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S.C. SUPREME COURT

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Opinion No. 5864 (S.C. Ct. App. Filed December 2, 2021)

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

Petitioners,

v.

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

Respondents.

APPENDIX

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

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

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

v.

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

RECORD ON APPEAL

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FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2016CP4203178

Treva C Flowers	**Tristan Flowers**	**Bang N Giep Md**	**Spartanburg And Pelham Ob-Gyn, Pa**

PLAINTIFF(S) **DEFENDANT(S)**

Submitted by: The Court

Attorney for: ☐ Plaintiff ☐ Defendant
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk: **On October 13, 2017, the Jury rendered a verdict for the defendant.**

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.
Note: Title abstractors and researchers should refer to the official court order for judgment details.
E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

ELECTRONIC SIGNATURE PAGE TO FOLLOW **2053**

Circuit Court Judge **Judge Code**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 2/17)

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For Clerk of Court Office Use Only

This judgment was entered on , and a copy mailed first class or placed in the appropriate attorney's box on , to attorneys of record or to parties (when appearing pro se) as follows:

Charles L. Henshaw Jr. 1534 Blanding St. Columbia, SC 29201

Lee Cannon Weatherly 40 Calhoun St., Ste. 400 Charleston, SC 29401
Dennis Gary Lovell Jr. 40 Calhoun Street Suite 400 Charleston, SC 29401

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

M Hope Blackley - Clerk of Court

Court Reporter: Pam Green

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

ELECTRONICALLY FILED - 2017 Oct 31 10:46 AM - SPARTANBURG - COMMON PLEAS - CASE#2016CP4203178

Spartanburg Common Pleas

Case Caption: Treva C Flowers VS Bang N Giep Md

Case Number: 2016CP4203178

Type: Order/Form 4

IT IS SO ORDERED !

s/ J. Derham Cole

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF **SPARTANBURG**)

Treva C. **FLOWERS**, Tristan **FLOWERS**,)
And Ashley Grace **FLOWERS**, an infant)
Under the age of fourteen (14) years, by)
And through her next friends, Treva C.) **VERDICT FORM**
FLOWERS and Tristan FLOWERS,)
)
Plaintiffs,)
) Civil Action No.: **2016-CP-42-03178**
)
)
Bang N. **GIEP**, M.D. and **SPARTANBURG &**)
PELHAM OB-GYN, P.A.,))
)
Defendants.)

1. Do you find that the plaintiffs have proven by the greater weight or preponderance of the evidence that the defendants, by and through Bang N. Giep, were negligent in the providing of medical care during and in the course of the birth and delivery of Ashley Grace Flowers *and* that such negligence was a proximate cause of some injury or other loss sustained by the plaintiffs ?

YES *or* **NO** *(Circle your finding)*

(***If*** you answered ***"NO"*** above, ***STOP*** and ***DELIBERATE NO FURTHER,*** your verdict would be for the defendants. ***If*** you answered ***"YES"*** above, go to Question ***#2***)

2. Do you find that the defendants have proven by the greater weight or preponderance of the evidence that the medical care rendered by the defendants, by and through Bang N. Giep, during the birth and delivery of Ashley Grace Flowers, was rendered in a genuine emergency situation where she was not medically stable and was in immediate threat of either death or serious bodily injury ?

YES *or* **NO** *(Circle your finding)*

(***If*** you answered ***"YES"*** above, ***STOP*** and ***DELIBERATE NO FURTHER,*** your verdict would be for the defendants. ***If*** your answer is ***"NO"*** above, go to Question ***#3***)

3. What is the total amount of actual damages that you find have been sustained by the plaintiff **Ashley Grace Flowers** which were proximately caused by the negligence of the defendant Bang N. Giep during and in the course of her birth and delivery ?

_____

($_____).

4. What is the total amount of actual damages that you find have been sustained by the plaintiffs **Treva C. Flowers** and **Tristan Flowers** which were proximately caused by the negligence of the defendant Bang N. Giep during and in the course of the birth and delivery of Ashley Grace Flowers ?

($_____).

October 13, 2017.

Foreperson

STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

TREVA C. FLOWERS, TRISTAN FLOWERS, and ASHLEY GRACE FLOWERS, an infant under the age of fourteen (14) years, by and through her next friends, TREVA C. FLOWERS and TRISTAN FLOWERS,

Plaintiffs,

vs.

BANG N. GIEP, M.D., and SPARTANBURG & PELHAM OB-GYN, P.A. (formerly SPARTANBURG OB-GYN, P.A.),

Defendants.

IN THE COURT OF COMMON PLEAS

C/A No. 2011-CP-42-4281

NOTICE OF INTENT TO FILE SUIT

Pursuant to S.C. Code § 15-79-125(A), the plaintiffs submit their notice of intent to file suit against the defendants above-named and state the following:

Ashley Grace Flowers is the minor child of Treva C. Flowers. Treva C. Flowers and Ashley Grace Flowers came under the medical care of Spartanburg Ob-Gyn, P.A., and its employees and agents, who managed the pregnancy of Treva C. Flowers in 2008. One of those employees was Bang N. Giep, M.D., who performed the birth delivery of Ashley Grace Flowers on October 7, 2008, at Spartanburg Regional Medical Center in Spartanburg County, South Carolina.

Treva C. Flowers's pregnancy with Ashley Grace Flowers was complicated by gestational diabetes, which was known or should have been known to Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.) and Bang N. Giep, M.D.. Ashley Grace Flowers suffered a brachial plexus injury at birth, after Bang N. Giep, M.D., encountered a

birthing complication known as shoulder dystocia and applied traction to deliver the baby vaginally.

Bang N. Giep, M.D., as an employee of Spartanburg & Pelham Ob-Gyn, P.A., deviated from generally recognized and accepted standards of care and failed to render medical care expected of a reasonably competent medical practitioner under the same or similar circumstances by applying excessive traction during the delivery of Ashley Grace Flowers and causing injury to her brachial plexus and by failing to properly advise the mother of cesarean section as a birthing option. The standard of care required the obstetrician in the face of shoulder dystocia to complete the vaginal delivery through a series of maneuvers without excessive traction. Excessive traction was manifested in this instance by an extremely large neuroma involving the entire brachial plexus in the area of the left clavicle with extensive damage to the C5, C6, and C7 nerve roots of the child's cervical spine. The neuroma most probably was caused by trauma during the birth process from excessive traction.

As a result of excessive traction during birth Ashley Grace Flowers suffered nerve damage within her shoulder that has resulted in permanent physical disability of her left arm and hand.

Treva C. Flowers and Tristan Flowers give notice of intent to file suit for their losses as parents of the minor child. Ashley Grace Flowers, an infant under the age of 14 years, gives notice of intent to file suit for her personal injuries by and through her next friends, Treva C. Flowers, her mother, and Tristan Flowers, her father.

Treva C. Flowers and Tristan Flowers have suffered and will suffer extraordinary financial losses related to Ashley Grace Flowers's medical, hospital, special needs, and caretaking expenses; and Ashley Grace Flowers endured and will endure personal injuries

including physical pain and suffering, mental anguish and emotional distress, physical disability and impairment, loss of enjoyment of life, physical disfigurement, and medical, hospital, and caretaking expenses. Treva C. Flowers and Tristan Flowers, individually and as representatives for the child, are informed and believe that their injuries and losses were the direct and proximate result of the negligence, wantonness, willfulness, recklessness, and gross negligence of Bang N. Giep, M.D., and employees and agents of Spartanburg & Pelham Ob-Gyn, P.A. Treva C. Flowers and Tristan Flowers is informed and believes that Spartanburg & Pelham Ob-Gyn, P.A., is liable for the acts and omissions of its agents and employees.

Under the law of South Carolina, Bang N. Giep, M.D. and Spartanburg & Pelham Ob-Gyn, P.A., can be subject to punitive damages for wanton, willful, or reckless misconduct.

Disclosures pursuant to the South Carolina Rules of Civil Procedure are attached, and the affidavit of an expert as required by S.C. Code § 15-36-100 is also attached.

By:

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ATTORNEYS FOR PLAINTIFF

RICHLAND COUNTY
2011 OCT -7 AM 9:24
H. THOMAS BLACKLEY

October 4, 2011

STATE OF SOUTH CAROLINA

COUNTY OF SPARTANBURG

TREVA C. FLOWERS, TRISTAN FLOWERS, and ASHLEY GRACE FLOWERS, an infant under the age of fourteen (14) years, by and through her next friends, TREVA C. FLOWERS and TRISTAN FLOWERS,

Plaintiffs,

vs.

BANG N. GIEP, M.D., and SPARTANBURG & PELHAM OB-GYN, P.A. (formerly SPARTANBURG OB-GYN, P.A.),

Defendants.

IN THE COURT OF COMMON PLEAS

C/A No. 2012-CP-42-1144

COMPLAINT
(Jury)

The plaintiffs complaining of the above-named defendants allege the following:

1. That the plaintiffs are residents of Greenville County, South Carolina.

2. That Ashley Grace Flowers is an infant under the age of fourteen (14) years, and she pursues this action by and through her next friends, Treva A. Flowers and Tristan Flowers, who are her parents.

3. That plaintiffs are informed and believe that defendant Bang N. Giep, M.D. is a resident of Spartanburg County, South Carolina.

4. That plaintiffs are informed and believe that defendant Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.) is a business organization organized and existing under the laws of South Carolina with its principal place of business being in Spartanburg County, South Carolina.

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SPARTANBURG COUNTY
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MHOPE BLACKLEY

5. That plaintiffs are informed and believe that at all times mentioned herein defendant Giep was an agent and employee of Spartanburg & Pelham Ob-Gyn, P.A. (formerly Spartanburg Ob-Gyn, P.A.).

6. That plaintiffs are informed and believe that Spartanburg & Pelham Ob-Gyn, P.A., is liable for the acts and omissions of its agents and employees pursuant to the law of respondeat superior.

7. That plaintiffs gave notice of intent to file suit on October 7, 2011, as required by S.C. Code Ann. § 15-79-125, in the Spartanburg County Court of Common Pleas, where the notice of intent was filed under docket number 2011-CP-42-4281.

8. That the matter could not be resolved through mediation, and a mediator declared an impasse between the parties on or about January 16, 2012.

9. That at all times mentioned herein defendant Giep was a medical doctor licensed by the State of South Carolina, and he held himself out as a specialist in obstetrics/gynecology.

10. That on October 7, 2008, at Spartanburg Regional Medical Center in Spartanburg, South Carolina, defendant Giep undertook to medically manage the labor of Treva A. Flowers and the birth of her viable, female child, Ashley Grace Flowers.

11. That the birth of Ashley Grace Flowers on October 7, 2008, was complicated by shoulder dystocia.

12. That in the course of delivery Ashley Grace Flowers suffered an injury to the brachial plexus nerve bundle on her left side and the C5, C6, and C7 nerve roots were severely damaged.

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13. That plaintiffs are informed and believe that the defendant Giep deviated from generally recognized and accepted standards of care, failed to render medical care expected of a

reasonably competent medical practitioner under the same or similar circumstances, and was negligent, wanton, willful, reckless, and grossly negligent in at least one of the following ways:

a. In applying excessive traction while delivering the baby;

b. In failing to recommend cesarean section delivery to the mother;

c. In failing to deliver the baby by cesarean section;

d. In failing to use timely and appropriate maneuvers to release the baby from shoulder dystocia during delivery.

Any and all of which defendant Giep knew or should have known was contrary to the health and well being of the mother and child.

FOR A FIRST CAUSE OF ACTION

(On behalf of Ashley Grace Flowers)

14. That plaintiffs incorporate the allegations of paragraphs 1–13 as if stated herein verbatim.

15. That plaintiffs are informed and believe that as a direct and proximate result of the acts and omissions of the defendants Ashley Grace Flowers suffered extensive damage to the C5, C6, and C7 nerve roots of her spine, resulting in permanent physical disability of her left shoulder, arm, and hand and causing her to endure physical pain and suffering; mental anguish and emotional distress; physical disability and impairment and loss of enjoyment of life; physical disfigurement; loss of income and earning capacity; and medical, hospital, and caretaking expenses.

16. That plaintiffs are informed and believe that Ashley Grace Flowers is entitled to recover compensation from the defendants for her actual losses and damages and to recover punitive damages as allowed by law.

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SPARTANBURG COUNTY
2012 MAR 12 P 1:20
M. HOPE BLACKLEY

FOR A SECOND CAUSE OF ACTION

(On behalf of Treva C. Flowers and Tristan Flowers)

17. That plaintiffs incorporate the allegations of paragraphs 1–13 as if stated herein.

18. That plaintiffs are informed and believe that as a direct and proximate result of the acts and omissions of the defendants Ashley Grace Flowers suffered extensive damage to the C5, C6, and C7 nerve roots of her spine, resulting in permanent physical disability of her left shoulder, arm, and hand and Treva C. Flowers and Tristan Flowers, as parents of the child, have suffered and will suffer extraordinary financial losses related to Ashley Grace Flowers's medical, hospital, special needs, and caretaking expenses during the period of her childhood.

19. That plaintiffs are informed and believe that Treva C. Flowers and Tristan Flowers are entitled to recover compensation from the defendants for actual losses and damages and to recover punitive damages as allowed by law.

WHEREFORE, the plaintiffs demand a jury trial and pray for judgment against the defendants for actual and punitive damages and for the costs of this action and for such further relief as the Court deems them entitled.

By: _____

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ATTORNEY FOR PLAINTIFFS

March 12, 2012

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SPARTANBURG COUNTY
2012 MAR 12 PM 1:20
M. HOPE BLACKLEY

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	CASE NO.: 2012-CP-42-1144
	)	
TREVA C. FLOWERS, TRISTAN FLOWERS, AND ASHLEY GRACE FLOWERS, AN INFANT UNDER THE AGE OF FOURTEEN (14) YEARS AND BY AND THROUGH HER NEXT FRIENDS TREVA C. FLOWERS AND TRISTAN FLOWERS,	)	**ANSWER OF DEFENDANTS BANG N. GIEP, M.D. AND SPARTANBURG & PELHAM OB/GYN, P.A.**
Plaintiffs,	)	
vs.	)	
BANG N. GIEP, M.D. AND SPARTANBURG & PELHAM OB-GYN, P.A. (FORMERLY SPARTANBURG OB-GYN, P.A.)	)	
Defendants.	)	

COMES NOW Bang N. Giep, M.D. and Spartanburg & Pelham OB/GYN, P.A., Defendants in the above-styled civil action, and present this their Answer to the Complaint and show the Court as follows:

FIRST DEFENSE

At all times relevant to the matters complained of in the Complaint, these Defendants exercised that degree of skill and care required of them by law.

SECOND DEFENSE

There is no causal connection between any alleged act or omission on the part of these Defendants and the alleged injuries or damages claimed by Plaintiffs.

THIRD DEFENSE

The claims for non-economic damages are limited in amount under South Carolina law.

FOURTH DEFENSE

Any claims for punitive damages, and the statutes of the state of South Carolina purporting to authorize those claims, violate these Defendants' rights as guaranteed under the Constitutions of the United States of America and of the State of South Carolina.

FIFTH DEFENSE

Defendants respond to the numbered allegations of the Complaint and show the Court as follows:

1. Defendants lack sufficient information to form a belief as to the truthfulness of the allegations of Paragraphs 1 and 2 of the Complaint. Therefore, those allegations can neither be admitted nor denied at this time.

2. Defendants admit the allegations of Paragraph 3, 4, and 5 of the Complaint. Defendants deny any allegations of negligence or liability in those paragraphs.

3. In response to the allegations of Paragraph 6, Defendants admit that Dr. Giep was acting within the course and scope of his employment with Defendant Spartanburg and Pelham OB/GYN, P.A. at the time of his rendition of medical care to the Plaintiff and Plaintiff's child. Defendants deny all other allegations of Paragraph 6.

4. In response to the allegations of Paragraph 7 and 8, Defendants admit that the Parties complied with the requirements of South Carolina law with regard to the Notice of Intent

to File Suit. Defendants deny any allegations of negligence on their part or liability to Plaintiffs that were contained in the Notice of Intent to File Suit proceedings.

5. Defendants admit the allegations of Paragraphs 9 and 10 of the Complaint.

6. In response to the allegations of Paragraphs 11 and 12, Defendants admit that the minor child suffered from various medical conditions, including shoulder dystocia, during delivery. Defendants lack sufficient information to form a belief as to the truthfulness of the remaining allegations of Paragraphs 11 and 12. Therefore, those allegations can neither be admitted nor denied at this time.

7. Defendants deny the allegations of Paragraphs 13, 15, 16, 18, and 19.

8. In response to the allegations of Paragraph 14, Defendants incorporate, as if fully set forth herein, their responses to Paragraphs 1 through 13.

9. In response to the allegations of Paragraph 17, Defendants incorporate, as if fully set forth herein, their responses to Paragraphs 1 through 13.

10. Defendants deny each and every allegation of the Complaint not specifically responded to in the preceding paragraphs of this Answer.

WHEREFORE, having fully responded to the Complaint, Defendants demand that they be dismissed with costs taxed against the Plaintiffs. Defendants further demand a trial by a jury of twelve persons.

SIGNATURE PAGE TO FOLLOW

Respectfully submitted,

CARLOCK, COPELAND & STAIR, L.L.P.

By: 

D. GARY LOVELL, JR.
State Bar No.: 69293
LEE C. WEATHERLY
State Bar No.: 71109

Attorneys for Defendants Bang N. Giep, M.D.
and Spartanburg & Pelham OB/GYN, P.A.

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843-727-0307

NOTICE OF APPEAL IN A CIVIL CASE

THE STATE OF SOUTH CAROLINA
In The Supreme Court

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178

RECEIVED
NOV 03 2017
SC Court of Appeals

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

Appellants,

v.

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

Respondents.

NOTICE OF APPEAL

Treva C. Flowers, Tristan Flowers, and Ashley F., an infant under the age of fourteen (14) years, by and through her next friends, Treva C. Flowers and Tristan Flowers, appeal the trial rulings of the Honorable J. Derham Cole dated October 9-13, 2017; Judge Cole's denial of motion for new trial on October 13, 2017; and the judgment entered by Judge Cole on October 31, 2017 for defendants. Among the grounds for appeal is that S.C. Code Ann. Section 15-32-230 is

unconstitutional pursuant to the equal protection clauses of the United States and South Carolina constitutions. Appellants received written notice of entry of the judgment on October 31, 2017.

November 1, 2017

s/ Charles L. Henshaw, Jr.
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Attorney for Appellants

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glovell@carlockcopeland.com
Attorney for Respondents

ELECTRONICALLY FILED - 2017 Oct 31 10:46 AM - SPARTANBURG - COMMON PLEAS - CASE#2016CP4203178

FORM 4

STATE OF SOUTH CAROLINA
COUNTY OF SPARTANBURG
IN THE COURT OF COMMON PLEAS

JUDGMENT IN A CIVIL CASE
CASE NUMBER 2016CP4203178

Treva C Flowers	Tristan Flowers	Bang N Giep Md	Spartanburg And Pelham Ob-Gyn, Pa

PLAINTIFF(S) **DEFENDANT(S)**

Submitted by: The Court

Attorney for: ☐ Plaintiff ☐ Defendant
☐ Self-Represented Litigant

DISPOSITION TYPE (CHECK ONE)

☒ **JURY VERDICT.** This action came before the court for a trial by jury. The issues have been tried and a verdict rendered.

☒ **DECISION BY THE COURT.** This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered. ☐ See Page 2 for additional information.

☐ **ACTION DISMISSED (*CHECK REASON*):** ☐ Rule 12(b), SCRCP; ☐ Rule 41(a), SCRCP (Vol. Nonsuit); ☐ Rule 43(k), SCRCP (Settled); ☐ Other: _____

☐ **ACTION STRICKEN (*CHECK REASON*):** ☐ Rule 40(j) SCRCP; ☐ Bankruptcy; ☐ Binding arbitration, subject to right to restore to confirm, vacate or modify arbitration award; ☐ Other: _____

RECEIVED
NOV 03 2017
SC Court of Appeals

☐ **STAYED DUE TO BANKRUPTCY**

☐ **DISPOSITION OF APPEAL TO THE CIRCUIT COURT (CHECK APPLICABLE BOX):**
☐ Affirmed; ☐ Reversed; ☐ Remanded; ☐ Other: _____

NOTE: ATTORNEYS ARE RESPONSIBLE FOR NOTIFYING LOWER COURT, TRIBUNAL, OR ADMINISTRATIVE AGENCY OF THE CIRCUIT COURT RULING IN THIS APPEAL.

IT IS ORDERED AND ADJUDGED: ☐ See attached order; (formal order to follow) ☐ Statement of Judgment by the Court:

ORDER INFORMATION

This order ☒ ends ☐ does not end the case.

Additional Information for the Clerk: **On October 13, 2017, the Jury rendered a verdict for the defendant.**

INFORMATION FOR THE JUDGMENT INDEX

Complete this section below when the judgment affects title to real or personal property or if any amount should be enrolled. If there is no judgment information, indicate "N/A" in one of the boxes below.

Judgment in Favor of (List name(s) below)	Judgment Against (List name(s) below)	Judgment Amount To be Enrolled (List amount(s) below)

If applicable, describe the property, including tax map information and address, referenced in the order:

The judgment information above has been provided by the submitting party. Disputes concerning the amounts contained in this form may be addressed by way of motion pursuant to the SC Rules of Civil Procedure. Amounts to be computed such as interest or additional taxable costs not available at the time the form and final order are submitted to the judge may be provided to the clerk.

Note: Title abstractors and researchers should refer to the official court order for judgment details.

E-Filing Note: In E-Filing counties, the Court will electronically sign this form using a separate electronic signature page.

ELECTRONIC SIGNATURE PAGE TO FOLLOW **2053**

Circuit Court Judge **Judge Code**

CPFORM4Cm
SCCA SCRCP Form 4C (Revised 2/17)

ELECTRONICALLY FILED - 2017 Oct 31 10:46 AM - SPARTANBURG - COMMON PLEAS - CASE#2016CP4203178

For Clerk of Court Office Use Only

This judgment was entered on , and a copy mailed first class or placed in the appropriate attorney's box on , to attorneys of record or to parties (when appearing pro se) as follows:

Charles L. Henshaw Jr. 1534 Blanding St. Columbia, SC 29201

Lee Cannon Weatherly 40 Calhoun St., Ste. 400 Charleston, SC 29401
Dennis Gary Lovell Jr. 40 Calhoun Street Suite 400 Charleston, SC 29401

ATTORNEY(S) FOR THE PLAINTIFF(S)

ATTORNEY(S) FOR THE DEFENDANT(S)

M Hope Blackley - Clerk of Court

Court Reporter: Pam Green

E-Filing Note: In E-Filing counties, the date of Entry of Judgment is the same date as reflected on the Electronic File Stamp and the clerk's entering of the date of judgment above is not required in those counties. The clerk will mail a copy of the judgement to parties who are not E-Filers or who are appearing pro se. See Rule 77(d), SCRCP.

ADDITIONAL INFORMATION REGARDING DECISION BY THE COURT AS REFERENCED ON PAGE 1.

This action came to trial or hearing before the court. The issues have been tried or heard and a decision rendered.

ELECTRONICALLY FILED - 2017 Oct 31 10:46 AM - SPARTANBURG - COMMON PLEAS - CASE#2016CP4203178



Spartanburg Common Pleas

Case Caption: Treva C Flowers VS Bang N Giep Md

Case Number: 2016CP4203178

Type: Order/Form 4

IT IS SO ORDERED !

s/ J. Derham Cole

CERTIFICATE OF SERVICE

I hereby certify that on this date I caused to be served a copy of the foregoing **NOTICE OF APPEAL** upon the individuals whose names and addresses are listed below placing a copy in the United States Mail with proper first-class postage affixed thereon.

RECEIVED
NOV 03 2017
SC Court of Appeals

Mr. D. Gary Lovell, Jr.
Mr. Lee Weatherly
Carlock, Copeland & Stair, LLP
40 Calhoun Street, Suite 400
Charleston, SC 29401-3531

CHARLES L. HENSHAW, JR.

Nov 2, 2017

THE COURT: All right. Ladies and gentlemen, as you know, you've been selected to decide this verdict in the case of Treva C. Flowers, Tristan Flowers, and Ashley Grace

Flowers. They are plaintiffs. They brought the lawsuit. It's been brought against Bang N. Giep, who's a medical doctor, and Spartanburg & Pelham OB-GYN, which is a professional association of doctors. And the lawsuit has been brought because the plaintiff claims that the defendant was negligent in the providing of medical care to her at the time that the child, Ashley Grace Flowers, was born, and that that negligence resulted in some physical injury to the child for which the plaintiffs are asking to be compensated.

In response to those allegations made by the plaintiff in their complaint, the defendant has responded by admitting that they had a physician/patient relationship and admitting to participating in the delivery of a child, but the defendant denies that he was negligent in any way in his providing medical care to any of the plaintiffs in this case, and, therefore, any injury that she may have suffered was not caused by his negligence but was caused by some other circumstance.

Now, this, this is what is called a medical malpractice or a medical negligence lawsuit. In this case, the plaintiff, Treva Flowers and Tristan Flowers, allege that they sought medical care from a doctor in a child delivery, that he provided care, and that he was negligent in the providing of that care.

Now, in order for a plaintiff to be entitled to a

recovery in a medical negligence lawsuit, the plaintiff has to prove four essential elements in order to be entitled to a recovery. If any of those four elements are not established, then the plaintiff is not entitled to recover against the defendant.

So, in a medical, medical negligence lawsuit, the plaintiff must first present evidence to the jury establishing what the applicable standard of medical care was that's relevant to the circumstances attending this particular case.

Secondly, the plaintiff has to prove that the defendant inappropriately deviated or departed from that applicable, applicable standard of care. In other words, it has to be proven that the defendant's care and treatment that was provided in this case did not conform to or comply with the applicable standard of medical care required of physicians if acting under the same or similar circumstances as established by the evidence in this case.

Thirdly, the plaintiff has to prove that any injury complained of was sustained and some loss was suffered, and that it was the defendant's deviation and departure from the applicable standard of care. In other words, it was the defendant's negligent providing of medical care that was a proximate cause of some injury claimed to have been sustained by the plaintiffs for which they are asking for

compensation.

Now, in this case, the way the trial will proceed is that, in a moment, the lawyers are going to address you in what are called opening statements. There are two occasions in the trial of a civil lawsuit where lawyers are permitted to address the jury and that is at the beginning of the trial before any evidence is introduced, then again at the conclusion of the trial after all of the evidence has been received, but keep in mind, as I've just indicated, that the evidence comes in -- the evidence upon which you will base your decision comes in-between the opening and the closing statements.

And so what the lawyers tell you in their opening and closing statements is not to be considered by you as any evidence upon which you will base your decision, and that's because the lawyers aren't witnesses to anything. They don't know anything about this case of their own personal knowledge or perception like witnesses will be testifying to when they take the witness stand and testify before you. The lawyers aren't gonna take the witness stand. They're not gonna be placed under oath, and they're not gonna be subjected to direct and cross-examination like every witness will be when the witness provides evidence here in Court, but you should listen to what the lawyers have to say even though it's not evidence because those statements do serve a

purpose.

The opening statements will serve to provide you with a basic understanding as to what this case is about from both the prospective of the plaintiffs and of the defendant so that you'll have some context in which to place the evidence that we will be receiving shortly thereafter.

The closing statements occur after the evidence has been received, and, again, while those statements are not evidence, it does afford the lawyers an opportunity to discuss with you the evidence that you have seen and heard during the trial of this case, and it will provide them with a chance to try to persuade you or to convince you that the evidence in the case does or does not support a particular decision depending upon which lawyer is arguing that case before you, and it's in-between those opening and closing statements accomplished by the lawyers that we actually receive the evidence upon which you will decide the facts and you will determine whether or not the plaintiff is entitled to a recovery.

The plaintiff has the burden of proof. As I've told you, the plaintiff has to prove those four essential elements in order to be entitled to a recovery. If the plaintiff does prove those four essential elements, then the plaintiff would be entitled to a recovery and the jury would have to determine what amount of money is appropriate to be

paid to the plaintiff by the defendant in order to compensate them for those losses and injuries proven to have been sustained. And, as I've stated, if the plaintiff fails to prove any one or more of those elements, then the plaintiff would not be entitled to a recovery and your verdict would be for the defendant.

The plaintiff goes forward first in their presentation because they have the burden of proof. They have to establish their entitlement to a recovery. Once the plaintiff has concluded in their presentation of evidence, the defendant will have an opportunity to present evidence. After all of the evidence has been received, you know that you'll hear from lawyers in their final summations after which I will instruct you on the law fully as it relates to the civil law generally, and as it relates to this particular type of cause of action specifically, and then you'll be asked to go back and begin with your deliberations, and, through that process, you'll examine all of the evidence.

You will evaluate the credibility of testimony of witnesses whether they be lay witnesses or expert witnesses. You will determine what you believe to be the facts as they relate to the allegations in this case. Once you've decided those facts, you'll then apply the law that I will have provided you, and you will determine whether or not the

plaintiff is entitled to a recovery. If the plaintiff is entitled to a recovery, recovery, then you determine the amount of damages. And if the plaintiff is not entitled to a recovery, then you will indicate your verdict is for the defendant.

Now, during the course of any trial, there are often times where there is a conflict in testimony. Now sometimes those conflicts don't make any difference because they don't relate to any material fact that needs to be decided in order for a jury to arrive at a decision. In other words, if it's said something occurred during the daytime and somebody else said it occurred in the nighttime, that doesn't matter what time it occurred. It's the event that's important, and, of course, it might be important if it's in the night in some, some given case, but not necessarily so. But if it's not a material fact, then it doesn't make any difference necessarily.

But where the testimony conflicts and it does relate to a material fact that needs to be decided by the jury in order to arrive at a decision, you are the persons who get to decide that fact. You are the persons who get to decide the credibility and the believability of any witness that testifies before you during the trial of this case. That goes for lay witnesses and it also goes for expert witnesses.

You are the judges of the facts. You determine what the facts are. It is your prerogative, in determining those facts, you get to assess the credibility of witness testimony, and whether it be a lay witness or an expert witness, you can believe everything that a witness testified to.

You may choose to believe none of it. You may believe some portion of a witness's testimony and reject some other portion of that same witness's testimony. You may believe one witness as opposed to several or several as opposed to one. But in order for you to be in a proper position to be able to fairly evaluate and assess a witness's credibility, you've got to give every witness that testifies the same degree of attention while they testify so that, in the end, when you do go back to begin deliberation, you'll be in a position to fairly evaluate their testimony in light of not just their own testimony given here in Court, but in light of all of the other testimony and other evidence received during the course of the trial. And it's also important that you keep an open mind throughout the course of the trial, and that simply means that you are not to begin making up your minds or formulating your opinions as to what you think the ultimate decision in this case ought to be until all of the evidence has been presented, until I have instructed you on the law, and until you've been asked to

begin with your deliberations in the case.

That is the process that has been designed over the last 240 years to ensure that you can arrive at a fair and just decision in any case, but specifically in this case today.

So, I do want to thank you in advance for your participation as well as for your careful attention.

I will ask that you please give the lawyers your attention now as they give you their opening statements.

Mr. Henshaw.

MR. HENSHAW: May it please the Court?

THE COURT: Yes, sir.

MR. HENSHAW: Ladies and gentlemen of the jury, my name is Charles Henshaw. I am very proud to be representing Tristan and Treva Flowers and their daughter, Ashley, in this case that we are going to present to you this week.

I hope that you will find it to be an interesting case. I hope that we will be able to present it to you in a way that you will be able to understand.

In a medical malpractice case, sometimes people feel concerned or they're very concerned that they won't be able to apply their own common sense and knowledge to the case. You certainly can do that. And by the time this case is over and you will know enough about the medicine that you will know what the standards of care are and what was to be

done or what should have been done on the night that Ashley Flowers was delivered on October 7, 2008, here at Spartanburg Regional Medical Center.

Bang Giep holds himself out in this community as a medical doctor. That means he has intended and graduated from a medical school where he was academically educated and trained in the principles and science of medicine. He puts the initials M.D. behind his name because he is licensed by the State of South Carolina to practice medicine in this state. Bang Giep holds himself out in this community as a medical specialist in obstetrics. That means he undertakes to help women by medically managing their pregnancies and delivering their babies at birth. For this, he entered and completed a residency program where he concentrated on obstetrics and gynecology and had multiple years of training in obstetrical standards and practices that are generally recognized and accepted by experienced and reasonable physicians.

By the time October 7, 2008, arrived, he knew what was to be done and he was expected to do it. That was his job. That's what he got paid for.

Doctor Giep further underwent testing to demonstrate his proficiency, which has allowed himself -- allowed him to hold himself out to the public as a board certified obstetrician meaning that he has been measured by national

standards of practice. Not just local standards.

In 1995, he joined Spartanburg OB-GYN, now Spartanburg Pelham OB-GYN, and he began practicing here in Spartanburg County where he and all the other members of the practice held themselves out to the public as board certified medical specialists in obstetrics.

A pregnant woman came under the care of Spartanburg OB-GYN for pregnancy in 2008, she could expect to see each of the doctors in the practice with the further expectation that each doctor was fully qualified and competent to manage her pregnancy. She could also expect that each doctor in the practice was fully qualified, experienced, and reasonably competent, competent to recognize and respond to complications of her delivery.

Much of obstetrical medicine is about managing the complications of pregnancy. Since the beginning of time, women have been having babies without the benefit of an obstetrician and without encountering risks of pregnancy, labor and delivery, that, in some cases, resulted in death, disfigurement, or physical impairment to either the mother, the child, or both, but science and medicine have showed that many complications of pregnancy can be managed and eliminated when the mother comes under the care of a reasonably competent practitioner.

Consequently, in modern times, most women choose to be

seen in pregnancy by board certified obstetrical specialists such as Doctor Giep. By law, by law, each of those women can expect that the practitioner will act according to generally recognized and accepted standards of care, and to do what would be expected of a reasonably competent practitioner under the same or similar circumstances.

That is the law and duty of every person who holds themselves out as a medical doctor in South Carolina, to act according to the standards of care, and to do what a reasonably competent practitioner would do under the same or similar circumstances. In this case, it's what a board certified obstetrician would do under the same or similar circumstances that presented themselves on the night of October 7, 2008, at Spartanburg Regional Medical Center.

Treva Flowers, at age 34, came under the care of Spartanburg OB-GYN in 2008 when she became pregnant for the first time. She and her husband, Tristan, wanted a baby. Tristan worked at Spartanburg Regional in communications and was recommended to Spartanburg OB-GYN.

Treva met every appointment and did everything she was told. Tristan usually went with her to every appointment. She circulated through the different doctors in the practice. That was the way that they had it set up. They wanted each patient to know every doctor, but she mostly saw Doctor Ashley Fowler, and she saw Doctor Giep in his office

three times during the multiple visitations she had in the office before she delivered.

In about her 32nd week of pregnancy, standard testing showed that she had gestational diabetes, a complication of pregnancy that sometimes caused babies to be large. Up until that time the pregnancy had been absolutely normal.

Treva, excuse me, Treva's gestational diabetes was managed by diet alone. She did not require Insulin. Otherwise, except for the gestational diabetes, the pregnancy went well and the baby developed normally. Four ultrasounds were taken during the entire pregnancy. They all showed that the baby was developing according to the norms.

The baby was considered to be big, about in the 85th percentile, but that's not abnormally large, and the ultrasound showed that there were no abnormalities in her development. There was nothing wrong with her legs or her arms, her toes, or her fingers. She was a normal healthy baby in utero.

Early on October 7, 2008, when Treva was at full term, only four days away from her due date of October 11, her water broke at home, early in the morning, two o'clock. First time baby, you can imagine the excitement.

As planned, Tristan took her to Spartanburg Regional where she was admitted for labor. She was admitted,

admitted under the care of Doctor Fowler, and Doctor Fowler managed her labor throughout the day until about seven o'clock in the evening.

Then Doctor Giep took over, according to the schedule of the medical practice. It was basically they work what they call half days, one doctor on, and then another doctor would come on, and Doctor Giep's turn -- it was Doctor Giep's turn to come on at about seven o'clock, maybe a little bit earlier.

But, by then, the baby's head -- by the time he came into the room where Treva was laboring, the baby's head was crowning. The nurses were calling for the doctor to be ready for the delivery. Crowning means that the baby's scalp was beginning to appear between the mother's legs. They could see the hair.

Doctor Giep came into the room, assessed the situation, and applied a vacuum extractor. He pulled twice with the vacuum extractor and the baby's head emerged.

Unfortunately, with the head out, the body would not come. The baby's left shoulder was caught or hung on the mother's pubic bone.

Now, this is called a -- this is a complication of labor known as shoulder dystocia.

We need to have the -- we're gonna need to have that -- there we go. I think we can see it now.

Thank you, Your Honor.

THE COURT: You, you need to leave the lights on is what you said?

MR. HENSHAW: Yes, sir.

THE COURT: Okay.

MR. HENSHAW: So they can -- yes, sir.

This is the pubic bone or the pubis symphysis of the mother's pelvis. In this case, this is the baby's left shoulder. The baby's head has been delivered, but the shoulder is caught behind the pubis symphysis not allowing the body to deliver, and that's called shoulder dystocia.

When shoulder dystocia will occur is unpredictable. It can happen in any pregnancy, but it does happen more often with larger babies or where there has been gestational diabetes, and this is where obstetricians earn their pay. They are trained in maneuvers that can free the baby's shoulder and allow the body to emerge.

Doctor Giep employed at least two of the maneuvers. They're called the McRoberts maneuver and suprapubic pressure. This is the opposite view of the shoulder dystocia.

Can you turn that?

The McRoberts maneuver is where the mother is directed and helped to pull her legs back toward her chest. Both legs come back. In this case, the nurse -- a nurse was used

on one side and Mr. Flowers was on the other leg pulling back, and that helps position the baby in a better position to allow the shoulder to be released. In addition, suprapubic pressure was used in this case, and there's where a nurse is directed by the doctor to use one of her hands or both to push down on the pubis symphysis, the pubic bone, or just above it actually and apply pressure to try to compress the shoulder so that it makes for a smaller presenting part to, to be released and come on out of the birth canal.

This depiction shows the nurse standing there, but, in this case, the nurse actually climbed up on a chair or some type of step stool so that she could get more leverage to push down on the shoulder.

There was a third maneuver that Doctor Giep will tell you that he used called the Rubin's Maneuver, which is where he actually attempts to move his hand up and take the shoulder and sweep it in a way that releases the shoulder. That was not documented in his records but -- and what the records indicate is that these two maneuvers, the McRoberts maneuver and the suprapubic pressure maneuver by the nurse, actually allowed the baby to be released within two minutes after the shoulder dystocia was recognized.

Ashley was born weighing seven pounds eleven ounces. An injury to her left shoulder was immediately apparent. She could not move her arm.

Doctor Giep and his attorney will tell you that the injury was unavoidable. They will say that the forces and complications of labor caused the injury. We say that Doctor Giep caused the injury to Ashley's left shoulder through negligence.

We know this because three nerves in her neck and shoulder, the nerve C5, C6, and C7, were ruptured. A fourth nerve, C8, was so badly stretched that it developed scarring. Scarring is called a neuroma. These were permanent injuries from which Ashley will never fully recover.

Show the illustration as the nerves.

Yeah, this one right here. That's fine. That's good.

Can we blow that up at all?

Is that, that as large as we can make it?

Okay. That's fine.

This doesn't illustrate very well, but depicted on this illustration are where the nerves come off the spinal cord.

You can see them here. This is the spinal cord and each of the nerves comes off and they are numbered five, six, seven, and eight, and then T1 I believe is what's depicted there. They were stretched so severely that C5, C6, and C7 were ruptured. Not just stretched. Ruptured. And then C8 was so badly stretched that it developed scarring, inflammation that caused it to scar over so that

no electrical stimulation could go through these nerves -- I mean go from the brain down the spinal cord and through these nerves into her arm.

When it was all over, at best, she had the movement of only two fingers. She couldn't flex the arm. She couldn't raise it. She couldn't move it laterally. Essentially it was dead.

Ruptured nerves and permanent injuries are not the expected results of shoulder dystocia. Shoulder dystocia is a bad complication, but this injury suffered by Ashley Flowers is not the expected result.

There are a group of cases where, in the course of delivering babies, temporary injuries to these nerves will be caused by stretching during the delivery, temporary injuries will be caused by stretching, and that is considered to be a -- that is considered to be an unfortunate, but accepted, complication of a shoulder dystocia occurring during the delivery of a baby. Ruptures and permanent injuries are not considered to be acceptable injuries occurring during the delivery of a baby because of shoulder dystocia.

The only time that this much force can be used by a doctor in delivering a baby is when the baby is facing near certain death, that there is no other way out, and then it would be considerable -- it would be considered acceptable

to sacrifice the arm in order to save the baby, but this baby was not at near certain death. And this much force was not necessary in order to save the baby, and that's the reason this was negligence. This was malpractice.

Negligence, malpractice, deviation, departure from standard medical care, they all mean the same thing. The doctor did not do what would be generally recognized and accepted of a reasonably competent practitioner under the same or similar circumstances.

And why do we know that?

Because by simply using McRoberts maneuver, and by suprapubic pressure, Ashley's shoulders released within two minutes, more like a minute, but within two minutes, and she was no where near death and this amount of force was not necessary.

Moreover, Doctor Giep himself, who documented what happened and who has testified in this case and will testify again, is, in no way, indicated this baby was near death and that he was in the process of having to make a decision to use this much force. He doesn't get up -- he doesn't get to get up and say to you I was trying to save this baby's life by using excessive force, that I was gonna sacrifice the arm in order to save the baby. That was never a decision that he had to make.

He didn't document it. He's never testified to it, and

if he tries to say it in this trial, he'll be changing his testimony and his documentation.

He asserts that he applied only gentle traction, but gentle traction does not cause ruptured nerves and does not cause permanent injury.

You will hear Doctor Giep and experts that his attorney has retained come and testify that what happened here may have been caused by maternal forces of labor. In other words, during the process of the mother having contractions to force the baby out, in combination with the shoulder impacting against the pubic bone, then that somehow caused damage to these nerves.

In the history of medicine, there is only one case where this type of damage, permanent injury, has been known to be caused to a baby who did not have traction applied during the -- who did not have traction applied during the delivery, and it was written up and published in medical journals. It was so unusual.

If nothing else, if this is that case or like that case, then Doctor Giep owed it to the entire world to publish this case so that other people could understand how it could happen even though he applied only general traction or no traction. That's how unusual it would be.

Now, at the end of this case, the judge will tell you that you're entitled to use your common sense and collective

wisdom in making a decision about what the truth is about what most likely happened. He will also explain to you that, when you make a decision in this case, you don't make it on the basis of absolute certainty or even scientific certainty or what you believe happened beyond a reasonable doubt. We don't have to prove our case beyond a reasonable doubt, and the reason I bring this up is cause what we have to prove to you is what probably happened, what probably happened, and the evidence will be, at the end of this case, is that when this type of injury occurs, that is ruptures of three nerves, severe stretching of a fourth nerve with permanent injury, what most probably happened is that Doctor Giep used too much force.

Now, he not only used -- in order to have a result like this, he most probably -- turn it please the other way.

All right. So, here's the way the baby's head is suppose to come out. It's suppose to come out in line with the body, but what most probably happened was -- is that there was what is called lateral traction. The baby's head, the opposite ear, in this case the right ear, was probably pushed down toward the lower shoulder, and it causes a stretch, and that stretch is more than that area of nerves can take. That area of nerves is called the brachial plexus, and you'll see injury to the brachial plexus.

And so, a combination of tugging on the head, along

with lateral traction toward the opposite shoulder, is what most probably caused this injury, and that's what's generally recognized and accepted to cause these injuries when they're permanent and when they, when they result in rupture. Otherwise, it should be published. The world needs to know cause that's malpractice.

That's medical negligence right there. That's a deviation from standard medical care. That's not what a trained board certified obstetrician is expected to do under these circumstances. Not when it's -- not when it's a situation where the doctor's not making a, a conscious decision to sacrifice the arm in order to save the baby.

There will be experts presented by both sides. We will present to you Doctor Edith Gurewitsch and, and her husband, Doctor Robert Allen. They are -- Doctor Gurewitsch is an obstetrician at Johns Hopkins University whose written extensively on the management of shoulder dystocia, and her opinion is, is that, unfortunately, Doctor Giep committed malpractice.

Doctor Allen is a biomedical engineer, and he has studied the forces that are involved in delivering babies with shoulder dystocia, and has studied the forces that can cause this type of injury. And he will explain how the -- what those forces are and what kind of tugging a nerve can withstand and what kind of tugging a nerve can not

withstand.

Doctor Gurewitsch herself has had a circumstance in which she delivered a baby with shoulder dystocia and there was permanent injury. She believes that the circumstances justified what she did in that case. She does not believe that what Doctor Giep did here, when he was able to release the baby within two minutes with two maneuvers, and there are at least five other maneuvers that can be employed that are known to physicians if they feel like they need to use them, and he did not need to implore all those maneuvers in order to deliver this baby.

So, under these circumstances, she does not feel that it fell within acceptable care to use as much force as he did to release this baby for the purposes of delivering.

Ashley Flowers is now nine years old and I feel that she's old enough to make an appearance in this courtroom and let it -- let her talk to you herself. If she was a younger child, I might only let her parents speak for her, but she's going to come speak to you tomorrow and she'll be here. And she's a beautiful young girl. Just beautiful. And charming, vivacious. Got a lot of spunk. And she would be nearly perfect except for her arm, which is disfigured.

She's had three surgeries to try to restore some function of the arm, and she's very proud of what she can do with it. She'll impress you with what she can do with that

arm, but she will never be whole, and she'll tell you that.

More than $600,000 has been spent to try to restore this arm, and she will live with a disfigured arm and a dysfunctional arm for the rest of her life. And I tell you that, in part, in hopes that you will appreciate and understand how important this case is to Ashley and her parents, but it's important to everybody in this courtroom. Absolutely important.

I will tell you that this case will move along very quickly. We hope to be through by the end of the week. That's pretty fast for a case of this magnitude, but we can do it, and the concern that we often have in a situation where we are moving this quickly is that jurors will not actually realize how important the case is until maybe the second or third day. And if you wait for that long to wake up to how important the case is, it will be too late. You will have missed significant testimony, and the failure to appreciate what you really need to appreciate to be able to decide this case.

We believe that, at the end of this case, you will understand that, number one, when a doctor -- a doctor is expected to know how to identify shoulder dystocia and how to deal with it. He's expected to know what maneuvers he needs to make in order to release the body. He's expected to be able to do that without applying too much force to the

baby's head and without applying lateral traction, dragging the baby's head over toward one shoulder so as to stretch the nerves in the opposite shoulder.

And if he fails to do that, under circumstances where there was no need to do that in order to save the baby's life, in other words, there was no need to sacrifice the arm in order to save the baby, then, under those circumstances, he has committed malpractice. And if he has committed malpractice, then the patient is entitled to be compensated for the injuries that she has sustained, and she has sustained much. And we believe, at the conclusion of this case, you will find on behalf of Tristan and Treva and Ashley.

Thank you.

THE COURT: Mr. Lovell.

MR. LOVELL: Thank you, Your Honor.

Good afternoon.

I'm Gary Lovell and I represent Doctor Giep and his practice in this lawsuit.

Opening statement is where we lawyers outline what we think the evidence will show in the case, and you heard the judge tell you a few minutes ago, because the plaintiffs have the burden of proof, they will go first. They'll take part of today and probably the remainder of today and probably all of tomorrow putting up their witnesses.

What I ask that you promise me at this early phase and promise Doctor Giep is that you don't start making up your mind until you've heard from our portion of the case, which comes possibly into Wednesday, maybe a little bit of Thursday, cause you won't have heard all of evidence about what happened in this scenario, what caused the injury that this young lady suffers until you've heard from our side of the case. So, please make me a promise that you won't make your mind up until you've heard all of the evidence.

Now, what plaintiff's attorney didn't tell you about this case and what the evidence is gonna show is, is -- he's right about a couple of things. This was a relatively uneventful pregnancy. Mrs. Flowers started with the practice in January of '08. Everything was going very well. She developed gestational diabetes after a few months, but it was managed very well with diet. Doctor Giep was one of the doctors that helped make that diagnosis.

Ultrasounds were showing what they could show, and ultrasounds aren't like an MRI or other studies that tell you everything about what's going on inside of the body, but they give you some, some rough idea of what's about the size of the baby, when it's probably gonna be due, does it have five fingers, five toes, two arms, two legs, but it doesn't tell you other things about what's going on inside the baby's body.

But everything went along well. This was a, a large baby, but not so large that there was concern that it might not deliver the natural way, vaginally.

So, in October, Doctor Flowers sat down with -- I mean Doctor Fowler sat down with, with Mrs. Flowers and said okay, your due date's coming up. You know, if we get a little further on, we might have to induce you, but we'll just wait and see what happens.

So, on October the 7th, about 2:30, 3:00 in the morning, her water broke. So, the induction was now no longer necessary. She's headed to the ER to the labor and delivery department of the hospital, and she's gonna deliver the baby.

The evidence will show that the doctor works 12 hours shifts, 7:00 at night till 7:00 in the morning is when, when Doctor Fowler was in. 7:00AM -- I'm sorry. I got it backwards. 7:00AM, yeah, Doctor Giep comes on duty and he has the next shift. He is the doctor who was on duty when the baby was delivered.

Doctor Giep will tell you that his standard practice is, when he's gonna deliver, he goes and evaluates the patient, checks on her. The labor and deliver nurses then follow the patient throughout delivery. And what you're gonna see, ladies and gentlemen, is that, as this delivery progressed, and I'm a little bit somewhat low tech, but

you're gonna hear from Nurse Phillips, who you heard about earlier, she was primarily the one that was following the patient pretty much all day when her shift started.

When the afternoon came, and these are all military times, so it's 19:47 is 7:47, they went into what's called the second stage of labor where mom starts pushing. Those of you who have children just really know what we're talking about. Mom starts pushing and the baby begins moving down the birth canal.

You're gonna hear some testimony from Doctor Giep and some other experts about what happens to babies as they move down the birth canal. You'll hear them testify about something that plaintiff's attorney alluded to called maternal forces. Maternal forces are where the contractions and the muscles that are contained within the body of the mother, and what I'm showing you here is an idea or diagram, and we'll have a lot of different videos of things, but as the body begins to move down the birth canal here, forces apply to it -- to the body and they affect parts of the body as the baby is moving down. Those are what's called maternal forces.

You're gonna hear that those forces have a profound effect on healthy babies, and they have an even more profound effect on babies who aren't quite as healthy.

One thing the plaintiff's counsel didn't talk with you

about that I think the evidence will clearly show, ladies and gentlemen, is that there's a point in time, beginning about here, when the mother had been pushing for quite a bit with contractions, the baby is moving down, and things are going as they expect. They have her on a medication called Pitocin to situate how the, the labor and the delivery is progressing, but there came a point in time, when the head began to crown, that the baby began to show evidence of what's called fetal distress.

And what that means is the doctors are measuring the baby's heartbeat as it's coming through the birth process, and you, by the end of this trial, will be able to read this thing that I'm putting up here. It's called a fetal monitor strip.

The top part shows the baby's heartbeat measured in beats per minute and there's little scales that go from 30 to 240. The little squiggly line is where the baby's heartbeat is, and the evidence will show that, as we got into the seven o'clock towards the eight o'clock hour, that this baby's heartbeat was in the 130 beats per minute range and it kind of stayed there. The bottom part is what shows the contractions of the mother, and as her muscles begin to contract, and the, and the birth process device is on there that measures them, and it shows when she's having contractions and when she's not, and kind of how big they

are.

At about 7:55, as the second stage was going, the nurses began watching these strips and they noticed, in about 8:04 in the afternoon, that the baby's heart rate began to change. It began to drop below the 120 where it had been staying, and it started getting into an area down here in the 90s. That was a little concerning. Not necessarily concerning enough that you worried that the baby may be having a lot of instant problems because babies can lay on their umbilical card, and it can cause a problem like that, or the mother can be shifting side-to-side and create some problems on the umbilical cord, and it can create that if it's just temporary.

The problem we had with this case is that, as the nurses began to change the position of the mother, the heart rate stayed down there low. It didn't come back up and stay up. So, at about -- at about 20:11, they decide we're gonna get Doctor Giep. So, they call him and he comes in to the bedside. They put the patient on her right side, moved her to her left side, and try to see if they could relieve the cord thing.

Doctor Giep comes in and he does his examination, and he'll explain to you what he does in his initial evaluation at that point, but he's concerned about this baby's heart rate. He's concerned that we're now down into the 90s and

it's not recovering. He's concerned that, if I let this continue and I let mom continue to try to deliver vaginally with natural contractions, this baby could get in trouble. So, he decides that what he's going to do is what's called a vacuum assisted delivery. He used a device called a Kiwi vacuum that he placed on the top of the baby's head when the baby was born or when the baby's head was doing what they called crowning, and he used that to assist in removing the baby or guiding the baby out to the position we see here.

Now, at this point, this is a suprapubic maneuver we're gonna talk about in a minute, but the vacuum extractor was used simply to try to assist the mom in getting the baby to deliver naturally. The problem developed. At that point, the baby's shoulder got stuck on the mother's pubic bone. That was the shoulder dystocia.

So, what you have was a baby who, for several minutes, had been having a heart rate in the 90s. That was concerning. You now have a baby whose shoulder has gotten stuck on the mother's pubic bone, which is what all of the doctors that come in here, including Doctor Gurewitsch, will agree is a medical emergency.

At that point, Doctor Giep will tell you he has but one option and that is to deliver this baby and deliver it within a period of a few minutes. After two or three or four or five minutes, the baby can develop brain injury.

The baby can develop cerebral palsy. The baby can even die. So, he's faced with a medical emergency at 20:18 and 20:19 where he has to deliver the baby.

Now, Doctor Giep will tell you, and we'll bring in the nurse that will also tell you, what he did to do that. The baby was safely delivered to the point where the vacuum had delivered the head, but once the shoulder got stuck, the baby has got to come out within a period of a few minutes. Doctor Giep will tell you that the first thing he asked the nurses to do was he asked them to put the patient in the McRoberts position, what you saw, with her legs elevated so that that would open up the pelvic anatomy with the mother. Nurse Phillips will explain this in her video deposition, but that, as they pulled the pelvis up, it opens it up and the hope is that that will be enough to free up that shoulder. Sometimes it works. Sometimes it doesn't.

Doctor Giep will tell you the next thing that he instructed the nurses to do was to apply the suprapubic pressure, and you'll hear from all of the experts that this was the appropriate thing to do. Try this. You've got the legs up. You've opened the pelvis. Hopefully the nurse pressing on the area of the shoulder will allow it to slide under that pubic bone. That's the hope. Hopefully that works.

Unfortunately, Doctor Giep will tell, in this

situation, it did not free the shoulder. He had to proceed to a third maneuver, and, in this third maneuver, it's called a Rubin II. He takes his hand and he inserts it into the mother's birth canal and he attempts to help guide the shoulder below the area of the pubic bone.

So, what he does, as you see here, he first -- before he does the Rubin II, he tries to reach in coming from this direction to see if I can grab the arm that's stuck and slide it forward and maybe it will come over. He couldn't reach the arm he'll tell you. So, then he used what's called Rubin II where he comes over and under, and he takes his hand and he very gently pushes that shoulder over towards the chest, and, when he did that, the baby delivered.

We'll have a video animation to show you that's a re -- a little more fluid way of showing what all I just described to you, but Doctor Giep will tell you that that's what he did in this case to deliver the baby. He delivered the baby using all three maneuvers within two minutes of the development of the medical emergency. He delivered a baby that didn't have brain damage. He delivered a baby who didn't have cerebral palsy. He delivered a live baby. Three of the complications that could have occurred if this baby had not been delivered in the manner it was.

You've heard a lot of testimony about what type of

forces the doctor used and what he wrote in his chart, and perhaps what he didn't write about the McRoberts, suprapubic, and then what he didn't write about Rubins II. He'll tell you the reason Rubin II is not written is that's something he always does in a procedure like this. When the applied suprapubic doesn't work, the McRoberts doesn't work, he always goes to Rubin II. The reason he writes the Rubin -- the McRoberts and the suprapubic is because somebody else is applying it, but he doesn't write the Rubin II down since that's something he does, and he always does it in that order.

One thing we do know is that, on the day of the delivery, the delivery was at, excuse me, 8:11 in the morning, he's handed the baby off to mom and everything and the baby's in NICU. At 9:11, he wrote the note summarizing of the occurrence and this is what you got to do in the hospital. You got to write what you do, you know, what's happened and when it occurred.

Well, he wrote in his note minimum traction performed. His handwriting is terrible, but he'll help interpret it. That's what he wrote at 9:11 describing the amount of forces that he used on the baby in this delivery.

Two days later he's talking to the parents again trying to explain to them what happened with the injury to this child, and he wrote in his note gentle and constant traction

applied to infant head after McRoberts maneuver, suprapubic pressure. Dystocia lasted approximately one minute. He wrote in his note a description of what he did.

Now, eight years after the fact, tomorrow, I think, you'll hear from Doctor Gurewitsch who's gonna say that's a lie. What he wrote in his note was -- is not true.

He didn't use minimum traction. He didn't use gentle positive pressure. He used 35 plus pounds of pressure on this baby's head. She'll tell you what was written in the notes, eight years ago, must be a fabrication. That's for you to decide.

We're gonna bring you some expert witnesses to talk about the care that Doctor Giep rendered, but, before that, I want to talk for a second about Doctor Giep. I want to talk about that.

Doctor Giep was born in Pennsylvania. His parents had come here from Vietnam. He went back over there with his parents for a while, and then moved back to the United States at the end of the Vietnam War. He attended college here at Wofford, went to medical school at the Medical University of South Carolina Charleston, did a residency, did training programs in obstetrics and gynecology, got board certified, as the plaintiff's counsel mentioned, where the boards were given to him. He took an oral test, written test. He was certified as being -- having expertise in

obstetrics and gynecology.

He started practicing medicine here in 1995 with his father. His brother joined the practice along with a lot of other doctors who you heard mentioned in our jury selection.

He has delivered hundreds, if not thousands, of babies. He has encountered shoulder dystocia, the hung shoulder as I call it, on other births both before and after this one. This is the only birth he's ever had that suffered a permanent injury. All the others were temporary. But what Doctor Giep will tell you is that, in his delivery of this baby, he used the same types of forces, the same direction of forces that he's used on all of the deliveries of babies he's had with shoulder dystocia.

Now, it will be for you to decide if what Doctor Giep describes to you and the method that he delivered the baby is what most obstetricians, in general, would have done under the same circumstances, the circumstances of a child whose got a heart rate that's dropping to a concerning level, the circumstances of a child whose got a dystocia, and circumstances where you try two of the basic maneuvers and it didn't work.

Doctor Giep will explain to you, as he wrote in his notes, the type of pressure he uses, the direction that he does it, his position with the mom as he's doing that, and you'll hear him describe how the position he is in prohibits

him from doing what the plaintiff's pictures show up there.

We'll have a couple of experts to talk about standard of care from the obstetrician only standpoint. We're gonna bring to you Doctor Robert Arnett. He's an OB-GYN doctor here in Spartanburg.

Doctor Arnett has looked at this case. He's reviewed all of the materials. He will come in and tell you that what Doctor Giep describes as doing and what he's written in his notes about the traction with the forces he used was what most OB-GYNs would have done. It was within the standard of care.

We'll also bring to you Doctor Roger Gowers. He's an OB-GYN that practices in Greenville. He will tell you the same thing, that he knows, from his training of residents and his experience, the types of forces that are used and he looks at what Doctor Giep did under the circumstances he was faced with, and these were the types of forces and the direction of forces that most doctors would do.

So, the question may be in your mind, at that point, well, how could the injury occur?

Well, we're gonna bring in a couple of other experts to talk about that issue. We will have for you Doctor Joseph Ernest, who is what's called a maternal fetal medicine specialist. That is an obstetrician/gynecologist who goes and gets even more training on what happens to babies when

they're developing and when they're being born.

What he's gonna tell you is that brachial plexus injuries can occur even when the forces applied by the physician during the delivery are the normal ones that, that all or most physicians will use. He'll explain to you that sometimes, when maternal forces and the baby is moving down the mother's birth canal before its head ever gets down to the crowning or the bottom part, that those forces and the movement of the baby itself can cause these types of nerve injuries. Very similar, if not like the ones that this patient suffered.

He'll also talk to you about other things that can happen to babies while they're being born that can cause the muscles and the tone in the area that protects the nerves to become a little bit weak and not provide the normal protection that babies who are healthy would have at the time of the delivery. He will tell you that, in this case, when he looked at the records of Miss Ashley Flowers after the birth, her muscle tone was not normal.

She started out with the fetal distress that we saw and the heart rate sort of dropping into the 90s, and Doctor Ernest will tell you and the evidence will show that, when a baby's beginning to have heart distress, sometimes the muscle tone becomes weak, and, when it becomes weak, it's not protecting the neck as it's moving down the birth canal.

And sometimes that can predispose those nerves to being injured when normal forces of delivery are used. He will tell you that's a possibility of what happened here.

How do we know that Ashley had a muscle tone that wasn't normal?

You're gonna hear from the NICU nurse, Ms. Dowis, I think, who will tell you that, when they scored the muscle tone of the baby after, they use a zero, one, and a two where zero is no muscle tone, two is normal, Ashley suffered or scored out a four. One minute after birth and a -- I'm sorry. A one -- at one minute after birth and a one at five minutes after birth or at four minutes later. That tells us that her muscle tone wasn't normal.

You'll hear the family testify that, when she was born, she was blue. She didn't cry normal and it took them a little while to get her crying, crying and up to normal. So, she wasn't a normal healthy baby at the time of birth. That can affect those nerves and make them more predisposed to the types of injuries she suffered when the shoulder dystocia occurred.

One thing plaintiff's counsel said that I agree on is that shoulder dystocia -- stuffed -- the shoulder is unpredictable. The doctors have no way of knowing this is going to occur until it occurs. You can't see it in advance. There's no test you can do that says oh, this

one's gonna be a dystocia and that one's not.

So, you'll hear from Doctor Ernest that there are reports in all of the medical research and the literature they write after it where people can develop a permanent brachial plexus injury with normal forces of traction. They surmise that it's because the nerves are injured before the baby ever gets down there. They surmise that the nerves are injured because the baby's tone is a little weak and that you score the ten, the fifteen, the normal pressures -- the normal angles, that's what causes the injury.

We'll bring you also another maternal fetal expert, Doctor Suneet Chauhan, who practices now in Houston who practiced here in Spartanburg for a while. He is one of the nationally recognized investigators on the causes of brachial plexus injury. He was part of the American College of Obstetrics & Gynecology, which most of these experts all belong to. They had a Task Force studying this very occurrence and they published the report a couple years ago that was called the Task Force Study on Neonatal Brachial Plexus Palsy. He was the number two author.

Doctor Chauhan will come in and explain to you many of the very things I've talked about and what causes these types of injuries, even when the doctor's not yanking or pulling hard, how these things can occur. He's also gonna tell you that, from the research he has done and he has

observed, this idea that just because there's an injury at a certain level of nerves, C4 to C5 to C6, C8, C7, that doesn't mean that that was caused by a doctor applying too much force or too much force in the wrong direction. He'll tell you there's no valid scientific support for that theory.

He'll also tell you, and I'll ask you to listen closely when he testifies, that there's no correlation between the fact that it's a permanent injury to the degree of force it is. Babies are all different. Things happen to them before -- while they're in the mom's womb and developing. Things happen as they're moving through the birth canal. And people are just different. Babies are all different and he'll tell you there's no scientific support for the theories that the plaintiff's experts will ask you to believe.

All of the doctors, Doctor Giep, Doctor Gowers, Doctor Chauhan, Doctor Arnett, Doctor Ernest will say that the techniques that Doctor Giep used and the rest of the delivery team were all within the standard of care, the standard of care practiced by obstetricians when faced with a patient with this type of delivery with the situation that they found themselves in with Ashley Flowers. When the medical emergency developed at the time of the shoulder dystocia, the responses were all appropriate.

Plaintiffs are bringing you the husband and wife team of Doctor Gurewitsch and Doctor -- Engineer Allen. They testify in a lot of these cases. They'll tell you how many and they make a lot of money doing it. You'll hear how much.

I ask that, as you listen to Doctor Allen's testimony and the things that he says are the basis for his opinions, ask yourself is it really based on real science. He's doing cadaver studies. He uses models that aren't live births. He's never done a live birth. He's never measured the forces that somebody like Doctor Giep uses in a situation like this. He's done some simulations. He's done some tests but what -- when you, when you get him on -- when you hear his testimony, I ask that you listen for how many actual doctors delivering real live babies who've had shoulder dystocia he's observed as he, as he arrives at all of his opinions.

To summarize, ladies and gentlemen, we believe, at the conclusion of the case, you'll have seen and we'll present evidence that Doctor Giep, when this shoulder dystocia occurred, a medical emergency was present, he exercised the skill and care that he had learned over his decades and decades of training and practice. He delivered this baby using the same degree of forces he had used on every other time, and that he complied with the standard of

care and the procedures that he utilized.

The baby was delivered in less than two minutes from the time of the dystocia. A lot of these folks will say, you know, that's good cause you only got about a five minute window before really, really bad things like brain injuries, cerebral palsy, and death occur.

I'd ask that you remember the promise I asked you to make. Wait until you've heard all the evidence before you make up your mind.

We hope to get it all in with you by Thursday. A couple of video depositions. They're not much fun to watch, but we ask that, when you do see them, you know, pay attention. You know, just because it's on a TV, it may be a little hard to pay attention to, but we ask that you pay attention, you make up your mind after you've heard all of the evidence, but, most importantly, I think, you know, as you're listening to people talk about what was done, when it was written, and things of that sort, I'd ask that you focus on what was written in September the -- I mean October the 7th at 9:11 in the morning, that minimum traction was performed, and the next two days later, when he's talking to the family, gentle and constant traction applied.

And when you hear the testimony of some of the other folks who are saying well, that just can't be right, because of all of these theories they have, just ask yourself what

was written back when this was done.

Thank you.

ROA 66

MR. HENSHAW: The question to Arturo Armenta posed on October 5, 2015.

We are here today to take your deposition and you likely or, as a matter of fact, I know that you've had your deposition taken before.

A. Yes.

Q. So, today I'm going to be asking you questions

primarily about your treatment of Ashley Flowers.

Am I correct in that the only materials you reviewed in this case are what is contained in your chart that you sent us under the request that we sent your office?

A. Yes.

Q. All right. You've not reviewed any depositions in this case, no outside medical records, no pleadings, no affidavits, nothing of that sort?

A. No.

Q. All right. Have you, in your -- both your medical and your academic pursuits, have you ever conducted yourself -- have you ever conducted, yourself, any studies on the injury thresholds of neonatal nerves?

A. No.

Q. Did you ever do any testing on Ashley Flowers' nerves to determine their strength?

A. No.

Q. Would you agree with me that every child is different, and even within the same child, there may be variations between the strength of tissues such as bones, muscle, nerves, tendons, ligaments, things of those -- that nature?

A. Yes.

Q. Okay. Let's kind of jump off into your treatment of Ashley Flowers, and I have marked as Exhibit 1 what

appears to me to be your final report regarding this surgery you performed on Ashley on June 5th, 2009.

Is that correct?

Is that your final report sort of memorializing what you saw during that surgery?

A. Yes.

Q. Another way to ask you would be, in your experience in dealing -- in repairing brachial plexus nerves, do you encounter a large variation in the amount of scarring that you see once you get in and dissect into that brachial plexus area?

A. Yes.

Q. Is that the amount of scarring that you see in the brachial plexus injury or, or that brachial plexus where there is an injury or where there is a separation of the nerves?

Does that medically tell you anything about the injury?

A. It can depending as to the amount of injury that you encounter.

Q. Are there times that you see minimal scarring with very severe injury, and are there times where you see extensive scarring in what is a less severe injury?

A. Yes.

Q. Would a good description of a neuroma be the scarring after a nerve injury where those nerves attempt to

reconnect with each other?

A. Yes.

Q. Does the size of a neuroma tell us anything about the amount of force that caused the separation of those nerves?

A. It can, yes.

Q. In this case, when you saw the scarring with Ashley Flowers, did that tell you anything about the amount of force that it required to create the injury that she sustained?

A. Yes, a rather large neuroma involving C5, C6, C7, C8, and the lower route would signify that she did sustain a large injury, traction injury, to her brachial, brachial plexus.

Q. And you kind of tailed off toward the end of that answer there. You did -- did you say that the neuroma encompassing C5, C6, C7, as well into C8, indicated that she sustained a large injury to her brachial plexus?

A. Yes.

Q. Okay. Now, when you, during that surgery, when you dissected down into the brachial plexus, that neuroma encompassed C5, C6, and C7 and tell me how much it encroached into that C8 area?

A. So, it says the C5 nerve root was noted to be encased in a large neuroma. However, we were able to free

the C8 nerve root and its contribution to the lower trunk from the neuroma without complication.

Q. Does that indicate that the neuroma or the scar tissue had grown into the C8 nerve, but that nerve was not injured?

A. Well, not necessarily. It just meant that there could have been a traction injury where it didn't rupture, but we were able to free it without causing damage to the nerve during the neurolysis.

Q. And would that be indicative, I guess, of or tell me, in your opinion, did the, did the C8 nerve rupture at some point and then, and then regrow together or was there not a complete rupture of the C8 nerve?

A. There's no way to tell that. The only thing you can tell is that there was some form of injury. It could have been a combination of what you described. However, just the fact that there was scar tissue around the nerve did signal some type of injury that then we were able to remove scar tissue from around the nerve.

Q. Is it also possible, in scenarios like that, for the scar tissue to, to form around the nerves that are above the C8 and grow into the C8 even if it was not injured itself?

A. Well, I wouldn't say, say that they were -- would grow into, but they might compress.

Q. Okay. Do we know whether or not that happened in this case?

A. No.

Q. Okay. No involvement of the T1 nerve?

A. No.

Q. And these nerves at C5, six, and seven, they're what's called ruptured?

Is that, is that accurate?

A. Yes.

Q. And the C5 through seven, that's what's considered the upper brachial plexus.

Is that fair?

A. C5/C6 are upper and C7 is middle trunk.

Q. All right. And nerves in that area, are they more likely to rupture or separate in the middle then separate at the root, at the spine, at the connection to the spinal canal because that's the area where they are generally the weakest?

A. Well, previous studies -- excuse me. Previous studies have shown that the upper roots are more, are more prone to rupture versus avulsion. So, they tend to be more pliable at that area versus weaker.

Q. All right. During this surgery, the scar tissue had also grown into the collar bone or the clavicle.

Is that correct?

A. It might have gone underneath, yes.
Q. And so you had to separate that collar bone in order to perform the surgery?
A. Yes.
Q. Describe that for me. Tell me how that -- tell me what, what that entailed and what, if anything, that that scar tissue growth into the clavicle indicated to you?
A. Well, the indication is that it's just a very large neuroma indicating a large amount of trauma, and the fact that the space that you have available on in a child this small, you're talking about a few centimeters. So, with the scar extending underneath the clavicle, in order to get appropriate exposure, so you can do -- have enough room to do surgery. You know, sometimes you have to separate the clavicle in order to get down into the large area, area of the injury.
Q. Before this case, had you ever had to do that before?
A. In my personal case, no, but in residency and training, yes.
Q. Okay. Have you had to do this, separate the clavicle or had scar tissue growing into an area of the clavicle where you couldn't have room to move since Miss Flowers surgery?
A. Yes.

Q. Okay. Now, the bone there wasn't injured before you had to separate it, was it?

A. From my recollection, no, but I do not remember whether she had a fractured clavicle prior or during birth.

Q. Okay. So, after you were able to expose these nerves, I guess dissect or take the neuroma away, send that off to pathology, you then harvested four nerves 4-centimeters in length, and you were going to use those to graft those C5, C6, and C7 nerves from the root to a, to a, I guess, a proximal location on the brachial plexus.

Would that be accurate?

A. Yes.

Q. And you didn't have to do any repair to C8 or to T1, correct?

A. Correct.

Q. Now, in many cases, there are injuries that you've performed surgery on where there are complete separations, either ruptures or avulsions, to the entire brachial plexus, C5, C6, C7, C8, and T1, right?

A. Correct.

Q. But this was not one of those cases?

A. No.

Q. All right. What, in your practice, is a general what I'll call spontaneous recovery rate meaning that the child's affected arm returns to normal function without

surgical intervention?

What is the general spontaneous recovery rate in children that have injuries only to C5, six, and seven?

A. I would say the great majority is kind of both with the literature and in conjuncture with the patients that we see, anywhere from 70 to 80 percent will recover spontaneously.

Q. All right. So, so, Ashley Flowers requiring surgery and not having a full recovery would, would not be a normal outcome for a child that had an injury to C5, six, and seven?

Would that be fair?

A. Yes.

Q. I included my exhibits as Exhibit 2, which is the pathology report from that initial brachial plexus surgery.

What, if anything, does that tell us about her brachial plexus nerves or her injury, if anything?

A. The fact that she did have, in fact, a traumatic neuroma involving C5, C6, C7, and then that there is a segment of a peripheral nerve of the interior division of the -- I'm assuming it's the upper trunk, and then the posterior division of the upper trunk.

Q. Does it tell us anything else?

A. Not in the diagnosis, but I have not gone through the microscopic description.

Q. Well, if you take a second to review that and tell me if it -- if microscopic description tells us anything else about this injury that you weren't able to discern while viewing it both with the naked eye and under the microscope you used during the initial procedure?

A. No, it falls within the general sort of findings that we have. It's a large neuroma involving the upper and middle trunks, and then, as we dissect distally and proximally, we have a, you know, healthier nerve that wasn't involved in the zone of injury.

Q. And so would it be kind of -- be fair to say that what you do here is you take, you take out the largest part of the neuroma, and then you kind of start slicing back, almost like slicing bread, until you find healthy nerve root and healthy distal nerves that you can then achieve that graft and make that connection with?

A. Yes.

Q. All right. I read previously where you said that a two and half to 3-centimeter gap between a nerve root and a distal nerve is about average. I read in your operative report here that there was a 4-centimeter gap between the C5 root and the suprascapular and the anterior division of the upper trunk.

How would you classify that?

A. As a larger than normal zone of injury.

Q. Other than measuring how large a graft that you need to, I guess, bridge that gap, was there any medical importance to that, that length of division?

A. Yes, of course, the smaller the nerve gap there is, the better chance for a better return of function. The larger the nerve gap is, you know, the decreased amount of nerve fascicles.

Q. Fascicles.

A. Fascicles that are able to per se repair themselves through the gap.

Q. Does that gap indicate that there was a, I guess, a break or a rupture and the two ends just ended up further apart or is that a situation where there were multiple breaks which led to varying pieces over that 4-centimeter gap?

A. That's a great question. It's difficult to answer. You know, you're -- I mean you'd have to have been present at the time of the -- of injury in order to make that microscopic diagnosis. The only thing you could really say by now is that there was a, you know, large area of injury and that the two nerve roots, as the proximal root tried to repair itself, it just got caught up in scar.

Q. So, other than knowing that there is, I guess, 4-centimeters between healthy nerve distally and healthy nerve proximally, there's not a whole lot we can tell about

the original injury other than it is now encased in scar tissue and it was not able to reconnect?

A. Yes.

Q. Okay. Other than having to separate the collar bone, was this initial surgery without complications?

A. Yes.

Q. Okay. Does the, does the rupture of C5 and C6 and C7, does that encompass the majority of brachial plexus injuries that are permanent or there have -- or that have long lasting residual effects?

A. A difficult question to answer. There's a lot of variation to that. They're the most common, upper and middle trunk, the ones and twos per your classification, but as the most common, they also recover most spontaneously.

Q. How many patients do you see or that are referred to your practice do not end up requiring surgery to regain full function of their injured extremity?

A. As I've answered previously, 70, 80 percent.

Q. And so, of those 32 or 20 to 30 percent of patients that do require surgery, how would you, how would Ashley Flowers injury fall in those in terms of severity?

A. Moderate.

Q. Does that mean essentially right in the middle?

A. Yes.

Q. So, about half of the patients you operate on have

less severe injuries and about half of the patients you operate on have more severe injuries?

A. Yes.

Q. All right. So, after the first surgery, did Ashley Flowers have some improvement in her -- the function of her left arm?

A. Yes.

Q. And -- but you did a second surgery on February 4th, 2011, it's my understanding, to relieve some shoulder contractures and further examine the nerves in her brachial plexus?

A. Yes.

Q. And I have marked as Exhibit 4 what it -- what I understand to be your final report from that surgery.

Is that accurate?

A. Yes.

Q. And I don't want you to kind of go through this little by little because, you know, I can, I can read what it says just as easily as you can read it to me, but my reading of that says there was severe scarring on the median radial ulnar and musculocutaneous nerves.

Is that a result of the June 5, 2009, surgery or were those undiagnosed issues from, from something that happened at birth?

A. No, it's not undiagnosed. It just all goes along

with the sequela.

Q. Sequela.

A. Sequela of the brachial plexus injury and shoulder contractures.

Q. Tell me how that scarring develops.

Is that scarring, it develops after your initial surgery?

A. Well, it's sort of a combination of the developments. As the shoulder contractures develop, so do the contractures in the arm and elbow and, you know, in some situations, hand. So, as a patient is able to fully move, function, you get tightness of the shoulder. You know, inflammation. Inflammation then causes a scar and, you know, continue and continue and continue.

Q. Okay. So, am I understanding you correctly then that the lack -- Ashley Flowers lack of ability to fully use her arm, it not only causes the contractures in muscles, but it also causes scarring in the nerves?

A. Yes.

Q. Okay. Thank you for explaining that to me.

A. Sure.

Q. Was that unusual to see that amount of scarring after one of your primary surgeries?

A. Yes.

Q. Do you have any thoughts as to why there was that

much scarring at the time of your second procedure?

A. Just going back and sort of evaluating the injury, back to the first surgery, it was a very severe injury. So, I would say, you know, just the fact that she did have a very large neuroma that required grafting of, you know, 4-centimeters as, you know, she didn't have, you know, a small gap to jump from, you know, 2-centimeters. It was 4-centimeters. So, that doesn't surprise me that she would, you know, continue to have significant residual deficits.

Q. All right. So, then you harvested -- I guess you cleaned up the neuroma or all of the scarring around those nerves, and then you decided to harvest the nerve from the muscle that runs between the shoulder and the shoulder blade in order to further, I guess, facilitate a conduction between, I guess, that was around the axillary nerve.

Is that right?

A. Yes.

Q. Okay. And when you, I guess, created or dissected the nerve from the teres major muscle, it was a little too short. So then you had to use a tiny piece of cadaver nerve to, I guess, bridge that -- the rest of that gap.

Is that right?

A. Yes.

Q. And then you released the muscles and tendons in order, to put it in layman's terms, to loosen up her

shoulder muscles?

A. Yes, to rebalance, that's correct.

Q. What causes the contractures necessitating those procedures?

A. Well, there's a -- kind of a lot of muscle and imbalance at play. So, with the upper trunk being weak and the axillary nerve being compressed by the triceps, tendon, and the humerus, sort of like a carpal tunnel. You know, the compression on the nerve will cause decreased function. Decreased function then causes a tighter joint, tighter muscles, less range of motion, you know, pain, et cetera, et cetera. So --.

Q. Okay. Now, after that procedure, did she continue to improve as you understand it?

A. Yes. However, she was still left with some residual deficits that continued to have a need for, you know, additional recovery.

Q. And that was accomplished with occupational therapy and things of that nature?

A. Yes.

Q. And you saw Ashley again on May 24th, 2014, to evaluate her.

Is that right?

A. Yes, April I think. Hold on. May 24th, yes, 2014. Sorry.

Q. And is that -- are your observations from that examination reflected in Exhibit 5?

A. Yes.

Q. And on that visit, she -- you scheduled or recommended that she have a third surgery.

Is that right?

A. Yes.

Q. Was that examination, in 2014, was that conducted in Charlotte or Texas?

A. In Charlotte.

Q. It says on there a temporary hold on occupational therapy.

Do you know why that was -- at that time -- why that was at that time?

A. Well, that was per the family. The first page is sort of the concerns or issues that the family has. So, I, I don't know why they held that for the family.

Q. Okay. It also says, on that first page, it says is the patient having pain now and circled no.

Is that generally accurate of children with this injury or it's not a painful condition?

A. For the most part, yes.

Q. Have you evaluated Ashley since May 24th, 2014?

A. Yes, we just saw her, let me get my record here, on 8/29/2015.

Q. If you can, tell me how she was doing on May 29th, 2015.

A. Well, the parental concerns were the same as the last visit. Change in function, same as last visit. OT, adjusting perimeters of OT. There's splinting at night and developmental level is first grade and she's not having any pain.

Q. Did you do any examinations about what type things she's able to do or not do in her activities of daily living?

A. Yes, she's still having deficits and weakness with the wrist and finger extension and still with some tightness in supination.

Q. And I meant more specifically did you inquire as to what things she was able to do and not do?

Such as can she button buttons or pick things up with her left-hand or --?

A. Yeah, she's having difficulty with the fine motor skills, excuse me, with the fine motor skills. As you say, you know, dressing, buttons, fine motor skills in school.

Q. Were there any visits in-between May 24th, 2014, and May 29th, 2015?

A. That's a good question. Let me -- I have to dig through the chart. One second. A quick cursory look, no.

Q. Okay. Did you have any surgeries planned at, at

the end of that visit?

A. We discussed the fact that she has some weakness in her deltoid and elbow contractures and weak wrist extension, and that she will eventually need additional tendon transfers in order to allow her to stabilize her wrist and increase function there.

Q. Other than the additional tendon transfers, are there any other future procedures that you believe that Ashley Flowers will need?

A. Well, she's continuing to have to splint her elbow due to elbow contractures. Right now the elbow extension protocols are working. So, you know, she may need a -- either biceps, tendon lengthening, or elbow contracture release in the future in addition to the tendon transfers for the wrist.

Q. Anything else?

A. Not unless something develops, no, not foreseen.

Q. Okay. Finally, Exhibit 6, is that your operative report for the third surgery performed on Miss Flowers?

A. That is correct.

Q. Is that an accurate depiction of the procedure -- of that procedure?

A. Yes.

Q. And there were no complications during that procedure in order to help the extension of her wrist?

A. Not that I recall offhand, no.
Q. All right. Ashley was first referred to you by Doctor Nelson.
Is that correct?
A. Yes.
Q. And I guess, although Doctor Nelson was working in Charlotte at the time, she had previously worked with you in Texas at the Texas Children's Hospital.
Is that accurate?
A. Yes.
Q. Okay. So then when she moved to Charlotte, she still sent all her patients with brachial plexus injuries, I guess, to you in Texas.
Is that right?
A. Yes.
Q. Okay. Was her presence in Charlotte the reason you, I guess, began operating a clinic in Charlotte twice a year?
A. Yes.
Q. You have written an article with Doctor Nelson, published last year, called Birth Brachial Plexus Update.
Is that accurate?
A. Yes.
Q. Now, I mark that as Exhibit 7. I'm just going to ask you a couple of brief questions about it.

On the bottom of Page 2 or Page 85, whichever way you're looking at it, but the second page of the article, at the bottom you cited study that says 80 or 88 percent of children with birth brachial plexus palsy play sports, which is similar to the general pediatric population.

Is that statistic, to your knowledge, still accurate?

A. Yeah, that portion was written by Doctor Nelson, but, you know, from a general understanding of general population, sure, yes.

Q. You don't have any reason to disagree with those studies?

A. No.

Q. On the next page, Page 3 or Page 81, whichever way you'd like to refer to it, at the top it says, in the first paragraph on the second column, first full paragraph, neuropathic pain is commonly reported in adults and older children after traumatic brachial plexus injuries. It is not generally described after birth brachial plexus injury.

Is that what we are talking about earlier where this is generally not a painful condition?

A. Yes.

Q. And the next full paragraph, was this also written by Doctor Nelson, the quality of -- excuse me. By Doctor Nelson?

A. The quality of life?

Q. Yes.
A. Yes.
Q. Okay. It says a pilot study on quality of life showed that most teens and their parents reported good quality of life despite residual impairments.
Do you have any reason to disagree with that part of your argument?
A. No.
Q. In your examinations of Ashley Flowers, have you ever determined that she had any developmental delays or any brain damage due to an injury at birth?
A. No, that's not my area of expertise. So, no.
Q. Okay. What I'm saying is you talked with the child.
You didn't notice anything out of the ordinary with her?
A. No.
Q. If she continues with her therapy and home exercises, would you expect her to continue to improve?
A. Yes.
Q. You did your undergraduate at Stanford, got your MD from Baylor in 1999.
Is that right?
A. Yes.
Q. You did a research fellowship at Baylor for two

years in the division of plastic surgery?

A. Yes.

Q. Then you did a general surgery residency and then a fellowship with the division of plastic surgery followed by three year plastic surgery residency?

A. Yes.

Q. And you concluded all of that in 2008.

Doctor, are you board certified?

A. Yes.

Q. By what certifying authority?

A. The American Board of Plastic Surgery.

Q. Is that one of the recognized specialties of the American Medical Association?

A. Yes.

Q. Please define the term neuroma.

A. Neuroma is a nerve that's encased in scar tissue and inflammatory mediators.

Q. What, in the context of a brachial plexus nerve, what would the term abruption mean?

A. Nothing. I think you mean avulsion.

Q. Avulsion, yeah, or avulsion, yes, sir. I was going to ask you to define that next.

A. So, avulsion is a tear of the nerve root from the spinal cord to where the cell body lies outside of the spinal cord -- canal. Sorry.

Q. And if there's a tear that is beyond that particular area, what would that be called in regard to a brachial plexus nerve?

A. If the cell body's in tact with the proximal portion and the tear is outside of the spinal canal, it would be a rupture.

Q. All right. Now, in terms of using this terminology, were there any avulsion of Ashley Flowers' nerves?

A. According to our testing, no.

Q. Were there any ruptures of her nerves?

A. We do believe that the C5, C6, C7, upper and middle trunk were ruptured, yes.

Q. All right. And then there was a neuroma that was found at the time of your surgery.

Is that correct?

A. Yes.

Q. Now, a neuroma being a type of scar formation. .

Would that have been immediately present at the time of the initial surgery?

A. No, it is something that develops.

Q. It develops over time?

A. Yes, as the nerve attempts to regenerate and you have scar and growth and nerve fibers entangled.

Q. Now, once you were able to perform surgery, as I'm

understanding correctly, doctor, that what you did was you surgically implanted nerve grafts to cover the area where there was no signal in the nerve roots of C5, C6, and C7?

A. Well, we removed the neuroma then and grafted the space that was left by the neuroma from the nerve roots to the distal nerve roots or the nerve ends.

Q. And did you place an individual nerve graft on C5 and then one on C6 and then on C7 or did, at any point, did you attempt to?

I'll just leave that as the question that you placed nerve grafts at C5 and then C6 and then C7.

A. We grafted individual strength of nerve, yes, from C6 -- C5, C6, and C7, yes.

Q. I see.

Have, have you or are you now able to determine which of the grafts were successful and which were not?

A. Well, she has some, you know, as we said, residual deficits predominantly in the posterior cord and some weakness in the shoulder. So, I would say, with C5, there was some limitation, and C7, there was some limitation.

Q. C5 would control what areas that a lay person could have recognized?

A. C5 predominantly controls your deltoid region. C6 controls your bicep. C7 controls your triceps and wrist and finger extension. And C8 and T1 control wrist and finger

flexion.

Q. Okay. So, where along her shoulder, arm, wrist, and hand does she continue to have deficits?

A. Well, she has issues at the shoulder with weakness. She has weakness at the triceps with elbow contracture and she has weakness of wrist extension, which is tied into the posterior cord.

Q. Now that she has had these surgical grafting implants, given that she continues to have some deficits in the arm, will you be recommending additional nerve grafts at anytime?

A. At this point, no. It's mainly tendon transfers or contracture releases.

Q. So, these weaknesses that you've identified, will they continue most likely for the rest of her life?

A. Yes.

Q. Have -- will you -- will, will there come a point when she is older and reaches physical maturity that you would consider making further recommendation either for functionality or cosmetic purposes?

A. Possibly, yes.

Q. Can you give any prognosis at this point as to where -- what areas you might want to consider discussing with the patient or the parents?

A. Elbow and wrist.

Q. What is it about her elbow that may cause you, in the future, to consider recommending further surgery?

A. She has an elbow contracture. So, she's unable to fully extend her elbow, and then her wrist, she's unable to fully extend her wrist.

Q. What type, if surgeries were to be recommended, can you say at this point what would that be?

A. Tendon transfers for wrist extension and either biceps, tendon lengthening to improve the extension of the elbow or contractor releases in the elbow.

Q. Are you able to say now what additional functionality would be achieved, if any?

A. Well, it will give her near normal elbow extension if we need to do that, and then it will give her an ability to extend her wrist or at least stabilize her wrist should she have a better grasp with her wrist in a neutral position or able to extend her wrist.

Q. All right. Are you able to say, at her age now, that -- say, at her age now, what the likelihood is that these procedures will be recommended or is that just too uncertain to know?

A. Well, it's highly likely that she will need tendon transfers for wrist extension.

Q. Now, the ability to raise her arm and place her hand behind her head, will she ever achieve that?

A. Well, she can do that currently with a lot of compensation, but she needs to continue physical therapy and strengthening, especially during growth spurts, in order to strengthen those muscles that are involved in that activity in order to regain better function.

Q. What I was going to ask is these injuries that Miss Flowers had, were they axonal nerve injuries?

A. Yes.

Q. That means that they went to the core of the nerve rather than just to the sheath of the nerve?

A. That's correct, yes. I understand, yes.

Q. You understand what I'm asking now?

A. Yes, sir, it was a completes rupture. So --.

Q. So, without there -- at the time that you undertook surgery, if there were to be no surgery, was there any possibility that C5, C6, C7 could have repaired themselves?

A. No.

Q. That's all the questions I have for you, doctor. Thank you.

ROBERT ALLEN, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q Please state your full name.

A Robert Harry Allen.

Q Where do you reside?

A In Baltimore.

Q And what is your age?

A Sixty-one.

Q What is your occupation?

A I'm a retired engineer. Faculty member from Johns Hopkins University.

Q All right.

A Biomedical engineering and obstetrics and gynecology.

Q Now, does Johns Hopkins have a department?

A Yes.

Q What is your relationship with that department?
A I was a faculty member in the Department of Biomedical Engineering and also in the Department of Gynecology and Obstetrics.
Q All right. Now, do you -- are you now retired?
A I am.
Q And so what have you retired from specifically?
A Specifically from teaching classes. I --.
Q And what classes did you -- have you taught?
A In the biomedical engineering department, I primarily taught design to biomedical engineers. Also taught biomechanics and I ran the independent design program. In gynecology and obstetrics, my role is primarily in simulation, simulation training of obstetricians.
Q Okay. Now, are you ending your affiliation from these activities completely?
A No.
Q What will you continue to do in your retirement?
A We're continuing with simulation training in obstetrics and I just gave a talk to the University of Washington, for example, to the obstetrics department.
Q Okay. So, where were you trained?
A I was trained as an engineer in New York at Stony Brook University as a Bachelor's of Engineering. I achieved a Master's of Science in -- at Berkeley in 1978, and I earned,

after working for a couple years, I went back and got a Ph.D. from Carnegie Mellon University in civil engineering in 1984.

Q All right. So, you have a Ph.D.?

A Yes.

Q And when you were on the faculty, are you referred to as Doctor Allen?

A Yes.

Q Okay. Now, in your interest -- well, tell us -- first of all, the term biomedical, what does that mean?

A Biomedical means, by itself, you kind of -- it's kind of like an adjective. So, biomedical engineering --

Q All right.

A -- is the application of engineering principles to biomedical systems.

Q All right. And what about the term biomechanical? Is that in any way related to the term biomedical?

A Yes, biomechanical is a subspecialty of bioengineering or biomedical engineering, and it relates to the mechanics of biomedical systems.

Q All right. Now -- so, when you are working at Johns Hopkins, are you working in the Department of Biomedical Engineering?

A Yes.

Q And as part of that biomedical engineering department,

do you teach biomechanical principles and knowledge?
A Yes, I developed a course in biomechanics at -- in the department of biomedical engineering. That was in 2007 --
Q All right.
A -- was the first time I offered it.
Q And -- but does your work in biomechanical principles and knowledge predate 2007?
A Yes.
Q And, and when did you get involved in biomechanical engineering?
A I first got involved by an invitation from a high risk obstetrician who was my neighbor at the time in Houston, and he had an engineering -- he tells me he has an engineering problem and would like me to help him and I did.
Q What was that -- what was that doctor's name?
A Doctor Bernard Gonik, G-O-N-I-K.
Q And what type of doctor was he?
A He was a high risk obstetrician or a maternal fetal medicine specialist.
Q And were you involved in academic work at that time?
A I was.
Q Where?
A I had an appointment at the University of Houston. He had an appointment -- and, and he had an appointment at the University of Texas Medical Center, which is also in

Houston.

Q So, what did the two of you set out to do?

A Doctor Gonik was very interested in figuring out how much force it takes to deliver a baby, and whether a certain position of the mother was helpful for resolving shoulder dystocia.

Q All right. So -- and what did the two of you do in order to try to make determinations about that?

A I developed a sensing system, a four sensing system that could be used during deliveries, and I also developed a simulator that could mimic the, the physical effects of shoulder dystocia.

Q And how did you apply these devices that you developed?

A For the measuring force in the clinical setting, we had sensors that were placed on the far fingertips of Doctor Gonik's hand, worn underneath the surgical glove, and these were wired off to a distant computer where, for each delivery, we were able to measure the force that he was applying during those deliveries.

Q What -- you mentioned that he was interested in a particular position that the mother could assume during delivery.

Did I understand you correctly?

A Yes.

Q And what position was that?

A It's called McRoberts position. It's kind of like -- it's when your knees -- when, when mom's knees are pressed against her shoulders. So, kind of like this.
Q And, and he was interested in knowing what that could do to facilitate a delivery?
A Yes.
Q And did it make any difference to him as to whether it was shoulder dystocia or a non-shoulder dystocia situation?
A He was particularly interested in shoulder dystocia.
Q Okay. So, did your research with Doctor Gonik result in any, any conclusions from a biomedical standpoint?
A Yes. From the clinical study, we were able to establish that routine deliveries, term deliveries, when we talk about deliveries, we're talking about head first deliveries through the birth canal, not cesarean section, and that it takes between five and ten pounds or so to deliver the baby. That's traction by the physician's hands on the head in order to deliver the rest of the body.
Q All right. Now, doctor, please keep any conclusions that you tell us about to what you know as a biomechanical engineer or biomechanical principles.
Okay?
A Yes.
Q That's gonna be very important because of the limitations on what you can testify about.

All right?
A Yes.
Q Now, so -- but recognizing that that's the way that we need you to deal in your testimony, what, what does a biomedical engineer such as yourself bring to research like you were performing with Doctor Gonik?
A The -- I mean throughout my career, this was done in the mid-80s. Throughout my career, I've focused on developing technology that would help understand the phenomenon, the mechanics of birth, and ultimately to help train obstetricians for better outcomes.
Q Well, is, is the birth of a baby a biomechanical, a biomechanical event?
A It actually was characterized that way in, in the 43 paper by, by Woods as a maneuver called the Woods maneuver, and he said, in the vast majority of cases, the birth of the baby is an engineering problem.
Q All right. And do you agree with that?
A Yes.
Q So, in looking at what happens in the birth of a baby, are you focused on the forces, the various conditions of force that can occur during that procedure?
A Yes, that's part of what I'm interested in.
Q All right. So, with Doctor Gonik in your first research with him, you were looking at -- were you looking

at forces?
A Yes.
Q And, and particularly what would happen when a patient was placed in the McRoberts position?
A Yes, we were looking at that and we had 29 deliveries in which we measured force, and it just so happened that two were shoulder dystocia where he actually employed McRoberts maneuver.
Q So, did that research result in any type of publication?
A Yes.
Q And where were you published?
A It was first published in the Journal of Instrumentation for Electrical Engineering and then subsequently published in Obstetrics and Gynecology.
Q And what is the Journal of Obstetrics and Gynecology?
A It's one of the primary journals in the field, and it's, it's ACOG, the American College of Obstetricians and Gynecologists central publication.
Q All right. Is it a peer reviewed publication?
A Yes.
Q And please explain what it means to be peer reviewed?
A Peer reviewed means that, when one has a research result, that they submit it to a journal, a specific journal, and the -- one of the editors who's in charge of

that field sends it out to different experts in the field, and they provide reviews. And based on the reviews, the editor makes a decision to either accept the paper, usually with some changes, or decline it and say you can't publish this. So, when those two publications were both -- were judged both by engineers and by obstetricians as being results that were worthy of publication.

Q Acceptable for publication?

A Yes.

Q Did -- to your -- well, that gets into medicine. We'll talk about that later.

But after you did the research, that first research with Doctor Gonik, did you continue to do research in this area of, of labor and delivery?

A Yes. So far we just talked about the clinical study with Doctor Gonik. I also go to our first simulator that simulated shoulder dystocia, and we demonstrated that fact McRoberts maneuver, mechanically, positioned the pelvis -- both face the pelvis from about 26-degrees in the vertical from ten and, as a result, it creates and flattens the, the curved part, the sacrum, and it also---

Q The sacrum is the spine -- the back bone?

A It's the---

Q The lower part of the back bone?

A The back bone that kind of curves, and then the, the

pubic bone, it raises the pubic bone almost a centimeter. And so those are advantageous positions of the pelvis for the baby to fit through.

Q All right. So, after that project, were there other projects that you've been involved in?

A Yes.

Q And what was the next one?

A The next one I was involved with, I moved to the University of Delaware in '88, and I worked with David Nagey, N-A-G-E-Y, the late David Nagey, has passed away since, also developing simulators and finding out more about traction and how to apply during different types of delivery.

Q And, and specifically looking at what areas in -- with Doctor Nagey?

A In that study, we looked at traction. When you talk about force, it has directions. So, one direction is this way, another direction is this way, and the three dimensions, another direction, another direction that way.

Q So, you use your finger to show directions and look---

A Horizontally.

Q One is side -- to the side?

A Yes.

Q Either side?

A Either side.

Q And the other one is down?
A Down or up.
Q And that's what forces can do?
A Yes.
Q To what area are these forces being applied that you're talking about?
A In the case that we were capturing, these were forces applied by healthcare providers to the fetal head during simulated shoulder dystocia.
Q All right. And you did that with Doctor Nagey?
A Yes.
Q And did that also result in a publication?
A Two publications.
Q And both involving the same areas of interest?
A Yes, both in engineering and in obstetrics and gynecology.
Q All right. And were they peer reviewed as well?
A Yes.
Q Do you recall what publications they appeared in?
A The first one, the engineering publication was in -- I think the journal title was Engineering, Physics, and Biology and the other publication was in the American Journal of Obstetrics and Gynecology, which is the other primary journal for obstetrical publications.
Q Now, from a bioengineering or biomechanical standpoint,

limiting, limiting it to that, what did you learn from that work with Doctor Nagey?

A We learned that the traction that doctors apply during routine difficulty in shoulder dystocia included both traction sideways or out and also traction vertically or down.

Q All right.

A And it also involved torque. So, to take the head, it was torqued to one side or the other kind of like going like this or this. We also were able to measure that.

Q All right.

A And what we observed was that that generally, from routine difficulty in shoulder dystocia, the forces generally increased and, and they increased in various ways. It's generally increasing lateral or vertical traction as shoulder dystocia develops, and that limiting those forces to, to a certain force value will reduce the risk of injury.

Q Now, this term traction is being used quite often in this case.

Please tell us what traction means to a biomechanical engineer or biomedical engineer.

A In a general sense, traction means pulling. I mean perhaps some of you have, if you ever had a neck injury, you were placed perhaps in traction. So, your head is being pulled from your body. It's done in other medical

procedures as well.

In this particular circumstance, we're talking about the forces that are applied by the doctor to the head at the time of delivery.

Q All right.

A And that, that is generally out and down.

Q All right. So, if the doctor can apply force to the baby's head called traction, what is, what is his means for doing that?

A He uses his hands and it's, it's the strength of his hands involved leaning into it. So, some body weight or pulling back. So, yeah.

Q And in the cases that you've looked at, have you limited your research to the placement of hands and the traction force that that involves?

A Well, one of the things that we learned was that different doctors apply their hands in different locations. Many apply it so that they're grabbing the fetal chin, and some apply it more sideways so that they're more on ear to ear.

Q What about devices such as forceps or, or vacuum extractors, have you researched in that area, the traction that can be applied when those devices are implemented?

A The traction that's been applied by forceps and vacuum have long been established in research from the 60s. We

were primarily not interested in that because it's -- they're not used after the head delivers.

Q Okay.

A They're taken off once the head delivers.

Q So, so, in terms of your involvement in, in these types of cases, it's involving what happens after the head delivers and the placement of the doctor's hands and the amount of traction that -- or, or force that gets applied? Is that correct?

A That's correct.

Q Okay. So, after you worked with Doctor Nagey, what was -- what did you do next that's related to this, this area?

A Well, I moved to the University of Maryland for a few years, and, at that time, I developed a relationship with Georgetown University and did research with a number of faculty in obstetrics there.

Q Okay. And what was the focus of that research?

A The focus was several fold, but, primarily, we wanted to do -- wanted to learn whether early McRoberts maneuver before the head delivery had any mechanical benefit, and we wanted to establish that the effect of delivery of a, of the posterior arm, which is a technique that's used to manage shoulder dystocia, was beneficial mechanically.

Q Is it, is it -- is that one of the maneuvers that a

doctor might use if faced with shoulder dystocia?
A Yes.
Q And there are -- do you, as a biomechanical engineer, do you understand that there are various maneuvers?
We've already talked about McRoberts.
Is that right?
A Yes.
Q We've talked about -- and now you're talking about taking the arm out --
A Yes.
Q -- before -- after the head delivers, but before the body delivers?
A Correct.
Q What about suprapubic pressure?
Have you done any research related to that?
A I've looked at the mechanical effects of suprapubic pressure.
Q And from a biomechanical standpoint, what is the effect of suprapubic pressure during a shoulder dystocia delivery?
A Suprapubic pressure is applied just over the pubic bone, and the idea is, if the shoulder -- if the baby's shoulder is there, and you're pushing down on it, you compress some of the soft tissue. And if you, if you're able to, you can rotate the shoulder into the, into a bigger dimension of the pelvis to make this easier for delivery.

Q All right. So, after you worked with doctors at Georgetown, University of Maryland on the effects of maneuvers such as early use of McRoberts, what did you do next in this area?
A Well, we, we did that. We established mechanical reasons why delivery of posterior arm was -- created more room than McRoberts maneuver, and then I joined Hopkins in 2000, and I've continued my research there for the last 15 years.
Q And do you teach?
A Yeah, I taught.
Q And, as part of your teaching, do you actually teach biomechanical engineers only or do you teach doctors?
A I teach biomedical engineers, I teach medical students, and I teach residents and attending physicians on mechanics of shoulder dystocia.
Q Have you lectured doctors on the area of shoulder dystocia and the forces that come into play?
A I've lectured many times to obstetricians and I discussed forces at play, forces that play, and also many other issues.
Q In order to acquire knowledge in that area of biomechanical engineering, what have you had to do?
A I mean the research that I described up to now was -- formed a large basis of that. I also became quite familiar

with the literature in the field. And so I was able to talk about it from a mechanical point of view that is of interest to obstetricians. Again, my reasons for doing this are helping to understand mechanics of it so that injuries, brachial plexus injuries, can be prevented in the future.

Q All right. Now, the literature that you're referring to, is this a new subject area for biomechanical engineers or people who work in, excuse me, bioengineers or is it an area that people who've been interested in these forces have -- it's been ongoing for some time?

A That's a good question. The original work on forces was a instrument that -- forceps and they actually used those for delivery. In terms of measuring the forces associated with delivery after the head is out, that hadn't been done until Doctor Gonik and I did it in the early -- mid-80s.

Q All right. Now---

A It's subsequently been done by others.

Q Okay. In more recent years, what has been the focus of your research?

A Oh, there are many. We looked at whether it's beneficial, whether an episiotomy is needed to manage shoulder dystocia.

Q And what is an episiotomy?

A It's, it's a cut of the perineal area to allow for more

room, soft tissue room, and the doctor needs to insert his or her hand. Makes it easier for that.

THE COURT: All right. You may continue with the direct examination.

MR. HENSHAW: Thank you.

Your Honor, at this time, I would offer Doctor Allen as an expert in biomedical engineering and the biomechanics within -- to the extent of that biomedical engineers or biomedical engineer can know an expert as to the biomechanics of, of birth.

MR. LOVELL: No objection on that limited---

THE COURT: All right. He is so qualified in that limited field.

MR. HENSHAW: Thank you.

CONTINUED DIRECT EXAMINATION

BY MR. HENSHAW:

Q Now, Doctor Allen, we were, in your qualification phase of your testimony, we were talking about forces that can come to bare during the delivery of a child and you've studied that?

A Yes.

Q And you've worked with different doctors in doing that?

A Yes.

Q And in terms of the forces that can come into play -- let me see. Excuse me.

Would this illustration be of any assistance to you in explaining to the jury where these forces apply and how they occur during the process of birth?

A Yes.

Q All right. Doctor, I don't know whether this will -- whether you could use this or not, but if it helps you explaining things, please use it.

So, what we have here is an illustration of a baby and does this illustration indicate that the baby's head had been delivered, but the body has not?

A Yes.

Q Okay. So, what forces are -- tell us what forces are at play for as a biomedical engineer.

A The forces that are at play are the maternal forces by the uterus, which pretty much are along this red line here.

THE COURT: Excuse me just a minute.

Would it help you any if you could stand up and, and look at that?

THE WITNESS: Yes.

THE COURT: All right. You see that microphone that's hanging down from the ceiling right in front of you here, the white one?

If you'll stand just behind it and project your voice upward -- not that one. Over here.

MR. HENSHAW: Right, right here.

THE COURT: And if you'll stand behind it, and project your voice upward best you can, it should pick up everything.

(WHEREUPON, the witness comes down from the stand.)

THE WITNESS: Okay. Is this good?

THE COURT: Sure.

A So, this shows basically the axises of the forces. As I indicated earlier, force has both a magnitude, a size, as well as a direction, and this is the direction of the uterine forces. And when doctors apply forces to the head, they're more lateral. And so they tend to act where the green arrow is, and there's a component that's both vertical and horizontal as I explained earlier.

Q All right. Now, is this what we're seeing here without the force of traction or is there traction involved in there as well?

A This is the clinician applied forces. That's traction.
Q All right. So, if the hands were actually showing there then and pushing down in that green arrow direction, that would be traction?
A Correct.
Q All right. But, but if that does not occur, if the -- basically if it's just the uterine forces, then, then that's a straight-line out?
A Yes, it's almost in line with the fetal spine.
Q All right. Now, the uterus, if you would, show us where that is?
A The uterus is this red area that encompasses the fetus.
Q And does that -- does the uterus apply any force that would be considered traction?
A It doesn't apply traction. It's a contracting muscle. Contracting muscles contract and, therefore, compress and, in this case, the fetus is compressed outward.
Q Is that a pushing motion?
A That is a pushing motion.
Q All right.
A Yes.
Q All right. Whereas traction is a pulling motion?
A Correct.
Q All right. And does that make a difference in terms -- as a biomechanical ear -- from what you know as a

biomechanical engineer, does that make a difference in terms of where forces get applied to the various parts of the baby?

A Yes, a pushing force tends to push things. A pulling force tends to pull things. So, if you look at it this way, a pushing force, when I put my fingers together like this, I'm pushing against one another and they're not moving. If I take a rubber band and I pull on it, that's traction.

Q All right. And when it comes to areas within the body such as nerves around the neck, does that make a difference in terms of what happens to those nerves?

A Yes, in terms of the, the nerves within the fetus, specifically the brachial plexus, the nerves, as you can see, are -- the shoulder -- the shoulder dystocia is up against here. The nerves that are deeply embedded in there. Not really affected that much in a shoulder dystocia by the, by the, by the expulsive forces of maternal contractions.

Q All right. Let me -- does this illustration help explain what you were telling us about by telling us where the locations of these nerves are?

A In a very crude sense. This is published, as you can see, in the 19th Century. So, it had a crude understanding of what was going on, but they already knew then that lateral traction had the potential to break the -- what they draw as the brachial plexus nerves. It's not anatomically

correct as we know today, but it's approximate.
Q All right. So, tell us what, what -- where the nerves are that are being affected.
A Now, I think this V is five. This VI is six. VII, seven, and I can't really make out the last two, but I assume they're the C8 and T1.
Q All right. And does this illustration help explain what you've just told us about?
A Yes, this is, this is actually published in Williams in 1941.
Q And what is Williams?
A It's, it's probably the primary textbook in obstetrics. It's been published for many, many years and it gets new editions every year or every so often.
Q All right. And so what is this illustrating?
A It's illustrating that the traction applied by the physician and left is downward traction. It causes stretching of, in this case, the left side of the neck and, in this case, there's upward traction showing that it can also be upward.
Q All right. Now, so, traction is pulling and the uterus compresses --
A Yes.
Q -- or pushes?
A Yes.

Q Is, is there a difference, from what you know as a bio -- from what you've studied as a biomechanical engineer in terms of these forces, is there a difference in terms as to what they do to the nerves of the brachial plexus, these different forces?
A Yes, the---
Q And what is that difference?
A The pushing forces of the uterus, when shoulder dystocia happens, have no affect on it. The traction forces do as shown in these two pictures.
Q And can you give us a reason, as a biomechanical engineer, why that would be the case?
A Well, if the nerves are, are here and you see this stretch, you can see that there's stretching that occurs as a result of the traction applied by the doctor. Without that traction, if you go back to the first image?
You want to go back?
Q Oh, go back to the first image.
All right.
A In this image, there are no indications of forces other than the external arrows, but you can just sense that, when the shoulder's up against the pubic bone and mom's pushing down or bearing down or contracting or both, that those, those forces are not affecting the baby.
Q Now, have you heard the term maternal forces of labor?

A Yes.
Q And, as a biomechanical engineer, what does that mean to you?
A As a biomechanical -- as a biomedical engineer, I understand what the muscle does. It contracts and it's a natural process. It allows the fetus to descend into the pelvis and actually make it out, and those forces are typically on the order of 20-pounds or so. That's the -- when there's, when there's a fetal heart monitor tracing, there's also measuring contraction strength, and based on that contraction, contraction strength, we can, we can understand what the forces are.
Q All right. And if, if you'll have a seat please, doctor.
A (The witness returns to the stand.)
Q Have either you or other experts attempted to measure what causes -- what amount of force causes injury to the nerve roots in-between C5 and C8?
A Yes, the first experience that we had was back in Houston where, among those 29 deliveries, and there were two shoulder dystocia deliveries, one of those infants suffered a fractured clavicle and a temporary brachial plexus injury. And we had the force value associated with that.
Q All right.
A So, that was a live birth. It's not something we

planned. It wasn't planned. It just happened and we saw that that force level was about 22-pounds of traction and it caused the temporary injury.

Q All right. Now, what, what is the difference between a temporary injury and a permanent injury as far as you're concerned?

A A temporary injury resolves over time spontaneously. It can take anywhere from hours to months. And a permanent injury is one that does not resolve into some deficit beyond typically two years.

Q All right. Are you familiar with the term rupture of, of C5 or C6 or C7?

A Yes.

Q And what does that mean to you?

A Rupture means a break in the nerve or a gap in the nerve.

Q And what -- how does that get characterized as to whether it's temporary or permanent?

A That indicates that it's permanent. It is a break in the nerve. That means the conduction from the nerve to the muscles is broken.

Q All right. Now, we've also heard the term neuroma and that's also been explained in Doctor Armenta's deposition.

What is it, what is -- are you familiar with that term as a biomedical engineer?

A Yes.
Q And what does that mean to you?
A The neuroma is also a permanent injury. It's one that where the -- there's scar tissue surrounding the nerve, but individual components of the nerve within the sheath are broken. And so it's, it's a partial rupture.
Q All right. And what -- is, is there any significance if, if there is a neuroma of C8?
A Yes, the extent of the injury is very important. The first nerves that are generally injured, if there is an injury, is C5 and C6. That's the -- go back to --.
Q Oh, okay.
A -- the nerve drawing. It's these two nerves and they do intersect. That's Erb's -- that's called Erb's point. And so an Erb's injury is -- that's E-R-B.

THE COURT: Be sure you use the microphone. That's the reason I had you stand up. You don't need to, but just be sure you turn and use the microphone when you respond.

THE WITNESS: Thank you.

So, that's the Erb's point and that's the most common place for an injury, whether it's temporary or permanent because that's the one that's most susceptible to the stretch.

Q All right.
A And so that was actually understood even then in 1897.

Q Now, Doctor Allen, if Ashley Flowers had a rupture of C5, C6, and C7 and a neuroma that encased those three nerves along with C8, as a biomedical engineer, do you have an opinion, to a reasonable degree of biomedical certainty, as to whether that injury -- those injuries to those nerves were most probably caused by traction or caused by compression?
A They're caused by traction.
Q And would there be any other forces, other than traction or compression, that could, could have caused injuries to those nerves in that way?
A No.
Q Doctor, are you related to Doctor Gurewitsch?
A Yes.
Q And what is your relationship with her?
A I'm her husband.
Q Okay. And have you worked on this case with her together or separately?
A That's my understanding. We don't talk about cases in the home, but I understand she was deposed in this case.
Q All right. Do you know anything other than that?
A No.
Q Have you coached her in any way about your opinions about this case?
A No.

Q And did she coach you in any way about her opinions in this case?
A No.
Q Have you given expert testimony before?
A I have.
Q And approximately how many jurisdictions have you been recognized as an expert?
A At least half the states --
Q Okay.
A -- and the federal government.
Q All right. Doctor, that's all the questions I have for you at this time. Please answer any questions defense counsel may have.
A Okay.
THE COURT: Mr. Lovell.
MR. LOVELL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. LOVELL:

Q Now, Doctor Allen --
A Morning.
Q -- fair to say you're not a medical doctor, right?
A Correct.
Q And I think you and I have met before on other cases of -- similar to this. So, it's not the first time we've seen each other.

A Correct.
Q You've not been licensed by any state to practice medicine?
A No.
Q Never delivered a baby yourself?
A Not a doctor, no.
Q You haven't been licensed as a certified scrub tech or a labor and delivery nurse?
Never done that?
A No, I'm not a medical care provider in any way.
Q No formal medical training?
A Correct.
Q You have never entered a delivery -- a labor and delivery room where you were the person in charge of delivering the baby when the baby had a heart rate that went from the 130s down to the 90s?
A No.
Q You have never been charged with the decision of how to manage the labor and delivery in a situation where a baby's heart rate dropped within a few minutes from 130 to down to the 90s?
A That's correct.
MR. HENSHAW: Your Honor, we will stipulate that Doctor Allen is only being called to testify as a biomedical engineer.

THE COURT: Okay.

Q As far as forces involved in labor, you've never inserted your hands into the mother's birth canal to try to maneuver an arm or rotate a shoulder?

