

STATE OF SOUTH CAROLINA
In the 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 II

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RECORD ON APPEAL INDEX

Volume I

Orders:

Order Granting New Trial Under Thirteenth Juror Doctrine, March 22, 2024 1

Verdict Form:

Verdict Form, April 20, 2023 5

Pleadings:

Plaintiff's Summons and Complaint, July 29, 2019 7

Amended Complaint, January 27, 2021.....23

Defendants Answer, February 25, 2021 39

Stipulation of Dismissal of Root, August 10, 2022 47

Stipulation of Dismissal of CAA, October 4, 2022 49

Stipulation of Dismissal of Palmetto, November 17, 2022 51

Motions, Supporting Memoranda:

Plaintiffs Motion for New Trial and Mistrial with exhibits, April 21, 2023 53

Plaintiffs New Trial Motion Under Thirteenth Juror Doctrine, April 26, 2023 83

Defendants' Response to Plaintiffs Motion for New Trial Under Thirteenth Juror
Doctrine, May 5, 2023 87

Defendants Response to Plaintiffs Motion for New Trial and Mistrial, May 5, 2023.....92

Transcripts:

Trial Transcripts.....

Vol 1, April 10, 2023 97

Vol 2, April 11, 2023 229

Vol 3, April 12, 2023 422

Volume II

Vol 3, April 12, 2023 (continued).....500

Vol 4, April 13, 2023	628
Vol 5, April 14, 2023	860

Volume III

Vol 5, April 14, 2023 (continued).....	1000
Vol 6, April 17, 2023	1069
Vol 7, April 18, 2023	1305

Volume IV

Vol 7, April 18, 2023 (continued).....	1500
Vol 8, April 19, 2023	1543
Vol 9, April 20, 2023	1750

Post Trial Transcripts, June 1, 2023.....	1920

Volume V

Trial Exhibits:

Plaintiffs' Exhibit 1 – Nursing Anesthesia Pre-Op Assessment.....	2042
Plaintiffs' Exhibit 2 – Pre-Anesthesia Report, 7/28/16	2048
Plaintiffs' Exhibit 3 – Anesthesia Chart for 3/26/09 Surgery	2049
Plaintiffs' Exhibit 4 – Anesthesia Chart for 8/11/11 Surgery	2050
Plaintiffs' Exhibit 5 – Anesthesia Chart for 7/28/16 (First Surgery)	2052
Plaintiffs' Exhibit 6 – Article: “Intraoperative Neuromonitoring” In Spine Surgery.....	2054
Plaintiffs' Exhibit 8 – Midland Orthopaedic Record 6/20/16.....	2062
Plaintiffs' Exhibit 9 – Midlands Orthopaedic Record 7/18/16	2065
Plaintiffs' Exhibit 10 – Midlands Orthopaedic Record 8/29/16	2068
Plaintiffs' Exhibit 11 – Midlands Orthopaedic Record 9/19/18	2077
Plaintiffs' Exhibit 12 – Prisma Discharge Summary	2081
Plaintiffs' Exhibit 13 – Operative Report 7/28/16.....	2083
Plaintiffs' Exhibit 14 – MRI Report 7/28/16	2086
Plaintiffs' Exhibit 15 – Neuromonitoring Record	2088
Plaintiffs' Exhibit 16 – Surgery Order Form	2148
Plaintiffs' Exhibit 17 – Summary of Office Visit Blood Pressures in 2016.....	2149
Plaintiffs' Exhibit 18 – Summary of Hospital Blood Pressures in 2016	2150
Plaintiffs' Exhibit 19 – Summary of Preoperative Blood Pressures in 2016.....	2155
Plaintiffs' Exhibit 20 – MRI Images from Mancuso	2152
Plaintiffs' Exhibit 21 – Surgical Care Attendee Form.....	2163
Plaintiffs' Exhibit 22 – Life Care Plan	2164
Plaintiffs' Exhibit 23 – Video of Crystal at Physical Therapy (Non-paper).....	2193
Plaintiffs' Exhibit 24 – Economic Loss Range.....	2195
Plaintiffs' Exhibit 25 – Photographs of James and Crystal Goodwin	2196
Plaintiffs' Exhibit 26 – Photographs of Crystal Goodwin.....	2200
Plaintiffs' Exhibit 27 – Video taken by Jazmine Goodwin (Non-Paper)	2204

Plaintiffs’ Exhibit 28 - Autoregulation Animation video presented to Dr. Jones (Non-Paper)	2206
Plaintiffs’ Exhibit 29 – Mean Arterial Pressure Chart.....	2208
Plaintiffs’ Exhibit 30 – Urine Output Chart.....	2209
Plaintiffs’ Exhibit 31 – Cake Photographs.....	2210
Plaintiffs’ Exhibit 32 – Medical Expense Summary.....	2258
Plaintiffs’ Exhibit 33 – Midlands Orthopaedic Medical Records.....	2259
Plaintiffs’ Exhibit 34 – STAT MRI Order.....	2265
Plaintiffs’ Exhibit 35 – 2009 Blood Pressure Index	2266
Plaintiffs’ Exhibit 36 – 2011 Blood Pressure Index	2267
Court’s Exhibit 8 – Deposition of Dr. Holbrook	2268

Volume VI

Court’s Exhibit 9 – Deposition of Dr. Holbrook	2484
Court’s Exhibit 12 – Deposition of Dr. Jones.....	2625

Other:

Notice of Appeal with exhibits, April 4, 2024.....	2833

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

1 MR. GOINGS: Oh, my response.

2 THE COURT: Yes.

3 MR. GOINGS: My response is that he spent 15 minutes with
4 this doctor trying to convey an understanding that she was
5 going to be paralyzed, regardless of having this surgery. She
6 didn't have -- and I'm showing that she didn't have these --

7 MR. DAVIS: I object. I object to that argument.

8 THE COURT: Everybody stop. I meant the legal response,
9 not --

10 MR. GOINGS: Oh.

11 THE COURT: -- not your factual argument. The objection
12 is overruled. You may proceed.

13 MR. GOINGS: Okay.

14 BY MR. GOINGS:

15 Q: Physical exam. Can you read that out loud?

16 A: On examination, there is no point tenderness to palpation
17 over the thoracic-lumbar spinal processes. She ambulates
18 satisfactorily. There is no gross focal or motor deficit in
19 the lower -- sorry -- lower extremities. She is able to step
20 up onto a low stool with either leg satisfactorily.
21 Sensations intact to a pinprick in the lower extremities.

22 Q: Okay. Doctor, does this show that she has any
23 neurological injury to her lumbar spine based on this physical
24 examination? Excuse me. Her thoracic spine?

25 A: Thoracic-lumbar spine is what it's referencing. And the

1 question was? I'm sorry.

2 Q: Does she have any injury to her cervical spine with this
3 type of physical examination?

4 A: You mean thoracal-lumbar?

5 Q: Yes, sir.

6 A: Right. Any injury?

7 Q: Yes, sir.

8 A: At the time, she's asymptomatic. So on the basis of the
9 physical exam and the -- we deal with the symptoms out there.
10 No. On the basis of what's written there, there's no evidence
11 of an injury.

12 Q: Okay. And this is before the surgery; correct?

13 A: That's right.

14 Q: You know, the snake eyes that you showed us and the white
15 -- the white high signal that should be gray on the MRIs? Do
16 you remember that?

17 A: I remember that.

18 Q: Someone who has these types of neurological and physical
19 examination findings, are those people that have snake eyes in
20 their -- in their spinal cord?

21 A: No, sir. That finding is -- as we discussed this
22 morning, is abnormal.

23 Q: Okay.

24 A: That -- that's not a description of a person who has
25 those kind of findings.

1 Q: Doctor, did Crystal Goodwin have snake eyes in her spinal
2 cord before this surgery?

3 A: No.

4 Q: Now, the MRI was performed at 2:30. Okay? The signal
5 went out at 10 -- 10:03. Is that enough time, that four-and-
6 a-half hours, is that enough time for the edema and the dead
7 tissue matter to show up on the MR scan?

8 A: It's enough time for the edema, but the tissue is not
9 necessarily dead at that time. It can go on to septic.

10 Q: Okay. There's enough time for the edema to show up;
11 correct?

12 A: Yes, sir.

13 Q: Okay. Opposing counsel asked you questions about a
14 radiologist or -- excuse me -- the ordering doctor, in this
15 case, a neurosurgeon, communicating with a radiologist. Do
16 you remember that?

17 A: Yes, sir.

18 Q: If there was a call to the radiologist to talk to the
19 radiologist, would you expect a medical record to reflect that
20 call was made?

21 A: Well, if the situation called for -- from a radiology
22 point of view, we have what's called non-routine
23 communication. So if the clinical situation required non-
24 routine communication -- because sometimes the doc just calls
25 and you talk and you don't have to put it in your report.

1 That happens all the time, every day. Right?

2 But if the situation is critical enough, then it's a
3 radiologist's obligation. If it requires non-communication,
4 that usually means there's some threat to function. Okay?
5 Some proximate or likely immediate threat to the patient of
6 some sort. If that talk was about that kind of a situation,
7 then that conversation should be -- if we're in that kind of
8 an acute and subacute situation and that conversation happens,
9 it should be documented in the report. And in fact, current
10 requirements for that is that it's documented. It's
11 documented that both parties understand the findings and the
12 meaning of the findings, and it's dated and timed.

13 Q: If this order for an MRI was serious and acute, it would
14 fall in that category; correct?

15 A: Yes.

16 Q: Okay.

17 A: This was a clinical situation. If the radiologist knew
18 about it, it would fall into non-verbal communication that I
19 just described and documentation.

20 Q: And you never saw any documentation of this communication
21 in the medical records; right?

22 A: I did not.

23 Q: Okay. The only thing we have is on the MRI report that
24 says she fell three days ago and got hurt; right?

25 A: Well, we have the whole rest of the report.

1 Q: We're talking about the history of why they examined this
2 --

3 A: Oh, the information. Yeah, that's the clinical
4 information that's available to the radiologist without a
5 conversation. Yes.

6 Q: The MRI image report that the radiologist created does
7 not reflect that he was told that the patient lost signal in
8 -- you know, in the OR, or that the patient lost feeling to
9 her legs, as documented in the recovery room, does it?

10 A: No, it wouldn't. Yes, sir.

11 MR. GOINGS: Thank you. No further questions for this
12 witness, Your Honor.

13 THE COURT: Anything further from this witness, Mr.
14 Davis?

15 MR. DAVIS: Yes, ma'am. Just briefly based on his
16 questions.

17 RECROSS-EXAMINATION

18 BY MR. DAVIS:

19 Q: Dr. Mancuso, when you spoke just a moment ago about
20 documenting an incidental finding that could be -- or any
21 finding by a radiologist of any study that perhaps is
22 unexpected, that that has to be communicated. According to
23 the American College of Radiology Standards and Guidelines,
24 that has to be communicated to the ordering physician and
25 documented on his report; correct?

1 A: Right. It's -- it's -- that interaction is a dual
2 responsibility, but if the radiologist just looks at the
3 study, which I think is what you're saying --

4 Q: Yes, sir.

5 A: -- and sees something --

6 Q: Right.

7 A: -- that requires nonverbal communication, that duty to
8 document and do whatever the nonverbal communication is. Some
9 of those systems are electronic. They send an electronic
10 message, or you pick up the phone and talk to the doc or
11 somebody that knows the patient.

12 Q: Right. And for example, if you're looking at an
13 abdominal CT scan and you see free fluid or free air in the
14 abdominal peritoneal cavity, that could be from a ruptured
15 bowel, a hole in the bowel. It could -- it could happen and
16 that was not what was expected. That's something that you as
17 a radiologist, in looking at that, you're going to pick up the
18 phone and call the -- the doctor and say, hey, you've got a
19 situation here you need to know about?

20 A: Yes, sir.

21 Q: And you would -- and you would document that. The
22 radiologist would document that on his report. Talked to Dr.
23 Smith about pneumoperitoneum. He acknowledged whatever,
24 however you want to do it. That's -- that's what the American
25 College of Radiology requires, or at least has guidelines; is

1 that fair?

2 A: Yeah. They strongly -- they strongly suggest that
3 process. Yes, sir.

4 Q: Okay. Strongly suggest, yes. And that's not the
5 situation here?

6 A: I don't know what that means, that's not the situation?

7 Q: Well, there's nothing in Dr. Graham's report where he
8 picked up the phone and called Dr. Holbrook?

9 A: No.

10 Q: And said this is what I find?

11 A: That's correct.

12 Q: He didn't do that?

13 A: No, he did not.

14 Q: Okay.

15 MR. DAVIS: Thank you very much.

16 THE WITNESS: Yes, sir.

17 THE COURT: All right. Thank you, sir. You may step
18 down.

19 MR. GOINGS: May he be excused?

20 MR. DAVIS: No objection.

21 THE COURT: All right. Dr. Mancuso, you are free to go.

22 THE WITNESS: Thank you.

23 THE COURT: Thank you.

24 All right, ladies and gentlemen. Let's take a short
25 break. Please return to your jury room. Don't discuss the

1 case.

2 (WHEREUPON, the jury exited the courtroom at 1:56 p.m.)

3 THE COURT: Okay. We'll take 10, 15 minutes.

4 (WHEREUPON, there was a break in the proceedings, after

5 which the proceedings resumed as follows.)

6 THE COURT: Ready for the next witness, folks?

7 MR. GOINGS: Yes.

8 THE COURT: All right. Yes? Yes, sir, Mr. Davis?

9 MR. DAVIS: Your Honor, before the jury comes in, would

10 it be appropriate at this time just to offer the original

11 deposition of Dr. Mancuso as a Court's exhibit with special

12 reference to page 59 and 60?

13 THE COURT: Absolutely.

14 MR. DAVIS: Is that okay?

15 THE COURT: Absolutely.

16 MR. DAVIS: Thank you, Your Honor.

17 MR. GOINGS: No objection.

18 MR. DAVIS: Thank you.

19 THE COURT REPORTER: Court's 3.

20 (WHEREUPON, the deposition transcript of Dr. Mancuso was

21 marked as Court's Exhibit Number 3.)

22 THE COURT: Thank you, ma'am.

23 MR. DAVIS: Thank you. Thank you, Your Honor.

24 THE COURT: Thank you.

25 All right. Please bring the jury, Mr. Bowen.

1 (WHEREUPON, the jury entered the courtroom at 2:34 p.m.)
2 THE BAILIFF: The jurors are seated, Your Honor.
3 THE COURT: Thank you.
4 Welcome back, folks.
5 Plaintiff can call their next witness.
6 MR. GOINGS: Thank you, Your Honor. May it please the
7 Court. The plaintiff would call Dr. Michael Shaufele.
8 THE BAILIFF: Come forward to be sworn, sir. Take your
9 left hand and place it on the Bible and raise your right hand
10 and face the clerk for me.
11 THE CLERK: Do you solemnly swear or affirm that the
12 testimony you are about to give in this case will be the
13 truth, the whole truth, and nothing but the truth, so help you
14 God?
15 THE WITNESS: I do.
16 THE CLERK: Please state your full name for the record.
17 THE WITNESS: Michael Shaufele.
18 THE CLERK: You may have a seat, please.
19 THE BAILIFF: Watch your step up, sir. Step up, please.
20 Adjust the microphone and speak very surely because she's got
21 to hear, the jurors need to hear you, all the attorneys, and
22 the last juror up there. All right?
23 THE WITNESS: Thank you, sir.
24 THE COURT: Your witness, sir.
25 MR. GOINGS: Thank you.

1 DR. MICHAEL SHAUFELE, being
2 first duly sworn, testified as follows:

3 DIRECT EXAMINATION

4 BY MR. GOINGS:

5 Q: Introduce yourself to the jury?

6 A: Sure. My name is Michael Shaufele.

7 Q: What do you do for a living?

8 A: I am a physician who specializes in physical medicine and
9 rehabilitation. I also practice pain management and sports
10 medicine.

11 Q: Are you also what is known as a physiatrist?

12 A: I am, yes. Physiatry.

13 Q: Are physiatry and pain medicine, physical rehabilitation
14 the same?

15 A: Correct.

16 Q: Do you perform operations?

17 A: No.

18 Q: Are you a non-operative spinal physician?

19 A: Yes.

20 Q: Do you treat patients that suffer from spinal cord
21 injuries?

22 A: Yes.

23 Q: Do you treat patients that are paraplegic or paralyzed?

24 A: Yes.

25 Q: Doctor, where do you practice medicine?

1 A: I practice in Atlanta, Georgia, right now at an
2 orthopedic practice called Resurgence Orthopedics.

3 Q: Give the jury the benefit of your education and
4 experience as a -- as a pain management, physical medicine,
5 and rehabilitation specialist.

6 A: I'm happy to do so. First of all, I didn't grow up in
7 the U.S. So if you noticed I have a funny accent, I apologize
8 ahead of time. I grew up in Frankfurt, Germany, went to
9 medical school there, went to the German military, and then
10 did my medical school education in Frankfurt, Germany. I did
11 my Ph.D. over there in non-surgical spine care, and then came
12 to the United States, did my residency training in physical
13 medicine and did rotations in Boston within the Harvard
14 system. I went back to Germany for two years to receive
15 advanced training in interventional spine care and
16 nonoperative spine care.

17 And then I was a -- came back to the United States and
18 was a faculty member at Emory University in Atlanta for 12
19 years, where I was residency program director, teaching
20 residents and fellows in physical medicine and rehabilitation
21 and pain management. And then for the last 12 years, I've
22 been in private practice in Atlanta.

23 Q: And what is the name of your practice?

24 A: The current practice is called Resurgence Orthopedics.

25 Q: And tell us about Resurgence Orthopedics?

1 A: So Resurgence Orthopedics is one of the largest
2 orthopedic practices in the country. We have across the
3 country about 400 physicians right now, and it's a combination
4 of operative and non-operative providers to take care of
5 patients with spinal problems, but also many other orthopedic
6 problems in the country.

7 Q: Doctor, when you practiced medicine and was going through
8 your training at Harvard, did you treat patients with spinal
9 cord injuries?

10 A: Yes.

11 Q: When you were practicing medicine and treating patients
12 at Emory University in Atlanta, were you dealing with spinal
13 cord patients?

14 A: Yes.

15 Q: Okay. In practice now today, do you treat and examine
16 spinal cord injury patients?

17 A: Yes.

18 Q: Have you been a professor of medicine?

19 A: I was professor of physical medicine, actually, associate
20 professor of physical medicine and rehabilitation and
21 orthopedics at Emory.

22 Q: When you were at Emory, did you publish any medical
23 articles or research journals in your specialty?

24 A: *[Inaudible due to coughing.]*

25 Q: Are you a certified independent medical examiner?

1 A: I am.

2 Q: And tell the jury what that is?

3 A: So let me explain first maybe what independent medical
4 examination is. Sometimes in -- in the medical world, there's
5 a need for a physician who's not involved in a patient's care
6 to give them an opinion, examine the patient, summarize the
7 case, and give some recommendations. That's what the
8 independent medical examination is.

9 To become certified as an independent medical independent
10 medical examiner, you have to have training in certain
11 specialties, such as physical medicine, but it could also be
12 orthopedics. It could be in other specialties, occupational
13 medicine, for example. And then --

14 Q: My -- the court reporter says talk into the microphone a
15 little bit.

16 A: Testing.

17 Q: Maybe speak a little louder.

18 A: How's that? Is that better?

19 Q: Okay.

20 A: All right. Sorry for that.

21 So in order to become a certified independent medical
22 examiner, you have to be certified in certain specialties,
23 such as physical medicine or orthopedics, neurology, depending
24 on what the -- the issue is, and then you have to go to a
25 training program. You have to take an exam. You have to be

1 recertified every -- every several years. You also have to
2 have a certain number of independent medical examinations that
3 you -- that you have to carry out before you're certified.

4 Q: Doctor, the court reporter has motioned for me to tell
5 you to speak up a little bit.

6 A: Okay. That's all right.

7 Q: Us lawyers are loud, but doctors are so soft spoken. All
8 right. Doctor, you're being compensated for your time here
9 today in court?

10 A: That is correct, yes.

11 Q: Okay. And this is a question that will be asked with
12 every expert that takes the stand in this. How much are you
13 being paid by the hour?

14 A: I charge \$600 per hour.

15 Q: \$600 per hour?

16 A: Correct.

17 Q: Now, Doctor, in the history of you testifying in legal
18 cases through depositions or at trial, what is the percentage
19 of times that you testify for the defense versus the times
20 that you testify for the plaintiff?

21 A: It's pretty much evenly split. I do a good bit of
22 medical defense work, but I also do in the setting of life
23 care planning and independent medical examination. That's a
24 lot of plaintiffs' work, but it's pretty much across the board
25 50 -- 50-50.

1 Q: Okay. So you don't have a side; is that right?

2 A: I do not.

3 Q: Doctor, do you have training, education, and experience
4 in examining patients who are paralyzed from a spinal cord
5 injury?

6 A: Yes.

7 Q: Do you have training, education, and experience in
8 understanding and treating the physical, the mental, and the
9 emotional effects of those who have suffered a spinal cord
10 injury?

11 A: Yes.

12 Q: And, Doctor, finally, do you have the training,
13 education, and experience in determining the type of medical
14 care, the type of therapy or treatment that someone who is
15 paralyzed, paraplegic, may need resulting from a spinal cord
16 injury?

17 A: Yes.

18 MR. GOINGS: Your Honor, at this time, we would tender
19 Dr. Shaufele as an expert in the field of physical medicine
20 and rehabilitation.

21 MR. HEITMAN: No objection.

22 THE COURT: Physical medicine and rehabilitation.

23 Ladies and gentlemen, I've given you the rules about
24 expert witnesses twice already. Those same rules apply to Dr.
25 Shaufele. He is an expert in the fields of physical medicine

1 and rehabilitation and will be permitted to give his opinion
2 testimony within his field of expertise. Like any other
3 witness, you give his testimony the weight and credibility you
4 think it deserves.

5 You may proceed, Mr. Goings.

6 MR. GOINGS: Thank you, Your Honor.

7 BY MR. GOINGS:

8 Q: Dr. Shaufele, have you reviewed the medical care and
9 treatment that Ms. Goodwin has gone through over the -- nearly
10 the last seven years --

11 A: Yes.

12 Q: -- of her life? Okay. Has the treatment that she's
13 received to date been reasonable and necessary?

14 A: Yes.

15 Q: Has she undergone any unnecessary medical treatment?

16 A: No.

17 Q: Has the treatment that she's received up until this point
18 been customary for the type of injury received?

19 A: Yes.

20 Q: Doctor, were you asked to examine Crystal Goodwin and
21 provide recommendations of her medical needs now and her
22 medical needs in the future based on a spinal cord injury?

23 A: Yes.

24 Q: And is this the type of exam that you performed for Ms.
25 Goodwin?

1 A: Yes.

2 Q: Okay. And what date did you actually examine her?

3 A: I would need to look it up, but I believe it was in 2020.
4 And then that was the evaluation in the office, and then we've
5 had a couple of follow-up conversations since then.

6 Q: Okay. It was during COVID; correct?

7 A: Correct.

8 Q: All right. Let me ask you, Doctor, first, is Crystal
9 Goodwin paralyzed?

10 A: Yes.

11 Q: Is Crystal Goodwin a paraplegic now?

12 A: Yes.

13 Q: What does paraplegia mean?

14 A: It means weakness of the limbs. In the setting of
15 paraplegia, it means weakness of the lower extremities.

16 Q: Are Crystal Goodwin's injuries permanent?

17 A: Yes.

18 Q: Is she faking her injuries?

19 A: No.

20 Q: Is she overstating her injuries?

21 A: No.

22 Q: Is she exaggerating her injuries?

23 A: No.

24 Q: Is she a malingerer?

25 A: Absolutely not.

1 Q: Is she someone who has done the things required by her to
2 try to improve her condition?

3 A: Yes.

4 Q: And you've seen that in the medical records?

5 A: Yes.

6 Q: Has Crystal given you any indication that she does not or
7 will not do the things required by her to get better?

8 A: No.

9 Q: Will Crystal Goodwin get better?

10 A: Her paralysis will most likely not improve. I think she
11 will be able to maintain some of her function and maybe gain
12 some strength with ongoing therapy and exercise, but the
13 fundamental severity of the injury will not likely improve.

14 Q: Over her lifetime, will she get better or worse?

15 A: She most likely will get somewhat worse because of the
16 aging process.

17 Q: A spinal cord patient -- are spinal cord patients more
18 susceptible to other types of related health conditions?

19 A: Yes.

20 Q: Explain that to the jury?

21 A: Sure. So as you probably heard about spinal cord
22 injuries and injury to the motor and the sensory nerves in the
23 spinal cord that result in weakness and numbness, lack of
24 sensation in the legs in Crystal's case, and if you think
25 about it, if you have loss of sensation to the skin in your

1 legs, one thing that can happen is you don't feel injuries as
2 much. So, for example, if you have a laceration to the skin,
3 for example, you may not feel it. It may get infected. So
4 that's an increased risk.

5 The other thing is because of the lack of sensations, you
6 may get what's called ulcers. An ulcer is essentially skin
7 breakdown from prolonged pressure on the skin, and a patient
8 with spinal cord injury may not feel it, and then down the
9 road, they may require ongoing treatment for that.

10 In addition to that, because patients with spinal cord
11 injuries are mostly in a wheelchair and cannot be as active,
12 they -- they lose bone density. Because they lose bone
13 density, they have an increased risk for osteoporosis, which
14 means thinning of the bones, and that can lead to an increased
15 risk of fractures.

16 And then maybe the biggest issue in particular in
17 Crystal's case that's an issue, a lot of spinal cord injury
18 patients do not have control of their bowel or their bladder
19 function. In Crystal's case, she has to self-catheterize
20 herself to relieve herself of urine because she does not feel
21 when she has to urinate, so she cannot go to the bathroom like
22 most people can or spinal cord injury patients can't.

23 So every time you put a catheter into your urethra, you
24 know, there's a potential that you introduce bacteria. So
25 patients with spinal cord injuries have a higher risk of

1 urinary tract infections. As a matter of fact, she just had
2 one a few days ago, and these recurrent urinary tract
3 infections have the risk of chronic kidney disease and chronic
4 kidney damage.

5 So those are the most important medical complications
6 specific to spinal cord injury in a paraplegic patient like
7 Crystal.

8 Q: Do you know how often Crystal goes to physical therapy?

9 A: She goes frequently. I'm not sure how many times a week,
10 but it's -- it's frequently, and she's been going throughout
11 her recovery phase and ongoing care.

12 Q: So you're aware she goes to physical therapy multiple
13 times a week?

14 A: Yes.

15 Q: If she can't get better and can't walk, why does she go
16 to physical therapy?

17 A: Well, if you -- the role of physical therapy in a spinal
18 cord injury patient is primarily to prevent further decline.
19 If you -- if you don't use your muscles, if you don't keep
20 strength, and even if you're having to lift, you will atrophy
21 more and you can do even less. So the purpose of therapy is
22 to maintain as much of the function as possible.

23 There's also positive effects from being in therapy,
24 exercising and being in an environment where it's safe maybe
25 to stand for a few seconds or take a few steps with the

1 supervision of a physical therapist. Many don't have the fear
2 of falling. So there's -- there's -- obviously, there's the
3 -- the functional aspect of the therapy, but then there's also
4 the emotional or psychological aspect of being up and being
5 able to be more mobile than normal.

6 Q: If Crystal stopped going to physical therapy, what would
7 most likely happen?

8 A: She would become more sedentary. She probably would lose
9 some of the function that she has right now, and she would
10 pretty much spend her whole time in a wheelchair.

11 Q: So is it fair to say, Doctor, that doing physical therapy
12 just keeps her where she is currently at?

13 A: Correct.

14 Q: Doctor, have you made recommendations for Crystal
15 Goodwin's future medical care?

16 A: Yes.

17 Q: Okay. And are those recommendations to a reasonable
18 degree of medical certainty?

19 A: Yes.

20 Q: When you examined Crystal, did you write a report or an
21 examination document?

22 A: I did.

23 Q: Okay. Did you bring that document here today?

24 A: I did, but I think you have it on a computer.

25 Q: If I gave you your copy, would that help?

1 A: Sure.

2 Q: Okay. I am going to put it on the computer for you to
3 see, but to the extent you need your copy, here it is. Would
4 this help perhaps in refreshing your memory as it relates to
5 Crystal Goodwin?

6 A: Yes. Thank you.

7 Q: Thank you.

8 MR. GOINGS: Your Honor, I don't intend to offer the
9 report as an -- as an exhibit for trial, but we'll publish it
10 and let the judge talk about it.

11 THE COURT: You mean let the witness talk about it?

12 MR. GOINGS: Excuse me. Yeah, yeah, the witness.

13 THE COURT: Any objection to him publishing any portions
14 of this?

15 MR. GOINGS: Just portions of it.

16 MR. HEITMAN: No, Your Honor.

17 THE COURT: Okay. You may proceed.

18 MR. GOINGS: Thank you. You don't want to read it?

19 THE COURT: Sure. You got a copy for me?

20 BY MR. GOINGS:

21 Q: All right. Doctor, it looks like this is a seven-page
22 document that you have; right?

23 A: That is correct, yes.

24 Q: And I'm just going to flip through. Is this the seven-
25 page document that you -- that you have in front of you?

1 A: Yes.

2 Q: And is this the report you generated after you examined
3 Crystal Goodwin?

4 A: I did.

5 Q: All right. And in making the recommendations of her
6 future medical needs, did you determine what her chief
7 complaints were, Doctor?

8 A: Yes.

9 Q: All right. And chief complaints are on page 3 of your
10 report?

11 A: Correct.

12 Q: All right. I'm just going to blow up on the monitor for
13 the jury to see. You have it in front of you. Publish and
14 tell the jury what her chief complaints were?

15 A: So since I have it in front of you, the date of the
16 examination is on July 15th, 2020, and her complaints at that
17 time, which have not substantially changed since then, were
18 first that she had paralysis, meaning weakness and inability
19 to move her legs in the right leg more than the left leg.

20 And second complaint was that she had decreased
21 sensation. She could not feel from her waist down on the
22 right side more than left.

23 She was incontinent in her bowel and bladder. I think
24 you heard that earlier. It means that she cannot control her
25 bowel function or her bladder function. So she may have

1 accidents of either stool or feces of -- or urine. And I'll
2 put that it's gotten better with treatment.

3 She has sexual dysfunction in her particular case, and
4 Crystal allowed me to talk about it. She has no vaginal
5 sensation.

6 She has what is called spasticity, which is an abnormal
7 motor movement in the legs. And you may be able to see this
8 when you watch Crystal, but you may have seen patients with
9 spinal cord injuries. They have sudden movements in the legs.
10 Those are not voluntary movements. Those are uncontrolled
11 movements that are a result of the spinal cord injury. They
12 are actually not functional. They can't do anything, but
13 they're actually often painful, eventually to the point that
14 sometimes they can be so violent they get thrown out of the --
15 out of the wheelchair. So that's what spasticity means.

16 She had numbness in both of her hands with some weakness.
17 She was complaining about neck pain, back pain, and she had
18 what's called dysesthesia. Dysesthesia is a funny medical
19 term, but essentially that normal sensation when you touch
20 your skin, what felt like a normal sensation becomes painful.
21 So it was an abnormal sensation. And then pain from the knees
22 down. And at that time, she was also complaining about some
23 right groin pain.

24 Q: Doctor, to a reasonable degree of medical certainty, what
25 are the cause -- what is the cause of these symptoms that

1 she's experiencing?

2 A: The patient has a spinal cord injury, and the majority of
3 those symptoms are caused by the spinal cord injury.

4 Q: Did you try to determine Crystal's functional status?

5 A: I did.

6 Q: Okay. And what was her functional status?

7 A: So functional status, the way I look at it as a physical
8 medicine and rehabilitation physician and the way we look at
9 it in a rehabilitation environment means what the patient can
10 do in their day-to-day activities. There's two main
11 components. The main component of that is called the
12 activities of daily living, and they have heard about that,
13 but it's things like basic things, like feeding yourself or
14 getting dressed or grooming. So that's what we look at, and
15 that's essentially part of this summary right here.

16 So her greatest complaint, as you can imagine, as we
17 talked about is that it was that she couldn't walk. That's
18 the number one functional limitation, and she gets around in a
19 manual wheelchair. So she propels the wheelchair.

20 And most of the time she uses for transfers -- transfers
21 meaning you're trying to get from a -- for example, from a
22 wheelchair to bed or from a wheelchair to a car. She will use
23 a sliding board, which is essentially a plastic board, and you
24 can put it at a little bit of an incline that allows you to --
25 to -- to slide into the bed or into the chair. So that's what

1 she would use for transfers.

2 She was able to or she can stand with a walker. So she
3 -- she does have some strength in her legs. So it's not that
4 she cannot stand at all, but she would need to hold on to a
5 walker. Someone would need to support her to stand up.

6 And for -- for all intents and purposes, she's unable to
7 ambulate for any functional distances. What we mean by this
8 is she cannot walk from here -- you know, from here from the
9 witness stand over to here without any -- without any
10 assistance.

11 And we've talked about the -- the urine incontinence
12 where she has to cath -- catheterize herself with a -- with a
13 catheter. It's usually like a rubber catheter. It's usually
14 a single use, and you have to insert it into the urethra and
15 into the bladder to relieve the urine.

16 Q: So -- so how many times a day does she have to do that
17 just to urinate?

18 A: It's four to six times. I think she may have been able
19 to cut it down to maybe four times, but that's typically the
20 recommended frequency.

21 Q: So let me get this straight. In order for her to
22 urinate, she has to catheter -- she has to cath herself?

23 A: Correct.

24 Q: Every time?

25 A: Yes. If she doesn't do it, her bladder will overflow.

1 She becomes incontinent. Or if you do it for too long, you'll
2 get kidney damage.

3 Q: So in the course of a week, if you cath yourself six
4 times a day, seven days in a week, what's the math?

5 A: That's 30 to 40 times a week, yes.

6 Q: What about the bowel function? How does she use the
7 bathroom number two?

8 A: So she has something that's called a bowel program and --
9 and I apologize ahead if it's a little bit graphic, but what
10 -- what happens in a spinal cord injury patient, they do not
11 have control of bowel function. So if you -- if you don't do
12 anything about it, the patient essentially becomes
13 intermittently incontinent of the bowel. They -- they just
14 soil themselves frequently throughout the day, usually small
15 amounts.

16 Fortunately, we've found some ways to improve that, and
17 it's called a bowel program. And what you do is you put
18 patients on a stool softener and then give them a medication
19 to help evacuate the -- the bowel, like Senokot or something,
20 and they've seen this over the counter, but then you do a
21 maneuver that's called a digital stimulation. You essentially
22 take your finger and you -- you put it in your anus. And that
23 digital stimulation actually helps relieve the -- the tension
24 on the muscles, the rectal muscles, and that allows you to
25 have a bowel movement.

1 Patients with spinal cord injuries, once they've
2 practiced, can actually have regular bowel movements, and they
3 don't soil themselves anymore, but it requires this maneuver,
4 and you have to be taught it. Some patients can't do it
5 themselves. Their -- their spouse or family member has to do
6 it for them.

7 Q: So she has no anal sensation?

8 A: So anus is the rectum, so it's the area around the
9 rectum. So she doesn't feel that, and that's one of the
10 reasons why she doesn't have control over her bowel movements.

11 Q: She has no vaginal sensation?

12 A: Correct. So the area of the vagina is -- is -- is -- no,
13 she doesn't feel it.

14 Q: Her menstrual cycle is irregular. Why is that?

15 A: So -- and fortunately, this has been resolved by now, but
16 in general, patients with spinal -- female patients with
17 spinal cord injuries tend to have irregular menstrual periods.
18 It has to do with hormonal changes.

19 In her case, she was able to see an OB-GYN, so she had a
20 procedure to ablate some of her -- some of the tissue in the
21 -- in the -- some of the -- some of the tissue so she no
22 longer has those irregularities.

23 Q: Okay. What about for the activities of daily living?

24 A: So this is what we mentioned -- what I mentioned earlier.
25 So those are the daily activities that are often affected in

1 patients with spinal cord injuries. So there's -- there are
2 several things she can do for herself, but for the most part
3 she does need some assistance with them.

4 So things like bathing, showering, personal hygiene,
5 dressing, toilet hygiene, she needs husband helping, the
6 assistance of her husband or other family members. She can
7 feed herself and she can groom herself, do her hair, and what
8 I mentioned is she can transfer with a sliding board, which is
9 that plastic board I talked about.

10 When I talked to Crystal recently, she has learned to do
11 the lower extremity dressing herself. So that's part of the
12 therapy in learning how to live with a spinal cord injury. So
13 there's some improvement, but most of these other things she
14 does need assistance with. It doesn't mean she is completely
15 dependent, but she does need assistance from family members to
16 do these activities.

17 Q: How does she drive?

18 A: So Crystal can drive. She has what's called hand
19 controls. And so for patients with -- with lower extremity
20 spinal cord injuries, you can adjust the car so you don't need
21 to use the gas pedal or the brake pedal. You can actually use
22 hand controls to do that. So the car can be altered to
23 accommodate for that. So she has learned that since I've --
24 I've seen her during my initial evaluation, but she never
25 drives without anyone next to her or with her.

1 Q: Is she able to get into the car on her own?

2 A: No. She requires assistance ass it's hard for her to get
3 in and out. She does use the sliding board because of the
4 difference in height between the wheelchair and the car,
5 depending on what kind of car you have, it's sometimes hard to
6 get in. So she does need assistance with that.

7 And then -- and then you also have to think about the --
8 the pragmatics of it. Right? So if you have a wheelchair and
9 you make it into the car, well, what do you do with the
10 wheelchair? Right? So you have to have the strength to get
11 the wheelchair next to the car and maybe throw it in the back
12 of the car. Some athletic spinal cord patients, paraplegic
13 patients can do that, but most of them cannot. It's just too
14 physically demanding.

15 Q: So even getting in a car is a two -- two-person job?

16 A: Correct.

17 Q: Did you -- in making the recommendations for her future
18 needs, did you review and determine what her occupational
19 history is or was?

20 A: Yes.

21 Q: Tell us about that?

22 A: So Crystal is a -- I'm not sure how to best describe it,
23 but I think a master baker. So she has her own baking
24 business. I've seen some of the pictures of the cakes that
25 she makes. So that's really her job. So she has a very

1 successful business with that.

2 Q: She's high school educated?

3 A: Correct.

4 Q: Did you also review her social history?

5 A: I did.

6 Q: And just generally tell us about the social history?

7 A: So Crystal lives in -- here in Columbia. I hope -- I
8 don't know if she lives in a suburb or not, but for someone
9 from Atlanta, that's close enough, I guess, and her husband,
10 James, lives with her. They've been married now -- I assume
11 it's more than 30 years or actually been together for 30 years
12 and married for another 15 years. I hope I got that right.

13 And James works for the city of Columbus. They have
14 three daughters, and --

15 Q: You mean Columbia?

16 A: Columbia. Sorry.

17 Q: That's all right.

18 A: That's right.

19 Q: Columbus is Georgia.

20 A: Yeah. That's right. I'm sorry.

21 Q: And they have three daughters?

22 A: They have three daughters, and I just learned she -- she
23 is the proud grandmother, so of -- of a little -- little one.

24 So they live in a single level home. To get into the
25 house, she uses a ramp. One Of the big problems with her

1 current setup is that her bathroom is not wheelchair
2 accessible. So for her to take a bath, she has to go into a
3 den and -- and take a -- take a bath in a little kiddie pool
4 where she sits and then douses herself with water, and then
5 she needs to be transferred out again because the regular
6 bathroom doesn't fit her wheelchair right now.

7 Q: In her past medical history, did you understand that she
8 was hypertensive, meaning she had high blood pressure?

9 A: Yes.

10 Q: What was her blood pressure when you examined her,
11 Doctor?

12 A: It was 150 over 90, which is slightly elevated.

13 Q: Thank you, Doctor. And in your report, did you also
14 perform a physical examination?

15 A: I did.

16 Q: All right. And can you tell us what you did to do a
17 physical examination of Crystal?

18 A: Sure. Yeah, I would do my -- my physical examination
19 focuses primarily on neurological function and motor function
20 and -- and the strength and the sensation of the legs. But, I
21 mean, I'm more than happy to demonstrate what I did.

22 Q: Yeah.

23 A: If you want to do that.

24 Q: That's fine. Do that.

25 MR. GOINGS: Your Honor, may the witness step down from

1 the witness stand?

2 THE COURT: Yes. It would again help if you stand on
3 Crystal's left side and face back this way.

4 THE WITNESS: Okay. All right.

5 THE COURT: And actually, if you could show us without
6 doing too much talking while you're down there, that'd be
7 good.

8 THE WITNESS: Okay.

9 THE COURT: You can demonstrate, but when you speak, just
10 speak loudly.

11 THE WITNESS: Okay. Thank you. Appreciate it.

12 So, hi, Crystal.

13 THE PLAINTIFF: Hi.

14 THE WITNESS: So for the jury, I have not examined
15 Crystal since 2020. So this is our -- this is our live exam
16 today.

17 So the first thing that I look at when I see a patient
18 come to my office, I observe how do they get in. So what I
19 saw is a patient that is driven by someone else, who is not
20 walking, who is in a wheelchair. Right? It's just a general
21 sort of observation.

22 And then, Crystal, I have a question for you. If I ask
23 you to stand up right now on your own, could you do that?

24 THE PLAINTIFF: No.

25 THE WITNESS: What would happen?

1 THE PLAINTIFF: The only [inaudible] along the floor.

2 THE WITNESS: Yeah. So it would be you would fall just
3 down. You couldn't --

4 THE PLAINTIFF: Right.

5 THE WITNESS: Your legs would not support you?

6 THE PLAINTIFF: No, sir.

7 THE WITNESS: Is that correct? Okay. Now, if you had a
8 walker in front of you, could you stand?

9 THE PLAINTIFF: Only if I had a gait belt and somebody
10 could pull the gait belt for me up.

11 THE WITNESS: So someone else would need to be with you?

12 THE PLAINTIFF: Uh-huh.

13 THE WITNESS: You could not do this on your own?

14 THE PLAINTIFF: No.

15 THE WITNESS: Correct? Okay. All right.

16 So that sort of a gives me a quick understanding about --
17 you know, we also want to be safe; right? Because I don't
18 want you to stand up in the office and fall down. Right? So
19 -- but it gives me an idea about your -- her level of injury.

20 Now, one of the things as a point of reference I would
21 like to do is get a -- get an idea about the strength of your
22 arms. Right? So can you raise your arms for me? You can do
23 that; right?

24 THE PLAINTIFF: Uh-huh.

25 THE WITNESS: Any problem with that at all?

1 THE PLAINTIFF: No.

2 THE WITNESS: Okay. Now, when I ask you to hold up your
3 arms like this and you push them up, you can do that; right?

4 THE PLAINTIFF: Yes.

5 THE WITNESS: So I want to do a Popeye for me. Can you
6 do this for me? So pull really hard against my hand.

7 See how she can pull that easily against me? Actually,
8 she's pulling the glitch here, and she's doing that. Right?

9 Okay. All right. So that is normal strength. Right?
10 You can see that she can do that. We actually grade that on a
11 scale from zero to 5. Zero is no strength at all. Five is
12 when you have full strength in your arms. That's what she has
13 right now.

14 I want you to do the same thing with your legs. Okay?
15 We're going to start on the right side for me, and I want you
16 to lift up that right hip for me. Can you do that for me?

