

1 pretty close, they are not word for word because I wasn't
2 here, but it's talking about serial ultrasounds. It's
3 talking about fundal measurements. May I show those?

4 MS. KENNY: I don't know if there is anything
5 different than what we saw yesterday. I thought that we
6 already settled that yesterday.

7 MR. BUCKINGHAM: It's what you have.

8 THE COURT: If it's what we went over yesterday,
9 and there was no specific objection made to it, you can
10 proceed. Again, if it does appear it's very confusing, we
11 can address that. I don't want to have a lot of objections.

12 MS. KENNY: That was not my intention.

13 THE COURT: I understand that. I just want to be
14 clear that it frustrates the jury, and that's our main goal,
15 above all else, is to make sure we are not frustrating the
16 jury with our performance.

17 MS. KENNY: Thank you, Your Honor.

18 MR. BUCKINGHAM: Thank you, Your Honor.

19 (Sidebar concluded.)

20 MR. BUCKINGHAM: Hello again. We apologize on
21 behalf of everybody. There are issues that we try to get
22 worked out before we take up the Court's time. Sometimes
23 they don't get worked out, and I apologize. So we will move
24 along now.

25 What brings us here today are safety rules, and

1 you are going to be hearing about those as we go through a
2 PowerPoint. These safety rules deal with patient safety
3 care that protect all of us from harm or death, only if
4 jurors enforce them. And that will be one of the things I
5 will be asking you to do as we go through this process is,
6 as we enter this trial, enforce patient safety. And we'll
7 go into greater detail as we go along.

8 And, you will notice, I'm probably not going to
9 get a lot closer to you than this because that's no-man's
10 zone right there. So forgive me if I don't get very close.
11 If you don't hear me, give me the hi sign and I will get
12 louder or I will get in the microphone over here.

13 I want to tell you the story about what happened
14 in this case. Having diabetes during pregnancy causes a
15 lady to have a big baby. Sometimes these babies can grow so
16 big that they literally get stuck in the birth canal, they
17 are too large to pass through. Babies that are too big to
18 be born safely vaginally must be delivered by cesarean
19 section in order to be protected, both the baby and the mom,
20 from harm.

21 The doctor you will hear from about this in this
22 trial who was doing the negligent acts was an obstetrician.
23 An obstetrician is a doctor that takes care of pregnant
24 ladies and then handles the delivery of their babies.

25 As I told you when we were picking the jury, in

1 medical mal practice cases, we are required to bring experts
2 to visit with you about the negligence that occurred and the
3 harm caused by that negligence.

4 Regarding the negligence claims, you will be
5 hearing from the obstetrician expert called by the
6 Plaintiffs, and only by the Plaintiffs. He is Dr. Michael
7 Gardner. Dr. Gardner is one of the preeminent obstetricians
8 in the country. He is currently the vice dean of clinical
9 affairs at the University of Las Vegas School of Medicine.
10 He cares for pregnant moms-to-be and is a professor of
11 medicine, of maternal fetal medicine at the department of
12 obstetrics and gynecology where he teaches resident doctors
13 obstetrics.

14 Dr. Gardner has attended the delivery of some
15 10,000 babies. That's a lot of babies. In this case, the
16 Defendant will not be calling an obstetrician expert to
17 rebut or to disagree with the testimony of Dr. Gardner. So
18 the only obstetrician expert that you will hear testify for
19 you about the negligence that we will tell you about is Dr.
20 Gardner. And Dr. Gardner will tell you that the Defendant
21 clinic's obstetrician committed multiple violations of the
22 standards of care, and that these violations caused the
23 harms to a mom and her baby that you will hear about.

24 First, the evidence will show that the Defendant
25 clinic's obstetrician did not order the right tests at the

1 right time for a pregnant mom with diabetes when her baby
2 showed warning signs that it was growing too big to be
3 safely delivered vaginally.

4 Second, the evidence will show that this baby
5 should have been delivered by cesarean section. It was way,
6 way too big to be safely delivered vaginally. However, in
7 this case you will learn that the Defendant clinic's
8 obstetrician delivered the baby vaginally.

9 Third, the evidence will show that no vacuum
10 device should ever have been used during the delivery of
11 this baby. You don't use a vacuum device on the delivery of
12 a baby of a diabetic mom. That's standard of care.

13 In this case you will learn that the Defendant
14 clinic's obstetrician delivered the baby vaginally and used
15 a vacuum device on the baby to try to pull him out of the
16 mother's birth canal, and she is diabetic. As a result of
17 the Defendant obstetrician not making the safety of his
18 patients a priority, a baby who was too big to be delivered
19 vaginally became stuck in his mom's birth canal, and both
20 baby and mom suffered devastating injuries as a result.

21 The pregnant patient in this case could have been
22 any mom-to-be, but she was Lorenza Botello. You met her a
23 moment ago. With her permission we will call her Lorenza
24 during the trial. The baby that brought her into the
25 Defendant clinic for care during her pregnancy was her

1 little boy, Jonathan.

2 Now let me tell you who we are suing. We are
3 suing Defendant Pecos Valley of New Mexico LLC. Sometimes
4 we will refer to Pecos Valley of New Mexico LLC as the
5 Defendant clinic, sometimes we will call them Pecos Valley.

6 Defendant Pecos Valley of New Mexico LLC has
7 nothing to do with the town of Pecos over near Glorieta.
8 Pecos Valley is an out-of-state corporation that runs
9 clinics down in Hobbs and Carlsbad.

10 Defendant Pecos Valley employed Jerry McLaughlin
11 M.D. Dr. McLaughlin was an obstetrician. He provided what
12 is called prenatal care for Lorenza at the Defendant's
13 clinic down in Hobbs. Ultimately he delivered Jonathan. It
14 is his negligent acts and omissions that are the cornerstone
15 of this trial.

16 Sadly Dr. McLaughlin passed away earlier this
17 year, so we won't be hearing from him directly during this
18 trial, but we have the Defendant's clinic's records, and
19 they will tell us what Dr. McLaughlin did, and, more
20 importantly for your considerations, what he failed to do.