A Not in a real delivery. I've done it in simulated deliveries.

Q We're only talking real deliveries and real ones.

A Okay.

Q Not simulations.

Okay. As far as managing the actual guidance of the baby's head after it has been delivered out with the body still inside and a shoulder dystocia has occurred, you've never physically put your hands on a live baby's head to do so?

A No.

Q Never warn the, the gloves that the doctors wear when they're doing that?

A I've, I've worn gloves. Not when they're doing the delivery.

Q Okay. When they're doing, that means by doing the, the live delivery, right?

You've never felt how slippery a baby's head as it's coming out of the mother's birth canal is when you put those gloves on, have you?

A Never have.

Q Have you ever sat at the stool that doctors like Doctor Giep sit on when they're doing a delivery, a live delivery where there's a live delivery going on?

Have you ever done that yourself?

A I have not.

Q Okay. Have you ever tried, when you're sitting on that stool and you've got your hands on the baby's head as Doctor Giep described, the maneuver of trying to do this downward traction you call it?

Have you ever done that in a real world setting?

A Not in a real world setting. In a simulated setting, yes.

Q And I think we just heard that you'll agree you're not qualified to come to this jury and give any opinion on the standard of care that should of been exercised by my client, correct?

A That's correct.

Q All you're doing is coming in here as an engineer and using engineering principles, and I think you called it bio -- as they applied to biomedical systems?

A Yes.

Q Now, let's talk for a second about these publications.

The one that you were talking about with Doctor Gonik, that was published, was it, in the early 90s?

1990 I think?

A 1991 and also 1989 was a simulation study.
Q Okay. And you've acknowledge that, since then, 27 years ago, a lot of other papers have been published on all of these issues by a lot of people besides you and Doctor Gonik?
A A fair number, yeah.
Q And you mentioned that the only forces y'all studied in Doctor Gonik's study were the forces that are applied by physicians, right?
A We had the, the uterine forces that were generated in those deliveries as well.
Q But as far as a study of the forces applied to the brachial plexus nerves in the shoulder dystocia scenario in a live birth, y'all aren't studying that?
A That can't be done. It can only be done in a simulator, which we have done.
THE COURT: You're, you're gonna have to get a little bit closer to that microphone please, sir.
THE WITNESS: Yes.
Q Now, let's talk about compressive forces and these stretch forces.
When we were looking at our suprapubic pressure diagram, and let me get the one I've got, just to set the -- sort of the stage for this, when you were looking at the diagram where you had the lines drawn sort of vertically and

horizontally, or I might have that backwards, you would agree, in general, that, as a baby is moving down the mother's birth canal is the term I'm using, that might not be the right one, as they get down towards the exit point, the babies move?

A Yes.

Q Their head might move one way, the body might move a little bit differently?

A They certainly do.

Q The shoulders rotate sometimes in a different direction from the head?

A Yes.

Q And as these forces you're talking about are the maternal forces, and, and we use that term.

That's just what the uterus and the stomach muscles are doing as the mom's having sort of these involuntary contractions?

A Yes.

Q And sometimes she's having voluntary contractions.

If they're saying push, push, and she's kind of pushing down, that creates forces, right?

A Yes.

Q And so all of those forces are acting upon this baby as it begins to transition from up here to down here to down here to down there, the various stages of delivery, right?

A Yes.
Q Okay. So, as the baby is moving down and these compressive forces begin to apply, when the baby's head gets down into the pelvis, what the doctors called engaged in the pelvis, the forces begin to come more from the back of the baby towards the head, right?
A That's truth through all of the second stage of labor, but yes, that's true.
Q And I'm talking from a mechanical engineer type standpoint.
A Yes.
Q And I've got sort of a diagram. It's not as fancy as the one y'all had, but it sort of shows the baby's position when the head is just barely coming out, and we're not in shoulder dystocia, correct?
A It's pretty close, but --.
Q Okay. But it's not---
A The shoulder's up against the pubic bone there.
Q But when we talk about the axial plane of the spine, you're talking about down the baby's spine, and if the head were straight like I'm standing, it would kind of be a straight-line?
A Yes.
Q Right?
A Yes.

Q But when the baby's heads turn as they're moving through the body and the shoulder's turn and things different, the axial spine is never really a straight up and down line?
A Well, the axial spine is straight, but yes, it, it -- as you demonstrated, the head moves around relative to the body. We actually studied that in -- during the cardinal movements when the baby's in the pelvis.
Q So, as the baby is coming down and these forces -- and the only way the forces can be passed from the bottom end of the baby up towards the head are really through the spine, right?
That's the only kind of ridged structure of the baby.
A I'm sorry. I didn't understand the question.
Q The way the forces, these compressive forces, get sort of passed through the baby's body are along that spine, the bones, and the connective ligaments?
A Well, it, it acts along the whole baby. It, it -- so, it really doesn't act just along the spine but---
Q Some down the spine.
A Right.
Q How about that?
Because you do have contractions that are occurring down here?
A Yes.

Q And muscle---
A Yeah.
Q The whole thing---
A It's contracting.
Q And obviously the lower---
A But the overall, the overall thrust to get -- to move the baby into the pelvis and out is in that direction.
Q And compression occurs as the baby is moving down and as those muscles are squeezing the baby's body and trying to help it exit the mother, right?
A Yes.
Q And that's the compressive forces that are part of the maternal forces of delivery?
A Yes.
Q And whether it's the contraction, involuntary compressive forces, or the mom being told push, push, those are compressive forces?
A Yes.
Q All right. When the baby's head has been delivered out of the baby's body, I'm gonna show you the suprapubic one. This is, again, not the one y'all have but similar.
But once the baby's head is out of the mom's vagina or bottom end, the head itself has now come outside and it's not subject to these forces of mom anymore, right?
A Correct.

Q But before the baby's head comes out, as it's beginning to exit the opening, there are compressive forces on the head, from an engineering standpoint, right?
A The compressive forces on the head are mostly before it's engaged in the pelvis, but, once it's engaged, the pressures are mostly on the body.
Q But the head has to push through something to come out, right?
A I mean it has to get through the pelvis and it's, it's usually a tight fit.
Q And, and you understand, in this case, Doctor Giep used a vacuum extractor to assist the pelvis -- the baby's head to getting out, right?
A Yes.
Q And that vacuum extractor doesn't exert tons of force on the baby coming out.
Most of the force is still mama's compressing, pushing from the inside out, correct?
A The force of the, of the, of the vacuum itself is, is applied to the head. It creates a vacuum. So, it's able to pull. The pulling forces created by the physician, and the contraction forces are the contraction forces. The relative size of those two is really dependent on, on how much traction's applied and how much contraction strength is.
Q And mom's anatomy and all?

A Yeah.
Q Lots of different factors go into all of these things we're talking about, right?
A Right, but the important point of the vacuum is it's, it's stretching the head and it's along its axis. And so its effect, mechanically, from the nerves is minimal.
Q And, at that point, the shoulder is not stuck behind the pubic bone?
A Correct. This is done before the head is delivered.
Q The body's still moving sort of as a unit?
A Yes.
Q And subject to the -- getting the different movements of the body and such?
A Right?
Q So, once the head is out, and the shoulder becomes stuck, as I've got here on my diagram, there are still forces coming from mama and the compressive forces on the way trying to get baby birthed---
A Yes.
Q ---and out, right?
And those do create compression in the area of the brachial plexus, those forces, right?
A No. No.
Q Why not?
A It creates compression between the pubic bone and the

end of the shoulder. The brachial plexus nerves are actually far deeper into the muscle. They're not being compressed.

Q The axial forces on baby's body are still going in generally that direction, right?

A Correct.

Q And so, as those forces get passed and the head begins to come out -- you've heard of the turtle sign, right?

A Yes.

Q And that's where, when the head delivers, the neck comes out and you've got the exiting vagina area, and then the head kind of goes back in?

A Yes.

Q And then a stretch and a retraction involved in that?

A Correct.

Q And that's what occurs, unfortunately, when brachial plexus happens a lot of times?

A A turtle sign is, is -- occurs during head and shoulder dystocia.

Q When this nurse, you told us, is pressing on this bone, the pubic bone, right here---

A Above the pubic bone.

Q Above it. I'm sorry.

The goal is to try to put pressure on the area here and maybe rotate the shoulder a little. Maybe press it below

the area that it's stuck.
A Exactly.
Q Again, compressive forces?
A Yes.
Q Okay. Not stretch, but compression?
A Compression.
Q Okay. Now, you understand in this case -- let me ask you.
You've reviewed all the depositions that were taken in this case, right, and---
A I don't know how many all of them are. I've reviewed quite a few.
Q Family members that were there. The doctor that did the delivery. The nurses that were present.
I assume you reviewed everybody that was in the room that had something to say about how the delivery went?
A I believe so, yes.
Q All right. Maybe not all the experts or whatever.
Did you review Doctor Armenta's?
A Yes.
Q Okay. And I think you heard -- were you in here when he testified a few minutes ago?
A Yes.
Q You heard him say and do you agree that there are variations in every baby, from one baby to the next, about

the strength of the various nerves in the brachial plexus?
A Yes, and there's also variation in anatomy.
Q Sure. Everybody's different.
A Everybody's different.
Q Every baby's different. You and I are different. We're all different.
And those variations are factors that can affect how strong the nerve is in responding to the engineering forces of delivery that you've been talking about, right?
A Yes, they can. The, the only way to know is to actually test them mechanically at different -- say at different gestations. That hasn't been done.
Q But Doctor Armenta, as you've heard, didn't test her nerves when he was operating on her to make any determinations about the conditions of her particular nerves, right?
A Correct.
Q And obviously you haven't done so either?
A Correct.
Q Did you hear Doctor Armenta state that, in his experience, and it sounds like he's done a lot of these severe injury type cases, sometimes he sees minimal scarring when he's in there looking at the nerves with his eyeballs---
A Uh-huh. (Affirmative).

Q ---with very severe injuries, and then also the converse, sometimes he sees extensive scarring with less severe injuries.

Is that consistent with what you heard and what you understand?

A I believe so. I didn't particularly hear that, but it sounds right.

Q Is axial force of the traction that you've talked about, you showed in those two diagrams that came out of that old medical book, one situation where the baby's head was angled upward towards this direction if mom's laying flat, and one where baby's head is angle downward, right?

A Correct.

Q That's what you call the lateral traction that might be applied during the delivery?

A Yes, that is applied during delivery.

Q In your review of the information associated with this case, didn't you see, in the deposition of Mrs. Bowen, where she said that -- the question was asked when the doctor was, as you say, pulling your grandchild, was he pulling him straight, pulling him up, or was he pulling him down, and her answer was straight, correct?

A I, I don't recall what -- but if you have it there---

Q Well, let's---

A ---and reading it accurately, I believe you.

Q Let's look at it.

Your Honor, I have the original deposition of Mrs. Bowen.

THE COURT: Okay.

Q I'm gonna open this original deposition.

I'll direct you over to Page 31, doctor.

First, let me get you to look at the front.

Do you see where it was taken December 8th of the 2015?

A Yes.

Q We had a court reporter and all that stuff---

A Yes.

Q ---is there.

On Page 31, beginning, beginning at Line Number 15, the question was okay. When the doctor was, as you say, pulling your grandchild, was he pulling him straight, was he pulling him up, was he pulling him down?

What was the answer she gave?

A She said he was pulling him straight.

Q That's information that's important cause that's somebody who's there watching the delivery, right?

A Yes, it's a lay person describing straight traction.

Q You haven't done an assessment on Ashley Flowers on the effect that the low muscle tone in her might have on the strength of her actual nerves in her neck, the brachial

plexus, right?
A No.
Q But you agree that low muscle tone can affect the strength of those nerves?
A The tone affects the muscles as opposed to nerves. They become weaker so that the brachial plexus is more susceptible.
Q When the muscles are less resistant to the forces of traction as you call it, right?
A Correct.
Q And so, if her muscle tone was a one instead of a two, her muscles would of been less resistant to the forces of the delivery and traction from either the doctor or whatever force that it came from?
A Yes.
Q Right?
The -- excuse me. I think that's all I have. Thank you very much, doctor.

REDIRECT EXAMINATION

BY MR. HENSHAW:

Q In terms of the angle at which the doctor was applying his hands and pulling the baby's head, does it necessarily remain constant once the doctor begins to pull?
A No, it definitely does not remain constant. That's not done.

Q So, hypothetically, could it be that there were times when he was pulling straight and then there were times when he was pulling at an angle?

MR. LOVELL: That calls for speculation, Your Honor. I object.

THE COURT: Rephrase it.

MR. HENSHAW: I didn't, I didn't---

THE COURT: He objected based on the fact that it caused this witness to speculate as to the answer.

Q All right. Well, the question you were asked only asked for a moment in time about what she saw.

Is that, is that what you understood?

A That's what I understood, yes.

Q All right. Does it necessarily mean that, if he was seen pulling straight at one time, that it absolutely means that he had to be pulling straight the entire time?

MR. LOVELL: Again, speculation, Your Honor. Objection.

THE COURT: I don't think this witness has that information, and, and, if he does, it doesn't help the jury. They can answer that question for themselves.

MR. HENSHAW: All right, sir. All right. Thank you, Your Honor. That's all the questions that I have.

THE COURT: All right. You may step down.

SHELLEY MAHAFFEY, being first duly

sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q. Please state your full name.

A. It's Shelley Hammett Mahaffey.

Q. Thank you.

You are a medical doctor, is that correct?

A. Yes.

Q. And do you practice here in Spartanburg?

A. Yes.

Q. What is the nature of your practice?

A. I'm a general, general pediatrician.

Q. And where do you practice here in Spartanburg?

A. I am employed by Spartanburg Regional, but I practice at the Medical Group of the Carolinas Pediatrics Westside.

Q. All right. Where did you go to Medical School?

A. Medical University of South Carolina.

Q. Graduating when?

A. In -- I'm sorry. '98.

Q. Okay. And did you have postgraduate training after that?

A. Yes, and---

Q. Where was that at?

A. ---residency at Texas Tech University.

Q. Are you a board certified---
A. Yes.
Q. ---pediatrician?
A. I am.
Q. Are you a general pediatrician or are you more specialized than that?
A. General pediatrician.
Q. Have you had a patient in your practice by the name of Ashley Flowers?
A. Yes, sir, I have.
Q. When did Ashley become one of your patients?
A. She was four months old.
Q. So, had you been acquainted with her at all at the time of birth or in that four month period---
A. No, sir.
Q. ---prior to her coming to your office?
A. No, sir.
Q. So, since she was four months old, have you continued to be her pediatrician?
A. Yes, sir.
Q. And are you continuing to be her pediatrician as we speak now?
A. Yes, sir.
Q. If you would -- if you continue to be her pediatrician in the future, to what age would she get to

before she was turned over to someone else?

A. Eighteen.

Q. And so that's the way that pediatricians go from birth to about 18.

Is that right?

A. Typically, yes, sir.

Q. What has been your role in Ashley's medical care since her -- since she was four months old?

A. We -- I've seen her for her well care. Just general well visits, immunizations, that kind of thing, and any sicknesses that she's come in for.

Q. Generally speaking, what has her health been up to this point?

A. She's in good health.

Q. Does she have any problems, any disease processes, or anything like that that will affect her health -- that have affected her health in the past or will affect her health in the future?

A. You mean in general --?

Q. In general.

A. -- or --?

Q. In general.

A. No, I mean she's a healthy -- she's a healthy girl.

Q. All right.

A. She's rarely sick and not, not in my office very

much.

Q. Does she have a medical problem with one of her extremities, specifically her left shoulder and arm and wrist---

A. Yes, sir.

Q. ---and hand?

A. Yes, sir, she does.

Q. To what, to what extent are you involved in the treatment of her left shoulder, arm, wrist, and hand?

A. Well, evaluating that is part of my well visits when she comes, and I'm the one who prescribes or continues to prescribe her occupational therapy and physical therapy.

Q. Does she have any problems or deficits with her right arm, shoulder, wrist, her hand?

A. No, sir.

Q. Does she have any problems with her right or left legs?

A. No, sir.

Q. Does she have any internal problems --

A. No, sir.

Q. -- or any -- does she have -- appear to have any deficits in terms of her intellectual capacity?

A. No, sir.

Q. So, as of today, if she has a medical problem, is it limited to her shoulder, arm, wrist, and hand?

A. Yes, sir.

Q. Can you just give us an overview as -- from your prospective as her pediatrician, as to what's going on with her left extremity?

A. Well, she has a brachial plexus injury and she has had several surgeries for that, but her, her limitation is of her shoulder, elbow, and, and hand in that, that arm.

Q. What is your role, at this time, in terms of the treatment of her left shoulder, arm, wrist, and hand?

A. As far as treatment for her, I really don't have a role at all. I -- it's like I said, prescribe her physical therapy or occupational therapy ongoing as she needs that.

Q. And who are the doctors who are specifically treating her left extremity or have been?

A. I'm not a hundred percent sure who she sees. I believe her surgical team is in Texas, but I, I've never had any interaction with them other than, you know, their notes when they come from postop and things.

Q. Do, do you have interaction with them so that you know what physical therapy, therapy to prescribe?

I mean do they give some direction with regard to that?

A. Not really in particular. That -- it would be -- my, my prescriptions are very generic. They are to the occupational therapists, evaluate and treat, as necessary. So, it's more the therapist that decides what physical

therapy she needs than me.

Q. Do you recall, from having worked with Ashley, the way that the arm appears?

A. Currently or --?

Q. Currently, yes, ma'am.

A. The last time I saw her I believe was her six year old well visit when I would of -- when she's almost seven. So, when I would of evaluated that. So, I'm not sure if there's been a difference between then and now, but she does not -- her shoulder is limited as far as how far up she can move her shoulder. Her elbow, I believe, stays in sort of a flexed position, but she has some mobility there, and her, her grip is, is affected, but has been getting stronger every time I've seen her, her hand grip. But she has some -- she has effects of her entire extremities, the shoulder, elbow, and wrist, and hand.

Q. Have you been able to observe how she's adapting to this particular problem with her left extremity?

A. I, I don't know if I can answer that specifically. I know that she does -- she's a precocious little girl and does things with her right hand, and has some, some function of her left extremity as well. Generally, she can do most things. I think that she has some limitation obviously because of that, that left arm, but other than that, I don't know that I can really comment on, on those things. Again,

I just see her for her, for her checkups. So, I'm not sure---

Q. Okay.

A. ---if I'm answering that correctly.

Q. That's, that's fine, Doctor Mahaffey. Thank you very much.

Now, please answer any questions defense counsel had.

A. Okay.

CROSS-EXAMINATION

BY MR. WEATHERLY:

Q. Doctor Mahaffey, my name's Lee Weatherly, and we've met for the first time today, but I represent Doctor Giep in the lawsuit that Ashley's parents have filed against him, and I'd like to ask you some questions kind of just on two topics today.

The first of those topics being actual mental development, and the second of those being the improvement in her left arm since she first started seeing---

A. Okay.

Q. Okay. And so first what I'd like to do is start at her 18-month checkup.

Okay. And I'm gonna hand you, if you would like to look at it, your record from that checkup.

A. Okay.

Q. And this checkup was done when Ashley was, I guess,

a year and a half old, right?
A. Yes, sir.
Q. And under the developmental milestones, at this time, Ashley's able to walk both forwards and backwards.
Is that correct?
A. Yes.
Q. And she was able to throw a ball?
A. Yes, sir.
Q. And she was able to use two word phrases like my toy or more please or things like that?
A. Yes.
Q. All right. She was able to stop -- stack three and four blocks on top of each other.
Is that right?
A. Yes.
Q. All right. She was able to use a spoon and a cup?
A. Yes.
Q. She was able to follow simple directions?
A. Yes, sir.
Q. And she could scribble on a piece of paper?
A. Yes.
Q. And she was able to point to some of her body parts such as you might say Ashley, where are your eyes---
A. Correct.
Q. ---and she could point to her eyes?

A. Yes, sir.
Q All right. And she could remove her clothing?
A. Yes, sir.
Q. And you did a neurological examination of her on that day?
A. Yes.
Q. And that was completely normal?
A. I mean that -- well, other than her, her arm.
Q. Sure.
A. And I did that as an extremity exam, but yes.
Q. And what I mean by the neurologic examination being her cognitive function?
A. Absolutely, yes.
Q. Okay. And there were no delays in her motor function, her language, or her social development?
A. No, sir.
Q. So, despite the events at her birth, including experiencing shoulder dystocia, there was no evidence that she suffered any type of brain injury, right?
A. No, sir.
Q. Okay. Now, at this point, at 18-months, when you examined her left arm, it just kind of hung by her side.
Is that accurate?
A. Yes, not as much as it had in the past, but, but yes, it still hung to her side.

Q. So, before she was a year and a half old, it, I guess, it had less function?

A. Yes.

Q. And it had improved by 18-months, but it still just kind of --?

A. Correct. She had had, let me see, one of her surgeries, I believe, by this time, and I had -- and there were some increase. I believe I said at the elbow was primarily where I had noticed increase range of motion.

Q. All right. What I'd like to do next is fast-forward to her two year well visit.

A. Okay.

Q. And I'll hand you your record from there.

Now, this was on July 21st, 2011, and she's born on October 7th, 2008. So, she's almost three years old at this point---

A. Yes.

Q. ---but it's called --

A. It's imperfect.

Q. ---the two year well visit?

A. Yes.

Q. Okay. Now, the arm that -- the description of the arm that you gave us before that it was just kind of hung by her side, it had improved by her two year well visit.

Is that correct?

A. Yes.
Q. She had increased range of motion meaning that she could move it around a lot better than she could before?
A. Yes, sir.
Q. And, by this time, she was able to grip things with her left-hand?
A. Yes.
Q. And she could move her elbow at this point.
Is that correct?
A. Yes.
Q. All right. And so that was a definite improvement over her two year well exam?
A. Well, this is the two year but yes.
Q. Excuse me. The 18-months.
A. Yes.
Q. I'm sorry.
A. No, that's okay.
Q. All right. Let's then go back to her development a little bit in the developmental milestones, but, first, before we talk about that, the gross and fine motor skills, the language skills, the social development, all of those things were still normal.
Is that right?
A. Yes, sir.
Q. And so, at two years, she's now able to walk up and

down the stairs.

Is that correct?

A. Yes, sir.

Q. She can walk backwards?

A. Uh-huh. (Affirmative).

Q. She can kick a ball at this point?

A. Yes, sir.

Q. All right. Now, she's gone from being able to stack three and four blocks to now she can stack five or six blocks.

Is that right?

A. Yes, sir.

Q. She knows at least 20 words at this point?

A. Yes, sir.

Q. And she knows her name?

A. Yes.

Q. And she can draw a line on a piece of paper with a pen or pencil at this point?

A. Yes.

Q. Okay. And she can follow what are called two step commands, correct?

A. Yes, sir.

Q. And could you give me an example?

What's a two step command that you would ask a two year old like Ashley on this visit to do to see if she can do

this or not?

A. We would just say can you pick up your cup and bring it to me or can you pick up your socks and put them in the laundry or hamper, or little hamper or something. Two, two, two steps.

Q. And she was able to do those things?

A. Yes.

Q. Okay. And she even imitates housework that her parents do like wiping off the countertop or such as those---

A. Right.

Q. ---and stuff like that?

A. Right.

Q. And so she met at two -- at her two year wellness check and met all of her developmental milestones.

Is that correct?

A. Yes, sir.

Q. Okay. And so, again, despite the events that occurred during her birth and despite having experienced a shoulder dystocia, at two years of age, there's no evidence that she suffered any type of brain injury.

Is that correct?

A. No, sir.

Q. Okay. All right. What I'd like to do next is you had done what's called or has prescribed her what's called

occupational therapy during your, during your treatment of her.

Is that correct?

A. Yes, sir.

Q. Okay. What I'd like to do is to hand you a couple of the notes that were in your chart about the occupational therapy.

A. Okay.

Q. And just ask you a couple of questions from those.

A. Okay.

Q. That occurred between that two year visit that you had with, with Ashley and the four year old checkup that we're gonna talk about in a second.

A. Okay.

Q. And so right after she was three years old, and this note is from October 31st, 2011, she got to the stage where she could pick up a small object like a Cheerio with her left-hand.

Is that right?

A. Yes. Yes, sir.

Q. Okay. And if we'll turn onto the next page with a note of January 31st, 2012. At this point, the occupational therapist noted that she's able to remove her coat all by herself by unzipping and zipping the zipper with her left-hand.

Is that right?

A. Let me just make sure.

Q. Take a---

A. Yes.

Q. ---second to read it.

A. Yeah, yeah, I see it. She is.

Q. And so, again, we're getting more improvement then from your two year well check that we just had two months prior, right?

A. Yes.

Q. Okay. She is learned how to wash her hands using, using both hands. So, kind of rubbing them together in, in that fashion.

A. Yes, sir.

Q. She can carry a plate and a bowl with both hands?

A. Yes.

Q. And she can use the restroom without assistance?

A. Yes.

Q. And she can eat independently without assistance?

A. Yes, sir.

Q. All right. If we -- and if we could skip ahead, I guess, to September 20th, 2012. At this point she's able to take her shoes and socks on and off all by herself.

A. Do I have that?

Q. Let me see. It would be on Page 276 at the bottom,

the 9/12/2012.

A. Oh, sorry. It's at the end.

Q. All right. So, by this point in her occupational therapy, she's able to take her shoes and her socks on and off all by herself?

A. Yes, sir.

Q. And she's learned how to take a T-shirt on and off by herself?

A. Yes, sir.

Q. And she's learned how to hold paper with one hand and cut shapes with scissors out of that paper?

A. Yes, sir.

Q. All right. And these are all significant improvements over what she had had at the two year old well check just a few months before?

A. Yes, sir.

Q. All right. What I'd like to do next -- and then, and then, again, just to clarify and looking again, in looking at these occupational therapy notes, you know, despite the events of her birth and the shoulder dystocia, we still don't see anything that would indicate she's had any sort of brain injury from birth or anything like that?

A. Not at all.

Q. All right. That's -- let's now move ahead to your four year old wellness check.

A. Okay.
Q. And let me go through the developmental milestones of things you like to see with a four year old when examining them. She can, at this point, she can sing a song?
A. Yes, sir.
Q. She can make a drawing of a person with three parts?
A. Yes, sir.
Q. Tell me what that is.
What does that mean, drawing a person with three parts?
A. Just, you know, when a, when a child first learns to draw a stick figure, it's a developmental milestone depending on what -- how many body ports they put on there. So, a three part would be at least the head and maybe legs or arms or something that would be --
Q. Okay.
A. -- a progression.
Q. All right. At, at this visit, she knew that she was a, a girl instead of a boy?
A. Yes, sir.
Q. She was able to distinguish between fantasy and reality?
A. Yes.
Q. And how do you tell that?

How do you tell whether they can distinguish fantasy from reality?

A. We really just kind of talk to them about whether or not they pretend and things like that, whether they show imagination when they play.

Q. All right. She was able to use words and speak in full sentences?

A. Yes sir.

Q. She could say, at this point, her first and last names?

She can say Ashley and Flowers?

A. Yes.

Q. Okay. She knows three or four colors?

A. Yes.

Q. And she's able to talk about her day?

So, you can ask her what did she do today, and she's able to describe it for you?

A. Yes.

Q. And now she's moved from building a tower with three or four blocks to five or six blocks of, of little while -- I think your previous visit was five or six blocks. Now she can build a tower with ten blocks.

A. Correct.

Q. She can hop on one foot?

A. Yes, sir.

Q. She can ride a bike that has training wheels?
A. Yes, sir.
Q. She's able to do that.
Okay. She can throw a ball, I guess, over her head instead of underhanded at this point?
A. Correct. Yes, sir.
Q. And I'm sure this is a, a big one for parents like myself, she can put her toys away?
A. Yes, sir.
Q. All right. The only developmental milestone, I guess, that she wasn't able to do as a four year old wellness check was she couldn't button clothes.
Is that correct?
A. That's correct.
Q. And was that due to the, the disability she still had of her left-hand?
A. Yes.
Q. Okay. So -- and her neurological exam was normal again?
A. Yes, sir.
Q. And she had no delays in motor skills or speech?
A. Correct. Other than, than probably the buttoning. Although there are four year olds who can't do that anyways, but that was, that would probably be the only thing I would say for that.

Q. All right. So, again, despite the events during her birth and including the shoulder dystocia, there's no evidence that she suffered any type of brain injury during birth?

A. Correct.

Q. All right. Now, the function of her left arm, you tested that function on this four year old wellness check?

A. Yes.

Q. All right. And that had improved significantly from the previous exams.

Is that correct?

A. Correct.

Q. All right. She had a strong grip at this point and she was able to abduct much more than the previous visit. Tell me what that means, abduct.

A. I, I didn't actually specifically say shoulder, but that would of been the range of motion of the shoulder. Abduct is to be able to raise the shoulder up.

Q. All right. Okay. And, at this point, you're still prescribing more occupational therapy for her?

A. Yes.

Q. What I'm gonna hand you next is one of the occupational therapy notes, and this one's from December 14th of 2012. And so this is just after she's four years old, four years old, and a couple of months.

And, at this point, she's able to, to reach over her head more than 90-degrees.

Is that right?

A. Yes.

Q. Can, can you show the jury what that means to be able to raise your shoulder more than 90-degrees?

A. Is it the Number 2 that you're talking about with the toy placed --.

Q. Yes.

A. Okay. She's specifically saying shoulder flexion. So, I'm assuming she's meaning up this way instead of abduction like I was talking about.

Q. Okay.

A. But, but I assume she's meaning this way. She can reach -- obviously, this is 90. So, above, above 90-degrees.

Q. All right. And, at this point in her occupational therapy, she is able to write shapes and lines?

A. Correct.

Q. And she's able to take off her, her pants on and off by themselves?

A. Yes.

Q. All right. Now let's go to your six year old wellness visit.

A. Okay.

Q. And, at this point, and this is on November 18th, 2014. At this point, Ashley is in school -- in kindergarten at Taylors Elementary, right?

A. Correct.

Q. Okay. And she's in normal classes?

A. Yes.

Q. She has good school performance?

A. Yes.

Q. She has no behavior concerns?

A. No.

Q. She's isn't in any kind of special education classes or anything like that?

A. No, sir.

Q. Excuse me.

And then, again, her neurological exam is normal. No delays in motor, speech, or anything like that.

A. Correct.

Q. At this point, she's able to jump rope.

Is that correct?

A. I, I -- yeah, that's what's in here. I'm not sure if she could do the rope herself, but jumping it, yes, she can.

Q. It was either that or maybe somebody, you know --

A. Doing the --

Q. -- Double Dutch --

A. Exactly.
Q. -- and she's able to get in the middle and jump rope?
A. Correct.
Q. And she plays an instrument that says.
A. Yes.
Q. What does that mean?
A. I'm, I'm not sure, but my nurse would of asked those questions. I didn't specifically ask her what instrument she played. So, I'm not sure.
Q. Okay. She has a lot of friends.
A. She does.
Q. And despite her left arm injury, she has high self-esteem.
Is that right?
A. Yes.
Q. All right. And so, again, here we are, we're at age six at this point, and despite what occurred during her birth and the fact that she experienced shoulder dystocia, we don't have any evidence of any brain injury due to lack of oxygen or anything like that, right?
A. Right.
Q. Okay. Now, the last thing that I'm gonna ask you about is the last examination that I have from the occupational therapist in kinetics with Greenville Hospital

on it, and this is the, the, the occupational therapy that you most recently prescribed.

Is that correct?

A. Yes, sir.

Q. Okay. And in this occupational therapy, she's getting some therapy with swimming.

Is that your understanding?

A. I believe so, yes, sir.

Q. What I ask you just to turn to Page 3 of that, and at the very top of the handwritten part, it says that she has progressed to the point where she's able to button and unbutton buttons.

Is that correct?

A. Yes, sir.

Q. So, that would be further progression from the last, I guess, examination you have where she wasn't able to do buttons. Now she can unbutton and button things.

A. Yes.

Q. All right. She can now tie her own shoes?

A. Yes, sir.

Q. Okay. So, at this point, and this was -- the date of this examination was January 27th, 2015. January 27 of 2015, we're continuing to see improvement in her function on her left arm, and she's continuing to be able to do the things that she couldn't do starting at four months, going

to 18-months, and going on and on and on.

Is that right?

A. Yes, sir.

Q. I don't have any further questions for you. Thank you.

A. Okay. Thank you.

REDIRECT EXAMINATION

BY MR. HENSHAW:

Q. Doctor Mahaffey, how would you describe the effort that Ashley has made over her lifetime to improve function in her left extremity?

A. She's been in therapy and occupational therapy. I believe she's had physical therapy to begin with, but occupational therapy at least weekly for -- since, since she was a baby.

Q. I mean she -- and on a personal level, has she worked hard?

A. Well, of course, yes.

Q. And to try to restore this?

A. Yes.

Q. She hasn't been lazy or, in any way, slackard in terms of --?

A. No, sir. No.

Q. She's, she's worked hard?

A. Yes, sir, she has.

Q. And would you attribute a lot of what is happened, beneficially to that left extremity, to her own hard work?
A. Yes, sir, I would say so.
Q. And that -- and the effort of her parents?
A. Yes, sir.
Q. And the -- obviously, the efforts of the therapy --
A. Yes, sir.
Q. -- therapist that have seen her?
A. Yes, sir.
Q. Despite that, does she have a normal left arm at this point?
A. No, sir.
Q. And, and, doctor, is it likely that she will ever have a normal left arm?
A. I don't know that I can answer that. It's not likely. I would say no.
Q. All right. Is she, for example, as a little girl, able to take her left arm, in combination with her left-hand, in combination with her right-hand, and tie a ponytail in her hair?
A. I don't know that specifically, that specific exercise. I, I don't -- from what I can tell from the range of motion, I would say no to that.
Q. So, does she have normal range of motion in the left arm?

A. No, sir.

Q. Would you agree, doctor, that, except for the left arm, if you're looking at the whole person of Ashley Flowers, that she is a completely normal little girl except for that left arm?

A. Yes, sir.

Q. That's all I have. Thank you.

MR. WEATHERLY: No further questions from me.

THE VIDEOGRAPHER: This concludes the video deposition of Shelley Mahaffey, MD.

ASHLEY FLOWERS, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q Hello.

A Hi.

Q All right. You see that microphone in front of you?

A Uh-huh. (Affirmative).

Q Have you ever sat behind a microphone before?

A No, sir.

Q Okay. Can you scoot up a little bit so you can speak more into the microphone and we can all hear you?

A (Witness complies.)

Q Tell us your name.

A Ashley Flowers.

Q All right. Ashley, how old are you?

A Nine years old.

Q And when is your birthday?

A October 7th, 2008.

Q And you just had a birthday party?

A Yes, sir.

Q Where was that?

A Pump It Up.

Q Where was that?

A Pump It Up.

Q At Pump It Up?

A (Witness nods affirmatively.)

Q And what kind of birthday party did you have?
A Descendants 2.
Q And what is Descendants 2?
A It's a Disney Channel movie.
Q Okay. And is that your favorite movie?
A Yes, sir.
Q And do you have a favorite character?
A Yes, sir.
Q And who is your character?
A Evie.
Q And why do you like Evie?
A Because she makes clothes.
Q Okay. And is that something you want to do?
A Yes, sir.
Q What do you want to do when you grow up?
A Be an illustrator or make clothes and be an artist.
Q Okay. And are you doing any of that yet?
A No, sir.
Q Okay.
A I just draw.
Q You draw.
Okay. How are you doing in school?
A Good.
Q And what grade are you in?
A Third.

Q What school do you go to?
A Rudolph Gordon.
Q And who is your teacher?
A Ms. Graham.
Q And do you get along with Ms. Graham?
A Yes, sir.
Q Okay. Do you know why we're here today?
A Yes, sir.
Q It has to do with your arm.
A Yes, it does.
Q And, and you understand that?
A Yes, sir.
Q Okay. Can you just step down?
Would it be all right, Your Honor, if I ask her to step down in front of the jury?
(WHEREUPON, the Court nods affirmatively.)
A (Witness complies.)
Q You understand that, that we all need to be able to see your arm?
A Uh-huh. (Affirmative).
Q Is that okay by you?
A (Witness nods affirmatively.)
Q That's a yes?
A Yes.
Q All right. You---

THE COURT: Now, now---
Q You need to speak up.
THE COURT: Yeah.
Mr. Henshaw, I don't know -- it's fine for her to step down so that you can show what you need to show, but you can't ask her questions while she's there because we can't hear her over here.
MR. HENSHAW: All right, sir. Okay.
Okay. So, turn toward the jury?
A (Witness complies.)
Q And hold your arms down by your side?
A (Witness complies.)
Q Okay. Now, can you hold your arm up like this please?
A (Witness complies.)
Q Okay. And can you raise your arms?
A (Witness complies.)
Q And can you hold your arm straight out please?
A (Witness complies.)
Q Okay. All right. Have a seat.
A (Witness complies.)
Q Do you remember the surgeries that you went through?
A No, sir, just one.
Q Okay. And, and did you do okay with that?
A Yes, sir.
Q Okay. And how do you, do you get along with the arm,

the arm in school?
A Sometimes.
Q What does that mean sometimes?
A In gym, I have to find a way how to do push-ups and some things too.
Q Okay. Now, are you playing any sports?
A No, sir.
Q Do you hope to?
A No, sir.
Q Are you swimming?
A No, sir.
Q Do you hope to -- are you not planning on doing any swimming?
A No, sir. Well, yes.
Q Okay. Tell us about that.
A I use to swim, but then I quit because I was a little afraid.
Q Okay. Now, can you tie your shoe?
A Yes, sir.
Q How long have you been able to tie your shoe?
A Since I was three years old.
Q And what about on the playground, can you jump rope?
A Yes, sir.
Q And how do you jump rope?
A I put the rope in front of me and turn it back.

Q Okay. You go backwards?
A Yes, sir.
Q Okay. What else do you like to do?
A Play soccer for fun --
Q Okay.
A -- and draw and color.
Q Okay. Do you have any problem with people looking at you or staring at you?
A Yes, sir.
Q And tell us about that.
A I get nervous and I get upset sometimes because, in public, if I go to a store with the mom -- the mall, the mall with my mom, people -- sometimes people stare at me and I don't like that.
Q Okay. How do you deal with it?
A I just leave it alone and I look around and I just stop looking.
Q Do any of your friends ever talk to you about, about your arm?
A They ask me what -- why is your arm bent and they try to straighten it.
Q Okay. And what do you tell them?
A I can't do that because I have an injury.
Q Okay. Ashley, that's all the questions I have for you. Please answer any questions that Mr. Lovell may have. This

is Mr. Lovell over here.

CROSS-EXAMINATION

BY MR. LOVELL:

Q Hey, Ashley. We have not met, but I don't have any questions for you today. Thank you.

A Okay. Thank you.

EDITH GUREWITSCH, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q. Please state your full name.

A. Edith Gurewitsch.

Q. Doctor Gurewitsch, we're here today to take your

deposition.

Have you participated in deposition proceedings before?

A. Yes.

Q. What is your occupation?

A. I'm an obstetrician/gynecologist.

Q. And where do you practice medicine?

A. At Johns Hopkins Hospital in Baltimore, Maryland.

Q. Okay. Do you hold a faculty position there?

A. I do.

Q. And what is that faculty position?

A. I am an associate professor in the Division of Maternal Fetal Medicine.

Q. So, you teach obstetrics and gynecology?

A. Yes, sir.

Q. Do you also practice and actually participate in the delivery of babies?

A. Yes.

Q. How do you -- how are those responsibilities divided in your particular practice?

A. Well, the teaching that we do is essentially on-the-job training. So, clinical practice is accompanied by residents and fellows and medical students who are simultaneously learning while we're treating patients.

Q. All right. Do you deal with complications of pregnancy in your practice?

A. Yes.
Q. Do complications of pregnancy include a condition known as shoulder dystocia?
A. Yes.
Q. What is shoulder dystocia?
A. Shoulder dystocia, the word dystocia means difficult delivery or difficult labor. Shoulder dystocia is a difficult delivery due to the infant's shoulder being caught. So, that -- this is a condition at the really -- at the last point of birth after the head has delivered through the vagina, and it's outside, but the body has not yet delivered. Normally that would follow very quickly in a matter of seconds. But, instead, the, the body is prevented from delivering such that it's because the shoulder is caught up against the mother's, the mother's pubic bone.
Q. Okay. Now, in addition to participating -- well, first of all, have you delivered babies where shoulder dystocia had occurred?
A. Yes.
Q. And have you researched the subject of shoulder dystocia?
A. Yes.
Q. What type of research have you done?
A. A number of different types of research. Retrospective, simulated, delivery training, analysis of

various maneuvers and their effect on the brachial plexus, methods by which to improve the outcome of shoulder dystocia, training for shoulder dystocia and the like.

Q. Where did you attend and graduate from Medical School?

A. Columbia University's College of Physician and Surgeons.

Q. And when was that?

A. That was in 1991.

Q. And, after 1991, did you continue to stay in academic medicine as well as practice medicine?

A. So, after medical school, I did a residency in obstetrics and gynecology.

Q. Where was that?

A. At Cornell. That was from '91 to '95, and then I did a two year fellowship in maternal fetal medicine also at Cornell from '95 to '97. And then I came to Johns Hopkins and I've been there ever since. So, I've been there 20 years.

Q. What is a fellowship in maternal fetal medicine?

A. So, most obstetrician/gynecologist will enter practice, whether it's academic or private practice, after completing a residency. Those who are interested in subspecializing, there's a number of different subspecialties. For example, those who do in vitro

fertilization are specialize -- specialists in reproductive endocrinology. Those who are interested in gynecologic cancer would do gynecologic oncology, and those of us who are interested in complications of pregnancy, high risk pregnancy, we do a fellowship in maternal fetal medicine.

Q. So, once you completed that fellowship, that's when you joined the faculty at Johns Hopkins?

A. Yes.

Q. When did you begin to turn your attention to researching and writing and you've written about shoulder dystocia as well.

Is that correct?

A. Yes.

Q. When did you turn your attention to researching and writing about shoulder dystocia as a complication of pregnancy?

A. Around 2003.

Q. And have you continued to be involved in that type of research and writing?

A. Yes.

Q. Is -- does it remain a matter of particular interest to you?

A. Yes.

Q. Now, in, in addition to your faculty assignment in the Department of Obstetrics and Gynecology, do you also

hold positions in other departments?

A. I have a joint appointment in biomedical engineering.

Q. Now, what is biomedical engineering?

A. Biomedical engineering is application of engineering concepts to medical conditions usually to solve medical problems, to research, develop devices, things like that.

Q. Now, has that, in any way, helped you in your research in shoulder dystocia matters or is it related in any way to the, to the research that you have done?

A. The research that I've done is -- it involves the analysis of forces involved in birth and involved in stretching the brachial plexus, and because of the research I've done in collaboration with biomedical engineering, you know, that's the reason for the point appointment.

Q. I see.

Now, you've mentioned the term brachial plexus several times. Please explain what brachial plexus is.

A. The nervous system is composed of the central nervous system, which is the brain and the spinal cord, and the peripheral nervous system, which controls sensation and movement of various parts of the body. The brachial plexus -- and those are all -- the peripheral nerves arise from and, and contribute to the spinal cord so that

sensations that you might feel, for example, are transported back to the brain, to the spinal cord, and then, both voluntary and reflex movement, is transmitted from the brain through the spinal column -- spinal cord out to the peripheral nervous system.

The brachial plexus is a series of nerve roots that arise from the spinal cord from the level of C5, cervical, cervical vertebrae 5, to---

Q. Is that in the area of the neck?

A. Yes, and then down to the thoracic -- the first thoracic vertebrae, which is right at the, at the level of the rib cage. So, the brachial plexus arises from, from the neck here and then it traces down across the shoulder and down the arm, and it controls sensation and movement of the shoulder, elbow, wrist, and hand.

Q. So, you -- are the nerves that comprise the brachial plexus, do they include the, the designations of nerve C5, C6, C7, C8, and T1?

A. Yes.

Q. So, basically five nerves?

A. Yes.

Q. And are they significant to the work you do in shoulder dystocia cases?

A. Yes.

Q. And why is that?

A. Because the shoulder is stuck on the pubic bone, if---

Q. The pubic bone of the mother?

A. Yes. And the baby's shoulder is, is obstructed by the pubic bone of the, of the mother, and the delivering clinician, whether it's a, a doctor or a midwife, isn't careful in recognizing and managing the obstruction, injury to the brachial plexus can occur, and sometimes that can be a permanent injury.

Q. So, in terms of the work that you're doing, does it include trying to prevent or teach doctors how to prevent brachial plexus injuries?

A. Yes.

Q. And you've been doing that since approximately 2000---

A. Three.

Q. 2003.

Now -- and you do this in conjunction with your husband?

A. Part, part of it, yes, we, we work together. We've done research together.

Q. And what is your husband's occupation?

A. He's a biomedical engineer.

Q. And where does he work?

A. He just retired from Hopkins.

Q. Okay. So, the two of you work together.
Have you written on the subject together?
A. Yes.
Q. And what types of articles have you written on, on the subject of shoulder dystocia and brachial plexus injury?
A. We've written original research articles, review articles. We have been invited to talks, scientific presentations at scientific meetings.
Q. Have you also served as an expert witness in medical cases before this?
A. Yes.
Q. In what jurisdictions have you been recognized as an expert or how many jurisdictions?
A. Across the United States.
Q. Okay. More than, more than ten states?
A. Yes.
Q. Okay. More than 20?
A. I believe so, yeah.
Q. Okay. And so in terms of your expertise or your practice in, in the field of medicine, have you come to recognize that there are generally recognized and accepted standards of care for how obstetricians are expected to deal with a condition of shoulder dystocia if they encounter it?
A. Yes.
Q. Are obstetricians trained in how to deal with

shoulder dystocia?

A. Yes.

Q. And when does that training begin?

A. Actually it begins in medical school. There's awareness of it in terms of actually managing it that would start in your residency.

Q. In the residency.

A residency is, is what?

A. It's your training period but -- it's four years --.

Q. Following medical school?

A. Correct. It's four years for obstetrics and gynecology.

Q. And is it during that period that doctors are first allowed to actually participate and, and, and actually take the role of delivering a baby that's hung up on the mother's pelvis because of shoulder dystocia?

A. Yes.

Q. Is that done with a experienced doctor such as yourself standing by and observing and instructing where necessary?

A. Yes.

Q. And, in some occasions, is it necessary for the experienced doctor to take over and deliver the baby?

A. Yes.

Q. Have you had to do that?
A. Yes.
Q. Now, the, the articles or the, the written materials -- the, the writings that you've done, either on your own or with your husband, have they been submitted -- what, what type of journals have they been submitted to and published?
A. They're known as peer reviewed journals. They're professional journals. We send a manuscript summarizing your methods, your objectives, results, and conclusions. You -- before publication, the manuscript is usually sent to two or three reviewers, who are familiar with the same type of research, for their critical evaluation, and if they believe it's worthy of publication, they will essentially give -- submit a report to editors who then make a decision about publication.
Q. Do you know how many articles you've submitted for peer review and publication related to shoulder dystocia?
A. About 12 or 13.
Q. Okay. And overall, in terms of your series of publications, how many publications have you had in your career?
A. Well, they're, they're sort of divided into different categories, but about 45 publications.
Q. And, and 12 to 14 of those have been specifically

related to the subject of shoulder dystocia?

A. Yes.

Q. Now, based upon your experience, training, and knowledge, were you familiar with generally recognized and accepted standards of care related to a doctor's management of shoulder dystocia in the timeframe of October 2008?

A. Yes.

Q. And were there generally recognized and accepted standards of care related to the management of the condition of shoulder dystocia in that, in that timeframe?

A. Yes.

Q. Essentially, in summary, what was a doctor expected to do, if he's in the process of delivering a baby, the baby's head comes out, and, and, unfortunately, the shoulder becomes entrapped and shoulder dystocia has occurred?

A. Well, first, and most important thing, is to recognize that that has happened. That can occur in one of two ways or, or both ways. Either the head, after it has delivered, pulls back just slightly, not all the way back into the vagina, but it retracts against the mom's bottom, which would indicate that the body is not following as, as it normally would.

Q. Is that called turtling?

A. That's called a turtle sign or a---

Q. Or a turtle sign.

A. It's a little bit of a misnomer because a turtle actually pulls its head all the way back into its shell. That's not what we mean with the turtle sign. It just means that the head pulls back a little bit against, against the body or, more commonly, after the head has delivered, a clinician is expecting that, with usual guidance, that the body will deliver on its own and instead encounters resistance.

The standard of care would then be to stop what you're doing, and then proceed with a series of maneuvers that, that would -- are designed to release the obstruction, the impaction, and throughout that process, it -- the standard of care is to be used no more force than you would use in a delivery that's not complicated by shoulder dystocia because it's the force that is potentially going to cause an injury. Especially to the brachial plexus.

Q. And was that the standard of care in October of 2008?

A. Yes.

MR. HENSHAW: At this time, I would offer Doctor Gurewitsch as an expert in obstetrics and specifically in the area of shoulder dystocia and brachial plexus injury.

MR. WEATHERLY: No objection.

Q. Doctor Gurewitsch, at my request, have you reviewed materials related to the labor and delivery of Ashley

Flowers at Spartanburg Regional Healthcare Hospital on October 7, 2008?

A. Yes.

Q. Okay. Can you give us a summary of the pertinent facts that you determined from the review of materials?

A. This was her first pregnancy that she carried to term. It was complicated by gestational diabetes. The labor progressed normally. The -- at the point that she became fully dilated, 10-centimeters dilated, and began to push, a decision was made to use a vacuum to assist with the delivery such that the second stage of labor was shortened to 13-minutes, which is considered a precipitous second state. So, she had an operative vaginal delivery and precipitous second stage of labor.

There was a complication of shoulder dystocia. It was recognized by Doctor Giep, her obstetrician who was performing the vacuum assisted delivery. He responded by calling for McRoberts position and suprapubic pressure.

Q. Now, these are the -- this -- these are maneuvers that can be utilized in the face of shoulder dystocia?

A. Yes.

Q. I'm sorry. I may have cut you off.

A. No, that's okay. And after somewhere between one minute and two minutes, the -- a baby girl was delivered weighing 7-pounds 11-ounces, and immediately, on delivery,

there was notice that the left arm was not moving normally. Ultimately, that -- usually 90 percent of those will recover, but this, but this one did, and it required surgery to repair the brachial plexus, and there are still deficits that remain today.

Q. All right. Now, you mentioned McRoberts maneuver. Please explain what that is.

A. Probably the best way to explain is to give an example of trying to move a piece of furniture through a door. So a lot of times, if you line up the furniture in one particular dimension, it's not gonna fit through the door. But if you either tilt the door or you tilt the piece of furniture, it will fit through the door. So, McRoberts is essentially the equivalent of tilting the door.

So, if you imagine that the, that the shoulders are lined up vertically, and that the pubic bone is actually a -- essentially a, a doorway, McRoberts maneuver is where you take the mom's legs out of the stirrups, bend her knees sharply back against -- towards her shoulder, and what that does is it rolls the pelvis backwards so that the pubic bone will, will be elevated some relative to the position of the shoulders.

Q. So, it changes the angle that the---

A. It changes---

Q. ---baby's body is coming out?

A. Relative to the pubic bone exactly. Now, if the baby is -- if that doesn't work, then that will just pull the, the shoulder further back. So, if that's not working, then you would try to do a different maneuver.

What was done in this case was supra, was suprapubic pressure. That's actually also done by the nurses. I neglected to say, when you take the, the mother's knees and, and flex them backwards, that's done with the assistance of, of nurses. The, the clinician, the delivering clinician still has their hands on the baby's head, and still guiding, guiding the delivery, and the standard of care requires that you wouldn't use any more level of force trying to get that baby delivered. Because if it actually works, if McRoberts position works, then the shoulder should be free now, and it wouldn't need any more than usual delivery traction to get the baby out.

So, with that not working, you shouldn't repeat over and over or pulling on that baby's head. Same thing with suprapubic pressure. Suprapubic pressure -- so, if you imagine that the shoulder is right behind the pubic bone, that you can actually feel that shoulder right above the mother's pubic bone on her, on her abdomen, on the belly, the -- a nurse can come from behind the baby's shoulder essentially -- usually with a fist or with a, with the heel of their hand to try to roll the baby off to a diagonal

position rather than the straight up and down of the shoulders.

Q. So, suprapubic pressure is applied by the nurse or by the doctor?

A. By the nurse.

Q. And is it applied just above the pubic bone with the, with the nurse's hand?

A. Yes.

Q. So, does that indicate then that, if suprapubic pressure was used in this case, that Doctor Giep, in instructing the nurse to apply this pressure, felt like that the shoulder that was being hung up was the, the shoulder that was in front of the mother's belly -- in the, in the front of the mother's belly or what they call the anterior position?

A. I think I understand what you're asking.

The -- when the shoulders are caught in a shoulder dystocia, the most common, better than 90 percent of the time, it's the shoulder that's behind the pubic bone and not behind the, the sacrum --

Q. Okay.

A. -- that which is the back bone --

Q. Okay.

A. -- of the pelvis. So, so, that's why suprapubic pressure is, is applied just behind, just above the, the

pubic bone to try to move the shoulder off that -- off angle so that it can slip out underneath the pubic bone.

Q. But if a -- but if a doctor directs the nurse to apply suprapubic pressure, does that mean he believes that it's the shoulder that's upward that is hanging up, and he's trying to get that pushed down below the pubic bone?

A. I mean that's what's most likely. Unless he feels it, though, he's not gonna know.

Q. Okay.

A. But it's a reasonable thing to ask her.

Q. Okay. There are cases where the lower shoulder can get hung up, as you say, on the -- on a location known as the sacral promontory?

A. Yes.

Q. But that's less likely?

A. Much less likely, yes.

Q. All right. Now, in, in this particular case, you -- was McRoberts maneuver the appropriate maneuver to undertake by Doctor Giep when he realized there were shoulder dystocia?

A. As an initial maneuver, yes.

Q. Okay. Was suprapubic pressure an appropriate thing to do once he recognized that there was shoulder dystocia?

A. Yes.

Q. Now, you mentioned that there could be other

maneuvers that he might utilize if those did not work.

Can you give us an explanation of those possibilities?

A. So, the most common for obstetricians, after trying McRoberts and suprapubic pressure, would be to actually reach in past the head into the vagina, and actually try to move the body in some way. So, there's a number of options. You can try, in a similar way to the suprapubic pressure, to just maybe roll the butt, the body only about 30-degrees, either clockwise or counterclockwise depending on the position, so that the shoulders are no longer straight up and down but are in a diagonal relative to the pelvis, which is a, a roomier way to fit through the door so to speak or you can actually turn the baby 180-degrees. That actually creates a forward motion and so it's more like a winding motion.

Q. Is that some kind of pelvic corkscrew maneuver?

A. Right. So, that's sometimes called corkscrew or Woods screw after the clinician who, who described that maneuver. So that can be done because that can also, in that winding process, essentially wind the baby right out from the obstruction.

Another possibility is to take the arm that is lowered down in a -- towards, towards the mom's bottom and attempt to deliver that first. And that would be sort of the equivalent of, let's say, a, a truck was stuck, was too big

to fit under an overpass. It would be the equivalent of letting the air out of the tires. So, it will let the whole body sink down so that it would fit to come through and that's called---

Q. What is that maneuver called?

A. Delivering the posterior arm. It has other names, but that's the most common.

Q. Have you ever heard of a term called the Rubin maneuver?

A. So, the 30-degree rotation is also known as Rubin's maneuver.

Q. Now -- and you reviewed the labor and delivery records?

A. Yes.

Q. And what did you find in the labor and delivery records as the type of maneuvers that were used to deliver Ashley Flowers?

A. McRoberts and suprapubic pressure were what was listed and suprapubic pressure---

Q. Okay. Were any others listed?

A. ---was listed by the nurse, and McRoberts and suprapubic pressure was in Doctor Giep's delivery -- written, handwritten delivery note.

Q. And did you find any other maneuvers indicated by the medical records?

A. No.
Q. And did you review any of the depositions?
A. Yes.
Q. Did you find that Doctor Giep indicated in his deposition that he used another maneuver of some type?
A. Yes.
Q. And what did -- what was that?
A. The Rubin maneuver.
Q. And would that have been appropriate?
A. It, it would of. All three, however, McRoberts, suprapubic, and Rubins, all involve still repeating traction on the baby's head. And so, while the maneuvers themselves are appropriate, it's the traction that is applied that risks the brachial plexus.
Q. Okay. And so, in this case, is the question whether -- not whether Doctor Giep used appropriate maneuvers, but whether he used an amount of traction that was unnecessary for the delivery?
Would that be an appropriate way to question -- to ask the question?
A. Yes, I think that's fair.
Q. And, and based upon the outcome, do you have opinions about whether or not Doctor Giep met the standard of care in the amount of traction that he applied?
A. So, there are a number of things that are

noteworthy. So, first of all, the fact that there was a shoulder dystocia, the fact that this was a permanent injury, the fact that it was evident immediately at birth, that there wasn't any evidence that the injury was longstanding, meaning it had occurred months early while in utero, which would of presented as a, a withered arm that was already of a different length. Some of the things we see later in, in the baby were not evident at birth. So, it suggested that, that -- an injury that occurred during the birth process.

The nature and extent of the injury. So, extent means how many nerve roots were involved. The -- almost the entire brachial plexus was involved. C5, C6, C7, and C8 all required some degree of surgical repair or dissection, and nerve grafts were needed to, to overcome the lack of -- essentially there was a, a split of the nerves, a rupture of the nerves, C5, C6, and C7, that, that -- so that such that there was no longer nerve conduction and there -- it would never recover without a graft.

Q. When you say nerve conduction, are you referring to the signal that gets transmitted from the brain, through the nerve itself, to whatever muscle that needs to be innervated?

A. Yes, it's not even necessarily of the, of what we call voluntary motion. Like if I were to decide I want to

pick up this pencil from the, from the desk, the brain sends a signal and I voluntarily move my arm, obviously through nerve signals, to, to various muscles but even reflexes. So, if I touch something hot, you pull away, which only goes to the spinal cord, but it still has to go out through the, the brachial plexus nerves in order to get that muscle contraction to, to pull your hand away.

Q. So, in Ashley Flowers case, was she subsequently treated and the types of nerve injuries identified in, in her arm?

A. Yes.

Q. And, and which shoulder or arm was affected?

A. Her left shoulder and arm.

Q. And---

A. Her left brachial plexus actually.

Q. In your opinion, is that most likely the shoulder that was up against the pelvis during the delivery?

A. Statistically so. We don't know from the record.

Q. The record does not specifically identify that?

A. No.

Q. Now, the, the types of injury to these nerves, were they all the same, C5 through C8, or did -- were they -- did they vary?

A. They varied.

Q. So, what do you understand, from the review of

medical records, as to how they varied?

A. So, the injury to the nerves of the lower plexus, like C8 and -- could -- essentially were involved and scarred, but if you loosen the scar, then there was return of, of nerve conduction. So, just the dissection alone was able to restore some function.

Q. That scarring around C8, is that called a neuroma --

A. Yes.

Q. -- when it occurs?

A. Yes.

Q. And is it significant to you that scarring formed around the C8 nerve?

A. It indicates that the nerve was injured and underwent a process of scarring.

Q. Okay.

A. A neuroma is a scar.

Q. And so -- and what about the other nerve, C5 through C7, what type of injury did they have?

A. So, even once they were dissected freely from the scar, they still could not conduct nerve impulses. And so grafts were, were -- essentially the damaged area was spliced out and then grafted.

Q. Okay.

A. Replaced.

Q. Did, did -- was the term rupture ever used?
A. No. Essentially nonconduction means that there's -- that, that there is a, a, a gap in the nerve tract such that there -- that it's not going to recover. As opposed to basically the nerve root was actually pulled out of the spinal cord. That would be called an avulsion, and that -- you would need to do a transfer because, if it's pulled out of the spinal cord, you can fix it all you want out here with grafts, but it's never gonna communicate with the spinal cord. But that wasn't---
Q. Cause it's not---
A. ---the case.
Q. ---connected up?
A. Correct.
Q. But the types of injuries that were found by the doctors who later treated Ashley, do they, in any way, form a basis of any opinion you may have as to what happened during the delivery?
Q. Well, in order to get the brachial plexus, which, as I described earlier, comes out of the lower portion of the neck and comes out across the shoulder. So, it's almost perpendicular to, to the spinal column. If the baby's head is coming out of the vagina, and the shoulder is stuck up here, and you pull downward very sharply so that you're getting this motion, ear to shoulder away from the top

shoulder, then you will stretch the brachial plexus nerves.

Now, we're all able to do this without injuring our brachial plexus. We can even have a temporary injury where it's pulled quite a bit, and then it takes a couple days to recover, but a permanent injury is when you -- when it actually snaps the nerve, and then the only way to fix that would be with a, with a reconstruction of the brachial plexus using grafts.

Q. Do you have an opinion, to a reasonable degree of medical certainty based upon your experience, training, and knowledge, as to what type of injury or damage occurred to Ashley Flowers C5, C6, C7, and C8 nerves?

A. I mean I think we've been through this.

Q. I understand, but, but I'm asking it to---

A. It required---

Q. ---an opinion---

A. It required primary reconstruction.

Q. Okay. And, in your opinion, was it most likely a stretch injury that caused that damage that required---

A. Yes. Yes, it was definitely a stretch injury.

Q. And that would be your opinion to a reasonable degree of medical certainty?

A. Yes.

Q. Is that, is that based upon your research?

A. No, I think any treating neurologist would, would

agree that the type of injury with a neuroma, and the pattern that was noted with a stretch injury, an injury of stretch, not of compression or infection or some sort of congenital maldevelopment or something like that.

Q. Do you have an opinion, to a reasonable degree of medical certainty based upon your experience, training, and knowledge, as to what the mechanism of stretch was that could cause that injury?

A. Well, the only way you can get the head to bend in that direction, which is, is, is not only sufficient to cause an injury, but necessary. In other words, you've got to get the head to bend laterally. If I were to put the same force straight perpendicular, I would barely move the brachial plexus, but it -- the more I bend the head, ear to the opposite shoulder, the more stretch and the more nerve roots would become affected.

So, in the case of a head first presenting vaginal delivery complicated by shoulder dystocia, there is scientific evidence that about 35 to 40-pounds of force applied more than 45-degrees away from the vertical axis is required to produce a, an injury of that extent.

Q. Now, if you -- you've already stated that there was a standard of care in 2008 related to the obstetrician not applying unnecessary amount of traction while the obstetrician held the baby's head during the, the maneuvers

to deliver the baby.

A. Yes.

Q. What about, in regard to the tilting of the head that you've just spoken about, were there a standard -- was there a standard or standards of care applicable to what a obstetrician should do in that circumstance?

A. Yes, I mean that's all part of the same standard, which is that, when you apply -- when you guide the head out from -- during a delivery, that it, it be balanced so that the -- you're not having a, a significant deviation of more than 45-degrees away in one direction or the other. That would be part and parcel of---

Q. Either upward or downward force?

A. Ordinary traction, which is what you're -- the standard of care requires that you use no more than, than, than what would be required in the delivery, but that's unobstructed, cause if you've relieved the obstruction, you shouldn't need that. And if you do any more than that, then you haven't relieved the obstruction and you need to do something else.

Q. Now, why does an obstetrician such as Doctor Giep need to have his hands on the baby's head in this situation at all?

A. There isn't a way that the baby was going to come out unless there's some, some guidance during maneuvers that

are essentially indirect, and they're just having the mom change position or apply suprapubic pressure. That doesn't help the baby actually deliver.

Q. So, in this situation, did Doctor Giep have to have his hands on the baby's head?

A. Yes.

Q. In order to be able to facilitate the delivery?

A. Yes.

Q. But are you questioning whether, when he had his hands on the baby's head, whether he maintained -- whether he stayed within the standard of care as to, number one, the amount of traction or pulling that he would do and whether or not he tilted the baby's head so severely that it would stretch the nerves in the baby's neck?

A. Yes.

Q. And based upon the researching that you've done or that you know has been done by others, do you have an opinion, to a reasonable degree of medical certainty, as to how much traction Doctor Giep most likely applied?

A. It would be at least 30, 35, to 40-pounds of, of force since all the evidence that we have is not from live births. And so the, the, the dead tissue is more fragile, and we know that 35 to 40-pounds of force would produce multiple level, nerve root level injury, would produce ruptures of the nerve tract. So, at least that much.

Q. And, in your opinion to a reasonable degree of medical certainty, based upon your experience, training, and knowledge, was 35 to 40-degree -- 40-pounds of pressure necessary to deliver Ashley Flowers?

A. In my opinion, it was not.

Q. And what is that based on?

A. Because the shoulder dystocia itself only lasted between one and two minutes. Let's just say one and a half minutes for the sake of argument. But even if it had lasted two minutes, ultimately the baby was able to come out doing McRoberts and suprapubic, but there would of been no justification for pulling that hard and that soon in a shoulder dystocia. So, more likely the baby rotated a little bit on its own over that minute and a half, and the obstruction relieved on its own, and -- but, in the mean time, a significant amount of traction was being applied that was unnecessary.

Q. Now, do you have an -- and I may of already asked this, but just to be sure that I've covered it.

Do you have an opinion, to a reasonable degree of medical certainty, as to the amount of tilt or upward or downward pressure on the baby's head that was applied to -- by Doctor Giep in this case?

A. That it was at least 45-degrees.

Q. Now, in your opinion to a reasonable degree of

medical certainty, was that necessary or unnecessary to deliver this baby?

A. It would be improper.

Q. Do you have an opinion as to whether or not that caused or contributed to the, the nerve injuries that Ashley Flowers suffered?

A. I believe it did.

Q. Now, what is the basis of, of that opinion that this was an unacceptable amount of upward or downward pressure on the baby's head?

A. Just as I said, in a normal delivery or an unobstructed delivery, which is the standard that would be held to, that you wouldn't use traction that was different from that. You need to have a balance of a -- of the head so that it, it's remaining fairly closely aligned with the spinal cord and not deviated significantly in either direction.

Q. Now, Doctor Gurewitsch, based upon your experience, training, and knowledge, do you hold any opinions that there were forces beyond Doctor Giep's control that caused injury to Ashley Flowers brachial plexus?

A. I do not.

Q. Have you ever heard the term maternal forces of labor?

A. Yes.

Q. What does that -- what does that mean to you?
A. That it would be the pushing force generated by the uterine contractions themselves, coupled with the mother's pushing effort, you know, where she's bearing down to push the baby out.
Q. Do you have any reason to believe that the, that any maternal forces of labor caused or contributed to Ashley Flowers having this degree of brachial plexus injury?
A. I do not.
Q. Now, are there, in fact, degrees of brachial plexus injury that a baby can experience because of shoulder dystocia?
A. Yes, about 30-percent of babies that -- whose delivery was complicated by shoulder dystocia will have some injury to the brachial plexus. As I said before, 90 percent of those are temporary injuries that usually resolve quickly. Some can take up to a year to two years to resolve, but still resolve completely without -- with just some physical therapy.
Q. Would Ashley Flowers brachial plexus injury be considered a temporary injury?
A. No.
Q. Would it -- how would it be characterized?
A. It would be permanent.
Q. And does that make a difference then in terms of

your -- what type of opinions you can develop about whether the doctor used unnecessary force or unnecessary traction or tilted the baby's head in an unnecessary, in an unnecessary way?

A. I mean it wouldn't be, as I said before, in order to have a permanent injury of the nature and extent that this baby had, it requires significantly more force applied in that lateral or deviated way, off axis way, to the head during delivery.

Q. Would maternal forces of labor be capable of that type of, of comparable force to the traction that you're describing?

A. No.

Q. Or would it, the maternal forces of labor, cause the baby's head to tilt downward more than 45-degrees?

A. No.

Q. What about anything that occurred during the baby's growth over the course of pregnancy, congenital type injuries?

Is there any evidence that Ashley Flowers had developmental problems during the pregnancy that would result in this type of injury to the brachial plexus?

A. No.

Q. So, in your opinion to a reasonable degree of medical certainty, are there any other forces, other than

those applied by Doctor Giep, that most probably caused the injury to Ashley Flowers brachial plexus?

A. No.

Q. Doctor, in your opinion, to a reasonable degree of medical certainty, based upon your experience, training, and knowledge, did Doctor Giep deviate from the generally recognized and accepted standard of care in the manner in which he delivered Ashley Flowers on October 7, 2008?

A. I believe that he deviated it from the standard of care in the application of traction that was more than necessary for the circumstances.

Q. Doctor, do you have an opinion, to a reasonable degree of medical certainty, based upon your experience, training, and knowledge, as to whether or not the deviations from standard of care that you've identified most probably caused injury or caused or contributed to injury of Ashley Flowers brachial plexus?

A. I believe it did.

Q. Doctor, do you have an opinion, to a reasonable degree of medical certainty, based upon your experience, training, and knowledge, as, as to whether the injuries sustained by Ashley Flowers to her brachial plexus could most probably have been avoided if Doctor Giep had followed standard medical care in the delivery of, of that baby?

A. Yes, I think he could of avoided the, the extensive

and permanent injury that occurred here.

Q. Okay. Doctor, if, if I may, I'd like to, to go off line so that I can review my notes and see whether I have any further questions before I turn you over to defense counsel for cross-examination.

A. Okay.

THE VIDEOGRAPHER: The time is now 4:14. We are going off the record.

(Pause.)

THE VIDEOGRAPHER: The time is now 4:20. We are back on the record.

Q. Doctor Gurewitsch, in, in your review of the records, did you find that Doctor Giep used a vacuum extraction device during his delivery of the baby?

A. Yes.

Q. Do you have an opinion, to a reasonable degree of medical certainty, as to whether the vacuum extraction device in any way caused or contributed to Ashley Flowers having permanent injury to her brachial plexus?

A. I do not think it contributed to the injury.

Q. Doctor, did you find in the record that, at the time of birth, Ashley Flowers was found to have a fractured clavicle?

A. Yes.

Q. And what is a clavicle?

A. The clavicle is a collarbone.

Q. And, doctor, do you have an opinion, to a reasonable degree of medical certainty, as to whether or not the fractured clavicle caused or contributed to Ashley Flowers having permanent injury to her brachial plexus?

A. My opinion is that the fractured clavicle did not cause or contribute to the brachial plexus injury.

Q. Does it have any association with the brachial plexus injury?

A. It has. It can result from a number of different mechanisms, any of which are plausible here. One is as a result of suprapubic pressure being applied forcefully causing a -- the collarbone to snap.

The other is the same force pulling the baby's brachial plexus. There's also pulling of the collarbone through the pubic, the pubic bone. And it also could be pushed through past the pubic bone either, which would cause compression and a fractured clavicle.

Q. That's all the questions that I have. Please answer any questions that defense counsel may have.

CROSS-EXAMINATION

BY MR. WEATHERLY:

Q. Doctor, my name's Lee Weatherly and I represent Doctor Giep and Spartanburg OB-GYN.

Did you just testify that Ashley Flowers suffered a

fractured clavicle during her delivery?

A. Yes.

Q. Did you review her medical records from the hospital when, when coming to your opinions in this case?

A. Yes.

Q. Did you review the x-rays that were taken of her clavicle in the hospital?

A. Yes.

Q. Did you note that none of those x-rays showed a fractured clavicle?

A. I thought there was fractured clavicle. So, I -- as I recall.

Q. And, doctor, when you are acting as an expert witness, you have the duty to review, to review all of the materials and to form your opinion based on an accurate review of those materials, do you not?

A. Yes.

Q. And so you were not aware that Ashley Flowers clavicle was not fractured during her delivery, but was later fractured during her brachial plexus surgery by Doctor Armenta so he could reach a different part of her scar tissue?

You were not aware of that?

A. I was not.

Q. Did you review his records?

A. Yes. So, the, the clavicle is typically purposely separated in order to explore the brachial plexus.

Q. Did you read his deposition, Doctor Armenta?

A. Yes, a while ago.

Q. And you didn't -- testifying here today under oath, you didn't remember that the first time that Ashley Flowers clavicle was fractured was when he did it during the surgery to repair her nerves?

You didn't know that?

A. No.

Q. Doctor, you serve as an expert witness very frequently, correct?

A. Yes.

Q. In fact, you make between a hundred and $150,000 a year testifying for lawyers in medical malpractice cases, correct?

A. Yes.

Q. You depend on that money you charge attorneys like Mr. Henshaw for half of your annual income, don't you?

A. Yes.

Q. And a lot of that is testifying against doctors just like Doctor Giep in cases involving shoulder dystocia just like this one, isn't it?

A. Yes.

Q. And none of that money goes to Johns Hopkins or

anyone like that?

It goes directly to you, correct?

A. Yes.

Q. And you're getting paid, what is it, $3,500 for coming to this conference room here in Baltimore, in your hometown, to testify on video for Mr. Henshaw and his clients, correct?

A. Yes.

Q. And your husband is Mr. Henshaw's other expert in this case, right?

A. I believe so, yes.

Q. Robert Allen, that's your husband, correct?

A. Yes.

Q. And your husband depends on cases like this for a third of his income, doesn't he?

A. Yes.

Q. Okay. He won't tell us how much he makes a year being a witness.

Do you know why that is?

A. No.

Q. But so, in total, about 40-percent of your family income comes from, comes from providing testimony in cases just like we're here from today?

A. Yes.

Q. All right. And your husband is who first got you

involved in shoulder dystocia issues, correct?

A. Yes.

Q. Okay. Cause he use to work with a doctor named Bernard Gonik on shoulder dystocia and brachial plexus insured, excuse me, in brachial plexus injury research, didn't he?

A. He did.

Q. And they were neighbors, correct?

A. Yes.

Q. Okay. And let me, let me rephrase my question.

Doctor Gonik's published research does not agree with your position that injuries like Ashley Flowers can only be caused from 35-pounds of physician traction, correct?

A. I can't answer that one way or the other.

Q. You've not reviewed his research --

A. I have.

Q. -- since he's split off from your husband?

A. I have reviewed that. It, it doesn't talk about any cause of permanent brachial plexus injury.

Q. But Doctor Gonik now does research on shoulder dystocia and brachial plexus injuries with a different biomechanical engineer named Michele Grimm in Michigan, correct?

A. Yes.

Q. Okay. We'll talk about -- well, let's go back to

your husband.

when he was no longer doing work with Doctor Gonik, you moved in next door to him, right?

He moved here to Baltimore and then you moved in next door to Doctor Allen, right?

A. No.

Q. All right. And then your husband picked you to work with him on his theories of brachial plexus injuries, correct?

A. We worked together.

Q. Okay. And then---

A. He never picked me.

Q. And then you started dating and then you got married, correct?

A. Yes.

Q. You kept your last name, Gurewitsch, for professional reasons and did not take the last name Allen, correct?

A. Actually I go by Gurewitsch-Allen professionally.

Q. Is any of the literature you've published have Gurewitsch-Allen?

A. Yes.

Q. Okay. I have not seen that research. So, I apologize.

My understanding is, and tell me if I'm incorrect, that

when you two are expert witnesses in cases, you have a pretty simple standard for taking on a case for a plaintiff's attorney is that, unless there are extreme circumstances, you believe, that when a child has a ruptured or avulsed brachial plexus nerve, the doctor must have been negligent.

Isn't that essentially what you and your husband's opinions boil down to?

A. I think that it's common, but it is not a formula. Each case is reviewed for its individual circumstances, but it is true that, that, unless there are extenuating circumstances, which is what we're reviewing, that a permanent brachial plexus injury that is moderate to severe is the result of traction that is more than usual traction, and what is being evaluated by me, I can't speak for him, he's not a physician, is whether that was medically justified.

Q. So, essentially, if you can't -- if there's no in medical justification, which often, in your mind, is a brachial plexus -- is a shoulder dystocia event lasting longer than five, six, or seven minutes, if that doesn't exist, and there is a rupture avulsion leading to a permanent injury in a child, you believe that the doctor must have been negligent, correct?

A. That would be a typical conclusion that I would

reach, yes.

Q. And what -- you've -- have you ever been to South Carolina?

A. Yes.

Q. What were you there for?

A. Just pleasure. Vacation.

Q. Have you ever met Doctor Giep?

A. No.

Q. Have you ever spoken to him?

A. Nope.

Q. And you requested that we come to Baltimore today to put your testimony on video.

Why was that?

A. Because of my clinical responsibilities. I can't take the time off that would be required to come for traveling the day before and then the day after giving testimony.

Q. All right. So, you're gonna be able to testify that Doctor Giep was negligent in this case without ever having to be in the same room with him, right?

A. Yes.

Q. And this is how you make half of your living, correct?

A. (No audible response.)

Q. Doctor, before coming here today, I read one of the

articles you and your husband wrote published back in 2007 just called Shoulder Dystocia.

Do you know the article that I'm talking about?

A. From 2007, in Seminars in Perinatology?

Q. Yes.

And, in that article, you and your husband give advice to experts and lawyers and all the such as to how to more effectively argue these shoulder dystocia cases in Court.

Those---

A. No, that's not---

Q. No?

A. No.

Q. Okay. In that article, do you not give advice to expert witnesses involved in shoulder dystocia cases?

A. No. No, I discussed the various arguments from an evidence -- from a medical evidence prospective.

Q. Okay. In this article---

A. But not advice.

Q. Would it be fair -- oh, excuse me. I apologize. I don't mean to interrupt, ma'am.

A. It's not advice of any kind. It was a -- the whole issue of Seminars in Perinatology was devoted to medical/legal issues in perinatology. I was asked to write a -- the two of us were asked to write a chapter or a contribution on shoulder dystocia, specifically the

medical/legal issues in shoulder dystocia, and review the typical plaintiff and defense arguments from the point of view of the medical literature period. No advice one way or the other.

Q. You don't tell them in this article what arguments will be more effective than other arguments?

A. No.

Q. I must have read it incorrectly. I apologize for that.

But you do give one good piece of advice in here that says, realistically, experts often have to make concessions to the opposing side because it's rare that all aspects of care were substandard.

You wrote that, right?

A. Yes.

Q. Okay. Well, let's, let's see what concessions we can, we can come up with from you right now.

Now, all of Mrs. Flowers prenatal, meaning the care before she went into labor, that was appropriate, wasn't it?

A. Yes.

Q. And the management of her gestational diabetes, that was appropriate, wasn't it?

A. Yes.

Q. And, in this case, it was appropriate for Doctor Giep to deliver Ashley Flowers the traditional way,

vaginally, wasn't it?

A. Yes.

Q. And you'll admit the standard of care doesn't require Doctor Giep or any of his partners to recommend or perform a C-section at anytime on Mrs. Flowers, do you?

A. I -- the standard of care would not require that, no.

Q. All right. And that's because, at 39 weeks and four days and approximately 3,500 grams, Ashley was not large enough of a baby to where the guidelines recommend a C-section, correct?

A. That's right.

Q. And doing a C-section on everyone, that's not a viable option to prevent brachial plexus injuries from shoulder dystocia, is that---

A. Not at all.

Q. Okay. Great.

So, so far, we're, we've got good care by Doctor Giep and the other members of Spartanburg OB-GYN, correct?

A. Yes.

Q. Great.

Let's talk about the first stage of labor. That's when the mom is having contractions and her cervix is opening, but she's not yet pushing.

Is that correct?

A. That's correct.
Q. And Doctor Fowler was the obstetrician who managed most of the first stage of labor, and then Doctor Giep came on towards the end, correct?
A. Yes.
Q. All right. And the first stage of labor, in this case, lasted 12-hours and two minutes, correct?
A. Yes.
Q. And towards the end of this first stage of labor, they gave Mrs. Flowers a does of antibiotics because she was what's called Group B strep positive meaning there was certain bacteria in her vagina, correct?
A. Yes.
Q. And that dose of antibiotics is to help prevent her from passing that infection onto her baby while the baby's being born, correct?
A. Yes.
Q. All right. And that was appropriate care, wasn't it?
A. Yes.
Q. And all of Doctor Giep's care of Mrs. Flowers and Ashley Flowers was appropriate during the entire first stage of labor, wasn't it?
A. From the point he took over, yes.
Q. Now, let's talk -- and all of Doctor Fowler's

management before Doctor Giep was all appropriate, wasn't it?

A. Yes.

Q. Now, let's talk about the second, the second stage of labor where Mrs. Flowers cervix is fully dilated and she can start pushing.

Now, you said, in your direct examination, that the second stage of labor was 13-minutes.

That's not correct, is it?

A. That's what it says in the record.

Q. Well, let me hand you Defendant's Exhibit 1, and I'll also, while we're at it, hand you the fetal monitoring strip marked as Defendant's Exhibit 3. Now, let's look at Defendant's Exhibits 1.

Did you review this before your testimony here today?

A. I did.

Q. Okay. And if you look over to hours and minutes, it says second stage of labor, it says 43-minutes, doesn't it?

A. I read that as -- I read that as 13-minutes.

Q. Okay. Well, let's look over here to complete dilated right next to there. That says at 19:32.

That means 7:32 in the evening, doesn't it?

A. Yes.

Q. Okay. And what time did -- was Ashley Flowers

born?

8:20 in the evening?

A. 8:20:51.

Q. Excuse me?

A. 20:51.

Q. Don't you mean 20:20?

8:20 in the evening?

A. I'm looking at the vaginal delivery spontaneous time. Oh, that's the placenta.

Q. That's when the placenta was delivered.

That's the third stage of labor?

A. 20:20.

Q. Let's stay in the second stage.

So, 20:20 -- 19:32 to 20:20, that's not 13-minutes, is it?

A. No.

Q. Okay. So, wouldn't it be more accurate to say that the second stage of labor, the period where the mom's cervix is fully dilated, wasn't 13-minutes, was it?

A. No.

Q. It's 43-minutes, correct?

A. Yes.

Q. All right. Now, when Mrs. Cervix (sic) was finally dilated, she began complaining of pain, correct?

A. Yes.

Q. All right. And do you recall that from the record?
A. There was a note.
Q. Sure. I'll be happy to---
A. A written note.
Q. I'll be happy to hand you that record and you can refer to it if you'd like so we don't -- so we're working off the same thing, ma'am.
A. This isn't what I was referring to. There's a delivery note.
Q. Well, you can look at 7:42 in the evening.
The nurse writes down patient complains of pain and cramping, correct?
A. Correct. She's not fully dilated yet.
Q. Well, ma'am, if you look at Exhibit 1, she's fully dilated at 19:32, correct?
A. Yes.
Q. And this note where she's complaining of pain is at 19:42, correct?
A. 19:42.
Q. So, this is ten minutes after she's fully dilated, correct?
A. Right. Yes.
Q. All right. So, the nursing staff, before they have her start pushing, they called the anesthesia team and they came to gave her -- to give her more pain medication,

correct?
A. Yes.
Q. And that was all appropriate care, wasn't it?
A. Yes.
Q. And then they took Mrs. Flowers catheter out, didn't they?
A. Yes.
Q. And that's important because, having the catheter in, can reduce the space that the baby has to come out of the birth canal, correct?
A. Yes.
Q. All right. And that was appropriate care, correct?
A. Yes.
Q. And so after they had taken care of Mrs. Flowers, her pain, and they had taken out the catheter, she started pushing at 7:55PM, correct?
A. Yes.
Q. All right. Now, not long after that, the baby's heart rate drops into the 90s and it had some attempt at a slow recovery, but with continued deceleration around 8:05PM, correct?
A. Yes.
Q. All right. And Doctor Giep has called and he arrived at Mrs. Flowers bedside at 8:11PM, correct?
A. Yes.

Q. Now, right before he got into the room, the nurses had turned off the Oxytocin that Mrs. Flowers was receiving because the baby's heart tones were down in the 90s, correct?

A. Yes.

Q. And that was good care, wasn't it?

A. Yes.

Q. And they had moved Mrs. Flowers onto her right side because they were afraid that the baby might be laying on the umbilical cord and that gravity was keeping that baby from getting the oxygen she needed, correct?

A. Gravity?

Q. They moved her onto her side so they could move the baby off of the umbilical cord if that was what was causing her heart rate to drop, right?

A. Actually, no. It increases the blood flow to the uterus.

Q. Okay.

A. That doesn't have anything to do with the cord.

Q. But all of that was because they were concerned the baby might not be getting enough oxygen at that point, correct?

A. That's the appropriate response to deceleration of the heart beat, yes.

Q. Very good.

And that's all good care, correct?
A. Yes.
Q. And they began giving Mrs. Flowers oxygen to try to get more oxygen to her, and, therefore, get more oxygen to the baby, correct?
A. Yes.
Q. And normal baby heart tones are usually between 110 and 160, correct?
A. Yes.
Q. And this baby's heart tones had been in the 130s, mostly the 140s, for most of the labor, hadn't they?
A. Yes.
Q. All right. So, a drop to 90 was something that attention needed to be paid to that, correct?
A. Yes.
Q. That was an unusual finding, right?
A. It's fairly typical of the second stage.
Q. But it's something that required action, correct?
A. Yes.
Q. All right. So, at this point, even before the shoulder dystocia occurs, there was some concern that from 8:05 to maybe 8:12 that the baby wasn't getting enough oxygen, correct?
A. I wouldn't agree with that.
Q. Well, there was at least enough concern to where

they had turned off the Pitocin. They had rolled her onto her side. They had given her oxygen.

They had done all of those things because they were concerned the baby wasn't getting enough oxygen, correct?

A. The appropriate response.

Q. Very good.

And, at that point, everything the medical staff was doing, during this second stage of labor, was appropriate, correct?

A. Yes.

Q. So, when Doctor Giep arrives, he's got the ability to then look at the fetal monitoring strip that you have there as Exhibit 3 and see what's been going on for the last say five or six minutes before he arrives, correct?

A. Correct.

Q. All right. And right after he arrives, at about 8:11PM, that heart rate starts to rebound at about 8:12PM, correct?

A. Yes.

Q. All right. And five minutes after he arrives, Doctor Giep orders them to restart the Oxytocin at 8:16PM, correct?

A. Yes.

Q. Now, that's appropriate, isn't it?

A. Yes.

Q. And Doctor Giep does an assessments of Mrs. Flowers and checks her cervical dilation, correct?
A. Yes.
Q. All right. And that's good care, correct?
A. Yes.
Q. He checks her pelvis, correct?
A. Yes.
Q. And that's good care?
A. Yes.
Q. And he was able to determine that the child was occiput anterior and that means that she's facing down, right?
A. Her head is facing down, yes.
Q. That's right.
And that would mean that her left shoulder would be anterior, which would be the one that's facing up, correct?
A. No, it wouldn't mean anything.
Q. Okay.
A. Occiput anterior, it wouldn't, no.
Q. But making that determination that the baby is occiput anterior, that's good care, correct?
A. Yes.
Q. And he was able to determine the baby was what he called a plus three station meaning Ashley Flowers head is all the way engaged in the mother's birth canal, correct?

A. Yes.
Q. And determining that is good care, correct?
A. Yes.
Q. All right. But then, again, we've got these previous decelerations and this previous heart rate in the 90s, and Doctor Giep didn't think he could get the baby delivered in a reasonable time.
So, he decided to use what's called a Kiwi vacuum to deliver the baby's head, correct?
A. Yes.
Q. And he's doing that because he's concerned that the baby won't have enough oxygen reserve to make it through a prolonged delivery, correct?
A. He didn't indicate one way or the other.
Q. Did you read his deposition, ma'am?
A. Yes.
Q. Okay. Do you remember, in his deposition, testifying that the reason he used the Kiwi was because he did not believe that he could deliver the baby in a reasonable amount of time without it?
A. He didn't think the mother could deliver it within a reasonable amount of time without a vacuum.
Q. Yes.
A. He did not say it was because he was concerned about a lack of oxygen.

Q. If it were not for a lack of oxygen, why would he be concerned that the mother would not be able to deliver the baby in 15 to 20-minutes?

A. He didn't say it was specifically 15 to 20-minutes, and one of the common indications for vacuum or forceps assisted delivery is to assist with maternal explosive effort, which is what he was describing.

Q. But he didn't say that the mom wasn't unable to -- was unable to push, did he?

A. He didn't say one way or the other, but he certainly didn't say he was concerned about fetal oxygenation.

Q. You don't recall that from his deposition?

A. No.

Q. Okay. Nevertheless, it was appropriate for Doctor Giep to use the Kiwi to assist in the delivery, correct?

A. Yeah, it was reasonable.

Q. All right. No criticisms for anything Doctor Giep did regarding the Kiwi, correct?

A. Nope.

Q. And -- now, using the Kiwi to get the baby's head out, Doctor Giep makes an incision that's called an episiotomy to give the baby more room to be fully delivered, correct?

A. Yes.

Q. And that's within the standard of care, correct?
A. Yes.
Q. And he also asked the nurse to call the NICU so there will be someone there to help with the baby should she be in distress when she's born, correct?
A. Yes.
Q. And that's good care, isn't it?
A. Yes.
Q. And this all happened before the shoulder dystocia occurred, correct?
A. Yes.
Q. And then, when he was able to deliver the head using the Kiwi, he bulbed the baby's nose and mouth and that's good care, isn't it?
A. Yes.
Q. All right. And he checked to make sure the baby's umbilical cord isn't wrapped around its neck because that's what may have been causing her decelerations a few minutes prior, correct?
A. No, you always check for the, the presence of umbilical cord because you don't want to deliver the body with the cord wrapped around the neck. You can damage the cord that way, and, and cause problems with the delivery. That's just routine.
Q. Do you remember Doctor Giep's testimony in this

case that he especially checked for a nuchal card, which means the umbilical cord wrapped around the baby's neck, in this case because the previous deceleration?

A. I don't recall that.

Q. Nevertheless, he's providing Mrs. Flowers and her baby excellent care here, correct?

A. He's providing reasonable care up to this point, yes.

Q. And when -- then, after the head was delivered, he asked the mom to push and used gentle downward traction to try and deliver the baby's body, correct?

A. That's what he testified to, yes. It's not in the record.

Q. All right. And asking the mom to push at that point, and using gentle downward traction is within the standard of care, correct?

A. Yes.

Q. But the baby's body doesn't deliver, does it?

A. That's correct.

Q. And when you have what we described earlier as the turtle sign, meaning the head is, is coming out, but then retracting slightly, kind of like when a turtle is scared and, to an extent, goes back into his or her shell, right?

A. Yes. Although the head does not go all the way back into the vagina.

Q. All right. And I think we described them earlier.
Now, if the doctor's paying close attention, this can be a sign of shoulder dystocia, correct?
A. That's correct.
Q. And Doctor Giep was paying close attention cause he saw this and diagnosed the shoulder dystocia, didn't he?
A. That's correct.
Q. And, in your opinion, some doctors don't diagnose the shoulder dystocia in this situation, and they just keep using traction until the baby's delivered, right?
A. That can happen.
Q. And that would be negligence, wouldn't it?
A. It depends on the circumstances.
Q. Well, if there's a shoulder dystocia and the doctor fails to diagnose it, fails to use any maneuvers, and just continues pulling on the baby until the baby's delivered, that would be negligence, right?
A. Usually, yes.
Q. Okay. And doctor -- but Doctor Giep didn't do that, did he?
A. No.
Q. No, he diagnosed it.
So, we have another -- yet another instance of Doctor Giep practicing the standard of care, correct?
A. Yes.

Q. All right. And a shoulder dystocia is not preventable in all cases, is it?
A. No, it's not.
Q. It's not predictable, is it?
A. No.
Q. And there's no doubt this is a medical emergency we have now, isn't it?
A. Yes.
Q. And a shoulder dystocia is not going to resolve itself, is it?
A. It can.
Q. Well, in this case, let's use this case, in this case, this shoulder dystocia is not going to resolve itself if Doctor Giep doesn't do something, is it?
A. It required maneuvers to get the baby delivered.
Q. Right.
It requires Doctor Giep to do something to release this shoulder, doesn't it?
A. Yes.
Q. All right. If Doctor Giep just stands there and does nothing, this baby is not going to deliver, is it?
A. That's correct.
Q. All right. And we will talk in a little bit about how long a shoulder dystocia can last before the baby starts having brain damage or die.

But, no doubt, for a shoulder dystocia, a baby can have a serious brain injury or can die as a result of a shoulder dystocia, correct?

A. It can.

Q. And that's -- and more likely than not, in this case with Ashley Flowers, if Doctor Giep doesn't do something when this shoulder dystocia occurs, the baby is going to die, isn't she?

A. I can't answer yes or no.

Q. If Doctor Giep does not do something in this case to relieve the shoulder dystocia, Ashley Rivers -- Ashley Flowers is going to have a brain injury, isn't she?

A. Again, can't answer that with reasonable certainty.

Q. Babies do die from shoulder dystocia, don't they?

A. They can.

Q. And that's because, when the head is delivered but the body is not yet delivered, the baby is not getting oxygen, correct?

A. It may not be getting oxygen.

Q. All right. And there's no doubt in this case, through the actions of Doctor Giep, that Ashley Flowers avoided brain damage and even death, didn't she?

A. Yes.

Q. I'm interested as to why you now can not give an opinion that, in this case, if Doctor Giep didn't do

something that Ashley Flowers would die.

A. Because all that was done was McRoberts and suprapubic pressure. He took -- which only takes a matter of seconds, and this was persisted for one to two minutes. In one place in the record it says one to two minutes. Another place it says approximately one minute.

More likely than not, over that period of time, the baby rotated to a position spontaneously that allowed it to eventually be delivered with the force that was used because the McRoberts and suprapubic pressure didn't resolve it earlier. So, that's the reason that if that had -- there had just been some care in the amount of traction that was used, just the passage of a minute to two minutes would of probably resolved the shoulder dystocia on its own. And so the risk of a life threatening situation wasn't there.

Q. Certainly Doctor Giep is taking care of this patient. Doctor Giep doesn't have evidence that, if he stands back and does nothing, the baby is gonna live and it's gonna resolve on its own, does he?

A. I didn't say he should stand back and do nothing. He is suppose to use no more than the amount of traction that you would need to use in a delivery that's not complicated by shoulder dystocia. He did not do that and he even testified, in, in his deposition, that he applied traction several times during the McRoberts and suprapubic

pressure instead of switching to other maneuvers to relieve the shoulder dystocia.

Q. Well, doctor, we're gonna talk about the other maneuvers that, that he says that he attempted in a minute. Let's go back to the shoulder dystocia.

Doctor Giep, once he diagnosed the shoulder dystocia, immediately began to employ maneuvers to un-lodge this shoulder from the mother's pubic bone, correct?

A. Yes.

Q. And that's good care, correct?

A. And it is provided that you maintain force and that is no more than that which he would use in a delivery that's not complicated by shoulder dystocia --

Q. All right. And---

A. -- which I don't believe he did in this case.

Q. Okay. We're gonna talk about the level of traction in a moment, but I want to get back to these things that Doctor Giep did right and that you are willing to admit that he did right.

He first instruction -- instructed the nurses to put the patient in the McRoberts position, which is her knees all the way up to sort of her shoulders, correct?

A. Yes.

Q. All right. And that's good care, correct?

A. Yes.

Q. All right. And we already talked about what the purpose of that is, to open up the birth canal, but he next instructed Nurse Natalie Phillips to perform suprapubic pressure, correct?

A. Yes.

Q. And you described that very well for us, how the nurse can then guide that shoulder underneath the pubic bone with that maneuver to try to unstick that shoulder, correct?

A. Yes.

Q. And Doctor Giep ordering Nurse Phillips to do that was good care, wasn't it?

A. Yes.

Q. And Nurse Phillips appropriately, appropriately applied that pressure in the correct spot, correct?

A. As best I can tell --

Q. All right.

A. -- as she documented it, yes.

Q. And all of that -- all of those actions were good care, correct?

A. Yes.

Q. All right. Now, at this point, while Mrs. Flowers is in McRoberts and Nurse Phillips is applying suprapubic pressure, that's when you have the single criticism of Doctor Giep's care, and you're saying that he was negligent and that he used 30 to 40-pounds of traction, and it's your

opinion that the standard of care only allows for up to 30-pounds of traction, correct?

A. Yes.

Q. All right. Now, so, your sole allegation of Doctor Giep, your sole allegation that he was negligent, was that he used as little as 5-pounds more traction during this maneuver than the standard of care allows, correct?

A. In combination with the direction in which he did it.

Q. Well, let's talk about that direction for a second, doctor, because you say that Doctor Giep used 45-degrees of downward traction, correct?

A. Had to have in order to stretch down to the level of C8 nerve root.

Q. But using 45-degrees of traction, if you -- no, excuse me.

Using 45-degree angle with your traction, if you're using, say, 30-pounds of force, is within the standard of care, isn't it?

A. No.

Q. Doctor, in this case, isn't it true that it wasn't the angle of his traction that was improper?

It was the angle combined with the amount of force?

A. Yes.

Q. All right. So, if he had used less force, the

45-degree angle, it's within the standard of care, correct?

A. No. But less likely to be injurious.

Q. Well, doctor, let's talk about -- you've reviewed the American College, the American College of Obstetrics and Gynecologist Neonatal Brachial Palsy Task Force report, correct?

A. Yes.

Q. Did your testimony that Doctor Giep applied, applied an angle of traction 45-degrees below the axis of the baby's spine?

A. Yes, that's how you can get a stretch injury all the way down to C8. It's the only way you can get a stretch injury down to C8.

Q. So, what pounds of force would it be acceptable to use that angle of traction?

A. It wouldn't be. That's below the standard of care. It's just less likely to have -- to cause a rupture or avulsion if it's less than 30-pounds. But the combination of lateral force, laterally applied force, in excess of 30-pounds is what caused this pattern of injury, what was necessary to cause that pattern of injury, and is below the standard of care.

Q. Now, doctor, if you could turn to Page 72 of your deposition in front of you, please, and turn to Line 12.

I asked you the question, I'm saying do you have an

opinion that Doctor Giep applied a further downward angle of traction beyond 45-degrees.

What was your answer?

A. I think it's about 45-degrees or so, yes.

Q. And I asked you so, in this case, it wasn't the angle of his traction that was improper. It was a angle coupled with the amount of force.

What was your answer?

A. Yes.

Q. Thank you.

A. Which is what I said here.

Q. Doctor, I understand or do you believe or do you not believe that Doctor Giep did a Rubin II maneuver as the final maneuver that he claims it took to relieve the shoulder dystocia?

A. I don't have an opinion one way or the other.

Q. Because whether or not he did that maneuver doesn't really matter for your opinion, does it?

A. No.

Q. But two or one and a half minutes is plenty of time to perform McRoberts with suprapubic pressure and move on to another maneuver, isn't it?

A. Yes.

Q. All right. And his description in his deposition of how he did the Rubin II maneuver is within the standard

of care, isn't it?

A. Again, provided that the traction that's applied at the same time or just after meets the standard of care, which I do not believe he met.

Q. When you're doing the Rubin maneuver or Rubin II maneuver, you're not applying traction, are you?

A. Yes, after you rotate the baby 30-degrees, you still apply traction to the head and neck.

Q. But after you've rotated the baby 30-degrees, the shoulder has been released, correct?

A. It may or may not have been released.

Q. But you understand that, in his deposition, he testified under oath that the Rubin II maneuver is what released the shoulder from behind the mother's pubic bone, correct?

A. Correct. And whether he did it or not, I believe the injury occurred during McRoberts and suprapubic press, and the application of traction during that time more likely than not.

Q. Very good.

And whether or not he wrote that he did or didn't do the Rubin II maneuver in his medical record wouldn't have had any outcome on this case or wouldn't of had any outcome on Ashley Flowers injury, would it?

A. Whether he wrote it?

Q. Yes.
A. No.
Q. And in this scenario, if he had used 30-pounds of traction instead of 35-pounds of traction, he would not have been negligent, correct?
A. Assuming it wasn't 45-degree lateral application, that would be correct, but then you wouldn't have an injury like this.
Q. So, in a nutshell, your opinion is, is that, between 8:18PM and 8:20PM, Doctor Giep used five more pounds of traction at 45-degrees that the standard of care allows, right?
A. That was at least what he did, yes.
Q. All right. And you understand that Doctor Giep strongly denies that he used any kind of scalp traction when delivering this baby, don't you?
A. I understand that.
Q. And has never -- he has never said otherwise, has he?
A. No, he hasn't.
Q. All right. Doctor, a baby that you delivered several years ago suffered from a permanent brachial plexus injury from a shoulder dystocia, didn't it?
A. Yes.
Q. Was that baby a boy or a girl?

A. I can't talk about that case.
Q. So, you can't tell me if that baby was a boy or a girl?
A. No.
Q. All right. But even though this baby, be it a boy or girl, had a permanent injury to his or her arm, you claimed you were not negligent in causing that injury.
Isn't that correct?
A. I can't talk about that case.
Q. You can answer the question as to whether you believe you were negligent or not.
So, you are not willing to say, even though that you have testified in the past extensively about that case, you're not willing to stay in front of this jury, and say whether or not you were negligent in the care of that child?
A. My willingness -- I am not allowed to talk about that.
Q. Well, why, why were you willing to talk about it in previously under oath, but you're not willing to talk about it now?
A. Now -- I was earlier.
Q. Who's not permitting you to talk about that case now?
A. I can't talk about that case.
Q. Well, this is gonna be heard in front of a judge,

and the judge is going to be able -- is going to either require you to answer these questions or not. So, part of that is going to be you explaining why you're not allowed to talk about that case now.

So, who is not allowing you to talk about that case?

A. I can not talk about that case.

Q. Why are you not allowed to talk about that case? What reasons?

A. I can't talk about it.

Q. Legal reasons?

A. I can't talk about it.

Q. Doctor, when you were testifying on direct examination, you stated that your opinions that Doctor Giep had breached the standard of care were based on your education, training, but, most importantly, your experience, correct?

A. Yes.

Q. And your experience with brachial plexus injuries, not only in your research, but also in your personal practice, went into formulating those opinions, correct?

A. For this particular case, no.

Q. So, your experience in delivering babies and how to respond to a shoulder dystocia had absolutely no role in the formulation of your opinions in this case?

A. No, I don't think that's a fair statement.

Q. So, your response to brachial plexus, I mean, excuse me, to shoulder dystocia events and, and your experience in 20 years as an obstetrician played a role in the, in the opinions that you have provided to this jury here today, correct?

A. Yes.

Q. And, doctor, you have experienced brachial plexus injuries in your patients in the past, correct?

A. Yes.

Q. All right. And one of those patients suffered from a permanent brachial plexus injury, correct?

A. I can't discuss that case.

Q. Doctor, isn't it true that you have testified under oath specifically in the past about this case?

A. Yes.

Q. All right. I'm gonna hand you a deposition from the case of Jackson v. Hankla that was pending in the State of Georgia in 2008. Hand you your transcript there.

Do you remember testifying as an expert in that case?

A. Not as I sit here today.

Q. I will ask you to turn to Page 28 of this deposition, and what I'd like for you to do is to read to yourself Page 28, Page 29, Page 30, and Page 31, and tell me when you've completed that.

A. Okay.

Q. And, in this deposition, you confirmed that you had delivered a baby in the past that had a permanent brachial plexus injury, correct?

A. I can't talk about that case.

Q. What I'm asking is this, this for the transcript of this you under oath says?

A. I understand the question. I can't answer it.

Q. Does this transcript state -- was this -- does this transcript contain sworn testimony by you that, in that delivery, you used suprapubic pressure, McRoberts, and a Rubin's maneuver, as well as a delivery of a Wood's Screw to deliver the posterior arm in that case?

A. I can't talk about that case.

Q. Does this transcript that you provided testimony under state that, despite the fact that this child had a permanent injury to her C5 and C6 nerve roots, you believed you complied with the standard of care?

A. I can't talk about that case.

Q. All right. Doctor, I'm gonna hand you a transcript from the case of Graves v. Robinson. It was pending in Clay County, Iowa and ask you to turn to Page 44. I'm gonna ask you to read Pages 44 and 45 of this transcript that was taken in 2010.

A. Okay.

Q. Doctor, you'd agree with me that your sworn

testimony in -- on May 12th, 2010, stated that you had delivered a child that had a permanent Erb's palsy as a result of a shoulder dystocia?

A. I can't talk about that case.

Q. Doctor, would you agree with me that this sworn testimony by you in 2010 states that you believe that, in that case, you did not deviate from the standard of care?

A. Same answer.

Q. Doctor, I'm gonna hand you one more transcript. This one is Perry v. Bronson Methodist Hospital taken September 8th, 2006, in Kalamazoo, Michigan.

Do you recall being an expert witness in this case?

A. Not as I sit here right now.

Q. I would ask you to turn to Page 99 of that transcript and please read Page 99, 100, and 101.

MR. HENSHAW: Do you have a copy of that, that deposition transcript please?

MR. WEATHERLY: Yes.

MR. HENSHAW: Thank you.

And the page number?

THE WITNESS: This page only -- this one only goes to Page 73.

MR. WEATHERLY: I'll hand you this.

MR. HENSHAW: Oh, okay. Do you have a copy for me please?

MR. WEATHERLY: That should -- it should be. I think you may have my good copy.

MR. HENSHAW: Oh, okay. Do you want this back?

MR. WEATHERLY: No, it's fine.

MR. HENSHAW: And what page was that?

THE WITNESS: This is a different deposition.

MR. WEATHERLY: Oh, excuse me. I'm sorry. Give me one moment please.

Charles, do you have Marsalik (phonetic)?

We've not yet discussed---

MR. HENSHAW: Yeah.

MR. WEATHERLY: Okay.

MR. HENSHAW: Yes, I do.

Q. Okay. Marsalik, doctor, I apologize.

This is a case pending in the State of Georgia, a deposition you gave March 9, 2011.

Do you recall being an expert witness in that case?

A. Not as I sit here right now.

Q. Then I'd ask you to read Pages 99, 100, and 101 please, and tell me when you're finished.

A. Okay.

Q. And, ma'am, this testimony, in 2011, states that you had a permanent brachial plexus injury in a patient you treated, correct?

A. I can't talk about that case.

Q. And that injury involved slow conduction of the nerves of C5 and C6, correct?

A. I can't talk about that case.

Q. And you testified, under oath in this transcript, it says this delivery lasted two minutes. You used McRoberts, suprapubic pressure, anterior Rubin, and Wood's screws in the delivery of the posterior arm to get the baby out, correct?

A. Again, same answer.

Q. All right. Let's talk about this case, ma'am.

You had your deposition taken on March 1st, 2016, in this case, correct?

A. Yes.

Q. And, in this case, could you please turn to Page 60?

A. (Witness complies.)

Q. I asked you the question, in this case, under oath, March 1st, 2016, you have had a permanent brachial plexus injury in a patient that you treated.

Is that fair?

What was your response?

A. I can't talk about that case.

Q. Ma'am, what was your response in the transcript?

A. I can't talk about that case.

Q. I asked you the question, and you would agree with

me that, in that real world scenario where you had a permanent brachial plexus injury, you applied somewhere between 20 to 25, maybe even 35-pounds of traction?

What was your response?

A. I can't talk about that case.

Q. And you are unwilling to tell this Court and this jury why you are unwilling to talk about that case, correct?

A. That's correct.

Q. All right. I will read your answer.

I asked you the question, on Page 60, Line 2, you have had a permanent brachial plexus injury in a patient you treated.

Is that fair?

Your response was yes.

Is there anything inaccurate about what I've just read?

A. I can't talk about that case.

Q Ma'am, on Line 5, I asked you, and you would agree with me, that in the real world scenario where you had a permanent brachial plexus injury, you applied somewhere between 20 to 25, maybe even 35-pounds, of traction?

Your response was yes.

Is there anything about what I just read of your under oath testimony only a year and a half ago incorrect?

A. Same answer.

Q. Doctor, I am confused because, in this transcript,

it states that, in the case where you had a permanent brachial plexus injury and you believe that you were not negligent, you applied "maybe even 35-pounds of traction" but, in this case, you claim that Doctor Giep applied 35-pounds of traction and was negligent.

A. The cases and the injuries and the management are different. I can't talk about the other case.

Q. But the level of traction that you estimate for both deliveries, one where you claim you weren't negligent and one where you claim Doctor Giep was negligent, are the exact same, are they not?

A. No.

Q. Thirty-five is not 35?

A. I'm -- I did not say that 35-pounds solely was the deviation from the standard of care. The direction, the maneuvers that were used are different. The, the circumstances are different. I'm limited in what I can tell you to explain the difference.

Q. Doctor, you just told us, a few minutes ago, that the angle of Doctor Giep's traction would of been appropriate if he had used less force, and you said the fact that he used 35-pounds of traction was what was negligent about this case and we have a case here---

A. That is not what I said.

Q. Well, we'll let the jury decide for themselves what

you said and what you didn't say.

So, is what you're telling me is that 35-pounds of traction, in a delivery that only lasts or a head to body interval in a shoulder dystocia that only lasts a minute and a half to two minutes, is acceptable?

A. No, the combination of force and direction and actually the rate at which and the number of times it's repeated are what -- are causative of an injury and whether or not they are within the standard of care or outside the standard of care. I can not give you a comparison cause I am limited in being able to compare it to another case, but that is not what I said about this case. The combination of laterally applied force in excess of 35-pounds.

Q. Now, doctor, all this estimation of pounds of traction both in your delivery, Doctor Giep's delivery, that's inexact because doctors aren't wearing gauges that tell them how much traction they're using during delivery, are they?

A. That's correct.

Q. And they're not---

A. But you can infer them from the nature and extent of the injury.

Q. But while they're actually delivering the baby, they have no monitor, no gauge, no measuring device that tells them the pounds of traction they're using, correct?

A. That's correct.
Q. And there is no device that shows them the angle of, of traction that they are applying, is there?
A. That's correct.
Q. All right. You're just going by feel, aren't you?
A. Yes.
Q. When you had any of your previous deliveries where there were any brachial plexus injuries, permanent or temporary, you're not wearing any sort of monitor that gauges you the amount of traction or the degree, were you?
A. That's correct.
Q. All right. And Doctor Giep's probably never been measured with the amount of traction he uses in deliveries, has he?
A. I wouldn't know one way or the other.
Q. Most doctors have not, have they?
A. That's correct.
Q. And these things are not the things that you and your husband use, they're not able for commercial use, are they?
A. No.
Q. And you admit that doctors actually apply greater force as the dystocia continues and this is sort of an unconscious phenomenon, correct?
A. Yes, that's why the standard of care requires you

to consciously limit the amount of force that's used to no more than what is used in a delivery that's not complicated by shoulder dystocia.

Q. And you say that's 30-pounds and Doctor Giep used 35-pounds, correct?

A. Yes.

Q. All right. But neither you or your husband have ever measured the traction that a doctor is applying in a delivery where a child had a permanent brachial plexus injury, have you?

A. That's correct.

Q. You don't have a single real life data point on this issue, do you?

A. Correct.

Q. And you're aware that, from 1995 until 19 or 2008 when Ashley Flowers was born and even since then, Doctor Giep's never had another brachial plexus injury in his career, has he?

A. Not that I'm aware of.

Q. And you're aware that he testified that he used the same traction in this case that he's used in every other shoulder dystocia he's ever had, right?

A. I'm aware.

Q. And you've never measured the traction that he applies in shoulder dystocia cases or any other delivery,

correct?

A. Correct.

Q. And certainly, under you and your husband's therapy, if he was applying 35-pounds of force during every shoulder dystocia, he would of injured every single baby, right?

A. No.

Q. Or if he was -- let me, let me rephrase that.

If he was applying 35-pounds of force at a 45-degree angle with every baby he delivered, every single one of them would be injured, wouldn't they?

A. More likely than not.

Q. But he hasn't had any, has he?

A. It's unlikely that, in those cases, he reached the level of force that is required to get the type of injury that the Flowers baby sustained.

Q. So, do you think that he is lying that he used the same traction, used the same angle in this delivery that he has in every other shoulder dystocia or do you think that this was something that unconsciously happened during the delivery and he doesn't recall it?

A. I think he's underestimating it.

Q. What you're doing, doctor, and correct me if I'm wrong, is you're simply using Ashley Flowers injury and then inferring the amount of traction that Doctor Giep used in

the delivery, correct?
A. Yes, to determine the cause of it, yes.
Q. And to determine the amount of traction you believe he applied, correct?
A. Correct.
Q. All right. And determine the angle you believe he applied, correct?
A. Yes.
Q. There's nothing that Doctor Giep could of written in his note that would change your opinion that he used 35-pounds of traction at a 45-degree angle, is there?
A. That's correct.
Q. In fact, in his note, he wrote minimum traction performed, didn't he?
A. Yes.
Q. And the next day he wrote a note that said gentle traction applied, didn't he?
A. Yes.
Q. And you ignore those in your opinion, don't you? You don't factor them into your opinion at all, do you?
A. I do. I believe he underestimated them as most obstetricians.
Q. And when he wrote these notes, there was no sort of lawsuit pending, was there?
A. There was an injury evident.

Q. Well, but that injury evident, most of these injuries and nine of the ten injuries that you've had resolve on their own, don't they?

A. I didn't have ten injuries.

Q. You've had nine temporary injuries and one permanent, correct?

A. I'm trying to recall. I don't believe there were that many, no.

Q. Do you recall, in one of the depositions that I just showed you, what you said under oath in there was that you had had ten injuries, nine were temporary, one was permanent, from just five minutes ago?

A. I don't remember which one.

Q. But temporary -- most shoulder dystocia and brachial plexus injuries are temporary and they resolve on their own, don't they?

A. They do.

Q. And there's no way to know, in the first few days in the hospital, whether an injury is gonna be temporary or permanent, is there?

A. No.

Q. And if an injury is temporary, there's not going to be a lawsuit, is there?

A. I would doubt it.

Q. All right. So, when Doctor Giep's writing this

note, he has no idea that he's gonna be sitting in a courtroom in Spartanburg, South Carolina in October of 2017 at nine years later, does he?

A. I can't answer that question.

Q. But his note doesn't matter to your opinion, does it?

A. I think he underestimated his traction.

Q. There's nothing that Doctor Giep could say in his deposition that would change your opinion that he used 35-pounds of traction, is there?

A. That's correct.

Q. And there's nothing that the nursing staff could say in their testimony that could change your opinion, is there?

A. That's correct.

Q. So, just so the jury understands, there's exactly one thing that you've used to determine that Doctor Giep was negligent?

A. No.

Q. And that is the---

A. To determine the cause --.

Q. There is only one thing that you've used to determine what you believe is the cause of Ashley Flowers injury, correct?

A. Yeah.

Q. And that's the injury itself, correct?
A. Yes.
Q. And there's only one thing essentially that you've used to determine that Doctor Giep used more traction than was necessary and that was the length of the time the shoulder dystocia existed, correct?
A. Yes.
Q. All right. Now, you had said earlier that you thought Ashley Flowers clavicle was fractured during the delivery, and then you learned that it was actually fractured during her brachial plexus surgery, right?
A. Yes.
Q. Now -- but you said you did read Doctor Armenta, the surgeon's deposition, correct?
A. A long time ago, yes.
Q. All right. Well, in your expert opinion, did you consider his testimony that 70 to 80-percent of his patients that have injuries like Ashley Flowers don't end up needing surgery and retain full function?
A. I, I don't recall reading it. I don't have any reason to, to dispute --
Q. Okay.
A. -- a statement like that.
Q. Did you consider his testimony that many injuries that injure the entire nerve, which means the sheath and the

axion, repair themselves?

A. Yeah, that's true.

Q. And did you consider the surgeon's testimony that Ashley Flowers nerves did not repair themselves because she grew a neuroma that prevented that from happening?