17 Okay. Is there anything? Try really hard.

18 Okay. All right. Now, what I want you to do is on that
19 right side can you straighten out that leg for me? Can we do
20 this? Like, kick a ball? Can you do that for me? Anything
21 there? You can't do that; right?

22 What about your foot? What about your foot? Is there
23 anything there?

24 THE PLAINTIFF: No, no.

25 THE WITNESS: Is there anything, any wiggle or anything

1 can you do? There's a little bit right there, some wiggle
2 right there. I don't know if you saw that.

3 Now on the left side, I think the left side is a little
4 bit better. Right? So show me what you can do on the left
5 side for me. Okay.

6 So you see she can lift this one up just a little bit
7 right here. Right? This is her hip flexor. Right? That's
8 maybe a 1 or a 2 on the rating scale of zero to 5.

9 Now can you kick this one out for me? Can you straighten
10 that one out? I want you to do it. A little hard to do
11 there? Okay? What about your foot on that side?

12 All right. So there's a little bit of movement of the
13 foot right there. Can you see that? There was just a little
14 bit right there. So on that left side. So let me show this
15 again. Can you pull this up? Great. There's a little bit
16 right there. Okay. Very good.

17 Now, so I think it's pretty clear that based on this, she
18 has pretty profound weakness in her legs. Right?

19 So let's talk about sensation for a second. Tell me
20 where your sensation is normal and then tell me where you --
21 where the sensation becomes abnormal or you don't feel it at
22 all.

23 THE PLAINTIFF: At my waist.

24 THE WITNESS: Can you show that to me where it is
25 roughly?

1 THE PLAINTIFF: Right here.

2 THE WITNESS: So right around your belly button?

3 THE PLAINTIFF: Yes.

4 THE WITNESS: Okay. All right. And does it go all the
5 way around?

6 THE PLAINTIFF: Uh-huh.

7 THE WITNESS: Okay. Now, do you feel anything down in
8 your legs? When I touch you, do you feel that at all?

9 THE PLAINTIFF: No.

10 THE WITNESS: Okay. Does it feel uncomfortable when I do
11 that?

12 THE PLAINTIFF: It's -- on this side, it feels painful
13 when you touch it.

14 THE WITNESS: On this side? So you feel it a little bit
15 more over there? What about over here? Do you feel it over
16 there at all?

17 THE PLAINTIFF: No.

18 THE WITNESS: Okay. All right. I want to do one more
19 thing, and then I'm done. I'm sorry. I don't want to upset
20 you. Let me see something here. I'm going to try to move
21 this here for a second.

22 I don't know if you guys see this, but see that motion?
23 See what she's doing? You see how she's spasming in her legs
24 right now? Can you see this? This is not normal. This is
25 not her movement. This is what I called earlier spasticity,

1 when she has motor motion, motor movements that are not
2 voluntary. This is because of a spinal cord injury. She's
3 not trying to move on her own. She can't control that. Okay?

4 All right. So let's see. As you can see, it's really
5 stiff right now. See I can't move it right now. So here.
6 All right. I'll do one other thing.

7 THE PLAINTIFF: We have seen this happen.

8 THE WITNESS: So if I don't do it, if we don't do
9 anything, it'll just stick out there?

10 THE PLAINTIFF: They just stay like that. Yes.

11 THE WITNESS: It's going to take a couple of minutes to
12 go down.

13 THE PLAINTIFF: Uh-huh.

14 THE WITNESS: Okay. That's the spasticity I was talking
15 about. I just wanted to show that that's part of the spinal
16 cord injury. Okay?

17 I'm going to let you go back. Thank you.

18 THE PLAINTIFF: Okay.

19 (WHEREUPON, the witness returned to the stand.)

20 BY MR. GOINGS:

21 Q: Doctor, I don't know if you can see this from where
22 you're standing -- where you're sitting, but her legs are
23 shaking right now. What is that called?

24 A: That's what I was referring to as spasticity. And I
25 apologize for that. It's my fault. I set it off a little

1 bit, but it -- it is a lack of control of the muscles because
2 of the spinal cord injury. It is a common side effect, if you
3 want, of a spinal cord injury. It is not voluntary. It's not
4 something that you control or can control. It is often
5 painful, and it can be, as you can see, fairly distracting.

6 Q: So, you know, just admittedly, if I see someone in a
7 wheelchair and then I see that their legs are able to move, I
8 immediately think, good, hopefully he or she will, you know,
9 be able to walk again. Is that a correct way to look at it or
10 --

11 A: This motor activity that you're seeing is completely
12 nonfunctional. As a matter of fact, it probably interferes
13 with their function. We often do conduct treatments to
14 improve that so it's not as uncomfortable and to reduce the
15 abnormal motion.

16 Q: You did a physical examination for us. You wrote down
17 your findings. But I want to talk about, you know, the
18 emotional and mental side of all of this. Doctor, do you have
19 experience in treating and educating us on the mental and
20 emotional aspects associated with a spinal cord injury?

21 A: So, first of all, I'm not a psychologist or a
22 psychiatrist. I'm not a mental health professional. Having
23 said this, working in this field, obviously the emotional
24 component is a big part, and that's what we do as physicians
25 to -- to hopefully help address that as well.

1 As you can imagine, with any sort of severe disability,
2 there's a big emotional component. Depression is much more
3 common, anxiety is much more common, and it needs to be
4 treated as such. It is an important part of the overall
5 rehabilitation plan to get mental health support as well.

6 Q: Did Crystal ever tell you that she was depressed?

7 A: Yes.

8 Q: What did she tell you?

9 A: So Crystal had a phase initially after the spinal cord
10 injury when she was severely depressed to the point that she
11 was thinking about committing suicide. And I hope I don't --
12 I'm not sharing too many private details here, but she was
13 clearly severely depressed, but I think through her family
14 support, her faith, and her strong personality, she was able
15 to pull herself out. She also was treated with medications
16 which -- which have helped to stabilize this.

17 Q: Doctor, in your career, have you had spinal cord injury
18 patients who tragically took their own life?

19 A: Yes.

20 Q: Do they feel like they're a burden to others?

21 A: It can be. I think, you know, as you can imagine,
22 there's a -- there's a large demand on the family and
23 caregivers. So for someone who is -- who is -- used to be
24 very independent, it can feel that way, yes.

25 Q: What is Crystal Goodwin's overall prognosis?

1 A: Well, from a neurological standpoint, I don't expect any
2 significant changes. Meaning the weakness, the loss of
3 sensation that you -- that you see today is most likely going
4 to stay. It hasn't really significantly changed over the last
5 several years. As a matter of fact, I have to tell you, based
6 on the exam that I have today, she's actually -- she has
7 gotten a little bit weaker than before. But for the most
8 part, it should remain relatively stable for her. It's
9 definitely not going to get better.

10 Q: Is she able to do any meaningful work outside the home?

11 A: It's very difficult because you have to get to -- to the
12 job. You have to, you know, be there, be in an office. I
13 think it's -- it's unrealistic to expect that someone with a
14 level of spinal cord injury that Crystal has to work full time
15 in a meaningful occupation.

16 Q: If she happened to try to walk or try to stand up and
17 fell, what kind of effects would that cause on her body?

18 A: Well, that would not be good for various reasons. We
19 talked, I think, initially about the lack of sensation. So if
20 you don't feel you have, you know, a laceration or a fracture,
21 sometimes you delay treatment. So that's the first thing that
22 can obviously be detrimental.

23 But let's say she had a fall and she had a fracture, for
24 example. She would need to be most likely in some sort of
25 cast or brace, and during that time she could not attend

1 physical therapy. She could not try to stand up in a parallel
2 bar with the physical therapist, and that would probably set
3 her back in overall function afterwards for a long period of
4 time, but sometimes you don't regain it back.

5 Q: The skin -- is the skin affected?

6 A: Yes.

7 Q: And explain that to the jury?

8 A: So I think you saw when I asked her about the sensory
9 level. Right? So she has decreased sensation below the waist
10 line. So on her right side there's a little bit of -- of
11 sensation, the left side not as much.

12 So imagine if you don't feel your feet or your legs, you
13 bump into something, you may not notice that you have an
14 injury. You may not notice that you have an ulcer. That
15 ulcer can get infected.

16 So again, skin complications are significant known
17 complications for patients with spinal cord injury and can
18 cause, you know, things like requiring surgery down the road,
19 plastic surgery to fix skin deficiencies and ulcers. So there
20 are potential secondary major complications, infection, things
21 like that.

22 Q: We know Crystal likes to spend a lot of time in the
23 kitchen baking, cooking. What about burns? How does burns
24 affect someone like her who has no sensation?

25 A: Well, that's -- you know, again, you know, the sensation

1 is critical when you have a burn because you treat it
2 afterwards. You may not feel that you have a burn and it gets
3 infected, and by the time it gets infected and it gets to your
4 bloodstream, you can get septic and get widespread infection.
5 So, obviously, there is some significant potential
6 complications associated with that.

7 Q: And, Doctor, you've developed thoughts based on
8 everything you know about her, the social history, her past
9 medical conditions, how she's performing in physical therapy,
10 her living conditions, her functional and occupational
11 history, all of that combined. Did you put that together in
12 coming up with a treatment plan?

13 A: I did.

14 Q: Okay. And do spinal cord patients generally have a
15 treatment plan?

16 A: Yes. They -- it is typically developed by the time of
17 discharge from a rehabilitation facility or if they're being
18 followed by -- by specialists like me, like a physiatrist.
19 We usually see patients once a year, twice a year, and make
20 sure that that treatment plan is followed or to address any
21 complications or issues that may arise.

22 Q: Okay. And are you consulted on what is the most likely
23 foreseeable treatment plan --

24 A: Yes.

25 Q: -- for spinal cord patients?

1 A: Yes.

2 Q: Okay. And you've done this over your career many times,
3 haven't you?

4 A: Yes.

5 Q: Doctor, I want to -- in your report, you have what the
6 future healthcare needs are. I'm going to put them on the
7 monitor as well so the jury can see them, and there's several
8 pages. If you'll go through those with us so the jury can --
9 can -- can understand the future needs of -- of Crystal going
10 forward.

11 A: Okay. So those are the recommendations in my report,
12 very similar to when you go to any physician and they write in
13 the report what kind of treatment plan you -- you would need.
14 So this follows a similar outline.

15 So my first recommendation was that she sees a physical
16 medicine and rehabilitation physician. So that's my
17 specialty, someone who is familiar with spinal cord injury
18 patients and their needs. Typically, that is required a
19 little bit more often in the beginning. Once the patients
20 become more stable, we can often go in the background -- in
21 the background a little bit, but that's typically once or
22 twice a year.

23 At the time when I saw her, I felt that she would benefit
24 from what's called a short-term inpatient rehabilitation
25 program. We have that at some of the facilities in Atlanta,

1 and the idea is to think about it like a boot camp for spinal
2 cord injury patients. Right?

3 So you admit them for a few days. They meet a bunch of
4 other patients with spinal cord injuries. And a lot of
5 spinal cord injury patients, quite frankly, learn from each
6 other. Right? I don't have a spinal cord injury. I can tell
7 you what can be expected, but talking to your peers can be
8 extremely helpful.

9 So that's the idea of the -- of the day program, and it's
10 not available everywhere, but we found it out to be quite
11 helpful. One of the examples in her case, it took her seven
12 years to learn how to dress herself in the -- in the legs,
13 while the rehab program probably would have taught her that in
14 five days. Right? So that's sort of the idea why some of
15 these accelerated treatment programs can be helpful.

16 I recommended that she sees a pain management doctor, as
17 she does have a good bit of pain, and she has seen a pain
18 management physician now. She is on chronic pain medications,
19 narcotic opioids to control her pain. So that was one of the
20 recommendations I had back then. She didn't see one back
21 then.

22 The second recommendation was, well, as you can imagine,
23 someone who had -- I think it was a total of five surgeries in
24 the spine, it's a good idea to follow up on the -- on the
25 surgery, you know, X-rays, maybe an MRI, something along those

1 lines. Some surgeons may say, well, you come in as needed.
2 Some surgeons like to see the patients in a regular interval
3 -- interval.

4 In this case, my sort of recommendation would be for her
5 to be seen by someone every 2 or 3 years. The main concern
6 that can happen is once you have these changes in the spinal
7 cord, they can progress and actually expand. It doesn't
8 happen that often, but if it does, then the patient loses
9 function and they -- actually, their spinal cord injury gets
10 worse. They get more -- more weakness, more numbness. So
11 that's something to look out for.

12 The third recommendation was that she sees a urologist or
13 a physician who specializes in bladder and the genitourinary
14 system. As we talked about earlier, patients with spinal cord
15 injuries are at an increased risk of kidney injuries. They
16 get frequent kidney damage. They get frequent urinary tract
17 infections. So the Spinal Cord Injury Association's
18 recommendations are that they see a urologist about once a
19 year for monitoring.

20 And then their quarterly follow-up with primary care
21 physician. And you may ask, well, she needs a primary care
22 physician anyway. Yes, that is correct, but someone who has
23 hypertension or other medical problems, they don't see their
24 primary care physicians but about once a year or if there's
25 any complication.

1 Because of her spinal cord injury, she has other medical
2 needs like skin breakdown and urinary tract infections, the
3 osteoporosis. So she needs to be seen more frequently by the
4 primary care physician as a result of that.

5 We've talked briefly about the mental health component.
6 I usually recommend an evaluation by a psychiatrist or a
7 psychologist, at least for the patient to have someone
8 available if there's a crisis to talk to.

9 We talked about the OB-GYN that she has had done. We
10 talked about the irregular menstrual cycles which have
11 stopped. Fortunately, she has followed through with that OB-
12 GYN and has had the appropriate treatment.

13 Q: And she actually had a procedure to prevent her from
14 having additional menstrual cycles. Is that what you
15 understand?

16 A: That is correct, yes.

17 Q: Okay. Do you know how old she is? 42? 45?

18 A: 45, yes.

19 Q: All right. She should still be having her regular
20 menstrual cycle though; right?

21 A: Correct.

22 Q: And going back to the -- the mental health component,
23 does the mental health component ebb and flow throughout the
24 course of a spinal cord injury?

25 A: Yes. I mean, I think it ebbs and flows as anyone can

1 imagine, and I'm sure some of us have experienced it for
2 themselves or family members. There's -- there's a lot of up
3 and down in mental health. It depends on external factors,
4 stress factors, all this. So absolutely, yes. It's a cycle
5 like -- like for anyone else.

6 Q: All right. Number 8?

7 A: I was there. We didn't talk about it earlier. One of my
8 concerns was -- and she had it in her complaints. Crystal was
9 complaining about numbness in her hands, that she sometimes
10 doesn't -- doesn't feel her hands. The concern here is with
11 the spinal cord injury patient, they use their arms a lot to
12 propel the wheels. They are at an increased risk for shoulder
13 injuries, but they're also at increased risk for carpal tunnel
14 syndrome. My concern was that she may have developed some
15 carpal tunnel syndrome, and that's a test to find out if
16 that's what she has. So that may still be an ongoing issue.

17 Q: This one deals with medical management, basically, the
18 medicine she'll need; right?

19 A: Correct. Yes. So this is sort of a list of the
20 medications that -- that she would need. Again, this is from
21 -- this was three years ago. There have been some changes, as
22 you can imagine.

23 Some physicians may decide to try medications, but the
24 basic principle of her medication program has not changed.
25 She is essentially on medications for all these conditions to

1 date.

2 Q: That's medications for depression and anxiety,
3 spasticity, pain, multiple pain medications. Looks like you
4 have three; right?

5 A: Correct. Yes.

6 Q: And then some type of medicine she needs to take for
7 bowel, and that's over the counter; correct?

8 A: It can be over the counter, yes. This is part of the
9 bowel program that we talked about. Yeah.

10 Q: And if the bowel is backed up and she has problems and
11 the bowel program is not working, is -- are there other
12 medications that she would be prescribed?

13 A: Yes.

14 Q: Okay. If her stool gets impacted, you know, because
15 she's using digital stimulation, is that something that may
16 require hospitalization?

17 A: Yes.

18 Q: Okay.

19 A: Because she could get a bowel obstruction, which can be
20 bad. It can cause bowel rupture and infection. It sometimes
21 requires surgery. So it's certainly not something that you
22 want to -- you know, you want to avoid that at all costs if
23 you can.

24 Q: 10 through 12?

25 A: So we talked about her pain a little bit. We talked

1 about the medication, some of the treatment recommendations
2 for the pain.

3 You saw the spasticity that we talked about, that
4 abnormal motion of the legs when she couldn't bend her knees
5 down. That's the spasticity. There are more advanced
6 treatments that we have available now. It's called a Baclofen
7 pump, and essentially what we do is we take a medication that
8 decreases those muscle spasms and that increase muscle tone.
9 We inject it into the cerebrospinal fluid. So it goes into
10 the spinal canal. It goes directly into the fluid that
11 surrounds the brain and the spinal cord. And by doing that,
12 it decreases that muscle spasm.

13 We usually do it as a trial. We just inject it to see if
14 it helps, just temporarily for a day, for example, and if she
15 gets good relief and her spasms are controlled and she doesn't
16 get too weak with it, we actually implant a pump. It's called
17 a Baclofen pump, and that pump is usually like a hockey stick
18 that's typically implanted in the abdomen or the belly, and it
19 delivers constantly medication into the cerebrospinal fluid,
20 and that decreases that muscle spasm so it wouldn't be as
21 painful, and she could have -- her legs would be more relaxed.
22 And that's a standard and widely accepted treatment of
23 patients for spinal cord injury with spasticity.

24 Q: So, Doctor, that would actually be a surgery that she
25 would have to implant a device that provided pain management;

1 correct?

2 A: Correct.

3 MR. HEITMAN: Objection to leading questions, Your Honor.

4 THE COURT: Overruled. Continue.

5 MR. GOINGS: Thank you.

6 BY MR. GOINGS:

7 Q: Now, you mentioned that she was on opioids earlier;
8 correct?

9 A: Correct.

10 Q: Tell us the effects of long-term opioid use?

11 A: So I think the biggest concern in the spinal cord injury
12 patient is opioids cause constipation or where they have
13 issues with that. So we have to weigh the benefit of the pain
14 medication and the potential downside of causing more
15 constipation.

16 And then, you know, I'm a pain management doctor. So I'm
17 a little bit, you know, sensitive to this subject, but there's
18 a certain number of patients, much less than we think, but
19 there's a certain number of patients who overuse or abuse pain
20 medications or become addicted to them.

21 Q: It can be hard to wean off of those medications; right?

22 A: Yeah. My experience is typically with a -- with a
23 chronic pain patient like -- like Crystal, once you start
24 them, it's very, very difficult to get them off pain
25 medications.

1 Q: So Crystal may go through withdrawals as she tries to get
2 off the opioids; right?

3 A: Correct.

4 Q: But have you got any indication that this lady right here
5 is doing anything to abuse opioids?

6 A: Absolutely not.

7 Q: In any of the medical records that you've seen?

8 A: No.

9 Q: Okay. Next, Number 11?

10 A: So physical therapy becomes a critical part of it.

11 Again, this is not physical therapy because you want to
12 resolve her neurological deficits or her spinal cord injury.

13 You want to maintain as much of the functions that she has.

14 So I was pretty conservative in my recommendations here
15 with physical therapy. She actually gets more than -- than
16 what I recommended, but she needs to be on a regular physical
17 therapy program that can be intermittent where she goes,
18 maybe, you know, twice a year for six weeks or so, or it can
19 be continuous. It depends a little bit on the local resources
20 and how much the patient wants to participate, but it's quite
21 difficult to participate in ongoing physical therapy.

22 Q: And, Doctor, you would defer to the physical therapist
23 about the frequency; is that correct?

24 A: Yes. The physical therapists have to set specific goals
25 for the patient to continue. So they cannot just continue

1 doing physical therapy and physical therapy. They have to see
2 some sort of gain or some improvement to continue to deliver
3 physical therapy, at least if you want to get paid for it by
4 -- by any of the insurance companies.

5 Q: Now, Doctor, if she stops doing physical therapy or she's
6 unable to afford it, what would happen? Because she's already
7 said that she can't improve.

8 A: Right, but she would essentially be in the wheelchair
9 like this without having really any significant physical
10 activity. So keep in mind, when she goes to physical therapy,
11 she works very hard. She's in parallel bars. She's in a --
12 she's in a harness. She's on a gait belt to try to stand up,
13 but she can only do this with the assistance of one or two
14 people or any of these assistive devices.

15 So what that does is it helps your cardiovascular system.
16 It maintains your range of motion. It improves your upper
17 extremity strength. So, like for any of us, you know, being
18 in an exercise program is helpful. For spinal cord injury
19 patients, even more so to maintain the basic function.

20 Q: Number 12?

21 A: Occupational therapy. Occupational therapists are -- I
22 describe them as like physical therapists of the upper
23 extremities. Right? This is sort of the best way to describe
24 it. I probably shouldn't, but I've said it in front of an
25 occupational therapist. But the idea is that they focus more

1 on upper extremity strengthening.

2 In the setting of a spinal cord injury patient, they
3 focus a little bit more on the activities of daily living.
4 They teach -- would teach Crystal how to dress her lower
5 extremities by herself. They would help her how to -- how to
6 reach for things with devices, for example, how to -- how to
7 bathe and showering. So it's they -- they teach you how to do
8 activities of daily living on your own.

9 Q: Number 13?

10 A: So these are just the basic devices that patients with
11 spinal cord injuries require. It seems like a long list, but
12 it's pretty standard. You need a wheelchair with the
13 appropriate cushion. You need a -- you need some sort of a
14 transfer to get into the shower or into the bathtub.

15 She has a foot drop, so she needs what's called an AFO or
16 a brace for the foot so the foot doesn't drop down.
17 Otherwise, it increases the risk of falls. She needs a
18 commode, the sliding boards we talked about.

19 She will need an electric wheelchair at some point. She
20 probably doesn't need it right now, but she also has the
21 support of her family or her husband to wheel her around for
22 longer distances. She can do it on her own for shorter
23 distances, but if she were to go from here to -- to downtown,
24 she couldn't do that. And if she didn't have the support of
25 the family, she would need to have an electric wheelchair to

1 get around, and at some point she probably will need it more
2 permanently. And then once you have an electric wheelchair,
3 you need to get a car to get the wheelchair in if you want to
4 go anywhere. So there's special vans for that.

5 And then she has required the typical things, you know,
6 for your bladder, for your bowel, like catheters and all that
7 kind of stuff to take care of -- of -- of their personal
8 hygiene and her bowel and bladder.

9 Q: And this is the last page of your future health care
10 needs, and it's 14 through 18 in your report; is that correct?

11 A: Yeah, that's right. We talked about the nursing supplies
12 for bowel and bladder care.

13 We typically recommend patients with spinal cord injuries
14 if they want to drive to have a driving evaluation. It's
15 often done by occupational therapists. We want to make sure
16 they're safe. It's for their safety, but also your safety.
17 And most of them can actually do quite well with the
18 appropriate equipment.

19 She does need home modifications. I haven't been to her
20 home, but Cathy Gragg-Smith, the life care planner, who I
21 think will be here tomorrow, was at her home. Her home is
22 currently not wheelchair -- or not equipped for someone who's
23 in a wheelchair. She can't -- she doesn't have a bathroom
24 that can be used appropriately. So she would need to have
25 some home modifications too for her to become more independent

1 in her home.

2 And then when her husband or family are not around, she
3 does need help at home. Right? I mean, if they're not
4 around, someone needs to help, go shop, take care of the
5 household. She cannot do that.

6 And what we see typically with patients with spinal cord
7 injury, once they get older, they get secondary medical
8 problems. Right? You get heart problems, you get lung
9 problems, you become less sedentary. And as a result there,
10 they have more support needs. So they may need a -- a medical
11 assistant or some sort of support personnel that comes to the
12 house to -- to help them out throughout the day, and she
13 doesn't need it right now. She does have the family right
14 now, but if the family is not around or if they're traveling
15 or away, she would need assistance right now.

16 Q: And, Dr. Shaufele, we're talking -- you know, you're
17 mostly talking about Crystal as she is today, and her husband,
18 James, who are both in their -- in their 40s and healthy, but
19 she's got a long life ahead of her, doesn't she?

20 A: She does, yes.

21 Q: And dealing with spinal cord patients in the latter years
22 of their life, tell the jury how it changes from activities of
23 daily living and a need for people to be there to help her?

24 A: So, I mean, first of all, patients with spinal -- with
25 paraplegia or lower extremity spinal cord injuries have a

1 fairly normal life expectancy. If you have spinal cord
2 injuries that affect the arms and lungs, that may change, but
3 for -- for a patient like -- like Crystal, her life expectancy
4 should be -- should be relatively normal.

5 But you can imagine if you live in a wheelchair all your
6 life, with all the additional demand of propelling your
7 wheelchair on your shoulders, your upper extremities, it
8 becomes harder and harder, particularly if you get injuries to
9 your arms. At some point, you may not be able to propel the
10 wheelchair. Well, now you're all of a sudden in an electric
11 wheelchair. Now you have to be -- anywhere you want to go,
12 someone has to be with you to drive the van.

13 So there is -- it becomes more and more challenging.
14 What I see with some -- some of the patients -- some of the
15 spinal cord injury patients, once they've been through this
16 for 20, 25 years, they get just tired of it. They just don't
17 want to -- they don't want to fight this much anymore. So
18 they -- they sort of surrender their disability a little bit
19 and become more dependent on others to help them out.

20 Q: Knowing Crystal and her personality, how would you
21 describe her?

22 A: Well, she won't let that happen as long as she can. I'm
23 pretty sure about that.

24 Q: If somebody is going to have to have a spinal cord
25 injury, you've got to have that heart, don't you?

1 A: You do. You do. It's very tough. It's very difficult,
2 but I'm always excited to see a patient like Crystal, who's
3 trying to make the best out of it and -- and has her family to
4 support her and has her faith. So it's -- it's good to see
5 someone see it like that.

6 Q: Now, the plan that you put together, would you say it's
7 liberal? Conservative? In the middle? Did you throw
8 everything in there? Did you take things out? How do you
9 process this type of plan?

10 A: Well, I'm going to stay away from political references,
11 but so it's a conservative plan on -- on the medical side.
12 Okay?

13 Q: Okay.

14 A: So what I mean by this is these are all things she will
15 need. Right? So there may be some other things that may
16 come up.

17 So we didn't put in, for example, if she has a skin
18 breakdown, she needs a skin flap to get operated on. Right?
19 We didn't put in there like -- like we heard earlier, if she
20 gets what's called adjacent or next level disc degeneration in
21 the spine, or she -- she loses some more function, and it is
22 determined that her -- that there's further injury to her
23 spinal cord or some analysis that require future surgery. We
24 did not put that in there.

25 So I would say this is what she needs. There's really

1 not anything in there that I would say she does not need at
2 this point, but there may be additional things that she may
3 require in the future.

4 Q: Would you say these are the bare necessities?

5 A: Well, I think living in the United States, yes. I think
6 this would be what I consider the -- the standard of what
7 spinal cord injury patients in the United States should
8 receive in this day and age, yes.

9 Q: Okay. Now, if Crystal did not come out of this surgery
10 paralyzed, would she need any of these future health care
11 needs?

12 A: No.

13 Q: Okay. You treat the spine in spinal cord patients;
14 correct?

15 A: Correct.

16 Q: If this surgery went as planned and was successful, would
17 Crystal be paralyzed in her lifetime because of her pre-
18 existing back condition?

19 MR. HEITMAN: Objection, Your Honor. Calls for
20 speculation.

21 THE COURT: Overruled.

22 BY MR. GOINGS:

23 A: So she was not paralyzed before she went into the -- into
24 the surgery. It is difficult to predict what would happen
25 down the road, but at the time of the surgery, she was

1 definitely not paralyzed.

2 Q: But the need and the reason for the surgery that she had
3 is something that you would say you should be able to recover
4 from and do reasonably well; correct?

5 A: Well, the purpose of the surgery is to prevent any sort
6 of neurological damage. Right? So if the surgery was
7 successful and uncomplicated, I would expect that she comes
8 out of the surgery and has no -- no evidence of -- of
9 paraplegia or loss of neurological function in her legs.

10 Q: Okay. And spine surgeons remove bone spurs on the spinal
11 cord every day; right?

12 A: Right.

13 Q: That's -- that's a common procedure that a spine surgeon
14 performs; correct?

15 A: Yes. Laminectomy is a common procedure for spine
16 surgeons.

17 Q: Spine surgeons every day treat patients who have spinal
18 stenosis; correct?

19 A: Correct.

20 Q: All right. And not everybody that has or had a bone spur
21 or has or had spinal stenosis is wheelchair bound; right?

22 MR. HEITMAN: Objection, Your Honor. Leading the
23 witness.

24 THE COURT: Overruled.

25 BY MR. GOINGS:

1 A: No. The purpose of the spine surgery is to prevent this
2 from happening, and the vast majority of patients who have
3 those surgeries do well.

4 Q: Thank you. Doctor, are your opinions here today, all the
5 statements that you've given to the ladies and gentlemen of
6 this jury, to a reasonable degree of medical certainty?

7 A: Yes.

8 Q: Okay.

9 MR. GOINGS: Please answer any questions opposing counsel
10 may have.

11 THE COURT: Mr. Heitmann?

12 MR. DAVIS: Your Honor, may I approach?

13 THE COURT: Sure.

14 (WHEREUPON, a bench conference was held off the record,
15 after which the proceedings resumed as follows.)

16 THE COURT: All right. Ladies and gentlemen, we need to
17 take a short break. Please return to your jury room and do
18 not discuss the case.

19 MR. DAVIS: Thank you, Your Honor.

20 (WHEREUPON, the jury exited the courtroom at 3:48 p.m.)

21 THE COURT: We'll be at recess for 10 or 15 minutes.

22 MS. GOODING: Your Honor, real quick for planning
23 purposes, do you have a plan as to what time you wanted to
24 wrap up for today?

25 THE COURT: I don't, but I mean, 5-ish is always good.

1 MS. GOODING: Okay. I'm just trying to figure out if
2 we're going to call one witness after this or two. So I just
3 -- I just didn't know what your kind of goal was.

4 THE COURT: I mean, if we can get two more done without
5 it being ridiculously late, then I'm okay with that. Yeah. I
6 don't have any place to be. Okay?

7 MR. HINSON: Thank you, Your Honor.

8 (WHEREUPON, there was a break in the proceedings, after
9 which the proceedings resumed as follows.)

10 THE COURT: Can we get the witness back up on the stand?
11 And you can go ahead and bring the jury, Mr. Bowen, as
12 soon as you get him situated.

13 (WHEREUPON, the Court exited the bench.)

14 (WHEREUPON, the jury entered the courtroom at 4:13 p.m.)

15 THE BAILIFF: The jurors are seated, Your Honor.

16 THE LAW CLERK: Judge Newman's father is doing a wedding
17 next door, and so he just pulled her out for one second.

18 THE BAILIFF: Oh.

19 THE BAILIFF: She's going to come right back, I promise
20 you.

21 (WHEREUPON, the Court returned to the bench.)

22 THE COURT: That was totally unexpected. Okay. Witness
23 still on the stand. Where were we?

24 Cross-examination, Mr. Heitman?

25 MR. HEITMAN: Thank you, Your Honor. May it please the

1 Court.

2 CROSS-EXAMINATION

3 BY MR. HEITMAN:

4 Q: Dr. Shaufele, you don't have a physician-patient
5 relationship with Mrs. Goodwin; true?

6 A: I do not.

7 Q: You have none of the duties of a treating physician of
8 Mrs. Goodwin because you're acting in a legal aspect; is that
9 correct?

10 A: I'm not a treating physician, correct.

11 Q: And your duties go to Mrs. Goodwin's attorneys in this
12 case; is that right?

13 A: Yes. I was hired by them. That is correct.

14 Q: But you don't have any duty to treat or diagnose? You
15 were just asked to perform an independent medical examination,
16 and that's what you did; correct?

17 A: Correct.

18 Q: You mentioned earlier about how much you get paid, and
19 you said, I believe, \$600 an hour; is that right?

20 A: That is correct, yes.

21 Q: And is that for creating the independent medical
22 examination?

23 A: It's -- I have a flat fee for -- of \$600 per hour if I
24 do any medical legal work.

25 Q: Okay. Does that include for deposition?

1 A: Deposition, the rate is higher.

2 Q: How much do you get paid for deposition?

3 A: Deposition is \$1,000 per hour.

4 Q: Okay. Is that for -- for how many hours?

5 A: We usually have a minimum of -- of two hours.

6 Q: Okay. And then after that, how much is it?

7 A: It's -- it's the same. It's \$1,000 per hour.

8 Q: And what about for your time at trial?

9 A: I charge a daily rate of \$5,000.

10 Q: Is that per day?

11 A: Yes.

12 Q: Okay. A daily rate, that would be per day. Okay. You

13 spent about 70 minutes with Mrs. Goodwin; is that correct?

14 A: On the initial evaluation, correct. Yes. That was face

15 to face time.

16 Q: When you -- when you examined her in person?

17 A: Correct.

18 Q: Do you have your independent medical examination with

19 you?

20 A: I think I gave it back.

21 Q: Okay.

22 A: I can get it.

23 Q: I can get you a copy.

24 A: Okay.

25 Q: Can I refer to this as an IME report?

1 A: Yes. IME stands for Independent Medical Examination.

2 Q: On the last page of your IME report, you have a
3 disclaimer; is that correct?

4 A: Yes.

5 Q: And it says that your report is based upon information
6 given to you, including the history by the patient and the
7 medical records provided to you; is that right?

8 A: That is correct.

9 Q: Who provided you with the medical records in this case?

10 A: The attorneys in the case, Crystal Goodwin's attorneys.

11 Q: Okay. And the list of the medical records you reviewed
12 are listed on the first page of your IME report; is that
13 right?

14 A: That is correct.

15 Q: And those would be the medical records that you relied
16 upon, in addition to the input from Mrs. Goodwin; is that
17 right?

18 A: That's correct.

19 Q: For your report?

20 A: But since then, I've reviewed some additional records.

21 Q: Okay. You reviewed her -- her operating note from her
22 2021 surgery; right?

23 A: I did at some point, yes.

24 Q: Okay. There isn't any reason why that information
25 provided to you would be limited or would be held back from

1 the total amount of records available; is that correct?

2 A: Not to my knowledge.

3 Q: You would want all the information you could get; right?

4 A: Yes.

5 Q: On page 2 of your report, it says under history and then
6 under injury that the patient states she underwent a thoracic
7 laminectomy in 2009 because of weakness in the legs. Surgery
8 was performed by Dr. Holbrook, neurosurgeon. Her symptoms
9 resolved post-surgically. In 2011, she required a revision
10 thoracic laminectomy because of scar tissue and recurrent
11 symptoms of weakness and numbness in the legs. Did I read
12 that correctly?

13 A: Yes.

14 Q: Is that information you obtained from Mrs. Goodwin or
15 from the medical records?

16 A: It's usually a combination of the review of the records,
17 what the patient tells me, and in some form -- in some form,
18 it's edited by me to make it comprehensive.

19 Q: Okay. And to your understanding, Mrs. Goodwin's --
20 Goodwin's issues in 2009 and 2011 were due to spinal stenosis;
21 is that correct?

22 A: That is correct.

23 Q: What is spinal stenosis?

24 A: Spinal stenosis means -- we talked about that earlier and
25 I think the jury heard about it, but it essentially means

1 narrowing of the spinal canal. The spinal canal usually has a
2 certain diameter. It contains the spinal cord. There's
3 usually space around the spinal cord. If that space around
4 the spinal cord is narrowed and it's decreased from normal, we
5 typically call that spinal stenosis. Stenosis means
6 narrowing.

7 Q: And so the 2011 surgery initially fixed the weakness that
8 Mrs. Goodwin had in her legs; is that correct?

9 A: That is correct.

10 Q: In the same section, if you skip down a few sentences, it
11 says in 2016 she fell in the bathtub and developed temporary
12 weakness in both legs. Did I read that correct?

13 A: Yes.

14 Q: So the weakness returned in her legs after she fell; is
15 that correct?

16 A: Correct.

17 Q: And that was what led to the laminectomy surgery that she
18 had in 2016; right?

19 A: Correct.

20 Q: And I believe you said that you're aware Mrs. Goodwin had
21 another surgery in 2021?

22 A: Correct.

23 Q: And the purpose of the 2021 surgery was to treat Mrs.
24 Goodwin's spinal stenosis also; correct?

25 A: The spinal stenosis, in my understanding, is also because

1 she's developed an instability as a result of the multiple
2 laminectomies. So when you do a laminectomy, you take bone
3 away. When you take bone away repeatedly from the spine, the
4 spine can become unstable. If it becomes unstable, a surgeon
5 has to go in and fuse those vertebra together, usually with --
6 with screws. And my understanding is that was the reason why
7 she had that last surgery.

8 Q: Okay. And in all fairness, you're not a neurosurgeon;
9 correct?

10 A: I am not.

11 Q: And if the purpose of Mrs. Goodwin's 2021 surgery was to
12 treat her spinal stenosis, that would be consistent with Mrs.
13 Goodwin's medical history; right?

14 A: Correct.

15 Q: Further down in your IME report under history and under
16 injury, it says she has been wheelchair dependent ever since
17 her surgery on July 28th, 2016, and she has been unable to
18 ambulate because of her lower extremity weakness. Did I read
19 that correctly?

20 A: Correct.

21 Q: And -- and what do you mean by ambulate? Because she's
22 -- she's able to ambulate in a wheelchair; correct?

23 A: Correct. So ambulate without a wheelchair. So what I
24 mean by that is walking normally, the day to day activities
25 without the use of the wheelchair.

1 Q: Okay. And did you get that information from the medical
2 records?

3 A: Well, that's a combination of the patient, her husband,
4 the life care planner, and a review of the medical records.

5 Q: Okay. But you took that information into consideration
6 in developing your recommendations for this case; correct?

7 A: That and my evaluation as well, yes.

8 Q: Sure. All right. I'd like to take a look at the
9 physical therapy note from October 2nd, 2019, from Columbia
10 Rehabilitation Center. I'll hand that to you. I'll also put
11 it up on the screen. Dr. Shaufele, this is a record from
12 Columbia Rehabilitation Center from her physical therapy.

13 These records were not provided to you by plaintiffs' counsel
14 when you were asked to create your IME report, were they?

15 A: No, but I've seen them since.

16 Q: Okay.

17 MR. GOINGS: Your Honor, I'm still not really sure what
18 document he's talking about because I don't have -- I've not
19 been provided a copy of that. So we're trying to find what
20 he's talking about.

21 THE COURT: Would you show it --

22 MR. HEITMAN: Yeah.

23 THE COURT: -- to --

24 MR. HEITMAN: I'll show it to plaintiffs' counsel, Your
25 Honor.

DR. MICHAEL SHAUFELE - CROSS BY MR. HEITMAN

1 MR. GOINGS: He showed it to me. He's asking the witness
2 questions about something I don't have.

3 THE COURT: He can do that.

4 MR. HEITMAN: Yes.

5 MR. GOINGS: Normally, the rule is you provide counsel
6 with a copy --

7 THE COURT: Sure.

8 MR. GOINGS: -- of what you have, and I don't know. I
9 wish I had a copy.

10 MR. HINSON: Me too.

11 THE COURT: So he's shown it to you. You just don't have
12 a physical copy of it?

13 MR. GOINGS: He handed it to me and then handed it to the
14 witness.

15 MR. HEITMAN: CRC 710.

16 THE COURT: Got it?

17 MR. HEITMAN: I apologize.

18 MR. GOINGS: Yeah.

19 THE COURT: Proceed.

20 MR. GOINGS: I misunderstood the Bates numbering. So --

21 MR. HEITMAN: Gotcha.

22 BY MR. HEITMAN:

23 Q: All right. So you did not have this record at the time
24 you created your -- your life care report; is that right?

25 A: That's correct.

1 Q: Okay. In this PT note under objective, it states patient
2 reports having a good time with her family or at her family
3 reunion, and her family was excited to see the video of her
4 walking. Did I read that correctly?

5 A: Yes.

6 Q: And your IME report said she could not ambulate; is that
7 right?

8 A: That is correct.

9 Q: Under functional status on page 3 of your report --

10 A: Can I make a comment on that?

11 Q: Sure.

12 A: So I think she -- she -- I've seen a video. I think when
13 I saw her at some point, I've seen it, and it was a video of
14 her in physical therapy. And I don't know if it's clear when
15 -- when we talk about walking in physical therapy what that
16 means is it means that she's either strapped into a harness
17 that could be from the ceiling that essentially takes away the
18 weight from the legs, and she -- she can take some steps, but
19 that's part of the rehabilitation program for spinal cord
20 injury patients. So you take the weight of the legs away to
21 ambulate just with the body weight.

22 I don't call that walking. I call it therapy. I mean, I
23 don't know if that's the video that -- that we're referring
24 to, but I just want to make it very clear that unless
25 everything I've seen so far is wrong, Crystal is not walking.

1 I want to make that clear.

2 Q: All right. Thank you, Doctor. Under functional status
3 on page 3 of your report, you state she is unable to ambulate
4 for any functional distances; is that correct?

5 A: Correct.

6 Q: And what is a functional distance?

7 A: That means you can do things for yourself. You can go to
8 the refrigerator and take out the milk or you can go to the
9 bathroom and take -- take a shower or do your personal
10 hygiene. So day to day walking, maybe an hour or two, if you
11 don't have an injury or neurological injury to our legs.

12 Q: About how many feet would you say that would be?

13 A: How many feet it would need to be to walk for functional
14 purposes?

15 Q: Sure.

16 A: Well, it depends on your functions. Right? If it's
17 basic function you go to the -- around your house, it may be
18 100 feet, 200 feet. If you want to walk for exercise outside
19 of your house, it's a half a mile. It's a mile. It depends
20 on what you define as -- as -- as the functional needs of a
21 patient.

22 Q: Well, Doctor, these are your words; right? Functional
23 distance?

24 A: Right, but I'm just explaining what functional distance
25 means, and it can mean different things to different people.

1 Q: Well, what did you mean?

2 A: I would say if I referred to a functional distance, so a
3 patient could -- or a person could do all the activities that
4 they normally do in a day without any limitations.

5 Q: All right. Let's look at Columbia Rehabilitation Center
6 record from 9/11/19. This is CRC 00360. Let's look down at
7 the assessment. It said patient tolerated session well.
8 Patient was able to ambulate 40 feet times two with RW. I'm
9 assuming that stands for rolling walker; is that right? Or do
10 you know?

11 A: CGA? It's contact guard assist. That means the
12 therapist is standing by the patient and supporting them.

13 Q: Okay. With wheelchair following. Patient was very happy
14 to see the progress she has made being able to ambulate with a
15 rolling walker. Did I make -- did I read that correctly?

16 A: Yes, that is correct.

17 Q: So it looks like on this date, Crystal was able to walk
18 with the help of a walker 40 feet times two. So that would be
19 about 80 feet; correct?

20 A: That is correct.

21 Q: Is 80 feet functional distance?

22 A: Yes, it is if you do it without a wheelchair following or
23 without a physical therapist standing by you and without
24 taking a break. This is therapy. This is not functional
25 walking.

1 Q: Your report and your recommendations that you made for
2 Mrs. Goodwin on 7/15/2020 assumes that Mrs. Goodwin has
3 reached maximum medical improvement; is that correct?

