

STATE OF SOUTH CAROLINA
In the Court of Appeals

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SC Court of Appeals

APPEAL FROM RICHLAND COUNTY
Court of Common Pleas

The Honorable Jocelyn Newman
Circuit Court Judge
2019-CP-40-04185

Case No. 2024-000548

CRYSTAL GOODWIN AND
JAMES GOODWIN.....

Respondents,

v.

MIDLANDS ORTHOPEDICS AND
NEUROSURGERY AND
DR. THOMAS J. HOLBROOK, M.D.....Appellants.

RECORD ON APPEAL
VOLUME I

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I certify that this Designation does not contain any matters which are irrelevant to this appeal.

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Crystal Goodwin and James Goodwin,

Plaintiffs,

v.

Midlands Orthopedics and Neurosurgery and
Dr. Thomas J. Holbrook, M.D.,

Defendants.

IN THE COURT OF COMMON PLEAS

FIFTH JUDICIAL CIRCUIT

Civil Action No. 2019CP4004185

**ORDER GRANTING NEW TRIAL BASED ON
THE THIRTEENTH JUROR DOCTRINE**

This matter comes before the Court for consideration of “Plaintiffs’ Motion for a New Trial Based on the Thirteenth Juror Doctrine,” which was filed on April 26, 2023. Defendants filed their “Response in Opposition to Plaintiffs’ Motion for New Trial Based on the Thirteenth Juror Doctrine” on May 5, 2023. A hearing was held on this matter on June 1, 2023.

For the reasons set forth below, Plaintiff’s motion is GRANTED.

FACTUAL AND PROCEDURAL BACKGROUND

Plaintiffs Crystal Goodwin (“Crystal”) and James Goodwin (“James”) filed this medical malpractice action July 29, 2019.¹ They amended their Complaint on January 27, 2021, alleging that Crystal was permanently injured when Defendant Dr. Thomas J. Holbrook, M.D. (“Dr. Holbrook”) performed a decompressive thoracic laminectomy (“the surgery”) on her on July 28, 2016. Plaintiffs also allege that as a result of the surgery, which was performed in a negligent manner, James has been deprived of the services, society, and companionship of his wife, Crystal, and has spent many hours providing care and therapeutic treatment for her. The Amended

¹ This is the date of filing of the Summons and Complaint. The Notice of Intent to File Suit was filed on April 29, 2019.

Complaint sets forth claims for medical malpractice, loss of consortium and ordinary negligence/negligent training against Dr. Holbrook and Defendant Midlands Orthopedics and Neurosurgery.

This case was tried before a jury from April 11 to April 20, 2023. At trial, Plaintiffs presented significant evidence of medical negligence and loss of consortium. Witness testimony established the appropriate standard of care and that Defendants breached the standard of care. Further, the evidence demonstrated that as a proximate result of Defendants' conduct, Crystal (and, therefore, James) was obviously permanently injured – she is effectively paralyzed from the waist down, having lost all control of her lower body.

Despite the evidence presented, the jury returned a verdict in favor of Defendants.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

The South Carolina Court of Appeals described the thirteenth juror doctrine in *Youmans v. S.C. Dept. of Transp.*, 380 S.C. 263, 670 S.E.2d 1 (Ct. App. 2008).

The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when he² finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts. The effect is the same as if the jury failed to reach a verdict. The judge as the thirteenth juror “hangs” the jury.

Id. at 272, 670 S.E.2d at 5 (citing *Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990)). “The doctrine entitles the judge ... to grant a new trial based solely upon the facts.” *Lane v. Gilbert Constr. Co., LTD*, 383 S.C. 590, 597, 681 S.E.2d 879, 883 (2009) (internal quotations and citations omitted). “[A] trial judge may grant a new trial upon the facts if the judge determines the verdict ‘is contrary to the fair preponderance of the evidence.’” *McEntire v. Mooregard Exterminating*

² Or she

Serv., Inc., 353 S.C. 629, 633, 578 S.E.2d 746, 748 (Ct. App. 2003) (quoting *Dent v. Redd*, 270 S.C. 585, 586, 243 S.E.2d 460, 460 (1978)).

Here, the Court finds that the evidence presently at trial simply does not support the jury's verdict. The Court, having heard all of the testimony and reviewed all of the evidence (and, of course, having an intimate knowledge of the applicable law), the Court is "convinced that a new trial is necessitated on the basis of the facts in the case." *Graham v. Whitaker*, 282 S.C. 393, 401, 321 S.E.2d 40, 45 (1984). Because the Court "is obligated to see that justice is done – it is duty-bound to grant a new trial" where, as here, the evidence does not support the verdict. *Ex parte Travelers Home & Marine Ins. Co. v. Stringfellow*, 427 S.C. 238, 244, 830 S.E.2d 718, 721 (Ct. App. 2019) (citing *Folkens*, 300 S.C. at 254-55, 387 S.E.2d at 267).

IT IS, THEREFORE, ORDERED that "Plaintiffs' Motion for a New Trial Based on the Thirteenth Juror Doctrine" is GRANTED, and that this case is REOPENED.

IT IS FURTHER ORDERED that this case not be placed on the Jury Trial Roster until a status conference is held to determine an appropriate trial date.

AND IT IS SO ORDERED.



Richland Common Pleas

Case Caption: Crystal Goodwin , plaintiff, et al vs Midlands Orthopaedics And
Neurosurgery , defendant, et al
Case Number: 2019CP4004185
Type: Order/Other

So Ordered

Jocelyn Newman

Electronically signed on 2024-03-22 13:05:56 page 4 of 4

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Crystal Goodwin and James Goodwin,

Plaintiffs,

v.

Thomas J. Holbrook, Jr. M.D. and Midlands
Orthopedics and Neurosurgery,

Defendants.

IN THE COURT OF COMMON PLEAS

FOR THE FIFTH JUDICIAL CIRCUIT

C.A. No. 2019-CP-40-04185

VERDICT FORM

Check "Yes" or "No" to the following question:

1. Do you find that the Defendants were negligent and that any negligence proximately caused injury to Crystal Goodwin?

 Yes (which means you have found in favor of the Plaintiffs)

 No (which means you have found in favor of the Defendants)

If you answered "Yes" to Question 1, also answer the following question:

2. Do you find that the Defendants were grossly negligent and/or reckless?

 Yes No

If you answered "Yes" to Question 1, also answer the following question:

3. Do you find that the Defendants engaged in fraud or made one or more misrepresentations related to the Plaintiffs' claims?

 Yes No

If you answered "Yes" to Question 1, also answer the following question:

4. Please state the total amount of damages, if any, sustained by the Plaintiffs Crystal Goodwin and James Goodwin as a result of Defendants' negligence:

For Crystal Goodwin:

- a. \$ _____ for **economic damages**, such as past and future medical, therapeutic, and other health-related services, as well as loss of earning capacity and other incidental expenses related to the injuries.

For Crystal Goodwin:

- b. \$ _____ for **non-economic damages**, such as past and future pain, suffering, mental and emotional anguish, loss of enjoyment of life, permanent injury, and impairment.

For James Goodwin:

- c. \$ _____ for **non-economic damages**, such as mental anguish, loss of the aid of his spouse, loss of society and companionship of his spouse, loss of services of his spouse, and time spent providing medical, therapeutic, and other health-related services to his spouse.

PLEASE SIGN AND DATE.

[Redacted Signature]

Foreperson

04/20, 2023
Date

Please let the bailiffs know when you have finished your deliberations.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
	)	Civil Action No.:
Crystal Goodwin and James Goodwin,	)	
Plaintiffs,	)	
vs.	)	
Midlands Orthopaedics and Neurosurgery,	)	
Thomas J. Holbrook, Jr., M.D., Carolina	)	SUMMONS
Anesthesiology Associates, P.A., Jennifer	)	
R. Root, M.D., and Prisma Health, f/k/a	)	
Palmetto Health,	)	
Defendants.	)	

TO: THE ABOVE-NAMED DEFENDANTS AND THEIR ATTORNEYS:

YOU ARE HEREBY SUMMONED and required to answer the Complaint in this action, of which a copy is herewith served upon you, and to serve a copy of your Answer to said Complaint on the subscribed, Finkel Law Firm LLC, 1201 Main Street, Suite 1800, Columbia, South Carolina, 29201, within thirty (30) days after the service hereof, exclusive of the date of such service and if you fail to answer the Complaint within the time aforesaid, judgment by default will be rendered against you for the relief demanded in the Complaint.

Respectfully submitted,

s/ Francis M. Hinson, IV

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	
	)	Civil Action No.:
Crystal Goodwin and James Goodwin,	)	
Plaintiffs,	)	
vs.	)	
Midlands Orthopaedics and Neurosurgery,	)	COMPLAINT
Thomas J. Holbrook, Jr., M.D., Carolina	)	(Jury Trial Demanded)
Anesthesiology Associates, P.A., Jennifer	)	
R. Root, M.D., and Prisma Health, f/k/a	)	
Palmetto Health,	)	
Defendants.	)	

The Plaintiffs, complaining of the above-named Defendants, would respectfully show:

Plaintiffs have completed all pre-suit filing requirements of South Carolina Code § 15-79-125, including the filing of a Notice of Intent to File Suit, which was filed with the Clerk of Court's office, and participating in a pre-suit mediation conference between the Parties. Further, in accordance with S.C. Code § 15-36-100, Plaintiff's Notice of Intent to File Suit contained a contemporaneous filing of an affidavit of merit, also attached hereto as **Exhibit A**.

THE PARTIES, VENUE, JURISDICTION, AND APPLICABLE LAW

1. Plaintiff Crystal Goodwin is a resident of South Carolina, who sought and received medical treatment in Richland County, South Carolina.
2. Plaintiff James Goodwin is a resident of South Carolina and presently and at all pertinent times is and was the lawful spouse of Crystal Goodwin.
3. Defendant Midlands Orthopaedics and Neurosurgery (hereinafter, sometimes referred to as "Midlands Orthopaedics") is a healthcare provider, organized and existing under the laws of South Carolina, and doing business and practicing medicine in Richland County.
4. Defendant Thomas J. Holbrook, M.D., is a physician residing and practicing medicine in South Carolina, who, at all pertinent times, was practicing medicine in Richland County
5. Upon information and belief, at all relevant times Dr. Holbrook was an agent and employee of Midlands Orthopaedics, and, with respect to the facts alleged herein, acted within the scope of his employment, agency, and/or duties there.

6. Midlands Orthopaedics is liable for Dr. Holbrook's negligence under the doctrines of *respondeat superior*, agency, and/or master-servant.

7. Defendant Carolina Anesthesiology Associates, P.A. (hereinafter sometimes referred to as "Carolina Anesthesiology"), is a healthcare provider, organized and existing under the laws of South Carolina, and doing business and practicing medicine in Richland County.

8. Defendant Jennifer R. Root, M.D., is a physician residing and practicing medicine in South Carolina, who, at all pertinent times, was practicing medicine in Richland County.

9. Upon information and belief, at all relevant times Dr. Root was an agent and employee of Carolina Anesthesiology, and, with respect to the facts alleged herein, acted within the scope of her employment, agency, and/or duties there.

10. Carolina Anesthesiology is liable for Dr. Root's negligence under the doctrines of *respondeat superior*, agency, and/or master-servant.

11. Prisma Health, which was formally known as Palmetto Health, owns and operates a hospital by name of Prisma Health Baptist and that was formally known as Palmetto Health Baptist (hereinafter sometimes referred to as "PH Baptist").

12. Crystal Goodwin sought the services of PH Baptist, as an institution, for the surgery at issue in this matter. While at PH Baptist, Crystal Goodwin was treated by an anesthesiologist (Dr. Root) who reasonably appeared to be an employee of PH Baptist.

13. Prisma Health is liable for the actions and inactions of Dr. Root under the laws of South Carolina, including the doctrines of ostensible agency and non-delegable duty. See Simmons v. Tuomey Reg'l. Med. Ctr., 341 S.C. 32, 533 S.E.2d 312 (2000).

14. The negligent acts, omissions, and liability of all Defendants includes that of their agents, principals, employees, and/or servants, both directly and vicariously, pursuant to principles of corporate liability, apparent authority, agency, ostensible agency, non-delegable duty, and/or *respondeat superior*.

15. At all relevant times a doctor-patient relationship existed between Dr. Holbrook and Crystal Goodwin.

16. At all relevant times a doctor-patient relationship existed between Dr. Root and Crystal Goodwin.

17. The events that give rise to this action occurred in Richland County.

18. As the lawful spouse of Crystal Goodwin, James Goodwin has a loss of consortium claim, in his own right, which is recognized as an independent action in South Carolina.

19. As described herein, multiple and separate occurrences of breaches of duties, responsibilities, and standards of care transpired and caused damage and injury to Plaintiffs.

20. As described herein, multiple and separate acts of negligence and gross negligence occurred. From each of these occurrences, there was an unfolding sequence of events which proximately caused damage and injury to the Plaintiffs. Though these occurrences may be by employees and/or agents of the same entity, the occurrences are distinct, ascertainable, and capable of being identified by a jury as different instances of conduct – each causing, by itself, injuries to the Plaintiffs.

21. In the event that the laws of South Carolina are determined to cap or otherwise limit the damages that may be recovered in this action, these caps/limits apply separately to the each of the Defendants listed herein.

22. In the event that the laws of South Carolina are determined to cap or otherwise limit the damages that may be recovered in this action, these caps/limits apply independently and separately to each claimant – that is to say, these caps/limits would apply independently and separately to Crystal Goodwin in her own right and to James Goodwin in his own right.

FACTS

23. On or about July 28, 2016, Dr. Holbrook performed a decompressive thoracic laminectomy on Crystal Goodwin. Dr. Root was the anesthesiologist during the aforementioned neurosurgery.

24. The decompressive thoracic laminectomy was performed at Palmetto Health Baptist, which is a Prisma Health facility. As a setting for the surgery, Ms. Goodwin sought the services of Palmetto Health as an institution and was treated there by an anesthesiologist (Dr. Root) who reasonably appeared to be an employee and/or agent of Palmetto Health Baptist.

25. With regard to the decompressive thoracic laminectomy, Drs. Holbrook and Root committed the following negligent acts and/or omissions, each of which constitutes a failure to comply with the applicable standard of care:

- a. failing to adequately and properly review and communicate preoperatively in order to establish Crystal Goodwin's baseline blood pressures and intraoperative mean arterial pressure;

- b. failing to properly monitor and maintain Crystal Goodwin's pressures at proper levels during the surgical procedure;
- c. failing to undertake appropriate action to raise Crystal Goodwin's pressures to safe and proper levels after a decline of pressures during the surgical procedure was evident;
- d. permitting Crystal Goodwin's pressures to remain at dangerously low levels for prolonged periods of time during surgery without undertaking efforts to raise her pressures to appropriate levels; and
- e. other negligent acts and/or omissions as discovery and trial may reveal

26. With regard to the treatment provided to Crystal Goodwin on or about July 28, 2016, the Defendants, their agents, ostensible agents, servants and/or employees, deviated from the applicable standards of care, and were negligent, grossly negligent, careless and/or reckless.

27. As a result of the above-described violations of the standard of care, Crystal Goodwin suffered a decreased perfusion of blood to her spinal cord that resulted in severe neurologic injury.

28. As a result of Defendants' negligent, grossly negligent, careless, reckless, willful and wanton conduct, Crystal Goodwin has been paralyzed.

29. As a result of Defendants' negligence, Crystal Goodwin has experienced great pain, undergone medical procedures, missed work, experienced a loss of enjoyment of life, has a reduced life expectancy, suffered mental and emotion anguish, required the expenditure of money for medical expenses, therapies, and other ancillary medical and health-related services, and suffered other damages.

FOR A FIRST CAUSE OF ACTION
(MEDICAL MALPRACTICE / NEGLIGENCE / GROSS NEGLIGENCE)

30. Plaintiff Crystal Goodwin realleges the paragraphs above as if repeated herein verbatim.

31. As described above, Defendants, their agents, ostensible agents servants, and/or employees deviated from the applicable standards of care, and were negligent, grossly negligent, careless and/or reckless in their treatment of Crystal Goodwin.

32. The above-described deviations from the acceptable standards of care, negligence, and/or grossly negligent actions and omissions combined and concurred as proximate causes of the injuries and damages sustained by Crystal Goodwin.

33. As a direct and proximate result of the negligent, grossly negligent, careless, reckless, willful and wanton conduct of the Defendants, their agents, ostensible agents, servants, and/or employees, Crystal Goodwin suffered in the past and will continue in the future to suffer:

- a. permanent physical injury and impairment;
- b. pain and suffering;
- c. loss of enjoyment of life;
- d. impairment of health;
- e. mental and emotion anguish;
- f. expenditure of money for medical expenses, therapies, and other ancillary medical and health-related services; and
- g. other damages as may be proven.

34. Due to Defendants' grossly negligent, careless, reckless, willful and/or wanton conduct, as described above, Crystal Goodwin is entitled to punitive damages from any and all of the Defendants who are either non-governmental or not entitled to the protections of the South Carolina Solicitation of Charitable Funds Act (S.C. Code §33-56-10 *et seq.*).

FOR A SECOND CAUSE OF ACTION
(LOSS OF CONSORTIUM)

35. Plaintiff James Goodwin realleges the paragraphs above as if repeated herein verbatim.

36. As described above, Defendants, their agents, ostensible agents, servants, and/or employees were negligent, grossly negligent, careless, reckless, willful, wanton, and deviated from accepted medical standards in treating Crystal Goodwin, who is James Goodwin's spouse.

37. As a direct and proximate result of the Defendants' negligent, grossly negligent, careless, reckless, willful and wanton conduct as set forth above, and for the injuries and damages set forth herein, James Goodwin has suffered the loss of the services, society, and companionship of his spouse, Crystal Goodwin, and has spent many hours providing care and therapeutic treatment for her.

38. As a direct and proximate result of the Defendants' negligent, grossly negligent, careless, reckless, willful and wanton conduct set forth above, and for the injuries and damages set forth herein, James Goodwin is entitled to compensation for such injuries and damages, including but not limited to:

- a. loss of the services of his spouse;

- b. loss of the society of his spouse;
- c. loss of the companionship of his spouse;
- d. time spend providing care and therapeutic treatment for his spouse;
- e. mental anguish; and
- f. other damages as may be proven.

39. Due to Defendants' grossly negligent, careless, reckless, willful and/or wanton conduct, as described above, James Goodwin is entitled to punitive damages from any and all of the Defendants who are either non-governmental or not entitled to the protections of the South Carolina Solicitation of Charitable Funds Act (S.C. Code §33-56-10 *et seq.*).

WHEREFORE, having fully pleaded, the Plaintiffs pray for damages against the Defendants in a sum sufficient to compensate them for their actual losses, for the costs of this action, for punitive damages, and for such other and further relief as the Court may deem just and proper.

Respectfully submitted,

s/ Francis M. Hinson, IV

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Attorneys for the Plaintiff

July 29, 2019

Columbia, South Carolina

EXHIBIT

“A”

AFFIDAVIT OF MERIT

I, Gary J. Lustgarten, M.D., being duly sworn, hereby swear and/or affirm and state as follows:

1. I am a licensed physician, currently engaged in the active, clinical practice of medicine and have been so since my graduation from medical school in 1965. I have been board certified by the American Board of Neurological Surgery and a practicing neurosurgeon since 1973. My board certification requires written and/or oral examinations for certification in the practice of neurosurgery. I have post-doctoral training in the specialty of neurosurgery about which specialty this opinion regarding the standard of care is offered. I was previously appointed as a clinical instructor in the Department of Neurosurgery at the University of Miami/Jackson Memorial Hospital and in the Department of Orthopedic Surgery at Nova Southeastern Medical School. Additionally, I am the past director of the spine center at Parkway Regional Medical Center and have actual professional knowledge and experience as a result of my having been engaged in the active clinical practice of neurosurgery for more than 40 years. My professional knowledge and experience encompasses both actual practice and teaching, together, which comprises a full time workload for the past four-plus decades. My qualifications are more fully set forth in my *curriculum vitae*, a copy of which is attached hereto.

2. I have been provided and reviewed medical records for Mrs. Goodwin from Midlands Orthopaedics & Neurosurgery and from Palmetto Health Baptist, as well as imaging studies from Imagecare, LLC. This review encompassed office notes from Midland Orthopedic & Neurosurgery and, from Palmetto Health Baptist, included Mrs. Goodwin's history and physical prior to surgery, surgical/operative reports, anesthesia records, progress notes, radiology report from an MRI performed on July 28, 2016, and discharge summary.

3. The records described above demonstrate that, on July 28, 2016, a decompressive thoracic laminectomy at T9-10 through T11-12 was performed on Crystal J. Goodwin (DOB: 03/02/1978). Based on my education, training and experience, I am familiar with the applicable standard of care relating to the performance of this neurosurgery.

4. I have reviewed the evidence submitted to me, and based upon my expertise, as set forth above, it is my opinion to a reasonable degree of medical certainty that Dr. Thomas J. Holbrook, Jr., and Dr. Jennifer R. Root, Mrs. Goodwin's respective surgeon and anesthesiologist for the aforementioned neurosurgery, committed the following negligent acts and/or omissions, which constitute a failure to comply with the applicable standard of care:

- a. failing to adequately and properly review and communicate preoperatively in order to establish Mrs. Goodwin's baseline blood pressures and intraoperative mean arterial pressure, which should be done prior to commencing a major surgical procedure, particularly in patient, such as Mrs. Goodwin, who has a history of hypertension and diabetes;

- b. failing to properly monitor and maintain Mrs. Goodwin's pressures at proper levels during the surgical procedure;
- c. following a decline of pressures during the surgical procedure, failing to undertake appropriate action to raise Mrs. Goodwin's pressures to safe and proper levels;
- d. permitting Mrs. Goodwin's pressures to remain at dangerously low levels for prolonged periods of time during surgery without undertaking efforts to raise her pressures to appropriate levels.

5. Following the thoracic laminectomy performed on the morning of July 28, 2016, Mrs. Goodwin had no voluntary movement in her legs and limited sensation below T10. To a reasonable degree of medical certainty, the above mentioned breaches of the standard of care were a direct and proximate cause of Mrs. Goodwin's injuries and the paralysis which she has suffered.

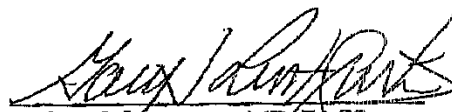
6. My opinions in this matter are based on the information contained in the records reviewed, as noted above, as well as my education, training, and experience. The factual bases of my opinions may be supplemented at a later time. This affidavit is given with the intent to comply with South Carolina Code of Laws §§ 15-36-100 and 15-79-125, which do not require me to state all negligent acts or omissions by a person/defendant. There may be additional bases for the opinions expressed herein that may be discovered or discussed at a later time, and I may testify to the information contained in this affidavit and additionally testify about opinions or other matters that may not be addressed in this affidavit. In the event that additional records are provided, or if other information is made available, I specifically reserve the right to amend or otherwise alter my opinions contained within this statement and to supplement or amend my opinions in this matter, whether by written means or by virtue of testimony.

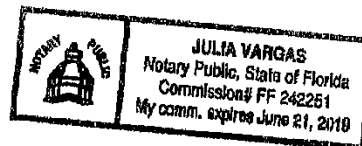
FURTHER AFFIANT SAYETH NOT.

Subscribed and sworn to before me
this 5th day of APRIL 2019.

Notary Public for the State of Florida

My commission expires: 6/2/2019


Gary J. Lustgarten, MD, FACS



GARY J. LUSTGARTEN NEUROSURGICAL ASSOCIATES, INC.
GARY J. LUSTGARTEN, M.D., F.A.C.S.
 DIPLOMATE AMERICAN BOARD OF NEUROLOGICAL SURGEONS

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CURRICULUM VITAE OF GARY J. LUSTGARTEN, M.D., F.A.C.S.

BORN: February 26, 1941, Brooklyn, New York

EDUCATION:

1954-1958	Wellington C. Mepham High School Bellmore, New York	
1958-1961	State University of Iowa Iowa City, Iowa	Bachelor of Arts
1961-1965	State University of Iowa College of Medicine Iowa City, Iowa Medical Doctor	1962-1963 Student Instructor in neuroanatomy 1964 extern, internal medicine
1965-1966	The New York Hospital Cornell Medical Center New York, New York	Surgical Internship
1966-1968	United States Air Force School of Aerospace Medicine Brooks Air Force Base San Antonio, Texas	
1967-1968	Chief of Flight Medicine Blytheville Air Force Base Blytheville, Arkansas	
1968-1974	Active Reserve USAF	

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1968-1973	University of Miami- Jackson Memorial Hospital School of Medicine Miami, Florida
1968-1969	University of Miami cont'd. Resident-Neurosurgery
1969-1970	Resident Neurology
1970-1971	Research Fellow Neurosurgery
1971-1973	Chief Resident Neurology Chief Resident Neurosurgery

HONORS:

1959	Omicron Delta Kappa – National Honorary Leadership and Scholastic Fraternity
1964	William Bean, M.D. – Internal Medicine Scholarship
1965	Alpha Omega Alpha – National Honorary Medical Fraternity
2005	Florida Physician of the Year Award

MEDICAL LICENSURE:

Florida License # 16186

Maine License # 015381

BOARD CERTIFICATION:

American Board of Neurological Surgery

September 1976

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PAST AND PRESENT SOCIETIES/ORGANIZATIONS:

1965	The New York Academy of Sciences
1973	Dade County Medical Association
1973	Florida Medical Association
1973	American Medical Association
1973	South Florida Neurological Society – President
1973	Florida Neurosurgical Society
1975	Fellow, American College of Surgeons
1975	Congress of Neurosurgical Surgeons
1976	Southern Neurosurgical Society
1980	Greater Miami Chapter of the American College of Surgeons
1981	American Association of Neurological Surgeons
1982	Greater Miami Easter Seal Society – Medical Advisory Board
1998	American Association of Spine Surgeons

TEACHING APPOINTMENTS:

1973-1976	Clinical Instructor – Department of Neurosurgery, University of Miami/ Jackson Memorial Hospital Miami, Florida
2000-2005	Clinical Instructor – Department of Orthopaedic Surgery Nova Southeastern Medical School, Davie, Florida

PAST HOSPITAL AFFILIATIONS:

Parkway Regional Medical Center 1973 – 2012
Chairman, Department of Surgery 1996-1999
Chief of Neurosurgery 1990 – 2004
Director of Spine Center

Jackson North Medical Center – Previously Parkway Regional Medical Center,

North Miami Beach, Florida

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PAST HOSPITAL AFFILIATIONS CONT'D:

Mt. Sinai Hospital, Miami Beach, FL 1973-1991
 St. Francis Hospital, Miami Beach, FL 1973-1991
 Miami Heart Institute, Miami Beach, FL 1973-1991
 Palmetto General Hospital, Hialeah, FL 1973-1991
 Osteopathic General Hospital, North Miami Beach, FL 1973-1991
 North Miami General Hospital, North Miami, FL 1973-1995
 Chief of Neurosurgery 1980-1985
 Miami General Hospital – became International Hospital 1974-1991
 Biscayne Medical Center – became Aventura Hospital & Medical Center
 1973-2000 Chief of Neurosurgery 1979-1984
 Osteopathic General Hospital of Hallandale, Hallandale, FL 1973-1991
 Hollywood Medical Center, Hollywood, FL 1985-1991

PRESENT HOSPITAL AFFILIATIONS:

Jupiter Medical Center, Jupiter, FL March 2011 to present

OTHER:

1980	Physician for 1980 USA Olympic Team
2/15/2001	National Leadership Award – Honorary Co-Chairman Physician's Advisory Board National Republican Congressional Committee
8/1995-Present	Florida Workers Compensation Certified Physician Expert Medical Advisor [Examiner] "EMA"

STATE OF SOUTH CAROLINA
COUNTY OF RICHLAND

Crystal Goodwin and James Goodwin,
Plaintiffs,

vs.

Midlands Orthopaedics and Neurosurgery,
Thomas J. Holbrook, Jr., M.D., Carolina
Anesthesiology Associates, P.A., Jennifer
R. Root, M.D., Prisma Health, f/k/a
Palmetto Health, and Erich Starn, CRNA,
Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT

Civil Action No.: 2019-CP-40-04185

SUMMONS

TO: THE ABOVE-NAMED DEFENDANTS.

YOU ARE HEREBY SUMMONED and required to answer the *Amended Complaint*, a copy of which is herewith served upon you, and to serve a copy of your Answer to said *Amended Complaint* on the subscriber at his office at 924 Gervais Street, Columbia, South Carolina 29201, within thirty (30) days from the service hereof, exclusive of the date of such service. If you fail to answer the *Amended Complaint* within the time aforesaid, judgment by default may be rendered against you for the relief demanded in the pleading.

January 27, 2021
Columbia, South Carolina

Respectfully submitted,

s/ Robert F. Goings

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HHP LAW GROUP, LLC
924 Gervais Street
Columbia, SC 29201
803-400-8277 (office)
803-845-4900 (facsimile)
brink@hhplawgroup.com

—and—

Robert F. Goings (SC Bar # 74855)
GOINGS LAW FIRM, LLC
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Columbia, SC 29201
803-350-9230 (office)
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rgoings@goingslawfirm.com
Attorneys for the Plaintiffs

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FOR THE FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
Plaintiffs,	)	
	)	
vs.	)	
	)	
Midlands Orthopaedics and Neurosurgery,	)	
Thomas J. Holbrook, Jr., M.D., Carolina	)	
Anesthesiology Associates, P.A., Jennifer	)	AMENDED COMPLAINT
R. Root, M.D., Prisma Health, f/k/a	)	(Jury Trial Requested)
Palmetto Health, and Erich Starn, CRNA,	)	
Defendants.	)	

Plaintiffs have completed all pre-suit filing requirements of South Carolina Code § 15-79-125. Further, in accordance with S.C. Code § 15-36-100, affidavits of merit, identifying at least one act of negligence by the Defendants, are attached hereto as **Exhibit 1** and **Exhibit 2**.

The Plaintiffs, complaining of the above-named Defendants, would respectfully show:

THE PARTIES, JURISDICTION, VENUE, AND APPLICABLE LAW

1. Plaintiff Crystal Goodwin is a resident of South Carolina, who sought and received medical treatment in Richland County, South Carolina.
2. Plaintiff James Goodwin is a resident of South Carolina and presently and at all pertinent times is and was the lawful spouse of Crystal Goodwin.
3. Defendant Midlands Orthopaedics and Neurosurgery (hereinafter sometimes referred to as "Midlands Orthopaedics") is a healthcare provider, organized and existing under the laws of South Carolina, and doing business and practicing medicine in Richland County.
4. Defendant Thomas J. Holbrook, M.D., (hereinafter sometimes referred to as "Defendant Holbrook" or "Dr. Holbrook") is a physician residing and practicing medicine in South Carolina, who, at all pertinent times, was practicing medicine in Richland County.
5. Upon information and belief, at all relevant times Defendant Holbrook was an agent and employee of Midlands Orthopaedics, and, with respect to the facts alleged herein, acted within the scope of his employment, agency, and/or duties there.

6. Midlands Orthopaedics is liable for Defendant Holbrook's acts and omissions under the doctrines of *respondeat superior*, agency, and/or master-servant.

7. Defendant Carolina Anesthesiology Associates, P.A. (hereinafter sometimes referred to as "Carolina Anesthesiology" or "Carolina Anesthesiology Associates"), is a healthcare provider, organized and existing under the laws of South Carolina, and doing business and practicing medicine in Richland County.

8. Defendant Jennifer R. Root, M.D. (hereinafter sometimes referred to as "Defendant Root" or "Dr. Root"), is a physician residing and practicing medicine in South Carolina, who, at all pertinent times, was practicing medicine in Richland County.

9. Upon information and belief, at all relevant times Defendant Root was an employee and/or agent of Carolina Anesthesiology, and, with respect to the facts alleged herein, acted within the scope of her employment, agency, and/or duties there.

10. Carolina Anesthesiology is liable for Defendant Root's acts and omissions under the doctrines of *respondeat superior*, agency, and/or master-servant.

11. Defendant Prisma Health (hereinafter sometimes referred to as "PH Baptist," "Palmetto Health," or "Prisma Health"), which was formally known as Palmetto Health, owns and operates a hospital by name of Prisma Health Baptist that was formally known as and operated under the name Palmetto Health Baptist. Prisma Health is a healthcare provider, organized and existing under the laws of South Carolina, doing business in Richland County.

12. PH Baptist is liable for the actions and omissions of its nurses, CRNAs (including Erich Starn), and other healthcare providers, staff and employees under the doctrines of *respondeat superior*, agency, and/or master-servant.

13. Crystal Goodwin sought the services of PH Baptist, as an institution, for the surgery at issue in this matter. While at PH Baptist, Crystal Goodwin was treated by an anesthesiologist (Dr. Root) who reasonably appeared to be an employee of PH Baptist.

14. Prisma Health is liable for the acts and omissions of Dr. Root under the laws of South Carolina, including the doctrines of apparent agency, ostensible agency, and non-delegable duty. *Simmons v. Tuomey Reg'l. Med. Ctr.*, 341 S.C. 32, 533 S.E.2d 312 (2000).

15. Defendant Erich Starn (hereinafter sometimes referred to as "Defendant Starn" or "CRNA Starn") is a certified nurse anesthetist, working in healthcare in South Carolina, who, at all pertinent times, was working in Richland County.

16. Upon information and belief, at all times relevant to this action, Defendant Starn was an employee and/or agent of Prisma Health, and, with respect to the facts alleged herein, acted within the scope of his employment, agency, and/or duties there.

17. Although Prisma Health may be determined an entity entitled to the benefits of the South Carolina Solicitation of Charitable Funds Act, because Defendant Starn was reckless, wilful, and/or grossly negligent, an action may be brought against him individually. See S.C. Code § 33-5-180.

18. The negligent acts, omissions, and liability of all Defendants includes that of their agents, principals, employees, and/or servants, both directly and vicariously, pursuant to principles of corporate liability, apparent authority, agency, ostensible agency, non-delegable duty, and/or *respondeat superior*.

19. At all relevant times a doctor-patient relationship existed between Dr. Holbrook and Crystal Goodwin.

20. At all relevant times a doctor-patient relationship existed between Dr. Root and Crystal Goodwin.

21. At all times relevant to this action, a healthcare provider-patient relationship existed between PH Baptists nurses, CRNAs and other healthcare providers and Crystal Goodwin.

22. At all times relevant to this action, a healthcare provider-patient relationship existed between CRNA Starn and Crystal Goodwin.

23. The events that give rise to this action occurred in Richland County.

24. This Court has jurisdiction over the subject matter of this action and over Defendants. Venue is proper in this Court because one or more of the Defendants is a resident of Richland County and because the events giving rise to this action occurred in Richland County.

25. As the lawful spouse of Crystal Goodwin, James Goodwin has a loss of consortium claim, in his own right, which is recognized as an independent action in South Carolina.

26. Healthcare providers have a legal and ethical duty to create a truthful and accurate medical record of the treatment that was provide to Crystal Goodwin. Creating a truthful and accurate medical record requires that material facts and events not be omitted from the record.

27. As described herein, multiple and separate occurrences of breaches of duties, responsibilities, and standards of care transpired and caused damage and injury to Plaintiffs.

28. As described herein, multiple and separate acts of negligence and gross negligence occurred. From each of these occurrences, there was an unfolding sequence of events which proximately caused damage and injury to the Plaintiffs. Though these occurrences may be by employees and/or agents of the same entity, the occurrences are distinct, ascertainable, and capable of being identified by a jury as different instances of conduct – each causing, by itself, injuries to the Plaintiffs.

29. There should be no cap on non-economic damages in action because of misrepresentations related to the claim and/or because Defendants created inaccurate, false, and/or misleading medical records with the purpose of avoiding a claim or liability. See S.C. Code § 15-32-220.

30. In the event that the laws of South Carolina are determined to cap or otherwise limit the damages that may be recovered in this action, these caps/limits apply separately to the each of the Defendants listed herein.

31. In the event that the laws of South Carolina are determined to cap or otherwise limit the damages that may be recovered in this action, these caps/limits apply independently and separately to each claimant – that is to say, these caps/limits would apply independently and separately to Crystal Goodwin in her own right and to James Goodwin in his own right.

FACTS

Facts Relating to the Surgical Procedure Performed on July 28, 2016

32. On the morning of July 28, 2016, Defendant Holbrook performed a decompressive thoracic laminectomy (hereinafter, sometimes referred to as “the surgery”) on Crystal Goodwin.

33. The decompressive thoracic laminectomy was performed at the Palmetto Health Baptist hospital. As a setting for the surgery, Crystal sought the services of Palmetto Health as an institution and was treated there by an anesthesiologist (Dr. Root) who reasonably appeared to be an employee and/or agent of Palmetto Health Baptist.

34. Defendant Root was the attending anesthesiologist for the surgery performed on Crystal Goodwin on the morning of July 28th.

35. Defendant Starn, one of Palmetto Health Baptist’s certified registered nurse anesthetists (CRNAs), was the CRNA for the surgery performed on Crystal Goodwin on the morning of July 28th.

36. At the time of and for many years prior to the surgery, Crystal had chronically high blood pressure.

37. Crystal's chronically high blood pressure was well documented in her medical records.

38. On July 22, 2016, a pre-operative assessment was conducted on Crystal by one or more of the Defendants and their employees/agents. During this assessment, Crystal's blood pressure was noted to be 156/92.

39. On the morning of July 28, 2016, and before the surgery at issue, Defendant Root performed a pre-anesthesia evaluation on Crystal. During this pre-anesthesia evaluation, Crystal's blood pressure was noted to be 160/99.

40. Crystal's history of chronically high blood pressure was well documented and demonstrated by the blood pressure recordings measurements made during the pre-operative assessment and pre-anesthesia evaluation.

41. When a patient undergoing surgery and general anesthesia is known to have chronically high blood pressure, the surgeon and anesthesiologist should ensure that the patient's blood pressure is maintained at a safe level during the procedure that accounts for the patient's chronically high blood pressure.

42. Despite being on notice that Crystal suffered from chronically high blood pressure, Defendant Holbrook and Defendant Root failed to make any appropriate plans and/or arrangements to ensure that her blood pressure would be maintained at a safe range during the surgery.

43. During the surgery, Crystal had low urine output.

44. Low urine output during surgery is a sign of inadequate blood perfusion.

45. Neuromonitoring was utilized during the surgery performed on the morning of July 28th.

46. One of the purposes of neuromonitoring during a spine surgery is to detect any potential neurologic problem(s) and thus provide the healthcare providers the opportunity to timely address and/or correct problem(s) and prevent the patient suffering permanent neurologic injury.

47. Defendant Root deviated from acceptable standards of care and was negligent, reckless, wilful, and/or grossly negligent by the following acts and omissions:

- a. failing to adequately and properly review and communicate preoperatively in order to establish Crystal's baseline blood pressures and an appropriate intraoperative mean arterial pressure;

- b. failing to properly monitor and maintain Crystal's blood pressures at proper levels during the surgical procedure;
- c. failing to recognize intraoperative and information events that indicated inadequate blood perfusion;
- d. failing to undertake appropriate action to raise Crystal's blood pressure to safe and proper levels after a decline of pressures during the surgical procedure was evident;
- e. permitting Crystal's blood pressure to remain at dangerously low levels for prolonged periods of time during surgery without undertaking efforts to raise her pressures to appropriate levels;
- f. other negligent acts and/or omissions as discovery and trial may reveal

48. At approximately 10:00 AM, neuromonitoring indicated that signal to/from Crystal's lower extremities had been lost.

49. At approximately 10:00 AM, the surgical neurophysiologist informed Defendant Holbrook and Defendant Starn that the neuromonitoring signal to/from Crystal's lower extremities had been lost.

50. After being informed that the neuromonitoring signal to/from Crystal's lower extremities had been lost, Defendant Holbrook asked the surgical neurophysiologist if there was anything wrong with her neuromonitoring equipment. The surgical neurophysiologist checked the equipment and relayed that the equipment was operating properly. Despite this information, Defendant Holbrook assumed the neuromonitoring equipment was malfunctioning and continued with the surgery.

51. When intraoperative neuromonitoring indicates signal loss during a surgical procedure, the standard of care requires the surgeon to take appropriate steps to address the possible causes. These steps include not only checking the neuromonitoring equipment, but also include such things as improving blood perfusion, reversing manipulation and widening decompression, and performing a wake-up test.

52. The standard of care requires a neurosurgeon to be familiar with and know how to perform a Stagnara wake-up test.

53. Upon information and belief, Defendant Holbrook was unfamiliar with the Stagnara wake-up test.

54. Defendant Holbrook deviated from acceptable standards of care and was negligent, reckless, wilful, and/or grossly negligent by the following acts and omissions:

- a. failing to adequately and properly review and communicate preoperatively in order to establish Crystal's baseline blood pressures and an appropriate intraoperative mean arterial pressure;
- b. failing to properly monitor and maintain Crystal's blood pressures at proper levels during the surgical procedure;
- c. failing to recognize intraoperative information and events that indicated inadequate blood perfusion;
- d. failing to undertake appropriate action to raise Crystal's blood pressures to safe and proper levels after a decline of pressures during the surgical procedure was evident;
- e. permitting Crystal's blood pressure to remain at dangerously low levels for prolonged periods of time during surgery without undertaking efforts to raise her pressures to appropriate levels;
- f. making the dangerous assumption that neuromonitoring equipment was malfunctioning, despite being told by the surgical neurophysiologist that there was nothing wrong with the neuromonitoring equipment;
- g. failing to improve blood perfusion after neuromonitoring had indicated a signal loss to/from the patient's lower extremities;
- h. failing to reverse manipulation and widen decompression after neuromonitoring had indicated a signal loss to/from the patient's lower extremities;
- i. failing to perform a wake-up test after neuromonitoring had indicated a signal loss to/from the patient's lower extremities;
- j. failing to receive proper education and training, including but not limited to not being familiar with the Stagnara wake-up test;
- k. failing to contact the attending anesthesiologist to inform her that neuromonitoring had indicated a signal loss to/from the Crystal's lower extremities; and
- l. other negligent acts and/or omissions as discovery and trial may reveal.

55. Although the medical record indicates that Dr. Root's time into the surgery was 7:24 AM (the approximate start of the surgery) and that her only time out of the surgery was 11:47

AM (the approximate conclusion of the surgery), upon information and belief, Dr. Root was not actually present in the operating room during the entire surgery. Upon information and belief, Dr. Root was not present in the operating room at 10:00 AM (the time neuromonitoring indicated that signal to/from Crystal's lower extremities had been lost).

56. After being informed that the neuromonitoring signal to/from Crystal's lower extremities was lost, Defendant Starn failed to inform Dr. Root (the attending anesthesiologist).

57. Although Dr. Root would come into the operating room several times after 10:00 AM, on each occasion Defendant Starn failed to inform Dr. Root that neuromonitoring had indicated signal loss to/from Crystal's lower extremities.

58. Upon information and belief, it was not until sometime after the completion of the spine surgery that Dr. Root was made aware that neuromonitoring during the surgery had indicated signal loss to/from Crystal's lower extremities.

59. The standard of care requires a CRNA to report any adverse events to the attending anesthesiologist in a timely fashion.

60. The standard of care requires a CRNA to report any significant changes in a patient's condition to the attending anesthesiologist in a timely fashion.

61. Palmetto Health's *Certified Registered Nurse Anesthesia Agreement for Clinical Practice* dictates that a CRNA is required to report any adverse events to the attending anesthesiologist in a timely fashion.

62. Palmetto Health's *Certified Registered Nurse Anesthesia Agreement for Clinical Practice* dictates that a CRNA is required to report any significant changes in a patient's condition to the attending anesthesiologist in a timely fashion.

63. The loss of neuromonitoring signal to/from the lower extremities of a patient undergoing a spine surgery is an adverse event.

64. The loss of neuromonitoring signal to/from the lower extremities of a patient undergoing a spine surgery is a significant change in a patient's condition.

65. Defendant Starn deviated from acceptable standards of care and was reckless, wilful, and/or grossly negligent in:

- a. failing to timely inform the attending anesthesiologist about the loss of neuromonitoring signal to/from Crystal's lower extremities at the time the signal was lost;

- b. failing to inform the attending anesthesiologist about the loss of neuromonitoring signal to/from Crystal's lower extremities during each occasion when the anesthesiologist entered the operating room after 10:00 AM; and
- c. other reckless, wilful, and/or grossly negligent acts and/or omissions as discovery and trial may reveal.

66. As a result of the above-described acts and omissions of the Defendants and their employees, agents, apparent agents, ostensible agents, and servants, Crystal Goodwin suffered a severe and permanent neurologic injury.

67. With regard to the treatment provided to Crystal Goodwin on or about July 28, 2016, the Defendants and their agents, ostensible agents, servants and/or employees, deviated from the applicable standards of care, and were negligent, grossly negligent, careless and/or reckless.

68. As a result of the above-described violations of the standard of care, Crystal Goodwin suffered a severe and permanent neurologic injury.

69. As a result of Defendants' negligent, grossly negligent, careless, reckless, wilful and wanton conduct, Crystal Goodwin has suffered a severe and permanent neurologic injury.

70. As a result of Defendants' grossly negligent, careless, reckless, wilful and wanton conduct, Crystal Goodwin has experienced great pain, undergone medical procedures, missed work, experienced a loss of enjoyment of life, has a reduced life expectancy, suffered mental and emotion anguish, required the expenditure of money for medical expenses, therapies, and other ancillary medical and health-related services, and suffered other damages.

Facts Relating to Incomplete, Inaccurate, and/or Withheld Medical Records

71. Healthcare providers are required to prepare medical records that are truthful, complete, and accurate.

72. Medical records should truthfully, completely, and accurately describe all important events that take place during a surgical procedure.

73. Following the surgery performed on the morning of July 28, 2016, Defendant Holbrook wrote an operative report. In this report, Defendant Holbrook failed to mention many important events. Defendant Holbrook withheld any mention that neuromonitoring was used during the procedure. Defendant Holbrook withheld any mention that, during the surgery, neuromonitoring indicated a loss of signal to the patient's lower extremities. Defendant Holbrook withheld any

mention that, after being informed that neuromonitoring indicated a loss of signal to this patient's lower extremities, he assumed that the equipment was malfunctioning.

74. As a result of Defendant Holbrook's material omissions from the first operative report, the medical record he created is misleading.

75. On the afternoon of July 28, 2016, Defendant Holbrook took Crystal back to the operating room for a second surgery. Following the surgery performed on the afternoon of July 28th, Defendant Holbrook wrote an operative report. In the second operative report for this second surgery, Dr. Holbrook described the indication as follows:

INDICATIONS: In recovering from anesthesia from the initial surgery, the patient had no voluntary movement in the lower extremities. She could localize sensation over the left lower extremity, but had no sensation below about a T10 level on the right. Repeat MRI scan of the thoracic spine was done which demonstrated some residual stenosis originating from the left at the superior portion of the laminectomy. Also edema within the cord at the superior portion of the laminectomy. The condition and findings were discussed with the husband by phone as he had already left the hospital, and the need for a repeat surgery. I believed that he understood and agreed to proceed.

76. Again, in this second report Defendant Holbrook withheld any information about how, during the surgery performed on the morning of July 28th, neuromonitoring indicated a loss of signal to the patient's lower extremities.

77. As a result of Defendant Holbrook's material omissions from the second operative report, the medical record he created is misleading.

78. Upon information and belief, after the surgeries performed on July 28, 2016, all of the Defendants were aware that, around 10:00, neuromonitoring had indicated a loss of signal to Crystal's lower extremities. Despite this information Defendant Holbrook, Defendant Root, Defendant Starn, and the other healthcare providers involved in Crystal's care failed to ensure that the hospital's medical record accurately reflected this event.

79. The medical records that the Defendants created do not truthfully, completely, and/or accurately reflect all of the important events that took place on July 28, 2016.

80. After the surgery performed on the morning of July 28, 2016, Defendants had access to Crystal's neuromonitoring records.

81. Upon information and belief, after the surgery performed on the morning of July 28, 2016, some or all of Defendants were provided Crystal's neuromonitoring records.

82. Despite having access to and/or being provided some or all of the neuromonitoring records, Defendants did not make the neuromonitoring records a part of Crystal Goodwin's medical chart with Palmetto Health.

Facts Relating to Inadequate Training of CRNAs and Failure to Follow Applicable Laws

83. The South Carolina Nurse Practice Act provides that a CRNA must practice pursuant to "approved written guidelines" that are developed by a CRNA and a supervising licensed physician" working in the hospital. See S.C. Code § 40-33-20(9).

84. The South Carolina Nurse Practice Act provides that a CRNA must practice within his/her approved written guidelines.

85. South Carolina law dictates the minimum of what the approved written guidelines must contain. These minimum contents/requirements can be found at S.C. Code § 40-33-34(H)(2).

86. Upon information and belief, Defendants Palmetto Health, Carolina Anesthesiology Associates, Root, and Starn failed to ensure that appropriate approved written guidelines were developed by a CRNA and a supervising licensed physician working at Palmetto Health. Upon information and belief, the guidelines that were approved were missing many aspects of what is required by South Carolina law, including but not limited to: (a) the name, address, and South Carolina license number of the registered nurse; (b) the name, address, and South Carolina license number of the supervising physician, dentist, or the physician director of anesthesia services or the medical director of the facility; (c) the dates the guidelines were developed, and dates the guidelines were reviewed and amended; (d) the physical address of the primary practice and any additional practice sites; (e) documentation of clinical privileges in the institutions where anesthesia services are provided; (f) policies and procedures that outline the pre-anesthesia evaluation, induction, intra-operative maintenance, and emergence from anesthesia; and (g) evidence of outcome evaluation for anesthesia services.

87. South Carolina law dictates that the approved written guidelines must be reviewed and re-signed annually by both the CRNA and the supervising physician. See S.C. Code § 40-33-34(H)(3).

88. Upon information and belief, Defendants Palmetto Health, Carolina Anesthesiology Associates, Root, and Starn failed to ensure that appropriate approved written guidelines were re-signed annually by CRNA Starn and his supervising physician. Upon information and belief, no

such approved written guidelines were signed by Defendant Starn and/or his supervising physician in 2016 or 2015 or for several years immediately preceding 2015.

FOR A FIRST CAUSE OF ACTION
(Medical Malpractice / Negligence / Gross Negligence)
(AGAINST ALL DEFENDANTS)

89. Plaintiff Crystal Goodwin realleges the paragraphs above as if repeated herein verbatim.

90. As described above, Defendants, their agents, apparent agents, ostensible agents, servants, and/or employees deviated from the applicable standards of care, and were negligent, grossly negligent, careless and/or reckless in their treatment of Crystal Goodwin.

91. The above-described deviations from the acceptable standards of care, negligence, and/or grossly negligent actions and omissions combined and concurred as proximate causes of the injuries and damages sustained by Crystal Goodwin.

92. As a direct and proximate result of the negligent, grossly negligent, careless, reckless, wilful and wanton conduct of the Defendants, their agents, ostensible agents, servants, and/or employees, Crystal Goodwin suffered in the past and will continue in the future to suffer:

- a. permanent physical injury and impairment;
- b. pain and suffering;
- c. loss of enjoyment of life;
- d. impairment of health;
- e. mental and emotion anguish;
- f. pecuniary loss, including the expenditure of money for medical expenses, therapies, home modifications, attendant care, and other ancillary medical and health-related services; and
- g. other damages as may be proven.

93. Due to Defendants' grossly negligent, careless, reckless, wilful and/or wanton conduct, as described above, Crystal Goodwin is entitled to punitive damages from any and all of the Defendants who are either non-governmental or not entitled to the protections of the South Carolina Solicitation of Charitable Funds Act (S.C. Code §33-56-10 *et seq.*).

FOR A SECOND CAUSE OF ACTION
(Loss of Consortium)
(AGAINST ALL DEFENDANTS)

94. Plaintiff James Goodwin realleges the paragraphs above as if repeated herein verbatim.

95. As described above, Defendants, their agents, apparent agents, ostensible agents, servants, and/or employees were negligent, grossly negligent, careless, reckless, wilful, wanton, and deviated from accepted medical standards in treating Crystal Goodwin, who is James Goodwin's spouse.

96. As a direct and proximate result of the Defendants' negligent, grossly negligent, careless, reckless, wilful, and wanton conduct as set forth above, and for the injuries and damages set forth herein, James Goodwin has suffered the loss of the services, society, and companionship of his spouse, Crystal Goodwin, and has spent many hours providing care and therapeutic treatment for her.

97. As a direct and proximate result of the Defendants' negligent, grossly negligent, careless, reckless, wilful and wanton conduct set forth above, and for the injuries and damages set forth herein, James Goodwin is entitled to compensation for such injuries and damages, including but not limited to:

- a. loss of the services of his spouse;
- b. loss of the society of his spouse;
- c. loss of the companionship of his spouse;
- d. time spend providing care and therapeutic treatment for his spouse;
- e. mental anguish; and
- f. other damages as may be proven.

98. Due to Defendants' grossly negligent, careless, reckless, wilful, and/or wanton conduct, as described above, James Goodwin is entitled to punitive damages from any and all of the Defendants who are either non-governmental or not entitled to the protections of the South Carolina Solicitation of Charitable Funds Act (S.C. Code §33-56-10 *et seq.*).

FOR A THIRD CAUSE OF ACTION
(Ordinary Negligence / Negligent Training)
(AGAINST DEFENDANT MIDLANDS ORTHOPEDICS & NEUROSURGERY)

99. Plaintiffs Crystal Goodwin and James Goodwin reallege the paragraphs above as if repeated herein verbatim.

100. A healthcare provider has a duty to ensure that the physicians and nurses it employs have received appropriate training and education.

101. Defendant Midlands Orthopedics had a duty to ensure that Dr. Holbrook was properly trained and educated.

102. The standard of care requires a neurosurgeon to be familiar with and know how to perform a Stagnara wake-up test.

103. Defendant Holbrook was unfamiliar with the Stagnara wake-up test.

104. In addition to being responsible for the acts and omissions of Dr. Holbrook, who was Defendant Midlands Orthopedics' employee, agent, apparent agent, ostensible agent, and/or servant, Defendant Midlands Orthopedics committed separate acts of negligence by failing to ensure that Dr. Holbrook was properly trained and educated.

105. As a direct and proximate result of the Defendant Midlands Orthopedics' negligent, grossly negligent, careless, reckless, wilful, and wanton failure to ensure that Dr. Holbrook was properly trained and educated, Crystal Goodwin and James Goodwin have suffered the injuries and damages set forth above and are entitled to compensation for such injuries and damages as set forth above.

FOR A FOURTH CAUSE OF ACTION
(Ordinary Negligence / Negligent Training)
(AGAINST DEFENDANT PALMETTO HEALTH)

106. Plaintiffs Crystal Goodwin and James Goodwin reallege the paragraphs above as if repeated herein verbatim.

107. A healthcare provider has a duty to ensure that the physicians and nurses it employs have received appropriate training and education.

108. Defendant Palmetto Health had a duty to ensure that the CRNAs it employed were properly trained and educated.

109. Defendant Palmetto Health had a duty to follow the South Carolina Nurse Practice Act.

110. Upon information and belief and as described above, Defendant Palmetto Health failed to ensure that the CRNAs it employed were properly trained and educated and also failed to follow the South Carolina Nurse Practice Act.

111. In addition to being responsible for the acts and omissions of Dr. Root, who was Defendant Palmetto Health's agent, apparent agent, ostensible agent, and/or servant, and also being responsible for the acts and omissions of CRNA Starn, who was Defendant Palmetto Health's employee, agent, apparent agent, ostensible agent, and/or servant, Defendant Palmetto

Health committed separate acts of negligence by failing to ensure that its CRNAs were properly trained and educated and by failing to follow the provisions of the South Carolina Nurse Practice Act.

112. As a direct and proximate result of the Defendant Palmetto Health's negligent, grossly negligent, careless, reckless, wilful and wanton failure to ensure that its CRNAs were properly trained and educated and by failing to follow the provisions of the South Carolina Nurse Practice Act, Crystal Goodwin and James Goodwin have suffered the injuries and damages set forth above and are entitled to compensation for such injuries and damages as set forth above.

FOR A FIFTH CAUSE OF ACTION
(Ordinary Negligence / Negligent Training)
(AGAINST DEFENDANT CAROLINA ANESTHESIOLOGY ASSOCIATES)

113. Plaintiffs Crystal Goodwin and James Goodwin reallege the paragraphs above as if repeated herein verbatim.

114. As the provider of anesthesia services at Palmetto Health Baptist, Carolina Anesthesiology Associates had a duty to ensure that the CRNAs it was managing and/or directing properly trained and educated and that a duty to follow the South Carolina Nurse Practice Act.

115. Upon information and belief and as described above, Defendant Carolina Anesthesiology Associates failed to ensure that the CRNAs it managed and/or directed were properly trained and educated and also failed to follow the South Carolina Nurse Practice Act.

116. In addition to being responsible for the acts and omissions of Dr. Root, who was Defendant Carolina Anesthesiology Associates' employee, agent, apparent agent, ostensible agent, and/or servant, Defendant Carolina Anesthesiology Associates committed separate acts of negligence by failing to ensure that the CRNAs it managed and/or directed were properly trained and educated and by failing to follow the provisions of the South Carolina Nurse Practice Act.

117. As a direct and proximate result of the Defendant Carolina Anesthesiology Associate's negligent, grossly negligent, careless, reckless, wilful and wanton failure to ensure that the CRNAs it managed and/or directed were properly trained and educated and by failing to follow the provisions of the South Carolina Nurse Practice Act, Crystal Goodwin and James Goodwin have suffered the injuries and damages set forth above and are entitled to compensation for such injuries and damages as set forth above.

WHEREFORE, having fully pleaded, the Plaintiffs pray for damages against the Defendants in a sum sufficient to compensate them for their actual losses, for the costs of this action, for punitive damages, and for such other and further relief as the Court may deem just and proper.

<signature on page following>

January 27, 2021
Columbia, South Carolina

Respectfully submitted,

s/ Robert F. Goings

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STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Crystal Goodwin and James Goodwin,

Plaintiffs,

v.

Midlands Orthopaedics and Neurosurgery,
Thomas J. Holbrook, Jr., M.D., Carolina
Anesthesiology Associates, P.A., Jennifer
R. Root, M.D., and Prisma Health, f/k/a
Palmetto Health, and Erich Starn, CRNA,

Defendants.

IN THE COURT OF COMMON PLEAS

C.A. NO.: 2019-CP-40-04185

**DEFENDANTS THOMAS J.
HOLBROOK, JR., M.D., AND
MIDLANDS ORTHOPAEDICS AND
NEUROSURGERY'S ANSWER TO
AMENDED COMPLAINT**

(Jury Trial Demanded)

The Defendants, Thomas J. Holbrook, Jr., M.D., and Midlands Orthopaedics and Neurosurgery, answering the Amended Complaint of the Plaintiffs, would respectfully show unto the Court the following:

Each and every allegation not specifically admitted, denied, qualified, or otherwise explained, is hereby expressly denied.

FOR A FIRST DEFENSE

1. Answering Paragraphs 1, 2, 3, 4, and 5 of the Amended Complaint, upon information and belief, these Defendants admit the allegations contained therein.

2. Answering Paragraph 6 of the Amended Complaint, these Defendants admit Dr. Holbrook was an employee of Midlands Orthopaedics during the time(s) at issue in this case. These Defendants deny that Dr. Holbrook was negligent in his care of the Plaintiff Crystal Goodwin.

3. Answering Paragraphs 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17 of the Amended Complaint, these allegations are not addressed to these Defendants and therefore no response is

required of these Defendants. To the extent that a response is required of these Defendants, these Defendants deny the allegations contained therein and demand strict proof thereof.

4. Answering Paragraph 18 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

5. Answering Paragraph 19 of the Amended Complaint, these Defendants admit a doctor-patient relationship existed between Dr. Holbrook and Crystal Goodwin during all times indicated in the medical records of Crystal Goodwin.

6. Answering Paragraphs 20, 21, and 22 of the Amended Complaint, these allegations are not addressed to these Defendants and therefore no response is required of these Defendants. To the extent that a response is required of these Defendants, these Defendants deny the allegations contained therein and demand strict proof thereof.

7. Answering Paragraph 23 of the Amended Complaint, these Defendants admit the events at issue in this case took place in Richland County.

8. Answering Paragraph 24 of the Amended Complaint, these Defendants admit that venue is proper in this Court and that this Court has jurisdiction over the subject matter of this action and over Defendants.

9. Answering Paragraph 25 of the Amended Complaint, these Defendants, upon information and belief, admit James Goodwin is the lawful spouse of Crystal Goodwin and these Defendants admit a lawful spouse can bring a loss of consortium claim in his or her own right as an independent action in South Carolina. These Defendants deny any allegations of negligence and demand strict proof thereof.

10. Answering Paragraphs 26, 27 and 28 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

11. Answering Paragraphs 29, 30, and 31 of the Amended Complaint, in the event the laws of South Carolina are determined to cap or otherwise limit the damages that may be recovered in these actions, these caps/limits will apply as indicated in accordance with South Carolina law. All allegations contained in Paragraphs 29, 30, and 31 inconsistent with South Carolina law are denied.

12. Answering Paragraph 32 of the Amended Complaint, these Defendants admit that on July 28, 2016, Dr. Holbrook performed a decompressive thoracic laminectomy on Crystal Goodwin.

13. Answering Paragraph 33 of the Amended Complaint, these Defendants admit the decompressive thoracic laminectomy was performed at Palmetto Health Baptist. These Defendants deny the remaining allegations contained therein and demand strict proof thereof.

14. Answering Paragraphs 34 and 35 of the Amended Complaint, these Defendants admit that Defendant Root was the anesthesiologist and Defendant Starn was the CRNA for Crystal Goodwin's surgery the morning of July 28, 2016.

15. Answering Paragraphs 36 and 37 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

16. Answering Paragraphs 38 and 39 of the Amended Complaint, these Defendants admit that Crystal Goodwin's blood pressure was 156/92 when tested on July 22, 2016 and was 160/99 during the pre-anesthesia evaluation on July 28, 2016.

17. Answering Paragraphs 40, 41, 42, 43, 44, 45, and 46 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

18. Answering Paragraph 47 of the Amended Complaint, and all subparts thereto, these Defendants deny the allegations contained therein and demand strict proof thereof.

19. Answering Paragraphs 48, 49, 50, 51, 52, and 53 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

20. Answering Paragraph 54 of the Amended Complaint and all subparts thereto, these Defendants deny the allegations contained therein and demand strict proof thereof.

21. Answering Paragraphs 55, 56, and 57 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

22. Answering Paragraph 58 of the Amended Complaint, these Defendants admit Dr. Root testified that she was not made aware of the loss of SSEPs until the end of the surgery.

23. Answering Paragraphs 59, 60, 61, and 62 of the Amended Complaint, these Defendants lack sufficient knowledge and information and thereby deny the allegations contained therein and demand strict proof thereof.

24. Answering Paragraphs 63 and 64 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

25. Answering Paragraph 65 of the Amended Complaint and all subparts thereto, these Defendants deny the allegations contained therein and demand strict proof thereof.

26. Answering Paragraphs 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, and 82 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

27. Answering Paragraphs 83, 84, 85, 86, 87, and 88 of the Amended Complaint, these allegations are not addressed to these Defendants and therefore no response is required of these Defendants. To the extent that a response is required of these Defendants, these Defendants deny the allegations contained therein and demand strict proof thereof.

28. Answering Paragraph 89 of the Amended Complaint, these Defendants would repeat all preceding admissions and denials as if fully repeated herein.

29. Answering Paragraphs 90 and 91 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

30. Answering Paragraph 92 of the Amended Complaint, and all subparts thereto, these Defendants deny the allegations contained therein and demand strict proof thereof.

31. Answering Paragraph 93 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

32. Answering Paragraph 94 of the Amended Complaint, these Defendants would repeat all preceding admissions and denials as if fully repeated herein.

33. Answering Paragraphs 95 and 96 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

34. Answering Paragraph 97 of the Amended Complaint, and all subparts thereto, these Defendants deny the allegations contained therein and demand strict proof thereof.

35. Answering Paragraph 98 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

36. Answering Paragraph 99 of the Amended Complaint, these Defendants would repeat all preceding admissions and denials as if fully repeated herein.

37. Answering Paragraphs 100, 101, 102, 103, 104, and 105 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

38. Answering Paragraph 106 of the Amended Complaint, these Defendants would repeat all preceding admissions and denials as if fully repeated herein.

39. Answering Paragraphs 107, 108, 109, 110, 111, and 112 of the Amended Complaint, these Defendants deny the allegations contained therein and demand strict proof thereof.

40. Answering Paragraph 113 of the Amended Complaint, these Defendants would repeat all preceding admissions and denials as if fully repeated herein.

41. Answering Paragraphs 114, 115, 116, and 117 of the Amended Complaint, these allegations are not addressed to these Defendants and therefore no response is required of these Defendants. To the extent that a response is required of these Defendants, these Defendants deny the allegations contained therein and demand strict proof thereof.

FOR A SECOND DEFENSE

42. These Defendants allege that any medical care given to Mrs. Goodwin was reasonable and in keeping with the standard of care.

FOR A THIRD DEFENSE

43. These Defendants assert that the Plaintiffs' claims are barred in whole or in part by the applicable statute of limitations.

FOR A FOURTH DEFENSE

44. These Defendants assert that Plaintiffs' claims for noneconomic damages are limited by the South Carolina Noneconomic Damage Awards Act of 2005, S.C. Code Ann §§ 15-32-200 *et seq.*

FOR A FIFTH DEFENSE

45. These Defendants assert that any claims for punitive damages, which are specifically denied by these Defendants, are subject to the provisions and limitations of S.C. Code Ann. §§ 15-32-520 and 15-32-530 and any other applicable provisions of South Carolina law.

FOR A SIXTH DEFENSE

46. These Defendants allege that any negligence, carelessness, recklessness, gross negligence, willfulness, or wantonness on the part of these Defendants, which are specifically denied by these Defendants, did not directly or proximately cause or contribute to the alleged injuries and damages stated in the Amended Complaint and, therefore, these Defendants should not be held liable for any such injuries or damages and plea such as a bar to this action.

FOR A SEVENTH DEFENSE

47. These Defendants allege that the alleged injuries and damages stated in the Amended Complaint were due to and/or proximately caused by the underlying injuries, medical condition(s) and/or complications of the patient in question and not by any alleged negligence, carelessness, or fault on the part of these Defendants.

FOR AN EIGHTH DEFENSE

48. These Defendants reserve the right to amend their Answer and to assert additional defenses as facts are developed in the course of additional investigation and discovery.

WHEREFORE, having fully answered the Amended Complaint of the Plaintiffs, these Defendants respectfully request that the matter be dismissed as to them and for any other relief deemed just and appropriate by this Honorable Court.

Respectfully submitted,

(Signature on Following Page)

s/ Andrew K. Heitman

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AND NEUROSURGERY

February 25, 2021
Greenville, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
vs.	)	
	)	STIPULATION OF DISMISSAL
	)	WITH PREJUDICE AS TO
Midlands Orthopaedics and Neurosurgery,	)	JENNIFER R. ROOT, M.D., ONLY
Thomas J. Holbrook, Jr., M.D., Carolina	)	
Anesthesiology Associates, P.A., Jennifer	)	
R. Root, M.D., Prisma Health, f/k/a	)	
Palmetto Health, and Erich Starn,	)	
	)	
Defendants.	)	

Pursuant to Rule 41(a)(1) of the South Carolina Rules of Civil Procedure, upon stipulation of all above-named parties in this matter, the claims between Plaintiffs and Defendant Jennifer R. Root, M.D., only, are dismissed with prejudice. Plaintiffs' claims and causes of action against the other Defendants (Midlands Orthopaedics and Neurosurgery, Thomas J. Holbrook, Jr., M.D., Carolina Anesthesiology Associates, P.A., Prisma Health, f/k/a Palmetto Health and Erich Starn) are to remain and continue. The parties will pay their own attorneys' fees and costs.

WE SO STIPULATE:

August ___, 2022.

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF RICHLAND	)	CASE NO: 2019-CP-40-04185
Crystal Goodwin and James Goodwin,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	STIPULATION OF DISMISSAL WITH
	)	PREJUDICE AS TO CAROLINA
Midlands Orthopaedics and Neurosurgery,	)	ANESTHESIOLOGY ASSOCIATES, P.A.,
Thomas J. Holbrook, Jr., M.D., Carolina	)	ONLY
Anesthesiology Associates, P.A.,	)	
Prisma Health, f/k/a Palmetto	)	
Health and Erich Starn, CRNA,	)	
	)	
Defendants.	)	
	)	

Pursuant to Rule 41(a)(1) of the South Carolina Rules of Civil Procedure, upon stipulation of all above-named parties in this matter, the claims between Plaintiffs and Defendant Carolina Anesthesiology Associates, P.A., only, are dismissed with prejudice. Plaintiffs' claims and causes of action against the other Defendants (Midlands Orthopaedics and Neurosurgery, Thomas J. Holbrook, Jr., M.D., Prisma Health, f/k/a Palmetto Health and Erich Starn) are to remain and continue. The parties will pay their own attorneys' fees and costs.

WE SO STIPULATE:

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
vs.	)	STIPULATION OF DISMISSAL,
	)	WITH PREJUDICE, AS TO
Midlands Orthopaedics and Neurosurgery,	)	DEFENDANTS PRISMA HEALTH
Thomas J. Holbrook, Jr., M.D., Prisma Health,	)	AND ERICH STARN
f/k/a Palmetto Health, and Erich Starn,	)	
	)	
Defendants.	)	

Pursuant to Rule 41(a)(1) of the South Carolina Rules of Civil Procedure, upon stipulation of all above-named parties in this matter, the claims between the Plaintiffs and Defendants Prisma Health, f/k/a Palmetto Health, and Erich Starn are hereby dismissed with prejudice. Plaintiffs' claims and causes of action against the other Defendants (Midlands Orthopaedics and Neurosurgery and Thomas J. Holbrook, Jr., M.D.) are to remain and continue. The parties will pay their own attorneys' fees and costs.

Respectfully submitted, this day, November 17, 2022.

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STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
vs.	)	PLAINTIFFS' MOTION FOR MISTRIAL
	)	AND MOTION FOR NEW TRIAL BASED
Midlands Orthopaedics and Neurosurgery,	)	ON JUROR MISCONDUCT
and Thomas J. Holbrook, Jr., M.D.	)	
	)	
Defendants.	)	

COMES NOW, pursuant to Rules 59 and 60 of the South Carolina Rules of Civil Procedure, the Plaintiffs respectfully seek a new trial based on significant issues of juror misconduct that were discovered after the verdict based on discussions with the foreperson regarding misconduct of Juror Stephanie Cribb-Creek (Juror # 68). The discussions post-trial with the foreperson caused Plaintiffs to further investigate Ms. Stephanie Cribb-Creek, and it was determined that she failed to answer material questions in *voir dire* related to her impartiality (or lack thereof). Plaintiffs are entitled to a new trial because the jury's verdict was tainted by the seating of Stephanie Cribb-Creek (Juror # 68) and the verdict reflects prejudice, partiality, corruption, and improper motive of the jury selection process and in deliberation. This motion is supported by the following:

- (1) *Exhibit 1* – Medical Licenses of Juror Stephanie Cribb-Creek from SCLLR
- (2) *Exhibit 2* – LinkedIn Page of Juror Stephanie Cribb-Creek
- (3) *Exhibit 3* – Medical Malpractice Lawsuit Against Juror Stephanie Cribb-Creek
- (4) *Exhibit 4* – Affidavit of Robert F. Goings, Esq.
- (5) *Exhibit 5* – Affidavit of Gabrielle Ross, Foreperson of Jury

I. Juror Misconduct – Disqualification of Juror Stephanie Cribb-Creek (Juror # 68)

This Court should not countenance the duplicitous conduct of Juror Stephanie Cribb-Creek (Juror # 68) revealed after the verdict. As discussed, with the information that has only now come to light relating misinformation given during the *voir dire* process, Stephanie Cribb-Creek (Juror # 68) should have been disqualified as a juror.

“Granting or refusal of a new trial is directed to the trial judge’s discretion.” *Gray v. Bryant*, 298 S.C. 285, 288, 379 S.E.2d 894, 896 (1989) (citing *Jenkins v. Dixie Specialty Co., Inc.*, 284 S.C. 425, 326 S.E.2d 658 (1985)). “A party seeking a new trial based upon the disqualification of a juror must show: (1) the fact of disqualification; (2) the grounds for disqualification were unknown prior to verdict; and (3) the moving party was not negligent in failing to learn of the disqualification before verdict.” *Id.* (citing *Thompson v. O'Rourke*, 288 S.C. 13, 339 S.E.2d 505 (1986)). The “standard for granting a new trial when it is discovered that a seated juror fails to fully respond to *voir dire* questioning” is as follows:

“[R]elief is required only when the court finds the concealed information would have supported a challenge for cause, or would have been a material factor in the use of the parties' peremptory challenges. The inquiry must focus on the character of the concealed information, not the mere fact that a concealment occurred.”