21 At the end of this trial we believe that Judge
22 Shaffer will instruct you that under New Mexico law,
23 Defendant Pecos Valley is legally responsible for the acts
24 and omissions of its employee, Dr. McLaughlin.

25 And here is why we are suing. The evidence in

1 the case will be that Lorenza's medical records from early
2 in her prenatal care with Dr. McLaughlin established that he
3 considered her to be a high-risk pregnancy. Dr. McLaughlin
4 considered her to be a high-risk pregnancy due to her having
5 diabetes.

6 This is a slide that indicates her records, and
7 you will see that he has her listed there, high risk due to
8 the diabetes. That will be a critically important factor as
9 we go through this trial. It is very important to know that
10 she is diabetic and for them to remember that she is
11 diabetic because that starts the ball rolling for what type
12 of care you are going to receive.

13 Gestational diabetes is a type of diabetes that
14 occurs while a lady is pregnant. It comes on due to the
15 pregnancy. Typically it will go away after the pregnancy.
16 Lorenza was actually pregestational diabetic. She was
17 diabetic before she got pregnant, and that heightens the
18 concern for a large baby, and you will learn that from the
19 expert.

20 When a baby has grown to be significantly larger
21 than average, it is called fetal macrosomia. Fetal
22 macrosomia. I'm going to be throwing some terms at you. I
23 will show them to you usually like this. You will see a lot
24 of these slides throughout the trial, so don't try to
25 memorize them, but you are going to hear macrosomia quite a

1 bit.

2 And what what means simply is a baby that's much
3 larger than expected. And in this case, the macrosomia is
4 due to the diabetes. As you can see on the left, a normal
5 baby on the right, that's a macrosomic baby due to the
6 diabetic condition.

7 The reason this is important is that the baby of
8 a diabetic mom can actually grow so big that by the time he
9 or she is ready to be born, it is not safe to deliver that
10 baby vaginally. It's because the baby is at risk of being
11 too large to pass through the birth canal.

12 If that happens, the baby becomes stuck in the
13 birth canal. When a baby becomes stuck, it's called
14 shoulder dystocia. Another big word, shoulder dystocia. It
15 classically happens with a fetal macrosomic baby that is
16 greater or larger than 9 pounds 15 ounces, equal to 4500
17 grams.

18 In this particular case you will learn that
19 Jonathan, although he is quite the small fellow now, was 11
20 and a half pounds. He was 5,400 some odd grams. A huge
21 child.

22 Shoulder dystocia is an obstetric emergency when
23 it occurs during birth. This is a medical illustration that
24 depicts a baby coming out, and you will hear it's probably
25 much like Jonathan came out, and you will see that as this

1 baby is coming out -- can everyone see this okay? I've got
2 a larger one if you need that. Everyone good with the
3 smaller panels?

4 JURORS: (Nodding.)

5 MR. BUCKINGHAM: If you'll look, you will see the
6 mother's pubic bone -- it says pubis -- and as the child is
7 coming through the birth canal, because of his size, his
8 right shoulder is getting hung up underneath that pubic bone
9 and he's stuck. He is not budging. It's a critical
10 emergency, and you will learn why in just a moment.

11 But shoulder dystocia is something that is
12 expected and should be anticipated to occur if you have a
13 macrosomic infant, particularly if it's a macrosomic infant
14 from a diabetic mom. That's why you look and perform a
15 cesarean section, and we'll get into that in just a few
16 minutes.

17 The reason why this is really critical is
18 because, at this point when the baby is in this position,
19 the baby is not breathing on his own. Even though his head
20 has emerged, he is not breathing. He is getting all of his
21 oxygen from the umbilical cord. That's his life support
22 system as he passes through the birth canal.

23 It is only once a baby completely emerges from
24 the womb and the uterus and the vagina, in other words, when
25 he is fully into the world, that's when they begin breathing

1 on their own. But when they are in transit, the only oxygen
2 they are getting is from mom and it's through the umbilical
3 cord.

4 The problem being, as the baby comes through,
5 there is a thing called cord compression, and this is a
6 depiction of that. The cord is being compressed as the baby
7 passes through the birth canal, and just like a garden hose
8 gets kinked and you don't get the water flow through it,
9 when you compress the umbilical cord, nothing gets through,
10 no blood, therefore no oxygen.

11 So when a baby is coming through and gets stuck,
12 it is an emergency because they are suffocating. They're
13 suffocating. If they are stuck for very long, they end up
14 with brain damage or they die.

15 Another bad thing that can happen when you have a
16 brachial plexus injury going on here, a shoulder dystocia
17 where the little fellow's shoulder gets hung up under the
18 pubis, at that point the doctor is confronted, and usually
19 as a rule, because the doctor knows that that baby is not
20 breathing, the doctor knows that baby has to get out to
21 survive, doctors will sometimes reach in and pull harder
22 than they need to pull, and when they do that, as they pull
23 that little head out and the bone is trapping that shoulder,
24 it is ripping what is called the brachial plexus.

25 And as you can see on these diagrams highlighted

1 in red, circled in yellow, that is the brachial plexus. All
2 of us have two of them. Y'all have them. I've got them.
3 Ours work, our arms work. Brachial plexus is a series of
4 nerves that originate in the spinal cord and then radiate
5 out to the shoulders down into the arms and down into the
6 hand. Brachial plexus. They are very delicate at birth and
7 they're very susceptible to damage.

8 And so if you've got a child coming through that
9 gets stuck, you have to be extraordinarily cautious to not
10 torque the head, to not pull unduly on it, and be very aware
11 that the brachial plexus is at risk.

12 This stretching injury can be even worsened if
13 you use what is called a vacuum device on the infant. You
14 will see there the depiction of a vacuum device being hooked
15 up. And it is attached to the child's head, a vacuum is
16 then drawn on it, a very strong vacuum that can even cause
17 brain hemorrhage. And then the baby is yanked out of the
18 birth canal by the way of that vacuum.

19 It is a cardinal rule, it is a standard that all
20 obstetricians know, you do not use a vacuum device during
21 the birth of an infant of a diabetic mother because of the
22 risk of that baby being large.

23 Another bad thing that can happen when you've got
24 a very, very large baby being pulled out of a mother that
25 cannot handle that size of baby being born are vaginal

1 tears. Here is a depiction of the different types of
2 vaginal tears that can occur.