4 A: That is correct.

5 Q: And you state on page 5 of your report that maximum
6 medical improvement is defined as the date after which further
7 restoration and recovery of function can no longer be
8 anticipated; is that correct?

9 A: That is correct.

10 Q: All right. I'm going to show you what's -- let's see --
11 the Columbia Rehabilitation Clinic record from 8/27/2020.
12 That would be CRC 260. And under subjective, it says patient
13 was very excited to report she was able to sidestep into her
14 bathroom and take a bath; is that correct?

15 A: Correct.

16 Q: Now, you mentioned to us earlier that she was taking a
17 bath in her living room in a kiddie pool; is that right?

18 A: That is correct.

19 Q: Let's go down to the assessment. It says that patient
20 was able to ambulate approximately 200 feet around the gym
21 with several rest breaks. Now, this is a note from 10/2/19,
22 which I believe was after -- was that after your report that
23 you created?

24 A: I think there's two -- two notes, and there's -- the note
25 that I have here says on top August 27th, 2020.

1 Q: I'm sorry. I was at the wrong date.

2 A: And that was indeed after I saw her.

3 Q: So after you saw her, she's already making improvements;
4 right?

5 A: Let me -- let me comment because I think -- and I hate to
6 talk to lawyers about legal terms, but the -- the definition
7 of maximum medical improvement is a definition that is -- that
8 is used in the Workers' Compensation environment. And what
9 that means is that you don't expect any significant functional
10 changes over the following 12 months. It doesn't mean that
11 there aren't any changes. There may be some fluctuations, and
12 there may be some good days and some bad days.

13 And what it really means is the overall underlying injury
14 is relatively stable. So you'll see some days where there's
15 going to be -- you know, like any -- any of us, we -- we work
16 out or if you run, sometimes you run a little bit faster or
17 sometimes a little bit slower. So those are just facts of
18 normal human performance. It doesn't change the underlying
19 injury that Crystal has.

20 Q: Crystal being able to use her own bathroom is -- is a
21 functional improvement; isn't that right?

22 A: It is.

23 Q: Okay.

24 A: But she doesn't do it regularly and she didn't do it as
25 of last week.

1 Q: You gave Mrs. Goodwin an ASIA A rating; is that correct?

2 A: That is correct.

3 Q: Is that the worst rating that you can give somebody?

4 A: Correct. So maybe for the jury, so spinal cord injuries
5 are graded on a scale from A to E. A is the worst injury and
6 E is the -- is a less severe injury because -- so to answer
7 the question, yes, that's -- it's the worst rating.

8 Q: Did you know that plaintiffs' neurosurgeon expert just
9 yesterday gave her an ASIA C rating?

10 A: Well, the reason why she is an ASIA A, I'm more than
11 happy to share that reference, is because she doesn't have
12 anal and rectal sensation. If you don't have anal or rectal
13 sensation, you're automatically an ASIA A. That's the
14 definition in the ASIA literature. So I respectfully disagree
15 with your plaintiffs' rating.

16 Q: At some point before her 2021 surgery, is it your
17 understanding Mrs. Goodwin began to regress in the progress
18 that she made?

19 A: Yes.

20 Q: And that's ultimately why she ended up going to see a
21 neurosurgeon and as a result had spine surgery in April of
22 2021; correct?

23 A: Correct.

24 Q: I'm going to show you another rehab or physical therapy
25 note. This is CRC 0331. This is from January 11th, 2021.

1 We'll go down to the assessment, and this note says patient
2 reported that her legs continues to feel like it did prior to
3 her surgery, and she is concerned about it. Patient said she
4 is going to try and see an M.D. This would be talking about
5 before her -- first of all, did I read that correctly?

6 A: Yes.

7 Q: And this would be referring to her 2016 surgery; correct?

8 A: Well, I can't -- I don't know. I don't think it says it
9 in there. I agree to this that, you know, it felt the same or
10 it feels the same as it did prior to the last surgery, but I
11 don't know the answer to that.

12 Q: At the time of this note, her last surgery would have
13 been the 2016 surgery; right?

14 A: When was the -- what was the date of the last surgery?

15 Q: April 2021.

16 A: Okay. So, yes, the answer is correct. You're right.

17 Q: Dr. Shaufele, you cannot say to a reasonable degree of
18 medical certainty that had Mrs. Goodwin not undergone a third
19 surgery, given her pre-surgical condition in 2016, she never
20 would have suffered from paralysis and the loss of function in
21 her legs, can you?

22 A: I cannot.

23 Q: Can anybody say that?

24 A: No.

25 MR. HEITMAN: I don't have any further questions, Doctor.

1 THE WITNESS: Thank you.

2 THE COURT: Any redirect?

3 MR. GOINGS: Yes, Your Honor.

4 REDIRECT EXAMINATION

5 BY MR. GOINGS:

6 Q: Doctor, the chance of Crystal Goodwin being paralyzed is
7 what? Based on that question he asked, what's the chance of
8 Crystal being paralyzed?

9 A: Without the surgery?

10 Q: No. With the surgery. She had the surgery, continued on
11 with a healthy life, what's the chance of Crystal Goodwin
12 being paralyzed here today?

13 A: It's low. The purpose of the surgery is to prevent this
14 from happening.

15 Q: One percent?

16 A: I don't know. It's low.

17 Q: Low?

18 A: It's low.

19 Q: Okay. Now, she can walk. She showed videos to her
20 family that she could walk. She showed videos to you that she
21 can walk. I heard those questions, and I turned around and
22 asked Crystal for her iPhone to get that video that she showed
23 you and her family bragging about her walking. Let's look at
24 that video, Doctor. Give me one second.

25 (WHEREUPON, there was a pause in the proceedings, after

1 which the proceedings resumed as follows.)

2 MR. GOINGS: Your Honor, I'm sorry. I'm trying to -- oh,
3 there we go. We got it.

4 (WHEREUPON, the video was played.)

5 BY MR. GOINGS:

6 Q: Crystal was walking, isn't she, Doctor?

7 A: Well, I think it is pretty self-explanatory. A couple of
8 things I want to point out. In order for her to accomplish
9 this, she has a brace on the right foot to keep the foot up so
10 she doesn't stumble. She has a walker. There is a physical
11 therapist who is trained in dealing with spinal cord injury
12 patients right next to her. She has a belt on so the
13 therapist can hold her up. Her husband is behind her with a
14 walker.

15 So we were talking about functional walking earlier.
16 This is therapeutic walking. This is not functional walking.
17 You cannot go to the refrigerator with this and get your milk
18 out of the refrigerator. I think it's pretty self-
19 explanatory.

20 MR. GOINGS: No further questions, Your Honor.

21 THE COURT: Anything further from this witness?

22 MR. HEITMAN: Nothing further.

23 THE COURT: Okay. Thank you. You may step down.

24 Call your next witness.

25 MR. GOINGS: Your Honor, at this time, we would call Ms.

1 Teresa Adkins.

2 THE BAILIFF: Come forward and be sworn. Place your left
3 hand on the Bible, raise your right, and face the clerk there.

4 THE CLERK: Do you solemnly swear or affirm that the
5 testimony you are about to give in this case will be the
6 truth, the whole truth, and nothing but the truth, so help you
7 God?

8 THE WITNESS: Yes.

9 THE CLERK: Please state your full name for the record.

10 THE WITNESS: Teresa Nguyen Adkins.

11 THE CLERK: You may have a seat, please.

12 THE BAILIFF: Watch your step up. Now, you've got a soft
13 voice. See that lady right there? She's got to hear you
14 through that thick glass. The judge has got to hear you. The
15 jurors have got to hear you. Talk loud for me. Okay? Thank
16 you.

17 TERESA ADKINS, being first duly
18 sworn, testified as follows:

19 DIRECT EXAMINATION

20 BY MR. GOINGS:

21 Q: Can you state your full name for the record, ma'am?

22 A: Teresa Nguyen Adkins.

23 Q: Ms. Adkins, what do you do for a living?

24 A: I am a surgical neurophysiologist.

25 Q: A surgical neurophysiologist. How long have you been a

1 surgical neurophysiologist?

2 A: Since I started training in 2001 and was board certified
3 in 2003.

4 Q: Where do you live?

5 A: Elgin.

6 Q: And where did you go to school?

7 A: I went to school at USC.

8 Q: University of South Carolina?

9 A: Yes.

10 Q: And did you graduate?

11 A: I did.

12 Q: What did you graduate in?

13 A: Bachelor of Science in biology.

14 Q: And did you receive a certification to become a
15 neurophysiologist?

16 A: I did in 2003, yes.

17 Q: Okay. And who are you employed by?

18 A: Currently, Specialty Care.

19 Q: Are you employed by any hospital?

20 A: No.

21 Q: What does a surgical neurophysiologist do?

22 A: I keep an eye on and monitor spinal cord and nerves and
23 brain as well, function in the brain and spinal cord in the
24 O.R. for brain and spine surgeries.

25 Q: So you're the person in the surgery room that is looking

1 at the neuromonitoring that is going on?

2 A: Yes.

3 Q: Okay. How many hospitals have you performed
4 neuromonitoring services for?

5 A: I am mainly at Richland right now. The company I work
6 for contracts with the hospitals. So Richland, Baptist,
7 Lexington, Providence Northeast, Parkridge. And the --
8 there's sometimes we -- we travel in the state and sometimes
9 out of state.

10 Q: How many surgical cases do you have on a weekly basis in
11 which you provide surgical neuromonitoring for?

12 A: It varies. It can be as many as ten cases. It can be as
13 low as four to five.

14 Q: In your career from 2001 to present, how many
15 neuromonitoring cases have you been involved in?

16 A: Hundreds.

17 MR. GOINGS: Your Honor, at this time, I would like to
18 tender Ms. Adkins as an expert in the field of surgical
19 neuromonitoring as a surgical neurophysiologist.

20 MR. DAVIS: No objection, Your Honor.

21 THE COURT: All right. You may proceed.

22 BY MR. GOINGS:

23 Q: Ms. Adkins, were you in the surgery room at Baptist
24 Hospital during Crystal Goodwin's operation?

25 A: I was, yes.

1 Q: Do you remember that surgery?

2 A: I do.

3 Q: And how many -- again, you've done hundreds?

4 A: At least, yes.

5 Q: Do you remember all hundreds of them?

6 A: No.

7 Q: But you remember this one?

8 A: Yes.

9 Q: Is there a reason why this one -- this surgery sticks out
10 in your mind?

11 A: Because there was post-operative deficits. We usually
12 follow the patient, do a post-op assessment, make sure it
13 doesn't change from pre-op, and we have to document that and
14 report that as well. So when we have events like that, we
15 tend to remember.

16 Q: Tell us, Ms. Adkins, what is intraoperative
17 neuromonitoring?

18 A: It's spinal cord nerve monitoring in the O.R.

19 Q: And how is it performed?

20 A: We place electrodes, sticky pads, needle electrodes on
21 the scalp and the muscles in the extremity all the way down to
22 the feet, arms, hands, leg, feet. And during the course of
23 the surgery, we'll stimulate sensory evoked potentials, which
24 is the posterior aspect of the spinal cord, and then motor
25 evoked potentials as well. And we get a baseline at the very

1 beginning, and then we just make sure the baseline doesn't
2 change from there. And if we do, we -- we report our
3 findings.

4 Q: What is the purpose of neuromonitoring?

5 A: To prevent injury.

6 Q: Is the purpose of neuromonitoring to identify a potential
7 injury in a timely manner and prevent it from being permanent?

8 A: Yes.

9 Q: And is that why neuromonitoring is used?

10 A: Yes.

11 Q: Are you working with a neurologist, a physician as well,
12 while you're doing your neuromonitoring?

13 A: Yes.

14 Q: And is he in the room with you?

15 A: He is not. He monitors remotely.

16 Q: He or she?

17 A: Correct.

18 Q: Okay. In this particular case, the reason I used he, it
19 was actually a male neurologist.

20 A: Right.

21 Q: Mr. -- Dr. Gregg; is that correct?

22 A: Yes, Dr. Gregg.

23 Q: Okay. Where was he located?

24 A: I believe he was in Nashville.

25 Q: Okay. And is -- is the purpose of neuromonitoring to

1 look for any problems in the motor function or sensory signals
2 of the nervous system during a surgery?

3 A: Yes.

4 Q: Okay. As a neuromonitoring physiologist, is it important
5 -- is that an important tool to provide a safe and effective
6 care for patients who are undergoing spinal care?

7 A: Yes.

8 Q: Do you agree with me, ma'am, that the loss of
9 neuromonitoring signal can be associated with potentially
10 devastating consequences?

11 A: Yes.

12 Q: And what are those consequences?

13 A: Numbness, weakness, paralysis.

14 Q: The ability to use your arms or legs?

15 A: Yes.

16 Q: Ms. Adkins, you would agree with me that one of the
17 purposes of neuromonitoring is to prevent someone from being
18 paralyzed as a result of surgery?

19 MR. DAVIS: Your Honor, I object to the leading.

20 THE COURT: Sustained.

21 BY MR. GOINGS:

22 Q: Describe to us the purposes of neuromonitoring as it
23 relates to the harmful effects of surgery?

24 A: Um --

25 Q: Explain to us the purpose of neuromonitoring as it

1 relates to safety?

2 A: So, as I said, to keep an eye on monitoring the spinal
3 cord and the nerves throughout the surgery, make sure it
4 doesn't change, and protect -- basically, protect the nerves
5 in the spinal cord.

6 Q: What can happen if the neuromonitoring signal is lost for
7 a long period of time?

8 A: It can have post-operative deficits.

9 Q: What are -- what's a postoperative deficit?

10 A: Deficit as in weakness, numbness, tingling, pain, and
11 again, paralysis.

12 Q: Injury?

13 A: Injury, yes.

14 Q: Ms. Adkins, do you have training, education, and
15 experience about what to do if your equipment tells you that a
16 patient has lost motor function or sensory signals to a part
17 of their body?

18 A: Yes. There are steps that we take.

19 Q: And what are those steps?

20 A: We first alert the surgeon and the neurologist that are
21 online, and then we check the patient's vitals, as well as the
22 electrodes, the technical components of it. Also, positioning
23 of the patient's legs, which were the lower extremities, were
24 -- we had the loss in and to -- to rule all that out.

25 Q: What else is done in the surgery suite?

1 A: As in?

2 Q: When the signal goes out?

3 A: We just go through all the checklists to make sure that

4 it's not anything technical --

5 Q: Okay.

6 A: -- going on.

7 Q: Is the first thing to check the equipment?

8 A: Yes.

9 Q: Okay. Did you check the equipment?

10 A: I did.

11 Q: Now, when Crystal was first in the operating room before

12 the surgery began, did you place the electrodes on her?

13 A: Before the operating room?

14 Q: Before the surgery began?

15 A: Yes, before the surgery began, I did.

16 Q: Okay. Did she have full neurologic function when she

17 went into the O.R.?

18 A: Yes.

19 Q: Did she have full neurologic function to her legs when

20 she was wheeled out of the O.R.?

21 A: I wasn't sure because I wasn't there when she woke up.

22 So the post-operative assessment was done in the PACU.

23 Q: When you left the O.R., did she have sensory to her legs?

24 A: SSEPs, no.

25 Q: And that's the only thing you could monitor at that time;

1 right?

2 A: Correct.

3 Q: So the answer is, no, she had no function to her legs?

4 A: With the -- correct. With the SSEPs, the loss of SSEPs.

5 Q: Okay. But when the surgery started, she had full
6 function; correct?

7 A: Yes.

8 Q: Did anything at the beginning of the surgery show that
9 she had less than full motor -- motor or sensory function to
10 her legs when the surgery began?

11 A: No.

12 Q: Okay. When did the signal go out to her lower extremity?

13 A: After the breathing tube was secured. There was an issue
14 with the breathing tube. And once she was stabilized there,
15 minutes. I don't remember.

16 Q: Have you -- have you seen the -- the records showing when
17 the breathing tube was -- was stabilized and when the -- the
18 SSEPs went out?

19 A: Yes, I have seen it.

20 Q: Okay. And the breathing tube is in the -- in the neck
21 area, and that would be the upper; correct?

22 A: Correct.

23 Q: Okay. But the lower went out, which is the legs;
24 correct?

25 A: Correct.

1 Q: Okay. Was it about 30 minutes later after the breathing
2 tube got stabilized that the lower extremities went out?

3 A: Maybe. I don't remember.

4 Q: Do you have your neuromonitoring records in front of you?

5 A: I don't.

6 Q: They've been marked as an exhibit in this case. I'm
7 going to hand them to you. If you need to look at them to
8 help refresh your memory, I will give them to you. I'm going
9 to hand you Exhibit 15. It's the neuromonitoring records from
10 Specialty Care. That's the company you work for; correct?

11 A: Correct.

12 Q: Can you turn to page 36?

13 A: Is it the red number?

14 Q: Yes, ma'am. No. Excuse me. The black number 36. And I
15 could probably help you so you don't have to go through the
16 documents if you want to look at this monitor. Can you see
17 that, ma'am?

18 A: Yes.

19 Q: Okay. At 9:58, what was being performed?

20 A: The laminar decompression.

21 Q: Okay. The surgery was going --

22 A: Correct.

23 Q: -- forward; correct? And it says SSEP stable at this
24 time at 9:58. Do you see that?

25 A: Yes.

1 Q: Okay. Can you read what's on the board?

2 A: Yes. 10:03, loss of bilateral lower SSEPs reported.

3 Surgeon acknowledged.

4 Q: So would the answer to the question be at 10:03 the
5 signal was lost?

6 A: Yes.

7 Q: Okay. And what did you do, ma'am, when the signal was
8 lost?

9 A: I reported to Dr. Holbrook and then checked to make sure
10 -- went through the steps to make sure it wasn't anything
11 technical and just trying to rule that out.

12 Q: Did you perform all the necessary steps?

13 A: I did.

14 Q: And what did the -- what did that reveal when you
15 investigated if the equipment was the problem?

16 A: I checked everything. It was working. The -- because
17 the uppers were still working fine. So I checked the
18 electrodes. Checked the positioning. Her positioning of her
19 legs were fine.

20 Q: And the equipment was operating correctly?

21 A: Correct.

22 Q: You troubleshooted it and everything came back; correct?

23 A: Correct.

24 Q: But the signal was still out?

25 A: Yes.

1 Q: And you told the doctor?

2 A: Yes.

3 Q: And do you recall what Dr. Holbrook told you when you

4 told him that nothing was wrong with your equipment?

5 A: I don't remember.

6 Q: Then 10:03:17, what does it say?

7 A: It says loss of bilateral lowers. 10:03? It's the same.

8 Q: 10:03. Well, this is a different time. This is at 17

9 seconds.

10 A: Oh, okay. Loss of bilateral lowers SSEPs reported.

11 Surgeon acknowledged.

12 Q: So, 17 seconds later, you told the surgeon again, Dr.

13 Holbrook, the signal's out?

14 A: Yes.

15 Q: And what did Dr. Holbrook tell you?

16 A: I don't remember.

17 Q: Then at 10:04:11, what does it say?

18 A: Loss of bilateral lower SSEPs recorded. Surgeon

19 acknowledged.

20 Q: So a minute later, you said it again to him; correct?

21 A: Yes.

22 Q: What did Dr. Holbrook tell you?

23 A: I -- I don't remember.

24 Q: Did you tell him there wasn't anything wrong with your

25 equipment?

1 A: I told him that I did all the checks and made sure
2 everything was still working.

3 Q: Did you hear Dr. Holbrook say we need to go get the
4 anesthesiologist so we can increase blood pressure?

5 A: I don't recall.

6 Q: 10:14:29, still doing the surgery; correct?

7 A: Correct.

8 Q: Now, is there an alarm that goes off on your equipment
9 when signal is lost?

10 A: No.

11 Q: For you, though, I mean, is there an alarm for you that
12 shows you the signal is lost?

13 A: Yes.

14 Q: So you're alerted; correct?

15 A: Yes. Because of the baselines and the -- the -- the
16 waveforms.

17 Q: Okay. 10:17, 10:17:34, what does it say?

18 A: Surgeon informed bilateral lower SSEPs remain out.

19 Surgeon stated he was not around the cord when lower SSEPs
20 reported to be lost.

21 Q: So 15 minutes later, you told him again the signal was
22 out; correct?

23 A: Yes.

24 Q: And he told you I wasn't anywhere around the cord?

25 A: Yes.

1 Q: And the surgery continued; right?

2 A: Yes.

3 Q: It looks like the surgery continued until -- the actual
4 operation itself continued to until 10:41:21; correct?

5 A: Yes.

6 Q: Okay. Now, when you are doing neuromonitoring, do you
7 have ability to see the vitals?

8 A: Yes.

9 Q: You're able to see what the patient's blood pressure is?

10 A: Yes.

11 Q: Do you have a separate cuff to check blood pressure?

12 A: No, I get it from the anesthesia.

13 Q: Okay. So you see it on the monitor?

14 A: Yes.

15 Q: Okay. Did you record the blood pressure of Crystal
16 Goodwin at times in your neuromonitoring?

17 A: Yes.

18 Q: Okay. What does it show at 9:56:18?

19 A: Blood pressure is 103 over 64.

20 Q: And you recorded that; correct?

21 A: I did.

22 Q: Is that accurate?

23 A: Yes. I got that from the anesthesia monitor.

24 Q: Did you tell the neuro -- the neurologist that you were
25 chatting with that you checked the equipment?

1 A: I did.

2 Q: And what did he say?

3 A: I don't remember.

4 THE COURT: I'm sorry?

5 UNIDENTIFIED MALE: Can I get a tissue? I don't need a

6 break.

7 UNIDENTIFIED FEMALE: Yeah, it doesn't matter. He can

8 get a tissue.

9 BY MR. GOINGS:

10 Q: How do you know that you checked the equipment?

11 A: I would document it.

12 Q: Was it documented that you checked the equipment?

13 A: I -- I don't remember. It should have been in there.

14 Q: Do you have the chat in front of you?

15 A: What pages?

16 Q: Turn to page 54. It says everything is hooked up?

17 A: I don't see a page -- I don't see a page number.

18 Q: Well, look at the monitor.

19 A: Where are the page numbers?

20 Q: Do you want to look at the monitor?

21 A: Yes. It says everything is hooked up.

22 Q: And then it looks like Dr. Gregg, Herb Gregg, says glad

23 you informed the surgeon?

24 A: Yes.

25 Q: Were you anxious that these lower signals remained out

1 for the rest of the procedure?

2 A: A little bit, yes.

3 Q: And why were you anxious?

4 A: Just couldn't figure out why they were out.

5 Q: The absent lowers are making me anxious. Do you see
6 that?

7 A: Yes.

8 Q: Did it also make you anxious to know that nothing was
9 being done by anyone other than you to check the equipment?

10 MR. DAVIS: Objection, Your Honor.

11 THE COURT: Overruled.

12 MR. DAVIS: Thank you.

13 BY MR. GOINGS:

14 A: Did it make me anxious?

15 Q: Yes, ma'am.

16 A: Yes.

17 Q: During the procedure, did it ever come to your mind or
18 were you worried that Ms. Goodwin could be paralyzed as a
19 result of the signal going out?

20 A: No, I don't think so.

21 Q: I'm going to ask it again. Okay? During the procedure,
22 did it ever come to your mind or were you worried that Ms.
23 Goodwin could be paralyzed as a result of the signal going
24 out?

25 A: Not paralyzed, possibly with numbness and tingling.

TERESA ADKINS - DIRECT BY MR. GOINGS

1 Q: You were deposed previously in this case; correct?

2 A: Yes.

3 Q: And you gave testimony under oath; is that correct?

4 A: Yes.

5 Q: All right.

6 MR. GOINGS: Your Honor, I'm going to hand the witness
7 her deposition transcript. Would Your Honor like to open it?

8 THE COURT: You can open it.

9 MR. DAVIS: Your Honor, this is his witness. Is he going
10 to impeach his own witness? I don't understand.

11 THE COURT: Apparently.

12 MR. DAVIS: I'm sorry?

13 THE COURT: Apparently, he is.

14 MR. DAVIS: Okay.

15 MR. GOINGS: She's not my witness. I'm calling her as a
16 witness.

17 THE COURT: I understand.

18 MR. GOINGS: Okay.

19 THE COURT: You may proceed.

20 MR. GOINGS: Thank you.

21 MR. DAVIS: Thank you, Your Honor.

22 BY MR. GOINGS:

23 Q: All right. Turn to page 53. And, Ms. Adkins, you were
24 actually subpoenaed to come here; correct?

25 A: Yes.

1 Q: Okay. So you received a subpoena to come to trial this
2 week; right?

3 A: Yes.

4 Q: Okay. Do you have the transcript in front of you, ma'am?

5 A: I do.

6 Q: Page 53. This is the exact question I just asked you,
7 and you said no. I'm going to ask it again. This time we're
8 going to read what you said in your deposition.

9 MR. DAVIS: Could you let me know what line it is?

10 MR. GOINGS: Page 53, line 8.

11 MR. DAVIS: Thank you.

12 BY MR. GOINGS:

13 Q: During this procedure, did it ever come to your mind that
14 you -- or were you worried that Ms. Goodwin could be paralyzed
15 as a result of the signal, and then you said possibly, yeah.
16 And I said going out and no one doing anything about it, and
17 then you said that's always the thought that occurs when the
18 signal is lost, but being paralyzed is one thing. We didn't
19 -- we weren't able to run motors. So if there was anything,
20 it might have been sensory defect.

21 A: Deficit.

22 Q: Deficit?

23 A: Yes.

24 Q: So when I asked the question, were you worried that she
25 could possibly be paralyzed, you said on line 11, possibly,

1 yes; correct?

2 A: Yes. And then I also said we weren't able to run motors.

3 If we were able to run motors, we would definitely see the

4 change and it would be an alert.

5 Q: And that's right. You were not able to run motors. You

6 only had SSEPs at the time; correct?

7 A: Correct.

8 Q: Okay. And because the motors were not in, you only had

9 to rely on SSEPs; correct?

10 A: Correct.

11 Q: And SSEPs going out can also lead to, you know, someone

12 being paralyzed; right?

13 A: Yes. Possibly, yes.

14 Q: Okay. Now, have you heard of the Stagnara wake-up test?

15 A: Stagnara, yes.

16 Q: Stagnara?

17 A: Yes.

18 Q: You've heard of the wake-up test; right?

19 A: Yes.

20 Q: Are you trained on what this test is?

21 A: Yes.

22 Q: Tell the jury what this test is?

23 A: It's -- during the surgery, if there's any questions with

24 monitoring or the patient's neurological aspect of it,

25 anesthesia would lighten up on the anesthesia, lighten up on

1 the drugs, wake the patient up enough just so that they can
2 follow commands, have them wiggle their hands, wiggle their
3 fingers, wiggle their toes. And if everything is all
4 copacetic, they put the patient back to sleep, and I believe
5 they usually finish the surgery.

6 Q: Okay. Was that done in Crystal Goodwin's case?

7 A: No.

8 Q: Was the wake-up test done?

9 A: No, it was not.

10 Q: Okay. When you alerted Dr. Holbrook that the signal went
11 out, did you hear Dr. Holbrook say someone go get the
12 anesthesiologist?

13 A: I don't remember.

14 Q: Did you hear Dr. Holbrook say what's her blood pressure?

15 A: I don't remember.

16 Q: Did you hear Dr. Holbrook say we need to increase her
17 blood perfusion?

18 A: I don't remember that either.

19 Q: Did you hear Dr. Holbrook say we need to increase her
20 blood pressure?

21 A: I don't remember.

22 Q: Did you hear Dr. Holbrook say we need to get a vascular
23 surgeon in here or somebody to see why the signals are out?

24 A: No, I don't remember.

25 Q: But you did tell Dr. Holbrook that the equipment was

1 fine; correct?

2 A: Yes.

3 Q: Ms. Adkins, you're familiar with the protocol for what to
4 do when signal is lost and there's not a mechanical or
5 equipment failure; correct?

6 A: I'm familiar with it, yes.

7 Q: Okay. And that protocol is to push steroids and to
8 increase blood pressure, isn't it?

9 MR. DAVIS: Your Honor, subject to my earlier objection.

10 THE COURT: I'm sorry? Subject to your earlier
11 objection?

12 MR. DAVIS: Well, that motion *in limine*.

13 THE COURT: Oh, yes, sir.

14 MR. DAVIS: Okay. So I just renew that.

15 THE COURT: Yes, sir.

16 BY MR. GOINGS:

17 Q: Okay. I'm going to ask the question again. So you
18 probably didn't remember what I asked, did you? Because I
19 forgot. Thankfully, I wrote it down. Is there a protocol for
20 when signal is lost and there is not a mechanical or equipment
21 failure?

22 A: Yes.

23 Q: Okay. And you said and told us in your deposition that
24 the protocol for a negative outcome of signal loss, meaning
25 there's not an equipment failure, there's not a mechanical

1 failure, is to push pressors, which is -- which are also
2 steroids, and to increase the blood pressure of the patient;
3 right?

4 A: Yes. From what my understanding is, when we have changes
5 in the O.R.

6 Q: And you see that in the O.R. when there's changes; right?

7 A: Yes.

8 Q: And you see that that's done. The blood pressure is
9 increased; right?

10 A: Yes.

11 Q: Did you see it done here?

12 A: I don't remember. I did not.

13 MR. GOINGS: Those are all the questions for this
14 witness, Your Honor.

15 THE COURT: Cross-examination, Mr. Davis?

16 MR. DAVIS: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. DAVIS:

19 Q: Ms. Adkins, have you and I ever met before today?

20 A: I don't think so.

21 Q: Okay. But you've met these plaintiffs' lawyers? I saw
22 them talking to you in the hall earlier today.

23 A: Yes. And can you repeat that question, that last
24 question?

25 Q: You -- you have spoken to these plaintiffs' lawyers today

TERESA ADKINS - CROSS BY MR. DAVIS

1 out in the hallway of the courtroom; is that right?

2 A: Yes.

3 Q: Okay. Are they the ones that subpoenaed you to be here
4 today?

5 A: Yes.

6 Q: Do you know? Okay. How would you -- I've got a cold.
7 I'm sorry if I sound a little raspy. I'll do the best I can.
8 If you can't understand me, please let me know.

9 A: Okay.

10 Q: I'm happy to try to make it more clear. I'll do the best
11 I can.

12 How would you characterize the SSEP signals before they
13 just went out at 10:03 or whenever that was? How would you
14 characterize them?

15 A: They were reliable and monitorable.

16 Q: And what does that mean?

17 A: That means that we have something. When we take a
18 baseline at the very beginning, we make sure that it's
19 suitable for monitoring, meaning the minimum amplitude of the
20 waveform and the latencies are there and normal for that
21 patient.

22 Q: Okay. Did you see any decrease in the SSEP signals from
23 9:31 when the rocuronium was done with the -- because it had
24 the problem with the kink in the airway, and they had to give
25 a paralytic drug, rocuronium. And you're aware of that;

1 right?

2 A: Yes.

3 Q: Yeah. You would have been aware of that. Anesthesia
4 gives the rocuronium; is that right?

5 A: Correct.

6 Q: Yeah. So when they paralyzed her because of the need to
7 take out the bite block because of the kink in the airway and
8 to intubate her, that was done at around -- that -- that was
9 finally stable and taken care of around 9:31; is that right?

10 A: I think so, yes.

11 Q: And do you remember Dr. Root, the M.D. anesthesia, being
12 in the room at that time? Do you remember that?

13 A: I don't remember, but I think she would have been in
14 there.

15 Q: Sure. And did you remember seeing Dr. Root coming in and
16 out of the -- of the operating room several times during that
17 procedure? Did you notice that?

18 A: I don't remember.

19 Q: Okay. If she did, you may not have -- it's
20 understandable. You're looking at your monitor?

21 A: Yes, sir.

22 Q: Or having your chat log with your offsite doctor
23 neurologist, Dr. Gregg?

24 A: Yes, sir.

25 Q: So I'm sure you were distracted from time to time doing

TERESA ADKINS - CROSS BY MR. DAVIS

1 what you're supposed to be doing; is that right?

2 A: Yes, sir.

3 Q: All right. Do you recall from your monitoring the SSEPs,
4 which is now the only thing you've got because the motor MEPs
5 aren't working because of the paralytic drug?

6 A: Correct.

7 Q: Right. Okay. So did you -- did you ever notice any --
8 any drift of the SSEP signal deteriorating leading up to 10:03
9 when they just went out?

10 A: When? Because of the paralytics?

11 Q: No, ma'am.

12 A: No?

13 Q: The SSEPs wouldn't be affected by --

14 A: Right.

15 Q: -- the paralytics?

16 A: Right. No, I did not.

17 Q: No drift? Things are just rocking along. Okay? As a
18 lay term?

19 A: Yes.

20 Q: Things are normal. Would that be a fair way to
21 characterize it?

22 A: Yes.

23 Q: And all of a sudden, they just -- they just quit working?

24 A: Yes.

25 Q: And you notified Dr. Holbrook?

1 A: I did.

2 Q: And then your -- your responsibility at that point is to
3 check your equipment?

4 A: Yes.

5 Q: And you did that?

6 A: Yes.

7 Q: And that takes some period of time?

8 A: Yes.

9 Q: How long does that usually take?

10 A: It can take a few minutes, up to 15 minutes, because once
11 we check something, we've got to run back over to the
12 equipment, run some tests, run some signals, see if anything's
13 come back, and then if that doesn't work, check something
14 else. And most of the time you can check stuff
15 simultaneously, like, again, the positioning, the electrodes
16 and the hookup and whatnot, and then try to run a couple more.
17 It's just a process to -- to go through the checklist.

18 Q: Sure. And you're trained in doing that checklist, aren't
19 you?

20 A: Yes.

21 Q: Because sometimes the machine doesn't work properly and
22 no fault of yours?

23 A: Correct.

24 Q: That -- that happens sometimes?

25 A: Yes.

TERESA ADKINS - CROSS BY MR. DAVIS

1 Q: Machines don't always work a hundred percent, any
2 machine, including neuromonitoring machines?

3 A: Yes.

4 Q: All right. Now, your training to become a neuromonitor
5 tech I believe you told us in your deposition is a one-week
6 course in Maryland; is that right? And then a -- then a two-
7 week course for trainees; is that -- is that correct?

8 A: When I started, we had most of the on-the-job training
9 shadowing with a senior clinician. And then we were -- my
10 training, I was sent up to our corporate office at the time
11 with Carolina Surgical Monitoring Services to do a week of
12 classroom training with the educators up there and then come
13 back and do some more shadowing. And then they would have a
14 week here and there that we would go up for training for more
15 extensive training.

16 Q: Kind of orienting to your new job?

17 A: Yes.

18 Q: All right. And you're not -- you haven't been to medical
19 school?

20 A: No.

21 Q: Okay. You're not claiming any expertise in neurosurgery
22 or medicine?

23 A: Correct.

24 Q: Okay. So when a signal is lost, the SSEP signals, the
25 sensory signals in this case that were lost when they suddenly

1 stopped working, it's an alert; correct?

2 A: Yes.

3 Q: Would that be the right way to characterize it?

4 A: Yes.

5 Q: All right. And that's when you let the surgeon know to
6 give them sort of a heads up and to let them know that you've
7 lost signal and let them know that you need to check
8 everything, as you just talked about, and see if it's good on
9 your end; right?

10 A: Yes.

11 Q: Okay. And you did that?

12 A: Yes.

13 Q: All right. And that can take up to 15 minutes?

14 A: It can.

15 Q: How long did it take in this case, if you remember? It
16 was a long time ago.

17 A: It -- I don't remember.

18 Q: Okay. That's fine. What you do is you check the
19 electrodes and everything, and if all that's good, then you
20 continue from there, and you let the surgeon know that it's
21 not on your end whenever that process of yours is done, your
22 checklist; is that right?

23 A: Yes.

24 Q: All right. And so you're trained -- what you're trained
25 to do is to check the electrodes and make sure that it's not a

1 technical change or problem with the equipment?

2 A: Yes.

3 Q: And you would agree that anesthesia also plays a factor
4 in it?

5 A: Yes.

6 Q: Okay. As well as positioning of the patient can affect
7 the signal?

8 A: Yes.

9 Q: Okay. So you check that as well? You mentioned that?

10 A: Yes.

11 Q: All right. All right. So for you, step one, when the
12 signal just drops out like it did in this case in the surgery,
13 let the surgeon know?

14 A: Yes.

15 Q: And you did that?

16 A: I did.

17 Q: In your deposition -- and I'm happy to let you look at
18 page 40 of your deposition if you want to refresh your memory.
19 It was some time ago that you were deposed in this case.

20 I need that Kleenex now. Thank you very much. Sorry.
21 Excuse me.

22 See page 40, line 23? Do you recall that Dr. Holbrook
23 said okay after you told him the signals had been lost? Is
24 that correct?

25 A: Yes.

TERESA ADKINS - CROSS BY MR. DAVIS

1 Q: All right. And you told him that you lost the lower
2 SSEPs bilaterally, both sides, both legs, and then he
3 acknowledged and said okay. And then you told him that you
4 had -- that you had checked the electrodes and the patient's
5 positioning and you checked with anesthesia yourself; true?

6 A: Yes.

7 Q: And according to the documentation that you've generated
8 as a neuromonitoring tech in the operating room, you
9 documented that Dr. Holbrook told you that he had -- he was
10 not around the spinal cord when those lower signals were
11 reported to be lost; true?

12 A: Yes.

13 Q: All right. You mentioned a moment ago, ma'am, about that
14 blood pressure. We'll look at it in a little more detail in
15 your chat log, but in your records, is it 103 over 64?

16 A: Yes.

17 Q: All right. Do you know how to calculate a mean arterial
18 pressure? If you don't, that's fine. I'm just asking you.

19 A: I don't remember.

20 Q: You used to know at one time?

21 A: Right.

22 Q: Okay. Well, I'll ask you to assume that that's an MAP of
23 77. We'll just assume that for the sake of the question.

24 Q: Yeah. They usually have it next to the blood pressure on
25 the monitor. So --

TERESA ADKINS - CROSS BY MR. DAVIS

1 Q: And that -- you called that -- you got that blood -- that
2 one blood pressure that was put in the record at 9:58:17 that
3 we recorded that, you got that from the anesthesia monitor?

4 A: Yes.

5 Q: That's monitors the anesthesia looks at; correct?

6 A: Yes.

7 Q: All right. Do you know what the blood pressure was for a
8 minute prior to that time?

9 A: I don't know.

10 Q: Do you know where it was 30 seconds prior to that time?

11 A: I don't.

12 Q: Do you know where it was 30 seconds to a minute after
13 that specific time?

14 A: No, sir.

15 Q: Okay. Now, your job is not to monitor the vital signs
16 and the blood pressure; right?

17 A: Right.

18 Q: Okay. It's not your job to look at, monitor, and
19 interpret the entitled CO2 monitor that the anesthesia has in
20 front of him, do you?

21 A: Right.

22 Q: And you don't -- it's not your responsibility to look at
23 the oxygen saturation monitor the anesthesiologist has in
24 front of him or her and look at and interpret the waveform and
25 the significance or meaning of that; isn't that true?

1 A: Correct.

2 Q: And if the anesthesiologist is monitoring all those
3 things going on and other things, whatever he or she is
4 monitoring, it would also include blood pressure, wouldn't it?

5 A: Yes.

6 Q: You're familiar with that, and they also measure the
7 pulse rate?

8 A: Yes.

9 Q: All right. Did you note the pulse rate at any time as to
10 whether it was normal or abnormal in the 9:55 to 10:05 time
11 frame?

12 A: No.

13 Q: Okay. Did you ever note any abnormal high or abnormal
14 low pulse rate at any time during the surgery?

15 A: No. I wouldn't have been looking at the pulse rate.

16 Q: Okay. Fair enough. That a CRNA is a certified
17 registered nurse anesthetist. Do you understand that?

18 A: Yes.

19 Q: All right. And that nurse has specialty training in
20 being able to monitor anesthesia and monitor a patient with
21 all these different things going on in the operating room;
22 correct?

23 A: Yes.

24 Q: All right. And an M.D. anesthesia can do the same thing,
25 obviously?

1 A: Yes.

2 Q: All right. Did you ever hear Erich Starn, the CRNA in
3 the operating room at that time, ever call out and say the
4 blood pressure is low --

5 A: I don't remember.

6 Q: -- at any time?

7 A: No, I don't remember. No.

8 Q: Did you ever recall when you announced the signal was
9 lost and Mr. Starn would have heard you say that it's yellow,
10 pretty close together --

11 A: Right.

12 Q: -- and operating; right?

13 A: Yes.

14 Q: Did you ever hear Mr. Starn say, well, I need to call Dr.
15 Root, the M.D. anesthesia? Did you ever hear him do that?

16 A: I don't remember. I didn't hear it.

17 Q: Okay. And you agree that it's -- it is a CRNA's job to
18 communicate with the anesthesiologist; correct?

19 A: Yes.

20 Q: Looking at -- do you still have Exhibit 15 in front of
21 you, ma'am?

22 A: What is that?

23 Q: It's -- it's your -- it's -- it's Specialty Care.

24 A: Okay.

25 Q: Yes, ma'am.

1 A: Yes.

2 Q: It's got a little yellow sticker that says 15 on it.

3 Okay. If you would look -- I know the writing is really

4 small, but I'm going to try to read it. If you'll look at

5 0054? Do you see that page? It's part of the chat log. It

6 would be in the back of that document. Can you discern that?

7 All right. Are you on that page, ma'am?

8 A: I think so.

9 Q: Okay. Do you see on the little lower right-hand side
10 there's a -- there's a red 53?

11 A: Okay. Yes.

12 Q: And then there's a black 0054 page number?

13 A: Yes.

14 Q: All right. Thank you. If you would look with me at the
15 time that's documented on this document as 8:58:20, and we
16 know in your time in the operating room time it's 9:58:20; is
17 that right?

18 A: Yes.

19 Q: Okay. So at 9:58:20, you're documenting SSEPs stable at
20 this time; is that right?

21 A: Yes.

22 Q: Okay. And then the little chat right above that,
23 chatting between you and Dr. Gregg, the M.D. neurologist, he
24 responds or says, agree, thanks, just a few seconds later; is
25 that right?

1 A: Yes.

2 Q: All right. So is he able to see what you're seeing on
3 the waveforms?

4 A: He is.

5 Q: Okay. So he agreed with you stable?

6 A: Yes.

7 Q: All right. At 10:01:47. All right?

8 A: I think 8:01.

9 Q: Excuse me. 9:01 would be 10:01.

10 A: 10:01. Okay.

11 Q: I'm sorry. We're going to have to keep adjusting to
12 Eastern -- Eastern time. So I know it's hard. It is for me.
13 And looking back, if you would flip back to page 0036 or red
14 page 35, either one of those if it would help you. Let me
15 know when you're there.

16 A: Okay.

17 Q: This is what you were asked a moment ago, and it's right
18 sort of in the middle of the page between those two boxes,
19 09:56:18, and that's in -- that's in your time, operating room
20 time; correct?

21 A: Yes.

22 Q: Okay. BP 103 over 64. Did I read that correctly?

23 A: Yes.

24 Q: All right. And you've told us that you got that from the
25 anesthesia blood pressure monitor?

1 A: Yes.

2 Q: All right. And looking back at -- flipping back to page
3 54 again that we were just looking at, your chat log, less
4 than two minutes after that is when you document SSEPs stable
5 at this time. And about several seconds later, that's when
6 Dr. Gregg says, yeah, I'm seeing that basically, and I agree.
7 Thanks. Did I read that correctly?

