concern that the fetus was in
14 trouble, so was fetal demise conceivable, and if
15 predictable means conceivable, then yes, the answer to that
16 question is yes. That's -- that's why they asked her to go
17 to the hospital for evaluation, potential delivery based on
18 their testing. They were worried about this baby. If
19 predictable -- I guess when you're asking that question,
20 I'm thinking, is it predictable or conceivable that it was
21 going to happen in the next 45 minutes, ---

22 Q Yes, sir.

23 A --- my answer to that question is no.

24 MR. DAVIS - One moment, please, Your Honor.

25 THE COURT - Yes, sir.

1 MR. DAVIS - Answer any questions that either of
2 these gentlemen may have for you, Dr. Newman.

3 THE COURT - Cross examination.

4 MR. JORDAN - Thank you, Your Honor.

5 CROSS EXAMINATION

6 BY MR. JORDAN -

7 Q Good afternoon, Dr. Newman.

8 A Good afternoon.

9 Q We've met before when we had an opportunity to take
10 your deposition down in Charleston.

11 A Yes, sir.

12 Q Before we get started talking about the treatment
13 received by Samantha Jamison, let me ask you, Doctor, is
14 grief, sorrow appropriate response, one that you expect
15 when a mother loses a child?

16 A Yes, sir.

17 Q And you say that you've seen that in your practice.

18 A Yes, sir.

19 Q Would not be unusual to suffer from depression or have
20 to be prescribed medications for that depression.

21 A I've seen that, yes, sir.

22 Q You've testified you've served as an expert before.

23 A Yes, sir.

24 Q I believe you started serving as an expert back in '86
25 or '87.

1 A Yes, sir.

2 Q I think you started off testifying in Oregon. Is that
3 correct?

4 A Yes, sir.

5 Q And you've testified in various states over the years.

6 A A couple.

7 Q South Carolina?

8 A Yes, sir.

9 Q Florida?

10 A I don't think I've ever given testimony in Florida.

11 Q Deposition in Florida?

12 A I have.

13 Q And let me ask you about depositions or testimony.

14 West Virginia?

15 A Yes, sir.

16 Q Kentucky?

17 A Yes, sir.

18 Q North Carolina?

19 A Yes, sir.

20 Q Georgia?

21 A Yes, sir.

22 Q And in Federal Court.

23 A Yes, sir.

1 Q And you've served -- first of all let me ask you --
2 you've testified what you charge. You testified \$350 an
3 hour to review, \$400 an hour. ---

4 A For deposition, yes, sir.

5 Q -- deposition. What about for court time?

6 A Depending on whether -- where the trial is and having
7 to go there, I've either charged by the hour or a daily
8 rate.

9 Q And you're charging by the hour for this case?

10 A Probably going to charge a daily rate.

11 Q And what's your daily rate?

12 A Twenty-five hundred.

13 Q And I believe you've done over 150 cases as an expert.

14 A Um ---

15 Q In that range.

16 A That might be the number of cases I've looked at.
17 That's not how many depositions I've done.

18 Q Given 50 to 60 depositions?

19 A Yes, sir.

20 Q And testified maybe 15 times in Court?

21 A I think I estimated 10 to 15 times.

22 Q And you've only given two depositions for the
23 plaintiff in 26 years.

24 A I think it's three.

25 Q You've never testified in Court for a plaintiff.

1 A Never.

2 Q Now, you've reviewed other cases for Mr. Davis ---

3 A Yes, sir.

4 Q --- over the years. How -- when'd you first review
5 your first case for Mr. Davis or his firm? How long ago?

6 A I could not -- I can't remember. I think -- I think
7 when you asked me this in deposition, my estimate was 10 or
8 15 years ago with a case involving a physician in Anderson.

9 Q Okay. I believe you testified in Rock Hill one time
10 before. Is that correct?

11 A Yes, sir.

12 Q Was it expert opinion involving same group?

13 A The -- I -- I believe -- I'm not positive. I think
14 the case in Rock Hill probably involved the same group.

15 Q Okay. Was it Dr. Taylor?

16 A Yes.

17 Q Okay. And you know Dr. Taylor with this group.

18 A Yes.

19 Q So not only do you know Dr. Robinson with this group,
20 going back about 30 years -- is that correct?

21 A That's correct.

22 Q --- you know Dr. Taylor with this group.

23 A Yes, sir.

24 Q And you know Dr. Rowland with this group.

25 A She was a resident in Charleston.

1 Q She trained under you down in Charleston. Is that
2 correct?

3 A Yes, sir.

4 Q Okay. So you know three of the doctors personally in
5 this group here that you're testifying for today.

6 A Yes, sir.

7 Q Now, you and Dr. Robinson were residents together.

8 A Yes, sir.

9 Q And you weren't just residents together. You lived in
10 the same neighborhood.

11 A Yes, sir.

12 Q Played basketball together.

13 A Yes, sir.

14 Q Had dinner and drinks frequently together.

15 A Not frequently, but we've had dinner together before.

16 Q And you still see Dr. Robinson.

17 A Yes, sir.

18 Q Last Memorial Day did you have dinner and drinks with
19 Dr. Robinson?

20 A We -- yes, I did.

21 Q Down at the beach.

22 A Yes, sir.

23 Q That was while this case was going on?

24 A Um, probably was, yes.

1 Q And, Doctor, I asked Dr. Moore this. I asked this
2 question, not trying to be offensive, but had an expert one
3 time that I didn't ask this question and he'd spent the
4 night in jail. So I think you drove up this morning. Is
5 that correct?

6 A Yes.

7 Q So I'm assuming you got to spend the night in your own
8 house -- your own house last night.

9 A I did.

10 Q Okay. Now, Doctor, you've worked for various -- as an
11 expert for various defense firms throughout this state. Is
12 that correct?

13 A Most of the cases I get asked to look at comes from
14 groups within this state, yes.

15 Q The Hood Law Firm down in Charleston.

16 A Yes, sir.

17 Q Defense firm down there, Robert Showers.

18 A Yes, sir.

19 Q Plowden Law Firm out of Columbia.

20 A I thought they were from Myrtle Beach, but I have
21 worked for the Plowden Law Firm before.

22 Q Okay. And I think I may ---

23 A Is that Richardson and Plowden?

24 Q Richardson Plowden.

25 A Yes, I have.

- 1 Q Spencer King with The Ward Law Firm out of
2 Spartanburg.
- 3 A Yes, sir.
- 4 Q Now, you work for MUSC.
- 5 A Yes, sir.
- 6 Q You're not in a private practice per se.
- 7 A No, sir.
- 8 Q And some parts of your practice are similar to a
9 private practice but others are not.
- 10 A Yes, sir.
- 11 Q You're in a teaching hospital.
- 12 A Yes, sir.
- 13 Q And you work for that hospital.
- 14 A Yes, sir.
- 15 Q Now, Doctor, you've -- I think you testified earlier
16 that you testified for a plaintiff one time that involved
17 monitoring of strips. Is that correct?
- 18 A Um, that was part of the problem with that case, yes.
- 19 Q And in that case the physician failed to recognize
20 changes on a strip and act aggressively.
- 21 A That is correct.
- 22 Q Now, when you reviewed the documents for Samantha
23 Jamison you basically did a summary of what you found. Is
24 that correct?
- 25 A (No response)

1 Q And you provided me with a copy of that document
2 during your deposition. You did a test case, I believe. Is
3 that right?

4 A That was not -- I wouldn't call that summary of what I
5 found. That was -- I wanted to put all the ultrasounds
6 that she had on one -- basically one page so I could kind
7 of look at them in sequence and see how they changed over
8 time.

9 Q Okay. I want to ask you about this exhibit to your
10 deposition, and on the bottom it says, fetal growth
11 overview, and this relates to the findings for Samantha
12 Jamison. Is that correct?

13 A That is correct.

14 Q Okay. And on the right-hand side at the very bottom,
15 there's some percentages. What are those?

16 A The growth percentile.

17 Q Okay. Now, the first time she came in on July 18th,
18 2008, how did you -- what did you calculate the growth
19 percentile as?

20 A The 46th percentile.

21 Q Forty-sixth percentile. The second ultrasound was on
22 what date?

23 A August 25th.

24 Q And what did you calculate the percentile as?

1 A It was the 19th percentile for that gestational -- all
2 these are for -- what percentile for that gestational age.
3 Q Okay. So a drop from 46th percentile down to 19th
4 percentile. Is that correct?
5 A That's correct.
6 Q And what did you calculate the percentile as on the
7 September 5th, 2008?
8 A Thirteenth percentile.
9 Q Okay. Thirteenth percentile. Thank you, Doctor.
10 Now, we've gone from the first ultrasound when she came in
11 to this practice -- we've gone from a 46th percentile down
12 to the 13th percentile. Is that correct?
13 A That is correct.
14 Q Now, you don't say that there's intrauterine growth
15 retardation until you get to the 10th percentile. Correct?
16 A Less than the 10th, yes, sir.
17 Q Okay. And so if you're taken 100 babies, only the
18 numbers one through 10 would be intrauterine growth
19 restricted. Is that correct?
20 A I'm not sure I follow that question.
21 Q Well, the -- the 10 percent.
22 A Well, it wouldn't be the 10 -- 10 out of those
23 necessarily 100; it would be -- you're applying the
24 measurements for those babies to a standard curve or a
25 normal curve, so all 100 of those may be normal or five of

1 them may be below the 10th percentile, or if it were
2 particularly high risk population, 20 of them may be below
3 the 10th percentile.

4 Q Is it fair to say that her growth -- the growth
5 percentile for Jayden, her son, was trending downward?

6 A Yes, it was.

7 Q Pretty fast.

8 A It -- I think that's an adjective that -- it was
9 trending downward. I don't necessarily -- wouldn't
10 necessarily call it fast.

11 Q But thirteen ---

12 A Those ultrasounds were done over like a three month --
13 two to three month period.

14 Q If Jayden's growth percentile dropped another three to
15 four percent, then you would say it was intrauterine growth
16 restriction that he was.

17 A It would be the below the 10th percentile.

18 Q And we'd already come down from 46 down to 13.

19 A That is correct.

20 Q In a matter of weeks.

21 A Over -- between July 25th and September 5th, so I'd say
22 that would be months.

23 Q Okay. And, Doctor, what is your understanding about -
24 - well, first of all, let me ask you, is it fair to say

1 that she was high risk, Samantha Jamison was a high risk
2 pregnancy?

3 A Yes, sir.

4 Q And is it your understanding she was first seen by
5 this practice on July 18th of 2008?

6 A Yes, sir.

7 Q And what is your understanding about who saw her that
8 day?

9 A Um -- I apologize. I can't remember whether it was
10 Dr. Miller or Dr. Benson, but I thought it was one of those
11 two. Maybe Dr. Miller.

12 Q Would -- let me see if I can pull up the record for
13 you. In your practice if someone comes in and they are a
14 high risk, are they seen by a physician?

15 A She was seen by Dr. Benson -- I apologize -- on the
16 18th.

17 Q On the 18th. Okay, and if Dr. Benson testified that he
18 didn't actually see her that day, would you dispute that?

19 A Let me re-read this. I might've spoke too soon.

20 (Pause) I would not dispute what Dr. Benson said. It
21 looks like the note's written by the -- Robin Pruette who's
22 the nurse practitioner -- the handwritten note, and the
23 handwritten note indicates that Dr. Benson ordered the
24 ultrasound and then Dr. Benson dictated an ultrasound
25 report. So I think if -- Dr. Benson may not have

1 personally seen her and instead only had seen the
2 ultrasounds.

3 Q Okay.

4 A So I would not disagree if he said he did not see her.

5 Q I'm having some technical difficulty. I'm going to
6 show you the record. Actually, I'll tell you what, the
7 chart's up here.

8 A Is that what you're looking for?

9 Q Yes. Is Robin Pruetto's name on there?

10 A Her name is on here as having provided a prescription.
11 The note is signed by a nurse, maybe D. Akers (phonetic),
12 and then there -- as I said there's a dictated ultrasound
13 report by Dr. Benson.

14 Q So, do you know whether Nurse Pruetto or Nurse
15 Practitioner Pruetto actually saw her that day, or do you
16 recall from the -- and you read Nurse Pruetto's deposition
17 as part of your preparation for testimony today.

18 A I did, but I -- I can't tell you who saw her that day.

19 Q Okay. I'm going to hand you Nurse Pruetto's
20 deposition and let you read a page and see if that
21 refreshes your memory. (Pause) Doctor, while they're
22 looking for that deposition I'll move on. Let me ask you,
23 in your practice when someone is transferred in with a high
24 risk pregnancy, is it protocol standard that they're seen
25 by a physician to develop a plan of care?

1 A It is. In our institution we have a very limited
2 number of -- I don't think we have any nurse practitioners.
3 We have a couple of nurse midwives. Some of the -- some
4 patients on intake are seen first by our nurse midwife.

5 MR. JORDAN - Your Honor, may I hand this up to
6 the witness?

7 THE COURT - Yes, sir. All right, this is the
8 deposition of Robin Pruette. As I told you, ladies and
9 gentlemen, it's the testimony of a witness -- there's a
10 witness taken under oath at a previous time.