3 The grade one is the mildest. Grade two, grade
4 three, and then grade four is the most severe. It is a
5 ripping, a tearing of the vaginal tissue down through the
6 perineum, actually into the rectum and into the rectal
7 vault. It's a very devastating injury for a woman. That
8 can be avoided if you don't take a baby vaginally that
9 should not be taken vaginally.

10 So a lot of terrible things can occur when a very
11 large baby, and a doctor tries to birth that baby vaginally.
12 So how does a doctor like Dr. McLaughlin, the Defendant's
13 employee, avoid having these bad things happen to his
14 patients? We will learn from Dr. Gardner shortly who is the
15 first witness I will call, we will learn from Dr. Gardner
16 that there are steps that every obstetrician knows that will
17 avoid these very things from happening. We will learn that
18 obstetricians have a duty to know these steps and to use
19 them when caring for their pregnant ladies.

20 As we discussed earlier, these steps are called
21 standards of care. Standards of care are accepted standards
22 in the obstetrician community. There are standards of care
23 in every medical specialty. Cardiology has them, orthopedic
24 surgeons have them, ophthalmologists have them. They are
25 just rules that are in place to protect us, the patients,

1 and our families and our children. And if the standards of
2 care are adhered to, all of those terrible things that you
3 saw don't happen. They just don't happen.

4 So the standards of care are critical. You
5 follow the standards of care. You know the standards of
6 care. You will hear evidence from the Plaintiff's side here
7 that they were not followed in this case. We were
8 discussing earlier the type of harm that can happen when
9 you've got a diabetic mom and a large baby called fetal
10 macrosomia.

11 One of the steps, one of the standards, one of
12 the requirements that is on an obstetrician is when you've
13 got a lady with diabetes is to perform serial ultrasounds.
14 You are going to hear that until you are blue in the face.

15 Serial ultrasounds are a very simple,
16 inexpensive, easy test to run. That's a photograph of a
17 lady having an ultrasound right there. It's a no-brainer
18 that that should have been done, serial. And what that
19 means is, over a set of weeks, you monitor the fetal growth.
20 Just at one at one point in time won't tell you much unless
21 the baby is already really big.

22 But what you do, and you will learn this from Dr.
23 Gardner, is, on diabetic moms, beginning at 20 weeks of
24 gestational age -- gestational age is the age of the fetus
25 inside the mama in weeks. I think I have an example here.

1 Here is one from Lorenza's records. At this
2 point Dr. McLaughlin determined she was 29 weeks and five
3 days -- actually, Jonathan is, and that's taken by way of
4 calculating from the last menstrual period before the
5 pregnancy. It's an easy calculation, and you will see it
6 throughout the records, every baby developing in the fetal
7 stage will be assigned a gestational age and then is kept up
8 with.

9 But beginning at age 20 weeks of gestational age,
10 that's when you begin serial ultrasounds on a diabetic mom.
11 We will discuss this in greater detail with Dr. Gardner, but
12 just remember, it's the amount of weeks that that baby has
13 been inside the mom.

14 We believe that the evidence will show that Dr.
15 McLaughlin had a duty to Lorenza and Jonathan both to order
16 repeat serial ultrasounds every four weeks after Jonathan
17 reached 20 weeks of age. That's the serial ultrasounds.
18 And you will hear that from the only obstetrician that's
19 going to be talking to y'all, Dr. Gardner. And we will
20 assert to you and the evidence will show that that did not
21 occur in this case.

22 From the medical records we know that Jonathan
23 was at 20 weeks gestational age somewhere around the
24 November 17-18, 2012 time frame. The evidence will be that
25 Dr. McLaughlin was supposed to start the serial ultrasounds

1 at that time, and that he neglected to do so. This will not
2 be disputed. The fact that he had that as a burden, as a
3 standard of care, that he had a duty to these folks to do
4 that, that won't be disputed, either.

5 So his negligent act in failing to do this will
6 go to you at the end of this trial unchallenged. At no time
7 during the entire pregnancy did Dr. McLaughlin ever order
8 any serial ultrasounds, and it's not to say that he didn't
9 have reminders along the way that he should have.

10 So that's what makes this negligence even more
11 egregious, because it's not just a momentary lapse of
12 judgment by Dr. McLaughlin that he forgot to do these serial
13 ultrasounds, he had reminders. Let me show you what I mean.
14 Like a lot of couples, Lorenza and Alvaro waited
15 a few years to start their family. I waited a lot of years
16 to start my family, and they waited a lot too. They had two
17 children when Lorenza was in her late 20s, and then when she
18 was 36 years old she became pregnant with Jonathan.
19 Because of that late age, she is considered to be
20 advanced maternal age, multigravida. This means that this
21 is her third pregnancy, this is her third baby, but she is
22 advanced maternal age, and that brings along risk of genetic
23 issues, down syndrome, things like that.
24 And she was sent up to UNM to some specialists
25 there at the Health Sciences Center at the University of New

1 Mexico in Albuquerque. And those specialists, genetics
2 specialists and obstetrician performed examinations on her
3 to determine if she was showing, or if Jonathan was showing,
4 more importantly, any signs of genetic issues, and there
5 were none. Everything was good. That's great news.

6 So those specialists wrote two letters back to
7 Dr. McLaughlin saying, "Everything looks good. Genetics
8 clear." But more importantly for your consideration, each
9 of those specialists recommended to Dr. McLaughlin that he
10 perform ultrasound examinations to monitor the fetal growth.

11 So not only did he have the standard of care
12 knowledge that he should have had that they were required,
13 he is getting letters telling him that you need to do
14 ultrasounds on this child to monitor the fetal growth, and
15 they even recommended the 22 to 24 time frame, week time
16 frame.

17 These letters were found in the Defendant's
18 records. They were ignored by Dr. McLaughlin. At no time
19 in this time frame did he order those recommended
20 ultrasounds. We will show you that those letters formed a
21 standard of care, that Dr. McLaughlin had to follow those
22 recommendations to order ultrasound exams on Jonathan to
23 monitor his growth. And we will show you the evidence that
24 he violated that duty. He violated the duty that he had to
25 Jonathan and the duty that he had to his mom.

