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THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

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**SC Court of Appeals**

APPEAL FROM GEORGETOWN COUNTY  
Court of Common Pleas

Larry Hyman, Circuit Court Judge

Appellate Case No. 2019-001304

Phillippa Smalling, individually and as Next Friend for  
Jahmerican M., a minor

Appellant,

v.

Lisa R. Maselli, M.D., both individually and  
as agent/employee of Carolina OB-GYN,

Respondents.

**RECORD ON APPEAL  
VOLUME 2 OF 2**

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1 pregnant woman, it can cause infection in the baby. And RI  
2 stands for rubella immune. Vital signs are stable. She's not  
3 having a fever. Fetal heart tones in the 130's. We had an  
4 internal monitor in. IFM stands for internal fetal monitor.  
5 CXTNS is contractions; so, she was contracting every two to  
6 four minutes. CX is cervix, that was her cervical exam with  
7 dilatation then a slash, then an effacement, which is the  
8 thinness, the thinning of the cervix and then a slash and then  
9 minus 3 was the station. So the baby's head was still high in  
10 the birth canal and my plan at that time was to call for an  
11 epidural and we expected a SVD, which is a spontaneous vaginal  
12 delivery.

13 Q: All right. That's your signature?

14 A: It is.

15 Q: Okay. So, the next one up, interim progress note, which  
16 is?

17 A: Interim progress note on 4/27, it was 3:50 A.M. just  
18 documenting the patient was comfortable. She received her  
19 epidural.

20 Q: Okay. So, anything unusual there?

21 A: Not with the epidural. But I did note that after the  
22 epidural, she had a deceleration, which was a decrease in the  
23 baby's heartrate for about 6 minutes. And I talked about the  
24 things that we did, the nurses and myself did to help  
25 alleviate that. We placed oxygen, we changed Ms. Smalling's

1 positions and we stopped the Pitocin.

2 Q: All right. And just beneath that, what does it say at  
3 04:45?

4 A: Well, prior to that, we did place an internal monitor.  
5 It's called a IUPC, which stands for intrauterine pressure  
6 catheter and we started fluid up inside to help clear out some  
7 of that bowel movement that the baby had had. And then at  
8 4:45, about an hour later, she felt some pressure, so I  
9 checked her again, but her cervix had changed minimally, if at  
10 all.

11 Q: All right.

12 A: So, we tried to restart the Pitocin at that time.

13 Q: Okay. So, now let's get to the 8 o'clock time period.

14 A: Okay.

15 Q: You are in the birthing suite along with Kathy  
16 Cossentino?

17 A: Yes,

18 Q: And indicates that David Hazeltine is in there as well?

19 A: Yes, he's the pediatrician.

20 Q: I want you to walk us through, if you would, this  
21 delivery?

22 A: Okay. So, as we saw from the records, the patient's  
23 completely dilated, she's 10 centimeters, so it's ready to  
24 push. So, what we do is I gown and glove. I have a hat and  
25 goggles on. I sit down in front of the patient and we've now

1 taken out the bottom part of the labor bed, which she's laying  
2 flat and place the stirrups, so that she can put her feet up  
3 on stirrups. And on the patient's right side was Kathy  
4 Cossentino, her labor nurse, and on the patient's left side  
5 was Mr. McCray, her husband and they assisted in just flexing  
6 the patient's legs normally that we do with every delivery so  
7 that as she pushes, it helps her focus her pushing and we  
8 started pushing.

9 Q: All right. Tell me what happens next?

10 A: So, we push and I think she pushed very effectively. She  
11 actually had a very short second stage of labor, about 14 or  
12 15 minutes from the time we started till the baby's head  
13 delivered. Once the baby's head delivered, we instructed her  
14 to push again. That would be normal and when you push with a  
15 contraction or I should say, you only push with a contraction,  
16 so that the push is more effective because it also has the  
17 strength of the mother's uterus and the contraction helping to  
18 deliver the baby. And with each contraction, we typically  
19 tell the patient to try to push 3 times for a count of 10 for  
20 each time and the nurses will help count to 10. So, after the  
21 baby's head was delivered, we did that and she pushed  
22 typically for 10 seconds and it was immediately noticed that  
23 the shoulder was not coming out under the pubic bone, that the  
24 shoulder was indeed stuck.

25 So, at that point in time, I diagnosed the emergency of a

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1 shoulder dystocia. I looked at Kathy, I told her to call out  
2 to another nurse, who I knew was sitting right outside the  
3 room. We were in the first room across from the nurse's  
4 station. That nurse was Missy Butterworth. And I said,  
5 again, help get Missy and bring in stools. So, we have stools  
6 in the labor and delivery area to help with occasions like  
7 this for shoulder dystocia. So, at that time, Missy comes in  
8 with the stools. She gives Kathy one, she comes around behind  
9 me, because I'm in front of the patient and she asks Mr.  
10 McCray to step aside so she can perform properly. McRoberts  
11 Maneuver and Mr. McCray came to behind my right shoulder at  
12 that point.

13 So, we performed McRoberts. Once we performed McRoberts,  
14 I instructed the patient again to start pushing. She pushed  
15 with one contraction, which would be about 10 seconds. We did  
16 not notice any change, I didn't feel any change as I was  
17 supporting the head, that the baby was coming down. So,  
18 behind me with all deliveries, I have what's called a delivery  
19 table. A little bit bigger than this area here and it sits to  
20 my right side because I'm right handed, so that I can reach  
21 for things as I need them and it could be suture or sponges or  
22 towels or anything. And at that time, I reached behind me and  
23 got a pair of scissors and I proceeded to do the procedure of  
24 the medial lateral episiotomy, which is an incision made on  
25 the patient's outer part of the vagina just to an angle to the

1 patient's right side of the rectal area. After doing that,  
2 thinking that could alleviate some of the soft tissue, which  
3 is just the patient's body habits, that may help deliver the  
4 baby. After I did that, I instructed her to push again; we  
5 did that for 10 seconds and no relief of the shoulder.  
6 So, I instructed the nurses to perform suprapubic  
7 pressure. So, at that time, the patient again was instructed  
8 to start pushing and I cannot recall which nurse did  
9 suprapubic. Typically it's going to be done with your  
10 dominant hand; that's what you have most control over. So, if  
11 both people are right handed, it was likely done by the nurse  
12 on the patient's left with her right hand and at that time,  
13 the nurses continue to hold her legs in McRoberts, which that  
14 hyperflexed position that we've been talking about and pushing  
15 down. When you do McRoberts, it helps tilt the pelvis.  
16 Instead of your pelvis being like this against the bed, it  
17 angles it and it helps open up the anterior front part of the  
18 pelvis. And so, the nurse performed suprapubic pressure,  
19 which you can perform for about 20 to 30 seconds. At that  
20 time, I had my hands on the baby's head and holding it and as  
21 soon as I felt the release, you can feel a pop, then I  
22 instructed the patient to push and that's where I added more  
23 moderate controlled to keep the shoulder staying unstuck from  
24 under that and effectively deliver the baby. All of that was  
25 about a 1 minute period of time.

1 Q: Thank you. A couple of follow up questions. You  
2 mentioned contractions and have we seen, this is -- I hand you  
3 what is marked as defendant's exhibit number 9. Is that a  
4 fetal monitor strip?

5 A: Yes, it is.

6 Q: Your Honor, we'd offer that into evidence.

7 MR. GRAHAM: No objection.

8 THE COURT: Without objection.

9 DEFENDANT'S EXHIBIT NUMBER 9

10 ADMITTED INTO EVIDENCE

11 BY MR. HOOD:

12 Q: We're not going to go through the monitoring strip. I  
13 just want you to help us understand, you know, what happens  
14 with -- because I saw contractions every 2 to 4 minutes, you  
15 mentioned earlier?

16 A: Uh-huh (affirmative response).

17 Q: When a mom is getting ready to deliver, how long are the  
18 contractions spaced typically?

19 A: Usually they're about every 1 to 2 minutes for effective  
20 contractions. That way you can push with the contraction.  
21 But you still give the uterus a time of rest in between each  
22 contraction.

23 Q: So, tell us how the pushing instruction and the  
24 contraction line up from a timing standpoint?

25 A: When you instruct a patient to begin pushing, you push

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1 with the contraction in conjunction with a contraction, so  
2 that you have both the uterus and the mom's expulsive forces  
3 working together to effect -- to be more effective of pushing.  
4 Q: And how long does that last?  
5 A: A contraction?  
6 Q: Or the contraction and pushing together?  
7 A: For as long as the contraction is typically about 30  
8 seconds.  
9 Q: And then when it stops, what happens with the pushing?  
10 A: You stop pushing in between contractions.  
11 Q: And physically, in terms of stopping pushing; is that  
12 necessary?  
13 A: Yes.  
14 Q: Why is that?  
15 A: Because, number 1, it's not effective for delivery, which  
16 is our goal. Number 2, it tends to tire out mom. You can  
17 just push continuously; you'd be exhausted. So, it gives the  
18 mom a chance to rest and it gives the baby a chance to recover  
19 from any of the compression forces that occur during a  
20 contraction and pushing together.  
21 Q: All right. Now, let me ask you about feeling change. I  
22 heard you say that; what specifically were you trying to  
23 describe?  
24 A: So, as my hands are on the baby's head and the head comes  
25 out, which happened very quickly, very efficiently, your hands

1 stay on the baby's head. You're supporting the head and  
2 you're ready for a normal vaginal delivery, which would be the  
3 mother pushes and you just angle the baby in an arc; it's  
4 called axial traction and you guide the baby out.  
5 Essentially, your hands are not doing much of anything accept  
6 supportive care for the head. At this point, when I applied  
7 what I -- what my definition was moderate controlled traction,  
8 was after the suprapubic pressure had worked to alleviate the  
9 shoulder dystocia and I felt that release. You can feel it  
10 because you feel a little bit of give. Then I instructed her  
11 to push and continue traction to deliver the baby.  
12 Q: And is this all happening, snap, snap, snap?  
13 A: Very quickly.  
14 Q: Like that?  
15 A: Very quickly, yes.  
16 Q: All right. I mean it's not suprapubic pressure, feel a  
17 pop, she takes her hands off and says oh, it just popped; now  
18 we can go ahead and deliver?  
19 A: It's almost all simultaneous.  
20 Q: Can you actually feel the shoulder get unstuck like that?  
21 A: What you feel is a -- is a give. I mean in your hands  
22 and I've done a lot of deliveries. You have muscle memory of  
23 what things feel like and you feel it's almost like a slight  
24 give and that's what I felt as the shoulder was unstuck with  
25 the suprapubic pressure.



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1 Q: All right. Let's talk about a few other records that you  
2 haven't had a chance to comment on. I'd like to go to your  
3 delivery note, which is defendant's exhibit number 6. Your  
4 Honor, we'd offer defendant's exhibit 6?

5 MR. GRAHAM: No objection.

6 THE COURT: Without objection.

7 DEFENDANT'S EXHIBIT NUMBER 6

8 ADMITTED INTO EVIDENCE

9 BY MR. HOOD:

10 Q: All right. We've seen this and I don't need you to read  
11 the whole thing; it's got too many words on it. 7:45 is the  
12 time, you didn't deliver the baby at 7:45, did you?

13 A: I did not. That was -- that was a notation error. The  
14 delivery note could not have been written prior to the  
15 delivery.

16 Q: You actually say 8:15?

17 A: Correct.

18 Q: Okay. Nuchal cord times one reduced. I didn't hear you  
19 describe that.

20 A: What can happen, nuchal meaning neck, neck area, so as  
21 babies move around inside of the mom's womb over the course of  
22 the pregnancy, they can get tangled up in the cord, the nuchal  
23 cord or cord around the neck is the most common; it happens  
24 about 1 in 5 deliveries or so. So, when the head is  
25 delivered, you can see the cord there. Your hope is that the

1 cord is not terribly tight that it can be elevated with your  
2 fingers and released over the baby's head. If it's not and  
3 it's too tight, you have to clamp it and cut it.  
4 Q: All right. Well this one says ---  
5 A: That was reduced without any issue.  
6 Q: All right. So, you do that and then you note here in  
7 your handwriting, McRoberts and suprapubic pressure given?  
8 A: That's correct, those were the two maneuvers to relieve  
9 the shoulder dystocia and it was successful.  
10 Q: Did you perform -- well, you talked about the episiotomy  
11 up here, right?  
12 A: Correct.  
13 Q: And we'll see elsewhere where the maneuvers are checked?  
14 A: Yes.  
15 Q: Did you perform a fourth maneuver where you just decided  
16 to pull harder?  
17 A: I did not, absolutely not.  
18 Q: What relieved the shoulder dystocia in this delivery?  
19 A: The suprapubic pressure placed by the nurse.  
20 Q: Let's look then at defendant's exhibit number 8, which is  
21 a shoulder dystocia progress note, which we would offer into  
22 evidence?  
23 MR. GRAHAM: What's the bates on that?  
24 MR. HOOD: 129.  
25 MR. GRAHAM: No objection, Your Honor.

1       **THE COURT:** Without objection.

2       **MR. HOOD:** Thank you, Your Honor.

3                   **DEFENDANT'S EXHIBIT NUMBER 8**

4                   **ADMITTED INTO EVIDENCE**

5       **BY MR. HOOD:**

6       **Q:** All right. So, we've been talking about this note for  
7 the last three days, shoulder dystocia progress note. I was  
8 asked about maneuvers used here; tell me about the order;  
9 first of all, who fills this out?

10      **A:** The physician fills it out. I filled this particular  
11 sheet out.

12      **Q:** All right. And let's start at the top, let's just work  
13 through this, this is the case note for shoulder dystocia.  
14 When you see complications, what do you identify?

15      **A:** Obesity is a pregnancy complication and that means prior  
16 to the time of labor or delivery.

17      **Q:** Okay. On this side, the left side of the paper, it talks  
18 about pregnancy complications. The right side has a column  
19 for labor complications.

20      **A:** That's correct, and I checked protracted first stage of  
21 labor, which is on your labor, the first stage of labor is  
22 labor up to the point of pushing.

23      **Q:** All right. So, let's stop for a second because I think  
24 that's the first time I think we've heard that. The first  
25 stage is when?

1 **A:** The first stage is when you begin labor; you could be 1  
2 centimeter or 5 or 7 centimeters, like Ms. Smalling was until  
3 you get pushing, which would be 10 centimeters.  
4 **Q:** And in this case, that was at 7:59?  
5 **A:** Yes.  
6 **Q:** And she pushed for 15 minutes?  
7 **A:** Yes.  
8 **Q:** All right. So, this whole timeline here would reflect  
9 what?  
10 **A:** The first stage of labor.  
11 **Q:** Okay. Now, so you indicate protracted first stage of  
12 labor and then you come on down here and you talk about the  
13 delivery. But just tell us real quick, what -- it says vacuum  
14 and forceps, what are those used for, by the way?  
15 **A:** So, a vacuum or forcep delivery is what we call a  
16 operative delivery, meaning it was not spontaneous and didn't  
17 happen on its' on. The provider put some sort of mechanism on  
18 the baby's head to facilitate delivery. There are various  
19 reasons we use those; it could be fetal distress, the baby's  
20 not tolerating labor, or the pushing, it could be that the  
21 baby is having a deceleration or bradycardia of the heartrate  
22 is very, very low and it could simply be that the mom is just  
23 exhausted and you're just trying to help facilitate delivery.  
24 **Q:** Where does the vacuum attach?  
25 **A:** The vacuum is attached to the presenting part of the head

1 that is at the opening of the vagina.

2 Q: And then what happens?

3 A: So, once we place the vacuum, you -- you place it in

4 between contractions and you apply a certain force of suction

5 on it and then with the next contraction, as the mom is

6 pushing, you effectively pull on the vacuum and she is

7 pushing.

8 Q: Is that -- that pulling, I mean, is a traction?

9 A: It's a traction force.

10 Q: And how is that applied and what angle?

11 A: Typically, it's an axial angle as we've been talking

12 about axial traction. So, it follows the head and angles up

13 as the baby's head comes out of the vagina. Your angle in

14 your arm follows attached to the vacuum.

15 Q: So, is it within the standard of care or an appropriate

16 indication to use a vacuum to facilitate that delivery?

17 A: Yes, it is.

18 Q: All right. What about forceps, what are those?

19 A: So, forceps look like two blades. You may have seen

20 pictures, that articulate or fit around the baby's head.

21 Again, we use them for the same indications as a vacuum. Both

22 of them can be used for similar indications. It's basically

23 provider preference as to which operative delivery choice you

24 make.

25 Q: All right. Those weren't used here either?

1   **A:**   They were not.

2   **Q:**   And in the appropriate case, are those within the  
3   standard of care to use ---

4   **A:**   Yes, absolutely.

5   **Q:**   --- those type of tools as well. All right. The real  
6   question in this case has to do with this next box here, level  
7   of traction applied. So, let me ask you, did you apply  
8   traction during this delivery?

9   **A:**   Yes, I did.

10   **Q:**   Do you apply traction in virtually all of your  
11   deliveries?

12   **A:**   Yes, I do.

13   **Q:**   Tell the jury what usual traction is for Lisa Maselli,  
14   please?

15   **A:**   So, in my years of experience and training, usual  
16   traction is where I'm placing my hands on the baby's head as  
17   it's coming out, out of the birth canal and with the next  
18   push, simply supporting the head, you're essentially guiding  
19   the head. There's not much force, there's not a lot of  
20   pressure, there's no need; the expulsive forces in the mom is  
21   effectively delivering the baby. This is why there's, you  
22   know, lots of times, babies just come out on their own, right;  
23   you've heard of people delivering at home. They really need  
24   in a usual situation, not much help for guidance at all.

25   **Q:**   So, you said the first thing was that the head delivered,

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1 right?

2 A: Yes.

3 Q: So, at the time the head delivered, were your hands on

4 the baby's head delivered, were your hands on the baby's head?

5 A: Yes, they were.

6 Q: Did you apply traction at that point in time?

7 A: Yes, I did.

8 Q: What amount of traction did you apply?

9 A: Gentle traction.

10 Q: Did the baby deliver?

11 A: He did not.

12 Q: All right. And that would be the diagnosis of shoulder

13 dystocia?

14 A: Yes, it was.

15 Q: All right. The second stage was what?

16 A: The next step was McRoberts Maneuver.

17 Q: While you're doing that, is the baby's head out of the

18 mom?

19 A: The baby's head is out of the mom.

20 Q: Did the baby's head ever go back inside the mom?

21 A: No, it did not.

22 Q: All right. So, the baby's head is out; are your hands

23 still on the baby's head?

24 A: Yes, supporting the baby's head.

25 Q: And once the legs are flexed back, do you ask the mom to

1 push with a contraction?

2 A: Yes, we do, to see if that maneuver of McRoberts would

3 then facilitate delivery.

4 Q: All right. And did you have your hands on the head at

5 that time?

6 A: I did, gentle traction, yes.

7 Q: Gentle, okay. Did that work?

8 A: No, it did not.

9 Q: The third step you did?

10 A: At that point, I performed a medial lateral episiotomy.

11 Q: Okay.

12 A: Yes, and we had another trial of pushing with gentle

13 traction.

14 Q: Did that work?

15 A: It did not.

16 Q: All right. Coming down my list, what happens next?

17 A: At this point, I've instructed the nurse to perform

18 suprapubic pressure.

19 Q: Now, at this point, how many times was suprapubic

20 pressure used on this particular patient?

21 A: One time.

22 Q: And at the time of the delivery, well, explain to us, I

23 mean, if you have a contraction and you have pushing and

24 you're trying to time it together and you're having nurses put

25 their hands above the pubic bone or wherever you're



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1 instructing them or we'll talk more about that in a minute.  
2 At what point in time, did you apply the moderate controlled  
3 traction that you just testified to?  
4 A: At the time of the suprapubic pressure, I just had my  
5 hands on the baby's head supportive and once the suprapubic  
6 pressure alleviated the shoulder dystocia, that's when I  
7 placed more moderate traction to facilitate delivery.  
8 Q: Okay. So, then you had you had the pop?  
9 A: Yes.  
10 Q: And then it was moderate?  
11 A: Yes...  
12 Q: And what does controlled mean?  
13 A: Controlled means that it's in normal fashion as far as  
14 angle... It was still an axial moderate controlled traction  
15 meaning that this was not something that was out of control,  
16 meaning turning or pulling in an unsafe fashion.  
17 Q: Since I said earlier, I asked you did you do four  
18 maneuvers and you said it was just three and now I've made a  
19 list with four things. I want to clarify that.  
20 A: Yeah.  
21 Q: This line right here, is the point in which shoulder  
22 dystocia is determined?  
23 A: Yes, after the delivery of the head.  
24 Q: All right. And so once in the shoulder dystocia box,  
25 there were three maneuvers?

- 1   **A:**   That is correct.
- 2   **Q:**   The McRoberts, was this excessive traction?
- 3   **A:**   No, it was not.
- 4   **Q:**   The time the episiotomy following that and then the  
5   pushing; was this excessive traction?
- 6   **A:**   No, it was not.
- 7   **Q:**   At the time of the suprapubic pressure where there was  
8   support being provided, did you apply excessive traction?
- 9   **A:**   No, I did not.
- 10  **Q:**   After the pop, when you described the moderate controlled  
11  traction delivering the body or the shoulders, was that  
12  excessive traction?
- 13  **A:**   No, it was not.
- 14  **Q:**   Did your moderate controlled actually pull the shoulder  
15  underneath the bone?
- 16  **A:**   No, it did not; the suprapubic pressure released the  
17  impacted shoulder.
- 18  **Q:**   Now, I want to talk about traction angles for a moment.  
19  If you have, let me just flip the page, tell us what the  
20  difference between axial and lateral traction is?
- 21  **A:**   So, axial traction is what's defined as the angle of  
22  delivering a baby that is line with the cervical thoracic  
23  spine.  So, keeping the head in line with the spine is  
24  typically a motion like this, almost like an arcing motion.  
25  It may slightly move to one side or the other, depending on

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1 which way the baby is coming out.

2 Lateral traction is where there's actually a downward

3 force that is stretching this area, not now, you can see it's

4 clearly not in line with the cervical thoracic spine. That is

5 the difference.

6 Q: Okay. So, I'm not going to try to draw that; I might let

7 you draw it in a minute. Let me ask you with respect to

8 lateral traction, what did you learn during your medical

9 training about the application of lateral traction during

10 vaginal delivery?

11 A: That it's inappropriate and should never be used.

12 Q: Have you ever thought that it is appropriate?

13 A: No, I haven't.

14 Q: Is that the old school, new school?

15 A: No, it's not.

16 Q: Has it always been that lateral traction is a no-no?

17 A: Yes, it has always been that way.

18 Q: When you were in residency, your first years in OB, did

19 you learn that?

20 A: Yes, I did.

21 Q: And every year thereafter?

22 A: Yes.

23 Q: And the continuing education since that time, whenever it

24 was in 2004, has any of that ever changed?

25 A: No, it hasn't.

1 Q: What about the idea of excessive traction, have you ever  
2 been taught to use excessive traction?  
3 A: No, I haven't.  
4 Q: We heard circumstances where a last ditch effort?  
5 A: Yes.  
6 Q: Have you -- have you ever encountered that situation?  
7 A: Thankfully, no.  
8 Q: Well, then with respect to excessive traction, tell us  
9 what that term means to Lisa Maselli, please?  
10 A: Excessive traction means to me, more traction than is  
11 necessary. It could be lateral, it could be a bending  
12 sensation or flexion of the neck or bending of the baby's neck  
13 and more than was needed to effect delivery.  
14 Q: So, let's see, I need to ask you about shoulder dystocia  
15 in general. Have you dealt with it before this incident?  
16 A: Yes, I have.  
17 Q: How often?  
18 A: Probably a couple of times a year.  
19 Q: All right. So, 3,000 births, what's that 20 or 30  
20 shoulder dystocias?  
21 A: That's correct.  
22 Q: And have you ever had a permanent brachial plexus injury  
23 other than this delivery?  
24 A: No, I haven't.  
25 Q: Have you ever had any brachial plexus injuries?

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1 A: No, I haven't.

2 Q: Have you ever followed a process other than your

3 customary process that you've described for us?

4 A: No, I have not.

5 Q: On occasion, well, how frequently does this process work

6 to effect delivery for your shoulder dystocias?

7 A: I would say 80 plus percent of the time.

8 Q: So, that would be ---

9 A: Very effective.

10 Q: --- there have only been a couple of times where you've

11 had to use these internal maneuvers here?

12 A: That's correct.

13 Q: What kind of training do you do to be prepared to handle

14 a shoulder dystocia?

15 A: Well, as we talked about before, we had 4 years of

16 residency where we're observed and taught various emergency

17 situations with an attending physician by your side to guide

18 you through. We do that. Once you're out in private

19 practice, we do drills on the floor. Typically, they're run

20 by a provider for the nurses. So, I may run a shoulder

21 dystocia drill. I mean, it's unannounced, it's kind of a

22 surprise. If it's a little bit slow on the floor, we'll

23 involve the nurses and that's a way to keep the skills aware

24 because these things do come up, they're unpredictable and

25 unpreventable, so you want the element of surprise. We do

1 that with our drills and most recently, we've been doing  
2 simulation labs where they're very sophisticated mannequin  
3 that is hooked up electronically, it has expulsive forces and  
4 ---

5 **MR. GRAHAM:** Judge, this is new since the deposition. We  
6 object on that basis.

7 **THE COURT:** Well, continue.

8 **BY MR. HOOD:**

9 **A:** --- we have simulation labs that travel around the state  
10 to all delivering hospitals. This has actually been going on  
11 for about 4 years now and they come twice a year to each  
12 hospital and it was an initiative started by the BOI, which is  
13 the Birth Outcomes Initiative for South Carolina to help  
14 promote healthy babies, healthy moms in the state and maternal  
15 fetal medicine specialists, which is a subspecialty of  
16 obstetrics run this simulation labs and are nurses, midwives,  
17 as well as physicians take part in these laboratory  
18 simulations.

19 **Q:** All right. Like a flight simulator for a pilot sort of  
20 thing?

21 **A:** Yeah.

22 **Q:** Do they grade you?

23 **A:** Not so much as grade you, they talk you through the  
24 emergencies, multiple emergencies; it's not just shoulder  
25 dystocia, it's postpartum hemorrhage, prolapsed cord, some of

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1 them are neonatal emergencies that the nurses work on. And  
2 so, again, similar to residency, you have someone there  
3 watching you go through the process and then critique and  
4 review and debrief about how the process was run. And a lot  
5 of it is not even just for individual training, but also for  
6 teamwork. You know, you have a doctor and someone that  
7 promotes how to work well as a team.

8 Q: Speaking of teamwork, did you lose your cool on this day,  
9 the 27th of April?

10 A: No, I didn't.

11 Q: Is this something that you're trained to respond to?

12 A: Yes, it is.

13 Q: Is it something that you're prepared to deal with in  
14 every delivery?

15 A: Yes, absolutely.

16 Q: Do you recall anyone yelling at you to stop during the  
17 delivery?

18 A: I do not recall anyone telling me to stop.

19 Q: Do you recall anyone in any delivery in your entire  
20 career telling you to stop?

21 A: No, I do not.

22 Q: Dr. Hazeltine was in the delivery room for the meconium  
23 staining you said?

24 A: That's why he was called, yes.

25 Q: Do you know where Dr., well, he's going to testify. I'll

1 ask him. Let me -- let me move on. We've heard some  
2 discussion about suprapubic pressure and how it was applied,  
3 that sort of thing. And so, I just need to ask you directly,  
4 you know, where are you in relation to the fists that's  
5 applying suprapubic pressure during the birthing process?  
6 **A:** I'm directly in front as I'm -- I sit for my deliveries.  
7 I'm sitting on the stool. My head is about level with mom's  
8 vaginal opening and I would say it's closer than an arm  
9 lengths away, so I'm probably within 18 inches to 2 feet from  
10 the suprapubic area.  
11 **Q:** All right. Did you observe four hands at one time  
12 pushing on mom?  
13 **A:** I did not. I have never observed that.  
14 **Q:** Had you observed that, what, if anything, would you do?  
15 **A:** I would have told them to stop doing that because then  
16 nobody is holding her legs and continuing McRoberts maneuver,  
17 which is conjunction with the suprapubic.  
18 **Q:** And I didn't ask you that, so you talked about McRoberts  
19 up here?  
20 **A:** Yes.  
21 **Q:** And then we mentioned the episiotomy. When you're doing  
22 this round of pushing with the episiotomy, is that with the  
23 legs flexed back at that time as well?  
24 **A:** Yes, absolutely. It's -- the maneuvers continue until  
25 one of them works and so, they're cumulative at least for the



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1 McRoberts and suprapubic, so we -- we keep the patient in  
2 McRoberts until delivery.

3 Q: All right. Now, how do you expect a nurse to do  
4 McRoberts and apply pressure to the above the pubic bone?

5 A: So, how they achieve that is whichever nurse is applying  
6 the suprapubic, you can apply it two ways, either your fists  
7 or with the palm of your hand. She's standing on the side of  
8 the patient and can affectively use her opposite hand to  
9 continue the hyperflexion of that leg. Sometimes in that  
10 event, just because of the physical weight and especially if a  
11 patient is numb from an epidural, we may ask the patient to  
12 also grab behind their thighs to save a little bit of the  
13 support.

14 Q: Let me, one other question. At the time the head is  
15 delivered here, if someone were to ask you to do a c-section,  
16 would you ever say, you'll do one when it's needed at that  
17 point?

18 A: No, I would never say that, and I've never been asked  
19 that question.

20 Q: Why not, why would you medically not do that?

21 A: Well, the head is out, number one. And I think when, in  
22 the previous testimonies, when we've educated the jury about  
23 there are more maneuvers to do, one of the last ditch  
24 maneuvers is called a zavanelli where you flex and replace the  
25 fetal head back into the womb and do an emergency c-section

1 and this is what's considered essentially a last ditch effort.  
2 **Q:** All right. Your Honor, I have a mannequin that they used  
3 to practice shoulder dystocia drills here and with your  
4 permission I'd like to have a doctor come down and show us  
5 what she's talking about.

6 **THE COURT:** Your witness?

7 **MR. GRAHAM:** Your Honor, that hasn't been identified.  
8 So, we would object.

9 **THE COURT:** He's not introducing it, I think he's using  
10 it for demonstrative purposes; is that right?

11 **MR. HOOD:** For sure. She's going to go back to whatever  
12 hospital she belongs to.

13 **THE COURT:** I'm going to allow it.

14 **MR. HOOD:** Can I borrow this table? I just need a word  
15 of caution, I mean it's a little eerie looking. You should  
16 have seen the people's faces when I was pulling it out of the  
17 car. Sorry about that.

18 **JUROR:** Judge, can we take a break?

19 **THE COURT:** Certainly. Let's take a break while you set  
20 up. All right? Let's give the jury a break and see, you  
21 remembered, I'm so happy that you remembered to do that.

22 **REPORTER'S NOTE:** (Jury retires to jury room 4:30 P.M.).

23 **THE COURT:** All right. Gentlemen, set it up; we're going  
24 to take about 10 minutes. All right?

25 **(COURT IN RECESS)**

1           **THE COURT:** All right. Let the record reflect we have  
2 our jurors and our alternates back in the courtroom. Thank  
3 you.

4           Mr. Hood?

5           **BY MR. HOOD:**

6           **Q:** Dr. Maselli, right before the break, I asked you to come  
7 down and demonstrate what happened during the one minute time.  
8 First of all, tell us about the orientation of the birthing  
9 bed?

10          **A:** So, we're using this to simulate the labor bed and what  
11 happens, the labor bed is made of three separate parts; it has  
12 a middle section, it has a bottom portion that can be taken  
13 away or just dropped down mechanically and it has an upper  
14 portion that can be elevated or placed up or down.

15               So, the patient lies in the bed and in a typical scenario  
16 mom is probably a little flatter than this when we start  
17 pushing and there are stirrups on either side. I think you've  
18 seen some pictures of those. Well, when we start pushing,  
19 we'd only put them on to push with her feet in the stirrups  
20 because it doesn't open up the pelvis; it doesn't give her a  
21 good angle to bear down on if she has to also push with her  
22 feet. You really want all the pushing forces to be down  
23 through into the vaginal and rectal area almost like you're  
24 having a bowel movement and that's how we instruct people to

1 push sometimes.

2 So, mom is here, essentially like this. If I were Nurse  
3 Cossentino, I would be on this leg holding it up, helping mom  
4 push. Mr. Hood would be Mr. McCray here, who is initially  
5 pulling on her on the patient's left side and I was seated  
6 right here on a stool facing Ms. Smalling.

7 Q: All right. So, John, why don't you come over here and  
8 help the other side. So, what was the orientation of the --  
9 you can hold up let two there. So, what was the orientation  
10 after the -- we'll side this down, grab the stool and slide  
11 down. So, the, there going to be somebody that she's  
12 completely blocking.

13 THE COURT: Pardon?

14 MR. HOOD: Everybody is okay, can everybody see?

15 THE COURT: Okay. All right.. Good.

16 BY MR. HOOD:

17 Q: All right. So, here we are; tell us what's going on.

18 A: So, we're sitting down. We confirm that she's ready to  
19 push, that she's 10 centimeters dilated, and we have a nurse,  
20 we have dad and I'm ready here, gowned and gloved ready to go.  
21 So, we instruct her to push and essentially within about 14 to  
22 15 minutes, we have delivery of the head. So, at that time, I  
23 instruct her to push.

24 Q: And let's just stop. No one can see your hands, the

1 whole case is about your hands. Let's turn this thing  
2 sideways at an angle. That's good. If you can speak up, we  
3 keep moving around. All right. All right. So, here we are,  
4 one minute, sorry.

5 **A:** Sorry, we're here. At this point, the baby's head is  
6 here and we instruct her to push again. One of the nurses  
7 will count with her, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10; one push  
8 and there's nothing happening. And so at that point, I don't  
9 have her push again, but we would typically push 3 times with  
10 each contraction. We've diagnosed the shoulder dystocia. I  
11 look at Kathy, who is to my left and say go out and get Missy  
12 and bring stools in; we have a shoulder dystocia. We need  
13 extra help. I would hold the leg or put the patient's leg  
14 back in the stirrup. Kathy walks to the door, leans out, says  
15 Missy, please come in with stools, we have a shoulder  
16 dystocia. Kathy takes her place back with now standing on a  
17 stool. Missy, the other nurse, comes behind and remember  
18 there's a big table right here by the delivery table with all  
19 the instruments. She walks behind that, asked Mr. McCray to  
20 let her stand there so she can effectively do suprapubic and  
21 he comes and stands behind my right side on the table, behind  
22 the table. And at that point, I say let's do McRoberts. We  
23 put the patient's head down slightly. We bring her legs open  
24 and hyperflexed, which is a little bit difficult to do with,

1 but we're doing it. Essentially, in real life, these would  
2 have been a little bit closer. The patient's head is, they're  
3 supporting the head at this angle; the patient's head is  
4 placed down again the whole goal is to open this up. Again, I  
5 say okay, push again, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, my hands  
6 are not moving; they're supporting the baby's head, the  
7 shoulder is not coming. So, they continue that position ---

8 **Q:** Why don't you just start pulling right there?

9 **A:** Not indicated, not appropriate. So, I turn around to my  
10 table and find the scissors. I cut the episiotomy, turn  
11 around, place the scissors back and go let's try it again. 1,  
12 2, 3, 4, 5, 6, 7, 8, 9, 10, nothing. I say apply suprapubic.  
13 One of the nurses places her fists just above the patient's  
14 pubic bone. I say continue McRoberts. You can do that; you  
15 can elevate the legs and as I said, we may have the patient  
16 just to help support the weight of them, dead weight leg, here  
17 and I continue to hold the baby's head for support and I have  
18 my hands on the head and the suprapubic pressure is applied  
19 probably about 10 seconds worth. I feel there's a little bit  
20 of a give and a release and I'm like let's go, now push and  
21 that's when I applied the moderate controlled traction to  
22 affect deliver after the suprapubic pressure releases the  
23 shoulder.

24 **Q:** And is mom pushing at the same time?

1   **A:**   She pushes when I told her to, not during suprapubic, but  
2   afterward so that it's essentially, I'm not pulling the baby  
3   out, the mom is pushing the baby out and we deliver the baby.  
4   At that time, we placed her feet back up in the stirrups, I  
5   clamp and cut the cord and immediately hand the baby off to  
6   Dr. Hazeltine, who is the pediatrician and the reason for that  
7   is because of the meconium. Remember I said, they like to do  
8   the special suction with a very long tube so the baby doesn't  
9   take a big breath, which is the first real breath in and so he  
10   takes the baby over to the warmer, which is going to be the  
11   patient's left shoulder off to the side. And at that time, I  
12   assess the situation, we deliver the placenta, the after birth  
13   that has to come out. Prior to that, we obtain blood from the  
14   cord; known as a cord blood sample. We send that to the lab  
15   on every delivery and because of the shoulder dystocia  
16   emergency, I also did what's called cord blood gas. I know  
17   we've been talking about that. I obtained that, sent that to  
18   the lab, delivered the placenta and then asked the nurse for  
19   suture to stitch and repair the episiotomy.

20   **Q:**   All right. So, let me get you to come demonstrate what  
21   you observed in terms of suprapubic pressure?

22   **A:**   Uh-huh (affirmative response).

23   **Q:**   I'll get off the stool and get out of the way.

24   **A:**   So the nurses are working to open and hyperflex, so these

1 aren't coming up here but coming up towards the patient's  
2 shoulders. They are elevated; they're on stools. So, probably  
3 a good 7 or 8 inches above where I am now. So, there's a good  
4 angle to apply suprapubic and the suprapubic is applied supra,  
5 meaning just above, so it's right above the patient's pubic  
6 bone and you can feel the pubic bone and it's a downward  
7 fashion and remember, because we're in McRoberts, this is  
8 anatomically almost slightly elevated because the whole pelvis  
9 has been tilted. And so then the nurse is pushing, pushing,  
10 pushing, pushing down because the shoulder is stuck right  
11 there. So, it's essentially pushing on the shoulder to  
12 decrease this diameter and effectively dis-impact the  
13 shoulder.

14 Q: All right. Now, did you see four hands up there ---

15 A: No, I did not.

16 Q: --- across the ---

17 A: No, I did not.

18 Q: How big is the pubic bone?

19 A: The pubic bone is about the size of your fist.

20 Q: All right. All right. Let's slide back. Okay. So,  
21 thank you. So, Dr. Maselli, while you were seated there, and  
22 you were just demonstrating with your hands on the baby's  
23 head. At any point in time, did you see what appeared to be  
24 the head stretching from the neck?



1   **A:**   No, I did not.

2   **Q:**   Earlier, I was going through the shoulder dystocia  
3   checklist and I asked you about forceps and vacuums and things  
4   like that, but those weren't used in this case, were they?

5   **A:**   No, unnecessary.

6   **Q:**   Okay.  I didn't want to confuse the issue.  I was just  
7   trying to find out what types of instruments can sometimes be  
8   used during the delivery.

9   **A:**   Yes.

10  **Q:**   All right.  So, now the baby's been delivered, the  
11  pediatrician is taking care of the baby; what are you doing  
12  with mom?

13  **A:**   So, after I hand the baby to Dr. Hazeltine, as I said, we  
14  obtained the two blood samples from the cord, delivered the  
15  placenta and repaired the episiotomy.  After that, I check  
16  again to make sure everything is what we call hemostatic or  
17  not bleeding, everything looks fine, all of the placenta is  
18  out and so, effectively, I get up to move all the table out of  
19  the way and the nurses then to proceed to get Ms. Smalling  
20  cleaned up.  You know, with warm light and we put the bed back  
21  together.  We've taken this bed apart, it can come apart and  
22  briefly, while she was doing that, I always step out to my  
23  dictation, write the note that you've seen and put the orders  
24  in, her routine postpartum orders for medication.  Then I come

1 back and we do a debriefing of the delivery, what happened.  
2 It was obviously a very scary process. There was a lot going  
3 on and nurses coming in and so, I wanted to talk about that.

4 Q: All right. We'll get to the conversation in a minute.  
5 The delivery note that you're stepping out, this is exhibit  
6 number, exhibit number 6, excuse me.

7 MR. GRAHAM: Is it handwritten?

8 MR. HOOD: It's handwritten.

9 BY MR. HOOD:

10 Q: That's when she stepped out to handwrite it; is that  
11 correct?

12 A: That's correct.

13 Q: All right.. We also have a dictated note which I'll hand  
14 to you; it's not I front of you. It is bate stamped, it's two  
15 pages, or it's not bate stamped, it's marked defendant's  
16 exhibit 5 and I would just ask if that's your delivery note?

17 A: This is the dictated, typed delivery note.

18 MR. HOOD: All right. Your Honor, we would offer  
19 defendant's exhibit 5?

20 THE COURT: Mr. Graham? Mr. Graham?

21 MR. GRAHAM: No objection.

22 THE COURT: All right. Without objection.

23 DEFENDANT'S EXHIBIT NUMBER 5

24 ADMITTED INTO EVIDENCE

1           **MR. HOOD:** Thank you.

2           **BY MR. HOOD:**

3           **Q:** Briefly, we've been through this. You've got noted on  
4 here a postoperative diagnosis. Active labor, spontaneous  
5 rupture, thinning, cutting umbilical cord, shoulder dystocia?

6           **A:** Correct.

7           **Q:** All right. You talk about the labor process here. I  
8 want to focus in on the second page of exhibit number 5, if we  
9 could, this top paragraph, where it says shoulder dystocia.  
10 Is this paragraph reflecting what you've just been describing  
11 for this jury?

12           **A:** Yes, on the demonstration, we did not talk about reducing  
13 the nuchal cord.

14           **Q:** And come down here, let see, you've got -- we'll talk  
15 about this. Cord gases, we're talking about the blood you had  
16 drawn?

17           **A:** Yes.

18           **Q:** 7.31 is normal?

19           **A:** Yes.

20           **Q:** That's good?

21           **A:** Yes, that's good.

22           **Q:** What is normal measuring?

23           **A:** Normal is measuring the amount of oxygen the baby was  
24 getting. It was not acidotic, which means low oxygen levels.

1 Q: All right. And so this note here, you can see would be  
2 dictated at 8:47; is that right?

3 A: Correct.

4 Q: And then looks like it was transcribed at 1 o'clock in  
5 that afternoon and then you signed it two days later?

6 A: Correct.

7 Q: All right. So, you encountered the shoulder dystocia,  
8 your handwritten notes reflect it, your dictated note reflect  
9 it; did you discuss it with the family or any part of the  
10 family?

11 A: Yes, afterward, Mr. McCray did go with Dr. Hazeltine, if  
12 I remember, to ask about the baby. I did ask Dr. Hazeltine  
13 after delivery, after I was finished with the episiotomy  
14 repair, it was obvious that the baby's right arm was not  
15 moving normally and I asked him about that and he said yes,  
16 we're going to the nursery for an x-ray and they took the baby  
17 to the nursery.

18 Q: Okay. You're familiar with the brachial plexus injuries  
19 from just your obstetrical knowledge, I trust?

20 A: Yes, that's true.

21 Q: And most of them resolve over a short period of time?

22 A: Most are transient within the first couple of years.

23 Q: Is there -- you say the first couple of years?

24 A: You can -- you can't document a permanent brachial plexus

1 injury until at least 1 to 2 years.

2 Q: So, in that first year then, up through that year sort of  
3 wishful watching, therapy?

4 A: Use therapy, yes.

5 Q: At that point in time, at the point of this delivery, did  
6 you have any way of knowing whether Jahmerican's injury would  
7 be permanent?

8 A: No, I had no way of knowing.

9 Q: And the only way to determine whether it is permanent is  
10 by the asset of time?

11 MR. GRAHAM: Objection to the leading, Your Honor?

12 MR. HOOD: Let me rephrase it.

13 BY MR. HOOD:

14 Q: How do you determine whether it's permanent?

15 A: If it meets the time criteria set up by the pediatricians  
16 to see if there are any other modalities successfully treated.

17 Q: All right. What other conversations do you recall having  
18 on the day of delivery, ma'am?

19 A: So, like I said, after I finished the repair, I walked  
20 over to Dr. Hazeltine, on my way out, he said we're going to  
21 do the x-ray. I went out and did my paperwork. I came back  
22 in, as I always do, even in a delivery that has no emergency  
23 associated with it, I -- when I finish the paperwork part, I  
24 always come back in even if it's just a hey, you did great;

1 how are you doing and then I either head back to the office,  
2 head back to the operating room or head home, depending on  
3 where I had come from and what time of day it is. And in this  
4 instance, I did the same. Both Ms. Smalling and Mr. McCray  
5 were appropriately so upset asking about the baby, what  
6 happened and didn't understand what happened. And so we ran  
7 through the process. I told them that it was a shoulder  
8 dystocia emergency and I said I know there was, you know,  
9 things going on, we asked you to move and things seemed to  
10 happen pretty quickly and told them that it is an emergency  
11 and that some babies don't do well with that. They are  
12 looking at the arm. Thankfully, the baby looks fine as far as  
13 any brain injury or lack of oxygen, but they're going to have  
14 to follow the arm is not going to be well.

15 Q: And was that your last interaction with the family on the  
16 day of the delivery?

17 A: Yes, it was.

18 Q: All right. I want to move to the next day then. And I  
19 would this marked as defendant's exhibit 25?

20 MR. GRAHAM: No objection.

21 THE COURT: All right.

22 DEFENDANT'S EXHIBIT NUMBER 25

23 ADMITTED INTO EVIDENCE

24 BY MR. HOOD:

1 Q: John, if we can pull up; do you have that? First of all,  
2 if you go to the top, there's a quote in here where it says  
3 alive; I think we heard some testimony about that earlier?

4 A: That is what it says. I did not write this note.

5 Q: All right. Whose note is this?

6 A: This is Dr. Christine Gerber, one of my partners at the  
7 time.

8 Q: And whose signature is on exhibit 25?

9 A: Dr. Gerber's.

10 Q: All right. Did you talk to Dr. Gerber between the time  
11 you left and the time Dr. Gerber got there?

12 A: No, looking back at the days of the week, this was a  
13 weekend and the 27th was a Saturday. Typically, when we do a  
14 call weekend, we do Friday, Saturday and Sunday all the way up  
15 until Monday morning. I don't recall what the specifics were,  
16 there was a schedule change; maybe we asked each other for a  
17 favor and needed to have a day or repay a day. So, I was  
18 working Friday through Sunday A.M. at approximately 7A.M. and  
19 Dr. Gerber must have come on at 7A.M. on Sunday, the 28th.

20 Q: Okay.

21 A: That's why she was rounding on Ms. Smalling during her  
22 first postpartum day.

23 Q: All right. And is that sort of routine for obstetrical  
24 practices in this area, where the person you deliver would be

1 seen by one of your colleagues?

2 **A:** Yes, absolutely. We cover all of our practices patients;  
3 we rotate the schedule just like any other day of the week.

4 **Q:** Okay. So, at this point, was there anything that was  
5 problematic with mom?

6 **A:** No, there is nothing to sign out is the term we use to  
7 talk to the next door coming on, if there is a certain  
8 concern, complication or issue with the patient. Ms. Smalling  
9 was our patient and she was doing well from the delivery.

10 **Q:** All right. We talked about the mom. How about the baby,  
11 I mean after you've handed the baby to Dr. Hazeltine ---

12 **A:** Uh-huh (affirmative response).

13 **Q:** --- when do you fade out and other doctors take over  
14 providing care and treatment for a newborn?

15 **A:** For the baby, essentially, once the baby is delivered, he  
16 or she is no longer my patient or part of my patient and so  
17 the pediatricians take over right away.

18 **Q:** All right. And that's what happened in this case?

19 **A:** Yes.

20 **Q:** Let me hand you defendant's exhibit 26, Your Honor, we'd  
21 offer that into evidence?

22 **THE COURT:** Yes, sir.

23 **MR. GRAHAM:** No objection.

24 **THE COURT:** Without objection.



**DEFENDANT'S EXHIBIT NUMBER 26**

**ADMITTED INTO EVIDENCE**

**BY MR. HOOD:**

**Q:** All right. This is a handwritten note; who's note is this?

**A:** This is the next day 4/29/13. This is written by Ann Morella, our certified nurse midwife, who Ms. Smalling had seen most of her pregnancy. This was the day of discharge.

**Q:** And did you go back and look to see who had seen Ms. Smalling in your office on the office visits?

**A:** When I initially came to the hospital when she was in active labor, I reviewed her prenatal records, just because I was not familiar with her prenatal history. And so I reviewed the records that evening.

**Q:** All right. And so, this Morella, was she the primary point person?

**A:** She was.

**Q:** And she's come back the day of the postpartum day 2?

**A:** Yes, it is now a Monday.

**Q:** And on Monday, she dictates what I'm handing to you as exhibit 10?

**A:** Yes, this is a discharge summary that any patient leaving the hospital, regardless of what you are admitted to the hospital for, has to have a discharge summary.

1 Q: All right. And exhibit 10, we'd offer into evidence?

2 MR. GRAHAM: No objection, Your Honor.

3 THE COURT: Without objection then.

4 DEFENDANT'S EXHIBIT NUMBER 10

5 ADMITTED INTO EVIDENCE

6 BY MR. HOOD:

7 Q: All right. So, exhibit 10, discharge, and I just want to  
8 draw your attention to the portion talking about, I can't read  
9 it, appropriate questions were asked and answered regarding  
10 his care. Would your colleague, Ms. Morella, have been in the  
11 position to provide answers to questions that families would  
12 have with respect to this situation?

13 A: From the maternal standpoint, yes.

14 Q: All right. Just a second. I'm going to hand you what's  
15 been marked for identification as defendant's exhibit 6, this  
16 is the mom's hospital chart and I'm going to direct you to  
17 page 85 of this exhibit.

18 A: Okay.

19 Q: And, Your Honor, we'd offer that into evidence please?

20 THE COURT: Could she identify the document?

21 BY MR. HOOD:

22 A: So, this is a document again of her paper charting still  
23 with a provider discharge form. So, this is the form that on  
24 the day of discharge is filled out by the doctor or nurse

1 midwife that's letting the patient go home that day.

2       **MR. GRAHAM:** Your Honor, I'm not sure what they're  
3 offering. If they're offering that one page we have no  
4 objection; if it's part of a bulk, I would object to it.

5       **MR. HOOD:** I excerpted it, so we'll just offer the page.

6       **THE COURT:** Okay. Thank you.

7       **MR. HOOD:** And we'll make that our next exhibit number  
8 which is

9 ---

10       **COURT REPORTER:** 27.

11       **MR. HOOD:** --- defendant's exhibit 27. Put 27 on that  
12 and we'll take care of it after the break.

13                       **DEFENDANT'S EXHIBIT NUMBER 27**

14                       **ADMITTED INTO EVIDENCE**

15 **BY MR. HOOD:**

16 **Q:** All right. John, can you pull that up for us? All  
17 right. So, hopefully we're looking at -- we're going to blow  
18 up those so we can read it. Follow-up visit information, do  
19 you see that third line?

20 **A:** Yes, so looking from the top down, she came in in labor,  
21 her discharge diagnosis was a delivery and the next line is  
22 discharge to home; she's going home. And so this is an  
23 interesting piece of paper. There's several different  
24 handwriting on here by different people. So, a lot of times,

1 to help facilitate our partners or colleagues that are coming  
2 after us, we fill out as much information as possible. So,  
3 the discharge or, I'm sorry, let's start at the top. The  
4 reason for admission, spontaneous labor and term IUP  
5 delivered. That is our nurse midwife's handwriting.

6 Q: Okay.

7 A: Discharge to home, 6 week postpartum visit slashed out  
8 Maselli, that is my handwriting as well as Rh positive and  
9 rubella immune, again it just advised the nurse that discharge  
10 if patient needs any additional medications. Pelvic rest is  
11 her activity. We recommend no -- anything in the pelvis, no  
12 intercourse, douching, postpartum.

13 Q: Okay. Let me just stop you for a second. I want to  
14 focus in on the follow-up visit. Did you scratch that out?

15 A: I did. So, initially when a patient came in and during  
16 her labor course, I was there at the hospital for that entire  
17 time trying to expedite some paperwork at the -- at the end.  
18 So, I wrote 6 week postpartum visit. It is hard to see what I  
19 wrote there. My guess is it's Ann because that's who she had  
20 seen throughout her -- her postpartum course and most of our  
21 nurse midwife's will see vaginal deliveries postpartum for  
22 their routine care.

23 Q: Why did you scratch her out?

24 A: The reason I scratched her out was after the shoulder

1 dystocia, I scratched her out and put my name there because I  
2 wanted to be sure that her visit was scheduled with me so I  
3 could again, review everything and check on the baby.

4 Q: Does that insure that when the visit is being scheduled  
5 that it goes on your schedule?

6 A: It goes on my schedule, yes.

7 Q: All right. And I'm going to direct your attention to  
8 pages 64 through 66 of your chart, which is exhibit number 1  
9 and ask you to tell us what we're looking at or what you're  
10 looking at there?

11 A: This is her note and our office chart is dated June 4th  
12 is her 6 week postpartum visit.

13 Q: All right. And who was there?

14 A: I was the provider giving care that day to her.

15 Q: And do you have any memory of that visit?

16 A: I do.

17 Q: Tell us what you remember from the visit?

18 A: I remember them coming in. We talked about how she was  
19 feeling, how she was doing, is she breast or bottle feeding,  
20 any problems with bleeding, revisited contraception, she had a  
21 full exam and I asked about the baby. She did not have the  
22 baby with her that day.

23 Q: All right. Any concerns expressed to you during that  
24 visit?

1   **A:**   Not that I can see.

2   **Q:**   And after that, did you have any other occasion to  
3   provide care and treatment to Ms. Smalling?

4   **A:**   I did not.

5   **Q:**   And how long after delivery was it to this visit?

6   **A:**   Approximately 6 weeks.

7   **Q:**   Thank you.   We would -- I don't recall Your Honor, if  
8   you admitted her chart, is in evidence?

9       **THE COURT:**   I thought we had already ---

10   **MR. GRAHAM:**   It's a bulk chart, Your Honor.

11   **THE COURT:**   Pardon?

12   **MR. GRAHAM:**   It's a bulk chart.

13   **THE COURT:**   The full chart, I will have marked.   I'll  
14   allow her to testify from it.   I'll give Mr. Graham the  
15   evening to determine whether there's any objectionable  
16   material in it and I will rule in the morning on that.

17       **MR. HOOD:**   Okay.   Thank you.

18   **BY MR. HOOD:**

19   **Q:**   All right.   We're wrapping up here.   We can put that back  
20   down.   At the time that you had to deliver, we're going to  
21   talk about that, but leading up to that moment back to the  
22   timeline; if you can imagine that first stage of labor up  
23   until 7:59, the end of the first stage of labor?

24   **A:**   Yes.

1 Q: Would you consider everything to be stable, medically  
2 stable for the baby?

3 A: Yes, sir.

4 MR. GRAHAM: Objection to leading, Your Honor?

5 THE COURT: I'll allow her to answer that.

6 BY MR. HOOD:

7 Q: Now, up until the head was delivered, did you see  
8 anything that made you concerned about stability?

9 A: No, I did not.

10 Q: Now, at 8:14, the head delivers?

11 A: Yes.

12 Q: After the shoulders failed to deliver, how would you  
13 describe the stability of the baby medically at that point and  
14 why?

15 A: At that point, the baby is considered unstable because  
16 the head is delivered, there is by sheer anatomy, compression  
17 of the cord because the baby's head is out, but it's oxygen  
18 supply is still through the umbilical cord that is now has  
19 been wrapped around the baby and is now pressed up against in  
20 the pubic bone and when you're encountering shoulder dystocia,  
21 though we know the movements to go through, we don't know how  
22 long it's going to take for those maneuvers to work to deliver  
23 the baby and how long can the baby tolerate this situation.

24 Q: Did you believe at that moment that when the head was

1 delivered, but the shoulders were not, that the baby was at  
2 immediate risk of harm or injury?

3 **A:** Yes, absolutely.

4 **Q:** Now, when the baby was delivered, we know that the data  
5 obtained afterwards, shows that he tolerated everything how?

6 **A:** He tolerated everything very well. Yes, thankfully.

7 **Q:** Did you have access to that information during the  
8 delivery?

9 **A:** No, that is a post-delivery laboratory value.

10 **Q:** Were you in an obstetrical suite at the time of this  
11 delivery?

12 **A:** Yes, I was.

13 **Q:** All right. So, when you were deciding the process to go  
14 through, did you have any way of knowing which maneuvers would  
15 or would not work?

16 **A:** You have absolutely no way of knowing. You can play the  
17 percentages, but have absolutely no way of knowing.

18 **Q:** And do you consider a shoulder dystocia to be a genuine  
19 medical emergency?

20 **A:** Yes, it absolutely is.

21 **Q:** And have you been trained that way?

22 **A:** Yes.

23 **Q:** Since medical school or since your residency rather?

24 **A:** Yes.



1 Q: Doctor, did you excessively pull to remove the baby from  
2 mom?

3 A: I did not.

4 Q: Doctor, did the motions that you used with your hands,  
5 was it consistent with what you'd done in other deliveries?

6 A: Yes.

7 Q: Do you believe that what you did caused the harm that  
8 we've been hearing about this week?

9 A: I do not believe that, no.

10 Q: Do you believe that the maneuvers that were followed and  
11 the process that you followed were consistent with excepted  
12 standard of care for obstetricians in this area?

13 A: Yes, absolutely, a hundred percent.

14 Q: And in this country?

15 A: Yes, absolutely.

16 Q: Bear with me just a minute, please?

17 A: Okay.

18 Q: I have no further questions at this time.

19 **THE COURT:** All right. Very well. It is 5:20. We'll  
20 continue with cross examination in the morning. Thank you.

21 Ladies and gentlemen, have a nice evening; be back at  
22 9:30 please. Thank you.

23 **REPORTER'S NOTE:** (Jury excused for the evening 5:18 P.M.)

24 **THE COURT:** All right. Gentlemen, we'll continue at 9:30

1 in the morning then. Thank you.

2 (COURT IN RECESS)

3 THE COURT: Please, just keep your seats. Why don't we -  
4 -- Are we ready to go? Bring the jury in?

5 MR. GRAHAM: Unless you want to address the bulk  
6 exhibits?

7 THE COURT: The what?

8 MR. GRAHAM: The bulk exhibits, 1, 2 and 3, where there  
9 were stacks of exhibits instead of individual ones. I don't  
10 know ---

11 THE COURT: Okay. If you want to, we'll do that.

12 MR. GRAHAM: Well, you asked us to look at them.

13 THE COURT: Well, okay. Well, I want I want you to do is  
14 tell me what you find offensive in those exhibits?

15 MR. GRAHAM: Well, just as -- as a sampling, just in  
16 general, relevance, hearsay, but to get more specific, there  
17 is ---

18 THE COURT: Why in the world would the charts and the  
19 medical records in a medical malpractice case not be relevant?

20 MR. GRAHAM: Well, because there's a lot of stuff in  
21 there that has nothing to do ---

22 THE COURT: Well, that's what we're talking about. The  
23 things that have nothing to do.

24 MR. GRAHAM: Okay. Well, there's it goes on and on about

1 ear infections, it's got advertisements in there about how you  
2 should treat infections, it's got stuff in there about  
3 sinuses, bronchitis, just all kinds of things that don't  
4 relate to mismanagement of shoulder dystocia or the arm injury  
5 or the treatment.

6 **THE COURT:** Okay. Well, let's hear from Mr. Hood. Mr.  
7 Hood, he says there are advertisements in there; I've never  
8 seen a chart with an advertisement, but Mr. Graham says  
9 they're advertisements in them?

10 **MR. HOOD:** If he just wants to point us to the exhibit  
11 and refer it so I can -- Judge, I'll tell you what, I'll just  
12 move in separately the exhibits I'm using. I don't want to  
13 waste any more time. Let's roll.

14 **THE COURT:** Thank you so much. Okay. All right. Let's  
15 bring in the jury then.

16 **REPORTER'S NOTE:** (Jury enters courtroom 9:35AM).

17 **THE COURT:** Good morning, ladies and gentlemen. We've  
18 got, I think all of our jurors and all of our alternates back  
19 in the courtroom. Mr. Graham, you may proceed with your cross  
20 examination.

21 **MR. GRAHAM:** Thank you, Your Honor.

22 **CROSS EXAMINATION OF DR. LISA MASELLI BY MR. GRAHAM:**

23 **Q:** Good morning, Dr. Maselli?

24 **A:** Good morning.

1 Q: You talked yesterday about having 3500 deliveries in your  
2 career, I believe?

3 A: Yes.

4 Q: How many of those were vaginal deliveries?

5 A: Probably around 80 percent.

6 Q: Okay. So, that makes what, about 2800?

7 A: Yes.

8 Q: Can I get you to step down please and fill out your name  
9 and the number of vaginal deliveries and so on. Forces of  
10 labor present, so maternal contractions, uterine, I mean  
11 maternal pushing, uterine contractions?

12 A: Yes.

13 Q: What is this one; 20 to 30, okay. I got it. I was  
14 impressed yesterday, you sounded good and your word choices  
15 were good.

16 MR. HOOD: Objection, Your Honor.

17 THE COURT: Please, please, Mr. Graham.

18 MR. GRAHAM: Yes, sir.

19 MR. HOOD: Can the witness go back to the witness stand?

20 THE COURT: Are you done with her there or you have some  
21 other questions for her there?

22 MR. GRAHAM: Well, she can go back. I have more of the  
23 chart up there.

24 THE COURT: All right. Thank you.

1 **BY MR. GRAHAM:**

2 **Q:** Doctor, before your testimony yesterday, how many times  
3 did you practice your testimony with video feedback?

4 **A:** I never practiced my testimony with video feedback.

5 **Q:** And how many times did you practice your -- your use of  
6 the mannequin?

7 **A:** Never, other than simulation drills.

8 **Q:** You talked yesterday about resident training and I  
9 believe that you indicated that you learned since very early  
10 in your resident training that in the event of a shoulder  
11 dystocia, it was very important not to use forceful pulling on  
12 a baby's head; did I hear that?

13 **A:** We were trained not to use excessive or lateral force  
14 with delivery.

15 **Q:** Okay. Well, is there some kind of forceful traction that  
16 you -- that you've thought was appropriate in those first  
17 minute or to?

18 **A:** With which delivery of the 2800; this specific case?

19 **Q:** I'm talking about as a resident, so that was long before  
20 this particular case?

21 **A:** Correct.

22 **Q:** As a resident, did you learn that all forceful pulling on  
23 a baby's head in a shoulder dystocia situation ---

24 **A:** We were never taught to pull on a baby's head and there

1 is a spectrum of force in delivering a baby.

2 Q: Were you, but you say you were taught to use it; were you  
3 taught not to use it?

4 A: We were taught not to use excessive or lateral forces in  
5 delivery.

6 Q: Okay. So, you were taught not to pull with force,  
7 correct?

8 A: There is force in any delivery.

9 Q: Okay. Well, yesterday you were talking about gentle  
10 guidance. You're saying that's force?

11 A: Any pressure on the baby's head at all is by definition,  
12 a force. There are spectrums as to the amount of pressure and  
13 force done with each delivery.

14 Q: Sure. And you used the word lateral, does lateral still  
15 mean other things to you like downward traction, even if the  
16 baby is facing up or down or are you talking about lateral  
17 traction where the head moves toward the shoulder?

18 A: Lateral traction is typically defined as the head moving  
19 towards the shoulder out of alignment with the spine.

20 Q: So, any time it moves to the shoulder, it's out of  
21 alignment with the spine, true?

22 A: If it's an excessive movement, true.

23 Q: Well, you say excessive, excessive movement. If it's a  
24 few degrees, if it's just a minor tilt of the head, with this

1 you say force that's always used, is that bending the neck?

2 A: It may be very slightly, but not in an excessive manner.

3 Q: All right. Were you taught -- in residency, were you  
4 taught that it was wrong to use bending of any kind or were  
5 you taught that it was okay to use bending as long as you felt  
6 like it was not excessive bending?

7 A: There should be minimal bending. We always were trained  
8 that way.

9 Q: Okay. Now, so we got -- we've got, you said don't use  
10 excessive force, don't use more than minimal bending, why are  
11 those -- are those important lessons that you learned in  
12 residency?

13 A: Very important.

14 Q: Okay. Why are they important?

15 A: They're part of our instruction to do vaginal deliveries,  
16 which is what our training was about for those 4 years.

17 Q: Sure, but why is it important not to use forceful pulling  
18 at the high end of the spectrum above gentle or slightly more  
19 than gentle?

20 A: You don't want to use that amount of force because of  
21 risk of injury to the baby, whether nerve damage or a  
22 fracture.

23 Q: And one of the risks of that kind of nerve injury is what  
24 we saw on the chart with the three nerve injury and avulsions

1 and the neuroma; that's one of the things that you were taught  
2 to avoid?

3 **A:** That's correct.

4 **Q:** And that was important in residency; was it still  
5 important in 2013?

6 **A:** Yes, always.

7 **Q:** And if someone in 2013 used more than gentle or slightly  
8 more than gentle pulling force, would that violate your  
9 training?

10 **A:** That would be against how we were trained.

11 **Q:** Okay. Would that represent a violation of a generally  
12 accepted standards of care for ordinary, average,  
13 obstetricians?

14 **A:** If it was excessive force, yes.

15 **Q:** Well, if it was more than gentle or slightly more than  
16 gentle, would that violate the standards of care?

17 **A:** If it was excessive and depending on the specific  
18 clinical situation.

19 **Q:** All right. I'm going to ask you to please listen to my  
20 question and try to answer it directly, if you would. If  
21 there is more than gentle traction or slightly greater than  
22 gentle traction in a shoulder dystocia situation, do you  
23 believe that would violate the standard of care for ordinary,  
24 average obstetricians?



1   **A:**    Depending on the shoulder dystocia event itself and where  
2    you were with maneuvers and how long it took to deliver this  
3    baby, it would depend on that.

4   **Q:**    All right.  Well, let's say -- let's say if you got a  
5    baby with good strips, reassuring strips for hours and hours  
6    and then you've got a diagnosis of shoulder dystocia, in those  
7    first 3, 4 minutes, do you believe it would be a violation of  
8    the standard of care for the obstetrician to use more than  
9    gentle or slightly more than gentle traction, a pulling force?

10   **A:**    If it was excessive, yes, I do.

11   **Q:**    Is greater than slightly more than gentle excessive?

12   **A:**    Sir, there's a spectrum of force and I can't answer what  
13    all physicians would do, only what I would do myself.

14   **Q:**    All right.  Tell us what you mean by excessive?

15   **A:**    So, other than a couple of people that I see in the room,  
16    probably most others have not had the opportunity to deliver a  
17    baby or have their hands on a baby's head for delivery.  So,  
18    there is a spectrum of force that can be used, difficult to  
19    understand if you've never done that procedure.  So, to put it  
20    in an everyday, if you're trying to get through a door and the  
21    door is slightly open, there's really gentle or no force to  
22    get through the door.  If the door is not open and you turn  
23    the knob and open it, that's slightly more than gentle force.  
24    But if you go to open that door and it's stuck and you're

1 pushing and pushing and pushing, that would be more excessive  
2 force. So, as you can see, in a very daily simple analogy,  
3 force can have a very full spectrum.

4 **Q:** Sure. Sure. And you keep, when you if greater than  
5 gentle is a violation of the standard of care, you keep  
6 referring to the word excessive. Can you give us a definition  
7 of excessive, instead of a story about the doors?

8 **A:** Yes, I gave one yesterday it was more than what was  
9 required in that specific delivery.

10 **Q:** So, in a situation like we had with Jahmerican, if it's a  
11 1 minute delivery, do you believe it would violate the  
12 standard of care for the doctor to use more than -- slightly  
13 more than gentle traction?

14 **A:** To use slightly more than gentle, the 1 minute is  
15 unfortunately a retrospective number. So, when we're  
16 delivering the baby, we don't know when it's going to work.  
17 It happened to be 1 minute in this case.

18 **Q:** Is it or is it not, please, ma'am, is it or is it not a  
19 violation of the standard of care in the first minute of a  
20 baby that has hours of reassuring heart monitoring, is it a  
21 violation of the standard of care to use more than -- slightly  
22 more than gentle traction; can you answer that please?

23 **A:** If the only method of delivery was the traction that  
24 released the impacted shoulder, that would be beyond. But if

1 a maneuver worked with the traction, it would not be.

2 Q: All right. Well let me see if I understand you. Are you  
3 saying that if you have nurses doing suprapubic pressure, it's  
4 acceptable in your mind for a doctor to use more than slightly  
5 more than gentle traction?

6 A: Not during suprapubic and as I explained yesterday with  
7 the mannequin, the suprapubic pressure released the shoulder,  
8 then the traction was placed. So, by definition, the traction  
9 facilitated the delivery, not the release of the shoulder  
10 dystocia.

11 Q: All right. Well, maybe it's just me being dense, but it  
12 seems kind of like you're going in circles. I thought you  
13 said that it was okay to use more than slightly more than  
14 gentle traction if -- if a maneuver was not working?

15 A: That's not what I said.

16 Q: Oh, that's not?

17 A: No, I'm sorry if you misunderstood. We don't use  
18 traction as force to deliver any baby or a shoulder dystocia  
19 situation. The traction is facilitating delivery after a  
20 maneuver has released the shoulder. There is a difference, I  
21 believe.

22 Q: All right. Well, you've used the word traction many  
23 times. Traction is simply pulling, right?

24 A: Traction, by definition, is a pulling force on any

1 object.

2 Q: All right. It's not pushing?

3 A: Correct, that's compression.

4 Q: And it's not -- it's not a tiny amount of force, pulling  
5 force, is it?

6 A: Well, by definition, it's a pulling force; it's not  
7 quantified.

8 Q: Well, let me ask you if you agree with this. Do you  
9 believe that traction is a pulling force that is sufficient to  
10 stretch an object?

11 A: By definition, it does put stretch on an object, yes.

12 Q: Okay. So, we're talking about, when you say traction,  
13 you're talking about using a pulling force that stretches?

14 A: Correct.

15 Q: And I don't want to belabor the point, but if you did use  
16 more than the gentle amount necessary when you say suprapubic  
17 to release the shoulder, if you use more than gentle traction  
18 at that point, that would be excessive, because it's not  
19 needed, correct?