11 Q Doctor, I would ask that you turn to page six.

12 A Page six?

13 Q Page six. At the bottom, and I had asked Nurse
14 Pruette if -- if there are any other times that she'd seen
15 Ms. Jamison, and if you would just read her answer there
16 beginning line 19 and see if that refreshes your memory
17 with regard to who actually saw her on that day.

18 A Page six doesn't have anything about -- doesn't have
19 that question. Line 19 is her response to a question about
20 her license being -- her license status.

21 Q I'm sorry. You're correct. They're different.
22 They're numbered differently.

23 THE COURT - Was there more than one?

24 Q I'm sorry. I handed you the wrong deposition.

1 THE COURT - It's the same person, but it's
2 apparently more than one.

3 MR. JORDAN - My apologies.

4 Q My question was just, does that refresh your memory as
5 to when Nurse Pruette actually saw her that day?

6 A Per her deposition here she says she did not ---

7 THE COURT - Don't read it, sir. Just read it
8 over and then you can say whether or not it refreshes your
9 memory. Just read it to yourself.

10 A It doesn't refresh my memory, no.

11 THE COURT - Thank you. Put it up there.

12 Q I want you to assume, Doctor, that when she's
13 transferred in with chronic hypertension and high risk
14 which you agree she had -- Correct? When she was -- had
15 chronic hypertension, she was a high risk pregnancy.

16 A Yes, sir.

17 Q I want you to assume that when she transfers in on
18 July the 18th, that she's not seen by a physician, that she
19 is not seen by a nurse practitioner but is seen by a nurse,
20 and that no physician develops a plan of care for her at
21 that time. Would that be below the standard of care?

22 A Again, if that were what happened, it would probably
23 not be within the standard of care, but I don't believe
24 that's what happened.

1 Q Doctor, would you agree that reduced fetal movement
2 would be a potential emergency?

3 A I believe that's a complication -- that is a complaint
4 that needs evaluation.

5 Q And would it be important to determine how long the
6 reduced fetal movement had been going on?

7 A That would be a question I would ask a patient under
8 those circumstances.

9 Q And would you want to document the record on that?

10 A I might or might not. To be honest I'd probably just
11 -- that'd be a question I would ask, but I would probably
12 just document it as decreased fetal movement.

13 Q But would you want to know though whether or not
14 there's a total lack of movement or whether or not there's
15 just a reduction?

16 A That would be a question I would ask.

17 Q And why is that important?

18 A Well, any patient complaint you would want to get an
19 idea of its nature and severity and I think a patient that
20 told me that she's feeling no fetal movement I would want
21 to know that. It might be a more significant finding than
22 decreased fetal movement; on the other hand if she told me,
23 well, it's just decreased from what I've been feeling the
24 last couple of weeks, that might not be as significant a
25 complaint and it might make it more -- you know, depending

1 on the results of my follow-up testing, it would -- it
2 would be helpful information to have to interpret along
3 with the results of the non-stress test.

4 Q I want you to take a look at the chart there on
5 September 5th, 2008 and do you see any recording on
6 September 5th, 2008 where there's any notation about how
7 much the fetal movement has decreased or when it started
8 decreasing?

9 A There is -- on this progress note form you're talking
10 about?

11 Q Yes, September the 5th ---

12 A Is it the same -- is that the same thing I'm looking
13 at?

14 Q (No response)

15 A No, it's not.

16 Q Here's the chart or you can step down, Doctor, if
17 you'd like.

18 A All right, I've got it, so -- please repeat the
19 question.

20 Q My question is, is there anywhere on that chart that
21 documents how much fetal movement had decreased or when the
22 decreased fetal movement was first noticed by Samantha
23 Jamison?

24 A No, there's no mention of either of those two things.

1 Q And, Doctor, when someone who has chronic hypertension
2 comes to your practice, do you routinely check their blood
3 pressure?

4 A Yes, sir.

5 Q Okay. And is it within the standard of care to check
6 the blood pressure?

7 A It is routine and considered part of a normal prenatal
8 visit.

9 Q Okay. Can you show me on the visit of September 5th,
10 2008 where there was any blood pressure that was checked?

11 A No, I don't think I found one.

12 Q We've established that Dr. Miller started doing -- or
13 asked her to do kick counts. Is that correct?

14 A Yes, sir.

15 Q And you want to do kick counts because you want to
16 know if the baby's moving -- well, you tell me. What are
17 you looking for there when you're doing kick counts? How
18 many times per hour or ---

19 A There prob -- I mean I suspect there's probably
20 variability in what different -- what different doctors
21 tell a patient. I ask a patient -- I ask my patients to
22 once a day -- I usually start somewhere between 26 and 28
23 weeks -- to once a day at a point in time when the baby is
24 usually moving and probably the most reliable times for
25 fetal movement are after meals or in the evening around

1 bedtime -- I ask the patient to lay down, get in a chair,
2 put their hands on their belly so they can feel for
3 movement as well as perceive and to look at the clock, see
4 what time it is, and then count 10 movements, and clusters
5 of movement can all -- you know, there are individual
6 movements -- not -- if a baby moves like that, that's four
7 or five movements, not just one -- to count 10 movements,
8 then look at the clock again and see how long it took.
9 Average baby will do that -- once it's active will move 10
10 times in somewhere between five and 25 minutes. I tell
11 them if it takes longer than an hour, they should do it
12 again immediately, and if they can't get 10 movements in
13 the second hour, they need to come to the -- contact --
14 contact our hospital, either come to our office during the
15 day or go to labor and delivery on nights and weekends for
16 a non-stress test.

17 Q And, Doctor, if -- why would you have someone do kick
18 counts if you don't want to know what the kick count is?
19 Isn't it a good piece of information to have and that's why
20 you do it?

21 A I'm not sure I understand that question.

22 Q Well, you have -- you have an expectant mother do kick
23 counts because you want to know if the baby's moving.

24 A Correct.

1 Q And that's a good piece of information to have,
2 because it can tell you when the decreased movement began,
3 and you can better determine if it's an emergency or not so
4 much.

5 A No, that's not -- we don't do it so to create a -- I
6 don't instruct them to do that in order to create a time-
7 line. I just do it for a specific purpose of fetal
8 surveillance, that if the baby is moving -- a moving baby
9 is a non-asphyxiated baby. But I don't do it for purposes
10 of creating a time-line.

11 Q Well, Doctor, would you agree that it's a clue as to
12 when the baby's condition started to deteriorate?

13 A If she had fetal movements yesterday and she doesn't
14 have them today, that would be -- that would tell me that
15 she -- the decreased fetal movement happened sometime in
16 the last 24 hours.

17 Q Okay. And so it would be a clue as to when the baby's
18 condition started to deteriorate..

19 A Possibly.

20 Q Okay. And so if you know that piece of information
21 and you know that the baby's condition began to deteriorate
22 48 hours ago versus two hours ago, you might treat that
23 patient a little bit different.

24 A No, I'd disagree. I don't think I would treat her any
25 different. It might -- it would be good information to

1 have, but it would not alter the evaluation that I'm going
2 to do. I'm still going to do a non-stress test.

3 Q Doctor, would you agree that the most likely cause of
4 death for Jayden is lack of oxygen?

5 A I don't know the cause of death, so I can't tell you
6 what the most likely cause of death is.

7 Q Would you agree though, Doctor, that the most likely
8 cause of death is lack of oxygen to the baby?

9 A I think that the majority of -- majority of fetal
10 demises are a result of lack of oxygenation. Why the baby
11 had -- why that happened is what I can't tell you.

12 Q Doctor, I'm going to refer you to page 48 of your
13 deposition.

14 A Which page? I'm sorry?

15 Q Page 48. Beginning with line nine, I asked you, okay,
16 and you said that your opinion was, that the cause of death
17 was -- I think you said was asphyxia, a lack of oxygen for
18 the baby, and what was your answer?

19 A I believe that the most likely cause of death was a
20 lack of oxygen to the baby. If I may, I'd just point out
21 that your next question is, do you know what caused the
22 lack of oxygen, and I said I don't.

23 Q Doctor, what is a fetal surveillance?

24 A It's -- I guess you can broadly define it as any
25 testing that we do of the baby to try to evaluate it's

1 normal development and well-being, and things that will be
2 included in that are -- fetal kick counts would be one --
3 ultrasounds to evaluate growth and fluid and dopplers, and
4 then fetal -- direct fetal testing such as non-stress test
5 or biophysical profiles.

6 Q And a biophysical profile is ---

7 A And to some degree -- well, I'll leave it at that.

8 Q Biophysical profile was one option for fetal
9 surveillance for Samantha Jamison.

10 A Yes.

11 Q And why do you do fetal surveillance?

12 A Typically -- I mean it's a -- it's a way to evaluate
13 the well-being of the baby. Ultimately it's try to protect
14 the baby and help with -- for -- have healthier outcomes.

15 Q And if you're concerned about growth or high blood
16 pressure, you can do non-stress test or biophysical profile
17 and that would be fetal surveillance for that baby.

18 A Those are components of fetal surveillance protocols,
19 and there are protocols and expected surveillance that's
20 done in certain -- in given circumstances.

21 Q And, Doctor, in your practice do you have high risk
22 patients that you follow on a weekly basis?

23 A Yes, sir, we do.

24 Q With a non-stress test and biophysical profile.

25 A Yes, sir.

1 Q And, Doctor, in your practice do you have patients
2 that you follow twice a week for a non-stress test or a
3 biophysical profile?

4 A There are some, yes, sir.

5 Q Doctor, in your practice do you have any patients that
6 you follow more than twice a week for either a non-stress
7 test or a biophysical profile?

8 A Probably not in the outpatient setting. There might
9 be some patients that are hospitalized for various
10 complications where we might do daily fetal testing.

11 Q But it's not unusual for you to have a high risk
12 patient in your practice that you see twice a week for a
13 non-stress test and biophysical profile.

14 A It's not unusual, but they would have to have an
15 appropriate indication to justify that surveillance.

16 Q And, Doctor, you can start biophysical profiles as
17 early as 26 weeks.

18 A You could.

19 Q So and Samantha was about 32 weeks at this point.

20 A Yes, ma'am. (sic) Well, excuse me. Yes, sir, and
21 she was at -- she was as of September 5th.

22 Q Okay. So ---

23 A Actually 31 and five or six, I think.

24 Q --- really 26 weeks, she was about close to that when
25 she first came into this practice, wasn't she?

- 1 A She was 24.
- 2 Q Twenty-four. So within two weeks of coming to the
3 practice, biophysical profile could've been started on a
4 high risk patient.
- 5 A Well, I think that you're -- again, you're -- there
6 are things that could be done and things that are
7 appropriate to be done. You could do anything. In a
8 patient with chronic hypertension without evidence of
9 growth restriction, particularly with normal doppler
10 studies, normal amniotic fluid, in our institution we would
11 not start either non-stress test or bio -- and/or
12 biophysical profiles -- we could use them interchangeably -
13 - until they were at least 32 weeks.
- 14 Q And she was 32 weeks on September 5th.
- 15 A As I said I think she was 31 and five days or six
16 days.
- 17 Q Six days, yes. And she had -- she walked in that day.
18 There was no ---
- 19 A But she wasn't 32 weeks when she presented at 24 weeks
20 and she wasn't on the 15th of Sept -- of August and at those
21 times the evaluations involved ultrasounds and those
22 ultrasounds did not generate an indication to start non-
23 stress testing or biophysical profiles.
- 24 Q September 5th, 2008 she was 32 weeks. Is that correct?
- 25 A I think ---

1 Q Within a day.

2 A -- we've said 31 and five or six.

3 Q And she was a walk-in that day.

4 A Correct.

5 Q So she was not there for a scheduled biophysical
6 profile or non-stress test.

7 A No, she was not scheduled that day.

8 Q And have you seen anywhere in the record where a non-
9 stress test or biophysical profile was scheduled for her
10 after September 5th, 2008?

11 A If I saw that I don't remember it at this point.

12 Q Would you agree, doctor, that physician, an
13 obstetrician has a duty to recognize an emergency and make
14 appropriate decisions to save the life of a mother or a
15 baby?

16 A Please repeat that question.

17 Q Certainly. Would you agree, Doctor, that a physician
18 or obstetrician must recognize an emergency and make
19 appropriate decisions to protect the life of a mother and a
20 child?

21 A I think they have an obligation to the best they can
22 to do those things.

23 Q And if they don't do those things, it would be a
24 breach in the standard of care?

1 A Not necessarily. There are some things that are
2 unpreventable and then there are some things that -- well,
3 I'll just say there are some things that are unpreventable.

4 Q Do you still have your deposition up there, Doctor?

5 A Yes, I do.

6 Q I'd ask that you refer to page 59. I'm sorry.

7 Beginning on page 58 -- I'm sorry -- at the bottom -- Now,
8 Doctor, would you agree with me that a physician has a duty
9 ---

10 MR. DAVIS - Well, what -- excuse me, what line
11 are we looking at?

12 MR. JORDAN - I'm sorry. Line 22, page 58.

13 MR. DAVIS - Okay. All right.

14 Q Now, Doctor, would you agree with me that a physician
15 has a duty to recognize an emergency or urgency as you said
16 and make appropriate decisions to protect the life of a
17 mother and child. At the top of page 59 what is your
18 answer?