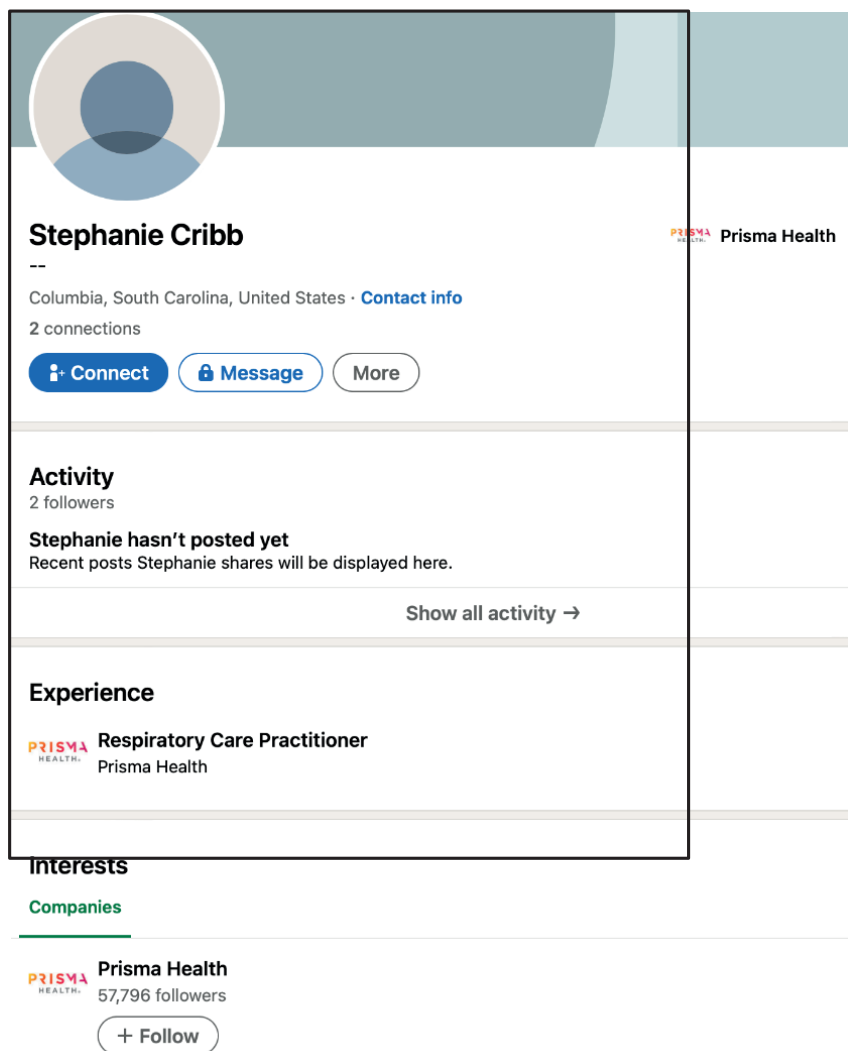
“The qualification of a juror is not to be determined alone by the fact that she declares her fairness and impartiality. *Id.* (citing *Brown v. S.H. Kress & Co.*, 170 S.C. 178, 170 S.E. 142 (1933)).

This standard is met because the seating of Stephanie Cribb-Creek (Juror # 68) would have both supported a challenge for cause and would have been a material factor in the use of the parties' peremptory challenges. After the question of “Have you or has any member of your immediate family ever been employed by a hospital, physician, or a medical facility,” at the Plaintiffs' request, the Court asked if any member or their immediate family has ever been employed by Palmetto Health/Prisma. Based on the individuals that identified themselves in response to the question,

Plaintiffs moved to strike for cause all jurors with any affiliation with Palmetto Health/Prisma. Stephanie Cribb-Creek (Juror # 68) did not identify herself as having any employment or affiliation, past or present, with Palmetto Health/Prisma. As discussed below, it is now known that this was untrue and that she is (or was) employed by Palmetto Health/Prisma and has significant affiliation with the hospital where the events of the case took place and that was previously a party to this very lawsuit.

Per the South Carolina Board of Medical Examiners, Stephanie Cribb-Creek (Juror # 68) is a licensed Registered Nurse (RN), a licensed Practical Nurse (LPN), and a licensed Pulmonologist/Respiratory Care Practitioner (RCP). These licenses are under her now discovered maiden name of “Stephanie Austin Cribb,” which is Juror #68, but her juror name is listed as “Creek/Cribb, Stephanie S.” Notably, her active license is still registered with “Palmetto Health.” See Exhibit 1 - Licenses with SCLLR. It appears that Stephanie Cribb-Creek (Juror # 68) actually worked for Palmetto Health/Prisma in 2009, 2011, and/or 2016, and thus she was employed at Palmetto Health/Prisma during the time periods for which the standard of care is relevant in the present case.

Although the information Stephanie Cribb-Creek (Juror # 68) provided the Clerk of Court, as listed on the juror list, states that she is employed by “Dorn VA”, her LinkedIn page (See Exhibit 2 – LinkedIn Page) reflects her employment with Prisma Health.



The fact that she was employed by Palmetto Health/Prisma (the same hospital where the alleged negligence occurred) and worked there during the same time when Defendant Holbrook had worked at and had privileges at Palmetto Health/Prisma was never disclosed in jury selection.

Without question, if Juror Stephanie Cribb-Creek (Juror # 68) would have been truthful in the jury selection process, Plaintiffs would have specifically moved to strike her for cause based on her employment and affiliation with Palmetto Health/Prisma alone. During jury selection, Plaintiffs strenuously argued that any juror or their spouse that had been employed by Palmetto Health/Prisma should be struck for cause. Plaintiffs assert they should be removed from the pool

because Palmetto Health/Prisma had been a party to this case and many of the allegations and defenses involve Palmetto Health/Prisma, and in fact, Palmetto Health/Prisma employees would be testifying and most of the evidence (including medical records and policies) involves or comes directly from Palmetto Health/Prisma.

Because several jurors, who identified themselves as having worked for Palmetto Health/Prisma were not struck for cause, Plaintiffs used three of the four peremptory challenges on jurors who truthfully identified themselves as having a past or present affiliation with Palmetto Health/Prisma. Juror Stephanie Cribb-Creek's (Juror # 68) untrue and deceitful responses in *voir dire* are the reason why she was not struck, either for cause or preemptively. Respectfully, relief is required because the concealed information of Ms. Cribb-Creek's past employment with Palmetto Health/Prisma would have supported a challenge for cause or would have been a material factor in the use of the parties' peremptory challenges.

Further and of significant prejudice, Juror Stephanie Cribb-Creek (Juror # 68) did **not** identify that she had been **personally named as defendant in a medical malpractice while she was employed at Palmetto Health.** On the request of the Plaintiffs, the Court asked the jury venire, "Have you or any member of your family been involved in a legal action, as a plaintiff or a defendant? If so, state the nature of the matter and whether you were a plaintiff or a defendant." Then the Court explained that this was a medical malpractice case and specifically inquired if any person had ever been involved in something similar. Other potential jurors knew that the Court and the parties were looking to determine this information, so much so that one potential juror stood up to disclose to the Court and the parties that while she had not been a party to a medical malpractice lawsuit, had, at one time, worked at a law firm in New York that handled medical malpractice cases. Nevertheless, Juror Stephanie Cribb-Creek (Juror # 68) remained silent and did not disclose that she, herself, had been sued in a medical malpractice case in Richland County.

The fact that Juror Stephanie Cribb-Creek (Juror # 68) failed to disclose this information is incredible. The caption of the lawsuit against her¹ is below and a copy of the lawsuit against her is attached as Exhibit 3 – Medical Malpractice Lawsuit Against Juror.

STATE OF SOUTH CAROLINA	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	CIVIL ACTION NO.: 02-CP-403259
Shannon Shady, individually and as Personal Representative of the Estate of Laci Breanna Shady; and Charlton Shady;	AMENDED COMPLAINT MEDICAL MALPRACTICE WRONGFUL DEATH SURVIVORSHIP ACTION JURY TRIAL REQUESTED
PLAINTIFFS,	
vs.	
Palmetto Health Alliance, d/b/a Palmetto Richland Memorial Hospital; and Pat Grigsby, R.N.,; and Stephanie Cribb, RCP,	
DEFENDANTS.	2002 SEP 25 AM 11:15 FILED BARTLETT, SC CLERK OF COURT

Shockingly similar to the allegations in the case at bar where she was seated as a juror, the allegations in this prior lawsuit involved complications from a surgical procedure and in which Stephanie Cribb-Creek (Juror # 68) was alleged to have failed to respond appropriately after “medical alarms” warned her of a significant and life-threatening condition, and that she failed to follow Palmetto Health’s policies and procedures. In the case before this Court, the allegations against Defendant Holbrook asserted that he failed to appropriately respond to “medical alarms” involving a surgery and that he failed to follow Palmetto Health/Prisma’s policies and procedures. The very themes of Plaintiffs’ case were shocking similarly to the allegations in the lawsuit previously filed against Stephanie Cribb-Creek (Juror # 68).

South Carolina precedent strongly supports declaring a mistrial and granting a new trial in this situation. In *State v. Woods*, 345 S.C. 583, 589, 550 S.E.2d 282, 285 (2001), the Supreme

¹ The case caption lists her as “Stephanie Cribb, RCP” but her name on the jury list is “Creek/Cribb, Stephanie S.”

Court granted a new trial because a juror “failed to respond to questions on *voir dire* which clearly applied to her, and because her concealment deprived respondent of information material to his intelligent use of peremptory challenges.” The *Woods* court reasoned that “[w]here the juror’s failure to disclose information is ‘without justification,’ *i.e.*, intentional, the juror’s bias will be inferred.” *Id.* at 589, 550 S.E.2d at 285 (citing case law holding that if a juror withholds “material information requested on *voir dire*, bias and prejudice are inferred from such concealment”). Proving that a juror’s failure to disclose information was “without justification” or “intentional,” the Supreme Court found that this standard was met because the question to the jury panel was “reasonably comprehensible and should have elicited a positive response from [the juror].” Juror bias is inferred, as a matter of law, based on the failure of a juror to respond truthfully in *voir dire*.

In the present case, at the very least, this Court’s description of the case and *voir dire* questions absolutely should have caused Juror Stephanie Cribb-Creek (Juror # 68) to reveal that she had an employment affiliation with Palmetto Health/Prisma. Further, this Court’s *voir dire* questions should have caused Juror Stephanie Cribb-Creek (Juror # 68) to reveal that she was a party to a lawsuit, in particular a party to a case involving medical malpractice where she was directly sued for negligence.

“The qualification of a juror is not to be determined alone by the fact that she declares her fairness and impartiality.” *Gray v. Bryant*, 298 S.C. 285, 288, 379 S.E.2d 894, 896 (1989). Instead, “the inquiry must focus on the character of the concealed information, not the mere fact that a concealment occurred.” *Id.* The character of the concealed information would have necessarily caused Juror Stephanie Cribb-Creek (Juror # 68) to be struck for cause by the Court, or a request that she be struck for cause from the Plaintiffs. Further, the fact that she had an employment affiliation with Palmetto Health/Prisma, alone, would have been a material factor in the Plaintiffs’ use of peremptory challenges. If the fact that she was named as a party in a medical

malpractice action would have been disclosed, this would even have caused the Plaintiffs to consider and make her the most critical juror to strike. (Exhibit 4 - Affidavit of Robert Goings).

II. Juror Misconduct – Juror Stephanie Cribb-Creek (Juror # 68) in Deliberations

Juror Stephanie Cribb-Creek (Juror # 68) tainted the deliberation process. A mistrial or a new trial is ordered based on juror misconduct in the deliberation process that result from external influences or misconduct that affects the fundamental fairness of the trial. In *Ethier v. Fairfield Mem'l Hosp.*, 429 S.C. 649, 655, 842 S.E.2d 355, 358 (2020), the South Carolina Supreme Court recently held that an affidavit of a juror is permissible for purpose for showing the juror misconduct affected the fundamental fairness of the trial in the deliberation phase of the trial. The Supreme Court reasoned, “While the burden to demonstrate prejudice is high, **when evidence strongly supports the fact that votes were changed as a result of a juror’s impermissible conduct, we cannot countenance such a tainted verdict.**” *Id.* (emphasis added).

Attached as Exhibit 5 – Affidavit of Gabrielle Ross, the foreperson of the jury. As her testimony reveals, Stephanie Cribb-Creek (Juror # 68) was very involved in the deliberation process. In fact, she was the first juror to start talking when the deliberation process began. She educated the jury about her own personal knowledge and history from having worked at Palmetto Health/Prisma and about her knowledge of some of the hospital’s policies and common procedures that were not presented during the trial. Further, she told fellow jurors that healthcare providers should not be personally responsible for not following the hospital’s policies. She talked about how she and other people she worked with at Palmetto Health/Prisma determined baseline blood pressure. She interjected her own medical knowledge and training as to determining baseline blood pressures and talked about her medical judgment and what she would have done. She interjected facts and evidence into the deliberations that were not part of the trial. Further, she offered to the

other jurors that, in order to find negligence, Defendant Holbrook would have to be *solely* negligent for what happened in the operating room and that there were policies which said that other people were also responsible for what happened in the operating room on the morning of Mrs. Goodwin's surgery. Stephanie Cribb-Creek (Juror # 68) told fellow jurors that Plaintiffs did not prove that Defendant Holbrook was the "Captain of the Ship" and multiple times said that unless one is the "Captain of the Ship" then he/she cannot be held negligent in a healthcare setting. As a result of her influence, especially because she presented as new evidence from her experience working in the same hospital system, the vote of the foreperson and other jury members reluctantly changed from a vote for the Plaintiffs to a vote for the Defendants.

Based on the Affidavit of Gabrielle Ross, Juror Stephanie Cribb-Creek's conduct of interjecting external evidence and imposing upon the jury her own medical judgment and decision making as a licensed pulmonologist and registered nurse, she became an "expert" for the jury that tainted a fair and impartial deliberative process. As a result of this tainted verdict, a mistrial or new trial should be granted.

CONCLUSION

For these reasons and any further arguments and support that follow in subsequent memorandum, this Court should grant a mistrial or a new trial in favor of the Plaintiffs so that they can present their case before a fair and impartial jury.

(Signature Page to Follow)

Respectfully submitted,

/s/ Robert F. Goings

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—and—

s/ Francis M. “Brink” Hinson IV

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Attorneys for the Plaintiffs

April 21, 2023

Columbia, South Carolina

[Print this page](#)**Board: Medical Board****South Carolina Board of Medical Examiners
Website Verification**

Palmetto Health Richland
3 RICHLAND MEDICAL PK
COLUMBIA, SC 29203-3389

Name: Stephanie Austin Cribb **Profession:** [RCP](#) **Office Phone:** 808-4347828
Basis: **School:** [MTC](#) **Graduation:** 05/24/1984
License No: 188 **Date Issued:** 07/24/1987 **Expiration:** 05/31/2023
Specialty: **Rx#:** **Rx Issue Date:**

Primary Source Verification of Graduation Certified

Hospital Affiliation (s): None

Credential Status: Active In Renewal

No disciplinary action taken by the Board. This certifies that the above licensee is in good standing.

Board Public Action History:[View Orders](#)[View Other License for this Person](#)

No Orders Found

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License History:

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STEPHANIE C CREEK
COLUMBIA, SC 29209

License number: 73159

License type: RN

Original Issue Date: 11/12/1997

Expiration: 04/30/2024

Status: Active

Privilege To Practice: Multi-State

Board Public Action History:[View Orders](#)[View Other License for this Person](#)

	License Number	Board	Has Board Orders
View	26573	NURSING	No

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STEPHANIE C CREEK
COLUMBIA, SC 29209

License number: 26573

License type: LPN.P

Original Issue Date: 09/23/1995

Expiration: 09/18/1996

Status: Inactive

Board Public Action History:[View Orders](#)[View Other License for this Person](#)

	License Number	Board	Has Board Orders
View	73159	NURSING	No

Individual listed above is in good standing with the SC Board of Nursing

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Stephanie Cribb

 Prisma Health

Columbia, South Carolina, United States · [Contact info](#)
2 connections

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Activity
2 followers

Stephanie hasn't posted yet
Recent posts Stephanie shares will be displayed here.

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 **Respiratory Care Practitioner**
Prisma Health

Interests

Companies

 **Prisma Health**
57,796 followers

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STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND

CIVIL ACTION NO.: 02-CP-40-3259

Shannon Shady, individually and as Personal
Representative of the Estate of Laci Breanna Shady;
and Charlton Shady;

PLAINTIFFS,

vs.

Palmetto Health Alliance, d/b/a Palmetto Richland
Memorial Hospital; and Pat Grigsby, R.N.,; and
Stephanie Cribb, RCP,

DEFENDANTS.

AMENDED
COMPLAINT

MEDICAL MALPRACTICE

WRONGFUL DEATH
SURVIVORSHIP ACTION

JURY TRIAL REQUESTED

BAIRD
C. SCOTT
G.S.

2002 SEP 25 AM 11:15

FILED

I. FOR A FIRST CAUSE OF ACTION: WRONGFUL DEATH

1. The Plaintiff, Shannon Shady, is the mother and duly appointed personal representative of the Estate of Laci Breanna Shady, having been duly appointed on or about the 17th day of October, 2000. The Plaintiff, Charlton Shady, is the father of the decedent, Laci Breanna Shady, who was a minor child at the time of her death on July 20, 2000.

2. The Plaintiffs are residents of the State of South Carolina and the Estate is being probated in Williamsburg County, South Carolina as Laci Breanna Shady died a resident and domiciliary of Williamsburg County, South Carolina.

3. The Plaintiffs bring this wrongful death action for the benefit of the statutory beneficiaries of Laci Breanna Shady, in accordance with the *South Carolina Code of Laws* (1976, as amended) Section 15-51-10, *et. seq.*

4. The Defendant, Palmetto Health Alliance [**Alliance**], upon information and belief, is a South Carolina corporation which owns and/or operates and does business as Palmetto Richland Memorial Hospital [**PRMH**] and which may qualify for treatment under Section **33-56-180**, 1976 S.C Code, as a charitable organization, which would limit damages against it, in accordance with the provisions of the laws of the State of South Carolina, although its employees whose conduct is adjudged to be reckless, willful, or grossly negligent are liable for damages without limitation.

5. **Defendants, Pat Grigsby, R.N., and Stephanie Cribb, RCP**, are agents and/or employees

STATE OF SOUTH CAROLINA

COUNTY OF RICHLAND

Shannon Shady, Individually and as
Personal Representative of the Estate
of Laci Breanna Shady; and Charlton
Shady

Plaintiffs,

v.

Palmetto Health Alliance d/b/a
Palmetto Richland Memorial Hospital;
and Pat Grigsby, R.N.; and Stephanie
Cribb, RCP,

Defendants.

IN THE COURT OF COMMON PLEAS
FOR THE FIFTH JUDICIAL CIRCUIT
Civil Action No.: 02-CP-40-3259

**AMENDED ANSWER OF DEFENDANTS,
PALMETTO HEALTH ALLIANCE D/B/A
PALMETTO RICHLAND MEMORIAL
HOSPITAL, PAT GRIGSBY, RN AND
STEPHANIE CRIBB, RCP**

FILED
202 OCT 24 AM 11:16
BARBARA A. SCOTT
C.C.C. & G.S.

Defendants Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital,
Pat Grigsby, R.N., and Stephanie Cribb, RCP, by and through their undersigned attorneys,
answer the Amended Complaint herein as follows:

FOR A FIRST DEFENSE

1. That each and every allegation of the Amended Complaint, which is not hereinafter specifically admitted, is expressly denied.
2. That these Defendants lack specific information upon which to form a belief concerning the allegations of Paragraph 1 as to the duly appointed Personal Representative of the Estate of Laci Breanna Shady (hereinafter "Decedent"), and therefore denies said allegations and demands strict proof thereof.
3. That these Defendants lack specific information upon which to form a belief concerning the allegations of Paragraph 2, and therefore denies said allegations and demands strict proof thereof.

CP EC

4. That the allegations of Paragraph 3 are admitted upon information and belief.

5. That only so much of Paragraph 4 is admitted as may be consistent with the qualification that on or about February 9, 1998, Richland Memorial Hospital and Baptist Health Care System of South Carolina entered into a joint operating agreement and transferred substantially all of their assets to the Palmetto Health Alliance. By way of further answer, Palmetto Health Alliance, at all times referenced in the Plaintiff's Amended Complaint and currently, was doing business as Palmetto Richland Memorial Hospital, a charitable organization as defined in §33-56-20 of the Solicitation of Charitable Funds Act, S. C. Code Ann. § 33-56-10 et seq. (Supp. 1999). It is specifically denied that Palmetto Richland Memorial Hospital is a subsidiary of Palmetto Health Alliance. This action is governed by the Solicitation of Charitable Funds Act and this Defendant pleads all immunities and defenses available under the Solicitation of Charitable Funds Act as potential defenses, including the statutory cap on damages set forth in S. C. Code Ann. § 33-56-180. Defendants further deny that any employee of Defendant, Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital, acted in a reckless, willful, or grossly negligent manner.

6. That only so much of Paragraph 5 is admitted in that Defendants Pat Grigsby, R.N., and Stephanie Cribb, RCP, are employees of Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital, and at all times relevant to this action, were acting in the course and scope of their professional employment with Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital, in rendering care to Decedent.

7. That only so much of Paragraph 6 is admitted as alleges or may infer that Defendant Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital acts by and through its employees, and is responsible for providing competent and skilled pediatric patient care.

8. That only so much of Paragraphs 7, 8, and 9 are admitted as may be consistent with Decedent's medical records, and these Defendants crave reference to those medical records as the best evidence of Decedent's medical condition at the times referenced therein.

9. That only so much of Paragraph 10 is admitted as alleges that these Defendants undertook the duty to render medical, nursing, and respiratory therapy care to Decedent in accordance with generally accepted standards of care applicable to hospitals, nurses, and respiratory therapists rendering care to patients for the same or similar condition under the same or similar circumstances.

10. That the allegations of Paragraph 11 and 12 are denied as to these Defendants.

11. That the allegations of Paragraph 13 are answered as if the answers to Paragraphs 1 through 10, set forth hereinabove, were incorporated herein verbatim.

12. That these Defendants lack specific information upon which to form a belief concerning the allegations of Paragraph 14, and therefore denies said allegations and demands strict proof thereof.

13. That the allegations of Paragraph 15 are denied.

FOR A SECOND DEFENSE

14. That any injury or damage as alleged in the Amended Complaint, including the death of the Plaintiffs' decedent, was due to and caused by Plaintiffs'



decedent's underlying medical condition and complications resulting therefrom, and as a result thereof, these Defendants are in no way liable to the Plaintiffs for the matters set forth in the Amended Complaint.

FOR A THIRD DEFENSE

15. That the injuries and damages alleged in the Amended Complaint, including the death of the Plaintiffs' decedent, did not result from any departure of generally accepted standards of care on the part of these Defendants, and as a result these Defendants are in no way liable to the Plaintiffs for the matters set forth in the Amended Complaint.

FOR A FOURTH DEFENSE

16. The Amended Complaint fails to state a cause of action upon which relief can be granted.

FOR A FIFTH DEFENSE

17. The Defendant, Palmetto Health Alliance d/b/a/ Palmetto Richland Memorial Hospital is a charitable organization, and this action is governed by the terms and conditions of the South Carolina Solicitation of Charitable Funds Act, which provides a limit on the amount of actual damages for which this Defendant may be liable, and this Defendant pleads this limitation as a cap on any actual damages recoverable by the Plaintiffs, and in addition pleads any and all other immunities provided by the Act.

FOR A SIXTH DEFENSE

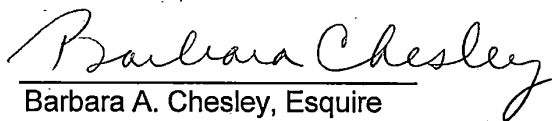
18. That any claim for punitive or exemplary damages as set forth in the Amended Complaint against these Defendants would violate these Defendants' constitutional rights under the due process clause in the Fifth and Fourteenth Amendments to the Constitution of the United States of America, Excessive Fines

BC

Clause in the Eighth Amendment to the Constitution of the United States of America, the Double Jeopardy Clause in the Fifth Amendment to the Constitution of the United States of America, and similar provisions in the Constitution of the State of South Carolina and/or the common law and public policies of the State of South Carolina, and/or applicable statutes and court rules, and these Defendants raise these defenses as a complete bar to the imposition of punitive or exemplary damage against it.

WHEREFORE, having answered the Amended Complaint herein, the Defendants, Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital, Pat Grigsby, R.N. and Stephanie Cribb, RCP, demand that the Amended Complaint be dismissed as to them, that the Plaintiffs be taxed with the costs of this action, and for such other and further relief as this Court deems just and proper.

This the 22nd day of October 2002, in Columbia, South Carolina.



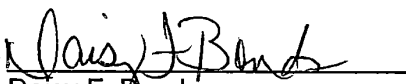
Barbara A. Chesley, Esquire
William C. McDow, Esquire
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(803) 771-4400

Attorneys for the Defendants
Palmetto Health Alliance d/b/a Palmetto
Richland Memorial Hospital, Pat Grigsby, R.N.
and Stephanie Cribb, RCP

CERTIFICATE OF SERVICE BY MAIL

I, the undersigned, an employee of RICHARDSON, PLOWDEN, CARPENTER & ROBINSON, P. A., attorneys for the Defendant, Palmetto Health Alliance d/b/a Palmetto Richland Memorial Hospital, Pat Grigsby, R.N. and Stephanie Cribb, RCP, do hereby certify that I have this date served the foregoing Amended Answer on the below-listed individuals by depositing a copy of same into the United States Mail, first-class postage prepaid, addressed to:

Diane M. Rodriguez
David W. Goldman
17 East Calhoun Street
Post Office Box 2038
Sumter, South Carolina 29151


Daisy F. Bonds
Legal Assistant to Barbara A. Chesley

Dated: 10/22/02

FILED
OCT 24 AM 11:16
BARBARA A. SCOTT
C.C.C. & G.S.

STATE OF SOUTH CAROLINA

IN THE COURT OF COMMON PLEAS

COUNTY OF RICHLAND

CIVIL ACTION NO.: 02-CP-05-_____

Shannon Shady, individually and as Personal
Representative of the Estate of Laci Breanna Shady;
and Charlton Shady;

PLAINTIFFS,

vs.

Palmetto Health Alliance, both individually and d/b/a
Palmetto Richland Memorial Hospital; and Palmetto
Richland Memorial Hospital; and Pat Grigsby, R.N.,
employee of Palmetto Health Alliance d/b/a Palmetto
Richland Memorial Hospital; and Stephanie Cribb,
R.T., employee of Palmetto Health Alliance d/b/a
Palmetto Richland Memorial Hospital;

DEFENDANTS.

**SECOND AMENDED
COMPLAINT**

MEDICAL MALPRACTICE

**WRONGFUL DEATH
SURVIVORSHIP ACTION**

JURY TRIAL REQUESTED

FILED
2023 JUL 18 AM 11:03
C.C.C. & G.S.

I. FOR A FIRST CAUSE OF ACTION: WRONGFUL DEATH

1. The Plaintiff, Shannon Shady, is the mother and duly appointed personal representative of the Estate of Laci Breanna Shady, having been duly appointed on or about the 17th day of October, 2000.

The Plaintiff, Charlton Shady, is the father of the decedent, Laci Breanna Shady, who was a minor child at the time of her death on July 20, 2000.

2. The Plaintiffs are residents of the State of South Carolina and the Estate is being probated in Williamsburg County, South Carolina as Laci Breanna Shady died a resident and domiciliary of Williamsburg County, South Carolina.

3. The Plaintiffs bring this wrongful death action for the benefit of the statutory beneficiaries of Laci Breanna Shady, in accordance with the *South Carolina Code of Laws* (1976, as amended) Section 15-51-10, *et. seq.*

4. The Defendant, Palmetto Health Alliance **[Alliance]**, upon information and belief, is a South Carolina corporation which owns and/or operates the Defendant, Palmetto Richland Memorial Hospital **[PRMH]** and which may qualify for treatment under Section **33-56-180**, 1976 S.C. Code, as a charitable organization, which would limit damages against it, in accordance with the provisions of the laws of the State of South Carolina, although its employees whose conduct is adjudged to be reckless, willful, or grossly negligent are

liable for damages without limitation.

5. The Defendant, **PRMH**, upon information and belief, is a subsidiary or member of the Defendant **Alliance** and is a hospital which also may qualify for treatment under Section **33-56-180**, 1976 S.C Code, as a charitable organization, which would limit damages against it, in accordance with the provisions of the laws of the State of South Carolina, although its employees whose conduct is adjudged to be reckless, willful, or grossly negligent are liable for damages without limitation.

6. Pat Grigsby, R.N., and Stephanie Cribb, R.T., are agents and/or employees of the Defendants who, at all times relevant to this action, were acting in the course and scope of their professional employment with the Defendant, **PRMH** and were responsible for providing nursing and respiratory care services to Laci Breanna Shady while she was in the PICU on July 12, 2000.

7. The Defendants, **Alliance and PRMH** own and/or operate a hospital and as such have a non-delegable duty to provide competent and skilled pediatric patient care in its institution, particularly in its Pediatric Intensive Care Unit (PICU), and to promulgate appropriate policies and procedures to provide for patients' health and safety.

8. On or about the 24th day of June, 2000, Laci Breanna Shady presented to the Defendant **Palmetto Richland Memorial Hospital** as a result of a single car motor vehicle accident in which she sustained a closed head injury. Laci Breanna Shady developed respiratory distress as a result of the injuries sustained in the motor vehicle accident. A tube was placed down her throat and into her windpipe (trachea) in order to provide her with oxygen and she was placed on a breathing machine (mechanical ventilator). Her neurological status began to slowly improve over the next several days.

9. On July 12th, 2000, Laci Breanna Shady underwent a surgical procedure to secure her airway, called a "laryngoscopy with tracheostomy", during which a surgical incision is made through the skin of the neck and into the trachea or windpipe. A small, firm, hollow, plastic tube called a "tracheostomy tube" is threaded into the surgical incision in the trachea (windpipe) so that oxygen can be delivered to the lungs. After this surgery, Laci was admitted to the PICU. During the afternoon of surgery, the connection between the breathing machine and the tracheostomy tube became disconnected on multiple occasions and it was reconnected by Defendant Pat Grigsby, R.N., or Defendant Stephanie Cribb, R.T., in the PICU either in response to an audible alarm, or in response to a request from the parents. Nothing was done to prevent the

breathing tube from disconnecting, although it was reconnected each time.

10. Plaintiffs Charlton and Shannon Shady left the PICU for a short time that evening and, upon their return, Laci's parents heard the alarm on the breathing machine (mechanical ventilator) sounding from Laci's room. The Plaintiffs rushed to Laci's bedside and found the breathing machine disconnected from the tracheostomy tube. Laci's chest was heaving as she struggled to breathe and her skin was a bluish color. No one had responded to her alarm. The Plaintiffs called out for assistance in reconnecting Laci to the breathing machine, however even after reconnecting it, the alarm continued. Defendant Pat Grigsby, R.N., or Defendant Stephanie Cribb, R.T., attempted to administer oxygen with an ambu bag, however, this made Laci's face and neck swell. During this time, Laci's heart rate began to drop and Laci went into cardiac arrest. Cardiopulmonary resuscitation (CPR) was initiated. An airway was eventually secured, however, Laci's condition deteriorated and she ultimately died on July 20th, 2000 as a result of the lack of oxygen to her brain.

11. The Defendants, **Pat Grigsby, R.N., Stephanie Cribb, R.T., Alliance and PRMH, acting through its employees/agent, including nurses, respiratory therapists and physicians,** were charged with the duty of providing a standard of care in the medical treatment of Laci Breanna Shady which would include one or more of the following particulars:

- (a) Provide competent and skilled health care providers to provide health care to pediatric patients in the PICU and to promulgate appropriate policies and procedures to provide for patients' health and safety; and/or
- (b) **Promulgate and** follow appropriate physician's orders; and/or
- (c) Institute appropriate and timely nursing **and medical** measures to observe for and minimize the risk of respiratory arrest; and/or
- (d) Institute nursing policies, protocols and procedures for appropriate monitoring of pediatric patients; and/or in having said policies, protocols and procedures, to adhere to the policies, protocols and procedures; and/or
- (e) Institute appropriate and timely care and interventions to provide appropriate monitoring of respiratory function in a pediatric patient at risk of respiratory distress and/or to immediately detect any symptoms consistent with respiratory distress; and/or
- (f) Institute appropriate and timely nursing, respiratory care **and medical** interventions to monitor, recognize and treat potentially life threatening conditions, including, but not limited to, securing ventilator connections **and maintaining an airway**; and/or
- (g) Notify a physician of signs or symptoms consistent with a potentially life threatening condition in a timely manner; and/or

- (h) Provide the appropriate level of nursing and respiratory care through qualified and experienced personnel; and/or
- (i) Provide adequate staffing of personnel to provide the appropriate level of patient care.

12. The Defendants breached the duty of care owed to the Plaintiffs, as set forth above in one or more of the particulars set forth, by negligent, grossly negligent, careless, reckless, and wanton conduct; and the Defendants Pat Grigsby, R.N., and Stephanie Cribb, R.T., breached their duty in a grossly negligent, careless, reckless, and wanton conduct.

13. The conduct of the Defendants, as set forth above, was a proximate cause of death of Laci Breanna Shady, and of damages to the statutory beneficiaries of the decedent, Laci Breanna Shady, who are her parents, Charlton and Shannon Shady, the Plaintiffs, which include medical bills and funeral expenses, mental shock and pain, wounded feelings, grief and sorrow, deprivation of love, affection, and society, and loss of companionship and guidance; thereby entitling the said beneficiaries to actual damages in the amount of One Million (\$1,000,000.00) Dollars and punitive damages in an amount to be determined by the a jury, except that if any of the Defendants **Alliance** and **PRMH** prove that they are entitled to charitable treatment under appropriate South Carolina Law, the total damages as to each Defendant may be limited to amounts as provided by law, although its employees whose conduct is adjudged to be reckless, willful, or grossly negligent are liable for damages without limitation, including punitive damages.

II. FOR A SECOND CAUSE OF ACTION: SURVIVORSHIP

14. The proceeding paragraphs are incorporated herein as if set out verbatim.

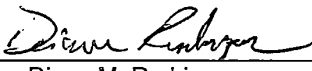
15. The Plaintiff, as the duly appointed representative of the Estate of Laci Breanna Shady, brings this survivorship action on behalf of the Estate of Laci Breanna Shannon, pursuant to Section **15-5-90** of the 1976 *South Carolina Code of Laws*.

16. As a direct and proximate result of the Defendants' conduct, as set forth above, the Plaintiffs' intestate, Laci Breanna Shady, suffered extreme pain and suffering prior to her death, entitling her Estate to damages and to reimbursement of funeral expenses, all in the amount of One Million (\$1,000,000) Dollars actual damages from each Defendant and punitive damages in an amount to be determined by the a jury, except that if either of the Defendants **Alliance** or **PRMH** prove that they are entitled to charitable treatment under appropriate South Carolina Law, the total damages as to each of these Defendants may be limited as provided by law, although its employees whose conduct is adjudged to be reckless, willful, or grossly negligent

are liable for damages without limitation, including punitive damages.

WHEREFORE, Plaintiff requests appropriate judgment against each of the Defendants for actual damages in the amount of One Million (\$1,000,000) on each cause of action and for punitive damages commensurate with the conduct of the Defendants, subject to any limitations imposed by South Carolina Law.

**BRYAN, BAHNMULLER,
GOLDMAN & McELVEEN, L.L.P.**

By:  (SAB permission granted)
Diane M. Rodriguez
David W. Goldman
Attorneys for the Plaintiffs
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P. O. Box 2038
Sumter, SC 29151
(803) 775-1263

Sumter, South Carolina
July 17, 2003

JURY TRIAL REQUESTED!

**BRYAN, BAHNMULLER
BRYAN, BAHNMULLER,
GOLDMAN & McELVEEN, L.L.P.**

By:  (SAB permission granted)
Diane M. Rodriguez
Attorney for Plaintiffs

ELECTRONICALLY FILED - 2023 Apr 21 4:09 PM - RICHLAND - COMMON PLEAS - CASE#2019CP4004185

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
vs.	)	AFFIDAVIT OF
	)	ROBERT F. GOINGS
Midlands Orthopaedics and Neurosurgery,	)	
and Thomas J. Holbrook, Jr., M.D.	)	
	)	
Defendants.	)	

Personally appeared before me, Robert F. Goings, who, being duly sworn, deposes and states the following:

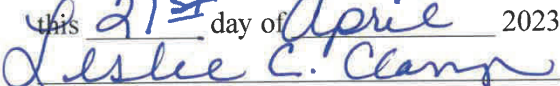
1. I am over eighteen years of age and competent to testify to the matter stated herein.
2. I am an attorney practicing law in Columbia, South Carolina. I have been licensed to practice law in the Palmetto State since 2006.
3. The majority of my legal practice has consisted of representing injured plaintiffs in civil litigation. As the lead attorney, I have tried numerous civil cases to verdict.
4. I was one of Crystal Goodwin and James Goodwin's attorneys in the above-captioned case.
5. To the best of my knowledge and recollection, during jury *voir dire* on April 7, 2023, Ms. Stephanie Cribb Creek (juror # 68) did not stand up or otherwise disclose that she had previously worked at Prisma Health (formally Palmetto Health) or that she had been a party to a civil lawsuit. Despite being ask questions that should have reasonably elicited such a response, Stephanie Cribb Creek (juror # 68) did not stand up or respond in any manner for me to believe she was a defendant in a medical malpractice action when she was an employee of Palmetto Health.
6. Since the conclusion of the case, it has come to my attention that Ms. Creek previously worked as a healthcare provider at Prisma Health and that, related to her work there, she was

previously a defendant in a medical malpractice lawsuit filed in Richland that involved claims and allegations that she failed to respond to medical alarms County (Civil Action No. 2002-CP-40-03259). Also, it appears that Stephanie Cribb Creek worked at Palmetto Health at or around the same times that Dr. Holbrook performed surgeries at Palmetto Health hospitals, including dates when Crystal Goodwin would have had her back surgeries.

7. Ms. Creek's prior employment as a nurse with the very same hospital system where the events of the Goodwin case took place (which was previously a party in this very action) is material information that would have been of the utmost importance to me during jury selection. Additionally, Ms. Creek having previously been a defendant in a medical malpractice lawsuit is material information that would have been of the utmost importance to me during jury selection.

8. Had this information (prior employment at Prisma Health and previously been a defendant in a medical malpractice suit) been provided by Ms. Creek during the *voir dire* process, I unquestionably would have moved to have her removed for cause from the jury pool. Had the trial judge denied such a motion, then I would have used one of the Plaintiffs' juror strikes to remove her from the jury pool. I used three (3) of the four (4) preemptive strikes on the three (3) jurors that had disclosed that an employment affiliation with Palmetto Health or Prisma. However, because Ms. Creek withheld and failed to disclose this information, I did not move to remove Ms. Creek for cause and did not use one of the Plaintiffs' juror strikes to remove her from the jury pool. FURTHER AFFIANT SAYETH NOT.


Robert F. Goings

Subscribed and sworn to before me
this 21st day of April 2023.

Notary Public for the State of South Carolina
My commission expires: 02-20-2030

STATE OF SOUTH CAROLINA)
)
COUNTY OF RICHLAND)

**AFFIDAVIT OF
GABRIELLE G. ROSS**

Personally appeared before me, Gabrielle G. Ross, who, being duly sworn, deposes and states the following:

1. I am over eighteen years of age and competent to testify to the matter stated herein.
2. I was a member of the jury in the trial of Crystal and James Goodwin verses Midlands Orthopaedics and Dr. Thomas J. Holbrook that took place from April 10-20, 2023. I was listed as juror number 269, and named to be foreperson of the jury.
3. When deliberations began, after a brief period of introductions, the very first juror to speak up and discuss her thoughts was Stephanie Cribb Creek (Juror # 68).
4. Ms. Creek began the discussion by telling the other jurors and me that she had been a nurse at Prisma Health for many years. It was unclear to me if she currently was a nurse as Prisma or had simply worked there in the past. Ms. Creek relayed to us many of her own, personal accounts from having worked within the same hospital system where the events of the case took place. She told us about her knowledge of the hospital's policies and common procedures there – much of what she mentioned relating to the hospital's policies and common procedures for doing things were not presented by either side during the trial. She talked about how she and other people she worked with at Prisma determine baseline blood pressure. She talked about her medical judgment and what she would have done. She mentioned that she would have a hard time being held responsible for following the hospital's written policies. Many of the things she told us about what should be negligence and the standard of care was not presented in court during the trial.
5. She explained to us that to find for the Plaintiffs, Dr. Holbrook would have to be solely negligent for what happened in the operating room and that there were policies which said that

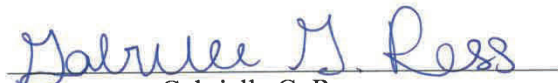
other people were also responsible for what happened in the operating room on the morning of Mrs. Goodwin's surgery. She said that Plaintiffs did not prove that Dr. Holbrook was the "Captain of the Ship." Ms. Creek said multiple times that unless you are the "Captain of the Ship" then you cannot be held negligent.

6. As a result of what Ms. Creek told me, what she presented as new evidence from her experience working in the same hospital system as where the surgery took place, my vote was reluctantly changed from a vote for the Plaintiffs to a vote for the Defendants. My vote was changed because she was able to convince others in the jury room to side in the defense.

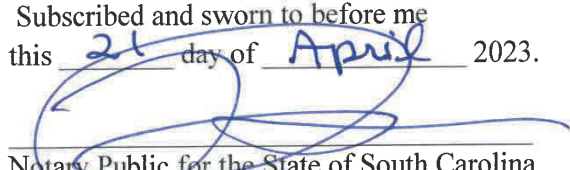
7. By what I observed in the deliberation room, other jurors were also influenced and changed their votes based on Ms. Creek telling us about her experience working at Prisma Health and by the information that she relayed to us about the hospital's policies and ways things are typically done there, all of which was not presented as evidence during the course of the trial. I remember thinking that Ms. Creek seemed to have an agenda.

8. If Ms. Creek's outside knowledge about Prisma Health's policies and ways things are typically done at the hospital were not supposed to be information for the jury to consider, then I do think that her involvement in deliberations impacted the fairness of our deliberations.

FURTHER AFFIANT SAYETH NOT.


Gabrielle G. Ross

Subscribed and sworn to before me
this 21 day of April 2023.


Notary Public for the State of South Carolina

My commission expires: June 22, 2030

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
COUNTY OF RICHLAND	)	FIFTH JUDICIAL CIRCUIT
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No.: 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
vs.	)	
	)	PLAINTIFFS' MOTION
Midlands Orthopaedics and Neurosurgery and	)	FOR NEW TRIAL BASED ON THE
Thomas J. Holbrook, Jr., M.D.,	)	THIRTEENTH JUROR DOCTRINE
	)	
Defendants.	)	

Plaintiffs hereby move for an order granting a new trial based on the Thirteenth Juror Doctrine on the grounds that the verdict was contrary to the greater weight of the evidence. *See, e.g. Adams v. Duffie*, 244 S.C. 365, 366, 137 S.E.2d 276, 276 (1964). In granting a motion for a new trial on these particular grounds, the Court is not required to recite specific facts to support its Order. *South Carolina Dept. of Highways and Public Transp. v. Mooneyham*, 275 S.C. 205, 206, 269 S.E.2d 329, 330 (1980). Therefore, Plaintiffs are not including a detailed recitation of the facts of the case, but instead defer to the Court's memory of the evidence presented at trial.

LEGAL AUTHORITY

"Under the 'thirteenth juror' doctrine, a trial judge may grant a new trial absolute when [s]he finds the evidence does not justify the verdict. This ruling has also been termed a granting of a new trial upon the facts." *Vinson v. Hartley*, 324 S.C. 389, 402, 477 S.E.2d 715, 722 (Ct. App. 1996). It is well settled in this state that "the trial judge has the authority and responsibility to grant a new trial when, in [her] judgment, the verdict of the jury is contrary to the fair preponderance of the evidence." *Adams v. Duffie*, 244 S.C. 365, 366, 137 S.E.2d 276, 276 (1964). A motion for new trial is properly granted where the trial judge is simply "not satisfied with the justice of the case and feel[s] that it should be tried before another jury." *Id.* Whether to grant the

motion “rests within the discretion of the trial judge” and “will not be disturbed [on appeal] unless [her] finding is wholly unsupported by the evidence, or the conclusion reached has been controlled by error of law.” *Mooneyham* 275 S.C. at 206, 269 S.E.2d at 330. For the trial judge’s finding to be supported by the evidence, it is only necessary that the moving party put forth evidence at trial that would support a verdict in the moving party’s favor, even if that evidence is in conflict with other evidence. *Id.* Such discretion is “founded upon the facts, the evidence, the witnesses, the trial circumstances, the verdict and the judge’s view of them.” *Vinson* 324 S.C. at 404, 477 S.E.2d at 723 (quoting *Fallon v. Rucks*, 217 S.C. 180, 189, 60 S.E.2d 88, 92 (1950)).

“The trial judge, sitting as the thirteenth juror charged with the duty of seeing that justice is done, has the authority to grant new trials when he is convinced that a new trial is necessitated on the basis of the facts in the case.” *Vinson*, 324 S.C. at 403, 477 S.E.2d at 722. “Traditionally, in South Carolina, circuit court judges have the authority to grant a new trial upon the judge’s finding that justice has not prevailed.” *Id.* (citing *Todd v. Owen Indus. Prods., Inc.*, 315 S.C. 34, 431 S.E.2d 596 (Ct. App. 1993)). Similarly, the judge may grant a new trial if the verdict is inconsistent and reflects the jury’s confusion. *Johnson v. Parker*, 279 S.C. 132, 303 S.E.2d 95 (1983) (reversing the denial of a motion for new trial where “the record [was] replete with evidence the jury was confused”); *see also Johnson v. Hoechst Celanese Corp.*, 317 S.C. 415, 453 S.E.2d 908 (Ct. App. 1995) (under “thirteenth juror doctrine,” trial court may grant new trial if judge believes verdict is unsupported by evidence and, similarly, new trial may be granted if verdict is inconsistent and reflects jury’s confusion). “The thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when [s]he finds that the evidence does not justify the verdict.” *Vinson*, 324 S.C. at 403, 477 S.E.2d at 722. “The effect is the same as if the jury failed to reach a verdict. The judge as the thirteenth juror ‘hangs’ the jury.” *Id.* For this reason, the trial

judge is not required to give specific factual reasons for granting the motion for new trial. *Id.* (citing *Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990)). Just as a juror would not be required to give justification for his or her findings, the trial court, sitting in its role as thirteenth juror, is required only to find that the evidence supported the side of the moving party to justify its grant of a new trial. *Id.*

In the current matter, Plaintiffs presented significant evidence in support of their case for medical negligence. Plaintiffs presented evidence that Defendants breached the standard of care by: (1) failing to establish or communicate Plaintiff Crystal Goodwin's baseline blood pressure before surgery; (2) failing to hold a preoperative timeout or otherwise communicate with the anesthesia team regarding Plaintiff Crystal Goodwin's chronic hypertension or the need to maintain her blood pressure higher than the average patient's, resulting in her blood pressure being kept well below the 20% standard for her pre-operative baseline; and (3) failing to follow the medical guidelines for what to do once the neuromonitoring signals to Plaintiff Crystal Goodwin's lower extremities were lost. Plaintiffs presented evidence that after Defendant Holbrook was repeatedly told by the neuromonitoring tech, Ms. Teresa Adkins, that the equipment was working properly and the signals remained out, Defendant Holbrook disregarded this information and chose not to follow any the steps to restore neuromonitoring signals, which would have included increasing Plaintiff's blood pressure and profusion. The standards of care were established through testimony from multiple medical experts and policies of Prisma Health (formerly Palmetto Health). The standard of care opinions were supported, in part, by Defendants' own witnesses, including Erich Starn, CRNA, and Defendants' expert witnesses, Dr. Steven Poletti and Dr. Francis Balestrieri. Indeed, the Court properly denied Defendants' Motions for directed verdict on the very grounds that Plaintiffs had presented at evidence establishing the standard of care, showing

Defendants' breach of the standard of care, and that Defendants' breach causing injury and damages to Plaintiffs.

CONCLUSION

The testimony and evidence presented at trial supported a finding that the standard of care was breached, and, if the standard of care had been followed by the Defendants, Plaintiff Crystal Goodwin would not have suffered such severe neurological deficit and paralysis. Based on the evidence presented, this Court can safely conclude that justice has not prevailed, and the parties should be entitled to try this case before another jury. Because Plaintiffs set forth evidence during the trial of this case that would support a verdict in their favor, and because the verdict was contrary to a fair preponderance of the evidence, Plaintiffs respectfully request that this Honorable Court grant Plaintiffs a new trial so that these matters may again be heard by a jury.

Respectfully submitted,

/s/ Robert F. Goings

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—and—

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Counsel for the Plaintiffs

April 26, 2023
 Columbia, South Carolina

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FIFTH JUDICIAL CIRCUIT
COUNTY OF RICHLAND	)	
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No. 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	<u>RESPONSE IN OPPOSITION TO</u>
Midlands Orthopaedics and	)	<u>PLAINTIFFS' MOTION FOR NEW</u>
Neurosurgery, and Thomas J. Holbrook,	)	<u>TRIAL BASED ON THE THIRTEENTH</u>
Jr., M.D.	)	<u>JUROR DOCTRINE</u>
	)	
Defendants.	)	
	)	

Defendants Midlands Orthopaedics and Neurosurgery and Thomas J. Holbrook, Jr. M.D, respectfully submit the following Memorandum in Opposition to Plaintiffs' Motion For a New Trial Based On The Thirteenth Juror Doctrine:

ARGUMENT

I. Plaintiffs' Motion For A New Trial Based on the Thirteenth Juror Doctrine Should Be Denied

After a 10-day medical negligence trial which resulted in a defense verdict, Plaintiffs move this Court for a new trial under the thirteenth juror doctrine. Plaintiffs do so with a generalized motion, which asks this Court to rule based solely on this Court's memory of the evidence. For the reasons that follow, Plaintiff's motion is not well-taken and should be denied.

In South Carolina, "[t]he thirteenth juror doctrine is a vehicle by which the trial court may grant a new trial absolute when [it] finds that the evidence does not justify the verdict. This ruling has also been termed granting a new trial upon the facts. *Folkens v. Hunt*, 300 S.C. 251, 387 S.E.2d 265 (1990). As a threshold matter, Plaintiff argues that their motion should be allowed because the verdict "was contrary to the greater weight of the evidence." (Plt. Mtn. p. 1) But that

is not the correct standard. The “greater weight” ruling request appears to ask the trial court to erroneously opine about the nature and quality of the evidence for the Plaintiff, as opposed to that of the Defendant. Thus, the motion is improper and should be denied for this reason alone.

Additionally, simply because trial courts retain the authority to apply the thirteenth juror doctrine, does not mean that they should do so. To that end, the South Carolina Supreme Court has instructed the trial bench that in order to invoke the thirteenth juror doctrine, the trial judge must be “**convinced** that a new trial **is necessitated** on the basis of the facts in the case.” *Graham v. Whitaker*, 282 S.C. 393, 401, 321 S.E.2d 40, 45 (1984) (emphasis added). That is because “[t]here is given to the trial judge a broad discretion **which has been used sparsely and rightly so.**” *Id.* (emphasis added); see also *Rock Smith Chevrolet, Inc. v. Smith*, 309 S.C. 91, 92, 419 S.E.2d 841 (1992). (“It is an authority well recognized **but seldom used in South Carolina courts.**”) (emphasis added); cf. *Worrell v. South Carolina Power Co.*, 186 S.C. 306, 313-314 195 S.E. 638, 641 (1938) (To invoke the thirteenth juror doctrine it must be presumed the trial court “recognizes and appreciates [its] responsibility, and exercises the discretion vested in him with fairness and impartiality). In addition, Defendants’ research has uncovered only **one** published case in which a trial court granted a plaintiff’s motion for new trial pursuant to the thirteenth juror doctrine following a defense verdict. *Trivelas v. S.C. Dep’t of Transp.*, 357 S.C. 545, 551-52, 593 S.E.2d 504, 508 (2004).

Application of these core principles should counsel this Court to leave the jury’s verdict intact. It is difficult to fathom a scenario where a trial court could be **convinced** that a new trial **is necessitated** based upon the facts here, given Plaintiff’s sparse motion. As a general rule, the jury has a time-honored role as the principal fact finder in South Carolina. Our Supreme Court has long directed that Courts “cannot pass upon the credibility of witnesses or the weight of the

testimony; these are matters for the jury[.]” *Dickson v. Girard Fire & Marine Ins. Co.*, 144 S.C. 183, 187 142 S.E. 348, 349 (1928); *see also Bass v. S.C. Dep’t of Soc. Servs.*, 414 S.C. 558, 570, 780 S.E.2d 252, 258 (2015) (“[N]either an appellate court nor the trial court has authority to decide credibility issues or to resolve conflicts in the testimony or the evidence.”); *cf. See Black v. Hodge*, 306 S.C. 196, 198, 410 S.E.2d 595, 596 (Ct. App. 1991) (“There remains the question of the inherent probability of the testimony and the credibility of the witness or the interests of the witness in the result of the litigation. If there is anything tending to create distrust in his or her truthfulness, the question must be left to the jury”)

Plaintiff’s brief restatements of their standard of care evidence do not warrant invading the province of the jury as the principal fact finder here. This is particularly so since Plaintiff’s motion does not factually address proximate causation in any meaningful fashion. But glossing over causation is problematic in light of plaintiff’s extraordinary request of this court. After all, “[a]s in any negligence action, the plaintiff in a medical malpractice action must establish proximate cause.” *Bramlette v. Charter Medical-Columbia*, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990) (emphasis added). Therefore, to grant Plaintiff’s motion here in the absence of an appropriate contrary causation showing would be grounded in legal error. *See South Carolina State Highway Dep’t v. Clarkson*, 267 S.C. 121, 126-27, 226 S.E.2d 696, 697 (1976) (order on thirteenth juror doctrine motion for a new trial would be reversed “if the conclusion reached was controlled by an error of law.”)

Here, “the jury was free to find that plaintiff’s witnesses were not credible and to not accept all or part of their testimony.” *First South Bank v. South Causeway, LLC*, 414 S.C. 434, 452-52, 778 S.E.2d 493, 502-03 (2015) That is because, even in a thirteenth juror doctrine posture, the trial courts often still defer to the jury, and properly so. *See Id.* (affirming trial court’s denial of

thirteenth juror doctrine motion for a new trial because “[r]esolving disputes over the conflicting versions of the facts and the correct inferences to draw from those facts falls squarely within the jury's role as finder of fact.”). In other words, just because a trial judge’s view of the evidence as to the contested issues may somewhat differ from the jury, declination to involve the powerful and rare remedy of the thirteenth juror doctrine is the natural and appropriate course. *See Richie v. Ingle*, Opinion No. 2004-UP-241, 2004 S.C. App. Unpub Lexis 365 (2004)(cited as an example of persuasive reasoning).

Here, the defendants’ evidence reasonably supports the jury's verdict. Defendants posited that Crystal Goodwin’s injury was not caused by low blood pressure and low blood perfusion, as was the claim by plaintiff experts, but was instead caused by a reperfusion injury. A reperfusion injury is unpredictable, unforeseeable, and unpreventable. Once it occurs, the injury is not treatable. Defendants’ evidence further illustrated that Dr. Holbrook appropriately responded to the neuro-monitor tech in the OR when it was announced that the SSEP signal suddenly went out. Dr. Holbrook then stopped his surgery, asked the tech to check to see if her equipment was working properly, asked anesthesia if there were any anesthesia issues (which would have included any issues of low blood pressure or low perfusion) and was informed that there were no issues. Dr. Holbrook then inspected the surgical wound site to see if there was any hematoma or anything he was doing that may have caused a loss of signal and when he did, he could not see anything that would have caused that sudden loss of signal. The above-cited evidence reasonably supports the jury's verdict and cannot be convincingly said to do otherwise.

This is not one of those rare cases where the thirteenth juror doctrine should be invoked. The defense verdict should consequently remain undisturbed and Plaintiff’s motion for a new trial should be denied.

CONCLUSION

For all the reasons set forth above and based on all arguments and grounds set forth to date, the Motion For a New Trial and For Mistrial should be denied.

Respectfully submitted,

s/Andrew K. Heitman
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Andrew K. Heitman, Esq. (SC Bar #102267)
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ahaitman@davissnyder.com

Attorneys for Defendants

May 5, 2023
Greenville, South Carolina.

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	FIFTH JUDICIAL CIRCUIT
COUNTY OF RICHLAND	)	
	)	
Crystal Goodwin and James Goodwin,	)	Civil Action No. 2019-CP-40-04185
	)	
Plaintiffs,	)	
	)	
v.	)	
	)	<u>RESPONSE IN OPPOSITION TO</u>
Midlands Orthopaedics and	)	<u>PLAINTIFFS' MOTION FOR NEW</u>
Neurosurgery, and Thomas J. Holbrook,	)	<u>TRIAL BASED ON THE THIRTEENTH</u>
Jr., M.D.	)	<u>JUROR DOCTRINE</u>
	)	
Defendants.	)	
	)	

Defendants Midlands Orthopaedics and Neurosurgery and Thomas J. Holbrook, Jr. M.D, respectfully submit the following Memorandum in Opposition to Plaintiffs' Motion For a New Trial Based On The Thirteenth Juror Doctrine:

ARGUMENT

I. Plaintiffs' Motion For A New Trial Based on the Thirteenth Juror Doctrine Should Be Denied

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is not the correct standard. The “greater weight” ruling request appears to ask the trial court to erroneously opine about the nature and quality of the evidence for the Plaintiff, as opposed to that of the Defendant. Thus, the motion is improper and should be denied for this reason alone.

Additionally, simply because trial courts retain the authority to apply the thirteenth juror doctrine, does not mean that they should do so. To that end, the South Carolina Supreme Court has instructed the trial bench that in order to invoke the thirteenth juror doctrine, the trial judge must be “**convinced** that a new trial **is necessitated** on the basis of the facts in the case.” *Graham v. Whitaker*, 282 S.C. 393, 401, 321 S.E.2d 40, 45 (1984) (emphasis added). That is because “[t]here is given to the trial judge a broad discretion **which has been used sparsely and rightly so.**” *Id.* (emphasis added); see also *Rock Smith Chevrolet, Inc. v. Smith*, 309 S.C. 91, 92, 419 S.E.2d 841 (1992). (“It is an authority well recognized **but seldom used in South Carolina courts.**”) (emphasis added); cf. *Worrell v. South Carolina Power Co.*, 186 S.C. 306, 313-314 195 S.E. 638, 641 (1938) (To invoke the thirteenth juror doctrine it must be presumed the trial court “recognizes and appreciates [its] responsibility, and exercises the discretion vested in him with fairness and impartiality). In addition, Defendants’ research has uncovered only **one** published case in which a trial court granted a plaintiff’s motion for new trial pursuant to the thirteenth juror doctrine following a defense verdict. *Trivelas v. S.C. Dep’t of Transp.*, 357 S.C. 545, 551-52, 593 S.E.2d 504, 508 (2004).

Application of these core principles should counsel this Court to leave the jury’s verdict intact. It is difficult to fathom a scenario where a trial court could be **convinced** that a new trial **is necessitated** based upon the facts here, given Plaintiff’s sparse motion. As a general rule, the jury has a time-honored role as the principal fact finder in South Carolina. Our Supreme Court has long directed that Courts “cannot pass upon the credibility of witnesses or the weight of the

testimony; these are matters for the jury[.]” *Dickson v. Girard Fire & Marine Ins. Co.*, 144 S.C. 183, 187 142 S.E. 348, 349 (1928); *see also Bass v. S.C. Dep’t of Soc. Servs.*, 414 S.C. 558, 570, 780 S.E.2d 252, 258 (2015) (“[N]either an appellate court nor the trial court has authority to decide credibility issues or to resolve conflicts in the testimony or the evidence.”); *cf. See Black v. Hodge*, 306 S.C. 196, 198, 410 S.E.2d 595, 596 (Ct. App. 1991) (“There remains the question of the inherent probability of the testimony and the credibility of the witness or the interests of the witness in the result of the litigation. If there is anything tending to create distrust in his or her truthfulness, the question must be left to the jury”)

Plaintiff’s brief restatements of their standard of care evidence do not warrant invading the province of the jury as the principal fact finder here. This is particularly so since Plaintiff’s motion does not factually address proximate causation in any meaningful fashion. But glossing over causation is problematic in light of plaintiff’s extraordinary request of this court. After all, “[a]s in any negligence action, the plaintiff in a medical malpractice action must establish proximate cause.” *Bramlette v. Charter Medical-Columbia*, 302 S.C. 68, 72, 393 S.E.2d 914, 916 (1990) (emphasis added). Therefore, to grant Plaintiff’s motion here in the absence of an appropriate contrary causation showing would be grounded in legal error. *See South Carolina State Highway Dep’t v. Clarkson*, 267 S.C. 121, 126-27, 226 S.E.2d 696, 697 (1976) (order on thirteenth juror doctrine motion for a new trial would be reversed “if the conclusion reached was controlled by an error of law.”)

Here, “the jury was free to find that plaintiff’s witnesses were not credible and to not accept all or part of their testimony.” *First South Bank v. South Causeway, LLC*, 414 S.C. 434, 452-52, 778 S.E.2d 493, 502-03 (2015) That is because, even in a thirteenth juror doctrine posture, the trial courts often still defer to the jury, and properly so. *See Id.* (affirming trial court’s denial of

thirteenth juror doctrine motion for a new trial because “[r]esolving disputes over the conflicting versions of the facts and the correct inferences to draw from those facts falls squarely within the jury's role as finder of fact.”). In other words, just because a trial judge's view of the evidence as to the contested issues may somewhat differ from the jury, declination to involve the powerful and rare remedy of the thirteenth juror doctrine is the natural and appropriate course. *See Richie v. Ingle*, Opinion No. 2004-UP-241, 2004 S.C. App. Unpub Lexis 365 (2004)(cited as an example of persuasive reasoning).

Here, the defendants' evidence reasonably supports the jury's verdict. Defendants posited that Crystal Goodwin's injury was not caused by low blood pressure and low blood perfusion, as was the claim by plaintiff experts, but was instead caused by a reperfusion injury. A reperfusion injury is unpredictable, unforeseeable, and unpreventable. Once it occurs, the injury is not treatable. Defendants' evidence further illustrated that Dr. Holbrook appropriately responded to the neuro-monitor tech in the OR when it was announced that the SSEP signal suddenly went out. Dr. Holbrook then stopped his surgery, asked the tech to check to see if her equipment was working properly, asked anesthesia if there were any anesthesia issues (which would have included any issues of low blood pressure or low perfusion) and was informed that there were no issues. Dr. Holbrook then inspected the surgical wound site to see if there was any hematoma or anything he was doing that may have caused a loss of signal and when he did, he could not see anything that would have caused that sudden loss of signal. The above-cited evidence reasonably supports the jury's verdict and cannot be convincingly said to do otherwise.

This is not one of those rare cases where the thirteenth juror doctrine should be invoked. The defense verdict should consequently remain undisturbed and Plaintiff's motion for a new trial should be denied.

CONCLUSION

For all the reasons set forth above and based on all arguments and grounds set forth to date, the Motion For a New Trial and For Mistrial should be denied.

Respectfully submitted,

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May 5, 2023
Greenville, South Carolina.

State of South Carolina	)	Court of Common Pleas
	)	Fifth Judicial Circuit
County of Richland	)	Case No. 2019-CP-40-04185
	)	
	)	
	)	
Crystal Goodwin and	)	
James Goodwin,	)	
	)	
Plaintiffs,	)	
	)	
-vs-	)	Transcript of Record
	)	DAY 1 OF 9 - VOLUME I
	)	April 10, 2023
Midlands Orthopedics and	)	
Neurosurgery and Dr. Thomas	)	
J. Holbrook, M.D.,	)	
	)	
Defendants.	)	
	)	

April 10-14 & 17-20, 2023

Columbia, South Carolina

B E F O R E:

The Honorable Jocelyn Newman, Judge; and a jury

Proceedings taken down by:
Elizabeth Harris
Official Circuit Court Reporter

Transcribed by:
Krystal J. Smith
Official Circuit Court Reporter III

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COURT REPORTER LEGEND

dashes	--	intentional or purposeful interruption or change in thought
ellipses	...	trailing off
[ph]		phonetically written
[sic]		written as said
[inaudible]		unable to hear or understand due to audio volume and/or interference/quality

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Richland County Judicial Center

RANDOM STRIKE SHEET

Judge Name: Newman, Jocelyn

Sorted By Random Nbr

Trial Type: Civil

Panel ID: JNewman 4/10/23

Description: JNewman 4/10/23

Trial

Courtroom: 2A

	NAME	JURORNBR	RACE	SEX	ST/PLTFF	DEF	CRT	REMARKS
1	Ross, Gabrielle G	269	B	F	()	()	()	
2	Withrow, Karen L	349	W	F	()	()	()	
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4	Marchant, Daniel C	202	W	M	()	()	()	~~PLTFF~~
5	Young, Danyelle V	358	B	F	()	()	()	~~PLTFF~~
6	Ford, Austin P	103	B	M	()	()	()	
7	McDonald, John W	208	W	M	()	()	()	~~PLTFF~~
8	Casto, Michael L	54	W	M	()	()	()	
9	Bagley, Andrew S	15	W	M	()	()	()	
10	Dilworth, Jason E Sr.	83	W	M	()	()	()	
11	Andreo, Robert M	9	W	M	()	()	()	
12	Shealy, Timothy R	288	W	M	()	()	()	
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1 APRIL 10, 2023

2 (WHEREUPON, the proceedings began.)

3 THE COURT: Okay. Good afternoon, everybody.

4 2019 -- I don't know if you got a caption, Elizabeth.

5 2019-CP-40-04185, Crystal Goodwin and James Goodwin versus

6 Midlands Orthopedics and Neurosurgery and Dr. Thomas J.

7 Holbrook, Jr., M.D.

8 All right. I've got a jury panel coming in in actually
9 about 15 minutes, but I did want to handle some motions *in*
10 *limine* before we get into jury selection. So let's start
11 with plaintiffs.

12 Ms. Gooding? Mr. Goings? How about it?

13 MS. GOODING: I think I'm going to be up first, Your
14 Honor.

15 THE COURT: All right. Tell me what you got.

16 MS. GOODING: So --

17 THE COURT: And identify yourself for the record,
18 please.

19 MS. GOODING: Jessica Gooding on behalf of the
20 plaintiffs, Crystal Goodwin and James Goodwin. May it please
21 the Court, Your Honor.

22 THE COURT: Yes, ma'am.

23 MS. GOODING: We filed two separate motions *in limine*.
24 Both of them have multiple parts.

25 The first one is labeled Plaintiffs' Omnibus Motion *in*

1 *Limine*, and we had submitted that to Mr. Davis and Mr.
2 Heitman and asked them which aspects of that they might agree
3 to. And I believe, Your Honor, we have narrowed it down, and
4 the only two that we need to discuss are Part 1 to that
5 motion and then Part 11.

6 THE COURT: Okay.

7 MS. GOODING: So the first motion is Part 1, and this is
8 our motion to -- such that if we call Dr. Holbrook during
9 plaintiffs' case in chief, that we should be allowed to ask
10 him leading questions and that Mr. Davis or Mr. Heitman
11 should not be allowed to ask him leading questions. That's
12 based on Rule 611(c), which specifically says that we can ask
13 leading questions.

14 And then we've cited to the *Hoffman* case, Your Honor,
15 for the proposition that the inverse is true. This was
16 actually a criminal case, but the Supreme Court specifically
17 held that the reason for the rule permitting leading
18 questions to an adverse witness on cross-examination is the
19 assumed hostility of the witness to the cross-examiner's
20 cause. And so where an adverse witness is shown to be
21 friendly or biased in favor of the cross-examiner, as, of
22 course, would be the case if his own counsel is questioning
23 him, that leading questions may not be used in examining such
24 a witness.

25 So on -- on those grounds and for exactly that reason,

1 we think it would be inappropriate for Dr. Holbrook's own
2 counsel to be able to lead him on cross-examination, should
3 we call him in our case in chief, and would move that they
4 not be allowed to do that.

5 THE COURT: Okay.

6 MR. DAVIS: I disagree. I think the rules of -- of
7 examination and cross-examination are blind to who calls who.
8 And if they call a witness, even if it's a hostile witness,
9 I'm fine with them leading, but it's cross-examination. I
10 should be able to lead the witness if I elect to do so.

11 THE COURT: Do you have case law to support that
12 position, sir?

13 MR. DAVIS: No. Just 40 years of experience in
14 practicing law.

15 THE COURT: Okay. The motion is granted.

16 There are -- there's reasoning behind each of the rules,
17 and -- and case law does support the proposition that cross-
18 examination is meant when a witness is hostile or presumed to
19 be hostile to the questioning attorney or party, as it were.

20 So that motion is granted. You'll not be permitted to
21 lead your own -- your own witness. But I mean, really, Dr.
22 Holbrook is more than a witness. He's an adverse party to
23 the case, but that motion *in limine* is granted.

24 MR. DAVIS: Your Honor, do I need to make exceptions to
25 protect my record when you make rulings?

1 THE COURT: I don't get into appellate work too much,
2 but --

3 MR. DAVIS: I don't either, but should the need arise, I
4 want to make sure.

5 THE COURT: Should the need arise, I -- yeah, you've got
6 to do what you've got to do to preserve the record, even if
7 that in some way is a continuing objection that's raised a
8 time or two. I don't want to lead you wrong as far as the
9 Court of Appeals goes.

10 MR. DAVIS: I understand.

11 THE COURT: You know.

12 MR. DAVIS: Thank you, Judge.

13 THE COURT: Yeah.

14 Next, Ms. Gooding.

15 MS. GOODING: Thank you, Your Honor.

16 Before we talk about Part 11 in this motion, let me -- I
17 do just want to put it on the record that my understanding is
18 that defense -- the defense has consented to the remaining
19 motions in this latest omnibus motion *in limine*.

20 And, Mr. Davis, do you agree with that?

21 MR. DAVIS: Absolutely. Most of the itemized things on
22 the -- on the omnibus motion *in limine*, I've never done and
23 have never thought about doing. So it's easy to consent to
24 something I never planned on doing, never have done.

25 THE COURT: Wonderful.

1 MS. GOODING: Thank you.

2 So, Judge, the next one we need to look at is on page 7
3 of that motion, and it's Part 11. This is our motion *in*
4 *limine* regarding apologies.

5 We would like an order of the Court to prohibit either
6 the defendant or his counsel or any -- anyone acting on his
7 behalf today or this week from being able to apologize or
8 express, you know, we're sorry that this happened to Ms.
9 Goodwin, and that's not something that's evidence in this
10 case. It's not relevant because it doesn't make any fact
11 more or less likely to be true, and that that's exactly the
12 kind of thing that is designed to appeal to the sympathies
13 and the passions of the jurors.

14 It does not have any probative weight but is only to
15 encourage them to make a decision based on something other
16 than -- other than the evidence. And, of course, you know,
17 it's very clear from our case law that it's inappropriate to
18 present any kind of arguments that are unfairly intended to
19 arouse the jury's compassion, prejudice, or biases.

20 And so, based on that, Your Honor, I mean, it doesn't
21 add anything to what the issues are in this case for somebody
22 to get up after seven years and say we're so sorry to hear
23 that this happened. The only purpose of that is for the jury
24 to make a decision based on something other than what the
25 evidence is in this case, and it shouldn't be allowed. It's

1 inappropriate.

2 THE COURT: Let me hear from the defense.

3 MR. DAVIS: Your Honor, they would reduce our case and
4 our defense to cold-hearted, unsympathetic, unexpressed
5 unfortune and misfortune for this lovely couple. That would
6 be improper. That would be an improper implication,
7 according to what they're asking us to do. I think that is a
8 -- that's way out of line.

9 I think appropriate comments, both by witnesses and
10 counsel in opening and closing, are very appropriate and
11 should be permitted. If there is sympathy, which is an
12 element of law that the Court is going to judge -- charge the
13 jury at the end of the case that sympathy should not be a
14 factor.

15 That doesn't mean we can't argue that you can't have
16 sympathy if we all do. I think that would be just -- just
17 shackling the defense and turning us into the cold-hearted,
18 we-don't-care defendant. That's exactly the picture they
19 want to paint by limiting us in those reasonable comments. I
20 object.

21 THE COURT: Ms. Gooding?

22 MS. GOODING: Your Honor, we cited to the *Maytag*
23 *Corporation v. Clarkson* case in our -- in our brief, and I've
24 got a copy if you would be interested in seeing it. This is
25 actually a District of South Carolina court case. It does

1 cite to South Carolina law on this issue regarding, you know,
2 inciting compassion, caprice, prejudice, and that sort of
3 thing. And it specifically says that arguments must be
4 confined to -- confined to the evidence and must not appeal
5 to passion, prejudice, or sympathy in an unfair way, and that
6 is precisely the point of making some kind of apology on the
7 stand.

8 I mean, they certainly do not have to come out and say
9 we're glad that this happened or anything that would make
10 them seem like horrible people, but to get up there and say,
11 gosh, we're just so sorry, it's an intentional appeal to the
12 jurors' sympathy to try to make the jurors sympathetic
13 towards the defendant, and it's -- under the case law, it's
14 -- it's not allowed. We are not allowed to make arguments
15 that intend to incite the jury to make a decision based on
16 sympathy and not on the facts of the case.