20 A: I do not look at it that way. The way I explained it  
21 yesterday, was when you are dis-impacting the stuck shoulder  
22 with shoulder dystocia and I feel that give, the nurses,  
23 everything doesn't just stop, because if it does, the shoulder  
24 can go back up. You have to facilitate delivery in some

1 manner and the slightly more than usual, which is what I  
2 marked on the sheet and explained yesterday, was to slightly  
3 use pressure to keep that unstuck shoulder unstuck and deliver  
4 the baby, which is what happened.

5 Q: You wrote that on a sheet, you say?

6 A: I checked the box, moderate controlled.

7 Q: Okay. I thought you just said, you wrote on something  
8 yesterday that ---

9 A: No, I explained yesterday.

10 Q: --- could I finish my question please, ma'am?

11 A: Yes, sir, I'm sorry.

12 Q: I thought you said you wrote something that said you used  
13 slightly more than gentle traction. In fact, you checked the  
14 box for moderate, correct?

15 A: That's correct and yesterday, I explained my definition  
16 of moderate controlled, since there are no definitions on the  
17 shoulder dystocia sheet..

18 Q: Okay. Again, you're a doctor and I'm not, but I'm trying  
19 to follow you. It sounded to me like you said, it would be  
20 excessive to use more than gentle or slightly more than gentle  
21 traction if it was not necessary, correct?

22 A: Well, correct, and I defined again my spectrum, my  
23 definition of moderate controlled as slightly more than  
24 normal. There was never more traction in this specific case

1 placed.

2 Q: Well, didn't you say that after the shoulder released,  
3 that you had to pull harder to keep the shoulder for somehow  
4 popping back?

5 A: What I said, I didn't pull harder, I placed more traction  
6 to keep the shoulder unstuck and then instructed Ms. Smalling  
7 to push and it was her expulsive forces that aided in  
8 delivery.

9 Q: All right. You say you didn't pull harder, you used more  
10 traction, right?

11 A: Right.

12 Q: All right. A moment ago, you told us that traction is a  
13 pulling force that causes an object to stretch. So, how can  
14 you not pull and pull hard enough to cause an object to  
15 stretch at the same time?

16 A: So, the moderate controlled or slightly more than usual  
17 after the dis-impacted shoulder was released with suprapubic,  
18 then I put just slightly more pressure, I did not pull the  
19 baby out. Ms. Smalling continued to push after that point as  
20 we instructed her and effectively delivered the baby.

21 Q: If you had continued to pull, would that have violated  
22 your training?

23 A: Well, that didn't happen in this case.

24 Q: If you had pulled, would that have violated your

1 training?

2 **A:** If it was more than necessary for this delivery, yes, and  
3 it was not.

4 **Q:** If you had pulled at that point, do you agree that it  
5 would represent a violation of the standard of care for  
6 ordinary, average obstetricians?

7 **A:** If it was more than necessary, yes.

8 **Q:** Let's talk about bending the neck. Do you believe that  
9 it is never appropriate for an ordinary, average physician to  
10 bend the baby's neck during a shoulder dystocia?

11 **A:** If you're applying lateral traction, which is a downward  
12 movement and you see that the head is stretching away from the  
13 shoulder, that is inappropriate, yes.

14 **Q:** At all times?

15 **A:** Well, anytime a baby delivers, there is a slight stretch  
16 and bend in the neck, even in an uncomplicated or non-emergent  
17 delivery.

18 **Q:** Sure and we're not talking about the mother's body; we're  
19 talking about the doctor's hands; you understand that?

20 **A:** Yes.

21 **Q:** Okay. Is it always improper to bend the baby's neck with  
22 the hands of an ordinary, average doctor?

23 **A:** If it's excessive lateral bending, it is improper,  
24 absolutely.

1 Q: Okay. You told us before that slight bending, you now  
2 believe is okay. Now, you're saying it's got to be excessive  
3 to be against your training; how do you define excessive in  
4 that respect in terms of neck bending?

5 A: Again, it's more than what's necessary to deliver the  
6 baby.

7 Q: Can you give us an angle of bend; can you draw it for  
8 example, can you draw it for us on this board, please, ma'am,  
9 could you step down?

10 A: I can try.

11 Q: Step down and tell us, first of all would you draw a  
12 picture of a baby?

13 A: I'm not an artist, but I'll do my best. So, this is mom,  
14 the belly, the head, the vagina is here, the baby's head is  
15 here, legs, it's going to be very hard for a non-artist.

16 Q: Well, why don't you just put the baby's head here, nose,  
17 mouth, eyes?

18 A: Okay.

19 Q: All right. What do you call minimal bending of the neck;  
20 could you just draw another face that shows how much that  
21 would bend for it to be minimal bending?

22 A: Well, I will try. I mean, it's very difficult; I don't  
23 have a protractor to look at angles here. It's a circle, I  
24 don't know how to draw a ---



1 Q: We will accept an imperfect circle, I promise. Okay.

2 Now, can you show the bend in the neck; you can just draw an  
3 arrow to show how much -- well, I mean, at the top of his  
4 head, assuming that you're bending the head to the left, how  
5 far would you draw that arrow to show how far do you think  
6 minimal bending would be?

7 A: It would be a very, small, short, arrow; it's essentially  
8 as the baby coming out of the birth canal.

9 Q: Do you believe that bending more than minimal would be  
10 against your training?

11 A: Yes, I've established that.

12 Q: Okay. So, anything more than that minimum amount of neck  
13 bending would be a violation of your training?

14 A: Yes.

15 Q: And anything more than that amount of minimal bending  
16 would represent a violation of the standard of care for  
17 ordinary, average obstetricians, true?

18 A: True, if it was excessive bending, that's true.

19 Q: Well, if it was more than the minimum, true, yes?

20 A: Yes.

21 Q: Okay. Thank you. You may return to your seat.

22 THE COURT: Doctor, you may come back to your seat.

23 DR. MASELLI: Thank you.

24 BY MR. GRAHAM:

1 Q: Is -- do you consider it important to avoid bending the  
2 neck more than minimal?

3 A: Yes.

4 Q: Why is that important?

5 A: Because of the risk of injury or damage.

6 Q: All right. And if you were to bend a baby's neck to the  
7 left more than minimal, does that put the brachial plexus  
8 nerves on the right side of the baby's neck at risk of  
9 brachial plexus nerve damage?

10 A: If you -- if you bend to the left it would be the  
11 contralateral side; that is correct.

12 Q: All right. And when you contralateral?

13 A: The opposite.

14 Q: All right. If you pull to the left, you put these in  
15 danger, right?

16 A: Correct.

17 Q: All right. Pull left, endanger the right, right?

18 A: Yes.

19 Q: That's what you meant when you said contralateral?

20 A: It is.

21 Q: Let's talk, I want to move on to a different topic. Let  
22 me just -- I want to ask you just a series of brief questions.  
23 Do you believe, do you still believe that early decelerations  
24 are the same as variable decelerations?

1   **A:**   When a deceleration is with a contraction, it can be  
2   called an early or variable deceleration.  They are  
3   interchangeable in that respect, yes.

4   **Q:**   All right.  So, would it be an accurate reflection of  
5   your testimony if I say early equals variable?

6   **A:**   In relationship to a contraction, I would agree.  You can  
7   have variable decelerations outside of a contraction pattern.

8   **Q:**   Early equals variable.

9   **A:**   With the contraction.

10   **Q:**   Right.  I'm a slow printer.

11   **A:**   I'm sorry.

12   **Q:**   Is it just for space, I'm running out of space here.  I  
13   didn't ---

14   **A:**   You can put CXTN would be an abbreviation.

15   **Q:**   Okay.  So, it's your abbreviation for contraction.  Do  
16   you still believe that hyperstimulating or overstimulating the  
17   uterus means more than 10 contractions in 10 minutes?

18   **A:**   No, it's more than 5 or 6 contractions in 10 minutes.

19   **Q:**   Okay.  When did you decide that it was 5 to 6 in 10  
20   minutes?

21   **A:**   That's the definition; did I misspeak earlier?

22   **Q:**   You told me, ma'am, did you misspeak earlier?

23   **A:**   You asked me when I thought it was 10 in 10 minutes.

24       **THE COURT:**  If she said it, show it to her, so she can

1 say, you know, when, what you're talking about.

2 **BY MR. GRAHAM:**

3 Q: At any rate, from for at least the last 2 years, you've  
4 known that -- that hyperstimulation of the uterus is I think  
5 you said more than 5 or 6?

6 A: In a 10 minute period of time.

7 Q: Is it -- all right. This might take more than -- and  
8 hyperstimulation is too much stimulation, right?

9 A: Right, it means an excessive number of contractions in a  
10 certain period of time. The uterus needs to rest in between  
11 contractions.

12 Q: Hyperstimulation means the uterus is pushing too hard or  
13 too frequently?

14 A: Too frequently. It has nothing to do with the pressure  
15 or magnitude of a contraction.

16 Q: You said more than 5 or 6 in 10 minutes?

17 A: Yes.

18 Q: Do you still admit that you gave this child Pitocin?

19 A: Yes, I did.

20 Q: Alright, and the purpose of Pitocin is to strengthen the  
21 contractions and to speed them up, right?

22 A: It's, the use of Pitocin is an augmentation drug and it  
23 helps strengthen the contractions and increases the frequency  
24 of contractions to effect ---

1 Q: The answer to my question is yes?

2 A: Yes, that's correct.

3 Q: All right. And you say you did give Pitocin. After you  
4 gave Pitocin the first time, did it cause any kind of reaction  
5 to how the baby was responding to the contractions?

6 A: The first time we gave Pitocin, it was only on for a very  
7 short period of time and there was a deceleration in the fetal  
8 heartrate, which means it went below where it had been and it  
9 was also right around the time that Ms. Smalling received an  
10 epidural and when you receive an epidural, your blood pressure  
11 can drop, which affectively can do the same thing. So, two  
12 methods to help the baby's heartrate were to stop the Pitocin  
13 and to give her medication to aid with the blood pressure drop  
14 after the epidural. There were other things too that we  
15 discussed, but those were specifically related to the Pitocin.

16 Q: Okay. But when you were using the Pitocin, at least for  
17 some periods of time, you were hyperstimulating the uterus,  
18 correct?

19 A: We weren't hyperstimulating, we were stimulating the  
20 uterus, so that her -- her cervix would dilate.

21 Q: Okay. But do you -- do you still believe that you had  
22 hyperstimulated at least for a few times?

23 A: I would have to review that section of the chart. I  
24 don't know if there were specific times where we may have

1 adjusted the Pitocin, which you can do if you encounter  
2 hyperstimulation situation, then you adjust the medication.

3 Q: All right. And you did cut it off for a while after the  
4 hyperstimulation?

5 A: I'm not sure that was hyperstimulation that caused us to  
6 turn it off the first time. I would have to review that part  
7 of the strip.

8 Q: Well, at any rate, you did stop the Pitocin for a brief  
9 period of time?

10 A: Yes, we did.

11 Q: And the baby came right back; his heartrate went right  
12 back where it should be?

13 A: Between stopping the Pitocin, medication to aid with her  
14 low blood pressure, placing oxygen and changing her position.  
15 With all four of those methods, we had a good result.

16 Q: Okay. And then, soon after that, you turned the Pitocin  
17 back on, right?

18 A: I'm not sure how long it was, but eventually we did turn  
19 it back on?

20 Q: And it stayed on throughout the delivery process, right?

21 A: To my knowledge, yes, it did.

22 Q: Do you have, one of the exhibits is the fetal heart  
23 monitor strips; it's exhibit 5. Would you look at that  
24 please, and tell me, how frequently were the contractions at

1 the end of this labor?

2 **A:** At the end of the labor. These are approximately every 2  
3 minutes.

4 **Q:** Thank you. Before we move on to another topic, let me  
5 just get you to explain one thing to me. I was a bit confused  
6 yesterday when you were talking about the right way to do  
7 suprapubic pressure. Is it to push the -- the pubic bone and  
8 the -- or the top shoulder down to the floor or toward the  
9 mom's birth canal?

10 **A:** So, you push it above; supra, meaning above, because it's  
11 on itself, you're pushing in a downward fashion, either with a  
12 fist or palm of your hand and when a patients in McRoberts  
13 position, a hyperflexed position we've been talking about, the  
14 angle is downward and sometimes with that flex, it's almost  
15 towards the vagina. You're not pushing towards the vagina,  
16 you're not trying to push into the vagina, but with the tilt,  
17 it's a slight angle.

18 **Q:** And do you believe that's appropriate when there's a  
19 slight tilt of the bed?

20 **A:** Not to the bed, to the mother's pelvis.

21 **Q:** Okay.

22 **A:** I was talking about the angle of the pelvis in the  
23 McRoberts maneuver.

24 **Q:** Okay. All right. When the angle of the pelvis is like

1 you just said, you -- and was it like that ---

2 A: Yes, it was.

3 Q: --- when you controlled the nurses about how they should  
4 do suprapubic in this case?

5 A: I instructed them to perform suprapubic pressure with the  
6 patient in McRoberts.

7 Q: And the pelvis was tilted at that point?

8 A: Yes, it was.

9 Q: So, at that point, you instructed the nurses to push down  
10 toward the floor and toward the vagina?

11 A: I instructed them to perform suprapubic pressure.

12 Q: And if they had done that correctly in the course of your  
13 control, they would have pushed it down and toward the vagina?

14 A: It would have been downward and angled and in this  
15 situation did effectively do it correctly because that's what  
16 dis-impacted the shoulder?

17 Q: Let's talk about patient safety. You mentioned a lot and  
18 I was happy to hear that. Patient safety has been big  
19 initiative for those in -- those above the -- the doctors, the  
20 average, ordinary doctors that are delivering babies, right?

21 A: Above the -- you mean like my boss or what do you mean  
22 above?

23 Q: No, like -- do you believe that patient safety is a topic  
24 that has come to the forefront in the last few years?



1   **A:**   Yes, I absolutely do.

2   **Q:**   Okay.  Before that, one of the leading causes of death in  
3   this country was medical errors in the hospital, true?

4   **A:**   I don't have that data, but there have been significant  
5   deaths due to medical error, yes.

6   **Q:**   And there have been -- whenever there's a serious injury  
7   to a patient in the hospital, that's almost always from  
8   medical errors, true?

9   **A:**   I would not say that, no.

10       **THE COURT:**  Take this jury out, please.  Thank you.

11       REPORTER'S NOTE: (Jury retires to jury room 10:12AM).

12       **THE COURT:**  Let me save some time.  I'm going to save you  
13   some time, Mr. Hood.  Mr. Graham, you know that's improper.  
14   We're not going into what may happen to someone else.  We're  
15   talking about this case.

16       **MR. GRAHAM:**  All right.  I hear you, Your Honor.

17       **THE COURT:**  All right.  I'm not going to have that.  Is  
18   that what you were standing up for, Mr. Hood?

19       **MR. HOOD:**   It is, Your Honor.

20       **THE COURT:**  Okay.

21       **MR. GRAHAM:**  I will, I just have a couple of more  
22   questions.

23       **THE COURT:**  Not on that.  Not on that issue.

24       **MR. GRAHAM:**  Not on -- not on any effects on somebody

1 else.

2       **THE COURT:** Okay. Thank you. We'll take a break. The  
3 jury is going to need it while they're out.

4                               **(COURT IN RECESS)**

5       **THE COURT:** Let's see if we can get the jury back in if  
6 they're ready to come back in. They may not have had enough  
7 time to refresh themselves. If they have, certainly bring  
8 them back in.

9       Mr. Hood, you want a curative charge, or you want to let  
10 it go.

11       **MR. HOOD:** I think we can let it go, Your Honor.

12       **THE COURT:** All right. Thank you.

13       **MR. HOOD:** As long as we don't revisit it.

14       **THE COURT:** Are they ready?

15       **BAILIFF:** There's one in the bathroom.

16       **THE COURT:** We still have one that's out? Okay. As soon  
17 as they're ready, let's bring them in, just as soon as they're  
18 ready.

19       **REPORTER'S NOTE:** (Jury enters courtroom 10:25AM).

20       **THE COURT:** All right. We have everyone back in the  
21 courtroom. You may continue.

22       **MR. GRAHAM:** Thank you, Your Honor.

23       **BY MR. GRAHAM:**

24       **Q:** Doctor, I want to ask you about a specific topic that Mr.

1 Hood asked you about yesterday. I believe you said that Dr.  
2 Blackmon was one of your colleagues.

3 **A:** No, the Lewis W. Blackmon was a safety award that I won  
4 with one of my colleagues.

5 **Q:** Okay. And who was that colleague?

6 **A:** Dr. Christine Gerber.

7 **Q:** Okay. Is it fair to say that your office is not limited  
8 to OBGYN; that there all kinds of other services that your  
9 office provides?

10 **A:** Carolina OBGYN, LLC is a corporation and it is limited to  
11 obstetrics and gynecologic care.

12 **Q:** But if you look on Carolina OBGYN website, it talks about  
13 a number of body rejuvenation services, correct?

14 **A:** That is correct. There are two other corporations in our  
15 building. One is called Smart Lipo and one is called Carolina  
16 Rejuvenation.

17 **Q:** All right. And whichever physician works in that,  
18 physician or physicians work in that office, are OBGYN's,  
19 correct?

20 **A:** Yes, there -- there are three of us in the group that  
21 also have other corporations that provide other services, but  
22 not under the name of Carolina OBGYN as was suggested.

23 **Q:** Is there anything in the office building that would tell  
24 patients those are different corporations?

1   **A:**   When you read the literature regarding it, it's on there  
2   and it is on our website as well.

3   **Q:**   Okay.  At any rate, on the website for Carolina'---

4       **MR. HOOD:**  Objection, Your Honor, hearsay and relevance.

5       **MR. GRAHAM:**  It's ---

6       **THE COURT:**  Restate the question again.  Let me hear the  
7   question once again.

8       **MR. GRAHAM:**  Yes, sir.

9   **BY MR. GRAHAM:**

10   **Q:**   Yes, sir.  Your website contains information about how  
11   patients can get various body rejuvenation services, including  
12   true sculpt, smart lipo and Mona Lisa touch, correct?

13   **A:**   That is correct.  I do not perform the first two; I do  
14   perform the third.

15   **Q:**   You do perform?

16   **A:**   Mona Lisa touch procedures.

17   **Q:**   Mona Lisa touch?

18   **A:**   Which is more of a gynecologic procedure; it is not  
19   cosmetic.  It is indicated for vaginal dryness and pain with  
20   intercourse after menopause.  The other two procedures, which  
21   I don't perform, are cosmetic.

22   **Q:**   Now, let's talk about your hands during that -- that last  
23   minute or so.  Your hands were on the baby's head when you  
24   diagnosed shoulder dystocia, correct?

1   **A:**   Correct.

2   **Q:**   And then when you asked the nurses to perform McRoberts  
3   position, your hands stayed on the baby's head, correct?

4   **A:**   Correct.  The only times my hands moved were to perform  
5   the episiotomy.

6   **Q:**   Okay.  So, from the time you diagnosed shoulder dystocia  
7   through the time baby's entire body was out, your hands were  
8   on the baby's head, except when you were doing the episiotomy?

9   **A:**   I was touching the baby's head during the whole delivery  
10   except for the episiotomy and even with the nuchal cord  
11   reduction, my hands were still on the head.

12   **Q:**   Okay.  So, I've heard from other doctors that, you know -  
13   --

14           **MR. HOOD:**  Objection.

15   **BY MR. GRAHAM:**

16   **Q:**   --- the episiotomy is pretty fast.  You just reach over  
17   and (cutting sound), is that ---

18           **MR. HOOD:**  Objection.  Hearsay.

19           **THE COURT:**  Rephrase your question and just ask her about  
20   the episiotomy.

21   **BY MR. GRAHAM:**

22   **Q:**   How fast are you in terms of reaching for the scissors  
23   and cutting a woman's vagina?

24   **A:**   5, 6 seconds, very fast.

1 Q: All right. So, for that -- for that minute of time of  
2 shoulder dystocia, your hands on the baby's head for how long?

3 A: 50 to 55 seconds.

4 Q: Okay. So, when you were talking about the traction or  
5 pulling or whatever you used, your hands were on the baby's  
6 head?

7 A: That's correct.

8 Q: And when you talked about minimal bending of the head or  
9 some degree of bending of the head, your hands were on the  
10 baby's head, right?

11 A: They were on the head the entire time..

12 Q: Yesterday, you talked a lot about shoulder dystocia as a  
13 genuine emergency?

14 A: I did.

15 Q: Okay. What I want to know is -- is after you diagnosed  
16 shoulder dystocia, did you do anything different from how you  
17 would handle any other shoulder dystocia, like an ordinary,  
18 average, obstetrician would do?

19 A: I did not.

20 Q: Did you pull harder or use too much traction because you  
21 were worried about oxygen to the baby?

22 A: I was always worried about oxygen because of the emergent  
23 situation, but I did not pull too hard because of that  
24 concern.

1 Q: Well, I'm not asking if you pulled too hard ---

2 A: You asked me when you pulled too hard was it because you  
3 were concerned of the oxygen deprivation and I just wanted to  
4 clarify my answer.

5 Q: I don't think that was my question, but let me ---

6 A: Okay.

7 Q: --- I can try again just to be sure?

8 A: Okay. Great.

9 Q: With respect to how much pulling force you applied to  
10 that baby's head, did you do any pulling that was harder than  
11 you would normally do because of any concern about reduced  
12 oxygen flow to the baby?

13 A: The amount of force used and all the maneuvers,  
14 everything is concerning about the lack of oxygen of the baby.  
15 So, everything that I did was out of concern for lack of  
16 oxygen to the baby during that one minute period of time,  
17 which I didn't know would be one minute.

18 Q: As opposed to every other shoulder dystocia, did you do  
19 anything different because of concern about the baby getting  
20 enough oxygen?

21 A: In any other shoulder dystocia, that is always your main  
22 concern, so my answer is no, I did nothing different from any  
23 other shoulder dystocia.

24 Q: And we heard about the nuchal cord yesterday. A nuchal

1 cord is just a cord that loops here instead of somewhere else,  
2 right?

3 A: Well, cords aren't necessarily looped anywhere else other  
4 than around a body part or they're just free floating and a  
5 nuchal cord is a cord around the neck, which is common.

6 Q: Yeah and what percentage of the time?

7 A: 20 percent, 1 in 5 or something.

8 Q: Some people think as much as a third?

9 A: Possibly.

10 Q: All right. At any rate, some nuchal cords can cause a  
11 real problem, right, it might be in a knot or they might be so  
12 tight that you have to double clamp and cut?

13 A: That's correct.

14 Q: All right. This was nothing like that, was it?

15 A: This was not a tight nuchal cord. I was able to release  
16 it without clamping and cutting it.

17 Q: All you had to do was this, right?

18 A: That's the maneuver to release a nuchal cord, correct.

19 Q: Okay. Because of that nuchal cord, did you do anything  
20 different in this one minute than you would have done in any  
21 other -- any other shoulder dystocia?

22 A: Other than the few seconds to release the cord, no.

23 Q: Because of any concern about oxygen, did you do anything  
24 different in terms of bending the neck toward the left ear?



1   **A:**   No, I did not.

2   **Q:**   Let's talk just briefly about stability.  I think we can  
3   probably -- I think we can probably share the conclusions  
4   about this.  The strips, the only way the baby has of talking  
5   so to speak, about how it likes those contractions is through  
6   the fetal heart monitor strips, right?

7   **A:**   That is one issue or one piece of information that we  
8   look at to acknowledge how the baby tolerates labor; that's  
9   correct.

10  **Q:**   And it covers the mother's contractions at the bottom?

11  **A:**   That's correct.

12  **Q:**   And it has those lines that you hope are squiggly at the  
13  top, so it measures the baby's heart rate?

14  **A:**   That is correct.

15  **Q:**   All right.  And if the baby is liking those contractions,  
16  he might actually have that heartrate go up some, right?

17  **A:**   That is correct.

18  **Q:**   What do you call that?

19  **A:**   That's an acceleration or an increase in the heartrate.

20  **Q:**   All right.  And we had accelerations here, right?

21  **A:**   We did.

22  **Q:**   All right.  And if the baby doesn't like a contraction,  
23  he tells you that by dropping his heartrate, correct?

24  **A:**   The heartrate will drop and depending on when you see the

1 drop is your level of concern.

2 Q: Right. And the only time there was any drop to speak of  
3 in Jahmerican was after he got -- after his mom got the  
4 epidural and after the Pitocin was given in that IV the first  
5 time, right?

6 A: Right, that was when we had a concern. There was a  
7 prolonged deceleration.

8 Q: Okay. And that followed -- well, the anesthesiologist  
9 did the epidural, but it also followed your decision to put  
10 Pitocin into the mother's IV, right?

11 A: I don't understand the question.

12 Q: You say there was this drop in the heartrate ---

13 A: Oh, so, yes, we stopped the Pitocin.

14 Q: All right. So, you gave Pitocin, there was an epidural,  
15 then you gave Pitocin, the heartrate went down; you stopped  
16 the Pitocin, the heart rate went back up?

17 A: Along with other measures, yes. That was one of the four  
18 measures that we did.

19 Q: Okay. But do you -- do you attribute -- let me -- let me  
20 rephrase this. Do you believe that the drop you described in  
21 the baby's heartrate was not particularly concerning due to  
22 the fact that you knew there had just been an epidural and you  
23 had just started Pitocin?

24 A: Well, a drop in the heartrate is always concerning

1 because you don't know if your reaction to it is going to  
2 work. So, we did four different things because it would have  
3 been concerning had the heartrate stayed down, which it did  
4 not.

5 Q: Sure, but once you stopped the uterine contractions,  
6 among other things, I mean, excuse me, once you stopped the  
7 Pitocin, among other things, in fact it was a very reassuring  
8 heart monitor strip, correct?

9 A: Yes, all of those things worked to recover the heartrate.

10 Q: And do you still believe that this fetal heart monitor  
11 strip was very reassuring throughout?

12 A: It was reassuring.

13 Q: Despite that drop, it was a very reassuring strip  
14 throughout?

15 A: Yes, it was.

16 Q: And that continued through the time you diagnosed  
17 shoulder dystocia?

18 A: It did. The -- it was always reassuring. There were  
19 variable decelerations with contractions, but nothing that  
20 caused significant concern.

21 Q: Okay. And one minute later, you had information about  
22 how the baby was doing, right?

23 A: Yes, we did.

24 Q: You had that from two different sources, right; you had

1 the Apgars?

2 **A:** Yes, they were good.

3 **Q:** They were very good, right?

4 **A:** They were very good.

5 **Q:** And you had the cord blood gases to see if there was any  
6 loss of oxygen?

7 **A:** Yes, thankfully, also very good.

8 **Q:** All right. I mean, everything about the medical  
9 stability of this child going into the shoulder dystocia was  
10 great, right?

11 **A:** I agree.

12 **Q:** Everything about this child's medical stability was great  
13 a minute later, right?

14 **A:** Thankfully, yes, I agree.

15 **Q:** And during that one minute of time, you had no evidence  
16 that there was any -- any change in the child's vital signs or  
17 oxygen level or any other objective measure of medical  
18 stability, do you?

19 **A:** What happens, I mean vital signs, the heartrate is the  
20 only thing that we know of the baby; we have no other vital  
21 signs, just blood pressure and temperature; we only know  
22 heartrate and what happens is the items that you -- we've been  
23 talking about all week, the Apgar scores and the cord gases  
24 were very good and those were all retrospective. We have

1 information after the fact. The concern is, is when you  
2 diagnose a shoulder dystocia, it is a medical emergency.  
3 Because there's been testimony this week that one of the bad  
4 things that can happen, nerve injury, clavicle, collar bone,  
5 or upper arm fracture, hypoxic injury, brain damage, cerebral  
6 palsy or death. So, when I'm sitting there, I make a  
7 diagnosis. The one of the things that can happen is death and  
8 that's unstable and an emergency in my eye and most  
9 physicians.

10 Q: Well, I understand that if a shoulder dystocia goes on  
11 and on, then there might be some of these things that you're  
12 talking about. ---

13 A: You don't know at the time.

14 Q: --- may I finish my question?

15 A: Yes, sir.

16 Q: But as far as this child is concerned, Jahmerican McCray,  
17 you have no objective evidence of anything going on with his  
18 actual body other than the heartrate, correct?

19 A: At the time of the shoulder dystocia, yes.

20 Q: Okay. And his heartrate was great?

21 A: It was fine, yes.

22 Q: It was great, right?

23 A: It was good.

24 Q: All right. Let's talk about who was in control of this

1 delivery. Ever since, I mean I realize you weren't in the  
2 room when the mom was laboring except for, you know, brief  
3 periods of time, but once the mom was complete, got that 10  
4 centimeter opening of the vagina that you talked about  
5 yesterday, once the mom was complete, were you there the whole  
6 time?

7 **A:** I was.

8 **Q:** All right. And there were -- the other people in the  
9 room, except for the epidural and except for at the very end  
10 when the pediatrician was there, the only people in the room  
11 were the mom, the dad, one nurse and then the second nurse  
12 came in?

13 **A:** So, if I can answer that question. At the time that the  
14 patient was complete and ready to start pushing, the people in  
15 the room were Ms. Smalling, her husband, myself, Kathy  
16 Cossentino, the labor nurse, and Dr. David Haseltine, the  
17 pediatrician, he attended the delivery.

18 **Q:** All right.

19 **A:** He was there the whole time she was pushing.

20 **Q:** Okay. But there was one nurse?

21 **A:** Yes, there was one nurse at the time.

22 **Q:** At that time, another nurse came in when you diagnosed  
23 shoulder dystocia?

24 **A:** A labor nurse with Dr. Haseltine, there was probably a

1 nursery nurse with him, but she was not involved in the labor.  
2 Q: Okay. Fair enough. At any rate, except for Dr.  
3 Haseltine, perhaps, who was in charge of the room?  
4 A: I'm in charge of the room.  
5 Q: All right. Who told the mom what to do?  
6 A: I did.  
7 Q: Did she cooperate?  
8 A: Yes, she did.  
9 Q: In every respect?  
10 A: Yes, she did.  
11 Q: Who was in control of what the dad -- where the dad went  
12 in the room?  
13 A: We asked him to move aside so we could effectively employ  
14 McRoberts maneuver. We didn't give him a specific place; he  
15 felt comfortable coming behind me.  
16 Q: Okay. He got behind your right shoulder where he could  
17 see everything?  
18 A: I don't know what he could see. As I spoke about  
19 yesterday, I'm about 18 inches or so from mom and then it's me  
20 on the stool and then there's a table larger than this area  
21 behind me to my right with all of my instruments and he was  
22 somewhere behind that. He would not be in the sterile field  
23 behind me and there between me and the table; he would be  
24 behind the table.

1 Q: Okay. And I know you've talked about the table, we've  
2 got a table here that's holding the exhibits?

3 A: Yes.

4 Q: Is the table that you were talking about this height,  
5 shorter or taller?

6 A: It's about that height and about that width, slightly  
7 shorter in length.

8 Q: All right. So, if you're here, mom's legs, your hands  
9 and the doctor's standing here, the table's not going to block  
10 his view?

11 A: No, no, I made no reference; my intention was not that  
12 the table was blocking his view. What my comment about that  
13 was, was that he was not -- I want it to be clear, he was not  
14 directly here next to me, that there was some distance. I  
15 don't know what he could see; he's a tall gentleman. I just  
16 wanted to make it clear where everything in the room was.

17 Q: Sure. But a relatively low instrument table ---

18 A: Yes.

19 Q: --- and a relatively tall man?

20 A: Yes.

21 Q: Both were in favor of a good view, correct?

22 A: And there is a light hanging from the ceiling that I  
23 angle to adjust so I can see into the vagina. I didn't look  
24 behind me at him. I don't know where he was in relationship



1 to the light.

2 Q: Okay. But at any rate, that light -- that light  
3 illuminated your hands and the vaginal opening?

4 A: Depending on where he was standing, he may have been able  
5 to see that very well.

6 Q: Okay. And the -- they -- you started with one nurse;  
7 were you in control of what she did and how she did it?

8 A: Yes.

9 Q: Then when the second nurse came in, were you in control  
10 of what she did and how she did it?

11 A: I instructed them on what to do.

12 Q: So, however they did McRoberts was your doing?

13 A: Well, it was my instruction to perform the procedure; my  
14 hands were not on the patient's legs. They were doing the  
15 procedure.

16 Q: Let me back up. I had a bad choice of words there.  
17 However those nurses performed McRoberts, whether they did it  
18 correctly or not, would be as a result of your instructions to  
19 them and the control that you had over them, correct?

20 MR. HOOD: Objection, Your Honor. May we address this?

21 THE COURT: All right. Let's take the jury out, so I can  
22 discuss that. Thank you.

23 REPORTER'S NOTE: (Jury retires to jury room 10:48AM).

24 THE COURT: All right. Mr. Hood?

1           **MR. HOOD:** Your Honor, it appears that plaintiff is  
2 trying to pursue a theory of vicarious liability whereby Dr.  
3 Maselli would somehow be liable for the acts or actions of the  
4 resident or the registered nurses.

5           **THE COURT:** And, Mr. Hood, I understand where you're  
6 going and I appreciate your -- your objection, but I think as  
7 he phrased the question, he's asking the doctor if it's, I  
8 believe where he's going, is asking the doctor did you  
9 exercise or was it your custom to exercise control over how  
10 these nurses in your operating theatre performed the maneuver  
11 and if she in fact says, I require them to be under my  
12 supervision, they're customarily under my direction, I require  
13 them to do it the way I want to do it, I correct them. I  
14 think that it's properly before the jury. I understand where  
15 you're coming from. You know, no captain of the ship here,  
16 they're trained, they're -- she just tells them to do it and  
17 they're supposed to do it properly. Is that where you're  
18 coming from?

19           **MR. HOOD:** One side of it. One of the issues is, a  
20 physician issues an order of instruction. The person performs  
21 it, the person who's performing it either does it  
22 appropriately or inappropriately, that person is trained how  
23 to do it, has policies and procedures on how to execute it,  
24 all of which are created and implemented and overseen by the

1 hospital. This doctor doesn't select the nurses, this doctor  
2 doesn't have the ability to hire and fire, this doctor doesn't  
3 pay the nurses, she doesn't control the manner and ease in  
4 which the work is done.

5 **THE COURT:** And I understand that, but he's asked her, do  
6 you take control and do you require that in your operating  
7 theatre.

8 **MR. HOOD:** Well, the problem with that is that in any  
9 circumstance where there's a surgeon and there has to be  
10 someone who is in control of the surgery or procedure and the  
11 doctor is. But what we're trying to extrapolate from that, is  
12 that puts that person in control position and they defacto  
13 become captain of the ship, which has not been recognized  
14 here. And so, she would inherently be liable potentially for  
15 the negligent act of another, which has not been pled, by the  
16 way, nor is it permissible and there would have been a motion  
17 on this, nor has there been any expert testimony that nursing  
18 standards of care have not been met.

19 **THE COURT:** And I really haven't heard any testimony and  
20 we go to relevance, but any testimony from any of your  
21 witnesses, Mr. Graham, that would indicate that this injury  
22 resulted from the suprapubic maneuver that was done. In  
23 fact, as I recall the testimony, it would not have caused it.

24 **MR. GRAHAM:** Right, it just made it harder to resolve.

1       **THE COURT:** So, why then would it be relevant how they  
2 did it?

3       **MR. GRAHAM:** Because there's testimony that they did it  
4 in a way that was totally different from this witness said was  
5 the correct way to do it and we've got testimony that doing it  
6 ---

7       **THE COURT:** But they're not parties.

8       **MR. GRAHAM:** I'm sorry?

9       **THE COURT:** They're not parties.

10       **MR. GRAHAM:** Correct. Correct. And we're not claiming  
11 that they violated any standard of care and I promise you, I'm  
12 not ---

13       **THE COURT:** Okay. From a probative standpoint, now let's  
14 look at it purely from 403. From a probative standpoint, what  
15 is the purpose of this question; what do you hope to elicit  
16 and why is it probative, what's the relevance?

17       **MR. GRAHAM:** Dr. Maselli controls, as she's testified to  
18 ---

19       **THE COURT:** She hasn't yet. She's in charge of the room,  
20 but she has not testified that she has the authority to  
21 override the way that the nurses perform their duties. I  
22 mean, she hasn't testified to that. I think that's where you  
23 were going and that's where Mr. Hood objected, right?

24       **MR. GRAHAM:** Yes, sir.

1           **THE COURT:** Okay.

2           **MR. GRAHAM:** Where I was going it also probative because  
3 it's indirect. I mean this is cross examination.

4           **THE COURT:** I understand.

5           **MR. GRAHAM:** He, yesterday, I'm sorry.

6           **THE COURT:** I understand. I'm following you.

7           **MR. GRAHAM:** And yesterday, Mr. Hood asked her questions  
8 about how far away were you from the nurses, if they were  
9 doing wrong, were you close enough to see it and correct it?  
10 So this is directly responsive to direct examination?

11           **THE COURT:** Did you ask that, Mr. Hood?

12           **MR. HOOD:** I did and it would be appropriate for a  
13 physician to interject if they observed something being done  
14 wrong, which she said she did not. I mean, again, I think  
15 that's -- that's appropriate. The nurses have independent  
16 nursing judgment.

17           **THE COURT:** Well, I mean then Mr. Graham, I would let you  
18 ask that question; did you observe anything inappropriate in  
19 the way they were performing the maneuver.

20           **MR. GRAHAM:** Well, I mean, I really don't want to ask  
21 her.

22           **THE COURT:** What you want to do is ask her is well, why  
23 didn't you correct them, right?

24           **MR. GRAHAM:** Well, I mean, I do want to get into as Jamie

1 asked her yesterday, you're in control, if you can see them,  
2 if they're not doing it the right way, you can correct them; I  
3 just want to repeat that, whatever they're doing, you would  
4 have been able to correct them if you thought they were doing  
5 it improperly and I mean, and then, you know, I don't have a  
6 lot in that direction after that, but I mean, it's really, I  
7 would cite as authority, Your Honor, the old, what's good for  
8 the goose is good for the gander.

9 **THE COURT:** Well, I would allow you to ask her if she  
10 observed anything inappropriate in the way they were doing it  
11 and I'll let you ask her, if you had, would you have asked  
12 them to modify it, what they were doing. I'll let you do  
13 that. I mean, what more do you want?

14 **MR. GRAHAM:** Well, Your Honor, that doesn't get me  
15 anywhere. It's cross examination.

16 **THE COURT:** Where do you want to get; that's what I'm  
17 asking you?

18 **MR. GRAHAM:** That she is in control and that no matter  
19 how they're doing it, if she think they're doing right, that's  
20 fine. If she thinks they're doing anything wrong, she's in  
21 control of that. We've got testimony they were doing it  
22 wrong. She's in control of them.

23 **THE COURT:** Well, whose testimony have we heard that they  
24 performed inappropriately?

1       **MR. GRAHAM:** Two nurses, four hands. This witness  
2 testified ---

3       **THE COURT:** What witness?

4       **MR. GRAHAM:** --- one fist.

5       **THE COURT:** I mean, who has testified other than a lay  
6 person?

7       **MR. GRAHAM:** Nobody, but I mean, he's right there. You  
8 don't have to have a medical degree to count hands, I say  
9 respectfully.

10       **THE COURT:** Well, I'm going to let you ask her if she  
11 observed anything inappropriate. I will let you ask her if  
12 she had, would she have asked the nurses to modify it and  
13 that's where I'll let you go with that. Okay?

14       **MR. GRAHAM:** Well, I mean, I hear you, Your Honor. That  
15 would just reinforce direct.

16       **THE COURT:** Well, have you pled respondent superior, have  
17 you pled agency or anything like that?

18       **MR. GRAHAM:** No, sir, we have not.

19       **THE COURT:** Okay.

20       **MR. GRAHAM:** And we aren't headed that way. We're not  
21 trying to ---

22       **THE COURT:** It sounds like it.

23       **MR. GRAHAM:** No, sir, we're just trying to avoid an empty  
24 chair problem where later on, they could say if anything was

1 done improperly, it was a nurse. I'd like to establish she is  
2 in control of whatever they did, right or wrong.

3 **THE COURT:** Well, I think she's already testified that  
4 the nurses -- how the nurses performed it in her view. I  
5 mean, that's Mr. Hoods witness.

6 **MR. GRAHAM:** Yes, sir, and all I'm asking, Your Honor,  
7 that I be allowed to cross. I mean, if he put his story out  
8 there with his question and answer, now I'm on cross  
9 examination. Respectfully, I don't think I should be required  
10 to ask his questions again.

11 **THE COURT:** Well, I'm going to let you ask this witness  
12 if she observed anything improper and if she had, if she would  
13 have asked that it be corrected. You're just asking her to  
14 speculate and if you want to question her about what she saw  
15 when the maneuver was being attempted, fine. Ask her all you  
16 want about that. Cross examine her about that. She's saying  
17 she saw nothing or that's my understanding that she saw  
18 nothing inappropriate. So, where do you want to go with that?

19 **MR. GRAHAM:** I'd like to challenge that, Your Honor. I  
20 mean, there's evidence.

21 **THE COURT:** Challenge it all you want. Challenge her  
22 statement that she saw them do it appropriately. Challenge it  
23 all you want. But what you want to do is get into a situation  
24 where you can somehow bring this around to she being



1 responsible for what a nurse did when you've not even pled it  
2 and I don't think that's appropriate. I'm going to let you  
3 ask her if she observed anything inappropriate. You can  
4 challenge her all you want on that and I'll even let you ask  
5 her if you had, would you have changed it, would you have  
6 asked the nurses not to perform it if they were doing it  
7 improperly; I'll let you ask that. I think that's a fair  
8 question.

9 **MR. GRAHAM:** It might be fair, but it's already been  
10 asked by the defense counsel because it supports his theory of  
11 the case. I'm never going to ask questions that favor the  
12 defense or at least I'm not going to do it on purpose and you  
13 know, if ---

14 **THE COURT:** I mean, how far do you want to go past that  
15 if she says yes, I would have asked them not to do it; then  
16 where do you want to go, Mr. Graham? I mean, what's your next  
17 question?

18 **MR. GRAHAM:** If -- if they -- if they in fact had done  
19 suprapubic improperly, do you believe it would have been your  
20 responsibility to correct that; instead of saying did you see  
21 it, if they had been would it have been your responsibility  
22 and would it have been within your control?

23 **THE COURT:** Now, within your control, I don't know, but  
24 as a physician, I'll let you ask her if as a physician, you're

1 attending a patient and you saw it being inappropriately  
2 administered, should you have responded to that; I'll let you  
3 ask her that?

4 **MR. GRAHAM:** Okay.

5 **THE COURT:** All right. If that's what you want to ask.  
6 Bring the jury in.

7 **MR. GRAHAM:** Your Honor, may I ask it as a hypothetical?

8 **THE COURT:** Pardon?

9 **MR. GRAHAM:** May I ask it as a hypothetical?

10 **THE COURT:** Okay.

11 **MR. GRAHAM:** I can't remember your exact words.

12 **THE COURT:** Okay.

13 **MR. GRAHAM:** I'll try to get as close as I can to your  
14 words.

15 **THE COURT:** Yes.

16 **BAILIFF:** I have one in the bathroom.

17 **THE COURT:** Okay.

18 **REPORTER'S NOTE:** (Jury enters courtroom 11:15AM).

19 **THE COURT:** All right. We have all our jurors and our  
20 alternates back in. You may proceed, Mr. Graham.

21 **MR. GRAHAM:** Thank you, Your Honor.

22 **BY MR. GRAHAM:**

23 **Q:** Doctor, I want to ask you a question. It goes to  
24 shoulder dystocia deliveries generally for not just you, but

1 other physicians, other obstetricians. In terms of whether to  
2 order nurses to do suprapubic, is that -- whose decision would  
3 that be to make?

4 **A:** It's the delivery attendant physicians.

5 **Q:** And when it comes to directing nurses how to do  
6 suprapubic pressure, whose decision would that be?

7 **A:** Well, I direct on when to do it, directing them how to do  
8 would be for a simulation drill or if I saw something  
9 improper.

10 **Q:** Do you believe if nurses are doing suprapubic pressure  
11 incorrectly, just a foot, foot and a half, from the doctor's  
12 eyes, that the doctor has any responsibility to play in terms  
13 of correcting the nurses?

14 **A:** Yes, absolutely. If I saw something done  
15 inappropriately, I would address it.

16 **Q:** And then when it comes to -- so, let me back up. When it  
17 comes to how hard to pull before you diagnose shoulder  
18 dystocia, you would be in control of that?

19 **A:** Yes.

20 **Q:** And then after you diagnose shoulder dystocia and you ask  
21 for McRoberts or order the nurses to do McRoberts, you would  
22 be in charge of how hard to pull there too, correct?

23 **A:** Yes.

24 **Q:** And then when you -- in terms of what to do next, you

1 would be in control of the decision to reach over and grab the  
2 scissors and cut through part of the mom's vagina, right?

3 **A:** That's correct.

4 **Q:** And then after you do that, you would be the one in  
5 charge of how -- or the one who makes the choice about how  
6 hard to pull at that point?

7 **A:** That is correct.

8 **Q:** And then, when you ask the nurses to put themselves in --  
9 well let me rephrase that. After the episiotomy, when you ask  
10 the nurses to do suprapubic pressure, you would be the one in  
11 control of how hard to pull at that point, true?

12 **A:** True.

13 **Q:** You would also be the one in control of how much bending  
14 of the neck would be applied?

15 **A:** True.

16 **Q:** And you would be the one in control about how long to  
17 keep pulling on the baby's head before you went into another  
18 maneuver, correct?

19 **A:** That's correct.

20 **Q:** And if you reached the point where you were about to use  
21 more than gentle traction, instead of pulling harder, instead  
22 of pulling forcefully, you'd be in control of whether or not  
23 to do an internal maneuver, correct?

24 **A:** That's correct.

1 Q: And you'd also be in charge -- in control of which  
2 maneuver to use?

3 A: That is correct.

4 Q: So, when we look at these various issues in terms of all  
5 the important events during that one minute period, you were  
6 in control, nobody else?

7 A: I was in control of what I did and what I ordered,  
8 correct.

9 Q: Is there anything in that, well strike that. Let me --  
10 let me go back and just make sure I've pinned down one point.  
11 To cause nerves from -- from forceful pulling and bending of  
12 the neck, to cause serious damage to the nerves on the right,  
13 the direction of pulling would -- would be either very strong  
14 traction or -- or forceful bending toward the left shoulder,  
15 right?

16 A: That could be one cause.

17 Q: Okay. But I'm just asking about left and right. To  
18 answer these ---

19 A: It would be the opposite side, correct.

20 Q: And if -- if that top shoulder is the right shoulder,  
21 then the way to injure the baby is to pull down toward the  
22 floor on the head?

23 A: Correct.

24 Q: When you were in residency, did you learn that when

1 babies' are born after a shoulder dystocia with one arm up and  
2 the other arm hanging down, that there was a possibility that  
3 a law suit would be brought?

4 A: I know there's a possibility of an injury.

5 Q: All right. Did you know there was a possibility of a  
6 permanent injury?

7 A: Always a possibility.

8 Q: And did you know the possibility that if there was a  
9 permanent injury that there may well be a lawsuit?

10 A: Always a possibility.

11 Q: To try to hold the wrongdoer accountable?

12 A: Always a possibility.

13 Q: You first learned that no later than residency, right?

14 A: Correct.

15 Q: And that hasn't changed any, has it

16 A: No, it hasn't.

17 Q: So, you knew that in 2013?

18 A: Yes.

19 Q: And you -- before you wrote any note in this case, before  
20 you talked to anybody about what you did in this case, you  
21 knew that this child's arm was hanging down?

22 A: I did observe that, yes.

23 Q: Left arm, wonderful?

24 A: Yes.

1 Q: Right arm hanging down with just a little twitch, a  
2 little twitch?

3 A: There was movement in the fingers, yes.

4 Q: Okay. There was movement against gravity, was there?

5 A: Not that I observed, no.

6 Q: So, to be clear, when you wrote the first note, you knew  
7 there was a chance of being sued?

8 A: There is always a chance in our field of being sued with  
9 every note.

10 Q: Especially if there is a three nerve injury with two  
11 complete avulsions, one partial avulsion and a large neuroma  
12 causing permanent damage?

13 A: I didn't have that information at the time I wrote the  
14 note.

15 Q: Okay. But you knew that there was at least some degree  
16 of possibility that what had happened to this child would lead  
17 to a permanent injury?

18 A: I knew that the arm looked injured, yes.

19 Q: And you knew it could lead to a serious life altering  
20 permanent injury?

21 A: If it was permanent, that could be possible, yes.

22 Q: Okay. So, you knew that when you wrote the handwritten  
23 note, correct?

24 A: Correct.

1 Q: You knew that when you dictated the other note?

2 A: Correct.

3 Q: You knew that when you talked to anybody, any of your  
4 colleagues or other doctors, you knew that?

5 A: Correct.

6 Q: I'm going to try to move forward.

7 A: Okay.

8 Q: And finish very shortly. You told us earlier about hands  
9 on the baby's head for that whole minute, except cutting the  
10 vagina. And you told us yesterday about hearing a pop. Were  
11 your hands on the baby's head when you heard that pop?

12 A: I didn't hear a pop, it was a pop sensation; it was a  
13 release ---

14 Q: Okay.

15 A: --- of the shoulder. There was no noise associated with  
16 it.

17 Q: When you felt the pop, your hands were on the baby's  
18 head, correct?

19 A: That is correct.

20 Q: Doctor, Dr. Maselli, one more thing. You've listed the  
21 nurses as witnesses, will they testify today or tomorrow?

22 A: I don't know what Jamie has ordered for our witness list.  
23 I don't know if they're testifying.

24 Q: The nurses may not testify?



1       **MR. HOOD:** Your Honor?

2       **THE COURT:** Mr. Graham, please, if you have questions  
3 like that, ask Mr. Hood. Thank you.

4       **MR. HOOD:** Your Honor, there's also a charge on the  
5 availability of witnesses to both parties, since he listed  
6 them as witnesses as well.

7       **THE COURT:** Okay. I understand.

8       **MR. GRAHAM:** Thank you, Your Honor. No further  
9 questions.

10       **DR. MASELLI:** Thank you.

11       **REDIRECT EXAMINATION OF DR. LISA MASELLI BY MR. HOOD:**

12       **Q:** You read the deposition of the nurses, right?

13       **A:** I did.

14       **Q:** And you're aware that the nurses did not recall this  
15 delivery?

16       **A:** That is true.

17       **Q:** So, the nurses couldn't come in here and tell this jury  
18 anything that they remembered about it?

19       **A:** That is true.

20       **Q:** That would just waste people's time?

21       **A:** Most likely.

22       **Q:** Very briefly.. Doctor, I spent a year in New Orleans  
23 after law school and a friend of mine said, you've got to put  
24 the skunk on the table. You were just asked down about the

1 medical records. Let's put the skunk on the table. Did you  
2 lie in these medical records?

3 **A:** Absolutely not.

4 **Q:** Did you create medical records because you were afraid of  
5 a lawsuit?

6 **A:** Absolutely not.

7 **Q:** Have you ever done that?

8 **A:** No, I haven't.

9 **Q:** If you felt like this injury was caused by your  
10 negligence, what would you do?

11 **A:** Nothing different than was done.

12 **Q:** If you felt like you used excessive traction, would you  
13 have noted it?

14 **A:** Yes.

15 **Q:** Did you note moderate controlled traction because that  
16 was what was done?

17 **A:** That's what was done, and I felt comfortable noting  
18 exactly what happened.

19 **Q:** If you make a mistake, would you stand up and own it?

20 **A:** I would.

21 **Q:** Is that the type of person you are?

22 **A:** It is.

23 **Q:** Have you ever been censored or anything at your hospital  
24 for falsifying, manipulating, manufacturing, medical records

1 to any degree?

2 A: No, I haven't.

3 Q: Accused of it?

4 A: No, I haven't been.

5 Q: Was the day the first time anyone has ever suggested that  
6 in your career?

7 A: Yes, it was.

8 Q: Control, you were in control of the delivery, true?

9 A: True.

10 Q: You were the delivering physician?

11 A: That's true.

12 Q: If you saw something that you wanted done differently,  
13 what would you have done?

14 A: I would have spoken up and addressed the concern.

15 Q: And did you see anything like that in this delivery?

16 A: No, I didn't.

17 Q: Thank you, ma'am.

18 A: Thank you.

19 **RE-CROSS EXAMINATION OF DR. LISA MASELLI BY MR. GRAHAM:**

20 Q: Just very briefly. There was a comment about the nurses  
21 not remembering anything. While they did testify that they  
22 didn't remember anything about this delivery, you recall they  
23 do remember what they normally did, what the hospital rules  
24 and regulations were, correct?

1     **A:**    I would assume so, yes.

2     **Q:**    Thank you.

3           **THE COURT:**  Mr. Hood?

4           **MR. HOOD:**  No questions, Your Honor.

5           **THE COURT:**  All right.  You may step down, Doctor, thank  
6     you.

7           Mr. Hood?

8           **MR. HOOD:**  Thank you, Your Honor.  At this time the  
9     defense calls Dr. David Haseltine.

10          **CLERK:**  Raise your right hand?

11                                           **DR. DAVID HASELTINE, HAVING BEEN**

12     **SWORN TESTIFIES AS FOLLOWS:**

13          **CLERK:**  Please state and spell your full name for the  
14     record?

15          **DR. HASELTINE:**  Haseltine.  H-A-S-E-L-T-I-N-E.

16          **CLERK:**  You may be seated.

17     **DIRECT EXAMINATION OF DR. DAVID HASELTINE BY MR. HOOD:**

18     **Q:**    Good morning, sir.

19     **A:**    Good morning.

20     **Q:**    Tell us your name, please?

21     **A:**    David Haseltine.

22     **Q:**    And Dr. Haseltine, what do you do for a living?

23     **A:**    I'm an internist and a pediatrician.

24     **Q:**    And so, where do you work?

1     **A:**    At Pawleys Pediatrics and Adult Medicine.

2     **Q:**    And how long have you been doing that?

3     **A:**    I've been here for 15 years.

4     **Q:**    Just briefly, could you tell us where you were trained  
5    and in what areas you're board certified?

6     **A:**    Sure.  I trained at the University of Tennessee in  
7    Memphis, Tennessee.  I spent 4 years in medical school there,  
8    4 years in combined internal medicine with pediatric residency  
9    program.  I'm board certified in internal medicine.

10    **Q:**    And do you maintain your board certifications in internal  
11    medicine?

12    **A:**    I do.

13    **Q:**    Are you here at my request and in response to a subpoena  
14    I issued to you?

15    **A:**    Yes.

16    **Q:**    Were you -- you were the pediatrician that was noted in  
17    the records in relation to the delivery of Jahmerican  
18    Smalling; is that right?

19    **A:**    Yes.

20           **MR. GRAHAM:**  Excuse me, Your Honor, I just noticed that  
21    there was a piece of medical record on the screen.  Mine just  
22    disappeared once I started talking, but could we find out if  
23    that document is an exhibit in evidence?

24           **CLERK:**  The screens aren't on.

1           **THE COURT:** Pardon?

2           **CLERK:** The screens aren't on because we were trying to  
3 fix that.

4           **THE COURT:** Who put it up?

5           **MR. RADECK:** It was a technical thing.

6           **THE COURT:** It apparently is -- I don't know what it was,  
7 Mr. Graham. Was on it on the jury's?

8           **JURY:** Yes.

9           **THE COURT:** Do we even know what it was?

10          **MR. RADECK:** Your Honor, I was plugging in my computer  
11 and it may have flashed momentarily. I didn't see it on my  
12 screen. So, I apologize.

13          **THE COURT:** All right. Ladies and gentlemen of the jury,  
14 for what attention you may have paid to it or observed it,  
15 please disregard. You may see that same document later. It  
16 may be introduced into evidence. It was flashed up  
17 inadvertently. It is not in the record. It is not now part  
18 of the evidence. You will disregard it totally. Okay?

19          All right. There you go.

20          **BY MR. HOOD:**

21          **Q:** Now, while he's doing that, I'm going to hand you what  
22 we've marked and is in evidence as exhibit 22. All right.  
23 We'll see if John can figure out how to pull it up, but this  
24 is the detail notes log at the top; do you see that, Doctor?

1   **A:**    Yes.

2   **Q:**    All right.  If you would just drive with me, if you look  
3   on the left hand side, it's got the date and time.  I'd just  
4   like to go to 7:59 in the morning, which is about three  
5   quarters of the way in?

6   **A:**    Okay.

7   **Q:**    All right.  Let's just move on.  Do you see 7:59 entry  
8   where it says comment, Dr. Maselli and Dr. Haseltine at  
9   bedside at 7:59?

10  **A:**    Yes.

11  **Q:**    So, why were you at bedside for this delivery?

12  **A:**    As a pediatrician, I'm called to a number of different  
13  reasons for delivery.  In this particular case, there was a  
14  presence of meconium, which is where the baby has actually  
15  pooped into the fluid surrounding it.  So, in that case, they  
16  need a pediatrician present to be sure to suction all of that  
17  out so that it does not go down into the lung and cause some  
18  additional harm to the infant.

19  **Q:**    And is that customary when this meconium is present for  
20  someone like you to be present?

21  **A:**    It is routine for this hospital.

22  **Q:**    All right.  And then would you have been present from  
23  this time, 7:49 or 7:59, excuse me, through the time of  
24  delivery, 15 minutes later?

1   **A:**    Yes.

2   **Q:**    And where were you in the delivery room?

3   **A:**    I would have been directly to one side of Dr. Maselli.

4   **Q:**    And walk me through, if you would, I just want to fast  
5 forward to 8:14. We've heard a lot of testimony about a  
6 diagnosis of shoulder dystocia and the management thereafter.  
7 During that -- during that delivery, Doctor, did you observe  
8 anything looked to be what you considered to be out of control  
9 or unusual for a delivery?

10  **A:**    I did not.

11  **Q:**    Did you observe any yelling or overhear any yelling,  
12 screaming of any sort?

13  **A:**    I did not.

14  **Q:**    Do you recall anyone instructing Dr. Maselli to stop  
15 pulling on the baby?

16  **A:**    I did not.

17  **Q:**    Do you recall anyone saying I want you to cut my wife or  
18 cut her stomach, anything to that affect?

19  **A:**    Absolutely not.

20  **Q:**    Do you recall anything out of the ordinary about this  
21 particular shoulder dystocia delivery?

22  **A:**    No, this was a particularly routine morning in delivery.

23  **Q:**    And how often have you been involved with deliveries  
24 where there are permanent shoulder injuries?



1   **A:**   I see it probably one every two years perhaps.

2   **Q:**   And in terms of -- are those patients that you are seeing  
3   or are those deliveries that you're seeing?

4   **A:**   Present at the delivery usually.

5   **Q:**   All right.  So, with respect to things like a shoulder  
6   dystocia, have you been in the room to observe those in cases  
7   other than this?

8   **A:**   Yes.

9   **Q:**   And did they, from time to time, when a shoulder dystocia  
10   is encountered, bring an on-call pediatrician in as well?

11   **A:**   If they know ahead of time, they will certainly try to  
12   call a pediatrician in at the time.

13   **Q:**   So, that would be one of those sort of like a high risk  
14   situation?

15   **A:**   Yes, that is considered an emergency.

16   **Q:**   All right.  And so in that standpoint, what are you there  
17   to do?

18   **A:**   Well, I'm there to provide care to the infant immediately  
19   after delivery, both to assess and if needed, to provide  
20   treatment in order to stabilize.

21   **Q:**   And let me then ask you, at the time of the delivery, did  
22   you observe Dr. Maselli twisting or turning or pulling or any  
23   maneuver with the baby's head with her hands on it at all?

24   **A:**   No.

1 Q: Thank you.

2 THE COURT: Mr. Graham?

3 CROSS EXAMINATION OF DR. DAVID HASELTINE BY MR. GRAHAM:

4 Q: Doctor, how long have you been practicing in Georgetown  
5 County?

6 A: 15 years.

7 Q: How long has Dr. Maselli been there?

8 A: I'm not certain, but for sometime I would think.

9 Q: Was she there before you got there?

10 A: I cannot remember at this point.

11 Q: Okay. But you were on -- you have privileges at the same  
12 hospitals?

13 A: Yes.

14 Q: All right. You're on the medical staffs?

15 A: Yes.

16 Q: Sometimes you're on the same committees?

17 A: We do attend some of the same committees.

18 Q: I assume there are various parties throughout the year  
19 for medical staff members and their spouses; is that ---

20 A: The hospital usually holds one a year at Christmas time.

21 Q: All right. And individual doctors may host their  
22 colleagues for parties at their own home?

23 A: They might.

24 Q: How long have you known Dr. Maselli personally?

1   **A:**   For the number of years that I've been here. But we've  
2   only known each other really professionally during that time  
3   period.

4   **Q:**   So, I'm sorry, how many years did you say you had been  
5   here, 15?

6   **A:**   I've been here 15, yes.

7   **Q:**   15. All right. What is HIPPA?

8   **A:**   It's the Health Information Portability and Privacy Act.

9   **Q:**   Were you a physician treating Jahmerican McCray?

10   **A:**   I was at the time of delivery, yes.

11   **Q:**   How long does a physician's obligation to respect and  
12   honor a patient's privacy last; does it end when the doctor --  
13   when the doctor/patient relationship ends or does it continue?

14   **A:**   No, I think it would continue.

15   **Q:**   It would continue?

16   **A:**   Yes. Uh-huh (affirmative response).

17   **Q:**   Yes? Yes?

18   **A:**   Yes.

19   **Q:**   How many times have you discussed this case with anybody  
20   prior to coming in here today and answering Mr. Hood's  
21   questions?

22   **A:**   I contacted my legal team once and we sat down to review  
23   what would normally happen during this type of trial.

24   **Q:**   And I certainly don't want to ask you what your lawyers

1 told you, that would be inappropriate. But are you aware that  
2 lawyers for one party, have the opportunity to talk to lawyers  
3 of another party?

4 **A:** I'm not a legal expert, so I don't know what would happen  
5 there.

6 **Q:** But, if, if someone ever wanted to try to circumvent the  
7 right to privacy under HIPPA, one way to do it would be to  
8 have a protected conversation with one's lawyer, have that  
9 lawyer talk to another lawyer and then have that lawyer's  
10 conversation with the witness protected by attorney/client  
11 confidences, true?

12 **A:** Again, I'm not a legal expert, so I couldn't really  
13 answer that question.

14 **Q:** You knew what was going to happen today, didn't you?

15 **A:** I don't understand the question?

16 **Q:** You knew what was going to happen today; you knew Mr.  
17 Hood was going to ask you some questions, you knew?

18 **A:** I knew he was going to ask about this particular child,  
19 yes.

20 **Q:** And you seemed to have a quick recall of this delivery;  
21 is that fair?

22 **A:** Yes, there was nothing out of the ordinary for this  
23 delivery.

24 **Q:** The question is, sir, you had a pretty quick response to

1 those questions about this delivery, didn't you?

2 **A:** They were straightforward questions that I answered.

3 **Q:** You had no advance warning of what questions would be?

4 **A:** No.

5 **Q:** No further questions.

6 **THE COURT:** Mr. Hood?

7 **MR. HOOD:** No questions, Your Honor.

8 **THE COURT:** You may step down, Doctor.

9 **DR. HASELTINE:** Thank you.

10 **THE COURT:** Thank you very much. Mr. Hood?

11 **MR. HOOD:** Thank you, Your Honor. At this time, the  
12 defense calls Dr. Chris Robinson.

13 **THE COURT:** Would the doctor, would either of you need  
14 him further, Dr. Haseltine?

15 **MR. GRAHAM:** No, Your Honor.

16 **MR. HOOD:** No.

17 **THE COURT:** Doctor, you're released -- if you're under  
18 subpoena, you're released. Okay?

19 **DR. HASELTINE:** Thank you, sir.

20 **CLERK:** Raise your right hand?

21 **DR. CHRISTOPHER JOE ROBINSON,**  
22 **HAVING BEEN SWORN TESTIFIES AS FOLLOWS:**

23 **CLERK:** Please state and spell your full name for the  
24 Court?

1       **DR. ROBINSON:**   Yes. Christopher Joe Robinson. C-H-R-I-  
2 S-T-O-P-H-E-R J-O-E- R-O-B-I-N-S-O-N.

3       **CLERK:**   You may be seated.

4       **DR. ROBINSON:**   Okay.

5       **DIRECT EXAMINATION OF DR. CHRISTOPHER ROBINSON BY MR. HOOD:**

6       **Q:**   All right. Good morning, sir.

7       **A:**   Good morning.

8       **Q:**   What do you do for a living?

9       **A:**   So, I'm a maternal fetal medicine specialist practicing  
10 high risk obstetrics; obstetrics, genetics within that as well  
11 as ultrasound.

12      **Q:**   Where do you live?

13      **A:**   I live in Mount Pleasant, South Carolina.

14      **Q:**   Before I -- well, let me back up. At my request, have  
15 you reviewed the medical records and depositions in this case  
16 to formulate opinions with respect to the delivery?

17      **A:**   Yes, sir.

18      **Q:**   All right. Before we get to those, let me just get you  
19 to provide a little context to the jury about your medical  
20 training. Could you just summarize for us, please, your  
21 medical training and background?

22      **A:**   Certainly. So, I attended the Medical University of  
23 South Carolina from 1996 to 2000, so we do 4 years of medical  
24 school followed by 4 years of residency training. You enter

1 into a match. I matched to the Medical University of South  
2 Carolina where I completed 4 years in obstetrics and  
3 gynecology training between 2000 and 2004. And then a very  
4 select of group of people are able to apply and be accepted to  
5 maternal fetal medicine training, which is an advanced  
6 training program in obstetrics involving high risk pregnancy  
7 care and I so I completed that training between 2004 and 2007.  
8 After completion of my training in 2007, I went on to complete  
9 a Master's of Science in Clinical Research, which is applied  
10 to clinical investigation, research and publications, things  
11 of that nature in 2 years between 2007 and 2009. Also being  
12 on faculty for the Medical University of South Carolina.

13 Q: All right. So, you said maternal -- let me ask you, are  
14 you board certified?

15 A: I am board certified, yes, sir.

16 Q: By what board?

17 A: By the American Board of Obstetrics and Gynecology. I'm  
18 board certified in both obstetrics and gynecology as well as  
19 maternal fetal medicine.

20 Q: All right. So, you mentioned maternal fetal medicine; is  
21 that a subspecialty within OBGYN?

22 A: It is.

23 Q: All right. And you talked about high risk; describe for  
24 us, if you would, generally what types of patients that

1 maternal fetal medicine specialists sees?

2 **A:** Certainly. So, first of all, our patient population are  
3 all pregnant women or they're women who are planning to become  
4 pregnant or they may be women who have just delivered that  
5 we're taking care of after they have delivered a baby. These  
6 individuals may bring into the table, risks that could be  
7 medical in nature. So, for instance, there could be diabetes,  
8 there could be high blood pressure, things of that nature in  
9 some of these cases. There could be surgical conditions they  
10 were concerned about, things like women who have undergone  
11 bariatric surgery, things like placenta abnormalities that  
12 require specialized surgery and there could be genetic  
13 conditions or babies that have abnormalities such as heart  
14 defects or brain abnormalities that we have to evaluate and  
15 make plans of care for how to take care of those babies at  
16 birth and after delivery.

17 **Q:** Is a MFM, the Maternal Fetal Medicine, is that a separate  
18 board certification process?

19 **A:** Yes, sir. So, basically there are two board  
20 certifications when you complete your obstetrics and  
21 gynecology training, you have to sit both for a written exam  
22 as well as an oral exam and that oral exam, you go before 6  
23 examiners and you actually have a face to face discussion  
24 about how you manage patients based upon a case list you have



1 collected. Then you go into training and you complete your  
2 maternal fetal medicine training and you repeat that. You  
3 have both a written examination as well as followed by an  
4 examination by actual individuals who are practicing as board  
5 examiners in maternal fetal medicine; there will be 6 of those  
6 individuals that will examine you on a variety of topics  
7 involving medical, surgical as well as genetic and ultrasound  
8 abnormalities that you would be working with.

9 **Q:** You mentioned or answered questions about cases and we've  
10 heard that before. Can you just walk me through, when you  
11 say, a case, what does that mean, like what is the bucket of  
12 information that you're working with?

13 **A:** Certainly. So -- so, when you're practicing, of course,  
14 during the day, you might see a number of patients during that  
15 day and you may take care of a number of patients. When you  
16 take your board examination, you have to take that collective  
17 number of cases. Each case is a patient, it's specifically a  
18 patient that brought to the table certain risks, may be  
19 medical, may be surgical, may be ultrasound or genetic, but  
20 you have to enumerate those cases and describe those as well  
21 as what your management was and then what the outcome was.  
22 So, in other words, we also report the outcome for the baby,  
23 what the outcome was long term, that's documented on a chart  
24 and then we have to send all of that in to the board so that

1 they can make copies of it, they distribute that to the  
2 examiners and when you go in and actually take that exam,  
3 that's what they're sitting there with, is all of those cases  
4 that you have taken care and they're evaluating what your care  
5 has been like through what you've done in those cases, as well  
6 as their oral examination.

7 Q: All right. So, you've got a patient's chart and you have  
8 to describe what your medical thinking and decision making  
9 was?

10 A: Yes, sir, that's correct.

11 Q: And you reduce that to writing?

12 A: That is correct.

13 Q: And that gets sent to the board?

14 A: That is correct.

15 Q: And a group of examiners has your stack of cases and your  
16 medical management and thinking?

17 A: That is correct.

18 Q: And then they fire questions at you about you did and why  
19 you did it?

20 A: That is exactly right. You're expecting to be able to  
21 really work on your toes because obviously, you never know,  
22 you may have 200, 300 of these cases per list and you're going  
23 to have 3 case lists that you go in there with. So,  
24 basically, you're going to have a large volume of patients

1 that you're responsible for knowing the management as well as  
2 any other questions the examiner might ask you about in the  
3 course of managing those cases.

4 Q: All right. So, and that's the American Board of  
5 Obstetrics And Gynecology process?

6 A: Yes, sir.

7 Q: All right. So, for -- whether it's Dr. Maselli or any of  
8 the other OB's who are board certified, that's the same  
9 process everybody goes through?

10 A: That is exactly right. So, it's a -- it's a standardized  
11 process for everyone who is going to pursue obstetrics and  
12 gynecology go through for that portion of the examination.

13 Q: Okay. So, how about publications, have you written  
14 anything or contributed to the medical literature in the field  
15 of obstetrics?