19 A I would say that is correct.

20 Q And it would be a breach in the standard of care not
21 to.

22 A And I said that is correct.

23 Q And, Doctor, would you agree that a doctor must convey
24 an emergency situation to a patient?

1 A Well, that's a broad statement and probably covers a
2 lot of different scenarios, but I think in general I would
3 agree with that.

4 Q Okay. And in most circumstances that would be a
5 breach in the standard of care to not do that, wouldn't it,
6 Doctor?

7 A Unless there was some reason not to, I would say that
8 that would be appropriate -- it would be inappropriate
9 counseling not to apprise the patient of situation they
10 were -- they were in.

11 Q And would you agree, Doctor, that a physician should
12 timely perform a c-section or deliver a child to insure the
13 safety of a child in an emergency situation?

14 A They should do the best they can to do a timely
15 delivery. Yes, I would agree with that.

16 Q And you agree, Doctor, that her NST was suspicious
17 enough that it required -- even if she hasn't done a
18 biophysical profile, an NST was suspicious enough as a
19 category two that it required further testing?

20 A I agree.

21 Q And you took a look at the doppler in this case. Is
22 that correct?

23 A I did.

24 Q And I had asked you about your opinions on that
25 doppler.

1 A Yes, sir.

2 Q And I'd ask that if your opinions on that doppler
3 changed if you would let know. Have your opinions on the
4 doppler changed?

5 A It has not.

6 Q Okay. Now, explain to the jury what a doppler is.

7 A As you know, the umbilical cord runs between the baby
8 and the placenta, and the placenta is the -- it's the
9 respiratory organ for the baby. It's where the mother and
10 the baby exchange oxygen and carbon dioxide. It's also
11 where they exchange nutrients for growth. Within the
12 umbilical cord, blood coming from the placenta back to the
13 baby runs through the umbilical vein, and there's one of
14 those. Blood going from the mother to the placenta goes
15 through the umbilical arteries and there are two of those.
16 And in a fetus, a large percentage of the baby's blood goes
17 through the umbilical arteries, because, again, that's how
18 the baby's getting oxygen, so what you can do with
19 ultrasound, is you can measure the flow of blood through a
20 -- what's called a doppler technique. And basically the
21 doppler technique creates a wave form by looking at the --
22 at the volume and speed of -- that blood is moving. So
23 when the placenta is unhealthy, and you've probably heard
24 the uteroplacental insufficiency -- that's a big five
25 dollar word -- it just means that the placenta's not

1 healthy and it's not working as it should. When a placenta
2 is unhealthy, there are structurally things wrong with it.
3 There are more vessels that are -- you know, that are
4 constricted, more vessels that are obliterated, there's
5 more calcification and infarctions, there's a lot of damage
6 to the placenta so that it is not a good exchange organ as
7 it normally is. Now, what normally happens is that the
8 placenta readily accepts all the blood that's coming
9 through the umbilical artery, so when you look at a doppler
10 study, when the baby's heart beats, you see a big whoosh of
11 blood that goes toward the -- that's going toward the
12 placenta. Then in between the heartbeats, because the
13 placenta is designed to be a passive receptor of blood,
14 blood still moves forward. So with a normal doppler study,
15 you see this pattern that prints out on the screen that's a
16 whoosh, whoosh, whoosh, but there's a continuous blood
17 moving forward, because that's the way the placenta's
18 supposed to work, and you can assess that in a very
19 somewhat crude way by doing what's called a
20 systolic/diastolic ratio. The systolic is when the heart
21 beats, and the diastolic is when the heart's resting. So
22 when during the systole you get a big whoosh, so that --
23 that level's up here. During diastole there's a smaller
24 whoosh, so that level's down here. So basically you put a
25 cursor on the systolic peak and the diastolic peak and the

1 systolic may be two times higher, three times higher, four
2 times bigger, but it creates a ratio, and there's a normal
3 ratio and a normal placenta. Averages about three to one.
4 As placentas get sick, the diastolic flow to the placenta
5 goes down. Now, during a heartbeat, blood's always going
6 to move forward. So the systolic peak is pretty much
7 always there, but as the placenta gets sicker and sicker,
8 it becomes more resistant to flow and you see less blood
9 flowing from the baby to the placenta during the pause
10 between heartbeats which is called diastole. So instead of
11 saying whoosh, whoosh, you see whoosh-whoosh. You see
12 lesser and lesser and less blood moving forward during
13 diastole, which means that that ratio gets bigger. So
14 unhealthy babies, instead of having a three -- two to one
15 ratio or a three to one ratio, they have five to one, six
16 to one ratios, which means really not so much that the
17 systolic peak's getting any bigger, but the amount of flow
18 during diastole is going down, and that's the -- that's
19 what you do during doppler studies. You can actually can -
20 - the most extreme abnormalities is you can have dopplers
21 where there is no flow to the placenta during diastole and
22 that's called absent end diastolic flow. That's a sicker
23 baby, and then the sickest of all babies are babies that
24 have reverse diastolic flow, and what you see in that
25 situation is -- if you -- you know, if you know about

1 dopplers at all, it's based on sound moving toward you or
2 away from you. During systole you get a peak, and then
3 during diastole you get a peak, but the peak's going in the
4 opposite direction; blood actually is bouncing back off of
5 the placenta because there is such high resistance in the
6 placenta. Reversal diastolic flow is one of the most
7 ominous things you can see and that's -- that's a baby
8 that's likely going to die within -- within a week. So in
9 this case her doppler studies were always normal and would
10 suggest the placenta was functioning as it should.

11 Q Doctor, I believe there was a one point six one ratio
12 for her?

13 A Yes.

14 Q Okay. And the chart actually goes from 5th percentile
15 to 95th percentile. Correct?

16 A Correct.

17 Q Okay. And isn't it true that the ratio for this baby
18 was actually -- didn't even register? It was below the 5th
19 percentile.

20 A Well, that's the discussion we had during the
21 deposition ---

22 Q I just asked if your opinion had changed.

23 A And my opinion was that a -- a S/D ratio below the --
24 below the 5th percentile was insignificant. Yes, I - I'm
25 sorry, not insignific -- but wasn't a clinically

1 significant finding. When people describe what represent
2 normal S/D ratios they create -- they measure all babies
3 and do a statistical analysis of the data and they come up
4 with the average and they come up with 10th and the 90th
5 percentiles and the 5th and the 95th percentile, but -- and
6 this -- she had one S/D ratio that was 1.6, though she had
7 another one, it was 2.1 or something like that, which I
8 think was more normal, but the point was that I made in the
9 deposition is that a low S/D ratio, despite the fact that
10 it's outside the normal range, doesn't have any clinical
11 significance that I'm aware of. It would suggest to be a
12 healthy placenta.

13 Q But it's an abnormal reading in that it's below the 5th
14 percentile.

15 A It's outside of a population norm.

16 Q So it's an abnormal doppler.

17 A If you call somebody that's seven feet tall abnormal,
18 I don't think they'd appreciate it. They're outside the
19 population norm, but it doesn't necessarily mean it's
20 abnormal.

21 Q Doctor, refer to page 64 of your deposition. When I
22 asked you if it was abnormal, what is your response?

23 MR. DAVIS - What line?

24 MR. JORDAN - Line one, page 64.

25 MR. DAVIS - Line one?

1 MR. JORDAN - Line one, page 64..

2 A Well, my answer actually starts on the preceding page.

3 Q Okay.

4 A It says, so she is 32 weeks, I think, about 32 weeks
5 at the time of the doppler. Her S/D ratio is 1.61, is
6 actually less than the 5th percentile, so I stand corrected.
7 I previously told you it was a normal S/D ratio. It is
8 abnormal in that it's less than the 5th percentile, however,
9 we don't worry about S/D ratios that are less than 5th
10 percentile. We only worry about S/D ratios that are
11 greater, that are high, that are higher than the 95th
12 percentile.

13 Q So ---

14 A Then you asked me why is that, and I basically gave
15 you the same explanation I just described to the jury.

16 Q And had you ever seen that before?

17 A Not that I can say. Our ultrasound technologist don't
18 highlight a real low S/D ratio, so it might've been on a
19 report and I didn't notice it.

20 Q And the top ratio number, the 1.61, that's when the
21 blood -- or the heart is pumping. Correct?

22 A Well, that 1.61 ratio is based on a comparison to the
23 systolic peak to the diastolic drop.

24 Q That's -- okay.

1 A So the 1.61 includes both systolic and diastolic
2 measurements.

3 Q What you want to see is about three to one for her ---

4 A I'd have to look at the graph, but anywhere 2.5 to 3.5
5 is probably in that normal range.

6 Q And that's because you want to see a strong heartbeat
7 pushing that blood and then you want to see normal blood
8 going through when the heart's not beating.

9 A Well, the dopplers aren't going to tell you whether
10 it's a strong heartbeat or a weak heartbeat. It is just
11 telling you the ratio between the amount of blood flow when
12 the heart beats versus when the heart isn't beating, and I
13 think is believed to represent placental resistance more-so
14 than the strength of contractility.

15 Q And, Doctor, you would agree that based on the non-
16 stress test, the abnormal doppler was low, below 5th
17 percentile, the abnormal biophysical profile, that that's
18 an emergency situation there in the office.

19 A Well, I would disagree with the way you've structured
20 that question. The doppler to me is a mitigating
21 circumstance. It is not contributing to any sense of
22 urgency over the case. I think her complaint of decreased
23 fetal movement, the suspicious biophysical profile and then
24 the -- excuse me -- suspicious non-stress test and then the
25 biophysical profile of two out of eight led the doctors to

1 believe that there was -- led Dr. Hilton to believe that
2 there was the potential -- potential risk to this baby,
3 that she wanted her urgently evaluated at the hospital, and
4 I think that's reasonable.

5 Q Doctor, turn to page 70 in your deposition, beginning
6 with line nine. I asked you, when you see an abnormal NST,
7 abnormal doppler, abnormal biophysical profile, I think
8 we've already agreed that's an emergency situation or
9 urgency: Is that correct? And what is your response?

10 A I said correct.

11 Q Okay. And you presume that the baby -- baby's
12 placenta is dysfunctional and that the baby's not getting
13 adequate oxygen. Would you agree?

14 A Well, if the biophysical -- if the non-stress test is
15 actually reflecting late decelerations and the biophysical
16 profile is correct of two out of eight, then the most
17 likely explanation for those findings would be
18 uteroplacental insufficiency.

19 Q And we agree that that's a problem for the baby.

20 A If that's the case, then that would be a problem for
21 the baby.

22 Q And if the baby doesn't get adequate oxygenation, the
23 baby's going to die, just like what happened here. Is that
24 correct?

1 A I would say could die. Not all babies getting
2 inadequate oxygenation die.

3 Q But that could happen.

4 A It could.

5 Q That's a possibility, and it's something that you know
6 is a possibility. Correct?

7 A Correct.

8 Q Okay. So you know that that is one of the
9 possibilities that will happen if a baby is not getting
10 enough oxygen, is not oxygenated, that death is one of the
11 possibilities.

12 A One of the possibilities.

13 Q That's foreseeable?

14 A No, it's not foreseeable. It's a possibility.

15 Q If the baby's not getting enough oxygen and that
16 continues, at some point in time death will occur. Is that
17 correct?

18 A I don't mean to parse words with you, but I think
19 that's -- I think that if there is a decrease -- if there's
20 uteroplacental insufficiency and decreased oxygenation to
21 the baby, then there is the risk of fetal death. It is --
22 but the other half of the question I don't think I agreed
23 with what you said. I'd have to hear that back exactly
24 what you said, but I don't think that you could reliably
25 predict it. It needs further evaluation.

1 Q My question though is, if -- assume the baby is not
2 getting adequate oxygenation and assume that that
3 inadequate oxygenation continues, can the death of a baby
4 be predicted at some point in the future, that it is going
5 to happen, just a matter of when?

6 A Again, it's -- it could happen. It is not necessarily
7 going to happen. There are a lot of babies that have
8 inadequate oxygenation over a long period of time and the
9 consequence of that might be that the growth is impaired;
10 it might be that the volume of fluid is low, but it would
11 not necessarily lead to either organ injury or death.

12 Q Doctor, if ---

13 A But that is in the realm of poss -- organ injury,
14 neurologic injury and death are all within the realm of
15 possibility of continued oxygen deprivation to a baby.

16 Q If all oxygen is cut off for the baby, how soon before
17 brain damage occurs?

18 A From animal models it seems like that's about 10 -- 10
19 minutes or so in the absence of any oxygen.

20 Q And that's predictable.

21 A It's -- it's fairly predictable, yes.

22 Q And asphyxia ---

23 A One baby might do a little bit better than the other,
24 depending on the baby's underlying characteristics, but,

1 yes, it's -- if you lose all oxygenation, injury is going
2 to occur in 10 minutes or so.

3 Q And a biophysical profile of two out of 10 is not good
4 is it, Doctor?

5 A Pardon me?

6 Q Biophysical profile of two out of 10 is not good.

7 A Not good?

8 Q Not a good result.

9 A In a complete biophysical profile that would be a very
10 poor result.

11 Q And the decels on contractions for the NST, that
12 basically means that during those contractions that the
13 oxygenation for the baby has dropped below a critical
14 level. Is that correct?