1 Another way that he had notice of these ongoing
2 requirements of these ultrasounds are warning signs by
3 little Jonathan when he was in the womb sending a telegraph
4 that his size is increasing too rapidly because his mom was
5 diabetic.

6 You will learn about something called fundal
7 height measurements. A fundal height measurement is a
8 measurement that's done very simply, every office can do it,
9 all it takes is a tape measure. And you take the tape
10 measure, and you measure from the top of the pubis to the
11 top of the uterus in centimeters. And by some amazing quirk
12 of nature, whatever that number is that you measure in
13 centimeters, that's supposed to be the age in weeks of the
14 gestational age.

15 So if the baby is 18 centimeters of measurement,
16 guess how old he is gestationally. 18 weeks. Mother
17 nature. But it's a very useful tool because, as a child is
18 growing, it's a very simple measurement to do, and you
19 record it, and you compare it to what the child is in
20 reality age-wise.

21 Here is an example. This is from Jonathan's
22 chart. In March that year, March 6, 2013, his
23 gestational -- his true gestational age based upon that
24 calculated measurement that goes to the very day based upon
25 the last menstrual period, his true gestational age was 35

1 weeks and four days. That's unequivocal, that's a given.

2 But the measurement was 38 centimeters. So he is
3 measuring to be an older child, three weeks older than he
4 really is. That's a warning sign. That's telling Dr.
5 McLaughlin that little Jonathan is growing more rapidly than
6 he is supposed to. Is everyone picking up on that? You see
7 that? Let's look at a couple more.

8 So we've got 3-15 -- and again, this is the
9 gestational age, it's not something that's guesswork, this
10 is the standard. 36 weeks, six days, yet the fundal height
11 measurement was 41 centimeters. So he is measuring to be
12 the age of 41 weeks when he was only 36 weeks. And for an
13 infant, for a fetus, that's a month's growth. That's a
14 month's growth at the end of the pregnancy when they are
15 growing their biggest. It's a warning sign.

16 Another one, at 3-22-2013, 37 weeks six days of
17 gestational age, 42 centimeters. Time and time again you
18 will see in these records that little Jonathan was sending
19 up a red flag -- I'm getting too big -- but Dr. McLaughlin
20 fails to address it, and Jonathan pays the price.

21 You will see some other red flags as we go
22 through here. There is a whole series of fundal
23 measurements through Dr. McLaughlin's records, and each and
24 every one of them shows an increasing gestational age, but a
25 much greater increasing age by fundal height in two days,

1 and Dr. McLaughlin reports it and does nothing.

2 You will hear evidence from Dr. Gardner that the
3 standard of care on Dr. McLaughlin, that he had a duty to
4 Lorenza and Jonathan to recognize the warning signs of
5 fundal height and gestational age discrepancy. It's as
6 clear as the bell in his records that he breached that duty
7 to Jonathan. He breached that duty to Lorenza.

8 Now, had Dr. McLaughlin followed the standard of
9 care and heeded the warning signs, he would have seen that
10 Jonathan was growing to be a very, very big baby, so big
11 that it was becoming very unsafe for him to be born
12 vaginally.

13 The evidence will show that the standard of care
14 actually required that he recommend to Lorenza a C-section
15 for delivering Jonathan; don't even consider a vaginal
16 delivery. I can't force you to get a C-section, but let me
17 tell you what's going to happen if you do. Your son is at
18 high risk of getting stuck in the birth canal. He can
19 suffocate while he is in there, he can get brain damage, he
20 can die, he can get a brachial plexus injury, and you can
21 even die, Lorenza. That's the obligation that the doctor
22 has. He needs to make it clear to her that little Jonathan
23 should be born by cesarean section.

24 And you will have Dr. McLaughlin's records. You
25 can look through them. I have looked through them a million

1 times. There is not a shred of evidence in those records
2 that he ever mentioned to her that she needs a cesarean
3 section for Jonathan's sake.

4 This is a cesarean section. This is why, when
5 you've got an extremely large macrosomic infant, why you do
6 a cesarean section. It avoids them having to pass through
7 the birth canal. He could be a hippopotamus and still be
8 taken easily by cesarean section.

9 That was what should have been done here. That's
10 what should have been recommended, and that's what wasn't.
11 You will hear from Dr. Gardner, he said it in deposition, I
12 assume he will say it here, that if Dr. McLaughlin had done
13 a cesarean section, we wouldn't be here, Jonathan would be
14 out playing baseball and having a good time. That's all it
15 took.

16 That's probably something that affects me more
17 than a lot of this because I know that Jonathan is going to
18 grow up, and he will learn at some point that all of that
19 disability that he feels on a moment-by-moment basis didn't
20 have to happen. It was needless. All it took was a
21 cesarean section. I'm sure that will be difficult for him
22 to accept.

23 It's undisputed that Dr. McLaughlin never
24 recommended a cesarean section to her because of Jonathan's
25 size. If you remember one thing as we go along through this

1 evidence, remember this: The right test at the right time.
2 That's all it took. That's all it took. The right test at
3 the right time.

4 So we move into the day of reckoning. This is
5 the admission record, and these records will be in evidence
6 for you to take back. When I talk to Dr. Gardner, I will
7 identify the medical record exhibit number so those of you
8 who take notes can write it down. There is not going to be
9 that many from us. There are very few actually, but you can
10 go through them in the jury room and see exactly what I'm
11 talking about. It's there in the medical records.

12 So this is the H and P, history and physical for
13 when Mrs. Botello went into the hospital to deliver
14 Jonathan. And once again, Dr. McLaughlin calculates the
15 gestational age to be 38 weeks and one day. I want you to
16 harken back, you've already learned how to measurement
17 fundal heights. He does it again. So at 38 weeks and one
18 day, he ought to be measuring what? How many centimeters?
19 38. What does he measure? 42 centimeters.

20 So even on the day that she comes in to deliver
21 Jonathan, there is a discrepancy between the expected
22 gestational age and the actual fundal height measurement.
23 You've got a fundal height of 42 centimeters which equals 42
24 weeks of gestation, a whole month older than what he should
25 be at that point.