16 A: Yes, sir.

17 Q: In what ways?

18 A: So, several ways. I mean, number one, I have conducted  
19 primary research myself, where I have published in the areas  
20 of obesity, preeclampsia, which is a type of high blood  
21 pressure that affects pregnant women, as well as looking at  
22 things like twin management, how to take care of twins in  
23 pregnancy, as well as writing some books and chapters on the  
24 prevention of pre-term birth and things we can do to prevent

1 pre-term birth. Most recently, I was part of a national  
2 coalition looking at the management of women that ulcerative  
3 colitis, Chron's Disease and inflammatory bowel disease and  
4 how to manage those patients in pregnancy, which has just been  
5 published this month in three journals. And so, I've also  
6 worked in artificial intelligence, artificial neuro networks  
7 in looking at how we can look and potentially predict outcomes  
8 with regard to hypertensive disease in pregnancy. I've also  
9 looked at ways to perform cesarean deliveries, especially with  
10 regard to women as to how to make the incision to reduce the  
11 risk of infection in some of those individuals.

12 **Q:** All right. And those articles that you're talking about,  
13 are those what we refer to as peer review?

14 **A:** Yes, sir.

15 **Q:** All right. And do you also do that, do you do peer  
16 review yourself?

17 **A:** Yes, sir. So, I am actually a peer reviewer for several  
18 journals in our specialty, including the American Journal of  
19 Obstetrics and Gynecology, American Journal of Perinatology as  
20 well as the British Journal of Obstetrics and Gynecology,  
21 ACTA, SCANDANAVICA, Obstetrical and Gynecology which is the  
22 Scandinavian Journal of Obstetrics and Gynecology. In  
23 addition to that, I sit as an associate editor for media for  
24 the American Journal of Obstetrics and Gynecology where I sit

1 on their board for reviewing those articles and I am also an  
2 associate editor for the American Journal of Perinatology,  
3 where I am the person who makes those decisions about which  
4 articles do progress beyond and do reach publication stage.

5 **Q:** So, as a peer reviewer then, what are the criteria that --  
6 that need to be applied before, you know, someone's article  
7 actually gets published, this peer review?

8 **A:** Absolutely. So, it's a very rigorous process, where we  
9 put articles -- we receive the article from the person who has  
10 written the article first of all. We look at what the topic  
11 of that article is; what the methods they have used and then  
12 we look for individuals who are independent from that group.  
13 So, in other words, these individuals may be in other parts of  
14 the United States or they may even be international, but they  
15 have some specialty or expertise in the area where that  
16 article has been published. So, in other words, when we send  
17 it out, we send it out to individuals who have not directly  
18 participated in doing that research, but rather it's -- think  
19 of it as a community of peers that understand what is being  
20 done with that research in making decisions about what should  
21 or should not progress at that point. So, those individuals  
22 then render an opinion on how they feel about that article,  
23 what they think the strengths of that article are, what the  
24 limitations of the article are and they actually are allowed

1 to ask questions of the individual who wrote that article.  
2 That then comes back to me and I'll look at their  
3 recommendations as well as what they recommended. I decide  
4 whether that article should continue on with publication or  
5 whether it should be rejected at that point. If it should  
6 continue on, we send it back to the people that wrote it and  
7 we say can you answer these questions for us and they answer  
8 those questions; that goes back to those original authors so  
9 that they can evaluate whether those things are pertinent, not  
10 pertinent and how would they change their manuscript for  
11 publication.

12 **Q:** Now, is that process designed or intended to make sure  
13 that the body of peer review literature is generally accepted  
14 by people in the field?

15 **A:** That is correct. It's important for several reasons;  
16 number one, not only is it accepted by the people in the  
17 field, but it's also a way to insure there's not bias in what  
18 makes into the medical literature and what is not. It's  
19 important that the medical literature be free of bias for what  
20 is published. And so, it's important that those publications  
21 make it through, irregardless of what the findings are, so  
22 that the rest of medicine, the rest of the individuals  
23 practicing know what the best options are in those cases.

24 **Q:** I will hand to you and ask you, is this a copy of your

1 updated CV?

2 **A:** Yes, sir.

3 **Q:** All right. Your Honor, we would offer that as  
4 defendant's exhibit 28?

5 **THE COURT:** Mr. Graham?

6 **MR. GRAHAM:** No objection.

7 **THE COURT:** Without objection, it's admitted.

8 **DEFENDANT'S EXHIBIT NUMBER 28**

9 **ADMITTED INTO EVIDENCE**

10 **BY MR HOOD:**

11 **Q:** Tell us a little bit about your current practice; what do  
12 you do during the week?

13 **A:** Yes, sir.

14 **Q:** What does your day look like?

15 **A:** Yes, sir. So, I'm a maternal fetal medicine specialist  
16 in Charleston, South Carolina as well as Summerville, South  
17 Carolina. So, we have two offices, where we see patients who  
18 are referred in for high risk conditions. We see patients on  
19 labor and delivery, and we deliver patients that are  
20 complicated sometimes on labor and delivery and assist with  
21 their delivery, when that is necessary. We also take call,  
22 where sometimes we deliver patients who are unassigned that  
23 come into the hospital for management.

24 **Q:** All right. Are you familiar with shoulder dystocia?

1   **A:**   I am, yes, sir.

2   **Q:**   And are you familiar with the management of shoulder  
3   dystocia?

4   **A:**   Yes, sir, I am.

5   **Q:**   Is that not something that you were taught in residency  
6   and medical school and things like that, but is that something  
7   that you've also taught?

8   **A:**   Yes, sir, that is correct.

9   **Q:**   All right.  I'll ask you how you teach it in a second,  
10   but before then, I'm going to ask where and in what capacity  
11   did you teach obstetrical management including complications  
12   like shoulder dystocia?

13   **A:**   Absolutely.  So, there's both, when you're training  
14   individuals on how to manage complications of delivery, for  
15   instance, you're working usually with a group of people.  Some  
16   of those people are medical students.  In other words, they're  
17   going through medical school and getting ready to go into  
18   residency.  And then there's individuals who are residents and  
19   they are actually in OBGYN residency and so they're actually  
20   doing hands on care at that point and you're training them.  
21   There's two types of training.  Sometimes there's training  
22   where you're in a classroom and you have -- you have a board  
23   and have slides and you show those slides to the individuals  
24   and you teach them how to do these things and maneuvers and



1 the -- the process of management of a shoulder dystocia. And  
2 then in other times, that's actually encountered on the labor  
3 and delivery suite, where we're the attending physician and go  
4 in there and actually assist in the management of the shoulder  
5 dystocia and walk them through the steps of shoulder dystocia  
6 with us as their guidance at that time and their guiding hands  
7 at that time.

8       So, for instance, this would be at the Medical University  
9 of South Carolina. I have also served as an associate  
10 professor at the University of Virginia in Charlottesville,  
11 Virginia. This would also be the University of Illinois in  
12 Champaign-Urbana, Illinois. So, I served in teaching in those  
13 roles in multiple places and positions.

14 **Q:** All right. That first part of training that you're  
15 talking about, classroom type stuff, that's sort of looking at  
16 diagrams and talking about concepts sort of like we're doing  
17 here?

18 **A:** That is correct, yes, sir.

19 **Q:** And then the other part is hands on or demonstrating what  
20 the feel of the process?

21 **A:** That's exactly right and so -- so when you're doing that  
22 hands on piece for instance, one of the key features of  
23 residency is, it's not one year, it's not six months, you have  
24 to do it for that four years so that you have enough

1 opportunity to see these complications occur. So, in other  
2 words, we don't get warning, we can't say to -- I can't walk  
3 in the morning and say today we're going to have a shoulder  
4 dystocia in room 6, let's all get ready. It happens and we  
5 have to be there to manage it at that point.

6 We also use simulations, so we also have some simulations  
7 that we use for demonstration of shoulder dystocia management  
8 as well. So, in other words, plastic pelvises with a plastic  
9 baby that's assisted through that pelvis, that sort of thing,  
10 to help demonstrate some of those -- some of those things and  
11 sometimes we use video as well.

12 **Q:** All right. Let me ask you to just explain to us all how  
13 you would go about conveying an obstetrical resident how you  
14 manage a shoulder dystocia; could you do that for us?

15 **A:** Yes. So, I think the very first thing is recognition.  
16 You know, the very first thing that has to happen when you any  
17 type of emergency and shoulder dystocia is a very real  
18 emergency. And so, we have to first communicate with them,  
19 how do you recognize it. So, for instance, the majority of  
20 babies, when we deliver, the baby glides out and we assist  
21 that gliding of the baby down and out of the birth canal and  
22 that occurs with guidance and very limited gentle traction,  
23 when that is taking place. So, that occurs.

24 Fortunately, God is good. He doesn't create a scenario

1 where the baby just falls out on the floor; the majority of  
2 the time, the baby does not come out of its' own volition. In  
3 other words, we still -- we still have to provide that  
4 guidance, but when that does not occur, in other words, that  
5 guidance is not occurring with that -- with that baby  
6 delivering and you don't see the emergence of that interior  
7 shoulder, then we know that something else is potentially  
8 going on and there could be some hints that tell us that  
9 that's going to happen. One thing, the baby may deliver and  
10 then the head pull back in. We sometimes call that a turtle  
11 sign, because basically, it pulls the little baby and its neck  
12 back up inside of the mother where it looks just like a turtle  
13 retracting its' head. So, that's one of the things that we  
14 teach those residents, is in the very early going,  
15 specifically to look for any kind of changes.

16 The other thing that you learn is you do so many  
17 deliveries and so many deliveries occur according to a certain  
18 predictable spectrum. In other words, the baby comes, the  
19 head appears, the mother pushes, the head then completely  
20 appears, we don't see that retraction take place, we got the  
21 head out; it's when that pattern is broken, when that is not  
22 occurring exactly that way that we begin to recognize that a  
23 shoulder dystocia is present. So, that's the very first  
24 thing.

1       The second thing we teach is that it's an emergency.  
2   Anytime you have an emergency, the first thing that all of you  
3   are taught to do and I teach my kids to do, is you dial 911.  
4   You want to get help. And so, that's what you do next; you  
5   call for help. That help arrives in a number of different  
6   individuals; in other words, pediatrics is going to be  
7   involved, you've got a stabilization team for the baby when  
8   it's -- when it is delivered. You also have an additional  
9   nurse usually come into the room at that point and they bring  
10   in stools to assist in getting into a position for performing  
11   the initial maneuvers for release of that interior shoulder.  
12   Because our focus is still on the getting the baby delivered  
13   at that point. We also discuss that while that baby is in --  
14   in limbo, meaning that the baby is not yet emerged to the  
15   outside, but yet, it's not inside enough to where blood supply  
16   is able to be established to the baby. We have to move  
17   effectively and in an appropriate manner to affect that  
18   delivery to take place because the baby cannot breathe while  
19   it is still inside the birth canal. So, the baby is not able  
20   to breathe, and the baby is fully dependent upon getting blood  
21   from the mom's placenta. While it's stuck in the birth canal,  
22   it doesn't have the opportunity to use its' cord to give it  
23   that blood supply. So, we're acting on a clock very similar  
24   to if we take a person to a swimming pool and put them under

1 water, there's only a certain amount of time they can tolerate  
2 being under water. We have to work to get that baby delivered  
3 at that point.

4       So, then we talk about what are the things that we can do  
5 initially that carry the least risk to the mother and to the  
6 baby. And certainly movement of the maternal pelvis by  
7 placing that mother in McRoberts position, getting each of her  
8 legs, getting them up and back, rotates the pelvis backwards  
9 and gives you more space up and down to allow that shoulder to  
10 come out. So, in some cases, that alone is going to be able  
11 to affect the ability of that delivery.

12       Now, again, it's not likely the baby is just going to pop  
13 out, it's not going to fall into the floor, it has to be  
14 guided at that point. So, we have to apply that same force  
15 traction to deliver the baby in an axial manner.

16       The next step, if that does not work, remember we called  
17 for help in those previous few steps. That help comes in,  
18 they set up those stools by the side and they place suprapubic  
19 pressure. That suprapubic pressure is usually a flattened  
20 hand or flattened knuckles into and just above the symphysis  
21 pubis. Pushing down, hopefully pushed this shoulder or roll  
22 this shoulder down, so that it can then come out and immerge.  
23 But again, that by itself does not result in the baby coming  
24 out at that point. So, we still have to provide that

1 assistance and traction to deliver the baby at that point.  
2 And at some points, when you do that, you can actually feel  
3 with your hands on the baby's head, you can feel that movement  
4 of that shoulder or you can feel the release of that shoulder  
5 take place to give you a hint that's the case.

6 If that does not work, it then depends on how much room  
7 there is posteriorly. You may cut an episiotomy to get  
8 additional room, but now the goals are going to move to  
9 internal. So, when we go to those internal maneuvers, we're  
10 going to encounter more risks potentially because of how we do  
11 those maneuvers. There's the possibility of doing what's  
12 called Rubin's maneuver, where we go in and put our fingers  
13 behind the shoulder and try to fold the shoulder into the  
14 chest, causing there to be less space and folding this baby up  
15 so that it can fit through underneath the symphysis pubis,  
16 fall down, fit through and come out at that point. Now, when  
17 you do that, there's a possibility of breaking bones and  
18 that's one of the concerns we have when that takes place. You  
19 can break a clavicle here, if the clavicle breaks to the  
20 inside, we can damage the lungs. There are two big vessels  
21 that lie behind the clavicle, an artery and a vein; you can  
22 puncture those and the baby can bleed very seriously, if that  
23 were to take place.

24 We also can take fingers and we can rotate backwards such

1 that we turn the baby. In other words, if I push against my  
2 clavicle here, this doesn't rotate any further backwards, but  
3 what I can do is rotate the whole baby. That's called a  
4 Wood's corkscrew maneuver. The Wood's corkscrew maneuver can  
5 rotate that interior shoulder out from under the symphysis  
6 pubis and allow it then to immerge and allow you to deliver  
7 that baby out of the pelvis at that point. When doing Wood's  
8 corkscrew, same thing is true, you're putting force against  
9 this interior shoulder, across the clavicle and you have to be  
10 careful of not breaking the clavicle or potentially causing an  
11 occult or definite injury to the baby at that point.

12 You can also reach around, so if this is the interior  
13 shoulder, you can reach around and you can try to deliver the  
14 posterior arm. So, you can take the baby's hand, take the  
15 forearm, guide it out with this out and I've created more  
16 space here and allowing this to drop down and this may allow  
17 now for this interior shoulder to be released and delivered  
18 and allow that baby to come out at that point. In doing that,  
19 the risk is breaking the humerus here. So, you can break the  
20 upper arm bone in the process of doing that.

21 So, all of these are possibilities. Beyond that, we get  
22 into possibilities that carry a lot more risks. So, for  
23 instance, there's in some countries where you don't have  
24 options to manage any other way, they may actually cut the

1 symphysis pubis. I'm a fast talker, I'm sorry. They may --  
2 they may cut the symphysis pubis. So, in other words, that  
3 bone that is in the mom's pelvis, is like this, between it has  
4 a little bit of cartilage. They may actually cut all the way  
5 down, split that to give additional room and that allows more  
6 pelvic room to come out. I have never seen it or done it, it  
7 is something that is described in text books and literature.

8 And then there's also the option of what's called pelvic  
9 replacement or zavanelli's maneuver, which is where you  
10 actually take the baby and you push it back up inside. Sounds  
11 like a great idea, the only problem is it's associated with a  
12 very high risk of breaking potentially the neck of the baby  
13 and that of course can leave the baby with potential paralysis  
14 for life in its upper and lower extremities when that takes  
15 place. So, zavanelli is also not a preferred maneuver. The  
16 idea between that is you would push the baby all the way back  
17 up and do a c-section to get the baby out at that point.

18 So, the key is with all of that management, the key is  
19 first of all, recognition and then also recognition that this  
20 is an emergency, where the baby is at death's risk while this  
21 is occurring, because it cannot breathe while inside.

22 Q: Okay. I have a couple of things I jotted down I wanted  
23 to get clarification. Did I understand you correctly that  
24 even if you feel the release of the shoulder after suprapubic



1 pressure is affected, the baby still needs to be delivered?

2 **A:** That is correct. So, the baby does not fall out in  
3 response to the shoulder and if you don't affect that delivery  
4 at that point, it's likely that's going to recur. In other  
5 words, that shoulder is going to go back into the position  
6 where it was and you're back where you're started at.

7 **Q:** And then you were describing, I think, initially with  
8 McRoberts and the birthing process and you said in an axial  
9 manner. What did you mean when you said an axial manner?

10 **A:** Yes, so -- so part of the discussion here is when you  
11 look at axial, you're trying to keep the head in alignment  
12 with the spine. And as the baby comes down the birth canal,  
13 that is not straight. In other words, the baby's spine is not  
14 straight with the bed. It is not a direct out position. The  
15 baby is coming down in a downward position as it emerges from  
16 the pelvis. So, actually, what you're doing is actually  
17 coming down with the baby and out; you're not coming straight  
18 out with delivery of the baby.

19 **Q:** Okay. And we're talking here in two dimensional planes  
20 in drawing or the flip charts, I mean is that what it's really  
21 like when you're delivering a baby?

22 **A:** It is not. And that's the reason that we cannot go into  
23 a classroom and show people videos on how to deliver a baby  
24 and then expect them to go out and do it. That's the reason

1 there's 4 years of training and hands on experience for  
2 delivering a baby.

3 Q: Right. So, there's -- you were here for Dr. Maselli's  
4 cross examination, right?

5 A: Yes, sir.

6 Q: And there was some testimony dealing about the movement  
7 of the neck one way or the other and I just want you to  
8 explain to the jury, during any routine delivery, does the  
9 head move from one side to the other?

10 A: It absolutely does.

11 Q: Is that problematic?

12 A: It is not. That is part of the normal birthing process.  
13 In other words, the baby navigates the mom's pelvis all the  
14 way down by moving in those planes. And so, there is no harm  
15 or issue with the baby having that deviation as it is  
16 delivering.

17 Q: And I think it was described as excessive bending of the  
18 neck; is that problematic?

19 A: That can be. If a person excessively bends the neck such  
20 that, you know, you are getting all the way over lateral and  
21 then also pulling, you're no longer in the axis of the spine  
22 and so that can be a problem because that could expose to more  
23 stretch.

24 Q: And, I mean, if you're talking -- are we talking about an

1 axis of the spine saying it's like this and a bending is like  
2 this; is that excessive?

3 A: No, sir.

4 Q: Can you measure it while you're delivering a baby?

5 A: No, sir, you cannot.

6 Q: Do you instruct your residents to say 3 degrees plus or  
7 minus?

8 A: We do not. There is no way to measure that or assess  
9 that. That is not an assessment that we make during delivery  
10 nor is it part of training of residents for delivery.

11 Q: All right. I want to -- are you familiar with the  
12 medical literature that's related to obstetrics?

13 A: Yes, sir.

14 Q: All right. And you're familiar with literature  
15 concerning shoulder dystocia?

16 A: Yes, sir.

17 Q: Literature concerning brachial plexus or shoulder  
18 injuries?

19 A: Yes, sir.

20 Q: And you're familiar with the articles talking about  
21 management of shoulder dystocia, causes of brachial plexus  
22 injuries, all of those sorts of things, true?

23 A: Yes, sir.

24 Q: All right. At this time, I would offer Dr. Robinson as

1 an expert in the field of obstetrics and gynecology as it  
2 relates to management of shoulder dystocia and the causes of  
3 brachial plexus injuries?

4 **THE COURT:** Mr. Graham?

5 **MR. GRAHAM:** I have no questions at this time, Your  
6 Honor.

7 **THE COURT:** All right. Then, ladies and gentlemen, he is  
8 being offered and he may at this time, give opinions on  
9 obstetrics, gynecology, shoulder dystocia management and  
10 brachial plexus management; is that correct?

11 **MR. HOOD:** Yes, sir, the causes of brachial plexus  
12 injury.

13 **THE COURT:** Okay. And I've spoken to you already about  
14 experts several times during this trial and you would apply  
15 the same standard to this witness.

16 **BY MR. HOOD:**

17 **Q:** Well, let's dive in here, I want to get an opportunity  
18 for the jury to hear the opinions that you formulated in the  
19 case. So, have you reviewed the -- the delivery records?

20 **A:** Yes, sir, I have.

21 **Q:** And you've reviewed the testimony?

22 **A:** I have, yes, sir.

23 **Q:** Did you formulate an opinion in this case, well, let me  
24 back up. With respect to the standard of care, do you

1 understand that to be what a reasonable, prudent, OB in the  
2 same or similar circumstances would do?

3 A: Yes, sir.

4 Q: All right. With that understanding, did you -- did you  
5 look specifically at the management of the shoulder dystocia  
6 that was in here?

7 A: Yes, sir, I did.

8 Q: And did you formulate an opinion about whether it was or  
9 it was not appropriate?

10 A: Yes, sir, I did.

11 Q: All right. Now, I'm going to get to the management of  
12 it, but I just to want to check off wholesale, everything  
13 leading up to it. In terms of the prenatal care and in terms  
14 of the first stage of delivery and the labor up until the  
15 point of shoulder dystocia recognition, do you believe that  
16 Dr. Maselli and her practice complied with the acceptable  
17 standard of care for providing care and treatment as well as  
18 the first stage of labor?

19 A: Yes, sir, they did.

20 Q: There was just recently a significant, not significant,  
21 but some discussion of Pitocin. Does Pitocin have anything to  
22 do with, with anything in this case?

23 A: It does not.

24 Q: All right. Well, let's not talk about it. Let's talk

1 about the management of the shoulder dystocia using that same  
2 framework you described earlier that you use with residents.  
3 Did you find that there was appropriate recognition of the  
4 shoulder dystocia in this case?

5 A: There was.

6 Q: And was that consistent with the standard of care?

7 A: It was.

8 Q: Now, you mentioned 911 or calling for help; was that  
9 done?

10 A: It was.

11 Q: All right. And was that appropriate?

12 A: It was appropriate.

13 Q: Instructions to carry out McRoberts, was that done?

14 A: It was.

15 Q: And was that appropriate?

16 A: It was appropriate.

17 Q: The episiotomy, was that done?

18 A: It was.

19 Q: And was that within the standard of care?

20 A: It was.

21 Q: Instruction to do suprapubic pressure, was that  
22 appropriate?

23 A: It was.

24 Q: And was that within the standard of care?

1 A: It was.

2 Q: All right. Now, you heard Dr. Maselli testify that after  
3 the suprapubic pressure released the shoulder dystocia, she  
4 felt she applied slightly more than gentle traction, slightly  
5 more than gentle, what she checked as moderate controlled; is  
6 that consistent with the standard of care?

7 A: It is.

8 Q: Is there a difference between moderate and excessive?

9 A: Yes, sir, there is.

10 Q: Are they two different words?

11 A: They are.

12 Q: Do you think of moderation and excess as the same?

13 A: I do not.

14 Q: With respect to the recognition and management of the  
15 shoulder dystocia in this case, is it -- do you have an  
16 opinion as to whether Dr. Maselli complied with the standard  
17 of care to a reasonable degree of medical certainty?

18 A: She did. She had very efficient care of the shoulder  
19 dystocia and also safe care during the shoulder dystocia.

20 Q: Nuchal cord, we've talked about that a little bit. What,  
21 if any, significance does that have as you look at the review  
22 of this case?

23 A: Certainly. So, nuchal cord is very common. That means  
24 that the baby actually has a loop, sometimes more than one

1 loop, in this case it was a single loop as described around  
2 the neck of the baby. When parents hear that, they're very  
3 scared, but what's fortunate is that the cord is very long.  
4 In fact, the cord is usually, you know, about as long as from  
5 there down to here. So, it's a very long cord. It gives the  
6 baby plenty of room to come down the birth canal. So, it's  
7 not the nuchal cord that's a concern per se. The concern is  
8 that the baby has brought the cord with its head to the  
9 outside and now cannot deliver. So, what we talked about, the  
10 baby can't breathe while it's in the birth canal. Now, the  
11 baby's cord is also coming out and back into the birth canal  
12 and with that lack of space, there can't be blood flow through  
13 that cord. So, the concern is not that of a nuchal cord,  
14 which is relatively common, nuchal cord happening about one in  
15 four deliveries, one in five deliveries or so. The concern is  
16 really that the baby has now brought the cord down and also  
17 occurring is a shoulder dystocia preventing that baby from  
18 delivering effectively and rapidly.

19 **Q:** And you said a couple of times, the baby can't breathe in  
20 the birth canal; why is that?

21 **A:** So, it can't expand its lungs and begins to start taking  
22 in air in and out while it's compressed within the birth  
23 canal. When we get the baby out, in fact, usually you're  
24 start to hear the cry and the baby beginning to start



1 breathing within a few seconds after delivery takes place, but  
2 the baby can't do that. So, while the baby is coming down the  
3 birth canal until it's totally out, it's dependent upon that  
4 cord to give it the oxygen and the supplementation so that it  
5 can do well and be stable during the course of delivery.

6 **Q:** Well, okay. So, and you've still got the cord attached  
7 and it's not like tied up a knot or something; why does it  
8 matter that the nuchal cord or the cord is wrapped around head  
9 and outside the body?

10 **A:** Yeah. So, so when we have -- we have another emergency  
11 called cord prolapse that occurs during obstetrics and  
12 gynecology. In other words, the cord falls out ahead of the  
13 baby and thus we don't know how long it's going to be before  
14 that baby actually comes out and delivers. During the time  
15 period that cord is outside ahead of the baby, the cord cannot  
16 pulsate and send blood. So, what's happening in that cord is  
17 the baby's heart is beating and the baby's heart is pushing  
18 that blood through the cord to the placenta to pick up oxygen  
19 from the mother's bloodstream. It can't do that. So, the key  
20 is, we've cut off that baby's lifeline. It's kind of like an  
21 astronaut, if you're out in outer space, there's no air out  
22 there. They depend upon their lifeline to give them that  
23 oxygen and supplementation and if we cut it, they suddenly  
24 don't have it anymore and then we're on a clock.

1 Q: Well, we didn't have a cord prolapse in this case?

2 A: We did not, but we had effectively a similar sort of  
3 scenario where we have the cord on the outside where it cannot  
4 transmit that blood back and forth.

5 Q: All right. And what I want you to do is explain to me  
6 why it can't transmit blood when it's on the outside?

7 A: Because there is pressure between the baby and the wall  
8 of the birth canal that is putting pressure on that umbilical  
9 vein. So, the vein itself can squeeze very easily and you can  
10 cut off the baby's blood supply with that very easily. So,  
11 because it's on the outside, the cord has come in, or it's  
12 come out and back in and it's going to be compressed on both  
13 sides of that where the blood cannot flow and get to that  
14 placenta when the baby is trying to -- when its heart is  
15 beating.

16 Q: Sort of like a hernia or something?

17 A: Kind of.

18 Q: Okay. What is the general preferred order of performing  
19 these interventions that you described; we don't need to go  
20 through the whole list, but if we maybe separate the external  
21 maneuvers or maybe suprapubic and McRoberts and then just lump  
22 together the internal ones; I mean is there a preferred order  
23 here and if so, what is it?

24 A: Yeah, there generally is. There's two things that kind

1 of controls this; one is, which is easiest and the second is,  
2 which is safest. I mean those are the two things that really  
3 guide the direction. So, for instance, putting a person in  
4 the external maneuvers like McRoberts and suprapubic pressure  
5 are positional maneuvers. Those positions the patient is  
6 placed is very easy to do it and it also does not carry risks  
7 to the baby that's above and beyond what those specific  
8 procedures are. So, we usually start with external maneuvers  
9 before moving to internal maneuvers.

10 Q: All right. And you talked about the emergency nature and  
11 I want to into that a little more specifically. Before I do,  
12 this particular shoulder dystocia, when you looked at the  
13 chart, did you see anything that would suggest that this one  
14 would be predictable?

15 A: No, sir.

16 Q: Did you see anything in this particular shoulder dystocia  
17 that would indicate to you that it would be preventable?

18 A: No, sir.

19 Q: And was there any indication that you saw that suggested  
20 that instead of having a vaginal delivery, this baby needed to  
21 be delivered via c-section?

22 A: No, sir.

23 Q: All right. Let's talk about the emergency and I want to  
24 talk about the issue of it, you described it as calling 911.

1 Why do you describe this or do you describe it as a genuine  
2 medical emergency and if so, why?

3 **A:** Yes, sir. So, anytime that you have an individual that  
4 cannot breathe on its own and cannot establish itself outside  
5 to be able to continue to thrive and do well, that person is  
6 experiencing a genuine emergency, because they have no control  
7 over that process of when they're going to come out and none  
8 of us knows the minute, second or hour that that is going to  
9 take place or that person is going to be able to transition to  
10 that. In other words, no one has a crystal ball to tell them  
11 what the future is like. We like to focus sometimes on the  
12 retrospectrogram, which is to look backwards and say well,  
13 this is what happened. None of us have that capability.  
14 That's the reason this is an emergency and has to be treated  
15 as such, as an emergency.

16 **Q:** Have you ever seen a published peer review or obstetrical  
17 literature about any timeframe or timeline that suggests that  
18 the baby has ---

19 **MR. GRAHAM:** Object to the leading, Your Honor.

20 **THE COURT:** I don't -- he hasn't even asked the question.  
21 You can continue.

22 **MR. HOOD:** Okay.

23 **BY MR. HOOD:**

24 **Q:** Have you ever seen anything published that suggests that

1 the baby has a 10 to 15 minute window of time before you have  
2 to worry about brain injury?

3 **A:** No, sir.

4 **Q:** What do you consider to be the window of time that is  
5 critical for the onset of potential of brain injury?

6 **A:** It is different for every different case and so, there is  
7 no specific time period that you can apply to say this is safe  
8 and this is not safe. And a brain injury is one of the things  
9 that we do worry about because there's no option of improving  
10 a brain injury once a brain injury occurs. So, we don't have  
11 the option of doing something to mitigate that.

12 **Q:** Meaning it's irreversible?

13 **A:** That is correct. That is correct.

14 **Q:** In the context of a shoulder dystocia, an ongoing,  
15 unresolved, shoulder dystocia, does every second count?

16 **A:** It does.

17 **Q:** What do you say to someone who would argue that the fetal  
18 monitoring strips, which are exhibit number, defendant's  
19 exhibit -- this is plaintiff's 5 actually, that the fetal  
20 monitoring strips show the baby had a good heart rate leading  
21 up to the delivery?

22 **A:** Yes, so once you have totally cut off the supply to that  
23 baby and you no longer have the ability to receive oxygen, the  
24 heartrate doesn't assure you of those things. So, the

1 heartrate is just that; it's the heartrate. The heart is not  
2 connected to how the brain functions. It's not connected to  
3 how other things function; it just means that the baby is  
4 alive.

5 **Q:** Well, I mean, if you note that the baby's doing well  
6 going into shoulder dystocia, does that change whether it's a  
7 genuine emergency?

8 **A:** In no way.

9 **Q:** Why?

10 **A:** Because number one, I do not know how long it will take  
11 for that baby to ultimately be delivered and number two, the  
12 baby cannot breathe or convert itself to breathing as it would  
13 on the outside when it's inside the birth canal.

14 **Q:** All right. And I want to shift to a similar topic, but I  
15 want to ask you about the immediate risk of harm, injury or  
16 death in a shoulder dystocia. What are the risks of -- to the  
17 baby in a shoulder dystocia?

18 **A:** So, during a shoulder dystocia, there can be prolonged  
19 time from immergence at the perineum or through the vulva to  
20 the time of delivery, which can decrease oxygenation and  
21 potentially lead to brain damage that's irreversible or a baby  
22 with cerebral palsy, that can't walk, move, learn and do  
23 things normally on a day to day basis. There's a risk of  
24 damage to nerves in the process. There's a possibility of

1 having brachial plexus injury that would affect one side  
2 generally, an arm, forearm and some degree of motion of the  
3 hand when that takes place. In fact, we know it's about 97  
4 times more likely if a shoulder dystocia occurs, that injury  
5 to nerves in an arm can occur. And so, it is -- it is a known  
6 factor associated with shoulder dystocia.

7 Q: You say 97 times more likely?

8 A: Yes, sir.

9 Q: Okay. Not percent, but times?

10 A: That is correct.

11 Q: What other types are there besides nerves and the oxygen  
12 issues?

13 A: Yeah, so you can also get into things like bruising as,  
14 you know, the baby is trying to come out and a possibility the  
15 baby may die as a result of never immersing or not immersing  
16 in time enough for delivery. There's also organ damage that  
17 can occur as a result of oxygenation. So, heart damage, other  
18 organs, the kidneys, liver, things of that nature that can be  
19 affected by that.

20 Q: And do you consider the risks that you just discussed in  
21 the context of a unresolved shoulder dystocia to be immediate  
22 risks?

23 A: Absolutely.

24 Q: And why is that?

1   **A:**   Because those risks begin at the point that the diagnosis  
2   took place. So, when the baby did not immerge immediately from  
3   the perineum, we have the baby outside clamping the cord,  
4   that's when the risk began. The risk was immediately present  
5   and it was ongoing, present at that point.

6   **Q:**   Let's talk about stability. Do you consider a baby in an  
7   unresolved shoulder dystocia situation where the head is  
8   outside and the body is inside, to be considered medically  
9   stable?

10   **A:**   I do not.

11   **Q:**   Why?

12   **A:**   Because a medically stable individual has the ability to  
13   support themselves without any external support whatsoever and  
14   a baby does not have any capability of transitioning itself to  
15   be able to breathe, thrive or continue to do well when it  
16   cannot breathe and it cannot receive blood supply.

17   **Q:**   Well, what do you say to those who, who suggest that  
18   information after delivery show that the baby tolerated the  
19   shoulder dystocia okay?

20   **A:**   What is said is that the outcome at delivery is what it  
21   is with the baby transitioning well, is that the obstetrician  
22   did a good job in managing that delivery and was able to  
23   affect that delivery in an amount of time that protected that  
24   baby from these adverse outcomes.



1 Q: And does the fact that the baby had a good heartrate  
2 going into the shoulder dystocia and positive findings in the  
3 labs afterwards have any bearing on whether the baby is stable  
4 during that unresolved window of time?

5 A: It does not. We have babies who have normal heartrates  
6 that come out and do not survive. So, heartrate is not a  
7 predictor or marker of a baby being stable. It does not mean  
8 that the baby is going to do well just because there's a  
9 heartrate. You know, that is the limitation that we have.  
10 So, we do not have the ability to do, you know, blood  
11 pressures, things of that nature, put monitors in, put the  
12 baby on ECMO, which is a machine to give the baby oxygen and  
13 nutrition from the outside; we can't do those things while the  
14 baby is in the birth canal. We literally have one option and  
15 that is delivery of the baby and the goal was to affect that  
16 delivery in the most effective manner that we can when an  
17 emergency like this is going on.

18 Q: At the moment the shoulder dystocia begins, do you have  
19 any way of knowing how much reserve oxygen the baby has at  
20 that point?

21 A: You do not.

22 Q: And do you have any idea of how long the reserve oxygen  
23 will last?

24 A: You do not.

1 Q: Do you have any idea of knowing whether the first  
2 maneuver, the second maneuver, any maneuver will actually  
3 work?

4 A: You do not. So, you have no guarantees. When you're  
5 working this emergency, you're working it according to your  
6 training; you're moving through the steps but you have no  
7 guarantees. There are babies that have not been delivered  
8 after all of this takes place and the baby does not survive.  
9 And so, there are no guarantees when you have an emergency  
10 like this and unfortunately, we also don't have any  
11 predictors. So, we have nothing that tells us who is going to  
12 have it and going back to that training experience, that's the  
13 reason it takes so long to learn this process, is you have to  
14 have four years of training and experience to see it.

15 Q: Well, the one thing you do know is that if nothing is  
16 done, nothing will happen?

17 A: That is correct. If nothing is done, the baby is not  
18 going immerge at its own volition and there is not going to be  
19 a survival if that is the case.

20 Q: All right. Everybody's different, so what I want to do  
21 is focus on the babies before they're born. Is there a way  
22 for you to know whether a particular baby will be more  
23 resilient to the trauma of the birthing process versus  
24 another?

1 A: There is not.

2 Q: Is there any sort of measuring or gauges to use to judge  
3 those sorts of things?

4 A: There is not.

5 Q: And does that factor into the risks associated with  
6 managing a shoulder dystocia?

7 A: It does, because we don't have any specificity as to  
8 which babies are going to immerge well and those babies that  
9 are not. And so, we don't know going into it and we don't  
10 have predictors that tell us that.

11 Q: Doctor, in your opinion, was the delivery, the shoulder  
12 dystocia encountered in this delivery a genuine medical  
13 emergency?

14 A: It certainly was.

15 Q: Doctor, in your opinion, was the -- was there an  
16 immediate risk of injury, harm or death to the baby during  
17 this shoulder dystocia delivery?

18 A: There absolutely was.

19 Q: And do you believe that the baby was medically unstable  
20 at the time of the shoulder dystocia in this delivery?

21 A: Yes, sir, it was.

22 Q: And is that because the baby couldn't survive on its own?

23 A: That is correct.

24 Q: And this delivery occurred in an obstetrical suite?

1   **A:**   Yes, sir, it did.

2   **Q:**   All right.  I would like to shift gears and talk a little  
3   bit about brachial plexus injury, some of the traction  
4   concepts and the injury in this case.  Your Honor, if you want  
5   to interrupt me at any point, I'm happy to go to lunch.

6           **THE COURT:**  We'll get there.

7           **MR. HOOD:**  Okay.

8   **BY MR. HOOD:**

9   **Q:**   Are you a member of ACOG; did I ask you that already?

10  **A:**   Yes, sir, I am.

11  **Q:**   And are you familiar with this, the Neonatal Brachial  
12  Plexus Palsy Book?

13  **A:**   I am.

14  **Q:**   Just generally describe to the jury what this is, if you  
15  would?

16  **A:**   Yeah.  So, this is a document based upon the best  
17  research or say, taking those peer review papers that we  
18  talked about, putting them altogether into one document to  
19  outline to an OBGYN things that they should be aware of in the  
20  process of what research is available in shoulder dystocia,  
21  what research is available in brachial plexus injury, where  
22  this is seen, what things have been looked at as far as risk  
23  factors for the condition as well as prediction and also,  
24  looking in some of the biomechanics of how injuries may occur

1 with shoulder dystocia. So, it really gives a -- it's a  
2 document that really pulls together the best of the peer  
3 reviewed literature by another group of peers to publish it  
4 into a set of informative guidelines and information for  
5 people to look at and use for education.

6 Q: All right. And we'll talk about that in a little bit.  
7 Let's talk about traction first and then we're going to talk  
8 about the book. How do you define traction?

9 A: So, traction is a force. It can be of two things; it can  
10 be exogenous, meaning it's applied from outside, such as the  
11 obstetrician is delivering the babies' head; it can be  
12 endogenous, meaning that's the force that's being applied to  
13 the baby, that is pushing the baby down the birth canal during  
14 the process of delivery.

15 Q: All right. And we were talking earlier, Mr. Graham and  
16 Dr. Maselli were talking earlier about the exogenous traction,  
17 right?

18 A: Yes, sir.

19 Q: That would be the hands of the physician?

20 A: That is correct, yes, sir.

21 Q: And I mean, is traction a bad thing in a delivery?

22 A: It is not; it's a necessary thing. So, traction has to  
23 be applied for a delivery to actually take place. It is very  
24 rare, sometimes when a very pre-term baby delivers, that say

1 is only 24 or 26 weeks where it is so little, that baby may  
2 deliver without anybody touching it. It may occur just  
3 spontaneously, but a term baby has to be guided through that  
4 delivery process. So, traction is necessary in the process.

5 **Q:** And is traction typically customarily used in vaginal  
6 deliveries?

7 **A:** It is, yes, sir.

8 **Q:** So, we've heard gentle traction, we've heard moderate  
9 traction, we've heard slightly more than gentle traction,  
10 we've heard excessive traction. How do you explain to  
11 residents, who are getting ready to go out and deliver babies  
12 wherever they may go, how they should use their hands during  
13 the birthing process?

14 **A:** That's a great point. So, basically, they have -- by the  
15 time they're getting ready to go out, they've already done  
16 hundreds of deliveries, by the time they go out. So, they know  
17 what the norm is. In other words, it's hard for me to sit  
18 here and tell you, if I give you a rope, how hard do I want  
19 you to pull on that rope. If I told you I want you to pull on  
20 it with minimal, if I want you to guide it, if I want you to  
21 do a little bit more than minimal, if I want to use moderate  
22 or if I want you to use excessive, it would be hard for you to  
23 understand what exactly you're supposed to be doing with that.  
24 So, what happens in training, is we teach people by use of

1 hands, by use in going into the delivery room with them  
2 actually supervising and performing that delivery with them.  
3 Sometimes, even with hands on top of hands in the process of  
4 guiding and showing them how much is appropriate. That's how  
5 we teach it. It's not a measure that is quantitative, meaning  
6 that we're going to attach a scale or we're going to do some  
7 type of actual objective measurement for that person. But  
8 once a person has been in practice and they're delivering  
9 babies, they know what that is. In other words, it's kind of  
10 like when you get in your car every day, you know, you've got  
11 to use a key and you know that key has to be turned with a  
12 certain amount of force to start that car. You're not going  
13 to turn it until the key totally breaks off in the switch and  
14 you're not going to turn it hard enough for the key to  
15 actually start the car. You know because you had experience  
16 and that experience is over and over and over again, that when  
17 you get back in the car and turn the key, you know how hard  
18 you're going to turn the key. The same is true for when we  
19 train in residence in doing vaginal deliveries.

20 Q: Okay. We live in a high tech world; we've got all sorts  
21 of gadgets that can measure even the smallest dimensions and  
22 pressures and weights and things like that. Why can't y'all  
23 just say you're only allowed to use X number of pounds per  
24 square inch?

1   **A:**   Because every delivery is different.  So, in other words,  
2   the size of the baby is different in each case.  The  
3   presentation of the baby in the pelvis is different in each  
4   case.  And so, there's no two that are identical and that's  
5   the reason the exact same amount of traction is not the same  
6   for each delivery.

7   **Q:**   Say that again?

8   **A:**   The amount of traction used is not the same for each  
9   delivery.

10  **Q:**   Does that mean if there's more in one delivery than it  
11  was another; that it's excessive?

12  **A:**   It is not.

13  **Q:**   Well, let's talk about the traction that was discussed --  
14  that you heard discussed today from the endogenous side, the  
15  doctor's side.  All right?  What you -- what you observed here  
16  today in the courtroom, was Dr. Maselli's description of the  
17  traction used during the delivery, was that traction in  
18  compliance and consistent with the applicable standard of  
19  care?

20  **A:**   It was.

21  **Q:**   Does that traction arise to a level of excessive traction  
22  in your opinion?

23  **A:**   It does not.

24  **Q:**   And why is that?



1   **A:**   Well, because number one, each time that you actually  
2   apply traction, you have to know what were the maneuvers that  
3   you have done. So, in this case, when traction is applied  
4   that results in delivery of the baby, we had a feeling that  
5   the shoulder had been released at that point. Once the  
6   shoulder is released, we have to deliver the baby. Okay?  
7   There's no more management of internal maneuvers and that sort  
8   of thing. Once that shoulder is released, we go ahead and  
9   deliver the baby at that point. If we don't deliver the baby,  
10   if we don't keep some traction, it's going to go right back to  
11   where it was and then we would not have achieved anything in  
12   the process of delivery of the baby. So, the amount of  
13   traction to necessitate delivery, once the shoulder has now  
14   removed itself from behind the symphysis pubis, is appropriate  
15   and needs to be done at that point.

16   **Q:**   I mean, could you also have a delivery where the  
17   suprapubic pressure resulted in just being able to gently  
18   guide it out afterwards?

19   **A:**   You certainly could. Both are possibilities.

20   **Q:**   And if gentle guidance wasn't doing it, but slightly more  
21   than gentle guidance does it; is that appropriate?

22   **A:**   It is appropriate.

23   **Q:**   And by the way, if -- if the traction is being applied in  
24   a lateral fashion and I'm using hands, if I'm doing it wrong,

1 you tell me, but if it's being done a curved fashion, we're  
2 talking about an axial straight line, how do you correlate  
3 those two concepts; you've got a curved pelvis and then you do  
4 this and we're talking about 90 and 180 degrees.

5 **A:** That is correct. So, it's different for each baby, but  
6 the baby does not come out along the straight axis of the bed.  
7 So, in other words, the baby, you know, axial traction,  
8 keeping the neck or the head in alignment with the spine is  
9 not directly out; it's actually going down and then as that  
10 baby immerges from the pelvis, it's going to point back up.  
11 So, it's not a straight line and that's really a key.  
12 Actually, the amount of degrees that you will go down in  
13 bringing the baby out in an axial position is between 25  
14 degrees and 40 degrees estimated. So, you will never come  
15 straight out, you will always go down and then back up.

16 **Q:** All right. Let's talk about exogenous or endogenous  
17 forces then. That's the internal forces that you were talking  
18 about earlier.

19 **A:** Endogenous.

20 **Q:** Excuse me, endogenous. Thank you. You just call those  
21 maternal forces?

22 **A:** That's correct.

23 **Q:** When you use that, what does it mean?

24 **A:** So, those are the forces that -- there's two different

1 types; there's the uterus, so the uterus is a muscle and  
2 that's where the baby has been living and that uterus is  
3 contracting and propelling the baby toward a forward position  
4 so that it can come out to the perineum, where we then take  
5 over and apply forces to deliver the baby to complete the  
6 delivery of the baby.

7 And then there's pushing forces, where a person is  
8 actually being told to bear down and push during that  
9 contraction to also help propel that baby outward. So, it's  
10 those two forces together.

11 **Q:** Well, how can those expulsionary forces that you're  
12 describing result in a pulling force?

13 **A:** So, if there -- if there is a point in which the baby  
14 becomes stuck, where the shoulder is behind that symphysis  
15 pubis and they're still pushing, that creates a pulling force  
16 when that is taking place.

17 **Q:** Why would that not just be a compression force?

18 **A:** Well, it's a combination of both. It can be a  
19 compression and a pulling force, but when that pushing is  
20 still going on and this is stuck and we're still propelling  
21 the baby forward, but this is stuck; we are moving this part  
22 of the baby ahead of this and thereby providing stretch.

23 **Q:** And even when, at that point, so that you've diagnosed  
24 the shoulder dystocia, has that already occurred?

1   **A:**   That has already occurred.

2   **Q:**   All right.  Once you rotate mom into McRoberts and use  
3   gentle guidance at that point and she's pushing; is it  
4   occurring at that point as well?

5   **A:**   It is.

6   **Q:**   And the same thing with suprapubic pressure or other  
7   points where mom's pushing?

8   **A:**   It is.

9   **Q:**   Before it's resolved.  And are you familiar with any  
10   literature that recognizes that those forces can cause  
11   shoulder injuries?

12   **A:**   Absolutely.  So, there is literature that has looked at  
13   babies that had no force applied whatsoever and developed an  
14   injury to the brachial plexus and damage to the movement of an  
15   arm.

16   **Q:**   And is there literature describing both permanent and  
17   temporary shoulder injuries?

18       **MR. GRAHAM:**  Objection, Your Honor, to the leading and  
19   also the improper use of ---

20       **THE COURT:**  He's not suggesting the answer, he's asking  
21   if there was.

22       **MR. GRAHAM:**  Yes, sir.

23       **THE COURT:**  I'll allow the question.

24       **MR. GRAHAM:**  And also, the learned treatise violation,

1 Your Honor.

2 **THE COURT:** All right. Thank you.

3 **BY MR. HOOD:**

4 **Q:** Do you remember the question?

5 **A:** Could you repeat the question?

6 **Q:** Sure. Are you familiar with a body of literature  
7 discussing the maternal forces are enough to cause both  
8 temporary and permanent injury?

9 **A:** Yes, sir.

10 **Q:** Is that discussed in this book?

11 **A:** It is.

12 **Q:** Do you consider this to be reasonably reliable?

13 **A:** I do.

14 **Q:** All right. So, if maternal forces can cause an injury,  
15 why don't we see just millions of children all over the place  
16 with these permanent injuries?

17 **A:** Because it doesn't happen in the majority of cases. So,  
18 in other words, it's not -- it's not something that happens  
19 that commonly. In fact, even shoulder dystocia itself is not  
20 a super common event. So, that's the reason a majority of  
21 babies don't have issues of that sort.

22 **Q:** What is the rate of occurrence?

23 **A:** The rate of what?

24 **Q:** Occurrence for a shoulder dystocia, let's start with

1 that?

2 **A:** Probably between like .6, on a high side, probably 1 and  
3 one-half percent or so.

4 **Q:** And then what is the percentage of babies born that  
5 suffer a permanent brachial plexus injury?

6 **A:** It can be as many as half of those.

7 **Q:** Are you familiar with constellation of forces as  
8 described in this book?

9 **A:** Yes, sir.

10 **Q:** Describe what that concept is, please?

11 **A:** So, you've got more than one thing occurring on the baby  
12 all at a given time. So, there's more than one force that's  
13 acting upon that baby; there's pressure, there's pushing  
14 forces, exogenous force, there's lot of other forces that are  
15 all coming together.

16 **Q:** And does this book also recognize that excessive lateral  
17 traction can cause these injuries?

18 **A:** It does, yes, sir.

19 **Q:** Well, on that point, what type of instruction do you --  
20 you provide to the residents that you're training about  
21 lateral traction, excessive traction, that sort of thing?

22 **A:** Yeah. So, we actually keep the baby in an axial position  
23 for delivery applying traction in an axial position. Traction  
24 is usual and needed for delivery, during the process of

1 delivery and we avoid lateral traction in delivery.

2 Q: And that's something that you're trained to do?

3 A: Yes, sir.

4 Q: All right. So, you know, what about in baby like  
5 Jahmerican, who doesn't have any congenital problems; does  
6 that mean that you can rule out that the forces, mom's forces  
7 were sufficient to cause an injury?

8 A: You cannot.

9 Q: Why not?

10 A: Because there's no way to know what exactly happened at  
11 the time to cause the injury to take place. In other words,  
12 we don't have monitors that we can apply in utero or monitors  
13 that we can apply to the baby to assess the baby while it's  
14 coming down and out through the birth canal.

15 Q: Now, what about the timing of the injury; is there a way  
16 to determine precisely the exact moment in which the injury  
17 occurs?

18 A: There is not.

19 Q: Why not?

20 A: Because again, we don't have ways of measuring things  
21 that are going on as far as traction, pulling, things of that  
22 nature, as the baby is immerging from the birth canal or as  
23 it's traveling down the birth canal, as it's being propelled.  
24 So, we don't have measures that can give us that information.

1 Q: Are you familiar with a school of thought from past years  
2 that talks about these type of injuries being exclusively  
3 related to excessive positional induced traction?

4 A: Yes.

5 Q: Do you subscribe to that school of thought?

6 A: No, sir.

7 Q: Why not?

8 A: So, basically over time, as the literature as amassed and  
9 we have more and more cases and especially case series that  
10 have come from, if you want to study shoulder dystocia for  
11 instance and it's not going to occur in every delivery, you  
12 have to look at thousands and thousands of individuals. So,  
13 you have to have a large case series to be able to look and  
14 see what is going on in the population. And so, as that  
15 body of literature has gone from what we think, and this is  
16 often what happens in medicine, we initially start out and  
17 think something is true and then as we begin to look at it  
18 over and over again, if we don't see what we think is true  
19 occurring every single time, our thinking changes and that's  
20 what has happened in this theory as well, which is as the  
21 literature has amassed, there's not evidence that traction  
22 injury, exogenous traction, is the cause of all shoulder  
23 dystocia.

24 Q: It doesn't mean it can't cause it?



1   **A:**   That is correct, it is -- it is a recognized cause, but  
2   it's not one that is found in all cases of shoulder dystocia.

3   **Q:**   All right.  So, the publication recognizes it.  If you  
4   pull laterally, excessively, that's down towards the floor too  
5   hard, you can cause shoulder injury?

6   **A:**   That is correct.

7   **Q:**   And that's something that's been known for years?

8   **A:**   That is correct.

9   **Q:**   Something that's been taught?

10   **A:**   That is correct.

11   **Q:**   Have you ever heard of anyone who proposes to use that as  
12   a delivery technique?

13   **A:**   I have not.  It's specifically something we teach  
14   against.  And so, in other words, the recognition that this  
15   was associated, is something that we recommend against.  It's  
16   just like with other types of delivery.  If we know that  
17   something is unsafe, that's something that we proceed with.  
18   You know, we're not going to expose the patient to something  
19   that's known to cause problems.

20   **Q:**   And based on what you heard on the witness stand today  
21   and have seen in the depositions, do you believe that the  
22   injury in this case was caused by Dr. Maselli?

23   **A:**   I do not.

24   **Q:**   Why not?

1   **A:**   Several things.  Number one is, she has been practicing  
2   for a long period of time with a lot of deliveries.  And so,  
3   if that were to be the case, and I have seen a series of cases  
4   where individuals have high rates of shoulder dystocia.  I  
5   mean, they have Erb's Palsy's occurring throughout the years.  
6   We would have a recognized problem if that is the case.  Also,  
7   if we had things going on that were unsafe.  The reason that  
8   there's more than one person in a delivery room and the reason  
9   there's one more person that are separated by their  
10   responsibilities, is so that it gets documented.  In other  
11   words, if I see something that's going on unsafe, it gets  
12   reported, we sit down in a meeting and we discuss how to  
13   correct it.  Before we start -- before I start knee surgery, I  
14   was in the operating room twice yesterday; once to transfuse a  
15   baby, to give a baby a blood transfusion in utero.  The last  
16   thing I tell everyone in the room after we introduce each  
17   other is if anyone sees an unsafe condition occurring in that  
18   space, they are to let me know and we will work to correct it.  
19   In other words, it puts everyone on the same playing field  
20   where everyone feels confident that they can report if  
21   something is going on that should not be occurring, it can be  
22   reported and corrected.  Because our number one focus, we  
23   don't go into medicine to expose people of harm; we go into I  
24   medicine to take care of people and we want to make sure we do

1 it the best we possibly can.

2 Q: In terms of the other testimony just ahead of you with  
3 Dr. Haseltine, he was not deposed in this case, so that was  
4 the first you heard of him. What in fact, if any, does that  
5 have with respect to the management of the shoulder dystocia  
6 from your perspective?

7 A: Right. So, it's -- it's -- he actually was there, he was  
8 a witness to it and he also was an independent party; he's not  
9 part of the obstetrical team. He was a part of the pediatric  
10 group and he did not see anything that was unusual, anything  
11 that was unsafe or anything that was out of the ordinary. If  
12 someone was in a room and someone was pulling, yanking,  
13 jerking on a baby, I would immediately stop that behavior and  
14 there would also be a report, if that were the case. That is  
15 not a safe approach to management of any delivery. No one  
16 wants their child or their grandchild treated in such a manner  
17 and that would result in an immediate report.

18 Q: Now, you talked about separate documentation. You're  
19 referring to the nurses and the doctor?

20 A: That is correct.

21 Q: And is the documentation, though separate, in this case  
22 consistent with each other?

23 A: They are.

24 Q: And so, the nurses were describing the same thing that

1 the doctor described?

2 **A:** They were.

3 **Q:** Let's shift gears and talk about permanent versus  
4 temporary. There are lots of injuries that resolve before  
5 they become permanent with respect to shoulder injuries,  
6 right?

7 **A:** That is correct.

8 **Q:** And what is the rate that injury goes from, it's  
9 classified as temporary before permanent?

10 **A:** So, generally, it depends upon which levels were involved  
11 and also what type of specific injury would sink to those  
12 levels. So, for instance, if C-5 and C-6 injuries were more  
13 than likely to resolve, so those are in the upper branches of  
14 the brachial plexus, those may actually recover function and  
15 be normal. As you get below that, 7 becomes, if you add 7 to  
16 that, that becomes less likely to recover, if you add 8 to  
17 that, that becomes less likely to recover and as you go lower,  
18 you get less and less recovery as time goes on.

19 **Q:** In this particular case, after Jahmerican is born, before  
20 the records are created, does anyone know which nerves have  
21 been injured?

22 **A:** They do not.

23 **Q:** Does anyone know the extent or the nature of the injury?

24 **A:** They do not.

1 Q: Is there any way to determine whether an injury by  
2 observing it, is going to be permanent versus temporary?

3 A: There is no way to know. We find that out through  
4 following physical therapy, interventions for the child, but  
5 we do not know.

6 Q: And what's the threshold before an injury is flagged of  
7 being permanent.

8 A: Usually, if you're not better by 6 months to a year,  
9 somewhere in that range?

10 Q: And if after 3 or 4 months, with therapy, time and  
11 everything resolves, that injury would be considered  
12 temporary?

13 A: It would.

14 Q: And is there any aspect of this case or the delivery or  
15 the description that indicates that the injury is more likely  
16 to be temporary or permanent at the time of delivery?

17 A: There is not.

18 Q: And is there a way for Dr. Maselli or the nurses to  
19 collaborate together to concoct a story about an injury they  
20 don't know whether is temporary or permanent?

21 A: There is not.

22 Q: Doctor, have the opinions that you've offered here today  
23 been to a reasonable degree of medical certainty?

24 A: Yes, sir, they have.

1 Q: All right. Please bear with me just one minute. Please  
2 answer any questions Mr. Graham may have.

3 THE COURT: All right. Ladies and gentlemen, we're going  
4 to break for lunch; it's about a quarter of. I would ask you  
5 to be back in your jury room at 2:15. Okay?

6 REPORTER'S NOTE: (Jury excused for lunch 12:43PM).

7 THE COURT: All right. We're at ease until 2:15. Thank  
8 you.

9 MR. HOOD: Thank you, Judge.

10 (COURT IN RECESS)

11 THE COURT: Okay. Bring them in.

12 REPORTER'S NOTE: (Jury enters courtroom 2:35 P.M.)

13 THE COURT: All right. We've got everyone back in the  
14 courtroom now. Mr. Graham, you may cross examine.

15 MR. GRAHAM: Thank you, Your Honor.

16 CROSS EXAMINATION OF DR. ROBINSON BY MR. GRAHAM:

17 Q: Doctor, good afternoon.

18 A: Good afternoon.

19 Q: I'm going to try to move through this as quickly as  
20 possible. I'm going to hop, skip and jump so, forgive --  
21 forgive that.

22 First of all, let me ask you this, Doctor, have you ever  
23 told us how many deliveries you had had, I forgot?

24 A: No, around 1500.

- 1 Q: Is that vaginal deliveries?
- 2 A: No, sir, that would be a combination of both.
- 3 Q: Okay. So, how many vaginal deliveries?
- 4 A: So, probably around 30 percent caesarean and 70 percent
- 5 vaginal.
- 6 Q: Okay.
- 7 A: So, that would be 150 times 7 or 450 -- 1050 plus.
- 8 Q: 1050?
- 9 A: Yes.
- 10 Q: How many times did you encounter shoulder dystocia?
- 11 A: Probably around 40 or 50 times.
- 12 Q: And how many times have you had a permanent brachial
- 13 plexus birth?
- 14 A: None, that I know of.
- 15 Q: How many of your shoulder dystocia deliveries involved
- 16 uterine contractions and maternal pushing?
- 17 A: I would say all.
- 18 Q: Thank you. Is there a difference between variable
- 19 decelerations and early decelerations?
- 20 A: Yes, sir.
- 21 Q: All right. What's the difference?
- 22 A: So, early decelerations are usually, they're both paired
- 23 with contractions, but early decelerations are usually where
- 24 there's a decrease in the heart rate with the contraction,

1 usually ranges around 15 maybe 20 beats decreased during that  
2 time period. Whereas, a variable deceleration is the same as  
3 with a contraction, but you have a decrease that's usually  
4 much greater than that.

5 **Q:** Now, remind me, are you currently teaching at MUSC or the  
6 University of Illinois or where?

7 **A:** University of Illinois.

8 **Q:** At the University of Illinois, when you teach your  
9 residents about various types of decelerations, do you -- at  
10 what year in the residency program do you teach them about  
11 early and variable decelerations?

12 **A:** Usually in the first, say 3 months or 1 month even.

13 **Q:** Would you expect in a qualified residency program, would  
14 you expect first year residents to know what those are?

15 **A:** Yes.

16 **Q:** Just in the first 3 months?

17 **A:** Yes.

18 **Q:** Would it surprise you for any Board Certified Obstetrician  
19 to think that variable decelerations and early decelerations  
20 are the same thing?

21 **A:** I think it depends upon the concept in which they're  
22 talking about them. For instance, they both occur with  
23 contractions and so, a lot of people take that information and  
24 they say these occur with contractions as whereas, the late



1 deceleration is the one that occurs after contractions. But,  
2 I think sometimes people do group them, you know, once they're  
3 out into practice and that's where I think, because both of  
4 them don't necessarily change management unless there's  
5 problems with variability in the fetal monitor.

6 Q: They mean different things though, right?

7 A: They are different types of decelerations, yes.

8 Q: Would you expect your residents to know that difference?

9 A: Yes.

10 Q: And let me ask you about uterine hyperstimulation. First  
11 of all, do you call it uterine hyperstimulation?

12 A: Not usually.

13 Q: What do you call it?

14 A: Tachysystole.

15 Q: Okay. And how would you define, I mean before I ask the  
16 question, is Tachysystole the new name that your professional  
17 organization came up with some years ago to substitute for  
18 uterine hyperstimulation?

19 A: It is.

20 Q: Okay. Would you expect somebody that keeps up with the  
21 practice to know that those words have changed?

22 A: I think oftentimes they do the words have changed, but the  
23 key is, is they've been reinforced over the years with the  
24 older terms. So, for instance, I still read a lot of PIH

1 charts, which stands for pregnancy induced hypertension, and  
2 that term really went away in about 2000, for instance. But  
3 to this day, I read that in charts, because when you're  
4 trained in something, you're trained over and over and over  
5 again to use a certain terminology and it's sometimes hard to  
6 get away from that. Whereas, now, we call that pre-eclampsia.

7 Q: Sure.

8 A: Yes.

9 Q: Do you see in charts nowadays uterine hyperstimulation as  
10 opposed to Tachysystole?

11 A: So, in general I don't see either. The reason being is  
12 because it doesn't affect management unless there's something  
13 that is going on to cause decelerations or progressive hypoxia,  
14 it doesn't make a difference.

15 Q: At any rate, how do you define uterine hyperstimulation or  
16 Tachysystole, whatever you want to call it?

17 A: Certainly. So, it was 6 or more contractions in a 10-  
18 minute period of time averaged over a 30-minute total period.

19 Q: Okay. So, let's see if I'm writing these definitions down  
20 correctly. So, early decelerations are not equal to variable?

21 A: That is -- they're equal in terms of when they occur with  
22 contractions, but they are caused by 2 different physiologic  
23 mechanisms.

24 Q: And I believe you said that hyperstimulation is 6

1 contractions, 6 or more contractions every 10 minutes, but you  
2 have to average it over 30 minutes?

3 **A:** That is correct.

4 **Q:** Now, when do you teach your residents at the University of  
5 Illinois, how to figure out what Tachysystole is or uterine  
6 hyperstim?

7 **A:** So, we don't really normally teach them anything more than  
8 that definition and what we're more focused on is not so much  
9 that definition or the focus of Tachysystole, but more so  
10 focused on if their fetal heartrate changes in response to  
11 that type of pattern. Because we know, for instance, that  
12 hyperstimulation and/or whichever term you want to use,  
13 Tachysystole, occurs with frequency during normal labor and  
14 delivery, even unstimulated labor and delivery, but it may not  
15 result in any change to the fetal stats and so ---

16 **Q:** Do you believe it's appropriate for a doctor that uses  
17 Pitocin, you know, often, regularly to know what Tachysystole  
18 is and how to look for it?

19 **A:** I think -- I think, again, I don't that Tachysystole is  
20 the driver, in other words, of -- so the answer would be no  
21 first. Because I believe that Tachysystole is not the driver  
22 of what the decision-making process is, but rather it is the  
23 fetal response. So, in other words, if there are contractions  
24 that are occurring to frequently as in Tachysystole and the

1 baby is having dips in the heartrate, that's important to know  
2 and to adjust. But, if that is not the case, then that does  
3 not necessarily require an imminent intervention.

4 Q: I understand, but do you expect your residents to know  
5 that?

6 A: So, yes, I try to teach them definitions and yes, sir.

7 Q: All right. Let's talk about the assumptions that you've  
8 made as the basis of your opinions here. First of all, you've  
9 assumed, or I believe, you still assume that anyone who's gone  
10 through a residency program in this country, complies with the  
11 standard of care?

12 A: I don't think that's always the case. What I am saying is  
13 people who go through a residency program in this country are  
14 exposed to a common amount of information and training to  
15 prepare them to become an Obgyn. So, in other words, there  
16 are national standards and those programs are reviewed based  
17 upon those national standards to ensure those things are  
18 occurring in these programs.

19 Q: But if someone lacks that knowledge of the ordinary,  
20 average obstetrician or lacks the skill about how to manage  
21 some condition like shoulder dystocia, for example, that would  
22 be -- that would be something that you believe could happen,  
23 even at a United States Residency Program?

24 A: I guess I don't understand the question exactly.

1 Q: I was just trying to restate what I thought you were  
2 saying. Let me say what I thought you were saying, and you  
3 can tell me if I'm right or need to tweak it somehow. I  
4 believe you told me that even if an obstetrician or even if a  
5 medical student and medical doctor goes through an obstetrical  
6 residency program, they may still come out without the  
7 appropriate knowledge needed to properly manage a shoulder  
8 dystocia and they may lack the skills to properly manage a  
9 shoulder dystocia; is that possible?

10 A: So, personally, I do not believe that, because this is an  
11 obstetric emergency that we focus on in training.

12 Q: Right.

13 A: And so, I do not believe that we let people finish without  
14 having exposure to shoulder dystocia and management of  
15 shoulder dystocia as well as other obstetric emergencies.  
16 That's the purpose of having that exposure to an extensive  
17 training program.

18 Q: And you know nothing about Dr. Maselli's residency  
19 program, do you?

20 A: Not her specific residency, no, sir, just that she  
21 completed a residency program.

22 Q: But, nevertheless, as you have approached your evaluation  
23 in this case, your opinions are based at least in part on your  
24 assumption that she went through a residency program and

1 therefore, she has the proper knowledge and skill to manage a  
2 shoulder dystocia safely?

3 **A:** So, I think -- yes, sir. Part of my evaluation of this  
4 case is exactly that. She did go through an approved  
5 residency program that then led to practice and years of  
6 practice has not experienced a permanent \*\* policy.

7 **Q:** Well ---

8 **A:** Until this case, I should say.

9 **Q:** Sure. And you've also assumed that everything in the  
10 chart is completely accurate, the truth, the whole truth and  
11 nothing but the truth?

12 **A:** So -- so, I do and I tell you why and basically you have  
13 multiple people documenting, and so, if a person wanted to  
14 take a chart and say something that is untrue, they could have  
15 easily just marked, you know, the usual traction and she was  
16 honest and put exactly what she had, which was moderate  
17 controlled traction. I think the charting actually is exactly  
18 that. It even supports the fact that she was honest in her  
19 charting and what actually happened in the case.

20 **Q:** And you've assumed that as -- a significant part of your  
21 opinions that you've expressed today, correct?

22 **A:** Yes, sir.

23 **Q:** There is -- or do you believe that the obstetrical  
24 residency program throughout the United States is foolproof in

1 terms of producing obstetricians who do not commit  
2 malpractice?

3 **A:** So, again, it is always possible that a person could  
4 commit malpractice or be out.

5 **Q:** But you have assumed that Dr. Maselli does not fall in  
6 that group?

7 **A:** Someone is raising their hand.

8 **Q:** Oh, I'm sorry.

9 **JUROR:** Move the easel please, so we can see you.

10 **MR. GRAHAM:** Certainly.

11 **JUROR:** Thank you.

12 **THE COURT:** There you go.

13 **BY MR. GRAHAM:**

14 **Q:** You have assumed that Dr. Maselli was not in that group?

15 **A:** That is correct, yes, sir.

16 **Q:** And I remember, there was a phrase in your deposition that  
17 I thought was fascinating. Do you remember talking about the  
18 sky is blue?

19 **A:** Yes, sir.

20 **Q:** All right. Is -- is this your understanding in how you  
21 approach your view of the practice obstetrics; if the sky has  
22 been blue for 7 days in a row, then you can bet your bottom  
23 dollar, it's going to be blue the next day?

24 **A:** No, I mean, you have to evaluate every case based upon the

1 specific circumstances that you're presented with along with  
2 the background data, as well as all of the descriptors from  
3 different people that are involved in the case and that  
4 involves nursing, pediatrics and other individuals that are  
5 also involved in that case. You have to put all of those  
6 pieces together.

7 **Q:** But in terms of Dr. Maselli, didn't you tell us that one  
8 of the reasons you believed that she did not commit  
9 malpractice is because she hadn't had a reported permanent  
10 injury before of April of 2013 and if the sky is blue before,  
11 it will blue again tomorrow?

12 **A:** So, based -- yes, sir. So, based upon the descriptors in  
13 the chart where I had different people reporting different  
14 things, everything from jerking and yanking on the baby to try  
15 to deliver the baby without evidence to support that, I did  
16 evaluate those pieces as well as the fact as a person who has  
17 delivered many, many babies without experiencing something  
18 like this or having any type of report of any previous history  
19 of those sorts of behaviors. So, you do have to weigh and  
20 look at the preponderance or the entirety of the chart to come  
21 with that.

22 **Q:** One thing we heard, I think we heard, something about some  
23 children's nerves being different from others. There's  
24 absolutely no reason to believe that there was anything



1 unusual about this child's nerves or vulnerability to injury  
2 or anything like that. There's no evidence at all, true?

3 **A:** I don't think we can ever know that for sure. In other  
4 words, once an injury has taken place, you don't have the  
5 original template that was there. Of course, we do know that  
6 there's a little bit of difference in how and what worked in  
7 this child and how transmission took place in some of the  
8 subsequent post injury studies that took place. But, I think  
9 it's just hard to know, because you can't evaluate it a priori  
10 or prior to the incident, I will say.

11 **Q:** Do you remember the question; the question was do you have  
12 any evidence at all that this child's nerves were more  
13 vulnerable to injury compared to normal children?

14 **A:** No, sir.

15 **Q:** So, for anybody to suggest the contrary, would be pure  
16 speculation, right?