A. Yes, I considered all of that in, in determining the nature and extent of the injury.

Q. And Ashley Flowers was making progress in recovering after she left the hospital, was she not?

A. Yes.

Q. All right. So, other than Ashley's eventual condition at six months when she had surgery, there's really nothing else different between her injury and one that -- and the one that recovers?

A. I, I don't know.

Q. Okay. All right. Let's talk about some literature for a moment.

Okay. The husband -- the research that you and your husband do, a lot of it involves you putting these sensors on testing doctors to see how hard they grip when they're delivering babies, correct?

A. I wouldn't say a lot of it. That was like two or three --

Q. Okay.

A. -- of our experiments.

Q. And you try to correlate that into how much traction is being applied, correct?

A. Yes, it was a calibration.

Q. And you've never measured a doctor in a case where a permanent brachial plexus injuries like this one has occurred, right?

A. That's correct.

Q. All right. And, and these devices are not worn in the field, that are not made available to the public, right?

A. That's correct.

Q. And you don't wear them when you're delivering babies, correct?

A. No.

Q. And in all of your testing, you've only measured, I think, doctors three times responding to a shoulder dystocia.

Is that accurate?

A. Yes.

Q. Okay. And, in one of those cases, Doctor Gonik used 22-pounds of traction?

A. I didn't -- I wasn't involved in that.

Q. That was your husband's study with Doctor Gonik, right?

A. Yes.

Q. And you've read that study, correct?

A. I have.
Q. You're familiar with it, right?
A. I am.
Q. And I think you cited it as a basis of part of your opinion, correct, in this 79 or so articles that you sent us a few days ago, the list had them?
A. Yes.
Q. All right. And, in that case, Doctor Gonik used 22-pounds of traction with one baby, and that baby had a temporary brachial plexus injury, and he used 22-pounds of traction with another baby and that baby had no injury, right?
A. Yes.
Q. And in another case, you let a resident get -- that had these gloves on get all the way up to 25-pounds of force before you stepped in, correct?
A. Yes.
Q. And that baby had no injury, right?
A. Yes.
Q. And this is because they're anatomical differences between babies, right?
A. In the Gonik paper, there was a difference in the rate of force, about three times as forceful, in the baby that was temporarily injured. In the case where I took over 25-pounds of force, it was clear that there was an issue in

terms of the baby delivering safely. And so I took over.

Q. Doctor, I appreciate those answers.

My question was, there are anatomical differences between babies, correct?

A. There are, but they're not explanations of the cases you've just described.

Q. What may injure one baby might not injure another one, correct?

A. Yes, within a range.

Q. So, the amount of force that might create a permanent injury, the one you had in one baby, might not create any injury at all in another baby, correct?

A. I can't talk about the case I had.

Q. Let me ask that in a, in a form that you are willing to answer.

An injury that creates a mild permanent injury in one baby might not even create any injury at all in another baby, correct?

A. That would be unlikely.

Q. But possible?

A. It's possible.

Q. Doctor, let's get back to the point about why shoulder dystocias are so dangerous, and it's because the baby likely isn't getting oxygen when her head is delivered, but her body is stuck due to the impaction of the shoulder,

correct?

A. There is likely a decrease in the blood flow through the umbilical cord, yeah.

Q. And so the oxygen, oxygenation to the baby and the cord Ph decreases to some degree during the shoulder dystocia, correct?

A. Yes.

Q. Now, some researches believe you have approximately four minutes before you risk serious brain injury, but you think it's closer to six or eight minutes, correct?

A. Yes.

Q. All right. And are you aware of two studies, one done by Hope in the UK, and the other done by Ling in China that is documented fetal death in cases of shoulder dystocia before five minutes?

A. Yes.

Q. Now, it's rare, but it does happen, correct?

A. Yes.

Q. And so a clinician doesn't know whether that case that they have -- that baby that they're delivering at that moment is going to be the rare case that dies in three minutes or four minutes or if it's one that can last six or eight minutes, do they?

A. They can't know that prospectively, no.

Q. And, doctor, even you would admit that this -- a

central nervous system injury, an asphyxia, that danger starts at about four minutes, right?

A. Yes.

Q. All right. And -- because, to some extent, as soon as the shoulder dystocia occurs, the baby starts declining, right, to some extent?

A. The standard of care requires protecting the baby from any injury, either to the limb or to the central nervous system, during a shoulder dystocia. They -- priorities shift at around four minutes because, in the first four minutes, the risk of asphyxia is low while the risk of injury to the brachial plexus with improper, improperly performed delivery techniques, most specifically traction if it's lateral and forceful, increases the risk of brachial plexus injury.

Q. Doctor, I appreciate all that, but that was not my question.

My question was, during a shoulder dystocia, the baby's condition is declining to some degree, correct?

A. It is.

Q. And with Ashley Flowers, she already had reduced oxygenation from between 8:05PM to 8:11PM, correct?

A. No, we don't not -- we do not know that.

Q. So, is it your opinion that, more likely than not, that when her fetal heart rate declined at 8:05 and was in

the 90s and there was a deceleration, that that was not evidence of reduced oxygenation?

A. Instantaneously, yes, but not continuous and not into the shoulder dystocia.

Q. My question though, doctor, is from 8:05 to 8:11, she had reduced oxygenation, correct, more likely than not?

A. I disagree.

Q. We don't know what was going on between 8:14 and 8:18 because we don't have a good tracing, do we?

A. Correct.

Q. And that's through no fault of Doctor Giep or any of the nurses, is it?

A. I guess I don't have an opinion on that.

Q. All right. So -- but, doctor, wouldn't you admit that there's a sense of urgency to deliver Ashley because, even before the shoulder dystocia, there was at least a concern by the doctor and the nurses that she wasn't getting sufficient oxygen?

A. No, I disagree with that.

Q. So, you---

A. -- like we discussed earlier.

Q. So, you disagree with the nurse's testimony and Doctor Giep's testimony that they were concerned about her oxygenation between 8:05 and 8:11?

A. I did not see them say that. He was concerned that

she wouldn't deliver on her own in a timely fashion. That, to me, is an, a -- assistance with maternal explosive efforts. There's a reason for doing the vacuum.

Q. Well, doctor, let's move forward then.

We know that, when she was born, she had reduced oxygenation levels, don't we?

A. No, she didn't.

Q. Well, doctor, she was born blue, was she not?

A. Most babies are.

Q. She was born blue at one minute and she was still blue at five minutes, was she not?

A. Her Apgars were five and seven. Those are the -- the one minute Apgar is not indicative of oxygenation. It's indicative of a need for some stimulation to encourage the baby to take breaths and Apgars of seven or more, which she had at five minutes, are normal.

Q. Doctor, let me hand you Defendant's Exhibit 6 so you can have the record actually in front of you.

Ashley Flowers color, at one minute, was registered as a zero out of two, was it not?

A. Yes.

Q. And, at five minutes, her color was registered at zero out of two, correct?

A. I don't have the Apgar scores --.

Q. And you can look at Defendant's Exhibit 1 if you'd

like to see that as well.

A. Yes.

Q. All right. And that is indicative of low oxygen content, correct?

A. No.

Q. Doctor, I'd ask you to turn to Page 31 of your deposition, please. Turn to Line 2 once you get there. Tell me when you're there.

I asked you the question, when you were under oath, said can we agree the first minute of life she was blue?

What was your response?

A. Yes.

Q. And I said can we agree still in the fifth minute of life she was blue.

What was your response?

A. Peripherally. Not centrally.

Q. All right. Can you then move to Line 18 please?

I asked you okay. What is blue indicative of?

Nothing?

What was your response?

A. To Line 18?

Q. Line 20. My question is on Line 18 and 19.

What is blue indicative of?

Nothing?

What was your response on Line 20?

A. Okay. I don't see where you're -- on the same page, on Page 31?

Q. Excuse me. Page 33.

On Line 18 on Page 33, I asked you what is blue indicative of?

Nothing?

What was your response then under oath?

A. Low oxygen content. Not lack of oxygen.

Q. So, I just asked you the question is Ashley Flowers being blue at five minutes indicative of low oxygen content. You said yes. In your deposition a year ago you said that's what blue is indicative of.

So, which one is it?

A It's indicative of low oxygen content. It's not---

Q Thank you.

A ---indicative of a lack of oxygen.

Q. These Apgar scores that we're talking about in Exhibit 6, these determine the condition of the baby in the first minute and the first five minutes of life, correct?

A. Yes.

Q. And they're done by doctor -- they're not done by Doctor Giep, correct?

A. That's correct.

Q. They're done by the NICU nurse. In this case, Amber Dowlis, correct?

A. Yes.
Q. And they're reported very clearly there on Exhibit 6, aren't they?
A. Yes.
Q. And at one and five minutes, Ashley Flowers had what's called low tone, correct?
A. Yes.
Q. And at one minute, it was a one, and, at five minutes, it was also a one, correct?
A. Yes.
Q. And what does that mean to you?
A. It's a part of a normal pattern with an Apgar of seven total.
Q. Now, at, at one, it means that she does not have full active motion. She has some flexion extension, but she's not completely flaccid, correct?
A zero indicates flaccid, correct?
The body -- the baby is limp, right?
A. Yes.
Q. And a two score means that the baby has active, full motion, correct?
A. For tone or movement?
Q. For tone.
A. Tone just means exactly that. It means the degree of which you, I guess, resist motion or have -- demonstrate

muscle contraction.

Q. Doctor?

A. One of her arms was injured.

Q. Doctor, look at Exhibit 1 for me please.

A. Exhibit 1?

Q. It's probably under the Task Force report you have there.

A. Okay.

Q. And there's a scale on Exhibit 1 for Apgar scores, correct?

A. Yes.

Q. And muscle tone, under zero, it says flaccid, correct?

A. Yes.

Q. And under one, it's says some flexion/extension, correct?

A. Yes.

Q. And two, it says active motion, correct?

A. Yeah.

Q. And so she got a one at one minute, and a one at five minutes meaning, at both of those stages, she had some flexion and extension, correct?

A. Yes.

Q. And that is more evidence of respiratory depression, correct?

A. No.
Q. Doctor, could you please turn to Page 35 of your deposition. Excuse me. Turn to Page 34 please.
I asked you the question, Ashley's muscle tone is one minute---
Q. I'm sorry.
Where are you reading?
Q. Page 34. Line 18.
A. Okay.
Q. Ashley's muscle tone at one minute and muscle tone at five minutes, how do you qualify that?
Your response was what?
A. It was a one.
Q. Very -- and I said okay. What does that mean to you?
What was your response?
A. There's some tone, but it's not normal tone.
Q. And then I asked the question, you just told me that her one and one minute -- one at five minutes was not indicative of respiratory depression, but when I asked you this a year ago, I said what is that normal tone indicative of, in your opinion?
What was your response?
A. Again, respiratory depression.
Q. So, is it evidence of respiratory depression like

you said a year ago or is it not like you're saying here today?

Which one is it?

A. Well, the question that's written, I obviously didn't hear it correctly because you said what is normal tone indicative of, and it would certainly not be indicative of respiratory depression. So, I was likely unclear on what you were asking me.

Q. Doctor, how many depositions have you done in your career?

A. I don't know.

Q. Hundreds?

A. Probably less than a hundred.

Q. Probably close to less than a hundred.

At the end of a deposition, you have the ability to request what's called errata sheet, do you not?

A. I do.

Q. Did you in this case?

A. I don't remember.

Q. And in an errata sheet, you're able to review the transcript and correct any errors, are you not?

A. I am.

Q. And, in this case, you did not correct any errors whatsoever, did you?

A. Not, not after I gave this deposition, no. But as

I made this here, it's clearly not a correct answer to that question as transcribed.

Q. Doctor, Ashley Flowers breathing and her reflexes were also not fully normal at one minute, were they?

A. At one minute?

Q. The one minute.

A. No.

Q. All right. Would you agree or disagree that, even though Doctor Giep delivered Ashley Flowers after one to two minute shoulder dystocia, she was born in some distress?

Would you agree with that?

A. Yes.

Q. And you don't think Doctor Giep, during this delivery, was using no care or acting recklessly, do you?

A. No, I do not.

Q. Okay. Let's first talk about the ACOG report.

You're a member of ACOG, right?

A. I am.

Q. All right. It's a well respected organization, isn't it?

A. Yes.

Q. How many doctors went into drafting that report? Do you know?

I count 12.

A. Well, I was gonna say 12.

Q. Okay. Twelve.
And those are all well respected researchers, aren't they?
A. Yes.
Q. And I think there's a biomechanical engineer, a pediatrician, and a neurosurgeon, and several rehabilitation physicians that went into drafting that report, correct?
A. Yes.
Q. And there are a number of professional organizations ranging from other OB-GYN organizations to pediatrics to pediatric neurologists and even in other countries that have endorsed that publication, correct?
A. Yes.
Q. And you've read that entire report, correct?
A. I have.
Q. And it's not fraudulent, is it?
A. No.
Q. It's not false, is it?
A. No.
Q. And none of the researchers there purposefully publishing any inaccurate, false, or fraudulent information, are they?
A. No.
Q. And you've not written to ACOG to criticize any of that report, have you?

A. I haven't.
Q. Okay. And that's, that's something that people do, don't they?
If they see literature, for instance, in your past, you've seen literature that you disagree with, and so you've written in to publications to criticize it, correct?
A. On two occasions.
Q. All right. But you didn't do that with this publication, correct?
A. No.
Q. All right. You said that you don't think that that publication agrees with any of your opinion, but one of the things the publications says is, because of the nonlinear behavior of tissues, such as nerve tissue, an estimate of the force needed to cause a nerve rupture can not be directly established, right?
A. Yes.
Q. And you don't think that statement contradicts the opinions you've given here today?
A. No.
Q. Okay.
A. I've actually said that you can't measure it directly.
Q. Let me give you another one.
You don't believe that a child can have a permanent

injury to a posterior shoulder without physician traction being a factor, correct?

A. Yes.

Q. You claim it's never been reported, right?

A. Correct.

Q. And that's important.

This isn't a posterior or shoulder injury case, this is an anterior shoulder case, but that's important because if the---

A. I'm sorry. I don't -- I'm not following what you just said.

Q. I just said that this case, Ashley Flowers case, is not a posterior shoulder case.

It's an anterior shoulder case more likely than not, right?

A. More likely than not, but I don't know.

Q. But posterior shoulder research is important because, if the posterior shoulder, being the bottom shoulder, can be permanently injured before the doctor can even reach the head to apply traction, those injuries would have a cause other than physician traction, wouldn't they?

A. No, you can't have a permanent injury that occurs before the doctor can reach the, the baby's head.

Q. Doctor, would you turn to Page 28 of this Task Force report and you've read this, right?

A. Yes.

Q. That area right under the bullet points, and tell me, isn't that exactly what that discusses, the fact that a posterior shoulder injury occurs before the doctor can apply traction?

It seems to indicate that those injuries are the cause other than physician traction.

Isn't that what that describes?

A. No, that's not how I read that.

Q. Okay.

A. During a posterior shoulder impaction, it's not talking about an injury, at the level of a sacral promontory, it's not possible for the clinician to apply, by extraction forces, that are often put forth as a cause of injury because the head has not delivered, but that's not when the injury occurred.

Q. So, you don't take that as meaning that the fact that there are posterior or shoulder injuries that are caused by that mechanism, before the physician can reach the head, is indicative there may be cause for brachial plexus injuries other than physician traction?

You don't take that meaning that?

A. Not permanent ones. No, that you're mixing up a whole bunch of different things. I don't --.

Q. Do you---

A. I don't disagree with this statement, but it is, it is vague at best. The cause of a permanent injury would not occur before the head delivers.

Q. You're aware---

A. And it doesn't talk about permanent versus temporary, and it actually doesn't talk about what's put forth as a cause of what kind of injury.

Q. Doctor, you're aware of medical research that exists that supports the position that persistent or permanent brachial plexus injuries can occur without shoulder dystocia, right?

A. Yes, they can.

Q. And you're aware of research that says that, correct?

A. Yes.

Q. And you're -- and there's research that exists that says that a mom's pushing can produce 30 to 40-pounds of force pushing the baby down the birth canal, correct?

A. It can, but it doesn't deviate the head more than 45-degrees from off axis.

Q. And there are studies, doctor, that conclude that permanent brachial plexus injuries can occur even when there is no shoulder dystocia, right?

A. We just said that, yes.

Q. Okay. And defendant's expert, Doctor Chauhan, has

written several of the articles, has he not?

A. He has.

Q. Are you familiar with those articles?

A. Yes.

Q. Now, this idea that a permanent brachial plexus injury can occur, even when there is no shoulder dystocia, even came up among your studies, did it not?

A. That's correct.

Q. And, in that study, you found that 90-percent of cases of permanent injury involved a shoulder dystocia, that ten percent of them, and I think that was just one single case, happened in the absence of documented shoulder dystocia, right?

A. That's correct.

Q. Okay. And so your explanation for that was that there was a shoulder dystocia that was not documented, correct?

A. Correct.

Q. But you never went to the doctor and asked them whether there was a shoulder dystocia that he failed to document, did you?

A. No.

Q. Tell me if my statement is accurate, that the position of the Task Force report and the doctors that -- and, and the writing that's in there, is that physician

traction absolutely can be one of the causes for injuries like Ashley Flowers, right?

A. Yes.

Q. They also write that injuries like Ashley Flowers can be caused by a combination of gentle traction and the maternal forces of labor?

A. Not like Ashley Flowers. They don't say that anywhere.

Q. You don't believe that that publication says that?

A. No.

Q. Okay. Would the authors of that publication know better than you as to what that says?

A. I would assume so but it's not -- I would challenge you to find it.

Q. Would you agree then, at the very least, that permanent brachial plexus injuries can be caused by a combination of maternal forces of labor and gentle traction?

A. I wouldn't call it gentle.

Q. Ordinary traction.

A. Permanent, permanent, but it would be mild.

Q. Okay. Do you agree that the, that Task Force report says that permanent brachial plexus injuries can be caused simply with the maternal forces of labor in the absence of physician traction?

A. I would need to see what the sentence was.

Q. You don't recall whether that Task Force report---
A. I don't think that---
Q. ---says that or not?
A. No, I don't think it says that about permanent injury.
Q. Doctor, you would agree with me that you and your husband's expert witness business depends a lot on there not being 100 percent absolute proof that permanent brachial plexus injuries like Ashley Flowers can be caused without physicians using stout traction?
A. I, I don't agree.
Q. So, if there was a videotaped delivery showing that there was absolutely no traction applied to a baby's head, and that baby developed a permanent brachial plexus injury like Ashley Flowers, that would you -- have no affect on 50-percent of your income and 30-percent of his income?
A. I, I don't -- no, it wouldn't.
Q. You think you would still be able to testify in cases filed just like this?
A. I think I would have to review each case for its specific circumstances and resultant outcome.
Q. Doctor, if there was a case of a permanent brachial plexus injury that involved a rupture, and there was a definitive video of that birth showing that the doctor applied absolutely no traction at all, would you then change

your opinion?

A. I would have to see the video.

Q. And a video like that would be incredibly rare to exist, wouldn't it?

A. I would think so.

Q. And, in fact, with temporary injuries, there's only been one video like that that exists today, right?

A. I don't know.

Q. Well, you wrote a paper on it, didn't you?

A. I did.

Q. You wrote a paper and, in that case, there was some speculation that temporary injuries could occur in the absence of physician traction, but there was no definitive proof yet, right?

A. Well, I mean the proof was in that video.

Q. I'm talking about before the video, doctor.

A. I, I don't understand the question then.

Q. There was some indirect research that, that insinuated that temporary injuries could exist in the absence of physician traction, but there was no definitive proof, was there?

A. Correct.

Q. But with this one in a million video where the mom said I don't want any traction applied during my birth, and a definitive video showing, proving, without a doubt, there

was no traction used in the delivery, now everyone accepts that temporary injuries can occur in the absence of physician traction, correct?

A. Correct.

Q. But we don't yet have a video like that for permanent injuries like Ashley Flowers, do we?

A. No.

Q. All right. Doctor, let's wrap this up.

This entire idea that only nerves that have stretched 50-percent will rupture, that's what is the basis behind your opinion that Doctor Giep applied 35-pounds of traction at a 45-degree angle, correct?

A. No.

Q. Well, doctor, it's your belief that nerves that are stretched to 50-degrees will always rupture or greater than 50-degrees will always rupture, isn't it?

A. 50-degrees?

Q. I mean 50-percent. Excuse me.

A. No.

Q. It is not your opinion that a brachial plexus nerve that is stretched, stretched in excess of 50-percent at a, at a 45-degree angle I guess will always rupture?

That's not your opinion?

A. No.

Q. Is it your opinion that Ashley Flowers nerves

stretched more than 50-percent and that's why they ruptured?

A. Yes.

Q. And is it your opinion that nerves, brachial plexus nerves like Ashley Flowers, don't always rupture at a greater than 50-percent stretch?

A. I'm sorry. Say that again.

Q. Sure.

Is it your opinion that Ashley -- that, that brachial plexus nerves at C5, C6, C7 can stretch greater than 50-percent without rupturing?

A. They can.

Q. They can?

A. Sure. They have to stretch at least 50-percent in order to rupture.

Q. But if they can rupture at a much less stretch, that means it would cause -- take much less force to rupture them, correct?

A. No.

Q. Well, we'll get to that in just a second. Let's go back to this.

So, is it your opinion that Ashley Flowers nerves must have stretched more than 50-percent to rupture?

A. More likely than not, yes.

Q. Now, when you deliver the baby that had the permanent brachial plexus injury, you believe that that

baby's nerves stretched only 50-percent, correct?
Correct?
A. I can't talk about that case.
Q. I'd ask you to turn to Page 82 of your deposition, please.
A. Sorry. Eighty --?
Q. 82?
A. 82.
Q. Line 10 please.
I asked you the question, and your injury that was a permanent injury but was not a rupture, did that require 50-percent stretch?
Your response was yes.
Did I read that accurately?
MR. HENSHAW: What line is that please?
MR. WEATHERLY: Line 10 to 13.
MR. HENSHAW: Of Page 82?
MR. WEATHERLY: Yes.
A. I can't talk about that case.
Q. Did I read that accurately?
A. I can't talk about that case.
Q. So, the difference between a permanent injury that was not a rupture and a rupture can be as little as the difference in 50-percent and just greater than 50-percent.
Is that accurate?

A. No.
Q. Well, I'm confused because your case, where you claim you were not negligent, had a 50-percent stretch and Doctor Giep's case where he is negligent just had a "more than 50-percent stretch."
That's the only difference, isn't it?
A. We're talking about what's a minimum, and you're making it sound like a maximum.
Q. Well, doctor, there are---
A. So, I don't agree with you.
Q. You have no idea how much more than 50-percent Ashley Flowers nerves stretched, do you?
A. No, all I know is that it had to be at least 50-percent.
Q. Because, at 50-percent, it breaks, right?
A. Yes.
Q. And so if it's only 50-percent, apparently it doesn't break, but if it's greater than 50-percent it breaks?
A. No. No, this is sort of rudimentary rules of logic. Just because a -- one sentence -- just because A follows B doesn't mean B follows A.
Q. Well, doctor, your testimony---
A. If what we have is a nonconducting nerve, in stretched nerve injury, for that to happen, it had to have

been at least stretched beyond 50-percent of its original length. That's all I can say about that.

Q. But, in your case---

A. We start with the basis that there is a rupture.

Q. But in your case, where there was a 50-percent stretch, you were not negligent, correct?

A. I can't talk about that case.

Q. Now, you determined that Ashley Flowers brachial plexus nerve stretched greater than 50-percent simply by looking at the operative report from the procedure done by the plastic surgeon in Texas, correct?

A. Yes.

Q. There's nothing measured during her birth that led you to that conclusion, correct?

A. Correct.

Q. Nothing in her -- in Ashley Flowers records at the hospital that led you to that conclusion, correct?

A. That's correct.

Q. Nothing in the witness testimony that leads you to that conclusion, correct?

A. That's correct.

Q. Nothing in the birth record that leads you to that conclusion, correct?

A. Correct.

Q. Nothing in the nurses' deposition that leads you to

that conclusion, correct?

A. Correct.

Q. And, in your opinion, if there had been some nerve function in Ashley Flowers, C5, C6, and C7 nerves, Doctor Giep wouldn't have been negligent in this case, correct?

A. I'm not sure I can answer to that yes or no.

Q. Doctor, please turn to Page 69 of your deposition, please.

I asked you the question in the deposition, everything in this case -- starting with Line 1. Everything in this case being exactly the same, except when you receive the operative or when you received an EMG from Doctor Armenta, and it says that a surgery was not necessary, that the, that this was some nerve function in C5, some nerve function in C6, some nerve function in C7. There was a residual deficit but surgery was not required and it did not indicate a full rupture. You asked me, and all the maneuvers and the amount of time and all that, and I told you all the same.

What was your answer?

A. That he could have met the standard of care.

Q. Thank you.

Doctor, you don't know the failure rate of a healthy baby's nerve, do you?

A. No.

Q. And what, what might rupture one baby's nerves

might not rupture another baby's nerves, correct?
A. That's correct.
Q. Even in the same baby, some nerves might be uninjured while other nerves are injured, correct?
A. Yes.
Q. There is no literature that tells you exactly how much force it takes to rupture a brachial plexus nerve, is there?
A. No.
Q. And none of your data comes from direct observation of live babies, does it?
A. No.
Q. It all comes from cadavers or animals or biomechanical models, correct?
A. Yes.
Q. And the other researchers have---
A. The same would be true with the other researchers.
Q. Sure, and that's what I was gonna say, doctor.
To be fair, all the other researchers have used this indirect evidence and come up with a conclusion that it takes far less stretch to injure a baby's brachial plexus nerves, haven't they?
A. That was not their conclusion, no.
Q. For instance, Doctor Grimm in Michigan, Doctor Gonik's new research partner, she claims that it only takes

18-percent stretch to rupture a baby's brachial plexus nerves, doesn't she?

A. No, she's citing the range that was found but not the median.

Q. Okay. But she -- the median is not what's important. It's the minimum for a case like this that what can rupture a baby's brachial plexus nerves.

So, if Ashley Flowers brachial plexus---

A. You're saying that. I don't agree with that.

Q. Doctor, if Ashley Flowers brachial plexus nerves could be ruptured at 18-percent, they would take far less traction than 35-pounds to rupture, would they not?

A. Not necessarily.

Q. But mighten they?

A. I, I think that's just an improper hypothetical question.

Q. Well, it may be an improper hypothetical question, doctor, but if it takes 18-pounds of force to, or, excuse me, if it -- if Ashley Flowers brachial plexus nerves only have to stretch 18-percent of their original length to rupture, it might take far less than 35-pounds of force to rupture them?

A. I don't think that's true. I mean you're talking about the elasticity of nerves. You would need more traction. It might only stretch 18-percent in, in a small

minimum number, but it may still require a lot of force depending on its elasticity. So, I don't think you can make that conclusion that it would take far less force.

Q. It might take, it might take the same force --

A. To rupture.

Q. -- but it might take a lot less, right?

A. No, I don't think that's necessarily normal.

Q. There's no circumstance---

A. And certainly not true from the data you're citing.

Q. Doctor, there's no circumstance where a nerve that takes 50-percent stretch to rupture would take more force than a nerve that takes 18-percent stretch to rupture?

A. That's not true. That's not true. It would depend on the elasticity, right?

I mean just think of, of silly puddy.

All right. The thinner piece that's more elastic, you pull, force, and it, it stretches more than 50-percent of its length. The same amount of force in a much stiffer thing of clay only manages to stretch it to 18-percent but that force is the same. You can't switch the corollary.

Q. But you will admit it might take less?

A. I don't think that we know that. I don't think that's ever been shown in any of the data that you're citing. So, I don't agree with you.

Q. Okay. Doctor, well, let's get back to your claim

that it takes greater than 50-percent stretch of nerve to rupture?

A. On average.

Q. And 35-pounds of force to create that stretch.

You claim to be using data in applying scientific principles to come up with that opinion, right?

A. That's correct.

Q. And you claim that, by using these principles, your conclusion should be fairly precise, shouldn't they?

A. I never said that.

Q. So, your opinions are not precise?

A. No, they are more likely than not. Within a reasonable degree of medical certainty.

Q. You're certainly not guessing or speculating, are you?

A. No.

Q. And any scientist using your scientific principles should be able to reach the same conclusions on the amount of stretch Ashley's nerves stretched during delivery, shouldn't they?

A. No, reasonable scientists disagree all the time.

Q. So, you don't think that your findings in how much stretch Ashley Flowers nerves must have stretched to rupture, that's not reproducible by other scientists?

A. Oh, sure, it is.

Q. And you would expect other experts, using the same formulas that you're using, using the same scientific data that you're using, to come up with the same opinions, wouldn't you?

A. Not necessarily.

Q. You don't think so?

A. No.

Q. So, if your husband's opinions in this case are 20-percent different than yours, that wouldn't concern you?

A. No.

Q. Thank you, ma'am. I have no further questions.

THE VIDEOGRAPHER: Sir?

MR. HENSHAW: Yes, thank you.

THE VIDEOGRAPHER: Are we finished?

MR. HENSHAW: No. Unless the doctor wants to take a break.

Are you okay?

THE WITNESS: I'm okay.

THE COURT REPORTER: Do you mind if I take one minute just to flip more paper in?

MR. HENSHAW: Absolutely. Sure. Let's go off the record then.

THE VIDEOGRAPHER: The time is 6:24. We are going off-the-record.

(Pause.)

THE VIDEOGRAPHER: The time is now 6:27. We are now back on the record.

REDIRECT EXAMINATION

BY MR. HENSHAW:

Q. Doctor Gurewitsch, in the field of medicine, is it standard methodology to, to look at examples of actual body tissue in order to determine the cause of a disease or other cause of illness or cause of death?

A. Yes.

Q. So, for an example, when a pathologist does an autopsy to determine the cause of death, he is specifically going into the body to look at the organs, the tissues, to look at what had previously -- what is the result of what previously happened in order to determine that cause of death.

Is that correct?

A. That's what they're attempting to do, yes.

Q. All right. So, in the methodologies that, that you have referred to today, is that consistent with the methodologies of determining medical causation?

A. Yes.

Q. Now, in this particular case, do we have a permanent injury to the C5, C6, C7, and C8 nerves of Ashley Flowers?

A. Yes, in terms of the required reconstruction, it

was limited to C5, C6, and C7. C8 required removing the scar.

Q. And was it limited to just one side of her body, the left side?

A. Yes.

Q. Now, you were asked extensively about questions of lack of oxygen and whether or not she had had lack of oxygen earlier in the labor.

Doctor, based upon your experience, training, and knowledge, if a child is going to suffer injury because of lack of oxygen, is it usually limited to just one area of the body like the left shoulder?

A. No.

Q. Is it usually system wide?

A. Yes.

Q. Is it called -- is it what is usually called global?

A. There's a lot of terminology, but it wouldn't be confined to one area, no.

Q. And is there any evidence that there was any damage done to the brachial plexus nerves of Ashley Flowers' right shoulder?

A. No.

Q. So, in and of itself, if you look at what lack of oxygen usually does and look at what happened to Ashley

Flowers, do you have an opinion, to a reasonable degree of medical certainty, as to whether the brachial plexus injuries that she sustained was caused by lack of oxygen?

A. Yes, I have an opinion. No, it was not.

Q. Is it more likely that the injuries that she sustained were the result of a -- some type of pulling and stretching of those nerves?

A. Yes.

Q. Now, is this simply based upon the research that you and your husband have done or are there other researchers who have also looked at the question of what can cause a permanent brachial plexus injury?

A. Actually, we haven't done the research on actual brachial plexus nerves. So, it's all on -- based on existing literature from other authors.

Q. From other authors?

A. That's correct.

Q. Peer reviewed authors?

A. Yes. Textbooks.

Q. Going back for how long?

How many years?

A. Since the 1800s.

Q. Since the 1800s?

A. Yes.

Q. Now, is it -- would it be fair to say that, if a

doctor uses traction, that it pulls the baby's head, but only pulls the baby's head enough so that it does not cause any brachial plexus injury, that that's within the standard of care?

A. More likely than not, yes.

Q. Okay. Is it fair to say that, more likely than not, if a doctor, in delivering a baby, pulls the baby's head, uses traction, so as -- that, when the baby is born, there is a temporary injury to the brachial plexus nerves, but then that temporary injury resolves, is not a permanent injury, that that's not considered to be a deviation of standard medical care in most circumstances?

A. It -- usually. Usually not.

Q. Okay. And -- but if a doctor, in applying traction to the baby's head, causes, pulls to such a degree that it causes permanent injury to the baby's brachial plexus nerves, at least in a situation where it causes injury to each of the nerves that make up the brachial plexus, all five of them, is that more -- most likely to be because the doctor used more pressure than was necessary to deliver the child under those circumstances?

A. It depends what the circumstances were.

Q. Well, I understand. But in the circumstances where the baby can be freed up with McRoberts and suprapubic pressure and the babies own turning within one to two

minutes.

A. I'm not following the question.

Q. Well, I'm just trying to determine at what point do we say, in the field of medicine, that a doctor has used too much traction, too much force in the application of traction?

A. It depends on the circumstances surrounding that delivery.

Q. Okay. But in circumstances such as Ashley Flowers situation where all five nerves sustained injury after the---

A. That's, that's an after effect.

Q. Oh, okay.

A. That's not the circumstances of the delivery.

Q. All right. Okay. All right. Well, thank you.

Circumstances that the doctor quickly diagnoses that there is shoulder dystocia after the turtle sign and begins to implement the maneuvers of the McRoberts and suprapubic pressure, and suprapubic pressure, and within one to two minutes the baby is delivered, under those circumstances where the child suffers permanent injury, is it most likely because unnecessary pressure was applied?

A. That would depend on the nature and extent of the injury.

Q. All right. And, and given the extent of the

injury, being all five nerves being implicated with injuries here, four of them being described as ruptured and one of them being described as stretched to the point where scar tissue formed and developed a neuroma, would that, most likely, in your opinion, be because there was unnecessary pressure applied to this baby's head?

A. Under those circumstances, yes.

Q. And that would be a deviation from standard medical care in your opinion.

Is that correct?

A. Yes.

Q. Now, doctor, you were asked about this booklet from the American College of Obstetrics -- Obstetricians and Gynecologists Neonatal Brachial Plexus Palsy.

A. Yes.

Q. And you're familiar with that book?

A. I am.

Q. And, in fact, you, you have several articles cited by this very booklet.

Is that correct?

A. That's correct.

Q. For example, at Page 86 in Appendix A, Number 25 is Allen, R.H., Gurewitsch, E.D., Temporary Erb Duchenne Palsy Without Shoulder Dystocia or Traction to the Fetal Head, a publication of obstetrical -- Obstetrics and Gynecology,

2005. That's one of your articles.

Is that correct?

A. That is.

Q. And that's cited by this booklet, Neonatal Brachial Plexus Palsy.

A. Yes.

Q. Also cited is Gurewitsch, Donithan, and Stallings, Moore, Agarwal, and Allen, Episiotomy Versus Fetal Manipulation, in Managing Severe Shoulder Dystocia, a Comparison of Outcomes, which was published in the American Journal of Obstetrics and Gynecology in 2004.

A. Yes.

Q. And that's also one of your articles?

A. Yes.

Q. And there are other articles throughout this publication that, that cite your publications for purposes of their inclusions?

A. Yes.

Q. Now, in this appendix is included Appendix A of this publication published by the American College of Obstetricians, Obstetricians and Gynecologist is a pamphlet called Shoulder Dystocia of the Royal College of Obstetricians and Gynecologists, Green Top Guideline Number 42, Shoulder Dystocia, and that's a British pamphlet of their organization of obstetricians?

A. Yes.
Q. And that cites two articles by you as well?
A. Yes.
Q. At Page 79, the Appendix A talks about management of shoulder dystocia, and, black letters, it states routine traction in an axial direction can be used to diagnose shoulder dystocia, but any other traction should be avoided.
A. Yes.
Q. Is that, in any way, different than what you stated to be the standard of care today?
A. No, it's not. It's the same.
Q. And is, in fact, that the standard of care that is followed not only in Britain but in America?
A. Yes.
Q. At Page 81 of Appendix A, in talking about the -- how should shoulder dystocia be managed, it states, at Page 81, the woman should be layed flat and any pillows should be removed from under her back. With one assistant on either side, the woman's legs should be hyper-flexed.
Is that what you were describing earlier today as being the -- is that the McRoberts maneuver?
A. It is.
Q. Okay. If the woman is in the lithotomy position, her legs will need to be removed from the supports and that's the -- is that consistent with what you understand

should be done?

A. Yes.

Q. Routine traction, (the same degree of traction applied during a normal delivery) in an axial direction should then be applied to the fetal head to assess whether the shoulders have been released. That's what the British organization says should be done.

Is that the standard of care in America as well?

A. Yes.

Q. And was it the standard of care in 2008?

A. Yes.

Q. And that's a situation where the doctor does not apply any more traction than would normally be necessary had the baby not had shoulder dystocia at all.

Is that right?

A. That's correct.

Q. And, and the doctor should not move the baby's head downward so significantly that it can cause stretching of the nerves within the neck.

Is that right?

A. Axial means along the axis of the spinal column.

Q. Just keeping it straight?

A. That's correct.

Q. Let the baby's head come, come on out straight with the body?

A. Keeping, keeping the head lined up with the baby's body.

Q. All right. And that's the standard of care?

A. Yes.

Q. And since the 1800s, have we known that if a doctor fails to meet these guidelines, then he, unnecessarily, runs the risk of stretching the baby, baby's nerves on one shoulder or the other and causing a brachial plexus injury?

A. I don't -- I can't answer about unnecessary cause you're not including any circumstances.

Q. All right. I'm sorry.

But, but that if he does not keep the baby's head in an axial direction or in, in -- and, and use routine traction, which means the same degree of traction applied during a normal delivery, then the doctor runs the risk of causing injury to the brachial plexus nerves on one side of the baby's body?

A. It can cause injury on both sides if you change direction.

Q. Okay. But, but---

A. But otherwise, yes.

Q. When we talk about this nerve injury to the brachial plexus, are we actually talking about simply how much the nerve gets stretched?

A. No.

Q. We're not?
It's not a matter of stretching the nerves?
A. It is a matter of stretching the nerves.
Q. And in terms of the injury -- in terms of causing injury is -- are we concerned that we will stretch the nerves and cause injury?
A. Yes.
Q. And so -- and the -- is the permanency of the injury usually or most likely determined by how much the nerves were stretched?
A. More often than not, yes.
Q. Doctor, do you have an opinion, to a reasonable degree of medical certainty, as to whether Ashley Flowers C5, C6, C7, and C8 nerves were stretched to the point that, during the delivery, to the point where it caused her to have permanent injury?
A. I'm sorry. I don't understand the question.
Q. Do you have an opinion, to a reasonable degree of certainty, as to whether or not the stretching of Ashley Flowers nerves during her delivery most probably caused her to have permanent injury to those nerves?
A. Yes.
Q. Do you have an opinion, doctor, as to whether it was necessary for Doctor Giep to stretch those nerves to that degree as to cause permanent injury to her brachial

plexus nerves?

A. Yes, it was.

Q. So, it was necessary for him to stretch those nerves that, that far?

A. To cause an injury like that?

Q. Right.

A. Yes.

Q. But was it necessary for him to do that in order to deliver her?

A. No.

Q. Do you have an opinion as to whether she most likely could have been delivered without stretching those nerves to that extent?

A. Yes.

Q. And what is that opinion?

A. That, that it -- this injury could have been avoided.

Q. Just to ask about these Apgars. You were asked about muscle tone.

If a baby has a head injury that affects their shoulder and their arm, can that be -- is, is that something that can have the appearance of a muscle tone problem?

A. Yes.

Q. So, when the nurse downgrades Ashley Flowers for muscle tone on the Apgar scoring, would it be correct to do

that if, if there was a brachial plexus injury?

A. Yes.

Q. You were asked about the fetal heart tone monitoring strip and what it showed about the baby's heartbeat, and about the circumstances prior to the baby's delivery.

Was there anything on that fetal heart tone monitoring strip that would medically justify the amount of traction Doctor Giep applied to Ashley Flowers after he diagnosed shoulder dystocia?

A. No.

Q. Was it a -- did the fetal heart tone monitoring strip indicate that he needed to apply so much traction that he could cause injury to the brachial plexus in order to deliver her?

A. No.

Q. In the moments -- in the, in the minutes, the two minutes that followed his diagnosis of the shoulder dystocia, was Doctor Giep facing an emergency of, of such gravity that it was going to, within that period of time, involve either death or serious bodily injury?

A. No.

Q. When you were asked about the amount of traction he applied being 35-pounds, you actually have stated, in your opinions, that he most probably used an amount of traction

in excess of 35-pounds.

Is that correct?

A. Yes.

Q. So, 35-pounds, something in excess of 35-pounds, but an unknown amount is what was problem -- most probably used by him.

Is that your opinion?

A. That it was at least that much.

Q. Okay. And, under these circumstances, would you expect a reasonably competent obstetrician to use that much traction to deliver the child?

A. Under these circumstances?

Q. Yes, ma'am.

A. No.

Q. And that would be your opinion to a reasonable degree of medical certainty?

A. Yes.

Q. Doctor, that's all the questions I have. Thank you.

TREVA FLOWERS, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q Mrs. Flowers, please state your full name.

A Treva Charese Flowers.

Q All right. Pull that microphone up just a little bit so that it gets closer to your mouth and we can hear you a little bit better.

Restate your name please.

A Treva Charese Flowers.

Q I think that's a little bit better. Thank you.

A You welcome.

Q Mrs. Flowers, where do you live?

A Simpsonville, South Carolina.
Q And where in Simpsonville do you live?
A 9 Scotts Bluff Drive.
Q Who lives there with you?
A My husband and my two children, Ashley and Josiah.
Q And who is your husband?
A Tristan Flowers.
Q And this is Mr. Flowers sitting over here next to you?
A Yes, it is.
Q And you've mentioned two children.
That would include Ashley?
A Yes.
Q And Ashley is how old now?
A She's nine years old.
Q And just had her birthday?
A Yes.
Q And you mentioned another child.
A Josiah, her brother, who will be four in December.
Q All right. And what -- when was Josiah born?
A December 30th, 2013.
Q All right. And do they get along?
A Sometimes.
Q Now, are you employed?
A No, I'm not.
Q Where did you -- where were you born?

Where did you grow up?
A I was born here in Greenville, South Carolina that -- that's where I spent most of my life. I moved away for the first time in, I believe it was, 1999. Tray and I, my fiance at the time, went off to college in Florida. So, that's my first time moving away.
Q Where did you go to schools here?
A Elementary school, I started out at Alexander Elementary School, which is in Greenville.
Q Okay.
A Middle school, Tanglewood Middle School, Carolina High School. About a year after that I started Greenville Technical College, and I went there for about three years and finished, but after -- let's see. After about a year of that schooling, I enrolled in ITT is where I met my husband, 1996.
Q ITT where?
A Technical -- in Greenville.
Q Okay.
A ITT Technical Institute, Institute in Greenville.
Q All right.
A I met, then at the time, boyfriend.
Q All right. So, when you started higher education after high school, what was your intent?
What kind of degree were you trying to get or what were

you trying to get into?
A Electronics engineering technology, and that's -- I did receive an associates degree, Associate of Arts. I'm sorry. Associate's of Science Degree in Electronics Engineering Technology, and---
Q Where did you get that?
A ITT Technical Institute.
Q Okay.
A And after that, like I said, we moved to, moved to Florida and with intent on getting a Bachelor's Degree in Telecommunications Engineering Technology, and we both received that about a year later.
Q And so have you been able to utilize that degree or those degrees?
A I have. I have. My, my first job from the Associate's Degree, I got a job at Robert Bosch in Anderson where I was a lab technician for the engineers. And when we moved to Florida, I got a job -- while we were in school in Florida, I got a job working at Siemens Information and Communications, I believe it was networks, ITNT, ITN, working as another lab technician.
Q Okay. And where else have you been employed?
A Let's see. Once I graduated from ITT in Florida in 2000, I joined the military about maybe two months later, and that's where I spent four and a half years in the

military.
Q Okay.
A And, after the military, I got out and I got a job at BMW Manufacturing and briefly, after that, I taught at ITT Technical Institute as an adjunct instructor for maybe six months. And that was my last place of employment, ITT and BMW.
Q All right. Now, when you were in the military, where were your assignments?
A My first assignment, basic training, was Fort Sill, Oklahoma. My first assignment was Monterey, California at the Defense Language Institute, and, let's see, after that -- I think I was out there about a year and a half. After September 11th, I came up on orders to transition to Germany. So, I spent about three years in Germany, and I was also deployed Iraq for about six months, and then redeployed back to Germany for the remainder of my duty.
Q All right. Where were you in Iraq?
A I was in Kirkuk, Iraq.
Q And was that a war zone?
A Yes, it was.
Q Okay. What was your assignment there in Kirkuk?
A I was actually a part of the Post Office. Our mission was to set up the first Post Office in the sector, and that's, that -- that's primarily what we done. I worked in

postal, postal operations my entire, entire military career plus or minus some other duties.

Q And how long were you there in Kirkuk?

A About six months.

Q Now, so, you came back to the States.

What was your relationship with Mr. Flowers during that, during that period of time?

A It was a good one.

Q Well, I understand it was a good one, but were y'all still engaged or not engaged or did you not know?

A Unfortunately we weren't engaged, but we were still on good terms as friends.

Q Okay.

A And we, and we, we got back together. So, yeah.

Q All right. So, when did you get married?

A We got married May 27th, 2006.

Q Okay. And was he employed by the time you -- when you were married?

A Yes, sir.

Q And what kind of work was he doing?

A He was working at Spartanburg Regional Hospital. No, excuse me.

At the time we were married?

Maybe he was still -- he maybe -- he, he may have been still with Siemens cause he worked for Siemens for a long

time, and then I think he got hired on at the hospital. My timing may be a little bit off but---

Q Okay.

A It was one of the two.

Q So, how long was it after you were married that y'all started looking to have a baby?

A About a year.

Q And did things go as planned?

A It did.

Q And you got pregnant?

A I did.

Q And this was your first baby?

A First one.

Q And that turned out to be Ashley?

A Yes.

Q Okay. Now, let's talk about your pregnancy. Just let us understand what you went through.

You got pregnant and how did you find out?

Home test?

A No, sir, not a home test. We were actually at the doctor's office at -- I think -- I was trying about nine months to conceive and it just wasn't happening. So, my husband and I discussed getting tested. He -- it was easier to get him tested first we were told. So, we got him tested, and before we even got his results back, I was going

to get tested. And while I was there to get tested, I performed urinalysis, and as soon as they checked it, I was pregnant. So, we never even got his results back before I find out I was pregnant, but he, he was good anyway. So --.

Q Okay. So, did you have a doctor already or did you have to seek out a doctor?

A I was actually going to Doctor Brenda Adams-Hudson and she's our, she's our family physician. I was going to her, but when I found out I was pregnant, she told me I needed to find an OB-GYN. And that's, that's when I sought out Doctor Ashley Fowler.

Q Okay. And what, and what practice was she in at that time?

A Spartanburg & Pelham OB-GYN.

Q And it was already being known as Spartanburg &, & Pelham at that time?

A It may have been Village at Pelham at the time.

Q Okay.

A Yeah.

Q And so about how far along were you when you first saw Doctor Fowler at Spartanburg & Pelham?

A Oh, not far at all. Maybe a couple weeks.

Q Okay.

A If, if I remember.

Q And so how did the pregnancy go under, under her --

under the management of Spartanburg & Pelham?
A It was well, you know. It was, from, from what I understand, normal. It was, it was --.
Q Now, did you understand that you had just simply be seeing Doctor Fowler the -- every time you went to, to the doctor's office or did they rotate you through the various doctors in the practice?
A I was rotated through the various doctors in the practice.
Q And you understood that?
A Initially, I thought she was gonna be my only doctor, but once I chose her, then it was explained I would be seen by other doctors because it's a group and I was okay with that.
Q And did you understand that one of the reasons for that was so that, in the event that another doctor had to cover at -- during your labor and delivery, you would have some familiarity with the doctor?
A That's correct.
Q All right. Did you see Doctor Giep during your course of office visits at Spartanburg & Pelham?
A I, I did see him.
Q Okay. And, as far as you know, through most of the pregnancy, did everything go okay?
A It did.

Q Now, we have already heard, and it's in evidence, that, at some point, you were diagnosed with gestational diabetes.

Is that correct?

Is that to your understanding as well?

A That's correct.

Q And approximately when was that?

A Oh, I was several months pregnant. I'm not sure how far along, but it wasn't at the beginning.

Q Okay. And so, once you were diagnosed with gestational diabetes, what were you told about it?

What was the plan?

A I was told that gestational diabetes could cause an enlarged baby, and that I would have to manage my diet -- well, manage the diabetes with diet and exercise. That's, that's all I remember though.

Q And, and -- and is that the way it went from that points on in terms of the gestational diabetes diet, excuse me, diet and exercise?

A It did.

Q Did you ever have to take any type of Insulin?

A No, sir.

Q Or any other type of medications related to the gestational diabetes?

A I did not.

Q Okay. Did you keep all your appointments?

A I did.
Q Did you do everything that the doctors told you to do during the pregnancy?
A Yes, I did.
Q And what were the plans as you got close to delivery?
A Could you be more specific?
Q Well, yes.
What were the plans in terms of what hospital you would go to, how you would get there, how you'd be admitted, that sort of thing?
A Okay. I'm sorry. The plan was -- well, we had already packed our bag, and the plan was to go to Spartanburg Regional Hospital. I think it was Spartanburg Regional Hospital at the time. And my husband was gonna take me and that's pretty much how it happened.
Q Well, were you preadmitted?
Do you know?
A I -- you know, I think I was.
Q Okay.
A I think so.
Q So, it was just a matter of you showing up when you needed to show up?
A Yes.
Q Okay. And when did that happen?
A October 7th, it was some time after midnight. I

don't, don't remember the exact time, but I was asleep and I felt the urge to go to the bathroom. So, as soon as I stood up, fluid flowed and, at the time, honestly, I wasn't sure if it was actually my water because I did have the urge to go to the bathroom, but there was no effort on my part to release. So, I assumed it was my water.

And I woke my husband up and I said, Tray, I think my water broke, and he said are you sure? He said how you know? And I said, well, I'm standing in fluid. So, I went to the bathroom. He said oh. He jumped up and he's like oh, let me call the doctor. And I can't remember if I called or he called.

But I went to the bathroom, you know, cleaned myself up and we hurried out the door -- but let me, let me back up. I, I did talk to Doctor Fowler and she said okay, I'll meet you at the hospital, and then we hurried out the door. And once we got there, I remember checking in at the, the desk in the -- on the labor, labor and delivery floor, and they put me into a small room and hooked me up to the necessary equipment for monitoring and I stayed there. It seems like a couple hours.

Q So, from what I take from your testimony is, is that, at home, both of y'all were just cooling, calm, and collected, and no, no excitement at all?

A I think he was more nervous than I was.

Q And so -- but he did get you to the hospital?
A He did fast.
Q All right. And you got in and they confirmed that your water had broke?
A Yes.
Q And that you were gonna be delivering?
A Yes.
Q And how far off -- how far was this from your due date?
A My actual due date was October 11th. So, four days.
Q All right. So, you were essentially full term?
Is that your understanding?
A Yes.
Q And had there been any discussions about any concerns about what would need to be done once you got to the hospital in your earlier meetings with Doctor Fowler or any of the other doctors?
A Any concerns about what would be done?
Q Right.
I mean was -- were you, were you -- did they consider you to be too big?
Did they consider you to be okay?
What was the -- what was your understanding about how things would probably go once you got to the hospital?
A Everything -- so, everything that I remember was normal. There was no---

Q Was it planned to be a vaginal delivery?
A Yes.
Q And you understood that?
A I did.
Q Okay. And this is your first baby?
A Yes.
Q So, you got there, the nurses confirmed that your water had broken, you were gonna be having a baby?
A Yes.
Q All right. What kind of room did you go into?
A Initially it was just -- it was pretty small, but just a regular bed, a TV, and they brought in the -- I think the monitoring machine. It was just a basic room. Maybe had a chair.
Q Okay. And so did you see Doctor Fowler?
A Eventually I did.
Q All right. And she examined you?
A She did.
Q Did she indicate that there was any particular concerns about you going forward and delivering the baby vaginally?
A No concerns.
Q Do you know whether they put you on any kind of medication to induce your labor?
A Not, not right away they didn't.
Q Did they ever?

A They did. Once I moved, they, like I said, eventually they moved me to the labor and delivery room where I would actually have Ashley, and they expressed to me that they were going to induce my labor because I was progressing kind of slowly to their opinion. And, at some point, I was given the medicine to induce.

Q Did you know that you were gonna have a little girl?

A I did.

Q And, and was that because of ultrasounds that had been done?

A Yes.

Q Do you know how many ultrasounds they did over the course of your pregnancy?

A At least three.

Q And did, did any of the doctors ever express any concerns about what the ultrasounds had shown?

A No.

Q How many times did you see Doctor Fowler that day? Do you remember?

A I don't recall exactly, but I know it was two. I remember she checked me initially for -- to, to see how far I had dilated and I remember seeing her again before she left to let me know her shift was over.

Q All right. She came in and saw you?

A She did.

Q Did she explain to you that another doctor would be taking over?
A Yes, she -- yes.
Q And did she explain who the doctor was?
A She didn't know.
Q And so approximately what time was it that she left and came to see you to let you know she was leaving?
A It was in the evening time. I don't remember exactly the time, but it was in the evening when she came by last.
Q And, by that time, were you in the labor and delivery room?
A I was.
Q And, by that time, were you being induced with medication?
A I had already been induced, yes.
Q Now, who was there that evening with you?
A That evening, I had a lot of family members. My -- both my in-laws were there, my sister-in-law, my sister, my mother, my cousin, her daughter. I think my niece was there. Maybe that was it. My husband, of course. But maybe that was it.
Q Did -- were they all in the room with you?
A Not at one time, no, sir. They would, they would take shifts --
Q Okay.

A -- and all, but I did see all of them at some point but not --.
Q What about your husband, did he stay in the room with you?
A Absolutely.
Q Okay. And so, as far as you knew, how did your labor progress?
A Slowly. It, it, it progressed pretty slowly. It seems, seems like forever. Like I, I said, I'd gotten there after midnight and then I didn't deliver until 8:20 the -- that same time. So, it was, it was fairly long.
Q Okay. Was that -- did anybody express any concern to you about the fact of, of the pace of your labor?
A Only when they told me they were gonna give me something for induction and---
Q Okay.
A ---that --.
Q Who told you and what did they say?
A One of the nurses, they -- she just said we're gonna give you something to help further along the process and that was it.
Q Okay. So, Doctor Fowler leaves.
Do you immediately see Doctor Giep or was it later that you saw Doctor Giep?
A No, it was later. Some time around 8:00ish when I saw

him.
Q Okay. What were the circumstances when he came into the room?
A Well, I was already -- I started pushing. Within the seven o'clock hour, I started pushing. One of the nurses instructed me to push, and I, at some point, I told him I felt pain and they said okay, let me give you another epidural, and they called for a doctor to come. But I -- it was a while before the -- I got the second epidural.
Q So, you had an epidural earlier?
A I had an epidural early and they told me it wore off. So, they give me a second one. Well, that, that one never took because, when they instructed me to push again, I still felt pain.
Q When you say that one never took, you're talking about the second epidural?
A The second epidural, I never felt a difference in the pain I had before.
Q Now, was Doctor Giep in the room when you were first instructed to push and you said you had pain?
A No, sir.
Q What about after the epidural, the second epidural was administered, were you still being asked to push?
A I was.
Q Was he in the room at that point?

A He was not.
Q Okay. And had you seen him or any other doctor after Doctor Fowler had left?
A Only the anesthesiologist if -- I'm not sure if they're doctors, but someone came in to -- they gave me something in my vein after the second one didn't take.
Q Okay.
A And that was, to my understanding, it was a doctor.
Q So, do you know how many pushes you made before you saw Doctor Giep?
A It was a couple. I don't remember exactly.
Q All right. When you were asked to push, were you in stirrups?
Had they put you in -- put up stirrups yet?
A I don't remember.
Q Okay. And so approximately how many times did you push before Doctor Giep came in?
A Approximately at least two or three. I don't, I don't remember exactly honestly.
Q Do you -- did the nurses inform you that they were getting ready to call the doctor?
Do you remember that?
A I don't remember her saying we need to call the doctor. I don't remember that. I remember her leaving or she, she left my bedside. I don't know if she left the room or she

just, you know, went to a corner, but she saw me before the doctor had come in.

Q Okay. Did the nurses make any examination of your pelvic area at any point that you remember?

A Not that I remember.

Q So, were they saying anything to you about whether they could or could not see the baby's head beginning to crown? Did you ever hear that?

A I did hear somebody say oh, this baby has a lot of hair. So --.

Q And was that before or after Doctor Giep came in?

A Before.

Q Okay. So, then did Doctor Giep arrive in the room?

A At some time he did.

Q Tell us what you remember from that point.

A Oh, I remember seeing Doctor Giep walk in the room, and he immediately came to my bedside, and started telling me -- and I remember a couple nurses saying push, push, and I know I had one at my right side, one at my left, and the doctor and my husband's at my left side. But I just remember people saying a lot, to just push, push. They just kept saying push. So, that's---

Q Okay.

A That was my job. I was pushing.

Q All right. And were you aware of what was happening

down below in terms of the baby's head being born or anything like that?

A I knew eventually she was coming. They saw the hair. So, I, I kind of knew she was coming, but --.

Q All right. But other than that, did you know when the head was born?

A No.

Q Were you aware or were you made aware that there was any problem delivering the body?

A No.

Q That wasn't something that you knew about?

A No, it wasn't actually mentioned.

Q All right. Was there anything unusual that happened during the baby's birth that you remember or what seemed unusual to you?

A You mean after she came out?

Q No, before she came -- got completely born.

A The only unusual thing I noticed, at some point, that Doctor Giep had a -- some type of monitor around his neck, and I remember him calling somebody. I don't remember what he said, but -- and then a nurse got -- it appeared that she got on my bed, but she was -- she's -- her body was higher than my husband, and he stands 5'11". He was next to my bedside.

So, to me, it seems like she was on my bed and she was

pressing on my stomach really, really hard. I thought that was unusual.

Q Okay. Do you recall having your legs put into stirrups at any point?

A Yes, they were in stirrups at some point.

Q Okay. Do you recall whether they were ever moved out of the stirrups into another position?

A They were. They were brought back behind me -- back behind me.

Q Okay.

A Yes.

Q And did you do that on your own or were you assisted in having your legs brought back?

A Oh, no, I was assisted by two people.

Q Okay.

A One person was---

Q Do you know who they were?

A There was a nurse over here and I'm not sure who grabbed the other one. There's a nurse on our bed. I really couldn't see who had the other one.

Q Okay.

A So --.

Q Do you recall being able to see Doctor Giep?

A At that point?

Q During that period of time when your legs are back and

the nurse is pushing.
A The nurse is on my stomach. If -- I couldn't really see him because the nurse was blocking my vision. She was in front of me.
Q Okay.
A I couldn't really see him.
Q All right. Do you recall him saying anything?
A No.
Q And were you, in any way, knowledgeable that you were in the middle of a birthing complication?
A No.
Q That was not known to you?
A It wasn't known. At least I didn't assume that.
Q Okay.
A So --.
Q Did you know that Doctor Giep cut you?
A After the fact I knew.
Q But while it was actually happening, were you aware of that?
A No.
Q And there wasn't any pain associated with that apparently?
A No, I couldn't feel anything.
Q Now, were you aware when the baby was born?
A Yes.

Q And before the baby was completely born, were you aware of any of the maneuvers that Doctor Giep was performing with his hands?
A No.
Q Okay. Do you have any way of knowing how much traction that he used or didn't use in the, in the delivery of Ashley?
A I don't know.
Q That's not something that you were in a position to know?
A No, that's not my area of expertise.
Q All right. So, Ashley is born and what did you know about her in the moment or moments right after she was born?
A I, I kept remember -- I kept listening for her to cry, and, a couple minutes later, I did hear that. They brought her over to my bedside. I got a quick glimpse at her and they took her out.
Q Okay.
A That's about all.
Q And did they allow you to hold her at that point?
A No, they didn't.
Q Okay. Do you -- did you know why they weren't allowing you to?
Did you expect them to let you hold her or not?
A Absolutely. I expected that.

Q And did they tell you why you were not being allowed to hold her?
A No.
Q Were you able to see her arms and legs?
A No, she was swaddled.
Q Okay. So, you didn't get to count her fingers and toes?
A No.
Q And what do you remember happening next?
A I remember Doctor Giep was still at the -- he was still attending to me at the bottom, and I do remember having to be sewn or stitched and it took a while. And then I was given something for pain. Said I was gonna be in a lot of pain. And the next time I woke up I was in my private room.
Q Okay.
A That's what I remember.
Q All right. And do you know what day it was when you woke up in your private room?
A When I woke up, it was still the same night, but closer to midnight.
Q All right. And was anyone there with you?
A My husband was there.
Q Okay. And when's the first time you saw a doctor after you woke up?
A Shortly after I woke up Doctor Giep came in.

Q Okay. And did he talk to you?
A He talked to my husband and I both.
Q And do you recall what he said?
A He said there was some complications and I remember three words. I remember shoulder dystocia, Erb's palsy, and brachial, brachial plexus. And that was, that was about -- he said it was -- he had trouble getting her out because her left shoulder was stuck against my pelvis bone.
Q Okay.
A And, after that, I just kind of zoned out because I mean it was just -- that was hard to hear.
Q These three words, had you heard those words before?
A No.
Q Did you know what they meant?
A Not at all.
Q Did he explain what they meant?
A I don't remember.
Q Okay. So, how did you do for the rest of the night?
A I was torn up. I was still in a lot of pain. I was emotional cause I hadn't had a chance to see my kid, and -- but, after he left, Tray and I were able to go to see her in the neonatal intensive care unit for the first time, and it was -- it was tough.
Q Why?
A When I saw her, she had some bruising on her face.

She's real, real greased up from the ointment they had put on her. She had tubes -- well, excuse me, stickers, which appeared to be -- I think I asked. They said they were monitors on her head. She had oxygen in her nose. She had a feeding tube. She was bandaged up and swollen, and she's just laying there.

And I was -- that's -- I counted her fingers and toes. Everything was fine, but it was, it was tough. It was tough looking at her, but that's my baby.

Q Now, were you able to observe anything about either of her arms?

A I saw, I saw her left arm bandaged, but I didn't know why. Yeah, I, I didn't know why right away, and I think, at some point, someone came over, either a nurse or a doctor, and, you know, they, they explained to us that she endured a lot of trauma, and that they was securing her arm so that, so that it wouldn't cause for further damage, but that was -- it was tough watching her just laying there.

Q How long did you stay in the hospital?

A I, I stayed an extra day. So, maybe three days at the most.

Q How long did Ashley stay in the hospital?

A She was in there two and a half weeks.

Q Okay. And did you understand why she was in there?

A Yes.

Q And what was that?
A Well, they were trying to get her oxygen level back to normal, and, like I say, she, she was on a feeding tube most of the time, and she had to have occupational therapy while she was in NICU. So, the therapist would come by at least once a day and---
Q And what was the occupational therapy -- therapist doing?
Do you know?
A Well, she was, she was exercising her arm because they told us that she had some paralysis in her arm, and they were trying to, you know, just keep it moving in hopes that she gets some movement in it before she left, but she never did.
Q Were you able to---
A She had---
Q ---see the arm without bandaging while she was still in the hospital?
A I don't, I don't remember.
Q Okay. But what about when you got home?
Obviously, was that a situation where you could take the bandages off and see for yourself what was going on with the arm?
A Yes, when I got her home, she didn't have any bandages, but what we had to do -- she, she -- we had to keep her arm

pinned to her, to her -- either her side or across her, her belly to keep from it just falling because it was completely limp other than just a tad bit of finger movement, which didn't come till later though. We had to pin it so that she wouldn't cause further damage to it if I answered your question correctly.

Q All right. Let me put up a photograph here and ask you about it.

A Okay.

Q Do you recognize this picture?

A Yes.

Q And tell us approximately when it was taken.

A At that time she was still in the hospital. I want to say she was still in the hospital because I remember the, the little shirt she had on. That was one of the first shirts given to us by I think, I think my mother-in-law gave her that shirt, and she was still in NICU at that time. So, maybe a couple days old and see her, her left wrist is bandaged because---

Q Right here?

A Yes, it's bandaged with that pin because---

Q This is the pin right here?

A Yes, it's connected to that and her shirt to keep her arm from banging along her side causing further damage.

Q And do you recognize this photograph?

A I do.
Q And when was approximately this taken?
A That was her first surgery. We were out in Texas and that was right before she was six months old.
Q Well, I actually meant for you to probably look at this picture. Let's see.
A Oh. Oh, we were at home then. She was maybe a month, or a couple -- well, she was more than a couple weeks, but between two and a half weeks and a month old.
Q All right. And was this the usual way that she would hold her, her hand and wrist --
A Yes.
Q -- on the left side at that point?
A Yes.
Q Did that change up until the time you went to Texas?
A It actually got worse than that.
Q As time went on?
A As time went on it got worse.
Q Were you instructed on how to do any type of exercises or therapies on the wrist, or arm, or shoulder?
A Before surgery?
Q Yes, before you went to Texas.
A We were instructed to do some stretching, range of motion, just gentle movement, in, out, you know, up, down. Just gentle range of motion movement.

Q And did, did that seem to cause things to improve or not?
A I really can't, really can't say.
Q Okay.
A Because she never really -- the only movement we ever saw was fingertips.
Q Okay.
A So, really no change. It's -- her arm eventually became rotated like this --
Q All right.
A -- before surgeries. So --.
Q As, as the months wore on?
A Yes.
Q Now, was she able to pull the arm in at the elbow?
A No.
Q Did she seem to have any movement in her shoulder?
A Not that I remember.
Q Okay. And what about the arm itself?
Did she use it in any way similar to the way she was using her right arm and hand?
A No.
Q So, did you seek out medical help for these conditions related to her left shoulder, arm, wrist, and hand?
A We did.
You mean outside of therapy?

Q Well, yes.

I mean what, what type medical -- what kind of medical help did you look for?

A We were actually referred to Charlotte at the -- I think it's called Carolinas Medical Center in Charlotte.

Q All right. Who made that referral?

A Doctor Giep referred us to Doctor Maureen Nelson in Charlotte because she specialize in kids with these type injuries. And while we were there, she told us about Doctor Armenta out in Houston, Texas, and the fact that they hosted a clinic about twice a year for kids with these type injuries, and she invited us to the clinic when the doctors came down. And we were introduced to Doctor Armenta at that time.

Q Where was that?

A That was in Charlotte. We had to drive to Charlotte to go meet them --

Q All right.

A -- at the clinic.

Q So, you first met with Doctor Nelson?

A Yes.

Q And how many visits did you have with her before you were introduced to Doctor Armenta?

A Oh, numerous.

Do you want a number?

Q Well, I mean---
A I---
Q Was it more than one or was it just the one visit and then you met Doctor Armenta?
A No, it's more than twice.
Q All right.
A More than twice.
Q Did she actually undertake any treatments before Doctor Armenta became involved?
A She instructed us on therapy and we just continued with therapy up until we met Doctor Armenta.
Q What did the therapy involve?
A Range of motion and stretching.
Q Where was it done?
A Initially, I did a lot of it at home, but she's had several people who did therapy with her. We were set up with BabyNet at Spartanburg Regional initially and -- excuse me. After she was born, we went to Spartanburg Regional for therapy for maybe a month, and then BabyNet got involved and started coming to our home. So, I did therapy with her at home. The BabyNet came in with occupational and physical therapy into our home, and --.
Q All right. So, then, through Doctor Nelson, you were introduced to Doctor Armenta.
Is that right?

A That's correct.
Q And that, that took place in Charlotte?
A It did.
Q But he was actually located in Texas?
A In Houston, Texas, yes.
Q Okay. And what did you understand was his working relationship with Doctor Nelson?
A They worked together to treat the kids with brachial plexus and other type of injuries related to or with a similar, similar injuries.
Q Did he undertake an examination of Ashley?
A He made an assessment, yes, a physical assessment of her when he saw her.
Q And then did he advise you as to what he thought could be done?
A Yes.
Q You---
A He did.
Q Was your husband also involved in that?
A Yes, he was there.
Q And what did you understand from him or what were his proposals to you as to what could be done?
A Well, he was saying, with Ashley's injury, typically it would require surgery to repair the nerve damage that was caused, and he said that the best time to do it is before

the baby is six months of age. And we were excited because he told us he had some, some really good results and we, you know, we agreed that that was a fair, a fair thing to do.

Q After, after you met him or even before you met him, did you check him out?

A We did. My husband did a lot of research. I mean he was, he was really good about finding out what shoulder dystocia, all those, all those three terms I mentioned, he did a lot of research. I mean he's my backbone in it to help kind of get things tied up. He was the driving force behind it all because I, I just -- I couldn't -- he, he was the one that, that helped.

Q Okay. So, were you satisfied that Doctor Armenta could do the job if you let him?

A Absolutely. Absolutely.

Q So, what plans were made?

A Well, it happened kind of fast. Short minute, notice. We made arrangements to have surgery set up. I believe it was within the month of him telling us that she needed it because we wanted to act fast, and he say he wanted to get it -- Doctor Armenta said he wanted to get it while the nerves are still kind of fresh, before they just go, you know, I guess completely -- I don't know. He, he wanted us to do it while the baby was still young before she started to get older is what he said.

So, we made plans to go out there and we flew and she was scheduled for surgery I think the following day. And they -- I think the surgery lasted oh, more than eight hours, and it took so long that everybody in the hospital waiting area went home. Even the receptionist. I mean she went home.

My, my husband and I were sitting in the waiting room just worried because I mean we were left with a phone, and we didn't know how to get in contact with the doctors. But eventually the doctors came out and they were like, they look like they were exhausted because the surgery took longer than they expected because, once they, once they got inside, they realized it was worse than they had anticipated.

So, they repaired what was there and then---

Q Was Doctor Armenta one of the doctors that came out to see you?

A Yes.

Q And what did he explain?

A He explained that there's a lot of damage. He said he had never seen an injury like this before, and that -- he, he said it was the worse one he had seen. And he said that one of her nerves was ripped from the spinal cord and he used the, the, the medical terms. But the way he explained it so I could understand, he said it was -- one was ripped

and some were torn or were stretched, and he mentioned C5, 6, 7, 8, T1.

He called out all these nerves and I had no clue what he was talking about, but he explained that there's a lot of scar tissue, and he had to remove that, and he put cadaver tubing in it, cadaver sheeting, to help regenerate some of the nerves that were severed, and that she's gonna be okay.

Q Okay. When was the first time you were able to see Ashley after that surgery?

A We saw her shortly after. Yeah, shortly after. It was that same night.

Q How long did you stay in the hospital with her?

A Oh.

Q Or how long did she stay in the hospital?

A At least two or three days if --.

Q And then where did you go?

Back home or to another facility or what?

A No, after we left Texas, we went back home and I remember following up in Charlotte with Doctor Nelson so that she could check Ashley's incisions and report back to Doctor Armenta that, you know, she was doing fine and stuff. So, we were back and forth to Charlotte a lot with Doctor Nelson since she was primary contact with Doctor Armenta.

Q Let me show you some pictures.

Do you recognize this picture?

A Yes.
Q And when was this taken?
A We were still in NICU. I'm sorry. Ashley was still in NICU at that time.
Q This is after she's born?
A Yes, that's after she was born.
Q All right. Well, I'm, I'm looking for a picture after she left the hospital in -- maybe this is a better picture.
Is this in Texas?
A Yes, that was in Texas after her first surgery.
Q Okay. So, is this when she's about ready to leave or so?
A No, not exactly. We were just -- her dad was giving her a ride around the hospital in the wagon. It's just to try to, you know, give her a change of environment from the hospital room.
Q All right. So, she's got a bandage on her left upper arm, and she's got some type of wrapping around her chest and abdomen.
What -- what's going on there?
And then she's got a bandage on her wrist as well.
What, what all is going on here?
A Okay. The band -- the waistband is to help keep the side bands, like the, the upper armband --
Q Okay.

A -- and the lower armband. They all are -- they're Velcro. So, the purpose was to help keep her arm stabilized because she had, she had an incision here.
Q An incision -- and tell -- and you need to---
A On her neck.
Q You need to tell us, when you point to that, what are you pointing to?
A Her neck. The left side of her neck, she had an incision right below the lower part of her ear, and it sort of made an S-shape all the way down to -- close to her armpit.
Q All right.
A Okay. So, the purpose of the bandages was to stabilize her arm during healing.
Q All right. Now, I'm not sure that we asked Ashley to point out any scarring like that yesterday.
Does she still have a scar there?
A She does, but it's very minimal.
Q All right.
A You can't hardly see it.
Q Okay. Now, is this a picture from Texas?
A It is.
Q And what does this show us?
A Okay. Before she had the bandage we showed you previously, they just wrapped her kind of in a Ace bandage.

That was right after surgery. That was probably like the next morning. And the leg has a bandage on it because Ashley had to have -- let's see. One -- she had to have three incisions on the, the left leg to remove nerves to repair the nerves in her brachial plexus.

So, she has an additionally -- she has four scars from that surgery, that one surgery alone, to help repair the nerve damage. She had---

Q And, at this point in her life, how do those scars appear?

A They're beautiful. They're beautiful.

Q All right. So, are they scarring that, that you would consider disfiguring or, or not?

A No, I actually have to look for the scars---

Q Okay.

A ---and they're very pretty.

Q All right. And she -- it looks like she's got something on her right-hand.

Is that right?

A Ah, she does. See, Ashley sucks she -- she sucked her fingers for a long time, and if I understand correctly, they put that on there because she had to have IV in that arm, and they didn't want her putting her fingers in her mouth and just try to -- so she wouldn't disconnect the tube that was in her. It just kind of covered it up.

Q Okay. Just so we can see what you might be referring to.
A Uh-huh. (Affirmative).
Q Is this a picture of her with her two fingers in the mouth?
A Yes.
Q So, you came home and were you trying to see when something might be happening because of the surgeries that had been done in Texas?
A Yes.
Q And how long was it before you saw what you thought might be an effect from the surgery?
A Let's see. She had to wear the bandages for about six weeks. So, after we removed the bandages, movement became almost instantaneously. I remember changing her diaper. I had her laying on my bed and her arm was at her left side, and she raised her forearm about an inch off the bed. And oh, I yelled for Tray and we come in and we were so excited. That -- that is the best thing we've ever seen other than her being born.

It -- oh, it just gave us hope. It gave us more -- we were, we were motivated. We wanted more. We wanted more. So, wow, that -- that's one of the best things I had ever seen.

Q So, what happened after that in terms of her progress

with that arm?
A Therapy became more aggressive. Like I said, she already had -- she was having OT and PT. Well, during the time of her healing, no therapy. But after bandages were removed, we were instructed to have therapy, and we had therapy at least -- OT twice a day. I mean, excuse me, twice a week and then physical therapy was coming in.

So, we had, I believe, therapy was three times a week for several months after that, and each time -- well, as time went on, she made progress meaning that instead of just an, just an inch, we got 2-inches and then we got 3-inches and we got just a little bit of elbow flexion. Pardon me if I'm using the wrong term. But her arm would -- she begin to move her arm just inward. She could bend her elbow a little.

We were just motivated by that. So, there's a lot of home therapy. I would incorporate therapy into play exercises. Every toy I bought for her had to be something that motivated that arm movement. So, I mean we, we just went hard at it. We went hard at it.
Q And did you feel like you had progress?
A Absolutely.
Q Now, in regard to other areas of Ashley's development, did she appear to develop without difficulty in terms of speaking and other milestones that babies are expected to

meet?
A Yes, we only had to incorporate speech therapy. I remember a speech pathologist coming through some time during the first year because he wanted to initiate, I guess, swallowing exercises. Like I say, she had a feeding tube when she was in NICU. She had swallowing issues during that time, and, for some reason, they wanted to continue to make sure that she strengthened these muscles here so that, you know, she could -- I guess so, so they could develop better.
Q All right. And -- but the speech therapy was how she speaks.
What about just being able to speak?
Did she begin to speak within the year?
A Oh, she did. She used -- she used a couple words. Ma. I mean she was fine. Ma ma, da da. She was fine.
Q What about crawling?
Was she able to do that?
A She never crawled. She had her own version of crawl.
Q And what was that?
A She sort of got down on one, one knee and -- okay. She got down on her right knee and her left leg, with her foot planted on the floor, she scooted her body across the floor kind of -- just kind of dragging her right leg, and that was her way of crawling.

Q What about sitting up?
A Eventually she sat up finally. We had some core strengthening that we had to work on because there was weakness on the left side. So, we had to incorporate, you know, exercises to try to strengthen her core muscles because of her balance was a little off for a while. Well, eventually she began to set up, sit up okay.
Q What about standing up or standing only?
A That was a challenge. So, she started walking around 14 months, but she, she, she was okay. After she got moving, she was on the go.
Q Okay. So, has she gone to school -- starting school at the same age as most other children start?
A Yes.
Q And how has she done in school?
A Very well.
Q And when you say very well, what does that mean?
A Academically?
Q Yes, ma'am.
A Honor Roll. She's in gifted and challenged program now as a third grader, but she's always made the Honor Roll. She loves school.
Q Does she have friends?
A Yes, a lot of friends.
Q And how do you feel that she's coping with the -- well,

before I get to that.

Tying her shoe, she said that she can tie her shoe.

When did she learn to tie her shoe?

A Age three.

Q Okay. And was that difficult for her or not?

A Not really. It was a challenge at first because the, the wrist was always kind of retracted, kind of bent inward toward her forearm, but she figured out a way to do it herself. She figured out a way to make it work for her, but she would watch her dad and I tie her shoes. She actually ties her shoes the way her dad ties his shoes, which is two bunny ears first. She didn't pick up the way I taught her, but she picked up the way her dad ties his shoes, and she just kept working and working until she got it.

She was three years old and I mean it's to the point that she got in kindergarten. She was tying the other kids shoes. So --.

Q Now, you mentioned that she had friends. I asked her yesterday about, you know, how -- what happens when people stare at her and then I asked her how her friends treated her.

What have you observed about other peoples' reactions to, to Ashley and, and the situation with her arm?

A Wow. It, it started early on. I remember we were getting Christmas pictures made, and I saw someone staring

at her because, the Christmas pictures, she had on a little short red dress, and we didn't have it pinned to her, to her dress. So, it just kind of hung there and I saw people looking and whispering. And I -- as time went on, I, I noticed more adults looking than kids.

So, it doesn't really bother her when she see adults looking at her. It's just the kids that constantly just Ashley, what's wrong with your arm? Why is it like that? Can you do this?

And she doesn't express to -- she tells me that she doesn't -- she try not to let it bother her while she's in school. But when she gets home, she shuts down. I mean when -- I can tell when something has gone wrong when she gets in the car cause I can see that -- I can see the tears in her eyes and she, she's -- it's like she's been holding in all day and she can't wait till she get home to let it all out.

So, she, she just kind of hold it in, but I have caught her in her room several times just screaming, just ranting, just uh, like just screaming so loud, and I'm like Ashley, what's wrong, baby? What's wrong?

And she's like nothing. I don't want to talk about it. And when I -- eventually I have to let -- I have to let her come around, you know, just kind of get it out, get calmed down, and, once we talk about it, the problem was some kid

either said something to her or she just feel really bad about something that she couldn't do at school.

Like in gym, she has alternate exercises. I mean she expressed to me that she feels real bad being the only kid that has to do an alternate exercise, but her teachers makes her feel really good about it. You know, they, they let her just do whatever she can tolerate, and they all understand what's going on. But it's, it's the kids and they probably don't mean any harm about it. I mean kids are kids.

But it bothers her to the point that she's coming home, and I caught her just, just, just hitting her arm hard as she can. And I said baby, why are you doing that? She said I wish I was never born, you know. I -- why do I have to have brachial plexus injury? She gets angry and it, it bothers---

Q She, she, she knows that term, brachial plexus?

A Absolutely. I -- when she could talk and respond to me in a way that I knew -- when we could hold conversation, get -- intelligent conversations, I taught her that term. So, four or five years old -- she's five, she started asking questions. I'm not gonna lie to her. I let her know, baby, there's this brachial plexus injury. This is what you have and I explained to her what happened when, when she was coming out. And five years old, she got questions and I'm giving her the answers.

And when I tell her -- if the kids ask her, I said baby, tell them. She got -- I passed kids I pass all day. I said if they want to know, I said spell it out to them. So, let them know what it is so they can go and read it for themselves.

Yeah, got to educate kids these days. So, I educated my daughter on it.

So, yes, she knows what happened to her. She, she knows and it's, it's, it's to the point for her, emotionally, I know that I'm gonna have to get her some help. I asked her, but, right now, she says no, I'm fine. I don't need help cause we pray a lot. I mean that's our way of dealing with it. We just pray and pray for those kids that have understanding and their parents and all the other adults out there who, who don't understand what these injuries are.

And it's all about bringing awareness to the community because a lot of people just don't know.

So, they stare. And it, it bothered me for a long time, and sometimes it, it -- it still bothers me, but I can address it now. I couldn't address it before without being angry. So, she, she's the same way, but she holds her -- she holds it out -- she holds it in all day, but when she gets home, she lets it out.

Q Now, what does she -- from your position or standpoint

as her mother, what are you observing that she is having problems with in terms of that arm and hand and wrist?

A You mean physically?

Q Yes. Yes, ma'am.

Can she move it -- can she move her -- all five fingers?

A She, she can move the fingers, but the issue is the fact that her wrist is bent anywhere, and she can't really, she can't really pick up anything with it. She still needs help putting a belt on. She's kind of got zip, you know, zipping her clothes okay, but sometimes she might need help putting a certain shirt on.

I taught her how to button and zip. I taught her how to dress when she was three years old. She started day care when she was three. So, I, I taught her -- my -- her therapist and I taught her how to dress herself as much as we could with that injury.

Q Okay. And can she get herself dressed now?

A She can get herself dressed now. She might need help buttoning some pants at times, but I'm kind of selective as to what type of clothes I buy her.

Q Have you had to make any modifications to her clothing?

A Absolutely. I use to make her belts. Recently I made her a belt, but I made it too small for her. But I use to make -- when she was younger, before she actually learned

how to put the, you know, the belt with the buckle with the little stick in it, before she learned how to use that, I made her some belts at home with just the, the snap in buckle. And then I had some with just the loops on it that I made for her because that seemed to be easier to put on.

I use to put little ponytail holders inside her, inside of the hole of her pants so that she could fasten it around the button on her pants because, with kids with brachial plexus injuries, it's difficult for them to button, but it's easier if you have a snap on your pants because they can snap it with one hand. But if you have a button, I find that it's difficult to button with one hand when you're, when you have an injury. I tried it myself, you know.

So, I put a little bow on that, on that -- in the hole of her pants so that she could pull it and fasten it around the button. And the spaghetti strap shirts, I have to put a, like a ribbon in with that because it falls off her shoulders. For those shirts that I can't adjust, even some shirts that I can, I have to tie some straps that won't fall off her shoulders. Even her dresses.

They don't make clothes for brachial plexus kids. So, at home, you have to find ways to make it work for them. So, that's what I did.

Q Are you still having to do that or has she progressed to the point now where she can handle these situations on

her own?
A I still have to tie the shirts. We haven't had any issues with pants because I try not to buy her jeans that button. She wears a lot of leggings. She -- things that she can just pull on, and she pulls her clothes on with one hand. She doesn't -- she can't -- as much as she tries, she has problems pulling her pants up with both hands. So, she can do a lot of things, but it's with her right arm.
Q Is she aware that you're making these accommodations for her condition or, or is that something you just sort of keep to yourself and---
A No, she knows. She, she picks out -- she picks out some of the stuff and we designed her belts, and she picks out -- she picked -- picks out the ribbon colors for her. I mean it's part of her outfit. So, she's, she's a part of it.
Q What about her hair?
Is she able to, to manage that on her own or do you have to help her with that?
A Primarily, I have to help her but she surmised me about a year ago. I said Ashley, I was like who platted your hair? She said I did. And because she can raise her left arm on this side this far, even though her arm is bent, she managed to plat her hair and I didn't see her do it, but she said she did it.

She just couldn't get the right side, and I mean it stayed together for a couple hours. Then it came loose but -- cause she couldn't -- she can't get it really tight. She has attempted to put ponytails in her hair. She can't do it tight, but she does -- but she does the best she can. She tries. She'll try anything.

MR. HENSHAW: Just one moment please.

(Pause.)

Q That all the questions I have at this time. Thank you. Please answer any questions the defense counsel may have.

THE COURT: Mr. Lovell.

MR. LOVELL: Thank you, Your Honor.

CROSS-EXAMINATION

BY MR. LOVELL:

Q Good morning, Mrs. Flowers.

A Good morning.

Q I've just got a few questions. I want to kind of back up to the delivery time.

Now, you were asked some questions earlier about the rotation of the doctors.

You understood that the reason that you saw every doctor in the practice was because you didn't know exactly when you would go in for delivery.

So, it might be that Doctor Fowler was on-duty or Doctor Giep or any of the other physicians at the group,

right?
A Yes.
Q And you were okay with that?
A Yes.
Q I'm sorry. Pull that a little close just so we can hear you.
And Doctor Giep saw you some number of times, and the -- while you were going through the pregnancy, right?
A Yes.
Q And you were comfortable with him when you saw him?
A Yes.
Q Okay. And when you saw him in the hospital on the night of your delivery, he came in to the room after the nurses had done something and, and said come in or some of the or in some way or another he came in the room to see you, right?
A Yes.
Q And I want to kind of make sure I've got an understanding because you told us about two rooms.
The first you were in when you got there was just sort of a smaller room and then they moved you to the labor and delivery room, right?
A Correct.
Q And on that one, you were in a bed that was adjustable, up, down, left, right?

A On that one, you mean the first room?
Q The delivery room. Labor and delivery.
A Oh, labor and delivery. I was on a, a bed with stirrups.
Q Okay. Do you recall the bed also being lowered where your bottom end was sort of lower than the upper end?
A I don't, I don't remember.
Q Don't remember?
A No.
Q Do you remember everything about that, that night?
I'm sure it was probably busy.
A You, you---
Q All the things that were going on that night, you can't remember every detail about it?
A I can't remember every detail, no, sir.
Q But when Doctor Giep came in the room, he went down to the end, business end I'll call it, the end where the baby was coming out, right?
A Right.
Q And so as you're there, you have your legs in the stirrups, and he's down on that end and I think you mentioned some family members were in there.
Your grandma was in there, Mrs. Bowen?
A Well, just my mother and my husband at that time.
Q And then, when the baby started coming out, Doctor Giep

stayed down at the business end?
A Right.
Q And the nurse got sort of up on your body doing what we now have been calling suprapubic pressure. I think you've heard that before.
A Uh-huh. (Affirmative).
Q And that kind of blocked your view of what was going on down where Doctor Giep was, right?
A Uh-huh. (Affirmative).
Q Is that a yes for her?
A I'm sorry. Yes.
Q Court reporters have a hard time taking down uh-huh and hu huh.
A Uh-huh. (Affirmative).
Q Okay. So---
A I'm sorry.
Q And I apologize for saying that.
But when Doctor Giep was actually doing whatever he was doing down there, you couldn't see him?
Fair enough?
A That's fair.
Q And I'm gonna go back to the epidural thing cause I was a little confused.
You mentioned the anesthesiologist came in and did an epidural at some point after you got into that labor and

delivery room, right?
A Right.
Q And that involved putting a needle in your back?
A Right.
Q And hooking it up to some bag with medication in it, right?
A Um.
Q Or it was---
A I remember a needle going in my back.
Q The second epidural you talked about, they didn't come do a whole new needle, did they?
A In my back they did.
Q They re-dosed it at that point with the same needle or a different needle?
A I had my back -- I mean he was behind me.
Q Okay. After the second epidural, and when you were actually delivering Ashley, you couldn't really feel what was going on on the business end?
A No.
Q So, the cutting that Doctor Giep did with an episiotomy, you couldn't feel that?
A No.
Q And what he was doing with his hand or what the, the -- how the baby was moving, you couldn't feel any of that either?

A No, I couldn't.
Q Okay. And after you woke off, and this is all after the delivery -- well, let me back up. You mentioned something.
When saw Ashley in the delivery room after she had been delivered, the NICU nurses were the ones that were taking care of her at that instant?
A I'm assuming that's who that was.
Q Doctor Giep was still down finishing the delivery, the delivery part, right?
A Yes.
Q Which included, I guess, delivering the placenta and then sewing up your episiotomy and those things?
A Yes.
Q Okay. When you saw Ashley, was it a minute or so before you heard her actually make a cry out?
A Uh-huh. (Affirmative).
Yes.
Q Thank you.
Later that night, when Doctor Giep came and talked to you and your husband after you had woken up and you were sort of back in the room, and he talked to you about what had occurred, he explained the injury that Ashley had suffered, right?
A I don't remember him explaining the injury.

Q You said he used terms shoulder dystocia, brachial plexus, and---
A Yeah, I'm sorry. Yes, he used those terms, yes.
Q Okay. So, he didn't hide anything about what had occurred in that?
A No.
Q Okay. You then stayed in the hospital a few days and Ashley a couple weeks, two and a half weeks?
A Yes.
Q And then y'all all, at that point, were able to bring her home?
A Yes.
Q And you had mentioned physical therapy and occupational therapy coming in and helping you and Ashley.
Was the last time you had either of those around 2011 for her when they came to your home and did it?
A The home -- let's see. The last home visit we had was -- I'm not sure of the exact date for a home visit, but the last therapy she had was in 2015.
Q So, a year, two years ago, plus or minus?
A Plus or minus.
Q And I assume she's doing exercises, as you told us, on her own with your help now?
A Yes.
Q And it sounds like she tries to pretty much do whatever

she can within her abilities with that arm as far as at the gym, jungle gym with the kids, at school, and things of that sort, right?

A Yes.

Q Would you say, from your experience -- your observations of her, that she's learning how to accommodate and do things within the abilities that she's got with her arm in the condition it's in?

A She's still learning, yes.

Q And over the years, now I think you said she was -- turned nine two days ago, three days ago?

A Yes.

Q She's beginning to learn more and more of these accommodations and things as she gets older and older?

A Yes, I -- I'm trying to teach her as best I can.

Q And I assume Mr. Flowers helps you with that too helping her learn to do things?

A He does.

Q And y'all have a good family support. I -- obviously, I think they help out a lot on that---

A Yes.

Q ---too as well?

You were asked questions by plaintiff's counsel about her learning and abilities.

She hasn't had any -- you've had no doctor say that

she's had any kind of a brain injury or problem like that as a result of her birthing, right?

A Right.

Q She's -- as far as you know from the testing and all that, she may be ahead of a lot of kids that are her age?

A She is.

Q Is that right?

And you continue to see Doctor Giep in the office there for some period of time even after the delivery for a year or so, two years maybe?

A No, a couple months.

Q A couple months for him that you continued to go to the practice for a period of time?

A No.

Q Okay. The last -- they would call you and check on Ashley though?

A Who would call and check on Ashley?

Q The office.

A No, not that I recall.

Q You don't recall having conversations with Doctor Giep or people at his office on how Ashley was doing?

A To check on her, I don't recall.

Q Okay. It could of happened and you just can't remember now?

A No, I don't recall that.

Q And you mentioned that Doctor Giep referred you up to the doctors in Charlotte to help take care of Ashley's---

A Yes.

Q ---arm issue?

All right. That's all. Thank you very much, ma'am.

A You're welcome.

TRISTAN FLOWERS, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HENSHAW:

Q Mr. Flowers, please state your full name.

A Tristan Tyrone Flowers.

Q All right. And be sure to speak up so we can all hear you.

Okay?

A Okay.

Q Where do you reside?

A In Simpsonville, South Carolina.

Q And who resides there with you?
A My wife and two children.
Q And what -- where were you born?
A In Andalusia, Alabama.
Q How old are you?
A I am 45-years old.
Q And were you raised there in Alabama?
A Until my junior year in high school when my parents moved to Greenville, South Carolina.
Q And you finished up high school there?
A Yes.
Q At what high school?
A At Eastside High School.
Q And, after high school, did you have any further education?
A I later, right after high school, I joined the United States Marine Corp.
Q All right. How long were you -- did you serve?
A Four years.
Q And where were your assignments?
A In Jacksonville, North Carolina, in Cherry Point, North Carolina where I was detached -- attached to the 22nd Marine Expeditionary Unit, which, at that point, I was assigned to naval ships and we toured the Mediterranean Sea.
Q All right. You were part of what type of squad?

A I was a part -- I was in radio and microwave communication, which I was attached to the Embassy Team, and what happens -- what we did is, anytime an American citizen was in a country and they did not feel safe, they were responsible for getting to the American Embassy, and our job was to get them from the American Embassy to -- back to a naval ship or to a safe location.

Q All right. And what year did you finish your military service?

A In 1994.

Q 1994?

A Yes, sir.

Q And once you completed your military service, what did you do then?

A I moved back to Greenville, South Carolina where my parents were living and started ITT Technical Institute.

Q And what type of degree did you seek there?

A There, electronic engineering degree, Associate's Degree in Electronic Engineering.

Q Did you get that?

A Yes.

Q And did you use it to get employment?

A Yes, I went to work for Siemens Communications where then I was a -- I moved to Atlanta, Georgia and worked at the world headquarters of Coca-Cola in Atlanta.

Q For Siemens?
A For Siemens.
Q How long?
A About two years there in Atlanta.
Q Okay.
A And I was currently dating my wife, Treva.
Q Okay.
A And moved back to Greenville. I thought I was gonna move back to Greenville, and once Siemens management realized I was back in Greenville, they then sent me to Columbia, South Carolina to work for BlueCross BlueShield.
Q All right. And how long did you stay with Siemens overall?
A I stayed with Siemens approximately nine years.
Q Did you finish up working -- I mean -- with them working down at BlueCross BlueShield in Columbia?
A I wanted to go back to school, and they worked me a lot. So, I told them I was gonna quit and go back to school. So, they gave me my resume -- I mean my resignation back and found me a job in Orlando, Florida where I could continue my education there. So, they gave me a job working out of my home in Orlando, Florida.
Q And what's the significance of Orlando, Florida?
A Because ITT Technical Institute was there and I wanted a degree, a Bachelor's Degree in Telecommunications.

Q All right. And so you went to Orlando, Florida?
A Yes.
Q And did you get the degree down there?
A I did complete my Bachelor's of Science Degree in Telecommunication.
Q And stayed with Siemens?
A Yes.
Q While you were down there?
A That is correct.
Q So, what did you do next?
A After completing my degree in Florida, we decided, my wife and I, or at the time my fiance and I decided to move back to Greenville, and I continued to work at Siemens while I was in Greenville. While I was in Greenville, a friend of mine told me about a position at Spartanburg Regional, and I applied for it and they, they hired me at Spartanburg Regional.
Q So, when did you start at Spartanburg Regional?
A This is, I think, in 2002.
Q And how long did you stay at Spartanburg Regional?
A About nine years.
Q And what were your responsibilities while you were there?
A I was responsible for their telecommunications. Anything to do with their voice or phone communications, all

of their telecommunications I was responsible for.
Q Okay. So, do you have any medical training?
A No.
Q So, while you were at Spartanburg Regional, you weren't there for any purposes to actually administer treatments or make diagnoses or anything like that?
A No.
Q Is that right?
A No.
Q You basically worked on their telephone system?
A That is correct.
Q And what about their other communication systems?
A That was other -- anything to do with communications or telecommunications, their video systems, any IT equipment that interfaced with communications at all.
Q I -- IT?
A Information technology.
Q Okay.
A I would sometimes work on a lot of different things when it came to information technology.
Q All right. So, you left there in what year?
A Approximately 2011.
Q All right. So, Ashley was born on October 7th, 2011. Is that right?
A That is correct.

Q While you were still an employee of Spartanburg Regional?
A That is correct.
Q Tell us about that.
Did you and your wife want to get pregnant, get pregnant?
A Yes.
Q Okay.
A Well, she did. Yeah, we did.
Q Now, you have a son from a previous relationship.
Is that right?
A That is correct.
Q And what is his name?
A His name is Hakeem Devonte Flowers.
Q All right. And just so we can know, you -- Hakeem, does he -- when he was born, did he have any complications?
Does he have any physical problems, ailments, anything like that?
A No.
Q In fact, he's an athlete.
Is that right?
A Yes, he was a, a all American receiver and he played at N.C. State.
Q Okay. And he's how much older than Ashley?
A He's currently 24.

Q Okay. But was he living with y'all at the time that she was born?
A Yes.
Q Now, and you have a third child.
Is that right?
A That is correct.
Q And that's a son as well?
A Yes.
Q And what is his name?
A Josiah Flowers.
Q Okay.
A Well, Tristan Josiah Flowers.
Q All right. And how old is Josiah?
A He is three.
Q Three.
And as far as, as he's concerned, does he have any physical disability, ailments, anything such as that?
A No.
Q Is he gonna be an all American too?
A We're working on it.
Q Now, let's talk about Treva's pregnancy with Ashley, and concentrate on it for a few questions.
You wanted to get pregnant, and once you found out she got pregnant, did, did you participate in helping her find an obstetrician who would be able to manage the pregnancy

and deliver the baby?
A Yes, we, we looked at several different doctors, and I asked people I work with and we decided on Doctor Giep.
Q All right.
A Well, I said -- not Doctor Giep. The practice that Doctor Giep's affiliated with, Spartanburg Regional OB-GYN.
Q All right. And once, once Treva started going to the practice for management of her pregnancy, did you participate?
A Yes.
Q Did you go to the office visits yourself?
A Yes.
Q How many did you go to?
A All of them.
Q Okay. Were you aware that, in that practice, the patients are expected to rotate through the different doctors who work in the practice?
A I learned that while attending the visits.
Q And was that okay by you?
A Yes.
Q Did you understand that you, you might not know particularly which doctor would actually be there to deliver the baby once that time came?
A That is correct. I did understand that.
Q And was that okay with you as well?

A Yes.
Q Did you meet Doctor Giep?
A In one of the visits I think I did remember him coming in visiting with us, but it was several different doctors. So, in the visits, I did meet him.
Q Okay. Now, as, as far as you knew, as the expectant father, did the pregnancy seem to be going well?
A Yes.
Q Did, did there come a time where you learned that Mrs. Flowers had gestational diabetes?
A Yes.
Q And how did you learn that?
A In one of the visits they explained what gestational diabetes is, and my wife and I discussed on how to manage that. She did a great job at managing it and making sure she did not do anything incorrect.
Q All right. And, and did she manage it with her -- by just simply regulating her diet?
A That is correct, diet, and, I think, exercise.
Q And, as far as you knew, from that point on when she was seen by the doctors, were they -- did they seem to be okay with the way that she was progressing in her pregnancy?
A That is correct. They -- things seemed normal.
Q All right. Any other complications that came up while she was pregnant that you became aware of?

A No.
Q We've been told that her due date was October 11, 2008. Were you aware of that?
A That is correct.
Q And were plans made between you and Treva as to how you were gonna handle that when the day came?
A Yes.
Q And what were the plans?
A We packed a bag. I drove the route that -- the route to get to the hospital all different times. I, I, I drove to Spartanburg Regional every day for work. So, I went -- I would drive in the mornings so I knew what traffic was like in the morning and at five o'clock, but I didn't know what the traffic was at, you know, twelve o'clock during the day or at, you know, ten o'clock at night. So, I tried that a couple different times to ensure, see which is the best way to go.

We packed a bag. I think she had her bag with her stuff and I had my bag with my stuff.

Q Okay. Were -- you were gonna check in too?
A Yes. Well, I was there to support.
Q Okay. Now, so, October 7 comes?
A Yes.
Q Actually October 6th I take it?
A That, that is correct.

Q Y'all went to bed?
A Yes.
Q And some time a little bit after midnight Treva gets up and says it may be time?
A That is correct.
Q All right. So, what -- tell us a little bit more detail about that.
A Well, I remember her waking me up and saying I think my water broke. Me being a guy, I asked well, how do you know that, and she says cause I'm standing here in water or fluid. At that point, I think we kind of -- reality set in. So, we started to prepare to go to Spartanburg Regional.
Q Okay.
A And so---
Q And---
A ---we, you know, we grabbed everything. She grabbed her bag. I forgot my bag and we got in the car and went to Spartanburg Regional.
Q All right. And did you make it in plenty of time?
A Yes.
Q All right. So, what happened when you got there?
A They checked us in. We went in through the entrance that they had already informed us that we were suppose to take the entrance you pull up. You call on the intercom. They let you in. You go park and then they took her in,

and, like she said earlier, to a small room where the nurses and different medical personnel would come in and check on her.

Q All right. So, at some point, did Doctor Fowler arrive on the scene?

A Yes.

Q And do you remember approximately when that was the first time?

A I do not remember the exact time. I just remembered seeing her and thinking okay, she's here, you know, cause we'd already discussed different doctors. You know, like the different doctors that would come through, and, in my mind, I'm thinking well, you know, she gets to see the doctor that she sees, you know, that she originally went to.

Q Okay. Doctor Fowler indicate any particular problems or unusual, anything unusual about what was happening during the labor?

A No, no issues or no problems.

Q Did you see Doctor Fowler again?

A Yes, we saw Doctor Fowler several times.

Q All right. And on any of those occasions did she indicate that there was any, any concerns out of the ordinary for a labor and delivery?

A No, there was no concerns.

Q From what you could observe as -- well, first of all,

were you in the room the entire time, most of the time, or just part of the time?

A I was in the room the entire time except for maybe going to get a soda or to the bathroom, you know. Well, I didn't, you know, cause the bathroom was there. I think I went and got chips and a soda or something, but I stayed there the whole time.

Q All right. Who else was in the room on a constant basis that day?

A The first room or the second when she moved to the labor and delivery?

Q Well, explain that.

Now, how long -- approximately how long was she in the first room?

A She was in the first room a pretty good while. You know, from -- I, I can't remember the exact time. I just remember she was in her room, and they moved her to another room.

Q Okay.

A So --.

Q Did you understand that they were moving her from say an examining room to a labor and delivery room?

A Oh, I knew we were in the labor delivery room when we got there with all the -- cause it was obvious we had all the equipment.

Q The first room or the---
A No, the, the second room.
Q The second room?
A Yeah.
Q And the first room is more of an examining room where she was seen by the nurses?
A Correct.
Q All right. And so she gets to the labor and delivery room?
A That is correct.
Q And did you know enough about the hospital setup to know that, at that hospital, if it's gonna be a vaginal delivery, they pretty much put the woman in the labor room and let her stay there?
A That is correct.
Q While she labors?
A That is correct.
Q All right. And that's what -- and that's what Treva did?
A That is correct.
Q Everything seemed to go okay as far as you were concerned?
A That is correct.
Q Was she having any unusual pains or anything like that that she was expressing to you?

A Not at that point.
Q All right. Did y'all plan for her to have an epidural?
A Yes.
Q And did she get one?
A Yes.
Q Did it seem to help?
A Yes, the, the first one.
Q The first one did?
A The first one.
Q All right, sir. So, the day wore on and she still hadn't delivered?
A That is correct.
Q That cause any concern to you?
A No, because really this is my first time being in the delivery room or going through the whole process the first time. The first time I wasn't there in the, you know, when my son, my son was born.
Q Okay. And were the nurses saying anything to you that caused concern to you?
A No.
Q So, at some point, did Doctor Fowler arrive and indicate that she was going off-duty and another doctor was coming on?
A Yes.
Q And approximately when was that?

A It was in the evening. I don't want to speculate the exact time, but it was in the evening I know some time after 5:00PM.
Q All right. And do you recall anything that she said at that point?
A She said a doctor would be relieving her, and I don't remember if she gave the name of the doctor. I just remember her saying a doctor would be relieving her.
Q And did it seem as though everything was going according to plan?
A That is correct.
Q All right. So, after that, what happened next that was of any significance to you?
A The next thing I remember -- well, after Doctor Fowler left, you know, the nurses started -- it, it -- trying to find the best way to explain it. The process continued and my wife, you know, was pushing and, you know, they were preparing to have a baby.
Q Now, she -- was she pushing the whole time during the whole day or did there come a point where she just started pushing?
A No, it was a point where she started pushing.
Q Now, did she do that on her own or did -- was she instructed to do that?
A No, she was instructed to do that.

Q By whom?
A By one of the nurses.
Q All right. Was the doctor in there when that first instruction came to push?
A No.
Q All right. But did, did you understand that, when the nurse made the instruction to push, that the nurse was identifying your wife as having reached the maximum point of the dilatation of her cervix?
A I didn't understand what exactly was happening. I mean they were -- the nurses would come in and talk and speak to my wife about different things on what was happening and how far along she was, but I didn't understand exactly what they were explaining. But I knew it was -- and they were saying this is expected, this is normal. So---
Q Okay.
A ---once I heard that, I was fine. I mean I was fine.
Q All right. Did you understand that, by telling your wife to push, it meant that the nurses had identified that the cervix was as open as it, as open as it could expect to get?
A Yes.
Q And that the baby's head would be emerging from that opening soon?
A Yes.

Q And with pushing, it would help move the head along?
A Yes.
Q All right. Were you in a position where you could observe the baby's head coming through the birth canal?
A No.
Q Where were, were you located?
A I was standing at her left shoulder.
Q Okay. Looking back toward her feet?
A Yes.
Q So, did they put her into stirrups?
Did they convert the bed and put up -- put stirrups up and then put her in stirrups?
A At some point she was in stirrups.
Q All right. Was Doctor Giep in at the time that they put her in stirrups?
A No.
Q So, when she began to push, who all was in the room that you can remember?
A My -- the nurses and my mother-in-law.
Q All right. And where was the mother-in-law?
A She was sitting kind of to the side of the bed.
Q Okay.
A You know, to the side of bed.
Q Did she stay in the entire time?
A She left out at some point but she didn't stay. You

know, she was there, but I remember her leaving at some point.

Q Were there other family present in the hospital?

A They were in the hospital, but not in the room.

Q And where were they?

A They were in the waiting room.

Q Okay.

A The waiting room.

Q All right. Was anybody keeping them informed as to the progress of the labor during the day?

A My mother-in-law at -- during the labor, you know, at some point she went out and informed them but not really.

Q Okay. So, did there come a point when Doctor Giep came into the room?

A Yes.

Q And was he ready to deliver at that point or did they have to glove and gown him or what did you observe?

A I observed -- I remember the nurse calling for a doctor several times, and then Doctor Giep came in and went to work. I don't remember him gloving up or anything, and I'm, I'm pretty sure -- well, I don't want to speculate. He came in and went to work as far as delivering the baby. He went straight to the bottom of the bed and started working.

Q All right. And was Treva's legs up in stirrups at that time?

A Yes, when he walked in the room.
Q And did he stand between her legs?
A Yes.
Q Okay. Could you tell what he was doing?
A No.
Q Okay. From where you stood?
A From where I was standing, I couldn't see exactly what he was doing.
Q Were you able to see his hands?
A No.
Q Were you able to see his face?
A Different times I could, but I -- I mean I could see him as he was working, his, his head, yes.
Q Okay. So, were you aware about the baby's head coming out of, out of the vagina and being born, the head being born?
A I, I did not know at the time the head was out.
Q Okay. And were you aware that Doctor Giep encountered a complication known as shoulder dystocia?
A I was not aware that he encountered shoulder dystocia. I didn't know what it was at that time, but when he came in and went directly to work, he appeared to be stressed.
Q Okay. And why, why do you say that?
A Cause he went straight to work. I mean, you know, it wasn't a conversation of hey, how you doing, you know, nice

day or anything like that. He went directly to delivering the baby.
Q All right. Were you aware that he used a vacuum extractor at some point?
A No.
Q Did you know anything about the vacuum extraction process?
A No.
Q So, in terms of any tools that he used, in terms of what he did with his hands or how he positioned his hands, were you able to observe any of that?
A No.
Q Okay. You could just simply see his face and he seemed to be working?
A Correct.
Q All right. Did he indicate that he was encountering a complication?
A No.
Q So, tell us what you do know about those moments while the baby was being born.
A At some point I remember the nurses saying -- telling my wife or one of the nurse grabbing one leg, and from what I can remember, another, another leg was up. I can't remember if I had the leg, but I remember another nurse up -- it appeared to be a stool, but she was taller than me.

She appeared to be in the bed, trying to get in the bed working on my wife's stomach area.

Q Okay. And, and could you tell what she was doing?

A I couldn't tell what she was doing. She was pushing or doing something there at my stomach -- my wife's stomach area.

Q Okay. And did you understand that that was because of a complication?

A No, I just knew, from my understanding of what I could gather, something was not right.

Q All right. So, were you getting concerned at that point?

A Very concerned. Go ahead. I'm sorry.

Q Well, it sounded like you wanted to---

A Well, what I was gonna say is what made me more concerned is because I was in information technology. Doctor Giep was wearing a Vocera badge, which I help installed, and I---

Q What, in fact, what is a Vocera badge?

A A Vocera badge is a little -- basically looks like a little small cell phone. It's about that long and about that wide.

Q Now, the court reporter can't---

A Oh.

Q ---can't take down your, your---

A It's about a inch wide and about 4-inches long.
Q Okay.
A Black. Has a button it -- and it -- it's used -- doctors or nurses use it, mostly, mostly doctors, to reach personnel when they need someone and he pressed the button on his Vocera badge requesting NICU nurses.
Q All right.
A He did that once. They did not appear. He did it again, and, shortly after that, they came in. By me working in IT or information technology, I helped install that and I knew that, in NICU, which is ICU for kids.
Q Intensive care unit?
A Intensive care unit for kids. Well, something was not right for him to call them.
Q Okay. So, he used the Vocera badge and he made a call and that caused you concern because of your knowledge from your employment there?
A That is correct.
Q All right. So, what else can you tell us that you recall about those moments during the birthing process, if anything?
A Just her legs being up and her pushing and the nurses, you know, there beside the bed pushing and the, the, that's---
Q Were you able to see the baby come out?

A I did not see her come out the birth canal.
Q All right. Did you see the baby after she came out?
A Yes, when she came out, I saw Doctor Giep give the baby to the NICU nurses.
Q Okay. And were you able to see anything about the baby that gave you an indication as to the baby's condition?
A No.
Q Were you able to see the baby's arm?
A No.
Q Were you able to see the baby's color?
A Yes.
Q And what was the color?
A It was blue.
Q And---
A She was -- my daughter was blue.
Q Okay. And what did, did the -- when he handed off the babies -- the baby to the nurses, what did they do?
A They started what I understood as working with my daughter. They swaddled her and was doing some other things and I heard her cry.
Q Okay.
A So, at that point, you know, I, I took a deep breath and they swaddled her and---
Q Swaddled her meaning they?
A In the, the -- swaddled is a way you fold the baby in a

blanket, you know, to keep them warm or basically they fold the blanket around the baby.

Q Okay. Did that prevent you from being able to see the baby's arms?

A Correct.

Q And/or legs or---

A That is correct.

Q Okay. And what did they do next?

A They took the baby and just placed her beside my wife's head like, you know, like just quick and then they took -- they left out the room.

Q Okay. And was that what you'd expected?

A No, not at all.

Q What had y'all expected once the baby was born?

A I thought my wife was gonna get a chance to hold the baby, you know, and, you know, kind of enjoy the moment, but that didn't happen.

Q Now, while y'all were still in the labor and delivery room, did Doctor Giep give any kind of explanation as to what had happened?

A No, not while we were in the labor, labor and delivery room. He continued to work on my wife.

Q All right. And when he finished working on your wife, did he give any explanation while y'all were still there?

A No.

Q Did you follow the baby down into the NICU?
A No.
Q Okay.
A I stayed with my wife.
Q Now, so, I take it she was transported up to a regular room in the hospital?
A That is correct.
Q And were y'all given any information once you arrived there about your baby?
A Yes, we were --.
Q What were you told?
A We were in the room. My wife was there. She was sleeping. Then, later that afternoon or later, you know, some time later after the -- we were in the room, Doctor Giep came in and sat down with us and started to explain about shoulder dystocia. Well, I shouldn't say explained. He, he told us that -- about shoulder dystocia, Erb's palsy, and the brachial plexus.
Q All right. Well, tell us as much as you can remember as specifically as you remember it about what he said.
A I remember him saying that he never wanted to experience that again, and he explained that, you know, that he talked about shoulder dystocia, Erb's palsy.
Q Had you heard that term before?
A No, never before.

Q And what did he tell you about it?
A It was when the child's shoulder gets caught on the mother's pelvic bone and that's what was explained at that time.
Q Okay. Did he explain what he had to do in order to free the baby from being caught on the mother's, on the mother's pelvic bone?
A No, he did not.
Q You were about to say he explained Erb's palsy?
A Yes.
Q What did he explain about that?
A It's -- Erb's palsy was and shoulder dystocia -- it -- Erb's palsy is a form of shoulder dystocia or well, you know---
Q At least that's what you understood?
A That's what I understood.
Q Okay. And he explained -- did he use the term brachial plexus?
Do you remember that?
A I don't remember that exactly. I do, I do remember shoulder dystocia and Erb's palsy.
Q All right. Did he indicate to you that nerves were involved in this?
A No.
Q And did he indicate that there would be a need to be

any particular treatment of your baby as a result of this at that time?
A No.
Q When did that happen?
A Well, while he was there, he informed us that he was going to refer us to Charlotte.
Q And was that that same evening that he came and had that discussion with you?
A I don't remember exactly when he referred to -- us to Doctor Nelson, but, at some point, he referred us to Doctor Nelson in Charlotte.
Q While you were still in the -- while your wife was still in the hospital?
A Yes.
Q And she was in the hospital for about three days?
A Yes.
Q And did he explain why he was making the referral?
A Because she had experienced shoulder dystocia.
Q Now, had you had an opportunity to see your baby by that time?
A No.
Q Not before he, he told you about Doctor Nelson?
A No.
Q It was -- so, before you saw your baby he told you about Doctor Nelson?

A Yes. Well, well, let me correct that. We were in the room and we hadn't seen the baby before Doctor, Doctor Giep came in.
Q All right.
A That's what it was.
Q But, but what I'm trying to understand is we know he can't -- based on your testimony, he came into the room and he said that he had encountered shoulder dystocia?
A That is correct.
Q And he explained that term and he explained Erb's palsy to you?
A That is correct.
Q And, and you had not seen the baby by that point?
A That is correct.
Q And you've testified that, at some point, while you were in the hospital, he made -- he said I want you to go see Doctor Nelson in Charlotte?
A That is correct.
Q Had you seen the baby by that point?
A I do not remember.
Q Okay. When you did see the baby, where did you see the baby?
A It was in NICU.
Q Did they bring the baby up to your room?
A No.