15 A If those are late decelerations, the late
16 decelerations reflect oxygenation going down during a
17 contraction -- babies don't get oxygen during a
18 contraction; the mother's blood can't get through the
19 uterus, and that's normal. We all went through that.
20 Babies tolerate that. Normal babies tolerate that, but
21 there are certain babies that because of other on-going
22 problems they don't tolerate it and when contractions occur
23 and the oxygen falls, the predictable amount that it does
24 during that contraction, the baby has a response to that
25 which is a late deceleration.

1 Q And you do a biophysical profile because you're
2 looking for a baby that is potentially -- or potentially
3 has asphyxia.

4 A That would be -- yes, that's the purpose of
5 biophysical profile.

6 Q And asphyxia, that's a baby that has an abnormality in
7 it's acid-based status such that is no longer functioning
8 normal.

9 A That's a reasonable definition, yes.

10 Q And Jayden had no tone, no breathing movements and no
11 -- no fetal movements. Agreed? Zeros on those scores.

12 A Over the period of time that it was -- the baby was
13 evaluated, that's correct.

14 Q Now, Doctor, if a baby is deteriorating, which one of
15 those things will disappear last?

16 A Tone.

17 Q Tone. So before anything -- or before tone
18 disappears, everything else has to disappear. Tone will be
19 the last thing. Why is that?

20 A When a baby is -- has inadequate oxygenation, the baby
21 will attempt to compensate for that, and the way it
22 compensates for that is to conserve energy, minimize its
23 activity. So when a baby has a problem with oxygenation,
24 usually the first thing to be lost is fetal movement, then
25 you tend to lose fetal breathing. That's -- some people

1 would say those two things are lost at about the same time.
2 But I think it's -- fetal movement's diminished first, then
3 fetal breathing, because those are -- for the baby those
4 are as strenuous a physical activity as a baby has. So the
5 baby will conserve its activity by stopping those
6 activities. The loss of body tone is thought to represent
7 a baby that's probably lost oxygenation to the point where
8 it is unconscious and is no longer maintaining its tone.

9 Q So about the time a baby loses tone, it's unconscious.

10 A I guess -- I mean we don't know that that's the case
11 in every case, but that's -- that's my interpretation of a
12 persistent loss of tone. Now, again, a baby in deep sleep
13 also loses body tone just the way you and I do. So that's
14 -- you need to -- it needs to be a persistent loss of tone
15 throughout the entire period of the biophysical profile.
16 I think we've all seen babies that are sound asleep and
17 they don't have much tone.

18 Q Doctor, in retrospect this baby really needed to be
19 born, didn't it?

20 MR. DAVIS - Objection. Your Honor, it is asking
21 for retrospect. That is not the standard of care to ask
22 any ---

23 THE COURT - Rephrase your question.

24 MR. JORDAN - I'll move on, Your Honor.

1 Q Doctor, is your understanding that Samantha Jamison,
2 got in the office that day at 8:40?

3 A That's my understanding, yes.

4 Q Okay. And I want you to assume that when she got
5 there at 8:40 that morning, that this baby had already loss
6 tone.

7 A I would disagree with you.

8 Q I want you to assume for purposes of this question ---

9 A Okay.

10 Q --- that she gets there at 8:40 in the morning.

11 Assume at that point, based on the fetal movement, no fetal
12 breathing movement and tone has already been diminished.

13 What condition would that baby be in at that point?

14 A If all those things were true, then there'd be a risk
15 that the baby could be asphyxiated and unconscious.

16 Q And if the baby is asphyxiated and unconscious at 8:40
17 in the morning, would you agree, Doctor, that waiting an
18 hour and twenty minutes for the first test is an
19 unreasonable period of time?

20 A I think that you've taken your hypothetical assumption
21 and have woven it into the -- into the case. This baby --
22 the non-stress test was not consistent at all with a baby
23 that had no tone, movement or breathing. In fact, the non-
24 stress test is pretty definitive that the baby was not
25 asphyxiated, unconscious and acidotic. So I don't think

1 it's -- I think the hypothetical isn't appropriate, because
2 the reality is that the non -- the baby didn't have those
3 conditions for an hour and forty-five minutes.

4 Q Doctor ---

5 A If the hypothetical is, should a baby with a actual
6 biophysical profile of two out of eight be left unevaluated
7 for an hour and a half, the answer to that question is yes.

8 Q Should be left ---

9 A No, should not be left.

10 Q Should not be left. Okay. I just want to make sure I
11 understand. A biophysical profile of two out of eight, two
12 out of 10, that baby should not be left unattended for an
13 hour and a half or a hour and twenty minutes. Assuming
14 that's the case.

15 A If you had done a test, a complete biophysical profile
16 for 30, 45 -- 30 to 40 minutes and had a biophysical
17 profile of two out of eight and then did no further
18 monitoring, evaluation, intervention, treatment, anything
19 for an hour and whatever amount of time, that would be
20 inappropriate, yes.

21 Q And, Doctor, if a baby is in an emergency situation --
22 and we know that the baby had a two out of 10 at 10:58. Is
23 that correct?

24 A Yes.

1 Q What time is your understanding when she left the
2 office?

3 A About 11:00 o'clock, just before 11:00 o'clock.

4 Q And what time is your understanding to when she was
5 seen by Dr. Benson?

6 A Dr. Benson saw her I think at 11:49.

7 Q Okay. And, Doctor, would you agree that for someone
8 that has a biophysical profile of two out of 10, that 49
9 minutes is a long period of time between evaluations?

10 A I would agree with that.

11 Q Doctor, would you agree that if someone from Rock Hill
12 Gyn-Ob had walked Samantha Jamison over so that 45 minutes
13 is not lost, that this baby might be alive today?

14 A And if they walked over, how quickly would they have
15 gotten there?

16 Q Well, I -- within five minutes of the office. If they
17 had gone with her, walked her through and you don't lose
18 the 45 minutes, would you agree that ---

19 A I think there is a possibility the baby -- the baby
20 would've been alive at the time of arrival there and I
21 would presume that the abnormality would've continued to
22 have been identified and there would be a pretty good
23 chance that a cesarean could have delivered a live born
24 infant.

1 Q Chronic asphyxia is not something that can be ignored,
2 is it, Doctor? It has to be treated.

3 A Again, it's a very broad general statement. I would
4 say that's probably true.

5 Q Doctor, when one physician is passing off the care to
6 another physician, the standard of care would require that
7 physician, number one, informing the patient of emergency,
8 and number two, informing the referring physician of the
9 emergency. Would you agree? And the hospital.

10 A Again, a lot of pieces to that question. I think I've
11 already answered the question about informing the patient.
12 I think it's appropriate and the patient should be informed
13 of the status of what's going on, and I think the standard
14 of care -- I think I answered that question, too, maybe for
15 -- earlier -- I think the standard of care would require
16 that that physician call ahead to the hospital to the
17 accepting physician, when again I guess was Dr. Benson, to
18 alert him to the -- that the patient was coming over, the
19 status, the nature of the emergency, what the referring
20 physician thought was going on and what needed to be done.
21 I don't -- I don't know there's any necessary requirement
22 to notify the -- I don't know who the hospital is. I think
23 by notifying Dr. Benson, any requirement of notifying the
24 hospital probably is taken care of.

1 Q But you wouldn't want to leave a voice-mail about an
2 emergency c-section, would you, to a hospital?

3 A I don't think that -- I don't think that would meet a
4 continuity of care requirement.

5 Q And you testified earlier that it was your opinion now
6 that the abdominal circumference, that the sonographer may
7 have made a mistake in that. Is that correct?

8 A I think it was under-measured a little bit.

9 Q Okay. You didn't tell me about that in your
10 deposition, did you?

11 A No, the records I had, the pictures were much smaller
12 and -- I mean these are a little bit fuzzy, but the quality
13 of pictures I had I couldn't see that.

14 Q Doctor, I want you to assume that -- well, first of
15 all you testified that this baby was no oligohydramnios.

16 A It was not.

17 Q Okay. Do you know why on a billing statement that the
18 diagnosis would be oligohydramnios? Or was that just a
19 mistake?

20 A I -- I don't know. I assume it's a mistake.

21 Q Do you know why Nurse Peake at 11:40 or late entry
22 would indicate that Samantha Jamison was transferred with a
23 diagnosis of oligohydramnios and IUGR?

24 A I do not know why.

25 Q That just a mistake?

1 A Miscommunication or a mistake.

2 Q And ---

3 A Or assumption.

4 Q -- miscommunication can be a problem, especially when

5 you're passing off care to another doctor. Would you

6 agree?

7 A I would.

8 Q Kind of like when a quarterback is handing a ball to a

9 running back, you want a good transfer. Correct?

10 A Correct.

11 Q And if you've got the Super Bowl, you want RG3 or Cam

12 Newton, Peyton Manning, Tom Brady, rather than your fifth

13 string backup. Right?

14 A I imagine so.

15 MR. JORDAN - Thank you, Doctor. That's all I

16 have.

17 THE COURT - Re-Direct.

18 MR. DAVIS - Thank you, Your Honor.

19 RE-DIRECT EXAMINATION

20 BY MR. DAVIS -

21 Q Dr. Newman, is there any indication from your review

22 of this case that there was any second string doctor taking

23 care of Ms. Jamison at any point in time in ---

24 A No, sir.

1 THE COURT - You already have it back. That's not
2 the one we're talking about. We're talking about the one -

3 --

4 MR. BOYD - This is -- this is the original.

5 THE COURT - So you've gotten that one back.

6 MR. BOYD - I do.

7 THE COURT - All right. And any objection to
8 that, gentlemen? Obviously a mistake.

9 MR. DAVIS - Judge, absolutely without objection,
10 and in that future case involving Ms. Pruette, we're never
11 going to make that an exhibit.

12 THE COURT - All right, sir, very good. All
13 right, good deal. All right, before we bring the jury out,
14 what's the status of the case from defense?

15 MR. DAVIS - Your Honor, we're ready to rest and
16 move forward with the closing argument if it please the
17 Court.

18 THE COURT - All right, so the defense rest at
19 this time. Correct?

20 MR. DAVIS - Yes, sir. Could we make motions now
21 or ---

22 THE COURT - We're going to go through that. Just
23 hold on a second. You're jumping ahead just a little bit.
24 So defense rest. Any reply testimony by the plaintiff?

25 MR. BOYD - None, Your Honor.

1 THE COURT - Now, as we did earlier, we will go
2 and do the motions now. When the jury comes back,
3 obviously, I'll ask you the position of defense, you can
4 tell the defense rest and you can tell me there's no reply
5 testimony and we'll go into closing arguments of counsel at
6 that point in time. So with that, that being the status of
7 the case, I'll be glad to hear any motions at this point in
8 time.

9 MR. BOYD - None from the plaintiff, Your Honor.

10 THE COURT - Defense?

11 MR. WILLIFORD - Yes, Your Honor, we'd just
12 basically like to renew our motions we made at the end --
13 at the close of the plaintiff's case on the same basis.

14 THE COURT - All right, sir. Just to reiterate
15 what I said at the close of the plaintiff's case regarding
16 the motion for directed verdict, the Court has to view the
17 evidence and all reasonable inferences in the light most
18 favorable to the non-moving party, the Court must determine
19 whether a verdict for the non-moving party would be
20 reasonably possible under the facts as liberally construed
21 in that parties' favor. Regarding that I do find that --
22 I'll respectfully decline to grant your motion for a
23 directed verdict. I do find that there is sufficient
24 evidence in the record to proceed on the plaintiff's claim
25 against all named defendants. It's not my job to decide

1 credibility or to resolve conflicts in the testimony and
2 the evidence. It's my job to decide whether or not the
3 evidence exist and do so find the evidence exist and
4 therefore, respectfully decline to grant your motion for a
5 directed verdict. All right, with that, just so that y'all
6 know, we're definitely going to go into the closing
7 arguments. It would be my intention at that point in time
8 to charge the law, but again, we have a captive audience.
9 I'm going to explain to them the situation. I'm going to
10 let them decide, because if we give -- if we go into the
11 charge and the law and I give it to the jury, it'd be my
12 position that it's their case until they've reached a
13 resolution for whatever length of time that might take.
14 Now, if it was an extraordinary long amount of time, I
15 would probably give them the option to come back tomorrow,
16 but I want them to understand when they get the case, it's
17 theirs until they come to a resolution. With that I will
18 give them -- again, they're the captive audience -- the
19 opportunity to come back tomorrow morning and hear the
20 charge on the law or continue on tonight until we reach a
21 resolution in the case. Thank you very much. Bring the
22 jury in.

23 (Jury returns to the courtroom)

24 THE COURT - All right, the position of the
25 defense at this point in time.

1 of money for the loss of a child. That doesn't come close
2 to even making a dent in the sorrow and the pain and the
3 suffering that she's gone through, but it's the only thing
4 we can do. I -- that's a figure I'm putting out. You can
5 choose any kind of figure you want. You can decide that
6 what I'm asking for is too much, or you can decide what
7 we're asking for is too little. That's your decision, but
8 I'm putting that out to you as a suggestion. I've said all
9 I'm going to say. Mr. Davis is going to give a closing
10 argument. I think I'll have an opportunity to come back
11 and reply to what he says, and then it will be in your
12 hands. Thank you.