17 **A:** I can't say that at all. There may be other experts that  
18 are involved at looking at things from a different viewpoint  
19 that may find something different. So, I would not project my  
20 opinion, I guess, onto others that may be working in that  
21 specific area.

22 **Q:** Well, speaking of speculation, would it be speculative of  
23 you to speculate what somebody else may or may not say, right?

24 **A:** That's correct.

1 Q: I just -- you went through a lot of questions about  
2 emergency, genuine emergency, immediate threat, medical  
3 instability. I wanted -- I want to understand what you're  
4 telling us. You named, I think, 4 different things;  
5 emergency, genuine emergency, immediate threat and medical  
6 instability. But the way you look at it, those aren't really  
7 4 different things, are they?

8 A: They are certainly interconnected. In other words, there  
9 are connections between those things, where sometimes they're  
10 not always absolutely connected, but most of the time, there  
11 are relationships between that.

12 Q: All right.

13 A: Yes, sir.

14 Q: If you believe there is an emergency and you believe that  
15 it necessarily follows that there is a genuine emergency ---

16 A: Yes, sir.

17 Q: --- do you believe it automatically follows that there is  
18 an immediate threat?

19 A: Yes, sir.

20 Q: Do you believe that it automatically follows that there is  
21 medical instability?

22 A: I do in most every case, yes, sir.

23 Q: And you did in this case?

24 A: Yes, sir.

1 Q: What percentage of should dystocia in your practice  
2 resolved with, McRoberts, suprapubic pressure and traction and  
3 nothing else?

4 A: So, the majority is what I would say. So, at least, you  
5 know 70 percent, you know, plus I would say. But of course,  
6 our rule in teaching is a little bit different sometimes. So,  
7 in other words, if we were teaching a resident or teaching an  
8 individual who has done many of these, we may start with  
9 having them do Woods corkscrew maneuver, Rubin's or  
10 potentially delivery of the posterior arm.

11 Q: Okay.

12 A: So, that the teaching experience is there.

13 Q: Right. McRoberts and suprapubic pressure are traction-  
14 based maneuvers, true?

15 A: That is correct. So, the maneuvers themselves are not,  
16 but to test the maneuver, in other words, to determine if the  
17 maneuver has worked, they require that you apply traction to  
18 see if the baby will deliver, yes.

19 Q: Okay. But there are some practitioners who apply traction  
20 throughout McRoberts and throughout suprapubic unless they go  
21 to get scissors to cut the episiotomy, fair?

22 A: Yes, sir.

23 Q: How long does it take to order and have nurses put a  
24 patient in McRoberts?

1   **A:** It depends on if they're both there at the time. But, you  
2   know, assuming that they are both there and able to get the  
3   legs out of the stirrups in easy fashion, I would say 5 to 7  
4   seconds, somewhere like that.

5   **Q:** And do you know how many nurses there were at this  
6   delivery?

7   **A:** Yes, sir. So, there was Ms. Butterworth, I believe and  
8   Ms. Cosotino.

9   **Q:** All right. Is it your understanding, they were both in  
10   the room at the time McRoberts was applied?

11   **A:** That is correct.

12   **Q:** So, 5 to 7 seconds for that position?

13   **A:** Yes, sir.

14   **Q:** And then how long does it take to get a pair of scissors  
15   to cut the mother's vagina?

16   **A:** To cut the perineum, I know we keep saying cut the vagina,  
17   but cut the perineum, it would probably be about I would say 3  
18   seconds or so. You have to turn around, you have to find them  
19   on the back table amongst all the other instruments and then  
20   you have to go down to separate the perineum away from the  
21   baby so that it's safe to actually make an incision with  
22   scissors there. So, there's a few steps in doing, you know,  
23   an episiotomy.

24   **Q:** It may have taken longer for you to explain that than it

1 did to actually cut the episiotomy?

2 **A:** It could, yes.

3 **Q:** How long does it take to order the nurse or nurses to  
4 perform suprapubic pressure and have them accomplish that?

5 **A:** So, they have to, you know, get a stool in place, get up  
6 on the stool and then apply pressure above the -- the  
7 symphysis pubis. I would say, you know, no more than 3 or 4  
8 seconds, but then you would do it for a period of time to  
9 assist in releasing that interior shoulder.

10 **Q:** And what -- and during that period of time, you would be  
11 applying traction?

12 **A:** Yes, sir.

13 **Q:** How long do you think is appropriate to be applying  
14 traction when the mother is, excuse me, when the nurses are  
15 applying suprapubic pressure?

16 **A:** So, I think for the duration of their intervention for  
17 trying to release the shoulder. Normal traction is done to  
18 provide that entire time period. A minute, if necessary, that  
19 sort of thing.

20 **Q:** But, with 5 to 7 seconds for McRoberts, order and obtain,  
21 3 seconds to obtain scissors and use them to cut, whatever  
22 that fancy word is ---

23 **A:** Yeah, perineum.

24 **Q:** --- and 3 to 4 seconds to order suprapubic and have it

1 started to be performed, you're talking a total range of about  
2 11 to 14 seconds?

3 **A:** No, I don't think it really runs that fast. I mean, I  
4 think getting a person in position, that sort of things, it's  
5 going to be longer than that.

6 **Q:** How much longer?

7 **A:** Maybe 20, 22 seconds, somewhere in that range, but it's  
8 going to be longer than you know, 13 total seconds.

9 **Q:** Well, let's go back through it. You said McRoberts 5 to 7  
10 seconds; how much ---

11 **A:** Well, I think -- no, I wouldn't change it, I think -- I  
12 think the thing is, is we're talking about putting the person  
13 in position versus testing. So, you're leaving out the part  
14 of testing to see if the baby is actually delivering between  
15 those individual steps.

16 **Q:** How long does that take?

17 **A:** I'll say, you know, 4 or 5 seconds maybe.

18 **Q:** All right. And then during those 4 or 5 seconds, the  
19 doctor is applying traction?

20 **A:** Yes, sir.

21 **Q:** All right. With that, are there anymore additions you  
22 think we should make?

23 **A:** No, I think that's appropriate.

24 **Q:** All right. So, that gets us up to 15 to 19 seconds?

1   **A:** Sure. That sounds reasonable. Probably around 19, 20,  
2   somewhere in that range.

3   **Q:** So, if we have a 60, excuse me, 60 second shoulder  
4   dystocia, then we've got somewhere between 41 and 45 seconds  
5   of just traction with the other maneuvers having already been  
6   accomplished?

7   **A:** So, I wouldn't necessarily say that I think you try these  
8   maneuvers sometimes more than once and things of that nature  
9   as well. So, for instance, with suprapubic, you would apply  
10  the pressure, you might move that hand laterally as you're  
11  applying the pressure to see if that releases, you know, so  
12  it's not as simple -- there's not a clock that is clicking off  
13  and giving these individual things second by second. So, I  
14  don't think it's an accurate representation of how obstetric  
15  practice takes place.

16  **Q:** Well, what if the doctor only tries these 1 time, not  
17  multiple times; then would 45 to 51 seconds of -- of pure  
18  traction fit?

19  **A:** It could, yes, sir.

20  **Q:** And some of the other times would also involve traction,  
21  right?

22  **A:** Yes, sir.

23  **Q:** And in fact, the whole thing would involve traction except  
24  for the 3 seconds to grab the scissors and cut perineum, I

1 think you said?

2 **A:** Right. That's absolutely true. I think you try and you  
3 reposition, you try again. So, I wouldn't say that it's  
4 necessarily continuous traction, no, sir.

5 **Q:** Okay. Even if the doctor said there was?

6 **A:** Well, if the doctor says it is, then that is the case, but  
7 it's not necessarily continuous traction the entire time  
8 period. There are people that are moving about making changes  
9 and attempting the delivery.

10 **Q:** Even if the doctor says there was continuous traction  
11 except for the scissor part?

12 **A:** I think -- I think if your hands are on the baby's head,  
13 you always have some degree of traction present, but we're not  
14 -- I mean it's just your hands are there. You're not going to  
15 release the baby, in other words.

16 **Q:** All right. You said earlier, you told us that a nerve  
17 injury was 97 times more likely if there's shoulder dystocia,  
18 correct?

19 **A:** A brachial plexus injury is 97 times more likely if a  
20 shoulder dystocia is encountered, yes, sir.

21 **Q:** All right. And you told us that you used traction  
22 maneuvers for, what was your percentage, like 70 or 80?

23 **A:** So, I would not call those traction maneuvers; I would  
24 call those McRoberts and suprapubic pressure. Neither



1 maneuver is a traction maneuver. So, I don't want to  
2 mischaracterize that as a traction maneuver. Traction is used  
3 to test the maneuver in between. So, in other words, as we  
4 talked about before, the baby will never immediately deliver  
5 as the result of performing a maneuver. There has to be an  
6 attempt to see if the interior shoulder is released as a  
7 result of that.

8 **Q:** I mean, my brain is far from infallible, but, Doctor, I'm  
9 quite certain that you told us just a minute ago, that  
10 McRoberts and suprapubic pressure are, are traction maneuvers;  
11 are you changing that?

12 **A:** That is not true. What I said is they involve traction to  
13 test the maneuver when it's done. Neither maneuver involves  
14 traction. In other words, putting the mom's legs back is not  
15 a traction maneuver.

16 **Q:** Okay.

17 **A:** And putting the mom's suprapubic pressure is not a  
18 traction maneuver.

19 **Q:** Your sworn testimony now is that you never said that  
20 McRoberts and suprapubic pressure were traction?

21 **MR. HOOD:** Objection, Your Honor, he's mischaracterizing  
22 his testimony.

23 **MR. GRAHAM:** I'm asking a question.

24 **THE COURT:** All right. Go ahead, Mr. Graham.

1 **BY MR. GRAHAM:**

2 **A:** If you'll repeat it, I'm sorry?

3 **Q:** Is it now your sworn testimony that you did not previously  
4 say that McRoberts and suprapubic pressure were traction  
5 maneuvers?

6 **A:** So, neither of those maneuvers are traction -- there's no  
7 such thing as a traction maneuver. There are only maneuvers  
8 to release shoulder dystocia. Traction is used to test the  
9 maneuver. That is a characterization that you used, but not a  
10 characterization that I would use in describing that.

11 **Q:** So, is it your sworn testimony that you did not say  
12 McRoberts and suprapubic pressure ---

13 **THE COURT:** I think he's answered it, Mr. Graham. Could  
14 you move on, I think he's answered that?

15 **MR. GRAHAM:** Yes, sir, I will move on.

16 **BY MR. GRAHAM:**

17 **Q:** At any rate, with people using McRoberts and suprapubic so  
18 frequently, I think you said 70 or 80, I think Dr. Maselli  
19 said 80 or something like that, somewhere in that ballpark?

20 **A:** Correct.

21 **Q:** With that percentage of maneuvers that do involve some  
22 degree of traction, there are certainly more injuries to the  
23 brachial plexus with that scenario, McRoberts, suprapubic and  
24 traction than there would be with internal maneuvers, correct?

1   **A:** That is not correct. There is no high quality literature  
2   that has suggested the use of internal maneuvers to be  
3   superior over that of external maneuvers such as suprapubic  
4   and McRoberts.

5   **Q:** All right. Well, are you familiar with the Croft  
6   Articles?

7   **A:** Yes, sir.

8   **Q:** Would you agree, at least, that avoidance of greater than  
9   usual traction reduces the rate of permanent injury  
10   dramatically?

11   **A:** So, I do not agree with that because the population is  
12   very different than that of the United States. So, for  
13   instance, in the United Kingdom, they did not have programs in  
14   place to manage or routinely manage shoulder dystocia and they  
15   were able to show a significant reduction in injury as a  
16   result of management of shoulder dystocia, but they're not  
17   starting with the same thing. In other words, if I held out  
18   and there are no plans to manage or how to manage a shoulder  
19   dystocia and I say I can reduce the risk by implementing it,  
20   that's not the same as already having a plan in place to  
21   manage this and being able to control the effects of shoulder  
22   dystocia.

23   **Q:** Are you suggesting that before the training, obstetricians  
24   in the UK were using too much traction?

1   **A:** No, I'm saying there was no standardized approach and so,  
2   in other words, the standardization and teaching of an  
3   approach improves the outcomes. The other thing to consider  
4   is our population is very different than their population. We  
5   have a very different geography and group of people than they  
6   have as well.

7   **Q:** At any rate ---

8   **A:** Yes, sir.

9   **Q:** --- at any rate, those articles do indicate that there  
10   were a fairly significant number of brachial plexus injuries,  
11   not dissimilar than from in this country?

12   **A:** Yes, sir.

13   **Q:** And that with training to avoid traction, greater than  
14   general traction, the number of permanent injuries over 12  
15   years has dropped to zero, true?

16   **A:** It has dropped, yes.

17   **Q:** To zero, right?

18   **A:** No, I don't believe zero.

19   **Q:** We can come back to that in a moment, sir. I don't want  
20   to take time with it right now. You said something earlier  
21   that I found interesting. You said, I'm reading my notes, so  
22   this might be a misquote, but I think the words were  
23   substantial. No one wants their child treated improperly.

24   **A:** Yes, sir, I agree.

1 Q: If a parent did see their child treated improperly, do you  
2 think they would be justified in losing their temper?

3 A: Yes, sir, I would believe that. I believe as a parent  
4 myself, I think -- I think any of us would feel that way.

5 Q: You are a member of ACOG, right?

6 A: Yes, sir.

7 Q: Well, do you use -- well, you -- I think you answered  
8 questions from when Mr. Hood was holding up the ACOG position  
9 paper of 2014?

10 A: Yes, sir.

11 Q: All right. So, you know what I'm talking about with the  
12 2014 position paper from ACOG?

13 A: I do.

14 Q: All right. Do you use that publication in your  
15 obstetrical practice?

16 A: I use it in teaching. I use it in evaluation of things  
17 that are coming out in the literature and I use it examining  
18 what the current database is for exposure to prenatal brachial  
19 plexus injury and how those occurred.

20 Q: That sounded like a no, you do not use that publication in  
21 your obstetrical practice, correct?

22 A: So, I use it in forming my obstetrical practice, but do I  
23 use it in -- in, you know, managing a patient at the bedside,  
24 the answer is no. That's what our training is for. So,

1 training is used for management of a patient. We would never  
2 manage a patient according to a piece of paper or book or a  
3 publication.

4 Q: Yes, sir. Yes, sir. One thing I find interesting about  
5 the acronym ACOG is apparently it stands for 2 things;  
6 American College of Obstetrics and Gynecology and American  
7 Congress of Obstetrics and Gynecology, true?

8 A: It's not actually both, but it had a period of time where  
9 it was called the Congress; that is correct.

10 Q: And actually, well, when do you say the Congress started?

11 A: I honestly cannot remember. We've called it ACOG, but  
12 there was a period of time that congress was used and it was a  
13 really bad college.

14 Q: Are you able to say under oath today that the congress has  
15 ended?

16 A: No. I can't say anything of that sort, because I remember  
17 ACOG, but I don't keep up with their acronym or what they're  
18 exactly using as far as college or congress.

19 Q: And in fact, the American Congress of Obstetricians and  
20 Gynecologists exists for the purpose of lobbying Washington  
21 for changes in the law to benefit the legal and financial  
22 interests of obstetricians?

23 A: Yes, sir, they do -- they do have a lobbying arm.

24 Q: And it's called the American Congress of OBGYNs?

1   **A:** Yes.

2   **Q:** Do you consider the -- well actually we had witness  
3 earlier indicate that this document is reliable. So ---

4   **A:** Yes, sir.

5   **Q:** Look on the first page under the conclusion section; do  
6 you see where I'm talking about?

7   **A:** Yes, sir.

8   **Q:** All right. I'm going to read that and then ask you if you  
9 ever read it. Conclusions, there are significant benefits to  
10 long-term, embedded training programs with improvements in  
11 both management and outcomes. A decade after the introduction  
12 of training there were no cases of brachial plexus injury  
13 lasting over 12 months in 562 cases of shoulder dystocia. Do  
14 you agree with that?

15   **A:** That is what it states, yes, sir.

16   **Q:** All right. And the title is Prevention of Brachial Plexus  
17 Injury - 12 years of shoulder dystocia training: an  
18 interrupted time-series study. So, I heard you testify  
19 earlier that shoulder dystocia could not be predicted or  
20 prevented, but in fact, nerve damage associated with shoulder  
21 dystocia can in fact be prevented, according to this study,  
22 true?

23   **A:** So, I don't know that that is necessarily true. I think  
24 the key thing is here, is you have a very controlled

1 population, which you're doing a very controlled study in and  
2 you don't know, because the number needed to examine to come  
3 up with that answer is much greater than the number enrolled  
4 in the study, because of it being a rare outcome. So, if  
5 you're familiar with Pulsan types of analysis, in regression  
6 model, you cannot model data like this for which you do not  
7 have an adequate number of cases to predict that that is the  
8 case or not the case. So, the reliability is based upon how  
9 many cases you have evaluated. So, it looks like here they  
10 have pretraining, which is what we talked about before where  
11 patients or providers, care providers had not been trained in  
12 the management of shoulder dystocia. And you have that  
13 compared to early training as well as weight training  
14 individuals.

15 **Q:** And the primary thrust of the training was to avoid  
16 traction or at least avoid greater than gentle traction?

17 **A:** I think the thrust of the training was to provide a  
18 standardized mechanism for the management of shoulder  
19 dystocia.

20 **Q:** Which was to maximize internal maneuvers and minimize  
21 traction, true?

22 **A:** True.

23 **Q:** Is there -- you mentioned or we just talked about the  
24 position paper, ACOG put out back in 2014. I'm going to read



1 from page, I think it's 29 and see if you -- well, let me ask  
2 you this. Does -- does that publication provide any training  
3 about how to prevent brachial plexus nerve damage in the  
4 shoulder dystocia context?

5 **A:** No, sir.

6 **Q:** All right. Let me read you this and see if you agree with  
7 it. The key principle to minimize stretching of the brachial  
8 plexus through the application of exogenous force, is to avoid  
9 lateral bending of the neck. That is moving the fetus' head  
10 out of alignment with the fetal cervicothoracic spine, whether  
11 down toward the floor or the ceiling; do you agree with that?

12 **A:** Yes, sir.

13 **Q:** All right. And just to try to break down some of the --  
14 some of jargon. Exogenous means what?

15 **A:** That means the person on the outside, the force that's  
16 coming from outside of the mother, not the part that the  
17 mother is pushing.

18 **Q:** Okay. And fetal cervicothoracic spine means what?

19 **A:** It's keeping this part of the spine aligned that's in the  
20 upper neck. So, in other words, where the head is positioned,  
21 to keep the spine in alignment.

22 **Q:** If we translate the medical terminology, I started to say  
23 mumbo-jumbo, but terminology, if we translate that into  
24 language I can understand, does it basically say that to

1 prevent brachial, or to prevent or at least minimize brachial  
2 plexus birth injuries in a shoulder dystocia context with the  
3 right shoulder on top, that doctors should avoid bending the  
4 neck down and they should avoid bending the neck up?

5 A: Yes, sir.

6 Q: And that's from the ACOG position paper?

7 A: Yes, sir.

8 Q: You're a member of that organization?

9 A: Yes, sir.

10 Q: And do you agree that bending the neck down or up would be  
11 a standard of care violation in any shoulder dystocia?

12 A: No, because it's dependent upon how much there is. So,  
13 for instance, you're keeping it aligned with the  
14 cervicothoracic spine, but what we're talking about is  
15 excessive bending where we get into positions where there's  
16 excessive touching of almost the ear to shoulder, that sort of  
17 thing.

18 Q: Excuse me, Doctor?

19 A: Yes, sir.

20 Q: If the doctor had not done any internal maneuvers and bent  
21 the baby's neck laterally up or down, that would violate the  
22 standards of care, true?

23 A: No, sir, because the head is always aligned with the spine  
24 by going down. In other words, this gets again that we're

1 where the angle actually is. The head has to be moved in a  
2 downward position to align the cervicothoracic spine and that  
3 angle is approximately anywhere from 20 to 45 degrees.

4 **Q:** Okay. But lateral is when the head is off axis, correct?

5 **A:** That is correct.

6 **Q:** All right. And I thought that's what the question was --  
7 I thought that's what my question was. If the doctor has not  
8 done any internal maneuvers yet, wherever the head is in the  
9 axial plane you talked about, it would be a violation of the  
10 standard of care to bend that head and neck in either  
11 direction toward the left shoulder or the right shoulder,  
12 true?

13 **A:** No, sir. So, you would have to bend it excessively.  
14 We're not talking about slight tilts this way or the other;  
15 we're talking about significant bending. So, that's where we  
16 would have a problem. Because if we bent the head over to a  
17 sideways position and tried to then apply traction. We're not  
18 talking about slight maneuvers left or right.

19 **Q:** Would lateral bending cause this injury, a three nerve  
20 injury, two complete avulsions, one partial avulsion and a  
21 large neuroma encompassing all three injured nerves; how much  
22 lateral traction would be required to cause this magnitude and  
23 permanency of nerve damage?

24 **A:** So, we don't even know that lateral traction is involved.

1 Q: Well, all right. Well, let me ask you a hypothetical  
2 question. Assume for the moment that lateral traction is in  
3 fact the cause of this injury. How much lateral traction  
4 would be required to cause this?

5 A: So, it's not just lateral traction; it is position, it is  
6 how much traction is placed and it's also dependent upon  
7 person specific aspects.

8 Q: Okay. Assume whatever you want to assume about those  
9 other variables, just lock it in. Assume those plus lateral  
10 traction caused this injury. How much lateral traction would  
11 it take?

12 A: It probably -- it could be a lot; it could be a little.  
13 It really depends upon what the specific factors were in the  
14 case and maybe none.

15 Q: If in fact downward traction and a shoulder dystocia to  
16 the right shoulder on top, if that had been the situation  
17 involving a one-minute shoulder dystocia with McRoberts and  
18 suprapubic pressure, lateral traction alone would have to be  
19 pretty strong to cause this type of injury, true?

20 A: I would assume, yes, sir.

21 Q: Have you read all the medical records in this case?

22 A: Yes, sir.

23 Q: All right. I'm holding what's been marked as Exhibit 7  
24 for demonstrative purposes.

1   **A:**  Okay.  Yes, sir.

2   **Q:**  Does this appear to be a letter from John McGillicuddy or  
3   Dr. John McGillicuddy at MUSC to Dr. Elias, Georgetown  
4   Pediatrics in Georgetown?

5   **A:**  Yes, sir, that is correct.

6   **Q:**  All right.  And am I reading this correctly?  He, meaning  
7   Jahmerican?

8   **A:**  Correct.

9   **Q:**  Was found to have a right -- a right brachial plexus  
10   paralysis at the time of birth.  His birth weight was 8 pounds  
11   14 ounces.  His Apgars were normal and no respiratory distress  
12   was noted.  Did I read that correctly?

13   **A:**  You did.

14   **Q:**  I think we may just have one more question, Doctor.  
15   You're familiar with how much and what percentage of  
16   obstetrical literature related to shoulder dystocia and  
17   brachial plexus nerve injuries have you read?

18   **A:**  I don't know that there's a way to quantify that, because  
19   oftentimes, the literature is very varied; it's all over the  
20   place.  In other words, the journals I subscribe to routinely  
21   are the Green Journal, which is a journal of obstetrics and  
22   gynecology and the Gray Journal for which I'm an associate  
23   editor.  And those two journals are the ones I receive  
24   routinely and then I also look into other journals based upon

1 specific interest and those sorts of things.

2 Q: Okay.

3 A: Yeah.

4 Q: So, the ones you subscribe to, Green and Gray, those are  
5 peer reviewed journals?

6 A: Yes, sir.

7 Q: And you probably get some in the mail that are just throw  
8 away type journals?

9 A: Well, those usually aren't peer reviewed. I wouldn't even  
10 really call those, they're more like ad magazines, I would  
11 say.

12 Q: Okay. And there are some other ones?

13 A: Yes, sir.

14 Q: But, based on all of the reading that you've done, have  
15 you ever seen any documentation or report of a child being  
16 born with this type of nerve damage caused by anything other  
17 than manipulation of the head and neck by the birth attendant?

18 A: Sure, there's cases of where just the baby was born by  
19 vaginal birth without any manipulation of the birth attendant.

20 Q: Well, I've got your deposition page, but let me just read  
21 here from my notes. Have you ever seen a stretch injury that  
22 involves two complete avulsions, one partial avulsion,  
23 involving a large tough neuroma and encompassing C-5 and C-6  
24 having been caused by anything other than manipulation of the

1 head by the birth attendant; you're not aware of any such  
2 evidence, are you?

3 **A:** No.

4 **Q:** Thank you. That's all I have.

5 **THE COURT:** Mr. Hood?

6 **MR. HOOD:** Thank you, Your Honor.

7 **REDIRECT EXAMINATION OF DR. ROBINSON BY MR. HOOD:**

8 **Q:** And that's because the articles describe the individual  
9 nerves that are hurt.

10 **A:** That is correct. So, there's not articles out there that  
11 go into that kind of detail to give you the specifics of  
12 exactly what the injury is and what resulted from the injury.  
13 That's the problem. A lot of the articles are really based in  
14 looking at retrospective large series based upon things like  
15 diagnosis codes. So, if someone comes into the office, has a  
16 diagnosis of said condition, it will be coded as said  
17 condition and then that will result in that case being  
18 identified by medical record review. That sort of thing.

19 **Q:** So, to Mr. Graham's last question, would it be fair to  
20 infer from your response that there's no way to have this  
21 injury ---

22 **MR. GRAHAM:** Objection to leading, Your Honor.

23 **THE COURT:** He hasn't asked the question yet. Let's hear  
24 the question.

1 **BY MR. HOOD:**

2 **Q:** In response to your last Q and A with Mr. Graham, is it  
3 fair to infer from that one way or the other about permanent  
4 brachial plexus injuries given that factual situation?

5 **A:** It is not.

6 **Q:** Why?

7 **A:** Because there's not that degree of specificity published  
8 in the literature and not that degree of evaluation in all  
9 cases. So, for instance, some cases will actually receive a  
10 surgical evaluation as did Jahmerican in this case, where you  
11 can actually look and make a diagnosis of exactly what is seen  
12 at that time. But many others will not.

13 **Q:** Okay. If he were to ask you that question slightly  
14 differently and said, Dr. Robinson, are you aware of any  
15 reported cases where there have been permanent brachial plexus  
16 injuries that were reported as a result of something other  
17 than excessive lateral traction, what would your answer to  
18 that question be?

19 **A:** It would be yes.

20 **Q:** And is it commonly reported?

21 **A:** It is.

22 **Q:** I just want to clarify this traction maneuver thing that  
23 the two of you were discussing. When mom's legs are flexed  
24 back, does that generate traction?



1   **A:** No, sir.

2   **Q:** So, explain to the jury what you mean by the use of  
3 traction in conjunction with flexing the legs back in  
4 McRoberts, please?

5   **A:** Right. So, when the mother is in stirrups, like in the  
6 lithotomy position, like we put mothers in for delivery. We  
7 have the legs apart, the legs are down in stirrups and if you  
8 were to look at the pubic bone, it is facing a little bit  
9 forward, so there's a little bit of a tilt to it. So, there's  
10 a circle and if you think about trying to pass something  
11 through a circle, if you tilt the circle, the circle will not  
12 accommodate as much size. So, when we put the person the  
13 McRoberts position and we pull those legs way back, that  
14 circle moves like this, then we get a bigger outlet for that  
15 baby to pass through and a bigger outlet to allow that  
16 shoulder to come through. And so, that's the key. That's all  
17 it does though. It does not result in the baby delivering and  
18 that's the key point. You have to test that your maneuver --  
19 so, it's not a traction maneuver at all. The traction is used  
20 to test whether the maneuver has released the shoulder.

21   **Q:** Those are the same thing with the suprapubic pressure?

22   **A:** That is correct.

23   **Q:** All right. Then y'all were trying to do some math here on  
24 seconds. I want you to assume this fact pattern for me since

1 you weren't here yesterday. Assume that the head of the baby  
2 is reported to have delivered at 8:14 and at that moment, the  
3 physician has her hands on the baby's head and is instructing  
4 the mom to push for 10 seconds and she counts out loud, 1, 2,  
5 3, 4, 5, 6, 7, 8, 9, 10 and tells her to stop. Makes a  
6 diagnosis of shoulder dystocia, immediately tells the  
7 attending nurse to go get help, that nurse leaves the room,  
8 comes back in, another nurse returns with two stools. They  
9 were instructed to perform McRoberts. McRoberts is performed,  
10 instruction to mom to push, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. No  
11 delivery. The physician reaches behind her, grabs the  
12 utensil, performs the episiotomy, turns back, instructs the  
13 patient to push, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. No luck.  
14 Instructs for suprapubic pressure, suprapubic pressure results  
15 in feeling a pop, the doctor delivers the baby. In that  
16 process, where the physician has described the time in which  
17 there's pushing, the duration of the pushing, would it be fair  
18 to say that there was 45 seconds of nothing but pulling on the  
19 baby's head?

20 **MR. GRAHAM:** Objection to leading, Your Honor.

21 **DR. ROBINSON:** It would not.

22 **THE COURT:** I'm going to allow the question.

23 **BY MR. HOOD:**

24 **Q:** You were asked questions about some of these things about

1 paper stimulation, variables. Variables early in labor, do  
2 the fetal monitoring and stress have anything to do with the  
3 management of the shoulder dystocia in this case?

4 **A:** They do not.

5 **Q:** With respect to the hyperstimulation, the definition of  
6 hyperstimulation and Tachysystole disorder?

7 **A:** Tachysystole.

8 **Q:** Tachysystole, does that have anything to do with the  
9 shoulder dystocia management in this case?

10 **A:** It does not.

11 **Q:** Did you see anything in the testimony to suggest that Dr.  
12 Maselli lacked the knowledge, training, experience to identify  
13 and manage shoulder dystocia?

14 **A:** I did not.

15 **Q:** Do you believe that she in fact has the requisite  
16 knowledge and experience and training to do so?

17 **A:** I do. She very efficiently managed this case and the baby  
18 was born very fortunately with good Apgars and a good cord gas  
19 because the other outcome in this case is permanent brain  
20 damage. And so, I think it was very efficient care and very  
21 timely care.

22 **Q:** Last topic. You were asked questions about emergency and  
23 whether one follows another. During our testimony, when I was  
24 asking you those questions, did you specifically look at the

1 nature of the shoulder dystocia to explain why it's a genuine  
2 emergency?

3 **A:** Absolutely.

4 **Q:** And, I mean, and is it fair to say that when you have a  
5 head delivered and no shoulder and the baby can't deliver on  
6 its' own, mom can't deliver the baby on her own, the baby  
7 can't breathe on its' own, and times ticking, it is a medical  
8 emergency?

9 **A:** It is. It's a -- it's a very serious emergency and it's  
10 one that's the reason we prepare for it and that's the reason  
11 she was able to perform in the way that she did to affect the  
12 baby's delivery.

13 **Q:** I'm sorry, go ahead.

14 **A:** So, it should be taken very, very seriously. When a  
15 shoulder dystocia takes place, you are on the clock. You may  
16 not take a baby home and that's something you will really have  
17 to take into consideration. That effective management, if we  
18 have a baby that can't function, can't walk, can't see, can't  
19 hear, because of hypoxi, we've got a very serious problem on  
20 our hands. So, we take this very seriously in managing these  
21 cases.

22 **Q:** And if the baby can't breathe on his or her own, or any  
23 creature or any human for that matter, do you consider that  
24 person to be stable?

1   **A:** I do not. You cannot be stable and not be able to  
2   breathe.

3   **Q:** All right. Have the opinions that you've offered been to  
4   a reasonable degree of certainty most probable?

5   **A:** They have.

6   **Q:** Thank you, sir. Nothing further.

7       **THE COURT:** You may step down. Thank you, sir.

8       **MR. HOOD:** Your Honor, two housekeeping matters on  
9   exhibits I just need to -- but also the next witness ---

10       **THE COURT:** Well, let me just --- are you ready to take a  
11   little quick break while we do that? Okay, I see some heads  
12   nodding. All right, take them back to their jury room.

13       **REPORTER'S NOTE:** (Jury retires to jury room 3:38PM)

14       **THE COURT:** All right, what do we have?

15       **MR. HOOD:** Well, Your Honor, you had before we started  
16   this morning I had indicated that I would pull out the  
17   exhibits that I specifically discussed and individually mark  
18   them

19       **THE COURT:** All right.

20       **MR. HOOD:** During the examination of Dr. Maselli I  
21   specifically went through the first office visit from her  
22   chart. The whole chart was marked as defendant's exhibit  
23   number 1. And we have marked that as an individual exhibit,  
24   defendant's exhibit number 11. And I also used from

1 defendant's exhibit 1, the last office visit which we have  
2 marked as defendant's exhibit 29 and we would offer those into  
3 evidence.

4 **THE COURT:** All right. Mr. Graham?

5 **MR. GRAHAM:** If those are what we talked about earlier,  
6 no objection.

7 **THE COURT:** Right. Without objection.

8 **DEFENDANT'S EXHIBIT NUMBERS 11 AND 29**

9 **ADMITTED INTO EVIDENCE**

10 **MR. HOOD:** All right. Then our next question, Your  
11 Honor, is about the video deposition, I think it's about 52  
12 minutes or so.

13 **THE COURT:** Okay, that will be good. Let's take 10  
14 minutes then.

15 **(COURT IN RECESS)**

16 **THE COURT:** Mr. Hood, this is a deposition?

17 **MR. HOOD:** It is, Your Honor.

18 **THE COURT:** Is it a video deposition?

19 **MR. HOOD:** It is, Your Honor.

20 **THE COURT:** Very well.

21 Okay, see if they're ready.

22 Has it already been set up to go through the monitors?

23 **Mr. Radeck,** I mean, is it ready?

24 **MR. RADECK:** Yes, Your Honor.

1           **BAILIFF:** We have one in the bathroom.

2           **THE COURT:** Okay. Just whenever they're ready bring them  
3 in.

4           **MR. HOOD:** Judge, just a point of preference for you,  
5 during the video taped deposition, you know, at this time I'll  
6 enter him as an expert in the area of pediatric neurology and  
7 do you want me to just pause it? I don't think Mr. Graham's  
8 got any questions to you.

9           **THE COURT:** I will ---

10          **MR. HOOD:** We can either let it roll or we can pause it.

11          **THE COURT:** Well, either way you want to do it. If you  
12 want me to tell the jury he's qualified to give an opinion I  
13 will. But ---

14          **MR. HOOD:** If you just do that at the beginning, we want  
15 have to stop it.

16          **MR. GRAHAM:** My agreement was that he was qualified to  
17 testify on pediatric neurology.

18          **THE COURT:** Pediatric Neurology.

19          **MR. HOOD:** That's it.

20          **THE COURT:** All right. What's his name?

21          **MR. HOOD:** His name is Michael Duchowney.

22          **THE COURT:** Duchowney.

23          Yes. We have everyone in the courtroom. Okay. Ladies  
24 and gentlemen, we're about to hear testimony by the way of a

1 video deposition. A deposition is a device used in our  
2 court's where it is suspected that the witness might not be  
3 available for trial and under certain circumstances, that  
4 person's testimony can be taken in advance. Sometimes it's  
5 merely taken before a court reporter like Ms. Todd or it may  
6 be done by a videographer and that's what we have here. We  
7 have a video deposition. Both parties were given notice and  
8 given an opportunity just like they would in a trial to  
9 examine the witness. This witness is Dr. Michael Duchowney.  
10 He is qualified as an expert in the field of pediatric  
11 neurology. You will assess his testimony just as though he  
12 were here testifying live. You will give his testimony such  
13 weight and value as you, the jury, deem appropriate. Treat it  
14 no differently than a live witness in this case but it will be  
15 presented to you by way of video and it should show up on your  
16 screens there in front of you.

17 Mr. Hood.

18 **MR. HOOD:** Thank you, Your Honor.

19 At this time, we will roll the tape.

20 **THE COURT:** Pardon?

21 **MR. HOOD:** At this point we'll roll the tape.

22 **THE COURT:** All right.

23 **REPORTER'S NOTE:** (Whereby video deposition of Dr.  
24 Duchowney is played).



1           **MR. HOOD:** Judge, I think there was one question and  
2 answer that, because of an objection and the editing, it got  
3 cut out. If I could just show Mr. Graham?

4           **THE COURT:** All right. While he's doing that, ladies and  
5 gentlemen of the jury, let me point out to you that there  
6 appeared to be breaks in the testimony in starting, that  
7 shouldn't concern you. That's where we -- it was much longer  
8 and it was edited and superfluous matters that were not  
9 germane to this were taken out. You should consider only the  
10 evidence that was presented to you and not be concerned with  
11 editing, either by the Court or the parties.

12           All right.

13           **MR. HOOD:** It was just one question and answer, if it's  
14 okay, Your Honor, I'll just publish it.

15           **THE COURT:** Okay.

16           **MR. HOOD:** The question was, I now -- from you know, or  
17 from that -- geez -- now from, you know, and maybe your  
18 earlier answer addressed this, but let me ask the question a  
19 slightly different way. From a neurologic prospective, do you  
20 consider the baby to be at immediate risk of harm in an  
21 ongoing shoulder dystocia situation? Answer, yes, I do. I  
22 think it's a very dangerous time and the baby is clearly in  
23 jeopardy. Thank you.

24           **THE COURT:** Thank you. All right. It's -- it's just a

1 few minutes before 5. I'm going to let you go. I need to do  
2 some things with these lawyers for the rest of the evening or  
3 for a while. So, I'm just going to let you go and ask you to  
4 come back at 9:30. Take them to their jury room please.

5 **REPORTER'S NOTE:** (Jury excused for the evening 4:52PM).

6 **THE COURT:** All right, gentlemen, Mr. Hood, let me ask  
7 you where we are in your case, if you don't mind telling me?

8 **MR. HOOD:** I have no problem telling you, Your Honor. We  
9 have an expert, Suneet Chauhan that will be here tonight and  
10 will go up first thing in the morning and then we plan to  
11 rest.

12 **THE COURT:** Okay. You anticipating maybe a couple of  
13 hours or so in that?

14 **MR. HOOD:** I'm thinking Mr. Radeck -- they get shorter as  
15 we go further along because there's less introductory  
16 information needed. So, I'm hoping that his direct will be in  
17 the 45 minute ballpark.

18 **THE COURT:** Okay. Well, I was thinking maybe together --  
19 -

20 **MR. HOOD:** Probably ---

21 **THE COURT:** A couple of hours, maybe. All right. Then  
22 let's talk about a charge. I am going to have Judge Price  
23 actually do the charge. We have been working on it together,  
24 but I'm going to allow him to actually read the charge to the

1 jury. In that it's been my practice always to have a  
2 transcript of the charge prepared in advance for you to use  
3 during your closings. I find that it is unnecessary to repeat  
4 the matters in the charge. Some attorneys want me to put, say  
5 the same thing 10 times. I give you the charge, so that you  
6 can shake it at the jury and say, see right here where the  
7 Judge says this. It makes it more concise, more clear, for  
8 the jury. Again, Judge Price is here shadowing me and he's  
9 here for the experience, so I'm going to let him read the  
10 charge that we prepared. Have they been given the charges  
11 rearranged?

12 **LAW CLERK:** I emailed them to him and we were going to  
13 wait and see whether you wanted us to send those, since they  
14 said the same thing, they were just ---

15 **THE COURT:** Yeah, and it's the same thing, the same  
16 charge, but Judge Price has put it in a little different, more  
17 friendly format. That was just a -- a first draft. He's put  
18 it in a better order. At any rate, if you have additional  
19 charges, let us have them. I've been asking you for them.  
20 The reason I want them is because when we finish that witness  
21 in the morning, I want you to be able to go into your -- into  
22 your arguments and following that, I will charge. We will not  
23 have time tomorrow to redo the charge. I want to have it done  
24 in the morning when we get here.

1           So, let me hear first from Mr. -- Mr. Graham.

2           **MR. GRAHAM:** I'm sorry, Your Honor, did you want  
3 objections or additions?

4           **THE COURT:** Either one, objections or additions, whatever  
5 you think you want in the charge.

6           **MR. GRAHAM:** Yes, sir. Could I have a moment just to  
7 locate my ---

8           **THE COURT:** Okay. Let's take a minute then.

9           **JUDGE PRICE:** I have a paper copy if you want to see the  
10 order in which it's going to be in?

11          **THE COURT:** Have you got it rearranged?

12          **LAW CLERK:** Uh-huh (affirmative response).

13          **THE COURT:** Send it to them; let them look at it. Okay?  
14 It's the same material, just in a different order.

15          **REPORTER'S NOTE:** (Counsel reviewing charge).

16          **LAW CLERK:** Judge Hyman would like to see y'all. You may  
17 want to grab your notes.

18          **MR. HOOD:** Are we going to talk about the charges back  
19 there?

20          **LAW CLERK:** (Affirmative response).

21                               **(COURT ADJOURNED)**

22          **THE COURT:** Please keep your seats. Thank you. All  
23 right. Gentlemen, let's put any matters that we may  
24 concerning the charge on the record. We have, Judge Price and

1 I have met with you, we've discussed it extensively last  
2 evening and this morning. I think there are some objections  
3 from the plaintiff, right?

4 **MR. GRAHAM:** Yes, sir, Judge.

5 **THE COURT:** Okay. And I will allow you to put those on  
6 the record and note them.

7 **MR. GRAHAM:** Yes, sir. Your Honor, first of all, we --  
8 we object to the decision not to charge section B of the  
9 medical emergency statute and ---

10 **THE COURT:** And that was the section involving ---

11 **MR. GRAHAM:** Prior relationship with patient/doctor  
12 relationship and prenatal case.

13 **THE COURT:** I mean there's absolutely no dispute that  
14 that exists, is there? I mean I thought we discussed that.

15 **MR. GRAHAM:** We discussed it and ---

16 **THE COURT:** And that was resolved.

17 **MR. GRAHAM:** Your Honor, you said you would let me put it  
18 on the record.

19 **THE COURT:** Okay. All right. But that is not even an  
20 issue here. The evidence is conclusive that Ms. McCray  
21 visited the clinic, was a patient of the clinic ---

22 **MR. GRAHAM:** Yes, sir.

23 **THE COURT:** --- had done the things that she should do  
24 and in the context of receiving prenatal care. Okay.

1           **MR. GRAHAM:** And the issue in the -- I mean, there is an  
2 appeal on point, Flowers vs. GIEP pending, it has not yet been  
3 reached for oral argument before the Court of Appeals.

4           **THE COURT:** All right.

5           **MR. GRAHAM:** That's an appeal by Charlie Henshaw. Lee  
6 Weatherly is on the other side. This case presents the same  
7 issue; it's a rather technical legal argument.

8           **THE COURT:** Okay.

9           **MR. GRAHAM:** I just want to put that on the record.

10          **THE COURT:** And it's noted. Thank you, sir.

11          **MR. GRAHAM:** Yes, sir. Secondly, there is one or two  
12 places in there where it talks about the doctor not being an  
13 insurer of a good outcome. We believe that the use of that  
14 word, insurer, is misleading and so we object to the use of  
15 that. I realize it's in the standard charges, but we believe  
16 that nevertheless, it -- it is misleading and so we would take  
17 exception to that.

18          **THE COURT:** All right. And it's noted for the record.

19          **MR. GRAHAM:** And on a similar vein the word guarantee,  
20 appears in the charges maybe three or so times and we would  
21 object to that being included for the same reasons.

22          **THE COURT:** Okay. And again, that is noted.

23          **MR. GRAHAM:** And there is a hindsight charge in there,  
24 which we believe would probably apply to questions of

1   obstetrical negligence, but would not properly apply to the  
2   determination of medical stability or immediate threat and for  
3   those reasons, we had asked for a clarification of hindsight  
4   applies to the one, but not the other and of course, Your  
5   Honor ruled you were not going to do that.

6       **THE COURT:**   Okay.   And I think that it's a correct  
7   statement of the law.

8       **MR. GRAHAM:**   Yes, sir.

9       **THE COURT:**   Okay.

10      **MR. GRAHAM:**   So, I believe that's it, Your Honor.

11      **THE COURT:**   All right.   Thank you very much.   And,  
12   gentlemen, I believe that we have hashed out the verdict form  
13   already as well; have we not?

14      **MR. HOOD:**   That's right, Your Honor.   On behalf of the  
15   defendant, we don't have any exceptions to either your charge  
16   or the verdict form.

17      **THE COURT:**   All right.   Very well.

18      **MR. GRAHAM:**   We have no objection to the verdict form.

19      **THE COURT:**   Okay.   I think we have very concise and  
20   complete and fair verdict form.   All right.   Now ---

21      **MR. HOOD:**   Judge, before you bring the jury in, we have  
22   just two items I just need to make sure the record reflects?

23      **THE COURT:**   Yes.

24      **MR. HOOD:**   One is the written transcript of the

1 videotaped deposition that was played.

2       **THE COURT:** Right.

3       **MR. HOOD:** We've marked this as exhibit 31. I don't  
4 believe it goes into evidence.

5       **THE COURT:** Has it been properly redacted?

6       **MR. HOOD:** It has. This is exactly what was played on  
7 the video.

8       **THE COURT:** Okay. And do you have any objection to that,  
9 Mr. Graham?

10       **MR. GRAHAM:** No, Your Honor.

11       **THE COURT:** Okay. Should the jury -- do you propose to  
12 make it an exhibit or ---

13       **MR. HOOD:** No, sir.

14       **THE COURT:** --- or simply mark it in case they have a  
15 question about it.

16       **MR. HOOD:** I just want to mark it as a court's exhibit  
17 because the court reporter doesn't transcribe the testimony.

18       **THE COURT:** I understand.

19       **MR. HOOD:** So it will be part of the record.

20       **THE COURT:** And that's probably a wise thing to do and  
21 would either of you have any objection should the jury request  
22 that testimony, to offer them the transcript of the video  
23 deposition?

24       **MR. HOOD:** No, sir, none.



1       **THE COURT:** Would you have any objection?

2       **MR. GRAHAM:** I would. Yes, sir.

3       **THE COURT:** So, you want them to be able to come back and  
4 see it again?

5       **MR. GRAHAM:** Oh, I'm sorry.

6       **THE COURT:** What I'm saying is this, Mr. Graham, should  
7 the jury come back and I believe that was Dr. Duchowney ---

8       **MR. HOOD:** Yes, sir.

9       **THE COURT:** If they were to come back and say we want to  
10 review the testimony of Dr. Duchowney, for the Court to say,  
11 we do have a written transcript of that testimony; would you  
12 prefer that or would you like to see the video again; to  
13 simply ask the jury that?

14       **MR. GRAHAM:** Yes, sir. I would object to both. If Your  
15 Honor, please, I doubt Your Honor is going to make transcripts  
16 available for any other witness, I think it would be  
17 prejudicial to the plaintiff for one of the defense experts to  
18 have their testimony re-presented with no opportunity ---

19       **THE COURT:** Then you said both. If the jury comes back  
20 and asks for any testimony, I'm going to let them hear it.

21       **MR. GRAHAM:** Okay.

22       **THE COURT:** In their deliberations if they come back and  
23 say we want to hear your witnesses' testimony, I'm going to  
24 let them hear it again.

1           **MR. GRAHAM:** As long as it's mutual.

2           **THE COURT:** It's going to be mutual. My only question is  
3 we do have that transcript and it has been redacted apparently  
4 and my question is, would anybody have any objection to giving  
5 the jury -- would you like, which one would you like; we'll  
6 let you have either one you want?

7           **MR. GRAHAM:** I think in fairness, the transcript because  
8 that's what they would be getting on the other witnesses,  
9 right?

10          **THE COURT:** Well, the other witnesses, what would happen  
11 is we would have to bring them back in and Ms. Todd would play  
12 back the testimony.

13          **MR. GRAHAM:** Okay. If the others are going to be audio  
14 replay, then I think this one in fairness should be the same.

15          **THE COURT:** That's just it, I don't know that we even  
16 have it in audio format; do we, Ms. Todd?

17          **COURT REPORTER:** I could find it.

18          **THE COURT:** You could play back Dr. Duchowney's audio?

19          **COURT REPORTER:** Yes, sir.

20          **THE COURT:** Well, we'll just see. Okay? If it comes up,  
21 I'll deal with it then. All right. Well, let's mark it.  
22 Mark it for identification. It makes the record more complete  
23 and easier should this matter go up on appeal.

24          **COURT REPORTER:** Judge, so I've got this marked as

1 defendant's, but does it need to be a court exhibit because  
2 this is not going back with them. So, how you want to ---

3 **THE COURT:** Let's mark it as a court's exhibit or mark it  
4 for identification; it doesn't go back if it's marked for  
5 identification.

6 **COURT REPORTER:** Identification. Okay. All right.

7 **THE COURT:** Okay? Either way, I don't think it makes a  
8 bit of difference.

9 **COURT REPORTER:** All right.

10 **DEFENDANT'S EXHIBIT NUMBER 3**

11 **MARKED FOR IDENTIFICATION**

12 **MR. HOOD:** The last housekeeping I have is defendant's  
13 exhibit 32 is the CD of Dr. Duchowney. It's without  
14 objection.

15 **DEFENDANT'S EXHIBIT NUMBER 32**

16 **ADMITTED INTO EVIDENCE**

17 **THE COURT:** Ms. Todd, I believe you have been with me  
18 enough to know that at the end of the trial, after the charge,  
19 the -- the actual transcript of the charge will be marked as a  
20 court's exhibit, but will go in. Okay?

21 All right. Are we ready?

22 **MR. HOOD:** Yes, Your Honor.

23 **THE COURT:** Okay. If you would, bring the jury in.

24 **BAILIFF:** Okay. Thank you.

1           **REPORTER'S NOTE:** (Jury enters courtroom 9:59AM).

2           **THE COURT:** All right. Ladies and gentlemen, please be  
3 seated everyone. Thank you for being back with us this  
4 morning. It's my understanding, but it certainly I don't want  
5 to bind anybody to this, but it's my understanding, we have  
6 one more witness to hear this morning and of course, then we  
7 will move on to the closing remarks and the charge as I  
8 indicated to you at the first of this trial would be the we  
9 would proceed. And I have looked at that weather outside and  
10 so that we can move this along, I -- the clerk is going to  
11 provide you some lunch today so that you can -- if we get to  
12 the deliberations before then, you can just go right into it  
13 and maybe save some time and be able to resolve this matter  
14 before going too far into the evening.

15           All right. Mr. Hood, if you would, call your witness?

16           **MR. RADECK:** The defense would call Dr. Chauhan.

17           **THE COURT:** Mr. Radeck, I'm sorry. Yes, sir, come  
18 around.

19           **CLERK:** Left hand on the Bible and raise your right hand?

20           **REPORTER'S NOTE:** (Witness sworn by the clerk).

21                                           **DR. SUNEET P. CHAUHAN, HAVING**  
22 **BEEN SWORN TESTIFIES AS FOLLOWS:**

23           **CLERK:** Please state and spell your full name for the  
24 record?

1   **A:**   My first name is Suneet, S-U-N-E-E-T, middle initial, P,  
2   last name C-H-A-U-H-A-N.

3           **CLERK:**   You may be seated.

4   **A:**    Thank you, ma'am.

5   **DIRECT EXAMINATION OF DR. SUNEET P. CHAUHAN BY MR. RADECK:**

6   **Q:**   Good morning, sir?

7   **A:**    Good morning, sir.

8   **Q:**   At my request, did you review the medical records of Ms.  
9   McCray and her son, Jahmerican?

10   **A:**   Yes, I did, sir.

11   **Q:**   Have you also reviewed the depositions in this case?

12   **A:**   Yes, I have, sir.

13   **Q:**   Are you prepared today to testify as to the opinions  
14   you've formed in this case?

15   **A:**   Yes, I am.

16   **Q:**   Okay. And your opinions are in the area of obstetrics  
17   and gynecology; is that right?

18   **A:**   Mostly obstetrics.

19   **Q:**   Okay. Can you, if you would, just give the jury a  
20   general understanding of who you are and where you came from?

21   **A:**   I'm Suneet Chauhan. I was born in India. I got my  
22   undergraduate at a small college in Philadelphia, the medical  
23   school at Thomas Jefferson. I was fortunate enough to join  
24   the United States Navy. My training was at Portsmouth Naval

1 Hospital in Virginia. After which, I did two year fellowship  
2 in just high risk pregnancy, so taking a pregnant woman with  
3 concerns. And since 1994, I've been practicing high risk  
4 pregnancy.

5 **Q:** Your Honor, we've premarked as defendant's 30, Dr.  
6 Chauhan's CV. At this time, we would move to submit that into  
7 evidence?

8 **MR. GRAHAM:** No objection.

9 **THE COURT:** Without objection, it's admitted.

10 **DEFENDANT'S EXHIBIT NUMBER 30**

11 **ADMITTED INTO EVIDENCE**

12 **BY MR. RADECK:**

13 **Q:** Dr. Chauhan, you mentioned the Navy, were you in the  
14 marines?

15 **A:** Yes, during my 8 years in the Navy, for 2 years I was at  
16 Camp Lejeune taking care of Marines, active duty.

17 **Q:** Where do you currently live?

18 **A:** Currently, I work in Houston, Texas.

19 **Q:** Okay. Do you have a family?

20 **A:** Yes, I do, sir.

21 **Q:** Will you tell me about them?

22 **A:** Oh, I'm sorry, a wife and 2 daughters.

23 **Q:** Okay. And you mentioned your practice, where do you  
24 currently practice?

1   **A:**   I'm a Professor of OBGYN at UT, Houston.  There are 10  
2   hospitals we serve; I go to at least 4 of them on a weekly  
3   basis.

4   **Q:**   Okay.  And just real briefly, I'd like to go back.  You  
5   mentioned residency and fellowship.  Now, residency training,  
6   can you just briefly explain what goes into that as far as the  
7   obstetrical and gynecological aspects?

8   **A:**   So, after you finish your medical school, you decide that  
9   I want to be OBGYN.  So, for 4 years we learn from simple,  
10   basic examination, to delivery, to c-section and even more  
11   complications and that's 4 years of training just to be called  
12   OBGYN.  And once you decide to pursue what we call a  
13   subspecialty focused on OB and not GYN, then you go back to  
14   school and training for 2 years at that time, which was in  
15   Mississippi, where we just take care of women with some  
16   complications, the most common being high blood pressure,  
17   diabetes and multiple pregnancy.

18   **Q:**   And Dr. Robinson, who was here yesterday testifying was  
19   also a maternal fetal medicine specialist and he was telling  
20   us how his residency, he had a lot of hands on training as far  
21   as delivering babies and handling shoulder dystocias; was that  
22   your experience as well?

23   **A:**   Yes.  So, Portsmouth Naval Hospital is one of the largest  
24   one in the Navy.  We did get my residency there was at least

1 2000 deliveries of the 4 years, if not more.

2 Q: How many deliveries, how many babies have you delivered  
3 in your career?

4 A: I would approximate about 6,000, 6 to 7,000.

5 Q: And of those deliveries, how many times have you  
6 encountered shoulder dystocia?

7 A: Usually shoulder dystocia happens 1 out 100 deliveries.  
8 So, 60, 70, probably.

9 Q: Are you board certified?

10 A: Yes, I am board certified both in OBGYN, general OBYN and  
11 a second board in high risk pregnancy or maternal fetal  
12 medicine, yes, I am.

13 Q: Okay. And have you recertified those over the years?

14 A: Yes, every year, as part of being certified, we have to  
15 take a test and I've taken it every year.

16 Q: So, I think the jury has heard that and that's when  
17 you're sitting in front of a panel with other doctors who are  
18 testing you orally on your knowledge?

19 A: Initially, for initial certification, so we go to Dallas  
20 and there's 6 people over 3 hours. They can ask you anything  
21 about OBGYN or MFM depending on the board.

22 Q: And overall, how many years have you been practicing  
23 medicine?

24 A: I finished my training in 1994, so, high risk pregnancy,



1 but I started delivering in 1986 when I was a resident of the  
2 Navy.

3 Q: And you mentioned your private practice, do you also have  
4 any teaching responsibilities?

5 A: Yes, currently in Houston, I teach from medical students  
6 to residents to other fellows and sonographers and midwives  
7 and a whole slew of people.

8 Q: Does that include the areas of shoulder dystocia?

9 A: Yes, and so when I'm on labor and delivery at least once  
10 every week and twice on at night time, so, next Friday I'll be  
11 there for 24 hours. So, anytime there's a shoulder dystocia  
12 or if there was one, we teach the resident and fellows and  
13 even medical students how to manage it.

14 Q: Okay. Have you -- have you ever spent any time in South  
15 Carolina professionally?

16 A: The longest place I ever worked was in Spartanburg, South  
17 Carolina.

18 Q: Can you tell me a little bit about your time in  
19 Spartanburg?

20 A: I was at the Spartanburg Regional Medical Center. I was  
21 their Maternity Director and myself and my partner, we had  
22 about 45 sonographers depending on what year. We taught the  
23 family medicine residents, we started a fellowship in family  
24 medicine, doctors who just want to focus on delivering babies

1 and I worked 5 days a week and I was on call in labor and  
2 delivery twice a month.

3 Q: I'm sorry we couldn't keep you here.

4 A: I made good friends.

5 Q: Let me ask you this, tell me about any medical societies  
6 that you are a member of?

7 A: I'm a member of what we call ACOG or American College of  
8 OBGYN, that's a society for all OBGYN's and the analogous  
9 things for high risk pregnancy doctor is called SMFM Society  
10 of Maternal Fetal Medicine, so I belong to both societies.

11 Q: And we've heard a lot about ACOG this week and I want to  
12 hear a little bit more about it during your testimony as well.  
13 Let me ask you this, on that note, as an OBGYN and a  
14 professor, do you keep current of the medical literature that  
15 applies to your medical field?

16 A: Yes, I do, sir.

17 Q: Do you consider yourself an expert on the medical  
18 literature that applies to your practice as an OBGYN?

19 A: I am very comfortable with it.

20 Q: You're a modest man; is that accurate?

21 A: Well, in India, that's how I was brought up, but let's  
22 say I'm very comfortable in managing (inaudible).

23 Q: Fair enough. Now, the private practice side is one  
24 aspect, also the teaching side. Tell me about any of the

1 research, the writing side of things, if you would please?

2 **A:** For multiple reasons, research and writing is my passion.  
3 So, we are currently working on shoulder dystocia. Just  
4 across UT Houston is Rice University, they call it the MIT of  
5 Texas, so in the bioengineering department we're trying to  
6 come up with a glove device, so the doctor can actually see  
7 the angle the head is coming down and we even a traction, so  
8 when the doctor is delivering, they can see how much force  
9 might be using and it has taken us about 2 years and we've  
10 still not finalized it. So we are working and to actually see  
11 as a delivery is happening and how much force traction, but  
12 that's more than the normal research.

13 **Q:** Okay. And I'm going to come back to that, I promise you.  
14 Have you yourself ever been published?

15 **A:** Yes, we have published multiple articles.

16 **Q:** Okay. Can you describe the sort of process behind  
17 getting the idea that you want to research, researching it and  
18 actually getting to the stage of publication?

19 **A:** These, I guess, can come from multiple places, either  
20 what the patient says, the doctor says or what they hear and  
21 then what we have to do is get an IRB. IRB is an  
22 Institutional Review Board. So, anytime you want to review a  
23 chart, it has to go to a committee, and they have to say yes,  
24 you can do that. We have done what we call observational

1 trial, where we are using the angle. I had to go to IRB there  
2 to approve of it. Once they approve of it, then you have it  
3 takes a year to 2 to do the actual study. Then you get the  
4 data, you synthesize it, you write the manuscript and it goes  
5 to the journal and then you try to get it published.

6 Q: So, it's not an easy process?

7 A: No. No, sir, it is not.

8 Q: Well, kind of what you described reviewing it, is that's  
9 what sort of known as peer review?

10 A: Yes, so peer review is an extra layer of let's say,  
11 critical thinking. So, once I send it, let's say on average  
12 15 to 20 pages, 2 or 3 people across the country or even  
13 globally, will look at what you are saying, what you have  
14 analyzed and what your vision and they will say yes, no or  
15 yes, but do this also. They send it back and then it gets  
16 accepted for publication.

17 Q: Now, I'm going to ask you about these later on, but the  
18 jury has heard a lot about the maneuvers that are used in the  
19 event of a shoulder dystocia; are you familiar with those  
20 maneuvers?

21 A: Yes, sir, I am.

22 Q: Okay. And is that something you -- are those things that  
23 you've used and taught over the course of your career?

24 A: I've used it since 1986.

1 Q: Okay. And the jury has also heard a lot about the  
2 brachial plexus injury; is that also something that you're  
3 familiar with?

4 A: Yes, I am.

5 Q: Okay. Can you just kind of briefly describe what it is,  
6 who treats it, that sort of thing?

7 A: So, brachial plexus is inability, so, when the baby is  
8 born, they can move both of their arms. It's inability to  
9 move one arm. So let's in this case, it's the right hand, so  
10 the right hand is limited and can't go all the way, so, that  
11 is my simple clinical version of what a brachial -- inability  
12 of an arm, hand or fingers.

13 Q: As an obstetrician, do you familiarize yourself with the  
14 literature that discusses the mechanisms of how that injury  
15 occurs?

16 A: Yes, I am.

17 Q: Okay. And are the causes of brachial plexus injuries a  
18 topic that you've researched and published about?

19 A: Yes, we have, sir.

20 Q: Okay. Real briefly, obviously your testimony here today  
21 is as an expert consultant; is that right?

22 A: Yes, sir.

23 Q: Okay. And you of course charge for your time to be here?

24 A: Yes, sir.

1 Q: How much do you charge?

2 A: \$600 per hour to be here and \$800 for travel testimony.

3 Q: Have you been qualified as an expert in South Carolina  
4 before?

5 A: Yes, I have.

6 Q: All right. Is that in the field of obstetrics and  
7 gynecology?

8 A: In obstetrics, yes, sir.

9 Q: Have you given opinions on the standard of care as it  
10 relates to the proper management of shoulder dystocia?

11 A: Yes, I have.

12 Q: Okay. And is that also true for the causes of brachial  
13 plexus injuries?

14 A: Yes, I have.

15 Q: At this time, I would offer Dr. Chauhan as an expert in  
16 the fields of obstetrics and gynecology as well as, the  
17 medical literature as it relates to the management of shoulder  
18 dystocia and cause of brachial plexus injuries.

19 THE COURT: Mr. Graham?

20 MR. GRAHAM: Your Honor, I have questions at this time.

21 THE COURT: All right. Ladies and gentlemen, he has now  
22 been qualified as an expert in the field of obstetric and  
23 brachial plexus injury ---

24 MR. RADECK: Correct, causes of brachial plexus injury.

1           **THE COURT:** And again, we have discussed the issue of an  
2 expert witness several times during this trial and would apply  
3 as well to this witness as well. Thank you.

4           **BY MR. RADECK:**

5           **Q:** All right. Doctor, I'm going to go ahead and get into  
6 your opinions and then we're going to go into them later. Let  
7 me go ahead and ask you this. Based upon your review of the  
8 records and depositions, do you have an opinion of whether Dr.  
9 Maselli met the standard of care during the delivery of  
10 Jahmerican?

11           **A:** Yes, Dr. Maselli absolutely met the standard of care  
12 during this delivery.

13           **Q:** Is that opinion to a reasonable degree of medical  
14 certainty, most probably?

15           **A:** More like yeah, absolutely, overwhelmingly she met the  
16 standard of care.

17           **Q:** And do you have an opinion as to whether or not Dr.  
18 Maselli caused the injuries to this child?

19           **A:** Dr. Maselli did not, did not cause injury to the child.

20           **Q:** Is that opinion also to reasonable degree of medical  
21 certainty, most probably?

22           **A:** Yes, it is.

23           **Q:** Dr. Chauhan, if Dr. Maselli didn't cause injury, how did  
24 this injury occur?

1   **A:**   Severe injury to the child is due to a lot of factors  
2   coming, we'll call it constellation or in a bad sense, perfect  
3   storm.   A lot of multiple things coming together in this case  
4   at this delivery while you're doing the normal routine thing,  
5   can lead to persistently plexus and that's what happened in  
6   this case.

7   **Q:**   Okay.   Can you just break down a little bit about what  
8   makes up this constellation of events?

9   **A:**   Yes, sir.   And so before the onset of labor, there is no  
10   reason to think that there was any injury to the brachial  
11   plexus, but once the contraction is started and the mother is  
12   contracting and is pushing an 8 pound baby.   So, there's a  
13   stretch once the head comes in.   So, the second stage, once  
14   the mother starts actually pushing was short, less than 30  
15   minute and when the head is coming down, it hits the bone or I  
16   call it the bladder bone, so, it's like a truck hitting the  
17   overpass.   So, that impaction and when the head comes out,  
18   then the normal maneuvers to relieve the stuck shoulder and  
19   normal traction used in deliveries is what led to since the  
20   contraction dissent impaction, shoulder hitting the bone,  
21   normal management and gentle traction, everything put  
22   together, it's what lead to this persistent injury.

23   **Q:**   What do you say to the people that say this injury can  
24   only be occurred by excess lateral traction?



1   **A:**   It's almost like saying, you know, Earth use to be flat,  
2   but since then some years ago, we learned Earth is not flat.  
3   So, it used to be that was the only thing, but our training  
4   has changed. Since 1986, I have seen a greater and greater  
5   emphasis on no traction, minimal or gentle traction. Since  
6   there are other explanations, which come not only from  
7   publications in the United States, but the last time counted  
8   at least 8 different countries that all support the thing that  
9   it's the constellation, it's everything put together, which  
10   leads to persistent brachial plexus palsy.

11   **Q:**   Is there any evidence in this case that there's excess  
12   lateral traction used by Dr. Maselli?

13   **A:**   There's no evidence. There's absolutely no evidence that  
14   excessive traction was used during this delivery.

15   **Q:**   Another point I wanted to ask you about was what about  
16   the fact that this baby didn't have any apparent abnormalities  
17   going into the emergency?

18   **A:**   So, you can have a totally normal baby at the start of  
19   the labor, but by the end of labor, especially with shoulder  
20   dystocia, have either damage to the brachial plexus nerve or  
21   one of the bones the left collar bone or one of the arm bones  
22   or brachial plexus, which results or persists in one's -- you  
23   can even break a neck or the baby can die. So, it's the  
24   spectrum of multiple poor outcome. Brachial plexus is just a

1 point in it, but brain damage to the child and death of the  
2 child, they're on the spectrum for delivery process.

3 Q: So, you could have a completely normal baby prior to the  
4 shoulder dystocia and the baby can still suffer permanent  
5 brachial plexus injury?

6 A: Yes, and worse, yes.

7 Q: Okay. Real quickly. When you were reviewing the records  
8 in this case, you looked at the prenatal records?

9 A: Yes, I did, sir.

10 Q: Was there anything that suggests this was somehow  
11 predictable or preventable?

12 A: No, the prenatal care was totally normal, well done and  
13 there was no reason to suspect even a shoulder dystocia, any  
14 problem until the labor.

15 Q: And is a shoulder dystocia predictable or preventable?

16 A: Overwhelming majority of the time, shoulder dystocias  
17 cannot be predicted. It cannot be anticipated or prevented.

18 Q: And in the first stage of labor in this case was slow and  
19 Dr. Maselli, you're aware, used Pitocin. Does Pitocin have  
20 anything to do with this case?

21 A: No. So, Pitocin is a medication we use to bring on the  
22 contraction in a more synchronized manner and that has nothing  
23 to do with brachial plexus palsy or even shoulder dystocia.

24 Q: Doctor, I'm going to talk now a little bit about traction

1 and then we're going to go into a little bit more of what you  
2 talked about as far as causes of brachial plexus injuries.  
3 Okay? And so, on traction, what is it?

4 **A:** It's, if you don't mind, I use my hand or both hands to -  
5 --

6 **MR. RADECK:** Your Honor, can he -- could I have him come  
7 down?

8 **THE COURT:** Certainly.

9 **BY MR. RADECK:**

10 **Q:** Doctor, if you don't mind. Sometimes it's hard for other  
11 to see as well. If you don't mind standing there, I'm sorry  
12 to interrupt.

13 **A:** So, with other doctors and patient have just learned to  
14 use my hand to describe just about every aspect of pregnancy.  
15 So, my simple delivery is this is the birth canal and the baby  
16 is coming down and this is the head, this is the spine. Okay?  
17 So, the baby is coming down and he gets stuck with the bone  
18 here and now you have this, in this case, right arm up, up  
19 meaning it's to the ceiling. So, what you have is the  
20 impaction of the shoulder dystocia. So the traction is the  
21 hand on the head, just gently guiding, maybe a little bit  
22 down, a little bit up, but the head gently being guided with  
23 the doctor's hand so the doctor's hand is on the head and then  
24 coming in a straight line. So, that's a gentle routine

1 traction with some angle going down or up, if not this way,  
2 this way or this, like that.

3 Q: While I have you here, you were kind of doing like this.  
4 Is somewhat of an angle and bending present in every delivery?

5 A: Absolutely. So, you can have an angle, slight angle  
6 down, slight angle up, gently this way, this way, but a gentle  
7 traction up or down is absolutely part of I would say 95 to 99  
8 percent of deliveries.

9 Q: And the doctor needs to have her hands on the baby's head  
10 during the delivery; is that right?

11 A: Yes, you don't want the head to go like this or anything,  
12 so you always support at least with one hand or two hands;  
13 once the head comes out, you're always supporting the head.  
14 That's just part of the way everyone has been trained since I  
15 started in '86.

16 Q: And the traction you're describing, is that, that's used  
17 in every delivery?

18 A: I would say 95, 99. I mean, rarely the baby just falls  
19 in the bed, but those are very exception. The majority of the  
20 time, when they're delivered, they use a gentle traction to  
21 keep the straight line, yes.

22 Q: Does -- does the traction vary or let me ask you this,  
23 can the traction vary from one delivery to the next?

24 A: Oh, absolutely. And, so, no two deliveries, no two

1 babies, no two mothers are alike. So, it's still gentle; it's  
2 like a handshake, no two handshakes are alike, but you know a  
3 gentle handshake (inaudible).

4 Q: Thank you. And, doctor, and does the word traction, is  
5 one way to describe it, do doctors vary in the way they  
6 describe that traction force?

7 A: Oh, absolutely. So, every doctor has a different  
8 definition or a different way to use and I would accept that  
9 as to be fair.