17 THE COURT: Is there a claim for punitive damages in
18 this case?

19 MS. GOODING: Yes, Your Honor.

20 THE COURT: Motion denied.

21 MR. DAVIS: Thank you, Your Honor.

22 THE COURT: Anything further from the plaintiffs? There
23 was a supplemental motion *in limine*?

24 MS. GOODING: Yes, Your Honor.

25 So the next motion is related to evidence of other

1 surgeries. And, Your Honor, I probably should have started
2 today by giving you a little bit more of a background on the
3 case.

4 This is a medical malpractice case. The allegations
5 against Dr. Holbrook include that the blood pressures for Ms.
6 Goodwin were maintained at an improper level during a back
7 surgery that Dr. Holbrook undertook on Ms. Goodwin in 2016,
8 and that that caused an injury in her spinal cord, which left
9 her paralyzed from the waist down.

10 And in fact, Dr. Holbrook had done two surgeries on Ms.
11 Goodwin prior to this 2016 surgery. So, of course, we have
12 all of the records that go along with two prior back
13 surgeries, one in 2009 and one in 2011.

14 And so the issues in this case range from some
15 anesthesia issues to some kind of protocol issues for what's
16 used during the operation, what's done before the operation,
17 what's done during the operation. And we have -- it is our
18 understanding that the defense intends to make some
19 comparisons between the surgery done in 2016 and the
20 surgeries done in 2009 and 2011 and, specifically, to compare
21 the mean arterial pressure that Ms. Goodwin had during those
22 surgeries.

23 Mean arterial pressure is kind of an average of the
24 pressure on your blood vessels at any given second, and it is
25 something that's calculated from blood pressure -- blood

1 pressures that are recorded during a surgery. And that's
2 going to be very key to -- to the case today. That's going
3 to be kind of the science that we're talking about.

4 And so it is our understanding that defendants wish to
5 compare the blood pressures or the mean arterial pressures
6 that Ms. Goodwin had during her 2016 surgery to those blood
7 pressures or mean arterial pressures that she had in both the
8 2009 and 2011 surgeries. And they're going to try to use
9 that as -- as part of their defense to say that, you know,
10 they're not liable because these things are -- are comparable
11 to what she had done before.

12 And our objection to that is that it brings, you know,
13 into issue a whole series of things that would not otherwise
14 be at issue. Our only allegation is that the standard of
15 care was breached in 2016. There are a few different ways we
16 say the standard of care is breached, but it all relates to
17 the July 28th, 2016, surgery.

18 And to bring in the prior surgeries and what her blood
19 pressures were during those prior surgeries would also
20 require us to bring in other information about what her blood
21 pressures were before those surgeries, what her medical
22 histories were before her -- those surgeries, what her
23 general health was before those surgeries, what else may have
24 been done during those surgeries, what the applicable
25 standard of -- standard of care was during those surgeries,

1 and it would require us to kind of try a case within a case,
2 because ultimately what we would be doing is the defense
3 would be saying we didn't breach the standard of care here
4 because we did it the same way in 2009 and 2011, and that
5 wasn't a breach of the standard of care.

6 And so then the plaintiffs would be put in a position of
7 either saying, well, 2009 and 2011 were also a breach of the
8 standard of care or the standard of care was different for
9 some reason in 2009 and 2011, and all of the information that
10 develop those facts would then have to end up coming into
11 evidence in order to give context to this presentation of the
12 blood pressures and the mean arterial pressures from the 2009
13 and 2011 surgeries. It would be a waste of time. It would
14 confuse the issues.

15 I think under Rule 403, this is very clearly the type of
16 evidence that should be kept out. Relevant evidence is that
17 that is of consequence to the determination of the action,
18 and this action is about whether the standard of care was
19 breached in 2016.

20 It's not about whether the standard of care was breached
21 in 2009 or in 2011, and it would be extremely confusing to
22 the jury, I think, to have all of this information put in
23 about 2009 and 2011 and how they compare and what's different
24 and what's the same, and then to be told, but then you're
25 only to decide on, you know, what -- whether things went

1 right or whether the standard of care was complied with on
2 the -- on the 2016 surgery.

3 And so, you know, we cited to the *Hamilton* case in our
4 brief, Your Honor, and I think that that's very helpful.
5 That's a case where they -- the defense sought to offer an
6 evaluation from a doctor that was done at a different time
7 and for a different purpose than what was at issue in the
8 case, but kind of could have some bearing on the case. And
9 the Court said, no, that has to be excluded because it
10 confuses the issues. That evaluation does not relate to what
11 is at issue in this case, and that's exactly the situation
12 that we have here.

13 What's at issue in this case is what was done in 2016,
14 what the standard of care was in 2016, and only 2016 evidence
15 with regard to what her blood pressures were needs to be
16 brought in in order to -- to make that determination. We
17 don't need to look at what her blood pressures were during
18 different surgeries done on a patient with a different
19 medical history and a different state of general health and a
20 different situation. It's very confusing to allow all of
21 that to come in.

22 THE COURT: Gentlemen?

23 MR. DAVIS: Thank you, Your Honor.

24 First of all, the 2009 surgery done by Dr. Holbrook on
25 the plaintiff was a decompressive laminectomy in the thoracic

1 spine. The surgery in 2011 was a decompressive surgery of
2 the thoracic spine. The surgery in 2016 was a decompressive
3 surgery in the thoracic spine.

4 The plaintiff's entire case is that somehow the blood
5 pressure in 2016 was allowed to go too low, which led to the
6 injury that she suffers from today. That's -- that's her
7 whole case.

8 We think it's fair -- and not only in light of our
9 having pled the preexisting condition as an affirmative
10 defense -- that we should be able to talk about comparing
11 blood pressures for the same surgery by the same surgeon on
12 three different occasions that were almost identical.

13 And they're saying, oh, the 2016 is when she suffered
14 this injury because the blood pressure got too low, and the
15 other two surgeries by the same surgeon on the same patient,
16 same surgery, the blood pressure was even lower, and no
17 injury happened. We think we have the right to show that
18 comparison, and that's reasonable.

19 So I object to her motion. We -- we aren't arguing
20 standard of care in 2009 or 2011. It's just strictly blood
21 pressure. That's it. That's all we're talking about, just
22 like we're talking about in 2016.

23 THE COURT: That motion is also denied, Ms. Gooding.

24 Now, I don't want to get into a trial within a trial, as
25 Ms. Gooding suggested it might go. I understand by way of

1 explanation comparison, but not -- we don't want to go too
2 far down that rabbit hole.

3 MR. DAVIS: Okay.

4 MS. GOODING: Thank you.

5 MR. DAVIS: I understand, Your Honor. We just have the
6 anesthesia records from whence we got the blood pressures,
7 just like they do in 2016. We're just comparing apples with
8 apples.

9 THE COURT: Yes, sir.

10 MR. DAVIS: Thank you.

11 MS. GOODING: Your Honor, if I may add one other thing
12 to that? There is no affirmative defense for a preexisting
13 condition in this case. There weren't any affirmative
14 defenses pled at all.

15 And our concern is that Ms. Goodwin was not the same
16 patient that she was in 2009 that she was in 2016, because
17 her history was different and her -- specifically, her
18 history with chronic hypertension was very different. She
19 had had hypertension for a much shorter time in 2009 than she
20 had in 2016.

21 And I want to be clear on this. I don't have the
22 impression that the defense is going to try to introduce
23 evidence in addition to what her blood pressures were in 2009
24 and 2011, only that our only way to combat that is to give
25 the jury the rest of the context with regard to those

1 surgeries, which would require us to present our evidence as
2 to why we believe she was a different patient, why we believe
3 that's changed what the standard of care was, or where that
4 standard of care fell in those years, and that that's going
5 to cause a lot more information to come into evidence in
6 order for us to be able to have an appropriate conversation
7 about that comparison than just the blood pressures. It's
8 going to be a lot more involved than that.

9 THE COURT: I understand your argument.

10 MS. GOODING: Okay. And, your Honor, our next motion is
11 with regard to not disparaging a witness or making any
12 comment that would imply any wrongful conduct because of a
13 video that was recorded.

14 MR. DAVIS: But we don't have a problem with that.

15 MS. GOODING: All right.

16 MR. DAVIS: I never -- that's never crossed my mind.
17 I'm sorry. I should have responded previously.

18 MS. GOODING: Not a problem.

19 MR. DAVIS: I appreciate that.

20 MS. GOODING: So by consent, Your Honor, there will be
21 no disparaging comments made or implications that Ms.
22 Goodwin, the daughter of Ms. Crystal and James Goodwin, did
23 anything wrong by -- by recording a video.

24 Our next motion *in limine* is with regard to defendant
25 being unable to make any reference to prior sanctions taken

1 against Dr. Lustgarten.

2 MR. DAVIS: Yeah. I was highly enlightened about their
3 expert, Dr. Lustgarten, and all this baggage that he's got.
4 I had no idea about any of it. Thank you. We have no -- no
5 intention of ever going into that.

6 MS. GOODING: Excellent.

7 MR. DAVIS: Although I was tempted to think about it,
8 we're not going there.

9 MS. GOODING: Not a risk we wanted to run, but thank
10 you, Mr. Davis.

11 MR. DAVIS: No problem.

12 MS. GOODING: And, Judge, we're moving through these
13 very quickly, Your Honor.

14 Okay. Our next motion is with regard to Dr. John
15 Sampson's testimony. This is an expert neurosurgeon named by
16 the defendant.

17 So the defendant, Mr. Holbrook -- I'm sorry. Dr.
18 Holbrook is a neurosurgeon, and then the -- the expert he
19 named is Dr. Sampson, expert neurosurgeon. And Dr. Sampson
20 was originally named as a person who is going to give a
21 standard of care opinion, but Dr. Sampson at that time was
22 being named by Dr. Root, who was the anesthesiologist who was
23 originally named in this case.

24 And so the anesthesiologist names Dr. Sampson to give a
25 standard of care opinion, and when we got to deposition and

1 started asking some questions about what his standard of care
2 opinions were with regard to anesthesiology, he indicated
3 that he was not going to testify as to standard of care, and
4 we've cited to this in our memorandum.

5 We actually included some block quotes from the -- from
6 the deposition. I think that that's very helpful. And Dr.
7 Sampson was very clear that he was not going to testify as to
8 what the standard of care is for an anesthesiologist.

9 And then we asked him -- and this is on page 10 of our
10 memo -- are you going to testify, then, as to what the
11 standard of care is for a neurosurgeon, and he said I don't
12 believe I've been hired to testify on behalf of Dr. Holbrook
13 either.

14 And then we continued to kind of ask him what his
15 opinions were on, and he said, well, I guess my understanding
16 would be that I have opinions around the causation of the
17 ultimate outcome for Ms. Goodwin, and to the -- the degree to
18 which that relates to anesthesia care, I might have an
19 opinion, but strictly with regard to standard of care, I
20 would not.

21 And we also asked him in his deposition what the term
22 standard of care meant, and he said, again at the bottom of
23 page 10, I don't know what a thoughtful, prudent person would
24 have done.

25 And we asked him do you agree that a physician can fall

1 below the standard of care in his or her treatment of a
2 patient, even if there was not an intent to harm the patient,
3 and again, he says I don't know. That's an interesting
4 question. I guess if they were poorly educated or reckless,
5 I guess they could.

6 And again, further down, asking about the standard of
7 care, he said that's not really my area of expertise. I feel
8 like that's a legal question, indicating that he's not able
9 to give an opinion on that.

10 And then, finally, when we asked what does and does not
11 comprise that standard of care is not within your area of
12 expertise, and he says I've never heard of the standard of
13 care terminology except in the context of legal cases. I'm
14 assuming it's perhaps different from state to state. I
15 really don't know. Again, I'm not an attorney.

16 And so at the deposition, we asked him questions almost
17 exclusively with regard to causation. You know, what do --
18 what is it that you think caused this injury to Ms. Goodwin,
19 and those are the opinions that he gave.

20 And, you know, as I've just explained, any time we tried
21 to ask him about the standard of care, he indicated, you
22 know, that's really a legal question. I'm not really, you
23 know, comfortable answering that.

24 After the deposition was over, so several months later,
25 Mr. Davis supplemented his discovery responses on behalf of

1 Dr. Holbrook now, and he gives -- in his identification of
2 Dr. Sampson, he gives what is basically the same way that Dr.
3 Root had identified him and then adds at the end, however, it
4 is expected that Dr. Sampson will testify consistent with his
5 opinion given in his sworn testimony in this case under oath
6 on May 17th, 2022, which, of course, is when we took his
7 deposition.

8 And so this identification of him as an expert on behalf
9 of Dr. Holbrook really says he's going to stick to what's in
10 the deposition, essentially, so that you don't have to take
11 his deposition again. I mean, that's -- that's what we
12 gleaned from this. If he's going to stick to what he said in
13 his deposition, in his deposition he said he wasn't going to
14 give standard of care opinions, even when he was specifically
15 asked about Dr. Holbrook, and that he was there to speak on
16 causation.

17 So we just want to be sure that during this trial that
18 he is consistent with that deposition testimony, that he
19 gives his opinion on causation, you know, consistent with
20 what was in his deposition, and that he does not give
21 standard of care opinions, that he does not use the phrase
22 standard of care, that counsel does not use the phrase
23 standard of care in questioning him, because he clearly was
24 not able to give any standard of care opinion at the time of
25 his deposition and should be limited to keeping with those

1 opinions in his deposition, since that's how he was
2 identified by Dr. Holbrook in this case.

3 After the deposition had been taken, they said that he
4 would give opinions consistent with that deposition
5 testimony. So we just want an order of the Court indicating
6 that -- that those do have to be consistent.

7 THE COURT: All right.

8 MR. DAVIS: Thank you, Your Honor.

9 THE COURT: Yes, sir?

10 MR. DAVIS: Just a brief procedural history. When Dr.
11 Sampson was deposed in May of 2022 by Mr. Hinson up at Duke,
12 he was -- he had been retained by the attorney who was
13 representing the anesthesiologist in this lawsuit. He
14 testified. He answered all of Mr. Hinson's questions.

15 And when the anesthesiologist -- as soon as the
16 anesthesiologist settled, as soon as I find out -- found out
17 about it, I called Dr. Sampson's office, asking to speak to
18 him and asked him if he would be willing to testify on behalf
19 of Dr. Holbrook in this case concerning the standard of care.
20 He said he was.

21 I immediately amended my response to interrogatories,
22 disclosed him now as our retained expert, and told them he
23 clearly says that he will be testifying that Dr. Holbrook did
24 not violate the standard of care, and that was some time ago,
25 back in 2022. I've never gotten a request from plaintiff's

1 counsel, hey, we want to know exactly what he's going to say
2 different. We want to re-depose him on those things. I
3 would have been happy to make that happen.

4 We disclosed the experts. If they want to take him
5 again, you know, they certainly had a right to do that. I
6 would not have objected and would have accommodated their
7 request. That request was never made.

8 The attorney took his deposition and questioned -- being
9 questioned by plaintiff's counsel, I want to just refer to a
10 few of the questions they asked and some of his answers.

11 Page 124, line 13. So I think Dr. Holbrook did all the
12 things that we normally would do, and I don't remember if it
13 was in his deposition or somebody else's. The reality is
14 that anything else you take time to do, including those --
15 these -- including things that I've actually thought was
16 ludicrous, like the wake-up test, none of that is going to
17 tell you anything.

18 Page 125. So I think what Dr. Holbrook did was he said,
19 well, okay, it's not the monitoring. So I'm concerned. So
20 let's close the patient up, wake them up. He was very
21 attentive. He was by the bedside almost immediately in the
22 PACU and tried to figure out what's going on. He got a
23 prompt MRI. He took her back to surgery, even though it
24 wasn't clear that what was going -- that that was going to be
25 helpful. Right?

1 Page 126. Question: You said earlier, just a few
2 minutes ago, Dr. Holbrook did all the things he could do.
3 What things did he do? Well, Dr. Sampson answers: He
4 checked the field. He, you know, examined if there was any
5 compression there. He checked the monitoring, you know,
6 things. Those are the things that are in his control, and at
7 that point, and then, frankly, I think, you know, I think he
8 did the right thing by, you know, closing the surgery up,
9 being attentive to the patient post-op.

10 Next question: Should he have contacted the
11 anesthesiologist to alert her of the loss of their
12 monitoring? Answer: No, I don't think that's his
13 responsibility at all. Page 126 and 127.

14 A few more and, again, responding to plaintiff's
15 questions. Page 129. Question: So this -- this figure here
16 has step one, check equipment. We agreed that Dr. Holbrook
17 did that; correct? Answer: Well, again, he was informed
18 that the neuromonitoring people were doing that. He wasn't
19 doing that. It would be inappropriate for him to do that.

20 Next question: Well, he directed that step one occur,
21 that the -- that the equipment was checked; correct? Yeah.
22 Collaboratively that happened, yes.

23 Question: Did he ever alert the attending
24 anesthesiologist for any anesthetic changes? Answer: I
25 don't think that the surgeon would even know if there was an

1 anesthetic change, so I'm not sure how he would be involved
2 in alerting the anesthesiologist. The anesthesiologist
3 should know anesthetic changes.

4 Question -- next question: Did he ever intake --
5 undertake to improve perfusion? Answer: Well, again, that
6 wouldn't be under Dr. Holbrook's purview, but in fact,
7 infusion -- or perfusion -- excuse me -- was actually
8 improved.

9 Question on page 131: Did he reverse the manipulation
10 or widen the decompression? Answer: Well, he certainly
11 looked in the field to determine if the decompression was
12 adequate and, in fact, on the post-operative MRI, they do
13 comment that there were -- there was a good decompression.
14 He wasn't really manipulating the spine in a case like this.
15 So reversing something that he didn't do wouldn't have made
16 any sense.

17 Next question: And he didn't perform a wake-up test;
18 correct? Well, he wouldn't have, because the wake-up test
19 really is something that is really pertinent to manipulation,
20 not decompression. The wake-up test is something that's
21 pretty archaic. To do a wake-up in a standard spine surgery
22 like this would really be akin to malpractice, actually.

23 Question -- it went on to page 133. Dr. Holbrook made
24 the right decision by closing the patient up and getting them
25 to the recovery room where they would have been fine.

1 Page 134. He continues, that's just not something
2 anybody in their right mind would do in this particular case.

3 Judge, those are answers from Dr. Sampson's deposition
4 taken by Mr. Hinson in response to his questions about the
5 standard of care. We submit that it would be inappropriate
6 for the Court to now say, oh, he can't testify to standard of
7 care.

8 THE COURT: Ms. Gooding?

9 MS. GOODING: Thank you, Your Honor.

10 We didn't take or ask to take Dr. Sampson's deposition
11 again because of the disclosure that says his -- he will
12 testify consistent with what he said at his sworn deposition,
13 which is where he repeatedly told us that he was not
14 intending to give standard of care opinions.

15 And the -- the identification that came before that
16 statement was just a mirror image of exactly what the
17 identification that came from Dr. Root's counsel. So we had
18 no reason to be concerned that he was going to now try to
19 give standard of care opinions after he repeatedly told us
20 that he wasn't going to give standard of care opinions, given
21 the way he was identified in this case.

22 And I think that something that's very important to note
23 with regard to some of those answers that Mr. Davis just read
24 to us is that Dr. Sampson continued to say what he would have
25 done. So on page 124, I think Dr. Holbrook did all the

1 things that we normally would do.

2 And there's a difference between saying I am here as an
3 expert. Based on my knowledge, understanding, and experience
4 in my field, I can tell you that the standard of care is X
5 and that that was complied with here versus saying, well,
6 that's what I would have done.

7 I mean, we've all had those situations where, you know,
8 somebody comes and asks us -- a law clerk comes to ask us a
9 question and say what's the rule on this, and sometimes the
10 answer is I know the rule, this is the rule, and this is how
11 you comply with it. And sometimes the answer is, I don't
12 know. What I would do is whatever.

13 And so there's a big difference between those two
14 things. And under the law, in order for him to give an
15 expert standard of care opinion, he has to be able to say
16 based on my training, experience, and knowledge, I can say
17 that this is the standard of care, and it was breached or it
18 was not breached.

19 He was clearly unable to do that in his deposition. He
20 was unclear on what the standard of care even meant. He told
21 us multiple times that he was not going to do -- give us
22 standard of care opinions, and that he should not be allowed
23 to now come in here and say, well, the standard of care is X,
24 Y, Z, and Dr. Holbrook complied with it when that is not what
25 he did in his deposition.

1 Did we ask him some questions that relate to some
2 standard of care issues? Yes, absolutely, we did. Did he
3 give an opinion this is the standard of care? He did not.

4 There were four defense lawyers in that room when this
5 deposition was taken. Not one of them asked him a single
6 question. Nobody cleaned this up. Nobody clarified anything
7 that he said was intended to be a standard of care opinion.
8 Nobody made it clear to us that what he was really intending
9 to do was to tell us what the standard of care was for Dr.
10 Holbrook. That's not what was done in the deposition, and it
11 would be inappropriate for him to be able to do it now at
12 trial.

13 THE COURT: All right. I'm going to disagree with you,
14 Ms. Gooding, because at the time that the deposition was
15 taken, he was retained on behalf -- or retained by an
16 anesthesiologist.

17 And when asked about whether he intends to offer
18 opinions about the standard of care for a neurologist, he
19 says, I don't believe I've been hired to do that. I don't
20 know the exact words. I don't know that I've been retained
21 for that, not that he's incapable of doing it. I don't
22 believe I've been hired to testify on behalf of Dr. Holbrook,
23 is what he says because at that point he hadn't.

24 But once discovery responses are supplemented and Dr.
25 Holbrook's counsel says in that response Dr. Sampson is

1 expected to testify that Dr. Holbrook and the other members
2 of his surgical team provided care to plaintiff within the
3 standard of care, then you're on notice that he intends to
4 talk about the standard of care with respect to Dr. Holbrook
5 and his surgical team. And maybe that was interpreted in a
6 way other than it was intended to be delivered, but the
7 information is there, the opportunity is there.

8 And of course, his scope of work changed when he was
9 hired by a different party. So now he's being disclosed as
10 an expert by Dr. Holbrook and intends to offer opinions
11 within the standard of care as to Dr. Holbrook. So that
12 motion is respectfully denied.

13 MS. GOODING: Thank you, Your Honor.

14 THE COURT: Are there additional plaintiffs' motion?

15 MS. GOODING: Yes, Your Honor, one more from us, and
16 this kind of relates to the motion that we just went through.

17 This is our motion to prohibit defendants from
18 presenting cumulative testimony. This is based on Rule 403,
19 where evidence, even though it is relevant, may be excluded
20 where its probative value is substantially outweighed by
21 considerations of undue delay, waste of time, or needless
22 presentation of cumulative evidence.

23 In this case, in addition to Dr. Holbrook having
24 identified Dr. Sampson now, he also identified Dr. Poletti,
25 who is a spine surgeon down at Southeastern Spine Institute

1 in Charleston. Both of them gave opinions from the
2 perspective of a spine surgeon or a surgeon that does the
3 same type of surgery that was done in this case, and their
4 opinions overlap significantly.

5 And under the *Wright v. Kraft* case, the Court of Appeals
6 held that it is proper to exclude evidence solely because it
7 is cumulative, causing a needless waste of time, even where
8 the two pieces of evidence offered are not exactly identical.

9 And in that case, they were not dealing with expert
10 witness testimony, but with a case that involved a lot of
11 damage that was done to -- to a vehicle, and they -- the
12 proponent wanted to introduce actual, like, physical pieces
13 of a vehicle in addition to photographs. And the judge said,
14 that's completely unnecessary. They've got the photographs.
15 They've got the testimony. It's a waste of time to kind of
16 keep piling on like that.

17 And there's -- there's not a lot of South Carolina
18 precedent specifically on this issue, but federal courts have
19 repeatedly held and recognized that in the context of expert
20 testimony, this is particularly important because multiple
21 expert witnesses expressing the same opinion on a subject is
22 not only a waste of time and needlessly cumulative, but it
23 also raises the unfair possibility that jurors will resolve
24 competing expert testimony by counting heads, rather than by
25 the evaluation or the quality or the credibility of the

1 testimony.

2 And so, essentially, our position here is that the
3 defendant should be required to -- to pick an expert. And --
4 and I am not intending to say that they can only call Dr.
5 Sampson or call Dr. Poletti, but to say that on a given
6 issue, one of them can give an opinion. They cannot be
7 called to just give identical opinion after identical opinion
8 after identical opinion, both of them testifying -- and I
9 think this is important -- from the same perspective, from
10 the perspective of a surgeon who is operating on the spine.

11 Not -- you know, neither of them is an anesthesiologist
12 or some other type of expert that would have a different
13 perspective on this issue. Both of them have testified that
14 they felt like her mean arterial pressures were sufficient.
15 Both of them have testified that they believe her urine
16 output was sufficient, which is going to be another one of
17 the things that we focus on in our case.

18 Both of them testified that the cause of her injury was
19 a reperfusion injury. I don't want to get into too many
20 details about that, but they -- they both give the opinion
21 that it was caused in the exact same manner. They both give
22 the opinion that the wake-up tests were outdated, which is
23 one of the excerpts that Mr. Davis just read to us.

24 They both indicate that Dr. Holbrook went through the
25 same steps that they would have gone through when the

1 neuromonitoring went out, which is the technology they were
2 able to use in the courtroom [sic] that actually monitors a
3 patient's nerve signals as the surgery is going on. And one
4 of the issues here is when that signal is lost, what steps
5 should be taken from there, and both of them gave the same
6 opinion with regard to what's done when the neuromonitoring
7 went out.

8 And so -- and those are their primary opinions. There
9 are some other smaller ones I feel sure that they overlapped
10 on. Again, their testimonies were very, very similar, and in
11 order -- for them to just have two different spine surgeons
12 come in and give the same opinion in addition to their
13 client, the spine surgeon, giving that opinion is just
14 unnecessarily cumulative. It's a waste of time.

15 And under 403, there's a real danger of there being a
16 prejudice based on this counting heads, you know, there being
17 multiple doctors saying the same thing when the -- the
18 addition of probative value is none. Right? If they're
19 giving the same opinion, then there's no additional probative
20 value to that, but there is this risk that the plaintiffs
21 will be prejudiced by the jury assuming that because multiple
22 doctors said the same thing on behalf of the defense, that
23 that must be a more credible witness.

24 To the extent that one of them wants to give a list of
25 opinions, and the other one wants to give a list of different

1 opinions, I don't see how we could object to that, Your
2 Honor, but I think that it's important that -- that they not
3 be allowed to just get up and regurgitate the same list of
4 opinions just back to back.

5 THE COURT: Gentlemen?

6 MR. DAVIS: Thank you, Your Honor.

7 First of all is because I'm given to understand at the
8 conclusion of this case, Your Honor will give the jury
9 appropriate and requested jury charges. I'm sure both sides
10 will have the same or similar requests. If not, the judge
11 will have her own set of malpractice charges.

12 And I believe one of those -- several of those charges
13 are going to touch on instructing the jury that -- about
14 expert witnesses and whether they can accept part of an
15 expert's testimony and reject others or reject -- reject the
16 whole thing. They can accept one expert, reject the other,
17 and it's not appropriate -- I'm paraphrasing what I've heard
18 from the bench at the conclusion of these kind of cases that
19 it's not appropriate for you to count witnesses for one side
20 or the other, and that -- I think that charge covers
21 everything.

22 We've got a neurosurgeon, orthopedic. We've got a
23 neurosurgeon in Dr. Sampson. We've got an orthopedic spine
24 surgeon in Dr. Poletti. They have different training and
25 experiences where they're coming to this case, which is the

1 same case, giving their opinions from their respective
2 opinions -- from their -- from their respective positions and
3 their training, education, and experience.

4 The fact they both come to the same conclusion shouldn't
5 be, well, you can't use one of them. I mean, I think the
6 judge's charges, which will be most appropriate and never
7 objected to by this side of the case, will -- will be to the
8 effect that you can't count witnesses. That would be
9 inappropriate. So I object.

10 THE COURT: That motion is denied as well. Your point
11 is well taken, Ms. Gooding, and if we had ten people saying
12 the exact same thing, I would agree with you wholeheartedly.

13 MR. DAVIS: I'd be broke.

14 THE COURT: But even if we had two saying the exact same
15 thing as if it were rehearsed or something, that's different.
16 But I -- I'm -- I imagine -- I don't know, I may be wrong,
17 but I imagine that these two experts will explain things in
18 slightly different ways.

19 I've not -- I mean, I see you provided deposition
20 transcripts. I've not had the opportunity to read them, and
21 I just received them a couple hours ago, but if it starts to
22 sound like one is echoing the other wholeheartedly, then a
23 contemporaneous objection would make sense, but -- but as I
24 see it now, I'm not going to exclude one or the other or even
25 -- even certain topics from being discussed with both of the

1 witnesses.

2 MS. GOODING: And, Your Honor, I wouldn't ask you to
3 exclude on the front end but just would ask that we be
4 allowed to -- to make this objection again, you know, if the
5 testimony shows, you know, that there -- that the evidence is
6 the same and that it is cumulative.

7 Or perhaps, Your Honor, if when the second witness is
8 called, we could give their testimony or receive their
9 testimony outside the jury's presence in order to make that
10 determination. Then we would be able to sort out, you know,
11 what was cumulative.

12 THE COURT: I'm not going to -- unless something arises
13 that shows me some greater need to do so, I don't intend to
14 have the testimony of the second expert proffered outside of
15 the presence of the jury.

16 You know, my concern would be a waste of time,
17 unnecessarily cumulative, but I don't know that any
18 particular testimony that they will offer will be unduly
19 prejudicial. It may be a waste of time, but I don't think
20 it's anything that needs to be handled outside the presence
21 of the jury.

22 Obviously, that's -- my opinion on that is subject to
23 change. I don't know what either of them will say, but
24 should that arise, of course, we'll deal with that at the
25 time. And -- and certainly contemporaneous objections would

1 be appropriate.

2 MS. GOODING: Thank you, Your Honor. The plaintiff
3 doesn't have any further motions *in limine*.

4 THE COURT: All right. Before we get to the defense
5 motions, let's pick a jury, because I've got -- I've had a
6 jury sitting down there for half an hour or so.

7 Any objections? Have you all exchanged proposed voir
8 dire?

9 MR. GOINGS: We have, Your Honor.

10 MR. DAVIS: Yes, Your Honor.

11 THE COURT: And any objection to the other's proposed
12 voir dire?

13 MR. DAVIS: We have no objection.

14 THE COURT: Any objection from the plaintiff to the
15 defense?

16 MR. GOINGS: No objection, Your Honor.

17 THE COURT: Wonderful. Madam Clerk, let's bring up the
18 jury panel.

19 (WHEREUPON, there was a pause in the proceedings, after
20 which the proceedings resumed as follows.)

21 (WHEREUPON, a bench conference was held as follows.)

22 MR. GOINGS: Your Honor?

23 THE COURT: Yes.

24 MR. GOINGS: There were two questions on the defendant's
25 voir dire that said, essentially, if you're not persuaded in

1 this case that Dr. Holbrook was violating the standard of
2 care to be able to render a verdict in favor of his practice,
3 and we've agreed that we'd also ask the inverse of that
4 question. If you are -- if you have been convinced that he
5 violated the standard of care, would you be able to render a
6 verdict against his practice?

7 And I -- actually, I think it's good. I'm just writing
8 them out right now to inverse. There's two questions, and
9 we'd just like to ask both -- both directions.

10 MR. DAVIS: I don't have any objection, Your Honor --

11 THE COURT: Okay.

12 MR. DAVIS: -- to that.

13 THE COURT: Okay.

14 MR. GOINGS: Thank you, Your Honor.

15 THE COURT: Thank you.

16 (WHEREUPON, the bench conference ended, and there was a
17 pause in the proceedings, after which the proceedings
18 resumed as follows.)

19 (WHEREUPON, a bench conference was held as follows.)

20 MR. GOINGS: Your Honor, 22 and 26 were redundant. So
21 we can strike 22.

22 THE COURT: Okay.

23 MR. GOINGS: And then that was the agreed upon converse
24 of 26 so it was asked essentially both ways.

25 THE COURT: Okay.

1 MR. DAVIS: That's agreed, Your Honor.

2 THE COURT: Okay.

3 MR. DAVIS: Thank you.

4 MR. GOINGS: Thank you, Ashby.

5 MR. DAVIS: Yes, sir.

6 (WHEREUPON, the bench conference ended and there was a
7 pause in the proceedings, after which the proceedings
8 resumed as follows.)

9 THE BAILIFF: The jury panel is present, Your Honor.

10 THE COURT: Thank you, sir.

11 Good afternoon, ladies and gentlemen. You are here for
12 jury selection for the trial of a civil case.

13 I'm Jocelyn Newman. I'm a circuit court judge here in
14 Richland County. On my right is my law clerk, Bailey
15 McDaniel, and on my left is Alex Hyman, a newly-elected
16 circuit court judge from the Fifteenth Circuit down by the
17 beach. So he is just sitting with me this week. He probably
18 won't be here the whole week, but that's who that is.

19 So I'm going to ask you some questions to determine your
20 fitness to serve as jurors for the trial of this particular
21 case. They're different from the questions that you were
22 asked during jury qualification this morning with the other
23 Judge Newman, who happens to be my father. He says he told
24 y'all that -- that this trial will probably last longer than
25 a week. So I'm hoping y'all remember that.

1 But anyway, I'm going to get into my questions that are
2 more specific to this case. Before I do that, I'm going to
3 have the clerk place you under oath.

4 THE CLERK: Please stand and raise your right hand to be
5 sworn.

6 Do you swear or affirm that you shall true answer make
7 to all such questions as may be directed to you by the Court
8 or by the order thereof? You shall speak the truth, the
9 whole truth, and nothing but the truth, so help you God?

10 THE JURY PANEL: I do.

11 THE CLERK: Thank you. You may be seated.

12 THE COURT: All right. Ladies and gentlemen, this is
13 what we call a medical malpractice case that concerns a
14 surgery that was performed in 2016 by Dr. Thomas Holbrook.
15 The plaintiffs in this case are Crystal Goodwin and James
16 Goodwin. That surgery was at the -- it was at Prisma Health;
17 correct?

18 MS. GOODING: Yes.

19 THE COURT: Back in 2016.

20 The first question is does any member of the jury panel
21 know anything about this case or think that you know anything
22 about it, think that you heard about it at all? If so,
23 please stand.

24 (WHEREUPON, no one stood.)

25 THE COURT: All right. As I've told you, the

1 plaintiffs, the people who brought this case, are Crystal
2 Goodwin and James Goodwin.

3 Are the Goodwins in the courtroom? If y'all will waive
4 at the jury panel?

5 They are sitting at that table, down to your left.

6 Is any member of the jury panel related by blood,
7 connected by marriage, or have any close personal
8 relationship with Crystal Goodwin or James Goodwin? If so,
9 please stand.

10 (WHEREUPON, no one stood.)

11 THE COURT: All right. The Goodwins are represented in
12 this matter by Robert Goings and Jessica Gooding. They are
13 of the Goings Law Firm that is on Calhoun Street in downtown
14 Columbia. They are also represented by Francis Hinson IV,
15 also known as Brink Hinson, of the HHP Law Group on Gervais
16 Street in Columbia.

17 Is any member of the jury panel related by blood,
18 connected by marriage, or have any close personal
19 relationship with Mr. Goings, Ms. Gooding, or Mr. Hinson?
20 Are you currently represented by any of them or have you been
21 represented by any of them in the past? Do you have any
22 business dealings whatsoever with the Goings Law Firm or HHP
23 Law Group? If so, please stand.

24 (WHEREUPON, no one stood.)

25 THE COURT: All right. Thank you, folks. You may have

1 a seat.

2 The defendants in this case are Midlands Orthopedics and
3 Neurosurgery and Dr. Thomas J. Holbrook, Jr.

4 Is Mr. -- Dr. Holbrook in the courtroom?

5 MR. DAVIS: Yes, ma'am.

6 THE COURT: Yes. Okay. Dr. Holbrook is waving at you.
7 Is any member of the jury panel related by blood,
8 connected by marriage, or have any close personal
9 relationship with Dr. Holbrook? Have you been treated by him
10 in the past or are you currently being treated by him? Do
11 you have any business dealings at all with Dr. Holbrook or
12 with Midlands Orthopedics and Neurosurgery? If so, please
13 stand.

14 (WHEREUPON, three people stood.)

15 THE COURT: Your name and jury number?

16 JUROR NUMBER 236: Oh, me?

17 THE COURT: Yeah, sure.

18 JUROR NUMBER 236: 236, Sarah Parker.

19 THE COURT: 236. And who do you know?

20 JUROR NUMBER 236: I don't know the plaintiffs, but my
21 sons are athletes, and we attend Midlands Orthopedics several
22 many times a year. So...

23 THE COURT: Okay. Would the fact that your sons are
24 treated at that practice affect your ability to give both the
25 plaintiff and the defendant a fair and impartial trial in

1 this case?

2 JUROR NUMBER 236: No.

3 THE COURT: Thank you. You may have a seat.

4 Your name and jury number, sir?

5 JUROR NUMBER 83: 83, Jay Silver.

6 THE COURT: Yes, sir.

7 JUROR NUMBER 83: I've had three surgeries there, most

8 recently June of last year. It was not this gentleman. It

9 was Aikens -- Atkins, but always had great results.

10 THE COURT: Okay. Would that affect your ability to

11 give both the plaintiff --

12 JUROR NUMBER 83: I believe, yes.

13 THE COURT: Okay. Yes, it would affect your ability to

14 be fair and impartial?

15 JUROR NUMBER 83: Yes.

16 THE COURT: Okay. Thank you, sir. You may have a seat.

17 All right. In the back, your name and jury number?

18 JUROR NUMBER 173: Also, my name is Gabriel Johnson,

19 173.

20 THE COURT: Yes, sir?

21 JUROR NUMBER 173: Dr. Holbrook performed on my father,

22 I believe.

23 THE COURT: Okay. How long ago?

24 JUROR NUMBER 173: I don't know exactly, but I was -- I

25 went to the appointment with him, I believe.

1 THE COURT: Was it within the past 5 years?

2 JUROR NUMBER 173: Uh --

3 THE COURT: Within the past 10 years?

4 JUROR NUMBER 173: It was within the past 10 years, yes.

5 THE COURT: Okay. And do you know if your father is

6 still treating with Dr. Holbrook?

7 JUROR NUMBER 173: I don't believe so.

8 THE COURT: All right. Have you been to any additional

9 doctor's visits with Dr. Holbrook with your father?

10 JUROR NUMBER 173: No.

11 THE COURT: Okay. Would that affect your ability to

12 give both the plaintiffs and the defendants a fair and

13 impartial trial in this case?

14 JUROR NUMBER 173: I don't think so.

15 THE COURT: Thank you. You may have a seat.

16 All right. Dr. Holbrook and Midlands Orthopedics and

17 Neurosurgery are represented in this matter by Ashby Davis

18 and Andrew Heitmann.

19 Gentlemen, would you stand and face the jury panel?

20 Any member of the jury panel related by blood, connected

21 by marriage, or have any close personal relationship with Mr.

22 Davis or Mr. Heitmann? Are you currently represented by them

23 or have you been represented by either of them in the past?

24 They are of the law firm of Davis and Snyder in Greenville.

25 Does any member of the jury panel have any business dealings

1 with Mr. Davis, Mr. Heitmann, or the law firm of Davis and
2 Snyder? If so, please stand.

3 (WHEREUPON, no one stood.)

4 THE COURT: Thank you, gentlemen. You may have a seat.

5 All right. There are several potential witnesses who may
6 testify in this case, and the question is the same as to each
7 of them. And that's whether you're related by blood or
8 connected by marriage or have any close personal relationship
9 with any of them.

10 Those potential witnesses are: Jazmine Goodwin; Jamarion
11 Goodwin; Jamia [ph] Goodwin; Judith Goodwin; Michael Goodwin;
12 Lacey Delbridge; Edna Delbridge; Reverend Dr. Solomon
13 Jackson, Jr.; Dr. Jennifer Root; Erich Reed Starn; Mario
14 Antoine Riley; Teresa Adkins; Frederick D. Jones, III, who is
15 a medical doctor; Dr. Gary J. Lustgarten; Donna Katherine
16 Blair; Michael Brandon Todd, a registered nurse; Sunny
17 Lorraine Jumper; Michael Shaufele, who is a doctor; Cathy
18 Maria Smith-Gragg, a registered nurse; Dr. Francis
19 Balestrieri -- Balestrieri?

20 MR. DAVIS: Balestrieri. It's a hard one.

21 THE COURT: Dr. Steven Poletti; Kevin Moore; John
22 Sampson, who is a medical doctor; Dr. Anthony Mancuso; Dr.
23 David Goltra; Dr. Charles Alford; Rodney Jackson; DeAnna
24 Glenn from Columbia Rehabilitation Clinic; Dr. Fred Jones
25 from Memphis, Tennessee.

1 Is any member of the jury panel related by blood or
2 connected by marriage to any of those potential witnesses?
3 If so, please stand at this time.
4 (WHEREUPON, no one stood.)
5 THE COURT: Has any member of the jury panel ever had
6 neck, back, or spinal surgery? If so, please stand.
7 (WHEREUPON, four people stood.)
8 THE COURT: All right. Let's begin here. Your name and
9 jury number again?
10 JUROR NUMBER 236: 236, Sarah Parker.
11 THE COURT: And was the surgery on your neck, back, or
12 spine?
13 JUROR NUMBER 236: It was actually my son. He had it on
14 his neck, and he ended up dying due to the surgery.
15 THE COURT: I'm sorry to hear that. How long ago did
16 that happen?
17 JUROR NUMBER 236: Three years.
18 THE COURT: I'm sorry for your loss.
19 JUROR NUMBER 236: Thank you.
20 THE COURT: Would that experience affect your ability to
21 be fair and impartial to both the plaintiffs and the
22 defendant in this case?
23 JUROR NUMBER 2361: Potentially depending on the
24 details.
25 THE COURT: Okay. Thank you. You may have a seat.

1 In the white turtleneck, your name and jury number?
2 JUROR NUMBER 68: 68, Stephanie Cribb-Creek.
3 THE COURT: Yes, ma'am?
4 JUROR NUMBER 68: I had back surgery probably about 15
5 years ago.
6 THE COURT: Would that experience affect your ability to
7 give both the plaintiffs and the defendants a fair and
8 impartial trial in this case?
9 JUROR NUMBER 68: No.
10 THE COURT: No? Thank you. You may have a seat.
11 Yes, sir, in the gray shirt, your name and jury number?
12 JUROR NUMBER 288: 288, Tim Shealy.
13 THE COURT: Yes, sir?
14 JUROR NUMBER 288: I had neck surgery about nine years
15 ago.
16 THE COURT: Would that experience affect your ability to
17 give both the plaintiffs and the defendants a fair --
18 JUROR NUMBER 288: No.
19 THE COURT: -- and impartial trial? No? Thank you.
20 You may have a seat.
21 Sir, your name and jury number?
22 JUROR NUMBER 338: Brandon Williams, 338.
23 THE COURT: Yes, sir?
24 JUROR NUMBER 338: I had a back surgery 17 years ago.
25 THE COURT: Would that experience affect your ability to

1 be fair and impartial in this trial?

2 JUROR NUMBER 338: I believe no.

3 THE COURT: Okay. Thank you. You may have a seat.

4 Has any member of the jury panel or any member of your

5 immediate family ever had a complication from a spinal

6 surgery? If so, please stand.

7 (WHEREUPON, no one stood.)

8 THE COURT: Has any member of the jury panel or any

9 member of your immediate family ever been employed by a

10 hospital, physician, or a medical facility? If so, please

11 stand.

12 (WHEREUPON, several people stood.)

13 THE COURT: All right. Let's start on the front row

14 with your jury number.

15 JUROR NUMBER 179: 179.

16 THE COURT: Thank you. You may have a seat.

17 Next?

18 JUROR NUMBER 163: 163.

19 THE COURT: Thank you. You may have a seat.

20 Actually, let's pause there. Let me go back to 179.

21 Was it you or a family member?

22 JUROR NUMBER 179: It was my dad. He used to work at a

23 dialysis center.

24 THE COURT: Okay. Thank you. You may have a seat.

25 163, you or --

1 JUROR NUMBER 163: Family member.

2 THE COURT: Okay. And what kind of work?

3 JUROR NUMBER 163: Housekeeping.

4 THE COURT: Okay. Thank you.

5 Now in the green?

6 JUROR NUMBER 219: 219.

7 THE COURT: Thank you.

8 JUROR NUMBER 219: Mom and brother. Mom, nurse.

9 Brother, social worker in a hospital.

10 THE COURT: Thank you. You may have a seat.

11 THE COURT: You?

12 JUROR NUMBER 54: 54. Ex-wife was a nurse.

13 THE COURT: Thank you. You may have a seat.

14 JUROR NUMBER 360: 360. I currently work with Bristol

15 Orthopedics on the spine team.

16 THE COURT: Thank you. You may have a seat.

17 JUROR NUMBER 202: 202. My wife's a physical therapist

18 at Prisma.

19 THE COURT: Thank you. You may have a seat.

20 JUROR NUMBER 339: 339. My wife is a nurse at Prisma.

21 THE COURT: Thank you. You may have a seat.

22 JUROR NUMBER 178: 178. My grandfather is a doctor, a

23 surgeon.

24 THE COURT: Thank you. You may have a seat.

25 JUROR NUMBER 15: 15. My mother-in-law is a nurse. My

1 brother-in-law is a physical therapist at a hospital.

2 THE COURT: Thank you. You may have a seat.

3 JUROR NUMBER 139: 139. My daughter is a registered
4 nurse.

5 THE COURT: Thank you. You may have a seat.

6 JUROR NUMBER 236: 236. My mother is a registered
7 nurse, and my father is a kinesiotherapist.

8 THE COURT: Thank you. You may have a seat.

9 JUROR NUMBER 303: 303. I was a pharmacist at Prisma
10 Health Tuomey.

11 THE COURT: Thank you. You may have a seat.

12 JUROR NUMBER 9: 9. My dad is an ophthalmologist -- or
13 an ophthalmologist, and my aunt's a NICU nurse.

14 THE COURT: Thank you. You may have a seat.

15 JUROR NUMBER 141: 141. My mother worked for Prisma at
16 the gift shop.

17 THE COURT: Thank you.

18 JUROR NUMBER 141: And then my daughter is an LPN.

19 THE COURT: Thank you. You may have a seat.

20 JUROR NUMBER 84: 84. I'm an OBGYN resident at Prisma,
21 and my husband is an orthopedic surgeon resident at Prisma.

22 THE COURT: Thank you. You may have a seat.

23 JUROR NUMBER 68: Number 68. I'm a registered nurse.
24 My husband's a pharmacist.

25 THE COURT: Thank you. You may have a seat.

1 JUROR NUMBER 369: 369. I worked at Baptist Providence
2 in South Carolina heart center.

3 THE COURT: Thank you. You may have a seat.

4 JUROR NUMBER 282: 282. My wife previously worked for
5 Prisma.

6 THE COURT: Thank you. You may have a seat.

7 JUROR NUMBER 108: 108. My mother is a PA.

8 THE COURT: Thank you. Have a seat.

9 JUROR NUMBER 78: 78. My mother is currently an
10 occupational therapist.

11 THE COURT: Thank you. You may have a seat.

12 JUROR NUMBER 263: 263. I just work for Prisma in
13 Lexington.

14 THE COURT: Thank you. Have a seat.

15 JUROR NUMBER 359: 359. My husband is a registered
16 nurse, and my daughter is on the neuroscience medical track.

17 THE COURT: Thank you. You may have a seat.

18 Has any member of the jury panel or any member of your
19 immediate family ever been involved in a legal action, a
20 lawsuit, either as a plaintiff, the person filing the
21 lawsuit, or as a defendant? If so, please stand. You or
22 your immediate -- immediate family members ever sued someone
23 or been sued? If so, please stand.

24 (WHEREUPON, several people stood.)

25 THE COURT: Okay. Let's start on the end here. Your

1 jury number, sir?

2 JUROR NUMBER 83: 83.

3 THE COURT: And was it you or a family member?

4 JUROR NUMBER 83: Me.

5 THE COURT: Plaintiff or defendant?

6 JUROR NUMBER 83: Defendant.

7 THE COURT: What kind of case?

8 JUROR NUMBER 83: Civil.

9 THE COURT: Anything involving medical --

10 JUROR NUMBER 83: No.

11 THE COURT: -- stuff. Okay. Has that case been

12 resolved?

13 JUROR NUMBER 83: Yes.

14 THE COURT: Would that experience affect your ability to

15 be fair and impartial to the plaintiff and the defendant?

16 JUROR NUMBER 83: No, ma'am.

17 THE COURT: Thank you. You may have a seat.

18 In the white shirt, your jury number?

19 JUROR NUMBER 139: 139.

20 THE COURT: Okay. Plaintiff or defendant?

21 JUROR NUMBER 139: I was a -- I was a defendant -- not

22 the defendant, but plaintiff. I sued someone for -- it was a

23 civil suit to someone for making something for my daughter.

24 It was over 20 years ago.

25 THE COURT: Okay. Would that experience affect your

1 ability to be fair and impartial in this trial?

2 JUROR NUMBER 139: No, it wouldn't.

3 THE COURT: Thank you. You may have a seat,

4 In the black cardigan, your jury number?

5 JUROR NUMBER 358: 358. I was a plaintiff twice.

6 THE COURT: What kinds of cases?

7 JUROR NUMBER 358: Civil.

8 THE COURT: Car accidents or --

9 JUROR NUMBER 358: One was a car accident.

10 THE COURT: Okay. Anything medical involved?

11 JUROR NUMBER 358: No.

12 THE COURT: All right. Are all those -- both of those

13 cases resolved?

14 JUROR NUMBER 358: Both are resolved, yes.

15 THE COURT: Would that experience affect your ability to

16 be fair and impartial to both the plaintiffs and the

17 defendants?

18 JUROR NUMBER 358: No.

19 THE COURT: Thank you. You may have a seat.

20 Let's go down to the front here. Your jury number, sir?

21 JUROR NUMBER 339: 339.

22 THE COURT: And was it you or someone else?

23 JUROR NUMBER 339: I was a defendant.

24 THE COURT: In what kind of case?

25 JUROR NUMBER 339: It was a civil case. My identity was

1 taken or used in a fraud situation.

2 THE COURT: Okay. Has that case been resolved?

3 JUROR NUMBER 339: Yes.

4 THE COURT: Would that experience affect your ability to
5 be fair and partial to the plaintiffs and to the defendants?

6 JUROR NUMBER 339: No.

7 THE COURT: Thank you. You may have a seat.

8 Yes, ma'am, on the end, your jury number?

9 JUROR NUMBER 369: Plaintiff. Car accident.

10 THE COURT: How long ago?

11 JUROR NUMBER 369: Lord.

12 THE COURT: Has it been resolved?

13 JUROR NUMBER 369: Yes.

14 THE COURT: Okay.

15 JUROR NUMBER 369: A long time.

16 THE COURT: And would -- can you still be fair and
17 impartial?

18 JUROR NUMBER 369: I'm sorry?

19 THE COURT: Can you still be fair and impartial to the
20 plaintiffs and the defendants?

21 JUROR NUMBER 369: Yes, ma'am. Yes.

22 THE COURT: And tell me your jury number?

23 JUROR NUMBER 369: 369.

24 THE COURT: Thank you. You may have a seat.

25 Right here, your jury number, please?

1 JUROR NUMBER 269: 269.

2 THE COURT: Okay.

3 JUROR NUMBER 269: I was the defendant in a car
4 accident.

5 THE COURT: Has that case been resolved?

6 JUROR NUMBER 269: Yes, ma'am.

7 THE COURT: Okay. Would that affect your ability to be
8 fair and impartial in this case?

9 JUROR NUMBER 269: No, ma'am.

10 THE COURT: Thank you. You may have a seat.

11 Yes, your turn.

12 JUROR NUMBER 303: 303. And we were defendants -- or
13 defendants in a case, lawsuit against the sale of a house.

14 THE COURT: Okay. Has that been resolved?

15 JUROR NUMBER 303: Yes.

16 THE COURT: Can you be fair and impartial?

17 JUROR NUMBER 303: Yes.

18 THE COURT: Okay. Your jury number?

19 JUROR NUMBER 78: 78.

20 THE COURT: And plaintiff or defendant?

21 JUROR NUMBER 78: My mother was a plaintiff in a car
22 accident.

23 THE COURT: Would that experience affect your ability to
24 be fair and impartial in the trial of this case?

25 JUROR NUMBER 78: No, ma'am.

1 THE COURT: Thank you. You may have a seat.
2 In the back, your jury number?
3 JUROR NUMBER 304: 304.
4 THE COURT: And you or someone else?
5 JUROR NUMBER 304: Me.
6 THE COURT: Plaintiff or defendant?
7 JUROR NUMBER 304: Plaintiff. Yeah.
8 THE COURT: Plaintiff in what kind of a case?
9 JUROR NUMBER 304: Carotid artery, neck injury.
10 THE COURT: Okay. Has that case been resolved?
11 JUROR NUMBER 304: Yes.
12 THE COURT: How long ago?
13 JUROR NUMBER 304: Six years.
14 THE COURT: Would that experience affect your ability to
15 be fair and impartial in the trial of this case?
16 JUROR NUMBER 304: No.
17 THE COURT: Thank you. You may have a seat.
18 Has any member of the jury panel or any member of your
19 immediate family ever served on a jury in a medical
20 malpractice case before? If so, please stand.
21 (WHEREUPON, one person stood.)
22 THE COURT: Your jury number, ma'am?
23 JUROR NUMBER 141: 141.
24 THE COURT: 141. Was it you or a family member?
25 JUROR NUMBER 141: No. I served as a juror.

1 THE COURT: Oh, you served as a juror in a medical
2 malpractice case?

3 JUROR NUMBER 141: Yes.

4 THE COURT: How long ago?

5 JUROR NUMBER 141: It has to be over 20 years ago.

6 THE COURT: Okay. Would that experience affect your
7 ability to be fair and impartial in the trial of this case?

8 JUROR NUMBER 131: No, ma'am.

9 THE COURT: Thank you. You may have a seat.
10 Okay. Has any member of the jury panel or any member of
11 your immediate family ever served on a jury in any type of
12 civil case, not a medical malpractice case? If so, please
13 stand.

14 (WHEREUPON, three people stood.)

15 THE COURT: Your jury number?

16 JUROR NUMBER 303: 303.

17 THE COURT: Was it you or a family member?

18 JUROR NUMBER 303: It was a family member, my husband.

19 THE COURT: What kind of case was it?

20 JUROR NUMBER 303: A murder trial.

21 THE COURT: How long ago?

22 JUROR NUMBER 303: Probably 15 years.

23 THE COURT: Okay. Would that experience affect your
24 ability to be fair and impartial in the trial of this case?

25 JUROR NUMBER 303: No.

1 THE COURT: Thank you. You may have a seat.
2 In the green, your jury number?
3 JUROR NUMBER 140: 140.
4 THE COURT: Was it you or a family member?
5 JUROR NUMBER 140: Me.
6 THE COURT: And how long -- what kind of case?
7 JUROR NUMBER 140: I think it was a child molestation
8 case.
9 THE COURT: How long ago?
10 JUROR NUMBER 140: Fifteen years.
11 THE COURT: Would that experience affect your ability to
12 be fair and impartial in this trial?
13 JUROR NUMBER 140: No, ma'am.
14 THE COURT: Thank you. You may have a seat.
15 Your jury number, sir?
16 JUROR NUMBER 9: 9. And it was my father who was on a
17 jury for a murder case.
18 THE COURT: Would your knowledge of his experience
19 affect your ability to be fair and impartial in the trial of
20 this case?
21 JUROR NUMBER 9: No, ma'am.
22 THE COURT: Thank you. You may have a seat.
23 Has any member of the jury panel or any member of your
24 immediate family ever suffered an injury as a result of a
25 medical procedure or medical care? If so, please stand.

1 (WHEREUPON, three people stood.)

2 THE COURT: So, 236, your son?

3 JUROR NUMBER 236: Uh-huh.

4 THE COURT: You can have a seat.

5 Ma'am, your jury number?

6 JUROR NUMBER 163: 163. Uncle, wrong body part removed,

7 recently died.

8 THE COURT: Would that experience affect your ability to

9 be fair and impartial in the trial of this case?

10 JUROR NUMBER 163: No, ma'am.

11 THE COURT: Thank you. You may have a seat.

12 Your jury number -- is it 9?

13 JUROR NUMBER 304: 304.

14 THE COURT: Oh, I tried. What do you have?

15 JUROR NUMBER 304: I had a neck injury from a

16 chiropractic experience.

17 THE COURT: Would that affect your ability to be fair

18 and impartial in the trial of this case?

19 JUROR NUMBER 304: No.

20 THE COURT: No? Thank you. You may have a seat.

21 Has any member of the jury panel or any member of your

22 immediate family ever suffered a spinal cord injury during a

23 surgery? If so, please stand.

24 (WHEREUPON, no one stood.)

25 THE COURT: Has any member of the jury panel or any

1 member of your immediate family ever suffered from chronic
2 back pain, spinal stenosis, or spinal cord compression? If
3 so, please stand.

4 (WHEREUPON, several people stood.)

5 THE COURT: All right. Let's begin on the front row
6 here. Your jury number?

7 JUROR NUMBER 163: 163.

8 THE COURT: Was it you or a family member?

9 JUROR NUMBER 163: I'm currently suffering from back
10 pain from a fall.

11 THE COURT: Okay. Thank you. You may have a seat.
12 Your jury number?

13 JUROR NUMBER 349: 349.

14 THE COURT: You or a family member?

15 JUROR NUMBER 349: Myself stenosis and my husband
16 stenosis.

17 THE COURT: Okay. Thank you. You may have a seat.
18 Yes, ma'am?

19 JUROR NUMBER 303: 303. My mother has chronic back
20 spasms, and she's had several surgeries for that.

21 THE COURT: I'm sorry. Repeat that last part?

22 JUROR NUMBER 303: My mother has had chronic back
23 compression fractures and stenosis, and she's had several
24 surgeries for that.

25 THE COURT: Okay. Thank you. You may have a seat.

1 Winthrop sweatshirt, your jury number?

2 JUROR NUMBER 15: 15.

3 THE COURT: Okay.

4 JUROR NUMBER 15: My stepmother has had chronic back
5 pain and quite a few surgeries.

6 THE COURT: Thank you. You may have a seat.
7 White turtleneck?

8 JUROR NUMBER 68: 68. I have suffered from chronic back
9 pain. My father has had chronic back pain as well.

10 THE COURT: Thank you. Have a seat.
11 Sort of the teal?

12 JUROR NUMBER 141: 141.

13 THE COURT: Yes, ma'am?

14 JUROR NUMBER 141: My mother suffers from back pain.
15 She's fell -- fallen several times backwards on a set of
16 stairs.

17 THE COURT: Okay. Thank you. You may have a seat.
18 On the end here, yes?

19 JUROR NUMBER 184: 184. My father-in-law had back
20 surgery two years ago to deal with an injury that happened as
21 a result from a fall.

22 THE COURT: Okay. Thank you. You may have a seat.
23 Your jury number, sir?

24 JUROR NUMBER 171: 171. My father has spinal stenosis,
25 had surgery three weeks ago.

1 THE COURT: Thank you. You may have a seat.
2 In the back?
3 JUROR NUMBER 173: 173. My father had back pain.
4 THE COURT: Thank you. You may have a seat.
5 In the back?
6 JUROR NUMBER 338: 338. Myself, my sister, and my
7 mother, spinal stenosis.
8 THE COURT: Thank you. You may have a seat.
9 In the front here?
10 JUROR NUMBER 339: 339. I just remember my father -- it
11 was maybe 15, 20 years ago -- broke his back after a fall in
12 the military.
13 THE COURT: Thank you. You may have a seat.
14 Has any member of the jury panel or any member of your
15 immediate family ever been a caregiver for someone who has
16 paralysis or someone who uses a wheelchair? If so, please
17 stand.
18 (WHEREUPON, several people stood.)
19 THE COURT: Your jury number?
20 JUROR NUMBER 269: 269. I used to be a caregiver at a
21 mental health elderly facility. I had a lot of patients with
22 wheelchairs and walkers.
23 THE COURT: Okay. Thank you. You may have a seat.
24 Your jury number?
25 JUROR NUMBER 184: 184. My mother works for an in-home

1 care company. She has had a number of clients over the years
2 with a variety of conditions --

3 THE COURT: Thank you.

4 JUROR NUMBER 184: -- who used a wheelchair.

5 THE COURT: Okay. Thank you. You may have a seat.

6 In the back?

7 JUROR NUMBER 173: 173. My family and me have helped
8 with a family member with ALS.

9 THE COURT: Okay. Thank you. You may have a seat.

10 Your jury number?

11 JUROR NUMBER 369: 369. My 98-year-old aunt has spinal
12 stenosis.

13 THE COURT: Thank you. You may have a seat.

14 Does any member of the jury panel feel that simply
15 because a lawsuit has been brought that a physician or doctor
16 is responsible or liable to the plaintiff? If so, please
17 stand.

18 (WHEREUPON, no one stood.)

19 THE COURT: Does any member of the jury panel believe
20 that just because a lawsuit has been filed against a doctor,
21 hospital, or health care provider that the doctor, hospital,
22 or health care provider must have done something wrong and
23 should be held liable? If so, please stand.

24 (WHEREUPON, no one stood.)

25 THE COURT: Does any member of the jury panel have any

1 bias or preconceived thoughts or feelings for or against
2 physicians, doctors, or the health care field that would
3 prevent you from being completely fair and impartial? If so,
4 please stand.

5 (WHEREUPON, one person stood.)

6 THE COURT: 260 -- no, 236?

7 JUROR NUMBER 236: Uh-huh.

8 THE COURT: Thank you. You may have a seat.

9 Does any member of the jury panel have any bias or
10 preconceived thoughts or feelings against a person who is
11 seeking compensation from someone else that would prevent you
12 from being fair and impartial? If so, please stand.

13 (WHEREUPON, no one stood.)

14 THE COURT: Does any member of the jury panel have any
15 political, social, or religious beliefs that would prevent
16 you from making a judgment regarding fault for injuries and
17 awarding money damages potentially? If so, please stand.

18 (WHEREUPON, no one stood.)

19 THE COURT: Does any member of the jury panel or any
20 member of your immediate family have any affiliation or
21 association with Solomon's Temple Baptist Church in Columbia?
22 If so, please stand.

23 (WHEREUPON, no one stood.)

24 THE COURT: Has any member of the jury panel or any
25 member of your immediate family heard anything about this on

1 the internet, read anything about this case in or -- in the
2 newspaper, know anything about this case or the parties to
3 this case? If so, please stand.

4 (WHEREUPON, no one stood.)

5 THE COURT: Has any member of the jury panel recently
6 read anything or heard anything about recent medical
7 malpractice verdicts or settlements or anything about medical
8 malpractice cases? If so, please stand.

9 (WHEREUPON, two people stood.)

10 JUROR NUMBER 358: 358.

11 THE COURT: Yes, ma'am?

12 JUROR NUMBER 358: I worked for a law firm. I'm a
13 paralegal.

14 THE COURT: Okay. What law firm was that?

15 JUROR NUMBER 358: Whetstone Perkins and Fulda.

16 THE COURT: All right. Would that affect your ability
17 to be fair and impartial to both the plaintiffs and the
18 defendants in the trial of this case?

19 JUROR NUMBER 358: No, Your Honor.

20 THE COURT: Thank you. You may have a seat.
21 Yes, ma'am, your jury number?

22 JUROR NUMBER 163: 163. I worked for a medical
23 malpractice law firm for nine years.

24 THE COURT: What firm was that?

25 JUROR NUMBER 163: It was in New York, Finger and

1 Finger.

2 THE COURT: Okay. Would your experience there affect
3 your ability to be fair and impartial in the trial of this
4 case?

5 JUROR NUMBER 163: It would not.

6 THE COURT: Thank you. You may have a seat.

7 Counsel, let me ask quickly. I -- I've lost track of
8 what the circles mean versus -- am I supposed to ask the
9 circled questions?

10 MS. GOODING: Yes. You still ask the circled questions.
11 I believe 22 we struck off, and then there's another question
12 for you on a piece of legal pad.

13 THE COURT: Right. But then there are --

14 MS. GOODING: 26.

15 THE COURT: -- two other numbers that are neither
16 circled nor crossed out that I'm --

17 MS. GOODING: Just -- that's not relevant at all.

18 THE COURT: Okay. Got it.

19 All right. Okay, ladies and gentlemen, next question.

20 Do you agree that a patient is owed a duty of reasonable
21 care by his or her doctor, but is not owed a duty of perfect
22 care? If you disagree with that, please stand. If you agree
23 that a patient is owed a duty of reasonable care, but is not
24 owed a duty of perfect care, then you can remain seated, but
25 if you disagree with that, please stand.

1 UNIDENTIFIED FEMALE: I feel like I'm confused by your
2 question.

3 THE COURT: Yeah, exactly. Yeah. I'm trying to think.
4 So I'll read it again.

5 Do you agree that a patient is owed a duty of reasonable
6 care by his or her doctor, but is not owed a duty of perfect
7 care? So I don't really want to interpret it too much. That
8 is the question. So if you agree that a patient is owed a
9 duty of reasonable care by their doctor, but not a duty of
10 perfect care, then you can remain seated. If you disagree
11 with that, please stand.

12 (WHEREUPON, one person stood.)

13 THE COURT: 236. You may have a seat.

14 Is there any member of the jury panel who thinks that
15 they are unable to separate facts from sympathy and render a
16 verdict based on the facts and not based on sympathy? If you
17 think that you are unable to do that, please stand.

18 (WHEREUPON, two people stood.)

19 THE COURT: 236. You may have a seat.

20 Your jury number again?

21 JUROR NUMBER 15: 15. 15.

22 THE COURT: 15? You do not believe that you are able to
23 base your verdict on the facts and not on sympathy; is that
24 correct?

25 JUROR NUMBER 15: It would be a struggle.

1 THE COURT: Okay. Just making sure. Thank you. Have a
2 seat.

3 All right. If, at the end of your deliberations in this
4 case, you believe that the evidence shows that Dr. Holbrook
5 was reasonable in his treatment of Ms. Goodwin, even though
6 there was a spinal cord injury, would you be able to render a
7 verdict in favor of Dr. Holbrook? If you believe that the
8 evidence shows that Dr. Holbrook -- Holbrook was reasonable
9 and met the standard of care in his treatment of Ms. Goodwin,
10 would you be willing to render a verdict in favor of Dr.
11 Holbrook? If you can do that, please stand up.

12 (WHEREUPON, several people stood.)

13 UNIDENTIFIED MALE: So it's an affirmative?

14 THE COURT: At this time, yes. If you can do that, if
15 you -- your job would be to determine whether Dr. Holbrook
16 was reasonable and met the standard of care. Even though Ms.
17 Goodwin was injured, if you can still find in favor of Dr.
18 Holbrook, then you should be standing.

19 Now, that means that if you're not standing, now I want
20 to reverse it. So everyone who's standing now, have a seat.
21 If you were not standing just a moment ago, stand, please.

22 (WHEREUPON, two people stood.)

23 THE COURT: 236. You may have a seat.

24 And remind me your jury number?

25 JUROR NUMBER 163: 163.

1 THE COURT: 163. Thank you. You may have a seat.
2 MR. GOINGS: May we approach briefly, Your Honor?
3 THE COURT: Sure.
4 (WHEREUPON, a bench conference was held as follows.)
5 MR. GOINGS: You have to talk through the little mail
6 slot here.
7 THE COURT: I know. I can't stand it. I've been
8 begging them to take this down.
9 MR. GOINGS: Judge, on paper, the requests sound
10 reasonable, but it's clear that we're getting way too --
11 THE COURT: Uh-huh.
12 MR. GOINGS: -- into the merits of the case --
13 THE COURT: Uh-huh.
14 MR. GOINGS: -- the law --
15 THE COURT: Uh-huh.
16 MR. GOINGS: -- that you give in the charges, and the
17 jury -- potential jurors are getting really confused.
18 THE COURT: Uh-huh.
19 MR. GOINGS: So do you have any more of these type
20 questions?
21 THE COURT: Uh-huh. That's why I saved them for last
22 because --
23 MR. GOINGS: Okay. Because I --
24 THE COURT: They're just not phrased as good voir dire
25 wise.

1 MR. GOINGS: Right. We object to any more of these
2 because it's just going to confuse the jury. So we're all
3 confused. They're confused.

4 THE COURT: Uh-huh.

5 MR. GOINGS: You're talking about the law and haven't
6 given them instructions on the law.

7 THE COURT: Uh-huh.

8 MR. GOINGS: You're giving them -- asking them their
9 thoughts on the law. So we would object to any further
10 questions like this. I think it would help us move along
11 better.

12 THE COURT: I think so too.

13 MR. GOINGS: Thank you.

14 THE COURT: Yeah.

15 MR. DAVIS: I don't have a problem with that.

16 THE COURT: Okay. Good, good.

17 (WHEREUPON, the bench conference ended, and the
18 proceedings resumed as follows.)

19 THE COURT: All right. Ladies and gentlemen, does
20 anyone know of any reason whatsoever that they've not already
21 told me about that they cannot be fair and impartial in the
22 trial of this case? If you know of anything that you've not
23 yet told me about that would prevent you from being fair and
24 impartial in the trial of this case, please stand at this
25 time.

1 (WHEREUPON, one person stood.)

2 JUROR NUMBER 138: I can be fair and impartial, but can

3 I ask a question?

4 THE COURT: Sure.

5 JUROR NUMBER 138: Just stand up and --

6 THE COURT: Stand up and give me your jury number.

7 JUROR NUMBER 138: It's 138. It's one of the lawyers.

8 So Robert Goings?

9 THE COURT: Goings, yes.

10 JUROR NUMBER 138: Yeah. Did you go to Wofford?

11 MR. GOINGS: I did, Your Honor.

12 JUROR NUMBER 138: Okay. So I -- I didn't -- it's been

13 so long, I didn't recognize him. We went to -- to college

14 together.

15 THE COURT: Okay.

16 JUROR NUMBER 138: And we were in the same term.

17 MR. GOINGS: My hair is a little different color than it

18 was.

19 JUROR NUMBER 138: But I --

20 THE COURT: Given the fact that --

21 JUROR NUMBER 138: -- can be fair and impartial. I just

22 -- it took me a long time to recognize who it was.

23 THE COURT: Okay. But you can still be fair and

24 impartial; is that correct?

25 JUROR NUMBER 138: Yeah, I think so.

1 THE COURT: Okay.

2 JUROR NUMBER 138: I haven't seen him in a long time.

3 THE COURT: Thank you, sir.

4 Anyone else?

5 (WHEREUPON, no one stood.)

6 THE COURT: All right. Ladies and gentlemen, we are now
7 going to select a jury for the trial of this case. I'm going
8 to have the clerk handle that. She's going to be calling out
9 some numbers between the attorneys. They are not your jury
10 members. We'll circle around back to your jury numbers in a
11 moment, but if y'all will indulge us just a few minutes.

12 Y'all need a minute?

13 MR. GOINGS: Your Honor, we have some matters of law to
14 take up on cause.

15 MR. DAVIS: As do we.

16 THE COURT: Y'all approach quickly.

17 (WHEREUPON, a bench conference was held off the record,
18 after which the proceedings resumed as follows.)

19 THE COURT: All right. Ladies and gentlemen, before we
20 do the jury selection, let me circle back to -- I don't know
21 that I asked this question directly, but did any member of
22 the jury panel or any member of your immediate family work
23 for Prisma Health? If so, please stand.

24 (WHEREUPON, several people stood)

25 THE COURT: All right. Let's start on the end in the

1 front. Your jury number?

2 JUROR NUMBER 339: 339.

3 THE COURT: You or a family member?

4 JUROR NUMBER 339: My wife.

5 THE COURT: Okay. And I'll tell all of you because I

6 intend to ask you whether you can still be fair and impartial

7 in the trial of this case. I'm told that this case does

8 involve Prisma Health, that there are documents with Prisma

9 Health all over them, that Prisma Health sort of runs through

10 this case.

11 Knowing that Prisma Health plays a big part in this

12 case, would that affect -- your wife working there, Juror

13 339, affect your ability to be fair and impartial in the

14 trial of this case?

15 JUROR NUMBER 339: No.

16 THE COURT: Thank you. You may have a seat.

17 Your jury number?

18 JUROR NUMBER 202: 202. My wife works at Prisma Health.

19 THE COURT: And would that affect your ability to be

20 fair and impartial?

21 JUROR NUMBER 202: I don't think so.

22 THE COURT: Thank you. You may have a seat.

23 JUROR NUMBER 316: 316. I work with Prisma Orthopedics.

24 THE COURT: And would that affect your ability to be

25 fair and impartial?

1 JUROR NUMBER 316: No.

2 THE COURT: Thank you. You may have a seat.

3 In the green shirt?

4 JUROR NUMBER 219: 219. My brother is a social work

5 worker for Prisma, and no, it would not.

6 THE COURT: Okay. Thank you.

7 Winthrop sweatshirt?

8 JUROR NUMBER 15: Juror Number 15. My brother-in-law

9 works for Prisma.

10 THE COURT: Okay.

11 JUROR NUMBER 15: As far as I know, it would not.

12 THE COURT: You could still be fair and impartial;

13 correct?