Q So, you had to go down and see the baby?
A I wheeled my wife over in the wheelchair to the NICU to go see the baby.
Q Was she allowed to hold the baby then?
A No, the baby, at that point, was still in a, you know, bed or some -- we could not touch the baby---
Q Okay. And---
A ---at that point.
Q And were you able to, to observe anything about your baby's condition?
A There was a lot of devices hooked up, connected to my daughter. I, I just remember seeing a lot of devices hooked up to my daughter.
Q Were you able to see her arm?
A Not at that point cause she was still swaddled.
Q Okay. Now, was she being seen by a pediatrician or a neonatal specialist while she was in the NICU?
A She was being seen by nurses and other doctors. I don't know exactly who they were.
Q Did you have any discussions with the nurses or the doctors about your baby's condition?
A Later on I did. While she was in NICU, yes.
Q Okay. And did they ever explain to you about shoulder dystocia or any problems that your daughter was having with her shoulder?

A Not at that point. They were more concerned with making sure she was stable and making sure she was okay.
Q Okay. But, at some point, did they talk to you about her arm?
A Yes.
Q And while you -- while she -- the baby was still in the hospital?
A That is correct.
Q What did you learn from them?
A That sometimes, with shoulder dystocia, they don't have movement in their arm, arm, but later, you know, it, it -- they don't really know, you know, from my understanding. They just tell you sometimes the child does not have movement in, in their arm.
Q All right. And when you say they didn't know, does that mean you don't know whether the movement's gonna return or, or going to emerge on its own or, or not emerge on its own?
A That is correct.
Q All right. That's what you understood?
A That's what I understood.
Q And it was a wait and see?
A That is correct.
Q So -- but did they make any referrals to other doctors for treatment of the shoulder?

A No, they did not.
Q But Doctor Giep did?
A That is correct.
Q And he was specific?
A That is correct.
Q And was Doctor Nelson?
A That is correct.
Q Did you follow his advice?
A Yes.
Q And when did you first see Doctor Nelson?
A I think maybe after she was released from NICU. Several months later we went to see Doctor Nelson.
Q All right. And Doctor Nelson did what?
A She evaluated Ashley and said okay, you know, she confirmed she did have shoulder dystocia, and then I remember the brachial plexus at that cause I started to research more and try to figure out what was actually wrong.
Q Okay. Did you understand -- did you learn, through your research, that this was a problem with nerves in her shoulder?
A That is correct.
Q Okay. And did you talk with Doctor Nelson and get confirmation of your research?
A That is correct.
Q So, did Doctor Nelson come up with a plan?

A Doctor Nelson then informed us about Doctor Armenta in Houston, Texas and informed us about the clinic that he -- so many times a year, a couple times a year, he will come to Charlotte, North Carolina to see kids with injuries like Ashley.
Q All right. And, as a result of that, did you look into Doctor Armenta's -- Doctor Armenta?
A Yes.
Q What did you do?
A I did research via the Internet. I also spoke with other parents that had seen Doctor Armenta, other parents who have not seen Doctor Armenta, and I read up on Doctor Armenta and Doctor Bergeron.
Q Okay. And did you feel like you had some choices?
A Yes.
Q And what did you understand your choices to be?
A There were other clinics or other surgeons of brachial -- that, that, that treated kids with brachial plexus. One being in Philadelphia. And out of choices I, I had, I decided to go or my wife and I decided to go with Doctor Armenta.
Q All right. Did you have a meeting with Doctor Armenta before he did the surgery?
A Yes.
Q Where did that take place?

A It was in Charlotte, North Carolina.
Q And what was done at that, at that meeting?
A He evaluated Ashley and he also instructed Doctor Nelson of some things to, to do, and he explained to us what sometimes needed to happen to try to correct the brachial plexus injury.
Q Did he make a recommendation at that time?
A I don't -- I think he did. Yes, he did make a recommendation for surgery.
Q And what -- for surgery?
A Yes.
Q And did y'all make a decision immediately or did you wait?
A It wasn't immediately. I wanted to research it more, but we did make a decision soon after that for the surgery cause we had to make a decision quick because, with brachial plexus injury in kids that, newborns, you want to have that surgery early versus later while the nerves are still growing and active.
Q All right. Did -- and did you relate that back to Doctor Armenta in some way --
A Yes.
Q -- that you wanted to go forward with the surgery?
A That is correct.
Q And you did go forward with the surgery?

A That is correct.
Q And that took place in June of 2009.
Is that right?
A April.
Q April.
A Yes.
Q What, what location?
A In Houston, Texas at Hermann Memorial Children's Hospital---
Q All right.
A ---in Houston, Texas.
Q And we've heard your wife's testimony about going out there and how you waited.
Anything that you can add to the circumstances of that surgery?
A I do remember waiting in the waiting room. You know, they started out that morning. It was a very long surgery. Like my wife said earlier, we were the only ones in the waiting room. So, there were cause for concern cause Doctor Armenta initially told us the surgery would take only a couple of hours. And then, after that passed and other parents left, the hospital personnel left, we were the only ones there that literally cut out the lights on us in the waiting room. Had to turn the lights back on.
A nurse did come to a partition like behind the desk

behind a glass and stick a phone out there, and said hey, we'll be in contact with you. They're still in surgery.

Q Okay. Was that cause for concern?

A Very. I was very concerned at that point.

Q All right. And was that concern relieved at some point?

A The phone did ring later, and I answered it and they told us, you know, that the surgery was over and Doctor Armenta and Doctor Bergeron would be out shortly.

MR. HENSHAW: All right. Your Honor, for the information of the Court and the jury, in evidence are all the medical records of, of Ashley Flowers, and, in addition to that, we've marked for identification -- we've, we've marked and placed into evidence the operative reports as well as an illustration that was done in Texas concerning the nerves that were operated on, and they're in these books and individual documents.

THE COURT: Okay. Thank you, sir.

MR. HENSHAW: Thank you.

So, how did Ashley progress after she had the surgery?

A You know, there we couldn't see, at that time, what was -- you know, cause she was bandaged up. Once everything was over with in Texas, they sent us home. She stayed bandaged for six weeks, and then, when she removed my wife or well, when we went to see Doctor Armenta -- not, I'm

sorry, Doctor Nelson in Charlotte, she removed the bandage, bandage and the stitches and we came home.

Well, I remember my wife being in the room with my daughter, and calling and screaming and saying, you know, and I run in and we saw slight movement. We really thought we won the Super Bowl. You know, we were running around the house and celebrating because we, first time, seeing movement in her arm.

Q What kind of movement did you see?

A It was just slight. I mean, you know, it was -- she didn't raise her arm, but she just, you know, tried to move her arm.

Q Now, up until that point in time, was it obvious that the left arm and hand were -- and the wrist were different than the right arm, hand, and wrist?

A Yes.

Q And can you explain to us how you saw it?

A It was turned like awkward or her, her palm was turned out before she had the surgery, but, after she had the surgery, it straightened up. So, it was straight like a, you know, beside her. It wasn't rotating in.

Q Did, did you have any understanding from Doctor -- talking with Doctor Armenta or Doctor Nelson, Nelson as to why the arm would change its configuration that way?

A No, but the nerves -- understood that the nerves, due

to the nerves being -- having issues or being severed, that's why they were -- it was that way.

Q All right. And they were injured?

A That is correct.

Q Okay. Nobody ever told you they had been severed. Is that correct?

A No, no, that's mine.

Q Okay.

A Yes, sir.

Q Now, so, following that surgery by Doctor Armenta, what type of treatments did Ashley receive?

A A lot of therapy. My wife did an outstanding job at giving our daughter therapy every day as much as you could. When the therapist, occupation and physical, would come by the house, she would make sure she understood exactly what they were doing and do the same thing or, or find out extra things that she could do to assist Ashley in her therapy.

Q Now, up until the time she became pregnant, had, had, had Treva been working?

A Yes.

Q And did she stop because of the pregnancy? Did she stop working because of the pregnancy?

A Yes.

Q She stayed, continued to work?

A She continued to work until she had Ashley.

Q All right. And then what happened in terms of her employment?
A She was no longer employed after that. I wanted to ensure that she had all the time she needed to do what was best for our daughter.
Q And, and before Ashley was born and had the complication of pregnancy, what was your plan for Treva going back to work?
A After six months, I figure okay, six months, that's plenty enough time. You know, she'll be back to work, but she never went back to work after that but, you know, we planned for her to be out.
Q Now, was -- did Ashley's condition, continuing condition have anything to do with whether Treva did or did not go back to work even after six months?
A Yes.
Q In what way?
A Because with all the therapy and to provide the correct therapy, I don't see how she was able to work and do that because she was either gonna have to take her to therapy or the therapy person, the therapy personnel will come by the home. With all the appointments, it was either not take Ashley and she go back to work or stay there with Ashley and get the proper care.
Q All right. And was that discussed in your family --

A Yes.
Q -- as to what needed to be done?
A Yes.
Q And the decision was not to go back to work?
A That is correct.
Q Now, did you see improvement in Ashley's arm?
A Yes.
Q And what did you see?
A She would move -- try to move it. You know, she started doing different things. She would, you know, move her fingers more. She would reach for stuff and she was figuring out ways to do things that she wanted to do. Like she may do it different, but she finds a way to do it.
Q Okay. And what about, what about crawling?
A She never crawled. She stooped.
Q Okay. Sitting?
A Yeah, she would sit. She -- her balance was off because it was like she didn't, you know, she didn't really know her arm was there. You know, for her, the way it was explained to me by a therapist is that we're going with both arms and we know they're there. She never knew her arm was there. So, she had to learn that she had an arm there. So, sitting sometimes, she would be off balance you know. So, she had to learn how to sit correctly.
Q Okay. What about pulling herself up or standing only?

A Therapy is what helped with all of that. It's the, it's the therapy that teaches the kid how to do those normal things that other kids just do.
Q Did she walk in the, in the usual timeframe for babies?
A Yes. Yes, sir.
Q And did you -- did -- could you tell whether her arm affected that?
A Yes, I mean she was off balance, but she walked.
Q Okay. So, there came a second surgery?
A That is correct.
Q Is that right?
And who performed that?
A Doctor Armenta.
Q And where was that one done?
A That was in Houston, Texas also.
Q And why was it done?
A That was done to help kind of straighten her cause kids with brachial plexus will try to -- will overcompensate and turn, turn back in where it was already straight, you know, either -- the first surgery helped straightened the arm correct, but then the shoulder tries to overcompensate. So, you have to straighten it -- straighten -- help straighten the kid back up.
Q And, from your point of view, how did that surgery go?
A Very well.

Q And, and did you see or notice a difference after it was completed and she recuperated from the surgery?
A Yes.
Q And what did you notice?
A That she was straighter and that she was getting more movement and, you know, trying to raise her elbow and her arm.
Q All right. And approximately when was that surgery? Do you remember?
A It was February of, I think, 2011.
Q What about a third surgery? Did she, did she undergo a third surgery?
A That is correct.
Q And where was that?
A That was in Houston, Texas also.
Q Who did it?
A Doctor Armenta.
Q And what was that surgery for?
A That was on her wrist, wrist and that is because her wrist is so called hooked and that's my term. That's not a medical term, but it's hooked. So, it was tried to straighten her wrist.
Q All right. And what did you observe about her wrist after that surgery and she recuperated?
A Well, once Doctor Armenta did the surgery, he realized

it was a lot of scar tissue. So, originally that surgery was going to be like a nerve transfer, but once he was there, and during the surgery, he realized there was a lot of scar tissue. So, he said he just removed the scar tissue hoping it would correct on its own, you know, so that he wouldn't have to so call waste a nerve because she may need another surgery later.

Q Did you go into that surgery with the understanding that his plan was to transplant or graft a nerve into the wrist?

A That is correct.

Q And, and he came out and had to report to you that he wasn't able to accomplish that?

A That is correct.

Q Did -- what did you notice after Ashley had that surgery?

A She stayed in a splint for a while so called like a, like people with carpal tunnel wear. My wife would put pretty stuff on it and decorate it so she would, you know, wear it, but she would try to move her wrist more --

Q All right.

A -- after that surgery.

Q Now, did these surgeries leave any scars?

A They did, but Doctor Armenta did an outstanding job at trying to disguise the scar. Actually, when we attend the

United Brachial Plexus Camp, several other parents have seen Ashley's scars and wanted to know who performed her surgeries, and we've actually recommended Doctor Armenta and they, you know, I don't know what they did after that point, but I've recommend him to several other parents.

Q All right. Now, what is the camp you attend?

A It's a United Brachial Plexus Camp. It's a camp that was -- that kids or personnel or adults also -- kids and adults with brachial plexus injury attend. It's held every two years. Originally it was held in Potosi, Missouri, about an hour outside of St. Louis. This past July or this past August, I'm sorry, it was in Daniels, West Virginia.

Q And how many camps have you attended?

A Three.

Q And so that's over the last six years?

A Yes.

Q And what, what types of benefits or activities does the camp provide?

A For us, it was life changing because Ashley got a chance to see other kids who had the same injury as she has. They talk about different things. They have round tables for fathers where I got a chance to meet with nothing but fathers who have kids with brachial plexus. My wife gets to attend a meeting with mothers. You get to meet other people who are experiencing what you're experiencing.

Q And has that been of any benefit to you?
A Oh, definitely, definitely because you learn what to expect. You get a chance to even -- like I like to attend the -- what they call round tables with the teenagers. You have a panel of teenagers to tell you what they're experiencing, how they're gonna experience it, when they're gonna experience it like for girls when it comes to prom and dating and, you know, the pain. Like right now, Ashley's not experiencing a lot of pain, but when she gets older---
MR. LOVELL: Objection, Your Honor.
Q Yeah.
MR. LOVELL: I think he's getting into---
Q You can't go into what, what you learned that may happen in the future.
A Okay.
Q But you can tell what the subjects were.
A The subject there is that what -- the kids explained to me what to expect later in life.
Q All right. Now, have you observed that this has been of any benefit to Ashley to go to those camps?
A Oh, yes, it's helped her self-esteem because she gets to talk to other kids who are experiencing what she's experiencing.
Q Have you noticed whether Ashley has any emotional issues that might relate to -- that, that do relate -- that

you believe relate to her arm?
A Oh, yes. Yes.
Q And what are they?
A Sometimes I've caught her getting upset with her brother, asking why---
Q Her older brother or her younger brother?
A Her younger brother. Asking why, excuse me, does he have use of both of his arms and she doesn't.
Q Any other issues that, that you have observed?
A Her hitting her arm. Having to explain to her what's wrong with her. So, trying to educate her on what the issue is or what her injury is.
Q Now, we've placed into evidence Exhibit 1, which is a summary of the bills that are related to Ashley's injuries to her arm.

Have you -- have you had a chance to see that?
A I have.
Q And I'm not gonna ask you to go through and read it off, but if you'll go to the, the end of it.

What, what is the total?
A $610,364.48.
Q Thank you.

Just one minute, Your Honor, please.

(Pause.)

MR. HENSHAW: Your Honor, that's all the questions I

have at this time.

Mr. Flowers, please answer any questions defense counsel may have.

A Okay.

THE COURT: Mr. Lovell.

MR. LOVELL: Thank you, Your Honor. Very briefly.

CROSS-EXAMINATION

BY MR. LOVELL:

Q Good afternoon.

A Good afternoon.

Q Good morning still or afternoon maybe now, Mr. Flowers. A couple of points going back to the delivery---

A Okay.

Q ---at the time. You told us about the period of time y'all were in one room and then transferred to labor and delivery.

Your wife was in labor for 17, plus or minus, hours?

A Correct.

Q And, during that time, she was having contractions well before they said push, push and all of that, right?

A Correct.

Q And they kind of started not so strong and got sort of crescendo stronger and stronger as the day went on?

A Correct.

Q You mentioned your mother-in-law.

That's Mrs. Bowen?

Is that her name?

A Correct.

Q She was at the hospital as well.

You told us about where you were, but, from your prospective, it's fair to say you really couldn't see what was going on on the business end where Doctor Giep was?

A That is correct.

Q You didn't see the baby's head crowning or the baby's head deliver or anything until Doctor Giep had the baby out and was handing her off to the intensive care people, right?

A That is correct.

Q And when Doctor Giep came in, I mean he went down and started working on delivering your child, right?

A That is correct.

Q Okay. And he worked the whole time he was there?

He wasn't cutting up with anybody or doing anything of that sort?

A That is correct.

Q When you saw the nurses you mentioned getting sort of up on the stool and begin pressing on the area of your wife's stomach, were their hands underneath the bedsheets or whatever?

Could you see where they were actually pushing her or were they hidden from your view by something?

A They was pushing on her abdomen where I couldn't -- you know, I didn't look exactly.
Q Okay. But you knew, at that point, something unusual was going on with the delivery?
A That is correct.
Q In your mind, was it sort of this is sort of an emergency scenario?
A I don't know if I would say an emergency, but something was wrong.
Q After the baby was fully delivered and handed off to the, to the NICU nurses, you mentioned that she was blue in color?
A Uh-huh. (Affirmative).
Q Is that a yes for her?
A That is correct.
Q And also that there was a period of time where she wasn't making noise or crying, right?
A That is correct.
Q But eventually the nurses stimulated or did whatever they did and the baby started crying?
A That is correct.
Q And I assume that was a big relief for you?
A That is correct.
Q Ashley was 7-pounds 11-ounces, right?
A That is correct.

Q And that wasn't -- the doctor said that's not abnormally big for a baby, right?
A That is correct.
Q And, as I understood, you saw Doctor Giep in the hospital before your wife went home, or however many times that was, and then you also went with her to a couple of the visits at his office after she got home, right?
A That is correct.
Q And, in those visits, Doctor Giep would always ask you guys how Ashley was doing, right?
A That is correct.
Q And he expressed concern about how, how your baby was doing after the delivery, right?
A When we went to the visit.
Q The camps you told us about, you mentioned they were every two years.
So, they started when Ashley was four years old?
A I don't remember the first one exactly we went to. She was three or four if I'm correct.
Q So -- and then when she was about six or seven and now this summer y'all went to one?
A Yes.
Q And she is found those kind of help her with her self-esteem as you've talked about?
A Everything.

Q Okay. And she's there with other people, not just kids I guess, who have similar types of, of brachial plexus injuries and different problems that they've had for things?
A That is correct.
Q I got one last question. I have a picture that I've marked as Exhibit 15.
MR. HENSHAW: No objection, Your Honor.
THE COURT: Okay.
Q Do you recognize that?
A Yes.
Q Tell me about when it was taken. I'm, I'm not sure on that.
A That was taken in this year.
Q Okay. There's a bunch of people in there. I'm just gonna ask. I can see you. This is Ashley and your wife's in the middle.
Correct?
A Yes.
Q And is that Josiah?
A Yes.
Q Who's the other lady?
A That's my sister-in-law.
Q Was this at some family event?
A This was at a family event, yes.
Q Was this before or after y'all went to the camp this

summer?
A This is before.
Q Thank you.
Your Honor, we move Defendant's 15 into evidence.
MR. HENSHAW: No objection, Your Honor.
THE COURT: It's admitted.
(WHEREUPON, Defendant's Exhibit No. 15 was received into evidence at this time.)
MR. LOVELL: That's all I've got. Thank you.
THE COURT: Anything else?
MR. HENSHAW: No, Your Honor. Not with this witness.
THE COURT: Okay. You may step down. Thank you.
THE WITNESS: Thank you.
MR. HENSHAW: Your Honor, that completes the plaintiff's case.

(WHEREUPON, the following takes place outside the

presence of the jury.)

THE COURT: Motions or other matters to address.

MR. LOVELL: Yes, Your Honor.

On behalf of Doctor Giep and Pelham Spartanburg OB-GYN, we move for directed verdict on the claims of negligence in this case.

Judge, this case is, according to all of the evidence we've heard, falls within the exception to the standard of care for obstetrical emergencies stated at Code Section 15-32-230. That code Section, Your Honor, states that, in actions involving medical malpractice claim arising out of the care rendered in the genuine emergency situation involving an immediate threat of death or serious bodily injury to a patient receiving care in an obstetrical suite, no physician may be held liable unless it is proven that the physician was grossly negligent.

The three precursors to that are that the defense must show, as the precursor, that the baby or the -- in this case, I guess the baby, the patient, was not medically stable and was in immediate threat of death or immediate threat of bodily injury. And in -- there's a couple of -- there's really only one case really that's talked about that in any detail. It's the Richland Memorial case at 350 S.C. 589.

There's also an unreported case, Gordon versus

Goldstein, and the cites are there, it basically states that when that's -- evidence has been produced by the defense in terms of the affirmative defense, the plaintiff then has the burden of proving that the doctor exercised gross negligence in the care of the case.

We've met our burden of proof through their expert of the precursors. Doctor Gurewitsch, who testified yesterday, testified, in several places, and I'll just quote them, Your Honor, at one point she was asked a question about shoulder dystocia.

It's not predictable, is it?

Q. And there's no doubt this is a medical emergency we have now?

Yes.

Talking about shoulder dystocia.

She also testified, Your Honor, that the question was asked, we will talk in a little bit about how long she was---

THE COURT: Well, excuse me just a minute.

Give me that quote.

This is a quote from her deposition?

MR. LOVELL: Yeah, I'm looking at the transcript.

THE COURT: And you said there's no doubt and she said yes?

MR. LOVELL: About medical emergency, yes, Your Honor.

Let me go back and read it for you.

THE COURT: Does that mean she agreed or she disagreed?

MR. LOVELL: She agreed it was a medical emergency.

THE COURT: Okay.

MR. LOVELL: Yes, sir.

And then the question was asked, but there's no doubt, for a shoulder dystocia baby, can have a serious brain injury or can die as a result of a shoulder dystocia, correct?

A. It can.

Q. Babies do die from shoulder dystocia, don't they?

A. They can.

And the question was, and that's because, when the head is delivered but the body is not yet delivered, the baby is not getting oxygen, correct?

Her answer was it may not be getting oxygen.

Q. All right. And there's no doubt, in this case through the actions of Doctor Giep, that Ashley Flowers avoided brain damage any even death, didn't she?

A. Yes.

And finally, Your Honor, the question was asked, would you agree or disagree that, even though Doctor Giep delivered Ashley Flowers after a one to two minute shoulder dystocia, she was born in some distress?

Would you agree with that?

A. Yes.

And you don't think Doctor Giep, during this delivery, was using no care or was acting recklessly, do you?

A. No, I do not.

So, Your Honor, we've met the precursor of showing there was a medical emergency, the baby -- that the baby was not medically stable as she just stated, that the baby was, at the point of shoulder dystocia occurrence, in immediate threat of serious bodily injury and/or death, and also that the doctor, their own expert's testimony, wasn't reckless or grossly negligent and that's the standard that would be applied in this case.

It's a medical, obstetrical emergency. He's held to a level of gross negligence. Gross negligence has been defined, and I've got a case of Pilot Industries versus Southern Bell, but also the Richland Memorial case referenced it, that South Carolina Courts have recognized gross negligence is only when the defendant has failed to exercise even a slight degree of care, which would be, in essence, exercising no care. She testified he did not exercise no care and was not reckless.

So, we've met the burden of proving that we have established that this doctor is held to a standard of gross negligence, and that that standard was at least met in this case through their own expert's testimony.

So, we move for directed verdict on the case in chief on that ground.

THE COURT: What other grounds do you have?

MR. LOVELL: Your Honor, on the damages that have been sought in the case, plaintiffs have alleged in the complaint they requested future medical expenses, future hospital or caretaking expenses, presumably for parent or children, and also loss of income, presumably future.

There's been no evidence of any future medical expenses that might be incurred. There was some testimony about potentially a surgery that could occur, but there's no evidence of what it would cost that the jury could rely upon to other than speculate to determine any amount of any of these alleged future damages. So, we would move for a directed verdict on that ground, Your Honor.

And they have also pled a claim of punitive damages, which requires clear and convincing evidence of gross recklessness, willful, wantonness, that degree of oppression that suggests a conscious indifference to the consequences. I think, through the testimony of their own expert, that doesn't exist in the case.

So, we move for directed verdict on thevpunitive damages claim as well.

THE COURT: Is that it?

MR. LOVELL: That's it, Your Honor.

THE COURT: Okay. Mr. Henshaw.

MR. HENSHAW: Your Honor, addressing the defense under Section 15-32-230, defense counsel has not given you a complete explanation of that statute. It does apply in certain situations involving emergencies in obstetrical and surgical suite, and that's indicated by Section A. And that is the only part that he believes is applicable to this case.

But the two other sections of that statute, B and C, are also applicable and indicate that the gross -- first of all, it is, it is not a complete immunity. It -- when it does apply, it only applies as to simple negligence or provides a qualified immunity for simple negligence, but not for gross negligence, and -- but even though immunity does not apply under Subsection B where there has been prenatal care by the practice, and we believe that those two sections are intended by the Legislature to be read together such that, in a situation like this where there has been a continuing management of the pregnancy and the patient is now in the labor and delivery room under the care of the practice that managed the pregnancy, the defendant does not get the benefit of the qualified immunity.

But more than that, Your Honor, is Subsection C, which says that the limitation on physician liability established by Subsections A and B, whether you read them together or

whether you read them independently of each other, shall only apply if the patient is not medically stable and in immediate, in immediate threat of death or in immediate threat of serious bodily injury.

That certainly was not the case when she was in the obstetrical suite. She was there all day and there's no indication, from any evidence, that indicated that she was in immediate threat or the baby was in immediate threat of death or immediate threat of serious bodily injury, and, in fact, our expert was asked that question.

In the two minutes that it took to release the body from the pubic bone and deliver the baby, was the baby -- was there a risk of death or serious bodily injury, and our expert responded to that and said no. That would come later and frankly would not come until there was a colloquy between defense counsel about how long that would be but -- and a dispute as to whether it was four or six minutes because Doctor Gurewitsch indicated that it would be six minutes and the defense wants to prove or claim that it's four minutes.

Either way, it doesn't apply in this case because everybody's in agreement that the baby's head was -- that the -- that if there was risk attached to shoulder dystocia, it happened and was eliminated within two minutes before there was a significant risk of death or bodily injury.

Now, the fact that the doctor then created the injury in the way that he went on to -- and created significant bodily injury because of the way that he twisted the baby, that was by his own, that was by his own actions and conduct and not because of a condition that it -- that he had to take over for and try to manage once it occurred.

So, Your Honor, the statute should not be actually even applied here given the language of the statute and the way that it should be interpreted.

As to the other reasons or basis for directed verdict as to punitive damages, defense counsel is correct that the expert of the plaintiff did indicate that she did not find gross or -- well, I think she was asked more specifically about reckless, wanton, willful misconduct. But even assuming that, that the definitions for those would be the same for gross negligence, then I'm not willing -- I would not necessarily agree that they are, but, but assuming that they are the same definitions, based on a conscious disregard, yes, and the expert did indicate she did not find that, but that's not for the expert to determine.

It's for the jury to determine, and the case law, in South Carolina, is, is that a finding of gross negligence, at least in most cases, is reserved as a question of fact for the jury and it's for the jury to determine.

In this case, it would be a reasonable inference that a

doctor who has his hands on the baby and is making a conscious effort to deliver this baby is in a position to know whether he is or is not -- in fact, we heard testimony about the amount of traction and what doctors perceive as the amount of traction, and, and also the lateral traction of the baby's head so that it pulls the nerves away from the spinal cord and stretches them. But he's in a position to know whether he is doing that. It is, therefore, he's in a position to be conscious of it, and the fact that he went ahead and did that, when there was no good reason to do that, could be the basis for a finding of conscious disregard and a basis for punitive damages.

The defendant can't have it both ways. He can't come into Court and say I -- this happened because I had to apply so much traction to get the baby out that I could not avoid this injury to the baby's nerves. First of all, he never said that he did that, but that is implied in terms of the way the defense is constructing its defense in that look how much force it can take to get the baby out, and what a doctor has to do in a situation that we want to call an emergency.

And, and so, if that's what the doctor did is that he made a conscious decision, but he wants to say it was within the standard of care, there's, then there's no evidence that you -- that he made that decision consciously, and, in fact,

he's written that he only applied a small amount of traction or reasonable traction in this case in order to get the baby out, but he doesn't deny that he used traction.

On the other hand, they want to suggest that it wasn't the traction at all that caused this injury. It was this irrepressible contraction force caused by the uterus, uterus that they're calling the maternal forces of labor, and they want to say that that is what caused injury to the baby's brachial plexus. And, of course, that is highly disputed by our experts who, number one, say there that's not possible and, number two, who, who clearly say that the only reason that this baby had the injuries that she did was because of the traction forces applied by the doctor.

So, that would be a question of fact for the jury to determine. So, we feel that there is a basis for the Court to allow the jury to consider punitive damages.

Your Honor, I say that at this directed verdict stage. I may -- I would reserve -- I do reserve the opportunity to make a different decision about that after the defense rests.

THE COURT: I'm satisfied you're gonna make that difference sitting here too.

MR. HENSHAW: Well, well, that's what usually happens in these cases, Your Honor, as you well know.

THE COURT: Oh, it's appropriate.

MR. HENSHAW: So, you know, I, I make the argument now, but I do want to tell you that, as we hear the defense, we very well may come back to the Court and say we, we agree and will take out the punitive damages. But I do want to give you a basis that, at this point, you should allow it to -- either take it under advisement or allow it to go forward.

THE COURT: All right. Let me ask you this.

Is it your view that the jury could make a determination as to the deviation from the standard of care without expert testimony?

MR. HENSHAW: Without that expert testimony?

THE COURT: Yes, sir.

MR. HENSHAW: I don't think so in this case.

THE COURT: All right.

MR. HENSHAW: I don't think this is a case of common knowledge.

THE COURT: All right. You're saying this is a case of common knowledge?

MR. HENSHAW: I said I don't think that this is a case of common knowledge.

THE COURT: All right. Well, if they can't determine if the defendant was negligent without expert testimony, how can they determine whether or not he was grossly negligent without expert testimony?

MR. HENSHAW: Because it's not a -- because this -- it's a question of the standard of care and what the doctor did to -- and, and what the doctor did in regard to that standard of care and how he did it.

THE COURT: Well, I know that but, but what I'm saying is the jury has to consider the expert testimony in deciding if the doctor was negligent.

MR. HENSHAW: Yes, sir. No -- well, I -- may I?

I'm sorry. I interrupted you, Your Honor.

THE COURT: Yes, sir, go ahead.

MR. HENSHAW: Your Honor, what my understanding our Courts have said is, is that, in most cases of medical malpractice, an expert is required to help the jury pursuant, I think, to Rule 701 as to scientific principles and standards of care.

How a doctor does his job pursuant to the standards of care, that can be within common knowledge, but I mean, generally speaking, you know, when I'm saying it's not a matter of common knowledge as to, you know, it would not be a case of common knowledge. That's not to say that there are certain things that, that would be within a juror's common knowledge, and I think that, whether or not he has a conscious disregard or whether he does, does not have a conscious disregard, does not require expert testimony. That's something that the jury has to determine.

Once they understand -- they have to -- the expert has to be there to help them understand what the standard of care is, but I don't think the expert has to be there to tell them whether it's a conscious disregard.

THE COURT: So, you're, you're telling me that the expert doesn't have to say that he deviated from the standard of care in some particular?

MR. HENSHAW: He has to say that much.

THE COURT: Okay. He---

MR. HENSHAW: Cause he has to explain what the standard of care is.

THE COURT: I understand.

And -- but, but you're saying also that the expert has to explain to the jury why there was a deviation because they can't determine that.

MR. HENSHAW: I think that's correct. I do think---

THE COURT: Well, certainly in this case.

MR. HENSHAW: I think that's correct, Your Honor.

THE COURT: All right. Well, if, if you have to have an expert to convince them that he was negligent, and they can't determine negligence without that expert testimony, then how can I determine if he was grossly negligent without that expert testimony?

MR. HENSHAW: Because it depends upon his -- because, once they understand from the expert what the standard of

care is and how the doctor deviated from it, I think that they can determine whether or not that was a conscious disregard.

THE COURT: Okay. I got you.

All right. Anything else?

You want to respond to him?

MR. LOVELL: Just one thing on that.

Their own witness testified though that, in her opinion, the doctor underestimated the forces as most obstetricians do not consciously disregarded anything.

So, I think you're right, Your Honor. They don't have expert testimony that can support a claim for punitive damages.

THE COURT: Well, it could be---

MR. HENSHAW: And I don't disagree with that, Your Honor.

THE COURT: All right. It could be made a lot easier, and I understand a lot of the questions asked of that witness, and there might of been some asked about being reckless, but was there actually one that asked her if he was grossly negligent or not?

MR. LOVELL: It was phrased did he exercise no care, which is the converse of slight care, and slight care is gross negligence, and she answered he didn't not answer -- not exercise no care.

How about that?

THE COURT: So, he must of exercised at least slight care.

MR. LOVELL: At least care.

THE COURT: All right.

MR. LOVELL: Some degree of care.

THE COURT: Okay. I'm gonna read the statute during the break. I didn't have it. So, I'll rule on it after lunch.

MR. LOVELL: Thank you, Your Honor.

Court's in recess until 2:30.

(WHEREUPON, Court was in recess for the lunch hour.)

THE COURT: I've got some more cogitating to do on motions. So, I'll just take them under advisement. At the present time, we'll proceed and then I'll let you know when I've decided it.

MR. LOVELL: Thank you, Your Honor.

MR. HENSHAW: All right, Your Honor.

Your Honor, before we begin, we have what amounts to a motion in limine based upon review of some of the documents that defense counsel intends to use if -- with the next witness.

He proposes to publish certain portions of a treatise called Neonatal Brachial Plexus Palsy, and assuming that he lays the appropriate foundation, I mean he's, he's gonna be

allowed to do that. I have no problem with that. It's the way in which he intends to do it where he has taken excerpts and blown them up on boards and wants to use those to publish those certain portions to the jury.

Mr. Lovell's showing you now one of those.

THE COURT: Okay.

MR. HENSHAW: Your Honor, I'm---

THE COURT: You're not, you're not -- are you intending to introduce it or just use them for demonstrative purposes?

MR. LOVELL: Just demonstrative. The witness will---

THE COURT: While the witness is testifying?

MR. LOVELL: ---lay the foundation. He'll talk about the statement. I'll hold it up.

THE COURT: Okay.

MR. LOVELL: When we're done with it, we'll move on. It doesn't get introduced into evidence.

THE COURT: Okay.

MR. HENSHAW: Well, I would refer the Court to Rule 803, Subsection 18 in regard to learned treatises, which basically -- which says, to the extent called to the attention of an expert witness, upon cross-examination, or relied upon the expert witness in direct examination, statements contained in published treatises, periodicals, or pamphlets on a subject of history, medicine, or other science, or art established as reliable authority by the

testimony and admission of the witness or by other expert testimony or by judicial notice. If admitted, the statements may be read into evidence, but may not be received as exhibits. This rule is in addition to any statutory provisions on this subject.

In my understanding of that rule is, Your Honor, you can publish -- once the witness, even on direct examination, acknowledges this as an authority, reliable authority, then, if he wants to publish portions of it, he can do that, but he can only do it by reading. He can not do it by demonstrative evidence or otherwise.

THE COURT: I don't agree with that.

MR. HENSHAW: All right, sir. That's my objection and that's what I note to the Court.

THE COURT: Okay. Anything else?

MR. LOVELL: No, sir.

THE COURT: All right. Bring the jury in.

Oh, wait. We got to move these things so the jury can get by.

MR. LOVELL: I am sorry, Your Honor.

THE COURT: How about taking those things there and lean them up against that podium for the mean time?

Good.

Who's the first witness you're gonna have?

MR. LOVELL: Doctor Chauhan, Your Honor, and he is

seated right here.

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

THE COURT: Good afternoon.

As you know, the plaintiff has rested in their presentation. So, we're now gonna proceed with evidence to be offered by the defendant.

Mr. Lovell.

MR. LOVELL: Your Honor, we call Doctor Suneet Chauhan to the stand please.

DOCTOR SUNEET CHAUHAN, being first duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

Q All right. Doctor, if you'll pull that microphone close so we can hear you, and would you introduce yourself to the jury?

Tell us your name.

A Yes, sir, my name is Suneet, S-U-N-E-E-T, last name Chauhan, C-H-A-U-H-A-N.

Q Thank you, Doctor Chauhan.

Tell us what kind of a physician you are.

What type of medicine do you practice?

A I initially started out as a general OB-GYN and then I went to additional training in Mississippi to specialize

just in high risk pregnancy. So, I don't do GYN anymore. I take care of pregnant women who have some kind of complications.

Q Tell us a little bit about your education and your training and your experience that led you to be a high risk pregnancy doctor.

A I did my undergraduate outside Philadelphia. Then went to medical school at Thomas Jefferson in Philadelphia after which I joined the Navy. I did my initial training at Portsmouth Naval Hospital in Virginia. I was with the Marine Corp for two years at Camp Lejeune in North Carolina.

After my training as an OB-GYN in the Navy, I served as a general OB-GYN at the United States Naval Hospital, Naples Italy, as a general OB-GYN. After about eight years, six months of service to the United States Navy, I was honorably discharged and I went to Mississippi to do two years of training just taking care of high risk pregnancy that ended in '92, and I've been high risk pregnancy doctor since 1992.

Q And where do you currently practice medicine in this high risk area?

A Currently I am stationed at UT-Houston, which is in Houston Campus. It's one of the University of Texas campus in Houston.

Q All right. And how many years have you been working there?

A Almost four years, sir.
Q Are you involved in any teaching of medical students or doctors in training?
A Yes, sir. So, we start off medical students, third year, fourth year medical students who are interested in OB-GYN, and then I'm also involved with education of 12, 12 times four, 48 residents who want to become general OB-GYN, and then we have fellows like my training in Mississippi. So, we have three fellows at each year. So, a total of nine fellows who want to grow up to just do high risk pregnancy. So, I teach from medical students to all the way to fellows.
Q Now, are you also involved in teaching in any other subjects besides high risk pregnancy?
A I have become adjunct professor in -- Rice University is right next to UT-Houston. I am in their biomedical engineering department. So, currently I'm working with the biomedical engineer. These are engineers who are interested in biomedicine. So, I help them with their research related to OB.
Q When you say OB, what do you mean by that?
A So, one of the things I'm working with the Ph.D. and the biomedical engineering is trying to objectively measure how far the head goes down during delivery, how much traction we use. We are also working with them in this postpartum hemorrhage or bleeding too much after delivery,

and we are gone to Africa with them to try to improve the outcome in Africa using bioengineering modeling.

Q Now, doctor, although you practice down in Texas, have you ever practiced in other states?

A Yes, I have, sir.

Q Where?

A After my fellowship, I was in Peoria, Illinois. Subsequently I was at Medical College of Georgia in Augusta after which I moved to Spartanburg. I was at the Spartanburg Regional Medical Center for seven years after which I moved to Wisconsin and then Norfolk, Virginia, and now Texas.

Q Now, in the seven years you were here in Spartanburg practicing medicine, what type of patients were you helping out?

A So, I was a high risk pregnancy. So, I did maternal fetal medicine, and I use to take call, up to three to four calls at night, where I practiced as a general OB-GYN at nighttime.

Q Which hospitals were you doing this at here in the Spartanburg area?

A Only at the Spartanburg Regional Medical Center.

Q Were you ever on any staff positions or administrative positions with Spartanburg Regional?

A No, I was just the director of maternal fetal medicine.

There were two of us and about four stenographers and multiple ancillary staff of nurses.

Q Now, when you were here in Spartanburg, did you know my client, Doctor Giep?

A Yes, I did. His office was above our floor, and we literally back -- my backyard was connected to his backyard.

Q And did you know his, his father, his brother, some of the other doctors over in his practice group?

A I knew his father. He was, not to get too Asian, but he was like a father figure. He advised me when we moved here. I admired him immensely. I met his younger brother. I think I was leaving when his younger brother was coming or starting. I think there was a brief overlap. Maybe a few months. But I knew Giep and I admired his father immensely.

Q Now, with this relationship that you've had with Doctor Giep and knowing his father and his brother, is that, in any way, affected the opinions you've given or you're gonna give us here that you formulated about the care that Doctor Giep rendered in this particular matter?

A It honestly has not because every opinion I have, I know sounds nerdy, is usually backed up by publication, by research either in America or from other countries or from national guidelines or national things. So, it's not just my opinion. Everything I would say will have a reference or a citation of an articles. So, these are the kind of

objective truth.
Q And, doctor, I may of missed it, but I think I forgot that.
Where did you attend college and what degree did you get there?
A In my undergraduate degree was at liberal arts college outside of Philadelphia called Arcadia, and my major were chemistry and biology. My medical school was at Thomas Jefferson in Philadelphia.
Q And you told us about your residency.
That was in -- when you were in the Navy program?
A Affirmative.
Q All right. What was your final rank there in the Navy?
A When I was discharged in 1992, I was a Lieutenant Commander in the Navy or a Major in the Army.
Q So, how many years have you been practicing as an obstetrician delivering babies, whether they be high risk or otherwise?
A I finished my OB-GYN training at Portsmouth Naval Hospital in 1990. So, I've been delivering babies since at least 1990 if you include my two years training as OB-GYN since '86.
Q And are you board certified?
A Yes, I'm board certified both in OB-GYN and in high risk pregnancy, maternal fetal medicine.

Q And have you had to recertify since you got initially board certified in those areas?
A Yes, sir. So, these years everyone has to be board certified -- recertified. That includes taking -- reading OB-GYN and MFM or high risk pregnancy articles, about 20, meet subject, doing the multiple choice questions. You submit it to the computer and they grade you.
Q We know you're licensed in Texas.
What other states are you licensed to practice medicine?
A I was licensed in South Carolina, Mississippi, Illinois, Virginia, and Wisconsin.
Q And I asked you about your hospitals you worked at here.
What, what ones are you practicing at there up in the Houston?
A So, Houston does more deliveries than any other city in America. We literally go to ten hospitals. Currently now I am going to five hospitals. So, depending on the day of the week, we go to different hospitals. I take care of high risk pregnancy primarily during daytime. At least two to four times a day I'm on labor and delivery in one of the biggest teaching centers, the main hub, and I'm on call three times in -- three times a month, two weekdays, and one 24-hours on the weekend when I'm on call actually doing the

delivery.
Q So, you're delivering babies yourself?
A I was on call this Sunday.
Q So, of all these other things, do you do research and investigation type activities as a doctor?
A The main reason for me to move to Houston was Houston is one of the 12 centers in America which does research in conjunction with 11 other institution (sic) where -- and I also, to be humble opinion, one of the best OB research center in America. I'm the head of that research. We call in principal investigators. So, I'm the principal investigator to do NIH research at UT-Houston.
Q What does NIH mean?
A National Institute of Health and Bethesda.
Q Okay. How many babies would say you've delivered over your years?
A And this is a reasonable estimate, but it is, it is an estimate, I would say seven, eight thousand.
Q And how many say last ten years?
A I'm averaging about 150, a hundred less. So, ten times a hundred, 150.
Q Per year?
A Yes, sir.
Q Now, are you familiar with the medical complication that we've all heard about called shoulder dystocia?

A Yes, I am.
Q And are you familiar with what is considered in the field of obstetrics to be the way that most physicians, most competently trained obstetricians, would manage and react to a situation where a patient develops shoulder dystocia during a delivery?
A Yes.
Q And that's what we kind of call the standard of care. Are you familiar with that?
A Yes, sir.
Q All right. And, in 2008, which was the time that this baby was to deliver, are you familiar with the standard of care required of obstetricians when faced with a shoulder dystocia?
A Yes, I was.
Q How many times have you personally -- well, first, let's -- have you personally, in your many deliveries that you've told us about and encountered shoulder dystocia during a delivery?
A We had one this Sunday.
Q So, how many times, over the course of your career, have you seen that you think?
A So, the national rates are anywhere in the country, it's about one out of a hundred deliveries. So, if you have a hundred babies born in any hospital, you'll encounter it

one time. Because I take care of high risk pregnancy, it may be higher. So, I would say at least one, if not more than one percent of all deliveries.

Q So, would that be in excess of 50 to a hundred?

A I wouldn't be surprised with that.

Q Now, another issue that we've heard about in this case involves fetal heart rates, and what's been termed as deceleration.

Is that something you're familiar with as an obstetrician?

A I'm -- not only am I familiar with it, matter of fact, when I was in the Spartanburg Regional Medical Center, I was invited to write the national guideline on fetal heart rate monitoring at that time. So, not the current one, but the one before. These are the national guideline of fetal heart rate monitoring during labor.

Q All right. And, doctor, let's talk about the management of shoulder dystocia.

When it's got an element of some decreased fetal heart rate, are you familiar with the, the management of that scenario similar to what happened with this delivery?

A Yes, I am.

Q Are you familiar with how most obstetricians, in general, would manage those conditions when they occur in a delivery such as what was faced with Doctor Giep or with

this patient?
A Yes, I am.
Q Are there any publications that you've been involved in that deal with this complication of brachial plexus palsy in newborns, in babies?
A While I was still at Spartanburg Regional, I wrote one of the largest series of brachial plexus incidents and we have written several publication of brachial plexus. Now I think we have over 20 publication on shoulder dystocia or brachial plexus. We were invited by ACOG, which is American College of OB-GYN, to write what I think is the best synthesis english literature on the topic brachial plexus at that time.
Q And what is that particular document called?
A It's called Neonatal Brachial Plexus Palsy.
Q And was that one that you were one of the authors or participants in that study?
A I was both an author and an active participation -- participant in the actual editing of the whole book.
Q Before we get into that, but I just want to ask you a few basic things.
You were retained to -- by my office to look at this particular case and the information about this -- Doctor Giep's care of this patient and this baby, correct?
A That is correct.

Q Did you review all of the medical records from Spartanburg Regional that related to Doctor Giep's care of the baby, both he and Doctor Fowler, while she was there in the hospital?
A Yes, I did.
Q Did you review the prenatal records from Spartanburg & Pelham OB-GYN prenatal care when she was pregnant up until the time she went to the hospital?
A Yes, I did, sir.
Q And have you reviewed the medical records from the doctors that treated Ashley Flowers after she left the hospital at Spartanburg Regional and the various therapies and surgeries and things of that sort?
A I'm not an expert on children and actual brachial plexus in the children, but I am -- know that she did have three surgeries. Matter of fact, it was in the same hospital where I'm currently employed at. So, I know she had surgery, but I'm not an expert on brachial plexus in children.
Q When you say you're not an expert on brachial plexus in children, you mean surgery on brachial plexus?
A Affirmative.
Q Okay. Are you -- do you have expertise in the area of what can cause those types of injuries in babies, in children?

A That is my area. So, how does pregnancy, labor, and afterbirth, any component of that, lead to or is associated, linked with cause brachial plexus, that is my area of interest.
Q But when it comes to the things such as what Doctor Armenta did with the surgery to attend to and improve the function, is that outside of your area of medicine?
A Absolutely.
Q Okay. So, with regard to the things you reviewed, did you also review the medical -- I mean -- I'm sorry, the depositions that were taken in the case including that of Doctor Giep, of the nurses that were involved in the labor and delivery process, both Mr. and Mrs. Flowers, the grandmother that was deposed in the case, along with all the various expert witnesses that were deposed?
A Yes, I have.
Q And from the medical records you reviewed, the depositions that you reviewed, did you get a good understanding of what occurred with the delivery, not only just the deliver, but from the time of the pregnancy all the way through the delivery with regard to this child and, and the services that Doctor Giep rendered?
A Yes, I have a, I have a pretty good understanding, yes, sir.
Q Were all of those materials that you were provided

helpful to you in assisting you to come to some conclusions about the standard of care exercised by Doctor Giep?

A Yes, they were.

Q And what -- from the prospective of what an obstetrician could do, what's your understanding of what the standard of care is that's required of him?

A The standard of care is what most doctors or most clinicians in similar situation would do in the United States given the similar circumstances.

Q And, doctor, do you feel that your education, training, experience, and your knowledge of this case would help our jury in kind of understanding the process of this delivery, whether the standard of care was exercised, and also what might of been potential causes of the injuries suffered by this child?

A Yes, it should.

Q Now, let's talk about your research in the area of brachial, brachial plexus injuries in neonatals, in babies.

How many years have you been involved in doing that type of research?

A I think my very first publication on this was when I was still in South Carolina. So, that was, I think, if I remember correctly, around 2005 is when it was published. So, let's say 2003. So, I've been working on it since 2003.

Q Okay. And, in addition to that, during this time, have

you also been delivering the babies and doing the things that you told us about earlier?

A One of my thing or my wife says is I do research instead of reading or doing crossword puzzle or watching football. So, that's my hobby. That's what I do at home in the evening and the morning.

MR. LOVELL: Your Honor, at this time, we move -- tender Doctor Chauhan as an expert in the area of obstetrics and brachial plexus injuries and management of children who present with shoulder dystocia and fetal distress during a labor and delivery.

THE COURT: Any objection?

MR. HENSHAW: Oh, no objection as to his qualifications as an expert as an obstetrician in regard to the standards of cares, but given what he has said here today and elsewhere about his knowledge of, of nervous system or particularly, in particular the brachial plexus part of the nervous system, I do not think that he is qualified to address the causes of brachial plexus injury.

THE COURT: Overrule the objection.

Q The various studies that you have done, the research you have done, has that been published in any peer reviewed -- I mean doctor reviewed publications?

A So that 20 plus articles we mentioned, I mentioned before on shoulder dystocia and/or brachial plexus, these

are all peer reviewed, which means that, once you write the manuscript, you send it to the journal. The editors of the journal send it to two or three people who are clinicians and/or researchers. They comment on it, edit it, criticize it, gives it thumbs up or down. They may ask for revision and, subsequently, it gets published if it gets thumbs up. So, that's call peer reviewed process.

Q And are you also familiar, from your research and your study in this area with other peer reviewed and published materials from other countries, not just here in the United States, on dealing with brachial plexus injury and its causes?

A At, at least twice we have summarized the literature. So, you can get on what we call PubMed and look at everything published on the topic of brachial plexus in the English language. You can pull all the article (sic) and I call it synthesize. You can take all the data and put it in a simple table. We have done at least that twice.

Q Now, doctor, from all of your research and your understanding in this area, is there an understanding you have about the percentage of cases of brachial plexus injury in babies in all of those studies that were not associated with the occurrence of a shoulder dystocia event where the shoulder gets stuck on a -- one of the maternal bone structures?

A Yes, I have.
Q What are -- is your understanding of that?
A So, the simple way to -- please forgive me if I try -- I'm not trying to be too simplistic. Let's imagine there are ten babies born with brachial plexus today at any hospital. If they're ten babies born with brachial plexus, over four, less than five, so, four and half will have no shoulder impacted. So, in ten case of brachial plexus, four and a half approximately will have no difficulty by the clinician, it could be a midwife or a doctor, in delivering the shoulder.

So, the baby comes out and there's no difficulty with delivery of the shoulder and the baby still has brachial plexus. So, it's about four out of ten, four and a half out of ten.
Q And of that four and a half out of ten, is there a percentage of those children that have this brachial plexus injury without shoulder dystocia that is deemed to be permanent?
A Yes. So, permanent, for us, means that the difficulty moving the arm has lasted at least for one year after birth. So, that's our limits of one year after birth, the baby, the child can not move the affected arm to the -- like the other arm. The chance of that is two out of ten. So, two and a half out of ten, which last for more than year, will not

have any documented shoulder dystocia problem.
Q I'm gonna go to the ACOG, American College of Obstetrics and Gynecology Task Force.
How many other doctors were involved in that process in the production of that particular report?
A So, in this, I believe there were about ten of us in different discipline. So, they were high risk pregnancy doctors, there was a neonatologist, and there was a biomedical engineer. There was a neurosurgeon. So, initially were invited. Then it was -- I think it's one of the most extensively peer reviewed, not only by other doctors, but other society on this topic. I'm not aware of any document which has undergone more extensive review or critical appraisal than any other publication on this topic.
Q In the earlier testimony I think from Doctor Allen, he indicated that, in the past, he had worked with a Doctor Bernard Gonik.
Was Doctor Gonik involved with the ACOG publication?
A Yes, he was one of the coauthors of this document.
Q In your opinion, is that report that came from the American College of Obstetrics and Gynecology Task Force, is that a reliable source on the subject of brachial plexus injuries both with and without the occurrence of shoulder dystocia during a delivery?
A At that time, it was the most comprehensive, exhaustive

synthesis or summarizing all the publication. Since its publication, I'm not aware of any publication which has contradicted the summary or the finding of this. To me, it is currently still the most reliable source of information on brachial plexus in English language.

Q And is that an authoritative source and text of information?

A I'm not aware of anything which is more authoritative.

Q In, in your opinions that you've formulated with regard to this case, and the injury suffered by this child, and the care rendered by Doctor Giep, did you rely upon the ACOG report and the contents of that to arrive at your opinions?

A Yes, because what's in there is part of my Lexicon or my -- call it my memory. I may not know word-for-word or verbatim, but that has become part of me cause I was literally involved from time zero in editing it extensively and having reviewed it and talked on the topic.

Q I'm gonna show you what's been marked as Exhibit 8 previously, doctor, and I've got the last page.

Now, is that a copy, a xeroxed copy of the Task Force report we've been talking about?

A Yes, sir.

Q And what's the official title of it that's printed on that?

A It's called Neonatal Brachial Plexus Palsy, and

underneath the logo of the ACOG, the American College of Obstetrician and Gynecologist.

Q About how many pages is that document, the substantive part of it?

A I would say over a hundred to a hundred and ten.

MR. HENSHAW: Your Honor, I need to inquire.

That's been marked as Exhibit 8 or has it been introduced?

MR. LOVELL: For record purposes only, Your Honor. I'm not moving it into evidence at this point.

MR. HENSHAW: Okay. I mean as long as it---

THE COURT: It's marked as a Court's Exhibit for use by the witness while he's testifying, but it will not be submitted to the jury.

MR. HENSHAW: Thank you, Your Honor.

Q I want to move to talking about, at this point, the delivery of the child.

As far as this, the prenatal course with this particular child doctor, was there anything about it, in your opinion, that was out of the ordinary or not well managed according to whatever the standard of care required under this patient's conditions?

A No, sir, the prenatal care or the care before delivery was more than adequate. I would say it was very good in the sense they diagnosed the diabetes during pregnancy,

gestational diabetes. As you said earlier, they did a wonderful job of controlling it, checking the sugar, getting the ultrasound, making sure the baby was not too big. So, the prenatal care from the first visit to the last visit was done very well.

Q And in terms of how babies are born, once Mrs. Flowers arrives at the hospital, her water has now broken, and in terms of the stages of labor, how do y'all, doctors, divide that up?

A So, before birth, we like to keep it simple. So, call it the Stage 1. So, from regular contractions. So, if you, if you -- forgive me. This, this is how I teach my medical students.

This is the birth canal. This is the baby or the water bag. So, this is zero centimeter. You start contracting. Then it opens up. Once you get to ten centimeter, that's a Stage 1. So, this is Stage 1. So, the baby is come from here, the birth canal has opened up. It's now 10-centimeters and then the mother starts pushing, and the baby -- when the baby's completely born, that's the Stage 2.

So, from 10-centimeter to the actual birth is a Stage 2 delivery of the placenta or the afterbirth is a Stage 3. So, one, two, three.

Q And in the course of this baby's development during the prenatal stage up until the time Mrs. Flowers gets to the

hospital, was there ever any need to or consideration of a C-section based upon baby's size or baby's condition?
A No, a C-section should not have been done in this case prior to the onset of the labor. There was no indication.
Q Was the baby of a size that normally would be susceptible or capable of a vaginal type delivery, the natural way?
A More likely than not, overwhelmingly, based on all the information available at the onset of labor, the baby should have born vaginally without any complication.
Q From your review of the medical records in that first stage of labor that you just described, was it uneventful?
A Yes, it was.
Q And why do you say that?
A In the sense that the -- admittedly, the labor was 17-hours and I'm not trying to minimize the pain. The fetal heart rate tracing was doing fine. Her vital signs were fine, and she progressed or the cervix dilated at a normal rate. Though 17-hours is a lot, from OB's point of view, that was a normal progression of labor and fetal well being while she was -- so before she started pushing.
Q Okay. And then before we start talking about the pushing part, which I think you called the second stage?
A Yes, sir.
Q Is that right?

I want to ask you some questions about brachial plexus injuries in general.

Can you explain to us, and from your understanding, the different ways that brachial plexus injuries can occur in a, in a neonate or a baby?

A So, I'm going to start with the least common and go up.

So, usually -- so, we talked about the anterior shoulder. Anterior shoulder is what faces the roof or the, excuse me, the bladder bone. So, you can get those injury quickly, a brachial plexus in the posterior.

So, even though this shoulder, the back shoulder, the one facing the bottom or the floor is not stuck against the bladder bone, you can still get it and this is even before the doctor has touched the head. So, there's a suggestion that the doctor doesn't even have to touch the head to get a brachial plexus. So, that's one.

The second one, we originally said, you know, they're also that when a woman has a C-section, so during a C-section, there's no way the bladder or the shoulder gets stuck behind the baby's bladder bone is when you're delivering without any impaction of the shoulder, you can still get brachial plexus.

The third one is as we mentioned before. About four and a half out of ten brachial plexus have no shoulder dystocia. That's been shown in American studies. We

recently showed it. It has been shown from countries outside United States. The very first report, if I remember correctly, actually came from Libya.

So, other OB-GYN in other countries have shown that you can have brachial plexus without shoulder dystocia in the last one, or the more common one, let's say five out of six, five and a half out of ten happen in conjunction with shoulder dystocia.

So, those are the four. The dock -- in the back bone without any impaction, Cesarean delivery without shoulder dystocia, and the last thing, with shoulder dystocia.

Q In the ones where there's no shoulder dystocia that occurred during the delivery, but the child has a brachial plexus injury discovered after the baby's delivered, what causes that?

A So, our understanding of what or how or what we hypothesize of what is happening is so, when the head is there, it lets the baby breathe, 7-pound, 8-pound, or 10-pound bad. It has to go from here to come out.

It takes force. Well, now, you can say well, this is only so many centimeter, but the head has to navigate through the birth canal and come out. That takes a lot of force. If you think about it, to push about an 8-pound through part of your body, and I've asked -- people have always said a kidney stone. Imagine pushing an 8-pound

kidney stone. It takes a lot to bring the baby out.

During the process of getting the baby out, you can have other traumas beside brachial plexus. You can even rupture the uterus. So, there's a lot of force being generated, and once the shoulder hits, so the head is coming out and the shoulder hits the bone, so the head is coming out in this, authors have suggested that they -- stretch. So, the head is coming out where the shoulder is struck.

In this case, without being stuck, the compression of the uterus is one of the thought process of what caused this brachial plexus injury without shoulder dystocia.

Q Now, doctor, you've been talking about how the babies come down and then I've got a diagram here that, for discussion purposes, I've marked as Exhibit 10.

Can you, with the Court's permission, come down and explain to us sort of how the baby moves down through the body?

THE COURT: Yes, he can, but now, you got a court reporter over here.

You understand that?

THE WITNESS: Yep.

Q So, what you got to do, doc, is you need to stand over on that side.

THE COURT: And keep -- let's do this.

Can you move -- go ahead and leave that right there for

now.

If you'll move that?

Yeah, and if you'll move that podium back towards the table?

MR. LOVELL: Got you. Thank you, Your Honor.

THE COURT: All right. Now, you can turn that. Kind of square it up. Well, let's have him -- I don't want his back to the court reporter. Square that up with the jury. Move this way.

All right. Now, I want him on the side where you're at.

MR. LOVELL: Where I'm standing now, right.

THE COURT: And I want the court, I want the court, the court reporter to be able to see your face as you speak.

THE WITNESS: Yes, sir.

THE COURT: Okay.

Q And I got a little pointer thing that might make it a little easier. So, you stand like about right where I am so she'll have an eyeball view of you and you can use this as a pointer.

Will that work?

THE COURT: You can move that up closer if you need to.

MR. LOVELL: Okay.

Q Come on down now, doc.

A Yes, sir.

Q So, stand about here.
A (Witness complies.)
Q So, what -- the question I had asked, doctor, was can you explain to us sort of -- if this diagram -- well, is this helpful in explaining how the baby moves down through the birthing process when a shoulder dystocia has not occurred.
A Yes, it is. So---
Q So, explain that to us.
A So, you know, as doctors can't remember, so we use to come out with a pneumonic device. My pneumonic device was head, feet -- I know it's misspelled -- this is spelled -- but e-d-i-f-e-e.

So, engagement is when the head has occurred about here. So, this is the, the prominence of the spine. So, this is where the head is coming down. Sir -- so then the first is engagement. So, the head has engaged and then the decent. So, now the head is coming down, and then there is a flexion so that the head is flexing in. So -- because if the head is stayed stretched, it doesn't come out. So, it has almost like to do a little bit of tucking, flexion, and then internal rotation.

So, internal meaning while it's still inside the mother it has to tuck in and rotate. So, it does internal rotation. Then it is going to do a little bit of extension.

So, from tucking in, now it's the baby's head is going to tuck out, and then extension, and then, once it comes out, it's going to do external rotation, and then the last thing is expulsion. So, the baby actually is getting pushed out. So, it's called head feet.

Q Now, to stop you briefly, doctor, you mentioned over here -- you stand over there and I'll just stand here and make -- talk loudly.

At this point, which you said is what the extension?

A Extension and external rotation.

Q Is the baby still inside the mother?

A Yes, it is.

Q And as the baby is coming down the birth -- and I use the word birth now.

Is that the right word?

A (Witness nods affirmatively.)

Q The birth canal, is it always in the same alignment, head, shoulders, and the rest of the body?

A No, because to squeeze -- literally the baby is squeezing. So, it's literally -- as you -- you know how you move the furniture when you're trying to get to the door?

So, you have to kind of rotate and move. Your baby has to do the same thing through the birth canal.

Q And the forces that you were talking about a few moments ago that get applied by -- during this process,

where are they coming from?
A So, the way I look at it, so, this is the uterus or what I call the baby's -- where the first room and the baby's like this. So, this contracts. So, the whole room, all these muscles around here, they all contract and they literally push the baby out.
Q And as the baby is moving down the birth canal and doing these different twistings or whatever you've described it, are the forces that are getting pushed upon the baby's body by the uterus reacting upon whichever part of the body of the baby is touching different other structures?
A Yes. So, the force comes all through the body because the baby has to come out. So, anything, the bone, the clavicle bone has been known to get broken. Leg bone broken during the birthing process. We've had skull fracture and brachial plexus is one of the other things. So, the fact that the baby can get trauma during coming out is a known phenomena not only to brachial plexus but just about every part of the body.
Q And in these lower two parts of our diagram, the baby's head, is it now outside of the mother's body?
A Yes. So, this is -- so now the baby's head is literally coming out. So, this part is visible. So, anyone, attendant or grandmother, would be able to see that. Mother wouldn't see it and the doctor will so. Now just the

head is out. Rest of the body is still inside the birth canal.

Q Is -- now, I look at this one though, the one that's marked E on our exhibit here, it looks like the baby is sort of looking downward as opposed to sideways.

What -- what's going on there?

A So, babies, when they come out, they often look down. So, we call it occiput -- this is the occiput bone anterior. That's up there and they look down. So, that is one of the more common way when the baby's come out. They can be looking down sideways, this way. Once in a blue moon, be looking up, but this is a very common way for the baby to come out.

Q And, in this case, which way was Baby Flowers coming out?

A My understanding is O-A. So, some -- akin to this. Something like this.

Q Now, in the last view here, we see the baby has -- is looking towards us.

How does that happen?

A So, it can have external rotation. So, either when the baby -- imagine this is the baby and this is the head. This is the face looking down. Either it can turn or with the doctor helps. It can turn. But when the mother is pushing, it can turn sideways. So that is known phenomena.

Q And is that what normally transpires between this point and this point, the baby is turning a little to the sideways?
A Yes.
Q Okay. Thank you, doctor.
Go back to the stand.
A (The witness returns to the stand.)
Q Now, doctor, we've talked about shoulder dystocia and our jury has seen some diagrams that talk about it. I hate to ask you to get down again.
Can you briefly come down and let's talk on shoulder dystocia?
A (The witness comes down from the stand.)
Q As we looked at the cardinal normal movements, can you explain to us what shoulder dystocia is, and, and we're really talking about the anterior, the upper shoulder in this case, correct?
A That is correct.
Q Can you show us, on this diagram, sort of how that happens?
A Yes, sir.
Q And, again, if you'll stand far back so the court reporter can hear -- and see your face and hear you.
A So, in this case -- so, these are the doctor's hand. So, this is when the head is literally come out of the birth

canal. So, these are the doctor's hands and then this time you do not know whether there's a shoulder dystocia. So, it looks like a normal head has come out.

When you try to deliver the baby, so with gentle traction, so, the head is out and you put the head just like this, you move slightly down that, most of the time, overwhelming majority of the time, the anterior shoulder, the one to the roof or the one to the bladder bone, the shoulder will just come out and then the whole baby comes out. Once you deliver the anterior shoulder, the one facing the roof, the whole baby comes out.

When you have a gentle traction, the baby -- the shoulder doesn't come out and the baby doesn't come out. That's the moment you know you have anterior shoulder.

So, this is the shoulder. This is the bladder bone or symphysis. This shoulder has impacted. So, the way I look at it, if this is the shoulder, it's stuck behind the bone. And so it will not move and this is a diagram of brachial plexus when it -- so, the baby's coming this way. This is stuck. There's some thought process that that process tried to -- and then this is trying to move the shoulder out. If the shoulder is stuck, we try different things.

One of them is you can move the shoulder, dislodge the shoulder by turning it towards the chest and this is a doctor's hand or a clinician's hand attempting to do that.

Once you dislodge this shoulder against the bladder bone, the rest of the baby comes out.

Q In this maneuver, are you attempting to turn the shoulder towards the baby's chest?

A Yes. So, this, this is the bone that's stuck. You can go like this. So, you can twist. You bring it to where it's inside the child's sternum or the midline and then you can decrease this way.

Q You call this, I think, the, the bladder bone.

Is that the pubic symphysis?

A Yes, symphysis pubis. So, this is the bone right here, pubic symphysis.

Q Thank you. Take a seat.

A Yes, sir.

(The witness returns to the stand.)

Q Now, doctor, in the last say ten years or so in the medical community, has there been a -- any changes in the thoughts about what causes brachial plexus injuries in babies who are born with that condition?

A Yes, there has been a gradual progression or changing in the thought process of the possible causes of brachial plexus, yes.

Q And, and what has been that shift or change?

A One of the earlier paper, when someone reported that it can happen with posterior shoulder was one of the reported

or wake-up call let's say. Then there were multiple reports, not only from United States, but other countries that they were reporting on brachial plexus without shoulder ever getting stuck. Then there were reports of C-section associated brachial plexus.

It was the combination of the three which made us, not me, but other investigators, propose the concept that the mother's forces, explosive forces, plus the impaction and the head coming down can lead to brachial plexus palsy.

Q Does the condition of the baby, prior to that very end when the head is come out, but, you know, prior -- before the crowning, I'll just use that, does the condition of the baby -- is there any thought in, in the research or in your opinion about the condition of the baby having a factor upon development of the brachial plexus injury?

A There are reports out there that the baby, if let's say the tone isn't good or the baby has some other thing going on or the baby is not at the optimum, then it takes less to injure the same brachial plexus.

Q And how does that -- I mean explain the, the, the science or whatever behind that?

A So, the way I look at it is, during any process, anything we do, we playing sports or anything, we can get injured. When we are not at our best, it takes less to get injured. So, if you're not in a good shape, imagine and we

played, I don't, flag football, tennis, or whatever, if we're not in a good shape or let's say we have a bad cold and do something, it takes lower threshold to get injured is the simple way I conceive of it.

Q And in babies who are suffering from a depression in fetal heart tones, does that affect the, the strength of the brachial plexus complex to resist injuries from the birthing process?

A And there are publications which it state that that is a truth statement.

Q And why is that?

A To me, it's the similar process. Babies who are not adequately oxygenated, it's like -- I always call it, you know, when I get a cold, if I get a cold, it takes less for me to get even more injured. So, that's the way I think of it in my mental image.

Q Now, doctor, in -- when a shoulder dystocia occurs and is recognized by the doctor, and, you know, the baby's not coming out after the head is delivered, is there a danger to the, to the baby at that point in time?

A Yes.

Q All right. What are those dangers?

A So, the moment you realize that the shoulder of the baby's not coming out, it is a moment where everything freezes and everyone will say well, it will be over in a

minute, but you do not know. I am personally aware of broken neck. I'm personally aware of babies dying on -- while they're shoulder dystocia. I'm personally aware of brain damaged baby, and, of course, of brachial plexus.

So, it can be spectrum of no problem with shoulder dystocia to permanent brain damage, the baby dying while is still inside -- half of -- just the head out and a permanent brain damage. So, it's a whole spectrum and, at that moment, you do not know which way this will end up.

Q And at the time that the dystocia is recognized, does the physician know how long it will take to resolve the dystocia before the remainder of the body or the baby is delivered?

A I wish we did. There is in way, at the moment you encounter shoulder, to see well, it's one minute, two minute, three minute, four minute, five minute. There is no way any clinician, using any sophisticated anything, can tell how long it will take before it's resolved.

Q And, doctor, is there a thought amongst the people that do what you do on how long the brain injury can begin to occur in a case of a shoulder dystocia where there's no fetal distress prior to the actual head delivering?

A So, one of the numbers we just throwing around, four to five minutes. Let's say four, five, six minute is in a general healthy population. So, that's "the average" but,

as you know, average doesn't apply. It can be as soon as two minutes. Some children do fine even after six, seven minute.

So, those -- the average is four to five minutes or some say four to six. Some people have put it at two minutes though some babies do fine even after seven, eight minutes.

Q And in a baby like Ashley Flowers, did you see where her heart rate changed from -- before Doctor Giep even got involved to the time of the delivery?

A Yes, I did, sir.

Q What happened there?

Tell us.

A So, usually the heart rate is around 110 to 160. So, 110 is the lower limit, 110 beats per minute is what we call it, but then it dropped to 90 and then it kept dropping and kept dropping for several minutes. So, that suggestion that, for whatever reason, the heart, which is our best approximate assessment of baby being oxygenated because, if your heart isn't beating, you're not oxygenating. As is simple thought process in our mind, is the baby's heart rate is down, way below what it should be normally while it was normal for hours and hours.

Q And how many minutes, approximately, was the baby's heart rate down before the dystocia event?

A I think several minutes, eight minutes, nine minutes. I mean I would have to look at the minute, but it was not a minute of a difference. For several minute before the vacuum was applied.

Q So, when the baby's head delivered in this case, did the fact that her heart rate had been lowered in that 90 range for that number of minutes, did that put her at a higher risk of potential serious bodily injury or, or even potentially death than the baby wasn't experiencing those, but had the same shoulder dystocia?

A So, shoulder dystocia alone is a sentinel event or a major event, which is linked with cerebral palsy on top of it. If you have a normal heart rate, even for several minutes, that has to weigh in on the clinician's mind that he or she has less time to resolve the shoulder dystocia, cause even with the healthiest babies, some babies, within two, three minutes, can have suffering. Once you start the heart rate at normal for let's say even five, ten minutes, then your clock is already set in before the shoulder dystocia.

Q So, at the time of the dystocia event, was Ashley Flowers, the baby, was she medically stable given the heart rate changes?

A No, Ashley was not stable even before the vacuum was placed. Ashley was absolutely not. It's almost additive.

So, the heart rate is abnormal, which is a risk factor for potentially brain damage. Once you have shoulder dystocia, now you have just multiplied, not multiply for whatever reason, now it has multiplied the problem. Now you have two major risk factor for baby.

Q At the time of the dystocia event, when it was recognized by Doctor Giep, was the baby, Ashley Flowers, at immanent risk of serious bodily injury or even potential death at that point in time?

A Absolutely.

Q And when you as an -- when an obstetrician encounters a shoulder dystocia, what's the primary goal?

A The primary goal is to deliver the child without excessive injury to the child and/or the mother.

Q And are there certain maneuvers that y'all, as obstetricians, commonly use in trying to accomplish that goal?

A Yes, we have several maneuvers we do to release the shoulder.

Q And kind of walk us through what the standard maneuvers that most obstetricians in general utilize when they encounter a shoulder dystocia?

A So, the first one, and it's actually called Doctor McRoberts who happened to be where I am just by coincidence, you take the -- both knees, if, if I'm pretend mother, and

take the knees and bring them backwards. So, the knees of the mother go towards the shoulder.

So, that's putting the legs back. That increases the distance between the back bone and the symphysis or the bladder bone. So, instead of being this, now it's bigger. So, the shoulder may come out. That's called McRoberts named after Doctor McRoberts from Houston.

If that doesn't work, then we have what we call symphysis or suprapubic pressure. So, right on the bladder bone or symphysis. You -- a nurse or one of the clinician would push down with the hope of moving the shoulder to this side. So, the shoulder is stuck like this. You press on the side and the shoulder comes under the bone.

Q Are they pressing the, the actual bone?

A No, it's right adjacent to the mother's bone. So, what you're doing is trying to press the shoulder to go under the bone.

Q And is that normally done when the mother is having a contraction?

A It can be. Some people do it with contractions. Some people wait without the contractions, but it is done after McRoberts usually.

Q And is McRoberts usually done with a contraction or without a contraction?

A And McRoberts is done as soon as you recognize. Some

people, these days, just deliver McRoberts and, at that point, decide. But as soon as you recognize shoulder dystocia, you put the leg back up. If that doesn't resolve it, within seconds you start suprapubic pressure.

Q And what other techniques do most obstetricians use besides McRoberts and suprapubic pressure?

A So, those are the first two. Then the third one is you can reach inside and actually bring the posterior arm, the arm which is on the floor, so, the top one is stuck. The one to the floor, you can actually go in, pull it out, or extraction of the posterior arm we call it. Once you take the posterior arm, the shoulder just presses down and there's more space. It falls below the symphysis or you can push, with the hand, the doctor can push the anterior shoulder forward or, if that doesn't work, then this one.

So, you try to -- what you're trying to do is compress the shoulder one way or another is what you are really trying to do.

Q And, doctor, from your review of the information, the medical records, the depositions, did you get an understanding of the maneuvers that Doctor Giep used in this particular delivery of Ashley Flowers?

A Yes, I did.

Q And have you -- I put together a video or have put together a video that demonstrates those.

Have you reviewed that video before coming in here today?

A Yes, I have.

Q And does it accurately depict what you understand to be the maneuvers that Doctor Giep utilized in his deliver of this child?

A Yes.

Q And would that be helpful in you explaining, in your mind, showing the video, what the maneuvers were?

A I'm more than happy to.

MR. LOVELL: Your Honor, I have the video ready to go and we've shown that and I'll let him talk about it.

And, doctor, I'm gonna hand you a laser pointer. I'm gonna play it up here hopefully.

A May I come down?

Q Yeah, if you need to step down over here so you can see it.

THE COURT: Let's do this.

You see, doctor, that microphone in front of you?

Yeah, the white---

THE WITNESS: Yes.

THE COURT: If you'll stand and just behind it, have it directed between you and the screen. Stand just behind it and kind of project your voice upward.

THE WITNESS: Yes, sir.

THE COURT: Then everybody should be able to hear.

THE WITNESS: Yes, sir.

(The witness comes down from the stand.)

MR. LOVELL: I apologize, Your Honor. I had it on but it shut it itself off. It should fire right up. There it is.

So, can you dim the light just a little so it's a little bit easier to see?

(WHEREUPON, the bailiff complies.)

THE COURT: Mr. Lovell, how about moving that---

MR. LOVELL: I'm sorry, Your Honor.

THE COURT: ---down a little bit?

Q Doctor, I'm starting the video at this point, and you tell me when to stop it and I will. I'd like -- what I'd like for you to do is to explain to the jury the -- what's happening as this progresses forward.

A If you do -- can I just stop for one second just if you don't mind?

I'm going to orient.

Q Yes, sir.

A So, this is what I call the bladder bone. I, I try to keep it simple. So, this is the symphysis or the bladder bone. Here is the shoulder. Here is the head. This is way before the head is coming out. This is the back bone. This is the posterior shoulder and this is the supine. Mother is

supine, what we are looking at.

So, this is before the head has come out and before the shoulder dystocia is right here.

Q And I'm gonna ask a really stupid question, but you mentioned earlier that, you know, towards the roof.

Would that be that way---

A Yes.

Q ---and this way?

A So, this is the anterior shoulder and that's the roof. On what you can see on this side is the posterior and this is the bottom or the floor.

Q So, I'll start the video, doctor. You tell me when to stop it. It's two minutes plus or minus. So --.

A So, this is the uterine wall, and this is what contracts all around. So, this is muscles, which is going to contract and push. This is just to orient you, the placenta, and this is the bladder bone. I'm gonna call it the bladder bone cause the bladder is right there.

So, now the head is -- and the baby's coming down because everything is contracting. So, the head is descending.

Go ahead please.

Now, the head -- stop please.

So now the head is -- so, it came down and now it's a little extended. So, the doctor can see this. There's no

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

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

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

A Yes, they do.

Q Okay. We see, doctor, some movement of that uterus.

What's that doing?

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

At this time, this is a Kiwi vacuum.

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

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

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

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

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

Q And was it reasonable to proceed in this manner?

Was that within the standard of care?

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

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

Q And was that done in this case?

A Yes.

Now, this is -- if you freeze it?

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

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

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

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

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

What's he looking for at that point?

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

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

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

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

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

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

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

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

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

Q Can you always grab that posterior arm---

A No.

Q ---with your fingers?

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

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

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

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

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

A Rubin maneuver.

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

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

Q Thank you, doctor.

A Thank you, sir.

Q You can sit back up there.

Thank you for the lights.

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

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

Q And you mentioned the traction that is applied by the

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

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

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

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

A May I, may I come down, sir?

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

A I can just point from laser from here.

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

Show us what we're talking about there.
A So, this is the baby's head and for the baby's crowning right now, and what you see, this is the baby's spine. What we try to do always is keep this in a straight-line, so when we bring the baby out as at the end in the video, it is almost in a straight-line with the spine.
Q But in the real word of delivering babies, is the spine always in a -- is the body always in a direct straight-line?
A As you know, we are all different and we all come out looking differently. No, this is a good ideal depiction of what's suppose to happen.
Q And is -- when y'all -- when an obstetrics -- obstetricians acting within the standard of care do grab on or attach their hands to the baby's head and guide it as it's coming out, is there some degree of upward or downward movement towards the ceiling or towards the floor that's -- that is employed?
A Even without shoulder dystocia, there's a -- so, when the head comes out, there's a little bit of movement going down and up. That is inevitable. For some head not to go down, it would be a rare exception. They always movements. Some up and down and that's just the normal part of delivery process.
Q Now, doctor, I want to go to the idea of what it takes to injure one of these nerves.

Is that something that you have studied?
A We are trying to study. There have been other publications, which have been cited, but I personally, as of today, not studied it though we're in the active process with environmental engineer.
Q Are there reliable studies that you're aware of that talk about the threshold for brachial plexus nerve injury to occur in live babies born with or without shoulder dystocia?
A I personally am not convinced that this is reliable threshold because one of my thing is, you know, the simplest thing about science is what we call reproducible. If you think this is it, then I, in a different hospital in a totally different setting, should be able to redo the whole thing and come to a similar measurements. So, it's almost like, you know, if you take a sack of potato in one hospital, another hospital, you put it on a weighing machine, it should always come to 10-pounds at both center.
We have tried to duplicate what is alleged pressure and all that. It is a good hypothesis but by some doctors done in very unusual circumstances, but, as of today, if those articles were to be published, and I'm an editor of OB journals, I would not accept them as scientifically valid anymore.
Q And, excuse me, doctor, is there, in the ACOG report with which you are an author, are there statements about

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

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

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

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

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

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

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

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

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

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

THE COURT: All right, sir. Overruled.

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

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

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

Do you adhere to that?

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

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

A Yes, I do.

Q And what was that?

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

Q Let me move it closer.

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

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

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

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

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

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

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

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

Q Okay.

A Internal McRoberts maneuver and suprapubic.

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

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

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

A Yes, sir.

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

A Yes, it did.

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

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

A No, it did not.

Q Did it suffer any type of cerebral palsy?

A No, it did not.

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

Is that fair?

A Yes, sir.

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

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

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

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

THE COURT: They're from the treatise?

MR. HENSHAW: Yes, sir.

THE COURT: All right. Note your objection and it shall continues.

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

A Yes, we did.

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

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

Do you agree with that?

A Yes, I do.

Q What's all that mean?

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

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

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

A No, they are not.

Q From one baby to the other?

A They are not.

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

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

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

A Yes.

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

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

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

A Yes, sir.

Q What does that mean?

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

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

A Yes, other authors have studied that.

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

force or resulting stretch?
A That is a corrected (sic) statement.
Q And what does that tell us?
A As I said, it's one in 10,000 phenomena for persistent brachial plexus. So, they -- no one has studied the nerve difference in that one case out of 10,000 to show that what is the threshold damage though some doctors, pardon the words, say yes, I know. But most of us, when you look at it objectively, and even if you just think about it not being an expert, the phenomena which happens once in 10,000 is so difficult. I have to do 10,000 nerve study just to find the one damage. So, this thing is a simple statement that we don't know yet.
Q And is there any accepted threshold for these types of injury?
A No.
Q Does the degree of this baby's injury, in your opinion, tell us anything scientifically about how the injury occurred, what caused the injury?
A So, the injury did occur during delivery, and during the proper management of shoulder dystocia. That we and I think we all agree. So, this injury did not happen before the child or the birthing process began, which is very uncommon.
So, yes, it did happen during the delivery process, but

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

opinion.
Q Now, doctor, in your education, training, and experience, could the injuries to Ashley Flowers have occurred even if a delivering obstetric doctor does all the maneuvers to relieve the shoulder dystocia perfectly and barely applies any traction to the child?
A Yes, both in my personal experience. So, I've had two brachial plexus injury. Even with normal traction, you can have brachial plexus injury. Others have reported that, even when doing everything properly to relieve the shoulder dystocia, you can -- it's one of my simple things. Even when we do everything right, sometimes things go wrong.

When we drive within the speed limit, obey all the street laws, we can still get in an accident. That phenomena exists in human life. That phenomena exists in the management of shoulder dystocia. Even when you do the very best, yes, we can have injury though it's exceedingly rare.
Q Doctor, I want to circle back around to standard of care and then we'll be done. Looking at -- from your review of the medical records and everything, up until the time of the -- when the nurses were doing all the maneuvers that they did prior to the occurrence of shoulder dystocia, were their actions all within the standard of care?
A Yes, they were.

Q When Doctor Giep got involved in the case and did the things that he did with regard to the application of the vacuum extractor, the maneuvers that he did and instituted, the suprapubic pressure, the McRoberts maneuver, and then backwards, the Rubin's II, those things, were those all within the standard of care what most obstetricians would have done when faced, when faced with a baby who presented as did Ashley Flowers on that October the 7th?
A I would say 95, 99 percent of us would have done the same thing.
Q And was that all within the standard of care, what, what he did?
A Yes, sir, absolutely within the standard of care.
Q And from your review of the records and his deposition and his description of the forces that he used, the minimal traction only or the gentle and constant traction and what he described in his deposition, were -- was that within the standard of care required of him as an obstetrician in the delivery of this child?
A Yes, it was.
Q And the manner in which he described doing the delivery and manipulation of the baby, was that also within the standard of care required of him in the delivery of this child?
A Yes, it was.

Q Sorry. Pardon me one moment.

(Pause.)

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

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

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

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

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

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

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

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

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

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

Q Ask the question again.

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

A Yes, I do.

Q And what is that?

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

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

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

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

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

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

A Yes, sir.

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

A That is a good approximation, yes.

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

A My recollection is it continued until five minutes.

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

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

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

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

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

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

A Yes.

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

A No, I wish it was true.

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

CROSS-EXAMINATION

BY MR. HENSHAW:

Q It's, it's Doctor Chauhan?
Is that a correct pronunciation?
A That's close enough, sir.
Q All right, sir. Doctor Chauhan, do you agree that axial traction is a pulling force applied in alignment with the fetal cervicothoracic spine?
Sometimes this is referred to as downward axial traction.
A I think that would be a reasonable statement though I wouldn't use all those words in one sentence, but it sounds reasonable, sir.
Q All right, sir. Would you agree that excessive traction is a pulling force that is greater than the inherent strength of the fetal brachial plexus?
A I could see why some would write that. I don't think I've written that, but I could see why someone would write that.
Q Well, it comes from your book.
You -- do you not know that?
A I, as you can imagine, there are, I'm going to guess, a hundred pages. Let's say one page is at least 50 sentence. So, 50 times a hundred. So, I can see why someone wrote that, and I have no problem with that statement.
Q Do you have the book?
A I have a xeroxed copy, sir.

Q Well, turn to the glossary.
Do you have that?
It will be at Page 73.
A One second, sir.
(Pause.)
A My paging number may be different than yours. On my Page 73, it's Table 5455.
Q Here.
The Inevitable Brachial Plexus, Brachial Plexus Palsy.
That's the book, right?
A Affirmative, sir.
Q And that's the one that you said was authority -- was authoritative?
A Yes, sir.
Q All right. Page 73.
And, and, doctor, we can play with numbers all day long. You're saying one page, but the glossary is intended to be the definitional basis for all the terms used on every page, isn't it?
A It is a simple summary or a definition of that word, yes, sir.
Q And doesn't it says expressive traction is a pulling force that is greater than the inherent strength of fetal brachial plexus?
A Give me a --.

Q It's in black letters.
A Yes, sir.
Q Excessive traction.
A Yes, I see it, sir.
Q And you don't agree with that?
A No, I didn't say that I didn't.
Q Well, you do agree with that?
A Yeah, that statement is there. I agree with that, sir.
Q Okay. And you would agree that that is the definitional term for excessive traction throughout this entire book?
A In that glossary, yes, sir.
Q Every page. Not just out of five or two out of, two out of 12. It's every page.
A Sir, I think you're making it somewhat disingenuous statement. To make what -- the statement you just did, I---
Q Answer the question.
It's every page, isn't it?
MR. LOVELL: Your Honor, I object.
THE COURT: He's answering. Let him finish his response.
MR. HENSHAW: Your Honor, may I?
THE COURT: You may.
(WHEREUPON, a bench conference was held out of the hearing of jury at this time.)

THE COURT: You may continue.

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

Do you agree with that definition of lateral traction?

A Yes, sir, I've read that.

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

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

Lithotomy position?

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

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

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

United States?
A That has been routine, yes, I agree with that.
Q All right, sir. And in terms of axial traction, we're talking about pulling the baby in alignment with its spine straight through the vagina.
Is that correct?
A As close to that, yes, sir.
Q All right. And do you agree that that needs to be done with the same amount of traction?
Regardless of whether it's a shoulder dystocia or whether it is a normal delivery, there is a routine amount of traction that's suppose to be applied?
A That is a correct statement, sir.
Q Do you agree that, in the United States, it is the standard of care that, when attempting to diagnose shoulder dystocia, routine traction in an axial direction can be used to diagnose shoulder dystocia, but any other traction should be avoided?
A And that seems to be a reasonable statement, yes, sir.
Q All right, sir. So, if other types of traction include lateral traction, as defined in the glossary of this book, lateral traction is to be avoided as a standard of care in the United States?
Would you agree with that?
A Yes, in an overwhelming majority of delivery, we do

avoid lateral fraction.
Q All right, sir. Now, allow me to further explore your relationship with Doctor Giep, the father of the defendant Doctor Giep.
You came to Spartanburg and you quickly identified with him as a mentor.
Is that right?
A Yes, he was one of my mentors, yes, sir.
Q Okay. Well, he was not just a mentor to you. You have described him as a professional father figure.
Is that right?
A I would agree with that statement.
Q And while you were in Spartanburg, you not only called on him, but, for professional reasons, but you developed an association with him so that you would seek out fatherly advice from him.
Isn't that correct?
A I respected his advice, and, yes, I did seek it out, yes, sir.
Q You sought advice from him on where to buy a house?
A Yes, I did, sir.
Q You sought advice from him as to where your kids should go to school?
A Yes, I did.
Q And so he was -- and you have described him as your go

to person as a father figure?
A While in Spartanburg, yes. That is a true statement, yes.
Q All right. And you continue to feel a great deal of allegiance to Doctor Giep, the father of the defendant in this case?
A I don't think I would use the words allegiance. I -- that's not a term I use from my culture. The better word I would use is respect. I have a lot of respect for him and his advice. And while I was in Spartanburg, I did seek it out and I did try to listen to it, but I left Spartanburg almost a decade ago, and, since I've left Spartanburg, I've never sought his advice.
Q All right. I understand and thank you, doctor.
But would you agree that, in your culture, one word would be to use respect, but another would be to use the word honor?
A I'm more happy with respect, but I can see why someone would interchange it, but that applies to the dad. Not the sons.
Q Okay. And it doesn't apply to the family?
A Not to the sons. They're my age.
Q Now, in terms of the work that you do, among the work that you do is, is that you have served as an expert witness in at least 40 medical malpractice cases.

Is that right?
A Probably more, yes, sir, I have.
Q And probably more than that?
A Now. By now, yes, sir.
Q Okay. You charge $800 an hour for trial testimony.
Is that right?
A That is correct, sir.
Q And in 70 percent of the cases that you have served as an expert witness, you have been a defense expert?
A Lately, a little bit more, but that is a correct statement, sir.
Q So, somewhat higher than 70 percent?
A Yes, sir.
Q And in this book that you helped write, and you were -- I take it you're considered -- you, you were one of the members of the Task Force that actually put together or compiled the information in this book?
A I actually wrote the complete -- did the whole Chapter 1. That's my chapter.
Q Okay.
A And then we edited everyone else's chapters. So, Chapter 1 is authored by me. The rest I edited.
Q And the Task Force, the, the obstetricians that were on the Task Force, included Doctor Robert Gherman?
A He's -- suggest -- I'm not trying to split hairs, but

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

Q All right.

A ---more as a maternal fetal medicine.

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

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

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

A In high risk pregnancy, that is correct.

Q In high risk pregnancy?

A Yes, sir.

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

Is that not right?

A That is correct statement, sir.

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

A You should ask him, sir.

Q Well, don't you know?

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

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

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

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

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

Q Okay.

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

Q But, in this case, Doctor Gherman was named as---

MR. LOVELL: Objection, Your Honor.

May we approach on this question?

THE COURT: Okay.

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

THE COURT: You may continue.

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

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

Q Oh, you did read some of his opinions?

A In this case, yes, I believe so.

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

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

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

Q You don't know---

A I accept that.

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

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

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

A That is my understanding, yes, sir.

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

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

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

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

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

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

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

As a medical doctor that has no validity, does it?
A That's an interesting question. I hope it's not true, sir.
Q Well, I understand.
But do you understand that the term reasonable medical certainty is a legal term that we use in the Court system, but it's not one that is routinely or even used for purposes of validating scientific principles, is it?
A One more time, sir.
Reasonable what?
Q Reasonable medical certainty.
A It's -- so, in scientific writing, we do not use the word reasonable medical certainty. We use -- we usually do some statistical analysis to say something. That is a true statement, sir.
Q All right, sir. And yet, this booklet that you wrote with this Task Force, when we get to the executive summary that was prepared, it says the Task Force recognizes that knowledge about NBPP, that means neonatal brachial plexus palsy, NBPP, right?
A That is correct, sir.
Q And that's the abbreviation used throughout the book for neonatal brachial plexus palsy?
A That is correct, sir.
Q The Task Force recognizes that knowledge about NBPP is

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A Yes, sir.

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

A One second, sir.

(Pause.)

A I'm there, sir.

Sir?
Q Yes, sir, you're there, and it's Table 2.1, various risk factors and their association with neonatal brachial plexus palsy.
A Yes, sir.
Q And there's Chauhan.
That's you?
A Yes, sir.
Q Second from the bottom.
A That is me, sir.
Q And it breaks down between number of cases with birthweight greater than 4,000 grams. Number of cases with birth weight greater than 4,500 grams. Number of cases with diabetes. Number of cases with shoulder dystocia.
You had 46 cases with shoulder dystocia?
A Yes, sir.
Q Right?
A Yes, sir.
Q And then it has number of cases with NBPP, and then it breaks it down, transient NBPP percentage, and permanent NBPP percentage. The transient NBPP percentage was 75-percent and the permanent was 10-percent.
A Yes, sir.
Q Not .01. 10-percent.
A Sir, I appreciate your reading this out, but I think

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

One in a thousand will get brachial plexus.

Okay?

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

Okay?

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

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

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

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

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

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

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

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

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

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

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

(Pause.)

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

Q What page is that, doctor?

A Page 4, sir.

Q Page 4?

A Uh-huh. (Affirmative).

Q All right, sir.

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

Okay?

Q All right, sir.

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

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

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

Q Well---

A Sir, if you would pause?

So, let's go to right there.

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

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

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

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

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

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

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

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

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

Isn't that true?

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

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

Isn't that correct?

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

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

None of them, did they?

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

Q Oh, I understand that.

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

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

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

that they used anything more than general traction, did they?
A That is correct, and that is how we are trained.
Q Because---
A Yes.
Q Because if they had, you wouldn't be defending that doctor, would you?
A That would be a correct statement.
Q All right. So, for you to be in a case like this, the doctor has to make the statement I did not use more than general traction?
A That would be correct, and it has to be collaborated by other clinicians who are in the room. That is correct.
Q Other clinicians, other doctors that are in the room?
A No, clinicians, to me, includes nurses in the room or any other healthcare provider. It could be a resident. It could be a colleague. So, yes, other clinicians.
Q Okay. But doctors?
A Not -- well, nurses, midwives.
Q Nurses.
Okay.
A Midwife.
Q Do you require that the doctors actually observed how the doctor uses his hands when you make that decision?
A Sir?

Q When you say I want corroboration, do you require that the other clinicians actually be able to observe what the doctor was doing with his hands?
A So, the only way to say if doctor used excessive by another person is for them to visualize it or see it some way, yes.
Q Oh, you only required on the -- whether it's excessive or not?
A Or even gentle traction if they see it, yes.
Q But, but do they have to be able to see it for the corroboration that you want in order to be involved in the case?
A Otherwise I don't see how one could corroborate that.
Q All right, sir. Where did you find a single witness in this case who saw Doctor Giep's hands on this baby's head?
A I think the grandmother was there who had a view of it, and none of the nurses have said it, and I'm having worked in the Spartanburg. The nurses are very honest. If they had seen it, they would have spoken up about it.
Q Well, wait, wait, wait, wait, wait, wait. No.
You said the corroboration requires that they either say that there -- they could see the hands and that there was gentle traction or that they could see that there was no excessive force, but if they can't see the hands on the baby's head, they can't corroborate that?

A That is true, sir. They're no nurses who have said it. The note clearly says it, more than one occasion.
Q But that's Doctor Giep. That's just him saying that.
A I think I know him to be trustworthy human being and---
MR. HENSHAW: Objection, Your Honor. Move to strike. He can't get into character.
THE COURT: Well, I understand, but that was in response to the question.
Overruled.
Q One of the things that is recommended by your manual that would allow for corroboration is a form that goes into a great deal of documentation about what happened during a shoulder dystocia case. You might turn to Page 99.
A One second, sir.
(Pause.)
A Ninety-nine?
Q Yes.
A Give me one second, sir.
Q Appendix C.
A Yes, I see that, sir.
Q All right, sir. And this is a patient safety checklist recommended by the American College of Obstetricians and Gynecologists?
A Starting in---
Q Is that right?

A ---August '12, 2012.
Q I understand.
Starting in August, 2012, that's when this form came out?
A Yes, sir.
Q But the significance of a form like this is so that there can be a complete statement about what types of maneuvers the doctor utilized during the procedure.
Isn't that correct?
A That is one way to do it, sir.
Q All right, sir. And if we look at this form, one of the things that is expected to be documented is Rubin maneuver.
Isn't that correct?
A Starting 2012, yes, sir.
Q All right. Starting in 2012.
But before that, you didn't document the Rubin maneuver?
A Sir, that varies from person to person, but I'm -- I personally still do not use this form. So, before 2012, whether it was applicable, I do not know as I sit here today.
Q But if you used a Rubin maneuver, would you document that?
A If I personally used it?

Q Yes, sir.
A Yes, I would document it.
Q You would definitely document it, even before 2012?
A That is a correct statement.
Q And you were here in what years in Spartanburg?
A If I remember correctly, I left in 2005.
Q And while you were here in Spartanburg, when you delivered babies with shoulder dystocia and you used the Rubin maneuver, you documented it then?
A Yes, sir, I would, sir.
MR. HENSHAW: Excuse me one minute, Your Honor, please.
(Pause.)
Q I'll move on.
Doctor, in the course of the events involving the birth of Ashley Flowers, the shoulder dystocia could not be recognized until the baby's head had emerged and was between the mother's legs.
Is that right?
A That is correct, sir. So, after the vacuum has been removed, the head is come out. And when we -- this case, Doctor Giep, is trying to deliver the baby, that's when you would recognize the shoulder dystocia. That is correct, sir.
Q And do you agree that was the point at which the doctor was expected to use his experience, training, and knowledge

to recognize there was shoulder dystocia?
A And I think that's a reasonable statement, sir.
Q All right. And he was trained to do that?
A Yes, sir.
Q And I think that your -- would you agree that, in your testimony here today, this situation where shoulder dystocia will occur during the birth of a baby is not a one in 10,000 event?
It happens, as you said, just last Sunday in your own facility. It happens every day in a birthing facility.
Isn't that right?
A It happens in one in hundred delivery. That is correct statement.
Q One percent.
One in every hundred deliveries?
A Approximately. That is correct, sir.
Q All right. So, it happens enough where doctors are expected to be specially trained or, or start training and understand that there is shoulder dystocia and how to recognize it because it's not a rare event. It's one in a hundred.
A That is correct, sir.
Q Okay. That is just as high as other medical events that are occurring in our community such as heart attacks?
A I honestly don't know enough about heart attack---

Q Right.
A ---to comment on that.
Q But, statistically, it's enough where doctors are expected to understand and appreciate it?
A I have made a point of never commenting on things I am not expert on. Heart attack is not my specialty and I do not comment on that.
Q And I apologize for that, doctor, and I don't, I don't want you to do that if you don't feel comfortable with it.
All I'm saying, in shoulder dystocia, is something that doctors are expected to be able to recognize and identify and begin to treat?
A That is correct, but, nonetheless, it is an obstetrical emergency.
Q Okay. And so, at the point that the baby's head comes out, was Ashley Flowers at risk for immediate death?
A And you -- so we know that the heart rate tracing has already dropped from normal range to down to 90, which is a major change.
Q Doctor, are you saying, based upon this record, that she was at risk for immediately dying?
A So, you can let me finish the---
Q I'm sorry.
A Okay. So, what we know is there is already something transpired before the shoulder dystocia. So, that alone, is

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

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

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

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

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

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

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

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

Isn't that correct?

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

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

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

chance the baby could have brain damage or death, yes.
Q And are you saying, aside from that threat of death, that in terms of serious bodily injury, to a reasonable degree of medical certainty, our legal term, not scientific certainty, but legal term, to a reasonable degree of medical certainty, that she had already had the injury to her brachial plexus?
Is that what you're saying?
A Sorry. One more time, please. I, I honestly lost you in that.
Q In terms, in terms of what you're telling us today, are you saying that, in your opinion to a reasonable degree of medical certainty, that she had already had the serious bodily injury to her brachial plexus before her head emerged and there was shoulder dystocia?
A No, I am not saying that the brachial plexus palsy happened before the head emerging. So, there's a stretching. So, some -- the process, it's not yes or no. It's a process. As you can imagine in an injury, the process began at the moment the head emerges, at that time, more likely than not, probably there was no brachial. But by the end of adequate management of shoulder dystocia, at that end, yes, there was.
Q At the end of the management there was?
A Yes.

Q And when was the end of the management?
A When Ashley's totally delivered and the feet are out.
Q All right. So, that was -- so there was a period, after the head, where the records indicate that she was delivered. It took one to two minutes.
Is that right?
A That is my understanding, sir.
Q Doctor, did you see in the record where Doctor Giep discontinued the Pitocin, which was being used to induce the labor?
A I thought it was the nurses, but I know Oxytocin was discontinued.
Q All right. Well, do you know whether that was just on their own or whether that was because Doctor Giep wanted them to?
Do you know?
A I do not know that as I sit here.
Q All right. And it, it was in response to her heart rate being -- decelerating into the upper 80s and 90?
A That is correct that the Oxytocin or Pitocin was discontinued because of that normal heart rate.
Q And there, there was a deceleration?
That's called a deceleration of the heartbeat.
Is that right?
A Yes, sir.

Q All right. And so is that the correct thing to do, discontinue the Pitocin because the heart rate has gone down?
A That is one of the correct thing to do, yes, sir.
Q And is that because, if you continue to infuse the mother with Pitocin, it increases the contractions, the increase in the contractions can, if the baby's not responding appropriately in terms of its heartbeat, then that can be devastating for the baby?
A That is one of the reasons is to resuscitate the baby so the baby -- yes.
Q All right. Did you see in the record where, after they had turned off the Pitocin, turned the mother on her side, the heart rate appeared to go back up?
A It did, but, at the end, when the vacuum was applied, the overall impression, which is accurate, that overall fetal well being was not assured and to expedite the delivery is the more prudent thing---
Q Well---
A ---and I would agree.
Q It was assured enough where Doctor Giep ordered the Pitocin to be restarted, didn't he?
A That may be, yes, sir.
Q Well, not maybe. It -- did you read the record? Did you see in the record where he reordered the

Pitocin to be restarted?
A I accept that, sir.
Q So, in his own mind, the baby's heart was strong enough and the baby had been resuscitated enough where the baby, the baby's mother could be restarted on Pitocin to help move that baby down the birth canal.
Isn't that right?
A No, you're forgetting one thing, sir. So, you have abnormal tracing. The baby's there. You have two options. Either to deliver the baby vaginally and/or do a C-section.
So, one way to help the C-section would be probably one of the worst thing one could have done considering how far the baby's up.
So, the other way to deliver vaginally is to use vacuum and Pitocin and mother's pushing. So, that's the way. So, at that moment, the concern was what is the best way to get the baby out considering the heart rate has been abnormal. So, start the Pit, do the vacuum, have the mother push, deliver with the push. Those were all reasonable thought processes.
Q And aren't you leaving out something, doctor, that that heart tone -- that fetal heart rate tracing had, in fact, gone back up to about 120 to 125 before he -- when he applied the Pitocin?
A Sir, as you know, no one should look at a second of the

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

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

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

A I will accept that as one of the reasons.

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

Isn't that right?

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

almost out to do what Doctor Giep was absolutely appropriate.

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

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

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

A At -- that is correct.

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

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

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

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

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

did not have to be resuscitated, did it?
A In part because of what Doctor Giep did. That is correct.
Q Well, they didn't have to do chest compressions to get her heart rate up. They didn't stop. She didn't have a zero in terms of her heart rate. It went back up.
Isn't that right?
A That is correct and, in part, because of Doctor Giep.
Q Did she breathe spontaneously?
A I do not know that as I sit here right now.
Q What did she go to the other twos for?
A So, she was off her color and tone. So, she had problems breathing, yes.
Q And -- well, I mean what did she get the twos for?
A I would have to see that, sir. I didn't memorize that, her score.
Q Okay. Well, what are the five things that you can -- that, that are scored?
A So, I do not do Apgar score. As in this case, most of them was done by NICU. But it is color, tone, heart rate, breathing, and reflexes is my understanding.
Q And reflexes?
A Yes, sir.
Q She got a two on reflexes?
A I don't know, sir. I'm sure you can pop that up in one

of your---
Q She -- crying, is that one of the things they get scored on?
A Sir, I did not memorize that, her scores.
Q And within five minutes, without a great deal of resuscitation, she was at a seven?
A That is correct, sir.
Q A -- you're familiar with the National Institutes of Health studies on birth trauma, aren't you?
A Could be more specific please?
Q Well, aren't you familiar with what the National Institutes of Health have said about what the requirements are for birth trauma, for there to be some indication that oxygen has been so insufficient that it caused a baby to be brain damaged?
A I don't know if that comes under birth trauma, but I am aware of ACOG and other national guideline on cerebral palsy, yes, sir.
Q Are you aware that, in order to qualify for a birth trauma, a baby has to be born with these scores, these Apgar scores that we're talking about, named after Virginia Apgar?
You know that, right?
A Yes, sir.
Q Did you know Virginia Apgar?
A Yes, sir, he--

Q Okay. Right.
A She's the only woman clinician I know with a U.S. Postage stamp.
Q All right.
A She was in Boston. She's a pediatrician neonatologist.
Q Right.
A Yes, sir.
Q So, you know Apgar scores?
A Yes, I do.
Q And you know that, in order for there to be considered birth trauma under the NIH guidelines, is that scores have to be zero or one, don't you, doctor?
A So -- and yes, but may I elaborate?
Q Certainly.
A So, first of all, it's not called birth trauma. I think you're mixing and -- words and you're just all over the place. To me, that's -- is there hypoxia, ischemic encephalopathy, and, by the way, I was one of the coauthors of that too, that workshop.
Q The 1984---
A Not that. Later one.
Q And that was the one that had the -- that was the one that specifically resulted in the NIH determining what was birth trauma?
A I don't---

Q Wasn't it?
A I don't recall in '98 and I don't think we called it birth trauma. That being aside, your point is valid that, to be called intrapartum brain damage, that Apgar has to be three or less beyond five minute, but that is after the fact. I would give the credit to Doctor Giep, his clinical work, his clinical acumen-ship, his bedside manner, that Ashley had Apgars of five to seven. To fall someone and not give credit at the same time is just not the American thing to do.
Q Well, my only point is, is that the, the issues involving babies, and when we say they have been deprived of oxygen sufficient to cause injury to the brain or another organ, is -- requires that the Apgars, as you say, are less than three. They have to be -- I thought they were zero and one. You're suggesting they could go up to a two.
But the fact is is that, if that's the requirement for oxygen insufficiency, Ashley never got there?
A That is correct, but there -- you're missing few things. So, that is -- if you want to say if the baby has a brain damage, the baby has to have a low Apgar, that is correct. But one of the sentinel event for cerebral palsy, believe it or not, is uterine rupture. The other one is shoulder dystocia.
One of the biggest risk factor that you can have in

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

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

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

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

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

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

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

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

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

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

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

He was expected to be able to do that.

Isn't that correct?

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

Isn't that true?

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

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

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

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

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

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

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

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

Isn't that true?

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

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

A Thank you, sir.

MR. LOVELL: No redirect, Your Honor.

DR. BANG NGUYEN GIEP,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

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

A. Yes, sir.

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

BY MR. LOVELL:

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

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

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

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

A. Yes, sir, I do.

Q. How long have you lived here?

A. I live here since 1975.

Q. All right. You're a doctor?

A. Yes, sir.

Q. What is your medical specialty?

A. I'm an OB-GYN.

Q. And with whom do you practice?

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

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

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

Q. Obstetrics gynecology?

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

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

A. Yes, sir.

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

delivery and afterwards?

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

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

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

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

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

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

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

A. I'm sorry.

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

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

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

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

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

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

Q. And are you board certified in any areas of

medicine?

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

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

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

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

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

Q. Have you done that every year?

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

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

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

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

Q. Are you married?

A. Yes, sir.

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

A. Her name is Julie.

Q. Do you have any kids?

A. Two kids.

Q. What are their ages?

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

Q. And where do they go to school?

A. They go to Dorman High School.

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

A. Yes, sir.

Q. Your brother and your father?

A. Yes, sir.

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

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

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

Q. Now, where were you born?

A. I was born in Philadelphia.

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

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

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

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

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

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

A. Yes, sir, I did.

Q. Where?

A. I attended Spartanburg Day School.

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

A. Yes, sir, I went to Wofford.

Q. And then medical, where was that?

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

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

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

Georgia.

Q. And how about residency?

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

Q. So eight total?

A. Eight total years after college.

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

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

Q. Was he big buddies with you?

A. No. We only dealt professionally, sir.

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

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

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

A. Yes, sir.

Q. Which ones?

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

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

A. The majority are.

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

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

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

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

Q. How about when you were in training?

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

Q. Which of those three were they?

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

Q. Where was that University Hospital?

A. This was in Augusta, Georgia.

Q. Got ya.

A. All three was located in Augusta, Georgia.

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

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

A. Yes, I do.

Q. And how do you do that?

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

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

A. Yes, I do.

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

A. Yes, I am.

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

situations that Ashley Flowers presented to you on October the 7th, 2008?

A. Yes, I do.

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

A. Yes, sir, I do.

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

MR. HENSHAW: No objection.

THE COURT: He is so qualified.

BY MR. LOVELL:

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

A. Yes, sir.

Q. How were you trained in that regard?

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

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

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

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

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

A. Yes, sir.

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

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

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

A. Yes.

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

A. Yes, sir.

Q. How do they do that?

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

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

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

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

A. Yes, sir.

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

delivery room?

A. Yes, sir.

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

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

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

A. No, sir.

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

A. Yes, sir.

Q. And how many of those had you had before Ashley Flowers?

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

Q. How about temporary injury?

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

Q. Before this event?

A. Yes, sir.

Q. Okay. And have some occurred afterwards?

A. Yes, sir.
Q. And in your experience with the other delivery you participated in back in your training, did that happen sometimes, even those when other folks were doing the procedure?
A. Yes, sir.
Q. I want to go move now into sort of what you were trained on how to do in preparing for shoulder dystocia or what to do with it when you have it, okay?
A. Yes, sir.
Q. When you're doing a delivery like you did with Ms. Flowers, kind of explain to us when you come into the labor and delivery room first, what's the bed like that the patient is sitting in?
A. Well the bed, most of the time the bed, to me, the bed is already broken down. So the patient is lying flat on her back. Her legs are in stirrups and the bed is to the ground.
Q. When you say the bed is to the ground, what do you mean?
A. Well, the delivery bed can be adjusted. It can be up to this level or lower level, just like this chair. And so what I like to do is for me, I like the table to be all the way to the bottom or as low as possible. (Indicating.)

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

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

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

A. Yes, sir.

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

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

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

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

wheels. (Indicating.)

Q. Does it roll?

A. Yes, sir, it rolls.

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes, sir.

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

A. Shoulder dystocia is unpredictable.

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

A. No, sir, it's unpredictable.

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

A. Yes, sir.

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

A. Yes, sir, I do.

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

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

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

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

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

A. A secondary maneuver.

Q. Secondary maneuver.

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

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

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

A. Yes, sir.

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

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

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

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

Q. So they start back at a certain level?

A. Yes, sir.

Q. And what do you tell them to do?

A. Bush em back further.

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

A. Yes, sir.
Q. And why are you doing that?
A. Basically the easiest way to explain it is kind of like a, just to open up the pelvis, so you have an extra just a few centimeters opening.
Q. And during that McRoberts maneuver, prior to the shoulder dystocia discovery, are you applying any forces to the baby at that point?
A. Can you repeat the question, sir? Sorry.
Q. When you have her in the McRoberts position --
A. Yeah.
Q. -- before you ever know about the shoulder dystocia --
A. Yes, sir.
Q. -- before the head is delivered, are you doing anything with the baby's head?
A. Well, I'm asking mom to push. And then with general traction I'm trying to guide the shoulder underneath the, the pubis, suprapubic bone.
Q. And is that before dystocia has occurred?
A. Yes, sir.
Q. Once we get into the scenario where the dystocia has happened, how were you trained in terms of the forces to apply at that point when you got her sort of back in your more McRoberts position?

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

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

A. No, sir, same force.

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

A. Yes, sir.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. And you're wearing gloves?

A. Of course.

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

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

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

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

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

normal delivery without a shoulder dystocia?

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

Q. For any delivery?

A. Any deliveries.

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

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

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

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

A. Yes, sir, I did.

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

A. Yes, sir.

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

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

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

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

deliver. (Indicating.)

Q. All right.

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

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

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

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

A. It's very difficult, sir.

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

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

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

A. Yes, sir.

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

A. Yes, sir.

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

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

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

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

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

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

A. It is not, sir.

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

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

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

courtroom?

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

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

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

Q. Why is that?

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

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

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

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

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

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

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

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

A. Yes, sir.

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

A. Yes, sir, I would.

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

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

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

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

A. Yes, sir.

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

A. You're really in trouble then.

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

A. No, sir.

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

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

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

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

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

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

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

Q. Why not?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Her labor had been progressing well.

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

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

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

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

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

A. Her cervix has to be dilated, sir.

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

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

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

A. Yes, sir.

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

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

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

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

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

A. Yes, sir.

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

Prior to that would contractions be going on?

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

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

A. Oh, yes, sir.

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

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

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

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

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

A. I'm sorry, repeat again.

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

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

Q. And the bottom?

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Yes, sir.

A. Nobody called me at 8:11.

Q. Okay.

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

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

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

Your Honor, can he step down?

THE COURT: (Nods head up and down.)

(Whereupon, witness leaves witness stand.)

BY MR. LOVELL:

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

A. (Nods head up and down.)

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

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

Q. Right.

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

Q. Why don't you highlight that where it's dropped in the '90s with this yellow thing.

A. Now, you know the normal heart rate is supposed

to be at the bottom, it should be about 110, which would be about right here. (Indicating.)

Q. What had been the range of this baby's heart rate prior to these changes that are going on?

A. So if you look at the entire strip, this is the first part, this is the second part. You can see it's been about 130 and now the heart rate dropped to 90. So there's about, about 40 beats dropped. So that's about equivalent to a third of a heartbeat that's dropped.

Q. Is that concerning or was that concerning for you?

A. Yes, sir, that's very concerning.

Q. Why?

THE COURT: Let me just mention, I don't think the court reporter can see him.

MR. LOVELL: Back up a little more. I'm gonna scoot this a little more.

THE COURT: Yeah.

MR. LOVELL: Is that good enough?

COURT REPORTER: Yes, sir.

BY MR. LOVELL:

Q. All right. Why was that concerning, Doctor?

A. Well, concerning because if you have a normal rate, about 130, okay, and you cut it to about a third, it's like -- the easiest analogy I can tell you is that

if you imagine holding your breath. Normally you would breath like this. (Indicating.) But if you hold your breath for a while, your heart rate is gonna go down where you start getting tired. And so the only way the baby gets oxygen from the mom is through the heart.

Okay, so the heart is beating, the option, transport option are on the baby. The baby is not breathing as a fetus, so the only way the baby is getting oxygen is through the mom, through the heart that the baby is beating. So normally right now the baby is normal, beating heart rate 130, just like you and I breath normally. But if you cut it down to 90, that means she's cutting a third, a third of oxygen supply of the baby. So that's why I think the baby is in trouble because you and I, you know, I'm not sure how long you can go with a third of oxygen supply cut off.

Q. And at this point in time, around 8:11-ish, when you see that what do you decide to do?

A. Like I was saying, this is when she was doing fine. This point you start noticing around 8:07. This is the part -- no, this is the part that I arrive around 20:11 p.m., sorry. (Indicating.) 20:11 ---

Q. Draw it in and then talk so you can back up and she can see you. Sorry about that.

A. What I did was I marked point 11, 8:11 p.m.,

that's when I arrived. I went ahead and marked that. I went ahead and marked where 110 beats is. I went ahead and marked where 110 beats is right here. So that's a lower limit normal. As you can see here the heartbeat is in the 90s.

So when you arrive there you have to look up the entire strip, as I was telling you beforehand, and we are seeing this strip. So when you look at it, you see the majority up until 20:11, the heartbeat is below 120, okay? She had some recovery up here. So when arrived here the heartbeat had been down, a third of the oxygen supply has been cutoff basically. She's been pushing, she's contracting.