13 THE COURT - Defense?

14 MR. DAVIS - May it please the Court.

15 THE COURT - Yes, sir.

16 MR. DAVIS - Ladies and gentlemen, Mr. Foreman,
17 thank you for your attention not just today but all week.
18 You didn't choose to be here. We're aware of that, but we
19 appreciate your service to your community and the time and
20 attention you have given to the attorneys in the case, to
21 the witnesses, to the Court, to Ms. Jamison and to my
22 clients. We have noticed your attentiveness and we
23 appreciate it. The questions that I'd like to ask you is -
24 - they're not -- they're not extensive and they're not
25 complicated. Based on the evidence in this case, was the

1 care rendered by Dr. Miller, Dr. Hilton and Dr. Benson
2 reasonable? Was it reasonable? Not perfect. Nobody gets
3 perfect care. The standard of care is reasonable care.
4 That's your question. That's what the Judge will charge
5 you when I -- when all the lawyers finish talking -- I know
6 you can't wait for that -- but when we sit down and we're
7 done -- and that time is coming -- one of the most
8 important parts of this case will come when His Honor,
9 either today or tomorrow, whenever he elects to do so,
10 tells you what the law is in this case in South Carolina
11 that you are to apply to the facts as you find them to be.
12 You are -- you are Judges of the facts. You have invisible
13 robes if you will. And those robes entitle you to be
14 Judges of the facts. What are the facts? The facts are
15 evidence. What is evidence? Evidence is testimony from
16 you heard -- you heard all week from various witnesses.
17 It's this big stack of documents and stuff that you'll have
18 in the jury room to look through it at any point that you
19 wish and to any detail that you elect and choose to do so.
20 That's evidence. Those are the facts. Please don't forget
21 your common sense that you woke up with Monday morning
22 before you were selected to be a juror in this case. Don't
23 leave that home when it comes time to make your decision in
24 this case based on the facts, based on the law. That's
25 what we ask more than anything else. Use your good common

1 sense, your good judgment, the way you evaluate people in
2 your every-day affairs. The Judge is going to tell you,
3 you know, you can believe one witness against many or many
4 against one. He's going to tell you that as finders of the
5 facts, as Judges of the facts and finders of the truth in
6 this case, you have the ability and authority to take a
7 part of what a witness says and throw out all the rest,
8 take all of what a witness says or take none of it. That's
9 up to you. I'm not here to suggest how you do that.
10 That's your job. That's your responsibility and we're
11 confident you'll discharge your responsibility in fairness
12 to all parties. Was this sad and tragic death of Jayden --
13 was it reasonably -- not perfectly or 100 percent, but was
14 it reasonably foreseeable given the facts that existed
15 before Jayden died? Was this sad and tragic death, was it
16 not only reasonably foreseeable, but was it reasonably
17 predictable? Look, you can predict who's going to win the
18 national championship. You can flip a coin and say, well,
19 it's Louisville or Michigan. We all know now who it was.
20 That isn't hard. It's Louisville, in case you didn't know.
21 Louisville won that game; they're national champions.
22 Before the game you might've predicted, it's probably going
23 to be Louisville, they've got a lot of speed. Might be
24 Michigan. Maybe that center's going to get good and maybe
25 player of the year's going to have a break-out night, Mr.

1 Burke, he didn't. But you didn't know that before the
2 game, did you? You just kind of make your best shot.
3 Well, this is a whole lot more complicated than predicting
4 who's going to win the national championship. You don't
5 have to go to medical school for four years, and you don't
6 have to do residency for four years and be board certified
7 and pass an examination, oral and written and then get
8 experience and practice in Ob-Gyn to predict the outcome of
9 a basketball game or to drive a car. This is a whole lot
10 more complicated than that. Is it reasonably foreseeable?
11 Is it reasonably predictable? Was this death reasonably
12 foreseeable, predictable given what was known at the time?
13 Not knowing who won the game or how this tragic event
14 turned out, but based on things as existed in real time
15 with these good trained doctors. Well, let's review some
16 of the plaintiff's case, because as my friend, Mr. Boyd,
17 correctly said and the Judge will tell you, they have the
18 burden of proof. They've got to prove and persuade you of
19 their case, that my doctors were negligent, that they fell
20 below the standard of care in some way that caused,
21 contributed or led to this tragedy. That's their burden.
22 So who'd they bring. I want to talk about two witnesses
23 and there are only two that I really care to talk about
24 from the plaintiff, Dr. Karotkin who is a pediatric
25 neonatology specialist. Dr. Karotkin's a fine fellow and

1 I'm sure he's good at what he does, and I don't have any
2 problem with that. He can take care of my grandkids
3 tomorrow, today, anytime, but he's not going to deliver any
4 of my grandbabies, because he's not a Ob-Gyn. And he told
5 you that. I'm not an Ob-Gyn; I'm not trained in that; I
6 don't have any opinions on the standard of care, so they
7 brought him in, this nice guy, good guy, well trained, well
8 qualified in his area, to say, essentially, well, you know,
9 my opinion is if Jayden had been born before he died, he
10 probably would've lived. Okay? And? Well, Dr. Karotkin,
11 you take care of 32 week-old premies all the time; Sure do,
12 they've got a 85 percent chance of making it, maybe 90
13 percent. So out of a 100 32 week-old babies born
14 prematurely, 10 to 15 of them are going to die of infection
15 or brain bleed or heaven knows what else, and he knows.
16 But that was his opinion; that was it. Well, Dr. Karotkin,
17 you're the neonatologist; you're their expert. Dr. .
18 Karotkin, do you have an opinion -- you've looked at this
19 case, you've looked at the records, you're a specialist in
20 pediatric neonatology, little premie kids that are born
21 prematurely, taking care of them and helping them survive -
22 - thank God for men like that; that God for people like
23 that. Dr. Karotkin, do you have an opinion what caused
24 this child to die? No, sir. Dr. Karotkin, do you have an
25 opinion what caused the decreased fetal movement that day?

1 I don't. Dr. Karotkin, do you know when this baby died
2 between 11:00 and 11:45, 47, whatever? No, sir. So that's
3 Dr. Karotkin. And then they brought you Dr. Phillips.
4 Dr. Phillips is a board certified obstetrics gynecologist
5 who by his sworn testimony has not delivered a baby since
6 2004, years before Jayden was living in the womb of his
7 mother. He hadn't delivered a baby since 2004. Now,
8 you've got to look at their experts and you've got to --
9 what is their opinion, what's the basis of their opinion,
10 what are the relative qualifications of all the experts you
11 heard from. Yes, what are their biases and prejudices, and
12 I'll get to that in moment. But let's look at Dr.
13 Phillips, because they've got the burden of proof. And,
14 please, understand, we don't have a burden of proof about
15 anything. The law doesn't require us to bring any experts.
16 We wouldn't have to put up a witness. The law doesn't
17 require us to put up any witnesses in any case. You got to
18 prove your case; prove your case. We're just going to sit
19 here; we're not going to cross examine a witness; we're not
20 going to put up any testimony; prove your case. And that
21 would be legally sufficient. We didn't do that, as you
22 know. We didn't do that. But Dr. Phillips came because
23 he's got to carry the water. He's got to carry the burden
24 of proof of negligence for the plaintiff's case. That's
25 his job. He's paid for it; all the experts are paid, but

1 he's been paid a whole lot over the years. He's like the
2 million dollar man by his own testimony, made over a
3 million dollars doing this, hundred and sixty, hundred
4 seventy thousand dollars in some years. You think he's got
5 a motive for keeping it going? Three or four times he's
6 reviewed cases for this law firm? You think he's got some
7 motive to keep it going? I think he probably does, and if
8 he doesn't and if you don't think so, throw that out;
9 disregard it. But let's look at what -- not so much he is
10 or who he is but what he said. I tried to take some notes.
11 I'm not a great note-taker, but I jotted some things down
12 as he testified, particularly under cross examination by my
13 partner, David Williford. These are some of the things he
14 said and admitted to under oath, mostly under cross
15 examination. There's a Proverb in the Bible that says, the
16 first to present his case seems truthful until another
17 comes and examines it. Well, this is cross examination,
18 and I've jotted some notes that I would ask you to reflect
19 on as you consider whether they have proven their case
20 through their expert, Dr. Phillips, not Dr. Karotkin. He
21 said that the NSTs did not constitute an emergency. That
22 was Mr. Williford's first question of him on cross
23 examination. And he showed to you, ladies and gentlemen,
24 that when he took his deposition a few months ago in this
25 case -- this case has been going on for a long time. A few

1 months ago he took Dr. Phillips' deposition up in New York
2 City. He hadn't even looked at the non-stress test strips,
3 but he formed his opinions. And so Mr. Williford during
4 the deposition said, well, I want you to look at the non-
5 stress test that were done on that day that Robin Pruette
6 ordered and she looked at and are a part of this case, have
7 been for years. Okay. And the deposition reads, perusing,
8 as he's looking at those strips for the first time. Under
9 oath and he's looking at them. And what does he say right
10 after that? These strips don't constitute an emergency.
11 That's his testimony. And that's his testimony to you in
12 this case. He told you that, well, in my opinion, this was
13 a rapid decline, and he said it a couple times. This --
14 this -- from NST through BPP to death was a rapid decline,
15 contradicting Dr. Karotkin, he says, oh, it was a slow
16 gradual process. The Ob-Gyn did not agree with that. He
17 agrees, Dr. Phillips does with the timing of the death with
18 a biophysical profile of two out of eight was
19 unpredictable. That was the word he used on cross
20 examination. I mean he wasn't led there. He said that.
21 It's either predictable, reasonably or it isn't. And Dr.
22 Phillips agrees that it was not reasonably predictable.
23 Those were his words. He agrees, according to his
24 testimony, that it was unforeseeable when this death would
25 occur. Those were his words. I hope you caught that. He

1 said, I don't know when the baby died. He said the fetal
2 demise occurred in this case fairly rapidly. There's no --
3 I have no criticism of the ultrasonographer; I have no
4 criticism of Robin Pruetto, the nurse practitioner in this
5 case; I have no criticism of Dr. Hilton when she instructed
6 Ms. Jamison go to labor and delivery. Much was made of the
7 fact that she may not have used the magic word emergency.
8 Lot of cross examination. Lot of questions from
9 plaintiff's counsel of our witnesses about that. Their
10 expert has no criticism of Dr. Hilton and how she told Ms.
11 Jamison to get to the hospital. He has no criticism of Dr.
12 Hilton when she instructed the patient, she -- he said that
13 Dr. Benson did not cause this patient to die by anything he
14 did or did not do. So they're saying, well, he should've
15 called for the patient; he should've called admissions; he
16 should've done something. We've already -- I'll get there
17 later. He said the implication was -- the implication
18 through all the questions of all the witnesses, Dr. Benson
19 had some duty under the standard of care to call -- or try
20 to call the patient when she wasn't there in 10, 15, 20
21 minutes. Their own expert Dr. Phillips said under oath to
22 you in this trial that Dr. Benson not doing that or doing
23 anything that day did not cause this baby or contribute to
24 this baby's death. Well, that's Dr. Phillips. That's
25 their case. That's their expert. That is their burden of

1 proof. Let's look very briefly at the defense case. I'm
2 not going to go through every witness. I promise you I
3 won't do that. You've heard enough; you've probably heard
4 too much, but it's my job and my responsibility to my
5 clients to tell you some things that I think might be
6 important for you to consider when you make your decision,
7 deliberate a verdict in this case. Well, what about Robin
8 Pruette? What about her? Ladies and gentlemen, you saw
9 today, I believe it was, today, that plaintiff's counsel
10 pulled Robin Pruette's deposition testimony out of a sack,
11 had the Judge unseal it and they asked the witness about
12 Robin Pruette's deposition in this case. You remember
13 that? That happened today. I think it was this afternoon.
14 How did they get Robin Pruette's sworn deposition testimony
15 about what she knew or didn't know or what she thought
16 about this case, because months ago they went down to
17 Lexington -- agreement with us and we were there -- my
18 partner David Williford was there -- and they put Robin
19 Pruette under oath and swore her to tell the truth, the
20 whole truth and nothing but the truth so help her God there
21 in her office in the Women's Center Lexington Hospital
22 where she is a nurse practitioner for another Ob-Gyn group,
23 and they asked her all manner of questions. They could've
24 asked her anything and she was under oath to tell the
25 truth, and she did. And a court reporter like this young

1 lady here, they take everything under oath and they reduce
2 it to a deposition and it looks like this and it's under
3 oath and it's under seal and they knew everything that
4 Robin Pruetto knew about this case months ago. And if they
5 thought it was so important for her to be here in trial to
6 tell you something about the case, they not only knew what
7 she was going to say, they could've issued a subpoena and
8 she would've been here. They could've called her in her
9 case, but they chose not to do that. And, ladies and
10 gentlemen, we chose not to call her, because honestly we
11 didn't think this trial required it, and let me tell you
12 why. We have this little blow-up here and we used it in
13 opening statement. I asked Ms. Jamison, did Robin Pruetto
14 do all these things; yes, I think she did, I recall, yes,
15 she probably did. These things were taken from Robin
16 Pruetto's deposition. Ms. Jamison said, yes, Robin did all
17 those things. Why do we need to bring her here? Dr.
18 Phillips has no criticism of Robin Pruetto. Why do we need
19 to bring her here? Maybe that's why they didn't want to
20 bring her here. There's no mystery about Robin Pruetto.
21 Please don't get distracted by that argument. Well, what
22 happened? On September 5th the evidence shows that she was
23 there at 8:40; she was the 18th or 19th person in the office
24 that day. That was a busy day. I don't know if it's any
25 busier than any other day. Doesn't matter. She signs in