14 JUROR NUMBER 15: Yes.

15 THE COURT: Have a seat.

16 JUROR NUMBER 84: 84. I work for Prisma and so does my

17 husband.

18 THE COURT: And can you still be fair and impartial?

19 JUROR NUMBER 84: Yes.

20 THE COURT: Thank you. You may have a seat.

21 JUROR NUMBER 121: 121. My mother worked at Prisma.

22 THE COURT: Okay. Can you still be fair and impartial?

23 JUROR NUMBER 121: Yes, ma'am.

24 THE COURT: Thank you. You may have a seat.

25 JUROR NUMBER 303: 303. I work at Prisma.

1 THE COURT: Okay. And can you still be fair and
2 impartial?

3 JUROR NUMBER 303: Yes.

4 THE COURT: Yes? Thank you. You may have a seat.

5 JUROR NUMBER 282: 282. My wife worked at Prisma until
6 a month ago.

7 THE COURT: Okay. And can you still be fair and
8 impartial?

9 JUROR NUMBER 303: Yes, I can.

10 THE COURT: Thank you. You may have a seat.

11 All right. Madam Clerk, before we get to jury
12 selection, I'm just going to have you call the roll and make
13 sure we've got everyone in here.

14 And when the clerk calls your number, if you will, raise
15 your hand, please.

16 Madam Clerk?

17 THE CLERK: Do you want me to call them by the name and
18 the number or just the number?

19 THE COURT: It doesn't matter. Well, name and number.
20 Let's do name and number. Make it easier.

21 THE CLERK: Okay. Jury Number 269 [sic], Karen Withrow.
22 Jury Number 179, Clayton Joyner.
23 Jury Number 202, Daniel Marchant.
24 Jury Number 358, Danyelle Young.
25 Jury Number 103, Austin Ford.

1	Jury Number 208, John McDonald.
2	Jury Number 54, Michael Casto.
3	Jury Number 15, Andrew Bagley.
4	Jury Number 83, Jason Dilworth.
5	Jury Number 9, Robert Andreo.
6	Jury Number 288, Timothy Shealy.
7	Jury Number 195, Roxann Lewis.
8	Jury Number 304, Peter Bradley.
9	Jury Number 43, Dwayne Bryant.
10	Jury Number 219, Michael Mitchell.
11	Jury Number 68, Stephanie Creek.
12	Jury Number 228, Labaron Nedd.
13	Jury Number 146, Tameka Harvey.
14	Jury Number 263, Jaekwon Robinson.
15	Jury Number 163, Sherryann Husbands.
16	Jury Number 171, Charles Jenkins.
17	Jury Number 204, Caroline Matthews.
18	Jury Number 282, Gordon Schell.
19	Jury Number 140, Brian Harmon.
20	Jury Number 90, Raymond Dues.
21	Jury Number 84, Sarah Dobbs.
22	Jury Number 173, Gabriel Johnson.
23	Jury Number 281, Sherando Scarborough.
24	Jury Number 321, Rodrickas Thomas.
25	Jury Number 338, Brandon Williams.

1 Jury Number 360, Olivia Avant.
2 Jury Number 78, Joshua Davis.
3 Jury Number 236, Sarah Parker.
4 Jury Number 369, Glenda Waddell.
5 Jury Number 339, Demetrius Williams.
6 Jury Number 184, Matthew Claussen.
7 Jury Number 141, Jeanette Carmen Scott.
8 JUROR NUMBER 141: Jeannie.
9 THE CLERK: Jeannie?
10 JUROR NUMBER 141: Jeannie.
11 THE CLERK: Jeannie? Ginny?
12 JUROR NUMBER 141: Jeannie.
13 THE CLERK: Juror Number 370, Helga Williams.
14 Jury Number 139, Yvonne Hanson.
15 Jury Number 108, Timothy Frisby.
16 Jury Number 303, Nancy Spivey.
17 Jury Number 178, Raphael Jones.
18 Jury Number 325, Shawn Barnes.
19 Jury Number 359, Quan Yan.
20 Is there any names I omitted?
21 (WHEREUPON, there was no response.)
22 THE CLERK: The names have been called, Your Honor.
23 THE COURT: All right. Thank you, Madam Clerk.
24 For purposes of the record, using the numbers on the
25 left, the following jurors are to be stricken for cause.

1 That's jurors on the list Number 9, Number 10, Number 21, and
2 Number 34.

3 Mr. Goings, as to the other matter, I'll allow you to
4 place your objection on the record after we have selected the
5 jury.

6 So back to picking a jury. They're going to be calling
7 out the numbers that are not your jury numbers. Your names
8 have been put in random order and renumbered. We'll get to
9 your jury numbers at the end once we've selected the people
10 to be on the jury. So y'all sit tight while the lawyers and
11 the clerk do a little bit of work to figure out who's going
12 to be on this jury panel.

13 We will do two alternates, Madam Clerk, and if you're
14 ready for jury selection, have at it.

15 MR. DAVIS: Your Honor, just for clarification, we're
16 using the numbers on the far left. We're going number 1, 2,
17 3, 4, 6, 7, all the way down to what number? Do you see what
18 I'm asking?

19 THE COURT: It should be --

20 MR. DAVIS: Twenty straight?

21 THE COURT: -- 1 through 23.

22 MR. DAVIS: Okay. Thank you.

23 THE COURT: The alternate -- first alternate from 24,
24 25, 26.

25 MR. GOINGS: Yes, ma'am.

1 THE COURT: And then the next one from 27, 28, 29.

2 MR. GOINGS: Thank you so much.

3 THE CLERK: The plaintiff strikes first, number to the

4 left. Plaintiff strikes?

5 MR. GOINGS: Plaintiff would strike Number 7.

6 THE CLERK: Plaintiff strikes Number 7.

7 MR. DAVIS: The defense strikes Number 5.

8 THE CLERK: Defense strikes Number 5.

9 Plaintiff?

10 MR. GOINGS: Plaintiff strikes Number 3.

11 THE CLERK: The plaintiff strikes Number 3.

12 Defendant?

13 MR. DAVIS: The defense strikes Number 14.

14 THE CLERK: The defense strikes Number 14.

15 Plaintiff?

16 MR. GOINGS: Plaintiff strikes Number 4.

17 THE CLERK: The plaintiff strikes Number 4.

18 Defendant?

19 MR. DAVIS: The defendant strikes Number 15.

20 THE CLERK: Plaintiff?

21 MR. GOINGS: The plaintiff strikes Number 23.

22 Defendant?

23 The plaintiff strikes Number 23. Excuse me.

24 Defendant?

25 MR. DAVIS: The defense strikes Number 18.

1 THE CLERK: Please strike your alternates using the
2 number between 24, 25, and 26. The plaintiff strikes first.
3 MR. GOINGS: 24.
4 THE CLERK: The defendant strikes?
5 MR. DAVIS: Number 26.
6 THE CLERK: The defendant strikes Number 26.
7 The plaintiff strikes? Second alternate using the
8 numbers 27, 28, 29.
9 MR. GOINGS: The plaintiff strikes Number 27.
10 THE CLERK: The plaintiff strikes Number 27.
11 MR. DAVIS: The defense strikes Number 29.
12 THE CLERK: The defense strikes Number 29.
13 Please allow me to review your strikes. For the
14 plaintiff, I have that you strike Number 24 and Number 27; is
15 this correct?
16 I'm sorry. I'm sorry. For the plaintiffs, your strikes
17 are 7, 3, 4, and 23?
18 MR. GOINGS: That is correct.
19 THE COURT: The alternate strikes are 24 and 27; is that
20 correct?
21 MR. GOINGS: That is correct as well.
22 THE CLERK: For the defense -- thank you.
23 For the defense, your strikes are 5, 14, 15, and 18?
24 MR. DAVIS: Yes, ma'am.
25 THE CLERK: For your alternate, you strike 26 and 29; is

1 that correct?

2 MR. DAVIS: Yes, ma'am.

3 THE CLERK: Okay.

4 THE COURT: Any objections to jury selection from the
5 plaintiff?

6 MR. GOINGS: Yes, Your Honor.

7 THE COURT: All right. Well, ladies and gentlemen of
8 the jury, I'm actually -- there are certain matters of law
9 that I need to discuss with the attorneys outside of your
10 presence. I'm actually going to send you back down to the
11 jury assembly room for a few minutes.

12 Don't discuss the case amongst yourselves or with anyone
13 else. Don't attempt to do any research about the case.
14 Everything that you learn about the case must come from
15 within this courtroom.

16 So go down to the jury assembly room. I'll call for you
17 when we're ready for you to come back, but go down there and
18 just pretend like you don't know anything about the case,
19 just the same as you were before you came in here this
20 afternoon. Thank you.

21 (WHEREUPON, the jury panel exited the courtroom at 1:53
22 p.m.)

23 THE COURT: All right. Mr. Goings?

24 MR. GOINGS: Thank you, Your Honor. May it please the
25 Court.

1 Your Honor, we had a sidebar, and we made a motion to
2 strike for cause any juror or potential juror with employment
3 at Prisma or their spouse having an employment with --
4 employment with Prisma. Your Honor, I know you've not heard
5 the evidence in this case. You've not even heard the
6 defendant's motions *in limine* and our arguments against
7 those, but you're going to see that Prisma has a huge bearing
8 in this case. Okay?

9 Prisma employees were sued in this case and settled.
10 Prisma Hospital was sued, and they settled in this case. The
11 doctor was operating as a physician surgeon on behalf of
12 Prisma. Now, he has a private practice at Midlands, but he
13 was operating on behalf of Prisma there.

14 Your Honor, the medical records deal with Prisma. This
15 issue -- this case deals with medical records at Prisma being
16 wrong and incorrect. It deals with nurses and CNRA -- CNRAs
17 doing things wrong. There was a lot of mistakes in the
18 surgery suite, not only by Dr. Holbrook, but by Prisma
19 employees.

20 And to have a -- a juror whose wife is employed by
21 Prisma or a husband who's employed by Prisma or who they're
22 employed by Prisma is -- is really bad. I know that they can
23 stand up in -- in voir dire and say, Your Honor, I don't -- I
24 think I can be fair and impartial, but they've not heard the
25 evidence.

1 Let me tell you what starts going through jurors' minds.
2 What if Prisma finds out that I'm on this jury? Are they
3 going to have any negative, adverse things to say about my
4 wife as an employee? Could my husband lose his job if I rule
5 against Prisma, essentially, in this case.

6 But -- but now we have two jurors -- actually, I had to
7 -- I had to use three strikes. Three of our preemptive
8 strikes had to be used on -- on -- on -- on Prisma employee
9 jurors.

10 And, Your Honor, I would think it's inappropriate --
11 highly inappropriate for any jurors to have any type of
12 connection. That's why the question is you or any close
13 member of your family. It doesn't get being a closer member
14 of your family than your spouse.

15 But instead, we had to use three of our strikes on
16 Prisma employees and, Your Honor, we strongly say that --
17 that this jury is -- is an improper jury, and it's not a -- a
18 panel or venire that is very impartial by purposes of the
19 fact that -- that Prisma is heavily involved in this case.
20 It's really a de facto defendant still in this case, and --
21 and Prisma is -- is -- is involved, and that's our position.

22 THE COURT: Yes, sir?

23 MR. DAVIS: Thank you, Your Honor.

24 First of all, Prisma is not a defendant in this lawsuit,
25 and by the rules of civil procedure, they're not allowed to

1 even know they ever were. There is nobody on this side of
2 the case that's ever going to criticize anybody that's
3 actually employed by Prisma in this entire case. That's --
4 that's not what we're ever planning on doing. Never were,
5 never will, and we're not -- that's not going to be an issue.

6 Secondly, Dr. Holbrook was not an employee of Prisma.
7 He was operating in Prisma as an employee of Midlands
8 Orthopedics, not Prisma. Just because a cat's born in a
9 garage doesn't make him a car. Just because he's operating
10 at Prisma doesn't make him a Prisma employee, and so I think
11 that reasoning just falls short.

12 I would object to counsel's argument and speculation
13 about what a jury might think or what he might or she might
14 feel as a -- as an employee of Prisma when Prisma is never
15 going to be accused of doing anything wrong in this case.
16 It's creative lawyering at best, and I certainly would
17 object. That's not relevant in this case. It cannot -- it
18 cannot be admitted.

19 In fact, in their motion *in limine*, one of them that I
20 agreed to was to the effect that we can't talk about the fact
21 that Prisma and Prisma employees were ever sued in this case
22 or were ever accused of anything wrong. I totally agree with
23 that. I don't think that would be proper -- it would be
24 improper and probably grounds for mistrial if they got into
25 that. I'm certainly not going to.

1 So I don't think -- and another thing, Your Honor, the
2 thing that -- that always troubles me with -- with these type
3 of motions at this point in the trial, this Court put these
4 jurors under oath to tell the truth. They all took an oath
5 before you. We all witnessed that. Nobody hesitated.

6 And to now call into question some motives and that,
7 well, maybe they weren't really telling the truth because of
8 some kind of imagined peer pressure is -- is just -- just
9 speculation and not founded in fact. So I object to his
10 characterization.

11 THE COURT: Yes, sir?

12 MR. GOINGS: Your Honor, opposing counsel stated we
13 don't plan to imply or point any fingers at any employee of
14 Prisma. Well, we know that cannot be true because there has
15 been one trial deposition taken in this case, and it is of
16 one of the plaintiff's experts, Dr. Fred Jones, who is from
17 Memphis, Tennessee.

18 The entire for-trial cross-examination of this doctor
19 was pointing the finger at a gentleman named Erich Starn, who
20 is a CRNA employed by Prisma. Okay? That is the whole
21 defense to this doctor is pointing the finger at, well,
22 shouldn't it be Erich Starn's fault, and Erich Starn is as a
23 Prisma employee. Okay? So to say now that we don't imply --
24 we won't imply or point any fingers at Prisma, that's what --
25 that's what they've done.

1 And so, in fact, you know, in essence, we have jurors
2 that had to be stricken preemptively by -- on us because of
3 this -- this whole Prisma issue. There should have never
4 been a Prisma-related juror to be even considered.

5 And for now for him to say that we're not going to do
6 that at trial, well, that can't be true, because we already
7 have one deposition for trial in the can, and that's exactly
8 what they did. And I can pull it out and show it to you if
9 you want to -- if you want to see it now, Your Honor.

10 THE COURT: What I would like is some legal authority to
11 support your position that no Prisma employee should be in
12 the jury panel.

13 MR. GOINGS: Well, I don't think there's a case that
14 says no Prisma employee should be on the jury panel, but
15 there is cases that say that -- that a juror needs to be fair
16 and impartial, and that's why you ask questions, do you or
17 any member of the jury -- do you or any -- any of your family
18 members are employed by Prisma? Okay? And Prisma is
19 involved in this case.

20 You know, you -- if the case was against Michelin and --
21 you know, and a juror said that his wife was employed by
22 Michelin, that juror would be most likely and should be
23 struck for cause. I mean, I've never had a -- I've never had
24 a judge allow a party like this to be able to -- to -- to
25 proceed and be considered as a -- as a juror, Your Honor.

1 And so -- and so -- and Mr. Hinson made a -- made a fine
2 point, and that's kind of what he said to Your Honor in
3 sidebar. We can see, like, aunts and uncles and cousins and
4 that sort of thing, but there's no closer family relationship
5 than a spouse, especially the economic version of it in the
6 sense that my spouse has to work. I don't want me ruling
7 against Prisma in this case or me finding fault or having to
8 find fault against a Prisma employee or Dr. Holbrook to be
9 found at fault, that that could potentially jeopardize our
10 family economically, and that's essentially what we have
11 here, Your Honor.

12 I'm not trying to re-argue our position anymore, and I
13 do respect your ruling, but I think you're going to see when
14 you hear the evidence in this case going forward, it will be
15 more clear of Prisma's role in this, and that's what we were
16 trying to explain to Your Honor at sidebar. So -- but I do
17 respect your opinion and your ruling.

18 THE COURT: All right. South Carolina Code 14-7-1020
19 provides that the Court shall on motion of either party
20 examine on oath any person who is called as a juror to know
21 whether he is related to either party, has any interest in
22 the cause, has expressed or formed any opinion, or is
23 sensitive of any bias or prejudice therein. If it appears to
24 the Court that the juror is not indifferent in the cause, he
25 must be placed aside as to the trial of that cause.

1 So what I'm getting at is how -- how is it to appear to
2 this Court that because these people are related to someone
3 who works at Prisma that they cannot be indifferent as to Dr.
4 Holbrook's -- Holbrook's liability?

5 MR. GOINGS: Well, you're not in -- the rule says
6 indifferent. You're not indifferent when it deals with one's
7 household income. You're not indifferent if it deals with
8 someone's household income when a part of the household is
9 employed by, in this case, Prisma. I mean, when they -- they
10 don't know the facts or the evidence in this case yet. And
11 respectfully, the Court doesn't because we haven't presented
12 anything, but -- but it's going to be clear, I think, to Your
13 Honor what we're talking about.

14 That you're -- the household income -- one's household
15 income, you're not indifferent to that if your spouse is
16 employed by Prisma and you're sitting on a jury that deals
17 with issues of professional negligence and liability of your
18 spouse's employer.

19 THE COURT: So what I understand the case to be dealing
20 with is whether Dr. Holbrook met the standard of care in his
21 treatment. That Prisma is not currently a party to this
22 action.

23 To the extent that Dr. Holbrook intends to point the
24 finger at another person, I would hope that that person has
25 been listed as a potential witness in this case, and I've

1 asked the jury about that person. The jury does not know
2 that person if they're on the witness list.

3 They've been given additional background of the case, as
4 much as I can share, that Prisma is all involved in the
5 actions in this case, and they still maintain that they can
6 be fair and impartial. I think it's -- it's taking a bit of
7 a leap, at least a couple additional steps, to determine that
8 some verdict in this case would affect the household income
9 of a potential juror when their spouse, brother-in-law, mom,
10 wife is employed by an entity that is not a party to this
11 action.

12 So I don't know. I mean, your objection in that regard
13 is -- is overruled, Mr. Goings.

14 MR. GOINGS: Thank you, Your Honor.

15 THE COURT: Any additional objections to jury selection
16 from the plaintiffs?

17 MR. GOINGS: No, Your Honor.

18 THE COURT: Any objections from the defense?

19 MR. DAVIS: No, ma'am.

20 THE COURT: Okay. Let's take a 10-minute break, and
21 then we'll bring the panel back up and seat the jury. Thank
22 you.

23 (WHEREUPON, there was a break in the proceedings, after
24 which the proceedings resumed as follows.)

25 THE COURT: All right, folks. I'm not entirely sure

1 what got lost in translation, but somehow between here and
2 the jury assembly room, our jury pool was dismissed for the
3 day. I don't know. I don't know where that came from. I
4 don't know.

5 MR. DAVIS: I didn't do it, Judge.

6 MS. GOODING: I didn't do it either.

7 MR. GOINGS: I didn't do it.

8 THE COURT: So I've already overruled Mr. Goings'
9 objection. We -- so we're going to stick with the pool we
10 have since there were no other objections to jury selection.

11 So the clerk's office will get those 14 people on the
12 phone and tell them to be back tomorrow morning at 9:30.
13 They will be seated and sworn then, and we will start the
14 trial.

15 So since they were dismissed, let's just go ahead to the
16 defense motions *in limine*.

17 MR. HEITMAN: Yes, Your Honor.

18 THE COURT: And we'll all move on from there.

19 MR. HEITMAN: Andrew Heitman, on behalf of Dr. Holbrook
20 and Midlands Orthopedics and Neurosurgery. Your Honor, we've
21 got five parts to our motion in *limine*.

22 But the first part is that lay witnesses should not be
23 allowed to offer test -- expert testimony. There's a lot of
24 specialized medical testimony in this case, Your Honor, and
25 really what we're concerned about is Teresa Adkins in this

1 case. In her deposition, she gave some testimony where she
2 was testifying to the protocols and procedures that
3 anesthesiologists and neurosurgeons should perform if signal
4 is lost.

5 She said that she wished Dr. Holbrook would have did the
6 protocol for negative outcomes for the loss of signals, and
7 she further testified as to the protocol performed by
8 anesthesiologists and surgeons within the surgical suite.
9 Whenever there's a loss of signal, she said, from what she's
10 seen in the O.R. is they'll push steroids and increase blood
11 pressure.

12 Your Honor, Ms. Adkins is a surgical neurophysiologist.
13 She has a bachelor's degree and a -- and a two-week training
14 course. She is not a medical doctor. She does not possess
15 the requisite education or experience or special knowledge or
16 skill or training to -- to give testimony as to what the
17 protocols and procedures are for neurosurgeons and for
18 anesthesiologists.

19 THE COURT: Yes, sir?

20 MR. GOINGS: Yes, Your Honor. May it please the Court.
21 Robert Goings.

22 Your Honor, Teresa Adkins is a surgical
23 neurophysiologist. She's been one for over 20 years. It's
24 just not a two-week course. Okay? She has a bachelor's
25 degree in science and biology. She's been doing this for 20

1 years. She's got extensive training and education.

2 Your Honor, one of the things, a huge part of this case
3 is the fact that while this lady right here, Crystal Goodwin,
4 was in surgery, the neuromonitoring device went off. And a
5 neuromonitoring device is this device that while you're being
6 operated on, there's these sensors that are placed all over
7 your body, and it records motor function and sensory
8 function.

9 The purpose of those -- those nodes on the body is that
10 if the patient loses signal, then the operation -- operative
11 team, including the surgeon, needs to know about it. Okay?
12 Because when it goes off, there's a protocol that everybody
13 in the surgery suite knows needs to be done, because if the
14 signals go out, it says that you -- that you're not having
15 any feeling in your legs or feeling in your arms if it's
16 upper.

17 Well, the signals went out to her lowers, and Dr.
18 Holbrook just kept doing the surgery, even though this
19 neurophysiologist is like, wait, hold on, she has no feeling
20 in her legs. He kept going and doing surgery.

21 She, 20 years' experience, her training and education,
22 knows that there is a protocol for what to do when the
23 signals go out. And she's the one that's in the room
24 monitoring the signals, and the protocol is very simple.
25 Anybody in the surgery suite knows it.

1 The protocol is, number one, check the equipment, see if
2 there's an equipment failure. She checked the equipment, and
3 she said, Doctor, there's not an equipment failure.

4 After that, what's supposed to happen is -- and she said
5 in her deposition, what's supposed to happen is is that you
6 push steroids and increase blood pressure. Why is that?
7 Because that's step two of what to do if your neuromonitoring
8 signals go out.

9 The reason that's important is because if they go out
10 and you follow the right protocol, they come back. If they
11 go out and you don't follow the right protocol, then what
12 happens is you're paralyzed. Crystal Goodwin is paralyzed.

13 And this surgical neuromonitoring physiologist testified
14 about what happened in that room, and she testified that the
15 -- here's the question. Is there a procedure that is
16 supposed to be performed in the surgery suite if the signals
17 go out? Yes, there is. What is that procedure?

18 And she talks about the procedure. The first thing is,
19 is to push steroids and increase blood pressure. Okay? And
20 then she talks about the second thing is is the Stagnara
21 wake-up test, and she describes how the wake-up test is done
22 because it's done in the surgery suite when she says, hey,
23 the alarm is off, there's no -- there's no feeling in the
24 lower legs.

25 So Teresa Adkins, a surgical neurophysiologist,

1 testified as to -- as to the protocol, what happens in the
2 surgery suite when that happens. We're going to -- we're
3 going to -- to -- we -- if we need to -- we'll -- we'll --
4 we'll have her tendered as an expert in the field of
5 neuromonitoring as a surgical neurophysiologist.

6 You know, the defense put her down as one of their
7 experts in the -- in the sense that because she provided
8 health care services to the plaintiff during the surgery
9 because they said anybody who rendered any -- any -- any type
10 of health care services during the operation may be called as
11 a witness in our case.

12 So, as it relates to Teresa Adkins, she can testify as
13 it relates to her training, her education, and her
14 experience, and she can testify as to the protocols that are
15 performed in the surgery suite when the signal goes out.

16 THE COURT: So do you intend to offer her as an expert?

17 MR. GOINGS: I can. I can offer her as an expert in the
18 field of neuromonitoring, because she is the only person that
19 knows how to do neuromonitoring. She's the only one that's
20 going to testify about the signals, the SSEPs, and the MAPs.
21 She's going to testify about what she did when it went out
22 and what wasn't done when it went out and what the protocol
23 is to be followed when it does go out.

24 I mean, she's -- she is in the surgery suite and, you
25 know, she's a fact witness. She's clearly a fact witness,

1 but she can also be a fact witness and a -- and to the extent
2 that she's going to testify as to any of her opinions, she
3 doesn't say her opinion is not that Dr. Holbrook did anything
4 wrong. Okay? She's not talking about the standard of care
5 of Dr. Holbrook. She's talking about the standard of care of
6 what happens when the signal goes out and what is done when
7 the signal goes out from a neuromonitoring standpoint.

8 And like I said, everyone in the surgery suite knows
9 that there's a *[inaudible due to coughing]* in the case.
10 There's an algorithm, a step chart of what to do. Step one,
11 step two, step three, step four when the neuromonitoring goes
12 out. Otherwise, why have neuromonitoring if -- if the signal
13 goes out, everybody just looks around and says, hey, the
14 signal is out?

15 I mean, the purpose of neuromonitoring is to have a
16 baseline, determine when the baseline goes out and, if the
17 baseline goes out, perform the functions that are required to
18 get the signals back so you can ensure that the patient is
19 safe from a neuromonitoring standpoint during the surgery.

20 Now, there's a case, the *Gooding* case, and it's called
21 *Gooding -- Gooding v. Saint Francis Xavier Hospital* from
22 1995. We -- we have -- I had a copy. Let me see if I can
23 find it, Judge.

24 That case stands for the -- in that case, the Court said
25 that an -- an EMT, a paramedic, can testify as to the

1 standard and the protocol to intubate a person. And that was
2 a case -- and here's the case cite, Your Honor, 317 S.C. 320,
3 and that was a case against an anesthesiologist.

4 So in that case, you had a paramedic talking about the
5 standard of care of intubating a patient and how to intubate
6 a patient and when you're supposed to intubate a patient.
7 And -- and the Court said the trial court erred in failing to
8 allow the EMT, the paramedic, to testify about the standard
9 of care for intubation in a case against a medical doctor.

10 So, Your Honor, it's our -- it's our position that
11 Teresa Adkins can testify not only as a fact witness, but to
12 the extent that we need to qualify her as an expert, she can
13 talk about neuromonitoring and the procedures and the
14 protocol to be performed in the surgery suite if -- if the --
15 if the neuromonitoring goes out because you've got to
16 understand, when the alarms go off in the surgery suite,
17 there's other people in the surgery suite, and some of the
18 testimony in this -- in this case is what other people did,
19 their interactions in the surgery suite, knowing that Dr.
20 Holbrook decided to keep on doing the surgery while this lady
21 laid there knowing to have zero function to her lower
22 extremities, and that's evidence in this case.

23 MR. HEITMAN: Your Honor, in the case that Mr. Goings is
24 referring to, paramedics are allowed to intubate patients all
25 the time. Neuromonitoring technicians don't perform these

1 protocols and procedures. They don't have any training for
2 it. She would just be testifying as to what she sees in the
3 court -- or in the surgical suite, and that's not coming from
4 her own skill, experience, or training.

5 She says -- she testified at deposition she has a two-
6 week training course and a bachelor's degree to be able to do
7 this neuromonitoring, and she's not even the one reading the
8 neuromonitoring signals. She's communicating with a
9 neurologist, who's actually the one interpreting these
10 signals and tells her she needs to notify the surgeon of
11 something.

12 THE COURT: I mean, I agree that, generally speaking,
13 the testimony of lay witnesses does not include expert
14 testimony. If what she intends to testify to is to educate
15 the jury based on her knowledge, training, and experience,
16 that sounds a lot like expert testimony, but if she's not
17 offered as an expert witness, she can't give expert
18 testimony.

19 If she's tendered as an expert, then, you know, I don't
20 know what field of expertise it would be. There's certainly
21 -- it would certainly be appropriate to conduct a voir dire,
22 to object to the admission of Ms. Adkins as an expert
23 witness, if appropriate, and I just sort of have to see how
24 the testimony comes about in order to rule on that.

25 MR. HEITMAN: Your Honor, we would -- we would ask, too,

1 that if she is identified as an expert witness, that it be
2 limited to the field of neuromonitoring.

3 THE COURT: I mean, I have to know what her education,
4 training, and experience is --

5 MR. HEITMAN: Yes, Your Honor.

6 THE COURT: -- before I can make that determination.

7 MR. HEITMAN: Yes, Your Honor.

8 THE COURT: Okay.

9 MR. HEITMAN: The second part of our motion *in limine*
10 deals with relevant evidence. Mostly we're concerned about
11 Dr. Holbrook's financial status and Midlands Orthopedics and
12 Neurosurgery's financial status coming into play in this
13 case. We don't believe that that is relevant at all until or
14 if the jury finds for punitive damages, Your Honor.

15 And secondly, there's been a lot of questions by
16 plaintiff's counsel to witnesses in this case asking if Dr.
17 Holbrook's hands shake. There's been no evidence in this
18 case that show that his hands shake, and we believe that any
19 questioning or commenting to that effect would be prejudicial
20 to Dr. Holbrook.

21 THE COURT: Ms. Gooding?

22 MS. GOODING: Thank you, Your Honor. May it please the
23 Court.

24 With regard to the financial information, Your Honor, we
25 have, as I mentioned earlier, alleged punitive damages in

1 this case. It's in paragraph 39 of our summons and complaint
2 and, certainly, the defendant's ability to pay is one of the
3 factors that a jury properly considers with regard to
4 punitive damages, and the Supreme Court has upheld that the
5 use of a defendant's net worth is a proper guide in
6 determining the ability to pay.

7 I understand the motion is a little bit confusing to say
8 -- it seems to say that we're not allowed to bring that up
9 until the jury finds that there should be punitive damages,
10 but as far as I'm aware, there's not been a motion to
11 bifurcate. And so until there's a motion to bifurcate, we
12 have to get all of our evidence in at one time in order for
13 the jury to be able to do that.

14 So we -- we would object to us being precluded from
15 getting in all the elements of punitive damages unless the --
16 the trial is bifurcated.

17 MR. HEIMAN: Your Honor, we'd like to make a motion to
18 bifurcate.

19 THE COURT: I figured that, Mr. Heitman.

20 MS. GOODING: I thought that might happen, Your Honor,
21 and in that case, Your Honor, I would move that the -- the
22 matter that you addressed earlier with regard to the
23 defendant not being allowed to apologize also be withheld
24 until the second half of the trial, because that really is
25 only relevant to the punitive damages claim.

1 MR. HEITMAN: No, it's not.

2 THE COURT: I heard, no, it's not, but let me have a
3 legal argument direct to the Court.

4 MR. HEITMAN: Your Honor, as far as the issue of -- of
5 apologizing, you know, that -- not -- not allowing us to --
6 to talk about that, I think Your Honor has already ruled on
7 that issue, and we don't believe that it goes to punitive
8 damages at all. That just goes to Dr. Holbrook as being a
9 human. So...

10 MS. GOODING: Just to say that his feelings about the
11 matter are not probative as to the merits of whether he
12 reached the standard of care, they might be probative as to
13 some of the elements that should properly be considered for
14 punitive damages, but not as to the breach of the standard of
15 care, which will be what is being decided in the first phase
16 in this case.

17 And so under 403, because it does elicit feelings of
18 sympathy and whatnot, then the potential for prejudice and
19 for the jury making a decision based on improper
20 considerations is substantially outweighed by the lack of
21 probative evidence or substantially outweighs. Excuse me.

22 THE COURT: And what does the plaintiff say about
23 bifurcation?

24 MS. GOODING: No objection to the bifurcation, Your
25 Honor. My understanding is that we can't say much about that

1 anyway.

2 THE COURT: All right. So the trial will be bifurcated.

3 MS. GOODING: So we know it's bifurcated.

4 THE COURT: Right. I'm glad you're aware. So --
5 right. We'll bifurcate the issue of punitive damages.

6 As to the apology by Dr. Holbrook, it's not particularly
7 relevant, and rarely do I have a motion about this. My
8 ruling really was, in large respect, tied to the punitive
9 damages issue.

10 I think as a small aside, it is not offensive. It is
11 not unduly prejudicial. It -- it makes the human a human in
12 the same way as you ask your client to -- to introduce
13 herself and how many kids and how many -- where are you from
14 and where did you go to high school? Where she went to high
15 school is not relevant to any fact that is at issue in the
16 determination of the case. So as a small aside, I think it's
17 permissible in the same way.

18 We're not going to get bogged down on whether he
19 apologized, what words he used, and that sort of thing. So I
20 guess I'm granting the motion to exclude or to prohibit any
21 mention of an apology except in some small fashion.

22 I know that's a very, very muddy ruling. I'm well
23 aware, but seriously, we don't need to get bogged down into
24 that. How many times did you apologize? What exactly did
25 you say? Was it really hurting your soul that you did -- I

1 mean, that's not the issue in the case.

2 But the same as a person who is in the military would
3 sit up there and say, yes, I have served our country for 28
4 years in the United States Army, you know, those are -- those
5 humanize the person.

6 MR. DAVIS: Yeah. Judge, if I may just respond briefly
7 --

8 THE COURT: Perfect.

9 MR. DAVIS: -- to your sentiments, and I appreciate what
10 you said.

11 You know, I don't -- I don't know that there's any plan
12 that Dr. Holbrook is going to take the stand at any point in
13 time and say, I am so sorry, but for him not to make some
14 comment very subtly that it's -- it's a real unfortunate
15 injury, I mean, that's as far as I think we're ever, ever
16 planning on going. We're not going to make this a flag-
17 waving event.

18 THE COURT: Right.

19 MR. DAVIS: So, you know.

20 MS. GOODING: And, Your Honor, we don't have any problem
21 with that. Our mission is really more focused on preventing
22 counsel from in opening or closing getting up and saying we
23 are just so sorry to hear that this happened and that being a
24 focus of kind of the argument and the way that it's presented
25 to the jury.

1 THE COURT: Is that it? Do you anticipate doing that?

2 MR. HEITMAN: No, Your Honor.

3 MR. DAVIS: No, we don't, but I surely would
4 respectfully contend in closing argument, depending on how
5 the evidence goes, that I can address the issue of sympathy
6 and in saying that, address the jury, you know, reasonably.
7 It's not a big deal, but -- but just to tell them, like,
8 we're all going to have sympathy as human beings for people
9 that are injured.

10 And that's not the issue in this case. We're not
11 contesting that. You'll have it. We hope you have it. You
12 should have it, but you can't -- the judge is going to tell
13 you you can't make your decision based on that. It should be
14 based on the evidence, and that's -- that's what I tell them.

15 MS. GOODING: That's not a problem.

16 MR. DAVIS: Okay.

17 THE COURT: And I don't think that's an objectionable
18 argument either.

19 MS. GOODING: Okay.

20 THE COURT: Okay.

21 MS. GOODING: So to respond to the shaking hands, that
22 was just an observation that one of our witnesses made of Dr.
23 Holbrook after the surgery, that she felt that his hands were
24 shaking, and that she might -- may testify to that just
25 because she's going to testify to everything that she

1 observed just, you know, regarding, you know, his state after
2 the surgery and that that was her observation, and I don't
3 think there's any reason to exclude that.

4 THE COURT: I don't believe so, either. That portion of
5 the motion is denied.

6 MR. HEITMAN: Thank you, Your Honor.

7 Part three of our motion is that there shouldn't be any
8 evidence of settlement on behalf of Erich Starn and Jennifer
9 Root for Prisma Health, pursuant to Rule 408. The note to
10 Rule 408 states, it's generally the rule of South Carolina
11 that evidence relating to settlements is not admissible to
12 prove -- admissible to prove liability, and the cite is
13 *Hunter v. Hyder* about that.

14 THE COURT: Any objection?

15 MR. HINSON: Absolutely, Your Honor, and I don't want to
16 belabor some of the -- well, I think some of the factual
17 history is necessary.

18 This suit began with Prisma Health as a defendant, Dr.
19 Jennifer Root as a defendant, and then later Erich Starn,
20 who's a CRNA, a nurse anesthetist, was a defendant. The
21 allegations against Erich Starn, the anesthesiologist, and
22 Dr. Jennifer Root were that they had improperly managed and
23 created an improper anesthesia plan for Ms. Goodwin on this
24 surgery that took place in 2016.

25 Your Honor, they were deposed in the course of this

1 case. At the time they were deposed, they were defendants.
2 At the time they were deposed, they absolutely had a bias to
3 say -- a reason to say there was nothing wrong with this
4 anesthesia plan, there was nothing wrong with the blood
5 pressures that were kept during this surgery.

6 Now, what opposing counsel doesn't mention from Rule 408
7 is the way Rule 408 ends is this rule does not require the
8 exclusion of evidence when the evidence is offered for
9 another purpose, such as proving bias or prejudice of a
10 witness. Your Honor, Rule 408 has this in mind.

11 We are not seeking to introduce that Dr. Holbrook or
12 Midlands has made some sort of offer to settle the case, but
13 the jury has to be informed that at the time Jennifer Root
14 and Erich Starn locked in their testimony under oath, they
15 absolutely had a prejudice and a reason to say there wasn't
16 anything wrong with this blood pressure, and Rule 408
17 contemplates that.

18 We're not asking for the jury to be heard -- to be told
19 how much Prisma paid, how much Jennifer Root and her
20 anesthesia group paid, but normally this rule is for the
21 plaintiff's benefit. The plaintiff doesn't want the jury to
22 think that she's already been compensated. That's a lot of
23 times what this rule is designed -- we don't want the jury
24 thinking, oh, gosh, well, there was already a defendant.
25 She's already been paid.

1 Well, we're kind of caught between a rock and a hard
2 place here. I mean, we recognize that's a risk that the jury
3 may think my client's already been fairly compensated, but
4 they've got to be able to hear that the -- that there's a --
5 there's a reason that Dr. Root and Erich Starn might be
6 testifying the way they are, and so we just think it's
7 important for them to hear that at the time they were
8 deposed, they were defendants in this action, and Rule 408
9 absolutely contemplates that.

10 MR. HEITMAN: Your Honor, even if Rule 408 doesn't
11 support our position, which we believe it does, it's still a
12 Rule 403 violation because it would be undue -- undue and
13 prejudicial to Dr. Holbrook to tell the jury, hey, these
14 people were named, and they all -- they all did the right
15 thing and settled. There must be some kind of liability
16 here.

17 The jury -- you know, jurors talk about that back in the
18 -- back in the room. They get together and they discuss,
19 hey, these parties settled. I wonder why Dr. Holbrook didn't
20 settle.

21 MR. HINSON: Your Honor, you've asked several times
22 about case law. There's a case in South Carolina on point on
23 this issue we cited in our brief that was filed this morning.
24 It's *Poston v. Barnes*. It's a Supreme Court case from 1987,
25 and in *Poston v. Barnes*, Poston was in a van owned by the

1 school district in Florence, and Barnes caused a wreck or
2 allegedly caused a wreck. Poston then sued both Barnes and
3 the school district.

4 And during the course of the litigation, Poston and
5 Barnes ended -- entered into a covenant not to execute.
6 Essentially, they settled their claims, and at trial Poston
7 wanted to enter evidence that Barnes had been a defendant,
8 had settled the claims, and our Supreme Court said it was
9 error not to allow that evidence into -- in front of the
10 jury. The Supreme Court stated the jury was denied
11 information to which it was entitled as to the resources of
12 remuneration available to the plaintiff and by whom such
13 remuneration be paid.

14 And I should begin here. The fact that the agreement
15 was not disclosed to the jury in this instance facilitates
16 inequity and injustice in the judicial process. Openness and
17 fairness of trials are essential to preserving the
18 effectiveness of our judicial system. And then it ends, we
19 conclude that appellant's motion seeking introduction of the
20 agreement into evidence should have been granted.

21 Again, Your Honor, we are not asking for them to know
22 the amounts, we're not asking them to know the dates, but it
23 is crucial that the jury understand the bias these two
24 witnesses had when they gave their testimony in this case.
25 And I have a copy of *Poston v. Barnes* if you'd like to see a

1 hard copy, Your Honor.

2 THE COURT: I'm looking at it right now, but it has to
3 do with a settlement device which does not fully release a
4 defendant while purporting to do so --

5 MR. HINSON: Well --

6 THE COURT: -- being subject to disclosure to the jury.

7 MR. HINSON: Your Honor, that is part of the case. And
8 what the Supreme Court is saying in that case is we don't
9 care whether you called it a covenant not to execute or a
10 covenant not to sue.

11 But then what they ultimately conclude is the reason the
12 name of the instrument doesn't matter is because it still
13 creates the same bias, and that's why it was relevant. So
14 you could call it a covenant not to execute, a covenant not
15 to sue, a covenant not to come take your house, whatever you
16 want to call it, but it went to show the reason that a party
17 would testify the way they would.

18 And the reason Erich Starn and Jennifer Root would say
19 there's nothing wrong with these blood pressures, that's
20 because they were in charge of them at the time, or at least
21 partially in charge of them. There was a reason they would
22 say that. They couldn't take -- take -- come to deposition
23 and say, well, you're right, Mr. Hinson. These are some bad
24 blood pressures for this lady. They couldn't say that.
25 Monty Todd would have strangled Erich Starn across the table.

1 I won't say that part. Your Honor, we won't ask about
2 that.

3 THE COURT: Yes, sir, Mr. Heitman?

4 MR. HEITMAN: Thank you, Your Honor.

5 If plaintiffs' argument is to show the bias of -- of
6 these witnesses because they were parties when they were
7 deposed, well, they're no longer parties to this case now.
8 So their testimony on the stand should not be biased,
9 according to their logic.

10 MR. HINSON: Well, Your Honor, the --

11 THE COURT: How do you intend to use the -- is it
12 previous deposition testimony or you just want to talk about
13 settlements in general?

14 MR. HINSON: Well, Your Honor, I think I would ask it
15 something like this. I mean, I -- you kind of caught me on
16 the spot here, but, Mr. Starn, earlier you testified that you
17 didn't believe anything was wrong with these blood pressures.
18 At the time you first gave that testimony, you were a
19 defendant in this case being sued for keeping the blood
20 pressures at improper level; isn't that correct? You were
21 being accused. At the time you first testified to that fact,
22 you were being -- there was a lawsuit, a civil lawsuit
23 against you, alleging that you had made an error in how you
24 kept these blood pressures.

25 THE COURT: So you want to ask the witness about some

1 prior consistent statements?

2 MR. HINSON: Well, I guess it depends on their
3 testimony, Your Honor, but I think it's important for the
4 jury to understand they had a reason, I guess. I mean,
5 again, you kind of caught me on the spot with how I would
6 exactly ask that question, but it goes to show their bias.

7 And again, I think the *Poston v. Barnes* case, while it
8 does talk at the beginning of that section about covenant not
9 to execute versus covenant not to sue, the reason is the
10 exact same. And again, I mean, if this wasn't the type of
11 thing that could come into evidence, what is that last
12 sentence of Rule 408 about?

13 This rule does not require exclusion when the evidence
14 is offered for another purpose, such as proving bias or
15 prejudice of a witness. This is not an -- Rule 408 is not an
16 absolute bar of prior settlements.

17 THE COURT: Well, it's not. I'm just trying to
18 determine whether it's appropriate here.

19 And I guess you don't know what question you're going to
20 ask, and I don't know. I can't envision how it's coming up
21 other than asking about a prior consistent statement, which
22 --

23 MR. HINSON: But I guess the point is, Your Honor,
24 they've locked it. They have presumably locked in their
25 testimony. And at the time they locked in their testimony,

1 assuming they don't want to impeach themselves or perjure
2 themselves -- assuming they don't want to perjure themselves,
3 at the first -- the time they first testified, they had a
4 reason to testify the way that they did.

5 THE COURT: Yeah. I just can't envision an appropriate
6 use of deposition testimony in a trial when the witness sits
7 here and says the same thing they said in the deposition.

8 MR. HINSON: Well, maybe -- and maybe the example I gave
9 of how it would be asked maybe could simply be, Mr. Starn,
10 you were sued in this case under allegations that you didn't
11 keep these blood pressures appropriately, weren't you? You
12 have been -- you were sued under a claim that these blood
13 pressures weren't appropriate, weren't you? And -- and, Your
14 Honor, that -- that explains the prejudice for why he's
15 coming into this -- to this courtroom and saying they -- they
16 weren't.

17 And I think you can do -- I believe we can craft that in
18 a way that doesn't say you gave a deposition before, didn't
19 you, without having -- the question can be crafted in a way
20 in saying you were sued, the allegations against you were
21 that you didn't create -- that you, as part of this team,
22 didn't maintain the blood pressures appropriately, and is
23 that -- that -- that would -- that would suffice to show the
24 bias that's there.

25 THE COURT: Sure. And that's not a 408 issue at all

1 because we hadn't talked about a settlement or resolution.

2 MR. HINSON: We don't have to say there was a
3 settlement, but we should be able to show that they were
4 prior parties.

5 MR. HEITMAN: Your Honor, to show that they were prior
6 parties is basically presuming they have settled, and I'll
7 say for the record, Erich Starn was not named in this case at
8 the time he gave his deposition. I know that plaintiffs'
9 counsel was using that as an example, but I just want the
10 record to be clear on that. We believe it's still -- you
11 know, Rule 408 and Rule 403 apply in this case.

12 THE COURT: 408 doesn't apply if he's not talking about
13 a settlement.

14 403, I can't find -- I don't have a 403 issue, as it is
15 stated to me now. It's -- if there's a different question or
16 it's posed in some other way during the course of the trial,
17 perhaps there would be an issue there, but, you know, I know
18 that lawyers get tunnel vision, but the jury doesn't know.
19 Just because a person was sued for something, they don't know
20 whether that means they paid money or the case could have
21 been dismissed on a motion to dismiss.

22 The fact that someone is sued means nothing. In fact,
23 you'll ask me to instruct the jury the fact that a person is
24 sued doesn't mean that they're liable for anything. And
25 certainly in a criminal case, you know, I'll charge the jury

1 that an arrest, indictment, etc., etc., is not evidence of
2 anything.

3 I mean, you know, I think it's innocuous. So that
4 motion is denied.

5 MR. HEITMAN: And, Your Honor, my -- my motion was that
6 no -- no mention of settlement should be --

7 THE COURT: Oh, sure. He says he's not going to mention
8 settlement. So...

9 MR. HEITMAN: Okay.

10 MR. HINSON: Your Honor? To be clear, Your Honor, we
11 want to be able to mention you had -- you were previously
12 sued in this case, and the allegations against you were X.
13 We don't intend to, at least at this point. If we do, we'll
14 bring it back up and address it with the Court if somehow we
15 think the door has been opened.

16 But at this point, the questions will be limited in such
17 a fashion. You were previously a defendant, the allegations
18 against you were X?

19 THE COURT: Yes, sir.

20 Next?

21 MR. HEITMAN: Your Honor, for part 4 of our motion, we
22 would ask that certain parts of the 30(b)(6) testimony
23 provided by Dr. Holbrook would be excluded in this case.
24 The 30(b)(6) notice, the topics that were provided to us,
25 during the deposition the plaintiffs' counsel went off of

1 those topics.

2 And while there -- while there is not a lot of
3 substantive case law on this, we did find a Fourth Circuit
4 opinion that states -- this is *Paparelli v. Prudential*
5 *Insurance Company*, 108 F.R.D. 727.

6 It states, accordingly, I rule that if a party opts to
7 employ the procedures of Rule 30(b)(6) to depose the
8 representative of a corporation, that party must confine the
9 examination to the matters stated within reasonable
10 particularity which are contained in the notice of
11 deposition.

12 So, Your Honor -- Your Honor, we would -- we submitted
13 the excerpts that we -- or the -- I guess the line numbers
14 where we've objected to that we believe is outside the scope
15 of the -- of the 30(b)(6) deposition, and -- and you should
16 have those lines.

17 THE COURT: Again, I don't know why we're talking about
18 deposition testimony when we have a live witness, other than
19 to use the deposition transcript for impeachment purposes,
20 and if it's being used for impeachment purposes, I -- I don't
21 really know that it matters so much what the topic was. The
22 idea there is that you've given one answer under oath and a
23 different answer in the courtroom. Why are we talking about
24 depositions when you've got the witness here?

25 MR. GOINGS: Well, Your Honor, this is a 30(b)(6)

1 deposition of a party and, under the rules, deposition of a
2 party can be used for any reason, not just solely for
3 impeachment. So I can actually play the 30(b)(6) deposition,
4 because that's the deposition of a party. So I can use it in
5 my case in chief as a witness.

6 THE COURT: Well -- and that's what I'm asking. How is
7 this --

8 MR. GOINGS: So --

9 THE COURT: -- going to come up?

10 MR. GOINGS: So I don't -- I don't know. They filed
11 this motion *in limine* with three pages of objections before I
12 even sent any deposition designations for the Midlands
13 30(b)(6) deposition. Okay?

14 But then I got this, and then I -- honestly, they've
15 moved to exclude, like, I mean, literally half -- all the
16 deposition basically. I mean, if you -- if you look at all
17 the -- all the page and line numbers, I mean, there's nothing
18 left but my name is Dr. Holbrook and I'm the 30(b)(6)
19 designee.

20 But they did. They did. They did. They did. But
21 here's the thing, Judge. We sent standard topics that you
22 find in almost every 30(b)(6) notice, every one of them. I
23 mean, it's really kind of like your standard interrogatories,
24 but your standard 30(b)(6) notice we sent, and the defendant
25 never filed a motion saying that the topics were not

1 understandable or vague or overly broad or they couldn't find
2 a person to testify. They never contacted us and said,
3 Robert, will you put your -- your -- your topics in a -- in a
4 little more specificity because I don't understand what
5 you're asking for.

6 This is what they did. They said if you want to take
7 the 30(b)(6) deposition of Midlands, we're going to designate
8 Dr. Holbrook because he's going to be the 30(b)(6) designee
9 for Midlands. And I said, well, you know, Dr. Holbrook is
10 retired and doesn't work for Midlands anymore. Are you sure
11 you want to make him your 30(b)(6) designee? Yes. We have
12 the right to name whoever we want as our 30(b)(6)
13 designation, and you've already taken Dr. Holbrook's
14 deposition, so you shouldn't be able to take his deposition
15 again. So we're going to file a motion for a protective
16 order to say you're not allowed to do a 30(b)(6) because the
17 person we've designated is the person that you've already
18 deposited.

19 So they filed that motion saying that we're just not
20 allowed to have a 30(b)(6) deposition, and it goes before a
21 hearing and there's an order that says absolutely -- order
22 from this Court that says, absolutely, we're entitled to do a
23 30(b)(6) deposition.

24 So we took the 30(b)(6) deposition of the designee that
25 they named, which is Dr. Holbrook, and now they're asking for

1 the harsh remedy to essentially exclude all meaningful
2 testimony of -- of Dr. Holbrook as the 30(b)(6) designee.
3 The case law was clear that a 30(b)(6) witness not only
4 testifies as to his or her personal knowledge, but to
5 corporate knowledge.

6 So if the witness has personal knowledge to answer a
7 question, he answers it based on the personal knowledge.
8 This -- the rule also says if he doesn't have personal
9 knowledge, that he's charged with discovering, quote,
10 corporate knowledge, asking people in the company the answers
11 to these specific topics. So whether it's personal knowledge
12 or corporate knowledge, the rule says that whatever comes out
13 of the witness's mouth, though, is binding on the company or
14 the entity, and so that's what we have. And --

15 THE COURT: Hold on. Let's pause, because what I'm not
16 going to do is go through the entire deposition. How about
17 let's get those designations --

18 MR. GOINGS: I did do them.

19 THE COURT: -- and look at the objections to the
20 designations.

21 MR. GOINGS: So -- so -- so after I got this, I then
22 sent him deposition designations. Okay? I didn't hear
23 anything back from the deposition designations. So this
24 weekend, I was reading and listening to the videotaped
25 deposition, and I actually trimmed down the deposition to

1 just 20 minutes. So it's real short.

2 And I gave that to him when I -- and so -- and I trimmed
3 it down. I got my video guy to trim it down. So we have the
4 30(b)(6) deposition that we intend to play down to 20
5 minutes, and we're entitled to play it under the -- under the
6 rules. It's not just for impeachment purposes. It can be
7 made --

8 THE COURT: I know.

9 MR. GOINGS: -- in our case in chief.

10 THE COURT: But there are some objections. So I need to
11 know what your designations are and what their objections to
12 those designations are.

13 MR. GOINGS: Well, their -- the objections to the
14 designations that we've been given, Your Honor, are that it's
15 outside the scope, and this is not outside the scope of the
16 -- the 30(b)(6).

17 THE COURT: Well, I know, but they're asking me to
18 decide that. And for me to decide that, I need to know what
19 we're talking about.

20 MR. DAVIS: Your Honor, just administrative clarity. At
21 11:30 this morning, I was given a revised Rule 32 designation
22 of those depositions. That was 11:30 this morning.

23 I don't know if they apply as to the Court, but Rule 32
24 requires them both by the Court 24 hours prior to them
25 publishing those depositions and then supplying counsel with

1 that. So I assume they gave it to you, I don't know. I got
2 them at 11:30 this morning.

3 THE COURT: That's the first I'm seeing it.

4 MR. DAVIS: Yeah. Okay. Then we'll start it at ten
5 minutes to 5 today.

6 MR. GOINGS: Your Honor?

7 MR. DAVIS: But anyway --

8 MR. GOINGS: I --

9 MR. DAVIS: Let me -- let me finish with mine, Robert.

10 THE COURT: Let him finish.

11 MR. GOINGS: On April 6th, I gave him those, which
12 includes --

13 MR. DAVIS: The first -- the very first designation we
14 got was we're going to -- we're going to publish the entire
15 deposition, both of them, eight hours' worth of testimony.
16 That was --

17 THE COURT: Oh, no. Listen, whether it started as the
18 whole thing or not, whether it's been trimmed down, my point
19 is I'm not going through the whole deposition, even if they
20 initially designated the entire deposition.

21 I -- I am concerned with what is currently in dispute,
22 what they intend to play 24 hours from now that --

23 MR. DAVIS: Right.

24 THE COURT: -- you disagree with, not everything in the
25 deposition.

1 MR. DAVIS: Your Honor, I've not had the time since
2 11:30 this morning to even look at their list, and I plan to
3 do that.

4 THE COURT: Right. Well, I haven't had the time just
5 now, so we'll take this up tomorrow. How about that?

6 MR. GOINGS: That sounds great. Thank you.

7 THE COURT: All right. Let's move on to the next
8 motion.

9 MR. HEITMAN: Judge, the last item on our motion is we
10 wish to exclude any mention of captain or the ship -- of the
11 ship, or Captain of the Ship Doctrine. The South Carolina
12 Supreme Court in *Ellis by Ellis v. Niles*, when referring to
13 the Captain of the Ship Doctrine, stated that it is now
14 largely discredited, but there's not really a whole lot of
15 case law on this I could find.

16 That was about it that mentions captain of the ship, and
17 it just states -- it says that it's largely discredited. So
18 we would ask that no mention of captain of the ship or
19 Captain of the Ship Doctrine be mentioned during the trial.

20 THE COURT: Ms. Gooding?

21 MS. GOODING: Thank you, Your Honor. May it please the
22 Court.

23 I think that we're okay with this one. I just want to
24 clarify. Certainly, we are okay with not using the phrase
25 "captain of the ship" or referring to anyone as a captain,

1 and we are not seeking to hold Dr. Holbrook vicariously
2 liable for anybody else's actions.

3 I do think it's appropriate for us to refer to this
4 being in his O.R., and that he is responsible for certain
5 things by virtue of the fact that he is the surgeon in the
6 O.R., and so we will be asking him questions about what he is
7 responsible for as the surgeon of the O.R., but we will not
8 refer to captain of the ship.

9 And then the second thing that I just wanted to clarify
10 is that we are saying that Midlands is vicariously liable for
11 the actions of Dr. Holbrook, and I don't think that that's
12 their motion, but I just want to be sure that we're clear on
13 that.

14 MR. DAVIS: That is not anything that we're making an
15 issue of.

16 MS. GOODING: Yeah.

17 THE COURT: Yes, sir?

18 MR. HEITMAN: Your Honor -- and their expert, Dr.
19 Lustgarten, makes mention that Dr. Holbrook was the only
20 neuroscientist in the room, so that suggests that he was
21 captain of the ship. And so we wish that any testimony like
22 that be excluded.

23 THE COURT: Okay.

24 MS. GOODING: We won't. We'll ask Dr. Lustgarten to not
25 say who is the captain of the ship. Not a problem, Your

1 Honor.

2 THE COURT: Wonderful. That's worked out. What else
3 before we leave for the day? Yes?

4 MR. GOINGS: To aid in the deposition that you've been
5 given, I have a copy of his deposition, and the portions that
6 are designated are -- the pages are highlighted. So this may
7 make it a lot easier for you if I hand this up to Your Honor.

8 THE COURT: Yes, sir.

9 MR. GOINGS: It's front and back. So if you have, like,
10 a little binder, you can put it on. I don't have one. I can
11 find one, but --

12 THE COURT: No. That's fine. I'll take it just like
13 that.

14 MR. GOINGS: And then the notice, the deposition notice,
15 is Exhibit 1 to the deposition, and it's right here, Your
16 Honor.

17 THE COURT: Perfect. Thank you so much.

18 MR. GOINGS: I can find a little binder back here if you
19 --

20 THE COURT: Not necessary. I've got one. Okay. Thank
21 you though.

22 MR. GOINGS: Thank you, Judge.

23 THE COURT: Anything else from the plaintiff?

24 MR. GOINGS: Nothing, Your Honor.

25 THE COURT: From the defense?

1 MR. HEITMAN: No, Your Honor.
2 THE COURT: See y'all at 9:30 tomorrow morning.
3 MS. GOODING: Thank you, Judge.
4 MR. GOINGS: Thank you.
5 (WHEREUPON, the proceedings adjourned for the day.)
6
7 --- CONTINUED IN VOLUME II ---
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State of South Carolina	)	Court of Common Pleas
	)	Fifth Judicial Circuit
County of Richland	)	Case No. 2019-CP-40-04185
	)	
	)	
	)	
Crystal Goodwin and	)	
James Goodwin,	)	
	)	
Plaintiffs,	)	
	)	
-vs-	)	Transcript of Record
	)	DAY 2 OF 9 - VOLUME II
	)	April 11, 2023
Midlands Orthopedics and	)	
Neurosurgery and Dr. Thomas	)	
J. Holbrook, M.D.,	)	
	)	
Defendants.	)	
	)	

April 10-14 & 17-20, 2023
Columbia, South Carolina

B E F O R E:

The Honorable Jocelyn Newman, Judge; and a jury

Proceedings taken down by:
Elizabeth Harris
Official Circuit Court Reporter

Transcribed by:
Krystal J. Smith
Official Circuit Court Reporter

1 APRIL 11, 2023

2 (WHEREUPON, the proceedings resumed at 9:47 a.m.)

3 THE COURT: All right. Good morning, folks.

4 I've just been handed some defendants' objections to
5 portions of the 30(b)(6) deposition of Midlands Orthopedics
6 and Neurosurgery, that Dr. Holbrook deposition as the
7 30(b)(6) designee that we discussed yesterday.

8 Is this 30(b)(6) deposition going to come up this
9 morning?

10 MR. HINSON: No, Your Honor.

11 THE COURT: Okay. So we can talk about this maybe at
12 lunchtime or over a break?

13 MR. HINSON: Yes, ma'am.

14 THE COURT: Wonderful. All right. Mr. Goings, what --
15 what say you?

16 MR. GOINGS: I was just going to let you know, Your
17 Honor, that we have Exhibits 1 through 16 that we want to
18 mark as admitted, with the exception of 6 and 7, which are
19 two learned treatises that we're going to mark for ID only.

20 And I -- when you walked in, Your Honor, I was with the
21 court reporter getting stickers for them, and I don't know if
22 you want to handle that now or later, but -- and the past
23 medical summary will be an exhibit. Opposing counsel have
24 consented to this document as well. I don't have an exhibit
25 number yet because this will come in later on in the trial.

1 So for what it's worth, I just wanted to put that on the
2 record.

3 There's also a request to admit as to the mean arterial
4 pressure that was recorded by the CNRA during the procedure,
5 and that deals with what the calculations were, because it's
6 a formula, and opposing counsel and I have -- have stipulated
7 to that as well, and we can hand that up and make that a
8 Court exhibit, as well. And -- and just so you know, that
9 was actually an exhibit to Dr. Holbrook's deposition -- Erich
10 Starn's deposition.

11 If we have some more that we've forgotten, we'll let you
12 know, Your Honor, but I just want you to know opposing
13 counsel -- we've worked together to try to streamline this as
14 much as possible for the benefit of everyone.

15 MR. DAVIS: And, yeah, for the record, I -- I do agree
16 that the admission of those documents, except for 6 and 7,
17 we've already discussed that.

18 THE COURT: Okay. Have 1 through 16 been marked or did
19 I interrupt that?

20 MR. GOINGS: The latter.

21 THE COURT: All right. Let's -- let's finish that then.

22 MR. GOINGS: Okay.

23 (WHEREUPON, there was a pause in the proceedings, after
24 which the proceedings resumed as follows.)

25 (WHEREUPON, Plaintiffs' Exhibits Number 1 through 5 and

1 Number 8 through 16 were admitted into evidence.

2 Plaintiffs' Exhibits Number 6 and 7 were marked for
3 identification only.)

4 THE COURT: All right. Is the plaintiff ready for the
5 jury?

6 MR. HINSON: Yes, Your Honor.

7 THE COURT: Is the defense ready?

8 MR. DAVIS: There is one matter that I thought about
9 early this morning that I feel compelled to have to bring up.
10 Yesterday, there was -- with -- with our motions that were
11 discussed back and forth, we talked about captain of the
12 ship.

13 THE COURT: Uh-huh.

14 MR. DAVIS: Ms. Gooding very specifically -- I don't
15 doubt for a minute that she's not going to ask anybody about
16 captain of the ship.

17 Dr. Lustgarten, when he testified in his deposition,
18 testified that, well, Dr. Holbrook is the only neuroscientist
19 in the operating room and, therefore, yada, yada, yada.
20 That's the same thing as saying he's in charge of everything,
21 and I would object to that characterization at trial, because
22 that indirectly implies he's responsible for everything that
23 goes on in the operating room.

24 I'm fine if he's going to say this is a standard of
25 care. This is what a neurosurgeon, in my opinion, is

1 required to do. He didn't do it. That violated the standard
2 of care. That's fine. That's his opinion.

3 But for him to make a gratuitous comment, like he did in
4 his deposition, well, he's the only neuroscientist in the
5 room, and he should have done this, that, and the other about
6 the blood pressure and told the anesthesiologist whatever, I
7 think that's -- that characterization touches on implying
8 that he was the captain of the ship and was responsible for
9 everything that goes on, and he's not.

10 Anyway, that's -- that was my only point, and I would
11 object to that if he proffers that, Your Honor.

12 MR. HINSON: Your Honor -- and first of all, forgive me
13 for kind of standing on the side. With Ms. Gooding back
14 here, it's kind of difficult because I don't want to bang
15 into her legs.

16 Your Honor, it is his operating room. He's in charge of
17 that operating room. Everyone is taking orders from him. If
18 he wants the anesthesia changed, he can direct anesthesia to
19 do those things.

20 The -- the comment that our Supreme Court has had about
21 -- kind of it's probably about the Captain of the Ship
22 Doctrine is -- is situations where, you know, there's a -- a
23 chief of medicine somewhere that has no idea what's going on
24 somewhere else, and they say, well, you know, Doctor So-and-
25 so is chief of medicine for the hospital. It's -- everything

1 that happens under him is his responsibility.

2 That's not what we're talking about here. We're talking
3 about an operating room where Dr. Holbrook is in it. He is
4 in the moment there, and he is the person in charge. I think
5 our expert should be able to say as a neurosurgeon, having
6 been in thousands of surgeries, it's my operating room and
7 everyone's taking direction from me, the neurosurgeon. I
8 don't understand why that needs to be a question that he
9 could give such -- such testimony.

10 THE COURT: So this refers back to defendants' amended
11 motion *in limine* Number .51, page 5 of that document that I
12 thought was resolved by consent yesterday.

13 I do have a note about Dr. Lustgarten, although I didn't
14 fill in that note. I don't know exactly what was said about
15 Dr. Lustgarten, but we did discuss that. To the extent that
16 there's not consent as to this motion now, having heard the
17 arguments of the parties, that captain of the ship motion is
18 denied.

19 I understand that it's not an appropriate legal theory,
20 but as I hear the testimony that is to be presented, I don't
21 think that that's objectionable or inadmissible or
22 inappropriate certainly to argue the legal theory that has
23 been discredited, this theory of liability. You know, that's
24 a separate matter, but I think that as lawyers, we get into
25 the weeds into the legal arguments, certainly, but John Q.

1 Juror doesn't know that this is a captain of the ship legal
2 theory that's been discredited, et cetera, et cetera.

3 For, you know, a surgeon, an expert to say, hey, this is
4 the operating room, and you're in charge of what's going on
5 in the operating room sounds to me like this being my
6 courtroom, even though it's the people's courtroom, but --
7 and -- and being responsible for what happens in this
8 courtroom, and people take direction from me.

9 That doesn't mean that if you punch somebody in the
10 face, Mr. Davis, that I'm liable for that, certainly, but I
11 don't think it's inappropriate -- an inappropriate comment.
12 And so that motion is respectfully denied.

13 MR. DAVIS: Your Honor, respecting your ruling, I just
14 want it noted for the record. I want to be protected on
15 appeal. Thank you.

16 THE COURT: Yes, sir.

17 MR. HEITMAN: Thank you, Your Honor.

18 THE COURT: All right. Anything else before we bring
19 the jury in?

20 MR. HINSON: Nothing from the plaintiffs, Your Honor.

21 THE COURT: From the defense?

22 MR. DAVIS: No, ma'am.

23 THE COURT: All righty. Bring the jury, please.

24 MR. HINSON: Your Honor, we will need to set up -- set
25 up a few things for opening. Would you like us to go ahead

1 and do that right now or -- it'll take just 2 or 3 minutes.
2 So --

3 THE COURT: You can begin that, but if it's going to
4 block my view of the jurors, then let's wait, because I don't
5 know where you're going to put that monitor.

6 MR. HINSON: Yeah, and I'm afraid -- well --

7 THE COURT: So let's just wait just a moment then.

8 MR. HINSON: Thank you, Your Honor.

9 THE COURT: I don't mind my view of the jurors being
10 blocked for some period of time, but not while I'm talking
11 directly to them.

12 MR. HINSON: Our intended setup shouldn't block your
13 view, Your Honor.

14 (WHEREUPON, the jury entered the courtroom at 10:09
15 a.m.)

16 THE COURT: They can sit wherever. We'll fix it --

17 THE BAILIFF: Okay.

18 THE COURT: -- in a moment.

19 You can keep your seats wherever you want to be. We are
20 going to move you around in just a minute, but for now,
21 you're good.

22 (WHEREUPON, there was a pause in the proceedings, after
23 which the proceedings resumed as follows.)

24 THE BAILIFF: The jury is seated, Your Honor.

25 THE COURT: All right. Thank you.

1 Good morning, ladies and gentlemen.

2 They're fine, wherever they are for right now.

3 THE BAILIFF: Okay.

4 THE COURT: Everybody can have a seat. And what we are
5 going to do -- so yesterday -- good morning. Welcome back.

6 Yesterday I sent you downstairs to the jury assembly
7 room. That was supposed to be for a break while we discussed
8 some matters of law in the courtroom, and I understand that
9 someone inappropriately, inadvertently -- I don't know how it
10 happened -- told you to go home, which should not have
11 happened.

12 We were ready to start this trial yesterday afternoon,
13 but now that I have you back, we've only brought back the
14 people who were selected as jurors. I hope that you're the
15 right folks.

16 What I'm going to have Madam Clerk do is call out the
17 names of the jurors to officially seat the jury. Now, for
18 these first twelve people before she gets to the alternates
19 -- we have two alternate jurors, and she'll let you know who
20 the alternates are. But if you're in the first twelve and
21 you are not seated down front, if you're seated on the back
22 row, then I need you to come down and take one of these seats
23 that are in the front here.

24 Madam Clerk?

25 THE CLERK: Jury Number 269, Gabrielle Ross.

1 THE COURT: 269. Okay. Thank you.

2 THE CLERK: Jury Number 349, Karen Withrow.

3 Jury Number 103, Austin Ford.

4 Jury Number 54, Michael Casto.

5 Jury Number 9, Robert Andreo.

6 THE COURT: You can stay right there. Why do you have

7 to move?

8 He could have stayed right where he was.

9 THE CLERK: Jury Number 288, Timothy Shealy.

10 Jury Number 195, Roxann Lewis.

11 THE COURT: You can stay there. You're not on the back

12 back row, unless you want to be closer. That's fine, too.

13 All right.

14 THE CLERK: Jury Number 219, Mike -- Michael Mitchell.

15 Jury Number 68, Stephanie Cribb-Creek.

16 THE COURT: If you'll come forward.

17 THE CLERK: Jury Number 146, Tameka Harvey.

18 THE COURT: If you'll come forward to that seat there.

19 THE CLERK: Jury Number 263, Jaekwon Robinson.

20 Jury Number 171, Charles Jenkins.

21 Alternate number one is Jury Number 140, Brian Harmon.

22 THE COURT: No. Brian Harmon should be on the back row.

23 THE CLERK: And alternate number two is Jury Number 173,

24 Gabriel Johnson.

25 THE COURT: Okay. Perfect. All right. Thank you,

1 Madam Clerk. We've got everyone here.

2 So we are now ready to begin the trial of Crystal
3 Goodwin and James Goodwin versus Midlands Orthopedics and
4 Neurosurgery and Thomas J. Holbrook, Jr., M.D. I'm going to
5 give you some preliminary remarks before you hear from the
6 attorneys, but before I do that, I'm going to have the clerk
7 place you under oath.

8 Madam Clerk?

9 THE CLERK: Please stand and raise your right hand to be
10 sworn. Do you swear or affirm that you shall well and truly
11 try the issues joined in this case and a true verdict give
12 according to the law and the evidence, so help you God?

13 (WHEREUPON, the jurors responded.)

14 THE CLERK: You may be seated.

15 THE COURT: All right, ladies and gentlemen. And
16 actually, before I get into my remarks, I need to ask you all
17 has anyone, any member of this jury or any alternate juror,
18 discussed the case with anyone, done any research about the
19 case, tried to investigate the case or any legal issues or
20 factual issues even overnight? If you have done any of that,
21 raise your hand.

22 (WHEREUPON, there was no response.)

23 THE COURT: Okay. Wonderful.

24 Now, before we begin this trial, I want to tell you that
25 this trial will probably be different from what you might

1 expect. Many people do not have the chance to attend actual
2 court sessions, as you're doing now, and may think from
3 watching television or movies or reading books that trials
4 are always full of intense action, high drama, and riveting
5 circumstances.

6 While all of these things may be true at times, this
7 trial is not for entertainment. It is a fundamental part of
8 our democracy, an effort to make sure that justice is done
9 between the parties before the Court. Making sure that
10 justice is done is often slow, deliberate, and repetitive,
11 the opposite of what you may have seen on television or in
12 movies or read in books.

13 This courtroom is a place of honor dedicated to the
14 protection and preservation of citizens' rights through what
15 many have called the greatest justice system ever created.
16 The attorneys appearing before you are advocates for the
17 parties they represent, but first and foremost, they are
18 officers of the court, sworn to uphold the integrity and
19 fairness of our judicial system and to help you in
20 understanding the evidence. You should expect them to be
21 professional, competent, and ethical in the representation of
22 their clients' interests.

23 Remember that you have just taken an oath to try this
24 case and reach a fair and just verdict. So you are also
25 expected to be professional, reasonable, and ethical. Thank

1 you for accepting the important responsibility of jury
2 service and for your contribution today to our justice
3 system.

4 Now, ladies and gentlemen of the jury, before the case
5 begins, I want to tell you how we will proceed. The first
6 thing that will occur is that the attorney for the plaintiff
7 -- and the plaintiff is the person who has filed this
8 lawsuit. That attorney will make an opening statement, which
9 is followed by a similar statement for the attorney by the --
10 by the attorney for the defendants.

11 These opening statements are not arguments. Those
12 arguments will come at the conclusion of the case. The
13 purpose of the opening statements is for each party to
14 outline their claims and the evidence which they intend to
15 present in support of those claims. Following the opening
16 statements, each side will present its evidence, with the
17 plaintiff once again going first.

18 Evidence may take many forms. It may be testimony of
19 sworn witnesses, documents, models, photographs, or some
20 other object. You should pay close attention to all of the
21 evidence which is presented by each party. You, the jury,
22 are the sole finders of the facts in this case, and no one
23 else will be permitted to weigh the evidence and render a
24 verdict based upon it.

25 After all of the evidence has been presented, the

1 attorneys will make their closing arguments. Unlike the
2 opening statements, the final remarks will be true arguments.
3 That is, each side will emphasize certain portions of the
4 evidence and try to persuade you to agree with their version
5 of the facts.

6 Keep in mind that the opening statements, as well as the
7 closing arguments of the attorneys, do not represent evidence
8 in this case. Give the attorneys your undivided attention
9 but remember that what they say is not evidence.