8 A: Yes.

9 Q: Then you go up two entries on page 54 to 10:02:48?

10 A: Yes.

11 Q: Just lost lower SSEPs; correct?

12 A: Yes.

13 Q: And about three minutes later, at 10:05, surgeon informed
14 and aware?

15 A: Yes.

16 Q: Did I read that correctly? Okay.

17 A: Uh-huh.

18 Q: At 10:07:36, going up a few entries, Dr. Gregg is -- I
19 don't know if it's chatting or texting. I'm not sure what
20 term I should use.

21 A: Chatting.

22 Q: Chatting? Okay. Thank you. All right. He says to you
23 what happened to the lowers, and that's -- that's referring to
24 lower SSEPs; right?

25 A: Yes.

TERESA ADKINS - CROSS BY MR. DAVIS

1 Q: Okay. And just a few seconds later, you say IDK. Is
2 that for I don't know?

3 A: Yes.

4 Q: I don't know. It was just in and then it went out. Did
5 I read that correctly?

6 A: Yes.

7 Q: All right. If you'll look with me, please, ma'am, at
8 page red 52, black page 53. This is -- I wish they were all
9 the same page number. It would be helpful, wouldn't it? If
10 you would look with me at Dr. Gregg's chat, beginning at --
11 I'm going to read the -- the time on -- on the log and then
12 we'll translate to -- to the operating time. Okay?

13 A: Okay.

14 Q: 9:27:39. So that would be 10:27:39 in your time; is that
15 right? Do you see there where Dr. Gregg says surgeon knows
16 what we have, question mark?

17 A: Yes.

18 Q: And right just several seconds later, do you respond to
19 him, yes, he -- I just reported that the lowers remain out,
20 and he said they were nowhere near the cord when the loss was
21 reported. Did I read that correctly?

22 A: Yes.

23 Q: All right. Thank you. So, essentially, according to
24 your records, at 9:58 a.m. in the operating room, Mrs. Goodwin
25 had full signal to her lower extremities and the sensors in

1 the SSEPs; is that right?

2 A: Did you say 9:57?

3 Q: At 9:58 a.m. I think we just looked at that, but I'm
4 happy for you to look at it again.

5 A: What did he say?

6 Q: Great question. Let me find it for you. See if I can.
7 It's red page 53, black page 0054.

8 A: Okay. What was the question again?

9 Q: Yeah. Okay. Thank you. Essentially, at 9:58, Mrs.
10 Goodwin had full signal to her lower extremities in the SSEPs?

11 A: Yes.

12 Q: Okay. At 10:03, your report says U plus L SSEPs, loss of
13 bilateral SSEPs reported. Surgeon acknowledged. What is U
14 plus L SSEPs? What's that?

15 A: Upper and lower.

16 Q: Upper and lower? Okay.

17 A: Oh, I believe it says it's the screenshot.

18 Q: Yeah.

19 A: The screenshot. It shows upper and lower. So U and L.

20 Q: Okay. That's what the U and L stands for.

21 A: And the comment is what I typed in.

22 Q: Thank you. Thank you very much. Regarding the --
23 regarding the Stagnara wake-up test you were asked about, Ms.
24 Adkins --

25 A: Yes.

TERESA ADKINS - CROSS BY MR. DAVIS

- 1 Q: Would you agree with me that when that's done, that's
2 almost always in the context of scoliosis surgeries, ma'am?
- 3 A: In my experience, I've only witnessed those in scoliosis
4 procedures.
- 5 Q: Right. Where they're manipulating the spine?
- 6 A: Yes.
- 7 Q: There's a deformity they're trying to correct?
- 8 A: Yes.
- 9 Q: Thank you. This wasn't a scoliosis surgery, was it?
- 10 A: No.
- 11 Q: Okay. I believe the protocol that you were asked about,
12 about steroids and increasing blood pressure, that you have
13 seen from time to time in the operating room; is that right?
- 14 A: Yes.
- 15 Q: Do you know what the blood pressures were when those
16 steroids and blood pressure -- excuse me -- was increased?
17 What were the blood pressures running?
- 18 A: I wouldn't remember. I don't remember that.
- 19 Q: Okay. If they were very, very low, you would expect
20 something to happen, wouldn't you?
- 21 A: Yes.
- 22 Q: You would expect the anesthesiologist who's monitoring
23 the blood pressure to raise the blood pressure, wouldn't you?
- 24 A: Yes.
- 25 Q: And it would be the judgment of the anesthesiologist or

TERESA ADKINS - CROSS BY MR. DAVIS

1 the CRNA, whoever is there as an anesthesia team in the room,
2 when something happens and the blood pressure is really low to
3 do something? When there's a loss of signal that may be
4 associated with a really low blood pressure, you would expect
5 the anesthesiologist, in your experience as a neuromonitoring
6 tech, in the O.R. in those situations to --

7 MR. GOINGS: Your Honor, I object to the questions
8 outside the scope of this witness's knowledge. He's asking
9 the job of a CNRA or a job of a anesthesiologist.

10 THE COURT: He's not. Overruled.

11 MR. DAVIS: Thank you, Your Honor. Okay. Let me try to
12 start over. See if I can make this in order. It's kind of a
13 long question. I probably would have objected too.

14 BY MR. DAVIS:

15 Q: Ms. Adkins, when you have seen this protocol that you
16 were asked about by the plaintiffs' counsel some time ago,
17 giving steroids, increase the blood pressure, first of all,
18 you can't remember in those times that you're thinking about
19 what the blood pressures were when they had to increase it;
20 correct?

21 A: Correct.

22 Q: Would you expect the anesthesiologist -- as a
23 neuromonitoring tech being familiar with that protocol, if the
24 blood pressure was really low and you lost signal, you'd
25 expect them to raise the blood pressure, wouldn't you?

1 A: Yes.

2 Q: Okay. As far as the -- the wake-up test, in this case,
3 obviously, it was not done. We're not saying that it was.
4 Would you agree, ma'am, that that would be within the area of
5 responsibility to make that decision -- that would be the area
6 of responsibility of the neurosurgeon, that he's going to wake
7 the patient up in the operating room while her back is open
8 and she's lying prone? That's his call; right?

9 A: Yes.

10 Q: Right. And it would -- would you agree that your
11 understanding as a -- as a well-qualified and very experienced
12 neuromonitoring tech, that it would necessarily be the surgeon
13 to weigh the benefits and the risks of doing that in the
14 operating room, or whether to proceed to close and get her to
15 the PACU, wake her up, and then get definitive MRI testing?
16 That's all within his area of expertise?

17 MR. GOINGS: Your Honor, now he's asking the standard of
18 care for neurosurgery.

19 THE COURT: Sustained.

20 BY MR. DAVIS:

21 Q: Is it your responsibility, ma'am, to decide if the
22 patient should be woken up at any particular time?

23 A: No, it's not.

24 Q: All right. Thank you. When something like what happened
25 in this case, when the SSEPs just go out very, very suddenly

TERESA ADKINS - CROSS BY MR. DAVIS

1 without any warning, no drift, that just like somebody would
2 flip the switch; right?

3 A: Yes.

4 Q: When something like that happens in the operating room,
5 as it did in this case, you don't make -- you don't make
6 recommendations to the doctors of what they should do or
7 should not do; fair?

8 A: Yes.

9 Q: All right. And in fact, it's the neurologist, Dr. Gregg?

10 A: Yes.

11 Q: Herb Gregg, is that --

12 A: Herb Gregg.

13 Q: Okay. Have you ever met him?

14 A: I have not.

15 Q: Okay. Dr. Gregg, who you're chatting with back and forth
16 during your work, collaborating, you're both seeing the same
17 thing and chatting back and forth in the records; right?

18 A: Yes.

19 Q: The doctor, the neurologist, Dr. Gregg in this case, he
20 would be the one who makes any recommendations; true?

21 A: Yes.

22 Q: In this case, Dr. Gregg did not make any recommendations
23 to anybody -- excuse me -- to any doctor in the operating
24 room, did he?

25 A: No.

TERESA ADKINS - CROSS BY MR. DAVIS

1 Q: In fact, your training tells you that the neurologist,
2 Dr. Gregg in this case, would give the recommendations about
3 any protocol based on the findings of the neuromonitoring he's
4 looking at; true?

5 A: Yes.

6 Q: And again, Dr. Gregg did not make any recommendations to
7 anybody about anything, did he? And I'm not saying that was
8 right or wrong. I mean, he didn't; right?

9 A: I don't remember.

10 Q: Okay.

11 A: I didn't see.

12 Q: All right. Can you explain some to the jury based on
13 your training and experience what the specialty of a medical
14 doctor that specializes in neurology -- what -- what -- what
15 he is, kind of what his specialty is about? What's neurology
16 about?

17 MR. GOINGS: Same objection, Your Honor.

18 THE COURT: Sustained.

19 BY MR. DAVIS:

20 Q: Was Dr. Gregg employed by Specialty Care that day as you
21 were?

22 A: Yes.

23 Q: Okay. And you agree that Dr. Gregg would have access to
24 the information in this chat log and your monitoring of the
25 signals during the course of this surgery; correct?

1 A: Yes.

2 Q: He can view your screen and you can both communicate with
3 each other in real time online?

4 A: Yes.

5 Q: So he can see all the blood pressures that you're
6 reporting to him; correct?

7 A: Yes.

8 Q: I may have missed some, but in looking through your
9 record, I think I only saw two, maybe three blood pressures in
10 the four-hour surgery that you -- that you documented. Would
11 that be about fair?

12 A: I think so, yes.

13 Q: Okay. And are you familiar with anesthesia records?

14 A: Yes.

15 Q: And you know that the anesthesiologist or the CRNA
16 documents blood pressures and pulse every five minutes in
17 those little grid lines. Are you familiar with that?

18 A: Yes. I didn't know they were five minutes, though.

19 Q: Okay. At no time in the surgery did Dr. Gregg ever pick
20 up the telephone and call you or call anyone else in the
21 operating room, including Dr. Holbrook or the
22 anesthesiologist; true?

23 A: True.

24 Q: Okay. Would you agree that Dr. Gregg would have had the
25 -- had availability -- if he needed to reach a doctor or if he

TERESA ADKINS - CROSS BY MR. DAVIS

1 needed to communicate directly with the doctor, he had that
2 ability?

3 A: Yes.

4 Q: You don't know if Dr. Gregg did anything whatsoever to
5 try to determine, investigate, troubleshoot, or determine why
6 her signals went out; right?

7 MR. GOINGS: Outside of the scope of this witness's
8 testimony about what somebody else knows. Objection.

9 THE COURT: Overruled.

10 BY MR. DAVIS:

11 Q: So you want me to repeat the question?

12 A: Yes.

13 Q: You don't know if Dr. Gregg did anything whatsoever to
14 try to determine, investigate, or troubleshoot to determine
15 why her SSEP signals suddenly went out?

16 A: I don't know.

17 Q: You don't remember if Dr. Gregg said anything about what
18 he was doing or if he was doing anything, do you?

19 A: I don't remember.

20 Q: You don't remember seeing him take any action to try to
21 determine what happened; correct?

22 A: Correct.

23 Q: Do you remember Dr. Holbrook when the signals were lost
24 and you notified him about it that it was not your machine, he
25 did seem concerned to you, didn't he?

1 A: Yes.

2 Q: And you would leave it up to the surgeon, in this case
3 Dr. Holbrook, as to what action, if any, to take when the
4 signals go out?

5 A: Yes.

6 Q: You agree that you can't see -- I mean, where you're
7 positioned in the operating room and what you're doing, the
8 things you're looking at, you can't see into the surgical
9 field, can you?

10 A: Correct.

11 Q: You can't see what he's doing with his instrumentation?

12 A: Correct.

13 Q: Is that fair?

14 A: Yes.

15 Q: Okay. You can't see whether he's near the cord or not
16 near the cord, can you?

17 A: No, I cannot.

18 Q: All right. It's the responsibility of Dr. Holbrook in
19 his judgment as a board-certified, trained, and experienced
20 neurosurgeon who's actually performing this operation to
21 decide how to respond when a signal goes out. Do you agree
22 with that?

23 A: Yes.

24 Q: Are you aware in your years of work as a neuromonitoring
25 tech in an operating room in spine surgery cases or in any

TERESA ADKINS - CROSS BY MR. DAVIS

1 case really where you're doing neuromonitoring, that the blood
2 pressure of a patient -- any patient in the operating room
3 under anesthesia fluctuates? It doesn't just stay the same
4 all the time; right?

5 A: Correct.

6 Q: You know that and you're not here to testify as to what
7 caused the neurologic injury to Mrs. Goodwin, are you?

8 A: Correct.

9 MR. DAVIS: One moment, please, Your Honor.

10 THE COURT: Yes, sir.

11 MR. DAVIS: Thank you.

12 Ms. Adkins, thank you very much for your patience with me
13 today. Nothing further.

14 THE COURT: Any redirect?

15 MR. GOINGS: I just need to clarify one or two things,
16 Your Honor.

17 THE COURT: Yes, sir.

18 REDIRECT EXAMINATION

19 BY MR. GOINGS:

20 Q: You know and have heard and have seen the Stagnara wake-
21 up test; right?

22 A: Yes.

23 Q: Okay. And you're not a medical doctor, but you know
24 about it; correct?

25 A: Yes.

1 Q: Okay. Now, I do want to clarify an implication that was
2 made. When opposing counsel came and started asking you
3 questions, he pejoratively said, well, you know, all these
4 people over here, you've never met me. Do you remember when
5 you were deposed? You were asked questions by all parties,
6 including Mr. Davis's associate, Andrew, weren't you?

7 A: Yeah. I don't remember, but yes, they were there. I'd
8 say yes.

9 Q: Yes. Then the defense deposed you as well; correct?

10 A: Yes.

11 Q: Okay. Now, do you remember him saying you were standing
12 out in the hall talking to all these people that you know? Do
13 you remember that?

14 A: I mean, we were just seeing what time I need to be in
15 here.

16 Q: Right. Because you told me tomorrow you're not going to
17 be available. So you wanted me to make sure you went up this
18 afternoon; right?

19 A: Yes.

20 Q: Okay. I've never once spoke to you about this case, have
21 I?

22 A: No.

23 Q: I've never once told you what to say or what to think
24 happened?

25 A: Right.

TERESA ADKINS - REDIRECT BY MR. GOINGS

1 Q: Okay. So when we were talking out there for probably
2 five seconds, that was when you asked me could you take me
3 today because I can't come tomorrow to trial?

4 A: Yes.

5 Q: Okay.

6 MR. GOINGS: Nothing further, Your Honor.

7 THE COURT: Anything further from this witness?

8 MR. DAVIS: No.

9 THE COURT: All right. Thank you, Ms. Adkins. You may
10 step down.

11 MR. DAVIS: I'm happy to have her be released.

12 MR. GOINGS: May she be excused from her subpoena?

13 MR. DAVIS: Yeah.

14 THE COURT: Absolutely. You're free to go.

15 THE WITNESS: Thank you.

16 THE COURT: All right. Let's call it a day, ladies and
17 gentlemen. 9:30 tomorrow morning. Please don't discuss the
18 case. Don't do any research about the case. Have a good
19 night.

20 (WHEREUPON, the jury exited the courtroom at 5:53 p.m.)

21 (WHEREUPON, the proceedings adjourned for the day.)

22

23 --- CONTINUED IN VOLUME IV ---

24

25

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 4 OF 9 - VOLUME IV
	)	April 13, 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 13, 2023

2 (WHEREUPON, the proceedings resumed at 9:37 a.m.)

3 THE COURT: Good morning, everybody. Are we ready to
4 begin for the day?

5 MR. HINSON: Yes, Your Honor. My witness did just step
6 out. Our first witness did just step out to the bathroom.

7 THE COURT: Okay.

8 MR. HINSON: But -- but just a quick, I guess,
9 housekeeping matter. We had one exhibit that we'd like to
10 move in by stipulation. It's Exhibit 21, which is the
11 surgical case attendee form.

12 THE COURT: Is that correct, Mr. Davis? Okay?

13 MR. DAVIS: Yes, ma'am.

14 THE COURT: Okay.

15 (WHEREUPON, Plaintiffs' Exhibit Number 21, surgical case
16 attendee form, was admitted into evidence.)

17 MR. HINSON: And I would -- I just wanted to bring to the
18 Court's attention one little issue we may have with the
19 records. It just -- it just popped up last night as I looked
20 at it.

21 The patient's age is stated on these records, but the age
22 that's stated depends on when Prisma and Monty Todd printed
23 them off. So it appears that she was -- in some of the
24 records she was 39 years old at the time of surgery. Some of
25 them she was 41 years old at the time of surgery, depending on

1 when they were produced.

2 So, Your Honor, I just wanted to bring that to the
3 Court's attention. So for instance, right there, it says
4 patient age, 41 years. That's incorrect. She was 38. I have
5 redacted it out of what we're going to put up, because I
6 thought it was confusing to the jury. Mr. Davis agreed with
7 that redaction, as I understood it.

8 THE COURT: Yes? He's nodding yes.

9 MR. DAVIS: Let me save my voice.

10 THE COURT: I understand. I'm hoping you're going to be
11 able to make it through this trial, because you seem to be
12 fading, you know, day by day.

13 MR. HINSON: And, Your Honor, at some point before all
14 these exhibits go back to the jury, we just need to make sure
15 that we don't need to correct that on any of the other ones,
16 because I'm afraid it may exist on a few other ones, because,
17 again, the printed date, somehow -- I've never seen that
18 happen in the record. Usually, it states the age at the time
19 of treatment, but somehow it's the age at the time of
20 printing. So we can -- but we'll get that addressed before
21 it's all said and done.

22 THE COURT: Okay. Anything else?

23 Yes, Ms. Gooding?

24 MS. GOODING: Just briefly, Your Honor. We have our
25 first three witnesses today. All have to be done by 3

1 o'clock. And so, obviously, I understand that's mostly on us,
2 and we're going to do our best. Just wanted to apprise the
3 Court that that's kind of our schedule today.

4 THE COURT: Okay. Very good.

5 MS. GOODING: Thank you, Judge.

6 THE COURT: Okay.

7 MR. HINSON: Hopefully, our witness will be back from the
8 restroom very shortly.

9 THE COURT: Okay.

10 MR. GOINGS: And, Judge, just to forecast -- sorry, we're
11 all standing up, but just to forecast for you, for planning
12 purposes, I know that you appreciate that.

13 Yesterday afternoon, Ashby advised us that two of his
14 experts would not be available to testify next week. And we
15 agreed that we don't have a problem with the Court taking
16 those two witnesses out of order in the sense that they are
17 available tomorrow, he said, and we consented to -- to that.

18 At -- at 9:30 or whenever we begin, Mr. Davis is going to
19 call his first of his two experts. I'm just telling you that
20 because I know you -- it's always good for you to kind of know
21 where things are. So -- so that we do not have an objection
22 to it, and we will consent to it to accommodate them.

23 THE COURT: Understood.

24 MR. GOINGS: It's not ideal for us, but we understand
25 that playing well in the sandbox goes a long ways for

1 everybody.

2 THE COURT: Absolutely. Yes?

3 MR. DAVIS: And, Judge, obviously, it's not ideal for us
4 either. We try to plan these things as best we can. We sort
5 of anticipated that that might be the case, and we're just
6 going to go out there and stick it out. We very much
7 appreciate Mr. Goings conceding that. Thank you.

8 THE COURT: Yes, sir.

9 MR. HINSON: Your Honor, our witness -- it looks like
10 we're ready to proceed.

11 THE COURT: All right. Bring the jury, please.

12 (WHEREUPON, the jury entered the courtroom at 9:43 a.m.)

13 THE BAILIFF: The jury is seated, Your Honor.

14 THE COURT: Thank you.

15 Good morning, ladies and gentlemen.

16 THE JURORS: Good morning.

17 THE COURT: I hope you are rested and refreshed and ready
18 for another day to listen to testimony. We're still in the
19 plaintiffs' case. They are prepared to call their next
20 witness.

21 MR. HINSON: Your Honor, the Court -- the Court? The
22 plaintiff calls Sunny Jumper.

23 THE BAILIFF: If you'll put your left hand on the Bible
24 and face her and raise your right hand.

25 THE CLERK: Do you solemnly swear or affirm that the

SUNNY JUMPER - DIRECT BY MR. HINSON

1 testimony you're about to give in this case will be the truth,
2 the whole truth, and nothing but the truth, so help you God?

3 THE WITNESS: I do.

4 THE CLERK: Please state your full name for the record.

5 THE WITNESS: Sunny Larine Jumper.

6 THE CLERK: You may have a seat.

7 THE WITNESS: Thank you.

8 THE BAILIFF: Speak in the mic.

9 THE WITNESS: Thank you.

10 SUNNY JUMPER, being first duly
11 sworn, testified as follows:

12 DIRECT EXAMINATION

13 BY MR. HINSON:

14 Q: Good morning, Ms. Jumper.

15 A: Good morning.

16 Q: Would you please state your full name?

17 A: Sunny Larine Jumper.

18 Q: Ms. Jumper, how is it that you came to be in the
19 courtroom today?

20 A: I was subpoenaed.

21 Q: Ms. Jumper, if you would, just tell us just a little bit
22 about yourself. Where are you from? Where did you grow up?

23 A: I'm originally from Swansea, South Carolina. I graduated
24 there, and my son and I just moved to Gilbert back in 2020. I
25 have a 14-year-old who plays JV soccer for Gilbert High

1 School. I've been a surgical tech now for ten years.

2 Q: You anticipated my next question, Ms. Jumper. What do
3 you do for a living? You said you're a surgical tech. What
4 is -- what is a surgical tech?

5 A: Basically, what a surgical tech is, is it's somebody who
6 gathers all the supplies and sets up for each surgery. It's
7 our job to know the ins and outs of every surgery that we do,
8 the routines of every surgeon that we work with. So we
9 basically are there from beginning to end, assisting and
10 handing the surgeon what he needs for each surgery.

11 Q: And tell us about your education and training you had to
12 complete in order to be a surgical technician?

13 A: There's a program at Midlands Tech. So I did my
14 associate's in applied health science, and I got my diploma in
15 surgical technology back in 2013.

16 Q: Are there any tests or certifications you have to do in
17 order to be a surgical technologist?

18 A: Yes. NBSTA does a certification test for our initial
19 certification, and then every two years, we have to do 30
20 continuing education credits to renew our certification and
21 keep it active.

22 Q: What does that mean, continuing education credits?

23 A: Just different tests, different activities, different
24 tests, different courses, and stuff that we take over the two
25 years to recertify every year just to kind of keep us updated

1 in what we do.

2 Q: Are you currently certified?

3 A: I am.

4 Q: And have you been continuously certified since what year?

5 I'm sorry. What year was it you first became certified?

6 A: 2013.

7 Q: Have you been continuously certified for the last ten
8 years?

9 A: Yes.

10 Q: And every time you've had to take a test or a
11 certification, did you pass on the first try?

12 A: Yes.

13 Q: And in those -- in that decade, Ms. Jumper, this may be
14 kind of hard to estimate, but to your best estimate, how many
15 surgeries have you participated in as a surgical technician?

16 A: Wow. A thousand or more.

17 MR. HINSON: Your Honor, we would move to qualify Ms.
18 Jumper as an expert in the field of surgical technology.

19 MR. HEITMAN: No objection.

20 THE COURT: All right. Ladies and gentlemen, I'll just
21 remind you that witnesses -- expert witnesses are permitted to
22 give opinion testimony, unlike other witnesses, and the
23 reasons for their opinions within the field of -- within their
24 field of expertise.

25 Ms. Jumper is qualified as an expert in the field of

SUNNY JUMPER - DIRECT BY MR. HINSON

1 surgical technology and will be permitted to give you opinion
2 testimony within the field of surgical technology. Give her
3 testimony the weight and credibility you think it deserves,
4 just like any other witness.

5 You may proceed.

6 MR. HINSON: Thank you, Your Honor.

7 BY MR. HINSON:

8 Q: Ms. Jumper, you aren't a neurosurgeon; is that correct?

9 A: Correct.

10 Q: But in your experience working in operating -- well, let
11 me ask this. You said you'd been in -- I think you estimated
12 how many surgeries?

13 A: Close to a thousand, maybe more.

14 Q: And is there a particular type of operation that you tend
15 to assist with or concentrate your work in more than other
16 types?

17 A: Orthopedics and neuro is my specialty.

18 Q: Okay. So you do that more than GYN surgeries or ear,
19 nose, and throat surgeries?

20 A: Yes.

21 Q: Okay. And in all those surgeries that you have been
22 involved in, spine and back surgeries, head surgeries,
23 neurologic surgeries, have you -- and I'm not asking you if
24 you performed it, but have you had the occasion to see
25 something called the Stagnara wake-up test performed?

1 A: Yes.

2 Q: And so you've seen that within the last ten years?

3 A: Yes.

4 Q: It's not some archaic thing?

5 A: No.

6 Q: In the approximately thousand surgeries you've been

7 involved in, have you been involved with some involving Dr.

8 Holbrook, Dr. Thomas Holbrook?

9 A: Yes.

10 Q: Again, I know it's probably not an exact number, but how

11 many would you estimate you've been involved with Dr.

12 Holbrook?

13 A: Fifteen to 20, maybe.

14 Q: How does your experience working with Dr. Holbrook

15 compare generally to experience working with other surgeons?

16 A: He's very fast. He's actually probably one of the

17 fastest neurosurgeons that I've ever worked with. He gets in

18 and gets things done, and he keeps a tight schedule. Dry

19 humor. He's funny, you know.

20 Q: Does -- when you said he likes to keep a tight schedule,

21 what do you mean by that?

22 A: He -- he -- he keeps on track. He likes to keep on

23 track. He likes to keep according to schedule. He likes to

24 get things done and get his day done.

25 Q: So the estimated end time is what he wants to achieve?

1 A: Yes.

2 Q: Ms. Jumper, what is a preoperative timeout or a
3 preoperative conference?

4 A: The preoperative timeout is something that we do before
5 every surgery. It's hospital policy so that we can discuss,
6 make sure the patient is the right patient, right surgical
7 site, to -- to address any concerns, whether there's
8 allergies, there's any hypertension issues, any previous
9 surgeries they may have had. Just it's -- it's for the entire
10 room a broad generalization so that we make sure we've got all
11 of our -- our I's dotted and our T's crossed before we start
12 each surgery.

13 Q: And so who typically would participate in that
14 preoperative conference or preoperative timeout?

15 A: Everybody in the room has their own part of the timeout.

16 Q: So surgeon?

17 A: Yes.

18 Q: Surgical tech?

19 A: Yes.

20 Q: Nurse?

21 A: Yes.

22 Q: Anesthesiology?

23 A: Yes.

24 Q: Both the anesthetist and CRNA?

25 A: Yes.

SUNNY JUMPER - DIRECT BY MR. HINSON

1 Q: In your experience working with Dr. Holbrook from 15 to
2 20 surgeries, did he do surgical timeouts or preoperative
3 conferences?

4 A: No.

5 Q: He skipped that part?

6 A: Yes.

7 Q: Ms. Jumper, we're here today on a case that involves the
8 events of July 28th, 2018, a surgery Dr. Holbrook performed on
9 Ms. Crystal Goodwin. Were you a part of that operation? Were
10 you in the surgical -- the operating room?

11 A: I was. I was the primary scrub on that case.

12 Q: Do you remember that particular surgery?

13 A: I do.

14 MR. HINSON: May I approach the witness, Your Honor?

15 THE COURT: Yes, sir. And, counsel, you need not ask
16 every time you approach the witness.

17 MR. HINSON: Thank you, Your Honor. I appreciate you
18 letting me know.

19 THE COURT: Yes, sir.

20 BY MR. HINSON:

21 Q: Ms. Jumper, I'm going to hand you what's been marked as
22 Plaintiffs' Exhibit 21.

23 MR. HINSON: Pull it up, please, Mr. Goings.

24 BY MR. HINSON:

25 Q: And, Ms. Jumper, just generally, could you tell us what

1 Plaintiff's Exhibit 21 is?

2 A: It's a case attendee list.

3 Q: And what is a case attendee list?

4 A: A case attendee list is -- basically, it's a list of all
5 -- it's the documented times of anybody who comes in and out
6 of the room for surgery, the nurses, the surgical techs,
7 anesthesia, if they're given a break, or any -- anybody who
8 becomes involved with the surgery, it's documented as to what
9 time they came in and what time they came out.

10 Q: Okay. And down here, entry 8, it says Sunny L. Switzer.
11 Who is that?

12 A: That's me. It's my maiden name.

13 Q: And from that document, what time does it indicate you
14 became involved or was in -- were in the operating room and
15 left the operating -- or operating suite?

16 A: Exposure to closure.

17 Q: And tell us what that means, exposure. What does that
18 mean?

19 A: Incision, start of the surgery.

20 Q: And closure?

21 A: Closure means closing the wound up. The surgery is over.

22 Q: So literally sewing up the -- the operating site.

23 A: Yes, from beginning to end.

24 Q: And you don't actually yourself do either of those
25 things?

1 A: I don't, no.

2 Q: Are you able to witness it?

3 A: Yes.

4 Q: Okay. And so if you were there, according to this
5 document, from 7:24 to 11:47, what would that indicate?

6 A: I was there for the entire case.

7 Q: Okay. Thank you, Ms. Jumper. And you, having
8 participated and been involved in a thousand-ish surgeries,
9 why is it that you remember this one?

10 Q: This is kind of a case that sticks with you. You don't
11 really forget it. It just -- it started like any regular
12 laminectomy surgery would start. I mean, we've done tons of
13 them. It's a normal case that we do in the operating room for
14 spines.

15 Q: So you've seen other laminectomies --

16 A: Tons of them.

17 Q: -- before?

18 A: Yes, yes.

19 Q: Please continue. I'm sorry.

20 A: And we -- we started the surgery like normal. We
21 proceeded like normal. Did everything like we normally would
22 for any other surgery. And we use neuromonitoring in our
23 spine cases, and probably halfway through the case maybe,
24 Teresa stopped us to let us know that she had lost the
25 readings to the lower extremities.

SUNNY JUMPER - DIRECT BY MR. HINSON

1 Q: And who is Teresa?

2 A: Oh, I'm sorry. She's the neuromonitoring tech that we
3 have.

4 Q: Okay. And you -- you didn't say the exact time. It was
5 about halfway through?

6 A: Uh-huh.

7 Q: Sorry. Is that a yes?

8 A: Sorry. Yes. I'm sorry. Yes.

9 Q: That's okay, Ms. Jumper.

10 A: Yes.

11 Q: And did Ms. Teresa Adkins -- how did she make it known to
12 you that the signal had been lost to the -- to the lower
13 extremities, the legs?

14 A: She told everyone in the room. She announced it as a
15 loud announcement, like, hey, you guys, stop. We got some
16 issues.

17 Q: Okay. And what happened next to your recollection?

18 A: Dr. Holbrook told her to check her equipment because it
19 wasn't anything that he was doing wrong.

20 Q: Okay.

21 A: Anywhere that he was.

22 Q: And, Ms. Jumper, did you -- I know you aren't the
23 neuromonitoring tech -- technologist, but you observed Ms.
24 Adkins checking her equipment?

25 A: I did.

SUNNY JUMPER - DIRECT BY MR. HINSON

1 Q: And approximately how long would you estimate that took?

2 A: A few minutes to make sure that everything was responding

3 like she needed. Yeah.

4 Q: And how did she -- what did she report back?

5 A: That her equipment was not faulty. That -- that

6 everything was still good to go.

7 Q: And what did you observe Dr. Holbrook say in response?

8 A: That it still was nothing that he was doing. It had to

9 be faulty equipment, faulty lines, reads.

10 Q: And then what happened?

11 A: We proceeded with the surgery.

12 Q: Ms. Jumper, this surgery lasted about four-and-a-half

13 hours; is that right?

14 A: Uh-huh.

15 Q: Is that a yes?

16 A: Oh, yes. I'm sorry.

17 Q: That's quite all right, Ms. Jumper. Having been involved

18 in a thousand surgeries, are you generally familiar with how

19 much urine a person should put out during a surgery?

20 A: Yes. Yeah.

21 Q: Would it surprise you to learn that during this four-and-

22 a-half hour surgery, the patient, Ms. Crystal Goodwin, only

23 put out 80 milliliters of urine?

24 MR. HEITMAN: Objection, Your Honor. That's outside the

25 scope of her expertise.

SUNNY JUMPER - DIRECT BY MR. HINSON

1 THE COURT: Overruled.

2 BY MR. HINSON:

3 Q: You may answer, Ms. Jumper.

4 A: Yes, actually.

5 Q: From your experience being involved in a thousand
6 surgeries approximately, a patient in a four-and-a-half hour
7 surgery, what would generally you'd expect a patient to
8 produce?

9 A: A lot more than that.

10 Q: Okay. Ms. Jumper, did -- getting back to the signal
11 loss, did you observe Dr. Holbrook ever asking anybody to go
12 get the -- well, was the attending anesthesiologist in the
13 room when the signal loss went out?

14 A: No.

15 Q: Did Dr. Holbrook ever instruct someone go get the
16 attending anesthesiologist?

17 A: No.

18 Q: And, Ms. Jumper, by your observation, looking at other
19 folks in the room, I understand they've got masks on, but you
20 can see their eyes; right?

21 A: Yes. Yes.

22 Q: By your observation, what was the response in the room
23 when Dr. Holbrook said, well, your equipment must be
24 malfunctioning, and he proceeded on with the surgery?

25 A: We all just kind of looked at each other like, wow, like

SUNNY JUMPER - DIRECT BY MR. HINSON

1 what the -- what the hell? It was kind of a shock moment.

2 Like, you don't really know what to do.

3 Q: Thank you, Ms. Jumper. Ms. Jumper, I'm going to show you
4 Exhibit 13, which is Dr. Holbrook's operative report. Now,
5 you, in your work, you don't write operative reports; is that
6 correct?

7 A: That's correct, I don't.

8 Q: And -- but do you occasionally see them in your -- in
9 your occasion as a health care provider?

10 A: Yes.

11 Q: Take a look at that operative report, and I want you to
12 take -- take time to look over it. Is there anything that
13 surprises you about it from having participated in this
14 surgery?

15 A: Why are there blanks?

16 Q: You're speaking of these blanks? I'll show you on the
17 screen here.

18 A: Uh-huh.

19 Q: Is that something you typically see in an operative
20 report?

21 A: No.

22 Q: All right. Anything else? Well, let me ask you this.

23 The very bottom of the -- at the very bottom of the report,

24 Ms. Jumper, it says Riley assisted with exposure and closing.

25 Who is Riley?

SUNNY JUMPER - DIRECT BY MR. HINSON

1 A: Mario Riley was the P.A. there.

2 Q: And what's a P.A.?

3 A: So, basically, a P.A. is a physician's assistant.

4 Orthopedics and neuro use them a lot, except for neuro P.A.s
5 only come in when it's time to do wound closure. That's
6 basically what their role is.

7 Q: And in your experience working with Dr. Holbrook, would
8 he typically have his physician's assistant involved with
9 exposure?

10 A: No.

11 Q: What could we look at, Ms. Jumper, to confirm whether or
12 not this sentence is true?

13 A: It would be on the case attendee list.

14 MR. HINSON: Pull up the case attendee list again.

15 BY MR. HINSON:

16 Q: Would you take a look at Exhibit 21, Ms. Jumper?

17 MR. HINSON: Mr. Goings, right here.

18 BY MR. HINSON:

19 Q: What time does the case attendee list indicate that Mario
20 Riley first entered the operating room?

21 A: 10:33.

22 Q: Would that be during the time of exposure or opening?

23 A: No. It would be at the end.

24 Q: So does that case attendee list confirm or jive with your
25 recollection that Mario Riley was not there at the beginning?

SUNNY JUMPER - DIRECT BY MR. HINSON

1 A: He was not there at the beginning, no.

2 Q: So was the last sentence of this operating -- this
3 surgical report that says Mark -- or excuse me -- Riley
4 assisted with exposure and closing; is that truthful and
5 accurate?

6 A: No.

7 MR. HINSON: No further questions at this time, Ms.
8 Jumper. Please answer any questions opposing counsel may
9 have.

10 THE WITNESS: Thank you.

11 THE COURT: Mr. Heitman?

12 MR. HEITMAN: Thank you, Judge. May it please the Court.

13 CROSS-EXAMINATION

14 BY MR. HEITMAN:

15 Q: Ms. Jumper, how many surgeries would you say that you've
16 assisted Dr. Holbrook with?

17 A: About 15 to 20.

18 Q: Okay.

19 A: Give or take.

20 Q: And he had been practicing for over 30 years; is that
21 right?

22 A: I wouldn't know how long he's been practicing.

23 Q: Okay. The only experience you have with neuromonitoring
24 is just what you observe as a surgical tech; is that right?

25 A: Yes.

SUNNY JUMPER - CROSS BY MR. HEITMAN

1 Q: You don't have any training on how to perform
2 neuromonitoring, do you?

3 A: I do not.

4 Q: And you don't have any training on how to interpret
5 neuromonitoring signals either, do you?

6 A: I do not.

7 Q: I believe you stated earlier that the neuromonitoring
8 technician and others in the room appeared to be surprised
9 when Dr. Holbrook said he thought the neuromonitoring
10 equipment was not functioning; is that correct?

11 A: Yes, that's correct.

12 Q: But you didn't actually ask anyone in the room if they
13 were surprised, did you?

14 A: No, I did not ask anyone in the room.

15 Q: That's just what you observed?

16 A: Observed, yes.

17 Q: And you don't know Dr. Holbrook's mental thoughts, what
18 they were on July 28th, 2016, do you?

19 A: No.

20 Q: And you never even talked with Dr. Holbrook during or
21 after the surgery about the loss of SSEP signals; is that
22 true?

23 A: That's true.

24 Q: And you're not a board-certified neurosurgeon; correct?

25 A: I am not.

SUNNY JUMPER - CROSS BY MR. HEITMAN

1 Q: Do you perform decompressive laminectomies?

2 A: I do not.

3 Q: Do you perform surgery of any type?

4 A: I do not.

5 Q: Did you go to medical school?

6 A: I did not.

7 Q: And you actually know plaintiffs' counsel, Mr. Hinson, in
8 this case; correct?

9 A: I do.

10 Q: You all have known each other for over 18 years; right?

11 A: Yeah. We met 18 years ago.

12 Q: How'd you all meet?

13 A: At traffic court.

14 Q: And y'all are even friends on social media; right?

15 A: Just on Facebook, yeah.

16 Q: And you don't have any criticisms with Dr. Holbrook in
17 this case; true?

18 A: True.

19 MR. HEITMAN: I don't have any further questions. Thank
20 you.

21 THE COURT: Any redirect?

22 MR. HINSON: Very briefly, Your Honor.

23 REDIRECT EXAMINATION

24 BY MR. HINSON:

25 Q: Ms. Jumper, you and I met in traffic court about 18 years

1 ago?

2 A: Twenty, probably. Yeah. Yes.

3 Q: We both had a heavy foot?

4 A: Yes. I was lost, and you were carrying documents. And I
5 think you were in law school at the time, and you were. So --

6 Q: Have you ever been to my house?

7 A: No.

8 Q: Have I ever been to your house?

9 A: No.

10 Q: Have you ever met my spouse?

11 A: No.

12 Q: Have I ever met your spouse?

13 A: No.

14 Q: Aside from social media, do we hang out?

15 A: No.

16 MR. HINSON: No further questions, Your Honor.

17 THE COURT: Anything further from this witness?

18 MR. HEITMAN: Nothing further.

19 THE COURT: Okay. Thank you, ma'am. You may step down.

20 THE WITNESS: Thank you. Thank you.

21 MR. HINSON: Your Honor, may Ms. Jumper be released from

22 --

23 THE COURT: Yes, you can be released. Don't take that
24 with you.

25 THE WITNESS: Sorry.

CATHY GRAGG-SMITH - DIRECT BY MS. GOODING

1 MR. HINSON: She may be released from her subpoena?

2 THE COURT: Any objection?

3 MR. HEITMAN: No objection.

4 THE COURT: Yeah. You're free to go, Ms. Jumper. Thank
5 you.

6 THE WITNESS: Thank you.

7 THE COURT: Call your next witness.

8 MS. GOODING: Your Honor, plaintiff calls Ms. Cathy
9 Gragg-Smith to the stand.

10 THE BAILIFF: If you'll place your left hand on the Bible
11 and raise your right.

12 THE CLERK: Do you solemnly swear or affirm that the
13 testimony you're about to give in this case will be the truth,
14 the whole truth, and nothing but the truth, so help you God?

15 THE WITNESS: I do.

16 THE CLERK: Please state your full name for the record.

17 THE WITNESS: Cathy Maria Gragg-Smith.

18 THE CLERK: You may have a seat, please.

19 THE BAILIFF: Remember to speak in the mic.

20 THE WITNESS: Yes, ma'am.

21 CATHY GRAGG-SMITH, being first
22 duly sworn, testified as follows:

23 DIRECT EXAMINATION

24 BY MS. GOODING:

25 Q: Good morning.

1 A: Good morning.

2 Q: Please introduce yourself to the jury?

3 A: Hi, I am Cathy Maria Gragg-Smith. Yes, it's a lot of
4 names. I am a registered nurse in the state of Georgia.

5 Q: Thank you. And what do you do for a living?

6 A: I am a certified life care planner, I am a certified case
7 manager, and I am a certified rehabilitation registered nurse.

8 Q: And do you have your own business at this point?

9 A: I do.

10 Q: Tell us about that?

11 A: It is Smith-Gragg Rehabilitation because the state of
12 Georgia thought that would be funny, but what I do through
13 that business is I provide life care planning services, case
14 management services, and some legal nurse consulting services.

15 Q: So I want to clear this up because it's something that we
16 have found to be confusing. Your name is Cathy Gragg-Smith,
17 but the name of your company is Smith-Gragg Rehabilitation; is
18 that right?

19 A: It is. And there's a short reason for that. In the
20 state of Georgia when you apply for a business license, they
21 request three names for your business, and they get to choose.
22 So when I got my license for my business back, it was -- they
23 chose Smith-Gragg Rehabilitation.

24 Q: It might be best if we just call you Cathy today.

25 A: That would work. I answer to Cathy. Yes, ma'am.

1 Q: Okay. Ms. Cathy, you mentioned three different roles
2 that you play through this company that you've started, and I
3 think they were legal nurse consultant; is that right?

4 A: Yes, ma'am.

5 Q: Nurse case manager and life care planner? And --

6 THE BAILIFF: The jury can't hear back here.

7 MS. GOODING: Please try to speak up and speak into the
8 microphone.

9 THE WITNESS: Okay. Y'all can't hear me?

10 THE COURT: And maybe pull the microphone up a little
11 bit.

12 THE WITNESS: I can do that.

13 THE COURT: Help her, Mr. Goings. Our audio system is
14 terrible.

15 MR. GOINGS: Talk into this thing.

16 THE WITNESS: Okay. Gotcha.

17 THE COURT: Yes. Unless you're right on it, it's hard to
18 hear.

19 THE WITNESS: Thank you.

20 BY MS. GOODING:

21 Q: Tell me about what you do as a legal nurse consultant?

22 A: Okay. I get referred cases from attorneys or community
23 folks. And so what I do when I get referred to cases, I
24 review medical records, look at clinically what happened to
25 this particular individual. And if they're asking me to

1 perform a life care plan, I have to individualize every life
2 care plan.