10 Q: Okay. So, does the standard of care require of any  
11 specific language?

12 A: No.

13 Q: How do you know, as a doctor, how much traction to use?

14 A: It's something we are taught. So, when I start teaching  
15 the medical students who are on their first night on call with  
16 me, we actually have a pelvis and a doll and we teach them to  
17 deliver; first they just observe, then they just to put their  
18 one hand or two hands so it's over a very gradual process that  
19 we teach them and it's like, you know, making an incision, cut  
20 or suturing, it's overtime you get them more and more and they  
21 see and learn.

22 Q: So, you're actually hands on with the resident students  
23 helping them get that feel?

24 A: Yes, we call it the July (inaudible) when they start in

1 July or July we're always literally the first year, we always  
2 put on our hand with their hand and then deliver them. That's  
3 just the way we do it in training.

4 **Q:** I think you're already touched on this, but is traction a  
5 set amount as far as however you measure it; ounce per inch or  
6 force pounds?

7 **A:** So, in some of studies, all of the studies that have been  
8 able to come up with a glove or something where they can  
9 measure it, but it's artificial, no one has been able to  
10 produce it. It has taken us over two years and we are trying  
11 to do it so it can be done as it's happening and it will go to  
12 your iPhone, but even working with some of the best bio-  
13 engineers at Rice University we have not made it successful  
14 where it's user friendly, but can be used outside in research.

15 **Q:** So, what you're doing at Rice, is it fair to say that's  
16 in the medical forefront on that issue?

17 **A:** To my knowledge, we are the only one doing it currently  
18 in America.

19 **Q:** What is lateral traction?

20 **A:** So, back again, this is the head, this is the birth canal  
21 and the head is here. The lateral traction is going sideways  
22 to the mother's left leg or the mother's right leg and that is  
23 -- I have not seen it and we have done studies on watching how  
24 that -- so this is lateral to the mother's right, to the left

1 or like extreme head down or extreme head up. Those are  
2 excessive and unnecessary traction or angles.

3 Q: And what is axial?

4 A: And so the spine is a straight, so in this case like  
5 this. So, axial is you just keep the baby maybe little 5  
6 degrees or 10 degrees up and down, but you -- the major  
7 direction of the baby is in a straight line with the baby's  
8 butt.

9 Q: Let me ask you this. I know you're aware that Dr.  
10 Maselli used moderate controlled traction in this case; was  
11 that appropriate?

12 A: Absolutely and I admire her candor.

13 Q: You talked about the gloves, trying to measure the amount  
14 of traction. Have you studied the issue of others in the room  
15 trying to observe sort of what the doctor is doing related to  
16 traction and angles?

17 A: Yes, we did the study and had a nice acronym ATT, and it  
18 was for angle, how far the head down go down, downward,  
19 upward, sideways to the mother's left or right and that's  
20 angle. Traction was 0 to 10, 10 being the extreme; we have  
21 seen zero being the baby literally fell out and that time, we  
22 actually walked in and this was our peer group and we got a  
23 consent and both myself and the one I was training or my  
24 partner would hold an iPhone, as soon as the head came out, we

1 would start the stop watch and that was the time. You were  
2 looking at the time from the head to the time the feet came.  
3 Both angle traction times. So, we had actually done the two  
4 people observing the same delivery process will come to  
5 different conclusions regarding the angle and the amount of  
6 traction, but they would be very good agreement or excellent  
7 agreement on how long it took from the head to the toe. So,  
8 that part was agreed upon, but the amount of traction and the  
9 angle used varies between the observer, which is in retrospect  
10 is what one should have taught.

11 **Q:** So, you're said there was two observers in that study?

12 **A:** Yes, so for -- we calculated the samples and consistently  
13 I was on the --- looking at the patient's head. I was on the  
14 left side. My junior colleague, she as on the patient's right  
15 and we did this over 40 plus deliveries.

16 **Q:** And so these are -- these are doctors that are the  
17 observers trying to estimate the amount of traction and the  
18 angle of traction, meaning whether there was any sort of  
19 lateral traction?

20 **A:** Yes, I was quote unquote experienced and she was doing  
21 her training to become an MFM.

22 **Q:** And so, the conclusion was, even those experts couldn't  
23 agree on the angles and the amount of traction used?

24 **A:** Absolutely correct.



1 Q: All right. Doctor, I told you we would talk about the  
2 causes of brachial plexus injuries and I'd like to talk about  
3 that now. I know you told me that's within your practice area  
4 and we've heard a lot about excess lateral traction this week.  
5 What are some of the other causes of brachial plexus injury?

6 A: People trained in America let's say in the last 10 or 20  
7 years is excessive lateral traction, a, we're taught not to;  
8 it's like doing CPR on the pubic bone and excessive would be  
9 when this is the head, you're going too far to the mother's  
10 left, mother's right, too far down or too far up, depending on  
11 how you define it. So, it's too much angulation down, up or  
12 to the left or the right. So, you can just like keep it in a  
13 gentle mid-range is what is normal.

14 Q: Well, tell me, what are endogenous forces; is that  
15 something you're familiar with?

16 A: Yes, I am. So, endogenous means inside so the mother's  
17 contractions and pushing the baby out; those are all  
18 endogenous forces inside the mother.

19 Q: Okay. Is that -- is that part of the constellation of  
20 events you mentioned earlier?

21 A: Yes, it is. So, it starts with the lateral contraction  
22 and the head coming down.

23 Q: And we've heard about avulsions in this case, being a  
24 three nerve avulsion permanent injury; can that happen without

1 excess lateral traction?

2 **A:** Yes, it can.

3 **Q:** Is that what happened in this case?

4 **A:** Most likely, yes.

5 **Q:** The timing aspect of the injury, can you determine when  
6 an injury occurs?

7 **A:** No, we cannot. So, in this case, we have nothing to  
8 believe that there was something wrong with the brachial  
9 plexus palsy since it did not happen before, but it definitely  
10 happened by the time the feet came out. So, somewhere in that  
11 process is when the injury happened.

12 **Q:** Dr. Chauhan, I know you're modest, but I do want to  
13 mention a few of the other articles that we haven't discussed  
14 yet that you were involved in. So, I'll know you'll be  
15 familiar with them and I want to start with the one that's  
16 tabbed number 16 on the folder that's in front of you.

17 **MR. GRAHAM:** Can we get the name, please?

18 **MR. RADECK:** It is titled Brachial plexus injury: A 23-  
19 year experience from a tertiary center.

20 **BY MR. RADECK:**

21 **Q:** Tell me, what is this study about?

22 **A:** So, while I was at the Spartanburg Regional Medical  
23 Center, one day I wanted to know more about brachial plexus,  
24 so I talked to my mentor, who was one of -- was the senior

1 author and the last author and he got me the data working with  
2 other co-authors for 23 years, everything that happened in  
3 Mississippi regarding brachial plexus in every chart. We had  
4 made up this 3 page of the things we needed for information.  
5 He sent me these sheets, I put it in excel and analyzed the  
6 data and presented it and much to our surprise, that won the  
7 national award that year for one of the best paper in the  
8 country, when we presented it and subsequently it was  
9 published in what we considered to be the best OBGYN journal.

10 **Q:** What does it tell us about the relationship between  
11 temporary and permanent injuries?

12 **A:** So, when a brachial plexus -- so lets the baby kind of  
13 move the arm, but on 360 days can do this, can move the arm,  
14 that's called transient, meaning more temporary. So, if it  
15 resolves within a year after birth, that's transient; if it  
16 persists for more than a year or 365 days later, baby cannot  
17 bring the arm straight up, that would be considered  
18 persistent. It's the definition of transient versus  
19 persistent.

20 **Q:** What, I mean, what are the odds of getting a temporary  
21 injury versus a permanent injury?

22 **A:** So, one of the things we did and surprisingly has been  
23 held up, not only in America, and different centers but in  
24 other countries, in 1,000 deliveries, imagine on average an

1 OBGYN does 100 and 150 deliveries a year. If there are 1,000  
2 deliveries, you'll get 1 transient; meaning it will come and  
3 then in 12 months resolve. If you do 10,000, you'll get 1 or  
4 2. So, in every 10,000 deliveries in Mississippi and other  
5 parts of the country and across the ocean, for every 10,000  
6 deliveries there is 1 persistent brachial plexus palsy.

7 Q: Did that study tell you anything about whether or not  
8 injuries occurred without even the presence of shoulder  
9 dystocia?

10 A: Yes, there were injuries which were persistent and there  
11 was no documentation or any suggestion that it was a shoulder  
12 dystocia, either in the doctor's notes or the nurses' note.  
13 We reviewed all of them.

14 Q: And you -- you took part in that so, I think I know the  
15 answer to this, do you consider that to be a reasonably  
16 reliable publication?

17 A: Let me just -- it won the award, it got published in the  
18 best journal, it has been validated not only in America, but  
19 also abroad. So, the fact that other people in other  
20 countries, including France, Ireland, have validated and cited  
21 it, I think it has been cited at least 200 times with other  
22 people who are publishing on brachial plexus have referenced  
23 it, I think it's -- I think we did a good job.

24 Q: Could I turn your attention to tab 17, please, I want to

1 ask you about another study of yours that is called  
2 Persistence of Neonatal Brachial Plexus Palsy Associated with  
3 Maternally Reported Route of Delivery?

4 A: Yes.

5 Q: Do you have that in front of you there, sir?

6 A: Yes, sir.

7 Q: Okay. Tell the jury what this one was about?

8 A: This is one of our more recent. The last one was our  
9 first publication on brachial plexus; this is our most recent.  
10 I as fortunate enough to meet with a neurosurgeon, so, he or  
11 she, Dr. Chang, at Michigan actually treats children with  
12 brachial plexus palsy. When a family comes in with a child  
13 with brachial plexus palsy, she has four or five gages, note  
14 everything and one of them is you know, did you have diabetes  
15 during pregnancy, did you have forceps, how did you deliver,  
16 did you get a shoulder dystocia. So, she had been collecting  
17 the data and didn't know what to do with it, so she invited me  
18 to come and help her analyze it. So, with her team and my  
19 team, we took the data of 387 brachial plexus palsy, which is  
20 still the largest group, but in comparison in Mississippi, we  
21 only had 80 over 23 years in Mississippi. Here we had almost  
22 400 brachial plexus palsy treated by a neurosurgeon and we had  
23 access to the medical record of the children, and we wrote  
24 what I think is even one of the more unique publication on the

1 topic.

2 **Q:** Doctor, I'd like to quote a portion of this article on  
3 the abstract section.

4 **MR. GRAHAM:** Excuse me, Your Honor, that was not included  
5 in the materials we got. Do you have a hard copy of that,  
6 please?

7 **MR. RADECK:** Mr. Graham, it was in the folder that we had  
8 sent prior to trial. I'll be happy to have you look at this  
9 one.

10 **THE COURT:** Step up, Mr. Graham, you can share it with  
11 him. You know, we have to make adjustments sometimes. You  
12 know?

13 **BY MR. RADECK:**

14 **Q:** Doctor, under the results section, "of 387 cases of NBPP,  
15 Neonatal Brachial Plexus Palsy, 8 percent (30) delivered via  
16 CD", what is that?

17 **A:** The CD is cesarean delivery, so during a cesarean  
18 delivery 30 out of 387 had a brachial plexus palsy.

19 **Q:** Okay. That's all I wanted to ask you about that one.  
20 Thank you. Doctor, can I turn your attention to tab 18,  
21 please?

22 **A:** Yes, sir.

23 **Q:** This is an article that you've also authored, co-  
24 authored, called Neonatal Brachial Plexus Palsy: incidents,

1 prevalence and temporal trends; same thing, kind of just give  
2 us a nutshell of what that article was about?

3 **A:** So, we look at everything published in English language  
4 to look at how often does brachial plexus happen and how has  
5 it changed over time, not only in America, but other  
6 countries. So, we divided all publication into those  
7 originating in America and those from foreign countries or  
8 other countries and compared the rate and how it changes over  
9 time in America and abroad.

10 **Q:** So, if I understand you correctly, this -- this takes a  
11 worldwide sort of view to determine whether or not this kind  
12 of injury can occur without the presence of shoulder dystocia?

13 **A:** Yes, it did. So, it summarized everything written in the  
14 English language both brachial plexus with and without  
15 shoulder dystocia at that time.

16 **Q:** So, in other words, this injury can occur without any  
17 traction whatsoever?

18 **A:** Yes.

19 **MR. GRAHAM:** Your Honor, I think he's misstating the  
20 testimony.

21 **THE COURT:** I'm going to allow it.

22 **BY MR. RADECK:**

23 **Q:** Doctor, have other -- and if the jury will bear with me,  
24 we just have a few more to discuss. Have other doctors

1 performed studies that support your work?

2 A: Yes, they have.

3 Q: Would you turn to tab 13 please; this is a publication  
4 entitled Permanent Erb Palsy: a traction-related Injury? Are  
5 you familiar with this publication?

6 A: Yes, I am.

7 Q: Okay. Do you find it reasonably reliable?

8 A: Yes.

9 Q: Okay. Do you support it?

10 A: Yes.

11 Q: And what does this tell us about causes of permanent  
12 injury when -- whether any -- whether or not traction was  
13 involved?

14 A: So, this report from California, a totally different part  
15 of the country and they also noted that brachial plexus palsy  
16 can occur without shoulder dystocia, without traction.

17 Q: Tab 14, please, sir? This is a publication called  
18 Spontaneous vaginal delivery: a risk factor for Erb's palsy?  
19 Are you familiar with this publication?

20 A: Yes, I am.

21 Q: Do you find it reasonably reliable?

22 A: Yes, I do.

23 Q: Do you support it?

24 A: Yes, I do.



1 Q: What does it stand for?

2 A: That also suggests that during a normal vaginal delivery,  
3 one can have persistent brachial plexus palsy. This was done  
4 in Los Angeles. So, in a different part of the country,  
5 different physicians were not related to each other, have  
6 noted the same phenomena happening as we did in Mississippi.

7 Q: So, we've discussed your publications, we've discussed  
8 some other doctors' publications, have any medical  
9 organizations researched and studied this issue?

10 A: Yes, they have.

11 Q: And is it fair to say that this is one of them or this is  
12 the one that you're familiar with?

13 A: Yes, I am, and that's one of them, yes.

14 Q: Okay. And what is this?

15 A: I call it the ACOG workshop on Neonatal Brachial Plexus  
16 Palsy or the monogram is how I described it.

17 Q: Okay. And the jury has seen this this week. We've  
18 touched upon it. Tell me a little bit more about your role  
19 with it and its creation?

20 A: So, bear with me. So, the story starts very simple. One  
21 day I get an email from ACOG saying that they are going to  
22 have a workshop on brachial plexus palsy, would you be  
23 interested in speaking and I said yes. The next thing we got  
24 was we'll send you everything published in English language,

1 but do your own search. There were, from my recall, were 380  
2 articles at that time published. We vetted, so there were  
3 about 10 to 14 people across the country. We met in  
4 Washington and we got assigned task. So, we decided how to  
5 like chapter by chapter what it should be. We got assignment  
6 to read and write the chapter. We went back home and then we  
7 started writing; then we met again several months later. We  
8 read everyone's and I never seen more writing or vetting or  
9 edited. We edited everything of each other. Once we  
10 finalized, we submitted to ACOG. ACOG then took it to other  
11 national guideline and eventually published after we did all  
12 the work.

13 **Q:** How long did it take to conform this?

14 **A:** My recall is from the time I got the email to when it  
15 came out, it was about 3 years. That's a reasonable recall of  
16 how long it took from the initial notice to when it came out  
17 in print.

18 **Q:** And this is -- this came out in 2014, right?

19 **A:** Yes, sir.

20 **Q:** Is it still current?

21 **A:** It is very current.

22 **Q:** Can you explain how so?

23 **A:** And so, currently, this is workshop at ACOG on topic of  
24 what we call practice bulletin. So, like how to manage high

1 blood pressure with pregnancy; how to manage diabetes. And  
2 so, I was there about a month ago in Washington, D.C. at ACOG  
3 headquarters, and the question came up. We also review all  
4 documents every 2 to 3 years on this topic is there a major  
5 paper, which makes us pivot or change what we said and less  
6 than a month ago, we had a committee of family medicine,  
7 midwife, OBGYN, MFM across the country and all 14 of us said  
8 there is nothing new to change it, if anything, our  
9 publication decided that, and other people confirmed what's  
10 written. So, we decided unanimously not to revisit or amend  
11 it or update this document less than a month ago.

12 Q: So, you still believe in this?

13 A: I'm not aware of anything better or anything that  
14 contradicts it.

15 Q: And to your knowledge, is this still used in teaching  
16 residents across the country?

17 A: Absolutely.

18 Q: Now, there's been some discussion, old school, new school  
19 and are you familiar with some literature that preceded some  
20 of the research and studies and years of work that went into  
21 going into this bulletin here?

22 A: Yes. So, old, even old, 100 year old cadaver study, we  
23 have to read all of them. So, I'm familiar with what was  
24 before and as the evidence in the 1980's came into newer

1 evidence, both from America and abroad.

2 Q: The article mentioned, out of the UK, I believe, it's  
3 called Croft's; is that something that you would have  
4 considered prior to filing your conclusions in this?

5 A: The Croft's article is cited in that and I'm familiar  
6 with that.

7 Q: Tell me about your opinions on Croft, the Croft's  
8 article, if any; do you have a copy in front of you?

9 A: Yes, I do.

10 Q: Okay.

11 A: And so, Dr. Croft in England they looked at what we call  
12 before you intervene. So, you before you change your  
13 management, you look at the data, what happened, and then you  
14 say I'm going to introduce a new practice in my hospital and  
15 then look at it what happens after you have new practice. So,  
16 we call it pre-intervention, post-intervention. So, he looked  
17 at few years before he changed the management of shoulder  
18 dystocia teaching on how to manage and then afterwards and he  
19 showed the brachial plexus before the teaching was here and it  
20 dropped to here and that conclusion is often misstated that  
21 they have no -- they made a major change in persistent  
22 brachial plexus that applies to that hospital. The way they  
23 were doing it was different than the way I was taught in the  
24 Navy starting in 1986. They were just adopting what we were

1 doing. McRoberts came from Texas. So, they were introducing  
2 what we were doing in America and they showed what we do in  
3 America changes their way so, they just caught up with what we  
4 were doing in America. I think it's a reasonable study for  
5 their hospital that has no application to American hospitals  
6 or American institutes.

7 Q: Does it have any application to the facts of this case?

8 A: Absolutely not.

9 Q: How many of the participants in that study were even  
10 performing the McRoberts maneuver?

11 A: Give me one second, I can tell you. So, before this type  
12 of training, it's a pre-training. Only 1 out of 3 shoulder  
13 dystocia were using McRoberts and this was in 1996 to '99.  
14 So, we were using McRoberts as early as 1986; it took them 10  
15 years after we started using it because it was discovered by a  
16 Texan and 1 out of 3 cases then when they ended the training  
17 99.6 or all 100 were. So, first, 1 out 3 or, you know, 30 out  
18 of 100, now 99. So, all they did was implement what was  
19 already being done. I mean, I distinctly remember that in the  
20 Navy in Virginia. So, all they did was catch up with the  
21 American practice.

22 Q: All right. Doctor, I would like to shift away from the  
23 literature a little bit and I want to talk about shoulder  
24 dystocia and whether or not it's a medical emergency. Is

1 shoulder dystocia a medical, a genuine medical emergency?

2 **A:** It is one considered one of the recognized, undisputed  
3 emergency; the other one being the cord comes, prolapses, the  
4 placenta erupts, the uterus is (inaudible), it is one of  
5 probably the top five emergency in OB that I'm aware of.

6 **Q:** Why is that?

7 **A:** Because within minutes, the baby can suffer brain damage  
8 and additional minutes later the mother can lose the baby and  
9 the baby die. We had that in Spartanburg. It is a known  
10 phenomena that babies can die or have permanent brain damage  
11 with shoulder dystocia along with brachial plexus and the  
12 other complication.

13 **Q:** You had a case in Spartanburg where a baby suffered a  
14 death from a shoulder dystocia?

15 **A:** Yes. Not me, but one of my partners did.

16 **Q:** Okay. Can you just list to me the risks that are  
17 involved with a shoulder dystocia?

18 **A:** Most shoulder dystocias are resolved, but once you get a  
19 shoulder dystocia, for the baby, let's just start with the  
20 mother. The mother is more likely to bleed more than usual  
21 and need transfusion; more likely to have her, please forgive  
22 this word, cut into the rectum or what we call 40 degrees, so  
23 the extension, there's a cut in the rectum are the two majors;  
24 they break their tail bone. So, those are for the mother.

1 For the child, it starts with the fracture of the clavicle;  
2 brachial plexus injury, which may resolve; fracture of the  
3 upper arm or humerus bone; and/or brain damage or cerebral  
4 palsy and/or death of the fetus once the head comes out and  
5 you don't resolve it within x minutes.

6 Q: Do you consider those to be immediate risk or threat,  
7 immediate risk of a threat of serious injury or death to the  
8 baby?

9 A: Absolutely, without a doubt. The moment you have  
10 shoulder dystocia, no one can tell you how long it will take  
11 to resolve and/or what injury the baby will have. So, it is  
12 considered an emergency and you have minutes or less to  
13 resolve the shoulder dystocia.

14 Q: And did I hear you say that that risk starts right away  
15 when it happens?

16 A: The moment your shoulder dystocia equals emergency as  
17 soon as the doctor says shoulder dystocia. All OBGYN's, all  
18 nurses know that's an emergency. You call for help just like  
19 many emergency, and that emergency happens the moment the  
20 doctor says or a clinician, it could be a midwife says  
21 shoulder dystocia.

22 Q: Tell me about when the baby's head is out and its body is  
23 still in stuck, why can't the baby breathe?

24 A: So, baby has not made the transition to be breathing on

1 their own; they're still connected to the cord for a lot  
2 mystical --- the way God made us, we are connected by the  
3 pipeline and that pipeline is very soft and pliable. So, it  
4 can impend the blood and oxygen to the baby's brain because  
5 it's stuck either against the birth canal because the baby is  
6 still -- the pipeline is connected by the cord and the belly  
7 button. So, between the belly button and out it's free  
8 floating as compared to in the amniotic fluid in the water, so  
9 we don't have that protection. In this case, there was even  
10 more complication of nuchal cord; the cord was wrapped around  
11 and so it was even more exposed. So, that makes this  
12 emergency even more emergent if there's a thing called  
13 emergent emergency.

14 **Q:** You mentioned the nuchal cord. If the cord was just sort  
15 of loosely draped around the baby's head, does that still  
16 provide that extra compromise that you were mentioning?

17 **A:** Yes, so we have noticed that nuchal cord is associated  
18 with the adverse outcome. Now, in this case it was loose, but  
19 there are other cases and you don't know it until you reduce  
20 it, that the shoulder dystocia is already started; so now, you  
21 have two things going on; a stuck shoulder and a loose nuchal  
22 cord literally sticking out from the neck and that's double  
23 jeopardy if you want to call it.

24 **Q:** Is the nuchal cord, even if it's loosely draped, is it



1 still -- it still has to go out and come back in the birth  
2 canal, right?

3 **A:** Yes, because it's connected with the belly button inside  
4 and only this part is -- the belly button where the cord is  
5 connected is still inside in the mother's birth canal.

6 **Q:** And so, how about a situation where there is no nuchal  
7 cord; is oxygen still compromised there?

8 **A:** Yes, it's compromised because the wall of the birth canal  
9 is compressing the cord, which is the -- may I stand up?

10 **Q:** Absolutely.

11 **A:** I don't mean to be so -- pretend I'm the fetus and this  
12 is the mother's birth canal, the cord is -- imagine this tie  
13 is the cord, it's literally impinging on me. So, the blood,  
14 which is coming out, it's a simple blood, it's like no thicker  
15 than an Italian pasta it's about this big and the blood is  
16 coming and there's a pressure. When you're inside, you are  
17 floating in a water bag; the water bag is gone and now you're  
18 impinging on both sides. So, that is an emergency, even if we  
19 don't have a nuchal cord.

20 **Q:** In that moment, when the shoulder dystocia is recognized,  
21 do you know how much oxygen reserves are in the baby at that  
22 point?

23 **A:** People have said that while increasing the heartrate  
24 tracing is the only way we know how the baby's oxygen looks

1 good, therefore, you shouldn't worry. That's a misnomer. In  
2 OB days, what we call sentinel event is what we call ---  
3 whatever the things was, think of it like a major earthquake  
4 and the floor drops and you don't know what will happen next.  
5 So, shoulder dystocia and rupture of the uterus, where the  
6 uterine wall just opens up, cord prolapses or a major  
7 placenta, all of them are what we call a major calamity or  
8 sentinel event. So, whatever happened at the time before that  
9 came out, you cannot depend on that. Because usually the  
10 heartrate has a nice prediction. Once you get a shoulder  
11 dystocia, it's like this; you're in a black hole, you don't  
12 know what will happen as you start to process of resolving it.

13 **Q:** Well, if one baby is -- came out of shoulder dystocia  
14 after, let's just say they were in there for 5 minutes and  
15 they didn't have an injury, can we assume that other babies  
16 will be the same way?

17 **A:** No, and you know, no children are alike. Two kids fall  
18 on the playing field; one doesn't even get a scratch, the  
19 other one has less traumatic. It happens to football players;  
20 it happens to kids. We do not respond to the same  
21 environment. Two different people don't respond to the same  
22 environment the same way.

23 **Q:** And we don't know how long it's going to last, right?

24 **A:** Oh, without a doubt. No one has figured out how to

1 predict how long the shoulder dystocia will last.

2 Q: And I know you mentioned this, but we don't know when  
3 that brain injury could occur; is that true?

4 A: It hasn't been finalized, but there are reports that it  
5 can happen as early as 3 minutes. So 3 to 5 minutes is the --  
6 5 minute you're in danger zone.

7 Q: Have you heard of any publication that suggests that a  
8 baby can go 10 to 15 minutes during a shoulder dystocia  
9 without oxygen?

10 A: I have not, nor would I believe that and I hope -- no, I  
11 have done this since '86. I've just read about everything in  
12 the English language on shoulder dystocia and brachial plexus  
13 palsy. There may be some recent I'm missing, but I'm not  
14 aware that a 10 minute is not depriving the baby that would be  
15 a working a miracle of all miracles.

16 Q: Would you describe an ongoing shoulder dystocia as the  
17 baby being in a medically stable or unstable condition?

18 A: It is very unstable because we don't know what will  
19 happen within the next 45 seconds or a minute or the next  
20 minute. So, it's very -- it's like hanging by, that cartoon,  
21 just by your finger.

22 Q: And I think you mentioned the fetal heart monitoring  
23 strips, which that indicates the heartrate of the baby?

24 A: Yes, it does, sir.

1 Q: Does a baby with excellent heartrate going into a  
2 shoulder dystocia, would that have anything to do with whether  
3 or not it's unstable?

4 A: No, I would not. Once, it's like saying, I was driving  
5 and I was flying, but then I got into a car accident, as soon  
6 as you get into a car accident, all bets of what was happening  
7 five minutes ago, how your health was, is totally off and it  
8 goes out the door. So, think of it like an emergency where  
9 you have no prediction, anyone could.

10 Q: And have there been cases where babies have had excellent  
11 heartrates going into a shoulder dystocia and have still have  
12 injuries?

13 A: My own, when I was a second year resident, we had a  
14 broken neck. So, sad case where management of shoulder  
15 dystocia the baby ended up with a broken neck and was  
16 paralyzed. So, there's a whole spectrum and going into that  
17 delivery, vaginal delivery and/or shoulder dystocia, no one  
18 had ever expected that. So, yes, it is absolutely  
19 unpredictable and an obstetric emergency.

20 Q: And the jury has heard about some tests that are done  
21 after the baby has already been fully delivered. In this  
22 case, core gas, Apgar scores; are you familiar with that those  
23 were done in this case?

24 A: Yes, I am familiar. Yes, I do know.

1 Q: Were they good results?

2 A: Both of them were very good results.

3 Q: Does that tell us anything about whether or not the baby  
4 is stable during the ongoing shoulder dystocia?

5 A: The only thing it tells me is the doctor and the nurses  
6 who relieved the shoulder dystocia did a good job because you  
7 can often have lower Apgars and/or abnormal PH. So, to me  
8 this is a testament of their excellent clinical work in  
9 managing obstetrics, not an indication that there was  
10 something wrong.

11 Q: Okay. Doctor, just to button up that subject of  
12 emergency, I want to ask you three questions. Is your opinion  
13 that this was a genuine medical emergency; is that to a  
14 reasonable degree of medical certainty, most probably?

15 A: I would say almost as sure as I can give anything in life  
16 or in OB, it was and shoulder dystocia continues to be a OB  
17 emergency across the country.

18 Q: And your testimony that this shoulder dystocia is an  
19 immediate risk of threat or injury to the baby or death; is  
20 that to a reasonable degree of medical certainty, most  
21 probably?

22 A: Beyond -- I mean, at the moment shoulder dystocia was  
23 diagnosed by the doctor, it is an absolute emergent and an  
24 unstable condition and you can't go look back and say well,

1 that wasn't because a good result. At the time of the  
2 shoulder dystocia, yes, it's an emergency and yes, it's  
3 unstable, without a doubt.

4 Q: And it's unstable to a reasonable degree of medical  
5 certainty, most probably?

6 A: Yes, sir.

7 Q: Okay. Dr. Chauhan, I'd like to shift now to Dr.  
8 Maselli's management of the shoulder dystocia in this case.  
9 And you're aware that she quickly and immediately recognized  
10 that a shoulder dystocia occurred, right?

11 A: Yes, she did.

12 Q: Okay. And was that reasonable and proper?

13 A: That is what I would expect, yes.

14 Q: Okay. And then she called in the nurses?

15 A: Yes, the calling for help is one of the first things you  
16 do when you recognize a shoulder dystocia, is call other  
17 people in the room.

18 Q: And you're aware she instructed the nurses to perform the  
19 McRoberts maneuver?

20 A: Yes, she did.

21 Q: Was that reasonable?

22 A: And that is quite reasonable.

23 Q: And then she performed an episiotomy; is that your  
24 understanding?

1 A: Yes, she did.

2 Q: And was that a reasonable thing to do?

3 A: Yes, a lot of clinician do episiotomy during shoulder  
4 dystocia.

5 Q: And why is that?

6 A: It allows them more room and if need me, put in the hand  
7 to do it, but it makes the room bigger so the shoulder can  
8 fall out from being stuck at the bone.

9 Q: And then, she instructed the nurses to perform suprapubic  
10 pressure?

11 A: Yes, she did.

12 Q: Okay. Was that the reasonable thing to do?

13 A: It is, absolutely is.

14 Q: Okay. Have you ever in your entire career heard of --  
15 well, let me back up for a second. So, nurses are typically  
16 on each side of the bed?

17 A: Yes, they are.

18 Q: Okay. In your entire career, have you ever heard of each  
19 nurse putting both hands down to perform that maneuver?

20 A: No, I cannot imagine in America having anyone trained in  
21 America and I've seen it since 1986.

22 Q: And then, Dr. Maselli described that as suprapubic  
23 pressure was being performed, she had her hands on the baby's  
24 head, keeping it stable, she felt a pop; the shoulder, the

1 release of the shoulder and then she applied the gentle  
2 moderate controlled traction to facilitate the delivery. Was  
3 that reasonable?

4 **A:** It's more than reasonable. That's how you would finish  
5 the delivery after you have resolved the shoulder dystocia.

6 **Q:** Was her application of moderate controlled traction in  
7 this case within the standard of care?

8 **A:** Moderate, yes. Maybe in more than a little but more than  
9 that, and I admire her candor for using the word moderate and  
10 there's nothing wrong with that.

11 **Q:** Okay. And there are other internal maneuvers that didn't  
12 need to be used in this case, right?

13 **A:** That is correct.

14 **Q:** Are there any risks with performing those?

15 **A:** Yes. Internal maneuver by definition, so these are  
16 external because you're still on the outside pushing the leg  
17 back, pushing on the suprapubic bone. Here you put in the  
18 hand in the birth canal and move the baby one way or take the  
19 arm out, which is to the floor. Those are called internal.  
20 As you add maneuvers, the more maneuvers you do, the greater  
21 the likelihood of brachial plexus. So, 2 or 3 maneuvers has  
22 less; 4 or 5 increases the chance of fracture and a brachial  
23 plexus palsy being persistent.

24 **Q:** Is there any guarantee that the maneuver will work?



1   **A:**   No, there isn't. At the start of shoulder dystocia, you  
2   know have no idea what will work or not. Think of it like  
3   suddenly, you're driving and you get a flat tire or the tire  
4   blows out and you have no idea what will happen. So, it's  
5   that kind of an emergency.

6   **Q:**   Do you believe that Dr. Maselli's actions were consistent  
7   with the training that you've undergone and taught regarding  
8   the proper management of shoulder dystocia?

9   **A:**   Absolutely, without a doubt.

10   **Q:**   Doctor, is moderate traction the same as excessive  
11   traction?

12   **A:**   Absolutely they are not. They are not. So, it's maybe  
13   more than gentle, but excessive is like that and gentle is  
14   this, so it's more like this; it's not even close to being  
15   this. It's at the lower end of the spectrum and the two are  
16   not the same.

17   **Q:**   Based upon everything you've reviewed, did Dr. Maselli  
18   properly manage the shoulder dystocia emergency in this case?

19   **A:**   Dr. Maselli, without a doubt, along with the 2 nurses who  
20   came in, did a very nice job of relieving the shoulder  
21   dystocia in a proper manner as consistent with national  
22   guidelines and practice and teaching.

23   **Q:**   Did she comply with the standard of care?

24   **A:**   The doctor did, absolutely she did.

1 Q: Did her actions cause the injuries in this case?

2 A: No, they did not cause the injury.

3 Q: Doctor, have all the opinions you've given me been to a  
4 reasonable degree of medical certainty, most probably?

5 A: Yes, they are.

6 Q: By the way, how many articles have you published?

7 A: We just finished with 345 articles.

8 Q: No further questions. Please answer any questions  
9 counsel may have.

10 A: Thank you, sir.

11 THE COURT: Mr. Graham, before you begin, the jury has  
12 been here a little over an hour. How about let's give them a  
13 break so that we don't have to interrupt your cross. Okay?  
14 Doctor, if you'd like to get something to drink or if you need  
15 anything, please.

16 DR. CHAUHAN: Thank you, sir.

17 REPORTER'S NOTE: (Jury retires to jury room 11:04AM).

18 THE COURT: We'll be at ease for 10 minutes or so until  
19 the jury is ready to come back in.

20 (COURT IN RECESS)

21 THE COURT: Bring them in. If you would, come back  
22 doctor.

23 All right. Thank you. Please be seated.

24 DR. CHAUHAN: Thank you, sir.

1       **THE COURT:** All right. Mr. Graham, you may cross.

2       **MR. GRAHAM:** Thank you.

3       **CROSS EXAMINATION OF DR. CHAUHAN BY MR. GRAHAM:**

4       **Q:** All right. Let's finish this chart here. Doctor, how  
5 many vaginal deliveries have you managed during your career?

6       **A:** This is an estimate; I would say about 4,000.

7       **Q:** And how many shoulder dystocias did you say you  
8 encountered?

9       **A:** So, 1 percent of that would be a reasonable  
10 approximation.

11       **Q:** So, 40.

12       **A:** 40.

13       **Q:** How many permanent brachial plexus birth injuries have  
14 you had?

15       **A:** If we speak of just brachial plexus, zero, but as I  
16 mentioned earlier, we have the broken neck and the paralyzed  
17 newborn. So, I've had worse than brachial plexus palsy.

18       **Q:** You're saying that broken bones are worse than nerve  
19 damage?

20       **A:** With a quadriplegic, yes. A broken neck, so the baby was  
21 paralyzed for life.

22       **Q:** But if you have a child who has the more common types of  
23 brachial plexus nerve injuries, you would much rather have a  
24 broken clavicle or a broken arm rather than a three nerve

1 permanent brachial plexus nerve injury, true?

2 **A:** That is a true statement, sir.

3 **Q:** So, you've had zero permanent injuries. Now, how many of  
4 your -- how many of your deliveries, your vaginal deliveries  
5 involving shoulder dystocia have involved maternal pushing and  
6 uterine contractions?

7 **A:** I would say overwhelming, almost all.

8 **Q:** Almost all. Okay. Doctor, I want to ask you some --  
9 some of these will be real easy questions. I want to go  
10 through them as fast as we can and I think some of them are  
11 pretty obvious. What percentage of obstetricians in this  
12 country, go through residency programs for obstetrics?

13 **A:** I would say almost a 100 percent would be my estimate.

14 **Q:** In terms of your work as an expert witness for defense  
15 obstetricians around the country, how many of those cases have  
16 you taken in per year in the last 5 years let's say?

17 **A:** For review, sir?

18 **Q:** I'm sorry?

19 **A:** To review a case?

20 **Q:** To review a case, yeah?

21 **A:** I would say my average is about 3 to 4 cases to review, 2  
22 to 3 approximately that ballpark range.

23 **Q:** Per year?

24 **A:** No, per month, I'm sorry, per month.

1 Q: And approximately how much -- what's your hourly rate?  
2 A: For trial \$800 per hour.  
3 Q: And when you said 2 to 3 per month, are you talking about  
4 trial testimony?  
5 A: No, sir, just review.  
6 Q: All right. How many -- how many cases per year do you  
7 give depositions on?  
8 A: I would say probably 1 or 2 a month.  
9 Q: And that's -- that's depositions and trial?  
10 A: There may be 3 a month.  
11 Q: You said 800 an hour for trial work; how much do you  
12 charge for basic review work and that sort of thing, talking  
13 to lawyers?  
14 A: \$600 per hour, sir.  
15 Q: And how much do you charge for depositions?  
16 A: \$800 an hour, sir.  
17 Q: So, on a case that goes to deposition, approximately how  
18 much will charge on an average for that type of case?  
19 A: I have not count -- I don't know, sir.  
20 Q: All right. Would it be at least 20,000?  
21 A: I have no way of knowing that, sir.  
22 Q: Would it be at least 30,000?  
23 A: I don't know the answer, sir.  
24 Q: Before 5 years ago, well, did you start doing this kind

1 of work?

2 A: I would say over 20 years ago.

3 Q: All right. So, for the first 15 years, how many cases  
4 were you taking on per month?

5 A: Early on it was few, then for 5 years there were none, so  
6 it's hard to make -- give you an overview, sir.

7 Q: So, when did you -- after you had a break in this kind of  
8 work, when did you start up again?

9 A: I would say about 8 or 9 years ago.

10 Q: So, we talked about the last 5 years; what about the 4  
11 years before that?

12 A: Probably less, but I don't -- I mean I've not done an  
13 average on the mathematical information on those.

14 Q: But your work in this field has picked up in the last 5  
15 years?

16 A: I would say maybe the first 2 years, but it's pretty  
17 stable for the last 2 or 3 years.

18 Q: Okay. So, after 2014, you had a jump and then it's  
19 leveled off after that?

20 A: I would say yes, sir.

21 Q: So, you can't answer any questions about much money you  
22 bring in from this kind of work?

23 A: No, sir.

24 Q: Can you tell us how your \$800 an hour compares to your

1 other income as a practicing physician?

2 **A:** No, I could not, sir. It's on my returns, but to me  
3 they're different. I don't know how to compare that.

4 **Q:** So, you're not willing to tell any of us today how much  
5 money you make from this kind of work?

6 **A:** I haven't calculated it honestly.

7 **Q:** We'll come back to that in a moment. You were talking  
8 about some nerve injuries that did not involve shoulder  
9 dystocia; you don't need shoulder dystocia to have lateral  
10 traction, do you?

11 **A:** Sir, if the head is not stuck, I cannot imagine anyone  
12 just for whatever reason, turning the head sideways. So, I  
13 think if there ever is a lateral traction, it is when you  
14 encounter shoulder dystocia, but with gentle traction, you  
15 would not move the head. I mean, I cannot imagine anyone  
16 trained in America, I've never seen anyone do that.

17 **Q:** You've never seen it with other -- are there any  
18 obstetricians you haven't seen deliver babies?

19 **A:** I only see -- I mean most obstetricians I have not seen  
20 it.

21 **Q:** So, of a hundred percent of the obstetricians and  
22 maternal fetal specialists in this country, what percentage do  
23 you think you've seen?

24 **A:** I would say small percentage.

1 Q: It would be way, way, way less than one percent, right?

2 A: I would accept that.

3 Q: So, what you've seen doesn't tell us much about what goes  
4 on in the real world, does it?

5 A: I respectfully disagree because I've seen people deliver  
6 in North Carolina; I've seen people deliver in Naples, Italy;  
7 I've seen people deliver in Connecticut; I've seen people  
8 deliver in Mississippi; I've seen people deliver in Illinois;  
9 I've seen people deliver in Spartanburg; I've seen people in  
10 Wisconsin, Norfolk, Virginia and Houston, Texas. Unlike most  
11 people, I've seen more people delivering in different  
12 environment than majority of the clinicians I have worked  
13 with.

14 Q: No matter where you've seen deliveries, there's way more  
15 than 99 percent that you have not seen; fair?

16 A: True, but we have been taught from similar books and we  
17 have similar books across the country.

18 Q: Are you prepared to assume that what you've seen in your  
19 tiny percent of deliveries, is a good basis for assuming that  
20 the other 99 plus percent of deliveries are the same as the  
21 ones you've seen?

22 A: More likely than not, yes, sir.

23 Q: You're willing to say to a reasonable degree of medical  
24 certainty that you can take a small sample and say that every



1 other doctor, every other obstetrician in this country  
2 complies with the standard of care?

3 **A:** So, we have in science what we call geographically  
4 dispersed so that experience is not local to one area. So,  
5 someone who has gone literally multiple states, I would say  
6 and is aware of the knowledge, both in birth and publication,  
7 and has seen people at conferences, I would say yes, more  
8 likely than not, the majority of the people deliver in similar  
9 manner, yes.

10 **Q:** And you're assuming, you're basing assumptions and making  
11 some speculation; would you say that's fair?

12 **A:** I think it's more than fair, so, yes, I do believe it's  
13 fair.

14 **Q:** Fair that you're making speculation?

15 **A:** I mean it's -- I'm speculating that we will have sunshine  
16 later today, but I think that's a reasonable speculation. So,  
17 I think with my experience since 1986, having worked with  
18 hundreds of people across the country and attended conferences  
19 where they've described that number I've written not only in  
20 America, but abroad. I think that's a very reasonable  
21 expectation and what I would say, yes, sir.

22 **Q:** Well, you talked about the weather; I didn't expect to  
23 have this conversation. But are you prepared to say that if  
24 is -- if we have a blue sky for 7 days in a row, that that

1 makes it to more likely than not that we'll have a blue sky  
2 the next day?

3 **A:** I'm glad you're running with that analogy; my only  
4 difference would be that I'm more like a weather reporter who  
5 had least studies weather and has it pretty good, so there may  
6 blue sky for 7 days, but if I know from my analysis and the  
7 book, that if I say it will be blue sky, then more likely than  
8 not, I would be right as meteorologist or a weather reporter  
9 tell us that. So, brachial plexus, shoulder dystocia, vaginal  
10 birth it's something not only have I looked at the blue sky,  
11 but I've studied people, I've ready everything in the English  
12 language and my prediction or my assessment is more likely  
13 than not pretty true.

14 **Q:** If you flip the coin and sometimes though it comes up  
15 heads, do you believe that it's going to come up heads the  
16 next time, just because it's come up heads before?

17 **A:** You see, now you're mixing metaphors; so, flipping a coin  
18 is 50/50; that's it. I mean it's by chance; there's no one  
19 training, but if someone were to train to do something and  
20 I've seen the training and it's not some luck thing, anything  
21 I've done work in Africa and on to India to do this; I'm not  
22 saying anything, but in English language, in America, the  
23 likelihood that it happens is very low. That's all I have to  
24 say on that subject.

1 Q: And that's the assumption that you brought to this case  
2 in terms of forming your opinions, fair?

3 A: Assumption, delivery notes, depositions, so it's the  
4 totality of the experience and research, reading the record  
5 and the deposition.

6 Q: Yes, sir, but anytime you're asked to defend a medical  
7 doctor or an obstetrician in court, in defense of a lawsuit,  
8 you're prepared to assume that that doctor met the standard of  
9 care unless they confess otherwise, true?

10 A: No, the same thing would apply if I were on the  
11 plaintiffs' side. So, if the evidence suggests so we have the  
12 contemporaneous record, we have the training, we only read the  
13 prenatal care was normal. So, no one is doubting that because  
14 we read it; yes, it's normal. Management of labor and  
15 delivery before we all agreed was normal. So, at the last  
16 minute, we're debating so my question, why did we assume  
17 prenatal care was normal; why did we assume that labor and  
18 delivery from the time of admission before the head comes out;  
19 why do we accept all that based on the same record, based on  
20 the same assumption, based on the same deposition, but by the  
21 way, we're going to not believe what happened in the last  
22 minute. So, I'm consistent in my assessment of the entire  
23 case.

24 Q: I'm very confused about one thing. You said when you're

1 representing or defending a defendant obstetrician, you're  
2 prepared to assume that they're within the standard of care  
3 unless they confess otherwise and then you said it's the same  
4 on the plaintiffs' side; I'm confused about that. Let's focus  
5 on that for a minute.

6 **MR. RADECK:** Objection to mischaracterization of his  
7 testimony, Your Honor.

8 **THE COURT:** Restate your last question. It gave me a  
9 little concern. I may not have understood your question, but  
10 can you ask that question again?

11 **MR. GRAHAM:** I'll try.

12 **THE COURT:** The preamble that you did --- take that ---

13 **MR. GRAHAM:** Yes, sir.

14 **BY MR. GRAHAM:**

15 **Q:** You told us, I believe, and correct me if I'm wrong, that  
16 you were prepared to assume that a doctor, defense  
17 obstetrician, you're prepared to assume that such a physician  
18 has acted within the standard of care unless they confess  
19 otherwise, true?

20 **A:** No, I did not say that, sir.

21 **Q:** Okay. Well, what's wrong with what I asked you?

22 **A:** So, doctor confession is one part of the component of the  
23 overall picture. So, we bring in our experience, our  
24 knowledge of the literature, if you do research on it, what

1 the doctor said, what the nurses said and the outcome and  
2 everyone in the room and you put everything; so, it's not  
3 confession of one; it is the sum entirety of who was present  
4 in labor and delivery, I would take that into account whether  
5 I'm for defense or for the plaintiff. It's the totality of  
6 the picture.

7 Q: So, you put together whether or not the doctor confessed  
8 and then basically your articles and similar-minded articles  
9 by similar-minded defense experts?

10 A: No, so the articles I'm citing, are not just from defense  
11 in America. The very article on brachial plexus palsy about  
12 shoulder dystocia was in early 1980's from Lybia. So people  
13 in Lybia have seen the same thing, people in Ireland, Siberia.

14 Q: Your Honor, we would object to testifying about those  
15 articles.

16 THE COURT: You asked the question; he's responding. I'm  
17 going to let him respond.

18 Go on, sir.

19 BY MR. GRAHAM:

20 A: Thank you. So, it's not the like-minded defense people  
21 in America. So, that article we reviewed of everything in the  
22 English language, there is a consistency what people are  
23 publishing in America versus outside America, including  
24 Siberia, Arabia and some middle-eastern country, Africa,

1 European Country. So, it's the consistency in anything in  
2 size; the more reproducible it is, the more you have to accept  
3 it.

4 **Q:** I understand. I'm sure you believe that fundal pressure  
5 is totally inappropriate in a shoulder dystocia context, true?

6 **A:** Yes, I do. That actually started in Canada. So, the  
7 Canadian found fundal pressure is associated with poor outcome  
8 and we accepted it and that's universally accepted.

9 **Q:** And just to be clear, well, I don't want to use my body.  
10 Could you stand up and use your body to show us what fundal  
11 pressure looks like?

12 **A:** Sorry, I don't have one of the better bodies, but so,  
13 fundal pressure right here. So the uterus is up here and the  
14 fundis or the top of the uterus is here. So, it's almost  
15 right below where people do CPR. This is fundis, this is  
16 suprapubic. So, this is the bladder bone, I call it, for non-  
17 medical people, this is funal. There's a difference of at  
18 least 35 to 40 centimeter between.

19 **Q:** And fundal pressure would involve pushing in what  
20 direction?

21 **A:** So, if fundal pressure is done or it used to be done,  
22 then it would be pushing the baby so the baby's butt is here,  
23 the head is here and it will be pushing from the butt, pushing  
24 the baby down through the birth canal.

1 Q: Okay. So, fundal pressure involves pushing the baby  
2 through the birth canal?

3 A: Well, pushing at the top of the uterus to push the baby  
4 out.

5 Q: All right. Suprapubic pressure is not supposed to be  
6 pushing the baby down the birth canal, is it?

7 A: May I stand up?

8 Q: Yes, sure.

9 THE COURT: Yes, sir.

10 BY MR. GRAHAM:

11 A: So, in suprapubic, what -- let's say shoulder is stuck  
12 and what you're trying to do is just so this is stuck on the  
13 bone; all you do is twist it inside and it slips out of the  
14 bladder bone. So, what you do is you just go like this and  
15 you push from the side and it will slip down and come out.

16 Q: Thank you for that. And so, the answer to my question  
17 is, in -- if you perform suprapubic pressure correctly, you  
18 don't push down toward the birth canal, true?

19 A: No, you're pushing down.

20 Q: You're pushing down to try to bend the shoulder away from  
21 the boney obstruction, right?

22 A: And that is correct and that is why it worked.

23 Q: All right. So, if the right shoulder is up, then the  
24 direction of movement for a shoulder, I mean for a suprapubic.

1 pressure would be not toward the birth canal, but toward the  
2 baby's chest, right?

3 **A:** But there's a mixing of angle, because to do this it  
4 could go this way, but the reason it worked in this case is  
5 because they didn't push the baby -- you can't push the baby  
6 down from suprapubic as you do with fundal. So, they just  
7 were able to release the shoulder by pushing down on the  
8 shoulder above the bladder bone.

9 **Q:** Okay. Let me understand what you just said. It's  
10 impossible to push toward the birth canal if you're using  
11 suprapubic.

12 **A:** I would never use extremes of word impossible, but the  
13 way nurses and we are trained, it is downwards towards to pop  
14 the shoulder by rotating the shoulder inwards.

15 **Q:** All right. Well, let me -- let me get away from the word  
16 impossible. Do you believe it would be highly unlikely for  
17 someone applying suprapubic pressure to push the baby down  
18 toward the birth canal in that direction?

19 **A:** So, you push the baby down by moving the shoulder  
20 inwards; that's how you do it, otherwise you can't because if  
21 the shoulder is stuck, you can't push the baby down because it  
22 only makes the shoulder more stuck. So, the only way you got  
23 the baby down was you popped the shoulder below it, pop it  
24 below and now the baby was quote unquote pushed down in the



1 process of delivery is the best way to put everything  
2 together.

3 **Q:** So, just because a nurse pushes a baby toward the birth  
4 canal, does not mean there using fundal pressure; they might  
5 just be using suprapubic incorrectly?

6 **A:** I have -- in 1986 I got that wrong on the test what are  
7 the following maneuvers should not be done and fundal  
8 pressure, I've not seen fundal pressure. So, no one should  
9 argue in this case there was fundal pressure. So, that's out.  
10 So, fundal pressure should not be applied into this case to  
11 confuse people.

12 **Q:** Certainly. I have no intention of trying to confuse  
13 anything, but let me ask you this, sir. You say, you missed  
14 an answer on the test. So, there was some degree of gap in  
15 your knowledge at that point?

16 **A:** 1986, when I was a second year resident, yes.

17 **Q:** Okay. And you were going through a residency program and  
18 yet, you had that knowledge gap?

19 **A:** That was in -- that's why we take the test and go through  
20 training, but that was early in my training, within 4 months  
21 of my training.

22 **Q:** A moment ago, we were talking about and we got away from  
23 it, but we were talking about you don't have to have shoulder  
24 dystocia in order to use lateral traction on a baby and I

1 believe you suggested that would be highly unlikely or words  
2 to that affect?

3 **A:** I would say more than suggest it. That would be -- I  
4 mean, first of all, without shoulder dystocia, the baby  
5 deliver in less than 60 seconds. Okay? So, the head comes  
6 out, there's no shoulder dystocia, the majority of babies  
7 deliver in seconds. So, I mean, that give the time to twist  
8 the head laterally, unnecessarily, in America, I mean unless  
9 the clinician is intoxicated. I mean, I cannot imagine in  
10 normal setting in America, anyone doing that.

11 **Q:** Well, let me ask you this, sir, do you know how big of a  
12 cut obstetricians around the country use when they're doing a  
13 c-section?

14 **A:** Yes, we know we are trained.

15 **Q:** They all use the exact same amount?

16 **A:** No. No, sir.

17 **Q:** Different amounts?

18 **A:** Yes, sir.

19 **Q:** All right. And if -- if the cut is not big enough for  
20 the head to get through, the doctor either has to bend the  
21 baby's neck to pull the baby out or add to the distance of the  
22 cut, right?

23 **A:** But the difference in c-section is there is no bone. So,  
24 the bone -- the shoulder bone is not stuck against the bladder

1 bone. So, the head has not come out. So, may I stand up?

2 **THE COURT:** Yes.

3 **DR. CHAUHAN:** Thank you, sir.

4 **THE COURT:** Certainly.

5 **BY MR. GRAHAM:**

6 **A:** So, with c-section, we bring the head up this way, so it  
7 cannot be that the shoulder got stuck against the bone. The  
8 head comes this way. So, there is no impaction, there's  
9 nothing, there's no reason for excessive traction to move  
10 shoulder because it's all soft tissue; there's no bone during  
11 c-section or delivery of a fetus during c-section.

12 **Q:** Just like downward traction with right shoulder up can  
13 cause nerve damage on the right side; upward traction with the  
14 right shoulder up can cause nerve damage on the left side,  
15 correct?

16 **A:** No, sir. I think we're getting away from this case, sir.  
17 Shoulder dystocia, so we have in this case, the right shoulder  
18 was upward toward the ceiling; that has a different mechanism  
19 than if the injury, brachial plexus is to the posterior, the  
20 one to the floor. That happens even before the head comes  
21 out. So, the two are not the same.

22 **Q:** Have you ever testified -- excuse me, have you ever  
23 written in one of your publications whether it was alone or in  
24 combination with co-authors, have you ever written that upward

1 traction should be avoided because it can damage the brachial  
2 plexus on the bottom side if the head was lifted up?

3 **A:** So, yes, anytime, as I said, you shouldn't do this nor  
4 should you do this, but we do this, we do this, we do this and  
5 certainly we all do this. So, yes, I agree we shouldn't do  
6 this because it could cause injury and there's no need to do  
7 that. So, yes, I agree, we shouldn't use excessive upward  
8 traction.

9 **Q:** And so, if the c-section cut is not big enough for the  
10 head to slide out easily, by the way, it never slides out  
11 easily in a c-section, does it?

12 **A:** When I do the c-section ---

13 **Q:** Well, you have to lift the head up, right?

14 **A:** Yeah, but that's why the rate of -- the majority of the  
15 time it does come out without difficulty, I would say.

16 **Q:** All right. And what about those other 99 percent plus  
17 obstetricians out there; do you know whether there's come out  
18 easy?

19 **A:** I do not, but they're -- if they're trained in America,  
20 it should.

21 **Q:** All right. You talked about awful it would be or  
22 completely wrong it would be to use fundal pressure in a  
23 shoulder dystocia situation. What about in a c-section, do  
24 you use fundal pressure in c-sections sometimes?

1   **A:**   No, never.

2   **Q:**   Have you ever seen other doctors use fundal pressure in a  
3   c-section?

4   **A:**   First of all, it's draped and there is no reason.  I have  
5   not seen, taught or heard of fundal pressure during c-section.

6   **Q:**   Written?

7   **A:**   Written.

8   **Q:**   What about those other 99 percent out there?

9   **A:**   There could be rogue case, but I've not seen or described  
10   or mentioned by any colleague and I've been doing this since  
11   1986, that anyone used fundal pressure in part because there's  
12   a drape up there and there's a limit of space and anesthesia  
13   is there.  I mean, I cannot imagine that.

14   **Q:**   Well, just to end this line of questioning, there's no  
15   way for you to know how much any other doctor, how much  
16   traction force, any other doctor applied in a delivery if  
17   you're not there, true?

18   **A:**   Yes.

19   **Q:**   And there's no way for you to know whether they applied  
20   lateral traction if you're not there, right?

21   **A:**   That would be a correct statement.

22   **Q:**   You don't know if they're twisting the head, correct?

23   **A:**   In trained in America, all that I would find it difficult  
24   to believe that someone for whatever intoxicated reason

1 decided to twist the baby's head and just go like this for  
2 whatever reason. I mean it would be -- it's like an ambulance  
3 driver, instead of giving CPR decided to CPR on my neck. I  
4 mean, I just -- I'm sure there could be someone who decided to  
5 give CPR on their neck, but I think can we can assume that  
6 someone trained in America, they're doing CPR's on the chest  
7 wall, not on my neck. So, I think those are reasonable  
8 assumptions in America.

9 **Q:** So, even though you've only seen far less than one  
10 percent, as you sit here today, you're prepared to assume that  
11 the other 99 percent plus obstetricians have never twisted a  
12 baby's head; is that right?

13 **A:** Just, no, I mean, in a one minute shoulder dystocia, I  
14 cannot imagine anyone twisting the neck, trained in America.

15 **Q:** I don't remember asking about a one minute shoulder  
16 dystocia. In that other 99 plus percent of doctors, you have  
17 no idea if they twist a baby's neck or not, do you?

18 **A:** No, but I've said it before, I think I am pretty  
19 reasonable and I've giving you my thought process of why I  
20 think my assessment is reasonable, more likely than not, or  
21 normally we did not twist.

22 **Q:** All right, sir. Moving along.

23 **A:** Thank you.

24 **Q:** You talked a lot about literature. How many articles did

1 you say you'd written?

2 A: 345 is the last count.

3 Q: Okay. You don't -- you're not telling us in this  
4 courtroom that any of those articles have clinical  
5 significance in an individual delivery, are you?

6 A: I'm implying that, yes, I am.

7 Q: You don't believe every case is different?

8 A: Yes, it is, but it is still within the same realm. I  
9 mean, I would say my shoulder dystocia and brachial plexus did  
10 apply here.

11 Q: All right. So, do you believe that in the articles that  
12 you've written about, when you talk about what's happened with  
13 other doctors and what happens with other doctors you've never  
14 seen, you believe all of that is reliable and applies to every  
15 delivery?

16 A: In -- in -- with, I mean, not everyone does not do the  
17 exact same thing, but within -- like when we go driving, not  
18 everyone goes 50 miles per hour; some go 49, 51, but no one  
19 should be going 80 miles an hour.

20 Q: Especially if the speed limit is 45 or 25?

21 A: I agree.

22 Q: All right. So, do you believe that your articles have  
23 importance to us and understand how this precious child had  
24 his life changed forever?

1   **A:**   Do they have what, sir? I missed that.

2   **Q:**   Do you believe, doctor, that the various articles you've  
3   written, can tell us what happens in every case including the  
4   delivery of the precious child of these parents that wound up  
5   with a three level nerve injury with two and a half avulsions?

6   **A:**   It's sheds light into it, yes, I do believe so.

7   **Q:**   Well, are you saying that your articles explain what  
8   happened?

9   **A:**   They shed light. They help us understand. They give us  
10   a reasonable explanation. They give us whatever you to use  
11   the terminology for the jury to decide.

12   **Q:**   Okay. And so, you have confidence in the accuracy of  
13   your studies as set forth in your articles?

14   **A:**   Yes, I have pretty good reliability.

15   **Q:**   Okay.

16   **A:**   And the analysis of the data we are using.

17   **Q:**   Yes, sir. Well, just turning to one of the articles that  
18   you said was reliable that was authored by you, I'm going to  
19   read some of it and see if you agree with this. "The  
20   weaknesses of our study need to be acknowledged. The data  
21   were retrospectively collected and the reports of mode of  
22   delivery, presence of shoulder dystocia and anti-natal  
23   characteristics were obtained from maternal report and not  
24   from medical records increasing the chance of recall bias."



1 Do you agree with that statement, sir?

2 **A:** I'm glad you brought that up. So, that speaks to the  
3 candor in the writing. So, no one should be audacious to say  
4 that this article is the only one. So, guess what, the same  
5 article, we won the award last year in October and we're in  
6 the process of publishing. So, out of 380, these were what  
7 the mother's supported. We actually went with the same co-  
8 author, Dr. Yang, the neurosurgeon, and we are the first one  
9 to actually go get hundred plus record of shoulder dystocia  
10 and link it to brachial plexus. So, we did the due diligence  
11 of -- a) acknowledging, so we weren't false (inaudible). B)  
12 we spent additional 2 years, we flew to Michigan, we analyzed  
13 the data with their statistician, we presented it at the  
14 National Meeting, the primary author won a nice check and an  
15 award for that and we are in the process. Signs make slow  
16 progress and yes, including the latest article, I believe what  
17 was written there is confirmed when we actually looked at  
18 hundred charts of shoulder dystocia or whatever happened in  
19 the delivery with persistent brachial plexus in Michigan,  
20 where we had no investment in the actual delivery. So, yes, I  
21 do believe our work in its entirety. So, what you have done  
22 is taken one paragraph, and I appreciate that, but you're not  
23 looking at the entire picture.

24 **Q:** All right. Well, all of your articles have that kind of

1 weakness, don't they, Doctor?

2 **A:** That's why you put not only -- so, I'm not saying that  
3 only my article says, noted by articles, clinicians in  
4 California. As I said, the very first article came from  
5 Lybia, Saudi Arabia. So, you take the entirety of the  
6 literature. I would not be cocky enough to say just because  
7 my article it's -- my article is a fraction of the word  
8 literature in the English language and among them, what I am  
9 saying in our articles, they're absolutely consistent with  
10 each other.

11 **Q:** In all candor, 3 or 4 or 500 articles you've written, all  
12 involve the weakness that was mentioned here, true?

13 **A:** Always some component of weakness. Every study does have  
14 a weakness. So, yes, in that study those were true, but in the  
15 next study, part of it not, because there was no recall bias.  
16 So, we got rid of that weakness.

17 **Q:** And you're proud of yourself for having the candor to  
18 admit the weakness in your articles in the articles  
19 themselves?

20 **A:** We all do. So, if all of our publication are a joint  
21 effort, in this case by neurosurgeon who actually treats it.  
22 So, with her knowledge, her knowledge of surgical brachial  
23 plexus palsy and a statistician, yes, I am proud of what they  
24 have written.

1 Q: All right. Maybe I misconcerd (sic), but I didn't hear  
2 any expression of candor when Mr. Radeck was asking you  
3 questions; I heard nothing about candor, that the articles you  
4 talked about had weaknesses?

5 A: Sir ---

6 Q: You didn't say anything about weaknesses in those  
7 articles to us today, did you?

8 A: So, anyone who thinks even let's say the most perfect car  
9 or anything you make is without any weakness would be fool-  
10 hearted; especially as a scientist because we keep learning  
11 and we keep making progression and you take the whole thing.  
12 So, everything taken with our publication with other  
13 publications in America, with other publications from  
14 different part of the globe, is what I'm bringing here.

15 Q: But you didn't tell anybody in this courtroom about those  
16 weaknesses, did you?

17 A: Sir, if asked, I'm more than happy to.

18 Q: Only because I brought up the questions, true?

19 A: No, but I never, nor did the congress, I never said those  
20 articles are perfect and they're the gospel. Everything is  
21 like anything human endeavor does -- has its limitation  
22 because you can only do this at a time. But the question is,  
23 how you're making the progress; how does it relate in its  
24 entirety of the literature I'm bringing.

1 Q: All right. You referenced the word congress, are you  
2 talking about the American Congress of Obstetricians and  
3 Gynecologists?

4 A: I didn't meant to mean Congress just now.

5 Q: I believe -- well, I thought I heard you say the word  
6 congress?

7 A: I meant colleagues.

8 Q: Colleagues.

9 A: On my bad Texan accent.

10 Q: No worries. I don't criticize anybody for that. But in  
11 terms of Congress, ACOG stands for two things, right?

12 A: Yes, I've heard it used twice or two different ways.

13 Q: The college and the congress?

14 A: Affirmative.

15 Q: All right. And you're a member of the congress?

16 A: I'm a member of ACOG. It has changed over time, but,  
17 yes, I am a member of ACOG.

18 Q: And you're a member of the congress part of ACOG, true?

19 A: No, my interest in ACOG is in their publication and  
20 evidence. So, we have written four national titles. So,  
21 three besides brachial plexus, I have co-authored with other  
22 people. And we are interest -- my interest is in publication  
23 and research. Other things ACOG does, I have minimal  
24 involvement or minimal knowledge of that.

1 Q: All right. So, you're only minimally involved in  
2 lobbying Washington for changes in the law to protect the  
3 financial interests of doctors?

4 A: I've never ever, never ever been part of that.

5 Q: All right. Those are other members of ACOG?

6 A: I wouldn't know about that. I don't partake in that.

7 Q: Well, what about those other 99 percent plus doctors that  
8 you've never seen deliver babies, are they part of that  
9 lobbying effort to -- to protect their financial interests?

10 A: I -- I know there are clinicians who do that, and I know  
11 ACOG, but that's not what I do.

12 Q: Moving on. Shoulder dystocia is a boney obstruction,  
13 right?

14 A: It's bone against bone, yes, sir.

15 Q: Top shoulder going through the birth canal encounters the  
16 mom's pubic bone, which blocks its dissent; shoulder bone  
17 against pubic bone?

18 A: Most commonly let's say. Yeah, in this case.

19 Q: Well, this case, that's what we're dealing with.

20 A: Absolutely, I would agree with you, sir.

21 Q: It's not a soft tissue obstruction, it's a boney  
22 obstruction?

23 A: The shoulder dystocia is bone against bone, but in this  
24 case, the right bone, yes.

1 Q: And you've written and testified, have you not, that the  
2 purpose of an episiotomy is not to give the head more room;  
3 it's to give the doctor's arm more room for internal  
4 maneuvers, true?

5 A: So, they -- why one cuts, extends the cut at the bottom  
6 so the head is towards the floor of the rectum, some do it to  
7 get more room; some people do it to see if the maneuvers will  
8 work. There are more than one reason to do an episiotomy;  
9 different doctors do it for different reasons.

10 Q: Yes, sir. Let's talk about you. You only use episiotomy  
11 in the shoulder dystocia context to get more room for an  
12 internal maneuver for your arm, true?

13 A: Personally, myself?

14 Q: Yes, sir.

15 A: Yes.

16 Q: You just don't know about those other 99 percent?

17 A: No, I do.

18 Q: Oh, you know about the other 99 percent?

19 A: No, I mean they have been written, so episiotomy on other  
20 people, what other doctor do have been written about when I'm  
21 at the conference talking, I've heard it from other people.  
22 So, yes, I have a reasonable sample of what other people do.

23 Q: What do you call reasonable sample, out of 100 percent,  
24 what do you call a reasonable sample?

1   **A:**   That I would be right in what at least 51 would do.

2   **Q:**   I thought when you said the word sample, you were talking  
3   about taking a smaller group and using that sample to project  
4   what a larger group would do; is that what you're saying?

5   **A:**   Yes.

6   **Q:**   All right. Well, I'm not asking you how much confidence  
7   you have, I'm asking you what percentage of 100 percent do you  
8   believe is a reliable sample source for you to decide what  
9   everybody else is doing around the country?

10   **A:**   So, first of all, it depends on the thing and in this job  
11   so, let's say I never left Spartanburg. I was born, raised,  
12   went to school there, did my and I never went outside. Then I  
13   would say I'm not -- I shouldn't go. But I've given national  
14   talks, people have talked to me, it's been written about, it's  
15   in the book, so it's the sum totality of that sampling. So,  
16   it's not just talking to people, it's what's in the text,  
17   what's in the guidelines and it's an ACOG publication. It is  
18   what I've learned what other peoples have done in their  
19   hospitals; it is when I met; that sample gives me confidence  
20   about what happens in other 99 percent of the deliveries.

21   **Q:**   Sure. Do you remember, you've talked before about the  
22   ACOG position paper that came out on shoulder dystocia and  
23   brachial plexus injuries back in 2014?

24   **A:**   So, the one on 2014 has not -- it's preferably involving

1 shoulder dystocia. So, yes, there is a different document  
2 just on shoulder dystocia, focuses on shoulder dystocia.  
3 There's a difference about predominantly focuses on the  
4 brachial plexus palsy.

5 Q: Yes, sir. You were a member of the task force that wrote  
6 that, right?

7 A: The one with brachial plexus palsy, yes, sir.

8 Q: Yes, sir. And Dr. Gurman was the chairman of that  
9 committee, right?

10 A: Yes, he was the chairman.

11 Q: He also flies around the country being an expert witness  
12 to protect defendant OBGYN's from lawsuits over life-changing  
13 injuries, true?

14 A: No, that's not true because believe it or not, I have met  
15 Dr. Gurman. He has been on the plaintiff's side on a brachial  
16 plexus. So, he thought the doctor did something wrong. I was  
17 on the other side. So, no, I've seen him on plaintiff cases  
18 too.

19 Q: All right. Apart from one or two plaintiff cases for one  
20 specific lawyer friend of his, the rest have been cases around  
21 the country defending obstetricians for life changing  
22 injuries, correct?

23 A: I mean, I can only account for what I know of Dr.  
24 Gurman's works. I think I met him 2 or 3 times on my side and



1 1 time on the other side. So, I only have experienced working  
2 with him on 4 cases.

3 Q: Four, and you were the defendant's expert on all of  
4 those?

5 A: On those 4 cases, yes.

6 Q: All right. And the plaintiff's lawyer was the same on  
7 all of them?

8 A: No, I do not know.

9 Q: You don't know that. So, you don't know that that's a  
10 personal friend of Dr. Gurman's?

11 A: No, I do not know.

12 Q: The other members -- the other obstetrician members of  
13 that task force are also regular fliers around the country to  
14 testify on behalf of defendant doctors, true?

15 A: No, I am so Joe Ouzounian, I'm sorry, I'm mispronouncing  
16 the gentleman from California, I've seen him on the  
17 plaintiff's side too.

18 Q: Well, you were talking earlier about 99 percent. You  
19 know at least 99 plus percent of his litigation support  
20 testifying work is on behalf of defendant's, true?