10 After the arguments are finished, I will explain to you
11 the law which applies to this case. You will then retire to
12 the jury room to consider the facts and the law, and once you
13 have done so, you will return a verdict in favor of one side
14 or the other.

15 Now, during the course of the trial, the plaintiff has
16 the burden of proving -- the plaintiffs in this case have the
17 burden of proving their claims and must meet that burden by
18 proving their claims by the preponderance or greater weight
19 of the evidence. What we mean by the greater weight of the
20 evidence can be illustrated by imagining a traditional set of
21 scales.

22 When the case begins, the scales are evenly balanced.
23 After all of the evidence has been presented, if the scales
24 should remain evenly balanced, or if they should tip even
25 slightly in favor of the defendant, then the plaintiffs have

1 failed to meet their burden of proof, and you will return a
2 verdict for the defendants. If, on the other hand, the
3 scales tip even slightly in favor of the plaintiffs, then the
4 plaintiffs will have met their burden of proof, and you will
5 return a verdict for the plaintiffs.

6 Now, I'd like to make a few additional comments before
7 the case begins. First, as I mentioned earlier, although I
8 am the only person who can tell you what the law is, you are
9 the only ones who can determine the facts. I didn't say that
10 earlier. You are the judges of -- the judges of the facts,
11 but I am the judge of the law. The law as given to you by
12 the Court is the only law you may consider. You must accept
13 it and follow it, even though you may disagree with it. I
14 cannot tell you what I think the facts are, and you cannot
15 disagree with me about what the law is or what the law should
16 be.

17 Your job is to take the law as I give it to you and
18 apply it to the facts as you find them from the testimony of
19 the witnesses and any other evidence that is presented. So,
20 as I said, although I am the only person who can tell you
21 what the law is, you are the only ones who can determine the
22 facts.

23 I do not have the right to indicate how I may feel about
24 any evidence presented, and throughout the trial my intention
25 will be to act as impartially as possible toward each party.

1 So do not think from anything that I say or do that I have
2 any opinion about the facts in this case. The law simply
3 does not allow me to have an opinion about the facts.

4 In addition, from time to time, an attorney will object
5 to some bit of testimony or evidence which the other side is
6 seeking to present. As in sports, business, or any other
7 structured activity, there are certain rules that both sides
8 must obey in presenting evidence. These rules have a
9 definite purpose. They ensure that the information you
10 receive is the most trustworthy and reliable evidence
11 available.

12 An objection is the procedure that's used for an
13 attorney to call a possible violation of the rules to the
14 Court's attention. And for this reason, you should not hold
15 any attorney's objections against their client, nor should
16 you conclude from my ruling on the objection that I favor one
17 side or the other.

18 Finally, I'll ask that you pay close attention to the
19 all -- to all of the evidence that is presented to you. It
20 is you, the jury, who will determine the facts in this case
21 and, as a result, you will have to evaluate the credibility
22 or believability of each witness who testifies in this
23 matter.

24 That means that it's your responsibility to pay close
25 attention to the witnesses, to observe them, to listen to

1 them, and to pay close attention to the attorneys and to the
2 Court. Do not let your thoughts wander, but give close
3 attention to the testimony, so that at the end of the trial,
4 you will be in a position to determine what the true facts
5 are, to apply the law to those facts, and thus render a true
6 and just verdict.

7 Until I advise you to begin your deliberations, you must
8 not discuss the case with anyone, including your fellow
9 jurors, friends, family members, and anyone involved in the
10 case. You may not use a computer, cell phone, or other
11 electronic device with communicating -- communication
12 capabilities at any time while in the courtroom or during
13 deliberations.

14 Now, during breaks for meals or overnight, of course,
15 you may use your cell phones and other devices, but you may
16 not at any time use those devices to get or send information
17 about the case. This includes information about a party, a
18 witness, an attorney, or a court officer, news accounts about
19 the case, research on any topics raised, any topics you may
20 think would be helpful in deciding the case, or any testimony
21 presented by any witness.

22 Please, it is important that you keep an open mind and
23 do not decide any issue in the case until all of the evidence
24 has been presented, the parties have made their closing
25 arguments, and I have instructed you on the law in this case.

1 We are now ready to begin the trial of the case. I will
2 first ask the attorneys if whether they object to anything
3 that I've just told you.

4 Any objections from the plaintiff?

5 MR. HINSON: No objections.

6 THE COURT: From the defense?

7 MR. DAVIS: No, ma'am.

8 THE COURT: All right. I'd ask that you give the
9 attorneys your undivided attention.

10 MR. HINSON: Your Honor, can we just --

11 THE COURT: Okay. Mr. Hinson?

12 MR. HINSON: We probably need two minutes just to set up
13 the courtroom.

14 THE COURT: Yes, sir.

15 (WHEREUPON, there was a pause in the proceedings, after
16 which the proceedings resumed as follows.)

17 MR. DAVIS: Your Honor, can we approach briefly?

18 THE COURT: Sure.

19 (WHEREUPON, a bench conference was held as follows.)

20 MR. DAVIS: We obviously are unable to see the screen.
21 Is it okay if we --

22 THE COURT: Yeah.

23 MR. DAVIS: -- sit in those chairs?

24 THE COURT: Oh, absolutely.

25 MR. DAVIS: Okay.

1 THE COURT: Absolutely.

2 MR. DAVIS: All right. I just want to be sure.

3 THE COURT: Yeah.

4 MR. DAVIS: All right. Thank you.

5 (WHEREUPON, the bench conference ended, and the
6 proceedings resumed as follows.)

7 (WHEREUPON, there was a pause in the proceedings, after
8 which the proceedings resumed as follows.)

9 THE COURT: Yes, sir?

10 MR. HINSON: May it please the Court?

11 THE COURT: Yes, sir.

12 OPENING STATEMENT ON BEHALF OF THE PLAINTIFFS

13 MR. HINSON: Good morning. My name is Brink Hinson, and
14 I have had the and have the privilege and honor to represent
15 Crystal and James Goodwin in this case. An opening statement
16 is the parties' opportunity to tell you a little bit about
17 the evidence you're going to hear this week, but before I get
18 into that, I'd like to ask you three questions.

19 Should doctors treat their patients as individuals? And
20 by that, what I'm asking is, is medicine some sort of one
21 size fits all kind of profession or do doctors have to treat
22 each patient differently according to their age and the
23 medical conditions that they have, any disease processes, any
24 -- any known conditions or expected conditions in their body,
25 or is it just what's good for one person is good for

1 everybody?

2 Question number two. Should doctors respond to medical
3 alarms and red flags? If a doctor gets back a lab value
4 that's way off the chart, should a doctor respond to it? If
5 the doctor is doing a procedure and alarms go off, should a
6 doctor respond to it or is it okay to presume there's some
7 sort of equipment failure? Would it be okay to say, well,
8 this lab value is way off, but I bet the labs got -- I bet
9 there's something wrong at the lab. Or should they
10 investigate it? There's an alarm going off in the operating
11 room. Should we investigate it?

12 And question number three. Should doctors create
13 medical records that are truthful, complete, and accurate?
14 Should doctors create medical records that mention everything
15 important that happened? Should they put the pertinent
16 information in the medical records they create or is it okay
17 for doctors to leave out important things that happened?

18 Now, as you've been told, this is a medical malpractice
19 case, and I don't believe we have any doctors on the jury.
20 I'm not a doctor. None of the attorneys are doctors, and so
21 I'd like to go through just a few terms and concepts that
22 you're going to hear this week and that you're going to hear
23 in opening statement so that we all kind of understand some
24 of these terms, some of these -- some of these ideas.

25 So the first one is hypertension, just a fancy medical

1 word for high blood pressure. Hypertension. High blood
2 pressure. Same thing.

3 The second one. Hypotension. Now, it sounds pretty
4 similar. Hyper and hypo. They mean the exact opposite. So
5 hypotension is low blood pressure.

6 Another term, mean arterial pressure. This is an
7 interesting one, often called MAPs. Now I want to talk about
8 this concept for a second.

9 Our hearts are beating. Thousands of heartbeats since I
10 started -- started talking just a few minutes ago. And when
11 our heart squeezes, that's the systolic blood pressure, and
12 then it relaxes or expands, and that's the diastolic. And
13 our heart spends about one-third of the time squeezed and
14 about two-thirds of the time relaxed. So if you want to
15 figure out someone's average blood pressure, you need to
16 account for the fact that one-third of the time it gets
17 squeezed and two-thirds of the time it's relaxed. So you
18 need to weigh it.

19 So there's going to be some math in this case to figure
20 out mean arterial pressures, but don't worry, we're not going
21 to ask you to do any math. Every time there's a mean
22 arterial pressure to be calculated, the attorneys or the
23 experts on the stand will do that math for you, but I do want
24 to explain where it's coming from. Some of y'all might like
25 math, and for those of you who are interested in how that

1 mean arterial pressure is calculated, let me show you real
2 quick.

3 So you take the systolic. Again, that's the squeeze,
4 one -- one-third of the time. You take the diastolic.
5 That's the two-thirds of the time. And you multiply the
6 diastolic by two to account that it's for more of the time.
7 Add those two numbers together and divide by three.

8 So what this is doing is it's weighting the diastolic.
9 It's giving it more importance in the calculation but still
10 taking into account the systolic. Again, I'm not asking
11 y'all to memorize this formula. Just letting you know where
12 it comes from. Mean arterial pressure.

13 Another concept we're going to talk about throughout
14 this case is vascular remodeling. So we talked about
15 hypertension, and so this is the consequence of long-term or
16 chronic high blood pressure. It's vascular remodeling.

17 So we have arteries in our body. The veins are what's
18 bringing blood back to our heart, but the arteries are what's
19 carrying blood to all of our organs. And arteries have
20 layers. They have an outside layer. They have a -- they
21 have a muscular wall inside. It's multiple layers. In fact,
22 there's a lot more than just three as shown in this picture,
23 but they have a muscular wall.

24 And if there's long-time, long-standing hypertension,
25 the evidence is going to show that what happens is that

1 muscle, just like muscles in your arms or wherever, if
2 there's a lot of pressure on it over time, that muscle will
3 build up. And when that muscle builds up, it's going to
4 actually make what's called the lumen, the inside of the
5 artery, smaller and so less blood can flow through it.

6 And there's another consequence the evidence is going to
7 show of long-time hyper -- this is why -- this is why our
8 doctors don't want us to have high blood pressure. It's
9 fortunate some of us have genetics. Thanks, mom. Thanks,
10 dad. That we can't help it, but the consequence, then, is
11 our arteries aren't able to expand and contract like they
12 need to.

13 As our blood pressure moves up and down during the day,
14 they need to be able to expand and contract to keep blood
15 flowing in a regular pace to our organs, but if we have long-
16 time, long-standing hypertension, the evidence is going to
17 show we lose the ability to do that quite as well. What's
18 going to happen is that artery is going to harden, and it's
19 not as pliable. It's not as able to -- to autoregulate the
20 amount of blood.

21 So another term we're going to hear is perfusion, fancy
22 medical word for volume of blood flow. Perfusion, the
23 volume, the amount of blood getting to something, and all of
24 our organs need perfusion. Some need different amounts of
25 perfusion than others. Kidneys, for instance, need a lot of

1 blood. They're very vascular organs that require a lot of
2 blood.

3 Ischemia. That is, again, fancy medical word for
4 insufficient blood flow to an organ. So if there is
5 ischemia, that means an organ isn't getting enough blood.

6 Infarction, kind of a long word, kind of funny word, and
7 then the kind of nickname for it, an infarct. That is tissue
8 death caused by infarction. So if you have ischemia, it goes
9 on for a while, you can suffer an infarction or an infarct.

10 Another medical term here, osteophyte. All it is, is a
11 bone spur. They're natural. People get them. Some people
12 get a lot of them. Probably all of us have one or two
13 somewhere in our body. They can occur in our hands and our
14 toes, and they can occur in our spines.

15 Thoracic spine. It's a model of the human spinal cord,
16 and it's generally divided into sections. You have the
17 cervical here, which is up here in your neck. You often hear
18 about your lumbar, which is down here towards your lower
19 back. But the big part in the middle here is the thoracic
20 spine, and we're going to talk some -- a lot this week about
21 T8 to T12, and that's -- that's here at the very bottom. So
22 we start at T1 and we go down to T12.

23 And within the thoracic spine there's an area called the
24 watershed region, and what it is is there's -- this is the
25 big artery near the spine, and it's got these smaller

1 arteries coming in to supply blood to our spinal cord. This
2 is a five or six times too big spinal cord, but you see,
3 there's still blood coming into the spinal cord. It needs --
4 it needs perfusion. Your spinal cord -- our spinal cords
5 need perfusion just like any other organ in the body.

6 So this is a vertebrae. This is five or six times too
7 big --four times too big. There's arteries nearby bringing
8 blood to the spinal cord, and so in this area called the
9 watershed, the evidence is going to show us that it actually
10 essentially gets blood last.

11 It's -- it's -- these areas right here are really
12 closely connected to this -- this little artery. It's got a
13 funny name. It's called the artery of Adamkiewicz. I've
14 been practicing saying that word for a while. Adamkiewicz
15 some people call it, the artery of Adamkiewicz.

16 And then there's an intercostal artery coming up. And
17 so this -- this area here in the middle kind of gets a little
18 trickle from the bottom and kind of gets a little trickle
19 from the top. It's not as well perfused in our bodies, for
20 whatever reason, as other areas of our spine. It's the most
21 susceptible if your blood pressure goes low.

22 Another question that I'm going to answer for you right
23 now, why are Midlands Orthopedics and Dr. Holbrook here?
24 Well, the reason they're here begins at Midlands Orthopedics'
25 downtown Columbia office on June 20th, 2016. Dr. Holbrook

1 saw a patient he had seen before. He had seen her for a
2 number of surgeries, including one back in 2009 and one in
3 2011.

4 And this patient comes back to him, and she reports that
5 she has fallen in her bathtub, and she has this numbness and
6 tingling that she's feeling. She's concerned. Dr. Holbrook
7 appropriately does imaging of her spine, and when he does
8 that imaging -- I'm going to put up an animation to kind of
9 help with this. Neuroradiology is pretty tough for -- for
10 us.

11 When he does that imaging, he finds -- and I'll just
12 summarize it -- a number of issues. He finds that there is
13 some scar tissue from his prior surgeries. In these prior
14 surgeries, he removed some of the lamina, which is this
15 little sticky-outy part right here. He removed some of the
16 lamina from two of the vertebrae, and scar tissue had
17 developed and it was kind of pressing on the spine. He also
18 found an osteophyte, one of those bone spurs, pressing on the
19 spinal cord.

20 Now, this patient is 38 years old at the time in 2016,
21 and she's had two prior surgeries in this area of the back.
22 And the evidence is going to show that she has long-standing
23 high blood pressure, and she has diabetic concerns. She's on
24 Metformin. She's been diagnosed as pre-diabetic. There's --
25 there's blood -- there's blood sugar issues going on with her

1 as well.

2 And then the office visits in 2016, June 20th, the
3 patient has a blood pressure of 152 over 12 [sic]. And
4 again, I told you we wouldn't have to do math. That's a mean
5 arterial pressure of 125. The evidence is going to show
6 that's pretty much where she ran. I mean, we all change our
7 blood pressures through the day, depending on a lot of
8 different things, but that was pretty normal for her in 2016.

9 She had an office visit on July 18th. It was a little
10 lower. This was pretty good for her. This is some of the
11 best she had in that time of her life, and they average out
12 to a MAP, a mean arterial pressure, of 111. That's a person
13 -- a patient with a higher than average blood pressure.

14 Dr. Holbrook appropriately decides to do surgery for
15 this patient. You will not hear any evidence in this case
16 that this was an inappropriate surgery, that she wasn't a
17 candidate for the surgery. She was. This is a surgery she
18 needed, absolutely. Totally appropriate.

19 And before the surgery, she goes in for a pre-surgery
20 evaluation at the hospital. She goes in about a week before.
21 It's actually six days before, and her mean arterial pressure
22 then is 156. Excuse me. Her blood pressure is 156 over 92,
23 a mean arterial pressure of 113, about where she ran usually.

24 And the morning of surgery, she goes in, they come in
25 and do an assessment. She's got a mean arterial pressure of

1 119. So her average there at the hospital is a mean arterial
2 pressure of 116. Take all those together, this is a patient
3 with an average mean arterial pressure of 113.5.

4 Now, there's a rule of thumb in anesthesia. The
5 evidence is going to show that the rule of thumb is you keep
6 a patient's blood pressure during surgery within 20 percent
7 of their baseline. So you keep them between their normal and
8 20 percent. That's the general rule of thumb.

9 Of course, like any rule of thumb, there's exceptions.
10 There's times when you might want it differently, but this is
11 the normal patient, keep them within 20 percent of baseline.
12 So for her, that's going to be just a little bit over 90, but
13 this is -- we're all individuals. It's not a one size fits
14 all thing.

15 This is a patient with chronic hypertension, two prior
16 surgeries, and diabetic concerns, and the evidence is going
17 to show for somebody with conditions like that, who has had
18 long-standing chronic hypertension, that has arteries that
19 have undergone this remodeling, that doesn't have the ability
20 to expand and contract, that have hardened, that doesn't have
21 the ability to regulate blood flow, when you're operating in
22 the watershed region, the evidence is going to show that
23 you've got to even bring that up more. You've got to keep
24 that patient during surgery closer to their mean -- their --
25 their baseline mean arterial pressure. It's not a one size

1 fits all proposition. This patient needed to be kept closer
2 to their 113 baseline.

3 So the morning of July 28th, 2016, at Palmetto Health
4 Baptist Hospital, now called Prisma, just down the way, Dr.
5 Holbrook, who's a neurosurgeon with Midlands, comes in to do
6 this back surgery to alleviate that osteophyte and remove
7 some of this scar tissue.

8 The patient comes in, and the evidence is going to show
9 that before a surgeon operates on a patient, there's supposed
10 to be something called a preoperative timeout. This is not a
11 difficult concept. It's the surgeon. It's his operating
12 room. He needs to bring his team together, which includes
13 his anesthesiologist, includes the scrub tech. It includes
14 his CRNA, everybody that's going to be involved in the
15 surgery.

16 And it's a quick conversation, two to three minutes.
17 Here's what we're doing today. Have we got the right
18 patient? Yep. Got the right patient. Understand where
19 we're doing the surgery? Understand where we're doing the
20 surgery.

21 Are there any things that we need to know about? Yes,
22 there are. Well, what is that? This patient has chronic
23 hypertension. This patient has had two surgeries in the same
24 area. This patient has diabetic concerns. And let's keep
25 her blood pressure a little higher during this surgery than

1 we would for other patients.

2 That didn't even take a minute. That's what was owed,
3 and the evidence is going to show that there was no
4 preoperative time out. The conversation I just -- just
5 described that took less than 60 seconds didn't happen.

6 So in the operating room on Thursday, July 28th, 2016,
7 there's something called intraoperative neuromonitoring being
8 used. So the patient who's under anesthesia has these little
9 electrodes all over her body and her head, and they're
10 monitoring the patient's neurologic function. Are they --
11 are they able to -- are they getting signal to their
12 extremities? This is used standard of care in neurosurgeries
13 today. Thank goodness we have this technology.

14 And there's a neuromonitoring technician in the room,
15 and then there's a neuromonitoring physician remotely. He's
16 actually in Memphis, Tennessee, watching all this information
17 come in. They're watching these little signals. You want to
18 see it moving up and down. That means the patient is moving
19 signal from their brain and spinal cord to their arms and
20 legs, and we do this for a reason. The evidence is going to
21 show this is for the patient's safety. We're not doing it
22 just for the heck of it.

23 The evidence is going to show this was the patient's
24 blood pressure during the surgery performed on July 28th,
25 2016. It starts off up here close to their baseline, and it

1 pretty quickly drops below. And he followed the 20 percent
2 rule of thumb. It's actually even below that for a good part
3 of the surgery.

4 And unfortunately, the reason that we keep the blood
5 pressure up happened in this case. It doesn't happen every
6 time, but it's the reason we try to keep it high. The
7 evidence is going to show that at 10 a.m., after this blood
8 pressure had been down below 90 for about half an hour, the
9 neuromonitoring signal to this patient's lower extremities
10 went completely out, meaning there's no signal going between
11 spinal cord and legs. Alarms should be going off.

12 So the neuromonitoring tech, the evidence is going to
13 show, brings that to the attention of Dr. Holbrook. Dr.
14 Holbrook, we have lost SSEPs, which is the signals they're
15 using. They're using MEPs and SSEPs. We have lost SSEPs to
16 the patient's spinal cord.

17 And the neuromonitoring tech in the room has this little
18 chat box, kind of -- kind of like an AOL chat room from back
19 in the day, and she is chatting with that doctor in Memphis,
20 Tennessee, that I mentioned because he's looking at it real
21 time too.

22 And the evidence is going to show -- now, this is -- I
23 just want to make sure to point this out. These times here
24 are in central time because that doctor's over in Memphis,
25 Tennessee. So it can be a little confusing at times.

1 Everything else you're going to see in the case other than
2 this chat box is in East Coast time, but the chat box is in
3 central time because the doc on the other side is in Memphis.

4 At 9:58 -- I'm going to go ahead and turn the time into
5 East Coast time. At 9:58, SSEP stated at 10:02 just lost
6 lower SSEPs. These are your uppers. These are your lowers.
7 At 10:05, surgeon and informed -- surgeon informed and aware.
8 And Dr. Herb Gregg, the doctor in Tennessee, at 10:08 says
9 glad you informed surgeon.

10 So when this occurs, when signal is lost, time is of the
11 essence. Things need to be done. The patient has lost
12 neurologic signal to the legs, and the evidence is going to
13 show that when something like this occurs, you're doing the
14 neuromonitoring for a reason.

15 The first thing you do, check your equipment. Make sure
16 everything's hooked up right.

17 Second thing you do, look for anesthetic changes. Is
18 there anything going on with anesthesia we need to know
19 about? Maybe the blood pressure is too low.

20 The third thing is improve perfusion, meaning get more
21 blood to the organs, particularly get more blood to the
22 spinal cord.

23 Fourth step. If this didn't work and this didn't work,
24 fourth step, reverse the manipulation or widen the
25 decompression, meaning surgical changes. Can we move some

1 tissue out of the way? Is there something that's stopping
2 the blood flow to the spinal cord?

3 And the fifth step, perform what's called a Stagnara or
4 a wake-up test, which is kind of a daunting thing. The
5 patient is on the table under anesthesia, and they lighten
6 the patient just a little bit so that they come to just a
7 little bit and say can you move your legs? Can you feel
8 this? And they keep doing these things with the patient
9 slightly out of anesthesia. Okay. We're going to raise your
10 blood pressure some more. Can you move your legs now?

11 These are the steps that should be done when the
12 neuromonitoring indicates a loss of signal. We're doing this
13 monitoring for a reason, and the evidence is going to show
14 that when neuromonitoring went off, Dr. Holbrook stopped at
15 number one.

16 The evidence is going to show that Dr. Holbrook asked
17 the neuromonitoring technician to check her equipment, which
18 she did. She said there's nothing wrong with my equipment,
19 and he said I think there is. Something must be wrong with
20 your equipment.

21 And he kept going. He did no other steps. The evidence
22 is going to show he didn't even alert the attending
23 anesthesiologist. The attending anesthesiologist isn't
24 always in the room. She's checking on other operating rooms.
25 And the evidence is going to show he didn't go get her,

1 didn't ask somebody to go get her. And when she came into
2 the room sometime later, he didn't even tell her this had
3 occurred.

4 He goes about the surgery, continues removing scar
5 tissue, widening the area with signal out. The patient will
6 wake up in recovery, paralyzed from the waist down.

7 After the surgery, Dr. Holbrook creates an operative
8 report. He creates a record of what happened and what he
9 did. That surgeon is -- when you go visit the doctor, the
10 doctor makes a little report or the progress note of you
11 coming in, what happened, what you said, what your complaints
12 were. Surgeons do the same.

13 And when he prepares an operative report, he doesn't
14 even mention that the neuromonitoring signal went out at 10
15 a.m. There's blanks in his operative report, and what he's
16 going to come tell us and the evidence is going to show, he's
17 going to say, well, that's -- I meant for that blank to be
18 about the neuromonitoring going out. That's what the blank
19 was supposed to be.

20 Well, he signed and verified the report two days later,
21 and the evidence is going to show he didn't even pay enough
22 attention to fill in the blanks. The operative report states
23 the identifiable cause within the wound was demonstrated.
24 And now he's going to say, well, what I meant was the
25 identifiable cause within the wound was not demonstrated.

1 He didn't take enough time to create an operative report
2 that reflected what happened. He didn't do it even when he
3 had a patient that went paralyzed in the surgery. He didn't
4 pay enough attention to create a truthful and accurate
5 operative report.

6 After the patient wakes up unable to move her legs, Dr.
7 Holbrook orders an MRI of her spine. And when physicians
8 order imaging studies, X-rays, CTs, MRIs, they tell the other
9 physician, the radiologist, why they're ordering it, because
10 it's helpful to the radiologist to understand kind of the --
11 the background of -- of what happened. What am I looking
12 for? What's -- what is the important information that I need
13 to understand?

14 So, Dr. Holbrook has had -- the evidence is going to
15 show he's had a patient he did back surgery on,
16 neuromonitoring went out two hours into the surgery, she woke
17 up paralyzed, and now he's ordering an MRI. And when he
18 writes the pertinent history, he writes prior thoracic spine
19 surgery, bilateral leg weakness, left greater than right,
20 since fall three days ago.

21 Ask yourself, is that truthful and accurate medical
22 record? Did he create a record that really told the story of
23 what happened?

24 He prepares a discharge summary. The discharge summary
25 is exactly what it sounds like. It's a summarization of the

1 important things that happened in the hospital, and the
2 evidence is going to show that one of the most important
3 things that happened at the hospital was at 10 a.m. when
4 neuromonitoring went out and indicated a total loss of
5 signal, and Dr. Holbrook assumed that it was an equipment
6 malfunction.

7 This discharge summary, the evidence is going to show --
8 you'll have a copy of this back with you -- doesn't even
9 mention, makes no mention whatsoever, that neuromonitoring
10 went out at 10 a.m. It makes no mention whatsoever that he
11 incorrectly assumed it was an equipment malfunction. No
12 discussion whatsoever in that record.

13 So the MRI that we talked about, one that was done a few
14 hours after surgery, shows an injury in the spinal cord, and
15 the evidence is going to show that that injury there is the
16 result of inadequate blood flow due to a patient with chronic
17 hypertension, vascular remodeling, two prior spine surgeries,
18 and that the image itself from a radiological standpoint is
19 an ischemic injury, ischemic, lack of blood flow. That's
20 what the evidence is going to show.

21 And there's more evidence in this case that demonstrates
22 that the patient didn't have adequate blood flow, adequate
23 perfusion, during this surgery. When we're -- when a patient
24 is undergoing surgery, they're monitoring all kinds of stuff,
25 heart rate, respiratory rate.

1 They also monitor urine output, and there's a certain
2 amount of urine output that a patient should have, again rule
3 of thumb, in surgery. And the evidence is going to show that
4 -- that they would like to see -- it's based on your weight.
5 What a smaller person should put out and what a -- what a
6 larger person should put out differ. The evidence is going
7 to show that the rule of thumb is around 1 milliliter per
8 kilogram of weight. The patient weighed 120 kilograms. So
9 you'd like to see about 120 milliliters of urine per hour and
10 at minimum half a milliliter of urine per hour. So minimum
11 of 60, really like to see around 120 milliliters an hour.

12 And this is recorded on the anesthesia record. They
13 write it down here. It says urine output. You'll see this
14 record in the case. And during the course of the whole
15 surgery, the entire surgery that was more than four hours
16 long, that's how much urine this patient produced. The
17 evidence is going to show this is how much urine she should
18 have produced.

19 And you may be asking, well, how much fluid did she get
20 during the surgery? Because how -- the amount of fluid I get
21 impacts how much I have to urinate. During the course of the
22 surgery, intravenously she was given 2,700 milliliters of
23 fluid. And in a more than four-hour surgery, the evidence is
24 going to show that that's how much urine she produced.

25 She should have been up here, and she was down here, and

1 the evidence will show that that is an indicator of a patient
2 who was not getting sufficient perfusion, sufficient blood
3 flow to what she was used to. The anesthesia chart, the
4 radiology, and the urine output demonstrate that this was an
5 ischemic injury, the result of perfusion.

6 Why are Crystal Goodwin and James Goodwin here? These
7 two folks right here. Well, they're here because Crystal
8 Goodwin is that patient we've been talking about. Back in
9 2016, she was 38 years old.

10 For 6 years, 8 months, and 13 days, Crystal has lived
11 her life in a wheelchair. As of today -- well, I'm sorry,
12 this is one day off because I thought I was going to give
13 this presentation yesterday. For 2,448 days, Crystal has
14 been in a wheelchair.

15 James and Crystal Goodwin's lives were forever changed
16 because of failure to treat her as an individual and not a
17 one size fits all patient. They were forever changed because
18 Dr. Holbrook didn't respond to alarms and red flags.

19 Crystal and James Goodwin are here because the law says
20 -- we have life expectancy tables. Kind of weird that the
21 law says how long we're supposed to live. Crystal and James
22 Goodwin are here because for the next 37 years, 3 months, and
23 16 days, she will spend her life in a wheelchair, 13,620
24 days. She has to cath herself. She doesn't have control of
25 urinary function anymore. She doesn't have control of her

1 bowels either.

2 They're here looking for justice from you. That's why
3 you're here, and I want to talk a minute about some of the
4 witnesses you're going to hear from this week.

5 One of them is Ms. Sunny Switzer Jumper. She's a
6 certified surgical technician. She was in the operating room
7 that day on July 28th, 2016, and we're going to hear from her
8 and what happened that day and how when Dr. Holbrook said I
9 think it's an equipment malfunction, everybody's eyes in the
10 room got wide.

11 You're going to hear from Deanna Glenn. She's a doctor
12 of physical therapy. She is Crystal Goodwin's physical
13 therapist. She treats Crystal three times a week, and she
14 has for five years. And you're going to hear from her about
15 how hard Crystal works and how this injury -- how she works
16 with Crystal to just keep her where she is.

17 She has a little bit of ability to move her legs. With
18 the help of a walker and braces, she can walk about 100 feet,
19 and she's functionally paralyzed. For all intents and
20 purposes, she's paralyzed.

21 You're going to hear from Dr. Gary Lustgarten. He is a
22 neurosurgeon, and he's going to talk to us about what the
23 standard of care is for a neurosurgeon, how blood pressure
24 should have been considered, how Crystal Goodwin should have
25 been treated as an individual, and what should have happened

1 when the neuromonitoring went off.

2 You're going to hear from Dr. Fred Jones. He's an
3 anesthesiologist, and you're going to hear from him by video.
4 Unfortunately, he's not going to be able to make it this
5 week. He had a conflict with call, and they lost some --
6 anyway, he -- he had to be at the -- in the hospital this
7 week to make sure they had enough anesthesiologists, but he's
8 going to talk to us about what anesthesia -- had standard of
9 care been followed, what anesthesia would have done had they
10 been made aware of the signal going off, and he's going to
11 explain to us how, had those things been done, the spine
12 could have been saved.

13 You're going to hear from Dr. Anthony Mancuso, Tony
14 Mancuso. He is a neuroradiologist, and he's going to talk to
15 us about the neuroimaging done after surgery and how the way
16 it looks, the imaging patterns can only be an ischemic
17 injury, and it fits from a low perfusion during the spinal
18 surgery.

19 You're going to hear from Dr. Michael Shaufele. He is
20 an expert in rehabilitation medicine, did part of his
21 training -- he's originally from Germany. He has this great
22 little hint of a German accent. He did training at Harvard.
23 And he's going to talk to us about what Crystal's needs are
24 for the rest of her life, what she needs as a result of being
25 in the wheelchair and being paralyzed and incontinent, and

1 he's going to talk to us also about what that's going to mean
2 as she gets older.

3 Crystal is 45 years old today, and what she can do today
4 and what she'll be able to do at 60 are very, very different.
5 He's going to talk to us about that and how paralyzed
6 patients' care needs will increase over time.

7 You're going to hear from Cathy Gragg-Smith, who's a
8 registered nurse, and she's a certified life care planner.
9 And she has taken those needs that Dr. Shaufele will talk
10 about and she's gone out and -- and just discerned the cost
11 of those things.

12 Wheelchairs don't last forever. They have to be
13 replaced. They wear out just like cars. And so she's gone
14 and found these -- found the price of all of these different
15 things that Crystal will need in her life, everything from
16 ramps to the tubes for cathing herself, and put that together
17 in what's called a life care plan. It's a tool to help
18 understand what her medical and therapeutic needs will be in
19 the future.

20 You'll hear from Dr. Charles Alford. He's not a medical
21 doctor. He's a Ph.D. He's an economist, and he will take
22 those numbers that Ms. Cathy Gragg-Smith -- Nurse Cathy
23 Gragg-Smith put together and put them in present day value.
24 That money today is different than money in the future.

25 You're going to hear from Jazmine Goodwin. Crystal and

1 James have three daughters. Jazmine is one of them. She's
2 going to come take the stand and talk to us about how her
3 family's life has changed and how hard her mother works, and
4 how her mother has done a remarkable job living her best life
5 despite the injuries she's suffered.

6 You're going to hear from James and Crystal Goodwin.
7 This picture is significant because it's one of the last
8 pictures they took together before July 28th, 2016, and
9 you're going to hear from them about how this injury has made
10 them stronger and how it's been tough, how it's been tough on
11 them and their family, and what they worry about, the future.

12 You're going to hear evidence that on August 1st, 2016,
13 Dr. Holbrook said the cause of the injury was something
14 during surgery that restricted the blood flow to that area of
15 the spinal cord, and you're going to hear evidence that he
16 says something different today.

17 Ladies and gentlemen, this is a civil case. It's not a
18 criminal case. No matter what you decide in this case,
19 nobody's going to jail. No matter what you decide in this
20 case, nobody's losing their license to practice medicine. In
21 fact, Dr. Holbrook is retired.

22 This case is not an accusation that anybody is an
23 incompetent doctor, a bad doctor. This case is about someone
24 making an error that was below the standard of care back in
25 2016, but your decision will have no impact on anybody's

1 license to practice medicine or anybody's freedom or anything
2 like that.

3 Also, in a civil case -- some of you -- there was a
4 trial in South Carolina that a lot of people might have
5 watched recently. It was a criminal case where the proof was
6 to beyond or to a reasonable doubt. That's not this case.
7 It's just a preponderance of evidence.

8 And the judge will instruct you at the end of this case
9 that if the plaintiff -- the two parties walked into this
10 courtroom with the scales of justice even. That's the way
11 the law is designed. You walked into this courtroom on an
12 equal playing field, and if the plaintiff has tipped those
13 scales ever so slightly, then we have met the preponderance
14 of evidence and we've proven our case.

15 Ladies and gentlemen, this is the smallest courthouse in
16 the United States of America. It sits in Arthur County,
17 Nebraska, built in 1915. It's smaller than this courtroom.

18 This is the largest courthouse in America. It sits in
19 St. Louis, Missouri. It's 30 stories tall.

20 And yesterday in Nebraska, in Missouri, and all over
21 this country, people like you came to serve on juries, and
22 most of them were thinking I have something better to do.
23 And I know this is an inconvenience. We appreciate that.
24 Everybody in the courtroom appreciates that.

25 But there is no better place for you to be this week

1 than where you're sitting right now. There is no higher
2 service that you can pay to your country and your fellow
3 citizens than to serve on a jury. You get to decide the
4 evidence. You are the conscience of this community, and you
5 get to decide if patients have to be treated like
6 individuals. You get to decide if doctors should respond to
7 red flags and alarms. You get to decide this week if medical
8 records should be truthful and accurate.

9 Your service is very important. As inconvenient as it
10 is, there is no better place for you to be, no higher service
11 that you could pay your fellow citizens than what you're
12 going to do over the next few days, and we thank you, both
13 sides.

14 Again, my name is Brink Hinson. I practice law here in
15 Columbia. These are my colleagues, Robert Goings and Jess
16 Gooding. And this is Crystal Goodwin and James Goodwin.

17 We sincerely thank you for your service. We thank you
18 for your attention. We thank you for the hard work you're
19 going to put into this -- this trial, and we look forward to
20 presenting our case to you. Thank you.

21 THE COURT: All right, ladies and gentlemen. Let's take
22 a short break. Please return to your jury room. Don't
23 discuss the case amongst yourselves. We'll bring you back
24 shortly.

25 (WHEREUPON, the jury exited the courtroom at 11:11 a.m.)

1 THE COURT: The Court will be at recess for 15 minutes.
2 (WHEREUPON, there was a break in the proceedings, after
3 which the proceedings resumed as follows.)
4 THE COURT: All right, folks. During the break, I
5 received a note from a juror that asked for that screen --
6 that monitor to be raised because some of the jurors could
7 not see it. I wish they had said something earlier so that
8 it could have been done during plaintiff's opening.
9 But just going forward, I assume you intend to use it
10 again. If there needs to be -- I don't know. If it can be
11 raised, great. If you need to back it up so that people can
12 see it, I don't know. Just for future use of that.
13 MR. GOINGS: Is it all right if I try to pull it up
14 right now?
15 THE COURT: That's fine.
16 (WHEREUPON, the jury note was marked as Court's Exhibit
17 Number 1.)
18 (WHEREUPON, there was a pause in the proceedings for
19 technical issues, after which the proceedings resumed as
20 follows.)
21 THE COURT: All right. Please bring the jury.
22 (WHEREUPON, the jury entered the courtroom at 11:43
23 a.m.)
24 THE BAILIFF: The jury is seated, Your Honor.
25 THE COURT: All right. Thank you.

1 We left off our -- concluding the opening statement on
2 behalf of the plaintiffs. It's now time for the defendants'
3 opening statement.

4 Yes, Mr. Heitmann?

5 MR. HEITMAN: May it please the Court.

6 THE COURT: Yes, sir.

7 OPENING STATEMENT ON BEHALF OF THE DEFENDANTS

8 MR. HEITMAN: Ladies and gentlemen of the jury, my name
9 is Andrew Heitmann. This is my co-counsel, Ashby Davis, and
10 together we represent Dr. Holbrook and Midlands Orthopedics
11 and Neurosurgery.

12 Dr. Holbrook is a neurosurgeon who's been -- who had
13 practiced over 30 years right here in your community in
14 Columbia before he retired in 2020. Dr. Holbrook was the
15 neurosurgeon who operated on Crystal Goodwin on July 28th,
16 2016.

17 However, that's not the first time that Dr. Holbrook
18 operated on Mrs. Goodwin. Dr. Holbrook also operated on Mrs.
19 Goodwin in 2009 and 2011. Mrs. Goodwin had -- unfortunately
20 has a long history of acute spinal stenosis. Spinal stenosis
21 is a narrowing of the spinal column, which can cause a
22 variety of symptoms, and most notably in Mrs. Goodwin's case
23 that it caused leg weakness.

24 You're going to get to hear from Dr. Holbrook in this
25 case. The plaintiffs may call him -- may call him in their

1 case or, if they don't, then we'll call him in our case. But
2 in any event, you'll get to hear from him, and he'll talk
3 about his role in this 2016 surgery, and he'll tell you what
4 he did in that surgery, and he's the only witness in this
5 entire trial who can tell you why he did what he did.

6 Now, Dr. Holbrook is not a TV doctor; okay? He's very
7 soft-spoken. We'll try to get him to speak up into the
8 microphone, but I ask that you please be patient with him and
9 listen very carefully to what he has to say, because it is
10 important.

11 The plaintiffs' whole theory of liability in this case
12 is that Mrs. Goodwin's blood pressure dropped too low during
13 the surgery. We don't believe that's what happened. We
14 believe that Mrs. Goodwin's blood pressure was maintained at
15 an appropriate range during the surgery.

16 What we believe happened was that Mrs. Goodwin suffered
17 what's called a reperfusion injury. And you're going to hear
18 from our experts, and they'll describe to you what a
19 reperfusion injury is, and they're going to tell you that a
20 reperfusion injury is not predictable. It is not
21 foreseeable. And once it -- and once it happens, there's
22 really nothing you can do to treat the situation.

23 Now, like I said, we don't believe that the -- the blood
24 pressures dropped too low. So we are not critical of the
25 anesthesiologist in this case or the CRNA in this case or the

1 anesthesia -- anesthesia care team as a whole. However, if
2 you do believe plaintiffs' theory of this case and you do
3 believe that the blood pressures dropped too low, that's not
4 Dr. Holbrook's responsibility.

5 Dr. Holbrook was the neurosurgeon in this case. It is
6 his job to perform the surgery in this case. The
7 anesthesiologist and the anesthesia care team are responsible
8 for monitoring the blood pressure in the appropriate range
9 during the surgery so that Dr. Holbrook can focus on what he
10 is doing.

11 The plaintiff has the burden of proof in this case to
12 prove to you by a preponderance of the evidence that Dr.
13 Holbrook was negligent. Now, what is preponderance of the
14 evidence?

15 I'm sure many of you are probably familiar with the
16 scales of justice. And at the end of this trial, you'll
17 weigh all of the evidence in this case. On one side, you'll
18 weigh the plaintiffs' evidence. On the other side, you'll
19 weigh the defendants' evidence.

20 And if you find at the end of this trial after looking
21 at all of the evidence that the evidence tips in favor of the
22 plaintiff, then you must enter a verdict for the plaintiff.
23 If, however, you find that the evidence in this trial is even
24 or tips in favor of the defendant, you must enter a defense
25 verdict.

1 The plaintiffs are also required to provide expert
2 testimony in this case. They are required to establish the
3 standard of care. What is the standard of care? Well, the
4 standard of care is what a reasonable doctor would do in like
5 or similar circumstances. In this case, what would a
6 reasonable neurosurgeon do in like or similar circumstances,
7 not what would a reasonable anesthesiologist do, but what
8 would a reasonable neurosurgeon do in like or similar
9 circumstances?

10 Their expert testimony is also required to tell you how
11 Dr. Holbrook fell below the standard of care. What did Dr.
12 Holbrook do or not do that was not reasonable in this case?

13 The expert testimony must also establish proximate
14 cause. Proximate cause is the link between the standard of
15 care and the injuries in the case. So, for example, did --
16 if a doctor falls below the standard of care, did falling
17 below the standard of care cause the injury? You have to
18 have that causal connection.

19 Medical malpractice cases are often very sad cases, and
20 this case is no exception. The judge will instruct you that
21 your verdict in this case cannot be based on sympathy. It
22 must be based on the evidence in this case. I also ask that
23 you wait until you've heard all the evidence in this case,
24 before making up your minds as to what happened.

25 When I was growing up, my younger brother and I -- we'd

1 get into fights all the time, as brothers tend to do, and
2 sometimes it would be my fault, sometimes it would be his
3 fault, but my brother would always run to my mom and blame
4 me. And my mom -- every time she would come to me and she
5 would ask me what happened, because she knew that it was
6 important to find out both sides of the story before --
7 before rendering judgment. And so I ask in a similar manner
8 that y'all do the same thing, that you wait until you've
9 heard all of the evidence in this case before making up your
10 minds.

11 At the end of this trial, Mr. Davis will have the
12 opportunity to come up here and talk to y'all. He'll go over
13 all the evidence in this case, and how it shows that Dr.
14 Holbrook was not negligent. And at that time, he'll ask that
15 you enter a defense verdict. Thank you.

16 THE COURT: The plaintiffs can call their first witness.

17 MR. GOINGS: Your Honor, we intend to publish various
18 responses to requests to admit. I don't know if you have a
19 general instruction about telling them what a request to
20 admit is first.

21 THE COURT: Any objection from the defense?

22 MR. DAVIS: I'm sorry. I was consulting counsel. What
23 was that again?

24 THE COURT: Mr. Goings intends to publish to the jury
25 certain requests for admission with a brief statement about

1 what that is.

2 MR. DAVIS: I'd like to see which ones he's talking
3 about. It's the first I've heard about it.

4 MR. GOINGS: And I thought you were going to -- I'm not
5 going to give the --

6 THE COURT: Oh.

7 MR. GOINGS: -- instruction what are requests. I was
8 asking if Your Honor would do that.

9 THE COURT: Oh, I'm sorry.

10 MR. GOINGS: Yes, ma'am.

11 THE COURT: Okay. Would you show Mr. Davis what we're
12 talking about?

13 MR. GOINGS: Yes, Your Honor.

14 THE COURT: Ladies and gentlemen, while they're doing
15 that, as Mr. Goings indicated, he intends to publish or read
16 to you certain requests for admission.

17 As we discussed earlier, there are certain rules by
18 which the attorneys must play. There is, in fact, a rule
19 book, and a lot of work goes into preparing for trial, and
20 that includes exchanging information between the parties.

21 One Of those procedures that they use to exchange
22 information is called requests for admission. These are
23 written statements that one attorney or one party can send to
24 the other party just asking them to either admit or deny that
25 a certain statement is true.

1 Mr. Goings intends to read to you, I assume, some things
2 that were admitted by the defendants in this case, Dr.
3 Holbrook and Midlands Orthopedics, once they sort out exactly
4 which things those are, but it's very simple to type up a
5 list of statements and admit that this is true or deny that
6 it's true. And that's what will be read to you momentarily.
7 (WHEREUPON, there was a pause in the proceedings, after
8 which the proceedings resumed as follows.)
9 MR. GOINGS: We want to publish to the jury in the
10 plaintiffs' case in chief.
11 THE COURT: What's the basis of your objection, Mr.
12 Davis?
13 MR. DAVIS: Your Honor, they're piecemeal. They sent
14 about five requests for admission, and if they're going to
15 publish all of them, that's fine. If they're going to
16 piecemeal it, I object.
17 THE COURT: They may be published over the defense
18 objection.
19 MR. DAVIS: Thank you, Your Honor.
20 MR. GOINGS: Admit that Crystal Goodwin has suffered a
21 neurological impairment to her legs that, more likely than
22 not, is permanent.
23 Answer of Dr. Holbrook: Denied.
24 Admit that at no point in time prior to the initiation
25 of this lawsuit did Midlands Orthopedics and Neurosurgery

1 ever undertake any sort of review or investigation to
2 determine what caused Crystal Goodwin to suffer a
3 neurological injury on July 28th, 2016.

4 Answer of Midlands Orthopedics: Quote, it is admitted
5 that Midlands Orthopedics did not undertake any sort of
6 review or investigation to determine any cause of Crystal
7 Goodwin's neurologic injury on July 28th, 2016, nor were they
8 required to do so. Nor were they required to do so.

9 MR. DAVIS: Your Honor, I'm going to object to the
10 repetition.

11 MR. GOINGS: That was --

12 MR. DAVIS: Excuse me just a minute.

13 MR. GOINGS: -- right out of yours.

14 MR. DAVIS: Your Honor, I object to the repetition and
15 emphasis. He's able to publish it. That's your ruling.
16 He's not allowed to repeat it.

17 MR. GOINGS: I read exactly what he wrote. He -- he
18 repeated it in the document.

19 THE COURT: Can I see the document?

20 MR. GOINGS: Midlands, Number 1. All right. Here's the
21 answer, Judge. I read this sentence.

22 THE COURT: Yes, sir.

23 The objection is overruled. It appears that Mr. Goings
24 has read exactly what is typed in those responses.

25 MR. DAVIS: So he's allowed to read the typewritten?

1 THE COURT: He read exactly what is typed in those
2 responses. If you look at the document, you'll understand
3 the Court's ruling. The objection is overruled.

4 MR. DAVIS: I'm sorry. Which one?

5 MR. GOINGS: The first page.

6 THE COURT: It's on the first page at the bottom -- the
7 bottom of the page?

8 MR. GOINGS: The middle.

9 THE COURT: The middle of the page. There may be a
10 typographical error on that document, but he's read exactly
11 what it's typed on the document. The objection is overruled.

12 You may have a seat, Mr. Davis.

13 MR. DAVIS: Thank you.

14 THE COURT: Mr. Goings, you may continue.

15 MR. GOINGS: Thank you, Your Honor.

16 Next question: Admit that prior to operating on Crystal
17 Goodwin on the morning of July 28th, 2016, you were aware
18 that Crystal had a history of high blood pressure.

19 Answer of Dr. Holbrook: Admitted.

20 Next: Admit that prior to operating on Crystal Goodwin
21 on the morning of July 28th, 2016, you were aware that a
22 blood pressure of 156 over 92 had been reported during her
23 pre-operative assessment conducted on July 22nd, 2016.

24 Answer of Dr. Holbrook: Admitted.

25 Next: Admit that hypotension is a condition that,

1 depending on its degree and duration, can impact how a
2 patient's intraoperative blood pressure should be managed.

3 Answer of Midlands Orthopedics: Denied.

4 Admit that shortly at or around 10 a.m. during the
5 operation performed on Crystal Goodwin on the morning of July
6 28th, 2016, the surgical neurophysiologist informed you that
7 there had been a loss of SSEP signal from Crystal's lower
8 extremity.

9 Answer of Dr. Holbrook: Admitted.

10 Admit that during the operation performed on Crystal
11 Goodwin on the morning of July 28th, 2016, neuromonitoring
12 correctly indicated that a loss of signal from Crystal's
13 lower extremity.

14 Answer of Dr. Holbrook: Denied.

15 Admit that during the operation you performed on Crystal
16 Goodwin on the morning of July 28th, 2016, something occurred
17 that resulted in a neurologic injury that has affected her
18 legs.

19 Answer of Dr. Holbrook: He says, Dr. Holbrook admits
20 that he performed the surgery on Crystal Goodwin on July
21 28th, 2016, and then subsequent -- subsequent to the surgery,
22 it was discovered that she had some sort of neurological
23 impairment in her legs, and it was re-operated on by Dr.
24 Holbrook that day. It is further admitted that Dr. Holbrook
25 does not know the cause of any neurologic injury to Ms.

1 Goodwin.

2 Admit that medical records should be truthful and

3 accurate.

4 Denied. However, this defendant admits that a physician

5 should prepare or maintain an adequate patient record of care

6 provided and that medical records should be reasonably

7 accurate and complete.

8 And last: Admit that you told Crystal Goodwin that her

9 2016 spinal cord injury was caused by, quote, something

10 during the course of the surgery irritated one of those blood

11 vessels or that sort of thing and caused it to occlude and

12 restrict the blood flow to that area of the spinal cord.

13 Answer of Dr. Holbrook: Denied.

14 Your Honor, those are all the requests to admit we plan

15 to publish to this jury.

16 THE COURT: Yes, sir. Call your first witness.

17 MR. HINSON: Plaintiff calls Dr. Gary Lustgarten.

18 MR. GOINGS: And, Your Honor, before we begin this

19 examination, let me just make sure that the jury can see this

20 or do we need to move it back some.

21 THE COURT: If you can adequately see the monitor,

22 ladies and gentlemen of the jury, if you will raise your

23 hand, please.

24 MR. GOINGS: So we're good?

25 THE COURT: Yes. Okay. Thank you.

DR. GARY J. LUSTGARTEN - DIRECT BY MR. HINSON

1 MR. GOINGS: Thank you, Your Honor.

2 THE CLERK: Do you swear that the testimony you are
3 about to give in this case to be the truth, the whole truth,
4 and nothing but the truth, so help you God?

5 THE WITNESS: Yes, ma'am.

6 THE CLERK: Thank you. You may be seated. State your
7 name for the record, please.

8 THE WITNESS: Gary J. Lustgarten.

9 DR. GARY J. LUSTGARTEN, being
10 first duly sworn, testified as follows:

11 DIRECT EXAMINATION

12 BY MR. HINSON:

13 Q: Dr. Lustgarten, would you please state your full name?

14 A: Gary J. Lustgarten.

15 Q: And, Dr. Lustgarten, I don't want to belabor it, but
16 tell us just a little bit about yourself. Where do you live?

17 A: So, presently, my wife and I reside in Jupiter, Florida,
18 and we're the proud grandparents of a newborn three months
19 ago.

20 Q: Congratulations. And, Dr. Lustgarten, what have you
21 done for a living for the last several decades?

22 A: I've practiced neurology and predominantly neurosurgery.

23 Q: And I'd like to go through a little bit about your
24 educational history and your work history. Let's start with
25 -- with college. Where did you go to college?

DR. GARY J. LUSTGARTEN - DIRECT BY MR. HINSON

1 A: University of Iowa in the Big Ten. I received my BA
2 degree. I received my BA degree from the University of Iowa.
3 I was on the University of Iowa wrestling team. And while in
4 college, I was elected to Omicron Delta Kappa, a national
5 honorary leadership and scholastic society.

6 Q: And then take us -- what -- after college, what did you
7 do next?

8 A: I went to medical school at the University of Iowa
9 College of Medicine. I finished fourth out of 120 in my
10 class. I received the William Bean Internal Medicine Award.
11 I was a student instructor in neuroanatomy, as well as an
12 extern on an internal medicine board on the side. That was
13 assigned to me by Dr. Bean. And during medical school, I was
14 elected to Omicron Delta Kappa, a national honorary medical
15 society.

16 Q: And then did you receive any additional training after
17 medical school?

18 A: Yes. I then went to New York and did my surgical
19 internship at the New York Hospital at Cornell Medical
20 Center.

21 Q: And after that, what did you do next?

22 A: Well, this was in the mid-60s. Uncle Sam invited me
23 into the service. So I spent two years of active duty in the
24 United States Air Force. I graduated from the School of --
25 School of Aerospace Medicine, flight training at Kelly Air

1 Force Base. Subsequently, I was stationed at Blytheville Air
2 Force Base in Arkansas, which is a SAC base, where I was
3 chief of flight medicine and hospital commander.

4 Q: And I think you may have answered this, but just to be
5 clear. So when you were in the Air Force, were you flying
6 planes or practicing medicine?

7 A: Both. Primarily, I was in charge of the medical care of
8 everybody who was on flying status, the active-duty members
9 and their families. As a result of me going through flight
10 school, I had so many hours of -- of flight time that I was
11 required -- I had to go through flight school to learn how to
12 use an ejection seat, how to use a parachute, how to be
13 qualified with an M-16, sidearms, all these things.

14 Q: And let's talk about medical education and training. Do
15 you have any additional medical education and training?

16 A: Yes.

17 Q: Tell us about that.

18 A: Subsequent to completing my tour in service, I went to
19 Miami, the University of Miami, Jackson Memorial Hospital,
20 where I did five years of training in both neurology and
21 neurological surgery. While I was at Jackson, I spent 6
22 years in the active reserves of the Air Force as well.
23 During my stay in residency training, I became board eligible
24 in neurology, then went on and became board certified in
25 neurosurgery.

1 Q: And so, Doc, take us now through kind of your work
2 history, starting with becoming board certified in
3 neurosurgery or, excuse me, as you said, neurology?

4 A: And neurosurgery.

5 Q Neurosurgery, yes. But take us through your work
6 history.

7 A: Well, I finished my residency training in 1973, came out
8 in private practice. I joined another neurosurgeon who was
9 trained at Johns Hopkins, Ken Luxembourg, and he and I
10 practiced together from 1973 until he passed away in 1991.

11 During that 18-year period of time, I was president of
12 the South Florida Neurosurgical Society. I was a chairman of
13 the Department of Neurosurgery at three of my twelve primary
14 hospitals. However, when my partner passed away in 1991, we
15 were on the staff of twelve hospitals, and I very quickly
16 realized I could not carry that burden.

17 So I cut my hospital affiliations from twelve down to
18 three. I eliminated pediatric neurosurgery, and by and large
19 I eliminated intracranial surgery. So basically, since 1991,
20 I've been doing exclusively spine surgery, as I did prior to
21 that time, but now no longer any cranial surgeries.

22 This took us through the year 2005. At that time, I had
23 a chat with my wife and decided to take the first step
24 towards retirement. Well, I've never achieved that.

25 However, between 2005 and 2010, I decided to eliminate

1 -- eliminate being the primary surgeon. I would be an
2 assistant surgeon or a co-surgeon. However, during that
3 five-year period of time, I made my way back to the operating
4 room 50 or 60 times as the lead surgeon, both on cranial
5 surgery and spine surgery, at the request of certain
6 patients, doctors, their wives, their families, friends, et
7 cetera.

8 During the time that I practiced in North Miami Beach, I
9 became acquainted with an orthopedic spine surgeon, Dr. Guy
10 Scuderi. He and I worked together for about eight years. We
11 got along very well. Our patients did great. We had --
12 we're both obsessive compulsive personalities, so we did well
13 in the operating room, seeing patients in the office. Our
14 wives got along. Our kids grew up together.

15 But then he moved up to Jupiter, Florida. Finally, year
16 after year, he invited me to join him in a practice, and
17 finally in 2010, being the nice Italian guy he is, he gave me
18 an offer I couldn't refuse, and I moved to Jupiter, Florida,
19 where I've been for the past now 13 years.

20 During this time, I still have the full practice of
21 neurosurgery. I'm in the office five days a week. No
22 patient waits more than 24 hours to see me. And I no longer
23 am the lead surgeon, but I do assistant or co-surgeon
24 procedures with Dr. Scuderi. That's basically seven months
25 of the year.

1 Since 2012, my wife and I summer up in Maine in Boothbay
2 Harbor. We're up there for 4 or 5 months a year. I also
3 have a Maine medical license, and I do pro bono work in
4 Maine.

5 Q: And what does pro bono mean?

6 A: For nothing. I see patients, I don't charge them.
7 There's -- there's no neurologist or neurosurgeon on the
8 Boothbay Peninsula, which is about 20,000 people. So each
9 summer I see 15, 20, 25 patients. I see them at my house, at
10 their home. We do a history and examinations. I order
11 diagnostic studies as necessary, and I treat them. If
12 anybody requires surgery, however, I send them down to Maine
13 Medical Center, where I have a relationship with the
14 Department of Neurosurgery there.

15 Q: Dr. Lustgarten, in your career, what would be your
16 estimate of how many spine surgeries you have been involved
17 in, either as the primary attending or as the assisting
18 surgeon?

19 A: Well, I know as the primary surgeon, well over 8,000.
20 As the assistant or co-surgeon, probably 1,500 to 2,000.

21 MR. HINSON: Your Honor, at this time, plaintiff would
22 offer Dr. Gary Lustgarten as an expert in the field of
23 neurosurgery and neurology.

24 MR. DAVIS: No objection, Your Honor.

25 THE COURT: All right, ladies and gentlemen. Normally,

1 a witness must testify as to their perceptions of what they
2 saw, smelled, touched, tasted, et cetera. However, when a
3 person, by virtue of their education, training, and
4 experience becomes an expert in some field, they are
5 permitted to testify as to their opinions within their field
6 of expertise.

7 Dr. Lustgarten is an expert in the fields of neuro --
8 neurosurgery and neurology and will be permitted to testify
9 as to his opinions within his field of expertise -- fields of
10 expertise. However, like any other witness, you give his
11 testimony the weight and the credibility you think it
12 deserves.

13 You may proceed, Mr. Hinson.

14 MR. HINSON: Thank you, Your Honor.

15 BY MR. HINSON:

16 Q: Dr. Lustgarten, as we go through your testimony today,
17 will you agree that unless you state otherwise, you will only
18 offer opinions and testimony that you hold to a reasonable
19 degree of medical certainty?

20 A: Yes, sir.

21 Q: And, Doc, I want to go through a few terms very quickly
22 just to make sure everybody's on the same playing field.
23 What does the term hypertension mean?

24 A: It means elevated blood pressure, generally interpreted
25 as being anything over 140 over 90 is considered

1 hypertension.

2 Q: And what does the term hypotension mean?

3 A: Hypotension is low blood pressure. Classically, shock
4 is defined as anything less than 90 over 60, although there
5 are people who walk around with blood pressures of that,
6 athletes, what have you, but hypotension generally is low
7 blood pressure in that range.

8 Q: And, Doc, what is the term mean arterial pressure? Just
9 briefly explain that term.

10 A: Mean arterial pressure is basically a formula that makes
11 you arrive at what a blood pressure is in an individual.
12 That formula is -- the mean arterial pressure is the
13 diastolic blood pressure -- the diastolic blood pressure is
14 the pressure within the heart that is -- the systolic
15 pressure, the heart contracts, squirts blood out. That's the
16 systolic pressure. As the heart refills, the pressure that
17 is within the chamber, the left ventricle residual, is the
18 diastolic pressure.

19 So mean arterial pressure is calculated by taking the
20 diastolic pressure plus one third of the difference between
21 the systolic and the diastolic. That's known as the pulse
22 pressure.

23 An example, if you have a blood pressure of 120 over 60,
24 systolic over diastolic, the diastolic is 60. The difference
25 between the two is 60, 60 from 120, 60. Take one third of

1 that. That's 20, and you add that 20 to the 60. So the mean
2 arterial pressure is 80.

3 Q: Doctor, as we go through testimony today, will you agree
4 to do that math for us so we don't all have to get out
5 calculators?

6 A: Not accurately, but I'll try.

7 Q: And does the mean arterial pressure -- does it weight
8 the diastolic then heavier than the systolic?

9 A: Yes.

10 Q: Okay. Can long-term hypertension, long-term high blood
11 pressure, cause something known as vascular remodeling?

12 A: Yes.

13 Q: And, Dr. Lustgarten, I brought some -- I brought some --
14 some props that may assist the jury.

15 MR. HINSON: May I approach the witness, Your Honor?

16 THE COURT: Yes, sir.

17 BY MR. HINSON:

18 Q: All right. Dr. Lustgarten, I'm going to hand you these
19 two funny looking things, if that is of assistance to you.

20 A: Like my yard at home.

21 Q: Doctor, would you explain to us vascular remodeling and
22 how that comes as -- is it -- well, how does vascular
23 remodeling relate to hypertension?

24 A: First, there are risk factors for an individual
25 developing microscopic and macroscopic arterial vascular

1 disease. Some of those risk factors are hypertension,
2 diabetes, obesity, but first and foremost, hypertension is
3 the primary culprit in causing somebody to have microscopic
4 and macroscopic arterial vascular disease.

5 Hypertension, quote, remodels the arterial wall. The
6 arterial wall has a lumen through which blood travels.
7 Inside the lumen, there's a lining of cells called
8 endothelial cells.

9 Q: So the lumen is -- is what?

10 A: It's the hole where blood travels. That is lined.
11 Lumen is lined by endothelial cells that sit on a basement
12 membrane. Just inside that, there is a elastic tissue called
13 the internal elastic lamina. Then comes the media, the
14 middle portion of the artery wall, which is a muscle. Then
15 you have the external elastic lamina. And then above that
16 you have the adventitia, which is a fibrofatty covering over
17 the artery.

18 Hypertension over a period of time remodels an artery in
19 that it causes the endothelium to become irregular. The
20 elastic lamina, which allows the blood vessel to expand and
21 contract, is destroyed. The muscle gets thicker. So the
22 wall of the artery gets thicker and, in the end, the artery,
23 instead of being a very pliable elastic, expand and contract,
24 becomes a very, rigid, tight, unyielding artery.

25 Q: So with the two things with you, the two hoses there,

1 which one -- is there one that would demonstrate an artery
2 before chronic hypertension?

3 A: This would be a normal artery that would -- if the blood
4 pressure goes too high, the blood vessel constricts. If the
5 blood pressure falls too low, the blood vessel dilates.
6 That's called autoregulation. Autoregulation normally takes
7 place between mean arterial pressures of 60 and 160.

8 However, in a hypertensive patient who undergoes the
9 changes in the wall of the blood vessel, the ability for the
10 artery to expand or contract, variable rise and fall in blood
11 pressure is negated. Somebody with hypertension has no --
12 their blood vessel has no control over the flow of blood
13 through it.

14 Q: And so with the -- the hoses there in front of you, does
15 one of them demonstrate what would happen after long-term
16 hypertension?

17 A: Well, this would be normal. It can expand and contract.
18 This is a remodeled vessel. It's rigid, firm. It does not
19 have the ability to dilate and constrict depending upon blood
20 flow. And in that regard, somebody who is hypertensive no
21 longer has the ability to autoregulate.

22 Q: And, Doctor, is this concept you've discussed here of
23 vascular remodeling -- is this something that the standard of
24 care would require any neuro -- neurologist and neurosurgeon
25 to be aware of?

1 A: Yes, sir.

2 Q: Doctor, I want to talk to you about the spine, and I
3 want to give --

4 MR. HINSON: May I approach the witness, Your Honor?

5 THE COURT: Yes, sir.

6 MR. HINSON: Thank you.

7 BY MR. HINSON:

8 Q: I'll give you this model right here. And what I want to
9 -- first, if you could, where is the thoracic region of the
10 spine?

11 A: We're looking at it from the back. These little bumps
12 going down are the bumps you feel going down your spine. The
13 spine is divided into the cervical spine, seven vertebrae,
14 the thoracic spine, twelve vertebrae, the lumbar spine, five
15 vertebrae. The sacrum is the fused segments. There are five
16 sacral segments that are fused together, and then the itty-
17 bitty coccyx at the end.

18 Q: And is there an area -- well, what is within those
19 vertebrae?

20 A: Well, the vertebrae form a house. And if you consider a
21 vertebra a house, the roof is this bump, the spine process
22 and the lamina. The side walls are the joints on either
23 side, the facet joints and the pedicles, which fuse the front
24 and the back of the vertebra. And the floor of the house is
25 the vertebral body and the discs between them, so that if you

1 consider a spinal canal, it has a roof, it has a sidewall.

2 In the sidewall is a window through which the nerve at each
3 level, these little yellow things going out on the right and
4 left, at each level, a nerve goes out, and then through the
5 center travels the spinal cord.

6 Q: And does the spinal cord require blood?

7 A: Yes, sir.

8 Q: Is there an area of the spinal -- well, let me just ask
9 this. Doctor, what is the watershed region of the spinal
10 cord? What does that term mean?

11 A: Watershed is a vulnerable area of the spinal cord
12 because of the blood flow that continues to get -- arborizes,
13 like the limbs on a tree getting smaller and smaller. And as
14 the blood goes down and comes up, the blood vessels get
15 smaller and smaller until the area between T4 at the top and
16 T9-10 at the bottom is the watershed area of the spinal cord.
17 That's an area where the blood supply is not nearly as good.
18 It's vulnerable to ischemia and infarction.

19 Q: And is there a particular artery -- what are the two
20 arteries that are feeding from the top and then from the
21 bottom, Dr. Lustgarten? What are the two arteries there?

22 A: The spinal cord has a major artery in front on the chest
23 belly side called the anterior spinal artery. The anterior
24 spinal artery supplies the front two-thirds of the spinal
25 cord. On the back side of the spinal cord are paired

1 posterior spinal arteries, and they supply the back one-third
2 of the spinal cord. In terms of neuromonitoring, the front
3 two-thirds supplied by the anterior spinal artery is
4 monitored by motor-evoked potentials.

5 Q: Let's hold off on that for just a second, Doc.

6 A: Okay.

7 Q: I'm just -- I want to talk about the watershed region
8 for the moment. So is there an artery coming in from kind of
9 the lower section there with this watershed region?

10 A: Yes. There's an artery called the artery of
11 Adamkiewicz. Adamkiewicz some people say, but Adamkiewicz.
12 He was a Polish neuroanatomist, and the artery of Adamkiewicz
13 in the great majority of people comes in on the left side at
14 T9. Now, 30 percent comes in on the right side. It may come
15 in at T8. It could come in at T10, but in the great majority
16 of people, the artery of Adamkiewicz, which forms the
17 anterior spinal artery, comes in on the left side of the
18 person at the level of T9.

19 Q: So you say 70 or you said some percentage? We're not
20 all the same?

21 A: No, everybody is different, and you have to consider
22 each individual. But when you look at the total population
23 as far as the artery of Adamkiewicz supplying the front two-
24 thirds of the spinal cord, that generally comes in on the
25 left side at T9.

1 Q: Doc, I want to talk now just a couple more concepts.
2 What is intraoperative neuromonitoring just generally
3 speaking? Just give us a kind of overview of that.

4 A: It's a real-time monitor that tells you what the
5 function of the spinal cord is, and to a lesser degree, the
6 nerves that come out of the spinal cord. That is -- there
7 are two types.

8 One is called SSEP. That's somatosensory evoked
9 potentials. That monitors the sensory pathways from the
10 periphery up the back of the spinal cord to the brain. And
11 then the MEPs, motor evoked potentials, that -- that monitor
12 the motor cells in the brain, coming down with fibers through
13 the front two-thirds of the spinal cord. So MEPs monitor the
14 front two-thirds of the spinal cord. SSEPs monitor the back
15 one-third of the spinal cord, and they have two separate
16 arterial supplies.

17 Q: And, Doc, is -- in your career as a neurosurgeon, have
18 you used neuromonitoring?

19 A: Yes, sir.

20 Q: Is it the standard of care today to use neuromonitoring
21 for spine surgery?

22 A: Yes. And let me define when you use it in spine
23 surgery. Any time you're operating on an area where there is
24 a spinal cord, neck, thoracic region, neuromonitoring is
25 mandated, you must use it. It's an early warning system. It

1 tells you, with immediate feedback, particularly the MEPs,
2 that if they disappear or go south, something's wrong going
3 on.

4 The SSEPs also are a very good monitor. However,
5 they're not as sensitive as MEPs because in many instances if
6 there is an injury to the spinal cord, it may take anywhere
7 between 5 and 30 -- 35 minutes for the SSEPs to reflect that.
8 MEPs give you instantaneous feedback right away something's
9 wrong. SSEPs may be delayed in acknowledging something's
10 wrong.

11 Q: And, Doc, why do doctors doing spine surgeries like you
12 just discussed -- why do they -- why do they do it? Are they
13 doing it just to add paper to the medical file? Is it an
14 academic pursuit? What's the reason for using it?

15 A: It's totally gamed to patient safety. It's an early
16 warning system that something is awry with one of a number of
17 things that could cause these monitoring devices not to
18 behave properly. But it's an early warning system that is
19 used exclusively for the safety of the patient.

20 Q: Doc, generally speaking, as a neurosurgeon, are there
21 issues that you have to consider regarding the patient's
22 blood pressure when doing a spine surgery?

23 A: Yes, sir.

24 Q: Just as a general concept, how does that work? What is
25 it you have to consider about blood pressure when you're

1 doing a spine surgery in the thoracic region?

2 A: Well, knowing that you have a watershed area of
3 vulnerability and knowing that autoregulation may or may not
4 be present, you must be acutely aware of maintenance of the
5 proper and appropriate mean arterial pressure so that the
6 spinal cord gets the blood it needs for oxygen and glucose.
7 The perfusion occurs because of the proper mean arterial
8 pressure. Now, mean arterial pressures can vary from patient
9 to patient.

10 Q: And --

11 A: So --

12 Q: Do you have more, Doctor?

13 A: And you determine what the mean arterial pressure is
14 based upon the history of what the patient's blood pressures
15 are. If they're elevated, you calculate it out and you find
16 out what the average mean arterial pressure is. That should
17 be maintained during the course of surgery.

18 Q: And does the standard of care for a neurosurgeon doing
19 an operation on the thoracic spine require that he or she
20 determine a patient's baseline blood pressure before
21 beginning surgery?

22 A: Yes, sir.

23 Q: Doc, in this case, have you reviewed the medical records
24 for Crystal Goodwin from Dr. Holbrook's chart at Midlands
25 Orthopedics?

1 A: Yes, sir.

2 Q: Doctor, I want to talk about the events of 2016, but
3 before we get there, had Crystal -- from your review of the
4 records, had Crystal Goodwin seen -- been seen by Dr.
5 Holbrook prior to 2016?

6 A: Oh, yes. Crystal was a patient of Dr. Holbrook's dating
7 back to at least 2009 when he did the first surgery on the
8 thoracic region at T8 or so, and then he did a second
9 operation in 2011 on Crystal at the T9 level, because she had
10 narrowing of her spinal canal that she was born with. And as
11 a result of arthritic changes and thickening of ligaments,
12 she also had acquired narrowing of the spinal canal that was
13 compromising the spinal cord. She did very well after that
14 second surgery for five years, until she came to see Dr.
15 Holbrook in June of 2016.

16 Q: All right.

17 MR. HINSON: And can we put up, I believe, what was
18 marked as Exhibit 8? Yep. Number 8.

19 And may I approach the witness with -- and hand him an
20 exhibit, Your Honor?

21 THE COURT: Yes, sir.

22 BY MR. HINSON:

23 Q: Doc, I'm going to hand you what's been marked as
24 Plaintiff's Exhibit Number 8, which is from the office chart,
25 the visit you just mentioned in June, on June 20th, 2016.

1 And what does that record reflect Crystal Goodwin was
2 presenting -- hold on one second. What does that record
3 reflect Crystal Goodwin was presenting for and what issues
4 she was complaining of?

5 A: Well, since the last surgery in 2011, Crystal had done
6 well for about five years, but subsequent to a fall, she
7 began to deteriorate. And when she came in to see Dr.
8 Holbrook on June 20th of 2016, she was complaining of
9 weakness in her legs, the left leg more than the right, as
10 well as numbness from the waist down.

11 At that time, Dr. Holbrook suspected that something was
12 wrong with her thoracic spinal cord. At that time, her blood
13 pressure was 152 over 112, which is a mean arterial pressure
14 of 125.

15 Q: And is that a high, low, or average blood pressure?

16 A: That's hypertension. That's an elevated blood pressure.

17 Q: Okay. And did the record reflect anything about whether
18 this was a chronic condition or some -- something that was
19 acute and just limited to that day?