Q. And when you got there and you saw it, had it been going on for some number of minutes before you got in with this lower heart rate?

A. Yes, sir. Basically you break down, this is one minute, two minute, three minute, four minute and then you can count up to about five minutes, sir.

Q. And so what did you do upon coming in and seeing this and having some concerns you just told us about? What did you do about deciding on the delivery status of Mrs. Flowers?

A. Well, first of all, when you come in here, you have to take this in realtime because the problem is

that you can't look back and say what could have been done, should have done, would have done. You have to take realtime. So when I'd arrived, it was here. (Indicating.) So upon arrival I notice the heart rate has been down. I notice that the nurse has done a couple things. She had decreased the Pitocin and shut it off. She had put the patient on her right-hand side, okay, to try to improve the oxygenation and to improve blood supply to the uterus. And she also gave mom oxygen. So at this time I went over ---

Q. Let me stop you right there. Why would the nurse stop the Oxytocin or Pitocin and do the right-side turn with the heart rate in that scenario?

A. What she's trying to do is called uterine cessation, so she's not sure what's going on. And so there's a protocol that we do. And the protocol dictates, number one, shut off the Pitocin. Number two, turn the mom on the side. And number three, give oxygen to improve the oxygenation to the baby.

Q. And was that the -- I'm sorry, was that the right thing for Mrs. Phillips to do?

A. Yes, sir.

Q. All right. Take us from what you were talking about now, what you did forward and why you did it.

A. So 20:11 after evaluating that, now we come to

about 20:12. So about right here. (Indicating.) So it took me that long to evaluate the script to be informed of what's going on. And now I walk over and examine the patient.

Q. All right. When you do that I want to ask, you said you walk over from where to where?

A. Basically we're in the delivery room. So the delivery room is probably from where I'm standing to where Ms. Flowers is standing is probably --

Q. You mean me standing?

A. -- half a distance.

Q. And when you left and you went over to do the examine (sic), where did you go?

A. What I did, about right here I went and examined the patient and I wanted to see what's going on. I wanted to check her. (Indicating.)

Q. Did you go on the business end?

A. Yes, sir, I'm on the business end.

Q. But on your stool?

A. At this time, the bed was not totally broken down yet, so I was sitting on the bed.

Q. Did you have to lower the bed at some point?

A. The bed was already lowered, sir.

Q. Did you have them break it down?

A. Yes, sir.

Q. What did that mean? I'm sorry.
A. When the bed is -- there's two components there's a front part, which the patient lies on there and if she puts her feet down it's fine. And when it's time to deliver you break the bottom part, which is this part from here down, so that way you can stand or you can sit between her legs in delivery. And that's what's going on, that part was being broken down. (Indicating.)
Q. And so did you do an examination of her where you were looking at the baby or trying to assess the baby?
A. Yes, sir, I was.
Q. What did you do?
A. Basically the first thing you do is you look at the patient. And at that time I know that she was -- the baby's head was, you could see the top of the baby's head.
Q. And what's that called?
A. That's called crowning or the top of the head is the scalp. Or in this case you could say that she had a plus three or crowning. Those terms are interchangeable.
Q. Plus three means? What's the plus, the three in the plus?
A. What we usually do is we divide to have an idea of where the head is. So we use bone structure in the

pelvis. And we use what are called ischial spine, which is a bone kind of pointing lateral in. And so we use that as a landmark.

So the baby is at the ischial spine, we call that zero. And we split zero to the outside opening by one-third. So if that ischial spine is zero, a third of the way down is plus one. Two-third of the way down is plus two. Plus three is when it's outside. So plus three is difficult. Plus two is that everybody's there. How do you know that? Well, if you can see the head without putting your hands in the vagina and opening up, that's plus three. If you have to put your hand in the vagina to feel a little bit, then that's plus two.

Q. And she was at what level?

A. She was at plus three or we call it crowning.

Q. So now you've done your evaluation, you've seen that the head is at plus three. You're now down at the business end. What did you do next with regard to the labor and the delivery?

A. So right here -- so this is when I'll be examining the patient.

Q. And why do you say that?

A. Well, this is when I came in. It takes about a minute to examine the patient. And then what I was trying to do with the heartbeat being down, what I was

trying to do is when I get a patient what we do is called scalp stimulation. It's a pain to work, but basically you're kind of touching the baby's head, scratching a little bit to see if you can wake the baby up to say hey, you know, breathe or in this case get your heart rate up, and it did. Went up heart rate a little bit.

So this situation I wasn't sure what's going on. I know the baby's heart rate has been down for about five minutes. So I went ahead and because you have a plus three, I want to see how is she doing pushing, get an estimate of how long it's gonna take her to push and deliver this baby. So that's why you can see she pushing, she pushing, she pushing.

Q. So did you let her do a couple, three pushes at that point in time?

A. Yes, sir.

Q. All right. But what about your concerns over the baby's heart rate?

A. Well, I was concerned because right here the heart rate went up. So at that time I'm like, okay, I may be okay. But then, as you can see here, it disappeared. And then here, you can see here, it went down to the 90s again. (Indicating.)

Q. All right. Now, when the heart rate went down to

the 90s again and you've allowed her to push a couple, three times, what did you do next as far as the delivery?

A. Well, the number one thing is that, you know, according to our standard that when you have the heart rate go down, you have about 30 minutes to try and deliver the baby. That's -- it's the standard. You need to deliver before 30, but if you deliver after 30 minutes, you're really not in the standards.

So upon arrival here, usually what I do is evaluate the patient. I like to see if I can deliver in the next 10, 15 minutes. Because why? Because then I'll be under authority. It probably takes about 20 minutes from the time his heart rate has gone down approximately.

So right here I asked her to push to see can she deliver upon that option. If she's not able to deliver in the next 10, 15 minutes, then I need to make a determination to do, A, how am I gonna get this baby out. With OB it's really simple. The only two questions you have to ask yourself, does the baby need to be delivered, yes or no. The second question, how do you deliver the baby? Do you deliver by c-section or do you deliver the baby naturally?

So to me the question is that when I approach

this right here, my answer is simple. Do I need to deliver the baby? The heart rate has been down, a third of the supply has been cut off. The answer is simple. Yes, we need to deliver the baby.

So the next question comes in, how am I gonna deliver the baby? Well, if the head is sitting right there, okay, then you really don't want to take the woman back for a c-section. Why? Because you take her back for a c-section you have a risk of complications. It's a major procedure. You have risk and complication, as far as entering to the mom, entry into internal organs. You predispose her to infection. Not only that, you also predispose her when she's pregnant and she may need to have another c-section. And multiple surgery could cause problems later down the road.

That's just on the mom itself. On a baby, when the baby's head is almost all the way out, you're gonna do a lot of trauma reaching down there to push that baby's head up, going up through the birth canal and go through the incision.

Q. Why would you have to push the baby's head back down?

A. Because if the head is at the opening outside and you do a c-section, you have to reach your hand down the birth canal to the top of the baby's head to pull the

baby up. And you have to do that on a c-section. So with at the plus three station, the head is basically you're seeing this much of the baby's head. It's the quickest and easiest way to deliver by either vacuum or forceps. (Indicating.)

Q. So your choices were to allow her to continue with the vaginal delivery or somehow think about a c-section?

A. No, sir. What I did was that at this time right here, I made a decision. Seeing his heart rate is down to 90, it's just not coming back up, I made a decision we need to deliver Ms. Flowers. That's the first decision. The second decision is what is the quickest and safest way to do deliver for her and for the baby. Then I decide we're going to deliver by vacuum.

Q. Okay. And is that a vaginal route?

A. Yes, sir, that's vaginal route.

Q. So at that point when you saw that the heart rate was where it was, had it rebounded to a point where you felt the baby had gotten back to its normal, you know, pre-depressed heart rate level?

A. No, sir. That's a misconception. And I'll tell you because you cannot take, like I told you before, you cannot sit here and take a picture in time. So if I showed you this picture by itself and asked how

everybody's doing, everybody's gonna say fantastic. If I show you this picture, how is the baby doing, everybody's gonna say bad. You have to look to see what's going beforehand because you don't have 20/20, you're not gonna be able to go well, you know, you could have done this or should have done this. This is realtime.

So at the time this is all you're seeing right here. And I'm seeing heart rate's been down. Heart rate's still down, I need to deliver this baby.

Q. So what did you do in terms of moving forward with the delivery at that point and then now we're a few minutes after you've been coming?

A. If I could mark this real quick. I'm sorry, ask your question.

Q. Now, what did you do at that point when you had decided that the safest thing to do is the vaginal delivery to proceed onward, as you have been allowing her to do?

A. I decided that we need to use a vacuum, because based on these contractions here pushing I do not think she was gonna be able to deliver this baby in the next 15 minutes or so.

Q. Did you restart the Pitocin?

A. I did.

Q. Why?

A. And the reason why I restarted the Pitocin is that with the vacuum, basically what you're doing with the vacuum is you're helping speed up the process. You're helping mom out. You also need in order for the baby to come out, two things must happen. You have to have a contraction to push that baby out. So you don't want to do a vacuum with no contraction. You want all the help you can get. So that's why you start Pitocin to get a contraction so that it'll help you out.

Q. Now this Pitocin medication, when it is discontinued does the effect of it just immediately go away like that? (Snaps fingers.)

A. No, sir. That's a good question. It does not. It takes the half line of Pitocin about 30 minutes.

Q. All right. When you turn it back on is it an immediate effect though?

A. It takes a couple minutes.

Q. So when you -- about what time did you restart the Pitocin? And I'll direct you to Exhibit 2 if that will help you on time.

A. That's something -- okay. About -- this is 18 at 17. About right here is when the Pitocin was restarted. And it was restarted with 13 units, in which that's what she was on before all this happened, given initially

when she started pushing. (Indicating.)

Q. Wait a minute. You restarted the Pitocin at this point in time. Was that because you were feeling like the heart rate had gotten back to assuring or normal level?

A. No, sir. I restart the Pitocin because I know I need to deliver this baby. I need all the help I can get.

Q. And was the heart rate still in that concerning level of the 90s at that point?

A. Yes, sir.

Q. All right. We restart Pitocin. What's next?

A. Well, one thing I need to point out is that, you know, when you see a heartbeat in the 90s like this, okay? You know there's a slope, what we recall recovery. So if the baby has good reserves, okay? And I'll give you an example. When you go swimming, you first dive down the water, you come up no issue. You go down for two more times, you come up, you're getting real tired from lack of oxygen. You kind of go (indicating). And so that's what's called slow recovery.

So when the heart rate dropped down the first time, if the heart rate goes up like this, we call that quick recovery, would not worry too much. As you can

see, here at an angle getting slower, getting longer to get back up to normal, get lower. So that's what's telling me that if, like, you and I would go swimming is when you go down in the water several times you're getting tired and tired and this heartbeat is showing it.

MR. HENSHAW: Your Honor, it is not appropriate for him to use the word you and directly address the jury in that way.

THE COURT: All right. Please do not.

THE WITNESS: Yes, sir. So as the heart rate goes down, it's already dropped by a third. And it showed that the recovery here is getting lower and lower, so we're getting exhausted.

BY MR. LOVELL:

Q. And when you say reserve, what do you mean by that term?

A. That the baby does not have enough oxygen to bounce back up like it was beforehand.

Q. All right. So at this point in time after you've started the Pitocin, walk us through the next step in the delivery.

A. So the Pitocin started at 20:16. I made the decision that I am going to go ahead and extract the delivery using a vacuum.

Q. Expedite the delivery using a vacuum?
A. Yes. Yes, sir. And so I ---
Q. Tell us about this vacuum that you're using.
A. A vacuum, it's just an instrument that'll create a little suction. You put it on the baby's head. And the idea behind it is to speed up the process of parting it as the head comes out. So as yesterday, before the baby come out, the baby has to clear underneath the bone. And then after that it has to extend up.
Q. Let me ask you, you said something about cardinal maneuvers. Let me put this up. This is our exhibit number 10, Doctor.
A. So the head right here, as you can see, the bone right here, the head has cleared that bone. (Indicating.)
Q. Underneath the bone?
A. Underneath the bone or the bladder bone and suprapubic. And so that's what I mean by the head has to flex, go underneath it, and then afterwards the head comes up. As the head comes out, that's when the head is being delivered right here. (Indicating.)
Q. And when you're putting this vacuum on the baby's head, where do you stick it?
A. I'm sticking it in the middle of the head or so. I'm sticking it at about right here.

Q. All right. And how does it assist you in helping the mom deliver the baby?

A. As the mom is pushing by having the vacuum, you help kind of keep the head down like this so it helps clear the bone easier. (Indicating.)

Q. Are you using the vacuum to pull?

A. Just gentle traction.

Q. Are you still having your hands on the baby's head at this -- or touching the baby at that point?

A. The hand is not touching the head. The hand is on the vacuum and the vacuum is touching the head.

Q. Now, after you apply the vacuum, what happened the next week with this delivery?

A. So the head comes out right here. (Indicating.) And so through this process -- if you could put that back up.

Q. (Puts up diagram.)

A. As you can see here, the vacuum is put at 20:18, which is marked by right here. (Indicating.) What I usually do ---

Q. And I'm just gonna -- when they typed this in, somebody puts that in or is that automatic?

A. They put that in, but you can see they put it a little bit afterward or, you know, a couple seconds after. You cannot put it at the same time in realtime.

Q. Who's doing that?

A. This is the nurse. The nurse is putting it down right there. (Indicating.)

Q. All right. Sorry I interrupted you. So after you put the vacuum on, tell us what happened next.

A. What I usually do is that before, before I put the vacuum on right here. (Indicating.) Before I vacuum there's a couple of things I want to do. The first thing I want to do is I make sure the head was already all the way down. The second thing I want to do is I want to make sure that I have the help that I need. What I mean by help is that I usually assign the nurse, in this case Ms. Phillips, to do suprapubic pressure if I need it.

I have the CST or tech that's in there to hold up the leg. I usually have the spouse or another nurse to hold the other leg. So in this situation, um, I believe that, um -- I'm not sure one of the nurse or Mr. Flowers holding one leg. The nurse, Ms. Phillips, was on her right side. So she was there just to monitor the baby. And then the CST, which was Ms. Cindy White, was holding the other leg.

Q. Okay.

A. So the bed is already down. I assign people what to do in case of things going wrong. I also notify

NICU, which is Neonatal Care Unit. The reason why is that with the heart rate going down, I'm not sure what kind of baby I'm gonna be getting. So I want to make sure I have all the help and everything I needed when I'm adjusting things.

Q. Okay. And where are you situated at this point in time?

A. Right here at this time I'm sitting between the leg on a stool, a rolling stool. Bed all the way down. Fully clothed, draped, ready to go.

Q. And vacuum was applied. Did it work?

A. Well, let me walk through. The vacuum was applied. What I usually do is I like to apply the vacuum through a contraction. What I mean by contraction, I'm not sure if -- I'll just walk through. With the contraction, I had to lead you in, we like the mom to push at least about three times. So we like the contraction to go up before we put the vacuum on. So in this particular case she's having contractions. I like to go up before I put on the vacuum, before I apply traction for the vacuum.

So I usually like to apply two tractions. The first traction -- the first traction I like to apply is for the head. The head will come underneath the bone here. (Indicating.) That's the first traction with the

first push. The second traction or through the second push, that's how the head comes out. The reason why I want to do that is I want this to come out at the maximum peak of a contraction so she can push through, so...

Q. Okay. And when you're doing that at the maximum peak of the contraction, is the goal that perhaps the contraction will let the baby go ahead and deliver on out?

A. The goal -- yes, sir. And also for, for mom pushing to rotate the shoulder internally also.

Q. Okay. Now, did the head deliver?

A. No, sir, it did not.

Q. The head did not deliver after the vacuum was applied?

A. The head delivered, the body did not.

Q. All right. So what did you do at that point? What did you do to figure out why this is happening?

A. Well, first of all, so the vacuum's at 20:18. We know that the suprapubic pressure was put on 20:19, according to the note there. So during this time with the two traction I was able to deliver a head. After I delivered the head, I went and checked to see if the baby had nuchal cord.

Q. Now we saw the video yesterday. How do you do

that check for nuchal cord? How is it shown?

A. I put my hand, fingers and check around the neck to see whether there's a cord, just like this. (Indicating.) The reason why I do that is to make sure was the cord compressing against the baby, was the cord strangling the baby, therefore, may have cut off the oxygen supply. In this case there was none.

Q. All right. And are you checking the position of the shoulders while you're doing the nuchal cord check?

A. You kind of have an idea, but not really. You kind of go -- you kind of put your hand in there in trying to check the cord and that's pretty quick.

Q. And when you're checking for the cord do you know whether or not a shoulder dystocia event has occurred?

A. No, sir, you don't.

Q. All right. What did you do next?

A. So after I checked the cord I bulb the baby.

Q. And is that what we saw on the video with the blue thing up here?

A. Yes, sir, just bulb the baby.

Q. Why are you doing that?

A. Just to get any amniotic fluid out of the nose, the throat so the baby doesn't swallow it or get it down in the lungs.

Q. And at that point in time do you know that a

shoulder dystocia has occurred?

A. No, sir, I do not.

Q. What happened next?

A. Now, the mother, she was already in her legs being pulled back. So I asked mom to push with gentle traction, sitting on a stool, trying to guide the baby down. The shoulder didn't come out. That's how you diagnose shoulder dystocia.

Q. And when you were doing this guiding of the baby down, were you moving the head in a downward position in any 15, 20, 30, 35 or greater degrees of movement?

A. No, sir. Just like, just like you're just sitting down like this, you basically guiding down just like that. (Indicating.)

Q. And are you keeping the baby's head as closely aligned to the spine direction as you could at that point?

A. You try to but, you know, the baby's moving and things of that, so you try your best.

Q. All right. What happened next?

A. So with that, with the first, first -- that was the third push, dystocia was diagnosed. So after the second push, I asked mom to stop. I asked Ms. Phillips, right here, that's 20:19 ---

Q. Can I stop you before you move to that. How did

you diagnose that dystocia had occurred?

A. Because, number one, the shoulder did not relieve, the shoulder didn't come out. So that's a diagnosis of shoulder dystocia.

Q. Does the baby -- did the baby's head do anything that you could see that gave you some inkling that there was a problem?

A. Yes, sir. It contracted back a little bit.

Q. What's that called?

A. It's called a turtle sign.

Q. And when that occurs and you say it kind of goes back, is the head out and then scoots back down towards the mom's body?

A. Yes, sir.

Q. All right. What happened now? What did you do next?

A. So bring up to 20:19. So this is -- that's when it has Nurse Phillips here to put on suprapubic pressure. As I've described beforehand, suprapubic pressure is her trying to move that shoulder from this position. This is the door handle. In this position to that position. (Indicating.) And so that's what I was hoping. That's what I asked her to do at 20:19, give suprapubic pressure, at the same time increase my McRoberts.

Q. And is mom trying to push as you're doing all of that?

A. Initially I will ask her not to push just for a second until we do the suprapubic pressure, then I ask mom to push.

Q. All right. And is that what happened in this case, according to our strip?

A. Yes, sir.

Q. All right. And what happened then?

A. So with suprapubic pressure, try and rotate this leg, with McRoberts trying to get this down that way, I want to see most of the time, about 50 percent of the time, it should clear. (Indicating.) So I give gentle traction straight and down. Gentle traction downward. The shoulder did not clear.

Q. All right. When you say gentle traction downward, are you again using the same degree of force you'd use on any delivery?

A. Yes, sir.

Q. All right. And what about this angle of downward, is it -- are you still keeping it as close as you can to the spinal axis of the baby?

A. Yes, sir.

Q. All right. And if you had been pulling, I'll use that term just loosely, guiding the baby or whatever,

your hands are on it, if you had been applying 20, 30, 35 or greater pounds, what would have happened to your body as you're sitting there next to mom?

A. I think, number one, if I was pulling really hard, then you know you're sitting on a stool, you pull hard, the stool would be rolling towards the mom. And that didn't happen. So, number one, I use the same traction. The stool didn't move so, therefore, I know I didn't, I did not pull hard.

Q. And at that point had you applied traction during the McRoberts into the suprapubic pressure phases of what we're looking at?

A. Well, with the initial right here, at the delivery after the vacuum, I did put general traction just for, you know, a few seconds, she didn't deliver. That's how I diagnosed shoulder dystocia. Then I asked mom to stop pushing. I did suprapubic pressure. Mom pushed again. Again I gave general traction. But after a second or two the shoulders are relieved and I stopped contraction.

Q. Before you did the suprapubic, did you have her do the way back leg?

A. Yes, sir, I did.

Q. And the ---

A. Well, she was already in McRobert beforehand.

Q. Did you do her even --
A. Yes, sir.
Q. -- further back than --
A. Right here, sir. (Indicating.)
Q. -- McRoberts?
A. Right here. (Indicating.)
Q. All right. And during that time are you hands on the baby?
A. At this time right here, if you're talking about right here, 20:19, I was doing suprapubic pressure. My hand was on the head right here at this exact moment right here. (Indicating.)
Q. Hands still in this position? (Indicating.)
A. Yes, sir.
Q. And baby's head wet at that point?
A. Yes, sir.
Q. And is it slippery?
A. Yes, sir.
Q. And what did you do next after the suprapubic didn't work?
A. Well, now this is 20:19. So now I diagnosed shoulder dystocia. My first maneuver hadn't worked. So now I'm going through the second maneuver, as you recall from the video yesterday. So I put my hand, because I'm right handed, I put my hand inside the vagina on her

left. I try to feel for this shoulder if I can. Really couldn't do a whole lot. Then I try and reach my hand up there, trying to grab the arm. I was then able to spend about 10, 20 seconds there trying to get the arm, could not.

So I take my arm out. My hand out, I should say. Not my arm, my hand out. I put my hand on the back of the baby's back, move up to the shoulder that was stuck on top. Then I try to find out this part right here. At the same time, which all happened about right here, I asked mom -- I mean, I asked Ms. Phillips to give me suprapubic pressure. At the same time I'm rotating the shoulder. So what's going on? If this is the door, I'm using, I'm trying to reach in here, move this over like this. At the same time I'm using the nurse to go up here to push. So I'm doing two things at the same time, trying to put my hand in, rotate it. Secondly, I'm asking the nurse to give suprapubic pressure to push that way. (Indicating.)

Q. All right. And when you're doing those maneuvers with your hand in the baby, do you have your hand on the baby's head?

A. No, sir.

Q. And I know it makes sense, but why not?

A. Well, I mean, you can't because if the baby's

head is right here, if you have your hand on the baby head, it limits what you can do. So really when the business end is open, it's very hard to put your entire hand in it. So at most you get maybe two, maybe three finger. Most of the time you only have two fingers in you have to maneuver.

Q. All right. Now, after you did this Rubin II maneuver what happened?

A. After the Rubin II maneuver, I was able to rotate the shoulder a little bit. And also, with Nurse Phillips giving suprapubic pressure, I thought there was some movement. So all that took about, I don't know, about right here. (Indicating.)

So at that time mom had a contraction. And so I thought, you know, I thought I moved it a little bit. Not a complete rotation. I thought there was some movement. I'm gonna ask mom to push. And ask Nurse Phillips to continue suprapubic pressure. At that time I was able to deliver the baby.

Q. And at the point in time when you delivered the baby, was that at about this 20:20 timeframe?

A. Yes, sir. Now, I need to let you -- I need to stress this point, is that when you have a baby coming out, any baby coming out, that's been in regardless of whatever shoulder dystocia no dystocia, as soon as the

shoulder clears the bone, what I usually do is I stop doing traction on the head. So I usually put my arm in it. Not my arm, my two fingers in underneath the armpit, pull the baby that way. The reason why I do that is that there's no traction whatsoever on the head, so that way.

Q. And is that what we saw on our video yesterday that you did?

A. I think so, sir.

Q. All right. Now, Doctor, during this window of time, really starting on the prior strip, but once you got to the point where you had begun the delivery and discovered the shoulder dystocia, given the things with the baby's heart rate and the fact that you now have a shoulder dystocia, was that baby medically stable?

A. No.

Q. And why not?

A. You had to take the total picture. Like I say, the total picture, heart rate down to 90, a third of the oxygen has been cut off, slow recovery. That's factor one. Number two, you've got a shoulder dystocia. So oxygen has already been cut off also, so you have two things going on.

Q. In shoulder dystocia in the medical world that you live in, is that recognized as an obstetrical

emergency?

A. Oh, yes, sir.

Q. Now, from that time when you recognized the dystocia in the 20:18, 19, whatever the time was, up until the time of the delivery, was the baby -- did the baby ever become medically stable or was it still medically unstable in that window of time?

A. Oh, unstable.

Q. All right. What about in that window of time from the shoulder dystocia through the actual full delivery of the baby, was it at risk, imminent risk of serious bodily injury or potentially dead?

A. Yes, sir.

Q. Tell us why.

A. Because when you have this situation here, we all know in a dystocia case, normal dystocia, normal baby, nothing wrong with the baby, you've got about four minutes until you got some damage. That's a average. Some babies have better reserve, some have low reserve. That's standard or that's normal. And this baby is already compromised, heart rate down. But all this time, this is about three, six, nine, about ten minutes now.

So when the heart rate's down, you've got a third of oxygen supply and so the baby's already compromised.

And on top of that you've got dystocia, so you really don't have an average of four minutes. You probably have a lot less, but how much you don't know.

Q. And do you have the luxury, as the doctor would, with things going on in that window of time, just to wait and see if maybe the mom will deliver the baby without you having to do the Rubin II or some other maneuver after you've tried suprapubic and McRoberts?

A. No, sir, you don't because, you know, everybody responds differently to the lack of oxygen. Some may have a lack of oxygen or some could hold their breath a lot longer, some can't. And at this time I don't know. All I know is that the baby's been compromised, so I don't know how much reserves they have and know the baby has low reserves based on the slow recovery.

Q. Now, Doctor, we heard two days ago, I think, in the testimony one of the experts that in her opinion you performed the McRoberts after the dystocia, followed by the suprapubic. And that at some point after the suprapubic the baby just rotated on its own that facilitated the delivery. Is that what happened in this case?

A. No, sir. I rotated, I helped to turn that baby a little bit.

Q. How do you know you did that?

A. Because I felt -- because if the baby rotated, the baby would have come out with McRobert and suprapubic. The baby not come out. I had my hand in there to physically push that shoulder, rotate that shoulder with the help of the nurse who did suprapubic.

Q. So you said if the baby had rotated on its own with the suprapubic or the McRoberts -- and I got those backward -- McRoberts or suprapubic, it would have come out on its own without any assistance?

A. I was there. If the shoulder had rotated, it's easy. Then I would not do any resistance. It would just rotate, put my hand in there and just psh, out already.

Q. Did you do this delivery using the same training and techniques and sort of your routine as you do or have done on all the prior shoulder dystocia event deliveries you have had?

A. Yes, sir.

Q. Okay. Let's go back up there.

(Whereupon, witness resumes witness stand.)

Now, Doctor, you were pointing a minute ago to Exhibit No. 2, the nurse's progress note. Who's writing all of this?

A. This is the nurse in this case. I guess the majority is Nurse Phillips.

Q. Okay. The stuff down at the end when we're talking about the application is suprapubic and all that, that's Natalie Phillips doing?

A. Yes, sir.

Q. All right. After the delivery of the child, Doctor, and I'm talking about the actual body coming out.

A. Yes, sir.

Q. At the point where you've got the body coming out, and you've done your Rubin II, are you on the stool at Rubin II time?

A. I'm always on the stool until the very end when the body comes out.

Q. All right. What did you do when the body came out? Did you get off the stool?

A. Like I was saying, so the shoulder has been delivered, anterior shoulder has cleared, has cleared the door handle, as you put it, on the door frame. Then I put my hands in here. Then I will stand up to deliver the baby like this, turn around, clamp the cord and hand off. (Indicating.)

Q. We heard some testimony that the mom didn't really get to hold the baby until after the NICU people had dealt with it and all. Is that kind of normal when you're dealing with a delivery with a problem like this

child had?

A. Normally I would love to hand the baby over, but in this case the baby was in distress, the baby was kind of limp with respiratory depression, so I want to get the baby over to NICU team first to make sure the baby's okay before doing anything else.

Q. Did you observe, did you look at baby Flowers before you, you know, before she was out of that room?

A. I caught a quick glimpse and I got her over quick to the NICU team.

Q. How did she look, the baby?

A. She looked like she'd been through a lot.

Q. Was she -- you mentioned the word limp, what do you mean by that?

A. Very minimal, if any, no tone.

Q. Was the baby in distress at that point?

A. I know the baby was in distress but, you know, once the baby come out, you know, I can't tell you.

Q. You heard some testimony earlier about the possibility the baby may have had a fractured clavicle. Did she have a fractured clavicle during your delivery?

A. Not I'm aware of, sir.

Q. Now, did you make a note about the delivery shortly after it occurred?

A. Yes, sir. I, um, it was about 9:00 p.m., sir.

Q. All right. I'm gonna put up on our thing, and you don't need to come down, Doctor.

A. Sir.

Q. Hopefully you'll be able to see. Is this the note, this one I've got sort of highlighted on here?

A. Yes, sir, that would have been 9 p.m. on that day, sir.

Q. And that's on Defendant's 11. I'm gonna ask you because your handwriting is challenging, can you read it for us? Let me give you a copy.

A. Yes, sir, I can read it. It's a typical doctor's handwriting. Basically it says 10/7/2008, 9 p.m. I used some abbreviation, so I'm just gonna read it out as it's not abbreviated.

(Reading.) Fetal heart tones to the 90s. Fetus at plus three station with head crowning, I control this. Vacuum applied with tool pull noted. Shoulder dystocia encounter with McRoberts maneuver and suprapubic pressure. Viable female deliver, infant handed to NICU. Midline episiotomy had been performed, third-degree extension noted. Third degree repair. Placenta delivered in tact with three vessel cord, as to the blood loss, 300 cc, shoulder dystocia lasted one to two minutes, minimal traction performed. (Ends reading.)

Q. Now, Doctor, did you go back and look at the strip to figure out how long the dystocia had lasted to the second or tens of seconds?

A. No, sir. She delivered around, I guess around 8:20, and so I had to sew her up. So this is written right afterwards. And so at the time the nurse would have had the strip and I just, you know, wanted to go ahead and write down my thoughts at the time at 9 p.m.

Q. Why did you make a note that minimum traction was applied?

A. The number one thing you always do in dystocia case or any deliveries, you want to make sure you use the same traction regardless. And so I want to make sure that, number one, I'm constant in the deliver. And, number two, I want to make sure that I put down my note to be aware that I'm still cognizant that minimal traction was performed.

Q. At this point do you know if the baby has a potential brachial plexus problem?

A. Well, you can tell that she has an injury. Her arm was limp.

Q. And was that something you noted at the delivery?

A. After I handed off the baby.

Q. At the point when you're writing this note at approximately 9 o'clock p.m., do you know it's going to

be a permanent injury?

A. No, sir. I've never had a permanent injury before this.

Q. At this point did you know that you were going to be sued over this delivery?

A. No, sir.

Q. I don't see written in here the Rubin II maneuver. Why is that not in your notes?

A. The reason I didn't write Rubin II, that's a standard protocol that I usually do. So because it's standard I don't write it.

Q. But you did write the McRoberts and suprapubic. Why did you include that?

A. Well, I write McRoberts and suprapubic pressure because that's something that requires assistance. And as you can see also there, I mean, I wrote that I put the vacuum on. That's normal, but I didn't tell how I put the vacuum on or what I did with the vacuum because that's protocol.

Q. You write the McRoberts and suprapubic because that is something you have to have assistance on?

A. Yes, sir. Have to have assistant on.

Q. All right. Now, did you -- we heard some testimony from the Flowers that you talked to them that night at some point.

A. Yes, sir.

Q. All right. If you have an in-depth discussion with them that night about the circumstances of the delivery and all the things that you had done and all the things that had occurred?

A. From my experience, most of the time after I do the delivery like this, I would go and check on the baby and I would go talk to the parents afterwards and tell them, you know, what happened, why I did the thing that I did, and what's going on. But from my experience, probably 99 percent of the time nobody remembers this conversation. They remember bits and piece of it. So I talked to them, but I usually try and come circle back the next day or two after things settle down, after they get through the process to explain a little bit more.

Q. Now, I want to show you what we marked earlier and it's in one of those big exhibits, but it's marked as Defendant's Exhibit Number 1. First, tell our jury what that document is.

A. Basically this is a summary of delivery room record.

Q. On that particular document, is that something that you personally complete?

A. No, sir, I don't complete. Honestly, I don't even look at it. That's by the nurse.

Q. What's the purpose of that record, though?
A. This is a record for the hospital.
Q. Now, is that something prior to today you've looked at and studied it in preparation for our ---
A. Yes, sir, I, I -- yes.
Q. On that record is there anywhere for you to, somebody to check off that a Rubin II maneuver was used?
A. No, sir, there is none.
Q. Anywhere for them to check off if, say, one of these wood screw maneuvers had to be used?
A. No, sir.
Q. Or a Zavanelli had to be used?
A. No, sir.
Q. Or a fractured clavicle had to be used?
A. No, sir.
Q. I do see on there a box for rotation and a box for forceps, what are those on -- what are those about?
A. Basically under that box it says vaginal delivery and it has two options or three options. Vacuum extraction, forceps or spontaneous. Rotation means rotation by the forceps. So the baby is coming out looking sideway, you would rotate the baby so either the baby looking down or up to deliver. So that's implying a rotational forceps.
Q. Did you have to do the forceps and a rotation in

this case that would be such checked on these boxes?

A. I don't do rotation forceps, sir.

Q. Okay. Now, let's go -- thank you, that's all I've got on that one.

Did you then meet with Mrs. Flowers? Well, first, you saw her the next day as well?

A. Yes, sir.

Q. The 8th?

A. Yes, sir.

Q. Sometime in the morning?

A. Yes, sir.

Q. Tell me what you wrote. Can you read that for us, please?

A. Yes, sir. I said: (Reading) around 11 o'clock doing well, routine care, infant moving hand, but not arm yet. (Ends reading.)

Q. And did you see her again the next day?

A. Yes, sir.

Q. Read that one for us.

A. The first one I said, I probably round her in the morning. (Reading.) Doing well, routine care, infant still in NICU. Blood pressure 10/8 up. Will continue to monitor. Prescription Darvocet times 30 on chart. (Ends reading.)

Q. When you're talking about blood pressure up and

all that, is that mom or baby?

A. Mom.

Q. Okay. At this point are you really involved in the baby's care?

A. No, sir.

Q. Is that something the intensive care and neonatal people are doing?

A. Yes, sir.

Q. All right. And did you see the patient again on that particular day?

A. Yes, sir. I ---

Q. Tell me, in your note here on Exhibit Number 5, you wrote that?

A. Yes, sir. I probably round -- I probably circled back with the family. That was around six-something p.m. 6:30 p.m.

Q. All right. Tell us what happened there, what you were doing.

A. I used some abbreviations, so I'll read without it. (Reading.) Discussed with family, husband and wife, concerning event. Explained to family reason for vacuum extraction as outlet, secondary decreased fetal heart tones. Gentle and constant traction applied of infant head after McRoberts maneuver and suprapubic pressure. Dystocia lasted one minute. Info on dystocia

and urged positive in the family. Will have patient return in two weeks. (Ends reading.)

Q. Now, at the point in time when you're seeing them on the ninth and that evening of the ninth, had you had an opportunity to go back and look at the strips and look at the notes that you and the nurses had made?

A. Yes, sir.

Q. All right. And is the reason you have a different, a little bit of a different time on how long the dystocia lasted?

A. Yes, sir.

Q. And, again, I don't see you having any writing in here about doing the Rubin II maneuver. Why is that?

A. Again, sir, that's, you know, it's a standard protocol that I usually do, so I don't, I don't write down standard protocol. So I usually -- you know, I know in my mind that there's shoulder dystocia. I know these are things that I did.

Q. All right. Why did you write the gentle and constant traction was applied?

A. Well, again, I want to make sure I reiterate that that's the number one priority in my mind, that use the same traction with every single delivery regardless of whatever.

Q. So at this point, you knew the baby had a

brachial plexus?

A. At that time I thought it was temporary plexus.

Q. Did you have any idea this was a permanent brachial plexus?

A. No, sir.

Q. Any idea that any lawyers were gonna be coming after you because of this delivery when you wrote this note at 6 o'clock, 6:30 10/9?

A. No, sir.

Q. Did you continue to see Mrs. Flowers while she was in the hospital before she left three days into it?

A. If I did, I didn't write it down. So that was my last note. I'm not sure. If I saw her the next day I would have written a note.

Q. Okay. Were you in any way mistaken about the degrees of traction you applied when you wrote the words minimal traction performed or gentle and constant traction applied?

A. No, sir.

Q. Were you in any way -- had you underestimated the amount of those forces that you applied in this delivery when you wrote those words minimal traction performed or gentle and constant traction?

A. No, sir.

Q. Were you concerned about this baby?

A. Yes.
Q. While she was there in the hospital?
A. Yes. I mean, I try to take care of every patient as they are my family members, so if you see a baby like that you would be very concerned.
Q. Would you continue to follow Ms. Flowers outpatient once she was out of the hospital?
A. Yes, sir.
Q. And did you have occasions to -- well, how long did you all continue to follow her or did you continue to follow her in doing office visits postdelivery?
A. I think I saw her one time for a postpartum check and I'm not sure I saw her another time, but the last note I have here was on April -- I guess for a complete -- April 30th, 2009.
Q. And at that point in April 30th, were you still having discussions with them about the injury that Ashley had suffered, this brachial plexus problem?
A. Yes, sir. I want to make sure the baby is doing okay and if the baby needs anything, the family needs anything, I want to make sure I'm available. So I must check on her, the baby, and making sure that she was doing okay.
Q. And you're not a pediatrician, you weren't in charge of the baby's care, were you?

A. No, sir, I was not.
Q. But had you connected them or referred them up to a pediatrician to help with potentially this plexus, brachial plexus injury?
A. I got some information and I gave it to them. And I said I heard great things about this doctor, so I said, you know, you could go ahead and check out this physician.
Q. Had you referred any of the other patients to Dr. I think it was, Newman was her name?
A. If there was any temporary brachial plexus injury, I would say need some information. Go ahead and start physical therapy. These are the people you may want too see.
Q. In this visit on the 30th of April, 2009, did you talk to Mr. and Mrs. Flowers about how the dystocia might have occurred or what might have caused the baby to get stuck?
A. Well, I wrote on my note that, you know, that I recommended she was crying again to have a c-section just because it is dystocia case. I wrote -- yeah.
Q. And what did you talk to them about as far as what happened?
A. Well, let's see, in my note I, I said, again, I discussed with patient concerning the shoulder dystocia,

that the pelvis was probably too small due to extensive shoulder dystocia and amount of cap done on an infant.

Q. Now, was this your ability, and having been through it all, to kind of figure out maybe why the baby got stuck in the birth canal?

A. Well, I think, you know, when I wrote the pelvis was too small, when I was -- really what I'm trying to say is that on that day with the baby moving down, the pelvis was not able to accommodate the baby and, therefore, the shoulder was stuck. If it had been a different day, it may be a different situation.

Q. If babies when they come down and the babies are moving through the birth canal, do they always come down the same way?

A. No, sir. They move, they move in different -- I mean, kind of move like this in moving in different ways moving down. (Indicating.)

Q. And is there the pelvis's ability to accommodate the baby moving through it, sometimes depending on the angulation of the baby as he was moving down?

A. Yes, sir.

Q. And sometimes does it just get in the wrong angle for the side of that particular pelvic outlet?

A. Yes, sir. That's why sometime, you know, you have a baby coming out looking head down. You have

sometime the baby coming out looking head up. It's the way the baby moves and the way the baby rotates down there.

Q. And is that why you ended up trying the suprapubic McRoberts and the successful Rubin II to help rotate the baby where it would go through the pelvic outlet?

A. Yes, sir.

Q. And it did work obviously?

A. Yes, sir.

Q. Was -- in your understanding from the baby in the hospital before everybody, she went home, did she have any brain injury of any sort?

A. No, sir.

Q. Cerebral palsy of any sort?

A. No, sir.

Q. And you noted you delivered a live baby?

A. Yes, sir.

Q. I'm gonna show you one last thing. Exhibit 19. Did your office continue to stay in touch with the Flowers family to sort of check up on how things were going?

A. Yes, sir.

Q. And this note I've given you, 19, what's the date on that one?

A. 4/9/2010.
Q. Read what is written in that note for us.
A. (Reading.) Check on new call. Patient states daughter is doing fine. Went to surgeon in March and surgery is scheduled when two years of age. States she can't raise arm. Can't read that part. Is to do other normal activities. States she had her records sent to Dr. Adams and she had her pap there last month.
Q. So ---
A. And then something about a nurse.
Q. And was that the practice's policy, your policy with the practice? Do you all kind of keep up with your patients and see how, especially in a scenario like this, how the baby's doing?
A. That's my policy, sir.
Q. All right, Doctor. Did you apply any unusual amount of traction or force to deliver this baby?
A. No, I did not.
Q. Would you have used the same forces in this delivery that you use or had used in all prior deliveries that you do?
A. Yes, sir.
Q. Did you apply any unusual direction of, of forces or traction to deliver this baby?
A. No, sir.

Q. Did you use traction and forces that were generally aligned with the axial spine of the baby as best you could?

A. Yes, sir.

Q. Did you apply greater -- 35 pounds or greater traction on this child?

A. It's hard -- I would not be able to. If I had done that, the stool would have rolled over and fallen down.

Q. Did you apply, 30, 45 degree angle of downward traction on this baby during the delivery?

A. Again, no, sir.

Q. Did you comply, Doctor, with the standard of care, that being what most competently trained doctors would do when faced with a situation like Ashley Flowers faced with the condition she was in both before the shoulder dystocia and from the time of shoulder dystocia through the delivery of the baby in your care?

A. Yes, sir, I did everything an OB-GYN would have done.

Q. You've been sued for malpractice. Do you have an opinion whether you committed malpractice in your care and treatment of Mrs. Flowers and her child?

A. I performed standard care. I did not perform malpractice, sir.

CROSS-EXAMINATION

BY MR. HENSHAW:

Q. Dr. Giep, do you agree that the definition of, medical definition of axial traction as it applies to circumstances of delivering a baby in shoulder dystocia means that a pulling force applied in alignment with the fetal suprathoracic spine, sometimes referred to as downward axial traction?

A. I think from my interpretation of it, the traction along the spine of the baby.

Q. All right. Do you agree that lateral traction is a pulling force that bends a fetus' neck by moving the ear toward the posterior shoulder, thereby opening the

posterior shoulder, thereby increasing strain on the contralateral angle of the neck and increasing strain on the brachial plexus, sometimes referred to as lateral bending, downward lateral bending or downward lateral traction?

A. The way I interpret that statement, so if you put the head here, then that's mine.

Q. All right, sir. So axial traction, based upon what you've told us, would be where the baby's head stays in alignment with the spinal column as the baby delivers?

A. In that picture -- in that picture it would be along this plane.

Q. All right, sir. So this baby's head, if there were traction to be applied, the hands here are not shown by -- of the doctor, but if traction were to be applied it would be in this straight direction all the way down?

A. It would be a little bit angled down a little bit to clear the shoulder, so...

Q. A little bit angled down?

A. Yes, a little bit.

Q. Maybe to here? (Indicating.)

A. I said a little bit of angle enough to clear the shoulder --

Q. All right.
A. -- away from the bone.
Q. Okay. But this would be an illustration of lateral traction as you defined it; is that correct?
A. That's what the picture depicts, so...
Q. Depicts lateral traction?
A. That's what the artist renders, yes, sir.
Q. All right, sir. Do you agree that the definition of excessive traction in this context is a pulling force that is greater than the inherit strength of the fetal brachial plexus? Obsessive traction.
A. I mean, to me excessive traction is more traction than you need to deliver the baby.
Q. All right. But do you agree that excessive traction has an effect on the baby's brachial plexus?
A. There's a lot of other factors that can affect it, sir.
Q. All right. Well, I understand that. But is excessive traction one of those within your context of what can affect brachial plexus?
A. Yes, sir.
Q. And the brachial plexus is the nerve system of C-4, C-5, C-6, C-7, C-8 and T-1; is that right?
A. Yes, sir.
Q. And that comes out of the spinal cord in the area

of the neck and into the shoulder?

A. Yes, sir.

Q. Do you agree that the standard of care of a reasonably competent obstetrician under the circumstances of delivering a baby who has encountered shoulder dystocia, is to apply routine traction, meaning the same degree of traction that would be applied in a normal delivery?

A. Yes, sir.

Q. And was that the standard of care on October 7, 2008?

A. Yes, sir.

Q. Do you agree that lateral traction should be avoided?

A. That's a fair statement.

Q. And do you agree that excessive traction should be avoided?

A. I can agree with that.

Q. And so do you agree that the standard of care on October 7th, 2008, was to avoid both excessive traction and lateral traction in the delivery of Ashley Flowers?

A. I agree.

Q. And this is -- is there a blow up on this thing? I mean, can it be enlarged?

THE CLERK: Yeah.

MR. HENSHAW: Right here? It's not very enlarged.

BY MR. HENSHAW:

Q. But this is your note that you entered shortly after Ashley was born. She was born at 8:20 p.m.; is that right?

A. Agreed.

Q. And you entered this note by your own time, by the time that you -- you put down the time as 9:00 p.m. as the time you entered this note; is that right?

A. Yes, sir.

Q. Now, you go through what you did here and it's in evidence, both under Plaintiff's Exhibit 1 -- 2, I believe, and all of those records and it's been separated out by the defendant as Defendant's Exhibit 4, and you go through that. And essentially what you did here was to state what you did to get Ashley delivered; is that right?

A. Yes, sir.

Q. And you stated in the order in which you did it, except for the statement about minimal traction performed.

A. I mean, I put down what was going through my head, so I can't sit here and say these are the exact chronological order because ---

Q. Well, let's go through what you say you did.
A. Yes, sir.
Q. So start at the very beginning. What is the first thing that you put down?
A. Fetal heart tones to the 90s.
Q. All right. And you've explained to us how that affected your decision process.
A. Yes, sir.
Q. What's the next thing you put down?
A. Fetus at plus three station.
Q. And would that have been in your order of looking at the heart rate and then doing a vaginal examination on your own to determine where the fetal head was?
A. Close.
Q. All right. And then so what's the next thing?
A. Plus three station, head crowning and shoulders.
Q. All right. And is that, so far are we staying within the order of the way things probably occurred?
A. Probably but not absolute.
Q. All right. Well, then the next thing that you have is that you placed the vacuum.
A. That's correct.
Q. And you've explained to us why you elected to use the vacuum to help assist the mother deliver this baby.
A. That's correct.

Q. All right. So, so far are we still in order of the sequence of the events?
A. Yes, sir.
Q. And then what's the next thing?
A. Vacuum applied with two pulls noted.
Q. All right. And then after that?
A. Shoulder dystocia encounter with McRoberts maneuver and suprapubic pressure.
Q. And so that is still consistently within the order of the events; is that right?
A. Yes, sir.
Q. And then what?
A. A viable female infant deliver.
Q. All right. And so that means you delivered the baby. And the term viable means what, a live baby?
A. A live baby, yes, sir.
Q. A live baby who is -- who has enough features about it that you expect it to continue to live within the period -- within the neonatal period; is that right?
A. No. To me a viable infant is that the baby has a heartbeat.
Q. All right. So you've got a live baby. So what's the next thing you've got?
A. Infant headed to NICU.
Q. All right. So are we still in the order of the

events?
A. Close enough.
Q. Okay. And what do you have next?
A. Midline episiotomy. Had to perform with third-degree extension noted.
Q. All right. So this is something that had occurred before the baby was born; is that right?
A. Yes, sir.
Q. But it's something that after the baby was born you were gonna have to deal with because you had to sew it up?
A. Yes, sir.
Q. And so what's next?
A. Placenta delivery intact with three vessel cord.
Q. Okay. Now, did the placenta deliver before the episiotomy was sewn up or did it deliver after?
A. In this instance it delivered after the episiotomy, so...
Q. So we're still in the order of things.
A. Yes, sir.
Q. And so what do you have next?
A. Estimate loss 300 cc.
Q. This is where you're estimating the blood loss?
A. Yes, sir.
Q. By the mother?

A. Yes, sir.
Q. Not by the baby?
A. No, sir.
Q. And I take it this bleeding is from the episiotomy that you cut?
A. No, sir. This is combination of the blood loss after delivery as well as the cut and the repair.
Q. Okay. So both.
A. And the placenta separating, yes, sir.
Q. But that estimate would come -- in terms of that estimate, that would come in the order of these events where it is now; is that right?
A. Yes, sir.
Q. What do you have next?
A. Shoulder dystocia lasted one to two minute.
Q. All right. And so that's a line that is out of order because the shoulder dystocia had occurred before the delivery of the baby?
A. Yes, sir.
Q. And before the episiotomy?
A. No. It would have -- yeah, after the episiotomy.
Q. I'm sorry, before or after?
A. After the episiotomy.
Q. So even before you recognize that there was a shoulder dystocia, you had already cut an episiotomy?

A. Yes, sir.
Q. And was that because you felt like -- well, tell us why you, you cut the episiotomy in this particular case?
A. Well, in this instance when you do a vacuum extraction, you put the vacuum on the baby's head. As the baby head comes out, being that this was a first-time mom, she was gonna tear. And at that time I thought that she was gonna tear so I just went ahead and just did an episiotomy to make sure that the tear is straight so it's easy to repair.
Q. All right. And did you do that before you applied the vacuum or after you applied the vacuum?
A. This is -- I'm doing the episiotomy as the head is about to come out after the vacuum was already applied.
Q. All right. So you had -- and I take it that you had, in fact, moved the baby down the birth canal with the two pulls by the vacuum extractor?
A. Well, the head was already down at the vaginal opening. What I did was flex the head and help the head to come out --
Q. All right.
A. -- the opening.
Q. So that's the only reason that you used the

vacuum was to turn the head?

A. I did not turn the head, sir.

Q. What did you do with it?

A. As I've stated before, what happened was the head, I flex the head so head go to chin so it can go underneath the bone. And then I help it so it goes up like that outside of that vaginal opening. (Indicating.)

Q. All right. And that's what I'm trying to understand is you put the vacuum on the baby's head.

A. Yes, sir.

Q. Engage it.

A. Yes, sir.

Q. And then did you use it to pull the baby's head down or up?

A. There's two things, sir. What you do is you guide the head, so put the chin to here so the head can go underneath the pubis bone. And then the natural progression for the baby's head is to (indicating). And that's what would do that. And so the vacuum is just to help assist to go up like that. (Indicating.)

Q. Well, the baby's head was crowning when you ---

A. Yes, sir. You see the top of the head.

Q. Before you did that?

A. Yes, sir.

Q. So what part of the baby's head needed to go underneath the pubic bone?

A. The majority of the baby's head, sir.

Q. The majority of it. All right. And so you lowered the baby's chin down, so that it could more easily pass under the pubic bone?

A. The idea behind the vacuum is to decrease the diameter going through the birth canal. So by doing this, you decrease the diameter of the head so it goes under easier.

Q. All right. And so you did two pulls with the vacuum extractor in order to accomplish that; is that right?

A. That's normal routine.

Q. Right.

A. Yes, sir.

Q. And that in and of itself would not have altered the baby's alignment in regard to this axial traction that, that ultimately should be applied; is that right?

A. That's the standard movement, the head coming out. It goes underneath the bone and the head extend out.

Q. I understand that, but that doesn't alter the axial traction that should be applied after the baby's head comes out.

A. I can't make that statement because I can't see what's going on beyond this. But that's a normal state -- normal maneuver.

Q. Well, do you have any reason to believe that it altered that axial traction in this particular case?

A. I can't tell you one way or another. I don't think so, but I can't sit here -- I don't have an x-ray. I can't go in and tell you.

Q. Well, what about did you in any way pull the baby's head so that the angle would have stretched the brachial plexus?

A. The only thing I did was guide the head down, guide the head up, normal as if she was delivering without a vacuum.

Q. Did you take the vacuum extractor and move the baby's head to the side, to the opposite -- toward its shoulder, either way?

A. No, sir.

Q. Okay. So the vacuum extractor is not likely to have caused the brachial plexus injury in this case, is it?

A. The only thing is it guide the head down and it guide the head up.

Q. My question, Doctor, is in terms of what you do know it is not likely that the vacuum extractor that was

used in pulling the head two times had caused any injury to this baby's brachial plexus?

A. I can't say that because I'm not sure what's going on with the shoulder from the brachial plexus behind the bone. The only thing I can tell you is what was going on with the head. I can't tell you what's going on with, with the nerve that was stuck behind the bone.

Q. Did you pull so hard that you could rupture C-5, C-6, C-7 with that vacuum extractor?

A. It's impossible to pull that hard with the vacuum. It would have pop off.

Q. All right. Did you in any way angle the vacuum extractor from side to side in terms of the baby's shoulders?

A. No, sir.

Q. Okay. And then as your final comment, minimal traction performed.

A. Yes, sir.

Q. Was that an afterthought or was -- why is that the very last comment here rather than being indicated up here when you were talking about the maneuvers and the order in which they occurred?

A. Sir, when I'm writing that stuff it's 9 o'clock that night. I just got through the delivery, a lot of

things running through my head, and so I'm doing the best job I can writing things down.

Q. And minimal traction performed, that would be your standard routine; is that right?

A. Yes, sir.

Q. That would be your standard protocol; is that right?

A. Yes, sir.

Q. Just like the Rubins II that you say you did.

A. I think you're taking it out of context, sir.

Q. Well, you're the one who said I didn't write down Rubins II even though I did it because that's my standard protocol.

A. Right.

Q. So is it this -- if this is your standard protocol why did you write this one and not write the Rubins II?

A. This is important.

Q. And Rubins II wasn't?

A. Rubin II is one of the maneuver that you can do.

Q. Well, do you -- it's one of the maneuvers you can do that you now say allowed this baby to deliver. That's not important?

A. When you have a shoulder dystocia, there's several maneuvers. The first maneuver is McRoberts

suprapubic. If that didn't deliver there's other maneuvers you do. And I have a standard protocol that I do.

Q. And some of the standard protocols you write down and some of the standard protocols you don't. Is that what you're saying?

A. No, sir, you're taking it out of context. I said the ---

Q. I'm not taking it out of context if this is what you've told us.

A. Well, I think you're playing words. I'm saying that what I do is that if I need assistant or someone participate in it I will write it down. If it's standard protocol I don't write it down. For example, I wrote here midline episiotomy performed, third-degree repair. I didn't write down how I repair it because it's standard protocol how I repair. Just because I didn't write it down didn't mean I didn't repair her.

Q. I understand that. And that's what I'm trying to find out. What do you write down, what do you don't? Because you're the one who said I don't write down standard protocols where I do it and don't need assistance. And I'm just trying to understand why you wrote down minimal traction performed because you did that without any assistance and you're saying that's

your standard protocol, but didn't write down the Rubins II, which you did without any assistance. And you say that's your standard protocol.

A. Well, you're taking two different things. And let me explain. First of all, let's take the shoulder dystocia by itself. With the shoulder dystocia there's protocol that I follow. If the protocol involved assistant, such as McRoberts suprapubic, I write it down. Rubin II, deliver posterior arm does not need assistant, so I don't write it down.

Traction is important because I want to stress in my mind, as I always do, use the same traction on every delivery whether or not it's a regular delivery or dystocia. It is more important in a dystocia case to make sure you use the same traction. So I'm emphasizing to myself beforehand and emphasize afterward I'm using the same traction. No more than what I usually do.

Q. Okay. So what you're telling us is that what people understand about your traction is important. That's the reason you wrote it down.

A. This note is for me, so I just put down minimal traction.

Q. This note is for you? This note is for the entire hospital, isn't it?

A. Well, it's for me to recall what I did in this

situation.

Q. Well, that's one of the things, but when people go and start looking at what you did in this situation, that's what the note is for.

A. I guess you can say that.

Q. All right. Or is that not true? This note is only for you?

A. No. It is part of the record, but the purpose of the note is for you to know what you did.

Q. All right. And so when we look back, you wanted to be sure that people knew that in your mind you only applied minimal traction; is that right?

A. Well, when I wrote this note it's for me to document I did minimal traction, for me to know that's what I did.

Q. Okay. Doctor, do you know what the phrenic nerve is?

A. I'm sorry, say it again, sir.

Q. Do you know what the phrenic nerve is?

A. It's a nerve in the diaphragm.

Q. And where does it start, do you know that?

A. I don't recall, sir.

Q. Is it in any way connected to C-4 and C-5?

A. I don't know, sir.

Q. You don't know that?

A. I don't remember that, sir.
Q. So you were earlier telling us about the baby's oxygenation. You were explaining that when the baby is in the womb it's a question about whether the heart is getting adequate oxygen; is that right?
A. I didn't say that exactly, sir.
Q. All right. Well, my point is or what I really want to get to is that you weren't trying to suggest that the baby was breathing while in the mother's womb before the baby delivered, are you?
A. No, sir.
Q. That's not what happens. What happens is that oxygen comes from the mother and makes its way to the placenta and then the oxygen passes through what is called a membrane barrier and is then brought into the baby by way of the umbilical cord which is attached to that placenta; is that right?
A. That's a way to look at it. But basically what it is, is that the baby does not actually breathe as an action of take a deep breath in and out. The way the baby gets its oxygen is from the mother. And the way it gets oxygen through the baby's body is through the heart beating and pushing that blood circulating the baby's body.
Q. Well, for the oxygen to get to the heart it has

to come through the placenta through the baby's umbilical cord; is that correct?

A. Yes, sir.

Q. And so one of the things that can explain why a baby's heart rate will decrease is if the cord is somehow compressed; is that right?

A. There's many factors, sir.

Q. But I -- but my question said that's one of the ways. Do you agree that that is one of the ways that the baby's heart rate will be decrease is because of compression of the umbilical? Is that right?

A. If the baby's compressed the cord enough, yes, it decreased the heart rate to the baby.

Q. And this notion that because that is one of the ways when nurses see a lowering of the baby's heart rate, like they saw in this case, they will move the mother's position, as they did in this case, to see whether that can relieve possible compression. They can't know because they can't see it, but they can suspect it and they can take action to try to relieve any compression on the cord; is that right?

A. The movement of the mother is an increase of blood supply to the uterus, to the placenta and there's two scenario. If the cord is there and the baby is laying on it, yes. It also be -- it could be that the

mom is not getting enough blood to the uterus. So by moving mom it increase the blood supply to the uterus.

Q. Are you capable of just simply saying yes or no to the question of don't nurses sometimes change the mother's position in hopes of changing the problem caused by cord compression?

A. Yes.

Q. All right, thank you. And that's what they did in this case, isn't it?

A. They ---

Q. Before you got there. That's what the records indicate.

A. They change the mother's position to increase the blood supply to the uterus, to the placenta. Now, I can't sit here and tell you whether they perceive as a cord compression or anything, but it's a standard protocol to increase the blood supply to the uterus.

Q. Are you able to just simply say yes or no to the question of isn't that what the nurses did in this case is that they changed the mother's position?

MR. LOVELL: Your Honor, I object. I think he's argumentative with his question in not allowing the witness to answer.

THE COURT: Overruled, continue.

MR. HENSHAW: Thank you, Your Honor.

BY MR. HENSHAW:

Q. Are you able to say simply yes or no to the question of did they change the mother's position?

A. They did change the mother's position, yes.

Q. All right. They did that before you got there.

A. That's correct.

Q. So it was not on your instruction, it was pursuant to a standard nursing protocol?

A. They would -- what they would do is, yes, they can change position before I got there. They can also change position when I got there and I instructed them to change position because we will flip from one side to the other.

Q. All right. And if we look at the -- I want to look at the fetal heart monitor strips. Let's -- let me just ask you to help us understand some things about these fetal heart rate monitor strips.

A. That's upsidedown, sir.

Q. I've got it upside down?

A. Yes, sir.

Q. So this bottom section here, this is where the electronic fetal heart tone monitor attempts to record the mother's contractions; is that correct? (Indicating.)

A. Yes, sir.

Q. And this top section here attempts to record the baby's heart beat; is that right? (Indicating.)
A. Yes, sir.
Q. And on this particular strip, which is earlier, but close to before you just arrived, we can see that it is recording the baby's heart rate. And one of the things that doctors and nurses want to look at is generally what the heartbeat is so they can establish a baseline; is that right?
A. Yes, sir.
Q. And in this case the baby's baseline was just above 120, maybe 130, as shown by this strip?
A. On this strip I'd say baseline is about 130.
Q. All right. And although that might seem high for an adult, that's about right for an unborn baby; is that right?
A. Normal range is 110 to 160.
Q. All right. So there is a 50 point space that the baby can fall into that's gonna be considered a normal range; is that right?
A. Yes, sir.
Q. Okay. And so at about 1:30 she is at a normal range at this particular point in time?
A. Yes, sir, compared to her baseline before, yes, sir.

Q. All right. Now, we see these increases in the heart rate. And one of the things that we do or you do with the electronic fetal monitor strip is that that tells you whether the baby is being responsive to contractions?

A. That has nothing to do with baby's response to contraction.

Q. A contraction won't cause a baby's heart rate to go up and make a bump like this?

A. Not necessarily, sir.

Q. All right. So then what explains her heart rate going up here?

A. Something caused her heart rate to go up.

Q. All right.

A. Could be she moved, she ---

Q. So you don't think it was the contractions?

A. It could be, but I can't say it's absolutely hundred percent it is.

Q. But the fact that it went up here is not a concern given this strip?

A. No, sir.

Q. Because even though it goes up, it comes back down and stays relatively close to the baseline; is that right?

A. Yes, sir.

Q. This is a continuation of the strip. Baby's still close to the baseline but has this elevation here that goes up to 160; is that right?

A. I believe so.

Q. All right. Nurses aren't calling you because they're concerned about this increase in heart rate, are they?

A. No, sir.

Q. And she comes back down and that strip continues on relatively close to 130 or so or within the normal range?

A. Yes, sir.

Q. Continuation of the strip. Baby's heart rate is still at baseline?

A. Yes, sir. But you know this is not a lot of movement up and down so it's stable.

Q. Not a lot of movement up and down. But as you said, that's not necessarily -- I mean, you wouldn't necessarily expect the baby's heart rate to go up and down because of these contractions. These are contractions every time you see on the lower panels, that represents a contraction, that upward -- that mountain looking thing; is that right?

A. Yes. What you pointed at is a contraction, yes, sir.

Q. That's a contraction. That's a contraction. That's a contraction. (Indicating.) There's three contractions here?

A. That just monitor what the monitor perceive is contraction. It could be mom, it could be a contraction, it could be mom pushing, it could be mom moving, getting up moving. It could be mom laying down will cause that elevation.

Q. All right. And that's the reason I said earlier this is where the electronic fetal heart tone monitor is attempting to monitor the mother's contractions.

A. Yes, sir.

Q. I didn't say that it does, but it's attempting to do that.

A. To its best ability, yes, sir.

Q. Okay.

A. Could I go back? With that, I mean you point out 130. You know, when you have a healthy baby, the heart rate does not stay flat. It goes up, return baseline. Goes up, return baseline.

Q. Well, let's continue on with these monitor strips. And this is a continuation of that. And it's pretty much the same as the one we just showed where there's not a lot of change in the heart rate. It's still right there about 130; is that right?

A. It is about 130. Not a lot of what we call variability. So not a lot of movement.

Q. And you don't -- and you prefer to see variability, but you don't always see it.

A. We would like to see variability in acceleration.

Q. Right. But you don't always see it.

A. It depends on the baby.

Q. Right.

A. The situation.

Q. Now, some other things that would be helpful to understand, Doctor, is what these segments are that are on the fetal heart tone monitor strip. Each of these segments represent this column right here, if I just go straight down inside the small rectangular blocks, that represents ten seconds? (Indicating.)

A. Yes, sir.

Q. And so when you're actually looking at the strips there is additional lines, and if you take each of these segments they represent one minute?

A. Six of those blocks represent one minute.

Q. Six of those blocks represent one minute. And so a little bit darker line if you can get close up to the strip so that you can see one minute, the next minute, the next minute. But six of these columns represents one minute?

A. Yes, sir.
Q. Okay. And the same thing in regard to the mother. We can see how many contractions she's having a minute; is that right?
A. Yes, sir.
Q. Now, on this situation here where, as you said, there does not appear to be much variability or hardly any variability at all, were the nurses calling you?
A. It depends on the situation before that strip. So I don't -- I mean, in this patient they did not call me.
Q. That's all I'm asking you is did the nurses call you in regard to what this lack of variability they were seeing on the strip?
A. I don't know what time that was, sir, so I couldn't tell you.
Q. Well, you know whether they called you or not in regard to lack of variability, don't you?
A. I didn't get there until between five and six, so I can't tell what time that was.
Q. Oh, I see. Okay. Well, I think we'll get to a strip that helps us identify the time. But don't the nurses usually note on these strips if a doctor is responding or coming into the room?
A. They're supposed to put down a note. Sometimes

they may forget.

Q. Okay. So the two doctors that they could have put down would either be you or Dr. Fowler. And there's no note that Dr. Fowler was called in regards to this situation, is there?

A. I don't know whether Dr. Fowler was called or not. I don't know.

Q. Did Dr. Fowler when you say you communicated with her before you took over coverage, did she tell you I'm concerned about the lack of variability on these strips?

A. She may have already evaluated the patient and deemed that was okay.

Q. I didn't ask that, Doctor. I asked you did she tell you that she was concerned about the variability on these strips?

A. At the time of checkout she said she was fine.

Q. Okay. This is the next strip and variability is returning.

A. Somewhat. Still minimal, but somewhat.

Q. But it is returning; is that right?

A. I'd say somewhat.

Q. Okay. And the next strip, this is all in real world a continuous strip that gets fed out of the machine; is that right?

A. Yes, sir.

Q. Variability returning here?
A. Yes, sir.
Q. Baby is still at the baseline?
A. Yes, sir.
Q. And because the screen isn't so good I'll show you, but there's a remark made by the nurse. Do you see that here?
A. Patient to the left side.
Q. All right. So they turned the mother over to her left side?
A. That's what it's saying.
Q. Do you know why they did that?
A. It could be for a number of reasons. It could be that she had an epidural, they want to turn her on her side make sure she's comfortable. And an epidural can be on one side or the other.
Q. All right. And do you see a time on there yet, Doctor?
A. (Witness shakes head back and forth.)
Q. No?
A. I do, but I can't read it.
Q. Okay. We just don't have good copies?
A. We don't have good eyes.
Q. Okay. I know I don't. But right here patient turned to left side, right? (Indicating.) That's the

remark.

A. That's the remark that was made.

Q. And then the next strip is baby still at baseline?

A. The front part, yes. I can't tell you about the latter part of the strip.

Q. Now, this is -- is this a problem in terms of the ability of the machine to monitor the heart when you get an art -- well, is that just an artifact or is that a true return of the baby's heart rate when it comes up there like that?

A. Artifact.

Q. Artifact?

A. I guess. I'm not sure. I'd have to look at the context to see.

Q. So somewhere or another the machine is not getting a clear signal from the baby's heart here; is that right?

A. You have to be there to listen to whether or not the heartbeat really went up or a machine had trouble picking it up.

Q. Okay.

A. It's trying to track the baby's heartbeat.

Q. But one of the things that can happen is that the machine will lose it's signal for some reason.

A. Yes, it can.
Q. And there's a number of reasons why that can occur.
A. Yes, sir.
Q. Now, was this an external monitor or an internal monitor?
A. I believe this was external.
Q. All right. That means the mother was wearing a belt around her abdomen?
A. I believe, yes, sir.
Q. And an internal monitor would actually put a sensor on the baby's head if that could be done?
A. Yes, sir.
Q. But here mother's wearing a belt?
A. Yes, sir.
Q. And so the belt can move, that's one of the things that can happen?
A. One of the possibilities that the monitor itself could move.
Q. The baby can get in a position where the sensor's not able to clearly pick up the baby's heartbeat. Is that another way that you can end up losing the signal?
A. The baby can move position and shift, yes, sir.
Q. All right. And because -- and, as you say, you have to be there. But if the nurses thought that this

was a serious problem with the baby, they should be calling the doctors?

A. That's correct.

Q. And they didn't call the doctors here as far as you know, did they?

A. I don't know.

Q. You don't have any reason to believe you got called, do you?

A. I don't recall.

Q. And so here's the next continuation. Is the machine having trouble picking up the baby's heartbeat?

A. Possibly.

Q. Okay. Here is the next strip. And somebody has done us the favor of actually reading the time that is on this strip. 1932 hundred hours military time, at least that's what this purports to say; is that right?

A. If that's what's written there.

Q. That would be 7:32?

A. Yes, sir.

Q. And had you taken over for Dr. Fowler by 7:32 p.m.?

A. Yes, sir.

Q. And here is this a pretty reasonable strip in terms of the collection of data by the fetal heart tone monitor?

A. Yes, sir.
Q. Is the baby still at baseline?
A. 130s, yes, sir.
Q. And these are -- do you have reason to believe that these are or are not contractions, these mountains and hills that are in the lower graft?
A. It's hard to tell, but it's probably contractions.
Q. Next continuation of that strip and baby is still at baseline?
A. 130s, not a lot of variability.
Q. Not a lot of variability. Is this probably an indication that mother's contractions are increasing?
A. Just telling that she's contracting.
Q. This indicates that right here the mother was given lidocaine. Why is that? I can show you. I can hand the strip to you, Doctor, if you need to look at it.
A. It said something about two percent lidocaine. I'm assuming that was for her epidural.
Q. Okay. And this is really just a matter of minutes after the 1932 reading. And if that's correct, this is somewhere between 7:32 and 7:50?
A. Without the two strip I can't confirm or deny it, sir. I don't know. I will take your word on it.

Q. All right, sir. Here's the next strip. And, again, someone has done us the favor of indicating the time at 1955; is that right?

A. That's what the writing says, sir.

Q. That would be 7:55 p.m., correct?

A. Yes, sir.

Q. And this part of the strip the baby is still at baseline?

A. Yes, sir. 130 with a little variability, yes, sir.

Q. And there's variability in this particular part of the strip; is that right?

A. Still not great but, yes, still some variability.

Q. So then we have this strip, which is the next portion of the continuation. And the baby is continuing at baseline in terms of its heart rate?

A. The first half of the strip, yes, sir.

Q. Okay. Well, what about the second half, are we losing signal here?

A. Near the latter part of the strip you can see right here somewhere in the 90s and this is decreasing right here.

Q. Okay.

A. So this is down to 90.

Q. Okay. And then over here is that a signal that

gives an indication that the baby's heart rate is in the 160 area?

A. Not necessarily because when you have a heart rate low, let's say, the machine sometime misperceive it and double it to think that's the baby's heart rate. So sometime if you have a true heart rate, let's say in the 60s, the machine can double it and think that it's at 120 until it can identify that's not correct.

Q. Okay. And if this is correct, this is around 8:04; is that right?

A. That's what it says, sir.

Q. So here a continuation of the strip at 8:07 p.m., we have the baby's heart rate again. According to the machine it was signals in the range of, I think, that's actually a 180?

A. I wasn't there, so I'm not sure that's a true 180 or that's a double of 90, times two that's 180.

Q. All right. Well, where's the 90? Is this the 90 right here? (Indicating.)

A. Yes, sir, there. (Indicating.)

Q. And so if we come across, the baby's heart rate is at 90 for one, two, three, four, five, six minutes or so, close to six minutes if you go by this?

A. I can't see the time, so I'm gonna take your word you counted those right.

Q. And then it goes back up to around 211?
A. Well, 2011, this is when I arrived and so my hand is inside the vagina doing the scalp stimulation. So that's part creating it to go up.
Q. So are you saying then that the baby responded to the stimulation of your hand while you're doing the vaginal exam, most probably?
A. Most probably.
Q. And that's a good sign that the baby is responding in that way; is that right?
A. It is a sign.
Q. Well, it's a good sign. I mean that's not considered to be detrimental to the baby, that's considered to be an indication that the baby has the ability to respond to that type of stimulation.
A. You still have the tape. You can't just take that one statement and say, okay, he respond to scalp stimulation, you're fine, leave the baby alone like that. You have to look at the entire picture. As I stated before, you have to look at the entire picture.
Q. Right. And, Doctor, do you understand that there is no criticism of you in this case of your interpretation of the strips and what you needed to do?
A. Well, sir, I just want to make sure because you're stating one event here. I want to make sure we

look at the entire picture.

Q. I understand. But do you understand that in terms of this entire --

(Whereupon, there was a crash in the courtroom.)

MR. HENSHAW: Did somebody break? I guess we're all right.

BY MR. HENSHAW:

Q. But really, seriously, back to my question, because I think it's important to know whether you understand that there has been no criticism of what you did during this phase of the delivery.

A. Yes, sir.

Q. That you interpreted that there needed to be some action taken in response to the lowering of this baby's heart rate. Do you understand that there's no criticism of that?

A. Yes, sir.

Q. Do you understand that there is no criticism of your decision to apply the vacuum extractor and pull twice in order to assist positioning the baby for delivery?

A. Yes, sir. But you also -- I understand. But like I said, you have to take this entire picture into consideration for the latter part.

Q. Okay. And taking this entire picture, there is

no -- do you understand there is no criticism of what was being done by either the nurses or by you during this phase?

A. Yes, sir. But I was trying to explain it because it's not as simple as one piece of domino. There are multiple pieces that goes into the final picture.

Q. Okay. And so -- but looking at this, the baby does respond apparently to your stimulation, but that would be your interpretation of what's going on here?

A. Somewhat at this point, yes, sir.

Q. All right. And then the final strip that we have is this strip. I believe this is the final strip. And so the baby is -- and let me show you, Doctor, so you can see it because this is hard to read. But if you look at 2007 it says oxytocin. Is that -- oxytocin is also called Pitocin, P-I-T, as opposed to oxy, so...

A. Yes, sir, it's the same thing.

Q. It's the same thing. And oxytocin or Pitocin is used to induce contractions in an expectant mother?

A. It can be either used to induce it or augment the string of contraction.

Q. All right. But it's a drug that has an effect on the uterus?

A. Yes, sir.

Q. All right. And when it has an effect, if it's

being effective, one of the things that it's expected to do is make the contractions more intense?

A. It can do that and also increase the frequency of the contraction.

Q. All right.

A. So the idea of make you use contraction.

Q. So the nurses or somebody, if you were there at 2011 and this is 2007 -- I mean, if you were there at 8:11 and this is marked at 8:07, this is where the nurses decided using their nursing judgment that they're allowed to use, that the Pitocin should be cut off; is that right?

A. Well, what's going on is the heart tone is down, they're not sure what's causing it, so when that happens they go ahead and do standard protocol.

Q. All right. And that standard protocol was to stop the Pitocin?

A. That's one of the standard protocol.

Q. All right. So the answer to my question as to whether or not that the nurses stopped the Pitocin at 8:07 is yes?

A. This nurse stopped the Pitocin at that time, yes, sir.

Q. So the answer is yes?

A. Yes, sir.

Q. Thank you. They didn't think they needed to call you at that point, did they?
A. I can't tell you what she's thinking.
Q. Well, do you recall getting a -- do you remember getting a call from a nurse at any time and saying, Doctor, we think you need to come in here and evaluate this patient?
A. I don't remember.
Q. Well, you didn't document that, did you?
A. I said I don't remember if they called me.
Q. All right. Well, is the reason you don't remember is because you did not document it?
A. I don't document every time a nurse calls me, sir.
Q. Okay. I understand that.
A. Yes, sir.
Q. But if a nurse -- but you have no way of knowing in terms of your recollection because you did not write it down?
A. I know that when a patient -- whenever a patient is completely pushing I am there at the hospital.
Q. Okay, I understand that. You are in the locality so that you can come if a nurse calls you?
A. Yes, sir.
Q. But you're saying you don't remember?

A. Yes, sir.
Q. And don't you agree that the reason you cannot remember is because there's no documentation indicating that you were called at this time?
A. I don't think I was called.
Q. Okay. So the nurse discontinues the Pitocin. You come in at 2000 -- at 8:11 and that is documented that you arrived at 8:11?
A. Yes, sir.
Q. And do you recall that you were called at that time because the nurse had determined that the cervix was fully dilated and the baby was crowning?
A. No, sir.
Q. Why did you come at 8:11 then?
A. Well, you can see the strip, the heart tone is in the 90s. So I'm on labor and delivery and you see a monitor.
Q. So you were in the hospital where you could see the monitor?
A. Yes, sir, I was in labor and delivery.
Q. Okay. And so you saw a monitor with Ms. Flowers electronic monitoring system?
A. The monitor has pretty much every patient who's on labor and delivery.
Q. Okay.

A. And so if there's an abnormality, they use a little red bar that goes up near that strip.

Q. So you saw that and you responded to the monitor, not a nurse?

A. That's correct, sir.

Q. And that's when you went to Ms. Flowers' room and came in at 8:11?

A. Yes, sir. I can't tell you whether a nurse was about to call me or not. I don't know. Only thing I know is I arrived at 2011.

Q. And did you immediately go to make a vaginal exam?

A. When you get there you have to see what's going on, so you have to review the strip and what's going on beforehand. You have to look at the vitals, is there a blood pressure. You have to look what's going on, then you go and examine the patient.

Q. All right. Before you went and did that, did you go up to -- and I'm not saying you should have, I'm just trying to find out the sequence of events. Did you go up to Ms. Flowers and say anything like hello, I'm Dr. Giep, I'm taking over for Dr. Fowler, or did you immediately go to assessing the patient?

A. When the heart tone is in the 90s, in an emergency situation like that, I will go in, look at the

strip, get the nurse to give me a quick what's going on, then I will go and check the patient.

Q. All right. So there wasn't any friendly colloquy between you and the family, it's let's go straight to business here and deal with these issues that seem to be on the strip?

A. Yes, sir.

Q. Okay. So that's something that you're trained to do; is that right?

A. I don't understand the question.

Q. Well, I guess what I'm asking about is your experience, training and knowledge. Now that you are -- you have this, what you call, an emergency, you're ready for it because you've been trained to be ready for it; is that right?

A. You've been trained for it, yes, sir.

Q. All right. Starting in medical school, followed by residency, plus the fact that by 2008 this was not your first time that you're dealing with a mother who has a baby with a heart rate in the 90s.

A. I mean, whenever you're in an emergency situation, regardless, I mean, you treat it as an emergency. It never becomes routine.

Q. I understand that, Doctor. I'm just trying to establish whether this was your first go round with a

patient having the issue of a baby in the 90 heart rate range or whether this is something you had seen before.

A. Seen before, sir.

Q. Okay. And so you knew what decisions or options you had available to you at that time?

A. Yes, sir.

Q. And you explained that to us. That in your training you knew that you had two options. One was to do a cesarian section or the other one was to vacuum assist this delivery. But either way what you wanted to do is get the baby out?

A. What I said beforehand is that in OB it's very simple. You have two questions, does the baby need to come out, yes or no? Second question, how do you get the baby out, c-section or vaginal?

Q. All right. So the answer to my question is just, yes, that those were your two options?

A. Yes, sir.

Q. All right. And you do understand there has been no criticism of the decision you made to use the vacuum extractor as one of your options?

A. Yes, sir.

Q. You understand that?

A. Yes, sir.

Q. And so -- and you've done this before. As you've

indicated, you've never had a baby before where you exercised -- where you in a shoulder dystocia that has had permanent brachial plexus injury. So I assume that at any time that you've used the vacuum extractor you've not had before this a baby that ended up with permanent brachial plexus injury; is that right?

A. Yes, that's correct.

Q. And there are injuries that can occur with a vacuum extractor if the doctor doesn't use it properly. Do you understand that?

A. Yes, sir.

Q. But with your training and experience and the knowledge that you brought there allowed you to use the vacuum extractor and there's no reason, nobody has suggested that that caused injury to this particular baby. Do you understand that?

A. Yes, sir.

Q. The -- after the vacuum extractor -- and if this is the last strip, this is the one that actually takes us up to the baby's delivery at 8:20; is that right?

A. Yes, sir.

Q. So this is -- here's the time right here. Can't read it on this screen, but it says 20/20. So right in here is where the baby's actually delivered. And we have tracings immediately before that. And are these

artifacts or are these actual signals from the baby's heart indicating where the baby's at? (Indicating.)

A. That's part of the signals.

Q. That is probably signals or not?

A. Probably, sir.

Q. And if they are signals, then it indicates that the baby's heart rate just before birth, if this is the birth and we count back 10, 20, 30, 40, 50, and this would be one minute before the baby's born, this would mean that the baby's heart rate is 120 at that time?

A. Sir, I can't -- I mean, you're taking this one spot right here so, yes, it's 120. But you have to take a look at the overall picture. So if you ask me is this 120 at that exact spot I'd say yes. If you ask me what's going on here, that's a different story.

Q. Well, I'm just trying to understand, you know, at the various segments what the information or data that we have available was, in fact, going on. And I understand that you're saying that you felt like you needed to move the delivery along because there were segments where the baby's heart rate was down in the 90s. But one minute before the baby was born it was back up to where it had been before that problem had occurred.

A. I disagree with that statement because if I can

explain, is that as I explained before, you cannot take this one picture in time and extrapolate, you can't. You're doing this in live time. So first of all, you don't know what's gonna happen after this. You don't know if the heart rate is gonna go down. You don't know what's going on. The only thing you can base it on is what happened in the past. In the past, the last 10 minutes she didn't have a decent ratio. Her heart tone has been down. So you can't really make a fair statement and say, well, if you look at here it's at 120 she's gonna be fine. You can't do that.

BY MR. HENSHAW:

Q. All right. Doctor, after the baby was born assessments were done as to the baby's status and that's done by way of an apgar scoring system; is that correct?

A. Yes, sir.

Q. And so you handed the baby off to the neonatal team; is that right?

A. For this delivery, yes, sir.

Q. You did that immediately?
A. Yes, sir.
Q. And the neonatal team began to work on the baby right there in the labor and delivery room; is that right?
A. They would take care of the baby right then, yeah.
Q. And then shortly after that they left to take the baby down to the NIC unit?
A. I would assume so, yes, sir.
Q. All right. But while they were still there in the labor and delivery room, they made an assessment using the apgar scoring system; is that right?
A. I would assume so.
Q. You don't participate in that?
A. I was busy taking care of the mom, sir, so I am not over it.
Q. Is the answer to the question you don't participate in that no, I don't?
A. I don't participate in it.
Q. All right. But you could -- you immediately realized that there was something wrong with the baby's arm, didn't you?
A. Well, you know, when I deliver the baby, the baby was basically no tone. So I can't sit here and say I

know 100 percent. I said, well, it looks like it but, you know, the baby had no tone, no movement, the arm was by its side like that, so I can't sit here and say yes, no. I said it looks like it, but I can't say definitively yes.

Q. Are you saying that the baby was flaccid?

A. Well, the baby came out, you know, with the hands like this and not responding. (Indicating.) And so I handed off the baby quick to NICU.

Q. When you say the baby had no tone are you saying that the baby was flaccid?

A. I don't understand your definition of flaccid. The only thing I can tell you is that the baby was like this, no muscle tone. The arms are out, the legs are out. (Indicating.)

Q. Doctor, this is the summary of the delivery room records.

THE COURT: Be careful of the microphone, please.

THE WITNESS: Yes, sir, sorry.

BY MR. HENSHAW:

Q. And this is the apgar scoring system that was used by the neonatal team to score what this baby looked at. And what they do is they look at each of these things first at one minute and then again at minutes. Do you understand that?

A. Yes, sir.

Q. And if we look at the apgar scoring system related to Ashley Flowers, this is the -- the first box is the heart rate. And the options that they can score on observing the baby are absent, slow, in the range of 100 or less, and then greater than 100. And if the baby is greater than 100, the baby gets a two. If it's slow the baby gets a one. And if there's no heart rate, then it's a zero. And they scored this baby a two. Do you understand that?

A. This is just a rough estimate of listing the heart rate.

Q. Well, is there any reason to believe that it's any less accurate than a fetal heart tone monitor strip that's externally monitored by way of the mother wearing a belt and trying to pick up heart tones while the baby's still in utero?

A. This is done manually, so they listen and they just estimate. So it's not hook up to a machine.

Q. Well, it's kind of like -- isn't it exactly like when you go to the hospital emergency room and they say we want to listen to your heart with a stethoscope or they take your pulse and they count it. They have, they have methods of trying to determine what the pulse rate is.

A. But they have machines to record that.
Q. Well, they also do it manually, don't they?
A. Well, you have to have a watch to count it.
Q. Well, is there any reason that they didn't do all that here?
A. I don't know.
Q. Well, for purposes of this baby's hospital record, that hospital's neonatal team that you called in to work on this baby said at one minute this baby had a heart rate greater than 100; isn't that correct?
A. Yes, sir.
Q. And it stayed there until the five minute came. And they did it again and it was still greater than 100; isn't that right?
A. Yes, sir.
Q. So then the next part of the chart, again it's difficult to read, is respiratory effort. And the options were absent, slow or irregular, and good or crying and the team gave the baby a one, which means that they were slow or irregular in terms of the breathing pattern. And at five minutes it was at two. Do you understand that?
A. Yes, sir.
Q. And then we have next, muscle tone. And they would give -- they had the option of giving the baby a

zero if the baby was flaccid. So you don't understand what the term flaccid means even though that's one of the ways that babies could score as soon as they're born?

A. Well, sir, this is assigned by the NICU team. So for me, as I hold a baby, I just didn't feel that the baby, you know, it was kind of limp. So to me limp is limp.

Q. My question is, Doctor, you said a few minutes ago that you did not understand how to define the word flaccid. That was not a word that you understood. And so I'm asking you now, do you not understand the word flaccid in the context in which apgar scores are made?

A. Sir, this is based on the judgment, the observation of the NICU nurse. So you may have one nurse who say the baby is score one. You may have a nurse score the baby zero. I can't sit here and tell you her thought process. The only thing I can tell you is the baby was limp.

Q. I understand that process, Doctor. I'm asking you about your knowledge. Do you understand the word flaccid?

A. I mean, if you're talking about flaccid as in limp, okay, I'll grant that to you.

Q. All right, sir. But they didn't score the baby

as being flaccid. Or if it means limp, they didn't score the baby as limp. They gave it baby a one. And one means some flexion of extremities. Do you understand that?

A. I understand some flexion of extremity, yes, sir.

Q. Okay. And, of course, with a brachial plexus injury that's not going to be, not going to move, is it?

A. But you have ---

Q. Not a severe one.

A. You have other extremities, sir.

Q. Okay. And those are the ones that could give you some flexion; isn't that right?

A. Well, you know, I was not there to sit here and define what that nurse meant by some flexion. So, you know, if you take a baby and you put out, you have two or three observers and it be close between flaccid and some flexion, some would say flaccid, some would say flexion. So the only thing I can go with what the record said.

Q. Now, the next category that was scored was reflex irritability. Do you know what that means, reflex irritability?

A. They just checked the baby respond crying.

Q. And they could have scored no response or they could have scored a grimace or they could have scored a

cry. And in this case they scored the baby as having a grimace at one minute, but then a cry at two minutes; is that right?

A. That's what they said.

Q. Okay. And then we get down to color. And the possible scores are blue or pale or the body is pink and the extremities are blue or the baby is entirely pink. And on this scoring system they gave a zero at one minute and a zero at five minutes. In other words, they're saying the baby stayed blue; is that right? Is that the way that should be interpreted?

A. That's what they're saying, yes, sir.

Q. And then they took the baby away.

A. Yes, sir.

Q. To go to the NICU?

A. Yes, sir.

Q. And so did Nurse Phillips fill this out? Is that Natalie Phillips who is the R.N. who signed off on all of this?

A. That's what it said, sir.

Q. So she took this down. And she was told these things by the neonatal team and then she put them down?

A. I would assume so.

Q. Did you ever go to the NICU to see the baby yourself?

A. Yes, sir.
Q. Did you talk to the doctors there?
A. Yes, sir.
Q. And is that where you learned about the clinic in Charlotte that can treat brachial plexus injuries?
A. I believe either they told me or they said the physical therapist or occupational therapist told me.

Q. Dr. Giep, if you recall that when we broke we had discussed that you did go see the baby in the NICU and you spoke to people there and that's where you probably learned about the doctors in Charlotte who could help with brachial plexus. Is that ---

A. Yes, sir.

Q. Okay. Doctor, did you -- do you regularly talk with members of the NICU team?

A. If there's something going on with the baby, I always check on the baby and ask them what's going on.

Q. And is the NICU team the same as the neonatal

team that came in and did the resuscitation?

A. There's a lot of nurses and people in there, so I can't tell you the exact team. But I talked to the people in the NICU.

Q. All right. And did -- was the doctors that you talked to, did they essentially take over the care of the baby from that point on?

A. Yes, sir.

Q. And the baby stayed -- if the baby stayed in the hospital for the next two-and-a-half weeks, they were the ones that were responsible for managing the baby's care during that time; is that right?

A. Yes, sir.

Q. Okay. But did you know that in addition to the labor and delivery team's record, which includes the apgar scoring that was signed by Natalie Phillips, in terms of the apgar scoring, the neonatal team also had its own form.

A. I would assume, sir. I didn't know that for sure.

Q. And now Ms. Phillips she was part of the labor and delivery team; is that right?

A. Yes, sir.

Q. Okay. And she would not have done the apgar scoring herself, would she?

A. No, sir, not in this case.
Q. Okay. In this case it would have had to be members of the neonatal resuscitation team?
A. Yes, sir.
Q. Okay. Doctor, let me show you what we put into evidence as Plaintiff's Exhibit 9. Have you seen this form before?
A. Not really, sir.
Q. All right. Well, do you realize that on this form there is also scoring of the heart rate, of the respiratory effort, the color, the muscle tone and reflex for a combination of the apgar score? Do you see that?
A. Yes, I see that.
Q. And if the first one was done, again, recalling that the birth was at 8:20 p.m. and so the first scoring was done one minute after birth, which is the standard way that apgars are scored; is that right?
A. Yes, sir.
Q. And so the heart rate was checked. And if we go down to the key, if there's a check that means normal, doesn't it?
A. That's what it says, sir.
Q. And in this case it was checked both at one minute after birth and at 8:26, which is five minutes

after birth, it was checked, right?

A. That's what they checked, sir.

Q. So the respiratory effort is marked down as a minus one. And that is both at the one minute and five-minute scoring periods; is that correct?

A. That's what it looks like, sir.

Q. And the color is marked down as minus two at both the one-minute and five-minute scoring periods; is that right?

A. Yes, sir.

Q. And muscle tone is minus two here, but it is checked as being normal at five minutes; is that right?

A. That's what it said on this paper, sir.

Q. All right. And reflexes are checked as being normal. And the total apgar score by the team that resuscitated the baby is five and seven; is that right?

A. That's what it said here, sir.

Q. All right. So do you realize that there is a difference in terms of the scoring and between what Ms. Phillips put down, who did not actually do the scoring but simply put down what she was told, and the team that actually did the scoring?

A. I can't explain it. That's between Nurse Phillips and the NICU.

Q. Okay. Now, a -- do you agree that a continuing

problem with the respiratory effort as indicated here, as not being normal at one or at five minutes, can contribute to the baby being blue in color both at one and five minutes?

A. Sir, I'm not a neonatologist, I'm not a pediatrician, so I mean I can't make that exact statement.

Q. You can't make that statement?

A. I mean, I can tell you respiratory efforts minus one and they got color as minus two, but I can't sit here and tell you as an expert.

Q. All right. Were you aware that the resuscitating team that the neonatal team that came in, within about 20 minutes after the baby was born sent the baby down for x-rays of the left arm and the chest?

A. If that's what it said, then that's what they did.

Q. Well, it's got 2140, so that's -- well, I've got that wrong. That's about an hour and 20 minutes later, I'm sorry. About an hour and 20 minutes after birth sends the baby down; is that right?

A. I assume, yes, sir.

Q. And the word stat means they wanted it done immediately after the order was entered; is that right?

A. That's my assumption.

Q. Do you know Dr. Brian Wood?
A. He's one of our neonatologists.
Q. And did you speak with him that evening after the baby was born?
A. I'm not sure. Whoever -- if he was there I would have spoke with him.
Q. So you don't recall whether you spoke with him or not before you went to see the parents?
A. I don't.
Q. Were you aware of this injury that he made into the baby's record that this infant had an elevated left hemi-diaphragm on initial x-ray suggestive of paralysis or eventration? What is the hemi-diaphragm, do you know?
A. I would assume they're talking about the diaphragm being elevated.
Q. All right. Well, what is the hemi-diaphragm?
A. Just a diaphragm separation the abdomen from the chest.
Q. Is it related to breathing?
A. That's the separation between the abdomen and the chest.
Q. All right. Is the diaphragm related to breathing?
A. Yes, sir.

Q. And if the hemi-diaphragm is paralyzed in some way, to some degree, does that mean that the baby is having a problem breathing?

A. Again, I'm not an expert but if you ask me, maybe.

Q. All right. He then goes on to write history of shoulder dystocia with brachial plexus injury, thorascopic evaluation to show paradoxical movement of the hemi-diaphragm? Do you know what he means by paradoxical?

A. I don't, sir.

Q. I consulted with Dr. Abrams from pediatric surgery. Do you know Dr. Abrams?

A. No I do not, sir.

Q. Who concurs that this is not a diaphragmatic hernia nor eventration. Do you know what the word eventration means?

A. No, sir.

Q. But his findings are consistent with paralysis of the left hemi-diaphragm. He suggests no surgical intervention is required at this time. However, she should require increase respiratory support. He would consider mication or pacing but this reference would be to avoid surgical intervention. His preference would be to avoid surgical intervention and allow the diaphragm

to have ample opportunity to return to functioning status.

And then he goes on to say: (Reading.) I spoke with the infant's parents, they are in agreement with the treatment plan at this time. (Ends reading.) Any of that discussed with you when you met with anybody at the NICU?

A. No, sir.

Q. This note is in exhibit. All of these are now exhibits in evidence. And this note -- well, what did I do with it? I walked off with it. It's in evidence as Plaintiff's Exhibit 11. And it was entered on November 1st, 2008, and it's a daily note. Do you know what a daily note is in the NICU?

A. I assume that's what they write everyday.

Q. Okay. And so it says: (Reading.) Baby Girl Flowers is a 3508 grand product of a 36-week gestation. Delivery was complicated by shoulder dystocia. It was a difficult delivery. The infant has a brachial plexus injury, as well as left hemi-diaphragm paresis. (Ends reading.) What does paresis mean?

A. It's not moving.

Q. (Reading.) Following admission, the infant was in respiratory distress, had cardiomegaly with extra cardio and chest x-ray. An echocardiogram was performed

which showed normal cardiac anatomy but the heart was displaced to the right. Chest x-ray also revealed an elevated left hemi-diaphragm. Lung fills were relatively clear as sepsis evaluation was performed and the infant was started on ampicillin and Gentamicin. Thoracoscopy was performed which showed paradoxical movement of the diaphragm consistent with paralysis of the hemi-diaphragm.

I spoke with Dr. Abrams who reviewed the films with me. He feels quite sure that this infant is not suffering from diaphragmatic hernia, but it is in fact a diaphragm paresis. He suggested no surgical intervention. (Ends reading.)

No, Doctor, let me ask you this. Do you understand as an obstetrician, as a doctor who's been -- as a doctor who's been trained as a medical doctor, that the diaphragm does not come into play in terms of breathing until the baby is born?

A. Yes, sir.

Q. I mean, we already discussed this. While the baby is in the womb, in utero, the baby is getting oxygen from the mother, through placenta, through the umbilical cord to the heart?

A. Yes, sir.

Q. And you explained that?

A. Yes, sir.
Q. So this is a situation that in regard to the hemi-diaphragm and the lack of performance by the diaphragm that only could occur after the baby was born, is that not right?
A. I can't say for sure yes or no.
Q. All right. Doctor, do you understand that the diaphragm is controlled or innervated by the phrenic nerve?
A. I assume so.
Q. And the phrenic nerve is innervated by C-4, nerve roots C-4 and C-5 coming off the spinal cord?
A. If you tell me then -- that I'm not sure.
Q. You don't disagree with that, do you?
A. I don't have my manual with me, so I would assume.
Q. Would you agree with this statement, Doctor? Extreme lateral traction on the shoulder during delivery can injure or transect the phrenic nerve and/or the brachial plexus by stretching their cervical roots. The traction occurs during delivery of the shoulder and cephalic presentations and delivery of the head and breach presentations. Cephalic presentations means head first presentations; is that right?
A. Yes, sir.

Q. Do you agree with that statement, Doctor?
A. I mean, if the statement said that, then I mean I'm not an expert so I can't sit here and tell you yes, no. I don't have no literature research to deny or agree to it.
Q. Would you agree with this statement? Involvement of the third to fifth and specially the fourth cervical roots results in diaphragmatic paralysis. Brachial plexus palsy is associated in 80 to 90 percent of cases while diaphragmatic paralysis occurs in approximately five percent of brachial plexus injuries. Would you agree with that?
A. Like I said, I'm not an expert in the area so I can't sit here and tell you yes or no.
Q. Would you agree with this statement? Factors associated with diaphragmatic paralysis are similar to those of a brachial plexus injury?
A. Again, I'm not an expert in that area so I can't sit here and tell you yes or no.
Q. Doctor, would you agree that based upon what the neonatal team determined about Ashley Flower's diaphragm that that most probably is the reason that she had the color blue?
A. I can't agree or disagree because I mean I don't know. The only thing I can tell you that to me as an

obstetrician, one, when the baby comes out it's blue, then it's probably due to what's going on before the actual body comes out.

Q. And would you agree that if the combination with rupture of C-5, C-6, C-7 nerve roots in her left shoulder and scaring of C-8, along with an injury that affected the phrenic nerve to such an extent that it caused hemi-diaphragm paresis that that most probably was the result of extreme stretching?

A. Again, sir, I'm not an expert. The only thing I can tell you in this case is that gentle traction was applied. So you'll have to ask the experts to that.

MR. HENSHAW: Just one moment, Your Honor. That's all the questions I have. Thank you, Your Honor.

MR. LOVELL: Just very briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. LOVELL:

Q. Doctor, you were asked a little while ago about a note that you wrote that afternoon within half an hour of the delivery. I'm just gonna hold it up. When you see a baby who has fetal heart tones in the 90s and the head is crowning, is it your normal procedure to stimulate the head of the baby to see what happens?

A. Well, when I see a plus three station, I'm examining the patient. And when I'm examining the

patient, my hand is inside the vagina. So, yes, I would try to stimulate the head, see if it helps any.

Q. And when we looked at that fetal monitor strip, when he was asking you questions on cross-exam, around the time when you would have been doing that, did you see a little bit of a response in the fetal heart rate?

A. Some response, yes, sir.

Q. Now, did you write that you did that in your note?

A. No, sir, I did not.

Q. Okay. But that's part of your normal routine?

A. Yes, sir.

Q. And after the head was delivered, is it your normal routine to check for that nuchal cord, especially in a baby who's got decreased fetal heart tones?

A. Yes, sir, it is.

Q. And did you do that in this case?

A. I did, sir.

Q. Did you write that step that only you did in your note as well?

A. No, sir, I did not.

Q. Is it your normal routine to bulb the baby, as we saw in the video, in the nose and the mouth?

A. Always, sir.

Q. And why do you do that?

A. That's standard practice, protocol.
Q. Did you do it in this case?
A. Yes, sir.
Q. Did you write that in the note?
A. No, sir, I didn't.
Q. Is that something only you did and you didn't have to ask somebody else to do?
A. That's correct, sir.
Q. The apgar scores that you were asked about, whether it was one minute -- I'm sorry, whether -- those are taken at one minute after delivery and then five minutes after delivery, right?
A. Yes, sir.
Q. And in that period from when you see the baby at zero minutes after delivery and you hand it over to whoever else you hand it to, can some things change in the baby in that minute?
A. Yes, sir.
Q. We heard testimony from both, I think, Mr. and Mrs. Flowers that initially they heard, you know, no baby cry and then some short time later they heard the baby cry. Is that one of the changes that happens in that minute or so?
A. Yes, sir.
Q. And whether that apgar muscle tone was a one or

minus two, are both of those not normal?

A. Yes, sir, not normal.

Q. Back to the last thing. I'm gonna talk about this lateral traction. When you are delivering the head, and you saw those diagrams, when the baby's head, when you're trying to deliver this -- up the shoulder that's on the top end towards the ceiling, do you have to give the baby a little bit of downward movement to facilitate that shoulder working?

A. Yes, sir, just very slightly.

Q. So in any delivery is there some degree of downward lateral traction?

A. Yes, sir. A little bit down, that's it.

MR. LOVELL: Okay. Thank you, that's all I have.

THE COURT: You may step down.

(Whereupon, witness leaves witness stand.)

MR. LOVELL: Cindy White, Your Honor, would be our next witness.

THE COURT: Okay.

(Whereupon, witness comes forward.)

THE CLERK: Do you solemnly swear or affirm the testimony you're about to give is the truth, the whole truth so help you God?

THE WITNESS: I do.

THE CLERK: Thank you, ma'am.

CINDY WHITE,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

Q. Scoot up a little bit closer to that microphone, Ms. White, so we can hear you. Thank you, ma'am.

What's your full name?

A. Cindy White.

Q. Where do you live?

A. Roebuck.

Q. What do you do for a living?

A. Right now I'm babysitting grand kids.

Q. Okay. In 2008 when Ashley Flowers was a patient -- was born and the mom was a patient, what were you doing at that time?

A. I was working as a surgical tech at Spartanburg Regional.

Q. Okay. And you've been in here listening to some of the testimony, so I'm gonna kind of fast forward through things. Were you involved in her delivery?

A. Yes.

Q. All right. How many years had you been a surgical tech doing labor and delivery at that time in 2008?

A. Since 1990. Well, I went to school in '94. I

finished school in '94. I actually started in '94, but I started as a student, so I was actually full time in '95.

Q. All right. And in that period of '95 up until around 2008 when Mrs. Flowers was in with her delivery, about how many deliveries had you observed as a surgical tech?

A. Hundreds.

Q. And were you working at Spartanburg Regional the whole time?

A. I went to work in '95 as full time in '95, and I worked a while. And then I stopped because my children had a lot going on. And then I went back to work in 2001.

Q. And so from '01 to '08 full time doing that?

A. Full time, third shift.

Q. And did you have occasion in that role to be in the delivery room when doctors other than Dr. Giep were delivering babies?

A. Yes.

Q. Delivering babies vaginally, the natural childbirth?

A. Yes.

Q. And did you have an occasion in that window of time when you first started at Spartanburg Regional up

until the time of 2008 to be in the delivery room when Dr. Giep was delivering babies?

A. Yes.

Q. Now, in the deliveries you saw with other physicians, did you also see occasions where the deliveries were complicated either by decrease of fetal heart tones or shoulder dystocia?

A. Yes.

Q. All right. Had you observed how other doctors dealt with those conditions?

A. Yes.

Q. In your role as a surgical tech, what exactly are you doing in the room during a delivery?

A. I'm assisting the doctor.

Q. So if he's down on the business end, are you relatively close to him?

A. I'm right beside him.

Q. Able to see everything that's going on?

A. I do.

Q. Do you have any role in terms of making all the entries in the chart that we've been looking at for the last ---

A. No.

Q. All right. And who's doing that?

A. The nurse does the charting.

Q. And in this case with this delivery was that Mrs. Phillips?
A. Yes.
Q. Now, do you know Dr. Giep outside of work or did you after you were in the hospital?
A. No, I just know him at work.
Q. As a surgical tech have you been trained on how to help in assisting the team there in the labor and delivery on responding to shoulder dystocia?
A. Yes.
Q. And have you done that --
A. Yes.
Q. -- over the course of all these years prior to 2008?
A. Yes.
Q. Do you do training at Spartanburg Regional --
A. Yes.
Q. -- or did you back then?
A. We did.
Q. How often did you all do that?
A. Once a year.
Q. Were you trained on how to put people in this McRoberts maneuver we've heard about?
A. We do.
Q. How about the suprapubic pressure part?

A. Yes.
Q. Now in 2008, at what point with Ms. Flowers' delivery, at what point would you have been in the labor and delivery room with them?
A. You mean when I came into the room?
Q. Yeah. When would you have been involved? Were you there the whole day or part of the day or how did that work?
A. Well, I came into the room beforehand to set up the room for her delivery, and then I went back out and waited until they called me.
Q. And about what time do they normally call you or did they call you to come in with her?
A. They call me when they call the doctor.
Q. And so throughout the -- I'm trying to remember the time. So it was about 20 minutes before the actual delivery, plus or minus, whatever the ---
A. Whatever time he goes in is usually I go in with him.
Q. In terms of the delivery room and the bed, was it set up as Dr. Giep told us a little while where the mom's -- the business end of the bed is fairly close to the floor?
A. Yes.
Q. And did he, from your observation, did he use the

stool, as he described using, to sit on while he's doing the things he does?

A. He always did. He always sat on the stool.

Q. And was the only time he stood up is when he's got the baby out and handed it off, from your observations over the years?

A. Yes.

Q. And are you involved in that NICU part at all?

A. No, I'm still helping him.

Q. Now, in this case when Dr. Giep recognized that there was a shoulder dystocia condition on Mrs. Flowers, what did he ask you?

A. Get her legs back.

Q. Was that the McRoberts type position?

A. Yes.

Q. Were her legs already somewhat back for the just regular labor?

A. They were in the stirrups, so we take them out of the stirrups and push them back as far as we can.

Q. And then when you all are -- were you one of the people that was applying that pushing back?

A. Yes.

Q. Do you remember who the other folks were that were doing that?

A. I'm not -- sometimes the dad will actually hold

the other leg back. Sometimes the nurse will. It's just according. I don't remember who was holding her leg at that time.

Q. And do you have recollection of Nurse Natalie Phillips doing the suprapubic pressure or did you do it?

A. She did.

Q. Okay. Did Dr. Giep, from your recollection, ever panic when this shoulder dystocia occurred?

A. No.

Q. Did you ever observe or have a recollection of seeing him panic at all during deliveries?

A. No.

Q. Did you have any recollection of seeing Dr. Giep pulling any harder than you had seen the other doctors pull in a delivery as it relates to Mrs. Flowers?

A. No.

Q. How about, was his arm straining? Was he grunting, groaning, making any noise to suggest he was struggling?

A. It was ordinary.

Q. Did the stool slide forward into the mother as he was doing whatever it is he did on the business end there during the delivery?

A. No.

Q. Did you ever see him have to brace and pull

himself back to try and deliver this baby?

A. No.

Q. If you had seen any of those -- well, and did you see him making any movements way down towards the floor when he was doing the delivery of this child?

A. Now, once I got the legs back I was sort of out of the view of seeing what he was actually doing there anyway, but I didn't see nothing that was not normal.

Q. Could you observe him, though, from how he looked and how he sounded and ---

A. Yes.

Q. Did you observe anything about what you observed and out of the ordinary of what you had seen either with him or with all of the other doctors you observed?

A. No.

Q. If you had seen something unusual in that regard, would you have made a note of it in that chart or ask Nurse Phillips to make a note of it?

A. No, I probably wouldn't. I didn't make any kind of notes of any kind in the chart. But I'm sure it would have been discussed between me and probably my charge nurse or my supervisor or somebody.

Q. Natalie Phillips as well?

A. Oh, yes.

Q. And would Natalie, from your dealings with her,

would that be something she would chart in it -- chart if there was something unusual that she observed or that you reported to?

A. If -- me and Natalie probably would have went to my supervisor together.

Q. After the baby was born did you stay with the mother while Dr. Giep was delivering the placenta and sewing up --

A. Yes.

Q. -- the episiotomy? So did you go with the infant at any point to the NIC unit?

A. No.

MR. LOVELL: Thank you, Ms. White. That's all the questions I have. Please answer any from the Plaintiff.

CROSS-EXAMINATION

BY MR. HENSHAW:

Q. The only reason you have any recollection of this case at all is because after the lawsuit was brought you went back and reviewed the record and then you talked with Natalie Phillips; isn't that right?

A. No, it's not.

Q. Well, isn't that what you testified in your deposition?

A. No, I did not. I never reviewed the record.

Q. Oh, you never reviewed the record?
A. No, I didn't.
Q. But you did talk to Natalie Phillips?
A. I asked Natalie when I found out this was going to be a lawsuit, I asked her to refresh my memory on who the family was. I didn't recognize the name.
Q. In your deposition didn't you say that you asked Natalie to refresh your recollection about what happened that day because that's when you came up with the statement that she was a pretty -- that Ms. Flowers was almost too pretty to be having a baby; isn't that right?
A. No, none of that's right. I asked Natalie to refresh my memory on which family it was and that's when she told me who they were. And I automatically remembered it because I remembered the patient.
Q. And when you say you don't have any -- had not had any involvement with Dr. Giep, you used to go to his office, or at least on one occasion you went to his office; isn't that right?
A. I did stop by his office to speak to his receptionist one time. I did not see him.
Q. And the receptionist was your daughter?
A. That's right.
MR. HENSHAW: That's all the questions I have, thank you.

REDIRECT EXAMINATION

BY MR. LOVELL:

Q. The fact that your daughter worked for Dr. Giep, did that make you come in here and change any truth of what you're saying here?

A. Absolutely not.

Q. Thank you, ma'am.

THE COURT: You may step down.

DR. ROGER HUNTINGTON GOWER,

Having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

Q. Scoot a little bit this way, Doc, so we can hear you.

A. Okay.

Q. Tell us your full name, please.

A. Roger Huntington Gower.

Q. And, Doctor, where do you live?

A. In Greenville.

Q. Okay. And I'm calling you doctor. I assume you're a doctor practicing in medicine.

A. Right. Correct.

Q. Tell us what kind of medicine you practice over in Greenville.

A. I'm a general OB-GYN doctor.

Q. When you say general OB-GYN, what does that mean?

A. It just means four years of residency after medical school.

Q. And do you deliver babies on a regular basis?

A. I do.

Q. How many years have you been delivering babies?

A. Since 1982, so 35.

Q. Now, tell us about your education. Give me college, medical school that led you to become an OB-GYN doctor.

A. Right. So went to college at Emory in Atlanta. Then medical school in Charleston. Did a year of internal medicine in Jacksonville and then back to Charleston for OB-GYN.

Q. When did you complete that medical training, Doctor?

A. So in '82 I finished the residency, moved to Greenville, took my boards, all that stuff. Been in the same practice ever since.

Q. And what's the name of your practice?

A. It's Greenville OB-GYN.

Q. How many doctors practice in that practice with you?

A. We have nine, nine physicians.

Q. And what hospitals do you do your services and delivery services?

A. Greenville Memorial and recently Patewood Hospital.

Q. Do you have any positions at the hospital or have you had any in your years of practice?

A. I've been involved in a lot of medical staff stuff. The president of the medical staff, credentials

committee. Practice manager for our group. And now I'm serving as vice chairman of our department for medical affairs quality and safety.

Q. When you say our department, what department are you talking about?

A. That's the OB-GYN department in Greenville.

Q. Have you been involved in teaching the medical students in the field of obstetrics ever in your career?

A. Yes. Yeah, we have medical students in Greenville.

Q. Do you hold any title associated with that?

A. Well, it's probably assistant or associate professor for Greenville, USC School of Medicine Greenville.

Q. How about professional organizations in the medical field, which ones do you belong to?

A. County Medical Society, State Medical Society, AMA, American College of OB-GYN, South Atlantic Association of OB-GYN.

Q. American College, is that what we've been calling ACOG?

A. That's ACOG. That's our --

Q. And are you board certified?

A. -- national. Board certified, yes.

Q. In what?

A. In OB-GYN.
Q. And how many years have you been board certified?
A. You take the exam two years into practice, so I was certified in '84, so that would be 33 years this December.
Q. So in your years of delivering children how many approximately have you delivered?
A. You asked me that in the deposition. I said it's about 150 a year since then, so that's like 4 or 5,000 maybe.
Q. And have you had experience with babies who develop fetal heart tones similar to what you saw in this case with this child?
A. Yes.
Q. How about shoulder dystocia?
A. Yeah. Shoulder dystocia that will come up, you know, a couple times a year.
Q. And is that something that in your personal deliveries you had children that ended up having a brachial plexus palsy from the shoulder dystocia?
A. I have. I have.
Q. Any of them been permanent?
A. Not to my knowledge, not a permanent one.
Q. But you've had some with temporary issues --
A. Temporary as well.

Q. -- of brachial plexus?

A. Yeah, temporary. And also, you know, just to expand. So I do also serve as the attending for the resident. We have a residency program. And so the residents are in house, so they have an attending. So they do the deliveries, but I'm there for the deliveries so I've been in a situation where they got stuck and you have to, much as you were talking about in the teaching this morning, the -- where you have to sort of step in and, you know, each level resident sort of has their go at it and sometimes you have to be the one to actually come in and to the maneuver that works.

Q. When you say they get stuck, you mean the residents --

A. The residents.

Q. -- get to a point where they're no longer able to do anything to facilitate the ---

A. Either that or I run out of patience.

Q. Okay. Speaking of the training, we heard from Dr. Giep earlier that when he was coming up, one way they trained him on how much force to use as he had his hands on a baby in a live birth and a teacher would be there with him, sometimes with their hands on them. Is that how you all do it as well sometimes?

A. Right. Yeah, that's what we did in residency. I

don't usually -- that would be a first year resident, so I don't usually teach them anymore, so I haven't done that in a while. But that's sort of the way we did it.

Q. Now, you're here today serving as an expert, right?

A. Yes, sir.

Q. Have you done this before as a potential expert?

A. I have.

Q. How many times?

A. I've reviewed quite a few cases, maybe 10 or 12 cases. I've testified in court maybe four or five times.

Q. And when you do this are you compensated for your time away from your medical practice?

A. I am.

Q. And at what rate?

A. For the depositions I think it's $200, maybe 300 for the chart review, 300 for the depositions. And then I really don't have one for testifying.

MR. LOVELL: And, Your Honor, at this time we tender Dr. Gower as an expert in the field of obstetrics and gynecologists -- gynecology and the encounter of shoulder dystocia and delivered babies with shoulder dystocia and fetal distress and others.

MR. HENSHAW: No objection to his being deemed

qualified as an expert as an obstetrician. I'm not sure that -- I don't agree that a sufficient foundation has been laid as to the treatment of babies who encounter shoulder dystocia following the birth. No foundation has been laid for that.

MR. LOVELL: I'm not tendering him for after birth. I'm talking about through labor and delivery.

THE COURT: Condition during birth and delivery?

MR. LOVELL: Yes, Your Honor.

MR. HENSHAW: No objection.

THE COURT: All right. He is so qualified.

BY MR. LOVELL:

Q. Just so we're clear, Doctor, when the baby is delivered even with shoulder dystocia or not and there's been some problem with the baby and it needs to be handled by the NICU, you're not involved in the NICU side of things, are you?

A. Correct, I'm not.

Q. You just do the deliveries and the labor and hand the baby off?

A. We're very fortunate to have them close by.

Q. In your action or work on this case, have you reviewed all of the medical records from Spartanburg Regional relating to this child's birth?