1 And the only reason that that is that way is
2 because he is so dang big. He's huge at this point. He is
3 the size of a 10- or 11-month baby if one was allowed to
4 remain in utero that long.

5 Another red flag. This one was waiving in
6 McLaughlin's face. This is on the day that he is going to
7 be born. And you would think, if you are caring about your
8 patients, if you are following the standard of care, they
9 could do an ultrasound because that's just a really quick
10 and easy check, because the ultrasound, the sonographer can
11 tell you this baby is approximately this size.

12 And you will hear from Dr. Gardner that had they
13 done an ultrasound on Jonathan on this day, that he would be
14 betting dollars to doughnuts that the ultrasound would come
15 back in excess of 4500 grams, macrosomic.

16 And had Dr. McLaughlin gotten the ultrasound, he
17 would have learned that Jonathan was too big to be born
18 vaginally and should have been taken by C-section. You will
19 learn from Dr. Gardner that another standard of care applied
20 here, that Dr. McLaughlin was -- should have ordered an
21 ultrasound.

22 Actually he will probably couch it in two ways.
23 He will say he should have ordered an ultrasound, or should
24 have gone right to a C-section. With that kind of
25 presentation, with a 42 fundal height and a 38 gestational

1 age, that just says C-section to Dr. McLaughlin. Sorry.
2 They both said it to him, too, he didn't listen.

3 If you had said it to Dr. Gardner, he would
4 listen. He delivered 10,000 babies. He will tell you when
5 you've got a child showing that kind of discrepancy,
6 especially on the day you are going to deliver, you do a
7 C-section. Simple. Dr. McLaughlin failed to do it. He
8 breached that standard of care.

9 I want to talk about one thing so we are not
10 confused by it, and I will have Dr. Gardner talk to you
11 about it, too. But in the informed consent that Dr. Gardner
12 had her sign -- sorry, getting confused. In the informed
13 consent that Dr. McLaughlin had Lorenza sign before he
14 performed the vaginal delivery, it addresses that if things
15 go south, if things crater during the vaginal delivery, you
16 may have a C-section performed.

17 But Dr. McLaughlin was not giving her notice that
18 she needed a C-section. He is just saying, I'm going to do
19 a vaginal delivery, but if problems arise, I may have to do
20 a C-section. And Dr. Gardner will be very clear in saying
21 that this is not the type of consultation or recommendation
22 that is necessary for a doctor to a patient when you are
23 counseling them that your baby is too big to be born by
24 other than by cesarean section. So I don't want you to get
25 confused about it.

1 But actually what this does, it even tightens the
2 negligence that you are going to hear about in just a few
3 minutes, because, going into this delivery, he had
4 permission to do a C-section. But what you will hear is,
5 come hell or high water, Dr. McLaughlin is getting that kid
6 out vaginally. He could have stopped at any moment, at any
7 moment and converted to a C-section because he had her
8 permission to do so.

9 And Dr. Gardner will explain that that's what he
10 should have done when he was confronted with this sudden
11 event of shoulder dystocia. Instead, Dr. McLaughlin plows
12 ahead, and he tells her, "We are going to go ahead and go
13 with the vaginal delivery. You are admitted for spontaneous
14 rupture of the membranes and early labor."

15 So it starts. And then it hits. This is his
16 handwritten note for the delivery, severe shoulder dystocia.
17 I wrote it and typed so you could see it. That's his
18 handwriting. That's what he encounters. And it was almost
19 guaranteed. When you've got an 11-and-a-half-pound baby
20 coming down a birth canal that's not built for that, the
21 baby is going to get stuck. And stuck he became for ten
22 minutes.

23 Dr. McLaughlin notes that he is unsuccessful in
24 precipitating delivery. Those are fancy words for saying,
25 the kid is stuck. I can't get him out. This is what's

1 occurring. Little Jonathan -- and this is exactly the
2 shoulder that got it because it's his right arm that is so
3 damaged -- he is stuck in her birth canal. He is stuck
4 underneath her pubic bone, and he is not budging.

5 And then the cord compression begins. This is
6 where it starts to get really serious because at this point
7 Jonathan is suffocating. He is not getting oxygen. This is
8 kind of a cross-section of an umbilical cord. And on the
9 left-hand side you will see what is comprised of inside the
10 umbilical cord. My laser beam isn't working. Jonathan had
11 it working a minute ago. Well, it doesn't show up.

12 But anyway, you've got good things coming from
13 the mother to the baby in the umbilical cord. You have
14 waste products leaving the baby to be excreted through the
15 mom. Life support, that's exactly what an umbilical cord
16 is, is life support. But when you compress it that's when
17 bad things happen because you are compressing it and two
18 things are happening. The oxygen isn't getting in by way of
19 mom's blood, and the waste products from the baby aren't
20 getting out.

21 And you will hear a bit more about that.
22 Jonathan was extremely acidotic. His base excess was -- it
23 was a low number, it was a minus number. And that says to
24 the doctors that were caring for him at a later time that he
25 was in a severely hypoxic state. Hypoxic meaning no oxygen.

1 He then goes into an anoxic state, and that means nothing,
2 no oxygen at all.

3 So that's what's happening when Jonathan is stuck
4 in the birth canal. And you will see, according to the
5 discharge summary, initially the baby's head was stuck in
6 the perineum with difficulty of delivery of the shoulder.
7 So the baby's head has come out, and it's actually called a
8 turtle sign.

9 And I have seen this in real life where the
10 baby's head comes out, but then that shoulder grabs and it
11 sucks back in like a turtle. It's literally in the
12 literature, the turtle sign. If you are an obstetrician,
13 that's a sign you don't ever want to see. That's a problem
14 because that tells you that that baby is stuck. And it
15 stayed this way for about ten minutes. Ten minutes.

16 How long can you hold your breath?

17 Now, you will learn from Dr. Gardner that babies
18 have reserve, and this is a good thing. And what that means
19 is, some babies can tolerate this, some babies don't.
20 That's why you pay attention to the warning signs because
21 you don't want to put a baby in this situation. It ain't
22 right.