3 So not every case that comes to me warrants a full-blown
4 life care plan. So a lot of times I call them back and say
5 here's kind of the next steps you need to do, it doesn't
6 warrant a life care plan, and I can help them map out what
7 they need to do next.

8 Q: So in some instances, you might review a case and say
9 this doesn't need a life care plan, and that's kind of your
10 role, and in some instances you look at a case and say this
11 needs a life care plan, and then you actually develop a life
12 care plan?

13 A: Correct.

14 Q: Okay. And then you also mentioned that sometimes you are
15 a nurse case manager. Tell us what a nurse case manager does?

16 A: Gotcha. Currently, I have, I believe, five patients that
17 I actually provide case management in their home. Actually,
18 two are in facilities. And what I do for those people is
19 routinely or episodically I go and see them and see how
20 they're doing with their injury.

21 I have three children, two adults, two are spinal cord
22 injuries, three are brain injuries. And so what I do is go
23 and look at kind of their plan of care, what are we doing. If
24 they're in the home, do they have all the services they need?
25 Are their medications working? Are they seeing their

1 physicians as they need to be seeing their physicians?

2 I also am a go-between between their physicians because a
3 lot of these folks don't understand their injuries long-term,
4 what the sequelae of their injuries can look like, and that's
5 just a big word that means kind of as they age through the
6 process of their injuries, how are they going to change. And
7 so I help smooth those ways with their physicians and go,
8 gosh, you know, you've been on gabapentin for 15 years. It's
9 no longer working. What can we try?

10 So that is my role as a case manager. My goal as a case
11 manager is to get a case to a point where they don't need to
12 see my face so frequently, that they're calling me and I can
13 act as a go-between, but that their cases are calm enough that
14 I can do most of what I do by telephone.

15 Q: As a nurse case manager, do you utilize life care plans?

16 A: I do, and one of the cases that I'm case managing now is
17 a case that I did the life care plan for. But I do have other
18 case managers that I refer for these cases that do refer back
19 to my life care plan. So when that happens, I often have a
20 community case manager reach out to me and go, hey, Cathy, I
21 saw you did the life care plan on this one. Can you tell me
22 what you saw when you were there?

23 And again, I've -- I have a good, good many years'
24 experience with spinal cord injury and brain injury. So I
25 sometimes will liaison with the community case manager even if

1 I'm not the case manager.

2 Q: So the case management is kind of the follow through on
3 the life care plan; is that fair?

4 A: It's fair. Yes, ma'am.

5 Q: Okay. And behind your name, you have a lot of letters.
6 You have RN, CRRN, CCM, and CLCP. Can you just tell us
7 quickly what each of those stands for?

8 A: Sure. RN is registered nurse, CRRN is the Certified
9 Rehabilitation Registered Nurse. CCM is the Certified Case
10 Manager, and CLCP is Certified Life Care Planner.

11 Q: And to become an RN, what kind of education and training
12 did you go through?

13 A: I gotcha. I went to the University of West Georgia and
14 graduated in 1989 with my Associates of Science in nursing. I
15 took the state boards and became a registered nurse in January
16 of 1990.

17 Q: And then do each of those certifications that you just
18 told us about require you to have a nursing degree first and
19 then additional training after that?

20 A: The CRRN and CCM do. The CLCP, the life care planning
21 certification, there's several different degrees you can have
22 to sit for that certification, but the nursing license was one
23 of them. The nursing degree was one of them.

24 Q: Tell me about your education and training specifically as
25 it relates to being a certified life care planner?

1 A: Sure. I was actually hired initially by an actual life
2 care planner, Lou Ray Arndt [ph]. She had been doing it for
3 decades. I had worked with her for decades through the
4 Shepherd Center, and when she was getting ready to retire, she
5 decided she wanted to hire somebody to mentor and pass along
6 her business to.

7 So when she hired me, she mentored me as I took the CLCP
8 course, which when I took it -- at the time I took it in 2014,
9 it was an online course through University of Florida and
10 again an e-learning course. So it was divided up into
11 modules. Each module had a final exam that you had to take
12 and pass before you could move to the next module.

13 Once I had finished all those modules, I had to send all
14 that in to the board that manages the CLCP and request an --
15 you know, an application. It was an application process to
16 sit for the certification exam, which I did, and then I sat
17 for the certification exam and passed it and became a CLCP.

18 Q: And you mentioned the Shepherd Center. You worked with
19 this other life care planner through your role at the Shepherd
20 Center. Tell -- tell the jury about what the Shepherd Center
21 is?

22 A: Sure. The Shepherd Center is a facility in Atlanta that
23 is -- gosh, it's been around since the late '70s. It moved
24 into the Shepherd Building, I believe, in 1982. I actually
25 went to work for them in 1986.

1 The whole point of the Shepherd Center was developed
2 because James Shepherd had a spinal cord injury in Brazil,
3 came back to the States, and his parents realized there was
4 nowhere in the southeast for him to do spinal cord injury
5 rehabilitation. He actually went to Craig out in -- right
6 outside of Denver, Colorado. So the parents proceeded to
7 raise funds and they were very passionate about it, and that's
8 kind of how the Shepherd Center was born. So that's what they
9 do.

10 It is a spinal cord injury/brain injury rehabilitation
11 facility. It has grown. I think when I started there, there
12 were maybe 64 beds. I think now there's 175 beds, and it is a
13 model center, which is something that they have to apply for
14 every few years. It kind of makes them a center of
15 excellence.

16 Q: And so all of the patients who are there have suffered --
17 excuse me -- suffered either a brain or spinal cord injury; is
18 that right?

19 A: Or neurological injury. There's the Multiple Sclerosis
20 Center as well. We see patients with amyotrophic lateral
21 sclerosis, otherwise known as Lou Gehrig's disease. Lots --
22 again, lots of multiple sclerosis, Guillain-Barre, a lot of
23 the neurological disease processes. In -- in the last ten
24 years, they've -- well, gosh, I've been gone longer than that.
25 The last 20 years they have the Shepherd Pain Institute. So

1 they do see some people from the community for pain
2 management.

3 Q: Tell us about the role or roles that you played while you
4 were at the Shepherd Center?

5 A: Sure. I actually started there as a nursing student.
6 They had posted a flyer in our break room that they were doing
7 a nurse extern program, and at that time, I was young and
8 didn't really know what I wanted to do in nursing. So I
9 thought, hmm, that looks interesting. I didn't know about the
10 Shepherd Center. So I applied for the externship program and
11 worked one on one with a registered nurse.

12 After my summer program, they offered me a scholarship if
13 I would stay for two years. Boy, did they get their money's
14 worth. I ended up staying for almost 25. So I did stay, and
15 once I was licensed, as I worked -- all the way through
16 nursing school, I worked at Shepherd, and then when I
17 graduated, I stayed and became a staff nurse. I worked on the
18 med surg unit, which was spinal cord injury and brain injury
19 mixed unit, and did that from 1990 to 1994, and then in 1994
20 became the education coordinator for the entire facility.

21 So I did family training. I did the checklists. So I
22 trained the patients. I also trained the families, and I also
23 had the lovely endeavor of training new nurses coming into
24 Shepherd of how they were going to be treating patients on the
25 units. And so I did that from 1994 until 2002, and in 2002 I

1 became the outpatient manager -- outpatient services unit
2 manager, and we have five outpatient clinics, actually six,
3 that we see about 120,000 patients a year.

4 Q: I like how you still say we. You still feel like you're
5 part of that team; right?

6 A: I do. I think I will always feel part of the family at
7 Shepherd. I was raised at Shepherd, so I do still feel like
8 part of the family.

9 Q: And you mentioned doing some training and education for
10 patients and their families. Are you teaching them how to
11 make accommodations and deal with new challenges that come
12 with spinal cord injuries?

13 A: I do. I did, yes. We had what they called key classes.
14 As the educator, I taught the key classes. They got a little
15 notebook, and they would come to class and we would talk about
16 -- and it was divided into body systems because what we see
17 with spinal cord injury is every body system is affected. We
18 don't think about that, but respiratory system can be
19 compromised because you may not be able to cough as well as
20 you did prior to a spinal cord injury. Your cardiac, your
21 heart. These folks become at a higher risk for diabetes,
22 cardiovascular disease because they're not as active as they
23 were prior to their spinal cord injury.

24 But it goes through all of those classes. So bowel,
25 bladder, skin. Skin integrity is a huge issue with spinal

1 cord injury because they can't feel it and can't move it like
2 they did before.

3 And I always encourage the jury to think about now how
4 many times you're moving in your chair because your bum gets a
5 little uncomfortable. Our patients can't feel that. So,
6 yeah, they'll just sit there through, and then all of a sudden
7 they have this huge wound because they didn't feel it, they
8 didn't move it, and -- and it -- and it's bad. So, again, is
9 we go through all of the body systems.

10 And then when we do the families, we also -- they get the
11 key classes as well, but they also have to demonstrate how to
12 -- and the patients have to too -- demonstrate how to take
13 care of their bowel and bladder. Most of our folks cannot
14 urinate or poop on their own. So are they doing a bowel
15 program? I have to actually go in there and watch them do the
16 transfer to whatever equipment they're going to use and
17 actually physically do their bowel program.

18 And so we kind of talk through how that's going to affect
19 them long term and those kind of things, and intermittently
20 capping is -- is a big deal. We think about -- actually, we
21 don't think about it. We take it for granted that we can pee
22 and poop on our own and we get in a schedule, but our patients
23 don't have that luxury.

24 They have to be on a schedule as to how often they're
25 emptying their bladder and how often they're emptying their

1 bowels, because that's the one thing that will keep these
2 patients from being really active in their own community. If
3 you're afraid you're going to pee or poop yourself, you
4 probably wouldn't go to Walmart; right? Makes sense. So we
5 teach them how to avoid some of those things.

6 Q: How many total years of nursing experience do you have?

7 A: Wow. Well, again, I started as a nurse extern in 1986,
8 but as far as being licensed, since 1990. I don't -- I don't
9 do the math anymore because it's terrifying.

10 Q: 33 years?

11 A: 30?

12 Q: Ish?

13 A: 33-ish.

14 Q: We won't hold anybody to the numbers. Okay? And have
15 you previously been qualified to testify as an expert witness
16 in court?

17 A: Yes, ma'am.

18 Q: And when you provide opinions and testimony in a case
19 like this or other types of cases, are you paid for your time?

20 A: Yes, I am.

21 Q: And do you do work, form opinions for, and testify for
22 both plaintiffs and defendants?

23 A: I do, yes.

24 Q: Do you charge the same rate no matter who you're working
25 for?

1 A: That is correct.

2 MS. GOODING: At this time, Your Honor, I would offer Ms.
3 Cathy Gragg-Smith as an expert nurse life care planner, and
4 rehabilitation nurse.

5 MR. HEITMAN: No objection.

6 THE COURT: You may proceed.

7 MS. GOODING: Thank you.

8 BY MS. GOODING:

9 Q: Ms. Cathy, how do you know Crystal Goodwin?

10 A: I met her in her home on -- I'll give you the date, if I
11 can see them. I'm going to knock this microphone and I'm
12 going to deafen somebody in the back. I apologize.

13 Q: And, Ms. Gragg-Smith, will you tell us what you're
14 referring to to refresh your recollection on that?

15 Q: Sure. I keep a patient file. It's got my handwritten
16 notes in it from my visits with Ms. Goodwin. And so I can
17 kind of walk through. Yes. It looks like it was July the 2nd
18 of 2020 was my initial evaluation with Ms. Goodwin in her home
19 here in Columbia, South Carolina.

20 Q: And what kind of assessment have you done for Ms. Goodwin
21 in this case?

22 A: Gotcha. Again, I saw her in her home, so I went and met
23 her. I believe James was there for the beginning part of my
24 visit, her husband, and he wasn't there for the entire visit.

25 Q: I don't mean to interrupt you, but can you tell us first

1 what the title of your document is? And then you can kind of
2 talk to us about the process of what you've done.

3 A: Life care plan.

4 Q: Great.

5 A: It is a -- it is called a rehabilitation and life care
6 plan.

7 Q: Okay. Please go ahead and tell us about the process that
8 you've gone through to -- to create that?

9 A: Sure. Again, what I did initially was I was contacted by
10 the attorney. Once we agreed that I would create a life care
11 plan for Ms. Goodwin, I requested medical records. I got
12 medical records. I reviewed those because, again, I want to
13 know kind of the gist, how the injury happened, what she
14 looked like at discharge, those kind of things.

15 And once I have done that, then I schedule an appointment
16 to go out and see them, again in their home or in the
17 facility, which I did in this case. And I think I said July
18 the 2nd of 2020, I drove over to Columbia, South Carolina, to
19 meet Ms. Crystal Goodwin in her home.

20 Once I did that, I did a head-to-toe physical assessment
21 type of situation where I saw her in her wheelchair. We
22 walked through a little bit about what had happened to her. I
23 made some suggestions about physicians that she needed to see.
24 I checked her sensation, her abilities to have some motor
25 movement in her lower extremities, her spasticity in her lower

1 extremities. We walked through her pain. Pain is very
2 subjective. So I did take her face value that her pain is
3 what she says her pain is.

4 We talked about how she performs her activities of daily
5 living. So there's several pages of handwritten notes, as
6 well as a ten-page evaluation form that goes through each of
7 those kind of activities.

8 Q: And once you completed your kind of interview and in-home
9 assessment with Ms. Goodwin, what was your next step?

10 A: I think I reached out to Mr. Hinson and informed him that
11 we needed to have a physical medicine and rehabilitation
12 physician do what is called an independent medical evaluation.
13 I would have given him a couple of names to -- to get that
14 accomplished. She did not have that particular physician in
15 her repertoire of doctors that she was seeing.

16 So when he chose who it was going to be, he let me know.
17 They scheduled the appointment. I actually attended that
18 appointment as well. And that --

19 Q: And the purpose of that would be to assess her for what
20 she would need in the future?

21 A: Yes, it was. And that -- that appointment happened on
22 July 15th of 2020 with Dr. Shaufele.

23 Q: And then once you had that information and you went about
24 generating this report, what kind of resources did you utilize
25 to put this report together and make sure you had a

1 comprehensive list of recommendations?

2 A: I gotcha. Well, I collaborated with Dr. Shaufele, who is
3 a physical medicine and rehabilitation physician, as well as
4 an -- and it always comes up. Did I go to these books
5 specifically for this case? I don't know that, but there is a
6 set of books out there through the Spinal Cord Injury
7 Consortium of Medicine and Paralyzed Veterans Association.

8 They both do a series of books on spinal cord injury and
9 its sequela. I know those. I have committed those to memory.
10 I've been doing this since a really long time, and so
11 occasionally if a question pops up, yes, I will go back to
12 that book and just kind of refresh myself, but did I do it in
13 this case? I can't remember if I did or didn't. Again, I
14 know them. I'm very comfortable with the information that's
15 in those booklets.

16 Q: But the information that you utilized came ultimately
17 from those?

18 A: It did. And that is a kind of a standard of practice for
19 people that treat spinal cord injuries, that -- that that
20 material is there and available for us to use as a standard.

21 Q: You used that fancy word again, sequela of spinal cord
22 injuries. Tell us one more time?

23 A: I'm sorry. I do like that word, but sequela, really all
24 that means is how is this person going to look as she ages
25 with this spinal cord injury? We understand, and I'm going to

1 use Ms. Goodwin as an example, if you don't mind.

2 She has had recurrent urinary tract infections, and as
3 you have recurrent urinary tract infections, that impacts your
4 long-term renal health. So we want to make sure that she gets
5 the appropriate education. She is on, as I recall and is
6 still on -- I do recall, because I spoke with her last week
7 before this trial started, just to kind of catch up with her
8 and see how much had changed.

9 She is still on what they call prophylactic antibiotics,
10 so she takes an antibiotic every day to help combat some of
11 that, but she still has recurrent urinary tract infections.
12 So kind of what I said to her last week and I said to her back
13 in 2020 was you need a urologist. Somebody needs to be
14 following you doing renal ultrasounds. We want to make sure
15 that that renal system stays healthy, because you only have
16 one set of kidneys to last you for your lifetime.

17 So we talk about -- again, that's my educator hat that I
18 put on, but that's very important. So sequela really is just
19 looking at, again, all those body systems and how are they
20 going to age with the spinal cord injury.

21 Q: And your report also includes the cost of what these
22 recommendations will be; is that right?

23 A: Yes.

24 Q: Where did you get the information about what things would
25 cost?

1 A: If there is a vendor listed, it warrants -- it's a phone
2 call. It represents a phone call. I call each time I create
3 a life care plan to that specific vendor and get their cost in
4 real time.

5 Q: And as you are gathering this information and creating
6 this report, you note down kind of as you're going in your
7 report all of the information that you gathered?

8 A: I do. That was an odd question. Yeah, we put it in.
9 It's a -- it's a data entry issue. So as we're getting costs,
10 we're putting them into the software that I use.

11 Q: Okay. And so you're creating the report
12 contemporaneously with the information that you're gathering
13 is what I --

14 A: Yes.

15 Q: -- meant to ask. And is this the type of document that
16 you regularly create in your business?

17 A: It is.

18 Q: And does it accurately summarize your observations, your
19 opinions, and the findings from the process that you have
20 covered?

21 A: It does. And, you know, I would ask that we keep in mind
22 that the very definition of a life care plan is it is a
23 dynamic document. People change. Things may get better or
24 they may get worse. So the -- the dynamic part of a life care
25 plan is that we are all dynamic. So we may change,

1 particularly as we go -- if we go through this.

2 Medications is one that I always -- I put a little
3 asterisk in there. I try to be as conscientious as possible.
4 So you understand that medications are going to change. New
5 medications are going to come out that are going to take the
6 place of other medications. And I can't predict that because
7 I don't know what the FDA is working on right this minute. So
8 -- but we do know that medications are subject to change. So
9 we anticipate that as I create a life care plan.

10 Q: And that's noted in your plan; correct?

11 A: It is.

12 MS. GOODING: Your Honor, I'd move Ms. Gragg-Smith's
13 report into evidence as Plaintiffs' Exhibit 22.

14 THE COURT: Any objection?

15 MR. HEITMAN: No objection.

16 THE COURT: Plaintiffs' 22 is admitted without objection.

17 (WHEREUPON, Plaintiffs' Exhibit Number 22, life care
18 plan, was admitted into evidence.)

19 BY MS. GOODING:

20 Q: Ms. Gragg-Smith, please feel free to refer to that report
21 as you may need to today. I noticed, you know, it goes
22 through the medical records that you've reviewed, and then you
23 have a narrative portion at the beginning of your report.
24 What -- what kind of -- just generally, what types of
25 information does that summarize?

1 A: I think what you have up there is -- is the start of the
2 -- what -- what is called conclusions and recommendations. So
3 I go through the medical records that were -- that were
4 reviewed. That wasn't all the medical records that I
5 reviewed, but that -- those were the ones that kind of gave me
6 a good background on Ms. Goodwin. The conclusions and
7 recommendations section goes through each kind of body system,
8 so we can address what I've put in the life care plan and why,
9 why it's there.

10 Q: Okay. And I see in that first section that you note that
11 Ms. Goodwin had not been given an ASIA score to determine
12 whether her injury is complete. Dr. Shaufele talked a little
13 bit about an ASIA score yesterday, but that's that A to E
14 scale?

15 A: It is, yes.

16 Q: And remind us which --

17 A: ASIA A --

18 Q: -- one is good and which one's bad?

19 A: None of them are great. ASIA A is complete. That means
20 that below that level of injury there is no motor, no sensory.
21 It's not coming back. They're not going to have it. So you
22 can poke them with a pen. They're not going to feel it. You
23 can pick their legs up. They're not able to hold them up in
24 space. So there's no motor and no sensory below that level of
25 injury in ASIA A.

1 B, C, and D are different, kind of differing or varying
2 degrees of what they call incomplete spinal cord injury, and
3 it just has to do with motor and sensory. It can be 50
4 percent motor, 50 percent sensory, dah, dah, dah. ASIA E is
5 there's no neurological -- no neurological deficits. So they
6 -- below that level of injury, they don't have neurological
7 deficits.

8 Q: Okay. And at the point that you examined Ms. Goodwin in
9 her home, she had not yet been assigned an ASIA score; is that
10 right?

11 A: She has not, and I do realize. Again, over time I do
12 this. I do life care planning, and I've done it all over the
13 -- the country at this point, and what I've realized is doing
14 this is with spinal cord injuries, most people don't assign an
15 ASIA score. The model centers do at Shepherd. So I was
16 really used to seeing that, but many of the outside acute
17 inpatient rehabilitation facilities do not.

18 Q: Dr. Shaufele testified yesterday that she had no feeling
19 in her private areas at all, and that she was considered
20 paralyzed. Do you agree with that opinion?

21 A: I do.

22 Q: And -- and in this assessment, you talk a little bit
23 about weight loss. Why is that significant to your assessment
24 here?

25 A: It impacts -- it impacts spinal cord injury patients.

1 The weight loss or weight gain over time affects their
2 abilities to sit appropriately in their wheelchair, and we
3 just don't think about that. If you're starting to gain
4 weight, you're going to push out those hips on the wheels and
5 start causing friction and rubbing and wounds. As you -- if
6 you get smaller, you're going to kind of go into that
7 wheelchair and you're not sitting appropriately on that
8 cushion, which also can cause wounds.

9 So we want to be very mindful that she's getting an
10 appropriate wheelchair and sitting evaluation. You can't just
11 go to Walmart and grab a wheelchair off the rack and throw her
12 in it because it needs to fit her for her body habitus and her
13 abilities to transfer in and out of that wheelchair.

14 Q: And you say she requires medical management by physical
15 medicine, rehabilitation, and neurology to manage the sequelae
16 from and due to her spinal cord injury. Just briefly tell us
17 what that means, since there's a lot of big words in that
18 sentence.

19 A: There is a lot. I'm sorry. The medical management for
20 -- again, the physical medicine and rehabilitation physician
21 is someone like Dr. Shaufele who knows spinal cord injury.
22 That's part of what they learned in their program, and it's
23 part of what they learned in their residency program. So they
24 understand how these people are going to age and why it's so
25 important to, again, make sure that she's going to an

1 appropriate wheelchair and seating clinic, that she's being
2 seen once a year at least to kind of let's address these
3 medications. How's your bowel program going? How's your
4 bladder program going? How are the medications that we
5 prescribed you for A, B, and C working for you? Is it
6 effective?

7 Because it's not like going to your primary doctor for a
8 cold or Tamiflu if you have the flu. These are things that
9 are going to be affecting her for the rest of her life. The
10 urologist I think I mentioned earlier is because she does have
11 what is deemed a neurogenic bladder, and those are just more
12 big words that mean -- I saw the spine down there.

13 At the very base of the spinal cord is what is called the
14 cauda equina. It looks like a horse's tail that comes out.
15 You can't really see it on this one, but they come out down
16 here and that's what affects your bowel, bladder, and your
17 sexual functioning. So those are very, very insulated nerves
18 that are down there, and so she does have a neurogenic bowel.
19 She also has a neurogenic bladder. She also has some issues
20 with her sexual functioning.

21 And again, those are things we can't see visibly. We
22 kind of ask the uncomfortable questions as to are you
23 lubricating like you used to? Is it uncomfortable? Do you
24 have an issue with positioning for having an intimate
25 relationship with your partner? So all those things come into

1 effect.

2 Urology can address some of those if those become an
3 issue. They can recommend some lubricating things, but
4 urology for me too also means we're looking, again,
5 diagnostically at that bladder and her renal system for the
6 rest of her life.

7 Q: And you just mentioned a number of issues that you see
8 come up in spinal cord patients with regard to their sexual
9 function. Does Ms. Goodwin have those concerns?

10 A: She does, and I have notes in my file. You know, again,
11 initially when I interviewed her, she did verbal -- and again,
12 because I do ask the hard questions. How is the -- how is
13 your intimate relationship with your spouse now?

14 And she did confess or admit that, you know, before this
15 -- this happened, they probably had intimate relationship
16 three times a week, and now they're lucky if they can do it
17 once a month. It was between the fact that she has to have a
18 bowel program, a bladder program, she wasn't lubricating as
19 well, and positioning can be an issue because she would get
20 very uncomfortable.

21 We actually even talked about a sex glider, I believe,
22 and I can't see Crystal's face, so I can't remember if she
23 remembers that conversation. They do make a piece of
24 equipment that addresses just that for spinal cord injury
25 patients, and it is a glider that you can use to help provide

1 that motion that you can no longer do.

2 Q: Okay. I noticed that you talk about both attendant care
3 that's required for activities of daily living and then
4 assistance with house cleaning. Do you separate those things
5 for the purpose of creating your report?

6 A: I do. And the attendant care, they can do light
7 housekeeping duties, but they don't do the heavy housecleaning
8 duties like getting in the bathtub and --

9 Q: Scrubbing it.

10 A: -- scrubbing it out or scrubbing the shower or those kind
11 of things, but the attendant normally in a plan of care -- and
12 again, I do community case management a lot. So what I hear
13 through the agencies is they clean behind what they just did.
14 If they're creating, you know, preparing meals, then yes, they
15 will clean the kitchen, but they're not going to clean out the
16 refrigerator, those kind of things. So there is a splitting
17 of hairs there, but there is a very clearly delineated thing
18 that attendant care will do versus what a housekeeper will do.

19 Q: Okay. And have both of those been recommended for
20 Crystal?

21 A: They have.

22 Q: Okay. You have mentioned a couple of times her bowel and
23 bladder program, and we did get to hear about that from Dr.
24 Shaufele yesterday, that she has to have a program and
25 regularly do that. But just from your perspective, as

1 somebody who has been an educator and who has had to teach
2 multiple patients who have had similar types of injuries how
3 to do intermittent catheterization, how to do digital
4 stimulation, I don't -- I don't want to ask you to talk for a
5 long time about this, but if you can just kind of explain the
6 technicalities of it and why it takes some training to learn
7 how to do those things for yourself?

8 A: Sure. And I will say, I think I mentioned to y'all
9 earlier I wanted you to kind of think about how many times
10 you're moving. Now that you're kind of paying attention to
11 that, your bottom gets sore. I would also encourage all the
12 women in the jury box now to think about when you urinate,
13 what are you urinating from, and are you sitting on that as
14 you're sitting in your chair? You are. I can just tell you
15 that.

16 So for people, for women in particularly that are going
17 to be wheelchair dependent, trying to -- we just don't think
18 about it every day, but trying to manage your clothing. So
19 get your pants down off your hips when you really don't feel
20 and can't move like you used to, but to get your hips rocked
21 up enough to find your anatomy. We don't -- most of us don't
22 take a mirror and look at our anatomical configuration down
23 there. But -- and for the men in the jury, y'all can go ahead
24 and cringe a little bit. There are multiple places to
25 catheterize on a female, not on a male. You got one. Unless

1 you have hypospadias, then you may have two.

2 But for most women, there are two. There is the vagina
3 and there is the meatus, and so women have to clearly
4 delineate which one they're cathing. And it is the meatus,
5 which by the way is the smaller of the two. So finding it and
6 being comfortable that that's what you're cathing is a big
7 deal. The catheter ends up going in about six -- about six
8 inches into the bladder.

9 Kind of how we teach folks is once you hit urine, you
10 want to go in another inch, because we want to drain that
11 bladder from the top to the bottom. One of the reasons people
12 get urinary tract infections is because they leave urine in
13 the bladder for a long period of time. It's not meant to stay
14 there. It's meant to be expelled.

15 So again, just don't take that for granted. I mean, we
16 really are. Y'all are sitting on what you would have to
17 catheterize. So you've got to be able to rock it up, get it
18 up and find the appropriate entry, and then it takes several
19 minutes. It's not like you just go in and you get it out, you
20 take it back out. It takes a while.

21 Many women have to kind of press on the outside of the
22 bladder to make sure we're emptying it well. You inch out
23 about half an inch at a time till you get to the bottom of the
24 bladder, and then you can pull the catheter out, clean
25 yourself, and pull your clothes back up.

1 For the bowel program, it is what is called a digital
2 stimulation. And what that entails is gloves, pads, and some
3 K-Y jelly or something that is water soluble. So you're
4 actually inserting a finger into the rectum or two fingers
5 into the rectal vault.

6 With Ms. Goodwin's injury, with most spinal cord injuries
7 that require a digital stimulation, they can't control that
8 internal sphincter, which comes out of your intestine and
9 empties the stool down into the rectal vault. They also can't
10 control that external sphincter, which allows that sphincter
11 to open and the stool to fall out.

12 So what you do is basically you go in there with -- with
13 your fingers and you are doing a motion that is this, and what
14 you're doing with that motion is to stimulate the intestinal
15 mucosa to move the stool down to that vault, open it up, let
16 it fall into the rectal vault. But then you also have to take
17 that -- it's a scooping motion. I know everybody is grossed
18 out. I'm so sorry I'm doing this before lunch.

19 And then you pull the stool manually. You have to remove
20 that stool because you can't -- that rectal sphincter doesn't
21 open. So once she pulls that out -- and this takes, again, a
22 minimum of about 30 minutes. You're going to continue doing
23 that motion until you don't feel stool coming down anymore.
24 Then you're cleaned out, because what will happen is if you
25 don't complete it, she does -- you know, one -- one rectal

1 vault full of stool, people will pull their pants up and
2 think, oh, I'm all done. Huh-uh. You need to make sure
3 there's nothing else going to come out of that intestinal
4 tract, because if you don't, then when she goes to transfer or
5 do any pressurized movement, it's going to push it out and
6 it's going to make a mess. She's going to have what is called
7 an involuntary, or she'll be incontinent of stool because
8 it'll just smush through that rectal vault and she'll have
9 stool in her pants.

10 And again, that is the one thing I'm telling you. For
11 all these years I've been doing this, bladder incontinence and
12 bowel incontinence is the thing that keeps people from being
13 really, really involved in their community because nobody
14 wants to pee and poop in their pants.

15 Q: Absolutely. The next thing that you discuss is Ms.
16 Goodwin being wheelchair dependent for mobility. She's using
17 a wheelchair now; correct?

18 A: Correct.

19 Q: And -- and she's using a manual wheelchair?

20 A: Currently, yes.

21 Q: And you have recommended for her wheelchairs going
22 forward. It says she will not be a functional ambulator.
23 What does -- what does that mean?

24 A: She can't walk. She just can't walk. Her legs don't
25 work. There's no walking. I think she stands, and she was

1 standing, actually, when I was at the home in 2020. And when
2 I spoke with her several days ago, her physical therapist has
3 now told her no more standing in the home. Apparently, she's
4 experienced some more weakness and numbness in those lower
5 extremities, so they're not letting her stand, even stand in
6 the home anymore on her own. She's standing with therapy.
7 That's it.

8 Q: And when you say she was standing when you spoke with
9 her, was she standing independently without holding on to
10 anything?

11 A: No, she was not. She -- she required something to lean
12 into and something actually to help pull her up out of the
13 wheelchair.

14 Q: Now, you've recommended a power wheelchair beginning at
15 age 60 to decrease wear and tear on her shoulders; is that
16 right?

17 A: It is. Kind of a rule of thumb for those of us that have
18 been doing spinal cord injury a long time, it's about 25 years
19 post-injury. We know that pushing your entire body weight
20 around in a wheelchair over time wears your shoulders out.

21 Q: And you want to keep her in a manual wheelchair for as
22 long as you can?

23 A: Absolutely.

24 Q: But the rule of thumb is that it takes about 25 years
25 before that's just not really likely anymore?

1 A: Correct.

2 Q: Okay. You also said that you talked to her about her
3 pain, and that you did a pain assessment with her while she
4 was in her home. How often does Ms. Goodwin experience pain?

5 A: Daily. Constantly. At the time, she had low back pain
6 and -- I don't want to lie. So let's see what I wrote down.
7 Yeah, low back pain was constant and legs. Her legs were
8 constant. It was radiating. It was constant, sharp, and
9 burning, right greater than left.

10 Q: And I believe we -- and we heard this yesterday, but your
11 report indicates that Dr. Shaufele recommended a Baclofen pump
12 to help control that?

13 A: And the way the Baclofen pump trial -- well, again, you
14 start with a trial. We would do the trial first. If the
15 trial is effective, then they can implant the actual Baclofen
16 pump.

17 Q: And that would require a procedure?

18 A: Correct.

19 Q: Okay. And then you also -- you know, pain management is
20 mentioned as far as addressing the pain; right?

21 A: Yes.

22 Q: And then at the end of this pain assessment, you talk
23 about a spinal cord injury comprehensive rehabilitation
24 program that would be a 1- to 2-week course, and I believe
25 that that maybe is what Dr. Shaufele described yesterday as

1 boot camp for people with spinal injuries?

2 A: It is. Shepherd Center has a day program, so it is for
3 outpatient folks that have -- they can either have been coming
4 directly out of acute inpatient rehabilitation or years later
5 they will come back for a refresher course, and it just,
6 again, goes through everything we've already talked about,
7 bowel, bladder, skin, respiratory, but it is compensatory
8 strategies how to manage this as we go forward.

9 And she didn't really -- she did have a rehab stay, but
10 it was not at a -- at a center of excellence. And I think
11 over time I have become, yes, a little bit of a medicine snob,
12 and that's okay. I worked at a center of excellence most of
13 my adult life. I would love to see all of my clients be able
14 to go to a boot camp at the Shepherd Center because it is,
15 again, a center of excellence.

16 Q: And it helps them to be more independent? Is that kind
17 of the goal?

18 A: It does, and it makes them understand kind of the
19 services they need going forward. Not everybody knows that.
20 I think I recommended some case management for Ms. Goodwin as
21 well because, again, I don't expect the general community to
22 understand what kind of physicians they need. They've never
23 needed that before. So to have somebody that understands
24 spinal cord injury kind of guide her through, get her set up
25 with the appropriate people, the episodic physical therapy

1 evaluations, those kind of things.

2 Q: And that would be 1 to 2 weeks of kind of classroom
3 training combined with hands-on training for learning things
4 like putting your pants on?

5 A: The day program would be, and they would recommend
6 equipment if she needs some equipment, those kind of things.

7 Q: You've also included some information about Ms. Goodwin's
8 home life, and you talked to us about, you know, the -- the
9 assessment that you did while you were in her home. What type
10 of home modifications did you determine that she would need
11 when you did that assessment?

12 A: Again, I don't want to get spanked. I am not a general
13 contractor, nor am I a home accessibility specialist. Again,
14 as a case manager, I do work with those people regularly, and
15 kind of what I saw was she had a -- as I recall, there was a
16 plywood ramp that went into a sunken kind of living area. The
17 home needs -- it needs to be modified for her environment.

18 I would -- we did put -- I did put a home accessibility
19 specialist in the life care plan that can walk through with
20 the Goodwins and see how does she achieve her activities of
21 daily living and what recommendations would they make, as well
22 as a budget to modify the home. But what I saw, again, there
23 was a plywood ramp so she could get into the living area.

24 Q: Inside her home?

25 A: Inside her own home. The other interesting thing that

1 still comes to mind -- and I've made notes of it when I spoke
2 to her last week, because there are things that stick out with
3 every client that I see. Hers was that she was achieving her
4 bathing activities in a kiddie pool.

5 So they would -- I know it sounds strange. She can't get
6 into the bathroom. So they would bring her chair. They would
7 put it in -- kind of jump it over into this, yes, round blue
8 kiddie pool, like you see in many people's yards, and then
9 bring her jugs of water, towels. She could bathe herself once
10 that she was in there, but she didn't have access to a shower.
11 So that's how they achieved her bathing.

12 I think that was probably the first question I asked Ms.
13 Goodwin when I spoke to her last week was are you still
14 getting your bath in the kiddie pool? She said yes. So
15 obviously there are modifications that need to be made to her
16 home to make her safe and accessible in her own home. Yeah.

17 Q: And how has Crystal responded emotionally to this injury?

18 A: She's sad. I made some -- I have some quotation comments
19 in my -- in my file, because what people say to me makes more
20 impact to me than -- than most. And I believe when I was
21 talking to her about how she was, because that is another
22 thing we -- we discuss is how are you doing, I mean,
23 emotionally, what's your mood like? If somebody told me --
24 you know, asked you what your mood was like, what would you
25 say?

1 And one of the quotes that sticks -- sticks with me about
2 Ms. Goodwin because she was very accommodating, very nice, but
3 she did say some days it can just be shitty. That was her
4 words, not my words. And then she did have some
5 symptomatology of depression. She got teary when we talked
6 about her intimate relationship with her spouse. You know,
7 not being able to have the same intimate relationship with him
8 that she had before caused her some depression. And the fact
9 that she's not as independent as she was prior caused her some
10 sadness.

11 Q: In spite of that sadness, has she been able to make
12 efforts to continue to improve and to kind of do the best she
13 can in the situation that she's in?

14 A: I think she has. She's still -- she does some baking, I
15 believe, for her community. She's still doing that. People
16 order cakes and things from her. In fact, when I was there in
17 2020, somebody knocked on the door and had ordered some cakes,
18 I believe, through their church. Please don't hold my feet to
19 that, but they showed up to pick up their order. So she is
20 still, again, attempting to do things the best way she can.

21 Q: Excellent. And I'd like to look with you at the -- the
22 chart section of your report.

23 A: Sure.

24 Q: The jury is going to be able to -- to look at this report
25 later and to kind of interpret it. So I want them to have a

1 good understanding of what it is that we're looking at.

2 And so beginning on page 1 of those charts, and this is
3 entitled projected evaluation. If you can just kind of go
4 through with us what the columns are so that we can kind of
5 understand. So starting with the item and service on the
6 left-hand side, what kind of things are we going to see over
7 here?

8 A: Gotcha. Well, the very first one is a driving
9 evaluation. Ms. Goodwin is driving, and she uses hand
10 controls, but nobody's ever done a driving evaluation. I am a
11 -- again, I worked at Shepherd. I can tell you without
12 blinking that the majority of spinal cord injury patients'
13 accidents happen are motor vehicular accidents. So I'm kind
14 of a stickler for road safety. There you go. So the driving
15 evaluation is one that I would recommend. I want to make sure
16 that she is safe and accessible in her vehicle.

17 Q: So is everything in this first column going to be
18 something that has been recommended for her future treatment?

19 A: Let's see. Yes. She had an orthopedic and spine
20 surgeon, so that's not a new recommendation.

21 Q: Okay. And let's just kind of go through the columns
22 before we get into some of the specifics.

23 A: Sure.

24 Q: In the second column, we have age and year kind of at the
25 top, and then a lot of these are split. And so it's beginning

1 and ending is the split I see. So is that when she would
2 begin and end those services?

3 A: Yes, our goal would be -- yes. The driving evaluation
4 needs to take place soon. So I don't carry that through life
5 expectancy. It's a one-time entry that needs to be done.

6 Q: And we see that here in the third column; right? One
7 time --

8 A: Yes.

9 Q: -- situation. And you wrote this report in 2020; is that
10 right?

11 A: I did. Yes, ma'am.

12 Q: And she was 42 at the time?

13 A: Correct.

14 Q: So anything that would be recommended to go ahead and
15 start or go ahead and get this evaluation if you can, is going
16 to say beginning 42 in 2020?

17 A: Correct.

18 Q: Is that a correct interpretation?

19 A: Uh-huh.

20 Q: And then as to the ending box, that's going to say
21 whether it's only expected through 2020 or expected for some
22 series -- series of years or expected for her life expectancy?

23 A: Correct.

24 Q: And that would be when that service is recommended to
25 end?

1 A: Or she passes, yes.

2 Q: Right. And then we see a number of different things in
3 this third column. You said the driving evaluation. That's a
4 one-time service. And some of those things will say a minimum
5 of one time, perhaps every 2 to 3 years. So they give how
6 often those things are recommended; is that right?

7 A: That is correct, yes.

8 Q: Okay. And in some instances, like for physical therapy,
9 I see, you know, how many sessions would be recommended in
10 each instance?

11 A: Yes. And it's important to understand on that first page
12 where you have projected -- projected evaluations, there is
13 physical therapy listed there, and that is somebody just kind
14 of coming in, evaluating her, doing all the range of motion,
15 doing all the sensory testing, and then they make
16 recommendations for the projected therapeutic modalities. So
17 the modalities are the hands on. They're going to a physical
18 therapist two or three times a week. They're doing their
19 exercises. They're doing -- you know, recommending equipment,
20 getting fitted for equipment, those kind of things.

21 So there's -- there's a couple of physical therapy.
22 You'll see them. It looks like it's duplicate. It's not.
23 Evaluations are just that, and a person evaluates you and
24 makes recommendations to your treating physical therapist as
25 to what needs to happen with the hands-on sessions.

1 Q: And then the hands-on sessions are separately
2 recommended?

3 A: Correct.

4 Q: And here on page 3, it indicates that the frequency and
5 replacement -- or replacement there says 12 to 20 visits per
6 occurrence, minimum of three to four occurrences. Would that
7 be three to four occurrences in her lifetime?

8 A: It would be. So kind of ultimately, if you can -- you
9 know, I try not to do math, but ultimately that would be 36 to
10 80 sessions that a physical therapy, when they do the
11 evaluation, they may choose to do five or ten sessions because
12 she's showing decreased weakness or increased weakness, those
13 kind of things. So they may need to work on her
14 strengthening, those kind of things. It's for the physical
15 therapist to determine how they use those sessions.

16 Q: And so if she's doing physical therapy two to three times
17 a week for an entire year, that would be over a hundred
18 sessions of physical therapy; correct?

19 A: Yes.

20 Q: And this plan accounts for 80 -- up to 80 sessions for
21 her lifetime?

22 A: Correct.

23 Q: Okay. So is it your effort to include in this plan kind
24 of only what you believe you can confidently say is going to
25 be necessary?

1 A: It is. It needs to be reasonable and medically
2 necessary. Again, the Consortium -- Spinal Cord Injury
3 Consortium of Medicine does a good job of giving us some
4 guidelines to use, and that is kind of one of the guidelines
5 they use.

6 Q: Okay. One Of the evaluations that you recommended -- and
7 this is on page 4 of your report -- is a psychologist or a
8 counselor. Again, looking at the -- the frequency that's
9 recommended here, does this account for her seeing a
10 psychologist or a counselor all the time for the rest of her
11 life?

12 A: It doesn't. Usually, what we look at is during those
13 life-changing events, a child gets married, a grandchild is
14 born, a spouse passes. We try to take into account she's
15 going to have to deal with things a little differently from a
16 wheelchair perspective than she would have as a normal,
17 functioning ambulator. So we do try to look at over her
18 lifetime, at her age now, what do we anticipate some of these
19 life change events may be.

20 Q: And for each of these things, you've given a purpose as
21 to why she'll need that recommendation: right?

22 A: Yes.

23 Q: And then moving along, you have a cost per unit. And so
24 here you -- for just to use as an example, you would estimate
25 that per visit to a psychologist or a counselor, she would pay

1 between 60 and \$150?

2 A: Yes, and that's a range of visits, because I don't know.
3 Will they do a 30-minute session? Will they do an hour
4 session? Will they do a two-hour session? That's not for me
5 to know and it's not for them to know. So I just get the
6 entire range.

7 Q: Okay. And then the comment here kind of helps give
8 context to what you're recommending?

9 A: It does. Yes, ma'am.

10 Q: Okay. And then for vendor, here you just have Columbia,
11 South Carolina, because you had to give a range, but for some
12 of these, you indicate, you know, Shepherd Center or Palmetto
13 Primary Care or some other provider that you have identified
14 as somebody that might be available to give Crystal that
15 service; is that correct?