21 A: No, I do not know that, sir.

22 Q: Do you remember the names of the other folks on that task  
23 force?

24 A: Some of them I do.

1 Q: All right. There, all of the obstetricians testify  
2 largely, almost primarily, if not primarily, for defendant's,  
3 defendant obstetricians, true?

4 A: I do not know that.

5 Q: And the only engineer on that task force, Michelle Grimm,  
6 she too, since 2014, has been marking a lot of money flying  
7 around the country defending these same doctors, true?

8 A: I do not know that, sir.

9 Q: All right. Well, let's see if you know this. Well, let  
10 me -- I'll get out these names here. The first one, Gurman,  
11 we talked about the second one, you, the third one is Steve  
12 Clark; do you know Steve Clark is a regular defense expert?

13 A: No, on the contrary, he is known as the plaintiff expert.

14 Q: Have you ever been a defense expert in a case where  
15 Steven Clark was the plaintiff's expert?

16 A: No.

17 Q: In fact, he worked at the -- at the Mormon Medical School  
18 in Salt Lake City for many decades before he was hired by a  
19 The Hospital Corporation of America, true?

20 A: I know he was in Utah and I know he was working for  
21 American Hospital Corporation; yes, I do know that and now he  
22 works across the street in Houston.

23 Q: Right. And then Bernard Gonik is the fourth author  
24 listed; do you know he's a regular or at least he was a

1 regular defense expert before he retired a few years ago for  
2 defense; correct?

3 A: No, I do not know that, sir.

4 Q: And we've talked about Michelle Grimm. Do you know of  
5 any member of your task force that was not a regular member --  
6 I mean a regular expert for defendant's in obstetrical  
7 negligence cases?

8 A: Yes.

9 Q: Who?

10 A: William Grobman.

11 Q: You believe that he does not testify?

12 A: To the best of my knowledge, he -- I've not heard or seen  
13 Dr. Bill Grobman from Northwestern testify.

14 Q: Okay. So, he's retired from his testifying work?

15 A: No, on the contrary, he's active as a clinician.

16 Q: But retired from expert work?

17 A: I -- I have not heard him doing expert work. Dr. Yang  
18 does not, who is a neurosurgeon.

19 Q: All right. And I was asking you about obstetricians.  
20 The only other obstetrician on the task force is Dr.  
21 Ouzounian, who you mentioned earlier, right?

22 A: Yes, I did mention him.

23 Q: The guy from Los Angeles or somewhere nearby?

24 A: Los Angeles, sir.

1 Q: That flies all around the country doing just what you do,  
2 defending these doctors in these lawsuits, right?

3 A: But as you know, I have been on plaintiff's side on  
4 shoulder dystocia twice. Granted it was a few decades ago,  
5 but I have been on the plaintiff's side of shoulder dystocia  
6 at lest twice; once in North Carolina and once in Georgia.

7 Q: All right. And all of the defense experts who are on the  
8 task force have been taking on a lot more cases since 2014,  
9 correct?

10 A: I don't know about the rest, sir, I can't comment on  
11 that.

12 Q: But you know you have?

13 A: In my case, yes, sir.

14 Q: And you made a lot more money?

15 A: But that's for multiple reasons, sir.

16 Q: I'm talking about the -- the work as a defense expert,  
17 flying around the country, trying to defend, defendant  
18 obstetricians, who have babies born with life changing  
19 injuries; you've made more money from that since the task  
20 force publication, the position paper came out by ACOG, true?

21 A: So, just for clarification, at the same time, there was  
22 one more sponsor on cerebral palsy. So, I'm on the book task  
23 force. So, the fact and I've been on 2 other national  
24 guidelines. So, this vision or this narrative that being in

1 task force entitles you get your money is totally false,  
2 because I would say six out of hundred articles we have  
3 written for at least six articles we like. We write 94  
4 articles on other topics. For every one brachial plexus task  
5 force, I've been on 3 others. So, this concept that we are  
6 writing or doing this to make money is not true, if you take  
7 the totality of the writing into account.

8 Q: Okay. So, that extra money might have come from other  
9 tasks forces in addition to this one?

10 A: Most of my money comes from seeing patients every day.

11 Q: So, you make more than \$800 an hour in your medical  
12 practice?

13 A: If you take the -- no, if you take 5 days a week, more  
14 than 50 hours a week, yeah.

15 Q: So, which one makes you more money; \$800 an hour  
16 defending doctors or treating patients.

17 A: My regular work makes more money.

18 Q: So, you make more than \$800 an hour.

19 A: No, sum totality.

20 Q: What does sum totality mean?

21 A: The total amount of money I take home.

22 Q: Okay. I'm not asking you about the totality; I'm asking  
23 you about money from defending doctors and money from treating  
24 patients; how do those compare?

1   **A:**   Per hour, I haven't calculated my hourly rate for taking  
2   care of patients.

3   **Q:**   But, you're under oath. Under oath, there's no way you  
4   can tell us that you make less money from helping defendant's  
5   than you do from helping patients, correct?

6   **A:**   At the end of the year, I make more money doing regular  
7   work.

8   **Q:**   When you signed on to be a member of this task force and  
9   the other task force for that matter, didn't you have to sign  
10   a disclosure statement about your financial interests?

11   **A:**   Yes.

12   **Q:**   All right. I'm going to read this from the -- from the  
13   brachial plexus position paper and see if you agree with this?  
14   All task force members, provided disclosure statements. No  
15   material, financial, business, or other interest that would  
16   compromise the author's ability to undertake unbiased  
17   scientific research and writing, was declared; do you agree  
18   with that?

19   **A:**   Yes.

20   **Q:**   All right. So, none of those -- none of those financial  
21   biases were declared; they existed, but they weren't declared,  
22   correct?

23   **A:**   No.

24   **Q:**   You said earlier that having 4 hands on mom's belly would

1 be completely ludicrous; nobody would ever think of that  
2 including all the 99 plus percent of deliveries that you've  
3 never seen; if that is so ridiculous, do you believe it would  
4 be incumbent upon an obstetrician to stop that and correct it,  
5 if it was happening a foot in front of her..

6 **A:** So, in this hypothetical case and being trained in  
7 American, saw nurses trained in America, 4 hand doing  
8 suprapubic simultaneously; yes, the doctor should have stopped  
9 the 4 hands from doing suprapubic at the same time.

10 **Q:** Not only should she stop them, but if she fails to stop  
11 them, that would be a violation of the standard of care, true?

12 **A:** If that happened and if it was not stopped, then, yes.

13 **Q:** And if it happened, do you believe that would assist in  
14 the resolution of shoulder dystocia or hinder or make more  
15 difficult, the resolution of shoulder dystocia.

16 **Q:** Because this would be the first case that I've seen or  
17 heard of described. I don't know what to say, sir.

18 **Q:** Just one more -- well, I'm nearing an end. I want to  
19 touch on just a couple of more things in the -- in the ACOG  
20 position paper about brachial plexus injuries. It lists a  
21 number of purposes at the beginning. There was nothing in the  
22 purpose list about figuring out what traction does to babies,  
23 was there?

24 **A:** I don't have recall either way, sir.

1 Q: Let's see if this refreshes your memory?

2 A: Can I see that please so I can read along, sir?

3 Q: Certainly. Okay. It's entitled task force objectives  
4 with 2, 4, 6, 8, 11 bullet points about the various objectives  
5 of this task force. Please tell me about any of those that  
6 suggest, let's figure out what happens when a doctor gives  
7 this traction to pull a baby's head so much that the nerves  
8 pull out of the spine?

9 A: Yeah, I think it's in the objectives.

10 Q: Sir?

11 A: Yes, it is in the objective.

12 Q: Which one?

13 A: So, in number 3, what is the pathophysiological,  
14 pathophysiological, physiological is what happens normal,  
15 patho is when it's abnormal mechanism for brachial plexus  
16 palsy with and without shoulder dystocia. That eludes to it  
17 focuses on traction. What are endogenous and exogenous.  
18 Endogenous are mother's, what we talked about exogenous is the  
19 traction inheriting the process of labor and delivery that may  
20 cause or contribute to the brachial plexus. So, 2 right there,  
21 I mean it was in the top 4, 2 of them. What mechanism of the  
22 geology of neonatal brachial plexus are offered by the peer  
23 reviewed literature that would focus on traction; that's 3.  
24 What are the biomechanical effects of maneuvers that would



1 touch on tractions, so, I can, out of those, I think at least  
2 3 or 4 which do talk about it.

3 Q: Okay. Well, thank you for that, doctor?

4 A: You're welcome, sir.

5 Q: All right. In answering that question, you used the word  
6 traction multiple times, but the word traction does not appear  
7 in any of these objectives, true?

8 A: Sir, I think that's because your knowledge of those words  
9 are limited and you are reading as an outsider. For anyone  
10 who writes on this topic, if you don't think those bullet  
11 points are touching or focused on traction, then you don't  
12 know what you're talking about.

13 Q: Sir, I plead guilty to not being as smart as you are.

14 A: No, on the contrary, sir, I think you are as a wonderful  
15 lawyer, but in that thing, anyone who doesn't see those  
16 traction in the word there.

17 Q: Where does it say in those objectives, let's figure out  
18 if we can stop permanent brachial plexus injuries if we stop  
19 forceful traction and bending of the neck?

20 A: So, first of all, the bullet points don't have that.  
21 That's an overarching team and part of that would be in there  
22 -- in the -- written about shoulder dystocia. So, I think  
23 your knowledge is very literal without knowing the nuances or  
24 the subtleties of -- of the literature, sir.

1 Q: All right. Just a couple of more questions and we'll be  
2 done. Do you remember, having been part of this organization  
3 that wrote this position paper, do you recall how various  
4 words and phrases were defined?

5 A: It depends which one, I mean, I -- this was done years  
6 ago. I mean, I don't have a photographic memory, but I know  
7 it was edited quite frequently.

8 Q: I'm sorry, edited what?

9 A: You know, edited writing, I call it.

10 Q: All right. Let's look at the glossary section. Tell if  
11 you agree with this definition of lateral traction, excuse me,  
12 let's see if you agree with this definition of traction.  
13 Traction, a pulling force that acts to elongate or stretch an  
14 object?

15 A: That's one definition, yes.

16 Q: That's your definition, your task force definition in the  
17 official ACOG publication about brachial plexus injuries,  
18 true?

19 A: So, that is, I would call it ours. So, it is the total -  
20 - it's -- this group, just like the constitution and  
21 everything, it's a group effort, so, yes, that is the ACOG's  
22 definition that you have cited, that is correct.

23 Q: You signed off on it, right?

24 A: Oh, yes, I did.

1 Q: Traction is a pulling force?

2 A: Yes.

3 Q: That stretches an object?

4 A: Okay.

5 Q: Or elongates an object, makes it longer?

6 A: Okay.

7 Q: You agree?

8 A: I mean, yes, that's what it says.

9 Q: Now, let's see what it says about excessive traction.

10 Let's see if you agree with your task force, task forces  
11 definition of excessive traction. A pulling force and then in  
12 parenthesis, traction, a pulling force that is greater than  
13 the inherit strength of the fetal brachial plexus; do you  
14 agree with that definition?

15 A: That is the definition, yes, I would accept it.

16 Q: Thank you. Nothing further.

17 A: Thank you, sir.

18 **THE COURT:** Mr. Radeck?

19 **MR. RADECK:** No questions.

20 **THE COURT:** Very well. Okay. Witness?

21 **MR. HOOD:** We're finished. At this time, Your Honor, the  
22 defense rests.

23 **THE COURT:** Defense rests. All right. All right.

24 Ladies and gentlemen, what we're going to do is send you back

1 to your jury room, relax for a few minutes. The clerk is  
2 getting you some lunch. When you have finished that lunch,  
3 I'm going to take up some things right now with the attorneys.  
4 When you have finished your lunch and you are ready to come  
5 back in, you let me know and see, I will go down to the Coke  
6 machine and cracker machine downstairs and these lawyers will  
7 be there having their lunch, because they're not going to  
8 leave. We're going to wait on you and when you're ready to  
9 come back in, you let us know and we'll have closings and a  
10 charge on the law. Okay. Thank you.

11 **REPORTER'S NOTE:** (Jury retires to jury room 12:32PM).

12 **THE COURT:** You may step down.

13 **DR. CHAUHAN:** Thank you, sir.

14 **THE COURT:** Everyone is -- the doctor, he's not going to  
15 be needed any further?

16 **MR. RADECK:** Not by me, Your Honor.

17 **THE COURT:** You're released from your subpoena then.

18 **DR. CHAUHAN:** Thank you, sir.

19 **THE COURT:** As far as the Court is concerned. All right.  
20 Do we have some motions?

21 **MR. GRAHAM:** Yes, sir, if Your Honor, please, the  
22 plaintiff moves for a partial directed verdict on two aspects  
23 of the, well, we look for a directed verdict at the medical  
24 emergency statute does not apply to this case and should not

1 be allowed to go forward as a defense for the defendants. It  
2 is an affirmative defense. We believe that they failed to  
3 make a proper showing of it being applicable and relevant to  
4 this case for two grounds. One is that the only evidence  
5 they've put in about medical stability relates to a theory  
6 that each and every emergency including shoulder dystocia,  
7 involves instability and the instability represents  
8 uncertainty.

9       **THE COURT:** Well, you know, I have heard witness after  
10 witness testify that a baby experiencing shoulder dystocia is  
11 in an unstable emergent situation. Now, you know the rule,  
12 Mr. Graham, is that whether there's any evidence, right?

13       **MR. GRAHAM:** Whether there's any evidence, if construed,  
14 and the non-moving parties favor, would mean that we're not  
15 entitled to a ruling in our favor. But, Your Honor, I  
16 acknowledge what you just said about the testimony. My point  
17 is, and I'll just state it very briefly for the record, my  
18 point is that when properly construed, the statute requires  
19 evidence, you know, so their burden of proof evidence of  
20 medical instability in this child, not just uncertainty that  
21 there might be problems in all children in this situation; it  
22 applies to this child. All the evidence shows that this child  
23 was doing great before, great after, with no evidence of any  
24 change during that ---

1           **THE COURT:** But, we have heard evidence that the strips  
2 are not necessarily an indication of -- of stability during  
3 the birth. I mean we've heard testimony concerning  
4 compression of nuchal cord; we've heard testimony concerning  
5 how that results in lack of oxygen; we've heard testimony  
6 concerning compression of the child's chest in the birth  
7 canal; we've heard expert after expert say that this is a very  
8 dangerous situation, that the outcome is in question, that the  
9 child is unstable because of the clamping or compression of  
10 the -- of the umbilical cord. You know, I'm required to look  
11 at this in a light most favorable to the non-moving party. I  
12 acknowledge and I think it goes without saying almost, it's  
13 axiomatic that Mr. Hood, Mr. Radeck, have the burden of  
14 proving by preponderance of the evidence the affirmative  
15 defense provided by this statute. But, I'm required to look  
16 at the -- the evidence in the light most favorable to them and  
17 I think that there is certainly significant evidence here.  
18 We've heard experts who testified specifically that this child  
19 was unstable, that this child was in a life threatening or  
20 injury threatening situation. We've heard witness after  
21 witness describe it as an emergent situation. I -- Mr. Hood,  
22 you even want to talk about this?

23           **MR. HOOD:** Your Honor, I do.

24           **THE COURT:** Yes, go ahead.

1       **MR. GRAHAM:** I just wanted to get it on the record.

2       **THE COURT:** Yeah, I understand. Mr. Hood, you want to --  
3 you want to put anything on the record?

4       **MR. HOOD:** I would just say with respect to his point,  
5 specifically, the witness has been asked, if at the time of an  
6 unresolved shoulder dystocia, is that stable and the answer  
7 has been uniformly, no, from our experts and the reason for  
8 that is the baby can't deliver itself, it's not ---

9       **THE COURT:** I think I heard it from their witnesses.

10       **MR. HOOD:** And also, they say that at that moment, the  
11 baby can't breathe, and our position is, if you can't breathe,  
12 you're not stable.

13       **THE COURT:** Okay. All right. And I would respectfully  
14 deny the motion for directed verdict.

15       **MR. GRAHAM:** Yes, sir, I understand.

16       **THE COURT:** Okay. And do you have another one?

17       **MR. GRAHAM:** Just another ground for that same ---

18       **THE COURT:** All right. I would deny it on that ground.

19       **MR. GRAHAM:** Yes, sir. And -- and I just want to get  
20 this on the record very, very briefly, Your Honor. We believe  
21 and there's a case on appeal on its way, on appeal, dealing  
22 with this same subject. Asserting where the plaintiff in that  
23 case asserts that if you interpret the entire statute, not  
24 just A and C, but if you also -- if you also include B in the

1 whole statutory analysis, that the mere fact of a prenatal  
2 care and a pre-existing doctor/patient relationship ---

3 **THE COURT:** Relationship?

4 **MR. GRAHAM:** --- takes away any requirement to prove  
5 gross negligence and so we would move to a directed verdict,  
6 against the applicability of that defense on that basis.

7 **THE COURT:** And I would simply say this. The common,  
8 unambiguous, language of the -- of the statute, I believe,  
9 would be otherwise and you know, until the Supreme Court rules  
10 otherwise, I think that that's controlled, and I would  
11 respectfully deny your motion on those grounds.

12 **MR. GRAHAM:** I understand. Thank you.

13 **THE COURT:** Mr. Hood, you want to -- you want to address  
14 it; I keep jumping ahead of you there, I'm sorry.

15 **MR. HOOD:** I don't, Your Honor. I think the statute is  
16 unambiguous and it's a question for the jury.

17 **THE COURT:** All right. Thank you, gentlemen. Okay.

18 **MR. HOOD:** Your Honor, at this point, I would renew our  
19 previously asserted motions, if you'll kindly allow me to  
20 adopt by reference, the motions previously made, I want re-  
21 state them?

22 **THE COURT:** You may.

23 **MR. HOOD:** Thank you.

24 **THE COURT:** All right. Thank you. All right. Let's



1 take a break and I'll tell you, it'll probably be safe for you  
2 know, maybe an hour. That just, I did go ahead and order some  
3 lunch for them. I would not at this juncture want anything to  
4 happen to our jury. I had a case here just the other day and  
5 had a wreck just before the jury began deliberations. We had  
6 a problem with that, lost jurors. I want to keep them here,  
7 so I ordered lunch for them. It's supposed to be here just  
8 before noon.

9 **CLERK:** She just went to get it a few minutes ago.

10 **THE COURT:** So, it will be here soon?

11 **CLERK:** Yeah.

12 **THE COURT:** Okay. So, it's going to be here quicker than  
13 I thought. So, be close by. Make sure that these clerks have  
14 your cell phone numbers if you leave the courtroom. Okay?

15 **(COURT IN RECESS)**

16 **THE COURT:** All right. Everybody ready to go?

17 **MR. GRAHAM:** Yes, sir, Your Honor.

18 **THE COURT:** All right. All right. The jury ready?

19 **REPORTER'S NOTE:** (Jury enters courtroom 1:42PM).

20 **THE COURT:** All right. Good afternoon. I hope everyone  
21 had a good lunch. We will resume the trial. The lawyers are  
22 going to give closing arguments at this time. All right? And  
23 I'm going to limit both parties to 45 minutes a piece. Okay?

24 **MR. HOOD:** Yes, sir.

1           **MR. GRAHAM:** Thank you, Your Honor.

2           **THE COURT:** All right.

3           **MR. GRAHAM:** Good afternoon. Thank you for your  
4 attention this week. We're reaching and end of your work. As  
5 you retire to the deliberation room soon, you might think you  
6 have one job. I think you have three jobs. The first job you  
7 have is to tell each other how you feel about the case. The  
8 second job you have so to tell the other jurors why you feel  
9 like you do about the case. Thirdly, you have the duty and  
10 the right to know that you have done your -- you have met your  
11 oath of -- that you took at the beginning of the case to base  
12 your decision on the evidence that came in today and to follow  
13 the law and base your decision solely on the evidence that's  
14 presented. I don't know who might know who, or who might have  
15 seen somebody in the courtroom, that kind of thing. You have  
16 the right to go home knowing that you've met your oath.. Now,  
17 I want to talk for a second. I don't want to rehash all of  
18 the testimony because you've heard plenty of it. I don't want  
19 to boar you with that, but I do want to point out a few common  
20 sense items. Starting with this, you heard the parents -- you  
21 heard the parents say that there were two nurses doing  
22 suprapubic pressure, two hands here, two hands here. Doctor  
23 Chauhan said, that's ridiculous nobody would ever do that.  
24 Everybody on the defense side says that's ridiculous. Doctor

1 Maselli said there was one nurse and one hand. But, what do  
2 the nurses say on the medical records? The nurses say, first  
3 Nurse Cossentino, then Nurse Butterworth, they both did  
4 McRoberts. Next, the second procedure was the same two nurses  
5 doing suprapubic pressure. We heard from everybody that it  
6 takes one nurse and one nurse only to do suprapubic. Now,  
7 from the nurses, we know that there were two nurses doing it.  
8 There's certainly been no evidence to the contrary. The  
9 records say two nurses. Doctor Maselli says one nurse -- I  
10 mean, one nurse and one hand. If there are two nurses doing  
11 suprapubic at the same time that's got to be more than one  
12 hand. If there are two nurses then that can be anywhere  
13 between two hands, three hands and four hands. The parents  
14 memory that this is four hands down here fits with two nurses.  
15 The doctor's testimony that, oh no there was one nurse and one  
16 hand doesn't match the official chart. Now, so I've kind of  
17 gotten into this, suprapubic pressure whether it's four hands  
18 or two hands or three hands, it was not done properly based on  
19 all of the evidence. The doctor testified that you push down  
20 toward the floor and toward the birth canal. The best  
21 description we got, the only consistent description we got was  
22 from Doctor Pliskow, our obstetrical expert, and from Doctor  
23 Chauhan, the defense expert right there. The way you do it  
24 is, I mean, if you push straight down what good does that do?

1 If you push toward the birth canal, what does that do? The  
2 right way to do it is for the nurse, one nurse, to get behind  
3 -- if the right shoulder is the one stuck then you get one  
4 nurse back here to push the shoulder in like that. The bone  
5 is back here and the shoulder is over here, then the baby can  
6 pass. You heard it from the defense expert, Doctor Chauhan.  
7 You heard it from Doctor Pliskow. We heard something  
8 different from Doctor Maselli. The third thing I want to  
9 mention, everybody has been ridiculing me for talking about  
10 Pitocin. I want to tell you why I did that. I'm not saying  
11 it's wrong to do Pitocin. What I'm saying is, if the forces  
12 of labor, if the mother pushing and if the uterine contracting  
13 to push the baby through the birth canal, if that's how these  
14 injuries happen then it would be wrong to use Pitocin. What  
15 does Pitocin do? You've heard it from everybody, Pitocin  
16 strengthens those contractions, speeds them up. If going  
17 through the birth canal can cause this kind of injury, then  
18 why would doctors be using Pitocin? It makes no sense.  
19 Doctor Robinson is a smart guy. I mean, we heard from a lot  
20 of smart guys from the defense this week. Doctor Robinson  
21 said some of the strangest things I've ever heard. He said,  
22 pushing is the same as pulling. I don't get that. The  
23 obstetricians want to say that the uterus contracting and the  
24 mother pushing, pushing that baby down the birth canal somehow

1 puts traction on the neck. But, the book I pulled out the  
2 other day -- the other day, sometime in the last hour the book  
3 I pulled out that he had authored, Doctor Chauhan had  
4 authored. I asked him what the definition was for traction.  
5 It's not a pushing force, it's a pulling force that stretches  
6 and makes an object longer, exactly what we've been saying.  
7 The doctor pulled the baby's neck. You heard the parents  
8 describing it, they were right there. They're not trained  
9 medical people, but do you have to be a trained medical person  
10 to see a woman pull back and pull back and pull back and  
11 stretch their baby's neck? That's what traction is, that's  
12 what leads to this. I'm not new to hearing this one thing  
13 that we heard repeatedly and that is, we kept hearing that  
14 OB's that go to resident programs in this country can do no  
15 wrong. We assume that they would confess if they acted  
16 wrongfully and ruined a child's nerves and arm forever, for  
17 the rest of his life. If they don't confess, then they're not  
18 guilty. If they went through a residency country, there's no  
19 way they would have acted outside of the standard of care.  
20 Well, guess what? Every -- well, Doctor Chauhan said  
21 virtually every, everybody else said every obstetrician in  
22 this country goes through a residency program. I don't know  
23 how you can become an obstetrician without doing that. So, if  
24 you take the position as the defense experts do, if you take

1 the position that this doctor and all other doctors who have  
2 gone through a residency program cannot be -- it's not  
3 possible for them to commit malpractice then that means that  
4 there's no such thing in this country as an obstetrician  
5 committing malpractice because they all go through residency  
6 programs. They're trying, they're trying to give  
7 obstetricians a license to do whatever it is that they chose  
8 to do, right or wrong, without a confession we'll go in there  
9 and swear under oath that everything that doctor did is  
10 absolutely clear that that doctor met the standard of care.  
11 Everybody can see that that doctor didn't do anything to cause  
12 this injury. Those guys get that from assuming there's no  
13 confession, there's no wrong. If that's how doctors get  
14 evaluated, then doctors face no consequences for messing up  
15 people's lives. This is about accountability. Do you want to  
16 hold a doctor accountable when they ruin somebody's arm for  
17 the rest of their life? Do you want to hold somebody  
18 accountable when they break the safety rules, when they take  
19 shortcuts in the safety rules and that causes harm to this  
20 baby? If you don't enforce safety rules ---

21 **MR. HOOD:** Objection, Your Honor. The applicable  
22 standard is the standard of care as opposed to safety rules  
23 that he's alluding to.

24 **MR. GRAHAM:** I'll rephrase.

1           **THE COURT:** Okay, thank you.

2           **MR. GRAHAM:** If you don't enforce the standard of care  
3 safety rules then what good are they? They're nothing if  
4 they're not enforced. My chart keeps flipping away. We've  
5 got -- it's hard to do math even when I'm not standing in  
6 front of people. Somewhere in the ballpark of 14,000 - 15,000  
7 babies, they all had maternal pushing. They all had uterine  
8 contractions. Of all these shoulder dystocias with the  
9 characteristics that the defense say caused a three nerve  
10 injury, only one has a permanent injury. Except for Doctor  
11 Robinson, she's had the fewest number of vaginal deliveries.  
12 Doctor Pliskow, the plaintiff's expert, had roughly two and a  
13 half times as many deliveries as she did. He's had none. The  
14 defense experts have had none. Those who use traction and  
15 pull necks might dodge a bullet, they might dodge a hundred  
16 bullets, they might dodge however many it was, they might  
17 dodge 40 or 50 bullets, but every once in a while a child  
18 takes a bullet. That shouldn't happen. Doctor Robinson  
19 again, I don't want to make a big deal about his comment but  
20 it's -- for a smart man, it blew my mind. Seven days of blue  
21 skies, well we can count on another day of blue sky. I mean,  
22 I went through 50 years without an Achilles tendon rupture. I  
23 wish I could say I hadn't had one in 50 years so I'm not going  
24 to have one tomorrow. I've had some employees be early for

1 work seven days in a row. I wish I could count on them being  
2 early the eighth day and I'm not talking about Eugene. How  
3 does the past tell us what's going to tell us what's going to  
4 happen tomorrow? But, that's his way of saying this is the  
5 first time she's been shown to have a permanent injury so that  
6 means, you know, she can't have caused a permanent injury  
7 because she hasn't in the past. Well, how does anybody ever  
8 get there first permanent injury on their watch if that first  
9 one doesn't count? If the first one doesn't count because you  
10 never had one then the next one doesn't count because you  
11 never had one, and third one doesn't count because you've  
12 never had one. This blue sky stuff is such a smoke screen.  
13 I've never seen or heard such a worse smoke screen. I heard  
14 something from Doctor Chauhan I did not expect to hear. The  
15 next record I would like you to look at is actually on your  
16 screens. So, we have -- it's kind of vague, but if you'll  
17 look at the total labor, we've got a baby laboring for seven  
18 hours and I guess that's 23 minutes. So, let's see how many  
19 minutes that is altogether. Let me see. Seven times sixty  
20 gets us up to 420 minutes. Then you add another 23, you get  
21 up to 443 minutes from the start of labor until the baby  
22 coming out. Now, I don't know how far it is for a baby to  
23 make that trip from here to all the way out, but it seems to  
24 me that it's probably more than four feet. I think that's



1 rounded up. So, if we take that 443 minutes and divide --  
2 well, if we divide the 48 inches, four feet and 48 inches --  
3 if we take that many inches divided by that much time we get -  
4 - well, let me multiply that by 60 to get back up to hours.  
5 That gets us six and a half inches per hour. Doctor Chauhan  
6 says, man it's like a truck smashing into an overpass, no  
7 wonder these nerves got ripped and pulled out of the spinal  
8 cord. We've got an 18 wheeler smashing into that overpass at  
9 a high rate of speed. That far in an hour, common sense.  
10 We've got more common sense before we get to the next section.  
11 We've got Doctor Maselli pulling during that suprapubic  
12 pressure period where we've got two nurses doing suprapubic  
13 pressure by pushing down and toward the birth canal. We've  
14 got the doctor pulling for most of those 60 seconds, three  
15 seconds to get the scissors, some other number of seconds to -  
16 - I can't remember what Doctor Robinson said but there was  
17 another seven seconds or so to move from one maneuver to the  
18 other or something like that. So, of the total 60 seconds,  
19 this woman is pulling for 50 seconds. Now, it seems kind of  
20 weird, if you're applying slightly greater than gentle  
21 traction for that long a period of time, it just seems really  
22 weird to me that you wouldn't just say, do I really want to  
23 keep pulling, pulling harder, puts the baby's nerves at risk.  
24 Do I really want to choose to pull harder or do I want to

1 choose to cut the episiotomy, stick my hand in there and  
2 rotate the shoulders with my hand? It's like, I don't know, I  
3 assume most people have moved furniture like I have.  
4 Sometimes you get -- you get a bedframe or a couch or a piano  
5 or something like that, you've got a door like this, you've  
6 got a piece of furniture that doesn't fit. But, it does fit,  
7 you just have to turn it the right way. That's all these  
8 maternal maneuvers are. You've got the right shoulder stuck  
9 behind the bone, let's reach in and do the shoulder like that.  
10 If suprapubic pressure doesn't get it there, let's do it with  
11 our own hand. Better yet, let's get suprapubic pressure going  
12 that way while we do that too. This is just like moving  
13 furniture. I mean, it's not rocket science. Alright, one  
14 more common-sense thing, for 50 seconds or so we've got this  
15 woman pulling. She's says slightly more than gentle traction.  
16 We know what the parents saw. She says slightly more than  
17 gentle traction and all of a sudden, she felt a pop. Doctor  
18 Chauhan told us there's not going to be a release of that  
19 shoulder from pushing down and over like the nurses were  
20 described doing. It just makes it stuck more. So, for there  
21 to be a feeling of pop we gotta have more than slightly gentle  
22 traction. We've got to have forceful traction, the kind that  
23 the parents described. I always worry in a case like this,  
24 we've got my client saying one thing. We've got the doctors

1 saying another thing. I'm not comfortable of accusing  
2 somebody of lying, but I don't think we have to. It's human  
3 nature, human nature to figure out how to convince yourself  
4 that you didn't do anything wrong. So, she may be very  
5 sincere in saying that she didn't do anything wrong. After we  
6 screw up we can convince ourselves of all kinds of things.  
7 One thing that stuck out in my mind was when Mr. Hood was  
8 asking questions to Doctor Maselli on the stand there and he  
9 said, Doctor Maselli if you had done something wrong to cause  
10 this child's nerve injury would you step up to the plate and  
11 acknowledge it was your fault and accept the duty to be held  
12 accountable? Of course I would, of course I would. Does that  
13 reign true? I want to talk just a little bit now about burden  
14 of proof. I talked about it briefly early on. This is not a  
15 criminal case. You do not have to get from the one goal line  
16 to the one-inch line on the other end. Anything past 50-yard  
17 line is the preponderance of the evidence. All it means is  
18 more than 50 percent. I like to think of it in terms of the  
19 scales of justice. If there's one extra reason to believe our  
20 side of the case, then that means we've met our burden of  
21 proof. If it's totally balanced, then the party with the  
22 burden of proof loses, the tie goes to the defendant. But, I  
23 submit to you we're nowhere close to a tie in this case.  
24 We've got way more, I submit and it's your decision to make,

1 but I believe we've got way more than a preponderance of the  
2 evidence. We've got way more than 50 percent. But, 50  
3 percent and a fraction is all we need to prove to win this  
4 case. Now, I'd like to now go to the TV screens or computer  
5 screens, I haven't gotten a good look at them. First, I'd  
6 like you to -- do we have preponderance of the evidence?  
7 Okay, preponderance of the evidence, I just talked about. I  
8 mean, this basically says what I was just saying, greater  
9 weight of the evidence like a set of scales. Now, what we're  
10 looking at is the law of the case, is the law that His Honor  
11 is going to charge you with. He was kind enough to print it  
12 out for us so we'd be able to use it and try to help you  
13 understand it right now. So, I mean, greater weight of the  
14 evidence, more than 50 percent. Next, I'd like to talk about  
15 direct and circumstantial evidence. Direct evidence is pretty  
16 much eye-witness testimony and you've got that from the  
17 parents. You've got some testimony as well from Doctor  
18 Maselli. But, you're entitled to not only look and listen to  
19 direct evidence, you're also entitled and should under the law  
20 look at circumstantial evidence. Circumstantial evidence is  
21 just as important in the law as direct evidence. This gives  
22 you an example, I went to bed last night when I woke up this  
23 morning there was six inches of snow on the ground. I didn't  
24 see a single flake of snow fall last night but I've got some

1 pretty convincing evidence that it snowed a lot last night.  
2 The nerve damage on the art that we did for you, the drawing  
3 there, that's like the snow on the ground. Do you really  
4 think you're going to get that from a baby going six inches  
5 per hour down through the birth canal? If that happened then  
6 why would we give Pitocin? Why would doctors use vacuums?  
7 Why would they use forceps? Anything to pull the baby down  
8 like that would risk life changing injury if they really  
9 believed that's how the injury occurs then it would be totally  
10 wrong, and we've got an image of the nerve damage. Next,  
11 credibility of witnesses is your job. You know, I don't want  
12 to insult you by telling you that I'm going to tell you who's  
13 got the more believability; that's your job. You know, you've  
14 got so many more eyes than I do. You've got so many more  
15 brains than I do. You can look at these guys, watch their  
16 body language, watch their contradictions, watch their --  
17 watch how they go sometimes like Doctor Chauhan from being one  
18 of the most confident and authoritative men on the planet  
19 until he starts hearing my questions about is pushing really  
20 pulling, how do we define traction, and that sort of thing.  
21 But, it's your decision to make about credibility. I  
22 personally was very much affected by the parents testimony. I  
23 don't know if you were or not. It's all up to you. Who do  
24 you believe? It's all up to you. Expert witnesses, the Judge

1 told us many times about expert witnesses so I'm not going to  
2 belabor this point. But, if there's special knowledge in a  
3 field that most of us, certainly me, don't know that much  
4 about then somebody like me or somebody in the audience is not  
5 allowed to just go up there and testify to how to deliver a  
6 baby, how do you operate on a nerve. All of that stuff we  
7 need expert witnesses for that, and this charge tells you  
8 about that. You decide credibility for expert witnesses just  
9 like you do for fact witnesses. The next charge here is  
10 evaluation. A patient is entitled to a careful evaluation.  
11 The doctor must be diligent, the doctor must use learning,  
12 judgment and skill that's usually approved in practice by  
13 doctors of ordinary learning under the same or similar  
14 circumstances. We believe we've proven that that hasn't  
15 happened, but your decision. On the next page, part two,  
16 there's a discussion here about a physician does not guarantee  
17 or insure the correctness. We're not asking anybody to  
18 guarantee or give us assurance that everything they do will be  
19 perfect. All we're asking for is that they live up to what  
20 the law requires, standard of care, it's a safety compliance.  
21 That's all we want, we've didn't get it. A physician who  
22 holds himself or herself out to be a specialist, an  
23 obstetrician, is bound to bring to those duties the degree of  
24 learning, skill ordinarily possessed by other obstetricians

1 under those same or similar circumstances. Standard of care,  
2 you've heard a lot about standard of care. Standard of care  
3 just means, in the law -- I mean, you'll hear it from His  
4 Honor but I've got the advance sheet here so I've got a pretty  
5 good idea what he's going to say. Standard of care basically  
6 means that when the doctor treats a patient, the law doesn't  
7 require perfection, but the law does require that the doctor  
8 use that degree of knowledge, care and skill, ordinarily  
9 possessed and used by doctors in good standing in the doctors  
10 field of medicine under the same or similar circumstances. I  
11 believe we've done that. It's up to you to make that call.  
12 Breach of the standard of care, I was talking about the  
13 standard that we must also prove, a breach or a departure from  
14 that standard of care. And when it came time, do we pull  
15 harder or do we stop pulling and go inside? There was a  
16 decision to be made, a choice to be made there. Doctor  
17 Maselli admitted she was in control of every step. It was up  
18 to her to choose how hard to pull. It was up to her to choose  
19 do I stop pulling and do an internal maneuver. Now, one  
20 interesting thing, you remember Doctor Chauhan said, normally  
21 and in his practice you would never cut an episiotomy unless  
22 you wanted to put your hand inside. Makes sense. The bone is  
23 blocking the shoulder, not the soft tissues. Cutting soft  
24 tissues doesn't help the baby come out. In this case,

1 different from most, after the McRoberts position with her  
2 legs, the doctor cut an episiotomy right then before she did  
3 the suprapubic pressure. Wonder why? Wonder why? Could it  
4 be that she wanted extra room for her hands so she could start  
5 pulling on that baby's head before it was all the way out. Is  
6 that consistent with her testimony or with the parent's eye-  
7 witness testimony? Think about that, your decision. And,  
8 there's a doctor's mistake or error is not a good enough  
9 reason for us to win this case. But, don't be misled by that  
10 language. That doesn't mean that her mistake gets her off the  
11 hook. It just means that a mistake alone doesn't matter.  
12 But, you have to act within the standard of care. If you  
13 don't act within the standard of care, that's a mistake -- I  
14 mean, that's a wrong that you are responsible for as a doctor.  
15 You're going to hear things about the difficulties and  
16 uncertainties in the practice of medicine, the  
17 unpredictability. But, you know from pretty much all of the  
18 testimony finesse not force, finesse. Don't go around  
19 stretching the baby's neck. Don't go around bending it down  
20 toward the floor or off to the side or bad things will happen  
21 to those nerves. There's a statement here that if there's  
22 more than one approved method then Doctor Maselli can chose  
23 which method she wants. And I'm sure Mr. Hood will say that's  
24 a key issue in this case. The only difference is whether



1 you're allowed to use gently and stop, or the defenses  
2 slightly more than gentle and stop. She said she did slightly  
3 more than gentle, if that's true then she would fall within  
4 those two schools of thought so to speak. But, if she pulled  
5 hard enough to stretch that baby's neck, there's no school of  
6 thought that says that's okay. That's very much not okay.  
7 Now, you're going to hear -- I mean, you already heard  
8 testimony about different theories about what causes this  
9 injury. The defense says, you know, the baby lost the  
10 lottery. He was born in the wrong birth canal, with the wrong  
11 uterus and mama not pushing right, even though she had drugs  
12 that Doctor Maselli put in her body to make her push stronger  
13 and more frequently. But, somehow it's the uterus' fault.  
14 That's one theory. The other theory is you stretch the baby's  
15 neck, you bend the baby's neck forcefully, I mean, what  
16 happens when you watch movies when somebody's neck gets  
17 stretched? Bad things happen, maybe they happen to bad guys  
18 but you know what I mean. So, those are not two schools of  
19 thought that matter. I mean, theories about causation don't  
20 allow the defense to say, oh we pick this school of thought.  
21 They get to pick the school of thought if there's more than  
22 one school of thought about how to act, gentle or greater than  
23 gentle. But, they had no benefit from stretching the neck or  
24 from saying it was the uterus' fault. I believe I may be

1 getting near the end of my time so let me just run through  
2 this. We've got some issues in this case, frankly, the  
3 hardest issue for you guys to decide is probably not about  
4 what I've talked about so far, standard of care, breach,  
5 that's what caused the damage. There's a special rule that  
6 comes into play about whether there is an emergency, certain  
7 kinds of emergencies that give us a higher standard that we  
8 have to prove. The law talks about genuine emergencies. I  
9 don't what a fake emergency is. I'm struggling to figure out  
10 what that word genuine is in there for. One reason I think it  
11 might be in there is to make a difference between the doctors  
12 trained to deal with this kind of emergency and say a  
13 dermatologist who's at a football game and somebody has a  
14 heart attack and she doesn't know how to treat heart attacks.  
15 I mean, that's a genuine emergency in the way I look at it.  
16 But, there's also an issue, they've got the burden of proving  
17 it's an emergency, absence of medical stability, immediate  
18 threat of harm. I'm not going to talk too much about  
19 immediate threat of harm. It depends on what the word  
20 immediate means to you. If it means now then there was, if it  
21 means in five minutes, then there wasn't. But, very healthy  
22 baby going into the one minute, very healthy baby coming out  
23 of the one minute. How can that not be medical stability? We  
24 keep hearing from the defense the threat of potential future

1 harm means there was medical instability. Medical instability  
2 has to do with heart rate, pulses, you know, if you have a sky  
3 rocketing temperature. I mean, those are the things that add  
4 up to medical instability. All they've got is to say there's  
5 a threat that something bad might happen. Well, that's in the  
6 different part of the law. Immediate threat of death or  
7 serious bodily injury is a different part of the law. Medical  
8 stability is not about a threat of harm. It's about how is  
9 this baby doing now. They put in no evidence about how this  
10 baby is doing now in terms of any medical instability.  
11 Proximate Cause, we have to prove that the injury wouldn't  
12 have happened without the negligence and that it was  
13 foreseeable. We know it was foreseeable. She said it's  
14 important not to do those things because it puts the baby in  
15 danger of nerve damage. Actual damages, I need to touch on  
16 briefly. We're entitled to get money to compensate  
17 J'American, whose filed for various items of damages that His  
18 Honor will tell you about. The injury itself, the  
19 disfigurement, having to walk around like this and be laughed  
20 at by other kids, the psychological scarring, the pain and  
21 suffering, physical and emotional, the loss of enjoyment of  
22 life, past and future medical expenses, reduced earning  
23 capacity, all those things we're entitled to and perhaps more.  
24 But, I'll come back to that next time I have a chance to talk.

1 But, you're going to be asked questions about a number of  
2 these other items. I do want to touch briefly if I have time,  
3 and apparently I have to talk fast. The jury verdict is in  
4 front of you. The first page here just says, you know, you  
5 can rule for us or them. Then we get to the verdict form  
6 itself. There's several questions here and your verdict has  
7 to be unanimous. But, number one, did the plaintiff prove a  
8 preponderance of the evidence? Preponderance is more likely  
9 than not, anything over 50 percent. Did we prove by that  
10 standard that defendant deviated from the standard of care?  
11 We ask that you fill that in yes. Number two, did we prove by  
12 that same standard that the defense deviation was approximate  
13 cause? We ask that you fill that in yes. Next, did the  
14 defendants prove by a preponderance of the evidence that the  
15 events of J'American's delivery constitute a genuine medical  
16 emergency? Everybody except Doctor Pliskow says a horrible  
17 genuine emergency. Doctor Plisko says, it starts out as an  
18 emerging emergency. I mean, that's the root word of  
19 emergency, it emerges. It's an emerging emergency at first,  
20 it becomes a genuine emergency once you really have to act  
21 fast. You know, if four minutes, five minutes have gone by,  
22 I'm not going to take this case. I think that's a genuine  
23 emergency. One minute? Perfect health before and after.  
24 Then we've got the next page, did the defendants prove that

1 J'American was not medically stable? All they proved, or all  
2 they tried to prove is that there was uncertainty about what  
3 might happen if the stuck shoulder stayed stuck too long. It  
4 didn't. He was in great health going in, great health a  
5 minute later. To me that adds up to medical stability, so we  
6 ask that you answer that one no.

7 **THE COURT:** You get another opportunity, so I would go  
8 ahead and wrap it up when you could, please.

9 **MR. GRAHAM:** Thank you, Your Honor.

10 **THE COURT:** Yes, sir.

11 **MR. GRAHAM:** That's it for now.

12 **THE COURT:** All right, Mr. Hood, I extended him a little  
13 bit of a leeway. I'll extend you the same courtesy if  
14 necessary.

15 **MR. HOOD:** Thank you, Your Honor. Can we get maybe a  
16 stretch break while we rotate the equipment?

17 **THE COURT:** Sure, we'll take a two-minute break.

18 (Jury exits courtroom at 2:33PM)

19 (RECESS)

20 **THE COURT:** Okay, bring the jury in. Thank you very  
21 much.

22 (Jury enters courtroom at 2:43PM)

23 **THE COURT:** Mr. Hood.

24 **MR. HOOD:** Your Honor, may it please the Court?

1           **THE COURT:** Yes, sir

2           **MR. HOOD:** Mr. Foreman, ladies and gentlemen of the jury,  
3 good afternoon. Let's try that again, good afternoon.

4           **JURY:** Good afternoon.

5           **MR. HOOD:** Alright, I said at the beginning we'd have a  
6 week and I wanted you to stay with me. We've got a little bit  
7 of time here that I want to wrap up what I think the critical  
8 evidence is and why I think Doctor Maselli is here telling her  
9 side of the story. I won't take the 45 minutes, but I do want  
10 to share with you what we think that are critical issues that  
11 explain what happened, how the emergency was managed, and why  
12 Doctor Maselli complied with the standard of care. The first  
13 thing I want to start with is a concept that a bad outcome or  
14 a bad result doesn't mean that somebody did something wrong.  
15 If that were the case, there'd be no reason for lawsuits and  
16 the Judge will charge you something to that effect. In this  
17 case, like all other cases, the plaintiff must prove the  
18 elements of their claim to your satisfaction. We've talked a  
19 lot throughout the course of the week about things that we  
20 agree with. We all agree that the prenatal care was good. We  
21 agree that the emergency, the shoulder dystocia was  
22 unpredictable and unpreventable. You may ask, if everyone  
23 agrees to it why do I keep asking people these questions?  
24 Well, when you start to look at whether an event is

1 predictable or preventable it has a significant impact on  
2 whether it constitutes an emergency and whether it constitutes  
3 a stable situation. And, it also has to do with the frame of  
4 mind and I'll talk about that in a little while as we talk  
5 about the recognition and the management of this shoulder  
6 dystocia. The recognition and diagnosis of a shoulder  
7 dystocia, by all accounts was appropriate. What does that  
8 mean? That means that you heard Doctor Maselli come down from  
9 the stand and testify about what transpired to lead her to  
10 conclude that the shoulder was stuck. That conclusion was the  
11 head was delivered, her hands were on the baby's head, counted  
12 to 10, and the shoulder didn't deliver. At that moment, as  
13 you heard her testify, she called -- told the nurse to go get  
14 help. So, it was appropriately recognized. Why does that  
15 matter? Because in an emergency where every second counts,  
16 the sooner that you recognize it, the better. The sooner that  
17 you identify it and start to address it, the better. And  
18 there's no criticism here, but it goes to whether she knows  
19 how to identify and handle these situations. We talked about  
20 APGAR, cord gases, in part because the plaintiff's contention  
21 is that if it's good going in and it's good coming out  
22 therefore the baby was stable the whole time. Well, I'm going  
23 to talk about that in a little more detail later. But, we  
24 recognize and everybody agrees that the APGAR's are good, the

1 cords are good, all the strips are fine. To us the good news  
2 is that reflects a management that avoided the train wreck.  
3 Pitocin, we just heard for the first time, not from a medical  
4 doctor, not from a board certified OBGYN that using Pitocin in  
5 this case somehow contributed or caused something. We just  
6 heard Mr. Graham's explanation for why he's been asking people  
7 Pitocin questions for five days. Well, instead of asking  
8 those experts to extrapolate what it means, we just heard his  
9 explanation. Does it have anything to do with the fact that  
10 there's a shoulder dystocia? No. I think what he's arguing  
11 is if you're using Pitocin to speed up the contractions and  
12 make them more forceful to speed up that first stage of labor  
13 then it must not be moving fast enough for the accident to  
14 cause harm. There's no argument about the use of Pitocin or  
15 that it causes or contributes in any way to a shoulder  
16 dystocia or to a brachial plexus injury. And then the last  
17 expert, Doctor Chauhan, was asked all of these questions about  
18 C-Sections. About the size of an opening for a C-Section and  
19 -- I don't know what that had to do with anything. There was  
20 no C-Section needed in this case, all of the doctors agree to  
21 that. There are cases where C-Sections are necessary, this  
22 wasn't one of them. Now, there are three big things that we  
23 do disagree with and I highlighted these at the beginning of  
24 the week. The standard of care, and that's really where I



1 want to start talking this morning -- or no longer morning,  
2 we're well into the afternoon. I want to talk about the  
3 standard of care. The standard of care is what a reasonable  
4 doctor would do in the same or similar circumstances. I told  
5 what I think will be something consistent with what the Judge  
6 will be charging you. He will send back with you a copy of  
7 the jury charge. If for any reason the words I'm using don't  
8 match up with his, I'm sorry they were supposed to. His words  
9 control, not mine. What would an ordinary doctor do in this  
10 field, in this situation? Well, that's why we bring you  
11 experts; to say, well from my perspective this is what I think  
12 a reasonable doctor should do. And from my perspective this  
13 is what I think a reasonable doctor should do. But, one thing  
14 that the law requires in evaluating the conduct of Doctor  
15 Maselli by you is that you don't use hindsight? Why is that?  
16 Because hindsight is 20/20, it's perfect vision, Monday  
17 morning quarterbacking, all of those sorts of things. When  
18 the outcome is known, the reaction changes on how you should  
19 do something. We all know plenty of examples in life where  
20 hindsight is 20/20. But, the law requires that we evaluate  
21 physicians, like Doctor Maselli, based on what they do at the  
22 time they were performing the treatment. If that only made  
23 sense, it only made sense to say in this environment, in this  
24 situation, in this moment the one minute what do you know?

1 And based on that knowledge were your actions appropriate? In  
2 the beginning of the week I said, there are two sides to every  
3 story and I submit to you there are two sides to this case.  
4 There are two sides, very different in this case; and before I  
5 called Doctor Maselli one could reasonable conclude form the  
6 story that we had heard that Doctor Maselli showed up with a  
7 Starbucks cup in her hand, peaked around the door and then  
8 came back in to deliver the baby. Well, that's not a very  
9 good impression of somebody. Not somebody that's delivering  
10 your baby, the most precious thing that you have. But, what I  
11 put up was exhibit number 22. Exhibit number 22 is a detailed  
12 log of all the interactions, not just with Doctor Maselli, but  
13 anesthesia, with the nurses, the changing of the nurses, all  
14 of their interactions. And I made this timeline, not to show  
15 you how long that stage of labor was, not to show you that it  
16 took six hours to make the progress, but to show you that  
17 Doctor Maselli was called, she was paged at 09, she calls back  
18 two minutes later and within 30 minutes she's at the patients  
19 bedside. She's not a Starbucks, she's not drinking coffee,  
20 she's at the patient's bedside. And she is again, one, two,  
21 three, four, five, six, seven, eight times in six hours and  
22 she never leaves. That's the other side of that story. And  
23 we heard interaction about frustration and the doctor just  
24 wasn't showing up and wasn't showing up. And it maybe that

1 some of these were forgettable events and they just don't  
2 recall them, and that's fine. But, the medical records, and  
3 Doctor Maselli reflect all of these interactions and each one  
4 of them is a moment in time where she is identifying what's  
5 happening, she's observing, watching the progress, there with  
6 the patient, ready to deliver. And you'll see in exhibit 22,  
7 these are all of the excerpts that you can see in front of you  
8 that correlate with my flip chart. So, Doctor Maselli -- the  
9 reason I went through and asked her all of these questions  
10 about her residency and her training and that sort of thing is  
11 to give you a sense of not only the science of medicine, but  
12 the art. The art of medicine is something that can't be  
13 taught in a book, that's the residency program. That's the  
14 four years of intensive on the job training where they put  
15 hands on your hands and where she was a chief resident and she  
16 taught other residents how to do and what to do. And what you  
17 heard was 20 years experience. You heard about her 3,000  
18 deliveries, 30 other shoulder dystocias. And, if you believe  
19 the plaintiff's theory in the case, which is that there were  
20 four hands going at one time, nobody was doing McRoberts, and  
21 Doctor Maselli just decided to pull harder, then one would  
22 think that she would have a string of problems behind her and  
23 she doesn't. And the reason she doesn't is because she was  
24 trained like every single obstetrician, that you don't place

1 lateral traction on a baby's head for any reason. You know,  
2 we spent so much time talking about traction, axial traction,  
3 lateral traction. And why is that? Because the word traction  
4 is not a bad word. It is usual, normal, happens in every  
5 delivery. But, then when you say, it's a pulling force, well  
6 if it's usual and what you do in every delivery and that's  
7 what you're trained to do; is it bad? No, it's not bad. But,  
8 we're going to call it a pulling force. Does that mean you're  
9 stretching the baby's neck every time you deliver a bay, of  
10 course not. Of course not. So, we talk about the training,  
11 we talk about all of these things to try to provide some  
12 context to what you do in these situations. And we saw from  
13 Doctor Maselli, she recognized it, she's got experience with  
14 it. And so what we look at in this visual you can see here,  
15 it's just a picture of a baby with a shoulder that's stuck.  
16 And the reason I wanted to show that, in part, we talked about  
17 this pubic symphysis and I don't know what the measurements  
18 are, but common sense can tell you how many fists can cover  
19 the pubic bone. Plaintiff says, well the nurses indicate  
20 there are two of them doing it. The nurses don't remember.  
21 Doctor Maselli is telling she sees one hand being applied.  
22 Maybe one nurse did it and then the other. We know from the  
23 medical records that McRoberts was performed. We know that  
24 they did suprapubic pressure. We know that. But, what we've

1 heard is their theory and their theory is that the nurses and  
2 Doctor Maselli have worked together to fabricate the records  
3 and they're just covering their own tail, because human nature  
4 is that we just convince ourselves whatever we need to. That  
5 was a little indignant what she was cross examined about  
6 whether she had conspired to change these records and things  
7 like that. And I talked about my friend from the Bayou and  
8 throwing the skunk on the table. Well, the reason for that is  
9 if you believe someone has truly altered the records, the time  
10 to confront them is when they're under oath. This is a great  
11 balancing right here, the witness stand. Nowhere to go and  
12 you're stuck answering whatever questions the other side poses  
13 you. Not only are you stuck, but there are 12 or 14 people  
14 who are judging your reaction. And so you have someone like  
15 Doctor Maselli who's spent 20 years in the community, she's  
16 spent 20 years in the hospital system. She's been the head of  
17 the perinatal, which is the obstetrical group for the  
18 hospital, winning with her partner a Lewis Blackman Safety  
19 Award. And the idea that she would fabricate a story to make  
20 herself feel better or exonerate her for a lawsuit is simply a  
21 bridge too far. And if one were to be inclined to tell  
22 stories to help themselves, would you expect them to check  
23 moderate controlled or would you expect them to check usual?  
24 I mean, if they're going to make a story up, don't make up a

1 bad one. Make up the best story you can. She didn't do that.  
2 She didn't do that because she didn't do anything wrong. We  
3 heard about observations and the differences that people had.  
4 But, we did not hear about Doctor David Haseltine, an  
5 independent pediatrician who's in the room. He's in the room  
6 not because Doctor Maselli wants him there to help, but  
7 because of the meconium staining issue. They needed a  
8 pediatrician, he's one of the ones they call, he was there.  
9 What were his observations? Nothing unusual. If no one's  
10 ever heard of a delivery where four hands are going in  
11 suprapubic pressure, one would expect that a pediatrician who  
12 attends birth to take care of babies afterwards would  
13 remember. Certainly, it wouldn't be complicit in some kind of  
14 cover up. The reason we talk about permanent versus  
15 temporary, most of the injuries are temporary which is good.  
16 And most of them resolve within a year. So, if at the time  
17 that you're preparing this record at 8:00 in the morning, or  
18 whatever time it was, 8:30, if you don't know that this is a  
19 permanent injury why would you be concocting a story if the  
20 odds are within a few months hopefully everything will return  
21 back to normal? It just doesn't add up. We heard about  
22 traction. We heard about traction from Doctor Adler and we  
23 heard about it from Doctor Pliskow and they said two different  
24 things. Now, Adler was clear, he's wasn't offering standard

1 of care testimony, and what he said, Adler said, was lateral  
2 traction. What Pliskow, the OB said, was just traction. He  
3 wouldn't say whether it was lateral or not and he couldn't say  
4 whether it was lateral or not because there was no evidence  
5 from the medical records, the observations or any other source  
6 that Doctor Pliskow identified that would give a reason to  
7 conclude that there was lateral, which is no not to do,  
8 traction. And we heard that axial traction, the normal  
9 process according to Doctor Adler, does not stretch the  
10 nerves. That's why using normal axial traction is the  
11 accepted way to deliver babies all over the world. And then  
12 Doctor Pliskow, and I asked him, I said, do you have four  
13 maneuvers, is this the forth maneuver? And he said, it was  
14 and that's why I made the second flip chart with Doctor  
15 Maselli. Leave it up to me to make a list of four things, and  
16 you'll remember I said, geez I just made a list of four things  
17 and there are only three maneuvers. So, we drew the box  
18 around it. This is the identification shoulder dystocia. How  
19 many maneuvers were there? There were three. How many  
20 maneuvers are documented here? There are three. How many  
21 maneuvers were discussed? There were three. According to  
22 Doctor Pliskow, to get to his theory of the case the McRoberts  
23 didn't work, suprapubic didn't work, the episiotomy didn't  
24 work, so move number four is just pull like crazy. Just pull,

1 pull harder, decide not to do internal maneuvers. The one  
2 thing OB's know not to do is that. That's what they're  
3 trained to do. Why? Because we refer to our training in our  
4 practice when we're confronted with an emergency situation,  
5 when we're confronted with a hostile situation you refer to  
6 your training. So, according to Pliskow in his mind, not in  
7 the evidence, that explains the whole case. But, then you  
8 hear Doctor Maselli talk and she told the whole delivery  
9 process. We brought in the mannequin. I mean, we've been  
10 talking about two dimensions for four days, or at that time it  
11 was three days, axial, lateral, this way, that way,  
12 suprapubic, towards this, towards that. Why don't you just  
13 show us what happened? And it reminds me of a 1950's country  
14 music guy, his name was Harlan Howard, he said, all you need  
15 for a good country music song is three cords and the truth.  
16 And so I listen to country music and I listen to some of the  
17 songs because some of them have things that sort of resonate.  
18 And one of the songs that came to mind about this case is a  
19 song called In Color, the musicians name is Jamey Johnson.  
20 It's about 10 years old, won a Grammy. In that story it's a  
21 ballad and what he's writing about is a grandfather who's  
22 describing to his grandson pictures from his life. He's got  
23 pictures from his time in World War Two and he was describing  
24 his tail gunner. He's got pictures of him getting married.



1 He's got some other pictures. And the chorus in the story, or  
2 in the ballad is that a picture's worth 1000 words but you  
3 can't see what these grey shadows are hiding. You should have  
4 been there and seen it in color. That's what the  
5 demonstration was, so you could see it in color. So you could  
6 see not the two dimensional tilting of the head this way or  
7 that way. But you could see in live color what was going on,  
8 why it was going on, and how it was going on. Doctor Robinson  
9 talked about the description. And it was interesting with  
10 Doctor Robinson having been in here for Doctor Maselli's cross  
11 examination and it was sort of like a bore. You know, he  
12 hears a test case. She's been explaining her case and now  
13 she's having to field questions from a hot panel that is cross  
14 examining her. And Doctor Robinson gets to observe and hear  
15 her answers and her description of what happens. And what is  
16 his response? Is what she did appropriate? Completely  
17 appropriate. Now, Doctor Chauhan, he wasn't here for that  
18 testimony but he reviewed the testimony before, the  
19 depositions, like the other experts. And he too agrees that  
20 in this circumstance what was described by Doctor Maselli on  
21 the stand, on the demonstration, in the medical records is  
22 consistent with the standard of care. It's a one minute  
23 emergency, one minute. This is, I believe, out of exhibit 22  
24 where it talks about the delivery of the head. And as I think

1 about a head coming out, if you just sort of step into the  
2 delivery room, there's no reason to anticipate anything  
3 untoward happening. Here comes the head, we expect the body  
4 to follow, hopefully the baby's going to be healthy, 10  
5 fingers, 10 toes. And the boom, you have an emergency and  
6 it's what I call the two minute drill. It didn't take two  
7 minutes in this case, it took about a minute. But, why is it  
8 called a two minute drill? If you ever played football you  
9 know that at the end of practice, every practice you're going  
10 to do what they call a two minute drill. The reason that you  
11 do a two minute drill, so when you get into the game if you  
12 have the ball and you need to score at the end of the game you  
13 know what to do in those circumstances. So, first team  
14 offense and first team defense go out there and practice a two  
15 minute drill. Not once, not twice, but every practice. It's  
16 like drilling in the military. The reason for that and the  
17 reason for that repetition and experience is so when the  
18 moment happens, you know exactly what to do. We talked about  
19 a minute and the reason I repeated when Doctor Maselli  
20 testified; one, two, three, four, five, six, seven, eight,  
21 nine, ten was because there was a game being played with the  
22 amount of time and that there was constant traction being  
23 applied. That's not what the testimony was. The head came  
24 out. She gave her 10 seconds of pushing, the shoulder didn't

1 come, stop, call for help. She's holding the baby, help comes  
2 in, they flex the legs back. Alright, here we go; one, two  
3 through 10. That doesn't work. She stops, reaches around,  
4 grabs the tool, cuts the episiotomy, puts it back, alright  
5 lets go, ten. Now, we do suprapubic pressure. They do it,  
6 she feels a pop and delivers. I did not want there to be any  
7 uncertainty as to what was exactly happening, for what  
8 duration, and the time was counted out loud for that reason.  
9 And so what we know is that the nurses and the doctor all used  
10 their training, their practice, and their preparation to  
11 execute the maneuvers necessary to effect delivery. And it  
12 worked. Suprapubic pressure worked. How do we know? With  
13 her hands on the baby she describes what she felt as a pop and  
14 she said, push, push, push and she helps deliver the baby.  
15 And so for a while there was a cross examination about, you  
16 know, maybe it was this point, and maybe it was that one, and  
17 maybe you remember me going like this. (Snapping) Well, the  
18 reason I was doing that was to try to instill that this is all  
19 happening in a moment of time. And what we're doing where  
20 you're breaking it up in still frame is you're back in two  
21 dimensions. You're still looking at it in black and white.  
22 You're not looking at it in color. And when you do, you  
23 realize that the team, the nurses, the doctor, they all  
24 executed and because they did thank goodness the train wreck

1 was avoided. Now, I'm not saying that this young man did not  
2 suffer injury. I told you that the very first day. There's  
3 no question about that and I'll talk about that in a minute.  
4 Now, I said earlier in the beginning of the case that the  
5 plaintiffs were trying to put words in Doctor Maselli's mouth.  
6 That they were trying to claim that this description was  
7 excessive lateral traction. Well, when their expert describes  
8 a forth maneuver, when there is no testimony to support it  
9 that is different. That's not wordsmithing, that's his  
10 interpretation of what had to have happened because the only  
11 other plausible explanation is that she did what she described  
12 and what's recorded. They want to take the concept of  
13 moderate control and turn it into something that is excessive.  
14 You heard about the spectrum. I mean, I don't know that there  
15 are two words that could be any more different, moderation and  
16 excess. I haven't heard a single obstetrician suggest that  
17 moderate controlled traction is excessive except for Doctor  
18 Pliskow who concluded that that's what it must have been. And  
19 Doctor Haseltine, if one side of the story is that there was  
20 twisting, pulling and jerking and you have someone who is  
21 sitting on a stool, reaches around, grabs a tool, hands here  
22 and you have someone else who is in the room it is important  
23 to know what that person's observations were. That's why we  
24 brought you Doctor Haseltine. I submit to you that when you

1 look at this case, this two minute drill that was executed,  
2 this is exactly the way in which a delivery is supposed to  
3 happen when you encounter one of these emergencies. The  
4 problem is we cannot prevent all injuries.. And there's  
5 nothing I can do or say or anyone else can say that's going to  
6 say there won't be any more injuries. There won't be any more  
7 birth traumas. Nobody can say that. That's why I asked our  
8 expert, can you guarantee a healthy baby? Of course not.  
9 Nobody can do that. Despite all of our advances, the rate of  
10 this happening across the country and around the world has  
11 stayed flat, that's what the articles say, that's what the  
12 model graph says. We have not really improved our results  
13 from the brachial plexus injuries, it's perplexing. If you've  
14 got all of the increased training, everybody knows about it,  
15 why aren't the numbers going down? So, let's talk about that.  
16 That's approximate cause. That's the second part of this case  
17 and that's the second question that will be on the verdict  
18 form. And this was the two schools of thought, I talked about  
19 the old school and new school. Like the earth is flat and now  
20 we realize that it's round. But, this isn't where one school  
21 of thought completely replaces another. When they figured out  
22 that the earth was round and it became uncontroverted, which  
23 took a while, nobody went back to thinking okay it's really  
24 flat. In this case, it has never been disputed that excessive

1 lateral traction can cause brachial plexus injuries. Nobody's  
2 ever disputed that. But, what I thought was really  
3 interesting about this was the way that Doctor Robinson  
4 described the evolution of medical literature and what he  
5 says, when we aren't experiencing in the field what we think  
6 we should be experiencing and what we're reporting, we have to  
7 rethink our medical knowledge. We have to revisit our current  
8 thinking. So, current thinking at the time must be physician  
9 induced excessive traction. But, hey, we're seeing all of  
10 these permanent injuries with cesarean sections, no shoulder  
11 dystocia, no traction at all. If there's no traction at all  
12 what's the explanation? So, they go back and rethink it.  
13 And they rethink it and they come up with the book and we  
14 talked about this all week. We brought you the author of the  
15 book who's read every article on shoulder dystocia that's ever  
16 been published in the English language. Not some, all. He's  
17 got 345 articles that he's published. He's clearly versed in  
18 the subject matter. But, we brought him not to talk about all  
19 of the other organizations that endorse this, we brought him  
20 to talk to you about why and how these things can happen. And  
21 that was maybe the second or third question John asked Doctor  
22 Chauhan, well if Doctor Maselli didn't do it, what happened?  
23 And he explained the constellation of forces that were in  
24 effect. And the fact that all of these folks publish it,

1 subject themselves to peer review, it's almost five years old  
2 and it's still, as of this month, the most current thinking in  
3 obstetrics about the nature and causes of these injuries,  
4 confirms that you can experience and there are unfortunately  
5 cases of permanent brachial plexus injuries as a result of the  
6 natural forces of labor and delivery. Doesn't mean that there  
7 are millions of them, the rate of incident doesn't change, but  
8 that explains why it's flat. And on the concept of  
9 approximate cause, Doctor Duchawney -- and I apologize that he  
10 wasn't here live, you know he had a previous scheduled thing,  
11 and it's hard to tune in, especially at 4:00 in the afternoon  
12 on a video. But, one thing he said was just crystal clear,  
13 that's why I put quotes around it; what caused the injury was  
14 a shoulder dystocia and what he's talking about is a movement  
15 down the birth canal running into the bone. And no one's  
16 suggesting that it's the speed of -- I guess that this is like  
17 a car accident, and I don't think that Doctor Chauhan was  
18 eluding to. And I'll come back because I have a picture of a  
19 truck that I want to show you. We talked about Doctor  
20 Robinson. I noted under Doctor Robinson, maternal forces.  
21 But I didn't note and what I talked with him significantly  
22 about were all of these internal maneuvers and the risks  
23 associated with those. Make no mistake that all of these  
24 maneuvers, as confirmed by the experts, pose risks to the

1 baby. None of them is risk free and all of them place strain  
2 of the brachial plexus, the shoulder. And so while you can  
3 say, it's not rocket science, you can just spin the shoulder  
4 around, I submit it is much, much more complicated than that.  
5 And so what Doctor Chauhan was talking about on the overpass,  
6 the analogy is talking about two things, one in motion, one  
7 stationary. And the traction force that's being applied is  
8 when the stationary object doesn't budge and the object in  
9 motion does. There's a continuation of forward progress or  
10 momentum until it arrests. That is pulling the head away from  
11 the shoulders. That is the pulling force. That is traction  
12 related to the delivery. That's what the analogy is about,  
13 not to suggest that this was high impact rate of speed or  
14 something along those lines. So, based on the overwhelming  
15 body of literature, we believe and the experts have shown that  
16 these injuries can occur. They can occur at the absence of  
17 lateral traction and the absence of something a physician did  
18 and explains why in a case where you have these maneuvers  
19 performed and a moderate controlled with suprapubic pressure  
20 release the shoulder, you still have a permanent injury. The  
21 last part of the case I'm gone talk about is this emergency  
22 statute, and I'm not asking you to read that. That is going  
23 to be read to you and provided by the Court. But, I said the  
24 train wreck a few times and I want you to picture this with me



1 if you would. If you were standing in a tunnel and there's a  
2 light at the end of the tunnel and there's a light behind you.  
3 You know the light behind you is bearing down, you can hear it  
4 coming and it's a train. The light is getting bigger. You do  
5 not know how far that train is away. You don't know how fast  
6 that train is moving. You don't know how far the end of the  
7 tunnel is and you don't know how quickly you can get there.  
8 That is a situation that an obstetrician faces when she has a  
9 shoulder dystocia. You are in the middle of an emergency and  
10 you don't know the answer to the key variables that involve  
11 avoiding a catastrophic brain injury or death, and every  
12 single second counts. Every single second. It doesn't  
13 matter, if you don't know how far you have, you have to think  
14 in terms of the state of mind. When you're looking in this  
15 situation do you consider that to be a genuine medical  
16 emergency? I sure hope so. I sure hope all OBGYNs consider  
17 it a genuine medical emergency. We've heard about stability  
18 and you'll hear about that, it's in the jury charge. Well, I  
19 submit to you if a baby's head has been delivered and his  
20 shoulders aren't and he can't breathe because the birth canal  
21 is restricting the lungs, the placenta is not providing the  
22 oxygen, and the baby can't deliver itself because it doesn't  
23 have oxygen; that is the definition of unstable. And if you  
24 don't know when the oxygen is coming and you don't know how

1 far the end of that tunnel is, you don't know how quickly that  
2 train is catching up to you because you don't know that it's  
3 going to work with McRoberts or suprapubic or Wood's screw or  
4 Rubins or even go through them all two three times. You have  
5 no idea, you have no idea. In that minute, is there  
6 stability? I think it stretches reason to suggest that for a  
7 minute where you have a situation that can't resolve itself  
8 and there's not an ability to provide life on its own, that  
9 that's stabile. Immediate threat of injury or death, there's  
10 been testimony about, it doesn't come up until five minutes,  
11 so it's not immediate. The vital signs are good so it can't  
12 be immediate. When you're talking about stability and  
13 immediacy, these are things you need to look at. If somebody  
14 jumps about of an airplane without a parachute their vital  
15 signs are fine. It's going to take a few minutes for the  
16 impact. Does that mean it's not an immediate problem? For  
17 this concept that you have five minutes to wait, I mean, if I  
18 fall over and have a heart attack right now, please don't wait  
19 five minutes to start CPR, please. You heard about the nuchal  
20 cord and this is not compromising, I just don't know how a  
21 baby who can't breathe is not in a genuine emergency, unstable  
22 and at immediate risk of harm. And that's why we'd ask you,  
23 if you get this far, to address these aspects of the  
24 obstetrical care. Now, you heard Mr. Graham talk about

1 damages and don't think that because I'm talking about damages  
2 I'm saying Doctor Maselli did something wrong. I told you  
3 that in the beginning, I've got a job to do, I'm going to  
4 address it. Really the only thing I wanted to comment on it  
5 was the economist talked about a life care plan. We never saw  
6 a life care plan. We never heard from a life care planner.  
7 And we never heard a doctor say that the items in this plan  
8 were necessary. We never heard a doctor say this is needed,  
9 medically necessary. I think if you look at the economist  
10 report, if it's of interest to you, you'll see the single item  
11 in there that's significant was, I think it was about three-  
12 quarters of the value of the life care plan had to do with  
13 home services that no one even testified to during the whole  
14 course of the trial. And if you've got to prove your damages  
15 like all other elements of your case with certainty beyond  
16 speculation, then you should do it. It wasn't done. Now, the  
17 Judge will tell you that all cases there are no friends to  
18 reward, there are no enemies to punish and it's worth a minute  
19 to talk about sympathy. If you start your deliberations and  
20 someone says, I just feel so bad for the baby; or I just I  
21 can't do it, I just feel too bad. Well, you're human. The  
22 challenge is you have to be able to say, yeah I feel that but  
23 I have to decide this not on my feelings, not on my sympathy,  
24 but based on the evidence in the case. And if you start down

1 that line then you stop weighing the evidence. When you stop  
2 weighing the evidence the system's useless, the whole system's  
3 useless. When you go into the jury room, y'all are on your  
4 own, all 12 of you. Two of you will be discharged. Twelve of  
5 you will stay. Once you get all of the evidence y'all get to  
6 start deliberating, no one else gets to interrupt, no one else  
7 comes in. Y'all communicate via note sort of like the  
8 selection of the Pope. We're waiting for the smoke to come  
9 out of the Vatican. And we don't know what happens back there  
10 but we do know that the law asks you, and you accepted in your  
11 oath that you will render your verdict in the absence of these  
12 items, like sympathy and passion and prejudice or emotion and  
13 only on the evidence. Because once we stop weighing the  
14 evidence our entire system is broken. The last thing I want  
15 to talk on is the believability of the witnesses. This is  
16 something that is 100 percent in your will house. I hope that  
17 having seen Doctor Maselli demonstrate what transpired in  
18 color in front of you puts your mind at ease knowing that she  
19 did what her training required. That she acted reasonably and  
20 appropriately. She identified the emergency and she followed  
21 her training through step one, two and three. And after the  
22 suprapubic pressure released the shoulder, delivered the baby.  
23 I want to thank you for your time. Before I sit down, there's  
24 one last thing I want to say. The plaintiff gets to get up

1 and respond. And I told you earlier the plaintiff gets to go  
2 first because they bear the burden of proof. I incidentally  
3 bear the burden of proof on that statue about the emergency,  
4 that's why I was presenting the evidence on it. The Judge  
5 will include that in the charge. Because the plaintiff has  
6 the burden of proof, you know, they get the advantage of going  
7 first and they get the advantage of going last. And I promise  
8 you I have no idea what Mr. Graham's going to talk about and  
9 you can bet dollar for donuts that I would like to have the  
10 chance to respond to the things that he's going to say. I'm  
11 not afforded that opportunity. But we wouldn't have it any  
12 other way. We couldn't fix problems in our system without  
13 juries. We can't resolve disputes without you. We can't  
14 resolve this one without you. On behalf of Doctor Maselli,  
15 John and myself and our practice, we thank you for your  
16 attention and we ask you to bring back a verdict that speaks  
17 the truth. A verdict for Doctor Maselli. Thank you very  
18 much.