20 A: Well, no. She had had hypertension for many, many years
21 and -- and I feel not adequately treated. But she
22 vacillated, but was continuously at hypertensive levels and
23 not very well controlled.

24 Q: And so if a patient presents to a neurosurgeon with
25 poorly controlled hypertension, does the standard of care

1 require the surgeon to take that into consideration as he
2 treats the patient?

3 A: Absolutely.

4 Q: Okay. And in response to that, did Dr. Holbrook order
5 imaging?

6 A: Yes. An MRI.

7 Q: All right. And did the --

8 MR. HINSON: Put up 23.

9 BY MR. HINSON:

10 Q: Okay. Dr. Lustgarten, would you just identify what --
11 just generally speaking, what are we looking at here?

12 A: This is an MRI of the thoracic spine from the side and
13 looking down on the spine.

14 Q: All right. And, Dr. Lustgarten, I've had a -- well,
15 we've -- there has been a graphic artist that added some
16 images to this.

17 MR. HINSON: Can you put 24 up, please, Mr. Goings?

18 BY MR. HINSON:

19 Q: Does that assist you in presenting to the jury these --
20 what's shown on that medical imaging?

21 A: Yes.

22 Q: And as a neurologist and neurosurgeon, do you read CTs
23 and MRIs of the spine?

24 A: Yes.

25 Q: And let's look first on the right-hand -- excuse me --

1 the left-hand side of the screen. Just generally speaking,
2 what are we looking at right there?

3 A: We're looking -- we're looking at the spine from the
4 side, a side view. Those big blocks are the vertebrae. That
5 kind of pale white, yellowish thing behind it is the spinal
6 cord. And then behind that, at the level of T8 to T9, we see
7 the aftermath of the prior surgeries that were done. And
8 then below that, there is compromise of the spinal canal from
9 T9 to T12.

10 Q: And you used the term aftermath. Do you mean to
11 insinuate Dr. Holbrook had done anything wrong in the prior
12 surgeries?

13 A: Oh, no, no. That's the normal scarring process and
14 healing, but there was scar tissue present at the T8 and T9
15 from the previous surgery, and now with the progression of
16 problems below at 9, 10, 11, and 12, she had bone spurs and
17 narrowing of her spinal canal, which, at least on
18 presentation to the office on June 20th of 2016, was
19 symptomatic in that she had spinal cord problems.

20 Q: All right. And just let's look at this one right here
21 in the middle. Show us -- tell us what we're -- just
22 briefly, Doc, what are we looking at there with this middle
23 one?

24 A: Okay. That's the house that was -- I could come down
25 and point it out.

1 Q: Sure, if you could.

2 MR. HINSON: Your Honor, may he come down and use the
3 screen?

4 THE COURT: Yes. I need him to stand where you're
5 standing and face back towards the jury.

6 MR. HINSON: Yeah. I'll swap -- I'll swap that.

7 THE COURT: And speak very loud.

8 MR. HINSON: I'll go over here.

9 BY MR. HINSON:

10 Q: Could you point with your fingers where each thing is
11 at?

12 A: The abdomen is here, the chest and abdomen. That's the
13 aorta actually.

14 Q: That's carrying blood?

15 A: That's carrying a lot of blood. And the back here is
16 right here. What we're seeing -- and I believe this is at
17 the level of T9-10. This is the vertebra, vertebral body.
18 These are the facet joints on either side, and that -- from
19 the facet joint on the left side here, a bone spur was
20 growing in and compressing the spinal cord.

21 Q: And I'll take that down. Doc, even on this far top
22 right, just generally what are we looking at there?

23 A: This is normal. This is at the T10-11 level. This is
24 the vertebral body. This is the spinal canal. This is
25 spinal fluid around the spinal cord, and the spinal cord has

1 a relatively normal configuration. However, there's a lot of
2 dense scar from previous surgeries.

3 Q: And the bottom -- the bottom image there, Doc?

4 A: This is a little bit further south between 11 and 12.

5 Q: So further -- closer to the legs?

6 A: Closer to the legs. This is the vertebral body, the
7 spinal canal. The house again, the floor, the sidewalls, the
8 roof. And at this level, there's a ligament that runs
9 between each vertebra on the back called the ligamentum
10 flavum. The ligamentum flavum was thickened and somewhat
11 compromising the spinal canal.

12 So Crystal Goodwin had spinal stenosis. And spinal
13 stenosis that she was born with, a congenitally narrow spinal
14 canal, and then an acquired stenosis on top of that formed by
15 scar tissue from prior surgery, as well as the formation of
16 bone spurs involving the roof of the house and the ligaments
17 that were thickened between the shingles of the house.

18 Q: Thank you, Dr. Lustgarten. Appreciate that. You can
19 take that back. And so after that imaging was done, Dr.
20 Lustgarten, was there a subsequent appointment in July?

21 A: Yes.

22 MR. HINSON: If I may hand up an exhibit to the witness?

23 THE COURT: Yes, sir.

24 BY MR. HINSON:

25 Q: Doc, I'm going to hand you what's been marked as Exhibit

1 9, which is the -- except that it's right here, Doc -- which
2 is the office note from July 18th, 2016, and tell us from
3 your review of the record what happened in that office visit?

4 A: Well, in this office visit, Dr. Holbrook again did a
5 history and physical examination. And lo and behold, the
6 neurological complaints she had a month before were gone.
7 The examination where she had weakness and loss of sensation
8 from the waist down the month before was gone. Her
9 neurological exam was normal.

10 I find that to be very significant, because the only
11 thing that could have caused something like that to occur on
12 the 20th and to disappear with a normal exam would be
13 vascular insufficiency -- insufficiency to the spinal cord,
14 where it's called a transient ischemic attack, TIA, where you
15 have a transient loss of neurological function due to
16 vascular insufficiency, ischemia, but then corrects itself
17 and reverts to normal. That's a red flag. That tells me
18 that Crystal Goodwin's spinal cord was extraordinarily
19 sensitive to the profusion of arterial blood to it.

20 On this occasion, her blood pressure was 129 over 81,
21 which is a mean arterial pressure of 97, and when you combine
22 the visit from June 20th with this visit, the average mean
23 arterial pressure that Dr. Holbrook was aware of was 111.

24 Q: All right.

25 MR. HINSON: Mr. Goings, could you put up Number 20,

1 please? I'm sorry. That was -- thank you.

2 BY MR HINSON:

3 Q: Doc, is what we put on the screen -- does that summarize
4 the data we've looked at, the evidence we've looked at with
5 regard to Crystal's blood pressures in Dr. Holbrook's office
6 in 2016?

7 A: Yes, sir.

8 MR. HINSON: Your Honor, we would move to introduce this
9 as Plaintiffs' -- the next numbered exhibit in the case as a
10 summary of information and evidence in the case.

11 THE COURT: 16?

12 MR. HINSON: Number 16.

13 THE COURT: No, we're not on 16. 17?

14 THE COURT REPORTER: Yes, ma'am.

15 MR. HINSON: 17.

16 THE COURT: Any objection to Plaintiffs' 17?

17 MR. DAVIS: Your Honor, we respectfully object. The
18 medical records are in evidence.

19 THE COURT: Let me see the document.

20 MR. HINSON: We're offering this as a summary, and plus
21 it helps the jury with the math. It's kind of a complicated
22 formula, at least it is for me.

23 MR. DAVIS: Your Honor, we don't have a disagreement
24 about it. I just think it's unnecessary and repetitive to
25 put a summary prepared by the plaintiffs' counsel into

1 evidence. We don't disagree with the math, and we don't
2 disagree with the numbers. We disagree and object to this
3 summary. That's all.

4 THE COURT: All right. Plaintiffs' 17 will be admitted
5 over the defendant's objection.

6 (WHEREUPON, Plaintiffs' Exhibit Number 17, medical data
7 summary, was admitted into evidence.)

8 MR. HINSON: Thank you, Your Honor.

9 THE COURT: Is one already marked? Have we done it?

10 MR. HINSON: Yes. Number 17?

11 THE COURT REPORTER: Yes.

12 MR. HINSON: All right.

13 THE COURT REPORTER: Plaintiffs' Number 17.

14 MR. HINSON: Thank you.

15 THE COURT: Mr. Hinson?

16 MR. HINSON: Yes, ma'am.

17 THE COURT: Are you at a good stopping point or no?

18 MR. HINSON: As good as any, Your Honor.

19 THE COURT: Okay. Yeah. I think it's a good time to
20 take a lunch break, ladies and gentlemen. So I'm going to
21 send you to lunch. Be back at 2 o'clock.

22 Don't discuss the case amongst yourselves or with anyone
23 else. Don't do any research about the case. Actually, you
24 know what? Y'all came straight up to the jury --

25 How did they get upstairs? Do they know how to get in

1 and out? Yes? Okay.

2 THE BAILIFF: We'll show them how to get out, Your
3 Honor.

4 THE COURT: Okay. I'll see y'all -- let's make it 2:15,
5 at 2:15.

6 MR. HINSON: Could I just briefly ask Your Honor,
7 please? This is the first time I've tried a case here with
8 the glass in the way. I just want to make sure everybody can
9 hear Dr. Lustgarten well. He's a little bit soft spoken, and
10 I just -- would you mind? I'd ask that you poll the jury to
11 make sure they can hear the witness well.

12 THE COURT: Is there anyone who cannot hear the witness?
13 Raise your hand if you're having trouble hearing Dr.
14 Lustgarten.

15 Okay. Good.

16 So let me excuse you to be back in your jury room at
17 2:15. Thank you.

18 MR. HINSON: Thank you, Your Honor. Appreciate it.

19 (WHEREUPON, the jury exited the courtroom at 12:40 p.m.)

20 THE COURT: Court is in recess until 2:15.

21 Dr. Lustgarten, do not discuss your testimony with
22 anyone over the lunch break.

23 THE WITNESS: Yes, ma'am.

24 THE COURT: All right. Thank you. 2:15.

25 (WHEREUPON, there was a break in the proceedings, after

1 which the proceedings resumed as follows.)

2 THE COURT: All right. Bring the jury, please.

3 (WHEREUPON, the jury entered the courtroom at 2:26 p.m.)

4 THE BAILIFF: All jurors are seated, Your Honor.

5 THE COURT: Thank you.

6 Welcome back, folks. We are still on the direct
7 testimony of Dr. Lustgarten after a lunch break. He is still
8 under oath and back on the witness stand.

9 Mr. Hinson, you may proceed with your direct
10 examination.

11 MR. HINSON: Thank you, Your Honor. May it please the
12 court.

13 THE COURT: Yes, sir.

14 BY MR. HINSON:

15 Q: Dr. Lustgarten, before the break for lunch, we were
16 talking about the blood pressures and the clinical picture
17 for Ms. Crystal Goodwin in June and July of 2016. What was
18 the -- the plan to treat the condition we've been discussing?
19 What was Dr. Holbrook's plan according to the medical record?

20 A: To decompress the lower thoracic spinal cord.

21 Q: All right. And is that a surgical procedure?

22 A: Yes, sir.

23 Q: And in doing that, did the record indicate that he
24 ordered neuromonitoring to be done?

25 A: Yes, sir.

DR. GARY J. LUSTGARTEN - DIRECT BY MR. HINSON

1 MR. HINSON: May I approach the witness, Your Honor?

2 THE COURT: Yes, sir.

3 BY MR. HINSON:

4 Q: Dr. Lustgarten, I'm going to hand you what's been marked
5 as 16. That's the -- I'm sorry. Well, we don't have it on
6 the screen, but that's all right. Dr. Lustgarten, would you
7 just identify what we've marked as Exhibit 22?

8 A: It's a surgical order.

9 Q: Sorry. Exhibit -- Exhibit 16. I misspoke. We're sorry
10 for the confusion. It's Exhibit 16.

11 A: It's a surgical order from Dr. Thomas J. Holbrook's
12 office.

13 Q: And in that one -- what is this -- essentially, just
14 what is the document? What is -- what does that mean, a
15 surgical order?

16 A: It alerts the operating room as to what the procedure is
17 that's going to be done, and what the needs of the surgeon be
18 for the treatment of the patient.

19 Q: And does that order include an order for
20 neuromonitoring?

21 A: Yes.

22 Q: Okay. All right.

23 MR. HINSON: Thank you, Mr. Goings.

24 BY MR. HINSON:

25 Q: All right. And so right here it says name of instrument

1 rep company, Teresa Adkins, Specialty Care Monitoring. Just
2 generally what is that?

3 A: I believe that is the neuromonitoring technician who
4 will be doing the physical part of the neuromonitoring.

5 Q: All right. And was ordering the neuromonitoring
6 appropriate and the appropriate measures to be within the
7 standard of care?

8 A: Absolutely.

9 Q: Okay. And, Dr. Lustgarten, was the -- was there a
10 preoperative assessment done prior to the surgery that would
11 take place on July 28th, 2016?

12 A: Oh, certainly, Dr. Holbrook did so in his office on July
13 18th, and then there was an evaluation at the hospital on
14 July 22nd.

15 Q: All right, Doc.

16 MR. HINSON: May I approach the witness, Your Honor?

17 THE COURT: Yes, sir.

18 BY MR. HINSON:

19 Q: I'm going to hand you what's been marked as Exhibit 1.
20 Just generally, could you identify what that document is?

21 A: Yes. This is the nursing assessment done preoperatively
22 on July 22nd.

23 Q: And just generally, what is the purpose of doing a pre-
24 operative assessment like this?

25 A: For the nurses to record vital signs, the paramount

1 physical exam history, et cetera.

2 Q: All right. And what was Ms. Goodwin's -- Ms. Crystal
3 Goodwin's blood pressure during that preoperative assessment?

4 A: 156 over 92.

5 Q: All right. Is that a hypertensive patient? Is that a
6 patient with high blood pressure?

7 A: Yes, sir.

8 Q: All right.

9 MR. HINSON: May I approach the witness, Your Honor?

10 THE COURT: Yes, sir.

11 BY MR. HINSON:

12 Q: Dr. Lustgarten, I'm going to hand you what's been marked
13 as Exhibit 2. And generally, Dr. Lustgarten, what is Exhibit
14 2?

15 A: This is the anesthesiologist doing an evaluation prior
16 to surgery at approximately 6:45 in the morning.

17 Q: All right. Is this done the morning of surgery?

18 A: Yes.

19 Q: And what does the record indicate her blood pressure was
20 that morning?

21 A: 160 over 99.

22 Q: Is that a patient with high blood pressure or who is
23 hypertensive?

24 A: Yes.

25 Q: All right. Doctor, looking at those two blood pressures

1 from the hospital done pre-surgery, what's the mean arterial
2 pressure for the one done in the preoperative assessment on
3 the 22nd?

4 A: 113.

5 Q: And what's the -- what is the mean arterial pressure of
6 the blood pressure done the morning of surgery before surgery
7 begins?

8 A: 119.

9 Q: And what do those average out to?

10 A: 116.

11 Q: All right.

12 MR. HINSON: Your Honor, we would offer in as Exhibit
13 18, a summary of that evidence and doing the math similar to
14 the one before. We'd offer that as Exhibit 18. Excuse me.
15 Yeah. Exhibit 18.

16 THE COURT: Any objection or same objection?

17 MR. DAVIS: Same objection, Your Honor. These records
18 are in evidence, and a summary certainly can be helpful if
19 there's a volume of records, but these aren't voluminous.

20 THE COURT: Plaintiffs' 18 is admitted over the
21 defendants' objection.

22 (WHEREUPON, Plaintiffs' Exhibit Number 18, summary of
23 medical evidence, was admitted into evidence.)

24 MR. HINSON: Thank you, Your Honor.

25 BY MR. HINSON:

1 Q: All right. So, Dr. Lustgarten, would the standard of
2 care for a neurosurgeon require him or -- he or she to take
3 this information, the preoperative blood pressures in the
4 office and then the preoperative blood pressures that were
5 obtained at the assessment the week before proximally and the
6 morning of, and look at all that to determine a baseline
7 blood pressure?

8 A: Yes, sir.

9 Q: And have you undertaken to summarize all that data and
10 determine an average baseline blood pressure for Ms. Goodwin
11 at the time of surgery in 2016?

12 A: Yes.

13 Q: And what is that baseline blood pressure average taking
14 all of that information?

15 A: Well, 113.5.

16 Q: All right.

17 MR. HINSON: Your Honor, we have one last demonstrative
18 similar that takes all four of those data points and does the
19 math to average them all.

20 THE COURT: Same objection, Mr. Davis?

21 MR. DAVIS: Yes, ma'am.

22 MR. HINSON: All right.

23 THE COURT: That will be Plaintiffs' 19 admitted over
24 defense objection.

25 (WHEREUPON, Plaintiffs' Exhibit Number 19, summary of

1 medical evidence, was admitted into evidence.)

2 BY MR. HINSON:

3 Q: Dr. Lustgarten, taking this information -- well, we're
4 going to get into the specifics of Crystal Goodwin in just a
5 second, but are you familiar with the 20 percent rule of
6 thumb, what's often referred to as the 20 percent rule of
7 thumb?

8 A: Yes, sir.

9 Q: And what is that? What does that rule -- rule of thumb
10 say?

11 A: Some anesthesiologists use that rule to define what the
12 lower limits of a mean arterial pressure should be. That is,
13 if the mean arterial pressure is 100, then it's acceptable by
14 the 20 percent rule to go no lower than 80.

15 Q: And are there -- with a patient like Crystal Goodwin,
16 did they need to be kept within the 20 percent rule or is
17 there something specific to that kind of individual?

18 A: No. This is a blood pressure that is specific to
19 Crystal Goodwin. Every patient needs to have a patient-by-
20 patient consideration. One shoe does not fit all,
21 particularly in a patient who has a multitude of preexisting
22 risk factors that places her arteries in jeopardy if her
23 pressure falls too low.

24 Q: And so for a patient like Ms. Goodwin, what would --
25 where would the blood pressure need to be kept during

1 surgery?

2 A: At 113.

3 Q: So -- and, Doc, I understand, but can -- can -- can
4 anesthesiologists keep a blood pressure like a -- like a
5 bullet?

6 A: No. The operating room is a living situation, so to
7 speak, and -- and the blood pressures will vary, but the
8 rules of the road need to be laid down by the neurosurgeon
9 who has the best knowledge of the patient and who is the only
10 neuroscientist in the room as to what the blood pressure
11 should be maintained at to ensure the safety of his patient.

12 Q: All right. So, Dr. Lustgarten, I put up a demonstrative
13 here with these blood pressures, but with -- over the course
14 of the surgery, which we know is going to begin at around
15 7:40 and go to about 11:45, and then mean arterial pressure
16 is running from 70 to 120. What does this green line
17 represent or -- excuse me -- this -- I'm not colorblind.
18 What does this blue line right here represent?

19 A: That is the baseline, a mean arterial pressure.

20 Q: And then what is kind of -- again, understanding it
21 can't be a bullet, what would be a reasonable safe range to
22 keep a patient like Crystal Goodwin?

23 A: Well, certainly, the baseline should be maintained, but
24 because this is a living situation and things can vary, I
25 believe the mean arterial pressure could fall down to 105,

1 maybe even 100, but no lower than that.

2 Q: And what is it about Crystal Goodwin that leads you to
3 say that? Well, is that the standard of care to keep her
4 within the range you just described?

5 A: Yes. Keep her at baseline or as close to that as
6 possible.

7 Q: So keep her within -- out of this danger zone down here?

8 A: Yes, sir.

9 Q: And what is it about Crystal as an individual that leads
10 you to say that?

11 A: Because of all of her preexisting risk factors that
12 places her spinal cord at jeopardy for arterial blood flow.
13 That is to say that she has a history of obesity at the time,
14 certainly hypertension, probably diabetes, the most
15 significant of those factors being hypertension, which it
16 causes remodeling of the blood vessel, which prevents
17 autoregulation from taking place, as well as the fact that
18 the operation was going to be in the watershed arterial zone
19 of vulnerability, plus the fact that she had had previous
20 surgery on two occasions, '09 and '11 at 8 and 9, where scar
21 tissue had formed, which possibly could have compromised the
22 blood supply coming in at that level.

23 Q: So, Dr. Lustgarten, if the patient had been undergoing
24 their first surgery without this prior scar tissue we've
25 discussed, if the patient didn't have a history of many years

1 at that point of hypertension, if the patient didn't have
2 diabetes, if the patient didn't have obese -- wasn't obese,
3 would the -- would there be more variation here of what would
4 be appropriate?

5 A: Yes. And if you had a normal, healthy patient without
6 any vascular risk factors, the 20 percent rule might be able
7 to be applied, but in my experience, I don't like that 20
8 percent rule because that's one shoe fits all. It's not
9 individualizing treatment by patient by patient. It's not
10 earmarking what the needs of each individual patient may be.
11 And I don't like the 20 percent rule. I like whatever the
12 baseline mean arterial pressure is, keep it at that level.
13 Maybe squinch a little bit lower, but not much.

14 Q: Dr. Lustgarten, is there a mechanism by which a surgeon
15 preoperatively should speak with his anesthesiologist and
16 discuss the patient?

17 A: Yes.

18 Q: And what does that -- what is that duty referred to as?

19 A: It's a team conference, and that is the pertinent people
20 in the operating room are the neuromonitoring tech,
21 anesthesia, and the surgeon. Perhaps the circulating nurse,
22 the scrub nurse are there.

23 But there is what is called a, quote, time out that has
24 nothing to do with this. A time out just says this is the
25 right patient in the right situation and the right operating

1 room, and we're going to operate on this part of the anatomy
2 and be it -- and what -- the problem is on the right side,
3 we're going to operate on the right side. That's a time out.

4 The conference is something that the individual who is
5 the neuroscientist who knows the patient better than anyone
6 --

7 Q: And when you say the neuroscientist, who are you
8 speaking of?

9 A: Dr. Holbrook.

10 Q: Okay. Go ahead, please.

11 A: The neuroscientist in the room, Dr. Holbrook, who has
12 more knowledge of this patient than anybody, needs before the
13 case even begins to talk with and conference with the
14 anesthesiologist and the neuromonitoring tech in that regard
15 very briefly. This will take maybe 60 to 120 seconds to do
16 all of this. You give those people a brief history,
17 examination, and diagnosis of the patient, of what the
18 diagnostics showed, what surgery that I am going to perform,
19 what position the patient is going to be in, what intubation.
20 That goes more with the cervical region than the mid or low
21 back.

22 And then the surgeon has to define what the parameters
23 of maintenance of blood pressure should be. This is an
24 educational, informative conference which may take 120
25 seconds to explain all of that, to alert anesthesia and the

1 neuromonitoring tech as to what the surgeon requires to
2 maintain the safety of his patient.

3 Q: So with regard to Crystal Goodwin, this preoperative
4 conference, should it have included information about where
5 the neurosurgeon would instruct anesthesia to keep his
6 patient's intraoperative blood pressure, the patient's blood
7 pressure during surgery?

8 A: Yes.

9 MR. DAVIS: Your Honor, I object to the leading. This
10 is his expert.

11 THE COURT: Sustained. Rephrase your question.

12 MR. HINSON: I'll rephrase.

13 BY MR. HINSON:

14 Q: Dr. Lustgarten, what types of information for Crystal
15 Goodwin should have been in that preoperative conference?

16 A: Regarding the mean arterial pressure, certainly the two
17 office visits recorded by Dr. Holbrook and the two
18 preoperative blood pressures taken by anesthesia. And you do
19 a sum total of that, and the average is 113.5.

20 Q: Should Dr. Holbrook have instructed the anesthesiologist
21 in the surgery as to where he would like Crystal Goodwin's
22 blood pressure during surgery kept, the range he would like
23 it kept?

24 MR. DAVIS: Same objection, Your Honor. It's leading.

25 MR. HINSON: Your Honor, it's -- I mean, I didn't

1 suggest an answer. It's a yes or no question.

2 THE COURT: Right. A leading question. The objection
3 is sustained.

4 MR. HINSON: I'll rephrase.

5 BY MR. HINSON:

6 Q: Your Honor -- excuse me. Your Honor? I've elevated you
7 from doctor to judge. I'm sorry. Dr. Lustgarten, would
8 there be direction to the anesthesiologist and, if so, what
9 would that -- what type? What would that direction include?

10 A: During this conference, the neurosurgeon would explain
11 to the anesthesia -- anesthesiologist, based upon his
12 knowledge of this patient over many years, that she is a high
13 risk patient for vascular ischemia and infarction because of
14 the history of hypertension and remodeling and the diabetes
15 and obesity and previous surgeries and no autoregulation and
16 the watershed zone being operated on. All this is
17 informative information that persuades the anesthesiologist
18 to keep the blood pressure at the level that the surgeon
19 wants in order to be safeguarding the patient, the patient's
20 best interest.

21 Q: Dr. Lustgarten, from your review of the materials,
22 deposition testimony that's been taken in this case, did such
23 a preoperative conference occur between Dr. Holbrook and the
24 anesthesiologist?

25 A: No, it did not, and I really have to refer to Dr.

1 Holbrook's deposition, page 20 -- 29. The historical
2 baseline blood pressure should be considered, and he
3 considered that. He didn't.

4 Page 35. The intraoperative blood pressure should --
5 quote, should be maintained in accordance with that
6 particular patient, which he doesn't do at all.

7 Page 37. For each patient, there may be a different
8 range where blood pressure should be maintained at by the
9 anesthesiology team.

10 So at least in my review of Dr. Holbrook's deposition,
11 he realized the importance of what the blood pressure should
12 be maintained at, and that this should have been relayed in
13 the preoperative conference to the entire team.

14 Q: Did you see any evidence that it was relayed to the
15 team?

16 A: No.

17 Q: All right.

18 MR. HINSON: May I approach the witness, Your Honor?

19 THE COURT: Yes, sir.

20 BY MR. HINSON:

21 Q: Dr. Lustgarten, I'm going to hand you Exhibit 5, which
22 would you just identify what we're looking at with Exhibit 5?

23 A: This is the anesthesiology record for the surgery which
24 was performed on the morning of July 28th.

25 Q: I've got two copies of it here because I want to write

1 on one. And, Dr. Lustgarten, what are we looking at right
2 here?

3 A: Those are the systolic and diastolic blood pressures.

4 Q: So the ones on the --

5 A: The arrow down is the systolic, the little arrow up are
6 the diastolics.

7 Q: And just so we understand, there's a lot of -- lot of
8 data here. It goes across several pages. What is the length
9 -- what is the interval or length of time between each of
10 these little lines running up and down?

11 A: Five minutes.

12 Q: From your review of this record, was Crystal Goodwin's
13 blood pressure maintained at a safe range for her during the
14 operation performed on July 28th, 2016?

15 A: No.

16 Q: Dr. Lustgarten, a minute ago you talked about the
17 preoperative conference. Did Dr. Holbrook violate the
18 standard of care by failing to have a preoperative
19 conference?

20 MR. DAVIS: Objection. Leading.

21 THE COURT: Overruled.

22 MR. DAVIS: Thank you.

23 BY MR. HINSON:

24 A: Yes, he did.

25 MR. HINSON: May I approach the witness, Your Honor?

1 THE COURT: Yes, sir.

2 BY MR. HINSON:

3 Q: Dr. Lustgarten, I'm going to hand you what's been marked
4 as Exhibit 15, the neuromonitoring records. And just
5 generally speaking, Dr. Lustgarten, just what is that you're
6 holding in your hand as Exhibit 15?

7 A: So this is the event log and tracings of the MAPs and
8 SSEPs from the baseline to when they disappeared.

9 Q: All right. And I want to turn your attention to page 36
10 of that record. I want to turn your attention to right here,
11 about halfway down on 36. What does that indicate with
12 regard to Crystal Goodwin's vital signs at 9:56 a.m.?

13 A: That her blood pressure was 103 over 64.

14 Q: Is that 103 over 64 charted on the anesthesia record?

15 A: No.

16 Q: Would -- would a patient have multiple blood pressure
17 cuffs on during the surgery?

18 A: No, there's only one blood pressure cuff here.

19 Q: Okay. So where would that information have to have --
20 this 103 over 64, where would that have come from?

21 A: I believe the technician would have looked up at the
22 screen that the anesthesiologist was utilizing to record the
23 blood pressures and taken it off that screen.

24 Q: Is that information available to the neurosurgeon as
25 well?

1 A: Yes. Sometimes the angle of the screen is not situated
2 where the surgeon may be able to see it, but the information
3 would be available if asked.

4 Q: And, Dr. Lustgarten, taking the -- all this data --

5 A: I might point out that the mean arterial pressure for
6 that is 77.

7 Q: For the --

8 A: 103 over 64.

9 Q: Okay. Great. Dr. Lustgarten, what are we looking at
10 here on this chart that's been prepared?

11 A: A graph of the mean arterial pressures from inception of
12 the case at -- what? Is that 7:50? I can't see it -- all
13 the way to what? Eleven?

14 Q: 11:45.

15 A: 11:45.

16 Q: Does this graph accurately summarize the mean arterial
17 pressures taken from the anesthesia record on both these two
18 pages, plus that extra data that we saw from the
19 neuromonitoring record?

20 A: Yes, sir.

21 MR. HINSON: Your Honor, we would -- plaintiffs would
22 seek to move this summary of the evidence in as Exhibit 20.

23 THE COURT: Same objection?

24 MR. DAVIS: Your Honor, that's a demonstrative exhibit,
25 and we object.

1 MR. HINSON: This is a tremendous amount of data with
2 this relatively complicated formula, and the parties actually
3 exchanged during the course of the discovery a request to
4 admit that we agreed as to the calculation of all the
5 pressures there.

6 THE COURT: The objection is sustained. This will not
7 be admitted into evidence.

8 MR. HINSON: Thank you, Your Honor. Appreciate your
9 consideration.

10 BY MR. HINSON:

11 Q: All right. Dr. Lustgarten --

12 MR. HINSON: Let me ask Mr. Davis. This is what we're
13 looking at here, please.

14 MR. DAVIS: Thank you.

15 BY MR. HINSON:

16 Q: What are we looking at there on the screen here?

17 A: Once again, the graph of the mean arterial pressures
18 from inception to end of case.

19 Q: And what is this? The mean arterial pressure baseline
20 would be where?

21 A: 113.

22 Q: So in this range right here, where I'm pointing?

23 A: Yes, sir.

24 Q: Okay. What does this graph tell you when you take the
25 data from this chart, plus the extra 77 from the

1 neuromonitoring record?

2 A: It tells me that her mean arterial pressures for nearly
3 the entire operative case was in the danger zone. I
4 particularly referenced the time between 9:20 a.m. and 9:55
5 a.m., and the reason for that is that with the
6 neuromonitoring methods being utilized, the MEPs after about
7 9:15 because of a muscle paralyzing agent that was given by
8 anesthesia because they were having trouble with the airway
9 tube, she was biting on it and moving on it, so they
10 paralyzed her.

11 Q: When you say -- now, when you say paralyzed, what do you
12 mean there?

13 A: They gave a drug. It's a neuromuscular blockade or
14 rocuronium, which prevents a chemical crossing from nerve to
15 muscle to make the muscle work. It blocks that transmission.

16 Q: And --

17 A: So --

18 Q: -- again, what was the purpose of giving that, though?

19 A: In order to situate and rearrange the tube. She was
20 biting on it. It was moving. So maybe they gave her that to
21 paralyze it to secure her airway, which is reasonable, but
22 the MEPs were lost. So all we're left with now are the
23 SSEPs, and the SSEPs dropped out at or about 10:03 in the
24 morning, but all the mean arterial pressures take -- and
25 remember I said the SSEPs may not show a change for between 5

1 and 33 or 35 minutes after the damage is done. That's why I
2 backed it up from 10 o'clock to 9:20 and recorded the blood
3 pressures between 9:20 and 9:55. They averaged 87, not
4 considering that one of 77, so her mean arterial pressures
5 were probably more in the 83 to 84 range, which was far
6 under, quote, the 20 percent rule and well under her mean
7 arterial pressure.

8 Q: Is this an appropriate blood pressure for Crystal
9 Goodwin?

10 A: Absolutely not.

11 Q: Dr. Holbrook -- Dr. -- Dr. Lustgarten, looking at
12 Exhibit 15, the neuromonitoring record, would you turn to
13 page 54?

14 A: Okay. I have it.

15 Q: All right. Dr. Lustgarten, what -- just what is it
16 we're looking at here? What is -- what is -- on page 54 of
17 Exhibit 15, what is going on here? What is this?

18 A: This is an event log, monitoring log that is being
19 recorded by the neuromonitoring technician in real time in
20 the operating room, and this information goes on to the
21 remote interpreter, the physician.

22 Q: And where do you understand Dr. Herb Gregg to be at this
23 point?

24 A: Pardon me?

25 Q: Dr. -- Dr. Herb Gregg? Is he in the operating room or

1 is he somewhere else?

2 A: Oh, no. He's remote. He's out in Colorado or wherever
3 he is.

4 Q: Does Memphis, Tennessee, ring a bell?

5 A: Right.

6 Q: Not that it matters, but he's not in the room?

7 A: Right.

8 Q: And is this essentially -- well, is he communicating
9 with someone? Dr. Herb Gregg?

10 A: This is information that is being supplied to him.

11 Q: Yep. By whom?

12 A: By the technician.

13 Q: Okay. And what is her name?

14 A: Adkins.

15 Q: Yep. And what does this record indicate? Keeping in
16 mind it's at -- on Central Time from Memphis, Tennessee, what
17 does it indicate happened at approximately 10:03 because it
18 says 9:02:48? What happened at 10:03 a.m.?

19 A: The SSEPs disappeared.

20 Q: And does that record -- that -- that chat log between
21 Ms. Adkins and Dr. Gregg, does it indicate that Dr. Holbrook
22 was made aware of the loss of signal?

23 A: Yes.

24 Q: Now, does the standard of care -- when neuromonitoring
25 signals, MM -- MMEPs -- I mean, MEPs have been lost due to

1 the biting on the endotracheal tube --

2 A: Probably due to the drug that was given.

3 Q: Okay. Do you have any criticism of Dr. Holbrook for
4 that?

5 A: No.

6 Q: And so now at 10:03, the other monitoring has been lost.
7 What did Dr. Holbrook do in response?

8 A: Nothing.

9 Q: Was that within the standard of care?

10 A: No.

11 Q: What does the standard of care require for a
12 neurosurgeon who, during the course of a spine surgery, loses
13 signal -- neuromonitoring signal from his patient's lower
14 extremities, from his patient's legs?

15 A: Well, the entire team is alerted. Each individual has
16 their own specific realm of influence and job that they have
17 to do to determine why a signal was lost, but it's a system
18 of checks and balances that if one part of the team
19 recognizes something is wrong on another member of the team,
20 he should alert that member of the team.

21 But what should happen on this occasion when this
22 dropped out, the neuromonitoring is -- first of all, the
23 surgeon surveys his operative field, and he'd bang the cord
24 and he'd do something with the cord. Did he do some act that
25 traumatized the cord? No, he did not. Dr. Holbrook said in

1 his deposition he did not do anything to explain the loss of
2 the SSEPs.

3 Then the neuromonitoring tech looks at the equipment,
4 the needles, the leads going to the machine, the hookups to
5 make sure everything there is in order. Everything there was
6 in order. Anesthesia checks the depth of anesthesia and the
7 agents that they're using.

8 And when all of that is done and everything is all
9 right, the only thing that you need to look at is the blood
10 pressure and the body temperature. The blood pressure across
11 the board here, mean arterial pressure was too low. This
12 caused ischemia and infarction of the spinal cord. The body
13 temperature was minimally lower than normal, but that was not
14 influencing anything.

15 Q: Doctor, does the medical record and the testimony you've
16 read in this case -- does it indicate that Dr. Holbrook ever
17 made the attending anesthesiologist aware of these events at
18 10:03?

19 A: No. And there are steps to be taken when that happens
20 to raise the blood pressure immediately. You give drugs that
21 will cause the blood vessels to constrict, like phenylephrine
22 to make the blood pressure go up. You give fluid load, but
23 you do everything you can to re-establish the mean arterial
24 pressure that the patient should have.

25 Q: Doctor, have you reviewed any medical literature related

1 to what to do if intraoperative neuromonitoring goes out?

2 A: Yes, sir.

3 Q: And have you brought that article with you today?

4 A: Yes.

5 Q: In your review, is that article reliable authority in
6 the field of neurosurgery and neuromonitoring?

7 A: Yes, sir.

8 MR. HINSON: Your Honor, we seek to publish this
9 article. We don't seek to admit it. We seek to publish this
10 article, "Management of Intraoperative Neuromonitoring Signal
11 Loss."

12 THE COURT: Does it have an exhibit number?

13 MR. HINSON: No. No, Your Honor.

14 UNIDENTIFIED MALE: It does.

15 MR. HINSON: It does have an exhibit number? I'm sorry.
16 It does?

17 UNIDENTIFIED MALE: It does.

18 MR. HINSON: It does.

19 THE COURT: Which exhibit number is it? 6 or 7?

20 MR. HINSON: 7, Your Honor.

21 THE WITNESS: 7, Your Honor.

22 THE COURT: Any objection to publishing Plaintiff's 7?

23 MR. DAVIS: No, Your Honor. I believe they've laid the
24 proper foundation.

25 THE COURT: Okay. You may proceed.

1 BY MR. HINSON:

2 Q: Doc, let me hand you a copy. You've got a copy with
3 you? Here's a clean one. Yep. Dr. Lustgarten, what are we
4 looking at there on the screen? You've got a copy there in
5 your hand. I know you're a little ways from the screen.

6 A: It's a treatise that was published by *ScienceDirect*,
7 Elsevier is the publisher, entitled "The Management of
8 Intraoperative Neuromonitoring Signal Loss."

9 Q: And the published date here is 2015. Would this be
10 before or after the surgery we're talking about?

11 A: Before.

12 Q: Does this article from *ScienceDirect* -- does it discuss
13 what you were previously talking about, what to do if
14 neuromonitoring signal is lost?

15 A: Yes, sir.

16 MR. HINSON: Could you please put up the algorithm
17 there? Just in case when technology fails me, I like to have
18 a backup. Mr. Goings is doing such a good job, I don't
19 necessarily need it.

20 BY MR. HINSON:

21 Q: But, Dr. Lustgarten, what are we looking at right here?

22 A: It's an algorithm of the steps taken when a signal is
23 lost.

24 Q: And is this algorithm, as you put it, is it -- how does
25 it compare with what you just discussed?

1 A: This is standard operating procedure of what is done by
2 the -- by the team, acting in concert and together, as to the
3 actions each individual takes and the team takes to solve the
4 problem.

5 Q: And in the operating room on June 28th, 2016, who's in
6 charge of that team?

7 A: The surgeon.

8 Q: In this case, who would that be?

9 A: Dr. Holbrook.

10 Q: And tell us from your review of the materials, the
11 deposition testimony that's been taken, how far down these
12 steps did Dr. Holbrook get?

13 A: Zero.

14 Q: Well, did he ask the neuro --

15 A: No. What I'm saying by that, there should be one
16 bracket above that, and that's where the surgeon checks what
17 he does. That stays zero. He did ask the equipment -- the
18 monitoring technician to check the equipment, which she did.

19 Q: And from your review of the materials, what did the
20 neuromonitoring technician tell him?

21 A: There was no problem with the -- the equipment.

22 Q: And what did Dr. Holbrook do in response?

23 A: I believe he felt that there was something wrong with
24 the equipment.

25 Q: Did he continue with the surgery or did he -- did he go

1 down the rest of his checklist?

2 A: No. He continued with the surgery.

3 Q: Was that an appropriate decision within the standard of
4 care?

5 A: It was inappropriate and outside the standard of care.

6 Q: Was it reckless to stop the check at step one?

7 MR. DAVIS: Your Honor, objection to the leading.

8 THE COURT: Sustained.

9 BY MR. HINSON:

10 Q: Dr. Lustgarten, how did -- what risk to the patient did
11 Dr. Holbrook's decision to stop at step one pose?

12 A: Permanent injury to the spinal cord, an infarction of
13 the spinal cord. The other thing I would just like to point
14 out in this article under paragraph 4.3, and I'll quote. A
15 minor drop in blood pressure can lead to significant SSEB
16 changes that may reverse with increasing perfusion pressure.

17 Q: Was the perfusion pressure ever increased in the face of
18 this signal loss?

19 A: No. As a matter of fact, if you go back to the
20 anesthesia record after all this took place, there was a
21 sustained period of time where -- you know, where the mean
22 arterial pressures --

23 THE COURT REPORTER: He's all over the microphone.

24 THE COURT: What?

25 THE COURT REPORTER: He's covered my microphone.

1 THE COURT: Oh, one of the -- somebody? There are
2 microphones up there.

3 THE WITNESS: Oh.

4 THE COURT REPORTER: Thank you.

5 BY MR. HINSON:

6 A: Is that the graph that you had there?

7 Q: I'll put that graph back up for you.

8 A: If you look to the right side --

9 Q: Right side of?

10 A: That graph.

11 Q: Okay.

12 A: In there, all of those. Nothing -- not only was nothing
13 done to increase the mean arterial pressure or perfusion
14 pressure, it got worse. The mean arterial pressures
15 continued to be amazingly low, adding insult to injury.

16 Q: What about this little -- this little spike right here
17 after the 77? Is that anything?

18 A: I can't explain that. I don't know what that was. It's
19 just out of context.

20 Q: But after that spike, how did the blood pressures look?

21 A: They were at or even less than what they were between
22 9:20 and 9:55.

23 Q: So, Dr. Lustgarten, so we understand, in the face of
24 this signal loss, what should Dr. Holbrook have done in --

25 A: After?

1 Q: In -- in layman's terms for us non-neurosurgeons.

2 A: He turns to anesthesia and say cut back on your
3 anesthesia and even go to intravenous anesthesia instead of
4 general, increase the blood pressure by giving volume, fluid
5 volume, and more importantly, chemicals that causes blood
6 vessels to constrict to raise the blood pressure. So you
7 give vasoconstrictor drugs, you give fluid load to increase
8 the blood pressure while you're changing the anesthesia from
9 a general to what is called TIVA, total intravenous
10 anesthesia, where you can even wake the patient up to ask
11 them to move. That's called the Stagnara wake-up test.

12 So after all of this is done, if a patient is still
13 paralyzed and not -- is still not responding to what is done,
14 you can wake the patient up, and the Stagnara wake-up test is
15 the gold standard for testing motor function in the patient.

16 And I might just state in the same article under
17 paragraph 4.5, it quotes, the gold standard for ultimate
18 assessment of functional integrity of the spinal cord during
19 surgery, it requires partial awakening the patient
20 interoperably to test the motor function.

21 So that's why I say you change from general to
22 intravenous anesthesia. You wake the patient up, and that is
23 the gold -- the gold standard for testing the integrity of
24 the motor pathways in the spinal cord. None of that was
25 done.

1 Q: Dr. Lustgarten, is the Stagnara wake-up test some
2 archaic thing that's never done anymore?

3 A: No. I -- no. And I realize several people in
4 depositions said it's archaic and it is not done. It's done.
5 This is an article in 2015.

6 Q: Was -- was the attending anesthesiologist in the room
7 when this signal loss occurred at approximately 10 o'clock?

8 A: Dr. Root was not in the room.

9 Q: What if -- what should have been done, if anything, with
10 Dr. Root having not been there?

11 A: Well, the surgeon and the CRNA should have asked for the
12 anesthesiologist to come back in the room and give her
13 opinion as to what's going on and what to do.

14 Q: If, for whatever reason, the CRNA didn't undertake to do
15 that, what should Dr. Holbrook have done?

16 A: He should insist that a board-certified M.D.
17 anesthesiologist come into the room to evaluate the
18 situation.

19 Q: Given that the CRNA did not alert the attending
20 anesthesiologist, was the standard of care complied with by
21 Dr. Holbrook not undertaking to have someone go bring Dr.
22 Root, the anesthesiologist, in the room?

23 A: The standard of care was not met.

24 Q: Approximately -- so approximately how much time would
25 elapse after the signal loss before the surgery was

1 completely over?

2 A: Approximately an hour and 45 to 2 hours.

3 Q: And so the surgery begins at -- or the patient goes
4 under anesthesia at 7:25. Approximately how long is the
5 whole surgery?

6 A: Probably four and a half, five hours.

7 Q: Dr. Lustgarten, what happened -- well, what was the
8 patient's condition then when she -- well, Crystal Goodwin's
9 condition when she woke up in recovery in the early part of
10 that afternoon?

11 A: She was paraplegic. She was paralyzed.

12 Q: When the signal went off and indicated there was no
13 SSEPs to the lower extremities, was there a timeliness issue
14 at that point? Did something need to be done or could it
15 wait till later?

16 A: It needed to be done immediately.

17 Q: And just generally from a medical standpoint, with
18 regard to the spinal cord, why did something need to be done
19 immediately?

20 A: Well, there's an entity called the -- the penumbra, the
21 neurological penumbra. That is the onset of symptoms due to
22 ischemia that is reversible if the ischemia is reversed. So
23 the ischemic penumbra can be reversed if proper action is
24 taken within 30, 45 minutes, an hour, even up to two hours.

25 Q: And if perfusion had been increased in response to this

1 signal loss at approximately 10 o'clock, if in the next, say,
2 hour, if the blood pressure had not been allowed to drop this
3 low, had it been brought up, do you have an opinion to a
4 reasonable degree of medical certainty as to what the outcome
5 would have been had the blood pressure been brought up in the
6 face of this signal loss?

7 A: Yes.

8 Q: And what is that opinion?

9 A: She would have recovered useful function of her lower
10 extremities and would have had control of her bowel and
11 bladder. Now, would she have gotten back to square one,
12 right back to normalcy? Might she have had a little bit of
13 sensory loss in the legs? Maybe a minor degree of weakness?
14 That's possible, but she would have been functional in her
15 activities of daily living with control of her bowel and
16 bladder.

17 Q: Would she be in a wheelchair today?

18 A: No, sir.

19 Q: She'd be able to control her bowel movements and her --
20 and her urine?

21 A: Yes, sir.

22 Q: Had the blood pressure been kept up around the 113
23 preoperative baseline, do you have an opinion to a reasonable
24 degree of medical certainty whether signal would have been
25 lost at approximately 10 o'clock?

1 A: I have an opinion.

2 Q: And what is that opinion, Dr. Lustgarten?

3 A: Signal would not have been lost.

4 Q: If that had occurred, would Crystal Goodwin be in a
5 wheelchair today?

6 A: She would not.

7 Q: After the surgery, were there any imaging studies
8 ordered?

9 A: Yes. An MRI was ordered by Dr. Holbrook.

10 Q: And --

11 A: Which was accomplished, I believe, at about 2:45.

12 Q: And was ordering the MRI appropriate?

13 A: Yes.

14 MR. HINSON: Could you pull up Number 14 for me?

15 May I approach the witness, Your Honor?

16 THE COURT: Yes, sir.

17 MR. HINSON: Thank you.

18 BY MR. HINSON:

19 Q: Dr. Lustgarten, I'll hand you what's been marked as
20 Exhibit 14. Just briefly, would you identify what that
21 document is?

22 A: It's the report of the MRI scan that was accomplished at
23 about 2:30 in the afternoon on July 28th.

24 Q: And does the -- when a physician, a neurosurgeon, orders
25 medical imaging, does he give information to the radiologist

1 or neuroradiologist that's going to read and interpret the
2 imaging?

3 A: Yes, sir.

4 Q: And what's this right here in the history section?

5 A: That is the information supplied by Dr. Holbrook to the
6 radiologist.

7 Q: Given what we know of the clinical picture from July
8 28th, 2016, was this a truthful and accurate history that he
9 gave to the neuroradiologist?

10 A: No.

11 Q: What's inaccurate about that?

12 A: Prior thoracic spine surgery, that's accurate.
13 Bilateral leg weakness, left greater than right, since a fall
14 two days ago. She was paralyzed in both legs, and the fall
15 had nothing to do with it. The proper information should
16 have been intraoperative loss of neuromonitoring signals.
17 Patient is paraplegic. I need a stat MRI.

18 Q: Did Dr. Holbrook comply with the standard of care in the
19 way he wrote the history section to the radiologist who will
20 be reading that imaging?

21 A: No, he did not.

22 Q: What are operative reports? I know that's a pretty
23 elementary question, but just generally, Dr. Lustgarten, what
24 are operative reports?

25 A: It's a memorialization of the events that took place in

1 the operating room from the surgeon's point of view, step by
2 step what he did during the operative procedure.

3 MR. HINSON: May I approach the witness, Your Honor?

4 THE COURT: Yes, sir.

5 MR. HINSON: Thank you.

6 BY MR. HINSON:

7 Q: Doctor, let's go -- I'm handing you what's been marked
8 as Exhibit 13. Just generally, could you identify that
9 document for us?

10 A: This is a dictated operative report accomplished on
11 Crystal Goodwin by Dr. Thomas Holbrook on July 28th.

12 Q: And is that document complete and accurate?

13 A: No, it's not.

14 Q: Tell us -- looking here at the second page, what about
15 this document makes it incomplete or inaccurate?

16 A: There's no description in this document of the loss of
17 the MEPs due to the patient being paralyzed chemically by
18 anesthesia at or about 9:15, 9:20 in the morning. There is
19 no mention of the loss of SSEPs at or about 10:03 in the
20 morning. There are just blanks.

21 Q: And did Dr. Holbrook sign and verify this document?

22 A: Yes.

23 MR. HINSON: Scroll down just a little bit, Mr. Goings.

24 BY MR. HINSON:

25 Q: Should a neurosurgeon sign an operative report with

1 blanks in it?

2 A: No. Any errors upon reading it should be corrected and
3 the blanks should be filled in.

4 Q: Should the operative report for the surgery performed on
5 Crystal Goodwin on July 28th, 2016, include a description of
6 the neuromonitoring going out at 10 a.m.?

7 A: Yes. Now, there is a sentence, blank remains stable up
8 to a point and then abruptly stopped. Well, you know, I know
9 what happened here. I know the record, but it doesn't state
10 what --

11 Q: Without --

12 A: -- went out.

13 Q: Without now knowing the record, without the benefit of
14 the record we've looked at, would that -- would that sentence
15 be -- would that sentence be clear?

16 A: It doesn't make any sense.

17 Q: It says here the identifiable cause within the wound was
18 demonstrated. Just in layman's terms, what does that mean?

19 A: That means he found something surgically that caused the
20 problem. That's an inaccurate statement.

21 Q: From reading the testimony in this case, what did it
22 actually mean to say?

23 A: It should have not. The identifiable cause was not
24 found. We know that.

25 Q: When surgeons sign and verify their operative reports,

1 should they take the time to make sure they're accurate and
2 truthful?

3 A: Yes.

4 Q: In the face of a patient going paralyzed on the
5 operating room table, should they take the time to make sure
6 that their operative reports are truthful and accurate?

7 A: Yes.

8 Q: Dr. Lustgarten, I'm going to show you one more document
9 with regard to this issue.

10 MR. HINSON: Well, may I approach, Your Honor?

11 THE COURT: Yes, sir.

12 BY MR. HINSON:

13 Q: I'm going to hand you what we've marked as Exhibit 12,
14 and just -- this is the discharge summary that Dr. Holbrook
15 prepared in this case. What is a discharge summary?

16 A: That's a chronological summary of the events that took
17 place from admission to discharge.

18 Q: Does this discharge summary in any place make mention of
19 the neuromonitoring signal loss at 10 a.m. on the operating
20 room table?

21 A: No.

22 Q: Is that information that should be included?

23 A: Yes.

24 Q: Does the standard of care require a neurosurgeon in a
25 situation like the one we've been discussing to make sure

1 that the operative report makes mention of neuromonitoring
2 signal loss at 10 a.m.?

3 A: Yes. It's important for the contemporaneous record, and
4 it's important to sustain that record for any medical health
5 care provider in the future who may take over care and
6 treatment.

7 Q: It says right here she underwent the -- she underwent
8 the procedure described above and was transferred to the
9 recovery room. In the recovery room, she was unable to move
10 her legs with good strength and was taken back to the
11 operating room for exploration for her thoracic incision.
12 Does that -- as a physician, does that imply to you that
13 there was something that happened in the operating room at 10
14 a.m.?

15 A: Yes.

16 Q: What?

17 A: It makes it appear as though he's searching for a reason
18 for what occurred.

19 Q: Dr. Lustgarten, I'm going to look again at the -- I'll
20 move this around just for a second -- at the anesthesia
21 record. And do you have a copy of that there with you, or
22 did I take it away from you? Let's see here.

23 A: I have a copy of it.

24 Q: You've got it?

25 A: It was in my notes.

1 Q: Here it is right here. And my question, Doc, down here
2 at the bottom, what's being monitored there? What's being
3 recorded?

4 A: Well, the estimated blood loss and the urinary output.

5 Q: And for somebody of Crystal Goodwin's size,
6 approximately how much urine would you expect a patient to be
7 producing in a surgery like this per hour?

8 A: Upwards of over 60 cc an hour.

9 Q: Okay. And so in a four-hour surgery, you'd --

10 A: Four and a half, five hours. Yeah.

11 Q: How much urine does this chart indicate Crystal produced
12 over the course of the entire four-and-a-half hour surgery?

13 A: 80 cc.

14 Q: What am I holding in my hand there, Doc?

15 A: A container that looks like it has 80 cc in it.

16 Q: Okay. And so would you expect a significantly larger
17 volume of urine to be created over the course of this four or
18 four-and-a-half hour surgery?

19 A: Absolutely. What this is indicative of is a poor
20 perfusion of the kidneys through the renal arteries, that her
21 mean arterial -- mean arterial pressure was low. Not enough
22 blood was being supplied to the kidneys through the renal
23 arteries. If not enough blood is being supplied, it can't be
24 filtered and excreted as urine. And the fact is that she
25 averaged maybe 15 or 16 cc an hour, as opposed to you need 30

1 cc an hour just to get rid of the nitrogenous products that
2 we make day in and day out. And a normal human being who
3 voids maybe 1500 cc a day, you're looking at 60 to 70 cc an
4 hour of urinary output is normal.

5 Q: Does this low urinary output that you just described --
6 does it support or relate to the discussion you've had
7 earlier about blood pressures?

8 A: It totally supports my opinion that the mean arterial
9 pressure is low. It created an ischemic infarction of the
10 spinal cord. It also had its effect on the kidneys. Then
11 one might ask, why didn't it affect other organs? Well, the
12 lungs. The patient was intubated, getting oxygen under
13 pressure, so the lungs wouldn't be affected. The heart has
14 much better collateral flow and extracts more oxygen than the
15 arteries involving the spinal cord.

16 And the only way to determine whether or not there was
17 more cellular damage in other organs would have been to do
18 some blood tests after surgery to test the function of the
19 heart. It's an enzyme. It's troponins. Test the function
20 of the liver by getting liver enzymes to see if there was any
21 cellular malfunction of other organs as a result of the low
22 mean arterial pressure. For sure, the spinal cord suffered.
23 For sure, at least temporarily the kidneys suffered.

24 Q: Did Dr. Holbrook --

25 A: No tests were done to confirm any other organ.

1 Q: Yeah. Yes, sir. Did Dr. Holbrook order those tests
2 that would show us that the liver and the heart or other
3 organs were --

4 A: No.

5 Q: What would be involved in ordering those tests?

6 A: A needle stick in the arm and drawing some blood.

7 Q: Any risk to doing that?

8 A: Very little.

9 Q: Had Dr. Holbrook ordered those tests, what do you
10 believe they would have shown?

11 MR. DAVIS: Your Honor, I'm going to object to that.
12 It's speculation. I mean, as an expert, I appreciate and
13 respect that, but that is pure speculation, what something
14 would have shown. It was never done.

15 THE COURT: Overruled.

16 MR. HINSON: Based on all the data -- thank you.

17 THE COURT: Overruled.

18 MR. DAVIS: Thank you, Your Honor.

19 BY MR. HINSON:

20 Q: Had those -- had those tests been done, in your -- to a
21 reasonable degree of medical certainty as a physician, what
22 would those tests have shown?

23 A: In my opinion as far as the liver is concerned, there
24 would have been a temporary rise in liver enzymes indicative
25 of cellular dysfunction as a result of hypoxia, anoxia from

1 lack of arterial oxygenated blood given to the liver.

2 Q: And you just used a new term for us, hypoxia. Just
3 generally, what is that term?

4 A: Less than normal oxygenation.

5 Q: Okay. And can low blood -- blood perfusion cause
6 hypoxia?

7 A: Yes. It's called ischemic hypoxia.

8 Q: All right. Dr. Lustgarten, were there records -- from
9 after Crystal is in the hospital, after she goes to rehab,
10 were there more office records with Dr. Holbrook?

11 A: Yes, sir.

12 MR. HINSON: May I approach the witness, Your Honor?

13 THE COURT: Yes, sir.

14 BY MR. HINSON:

15 A: It was August.

16 Q: I'll hand them to you. I'm going to hand you two office
17 records, 10 and 11, Exhibits 10 and 11. I'll hold up 10.
18 And just generally speaking, Dr. Lustgarten, what is Exhibit
19 10?

20 A: It's a follow-up office visit of August 29th, 2016.

21 Q: And at the time he was seeing Ms. Goodwin before this
22 lawsuit had been filed, so after the event in the office --
23 or excuse me. After the event in the operating room before
24 there's a lawsuit, how did he describe what had occurred to
25 her spinal cord?

1 A: She had an ischemic event to her spinal cord during
2 surgery.

3 Q: And again, what is an ischemic event?

4 A: Ischemic meaning a lack of blood flow, lack of oxygen
5 and glucose going to the spinal cord tissue.

6 Q: All right. And let's look at Number 11, please. This
7 is a -- if you turn to Exhibit 11, that's the office visit
8 from 9/19/2018. I can't find what I was looking for. My
9 apologies. That's all right. Dr. Lustgarten, from your
10 review of the materials, including -- and -- well, what is
11 Crystal Goodwin's neurologic condition today?

12 A: The office visit prior to surgery on July 20th,
13 Crystal's neurological exam was normal. The American
14 Association of Spinal Injury has a classification of spinal
15 cord injuries from A to E. A, you're totally out. B, you're
16 totally out of motorized, limited sensation. C, you have a
17 little bit of motor activity. D, you have motor activity
18 where you can ambulate, but you're still weak, but you can
19 participate in your functions of -- activities of daily
20 living. E is normal. Prior to surgery, Crystal Goodwin was
21 E. After surgery, being wheelchair bound, weakness in her
22 legs, sensory loss, bowel and bladder, she would an AISA, A-
23 S-I-A, C, which basically precludes her from participating in
24 her normal activities of daily living.

25 Q: For all intents -- well, is she functionally paralyzed?

1 A: Yes.

2 Q: Is that condition -- at this point in 2023, is it
3 permanent or is it reasonable to expect she'll make recovery?

4 A: It is permanent.

5 MR. HINSON: If you would pull up 11 real quick? I did
6 find what I was looking for.

7 BY MR. HINSON:

8 Q: Looking back at Exhibit 11, the office -- the office
9 note from 9/19/2018 after the surgery but before the lawsuit,
10 how did Dr. Holbrook describe the injury at that point?

11 A: This was an ischemic injury to the spinal cord.

12 Q: And is what you've described with this low blood
13 perfusion -- is that -- is that -- is that also a type of
14 ischemic injury?

15 A: That is an ischemic injury.

16 Q: From your review of the record, did she suffer a
17 reperfusion injury like Mr. Heitman discussed in opening
18 statement today?

19 A: No.

20 Q: Tell us why not, why this doesn't fit with a reperfusion
21 injury?

22 A: Reperfusion and energy created by reperfusion is not
23 globally, even nationally and internationally, accepted by
24 experts right down the line. It's a very equivocal
25 diagnosis. It's a diagnosis of exclusion.

1 Q: And what does that mean, diagnosis of exclusion?

2 A: That means after you've ruled out every other reason for
3 the problem to exist, you might be able, under certain
4 conditions, to point your finger and say this was a re-
5 expansion syndrome. That's number one.

6 Q: Re-expansion and reperfusion?

7 A: Reperfusion causes expansion of the spinal cord and
8 injury.

9 Number two, in my experience, I've never had a patient
10 with a reperfusion injury, but in reading what literature is
11 available -- and there's not much. Patients who get
12 afflicted with a reperfusion injury have generally normal
13 arteries. That is arteries that can expand and contract,
14 they're flexible, they're elastic. They can allow this surge
15 of blood under pressure to cause mechanical damage to the
16 spinal cord and then subsequently chemical damage.

17 Crystal Goodwin had arteries that were like a rock. You
18 know, they -- they dampened, if anything, the effects of a
19 reperfusion syndrome.

20 Number three, at the time of this insult, her mean
21 arterial pressure was 86, 87. She never had a real surge of
22 high-pressure arterial blood flow getting through to cause a
23 reperfusion syndrome.

24 So for any one of a number of reasons, I cannot accept
25 any explanation of her injury other than spinal cord ischemia

1 and infarction, and that a reperfusion re-expansion syndrome,
2 in my opinion, is off the wall.

3 Q: How confident are you, Dr. Lustgarten, that this is not
4 a reperfusion injury?

5 A: 105 percent.

6 Q: Doctor, does the record support an ischemic injury?

7 A: Yes.

8 Q: Dr. Lustgarten, was the standard of care met in Dr.
9 Holbrook's 2016 treatment of Crystal Goodwin?

10 A: It was not.

11 Q: Had the standard of care been -- well, did the standard
12 of care not being met -- how did that impact Crystal Goodwin?

13 A: It caused an irreversible and permanent injury to the
14 spinal cord.

15 MR. HINSON: Thank you, Dr. Lustgarten. No further
16 questions at this time. Please answer any questions opposing
17 counsel might have.

18 THE COURT: Before cross-examination, let's take a short
19 break. Please return to your jury room. Please don't
20 discuss the case.

21 MR. DAVIS: Thank you, Your Honor.

22 (WHEREUPON, the jury exited the courtroom at 3:37 p.m.)

23 THE COURT: Court will be in recess for 15 minutes.

24 (WHEREUPON, there was a break in the proceedings, after
25 which the proceedings resumed as follows.)

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1 THE COURT: All right, folks. Let's do this. Let's
2 bring the jury, please.

3 (WHEREUPON, the jury entered the courtroom at 4:01 p.m.)

4 THE BAILIFF: All jurors are seated, Your Honor.

5 THE COURT: Thank you.

6 All right. It's now time for the cross-examination of
7 Dr. Lustgarten.

8 You may proceed.

9 MR. DAVIS: May it please the Court?

10 THE COURT: Yes, sir.

11 CROSS-EXAMINATION

12 BY MR. DAVIS:

13 Q: Iowa?

14 A: Yes, sir.

15 Q: Ever heard of Storm Lake?

16 A: Yes, I have.

17 Q: I graduated from high school there a long time ago.

18 A: You can't be all bad if you're an Iowan.

19 Q: I know. Thank you. When you mentioned the Air Force
20 duty, was that a result of the Berry plan?

21 A: No.

22 Q: It's a different scholarship situation?

23 A: No, I was just drafted.

24 Q: Oh, you were drafted? Okay. Sorry.

25 A: The good old-fashioned way.

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1 Q: The good old-fashioned way. And, Air Force, you said a
2 SAC base. That's a Strategic Air Command; is that right?

3 A: Yes, sir.

4 Q: What do they fly out of that base?

5 A: B-52s and 135s.

6 Q: Thank you for your service to our country, sir.

7 A: You're welcome.

8 Q: I want to ask you, as we kind of began about the artery,
9 I don't know how you call it, Adamkiewicz or Adamkiewicz?

10 A: Adamkiewicz. Yes, sir.

11 Q: Adamkiewicz. All right, sir. Does everybody have one
12 of those?

13 A: One hundred percent I can't say that, no.

14 Q: Okay. And when you're doing an operation like a
15 decompressive laminectomy, as Dr. Holbrook was doing in this
16 case, T9 through 12, can you see it?

17 A: No.

18 Q: The plaintiffs' counsel was -- and a lot of the exhibits
19 that he was putting up showed you some -- some images of the
20 -- I think it was a preoperative MRI that was ordered by Dr.
21 Holbrook of his patient, Ms. Goodwin, and there were sagittal
22 or side view and then a couple of axial or looking top down
23 the T9 and T10 levels. Do you remember that?

24 A: Yes, sir.

25 Q: And then there was something that kind of overlaid, he

1 said, an artist's rendering. It was labeled with different
2 things. Do you remember seeing that?

3 A: Yes, sir.

4 Q: Were you aware that that's a -- those are exhibits that
5 were prepared by the defendants? Were you aware of that?

6 A: Good artist.

7 Q: Thank you. So you agree that those are accurate?

8 A: I believe for illustration purposes and teaching
9 purposes, yes.

10 Q: Thank you. That sphere-like osteophyte in those images
11 that we prepared that they used that we saw pressing as you
12 look at that axial image, looking down on that T9, is that
13 osteophyte kind of like a spear pushing into the spinal canal
14 and displacing the cord off to the left. Do you know how
15 long that had been there?

16 A: I would say probably for years.

17 Q: Years?

18 A: Gradually getting bigger and bigger.

19 Q: Yes, sir.

20 A: It came from the facet joint. The facet joint was
21 mobile, degenerated, and started forming a bullishly large
22 osteophyte.

23 Q: Now, that's not Crystal Goodman's fault that that
24 happened?

25 A: No.

1 Q: It's not Dr. Holbrook's fault that that happened?

2 A: No, sir.

3 Q: It just happened?

4 A: Yes, sir.

5 Q: All right. And when -- when a -- when a bone -- an
6 osteophyte is a piece of bone?

7 A: Yes.

8 Q: Pushes into the spinal canal and moves the spinal cord
9 off to one side, like we saw in those pictures that we
10 prepared and they showed you, can that cause ischemia?

11 A: It's possible, but as I pointed out, that osteophyte was
12 progressive over a good period of time, and the spinal cord
13 can comply and adapt to something that's slowly pressing on
14 it.

15 Q: At some point, it can't adapt anymore, can it? I mean,
16 at some point it says, you know, I can't adapt anymore?

17 A: At some point decompensation occurs, but not at the time
18 of surgery on July 28th.

19 Q: But that's what -- something brought her back to Dr.
20 Holbrook after he operated on her twice in 2009 and 2011.

21 In June of 2016, she's back in the office with Dr. Holbrook,
22 her surgeon, and she's got complaints of leg weakness and
23 numbness; right? And he orders an MRI, this magnetic
24 resonance imaging, to try to see what's going on in there?

25 A: Yes, sir.

1 Q: And that's where he found out and the MRI showed that --
2 that bone pushing the canal to the side?
3 A: Yes.
4 Q: Okay. You were asked a good bit of questions and
5 understandably so about blood pressure in this case and the
6 anesthesia records that recorded the blood pressure. Do you
7 remember when he showed you the anesthesia record? Well,
8 I'll --
9 MR. DAVIS: Do you mind if I use yours?
10 MR. GOINGS: Yeah. No problem.
11 MR. DAVIS: Thank you.
12 BY MR. DAVIS:
13 Q: This is a pretty standard anesthesia record used in a
14 lot of hospitals across the country, isn't it?
15 A: Yes, sir. I believe that's the second page.
16 Q: Okay. Well, just for illustration purposes.
17 A: All right.
18 Q: Thank you, I appreciate that. Would you -- would you
19 want me to get the first page?
20 A: No. Whatever you'd like to illustrate.
21 Q: Okay. Thank you, Doctor. These little grids here, each
22 one of those little grids represents five minutes, doesn't
23 it?
24 A: Yes, sir.
25 Q: So if the blood pressures are recorded with these check

1 marks, the down check marks and the up check marks, those are
2 blood pressure readings?

3 A: Yes, sir.

4 Q: And they're recorded every five minutes?

5 A: Correct.

6 Q: It doesn't mean she doesn't have blood pressure in
7 between?

8 A: That is true.

9 Q: It could have been higher or lower in between?

10 A: It's possible.

11 Q: Sure. So if I hand you the anesthesia record, if I can
12 find it --

13 MR. DAVIS: I don't remember what exhibit that is.

14 MR. HINSON: 8.

15 MR. DAVIS: Okay. Thank you.

16 BY MR. DAVIS:

17 Q: Do you still have that with you?

18 A: I have my own copy.

19 Q: Okay.

20 A: It's marked up.

21 Q: I'm happy for you to look at your copy.

22 MR. HINSON: It's Number 1.

23 MR. DAVIS: It's Number 1. It's right here.

24 MR. HINSON: I'm sorry. I understand.

25 MR. DAVIS: 3?

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1 MR. HINSON: It's Number 5.

2 MR. DAVIS: Okay. Number 5. All right. Yeah. Thank
3 you, Mr. Hinson.

4 BY MR. DAVIS:

5 Q: Doctor, you can just look at this in evidence. So you
6 can handle that. In looking at the anesthesia records, what
7 do you discern the blood pressure was at 9:56? How would you
8 interpret that?

9 A: It looks like 120 over 70.

10 Q: And what would you interpret it at 9:57?

11 A: It's not there.

12 Q: It's not there. How about 9:58?

13 A: No, it's not there.

14 Q: 9:59?

15 A: It's not there.

16 Q: 10 o'clock?

17 A: It's there.

18 Q: What is that, sir?

19 A: 130 over 100.

20 Q: Okay. What do you discern from the anesthesia records,
21 sir, the blood pressure was at 9:55?

22 A: 117 -- 118 over 70.

23 Q: Yes, sir. How about 10:05?

24 A: 120 over 80.

25 Q: All right, sir. Looking back -- and I'll try to get the

1 neuromonitoring one.

2 MR. DAVIS: Is that in evidence?

3 MR. HINSON: Yes.

4 MR. DAVIS: Okay.

5 BY MR. DAVIS:

6 Q: He asked you some questions, sir, about the
7 neuromonitoring log, and I'm going to find that here for you.
8 It's kind of a thick exhibit. Here it is, Exhibit Number 15.
9 He asked you some questions about that, and I'd like to ask
10 you a few questions, too, if I could. Look with me, please,
11 sir. I think you said it was page 36, specialty care 0036, a
12 little number on the bottom right-hand side, sir.

13 A: 0036? Yes.

14 Q: You have that?

15 A: Yes.

16 Q: Right in the middle of that page. Let me read this and
17 tell me if you agree with what that record says. 09:56:18.
18 Do you see that between those two graphs on that page for
19 timing? Do you see that?

20 A: 9:56:18. Yes, sir.

21 Q: And would you agree that that would mean 9:56 and 18
22 seconds?

23 A: Yes, sir.

24 Q: All right. Now, the anesthesiologist is recording blood
25 pressures on his pre-printed chart every five minutes. So he

1 just did one at 9:55. He's not going to do another one until
2 10 o'clock, but the neuromonitoring tech records on her sheet
3 at 18 seconds after 9:56, BP 103 over 64. Did I read that
4 correctly?

5 A: Yes, sir.

6 Q: Now, I want you to turn on that same neuromonitoring log
7 to page 0054, the chat log that he asked you about. Just let
8 me know when you're there, sir.

9 A: All right.

10 Q: All right, sir. If you will, read from the bottom up
11 until you get to the entry that's at 9:58:20, and we know
12 it's 9 -- it's -- it's -- it says -- I'm sorry. It says
13 8:58:20 a.m. That's where the doctor was that was looking at
14 this, Dr. Gregg, but where Teresa Adkins, who was there in
15 the operating room, it was actually 9:58, wasn't it?

16 A: Yes, sir.

17 Q: So she records at 9:58:20, two seconds after she records
18 that blood pressure, she records SSEP stable at this time.
19 Did I read that correctly?

20 A: You did.

21 Q: The very next entry above that, because it kind of goes
22 from the bottom up in kind of reverse chronological order for
23 whatever reason, the very next entry above that at 9:01:47,
24 which we know is 10:01:47, Dr. Gregg, wherever he is, the
25 M.D. neuro -- neurologist; is that right?

1 A: Memphis, I believe.

2 Q: Memphis. Okay. Where --

3 A: Yes.

4 Q: I forgot where it was. I'm sorry. I'm glad you
5 remembered. He records in the chat log agree?

6 A: Yes, sir.

7 Q: Okay. So he's saying, yeah, Teresa, I agree those SSEPs
8 are stable?

9 A: Yes, sir.

10 Q: Right. Then if you go up two entries at -- at -- I'm
11 going to say 10:02:48 on this log, it says 9:02:48. Teresa
12 records just lost lower SSEPs?

13 A: Yes, sir.

14 Q: Between her entry at 9:58:20, where she says they're
15 stable, and the doctor a few seconds later says, yeah, I
16 agree, is there any documentation on this chat log where the
17 signals are starting to drift down, sir?

18 A: No.

19 Q: They just went out, didn't they? I mean, that's what
20 this -- what this record reflects?

21 A: Yeah.

22 Q: Okay. And then at -- at 10:07:36, Dr. Gregg says what
23 happened to the lowers; right? Did I read that correctly?

24 A: Yes.

25 Q: And the next entry, Teresa Adkins responds to him there

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1 on the chat log. She responds to him less than 10 seconds
2 later. IDK, I don't know, it just -- it was just in and then
3 it went out. Did I read that correctly?

4 A: Yes, sir.

5 Q: Turn with me then if you would, sir, to page 0053 in
6 this chat log, and if you would, kind of start from the top.
7 I know it's reverse chronology. It's always hard for me to
8 do that, but probably a lot easier for you, sir, but if
9 you'll go down 1, 2, 3, 4, 5, 6, 7, 8 from the top, where --
10 and the time, sir, is -- and I'm going to translate this to
11 the time that it was in the operating room. At 10:27:39, Dr.
12 Gregg says surgeon knows what we have? Did I read that
13 correctly?