A. I have.

Q. And prenatal records, did you review those?
A. I have.
Q. Did you also review the records that related to the baby's time in the hospital after the birth? Not necessarily -- did you review the documents?
A. I did briefly go through those, but didn't in not much detail.
Q. Did you hear -- excuse me. Did you read the depositions of both the Plaintiff, Mr. and Mrs. Flowers, the grandmother, I think Mrs. Bowen, Dr. Giep, Mrs. Phillips, Nurse Phillips, Mrs. White, who just testified, along with the various other experts involved in this? Did you review all of those?
A. I did review them in the past.
Q. And all that information you reviewed, did it give you a good understanding of what occurred during the course of this delivery unit and what the witnesses to the delivery observed about what was going on at the time?
A. Yes.
Q. Do you feel that you have enough information upon which to base an opinion on whether or not Dr. Giep exercised the standard of care required of him as an obstetrician and his management of this labor and delivery on the delivery of this child when the shoulder

dystocia occurred?

A. Yes, I did.

Q. What's your opinion in that regard?

A. I didn't see anything in the care of this patient that was below the standard of care.

Q. Now, when you use the term standard of care, how are you defining that?

A. That would be the care that any well trained, competent OB-GYN would exercise in their medical care of a patient.

Q. Okay. Now I want to back up. Before the delivery, did you observe those fetal monitor strips that we've been all looking at now for a day, day-and-a-half?

A. Yes.

Q. Now, you've been in the courtroom during Dr. Giep's testimony, so did you see the ones that were displayed here in the court?

A. I did.

Q. From your review of the fetal monitor strips, as we get within the, say, ten minutes prior to the head being delivered in this child in roughly 2000 -- 8:04, 2004, up until about 2011, 12, 13, in your opinion was there a problem with the baby's heart rate that would make most OB-GYNs a bit concerned about the baby's

health and wellbeing?

A. So, yeah, the end of the fetal monitor strip, when the heart rate decelerated and was in the 90 range for like five to seven-minute range, so that was, that was certainly a concern.

Q. Now, Plaintiff's counsel asked some questions, and you may have seen where the heart rate went up a little for a time and then sort of comes back down. Tell us what that means as an OB-GYN under those total circumstances.

A. Right. So the, you know the baby's probably been deprived of oxygen for five to seven minutes at that point. You've -- the patient -- and it is in a clinical situation. You can see the head, it's crowning. Probably the nursing staff all knew. Dr. Giep probably knew that they could deliver the baby fairly expeditiously, so they made the decision. And in the course of that, the heart rate did come up briefly, but it went right back down.

Q. And when you ---

A. So they just sort of ended back to whatever caused the problem with the baby's heart rate in the first place was still present, even though it did come up.

Q. And when you all are at that point before the

baby has delivered, do you really know what's causing that depression of the heart rate?

A. No.

Q. And all the ---

A. It is a very indirect measure of how -- of sort of the fetal wellbeing. It could be any number of reasons.

Q. Do you all rely upon any direct measure to make the decision on what we're gonna do next?

A. Sure. You know that after a period of time that the baby's gonna start to get acidotic, that the oxygen level for the baby's gonna go down. It runs the risk of brain injury and, you know, you're talking some serious, serious problems.

Q. And is there any way of knowing how long it would take for any of those things, the acidosis, the brain injury or even death to occur once the fetal problems start?

A. No, but it is time related. The longer it goes on the more risk you have.

Q. So when Dr. Giep made the decision to go ahead and restart the Pitocin, have the patient do a couple of pushes and then apply the vacuum, was that all in your opinion within the standard of care?

A. Yes.

Q. Once the baby's head delivered, when Dr. Giep decided at that point that he was going to check for the neutral porters, is that within the standard of care?

A. Sure.

Q. Is that what most doctors normally do as the first step once the head's out, especially in a baby like this one?

A. Absolutely.

Q. Why is that?

A. Well, because one of the causes of the heart rate dropping is cord compression or a nuchal cord can be associated with a heart rate dropping like that. So you want to check because you can't really deliver a baby with the cord still, still around the neck. You've got to reduce it. So that would be an impediment to deliver, a further impediment to deliver.

Q. And the bulbing out of the baby's nose and mouth, that's something that is in the routine or it has to be done at that point once the head is delivered?

A. Yeah. It's actually -- yeah, it's -- you know, it's what we have always done. It's becoming a little more optional for some reason, but that's another story.

Q. Why did you all -- why do you all do it?

A. Just to clear the airway because as soon as the baby comes out and takes that first breath you want the

-- you don't want the baby with any amniotic fluid or whatever else is there.

Q. And that's a question I want to ask you just from an obstetrician standpoint. When the baby is inside momma's body, is it breathing as we breathe now, you know, in and out where your diaphragm is helping you do all of that?

A. Well, you know, actually, you know, I don't think -- I don't know that it's been discussed yet, but one of the assessments that we do for food and wellbeing has to do with looking for breathing motions on ultrasound. Maybe you've discussed that elsewhere. So that does happen. The diaphragm is working, so the baby's working. That's a sign of fetal wellbeing as well. But, and maybe that wasn't exactly the question you were asking. The baby's not moving air obviously.

Q. Right. Because their head is inside the body?

A. Yeah, there's no, no oxygen.

Q. If there has been some entry to that nerve, whatever one that rise the diaphragm is --

A. Right.

Q. -- as the baby is coming down the birth canal before the head ever comes out, would you know that?

A. No.

Q. Now moving forward, once the head was delivered

in this case and Dr. Giep had done the blow thing and the nose and mouth thing, when he moved forward to the McRoberts type maneuver, was that, in your opinion, something that was within the standard of care, as he described it? I think you were in here when we talked about it.

A. Yes.

Q. All right. Help us understand why.

A. Yeah. So, yeah, we've been doing McRoberts for a long time and discovered that when you rotate the legs back, a lot of babies that aren't coming out, shoulders that sort of seem impacted, loosen up and will deliver pretty easily. In fact, it works most of the time. McRoberts alone without anything else.

Q. And does the doctor always have hands providing traction during the McRoberts thing maneuver?

A. Yeah. So you do the McRoberts and then hopefully that disimpacts the shoulder and then you pull the baby. But you wouldn't probably necessarily -- you know, it's all sort of all simultaneous.

Q. Okay. Let me ask a question that probably sounds stupid. But when you're the doctor and you're down on the stool, like Dr. Giep described, and you've got your hands in that position, when all of these things are going on do you tend to keep your hands on the baby's

head to some extent to protect it from I guess if it were to become lucid or were to deliver suddenly?

A. Oh, yeah. Yeah, yeah, because a precipitous delivery is not good for the baby. And even a precipitous delivery can cause brachial plexus injury as well. Plus there's a maternal result of a rapid delivery is much more likely to cause trauma to the, to the mom.

Q. When you say maternal, that's something that might hurt the mother herself?

A. Right. Just much more likely to get a vaginal tear that's problematic.

Q. Now, when Dr. Giep, you heard his testimony about how he described the forceps that he was using during the McRoberts and the suprapubic, you know, after the head had delivered. Minimum traction and gentle constant forces, are those the types of forces that can be expected to use under the standard of care?

A. Yes.

Q. Help us understand why.

A. Yeah. So, yeah, as has been well discussed already, the -- you want to keep sort of general constant pressure. You don't want the kind of jerking movements. You don't want anything to jerk. Much more likely to, A, get the baby stuck or, B, cause an injury.

And, you know, excessive force has a potential to cause problems.

Q. In your review of the information, including the depositions of the family members of Mr. and Mrs. Flowers and Mrs. Bowen, the grandmother, did you see any information that led you to conclude about how Dr. Giep was moving the baby or handling the baby's head as the baby was going through all these things?

A. Well, yeah, in listening to the -- in reading over the depositions and so on, you know, it sounded as if you could sort of get a sense of the maneuvers that occurred and sort of the step-wise process. And, you know, escalating what he had to do to deliver the baby.

Q. How about in terms of the angle for traction that was being applied? Did you see in the grandmother's deposition where she described that he was pulling it straight out?

A. I did read that.

Q. And is that what is the general direction you all pull when you're doing these things?

A. Right. Right.

Q. Now, we've heard some testimony earlier, some, I guess, questions earlier about this idea of the axial spine that the forces are always on the axial spine. And the baby's outside of the mother's body but the body

is still inside, are you able to see what the spinal angle is?

A. No. You just have to sort of infer from the, sort of, the normal direction of the pelvis and then the further away it would be.

Q. And is there, as you're maneuvering the baby, assisting it and guiding it out, is there some degree of movement of the head and the body as it's coming out?

A. Well, yeah. Yeah, to get the shoulder down, yeah, there is a slight amount of downward traction.

Q. Is that acceptable within the standard of care?

A. It's a routine. Yeah, so it is in the standard of care and it's routine.

Q. Why do you have to apply that slight amount of downward movement?

A. Well, just to -- yeah, you know, if you're there you can kind of see, but the shoulder still does have to come under the pubic bone and to come under the pubic bone it'll get pushed down a little bit, so you just assist in the direction that the baby will already be going.

Q. And were all those descriptions that you saw about manner in which you saw and were available or the manner in which Dr. Giep applied the forces outward and downward, were all of those in your opinion within the

standard of care of what most obstetricians would have done when faced with a patient like this in this scenario?

A. I thought they were.

Q. Now, moving to one other topic. When the baby's head was out and the shoulder dystocia was identified, based on everything you reviewed was that baby medically stable at that point?

A. At the time of delivery?

Q. At the time that the head had delivered.

A. Well, the head, is the baby stable? Well, you don't really know. I mean, you've got, you've got the heart rate down for a period of time. You've got a shoulder dystocia diagnosis so, yeah, the baby's in pretty significant jeopardy at that point.

Q. And with the heart rate having dropped and then rebound and then drop back again, is that an area of stability of that medical conditional of whatever is causing the heart to do that?

A. I wouldn't think so.

Q. Now, at the point the head was delivered and up until the remainder of the baby's body was delivered, was that baby at some imminent risk of some serious bodily injury or even potentially dead?

A. Sure.

Q. Can you explain why you say that?
A. Sure. I mean, you know, we've -- I have never experienced a shoulder dystocia that you couldn't resolve, but you do read about that from time to time. You all heard a little bit about that Zavanelli maneuver that's just sort of life saving where you push the baby back and do an emergency C-section and the outcome from that is terrible, the statistics on that.
So you don't get the shoulder delivered, you're -- the baby's gonna be hypoxic and probably a significant brain injury and that sort of thing. So that, that's what you're facing at this point once you get the shoulder dystocia.
Q. And during that window of a minute to two minutes that this child was experiencing the shoulder dystocia before the body was, you know, the rest of the body was delivered, was it at risk during that entire window of a couple minutes or whatever?
A. Sure.
Q. And is there any way Dr. Giep or any doctor in that scenario knows how long they got to sit there and do whatever ---
A. You don't know how long the shoulder dystocia is gonna take.
Q. And do you know how long the reserve of the baby

is gonna be able to hold up for whatever else?

A. No. No. We had one, we had one about seven minutes about two weeks ago and it was pretty, pretty stressful. Fortunately the baby didn't have any damage.

MR. LOVELL: Thank you, Doctor, please answer any questions the Plaintiff has.

CROSS-EXAMINATION

BY MR. HENSHAW:

Q. You've been an expert witness before?

A. I have.

Q. And reviewing the materials of various witnesses is part of the job of the expert; is that right?

A. Yes.

Q. You're charging, you said you couldn't -- well, you didn't know what you were charging here, but previously in your deposition in this case you indicated you're charging $3,000 per day for trial work.

A. Okay.

Q. Is that right?

A. Sounds good. Yeah.

Q. Sounds okay?

A. I'll do it.

Q. And you have reviewed these materials and so you are relying in part, but you're relying upon what Barbara Bowen, the grandmother, said about Dr. Giep

pulling the baby straight.

A. Well, I answered that question. That didn't really fit -- that wasn't really part of my original review of the case and my reasons to think that, that this case was within their standard of care.

Q. Well, you didn't give that qualification when you were just asked about it. You just said, yeah, I understood that it was being pulled straight and indicated that that was ---

A. I said that I had read it.

Q. All right. Well you also read, then, that she said that: (Reading.) And she was pushing and all of a sudden the baby's head came out and the doctor was pulling. The nurse that was standing to the side of her was pushing on her stomach. And then when the doctor was pulling her head, all of a sudden he stood up. That scared me. He stood up and he was still pulling. (Ends reading.) Did you rely on that too?

A. No, I wouldn't probably rely on that.

Q. So you rely on some things in a witness's deposition if it suits you but you don't rely on the others?

A. Well, I wouldn't qualify if it suits me. I think you, you know, I would agree I rely on some parts more than others. Just like when you're interviewing a

patient, they tell you some things that sort of make sense medically and some other things that sort of don't exactly make sense, so...

Q. I mean, you ---

A. But I didn't rely on her, her deposition to form my opinion, so I just answered the question that I did read it.

Q. You don't even know what she meant by the term straight, do you?

A. No.

Q. Because if Ms. Flowers was in a McRoberts position but essentially prone on the bed and the doctor pulled straight, that wouldn't be right, would it?

A. Well, the ---

Q. Because that would be lifting the baby's head up.

A. Well supine, not -- prone would be face up.

Q. Well, supine. I should have said supine, I apologize.

A. So that threw me off to start it off.

Q. All right. Let me start over then. If she was supine in McRoberts position and the doctor, I mean, one view of straight would be to pull straight out from that, that would not be appropriate because that would not keep the baby's head in alignment with the spinal column, would it?

A. Right.
Q. So if you rely upon Ms. Bowen's testimony that he pulled out straight, well that's the same as saying that Dr. Giep was negligent, aren't you?
A. Well, I didn't -- I'm not relying on her testimony.
Q. Okay.
A. I wouldn't. I read it.
Q. But you are relying upon Dr. Giep's testimony when he says I just used mild traction?
A. Yeah, Dr. Giep.
Q. Dr. Giep. You're relying on that when he just says I used mild traction?
A. I am.
Q. All right. And as far as the nurses are concerned, you didn't find anything in there to corroborate Dr. Giep whether he used mild traction or not because they all say they didn't see it; isn't that right?
A. Can you repeat the question.
Q. I said, in terms of corroborating Dr. Giep's statement that he used mild traction, the nurses weren't in a position to corroborate that because they all said they didn't see it, right?
A. Yeah, possibly so. Yeah.

Q. And what we do know, though, is that this baby has injury ruptures to C-5, C-6, C-7 and C-8.

A. Right.

Q. That's a pretty severe injury, isn't it?

A. Well, I would think so. I'm not gonna testify about the, about the neurological part of it, but yeah.

Q. Well, you can testify to your own experience, which is you've been delivering babies since the 1990s, and you have had about three cases a year that involved shoulder dystocia; is that right?

A. Of some degree, sure.

Q. And you've never had a permanent injury, have you?

A. I don't believe so. Not aware of it.

MR. HENSHAW: That's all the questions I have, thank you.

MR. LOVELL: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. LOVELL:

Q. Doctor, I want to make sure we're clear on the testimony of Ms. Bowen about the straight. To clear my mind I had to read it over. I'm looking at Page 31, Line 12. The question that was asked and the context of the answer was: (Reading.) When the doctor was, as you say, pulling your grandchild, was he pulling him

straight or was he pulling him up or was he pulling him down and the answer was straight. (Ends reading.) Right?

A. Straight.

Q. Is that what you read in the deposition?

A. That's what I read.

MR. LOVELL: Thank you, Your Honor.

THE COURT: You may step down. Thank you.

DR. ROBERT ARNETT,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

Q. Dr. Arnett, would you give us your full name for

the record, please.

A. Robert Michael Arnett.

Q. Where do you live, Doctor?

A. I live here in Spartanburg.

Q. And what do you do for a living?

A. I'm now a -- I used to be an OB-GYN. I guess I'm doing just gynecology now with the women's clinic in Spartanburg.

Q. Women's clinic here in town?

A. In town, yes.

Q. Where's your office located?

A. Our office is at 475 Haywood.

Q. How many years have you been practicing here in Spartanburg as a doctor?

A. Since 1991, so that would mean that is 26.

Q. You mentioned that you're no longer doing obstetrics. When did you quit doing that?

A. I stopped doing it at the end of 2009.

Q. So back in 2008 were you actively delivering babies?

A. Yes.

Q. And how many years at that point had you been actively been delivering babies?

A. Eighteen. Well, not counting residency. I guess, you know, you always don't know when you count

that or not, so that would be another four.

Q. All right. Tell us about your training to become a doctor.

A. I went to the Medical University of South Carolina, did four years there. And then I did my residency training at the Medical University of South Carolina as well.

Q. All right. And college before medical school?

A. I went to the United States Air Force Academy for four years and then flew airplanes with the Air Force for a little bit before I started medical school.

Q. How many years were you in the military total?

A. Well, I was in seven before I started medical school and then I did reserves afterwards for a total of 22.

Q. And what was your highest rank in the military?

A. Lieutenant Colonel.

Q. Honorably discharged?

A. I just retired, so I guess that's honorable.

Q. They invite you to retire if you do it on your own.

A. There you go.

Q. Did you belong to any professional organizations in the field of medicine, Doctor?

A. Yes. The county Medical Society, the State

OB-GYN Society, ACOG, which is the American College of Obstetrics and Gynecology. The South Atlantic, which was also mentioned.

Q. How about hospitals, which ones when you were delivering babies, where did you deliver your babies?

A. Originally I started both at the Regional and at Mary Black. And then after about five years we went exclusively to Spartanburg Regional.

Q. When you say we, how many other doctors are in your practice?

A. At one time we had -- back then we had eight and now we have seven.

Q. And are you board certified in your field and if so, which one?

A. Yes. I'm board certified in OB-GYN still.

Q. And how many babies, when you were delivering babies, let's take it up to about 2008, how many babies do you think you delivered?

A. Probably about a little under 3,000 in residency and maybe another 3,000 after that.

Q. And were you familiar from your educational training and all the babies you delivered on how obstetricians in general would deal with issues such as fetal distress, like in this case, or shoulder dystocia like in this case?

A. Yes.
Q. And are you familiar with the standard care required of you guys as obstetricians in doing those types of deliveries with those types problems?
A. Yes.
Q. And under the standard of care that existed in 2008?
A. Yes.
Q. And how did you keep up with all of the nuances of doing those deliveries back when you were doing them?
A. Well, we all went to meetings to get certain courses that we would take. The board certification requires you to take a test periodically, and then every year you have to also read articles that keep you up to date. And, you know, general reading. You know, you're gonna read different, different things periodically to keep up to date with getting magazines to read and see some of the articles.
MR. LOVELL: Your Honor, we tender Dr. Arnett as an expert in the field of obstetrics and gynecology and the recognition and management of shoulder dystocia in delivering babies with that or with the fetal distress condition.
MR. HENSHAW: May I voir dire?
THE COURT: You may.

VOIR DIRE EXAMINATION

BY MR. HENSHAW:

Q. Just a couple of questions. When was the last time you delivered a baby?

A. In December of 2009.

Q. 2009?

A. Yes, sir.

Q. All right. And not since then?

A. No.

Q. You only work in the field of gynecology?

A. Yes, since 2009.

Q. All right, thank you.

MR. HENSHAW: No objection, Your Honor.

THE COURT: He is so qualified.

CONTINUED DIRECT EXAMINATION

BY MR. LOVELL:

Q. And I forgot to ask, Doctor, in your experience do you all have medical students that you've trained or been involved in teaching over the years?

A. We have some medical students that come from the local college, the osteopathic school here, but I haven't been involved with them with obstetrics. More with the family medicine residents and the GYN residents that are at the Regional Hospital that we will occasionally supervise.

Q. Now, do you know Dr. Giep on a personal level?
A. Yes.
Q. All right. How do you know him?
A. We interact at the office -- or at the hospital is where we generally see each other. I think I've seen him one time at some meetings. I knew his father. His father helped train me earlier in my, my area.
Q. Do you out go out to dinner and socialize with Dr. Giep?
A. I have not been out to dinner that I -- probably maybe 15, 18 years ago we were at the same meeting and I think he and his wife and I may have eaten dinner together once.
Q. Is his group a competitor with your group when it comes to obstetrics and gynecology?
A. Well, we would all prefer that the other patients come to me instead of him, yes.
Q. Have you served as an expert witness previous to today?
A. Yes.
Q. How many times?
A. Testifying probably five or six. Total cases probably 15.
Q. Cases you might have reviewed, but only five or six you testified and gave a deposition in?

A. Well, no, the depositions I probably gave more of those. I might have given seven or eight depositions. You don't always go to trial with a deposition. You might give one and then have to come to trial.

Q. And are you paid, compensated for your time away from your practice?

A. Yes, I am.

Q. And at what rate?

A. I review the records for $300. The depositions I do for, I want to say, 1500. I can't -- I haven't looked at my scale in a while. And then the trial is 3500.

Q. Let's talk about your experience with shoulder dystocia. In your thousands and thousands, I forget what number you said of deliveries, have you had experiences where your patients developed shoulder dystocia with the baby?

A. Yes, I wouldn't think any obstetrician hadn't had that.

Q. About how many times?

A. I probably over estimate my shoulder dystocias. I would say probably 200 times that I've had an actual shoulder dystocia. But out of those most of them were mild and resolved very easily and with just the first McRoberts maneuver. Then maybe I'd say 50 to 60 that

I've had that are -- that required more and that would be more moderate or severe.

Q. Have you had a scenario with a brachial plexus injury after a shoulder dystocia event?

A. I have had, yes.

Q. And how many times has that occurred?

A. I think I've had five.

Q. Have you ever had that occur on what you consider to be an easy shoulder dystocia delivery?

A. Yes. I actually had one where I would say it would have been very easy. We hardly had any traction at all.

Q. Explain that. What do you mean by all of that?

A. Basically where we're only -- the way I look at the severity is how many -- how long it takes, how many maneuvers you use, how much trouble or things that you have to do to get the baby out. And so the mild ones generally just resolve when they do this McRoberts that you guys approved I don't know how many times.

And McRoberts is basically just opening -- the pelvis is not solid, it's -- it moves. And when you do McRoberts it helps open up this part of the pelvis so that you have more room to get the baby out with the shoulders. (Indicating.) And in the particular case that I had that I had a shoulder dystocia with a

brachial plexus injury where literally I think they just did McRoberts, I didn't do any traction in it then.

Q. And have you had occasions with shoulder dystocia injury, you've had a brachial plexus injury that did not resolve?

A. I had one case that the last time I talked to the patient's mother there was still some sort of deficit, which was about six years afterwards. So I don't know if it resolved. I would tend to think not.

Q. And in that scenario was that an easy delivery, an easy shoulder dystocia? How would you qualify it?

A. I would say that one was probably easy to moderate, something like that.

Q. Did you apply what in your mind was excessive traction?

A. No. We did McRoberts and did the suprapubic pressure and that got the baby out. And it didn't take long. So, again, if you use time as a severity it was a very short one.

Q. All right. In terms of long, was it one minute to two minutes? How do you quality that?

A. To me, you know, a minute to two minutes is a fairly short shoulder dystocia.

Q. Now, Doctor, from all -- I'm gonna ask you to sort of set the foundation. Have you reviewed all the

medical records related to this child's, the prenatal records with Mrs. Flowers, Mrs. Flowers in the hospital records, the records of the delivery and the records of before and up until when everybody went home?

A. Yes. And I looked at all the depositions as well.

Q. Including mom, dad, grandma, Dr. Giep, all the other folks --

A. Yes.

Q. -- we've previously testified about? With all of that did you arrive at an opinion on whether or not Dr. Giep and his management of this labor and delivery and in the delivery itself exercise the standard of care required of him as an obstetrician in those circumstances that were faced with this baby?

A. And I think the way I always look at it is the standard of care is what would your -- is a reasonable prudent doctor do in similar situations with similar training, and I feel like I'm just where Dr. Giep is, just where Dr. Gower is, I've done general training, and in my mind I didn't see anything in the records that would reflect that he went below the standard of care.

Q. And from his testimony and what you heard in the courtroom and what you read in the other depositions, was there anything that led you to think that Dr. Giep

applied forces or direction of forces that was outside of what most obstetricians would do in a scenario like this with this case?

A. No, I didn't see that.

Q. And we just talked about it here and you heard the testimony of Ms. Bowen. Did you read her testimony?

A. Yes, I did.

Q. And did you see the testimony of the parents and the nurses about the demeanor of Dr. Giep in the delivery room at the time he was at the business end doing whatever he was doing?

A. I did.

Q. Did any of that suggest to you that he was acting outside of the standard of care with the forces he applied or the manner or direction that he applied with it?

A. You know, and I tend to think that the parents and the in-laws and all those definitely are saying what they saw and remembered. Sometimes if you're not in that field you don't know exactly. Things that look awful to somebody that doesn't see them everyday can look -- can be very normal. Any time you're reaching inside somebody, that doesn't look normal. And it's, I think, can be -- can look like there's something more going on than may be. In their testimony I didn't see

anything that was outside of the area of normal.

Q. Now, Mrs. White, who just testified, and Mrs. Phillips, who we'll play by video in a little bit, do you know them from your years in the hospital?

A. Yes, I do.

Q. And have delivered babies where they were there assisting you as either the surgical tech or the RN nurse?

A. I've delivered babies with shoulder dystocias with both of them.

Q. And are they good and competent nurses?

A. They are excellent. Natalie and ---

MR. HENSHAW: Objection, Your Honor, that's not relevant for this case and it goes into areas of reputation.

THE COURT: Sustained.

BY MR. LOVELL:

Q. In terms of their actions as nurses in delivering, as you've heard Ms. White describe it and you read in Mrs. Phillips deposition testimony, do they have -- are they in a position to observe what the doctors enumerated in the courtroom as you saw it?

A. Yes.

Q. And did you see anything in what they described in how they observed it that suggested that what Dr.

Giep was doing on that particular day was any different than what any other obstetrical doctor acting within a standard of care would have done under those circumstances?

A. No. I didn't see where they said anything like that. And if they had seen something like that I would have thought they would have put it down or told their supervisor.

Q. Dr. Giep went through the maneuvers that he uses as a routine, including the nuchal cord, the bulbing of the baby, the suprapubic pressure and the McRoberts maneuver, I got those backwards again, and the other things he described, the Rubin II, are those the maneuvers in that order that most obstetricians use when faced with a dystocia event?

A. I would think that most -- when you start getting down to the secondary maneuvers everybody does something a hair different. McRoberts probably, I would say, 100 percent of people do that first. Suprapubic pressure probably 99.5 percent of people do that second. And then after that there's either gonna be somebody trying to get the posterior arm, is what Dr. Giep tried to -- I'm sorry, Dr. Giep tried to describe, which it is very difficult and used to be my go to.

But it's so hard. And I found that rotational

maneuvers work so much better that I went to a rotational movement before I would actually try doing the posterior arm. And I generally use the wood screw, which is a little different. Dr. Giep uses Rubin, which pushes in the wood screw. It's more of a pushing motion.

But they all are trying to rotate the shoulders to that they're, instead of being up and down, they're a little off to the side. And typically when you do a wood screw maneuver, or I haven't really seen a lot of Rubins, but once it gets going and the patient's pushing, the baby will literally spin around as it comes out. And that's what I have used, you know, the most as a secondary maneuver.

And then after that you're looking at possible fracture of a clavicle to try and bring the shoulders in to make less room. Then you're looking at -- I never even thought about doing a Zavanelli maneuver.

Q. The wood screw and the Rubin, those secondary maneuvers, is it within the standard of care to use a Rubins first as opposed to the wood screw first?

A. Yes. And most people are -- what I used to teach the residents is you should have the things you do boom, boom, boom in your mind before we ever walk in there because shoulder dystocia is you just don't know when

they're gonna happen. And so you have to have what you're gonna do and how you're gonna do it in your mind so you're not panicking when all that happens.

Q. Now, Doctor, I want to shift gears just a second and ask you this. When the baby had the drop in the fetal heart rate, was it at a risk of injury or was it in trouble?

A. It was. It was in trouble as far as we can tell at that time. I would have been concerned and done the exact same thing that Dr. Giep did.

Q. When the baby's head had delivered and the shoulder dystocia was discovered, at that point in time was the baby medically stable with its heart rate and what was going on?

A. No. Once you're in a shoulder dystocia, you don't -- that's the definite or it's one of our few -- that's one of our obstetric emergencies and you don't know how the baby is going to do at any one time during that process. And so I would say -- and there's a possibility of fractures. There's a possibility of fetal death at that point from a shoulder dystocia.

Q. And is that in that window from the time of dystocia recognition in the next minute and a half, two minutes, whatever it was, is the baby at risk of immediate serious bodily injury or even --

A. During --
Q. -- death?
A. During that whole time the baby is at risk. Now, the -- I think most of us would agree that the longer it goes, the more that we're gonna worry about injuries because then you're starting to look at procedures that may injure the baby.
Q. So during that window of time is baby medically unstable, baby at imminent risk of serious bodily injury or even death?
A. Yes.
Q. And does the doctor have unlimited time to get the baby out?
A. No. And to go along with that, because the heart rate was down a little bit beforehand in that period of five to seven minutes, then it's -- I would normally say if you have none of that, you probably have five to six minutes that you're working on. In that case probably three or four minutes.
Q. Now, Doctor, you've heard some testimony earlier in the week about the degree of forces that those folks thought would apply. Dr. Gurewitsch, she testified she thought Dr. Giep used greater than I think 35 pounds of pressure in his traction of force or whatever the word is. In your opinion in a position where a physician is

on the stool sitting low with his hands over the baby's ears or side of the face is that possible?

A. In my opinion no. If you're sitting on a stool and you're trying to pull, that's the whole reason you sit on a stool with a forceps delivery is so that -- or a vacuum delivery or a shoulder dystocia, is so that you wont put more pressure because if you're, you know, if you're standing you can put the weight of your body along with that. When you're sitting, that takes the weight of your body out. And then I'd never really seen forces or pounds put to this particular question. I never looked at it until I saw her testimony.

And when I saw her testimony I just said, gosh, 35 pounds is a lot of pounds. And I started looking at it and I said how much? I'd never done a simulator and so I didn't know -- I really didn't know how many pounds I might pull with a normal delivery. And so I tried to sort of figure it out a little bit at home. I had a scale that could tell me.

MR. HENSHAW: Your Honor, this is beyond the qualifications of what he was allowed to testify to as an expert. He's now getting into biomechanics.

MR. LOVELL: I think he's talking about his experience in trying to determine if 35 pounds was doable.

(Whereupon a bench conference was held off the record.)

THE COURT: Overrule the objection.

BY MR. LOVELL:

Q. Doctor, I was asking you questions about 35 pounds of pressure. Continue on where you were on what you were doing to figure out if you can do that.

A. Well, it just seemed like a lot of pounds to do this way, and so I just tried to figure out how much that might be. And I used a scale that you can pull this way. (Indicating.) And you really had to strain and pull to get up to 30 pounds. I couldn't get over 30 pounds.

And so I'm not -- that's why I say, when I did moderate or when I did just normal pressure, I did about a little under ten. When I did at -- when I did what I thought was more than that where I might be at the five or six-minute point of a dystocia, I probably did 15, 20. And I literally was shaking to get it up to 30.

Q. And when doctors are doing deliveries like we've heard in this one and you've got the gloves on, either latex or whatever, is the baby's head slick?

A. Yes.

Q. And when you're applying your hands in this direction and you're trying to bring it towards coming

out, is that different even when you were doing your little experiment with a dry area? (Indicating.)

A. Well, even different. Yeah, because a baby's head is very gentle or, you know, it's very delicate and so you couldn't, you know, you just can't squeeze very hard to do that. So it would be hard to, hard to...

Q. When a physician is down in this position, and as Dr. Giep has described, moving downward towards the floor, in your opinion would it be 35, 45 degrease of ability there under that position?

A. I would think he could get maybe 20, 25. I don't think he could get 35 or 40. But I don't -- I've never looked at that.

Q. Sure. When you all are delivering, by you all I mean obstetricians in general, are ---

MR. HENSHAW: Your Honor, I would object and move to strike that last testimony. He gives the answer and says I don't know I've never really looked at it. I think it should be struck and ---

THE WITNESS: Well, I've never measured it.

MR. LOVELL: Hold on a second, Doctor. Judge, I think he's giving his opinion. He's telling his basis. I'll followup with how does he know this.

THE COURT: Overruled. You'll be able to examine him.

MR. HENSHAW: All right, thank you.

BY MR. LOVELL:

Q. Have you ever measured it, Doctor?

A. No.

Q. When you were delivering, when obstetricians are delivering a baby, we've heard a lot about axial spine, is it necessary in order to facilitate the baby coming out to move some degrees up, down, left or right as you're moving and helping the baby in the delivery process?

A. Yes.

Q. All right. Explain why that is.

A. Well, depending on where, you know, it depends on whether you're talking about when the head's out or in. When the head's in, the head's in a different position, sometimes you're trying to, trying to get to see where it's gonna go. And then once it comes out, you're trying, especially if you have a dystocia, you're trying to move the shoulders out of the straight up and down line, so you're trying to get things to push and you're trying to move them around.

And then once you do that, you're trying to get them underneath the symphysis, the pelvic bone that's right there that everybody keeps talking about. We're trying to get the shoulder underneath that, and you're

gonna have to take just a little bit of downward pressure to get there.

MR. LOVELL: Please answer any questions the Plaintiff may have. Thank you, Doctor.

THE WITNESS: Okay.

CROSS-EXAMINATION

BY MR. HENSHAW:

Q. Please indulge me, Dr. Arnett.

A. Sure.

Q. I just need to see if I can find something here.

A. You all have a lot of things.

Q. Just to -- I may be covering some things you've already answered.

A. Okay.

Q. So just indulge me in that too, okay?

A. Sure.

Q. You're being paid about $3,000 today to be here?

A. 3500.

Q. 35, okay. And are you still working for Spartanburg Regional Medical Center?

A. Yes, sir.

Q. Are you still working for the Medical University of South Carolina?

A. I never worked for them. I was a clinical instructor, so I helped instruct. I didn't get paid for

it.

Q. Were you somehow involved in the residency program?

A. Yes.

Q. And you weren't paid for that?

A. No.

Q. Okay. But you were involved in the residency program?

A. Both here and down at M -- with the MUSC resident that came up.

Q. And you first got to know Dr. Giep, in fact, when you were at MUSC in Charleston; is that right?

A. Um, I'm not sure if I didn't meet him before that with his dad up here.

Q. Okay.

A. I can't remember.

Q. But, but you all were -- he was in medical school, maybe a fourth year, and you were a resident when you all were --

A. He was -- yes.

Q. -- beginning to become doctors?

A. He was either a third or a fourth-year resident when I was down there doing OB and GYN.

Q. I mean, I hate to say baby doctors, but --

A. I understand what you're saying.

Q. -- that applies in both ways?
A. Sure.
Q. You all were baby doctors and you were becoming baby doctors; is that right?
A. Well, yeah. I see where you're going, yes, sir.
Q. So you've known Dr. Giep for a long time. And then you came back home to Spartanburg and so did he?
A. Yes, sir.
Q. And you don't mean in any way to suggest that because you're competitors you would ever undertake to use a trial to undermine a competitor, are you?
A. No, I'm not saying that at all.
Q. That was -- that's just the sort of off-handed way of saying we know each?
A. Right.
Q. And you've both been in the same community for a long time?
A. I guess it's a way of saying that, you know, that we're not necessarily close.
Q. And you would look out for him if ---
A. I have. I think if there was something that I needed to tell him I would.
Q. Okay. The -- had you said that before 2009 when you stopped delivering babies you had delivered up to, what, 3,000 babies?

A. Delivered probably 3,000. A little under that in residency. Maybe a hair over that or somewhere in that range.

Q. And maybe had as many as, what did you say, 80?

A. No I said 200.

Q. 200?

A. 200 very, you know, but probably 50 to 70, 80 more that other people may be more inclined to call them more severe dystocia. In residence or somewhere in that range.

Q. Do you know Dr. Chauhan?

A. Chauhan, yes.

Q. Chauhan?

A. Yes.

Q. And he also worked here in Spartanburg; is that right?

A. Yes, sir.

Q. And when he was here he was doing research?

A. Yes.

Q. Were you contributing to his research?

A. No, not that I know. Now, I don't know if he took numbers from my deliveries and somehow that may be a contribution, but I wasn't actively giving him anything.

Q. Were you here yesterday when he testified?

A. No, I was not.
Q. He was -- he indicated that he's been looking for shoulder dystocia cases ever since he became a baby doctor and was having a hard time finding them. And he only could come up with like 90 over a period of 20 or 30 years and that you've got 200.
A. And, again, I probably -- if I have any kind of, any kind of difficulty with the shoulder that I have to use a maneuver, then generally I call that a shoulder dystocia. And there's -- some people may not call it that. Again, probably more on the lines of what he's thinking may be closer to 50 to 60.
Q. Okay. But you've never offered him your series of cases to look at?
A. I don't have a series that I could offer him.
Q. Okay. Now, and of that you've had one case that you've identified as potential or permanent brachial plexus injuries?
A. One that I can remember, yes, sir.
Q. All right. And you only know about that because you had occasion to speak with the mother about six years out?
A. Yes, but that was a ways back.
Q. All right. Did you know what nerve roots had been affected in that child?

A. I did not.
Q. You don't know whether they had been ruptured?
A. I, I don't know.
Q. You don't know whether they had been avulsed?
A. No, sir.
Q. You really don't know anything about the circumstances of that child's injury other than mother's told you he's still having problems?
A. Still having problems with his arm, yes, sir.
Q. All right.
A. But it had improved over time, is what she said.
Q. Okay. Don't know the way that it looked?
A. No, not at all.
Q. Whether the wrist was turned in or the hand was turned under?
A. No.
Q. None of that?
A. No, sir.
Q. Okay. Doctor, what is Erb's palsy? Do you know that term?
A. Erb's palsy is a palsy from the shoulder dys -- or from the brachial plexus injury where you have a problem with the wrist.
Q. Okay. And it's a problem with the wrist?
A. (Witness nods head up and down.)

Q. Does it ever --
A. Well, I mean ---
Q. -- create facial problems?
A. Um, I'm not sure that I know enough to make a competent, or to give a clinical opinion on that.
Q. All right. Are you familiar with whether an injury to C-4, C-5, as a result of shoulder dystocia causing brachial plexus injury can cause respiratory problems in a child?
A. That wouldn't be my area of expertise. I don't think I can give you a comment on that.
Q. So you don't know whether the phrenic nerve could be affected by this type of injury?
A. I've heard that phrenic nerves are affected, but I couldn't give you even a how that happens or where it is or -- it's just not part of my, my training.
Q. Do you, do you generally understand as a medical doctor who's been given some anatomical training in medical school that the phrenic nerve relates to the diaphragm?
A. Yes.
Q. It's that much that we can --
A. Yes.
Q. -- establish --
A. Uh-huh.

Q. -- with you? Okay. Now, you're not a biomedical engineer, are you?

A. I've had some engineering, but I'm not a biomedical engineer.

Q. We've heard some testimony from the experts, not just the plaintiff's experts, about use of dummies or synthetic models that doctors use to try to test how much pressure they're applying. Have you ever done that?

A. No.

Q. So instead of going to your bathroom scale, was there a model or dummy that you could have gone to and tested how much 35 pounds is?

A. There's not one around here that I know of, but I haven't actually looked. I, I didn't even think about pounds until the other day.

Q. I understand.

A. And I got a -- not really a bathroom scale, it's a luggage scale, if you want to know.

Q. Oh, okay. All right. And were you in any way in terms ever using the scale actually trying to reproduce some of the things that have been discussed here, such as lateral traction where there's a bending?

A. This would have been more a straight axial type because you can't -- I mean, you can pull it down that

way, but it's not gonna tell you.

Q. Okay.

A. You know, it's always gonna be the same amount of pull when you bring it.

Q. All right. So would you agree, Doctor, that you certainly would not want to publish your results?

A. No, sir, you're correct.

Q. Because really it's not scientifically valid at all, is it?

A. It just gives me an idea probably how much I was giving the forces that I might use just in my own mind.

Q. Okay. And, Doctor, I hate to bring this up.

A. Uh-huh.

Q. But this one baby that you know of that where the mother came and said my baby is -- my child is still having problems and you're thinking that that might be a permanent injury, you don't recognize or acknowledge that you used too much traction in that baby's case, do you?

A. No.

Q. And, in fact, you've been involved in other cases where you defended the actions of doctors and none of them have ever acknowledged that they used too much traction, have they?

A. I've only been in one case.

Q. Okay. But in that case the doctor ---
A. The doctor said he didn't touch the baby's head.
Q. Didn't even touch the baby's head?
A. Or do any kind of traction and let it rotate.
Q. Okay. Have you been involved in any peer review proceedings at the hospital where you had to go in and look at the conduct of obstetricians who delivered babies under these circumstances?
A. I was the department chairman in the '90s. I'm sure we might -- we probably -- we all look at our shoulder dystocias to see what happens and what went on, but I don't remember anything specific.
Q. Did any of the doctors that were interviewed as part of those processes ever acknowledge that they had used excessive traction?
A. None that I can remember. Now, I'm gonna tell you I have written it on a document on my, on two of my deliveries where I used more than what I would consider minimal traction.
Q. Did you feel like you had a reason to --
A. Yes.
Q. -- use excessive traction?
A. We were into six, seven minutes of it.
Q. Okay. So in other words, you were faced with a situation where you either -- you had to sacrifice the

arm in order to spare the baby?

A. Well, I ---

Q. Or at least took that risk?

A. I was, I was running out of ideas and I've never done a Zavanelli maneuver, don't think I ever will.

Q. And that's where you actually push the baby back up into the uterus?

A. I figured that's gotta be worse than what I was gonna do, so... And I didn't have an injury with either one of those, so...

Q. But in that situation where you are six to seven minutes down the path with the baby's head out and the baby's still not coming, that's when a doctor is faced with probably the most dreaded, one of the most dreaded decisions he can make.

A. Yes, sir.

Q. Which is I either take the risk of sacrificing the arm to spare the baby or I don't and the baby is likely to die.

A. Yes, sir.

Q. Okay. And so when you say you've actually written that and you've faced that decision, that dilemma, you've written it and explained why you did what you did?

A. Yeah. Well, I mean, I, I put it in. Typically

I'll put it in at the bottom of my note if I have a shoulder dystocia how much traction I use.

Q. But in this particular case that we have here in this court, there's no indication that Dr. Giep was at the point where he was faced with that dilemma?

A. No. No.

Q. There's no indication that he was intentionally sacrificing the arm in order to spare the baby.

A. There was no -- this wouldn't have been the time where I would have thought he would have tried more than just what he'd described, which was general traction or mild traction.

Q. And did you find in the records that there is some difference but, regardless, the time that it took him to use the maneuvers and get the baby out was between one and two minutes?

A. No, that's what I saw.

Q. All right.

MR. HENSHAW: Just one moment, please, Your Honor.

BY MR. HENSHAW:

Q. Do you agree, Doctor, that under the circumstances that exist in this case that lateral traction would be a deviation from standard medical care? -

A. No.
Q. Pulling the baby's head away from the impacted shoulder?
A. No. I think you can still use some downward traction to ---
Q. And ---
A. Most people would call it minimal downward traction.
Q. Okay. But is there a limit on what is allowed within that standard that you're trying to tell us about?
A. I would think if you went -- and, again, I don't know if the baby's head is coming down, I mean, I'd almost have to see what -- to me minimal traction means you bring it down slightly. And probably anything much past that I think would not -- would be more than we would recommend at one to two minutes. Now at four to five minutes then, yeah, you might want to pull down a little bit more in that direction.

MR. HENSHAW: All right. That's all the questions I have. Thank you, Doctor.

MR. LOVELL: Very briefly, Your Honor.

REDIRECT EXAMINATION

BY MR. LOVELL:

Q. Doctor, did I hear you say that when you write

the amount of traction you use in a shoulder dystocia delivery, you write it at the end of your note, like this? (Indicating.)

A. Generally I put the standard stuff and then I do the shoulder dystocia at the bottom.

MR. LOVELL: That's all I have.

THE COURT: You may step down.

MR. LOVELL: Your Honor, we call Natalie Phillips by video taken on 9/17/2017 in Knoxville.

(Whereupon, plays video of deposition of Natalie Phillips.)

NATALIE PHILIPS,

having first been duly sworn, was examined and deposed as follows:

DIRECT EXAMINATION BY MR. WEATHERLY:

Q. Good morning, my name's Lee Weatherly, and I represent Spartanburg & Pelham OB/GYN. And we're here today to take your deposition on video, we have a camera here, to be played in front of a jury at the trial of this case happening the week of October 9th. Could you start by telling the jury who you are and where you live right now?

A. My name's Natalie Phillips, and I live in

Knoxville, Tennessee.

Q. And why do you currently live in Knoxville?

A. We moved here about three years ago from Spartanburg.

Q. Okay. And when you say "we," who is that?

A. My family, my husband and my two kids.

Q. All right. So you have two children now. Are you expecting again?

A. Yes. Third coming in January.

Q. Congratulations. What does -- let me ask a couple of questions about your husband first. What does your husband do for a living?

A. He's a worship pastor at a church here.

Q. And where was he born and raised?

A. He was born in Texas, but he was raised in Spartanburg.

Q. Back in October of 2008, did you live near Spartanburg?

A. Yes.

Q. And where did you live?

A. Boiling Springs.

Q. And was your husband working for a church there around Spartanburg at that time?

A. Yes.
Q. What was he doing there?
A. At that time he was a junior-high pastor.
Q. And where were you born and raised?
A. Spartanburg.
Q. And where did you go to high school?
A. Boiling Springs.
Q. Were you a labor and delivery nurse who was present for the delivery of Ashley Flowers back in the October 2008?
A. Yes.
Q. Was there also what's called a scrub tech named Cindy White who was involved in the delivery of Ashley Flowers?
A. Yes, to my knowledge, yes.
Q. Other than today, here in this deposition, the only other time we've met is when Mr. Henshaw took your deposition about a year ago?
A. Correct.
Q. Do you remember the Ashley Flowers delivery?
A. Vaguely, yes. Somewhat. A little.
Q. And why does that delivery stick out in your mind as opposed to some others?
A. In initial introduction I found he worked

at the hospital, and it was one of my first shoulder dystocias. I had been working there about a year.

Q. And when you say "he," who do you mean?

A. The father.

Q. Okay. So Ashley Flowers' father -- what did you say? He worked where?

A. At the hospital.

Q. Okay. Describe for the jury back in 2008, were you what's called a labor and delivery nurse?

A. Yes.

Q. And what does that mean?

A. That means I took care of the patients and the babies or soon to become or delivered babies, yeah. I was the primary nurse for those patients.

Q. All right. So when --

A. Laboring patients.

Q. So when moms were in the hospital to deliver babies, you were sort of the nurse who was in charge of that patient while they were delivering and before they were delivering?

A. Correct.

Q. All right. Did you go to school to be able to do that?

A. Yes. I went to school to be a nurse, a

registered nurse.

Q. All right. Describe for the jury kind of what education and training you had to go through to become a labor and delivery nurse?

A. Well, I went to USC Upstate for my prerequisites, and I transferred to Spartanburg Community College to have my associate's degree in nursing. And, of course, we all have to take our boards, NPLEX, and then I was hired at Spartanburg Regional as a labor and delivery nurse right out of school.

Q. And how long were you a nurse -- or let me ask you, right now, what do you do now?

A. I'm a stay-at-home mom.

Q. How long were you a labor and delivery nurse before you decided to stay home and be a mom to your children?

A. Seven years.

Q. And was the last time you were a nurse, I guess, about 2014?

A. Uh-huh.

Q. So would that make it from 2007 to about 2014 you were an actively practicing labor and delivery nurse?

A. Correct.

Q. And where did you start your career as a labor and delivery nurse?

A. At Spartanburg Regional.

Q. And did you do that the whole time you were there?

A. Yes.

Q. Do you still hold a nursing license?

A. Yes.

Q. Where do you hold that?

A. Tennessee.

Q. Do you have to do continuing education to keep that nursing license active?

A. Yes.

Q. How many babies do you think you participated in the delivery of during that seven-year period?

A. Hard to say. We would usually do about two a shift every, you know, 12 hours usually, so I worked for seven years, so hundreds, I don't know.

Q. So you participated in the birth as a labor and delivery nurse of hundreds of children?

A. Yes, I would say, yeah.

Q. Have you seen or worked with a number of different obstetricians other than Dr. Giep?

A. Yes.

Q. And before the delivery, before the birth of Ashley Flowers, had you been involved in deliveries where a shoulder dystocia occurred?

A. Before Ashley?

Q. Yes.

A. Yeah.

Q. And after Ashley Flowers' birth, were you involved in deliveries that involved shoulder dystocias?

A. Yes.

Q. And have you witnessed other doctors, other than Dr. Giep, in how they handle and treat and react to a shoulder dystocia occurring?

A. Yes.

Q. Have you been trained as a nurse on how to respond to a shoulder dystocia?

A. Yes.

Q. Tell me a little bit about the training that you underwent during your seven years as a nurse as to how to respond to a shoulder dystocia?

A. We would -- our unit educator would go over, at least one or twice a year, a mock drill. We would deal with a manikin and a fetal monitoring strip and also have to take a test.

Q. And tell me what that was like when you

had a monitor, a fetal monitoring strip. Explain that a little more to me and the jury.

A. We would just go through a scenario, and we would go through the steps and interventions that we would need to have to go through of doing a shoulder dystocia when it occurred.

Q. And you would do that every year?

A. At least, uh-huh.

Q. Have you been trained in how to put a patient in what's called the McRoberts' position?

A. Yes.

Q. And have you been trained on how to correctly apply what's called suprapubic pressure?

A. Yes.

Q. Let me shift gears, ma'am, and talk a little bit about the delivery of Ashley Flowers. Were you in the deliver room for the birth of Ashley Flowers?

A. Yes.

Q. And what was your role in that delivery?

A. I was a primary nurse.

Q. And what does that mean being the primary nurse?

A. I was the one -- I was the nurse responsible for her.

Q. All right. And were you there from when you started your shift at around 7:00 p.m. until Ashley was born until 8:20 p.m.?

A. Yes, I was her nurse there.

Q. I'm going to hand you what I have marked as Defendants Exhibit 2.

A. Uh-huh.

Q. And ask you to take a look at that and tell me if after 19:00, and that means 7:00 p.m.; is that accurate?

A. Uh-huh.

Q. Okay. Starting at 7:00 p.m., if that's your handwriting on that medical record?

A. After 7:00 p.m., yes.

Q. And did you take, I guess, what's a handoff from another nurse at 7:00 p.m. who had been treating Ms. Flowers before your shift started?

A. Yes, it looks like it, uh-huh.

Q. And these recordings that you made on Exhibit 2 in this medical record, were those made on the night of Ashley Flowers birth?

A. Uh-huh.

Q. And you have to say --

A. Yes.

Q. -- "yes" for our Court Reporter here?

A. Yes.

MR. WEATHERLY: Thank you. At this time I would like to admit Defendants Exhibit 2 into evidence, please.

MR. HENSHAW: No objection.

(Defendants Exhibit 2 - Nurse's Progress Record.)

BY MR. WEATHERLY:

Q. All right. Could you hold that record up for the camera to show the jury sort of where your writing on this document is? You can just point to it.

A. Yes, 19:00, to 20:20.

Q. All right. Thank you. And feel free to refer to that record whenever you need to. Starting at 7:12 p.m., did you have to give Ms. Flowers some medications?

A. Yes, looks like ampicillin.

Q. Why did you have to do that?

A. It was a doctor's order he wrote.

Q. All right. And then at 7:32 or 19:32, did you do an exam of Ms. Flowers?

A. It looks like it, yes, sir.

Q. And what did that exam show?

A. It says SVE, sterile vaginal exam, with the mom being completely dilated, completely effacing

at zero station.

Q. Tell me what those three things mean? Completely dilated and completely effaced and at zero station?

A. Completely dilated, she was 10 centimeters. Completely effaced means her cervix was thinned out completely, and zero station is where the baby's head was in relation to the pelvis.

Q. Does this mean that Ms. Flowers is, for lack of a medical term, ready to push?

A. Yes. Correct.

Q. I'm going to hand you what's been marked as Defendants Exhibit 1 and ask you if some of your handwriting is on this medical record?

A. It is.

Q. Could you'll show the jury on the camera there where on that document your handwriting is?

A. Okay. "Dr. Giep" here. Let's see. "Completely dilated," the hours and minutes of each stage. "Ampicillin" here I administered at 19:12. And the date of time of delivery. Those are my initials and the time I put the Pitocin gave after delivery.

Let's see. Episiotomy, the first degree midline there, and the laceration, third degree midline, that's me. The placenta, 20:51, and estimated

blood loss within normal, that's me. Core vessels, three, that's me.

Complications, shoulder dystocia and vacuum, that's me. Apgars, the one minute, five minute, that's me. And the weight, 7 pounds, 11 ounces, is me. Let's see. Oh, guarded condition at NICU, that's me. And then the sponges and needles accounts there, that's me. And the Apgar scores down there is me, and the signature, R.N., Natalie Phillips. And I said that Cindy White was there as well.

Q. Okay. Did you write all of this documentation on the medical record that's Exhibit 1 on the night of Ashley Flowers' birth?

A. Yes.

MR. WEATHERLY: At this point I would like to move Exhibit 1 into evidence, please.

MR. HENSHAW: No objection.

(Defendants Exhibit 1 - Spartanburg Regional Healthcare System record.)

BY MR. WEATHERLY:

Q. Did you record on this Defendants Exhibit 1 the time that Ms. Flowers was completely dilated?

A. Yes, I recorded that, uh-huh.

Q. And I'm going to hand you now what's been

marked as Defendants Exhibit 3, and could you tell the jury what that is?

A. That is a fetal monitoring strip.

Q. And explain to the jury how that record is made, to the best of your knowledge?

A. It's just a strip that prints out on the monitor of the baby's heart rate and mom's contractions.

Q. If you could show the jury, hold it up --

A. Yeah.

Q. -- and show sort of what that top grid is and explain to them what that is and then explain to them what the bottom grid is.

A. The top is the baby's heartbeat, the rate is the 130s.

Q. And how is that measured? How do you get that reading?

A. You see the "120" there and it goes up by tens, so that's 20, that's 30, and that's about where the baby's heart rate is.

Q. I guess my question is, how does the computer get the information to print that out?

A. Oh, we have monitors on the mother's stomach --

Q. Okay.

A. -- that relays us to the --
Q. All right. Now, what's the bottom grid?
A. That's the mom's contractions. And this is kind of hard to read here, but these kind of hills are the mom's contractions.
Q. Okay. Now, is there some writing in between those two grids? Some typed in information?
A. Yes, yes. Blood pressure that prints out -- once it takes from the monitor, it prints out from an actual strip that's coming from the monitor, and then there's also a type -- a thing we can type in messages that prints out on the strip, which I did.
Q. And that area that's typed in, for instance, the first page, I think it says, "SVE" --
A. Uh-huh.
Q. -- "C/C/O NP, R.N."
A. Uh-huh.
Q. Is that information that you would have typed in this record?
A. Yes.
Q. And is there other information in the subsequent pages that you would have typed into that record?
A. Yes.
Q. And would you have been typing that in at

the same time as these events were occurring?
A. Around about, yes.
MR. WEATHERLY: At this time I would like to move Exhibit 3 into evidence as well.
MR. HENSHAW: No objection.
(Defendants Exhibit 3 - Printout of fetal monitoring strip.)
BY MR. WEATHERLY:
Q. Okay. Let's go back to 7:32. You just told us that Ms. Flowers at this point was ready to start pushing. At 7:42, about ten minutes later, did she have some complaints?
A. It looks like it, yes.
Q. And describe for me what her complaints were at 7:42?
A. It looks like on my notes, it says, "Patient complains of pain and cramping," and then I notified anesthesia.
Q. And you already answered my next question is, what did you do about that?
A. Notified anesthesia.
Q. And did an anesthesiologist come then to the room?
A. It looms like it 19:44.
Q. And what did the anesthesiologist do,

according to your record?

A. It says, "Anesthesia at bedside, five cc of two percent lidocaine administered."

Q. Is that pain medication?

A. Yes. They give it through the epidural catheter that's in her back.

Q. And was that effective in alleviating Ms. Flowers' complaints.

A. It looks like it. It looks like they gave a little bit more of it at 19:46, but, yes, as far as my notes, yes.

Q. And then what did you do after her pains or complaints of pain were alleviated? What did you do at 7:47?

A. Removed her Foley catheter.

Q. Now, why is it important to do that when she's getting ready to start pushing?

A. When you put a Foley catheter in, there is a balloon that's inflated with saline, so we have to deflate that so it doesn't prevent the baby's head from coming down the birth canal.

Q. And were you able to remove that Foley catheter?

A. Yes, it looks like it.

Q. And did Ms. Flowers start pushing after

that?

A. Yes, it looks like it at 19:55, yes.

Q. Based on your records and the fetal monitoring strip that's Exhibit 3, what was Ashley Flowers' baby's normal baseline heart rate during labor, approximately?

A. It looks to be about 130. Yeah. Yes, uh-huh.

Q. At about 8:07 or 20:07, did the fetal monitoring strip show that the baby's heart rate had dropped?

A. Yes.

Q. And what had it dropped to?

A. Like, the nineties. It's kind of broken up, but, yes, going into the nineties.

Q. And did you document that on Exhibit 2?

A. Yes.

Q. And what did you do in response to the baby's heart rate dropping into the nineties?

A. I turned the Pitocin off.

Q. What are you -- as a nurse, what are you concerned about there with the baby's heart rate being in the nineties?

A. I mean, we just didn't want -- I just didn't want the heart rate to stay there in the

nineties. I went to shut off the Pitocin so it's less stimulus on the baby, the contractions.

Q. Other than turning off the oxytocin, what else did you do in response to the heart rate being in the nineties?

A. It looks like at 20:11 I put the patient on the right side.

Q. And what are you trying to accomplish by doing that?

A. Sometimes position changes helps with maybe the baby's head is compressing on the umbilical cord, and it alleviates that.

Q. And does the shifting of the patient, are you hoping that that pulls the baby -- sort of using gravity to pull the baby's off of the umbilical cord?

A. Yes.

Q. And why would you be concerned about the baby's head being on the umbilical cord? What can that cause?

A. Just decreased heart rate and cut off the blood flow to the baby.

Q. Did you also give the mom oxygen at that time?

A. Yes, it looks like 20:08.

Q. And why are you giving the mom oxygen at

8:08 p.m.?

A. To increase the oxygen to mom and to baby to help with the heart rate.

Q. Do you have some concern during this period that the baby is not getting enough oxygen?

A. Yes. To some degree because it wasn't recovering, the heart rate wasn't recovering.

Q. And how long was the baby's heart rate in the nineties while all this was going on?

A. Let's see. About five minutes, four or five minutes.

Q. And did Dr. Giep arrive in the delivery room at 8:11 p.m.?

A. It looks like it, yes, sir. Yeah.

Q. And what did you chart on Exhibit 2 and Exhibit 3 that he did shortly after he arrived?

A. It says patient to right side at 20:11, Dr. Giep at bedside. And at 20:16 it says Dr. Giep, it's a verbal order to restart Pitocin at 13 milliunits.

Q. All right. Is some of the tracing after Dr. Giep arrived at 20:14, 20:15 and 20:16, is it somewhat hard to follow?

A. Yes. It's broken up because we're doing position changes. And because at that point it's still

in external -- it's on the mom's tummy, so we're doing position changes and pushing.

Q. Even though you don't have a consistent line on this strip, are you still able to hear the beat of the heart there in the room?

A. Yes.

Q. And are you trained to be able to tell the difference between a heart rate in the 130s and a heart rate in the nineties?

A. Yes.

Q. Did you next document that Dr. Giep used a Kiwi to help deliver the head of Ashley Flowers?

A. It looks like vacuum. Yeah, vacuum applied.

Q. And is Kiwi a type of a vacuum?

A. Yes.

Q. Is it sort of a small handheld pump-type thing?

A. Yes.

Q. Did you note that he pulled twice on the vacuum or the Kiwi to deliver the head?

A. It looks like it, yes, sir.

Q. And how could you tell that he pulled twice during this delivery?

A. Well, there are drapes up, but I can

still see from his upper to lower arms up to his head.

Q. So were you able to see the movement of his arms twice?

A. Yes.

Q. Did you document the use of the Kiwi both on the fetal monitoring strip and on Exhibit 2?

A. Yes, sir, it looks like it, yes.

Q. Now, did that vacuum ever pop off of Ashley Flowers' head because he was pulling too hard on it?

A. Not that I can remember.

MR. HENSHAW: Objection. Calls for speculation.

BY MR. WEATHERLY:

Q. Let me rephrase that question. When Dr. Giep was using the Kiwi, to your knowledge did it ever pop off of Ashley Flowers' head?

A. Not that I can remember. I don't recall.

Q. Is that something that, if there was what's called a "popoff," you would ordinarily document?

A. Yes.

Q. All right. When Dr. Giep began using the Kiwi, did you then call for the NICU team?

A. Yes. There's an intercom system in the

room right beside the patient's beside. I can call and the secretary comes over the speaker. And I called for NICU at that point, yes.

Q. And would that be before the shoulder dystocia ever occurred?

A. Yes.

Q. Okay. All right. Now, when Dr. Giep determined that Ashley Flowers was experiencing a shoulder dystocia, did he then instruct the nurses to have the mom in McRoberts' position and for someone to apply suprapubic pressure?

A. Yes.

Q. And were you the person that applied suprapubic pressure in this case?

A. Yes.

Q. And that's something that you were trained to do?

A. Yes, sir. Uh-huh.

Q. Could you demonstrate for the jury because we have a have video here --

MR. WEATHERLY: And if the Videographer could pan back a little bit.

BY MR. WEATHERLY:

Q. If you could sort of show the jury what suprapubic pressure is and describe how you apply it?

A. I just take my hand, usually my dominant hand, usually in a fist and usually take it right to where her pubic bone is right near her pubic bone and apply pressure at an angle to kind of dislodge the baby's shoulder as the mom is pushing.

Q. Now, are you standing on the ground while you're doing this?

A. No. I'm usually -- the bed's elevated so we have a stool, so it helps us get closer to the mom. And in the bed, sometimes in the bed, sometimes at the bedside.

Q. Okay. Now, did you document that you did suprapubic pressure there on Exhibit 2?

A. Yes.

Q. And did you also document that on Exhibit 3?

A. Is that the fetal monitoring --

Q. Yes, ma'am.

A. -- strip? Yes, this -- yeah, at 20:20.

Q. It says "supper," but --

A. Yeah.

Q. -- did you mean to write "supra" there?

A. Yes, it was really fast, yeah.

Q. Okay. And were you looking at Dr. Giep while you were applying this suprapubic pressure?

A. My -- it was -- my vantage point was either the mom or his -- yes, at him.

Q. All right. Did you ever feel like this suprapubic pressure was releasing the shoulder? It was being effective?

A. I couldn't tell. He'd instruct to me, "yes, that's good," or, "no, it's not helping," because I couldn't see the baby's head.

Q. Did you apply that suprapubic pressure until Dr. Giep told you to stop?

A. Yes.

Q. Did the NICU team arrive shortly after the shoulder dystocia was diagnosed by Dr. Giep, according to your records on Exhibit 2?

A. Yes.

Q. And could you see what Dr. Giep was doing with his hands, either while you were applying suprapubic pressure or immediately afterwards?

A. No. I could just see a little bit of his forearm and his arms.

Q. If he put his hands into Ms. Flowers' vagina to try to do any sort of maneuvers or anything to release that shoulder, would you have been able to see that?

A. No.

Q. And if you weren't -- well, excuse me, let me -- after the child was delivered, were you involved in the resuscitation efforts, or was that left to the NICU team?

A. That was the NICU team.

Q. Who, to your recollection, was involved in attempting to resuscitate Ashley Flowers?

A. It was just the NICU team. And at that point I didn't know who was there, the nurses specifically.

Q. Were you responsible for determining what is called the "Apgar scores" for Ashley that are listed on Exhibit 1?

A. No, I did not assign that.

Q. Was that something done by the NICU team and then called in to you to put on this record?

A. Yes.

Q. All right. Ms. Phillips, just a couple of more questions for you. To your knowledge, did Dr. Giep ever use any level of traction on Ashley Flowers' head at any time during this delivery that was different from what you've seen other physicians do, either before or after this shoulder dystocia?

A. No, not to my knowledge. I couldn't see

where his hands were.

Q. Did you see any signs from Dr. Giep such as flexed biceps or flexed shoulders or grimacing on his faces or anything like that that would indicate to you that he was straining to do anything during the shoulder dystocia?

A. No.

MR. HENSHAW: Objection. Leading.

BY MR. WEATHERLY:

Q. Did you notice anything about Dr. Giep's, either his physical presentation or his -- how he was acting during the shoulder dystocia that would indicate to you that he was straining and pulling on Ashley Flowers' head?

A. No.

Q. Did you ever during this delivery see Dr. Giep pulling Ashley Flowers' towards the floor?

A. I couldn't see the baby's head. I couldn't tell you.

Q. In your seven years, I guess, of participating in delivering babies, did you see Dr. Giep in this case do exactly what you've seen other obstetricians do when confronted with this emergency?

A. I'm sorry. Can you --

Q. Sure. In your seven years of being a

labor and delivery nurse, did you see Dr. Giep do exactly what you've seen other obstetricians do when confronted with this emergency?

A. Yes.

Q. When the shoulder dystocia occurred, did you or Cindy White, the scrub tech, or Amber Dallas, the NICU nurse, did any of you ever panic?

A. Not to my knowledge, no.

Q. When the shoulder dystocia occurred, did Dr. Giep ever panic?

A. No, not that I can recall.

MR. HENSHAW: Objection. Calls for speculation.

BY MR. WEATHERLY:

Q. Did you see any signs or did you see any actions or statements by Dr. Giep during this delivery that would indicate to you that he had panicked?

A. No, not that I can remember.

Q. If you had seen something unusual, such as Dr. Giep pulling hard on this -- on Ashley Flowers' head, would you have -- what would you have done?

A. Documented it.

Q. And anywhere in the records that you've seen in this case, is there anywhere that you documented that that happened?

A. No, not that I can see, no.

MR. WEATHERLY: Ma'am, I don't have any further questions for you. I'm sure Mr. Henshaw will have a few questions for you.

THE WITNESS: Okay.

MR. HENSHAW: Let's take a break.

VIDEOGRAPHER: The time is 11:14. We're going off the record.

(Whereupon, the deposition was in recess.)

VIDEOGRAPHER: The time is 11:23. We're back on the record.

CROSS-EXAMINATION BY MR. HENSHAW:

Q. Ms. Phillips, we have talked before. I think I took your deposition sometime ago in this case; is that right?

A. Yes, sir.

Q. And at the time that I took your deposition before, you were a little bit undecided about whether you would go back into nursing; is that right?

A. Yes.

Q. Have you decided now that you're not going back into nursing, that you're going to be a full-time mom?

A. For now, yes.

Q. Okay. So, in terms of your plans of going back into nursing, you don't know whether that will ever happen or when it will happen; is that right?

A. Yes, I don't know when. I'd like to, but right now, no.

Q. All right. Now, but you were a full-time nurse at Spartanburg Regional Healthcare System on October 7, 2008; is that right?

A. Correct.

Q. You had been a nurse for approximately one year at that hospital; is that right?

A. Yes.

Q. And it was -- when I say you had been a nurse for approximately one year at that hospital, that was the full extent of your experience working as a nurse was that one year at the time that this delivery occurred?

A. Yes.

Q. Now, the system that was in place in October 2008, called for you to be Ms. Flowers' primary nurse beginning at 7:00 p.m. on October 7th; is that right?

A. Yes.

Q. You also were assigned to be the primary nurse of another expectant mother that same evening

beginning at 7:00 p.m. Am I correct about that?

A. More than likely, yes.

Q. All right. Tell me about that other patient. What happened with her?

A. I don't remember.

Q. Okay. So you don't remember that case at all?

A. No, sir.

Q. And the reason that you remember the Flowers case is because you had seen Mr. Flowers working at the hospital?

A. No, had not -- I had not seen him. We -- on our initial introduction, I'd -- he said that he worked at the hospital, so we had that in common.

Q. Okay. And that's the reason that you remember this case at all?

A. Well, no. That and it was one of my first shoulder dystocias.

Q. Was it one of your first shoulder dystocia cases or your first shoulder dystocia case?

A. To my knowledge, one of the first.

Q. Okay. How many had you had by that time?

A. I don't know.

Q. Okay. But you recognize that shoulder dystocia was something that you could expect to

experience as a labor and delivery nurse; is that right?

A. Yes, sir.

Q. You had been trained in nursing school that that was an expected complication of a delivery; is that right?

A. Yes, sir.

Q. And you had even had training in how to follow specific instructions from a doctor delivering a shoulder dystocia baby; is that right?

A. Yes.

Q. So, while this is an unfortunate complication that can occur, it's something that you and other nurses were trained to deal with?

A. Yes, sir.

Q. And did you realize as a trained nurse that the doctors who delivered these babies were also trained to deal with shoulder dystocias?

A. Yes.

Q. And that there were -- and that shoulder dystocia was not a hopeless situation. It was one that could be managed and the baby could be delivered without any permanent damage or harm; is that right?

MR. WEATHERLY: Objection to the form. Speculation.

BY MR. HENSHAW:

Q. Well, you were trained that there were methods that were known and utilized by trained doctors to deliver these babies so that they didn't have permanent injury; is that right?

MR. WEATHERLY: Objection to the form. Speculation.

THE WITNESS: Yes, they --

BY MR. HENSHAW:

Q. Go ahead and answer the question.

A. Yes, yes.

Q. So, in this case, when you came on at 7 o'clock, did everything appear to be going as expected for Ms. Flowers' delivery of her baby?

A. Yes, sir.

Q. She -- was she in for a planned delivery on that date? In other words, was she scheduled to come in and deliver on that date that she was at term?

A. I can't -- I don't recall. I don't remember if it was.

Q. Well, you would have known that when you took report --

A. Right.

Q. -- from the nurse who went off at 7 o'clock; is that right?

A. Right. But I can't remember specifically. I don't know if it was an induction or if she --

Q. And had she come in and been induced to cause her to have contractions so that she could deliver the baby vaginally?

A. Yes, it looks like it. We gave Pitocin.

Q. And as far as you knew when you came on at 7 o'clock, she had proceeded through the labor according to plan? In other words, there had not been anything unexpected; had there?

A. No, sir.

Q. There was no reason to believe that the baby was damaged during the development of pregnancy; was there?

A. No. No, sir.

Q. And there are stages of labor, and Ms. Flowers had proceeded through those stages of labor as expected by the time you had arrived?

A. Yes, sir.

Q. Okay. When you came in at 7 o'clock, based upon what you can remember and based upon the records, there was nothing particularly unusual about the way that she was proceeding toward delivery; was there?

A. Not that I can remember, no, sir.
Q. All right. Now, who were the family members that were with Ms. Flowers in her room? Do you remember that?
A. I just remember her husband and the patient.
Q. All right. Do you remember any other family members being present?
A. I don't.
Q. All right. You came in at 7 o'clock. How many times did you go in and out of Ms. Flowers' room?
A. Several. I don't know a specific number. I'm sorry.
Q. All right. Now, Dr. Giep, were you aware that he was her attending physician for purposes of delivery that day?
A. Yes, sir.
Q. What group was he working with?
A. Spartanburg OB, I believe.
Q. I'm sorry. What was that?
A. Spartanburg OB.
Q. And did you understand that Spartanburg OB and Dr. Giep had been imagining Ms. Flowers' pregnancy for most of the duration of her pregnancy?

A. Yes. I would have seen those on those records, yes.

Q. All right. He wasn't be called in because she didn't have a doctor; was he?

A. No.

Q. He was expected to be there for the delivery of this baby that was planned; is that right?

A. Yes, sir.

Q. He was not being called in because of any emergency; was he?

A. No, that was -- no, no.

Q. All right. So you were there at 7 o'clock, you went in and out of her room on a number of occasions. During -- from 7 o'clock up until the point that Dr. Giep came in are, what was it -- what time did he come in for the delivery?

A. It looks like Dr. Giep at bedside at 20:11.

Q. 20:11, and that would be 8:11 p.m.; is that right?

A. Yes.

Q. From 7:00 p.m., when you came on duty, until 8:11 p.m., how many times did Dr. Giep come into the room?

A. I don't remember. I'm sorry. I don't

recall.

Q. Would you normally have documented each time that he had come into the room to be at the patient's bedside?

A. Usually, yes, sir.

Q. And in this record which we've put into evidence, do you find that the only time documented that Dr. Giep came into the room after you arrived was at 8:11 p.m.?

A. Yes. As far as my notes, yes.

Q. And did he go back out of the room, or did he stay there through the delivery?

A. I'm pretty sure he stayed from 20:11 to delivery, yes, sir.

Q. And the baby was delivered at 8:20 p.m.; is that right?

A. Yes, it looks like it.

Q. So the course of events involving Dr. Giep's delivery of this baby are reflected by records from 8:11 p.m. until 8:20 p.m. a period of nine minutes; is that right?

A. Yes, sir.

Q. Now, so he was there at 8:11. And up until 8:11, had everything gone, in terms of this labor and delivery, as planned up until 8:11?

A. Yes. I mean, yes.
Q. There was a point where the baby's heart rate decelerated; is that right?
A. Correct, yes.
Q. The baby had a baseline heart rate of about what?
A. Let's see. It looked to be about like 120s -- or, no, I'm sorry, 130s to 125, something like that.
Q. Now, that's during the period of time that you were there. You don't know what the baseline was earlier in the day; do you?
A. No, sir, not that I -- no, not that I know.
Q. But 125 to 130 is a normal heart rate for an unborn baby waiting to be delivered; is that right?
A. Yes.
Q. And some of the things that you look at as a nurse include, in terms of how the baby is doing, is whether or not there has been any unusual discharges by the baby during the later stages of the delivery; is that right?
A. Yes. According to --
Q. In other words, you looked for meconium?
A. Yes. But we -- I mean we usually don't

see that until -- yeah, that, we see that when they rupture the membranes, we can see meconium at that point or after delivery.

Q. And meconium can be significant to a nurse and a doctor, because it's not a usual finding in a normal delivery; is that right?

A. Not normally, no.

Q. It indicates that the baby has been under some sort of abnormal stress that may be causing the baby to be harmed; is that right?

A. Yes, or if they're -- but sometimes if they're over due date, sometimes that plays into factor too if they have meconium.

Q. But this baby was not over due date?

A. Yes, not that I can remember, yes, sir.

Q. And what meconium is is actually fecal material expressed by the baby's bowels?

A. Correct.

Q. In this case, this baby has no meconium; is that right?

A. Not that I can remember. Not from the notes. It says that the ruptured membranes, it says clear. It was clear. No meconium.

Q. Meconium is significant enough to have part of the summary of the delivery room record. The

hospital specifically has a place for you to check whether meconium was present at any time during the delivery; is that right?

A. Yes, sir.

Q. And in this case nothing was checked in regard to meconium; was there?

A. No, not that I can see, no.

Q. And so if meconium is a sign of unusual stress on the baby during the delivery, that was not a sign present in this case; was it?

A. No, not that I can remember, no, sir.

Q. All right. Now, another feature of a delivery that nurses pay attention to is how well a baby's heart responds to a mother having contractions; is that right?

A. Yes.

Q. What you want to see is that every time that the mother has a contraction, the baby's heart rate goes up; is that right?

A. Yes, that's shows good viability, yes.

Q. Generally speaking?

A. Yes.

Q. So if the baby's heart rate, baseline heart rate is 125 to 130, you would like to see it go up at least 15 beats per minute?

A. Yes.

Q. Now, in this particular case, from what you've seen in terms of the fetal heart tone monitoring strip, this baby's heart rate is exactly that. Every time the mother has contractions, the baby's heart rate would go up, with the exception of that one time it decelerated to nine; is that right?

A. To 90, yes, sir.

Q. To 90, that's what I meant to say.

A. Yes.

Q. So and that should be because, at that particular point in time, the baby has -- I mean, the possibility is -- and that's all we can say --

A. Right.

Q. -- isn't it, is that for that one time the baby had rolled over and compressed the umbilical cord?

MR. WEATHERLY: Objection. Calls for speculation.

THE WITNESS: Possibly. But there are times too when the baby's heart rate goes down, we're pushing because there's head compression.

BY MR. HENSHAW:

Q. Just from pushing?

A. Yes, sir. There's --

Q. So a onetime deceleration is not particularly concerning to an experienced labor and delivery nurse such as yourself; is it?

A. No.

Q. It was not concerning enough where you felt like you needed to call Dr. Giep and tell him about that; was it?

A. No, but usually -- well, go ahead. I'm sorry.

Q. Sorry. Go ahead.

A. Well, I don't know for sure in this case particularly, but a lot of times the doctors would sit at the -- outside -- in the nurse's station there's monitors there, a big screen with everyone's -- the strips printed on the screen so they can see what's going on.

Q. I understand. But it was not something that you felt like you needed to call him or go to him and discuss with him when it occurred that one time?

A. Yes.

Q. You did or did not go?

A. No. I'm sorry. No, I didn't. I was in the room with the patient. No, so I didn't, no.

Q. And, in fact, it was the kind of situation that nurses are allowed to take a nursing

action in order to correct it; is that right?

A. Yes. We have interventions that we do, you know.

Q. Nursing interventions?

A. Yes.

Q. And in this case the nursing intervention was to roll the mother over on one of her sides?

A. Correct.

Q. Is that right? Sorry?

A. Correct. Yes, yes.

Q. And you got a positive response from that; didn't you?

A. Yes.

Q. The babies heart rate began responding again to mother's contractions just the way she was supposed to; is that right?

A. Correct. Yes.

Q. Now, Dr. Giep was not in the room yet when all of that happened; was he?

A. It doesn't look like it, not when I was doing the interventions, no.

Q. Okay. And the -- you took the interventions, and by the time he arrived the baby's heart was back to doing what was considered to be helping; is that right?

A. Yes, it looks like he came in at -- yeah, the 2011 and it came up for a couple of minutes, yes.

Q. All right. So he's there and does it appear to you that he's there because the mother is ready to deliver, that her cervix has expanded to the maximum point. The baby is crowning; that is, the baby at least a portion of the baby's head is beginning to show. And the expectation is that with a few pushes by the mother, in combination with her contractions, the baby should deliver. Is that right?

A. Yes.

Q. And that's when the doctor gets called because he needs to be the one who's going to catch the baby; is that right?

A. Right. We wouldn't want the head to be too -- I didn't like the head to be too much crowning before they come in because I didn't want to deliver the baby, right.

Q. Because some babies will just slip through. And if the doctor or somebody's not there to catch it, the baby could fall to the floor.

A. Right. But I don't remember specifically where the baby's head was, if it was crowning or what at this point. I don't remember.

Q. But Dr. Giep is there. And under normal

circumstances, do you remember in this case whether he began to move the mother into a position where he could stand between her leg and catch the baby?

A. Yes. Usually that's the sequence of events, yes.

Q. All right. Did that entail putting the mother's legs up into stirrups?

A. Yes.

Q. And you had to convert the bed in order to put the stirrups onto the bed so she could do that; is that right?

A. Yes. Usually the lower part of the bed would drop down, it would be removed and then we would put her legs in the stirrups.

Q. And while some of that was being done, Dr. Giep would have gloved and gowned himself so that he could be more sterile as he caught the baby?

A. Correct.

Q. So he was in place and then something happened where he realized that the baby was not coming out as expected; is that right?

A. Yes.

Q. Do you know whether he actually declared during that that he had recognized shoulder dystocia?

A. I can't remember specifically, but

usually they say, you know, "Prepare for a shoulder dystocia."

Q. All right. Now, had he applied the vacuum extractor at that point?

A. Not that I can remember. I just --

Q. So did he apply the vacuum extractor after he identified shoulder dystocia?

A. I don't remember. Usually they say, "Prepare for a shoulder dystocia," and then that's when they -- we get the patient in position, and they apply the vacuum.

Q. All right. So if he identified that there had been shoulder dystocia, do you understand that that means that the baby's head was all the way out and up to the neck?

A. I couldn't see the baby's head at that point. I don't remember.

Q. All right. But do you understand that the definition of shoulder dystocia means that the baby's head was out?

A. Not -- I mean not necessarily they can see signs of turtling.

Q. Well, the baby's head comes out, and then kind of retracts back in, but the baby's head had come out?

A. Yeah, I guess. I don't know. I didn't see it. Sorry.

Q. But, as a nurse, is that what you usually understand is that the baby's head has come out, but the body is not coming out?

A. Yes.

Q. So Dr. Giep applies the vacuum extractor to the baby's head, and you've got that noted in your Nurse's Progress Record of Exhibit 2; is that right?

A. That the vacuum was applied?

Q. Yes.

A. Yes, at 20:18.

Q. All right. Now, you have and what you wrote there, that's in your handwriting and signed by you?

A. Yes, sir. It looks like it, yes, sir.

Q. "Vacuum applied by Dr. Giep." Is that what you said?

A. Yes.

Q. And then you wrote "two pulls?"

A. "Times two pulls," yes. It looks like it, yes, sir.

Q. "Times two pulls?"

A. Yes, sir.

Q. And then your signature?

A. Yes, sir.
Q. And then is it correct that when you wrote two pulls, that means that the vacuum extractor popped off at least one time?
A. No. It's pulls, so he's pulling with his arms, so I don't remember a popoff. That's not what that is.
Q. Well, in your deposition, do you have that?
A. Yes.
MR. WEATHERLY: Charles, she doesn't have it in front of her. We don't --
MR. HENSHAW: Do you have a copy that you can put in front of her?
THE WITNESS: Okay. I have one, yes, sir.
BY MR. HENSHAW:
Q. All right. Just one minute. Let me find the page. Now, you actually don't recollect -- you stated earlier that the vacuum extractor did not pop off or that you did not write that it popped off, but you don't really have a recollection as to whether it popped off or not; do you?
A. I don't remember, no. I'm sorry.
Q. Okay. And if the vacuum extractor did

come off, would you normally indicate "vacuum twice" on this record?

A. If it had popped off?

Q. Well, no, just if it had come off?

A. Well, I can't really -- you can usually hear a popoff, that's when I would usually document it. But if it had come off and I didn't hear it, I wouldn't have known because I can't see his hands.

Q. Well, turn to page 81 of your deposition?

A. Okay. Okay.

Q. And did I ask you, "If it had come off and had to be reapplied, would you normally indicate 'vacuum twice' on this record?" And didn't you say, "Usually or a popoff, yes, usually?"

A. Okay. So the question was, "If it'd come off and had been reapplied, you would normally indicate 'vacuum twice' on the record?" Yes. Or -- yes.

Q. And you were under oath when you gave this testimony at least a year ago?

A. Yes, sir.

Q. Now, in addition to indicating that -- well, in this case where you put two pulls, does that mean you saw Dr. Giep with the vacuum extractor in place, and he pulled twice using the vacuum extractor?

A. Yes, that I can remember or what's in the

notes. Yes. I'm going by what the notes says, yes.

Q. All right. So there was some pulling force with the vacuum extractor itself; is that right?

A. Yes.

Q. And he was unsuccessful in delivering the baby using the vacuum extractor and pulling twice on the baby's head; is that right?

A. I don't remember. I don't recall.

Q. Well, is that the way the notes read, that he was unsuccessful with his two pulls by the vacuum extractor?

A. It doesn't say that in my notes.

Q. All right. Well, after the 20:18 note --

A. Yes, sir.

Q. -- you wrote a note "suprapubic pressure applied for shoulder dystocia?"

A. Okay. Right.

Q. Is that right?

A. Yes.

Q. You would not have done that if he had been successful in pulling the baby out with the vacuum extractor; would you?

A. Okay. No.

Q. So, by circumstance, at least as an experienced nurse, you would have to say these notes

indicate that he pulls once with the vacuum extractor, but was not successful in delivering the baby; is that right?

A. I would assume, so.

Q. That's most likely what happened?

A. Yes.

Q. And you were the nurse who applied the suprapubic pressure; is that right?

A. Yes, sir. It looks like it, yes.

Q. And, by doing that, you took your hand and placed it down on through the pubic -- to the mother's pubic bone underneath the drapes that were across her legs and abdomen?

A. Yes.

Q. And pressed down when Dr. Giep told you to press down; is that right?

A. Yes.

Q. And did you understand as a nurse that what was hoped would happen would be that you would be able to compress the baby's shoulder so much that it would release the baby and allow for the delivery?

A. Yes, that was what was hoped, yes, sir.

Q. Okay. You were not pressing down to try to push on the baby's head. You were pushing down to press on the baby's shoulder; is that right?

A. Yes.

Q. And do you know whether or not your application of suprapubic pressure released the baby or not?

A. I don't know. They usually say "stop," you know, with the suprapubic pressure when it's released, the shoulder is released.

Q. Okay. So, well, do you know whether or not your application of suprapubic pressure did compress the shoulder enough to release the baby?

A. I couldn't tell you. I wasn't at that vantage point. I don't know. I couldn't see the baby's head.

Q. All right. Now, while you were applying suprapubic pressure -- well, first of all, is that a situation where you have to apply a considerable amount of force downward to try to release the shoulder?

A. Yes.

Q. In some situations you actually will get in bed with the mother on top in order to apply enough pressure; is that right?

A. In some situations, yes, on the mother's side, yes.

Q. Okay. And in some situations you'll get up on a stool --

A. (Nods head affirmatively.)
Q. -- to be able to get enough leverage to apply that kind of pressure --
A. (Nods head affirmatively.)
Q. -- to try the release the shoulder; is that right?
A. Yes, sir.
Q. Okay. And in this case you used the stool; is that right?
A. I would assume so, yes.
Q. Okay. Now, during your application of the pressure, are you concentrating to be able to get your hand in the right place and be able to apply the pressure in a considerable way?
A. Yes. That's my main job so I'm trying to --
Q. Okay.
A. -- yeah, right at that moment.
Q. While you're doing that, Dr. Giep is -- has his hands -- or had his hands around the baby's head; is that right?
A. I don't -- I would assume so, but I don't know. I couldn't see his hands.
Q. Okay. So whether he was -- had his hands around the baby's head, you don't know whether that's

the case?

A. Not in this particular moment, no. I'm sorry. No.

Q. Whether he bent the baby's head downward, you don't know because you couldn't see that; is that right?

A. Right. I was concentrating on putting suprapubic pressure down towards the mother's --

Q. Right.

A. -- pubic bone.

Q. Whether or not he bent the baby's head upwards, you don't know that either; do you?

A. No, sir.

Q. All right. And whether or not he was applying traction to the baby's head, you don't know that either?

A. I couldn't tell you, no, sir.

Q. I'm sorry?

A. No, sir.

Q. Because you are concentrating on your main job, which is to apply pressure to the baby's shoulder; is that right?

A. Yes, sir.

Q. The baby did come out. Do you know whether Dr. Giep used any type of turning motions or

sweeping motions inside the mother's birth canal with his hands?

A. No, I don't know.

Q. What you do know is that the procedures that are utilized by doctors to release a baby from shoulder dystocia is that he did use the McRoberts' procedure, which is the pull the mother's legs back up toward her head?

A. Yes, that's part of the protocol.

Q. And he directed you to apply suprapubic pressure; is that right?

A. Yes, sir.

Q. That's a yes?

A. Yes.

Q. Whether or not he used a procedure called the Rubin's procedure or any other, the corkscrew maneuver, you don't know whether he did that or not; do you?

A. No.

Q. And it's not noted in your record as to whether he did those other procedures?

A. No, it's not noted.

Q. Okay. The baby delivered at 8:20 p.m.; is that right?

A. Yes, sir, it looks like it.

Q. And you noted that there had been vacuum extraction on the Summary of Delivery Room Record, which is Exhibit 1, Defendants Exhibit 1; is that right?

A. Right. "Complications: Shoulder dystocia and vacuum."

Q. But when it comes to other methods, such as rotation, you don't have that checked; do you?

A. On this particular record, they don't have those itemized things that you can check.

Q. Well, look at in the middle of the page --

A. Yes, sir.

Q. -- under "vaginal delivery?"

A. Yes, sir.

Q. And it has a checkmark in one, and you've checked "vacuum extraction?"

A. Let's see. Vaginal delivery.

Q. Right in the middle of the page --

A. Yes. Forceps, yes.

Q. -- on the right-hand side.

A. Yes. Rotation, yes. Okay. Yes. I see, yes.

Q. All right.

A. And "rotation," yeah.

Q. So rotation --
A. Yes.
Q. -- is on this page?
A. Okay. You're right.
Q. And you did not check it?
A. No.
Q. So you neither observed rotation and apparently Dr. Giep did not tell you that he had used rotation?
A. Right.
Q. Forceps is not checked, so you neither observed the use of forceps and Dr. Giep did not tell you that he used forceps?
A. Right.
Q. And, of course, this would not be considered a spontaneous delivery because of the complication of the shoulder dystocia; right?
A. Right.
Q. You noted that under "Anesthesia" that there had been an epidural, but that had been done considerably before the delivery and the shoulder dystocia; is that right?
A. Right.
Q. You noted that an episiotomy was cut by Dr. Giep?

A. Right. And that's something he would have told me.

Q. He did it one degree off the midline or -- well, he did -- well, explain to me what he did in terms of an episiotomy?

A. Like I said, that's something he would have told me. I wouldn't have seen it.

Q. Okay. And episiotomy is where he makes a cut in order to give more expansion of the birth canal; is that right?

A. Correct, yes.

Q. This baby, once it's delivered, the cord had to be cut. And one of the things, if a baby -- if a baby appears to have suffered from lack of oxygen, one of the things that normally will be ordered is a cord blood gas; is that right?

A. Normally, yes.

Q. But in this case there was no cord blood gas ordered; is that right?

A. From what I'm looking at in the documentation, no.

Q. Okay. So apparently nobody felt like that this baby was suffering from a depravation of oxygen such that it needed to best tested to determine whether the baby was adequately oxygenated?

MR. WEATHERLY: Objection. Speculation.
BY MR. HENSHAW:
Q. Well, go ahead and answer.
A. Okay. I'm sorry. Could you re-ask the question? I'm sorry.
Q. I'll try to rephrase it or repeat it. From the circumstances of this record, it does not appear that anybody was concerned enough about the baby's oxygenation that a cord blood gas was ordered?
A. Right. That would have come from the doctor, yes.
Q. All right. So the doctors didn't do that?
A. No, not to my knowledge.
Q. And that could have come from either Dr. Giep or it could have come from the doctor who was on the resuscitation team; is that right?
A. Yes.
Q. And do you recall the resuscitation team being present at the point that this baby delivered?
A. Yes.
Q. And was the baby handed over immediately to the resuscitation team?
A. Yes.
Q. And in terms of what the resuscitation

team did, is it indicated that, in terms of oxygenation, they simply bolt-suctioned the baby's mouth?

A. Where would that -- yes. Resuscitation, yes, sir.

Q. Now, other things that were -- that could have been done if they felt it necessary would have been to actually put an oxygen mask over the baby to be able to feed it oxygen; isn't that right?

A. Right. But I don't remember what they did. I wasn't -- the NICU team was around the baby doing the resuscitation.

Q. Well, I understand that, but if you go down to your Summary of Delivery Room Record, in which you are gathering information about what happened, there is a place for what type of resuscitation is done; isn't --

A. Right.

Q. -- that right?

A. Correct. Because that's -- yeah, because I saw the doctor had the baby and he was bulb suctioning, and that's all I saw or would remember.

Q. All right. So, you know, if they needed to inform you that they needed to put a mask over the baby and resuscitate it, they didn't do that because

you didn't check "Bag & Mask." Did you?

A. Right. Because I didn't see it and they didn't relay that message to me to document it.

Q. Right. One of the things that can be done in order to oxygenate a newborn baby is to actually put an airway tube or intubate the baby with an airway tube?

A. Right.

Q. And you didn't check that either; did you?

A. No.

Q. And, in fact, you don't even have -- where you could have checked "oxygen," which would have just simply been putting blow-by oxygen near the baby's face, that's not checked neither; is it?

A. No.

Q. Now, you saw the baby because you walked by the bassinet where they had done the resuscitation; is that right?

A. Yes, very briefly.

Q. But in passing by the baby's bassinet, you did not note anything wrong the baby's arm or any particular abnormalities about the baby following the delivery?

A. No, sir, because the NICU team was taking

care of the infant. At that point, I was focussed on the mom.

Q. Right. And, in fact, were the circumstances such that you would not want to be hanging around the bassinet admiring the baby, looking at the baby, inspecting the baby, because that was not your job; that was the job of the resuscitation team and you basically needed to get out of their way.

A. Right.

Q. So if the baby did have a problem with its arm, it's not unusual that you would not have noticed it under the circumstances that you were involved with the baby's delivery; is that right?

A. Would I have noticed it?

Q. Yeah.

A. Usually, but I don't recall in this -- I don't recall in this circumstance. I don't remember.

MR. HENSHAW: Okay. I believe that's all the questions that I have for you, Ms. Phillips. Thank you very much.

THE WITNESS: Okay. You're welcome.

REDIRECT EXAMINATION BY MR. WEATHERLY:

Q. Ms. Phillips, I have a couple of follow-up questions --

A. Yes.

Q. -- for you. Mr. Henshaw had asked you a series of questions about the vacuum and whether or not you remembered a popoff, and he pointed you to one section of your deposition. I would like for you to turn to another section of your deposition. If you could turn to page 102, please.

A. Okay.

Q. Okay. And this is the same deposition where you were under oath back in January 2016; is that right?

A. Yes.

Q. Okay. I'm going to start on line eight, and I'm going to read a question that you were asked and ask you to give the response that you gave then. And you were first asked, "I had a question about the two pulls that is marked at 20:18." And what was your response?

A. "Yes."

Q. And was that the same pulls that Mr. Henshaw was asking you about?

A. Yes.

Q. Okay. And then you were asked, "And tell me if I understood this correctly, is a popoff where you apply the pressure of the vacuum, you pull on the vacuum, and the suction pump at the end of the vacuum

actually pops off the child's head. Is that different than a 'pull.'" What was your response?

A. "Yes."

Q. And is that the same testimony you gave here testimony?

A. Yes.

Q. And then you were asked, "Tell me what the difference is," and what did you say in your testimony then?

A. It says, "A pull is the vacuum. It's still applied to the baby's head and is not relieve -- doesn't relieve the suction, that I remember. I don't remember a popoff."

Q. And is that the same testimony you gave here today?

A. Yes.

Q. And then you were asked, "Did I understand correctly that your documentation of two pulls was based on you viewing Dr. Giep?" Now, what was your response?

A. I said, "His arm movement."

Q. And is that the same testimony you've given here today?

A. Yes.

Q. And then you were asked, "His arm

movement, did you ever hear a popoff during his application of the vacuum?" And what was your response?

A. "Not that I can remember."

Q. And that is -- is that the same testimony that you've given here today?

A. Yes.

Q. I have two more questions for you. You were asked some questions about the training that physicians undergo to treat a shoulder dystocia and whether or not that can avoid injuries to the child.

Have you done any research into brachial plexus injuries, both with or without a shoulder dystocia?

A. Not really, no.

Q. Do you have any personal knowledge as to whether or not brachial plexus injuries are avoidable in every case, even if the doctor does everything within the standard of care?

A. It's -- yeah, sometimes it's not avoidable.

MR. WEATHERLY: I don't have any further questions, ma'am. Thank you.

MR. HENSHAW: Thank you, Ms. Phillips.

DR. JOSEPH M. ERNEST, III

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. LOVELL:

Q. Dr. Ernest, tell us your name, please.

A. My name is Joseph McDonald Ernest, III. I go by Mack.

Q. Scoot up just a little bit there so we can hear you. Tell us where you went to school to become a doctor.

A. I went to school at William Carey College in Hattiesburg, Mississippi. I went to medical school at the University of Mississippi. When I finished medical school I came to Charlotte, did residency at Carolina's Medical Center. When I finished there, I went to Wake Forest University, which was then called Bowman Gray School of Medicine.

In Winston/Salem did a fellowship in maternal fetal medicine. I stayed on the faculty there for 26 years. I then went back to Charlotte to be the chairman of the department at Carolinas for six years and retired in 2014.

Q. And, Doctor, you mentioned maternal fetal. Is that your area of specialty?

A. Yes.

Q. And are you board certified in that area?

A. I'm board certified in obstetrics and gynecology and maternal fetal medicine.

Q. In your experience and all, do you teach doctors to do what obstetricians and gynecologists do when delivering babies?

A. I teach medical students, residents and

practicing physicians, yes.

Q. And have you in that teaching also used any devices to help kind of figure out the forces that are applied when doing deliveries, whether they're shoulder dystocia or otherwise?

A. We teach by feel, so in the beginning doctors learn how to feel with their hands on the baby's head and my hands around them to help them understand how much traction is appropriate. I then observe them. We also have simulators. We have those in Winston/Salem. We have very advanced simulation there in Charlotte where we had a full manacan that we would do delivery -- would teach deliveries.

And we actually had a device that we can measure the traction of the force that was being applied by the physician. We could set it so it could be a normal delivery or a shoulder dystocia type delivery and you can monitor and measure the force. And we would use that to teach how much force is appropriate.

Q. And, Doctor, were you involved yourself in the use of that device that you just -- this manacan thing you talked about and using it and making it work and measuring forces and studying the amount of forces that you applied?

A. Yeah. We used it for resident teaching and we

had courses that we would have practicing physicians come in to give them ideas about how much traction they were applying. We have a resident that did a research project with it, looking at different types of traction forces.

Q. Now, you gave us your educational background. Have you ever been on -- we've heard about board certification, I assume you are.

A. Yes.

Q. And you're board certified in what?

A. In obstetrics, gynecology and maternal fetal medicine.

Q. Have you ever been involved in being the person who gives the test for those, any of those?

A. Yes. I was a board examiner for between 15 and 20 years, which meant that I was on the team that was the final decision about whether a person became board certified. Those were done in Chicago and in Dallas. And we would go for a week. Several hundred of us would go for a week and we would examine 20 or 30 doctors that wanted to be board certified.

Q. Fair to say you delivered some babies in your day?

A. Yes.

Q. How many?

A. Several thousand. I delivered probably one to 2,000 myself. And then I observed or assisted with several thousand more.

Q. And in your teaching of doctors, learning how people do it, delivering of babies, are you familiar with the standard of care of what most obstetricians do when they're faced with a shoulder dystocia event or fetal distress or just in general when delivering babies?

A. Yes.

Q. Have you had occasion in your experience to encounter this shoulder dystocia condition?

A. Yes.

Q. Tell us about that.

A. Well, we -- one of the first things we teach and one of the first things I learned when I was a resident was how to manage a shoulder dystocia. That's -- that's generally the thing -- one of the first things you do the first week you start residency. And, actually, some of us got that as students.

And so you experience it. It's unpredictable. And so you have to learn it from the very beginning so that if you're the highest level of person in the delivery room at the time the shoulder dystocia occurs, you know how to handle it.

So I had those all through residency, and then I had them as a practicing physician in Winston/Salem. I had those in Charlotte. And I taught and observed residents managing those and taught them how to manage them as well.

Q. How many have you seen in your career, either directly when you're doing the primary delivery and the watching other folks?

A. Dozens, maybe hundreds.

Q. Did some of those involve permanent injuries?

A. Yes.

Q. And the ones that involved permanent injury, were you the one that was the primary delivery doctor?

A. There were two that I recall. One was as a resident. And as a resident you don't get a chance to follow the patient for months and months after they go home. The extent of the injury I think was probably permanent but I didn't have a one-year followup to know. I had a second patient when I was practicing that I delivered myself that had an injury that lasted several months and I think was permanent but I'm not sure because, again, I didn't have the, the full of range to follow that one up either.

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

labor and delivery of babies with and without shoulder dystocia. Also, in the area of, I guess it would be, biomechanics of the forces involved in labor and delivery, as well as his experience in measuring the forces applied by physicians in general.

MR. HENSHAW: No objection to his qualifications as an expert in obstetrics. I would object to his qualifications as a -- in biomechanics. He hasn't laid any foundation indicating that he has that.

THE COURT: All right. Lay some foundation.

BY MR. LOVELL:

Q. Let's talk about the biomechanics of delivery. Have you through your study in engineering, edu -- I mean, study, education and experience learned about the forces that are applied by the mom, the maternal forces during the labor process when the baby starts moving down those cardinal stages of labor?

A. Yes, I have. We, in many deliveries, insert a catheter into the uterus that measures the intrauterine pressure. And the pressure that's generated by the uterus and by the contractions and by McRoberts, which also generates pressure or force, are the endogenous forces which are the maternal forces that happen on the baby. It pushed the baby down the birth canal. So we, we use those to determine how to proceed with the

delivery.

And then the exogenous forces, which are the ones that the delivering person applies, I've done again by my experience. I taught it and I observed it and then we measured it in our simulation lab, both in Winston/Salem and in Charlotte.

Q. And you used the term we, Doctor. Does that include you, along with other people that are working with you in all these studies with both the endogenous and the exogenous ones?

A. Right.

MR. LOVELL: Your Honor, we would again tender him as an expert in biomechanics.

MR. HENSHAW: If I may, Your Honor?

THE COURT: All right.

VOIR DIRE EXAMINATION

BY MR. HENSHAW:

Q. Doctor, have you published any of these studies?

A. We had one, one study that was presented at a state medical meeting that the resident chose not to publish that.

Q. And that was a resident study, not your study?

A. That was a resident study that I helped with, yes.

Q. All right. And what was the specifics of that

study?

A. The specifics were that we measured the different traction forces by physicians to see if they could gage when they were getting up to a level that would be excessive. And that's what we -- that's what she presented at that meeting.

Q. So you have not had a study that's been peer reviewed?

A. That's correct.

Q. And so the methodologies that you've chosen to use have not been subjected to peer reviewers who determine by way of publication or for purposes of publication whether or not it's scientifically valid?

A. It was reviewed by the people that decided to invite her to speak at the meeting. It was not peer reviewed in the sense that it was published. So it had a review, but not the type of peer review for publication.

MR. HENSHAW: Same objection, Your Honor.

THE COURT: All right. Mr. Lovell, let me ask you this. Do you intend to ask him about these pressures and forces or is this going to be based on his own training and experience or somebody else's?

MR. LOVELL: Well, I'm gonna ask him some questions about the pressures and forces in his

experience on the mother's maternal forces. And he told us about the study he has participated in and live body deliveries with that, so that comes with his experience and training. The others come from his experience and training in the study he assisted the resident on that.

THE COURT: All right. Well, I'm gonna, I'm gonna permit him to testify about those matters if he can testify to it of his own personal training and experience.

MR. LOVELL: Sure. Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

BY MR. LOVELL:

Q. Doctor, have you served as an expert before today?

A. Yes, sir.

Q. How many times?

A. I've reviewed probably 3 or 400 cases. I've been in court two or three dozen times. And I've probably given 40 or 50 depositions.

Q. And do you always do it just for lawyers like me representing the physician?

A. I do it on behalf -- I've reviewed cases for both defense and plaintiffs.

Q. And are compensated for your time when doing so?

A. Yes.

Q. What percentage of your total income do you make doing this expert witness testimony?

A. It varies from year to year. I don't know what it will be this year. I have other income from retirement. I have income from presentations with a pharmaceutical company, so it varies from year to year.

Q. When you were practicing medicine actively before you retired, how much of your income was from expert income?

A. Probably 10 to 15 percent.

Q. We hired you in this case. Have you reviewed the medical records from Spartanburg related to her labor and delivery, prenatal course, the depositions of all the family members, including mom, dad, grandmother, the deposition of Dr. Giep, all the other expert depositions?

A. Yes.

Q. And were you here in court hearing the testimony all day today I take it?

A. Yes.

Q. From all of the information you gathered, do you have enough information to where you feel comfortable giving an opinion about the standard of care and potentially the cause or the contributing factors to the injury in the child?

A. Yes.
Q. And can you give us all of those opinions to the reasonable degree of medical certainty or probability?
A. Yes.
Q. All right. Doctor, I want to show you very, very briefly the board that has been in evidence and the jury has seen it. It is this one here. Are you familiar with this board? (Indicating.)
A. Yes.
Q. In fairness, is this something that you provided me as an example of the cardinal movements of labor?
A. Yes.
Q. In this movements of labor, we've heard testimony already about what happens to the baby, but describe for us from your experience and training and the things that you've done studying the degree of forces that apply to the baby during the time it's moving down towards the baby down towards the outlet.
A. Can I come up there and point it out?
Q. Yeah. I'm gonna get a thing to put it on. So, Doctor, when we do this you gotta -- you saw how Dr. Giep had to stand. I'll put this here and you stand where I'm standing. And talk so the court reporter can see your face. And I'll give you a pointer.
(Whereupon, witness leaves witness stand.)

A. Okay. When the baby comes down the birth canal, it has to twist and turn and move his head and rotate to fit. It's not a straight tube because there are obstructions that the baby has to pass. And the cardinal movements of labor are what we use to teach medical students and residents and juries about how babies get from inside to outside.

And the things I wanted to show you were one of the positions right here. This little area here is the pubic bone. And it actually is an arch. It looks like this. But if you look at it in cross section, it's just a round circle. So if you think about that as an arch or an upside down V, the baby has to get under that.

And in order to get under that, if the shoulders come down straight, they don't fit because the shoulders will get caught behind it. You can see right here the shoulder is behind it. And so if the baby continued to go straight down, that shoulder would be caught there. And that's what happens with the shoulder dystocia.

So what the baby has to do is it has to rotate. And you can see in this picture, that's what that baby's done. You see the shoulder has rotated around. So what you've been hearing today is the different maneuvers that you use when we recognize that the shoulder has been caught behind the pubic bone, but the head

continues to come down. (Indicating.)

It's a little bit of a different concept. If you think about going to get your haircut. When you're in that chair that the stylist or the barber pushes up, because it pushes on your spine, you start going up in the chair. And if there were something on your shoulder that kept you from going up ---

MR. HENSHAW: Your Honor, he used the word your and to speak in that way directly to the jury is inappropriate.

THE COURT: All right. Don't inject the jury into your statement, please.

THE WITNESS: When I am in the chair and the woman who cuts my hair pumps that chair, I move up. If there was something on my shoulder that kept my shoulder from moving with my body, my spine, my neck, and my head, the nerves in my shoulder, my brachial plexus would continue to go up, but my shoulder would stay put. And that's what happens in a shoulder dystocia.

And that's what happens when you see what you've heard about in the turtle spine. The baby is being pushed up and the spine and the body and the nerves and the head are all moving at different rates than the shoulder because the shoulder has been stuck behind the pubic bone. So the brachial plexus can get stretched at

that time. So what we need to do when we recognize that, when we recognize that the head is retracting back and we apply gentle traction and there's no movement of the baby's shoulders after the head comes out, we do maneuvers to try to rotate and get that shoulder, which is here into this position. (Indicating.)

Some other things we do is McRoberts. We pull the legs back. That not only opens up the pelvis a bit and also put pressure inside the mother's abdomen to help push the baby down a little bit more. We do suprapubic pressure by pushing -- and I'm gonna have to come over here. We push our fists -- and Ms. Phillips was saying that on her video. We put our fists right here on the abdomen and we push to try to get that shoulder to rotate. That's what suprapubic is.

Sometimes we try to reach in and we try to reach in to get the posterior arm because if you can get the arm out, then the shoulders are narrower and they can get in better. Sometimes then if we can't do that, we do the rotational maneuver. And the Rubin maneuver is one where we push on the back of the shoulder to try to collapse or reduce the width of the shoulders to get them to come out.

Sometimes we push forward. That's the wood screw maneuver. We try to rotate the baby. And by rotating

the baby, we're again turning the baby to get it in this position. So as long as the shoulder is here, it doesn't tend to come out. And our goal is to do maneuvers to get the baby into this position so the baby can come out. (Indicating.)

BY MR. LOVELL:

Q. Have you, Doctor, done studies where you all have measured the amount of forces that the contractions from the mother's uterus create on the baby, and this is before the head ever gets down, or when she's doing the pushing, pushing that the nurses are telling, or let's say even up until the time of maybe that initial McRoberts thing when they're lifting the leg back? Have you all studied that?

A. Those studies have been done. I have done pressure measurements inside the uterus. People have taken those measurements further and they've actually measured the pressure of the contractions and they've measured the pressure as the mother pushes down called Valsalva. And they're measurements where the McRoberts is done.

Q. How is this measurement done on the inside of a person? First let me ask, is it a live person who's pregnant and about to have a baby?

A. Right. We routinely put a pressure catheter in

when we're not sure labor is adequate. It's just a little tube that slides up next to the baby's head in the uterus and it measures the pressure inside when women have contractions. That tells us how much Pitocin to give, if we're giving Pitocin, or whether the labor's adequate. Studies have taken it a bit further and used a different type of sensor and they measure the pressure and the contractions and with the mother pushing down and with the McRoberts.

Q. In your experience from what you've done and you've learned in doing those things, how much pressure can the mom's forces of either the involuntarily contractions or the push, push, push or the McRoberts, how much force can that put on a baby as it's coming down before it ever gets to the point where we've got a hung up shoulder?

A. The easiest way is to write that down. Can I use the flip chart?

Q. Let me get it. Let's move it where folks can see. And again, Doctor, I'm gonna scoot this one down a little bit. If you could stand where the court reporter can hear you.

A. Force is measured in different ways. Force can be measured in pounds, which we can relate to. Force is also measured in Newtons.

THE COURT: I'm sorry, but we're not hearing over here.

THE WITNESS: Oh, I'm sorry. Force can be measured in pounds or it can be measured in Newtons. And some studies give it -- give the force in Newtons and some in pounds. Just for reference, if you hear me say Newtons, one pound equals four Newtons. And so sometimes we talk about Newtons in pounds, but when people -- when studies have been done measuring the internal force before the doctor ever gets their hands on the baby, they found that there are about 160 Newtons. These are the endogenous forces. These are the ones inside that the mother and the uterus and the McRoberts generate. 160 Newtons. That equals about 40 pounds.

So before anybody gets to touch the baby, that's how much force has been generated on the baby or the head or the shoulder, if the shoulder's impacted. That's the force that we know is happening before the baby gets out.

Now, people have also measured exogenous forces. And there are a lot of studies. Dr. Allen has done studies with these that you heard, I think, testify. Dr. Gherman has done these studies. But there have been very few that have measured how much we actually pull on

babies. The most I have found in the literature on a real live human that anybody's pull is 135 Newtons. And that was a paper published in 2010.

So this is what we know is internal. The most I've seen reported is 135. That equates to about 35 or so pounds. The one other number that I think -- well, that's plenty of that. But this is internal forces. The most I've seen reported is that, and that's external forces that the doctor would generate. (Indicating.)

Q. Now, Doctor, if this amount of forces is being generated as 1600 -- 160 Newtons or 40 pounds by mom and the contractions and the McRoberts lifting of the leg, do you have an opinion where there is a threshold that you accept as a threshold for an injury to nerves in a baby's brachial plexus?

A. Well, it's not my opinion. There have been very few studies on humans to know what type of force can actually injure a baby. We know that stretch can injure the nerve and we know compression can injure a nerve. And so it's impossible to measure that, that level on live humans. They get it done on cadavers, on stillborn babies.

The number that I've seen, and really the only number I've seen in humans, and these were, these were babies that had died either during labor or after birth

was about 190 Newtons. So this is a -- again, this is a study with humans, but it's not a study with live humans. We can't measure that with live humans.

Q. Okay. And what's this in pounds, roughly?

A. Well, we divide that by four, so that would be about 45.

Q. So, Doctor, if a baby is subjected to this degree of pounds with the contractions and the push, push and the McRoberts and the threshold is this, the doctor is applying normal gentle traction, as you've studied and understood it, is there a lot of room for potential pressure that can create this injury?

A. There's not. And that's why I think it's -- for years we couldn't figure out why somebody who's had injury that didn't seem to have excessive traction and others did. And as we study more about what's going on inside, it makes more sense. If this is going on before we ever get to the baby and this is the level that we may start seeing injury, it doesn't take a lot of traction, and as a matter of fact, well within the normal range of traction for some babies to be injured.

Different babies have different levels of susceptibility to injury. We know that. And so, if this is the level that we have to use as a potential injury, this is what's already going on if you just

generate five or ten pounds more, which is well within the normal range for a delivery, then some babies are gonna be injured.

Q. And, Doctor, can the condition of the baby while it's in the mom with low muscle tone, can that affect that threshold for injury that we've got here?

A. Yes. That's been shown in studies that if babies are depressed at birth, measured in different ways, and they don't have the muscle tone to protect their nerves, they're more susceptible to injury.

Q. And from your review of all this stuff that we sent you on this and what you've seen, was Ashley Flowers suffering from some degree of not normal muscle tone?

A. She was either limp or flaccid, depending on your definition. And that was based on what Dr. Giep saw when he delivered her and that's what the neonatology team said when they did their apgar scores.

Q. So we heard earlier in this trial a statement that when an injury that's permanent occurs in a baby, that it has to be because the doctor either applied greater than 35 pounds of traction and/or in combination with an angulation of delivery downward of more than, I think, it's 40, 45 degrees. Do you agree with that as a valid statement?

A. That is not a valid statement.
Q. Explain to us why or why not.
A. It's just not true. There is no evidence, there's no scientific evidence that an injury by itself tells you that there is an excessive force generated by the doctor. That just -- it just doesn't exist.
Q. Is the extent of the injury, the number of nerves that might be damaged or the residual deficit that the child might have as a result of a brachial plexus event, is that indicative of the amount of forces that the doctor applied or the direction in which the doctor applies it?
A. No.
Q. And why do you say that?
A. There is no evidence that the extent of the injury reflects the degree of traction or the angle at which the traction was applied.
Q. Let's talk about Dr. Giep's -- actually, thank you, Doctor, you can go back.
A. Thank you.
(Whereupon, witness returned to witness stand.)
Q. Actions when delivering this child. First I'll ask, do you have an opinion whether or not Dr. Giep, his actions in delivering the child and the forces that he used and the direction of the application of those

forces was within the standard of care of what most obstetricians would have done under the circumstances he was presented with in this delivery?

A. Yes.

Q. What are your opinions?

A. That he acted well within the standard of care and used very good judgment to deliver this baby.

Q. And from what you saw on all the evidence you reviewed, was there any evidence to suggest that he used excessive downward angle of lateral traction when delivering the child?

A. I see nothing to indicate he used lateral traction. You used two different terms there and I think that may be a little more confusing. We normally apply downward traction, but we don't apply lateral traction. If we're delivering a baby and we're pulling like this, it's normal to pull down but you don't flex. You pull down at an angle, but you don't bend the head because if you bend the head and have the ear go towards the shoulder, that stretches this brachial plexus.

So it's okay to pull this way and it's okay to pull this way, but it's not okay to pull this way. And I don't see anything in what I read or what he said or what he understands he's supposed to do or what others saw, that he did anything but pull in the right

direction. (Indicating.)

Q. You see in his notes both on the day of delivery and a day and a half later where he indicated minimal traction applied on the day -- he wrote the note on the day of the delivery. Gentle constant on the other one. Is that the description of forces that are within the standard of care?

A. Yes.

Q. Now, there was some questions asked of Nurse Phillips about this exhibit, this summary of delivery room record, I think it was. Are there, Doctor, are you familiar with those types of forms?

A. Yes.

Q. And on there it lists several checked boxes. First, is there a check box on there for doing a Rubin II maneuver?

A. No.

Q. Or a wood screw maneuver?

A. No.

Q. It has on there forceps rotation and some other checks -- boxes that are not checked. Does, in your opinion, do those apply to the -- a notation of a rotation maneuver such as a Rubin II or a wood screw?