19 **THE COURT:** Alright, Mr. Graham.

20 **MR. GRAHAM:** Thank you, Your Honor.

21 Alright, I've got 10 minutes so I need to talk fast.

22 While he's doing that, I've got to say this, of all the people  
23 in here that want to play football there's one that never  
24 will. There was a comment about nobody was supporting a life

1 care plan that's going to need in home services, that's not  
2 true. Doctor Adler, the very first day, so maybe it was  
3 forgotten, but Doctor Adler talked about the need for future  
4 services, therapy, all of the other kinds of help he needs,  
5 plus the help doing things that he can't do because his arm  
6 won't allow him to do two-handed activities. It won't allow  
7 him to reach up. It won't allow him to do all the different  
8 movements he was talking about and that's why he needs those  
9 extra services. There was talk about sympathy, frankly, I'm  
10 worried about someone having sympathy for the doctor. If  
11 anybody is a neighbor or a church member of hers or any other  
12 kind of connection. If any of the folks who've been sitting  
13 behind counsel table all week happen to be a nurse in the  
14 office of your doctor, or some other reason they are here to  
15 try to influence you, I worry about that. Don't be  
16 intimidated, don't have sympathy for the doctor. Mr. Hood  
17 talked about a car wreck, or a train wreck, or a truck wreck.  
18 Let me talk about a standard car wreck. Alright, just picture  
19 a car totaled in really bad shape, you think somebody had to  
20 die. Hopefully, not, but the driver who caused the wreck  
21 says, I wasn't going more than 20 miles an hour and the eye  
22 witness says, officer she had to be going at least 80. The  
23 facts are in dispute. What do you do? There's one silent  
24 witness that tells the truth beyond any doubt, the car. If

1 somebody has a smashed up car that bad, is it consistent with  
2 20 miles an hour or more than 80? That nerve is the smashed  
3 up car. This case is about broken trust. They've lost their  
4 trust in the doctor and in many aspects the medical system.  
5 Broken trust, broken nerves and broken heart. I had a hard  
6 time not crying in court, in public, when I heard the story  
7 about, please God give me a new arm so my parents can be proud  
8 of me. The damages that you will cover, that you will charged  
9 to award money for, to compensate. Compensate basically is  
10 like the scales of justice. The amount of money needs to  
11 match the amount of harm. So, we've got economic loses which  
12 you've heard about from Doctor Wood. There was a range -- I'm  
13 not going to tell you what to do, that's not my prerogative.  
14 But, I will tell you that this is the kind of case where a  
15 million dollars for the human loses is very reasonable and I  
16 suggest that we've got economic out of pocket loses, past and  
17 future, that add up between 800 and a million. So, if you  
18 figure like \$900,000 for that or a little more and a million  
19 or so for the human loses then that gets you to a range of two  
20 million, which I submit to you is kind of like living in  
21 America I can put my heart on my chest and if I were in your  
22 shoes believe that I've done justice and I could be proud. I  
23 could not have restless nights thinking I had done this family  
24 a disservice. I want to go over a couple of things here

1 again. You may be asked, depending on how far you get on the  
2 form, you may be asked if the defense were grossly negligent.  
3 You'll have the definition ---

4 **MR. HOOD:** Objection.

5 **THE COURT:** Okay, one second. Yes, sir.

6 **MR. HOOD:** Rule 43. I never addressed gross negligence.

7 **THE COURT:** Please address only what he stated in his  
8 argument, okay. Just stick with that, please. If he didn't  
9 bring it up in his closing, then you can't rebut it.

10 **MR. GRAHAM:** I thought he did, but ---

11 **THE COURT:** I don't believe he did.

12 **MR. GRAHAM:** Okay. I'll move on, Your Honor. Thank you.

13 **THE COURT:** Thank you.

14 **MR. GRAHAM:** There's -- besides the injury -- there's one  
15 other party that has nothing to do with the disagreement in  
16 this courtroom all week and that is the MUSC surgeon who said,  
17 no respiratory distress was noted. The independent doctors  
18 find him stable. So, I just want to touch on a couple of  
19 things that are involved in this child's losses. He'll never  
20 be able to play sports. Just think he can't go hunting, he  
21 can't load a firearm. He can't change a tire. He can't  
22 defend himself from the bullies. He can't -- I mean, he's got  
23 dressing issues. He's got -- I mean, imagine dating and  
24 trying to woo a woman to be his wife, that takes a lot of



1 self-confidence. Being a parent, he can't bond with his  
2 children the way he would like to. As a grandparent, which I  
3 can relate to, not being able to have the joy of bonding with  
4 your grandchildren in a physical way as well as emotional.  
5 There's so many things and this is the one day in his life to  
6 recover damages for every second, every minute, every hour,  
7 every day, every week, every month, every year for the rest of  
8 his life, his life expectancy. I can't remember the exact  
9 number, it's in Doctor Wood's report but for all of that time  
10 he's going to suffer. He's going to need help. He's going to  
11 not have the life that his parents expected for him and that I  
12 expect for my children. You are the conscience of the  
13 community ---

14 **MR. HOOD:** Objection, Your Honor. We addressed this in  
15 opening. Improper.

16 **THE COURT:** He's asked you not to impassion the jury.  
17 So, let's just move on from that. Am I correct? Is that what  
18 you're ---

19 **MR. HOOD:** Yes, sir.

20 **MR. GRAHAM:** Not to do what, sir?

21 **THE COURT:** Impassion the jury. Don't put yourself or  
22 allow them to put themselves in the same position.

23 **MR. GRAHAM:** Oh, I didn't think I did. Are you talking  
24 about the community part?

1       **MR. HOOD:** Yes.

2       **THE COURT:** Yes.

3       **MR. GRAHAM:** Okay. When professionals take safety  
4 shortcuts and are not held accountable, what do you think  
5 happens? What do you think happens? We don't often have the  
6 power to do justice. Sometimes we feel overwhelmed with  
7 government, corporations. Sometimes we feel a loss of  
8 individual power but when God gives us an opportunity to do  
9 justice, we must be emboldened. We must be emboldened. This  
10 child wants a new arm so his parents can be proud of him.  
11 Please give him the money that he's entitled to. Thank you.

12       **THE COURT:** Alright, thank you so very much.

13       All Right. Members of the jury, now is my opportunity to  
14 give you the law in which you will utilize in your  
15 deliberation of this case. Before I do so, I just want to  
16 kind of explain. You must take the charge as a whole. You  
17 can't give it any more emphasis in one part and less emphasis  
18 as to another; you must take this charge collectively and as a  
19 whole. Fortunately, you are going to get a copy of this for  
20 your deliberation in the deliberation room, but for purposes  
21 of charging you, I'm going to read it as I have obviously not  
22 committed all of this to memory. Once I have charged you on  
23 the law, I'm going to come down and show you the verdict form.  
24 They, lawyers have kind of shown you little bits and pieces of

1 it, but I'll show you exactly how this verdict form should be  
2 gone through and then just give you some instructions  
3 following that. Okay?

4 I now charge you on the law. I remind you that, during  
5 this trial, you and I have certain duties to perform. As the  
6 Trial Judge, it is my responsibility to preside over the trial  
7 of this case and I also have the duty to rule on the  
8 admissibility of the evidence offered during this trial. You  
9 are to consider only the evidence before you. If there was  
10 any testimony ordered stricken from the record during this  
11 trial, you must disregard that testimony. You are to consider  
12 only the testimony which has been presented from the witness  
13 stand, any exhibits which have been made a part of the record  
14 in this case, and any stipulations of counsel.

15 I have the additional duty to charge you the law that is  
16 applicable to this case. It is your duty as jurors to accept  
17 and apply the law as I now state it to you. If you think you  
18 have any idea as to what the law is or what the law ought to  
19 be and it does not agree with what I tell you the law is, you  
20 must forget that idea because you are sworn to accept the law  
21 and apply the law exactly as I state it to you.

22 In every case tried in this court before a jury, the jury  
23 becomes the sole and exclusive judge of the facts. A Trial  
24 Judge cannot comment on or make any statement about the facts

1 in a case. Since you are the sole judges of the facts, do not  
2 think by anything I have said during the trial that I have any  
3 opinion about the facts in this case. The law does not allow  
4 me to have an opinion about the facts.

5 The burden of proof in this case is by a preponderance of  
6 the evidence. A preponderance of the evidence simply means  
7 the greater weight of the evidence. It is evidence which, as  
8 a whole, shows that the facts sought to be proved is more  
9 likely true than not true.

10 This could be illustrated by imagining a set of scales.  
11 When the case begins, the scales are even. After all the  
12 evidence has been presented, if the scales remain even or if  
13 they tip even slightly in favor of the defendant, then the  
14 plaintiff has failed to meet the burden of proof and would not  
15 be entitled to recover in this case. If, on the other hand,  
16 the scales tip even slightly in favor of the plaintiff, the  
17 plaintiff will have met the burden of proof and you should  
18 return a verdict for the plaintiff.

19 The preponderance of the evidence is not determined by  
20 the number of witnesses. Instead, it must be determined by  
21 the greater weight of all of the evidence.

22 There are two types of evidence generally presented  
23 during a trial - direct evidence and circumstantial evidence.

24 Direct evidence is the testimony of a person who claims

1 to have actual knowledge of a fact, such as an eyewitness. It  
2 is evidence which immediately establishes the main fact to be  
3 proved.

4 Circumstantial evidence is a proof of a chain of facts  
5 and circumstances indicating the existence of fact. It is  
6 evidence which immediately establishes collateral facts from  
7 which the main fact can be inferred. Circumstantial evidence  
8 is based on inference and not on personal knowledge or  
9 observation. It is proof that does not actually establish the  
10 fact in question, but that asserts or describes something else  
11 from which you may reasonably infer the truth of the fact or  
12 at least reasonably infer and increase the probability that  
13 that fact is true. For circumstantial evidence to be  
14 sufficient to warrant the finding of fact, the circumstances  
15 must lead to that fact with reasonable certainty. The facts  
16 and circumstances should be considered in light of ordinary  
17 experience and common sense. The existence of a fact cannot  
18 be based on speculation, surmised or conjecture.

19 The law makes absolutely no distinction between the  
20 weight or the value to be given to either direct or  
21 circumstantial evidence. Nor is a greater degree of certainty  
22 required of circumstantial evidence than of direct evidence.

23 Necessarily, you must determine the credibility of the  
24 witnesses who have testified in this case. Credibility simply

1 means believability. It becomes your duty as jurors to  
2 evaluate the evidence and determine which evidence convinces  
3 you it is true.

4 In determining the believability of witnesses who have  
5 testified in this case, you may believe one witness over  
6 several witnesses or several witnesses over one witness. You  
7 may believe a part of the testimony of a witness and reject  
8 the remaining part of the testimony of that same witness. You  
9 may believe the testimony of a witness in its entirety or  
10 reject the testimony of a witness in its entirety. You may  
11 consider whether the witness has an interest in the result of  
12 the trial, whether the witness is prejudiced towards either  
13 the plaintiff or the defendant, the opportunity for the  
14 witness to have seen the matters, the way the witness acts on  
15 the witness stand.

16 Witnesses are available to both parties, and you should  
17 draw no inference as to the absence of a witness.

18 If the opinions of medical experts are relied on to  
19 establish proximate cause, the expert must state with  
20 reasonable certainty that in his or her professional opinion,  
21 the plaintiff's injuries most probably resulted from the  
22 negligence of the defendant. If it is not necessary -- it is  
23 not necessary that the expert use the words most probably. It  
24 is enough for the expert to state that it is the expert's

1 professional opinion that the defendant's negligence was most  
2 likely one among the possible causes of the plaintiff's  
3 injuries.

4 As a general rule, in cases of this nature, expert  
5 testimony is necessary on the following issues: 1, what are  
6 the generally recognized and accepted practices and procedures  
7 which would be followed by average component practitioners in  
8 defendant's profession under the same or similar  
9 circumstances? 2, In what manner, if any, the defendant  
10 doctor departed from such practices and procedures? 3, Was  
11 defendant's departure from such general recognized practices  
12 and procedures, if any, approximate cause of plaintiff's  
13 alleged injuries and damages?

14 A patient who is treated by a doctor is entitled to a  
15 careful evaluation. The evaluation should be made with a  
16 diligence and methods of diagnosis that are usually approved  
17 and practiced by doctors of ordinary learning, judgment and  
18 skill, acting under the same or similar circumstances.

19 In order to prove that the defendant was negligent, the  
20 plaintiff must prove that 1, the patient's physical condition  
21 required a careful doctor to investigate further before  
22 continuing a course of treatment or care; 2, the defendant did  
23 not make this investigation; and 3, as a direct and proximate  
24 result of the defendant's failure to investigate, the patient

1 received improper treatment or care from which the patient  
2 later suffered an injury.

3 A physician does not guarantee or insure the correctness  
4 of her diagnosis, and it is not responsible for a mistake in  
5 diagnosis if she uses the proper degree of skill and care.  
6 Whether a physician was negligent making a diagnosis must be  
7 determined in the light of conditions existing and facts known  
8 at the time the diagnosis was made and not in light of  
9 knowledge gained through subsequent or later developments.

10 A physician who holds himself out to be a specialist is  
11 bound to bring to the discharge of his professional duties as  
12 a specialist that degree of skill, care and learning  
13 ordinarily possessed by specialists of a similar class under  
14 the same or similar circumstances. Accordingly, one who holds  
15 himself or herself out as a specialist, who undertakes a  
16 service in a special branch of medicine -- of medical science,  
17 owes to his patient, the duty of possessing that degree of  
18 learning and skill ordinarily possessed by specialists of good  
19 standing.

20 The plaintiff claims that the defendant committed medical  
21 malpractice, which is a form of carelessness or negligence.  
22 In order to recover for medical malpractice, the plaintiff  
23 must prove by a preponderance or greater weight of the  
24 evidence: 1, the standard of care; 2, a breach of the standard



1 of care; and 3, proximate cause; and 4, damages.

2 The plaintiff must prove the standard of care the  
3 defendant owed to the plaintiff in treating the plaintiff.

4 When a doctor treats a patient, the law does not require  
5 perfection; the law does require that the doctor use that  
6 degree of knowledge, care and skill ordinarily possessed and  
7 used by doctors in good standing in the doctor's field of  
8 medicine, under the same or similar circumstances and that the  
9 doctor followed the generally accepted practices and  
10 procedures in the profession.

11 In an action involving a medical malpractice claim  
12 arising out of care rendered in a genuine emergency situation  
13 involving an immediate threat or death or serious bodily  
14 injury to the patient receiving care in an emergency  
15 department or in an obstetrical or surgical suite, no  
16 physician may be held liable unless it is proven that the  
17 physician was grossly negligent. This limitation on physical  
18 liability -- physician liability, shall only apply if the  
19 patient is not medically stable and immediate threat or death  
20 or an immediate threat of serious bodily injury.

21 The defendant has the burden of proving the existence of  
22 a genuine emergency situation, the medical instability of the  
23 patient, and the immediate threat of a death or serious bodily  
24 injury from the higher proof of gross negligence -- for the

1 higher proof of gross negligence to apply. The defendant must  
2 make this proof by a preponderance or greater weight of the  
3 evidence.

4 Next, the plaintiff must prove that the defendant  
5 negligently departed from the standard of care in treating the  
6 plaintiff.

7 Negligence is the failure to do what an ordinarily  
8 careful doctor in the defendant's field of medicine would have  
9 done under the same or similar circumstances or the doing of  
10 something that an ordinarily careful doctor would not have  
11 done under the same or similar circumstances.

12 A doctor is not insurer of a cure or even of a positive  
13 result. Therefore, the mere fact that a treatment does not  
14 benefit the patient or that it even harms the patient does not  
15 in and of itself mean that the defendant was negligent. A bad  
16 result, injury, death or failure to cure is not by itself  
17 enough to show that the defendant was negligent.

18 Similarly, a doctor's mistake or error in making a  
19 decision alone, does not constitute negligence. If, however,  
20 a doctor fails to gather information reasonably available,  
21 which a reasonable doctor would have gathered before making a  
22 decision, the doctor fails to comply with the recognized  
23 standard of medical care, which would be exercised by a  
24 similar doctor under similar circumstances.

1       The difficulties and uncertainties in the practice of  
2 medicine and the unpredictable variations in response to the  
3 treatment are such that no doctor can guarantee results.  
4 Where there is more than one recognized diagnosis or treatment  
5 and no one of them is used exclusively and uniformly by all  
6 doctors in good standing, it is not negligence for a doctor in  
7 making a decision to choose one of the approved methods, even  
8 when the choice later turns out to be a wrong selection.  
9 Qualified doctors and experts may differ as to what  
10 constitutes the best course of treatment and these differences  
11 do not amount to malpractice. Whether doctors in good  
12 standing disagree or when medical authorities are divided with  
13 regard to a specific course of treatment or care, then the  
14 doctor is bound only to exercise her best judgment in  
15 determining which course, on the whole, is best for the  
16 patient. Just because another doctor might have used a  
17 different course of treatment, does not make the defendant  
18 negligent. However, if a doctor does not have the degree of  
19 learning and skill required or if the doctor does not use the  
20 care required, it is not defense to a charge of negligence,  
21 that the doctor did the best that she could.

22       In considering whether the defendant made a reasonable  
23 decision, you must consider the decision in relation to the  
24 facts as they existed at the time and not in the light of what

1 hindsight may reveal.

2       A qualified physician or surgeon does not guarantee or  
3 insure the correctness or safety of her treatment. And  
4 ordinarily, she is not responsible for any adverse  
5 consequences of treatment if she uses the requisite degree of  
6 skill and care. Generally stated, a qualified physician or  
7 surgeon is not liable for an error or mistake in judgment if  
8 she applies ordinary and reasonable skill and care, keeps  
9 within the recognized and approved methods and forms her  
10 judgment after a careful and proper examination or  
11 investigation, in light of the knowledge possessed by the  
12 medical profession, at the time she renders the service.

13       A physician, in the attendance and care of a patient, is  
14 not required to use the utmost degree of care and skill of  
15 which the human mind is capable. She is only required to  
16 exercise that degree of knowledge, care and skill, ordinarily  
17 possessed by members of her profession in good standing, under  
18 the same or similar circumstances.

19       Finally, the plaintiff must prove that the defendant's  
20 negligence proximately caused the plaintiff's damages.

21       Proximate cause is something that produces a natural  
22 chain of events, which, in the end, brings about the injury.  
23 It is the direct cause of the injury.

24       To prove that the defendant's negligence was proximately

1 caused the plaintiff's injury, the plaintiff must first prove  
2 causation and fact. This is proven by showing that the injury  
3 would not have occurred but for the defendant's negligence.

4 The plaintiff must also prove legal cause. Legal cause  
5 is proven by showing that the injury was foreseeable. This  
6 means that the injury occurred as a natural and probable  
7 consequence of the defendant's negligence. The plaintiff must  
8 prove that some injury from the defendant's negligence was  
9 foreseeable; but does not have to prove that the particular  
10 injury that occurred, was foreseeable. However, the defendant  
11 cannot be held responsible for something which could not be  
12 expected to happen.

13 Proximate cause does not mean the only cause. There may  
14 be more than one proximate cause. The defendant's act can be  
15 a proximate cause of the plaintiff's injury if it was at least  
16 one of the direct concurring causes of the injury.

17 Proof of proximate cause must also be established by  
18 expert testimony where either the origin of the injury is  
19 obscured and not readily apparent to a lay person or where  
20 there are several equally probable causes of the condition.

21 In the practice of the medical arts, there is a  
22 presumption that medical or surgical services are performed in  
23 an ordinarily skillful manner and the burden is on the one  
24 receiving such services to show a lack of due care, skill and

1 diligence and in such a case as stated above, the proof  
2 ordinarily required to overcome such presumption of care,  
3 skill and diligence, must be given by others qualified as  
4 expert witnesses in the particular professional field.

5       There is a general principal applied that where the cause  
6 of the plaintiff's injury may be as reasonably attributed to  
7 an act for which defendants are not liable, as to one for  
8 which they are liable, plaintiff has failed to carry the  
9 burden of establishing that the injuries were the proximate  
10 result of the defendant's negligence.

11       Gross negligence is the intentional, conscious failure to  
12 do something which is incumbent upon one to do or the doing of  
13 a thing intentionally that one ought not to do. It is the  
14 failure to exercise slight care. Gross negligence has also  
15 been defined as a relative term and means the absence of care  
16 that is necessary under the circumstances.

17       If you decide that the plaintiff is entitled to a  
18 verdict, your next step would be to decide how much money the  
19 defendant should be required to pay.

20       Actual damages are to compensate the plaintiff for the  
21 plaintiff's injuries or loss and to put the plaintiff as near  
22 as possible in the same position that the plaintiff was and  
23 before the incident occurred. In other words, actual damages  
24 would be the actual losses and expenses which the plaintiff

1 has suffered because of the defendant's negligence.

2 A verdict in the case cannot be based upon sympathy,  
3 passion, prejudice or emotion or some other consideration not  
4 found in the evidence.

5 Neither the existence, causation or amount of damages can  
6 be left to conjecture, guess, or speculation.

7 Actual damages include both economic and non-economic  
8 damages.

9 A plaintiff is never entitled to recover conjectural or  
10 speculative damages. But if you find the plaintiff is  
11 entitled to a verdict for actual damages, your verdict should  
12 include an amount to cover any past, present and future  
13 damages which were proximately caused by the defendant. Any  
14 future damages must be reasonably certain to occur in the  
15 future as a result of the defendant's acts. Actual damages  
16 need not be proven to a mathematical certainty or be based on  
17 evidence of the precise amount of damages the plaintiff has  
18 suffered. Instead, the evidence must allow you to determine  
19 what amount of damages is fair, just and reasonable.

20 Any future damages must be reasonably calculated to have  
21 resulted from the alleged injury or damage sustained in this  
22 case. Future damages must be reduced to their present cash  
23 value.

24 The plaintiff must prove that expenses caused by the

1 injury were necessary and reasonable.

2 Actual damages for a plaintiff who has been physically  
3 injured include pain and suffering, both past and future, as  
4 well as, mental anguish, impairment of health or physical  
5 condition and disfigurement. The plaintiff may also claim  
6 lost wages due to absence from work and reduced earning  
7 ability for the future.

8 In determining the amount of compensation for personal  
9 injuries, it is proper to consider past and present aspects of  
10 the injury. This would include physical and mental pain and  
11 suffering, expenses incurred for necessary medical treatment,  
12 loss of time and income, which resulted from the impairment of  
13 the ability to work and earn a livelihood, the loss of  
14 enjoyment of life suffered as a result of the injury and any  
15 other losses which are reflected by the character of the  
16 injury.

17 The injured party may recover from those future damages  
18 that are reasonably sure to result from the injuries. The  
19 principal underlying compensation for future damages is that  
20 only one action can be brought and therefore, only one  
21 recovery had. It is proper to include in the estimate of  
22 future damages, compensation for loss of capacity for work or  
23 attention to the plaintiff's ordinary business, future medical  
24 expenses and pain and suffering which will, with reasonable



1 certainty, result.

2 Pain and suffering compensates the plaintiff for physical  
3 discomfort and emotional response to the sensation of pain  
4 caused by the injury itself. There is no definite standard by  
5 which to compensate the plaintiff for pain and suffering. You  
6 have the authority to determine the amount, if any, to be  
7 allowed for pain and suffering, using common and reasonable  
8 judgment to ensure that the damages are just and reasonable in  
9 light of the testimony and evidence presented in this case.

10 Mental suffering, apprehension, shock, fright, emotional  
11 upset, humiliation and anxiety, either present or expected in  
12 the future, can be properly considered as an element of  
13 damages. The amount of damages for mental suffering cannot be  
14 exactly measured.

15 Loss of enjoyment of life compensates the plaintiff for  
16 limitations on the plaintiff's ability to participate in and  
17 derive pleasure from the normal activities of daily life.

18 As to your verdict, there are two possible verdicts which  
19 you may find in this case: for the plaintiff or for the  
20 defendant. There is no significance whatsoever in the order  
21 in which I state these possible verdicts; it is simply that  
22 one must be stated first.

23 All 12 of you must agree on the verdict. Your verdict  
24 cannot be based on sympathy, passion, prejudice, emotion or

1 any other consideration not in evidence in favor of either  
2 party.

3 I'm now going to come down and show you the verdict form  
4 that we have in this case. I'll get up close just so you can  
5 see it and we'll kind of go through it briefly.

6 So, this is your actual verdict form that you take back  
7 into the room with you. This is the case caption, just simply  
8 the case number. Obviously, this is the verdict form, these  
9 are the parties and then these are what you'll need to  
10 consider in your deliberation. I'll read them just so you'll  
11 understand. We, the jury, unanimously find as follows: did  
12 the plaintiff prove by preponderance of the evidence that the  
13 defendant deviated from the standard of care; yes or no. If  
14 the answer to question one is no, stop and deliberate no  
15 further. If the answer to question 1 is yes, continue on to  
16 question number 1. Question number 2. Did the plaintiff  
17 prove by preponderance of the evidence that the defendant's  
18 deviation from the standard of care was a proximate cause of  
19 the plaintiff's injuries; yes or no. If the answer to  
20 question 2 is no, stop and deliberate no further. If the  
21 answer to question 2 is yes, continue on to question 3. Did  
22 the defendant prove by preponderance of the evidence that the  
23 events of Jahmerican's delivery constitutes a genuine medical  
24 emergency; yes or no. Proceed to question 4. Did the

1 defendant prove by preponderance of the evidence that  
2 Jahmerican was not medically stable at the time of the events  
3 in question; yes or no. Proceed to question 5. Did the  
4 defendant prove by a preponderance of the evidence that there  
5 was an immediate threat of death or serious bodily injury to  
6 Jahmerican at the time of the events in question; yes or no.  
7 If the answers to questions 3, 4 and 5 are yes, go to question  
8 6. If the answer to either question 3, 4, 5 is no, do not  
9 answer question 6 and continue to question 7. Question 6, did  
10 the plaintiff prove by a preponderance of the evidence that  
11 the defendant was grossly negligent; yes or no. If the answer  
12 to question 6 is yes, go to question 7. If the answer to  
13 question 6 is no, stop and deliberate no further. Question  
14 number 7. What is the amount of damages sustained by the  
15 plaintiff; we have a line here for economic damages, a line  
16 for non-economic damages, and then you would just total the  
17 two and place here on total damages. All right?

18 Mr. Foreman, you'll be tasked to fill out the verdict  
19 form. When there's a verdict, you simply just let the bailiff  
20 know and he'll bring you back in. In a moment, I'm going to  
21 ask you to go back. I'm going to ask you not to begin your  
22 deliberations. There's some matters for the Court to take up  
23 before we send the exhibits back. So, please, when you're  
24 excused to the jury room, do not begin deliberating. At the

1 time I will send the clerk or the bailiff back with the  
2 exhibits and we will instruct you to go ahead and begin your  
3 deliberations.

4 Just a couple asides. When you're deliberating, you're  
5 deliberating altogether. Okay? If someone excuses themselves  
6 to the restroom or wants to go take a break, please just stop  
7 the deliberation. Everyone needs to participate in it  
8 together equally. All right? All right.

9 I'm going to go ahead and ask you to go back to the  
10 deliberation room, to the jury room. If you'll just, Mr.  
11 Bailiff, if you'll just take the 2 alternates and just  
12 segregate them for the time being, just return the 12 to the  
13 jury room. Okay? All right. Also, if you have any  
14 questions, if any one of you has any questions, please just  
15 submit it to writing, give it to the foreman, he will give it  
16 to the bailiff and it will be brought out to us. Okay? All  
17 right. Anything else? All right.

18 **REPORTER'S NOTE:** (Jury retires to jury room 4:03PM).

19 **THE COURT:** All right. Thank you very much. All right.  
20 Any exception from the plaintiff?

21 **MR. GRAHAM:** No, Your Honor.

22 **THE COURT:** From the defense?

23 **MR. HOOD:** No, Your Honor.

24 **THE COURT:** Very well. All right. Come up here, if you

1 don't mind, take a look at all of the exhibits; make sure that  
2 y'all agree on them and we'll send them back.

3 **REPORTER'S NOTE:** (Counsel review exhibits).

4 **THE COURT:** Mr. Hood and Mr. Graham, you've got your  
5 admitted exhibits there together pretty much, right. I mean  
6 we know.

7 **MR. GRAHAM:** We're just finishing.

8 **THE COURT:** Sallie efficiently separated those.  
9 All right. Everything is there?

10 **MR. RADECK:** We're all good.

11 **THE COURT:** Okay.

12 **MR. GRAHAM:** Thank you.

13 **THE COURT:** If you would take that to the jury room.  
14 Tell them to begin their deliberations, that' they're good to  
15 go. Bring the 2 alternates out. Okay?

16 **BAILIFF:** Okay, Judge.

17 **THE COURT:** Make sure he just takes the stacks he's  
18 supposed to.

19 **REPORTER'S NOTE:** (Jury to begin deliberations 4:06PM).

20 **THE COURT:** All right. Well, unfortunately, you know  
21 what's going to have to happen. You got to sit through the  
22 whole thing. But, unfortunately, don't get to participate in  
23 the deliberations. So, we want to thank you so very much for  
24 your service. I know it seems odd, but you'd be surprised how

1 many times we use alternates. So, it's a huge necessity. I  
2 hope you enjoyed it. I hope that we stayed on pace and you  
3 had a good experience, but at this point in time, you are  
4 excused and free to go.

5 **ALTERNATE 1:** Thank you, sir.

6 **ALTERNATE 2:** Thank you, Your Honor.

7 **THE COURT:** Thank you for being here.

8 All right. We'll be in recess.

9 **(COURT IN RECESS)**

10 **THE COURT:** Thank you very much. Keep your seats. All  
11 right. So, we have a question and the question reads may we  
12 see the ACOG manual. Todd Johnson, signed by Todd Johnson.  
13 I'm just going to instruct them that they are only to consider  
14 evidence and exhibits that have been presented at trial. Any  
15 objection?

16 **MR. GRAHAM:** No, Your Honor.

17 **MR. HOOD:** Do you think you ought to just tell them, that  
18 wasn't introduced into evidence?

19 **THE COURT:** Sure.

20 **MR. HOOD:** So, that we don't get another question.

21 **THE COURT:** Sure. Okay. Bring out the jury.

22 **BAILIFF:** You want to bring the jury in?

23 **THE COURT:** Yeah, bring them in.

24 **REPORTER'S NOTE:** (Jury enters courtroom 5:18PM).

1       **THE COURT:** All right. So, I received your letter and  
2 your notes says, may we see the ACOG manual. You can only  
3 consider testimony and exhibits that were presented and  
4 entered into evidence in trial and the ACOG manual was not one  
5 of those exhibits. So, you're not to consider it. Only those  
6 parts of the manual that may have been submitted into  
7 evidence, but not the manual, it was not entered into  
8 evidence. Okay?

9       **FOREMAN:** Okay.

10       **THE COURT:** All right. Thank you very much. Return to  
11 your deliberation.

12       **REPORTER'S NOTE:** (Jury retires to jury room 5:18PM).

13       **THE COURT:** Sallie, will you mark this as our Court's  
14 exhibit, whichever one is the next one?

15       **COURT REPORTER:** 2, I will.

16       **THE COURT:** Okay. Thank you.

17       **COURT REPORTER:** You're welcome.

18                               **(COURT IN RECESS)**

19       **THE COURT:** Thank you. Thank you. All right. We've got  
20 another question. The question reads, if we cannot agree on  
21 questions 1 and 2, but have agreements on 3, 4, 5 and 6 that  
22 reaches a conclusion, can we bring that. Signed. Todd  
23 Johnson.

24       Has anybody got a copy of the verdict form, I mean it's

1 possible ---

2 **MR. GRAHAM:** I probably have one over here.

3 **THE COURT:** --- that answering those questions may ---

4 **MR. HOOD:** Render a verdict?

5 **THE COURT:** Yes.

6 **LAW CLERK:** She's probably going to have to send it.

7 **THE COURT:** Can somebody just print one off for us.

8 **LAW CLERK:** We're working on it.

9 **THE COURT:** Can that be brought up here please?

10 **LAW CLERK:** She's printing it. I had to forward it to  
11 her.

12 **THE COURT:** We going to get a hard copy or we got ---

13 **LAW CLERK:** You'll get a hard copy.

14 **THE COURT:** Okay. All right. Question number 1, did the  
15 plaintiff prove by a preponderance of the evidence that the  
16 defendant deviated from the standard of care. That question  
17 they've not answered apparently.

18 Number 2, did the plaintiff prove by a preponderance of  
19 the evidence that the defendant's deviation from the standard  
20 of care was proximate cause of the plaintiff's injuries; that  
21 question they haven't answered.

22 Question 3, which they have answered, did the defendants  
23 prove by a preponderance of the evidence that the event of  
24 Jahmerican's delivery constituted a genuine medical emergency.



1 Now they have some answer to that.

2 Number 4, did the defendants prove by a preponderance of  
3 the evidence that Jahmerican was not medically stable at the  
4 time of the events in question; they've answered that.

5 And they've answered 5, which was also did the defendants  
6 prove by a preponderance of the evidence that there was an  
7 immediate threat of death or serious bodily injury; they've  
8 answered that.

9 The instructions say, if the answers to questions 3, 4  
10 and 5 are yes, go to 6. If the answer to either question 3, 4  
11 or 5 is no, do not answer question 6 and continue to 7.  
12 They've answered, 3, 4 and 5. If they answered those  
13 affirmatively and they have answered question 6. 6 could have  
14 been answered that the plaintiff has proved grossly negligent  
15 conduct. So, the appearance is they have -- if they followed  
16 the instructions to go from 3, 4 and 5 to 6; there would  
17 necessarily have to been a finding that the defendants have  
18 prevailed in proving by a preponderance of evidence that the  
19 defendants -- or that the higher standard of gross negligence  
20 must apply in order for them to go to question 6. If they  
21 have followed the instructions. If they have followed the  
22 instructions.

23 Now, if that is the case -- all right. Okay. What if  
24 they have answered 3 affirmatively, 4 affirmatively, 5

1 affirmatively and 6 indicating no, are they done? Because  
2 questions 1 and 2 would then become moot, would they not?

3 **MR. GRAHAM:** As I read the instructions, Your Honor, they  
4 would have disobeyed the instructions in the charge, if they  
5 went to 3 without -- without -- seems to me that if they can't  
6 do 1 and 2, then they're not -- they can't follow the  
7 instructions about where to go next. So, our position would  
8 be that, you know, either, if they ultimately cannot reach a  
9 verdict that follows the instructions, then it seems to be  
10 like they would be hung. If they can reach a verdict that  
11 follows the instructions, then whatever it is. But I don't  
12 think -- I don't think it would be right to start amending the  
13 verdict form.

14 **THE COURT:** Let me hear from you, Mr. Hood?  
15 They haven't said they're hung.

16 **MR. HOOD:** No, we haven't gotten anything like that. But  
17 I've got one thought is, you know, we tried to simplify things  
18 by doing it in this order.

19 **THE COURT:** I think they're asking us is that all they  
20 have to do?

21 **MR. HOOD:** They are. It seems to me, but so the  
22 challenge I have is if they've answered 3, 4 and 5 in the  
23 affirmative and 6 in the negative, then why would we compel 12  
24 people to try to reach an agreement or not an agreement as to

1 1 and 2 if it doesn't matter. I think that's the really  
2 challenge. I mean, if -- if at the end of the day they're  
3 going to get to where they already are in the emergency  
4 statute, what difference does it make how they answer 1 and 2?

5 **THE COURT:** I think that what we need to do is put the  
6 question to the jury and simply asked them, have they reached  
7 a point in their deliberation, where they unanimously have  
8 determined that the defendants have proven by a preponderance  
9 of the evidence that this was a genuine emergency, that the  
10 child was medically unstable and that there was an immediate  
11 threat of death or bodily injury and thus, requiring the  
12 plaintiff to prove its case by the higher standard of gross  
13 negligence. I think the jury knows what they've done. I just  
14 think that we don't and I'm afraid that the way the verdict  
15 form is done, is putting them in a position of saying well,  
16 what do we do about these other questions because we've  
17 answered them down here. I'm open to suggestions. What do  
18 you want to do?

19 **MR. GRAHAM:** I don't -- I would oppose amending the  
20 verdict form, basically by saying you can skip over some  
21 things. You know, if they can't agree on those, then ---

22 **THE COURT:** Well, what if I instruct them this -- this  
23 way? What if Judge Price instructs them in this fashion? If  
24 you have found that the higher standard of proof, that being

1 gross negligence, would be required of the plaintiff and you  
2 have found no gross negligence, if that is what your unanimous  
3 decision is at this time, you need go no further. If that is  
4 not your finding, then you must continue your deliberations.

5 All right. This is what we're going to do. We're going  
6 to charge them this way. We're going to tell the jury that if  
7 in answering questions 3, 4 and 5, we're not going to touch 6.  
8 If you have answered 3, 4 and 5 unanimously, finding that  
9 there was a genuine medical emergency, that the child was not  
10 medically stable and that there was imminent threat of death  
11 or serious injury, thereby requiring the plaintiffs proof to  
12 be that of gross negligence, then you need not answer  
13 questions 1 and 2. If you have not made those findings, you  
14 must answer questions 1 and 2.

15 **MR. GRAHAM:** Are you asking me ---

16 **THE COURT:** Well, I'm just telling you, I think that's  
17 the way -- they have obviously some confusion, I think that if  
18 they have made those findings, 1 and 2 are irrelevant, need  
19 not be answered. But 6 and 7 would require answers. I don't  
20 want to go into 6. I don't want to talk about it. I just  
21 want to say if they -- or, Judge Price and I believe that if  
22 we say they've answered 3, 4, and 5, thereby raising the  
23 standard, then 1 and 2 need not be answered, but 6 and 7 must  
24 be answered, according to the instructions on the verdict

1 sheet.

2 **MR. GRAHAM:** Have they answered 6?

3 **THE COURT:** They say they have answered 6.

4 **MR. GRAHAM:** Okay. That's what I thought you said  
5 earlier.

6 **THE COURT:** But I don't want to go to 6. I just want to  
7 tell them that if they've answered in their unanimous answers  
8 the 3, 4 and 5, if they have found that a higher standard must  
9 be reached, then they need not answer questions 1 and 2.  
10 Otherwise, they must answer questions 1 and 2. Because in  
11 that situation, they'd be back to the lower standard.

12 **MR. GRAHAM:** I hear you, Your Honor, and I would -- I  
13 just note an objection for that.

14 **THE COURT:** Okay. All right. How about you, Mr. Hood?

15 **MR. HOOD:** I'd be interested if the plaintiff has another  
16 alternative, to hear what it is.

17 **THE COURT:** Well, I mean, I'm open, but ---

18 **MR. HOOD:** Yeah.

19 **THE COURT:** But I don't know what his alternative is  
20 other than he says I don't want to amend the verdict sheet.  
21 Well, we're not amending it.

22 **MR. GRAHAM:** Well, I mean if -- it's hard to wrap my  
23 brain around this, Your Honor, but it seems to me that they  
24 are instructed after number 2, they're instructed if the

1 answer is no, stop and deliberate no further. So, without an  
2 answer, that's not applicable. If the answer to 2 is yes,  
3 continue on to number 3.

4 **THE COURT:** Well, I'm telling them, unless they have made  
5 a finding that the gross negligence standard applies, they  
6 should go back and do 1 and 2. But they have made a finding  
7 that the gross negligence standard does apply, questions 1 and  
8 2 have no meaning at all. I mean, they need not be answered,  
9 if they cannot reach any kind of verdict on that. They're  
10 talking about a simple negligence standard that's not  
11 applicable to the case if they have found that the gross  
12 negligence standard is out.

13 **MR. GRAHAM:** Yes, sir.

14 **THE COURT:** Okay. I'm going to make it clear, if they  
15 need to go back if they have not made that point.

16 **MR. GRAHAM:** Okay. Well, I'll just state an objection  
17 for the record and leave it at that.

18 **THE COURT:** Okay. All right. Mr. Hood?

19 **REPORTER'S NOTE:** (Bench conference with counsel).

20 **REPORTER'S NOTE:** (Jury enters courtroom 6:17PM).

21 **THE COURT:** All right. We have received your letter and  
22 the letter states, if we cannot agree on questions 1 and 2,  
23 but have agreements on 3, 4, 5 and 6 that reaches a  
24 conclusion, can we bring that.

1           So, let me talk to you just real quickly about 3, 4 and  
2 5. Okay? If in fact, y'all have unanimously concluded that  
3 Jahmerican's events were a genuine, medical emergency and that  
4 Jahmerican was not medically stable or excuse me, yes, and  
5 there was an immediate threat of death or serious bodily  
6 injury, if you have found those in the affirmative or yes, you  
7 would go to 6 and 7. Okay?

8           Contrary to that, if you have found the answers to that  
9 to be no, you must answer questions 1 and 2. All right.  
10 But 1 and 2 are not necessary, if you have answered 3, 4 and 5  
11 as yes.

12       **FOREMAN:** Without the sheet in front of me, I can't -- I  
13 can't -- I'm not sure I can ask it without the sheet that  
14 does that, but I'm not sure that that's the way that it went  
15 with the questions.

16       **THE COURT:** Mr. Bailiff? We have a blank one; this is  
17 front and back.

18       **FOREMAN:** So, it says if the answer to question 6 is yes,  
19 go to question 7. If the answer to question is no, then stop  
20 and deliberate no further.

21       **THE COURT:** Okay.

22       **FOREMAN:** So, we do not automatically go onto question 7  
23 if our answer is no.

24       **THE COURT:** That is the way it is stated on the verdict

1 form. That's correct.

2 **FOREMAN:** Okay. So, can we give you our answers on our  
3 sheet without answering 1 and 2?

4 **THE COURT:** Yes.

5 **FOREMAN:** Okay.

6 **THE COURT:** All right. Does that answer your question?

7 **FOREMAN:** Yes, Your Honor.

8 **THE COURT:** All right. Y'all can go back and continue  
9 your deliberation.

10 **REPORTER'S NOTE:** (Jury retires to jury room 6:20PM).

11 **THE COURT:** Sallie Beth, will you mark this for me  
12 please?

13 **COURT REPORTER:** I will.

14 **THE COURT:** All right. We're at ease for a few moments.  
15 Do y'all have any -- did I mess anything up; any objections to  
16 anything that was stated other than what you've already stated  
17 for the record?

18 **MR. GRAHAM:** Well, it -- it's no big deal. It sounded to  
19 me like you said something a little confusing about 6 and 7,  
20 but I think -- I think his question sorted it out.

21 **THE COURT:** Okay. No problem.

22 **(COURT IN RECESS)**

23 **REPORTER'S NOTE:** (Jury enters courtroom 6:25PM).

24 **THE COURT:** All right. Thank you, sir. All right. Mr.



1 Foreman, have y'all reached a verdict?

2 **FOREMAN:** Yes, sir.

3 **THE COURT:** All right. Is the verdict unanimous?

4 **FOREMAN:** Yes, Your Honor.

5 **THE COURT:** All right. Please give it to the bailiff.

6 All right. Mr. Bailiff, if you will give this to Madam Clerk.

7 If you will publish the verdict for us, please?

8 **CLERK:** State of South Carolina, County of Georgetown,  
9 Phillippa Smalling, individual and as next friend of  
10 Jahmerican M. a minor, versus Lisa R. Maselli, M.D. both  
11 individually and as agent employee of Carolina OBGYN. We, the  
12 jury, unanimously find as follows. Number 3, that the  
13 defendants proved by a preponderance of evidence that the  
14 events of Jahmerican's delivery, constitutes a genuine,  
15 medical emergency; yes. Did the defendant prove by a  
16 preponderance of evidence that Jahmerican was not medically  
17 stable at the time of the events in question; yes. Did the  
18 defendants prove by a preponderance of evidence that there was  
19 an immediate threat of death or serious bodily injury to  
20 Jahmerican at the time of the events in question; yes. Did  
21 the plaintiff prove by a preponderance of the evidence that  
22 the defendants were grossly negligent; no. Signed, Jury  
23 Foreman, Todd W. Johnson.

24 **THE COURT:** Would you like to poll the jury?

1       **MR. GRAHAM:** Yes, sir, Your Honor.

2       **THE COURT:** All right. Madam Clerk?

3       **CLERK:** Ladies and gentlemen of the jury, when I call  
4 your jury number, please stand and answer the question that I  
5 am about to pose to you after each answer.

6       Jury number 62, was that your verdict and still your  
7 verdict?

8       **JUROR 62:** I'm sorry, can you repeat that?

9       **CLERK:** Was this -- was that your verdict and is this  
10 still your verdict?

11       **JUROR 62:** Yes, ma'am.

12       **CLERK:** Juror number 104.

13       **JUROR 104:** Yes, ma'am.

14       **CLERK:** Was that your verdict and is this still your  
15 verdict?

16       **JUROR 104:** Yes.

17       **CLERK:** Juror number 155. Was that your verdict and is  
18 this still your verdict?

19       **JUROR 155:** Yes.

20       **CLERK:** Juror number 170. Was that your verdict and is  
21 this still your verdict?

22       **JUROR 170:** Yes, ma'am.

23       **CLERK:** 121, was that your verdict and is this still your  
24 verdict?

1           **JUROR 121:** Yes, ma'am.

2           **CLERK:** 35, was that your verdict and is this still your  
3 verdict?

4           **JUROR 35:** Yes, ma'am.

5           **CLERK:** 143, was that your verdict and is this still your  
6 verdict?

7           **JUROR 143:** Yes, ma'am.

8           **CLERK:** 109, was that your verdict and is this still your  
9 verdict?

10          **JUROR 109:** Yes, ma'am.

11          **CLERK:** 48, was that your verdict and is this still your  
12 verdict?

13          **JUROR 48:** Yes, ma'am and yes, Your Honors.

14          **CLERK:** 83, was that your verdict and is this still your  
15 verdict?

16          **JUROR 83:** Yes, ma'am.

17          **CLERK:** Number 2, was that your verdict and is this still  
18 your verdict?

19          **JUROR 2:** Yes, ma'am, it is.

20          **CLERK:** 168, was that your verdict and is this still your  
21 verdict?

22          **JUROR 168:** Yes, ma'am.

23          **THE COURT:** Thank you, Madam Clerk.

24          Ladies and gentlemen, thank you so much for your service.

1 This has been a long case. It's been a complicated case. You  
2 know, any person who comes before the Court in this country is  
3 entitled to have a dispute resolved by a jury of their peers.  
4 You're not legal experts, you're not medical experts; we know  
5 that. These questions involve legal issues and medical  
6 issues, but there's no better way to resolve these questions,  
7 than to bring a group of citizens who have no interest in the  
8 case, who bring nothing to the Court but their good common  
9 sense. Because that's what it takes to resolve these kinds of  
10 cases. It's very rare that we try a case like this. We try a  
11 lot of them here in Horry County and Georgetown County. My  
12 clerk in Horry County tells me that we have about 10,000 cases  
13 a year filed. You know, if I could try a case every 2 days  
14 and finish it and I never took a vacation, I never missed a  
15 day's work, I never got sick, I was there 52 weeks out of the  
16 year, it would take me 80 years to try the cases that are  
17 filed in one year just in Horry County, not counting  
18 Georgetown. We employ many methods to prevent having to come  
19 and require you to do it. We have mediations, arbitrations,  
20 status conferences, all sorts of things to help us resolve the  
21 case, but in the end, we must rely on our citizens to serve as  
22 jurors. You have had a tough case. You have had a long case;  
23 I know you're tired. But I can't tell you how we appreciate  
24 your service here this week. If you hadn't been here, this

1 case would be still ongoing, and these parties needed to have  
2 this matter resolved. It's been going on for I think about 5  
3 years, in 2013 is when this child was -- was born. It needed  
4 to be resolved and we could not do it and we have to rely on  
5 you. Thank you so much for being here. You're going to get  
6 that great big check in the mail soon for your service, I'm  
7 almost embarrassed to tell you what it will be. I'm not going  
8 to tell what it will be. It's a pittance compared to the  
9 service that you have rendered. Thank you again. You are  
10 free to leave, and you may claim this as your jury service for  
11 the next 3 years. That's it. Please make sure that they get  
12 out okay.

13 **BAILIFF:** I will.

14 **THE COURT:** Thank you.

15 **REPORTER'S NOTE:** (Jury excused 6:34PM)

16 **THE COURT:** Motions?

17 **MR. GRAHAM:** Yes, sir. We would renew our motion for  
18 directed verdict and make a motion for a new trial absolute.

19 **THE COURT:** All right. And I would deny your - your  
20 motion. We've had a long trial. I think everything -  
21 everyone has been able to get in practically everything that  
22 they wanted. I think it's been a fair trial. There has been  
23 evidence, certainly to support the jury's verdict and I would  
24 respectfully deny your motion for a new trial. Thank you.

1 All right. Thank you, gentlemen. I have enjoyed it; no,  
2 I haven't. I have - I have - it's been much more pleasant  
3 than it could have been, let me put it that way. I always  
4 like to have lawyers who are prepared and well versed in the  
5 subject matter and good witnesses whenever I try a case like  
6 this and I appreciate that on your behalf. Thank you again.

7 MR. HOOD: Thank you, Judge.

8 (COURT ADJOURNED)

9

4/28/13  
10:00 AM

PPD #1

Shoulder Dystocia

ORDER OF  
RECORDING

1. Date and time of examination
2. State of positive findings noted previously
3. New signs and symptoms
4. Complications
5. Changes of impressions or diagnosis
6. Record of treatment given
7. Results of treatment
8. Signature of physician making observations

The pt + especially her husband are appropriately concerned re: Baby movement.

Mom grateful baby is "alive"  
States her 9yr old in Jamaica was nearly 9lbs to No problems

Dad wants to know definitively if am will be all right  
Prolonged discussion - both parents. Baby needs to have close pediatric Flx and possibly phys. therapy.

Discussed C's if another baby.

april 155

pg @ 4-2.

Breast feeding

Stable. probable disch tomorrow

PROCESS NOTES

Gerber  
Rev 3/08

Georgetown Memorial Hospital

LABOR RECORD

Pt. Status: ADM IN

Rpt#: 0427-0060

PT DOBAGE: 11/29/1976 \ 36

**PATIENT NAME:** SMALLING, PHILLIPPA S

**MEDICAL RECORD #:** M000378404

**ADMISSION DATE:** 04/27/13

**ACCOUNT #:** G00006478588

**ATTENDING PHYSICIAN:**

**RM#:** 0202-01

LISA R MASELLI

**ATTENDING PHYSICIAN:**

Dr. Maselli.

**PREOPERATIVE DIAGNOSES:**

1. Intrauterine pregnancy at 40 weeks
2. Active labor.
3. Spontaneous rupture of membranes
4. Thin meconium.

**POSTOPERATIVE DIAGNOSES:**

1. Intrauterine pregnancy at 40 weeks
2. Active labor.
3. Spontaneous rupture of membranes
4. Thin meconium.
5. Nuchal cord x1.
6. Shoulder dystocia.

**PROCEDURES PERFORMED:**

1. Spontaneous vaginal delivery.
2. Pitocin augmentation.
3. Epidural.
4. Fetal monitoring.
5. Amnioinfusion.
6. Mediolateral episiotomy and repair.

**HISTORY OF PRESENT ILLNESS:**

The patient is a 36-year-old African American female at 40 weeks who presents to labor and delivery in active labor with spontaneous rupture of membranes approximately 15 minutes prior to admission. She was 7 centimeters on admission, the head was at -3 station. Thin meconium was noted. The patient was admitted and epidural was placed. Internal monitoring with both internal fetal monitoring and intrauterine pressure catheter was placed and amnioinfusion was performed. The patient was augmented with Pitocin. She had a slow labor progress from 7 centimeters to completely dilated and was eventually completely dilated in zero station. She had a fairly shortened second stage of labor and on 04/27/2013 delivered a viable term male infant by spontaneous vaginal delivery over a medial lateral episiotomy. Delivery of the head was at 8:14, delivery of the body was at 8:15. Weight was 8 pounds, 13 ounces, Apgars of 8 and 9. Nuchal cord x1 was easily reduced.

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED

<Electronically signed by.....>

Tidelands Georgetown Memorial (mom) 021



Georgetown Memorial Hospital

LABOR RECORD

PAGE 2

PATIENT: SMALLING, PHILLIPPA S

MEDICAL RECORD #: M000378404

Rpt#: 0427-0060

Pt. Status ADM IN

---

Shoulder dystocia was encountered after delivery of the head and reduction of the nuchal cord. This occurred for approximately one minute period of time. A mediolateral episiotomy was performed and McRoberts maneuver as well as suprapubic pressure by the nurses was given. The infant then delivered. The cord was clamped and cut and the baby was handed to Dr. Haseltine who was the awaiting pediatrician secondary to meconium.

Delivered by Dr. Lisa Maselli.

PEDIATRICIAN:

Dr. Haseltine.

ESTIMATED BLOOD LOSS:

450 milliliters

SPECIMENS:

Cord gas, cord blood, and placenta. Cord gas pH was 7.31. Repair of the episiotomy was performed with 3-0 Vicryl suture without difficulty.

At the time of this dictation, the patient is doing well and will be taken to postpartum in stable condition. The baby was taken to the nursery for observation and is currently breathing on his own and doing well. There is decreased movement of the right arm. No crepitus is noted in the clavicle area. X-ray is pending. The baby is moving his hand and fingers well at this time.

CC:

LRM: 8000004

D: 04/27/2013 08:47:54T: 04/27/2013 13:08:33 DOCUMENT: 634647

---

Dictated by: LISA MASELLI MD

<Electronically signed by LISA MASELLI MD> 04/29/13 0723

copy: MASELLI, LISA R

MASELLI, LISA R

MASELLI, LISA R

THIS IS A DRAFT REPORT UNTIL REVIEWED BY THE PROVIDER AND MARKED  
<Electronically signed by.....>

4-27-13 0745

Del Note

ORDER OF  
RECORDING

1. Date and time of examination
2. State of positive findings noted previously
3. New signs and symptoms
4. Complications
5. Changes of impressions or diagnosis
6. Record of treatment given
7. Results of treatment
8. Signature of physician making observations

Viable term ♂ del SVD i medialateral  
epuratory @ 0815. wt 8#1303 Appx 8/9  
Nuchal cord x1 reduced.  
Shoulder dystocia encountered for 1min  
period of time. Mc Roberts & Symphysial  
pressure given.  
Spec cord gas, cord bl, placenta  
Del by Maselli  
Peds Hareltoni  
EVL 450cc  
Cord gas pH = 7.31  
Repair performed i 3.0 vicryl.  
Baby to nursery for observation.  
Man op in stable condition  
Dictation for details.

Maselli  
#634647

PROGRESS NOTES

Rev 3/06



PN-PROG0700

Tidelands Georgetown Memorial (mom) 028

4-27-13 0350

ORDER OF  
RECORDING

1. Date and time of examination
2. State of positive findings noted previously
3. New signs and symptoms
4. Complications
5. Changes of impressions or diagnosis
6. Record of treatment given
7. Results of treatment
8. Signature of physician making observations

Pt. comfortable i epidural  
Decel to 90's lastly ~ lemin  
O2 placed, positioned changed.  
Pit had been on for few minutes @ 4mm  
it was turned off.  
IUPC placed i amniotomium started.  
Return to baseline FHTS 150's now i  
variables.  
Cervix unchanged. 7/90/-2/3 Jmcell

4-27-13 0445

Pt i same pressure  
FHTS 150's i mild variable

Cx 7-8/-2

Will try to restart pitocin + implement  
position changes Jmcell

PROGRESS NOTES

Rev 3/06



PN-PROG0700

Tidelands Georgetown Memorial (mom) 029

# SHOULDER DYSTOCIA PROGRESS NOTE

DATE/TIME

4-27-13 0830

Estimated Fetal Weight on Admission

7 1/2#

Pregnancy Complications

☒ Yes ☐ No

Labor Complications

☒ Yes ☐ No

- ☐ Diabetes
- ☐ Gestational Diabetes
- ☐ Postdates
- ☒ Obesity
- ☐ Prior Shoulder Dystocia
- ☐ History Macrosomia
- ☐ Other

- ☒ Protracted First Stage
- ☐ Protracted Second Stage
- ☐ Arrest of Descent
- ☐ Significant Molding
- ☐ Other

Delivery Mode

☒ Spontaneous ☐ Vacuum ☐ Forceps

Level of Traction Applied

☐ Usual ☒ Moderate/Controlled ☐ Other

Neonatal Anterior Shoulder

☐ Left ☒ Right ☐ Other

Maneuvers Used

Time

Order

- ☒ Episiotomy
- ☒ McRoberts
- ☒ Suprapubic Pressure
- ☐ Woods Screw
- ☐ Posterior Arm
- ☐ Other

2  
1  
3

Total Duration of Shoulder Dystocia

(time of delivery of head to delivery of baby) 1 minutes

Cord Gases Sent

☒ Yes ☐ No

Neonate

Weight

8#1303

Apgars

8/9

Pediatrician Notified

☒ Yes ☐ No

Attended Delivery

☒

Delivery Discussed with Parents

Comments

After Delivery Cord gas WNL

(R) Arm & minimal movement

(R) Hand + fingers are moving

Signature

J Maselli, MD

600006478588

SMALLING, PHILLIPPA S

DOB: 11/29/1976

MASELLI, LISA R

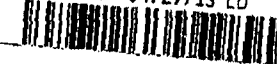
ADM Date: 04/27/13 LD

M000378404

Age: 36

Sex:

0240



**\* Exhibit 31 (Identified by Defendants and proffered as a Court Exhibit)**

**This Exhibit represents a heavily edited transcript of a videotaped trial deposition of Dr. Michael Duchowny. Its final edits were made in the courtroom shortly before its presentation to the jury. Appellant's counsel just realized he does not currently have in his possession a version of the transcript which accurately reflects these final edits. He is seeking to obtain such version and proposes, with leave of the Court, to include it as part of an Amended Record of Appeal.**

STATE OF SOUTH CAROLINA  
COUNTY OF GEORGETOWN

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT  
C/A NO.: 2016-CP-22-00863

Phillippa Smalling, Individually, and as  
Next Friend of Jahmerican M., a Minor,  
Plaintiff,

vs.

Lisa R. Maselli, M.D., both individually  
and as agent/employee of Carolina  
OB/GYN,

Defendants.

**PLAINTIFF'S PRE-TRIAL BRIEF**

TO: THE HONORABLE LARRY B. HYMAN, JR. PRESIDING JUDGE OF THE FIFTEENTH  
JUDICIAL CIRCUIT

**I. CONCISE, NON-ARGUMENTATIVE STATEMENT OF THE FACTS**

**A. STATEMENT OF UNDISPUTED FACTS**

This is an obstetrical negligence claim involving allegations of negligence and other wrongdoing by Defendant Dr. Maselli during the birth of Jahmerican (hereinafter, "J.M."), which caused him to sustain severe and permanent injuries to his brachial plexus nerves on the right side. Brachial plexus nerves provide motor function to the muscles in the shoulder area, arm and hand, as well as certain sensory functions.

After learning she was pregnant, Phillippa Smalling (hereinafter, "Phillippa"), J.M.'s mother, sought and received prenatal care from Dr. Maselli's obstetrical group, the Defendant Carolina OB/GYN. On April 27, 2013, Phillippa was admitted to Georgetown Hospital for labor and delivery. Upon her admission, Dr. Maselli was responsible for managing Phillippa's labor and delivery.

After J.M.'s head delivered, his top shoulder ("anterior" shoulder) did not deliver with normal and gentle traction, signaling an obstetrical complication known as "shoulder dystocia."

This complication results in a delay in delivery of the baby's body, usually caused, as in this case, by the top shoulder becoming lodged behind the mother's pubic bone in its passage through the birth canal.

Standard obstetrical teaching provides several techniques and maneuvers to resolve the shoulder dystocia and deliver the baby injury-free. Some of these are external to the mother's body and can be performed by nurses. Others are internal, meaning inside of the mother's birth canal. These can be performed only by a physician.

Dr. Maselli ordered the nurses to perform two external maneuvers in this delivery, McRoberts positioning and suprapubic pressure; and she herself cut an episiotomy. These, plus normal and gentle traction by Dr. Maselli, did not release the top shoulder. At that point three commonly used internal maneuvers were available for Dr. Maselli to use to release the shoulder safely, with no increase in her traction on the baby's head or bending of his neck. These are the Rubin's maneuver, the Woods maneuver and the posterior ("bottom") arm delivery method. Dr. Maselli chose not to take advantage of any of these common safety maneuvers for which she was trained. Instead, Dr. Maselli chose to try to release the top shoulder by manipulating the baby's head more forcefully. With the nurses performing suprapubic pressure according to her orders, Dr. Maselli pulled Jahmerican's head out and down with increasingly force.

J.M. was delivered approximately one minute after his head delivered. Unfortunately, J.M. was delivered with traumatic injuries to the brachial plexus nerves on the right side of his neck. His right arm hung limp following his birth, paralyzed except for minimal movement of his fingers. The slight finger movement gave the doctors hope that C-8 and T-1 of his brachial plexus nerves may be recover, with no permanent damage to those nerves. Fortunately, that did occur.

In contrast, three of his nerves have severe and devastating permanent damage. The child's C-5 and C-6 nerve roots are completely avulsed from his spinal cord; and the C-7 nerve root is partially avulsed. A large neuroma formed, encompassing the three injured nerves. With multiple surgeries and extensive rehabilitation and therapy, J.M.'s right shoulder and arm have improved somewhat, but he has significant residual impairments which are permanent. His impairments and disabilities include, among others, loss of muscle mass and strength, reduced range of motion in his right arm in all directions. He will never be able to perform activities requiring two arms, and will have no use of his right arm except as a helper arm. In addition, J.M. suffers adverse effects on various other bodily functions, including gait, balance and skeletal symmetry. The awkward posturing of his right arm represents disfigurement. That plus his inability to perform like his peers is already a source of teasing and embarrassment.

### **B. DEFINITIONS OF KEY MEDICAL CONCEPTS**

To better understand the basic facts of this case, it is helpful to understand the medical terms and terminology that will be presented to the jury. The following are some of the medical terms that may be discussed and or demonstrated during the trial:

1. "Brachial Plexus Nerves" are a complex of nerves which exit the spine in the neck region and provide motor function to the muscles of the shoulders, arms and hands, as well as some sensory function. The brachial plexus nerves on the right provide motor and sensory function to the right shoulder, arm and hand, and the left side brachial plexus provides the same function on that side. The brachial plexus nerves exit the spinal cord at C-5, C-6, C-7, C-8 and T-1, with "C" referring to the cervical spine and "T" referring to the thoracic spine.



2. "Brachial Plexus Birth Injury" is injury to one or more of the brachial plexus nerves which occurs during delivery. Some injuries are temporary; others are permanent; and the latter vary in type of damage, location and severity.

3. "Permanent" Brachial Plexus Birth Injury is a brachial plexus birth injury that persists for more than 18-24 months, according to pediatric neurologists, surgeons, and other specialists who treat the injury. Some obstetricians, who do not treat the injury, assert that a brachial plexus birth injury is permanent if it persists for more than 6 or 12 months.

4. "Transient" or "Temporary" Brachial Plexus Birth Injury is a brachial plexus birth injury which heals before 18-24 months, according to pediatric neurologists, surgeons, and other specialists who treat the injury. Some obstetricians, who do not treat this injury, assert that a brachial plexus birth injury is transient or temporary if it heals within 6 to 12 months.

5. Most often, and in this case, "Shoulder Dystocia" is difficulty delivering the top ("anterior") shoulder during a head-first vaginal delivery, because that shoulder becomes lodged behind the mother's pubic bone ("maternal symphysis pubis") during its passage through the birth canal.

6. "Traction" is a pulling force that acts to stretch an object.

7. "Gentle Traction" is that degree of pulling force that is normally used to guide out the top ("anterior") shoulder in a normal vaginal delivery uncomplicated by Shoulder Dystocia.

8. "Excessive Traction" is the same as "Greater Than Gentle Traction." Some define "Excessive Traction" as that degree of traction which is sufficient to cause injury.

9. "Axial Traction" is a pulling force on the baby's head applied in alignment with the neck and chest portion of the baby's spine ("cervicothoracic spine").

10. "Lateral Traction" is a pulling force on a baby's head which pulls one ear closer to the shoulder on that same side, thereby increasing the opening of the angle between the neck and shoulder on the opposite side, thereby increasing the stretch on the brachial plexus nerves on that opposite side.

11. "Rupture" of a brachial plexus nerve is the result of traumatic ripping and tearing of a nerve, either partially or completely.

12. "Avulsion" of a nerve root is the result of traumatic force sufficient to rip the nerve root out of the spinal cord itself. Nerve root avulsion may also be partial or complete.

13. "Muscle Fibrosis" is the result of muscle scarring often seen as a result of significant trauma to nearby nerves.

14. "Neuroma" is a wad of damaged nerve cells, fibrotic muscle tissue, fat, blood and other components that may form near the site of a significant nerve rupture or avulsion. The presence of a neuroma makes surgical repair of the nerve more complex and less likely to succeed.

15. "McRoberts positioning" involves pushing back the mother's legs (usually by two nurses) so the mother's hips and knees are firmly flexed back toward her shoulders. McRoberts positioning is one of the techniques nurses can use, upon order of the obstetrician, to try to facilitate the resolution of shoulder dystocia by altering the angle of the pelvic opening.