14 A: Yes, sir.

15 Q: And the next entry, just a few seconds later, Ms. Adkins
16 says yes. He -- I just reported that the lowers remain out,
17 and he said they were nowhere near the cord when the loss was
18 reported. Did I read that correctly?

19 A: Yes, sir.

20 Q: If you turn to page 0052, sir, in this continuing chat
21 log and starting from the top, I'll try to count them, sir,
22 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 down where it says 10:01:37.
23 We know it's 11:01:37; right?

24 A: Yes, sir.

25 Q: Teresa Adkins there in the operating room, chatting with

1 her doctor offsite in Memphis, says could it possibly be from
2 head repositioning and got extended? Did I read that
3 correctly?

4 A: Yes.

5 Q: And a few seconds later, Dr. Gregg says yes. Did I read
6 that correctly? At 10:01:52, which is 11:01:52.

7 A: That's what it says, yes.

8 Q: The very next entry from Teresa Adkins in this back and
9 forth discussion, she in the operating room and Dr. Gregg in
10 wherever he is looking at everything, at 11:02:50, just a few
11 seconds later, Teresa Adkins documents that's really the only
12 thing I can think of. Did I read that correctly?

13 A: Yes.

14 Q: And the entry right above that -- I'm almost done -- at
15 11:03:44, Dr. Gregg says would have to be something that
16 caused issue with medial portion of the posterior columns.
17 Did I read that correctly?

18 A: Yes.

19 Q: Thank you.

20 A: I'd like to -- I'd like to point out --

21 Q: Yes, sir.

22 A: This fully involved the lower extremities, where if due
23 to the neck, the upper extremities would have dropped out as
24 well.

25 Q: Thank you. Did you -- would you wish to say anything

1 else? I'm happy to --

2 A: No, sir. I just wanted to point out that anatomical
3 fact.

4 Q: All right, sir. Thank you. You were asked some
5 questions about Exhibit 7, which was this medical article.
6 Do you still have that with you? If not, I'll put it in your
7 hand. I don't expect you to have memorized it. It's right
8 here, I believe. Let's see. Do you still have that, by any
9 chance?

10 A: I have it somewhere.

11 Q: I'll find it.

12 A: Yeah.

13 Q: Okay.

14 A: It's right here.

15 Q: Well, here, let me just -- I know you've got it. Let me
16 just have you -- if you would, look at the exhibit that's in
17 evidence. Okay? Or it's not in evidence. It's marked for
18 identification. But you read from it, I believe; is that
19 right?

20 A: Yes.

21 Q: Okay. Let me ask you to read with me under background,
22 and if you would go to the column on the right side, second
23 paragraph, it starts TC MEPS. Do you see that paragraph
24 there, sir?

25 A: Yes.

1 Q: Let me read this second sentence. In a study of 176
2 patients who underwent surgery for spinal deformity
3 correction. What is spinal deformity correction surgery,
4 sir?

5 A: Scoliosis curvature of the spine or a slippage of one
6 vertebra on another.

7 Q: And this wasn't scoliosis?

8 A: No, it wasn't.

9 Q: Okay. Down just below that after the words in the
10 sentence that end with detection of neurologic deficits, do
11 you see where I am where that next sentence starts similarly?

12 A: Yes, sir.

13 Q: Similarly, a study of 172 scoliosis patients, and that's
14 what you just were talking about?

15 A: Correct.

16 Q: And Crystal Goodwin doesn't have scoliosis?

17 A: That is correct.

18 Q: And this was not a scoliosis surgery, was it?

19 A: That is correct.

20 Q: Looking at the next page under paragraph 3, managing
21 signal change?

22 A: Yes, sir.

23 Q: If you'll look about halfway down that first paragraph,
24 sir, where it begins a Dutch group study, do you see -- do
25 you see where I'm -- where I'm at?

1 A: Yes, sir.

2 Q: Let me read this and ask you something about it. A
3 Dutch group studied 145 patients undergoing spinal deformity
4 surgery. That's that scoliosis kind of surgery?

5 A: Yes, sir.

6 Q: Looking at paragraph 4, heading 4.2 under step two,
7 assess for changes in anesthesia. Do you see that heading,
8 sir?

9 A: Yes, sir.

10 Q: Let me read that last sentence. However, further
11 studies are required to validate the benefits of total
12 intravenous anesthesia in spine surgery patients. That's
13 that TIVA you mentioned?

14 A: Yes.

15 Q: Right? Total what? Help me.

16 A: Total intravenous anesthesia.

17 Q: So if we say TIVA, it's total intravenous --

18 A: Anesthesia.

19 Q: -- anesthesia? Okay. What kind of anesthesia did she
20 have?

21 A: General, sevoflurane.

22 Q: Sevoflurane?

23 A: Yes.

24 Q: And there was rocuronium introduced, which is a muscle
25 paralyzer?

1 A: I think about 9:15.

2 Q: Yeah. And that was because she -- she had a kink in her
3 airway?

4 A: So there was some type of problem with the airway they
5 had to fix.

6 Q: Okay. And if the anesthesiology folks testified that
7 it's a kink in the airway, you would not have a dispute with
8 that?

9 A: No.

10 Q: Okay. And that can be a pretty serious situation for a
11 patient in an operating room having a problem with their
12 airway, isn't it?

13 A: Yes. But if that be the case, I would wonder in the
14 prone position in an obese patient why they didn't use a non-
15 kinking tube.

16 Q: Well, that's anesthesia's call, isn't it?

17 A: Yes, sir.

18 Q: Thank you.

19 A: But that's something I, as a neurosurgeon, would discuss
20 with anesthesia, with the positioning and the type of
21 intubation, et cetera.

22 Q: Paragraph 4.3 right below that, step three, optimize
23 cord perfusion environment?

24 A: Yes.

25 Q: The last -- the last sentence of the first paragraph,

1 sir, a minor drop -- this is what you read. A minor drop in
2 blood pressure can lead to significant SSEP changes that may
3 reverse with increasing perfusion pressure. It doesn't say
4 it will. It says it may. So it may not; true? According to
5 this article?

6 A: Yes, sir.

7 Q: Right. The next sentence there right after that, in the
8 author's experience, the people who wrote this article, to
9 ensure adequate cord perfusion, mean arterial pressure should
10 be elevated to 80 to 90; correct? I mean, that's what it
11 says?

12 A: Yes. And these are in normal patients who don't have
13 vascular risk factors.

14 Q: Does that -- is that what that says here? These are
15 normal patients with normal risk factors? Is that what that
16 says?

17 A: They don't describe the patient, but that would be an
18 acceptable mean arterial pressure in normal patients without
19 vascular risk factors. In patients with vascular risk
20 factors, it is not.

21 Q: And I appreciate your opinion, sir. You're entitled to
22 them, but that's not what this article says, does it?

23 A: It doesn't say one way or the other.

24 Q: No.

25 A: Nor does it describe the type of patient and their

1 experience. I would wonder what their experience is.

2 Q: Right below that that I've read and you and I have just
3 discussed, that article that you referred to said in a study
4 of 37 patients undergoing three column osteotomies for rigid
5 pediatric spinal deformities, and it goes on and on. That --
6 that was not this case, was it?

7 A: That is true.

8 Q: The next page at the very top, the sentence that began
9 similarly. Let me ask you about this. Similarly, in another
10 study -- this is about the fourth or fifth study they've
11 talked about that's all been scoliosis.

12 A: So that is not applicable to --

13 Q: Yeah.

14 A: -- Crystal Goodwin.

15 Q: Similarly, in another study of 35 adults with fixed
16 sagittal balance undergoing deformity correction surgery, an
17 increase in cord perfusion pressure through volume or
18 pharmacologic measures resulted in TC MEP improvement in ten
19 of 25 patients, not even half. And those -- and that, again,
20 is not the surgery we're talking about here, is it?

21 A: That's correct.

22 Q: Paragraph 4.4, step four, reverse manipulation and widen
23 decompression. You were asked about that?

24 A: Yes.

25 Q: Let me read this, sir, in that. You see the sentence

1 that begins toward the top of that paragraph, the signal
2 changes frequently? Do you see that?

3 A: Yes.

4 Q: The signal changes frequently occur after mechanical
5 manipulation of the spine. It is important to address or, if
6 possible, reverse the offending step. That never happened in
7 this case? There was no manipulation going on?

8 A: That is correct.

9 Q: For example, if the signal change developed after
10 compression or distraction across a spinal level, T9 for
11 example, then it is important to reverse that manipulation,
12 but that's not what happened in this case?

13 A: That's correct.

14 Q: Finally, at the bottom under 4.5, step five, Stagnara
15 wake-up test, second to last sentence at the bottom of that
16 page on the left column. I'll read the whole sentence.
17 However, if steps one through four do not lead to a
18 satisfactory restoration of SSEP and TC MEP amplitudes, a
19 Stagnara wake-up test may be considered if the surgical team
20 believes that the potential benefits outweigh the risks. Did
21 I read that correctly?

22 A: Yes, sir.

23 Q: In your opinion, Dr. Lustgarten, are there any risks to
24 the patient when she is being operated on and there's an
25 incision that big in her back where the doctor is operating,

1 decompressing her spinal column from T9 to T12, and she is
2 prone, unlike the diagram that he showed you where she's
3 supine like this, the drawing, and she is lying out like this
4 and she is on her stomach and that back is open and the
5 signal goes out, are there any risks to that patient for just
6 waking her up right there?

7 A: Very little. As a matter of fact, what you describe 90
8 percent of the Stagnara wake-up tests are done exactly in
9 patients like that, prone on a Wilson frame or a Jackson
10 table.

11 Q: Do you know what kind of table they were using? Was it
12 a Jackson or a Wilson table?

13 A: I don't know. It doesn't describe it.

14 Q: Does it make a difference to you?

15 A: Well, they are varied, particularly when somebody weighs
16 670 pounds, it might make a difference as far as the chest
17 and abdomen being compressed.

18 Q: And when they put a patient in a prone position where an
19 operation like she had on July 28th, 2016, they used padding,
20 don't they? Chest roll, stomach roll, make sure the face is
21 protected and the arms are protected?

22 A: Yes.

23 Q: So they don't get compressed?

24 A: No. It prevents injury, but it further compresses the
25 chest or the abdomen.

1 Q: Okay. Could that have any -- any impact or effect at
2 all on urine output?

3 A: Absolutely.

4 Q: Okay.

5 A: In that when somebody's in the prone position with their
6 chest and abdomen being compressed, they have less cardiac
7 return. They have venous pooling, less cardiac return, less
8 cardiac output, less renal perfusion.

9 Q: You were asked a question about the MRI report that was
10 generated by Dr. Blease Graham, the radiologist who was
11 tasked with reading and making an interpretation of a post-
12 operative MRI after Dr. Holbrook took Ms. Goodwin to the
13 recovery room, had anesthesia wake her up, and then he came
14 to the bedside, hey, can you move your legs? No. We need an
15 MRI. And I think you said earlier that that was an
16 appropriate thing to do at that point?

17 A: It was an appropriate test to order, but an
18 inappropriate history given to the radiologist.

19 Q: How do you know, Doctor, what history was given to the
20 radiologist? Where's that evidence?

21 A: What was written on the top as far as the history is
22 concerned.

23 Q: Is it your opinion and is it your opinion today, sir,
24 that when a radiologist puts history and indication that
25 every single time they got it from the surgeon?

1 A: No. Usually the history precedes the radiologist seeing
2 the patient or doing the study. The referring physician
3 usually gives that history.

4 Q: Is there any evidence in this case that you've seen in
5 any depositions that you've read from anybody in this entire
6 case that you reviewed where Dr. Graham said I got this
7 information from Dr. Holbrook? This is where I got that
8 information?

9 A: I didn't read Dr. Graham's deposition.

10 Q: Well, it wasn't taken, was it?

11 A: Well, Dr. Holbrook's deposition was, and he didn't
12 answer that question.

13 Q: You didn't answer my question.

14 A: Who filled out the top history?

15 Q: Well, Dr. Holbrook will testify later about that, so
16 we'll just wait. Okay? So would you agree with me, at
17 least, that a radiologist can glean from a variety of
18 different sources what the indications are for a particular
19 study he is responsible for interpreting, regardless of what
20 the indications may be? That he can get that from the
21 medical records, he can get that from history and physical,
22 he can get it from any of the records that are generated,
23 including the anesthesia record, if that's available to him
24 at that point as to what happened?

25 A: If it's available.

1 Q: Right.

2 A: Yes.

3 Q: Sure. And is there any evidence in this case that
4 you're aware of that Dr. Graham got that indication for the
5 MRI from any other source than -- other than what you contend
6 was Dr. Holbrook, sir?

7 A: I don't see any evidence that he got any other
8 information.

9 Q: Okay. In 2005, I think -- I think, and if I misstated,
10 I apologize ahead of time. 2005, I believe you said, you
11 stopped doing surgeries on the spine; is that right?

12 A: Wrong.

13 Q: I apologize. Correct me.

14 A: What I said, in 2005 I took the first steps towards
15 retirement.

16 Q: I gotcha.

17 A: In that I made the conscious decision not to be the lead
18 surgeon anymore.

19 Q: Okay.

20 A: However, between '05 and 2010, I was the lead surgeon in
21 probably 30 or 40 cases that I was asked to operate on,
22 doctors, their wives, relatives, things like that, both head
23 and spine.

24 Q: Thank you for correcting me. Your first medical
25 malpractice case that you reviewed as a potential export --

1 expert was back in 1980?

2 A: For the defense. Yes, sir.

3 Q: And you continue to do that through today; correct?

4 A: For the past 43 years. Yes, sir.

5 Q: You've averaged between -- since that time, between 40
6 and 60 cases a year until maybe 10 or 12 years ago; is that
7 right?

8 A: Yes, perhaps 15 years ago.

9 Q: In the last 2 or 3 years, you've averaged maybe 12 to 14
10 cases a year over the past five years? Would that be fair?

11 A: Actually, this past year was eight, but before that I
12 think it was 12.

13 Q: Okay. In your first 20 years as an expert witness, you
14 were doing somewhere between 10 and 20 depositions a year?
15 Was that fair?

16 A: Yes, sir.

17 Q: And so that would total somewhere under 500 depositions
18 in medical malpractice cases like this as an expert witness;
19 right?

20 A: Perhaps.

21 Q: I'm not good at math. You're probably a lot better than
22 I am, but --

23 A: You did the math, not me.

24 Q: Okay. Well, if the math is wrong, I stand corrected. I
25 flunked math. Sorry. For the first 40 years --

1 A: I'll let you do the mean arterial pressures.

2 Q: Sir?

3 A: I'll let you do the arterial pressures next time.

4 Q: I'm not doing that. For the -- I'll leave that to you.

5 For the first 40 years of your work as an expert witness for
6 plaintiffs and defendants -- I'm not trying to say otherwise.

7 A: Yes, sir.

8 Q: You testified maybe three to five times a year, kind of
9 like what you're doing today; is that right?

10 A: At trial, yes.

11 Q: At trial. Yes, sir. All right. And the last ten years
12 or so, when you went from about zero to two per year that you
13 testified at trial? Would that be -- that'd be fair?

14 A: Yes. Actually, I did no trials in '22, '21, '20. I
15 think the last trial before this year --

16 Q: Yeah.

17 A: -- was back in '18 or '19.

18 Q: Okay. We haven't been to trial a lot either in 2021.

19 A: I know. Probably same reasons; right?

20 Q: Yeah. Same reasons. Yes, sir. When you gave your
21 testimony, your opinion testimony, when you were deposed in
22 this case, down in -- was it Jupiter, Florida?

23 A: Yes, sir.

24 Q: All right. In March of 2021, by that time that year,
25 you had reviewed three cases for -- for Mr. Hinson's law

1 firm; is that right?

2 A: Yes, sir.

3 Q: Have you reviewed any cases for him since March of 2021?

4 A: I think one additional.

5 Q: So a total of four, including this one? Would that be
6 fair?

7 A: I believe so.

8 Q: Okay. At your deposition in March of 2021, you told us
9 that you'd spent about 24 hours reviewing the various
10 materials in this case. Would that be fair?

11 A: Yes.

12 Q: How many hours approximately have you spent since March
13 of 2021 preparing for your testimony and doing whatever you
14 need to do? I'm not quibbling about it. Give me an
15 estimate?

16 A: About 10 to 15 more hours.

17 Q: All right. And all experts get paid for their time?

18 A: Yes.

19 Q: Ours do. Yours do. I mean, the plaintiffs' do. It's
20 not a secret. And you told us at your deposition that you
21 charged \$600 an hour for review; is that right?

22 A: Yes, sir.

23 Q: And when you were actively engaged in the full-time
24 practice of neurosurgery, your percentage of your annual
25 income derived from your work as an expert was anywhere from

1 8 to 12 percent a year; is that right?

2 A: Yes, sir.

3 Q: And now that your surgical income has markedly
4 diminished -- and that's not a pejorative. That's -- I'm not
5 criticizing that.

6 A: But it's accurate.

7 Q: Okay. That's fine. Your annual income now for medical
8 malpractice reviews and testifying is around 25 percent of
9 your total annual income? Would that be --

10 A: Yes.

11 Q: -- still be fair? Okay. How many -- and I apologize.
12 I should have written this down earlier. I know you've
13 already testified to this, but tell me again if you would,
14 please, sir, how many years were you -- were you in full-time
15 practice as a neurosurgeon, including the time where -- kind
16 of the 2005 to 2010?

17 A: Well, I am still practicing neurosurgery full time.

18 Q: Okay.

19 A: But certainly from -- in private practice from '73 until
20 2010. When I came up to Jupiter, Florida, with my present
21 partner, the rules changed --

22 Q: Yeah.

23 A: -- because I take 4 or 5 months a year off. So I'll
24 practice 6 or 7 months a year in Jupiter, and I'm in the
25 office every day.

1 Q: Can you just do the math for me and tell me about how
2 many years you've been practicing neurosurgery?

3 A: Well, private practice since 1973. It's 50 years.

4 Q: I'm sorry?

5 A: Fifty years.

6 Q: Okay. Thank you, sir. And I think you said you take
7 some time off and go to Maine?

8 A: Yes, sir.

9 Q: Boothbay?

10 A: Boothbay Harbor.

11 Q: Beautiful place.

12 A: Yes.

13 Q: And you do some -- some -- we lawyers call it pro bono
14 work. I don't know what you call it.

15 A: That's what I call it too.

16 Q: Okay. You do work for free?

17 A: Yes, sir.

18 Q: And you help some people?

19 A: Yes, sir.

20 Q: All right. You don't have to have air conditioning in
21 the summer in Maine, do you?

22 A: On occasion.

23 Q: Not very often?

24 A: Not very often.

25 Q: Okay. Do you have an estimate -- and I'll take any

1 estimate that you want to give me, sir -- about how many
2 decompressive laminectomies, like was done in this case, you
3 have had the occasion to perform?
4 A: 4- or 5,000.
5 Q: All right, sir. You agree, I think -- and if you don't,
6 let me know -- that Ms. Goodwin had a condition known in
7 neurosurgery as spinal stenosis in her thoracic region of her
8 back, which was both congenital, something she was born with,
9 and also acquired; is that accurate?
10 A: Yes.
11 Q: And would you agree that that condition compromised her
12 spinal canal where the spinal cord lives?
13 A: Yes, sir.
14 Q: And I think you've already testified that you're aware
15 that she had a surgery in 2009 in the T8-T9 area, and then
16 another surgery by Dr. Holbrook in that same area in 2011;
17 true?
18 A: Yes, sir.
19 Q: When an operation is performed on the human body, even
20 in the spine, it's well known in medicine to cause scar
21 tissue, isn't it?
22 A: Yes, sir.
23 Q: And that's what we see on the sagittal images that we
24 prepared for our exhibits that they showed you?
25 A: Correct.

1 Q: Can scar tissue become calcified or partially calcified?

2 A: You're going to have to have what's called heterotrophic

3 calcification in scar tissue. Yes, sir.

4 Q: Okay. And do you have an opinion as to whether or not

5 on July 28th, 2016, some of that scar tissue at the T8-T9

6 area had become partially calcified?

7 A: At T9.

8 Q: At T9? T9 was where all the damage was done in this

9 case, wasn't it?

10 A: Well, the damage was from T8 to T10.

11 Q: Okay. Do you remember where the neuromonitoring tech

12 told her doctor online where the signal went out? What --

13 A: Where or when?

14 Q: What level? What level of the spine?

15 A: I don't recall, but certainly in the lower extremities.

16 Q: Well, bad question. I apologize. Thank you for helping

17 me to clarify. Would you agree with me that all the damage

18 was done at the T9 area in light of the MRI that was

19 performed immediately following her waking up in the recovery

20 room?

21 A: No. I believe that there was an ischemic infarction of

22 the spinal cord from T8 to T10 manifest on that MRI scan.

23 Q: Okay. After Dr. Holbrook's first surgery, she seemed --

24 or second surgery in 2011, I think you testified she seemed

25 to have done pretty well until she fell a month or so before

1 she went to see him in 2016; is that right?

2 A: Yes, sir.

3 Q: When Dr. Holbrook examined her in the office, he
4 documented mild weakness in her left leg with some decreased
5 sensory sensation from the waist down, and that was before he
6 did any surgery in 2016; true?

7 A: Yes, sir.

8 Q: After Dr. Holbrook ordered and reviewed the MRI prior to
9 his surgery of July 28th, 2016 -- and I think that this is
10 what confused me. I think in our deposition with you, I kept
11 saying the surgery was on June 28th or the -- the MRI was. I
12 think we -- I think I know now -- correct me if I'm wrong --
13 was June 28th?

14 A: Correct.

15 Q: And then a month later, July 28th, is when the operation
16 happens. Did I get that right?

17 A: Yes.

18 Q: Okay. And you don't take issue with the fact that the
19 decompressive laminectomy that Dr. Holbrook planned for Ms.
20 Goodwin was indicated and appropriate, the doing of the
21 surgery?

22 A: Totally agree.

23 Q: Okay. In fact, you agree that he had all the -- he had
24 all the indications to do the decompressive -- posterior
25 decompressive laminectomy, which he did, in fact, do on July

1 28th; true?

2 A: Yes.

3 Q: The congenital stenosis that you talked about a little
4 bit earlier means that the bone that connects the front to
5 the back of the vertebral pedicle was shortened at birth, so
6 that the spinal canal was narrowed. Did I get that right?

7 A: Yes. It's a foreshortened pedicle, and the pedicle goes
8 from the vertebral body back to the facet joint.

9 Q: Okay. And you talked about the spinal column, and you
10 talked about sort of analogy to a house, I think, earlier?

11 A: Yes.

12 Q: Do you remember that? Okay. And you'd agree that the
13 spinal canal, inside of that canal is where the spinal cord
14 lives?

15 A: Yes.

16 Q: If that's an appropriate analogy? Is it?

17 A: It is.

18 Q: In addition to that congenital condition of stenosis and
19 her spinal canal being narrowed, superimposed on top of that,
20 what she was born with, not her fault, nobody's fault, she
21 had degenerative changes in the posterior elements of the
22 spinal canal?

23 A: Right.

24 Q: Which caused her to have an acquired stenosis in
25 addition to the congenital? Did I get that right?

1 A: Yes, sir.

2 Q: All right. How old was she then, sir? Do you remember?
3 Best memory.

4 A: You're talking about in 2016?

5 Q: Yes, sir.

6 A: Thirty-eight.

7 Q: Okay. Do you remember how old she was in 2009 when she
8 first had these stenosis issues and so forth?

9 A: About 30.

10 Q: In your -- in your experience, is that kind of on the
11 young side to have those kind of problems?

12 A: Yes. But, you know, there are degrees of congenital
13 stenosis, and Ms. Goodwin evidently had a fair amount of
14 congenital stenosis. Later on superimposed on that was
15 acquired disease.

16 Q: All right, sir. And you would agree, just -- just a
17 perspective here, the 2009 surgeries that he offered and
18 proposed to her and performed and the 2011 surgeries that he
19 proposed and offered and did for her were both indicated?

20 A: Yes, sir.

21 Q: And you agree that the history, the examinations, the
22 diagnostic surveys done by Dr. Holbrook in all of these
23 surgeries, all three, were very good, and you agree with the
24 need for the surgery that he performed on July 28th, 2016;
25 true?

1 A: Yes.

2 Q: The surgery that Dr. Holbrook performed on Ms. Goodwin
3 in July of 2016, which is the subject matter of this lawsuit,
4 was a major operative procedure and had certain risks that
5 would be associated with any major operation under general
6 anesthesia; correct?

7 A: Yes.

8 Q: Some of those risks included involvement of several
9 different organs -- organ systems in the body, like the
10 pulmonary system, the lungs, the cardiac heart system, the
11 gastrointestinal system, the genitourinary complications,
12 blood clots, pulmonary emboli; correct?

13 A: Yes, sir.

14 Q: Let's talk about pulmonary emboli. Would you agree with
15 me that if a patient, no fault of their own or anybody else,
16 develops a pulmonary emboli, a clot in their lungs, that can
17 kill them in seconds, sir?

18 A: Yes.

19 Q: And that was one of the risks to that surgery?

20 A: Yes.

21 Q: Specific to spine surgery, you agree that there are
22 always the risks of infection, spinal fluid leaks, nerve root
23 and/or spinal cord injury and damage, which could lead to a
24 worsening of the patient's neurological conditions that they
25 did not have prior to that surgery; correct?

1 A: It's possible. Yes, sir.

2 Q: You would agree that the spinal cord damage that you
3 said is a risk to that surgery, the surgery of July 28th,
4 2016, the neurologic damage, all of those things can happen
5 and any of those risks can happen to a patient in spite of
6 good and appropriate care done within the standard of care by
7 the neurosurgeon; isn't that true?

8 Q: As a general statement, not particularly applicable to
9 this case, yes.

10 Q: Do you agree that Dr. Holbrook doesn't lack any training
11 or experience or knowledge in the area of neurosurgery to be
12 able to perform that surgery he offered to her; right?

13 A: I think he's qualified to do that surgery. Yes, sir.

14 Q: In spite of the unfortunate complication to Ms. Goodwin,
15 you agree that she did incrementally improve, at least for
16 the first 30 days after that operation? It then seemed to
17 sort of level off? Would that be accurate?

18 A: Yes, sir.

19 Q: Have you reviewed any of the physical therapy notes?
20 There's a thousand pages or so of them.

21 A: No, sir.

22 Q: Okay. And I understand. That's fine. You're not a
23 physical therapist, but would it surprise you to know that
24 those physical therapy notes on many occasions through '18
25 and 2019 documented that she's able to walk a lap around the

1 gym? She's able to ambulate 50 feet? She's able to walk
2 into her bathroom and get into her bathtub unassisted? She's
3 able to get in and out of her husband's truck without a slide
4 board? Were you -- were you aware of any of those?

5 A: No, sir.

6 Q: Dr. Lustgarten, in your opinion -- I think you've said
7 this. I apologize if I'm going way over my time here, but
8 the SSEP signals may take between -- I think you said 5 and
9 35 minutes after there is damage to the cord from whatever
10 may be causing the damage. Would that be accurate?

11 A: After there's an insult to the cord that would be
12 reflected in SSEPs, there can be a delay of between 5 and 35
13 minutes.

14 Q: Okay. So if there's -- if there's a -- there's an
15 insult to that cord and there's damage and it's -- it's
16 there, it's whatever caused it, bam, it happens, that the
17 monitoring signals -- there's a latency or there's a delay in
18 how they average signals and they report out anywhere from 5
19 minutes after that to 35 minutes?

20 A: Yes.

21 Q: Correct? Okay. In other words, after the damage had
22 already been done to the spinal cord from whatever caused it,
23 the SS -- SSEP, the sensory signal changes, may take another
24 anywhere from 5 to 35 minutes to reflect that change in
25 measurement?

1 A: Yes.

2 Q: Okay. And I believe your opinion is that, as you see
3 things in your opinion, you believe that the critical blood
4 pressures in the surgery of July 28th, 2016, were between
5 9:30 a.m. and 9:55 a.m.?

6 A: 9:20.

7 Q: 9:20. Did I say 9?

8 A: You said 9:30.

9 Q: Thank you for correcting me. I've got it written right
10 here, 9:20. I didn't read what I got. Well, now you're
11 embarrassing me. I'll put mine up. All right. I got it.
12 Thank you. 9:20?

13 A: Yes.

14 Q: All right. Thank you, sir, for that correction. So you
15 would agree that the mean arterial pressure, that -- that
16 equation, between 9:20 and 9:55, I think you said it averaged
17 87?

18 A: Yes, sir.

19 Q: You made some reference to -- let me ask you about this
20 20 percent rule. In your deposition, do you recall when you
21 were asked about that 20 percent rule, where it's written,
22 your response was, quote, go ask anesthesia, end quote? Did
23 I -- did I remember that correctly? And I'm happy to let you
24 look at your deposition.

25 A: No. I have it right here.

1 Q: Okay.

2 A: You're right. That's an anesthesia, quote, rule.

3 Q: Yeah.

4 A: I've never seen it written anywhere, recorded,
5 memorialized, written up in the literature. It's more word
6 of mouth in normal people.

7 Q: You would agree that there's about a 1 percent
8 complication rate of a spinal cord injury in an operation
9 like that which was performed on Ms. Goodwin on July 28th,
10 2016?

11 A: When she had a normal neurological exam going in, I'll
12 accept a 1 percent rate as being a complication of surgery.

13 Q: Okay. And I'm happy to refresh your memory with your
14 deposition if you wish for me to. I'm happy to do that.

15 A: No.

16 Q: I don't want to misquote you.

17 A: But I understand complications can occur absent
18 negligence. Complications can occur as a result of
19 negligence.

20 Q: Yes, sir.

21 A: I think 1 percent is a fair number absent negligence.

22 Q: Do you agree that when a neurosurgeon operates within
23 the standard of care and exercises the appropriate clinical
24 judgment, complications can still occur that can cause a
25 result and result in the same conditions that Ms. Goodwin

1 suffers from today? True?

2 A: It's possible.

3 Q: And you would agree that if scar tissue is located at
4 the T9 level and it's dissected, the dissection can cause
5 problems or complications to the patient with the kind of
6 surgery he was performing in July of 2016; true?

7 A: It's possible, but those complications are usually dural
8 tears with cerebrospinal fluid leaks and not a spinal cord
9 injury.

10 Q: The kind of problems that the dissection of the scar
11 tissue can cause, Dr. Lustgarten, you agree that that would
12 include nerve root damage, spinal cord damage, tearing of the
13 dura with a spinal fluid leak; correct?

14 A: Yes. All of those are possible.

15 Q: Explain to the jury, if you would, please, sir, what is
16 the dura? What is that?

17 A: The dura is a membrane that covers the spinal cord.
18 There are three layers. The dura is the external, almost
19 like the thickness of a sheet of paper. Then there is the
20 arachnoid, which is like cellophane, under which is spinal
21 fluid, and then there's the pia mater, which is very, very
22 closely applied filamentous structure directly applied to the
23 neural structure.

24 Q: Okay. You can't see the spinal cord when you're doing a
25 decompressive laminectomy, can you?

1 A: Directly, no.

2 Q: Right.

3 A: But I have to state that when Crystal was re-operated on
4 by Dr. Holbrook, Dr. Holbrook did not find a tight, distended
5 dura. He didn't describe that at all, meaning at least to
6 his eyeball, looking through the dura or at the dura, it
7 wasn't tense as a result of the spinal cord being markedly
8 swollen.

9 Q: Did you read the MRI report? Excuse me. Forget the
10 report. Did you look at the images of the MRI that he
11 ordered after Crystal was awakened by anesthesia in the
12 recovery room, taken to the MRI, and then had those images
13 done? Did you ever look at those images yourself, sir?

14 A: Yes, sir.

15 Q: I mean, neurosurgeons can -- in all fairness, can read
16 your own films. You all are trained to do --

17 A: Yes, sir.

18 Q: You're trained to do that?

19 A: Yes, sir.

20 Q: Competent to do that? Experienced?

21 A: Yes, sir.

22 Q: Did you -- did you see the swelling of the spinal cord,
23 sir?

24 A: I saw a signal change in the spinal cord from T8 to T10
25 and, in my opinion, that signal change represented an area of

1 ischemic infarction. And might there have been some swelling
2 around it? Yes, but an ischemic infarction causing damage to
3 tissue and destruction of the blood brain barrier and
4 liberation from cells of cytokines and free radicals can
5 cause a -- a secondary chemical reaction with swelling. All
6 of that is very, very possible with an ischemic infarction.

7 Q: It's also very possible with a reperfusion injury, can't
8 it?

9 A: That's possible, but generally with a reperfusion
10 injury, you need to have a pressure head of arterial blood
11 hitting that area, causing it to be damaged and swollen.
12 When this injury occurred, her mean arterial pressure between
13 9:20 and 9:55 is 87. There was no real pressure head to
14 cause a precipitous injury due to the pressure of the artery
15 having blood in it. That's number one.

16 And number two, her arteries were like that rubber hose
17 I had up here before. Because of hypertension, the wall was
18 rigid, had lost its elasticity, and it dampened, if anything,
19 the effects of any blood rushing into it.

20 Q: How do you know that?

21 A: Pardon me?

22 Q: How do you know that?

23 A: Because that's what happens in the arteries in people
24 who have sustained hypertension, and there are all kinds of
25 articles written on that.

1 Q: How do you know she had that condition at 38 years old?
2 A: Well, I didn't biopsy her artery.
3 Q: Okay.
4 A: But she had hypertension for many years.
5 Q: Doctor, looking at these exhibits that were shown to you
6 by plaintiffs' counsel -- I'll just put them in your hand.
7 A: Yes, sir.
8 Q: Do you see where that big spike is? It was at the 110,
9 that sudden, just steep mountain spike on those graphs?
10 A: Yes.
11 Q: What time was that?
12 A: It states 10 o'clock.
13 Q: 10 o'clock?
14 A: Yes, sir.
15 Q: And the signal was announced to have been lost at 10:03
16 and some seconds; correct?
17 A: Correct.
18 Q: Right after that big spike of blood pressure, sir?
19 A: According to this graph, yes.
20 Q: Right. You agree that in Dr. Holbrook's operative note
21 of July 28th, 2016 -- and I'm happy to put it back in your
22 hand if you need to look at it. Okay? He states that he, in
23 fact, did remove the spinous processes of T11 and T12, and
24 that he was dissecting scar tissue partially calcified over
25 the backside of the spinal cord, the posterior dura through

1 the T9-T10 level; correct?

2 A: Yes, sir.

3 Q: During the surgery, when it was announced that the
4 signal -- as the neuromonitoring tech documented in her chat
5 with the doctor she's reporting to, the signal just went out,
6 that at that time, you agree it's appropriate for Dr.
7 Holbrook to have paused his surgery, inspect his wound site
8 to see if there's anything that he was doing that may have
9 caused that sudden light switch to flip off and the signals
10 to be lost; would that be correct?

11 A: Yes, sir.

12 Q: At the same time, he should have looked to see if the
13 machine was recording okay, if the -- if the neuromonitoring
14 equipment was functioning the way it's designed to function,
15 because sometimes it doesn't; isn't that true?

16 A: That's true.

17 Q: So it would have been appropriate for him to say check
18 your equipment?

19 A: Yes.

20 Q: However long it takes the neuromonitoring tech, whether
21 -- you know what? She'll testify, but whatever time it took
22 her to check it, we're not quibbling about that. But
23 whatever time it took, she takes whatever time she needs to
24 to say, yeah, it's not working or, no, the equipment is
25 working, and then she would tell that to the surgeon because

1 he said check your equipment?

2 A: Correct.

3 Q: It's appropriate to do that, isn't it?

4 A: Yes.

5 Q: And it would also be within the standard of care to say
6 something to the anesthesia team, whoever is in the room,
7 whether it's the M.D. anesthesia -- who's not always in the
8 room all the time, you know that?

9 A: Yes, sir.

10 Q: But the CRNA. Let's talk about CRNA, certified
11 registered nurse anesthetist, Erich Starn, in the operating
12 room on July 28th. He was flying the plane, wasn't he, for
13 anesthesia?

14 A: He was one of the members of the crew. Yes, sir.

15 Q: And he's a member of the anesthesia crew who's in the
16 pilot seat looking at all the monitors, doing the
17 sevoflurane, checking the blood pressure, checking the urine
18 output, checking all the things. I mean, that's his --
19 that's -- that's what he does, doesn't he? And he's there.
20 He's boots on the ground; right?

21 A: Yes.

22 Q: And the M.D. anesthesia, Dr. Root, while she is
23 responsible for that operating room, she is responsible for
24 two or three other operating rooms at the same time. You're
25 familiar with that?

1 A: Yes, sir.

2 Q: So it's not unusual at all for the M.D. anesthesia not
3 to be in the room at any particular point in time?

4 A: That's true. They're usually there for intubation and
5 extubation and come in sporadically throughout the case.

6 Q: So if I could use that rough analogy -- you're an Air
7 Force guy, if I may. If not, I mean no disrespect
8 whatsoever. Dr. Root, the M.D., the doctor anesthesia comes
9 in when the plane is taking off. Real important time in a
10 flight, intubation?

11 A: Yes, sir.

12 Q: And she's back there when the plane's landing, when
13 they're going to take the sevoflurane out and reverse the
14 anesthesia and wake her up?

15 A: Yes, sir.

16 Q: In between, when that plane is flying, to use an Air
17 Force analogy, somebody's got to be at the controls, and that
18 was Erich Starn, wasn't it?

19 A: Or the autopilot.

20 Q: Okay. Well, somebody -- somebody's got to be there --

21 A: Correct.

22 Q: -- looking at the gauges and things?

23 A: Yes.

24 Q: Recording the blood pressure every five minutes, other
25 things. You would agree that the best way to get a patient

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1 to get the best diagnostic test when something like what
2 happened in this operation happened, the signals just flipped
3 the switch and they're gone, they're there and they're gone,
4 the best test to try to find out what's going on, if you can,
5 is if -- particularly if you notice when the anesthesia comes
6 in and they take over and they get her to the recovery room
7 and they're there in the recovery room until a patient can
8 respond. Is that how it works?

9 A: Yes, sir.

10 Q: And when she responds and Dr. Holbrook is summoned to
11 come, she's awake and he says, Crystal, can you move your
12 legs, and when she can't, the best test he can do is get an
13 MRI right then and there, isn't it?

14 A: Yes, sir.

15 Q: And that's exactly what he did, didn't he?

16 A: Yes, sir.

17 Q: Trying to find out what happened, what's going on?

18 A: Correct.

19 Q: And in this case, Dr. Holbrook closed up the operation.
20 I want you to assume that closure happened at 11:02 a.m.
21 Let's assume that for the sake of the question. Does that
22 sound about right to you?

23 A: Yes.

24 Q: Then the anesthesia -- M.D. anesthesia comes in to land
25 the plane. She's there with Erich Starn, the certified

1 registered nurse anesthetist, who -- I mean, they're trained
2 to do what they do; right?

3 A: Yes, sir.

4 Q: Okay. She comes in, and she and Erich are waking her
5 up, and that's -- they do that in the operating room for some
6 period of time; correct?

7 A: Yes.

8 Q: And then when they get her to whatever level of
9 consciousness or awakesness that they, as anesthesiologists,
10 feel is appropriate, they move her to the PACU, the recovery
11 room; is that right?

12 A: Yes, sir.

13 Q: And they're still in charge of the patient in the
14 recovery room, the anesthesia? Would that be fair?

15 A: Yes.

16 Q: Okay. So you agree it was appropriate for Dr. Holbrook,
17 once they got her to the recovery room, they got her awake,
18 the anesthesia team got her awake, and he could examine her
19 and talk to her based on his findings of leg weakness and
20 bilateral leg weakness, he ordered the MRI and got that done?

21 A: Yes.

22 Q: And that was appropriate, wasn't it?

23 A: Yes. Because at that point in time, he felt he did
24 nothing wrong in surgery to create the problem. He knew it
25 wasn't a technical neuromonitoring problem, and he knew it

1 was not an anesthesia gas problem.

2 Q: Right. So he's -- he's trying to find out what
3 happened, what caused this. Let's do an MRI. MRIs don't
4 always tell you. They don't always give you a cause, do
5 they?

6 A: Not all the time.

7 Q: Not all the time. He did that, and then he said, I'm
8 going -- I'm going back. I'm going to take her back to
9 surgery. There's that scar tissue up there at T8-T9. Maybe
10 -- maybe that's got something. You know, he's -- it's a Hail
11 Mary, just doing what he can, isn't he?

12 A: You're right. It was a Hail Mary.

13 Q: And there wasn't anything that he could do at that point
14 that was going to change Crystal -- Crystal's condition;
15 correct?

16 A: True.

17 Q: Would you agree with me that the MRI that he ordered and
18 was performed and he -- you know, like you, he can read his
19 own MRI. Dr. Graham read it as well, whatever, and issued
20 his report for whatever it may be worth, not -- you know, not
21 getting there, but the MRI that he performed that you -- you
22 read, you looked at the images?

23 A: Yes, sir.

24 Q: It didn't demonstrate a cause of any ischemia, did it?

25 A: Well, it had findings in it consistent with ischemia.

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1 The signal change between T8 and T10 was more or less central
2 in the distribution of the anterior spinal artery and would
3 be consistent with an ischemic infarction.

4 MR. DAVIS: Your Honor, I'd like to open this
5 deposition.

6 THE COURT: Yes, sir.

7 MR. DAVIS: If I can. Your Honor, we may need to take a
8 quick bathroom break.

9 THE COURT: Yes, sir.

10 All right, ladies and gentlemen. Please return to the
11 jury room. Do not discuss the case.

12 (WHEREUPON, the jury exited the courtroom at 5:09 p.m.)

13 THE COURT: We'll take a 10-minute break.

14 MR. DAVIS: Thank you, Your Honor.

15 (WHEREUPON, there was a break in the proceedings, after
16 which the proceedings resumed as follows.)

17 MR. DAVIS: Your Honor, I am almost done.

18 THE COURT: Okay. All right. Go ahead and bring the
19 jury.

20 (WHEREUPON, the jury entered the courtroom at 5:23 p.m.)

21 THE BAILIFF: The jurors are present, Your Honor.

22 THE COURT: Thank you, sir. Excuse me.

23 Mr. Davis, you may resume your cross-examination.

24 MR. DAVIS: Thank you, Your Honor.

25 BY MR. DAVIS:

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1 Q: Dr. Lustgarten, I'd like to put your hands on your
2 original deposition just to refresh your recollection about
3 one small matter.

4 MR. HINSON: Your Honor, objection. I'm not sure that
5 there's been a question yet which he needs to show the
6 deposition. I'm just not sure about that.

7 MR. DAVIS: I think I asked it. Let me -- let me
8 rephrase it.

9 MR. HINSON: Okay.

10 MR. DAVIS: Yeah. Thank you, Mr. Hinson.

11 THE WITNESS: No problem.

12 BY MR. DAVIS:

13 Q: You can still hang on to your original deposition, if we
14 need to. Yeah. That's fine. In your opinion, the post-
15 operative MRI did not demonstrate a cause of any ischemia;
16 true?

17 A: That's true.

18 Q: All right. Thank you. And I think you agree that
19 nothing that Dr. Holbrook did, like dropping an instrument or
20 something mechanical, caused the sudden loss of signal;
21 correct?

22 A: I agree.

23 Q: When doctors use the word iatrogenic -- that's a big
24 word, but when doctors use that, you would agree that that
25 refers to something that happened during surgery; is that

1 right?

2 A: Yes.

3 Q: Okay. And you agree that one can have an iatrogenic
4 injury, something happens during surgery that may be quite
5 serious and devastating to the patient, even though the
6 surgeon was operating appropriately, reasonably, and within
7 the standard of care; true?

8 A: True, if we're eliminating blood pressures and things of
9 that nature, yes. I don't believe Dr. Holbrook did anything
10 mechanically wrong to create the injury.

11 Q: Thank you. There's been some discussion in this case.
12 You may have seen it reading through the depositions that you
13 reviewed, and I think you reviewed a lot of depositions in
14 this case?

15 A: Yes, sir.

16 Q: Okay. In a lot of depositions taken by plaintiffs'
17 counsel, questions that -- that was -- that were posed by
18 plaintiffs' counsel to Dr. Holbrook about some blanks
19 appearing in his operative note. Do you remember that?

20 A: Yes, sir.

21 Q: And they asked you about that a little while ago,
22 earlier today?

23 A: Yes, sir.

24 Q: You agree that any blanks in his operative note that day
25 did not cause or contribute to any injury that Crystal

1 Goodwin suffered; correct?

2 A: I agree.

3 Q: All right. In your opinion, within a reasonable degree
4 of medical certainty, had Ms. Goodwin, for whatever reason,
5 decided not to have the surgery offered by Dr. Holbrook on
6 July 28th, 2016, she would most probably -- she most probably
7 would have had progressive symptomatic myelopathy and would
8 have required surgery; correct?

9 A: Yes.

10 Q: Explain, if you would, please, sir, to the jury that --
11 what is progressive symptomatic myelopathy? What does that
12 mean?

13 A: That means involvement of the spinal cord that became
14 symptomatic, weakness, numbness, or difficulty with bowel and
15 bladder.

16 Q: Thank you. And you would agree that progressive
17 symptomatic myelopathy means, in Ms. Goodwin's case, spinal
18 cord dysfunction; correct?

19 A: Yes.

20 Q: And --

21 A: And she did not have that prior to surgery.

22 Q: No. I'm talking about post-op.

23 A: Post-op, yes.

24 Q: Yes, sir. Yes, sir. And can myelopathy be seen on a
25 magnetic resonance imaging, an MRI? Can evidence of

1 myelopathy --

2 A: Yes.

3 Q: Do you recall looking at the MRI of November of 2016?

4 A: Yes. And that MRI showed what is called cystic
5 myelomalacia, which is on a continuum of events of evolution
6 of the development of an infarct, dead tissue that is then
7 reabsorbed by body mechanisms and replaced with a fluid-
8 filled cyst. So that finding on the MRI is very consistent
9 with an ischemic infarct evolving over months to form a
10 cystic area of abnormality within the spinal cord.

11 Q: Thank you. And spinal cord dysfunction can result in
12 bilateral leg weakness, sensory changes, bowel and bladder
13 problems, and disturbance in ability to walk; true?

14 A: Yes.

15 Q: And that unfortunate complication can occur even in the
16 absence of any negligence on the part of the operating
17 surgeon; true?

18 A: Extraordinarily rare, but it can happen.

19 Q: And you would agree that, in your opinion, had she not
20 had that surgery on July 28th, 2016, she would have had
21 progressive spastic weakness of the legs, progressive sensory
22 difficulties, bowel and bladder involvement, if she had never
23 had that surgery on July 28th; true?

24 A: Well, if she developed anything consistent with the
25 myelopathy.

1 Q: Yeah.

2 A: You would certainly intervene and do surgery long before
3 she has a spastic paraparesis.

4 Q: So the question is, do you agree that more probably than
5 not all that would have occurred had she not had that
6 surgery? True?

7 A: Eventually, in my opinion, yes.

8 MR. DAVIS: Thank you, Doctor. Appreciate your
9 patience.

10 THE WITNESS: Thank you, sir.

11 MR. DAVIS: Yes, sir.

12 THE COURT: Redirect?

13 MR. HINSON: Thank you, Your Honor. Very brief. I know
14 it's getting late in the day.

15 THE COURT: Yes, sir.

16 REDIRECT EXAMINATION

17 BY MR. HINSON:

18 Q: Dr. Lustgarten, I didn't count them up, but over the
19 course of questions from Mr. Davis, you used the term
20 ischemia and ischemic in -- infarct several times. Remind us
21 what that means?

22 A: It means lack of arterial blood flow supplying oxygen
23 and glucose to any body tissue to help it live and go on.
24 When that is amputated, tissue dies, and it's an infarct. So
25 when you have lack of blood going to the tissue, in this

1 instance due to the low mean arterial pressure, the outcome
2 is an infarct.

3 Q: And did Dr. Holbrook's own records from prior to this
4 lawsuit describe an ischemic event?

5 A: Yes.

6 Q: Doctor, in your decades and career as a neurosurgeon,
7 have you had the occasion to see many patients with worse
8 stenosis than what Ms. Goodwin had?

9 A: Yes.

10 Q: And are there patients that you -- you've treated with
11 bigger osteophytes, bone spurs, than what Ms. Goodwin had?

12 A: Yes.

13 Q: And the patients you've treated with worse stenosis and
14 bigger osteophytes, did they suffer paralysis in their
15 surgeries?

16 A: None of my patients have. That's correct.

17 Q: Does having severe stenosis and a big osteophyte make it
18 likely that a surgery of this type will result in paralysis?

19 A: It doesn't make it likely. The object of -- excuse me
20 -- of surgery is to correct the problem and have the patient
21 remain in the same neurological condition that they were
22 going into surgery.

23 Q: And earlier, Mr. Davis asked you about risks of this
24 surgery. Is a risk of a surgery like this -- is it a risk
25 that the blood pressure will be inadequately maintained? Is

1 that a risk that the patient should accept?

2 A: No.

3 Q: Is a risk of a surgery like this that the patient should
4 accept -- is it that an alarm indicating total loss of signal
5 to the legs will go off, and that nothing more than checking
6 the equipment will occur? Is that a risk? An accepted risk?

7 A: It's not an accepted risk.

8 MR. HINSON: If you will, Mr. Goings, put that up.
9 Thank you.

10 BY MR. HINSON:

11 Q: I'm going to -- Mr. Davis asked you about the
12 neuromonitoring, and you may be able to see this on the
13 board. If not, I can get you that -- that document.

14 MR. HINSON: It'll be on -- it'll be on 52 or 53. All
15 right.

16 BY MR. HINSON:

17 Q: So again, we're on Central Time, Memphis time here.
18 Signal goes out around 10 o'clock. And so this would be
19 10:23:11. What does the record indicate that Dr. Gregg Herb
20 [sic] said to the technician at that time?

21 A: I'd have to have that record. There we go. Also, there
22 was a sudden change in bilateral lower extremity lower SSEPs.
23 If that is not a technical issue, would expect something that
24 can happen quickly, like a vascular or traumatic cause. We
25 know there was no traumatic cause.

1 Q: So if -- is insufficient blood flow -- would that --
2 would that be included in vascular events?

3 A: Yes.

4 Q: All right.

5 MR. HINSON: And, Mr. Goings, if you go to the next page
6 at 9:39:08 there at the bottom.

7 MR. GOINGS: What page?

8 MR. HINSON: It's page 52.

9 MR. GOINGS: Thank you.

10 MR. HINSON: If you'll stand right there, Mr. Goings.

11 BY MR. HINSON:

12 Q: And at 9 -- or excuse me, 10:39, just a little bit
13 later, so now we're about 40 minutes afterwards. What did
14 Dr. Gregg Herb -- what does the record indicate that Dr.
15 Gregg Herb wrote to Ms. Adkins?

16 MR. HINSON: Can you make that part larger?

17 BY MR. HINSON:

18 A: The possible waves that you were marking for the lowers
19 are very concerning if correct. The absent lowers are making
20 me anxious.

21 Q: Thank you. And what does -- what does the record
22 indicate that Ms. Adkins said back?

23 A: Me too.

24 Q: Earlier, Mr. Davis asked you about how positioning can
25 have an impact on renal function. Can -- would position

1 alone explain only 80ml of urine being produced in this four-
2 plus -- four-and-a-half-hour surgery?

3 A: No, not at all. When I tried to explain that,
4 positioning notoriously decreases cardiac output by 20
5 percent. When you have decreased cardiac output, you have
6 decreased blood flow to all organs, one of which is your
7 kidneys. If the kidneys don't get their blood flow, the
8 blood can't be filtered and you don't make urine.

9 Q: So does positioning explain low urine output? Does the
10 surgical positioning explain the low urine output?

11 A: Not entirely, no.

12 Q: All right. And Mr. Davis asked you about times that we
13 had worked together before. Have I sent you cases that we
14 didn't end up working on?

15 A: There have been, I believe, two cases that I did not
16 feel were meritorious.

17 Q: In other words?

18 A: I turned them down.

19 Q: You didn't believe the standard of care was violated?

20 A: Correct.

21 Q: And you told me, Mr. Hinson, don't bring that case?

22 A: Correct.

23 Q: And I followed your advice. Earlier, Mr. Davis asked
24 you about scar tissue and the -- you talked about the degree
25 of scar tissue. Did the degree of scar tissue that was known

1 going into this surgery -- did that put the patient at risk
2 and give reason to keep the mean arterial blood pressure
3 during the surgery higher?

4 A: Yes.

5 Q: Explain to us how?

6 A: Scar tissue can act as a mask. It also can amend or
7 abbreviate arterial blood flow by growing around the arteries
8 and compromising the blood flow. So it's even more of a
9 reason in the presence of scar tissue to keep the blood
10 pressure up.

11 MR. HINSON: If you'll put that one up, Mr. Goings?

12 BY MR. HINSON:

13 Q: All right. So earlier Mr. Davis asked you about this
14 spike here at 10 o'clock. There is a delay between the time
15 of injury and the time it shows on SSEP; right?

16 A: Oh, correct.

17 Q: So if it were a reperfusion event, given that there's a
18 delay, could this be the reperfusion event?

19 A: I don't believe so.

20 Q: Because of the delay, what --

21 A: The injury had already occurred.

22 Q: In the 5 to --

23 A: In the 5 to 35 minutes before.

24 Q: So this range right here?

25 A: Correct.

1 Q: And just -- and I know you yourself are not an
2 anesthesiologist and you yourself are not a CRNA, but you're
3 generally familiar with the training necessary to become an
4 anesthesiologist versus a CRNA?

5 A: Yes, sir.

6 Q: Who has more training?

7 A: The anesthesiologist.

8 Q: If there's something wrong on the plane, do you want the
9 steward, the -- the flight attendant to know or do you want
10 the captain to know?

11 MR. DAVIS: Your Honor, this is not responsive to my
12 cross-examination.

13 MR. HINSON: He -- he literally made the same analogy,
14 Your Honor.

15 THE COURT: The objection is overruled.

16 MR. DAVIS: Thank you, Your Honor.

17 BY MR. HINSON:

18 Q: And -- and so if there's a warning light on the plane
19 going off -- well, if there's neuromonitoring signal lost in
20 the operating room, does the anesthesiologist need to be
21 told?

22 A: Yes.

23 Q: When the anesthesia -- if the anesthesiologist isn't in
24 the room and nobody goes to get the anesthesiologist and the
25 surgeon doesn't instruct somebody to go get the

1 anesthesiologist, when the surgeon comes in to make check in,
2 as you discussed -- excuse me. When the anesthesiologist
3 comes in to check in, what does the standard of care require
4 the surgeon to do, assuming this signal loss has occurred?

5 A: To inform the anesthesiologist of the events that took
6 place and let's look for a treatable cause. In this
7 particular case, increase the blood pressure.

8 Q: Earlier -- this MRI that was ordered was around what
9 time?

10 A: Approximately 2:30 or thereabouts.

11 Q: So four-and-a-half hours after this signal loss?

12 A: Correct.

13 Q: At that point, could anything be done?

14 A: No.

15 Q: Earlier, Mr. Davis asked you and you agreed that it
16 wasn't anything mechanical that caused this injury?

17 A: True.

18 Q: Do you have an opinion that something non-mechanical
19 caused this injury?

20 A: Yes.

21 Q: And what is that?

22 A: The fall in the mean arterial pressure causing
23 insufficient blood to be delivered to the spinal cord,
24 causing ischemia and ultimately an infarction.

25 Q: With all your education, training as a neurosurgeon,

1 your decades of experience, and all the materials you
2 reviewed in this case, how certain are you of that, Dr.
3 Lustgarten?

4 A: 105 percent.

5 MR. HINSON: Thank you, Doctor. No further questions.

6 THE COURT: Anything further from this witness?

7 MR. DAVIS: Are we allowed recross?

8 THE COURT: Yes, sir.

9 MR. DAVIS: All right. Very briefly, Your Honor. Thank
10 you.

11 RECROSS-EXAMINATION

12 BY MR. DAVIS:

13 Q: Doctor, do you still have that neuromonitoring log with
14 you? I think it was page 0052. Okay.

15 MR. DAVIS: Is that -- is it 15? Is it up there?

16 MR. HINSON: It is.

17 MR. DAVIS: Okay. Hang on one second.

18 BY MR. DAVIS:

19 Q: Doctor, let me -- here you go.

20 A: 52?

21 Q: Here we go. Look at the exhibit, 0052, sir.

22 A: Yes, sir.

23 Q: Okay. If you would -- let me ask you about this. Would
24 you look at the entry at -- I'm going to -- I'm going to call
25 out the Central Time, 9:53:07 a.m., Gregg Herb, that's Dr.

1 Gregg Herb [sic].

2 A: Where he says thank you?

3 Q: No, sir. I'm sorry. 9:53:07, page 0052, from Dr. Gregg
4 where it says -- or 9:57 present. Do you see where I'm
5 reading?

6 A: Yes, sir.

7 Q: Okay. Let me read this and ask you something. 9:57
8 present and 10:04 absent, with no indication that we would
9 lose them. That's the neurologist making that comment.
10 Right above that, Teresa Adkins, the neuromonitoring tech in
11 the operating room, says agree. Did I read that correctly?

12 A: Yes, sir.

13 MR. DAVIS: Nothing further. Thank you.

14 THE COURT: Thank you, sir. You may step down.

15 THE WITNESS: Thank you, ma'am.

16 THE COURT: If you didn't bring it with you, don't take
17 it with you when you go.

18 MR. HINSON: Your Honor, can Dr. Lustgarten be excused?

19 MR. DAVIS: Absolutely no objection, Your Honor.

20 THE COURT: You are free to go. Thank you.

21 THE WITNESS: Thank you, Your Honor.

22 MR. HINSON: Thank you, Dr. Lustgarten.

23 THE COURT: All right, ladies and gentlemen. We will
24 call it a day. Be back in your jury room tomorrow morning at
25 9:30. Please do not discuss the case. See you then.

1 (WHEREUPON, the jury exited the courtroom at 5:44 p.m.)

2 THE COURT: 9:30 tomorrow. We'll talk about what

3 evidence at 9:30.

4 MR. HINSON: Thank you, Your Honor.

5 (WHEREUPON, the proceedings adjourned for the day.)

6

7 --- CONTINUED IN VOLUME III ---

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State of South Carolina	)	Court of Common Pleas
	)	Fifth Judicial Circuit
County of Richland	)	Case No. 2019-CP-40-04185
	)	
	)	
	)	
Crystal Goodwin and	)	
James Goodwin,	)	
	)	
Plaintiffs,	)	
	)	
-vs-	)	Transcript of Record
	)	DAY 3 OF 9 - VOLUME III
	)	April 12, 2023
Midlands Orthopedics and	)	
Neurosurgery and Dr. Thomas	)	
J. Holbrook, M.D.,	)	
	)	
Defendants.	)	
	)	

April 10-14 & 17-20, 2023
Columbia, South Carolina

B E F O R E:

The Honorable Jocelyn Newman, Judge; and a jury

Proceedings taken down by:
Elizabeth Harris
Official Circuit Court Reporter

Transcribed by:
Krystal J. Smith
Official Circuit Court Reporter

1 APRIL 12, 2023

2 (WHEREUPON, the proceedings resumed at 9:37 a.m.)

3 (WHEREUPON, the blood pressures chart was marked as
4 Court's Exhibit Number 2.)

5 THE COURT: Good morning, everyone. All right. Are we
6 ready to proceed? Anything before we bring the jury?

7 Mr. Goings?

8 MR. GOINGS: For the record's sake, Your Honor, the
9 chart, the blood pressures that Mr. Hinson tried to get in
10 yesterday, that you objected -- that was subject to objection
11 and Your Honor sustained the objection, we marked that as
12 Court's Exhibit 2.

13 The deposition designations, we can come up and chat with
14 you about that, about our approach, if you want to.

15 MR. DAVIS: Yeah.

16 THE COURT: Do we need that this morning or no?

17 MR. GOINGS: I think we've short circuited some things we
18 can tell you about.

19 THE COURT: Okay. Sure. Talk to me. But y'all don't
20 need to approach. There's no jury in here. What are we --
21 what are we doing?

22 MR. GOINGS: We don't want it on the record.

23 THE COURT: You don't want it on the record?

24 MR. GOINGS: Well, we do, but --

25 THE COURT: Well, exactly. So if you want it on the

1 record.

2 MR. GOINGS: No, we don't. Just -- we'll just talk to
3 you. Go ahead.

4 (WHEREUPON, a bench conference was held off the record,
5 after which the proceedings resumed as follows.)

6 THE COURT: Okay. Anything else before we bring the jury
7 this morning?

8 MR. GOINGS: No, Your Honor.

9 MR. DAVIS: No, Your Honor.

10 THE COURT: Bring the jury, please.

11 (WHEREUPON, the jury entered the courtroom at 9:41 a.m.)

12 THE BAILIFF: The jury is seated, Your Honor.

13 THE COURT: Thank you.

14 Good morning, ladies and gentlemen.

15 THE JURORS: Good morning.

16 THE COURT: We are still on the plaintiffs' case. Please
17 give them your undivided attention as they call their next
18 witness.

19 UNIDENTIFIED MALE: Good morning, Your Honor.

20 THE COURT: Good morning.

21 MR. GOINGS: May it please the Court?

22 THE COURT: Yes, sir.

23 MR. GOINGS: We would call Dr. Anthony Mancuso.

24 THE COURT: If you'll come around to be sworn.

25 THE BAILIFF: Come around to be sworn, please. Place

DR. ANTHONY MANCUSO - DIRECT BY MR. GOINGS

1 your left hand on the Bible. Raise your right and face the
2 clerk that way.

3 THE CLERK: Do you solemnly swear or affirm that the
4 testimony you are about to give in this case will be the
5 truth, the whole truth, and nothing but the truth, so help you
6 God?

7 THE WITNESS: Yes, ma'am.

8 THE CLERK: Please state your full name for the record.

9 THE WITNESS: Anthony Mancuso.

10 THE CLERK: You may have a seat, please.

11 THE WITNESS: Thank you.

12 THE BAILIFF: You need to speak loud enough where she can
13 hear you and all the way to the last person in the jury box.

14 THE WITNESS: All right.

15 THE BAILIFF: Okay?

16 THE WITNESS: Thank you.

17 DR. ANTHONY MANCUSO, being first
18 duly sworn, testified as follows:

19 DIRECT EXAMINATION

20 BY MR. GOINGS:

21 Q: Good morning.

22 A: Good morning.

23 Q: And, Doctor, would you introduce yourself to the ladies
24 and gentlemen of this jury?

25 A: Good morning. I'm Anthony Mancuso.

1 Q: Are you a medical doctor?

2 A: I am.

3 Q: What type of medical doctor?

4 A: I'm a diagnostic radiologist specializing in the area of
5 neuroradiology.

6 Q: Would you refer to that as you're a neuroradiologist?

7 A: That's correct.

8 Q: How long have you been a physician, Doctor?

9 A: About 50 years.

10 Q: And where do you practice?

11 A: University of Florida, College of Medicine, UF Health in
12 Gainesville, Florida.

13 Q: What is your position there?

14 A: I'm a professor of radiology, and I'm the chairman of the
15 Department of Radiology.

16 Q: So you're the head radiologist for the University of
17 Florida Medical School?

18 A: In Gainesville, yes. There's another head in
19 Jacksonville.

20 Q: How long have you been the head radiologist for the
21 University of Florida?

22 A: Twenty-three years.

23 Q: Do you train and instruct students that are in medical
24 school?

25 A: Yes, we train and instruct. We actually developed

1 special online electronic methods of training medical

2 students, and so we do train medical students. Yes, sir.

3 Q: Do you also, you know, treat patients as a radiologist?

4 A: Every day.

5 Q: So you're still active in practice?

6 A: Right. And by treat, I mean -- when I say treat, I mean
7 I interpret their studies. I talk to the doctors who ordered
8 the studies and maybe emergently sometimes in advocacy or
9 consultant in the medical decision-making for patients.

10 Q: And how old are you?

11 A: Seventy-five.

12 Q: Will you, just generally, Doctor, explain to the jury
13 what a radiologist does?

14 A: We have a bunch of imaging tests. You're probably
15 familiar with them as regular X-rays, ultrasound scans, CT
16 scans, and MR scans, and we have other procedures that are
17 more invasive, but I don't do those anymore. And we use all
18 of those imaging studies to answer questions that are asked by
19 treating doctors, so that we help them make decisions in the
20 path of their medical decision making. So we -- we read these
21 images. We make a report. Sometimes we speak directly to the
22 doctors if it's a really emergent situation.

23 Q: So if someone has an X-ray or a CAT scan or an MRI, you
24 as a radiologist would read it; right?

25 A: Yes.

1 Q: Okay. And do you have your fellowship in radiology?

2 A: I do.

3 Q: How many fellowships do you have?

4 A: One.

5 Q: In what?

6 A: A two-year fellowship in radiology.

7 Q: Is there any higher training or certifications you can
8 have as a radiologist and a fellowship radiologist?

9 A: A two-year neuroradiology fellowship that I did is the
10 highest level of training for a neuroradiologist.

11 Q: There's not a lot of neuroradiologists walking around, is
12 there?

13 A: Depends on what you mean by a lot. I mean, it's like
14 probably 5- or 7,000 in the United States.

15 Q: Wow. Out of the entire population, 5- to 7,000 people do
16 what you do?

17 A: I think that is fair. I'm basing that on the number of
18 people that belong to that society, the American Society of
19 Neuroradiology, which I'm not sure about, but it might be in
20 that range.

21 Q: Tell the jury what maybe organizations you've been a part
22 of, credentialing you've been a part of, and any type of
23 leadership role that you may have had in those organizations?

24 A: Well, it's a number of them over the years. For
25 societies, that's national kind of society memberships, and

1 there's a really large society of, I think, over 100,000
2 radiologists who do all the radiology called the Radiologic
3 Society of North America. I've been in that since 1970.

4 Because I trained for a two-year fellowship in
5 neuroradiology, I was admitted to the American Society of
6 Neuroradiology, which is a society of us neuroradiologists in
7 the United States and Canada I think too.

8 Those are the main, and then I belong to what's called
9 the -- the Academic University of Radiology, and that's
10 essentially an educational group of educational leaders. And
11 inside that group, I belong to something that's called the
12 Society for the Chairmen of Academic Radiology, SCARD, S-C-A-
13 R-D. Most of the chairman in the United States belong to that
14 Society of Radiology leaders.

15 And you asked me -- there was another part to that?

16 Q: Any type of distinctions you received, like being
17 president of an organization or receiving a presidential
18 award?

19 A: Oh, yeah. So there's another society that that I've been
20 involved in since the late '70s called the American Society of
21 Head and Neck Radiology, and I was the president of that back
22 in the '80s, I think it was, and I did receive a lifetime gold
23 medal. I don't know if you're talking about that, but for my
24 service to that society.

25 Q: And, Doctor, I know how humble you are, and I'm just

1 going to brag on you a little bit. Isn't it true, Doctor,
2 that you pioneered the first clinical research MRI to the
3 state of Florida, essentially you brought the MRI to the state
4 of Florida?

5 A: Yeah. I was recruited from UCLA, where I trained, and
6 the University of Utah, where I was for a couple of years, to
7 start the MRI program, the first MRI program in the state --
8 state of Florida. That MRI was brand new in 1983 is when I
9 went to UF. I was recruited there.

10 I don't know if I would say pioneered, but certainly I
11 was fortunate enough to be working with a great group of
12 scientists at UF who had the first MRI scanner at UF, and I
13 was what they called the clinical director of that, and I also
14 ran the research part of that for my first ten years at the
15 University of Florida.

16 Q: Well, if you Google yourself on the University of
17 Florida's website, it actually says you pioneered it.

18 A: Really?

19 Q: Yeah.

20 A: Well, that's very nice. Thank you. There are -- there
21 are plenty of other people who were the true pioneers of MRI,
22 but I did -- I did -- like I said, was fortunate enough to be
23 recruited to work with a group of really good scientists at UF
24 who were -- were actually pioneers in the technology, but not
25 me.

1 Q: Doctor, have you published or submitted medical articles
2 in research journals in the field of radiology and
3 neuroradiology?

4 A: I have.

5 Q: How many?

6 A: Probably around 180 and still producing, and my articles
7 nowadays are mostly about re -- sorry -- education and
8 educational research.

9 Q: Have you met me, Ms. Gooding, or Mr. Hinson before this?

10 A: No, I think this is the only time I've worked with your
11 group.

12 Q: Okay. And in your career, you've testified in favor of
13 physicians?

14 A: I have, yes, sir.

15 Q: Okay. Do you have a side or are you just in the middle?

16 A: In medical malpractice matters, my -- my record reflects
17 that it's about 50-50. It might be sometimes a little more on
18 the plaintiff side and sometimes a little more on the defense
19 side, depending on the year, but it's about 50-50 over the
20 last 20 years, I think.

21 Q: And you don't seek out this work? People come to you
22 because you're an expert; right?

23 A: I don't seek it out. I don't advertise. They come to
24 me.

25 Q: Now, do you visit South Carolina much?

1 A: Yes, sir. About once a year.

2 Q: And why is that, Doctor?

3 A: Well, so I've been involved in classical ballet since I
4 was at UCLA, and -- and so when I got to Gainesville, I became
5 affiliated with a dance company there that's now called Dance
6 Alive National Ballet. And my children -- now not children,
7 22 years old now -- and I travel and perform with the company,
8 and we have the pleasure of going -- every year pretty much
9 for the last ten years, going to Newberry, South Carolina, and
10 performing at the Opera House there.

11 Q: You performed at -- performed at the Newberry Opera
12 House?

13 A: Yeah, with a company of professional dancers. We do *The*
14 *Nutcracker*. I'm sorry. We do *The Nutcracker*, and I do the
15 lead role. My kids actually did the two kid leads for a few
16 years, but then grew out of it.

17 Q: So you are the nutcracker?

18 A: Yes, sir, I do. I do the -- play this weird sort of
19 magician guy called Blossom. I have sort of a part. It
20 doesn't require any technical dancing. I'm a little past
21 that.

22 Q: Okay. So in addition to being a neuroradiologist, you're
23 not a ballerina? Are you a ballerina?

24 A: No.

25 Q: You know ballet?

1 A: They call us danseurs.

2 Q: Okay. You're a danseur.

3 A: Sorry.

4 Q: All right.

5 MR. GOINGS: Your Honor, at this time, I would like to
6 tender Dr. Mancuso in the field of neuroradiology as an
7 expert.

8 THE COURT: Any --

9 MR. DAVIS: No objection.

10 THE COURT: All right. Ladies and gentlemen, Dr. Mancuso
11 is an expert in the field of neuroradiology.

12 As I told you yesterday, experts are permitted to give
13 opinion testimony where other witnesses are usually not, but
14 as with any other witness, give Dr. Mancuso's testimony the
15 weight and credibility you think it deserves.

16 You may proceed, Mr. Goings.

17 MR. GOINGS: Thank you, Your Honor.

18 BY MR. GOINGS:

19 Q: Doctor, any opinions and any testimony that you give here
20 today, it needs to be given to a reasonable degree of medical
21 certainty unless you tell us otherwise. Okay, Doctor?

22 A: I understand.

23 Q: Thank you, sir. Were you asked to review what happened
24 to Crystal Goodwin on July 28th, 2016?

25 A: I was.

1 Q: What type of materials generally did you review, Doctor?

2 A: Well, being a neuroradiologist, I got all of the imaging
3 studies, the MRI studies to look at and to review and the
4 reports. And I also received fairly extensive medical records
5 around the time of the events of July 28th, 2016. I got the
6 medical records, the surgical records, the operative notes,
7 and -- and those records. And I also received -- after I had
8 reviewed all those materials, I also received the depositions
9 as they evolved over time.

10 Q: And have you been -- are you paid for this time?

11 A: I am.

12 Q: And what is the hourly rate, Doctor?

13 A: \$800 an hour.

14 Q: Okay. And you're familiar that expert witnesses, expert
15 doctors like you, get paid for their services, whether they're
16 on the plaintiffs' side or the defense side or in between;
17 right?

18 A: That's correct.

19 Q: Okay. And if the defense hired you in this case, would
20 your opinions be the same?

21 A: Yes.

22 Q: Have you been able to determine, Dr. Mancuso, the reason
23 why Crystal Goodwin is sitting in a wheelchair today?

24 A: Yes, sir.

25 Q: Let me ask you this. Is Crystal Goodwin paralyzed?

1 A: Yes, sir.

2 Q: Have you been able to determine why she's paralyzed?

3 A: Yes, sir.

4 Q: And are your opinions as to why she's paralyzed to a
5 reasonable degree of medical certainty?

6 A: They are.

7 Q: How sure are you about your opinions?

8 A: With regard to the fact that she had a -- a -- a vascular
9 -- an ischemic vascular event that caused an infarction of her
10 spinal cord.

11 Q: Due to what?

12 A: Due to a lack of perfusion of the spinal cord and most
13 likely diminished blood supply to the cord caused by low blood
14 pressure. To the -- to the extent of that opinion, I'm a
15 hundred percent sure that she had a spinal cord infarction.

16 Q: Thank you, Doctor.

17 A: Well, as close to a hundred percent as things get in
18 medicine. We always say nothing is a hundred percent in
19 medicine, but -- but it's close to a hundred percent as things
20 go that she had a spinal cord infarction or death of her
21 spinal cord related to that lack of blood flow.