A. No. This, this box rotation refers to a procedure where we can put forceps around a baby's head

and rotate the head. It has nothing to do with the Rubins or a shoulder dystocia at all.

Q. Doctor, do you have an opinion as to what was the cause of Ashley Flowers brachial plexus injury that she suffered or has suffered from after this delivery?

A. Yes.

Q. All right. Tell us about that.

A. I think it's most likely a stretch and/or compression injury during the process of the labor and delivery. I see nothing to indicate that Dr. Giep was the reason for that injury, and so I think it was a labor and delivery issue.

Q. And is that a combination of the maternal forces of contraction and push, push and the McRoberts and everything else that sort of occurred, and did that contribute to this injury?

A. It could have been strictly the endogenous forces or it could have been a combination. I see nothing to indicate that it was because Dr. Giep did anything wrong.

Q. Thank you, Doctor. Please answer any questions the Plaintiffs may have.

CROSS-EXAMINATION

BY MR. HENSHAW:

Q. Doctor, did you bring the data with you today?

A. What data is that?
Q. Huh?
A. What data is that?
Q. The data of the endogenous forces that you say that you've compiled.
A. No, sir. I didn't compile those. Those are articles that were published in the peer review literature.
Q. What articles?
A. Where are they?
Q. What are they?
A. The article that I'm referring to there for the 160 is an article about Bhumichi (phonetic).
Q. Where is it? Did you bring it today?
A. It's on my computer.
Q. Okay. On your computer?
A. Yes, sir.
Q. And when was it written?
A. When was it written? I don't remember the exact date of publication.
Q. That was not your study?
A. No, sir. It was published in the peer review literature.
Q. You don't have a study?
A. I don't have a study, no, sir.

Q. You're not a biomedical engineer?
A. No, sir. I'm a medical physician that delivers babies.
Q. Have you worked with a biomedical engineer?
A. I have read many of the biomedical engineer literature, but I've not worked with one personally.
Q. Have you ---
A. No.
Q. You have not worked with one personally?
A. No, sir.
Q. You testify quite often; is that right? You've had about, what, how many cases?
A. I've reviewed 300 to 400. And I probably on court two or three dozen times.
Q. And your rate for services?
A. Is $400 an hour.
Q. How many hours have you had in this?
A. I have not added them up. I don't know.
Q. When we took your deposition you didn't mention any of these articles, did you?
A. I don't know that we discussed those then.
Q. Well, so you came into this case, you had opinions, you were named as an expert, but you did not have these opinions at the time we took your deposition; is that right?

A. Well, I had these opinions. I've -- this is published well known literature.

Q. But you did not state any of these opinions in your deposition, did you?

A. The opinions about the endogenous forces?

Q. Yes.

A. I don't remember specifically whether we talked about endogenous or not.

Q. And you were asked what you were gonna talk about in this case and you said I'm gonna talk about standards of care and causation.

A. That's correct. And this is part of the causation issue, yes.

Q. I understand. And you understood when we took your deposition that when you were asked about what you were going to say you were expected to tell us truthfully what you were gonna test -- in completeness what you were going to say. And you didn't say anything about this, did you?

A. I'm not sure you asked me about this.

Q. I did ask you about what you were going to say, didn't I?

A. I don't know that I could have told you every single thing I was going to say because I'm not sure what you or Mr. Lovell would ask me. We talked about

standard of care. We talked about causation. This is part of that.

Q. Any other articles?

A. If you ask a question -- well, there's another article referred to there about the exogenous forces.

Q. Not your article though?

A. No, sir. That was published in a journal, but I did not write that one, no, sir.

Q. And you told the jury earlier that you have actually studied this yourself by placing some type of sensor device inside the uterus that would give you some idea about the maternal forces.

A. No, sir. What I said was I have used entry and pressure catheters which are the same methodology to measure the intrauterine pressure which was part of the study that I mentioned by Bhumichi which measured the intrauterine pressure as part of this study that came up with 160 Newtons.

Q. And you did that with a resident when you put these intrauterine devices in?

A. No. We do that with a lot of deliveries when we are inducing labor or we're measuring the adequacy of labor.

Q. And you collected the data and attempted to publish it or not?

A. No. There's no publication in this. This is a clinical process that we do to measure the intrauterine pressure.

Q. Now, do you have that data with you today?

A. I can tell you what it shows, but I don't have any data because it's a clinical experience over a number of years.

Q. You can tell us what it shows, but you're not able to actually let us verify it by looking at the data?

A. The data comes from probably 2 to 3,000 deliveries and my experience that the intrauterine pressure is similar to what was measured in the article, so I can validate it myself that the pressure that they generated in these 22 patients was what I would have expected so that when I look to see what the endogenous forces are I can believe that article.

Q. Now, one of the things that's different between endogenous and exogenous is the head does not appear; is that right?

A. The endogenous is before the head comes out, yes. And the exogenous is after, yes.

Q. Which means that the birth canal is aligning the head with the spine in those cases; isn't that correct?

A. It usually does that. Not always, but it does

that most of the time.

Q. All right. And by doing that, if there are maternal forces from the uterus on the baby, by aligning the head with the spine it is evenly placing those forces on the various parts of the baby's body that can be compressed?

A. No.

Q. It is spreading out. It is distributing the pressures?

A. Well, they're uneven because the baby's head is rotating and it's flexing, so there are differential forces on the brachial plexus depending on where the baby is in the delivery process.

Q. From a biomechanical standpoint, it would be expected that the pressures would be even on the shoulders and on the crown of the head, is that not correct?

A. It ---

Q. It's a dispersement of -- it's a dispersement of force.

A. It depends on where the baby's head is. Before the baby's head descends that would be correct. As the baby's head descends and turns and flexes, then those forces are probably gonna be somewhat different.

Q. And so when the baby's head comes out and the

doctor places his hands on the baby's head, then he at that point is in a position to control the forces that can be applied to the shoulders, is that not correct?

A. Not all of them, but some of them, yes.

Q. All right.

A. Because the mother is still pushing and the Valsalva is affecting the force on that shoulder. And there's compression going on. There's McRoberts going on. But some of the force will be directed by the delivering doctor, yes.

Q. And he can displace these forces that will affect the nerve roots that are in the shoulder whether he keeps the head straight or whether he turns the head; isn't that correct?

A. No.

Q. If he applies lateral traction, you don't believe that that can displace the forces and damage one shoulder and protect the other?

A. Those are -- there were two different questions there. The lateral traction, the lateral deviation increases the stretch on the brachial plexus and can cause injury, but it doesn't displace the forces that are already there because those forces are gonna be there whether he does lateral traction or not. So he doesn't do anything to displace the forces that are

already being present.

Those endogenous forces, the maternal forces, what he's doing is changing the direction of the force, bringing the shoulder under the pubic bone to minimize the force that the mother and the uterus and the McRoberts are generating, but he's not really displacing them.

Q. Well, Doctor, can we just -- don't you agree that it's just common sense that if you position the head down so that it stretches the nerves on one shoulder, the nerves on the other shoulder are not under that same type of pressure? They're not under any -- they're under either no pressure or very little pressure. Do you not agree with that?

A. That's a different question but, yes, that is correct.

Q. All right. So the doctor is controlling where the forces will be applied and where they will be directed and he can create, by how he positions the head, he can create forces that can do damage in one shoulder and not the other?

A. He's not displacing the forces coming from inside.

Q. I understand that, Doctor.

A. He is directing the forces that are being

generated on the outside, yes.

Q. But he is creating forces that will cause damage to one shoulder and not the other?

A. If he applies lateral traction or pulls too hard, he can create traction that can cause injury, that's correct. That didn't happen here, but that's possible.

Q. Well, you don't know whether it happened here because you don't do any studies of the cervical nerves yourself. You've not ever done an examination of those nerves, have you?

A. I don't think anybody's ever studied the cervical nerves to see what kind of traction causes injury on live humans. But, no, I haven't done that.

Q. Not live humans, but they've done it in cadavers.

A. That was -- there have been very few studies in baby cadavers, yes.

Q. And they've -- and there's a study out of Sweden that involved, what, 100,000 births that --

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

Q. -- validated or documented what can happen when lateral traction is applied.

A. Are you referring to the Malburg study?

Q. I just know it's out of Sweden. Is that a -- are you familiar with that?

A. There are many, many studies out of Sweden, so

I'm not sure to which one you refer. But there is one by a doctor named Malburg. It was not a study looking at nerves. It was a study in which they asked the delivering midwife or doctor to estimate how much force they generated and they tried to come up with some connection with whether the traction would cause an injury. They had different delivery processes there, but if that's the Malburg study, then that was a Swedish study that looked at deliveries, but not in nerves per se.

Q. Now, Doctor, do you agree that the standard of care in the United States in October of 2008 was not to apply excessive force during the delivery of a shoulder dystocia?

A. That's correct.

Q. Do you agree that the standard of care in the United States was not to apply excessive -- excuse me, lateral traction during the delivery of a shoulder dystocia?

A. Lateral flexion, yes. Flexion is the key. Not -- I think traction and flexion can be confusing because, again, downward does not mean lateral. So what you don't want to do is bend the head so that the ear goes towards the shoulder, but you do pull down. So lateral flexion is what we want to avoid.

Q. Well, Doctor, you're familiar with natal brachial plexus palsy?

A. Uh-huh, yes.

Q. And published by the American College of Obstetrics and Gynecology?

A. Yes.

Q. And are you familiar with the glossary?

A. Yes.

Q. And do you agree with this statement: Lateral traction, a pulling force that also bends the fetus' neck by moving the ear toward the posterior shoulder, thereby opening the contract -- contralateral angle of the neck increasing strain on the brachial plexus, sometimes referred to as lateral bending, downward lateral bending or downward lateral traction. Do you accept that as the definition of lateral traction?

A. That is a definition of lateral traction. But I want to make sure it's clear that what we're talking about is bending. The bending is the key. The flexion is the key. Not the fact that the traction is downward. It's the fact that it's the bending that can cause the injury.

Q. Because it creates more stretch in the opposite shoulder, the one's that's hung on the, in this case, on the suprapubic bone.

A. Yes.
Q. Is that correct?
A. Yes.
Q. And do you agree with the glossary definition of this manual that excessive traction is a pulling force that is greater than the inherent strength of the fetal brachial plexus?
A. That's a good definition. In relation to the nerves, there are other definitions that excessive traction in relation to how much the doctor generates, but that is a definition that is specific to the nerves and how much they can tolerate because we know that some nerves can tolerate more traction than others.
Q. And do you agree that axial traction shall be defined as a pulling force applied in alignment with the fetal cervicothoracic spine, sometimes referred to as a downward axial traction?
A. Yes, that's a good definition.
Q. And so if we were to incorporate these terms into the standards of care, it would be acceptable care for a doctor to utilize axial traction; that is, keep the baby's head in alignment with the spine during the delivery?
A. That would be pulling straight, yes, rather than bending.

Q. Well, straight depends upon when you mean -- when you say straight, that means in alignment with the spine?

A. That's correct.

Q. Because if you really pull straight out, you would have elevated the baby's head in a way that was inappropriate; isn't that correct?

A. Not necessarily. That would be horizontal. Straight would be in relation to the actual spine.

Q. Okay.

A. And bending would be bending the head so that the ear is next to the shoulder.

Q. And that, again, lateral traction would be a deviation from standard medical care in 2008 during delivery of a shoulder dystocia.

A. Uh-huh. That's correct.

Q. Correct?

A. Yes.

Q. All right. And the standard of care is more -- it even goes further than that and requires that the amount of traction should be no more than what would be done in a routine normal delivery; is that correct?

A. Well, there are different levels of traction that would be applied in a routine normal delivery. So what we would -- what would be a better way to look at that

would be to say don't use more than you need, but try to stay within the range that you have used for the other 3,000, 5,000 deliveries that you've performed.

Q. Well, in Britain do they not say that routine traction is the same degree of traction applied during a normal delivery?

A. They may say that in Britain and that may be a good definition in Britain. I think that the key in the standard of care is not to use more than you need and excessively be more than you need. Sometimes you need just enough to keep the baby from dropping on the floor. Sometimes you need enough to apply to help the baby out. Sometimes you need enough to save the baby's life. There are different levels of that, all of which could be in a standard delivery.

Q. Now, and so one of the things that has to be considered are the circumstances of that delivery. And in this particular case, did you see any need where Dr. Giep needed to sacrifice the arm in order to spare the baby?

A. I did not.

Q. And so he would not need to apply, and it would be outside the standard of care if he applied traction to such a degree that he sacrificed the arm in this case; isn't that correct?

A. That's correct.
Q. Do you agree with that?
A. I would agree with that, yes.
Q. Doctor, do you agree that in this case there were ruptures of C-5, C-6 and C-7?
A. They did not see them, but they suspected that from the neuroma that they took out.
Q. Doctor, do you agree that there was significant stretching of C-8 to the point that it caused scarring formation around the C-8 nerve root?
A. I don't know that the neurosurgeon said there was stretching. I think what he said was that the C-8 was encased in that scar, which is called a neuroma, and it was not working until they removed the scar and it began working again.
Q. Did you ---
A. So I don't know that he had any comment about the stretching of it.
Q. Did you not read his deposition where he specifically stated that it was because of stretching?
A. I read the operative note. And I don't remember what he said in his deposition, but in the operative note they said that when they dissected out the neuroma, that the nerve C-8 began working. But I don't remember specifically what he said in his deposition.

Q. And, Doctor, in terms of -- or do you recognize that respiratory efforts can be affected by damage caused by injury to C-3, C-4, C-5?

A. Yes. That's the phrenic. Those are components of the phrenic nerve.

Q. And did you find in this record that there was a problem with Ashley's phrenic nerve, most probable?

A. Yes.

Q. And is that most probably the result of whatever forces were causing injury to these nerves?

A. Since it is a nerve next to those, probably the same force affected C-4, which is usually the phrenic nerve. And then five, six and seven.

Q. Okay. So you would agree that most probably that whatever was causing injury to these other nerves was causing her respiratory difficulties after birth?

A. That would be my suspicion because that is something that we see from time to time with a shoulder dystocia on a brachial plexus injury.

Q. So in effect, as a result of this birth, she had injuries to C-4, C-5, C-6, C-7 and C-8, five of the cervical nerves in the brachial plexus?

A. I think three of those were permanent, five, six and seven. I think four I don't think was permanent. And I think eight was not permanent, but they were all

affected by the delivery, yes.

Q. That's all the questions I have, thank you.

A. You're welcome.

REDIRECT EXAMINATION

BY MR. LOVELL:

Q. All of the nerves in the brachial plexus, are they affected by the maternal forces of either momma pushing, which I think you called Valvulva (sic)?

A. Valsalva.

Q. The contractions, and then the McRoberts?

A. Yes. Yes, they are.

Q. So whether it's C-3, C-4, C-5 or whatever, they're all affected by those forces?

A. They can be affected by those forces, by the endogenous forces, yes.

Q. And the nerves at the phrenic level and the C-8 level, just like the four -- I mean, the five, the six or the seven, would be protected if the muscle tone was normal, but if the muscle tone is less or if the baby is in distress, those likewise can be more susceptible to injury, that whole bunch?

A. Yes.

MR. LOVELL: That's all the questions I have.

THE COURT: You may step down.

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

Friday, October 13th, 2017

THE COURT: All right, gentlemen. Let's readdress the directed verdict motions.

MR. LOVELL: Thank you, Your Honor.

On behalf of Doctor Giep and Spartanburg Pelham OB-GYN, we would renew the directed verdict motions we made at the close of the plaintiff's case, and just to summarize those, Your Honor, in general, they were first that the defendants are entitled to directed verdict under 15-32-230, emergency statute.

We think the evidence has shown that occurred in this case, and that there's no evidence to support that this was an -- to suggest this was not a medical emergency as defined under the statute or that the doctor acted in gross negligence as we've argued earlier.

THE COURT: All right. That motion is denied. I think it's a question of fact.

MR. LOVELL: Secondly, Your Honor, on the issue of punitive damages, we renew our motion in regard for the same reasons we state.

THE COURT: What's the position of the plaintiff?

Punitive damages, are you withdrawing?

MR. HENSHAW: Your Honor, we will be withdrawing punitive damages.

THE COURT: All right. That's granted.

MR. LOVELL: On the issues of the gross negligence allegations, we move for a directed verdict on that as well.

THE COURT: What's the plaintiff's position?

MR. HENSHAW: Your Honor, we will also be withdrawing our allegations of gross negligence.

THE COURT: That motion is granted.

MR. LOVELL: Your Honor, we had made motions on certain of the damage elements, future medical expenses. We don't think sufficient testimony has been introduced as to the amount or cost of any of those for a jury to be able to reasonably conclude what those might be.

THE COURT: All right. What's the plaintiff's position?

MR. HENSHAW: In regard to future economic damages, Your Honor, we acknowledge that the evidence, at this point, is too speculative in order for the jury to take into---

THE COURT: All right. That motion is granted.

MR. HENSHAW: ---consideration.

MR. LOVELL: Your Honor, on the potential loss of future income of the child, we think there's been inadequate evidence in that regard as well.

MR. HENSHAW: The same thing---

THE COURT: Well, that's economic.

MR. HENSHAW: ---there, Your Honor.

THE COURT: That's economic. That's granted.

MR. LOVELL: And the final one, Your Honor, was on -- there was an allegation in the complaint of loss of income of the parents. There's no evidence to support that.

THE COURT: That's economic too. That's granted.

MR. HENSHAW: That -- well, we, we do think that there was economic loss by the parents as reflected by the billing summary, but that's the only factual evidence that's in -- the only facts that are in evidence at this time.

THE COURT: All right.

MR. LOVELL: And, Your Honor, one final point.

On the issue of the applicability of the medical emergency statute, 15-23 -- I think 15-32-230, we believe though that is a defense that has been raised in this case, both through the evidence pretrial, and then because, obviously, you've heard the evidence we've heard all week.

So, we would ask that the Court allow an amendment of our answer to incorporate that as an affirmative defense understanding that we do have the burden on that.

THE COURT: What's the plaintiff's position?

MR. HENSHAW: Your Honor, we agree that it has been -- that it has been litigated, that is through discovery and through this trial, and that it is---

THE COURT: No, no prejudice?

MR. HENSHAW: Sir?

THE COURT: No prejudice to the plaintiff?

MR. HENSHAW: No prejudice that it -- that it is being added as an affirmative defense. However, we do have a motion to strike it as an affirmative defense at the appropriate time.

THE COURT: All right. Motion to amend is granted.

MR. LOVELL: That's all from the defense, Your Honor.

THE COURT: All right. Mr. Henshaw.

MR. HENSHAW: Your Honor, we would now turn to exactly that and move to strike the affirmative defense as to the emergency medical statute. We do not believe, for several reasons, that it is applicable as a matter of law.

Number one, we believe that the section that provides that it is not to be applied in situations where there has been an ongoing physician/patient relationship is inclusive of all the other provisions of that statute. And since there was a -- it's been established, without any evidence to the contrary, that there was an ongoing relationship between Mrs. Flowers and the practice, we think that, for that reason, the statute is not applicable and that that affirmative defense should be struck.

In addition to that, Your Honor, we do not believe that it is applicable under Subsection -- because of Subsection C, which says the, the immunity shall not apply unless it is shown that there was an immediate risk of death or an

immediate risk of serious bodily injury. While we realize that one of the experts that was proffered by defense said that it should be applicable, and it was immediate, it was immediate, it -- there was no basis for that statement under the circumstances that the, the only -- there was no death that would of occurred within four to six minutes after the dystocia was recognized, and no serious bodily injury, which was, in this case, would have been brain injury that would have occurred within four to six minutes after the shoulder dystocia was recognized.

And, for that reason, we do not believe it's applicable as a matter of law. That is the overwhelming evidence in this case. And, for that reason, we would move to strike.

THE COURT: All right. Mr. Lovell.

MR. LOVELL: Your Honor, we believe that both Sections A and C of 15-32-230 are applicable under the facts of this case, and we prevented -- presented evidence from both Doctor Giep, Doctor Chauhan, Doctor Gower, and Doctor Arnett that it was a medically unstable scenario with a baby that was at immanent risk of serious bodily injury and/or death from the time of the dystocia through the time of the delivery with full body impairment.

MR. HENSHAW: Your Honor, I, I failed to also raise the constitutional issues that we want to raise in regard to that statute. It is a new statute. It came in under the

Medical Malpractice Reform Act of 2005. It has not been tested, to my knowledge, on a constitutional basis.

It clearly sets up categories of, of doctors and patients that are treated differently than other doctors and patients in the medical malpractice context. We believe that it denies equal protection to the categories that are raised without a rational basis, and we would ask the Court to declare the statute unconstitutional.

MR. LOVELL: Your Honor, we believe the statute is constitutional. It does establish a rational basis for legitimate governmental interest or community interest, and we think it's constitutional.

THE COURT: Well, I'll say this is my first encounter of a trial with this particular statute, and I've read it several times. And while I think, in some respects, it's somewhat confusing, it does appear to be addressing two of -- the Legislature appears, from the language, to be addressing two, what they consider, to be two separate and distinct situations. And the language would indicate that both in A, B, and in C when it says further the limitations on liability established under Sections A and B shall only apply where care is rendered prior to a patient's discharge.

So, they appear to be looking at it like it's two separate and distinct situations. B, obviously, relating to a physician with no previous doctor/patient relationship

with a patient. But Subsection A, which the defense contends is applicable, does say that, in an action involving medical malpractice arising out of care rendered in a genuine emergency situation, which is described in the statute, is immune from a medical malpractice claim unless gross negligence is shown, and it says no physician may be held liable unless under the circumstances as set forth in Subsection A.

So, based upon my reading of the statute, I think it's applicable. I do think that it, it is an affirmative defense. It has to be established by the defense, and, therefore, the motion to strike, it is denied.

Also, I don't see any constitutional depravation. Therefore, your motion to declare it unconstitutional is also denied.

All right. Anything else?

MR. HENSHAW: Not from the plaintiff, Your Honor.

MR. LOVELL: No, sir, Your Honor.

THE COURT: All right. Now, each of you have a copy of my proposed verdict form.

MR. LOVELL: Yes, sir.

MR. HENSHAW: Yes, we do.

THE COURT: Now that we've addressed the, the issues and narrowed those somewhat, is that form acceptable to both?

MR. LOVELL: It is acceptable to the defense, Your Honor.

MR. HENSHAW: Yes, Your Honor.

THE COURT: Okay. All right. Y'all ready for the jury?

MR. LOVELL: Yes, Your Honor.

THE COURT: Okay. Bring them in please.

THE COURT: Good morning, ladies and gentlemen.

As you know, when we recessed yesterday, all of the testimony and other evidence to be introduced in this case had been received, and, therefore, what remains to be done are the lawyer's final summations, after which I'll instruct you on the law, and then you'll begin with your deliberations in the case.

Now, the way that is accomplished, the plaintiff has the burden of proof. So, the plaintiff goes first in the final argument. After the plaintiff concludes, the defense has the opportunity to respond and to present argument as to the defense's position. And then the plaintiff is permitted a brief reply response to those matters brought out by the defendant. That way everybody has a chance to talk about the other's position and address it with the jury.

So, please give the lawyers your attention as they give you their final summations.

MR. HENSHAW: May it please the Court?

THE COURT: Mr. Henshaw.

MR. HENSHAW: Ladies and gentlemen, much of obstetrical medicine is about managing complications of pregnancy. When Treva Flowers became pregnant with Ashley in 2008, she encountered two of those complications, gestational diabetes and shoulder dystocia.

Gestational diabetes was properly managed by the doctors at Spartanburg & Pelham OB-GYN. The shoulder dystocia was not.

As a result, Ashley Flowers has permanent disfigurement and physical impairment of her left shoulder, arm, wrist, and hand. You, the jury, will now be deciding whether Doctor Bang Giep was negligent and committed malpractice on October 7th, 2008, at Spartanburg Regional Medical Center

when he delivered Ashley.

The law in South Carolina requires that every medical practitioner act according to generally recognized and accepted standards of care and do what would be expected of a reasonably competent practitioner under the same or similar circumstances.

Your verdict must be unanimous. You do not arrive at your verdict by majority decision. Each of you must be convinced, by a preponderance of the evidence, as to what happened, and then come together for a verdict that speaks the truth. Due deliberation and wisdom and judgment and common sense are the hallmarks of a true and just verdict. You have no friends to reward. You have no enemies to punish. You are the jury.

Treva Flowers, her husband, Tristan, wanted a baby. Tristan worked at Spartanburg Regional in the communications and was recommended to Spartanburg OB-GYN. Treva met every appointment, and did everything she was told. Tristan usually went with her to the office visits.

As you heard, he was there that night when they went to Spartanburg Regional Medical Center at 2:00 in the morning. Treva circulated through the different doctors in the practice. She mostly saw Doctor Ashley Fowler, but she saw Doctor Giep in her office three times before she delivered.

In about her 32 week of pregnancy, standard testing

showed that she had gestational diabetes, a complication of pregnancy that sometimes can cause babies to be large. Treva's, Treva's gestational diabetes was managed by diet. Otherwise, the pregnancy, the pregnancy went well and the baby developed normally.

The baby was considered big at about the 85-percent in size, but ultrasound showed there were no abnormalities.

Early on October 7, 2008, Treva's water broke at home. As planned, Tristan took her to Spartanburg Regional where she was admitted for her labor. She was admitted under the care of Doctor Fowler, who managed her throughout the day until about 7:00PM. Then Doctor Giep took over according to the schedule of the medical practice.

Doctor Giep held himself out as a specialist in obstetrics. He was trained to handle obstetrical complications such as shoulder dystocia, which, according to the evidence in this case, happens about one in every hundred deliveries.

For him, as a board certified obstetrician, shoulder dystocia was a foreseeable event. It wasn't gonna happen with every delivery, but it was something that he began to learn about in medical school and then in his residency and had experience with in the years before 2008, and knew that any pregnancy could result in shoulder dystocia.

He was trained in how to manage it, how to resolve it

so that a baby would not suffer injury as the result of his maneuvers.

By October 7 or by the time that -- excuse me. By the time that Doctor Giep arrived in the labor room, the baby's head was crowning meaning that the baby's scalp was beginning to appear between the mother's legs. Doctor Giep arrived in the labor and delivery room about 8:11PM. Treva had been laboring since about 2:00 in the morning. Her labor had been augmented by a drug called Oxytocin or Pitocin to promote her contractions.

At about 8:07PM, before Doctor Giep arrived, the external electronic fetal heart monitor showed that the baby's heart rate had decreased from a baseline of 125 beats per minute to 90 beats per minute. The labor and delivery nurse, Natalie, Natalie Phillips, stopped the Oxytocin.

When Doctor Giep arrived at 8:11PM, he had the mother turn on her right side hoping that the baby's heart rate would improve. He waited five minutes without doing anything at that point. Not that that was wrong, but he waited five minutes to see what would happen and then he restarted the Oxytocin.

He waited some more and, at 8:18PM, he applied a vacuum extractor to the baby's head. A vacuum extractor is sometimes called a Kiwi extractor, and he applied it to the baby's head and he pulled twice. At 8:19 -- at 8:19PM, the

baby's head was out of the birth canal.

This is all documented.

Is this on?

THE LAW CLERK: Press the power button.

MR. HENSHAW: There it goes.

What we have done, by agreement, is placed all of Ashley's medical records into evidence, and y'all are certainly welcome to go through it page by page if you'd like. But what we have done, by agreement, is each of us, each, when I say each, each lawyer has placed into evidence, under separate exhibit stickers, pages from these records that we think are the most important things for you to consider. And so you will find what I'm about to show you in these records. I believe it's Exhibit 9 or 10. And you'll be able to look at this and the other records.

And this is the record of Natalie Phillips. It's the nurse's progress note. And because of the way that evidence has to be presented, it may have seemed out of order or not necessarily in chronological fashion. But we, we -- when we got to Mrs. Phillips deposition yesterday, this is the record from which she testified, and this is the record that's in the mother's hospital record as to what happened that morning or that night on August 7th, 2008, and it's very informative as to what happened because it tells us the times of things, which, in this case, can become very

significant.

And so the part that, that I believe is most critical, and, again, my opinion is not that important, but in terms of me explaining what I think is most important, I think that it begins around 7:55 when she notes that the patient begins to push, and that means that the mother is entering the second phase of her labor. She's been laboring since about two o'clock in the morning, and now she has reached a point where she is fully dilated. She is -- the baby is head first down ready to come out, and the mother is beginning to push and that's at 7:55PM.

It's 12-minutes after that, at 8:07PM, that the nurse recognizes that the fetal heart tones have dropped into the 90s. Up until that point they had been around 125 beats per minute, which is average for a baby in-utero. That, of course, would not be a normal heart rate for an adult, but, for a baby that's not yet born, 125 beats is the average. And that was her baseline and she had maintained that for most of the day up until 8:07.

So, Natalie Lee Phillips, as she testified and she indicates in this record, made a nursing decision, which she was allowed to do, to decrease or stop the Oxytocin or the Pit drip and she did that because the babies -- and she says, for fetal heart tones in the 90s.

A minute later, she puts an, an oxygen mask on the

mother to let her get some oxygen to see whether or not that might improve the baby's heart rate and bring it back up above a hundred because that's what they want to do. They want to see the baby's heart rate above a hundred.

Then, at 2:10, she shuts down the Pit drip or the Oxytocin completely. She previously had decreased it, but now she -- now it is off. Again, because the fetal heart rate has remained in the 90s. So, that's approximately three minutes where the heart rate has been in the 90s.

Then, at 2:11, Doctor Giep comes into the room, and the patient is turned in her right side. Doctor Giep testified that he's the one that directed the patient be turned on her right side. It's a maneuver that both doctors and nurses can make in order to try to improve the baby's heart rate. Sometimes the baby will get in a position where they begin to compress the cord, and it makes the heart rate go down. And by moving the mother onto one side or the other, it can sometimes relieve that compression if that's what's going on.

So then he waits because the next entry by Mrs. Phillips is at 20:16, 8:16PM. Doctor Giep gives a verbal order to restart the Pitocin. He is explained, in this case, that he wants to move the baby. He wants to go ahead and get the delivery done.

The birth, the baby's fetal heart monitor strips

indicate that there has been some recovery in the baby's heartbeat by this time. And so apparently he feels that the baby can tolerate the mother having Pitocin. Pitocin is given to enhance the contractions. It's, it's given to increase the number of contractions early on. It's given to start the contractions. In this case, it's being given to enhance the contractions to try to push the baby out.

Then, two minutes later, he applies the vacuum or the Kiwi extractor to the baby's scalp and he pulls twice. That says times two pulls. And he pulls twice. And the baby's head comes out. And, under most circumstances, if there's not gonna be a complication, the body immediately follows, but it didn't in this case.

And so he's got the head out. And he realizes, apparently some time around 20:18, that he's got shoulder dystocia. And he realizes that because the body is not delivering. I don't believe that the turtle sign was documented, but there may have been what is called the turtling sign where the baby's head comes out and then recedes back. Not just up to the chin. Not completely. But it goes backwards instead of continuing to come forward, and that is good evidence, to a trained doctor like Doctor Giep, that he is now encountering a baby whose, whose one it -- whose shoulder, one of its shoulders, is being obstructed by the mother's pelvis.

In this case, it's pretty apparent that he believed that it was the left shoulder, the one that was highest up, the one that was closest to the front of the pelvis, that was being obstructed by the mother's pubic bone.

There's another form of shoulder dystocia where the baby's shoulder can get blocked by the spine, the bony spine, the prominences of the bony spine, but that's not what he thought here and that's what was occurring here. This was a shoulder dystocia where the baby's left shoulder was being blocked by the pubic bone, and we know that that's what he thought and because he then had Mrs. Phillips begin to apply suprapubic pressure.

She climbed up on a stool. Well, first they put the mother's legs into what is called the McRoberts position. It's called the McRoberts maneuver. And her legs were pulled back toward her chest. They were taken out of the stirrups and pulled back toward her chest, and then Mrs. Phillips climbed up on a stool, and with her hands, began to apply pressure downward just at or near -- right behind the pubic bone in order to release the shoulder, to try to get it to move, to unblock it, and that occurred at 20:19.

Now, please understand, up until this point, we have no criticism of what Doctor Giep did or what any of the doctors did at Spartanburg & Pelham OB-GYN. You've heard a

cross-examination of Doctor Gurewitsch in which the defense lawyer said let's go down everything they did right. And they started early in the pregnancy and named off everything that we had -- that we never said was done wrong, and it was a long list.

If a person gets in a car and they drive a hundred miles, and they stop at every light, and they yield at every yield sign and they stop at every stop sign, and they never go over the speed limit, they adhere to every rule, but then, after a hundred miles, after they've done all of that, they run a red light, are they responsible for the mistake?

The answer is yes.

They don't get to come in and say look at how many red lights I stopped at. Look at how many stop signs I stopped at. Look at how many yield signs I adhered to. Look at all these things I did right. So, don't hold me responsible for what I did wrong.

No, that's not the way it works. That's not the law, and that's the situation here.

Yes, Doctor Giep, the other doctors, they did a lot right. They don't -- unfortunately, they don't get credit for that when they did something wrong as severely as what happened next. They just don't.

And what happened next is this. Doctor Giep had his hands on the baby's head. He may of been sitting. He may

have stood up. Either way, the circumstances of this case are -- show that he pulled with excessive traction and pulled the baby's head away from the shoulder that was impacted by the pubic bone, and, by doing that, he ruptured the nerve roots at C5, C6, and C7. He stretched the -- and that was all my stretching, but then they ruptured. They got stretched so much they ruptured, and then the stretching was severe enough to damage C8, which then ultimately developed scarring called a neuroma and was also injured.

There's also an indication that temporary injuries were caused, those were all permanent, to the phrenic nerve, which runs down and affects the diaphragm and affects the baby's ability to breathe, and, for a considerable time and for -- during the hospitalization, treatment had to be given because Ashley had a paralyzed diaphragm and could not breathe properly and could not get adequate oxygenation.

The judge will tell you that circumstantial evidence is to be given the same weight and significance and can be accepted in the same way as direct evidence. Direct evidence is usually in the form of eye witness testimony. There is one eye witness in this case to what Doctor Giep did in regard to holding that baby's head, and, unfortunately, he's the one eye witness.

Every doctor that took the stand, every doctor that took the stand who said that they have ever, ever had an

opportunity to examine one of these cases and become involved, either on the plaintiff's side, my side, the patient's side, or on the defendant's side, Doctor Giep's side, said no doctor has ever admitted, ever admitted to applying too much traction or to applying what is called lateral traction where they bend the head downward away from the obstructed shoulder. They never do it.

So, in terms of direct evidence, it's, it's what it is. It's a doctor who doesn't want to be blamed for causing a permanent injury to a child and so they never admit it. Maybe they don't recognize it. Maybe they just want to cover it up. But, under any circumstances, direct -- the, the doctor's statement when he writes in I only used gentle traction, that's what you're gonna see every time that one of these things happens. And if that's all it takes to excuse what happened to my client or anybody else is for him to write gentle traction and then sign his name in order to escape responsibility for what happened, then we don't have a system of justice cause our system of justice says that, if you negligently injure someone, then you are responsible for compensating them for their injuries, to make them whole to the extent that compensation can make them whole. That's what our justice system requires.

So, I'm not saying that you can't believe Doctor Giep if that's what you conclude in your deliberations, if they

are good and complete deliberations. If that's what you conclude, that he did not pull too hard, that he did not bend that head away from the obstructed shoulder, you can conclude that and that would be based upon the direct evidence.

But I do suggest as well that the circumstantial evidence where we know that what happened to Ashley is that she ended up with these ruptured nerves, and that the arm appeared to have a brachial plexus injury immediately after birth, all of these circumstances indicate that something more than general traction was applied. And we -- and that -- and, in fact, the evidence preponderates in favor of finding that Doctor Giep did not apply general traction, that he applied excessive traction.

Now, you will recall that every witness who was an expert in obstetrics told you that it is the standard of care, generally recognized and accepted standard of care, that a reasonably competent physician, under these circumstances, should only apply the same amount of traction that they would apply in a normal delivery. It should never be more than that. That that is, in fact, the standard of care.

And so if this was excessive traction, and also -- they also told you that lateral traction, not the, the -- not to apply lateral traction is the generally recognized and

accepted standard of care. So, if the circumstances say to you, as a jury, that he did apply excessive force, that he did apply lateral traction, then that would be a deviation from standard medical care.

Just to refresh, this is the circumstances that amounts to a deviation from standard medical care. This is where lateral traction is on the head. Doctor Giep wants you to believe that he, by, by staying in a sitting position when he delivers the baby, he could not cause injury to the baby because he wouldn't be able, by sitting there, to pull hard enough. Really -- what he's really saying is to pull hard enough while he is in a seated position.

There is nothing about -- and staying in a seated position that prevents him from applying lateral traction while he's in a seated position if that's what he did. Again, that's his testimony that that -- he's the only one who knows that and to testify to that, but the circumstances, suggest whether he was seated or whether he was standing, he applied lateral traction to this baby's head, and that's what caused the brachial plexus injury when the shoulder was up against the pubic bone as indicated and shown by this illustration.

There are some circumstances where a doctor doesn't have a choice. There are some circumstances where the doctor is faced with the dilemma of either sacrificing the

arm or losing the baby. That was not one of these cases.

No expert found, when they looked at this situation, that the baby was facing that. Every expert said that was only going to happen if he got down the road four minutes or five minutes or six minutes after the diagnosis of shoulder dystocia, but the record indicates that it was only about a minute because the testimony was -- is that the reason that he had the nurse apply suprapubic pressure is cause that's when he diagnosed shoulder dystocia. The baby's head was out, the rest of the body would not come, and that occurred at 20:19, and, a minute later, after the suprapubic pressure was applied, he was able to deliver a viable infant.

So, he wasn't four minutes down the road or five minutes down the road or six minutes down the road. He was not in a place where he had to make that horrible decision do I sacrifice the arm in order to spare the baby. That wasn't what happened here. It wasn't that type of situation.

Now, we agree that this is called, when shoulder dystocia arises, and Doctor Gurewitsch testified to this, that this is called a obstetrical emergency, but it's an obstetrical emergency that does not pose immediate risk to life or immediate risk of death or an immediate risk of serious bodily injury. That would not happen until the baby was -- until the shoulder dystocia had been in existence for

at least four minutes.

Despite that, one of the questions that you're going to have and that you have to answer is was this a medical emergency that posed the immediate risk of death or the immediate risk of serious bodily injury because, in South Carolina, we have a statute that says that, in a obstetrical situation, in a labor and delivery suite, where there is a medical emergency, then the doctor is immune from any type of lawsuit like this that can hold him responsible.

And so, if you find that this baby was at immediate risk of death or at immediate risk of serious bodily injury because of the obstetrical emergency that occurred when she had shoulder dystocia, then Doctor Giep will have the burden. He'll be immune under those circumstances, and you have to make that decision, but it wasn't that type of emergency. It had not gotten to that far. He is not immune from being responsible for what happened to Ashley Flowers.

The defense has put up a lot of experts. People who knew Doctor Giep, who knew Doctor Giep's father, some of them. You're entitled to take into consideration the biases and prejudices of every, of every witness.

What was their demeanor on the stand?

How did they answer the questions?

Did they try to avoid answering questions?

Did they try to change the question and give an answer

to something that was not asked?

You're entitled to take all of that into consideration in your determination of whether or not the expert or the witness is believable. You do not make a decision based upon the number of witnesses that any side presents. This is not a popularity contest. Whoever brings in the most witnesses wins. That's not the way that it works.

You can believe part of a witness' testimony and disregard the rest as not believable. You can believe several witnesses and not believe one witness or you can believe one witness over many witnesses, and the ultimate goal is to arrive at the truth.

Your verdict must speak the truth, and you come to that as a deliberative body. You don't go back into the jury room and say let's take a vote and whoever has the most votes by the jury wins. That's not the way it works.

Everybody on the -- on a jury must, themselves, come to the belief of what is the truth, and then all 12 of you, collectively, must come to that same belief, and that will be your verdict. That will be your verdict and that takes deliberation. That takes -- and the reason that we have 12 people is because, in our experience in the American system of justice, we have found that bringing 12 people together who work together to try to arrive at the truth is the best way to arrive at the truth. We don't let one person make

that decision. We let 12 people make that decision. And it is absolutely amazing what the collective wisdom of a jury can do when they act in fairness, when they deliberate in the appropriate way, when they use their common sense and they come to a conclusion about what happened in a case like this.

The damages that we seek are these. You, you saw Ashley. We are convinced that Ashley will succeed in spite of her injury. She is a special little girl. We don't think that she will be hampered in a way that affects her ability to make a living, and we're not seeking economic damages for her working because we, frankly, believe that it would just be speculative as to whether she will not be able to make a living. If we could prove that, if she had the kind of injury where she couldn't go out and do work at all, we would be here asking you for economic damages for her working life, but that's not what we're gonna seek here. We don't seek that.

So, that will not be part of our damages in regard to Ashley. We will not be seeking economic damages.

Moreover, Doctor Armenta was only able to speculate or suggest, as a possibility, as to whether she will need surgery in the future, and there was no indication that he was able to give us indicating that. While he said there's a good chance, but not a probable chance at this point where

he can say for sure that she's going to need surgery. Even if he did, it would probably be when she is still a minor child. Maybe around the age of 15.

So, that will not be her responsibility. So, we're not seeking economic damages for her in regard to that surgery or that possible surgery either.

But what he is saying is, and what we believe is that, regardless of whether she has another surgery or not, she will still be a -- left with a deformity, and she will still be left with an impairment in terms of the every day, every moment use of her left-hand, and she will have to live with for the rest of her life.

And we have a mortality table that comes into play at this point that indicates that her expected life is about until age 80. And she's nine years old now. And she's 71 years from that. If she is dying at that time, she will still be looking at a deformed wrist and a deformed hand that bends upward that she will have lived with all of her life.

Now, at nine years old, she's a sweet, cute, beautiful little girl, and she'll grow into a sweet, beautiful young woman.

But will she still be as appealing to a young teenage boy when she has an arm like that?

We don't know, but human nature being what it is, is

that she will suffer some indignities, and she will still have to live with it. She'll still have to face it.

Will she still be coming home and saying why was I born with this?

Will she still be looking at her brother, who may grow in to be an All American himself like his older brother, and look at him and saying why am I the one?

And I think that your common sense tells you that, that, in all fairness, if we are going to recognize that she should be made whole, then those things should be considered. Her disability, her disfigurement should all be considered in terms of the damages that you seek. And I can't tell you what you should award for something like that because it's not, it's not economic. It's not where I can say oh, I've got a bill for this, and I can tell you how much this costs in the market place.

I don't know what 12 jurors -- I mean that's the reason that you're 12 and you're the ones who make the decision.

Is it a, is it a verdict of $500,000 that would make her whole?

Is it a verdict of a million dollars, two million dollars?

What is it, what is it worth not to suffer with that type of deformity for the rest of your life, for the next 70 some odd years, for the time period that you've already

suffered because the damages take into consideration not only the deformity itself, but the physical pain?

And she's had three surgeries. And every one of those surgeries has involved some pain. And the mental anguish and emotional distress. And we know to what extent that has been. Not to be able to tie a ponytail in your hair. To only be able to braid one side of your hair.

Is she gonna get asked to the prom?

And if she does, who's gonna dress her?

Who's gonna set -- who's gonna set her hair?

We do seek economic damages for the parents. By law, it is the responsibility of a parent to take care of their child, and when there are special needs, our law rewards the parents or awards the parents for what it has cost them, economically, to pay for those special needs.

So, we have an extended hospital, hospitalization immediately after birth. That's an economic damage. It's listed on our summary of the bills. We have the hospitalizations in Texas and this payment of the surgeons for the three surgeries that she's already had.

We've had physical therapy. We've had occupational therapy. We've had speech therapy related to the respiratory problem that she had, and all of that is listed and it comes to around $610,000. And that has all been the parent's responsibilities.

By law, we are not allowed to seek any award for the parents for their emotional pain from watching their child go through this. That's not what we're allowed to recover, and we don't seek that, but we are allowed to recover for that monetary expense and that's what those bills reflect. And they're entitled to get that back, and that's an exact number. And we seek every bit of that.

And, in fact, that billing summary was stipulated to as to the bills. They're not stipulating that we should recover it, but they are stipulating as to the amount that's stated in that billing summary. And you will have to consider that in deciding what your verdict should be.

You will have a verdict form and it will ask you questions, and the first question in my summary is do you find that Doctor Giep, on behalf of the defendants, was negligent and caused injury -- unnecessary injury or caused injury to Ashley Flowers. If you answer no, then that's a defense verdict. If you answer yes, you have other questions that you'll need to answer because the next question is whether or not this was an emergency situation in which the -- in which Ashley faced immediate death or immediate risk of death or immediate threat of death or threat of serious bodily injury.

Now, if you answer yes, then that's the defense verdict. If you answer no, then you go to the next

question, and the next question has to do with the damages. And you're asked about the damages sustained by Ashley Grace Flowers, and then -- and whether or not she has those damages, and then you decide what that will be. And then the fourth question is do you find that the parents, Treva and Tristan Flowers, have sustained damages because of Doctor Giep's negligence, and then you determine what that is and you place that if you so find.

Doctor Giep and Spartanburg & Pelham OB-GYN will be treated, for purposes of your verdict, as one party. The law in South Carolina is, is that you have an employer and you're -- and, during the course of your employment, you commit an act of negligence, then the employer is liable just as you are. And so we -- for purposes of your consideration, you will consider Spartanburg & Pelham OB-GYN and Doctor Giep to be the same party. And that's how you arrive at your verdict.

I get to speak to you one more time in response to the defense lawyer's closing argument. I want to thank you for the attention that you have given to all of us during this time. I hope that you recognize, and I'm sure Mr. Lovell will repeat this, how important this is to both sides, to both parties that whether one of the parties wins or loses, we all want to leave here feeling as though justice was done, that we got fairness from the jury, that we got due

consideration from the jury. And so we appeal to that and I thank you for you consideration.

THE COURT: Mr. Lovell.

MR. LOVELL: May it please the Court?

Morning, ladies and gentlemen.

On behalf of Doctor Giep and Spartanburg & Pelham OB-GYN, I want to thank you for the attention you've given us all week. We've tried to move things along, but it's been a long week. So, I want to thank you on their behalf.

Plaintiff's counsel is correct. In this case, you have really two major questions to answer. The first being was Doctor Giep negligent.

Did he commit a breach of the professional standard of care?

Was he -- did he commit malpractice?

That's kind of what it boils down to.

The judge will tell you that the burden of proof on that issue lies with the plaintiffs. They have to prove, to your satisfaction by a greater weight of the evidence, that Doctor Giep committed professional negligence.

The second question that you have to ask or answer and that the judge will ask you to answer is was this birth in a circumstance that is a medical emergency as the law in our state defines it. And the judge will tell you what the law is. He'll give you the definition of that, and that's a

question the judge will ask you to define.

What I want to do, very briefly, is kind of walk through some of the legal concepts that the judge will tell you in his charge, and then talk to you a little bit about the way they interact with the case.

So, on this issue of negligence, the judge will define for you that that requires that the plaintiff show that Doctor Giep deviated from the standard of care that was required of him as an obstetrician. The judge will tell you that and he'll define that term and he says was there care provided by my client, Doctor Giep, that didn't conform to the standard of medical care of most obstetricians. He'll tell you that a doctor like Doctor Giep only is required to bring reasonable care, skill, and diligence in his care of a patient under the circumstances he's faced with.

There's no magic formula that you plug in and the standard of care is always like that regardless of the circumstances, circumstances of the delivery or the labor. The standard of care that has to be required is what was Doctor Giep faced with on October the 7th of 2008.

The judge will also, I think, tell you that, when you're trying to assess whether Doctor Giep was complying with the standard of care, you can't use any hindsight. He'll tell you this is not a judgment that's made in hindsight after you know the, the results of what happened.

You can't look back and say oh, he should of done this, should of done that. You got to put yourself in the shoes of Doctor Giep at the time he's standing at the, at the patient's bedside or delivering the baby herself.

I think the judge will define the standard of medical care as applicable to be the generally recognized standards, practices, and procedures that were exercised by the average competent obstetrician under same or similar circumstances. And an important thing I think the judge will tell you is the standard of care can only be established through expert testimony.

I can't come in, as a nonmedical doctor, and say here's what the standard of care is. You have to have a medical degree or be a medical expert to do that. And one other thing the judge will tell you that you can not presume, from the outcome of an event or the fact that an injury occurred, that the doctor must have been negligent. It has to be proven by competent medical evidence. You can not infer that, solely because an injury occurred or there was an occurrence that nobody expected or wanted or a bad consequence of treatment, that the doctor was negligent. The law doesn't permit that.

The mere fact that a complication occurs is not, in and of itself the judge will tell you, sufficient to establish the issue of negligence. That burden of proof lies with the

plaintiffs.

And why -- why is that allowed?

The judge will tell you that medicine is an exact science. Some people call medicine an art, and, like anything in art, there's no precise way that things can be done. No precise way that it happens.

The judge will tell you that, because medicine is an act -- inexact science, that physicians are not held to absolute accuracy. They're not held to a standard of infallibility. They're not held to being required to provide the utmost perfect standard or perfect skill, and they're certainly not someone who's an ensurer of a beneficial result in any scenario where they're involved in providing care.

The judge will also, I believe, instruct you that the law says a physician is not liable for an error or mistake in judgment as long as he applies the ordinary and reasonable care, ordinary and reasonable care that is recognized and approved in the obstetrician field in general, the types of methods and manner of treatment that most obstetricians use.

So, I am gonna talk briefly now a little bit about the knowledge, the training, and the experience that Doctor Giep had, and it's important, ladies and gentlemen, from my prospective, that you understand that, when Doctor Giep came

into this delivery, he brought all of the skills that he had been trained on, the methods and manners that he had learned from medical school, through residency, through his practice, through his keeping up with medical literature, and all of those things, what he knew to do in a scenario when faced with medical emergencies, when faced with fetal heart tones. I know y'all probably got sick of hearing me ask about the depressed fetal heart tones and what could happen when a shoulder dystocia occurred, but those are the things that Doctor Giep was faced with.

So, the question is did Doctor Giep use the methods and procedures that most doctors would use, the types that he was trained on, when faced with the issues that arose during this delivery?

So, let's talk about that very briefly.

What did he do?

Well, we know that plaintiff's counsel and even their expert has agreed, when he came in, he assessed that fetal monitor and looked and noted that the heart rate had gone from about 120 down to about 90. Doctor Giep said that's about a 30-percent reduction in the blood flow of oxygenated blood to the body.

Did he do nothing about it?

Of course, not.

You saw that he exercised his skill, the training, and

knowledge, and did things to respond to that condition. He was concerned about it. He told you, and you've heard all the experts talk, and you'll have the fetal monitor strips. It was at 130. It had dropped down to 90. Then did a few things. It jumps up, but it drops back down, and it was persistently low. On up until the minute or so prior to the actual delivery, that fetal heart rate was not stable. It was not reassuring, which is one of the medical terms they use.

It was not something that felt -- that made the doctor feel comfortable with just allowing Mrs. Flowers to continue to push, push, and push until the baby was delivered, because a low heart rate can mean a lot of things, but it can end up in a scenario where a baby has got brain damage, the baby's got cerebral palsy, or the baby can die. And that's before shoulder dystocia ever occurs.

So, the doctor was concerned about it and did things about that.

What did he do?

He proceeded to go ahead and expedite the delivery, and you've heard every expert that got on this witness stand says that's the right thing to do. When you think it's gonna be a potential of time that the baby's gonna be in distress, you can't just sit there and do nothing cause you don't know how long that baby's reserve is gonna last. You

already know the reserve is weak because, for about eight minutes, nine minutes, ten minutes, I don't know the exact number, the heart rate's been kind of doing this, but it's staying down and that tank is beginning to become empty. The tank of reserve of the energy that the baby needs.

So, the doctor decides let's deliver this baby as quickly as I can. C-section, not an option. Too unsafe for you, mom. Too unsafe for baby. Takes too long to do it. I think I can help her assist the delivery. I can do the Pitocin, do the maneuvers, use the Kiwi, all of those things.

So, he acted appropriately and every expert, including Doctor Gurewitsch, plaintiff's expert, has come in and said he handled that stuff correctly. That shows you the skill and care and training and the knowledge base that Doctor Giep had.

What did he do at the time the baby's head had delivered?

Well, you heard him testify. He checked for a nuchal cord to see if that was the reason that this baby's heart rate was down, the cord wrapped around it sort of choking a little bit of the baby's blood flow. Nothing there.

I bulbed the baby's nose and mouth. He did that. Recognized that the shoulder dystocia had occurred, as he's observing the baby not coming out, and he's doing this test

traction, nothing's working, he's doing, as you heard every expert say, include theirs, what's required under the standard of care. What doctors who had been well trained know to do he did.

He requested, as you've seen a bunch, the timely application of the McRoberts maneuver, and you heard Nurse Phillips and Ms. White testify about what they do with that and the doctor talked -- and every witness said that's what you do. That's the first thing in the routine that doctors have been trained, let's go to McRoberts, let's see if that works. Unfortunately, in this situation, it did not.

What did they do next?

Doctor Giep says let's try the suprapubic pressure and he, with Nurse Phyllis, Phillips, assistance tried suprapubic pressure. Didn't work. You saw on the video that we showed the other with Doctor Chauhan how they do it. You saw, from Nurse Phillips video when she described how it worked, how they try to make it work and one is suppose to do in sort of moving the shoulder down. It didn't work.

Both after McRoberts and suprapubic, the doctor assessed the baby to see did it work, did it happen, did -- was it successful and no, it didn't occur.

So, he took his skills, he took his training, he took his knowledge and went to the next step, and he went ahead and decided that I will try to reach in and grab the baby's

arm and see if I can pull the shoulder myself. You saw it on the video how that works, how they take their fingers and kind of reach in. Didn't work. Couldn't grab it. I think you heard from, I think it was Docker Arnett said hard as heck to do it and it doesn't work a lot of times, that you can't reach far enough in, and the doctor described -- Doctor Giep describe that he then went to the Rubin II, the next maneuver in the list.

Now, you did hear from I think it was Doctor Arnett and maybe Doctor Gower that, when you get to those secondary maneuvers, there are several different ones you can use. You can use the Rubin II. You can do this thing called the Woods' Screw, either of which are acceptable. Doctor Giep told you he's trained in using the Rubin II that was the easiest for him to do. He can put his hand behind the baby and gently turn.

No witness has come in and said it's beneath the standard of care to try the Rubin II. Not even Doctor Gurewitsch or the Woods' screw, using the one. Fortunately, at this time, the Rubin II worked.

So, the doctor also showed you what else he did, and that was -- I apologize. I want to use my boards.

Let's see. The other thing that the doctor testified that he did do was use his skill and the way he was trained to apply minimum traction performed.

Now, he told you that he uses and used the same degree of force, the same degree of traction, whatever word you want to call it, that he uses on every delivery, whether it's the shoulder dystocia delivery or not, but he used minimum traction. He also told you that he used the same degree of manipulation of the head, this lateral traction or force or whatever -- anything you want to call it, but he always does.

You heard all of the doctors say, you know, babies aren't static. They're not like a shoe where you just pull things straight out. Babies usually move a little bit and you got to move their heads a little bit to try to move them down at the shoulder. You try to do everything to the minimum. You keep that axial traction as close as you can do it under the circumstances, but you can't see the whole baby's body when the head is only out, but he described what he did in the terms of the delivery itself and manipulation of the baby's body.

And that as he's sitting down there, he can not apply the 45-degrees of traction that Doctor Gurewitsch says she thinks he applied to cause an injury, and he certainly can not, as he's sitting on that wheeled stool, apply 35-pounds or greater traction that Doctor Gurewitsch says because he would be pulled into the mother, fall over off the stool, and, if he was leaning trying to do the traction, the stool

would fall over and he says he never does that. That's for y'all to decide if you believe what he's telling you.

We do know that, at the conclusion of all of his activities, the one thing that happened with the baby is, despite the fetal heart distress, the low heart rate, despite the shoulder dystocia, despite a period of time that the suprapubic and McRoberts didn't remove that, the baby was delivered without brain injury, did not have cerebral palsy from the low blood flow, did not have death.

And those are three things that can happen, and you heard all of the doctors talk about how quickly it can happen and how unpredictable it is. From the time a dystocia occurs, you don't have a crystal ball. You don't have the benefit of hindsight to say oh, she's gonna deliver in two minutes. I don't got to worry about brain death or injury. That that is a problem that you have to worry about immediately right then because you don't know how long this baby's gonna be able to withstand the forces of the dystocia, the lack of blood flow that occurred before the birth, about eight, or nine, or ten minutes, and certainly at the time the head is stuck in the mom's vaginal opening and compression there. You don't know how long this baby can hold out, especially one whose been in the scenario of six, seven, eight minutes. So, you got to do what you know and what is necessary to deliver the child at that point.

Now, I want to talk briefly about this issue of direct evidence and what the notes show. Excuse me.

Doctor Giep's note that I've got up here on the board, and at nine o'clock, and he read all the, the handwriting on it, he described using minimum traction. This is direct evidence. It was written at a time 20 minutes after the delivery of this child. Doctor Giep, probably it took some time to deliver the placenta that comes out after the baby and to do the episiotomies and do everything they do, but within 20 to 30 minutes he's writing his note, and he wrote, at that time, what he did.

The next day -- and all of these are in evidence. You'll see it on Exhibit 4 when you go back to your deliberations. The next, two days later he's meeting with the Flowers family, with mom and dad, talking about what happened.

He told them what he did, but he also wrote again gentle and constant traction applied to the infant's head. Again, that's direct evidence.

And you might ask well, maybe he's worried he's gonna get sued. Maybe he's worried about the time. Maybe he's just writing this as a CYA, but ask yourself this.

At the point in time when he's writing the first note, and at the point in time when he's writing the second note, 10/7, 10/9, he doesn't know that this is a permanent injury.

You've heard the testimony of everybody, including Doctor Gurewitsch, their expert, say that the majority of brachial plexus injuries, from whatever cause, shoulder dystocia or they can occur without shoulder dystocia, are temporary. They resolve within a period of days, weeks, months. Some of them might last a little longer, but all physicians, including Doctor Giep know these things are temporary. You don't worry about them because they're gonna get better most of the time.

So, he would have no motivation or fear of lawsuit that he's gonna be writing his CYA note. And I can promise you, if Doctor Giep were writing a CYA note, it would be a heck of a lot better then the two he wrote here.

Secondly, lady and -- ladies and gentlemen, you heard the issues Doctor Giep -- I'm sorry.

At the time all this was done, Doctor Giep doesn't even know the extent of the brachial plexus injury. You've heard a lot of the testimony from their experts and Doctor Armenta, who was sued three, four, five, six, seven, whatever the numbers were, but how do you do that at that point?

None of that was recognized until weeks and months later. So, Doctor Giep doesn't know the extent of the injury. He's writing this note because he's recording. As you heard Doctor Arnett say, well, Doctor Arnett testified

we write our notes and not have a dystocia. The beginning of my note I write the degree of traction or forces that I used, and he said, one of his where he used moderate force, he wrote moderate force in there, you can always write it at the beginning of the note, and I specifically asked Doctor Arnett, who's been practicing at that same hospital, where do you write it?

At the end of the note. He said right there.

You heard earlier, some question about well, no doctor ever writes that they use anything other than minimal traction. Doctor Arnett testified that he does, did, and that the scenario we have is permanent brachial plexus injury.

Does he write in the report what he did?

And I tell you that that's what Doctor Giep did. He recorded what he did in terms of applying the forces. He wasn't worried about lawyers, wasn't worried about things. Just writing what you did.

Now, back to these notes just briefly. Plaintiffs allege that, because Doctor Giep did not write in the note that he did a Rubin II maneuver, must not have happened. Not written. Didn't do it.

Well, let's take their same logic. If, if that's right, if you don't write something, you don't do it. The flip side is, I guess, is, if you wrote it down, that's what

you did.

So, we go with their logic. You got to write it down to say what you did. Clearly, the doctor wrote, twice in the note, I did apply minimum traction. I did apply a gentle and constant traction.

The other thing in terms of eye witnesses and direct testimony, the plaintiff's experts ignore, as has the presentation to you on the plaintiff's side of the case, direct testimony of people who were in the room.

I asked Doctor Allen, their witness, did you review the sworn deposition testimony of Grandmother Bowen, who was there seated and observing his delivery?

Yep.

Did you see the question that was asked, when you were observing Doctor Giep with his hands on the baby, did it appear that he was pulling the baby up towards the ceiling, down towards the floor, or straight out?

Her testimony was straight out.

Direct evidence.

You heard the testimony of Ms. White and Nurse Phillips yesterday, both of whom were in the room, admitted they're not seeing the doctor's hands inside of the vagina, but you heard them both say we could see his upper arms, his body. We could see his face.

He did not appear to do anything differently than every

other doctor we've ever watched do regular delivers or shoulder dystocia deliveries. He wasn't grimacing. He wasn't grunting. He wasn't panting. He wasn't flexing his arms. He was just doing what he's seen everybody else do, what every obstetrical -- obstetrician does under similar circumstances, circumstances, and situations. That's direct evidence, ladies and gentlemen.

Doctor Giep told you how he delivers the children, babies, when he's sitting on a stool. It's for you to decide, using your judgment and common sense, whether he would be able to apply 35 plus pounds of pressure or traction on a baby sitting on the stool. You heard Doctor Arnett said he's tried to do it. He can't do it.

It's for you to decide whether his position sitting on a stool, and you heard both Nurse Phillips and Ms. White say, he delivered the baby sitting on a stool. That's what the doctor said. Nobody's come in here and said he's standing up while he was doing all of these maneuvers. Sure, he's sitting on the stool. Once the baby is delivered, the whole body is out, he has to stand up to cut the cord and hand it to the NICU people. He does stand at that point, but everything else is done on the stool.

It's for you to decide would it be virtually impossible for him to be in that position doing the 35 plus pounds of traction that their expert said was where the cut-off line

for malpractice is or the greater than 45-degrees of downward traction, which is the cut-off line for malpractice. So, we've all decided that was reasonable and could occur.

One other thing that the plaintiffs seem to want to ignore about records and such, they read you a lot of quotations out of the part of the, I forgot what you call it, but part of -- the definitions part of that ACOG Task Force bulletin, the glossary. That was it. And they say oh, they went to every one of our experts, that I'm reading this glossary, and it defines such and such and such and such.

So, they want to rely on the glossary and what's written in the ACOG report when it supports what they think happened here, but they don't want to rely upon any portion of the ACOG report that doesn't fit their version of events about how these types of injuries occurred and what causes them.

I asked Doctor Chauhan quite a few questions about that. One of which I asked him, I said, doctor, do you -- is it published in this ACOG Task Force and do you agree with the statement no published clinical or experimental data exists to support their contention that the presence of persistent, as compared to transient, neuro brachial plexus palsy implies the application of excessive force by the

birth attendant. He said I agree with that.

There's no evidence, he explained it in a little less complicated terms, there's no evidence that, because you got a permanent -- you got an injury at all, much less a permanent one, that it's the pulling force of the doctor that caused it. No evidence of that. No scientific basis.

So, I went and asked him all right, let's go to the next part.

Is it written in that report, that one that the plaintiffs want to rely on bits and pieces of, that significant variation exists between individuals both in terms of the mechanical properties in anatomy because of the nonlinear behavior of tissue such as nerve tissues, an estimate of the force needed to cause a nerve rupture can not be directly established.

And then I asked, the nerve tissue properties in newborn brachial plexus has not been adequately studied to establish the threshold for damage based on either the applied force or resulting strategy?

Again, he explained all right. It's not scientifically valid to come in, it's not credible, it's not competent to come in and try to make the assumption that, because there's an injury, it had to be because somebody pulled too hard or went the wrong direction. That's what he said they studied in all of that Task Force with the 20 odd authors and all

the people that were involved. That was one of the conclusions they arrived at and published in this document that was peer reviewed and all of the other things they talked about.

And then, finally, I asked him all right. What about clinician applied traction, the statement clinician applied traction in lateral bending of the fetal neck have been implicated as causative factors in some cases of neonatal birth, brachial plexus palsy. However, neonatal brachial plexus palsy also has been shown to occur entirely unrelated to traction with studies demonstrating cases of both transient and persistent brachial plexus palsy in fetuses delivered by cesarean without shoulder dystocia. Other studies have recorded brachial plexus palsy occurring in the posterior shoulder in the presence of a delivery complicated by anterior shoulder impaction.

And I said well, you know, what's all that mean?

He says it just means that it happens sometimes when there's no shoulder dystocia. It happens sometimes when cesarean sections are done, and you can't say that, because you have a permanent injury, it was because of what the doctor did in applying the traction after shoulder dystocia.

I brought experts in to testify about standard of care. You may think they're biased because they knew Doctor Giep. You may think they're biased because they knew his father.

They all practice in the Upstate. Some of them here in the city. Some of them are competitors of his.

They all testified that, based upon everything they saw, the totality of the chart, and Ms. Bowen's deposition, Ms. Phillips' deposition, Ms. White's sworn testimony, the parent's testimony, what they saw in the records, that, in their opinion, Doctor Giep complied with the standard of care, that he did what most competently trained obstetricians would do under like circumstances, similar surrounding conditions.

The plaintiffs brought you one expert witness to talk about standard of care by videotape, Doctor Gurewitsch. I guess she testified too busy to come live. She didn't come down here. So, you saw her on videotape.

She repeatedly refused to answer a litany of questions. I can't answer that question. I'm not gonna answer that question. Over and over. It's for you to judge her credibility, but I ask you this.

What bias does she have?

She gets paid a hundred and 50 -- a hundred to $150,000 a year herself, half of her income, to come in and testify against doctors like Doctor Giep and doctors around the United States in these types of lawsuits arising out of birth issues. Her husband also does the same thing. You heard him, Doctor Allen. He makes a third of his income

doing this, going around the United States testifying in cases against doctors. Between the two of them, and I think they said it was a third or a quarter of their whole family income.

They came up and told you about their opinions about how things occurred, but I ask you were they using real science or junk science?

That's for you to decide.

The judge is gonna tell you -- and backing up. Doctor, excuse me, Gurewitsch said the only way this act -- incident and injury could occur was Doctor Giep had to be applying more than 35-pounds of traction or maybe 35-pounds and greater, I can't remember exactly, and greater than 45-degrees of downward flexion, downward extension. That's the only way it could occur. It's her opinion and she talked to you about her basis of that.

Yet, she also said and agreed that every time there is a permanent brachial plexus injury, in her condition, in her opinion, every time that the doctor who was delivering the baby had to have been negligent, had to have applied too much force, too much downward force, but one exception to that rule. Her rule, the Gurewitsch Rule, one exception is in the case where she had a delivery that involved permanent brachial plexus injury to a baby.

When she delivered the one that had that, she wasn't

negligent. She did everything appropriate. She's the only doctor out of the hundreds that she has testified against who had a permanent brachial plexus palsy injury that didn't do it, wasn't negligent in the way they did it. Ask yourself who's biased in that regard.

The judge will tell you that the burden of proof of negligence lying on the plaintiffs, and they have to present to you competent and credible evidence of what the standard of care is, and that there was a breach of the standard of care. They can't rely on what you think is not competent or credible or is junk science. If that's all they rely on, they haven't met their burden of proof.

The judge will instruct you, I believe, that in the absence of the proof to your satisfaction of competent and credible evidence to the contrary, it shall always be presumed that the doctor has complied with the applicable standard of care.

In this case, you don't have to presume that Doctor Giep complied with the standard of care because I proved it to you by bringing all of these witnesses in, by bringing four obstetricians, two obstetricians, and two obstetrician specialist with maternal fetal. Doctor Chauhan, Doctor Arnett, Doctor Gower, Doctor Ernest, and I would tell you I think Doctor Giep's as much of an expert as those guys. Maybe not in the maternal fetal side, but in the obstetrical

side cause he's been delivering thousands and thousands of babies himself.

We showed you, in the chart, where he wrote the degree of forces. We have proven that he complied with the standard of care even though that wasn't our burden.

So, you will have a verdict form when you go back. The question one, it's kind of long, but I'll summarize it as plaintiff's counsel did.

Do you think the plaintiffs have met their burden of proving that Doctor Giep was negligent, yes or no?

If your answer to the question is no, they have not met their burden of proof that he was professionally negligent, committed malpractice, then your deliberations end.

Second question you have to answer. Have the defendant's proven, my burden, our burden, that this care, medical care rendered by Doctor Giep during the birth and delivery of this child, was rendered in a genuine, medical emergency situation where the child was not medically stable and was in immediate threat of serious bodily injury or death at the time?

Now, the judge will define all those terms for you. He will define the term immediate. I think he's gonna define it in terms similar to this. Current. Present. Actual. Existing. Urgent. Sudden. Those are some of the terms the judge tell you the law defines the word immanent, I'm sorry,

immediate, but also, ladies and gentlemen, we presented evidence from which you can reach that conclusion sort of on your own without any help from anybody else.

We showed you, on all these fetal monitor strips, and you'll have them back there, they're, again, exhibits with stickers from both of us, plaintiff's counsel alluded to it, but Doctor Giep showed you that, even as far back as, you know, eight, nine, ten minutes before, that baseline started dropping and got low. Then, as he got closer to the time of delivery, as the baby got closer, this is the board Doctor Giep drew on. Still got this thing. Yeah, it rebounds, but look at the trend. It's going back down. It's going up. It's not medically stable. It's not gone back to that, you know, wiggly line that you saw early on. It's kind of doing this and the trend is not looking good.

Doctor Giep told you that that concerned him. He was worried about the baby's well being. And plaintiff's counsel mentioned that, in his opinion, there were two complications in this pregnancy or in this birthing experience. One, the gestational diabetes, and, secondly, the shoulder dystocia.

I would present to you that perhaps there was a third, and that was the fetal distress from when the strip changed because clearly the nurses and the doctors were concerned about it. They did things about it.

The shoulder dystocia itself created an obstetrical emergency. Even Doctor Gurewitsch conceded shoulder dystocia is an obstetrical emergency. The doctor has to do something and he has to do it in a relatively short period of time.

There's a debate amongst the experts.

Is it six minutes, is it four minutes that the serious injury -- the brain injury can occur and the death can occur?

Some said, you know, the average might be four to six, but that's just the average. Some babies have bad things happen within a minute or so. Some a little longer. It depends on the reserve.

Well, we know, in the fetal monitor strip, this baby's reserve, direct evidence, her fetal heart rate had declined and was not steady and wasn't stable. We know, looking at the records from the Apgar scores, scores you heard that her muscle tone, and one of them was a minus one which two being normal and minus one not being good one was a minus two.

But even the direct testimony of Doctor Giep, the nurses, and even the family, the baby was blue. She was limp, placid, whatever you want to call, she wasn't doing anything for some period of time until they heard her cry. That's evidence that, at the time, in the two minute window following the dystocia event and beine recognized in the

delivery of the baby, this baby was in trouble. This baby's muscle tone was in trouble. Her heart beats weren't normal. She was in trouble. And, fortunately, because she was able to be delivered in a couple, two minutes, she didn't suffer the brain injury. She didn't suffer death, but we don't know that at the time and she was at a risk of all of that.

It was a present risk. It was actual risk. It was an immediate risk of serious bodily injury from the time of the dystocia event until the time the entire body was delivered or the cord was cut she was handed off to a NICU unit at about 20:20, two minutes there, maybe less than two minutes. Doctor Giep said that, if you look at the strip, the whole thing is maybe a minute, a minute and a half.

So, there's no way for these doctors to present when that serious bodily injury death can occur, but we all heard testimony from every one of them it can happen within a matter of a very, very, very, very short period of time.

We believe that we have met the burden of proving that this was a genuine medical emergency. The baby was medically unstable, that there was an immediate risk for death or serious bodily injury. So, we believe, when you get the jury verdict form and you see question two where you're asked the question was this is a medical emergency and was the baby in immediate risk of serious bodily injury or death, you should circle yes. And when you circle yes,

if you've gotten to that point, then your deliberations will end.

Now, at the -- you've heard some testimony earlier in this trial and you saw young Ashley, and I will tell you the one thing that comes into play, when you see a beautiful, beautiful young lady like that, and you see parents who are obviously very, very interested in their daughter and doing magnificent and great things to help her develop despite the problems that she suffers, and it sounds like a great family, we all feel sympathy. And we all think gosh, you know, it's so sad that it happened.

Well, the judge is gonna tell you sympathy is something that you can not base your jury verdict on. You have to base it on the evidence, competent medical evidence on the standard of care, with evidence you saw in this courtroom. And while we are -- our hearts all go out for this young lady, that can not be the basis of your jury verdict.

We all wish this had never occurred. Doctor Giep, everybody in this room, but that can't be the basis of your verdict. You have to decide it based upon the evidence, and whether the plaintiff met their burden of proof by competent, credible medical evidence that Doctor Giep breached the standard of care and did what most OB-GYN doctors would normally do.

So, you probably ask yourself the question all right,

Gary, what in the world caused this problem?

I asked myself that.

Why does this child have the injury if it wasn't the doctor pulling too hard, pulling down, or whatever, even as Doctor Gurewitsch claims, 35-pounds of force or greater than 45-degrees?

So, I presented a good bit of evidence, direct evidence, about that issue to you. We presented, through all the various experts, the maternal fetal people, Doctor Chauhan, Doctor Ernest, and Doctor Gower, even Doctor Giep, and I think, if I heard correctly and remember correctly, Doctor Allen who then conceded that a weakened motor area of the nerve -- of the muscles in the area of the brachial plexus, if those muscles were weak, the motor tone or motor strength is not normal, then that provides less resistance to the forces of coming down on the mama's birth canal, coming down to the shoulder when the shoulder gets stuck. That nerve is not as -- that muscle area is not as resistant and, thus, those nerves are more susceptible to injury from the normal forces that occur in any delivery.

We also heard testimony that, when the fetal heart rate is decreased, that can cause that muscle tone to become weak, and there's direct evidence in that chart in those Apgar scores that her muscle tone was not normal. At a minute after the delivery it was not normal. At five

minutes after delivery, it was still not normal.

The experts all told you that tells you that muscle tone was not normal as this child was experiencing the fetal heart rate depression and coming on down and coming on out.

I had Doctor Ernest spend some time yesterday talking about what happens to the baby as it moves down the mother's birth canal, and he showed you these diagrams and he described babies move shoulders and the head turns in various positions. And he told you that, as the movement of the baby's head comes down, that places stresses on the neck, on the shoulders, on the -- all parts of the baby's body.

And then he talked about the forces that are involved in those various times and movements and he wrote all this up here, and I'll be honest, I'm not familiar with newtons and all, but he said that the exogenous forces. He described them as when the mom's uterus is contracting, and that's sort of involuntary, it creates forces.

When the mom is asked to push, push, push, and he used the term I think Valsalva, that creates forces that, when they put the legs in just the standard type McRoberts, before you ever have shoulder dystocia, just when the legs are up, that creates forces, and he said all of the studies where they have put pressure catheters inside women who are pregnant at the same stage where they're measuring the

pressures, they have proven that those pressures are in the range of 160 newtons for 40-pounds. And he said they also have done those studies of the, the cadavers things on when the nerves can become injured, and that's normally at about 190 newtons or 45-pounds.

So, it's pretty darn lots of forces going on while the baby is coming down, and he said that, when you look at all of these forces combined in a scenario that you have like with, with Ashley, motor tone is low. The nerves aren't being protected by the muscle that would normally be tighter. You've got an area of fetal distress. You've got the force of the mom. You've got a shoulder dystocia. You do have forces applied by the doctor.

He said, you know, doesn't take much for doctor forces to create the difference between those two, but you use the normal forces you use and they apply various, five, ten, whatever the pounds are, doesn't take much and it's a constellation of all of that that leads to injury. It's not just that the doctor pulled too hard or harder than most doctors would do or at an angle that was excessive.

And I asked Doctor Chauhan, you know, all right. Talk to me about some statistics about brachial plexus injury, and what he told us was 46-percent of all neonatal brachial plexus palsy injuries occur in the absence of documented shoulder dystocia, but when there's no shoulder dystocia at

all, 46-percent of the brachial plexus injuries occur in that scenario. And, in permanent brachial plexus injuries, 26-percent of them occur in the absence of documented shoulder dystocia.

That supports the very theory of this maternal exogenous forces there that can cause it.

Do we know why it happens in some babies and others?

Not a hundred percent. They have ideas about the weakened muscle tone and just, you know, everybody's born and built a little differently, but that's, in essence, sort of an explanation of how the injury can occur without the doctor having done something that was beneath the standard of care or negligent or malpractice.

The judge will tell you that the occurrence of an injury alone can not serve as the basis, the sole basis, for the finding that doctor -- that a doctor committed negligence.

So, ladies and gentlemen, I'm about to sit down. I won't get to get up and he's gonna get up and talk about what I've said. I don't get to come back again.

So, I'd ask that you remember the things that I've talked about, and, as you're answering the questions on the verdict form, when you get to question one, have the plaintiffs proven that Doctor Giep committed malpractice, was negligent in this case, you answer that no and that your

deliberations will end.

On answer two, if you get to it, the question two, if you get it to, was this a medical emergency for the doctor?

I ask that you answer the question yes cause that's what we've shown through the evidence, the competent, credible medical evidence in this case, occurred.

I want to thank you again for your time. I paid attention to y'all as y'all were paying attention to me. And that promise I asked you at the very beginning where you wait till you've heard all the evidence before you make up your mind, I noticed everybody was paying attention when I started putting my witnesses up, and I want to thank you for that because it's important that you hear the whole story from Doctor Giep, from the nurses, from the experts so you can make a, a decision that considers all of the evidence.

And as is -- sorry as we all feel for the condition the child is in, remember the judge will tell you what that -- the legal standard you have to apply is. That the plaintiffs have the burden of proving that Doctor Giep, by the greater weight of the evidence, more, more likely than not, committed malpractice in the case, and we think the answer to the number one question should be no on that, and we ask that you handle it this way in this case.

Thank you very much for your time.

MR. HENSHAW: Gary, leave the things from Doctor Ernest

please.

MR. LOVELL: I'll just leave it all.

MR. HENSHAW: All right. Good. Thank you.

May I, Your Honor?

THE COURT: Mr. Henshaw.

MR. HENSHAW: Thank you.

Ladies and gentlemen, one of the things that you should not leave behind when you evaluate the witnesses, and even though they may come to you with a very impressive, very impressive resume, all the schools they've been to, all the organizations that they're members of, nonetheless, you should not set aside your own common sense and judgment in looking at these because a resume can impact, pad a lot, particularly when the experts are biased or prejudiced as many of these experts clearly were.

They're defense experts. They regularly round in these cases, and appear in these cases. And now they've got a book that's been sanctioned by the American College of Obstetrics and Gynecology called Neonatal Brachial Plexus Palsy, and that became apparent when Doctor Chauhan when he was asked about it, and the, the key to the book, because the people who control what goes into the book, is not all the contributing authors. Contributing authors just get cited, but it's the committee itself, the Task Force on Neonatal Brachial Plexus Palsy that was put together by the

American College of Obstetrics and Gynecology to write this book.

And we went down the list with Doctor Chauhan, and every one of these who are obstetricians, and that's who I asked about, and Doctor Grimm, who is a biomedical engineer, are defense experts.

This is their playbook. This is what they are using and coming in and saying we have a document. We have a source. We have an authority that establishes what we want to tell you, as a defense expert, on behalf of doctors who get accused of causing these types of injuries. They put it together, and that's what they have, and that's what we wanted to point out.

Now, what's interesting about that is that Doctor Gurewitsch -- I mean they can't avoid citing to people who have worked for years and years in this area. And so they couldn't avoid citing to both Doctor Allen and to Doctor Gurewitsch because these are two of the pioneers in this area of study of medicine and shoulder dystocia and the stresses that can cause injury to a baby.

And so Doctor Gurewitsch and Doctor Allen are both cited, but then we have these portions or some of the -- more than just these portions. We have these theories that have been put out by the book as an explanation of trying to suggest that there are other things that can happen during

the delivery that can cause injury to a baby's shoulder.

What did Doctor Allen tell you?

There are two forces at play. Two forces at play here. One is a compression force, and one is a stretch force, and, of course, that makes sense.

The uterus pushes the baby out. It compresses the baby's rear end in the situation where the baby's a head first baby. It compress the baby's rear end and pushes that baby forward down the birth canal and out. That's a compressive force. Think about that, ladies and gentlemen.

What that means is you're not stretching. You are compressing, and, to the extent that that's a compressive force, it can only push the nerves together, but there's no indication at all that these nerves were damaged because of a compressive force. That's a different type of injury. And that's what you heard from Doctor Gurewitsch.

This was -- and when you have a compressive force, when you have the force that can cause injury like a rupture that you have ruptures here, then what you have is a stretching force. And so you have Doctor Gurewitsch, after Doctor Allen explains that you have these two forces at work, those are the only two forces at work. Doctor Gurewitsch says yes, and when you have rupture of C5, six, and seven, as explained by Doctor Armenta after he did his first surgery, then you have a stretch that went to such a degree that it

was an excessive stretching force. A traction, a traction force, a pulling force. Not a pushing force. A pulling force that caused injury to these nerves and that makes sense.

What doesn't make sense is when an expert gets up and tells you, and actually it was experts, that we've put a -- and this is a doctor -- this Doctor Ernest. He says I've done all this.

Well, this is very interesting pronouncements, but it's never been published. It's never been peer reviewed. No other doctors have looked at and accepted it. It's just something that he wanted to come and tell you, and what he's telling you, just use your common sense here now cause this is, this, this is significant, he wants to tell you that he's put an instrument inside a mother's womb, uterus, while she was delivering a baby and found that the uterus could produce 40-pounds of pressure.

Now, that's a compressive force again, and he didn't talk about that being a compressive force. He just wanted to tell you it's 40-pounds of pressure. Then he wants to tell you that the exogenous force that can be utilized in a situation like this is that no doctor has ever been able to do more than 35-pounds.

Now, this is the equivalent of whether or not the doctor, like Doctor Arnett says, can pick up a suitcase and

then he says, you know, I can't pick up any more than 35-pounds.

Now, look at this man over there.

All he can lift is 35-pounds?

He's got a problem.

It does not make sense that a man his age can only pull at the pace of 35-pounds. That makes no sense at all, but yet, that's what this stands for. That's what this represents. That's what they're trying to pull over on you, that he can only do 30 -- his muscles in both of his arms only have the capacity, maximum, because no doctor has ever done it before, to pull a -- 35-pounds. Then what he wants to tell you is, is that it takes 45-pounds to break a nerve.

So, what he's trying to suggest is, is that doctors can not break nerves. Yet, we have a standard of care, apparently around the world, cause Doctor Chauhan established it was in Britain. He certainly established it was in the United States cause I kept asking him is that the United States standard and they all said yes. We have a standard of care that says a doctor should never, never apply more traction than he would in a routine delivery. That's the standard of care.

Doctor Gurewitsch said, you know, if you -- that is the standard and she admitted doctors actually apply more than that. But, but the standard of care is not to apply more

traction than you would in a routine delivery and that's about 10-pounds cause she just ever so lightly wants to hold that baby because -- and the reason for the standard. There's no point to have that standard unless you're trying to protect something.

And what are they trying to protect?

They're trying to protect the nerves in the shoulders. So, we know that if you can stick to that standard, if you can keep it at what you do on a routine basis, you don't cause injury to these nerves. That's the standard of care.

Doctor Gurewitsch is another doctor who does not want to admit that she applied excessive traction to a baby, and yes, and it wasn't that she wouldn't answer all the questions, but she would not answer questions about that particular case, and she would not tell you why and I wish she would. She would of told me. But she didn't.

But, nonetheless, she's just another -- if you look at it, she's just another doctor who doesn't want to admit that they negligently caused injury to a child. That doesn't mean that her, her opinions about injuries and her information about what can cause these injuries and about the deviation from standard of care is not applicable to this case, and it very well will be used against her in her case and should be. And maybe she'll be held responsible for doctors who just simply will never acknowledge that they

used too much traction or that they bent the baby's head the wrong way.

It is significant that this was not a -- it is significant in determining Doctor Giep's concerns about what happened to this baby. And remember that, when he wrote this at 9:00PM and the baby was born at 8:20, the baby had been taken to, by the neonatal team, to the NICU, and then, some time after nine o'clock, sent up for a chest x-ray to see what was going on. And later that night, Doctor Giep went to -- up to the NICU and spoke with the doctors and, by that time, knew there was a brachial plexus injury.

So, he may or may not have known at 9:00PM, when he wrote this note, minimal traction performed, but the -- and -- but the reason that I wanted to go through this with him is that there was an order that he was obviously following, and then he goes back and has this at the end. And, of course, the question arises and, and he says no, this is just where he normally puts it, and that very well may be true. It also may be that he wrote it in after he went up and talked with the doctors.

But it -- but this is his note where he's describing what happened in his delivery of Ashley Flowers. It is -- it is specific to that purpose and you would expect him to make comment about what the traction would be just as you would expect him to make comment about all of the

procedures, particularly where the baby is born and has a medical problem.

And you heard Doctor Chauhan, who worked at that very hospital, say he would normally expect a doctor to put in if he used the Rubin II maneuver that Doctor Giep says he did. He would expect that to be in the note. And when he worked at Spartanburg Hospital, he put it into the note. That was his practice.

But this is what Doctor Giep says he does, that he puts in some things about the, the delivery, and does not put in others. And he initially started by saying, you know, if I do that as part of my routine, I don't put it in and that's the reason I didn't comment about the Rubin II. Well -- and it -- and if I didn't call on anybody else to help me do it, then I don't put it in. That's just my procedure.

So, then why does he put in that he has minimum traction performed?

He didn't call on anybody else to put their hands on the baby's head and pull. Nobody else got involved in that part of it, but yet that became part of his note.

All right. It really doesn't make any difference whether he did the Rubin II or not. The baby came out in about a minute and Doctor Gurewitsch says the injury had already occurred when he did it. That's -- the injury doesn't occur when they do the Rubin II. The injury occurs

when they have their hands on the baby's head and they call for suprapubic pressure and they have done the McRoberts maneuver.

It had already occurred. He had already applied too much traction, and he had already bent the baby's head and he had already caused the nerve damage. That's not whether he did it or whether he didn't it. That doesn't make any difference here at all.

But then minimal traction performed. So, then, appropriately, two days later, Doctor Giep meets with the parents, and he writes a note saying I met with the parents, and I explained the reason for the vacuum extraction or why the vacuum extractor was used. And he said that he discussed with family, husband and wife.

But then he goes back into the traction part. He's still thinking about it. He's still worried about it. He's still concerned about it, and it's not a significant difference, but now it's not just minimal traction. He's now saying gentle traction and he's saying constant traction, which he didn't say before.

Right after he did it, he didn't say general and constant traction. He just said minimal traction. But he's still thinking about it. He's worried about it and he ought to be.

We agree that Doctor Giep was not an ensurer of the

outcome here or he didn't guarantee an outcome. We don't have to prove that he did ensure in order to win our case.

What he was obligated to do and what he had a duty to do was render standard medical care to this mother and the baby, and we believe the evidence shows that he probably didn't do that.

Now, the, the -- it is not inappropriate to look at the damage done to try to determine why it happened. That is the way -- that is called forensics. That's what we do when we do autopsies. If somebody dies under suspicious circumstances, we do an autopsy and look at their tissues, and we try to the -- determine from that and come to conclusions with experts, such as the pathologist, why it happened. And that's what happened here.

It was done by Doctor Armenta when he did the surgery on the baby. He wasn't specifically there to try to determine whether Doctor Giep stretched these nerves or not, but that was what he concluded.

In his testimony that was presented to you, he said this was a traction injury. That is the very specific word he used. Traction is pulling. Traction is stretching. It's not the maternal forces of labor that caused it. Those are compaction forces. Not -- that's not stretching. That's not traction.

So, it is true that, as a matter of law, you don't give

compensation for negligence simply because somebody had a bad outcome in a medical treatment. But that doesn't mean that you can't look at what was determined in the course of that -- in the course of, of surgery of that particular complication to determine why there wasn't -- whether there was negligence and how it occurred, and whether or not you should award compensation for the negligent act.

We're not seeking compensation just because there was a bad outcome. We're seeking compensation because Doctor Giep did not exercise standard medical care. He used too much force. He used excessive traction. He bent the head.

There's -- there is some confusion by defense counsel about what is required by them to prove as an affirmative defense, that they are entitled to the immunity of the medical emergency statute. You don't look at whether the doctor is considering that it could be a -- that it could be a risk of death or a risk of serious bodily injury.

You look at whether or not there was, in fact, to the patient, an immediate risk of death or serious bodily injury. And that would -- did not occur and never did occur in this case because it was not going to occur. There was not going to be an immediate risk of death or serious bodily injury for some four minutes after the shoulder dystocia was recognized. It never got that far.

Within one minute the baby was delivered, and the risk

was -- and whatever risk there were, and they weren't immediate, went away.

Just a few more points. Well, just this is the last one.

We're not here seeking your sympathy. The defense counsel is absolutely right and the judge will instruct you that sympathy should not be a part of your determination as to whether my clients recover from Doctor Giep. So, leave sympathy out of it.

Ashley will get all the sympathy, sympathy she needs for the rest of her life. And so that's not what we're seeking here, but this is also a two edge sword.

Some jurors find it difficult to make an accusation against a doctor just because he's a doctor, and that shouldn't come into play either. That's a type of sympathy and you shouldn't use that as a basis for your decision either. You need to set that aside. And if that is in your mind, please do because that's the only way you can do your duty as a juror.

I also want to thank you for your attention in this case. It has -- I have been proud to represent these clients. They have done a remarkable job with this child, and it has been my pleasure to see them with her, and to see how she has grown. I've had this case for a long time, and I've seen her grow up, and she's a remarkable child, and a

lot of it is due to these people right here.

So, it has been my pleasure to represent them, and I hope that I have done, done it -- done the right by them. I hope I've asked all the questions that they wanted asked. I hope I've investigated all that they needed to have investigated. I hope I've asked all the questions that you wanted asked. I hope that I haven't done anything to offend you, but, if I have, please lay that aside too because it's only right they be given justice regardless of what I do.

And so now I'm at the end of the case. I'm done. And I'm turning it over to you. And I hope that you will feel, at the end, that you can be proud of your decision, that you can walk out of here today, and this is finished today, that you can walk out of here and say, you know, we did the right thing. I don't care who asked me about it later, whether or not they like it, I know what the right thing is and I did it.

Thank you.

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

THE COURT: Mr. Foreman, ladies and gentlemen of the jury, you, of course, have heard and seen all of the evidence presented during the trial of the case. You've also now heard the final summations of the lawyers so -- that have been provided to you, and I will now provide you with the legal instruction that you are to apply in the case, and then you'll be asked to go back and -- to begin with your deliberations.

And, through that process, you'll examine all the evidence. You'll decide the facts. You'll apply the law and you will arrive at a fair and just decision, whatever that decision may be.

It is your exclusive prerogative to determine what the facts are. You do that through your own common sense examination and evaluation of all of the testimony and other evidence received during the trial of this case. You 12 jurors alone will determine what weight, value, and effect

to give to any particular witness' testimony or other evidence in the case. Your sole objective, of course, is to simply render a fair and impartial decision based upon that evidence and the facts as you determine those facts to be relating to that evidence and the allegations, and then your application of the law as I will have provided it to you.

Now, under the law of this state, while you are the judges of the facts, I am judge of the law, and that just simply means that nobody's gonna tell you how to arrive at your determination of fact in this case. You do that, as I just stated, by the exercise of good judgment and common sense conscientiously applied to the testimony and the evidence received during the course of the trial.

You must, however, under your oath as a juror, accept the law as I provide it to you as being the law that you are to apply in this case. In other words, you are never to concern yourself with what you thought the law was before you came to serve as a juror this week or what you think the law ought to be. You must simply, under your oath as a juror, accept the law as I provide it to you as being the law that you are to apply in the case, and then you simply take that law and you apply it to the facts as you 12 jurors determine those facts to be based upon your common sense examination and evaluation of the evidence received during the course of the trial.

Now, in this case, as you know, this is a civil action arising from a physician/patient relationship that existed between the plaintiffs, Treva C. Flowers and Ashley Grace Flowers, and the defendant, Bang N. Giep, and his medical practice, Spartanburg & Pelham OB-GYN, P.A. This is commonly referred to as a medical negligence case or a medical malpractice case.

Now, in this case, the plaintiff is alleging that the plaintiff, Treva Flowers, was a patient of Spartanburg & Pelham, OB-GYN, P.A. who was provided medical care to her during her pregnancy, and eventually the birth and delivery of her child, Ashley Grace Flowers, which was provided by Bang N. Giep, M.D., who was employed by the medical practice.

The plaintiffs further alleges that, during and in the course of that professional relationship, Doctor Giep failed to render medical care in accordance with the applicable standard of medical care required of an obstetric physician in assisting with the delivery of a child.

The plaintiffs further allege that Doctor Giep's deviation from that applicable standard of obstetrical medical care proximately caused injury to Ashley Grace Flowers and other losses suffered by each of the plaintiffs.

Now, in response to those allegations and those claims, the defendants admit that Doctor Giep was employed by the

medical group. They do admit that they did provide prenatal care to Treva C. Flowers, and they do admit that Doctor Giep did provide labor and delivery services to Treva C. Flowers during the course of the birth and delivery of Ashley Grace Flowers.

The defendants deny that the medical care that was provided by Doctor Giep failed to conform to the applicable standard of medical care required of an obstetric physician under the circumstances then existing, and, therefore, they deny that the medical care provided by Doctor Giep was a proximate cause of any injury or harm that the plaintiffs complain of.

The defendants further allege that, if the defendants are shown to have, in any way, been negligent in the care provided, that such conduct occurred during and in the course of a genuine medical emergency situation, and, therefore, under the law, the defendants are not to be held responsible for that claim of negligence.

Now, the burden is -- always is upon the plaintiff, in bringing the lawsuit, to prove their entitlement to a recovery. They must prove their entitlement to a recovery by what's referred, what's referred to as the greater weight or preponderance of the evidence. And what is meant by the greater weight or preponderance of the evidence may be illustrated by your imagining a traditional set of weighing

scales.

And when the trial begins, those scales are absolutely even. As the trial progresses, and evidence is received, you may be placing that evidence on one side of those scales or the other. That is for or against some proposition asserted by one party or the other. But, in the end, after you've carefully weighed all of that evidence in your minds, if those scales remain absolutely even or if they tip in favor of the defendant, then the plaintiff will have failed in their burden of proof. That is the burden of proving their entitlement to a recovery by the greater weight. And, at the same time, if those scales tip even slightly in favor of the plaintiff, then the plaintiff will have met their burden of proof, the burden of proving their entitlement to a recovery by the greater weight or preponderance of the evidence.

Now, of course, there is no method for you to actually weigh evidence. You do that through a mental exercise using your own good judgment and common sense in order to accomplish that task that you have been called upon to perform.

Now, as I've told you, you are the sole judges of the facts in this case. You are, therefore, necessarily, the sole judges of the credibility and the believability of each witness that has testified during the course of this trial.

You 12 jurors alone will decide what weight, value, and effect to give to any particular witness' testimony or other evidence in this case.

Again, your sole objective is to simply reach the truth in the matter and to render a fair and impartial decision based upon your consideration of that evidence. But, in evaluating and assessing the credibility of witness' testimony, there are a number of factors which you should consider, and I'm going to list those factors for you.

You should consider the demeanor of the witness. That is how the witness appeared to you when the witness testified from that witness stand before you.

Was the witness straightforward in responding to questions or was the witness hesitant or evasive in responding to questions that were asked of the witness?

Simply put, did the witness appear to be -- appear to you to be telling the truth and to have knowledge of the facts to which that witness has testified. You should also consider whether or not the testimony of a witness is consistent or is it inconsistent with that witnesses own testimony provided here in Court or whether it was consistent or inconsistent with other statements, either under oath or not under oath, made by that same witness outside of Court. And you should consider whether or not the testimony of a witness is consistent or is it

inconsistent with other witness' testimony and other evidence received during the course of the trial.

You should also consider how the witness came to know the facts to which that witness has testified. In other words, what was that particular witness' opportunity and ability to perceive the existence of those facts to which that witness has testified by having previously used his or her senses, and then what is that particular witness' ability to be able to come into Court and to accurately recollect to you as to what they have previously perceived.

You should also consider any bias or prejudice or interest that you find a witness might have with respect to a case.

In other words, do you find some reason that a particular witness would come into Court and would testify one way or another to help or hurt one side or the other?

And you may consider any interest that a witness might have in the outcome of this case if you determine that that witness does have such an interest, and you find that that interest would bare upon that particular witness' credibility. You should also consider whether or not the testimony of a witness is strengthened or is it weakened by other testimony or other evidence received during the course of the trial.

Now, during the course of this trial, you have also

heard certain testimony that has been received from persons who have been declared to be and qualified to testify as experts in a particular field. You are instructed that, although lay witnesses are generally limited to testify only to facts within their own personal knowledge, experience, or perception, and are not allowed to give opinions regarding the matter, certain witnesses, who do have special education, training, or experience in relation to a particular subject matter, may be considered an expert in a particular field. And when that person is qualified as an expert in that field, then they may give testimony in the form of an opinion as it relates to the facts of the matter which is the subject of this particular lawsuit.

These conclusions and these opinions are evidence to be considered by the jury along with all of the other testimony and evidence received during the trial of the case in arriving at your decision. If you find that the opinions of an expert witness are not based upon sufficient education, training, experience, or a proper consideration of the facts that relates to this case, then the jury may reject those opinions in their entirety or in part just like the jury may do with any other witness that has testified during the trial of the case.

Where there is a conflict in expert testimony, just like with any other testimony, the jury must determine that

which is the most credible and believable based upon the jury's consideration of the relative qualifications of the experts and their consideration of the relevant facts relating to the case as well as any bias, prejudice, or interest that they may have.

Now, because you are the judges of the facts and because you are the judges of the credibility of each witness that has testified during this trial, you are permitted to believe as much or as little of what a witness has testified to as you deem is appropriate, and, therefore, you may believe everything that a witness testified to. You may choose to believe none of it. You may believe some portion of a witness' testimony and reject some other portion of that same witness' testimony.

You may believe one witness as opposed to several or several as opposed to one, but whatever your good judgment and common sense tells you is the most believable and credible evidence and testimony is the testimony and evidence that you should accept, and you should reject any testimony or other evidence that you find not to be credible or believable.

Again, your sole objective is just simply to render a fair and impartial decision based upon the evidence, the facts as you've determined them to be, and then your application of the law that I will have provided you.

Now, while there are various forms of evidence such as testimony, photographs, documents, charts, and other type of physical exhibits, there are really only two types of evidence. Either or both of those types of evidence may be used to prove any fact in issue independently or in combination, but the two types of evidence are direct evidence and circumstantial evidence.

Direct evidence is the testimony of a person who testifies from actual knowledge of the fact. It is testimony by a person who has perceived the existence of a fact by means of his or his senses, and then they come into Court and they testify as to what they have previously seen or heard or felt for that matter. Direct evidence proves the existence of a fact directly and does not require any deduction or inference to be made.

Circumstantial evidence, on the other hand, is the proof of some other fact or set of facts, which taken either singularly or collectively, may prove the existence of a fact in question as a necessary consequence. That is through an inference. And an inference is simply a deduction of fact that may logically and reasonably be drawn from the proof of some other fact or set of facts.

It is a fact not proven by the direct testimony of a witness based upon their personal perception, but it is a conclusion which might reasonably be drawn from the proof of

other facts. In other words, you may infer that a particular event occurred or that a particular fact exists based upon the proof of sufficient factual circumstances which would reasonably warrant your arriving at that particular conclusion.

The law makes no distinction between the weight or value to be given to direct evidence and circumstantial evidence nor is a greater degree of certainty required of circumstantial evidence as opposed to direct evidence. And where there is more than one reasonable inference that might be drawn from the evidence in the case, it is for the jury to determine what is the most probable and reasonable inference to accept in the exercise of good judgment and common sense.

Now, as you know, this is a medical negligence, medical negligence lawsuit, medical malpractice lawsuit. In a medical negligence lawsuit, medical malpractice lawsuit, the plaintiff has the burden of proving four essential elements, by the greater weight or preponderance of the evidence, before the plaintiff would be entitled to a recovery of any type of compensation.

The first element. The plaintiff must present evidence in order to establish the standard of medical care applicable and relevant to an obstetric physician in the delivery of a child under the circumstances attendant to

this particular case. In other words, the plaintiff has to establish what would the average competent obstetric physician be expected to do or be expected to avoid doing when assisting with a delivery of a child under the circumstances of this particular case.

Secondly, the plaintiff must prove that there was an inappropriate deviation or departure from the applicable standard of care by the defendant physician. In other words, the plaintiff must prove that the defendant's care and treatment did not conform to the standard of medical care applicable to and required of an obstetric physician under the circumstances attendant to this particular case.

Thirdly, the plaintiff must prove that injury has been sustained or some loss has been suffered.

And, fourthly, the plaintiff has to prove that it was the defendant's deviation and departure from the applicable standard of medical care that proximately caused some injury or other loss claimed to have been suffered by the plaintiffs.

Now, with regard to the first element, the standard of care, you are instructed that the plaintiff has the burden of presenting evidence establishing the generally recognized standards, practices, and procedures which would have been exercised by the average competent obstetric physician if acting under the same or similar circumstances as

established by the evidence in this case. In other words, the plaintiff must establish, by competent evidence, what professional duty was owed by Doctor Giep to Ashley Grace Flowers in the providing of medical care and treatment relevant to that child's delivery under the circumstances of this particular case.

In that regard, you are instructed that you are not permitted to create your own standard of care in deciding whether or not Doctor Giep's conduct did or did not fulfill the duties imposed upon him under the law and medical standards. The standard to be applied by you jurors is did the defendant possess that degree, that degree of learning, knowledge, and experience, and did he exercise that degree of care and skill in the providing of medical care and treatment to Ashley Grace Flowers that is required of the average competent obstetric physician if providing medical care and treatment under the same or similar circumstances as established by the evidence in this case, and it, therefore, follows that, because you not experts in the field of medicine and the specialty of obstetrics that is the subject of this particular case, the only way you may properly determine whether or not the defendant's conduct did measure up to the appropriate standard of medical care is by your consideration of testimony provided during the trial by persons who have been called and qualified to

testify as expert witnesses as to the applicable accepted standards, practices, and procedures which are required of a reasonably competent obstetric physician in providing medical care and treatment to a patient under the circumstances of -- attendant to this case.

In that regard, you are instructed that every patient who is treated by a physician is entitled to a thorough and careful examination using appropriate methods of diagnosis and treatment in order for the physician to appropriately determine the condition of the patient so that the appropriate course of care and treatment can be properly determined. When there is a risk of substantial danger present, and the symptoms of the patient are consistent with such a risk, the obstetric physician has a duty to respond in proportion to the risk. The greater the risk of the condition to the patient, the greater the duty of the obstetric physician to respond appropriately and to provide appropriate care in compliance with the applicable standard of care.

In undertaking the care and treatment of a patient, the law requires that an obstetric physician possess the requisite degree of learning, skill, and experience necessary to accomplish the purpose for which he was employed, and he must exercise reasonable care, skill, and diligence in the application of his knowledge, training, and

experience to the providing of medical care to his patient. He is required to do that which the average, ordinary, reasonable, competent obstetric physician would do in the providing of medical care and treatment to a patient when acting under the same or similar circumstances.

Secondly, the plaintiff must establish that the defendant deviated from the applicable standard of care. You are instructed that the plaintiff must establish that the defendant, in this case Doctor Giep, did fail to provide medical care to Ashley Grace Flowers in accordance with the applicable standard of care. In that regard, you are instructed that a physician who holds himself out to be a specialist in a particular field of medicine must have the same degree of learning, knowledge, experience, and skill possessed by a specialist in good standing in the same field or specialty, and, further, must exercise the same degree of care and skill in the providing of care and treatment to his patient that would have been exercised by the average competent specialist in the same field of medicine if providing care under the same or similar circumstances.

In other words, the plaintiff must prove that Doctor Giep did something that an ordinary, and reasonable, competent obstetric physician would not have done or Doctor Giep failed to do what an ordinarily reasonable, competent obstetric physician would have done if acting under the same

or similar circumstances attendant to this particular case. And, if so, the physician would be deemed to have been guilty of medical negligence by that failure to comply with the appropriate standard of care.

You are instructed that medical negligence is never to be presumed nor may negligence ever be inferred solely from evidence of an injury occurring during the course of treatment or from a bad consequence resulting from treatment. Medical negligence must be affirmatively proven by competent and credible evidence. In the absence of competent and credible evidence to the contrary, it shall always be presumed that the physician has properly fulfilled the professional duty owed by him to his patient.

The law does not require of a physician absolute accuracy, whether in his practice or in the exercise of his judgment, nor does the law hold any physician to a standard, standard of infallibility nor does it require that he perform with the utmost care and skill of which some physician may be capable. It does, however, require of him, in the practice of his profession and skill, to possess that degree of learning, knowledge, experience, and skill, and to exercise that degree of skill and care which is exercised by an ordinary competent obstetric physician if acting under the same or similar circumstances.

A physician is not an ensurer of a beneficial result

from care or treatment, but must comply with the applicable medical standard of care. Negligence on the part of a physician may not be inferred solely from a bad result or from a known risk associated with a particular condition or from child birth. The mere fact that a complication occurs during the course of medical care or that, during the providing of that medical care, some injury or some harm occurs to the patient is not, in and of itself, sufficient to establish negligence on the part of the physician. An obstetric physician is not liable for a error or a mistake in judgment if he applies ordinary and reasonable care within the recognized and approved methods and procedures and forms his judgment after careful and proper examination of the patient in light of the standard of care at the time that the care is rendered.

In order to establish negligence on the part of the physician, there must be proven a departure and a deviation from the generally accepted and recognized standards, practices, and procedures applicable to obstetric physicians acting under the same or similar circumstances which are attendant to this particular case.

Medicine is an exact science and competent, qualified physicians may differ on what is a preferable method or procedure in accomplishing the purpose for which they are employed. The mere fact that one physician may use a

different approach than another in the employment of a particular method or procedure does not mean that one or the other is negligent so long as the approach employed by the physician complies with the medical standard of care applicable to those obstetric physicians acting under the attendant circumstances.

In other words, where there is more than one generally recognized method, practice, or procedure to be employed, the physician may utilize any of those approved methods in the exercise of his best judgment so long as it is shown that the method utilized is within the applicable standard of medical care. In determining whether an obstetric physician has exercised reasonable care and judgment in the application of a particular approved procedure, you must consider his judgment in relationship to the facts as they existed at the time that the judgment was made, and not in light of what hindsight might reveal.

You are further instructed that South Carolina Code annotated Section 15-32-230 -- and the Code of Laws is just these volumes, and these volumes have a lot of laws and rules and regulations that govern our conduct in a variety of ways, and one particular section that could be applicable in this case, depending upon your determination of the facts, is that particular section, 15-32-230.

That section provides that a physician who commits some

act of negligence in the course of the providing of medical care and treatment to a patient in an emergency department or in an obstetrical or surgical suite is not liable in a claim of malpractice if that care is rendered in a genuine emergency situation which involves an immediate threat of death or serious bodily injury to the patient receiving that care.

The statute further provides that the immunity and the limitation on liability from a claim of medical negligence, as provided for in that statute, shall only apply where it is proven that the patient is not medically stable and the patient is in immediate threat of either death or of serious bodily injury. Where a physician claims immunity from liability based upon this particular statute, the burden is on the physician to establish that the care provided to the patient was rendered in a genuine emergency situation, that the patient was not medically stable, and was in immediate threat of either death or serious bodily injury, and the defendant would have the same burden of establishing entitlement to liability under that statute, and the same standard that the plaintiff has in proving that the defendant is liable for any injury they claim to have sustained.

So, when either party has the burden of proving something to the jury, they have to prove that fact by the

greater weight or preponderance of the evidence.

Now, within the meaning of the statute, immediate refers to an event which is current, present, actual, existing, sudden, or urgent.

Serious bodily injury refers to an injury which causes a substantial risk of death or which causes serious permanent disfigurement or protracted loss or impairment of the function of a bodily member or organ.

All right. So, the first two are what are the -- what is the standard of care.

Number two, what -- was there a deviation or departure from the standard of care.

The third element is proximate causation. The plaintiff must prove that any injury to Ashley Grace Flowers or any loss to the other plaintiffs was proximately caused by Doctor Giep's medical negligence by his deviation or departure from the applicable standard of medical care applicable to the circumstances here.

The mere fact that an injury or loss has been suffered or even that a person has breached a duty of professional care owed to another or otherwise shown to have been negligent in some respect does not, in and of itself, establish liability or responsibility on the part of any person unless proximate causation has also been established by the greater weight or preponderance of the evidence.

Therefore, even if you find that the plaintiff has proven Doctor Giep breached a legal duty owed to his patient, and you further find that some loss has previously been suffered by the plaintiff, she would still not be entitled to a verdict against Doctor Giep unless you further find that it was the negligence of the defendant that was a proximate cause of the injury or any loss suffered by the plaintiff.

The law defines the proximate cause of an injury to be something that produces a natural chain of events, which, in the end, brings about the result. In other words, the proximate cause is the direct cause without which the event and the resulting injury would not have occurred.

Where the cause of an injury may be as reasonably attributed to an act or cause for which the defendant is not liable as to one for which the defendant is liable, the plaintiff will have failed to establish that any injury was proximately caused by the fault of the defendant. It is only when the fault, if any, proven on the part of Doctor Giep was a proximate cause of some injury proven to have been sustained and suffered by Ashley Grace Flowers that Doctor Giep and his practice would be held responsible and the plaintiff would be entitled to a verdict.

In order for any negligence of a defendant to be a proximate cause of an injury, it necessarily -- it is

necessary, necessary that some harm from that negligence be foreseeable. It is not necessary that the defendant did or should have contemplated the particular event or harm which did occur. It is sufficient if he should have foreseen that his negligence would probably result in harm of some kind to the patient, and that that harm was a natural and probable consequence of that negligence. Where, as here, the plaintiff relies upon the testimony of an expert witness or witnesses to show a casual connection between an injury and some alleged deviation from the applicable standard of care, the testimony must meet the most probable rule.

It is not sufficient that the injury possibly or could have or might have resulted from the cause alleged, but the expert must go further and state, in some similar form or fashion, that taking into consideration all of the relevant factors and the evidence in this case, it is the expert's professional opinion that the resulting question most probably, to a reasonable degree of medical certainty, came from the cause alleged.

I'm now going to instruct you on the law as it relates to damages because the fourth element is that the plaintiff has to prove that they suffered some injury and suffered some loss. And so I'm gonna instruct you on the law of damages, but the fact that I am instructing you on the law as it relates to the issue of damages should not be taken by

you as any indication by me that you are to award damages in this case. I must simply provide you with that explanation as to the law as it relates to the issue of damages in the event that you find the plaintiffs are entitled to a recovery of damages based upon your consideration of the evidence, your determination of fact, and your application of the law to the facts as you determine them to be.

Now, there are two types of damages. Those two types of damages are actual damages and punitive damages. Punitive damages are not being sought in this case. It's not applicable to the facts of this case, and they would not be appropriately awarded in this particular case.

So, the only damages or types of damages that you will be considering, if you determine damages should be awarded to the plaintiffs, would be actual damages, and actual damages are monies or compensation paid to the plaintiff, which is intended to compensate an injured person or a plaintiff, and that is to put that person as near as possible as they could be placed into the same position that they were in before the event occurred, and any injury was sustained. In other words, actual damages would be the actual expenses caused as well as other losses, both tangible and intangible, suffered by the plaintiffs because of some negligent conduct on the part of the defendant.

A plaintiff who has been personally injured or

sustained some loss due to the negligent conduct of another is entitled to be compensated for all of those losses, both tangible and intangible, which are proximately caused by that negligent conduct, and such an award would properly include compensation not only for those losses, cost, or expenses which have already been shown to have been sustained by the plaintiffs, but would also include compensation for any damages which are proven to be reasonably certain to occur in the future so long as they are proven to have been proximately caused by the negligence.

Now, with regard to Ashley Grace Flowers claim, she's not seeking what are referred to as economic damages. She's not seeking cost of medical care, treatment, that sort of thing. Those are damages that have been -- that are being sought by her parents. As her parents, they're obligated to pay for those costs on behalf of a child. And so, when they incur those costs on behalf of a child, then the parents may recover for those costs that were incurred because of injury or harm suffered by the child so long as it is the result of negligence proven on the part of the defendant.

But with regard to Ashley Grace Flowers, she may be compensated for damages which are noneconomic in nature, and those include compensation for physical pain and suffering. Pain and suffering is a material element upon which a

recovery may be based. Such damages have no market price. They're not capable of exact measurement. There is no fixed rule or standard by which such damages may be measured, and, therefore, any damages to be awarded for any pain and suffering suffered by Ashley Grace Flowers, if proven, must be left to the judgment of the jury and considered in light of your own life experiences, and in the exercise of good judgment and common sense.

A person who is suffered personal injury due to the negligence of another may also be entitled to compensation for any mental anguish or suffering, which would include fright, nervousness, grief, anxiety, worry, shock, humiliation, embarrassment, apprehension, or any other type of emotional distress. An injured person may recover for mental anguish and other types of damages that are -- that have just been described brought about by bodily injury and suffering.

A person who has suffered physical injury due to the negligence of another may also be entitled to compensation for the loss of any enjoyment of life. Loss of the capacity to enjoy life resulting from personal injury may also be compensated for in the event you determine the plaintiff has proven to have suffered such damages.

Like pain and suffering, those damages have no market price. There is no fixed standard or rule by which they can

be measured. They're not -- measure. They're not capable of exact measurement, but damages for the loss of an enjoyment of life are designed to compensate for the limitations of an injured person's ability to participate in and to derive pleasure from the normal activities of daily life as well as for any inability of that injured person to pursue her normal talents, recreational interests, hobbies, or advocations.

And a person who has suffered physical injury due to negligence of another may also be entitled to compensation for any permanent impairment of her physical and/or mental or emotional condition, and that would include any disfigurement resulting from physical injury or treatment relating thereto as well as the loss of any bodily function.

Now, with regard to the parent's claim related to economic damages that they contend were incurred as a result of medical care and treatment provided to Ashley Grace Phillips (sic), you are instructed that the parents may be entitled to compensation for all reasonable and necessary expenses which were incurred for medical treatment, and that would include physician's fees, hospital charges, physical and mental therapy costs, medication, medical equipment, and any other thing associated with that medical care and treatment.

You are further instructed that where you are called

upon to determine damages, and there is evidence of future damages or permanent impairment of mental or emotional condition, as well as physical condition, it may be necessary for you to determine, in making that award of damages, the probable life expectancy of Ashley Grace Flowers. Life expectancy is the period of time that a person of a given age and sex is expected to have according to statistical or actuarial tables. Life expectancy is merely an estimate of the probable average remaining length of life of a person, and, in this state, we have a statutory table of life expectancy which has been admitted into evidence and judicially noticed, and it may be considered in your determining the average remaining length of life of Ashley Grace Phillips (sic) based upon her age and sex. Those tables provide that a female person nine years of age has a probable remaining life expectancy of 72 years.