16. "Suprapubic pressure" involves placement of the nurse's hand or fist on the outside of the mother's body, near her pubic bone, applying pressure on the baby's top shoulder, toward the baby's chest. Suprapubic pressure is one of the techniques nurses can use, upon order of the obstetrician, to try to dislodge the top shoulder from behind the mother's pubic bone to try to facilitate the resolution of shoulder dystocia.

17. “Wood’s maneuver” is performed with the physician’s hand inserted into the birth canal to rotate one of the baby’s shoulders “posteriorly,” or toward the baby’s back. This is one of the physician’s maneuvers which are available to try to facilitate the resolution of shoulder dystocia.

18. “Rubin’s maneuver” involves the physician’s hand being inserted into the birth canal to rotate one of the baby’s shoulders “anteriorly,” or from the back of the shoulder to the baby’s chest. This is another of the physician’s maneuvers which are available to try to facilitate the resolution of shoulder dystocia.

19. “Posterior arm delivery” is a method in which the physician delivers the bottom (“posterior”) arm and shoulder first, rather than the usual method of delivering the top (“anterior”) shoulder first. This is yet another physician’s maneuver which is available to facilitate the resolution of shoulder dystocia.

## **II. AN OBJECTIVE STATEMENT OF THE FACTS IN CONTROVERSY**

The facts in controversy are closely aligned with the elements of medical malpractice cases. The parties disagree about applicable standards of care, breaches thereof by Dr. Maselli, causation, extent of the child’s damages, inapplicability of the medical emergency statute, and the appropriateness of punitive damages.

## **III. LEGAL ISSUES**

Plaintiff anticipates that most of the legal issues will include those typically addressed in a medical malpractice case, i.e. standards of care; breaches; causation; and damages. Plaintiff directs the Court’s attention to the following issues:

A. Defense counsel may assert that Plaintiff's experts rely on *res ipsa loquitur*, but that is incorrect. *Res ipsa* is where Plaintiff argues that the injury itself proves negligence. In this case, Plaintiff does not assert that J.M.'s injury proves negligence. Plaintiff does assert that under the facts and circumstances of this case, her severe permanent injury, including three complete nerve ruptures and development of a large neuroma, proves that Dr. Maselli applied greater than gentle traction to J.M.'s head and neck. Whether excessive traction is negligent or not depends on consideration of other factors, such as the time that passed between the delivery of the baby's head and the rest of the body; the safety maneuvers that had not yet been attempted, etc. In this case, Dr. Maselli's greater than gentle traction was negligent, because she chose not to use appropriate safety maneuvers, but instead chose to increase traction to affect the delivery of J.M.'s shoulder within one minute after her head delivered.

B. Plaintiff anticipates that the defense will argue that the medical emergency statute applies in this case. The medical emergency statute is set forth in S.C. Code Section 15-32-230. Plaintiff asserts that the statute does not apply to this case for a number of reasons. Because explaining Plaintiff's position on this critical issue would be longer than would be expected for inclusion in a pretrial brief, Plaintiff will address this issue in a separate filing.

C. The non-economic cap set forth in S.C. Code Section 15-32-220 et seq., if applicable, would apply separately to each Defendant. However, subsection (E) signifies that the non-economic cap is not applicable because Dr. Maselli was grossly negligent, willful, wanton, and/or reckless, and such conduct was the proximate cause of Plaintiff's non-economic damages. The damages cap is also inapplicable because Dr. Maselli has engaged in misrepresentation related to the claim.

D. Certain other legal issues are addressed separately in Plaintiff's Motions in Limine

#### IV. EXHIBITS AND WITNESSES

A. Plaintiff's exhibits are listed below.

| Exhibit No. | Exhibit name                                                              |
|-------------|---------------------------------------------------------------------------|
| 1           | ER Nursery record <b>Georgetown Mem Hosp (HLF) (child) 0053</b>           |
| 2           | Handwritten note <b>Tidelands Georgetown Memorial (mom) 026</b>           |
| 3           | MUSC Operative Note 1; <b>MUSC 19-21</b>                                  |
| 4           | MUSC Operative Note 2; <b>MUSC 32-34</b>                                  |
| 5           | Fetal Heart Monitoring Strips <b>Georgetown Mem Hosp (HLF) 357-363</b>    |
| 6           | Labor Record <b>Tidelands Georgetown Memorial (mom) 21-22</b>             |
| 7           | MUSC Progress Note <b>MUSC 14-15</b>                                      |
| 8           | MRI Report <b>MUSC 0008</b>                                               |
| 9           | Carolina OB-GYN <b>001-041</b>                                            |
| 10          | Tidelands Letter May 19, 2014 <b>Tidelands Next Step 176</b>              |
| 11          | Delivery Report <b>Tidelands Georgetown Mem (mom) 204</b>                 |
| 12          | Shoulder Dystocia Progress Note <b>Tidelands Georgetown Mem 27</b>        |
| 13          | Handwritten Delivery Note <b>Tidelands Georgetown Mem 28-29</b>           |
| 14          | Nurses Delivery Notes <b>Tidelands Georgetown Memorial (mom) 199- 208</b> |
| 15          | Shriners Op Note 1 <b>Floyd Brace 0007</b>                                |
| 16          | Shriners Op Note 2 (Not Bates #)                                          |
| 17          | Tidelands Next Step Rehabilitation <b>1-394</b>                           |
| 18          | Georgetown Mem Hospital Records (child) <b>1-242</b>                      |
| 19          | Shriners Medical Records <b>001 - 200</b>                                 |
| 20          | Floyd Brace Company Medical Recs <b>001- 027</b>                          |
| 21          | MUSC Medical Records <b>1 - 58</b>                                        |
| 22          | MUSC Medical Records <b>1- 389</b>                                        |
| 23          | Medical Billing Summary Chart                                             |
| 24          | Yearly calendars indicating medical appointments                          |
| 25          | Life Care Plan of Maria Vargas                                            |
| 26          | Report of Dr. Wood                                                        |

|    |                                           |
|----|-------------------------------------------|
| 27 | Report of Dr. Adler March 5, 2016         |
| 28 | Report of Dr. Adler November 5, 2018      |
| 29 | Report of Charles Vanderkolk              |
| 30 | CV Dr. Adler                              |
| 31 | CV Dr. Pliskow                            |
| 32 | CV Charles Vanderkolk                     |
| 33 | CV Dr. Wood                               |
| 34 | Website – Carolina OB-GYN                 |
| 35 | Photograph of Defendants' Office Building |
| 36 | Photographs of minor Plaintiff            |

In addition, Plaintiff identifies the following as potential exhibits at the trial in this matter:

1. Any and all records produced by either party during discovery may be used.
2. Any and all medical records pertaining to the medical care provided to Phillippa Smalling and J.M. obtained during discovery may be used.
3. Enlargement of certain medical records.
4. Videotapes and/or transcripts and exhibits of depositions of any and all fact and/or expert witnesses currently identified by either party.
5. Any and all medical periodicals, journals, texts, papers, or other publication of any kind relied upon by any expert witness (consistent with the learned treatise rule).
6. Medical Illustrations, models and visual demonstratives:
  - a. Certain medical records identified as trial exhibits
  - b. Shoulder Dystocia
  - c. Shoulder Dystocia standard maneuvers
  - d. Calendars showing office visits
  - e. Billing Summary
  - f. Summary of Damages

- g. Anatomy of Brachial Plexus
- h. J.M.'s Nerve Damage
- i. Video Illustrating improper OB Management of Shoulder Dystocia similar to J.M.

B. Plaintiff's witnesses are as follows:

- 1. Phillippa Smalling
- 2. Anthony McCray
- 3. Dr. Daniel Adler
- 4. Vanessa Holmes
- 5. Dr. Steven Pliskow
- 6. Charles Vanderkolk
- 7. Dr. Oliver Wood

Plaintiff reserves the right to call in her case in chief one or more of the following witnesses:

- 1. Dr. Lisa Maselli
- 2. Melissa Butterworth, RN
- 3. Kathy Cossentino, RN

#### **V. UNUSUAL PROBLEMS RELATING TO EVIDENCE**

A. Plaintiff has numerous motions in limine, which are set forth in a separate motion filed contemporaneously with this pre-trial brief.

B. Certain of Plaintiff's experts are from out-of-state. Plaintiff requests the Court to allow such experts to finish their testimony on the day it starts, if at all possible. These witnesses include Dr. Pliskow from West Palm Beach, FL and Dr. Adler from New York, NY, Charles Vanderkolk, from Asheville, NC.

C. Because of the sensitive nature of testimony being presented about J.M., Plaintiff desires that he not be present for trial.

D. Plaintiff intends to use video clips of Dr. Maselli as a basis for her experts' testimony during direct examination. The inclusionary rule does require mandatory inclusion of

defendants' designations in all cases, just where it serves the interests of justice. Therefore, in the interest of efficiency, it is requested that Defendants play any such clips during their permitted cross examination period.

D. Dr. Oliver Wood, Plaintiff's expert economist, is expected to testify to the present value of J.M.'s economic losses. Those include reduced earning capacity and future health care needs. The former is set forth in a report by Dr. Charles Vanderkolk, Plaintiff's vocational expert, who is expected to testify at trial. The latter is set forth in a Life Care Plan prepared by Maria Vargas MS, CRC, CLCP, who will not be testifying.

The defense is expected to object to Dr. Wood's testimony related to the Life Care Plan. Dr. Wood's testimony on that subject is proper, and should be allowed, for two reasons. First, Rule 703, SCRE allows for expert testimony to be given when based upon facts and data made known to the expert before trial, if such facts and data are "of a type reasonably relied upon by experts in the particular field...." Dr. Wood's testimony about the Life Care Plan is admissible under this Rule. Second, and directly to the point, our Court of Appeals has already determined that it is proper for Dr. Wood to testify to a Life Care Plan when the author thereof does not testify. *Hundley v. Rite Aid*, 339 S.C. 285, 529 S.E.2d 45 (Ct. App. 2000).

## **VI. UNUSUAL QUESTIONS OR MATTER WHICH SHOULD BE BROUGHT TO THE ATTENTION OF THE COURT**

Plaintiff will address the inapplicability of the Emergency Medical and Obstetrical Care Act in a separate filing, because of its length.



## VII. STATUS OF SETTLEMENT NEGOTIATIONS

A settlement could not be reached at mediation. Plaintiff's litigation expenses have subsequently increased substantially.

Respectfully submitted,

Greenville, South Carolina

GRAHAM LAW FIRM, P.A.

March 31, 2019

By: s/Edward L. Graham  
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Attorney for Plaintiff

STATE OF SOUTH CAROLINA  
COUNTY OF GEORGETOWN

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT  
C/A NO.: 2016-CP-22-00863

Phillippa Smalling, Individually, and as  
Next Friend of Jahmerican M., a Minor,

Plaintiff,

vs.

Lisa R. Maselli, M.D., both individually  
and as agent/employee of Carolina  
OB/GYN,

Defendants.

**PLAINTIFF'S BREIF IN OPPOSITION TO  
DEFENDANTS' ARGUMENT OF THE  
APPLICABILITY OF THE EMERGENCY  
STATUTE DEFENSE**

TO: THE HONORABLE LARRY B. HYMAN, JR. PRESIDING JUDGE OF THE FIFTEENTH  
JUDICIAL CIRCUIT

The Defendants intend to be heard on the applicability of the Emergency Medical and Obstetrical Care Act. The statute confers qualified immunity to (1) certain physicians; (2) providing care in certain locations; (3) involving certain types of care; (4) in certain types of emergencies; (5) subject to certain exceptions. The qualified immunity requires that Plaintiffs in a medical malpractice case must prove a higher standard of wrongdoing, rather than ordinary

negligence, where certain facts and circumstances apply to the alleged medical malpractice. For reasons hereinafter set forth, the statutory defense is unavailable to the Defendants in this case.

Subsections (A) and (B) of S.C. Code of Laws Section 15-32-230, properly read together, renders the statute inapplicable to cases alleging negligent obstetrical care where the pregnant patient had established a prior doctor-patient relationship with the defendant obstetrician and had received prenatal care. There is no dispute, much less any genuine dispute, that the plaintiff mother had established a prior doctor-patient relationship with the defendant OB and had received prenatal care. Thus, the OB's asserted statutory defense is unavailable as a matter of law.

Subsection (A) refers to "care" provided in a "genuine emergency situation" to a patient in an "emergency department, or in an obstetrical or surgical suite." That Subsection references "care" generically, and does not specify which specialty practice area is subject to the statute, nor what type of care is subject thereto. If statutory exceptions do not apply, the physical location of the care determines whether the physician will have immunity from negligently inflicted injury.

Those locations include an emergency department, an obstetrical suite or a surgical suite. Specifying those locations does not identify the medical specialty to which the statutory protection applies, nor the type of care provided in such locations. Specialists other than emergency physicians frequently provide care in emergency departments. Specialists other than obstetricians provide care in obstetrical suites. Specialists other than surgeons provide care in surgical suites.

In contrast to Subsection A, Subsection B refers specifically to "obstetrical care." It only requires care "on an emergency basis," rather than "in a genuine emergency situation." It does not limit the location where such care must have been provided for the statutory exceptions to apply.

Thus, as compared to Subsection A, Subsection B addresses (1) a specific medical specialty, i.e., obstetrics, (2) in every “emergency situation,” not just “a genuine emergency situation;” and (3) more locations where that care may be provided for the statute to apply.

Certain restrictive parts of Subsections (A) and (B) are consistent. For example, both Subsections restrict the qualified immunity to situations where the patient is “not medically stable” and is in “immediate threat of death” or “serious bodily injury.” Only Subsection (B), however, has an additional restriction on its qualified immunity. Qualified immunity for obstetricians is available only if “there is no previous doctor/patient relationship between the physician or a member of his practice with a patient” or if “the patient has not received prenatal care.”

It would be illogical and contrary to well-established principles of statutory construction to apply the immunity provisions of subsection (A) to obstetricians without simultaneously applying the additional restrictions on immunity for obstetricians set forth in subsection (B). “The cardinal rule of statutory interpretation is to ascertain and effectuate the intention of the legislature.” *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). “When a statute’s terms are clear and unambiguous on their face, there is no room for statutory construction and a court must apply the statute according to its literal meaning.” *Sloan v. Hardee* 371 S.C. 495, 498, 640 S.E.2d at 459. In interpreting a statute “(w)ords must be given their plain and ordinary meaning without resort to subtle or forced construction to limit or expand the statute’s operation.” *Id.* Further the “statute must be read as a whole and sections which are a part of the same general statutory law must be construed together and each one given effect. *S.C. State Ports Auth. V. Jasper Cnty.*, 368 S.C. 388, 398, 629 S.E. 2d 624, 629 (2006). “If the statute is ambiguous...Courts must construe the terms of the statute.” *Town of Mt. Pleasant v. Roberts*, 393 S.C. 332, 713 S.E. 2d 278 (2011).

The statutory language must be construed considering the intended purpose of the statute. *Id.* A court must not construe a statute in a way that leads to an absurd result or renders it meaningless. *Lancaster Cnty Bar Ass’n v. S.C. Comm’n on Indigent Def.*, 380 S.C. 219, 670 S.E. 2d 371 (2008). (“In construing a statute, this Court will reject an interpretation when such an interpretation leads to an absurd result that could not have been intended by the legislature”.) These are well-established rules of statutory construction. See *Ranucci v. Crain*, 409 S.C. 493, 763, S.E.2d 189 (2014).

If Subsection A were interpreted to apply to obstetricians on its own, without reference to Subsection B, then obstetricians would receive qualified immunity (1) whether or not there was a prior doctor-patient relationship; (2) but only in “genuine” emergency situations; (3) only if the care was being provided in an emergency department, obstetrical or surgical suite; and (4) only if other limitations on qualified immunity were absent. That would be an absurd result, as Subsection B, applicable only to obstetricians, (1) does not require a “genuine” emergency; (2) does not limit the location of the care alleged to be negligent; (3) yet is inapplicable if there was a prior doctor relationship and the patient received prenatal care. Stated differently, obstetricians may benefit from qualified immunity under Subsection A but not Subsection B; yet may also receive qualified immunity under Subsection B but not Subsection A. That is patently absurd, so the statute’s Subsections cannot be construed as applying to obstetricians separately. Further, applying Subsection A to obstetricians when there is a prior doctor-patient relationship and prenatal care would render superfluous those parts of Subsection B. That too would offend traditional maxims of statutory construction.

However, the statutory Subsections apply to other fact situations and other providers, it is crystal clear that the General Assembly did not intend for obstetricians to benefit from qualified

immunity where there was a prior doctor-patient relationship and prenatal care. As there is no question but that Angela had established a prior relationship with the defendant OB and received prenatal care. There is no dispute about those facts, much less any genuine dispute.

## **VII. STATUS OF SETTLEMENT NEGOTIATIONS**

A settlement could not be reached at mediation. Plaintiff is available and willing to continue to reach an agreement should defendants be willing to continue settlement discussions.

Respectfully submitted,

GRAHAM LAW FIRM, P.A.



Edward L. Graham

**Attorneys for Plaintiff**

March 29, 2019

|                                                 |   |                                    |
|-------------------------------------------------|---|------------------------------------|
| STATE OF SOUTH CAROLINA                         | ) | IN THE COURT OF COMMON PLEAS       |
|                                                 | ) | FOR THE FIFTEENTH CIRCUIT          |
| COUNTY OF GEORGETOWN                            | ) |                                    |
| Phillippa Smalling, Individually and as Next    | ) | C/A No. 2016-CP-22-00863           |
| Friend of Jahmerican M., a minor,               | ) |                                    |
|                                                 | ) |                                    |
| <i>Plaintiff,</i>                               | ) |                                    |
|                                                 | ) |                                    |
| Versus                                          | ) | <b>DEFENDANTS' PRE-TRIAL BRIEF</b> |
|                                                 | ) |                                    |
| Lisa R. Maselli, M.D., both individually and as | ) |                                    |
| agent/employee of Carolina OB/GYN,              | ) |                                    |
|                                                 | ) |                                    |
|                                                 | ) |                                    |
| <u><i>Defendant</i></u>                         | ) |                                    |

TO: THE HONORABLE LARRY B. HYMAN, JR., PRESIDING JUDGE OF THE  
FIFTEENTH JUDICIAL CIRCUIT:

The Defendants Lisa R. Maselli, M.D., both individually and as agent/employee of Carolina OB/GYN (hereinafter "the Defendants"), by and through their undersigned counsel and pursuant to Rule 16(c) of the South Carolina Rules of Civil Procedure, respectfully submit the following Pretrial Brief to the Court:

**1. A CONCISE, NON-ARGUMENTATIVE STATEMENT OF THE FACTS OF THE CASE.**

This is a case involves the labor of Phillippa Smalling and the delivery of her son, Jahmerican. On April 27, 2013, Ms. Smalling presented to Georgetown Memorial Hospital in active labor. Dr. Maselli managed the delivery. Ms. Smalling was also a patient of Dr. Maselli's practice, Carolina OB/GYN, during her pre-natal care. Dr. Maselli encountered the complication of shoulder dystocia during the delivery which lasted approximately one minute. Dr. Maselli utilized two external maneuvers, McRoberts and Suprapubic pressure, to resolve the shoulder dystocia in approximately one minute. The baby was later diagnosed as suffering a brachial plexus injury to his right shoulder.

**2. AN OBJECTIVE STATEMENT OF THE FACTS IN CONTROVERSY.**

Plaintiff, through her experts, contend that Dr. Smalling breached the standard of care in her management of the shoulder dystocia by allegedly applying excessive lateral traction during the delivery process that caused a permanent brachial plexus injury.

The Defendants will prove that Dr. Maselli complied with the standard of care at all times, properly managed the shoulder dystocia emergency, and, by act or omission, did not cause Jahmerican's brachial plexus injury.

**3. THE LEGAL ISSUES INVOLVED.**

- A. General South Carolina case law regarding medical malpractice.
- B. South Carolina Non-Economic Damage Awards Act of 2005, S.C. Code § 15-32-200, et seq.
- C. South Carolina Code Ann. § 15-32-510, et seq.
- D. South Carolina Code Ann §15-32-230, et seq.

**4. A LISTING OF EXHIBITS, INDICATING THOSE TO WHICH THERE IS A DISAGREEMENT AND A LISTING OF WITNESSES WHO MAY BE CALLED.**

**A. Exhibits**

The following is a list of the exhibits known at this time. This list may be changed or supplemented closer to or at the time the Defendants present their case.

I. Medical records, literature and other documents produced by the parties including, but not limited to, the following:

|   |                                      |                                               |
|---|--------------------------------------|-----------------------------------------------|
| 1 | CAROLINA OB/GYN CHART                | CAROLINA OB/GYN 0001-0066                     |
| 2 | GEORGETOWN HOSPITAL RECORDS (MOTHER) | GEORGETOWN MEM HOSP (HLF) (0001-0356)         |
| 3 | GEORGETOWN HOSPITAL RECORDS (CHILD)  | GEORGETOWN MEM HOSP (HLF) (0001-0242)         |
| 4 | PRE-DELIVERY PROGRESS NOTES          | GEORGETOWN MEM HOSP (HLF) (0131-0132)(MOTHER) |



|    |                           |                                                  |
|----|---------------------------|--------------------------------------------------|
| 5  | DICTATED DELIVERY NOTE    | GEORGETOWN MEM HOSP<br>(HLF) (0111-0112)(MOTHER) |
| 6  | HANDWRITTEN DELIVERY NOTE | GEORGETOWN MEM HOSP<br>(HLF) (0130)(MOTHER)      |
| 7  | NURSE DYSTOCIA SHEET      | GEORGETOWN MEM HOSP<br>(HLF) (0119)(MOTHER)      |
| 8  | DOCTOR DYSTOCIA SHEET     | GEORGETOWN MEM HOSP<br>(HLF) (0129)(MOTHER)      |
| 9  | FHM STRIPS                | GEORGETOWN MEM HOSP<br>(HLF) (0357-0363)(MOTHER) |
| 10 | DISCHARGE NOTE            | GEORGETOWN MEM HOSP<br>(HLF) (0083)(MOTHER)      |
| 11 | PRE-NATAL VISITS          | CAROLINA OBGYN 0016-<br>0019, 0044-0045          |

II. Additionally, the Defendants hereby identify the following as potential exhibits at the trial of this case:

- a. Medical illustrations, models and visual demonstratives.
  - i. Image of Normal Fetal Presentation
  - ii. Image of Shoulder Dystocia
  - iii. Image of McRoberts Maneuver
  - iv. Image of Suprapubic Pressure
  - v. Image of Mediolateral Episiotomy
  - vi. Video animation of delivery with shoulder dystocia
- b. Exhibits to any depositions taken in this case.
- c. Enlargement of certain medical records may also be used.
- d. To the extent not identified above, any and all records produced by any party
- e. Any and all medical records concerning the medical care provided to Phillippa Smalling and Jahmerican which were obtained during discovery may be used.
- f. Transcripts of the depositions of any and all fact and/or expert witnesses currently named by either party. Specifically, Defendants will introduce

the trial deposition testimony of its expert Dr. Michael Samuel Duchowney, M.D.

- g. Any and all medical periodicals, journals, texts, papers, or other publication of any kind relied upon by any expert witness.
- h. Curriculum Vitae of various experts.
- i. Any and all records produced by either party in discovery may be used.
- j. Applicable sections from the S.C. Code of Laws regarding medical malpractice lawsuits and the introduction of expert testimony.

#### **B. Witnesses**

The Defendants reserve the right to call any party and witnesses (a) listed in Answers to Interrogatories or otherwise listed by the Plaintiffs; (b) those witnesses previously identified and/or deposed by any party, (c) reserve the right to call rebuttal witnesses and finally; (d) reserve the right to supplement or amend this list as this case progresses. At this time, the Defendants would identify the following witnesses:

- 1. Dr. Lisa Maselli, M.D.
- 2. Dr. Christopher J Robinson, M.D.
- 3. Dr. Michael Samuel Duchowney, M.D.
- 4. Dr. Suneet P. Chauhan, M.D.
- 5. Melissa Butterworth, RN
- 6. Kathy Cossentino, RN
- 7. David Haseltine, M.D.

#### **5. ANY UNUSUAL PROBLEMS RELATING TO EVIDENCE TO BE INTRODUCED, ETC.**

The Defendants will submit two Motions *in Limine*: (1) Exclusion of Reptile litigation tactics; and (2) Exclusion of testimony from Vanessa Holmes. As noted above, Defendants will introduce the trial deposition testimony of Dr. Duchowney. This deposition contained a large number of objections that the court will need to address.

**6. ANY UNUSUAL QUESTION OR MATTER WHICH SHOULD BE BROUGHT TO THE ATTENTION OF THE COURT.**

The Court will hear arguments concerning the applicability of the Emergency Medical and Obstetrical Care Act located at South Carolina Code Ann§ 15-32-230, et seq. This statute provides that in an obstetrical emergency, the doctor is not liable unless she is found to be grossly negligent. The statute reads as follows:

(A) In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care in an emergency department or in an obstetrical or surgical suite, no physician may be held liable unless it is proven that the physician was grossly negligent.

(B) In an action involving a medical malpractice claim arising out of obstetrical care rendered by a physician on an emergency basis when there is no previous doctor/patient relationship between the physician or a member of his practice with a patient or the patient has not received prenatal care, such physician is not liable unless it is proven such physician is grossly negligent.

(C) The limitation on physician liability established by subsections (A) and (B) shall only apply if the patient is not medically stable and:

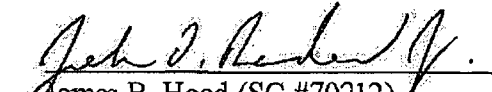
- (1) in immediate threat of death; or
- (2) in immediate threat of serious bodily injury.

Further, the limitation on physician liability established by subsections (A) and (B) shall only apply to care rendered prior to the patient's discharge from the emergency department or obstetrical or surgical suite.

**7. A STATEMENT THAT SETTLEMENT NEGOTIATIONS WERE ATTEMPTED BEFORE THE DATE OF THE PRE-TRIAL HEARING, AND THE STATUS OF SETTLEMENT NEGOTIATIONS.**

Settlement negotiations have been attempted unsuccessfully. The Defendants are ready to move forward with trial.

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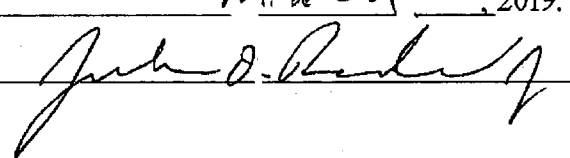
*Attorneys for the Defendants*

March 28, 2019  
Charleston, South Carolina

**CERTIFICATE OF SERVICE**

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

This 28 day of March, 2019.



STATE OF SOUTH CAROLINA  
COUNTY OF **GEORGETOWN**

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT  
C.A. No.: **2016-CP-22-00863**

Phillippa Smalling, Individually and as Next  
Friend of Jahmerican M., a Minor,

Plaintiffs,

v.

Lisa R. Maselli, MD, both Individually and  
as agent/employee of Carolina OB/GYN,

Defendants.

**MOTION FOR PARTIAL SUMMARY  
JUDGMENT, OR IN THE  
ALTERNATIVE, AN ORDER  
GRANTING A STAY OF TRIAL UNTIL  
PENDING APPEALS IN OTHER CASES  
RESOLVE MATERIAL ISSUES LIKELY  
TO ARISE IN THIS CASE**

PLEASE TAKE NOTICE that the Plaintiff, Phillippa Smalling, by and through her undersigned Counsel, pursuant to Rule 56 of the South Carolina Rules of Civil Procedure moves for Partial Summary Judgment as this Plaintiff is entitled to judgment as a matter of law.

1. Plaintiff hereby moves for Partial Summary Judgment to preclude the expected statutory defense under **S. C. Code of Laws Section 15-32-230**, representing a liability shield for negligently inflicted harm in the context of certain alleged obstetrical emergencies. This statute fails to define its key words and phrases, including, *inter alia*, “genuine emergency,” “immediate threat,” and “medically stable.” Plaintiff asserts that the statute, properly construed, is immaterial to the facts and circumstances of this case. That is because the plaintiff was a patient of the defendants during her prenatal care; and this case involves, *inter alia*, no “genuine emergency” outside of Defendant Dr.

Miller's specialty practice. This motion is based upon such authorities and materials as will be presented to the court at or before the hearing of this motion.

2. In the alternative, Plaintiff moves for an Order granting a stay of trial until pending appeals in other cases resolve material issues likely to arise in this case. There are two appellate cases now pending before the S. C. Court of Appeals which address various novel and complex legal and medical issues arising under **S. C. Code of Laws Section 15-32-230**. Those issues also arise in this case. This case currently appears on a roster of cases to be scheduled for a date certain trial sometime in the months of January through March 2019. If then tried, many novel and complex medical and legal issues arising under the statute will require evidentiary rulings as well as rulings concerning many proposed requests to charge. There will be much disagreement about the correct definition of the key words and phrases, and the applicability of various interpretations of the statutory defense to particular fact patterns. Resolution of these thorny issues in any obstetrical negligence case is likely to be inconsistent with the rulings made by other trial and appellate courts about similar issues.

If this case is tried prior to the Appellate Court's finding, an appeal of this case is virtually guaranteed from one or both sides, because the resolution of numerous issues in this case are highly unlikely to be consistent with presently unknown future rulings by our appellate courts in the two pending cases on appeal. Retrial is likely to be the result, with consequential expense to all litigants as well as the court. If trial is stayed until after such appeals are concluded, this court will have guidance from the appellate courts about statutory definitions, applicability to certain fact patterns, and related matters. A stay would minimize the likelihood of an appeal and retrial regarding novel statutory issues. A stay would thus serve the interests of judicial economy and preservation of

judicial resources and would also allow the parties to avoid unnecessary duplicative costs. For these reasons, at least one other court has determined that a stay is desirable and has entered its order accordingly.

The parties have conferred and counsel for Defendant has informed Plaintiff he cannot consent to the Motion.

WHEREFORE, Plaintiff moves this Honorable Court to GRANT her Motion for Partial Summary Judgment to preclude the expected statutory defense under **S. C. Code of Laws Section 15-32-230**. Or, in the alternative, Plaintiff moves this Court to GRANT her Motion for an Order granting a stay of trial until pending appeals in other cases resolve material issues likely to arise in this case.

Respectfully submitted,

GRAHAM LAW FIRM, P.A.

By: /s Edward L. Graham  
Edward L. Graham  
Attorney for Plaintiff

Post Office Box 550  
Florence, SC 29503

October 17, 2018

STATE OF SOUTH CAROLINA  
COUNTY OF GEORGETOWN

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT  
C.A. No.: 2016-CP-22-00863

Phillippa Smalling, Individually and as Next  
Friend of Jahmerican M., a Minor,

Plaintiffs,

v.

Lisa R. Maselli, MD, both Individually and  
as agent/employee of Carolina OB/GYN,

Defendants.

**PLAINTIFF'S RULE 59(e) MOTION FOR  
NEW TRIAL**

TO: THE HONORABLE LARRY B. HYMAN, JR. PRESIDING JUDGE OF THE  
FIFTEENTH JUDICIAL CIRCUIT

Plaintiff, by and through her counsel submits her Rule 59 Motion for a New Trial.

A new trial may be granted to all or any of the parties and on all or part of the issues (1) in an action in which there has been a trial by jury, for any of the reasons for which new trials have heretofore been granted in actions at law in the courts of the State; and (2) in an action tried without a jury, for any of the reasons for which rehearings have heretofore been granted in the courts of the State. On a motion for a new trial in an action tried without a jury, the court may open the judgment if one has been entered, take additional testimony, amend findings of fact and conclusions of law or make new findings and conclusions, and direct the entry of a new judgment.

In this Motion Plaintiff reiterates and clarifies with specificity the grounds for her post-trial motions and seeks verification that the Court's denial of her motions represents a ruling on each and every such ground. These grounds apply to each of her post-trial motions, including renewal of her motion for directed verdict, as well as her motions for judgment notwithstanding of the verdict and new trial.



Specifically, Plaintiff asserts the following grounds in support of her post-trial motions:

1. As a matter of law, the statutory defense set forth in S.C. Code of Laws section 15-32-230 is inapplicable to this case. It should have been disallowed either at the partial summary judgment stage or by directed verdict. It was error for the Court(s) to deny those motions. The purported defense is inapplicable to this case for several reasons, including the following:
  - a. The Defendants failed to make a *prima facie* showing of a “genuine emergency” (or a “genuine” emergency) and therefore failed to create a jury question regarding whether the shoulder dystocia in this case was a “genuine emergency” (or a “genuine” emergency).
  - b. “Genuine emergency” (or “genuine” emergency) is a legal term of art which is not defined in the statute. As a matter of statutory construction, “genuine emergency” must mean something other than “emergency,” or the word “genuine” would be superfluous.
  - c. Shoulder dystocia is a complication of vaginal labor and delivery for which obstetricians, including Dr. Maselli, receive training to manage and resolve within the applicable standards of obstetrical care. Therefore, as to obstetricians, shoulder dystocia is not a type of “genuine emergency” for which the statute provides qualified immunity.
  - d. In this case the fetal heart monitoring strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder dystocia in this case does not meet the standard of “genuine emergency.”

- e. In this case, the shoulder dystocia was resolved in approximately one minute. Therefore, this shoulder dystocia does not meet the standard of “genuine emergency.”
- f. In this case, Dr. Maselli was at the Plaintiff’s bedside when the shoulder dystocia complication arose. Therefore, this shoulder dystocia does not meet the standard of “genuine emergency.”
- g. The Defendants failed to make a *prima facie* showing of an “immediate threat” (or “immediate” threat) of death or serious bodily injury and therefore failed to create a jury question regarding whether there was an “immediate threat” (or “immediate” threat).
- h. “Immediate threat” (or “immediate” threat) is a legal term of art which is not defined in the statute. As a matter of statutory construction, “immediate threat” must mean something other than the immediate threat which is part and parcel of every emergency, or the phrase would be superfluous.
- i. In this case the fetal heart monitoring strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder dystocia in this case does not meet the standard of “immediate threat.”
- j. In this case the shoulder dystocia was resolved in approximately one minute. Therefore, this shoulder dystocia did not meet the standard of “immediate threat.”

- k. In this case Dr. Maselli was at the Plaintiffs' bedside when the shoulder dystocia complication arose. Therefore, this shoulder dystocia does not meet the standard of "immediate threat."
- l. Shoulder dystocia does not itself automatically represent an "immediate threat" for all patients or for this patient.
- m. Potential future death or serious bodily injury from unresolved shoulder dystocia does not equate to an "immediate threat" for all patients or for this patient.
- n. The Defendants failed to make a *prima facie* showing that the minor was "not medically stable" (or not medically "stable") and therefore failed to create a jury question regarding whether the patient was "not medically stable" (or not medically "stable").
- o. "Not medically stable" (or not medically "stable") is a legal term of art which is not defined in the statute. As a matter of statutory construction, "not medically stable" must mean something other than the medical instability present in any emergency, or it would be superfluous.
- p. In this case the fetal heart monitor strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder dystocia does not meet the standard of the patient being "not medically stable."
- q. Because the shoulder dystocia in this case lasted approximately one minute, it does not meet the standard of the patient being "not medically stable."

- r. In this case the baby's Apgars were very good, eight at one minute and nine at five minutes. Therefore, the baby in this case does not meet the standard of "not medically stable."
- s. Temporary loss of oxygen for a brief period of time is present in every vaginal delivery. Therefore, the baby in this case does not meet the standard of "not medically stable."
- t. Shoulder dystocia does not itself automatically represent that all patients or this patient is "not medically stable."
- u. Potential future death or serious bodily injury from unresolved shoulder dystocia does not equate to "not medically stable."
- v. Section A of the statute does not specify any particular medical specialty for which qualified immunity is provided. Instead it provides potential qualified immunity to any and all medical doctors depending on the *location* where the care was provided. Section B is the section which addresses obstetricians specifically. Under traditional principles of statutory construction, these sections must not be interpreted separately, but must be construed as part of the whole, with specifically applicable provisions taking precedence over general provisions. Stated differently, the statute must be construed so as to apply Section B to obstetricians, rather than Section A.
- w. It is undisputed that Plaintiff had prenatal care and had a prior doctor/patient relationship with members of Dr. Maselli's practice.

- x. The defense failed to request any charge which would have provided the jury with correct definitions of the key legal terms of art in the statute, i.e., “genuine emergency,” “immediate threat, and “not medically stable.”
  - y. The purpose and intent of this statute do not apply to the facts and circumstances of this case.
2. For the reasons stated above, it was error for any part of the statute to be charged to the jury.
  3. For the reasons stated above, and in the alternative, in light of the Court’s decision to charge portions of the statute, it was error for the Court not to charge Section B of the statute, in addition to what he charged.
  4. It was error for the Court to give the standard “hindsight” charge without clarifying that this charge relates to negligence only, and not to determining whether there was a “genuine emergency,” an “immediate threat...,” or patient “not medically stable.”
  5. It was error to preclude counsel for Plaintiff from addressing in his reply closing argument the definition of gross negligence which was to be included in the judge’s charge to the jury.
  6. It was error to preclude counsel for Plaintiff from arguing, as part of his reply closing argument, that Plaintiff had proven gross negligence on the part of Dr. Maselli.
  7. “Gross negligence” is relevant to the case only with respect to the statutory defense, which is an affirmative defense. Regardless of the extent to which defense counsel did or did not address “gross negligence” in his closing argument, he unquestionably discussed other elements of his affirmative defense, a critical part of which is the requirement that Plaintiff

prove the elevated culpability standard of gross negligence, if the statute should be deemed applicable. It was error to deny Plaintiff's counsel the right, in reply closing argument, to address and argue any or all portions of the affirmative defense.

8. It was error to accept a verdict on a form which demonstrated on its face that the jury had chosen not to follow the Court's charge on how the deliberations should proceed and how the verdict form must be completed.
9. Any other grounds set forth in the record.

Respectfully submitted,

Greenville, South Carolina

GRAHAM LAW FIRM, P.A.

April 15, 2019

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Attorney for Plaintiff

STATE OF SOUTH CAROLINA  
COUNTY OF **GEORGETOWN**

IN THE COURT OF COMMON PLEAS  
FIFTEENTH JUDICIAL CIRCUIT  
C.A. No.: **2016-CP-22-00863**

Phillippa Smalling, Individually and as Next  
Friend of Jahmerican M., a Minor,

Plaintiffs,

v.

Lisa R. Maselli, MD, both Individually and  
as agent/employee of Carolina OB/GYN,

Defendants.

**PLAINTIFF'S AMENDED MOTION  
UNDER RULE 59(e), SOUTH  
CAROLINA RULES OF CIVIL  
PROCEDURE**

TO: THE HONORABLE LARRY B. HYMAN, JR. PRESIDING JUDGE OF THE  
FIFTEENTH JUDICIAL CIRCUIT, AND JAMES HOOD, COUNSEL FOR  
DEFENDANTS

Pursuant to Rule 59(e), SCRCP, Plaintiff hereby moves this Court for an order altering or amending its oral order denying Plaintiff's post-trial motions. Plaintiff has not received written notice of entry of the order. However, in an abundance of caution, Plaintiff filed and served her motion under Rule 59 (e) on April 15, 2019, within ten days of the date the presiding judge orally denied her post-trial motions on April 5, 2019. That motion is being hereby amended. In the event Plaintiff receives written notice of entry of the Order, Plaintiff intends to re-file and re-serve this motion.

Plaintiff seeks an order from this Court, clarifying whether its prior oral ruling addressed all aspects of the Plaintiff's post-trial motions and supporting grounds. In this Motion, Plaintiff reiterates and clarifies with specificity the grounds for her post-trial motions and seeks verification that the Court's denial of her motions represents a ruling on each and every such ground and/or to alter or amend the judgment as the Court deems proper. These grounds were asserted in support

for each of her post-trial motions, including renewal of her motion for directed verdict, as well as her motions for judgment notwithstanding of the verdict and new trial.

Those supporting grounds are as follows:

1. As a matter of law, the statutory defense set forth in S.C. Code of Laws section 15-32-230 is inapplicable to this case. It should have been disallowed either at the partial summary judgment stage or by directed verdict. It was error for the Court(s) to deny those motions. The purported defense is inapplicable to this case for several reasons, including the following:
  - a. The Defendants failed to make a *prima facie* showing of a “genuine emergency” (or a “genuine” emergency) and therefore failed to create a jury question regarding whether the shoulder dystocia in this case was a “genuine emergency” (or a “genuine” emergency).
  - b. “Genuine emergency” (or “genuine” emergency) is a legal term of art which is not defined in the statute. As a matter of statutory construction, “genuine emergency” must mean something other than “emergency,” or the word “genuine” would be superfluous.
  - c. Shoulder dystocia is a complication of vaginal labor and delivery for which obstetricians, including Dr. Maselli, receive training to manage and resolve within the applicable standards of obstetrical care. Therefore, as to obstetricians, shoulder dystocia is not a type of “genuine emergency” for which the statute provides qualified immunity.
  - d. In this case the fetal heart monitoring strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder



dystocia in this case does not meet the standard of “genuine emergency.”

- e. In this case, the shoulder dystocia was resolved in approximately one minute. Therefore, this shoulder dystocia does not meet the standard of “genuine emergency.”
- f. In this case, Dr. Maselli was at the Plaintiff’s bedside when the shoulder dystocia complication arose. Therefore, this shoulder dystocia does not meet the standard of “genuine emergency.”
- g. The Defendants failed to make a *prima facie* showing of an “immediate threat” (or “immediate” threat) of death or serious bodily injury and therefore failed to create a jury question regarding whether there was an “immediate threat” (or “immediate” threat).
- h. “Immediate threat” (or “immediate” threat) is a legal term of art which is not defined in the statute. As a matter of statutory construction, “immediate threat” must mean something other than the immediate threat which is part and parcel of every emergency, or the phrase would be superfluous.
- i. In this case the fetal heart monitoring strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder dystocia in this case does not meet the standard of “immediate threat.”
- j. In this case the shoulder dystocia was resolved in approximately one minute. Therefore, this shoulder dystocia did not meet the standard of “immediate threat.”

- k. In this case Dr. Maselli was at the Plaintiffs' bedside when the shoulder dystocia complication arose. Therefore, this shoulder dystocia does not meet the standard of "immediate threat."
- l. Shoulder dystocia does not itself automatically represent an "immediate threat" for all patients or for this patient.
- m. Potential future death or serious bodily injury from unresolved shoulder dystocia does not equate to an "immediate threat" for all patients or for this patient.
- n. The Defendants failed to make a *prima facie* showing that the minor was "not medically stable" (or not medically "stable") and therefore failed to create a jury question regarding whether the patient was "not medically stable" (or not medically "stable").
- o. "Not medically stable" (or not medically "stable") is a legal term of art which is not defined in the statute. As a matter of statutory construction, "not medically stable" must mean something other than the medical instability present in any emergency, or it would be superfluous.
- p. In this case the fetal heart monitor strips were reassuring through the time Dr. Maselli diagnosed shoulder dystocia. Therefore, the shoulder dystocia does not meet the standard of the patient being "not medically stable."
- q. Because the shoulder dystocia in this case lasted approximately one minute, it does not meet the standard of the patient being "not medically stable."

- r. In this case the baby's Apgars were very good, eight at one minute and nine at five minutes. Therefore, the baby in this case does not meet the standard of "not medically stable."
- s. Temporary loss of oxygen for a brief period of time is present in every vaginal delivery. Therefore, the baby in this case does not meet the standard of "not medically stable."
- t. Shoulder dystocia does not itself automatically represent that all patients are or this patient is "not medically stable."
- u. Potential future death or serious bodily injury from unresolved shoulder dystocia does not equate to "not medically stable."
- v. Section A of the statute does not specify any particular medical specialty for which qualified immunity is provided. Instead it provides potential qualified immunity to any and all medical doctors depending on the *location* where the care was provided. Section B is the section which addresses obstetricians specifically. Under traditional principles of statutory construction, these sections must not be interpreted separately, but must be construed as part of the whole, with specifically applicable provisions taking precedence over general provisions. Stated differently, the statute must be construed so as to apply Section B to obstetricians, rather than Section A.
- w. It is undisputed that Plaintiff had prenatal care and had a prior doctor/patient relationship with members of Dr. Maselli's practice.

- x. The defense failed to request any charge which would have provided the jury with correct definitions of the key legal terms of art in the statute, i.e., “genuine emergency,” “immediate threat, and “not medically stable.”
  - y. The purpose and intent of this statute do not apply to the facts and circumstances of this case.
2. For the reasons stated above, it was error for any part of the statute to be charged to the jury.
  3. For the reasons stated above, and in the alternative, in light of the Court’s decision to charge portions of the statute, it was error for the Court not to charge Section B of the statute, in addition to what he charged.
  4. It was error for the Court to give the standard “hindsight” charge without clarifying that this charge relates to negligence only, and not to determining whether there was a “genuine emergency,” an “immediate threat...,” or patient “not medically stable.”
  5. It was error to preclude counsel for Plaintiff from addressing in his reply closing argument the definition of gross negligence which was to be included in the judge’s charge to the jury.
  6. It was error to preclude counsel for Plaintiff from arguing, as part of his reply closing argument, that Plaintiff had proven gross negligence on the part of Dr. Maselli.
  7. “Gross negligence” is relevant to the case only with respect to the statutory defense, which is an affirmative defense. Regardless of the extent to which defense counsel did or did not address “gross negligence” in his closing argument, he unquestionably discussed other elements of his affirmative defense, a critical part of which is the requirement that Plaintiff

prove the elevated culpability standard of gross negligence, if the statute should be deemed applicable. It was error to deny Plaintiff's counsel the right, in reply closing argument, to address and argue any or all portions of the affirmative defense.

8. It was error to accept a verdict on a form which demonstrated on its face that the jury had chosen not to follow the Court's charge on how the deliberations should proceed and how the verdict form must be completed.
9. Any other grounds set forth in the record.

Respectfully submitted,

Greenville, South Carolina

GRAHAM LAW FIRM, P.A.

April 16, 2019

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|                                                 |   |                                         |
|-------------------------------------------------|---|-----------------------------------------|
| STATE OF SOUTH CAROLINA                         | ) | IN THE COURT OF COMMON PLEAS            |
|                                                 | ) |                                         |
| COUNTY OF GEORGETOWN                            | ) | FOR THE FIFTEENTH CIRCUIT               |
| Phillippa Smalling, Individually and as Next    | ) | C/A No. 2016-CP-22-00863                |
| Friend of Jahmerican M., a minor,               | ) |                                         |
|                                                 | ) |                                         |
| <i>Plaintiff,</i>                               | ) | <b>DEFENDANTS'</b>                      |
|                                                 | ) | <b>RESPONSE IN OPPOSITION TO</b>        |
| Versus                                          | ) | <b>PLAINTIFF'S MOTION FOR NEW TRIAL</b> |
|                                                 | ) |                                         |
| Lisa R. Maselli, M.D., both individually and as | ) |                                         |
| agent/employee of Carolina OB/GYN,              | ) |                                         |
|                                                 | ) |                                         |
| <i>Defendant.</i>                               | ) |                                         |

TO: EDWARD L. GRAHAM, ATTORNEY FOR THE PLAINTIFF:

The Defendants Lisa R. Maselli, M.D., both individually and as agent/employee of Carolina OB/GYN (hereinafter "the Defendants"), by and through their undersigned counsel, submits the following Response in Opposition to Plaintiff's Motion for New Trial Absolute and/or Judgment notwithstanding the Verdict.

### STATEMENT OF FACTS

This is a case involves the labor of Phillippa Smalling and the delivery of her son, Jahmerican. On April 27, 2013, Ms. Smalling presented to Georgetown Memorial Hospital in active labor. Dr. Maselli managed the delivery. Ms. Smalling was also a patient of Dr. Maselli's practice, Carolina OB/GYN, during her pre-natal care. Dr. Maselli encountered the complication of shoulder dystocia during the delivery. Dr. Maselli utilized two external maneuvers, McRoberts and Suprapubic pressure, to resolve the shoulder dystocia in approximately one minute. The baby was later diagnosed as suffering a brachial plexus injury to his right shoulder. This case was tried the week of April 1, 2019 before the Honorable Larry Hyman and resulted in a jury verdict in favor of Defendants.

In utilizing the verdict form, the jury found the Defendants proved by a preponderance of the evidence that the facts of this case arose out of a genuine emergency situation where the patient was not medically stable and there was an immediate threat of death or serious bodily injury.<sup>1</sup> The jury then found that Plaintiff failed to prove by a preponderance of the evidence that the Defendants were grossly negligent. Following publication of the verdict, and at the insistence of the Plaintiff's counsel, the Court polled the jury with each member affirmatively indicating his or her continued agreement with the verdict. After the jury verdict was read and the jury was excused, Plaintiff's Counsel immediately move for a New Trial. After considering the Plaintiff's Counsel's arguments, the Court denied the motion. On April 15, 2019, the Plaintiff filed a Motion to Alter and Amended under Rule 59(e), however, the body of the motion cited Rule 59(a). On April 16, 2019, Plaintiff filed an Amended Motion under Rule 59(e). Plaintiff now seeks clarification whether the Court's prior oral order denying Plaintiff's post-trial motions considered certain specific grounds and to alter or amend the judgment as the Court may deem proper. For the reasons stated herein, the Defendants respectfully submits that the Plaintiff's Motion should be denied in full.

### **STANDARD**

The grant or denial of new trial motions rests within the discretion of the circuit court, and its decision will not be disturbed on appeal unless its findings are wholly unsupported by the evidence or the conclusions reached are controlled by error of law. *Umhoefer v. Bollinger*, 298 S.C. 221, 224, 379 S.E.2d 296, 297 (Ct. App. 1989). "However, where there is competent evidence to sustain the jury's verdict, the circuit court may not substitute its judgment for that of the jury."

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<sup>1</sup> Emergency Medical and Obstetrical Care Exception ("Obstetrical Medical Emergency Exception") located at South Carolina Code Ann §15-32-230, et seq

*State v. Hill*, 394 S.C. 312, 319, 714 S.E.2d 879, 883 (Ct.App. 2011) (citing *State v. Prince*, 316 S.C. 57, 63, 447 S.E.2d 177, 181 (1993)). The requirement imposed upon the court by Rule 52(a), SCRCP to "find the facts specially and state separately its conclusions of law" is limited to cases tried without a jury or with an advisory jury and is inapplicable here. See, e.g., Rule 52(a), SCRCP; *Bailey v. Segars*, 346 S.C. 359, 550 S.E.2d 910 (Ct. App. 2001) (stating a form order denying a motion for JNOV and new trial coupled with the transcript of the proceedings was sufficient to allow appellate review and a Rule 59(e) motion was not required to preserve issues for appeal), cert. granted on other grounds (Jan. 10, 2002); *Armstrong v. Union Carbide*, 308 S.C. 235, 417 S.E.2d 597 (Ct. App. 1992) (stating that while order of the circuit court did not separately list and specifically address each of the twenty-nine exceptions raised, it was clear from reviewing the order that all grounds raised below were considered).

The purpose of Rule 59(e), SCRCP, to alter or amend the judgment is to request the trial judge to "reconsider matters properly encompassed in a decision on the merits." *Collins Music Co. v. Igt*, 353 S.C. 559, 562-563, 579 S.E.2d 524, 525 (Ct. App. 2002) (quoting *Arnold v. State*, 309 S.C. 157, 172, 420 S.E.2d 834, 842 (1992)).

### **ARGUMENT**

#### **I. The Plaintiff's Motion to Alter and Amend Under Rule 59(e) Should be Considered an Unnecessary Second Rule 59(a) Motion or an Improper Rule 59(e) Motion.**

Plaintiff moved for a new trial on April 5, 2019 immediately after the jury was discharged. Judge Larry Hyman listened to the arguments from Plaintiff's Counsel and subsequently issued a denial of the Motion for New Trial from the bench. The transcript from the trial is not currently available, but a number of the grounds contained within Plaintiff's current Rule 59(e) motion were considered. Apparently out of an abundance of caution to preserve issues for appeal, the Plaintiff now seeks confirmation from the Court that it ruled on a number of specific grounds for a new



trial. As noted above, the Court is not required to specifically address in its order each and every ground contained within a new trial motion. To the extent Plaintiff's Rule 59(e) motion recites grounds already argued in its post-trial motion, Plaintiff's Rule 59(e) motion is essentially a second Rule 59(a) motion. This is improper. *Collins Music Co. v. Igt*, 353 S.C. 559, 566, 579 S.E.2d 524, 527 (Ct. App. 2002) (holding that the party's second post-trial motion was not an appropriate Rule 59(e) motion; instead it was simply a successive motion for JNOV and new trial.).

Alternatively, to the extent the Plaintiff now raises new arguments not previously raised in its prior new trial motion, those issues are waived. *See Hickman v. Hickman*, 301 S.C. 455, 456-457, 392 S.E.2d 481, 482 (Ct. App. 1990). A party cannot use Rule 59(e) to present to the court an issue the party could have raised prior to judgment but did not. *See Natural Resources Defense Council v. U.S. E.P.A.*, 705 F. Supp. 698, 701 (D. D.C. 1989), vacated on other grounds, 707 F. Supp. 3 (D. D.C. 1989) ("Rule 59(e) motions are not vehicles for bringing before the court theories or arguments that were not advanced earlier."); *Smith v. Stoner*, 594 F. Supp. 1091, 1118 (N. D. Ind. 1984) ("Issues which could have been presented to the court for consideration previously, but which were not, are not the proper subject of Rule 59(e) relief; the issues are waived."). The trial transcript will reflect what issues were properly preserved for appeal.

**II. On the Merits, Plaintiff's Rule 59(e) Motion Should be Denied, Because the Court Properly Found that the Obstetrical Medical Emergency Exception (S.C. Code Ann. § 15-32-230) Applied to This Case and Properly Charged and Incorporated the Applicable Provisions of the Statute on the Verdict Form.**

The South Carolina Noneconomic Damage Awards Act of 2005, S.C. Code Ann. § 15-32-230, provides in pertinent part:

**"Emergency medical and obstetrical care exceptions.**

(A) In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care in an emergency department or in an

obstetrical or surgical suite, no physician may be held liable unless it is proven that the physician was grossly negligent.

(B) In an action involving a medical malpractice claim arising out of obstetrical care rendered by a physician on an emergency basis when there is no previous doctor/patient relationship between the physician or a member of his practice with a patient or the patient has not received prenatal care, such physician is not liable unless it is proven such physician is grossly negligent.

(C) The limitation on physician liability established by subsections (A) and (B) shall only apply if the patient is not medically stable and:

(1) in immediate threat of death; or

(2) in immediate threat of serious bodily injury. Further, the limitation of physician liability established by subsections (A) and (B) shall only apply to care rendered prior to the patient's discharge from the emergency department or obstetrical suite.

Due to the evidence and testimony at trial, it was proper for the Court to incorporate the applicable provisions of the Obstetrical Medical Emergency Exception in its charge to the jury and on the verdict form. "If there is any evidence to support a jury charge, the trial judge should grant the request." *State v. Brown*, 362 S.C. 258, 262, 607 S.E.2d 93, 95 (Ct. App. 2004). There was abundant evidence in the record showing that shoulder dystocia constitutes a genuine emergency situation, that the patient was not medically stable, and that there was an immediate threat of death or serious bodily injury.

The Defendants provided testimony from Dr. Maselli and all three defense experts who concluded that the shoulder dystocia is a genuine medical emergency, which puts the patient in a medical unstable position and in immediate threat of serious bodily injury. Only Plaintiff's expert Dr. Pliskow rejected the fact that the shoulder dystocia was a genuine medical emergency, stating that it can become one if the shoulder dystocia is not timely resolved. Plaintiff's reliance upon analytics (i.e. APGAR score, cord gas) that are obtained after the resolution of the shoulder dystocia is misplaced. All experts agreed that the information obtained from those tests are not

available until after the shoulder dystocia is resolved. One cannot use hindsight to determine whether the shoulder dystocia was a medical emergency. Defense expert Dr. Chauhan testified that the positive results from those tests only indicate that Dr. Maselli did a good job in resolving the emergency.

It was undisputed that a failure to resolve the emergency can lead to brain damage or death, because the baby is unable to breathe on its own while the shoulder dystocia is ongoing. Yet, the Plaintiff's argue that while Jahmerican might have become medically unstable if enough time had passed, the Obstetrical Medical Emergency Exception does not apply in this instance because the threat or risk did not materialize since she was delivered in approximately one minute of Dr. Maselli encountering the shoulder dystocia, instead of pushing the limit to the five to ten minutes (even up to 15 minutes according to Dr. Pliskow) of critical danger zone of brain damage or death. The Plaintiff's argument flies in the face of logic and common sense. Finally, it was undisputed that the care was rendered in an obstetrical suite.

The Court also properly determined that subsection (B) does not apply, because it was undisputed that Plaintiff received her prenatal care from Dr. Maselli's practice. The applicability of the Obstetrical Medical Emergency Exception, and how it should be included on the verdict form, was discussed and argued at length in the judge's chambers. These issues were later put on the record by Plaintiff's counsel and ruled upon by Judge Hyman. The "goal of statutory construction is to harmonize conflicting statutes whenever possible and to prevent an interpretation that would lead to a result that is plainly absurd." *Hodges v. Rainey*, 341 S.C. 79, 91, 533 S.E.2d 578, 584 (2000).

While the Obstetrical Medical Emergency Exception speaks of “a genuine emergency situation,” “immediate threat” and “not medically stable” as seemingly separate elements, the medical evidence is not quite so distinct. And, while it is apparent from the trial testimony that there was a dispute between the different experts as to implications of Jahmerican’s medical condition at the time of delivery, there was sufficient evidence presented for the jury to decide, on proper instructions from the Court, whether the Obstetrical Medical Emergency Exception applied. It was proper for the Court to instruct the jury on the applicable provisions of the Obstetrical Medical Emergency Exception in its charge and incorporate the applicable provisions into the verdict form.

**III. The Court Properly Sustained Defendants’ Objection to Plaintiff’s Counsel Raising New Arguments During her Closing Argument Reply.**

Rule 43(j) of the South Carolina Rules of Civil Procedure plainly states that “... The Party having the right to open shall be required to open in full, and in reply may respond in full but may not introduce any new matter.” The Court properly denied Plaintiff’s Counsel’s attempt to discuss gross negligence during the closing argument reply, because the topic of gross negligence was not discussed during Plaintiff’s original closing or Defendants’ closing. In *Ketterman v. South Carolina Farm Bureau Mut. Ins. Co.*, 302 S.C. 276, 395 S.E.2d 187 (Ct. App. 1990), the Plaintiff introduced in his reply closing argument testimony regarding a formula for determining punitive damages. Plaintiff’s counsel had previously mentioned punitive damages, but he had not specifically set forth a formula for determining punitive damages. *Id.* The Court found that the Plaintiff “quite obviously” violated Rule 43(j) with his new discussion of a punitive damages formula. *Id.*

Here, the topic of gross negligence was not discussed at all by Plaintiff's counsel in his closing argument. While Defense counsel argued the elements of the Obstetrical Medical Emergency Exception, there was never any mention of gross negligence. The necessary burden of proof for the Obstetrical Medical Emergency Exception (gross negligence) is distinct from the elements needed to establish the Exception. Therefore, the Plaintiff's discussion of gross negligence was "quite obviously" something new that would have violated Rule 43(j). The trial judge correctly sustained Defense Counsel's contemporaneous objection.

**IV. In Filling Out the Verdict Form, the Jury Appropriately Followed the Charges on the Law and the Court's Instructions.**

The jury properly applied the law as charged to the facts of the case. In doing so, the jury reached a final decision on the merits. The jury's decision rendered the remaining questions on the verdict form inapplicable. While the jury asked the court for clarification that its job was done, that clarification was provided by the Court. It would have been improper for the Court to then instruct the jury to consider additional questions on the verdict form that no longer applied, particularly where any answers provided by the jury on those questions would still have resulted in a defense verdict. The real concern is that the jury had already indicated it had not reached a unanimous decision on the first two questions, and forcing further deliberations would likely have resulted in a hung jury. It was more important for the Court to ensure the jury had applied the law to the facts, as opposed to ensuring technical compliance with the order of the questions on the verdict form.

The verdict form included a list of questions in which the jury was to consider in reaching its verdict. As noted above, it was proper for the judge to include the elements of the Defendants affirmative defense, the Obstetrical Medical Emergency Exception, on the verdict form. The first two questions on the verdict form addressed the standard questions for a medical malpractice case: 1) whether the Plaintiff proved by a preponderance of the evidence that the Defendants deviated from the standard of care; and 2) whether the Plaintiff proved by a preponderance of the evidence that the deviation from the standard of care was a proximate cause of the Plaintiff's injuries. The affirmative defense questions consumed questions 3, 4, 5, and 6 on the verdict form. After a couple hours of deliberations, the jury informed the court that it did not agree on the first two questions but had reached a decision as to the next four questions relating to the Obstetrical Medical Emergency Exception. The jury reached a unanimous decision that Defendants established the necessary elements of the Exception, and that Plaintiff did not prove the Defendants were grossly negligent. The jury wanted to know whether it needed to answer the first two questions, even though their responses resulted in a verdict.

Judge Hyman presided over the majority of trial; however, Judge Bentley Price was also present and observed the majority of the trial. Judge Price presided over closing arguments and charged the jury with the law. Judge Price and Judge Hyman both participated in answering the jury's question about the verdict form. The Court instructed the jury that, if they had reached a decision as to questions 3, 4, 5, and 6 on the verdict form, then their job was done and a final decision was reached. A few minutes after receiving their requested clarification, the jury returned a defense verdict.

In this case, any confusion by the jury was clarified by the Court. The jury merely sought confirmation that their decision was final and they no longer needed to address the first two questions that would not have impacted the outcome. Once the jury determined that the affirmative defense applied, the Defendants were entitled to the benefit of having their behavior judged under a gross negligence standard. It defies logic to then instruct the jury to continuing deliberating over whether the defendants deviated from the standard of care when the answer to that would not alter the outcome. The jury had already determined that the Plaintiff was required to prove Defendants were grossly negligent and had failed to do so.

Moreover, the jury had informed the court that it was deadlocked over the first two questions. It would be improper for the court to demand strict compliance with the order of the questions on the verdict form, especially when doing would have either been futile or would have likely resulted in a hung jury. Any combination of responses to the first two questions would have still resulted in a defense verdict. The real concern was that demanding answers to questions 1 and 2 would likely have resulted in a hung jury over questions that would not have changed the outcome of the case. During its jury charge, Judge Price provided a detailed description of the applicable law and the burden of proof. It is the province of the jury to use their collective judgment in applying the law to the facts of the case. They did so and reached a final decision. It would have been imprudent for the Court to interfere and force the jury to consider additional questions that would have no effect on their final decision.

**V. There is no Statutory or Case Law Support for the Notion that Hindsight is Appropriate When Considering the Obstetrical Medical Emergency Exception**

Plaintiff believes it was error for the Court to not have specifically instructed the jury that hindsight may be used when determining whether the elements of the Obstetrical Medical Emergency Exception were satisfied. There is no support for Plaintiff's argument and, even if the charge should have been included, the charges as a whole reflected South Carolina Law and it is not reversible error.

In reviewing jury charges for error, we must consider the court's jury charge as a whole in light of the evidence and issues presented at trial. If, as a whole, the charges are reasonably free from error, isolated portions which might be misleading do not constitute reversible error." *Keaton v. Greenville Hosp. Sys.*, 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999) (citing *Bragg v. Hi-Ranger, Inc.*, 319 S.C. 531, 462 S.E.2d 321, 330 (Ct. App. 1995) (additional internal citations omitted).

The Defendants can find no support for the contention that the Court committed error by not clarifying to the jury that the standard hindsight charge should not apply to the Obstetrical Medical Emergency Exception. The statute itself does not mention hindsight or support Plaintiff's position. And Defendants found no cases addressing whether a Court should instruct a jury that hindsight may be used when assessing this specific affirmative defense. In short, the Court's failure to not charge something that is not the law in South Carolina cannot be error.

To the contrary, the judge properly charged the jury that hindsight is inappropriate in medical malpractice actions. The prohibition on using hindsight to judge a physician's actions in a medical malpractice is well established. *See Keaton v. Greenville Hosp. Sys.*, 334 S.C. 488, 496, 514 S.E.2d 570, 574 (1999) (internal citations omitted). The hindsight charge stems from the



language setting forth the standard of care in medical malpractice actions. The South Carolina Supreme Court first set forth the standard of care for a medical practitioner, noting that "[th]e degree of care which must be observed is, of course, that of an average, competent practitioner acting in the same or similar circumstances." *King v. Williams*, 276 S.C. 478, 482, 279 S.E.2d 618, 620 (1981). The Court of Appeals later defined medical malpractice as "the failure of a physician to exercise that degree of care and skill which is ordinarily employed by the profession generally, under similar conditions and in like surrounding circumstances," *Jernigan v. King*, 312 S.C. 331, 333, 440 S.E.2d 379, 381 (Ct. App. 1993). The Court of Appeals addressed the issue of hindsight by stating: "The physician's chief concern when treating a patient should be the patient's best interests and not what a lay jury, untrained in medicine and employing perfect hindsight, might later conclude he or she should have disclosed." *Hook v. Rothstein*, 281 S.C. 541, 553, 316 S.E.2d 690, 697-98 (Ct. App. 1984).

Here, the Court properly charged the jury on hindsight as follows:

IN CONSIDERING WHETHER THE DEFENDANT MADE A REASONABLE DECISION, YOU MUST CONSIDER THE DECISION IN RELATION TO THE FACTS AS THEY EXISTED AT THE TIME, AND NOT IN LIGHT OF WHAT HINDSIGHT MAY REVEAL.

This charge was the only mention of hindsight in all 16 pages of the Court's charges. The case law shows that hindsight is generally improper in medical malpractice actions. It would be impractical and confusing to the jury to hear instructions that hindsight cannot be used, but that it is proper in certain situations. Yet, even if Plaintiff was correct that hindsight can be applied to certain defenses in a medical malpractice action, which is not the law, the charge used in this case arguably already did limit the prohibition on the use of hindsight to the doctor's actions, and not as to whether there was a genuine medical emergency, whether the baby was medically unstable, or whether the baby was in an immediate risk of serious bodily injury or death. In sum the Court's

charges, "as a whole", accurately reflected the law in South Carolina and were reasonably free from error. *See Keaton*, 334 S.C. 488, 497, 514 S.E.2d 570, 575 (1999).

### **CONCLUSION**

For the foregoing reasons, Defendants Lisa R. Maselli, M.D., both individually and as agent/employee of Carolina OB/GYN respectfully request that the Court deny the Plaintiff's Rule 59(e) Motion.

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**s/ James B. Hood**

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*Attorneys for the Defendants Lisa R. Maselli, M.D.,  
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Carolina OB/GYN*

**April 18, 2019**

Charleston, South Carolina



# GRAHAM LAW

*Shining a Light on Safety, Guiding the Way to Justice.*

Edward L. Graham, Esq.

August 5, 2019

VIA US MAIL

Clerk of Court  
Court of Appeals  
1220 Senate Street  
Columbia, South Carolina 29201

RE: Notice of Appeal  
Case No. 2016-CP-2200863  
Appeal from Georgetown County

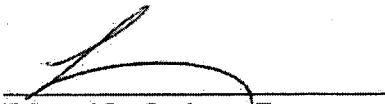
Dear Clerk,

I have enclosed the following for docketing:

1. Notice of Appeal
2. Proof of Service of Notice of Appeal
3. Proof of Service regarding this correspondence
4. Copies of the Orders which the Appeal concerns
5. Check in the amount of \$250.00.

Please clock a copy of the Notice and return it to me in the enclosed envelope.

Sincerely,



Edward L. Graham, Esq.  
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cc: James B. Hood  
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957 of 962

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM GEORGETOWN COUNTY  
Court of Common Pleas

Larry Hyman, Circuit Court Judge

---

Case No. 2016-CP-2200863

---

Phillippa Smalling, individually and as Next Friend for  
Jahmerican M., a minor

Appellant,

v.

Lisa R. Maselli, M.D., both individually and  
as agent/employee of Carolina OB-GYN,

Respondents.

---

NOTICE OF APPEAL

---

Phillippa Smalling, individually and as Next Friend of Jahmerican M., a minor, appeals the Orders Denying Plaintiff's Motion for New Trial and Plaintiff's Motion to Alter/Amend of the Honorable Larry Hyman dated June 27, 2019 and entered of record on June 27, 2019. Appellant received written notice of the Order(s) on that date.

/s Edward L. Graham  
Edward L. Graham  
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Attorneys for Appellant

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Other Counsel of Record:  
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Attorneys for Respondent

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM GEORGETOWN COUNTY  
Court of Common Pleas

Larry Hyman, Circuit Court Judge

---

Case No. 2016-CP-2200863

---

Phillippa Smalling, individually and as Next Friend for  
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Appellant,

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NOTICE OF APPEAL

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/s/ Edward Graham  
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**RECEIVED**

MAY 14 2020

**SC Court of Appeals**

THE STATE OF SOUTH CAROLINA  
In the Court of Appeals

---

APPEAL FROM GEORGETOWN COUNTY  
Court of Common Pleas

Larry Hyman, Circuit Court Judge

---

Appellate Case No. 2019-001304

---

Phillippa Smalling, individually and as Next Friend for  
Jahmerican M., a minor

Appellant,

.v.

Lisa R. Maselli, M.D., both individually and  
as agent/employee of Carolina OB-GYN,

Respondents.

---

**CERTIFICATE OF COUNSEL**

---

The undersigned hereby certifies that the Record on Appeal contains all material proposed to be included by any of the parties (with one exception)\* and not any other material.

**GRAHAM LAW FIRM, P.A.**

---

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Attorneys for Appellant

May 11, 2020

\*The exception relates to Exhibit 31, designated by Respondents for inclusion in the Record on Appeal. This exhibit was identified by Defendants at trial and proffered as a Court Exhibit. This Exhibit 31 is an edited transcript of the video deposition of Dr. Duchowny. It was edited for jury presentation in the courtroom based on agreements between counsel and rulings

made by the trial court just before the video was published to the jury. Appellant's counsel does not possess a copy of the transcript in this final edited form, which is the version marked for identification as Exhibit 31. Counsel has addressed the issue in this Record on Appeal by including an explanatory statement where Exhibit 31 would otherwise appear. Counsel seeks to obtain a copy of the transcript which accurately documents these final edits. Counsel will then move to amend the Record on Appeal, by including the correct edited version in its proper place.