23 So we've got this brachial plexus going on.
24 Jonathan is finally pulled out. The brachial plexus is
25 severely damaged. So not only is he pulled that way, but he

1 also applies the vacuum extractor to make things worse,
2 because, if you are not getting hard enough traction with
3 your hands, when you stick the vacuum on and yank him out,
4 that is ripping the brachial plexus apart.

5 So you will hear that Jonathan has an avulsion
6 injury. That's not a stretching injury, and we will talk
7 about the classic injury. But an avulsion is where it's
8 literally ripped away from the spinal cord. That speaks to
9 the degree of force that McLaughlin was putting on him with
10 that vacuum.

11 You will learn from Dr. Gardner that the standard
12 of care was that Dr. McLaughlin had a duty to not use the
13 vacuum to deliver the baby of a pregnant woman who is
14 diabetic, and you will learn that that is a breach in using
15 it.

16 Here is further evidence in Dr. McLaughlin's own
17 handwriting of the ten minutes after delivery of the head at
18 14:05, so five minutes after 2 his head comes out.
19 Jonathan's body is successfully delivered at 2:15. Ten
20 minutes, ten minutes of no oxygen. Documented. There is no
21 question about this.

22 He also had a fracture of the left arm because at
23 some point Dr. McLaughlin is doing anything he can, vacuum
24 and everything, and he reaches in and breaks the arm trying
25 to get him out.

1 I skipped over something I wanted to show y'all
2 here. It stayed this way for ten minutes, but pay attention
3 to this. Then the baby was delivered apneic. Apneic means
4 he is not breathing. With no pulse or heart rate, that
5 means his heart isn't working. He is cyanotic. That means
6 he is blue and he's got floppy tone. Jonathan is dead.

7 There are things that measure viability of a
8 baby. They are called APGAR scores. If you've had a baby,
9 you pay attention to the APGAR scores. You want big
10 numbers, because what an APGAR score is, it's a measure
11 right here. You can measure the appearance, how they look;
12 the pulse, that's the P part. The G is the grimace, do they
13 react to pain. The A is activity, and the R is respiration.
14 And, in this particular case, Jonathan scored zero. He had
15 nothing, no signs of life. He was stillborn. He was
16 stillborn. He was dead at one minute. He was dead at five
17 minutes.

18 Now, they are performing CPR on the little
19 fellow, so it's not like he had ten minutes of no oxygen and
20 then another five minutes of no oxygen for a total of 15
21 minutes. I think that during that five minute period when
22 they're pumping on him, he is probably getting some oxygen,
23 but not much.

24 But finally they get a heart rate. After five
25 minutes they are getting a heartbeat. And the nurse reports

1 that they have gotten him up to above 100 beats per minutes.
2 So at ten minutes he has a score of three. And at 15 he has
3 a score of five. And at 20 minutes he has a score of seven.

4 Normally you get two scores. You get one minute
5 and five minutes, and they are usually eight at one or ten
6 at one and then ten at five. That's a normal baby. That's
7 a good baby. The baby's going to be fine, healthy,
8 breathing, heart beating, everything is good.

9 Jonathan, because of Dr. McLaughlin's failures to
10 meet the standard of care, is dead for the first five
11 minutes of his life, but then he comes and starts showing
12 signs of life.

13 This is the discharge summary. Newborn male
14 infant born by vaginal delivery who experienced birth
15 asphyxia. That's suffocation. If you asphyxiate, you
16 suffocate. With cardio respiratory failure, that means no
17 heart rate, no breathing.

18 And they transfer Jonathan down to the neonatal
19 unit, neonatal intensive care unit down at Odessa Regional
20 Hospital in Odessa. He is life flighted down there, I
21 think, by helicopter. And he falls under the care of
22 Dr. Patel who is a neonatologist. A neonatologist is a
23 specialist that cares for infants that are in trouble.
24 Dr. Patel runs the NICU down there. He personally brought
25 in one of the first cooling units in the southwest.

1 And the cooling unit is what made the difference
2 in Jonathan. Have you ever heard stories about the children
3 that fall in the ponds up north, the ice ponds, and they are
4 down under the water for 30 minutes, and then miraculously
5 somebody finds them under the ice and bring them up and they
6 take them to the hospital and low and behold they are okay.
7 Have y'all heard of that? It's called the mammalian diving
8 reflex that allows them to do that.

9 And so scientists started studying those kids
10 that survived under water for long periods, and they found
11 that it's that extreme cold that drives those children into
12 successful recovery because that extreme cold drives all of
13 the blood to one place, the brain. And it keeps the brain
14 alive, but the most important thing it does, it slows down
15 the metabolism.

16 Everything slows down, but the brain cells
17 particularly. So if their metabolism is slowing down, they
18 are not generating the waste, they are not creating the
19 havoc that would have happened in his brain had he not
20 cooled it.

21 So thank the good lord they started cooling him
22 almost immediately in the helicopter. And when he got down
23 to the NICU, they took him down to I think about 89 to 90
24 degrees, and they kept him there for about four or five
25 days. He was in a coma, but they kept him cool. And then

1 they slowly warm them up, and it makes a world of
2 difference.

3 I think you will probably hear from a pediatric
4 neurologist that we are going to have come talk to y'all
5 that, had they not cooled Jonathan, he would probably have
6 severe cerebral palsy. But they cooled him. And so
7 Jonathan had a remarkable recovery from a death, not a near
8 death, from a death experience. Pretty amazing.

9 But it's not without its aftermath. You will
10 learn from the experts that we call about the various
11 injuries that have been endured in this case, all the result
12 of Dr. McLaughlin's negligence. All of it. And
13 particularly with the brachial plexus injury, I don't think
14 they are going to dispute the causes.

15 They can't dispute that he was negligent because
16 they are not calling an expert to tell you otherwise. The
17 only expert that's going to talk to you about Dr.
18 McLaughlin's care is Dr. Gardner. And Dr. Gardner will tell
19 you that, not only was he negligent, he was likely grossly
20 negligent. He was terrible. He just did not understand why
21 McLaughlin overlooked all of these warning signs, and there
22 were so many, any one of them could have made a difference.

23 But the defense here, we will have to wait and
24 see what they have to say about it, but I think they may
25 say, "Yeah, McLaughlin may have been negligent. Probably

1 can't dispute that the brachial plexus injury was caused by
2 that." We will have to wait and see. Up to this point in
3 time, they have said, "We didn't anything wrong."