16 A: That's correct.

17 Q: Okay. And how did you determine which providers to use
18 in those contexts?

19 A: If she had the provider already, like with her primary
20 care physician, we used that, that cost. We called that
21 office and got that cost. If she didn't have that vendor,
22 then I had to choose one geographically close to her,
23 obviously except for the day program, because not many people
24 have that. That is kind of indicative of the Shepherd Center
25 and what they offer. But if she had the vendor, that's who I

1 used. And if I didn't, I tried to stay as geographically
2 local to Ms. Goodwin as I could.

3 Q: Okay. Thank you.

4 A: Sure.

5 MS. GOODING: Judge, may we approach briefly?

6 THE COURT: Yes.

7 (WHEREUPON, a bench conference was held off the record,
8 after which the proceedings resumed as follows.)

9 THE COURT: Ladies and gentlemen of the jury, do you need
10 a break? Raise your hand if you need a break.

11 Yeah? Okay. Let's take a short break. Return to your
12 jury room. Do not discuss the case. Thank you.

13 (WHEREUPON, the jury exited the courtroom at 10:58 a.m.)

14 THE COURT: All right. We'll give you 10, 15 minutes.

15 MR. GOINGS: I'm sorry. Thank you, Judge.

16 THE COURT: You can step down from the witness stand.
17 Don't discuss your testimony.

18 THE WITNESS: Oh, thank you.

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

21 THE COURT: All right. I've got a note from the jury.

22 Is it possible to ensure the TV is out of the way when
23 not being used? It is blocking the view of some jurors to be
24 able to see reactions around the room.

25 So we need to figure out where it can be placed. I'm

1 wondering if it can block me slightly. I know they asked to
2 raise it, but I wonder if lowering it but pulling it back
3 towards me sort of perpendicular to the court reporter?

4 MS. GOODING: So while we're utilizing it or for storing
5 it?

6 MR. GOINGS: Over here? Okay. Yes, we can do that. We
7 just need to get an extension cord.

8 THE COURT: Okay.

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

11 (WHEREUPON, the jury note was marked as Court's Exhibit
12 Number 4.)

13 THE COURT: Let's bring the jury, please.

14 (WHEREUPON, the jury entered the courtroom at 11:42 a.m.)

15 THE BAILIFF: The jury is seated, Your Honor.

16 THE COURT: Thank you.

17 All right, ladies and gentlemen. I got your note, and I
18 hope that I have addressed your concern. We've been in here
19 trying to reconfigure things where everyone who needs to see
20 the monitor can see. We moved at least one of you out of the
21 corner over there, in part because of the Plexiglas that you
22 have to look through. With the monitor being where it is, I
23 think it's probably a better view to have you on the back row.

24 So I think the witness can see the monitor. Counsel can
25 see it. Defense counsel can see the witness. I'm hoping

1 we've addressed everything. If not, you will let me know at
2 some point.

3 But the only thing is, I can't see Ms. Gooding, but I
4 know you're down there, Ms. Gooding. You may proceed with
5 your direct examination.

6 MS. GOODING: Thank you, Judge.

7 BY MS. GOODING:

8 Q: All right. Ms. Cathy, we left off on page 5 of your
9 report, and this entire page relates to the wheelchair and
10 things related to her wheelchair. So I just want to be sure
11 that -- that it's clear these -- are these redundant items?

12 A: No, the first one is the manual wheelchair. Just
13 describes what kind of back Ms. Goodwin has on her chair. The
14 second one does say manual wheelchair, but that's for
15 maintenance.

16 Q: And so this indicates that every year, except for the
17 first year she gets one, she should have the wheelchair
18 maintained?

19 A: Correct.

20 Q: And then the same holds true for the power wheelchair?

21 A: Yes.

22 Q: And here does this indicate what we talked about earlier,
23 that the power wheelchair is something that she will start
24 purchasing when she reaches the age of 60?

25 A: Yes.

1 Q: So that'll be another 15 years from now. Did I do that
2 math right?

3 A: Yes.

4 Q: Close enough.

5 A: I think you did.

6 Q: And the sliding board relates to transfers on and off of
7 the wheelchair; is that right?

8 A: That is correct, yes.

9 Q: The last item on this chart, which is actually on page 6,
10 refers to a wheelchair cushion, and is that what you were
11 referring to earlier when you were talking to us about how
12 important her -- important it is that her wheelchair fits her?

13 A: It is. With a cushion, it also provides her some
14 stability for her buttocks and allows her to do weight shifts,
15 those kinds of things. So, again, the cushion is chosen by
16 the wheelchair seating clinic, what kind of cushion she needs,
17 and that may change throughout her lifetime. What I costed it
18 is what she has now.

19 Q: Okay. And pages 7 through 9 deal with some types of
20 medical equipment, a lot of which you've already talked about,
21 the walker and the bedside commode. On page 9, it
22 specifically indicates that she will need adaptive aids for
23 her life. Can you tell us what adaptive aids means?

24 A: Sure. They're -- they're things like reachers. We've
25 all seen a reacher that you can get things off of countertops

1 or off the floor with, because you don't have the abilities to
2 bend or reach up as well as you used to, but they can also
3 include things like a long-handled bath sponge. She can get
4 in the tub, but she probably can't bend over well to wash her
5 feet. So the long-handled bath sponge gives her the ability.
6 Kind of all of those things are to maximize her independence.

7 Q: And so you've accounted for her needing some type of
8 adaptive aid every 2 to 3 years?

9 A: And those actually will coincide with her occupational
10 therapy and physical therapy evaluations. At that time, those
11 therapists, once they have evaluated her, can make
12 recommendations as to what equipment would be best for her.

13 Q: Okay. On page 10, you include a list of supplies, and it
14 looks like this is the stuff that you kind of talked to us
15 about earlier in order for her to take care of herself, take
16 personal care of herself, catheters, underpads, gloves, etc.
17 She's going to have to buy these things all the time because
18 they're disposable items?

19 A: That's correct.

20 Q: And then the next couple of pages refer to medications,
21 and you touched on this early on when we were talking about
22 your -- in the narrative portion of your report and that you
23 said that medications kind of fluctuate?

24 A: They're going to vary, and we anticipate that. And you
25 can see in each entry there is an asterisk, and there's an

1 asterisk at the bottom of the page that says medications may
2 vary, conditions for which they are prescribed are considered
3 chronic. We anticipate them to change.

4 What I costed is what she was on unless there -- I don't
5 think we put any trials, but before I say that, let me -- he
6 did. Dr. Shaufele had recommended a couple of medications to
7 trial, and so those are going to be in the charts as daily for
8 a minimum of three months. We don't know how she'll respond
9 to those medications. She may need to be on them for her
10 lifetime, but because she hasn't taken them yet, we didn't put
11 them in for her lifetime. We put them in for trials to see if
12 they're effective.

13 Q: Is it more likely than not that she will continue to need
14 some type of medication to manage these concerns?

15 A: It is. Yeah, yeah, it is.

16 Q: Okay. And exactly what she's paying for those
17 medications in a given month may go up and down over time?

18 A: Sure. Again, with new medications hitting the market,
19 those medications are going to come out and be more expensive
20 than what we have costed. All the medications that I cost in
21 the plan are if there is a generic available, that is what I
22 costed. For some medications, there's not going to be a
23 generic available, and those are going to be more expensive
24 medications, and over time they too will decrease in cost, as
25 medications do.

1 Q: But on average, do you think that the costs included in
2 your plan are a good estimate of what she will be paying for
3 medications, even as they fluctuate exactly what she's taking?

4 A: It is. It is the best I can do, given the information
5 that I have when I create the plan.

6 Q: And the next section of your charts relates to health
7 care, and we've -- we've touched on this a little bit, but
8 you've included different levels of attendant care before and
9 after age 64; is that right?

10 A: Yes.

11 Q: And so prior to that, that -- prior to her turning 64,
12 you are accounting for her to have four hours a day for a six-
13 month period while she kind of adjusts to things, but then
14 only as needed?

15 A: Correct.

16 Q: And after, when she turns 65, you expect that need to be
17 more consistent?

18 A: I do, yes.

19 Q: Okay.

20 A: Excuse me.

21 Q: And does -- does your opinion that she is only going to
22 need attendant care as needed until she's about 65 -- does
23 that kind of depend on her being able to accomplish some of
24 the other things that are included in this life care plan,
25 such as home modifications, having the appropriate equipment?

1 A: Sure. Living in an accessible environment, she will be
2 more independent. Until that happens, she will need some
3 assistance with her activities of daily living.

4 Q: Okay. And then you've already said the domestic
5 assistance really relates more to somebody to scrub the
6 bathtub, somebody to get in and clean out the refrigerator.
7 Those things that aren't done day to day on a day-to-day
8 basis. So that's separate from attendant care?

9 A: Correct. And we did that, yes, twice a month.

10 Q: And house and yard maintenance is also separate from both
11 of those categories?

12 A: It is. And as you can see under the comment house and
13 yard maintenance, I did include the comment that that would be
14 required in absence of her spouse.

15 Q: Your understanding is that he currently takes care of
16 that?

17 A: It is.

18 Q: Okay. On page 15, you have a future medical care routine
19 chart, and it looks like these are appointments or types of
20 tests and treatments that she may need on various frequencies.
21 So CBC is like a blood draw test; right?

22 A: It is complete blood count and a complete metabolic
23 profile, and we do those because of some of the medications
24 that she's on can be damaging to her liver and kidneys. So we
25 want to make sure we're watching that.

1 Q: So a couple of times a year for that. There's a couple
2 of tests on here that Dr. Shaufele recommended that would be a
3 one-time test, some MRIs, renal ultrasounds that are -- that
4 are consistent but not -- not -- not frequent like the
5 physical therapy might be?

6 A: Correct. The renal ultrasound is once a year and, again,
7 that is laid out by the Spinal Cord Injury Consortium of
8 Medicine gives us that. So we know that to be true, as well
9 as the urodynamic study on page 16.

10 Q: Have you included in this chart any routine care that is
11 just recommended for the average adult?

12 A: Again, CBC and CMP. Most people get some kind of lab
13 work done yearly with their physical. Again, we included it
14 an extra one to two times per year, but again, because of the
15 medications that she's on can be affecting her bladder, her
16 renal system, as well as her liver.

17 Q: So you took into account that an adult over the age of 65
18 should probably be having blood work done once a year anyway,
19 or an adult, any age, probably and -- and came to the
20 conclusion that she needed an additional one to two times?

21 A: Yes.

22 Q: And that's what that frequency indicates?

23 A: It does, yes.

24 Q: Okay. Did you include in this report anything that had
25 been recommended to Ms. Goodwin prior to her July of 2016

1 surgery?

2 A: Not that I could see, no.

3 Q: Finally, the -- you know, not quite at the last stage
4 here, page 17 is the transportation page, and this includes
5 that -- the hand controls Dr. Shaufele told us about?

6 A: Correct.

7 Q: And that would allow her to drive?

8 A: It does, yes.

9 Q: Has she actually been assessed for that yet?

10 A: No, she has not had a driving evaluation. Somehow they
11 found somebody that was selling hand controls, and they put
12 them in her vehicle, but she has not had a formal driving
13 assessment or had not when I was there in 2020.

14 Q: How do those hand controls work?

15 A: I don't drive with hand controls, so I don't know.

16 They're wired into the car, and they have where you can do the
17 gas and the brake and put it in gear. Not gear. You can use
18 the gears with your hands, but it's the gas and the brake.

19 Q: And so they -- they take things that are usually done
20 with our feet while driving and make them things that we now
21 do with our hands?

22 A: Correct.

23 Q: Okay. And this indicates that that would need to be
24 redone every 10 to 15 years; right?

25 A: That is actually a recommendation I get from Mobility

1 Works. So when I call and get the cost of the hand controls,
2 they help guide me as to how often they recommend those get
3 replaced.

4 Q: Okay. And that would be with a vehicle that they
5 continued to own for that entire time; correct?

6 A: They are -- actually, they -- you can take it out of one
7 vehicle and put it in another.

8 Q: Okay. Great. And then the next item is the modified van
9 with lift. Is that to assist with getting in and out of the
10 vehicle?

11 A: It is. Getting the wheelchair into -- into and out of
12 the trunk or into and out of the back seat. Again, we don't
13 think about how heavy those are and do they fold up and can I
14 reach over? So, yes, the modified van with a lift would allow
15 her to drive up onto a lift, be lifted up, and she could drive
16 into the driver's seat.

17 Q: Okay.

18 A: Locked down.

19 Q: Is there anything included on this list that would help
20 her actually load a wheelchair into the vehicle?

21 A: Again, she wouldn't have to get out of the wheelchair in
22 the modified van with a lift. She actually would drive from
23 her wheelchair. She wouldn't have to transfer into a driver's
24 seat. They make lockdowns.

25 Q: Okay.

1 A: So she would drive into the space where the -- the seat
2 goes, and the van would lock it down for her, and then she can
3 put her seatbelt on, all those things in her wheelchair.

4 Q: On page 18, you discuss architectural renovations or
5 housing modifications, and the per unit cost indicates it's
6 \$85,000 and some change; correct?

7 A: Correct.

8 Q: And then if you look down here, does this kind of
9 describe the -- the changes that are being referred to by this
10 cost?

11 A: It does. That cost comes from the VA Housing Authority
12 grant. So it -- that's the budget. I try to use costs that
13 are reproducible. This is the number that is allowed me
14 through the VA Housing Authority grant, and that is their
15 recommendation. So I just include them. So I'm not making
16 recommendations.

17 Q: Okay. And so that recommendation is to have a carport or
18 garage with a covered walkway, and what's the purpose of that?

19 A: Again, none of us think about -- well, none of us like to
20 run out in the rain and get in our vehicle if we don't have
21 to, but when you're in a wheelchair and it takes you longer to
22 get there and you have a powered wheelchair in particular,
23 you've got a motor you've got to be mindful of. So it is to
24 help protect that wheelchair, as well as the client.

25 Q: Accessible entrances with 36-inch doorways throughout.

1 So that's pretty self-explanatory. You've got to be able to
2 fit the wheelchair through the door?

3 A: Most wheelchairs, I mean, even for -- well, I won't say
4 for everybody, but most wheelchairs are 32 inches or wider,
5 and you need that clearance room to be able to push. So they
6 do recommend 36-inch doorways.

7 Q: You recommend emergency access off of the bedroom.
8 Explain that to us?

9 A: You know, it's one of the -- again, one of those things
10 none of us ever think about on a regular basis, but I do.
11 Again, it's kind of where I live and breathe. I always have
12 to look at my clients' homes and decide where they sleep, if
13 the house caught on fire at 3 a.m., could they get out without
14 having to go through the main part of the fire? So we do, and
15 it has always been recommended that there's emergency access
16 out the bedroom in case something drastic were to happen and
17 they needed to get out, because getting out, even with my
18 amputation clients trying to get on a -- you know, a
19 prosthetic leg and strapped into it and all those things and
20 get out of a burning home is an issue. So that is why they
21 recommend an emergency access off the bedroom.

22 Q: It's going to take longer for a spinal cord injury
23 patient to get out to evacuate than it would somebody that
24 doesn't have that kind of injury?

25 A: Correct.

1 Q: And accessible bathroom?

2 A: Pretty self-explanatory. Everybody needs to have access
3 to the bathroom to get a shower, do your bowel program, empty
4 your urine if you're doing your bladder program, those kind of
5 things.

6 Q: And does that require the bathroom to be wide enough to
7 be able to turn a wheelchair around once you're in the
8 bathroom?

9 A: Again, they want to look at 36-inch doorways. They kind
10 of have to work with what they have. So that's why I have the
11 home accessibility specialist go out, which is normally an
12 occupational therapist does the home accessibility because
13 they're the ones that work with the activities of daily
14 living. So they get to go and see.

15 Not everybody's home is equal. We know that. So that's
16 why the occupational therapist is so important because they
17 can go in and see how are we accomplishing things today, and
18 what changes can we make to this particular home to make it
19 more safe and more accessible for this particular person to
20 accomplish their activities of daily living?

21 Q: And a cost for that specialist is also included in your
22 report?

23 A: It is. Yes, ma'am. I think it's on the first -- the
24 first page, evaluations.

25 Q: Now, this does not include any modifications to the

1 kitchen or any other area of the house to make things more
2 accessible in those rooms; right?

3 A: I mean, it is an overall budget. So, actually, that
4 would take place between that home accessibility specialist
5 and the Goodwins. They get to choose what is -- where is it
6 she needs to be safe and accessible. They may choose to do
7 that, but that is up to them.

8 Q: But this number that is published doesn't include
9 accounting for that?

10 A: It doesn't. And actually, that -- that budget has
11 increased. I saw that number as I was looking through her
12 charts and, again, the VA about every six months addresses
13 this. And I do so many of these. I think currently in 2023,
14 our budget now is 109,000 and some odd dollars. So they
15 address it every -- about every six months, and they increase
16 it based on building supplies and yada, yada.

17 Q: And since that number is published by the VA, is that a
18 cost that would be available to Crystal and her husband as
19 nonveterans to achieve those modifications?

20 A: It would not.

21 Q: Okay. The last portion of your report deals with
22 potential complications, and this chart looks a little bit
23 different than the other one.

24 A: It'll be the next page.

25 Q: So this doesn't have quite as much information on it.

1 All of the costs are listed as undetermined, and then we have
2 just a comment as to what kind of additional things might be
3 needed. Tell us what the potential complications chart is --
4 is designed to encompass?

5 A: Sure. For me, it is -- again, I think -- I hope I've
6 made it clear I like to use the life care plan as a little bit
7 of an educational tool. So whoever is going to be managing
8 Ms. Goodwin's care after we pass off this -- this life care
9 plan can kind of keep an eye on what we know, our potential
10 complications, or that lovely word that nobody seems to like,
11 that sequela of spinal cord injury orthopedic complications
12 become an issue. Psychological and depression complications
13 become an issue. All of these things that are listed in
14 potential complications, for lack of a better way to explain
15 it, they're less likely than not to happen, but they are
16 realities that can happen.

17 Again, when we look at orthopedic complications, it's an
18 easy one for me to explain, because what we know is that
19 spinal cord injury patients -- again, I don't get to make this
20 up. The Spinal Cord Injury Consortium has done a good job of
21 this, letting us know that these people are -- they're going
22 to have earlier onset osteoporotic changes. Bones are going
23 to get weaker earlier in their lifetime. And so as they
24 transfer, we end up with a lot of folks kind of down the road
25 that have pathologic fractures. They didn't do anything.

1 They didn't fall. They just moved funny, and the bones are
2 more porous and they will break.

3 So again, knowing what is lying ahead for these folks
4 becomes really, really important. My goal as a case manager
5 is, again, I want to avoid as many of these secondary
6 complications as I can because that keeps them out of the
7 hospital. It keeps them healthy. It keeps them moving along
8 with life and not -- not being sick.

9 Q: So the items that you've costed in your report are the
10 things that you can say to a reasonable -- reasonable degree
11 of professional certainty, more likely than not, Crystal
12 Goodwin will need in her lifetime?

13 A: Correct.

14 Q: And these items are other things she should be on the
15 lookout for, because something's probably going to come up,
16 but we don't know what yet?

17 A: Correct.

18 Q: Okay. Have all of your opinions today been to a
19 reasonable degree of professional certainty?

20 A: They have.

21 Q: And do you follow the same process to create a life care
22 plan every time you do it?

23 A: I do. We have a methodology, and I do follow our
24 methodology, yes.

25 Q: And in this case, part of that process was going over the

1 entire report with Dr. Shaufele to discuss those
2 recommendations and really get a solid foundation for what
3 needed to be included?

4 A: Correct.

5 Q: And if Mr. Heitman or Mr. Davis had asked you to create
6 this plan, would it include the same things?

7 A: It would. When I work on the defense side, it's a little
8 bit different. I usually don't have access to the patient or
9 the -- or -- or a physician. So it is a little different, but
10 yes, I follow the same methodology.

11 MS. GOODING: Thank you. I have no further questions.

12 THE WITNESS: Thank you.

13 THE COURT: Cross-examination, Mr. Heitman?

14 MR. HEITMAN: We don't have any questions. Thank you.

15 THE COURT: All right. Thank you. You may step down.

16 THE WITNESS: Thank you.

17 THE COURT: If there is an exhibit, anything you didn't
18 bring with you, don't take with you, please. Thank you.

19 THE WITNESS: I'm flying back to Georgia. Y'all don't
20 want me to have it.

21 MS. GOODING: Your Honor, can she be excused from her
22 subpoena?

23 THE COURT: Any objection?

24 MR. HEITMAN: No objection.

25 THE COURT: All right. You are free to go, ma'am.

DEANNA GLENN - DIRECT BY MS. GOODING

1 THE WITNESS: Thank you.

2 THE COURT: Thank you.

3 You tell me. Should we call the next witness?

4 MS. GOODING: Judge --

5 THE COURT: Or take a lunch break?

6 MS. GOODING: I think we should go ahead and call her. I
7 think we probably can get through direct in time for a
8 reasonable lunch break.

9 THE COURT: Okay. Call your next witness.

10 MS. GOODING: All right. Thank you, Your Honor. The
11 plaintiff calls Ms. DeAnna Glenn to the stand.

12 THE BAILIFF: Put your left hand and raise your right
13 hand.

14 THE CLERK: Do you solemnly swear or affirm that the
15 testimony you are about to give in this case will be the
16 truth, the whole truth, and nothing but the truth, so help you
17 God?

18 THE WITNESS: Yes.

19 THE CLERK: Please state your full name for the record.

20 THE WITNESS: DeAnna Glenn.

21 THE CLERK: You may have a seat, please.

22 THE BAILIFF: Speak a little louder and speak into the
23 mic.

24 THE WITNESS: Okay.

25 DEANNA GLENN, being first duly

1 sworn, testified as follows:

2 DIRECT EXAMINATION

3 BY MS. GOODING:

4 Q: Good afternoon.

5 A: Hello.

6 Q: Please introduce yourself to the jury?

7 A: Say it one more time?

8 Q: Please introduce yourself to the jury.

9 A: Hi, I'm Deanna Glenn. I'm -- I grew up here in Columbia,
10 South Carolina. I'm a mother. I have two kids.

11 Q: How long have you lived in the Midlands?

12 MR. GOINGS: Hold on a second. They're going to make you
13 talk into this microphone.

14 THE WITNESS: More?

15 MR. GOINGS: Yeah, she can't hear you.

16 THE WITNESS: Okay.

17 MR. GOINGS: So try to talk into this mic.

18 THE WITNESS: Right there? Okay.

19 MR. GOINGS: Thank you.

20 BY MS. GOODING:

21 Q: You grew up in this area?

22 A: Yes, I did.

23 Q: And what do you do for a living?

24 A: I'm a physical therapist. I work at the Columbia
25 Rehabilitation Clinic.

1 Q: Please give us the story on your education and training
2 and what it took for you to become a physical therapist?

3 A: Okay. I got my undergraduate degree at the College of
4 Charleston, a bachelor's in biology, and then I went to the
5 Medical University of South Carolina and received my doctorate
6 in physical therapy. While there, I did four clinical
7 rotations in different settings.

8 Q: And as part of your practice, do you treat patients with
9 spinal injuries?

10 A: Yes.

11 Q: Do you help patients to rehab after injuries or
12 surgeries?

13 A: Yes.

14 Q: As part of your practice, do you assess patients'
15 abilities to complete activities of daily living?

16 A: Yes.

17 Q: What kinds of things do you do as a physical therapist to
18 help patients with their functional movement or help them to
19 improve their capabilities?

20 A: We work on improving their range of motion in all their
21 joints. We do strengthening exercises for their upper body,
22 lower body, their core, and we work on balance activities.

23 Q: Great. As part of your practice, do you assess patients'
24 progress and help them to formulate continuing goals for their
25 care?

1 A: Yes.

2 MS. GOODING: Your Honor, at this time we would tender
3 Ms. Glenn as an expert in the field of physical therapy and
4 rehabilitation.

5 MR. HEITMAN: No objection.

6 THE COURT: You may proceed.

7 MS. GOODING: Thank you, Your Honor.

8 BY MS. GOODING:

9 Q: Ms. Glenn, it's my understanding that you have treated
10 Ms. Crystal Goodwin for the last few years; is that right?

11 A: Yes.

12 Q: And --

13 A: About five years.

14 Q: I'm sorry?

15 A: About five years.

16 Q: Five years. And did you create records contemporaneously
17 with your treatment of her?

18 A: Yes.

19 Q: Has she sometimes seen other therapists in your office
20 over the course of those five years?

21 A: Occasionally, yes.

22 Q: And do they also create records when they see her?

23 A: Yes.

24 Q: Do you rely on their records and any information that
25 they may communicate to you in treating, assessing, and

1 diagnosing Ms. Goodwin?

2 A: Yes.

3 Q: And do you kind of reassess her periodically to make sure
4 that you all are keeping up with present goals?

5 A: Yes, we do.

6 Q: Are you here pursuant to subpoena today?

7 A: Yes.

8 Q: I'd like to ask you some questions regarding Ms.
9 Goodwin's care and ask you about your opinions on her
10 treatment and her prognosis, and I just want to ask you at the
11 beginning that you only give me an opinion that you're able to
12 state to a reasonable degree of professional certainty. Are
13 you okay with that?

14 A: Yes.

15 Q: Okay. And if you would like to look at your records, did
16 you bring your copies of your records with you?

17 A: Yes, I did.

18 Q: Okay. If you would like to look at your records in order
19 to respond to my questions at any point, please go ahead and
20 refer to them.

21 A: Okay.

22 Q: When did Ms. Goodwin first treat at Columbia
23 Rehabilitation Clinic?

24 A: July of 2018.

25 Q: And at the time of her initial evaluation, what was her

1 diagnosis?

2 A: Acute infarction of spinal cord.

3 Q: Where did that diagnosis come from?

4 A: The referral from the doctor.

5 Q: So the doctor who referred Ms. Goodwin would have
6 included that as her diagnosis?

7 A: Yes.

8 Q: And in this case, is that Dr. Holbrook? That's on page 4
9 of your record.

10 A: Yes.

11 Q: Okay. What was her reason for needing therapy at this
12 point?

13 A: She was coming in to work on getting stronger,
14 strengthening. Her goal was overall to be able to walk again.

15 Q: And at that initial evaluation, what were her subjective
16 complaints? What did she tell you her concerns were?

17 A: She spoke about having a lot of pain in her back. And
18 again, she just stated that she wants to get out of this
19 chair.

20 Q: What was the mechanism of her injury?

21 A: A surgery that she had in July of 2016, and she said her
22 spinal cord was damaged during the surgery.

23 Q: As a part of that initial evaluation, was an objective
24 examination done?

25 A: Yes.

1 Q: What's the difference between subjective and objective?

2 A: Subjective is what she told us, and objective are
3 measurements that the therapist took where we took strength
4 levels. We may have observed how she transferred, if she was
5 able to -- well, sensation, things of that nature.

6 Q: Okay. And I see in your objective examination, you have
7 left and right here listed for a number of different muscle
8 testing? Can you --

9 A: Correct.

10 Q: Excuse me. Tell us briefly what -- what you do in order
11 to make this assessment?

12 A: So those are left and right, speaking about her legs, and
13 we were checking her strength levels just out of a score of 5
14 that shows, like for her hip flexion, that they're both pretty
15 weak. A 1 is that she can't move it against gravity. There's
16 -- we can palpate the muscle and feel a little bit of a
17 twitch, but she's not actually moving it, able to lift it up.

18 Whereas for knee extension, kicking her leg out straight,
19 she has a 3 plus and a 2 minus, meaning she could not on the
20 right fully move it against gravity. She couldn't fully
21 straighten her leg out. Same thing on the left. She could
22 straighten it some, but she couldn't -- we couldn't apply any
23 pressure to it. She couldn't resist the pressure.

24 Q: And those plus and minuses, can we kind of think of that
25 like we might for a letter grade?

1 A: Right.

2 Q: Like a B plus is a little better than a B?

3 A: Right.

4 Q: A B is a little better than a B minus?

5 A: Correct.

6 Q: Same thing here? Okay. And these are tests that you

7 kind of perform periodically as you're reassessing Ms.

8 Goodwin; right?

9 A: Yes.

10 Q: And have they fluctuated during your treatment of her?

11 A: They have. She has good days and bad days where her pain

12 is worse on some days. Some days her legs are shaking a lot

13 more, and it'll fluctuate through all of our notes. It goes

14 up and down.

15 Q: With regard to the special tests that indicates here have

16 been done, I see WC mat transfer. Does WC stand for

17 wheelchair there?

18 A: Yes.

19 Q: And how does it indicate she was able to do that?

20 A: That she required assistance from a family member.

21 Q: Okay. And the mat that is being referred to here, can

22 you tell us what that is?

23 A: It's our treatment mat. It's like a cushion mat in our

24 gym at my clinic.

25 Q: And how -- where is it off the ground?

1 A: It's about the height of her wheelchair.

2 Q: Okay. So kind of a low table with a --

3 A: Right.

4 Q: -- cushion on it?

5 A: Right. Correct.

6 Q: Okay. And during that assessment, it looks like you also
7 asked her to try to go from sitting to standing in the
8 parallel bars; is that correct?

9 A: Correct. And she required contact guard assistance,
10 meaning we had a gait belt on her, and we had our hand there
11 just in case she were to fall. And yes, contact guard
12 assistance. Yes. And she was able to stand about 10 seconds.

13 Q: So once you were able to help assist her to stand up, she
14 could stand for about 10 seconds while --

15 A: Holding onto the parallel bars, correct.

16 Q: Okay. What does pressure relief -- pressure relief
17 independent mean?

18 A: Meaning that she could push up through her arms to lift
19 her bottom up to prevent pressure sores.

20 Q: And here, does this indicate the test for sitting on the
21 edge of the mat?

22 A: Correct. And she was independent. Well, modified
23 independent. She may have used her arms to help stabilize
24 herself.

25 Q: So she was able to sit independently, but she wasn't

1 comfortable lifting her arms up off the table?

2 A: Correct.

3 Q: And at this initial evaluation, did y'all set some goals
4 for Ms. Goodwin?

5 A: We did.

6 Q: Let's go over those quickly. And you kind of have goals
7 to assess different types of problems that she had that you've
8 already told us about; right?

9 A: Right.

10 Q: And so this first goal says patient to stand with family
11 with -- is that contact guard assistance again?

12 A: Yes.

13 Q: And you want her to stand for two times a day for 3 to 5
14 minutes each?

15 A: Yes.

16 Q: And so, at this point, these are all goals that we're
17 setting. These are things that she's not yet able to do?

18 A: Right. She cannot do them yet.

19 Q: Okay. And a goal related to her -- goals related to her
20 pain are to decrease her pain to 3 out of 10?

21 A: Yes.

22 Q: What was the level to start with? Do you recall?

23 A: At worst, she rated a 10 out of 10 right there.

24 Q: Okay. And then to decrease pain by centralizing the
25 radicular symptoms. Can you tell us what that means?

1 A: She was having symptoms down her leg, pain, and we wanted
2 to centralize it to her back where it was actually coming from
3 to take the pain out of her legs.

4 Q: So instead of pain that kind of shoots down --

5 A: Shoots down.

6 Q: -- the leg?

7 A: We want to centralize it to her back.

8 Q: Localize it as best you can?

9 A: Yes.

10 Q: Next goal is to improve her sitting posture while she's
11 sitting in the wheelchair?

12 A: Yes.

13 Q: And what is the lumbar roll that you refer to there?

14 A: It's a McKenzie roll. It's like a cylinder and it's
15 cushioned. And, you know, we have a natural curve in our
16 lower back, and it helps to give your back support so that
17 you're sitting up nice and tall and not flexed, and it takes
18 pressure off the lower back.

19 Q: And then with regard to these growth assessments, your
20 goal is to be at a 2 plus on the left and a 2 minus on the
21 right; correct?

22 A: Correct.

23 Q: And would that mean that the goal would be to be at least
24 that good in every category that you just kind of showed us?

25 A: Yes.

1 Q: And then the last goal here is that she be able to stand
2 in the parallel bars for five minutes, and then it says SBA.
3 What does that mean?

4 A: Standby assist. Where before contact guard, we had a
5 hand on the belt just in case she needed us. Standby, I'm
6 just standing there, but I don't have to put any hands on her.

7 Q: So you wanted her to get to a point where she could stand
8 up for five minutes, holding on to those parallel bars?

9 A: Correct.

10 Q: Without you touching her?

11 A: Correct.

12 Q: Okay. And then that goal also includes being able to
13 ambulate for five feet in the parallel bars with minimum
14 assistance; right?

15 A: Right.

16 Q: And about what is the length of the parallel bars at
17 physical therapy?

18 A: Give or take about five feet. They're not very long.

19 Q: Okay.

20 A: Yeah.

21 Q: So you essentially want her to be able to --

22 A: Walk all the way.

23 Q: -- walk from one side to the other?

24 A: Yes.

25 Q: Okay. And then you want her to be able to do that ten

1 times in a row?

2 A: Yes.

3 Q: Okay. And with -- what do you mean by with minimum
4 assistance in that context?

5 A: Where at times when she was walking, when we did start
6 doing that, she required some assistance to move her legs
7 forward. She wasn't strong enough to advance her leg, and I
8 would have to pull it forward. So that's helping her some,
9 but she's doing most of the work. I'm just helping the last
10 little bit.

11 Q: Okay. So that's not like the contact guard assistance
12 that you've already told us about, where you're just kind of
13 holding on to her waist. You're physically bending down,
14 grabbing her foot, and moving it forward?

15 A: Moving it forward, yeah.

16 Q: Or assisting her with moving it?

17 A: Right.

18 Q: And that's -- that's the goal to get to that point;
19 right?

20 A: Yes.

21 Q: Okay. I'd like to ask you about some of the exercises
22 that you have had Ms. Goodwin do over the last five years,
23 just to kind of give the jury an idea of -- of the types of
24 things that you're doing while you're there and what you're
25 doing in order to work on these types of goals.

DEANNA GLENN - DIRECT BY MS. GOODING

1 MS. GOODING: And, Your Honor, would it be okay for her
2 to step down off of the stand to show us a few of these
3 things?

4 THE COURT: Yes. Make sure you speak very loudly.

5 THE WITNESS: Okay.

6 BY MS. GOODING:

7 A: All right. So she would be holding on to something. So
8 we may start her with -- come out here?

9 Q: Yeah. If you can step back a little bit so everybody can
10 see you?

11 A: So she'll be holding on to something, and we will have
12 her do calf raises where she would go up and down on her toes
13 as best she can. She uses her arms a lot for her, but it's
14 good for her to weight bear through her legs for that. We
15 would have her do squats, mini squats. That's squatting down
16 and pushing back up.

17 We would also have her do standing abduction, trying to
18 swing her leg out. With this one, it was pretty hard for her,
19 especially in the beginning. I would have to basically be
20 squatting helping her to bring her leg out to the side. We
21 would also have mat exercises where she would lie on her
22 stomach on the mat and do hamstring curls where you would bend
23 your knees.

24 Q: And did you ever modify those for Crystal?

25 A: I did have to because her legs get really stiff, so I

1 would have to bend her legs. I would bend them and then to
2 about 45 to 90 degrees and have her pull the rest of the way.
3 And I would have to get her cues the entire time because she
4 couldn't really feel her legs to know if she was bending it.
5 So I would have to say, keep going, keep going, or tap her leg
6 to make the muscle fire.

7 Q: Okay. And those first couple that you showed us, it kind
8 of looked like you were holding on to a ballet bar as you were
9 doing it.

10 A: So she would be on the parallel bars, or sometimes I
11 would have her -- she would face the bars, but holding on to
12 something.

13 Q: And would she also have other assistive devices for some
14 of those exercises?

15 A: For the exercises, well, she always would have her
16 wheelchair behind her because she never knew if her legs would
17 buckle and she would go down to the chair.

18 Q: Did you use that belt?

19 A: She always has a belt on her. In the beginning, she used
20 to have full leg braces to help lock her legs in because they
21 would buckle. So she would have, like, a knee, ankle, foot
22 orthotic that she would wear in the beginning.

23 Q: Is this what you're referring to?

24 A: Yes.

25 Q: Can you kind of hold that up and just demonstrate to the

1 jury how that can be helpful?

2 A: As you can see, she can't bend. It won't bend at all.
3 So it locks her legs in place so it won't buckle. And by
4 buckle, her legs would just give at any moment. So this would
5 hold it still for her.

6 Q: Okay. And then I think you also just referenced this
7 one?

8 A: This we used later on after she started. Once she was
9 able to stand in the bars for 7 minutes or so, we start
10 working on walking in the bars. She did it with this at
11 first, with me squatting, advancing her leg, helping her pull
12 it through. As she got stronger, I sent her to get fitted for
13 an AFO because I don't know if you remember the strength
14 levels for her right foot, but she's not able to bring her
15 foot towards her. She's not able to bring her toes towards
16 her.

17 So if you're walking, your toe would drag. This keeps
18 her foot flexed almost. So as she walks, it keeps her foot up
19 so her toe won't drag. So she needed to be fitted for this to
20 be able to walk on the bars with me, and this is what she uses
21 to this day. If she's ever up, she has to use this.

22 Q: I'll swap these out for you. While you're standing up,
23 just go ahead and show us what this is and explain that to us?

24 A: It's a solo step. It's a harness that she used to wear
25 when we were in the parallel bars working because, like I was

1 saying, I would have to bend down and advance her leg. This
2 had a cable coming from the ceiling that would prevent her
3 from falling because if I'm squatting, pulling her leg, I
4 can't also hold her up at top. So this was for safety. So if
5 she did go down, she wouldn't fall. It would hold her up.

6 Q: And this kind of straps around her like a vest?

7 A: Yes. It goes to her legs and buckles up and buckles up.
8 So if she did sit down, she would just be hanging.

9 Q: This is pretty heavy?

10 A: Yes.

11 Q: You can go ahead and take a seat. And, Ms. Glenn, you
12 only brought one of these today, but did Crystal wear these on
13 both legs?

14 A: Yes, she had two of them.

15 Q: Now, do any of the exercises you're doing -- are any of
16 those able to help improve her bowel or bladder function?

17 A: No.

18 Q: They were only working on those muscles in the legs?

19 A: Correct.

20 Q: Legs, feet, ankles?

21 A: Yes.

22 Q: Whatever?

23 A: Correct. Uh-huh.

24 Q: And are you doing exercises that affect both her strength
25 and her range of motion?

1 A: Yes. I will manually stretch her quads in front of her
2 thigh when she's laying on the mat. I will manually do that.
3 She's not able to do the stretching by herself.

4 Q: Okay. And how often was Crystal coming to see you for
5 physical therapy when she started?

6 A: Three times a week.

7 Q: Has she continued with that schedule?

8 A: Yes.

9 Q: Okay. Let's look to July 8th, 2019. So this is about a
10 year later, actually, and that's on page 28 and 29 of your
11 records. And we'll put it up here. Tell us about this under
12 the history of present condition, mechanism of injury section,
13 what's kind of her history with physical therapy?

14 A: The history of the present condition?

15 Q: Yes, ma'am. I think it talks about physical therapy
16 before she got to you.

17 A: Correct.

18 Q: I was just curious about it.

19 A: Yes. She was at HealthSouth for inpatient rehab after
20 she was discharged from the hospital, and then she also had
21 home health for a while.

22 Q: So she had done some physical therapy before she got to
23 you?

24 A: Yes. And outpatient. She did the inpatient rehab. I
25 believe she may have had some home health and then outpatient

1 until that therapist released her because they resigned, and
2 then she came to us.

3 Q: Okay. And by this point, about a year after you've
4 started treating her, had she had some improvement in that
5 strength from the hip flexion and abduction, knee flexion and
6 extension and the ankle flexion, as you told us about earlier?

7 A: Yes, she had some improvements, more so on her left side.

8 Q: Okay. With regard to her goals, which are -- are at the
9 bottom of page 29, it looks like by this point she had met the
10 goal of improving her posture; is that right?

11 A: Right.

12 Q: And she had, as you just said, some improvement with her
13 strength?

14 A: Right.

15 Q: And she had some success in the goals related to what she
16 was doing in the parallel bars; right?

17 A: Yes.

18 Q: That last comment on -- on her goal number 5, what does
19 this indicate, stood for 7?

20 A: She was able to stand for 7 minutes in the parallel bars.

21 Q: So on this date was the first time she was -- she hit
22 that milestone? She was able to stand for 7 minutes in the
23 parallel bars?

24 A: Yes.

25 Q: It took her a year to get there. What -- at this point,

1 was she able to ambulate 5 feet back and forth by 10 laps?

2 A: She did 5 feet in the parallel bars with min assist.

3 Q: Okay. So that goal is 75 percent met. So does that
4 indicate to you that she was able to do it once, but not all
5 the way up to 10 times?

6 A: Correct.

7 Q: And even with the increase in the strength that she had
8 that was fairly significant, 7 minutes is kind of her maximum
9 on how long she's able to stand supported by her arms?

10 A: At that time, yes.

11 Q: Okay. I next wanted to ask you about page 42. This is
12 from 7/15/19 in your records, and it looks like this is an
13 order?

14 A: Yes. This is when we were starting to walk more in the
15 parallel bars and she wasn't needing the full braces much, and
16 I was requesting a prescription for her to get the AFO, the
17 smaller brace.

18 Q: So then that's --

19 A: Yes.

20 Q: -- this?

21 A: Yes.

22 Q: Remind me what AFO stands for?

23 A: Ankle foot orthotic.

24 Q: Okay. Ankle foot orthotic. And so Crystal had one of
25 these of her own? Well --

1 A: This is --

2 Q: -- you're putting in the order for her to?

3 A: Yes. At that time, yes.

4 Q: Okay.

5 A: She was going to get fitted for one.

6 Q: And this keeps her foot even?

7 A: Right. So her toe doesn't drag because she can't
8 actively -- she doesn't have the strength to pull up her toes
9 herself.

10 Q: And so let's look at August 14th, 2019. This is after
11 she was able to get the ankle foot orthotic. And under
12 assessment, does it indicate that she seemed to have some
13 success with that? Was it helpful to her to get that
14 orthotic?

15 A: Yes. She was able to walk in the parallel bars wearing
16 the AFO.

17 Q: And I believe this is the first date that indicates
18 patient is able to ambulate independently with parallel bars
19 with AFO today. Did I read that correctly?

20 A: Right. Without me helping her to advance her leg.

21 Q: Okay. And then where it says patient only required very
22 little assistance in placement of RLE when sidestepping in
23 parallel bars, tell us what that means?

24 A: I had her stand up and sidestepping down the bars, and I
25 didn't have to -- a lot of times, because it's harder to go

1 that way and you're holding in a different way because you're
2 holding different bars in front of you, so that's much harder
3 for her. I didn't have to help her that day with moving her
4 leg to the side, more so probably as she was coming back down
5 the bars I didn't have to. Sometimes I have to put my foot in
6 between her leg and push the right leg out. I didn't have to
7 do that as much that day.

8 Q: Okay. And again, all of these exercises are done in the
9 parallel bars with that belt on?

10 A: Yes. She always wears a belt.

11 Q: In case she needed help?

12 A: Yes.

13 Q: Did she at this point have similar goals to those that
14 you set in 2018?

15 A: Yes.

16 Q: And so you still have a goal of her standing with her
17 family at home?

18 A: Yes.

19 Q: Still have a goal of trying to decrease that pain?

20 A: Correct. Yes.

21 Q: Have you really made any progress with Crystal in
22 decreasing the pain that she has?

23 A: No. Her pain is pretty constant.

24 Q: She met the goal for her good sitting posture?

25 A: Yes.

1 Q: That's good news. And then you have 75 percent with
2 regard to the -- the strength improvement. Tell us kind of
3 what you're looking for there?