22 Q: How important is blood flow to the spine?

23 A: Well, in my area, it connects spine and brain. To be
24 responsive to your question, the tissue that's in the brain
25 and the spinal cord, it's a lot alike, and it's probably the

1 most vulnerable tissue in the body to lack of blood flow
2 because it will be damaged or die the quickest of any tissue
3 in the body when it doesn't get blood flow.

4 And so why is that tissue dependent? Blood brings two
5 things to the nervous system that it has to have to operate
6 normally and not die, oxygen and sugar/glucose. And they have
7 to get to the -- they have to get to the brain and spinal
8 cord. They have to get to the gray and white matter. Both
9 the brain and the spinal cord have gray and white matter, and
10 it turns out also that the gray matter sort of works hard
11 metabolically. So it's especially dependent to where based on
12 the blood bringing oxygen and sugar/glucose to those tissues
13 that are very vulnerable tissues to lack of blood supply.

14 Q: How important is the correct flow -- the correct flow
15 amount of blood going into the spinal cord?

16 A: There has to be enough blood flow to bring enough of the
17 oxygen and glucose/sugar. It has to be enough to sustain that
18 supply. And so you have to have enough pressure pushing
19 through the blood vessels and getting to the targets, which is
20 the gray and white matter in the spinal cord and brain. We'll
21 talk about spinal cord exclusively. So you have to have
22 enough pressure to get the blood to have it break down those
23 nutrients there. So it's critical, I guess, the short answer
24 to your question.

25 Q: The correct blood pressure is important for a healthy

1 spinal cord; correct?

2 A: Yes, sir. You have to have the correct blood pressure so
3 that -- because that's a measure of how the blood is getting
4 to its target, in this case the spinal cord.

5 Q: If you don't have correct blood pressure, that can be
6 dangerous; correct?

7 MR. DAVIS: Your Honor, I'm going to object to the
8 leading.

9 THE COURT: Sustained.

10 BY MR. GOINGS:

11 Q: Is it dangerous to have incorrect blood pressure, blood
12 flow, going to the spinal cord?

13 A: Well, yes. It's bad to have low blood pressure, you
14 know. So -- well, high blood pressure can cause bleeding, but
15 -- so any blood pressure abnormality is a problem, but in this
16 particular case, we're talking about the oxygen and glucose
17 not getting to the gray and white matter. Then you have to
18 avoid low blood pressure because the blood flow won't get
19 there.

20 Q: Doctor, I want you to educate us on the anatomy of the
21 vascular structure of the spine from a neuroradiology
22 standpoint.

23 MR. GOINGS: Your Honor, may the witness come down and --
24 and -- and illustrate that to us.

25 THE COURT: He can step down. I just need him to --

DR. ANTHONY MANCUSO - DIRECT BY MR. GOINGS

1 I need, Dr. Mancuso, for you to stand so that you're
2 facing back towards the court reporter. So sort of where Mr.
3 Goings is standing right now on that side of the screen.

4 MR. GOINGS: Just stand right here.

5 THE WITNESS: Yeah.

6 MR. GOINGS: Make sure you're loud enough so the court
7 reporter can hear you and the -- and the jury.

8 THE COURT: Make sure you speak loudly, and it helps for
9 her to be able to see your mouth.

10 THE WITNESS: Yeah. Please, if I mumble, tell me I'm
11 mumbling. Okay?

12 THE COURT: Absolutely.

13 THE WITNESS: Okay.

14 MR. GOINGS: And also try not to turn your back to the
15 jury when you look at this, because that leads to mumbling.

16 THE WITNESS: Got it. Okay.

17 BY MR. GOINGS:

18 Q: All right. What are we looking at, Doctor?

19 A: Can I bring this -- my model over to start with?

20 Q: Sure. Which one do you want?

21 A: The --

22 Q: This?

23 A: That one. Yeah. No, no, no, no, no. Yeah, that one,
24 please.

25 Q: You want this one too?

1 A: Maybe.

2 Q: Okay.

3 A: This is just to get started and oriented. This is the
4 whole spine and back of the head up here. That's what this
5 thing is, and that is the tailbone down here. The tailbone is
6 down here. And I just want to make sure before we look at
7 these pictures we're going to look at --

8 Q: Talk a little louder.

9 A: Before we look at these pictures -- is that good enough?

10 Q: Well, she told me that.

11 A: Oh, okay. I'm sorry.

12 All right. To get oriented, we're going to be talking
13 about -- there's three parts of the spine: the cervical,
14 thoracic, the lumbosacral. We are going to be talking about a
15 segment of the spine that's here in the thoracic part. So I'm
16 going to show you cutaway pictures here just of this area that
17 represents the anatomy in this area where the surgery was.

18 Q: Okay.

19 A: So in the model what you just saw were the vertebral
20 bodies and the various segments of the spine. And in the
21 thoracic region are 12 segments, and each of those segments
22 has to get -- the spinal cord has to get a blood supply.
23 Okay?

24 So if you imagine now that we're looking at that part of
25 the spinal column that I just showed you, the thoracic part,

1 these are the -- this is actually what's called the spine.

2 These are the vertebral bodies. Okay? And then right in
3 front of that is the large -- the large vessel that feeds
4 blood to the whole body.

5 Q: What is that called?

6 A: It's called the aorta.

7 Q: Okay.

8 A: Okay. And in this case, it's called the descending
9 aorta, because the ascending goes up to that part and gives
10 off the vessels that go to the head, and this gives off the
11 vessels that go to the rest of the body, the descending aorta.

12 So the descending aorta is responsible for the blood
13 supply in the spinal cord in the thoracic and lumbar area.
14 And at each level, it gives off particular branches, because
15 the blood supply to the spinal cord is what we call segmental.
16 It's in segments, it's in pieces, but it's fed by various
17 arteries, and here it's fed by this artery and then the aorta.
18 And at each of these levels, the aorta gives off a branch that
19 comes around the back of the spine, and it enters the canal
20 that the spinal cord is in back here. So this is the spinal
21 cord.

22 Q: So I want to -- I want to highlight. What I did -- what
23 I highlighted, is that the spinal cord in this illustration?

24 A: That is the spinal cord, and these are the nerve roots
25 that come off at each level to the various parts for the

1 sensory and motor muscle function and other functions of the
2 body.

3 Q: Okay.

4 A: So that's the spine. The spinal cord and the nerve roots
5 are highlighted in yellow.

6 Q: So let's go to this highlighted area. Okay? Just kind
7 of -- just kind of drill -- drill in. What are we looking at
8 now, Doctor?

9 A: Well, if you'll go back, I can --

10 Q: Okay.

11 A: So if you imagine that -- I wanted to make one more
12 point. Each of these arteries, they're radicular arteries.
13 Okay? That's what they're called because they just come out
14 at each segment to supply the cord. And the anatomy of the
15 radicular arteries as they come off the aorta or other vessels
16 that feed the cord, again, it comes off in segments.

17 Now, what did you say? Oh, wait, wait, wait. So if you
18 take this spinal cord here like a loaf of bread and you cut
19 through it a slice, that's what we're going to see in the next
20 one.

21 Q: Okay.

22 A: So this would be, like, the front of the spinal cord, and
23 the other word we use for front is anterior in medicine. And
24 this would be the back of the spinal cord, and the word we use
25 for that in medicine is posterior. Okay?

1 So this is the front of the spinal cord. This is the
2 back. These are the nerve roots that I said come off at each
3 level. And this is a picture of -- of what a cross section or
4 also called axial section on an imaging look like this of --
5 of the spinal cord itself and its box.

6 Q: Now, yesterday you were in the courtroom some of the time
7 because we thought you were going to go as a witness, but we
8 didn't get to you. You heard witnesses talk about the
9 watershed region?

10 A: I did.

11 Q: Explain to the jury what the watershed region is and how
12 that is something we need to understand in this case?

13 A: Yeah. Watershed, watershed regions, if you -- if
14 anywhere, it's important to know reality both in the brain and
15 in the spinal cord. And watershed areas -- if you have two
16 blood supplies coming from two different places, the watershed
17 area is the area that's in between those two blood supplies.

18 So it's a very important concept in -- in stroke imaging,
19 and what we're talking about here today is an infarct, like a
20 stroke of the spinal cord. So the watershed is -- is an area
21 that is, for whatever reason, at greater risk for being under
22 supplied or in between two vascular territories.

23 Q: And why is that? Have you ever heard of this being
24 described by the -- the sprinkler system?

25 A: Yeah. Well, that's what I use when I teach.

1 Q: Okay.

2 A: So in particular when we're talking about watershed in
3 this particular circumstance that we have here today, this --
4 the spinal cord, you can -- you can imagine that this is your
5 lawn and your acreage here. Okay? And you have two sprinkler
6 systems coming into it. You've got one coming in from the
7 front that supplies most of the lawn or the acreage you're
8 trying to water.

9 Q: And that would be in purple; correct?

10 A: That's in purple from what's called the anterior, the
11 front spinal artery, and that supplies more than half, about
12 two-thirds of the cord from -- from the front part. Then
13 these same radicular arteries that come up, now they're called
14 radicular medullary, and those are just -- medullary just
15 means it's going into the spinal cord. That's what the
16 medullary part of that word means. So now we've got also
17 coming from these radicular artery branches a vessel that
18 comes around to the back of the cord or the posterior spinal
19 artery, and that supplies this part.

20 And so if you look at that as two sprinkler systems in
21 the front and the back, if you were to step on one of these
22 hoses, you'd see the watershed area. The watershed area is
23 the area between these two things, between these two sprinkler
24 systems. Right?

25 If you cut -- you can do two things. You can step on the

1 hose. Okay? And you'll get a zone. Where the water flow
2 diminishes, you'll get a zone where the lawn is not going to
3 get water. In the case of spinal cord, blood -- blood supply
4 is not going to get there. So that is the watershed area of
5 the spine.

6 So it's also called the border zone. We'll talk about
7 that. So I don't know if you've heard the term border zone,
8 but neuro tissue dies. If it's in between two blood supplies,
9 we use the term border zone as synonymous with watershed area
10 in stroke, meaning in stroke or infarct type scenario.

11 So the other thing, you could step on the hose and the
12 sprinkler systems won't work as well and you get a dry area in
13 between or an area of lack of blood. Or you can turn down the
14 spigot. Right? It has the same effect. This hose has less
15 water. So you -- so the amount of lawn you water here in the
16 sprinkler system metaphor comes back, and the same thing.
17 It's being fed from the same spigot. Right? The aorta is the
18 spigot or the radicular medullary artery could be compared as
19 a spigot too. If you turn down the spigot, you get the same
20 problem. The blood flow or the water will back up and you get
21 a dry zone in the middle.

22 And in the cord in particular, getting the dry zone in
23 the middle is particularly bad because this H-shaped thing,
24 this funny looking H here in the middle, that's a gray matter.

25 Q: So when you were talking about gray matter and white

1 matter earlier. That's the gray matter?

2 A: That's the gray matter, and this is where most of the
3 metabolic activity or the demand -- there's a much higher
4 demand for oxygen and glucose/sugar in the gray matter because
5 that's where all the little synapses are firing to tell your
6 body, like, I'm moving my hands. It's telling my body to move
7 my hands. Help me stand up, you know, so my legs aren't weak.

8 And so that activity is going on in the gray matter. Out
9 in the white matter, what's happening is those are
10 transmitting things from the brain going down, like helping me
11 to have my balance and stuff. Those white matter tracts are
12 much less dependent. They have to have glucose and sugar to
13 live, but they're much less dependent on it metabolically.

14 So if you back off in the sprinkler system, that
15 illustration again, once you start backing away, you will
16 disproportionately undersupply the gray matter because it's in
17 the center of the cord, and that can create what's called a
18 central cord syndrome.

19 Q: Okay. Thank you. And I see at the bottom it says -- and
20 I don't know if I pronounce it right. Adamkiewicz? That's
21 it; right?

22 A: Yeah. There's a few ways to say it.

23 Q: What are the ways?

24 A: Adamkiewicz and Adamkiewicz.

25 Q: And I didn't say it either one of those ways.

1 A: You said it some strange southern way.

2 Q: Yeah, I said it like -- I said it like a boy from Union,
3 South Carolina.

4 A: Right.

5 Q: Which is actually right beside Newberry.

6 A: Yeah. I was just going to say it.

7 Q: I'm going to come see you in December for *The Nutcracker*.

8 All right. So I didn't say it right. You said it right
9 two different ways. What's the importance of the Adam?

10 Q: So the -- the -- the Adamkiewicz artery is -- is a -- is
11 -- there's blood supply that comes from -- to the upper part
12 of the -- this thoracic part of the spinal cord, and there's
13 stuff that comes from below. And this is a -- this is a very
14 unique artery in that it supplies usually about four segments
15 of the spinal cord. The spinal cord is on the other picture.
16 Of the spinal cord supply, it can go anywhere from T7 actually
17 down to L1, but it usually goes from about T8 to about T11.
18 So that's how many? Eight, nine, ten, eleven. That's four
19 segments. Right?

20 So this artery in between the territory of the arteries
21 is in the more upper part of the cord and lower part of the
22 cord is -- is supplying blood in most -- the vast majority of
23 people to four segments of the -- of the spinal cord.

24 Q: This is another illustration. Is the gray matter that
25 you're talking about referred to in this illustration, this

1 model which you have in your hand?

2 A: Yes. The gray matter is gray.

3 Q: And the white matter is white?

4 A: Oh, the white matter is these things, and these fibers --
5 they're running up and down this way. And the gray matter,
6 you can see this is -- yeah, this is actually a good model.
7 You can see how the gray matter is the business because it's
8 supplying all the impulses out to the body. See, it's going
9 out to these nerve roots that there's a nerve root that goes
10 the arms and legs, et cetera, et cetera.

11 So you notice that all these little white neural
12 connections, they're all coming out of the gray matter, and
13 that's what I explained earlier. It's doing most of the heavy
14 lifting with regard to sensory and motor function, and then
15 it's coordinating it with the impulses that are coming down to
16 the brain. Like, there's some columns here back here that
17 help you stand up straight and not fall over and stuff like
18 that.

19 Q: Okay. And you, as a neuroradiologist, what we see here
20 in the model and in this artist's rendition, you see it in
21 your own way, through an image, through an MRI; is that
22 correct?

23 A: That's correct.

24 Q: Okay. And you're specially trained to look at that image
25 and see what you're looking at; correct?

1 A: I look at them every day.

2 Q: Okay. Doc, let me put your testimony in context to the
3 jury based on what we heard yesterday, just a little timeline.
4 Look at this, Doctor. So we have from 7:45 to 10:03. We
5 talked about this yesterday. From our standpoint, the blood
6 pressure was in the danger zone. Then at 10:03, the signal,
7 the neurological signal to the legs, went out. And then from
8 10:03 to roughly noon, blood pressure remained in the danger
9 zone. And then at 2:30 p.m., an MRI was performed. Is that
10 your understanding of just the general timeline?

11 A: Yes.

12 Q: Okay. Was the MRI performed at 2:30 p.m.?

13 A: No, I think it was later.

14 Q: Okay. Do you think it was later than 2:30?

15 A: Maybe. I know it was -- I'm sorry. Interpreted later.

16 Q: Yeah.

17 A: It was performed -- I'm sorry.

18 Q: I'm talking about performed.

19 A: I know.

20 Q: In the -- in the --

21 A: Yeah.

22 Q: -- container.

23 A: When I think about MRIs, I think about when it was read.

24 Q: Yeah. Because the report was written a little later?

25 A: Right.

1 Q: It was actually performed at 2:30?

2 A: Yes, sir. That's what it says on the study.

3 Q: Okay. So what's the time difference between 10:03 signal
4 going out to 2:30, the image being performed?

5 A: Four-and-a-half hours.

6 Q: Okay. Thank you. Now, Doctor, let's talk about images,
7 but before we talk about the images you reviewed, let's talk
8 about bananas. I was coming into court with these bananas.
9 Somebody asked me if I was going to do a banana trick, and I
10 didn't know what that meant, but I said somebody else is going
11 to do a banana trick. So talk to us about bananas and MRI
12 imaging.

13 A: I don't need a whole bunch.

14 Q: You need a knife?

15 A: No, not really.

16 But -- so when we talk about how to look at -- how I look
17 at images is, is that when we look at images from an MR unit,
18 we look at them in slices. So if you remember the spine
19 thing, if you -- there's two ways to think about the spine.
20 You can think about it sort of as a loaf of bread in an
21 upright -- and we're talking about this part of the spine
22 here. If you look at it from the back, the thoracic spine
23 curves a little bit like this. As you get older, it
24 unfortunately curves a little bit more, and so we have a curve
25 in it.

1 And when we look at this on imaging, we look at it
2 generally in two views or two what we call planes, and one of
3 them is if you imagine the spine and the spinal cord as -- as
4 this banana-shaped structure, if we -- if the machine -- we
5 can ask the machine to slice it this way, and so I'll be using
6 the term sagittal images. Right? So when we slice it this
7 way so that it opens up and looks like that, then we're
8 talking about that as a sagittal image. Right?

9 And then if we take this banana and we ask the machine we
10 want to see cross-sections of it, they're called axial
11 sections because they're across the axis of the body. So the
12 axis of the body, the machine is cutting this way like a loaf
13 of bread or cutting the banana up into little slices like that
14 there. Those will be what the axial slices look like.

15 Q: Okay. And is it important to look at MRI imaging with
16 the sagittal and the axial together at times?

17 A: Yeah, we generally view those, if not side by side, we
18 view them one after another, but they're frequently up side by
19 side, and there's lines that tell us. In the sagittal,
20 there'll be a line that says, okay, this banana slice here
21 came through this area here.

22 Q: Got it. So to determine where this banana slice came
23 from, you have to see where on the half banana it's located?

24 A: Yes. And the MR machines take -- take -- take care of
25 that. They -- if you put two -- the sagittal slice up with

1 the axial slice, the sagittal slice will show you where the
2 axial slices came from. So that's how -- that's the
3 explanation for what we call these images when they come out
4 on our work or computer workstation and read them. And that's
5 -- those are the standard terms used in imaging to describe
6 these.

7 And you can also do -- you can tell MR to do this in any
8 plane. I mean, you can tell them to cut this way too or weird
9 angles and stuff like that. But generally in spine and the
10 spinal cord, we're looking at the sagittal and the axial.

11 Q: Thank you, Doctor. Now let's look at the spinal cord,
12 and these are actually images that you reviewed of Crystal
13 Goodwin; correct?

14 A: Yeah.

15 Q: This is actually her spine?

16 A: Yes.

17 Q: Okay. Go through with us, Doctor, the images of
18 Crystal's spine and educate us on what you're seeing and what
19 that means to you from a neuroradiological standpoint.

20 A: So from -- so from what I said before, this is an axial
21 section. So they get oriented in -- in -- in MR way back when
22 it started back in the early '80s --

23 Q: And MR means MRI?

24 A: MR and MRI are the same thing. We just shortened it
25 because we don't want to say RI all the time. Right? So --

1 so it was decided when MR -- MRI started back in the '80s that
2 we were going to view these axial images from the feet up.
3 Okay? As if the feet up. So the right side of the patient is
4 on the left of the picture and the left side is on the right.
5 You're looking at the body as if we're looking at it from the
6 opposite, to get oriented.

7 And then in these axial sections of the spine -- again,
8 just to get oriented, this is the vertebral body of that
9 segment. Okay? And then inside, and then these are the bones
10 in back. This is -- these are called the posterior elements.
11 These are the facet joints. These are -- this is the lamina.
12 Right?

13 And then these are hooked, which you can't see on this
14 slice because we're at the level where the nerve roots come
15 off. They have to have little tunnels that get out of the
16 spine through there. So those are little tunnels and the
17 nerve roots.

18 And in the center here is called the spinal canal, and
19 that's close to the bone in front, the vertebral body, and the
20 bone in the back makes the tunnel, and we call that the spinal
21 canal. Inside the canal, there's a little bit of fat, and
22 then there's a sac. It's sort of a tough sac called the dural
23 sac. Then there's thecal sacs. And people might say -- you
24 might hear that word, but it's a sac.

25 And in the spinal -- and then there's fluid filling that

1 sac that's pumped down mostly from the brain in order to bathe
2 the spinal cord. So around the spinal cord is white so that
3 the thin black line, that's that thick dural sac. It's pretty
4 tough. Inside that, there's fluid. And the spinal cord is
5 this gray thing in the middle that is -- is bathed in that
6 fluid in that sac.

7 Q: Okay. Does this picture represent a normal cord?

8 A: Yes.

9 Q: And what was the date of this MRI?

10 A: June 28th, 2016.

11 Q: Was that the date of the surgery or one month before the
12 surgery?

13 A: One month away.

14 Q: Normal cord one month earlier?

15 A: Yes. Well, at that level.

16 Q: Okay. Right. What are we looking at here, Doctor?

17 A: We're looking at a -- on Crystal Goodwin on July 28th,
18 2016, we're looking at an MRI that was done in a manner with
19 -- we call these pulse sequences over here. That's the
20 instructions. We tell the machine of how we want the tissues
21 to look like. So we say, machine, an MR machine, go out and
22 do this and this to get pictures that look like that. Okay?
23 And it depends on what you want to look at.

24 So in this case to reorient, that's the vertebral body
25 and that's the sac inside the spinal canal. And that's the

1 spinal cord inside the sac, surrounded by fluid on the 28th,
2 the date of surgery.

3 Q: So the day of surgery, this would be after the surgery at
4 13:58. Would that be 2:58 that this image was actually taken?

5 A: 1358 military time would be -- that's acquisition time.
6 That's how long it took to do the sequence.

7 Q: Okay. Okay. All right. Okay. That's not -- that's not
8 --

9 A: The time of the exam should be somewhere on here.

10 Q: But this was on the day of the surgery after the surgery;
11 correct?

12 A: That's right. And that just -- that just means -- the
13 1358, not to get anybody confused, that's not clock time.
14 That's the time it took to do this one sequence out of several
15 sequences.

16 Q: Okay. Now, where is the spinal cord in this -- in this
17 image?

18 A: I think I already showed them right there.

19 Q: Okay. Let's zoom in on that.

20 A: So this is a zoomed-up image. Vertebral body, spinal
21 canal, fluid around the spinal cord. Spinal cord itself is
22 right there. That's that gray thing.

23 Q: Okay. So this is the axial view. Let's show them --

24 A: Well, wait. Go back.

25 Q: Okay.

1 A: And inside that gray thing, if you remember the normal,
2 there's two white dots that don't belong there.

3 Q: Okay. All right.

4 A: So the cord is abnormal at that level on that scan on
5 that day.

6 Q: All right. Now, we took the banana slice in half, the
7 sagittal view?

8 A: Right.

9 Q: Show us what we're looking at, Doctor?

10 A: So here we're looking -- now we're looking at a side view
11 of the spine. Okay? The sagittal view. The vertebral bodies
12 are here. Each segment is defined as what they call motion
13 segments, because the vertebral body above, the vertebral body
14 below, the disc in between, and those elements in the back,
15 that's a motion segment because the spine is supposed to let
16 you move, balance, and stuff.

17 So these are the various segments. And this is the
18 spinal cord coming down inside the spinal canal. Inside the
19 white is the fluid in the sac around the spinal cord. The
20 spinal cord is the gray tube coming down here.

21 And -- and -- and -- and then we see -- we come down to
22 this area. The cord changes the way it looks. It starts
23 changing right about here on this picture and right about
24 there on that picture. And then back here, we have the
25 effects of the surgery on that day.

1 Q: Okay.

2 A: The effects of the soft tissue, the approach to the
3 surgery and the -- and when they took off the back parts.

4 Q: Okay. Doctor, show us what we're looking at here?

5 A: So we're going to examine the -- the segments of the cord
6 that show evidence of -- of ischemic injury or lack of blood
7 supply. Okay? And we're starting on a section on the
8 sagittal view, that T9-10. This is -- this is T8, and what
9 we're showing is that this particular axial view here with the
10 spinal cord and the abnormal white there. So a little bit off
11 center in the spinal cord, a little off center in back. That
12 this abnormality of the cord goes as high as mid T8. Okay?

13 And -- and that's important because this means that
14 dominantly the gray matter in the one part of the H and a
15 little bit of the white matter there is involved all the way
16 up to the T8 level, which goes back to thinking about the --
17 the artery of Adamkiewicz, because remember what I said at
18 these four territories, usually about T8, most usually about
19 T8 to T11.

20 So we know that this spinal cord was damaged at least to
21 this level of T8, and if there's that much there, if we added
22 a slice a little higher, it probably still showed. So --

23 Q: Does this show a damaged spinal cord?

24 A: I'm sorry. Yeah. So this is the spinal cord, and that's
25 the damage that's a little bit off center up -- up at T8.

1 Q: So to orient ourselves to what we see in this image on
2 the -- on the right, which is the axial, this banana cut slice
3 is here?

4 A: Yes, sir.

5 Q: Okay. And this says central cord infarction. What is
6 central cord infarction?

7 A: Infarction is -- and of course, that's based on the
8 outcome of the patient and what they know about it, but -- so
9 infarction is dead tissue. It's end-stage dead tissue.
10 That's the medical word for it. If you have a heart attack
11 and your heart muscle dies, it's called a myocardial
12 infarction.

13 In this case, there was lack of blood supply to the cord.
14 It eventually resulted in the cord being infarcted or that
15 part of the cord being dead tissue eventually. It could be
16 evolving toward death, but we know that it ends up by her
17 follow-up scans and her neurologic deficits that the cord was
18 infarcted.

19 Q: And you used the word infarct earlier, and I'm just
20 asking you, does this image show infarction from a
21 neuroradiological standpoint?

22 A: It shows developing infarction. Yes, sir.

23 Q: Okay. And is this -- where is this to the operative
24 site?

25 A: Just the segment above. The operative site began with

1 the T9-10 disk space. So at this level here.

2 Q: Okay.

3 A: So that's a segment plus, maybe, you know, as much as a
4 segment and a half or segment and three quarters above the
5 operative site.

6 Q: And the operative site is where that bone spur was;
7 correct?

8 A: That's right.

9 Q: Okay. So --

10 A: Well, that's not exactly right. The bone spur was at the
11 top of the operative site because they had -- they -- they --
12 they did a multi-level removal or laminectomy of the segments
13 below.

14 Q: Okay. So the operative site of the bone spur was -- was
15 a segment below where my hand is located?

16 A: That's correct.

17 Q: Okay. But above the operative site, there was spinal
18 cord death above it; correct?

19 A: Yeah, approaching two segments above it.

20 Q: Okay. Doctor, this shows us what?

21 A: This shows us the center part of the insult to the cord,
22 and it -- it shows -- this is right above -- I think we have
23 another picture, but it comes right about through there, I
24 think.

25 Q: Yeah, I think that shows the level of the infarct; is

1 that correct?

2 A: Yeah. So that -- it comes through just above the
3 operative site and the -- what's left of relatively normal
4 tissue. So, again to orient, that's the fluid outside the
5 spinal cord. That's the thecal sac. This white is the fluid
6 outside that the spinal cord is bathed in, and this is a
7 central cord injury here. Okay?

8 It's all in the center, that most vulnerable part.
9 Remember when we talked about the -- the watershed and the
10 sprinkler system and -- but what's left is the periphery of
11 the cord here, and that whiteness in the cord is in the cord
12 swelling.

13 Q: And what causes dead tissue in the central part of the
14 cord?

15 A: Well, one of the things that would cause it is a lack of
16 blood flow.

17 Q: Okay. Blood pressure?

18 A: Yeah. Well, blood pressure in this matter seems to be
19 the most likely explanation for the lack of blood flow, yes.

20 Q: Okay. What are we looking at here?

21 A: So this illustration is to show that -- that -- the
22 extent of injury from top to bottom. So on this sagittal
23 slice, I think we've been oriented enough now. Previously, we
24 saw the cut that was up the -- the damage to the central part
25 of the cord in the long center --

1 Q: Right in here?

2 A: -- was up in this level. And -- and then we just saw one
3 that was around here where the cord was centrally injured, and
4 now we'll see the -- the extent of the injury below the
5 operative level, and that's what this picture is. So spinal
6 cord here with the white dot there and the white dot there or
7 the white area, I should say. It's not a dot. Right? And if
8 you remember the pictures and the -- the models of the spinal
9 cord, that whiteness is in the gray matter dominantly. It
10 could be a little bit of white matter, but this is really
11 central cord.

12 And -- and it's -- what? A -- the level of the
13 osteophyte, that is a segment, at least a full segment, and
14 that's down. Now we're getting down to T11. That's T10. So
15 now you'll see that the top and the bottom of this goes from
16 T8 to T11, which is the territory of the -- it's normally
17 supplied, like I said, by the artery of Adamkiewicz.

18 Q: And this pattern?

19 A: It's a fairly -- it's a pattern where it's just gray
20 matter, and essentially is a pattern that's -- that's in -- in
21 this setting is due to a -- is a spinal cord injury, vascular
22 injury pattern, ischemic infarction pattern.

23 Q: Okay. Due to what?

24 A: In this case, again, it appears that it was due to a
25 transiently inter-operatively reduced blood pressure.

1 THE COURT: Oh, you started mumbling there.

2 THE WITNESS: Oh, I mumbled. Sorry. Yes.

3 BY MR. GOINGS:

4 A: It appears that, in this case, it was due to a
5 transiently lowered blood pressure during surgery or lowered
6 blood pressure during surgery.

7 THE WITNESS: More? Okay. Thank you. Just keep telling
8 me.

9 BY MR. GOINGS:

10 Q: All right. So let's zoom in on this. This is below the
11 operative site.

12 A: It is. Well, it's below the operative site where the
13 disc was. Right? Because the operative site is -- well.

14 Q: Now, you said that this is a significant pattern which
15 you see here below the operative site? What we're seeing here
16 is a -- it's significant; right?

17 A: It is, yes.

18 Q: And tell -- tell us why this is significant?

19 A: It's significant to try to figure out what's going on
20 because part of my job as an imager is to help the decision
21 making and to suggest the -- to the treating doctors what's
22 most likely causing the patient trouble, in this case, you
23 know, profound weakness in the lower extremities.

24 You know, with an infarct -- developing infarct at this
25 level of the cord, and this pattern that you refer to helps me

1 identify the cause. And in this case, this is a pattern
2 that's -- that's -- in this setting, it could be caused by
3 other things, but in this setting, it's characteristic of cord
4 infarct or what will eventually be dead cord.

5 Q: Okay. And all the imaging that you've seen and we showed
6 the jury, they're from the imaging disc; correct?

7 A: They are.

8 Q: True and accurate?

9 A: Yes.

10 Q: Now, the lines that can be drawn that we showed you,
11 those are lines that can be actually drawn on the imaging for
12 you as a clinician in making notations; correct?

13 A: Yes. You mean can I annotate images if I want?

14 Q: Yeah. Yes.

15 A: Yeah, sure.

16 Q: And that's what -- that's what we have here; correct?

17 A: Yeah. And then -- and we also have ones where the
18 machine puts it on. So yeah. So this is -- this is a line.
19 I'm sorry I failed to mention this. This is the line that the
20 machine draws that tells us where this axial sliced through.
21 So -- so the machine knows what it did when it did the
22 sagittal. It knows what it did. It's computer memory, and
23 then it draws this line to tell us that when you're looking at
24 this, this slice comes from there.

25 Q: All right.

1 A: So -- so, also, if I wanted to, I could draw on the films
2 or put notations and stuff on it. I don't know if that's what
3 you were asking.

4 MR. GOINGS: Your Honor, at this time, we'd like to move
5 into evidence the -- sorry -- the MRI images that have been
6 shown to -- to the jury, Your Honor, as Plaintiffs' Exhibit --
7 what is next?

8 THE COURT REPORTER: It's 20.

9 MR. GOINGS: 20, Your Honor.

10 THE COURT: Any objection?

11 MR. DAVIS: No, Your Honor.

12 THE COURT: Plaintiffs' 20 is admitted without objection.

13 (WHEREUPON, Plaintiffs' Exhibit Number 20, MRI images,
14 was admitted into evidence.)

15 BY MR. GOINGS:

16 Q: As a neuroradiologist and a professor, have you had any
17 occasion to teach and train medical students about what this
18 image represents?

19 A: Yeah, we do. We teach this very expressively. It's --
20 it's the -- spinal cord infarction is not -- is not common,
21 but you have to know when it's going on. So all of what we're
22 talking about today, pretty much the way we discussed it with
23 everybody here is -- is what we teach about. We have to teach
24 what we've been talking about all the way from how you read
25 the studies to what these studies mean. So --

1 Q: What is -- what is significant about this from being
2 descriptive as to what this represents when you -- when you're
3 talking about this with your students?

4 A: Yeah, sometimes there's medical -- what we call jargon,
5 sort of stuff we call things. And when we teach about spinal
6 cord infarct and spinal cord diseases, this pattern where you
7 see the spinal cord like that is, I guess, sort of in an
8 insensitive way, perhaps, and sometimes medicine amongst
9 doctors gets a little insensitive when we're not with
10 patients, and sometimes that's called snake eyes when we teach
11 the students, and there's some other terminology that's used
12 to describe it. It's very descriptive, but we teach that
13 because this pattern is usually associated with -- with an
14 outcome that's not good for the patients.

15 And then, of course, the reference to snake eyes is dice
16 play. It's a bit insensitive. The reference to snake eyes is
17 like dice play, even though it's a little insensitive.

18 Q: So this would be referred to as a snake eye pattern?
19 Why? Because does it look like snake eyes?

20 A: Well, it might to some people. I mean, you know, it's a
21 -- that could look like the head of the snake and -- and --
22 and so that's just what you call it.

23 Q: Okay.

24 A: I learned this.

25 Q: But it's a snake?

1 A: Yeah.

2 Q: So some students say they see a snake; right?

3 A: Yeah. There's the eyes and there's that. So --

4 Q: What other animal does certain students say they see?

5 A: Yeah, some people call it owl eyes. But to answer your
6 question, the way we teach, we -- we use these kinds of terms
7 to sort of solidify things in people's minds so that they
8 recognize the pattern and recognize what it might be called.
9 So those are sort of teaching jargon. It's not medical. It's
10 not medical talk.

11 Q: What do you see in here? Snake eyes or owl eyes?

12 A: Me? I mean, honestly, I've always -- when I was taught,
13 I was taught it was snake eyes, but actually, it looks a
14 little bit more like owl eyes. It's -- I've never seen -- I
15 never -- I never actually heard it called owl eyes.

16 Q: Some of your students have called it that; right?

17 A: They might, yeah. Some of my colleagues might.

18 Q: What does this show, Doctor, this line?

19 A: So we took some time to look at the samples of the
20 sections above and below the area of the operation where the
21 bulk of the -- the osteophyte was, and this is a -- the green
22 line constitutes the minimum top to bottom extension of this.
23 It could go a little higher. It could go a little lower. And
24 so -- so this notation on here indicates that this main area
25 of central cord injury has a tail on it.

1 And if you cut the cord through that, you'd see some --
2 some expression of that central cord injury pattern here, the
3 so-called owl eye pattern all through these areas that are --
4 I think are a little harder to see in a sagittal. You know,
5 to know that that's really abnormal, you have to look at the
6 axial and see those owl eyes or snake eyes. So the -- so
7 those findings, the owl eyes or snake eyes as an expression of
8 cord injury, the green line is showing the extremes of what
9 you could call the tail of this injury zone, the central cord
10 injury zone.

11 Q: And what is this, Doctor?

12 A: This is a -- could you go back to the smaller version?

13 Q: Yes, sir.

14 A: That one was blurry. Yeah, this is good. So this is --
15 I actually -- earlier, I said I can annotate images. So when
16 I was asked to -- to form opinions originally about this, you
17 and I had a conversation. You said, you know, that -- that
18 you'd like some explanation of what we were talking about. So
19 I made these annotated images showing that there's a central
20 cord edema pattern here, and then two tails of it here and
21 what I'll call a tail there.

22 And you had questions, and I had to explain to you that
23 -- that this territory from T8 down to T11 represented the --
24 so I'm calling here the anastomotic artery of A. A means
25 Adam, Adamkiewicz. It's called the -- technically, it's the

1 greater anastomotic artery of Adamkiewicz is the official
2 name, and they call it the greater because it supplies four
3 segments, most commonly from T8 to T11.

4 Q: And that corresponds with the length of this dead tissue
5 all along the artery of Adamkiewicz?

6 A: Yeah. The follow-up studies show that the cord is the --
7 has -- you know, it has -- it fits with the neurologic
8 deficits that -- that Ms. Goodwin has, and it fits with the --
9 the follow-up images that show that this -- this cord was --
10 it essentially was dead on the -- you know, the follow-up
11 images a year or more away.

12 Q: Okay. Now, yesterday, the defense said that we're going
13 to prove that this injury, the reason why she's paralyzed, was
14 caused by something called reperfusion.

15 MR. DAVIS: Your Honor, I would object to that question
16 and the characterization. It's not accurate, and it's
17 inappropriate.

18 MR. GOINGS: That's exactly what he said.

19 THE COURT: Overruled.

20 BY MR. GOINGS:

21 Q: Do you recall that yesterday?

22 A: I do.

23 Q: Okay. My question for you is this. The imaging studies
24 that you reviewed in your work in this case, being as a
25 neuroradiologist, is what you reviewed on an MRI a reperfusion

1 injury?

2 A: It's primarily an ischemic cord vascular injury. It's
3 characteristics of an infarct in the distribution of the
4 artery of Adamkiewicz. The territory is the same. The
5 pattern is that of an infarct and -- and -- and your question
6 was?

7 Q: My question is this. Is Ms. Goodwin in a wheelchair
8 today because this is only a reperfusion injury?

9 A: The answer to that is no. The -- the -- the primary
10 inciting event here is -- is a characteristic and -- and for
11 all the reasons that we've spent some time understanding its
12 extent, the way it looks, essentially involves the gray matter
13 more than the white matter.

14 For all that, for all those reasons, the inciting event
15 here, the causative event is lack of blood flow to the cord.
16 Whether or not her blood pressure a little later could have
17 been reestablished and there is a reperfusion component,
18 possible. Unlikely. Reperfusion is extremely -- reperfusion
19 injuries in the spinal cord, not in the brain, is extremely
20 rare. I mean, very rare.

21 Q: How -- what percent chance that she's in a wheelchair
22 because the defense's theory of a reperfusion injury is there?

23 A: None. She's in the wheelchair because of a -- an
24 ischemic event to the cord --

25 Q: Right.

1 A: -- that may have been associated with a component of --
2 of -- of reperfusion. So she has a cord infarct when her
3 blood pressure drops. She gets out of surgery. She comes
4 back. Her blood pressure I know from the record goes back up
5 to her hypertensive state.

6 To have reperfusion, you have to have ischemia to begin
7 with or infarct to begin with. That's the way we see it in
8 the brain. Common -- not uncommonly, but frequently. Okay?
9 So you have to have an ischemic event to have reperfusion.
10 Okay? You have to have ischemia for the -- the area that's
11 lacking blood supply to be reperfused to get blood flow back.

12 So it could have happened. She gets the infarct due to
13 the low blood pressure or the evolving infarct. Her blood
14 pressure is low. It comes back. She gets back to the ICU,
15 where she is before she gets the MRI. Her blood pressure goes
16 back up to hypertensive state. And yeah, some blood flow
17 could have reached that area and increased the damage in the
18 area.

19 Q: So you're saying any reperfusion would have occurred
20 after she had already lost her signals hours later when she
21 was in the recovery room?

22 A: Right. Because her blood pressure -- because then it
23 makes sense that she had the infarct due to the ischemic event
24 due to the low blood pressure. The pressure goes back up, and
25 you can -- you can then reperfuse, actually at a higher blood

1 pressure than normal.

2 This happens in the brain just like in -- so people have
3 brain infarcts and arteries plug. Right? And part of the
4 brain dies. Somebody goes in and pulls the clot out of the
5 vessel, and the infarct -- the infarcted brain tissue gets
6 worse. That's reperfusion. It's not common in the brain, and
7 it's rare as can be in this -- in the thoracic cord, it's very
8 rare, and in the cervical cord, it's still rare.

9 So I think the answer to your question is that
10 reperfusion can be part of what we call the pathophysiology,
11 how things happen, but I believe if reperfusion occurred, it
12 occurred after the primary infarct to the cord.

13 Q: Okay. So that's what I wanted you to explain. If there
14 is any reperfusion ever, that would be after there was an
15 infarction due to low blood supply, low blood pressure?

16 A: It's the only -- that's the only thing that makes factual
17 sense. I mean, you know, I said earlier that you asked me
18 what my job was trying to help clinicians think through how
19 things happen. The -- the -- what I see in the images is
20 compelling that there was an infarct to begin with. So to
21 answer your question --

22 Q: During surgery?

23 A: During surgery because -- because I think the record and
24 everyone that I read in depositions agrees it wasn't a
25 mechanical thing. Adamkiewicz wasn't clipped off. There

1 wasn't any interference. There wasn't any compression,
2 anything else to explain it.

3 That leads to low blood pressure. You take the low blood
4 pressure, put it together with the monitoring things that went
5 on intraoperatively, put it together with a pattern that's --
6 I'll use the word classic, very characteristic -- when you say
7 classic in medicine, we mean very characteristic -- for an
8 infarct.

9 That makes the -- the line of reasoning, when you think
10 through this, that there was an infarct while the blood
11 pressure was low. She gets out. Her blood pressure goes back
12 up to -- I don't know -- 130 over 90 or so, or something like
13 that. And after she gets out of surgery where she had the
14 infarct, it started to get some reperfusion component to -- to
15 the -- to the picture we're looking at.

16 Q: Doctor, are you saying that she had a spinal cord injury
17 due to infarction, which is caused by her blood pressure being
18 too low at levels above the operative side and extends all the
19 way down below the operative side?

20 A: Right. At least -- at least a segment to a segment and a
21 half above and below the operative site.

22 Q: If it was just a reperfusion, the area where she had that
23 bone spur was reperfused, where would that be located?

24 A: Well, so there's two -- two answers here. Well, the
25 answer is where would it be and what would it look like?

1 Q: Yes.

2 A: Okay. Just thinking like a radiologist, when you get
3 these rare reperfusion injuries, over the years from what I've
4 read about them because I've never seen one proven, it comes
5 up in the spinal cord, but it usually comes up only if maybe
6 this happened because there was no other reason for it. Okay?
7 And so -- so when reperfusion injuries occur, they typically
8 are restricted to the original operative site, the original
9 site where that osteophyte was. They don't spread up and down
10 like an infarct does.

11 And then what does it look like? It looks like it
12 involves the whole cord because reperfusion injury,
13 theoretically -- this isn't proven. It's hardly even proven
14 in animals, but the reperfusion injury in the brain is
15 believed to be due to the blood getting there and then the
16 blood releases more oxygen that then -- sorry for the
17 complication. It free radicals, and that makes more
18 inflammation. So it should involve the whole cord, not just
19 the center of the cord.

20 Q: Okay. So reperfusion injury involves the whole cord,
21 which we don't have; correct?

22 A: We have -- on all the images, we have a central cord
23 pattern.

24 Q: And a reperfusion involves localized in the area where
25 the operative site would be where you're removing the

1 osteophyte, the bone spur, off the --

2 A: Right.

3 Q: -- the cord; right?

4 A: Yeah. And the other side of that argument, it should not
5 be expressed in the full territory of an artery that's
6 commonly present there.

7 Q: Okay. A reperfusion injury would not -- of the spinal
8 cord would not affect the entire location where that one
9 artery goes in and provides blood to the spinal cord; right?

10 A: Not based upon the theories that I'm aware of on
11 reperfusion injury.

12 Q: All right. Have a seat, Doctor. Thank you for going
13 over that with us.

14 A: All right.

15 Q: All right. Doctor, you said about an hour ago when you
16 started that in your professional opinion, being a physician
17 over 50 years, it is your opinion to a reasonable degree of
18 medical certainty that she had a spinal cord infarction to the
19 center cord, extending levels above and below where the
20 operative site was for the -- for the bone spur, and that the
21 infarction was caused by a loss of blood pressure, blood
22 supply to that region; is that correct?

23 A: I did.

24 Q: Okay. And you said that that opinion is -- if it's not a
25 hundred percent, it's 99.9, as sure as you can be with medical

1 certainty. Isn't that what you said?

2 MR. DAVIS: Your Honor, all this has been asked and
3 answered.

4 THE COURT: Sustained.

5 MR. GOINGS: I know, but I'm trying to lead into this
6 next question. I'm just kind of recapping what he said.

7 THE COURT: Just get to your next question --

8 MR. GOINGS: All right.

9 THE COURT: -- without the recap.

10 MR. GOINGS: All right.

11 BY MR. GOINGS:

12 Q: What percentage chance do you ascribe to the defense
13 theory that she's in a wheelchair only because of a
14 reperfusion?

15 A: None, only because of a reperfusion. I believe it's
16 because of an infarction, maybe with a component of
17 reperfusion that happened later on.

18 MR. GOINGS: No further questions. Please answer any
19 questions opposing counsel might have.

20 But I assume you want to take a break.

21 THE COURT: I do want to take a break. Counsel approach.

22 MR. GOINGS: You gave me that look. That's why I said
23 that.

24 THE COURT: Yeah.

25 (WHEREUPON, a bench conference was held off the record,

1 after which the proceedings resumed as follows.)

2 THE COURT: All right, ladies and gentlemen. I think
3 that this is -- I know it's a little unconventional. It's a
4 little early, but we're going to take a lunch break now. I'm
5 going to excuse you until 1 o'clock. So, I mean, if you're
6 not hungry yet, maybe at noon or 12:30, you will be, and you
7 can get back here at 1 o'clock and we'll proceed with the case
8 then.

9 Don't discuss the case amongst yourselves or with anyone
10 else. Don't do any research about the case. Just go have a
11 good break and be back at 1 o'clock.

12 (WHEREUPON, the jury exited the courtroom at 10:55 a.m.)

13 THE COURT: All right. We are actually going to break
14 until 1 o'clock.

15 Dr. Mancuso, don't discuss your testimony with anyone
16 over the break.

17 I'll see you all back at 1 o'clock.

18 (WHEREUPON, there was a break in the proceedings, after
19 which the proceedings resumed as follows.)

20 THE COURT: All right. Good afternoon, folks. Are we
21 ready to resume with cross-examination?

22 Dr. Mancuso, if you'd come back up to the stand.

23 And you can bring the jury, Mr. Bowen.

24 (WHEREUPON, the jury entered the courtroom at 1:11 p.m.)

25 THE BAILIFF: The jurors are seated, Your Honor.

DR. ANTHONY MANCUSO - CROSS BY MR. DAVIS

1 THE COURT: Thank you.

2 Welcome back, folks. Hope you enjoyed that lunch break.

3 We are -- we had just finished the direct examination of Dr.

4 Mancuso. If you'll give the defense your attention for cross-

5 examination.

6 Mr. Davis?

7 MR. DAVIS: Thank you, Your Honor. May it please the

8 Court.

9 CROSS-EXAMINATION

10 BY MR. DAVIS:

11 Q: Dr. Mancuso, I managed to get a cold last night, and I'm

12 a little -- little raspy. So if you can't hear me, please let

13 me know. I'll try to do the best I can to speak up. Okay?

14 A: I will.

15 Q: All right. Doctor, about how many hours have you spent

16 so far in reviewing the case, consulting with the attorneys,

17 your deposition testimony in this case, and trial preparation?

18 A: Probably about 20 hours.

19 Q: All right, sir. The list of cases that you supplied to

20 us before your deposition that was taken back in October of

21 last year listed 109 medical malpractice cases where you

22 served as an expert. Would that be accurate?

23 A: Yeah. Over 20 years.

24 Q: Yeah. Okay.

25 A: Right. Yes, sir.

1 Q: And you tell us the percentage of your income generated
2 since 1997 doing expert witness work varied from as much as 35
3 to 40 percent to maybe less than 25 percent today. Is that
4 still fair?

5 A: That's fair. It's 25 percent.

6 Q: Okay, sir. Doctor, you don't have any knowledge or any
7 information or evidence of what anybody may have told Dr.
8 Graham, who interpreted the post-operative MRI, Dr. Blease
9 Graham, as to the reason or indication for that post-op MRI;
10 true?

11 A: Only what was written on the request as the history.

12 Q: Right.

13 A: Yes, sir.

14 Q: And you're not saying to this jury that Dr. Holbrook
15 communicated directly with Dr. Graham any of that history that
16 Dr. Graham, from whatever source he got it from, put on the
17 top of his report; correct?

18 A: That's right. I don't know who wrote that down in that
19 history section.

20 Q: All right. Thank you, sir. And as a radiology
21 consultant like yourself, like Dr. Graham was in that case,
22 the post-operative MRI that we've been looking at, when he
23 serves and you serve as a radiology consultant to the ordering
24 physician, if there's no communication between you and the
25 ordering physician as to the indication or history of the

1 patient, you as the -- as the radiology consultant can access
2 the electronic medical records and look at the preoperative
3 history and physical and can put that down as a reason for the
4 study if you elected; correct?

5 A: Well, there's two parts to that question.

6 Q: Okay.

7 A: So just maybe you can help me. You said no
8 communication. Do you mean at all?

9 Q: Correct.

10 A: No -- not even a written history that was there?

11 Q: Yeah. The ordering physician doesn't put down an
12 indication for it. He doesn't tell you about it. There's no
13 communication. If you need to find that out, you can go back
14 to the electronic medical records, and you can access
15 preoperative history information and put something down, can't
16 you?

17 A: Let me answer the second part first.

18 Q: All right.

19 A: Yes, you can. If the record is available, you can go
20 back in and look at it.

21 Q: All right.

22 A: Just technically speaking, for billing purposes there,
23 it's not proper for there to be no communication. You cannot
24 bill for or do a study compliant with federal rules, CMS rules
25 and the insurance companies, without having some indication

1 like the one that was written down. I just want to be clear.

2 Q: Sure.

3 A: Because you're saying no communication.

4 Q: Yeah, yeah. And you don't know in this case, in all
5 fairness to you, whether there was any communication from Dr.
6 Holbrook to Dr. Graham?

7 A: That's fair because I don't know who wrote down that
8 history in the order you read.

9 Q: All right. Thank you. Just a second, please. The June
10 28th, 2016, MR -- can I just call it that? MR?

11 A: That's fine with me.

12 Q: Okay. Of the thoracic spine, you looked at those images
13 as part of your review in this case, sir?

14 A: I did.

15 Q: Okay. And you agree that that was a preoperative MR that
16 was ordered by Dr. Holbrook when Crystal Goodwin, his long-
17 time patient, had come to him with new complaints of bilateral
18 leg weakness; true?

19 A: Yes.

20 Q: And you observed in looking at those images, I think it
21 was June 28th, a month before the surgery, 2016, what you call
22 adjacent level changes in T6, T7, and T8; correct?

23 A: Yes.

24 Q: And explain to the jury, please, sir, what you mean by
25 adjacent level changes in the thoracic spine?

1 A: When you operate on the spine at a level, and if for some
2 reason that level is made rigid with some sort of fusion
3 between the segments, the movement of the spine is not a --
4 movement of the thoracic spine, the movement of the spine
5 causes the degenerative changes between the disc and the --
6 and the vertebral body, and also in the small joints in the
7 back of the spine to -- in some people, about 15 percent of
8 the cases show a more rapid progress of the degenerative
9 changes that we see naturally with aging. It's called
10 adjacent level disease because it's right next to where the
11 surgery was. Everybody doesn't get it. It's about 15 percent
12 chance it happens.

13 Q: Okay. Let's go if it did happen.

14 A: Well, that was my interpretation of the findings.

15 Q: Yes, sir.

16 A: So --

17 Q: You would agree that since the prior study in 2011, you
18 would say that there is evidence of progressive adjacent level
19 disease above and below the prior area of surgery back in
20 2011; correct?

21 A: Yes. That's the right time course for it, and -- and
22 those would be adjacent levels. Yes, sir.

23 Q: Yes, sir.

24 A: And I would have to base that opinion on something that
25 was previous reasonably, you know, right a few years before.

1 Q: Yes, sir.

2 A: Because that takes a while to develop.

3 Q: Yes, sir. Thank you. And you'd agree that the area of
4 most progression was from the facets in the T9 level from the
5 left side with displacement of the spinal cord; correct?

6 A: Yes, sir.

7 Q: And displacement of the spinal cord to you means that the
8 bony element, like the facets, can actually protrude into the
9 spinal canal, and then they can actually push the thecal sac
10 and the cord to the other side; true?

11 A: That's correct. True.

12 Q: And that's what you see on those preoperative images on
13 June 28th of 2016?

14 A: Yes, sir.

15 Q: And again, those are images done before -- a month before
16 Dr. Holbrook's surgery about a month later; right?

17 A: They are.

18 Q: When you see what's going on in those preoperative images
19 that you reviewed in this case, sir, you would agree that for
20 the patient, that's not a good thing, and the question is
21 whether or not it causes or generates some symptoms; true?

22 A: That's right. We always look for what we call a symptom
23 generator when we interpret these studies for our treating
24 doctors. Yes, sir. What -- what constitutes a reasonable
25 symptom generator.

1 Q: All right. And Ms. Goodwin, if she presented herself to
2 Dr. Holbrook earlier in June of 2016 with complaints of
3 increasing leg weakness in both legs, you would agree that
4 that would be the kind of symptoms that could be generated by
5 what you're seeing in those preoperative MRI images; true?

6 A: They could be contributory. Yes, sir.

7 Q: All right, sir. So you would agree that if the
8 displacement that you see in the pre-operative MR images,
9 displacement of the spinal cord, if that matches up with the
10 physical exam by the physician and the complaint by the
11 patient, you would assume that what you're seeing on those
12 images are generated symptoms?

13 A: Yes, sir. I would expect a dermatomal sensory symptom,
14 which would come around the left side probably and come to
15 near the belly button.

16 Q: Okay.

17 A: In that dermatome, and maybe some -- maybe some leg
18 symptoms too.

19 Q: And explain to the jury, please, sir, because this is the
20 first time we've heard that, dermatomal.

21 A: Dermatomal. When we looked at the -- the model, the
22 little model with all the nerve roots coming out of it, at
23 each motion segment where there was --

24 Q: This one?

25 A: Yeah. Sure. That's right side up. As -- as these --

1 these sensory that come out of the back and motor here, the
2 sensation and muscle sensory, come out, they join together and
3 they form a nerve that goes through a particular body of the
4 area that is related back to the spinal segment.

5 It's not exact. There's a little bit of overlap between
6 one and another, but in general, you can predict the -- the
7 sensory level. If you have numbness or tingling in a root,
8 you can predict the pattern of that.

9 In this case, it would be on the left side at T9-10, will
10 generally come around the side and go down near the belly
11 button as a sensory level. So that's sort of what I was
12 explaining, and that -- that's -- those dermatomes relate --
13 yeah, actually, they draw pictures and you can draw a picture
14 on the body where those symptoms would be related to the
15 specific nerve roots you're talking about at each symptom,
16 each one of these things that come out of this little sort of
17 tunnel here, but it's a little tunnel. These come out. They
18 run down next to the spine, out to the legs, and then out to
19 the rest of the body.

20 Q: Thank you, sir. Doctor, you agree that it's reasonable
21 to assume that Ms. Goodman had symptoms and that they were
22 likely symptoms related to what was going on at the left side
23 of her T-9; correct?

24 A: For sure the sensory symptoms, if she had them in that
25 dermatome, but the leg symptoms would be both lower

1 extremities. So that's not unreasonable to think about that
2 as a cause of the transient leg weakness, but I think it got
3 better.

4 Q: And then you also agree that that is possibly related to
5 the displacement of the sac and the spinal cord itself, as you
6 have already explained to the jury about; true?

7 A: Yes, sir.

8 Q: And you agree that the displacement of that sac and the
9 spinal cord itself by that osteophyte moving it from one side
10 of the canal to the other was a new finding since 2011; true?

11 A: It is. And also, it's not just the spinal cord, but when
12 those osteophytes come out, they can pinch off that nerve root
13 that's coming out at that level, too. So it actually did
14 something to pinch off the one at the root and in some parts
15 of the spine the one that's next one down. So it's two
16 reasons for those kinds of symptoms, but it's the osteophyte
17 that is the culprit as the symptom generator, either nerve
18 root or cord or displacement of cord or both.

19 Q: Okay. Thank you. And you'd also agree that it was a
20 largely new and much more advanced form of the disease than
21 was present in 2011?

22 A: Yes, sir, I agree.

23 Q: When reviewing images from 2009 to 2011, you would agree
24 that it's fair to say that you are seeing degenerative changes
25 that are progressing even in that period of time; correct?

1 A: Yes, sir.

2 Q: And you'd also agree that in 2011, when Ms. Goodwin had
3 -- was about, I think, 34 years old -- I'm not sure of her age
4 then. It's unusual in your opinion and your experience, sir,
5 to see that degree of degeneration in somebody's spine,
6 somebody at that age?

7 A: It's -- it's unusual, and the pattern is somewhat
8 unusual. And actually, in the mid-thoracic region, unless
9 there's some reason, like work or something, it's unusual,
10 both pattern and age, for that much change. Changes start for
11 people in their 20s. But to answer your question, that much
12 and in that pattern can be reasonably characterized as
13 unusual.

14 Q: And looking at the report from -- I think Dr. Graham was
15 the radiologist who interpreted the post-op MR. I don't know
16 if you picked up on that, Doctor.

17 A: Yes, Dr. Graham was the interpreter of the July 28th,
18 2016, MR.

19 Q: Yes, sir. The one that Dr. Holbrook ordered after she
20 was waking up and couldn't move her legs?

21 A: We'll agree, yes.

22 Q: Okay. And looking at that report -- and I know you and I
23 talked a lot about that at your deposition. I'm not going to
24 go that long today. You're probably glad and probably the
25 jury is too, but he mentions that at the T9-T10 level -- and

1 I'll be happy to pull the report up. I'm just going to quote
2 it. If you want to look at the report, I'm happy to put it
3 up, sir.

4 A: No. I don't need it. I've read it, and I'm familiar
5 with it. I'm sure you'll get it right.

6 Q: Well, I appreciate your confidence. I'm just quoting Dr.
7 Graham when he says, quote, there is a persistent canal
8 stenosis created by residual facet hypertrophy on the left,
9 together with residual spondylotic disc bulging, end quote.
10 Would you explain to the jury, break that down for us lay
11 folks what he is saying, what you understand that to be?

12 A: Yes. So there was a sizable osteophyte there doing the
13 things we've already discussed. We're talking about
14 specifically T9-10 on the left side, the surgery. That's the
15 findings you're referencing?

16 Q: Correct.

17 A: I don't need it.

18 Q: Yes, sir.

19 A: So yeah. So it is describing when a surgeon goes in
20 there and takes that anatomy down. There's not necessarily a
21 necessity to take it all down. You just take enough down to
22 make room for the cord and the other things.

23 And so what I think -- it's always hazardous to interpret
24 somebody else's words, but what Dr. Graham was saying, the
25 disc at that level was degenerative, and it probably wasn't

1 taken all the way down. There's still some there in the
2 osteophyte related to the disc and -- and for the back part of
3 the spine, which is the facet portion of that osteophyte, it
4 was taken down, but there's still a little bit left is the way
5 I interpret that.

6 Q: Thank you. And you'd agree that Dr. Graham in his report
7 says that, it's correctly and accurately stating that
8 hypertrophy references the osteophyte?

9 A: Yes, sir. That was the most hypertrophic thing there,
10 and that's reasonable that he would be referencing that. Yes,
11 sir.

12 Q: You would also agree that Dr. Graham is saying in his
13 report that the spinal canal narrowing has a contributory
14 component from the disc, the soft material between the
15 vertebra, and that's what spun the ligaments.

16 A: Oh, I'm sorry. I left that part out. Yeah.

17 Q: That's okay.

18 A: So --

19 Q: I just wanted to remind you. That's my fault.

20 A: No. That's all right. So the spondylitic refers to the
21 vertebral body and this together, the soft parts in between,
22 and the spondylitic refers to the osteophytes that form around
23 the edge of the disc. It's spondylitis. Does that help?

24 Q: Sort of. So we've got the discs in between?

25 A: And this is the bodies of the -- body of the vertebra.

1 That's what spine below refers to. It's this part of the
2 spine. And spondylitic changes, so the adjective, it refers
3 to the changes around the margins of the vertebral body that
4 grow to surround and support the function that the disc loses.
5 That's a spondylitic disc, and the osteophytes that form as
6 the disc wears out sort of compensate for it.

7 Q: Thank you, sir.

8 A: Yes, sir.

9 Q: If you were generating a report based on the post-
10 operative MRI that Doctor Graham has done his report about,
11 you would suggest that there is acute edema that is explaining
12 the weakness that Crystal Goodwin has experienced post-
13 operatively in her lower legs; correct?

14 A: Yes. I would explain that there is an edema spreading in
15 the central part of the cord, and that is the explanation for
16 the leg weakness. Yes, sir.

17 Q: And your impression would have said something about there
18 is edema rather than what he calls, quote, increased signal?

19 A: Yeah. That's an interchangeable term. The -- the
20 increased signal is the thing -- it's the white area is what
21 it is. That is the white area. That's the MR medical jargon
22 for that is increased signal. So the cord -- the normal cord
23 is sort of dark. The edema part is white that we've seen, and
24 so that's referred to as increased signal intensity. It just
25 means it's whiter, and it's because -- I would say it's

1 because of edema.

2 Q: Okay. And as you explained earlier, sir, we were showing
3 us some of the images of the post-operative MRs, and the
4 sagittal but more likely the axial images, when you showed the
5 white area inside the spinal cord, that's abnormal?

6 A: That's abnormal. Yes, sir.

7 Q: When you see something too white, that's not right? It's
8 not -- it's not normal?

9 A: Inside the cord, yeah.

10 Q: Inside the cord?

11 A: Yes.

12 Q: It's not supposed to be white?

13 A: No.

14 Q: The same with the brain?

15 A: So on the same sequences that are sensitive, the blue
16 areas, too white is abnormal, and it means there's some
17 disease process there that's resulting in some local swelling,
18 which is the -- edema is the fancy word for it.

19 Q: I understand.

20 A: Well, fluid where it shouldn't be.

21 Q: So you would have just interpreted that as cord edema or
22 cord swelling? Would that be the same meaning in that segment
23 of the cord that explains the lower bilateral leg weakness
24 that she was experiencing in the recovery room after the
25 anesthesia wore off; is that correct?

1 A: That's how I would describe it.

2 Q: Sir?

3 A: That's how I would have described the finding.

4 Q: Yeah.

5 A: But that wouldn't be my whole opinion about what's going
6 on, just -- just to make sure.

7 Q: I understand.

8 A: All right.

9 Q: You'd also say the cord is swollen and explains the leg
10 weakness, and it's not due to compression. So it must be due
11 to something else. Would that be fair?

12 A: Yes.

13 Q: If you were interpreting?

14 A: Yeah. That's one of the more important parts of the
15 reasons for doing that study. Make sure it's not something
16 pushing on the cord. So, from that study, we understand that
17 the disease process that's going on is -- is central to the
18 cord or centric or from the cord. It's a process that's
19 involved in the cord and not coming from the outside, nothing
20 pushing it and hurting it in that way.

21 Q: Okay. The artery -- I'm going to try it -- of
22 Adamkiewicz? Is that okay?

23 A: Perfect.

24 Q: Or Adamkiewicz? Is that okay too?

25 A: One is east coast and one is west coast.

1 Q: Which do you prefer?

2 A: Adamkiewicz.

3 Q: Well, we'll use Adamkiewicz for you, sir. The artery of
4 Adamkiewicz that you spoke of to the jury earlier is a very
5 small artery that you cannot see on the MRI; true?

6 A: Yeah. The lumen is less than a millimeter up to maybe a
7 millimeter and a half. So that's pretty small.

8 Q: You can't see it on an MR?

9 A: Oh, not on a routine MR like we have. You need a really
10 special MR to see it, but that's not what we have.

11 Q: Okay. Typically, the artery of Adamkiewicz typically
12 comes off at T9, and typically it's on the left at T9;
13 correct?

14 A: Yes.

15 Q: And I think you said that earlier. I just want to make
16 sure I got that down right.

17 A: I said it in my deposition properly if that's what you
18 mean by earlier.

19 Q: Yes.

20 A: But that's true. That's a true statement. It's about 80
21 percent of the time it comes off on the left about the T9. So
22 --

23 Q: Yes, sir.

24 A: -- a majority of them.

25 Q: I'm sorry. Don't mean to interrupt you. Are you

1 finished?

2 A: Yes, I am.

3 Q: I just wanted to confirm that you did state it.

4 A: I'm sorry.

5 Q: I'm sure you remember it.

6 A: Yes.

7 Q: You remember it well?

8 A: Yes.

9 Q: And you have heard of a reperfusion injury? You talked
10 about that a little bit earlier this morning?

11 A: Yes, I did.

12 Q: And you would agree that a reperfusion injury can be
13 shown on an MR that was done post-operatively on July 28th,
14 2016?

15 A: It can be. Yes, sir.

16 Q: You agree that a reperfusion injury would look like edema
17 on an MR without contrast; correct?

18 A: Yes.

19 Q: And this was an MR without contrast?

20 A: That's correct.

21 Q: Generically, on a T2 weighted image, it would look like
22 an increased signal, just like what Dr. Graham notes in his
23 report and just what you have just testified to; correct?

24 A: Yes.

25 Q: And you agree that an edema pattern in the cord shown on

1 an MR without contrast, could be seen as a result of
2 reperfusion; true?

3 A: Yes.

4 Q: And I believe you hold the opinion that that means that
5 it was ischemic to begin with? Is that fair for you?

6 A: Yes. Reperfusion means the tissue has to be under-
7 perfused to begin with to have reperfusion.

8 Q: If it was ischemic to begin with, it could either be
9 acute, something happened very suddenly or recently to the MR,
10 or chronic, something that happened some time ago; true?

11 A: Well, chronically some time ago, it would probably be
12 healed with miosis by then, but yeah, to answer your question,
13 yes, that's possible, yeah.

14 Q: Okay. In this case, you are unable to rule out that
15 Crystal Goodwin suffered a reperfusion injury; isn't that
16 true?

17 A: As part of the -- as part of the cause. It is not the
18 dominant cause of what went on because of the pattern of
19 abnormality in the cord. The dominant cause is an infarct,
20 and reperfusion could be part of that sequence of events.

21 Q: Doctor, let me hand you a copy -- actually, it's the
22 original of your deposition, and if I might give you a page
23 number.

24 MR. GOINGS: Your Honor?

25 THE COURT: Yes, sir?

DR. ANTHONY MANCUSO - CROSS BY MR. DAVIS

1 MR. GOINGS: I'm going to object to what is an improper
2 impeachment because he has not said anything inconsistent with
3 his prior testimony. So he has to have inconsistent prior
4 testimony where he opens up the sealed transcript and hands it
5 to the doctor.

6 THE COURT: Yes, sir.

7 Mr. Davis, where are we going?

8 MR. DAVIS: I want to ask him about the question I just
9 asked him, have him read his answer at his deposition, which
10 is inconsistent with what he just said.

11 MR. GOINGS: He just said that the question was how --

12 THE COURT: I wasn't at the deposition. Neither was the
13 jury. I don't know whether it's inconsistent or not.

14 MR. GOINGS: Well --

15 THE COURT: I'll -- the objection is overruled.

16 MR. DAVIS: Thank you, Your Honor.

17 THE COURT: Mr. Davis, you may proceed.

18 MR. DAVIS: Thank you.

19 BY MR. DAVIS:

20 Q: Doctor, would you look at page 60 with me of your
21 deposition, sir?

22 MR. GOINGS: Can I see it?

23 MR. DAVIS: Okay. Let me -- let me get to it.

24 BY MR. DAVIS:

25 Q: And I want to read something and ask you a question about

1 it. Page 60, line 1.

2 Question: Are you able to rule out a reperfusion injury
3 in this case?

4 Your answer -- and I'm going to read your entire answer.
5 I won't leave anything out.

6 Well, no, but it's the same. I cannot do that, to answer
7 your question, but it's the same disease process. Reperfusion
8 means --

9 MR. GOINGS: Your Honor, again, I'm going to renew my
10 objection because he said just this on the stand.

11 THE COURT: Let me see the transcript, Mr. Davis.

12 MR. DAVIS: Sure. I'm happy to stop reading there, but I
13 thought it was fair to read his entire answer.

14 THE COURT: The objection is sustained. There's no need
15 to go any further. It's not a proper attempted impeachment.

16 MR. DAVIS: Would you note my objection, please?

17 THE COURT: I'm sorry. What did you say?

18 MR. DAVIS: Would you note my exception to your ruling?

19 THE COURT: The court reporter will do that.

20 MR. DAVIS: Thank you.

21 BY MR. DAVIS:

22 Q: Doctor, to be simple about it, you agree that this could
23 be a reperfusion injury; true?

24 A: If -- the reperfusion could be contributing to what we
25 see, but not what I would agree to, as the dominant event is

DR. ANTHONY MANCUSO - CROSS BY MR. DAVIS

1 an infarct that could become compounded by reperfusion,
2 perhaps after the blood -- the blood pressure of the patient
3 was normalized when she came out of the operating suite.

4 Q: But that's not what you told me under oath at your
5 deposition, was it?

6 A: Well, when we discussed that, I was discussing general
7 questions about reperfusion. The question was, could I rule
8 it out, and a more complete answer would be I can't rule it
9 out as part of what was going on. That was -- that's the
10 intent of that answer, and that's the answer to that.

11 Q: But that was not what you said at your deposition; is
12 that fair?

13 MR. GOINGS: Your Honor, again, I would like to renew my
14 objection as to this improper impeachment.

15 THE COURT: The objection is sustained.

16 BY MR. DAVIS:

17 Q: You're not here to offer any opinions on the standard of
18 care of Dr. Holbrook as a neurosurgeon, are you, sir?

19 A: I am not.

20 Q: You're not saying that Dr. Holbrook did something,
21 directly or indirectly, that caused or contributed to this
22 unfortunate and ultimate injury, are you, sir?

23 A: I am not.

24 MR. DAVIS: One moment, please, Your Honor?

25 THE COURT: Yes, sir.

1 BY MR. DAVIS:

2 Q: Dr. Mancuso, in your experience as a -- excuse me --
3 neuroradiologist, have you ever seen or heard about an
4 isolated spinal cord injury in the thoracic spinal cord as a
5 result of low blood pressure without affecting some other --
6 more than one organ?

7 A: I don't have that -- that context. I've experienced
8 probably ten or more cases of isolated thoracic cord injury
9 from under-perfusion, but it's usually in the setting of a
10 spinal AVM, arterial venous malformations, or in the setting
11 of abdominal problems where the perfusion to Adamkiewicz gets
12 -- or Adamkiewicz gets cut off, but I -- so I'm not quite sure
13 what isolated injury. Oh, you mean isolated from other organ
14 systems? I'm sorry.

15 Q: Yeah.

16 A: I understand your question.

17 Q: Yeah.

18 A: I can't answer that. I don't -- I don't know what the
19 status of all the other organs in the patients that I see is
20 as -- as in imaging.

21 Q: You're not holding yourself out as an expert in blood
22 pressure interoperably, are you?

23 A: I am not.

24 Q: Okay. Thank you very much.

25 A: Yes, sir.

REDIRECT EXAMINATION

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BY MR. GOINGS:

Q: Now, Doctor, the reason why a patient has this type of surgery is to correct a problem; correct?

A: It is because of a symptom generator that has been reasonably identified, and the treatment -- the surgical treatment is aimed at getting rid of that symptom generator. Yes, sir. They have to have a reason for the surgery, just like they have to have a reason for the imaging.

Q: Right. The purpose of the surgery is not to paralyze anyone, is it?

A: Of course not.

Q: Okay.

MR. DAVIS: Your Honor, I fail to see how this is responsive to anything in cross-examination.

MR. GOINGS: They -- they --

MR. DAVIS: I object.

THE COURT: The objection is overruled.

BY MR. GOINGS:

Q: Now, you saw Ms. Goodwin's treatment notes at Midlands Orthopedics in the month before she underwent the surgery; correct?

A: I did.

Q: Okay. I have on the monitor a document that's in evidence, and this is from Midlands Orthopedics on 7/18/2016,

1 7/18/2016. I'm going to represent to you this is the last
2 time that Ms. Goodwin walked in to Midlands Orthopedics before
3 this surgery. And there was a review of symptoms and a
4 physical exam, wasn't there?

5 A: Yes, sir.

6 Q: Okay. I've highlighted the review of symptoms. She
7 reports no incontinence. What does that mean?

8 A: That means she is able to manage her urinary flow without
9 any of it spilling out of her urethra by accident.

10 Q: So she wasn't self-cathing herself before this surgery,
11 was she?

12 A: No, of course not.

13 Q: It says no difficulty urinating. What's this next? No?

14 A: Hematuria, blood in the urine.

15 Q: No blood in the urine. Then it says no muscle aches, no
16 muscle weakness, no joint pain, no back pain, not swollen in
17 any extremities. Do you see that?

18 MR. DAVIS: Your Honor, with all due respect, I object to
19 this line of questions as having nothing to do with anything I
20 covered. This is talking about an office visit. I never
21 mentioned anything to him asking him anything about an office
22 visit. I object.

23 THE COURT: I understand your objection.

24 MR. GOINGS: Continue?

25 THE COURT: What's your response?