4 But now that they face y'all, I think the story
5 is going to change, because this case has been on file for
6 two years, maybe, and in their pleadings, all along, they
7 have pled in their written documents that they filed telling
8 the Court and telling us --

9 MS. KENNY: Your Honor, may we approach?

10 THE COURT: Yes.

11 (Sidebar.)

12 MS. KENNY: Your Honor, this is argument. This
13 is not what the evidence is going to show. This is complete
14 argument about the defense position, and that's exactly what
15 I was talking about this morning.

16 THE COURT: Mr. Buckingham?

17 MR. BUCKINGHAM: I haven't gotten to that slide
18 yet. This is not argument, this is simply stating the
19 facts. They have denied negligence all along. I will show
20 the pleadings.

21 THE COURT: I don't think that's proper for an
22 opening statement. You can -- it is proper for you to say
23 they are not going to call their own expert that you know,
24 and that's not in dispute, but I think you are crossing the
25 line over into argument. And I don't think that's proper in

1 an opening statement to tell them what their position has
2 been up until this point in time. Again, I think that does
3 cross a line over into argument, so I'm going to sustain the
4 objection.

5 (Sidebar concluded.)

6 MR. BUCKINGHAM: So as far as the causation, we
7 will have to see what they say, but I can tell you what the
8 evidence will be. The evidence is going to be that when he
9 went down to Odessa, he was treated there by a neonatologist
10 who has no dog in this fight. He is not hired by anybody.
11 He was treating Jonathan when Jonathan was days old.

12 And when Jonathan was less than -- about three
13 weeks old, that neonatologist -- this is in his discharge --
14 he said, "Jonathan has a brachial plexus palsy." That means
15 that these nerves had been terribly damaged. And palsy
16 results from that. I don't know if you all saw Jonathan's
17 arm, but that's the palsy that results from that, and that's
18 a permanent situation. There is nothing that can be done to
19 help that.

20 He also said that Jonathan had suffered a hypoxic
21 ischemic brain injury. And you want to make a note of that
22 because you are going to be hearing a lot of that from both
23 sides. One side is going to say true, and one side is going
24 to say not true. But if we look at the record back before
25 there was any lawsuit, back before any experts got involved,

1 back before lawyers got involved, the discharge summary --
2 and I will give you this number when I call Dr. Gardner for
3 the record so you can pull it and look at it in the jury
4 room -- but the discharge summary for Dr. Patel, the
5 neonatologist at the NICU that saved, basically Jonathan's
6 life, he said that he has a hypoxic ischemic brain injury,
7 and we'll go into detail in just a second.

8 He also identified the fracture of the humerus.
9 That's the left arm that the doctor broke trying to get
10 Jonathan out. So the brachial plexus injury, this a little
11 blowup to give y'all an idea of what we have been talking
12 about. If you look, you can see the nerves leading -- this
13 isn't Jonathan, but it's a little boy -- leading to the
14 right of the spinal cord, running out into the arm, that
15 whole bundle of nerves is the brachial plexus.

16 That's why they call it brachial plexus, because
17 it's a large bunch of nerves. And each one of those nerves
18 is ending up at a certain part of the arm. Some stop up
19 here in the shoulder, some are longer down to the elbow,
20 some of them are super long that get down to your hand.

21 Probably the ones that get down to the hand are
22 the ones that are avulsed, ripped, because his little hand
23 is, it can't do much. You'll hear that it's a severe
24 injury. And he has some arm movement like this. He had
25 surgery. They put him through surgery at UNM on his

1 shoulder, and that helped him a little bit. That gave him a
2 little bit of motion. It didn't do much for the elbow, or
3 the arm or the hand.

4 And at the bottom here you will see the different
5 types. The avulsed, that's where it's totally ripped out of
6 the spinal cord. The ruptured nerve is where it's broken as
7 it runs through that area, but not ripped out of the spinal
8 cord. And then stretched, the stretched nerve, that's your
9 best-case scenario. If you have a brachial plexus injury
10 you want a stretched nerve because there is a chance that
11 nerve will regenerate and you can recover some function.

12 As a matter of fact, a lot of children that have
13 brachial plexus injuries, a year later you don't see it
14 because their nerves were just stretched. They weren't
15 ripped out of the spinal cord like Dr. McLaughlin did to
16 little Jonathan.

17 And this is noted in the discharge summary when
18 they sent him down to the NICU from Lea Regional.
19 "Extremities not moving upper ones." Of course he is not
20 moving his left one because it's broken. He is not moving
21 his right one because he is paralyzed. He didn't have any
22 function. So that's documented at the birth hospital.

23 And that's Jonathan. I have gotten to know him.
24 He is very shy, but a cute little fellow. I will let the
25 parents develop him with you, but if you'll look at his

1 right arm, you will see that the little hand is kind of --
2 it's called a waiter's tip hand. In the medical literature,
3 I told you about the turtle sign, well, this one is called
4 the waiter's tip because back a long time ago for whatever
5 reason, the waiters were embarrassed at getting tips, so
6 they would go like this and they go by and you tip them.

7 Well, that's the way a brachial plexus hand ends
8 up like this, I guess because the nerves don't function, but
9 the hand ends up like that, waiter's tip hand, and Jonathan
10 has that.

11 I put this in because this is really important
12 for y'all to know and to talk about and understand.
13 Jonathan, you saw him, he is the cutest little kid. He's
14 five years old. But Jonathan is going to grow up, and I
15 don't want y'all to not remember that. This is not just a
16 little five-year-old boy that has a bad arm and brain
17 injury, this is a little boy that's going to be a 40-
18 year-old man with a terribly injured arm and a brain injury.

19 He is going to be a 65-year-old man with a bad
20 injured arm and a brain injury. And as we go through this
21 trial, keep that in the back of your minds, particularly
22 when we start talking about what we call damage in this
23 case, because this is a lifetime event for him. He is going
24 to outlive all of us, and he will be dealing with this arm
25 and this brain injury way into, and if you reach the opinion

1 that there was negligence involved here, which I don't know
2 how you couldn't, then you start talking about damage as
3 being appropriate. And the damage is not just for today,
4 it's for 70 years. That's why that slide is in here.