So, you may consider this evidence, along with any other evidence bearing upon the probable life expectancy of Ashley Flowers including her age, health, physical condition, and any other relevant factors relating, relating to that issue in determining her probable remaining life expectancy.

Your verdict in this case, as in every case, must be based solely upon the evidence which has been received during the course of this trial. Your determination of the

facts that relate to the allegations as you determine them to be in your application of the law as the Court has provided it to you. Your verdict must be determined without bias or prejudice for or against either party, and you may not allow your decision to be governed by any passion, prejudice, bias, emotion, sympathy, or any other consideration found outside of the law and evidence in this case.

In every case, the petit jury of the Circuit Court shall consist of 12 members and all jurors in any trial must agree to a verdict in order to render the same, and, therefore, any decision that you reach must be unanimous. All 12 of you must be in agreement before any decision may be rendered and returned to the Court.

Now, Mr. Foreman, and ladies and gentlemen of the jury, when you go back to deliberate, I'm gonna send with you, in addition to all of the evidence that has, that has been introduced during the trial, a verdict form. And when you complete that verdict form, there's some questions on it and some other provisions. And as you make those determinations of fact and apply the law, and you have an answer to the question, just indicate that response beneath the question that's been asked.

The verdict form, you'll have it in there with you, but the first question on the verdict form is simply do you, the

jury, find that plaintiffs have proven, by the greater weight of the evidence, that Doctor Giep was negligent in providing the medical care and that that negligence was a proximate cause of some injury or loss sustained by the plaintiffs. You have two potential responses, yes or no. Whichever that response is, circle it.

If your answer is, is no, then you stop and deliberate no further. Then your verdict would be for the defendant because no means the plaintiff has failed to prove the defendant was negligent and that any injury was proximately caused by any negligence.

If your answer is yes to that question, you do find the defendant to have been negligent, and that the negligence did proximately cause some injury or loss, then you go to question two. Question two relates to the allegation of treatment provided in a genuine emergency situation, and that question simply asks do you, the jury, find that the defendants have proven, by the greater weight of the evidence, that the medical care rendered by the defendant, through Doctor Giep, was rendered in a genuine emergency situation where the patient was not medically stable, and was in immediate threat of either death or serious bodily injury.

If your answer is yes to that question, it was during the course of that genuine medical emergency, then you would

stop and deliberate no further. Your verdict would be, in that case, for the defendant. If you answer no to that question, then you would proceed to the -- provisions three and four of the verdict form, and three and four are simply separate provisions for any damages to be awarded to Ashley Grace Phillips (sic) and any damages to be awarded to Tristan Flowers, Flowers and Treva Flowers, the parents.

So, simply put, provision three says what is the total amount of actual damages that you find have been sustained by Ashley Grace Flowers which were proximately caused by the negligence of the defendant, and, provision four, what is the total amount of actual damages that you find have been sustained by Treva Flowers and Tristan Flowers which were proximately caused by the negligence of the defendant.

Once you complete the verdict form -- and let me say this. In the event you determine damages are to be awarded and you determine the amount, Mr. Foreman, I'm gonna ask that, when you complete the verdict form, you'll see a line and beneath that you'll see a dollar mark. Any damage award that you find is appropriate, you need to write that out in words and then you can insert the numerical equivalent below it.

Once the verdict form has been completed, Mr. Foreman, if you'll sign your name as the foreperson. You're the only person that needs to sign the verdict form. Knock on the

door. Tell the bailiff that you've reached a unanimous decision and we'll bring you back to receive that verdict.

When that time comes and you tell the bailiff you've arrived at your decision, you may give him the evidence, or her, but you will hold on to the verdict form. I'll receive the verdict form from you after you return from the jury -- to the courtroom. So, hold on to the verdict form, but you can give the bailiff all of the evidence.

Now, during your deliberations, there may come a time where you have a question about evidence or facts that relate to this case. You may even believe that there's something else out there that you'd like to have and you ask for something else to be submitted.

Please understand that the evidence that is going to be introduced in this case has already been introduced. If it was not introduced during the trial, it can not be introduced now. So, even if there is something out there that you think would be helpful, you can not have it because it was not introduced. So, please don't inquire about whether you can have additional evidence. You can not. It's just simply what it is.

Now, we're gonna verify all of the exhibits before they go back with the lawyers, myself, and the court reporter. That doesn't mean that something doesn't get misplaced. So, when you go back and you're sorting through the evidence, if

you think something was introduced, but you don't have it in the jury room, you let me know of that fact and if it's not there we'll find it. I'm just saying that anything that was not introduced can not be introduced now, but everything that was introduced should be in the jury room with you.

If you -- and I can't answer questions that relate to issues of fact, but if you have a question about a witness' testimony and you think that listening to that witness' testimony, in whole or in part, will help you resolve that question of fact, we can bring you back to listen to a witness' testimony in its entirety or just some portion if that's all you need.

I don't have transcripts of the witness' testimony. So, if you need to have testimony replayed, let me know. We'll bring you back and have that witness' testimony replayed in whole or in part.

If, at anytime, you ever have a question about the law that's applicable, I am permitted to answer those questions. So, if you need for me to give you a complete re-instruction on the law, I can. If you simply want me to give you a, an explanation or a clarification of some point of law that I provided, I can do that too.

So, if, at anytime, you have a question about the law that you are to apply and you need some re-instruction, explanation, or clarification, you let me know and I'll

provide you with that additional instruction, explanation, or clarification.

Mr. Foreman, if, at anytime, something arises that needs to be brought to my attention while you're deliberating, if you'll write that, the request or that question or that issue on a piece of paper, give it to the bailiff. He'll provide it to me and I'll respond accordingly.

During deliberations, if we have smokers on the jury, you can smoke. I'm not recommending that, but if you want to smoke, you can. You'll have to be taken outside to accomplish that to a purpose. So, if you want to smoke, tell the bailiff. He'll take you outside.

You are instructed, however, that deliberations have to stop if any juror, any juror is absent for any authorized purpose. So, if a juror goes to smoke or goes to the restroom or whatever, deliberations should, should stop. They should only resume when all 12 are present so that all 12 can participate in those deliberations.

I'm guessing that all of you -- sir?

THE FOREMAN: Including the alternate?

THE COURT: I'll get there.

THE FOREMAN: All right.

THE COURT: I'm not through yet, but I'm close.

I'm guessing that all of you, while you might not be

smokers, you are eaters and I guess you've all ordered lunch. And your lunch may be here now or it may be here shortly.

When you go back to deliberate, you will be provided your lunch and you can eat it while you deliberate or you can stop and eat lunch and then deliberate after you eat lunch. That's up to you. I'm not gonna give you any suggestions about that. That's your, that's your prerogative.

I think that might be everything. But, if it's not, I'm sure one of these lawyers will remind me that I failed to provide you with some information that I should have. And if I agree with that, I'll bring you back in order to provide you with that additional information. If I do not need to bring you back, I'll send word by way of the bailiff that you may begin your deliberation. And, in that event, he'll bring to the jury room all of the exhibits which have been introduced, and, to you, Mr. Foreman, he'll also provide the verdict form.

So, with that, I'm gonna ask the 12 primary jurors, which does not include the alternate, 12 primary jurors will please go with the bailiff to your jury room. The alternate juror will stay in the courtroom with me, and you jurors are instructed not to begin deliberations until I send you word to do so.

THE ALTERNATE JUROR: Thank you, sir.

THE COURT: Thank you again for your participation.

(WHEREUPON, the following takes place outside the presence of the alternate juror.)

THE COURT: Are there any exceptions taken to the instruction or request for additions to the instruction by the plaintiff?

MR. HENSHAW: Your Honor, we continue our objection as to the charge that was given in regard to the medical emergency statute for the reasons that I stated earlier, and cause we do not feel that that is appropriately included in this case for the reasons I stated earlier.

THE COURT: All right. Mr. Lovell.

MR. LOVELL: No exceptions or objections.

THE COURT: All right. Let me ask y'all to verify the exhibits please before we go back.

(Pause.)

THE COURT: All right. All the exhibits are accounted for?

MR. LOVELL: Yes, sir, Your Honor.

MR. HENSHAW: Yes, sir.

THE COURT: And you've reviewed the verdict form?

MR. LOVELL: Yes, sir.

MR. HENSHAW: Yes, sir.

MR. LOVELL: Yes, sir.

THE COURT: Take the exhibits back. Give them the verdict form. Tell the jury to begin deliberations and notify us when they're concluded.

We'll be at ease while the jury is deliberating.

MR. LOVELL: Thank you, Your Honor.

MR. HENSHAW: Thank you, Your Honor.

(WHEREUPON, the jury began deliberations at 12:59PM, and returned with a question at 6:42PM.)

THE COURT: Mr. Foreman, have you and your fellow jurors been able to arrive at a unanimous decision?

THE FOREMAN: No, sir.

THE COURT: Let me say that at anytime that you have conflicting information, it might be sometimes difficult for even two people to come to an agreement, and sometimes it becomes correspondingly more difficult when you have more than two people, such as 12 people, trying to come together and agree on a particular fact. But, nevertheless, more often than not, when we have juries selected to consider evidence in cases and to render decisions, they are, more often than not, able to arrive at a unanimous decision.

Now, if we excuse you now, it doesn't mean that anybody wins or anybody loses. It just means that, at some other time, some other week, we are gonna come back into this courtroom and the same lawyers are gonna be here. The same parties are gonna be here. The same witnesses are likely

gonna testify to the same information they provided you. And some other 12 people are gonna be asked or called upon to arrive at a decision. And I don't have any reason to believe that 12 other people can do any better job than coming to a decision than you can.

So, what I'm gonna ask you to do is to go back and to continue with your deliberations in an effort to arrive at a unanimous decision if you can.

Now, going back doesn't mean that I'm trying to coerce any juror or pressure any juror into changing your mind or your decision so long as it's based upon reasonable information, and you're satisfied with it, you thought about it, you've come to that conclusion, and you believe that that's the appropriate decision. And, if that's the case, nobody's gonna try to make you change your mind.

All I want for you to do is to go back and to simply discuss it some more, reevaluate your position, share your opinions, and your views with your fellow jurors in an effort to try to arrive at a unanimous decision if you can without doing violence to your own conscious.

Now, if any juror has a problem with continuing that can be resolved by making a phone call, we're happy to make those arrangements for you. If you have problems that can not be resolved by making a phone call, I'm gonna ask that you please let me know of the fact. Send me a note letting

me know what juror that has an issue or what the problem is the jurors needs to address. And then if we can try to resolve it, we can. If not, we'll try to make some other arrangements.

But right now, I ask you to go back and please continue with your deliberations, but you let me know if you need to make a phone call or you have some problem that can not be resolved with that phone call.

Okay.

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

THE COURT: Any objection to the instruction?

MR. HENSHAW: None from the plaintiff, Your Honor.

MR. LOVELL: None from the defendant, Your Honor.

THE COURT: All right. We'll be at ease while we wait for a decision.

MR. HENSHAW: Thank you, Your Honor.

(WHEREUPON, the jury panel continued with deliberations at 6:46PM, and returned with another question at 7:32PM.)

THE COURT: You want to see the note?

(Pause.)

THE COURT: Bring the jury in.

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

THE COURT: All right. Mr. Foreman, I understand that

you and your fellow jurors, excuse me, wish for me to reinstruct you on the law of circumstantial evidence?

THE FOREMAN: Yes, sir.

THE COURT: Well, I'm gonna go ahead and, and read you the definition of direct evidence so we'll be certain we understand the contrast between the two.

THE FOREMAN: Okay.

THE COURT: Direct evidence is the testimony of a person who testifies from actual knowledge of that fact. It is testimony by a person who has perceived the existence of a fact by means of his or her senses, and then they come into Court and they testify as to what they have previously seen or heard or felt or perceived. Direct evidence proves the existence of a fact directly, and does not require any deduction or inference.

Circumstantial evidence, on the other hand, is proof of some other fact or set of facts, which taken either singularly or collectively, may prove the existence of a fact in question as a necessary consequence by a deduction or an inference, and an inference is simply a deduction of fact that may logically and reasonably be drawn from proof of some other fact or set of facts. It is a fact not proven by the direct testimony of a witness based upon that person's personal perception, but it is a conclusion which might reasonably be drawn from the proof of some other

facts.

In other words, you may infer that a particular event occurred or that a particular fact exists based upon the proof of sufficient factual circumstances which would reasonably warrant your arriving at a particular conclusion. The law makes no distinction between the weight or value to be given to direct evidence and circumstantial evidence nor is a greater degree of certainty required of circumstantial evidence as opposed to direct evidence.

Where more than one reasonable inference may be drawn from the circumstantial evidence in the case, it is for the jury to determine what is the most probable and reasonable inference to accept in the exercise of good judgment and common sense.

Okay. All right. Please retire. If you need additional instructions, let me know.

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

THE COURT: Any exception to the instruction?

MR. HENSHAW: None from the plaintiff, Your Honor.

MR. LOVELL: No, sir, Your Honor.

THE COURT: All right. We'll continue to be at ease.

(WHEREUPON, the jury returned to deliberations at 7:36PM, and returned with a verdict at 8:25PM.)

THE COURT: I'm told the jury has reached a verdict.

Are you ready to receive it?

MR. HENSHAW: Plaintiff's ready, Your Honor.

MR. LOVELL: Yes, Your Honor.

THE COURT: All right. Bring them in please.

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

THE COURT: Mr. Foreman, have you and your fellow jurors reached a unanimous decision?

THE FOREMAN: Yes, Your Honor.

THE COURT: And have you reflected that decision on the verdict form as requested?

THE FOREMAN: Yes, Your Honor.

THE COURT: And did you sign your name as the foreperson?

THE FOREMAN: Yes, sir.

THE COURT: If you'll please hand that over to the bailiff.

(WHEREUPON, the foreman complies.)

THE COURT: All right. In response to the special interrogatory verdict form in Case Number 2016-CP-42-03178, in response to the questions asked of jury by way of a form, the first question, do you find that the plaintiffs have proven, by the greater weight or preponderance of the evidence, that the defendants, by and through Bang N. Giep, were negligent in the providing the medical care during and

in the course of the birth and delivery of Ashley Grace Flowers, and that such negligence was a proximate cause of some injury or other loss sustained by the plaintiffs?

The jury's response is yes.

Question 2. Do you find that the defendants have proven, by the greater weight or preponderance of the evidence, that the medical care rendered by the defendants, by and through Bang N. Giep, during the birth and delivery of Ashley Grace Flowers was rendered in the genuine emergency situation where she was not medically stable, and was in immediate threat of either death or serious bodily injury?

The jury's response is yes.

Signed by the foreperson, today's date.

Is this the verdict of each one of you jurors, and if it is your verdict and still your verdict, I would ask that indicate such by raising your right-hands.

(WHEREUPON, all jurors raise their right-hands at this time.)

THE COURT: Let the record reflect that all jurors have responded in the affirmative.

Are there any other matters we need to address with the jury present?

MR. HENSHAW: We would like to have the jury polled, Your Honor.

THE COURT: All right. Poll the jury please, ma'am.

(WHEREUPON, the jury was polled and all jurors answered in the affirmative that this was and still is their verdict.)

THE COURT: Thank you.

Any other matters we need to address with the jury present?

MR. HENSHAW: No, Your Honor.

MR. LOVELL: No, sir.

(WHEREUPON, the jury was dismissed from the courtroom at this time.)

THE COURT: Are there any matters that need to be addressed before we recess?

MR. LOVELL: No, sir, Your Honor.

MR. HENSHAW: Your Honor, on, on behalf of the plaintiff, I would move at this time for a new trial on the grounds that the -- based upon the, the motions that I made on behalf of plaintiff earlier in the case to strike the medical emergency defense, and the judges -- and, and also objection to your charge in regard to the medical emergency defense on the grounds that it was not applicable to this case as written by the statute, and further on the grounds that the statute denies equal protection to patients such as my clients in that they are unreasonably classified or classified and categorized differently from other patients,

and also allows doctors such as Doctor Giep to be classified and categorized differently from other doctors in a way without a rational basis, and, therefore, denying my clients equal protection under the law.

THE COURT: All right. That motion is denied.

Any others?

MR. HENSHAW: That would be the basis of a new trial motion on behalf of the plaintiffs, Your Honor.

THE COURT: All right. Motion is denied.

MR. HENSHAW: Yes, sir.

THE COURT: Anything else?

MR. LOVELL: No, sir, nothing from the plaintiff.

MR. HENSHAW: No, sir.

THE COURT: All right. Court is in recess.

(WHEREUPON, three notes from the jury were marked as Court's Exhibit Nos. 1 through 3 and received into evidence at this time.)

* * *END OF REQUESTED TRANSCRIPT OF RECORD* * *

C E R T I F I C A T E

I, Pamela E. Green, Official Court Reporter for the Seventh Judicial Circuit of the State of South Carolina, do hereby certify that the foregoing is a true, accurate and complete Transcript of Record of the proceedings had and evidence introduced in the trial of the captioned case, relative to appeal, in the Court of Common Pleas for Spartanburg County, South Carolina, on the 9th, 10th, 11th and 13th days of October, 2017.

I do further certify that I am neither of kin, counsel nor interest to any party hereto.

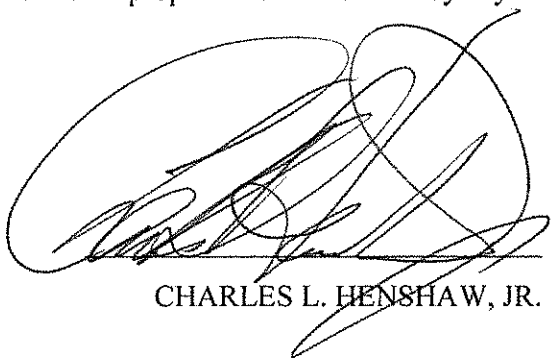
December 20th, 2017

Pamela E. Green

PAMELA E. GREEN, Court Reporter

Certificate of Counsel

I certify that the Record on Appeal contains all material proposed to be included by any of the parties and not any other material.



CHARLES L. HENSHAW, JR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178

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

v.

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

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Statement of Issues on Appeal

Was it error to apply S.C. Code Ann. § 15-32-230(A) to the exclusion of § 15-32-230(B) and render judgment for defendants in medical malpractice claims arising from emergency obstetrical care when the plaintiffs had a previous doctor/patient relationship with the defendant physician and other members of his practice and received prenatal care?

Statement of the Case

This medical malpractice case was commenced in the Spartanburg County Court of Common Pleas by filing a Notice of Intent to File Suit on October 7, 2011, pursuant to S.C. Code Ann. § 15-79-125. *See* Notice of Intent to File Suit (ROA 6). The matter could not be resolved by mediation, and a mediator declared an impasse between the parties on January 16, 2012. A Summons and Complaint were filed on March 12, 2012. *See* Complaint (ROA 9).

Plaintiffs Treva C. Flowers and Tristan Flowers brought causes of action on behalf of themselves and on behalf of their daughter, Ashley F., a minor child. *See* Complaint (ROA 9). The defendants were Bang Giep, M.D., and the medical practice where he was employed, Spartanburg & Pelham OB-GYN, P.A. (formerly Spartanburg OB-GYN, P.A.).

The plaintiffs alleged that on October 7, 2008, at Spartanburg Regional Medical Center, Dr. Giep, a specialist in obstetrics, undertook to medically manage the labor of Treva Flowers and the birth of Ashley F., who was a viable, female child. They alleged that when the birth became complicated by shoulder dystocia, Giep's application of traction to deliver Ashley F. caused permanent, severe injuries to cervical nerve roots contained within her left brachial plexus nerve bundle. They alleged that Dr. Giep was negligent, wanton, willful, reckless, and grossly negligent in his application of traction and in failure to properly use maneuvers to release the child from shoulder dystocia. *See* Complaint ¶¶ 10-13. (ROA 10).

The cause of action brought for Ashley F. sought compensation for permanent physical disability of the child's left shoulder, arm, and hand and for other personal injuries,

including physical disfigurement. *See* Complaint ¶ 15-16. (ROA 11). In the second cause of action, Treva and Tristan Flowers, as parents, sought recovery for extraordinary financial losses related to the child's medical, hospital, special needs, and care taking expenses during her childhood. *See* Complaint ¶ 18-19. (ROA 12).

The defendants generally and specifically denied the plaintiffs' material allegations, but admitted that Giep was an agent and employee of Spartanburg & Pelham Ob-Gyn, P.A., and was acting within the course and scope of his employment during the delivery of Ashley F. They admitted that during the delivery the child suffered from various medical conditions, including shoulder dystocia. *See* Answer ¶¶ 2-3, 5-6 (ROA 14-15).

The case came to trial on October 9, 2017.

After presentation of the evidence, the trial judge allowed defendants to amend their answer to incorporate S.C. Code Ann. § 15-32-230 (A) as an affirmative defense. (ROA 903:11-904:06). Plaintiffs' counsel moved to strike the affirmative defense on grounds that it should not be applied when there was no factual dispute that plaintiffs had prenatal care and a prior doctor/patient relationship with defendant Giep and other doctors in his medical practice pursuant to § 15-32-230(B). The motion to strike was denied. (ROA 906:13-907:15).

The trial judge told the jury, "The defendants . . . allege that if defendants are shown to have, in any way, been negligent in the care provided, that such conduct occurred during and in the course of a genuine medical emergency situation, and, therefore, under the law, the defendants are not to be held responsible for that claim of negligence." (ROA 980:13-

18). The trial judge then charged the jury with the provisions of subsections (A) and (C) of § 15-32-230, excluding the provisions of subsection (B).

> *You are further instructed that South Carolina Code annotated Section 15-32-230 and the Code of Laws is just these volumes, and these volumes have a lot of laws and rules and regulations that govern our conduct in a variety of ways, and one particular section that could be applicable in this case, depending upon your determination of the facts, is that particular section, 15-32-230. That section provides that a physician who commits some act of negligence in the course of the providing of medical care and treatment to a patient in an emergency department or in an obstetrical or surgical suite is not liable in a claim of malpractice if that care is rendered in a genuine emergency situation which involves an immediate threat of death or serious bodily injury to the patient receiving that care. The statute further provides that the immunity and the limitation on liability from a claim of medical negligence, as provided for in that statute, shall only apply where it is proven that the patient is not medically stable, and the patient is in immediate threat of either death or of serious bodily injury. Where a physician claims immunity from liability based upon this particular statute, the burden is on the physician to establish that the care provided to the patient was rendered in a genuine emergency situation, that the patient was not medically stable, and was in immediate threat of either death or serious bodily injury, and the defendant would have the same burden of establishing entitlement to liability under that statute, and the same standard that the plaintiff has in proving that the defendant is liable for any injury they claim to have sustained.*

(ROA 994:18-995:23). Plaintiffs' counsel objected to the jury instructions relating to the medical emergency statute on grounds they were not appropriate to the case for the reasons stated in plaintiffs' motion to strike. (ROA 1011:05-12).

The jury commenced deliberations and returned a verdict on October 13. In a special verdict form submitted to the jury, the trial judge asked:

> *Do you find that the plaintiffs have proven by the greater weight or preponderance of the evidence that the defendants, by and through Bang N. Giep, were negligent in the providing of medical care during the birth and delivery of [Ashley F.] and that such negligence was the proximate cause of some injury or other loss sustained by plaintiffs?*

The jury responded 'Yes,' and moved to the next question, which asked:

> *Do you find that the defendants have proven by the greater weight or preponderance of the evidence that the medical care rendered by the defendants, by and through Bang N. Giep, during the birth and delivery of [Ashley F.] was rendered in a genuine emergency situation where she was not medically stable and was in immediate threat of either death or serious bodily injury?*

The jury responded 'Yes,' and was directed to "***STOP*** and ***DELIBERATE NO FURTHER***, your verdict would be for defendants." *See* Verdict Form (Court's emphasis) (ROA 4).

The plaintiffs moved immediately for new trial, and the motion was denied. (ROA 1019:15-1020:05).

Judgment was entered on October 31, 2017. *See* Judgment (ROA 1). The plaintiffs filed Notice of Appeal with the South Carolina Court of Appeals on November 3, 2017. *See* Notice of Appeal (ROA 17).

Standard of Review

An issue regarding statutory interpretation is a question of law. *S.C. Coastal Conservation League v. S.C. Dep't of Health & Envtl. Control*, 390 S.C. 418, 425, 702 S.E.2d 246, 250 (2010). "When reviewing an action at law, on appeal of a case tried without a jury, the appellate court's jurisdiction is limited to correction of errors of law." *Epworth Children's Home v. Beasley*, 365 S.C. 157, 164, 616 S.E.2d 710, 714 (2005). Questions of statutory interpretation are questions of law, which the appellate court is free to decide without any deference to the court below." *Grier v. AMISUB of S.C., Inc.*, 397 S.C. 532, 535, 725 S.E.2d 693, 695 (2012).

Argument

Was it error to apply S.C. Code Ann. § 15-32-230(A) to the exclusion of § 15-32-230 (B) and render judgment for defendants in medical malpractice claims arising from emergency obstetrical care when the plaintiffs had a previous doctor/patient relationship with the defendant physician and other members of his practice and received prenatal care?

Statement of Facts

Treva Flowers became pregnant in 2008 and quickly employed defendant Spartanburg Ob-Gyn, P.A. for her prenatal management and delivery. (ROA 321:05-22, 382:23 – 383:06). She and her husband kept every office appointment, rotating through each physician in the practice, including defendant Giep. (ROA 322:08-21, 323:25 – 324:01, 367:07-11, 383:07-14, 384:02-05). During the pregnancy, Treva Flowers developed gestational diabetes that was controlled by diet, but her child appeared to have a normal gestation, and she was planned for vaginal, full-term delivery on or about Oct. 11, 2008. (ROA 322:24-25, 323:01-21, 326:08-09, 327:01-02, 384:09-23).

Shortly after midnight on Oct. 8, 2008, Treva Flowers went into labor at home. Several hours later she was admitted to Spartanburg Regional Medical Center for labor and delivery by Dr. Ashley Fowler, one of the physicians in Dr. Giep's practice. The mother labored in the hospital's obstetrical unit through the morning and afternoon without apparent complication and was ready to deliver her child by 8 p.m. (ROA 594:01-12, 597:15-22). Dr. Giep, who had replaced Dr. Fowler that evening, came to the mother's bedside at 8:11 p.m. when he saw a deceleration of the baby's heart-rate on a monitor screen in the hospital. (ROA 596:16-597:21). To expedite the delivery, Giep applied a vacuum extraction device to the baby's scalp at 8:18 p.m. and was able to deliver the head (ROA 617:23-618:07), but as the baby descended further in the birth canal, her left shoulder became obstructed by the mother's pubic bone. (ROA 619:18, 871:08-25), a medical condition known as shoulder dystocia.

Shoulder dystocia is a well-known complication of obstetrical medicine. Because doctors cannot predict which of their obstetrical patients will encounter shoulder dystocia during delivery (ROA 579:06-14), obstetricians are trained beginning in medical residency to diagnose and treat shoulder dystocia. (ROA 572:13-573:08). Utilizing the nursing staff and a series of well-established maneuvers, a doctor can usually enlarge the mother's birth outlet and release the baby's obstructed shoulder from the impingement in a matter of minutes. (ROA 666:20-667:03). In Ashley F.'s case, Dr. Giep delivered her at 8:20 p.m., less than two minutes after the dystocia was diagnosed at 8:19 p.m. (ROA 624:21-24, 630:20-22, 638:04-05).

To perform the maneuvers, Dr. Giep was required to place his hands on the baby's head and apply traction. (ROA 627:13-20). The direction and the amount of traction to be

applied has been well-established by generally recognized and accepted standards of care and should have been 'gentle' and with the same traction necessary to deliver a baby who is not impeded by dystocia. (ROA 655:03-09, 19-22; ROA 668:11-17). Under standard practice, the traction applied by Giep should have kept the baby's head in alignment with her spine and not flexed the baby's head significantly toward the baby's lower shoulder. Unnecessarily forceful traction could stretch nerve roots in the baby's neck and shoulder and would not meet the standard of care.

Ashley F. was born with a 'limp' left arm (ROA 638:20-21). Dr. Giep's deviation from standard care was established when Dr. Arturo Armenta, who subsequently performed surgery to repair the brachial plexus nerve bundle in Ashley's left shoulder, found that her C-5, C-6, and C-7 nerve roots had been ruptured and her C-8 nerve root had been stretched so much that it developed a neuroma caused by scarring. (ROA 71:15-72:08, 73:06-09).

Plaintiffs' biomechanics expert, Dr. Robert Allen testified permanent brachial plexus injuries involving multiple nerve ruptures and neuromas are stretch injuries known to occur following shoulder dystocia only from a physician's force and flexion of the baby's head. (ROA 119:16-17). Plaintiffs' obstetrical expert, Dr. Edith Gurewitsch, testified Ashley F.'s shoulder most probably could have been released from dystocia with traction no greater than traction applied to non-dystocia births. She said traction that ruptured three nerve roots and caused a neuroma to a fourth was unnecessarily forceful, misaligned, and deviated from standard obstetrical care. (ROA 190:09-16, 207:01-208:17, 211:04 -212:01).

The jury apparently agreed and found the defendants were negligent in the providing of medical care during Ashley's birth and delivery and caused injury. *See* Verdict Form. (ROA 4). The plaintiffs did not seek to prove gross negligence, however, and the verdict was rendered for the defendants when the jury found that the medical care occurred in a genuine emergency where Ashley F. was not medically stable and was in immediate threat of either death or serious bodily injury. *See* Verdict Form. (ROA 4).

Law

At issue is whether the trial judge should have interpreted S.C. Code Ann. § 15-32-230(A) to be applied as "separate and distinct" from S.C. Code Ann. § 15-32-230(B), rendering moot the plaintiffs' prenatal care and doctor/patient relationship with Dr. Giep and other physicians in his practice prior to the obstetrical emergency that gave rise to the medical malpractice claims. By doing so, the trial judge failed to carry out the legislature's intent to preserve the rights of plaintiffs to sue for ordinary negligence in obstetrical emergency malpractice cases where doctor/patient relationships and prenatal care had been established.

Section 15-32-230 provides as follows:

> *Section 15-32-230. (A) In an action involving a medical malpractice claim arising out of care rendered in a genuine emergency 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.*

S.C. Code Ann. § 15-32-230.[1]

This appeal turns upon the proper application of two subsections of the same statute. Subsection (A) deals generally with "genuine" emergencies in "emergency departments, obstetrical suites, and surgical suites" and does not specify what type of care is needed to address the emergency. The physical location of the care determines whether the physician will have qualified immunity under subsection (A). *See* S.C. Code Ann. 15-32-230 (A). Non-obstetrical emergencies that sometimes require care within obstetrical suites include stroke, myocardial infarction, and acute asthma. *See* Tillet, *Nonobstetrical Emergencies in the Obstetrical Unit*, J' OF PERINAT NEONATAL NURS., 2013 Jan-Mar, 27(1): 5-7. Such nonobstetrical emergencies can also involve some of the many non-

[1] Section 15-32-230 was a component of the South Carolina Noneconomic Damage Awards Act of 2005 which comprehensively reformed medical malpractice law in South Carolina. In addition to defining and setting limits on noneconomic damages, the Act defined 'ambulatory care facility,' 'health care institution,' 'health care provider,' 'hospital,' 'institutional general infirmary,' 'nursing home,' 'renal dialysis facility,' 'skilled nursing services,' and 'medical malpractice.' See 2005 Act No. 32, Section 2, eff July 1, 2005, for causes of action arising after that date. The Act further provided procedural provisions for Offers of Judgment, designations and requirements of expert witnesses, and requirements for expert witness affidavits. The Act required that before filing a medical malpractice lawsuit, the plaintiffs must give notice of their intent to file suit. It established mandatory mediation requirements expressly for medical malpractice actions, and it modified the Medical Disciplinary Commission. Id.

patient visitors to obstetrical suites awaiting a birth. *Id*. Subsection (A) is not specific as to the type of emergency but is only specific as to the physical location where the emergency care is being rendered. *See* S.C. Code Ann. 15-32-230 (A).

Subsection (B) deals specifically with "a medical malpractice claim *arising out of obstetrical care* rendered by a physician on an emergency basis," regardless of the physical location of the care. *See* S.C. Code Ann. 15-32-230 (B) (emphasis added). If the legislators wanted to exclude the specified qualifications for immunity contained within subsection (B), they needed only to remove the subsection from the statute. Apparently, the legislators intended subsection (B) to provide additional qualifications for immunity from claims arising out of obstetrical care.

Both subsections allow the physician to be liable for gross negligence but provide immunity from liability for ordinary negligence. *Id.* Subsection (B), however, allows the immunity from ordinary negligence 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."[2]

Denying plaintiffs' motion to strike the affirmative defense raised by Section 15-32-230(A) & (C), the trial court ruled that unless gross negligence was shown the legislature intended to limit physician liability for genuine emergencies regardless of a previous doctor relationship or prenatal care. Without noting that subsection (B) was specific to obstetrical care while subsection (A) was not, the trial judge found that the

[2] Other qualifications necessary for immunity under either subsection: (1) the patient must not be medically stable, and (2) the patient must be in immediate threat of death or serious bodily injury. Moreover, the limitation on liability only applies to care rendered before discharge from the emergency department, obstetrical suite, or surgery suite. See S.C. Code Ann 15-32-230(C).

subsections were "separate and distinct," and subsection (A) was applicable as an affirmative defense. Over plaintiffs' objection, he instructed the jury with the law of subsection (A). (ROA 1011:05-12).

> *THE COURT: Well, I'll say this is my first encounter of a trial with this particular statute, and I've read it several times. And while I think, in some respects, it's somewhat confusing, it does appear to be addressing two of - the Legislature appears, from the language, to be addressing two, what they consider, to be two separate and distinct situations. And the language would indicate that both in A, B, and in C when it says further the limitations on liability established under Sections A and B shall only apply where care is rendered prior to a patient's discharge. So, the appear to be looking at it like it's two separate and distinct situations. B, obviously, relating to a physician with no previous doctor/patient relationship with a patient. But Subsection A, which the defense contends is applicable, does say that, in an action involving medical malpractice arising out of care rendered in a genuine emergency situation, which is described in the statute, is immune from a medical malpractice claim unless gross negligence is shown, and it says no physician may be held liable unless the circumstances as set forth in Subsection A. So, based upon my reading of the statute, I think it's applicable. I do think that it, it is an affirmative defense. It has to be established by the defense, and, therefore, the motion to strike, it is denied.*

(ROA 906:13-907:12).

If Section 15-32-230(A) had not been applied as an affirmative defense to protect Dr. Giep from liability for ordinary negligence, then the jury would have determined damages arising from the ordinary negligence and judgments would have been entered for monetary amounts in accord with S.C. Code Ann. § 15-32-220.[3]

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[3] *Section 15-32-220. (A) In an action on a medical malpractice claim when final judgment is rendered against a single health care provider the limit of civil liability for noneconomic damages of the health care provider is limited to an amount not to exceed three hundred fifty thousand dollars for each claimant, regardless of the*

"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* at 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." *Sloan v. Hardee* at 499, 640 S.E.2d at 459. 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

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number of separate causes of action on which the claim is based, except as provided in subsection (E).

(B) In an action on a medical malpractice claim when final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages is limited to an amount not to exceed three hundred fifty thousand dollars for each claimant, regardless of the number of separate causes of action on which the claim is based, except as provided in subsection (E).

(C) In an action on a medical malpractice claim when final judgment is rendered against more than one health care institution, or more than one health care provider, or any combination thereof, the limit of civil liability for noneconomic damages for each health care institution and each health care provider is limited to an amount not to exceed three hundred fifty thousand dollars for each claimant and the limit of civil liability for noneconomic damages for all health care institutions and health care providers is limited to an amount not to exceed one million fifty thousand dollars for each claimant, except as provided in subsection (E).

meaningless. *See 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).

Statutes in derogation of the common law are to be strictly construed. *Epstein v. Coastal Timber Co.*, 393 S.C. 276, 285, 711 S.E.2d 912, 917 (2011). "Under this rule, a statute restricting the common law will 'not be extended beyond the clear intent of the legislature.'" *Grier*, 397 S.C. at 536, 725 S.E.2d at 696. Statutes limiting a claimant's right to bring suit are subject to this rule. *Id*.

Statutes adopted at the same session of the Legislature are to be construed together, with the purpose of harmonizing them, and, if they are necessarily inconsistent, the statute dealing with common subject-matter in a minute and particular way will prevail over one of a more general nature. See *State ex rel. South Carolina Tax Com. v. Brown*, 154 S.C. 55, 151 S.E. 218 (1930); *Smith v. South Carolina State Highway Commission*, 138 S.C. 374, 136 S.E. 487.

Subsections (A) and (B) are each clear when viewed in isolation, but when the subsections are parts of the same statute, a reviewing court must look beyond the plain language of individual subsections and discern the underlying purpose of the statutes and their operational effect. *See Ranucci* at 499. Being part of the same statute, subsections (A) and (B) have a shared purpose in providing qualified immunity to physicians in various emergency situations. *Cf. Ranucci* at 499. Subsection (C), which references both (A) and (B) when providing additional qualifications for the physician's immunity, plainly states,

"[t]he limitation on physician liability [is] established by subsections (A) *and* (B). *See* § 15-32-230(C) (emphasis added).

The legislature clearly intended to have these subsections operate together to establish when qualified immunity would apply in various emergency situations and when it would not. The subsections of § 15-32-230 were not intended to be read as "separate and distinct," with subsection (A) applied in isolation to the exclusion of subsection (B). Rather, section 15-32-230 must be read so that it incorporates all provisions of the statute, including the provision of subsection (B) preserving recovery for ordinary negligence in obstetrical care if there has been a prior doctor/patient relationship or prenatal care. *Cf. Ranucci* at 499-500. Otherwise, the legislature's words demonstrating a clear intent to preserve patients' rights of recovery for negligent obstetrical care, if the patients have had either a previous doctor/patient relationship or prenatal care, will have no efficacy.

Conclusion

The judgment should be reversed, and the case remanded for a trial on damages only.

By: _____

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May 14, 2018

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-03178
Appellate Case No. 2017-002299

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

v.

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

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STATEMENT OF ISSUES ON APPEAL

I. Did the trial court correctly interpret S.C. Code Ann. § 15-32-230 such that only subsections (A) and (C) of that statute apply to the facts of this case?

II. If a new trial is ordered, is any such new trial required under S.C. Code Ann. § 15-33-125 to be a new trial as to both liability and damages because Appellants were not entitled to a directed verdict as to liability in the original trial?

STATEMENT OF THE CASE

This appeal arises from a judgment entered in favor of Respondents Dr. Bang N. Giep, M.D. ("Dr. Giep") and Spartanburg & Pelham OB-GYN, P.A. (collectively, "Respondents") in a medical malpractice lawsuit based on the medical emergency defense established by section 15-32-230 of the South Carolina Code. (Tr. Vol. I, 762:22–763:14, R. 1017–18.) Appellants Treva C. Flowers ("Mrs. Flowers") and Tristan Flowers ("Mr. Flowers"), together with and on behalf of their minor daughter, Ashley F. ("Ashley") (collectively, "Appellants"), filed a Notice of Intent to File Suit on October 7, 2011, as required under section 15-79-125 of the South Carolina Code. (Notice of Intent, R. 6.) The parties were unable to resolve the matter through mediation, and the mediator declared an impasse on January 16, 2012. Subsequently, Appellants filed the Complaint on March 12, 2012. (*See* Compl., R. 9.) Appellants alleged that Dr. Giep was "negligent, wanton, willful, reckless, and grossly negligent" in his response to the shoulder dystocia which complicated Ashley's birth. (Compl. ¶¶ 11–13, R. 10–11.)

The trial of the case began on October 9, 2017, before Judge J. Derham Cole. (Tr. Vol. I, 1, R. 23.) Following the close of Appellants' case, Respondents moved for a directed verdict on the issues of liability, future damages, and punitive damages. (Tr. Vol. I, 511:4–515:23, R. 428–32.) Appellants made no motion for directed verdict at that time, and Judge Cole took Respondents' motion under advisement. (Tr. Vol. I, 511:2–528:7, R. 428–45.) Upon the close of Respondents' case, Respondents renewed their motion for directed verdict and, with the Appellants' consent, Judge Cole granted Respondents a directed verdict as to Appellants' claims for punitive damages, future damages, and gross negligence. (Tr. Vol. I, 645:6–647:5, R. 901–03.) The trial court denied Respondents' motion as to liability based on simple negligence, however, finding it was a question of fact for the jury. (Tr. Vol. I, 645:17–18, R. 901.) At that point, Respondents also moved to amend their answer to include the affirmative defense

established in South Carolina Code Section 15-32-230.[1] This motion to amend was granted without objection by Appellants. (Tr. Vol. I, 647:11–19; 648:2–6, R. 903, 904.) Although Appellants did not object to Respondents amending their answer to assert section 13-32-230 as a defense, they moved after amendment to strike the defense, contending it was inapplicable to the facts of this case. (Tr. Vol. I, 648: 9–12, R. 904.) Specifically, Appellants argued section 15-32-230(B) denies immunity "in situations where there has been an ongoing physician/patient relationship" such as the "ongoing relationship between Mrs. Flowers and [Respondents.]" (Tr. Vol I, 648:13–21, R. 904.) Judge Cole disagreed with Appellants' reading of section 15-32-230 and instead interpreted the statute as follows:

> [W]hile I think, in some respects, it's somewhat confusing . . . the Legislature appears, from the language, to be addressing two, what they consider, to be two separate and distinct situations. And the language would indicate that both in A, B, and in C when it says further the limitations on liability established under Sections A and

---

[1] Section 15-32-230 provides:

> (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.

S.C. Code Ann. § 15-32-230.

> B shall only apply where care is rendered prior to a patient's discharge.
>
> So, they appear to be looking at it like it's two separate and distinct situations. B, obviously, relating to a physician with no previous doctor/patient relationship with a patient. But Subsection A, which the defense contends is applicable, does say that, in an action involving medical malpractice arising out of care rendered in a genuine emergency situation, which is described in the statute, is immune from a medical malpractice claim unless gross negligence is shown, and it says no physician may be held liable unless under the circumstances as set forth in Subsection A.

(Tr. Vol. I, 650:15–651:8, R. 906–07.) Thus, Judge Cole determined the evidence could support the defense under subsections (A) and (C) of the statute, creating a question of fact for the jury as to whether the requirements of subsections (A) and (C) were present—in particular, presence of a genuine emergency situation where the patient is not medically stable and is in immediate threat of death or serious bodily injury. Consequently, Judge Cole denied Appellants' motion to strike. (*See* Tr. Vol I, 650:13–651:12, R. 906–07.) Appellants made no motion for directed verdict at the close of all evidence.

Judge Cole then provided the parties with his proposed special verdict form, which consisted of four questions to be posed to the jury. (Tr. Vol. I, 651:19–652:3; R. 907–08; Verdict Form; R. 4–5.) The first question asked for a determination by the jury as to whether Respondents were negligent and whether such negligence was the proximate cause of the Appellants' injuries, and, if answered in the negative, the form instructed the jury to stop deliberations. (*Id.*) The second question focused on the requirements of section 15-32-230(A) and (C), and asked the jury to determine whether the medical care provided was rendered in a genuine emergency situation where the patient was not medically stable and was in immediate threat of either death or serious injury and, if answered in the affirmative, the form instructed the jury to stop deliberations. (*Id.*) The third and fourth questions on the form, if reached, asked the jury to determine the amount of

Ashley's and Mr. & Mrs. Flowers' actual damages, respectively. (*Id.*) Appellants made no objection to the special verdict form. (Tr. Vol. I, 651:19–652:3; R. 907–08.)[2]

Following the trial court's instructions to the jury, which included instructions regarding subsections (A) and (C) of section 15-32-230 (Tr. Vol. I, 738:18–740; R. 994–96), Appellants objected to that portion of the charge based on the argument they asserted with regard to their motion to strike. (Tr. Vol. I, 756:8–12, R. 1011.) Once again the trial court asked the parties about the special verdict form, and Appellants indicated that they had reviewed it and offered no objection. (Tr. Vol. I, 756:22–25, R. 1011.)

The jury answered the first question on the special verdict form in the affirmative, finding that the Respondents were negligent and that this negligence was the proximate cause of some injury sustained by the Appellants. (Verdict Form; R. 4–5.) However, the jury then answered the second question in the affirmative, finding that the medical care provided was rendered in a genuine emergency situation where the patient was not medically stable and was in immediate threat of either death or serious injury. (*Id.*) As instructed by the verdict form, the jury then ceased all deliberations making no findings as to the amount of Appellants' actual damages. (*Id.*)

Upon this verdict being rendered, Appellants moved for a new trial based on the denial of their motion to strike the affirmative defense of section 15-32-230 and their objection to the jury

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[2] To the extent Appellants seek to challenge the verdict form, that issue is not properly preserved for this Court's review. *See Johnson v. Hoechst Celanese Corp.*, 317 S.C. 415, 421, 453 S.E.2d 908, 912 (Ct. App. 1995) ("Any alleged error with the . . . verdict form [is] a trial error which must be preserved for appeal."). "There are four basic requirements to preserving issues at trial for appellate review. The issue must have been (1) raised to and ruled upon by the trial court, (2) raised by the appellant, (3) raised in a timely manner, and (4) raised to the trial court with sufficient specificity." *S.C. Dep't of Transp. v. First Carolina Corp. of S.C.*, 372 S.C. 295, 301–02, 641 S.E.2d 903, 907 (2007) (internal quotation marks omitted). While Appellants objected to certain of the trial court's jury charges, they never raised any objection or complaint regarding the verdict form or the judge's instructions thereon. (Tr. Vol. I, 756:5–765:13, R. 1011–20.)

moved to a labor and delivery room at 7:55 p.m. (Tr. Vol. I, 262:8; 295:6–8; 299:15–17; 411:1–6; 414:2–8; 415:9–11; 474:22–475:2, R. 191, 224, 228, 328, 331–32, 391–92.)

Dr. Giep, who had taken over when Dr. Fowler's shift ended, arrived in the delivery room at 8:11 p.m., responding to a drop in the baby's heartrate of more than 33% from 130 beats per minute ("BPM") to 90 BPM.[4] (Tr. Vol. I, 299:18–25; 413:23–25; 564:16–17; Tr. Vol. II, 41:16–19; 47:19–22; 48:6–9, R. 228, 330, 482, 596, 602–03; *see also* Tr. Vol. I, 412: 1–5, 10–15, R. 329.) Dr. Giep was able to accelerate the heartrate by stimulating the baby's scalp; however, the heartrate continued to fluctuate. (Tr. Vol. I, 302:16–19; Tr. Vol. II, 55:1–7, 20–24, R. 231, 610.) Concerned that the baby was not receiving enough oxygen, Dr. Giep applied a Kiwi Vacuum to the baby's scalp to expedite delivery and was able to successfully deliver the head at 8:18 p.m. (Tr. Vol. I, 203:11–14; 262:8–11; 304:8–10; 573:4–8; Tr. Vol. II, 49:6–16; 59:20–23, R. 134, 191, 233, 490, 604, 614.)

Once the baby's head had been delivered, Dr. Giep asked Mrs. Flowers to push again and applied gentle traction.[5] (Tr. Vol. II, 69:4–8, R. 624.) When the baby's shoulders did not immediately deliver and the head contracted back slightly, Dr. Giep diagnosed that the baby's left should had become obstructed by Mrs. Flowers' pubic bone, a medical condition known as shoulder dystocia.[6] (Tr. Vol. I, 205:18–19; 251:7–9; 251:13–15; Tr. Vol. II, 69:4–8; 70:5–14, R. 136, 180, 624–25.) Dr. Giep immediately stopped applying traction to the baby's head and asked Mrs. Flowers to stop pushing. (Tr. Vol. II, 28:1–6; 69:23, R. 583, 624.)

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[4] The target heartrate for infants during birth is between 110 and 160 BPM. (Tr. Vol. I, 564:14–16, R. 481.)

[5] The medical term "traction" refers to a pulling movement. (Tr. Vol. I, 168:22, R. 107.)

[6] "[T]he word dystocia means difficult delivery or difficult labor." (Tr. Vol. I, 251:6–7, R. 180.) Shoulder dystocia specifically refers to an unpredictable delivery complication in which the infant's "body is prevented from delivering . . . because the shoulder is caught up against the mother's . . . pubic bone." (Tr. Vol. I, 251:13–15; 309:4–5; Tr. Vol. II, 24:7–14, R. 180, 238, 579.)

As he was trained to do, Dr. Giep instructed the nurses to pull Mrs. Flowers' legs back into a position with her knees pressed back towards her shoulders ("the McRoberts position") in order to elevate her pubic bone relative to the position of the baby's shoulder and thereby create more room for the shoulder to deliver. (Tr. Vol. I, 162:1–3; 166:1; 263:18–22; 418:6–9; 479:21–23; 566:23–567:2; Tr. Vol. II, 25:3–16; 70:17–25; 175:10–15, R. 101, 105, 192, 335, 396, 483–84, 580, 625, 729.) Dr. Giep also had one of the nurses apply suprapubic pressure just above Mrs. Flowers' pubic bone in an attempt to rotate the baby's shoulder under the pubic bone. (Tr. Vol. I, 171:20–25; 205:24–206:2; 264:19–265:2; 417:18–418:2; 479:24–480:6; 567:9–22; Tr. Vol. II, 25:9–11; 70:17–25; 176:4–6, R. 110, 136–37, 193–94, 334–35, 396–97, 484, 580, 625, 730.) Once Mrs. Flowers was in the McRoberts position and suprapubic pressure was being applied, Dr. Giep asked her to try pushing again while he began applying gentle traction to the baby's head. (Tr. Vol. II, 71:3–23, R. 626.) When the shoulder still did not release, Dr. Giep attempted to deliver the baby's bottom arm before successfully performing a Rubins maneuver—placing his hand on the baby's back and rotating the shoulder under the pubic bone. (Tr. Vol. II, 25:15–25; 73:24–74:19, R. 580, 628–29.) As soon as the shoulder released, Dr. Giep was able to hook his fingers under the baby's armpits and gently pull her out the rest of the way. (Tr. Vol. II, 76:1–6, R. 631.) Ashley was fully delivered at 8:20 p.m. (Tr. Vol. I, 413:10; Tr. Vol. II, 83:4–5, R. 330, 638.) Following Ashley's birth she was diagnosed with a brachial plexus injury caused by ruptures of her C5, C6, and C7 nerves during birth. (Tr. Vol. I, 134:6–9; 152:7–13; 219:5, R. 73, 91, 148.)

At trial, the parties presented extensive, conflicting expert testimony regarding the proper procedure when confronted with shoulder dystocia as well as the potential causes of a permanent brachial plexus injury like the one Ashley suffered. In particular, Appellants' experts opined that Ashley's injury could only have been caused by excessive downward traction exerting between

thirty-five and forty pounds of force on her head and neck. (*See* Tr. Vol. I, 187:16–17; 189:8–9; 193:1–8; 206:3–6; 273:19–274:6; 275:17–21, R. 118, 120, 124, 137, 202–04.) On the other hand, Respondents' experts testified that brachial plexus injuries can be caused by the forces generated by a mother's contractions and can occur even when minimal or no traction is applied at all. (Tr. Vol. I, 561:6–9; 587:1–6; 593:2–7; Tr. Vol. II, 260:3–15; 262:13–21, R. 478, 504, 510, 876, 878.) The one thing upon which all the medical experts agreed, however, is that shoulder dystocia is an unpredictable, obstetrical emergency that places the baby at risk of death or serious bodily injury. (*See* Tr. Vol. I, 309:4–8; 310:1–4; 339:23–340:11; 341:4–6; 341:18–20; 564:1–3; 565:11–20; 566:1–10; 628:3–12; 628:20–629:15; 640:9, 16–19; 641:1–4, 8–9; Tr. Vol. II, 24:7–14; 48:10–12; 76:24–78:15; 140:24–25; 141:21–23; 191:10–14; 198:11–25; 199:14–19; 220:4–221:11, R. 238–39, 268–70, 481–83, 545–46, 557–58, 579, 603, 631–33, 694–95, 745, 752–53, 774–75.)

After deliberating for close to seven hours, the jury returned and indicated it had not reached an unanimous verdict. (Tr. Vol. I, 757:7–11, R. 1012.) At that time, the court gave the jury an *Allen*[7] charge and encouraged the jury to continue their deliberations. (Tr. Vol. I, 758:12–759:9, R. 1013–14.) Neither party raised any objection to the court's *Allen* charge. (Tr. Vol I, 759:12–14, R. 1014.) Less than an hour later, the jury sent a note requesting reinstruction on the law of circumstantial evidence. (*See* Tr. Vol. I, 759:18–760:2, R. 1014–15.) In order to ensure the jury fully understood the law, the court reinstructed the jury on both direct and circumstantial evidence and sent them back to continue their deliberations. (Tr. Vol. I, 760:4–761:16, R. 1015–16.) Again, neither party objected to the court's instructions. (Tr. Vol. I, 761:19–21, R. 1016.) Shortly thereafter, the jury returned and rendered its verdict. (*See* Tr. Vol. I, 761:23–763:14, R. 1016–18.)

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[7] *Allen v. United States*, 164 U.S. 492, 17 S. Ct. 154, 41 L. Ed. 528 (1896).

STANDARD OF REVIEW

Decisions regarding jury instructions and motions to strike affirmative defenses are addressed to the sound discretion of the trial court and will not be reversed on appeal absent an abuse of that discretion. *See, e.g., Carson v. CSX Transp., Inc.*, 400 S.C. 221, 229, 734 S.E.2d 148, 152 (2012) (noting decisions as to particular jury instructions are within the trial court's discretion); *Kirkland v. Peoples Gas Co.*, 269 S.C. 431, 436, 237 S.E.2d 772, 774 (1977) (same with respect to motions to strike an affirmative defense). A trial court commits an abuse of discretion only when its decision is controlled by an error of law or is entirely unsupported by the evidence. *Stephens v. CSX Transp. Inc.*, 415 S.C. 182, 197, 781 S.E.2d 534, 542 (2015) (quoting *Cole v. Raut*, 378 S.C. 398, 404, 663 S.E.2d 30, 33 (2008)).

A trial judge is required to charge only the current and correct law of South Carolina. *Clark v. Cantrell*, 339 S.C. 369, 390, 529 S.E.2d 528, 539 (2000); *McCourt v. Abernathy*, 318 S.C. 301, 305, 457 S.E.2d 603, 606 (1995). When "reviewing jury charges for error, the appellate court must consider the circuit court's jury charge as a whole in light of the evidence and issues presented at trial." *Hennes v. Shaw*, 397 S.C. 391, 402, 725 S.E.2d 501, 507 (Ct. App. 2012) (citing *Welch v. Epstein*, 342 S.C. 279, 311, 536 S.E.2d 408, 425 (Ct. App. 2000)). An erroneous jury charge is grounds for reversal only where the appellant can demonstrate error and prejudice. *Cole*, 378 S.C. at 405, 663 S.E.2d at 33.

ARGUMENT

I. The Trial Court Properly Interpreted Section 15-32-230, Correctly Denied Appellants' Motion to Strike, and Properly Instructed the Jury as to Only the Relevant Provisions of That Statute.

The controlling question before this Court is one of statutory construction: whether subsections (A) and (B) of section 15-32-230 establish physician immunity in separate circumstances or, as Appellants contend, whether subsection (B) qualifies and limits the immunity

created in subjection (A). (*See* App. Br. at 16.) Appellants do not dispute the applicability of subsections (A) and (C) of section 15-32-230—which establish immunity for ordinary negligence in medical care rendered by physicians in an emergency department, an obstetrical suite, or a surgical suite during genuine emergency situations where the patient is medically unstable and in immediate threat of death or serious bodily injury—nor do Appellants question the jury's findings of fact under these provisions.[8] S.C. Code Ann. § 15-32-230(A), (C). Indeed, the only issue on which the parties disagree, and the sole basis for Appellants' appeal, is the import of subsection (B) to the facts of this case.

A. S.C. Code Ann. § 15-32-230 is not ambiguous.

"The first question of statutory interpretation is whether the statute's meaning is clear on its face." *Kennedy v. S.C. Retirement Sys.*, 345 S.C. 339, 346, 549 S.E.2d 243, 246 (2001). "'If a statute's language is plain and unambiguous, and conveys a clear and definite meaning, there is no occasion for employing rules of statutory interpretation and the court has no right to look for or impose another meaning.'" *Id.* (*citing Paschal v. State Election Comm'n*, 317 S.C. 434, 436, 454 S.E.2d 890, 892 (1995)). Appellants do not contend that either subsections (A) or (B) of section 15-32-230 are ambiguous. In fact, Appellants admit that "[s]ubsections (A) and (B) are each clear when viewed in isolation . . . ." (App. Br. at 19.) Appellants' contention is that subsection (B) impliedly qualifies or limits the immunity granted in subsection (A) for cases involving obstetrical

[8] Respondents note that Appellants never objected to the jury's findings as incorrect or unsupported by the evidence, nor do they argue as much on appeal. (*See generally* App. Br.) Accordingly, the jury's conclusions that (1) the circumstances of Ashley's birth and delivery constituted a genuine medical emergency; (2) Ashley was medically unstable during the birth and delivery process; and (3) Ashley was in immediate threat of death or serious bodily harm are now the law of the case. (Tr. Vol. I, 763:5–13, R. 1018; *Judy v. Martin*, 381 S.C. 455, 458, 674 S.E.2d 151, 153 (2009) ("Under the law-of-the-case doctrine, a party is precluded from relitigating, after an appeal, matters that were either not raised on appeal, but should have been, or raised on appeal, but expressly rejected by the appellate court.").)

care where the physician has a prior doctor/patient relationship with the patient. No such qualification or limitation is mentioned in (A) or (B), however, and the unambiguous immunity established in (A) clearly applies to the facts of this case.

Section 15-32-230 was added to the South Carolina Code in 2005 as part of the South Carolina Noneconomic Damages Awards Act of 2005. Prior to that time, South Carolina already had a "Good Samaritan" statute found at S.C. Code Ann. § 15-1-310 which provides that "[a]ny person, who in good faith gratuitously renders emergency care at the scene of an accident or emergency" is only liable for acts or omissions amounting to gross negligence or willful or wanton misconduct arising from that emergency care. Section 15-32-230, however is different from the Good Samaritan statute in that it is not limited to gratuitously provided care and applies only to physicians in specifically delineated situations. In particular, section 15-32-230 provides:

> (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.

S.C. Code Ann. § 15-32-230.

Looking to the plain and ordinary meaning of the separate subsections of this statute, subsections (A) and (B) address different and distinct situations establishing an immunity for simple negligence in both situations, and neither subsection operates to limit the other. Subsection 15-32-230(A) provides protection for any physician who renders care in a "genuine emergency situation" to a patient who is receiving that care in an emergency department, obstetrical suite, or a surgical suite. Thus, the immunity established in (A) is limited so as to apply only to care provided in three specific locations: (1) an emergency department; (2) an obstetrical suite; and (3) a surgical suite. There is **no** limitation on the type of medical care provided and there is **no** limitation based the existence of a prior doctor/patient relationship. The care does need to be rendered in a "genuine emergency situation," and must be rendered in one of the three places designated in this section of the statute.

Subsection 15-32-230(B), on the other hand, establishes protection for any physician who provides **obstetrical care** on "an emergency basis where there is no prior doctor/patient relationship or the patient has not received prenatal care." Therefore, the immunity established in (B) is limited to obstetrical care, and is further limited to situations in which there is no pre-existing doctor/patient relationship between the physician (or a member of his practice) and the patient, or the patient has not received prenatal care. Subsection (B) is not limited to care provided in an emergency department, obstetrical suite, or surgical suite, and would apply to care provided anywhere outside of those locations. Also, the care need not be rendered in a "genuine emergency situation," but must be rendered "on an emergency basis where there is no prior doctor/patient relationship or the patient has not received prenatal care."

Subsection 15-32-230(C) then places specific restrictions on the physician immunities provided for in both subsections (A) and (B), restricting that immunity to situations where the patient is not medically stable and is in immediate threat of death or serious bodily injury. Subsection (C) further has a temporal feature, providing that immunity only applies for care rendered before a patient is ultimately discharged from an emergency department, obstetrical suite, or surgical suite.

Thus, the first immunity created in section 15-32-230 is that ***any physician***, providing ***any type of care*** **in** ***an emergency department, obstetrical suite, or surgical suite***, in a "***genuine emergency situation***" where the patient is medically unstable and is in an immediate threat of death or serious bodily harm, is immune from liability for simple negligence. S.C. Code Ann. § 15-32-230(A). It does not matter what type of medical care is being provided. *See id.* It also does not matter if the physician (or his practice) has a prior doctor/patient relationship with the patient. *See id.* What does matter is where the care is provided—it must be care provided in an emergency department, obstetrical suite, or surgical suite. *Id.* The fact that "obstetrical suite" is specifically included in (A) unambiguously shows that this immunity applies to emergency obstetrical care (amongst other types of medical care) regardless of the existence of a prior doctor/patient relationship.

Section 15-32-230(B) then creates a separate and distinct simple negligence immunity for ***any physician*** who provides ***obstetrical care*** on an "***emergency basis***" in a situation where the patient is medically unstable and is in an immediate threat of death or serious bodily harm, ***so long as that physician (or his practice) has no prior doctor/patient relationship*** with the patient. This immunity would apply to obstetrical care provided on an emergency basis in any place, including any place outside of an emergency department, obstetrical suite, or surgical suite. Thus, subsection

Subsection (A) addresses a situation where a physician is providing care, planned or unplanned, and, while that care is being provided, an emergency situation relating to the health of the patient suddenly arises. Specifically, subsection (A) applies to "care rendered in a genuine emergency situation involving an immediate threat of death or serious bodily injury to the patient receiving care." S.C. Code Ann. § 15-32-230(A). The fact that a "genuine emergency situation" arises during the provision of that care is a trigger for this immunity, which is then further qualified by the requirement that the care be provided in an emergency department, obstetrical suite, or surgical suite, which are the places where such "emergency situations" are most likely to occur. For example, subsection (A) would apply in a situation where a patient is having routine surgery in a surgical suite and an unexpected complication occurs rendering the patient unstable and in immediate threat of death. Subsection (A)'s specific inclusion of "obstetrical suite" in its scope would also make it applicable to a situation where a physician is delivering a baby and an unexpected complication—such as shoulder dystocia—arises, rendering the baby medically unstable and in immediate threat of death or serious bodily harm.

Subsection (B), on the other hand, addresses a situation where a physician is unexpectedly providing obstetrical care. Specifically, subsection (B) applies to "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." S.C. Code Ann. § 15-32-230(B). The fact that the care is being provided "on an emergency basis" is a trigger for this immunity. That the provision of obstetrical care by the particular physician is unplanned is further delineated by the requirement that there be no prior doctor/patient relationship or that the patient previously received no prenatal care. For example, subsection (B) would apply in a situation where a pregnant woman in labor presents herself at a doctor's office or medical

clinic or hospital, and a physician who was not expecting to provide obstetrical care is thrust into a position of providing that care to this patient. If, in that situation, a complication arises that results in the mother or the baby becoming medically unstable and in immediate threat of death or serious bodily harm, that physician is immune from liability for simple negligence.

By creating this distinction between "care rendered in a genuine emergency situation" and "obstetrical care rendered on an emergency basis," the General Assembly was addressing two distinctly different situations. While it is possible that both subsections (A) and (B) could apply to the same situation (pregnant woman in labor shows up at an emergency room), there are clearly situations that are specific to each subsection. The subsection applicable in the instant matter is subsection (A) because, while Ms. Flowers went into labor a few days early, the delivery was an expected procedure and Dr. Giep was part of the practice that was providing her with obstetrical care. What triggers subsection (A) immunity here is that, during that delivery in an obstetrical suite, a genuine emergency situation involving an immediate threat of death or serious bodily arose.

The trial court correctly interpreted the statute as applying to "two separate and distinct situations" and correctly ruled that subsection (A) would apply if the jury found that the medical care in question, which undisputedly occurred in an obstetrical suite, was rendered in a genuine medical emergency situation where the patient was not medically stable and was in immediate threat of death or serious bodily injury. (Tr. Vol I, 649:13–650:12; R. 905–06.) The trial court also correctly determined that, because there was a prior doctor/patient relationship present, that subsection (B) did not apply and that the jury need not be instructed on that inapplicable subsection. In fact, had the trial court included subsection (B) in its instruction, the inclusion of an irrelevant provision could have constituted reversible error. *Berberich v. Jack*, 392 S.C. 278,

Int'l, Inc. v. S.C. Dep't of Revenue, 406 S.C. 132, 139, 750 S.E.2d 65, 69 (2013) (quoting *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007)). Accordingly, courts must "'read the statute as a whole' and 'should not concentrate on isolated phrases within the statute.'" *Id.* (quoting *CFRE, LLC v. Greenville County Assessor*, 395 S.C. 67, 74, 716 S.E.2d 877, 881 (2011)). Thus, "[w]ords in a statute must be construed in context, and their meaning may be ascertained by reference to words associated with them in the statute." *S.C. Energy Users Comm. v. S.C. Public Serv. Comm'n*, 388 S.C. 486, 491, 697 S.E.2d 587, 590 (2010). Additionally, courts must "presume the legislature did not intend to do a futile act" and the court "is constrained to avoid an absurd result." *Buscemi*, 417 S.C. at 274, 789 S.E.2d at 760; *see also Matter of Decker*, 322 S.C. 215, 219, 471 S.E.2d 462, 463 (1995) ("A statute should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous."). Similarly, "[o]ur courts are constrained to avoid a statutory construction that would have the effect of reading a provision out of a statute." *Buscemi*, 417 S.C. at 274, 789 S.E.2d at 760.

Appellants contend that the immunities created in subsection (A) and (B) are not "separate and distinct," and assert that, despite the fact that (A) specifically addresses care provided in "obstetrical suites," (B) operates to limit (A) making it inapplicable to obstetrical care provided by a physician with a prior doctor/patient relationship. (App. Br. at 14.) This contention is incorrect. Appellants' forced construction would improperly limit the operation of (A), and would improperly render the specific inclusion of "obstetrical suite" in (A) to be meaningless.

By including "obstetrical suites" as one of the three locations where section (A) immunity applies, the General Assembly clearly intended obstetrical care to qualify. Appellants suggest that the General Assembly's inclusion of "obstetrical suite" in (A) was intended to apply the immunity only as to "non-obstetrical emergencies" involving obstetrical patients or medical emergencies

involving "non-patient visitors" in an obstetrical suite. (App. Br. at 15–16.) Such a tortured interpretation is nonsensical and absurd. In subsection (A), the General Assembly identified the three places physicians were likely to encounter life-threatening medical emergencies and established an immunity from simple negligence for ***any*** type care provided at those three locations. In subsection (B), the General Assembly created a separate simple negligence immunity for emergency obstetrical care provided anywhere if the performing physician had no prior relationship with the recipient.

Subsection (B) does not qualify or limit the immunity granted in subsection (A), but rather establishes its own separate immunity for physicians providing obstetrical care on an emergency basis where there is no previous doctor/patient relationship. If the General Assembly had truly intended subsection (B) to limit the immunity for emergency obstetrical care granted in subsection (A) only to situations in which there was no existing doctor/patient relationship or prior prenatal care, it easily could have included language to that effect in either subsections (A) or (B).[9] In fact, the General Assembly included limiting language in subsection (C) by providing that the liability limitations "established by subsections (A) and (B) shall *only* apply" under certain circumstances. S.C. Code Ann. § 15-32-230(C) (emphasis added). Thus, the General Assembly was perfectly capable of including qualifying language in subsections (A) or (B) had it wished to do so. *Cf. Machin v. Carus Corp.*, 419 S.C. 527, 545, 799 S.E.2d 468, 477 (2017) (noting that "if the legislature intended to allow non-parties to be included on the jury verdict form, it would have used terms other than 'defendant' and 'defendants' in drafting subsection (C), just as it used the

[9] For example, the General Assembly could have removed the word "obstetrical suite" from (A), or drafted (A) to read "arising out of care, other than obstetrical care rendered by a physician with a prior doctor/patient relationship with the patient, rendered . . . ." Alternatively, they could have drafted (B) to specify that its limitations also applied to "obstetrical care provided in an emergency department, obstetrical suite, or surgical suite."

different term—potential tortfeasor—in subsection (D)"); *Hardee v. McDowell*, 372 S.C. 413, 419, 642 S.E.2d 632, 636 (Ct. App. 2007) ("If the state legislature had intended for a contractor to collect documentation of insurance from a subcontractor once a year, it could have drafted the statute to reflect that intent.").

Appellants' argument that "the legislators intended subsection (B) to provide additional qualifications for [the] immunity [established in subsection (A)] from claims arising out of obstetrical care" is contrary to both the unambiguous language and clear intent of section 15-32-230. (App. Br. at 16.) Subsection (B) is not a restriction on the immunity established (A). It is a separate immunity that applies independently in circumstances where (A) may not apply. Subsection (C) explicitly refers to *both* subsections (A) and (B) as establishing "limitation[s] on physician liability." S.C. Code Ann. § 15-32-230(C). In other words, according to the plain language of subsection (C), subsection (B) is intended to grant *additional* immunity to that established in subsection (A), specifically for physicians who respond in obstetrical emergencies, even in locations other than an emergency department, obstetrical suite, or surgical suite, and who have no previous relationship with the patient. *See id.*; *Perry*, 409 S.C. at 140, 761 S.E.2d at 253 ("The plain language of a statute [itself] is considered the best evidence of the legislature's intent."). Furthermore, Appellants' interpretation is completely contrary to the public policy behind the General Assembly's enactment of section 15-32-230—seeking to limit physician liability in emergency medical care situation. Not only would Appellants' interpretation expand rather than limit physician liability, but it would also discourage physicians from responding to obstetrical emergencies occurring in an emergency department, obstetrical suite, or surgical suite in which their own patients become involved. That clearly cannot be and is not what the legislature intended by incorporating subsection (B) into the medical emergency statute.

The General Assembly purposely drafted subsection (A) to provide immunity to physicians rendering care in genuine emergency situations based on the locations where such care is most likely to be treated. Significantly, an obstetrical emergency could arise anywhere and, while the medical care required to address that emergency will typically occur in an obstetrical suite, it is highly likely that such care also will be rendered in locations outside of an emergency department, obstetrical suite or surgical suite, and that a physician with no prior relationship with the patient may end up providing that obstetrical care on an emergency basis. Thus, the General Assembly addressed immunity in those instances through section 15-32-230(B). It would be an absurd interpretation to suggest that the General Assembly did not intend for emergency care "in an obstetrical suite" to include obstetrical care. Such an interpretation would render the phrase "in an obstetrical suite" in subsection (A) entirely superfluous. *Buscemi*, 417 S.C. at 274, 789 S.E.2d at 760 (noting "courts must presume the legislature did not intend to do a futile act," and "statute[s] should be so construed that no word, clause, sentence, provision or part shall be rendered surplusage, or superfluous").

Therefore, the only rational statutory construction of section 15-32-230 is that articulated by Judge Cole: that subsection (A) applies to any and all emergency care, including obstetrical care provided in an obstetrical suite, regardless of whether there is a preexisting doctor/patient relationship, while subsection (B) applies only in situations where a physician provides obstetrical care on an emergency basis where there is no prior doctor/patient relationship with the patient, including obstetrical care provided in locations other than those addressed in subsection (A). (*See* Tr. Vol. I, 650:15–651:12, R. 906–07.) Accordingly, subsection (A) applies to the facts of this case because Dr. Giep was providing emergency obstetrical care in an obstetrical suite, and (B) does not apply because Dr. Giep had a prior doctor/patient relationship with the patient. (*See* Tr.

Vol. I, 404:20–405:22; 466:15–20; Tr. Vol. II, 21:11–18; 40:9–12; 41:2–19, R. 321–22, 383, 576, 595–96.) Thus, Judge Cole did not abuse his discretion in denying Appellants' motion to strike or in charging the jury only on the relevant subsections (A) and (C) of section 15-32-230. *See Kirkland*, 269 S.C. at 436, 237 S.E.2d at 774 ("A motion to strike is addressed to the sound discretion of the trial judge."); *Carson*, 400 S.C. at 240, 734 S.E.2d at 158 (upholding jury charge and holding "it was within the circuit judge's discretion to omit this particular statutory language because of its perceived irrelevance to the issue of CSX's negligence and because of the risk of confusing or misleading the jury"); *Fairchild v. S.C. Dep't of Transp.*, 385 S.C. 344, 350–51, 683 S.E.2d 818, 822 (Ct. App. 2009) (holding "jury instructions should be confined to the issues made by the pleadings and supported by the evidence"). Therefore, the judgment for the Respondents should be affirmed.

II. Pursuant to S.C. Code Ann. § 15-33-125, Any New Trial in This Case Must Be as to Both Liability and Damages and Cannot Be Limited to the Issue of Damages Alone.

To the extent Appellants seek a new trial on the issue of damages alone, such relief is improper in this case. (*See* App. Br. at 17.) Rather, should this Court reverse the trial court's judgment and order a new trial, S.C. Code Ann. § 15-33-125 requires that any such new trial must be as to both liability and damages. Section 15-33-125 of the South Carolina Code provides:

> A new trial may be granted to the plaintiff on the issue of damages only and not liability when the only reasonable inference to be drawn from all the evidence, viewed in the light most favorable to the defendant, is that the plaintiff is entitled to a verdict in his favor on the issue of liability as a matter of law. Unless the plaintiff is entitled to a directed verdict on the issue of liability, any new trial must include both issues of liability and damages.

S.C. Code Ann. § 15-33-125. This Court has repeatedly held that section 15-33-125 prohibits new trials solely on the issue of damages where the question of liability was contested. *Stevens v. Allen*, 336 S.C. 439, 453, 520 S.E.2d 625, 632 (Ct. App. 1999), *aff'd*, 342 S.C. 47, 536 S.E.2d 663 (2000)

("Since liability was contested in this case, a new trial as to damages only would be inappropriate."); *Sullivan v. Davis*, 317 S.C. 462, 468, 454 S.E.2d 907, 911 (Ct. App. 1995) ("Here, because the evidence on liability was disputed, the judge could not have directed a verdict. Therefore, the new trials must include issues of liability and damages."). The South Carolina Supreme Court has also recognized that "[s]ection 15-33-125 limits new trials on the issue of damages to situations where the plaintiff is entitled to a directed verdict on the issue of liability." *Stokes v. Denmark Emergency Med. Servs.*, 315 S.C. 263, 266, 433 S.E.2d 850, 851 (1993).

In this case, Respondents moved for directed verdict on the issue of liability and the trial court denied the motion, finding liability to be a question of fact for the jury. (Tr. 511:4–6; 645:6–18, R. 428, 901.) Not only have Appellants never move for directed verdict or JNOV on the issue of liability—effectively conceding that the issue is disputed—but Appellants explicitly argued to the trial court that Respondents' liability "would be a question of fact for the jury to determine." (Tr. 520:14–15, R. 437.) There is no question that the evidence in this case does not entitle Appellants to judgment as a matter of law on the issue of liability. The fact that the jury's verdict below included a finding of simple negligence by Respondents has no bearing on this analysis. The jury's verdict is merely a verdict, and does not equate to a "directed" verdict. In a verdict, the fact-finder determines the factual issues, in a directed verdict the court finds that "the only reasonable inference to be drawn from all the evidence, viewed in the light most favorable to the defendant, is that the plaintiff is entitled to a verdict in his favor on the issue of liability as a matter of law." Thus, pursuant to section 15-33-125, any new trial ordered would necessarily have to address both liability and damages. *See Sullivan*, 317 S.C. at 468, 454 S.E.2d at 911.

CONCLUSION

For the foregoing reasons, this Court should find no error in the trial court's jury instructions and ruling on Appellants' motion to strike, and uphold the jury's verdict and the trial court's entry of judgment in favor of Respondents.

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-03178
Appellate Case No. 2017-002299

RECEIVED
JUN 13 2018
SC Court of Appeals

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

v.

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

CERTIFICATE OF COUNSEL

The undersigned certifies that this Final Brief of Respondents complies with Rule 211(b), SCACR.

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In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

The Honorable J. Derham Cole,
Circuit Court Judge

RECEIVED
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SC Court of Appeals

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

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

v.

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

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I, the undersigned Paralegal of the law offices of Nelson Mullins Riley & Scarborough LLP, attorneys for Bang N. Giep, M.D., and Spartanburg & Pelham OB-GYN, P.A. (formerly Spartanburg OB-GYN, P.A.), do hereby certify that I have served all counsel in this action with a copy of the pleading(s) hereinbelow specified by mailing a copy of the same to the following address(es):

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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-3178

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v.

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Statement of Issues on Appeal

Was it error to apply S.C. Code Ann. § 15-32-230(A) to the exclusion of § 15-32-230(B) and render judgment for defendants in medical malpractice claims arising from emergency obstetrical care when the plaintiffs had a previous doctor/patient relationship with the defendant physician and other members of his practice and received prenatal care?

Statement of the Case

On respondents' counsel's motion to amend, appellants' counsel acknowledged to the trial judge that facts concerning a medical emergency during the labor and delivery had been litigated and that respondents were entitled to amend their answer to include the affirmative defense allowed by S.C. Code Ann. § 15-32-230. At the same time, appellants' counsel gave notice of his motion to strike the affirmative defense at the appropriate time. ROA 903:11 – 904:06. When respondents' attorney finished his trial motions, appellants' attorney immediately presented his motion to strike on grounds that section 15-32-230 was not applicable as a matter of law. ROA 904:09-21. Apodictically, the motion to strike was essentially a motion for a directed verdict as to the affirmative defense. *See Wright v. Craft*, 372 S.C. 1, 33, 640 S.E.2d 486, 503 (Ct. App. 2006); *Allison v. Charter Rivers Hosp., Inc.*, 334 S.C. 611, 615, 514 S.E.2d 601, 604 (Ct. App. 1999).

Contrary to respondents' assertions and in accord with their motion to strike and objection jury charge objections, appellants do dispute the applicability of subsection (A) and disagree that the jury should have been required to make factual findings for applying subsection (A).

Standard of Review

An issue regarding statutory interpretation is a question of law. *S.C. Coastal Conserv. League v. S.C. Dep't of Health & Envtl. Control*, 390 S.C. 418, 425, 702 S.E.2d 246, 250 (2010). "Questions of statutory interpretation are questions of law, which we [the appellate court] are free to decide without any deference to the court below." *Grier v. AMISUB of S.C., Inc.*, 397 S.C. 532, 535, 725 S.E.2d 693, 695 (2012). The granting or refusal of a motion to strike is subject to the trial judge's discretion but can be reversed if the trial judge's action was an abuse of discretion or controlled by an error of law. *See Gates at Williams-Brice Condo. Ass'n v. DDC Constr., Inc.*, 418 S.C. 282, 792 S.E.2d 240 (Ct. App. 2016) (citing *Brown v. Coastal States Life Ins. Co.*, 264 S.C. 190, 194-95, 213 S.E.2d 726, 728 (1975). Where an appellate court is deciding whether the trial judge properly denied a motion to strike based on a question of law, the appellate court should decide the questions of law also with no deference to the circuit court's findings. *See Gates* (citing *Verenes v. Alvanos*, 387 S.C. 11, 15, 690 S.E.2d 771, 772-73 (2010).

Argument

Was it error to apply S.C. Code Ann. § 15-32-230(A) to the exclusion of § 15-32-230 (B) and render judgment for defendants in medical malpractice claims arising from emergency obstetrical care when the plaintiffs had a previous doctor/patient relationship with the defendant physician and other members of his practice and received prenatal care?

In *Ranucci v. Crain*, 409 S.C. 493 (2014), the South Carolina Supreme Court reversed lower courts that found separate and distinct purposes in statutory subsections that

had been created for a singular legislative purpose. As here, the lower courts in *Ranucci* accepted defendants' arguments that the plain and ordinary meaning of different sections within the same legislative act, (here S.C. Code Ann. § 15-32-230[1]) rendered those sections separate and distinct in their applications. The Supreme Court, however, said the lower courts were wrong.

> *"It is well settled that statutes dealing with the same subject matter are in pari materia and must be construed together, if possible, to produce a single, harmonious result."*

Ranucci, 409 S.C. at 501(quoting *Joiner ex rel. Rivas v. Rivas*, 342 S.C. 102, 109, 536 S.E.2d 372, 375 (2000).

Even without delving into the specific text of each statute, the Supreme Court in *Ranucci* found that the General Assembly's internal cross-referencing of the statutes manifested an intent for the sections to be read *in pari materia*. *See Ranucci*, 409 S.C. at 501. Similarly, subsection (C) of section 15-32-230 pulls subsections (A) and (B) together by clearly referring to them both.

> *(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*

[1] For convenient reference, S.C. Code Ann. § 15-32-230, is republished here:

(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.

> *immediate threat of death; or (2) in immediate threat of serious bodily injury.*

S.C. Code Ann. § 15-32-230(C).

Note that the "limitation on physician liability" mentioned by subsection (C) is a singular limitation established by subsections (A) *and* (B) together, rather than separate and distinct limitations as argued by respondents. Further note that while the term "genuine emergency" is stated as a qualification in subsection (A), and subsection (B) only requires care on an "emergency basis," subsection (C) provides no limitation on liability under either subsection unless the patient is "not medically stable" and under threat of "immediate death" or "immediate serious bodily harm." Because of 15-32-230(C), there is no distinction within the subsections as to the level of emergency necessary to qualify for the immunity.

As further evidence that the subsections are *in pari materia*, the last sentence of subsection (C) provides:

> *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.*

S.C. Code Ann. § 15-32-230(C).

The respondents wrongly asserted to the contrary that "(s)ubsection (B) is not limited to care provided in an emergency department, obstetrical suite, or surgical suite, and would apply to care provided anywhere outside of those locations." *See* Respondents' Brief at p. 13.

The respondents also wrongly asserted that the term 'obstetrical suite' was specifically included in subsection (A) to give physicians immunity from simple negligence for emergency obstetrical care regardless of the existence of a prior

doctor/patient relationship. The General Assembly understood that all emergency care in an obstetrical suite is not necessarily emergency obstetrical care. Nonobstetrical emergencies that sometimes require care within obstetrical suites include stroke, myocardial infarction, and acute asthma. *See* Tillet, *Nonobstetrical Emergencies in the Obstetrical Unit*, J' OF PERINAT NEONATAL NURS., 2013 Jan-Mar, 27(1): 5-7. Such nonobstetrical emergencies can also involve some of the many non-patient visitors to obstetrical suites awaiting a birth. The term 'obstetrical suite' in Subsection (A) should not be equated with 'obstetrical care,' a term exclusive to subsection (B). The legislature is presumed to have fully understood the meaning of the words used in a statute and, unless this meaning is vague or indefinite, intended to use them in their ordinary and common meaning or in their well-defined legal sense. *See Pee v. AVM, Inc.*, 344 S.C. 162, 168, 543 S.E.2d 232, 235 (Ct. App. 2001).

By failing to read subsections (A) and (B) *in pari materia*, respondents create the absurd and non-harmonious result that subsection (A) should grant a physician qualified immunity in the very same situation that subsection (B) would deny the physician qualified immunity. A court must reject interpretation of a statute "which leads to an absurd result or renders it meaningless." *Ranucci*, 409 S.C. at 500-01.

A well settled rule of statutory construction is that the court must ascertain the intent of the legislature and give it effect so far as possible within constitutional limitations. When a statute is a part of other legislation, designed as a whole to establish an expressed state policy, the court should strive to effectuate that policy. To aid in its construction, the statute must be read in the light of cognate legislation. *See Gregg Dyeing Co. v. Query*, 166 S.C. 117, 123 (1931) (citing *Tallevast v. Kaminski*, 146 S.C. 225, 143 S.E. 796 (1928)). Statutes

on the same subject "shall be taken together and construed *in pari materia*; even though there be no express reference by the latter statute to the former." *See Gregg Dyeing Co.*, 166 S.C. at 123 (citing *State v. Fields*, 2 Bail. 554, 555 (1832)).

"The rule that statutes *in pari materia* should be construed together applies with peculiar force to statutes that are contemporaneous." *Gregg Dyeing Co.*, 166 S.C. at 123. "'There is no rule better supported by justice and wisdom than that, when there are several Acts on the same subject, they should be read together as one Act, so far as their provisions are consistent; as by this means, the mischief, the remedy, and the intention, of the legislature, are more distinctly seen and applied.'" *Gregg Dyeing Co.*, 166 S.C. at 123 (citing *Richards v. McDaniel*, 2 Mill S.C. 18). While, generally, reference to statutes *in pari materia* for purposes of construction has been made largely where there is ambiguity in the language of the statute construed, this principle has not been limited solely to such instances. "Statutes *in pari materia* must be construed together and given a construction, if possible, which violates no constitutional provision." *Id*. (citing *Neil v. Independent Realty Co.*, 317 Mo. 1235, 298 S.W. 363 (1927)). When two acts are "cognate parts" of a single purpose (in this case providing qualified immunity for emergency medical care), the two acts should be considered as "inextricably" interrelated and construed *in pari materia*. *See Gregg Dyeing Co*., 166 S.C. at 123-24.

Reading the subsections of S.C. Code Ann. § 15-32-230 *in pari materia*, the General Assembly clearly intended to grant qualified immunity to all physicians providing emergency care in an emergency room, obstetrical unit, or surgical suite to an unstable patient facing an immediate threat of death or serious bodily injury, except when the

physician was providing obstetrical care and the patient had undergone prenatal care or had a pre-existing medical relationship with the doctor or his practice.

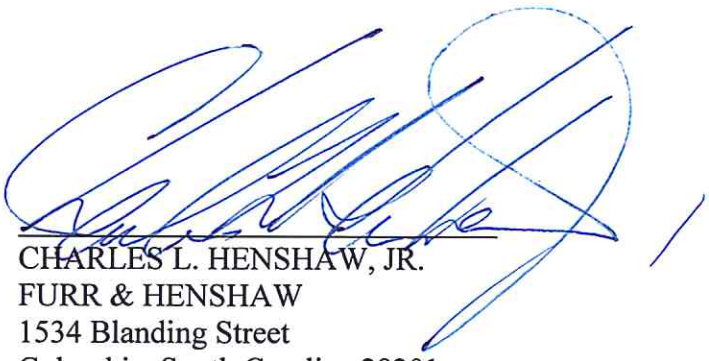
This interpretation is bolstered by the last legislative expression rule, which provides that where conflicting provisions exist, the last in point of time or order of arrangement, prevails. *See Eagle Container Co., LLC v. Cty. of Newberry*, 366 S.C. 611, 622 S.E.2d 733 (Ct. App. 2005) (citing *Ramsey v. County of McCormick*, 306 S.C. 393, 397, 412 S.E.2d 408, 410 (1991); *Feldman v. S.C. Tax Comm'n*, 203 S.C. 49, 51, 26 S.E.2d 22, 24 (1943)). Further, "where there is one statute addressing an issue in general terms and another statute dealing with the identical issue in a more specific and definite manner, the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect." *Eagle Container Co.* 366 S.C. at 629 (citing *Wilder v. South Carolina Hwy. Dep't*, 228 S.C. 448, 90 S.E.2d 635 (1955).

Neither of these rules were addressed by respondents, but both lead to the conclusion that the trial judge was wrong to apply subsection (A) to the exclusion of subsection (B).

Conclusion

The judgment should be reversed, and the case remanded for a trial on the issues of liability and damages.[2]

[2] Pursuant to S.C. Code § 15-33-125 appellants agree with respondents that a new trial in this case must be as to both liability and damages and not as to damages alone.

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THE STATE OF SOUTH CAROLINA
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Appellate Case No. 2017-002299

Appeal From Spartanburg County
J. Derham Cole, Circuit Court Judge

Opinion No. 5864
Heard June 23, 2020 – Filed October 6, 2021

AFFIRMED

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C. Mitchell Brown and Brian Patrick Crotty, both of Nelson Mullins Riley & Scarborough, LLP, of Columbia; and Dennis Gary Lovell, Jr., of Copeland, Stair, Kingma & Lovell, LLP, of Charleston, all for Respondents.

WILLIAMS, J.: Treva C. Flowers, Tristan Flowers, and their daughter Ashley F. (collectively, Appellants) brought a cause of action against Dr. Bang N. Giep and

Spartanburg & Pelham OB-GYN (Doctor and OB-GYN respectively, Respondents collectively) for injuries suffered by Ashley during birth. Appellants assert the trial court erred in denying their motion to strike Respondents' affirmative defense of emergency medical care. We affirm.

FACTS/PROCEDURAL HISTORY

At issue in this case is the interpretation of section 15-32-230 of the South Carolina Code (Supp. 2020), which provides physicians immunity from simple negligence in certain medical malpractice suits. The statute provides:

> (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.

Id.

Appellants brought this medical malpractice action against Respondents, alleging Doctor breached the standard of care during Treva's delivery on October 8, 2008. During delivery, a complication known as shoulder dystocia occurred.[1] Appellants alleged that Doctor failed to properly manage the shoulder dystocia, which caused Ashley to suffer an injury to her brachial plexus nerves.

After unsuccessful mediation, Appellants filed a complaint alleging Doctor was negligent and grossly negligent and OB-GYN was liable as his employer. The case was tried before a jury, and after both parties rested, Respondents moved for a directed verdict on the issue of gross negligence. Appellants subsequently withdrew their allegation of gross negligence, and the court granted the motion. Respondents also moved to amend their answer to assert the affirmative defense of emergency medical care found in subsection 15-32-230(A). Appellants consented to the amendment because the issue had been litigated, and the trial court granted the motion. Appellants immediately moved to strike the defense, arguing it was inapplicable because Treva had received prenatal care and she had a prior doctor/patient relationship with Doctor and members of his practice. Appellants argued that, when section 15-32-230 is read as a whole, subsection (B) limits the immunity provided in subsection (A) if the physician provided obstetrical care. The trial court held the statute describes "two separate and distinct situations" in which a physician cannot be liable for simple negligence and denied Appellants' motion to strike the affirmative defense. The court included subsections (A) and (C) in its jury instructions.

After deliberating, the jury returned a verdict in favor of Respondents. The jury found that although Respondents negligently harmed Ashley, the negligence occurred while Doctor rendered care in a genuine emergency situation in which Ashley was medically unstable and in an immediate threat of death or serious bodily harm. Appellants moved for a new trial, asserting the court should have struck the affirmative defense. The trial court denied the motion, and this appeal followed.

ISSUE ON APPEAL

Did the trial court err in interpreting subsections 15-32-230(A) and (B) as distinct and separate defenses from ordinary negligence and in denying Appellants' motion to strike the affirmative defense?

---

[1] During childbirth, shoulder dystocia occurs when the baby's shoulder catches against the mother's pubic bone and fails to enter the pelvis, stalling the delivery.

STANDARD OF REVIEW

Statutory interpretation is a question of law, and this court may interpret a statute without any deference to the trial court. *DomainsNewMedia.com, LLC v. Hilton Head Island-Bluffton Chamber of Com.*, 423 S.C. 295, 300, 814 S.E.2d 513, 516 (2018). A ruling on a motion to strike is within the sound discretion of the trial court and will not be reversed on appeal absent an abuse of discretion. *Totaro v. Turner*, 273 S.C. 134, 135, 254 S.E.2d 800, 801 (1979). A trial court abuses its discretion when it commits an error of law, makes a factual finding that lacks evidentiary support, or fails to exercise any of its vested discretion. *State v. Allen*, 370 S.C. 88, 94, 634 S.E.2d 653, 656 (2006).

LAW/ANALYSIS

Appellants do not argue on appeal that the shoulder dystocia was not a genuine emergency situation in which Ashley was medically unstable and under an imminent risk of death or serious bodily injury. Accordingly, it is the law of the case. *See Atl. Coast Builders & Contractors, LLC v. Lewis*, 398 S.C. 323, 329, 730 S.E.2d 282, 285 (2012) (stating an unappealed ruling is the law of the case). Because this constitutes evidentiary support for the affirmative defense and grounds for denying the motion to strike, the trial court's denial amounts to an abuse of discretion only if the court erred in interpreting section 15-32-230. *Totaro*, 273 S.C. at 135, 254 S.E.2d at 801 (stating a motion to strike is reviewed for an abuse of discretion). Appellants argue the court erred in interpreting the statute as providing "separate and distinct" defenses rather than one defense.

Appellants assert the General Assembly intended for subsections (A) and (B) to apply together, rather than separately, to provide immunity for care rendered in certain locations while imposing additional requirements for obstetrical care. Stated another way, Appellants contend subsection (A) provides a defense for a physician rendering care in a genuine emergency situation in, among other places, an obstetrical suite. However, if the care provided is obstetrical care, Appellants argue subsection (B) then limits subsection (A), precluding the defense if the physician or a member of his or her practice has a prior doctor/patient relationship with the patient or if the patient received prenatal care. Appellants submit that because Doctor provided obstetrical care and had a prior doctor/patient relationship with Treva and she previously received prenatal care, Doctor could not invoke the

affirmative defense and the court erred in denying their motion to strike. We disagree.

"The cardinal rule of statutory interpretation is to ascertain and effectuate the intention of the legislature." *DIRECTV, Inc. & Subsidiaries v. S.C. Dep't of Revenue*, 421 S.C. 59, 70, 804 S.E.2d 633, 638 (Ct. App. 2017) (quoting *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007)). "What the General Assembly says in the text of the statute is the best evidence of its intent, and this [c]ourt is bound to give effect to the legislature's expressed intent." *Aiken v. S.C. Dep't of Revenue*, 429 S.C. 414, 419, 839 S.E.2d 96, 99 (2020). "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." *Ranucci v. Crain*, 409 S.C. 493, 500, 763 S.E.2d 189, 192 (2014) (quoting *Sloan*, 371 S.C. at 498, 640 S.E.2d at 459). "Words in the statute should be given their plain and ordinary meaning without resulting to forced or subtle construction." *Original Blue Ribbon Taxi Corp. v. S.C. Dep't of Motor Vehicles*, 380 S.C. 600, 608, 670 S.E.2d 674, 678 (Ct. App. 2008). "The legislature is presumed to have fully understood the meaning of the words used in a statute and, unless this meaning is vague or indefinite, intended to use them in their ordinary and common meaning or in their well-defined legal sense." *Id.* (quoting *S.C. Coastal Conservation League v. S.C. Dep't of Health & Env't Control*, 380 S.C. 349, 367, 669 S.E.2d 899, 908 (Ct. App. 2008), *rev'd on other grounds*, 390 S.C. 418, 702 S.E.2d 246 (2010)).

Section 15-32-230 has been interpreted to be in derogation of the common law. *See Byrd as Next Friend of Julia B. v. McLeod Physician Assocs. II*, 427 S.C. 407, 414, 831 S.E.2d 152, 155 (Ct. App. 2019). Therefore, it must be strictly construed. *See id.* ("Statutes in derogation of the common law are to be strictly construed." (quoting *Eades v. Palmetto Cardiovascular & Thoracic, PA*, 422 S.C. 196, 201, 810 S.E.2d 848, 850 (2018))). "Under this rule, a statute restricting the common law will not be extended beyond the clear intent of the legislature." *Id.* (quoting *Eades*, 422 S.C. at 201, 810 S.E.2d at 850).

From a plain reading of the text, we find subsection (A) describes a physician that encounters an emergency while providing care whereas subsection (B) describes a physician treating a patient previously unassociated with the physician or his or her practice or lacking prior prenatal care. Because subsections (A) and (B) describe different factual scenarios in which a physician might provide negligent care, we find the legislature intended subsection (B) to apply separately from subsection (A) rather than as a limitation to (A). Moreover, the language within subsection (B)

neither indicates that it is a limitation on the defense provided in subsection (A) nor does it state that subsection (A) only provides a defense for obstetrical care if the requirements within subsection (B) are satisfied. *See Hardee v. McDowell*, 372 S.C. 413, 419, 642 S.E.2d 632, 636 (Ct. App. 2007) ("If the state legislature had intended for a [particular result], it could have drafted the statute to reflect that intent."), *aff'd as modified on other grounds*, 381 S.C. 445, 673 S.E.2d 813 (2009). To adopt Appellants' interpretation and read subsection (B) as a limitation to subsection (A) would be a "forced construction" of the text's plain language. *See Original Blue Ribbon*, 380 S.C. at 608, 670 S.E.2d at 678 ("Words in the statute should be given their plain and ordinary meaning without resulting to forced or subtle construction.").

Accordingly, we find section 15-32-230 provides a defense against simple negligence in two separate and distinct scenarios. Thus, we hold the trial court did not err in its interpretation of section 15-32-230 and in denying Appellants' motion to strike the defense. *See DomainsNewMedia.com*, 423 S.C. at 300, 814 S.E.2d at 516 (stating statutory interpretation is a question of law that is reviewed de novo); *Totaro*, 273 S.C. at 135, 254 S.E.2d at 801 (stating motions to strike are reviewed for an abuse of discretion); *Allen*, 370 S.C. at 94, 634 S.E.2d at 656 (stating a trial court abuses its discretion when it commits an error of law or makes a factual finding unsupported by the evidence).

CONCLUSION

Based on the foregoing, the trial court is

AFFIRMED.

KONDUROS and HILL, JJ., concur.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

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

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

Appellants,

v.

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

Respondents.

APPELLANTS' PETITION FOR REHEARING

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MOTION

The appellants move for rehearing of the decision of the South Carolina Court of Appeals, entered October 6, 2021and affirming the order of the Spartanburg County Court of Common Pleas denying appellants' motion to strike Respondents' affirmative defense of emergency medical care.

This motion for rehearing is made pursuant to SCACR Rule 221 and is based on grounds that the Court of Appeals overlooked or misapprehended the following points:

1) Subsection (C) of S.C. Code Ann. § 15-32-230 must be read *in pari materia* with subsections (A) and (B) and not ignored as was done by the trial court and Court of Appeals.
2) The "last legislative expression" rule required subsection (B) to prevail over subsection (A).
3) When there are two legislative expressions on the same issue, a more specific statute must be considered an exception to, or a qualifier of, the general statute and given such effect.
4) Pursuant to §15-32-230(C) the legislature intended subsections § 15-32-230(A) & (B) to be read as a singular "limitation" and not as "separate and distinct" limitations as interpreted by the trial court and Court of Appeals.
5) The legislature did not intend § 15-32-230(B) to apply separately from § 15-32-230(A) rather than as a limitation to § 15-32-230(A).
6) S.C. Code Ann. § 15-32-230 does not provide a defense against simple negligence in two separate and distinct scenarios.

7) The trial court erred as a matter of law and abused his discretion by denying the appellants' motion to strike the doctors' affirmative defense of emergency medical care.

MEMORANDUM

The Court of Appeals found that the legislature intended S.C. Code Ann. § 15-32-230(B) "to apply separately from subsection (A) rather than as a limitation to (A)." Without any consideration of § 15-32-230(C), the Court of Appeals held that the language of subsection (B) "neither indicates that it is a limitation on the defense provided in subsection (A) nor does it state that subsection (A) only provides a defense for obstetrical care if the requirements within subsection (B) are satisfied." *See Flowers v. Giep*, 2021 S.C. App. LEXIS 121, *7-8, 2021 WL 4570930 (S.C. Ct. App. October 6, 2021).

The Court of Appeals overlooked that the singular legislative purpose of § 15-32-230[1] is

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[1] In its entirety S.C. Code Ann. § 15-32-230 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.

to provide a limitation on liability in certain emergencies "unless it is proven such physician is grossly negligent." While subsection (A) provides that simple negligence generally will not impose liability 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, subsection (B) provides simple negligence will impose liability on a physician or practice that had a previous physician/patient relationship with the victim for obstetrical care. In other words, subsection (B) provides an exception to subsection (A).

In *Ranucci v. Crain*, 409 S.C. 493 (2014), the South Carolina Supreme Court reversed lower courts that found separate and distinct purposes in statutory subsections that had been created for a singular legislative purpose. As here, the lower courts in *Ranucci* accepted defendants' arguments that the plain and ordinary meaning of different sections within the same legislative act, rendered those sections separate and distinct in their applications. The Supreme Court, however, said the lower courts were wrong.

> *"It is well settled that statutes dealing with the same subject matter are in pari materia and must be construed together, if possible, to produce a single, harmonious result."*

Ranucci, 409 S.C. at 501(quoting *Joiner ex rel. Rivas v. Rivas*, 342 S.C. 102, 109, 536S.E.2d 372, 375 (2000)).

The Supreme Court in *Ranucci* found that the General Assembly's internal cross-referencing of the statutes manifested an intent for the sections to be read *in pari materia*. *See Ranucci*, 409 S.C. at 501. Similarly, subsection (C) of § 15-32-230 twice cross references subsections (A) and (B) as establishing a singular limitation.

> *(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.*

S.C. Code Ann. § 15-32-230(C) (emphasis added).

The "limitation on physician liability" cross referenced by subsection (C) clearly should be interpreted as a singular limitation established by subsections (A) *and* (B) together, rather than separate and distinct limitations as found by the Court of Appeals.

Another pertinent rule of statutory construction overlooked by the Court of Appeals is the "last legislative expression" rule, which provides that where conflicting provisions exist, the last in point of time or order of arrangement, prevails. *See Eagle Container Co., LLC v. Cty. of Newberry*, 366 S.C. 611, 622 S.E.2d 733 (Ct. App. 2005) (citing *Ramsey v. County of McCormick*, 306 S.C. 393, 397, 412 S.E.2d 408, 410 (1991); *Feldman v. S.C. Tax Comm'n*, 203 S.C. 49, 51, 26 S.E.2d 22, 24 (1943)).

Also overlooked is the rule of statutory construction that where one statute addresses an issue in general terms and another statute dealing with the identical issue addresses the issue in a more specific and definite manner, 'the more specific statute will be considered an exception to, or a qualifier of, the general statute and given such effect." *Eagle Container Co.* 366 S.C. at 629 (citing *Wilder v. South Carolina Hwy. Dep't*, 228 S.C. 448, 90 S.E.2d 635 (1955).

In this case subsection (A) pertains generally to medical emergencies occurring in obstetrical suites, surgical suites, or emergency departments regardless of whether the medical problem is obstetrical. Subsection (B) specifically pertains to emergencies arising in the course of obstetrical care. The conflict as to which will prevail must be resolved in favor of subsection (B),

which is more specific to the type of emergency and follows subsection (A) in the order of the statute.

CONCLUSION

Appellants' petition for rehearing should be granted, the issues raised by the petition should be reconsidered, the order of the trial court should be reversed, and the case should be remanded for new trial.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on October 19, 2021, I had copies of Appellants' Petition for Rehearing placed into the United States mail postage paid for First Class delivery for service upon the following counsel of record:

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CHARLES L. HENSHAW, JR.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

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SC Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Derham Cole, Circuit Court Judge

Case No. 2016-CP-42-03178
Appellate Case No. 2017-002299

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

v.

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

Respondents' Return to Petition for Rehearing

Pursuant to Rules 221(a) and 240(e), SCACR, Respondents Dr. Bang N. Giep, M.D. ("Dr. Giep") and Spartanburg & Pelham OB-GYN, P.A. (collectively, "Respondents") hereby submit this return to Appellants' Petition for Rehearing.

In *Flowers v. Giep*, Op. No. 5864 (S.C. Ct. App. filed October 6, 2021) (Shearouse Adv. Sh. No. 35 at pp. 28-34) ("Op. No. 5864"), the unanimous Panel of this Court affirmed the circuit court's denial of Appellants' motion to strike Respondents' affirmative defense of emergency medical care. This Court correctly held that subsections (A) and (B) of S.C. Code Ann. § 15-32-230 provide "a defense against simple negligence in two separate and distinct scenarios," and further upheld the trial court's interpretation that only subsection (A) and (C) applied in this

particular situation. (Op. No. 5864 at p. 33). Appellants now seek rehearing on this issue. As explained more fully below, rehearing of this matter is not warranted under Rule 221 because the Panel's opinion is correct and well-reasoned and does not overlook or misapprehend any points of fact or law. Therefore, Respondents respectfully request that this Court deny Appellants' Petition for Rehearing.

Standard of Review

A petition for rehearing must "state with particularity the points supposed to have been overlooked or misapprehended by the court." *Herron v. Century BMW*, 395 S.C. 461, 466, 719 S.E.2d 640, 643 (2011) (quoting Rule 221(a), SCACR). In order to prevail on a petition for rehearing, the petitioner must demonstrate the Court overlooked or misapprehended their argument. *Kennedy v. S.C. Retirement Sys.*, 349 S.C. 531, 532, 564 S.E.2d 322, 322 (2001). The purpose of a petition for rehearing "is not to present points which lawyers for the losing parties have overlooked or misapprehended, nor is it the purpose of the petition for rehearing to have the case tried in the appellate court a second time." *Herron* at 466, 719 S.E.2d at 643 (quoting *Kennedy v. S.C. Ret. Sys.*, 349 S.C. at 532, 564 S.E.2d at 322). Thus, our appellate courts will deny a petition for rehearing whenever "the points set forth in the petition have all been considered and expressly decided against the respondent by this Court in the opinion filed." *Clemmons v. Nicholson*, 188 S.C. 124, 198 S.E. 180, 183 (1938). As explained herein, Appellants have not met the heavy burden that they face in seeking rehearing of the Panel's decision.

Argument

In their Petition for Rehearing, Appellants reassert the same arguments they previously made to this Court seeking a misinterpretation of S.C. Code Ann. § 15-32-230. Appellants now assert that this Court overlooked or misapprehended these arguments. As with their prior briefing to this Court, Appellants' Petition for Rehearing argues that subsections (A) and (B) of 15-32-230

do not establish separate and distinct defenses for physicians against simple negligence in medical malpractice actions. Rather, Appellants contend that these two sections actually create a "singular limitation," and that subsection (B) modifies or limits subsection (A) by creating an exception to the defense established in (A). Appellants continue to attempt to support this position by relying on statutory construction rules such as the "last legislative expression" rule, "specific vs. general" legislative expressions, and the assertion that all of section 15-32-230's subsections are not being properly read together. Appellants are incorrect. This Court properly rejected these same arguments and held that subsections (A) and (B) of 15-32-230 each establish a separate and distinct defense as to simple negligence for physicians in certain circumstances which is then subject to the requirements of subsection (C).[1] (Op. No. 5864 at p. 33). This Court then correctly held that it was subsection (A) that applied to this situation. Appellants' reassertion of the same arguments in this Petition should be similarly rejected by this Court and the Petition should be denied.

I. This Court correctly held that subsections (A) and (B) of 15-32-230 apply in separate and distinct scenarios.

The full text of Section 15-32-230 is 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

[1] Subsection (C) provides that the defense for physicians against simple negligence in medical malpractice actions established by both subsection (A) and subsection (B) only applies where the patient is not medically stable and is either in immediate threat of death or in immediate threat of serious bodily injury. S.C. Code Ann. § 15-32-230(C). As the Court noted in its Opinion, there is no dispute in this case as to whether these conditions were met. (Op. No. 5864 at p. 31).

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.

S.C. Code Ann. § 15-32-230. In Opinion No. 5864, this Court held that a "plain reading of the text" of this statute established that subsections (A) and (B) apply to different factual scenarios, and, therefore, the simple negligence defense established by this statute applies in "two separate and distinct scenarios." (Op. No. 5864 at p. 33). Appellants have presented no basis to reconsider that sound ruling.

A. Subsection (A) applies to emergency situations in certain specific locations and clearly applies to the facts of this case.

Subsection (A) provide the defense against simple negligence for any physician who renders care in a "genuine emergency situation"[2] to a patient in an emergency department, obstetrical suite, or a surgical suite. There is **no** limitation on the type of medical care provided and there is **no** limitation based the existence of a prior doctor/patient relationship. Subsection (A)'s specific inclusion of "obstetrical suite" in its scope makes apparent that, based on the facts here, this Court correctly affirmed the trial court as to the applicability of the defense of immunity from simple negligence claims.

B. Subsection (B) applies to obstetrical care rendered on an emergency basis by a physician with no prior relationship with the patient and, by its clear language, and *does not* apply to the facts of this case.

[2] As this Court noted, there was no issue as to whether the requirement of a "genuine emergency situation" was met. (Op. No. 5864 at p. 31).

Subsection (B) provides a defense against simple negligence for any physician who provides obstetrical care on "an emergency basis where there is no prior doctor/patient relationship or the patient has not received prenatal care." Significantly, the immunity established in subsection (B) is not limited to care provided in an emergency department, obstetrical suite, or surgical suite, and would apply to care provided anywhere whether inside or outside of those locations, where there was no pre-existing physician-patient relationship. Contrary to Appellants' misinterpretation, subsection (B) neither revokes any immunity provided to a physician under subsection (A), nor does it specifically impose liability on any physician who does not qualify for subsection (B)'s immunity. Rather, it simply establishes an immunity for a situation where a physician is providing obstetrical care to a previously unknown patient. That was not the case in this matter, making subsection (B) inapplicable and irrelevant. Therefore, this Court correctly affirmed the trial court's ruling.

C. This Court correctly held that subsection (B) does not limit or restrict the application of subsection (A).

In Opinion No. 5864, this Court correctly concluded that the legislature intended "subsection (B) to apply separately from subsection (A) rather than as a limitation to (A)" and that "the language within subsection (B) neither indicates that it is a limitation on the defense provided in subsection (A) nor does it state that subsection (A) only provides a defense for obstetrical care if the requirements within subsection (B) are satisfied." (Op. No. 5864 at p. 33). Appellants persist in their attempt to mischaracterize the language of subsection (B) in order to create a limitation subsection (A). As this court found, subsection (B) ***creates a defense*** for a physician in a specific scenario—where obstetrical care is provided on an emergency basis for a patient with whom the physician or his/her practice does not have an existing physician-patient relationship. Nowhere does it attempt to impose liability on a category of physician who might otherwise meet the

requirements of subsection (A). Appellants, however, attempt to recast subsection (B) as "impos[ing] liability on a physician or practice that has a previous physician/patient relationship. (Petition at p. 5). Thus, rather than relying on the actual language of subsection (B) that creates an immunity in a certain circumstance, Appellants argue that subsection (B) must be read to bar immunity for anyone who does not qualify within the limited scope of (B). This is incorrect. Appellants' forced construction would improperly limit the operation of (A), and would improperly render the specific inclusion of "obstetrical suite" in (A) to be meaningless. Thus, this Court should continue to reject this argument.

D. Appellants' reliance on various statutory construction rules to rewrite S.C. Code § 15-32-230 is misplaced.

In their petition, Appellants seek to support their contention that subsection (B) acts to limit subsection (A) by relying on various statutory construction rules in an attempt to change what the plain language of the statute actually provides. As an initial matter, such rules are only applicable where the statute in question is ambiguous. "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." *Ranucci v. Crane*, 409 S.C. 493, 500, 763 S.E.2d 189, 192 (2014) (quoting *Sloan v. Hardee*, 371 S.C. 495, 498, 640 S.E.2d 457, 459 (2007). Here, there is no ambiguity, so Appellants' reliance on these rules of construction is misplaced. Subsections (A), (B) and (C) of 15-32-230 do not require the application of rules of construction to ascertain or harmonize their meaning. The plain language of these three sections does not render them inconsistent. (A) and (B) provide a defense against simple negligence in certain delineated situations and (C) imposes certain limitations on the application of both (A) and (B). Additionally, as described below, the rules of construction relied upon do not actually have the effect desired by Appellants.

1. Subsection (C)'s referencing of both subsections (A) and (B) does not result in (A) being limited by (B).

The first rule of construction that Appellants misapply is "for the sections to be read *in pari materia*." (Petition at p. 5). Appellants cite to the *Ranucci* case for this proposition. The *Ranucci* case dealt with two different statutes that contained internal cross references and addressed the same subject matter. The actual rule is stated as "statutes dealing with the same subject matter *are in pari materia* and must be construed together, if possible, to produce a single harmonious result." *Ranucc*i, 371 S.C. at 501, 640 S.E.2d at 193 (quoting *Joiner ex rel. Rivas v. Rivas*, 342 S.C. 102, 109, 536 S.E.2d 372, 375 (2000). Appellants then contend that this Court violated this rule of construction by disregarding subsection (C) which twice references "the limitation on physician liability established by subsections (A) and (B)." (Petition at p. 4-6). Appellant assert that because the word "limitation" in this sentence is singular rather that plural, this must have the effect of merging subsections (A) and (B) into one "singular limitation" wherein (B) limits (A).

Appellants read the use of the singular in the phrase "The limitation of physician liability" to mean that subsection (A) and (B) are not independent. Appellants are mistaken. Subsections (A) and (B) apply to separate situations, but they share a common effect—they both limit the qualifying physician's liability to only gross negligence. The limitation of liability is the same for both scenarios—thus the use of the singular word "limitation" is grammatically correct.

2. The "last legislative expression" rule does not apply.

Appellants next attempt to have subsection (B) limit (A) through the misapplication of the "last legislative expression" rule—that where conflicting provisions exist the last in point of time or order of arrangement prevails. (Petition at p. 6). In support of the application of this rule, Appellants cite to the Court of Appeals opinion in *Eagle Container Co., LLC v. County of Newberry*, 366 S.C. 611, 622 S.E.2d 733, (S.C. App., 2005), which invoked this rule when faced

with what it perceived as conflicting Articles in a zoning ordinance. This opinion, however, was reversed by the Supreme Court in *Eagle Container Co., LLC v. County of Newberry*, 379 S.C. 564, 666 S.E.2d 892 (2008). Specifically, the Supreme Court noted that "the last legislative expression rule … is purely an arbitrary rule of construction and is to be resorted to only when there is clearly an irreconcilable conflict, and all other means of interpretation have been exhausted" and concluded that there was no irreconcilable conflict between the different zoning ordinance Articles in question because they served different functions. *Eagle Container*, 379 S.C. at 572, 666 S.E.2d at 896 (internal quotation omitted). Here, there is no conflict between subsections (A) and (B), let alone an "irreconcilable" conflict. As both the trial court and this Court found, subsections (A) and (B) serve separate functions and are not inconsistent. Thus, there is no basis for the application of this rule of construction.

3. Subsections (A) and (B) are both "specific" rather than "general."

Appellants also seek the application of the statutory construction rule that where there is a statute dealing with a subject in general terms and another statute dealing with a part of the same subject in a more specific and definite way, the special statute will be considered as an exception to, or qualification of, the general statute. (Petition at p. 6). Appellants contend that (A) is more general and (B) is more specific. This is incorrect. Subsections (A) and (B) each address specific and separate situations. Neither can be accurately described as more general than the other. In addition to the fact that both subsection address specific rather than general situations, they simply are not in conflict with each other, such that there is no need to apply one as an exception or qualification to the other.

Therefore, none of the statutory construction rules proffered by appellants are applicable to this situation and the Petition for Rehearing should be denied.

Conclusion

For the reasons set forth herein, and for the reasons and arguments set forth in Respondents' appellate brief, which should be deemed incorporated herein, this Court should deny Appellants' Petition for Rehearing.

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November 1, 2021

The South Carolina Court of Appeals

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

v.

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

Appellate Case No. 2017-002299

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

H. Bruce Williams J.

J.

D. Garner J.

Columbia, South Carolina

cc:

FILED
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The Honorable J. Derham Cole