1 at 8:40, and we know -- and we took the deposition of
2 Michelle Sharpe. It took about 10 minutes to video-tape it
3 and all this stuff about the NST strips. It wasn't 8:50
4 like it shows on the stamp. It was 9:50 or 10:00 o'clock
5 before that NST started, and that is really pretty much
6 without dispute. What happened between 9:40 and whenever
7 Robin saw her, all these things, every one of them. They
8 would've had to -- she waited; no question about it. Every
9 witness I asked, is there any evidence that Ms. Jamison was
10 not seen as soon as possible given the facts and
11 circumstances of her complaint of decreased fetal movement,
12 a fairly common complaint in a OB office, and given the
13 fact that she got there at 8:40. That's early. I mean
14 that's not her fault. I'm sure she couldn't have got
15 there any sooner. It's not her fault. But the fact is she
16 was the 19th or 20th person to sign in and everybody else had
17 to get seen. She -- it did not constitute an emergency
18 when she came in. How do we know that? Because Dr.
19 Phillips said at 10:34 -- at 10:34 a.m. when the NST was
20 finished -- and that's the last time on that NST strip --
21 based on those strips at 10:34 there is no emergency.
22 That's their expert. There's no emergency here. So an
23 hour and 10, an hour and 15, an hour and 20 minutes,
24 whatever it was she had to wait, she was taken back, she
25 was called by the triage nurse; the nurse makes a note; she

1 talks to her; she draws a little arrow down, FM, for
2 decreased fetal movement, takes some vital signs or
3 whatever she does and gives the chart to Robin Pruette,
4 puts her in a room. That all takes time, and it was a
5 reasonable amount of time that went by I submit. Robin
6 comes in, she doesn't know her, she does know her, doesn't
7 matter. Ms. Jamison, hi, how are you doing, why are you
8 here, I see the chart, decreased fetal movement, tell me
9 about it, what's going on, I'm going to examine you, okay,
10 oh, I hear the heart rate. Ms. Jamison told you about
11 that. Yes, I feel it - I heard the heart rate with Robin.
12 I was reassured by that. Well, who wasn't? Well,
13 everybody was. Well, what happened then? Robin, in her
14 judgment as -- not a nurse; she's not a nurse. She's a
15 nurse practitioner. That's a --- you kick it up another
16 level. It's just not a nurse, and there's nothing wrong
17 with just nurses. Okay? But she's a nurse practitioner.
18 It's a higher level of education and training. Nurses
19 can't diagnosis. Nurse can't prescribe medicines. Nurse
20 practitioners can. And Robin as a nurse practitioner saw
21 her appropriately, timely and appropriately said I want to
22 do a NST, decreased fetal movement, you're in that line;
23 and I don't care how many kick counts you've had in the
24 last 24 hours or four days or four weeks, it doesn't matter
25 to me; you've got decreased fetal movement; our practice is

1 -- out standard is in this office, you get in line for an
2 NST, and that's exactly what she did. Wendy Knox testified
3 that she took Ms. Jamison down the hall; she hooked her up
4 to the NST and for 34 minutes that NST ran and she would
5 check on her from time to time. There's no dispute about
6 that. She took those strips in her hand and took them back
7 to Robin who ordered it. Robin -- I don't know how long it
8 took Robin to look over those strips and make a decision;
9 we need a doctor and a BPP. Thirty seconds, a minute, it
10 doesn't matter. Everybody agrees that what Robin did was
11 appropriate, not just what she did but when she did it and
12 how long it took her to do it. So down the halls she goes
13 again with Wendy, and she's waiting now for Jane McCain,
14 this ultrasonographer that's in the office of this
15 practice. She's one of two ultrasonographers. They have I
16 think two machines. I don't really know, but let's say
17 they only have one. That's one than they're required to
18 have under the standard of care. The standard of care that
19 day would've been perfectly acceptable across this country
20 in an office just like there's to say, you need a
21 biophysical profile, we're sending you to the hospital,
22 whether it's across town or across the street, and it might
23 take an hour or two to get that BPP done, because the
24 standard of care doesn't require offices like my clients to
25 have trained technicians like Jane McCain and machines like

1 they have in their office to do these in the office to save
2 time for their patients, but they did that. Another
3 example if I might suggest of something exceeding the
4 standard of care by this practice, just another block in
5 that wall. So 10:48 and we've got the time stamp --
6 you've seen it; you've heard it. You've got it; it's in
7 evidence, 10:48, probably 10:47, she's in the room, Jane is
8 beginning. At 10:48 she takes her first picture. She's
9 working that transducer around looking for reassuring
10 things, because the NST had some problems with it. It's --
11 I don't know, it's indeterminate; we've got to do another
12 step. Everybody agrees that was the thing to do. So Jane
13 was the person and she did her ultrasound and by this time
14 Wendy had most likely gotten to Dr. Hilton and grabbed her
15 and said, you need to see this patient; Wendy said you need
16 to see this patient, because Robin said she needs to see a
17 doctor and she's already in doing the biophysical profile,
18 so what does Dr. Hilton do? Within 10 minutes, within --
19 it starts at 10:48; before 10:58 Dr. Hilton is in the room,
20 in the room. She's not -- well, when she gets done -- when
21 she gets that 40 minute test done, send her into the room
22 and I'll see her. And that -- you know, ladies and
23 gentlemen, that would've been within the standard of care.
24 That would've been acceptable even for their expert. Nope,
25 that didn't happen. Dr. Hilton says, no, her word, I'm

1 anal, OCD. I'm above and beyond is what you was saying in
2 a way that I would characterize it. You can determine how
3 you want to characterize it. She is in that room leaning
4 over the shoulder looking at the screen as Jane is going
5 through it, and Jane McCain will not stop a 40 minute
6 procedure unless a doctor orders her to do so, because she
7 knows what she's -- her responsibilities are. And Dr.
8 Hilton said, I've seen enough, decreased fetal movement,
9 I've got a two out of eight, that's not good. Zero, two,
10 four, who cares, it's not good; Dr. Hilton saw enough; two
11 out of eight, stop it at 10 minutes; Ms. Jamison, I want
12 you to go to the hospital; do you know how to get there? I
13 do; I've been there; do you have transportation? Yes,
14 ma'am, I do. Ms. Jamison, I want you to go to the -- you
15 can see her doing this; you can see her going this to Ms.
16 Jamison right there in that ultrasound room. And you saw
17 her testify and you know what she's like, and she's looking
18 in the face of Ms. Jamison, saying, Ms. Jamison, you need
19 to go to labor and deliver; do you know where that is? yes,
20 ma'am, I do; do you have a car? I do, I've got my own
21 transportation; you know it's just a few minutes; yes,
22 ma'am, I know I've been there; do no pass go; do not
23 collect \$200 dollars; go directly to labor and delivery;
24 I'm going to call my partner Dr. Benson; they will be
25 waiting for you. And Dr. Phillips says, their expert says,

1 that met the standard of care in instructing a patient.
2 That's their expert. So what does Dr. Hilton then do? She
3 walks out of the office, the door is still open, she picks
4 up the phone right outside I think was Doctor -- can't
5 remember who's office it was -- anyway somebody's --
6 Robinson, Dr. Robinson's office, right outside the ultra --
7 she picks up the phone in the hall and calls labor and
8 delivery, talks to a nurse, says I -- give me Dr. Benson.
9 Dr. Benson gets on the phone and she tells him everything
10 that she knows about this patient that she has seen for the
11 first time in her life, and she expresses her concern, and
12 you know she did. You know she didn't sugarcoat that and
13 you know she told Dr. Benson in no uncertain terms her
14 concern and the basis and reason for them. And Dr.
15 Benson's on the other line; he's in scrubs. He's got his
16 scrubs on; he's in labor and delivery, and he takes that
17 phone call and what does he do? As soon as he gets off the
18 phone with Dr. Hilton, he assembles a team, including a
19 anesthesiologist, it's Dr. Lupo; you'll see the name in the
20 records, anesthesiologist, Dr. Lupo. He got the
21 anesthesiology alerted; we've got a lady coming in; we
22 might have to do a really quick c-section; I want you to be
23 ready; get an OR clear; I want the decks cleared; we got
24 somebody coming in; nurses, nurses, we got a lady coming
25 in, Samantha Jamison; she's coming in from our office, when

1 she hits those doors and comes through the labor and
2 delivery, you get her ready, you get her on the table, you
3 assess her and as soon as you get her settled in, you give
4 me a call and I'm on the way. And so what did he do, just
5 go down to the doctor's lounge and have a cup of coffee,
6 watch television, take a nap? Really? He went back to
7 taking care of the four or five or six ladies that were in
8 various stages of labor on labor and delivery that he alone
9 was responsible for that morning. He just finished doing a
10 c-section at 10:00 o'clock, and he wasn't sitting around
11 doing nothing. He knew he's got somebody coming in that
12 might be an emergency c-section. He's got to do an
13 evaluation and everybody knew that was going to have to
14 happen. You know he wasn't going to take a long doing an
15 evaluation on that lady, Ms. Jamison, when she came
16 through. But he would take whatever time he needed to be
17 sure, because you don't want to deliver a 32 week premature
18 infant that something's wrong because decreased fetal
19 movement. You don't know what's happening. You've got to
20 make that decision very carefully and very reasonably and
21 very prudently but quickly. And this veteran doctor --
22 he's not a rookie like maybe Dr. Hilton was, you know.
23 He'd been at this in the trenches about 20 years by this
24 time. He'd been in Desert Storm; he'd been under fire; he
25 understands how that works, and Dr. Benson got his team

1 ready; he got an OR ready; he got anesthesia ready, told
2 his nurses to get ready and went about his business taking
3 care of his four or five patients, getting them ready,
4 getting them tucked in, getting them settled in, because he
5 knows there's a possibility of an emergency c-section
6 coming in any minute. You know how time flies? You know,
7 everybody says time flies when you're having fun. When you
8 enjoy what you're doing and when you're real busy, time
9 just flies by. He wasn't sitting there going, well, it's
10 been five minutes, it's been 10 minutes. And the standard
11 of care didn't require him to. The standard of care
12 required him to take care of his patients that he was
13 responsible for already in the hospital and get ready for
14 the one coming, and that's exactly what Dr. Benson did.
15 And the nurse, Betsy Peake, who made a note -- it's her
16 notes, not Dr. Benson's note -- documents on the electronic
17 medical records that at 11:40 Ms. Jamison came through the
18 doors of labor and delivery for the first time that day,
19 11:40. And what did they do? They implemented the plan
20 that Dr. Benson had put into play when he got off the phone
21 with his partner, Dr. Hilton. And what did those nurses
22 do? They carried the plan out. They said go -- now, this
23 is according to Ms. Jamison. This is her testimony. Go to
24 the restroom, change clothes, come back, get in bed, settle
25 in and get that fetal monitor on; now we're not hearing

1 anything, where in the office was it that they found the
2 heart rate, because there was a heart rate of 155 beats a
3 minute at 10:55 a.m.; that wasn't that terribly long ago;
4 it's 10:40, but where's -- where'd they find that heart
5 rate? Was it over here? Was it over here? And they're
6 searching. You know, the last thing the nurse wants to do
7 is make that awful discovery, when there's a heart rate and
8 now there's not -- no heart rate. And she couldn't find a
9 heart rate. And I don't know how long it took them to make
10 that decision, but something happened shortly after Ms.
11 Jamison came through those doors. At 11:00 -- by 11:43
12 according to the records, not our records, hospital
13 records, somebody from admissions came up from admissions
14 to labor and delivery and did whatever paperwork was needed
15 while she was getting settled in, while the
16 anesthesiologist, according to Ms. Jamison, was there in
17 the room with her, and admissions came in and admitted her
18 at 11:43. At 11:47 they turned the machine on and they
19 still couldn't find a heart rate and they called Dr. Benson
20 and he was there in less than two minutes, and you know, he
21 didn't look forward to that meeting. And there is some
22 pretty emotion from this warrior when he testified about
23 that moment. I know you felt it. It was real. That's not
24 a happy day for a Ob-Gyn. It's not a happy day for mama.
25 It's not a happy day for anybody. But he had the