5 Let me talk to you about the brain injury for
6 just a moment. I know y'all are getting tired. So hypoxic
7 ischemic brain injury, those two big words at the front,
8 hypoxic ischemic. Hypoxic, that is the cord compression
9 that occurred where the blood is shut down not getting to
10 Jonathan and the blood is what carries the oxygen. So
11 that's the hypoxic part. He is not getting oxygen into his
12 body that he needed during that ten-minute period, maybe the
13 five-minute period, but definitely the ten-minute period.
14 Hypoxia, no oxygen, or minimal. Probably no with the
15 compression.

16 I think I put this in here to remind us it was
17 for ten minutes and that he was apneic at the time.
18 Ischemic, that's a separate portion of this injury, and the
19 ischemia is this. Again, it's tied into the compression of
20 the cord because, as Jonathan is stuck there for ten minutes
21 without oxygen, he dies. Because, when he is born, he comes
22 out, he has no heart rate, and that had been going on for
23 some time. And when you don't have a heart rate, you are
24 not pumping blood, and when you are not pumping blood, that
25 is ischemia. Loss of blood, little blood, not enough blood.

1 He is not getting the blood that he had to his brain because
2 his heart is not working.

3 So it's a two-part brain injury, hypoxic and
4 ischemic, both of those combined for a double whammy. This
5 is a fellow that you will hear from probably Friday. His
6 name is Dr. Brian Woodruff. Dr. Woodruff is a pediatric
7 neurologist. He was seeing Jonathan, he's examined
8 Jonathan, and he will talk to you about his opinions as to a
9 brain injury.

10 And he will tell you just what the neonatologist
11 told you in his record, Jonathan has a brain injury. It's
12 going to be contested by the Defendants. And so what you
13 will need to do is weigh out that -- remember, you probably
14 heard more of 51-49 than you wanted to at all times, but
15 that's one reason why I was talking to you about that is
16 because I knew that it was going to come down to this
17 disagreement on brain injury.

18 And the burden that I've got to convince you is
19 what is more likely than not. What is the greater weight of
20 the evidence. My burden is not to persuade you absolutely.
21 If someone goes back into the jury room and says, "I'm not
22 convinced," you have to tell them, "That's not the standard.
23 The standard is 51 percent." So as you listen to the
24 evidence, I believe the evidence will show that we will be
25 carrying our burden to have you believe that he has a brain

1 injury, but it's up to y'all.

2 One of the evidence that you are going to take
3 into account is this fellow. His name is Dr. Arthur Joyce.
4 You will hear from him tomorrow, I think. Dr. Joyce is a
5 pediatric neuropsychologist. What they do is they test,
6 they test kids, and they put them through a two-day battery
7 of mental tests, and physical ones, too. And they study
8 records and they determine whether or not there is evidence
9 of a brain injury. And he will tell you, yes, there is
10 evidence of a brain injury.

11 And you will also hear from a Dr. Isom. Dr. Isom
12 will come in and he will be talking to you about the care
13 that's necessary to take care of Jonathan for his lifetime.
14 He is a rehabilitation specialist.

15 Really briefly on Lorenza's injury, you have seen
16 that, but here is where it is. In Dr. McLaughlin's
17 handwritten notes, he says he caused a fourth degree
18 perineal laceration. Fourth degree, the worst it can be.
19 The worst. And this is not -- if you've had babies or your
20 wives had babies, sometimes they do an episiotomy where they
21 actually make a cut. That's not this. This is a ripping of
22 all flesh and muscle and tissue.

23 What the defense says -- I'm not supposed to say
24 a whole lot about this, so I won't. I think they will say
25 there is no brain injury, and they are going to call doctors

1 to tell you. They are going to call a pediatric neurologist
2 to tell you that. They are going to call a doctor out of --
3 they are all out of Colorado. I think they all work
4 together.

5 They are going to call a lady that's a rehab
6 specialist. An interesting lady, Dr. Wilson, she is in a
7 wheelchair herself. And I was fortunate to go up and meet
8 her and take her deposition. And she is going to tell you
9 that the brachial plexus -- she won't talk about the brain
10 injury, but she'll talk about the brachial plexus injury.

11 And she'll say, it sounds like no big deal,
12 what's -- she is going to say, "We can accommodate for
13 things, we think, with devices. It will be a lifelong
14 issue, but he can handle it and accommodate it." That's her
15 bottom line.

16 They've got a Dr. Kirk, who is a pediatric
17 neuropsychologist kind of along Dr. Joyce's lines, and he
18 did a little testing on Jonathan, and he will tell you he's
19 normal. Average. Dr. Joyce will tell you -- and he did a
20 thorough IQ test on him -- Jonathan's IQ is 74. That is
21 barely above not functional.

22 But Dr. Kirk, the defense neuropsychologist will
23 tell you, he is almost 100. He can go to college. That's
24 what they are going to say. So that's the situation you are
25 going to have. You are going to listen to the evidence. We

1 are going to talk put on our talk, and they are going to put
2 on their talk, and then you weigh it out when you all get
3 back there to deliberate and you figure out who has put on
4 the greater weight of the evidence. And y'all decide for
5 Jonathan or against him.

6 I want to thank y'all for taking the time to
7 listen to me and not falling asleep. I know it's hard, but
8 thank you. One last thing, they're good attorneys. They
9 are going to put on a heck of a case. I have worked with
10 them -- Mr. Dekleva, he and I worked together 20 years ago,
11 and we ended up with a mutual respect, so I think this will
12 be an interesting trial on y'all's part, so thank you.

13 THE COURT: I would suggest that we take our
14 morning break now so that the jury can stretch and be
15 prepared to give you their undivided attention as well.

16 So members of the jury we are going to take our
17 morning break. Try to be back in the courtroom by 10:45 so
18 we will be as prompt and timely as we can. We will be in
19 recess until then. All rise for the jury.

20 (Jury out.)

21 THE COURT: Did you e-mail the revised version to
22 me?

23 MS. KENNY: I did not, but we've got it.

24 MS. ARMSTRONG: It has been forwarded to Your
25 Honor.