4 A: Her left side was getting stronger. She had some
5 improvements on the right. I gave it 75 percent because the
6 right wasn't as strong as the left. She still wasn't able to
7 fully extend, like, extend her leg and hold it against gravity
8 or me pushing down on it. The strength just wasn't there,
9 more so on her right side.

10 Q: We're still working on increasing the endurance or the
11 number of times that she's able to do that 5 feet in the
12 parallel bars; is that right?

13 A: Right.

14 Q: And in the comment section just above there, I think it
15 indicates that she was able to sidestep in the parallel bars
16 only 1 to 2 laps at this point?

17 A: Right. And that varied from session to session.

18 Q: Let's talk about the process that you all went through to
19 try to get Crystal walking, and I know that you talked about
20 it a little bit when you were showing us these -- these
21 devices, but when -- when she first came in, step one, before
22 she started walking, was what?

23 A: Being able to just stand in the parallel bars.

24 Q: And when you first were doing that, did you have -- were
25 you using these at all?

1 A: I'm not sure. I know I definitely had a gait belt on
2 her.

3 Q: Okay.

4 A: I was definitely there in case she -- and she had a
5 wheelchair behind her.

6 Q: Okay. And then when she started walking?

7 A: She definitely had that.

8 Q: Okay. And when she first started, were you using these
9 leg braces?

10 A: Yes. She was using that while just standing and also
11 when we initially started walking.

12 Q: Okay. And then we just looked at an order that you put
13 in once she got a little bit better to go ahead and get that
14 ankle foot orthotic?

15 A: Yes.

16 Q: Okay. And does she eventually accomplish this goal that
17 we see here?

18 A: Yes.

19 Q: That she can go back and forth?

20 A: She was able to walk back and forth in the parallel bars.

21 Q: Okay. Great. Once -- once she is able to go back and
22 forth across the parallel bars, what's the next step in trying
23 to get her, you know, walking a little bit more?

24 A: Then we started walking with a rolling walker to get her
25 used to that, and then eventually we moved out of the bars,

1 and I had her walk in the gym with a gait belt, her AFO on,
2 the wheelchair following, and a rolling walker.

3 Q: Okay. So when you first introduced the walker, she was
4 actually walking with the walker in between the parallel bars?

5 A: Yes, I believe so. Yes.

6 Q: Okay. And then once you kind of moved past that, you had
7 her going into the gym so she could walk a little bit further?

8 A: Yes.

9 Q: Okay.

10 A: Because she was able to walk back and forth at that time.
11 So she needed to be able to go a little bit further because
12 the bars aren't very long.

13 Q: Okay. And when you're doing that walking in the gym, you
14 said she had the rolling walker?

15 A: Yes.

16 Q: The ankle foot orthotic?

17 A: Yes.

18 Q: And this is metal?

19 A: Yes. Well, I don't know if it's metal. I don't -- I
20 don't make it, but it's firm. It is firm, yeah.

21 Q: This isn't giving her any flex?

22 A: Right. It doesn't move. Yes.

23 Q: We won't get into what the -- what the material is. You
24 had that belt on her so you can give her contact assistance?

25 A: Yes.

1 Q: You have hands on her the whole time?

2 A: Yes.

3 Q: Is that for safety?

4 A: Yes. For safety.

5 Q: And then somebody else is following her with a
6 wheelchair?

7 A: Yes.

8 Q: So that's a two-person job?

9 A: It is.

10 Q: Has she progressed beyond walking as you just described
11 it?

12 A: No.

13 Q: To this day, she has not?

14 A: No.

15 Q: Okay. Have you continued to work on the distance that
16 she's able to go with all of those assistive devices that
17 you've just described?

18 A: Yes. Using all of that, I want her to be able to walk
19 laps around the gym, but it fluctuates. It all depends on her
20 pain that day. It depends on if her legs are buckling more
21 that day, if she's having muscle spasms that make her shake
22 uncontrollably, all of that tires her out. So my goal is,
23 yes, for her to walk a lot longer around the gym, but it just
24 -- it changes from session to session.

25 Q: Has she ever, in the entire time that you've been working

1 with her, taken a step without holding on to parallel belt --
2 parallel bars or a rolling walker for support?

3 A: Never.

4 Q: Okay. Does she have to rely on some upper body strength
5 to be able to use those devices?

6 A: She uses a lot of upper body strength. It's mostly upper
7 body. Her legs have gotten stronger, but they're -- they're
8 stiff, so, like, when we're taking a step, we kind of flex our
9 hip a little bit. She's not able to do that as she's walking.
10 So she uses her upper body to kind of press up a little bit to
11 try to advance her legs some.

12 Q: And do you sometimes do exercises with her to improve her
13 ability to rely on those upper extremities?

14 A: We do some. Occasionally we'll do some, like, TheraBand,
15 the elastic bands. We'll do some strengthening with that, but
16 she gets a lot of upper body workout during the session
17 because she's having to lift herself up all the time. So --

18 Q: If she's having pain in her shoulders or arms, do you try
19 to address that?

20 A: I do.

21 Q: Through therapy?

22 A: Yes.

23 Q: Because she needs those?

24 A: Right. She needs her arms, yes.

25 Q: Okay. Did Crystal's family members ever come to physical

1 therapy with her?

2 A: She always had somebody with her. Every visit there was
3 a family member there.

4 Q: And did they stay with her?

5 A: Yes, because they helped during the sessions. Usually,
6 it's her family member pushing the wheelchair because I have
7 my hands on her.

8 Q: Do you see any of those family members that came with her
9 today here in the courtroom?

10 A: I do. Her husband. Her mom has been there before, too.

11 Q: Wonderful, wonderful. And was -- was her family
12 encouraging of her when they were there?

13 A: Very encouraging, because even when she's tired -- and
14 she works hard in there. Even when she's tired, they're there
15 encouraging her, like, you can go a little bit further, mom,
16 go a little bit further. So she has a great support system.

17 Q: Do they ever take videos of her to help track her
18 progress?

19 A: They do, yes.

20 Q: And have you had an opportunity to review some of those
21 videos?

22 A: Yes.

23 Q: I'd like to show you a video from one of the physical
24 therapy sessions, and this is from September 11th of 2019, and
25 we're going to put it up on the screen here. So, if you can,

1 point out who you see and what y'all are doing and any of the
2 assistive devices that are being utilized, you know, as best
3 you can to point those out, that'd be very helpful.

4 A: Okay.

5 (WHEREUPON, the video was played.)

6 A: Well, that's me and, of course, Crystal, and her husband
7 pushing the chair. She has the AFO on her right foot, the
8 walker, with the black strap around her right ankle.

9 THE COURT REPORTER: Can you pause it while she's
10 talking?

11 THE COURT: Okay. Pause.

12 (WHEREUPON, the video was stopped.)

13 THE COURT: It's hard for the court reporter to hear with
14 the audio going on the video and the witness talking.

15 MS. GOODING: Well, we'll just play the video and then
16 I'll ask her after if that's okay.

17 THE COURT: Yes.

18 (WHEREUPON, the video was played and then stopped.)

19 BY MS. GOODING:

20 Q: Was that a first for her?

21 A: That's the first time she walked out of the parallel
22 bars.

23 Q: Is that an emotional moment?

24 A: Very much so. Everybody was happy at this at the office.

25 Q: And when you say everybody at the office was happy,

1 you're referring to other physical therapists who were there?

2 A: Yes. Office staff. Everybody was excited for her.

3 Q: I guess by this time she had been coming for over a year?

4 A: Right. Yes.

5 Q: People -- people knew her. Does this video accurately
6 portray the work that Crystal was doing in physical therapy in
7 September of 2019?

8 A: Yes.

9 MS. GOODING: Your Honor, I would like to move this video
10 into evidence as Plaintiffs' Exhibit Number 23.

11 MR. HEITMAN: Your Honor, we would like to object to
12 that. I'm not sure if it's evidence.

13 THE COURT: What's the legal basis that makes it
14 objectionable?

15 MR. HEITMAN: It's not part of medical records. It's
16 just a bunch of evidence.

17 THE COURT: That will be Plaintiffs'?

18 MS. GOODING: 23, Your Honor.

19 THE COURT: 23 admitted over the defense objection.

20 (WHEREUPON, Plaintiffs' Exhibit Number 23, video, was
21 admitted into evidence.)

22 MS. GOODING: Thank you, Your Honor.

23 BY MS. GOODING:

24 Q: Ms. Glenn, when your records indicate that Crystal walked
25 for a certain distance or Crystal ambulated for a certain

1 distance, is this the -- the walking that you're referring to?

2 A: Yes. That's the only way she walks.

3 Q: Okay. And you can actually see -- where this video is
4 paused, you can see the contact belt that you've been talking
5 about pretty well there?

6 A: Right. And the AFO, yes.

7 Q: That strap there?

8 A: Yes.

9 Q: That's the AFO that she used. And this is the rolling
10 walker?

11 A: Yes.

12 Q: All right. And then is it -- is the wheelchair always
13 that close behind her as she's doing this?

14 A: That close, yes.

15 Q: What's the purpose of that?

16 A: Her legs will buckle and she buckles, as give, like where
17 she almost falls down, and the chair is there to catch her if
18 we need to. Or she has trembling in her legs, which fatigues
19 her, and she needs to sit down right then. So we can't get to
20 a mat or something when she has to sit down right then.

21 Q: Okay. And at the very next visit on September 13th,
22 2019, this is page 95 in your records. What does she report
23 very first thing to you?

24 A: That her family was happy and excited to see the video of
25 her walking in the gym.

1 Q: And that's the video that we just watched?

2 A: Yes.

3 Q: Shortly thereafter on September 18th, 2019, it looks like
4 Crystal reported another accomplishment to you at that visit?

5 A: Yes. That she was able to get into her husband's truck
6 today with assistance from him.

7 Q: What types of assistance could Crystal utilize in order
8 to get in and out of a vehicle?

9 A: He probably had to lift her into the truck. She just
10 probably hadn't been in there in his truck for a while, but
11 she didn't have the strength yet to step into the truck. But
12 she wouldn't have been able to do it by herself.

13 Q: And on the assessment that day, it indicates that her --
14 patient's husband -- so Mr. James -- provided CGA or contact
15 assistance during the ambulation to instruct him on how to
16 ambulate with the patient at home. Did I read that right?

17 A: Yes.

18 Q: What was the purpose of that?

19 A: So our goal is for her to try to stand more at home, try
20 to walk at home as well, but he needed to be instructed on how
21 to keep her safe as well. And so that's what we worked on
22 that day.

23 Q: Have you ever recommended to Crystal that she practice
24 standing or walking at home when she does not have the
25 assistance of a family member?

1 A: Never. No. She would need at least two people with her
2 to walk, somebody to have their hand on her and another person
3 with the wheelchair right behind her.

4 Q: And so you took the time during physical therapy to train
5 her husband on how to provide that assistance for that safely?

6 A: Right.

7 Q: About a month later on October 18th, 2019 -- and this is
8 page 119. 119 of your record starts the record. I'm actually
9 going to look at 120 with you. The assessment says patient is
10 very motivated with physical therapy and is pleased with her
11 progress so far. Did I read that right?

12 A: Yes.

13 Q: Let's look a little bit at what -- what that progress is
14 that she's excited about, and I think it indicates in the --
15 in the comments there kind of what all of her accomplishments
16 are.

17 A: That she was -- had been able to stand more than 5
18 minutes, which we know because she was also able to walk 150
19 feet with the rolling walker and contact guard assist with the
20 wheelchair following, and she also needed rest break as
21 needed. So she did a total of 150 feet, but it wasn't all at
22 one time. She would rest and sit down if she needed to.

23 Q: 150 feet is about the distance from you to the back of
24 the courtroom? Would you say that's about right?

25 A: Probably, yes.

1 Q: And she was very pleased at this point to be able to get
2 that far, even though she had to take multiple breaks during
3 that time?

4 A: Yes.

5 Q: And would that have been on a flat surface?

6 A: Yes.

7 Q: And again, with the walker, the belt, the wheelchair?

8 A: The AFO, all that, yes.

9 Q: Let's look at November 4th, 2019. This is page 141 of
10 your records, and here it indicates patient says that she was
11 able to walk at home to her couch. Patient also stated that
12 she was able to transfer sit/stand from the couch. Now, this
13 obviously happened in her home?

14 A: Correct.

15 Q: But would have been done under your direction. What kind
16 of walking was she doing at home?

17 A: The same that you saw in the video. She would still need
18 somebody there to hold on to her. She would need a walker.
19 She would have to have her AFO on and the wheelchair right
20 behind her.

21 Q: Have you ever had any reason to believe or any concerns
22 that Crystal has not followed your recommendations to take
23 part in those safety measures when she has attempted to -- to
24 do any walking or standing?

25 A: Oh, no. She's very much -- she does not want to fall and

1 she's always safe.

2 Q: I want to look a little bit at her progress and goals on
3 this visit, and I understand that there's a difference in
4 these records between the daily notes and the progress notes;
5 is that right?

6 A: Yes.

7 Q: Tell us just briefly what that difference is?

8 A: So the daily note is a quick summary of how she did that
9 day. So I may have said that she had trouble like pain and
10 was unable to walk as far that day or I may say that she
11 walked for 25 feet.

12 The assessment or the progress note is what we send to
13 the doctor, and that's usually a little bit more detailed.
14 I'll also include that she needed a rolling walker and a
15 wheelchair following her, but that's not always on the daily
16 note, because anybody in our office already, if they were to
17 work with her, they would know that she needs all that stuff,
18 and they can also look at her strength levels to know that she
19 would need an AFO, that she would need a walker. And so
20 that's not always included in the daily note, but it's in the
21 assessments.

22 Q: Okay. So the assessments or the progress notes are a
23 little bit more detailed?

24 A: Right.

25 Q: And is that when you update her goals?

1 A: Yes.

2 Q: And what goals she's met and add new goals?

3 A: Yes.

4 Q: Okay. And then do those goals kind of continue to carry
5 forward until she gets to that next assessment?

6 A: Yes. A lot of the documentation carries over to the next
7 note until we drop -- it drops off. We take it off if it's
8 not current or correct anymore.

9 Q: And at this point, she's doing well enough that you added
10 a couple of new goals; is that right?

11 A: Yes. For her to walk a little bit further with standby
12 assist but still the wheelchair following, meaning I'm right
13 beside her, but I don't have to have my hands on her. But she
14 still needs the wheelchair right behind her because you never
15 know when she may need to sit down.

16 Q: Would she still be using the walker and the AFO?

17 A: She will still need a walker. She will still need the
18 AFO.

19 Q: And, you know, these records have indicated that she has
20 -- has made good progress. Was her progress linear in terms
21 of how long she's able to stand and how far she is able to
22 walk?

23 A: It goes up and down because at that time she was able to
24 stand for 7 minutes. A couple weeks ago, she was only able to
25 stand for about 2 minutes and 20 seconds or so because of the

1 pain. She was having bad burning in her calf and was unable
2 to stand any longer. So it goes up and down depending on how
3 -- what her pain levels are that day.

4 Q: Can you explain us -- explain to us a little bit how
5 Crystal can be a patient with a spinal cord injury who has
6 weakness in her legs, partial paralysis, functional paralysis,
7 but also has pain in those same extremities?

8 A: Her -- she has an incomplete injury, and so there's
9 sensory and motor neurons. So she has weakness, as you can
10 tell. Like, one side is weaker than the other. Her left leg
11 is just a little bit stronger. She also has less sensation on
12 one side, and she'll have some feeling on one side more than
13 the other, just because it's an incomplete spinal cord injury.

14 Q: And when y'all have been able to work on Crystal standing
15 for a period of time, have you also attempted to help to work
16 on her ability to stand only supporting herself with one arm?

17 A: We have because her -- her goal is to be able to walk
18 without any assistance. So the next step would be to try to
19 use just one hand to hold on to. So we -- several years ago,
20 she -- I had her play on the Wii. I think she was playing
21 with her daughter. So we did that. I also had her write a
22 note to her husband or told her she could write a love note to
23 her husband just to practice standing and not having both
24 hands on support. So we did work on that, yes.

25 Q: Is -- is working on that an important goal for somebody

1 who would like to be able to cook and bake?

2 A: Yes. Yes.

3 Q: And sidestepping is another thing that you've noted in a
4 number of these records. Right here it says patient had a
5 little more difficulty today sidestepping on the parallel
6 bars. It seems like that's really been an area that she's
7 gone up and down in these notes?

8 A: Yes. We originally started trying to sidestep because
9 she told me early on that one of her main goals was to be able
10 to get into her bathroom, and her chair wouldn't fit in there
11 and it was hard for her husband to go with her. So in order
12 to get in there, she would need to be able to sidestep, and
13 that's where that goal in us working on that came from because
14 she said she hadn't been in her own bathroom. And I believe
15 at that time, when she started with me in 2016, she hadn't
16 been in her bathroom in, like, three years, I think she told
17 me.

18 Q: 12/4/19, December 4th, 2019. This is page 158 in your
19 notes. It indicates that she was able to stand about 10 to 15
20 minutes while doing Wii bowling with her daughter. Is that
21 what you were just referring to?

22 A: Yes. And she still has the walker there and I was still
23 there holding on to her, and the wheelchair is still behind
24 her. Yes.

25 Q: Okay. But she was able to take that one hand off so that

1 she could use that --

2 A: Yes.

3 Q: -- Wii remote?

4 A: Uh-huh.

5 Q: And she was -- she was very pleased with that?

6 A: She was excited, yes. Uh-huh.

7 Q: And that was only for about 10 to 15 minutes?

8 A: Right.

9 Q: Does she tend to tire out when she's doing these things?

10 A: Yes. Especially for her, if it's a day when her legs are
11 having more spasms, it -- it's involuntary. Like, she can't
12 control it, so it tires her out.

13 Q: I'd next like to look at December 18th, 2019. This is
14 page 165 in your records, and it looks like at this point
15 Crystal comes in and tells you that she had achieved a huge
16 goal. What has she achieved at this point?

17 A: She was able to walk into her bathroom.

18 Q: Do you remember this?

19 A: I do because she was very excited because, again, she had
20 told me that it had been years since she had been in her
21 bathroom, and everybody likes that type of privacy to be able
22 to go into your bathroom and do your business. And she was
23 very excited that day that she was able to.

24 Q: And at this point, was she able to do anything other than
25 just stand in the bathroom?

1 A: I believe she used the toilet that day.

2 Q: Would have used the toilet to cath herself?

3 A: Or she may have sat down to rest, but I just know she was

4 there. Yeah.

5 Q: Okay. And on the same day, she also reports pain,

6 doesn't she?

7 A: Yes.

8 Q: Is an incomplete injury like Crystal has, as you've just

9 described with some sensory and motor function, more painful

10 than a complete injury would be?

11 A: It probably varies from person to person.

12 Q: Let's look at March 4th, 2020, and this is page 215 in

13 your records, and it looks like Crystal has some new goals.

14 What are those?

15 A: To go up and down stairs. Well, she walks in her

16 bathroom at home, but she wants to be able to go up and down

17 stairs, the steps, and also get into her bathtub at home.

18 Q: So March of 2020, she sets the goal that she wants to be

19 able to get into that bathtub?

20 A: Yes.

21 Q: And in the assessment here, I see that this is one of

22 those days y'all had to do some shoulder exercises?

23 A: Yes, we did.

24 Q: And then what else were y'all working on on that day?

25 A: Being able to step up onto a two-inch step.

1 Q: Would you recommend that Crystal attempt to navigate
2 steps outside of therapy?

3 A: No, no.

4 Q: Would that be dangerous for her?

5 A: It would be. On here, she was just able to do it with
6 her left leg. She wasn't able to stand up or step up with her
7 right leg.

8 Q: And on 8/27/2020, which is page 260 of your records and
9 almost six months after that March 4th date, what did she
10 report?

11 A: That she was having heavy bleeding, and she was following
12 up with her M.D. on Monday. That she was very excited to
13 report that she was able to sidestep into her bathroom and
14 take a bath.

15 Q: Were you proud of her?

16 A: Very proud of her.

17 Q: Now, do you remember talking to Crystal about this?

18 A: Yes.

19 Q: And what did she tell you?

20 A: That she was able to take a bath, but it was very
21 difficult. That it required three people to help her to get
22 in and out of the bathtub because she can't step in or out by
23 herself. So she was happy to be able to do it, but it was too
24 hard to do that daily.

25 Q: And did she still have to use the bedside commode in the

1 tub?

2 A: Yes.

3 Q: Okay. So she -- she wasn't taking a bath like most
4 people would picture taking a bath?

5 A: Right. No. Yeah.

6 Q: Let's look at December 2nd, 2020, and this is page 312 of
7 your records. And this is one of those longer, more detailed
8 notes that you were telling us about. And in the comments, it
9 says patient reports being able to take baths now in the
10 bathroom. Do you see that?

11 A: Yes.

12 Q: Does that indicate to you that she was continually taking
13 baths in the bathroom?

14 A: No. I was just documenting that she had done it that one
15 time.

16 Q: As far as you know, she did it one time?

17 A: Yes.

18 Q: Is that the type of thing that you guys talked about that
19 you kept up with? You wanted reports from her on what she was
20 able to accomplish when she was away from there?

21 A: Yes. Because I would see progress, of course, in therapy
22 with her, but I wanted to also know what she saw, what she was
23 improving with at home in her daily life.

24 Q: Okay. The comments also say here transfers independently
25 without use of a sliding board. We've talked about this a

1 little bit in this case, but just remind the jury what a
2 sliding board is?

3 A: Patients will use it to transfer from, like, their
4 wheelchair to another surface, whether it be the mat or their
5 couch at home, their bed, just from their chair to a different
6 surface.

7 Q: And the fact that she's able to do transfers
8 independently without a sliding board, what would that mean?

9 A: In our clinic, she was able to go from her wheelchair to
10 the mat without use of a sliding board. The mats are about
11 the height of her chair, and she was able to push up through
12 her arms and lift her hips over to the mat. The wheelchair
13 would have to be, like, right up to the mat though.

14 Q: Okay. So she would kind of push up on the arms of her
15 wheelchair?

16 A: Uh-huh.

17 Q: And scoot her bottom over?

18 A: Onto the -- the wheels of her wheelchair I think she
19 uses.

20 Q: Okay.

21 A: Yes.

22 Q: And --

23 A: But it's all upper body. No -- she's not using her lower
24 body for it.

25 Q: Okay. So, at this point, her upper body had gotten

1 strong enough that she's able to do this without sliding?

2 A: Yes.

3 Q: She was kind of able to hold herself up long enough?

4 A: Right, to shift over to the mat, yes.

5 Q: Okay. And you said that was kind of an even transfer?

6 A: Yes.

7 Q: Okay. Is that another one of the things that y'all were
8 working on in physical therapy?

9 A: Yes.

10 Q: Okay. And it looks like from this note she has continued
11 making some progress in her standing tolerance; is that right?

12 A: Yes. She was up to or greater than 15 minutes at that
13 time.

14 Q: And she is able to sidestep in the parallel bars how
15 much?

16 A: Two to three laps.

17 Q: And again, she's walking with contact guard assistance,
18 rolling walker, rest breaks, wheelchair behind her, but how
19 far had she achieved at this point?

20 A: She did 215 feet with rest breaks as needed and 115 feet
21 that at that time without a rest break.

22 Q: And is she able to go those distances currently?

23 A: No. No. She needs -- no. It's been harder for her to
24 walk lately.

25 Q: Let's look at January 11th, 2021. This is page 331 of

1 your records. And again, in the assessment it indicates that
2 she -- she did pretty well in the session, but she did have
3 some fatigue and that you're encouraging her to walk and stand
4 more at home in order to improve her endurance; is that
5 correct?

6 A: Yes.

7 Q: It also says that patient reported that her legs felt
8 like they did prior to her surgery, and that she is concerned
9 about that and is going to talk to her M.D.; is that right?

10 A: Yes.

11 Q: So at the next visit, which is 1/13/21, which is page
12 333, you see a little bit about what she's dealing with right
13 here. It says she attempted to sidestep in the parallel bars
14 but was only able to make it a few steps due to her LE.

15 That's --

16 A: Her lower extremities.

17 Q: Okay.

18 A: Her legs.

19 Q: Buckling and weakness in her legs; is that right?

20 A: Right.

21 Q: Did she have an issue with her legs buckling at one point
22 prior to that 2016 surgery?

23 A: No. Prior to 2016, no.

24 Q: Something propelled her to -- to get that surgery?

25 A: Well, not that I'm aware of because I didn't know her

1 then. I'll just say it that way. Not that I'm aware of.

2 Q: Okay. Is this leg -- her leg buckling the concern that
3 she has regarding the weakness in her legs?

4 A: Say that one more time, please?

5 Q: Her legs buckling?

6 A: Yes.

7 Q: When that -- when you're referring to that concern about
8 the weakness in her legs, is this what she's referring to?
9 The legs buckling?

10 A: Yes. Because it's scary because she doesn't want to
11 fall. Like, she could just hit the floor.

12 Q: And as far as you know, that was not an ongoing problem
13 for her prior to 2016?

14 A: Not that I know of.

15 Q: Let's look at June 3rd, 2021. This is page 385 in your
16 records, and it looks like this is after Crystal has had a
17 little hiatus from physical therapy, and this is her first
18 trip back to physical therapy for a few months. It says
19 patient S/P. Does that mean status post?

20 A: Yes.

21 Q: In other words, this has just happened?

22 A: Yes.

23 Q: And -- and a laminectomy, which is a surgery; correct?

24 A: Correct. Yes.

25 Q: And it indicates that she got two rods and four screws.

1 Is that your understanding?

2 A: Yes.

3 Q: Would -- would that hardware have helped to stabilize her
4 spine?

5 A: Yes. The rod and screws, yes.

6 Q: Okay. And if you look to the comments on the following
7 page, we see kind of an update on where she is at this return
8 to therapy, and it indicates that her standing tolerance is
9 about 1 to 2 minutes at this point?

10 A: Right.

11 Q: Do you have to build her back up after this?

12 A: Yes.

13 Q: Okay. So let's look. We'll go about a year forward to
14 -- to see that progress. May 6th, 2022. This is on page 598
15 of your records. And this record includes some history so
16 that we're kind of able to see what her -- her reports have
17 been and her subjective complaints over the last year or so
18 before this visit. And so read to us what the concern was on
19 June 30th, 2021?

20 A: And what page is this?

21 Q: I'm sorry. Page 598 from May 6th.

22 Q: Oh, June 30th. Patient reports her legs have been more
23 stiff lately, and she will speak with M.D. about it tomorrow
24 at her appointment.

25 Q: And what's her complaint on 9/1/2021?

1 A: Patient continues to report frequent shaking of bilateral
2 lower extremity, pain in her lower back and along her
3 incision, and decreased lower extremity strength, right more
4 than left.

5 Q: And in October and December of 2021, does she have
6 similar reports of pain and stiffness?

7 A: Yes. And her legs shaking.

8 Q: And is she able to control that shaking in her legs?

9 A: No.

10 Q: Is that -- does that inhibit her voluntary movement when
11 that's occurring?

12 A: Yes. If we're walking and she starts shaking, she -- she
13 usually will just stop and stand there to see if it'll calm
14 down. Sometimes she'll try to walk through it, but it just --
15 it completely tires her out. So we usually have to sit down.

16 Q: And again, in February, March, April of that year, she
17 indicates that she has pain and shaking in her legs and -- and
18 pain in her back as well; right?

19 A: Yes.

20 Q: What about on April 28th, 2022? What does she tell you
21 about?

22 A: She states that it tooks her 20 minutes -- it took her 20
23 minutes to put on her pants because her legs were shaking so
24 bad.

25 Q: And on May 6th, 2022, she says that her back has been

1 hurting. What does she report about that back pain?

2 A: That she had difficulty sleeping the last two nights.

3 Q: But she still came to physical therapy; right?

4 A: She always came, no matter how she was feeling. If she
5 could get there, she would, and she worked hard.

6 Q: And if we'll -- if we look at the assessment and look at
7 the goals here -- this is on page 599. We're able to see that
8 she has made some improvement to those goals that you set back
9 about a year earlier?

10 A: Yes.

11 Q: Has she made any progress in decreasing her pain?

12 A: No.

13 Q: What about with regard to her posture and building that
14 back up?

15 A: She was about 50 percent there.

16 Q: Compliant with using that lumbar roll that you told us
17 about?

18 A: Right.

19 Q: So she was able to do that piece at home at least?

20 A: At times, yes.

21 Q: Okay. And with regard to her strength, how is she doing?

22 A: About 40 percent. It was -- she was getting stronger,
23 but it wasn't -- she couldn't -- she wasn't at 3 plus yet.

24 Q: So she's about 40 percent of the way to that 3 plus,
25 which -- is that what you described as being able to -- to

1 move against gravity but without any pressure?

2 A: Correct.

3 Q: Okay. So she was kind of significantly behind. She was
4 60 percent behind that at this --

5 A: Right.

6 Q: That's your best guess?

7 A: Yes.

8 Q: Okay. But she was able again to ambulate 10 feet in the
9 parallel bars with minimum assistance?

10 A: Correct.

11 Q: Minimum assistance, as opposed to contact guard
12 assistance or standby assistance means that you're nudging?

13 A: Having to help her a little bit more. Hold on to her a
14 little bit more or help advance a leg, but she required some
15 -- a little bit more assistance than me just having my hand on
16 the belt.

17 Q: And -- and you set some additional goals for her to try
18 to continue to achieve at that point?

19 A: Yes.

20 Q: You said she's still treating with you about three times
21 a week; is that right?

22 A: Yes.

23 Q: I'd like to look with you at her most recent progress
24 report from this year, which is -- that we have in the records
25 that we've been able to get, which is March 21st, 2023. This

1 is on page 724 of your records. So this is a reasonably good
2 assessment of where Crystal stands today; is that right?

3 A: Yes.

4 Q: So this would have been five weeks ago or something like
5 that?

6 A: Yeah.

7 Q: Not even that long. And again, at the beginning of this
8 record, you see the kind of ongoing complaints that go back
9 related to her pain and her legs shaking?

10 A: Yes.

11 Q: And have you also noticed or -- I'm sorry -- noted some
12 concerns about her feeling down?

13 A: Yes. She stated that on -- well, that was December 8th
14 of '21. She stated that she was feeling down, and she would
15 tell me that off and on, that she would have some days where
16 she felt discouraged or just upset that -- of where she is now
17 and not being able to walk and stuff and do other activities
18 at her home or with her family members. So she would talk
19 about that off and on throughout all of our sessions.

20 Q: When she was feeling accomplished, did she tend to be --
21 have a better mood?

22 A: Yes. Uh-huh.

23 Q: And was it difficult for her to have those dips in her
24 treatment, as you kind of described earlier on a good day or
25 down?

1 A: Right. It was hard because sometimes she feels like
2 she's not as strong as she was a couple years ago or why is
3 today so bad when I could do this at our last session? It was
4 just up and down, and it affected her mood sometimes. Not
5 that it affected how hard she worked in there, but she would
6 just say that she was feeling a little bit down.

7 Q: And her -- her goals still are what we've been talking
8 about along and along, build up the endurance to stand in
9 those parallel bars, improve that posture, continue to gain
10 strength, ambulate for further distances with the -- with the
11 assistive devices that you've told us about?

12 A: Right.

13 Q: Right?

14 A: Yeah.

15 Q: I see here that Crystal's stated goal is to be able to
16 walk without assistive devices?

17 A: Right.

18 Q: Tell me about that. Is that a goal that you set for her?

19 A: That's her goal. That's what she would like to achieve,
20 yes.

21 Q: And she's been doing physical therapy with you for about
22 five years now?

23 A: Yes.

24 Q: And she was doing physical therapy somewhere else even
25 prior to that?

1 A: Yes.

2 Q: And at this point in her physical therapy and rehab, has
3 Crystal been able to stand at all without holding on to
4 something?

5 A: No.

6 Q: Has she ever been able to take a step without the use of
7 all those assistive devices that you've told us about?

8 A: No.

9 Q: How realistic is her goal of being able to walk without
10 assistive devices?

11 A: And it's hard for me to say this because I don't tell my
12 patients that they can't do something, but from what the
13 progress I've seen over the years, she's going to always have
14 to have an assistive device. She's going to always have to
15 have the AFO, the ankle orthotic. She's going to always need
16 a walker, and she's going to always have to have the
17 wheelchair with her.

18 Q: Do you expect to a reasonable degree of professional
19 certainty that Crystal will ever be able to walk without those
20 assistive devices ever again?

21 A: No.

22 Q: And to a reasonable degree of professional certainty, do
23 you think that Crystal will ever be in a position where she
24 isn't required to have a wheelchair ever again?

25 A: No.

1 Q: Do you expect that Crystal will continue to need physical
2 therapy going forward?

3 A: Yes.

4 Q: And assuming that her progress stays somewhat consistent
5 with what you've had over the last five years, will you
6 continue to recommend that that be regular physical therapy at
7 least two to three times per week?

8 A: Yes.

9 Q: In your professional assessment, do you have any
10 reasonable -- reason to believe that Crystal will make any
11 significant progress in diminishing her pain through physical
12 therapy?

13 A: No.

14 Q: And have all of the opinions that you've provided here
15 today been to a reasonable degree of professional certainty in
16 your field of physical therapy and rehabilitation?

17 A: Yes.

18 MS. GOODING: I don't have any further questions.

19 MR. HEITMAN: Your Honor, we don't have any questions
20 either.

21 THE COURT: Wonderful. Then you may step down. You are
22 free to go.

23 MS. GOODING: Your Honor, Ms. Glenn is also under
24 subpoena. May she be excused?

25 MR. HEITMAN: No objection.

1 THE COURT: Okay. Ms. Glenn, you are free to go. You
2 are free from your subpoena.

3 THE WITNESS: Thank you.

4 THE COURT: All right, ladies and gentlemen. We will now
5 take a lunch break until 2:30. Please do not discuss the
6 case. Don't do any research about the case. Be back in the
7 jury room at 2:30.

8 (WHEREUPON, the jury exited the courtroom at 1:10 p.m.)

9 THE COURT: All right. We'll be in recess until 2:30.

10 (WHEREUPON, there was a break in the proceedings, after
11 which the proceedings resumed as follows.)

12 THE COURT: Good afternoon, folks. Are we ready for the
13 next witness? Anything before we bring the jury from the
14 plaintiff?

15 MS. GOODING: No, Your Honor.

16 THE COURT: The only one not looking at a device is Mr.
17 Goings.

18 Anything from the defense?

19 MR. DAVIS: No, Your Honor.

20 THE COURT: Oh, you do have an issue?

21 MR. GOINGS: Yeah, I was -- I was -- I was getting my
22 technology right, my device. Not an issue, but just to let
23 you know our next witness is going to be rather short. Dr.
24 Alford. You've probably seen him grace the courtroom before.
25 He's going to be short.

1 And then after that, we plan to play some videotape
2 depositions, and I don't know if that's something you want to
3 take up now or after Dr. Alford. I'm, again, just deferring
4 to you, kind of giving you a forecast.

5 THE COURT: Yeah, we can do that now. Let's talk about
6 depositions. What deposition? Whose deposition?

7 MR. GOINGS: The deposition of Dr. Thomas Holbrook in the
8 30(b)(6) deposition of Midlands Orthopedics, in which Dr.
9 Holbrook was designated as the -- as the representative.

10 We have made designations. Defense counsel has objected
11 to those and provided in the alternative counter designations.
12 And we have the video prepared to play.

13 I just -- in respect to my -- my colleague, I told him
14 that -- that his arguments, as you know, his designations
15 would -- I just wanted to make sure they're fully preserved
16 and -- and you understood what those are on the record. So I
17 know he's given you written submissions. I don't know if you
18 want to go hear them orally or not, but I just -- out of
19 respect to my colleague, I did tell him that it would be fully
20 preserved. I know his voice is kind of not up to par right
21 now. So you can say I'm speaking for him as well.

22 THE COURT: Right. I -- I do have defendants' counter
23 designations, Dr. Holbrook's deposition, and then objections
24 to the 30(b)(6) deposition, objections to Dr. Holbrook's
25 discovery deposition, and then objections to the designations

1 of Anne Margaret McGraw's deposition.

2 MR. GOINGS: I'm not playing that. You don't need to
3 worry about Anne Margaret McGraw, Your Honor.

4 THE COURT: Just identifying the document.

5 MR. GOINGS: Okay.

6 THE COURT: To save Mr. Davis's voice, I will just have
7 these two documents marked as Court's exhibits so that his
8 objections are noted for the record, and he need not speak
9 them right now. I'm just trying to clean up where I've
10 scribbled on the document.

11 (WHEREUPON, the documents were marked as Court's Exhibits
12 Number 5 and 6.)

13 MR. DAVIS: Thank you, Your Honor.

14 THE COURT: Yes, sir.

15 MS. GOODING: Your Honor, there were a few objections to
16 portions that we did not end up designating. Do you want me
17 to -- to read out which objections still apply or do you feel
18 like you've got that covered with the documentation?

19 THE COURT: Then let's also mark as a Court's exhibit
20 Plaintiffs' amended deposition designations.

21 (WHEREUPON, the document was marked as Court's Exhibit
22 Number 7.)

23 THE COURT: I did note in going through the designations
24 and the objections that there were, in fact, objections to
25 portions of the deposition that had not been designated to be

1 played. So I think that covers all of that.

2 I understand Mr. Davis's objection to certain portions,
3 certain designations. Those objections are overruled.

4 And I understand, Mr. Goings, that you have appended to
5 plaintiffs' designations the counter designations; is that
6 correct?

7 MR. GOINGS: Correct. Without objection.

8 THE COURT: Okay.

9 MR. GOINGS: And by consent.

10 MR. DAVIS: That's -- that's correct, Your Honor.

11 THE COURT: All right.

12 MR. DAVIS: Thank you very much.

13 THE COURT: Thank you. How long is --

14 MR. GOINGS: Well, with his counter designations, they
15 got a little bit longer. So the -- the first deposition --
16 well, the 30(b)(6) deposition of Dr. Holbrook is about 32
17 minutes. The deposition of Dr. Holbrook is about 52 minutes.
18 So they really almost kind of increased in size by two from --
19 from what they previously were.

20 THE COURT: And which do you intend to play first?

21 MR. GOINGS: I perhaps will play the short one first, the
22 30-minute one.

23 THE COURT: Okay.

24 MR. GOINGS: Because, honestly, I would predict that Dr.
25 Alford's examination would probably be less than 15 minutes,

1 and then we can go straight into the first deposition, which
2 is shorter. That'll give you about an hour of testimony, and
3 then break after that.

4 THE COURT: That's fine.

5 MR. GOINGS: Before the second one.

6 THE COURT: That's fine. Okay.

7 MR. DAVIS: Thank you, Your Honor.

8 THE COURT: Yes, sir.

9 Bring the jury, please.

10 (WHEREUPON, the jury entered the courtroom at 2:50 p.m.)

11 THE BAILIFF: All jurors are seated, Your Honor.

12 THE COURT: Thank you.

13 Welcome back, ladies and gentlemen. We're still on the
14 plaintiffs' case. They're going to call their next witness.

15 MR. GOINGS: Good afternoon, Your Honor. The plaintiffs
16 will call Dr. Charles Alford.

17 THE BAILIFF: Dr. Alford, if you'll put your left hand
18 there, and I'll put that up there for you. And raise your
19 right hand for that lady there.

20 THE CLERK: Do you solemnly swear or affirm that the
21 testimony you are about to give in this case will be the
22 truth, the whole truth, and nothing but the truth, so help you
23 God?

24 THE WITNESS: Yes, ma'am.

25 THE CLERK: Please state your full name for the record.

DR. CHARLES ALFORD - DIRECT BY MR. GOINGS

1 THE WITNESS: Charles L. Alford.

2 THE CLERK: You may have a seat, please.

3 THE WITNESS: Thank you.

4 THE CLERK: And please speak clearly in the mic.

5 THE WITNESS: Okay.

6 THE COURT: Your witness.

7 MR. GOINGS: Thank you, Your Honor.

8 DR. CHARLES ALFORD, being first
9 duly sworn, testified as follows:

10 DIRECT EXAMINATION

11 BY MR. GOINGS:

12 Q: Dr. Alford, introduce yourself to the ladies and
13 gentlemen of the jury?

14 A: I'm Charles Alford.

15 Q: The court reporter cannot hear in her box.

16 A: Okay. It's all right.

17 Q: So you have to literally talk into the microphone.

18 A: Okay. Okay.

19 Q: Perfect.

20 A: Got it.

21 Q: All right. Dr. Alford, tell the jury a little bit about
22 yourself, and I called you Dr. Alford, but you're actually
23 also Professor Alford; right?

24 A: Well, yeah. I -- I am Charles Alford. I taught at
25 Furman University for 32 years in the Department of Economics

1 and Business. I retired there 20 years ago. I retired there
2 in 2003. I started a consulting practice dealing with
3 appraising businesses and litigation matters like this and
4 some other matters about 50 years ago and still going to work.
5 So --

6 Q: Well, good, Dr. Alford. And you actually know every
7 lawyer in this courtroom; right?

8 A: Pretty much, yeah.

9 Q: And you've worked for the defense?

10 A: Right.

11 Q: Ashby Davis?

12 A: I have, yes.

13 Q: And you've worked for me before as well?

14 A: Sure. Yes.

15 Q: In fact, you have other cases with me, and you have other
16 cases with Ashby; right?

17 A: Yeah. I think right now I have one case with Mr. Davis.
18 Yeah.

19 Q: Explain to the jury your training and experience and
20 education as it relates to providing opinions related to
21 economic losses?

22 A: Well, I went to Wofford College. I majored in economics.
23 I graduated from Wofford in 1968. I then left Wofford and
24 went to the University of Alabama. I studied economics and
25 business at the University of Alabama, earned a Ph.D. there.

1 Had fields in marketing and quantitative methods and
2 economics.

3 I went to Furman University in 1971. I taught in the
4 economics department. I taught business courses. I taught
5 economics courses, taught microeconomics, macroeconomics,
6 urban economics, personal finance, a lot of other things that
7 I thought were more interesting usually than my students
8 thought were, but nevertheless, I taught those courses for 32
9 years.

10 During that period, right after I got to -- to Furman, I
11 started -- I started consulting and have done that ever since.
12 So, you know, the consulting either deals with assessing the
13 value of a closely held, privately-owned company or dealing
14 with damages in -- in litigation matters like this and others.
15 It might be unfair trade practices. It might be patent
16 infringement. It might be lost earnings. It might be the
17 cost of a life care plan like this. It might be valuing
18 household services or valuing someone's personal time. So,
19 you know, damages and lawsuits are varied, and they're sort of
20 all over the board, and that's where I come in.

21 Q: Furman University has you listed as professor emeritus.
22 What does that mean?

23 A: That's a -- that's an egghead term for old and out to
24 pasture, pretty much. You know, if you've been there long
25 enough, they'll -- they'll call you that when you retire. So

1 here I am.

2 Q: Thank you, Doctor.

3 MR. GOINGS: Your Honor, I would tender Dr. Alford,
4 Professor Alford, as an expert in economics and the evaluation
5 of economic losses.