1 responsibility to come in and take that transducer and try
2 to search for a heart rate hoping against hope he'd find
3 one. Those are good nurses. The nurses were good. They
4 knew what they were doing. But the doctor's got to make
5 the call, so he comes in and he can't find it. And he
6 sucks up the courage and the professionalism and tells this
7 dear lady that she has just lost her child of 32 weeks
8 gestation, and that's hard one for everybody. A few
9 minutes later Ms. Jamison, understandably, Doctor, would
10 you just check one more time? Would you check one more
11 time just to be sure? And he gladly does that. Yes,
12 ma'am, I'll be glad to. And he does it again; maybe it
13 takes a long time, and he's got to tell her again, no,
14 ma'am, there's no heart rate, your baby's died. We can do
15 a c-section; we don't have to do it today; you can come
16 back later, there's no rush. Well, I want to think about.
17 Her mom comes. I know it's a sad time. Terrible time.
18 And Dr. Benson leaves and he gives them the privacy of
19 taking whatever time they need, because now, ladies and
20 gentlemen, there's no emergency, there's no rush, it's
21 over. We just got to finish what we got to do. So he
22 gives them that time and while he -- while Ms. Jamison and
23 her mom are I'm sure, I'm sure crying together, upset,
24 shocked, the nurse documents when she came through the
25 doors at 11:40 she was frightened. That was the nurse's

1 words. I understand that. She didn't know what was going
2 to happen. She didn't know what had happened, and then
3 when she got that shocking news I'm sure she was torn up.
4 So what happens according to the nurse's note at 1357? Dr.
5 Hilton who had called over to labor and delivery to check
6 on how Ms. Jamison was doing is told that Ms. Jamison's
7 baby didn't make it. And what does she do? You saw the
8 sign-in sheets. You saw what a busy day she had. She got
9 out -- she got out of her office and got over to the labor
10 and delivery right away, and she walked up to labor and
11 delivery and she walked into Ms. Jamison's room and she
12 went to her bedside and said I'm so sorry; I'm so sorry. I
13 don't know what happened. I don't know why your baby died.
14 Can I pray with you; yes, pray for me. And then she left.
15 And then she and her mother made a hard decision, let's do
16 it today. And later that afternoon Dr. Benson did what I'm
17 sure an Ob-Gyn dreads doing more than anything else is
18 delivering by c-section a baby that didn't make it; whether
19 it's three days or 38 weeks, it doesn't matter. It's a
20 terrible thing. Ladies and gentlemen, that's the case.
21 Those are the facts. Those are the facts and the evidence
22 that you need to determine as you deliberate. The Judge is
23 going to give you the law. I'm not going to give it to
24 you. I'm a lawyer, but I'm not a Judge. The Judge is the
25 lawgiver. I expect some of the things he'll tell you in

1 his instruction to you include that if you judge the
2 doctors, which you must do, you must judge them, to the
3 extent that you judge what they did and their exercise of
4 their judgment this day for this lady, you can't use
5 hindsight. You can't know who won the national
6 championship ahead of time. You can't even know who made
7 it to the final four. That's hindsight. You can't use
8 that when you judge them and how they exercised their best
9 judgment in behalf of their patient that day. You judge
10 them based on what they knew and was it reasonable, and
11 what they did based on what they knew was it reasonable. I
12 expect that he'll tell you that the standard of care is
13 defined like this. The standard of care in South Carolina
14 that you have to apply to my clients is what the reasonably
15 prudent, not perfect, but the reasonably competent, not
16 perfect doctor, would have done or would not have done
17 under the same circumstances. What does that look like?
18 Let me suggest to you. Everything that Dr. Miller did,
19 everything that Dr. Hilton did and everything that Dr.
20 Benson, that fleshes out for you the standard of care in
21 this case, and that's based on the evidence, that's based
22 on partly the opinions of Dr. Phillips, their expert, and
23 it's certainly based on the opinions of the experts that we
24 brought. You want to throw their deposi -- or their
25 testimony out? You want to take Dr. Mark Moore and say,

1 well, he was represented by Ashby Davis 15 or 20 years ago,
2 that's why he's here. Throw his -- throw his opinions out.
3 Don't regard them at all if that's what you want to do. If
4 you think he was to be so biased and so prejudiced that he
5 can't give an honest review of the case and say, I know
6 malpractice when I see it and I know when it's met the
7 standard of care, and if you think that my relationship
8 with him influenced that opinion, throw it out, don't even
9 consider it. Dr. Roger Newman is a bit of a different
10 animal, and if you think that Dr. Roger Newman is going to
11 come to this Court or any Court in South Carolina, in this
12 case particularly, and have his opinion as a Professor at
13 the Medical University of South Carolina, as a board
14 certified in credential in maternal fetal medicine
15 specialist, if you think that guy is going to be influenced
16 based on somebody he knew in school 30 years ago that he
17 still keeps up with -- when was Memorial Day? It was
18 almost a year ago. Close friends? I doubt it. But you
19 want to set that aside and take all his opinions and make
20 that the basis of rejecting every opinion he had, you do
21 so. That's your decision, not mine. But one thing I want
22 to ask you about Dr. Newman -- I want to remind you about
23 if I could as I wrap this up. On Dr. Newman's CV -- it's
24 this booklet we put in evidence -- the one thing in there --
25 it's on a fourth or fifth page -- American College of

1 Obstetrics and Gynecology, Board Examiner; Board Examiner.
2 He doesn't just teach medical students and Ob-Gyn residents
3 and maternal fetal medicine fellows at MUSC. That's not
4 the only thing he does. He takes care of patients. '
5 Delivered a baby last Friday. But every now and then he
6 goes to Dallas where he'd just been the last two or three
7 days apparently, where he is an oral board examiner for
8 every man and woman who goes through medical school and
9 four years of Ob-Gyn residency training beyond that and
10 they want to be board certified in this specialty. They've
11 got to go through him and he determines whether they're
12 going to be board certified or not. That's who they want
13 you to throw opinion out because he knows Joe Robinson and
14 he had the misfortune if you want to call it that of going
15 to residency with him 30 years ago. So throw their
16 opinions out if you want to. That's your prerogative.
17 That is totally up to you. You don't have to regard
18 anything they said. But what are you left with? Throw
19 them out. You're left with Dr. Greg Miller who's not a
20 named defendant in this case, and he testified a good bit
21 the other day. And you're left with Dr. Hilton and her
22 testimony and her explanation what she did and how she
23 explained it and how she defended herself, and then you're
24 left with Dr. Chris Benson. Throw out Dr. Moore; throw out
25 Dr. Newman if you'd like to do that, if you think that

1 they're so biased they can't give you an honest opinion,
2 and if you think Dr. Newman is going to put his national
3 reputation on the line for this case or any case, you set
4 it aside; then you're stuck with these three people and
5 then make your decision based on what they said. Was their
6 care reasonable? Did it meet the standard of care? Ladies
7 and gentlemen, the scales of justice are what you use.
8 It's a mental weighing exercise as you weigh the evidence.
9 Our lady of justice -- you may have seen the statues. You
10 maybe seen pictures of them from time to time, and she's in
11 a long white flowing robe for purity. She holds the scales
12 in one hand; in another hand she holds a sword to enforce
13 her rulings, her findings. That's like you. But there's
14 another thing you've got to remember about our lady of
15 justice. She's blindfolded. She's got a cloth blindfold,
16 tied around her face. Why? It's because as she weighs the
17 evidence, she's not looking -- she's not looking at where
18 the plaintiff comes from or where the defendant comes from;
19 she's not looking at the educational level discrepancies;
20 she's not looking at, well, this is Ms. Jamison and these
21 are Ob-Gyns I've got to weigh that -- she's not considering
22 that. She's not considering any bias, any prejudice,
23 anything that would unduly influence her by seeing who it
24 is or what it is. She's just weighing the evidence on the
25 scales, and when she's done with that, as you must do, make

1 your decision. There's three options. One is, if you
2 weighing the evidence, as you must do -- it's a mental
3 exercise -- if you decide at the conclusion of all your
4 deliberations that the evidence tips ever so slightly in
5 favor of Ms. Jamison, that she has proven and persuaded you
6 that these doctors were negligent and that their negligence
7 caused or contributed to the death of Jayden, then if that
8 is your decision based on the evidence and the law, then
9 you must find for the plaintiff and award whatever damages
10 you deem appropriate. That's the law. There are two other
11 options. One option is, if it tips ever so slightly in
12 favor of the defendant doctors, you would find for the
13 defendants, and the third option is if it's -- as my friend
14 Mr. Boyd accurately described to you, if after you weigh
15 all the evidence, it's even, it's at least even, you should
16 return a verdict for Dr. Hilton, Dr. Benson and Rock Hill
17 Gyn-Ob. Verdict is a latin word. It comes from two words
18 that mean to speak the truth, vera dicto. Vera dicto means
19 to speak the truth. This is a copy of what I expect to be
20 a verdict form that the Judge will explain to each of you,
21 and particularly Mr. Foreman to you since you will have the
22 responsibility to sign it. It has three questions. First
23 question, do you find that the defendant, Ansley L. Hilton,
24 M.D., individually and as agent, servant or employee of
25 Rock Hill Gynecological and Associates, PA, negligently

1 departed from the standard of care in treating the
2 Plaintiff, Samantha Jamison, and that this negligence,
3 negligent departure from the standard of care proximately
4 caused the plaintiff's injuries, the death of Jayden and
5 any grief and suffering that understandably Ms. Jamison has
6 and will undoubtedly suffer. If after you weigh the
7 evidence, apply the law to the evidence, if your
8 determination, the 12 of you unanimously determine yes, and
9 then you would mark yes; if it's no, you'd mark no. And
10 you're not done yet. Turn the page, and then consider
11 exactly the same question and this time regards Dr. Benson,
12 and the third Defendant, Rock Hill Gynecological and
13 Obstetrics, PA. If you find -- if you find from the
14 evidence or lack of evidence that they have not sustained
15 the burden of proof or that we have sustained our burden of
16 proof which we don't have, but if you think they didn't
17 commit any negligence, then you would just check, Mr.
18 Foreman, with a unanimously consent of all fellow members
19 of the jury, you would check no to each question and then
20 third page, Mr. Foreman, you would sign and put whatever
21 date it is you reach your unanimous verdict. The Judge
22 will instruct you further in that regard. I ask you and
23 implore you on behalf of my clients and your responsibility
24 as citizens in this community, do your job; do it well; do
25 it conscientiously and do it deliberately in weighing the

1 evidence and returning your verdict based on the evidence,
2 based on the truth and let your verdict speak the truth in
3 this case, and you will have served Ms. Jamison and her
4 family and these doctors in this community well if you do
5 so. I want to thank you on behalf of my clients ahead of
6 time again for your attention to their case. It has not
7 been an easy time for them. I think you've seen that. But
8, they wanted to tell you their story, and they wanted to let
9 you make the decision based on the evidence and the law
10 whether they were negligent and their negligence caused
11 this tragedy. I suggest to you that the verdict could be
12 if you so choose unanimously for all three defendants in
13 their favor, no, they were not negligent. But that's up to
14 you, and we give the case to you now. We entrust it to you
15 and thank you for all your kind attention.

16 THE COURT - Final argument.

17 MR. BOYD - Mr. Davis talked a lot about Dr.
18 Newman and what he said. I just want to -- let's talk
19 about that a minute. Dr. Newman said that lack of fetal
20 movement in a high risk patient was a potential emergency.
21 He agrees with Dr. Phillips about that. Said you have to
22 treat -- if it's a potential emergency, basically you have
23 to assume the worst and hope for the best, and you have to
24 treat it as an emergency for the mother and the child.
25 What else does Dr. Newman say? He says, you know, a

1 THE COURT - Thank you very much. You may be
2 seated. Thank you. All right, counsel, I understand that
3 the jury has reached a verdict in this matter. Is the
4 plaintiff ready to receive it?

5 MR. BOYD - Plaintiff's ready, Your Honor.

6 THE COURT - And the defense?

7 MR. DAVIS - Yes, sir.

8 THE COURT - All right, very good. I'm sure it
9 goes without saying, but since I do it in every trial, I
10 will tell everybody, we asked this jury to do an extremely
11 difficult task. I do not know what the verdict is. We
12 will all find out that verdict together. We will receive
13 the verdict with respect and silence. Thank you very much.

14 (Jury returns with verdict at 8:58 p.m.)

15 THE COURT - All right, Mr. Foreman, I understand
16 your jury has reached a verdict. Is that correct?

17 MR. FOREMAN - Yes, Your Honor.

18 THE COURT - All right, could you hand the verdict
19 forms to the bailiff, please, sir.

20 (Verdict form is handed up to the Court)

21 THE COURT - Madam Clerk, you may publish the
22 verdict.

23 DEPUTY CLERK - In the State of South Carolina,
24 County of York, Court of Common Pleas 16th Judicial Circuit,
25 the case of Samantha Jamison vs. Ansley L. Hilton, MD,

1 individually and as agent, servant or employee of Rock Hill
2 Gynecological and Obstetrical Associates, PA, Christopher
3 B. Benson, MD, as agent, servant or employee of Rock Hill
4 Gynecological and Obstetrical Associates, PA, and Rock Hill
5 Gynecological and Obstetrical Associates, PA, case number
6 2011-CP-46-00683, as to the first question, do you find
7 that the Defendant, Ansley L. Hilton, MD, individually and
8 as agent, servant or employee of Rock Hill Gynecological
9 and Obstetrical Associates, PA, negligently departed from
10 the standard of care in treating the Plaintiff, Samantha
11 Jamison, and that this negligent departure from the
12 standard of care proximately caused the plaintiff's
13 injuries, the answer is, no. Question two, do you find
14 that the Defendant, Christopher B. Benson, MD, as agent,
15 servant or employee of Rock Hill Gynecological and
16 Obstetrical Associates, PA, negligently departed from the
17 standard of care in treating the Plaintiff, Samantha
18 Jamison, and that this negligent departure from the
19 standard of care proximately caused the plaintiff's
20 injuries, answer, no. Third question, do you find that the
21 Defendant, Rock Hill Gynecological and Obstetrical
22 Associates, PA, negligently departed from the standard of
23 care in treating the Plaintiff, Samantha Jamison, and that
24 this negligent departure from the standard of care
25 proximately caused the plaintiff's injuries, answer

1 indicated is yes. Question two, please state the total
2 amount of damages, if any, sustained by the Plaintiff,
3 Samantha Jamison, the amount of \$90,000.00 dollars, signed
4 this date April 12, 2013, by Daniel Moses, the foreperson.
5 Ladies and gentlemen of the jury, if this is your verdict,
6 please indicate by raising your right hand.

7 (All jurors affirm)

8 DEPUTY CLERK - Thank you. Let the record show
9 all hands are raised.

10 THE COURT - The jury having affirmed the verdict
11 by the raising of their hands, does the plaintiff wish the
12 jury polled?

13 MR. BOYD - No, sir.

14 THE COURT - Does the defense wish the jury
15 polled?

16 MR. DAVIS - Yes, sir.

17 THE COURT - All, Madam Clerk, if you would poll
18 the jurors individually, please, ma'am.

19 DEPUTY CLERK - When I call your name, if you'll
20 please stand and answer the questions as asked of you and
21 then you'll be asked -- you can have a seat. Jerry N.
22 Dickson, Jr., Juror Number 30. Mr. Dickson, was this your
23 verdict?

24 JUROR - Yes.

25 DEPUTY CLERK - Is it still your verdict?

1 JUROR - Yes.

2 DEPUTY CLERK - Thank you. Patricia P. Cribb.

3 Ms. Cribb, was this your verdict?

4 JUROR - Yes, it was.

5 DEPUTY CLERK - Is it still your verdict?

6 JUROR - Yes, it is.

7 DEPUTY CLERK - Thank you. Mr. Daniel W. Moses.

8 Mr. Moses, was this your verdict?

9 JUROR - Yes.

10 DEPUTY CLERK - Is it still your verdict?

11 JUROR - Yes.

12 DEPUTY CLERK - Thank you. Mr. Curtis L. Dias.

13 Mr. Dias, was this your verdict?

14 JUROR - Yes.

15 DEPUTY CLERK - And still your verdict?

16 JUROR - Yes.

17 DEPUTY CLERK - Thank you. Mr. Gordon E. Gore.

18 Mr. Gore, was this your verdict?

19 JUROR - Yes.

20 DEPUTY CLERK - And still your verdict?

21 JUROR - Yes.

22 DEPUTY CLERK - Thank you. Ms. Nancy L.

23 Vanderbleek. Ms. Vanderbleek, was this your verdict?

24 JUROR - Yes, ma'am.

25 DEPUTY CLERK - And still your verdict?

1 JUROR - Yes, ma'am.

2 DEPUTY CLERK - Thank you. Mr. Bobby C.

3 Shillinglaw, Jr. Mr. Shillinglaw, was this your verdict?

4 JUROR - Yes, ma'am.

5 DEPUTY CLERK - And still your verdict?

6 JUROR - Yes, ma'am.

7 DEPUTY CLERK - Thank you. Ms. Wanda Lloyd. Ms.

8 Lloyd, was this your verdict?

9 JUROR - Yes.

10 DEPUTY CLERK - And still your verdict?

11 JUROR - Yes.

12 DEPUTY CLERK - Thank you. Mr. David E. Krepps.

13 Mr. Krepps, was this your verdict?

14 JUROR - Yes, ma'am.

15 DEPUTY CLERK - And still your verdict?

16 JUROR - Yes, ma'am.

17 DEPUTY CLERK - Thank you. Mr. Donald R. Helms.

18 Mr. Helms, is this your verdict?

19 JUROR - Yes, ma'am.

20 DEPUTY CLERK - And still your verdict?

21 JUROR - Yes, ma'am.

22 DEPUTY CLERK - Thank you. And, Ms. Raksha R.

23 Patel. Ms. Patel, was this your verdict?

24 JUROR - Yes, ma'am.

25 DEPUTY CLERK - And still your verdict?

1 JUROR - Yes, ma'am.

2 DEPUTY CLERK - Thank you.

3 THE COURT - All right, the jury having been
4 polled and affirmed the verdict, it is the Court's
5 intention to release the jury at this time. Is there any
6 objection from the plaintiff?

7 MR. BOYD - None, Your Honor.

8 THE COURT - From the defense?

9 MR. DAVIS - No, sir.

10 THE COURT - All right, very good. Ladies and
11 gentlemen of the jury, I want to thank you. I am extremely
12 impressed by the diligence and hard work and all the effort
13 that y'all put in this case. I want to thank you. You did
14 everything the Court could've expected you to do regarding
15 this case. It was a difficult case; you worked very hard.
16 I want to thank you. I appreciate your service very much.
17 You did yeoman's work. There's no question about it.
18 Thank you. You are discharged at this time.

19 (Jury exits the courtroom)

20 THE COURT - All right, motions, counsel?

21 MR. BOYD - Your Honor, we'd move for the costs to
22 be added. The only one I could really say at this time is
23 the filing fee of \$200.00 dollars. I don't have available
24 other, but I least move for the filing fee costs of \$200.00
25 dollars be added.

1 THE COURT - The statutory cost shall be awarded.
2 I'll be glad for you to make a filing with the Clerk of
3 Court regarding those. If there is any objection to that
4 by the defense, I'll retain jurisdiction over that
5 particular question, but you make a filing with the Clerk
6 as to those costs and they shall be awarded.

7 MR. BOYD - Thank you.

8 THE COURT - Any other motions from the plaintiff?

9 MR. BOYD - None, Your Honor.

10 THE COURT - Motions from the defense?

11 MR. DAVIS - Your Honor, it is 9:00 p.m. on a
12 Friday night, and I would respectfully request 10 days to
13 file post-trial motions.

14 THE COURT - I appreciate that. If I was the
15 Resident Judge here, I would probably accept that, but I
16 need for you to go forward with your motions at this time.
17 Thank you very much.

18 MR. DAVIS - May I have a moment, Your Honor?

19 THE COURT - Yes, sir.

20 MR. DAVIS - Thank you. (Brief pause) May it
21 please the Court.

22 THE COURT - Yes, sir.

23 MR. DAVIS - Defense would respectfully move for
24 either a new trial or a vacation of the judgment pursuant
25 to Rule 59 and 60 on the basis that the verdict as rendered

1 by the jury is inconsistent in that they clearly and
2 unanimously held that Dr. Hilton, a named defendant was not
3 liable or negligent and Dr. Benson, a named defendant is
4 liable or negligent, and then found the corporation liable
5 and awarded damages, and I believe the Court's correct
6 instruction on the law to the jury is that a corporation
7 cannot act on its own but must act through its agents,
8 servants of (sic) employee, the agents, servants or
9 employees in this case, Dr. Hilton, Dr. Benson have been
10 found by the same jury as to be not liable, not negligent,
11 and accordingly it's at least an inconsistent verdict and
12 also on the grounds that a directed verdict should've been
13 granted for all defendants at the close of the plaintiff's
14 case and at the close of the defense case, which was denied
15 by the Court. It is for those reasons and on those
16 grounds, Rule 59 and 60 that we would respectfully move for
17 a new trial or a vacation of the judgment being legally
18 inconsistent and unsupported by the facts.

19 THE COURT - Counsel?

20 MR. BOYD - Yes, sir, Your Honor, in this case
21 there was -- the corporation was named separately as a
22 defendant, not just through the agency. It was submitted
23 to the jury separately. I don't believe there was any
24 objection to the corporation being named separately when it
25 was submitted to the jury, so I would contend that the

1 defense has waived that. Over and above that, Your Honor,
2 there was evidence in the record and argued before the jury
3 and went through the jury that other agents of the
4 corporation who may have not been named defendants were
5 negligent, that is, Dr. Miller and Dr. Pruette -- I'm
6 sorry, Nurse Pruette -- perhaps other people, so there --
7 there are other agents and the corporation itself could be
8 liable through them. Thank you.

9 THE COURT - All right, thank you.

10 MR. DAVIS - Your Honor, may I respond to that
11 just briefly with your indulgence?

12 THE COURT - Yes, sir.

13 MR. DAVIS - There is absolutely no evidence in
14 this record from their expert witness that any employee of
15 Rock Hill Gyn was negligent and that their negligence, Dr.
16 Miller, Robin Pruette, proximately caused or led to any
17 injury. The specific testimony of Dr. Phillips, their only
18 standard of care expert, was specifically to the effect
19 that it did not cause any harm, injury or death to this
20 infant. This verdict should be returned in favor of Ob-Gyn
21 and the Judge should enter a verdict in favor of them as a
22 matter of law.

23 THE COURT - Thank you. (Pause) All right, I'm
24 going to refer specifically to -- I'm just going to the
25 motion to some testimony by Dr. Douglas Phillips by doing

1 so is only to point out a particular aspect of the point.
2 I am relying upon the entirety of the evidentiary record in
3 this matter in making this ruling. Dr. Douglas Phillips in
4 his testimony made a comment that you hope for the best and
5 prepare for the worst, something that was echoed by Dr.
6 Hilton in her testimony. After that he specifically stated
7 that a delay in treatment was a breach of the standard of
8 care and contributed to the death. The delay in treatment
9 from the facts and evidence presented in this matter can be
10 applied to employees, agents, servants and/or
11 representative of Rock Hill Gynecological and Obstetrical
12 Associates, PA that were not specifically named as specific
13 defendants to this case. There was delay in several
14 aspects that was testified to. Since there is expert
15 testimony and factual evidence to support that expert
16 testimony, the Court would respectfully decline to grant
17 your motion for a new trial, and I would further state that
18 it is not inconsistent with a finding that the actions of
19 the two doctors were not negligent in this matter. The
20 verdict can be supported by facts and evidence in the
21 record regarding actions of the corporation through other
22 agents, servants, employees and/or representatives that
23 could be classified as negligent and therefore, the verdict
24 is not inconsistent. Now, regarding a motion for a new
25 trial, regarding a motion for a new trial and a judgment

1 notwithstanding the verdict, the Court views again all the
2 evidence and the reasonable inferences in the light most
3 favorable to the party, non-moving party, I find that there
4 being sufficient evidence, proper evidence supported by
5 medical expert testimony that reasonably supports the
6 verdict, the Court would respectfully decline to grant your
7 motions in this particular matter. As to the additional
8 motion regarding the Court not granting the directed
9 verdict, the Court believes that I properly ruled on the
10 directed verdict motions at the time they were presented
11 and that they were properly denied at that point in time,
12 and I again respectfully decline to grant your motion in
13 that regard. Further motions on behalf of the defense?

14 MR. DAVIS - That's all I can think of at 9:00
15 o'clock Friday night, Judge. Thank you very much.

16 THE COURT - All right, I appreciate it. Thank
17 y'all.

18 MR. BOYD - Thank you, Your Honor.

19 THE COURT - All right, this matter is concluded,
20 and this term of Common Pleas Court 16th Judicial Circuit is
21 adjourned sine die.

22 (Notes marked as Court's Exhibits 2 and 5.)

23 (Court in recess at 9:30 p.m.)

24 * * * * *

25

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

Steven H. John, Circuit Court Judge

Case No.: 2011-CP-46-00683

RECEIVED

MAY 14 2014

SC Court of Appeals

Samantha Jamison, as Personal Representative of the
Estate of Jayden Joenelle Jamison-Barber, deceased.....Respondent,

v.

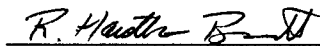
Ansley L. Hilton, MD, individually and as agent,
servant or employee of Rock Hill Gynecological
and Obstetrical Associates, PA; Christopher B.
Benson, MD, as agent, servant or employee of Rock
Hill Gynecological and Obstetrical Associates, PA;
and Rock Hill Gynecological and Obstetrical Associates,
PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

The undersigned hereby certifies that the Record on Appeal contains all material
proposed to be included by any of the parties and not any other material.

Respectfully submitted,



Thomas C. Salane
R. Hawthorne Barrett
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THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM YORK COUNTY
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RECEIVED

APR 24 2014

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Samantha Jamison, as Personal Representative of the
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and Obstetrical Associates, PA; Christopher B.
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and Rock Hill Gynecological and Obstetrical Associates,
PA, Defendants,

Of whom,

Rock Hill Gynecological and Obstetrical Associates, PA, is the.....Appellant.

PROOF OF SERVICE

The undersigned, an attorney in this matter for the Appellant, certifies that I have this 24th
day of April, 2014, served copies of the Record on Appeal upon counsel of record for the
Respondents by causing them to be deposited in the United States mail with sufficient postage
affixed, addressed to: James W. Boyd, Post Office Box 36425, Rock Hill, SC 29732 and D.
Bradley Jordan, P.O. Box 11785, Rock Hill, SC 29731.

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April 24, 2014