6 MR. DAVIS: Well, okay.

7 THE COURT: You may proceed.

8 BY MR. GOINGS:

9 Q: You're not out in the same pasture with -- with him, are
10 you?

11 A: I --

12 MR. DAVIS: Your Honor, I'm going to have to object.

13 THE COURT: Object, right.

14 THE WITNESS: Am I under oath?

15 MR. GOINGS: You set it up perfectly. I had to.

16 BY MR. GOINGS:

17 Q: What did I retain you to do?

18 A: To evaluate the -- the certain elements of the economic
19 damages in this case to Ms. Goodwin. Specifically, what I
20 dealt with was determining the present value of the life care
21 costs that are projected for her to incur and to value a small
22 loss in leisure time. And so, in this case, my analysis is
23 limited to those two things.

24 Q: Tell the jury what you reviewed and considered? And
25 before you do that, the witness right before you, as you were

1 not in the courtroom, was Cathy Gragg-Smith with the
2 rehabilitation services.

3 A: Uh-huh.

4 Q: She testified. So if you use her name, I think they'll
5 know who you're talking about.

6 A: Yeah, yeah, she -- she's -- she's a life care planner.
7 I'm not. That's -- that's really out of my bailiwick. So I
8 don't have any opinion with regard to what Ms. Goodwin's needs
9 are. That -- that rests with someone else, but in this case,
10 Ms. -- the life care planner. I can never pronounce her name
11 correctly.

12 But the way these things shake out is that the -- the --
13 the life care planner will say, okay, in my opinion, this
14 person needs these items. The person will need them with this
15 frequency, you know, every month, every year, every 3 to 5
16 years, whatever the life care planner says the need will be
17 and the duration of the need. The need might -- might be for
18 the next five years or the need might be for life expectancy.

19 With life expectancy in South Carolina state court, we
20 use -- we use the statutory table. There's -- there's a South
21 Carolina mortality table that says here's how long you're
22 supposed to estimate this person will live. Okay? So I used
23 that -- that table.

24 Then the final thing that the life care planner does is
25 to say here are the costs today of these items. You know, she

1 might -- might be -- might need a medication that's going to
2 cost \$10 a month, let's say. Okay? And she'll need that for
3 the rest of her life.

4 Then -- then my job really gets pretty easy. I do two
5 things. I consider what the increases in those prices will be
6 because, as we all know, regardless of what we're buying,
7 prices are going to increase over time. So I have to have
8 some kind of basis for estimating how the prices of those
9 various items are going to change over time.

10 Now, the way I do it, the Social Security Administration
11 provides us a projection of the long-term rate of inflation.
12 Now, we know that in the last couple of years it's been
13 haywire, but -- but honestly, people don't expect that to
14 continue. The long run projected rate of inflation is 2.4
15 percent a year. Okay? So that might -- that eases our mind a
16 little bit, as opposed to thinking it might be 6 or 7 percent
17 a year from here on out.

18 And then I look historically at different medical care
19 categories, like physician services or services of therapists
20 or -- or medical equipment and supplies, and I see how those
21 prices have tracked inflation over the last 20 years. You'd
22 be surprised, but in fact, over the last 20 years, except for
23 medications, all of the categories that -- that are identified
24 by the life care planner as being needed by Ms. Goodwin, their
25 prices have increased a little bit less than inflation over

1 the last 20 years.

2 You know, we're all accustomed to thinking that -- that
3 medical prices are going crazy. Okay? But I can tell you
4 that is due primarily to hospital care, both inpatient and
5 outpatient, it's due to insurance, and it's due a little bit
6 to prescription drugs, but not very much to those. For most
7 of the items, particularly medical equipment and supplies, the
8 prices have almost not increased. If you look at their -- if
9 you track their prices relative to inflation, their prices
10 have increased much less than inflation.

11 So that's -- I got a little bit long-winded. I'm sorry,
12 but that's the first thing I have to do is to say, okay, how
13 do we project? For however many years she's going to need
14 these items, what do I project the inflation rate to be for
15 each of these items?

16 And then you have to do a second thing because, you know,
17 in a perfect world, you'd have someone come in every year and
18 say, okay, these are her needs this year. Let's -- let's see
19 whether we need to provide for those needs, but that's
20 obviously not how it works. And you would be glad that's not
21 how it works, because you don't -- wouldn't have to come back
22 every year and make the same decision.

23 So if -- if you decide she needs to be awarded some
24 amount of money to meet these needs, well, you have to
25 recognize that if she receives that money now, she can earn

1 some interest on it. Okay? She can set it aside and earn
2 some interest on it.

3 So if she needs \$100 a year from now, she really only
4 needs about roughly \$96 now for it to grow to -- to \$100. If
5 she needs \$100 20 years from now, then she'll only need a
6 fraction of that \$100.

7 So that procedure is -- the egghead term is discounting
8 the present value, but what it really means is I'm backing
9 interest out. I'm saying how much would she need today
10 earning interest, and I use interest on treasury rates. It's
11 -- it's risk free, and you can manage your liquidity. That
12 is, you can make the money available in the year in which it's
13 needed.

14 So I determine what the rates are for each future year
15 because the rates differ, and they've recently gone up
16 significantly. The long run rates now are in the neighborhood
17 of about 4 percent higher than the projected rate of
18 inflation. So when I discount the present value, I do those
19 two things. I say here's something that's going to cost me
20 \$100 now. I project what it's going to cost 20 years from now
21 based on the inflation rate, and then based on the interest
22 rate that you can earn over the next 20 years, here's the
23 amount that you'd need now.

24 And it's going to take more than 15 minutes if I stay
25 this longwinded, but that's essentially what I did for these

1 -- these life care items. The life care planner identifies a
2 dozen or so items. She's testified to that. You've heard it.
3 All I'm doing is saying here's the value today to -- to enable
4 someone to purchase those items when they're needed.

5 I do it two ways. The life care planner will -- will
6 say, okay, for example, this -- this -- this orthopedic
7 appliance. Okay? It may be needed every 3 to 5 years. She
8 has one in there, for example, where a prosthetic might be
9 needed every 3 to 5 years, and the cost in today's dollars is
10 going to be 600 to \$800. Well, if you think about it, if she
11 only needs it every five years and if she can get it for \$600,
12 that's an average of \$120 a year, but if she's going to need
13 it every three years and it costs \$800, that's about \$265 a
14 year. So that's a pretty big range.

15 I'm no more capable than -- than you or anybody else to
16 say here's -- here's what the value ought to be. So I do the
17 low end and I do the high end. I make an assumption that --
18 that Ms. Goodwin can always get it at the lowest price with
19 the least frequency that she'll ever need and the lowest
20 duration that she'll ever need. On the other end, I assume
21 that she'll always have to pay the highest price, she'll
22 always need it with the greatest frequency and the longest
23 period of time. So obviously that's going to give a range.

24 And I mean, if you buy what the life care planner says
25 and if you buy what I say, you still have a pretty big

1 decision to make, because that range in present value dollars
2 is for the life care plan \$1.134 million, one million three
3 hundred -- \$1,133,979, and the upper end is \$2,378,990.

4 And I explained to you why that range is so big. It's a
5 big range, but I'm not capable of saying out of that range,
6 you pick this number. That's -- if y'all are going to pick a
7 number, you know, that's the way you're going to. At least
8 you'll understand what I did, and then you can decide whether
9 you want to pick a number like that or not? I don't know.

10 But the low end means she's always successful in getting
11 something at the lowest possible price. She'll need it for
12 the least frequency. If the life care planner says every 3 to
13 5 years, it'll only be every five years. And for the shortest
14 duration of need. The upper end is the opposite assumptions.

15 Q: Dr. Alford, let me make sure I understand. This is only
16 for medical therapy and treatment needs from today forward;
17 correct?

18 A: That's right. Yeah. I should have said that.

19 Q: Okay.

20 A: It -- if she has incurred expenses up to now, that
21 doesn't require me to tell you what those are. So it doesn't
22 include anything but from today, actually, from the 10th, from
23 this past Monday forward through her life expectancy.

24 Q: You mentioned to the jury about the South Carolina law.
25 You called it the mortality table?

1 A: Yeah.

2 Q: Or life expectancy table? What does South Carolina law
3 say that Crystal will live from today forward?

4 A: 37.29 years.

5 Q: So for roughly the next 40 years, just rounding up.

6 Roughly for the next 40 years, if she needs the least amount
7 of care possible for the least amount of price, the floor
8 would be \$1,000,129. Did I say that correctly?

9 A: You almost did. \$1,129,139.

10 Q: Excuse me, 139. Okay.

11 A: Yeah.

12 Q: All right. Now, if she needs more over her lifetime and
13 let's say that prices that you've estimated are actually
14 higher than -- than what you've estimated, then it's the
15 highest, not the lowest amount. The highest would be roughly
16 2.37 million; correct?

17 A: Yeah. But now -- but I want to be real clear that that's
18 -- that's not based on an assumption that maybe inflation will
19 take off again. That's simply based on assumption that given
20 the life care planner's prices as they are today, she's going
21 to have to pay the highest price.

22 Q: Okay.

23 A: And she needs it most -- more frequently.

24 Q: And you said historical average for inflation for the
25 last 50 years is what?

1 A: Oh, I don't know what it's been for the last 50 years.

2 Q: Is it two point --

3 A: But -- but projected, it's 2.4 percent going forward.

4 Q: And that's based on historical data; correct?

5 A: No, no, that's -- well, the Social Security
6 Administration every year makes a projection, and their next
7 projection won't come out until about July. Okay? And I can
8 tell you precisely the annual inflation rate in 2021 was 5.26
9 percent, based on the Social Security Administration. Some --
10 some say it's higher, some say it's lower, but, you know, it's
11 more than twice what it normally is.

12 In 2022, they projected it at 4.54 percent, in 2023 only
13 2.33 percent, and then 2.4 percent thereafter, but my
14 projection of the medical items is less than that. For
15 example, just as an example, one of the big items is medical
16 equipment and supplies. Well, that's -- over the last 20
17 years, that's grown at a rate 1.93 percent less than the rate
18 of inflation. So I've used a growth rate in medical equipment
19 of 2.4 percent minus almost 2 percent, or about half of 1
20 percent.

21 Q: Okay. But if -- let's say if we don't get inflation
22 under control and the next 20 years, you know, inflation stays
23 what it is today, you would agree with me that this number
24 would be actually higher; correct?

25 A: Yeah. But I'd agree with you that both of those numbers

1 would be higher.

2 Q: Right. Okay.

3 A: The limits -- the limits of that range would be -- would
4 be higher.

5 Q: So these numbers for future medical care assumes that our
6 government is right when they say we're going to get inflation
7 under control; right?

8 A: Yeah. That's right.

9 Q: Okay. And nobody anticipated that inflation would be as
10 high as it is today five years ago; right?

11 A: No, of course not.

12 Q: Okay. And so you, as an economist, sometimes it is hard
13 to -- to look into the future because you don't really know
14 what could happen. All you know is what's happened in the
15 past; right?

16 A: If I knew what was going to happen, I would have been
17 retired a long time ago.

18 Q: Now, Dr. Alford, this is for future medical care; is that
19 correct?

20 A: Right.

21 Q: Is there another component of Ms. Goodwin's economic
22 losses that you evaluated?

23 A: A -- really a small component. Ms. Goodwin said that --
24 you know, and the life care plan includes provision for some
25 heavy housecleaning, you know, stuff that she can no longer

1 do. What she says is that there are still things that she can
2 do, but it takes her longer to do it.

3 Well, that -- that's really eating into what would be her
4 leisure time and which is -- I'm going to tell you, that's
5 obviously very hard to value. You know, one way you could
6 value it is to say, well, how much would someone have to pay
7 me in order to work additional hours because that's one way of
8 looking at what the value of your leisure time is.

9 It's really hard to do. We know that -- that -- that --
10 that -- that requiring more time to do tasks, I mean, just not
11 the heavy stuff that the life care planner is talking about,
12 but just routine stuff. You know what I mean? This morning I
13 -- I loaded my dishwasher. Well, I unloaded it, and I loaded
14 it, and I fixed my oatmeal, and you might have done a lot of
15 the same things, you know? And I put some clothes in the
16 dishwasher [sic], and I was walking around the whole time
17 doing it.

18 Now, if I'm in a wheelchair doing it, it's going to take
19 me longer to do. It's going to take me more time, and that's
20 time that I could have been idling or watching TV or whatever
21 I want to do. Well, that has value. Now, I mean, I'm going
22 to tell you it's hard for me and it's hard for you to decide
23 what that value is, but there's no doubt that -- that there's
24 some value to your time if you have to use it.

25 You know, one way of looking at it is what if you had a

1 job where you had certain tasks to do and you get injured, you
2 know, you're in an automobile accident or something like that,
3 and you go to your -- your -- your employer and say I can
4 still do this, but it's just going to take me longer, and your
5 employer says, well, that's fine. If you want to keep doing
6 it, I'll pay you what I was paying you, but maybe you're going
7 to have to work ten hours a day instead of eight hours a day,
8 and that's on you. Well, most of us would say you've incurred
9 a loss there because it's time that you would not have had to
10 invest in that activity.

11 The way I value it is the same way that I value household
12 services, and that's -- that's actually quite low. I used an
13 hourly rate in this case of \$10.45 an hour. That was in 2020
14 dollars. It increases for inflation every year based on those
15 rates I was talking about, but I valued her -- her lost
16 leisure time like that.

17 It's two hours a day based on what she said, 14 hours a
18 week. I do it for 50 weeks instead of for 52 weeks, but --
19 but --

20 Q: Why is that?

21 A: Well, because -- because we -- you know, some of us take
22 vacations from time to time, or some of us maybe just get lazy
23 from time to time and don't do all of our chores.

24 Q: Okay.

25 A: So -- so I just typically use 50 hours instead of -- I

1 mean, 50 weeks instead of 52 weeks.

2 Q: Okay.

3 A: But I did that, and then I did the same thing. I
4 projected. I took that hourly value and I increased it for
5 inflation, and then I reduced it to present value, backing out
6 the interest.

7 I don't do that to her statutory life expectancy though.
8 That goes to what's called full functional life expectancy,
9 because most of us know -- I can already start to tell you
10 that in your latter years, you're not going to do quite as
11 much as you did in your earlier years. And so most of us have
12 -- there's a statistical measure called a full function life
13 expectancy, which says, generally, if you've got a life
14 expectancy of -- of -- let's say for a given person 30 years,
15 you might have 27 or 28 more years of actually being able to
16 be pretty active and doing stuff around the house. Okay? So
17 I use that full function life expectancy, which is a little
18 bit less than life expectancy. It's based on a published
19 table that economists use.

20 Q: And your report that I have, you have a lot of tables,
21 and it's really thick with mathematical calculations and
22 tables, isn't it?

23 A: Yeah, yeah.

24 Q: What did you calculate as to her loss of leisure time
25 that you referred to there?

DR. CHARLES ALFORD - DIRECT BY MR. GOINGS

1 A: Well, that was in the last table, but the value is
2 \$232,533. That is two hours a week. Okay? Or two hours a
3 day. I'm sorry. At \$10.45 an hour.

4 Q: Did any of your calculations as to loss -- economic
5 losses include any lost wages or loss of earning potential or
6 earning capacity?

7 A: No.

8 Q: Okay. What is the combination when you combine the cost
9 of her future medical care going forward to her lifetime and
10 that small component of loss of leisure time up to her
11 functional work history?

12 A: It is the -- well, the lower limits and the upper limits
13 for the life care stay the same. You just add that additional
14 amount to it, and the range is \$1,366,512 or \$2,611,523.

15 Q: So that we can see those numbers, Professor Alford, I
16 handed you a piece of paper that says future economic losses.
17 Do you mind writing that range for us and signing your name?

18 (WHEREUPON, the witness complied.)

19 MR. GOINGS: Thank you, Dr. Alford.

20 Your Honor, at this time, I'd like to move this into
21 evidence showing the calculations, the summary of the
22 calculations as it relates to the future economic losses.

23 MR. DAVIS: No objection.

24 THE COURT: That's 24?

25 THE COURT REPORTER: 24. Yes, ma'am.

1 THE COURT: Admitted without objection.

2 (WHEREUPON, Plaintiffs' Exhibit Number 24, economic
3 losses range, was admitted into evidence.)

4 BY MR. GOINGS:

5 A: Yeah, I have a correction to make.

6 Q: Okay. Do you want me to --

7 A: No, no, no, not on that.

8 Q: Okay.

9 A: But on what I said earlier. I -- I did it to -- I did it
10 for 52 weeks, not 50 weeks. I was wrong about that. I did it
11 for 52 weeks. So -- I'm pretty sure. Let me check my
12 arithmetic. Yeah, I did it for 52 weeks. I'm sorry.

13 Q: How would that change the calculations? Would it be --
14 would it be significant?

15 A: Well, it would be -- if I had done it for 50 weeks as I
16 -- as I thought I had done it, it would reduce that 232,000 by
17 about 4 percent, by about 8- or \$9,000.

18 Q: Okay. So 52 weeks, but if, you know, people go on
19 vacation and -- or like you used the word sometimes we get
20 lazy during the year, you would take about \$6,000 off of this?

21 A: About 9,000 off of it. Yeah.

22 Q: Okay.

23 A: Yeah. And I apologize.

24 Q: That's okay.

25 A: I should have looked at it more carefully.

DR. CHARLES ALFORD - DIRECT BY MR. GOINGS

1 Q: That's okay. Are your opinions here today and the
2 numbers you wrote down on the paper -- are they to a
3 reasonable degree of economic and financial certainty?

4 A: Yes, sir.

5 MR. GOINGS: Thank you. Please answer any questions that
6 -- that our colleague has, Mr. Davis.

7 CROSS-EXAMINATION

8 BY MR. DAVIS:

9 Q: Can you hear me?

10 A: I can, yes, sir.

11 Q: I can't hear myself.

12 A: I can barely hear you.

13 Q: I'm going to do the best I can, Dr. Alford.

14 A: Okay.

15 Q: You're not assuming that anybody's at fault in this case?

16 A: Not at all.

17 Q: That's not your role?

18 A: That's right.

19 Q: You're -- and I don't mean any disrespect. You're
20 crunching the numbers that were supplied to you by the life
21 care planner?

22 A: Yeah. Yeah, that's -- that's commonly what people will
23 say that I have done. Yeah.

24 Q: Okay. And you're not passing judgment on any of those
25 needs, whether they are valid or invalid. You just -- you're

1 just taking what she did and you're reducing it to present
2 value --

3 A: That --

4 Q: -- in terms of today's dollars?

5 A: That's exactly right.

6 MR. DAVIS: Thank you very much.

7 THE COURT: Anything further?

8 MR. GOINGS: No, Your Honor. Can the witness be excused?

9 THE COURT: Any objection?

10 MR. DAVIS: No.

11 THE COURT: All right. Thank you, sir. You're free to
12 go.

13 THE WITNESS: Thank you.

14 THE COURT: All right. Ladies and gentlemen, I
15 understand that the next witness will provide testimony by a
16 videotaped deposition. Mr. Goings is getting that ready for
17 you right now.

18 A deposition is an out-of-court procedure where witnesses
19 are placed under oath and asked questions and give answers
20 much the same way they do live in the courtroom. Just
21 sometimes a witness, for whatever reason, can't appear in
22 court or -- or even if they can appear in court, sometimes
23 these depositions are done. Actually, pretty often they're
24 done in advance just as a way to interview witnesses to
25 prepare for a trial.

1 So that's what we're going to hear next. That's -- as I
2 said, they're placed under oath. They can have attorneys
3 there, but the plaintiffs' attorneys are there. The
4 defendants' attorneys are there. So everyone's represented.
5 It's just out of court instead of sitting live on the witness
6 stand.

7 Mr. Goings?

8 MR. GOINGS: Thank you, Your Honor. Should we move the
9 TV up since this is a video and there's not going to be any
10 testimony? If we keep it close to the witness box?

11 THE COURT: Sure. Yes.

12 MR. GOINGS: Okay.

13 THE COURT: And I'm sorry. Tell me which witness this
14 is?

15 MR. GOINGS: Thank you, Your Honor. This is the
16 videotaped deposition, the 30(b)(6) deposition of -- and Dr.
17 Holbrook was the designee from Midlands. So I don't know if
18 you have an instruction about what a 30(b)(6) deposition is or
19 not.

20 THE COURT: I don't. Okay? But I will freestyle.

21 So, ladies and gentlemen, as I said, witnesses sometimes
22 give deposition testimony. They're placed under oath, but
23 sometimes the attorneys want to get testimony on behalf of a
24 company, a corporation or something like that. So businesses,
25 companies, of course, are buildings; right? They can't --

DR. THOMAS HOLBROOK - 30(b)(6) DEPOSITION

1 they don't have voices. They have to speak through people,
2 through their representatives.

3 And so the South Carolina Rules of Civil Procedure, Rule
4 30(b)(6), is the rule about corporate depositions,
5 essentially. So I'm told that Midlands Orthopedics and
6 Neurology was sought to be deposed, and they designated Dr.
7 Holbrook as their representative.

8 So when you hear the term 30(b)(6) deposition, that's all
9 it is. It's -- it's a business deposition, but a person has
10 to show up. And in this case, it was Dr. Holbrook. So that's
11 what we're going to hear.

12 MR. GOINGS: Thank you, Your Honor.

13 THE COURT: Y'all may proceed.

14 (WHEREUPON, the 30(b)(6) videotaped deposition of Dr.
15 Holbrook was played. Transcribed as follows.)

16 30(b)(6) DEPOSITION

17 BY MR. GOINGS:

18 Q: Doctor, are you familiar with the deposition process?

19 A: Somewhat.

20 Q: Have you given a deposition before?

21 A: Yes.

22 Q: How many times have you given a deposition?

23 A: Several.

24 Q: And that's including your career as a -- as a
25 neurosurgeon?

1 A: Yes.

2 Q: Does Midlands Orthopedics take any responsibility
3 whatsoever for Crystal Goodwin being paralyzed today?

4 A: Crystal Goodwin is not paralyzed today.

5 Q: How would you describe Crystal Goodwin's physical state?

6 A: As far as her neurologic state?

7 Q: Yes, sir.

8 A: I say she has significant weakness and numbness in her
9 legs.

10 Q: Okay. So you disagree that she's paralyzed?

11 A: Correct.

12 Q: Do you agree that she has paralysis?

13 A: She is not paralyzed.

14 Q: Can someone have paralysis and not be totally paralyzed?

15 A: Paralyzed means to me no function. So you're either
16 paralyzed or you're not.

17 Q: All right. So if you're -- if you have some function, in
18 other words, you're not paralyzed?

19 A: That would be correct.

20 Q: Do you understand why Crystal Goodwin believes she's
21 paralyzed today?

22 A: Did you tell her that?

23 MR. DAVIS: Objection to the form.

24 BY MR. GOINGS:

25 Q: Do you understand why she believes she's paralyzed today?

1 A: Did you tell her that she was?

2 Q: I'm asking you. Do you understand why Crystal Goodwin
3 believes she's paralyzed?

4 A: It might be best to ask her that question.

5 Q: At the time of this surgery and in the weeks and months
6 and years leading up to the surgery, you would agree with me
7 that Crystal Goodwin did, in fact, suffer from chronic
8 hypertension?

9 A: She had hypertension when I saw her. I'm not sure
10 exactly how long she had it.

11 Q: How did you know that she had hypertension or high blood
12 pressure?

13 A: She said she did.

14 Q: So she told you she had hypertension?

15 A: Yes.

16 Q: Did your office, Midlands Orthopedics, perform any tests
17 or studies to determine if she had hypertension?

18 A: We took her blood pressure.

19 Q: Did the blood pressure readings reveal or show that
20 Crystal Goodwin had hypertension?

21 A: I believe one of the readings did and one of them did
22 not.

23 Q: Does Midlands Orthopedics also contend the Crystal
24 Goodwin sustained an injury to the spinal cord during the
25 surgery?

1 A: Yes.

2 Q: Do you agree that the injury to the spinal cord was most
3 likely the result of an ischemic event?

4 A: Yes.

5 Q: What does ischemia mean?

6 A: It means that there is a vascular event. A stroke in the
7 spinal cord or any stroke is ultimately related to a vascular
8 event.

9 Q: Does ischemia in layman's terms mean tissue death?

10 A: Not necessarily.

11 Q: Can ischemia cause tissue death?

12 A: It can.

13 Q: Is tissue death often the result of ischemia?

14 A: Sometimes it is.

15 Q: Prolonged ischemia can lead to tissue death; correct?

16 A: Not necessarily.

17 Q: But you would agree that tissue death is a known result
18 of ischemia; right?

19 A: It can be, but not necessarily.

20 Q: It's not always; right?

21 A: Correct.

22 Q: But it's a foreseeable outcome of ischemia for the tissue
23 to suffer what's been known as tissue death; right?

24 A: That's a possibility.

25 Q: A known possibility?

1 A: Yes.

2 Q: A known result?

3 A: Yes.

4 Q: Ischemia is the restriction in the blood supply to
5 tissue. Is that a correct statement?

6 A: That sounds reasonable.

7 Q: When blood supply to tissue is restricted, this can
8 result in a shortage of oxygen needed to keep the tissue
9 healthy and alive; right?

10 A: Yes.

11 Q: And when the tissue is deprived of oxygen and sufficient
12 blood flow, the tissue can become damaged; isn't that true?

13 A: It can.

14 Q: And that is a known result; right?

15 A: Yes.

16 Q: The purpose of proper perfusion is to ensure that the
17 tissue receives a sufficient amount of blood flow and oxygen;
18 is that right?

19 A: Correct.

20 Q: An ischemic event, including tissue death, can be the
21 result of improper perfusion levels; is that fair?

22 A: It's possible, but not in this case.

23 Q: But improper perfusion levels can lead to an ischemic
24 event?

25 A: Crystal had adequate perfusion levels.

1 Q: Doctor, improper perfusion levels can lead to an ischemic
2 event resulting in tissue damage or death; correct?

3 A: Crystal always had a proper perfusion level. So that
4 doesn't apply in this case.

5 Q: Do you agree that improper perfusion levels can lead to
6 an ischemic event resulting in tissue death or tissue damage?

7 A: In a hypothetical case, that's possible.

8 Q: Well, you're also taught that in your training as a
9 physician, in particular a neurosurgeon; right?

10 A: Yes.

11 Q: Okay. And you're taught in med school and through your
12 fellowship and through your training that if a patient's
13 perfusion levels are not kept at the adequate levels, that an
14 ischemic event may occur, resulting in tissue damage and
15 tissue death; right?

16 A: Not necessarily.

17 Q: Well, that's not always the case, but that is a known
18 result or foreseeable outcome to improper perfusion levels,
19 isn't it?

20 A: Could it ever happen? Yes.

21 Q: Is it true that low perfusion or low blood flow can
22 result in an ischemic injury similar to a stroke to the spinal
23 cord?

24 A: Is this a hypothetical case again?

25 Q: If you want to consider it hypothetical.

1 A: I mean, is it hypothetical or does it apply to Crystal?

2 Q: When you go through med school, are you taught
3 hypotheticals?

4 A: Sometimes we do look at hypothetical situations.

5 Q: Are you trained on hypothetical situations?

6 A: Sometimes we will talk about cases that are hypothetical
7 cases.

8 Q: And in your training as a medical physician, you're
9 taught that low blood flow or lack of perfusion can result in
10 an ischemic injury; isn't that true?

11 A: That's a possibility in this hypothetical case you're
12 talking about.

13 Q: Okay. Can perfusion levels be altered during surgery?

14 A: Yes.

15 Q: How can perfusion levels be altered during surgery?

16 A: Well, they can be made to go up or down as needed.

17 Q: How is one's perfusion level increased during surgery?

18 A: Well, you could give medicine or you could give fluid
19 would be two ways.

20 Q: And whose role is it to give medicine or give fluids to
21 increase perfusion levels?

22 A: Well, in this particular case, there was no indication to
23 give medicine or fluids, and I would say that the risk of
24 doing that outweighed the potential benefits.

25 Q: How -- whose role or responsibility is it to increase

1 perfusion levels during surgery?

2 A: To actually do that? Anesthesia.

3 Q: Okay. Do you -- as the neurosurgeon, can you make that
4 recommendation to anesthesia?

5 A: Yes.

6 Q: Okay. And how are perfusion levels decreased during
7 surgery?

8 A: Drugs, usually.

9 Q: And you, as the neurosurgeon in the room, can make that
10 recommendation to anesthesia?

11 A: Yes, I have done that in cases from time to time.

12 Q: Did anyone with Midlands Orthopedics discuss Ms.
13 Goodwin's blood pressure to Dr. Root or anyone with the
14 anesthesiology team prior to starting the procedure?

15 A: I don't recall right offhand.

16 Q: Any other evidence or reason why you believe these four
17 blood pressure readings are artificially high?

18 A: Those are three good reasons right there.

19 Q: What is her baseline blood pressure then?

20 A: That was not determined.

21 Q: Not determined by who?

22 A: Anyone.

23 Q: Why wasn't it determined?

24 A: It's not necessary.

25 Q: Why wasn't it necessary?

1 A: Why are you saying it was?

2 Q: Well, in your previous deposition, you said that
3 everybody knows what the baseline blood pressure was.

4 MR. DAVIS: Where in the deposition do you see that?

5 BY MR. GOINGS:

6 A: What line is that?

7 Q: Lines 6 through 8.

8 MR. ROBINSON: Object to the form of the last question.

9 BY MR. GOINGS:

10 A: That's not what that says.

11 Q: All right. Let's go back to page 28. I'm going to read
12 it out loud. I'm going to read the question, and you can read
13 your answer. Let's go to line 15 on page 28. Question,
14 without objections being read.

15 The question. Do you agree that when determining where
16 to keep a patient's blood pressure during anesthesia, the
17 patient's historical baseline blood pressure should be
18 considered?

19 And your answer?

20 A: That should be -- could be considered.

21 Q: That's not what you said. It says -- read what you said?

22 A: I said it is considered. Okay. That's what I said.

23 MR. ROBINSON: Object to the form of the question.

24 BY MR. GOINGS:

25 Q: Next question. And it should be considered?

1 What's your answer?

2 A: I said it is considered. I mean, that's just a normal
3 part of the process. Every patient's baseline blood pressure
4 is observed before surgery.

5 Q: Next question. How far would one go back to look at
6 baseline blood pressure?

7 What's your answer?

8 A: I don't know.

9 Q: Question. Whose job is that?

10 What's your answer?

11 A: Is it to look at the blood pressure?

12 Q: To determine baseline blood pressure?

13 What is your answer?

14 A: To determine the baseline blood pressure, I think that's
15 something that everybody knows what the baseline blood
16 pressure is.

17 Q: All right. So --

18 MR. DAVIS: With all due respect, I know it's a
19 continuing objection, but --

20 MR. GOINGS: Absolutely.

21 MR. DAVIS: -- I object to that as not being responsive
22 to any topic that's listed under Rule 30(b)(6).

23 MR. GOINGS: I respectfully disagree, but I thank you for
24 your objection.

25 MR. DAVIS: Thank you.

1 MR. ROBINSON: Same objection.

2 BY MR. GOINGS:

3 Q: Doctor, what was Crystal Goodwin's baseline blood
4 pressure?

5 A: We don't have one.

6 Q: The blood pressure readings in your medical records on
7 the -- and on the date of this surgery do not indicate a range
8 of her baseline blood pressure?

9 A: I think in order to get an accurate baseline blood
10 pressure, you would need several blood pressures over a period
11 of time to formulate what an accurate blood pressure would be.
12 I think just taking three or four blood pressures, some of
13 which are known to be artificially high, is not an accurate
14 baseline blood pressure.

15 Q: Did you ask Crystal Goodwin what her blood pressure ran
16 consistently?

17 A: I don't recall.

18 Q: Did you ask Crystal Goodwin what she believed her
19 baseline blood pressure to be?

20 A: No.

21 Q: Did you ask Crystal Goodwin if she believed that she was
22 a -- a person who suffered from high blood pressure or
23 hypertension?

24 A: She said she had hypertension.

25 Q: Do you dispute or doubt that Crystal Goodwin's baseline

1 blood pressure is in the level of someone who suffers high
2 blood pressure or hypertension?

3 A: I think she has hypertension.

4 Q: Okay. If she has hypertension, do you agree that her
5 blood pressure should be kept during a surgery or an operation
6 at a level that's consistent with her baseline hypertensive
7 state?

8 A: I don't believe we've determined an accurate baseline
9 blood pressure.

10 Q: What do you need to determine an accurate baseline blood
11 pressure?

12 A: A series of blood pressures over a period of time.

13 Q: You said that you can't determine what her baseline blood
14 pressure is?

15 A: I believe that her blood pressures that we have here were
16 adequate and satisfactory and safe to proceed with this
17 surgery.

18 Q: Based on the blood pressure readings that you did have,
19 what would be her baseline blood pressure?

20 A: You can't determine it.

21 Q: What would you need to determine her baseline blood
22 pressure with the four baseline -- of the four blood pressure
23 readings that you had prior to the surgery?

24 A: I don't think you can do it, get an accurate reading with
25 just those four.

1 Q: But you agree that determining baseline blood pressure is
2 important before starting any surgery?

3 A: Knowing what the blood pressure is at the start is
4 important. I wouldn't consider that a normal baseline blood
5 pressure over a period of time.

6 Q: But determining baseline blood pressure is something that
7 is to be considered prior to surgery; right?

8 A: It could be. Not necessarily.

9 Q: Did Ms. Goodwin become hypotensive during the surgery?

10 A: No.

11 Q: What does hypotensive mean?

12 A: Low blood pressure.

13 Q: And what does it mean to become hypotensive during
14 surgery?

15 A: It means that you had hypotension during surgery.

16 Q: So low blood pressure during surgery?

17 A: Yes.

18 Q: Why do you believe she was not hypotensive?

19 A: I looked at the readings. They're all within normal
20 limits.

21 Q: What are the normal limits?

22 A: I believe that all of those pressures are within normal
23 reasonable blood pressures.

24 Q: What are the normal reasonable blood pressures?

25 A: I can't give you a specific number for a patient. I

1 think that it's -- it varies depending on the patient.

2 Q: Is there a particular range?

3 A: I mean, there's maybe a general range. I can't give you
4 a specific number.

5 Q: What's the general range?

6 A: I can't give you a specific number. It's individual for
7 each patient.

8 Q: So blood pressures should be kept individual for each
9 patient?

10 A: I think you should individualize blood pressure treatment
11 to that patient.

12 Q: And what do you individualize it to?

13 A: What you think is reasonable.

14 Q: And when you think what is reasonable, some of the
15 information you use is what is a patient's past blood
16 pressure?

17 A: You could.

18 Q: What else is used during surgery to determine the
19 reasonable acceptable range of one's blood pressure?

20 A: What the blood pressure reading is.

21 Q: In order to conclude that Ms. Goodwin was not hypotensive
22 during surgery, you would have to find out and determine what
23 her baseline blood pressure really was; right?

24 A: No.

25 Q: Ischemia is a known result of prolonged hypo --

1 hypotension -- hypertension; correct? During surgery?

2 A: What?

3 Q: Is ischemia a known result of prolonged hypotensive -- of
4 a prolonged hypotensive state during surgery?

5 MR. ROBINSON: Object to the form.

6 BY MR. GOINGS:

7 A: Not necessarily.

8 Q: Can ischemia be the result of a prolonged hypotensive
9 state during surgery?

10 MR. ROBINSON: Object to form.

11 BY MR. GOINGS:

12 A: If it was low enough and for a long enough period of
13 time, it could.

14 Q: How long and low is it needed to be for hypotension --
15 for a hypotensive state to result in ischemia?

16 A: That would be an individual thing. I can't give you a
17 number.

18 Q: In Ms. Goodwin's case, how low and how long would her
19 hypotensive state need to exist to result in ischemia?

20 A: I can't give you an exact number.

21 Q: Can you give me a range?

22 A: No.

23 Q: Can anyone give a range?

24 MR. DAVIS: Object.

25 BY MR. GOINGS:

1 A: I think it would be individualized.

2 Q: Okay. And as to the individual of Crystal Goodwin, how
3 low and how long does the blood pressure need to be to result
4 in ischemic changes to the spinal cord or spinal column?

5 A: There's no way to calculate that.

6 Q: What does hypo -- hypoperfusion mean?

7 A: Low perfusion.

8 Q: Does that result in impaired flow of oxygen-rich blood to
9 the spinal cord?

10 A: Not necessarily.

11 Q: Can hypoperfusion lead to the impairment of oxygen-rich
12 blood to the spinal cord?

13 A: Is it possible in a given situation? Yes.

14 Q: And that is, in fact, a known result of hypoperfusion,
15 isn't it?

16 A: Not necessarily. It could be.

17 Q: When you say not necessarily, explain your answer?

18 A: You could have low blood pressure that had no adverse
19 effect.

20 Q: And you can have low blood pressure and have an adverse
21 effect?

22 A: Yes.

23 Q: Does Midlands recognize that what might be an adequate
24 and an appropriate blood pressure for one patient may be
25 inadequate and inappropriate for another patient for the same

1 exact procedure?

2 A: I think that pressures vary depending on the patient.

3 Q: If a patient has a blood pressure of 152 over 112, 129
4 over 81, 156 over 92, 160 over 99, where should the blood
5 pressure for that patient be kept while under anesthesia for a
6 surgery?

7 A: Well, it would -- some of that would depend on whether or
8 not you thought that those were accurate blood pressures and
9 should you use those solely to base your decisions on.

10 Q: In the medical records that you've reviewed from Midlands
11 Orthopedics or Prisma Baptist, formerly Palmetto Health
12 Baptist, is there any notations, any reference that the blood
13 pressure readings were inadequate or -- excuse me, were --
14 were not correct or inaccurate?

15 A: I believe all the blood pressures that were recorded
16 during surgery were within normal limits.

17 Q: Right, but the pre-intubation blood pressures from the
18 day of the surgery back weeks and several months, based on
19 those, does Midlands contend that any of those blood pressure
20 results were not -- not accurate?

21 A: I think those were the blood pressures that were taken at
22 that time, but there's reason to believe that several of those
23 were artificially high.

24 Q: Is there any notation on the date of surgery that either
25 you or anyone from the anesthesiology team considered that

1 those blood pressures were artificially high and could not be
2 or should not be considered?

3 A: The preoperative blood pressure that was high was
4 considered and was felt to be satisfactory and safe to proceed
5 with the surgery.

6 Q: But you never had any communications with Dr. Root or
7 anyone on the anesthesia staff about what the blood pressure
8 should be set at during this procedure; is that fair?

9 A: That was not necessary.

10 Q: Okay. So you didn't have any of those communications
11 with anesthesiology?

12 MR. ROBINSON: Object to form.

13 BY MR. GOINGS:

14 A: That was not necessary in this case.

15 Q: Why was that not necessary?

16 A: I think this was a standard -- this case was managed in a
17 standard manner.

18 Q: Was Crystal Goodwin a standard patient for this type of
19 procedure?

20 A: I think she was a type of patient that typically has this
21 type of surgery.

22 Q: Does Midlands Orthopedics agree that the proper way to
23 maintain blood pressure during surgery is to keep it as close
24 as possible to that particular patient's baseline blood
25 pressure?

1 A: I think that's an individual thing.

2 Q: And what individual factors or characteristics should be
3 reviewed to determine proper blood pressure during surgery?

4 A: I think some of it is some of the parameters that they
5 look at during the surgery.

6 Q: Is some of the parameters to look at before surgery is
7 the patient's history of blood pressure?

8 A: That's considered.

9 Q: Is it important to maintain blood pressure during surgery
10 as close as possible to that particular patient's baseline
11 blood pressure?

12 A: Not necessarily.

13 Q: Why would that not necessarily be true?

14 A: Well, you might want to make it lower for certain
15 reasons.

16 Q: For this surgery that Crystal had, why would it not be
17 important to maintain the blood pressure in a range during
18 surgery that would be as close as possible to that particular
19 patient's baseline blood pressure?

20 A: I think it should be kept at a reasonable level, and it
21 was done.

22 Q: What is a reasonable level though?

23 A: What her level was was reasonable.

24 Q: And what was that level kept at?

25 A: These levels, these that you see during her -- they're

1 recorded during her surgery. I think those are all reasonable
2 blood pressures.

3 Q: And what did Midlands Orthopedics and the hospital do to
4 determine what the reasonable blood pressure levels should
5 have been for Crystal Goodwin during this surgery?

6 A: I think the blood pressure readings that we had were
7 adequate to proceed with a safe surgery.

8 Q: What did you do, Doctor, on behalf of Midlands
9 Orthopedics to determine a safe intraoperative blood pressure
10 for Crystal Goodwin during this surgery?

11 A: I looked at the blood pressures that she had
12 preoperatively, and I felt that those were satisfactory to
13 proceed safely with the surgery.

14 Q: And you did that when?

15 A: Before the surgery.

16 Q: The day of the surgery?

17 A: I would have seen the others when they -- when she was in
18 the hospital. I mean, when she was in the office
19 preoperatively.

20 Q: If mean arterial pressure is not kept at a safe level
21 during surgery, can a patient become permanently injured?

22 A: Crystal's was kept at a safe level throughout her
23 surgery.

24 Q: Okay. But if it wasn't kept at a safe level during
25 surgery, the patient can be permanently injured; correct?

1 MR. ROBINSON: Object to the form.

2 MR. DAVIS: Same objection.

3 BY MR. GOINGS:

4 A: It's possible.

5 MR. BRADLEY: Same objection.

6 BY MR. GOINGS:

7 Q: It's possible?

8 A: Possible.

9 Q: And isn't it true that medical literature and your
10 training and education as a neurosurgeon is consistent with
11 the fact that failing to keep mean arterial pressure at a safe
12 level during surgery for a period of time can result in
13 permanent injury to a patient?

14 MR. ROBINSON: Object to form.

15 BY MR. GOINGS:

16 A: Crystal's was kept at a safe level.

17 Q: I understand you believe Crystal's was, but in a
18 situation when mean arterial pressure is not kept at a safe
19 level during surgery, a patient can be permanently injured;
20 correct?

21 A: If it was not kept at a safe level, it could cause an
22 injury, yes.

23 Q: Okay. And when the mean arterial pressure is kept too
24 low, that can result in a lack of perfusion; right?

25 A: Not necessarily.

1 Q: But it can result in lack of perfusion?

2 A: It could.

3 MR. ROBINSON: Object to form.

4 BY MR. GOINGS:

5 Q: If the mean arterial pressure is kept too low, what else
6 could occur as it relates to blood flow. other than a lack of
7 perfusion?

8 A: Well, if it were kept low enough for a long enough period
9 of time, it could have adverse effects.

10 Q: Like what?

11 A: Like, it could affect -- it could affect cell function in
12 various body systems.

13 Q: And it's effect -- effect on cell function can result in
14 cell deterioration and death; correct?

15 A: If it was bad enough, it could.

16 Q: And tissue death, particularly in the spinal cord, can
17 result in permanent injury, including total paralysis or what
18 some consider to be partial paralysis; correct?

19 A: It's possible.

20 Q: Okay. When Midlands Orthopedics has a neurosurgeon in
21 the surgery suite in the room, is that person the most
22 knowledgeable as to neuroscience?

23 A: For that particular patient at that particular time, yes.

24 Q: You testified earlier that you would have had records
25 sent to the hospital before surgery. Do you recall that?

1 A: May have.

2 Q: May have?

3 A: We oftentimes do.

4 Q: In this particular situation, this particular surgery,
5 can you state with certainty that Crystal Goodwin's records
6 from Midlands Orthopedics was sent to the hospital before
7 surgery?

8 A: Well, you can look at the hospital records and see if
9 they're there, but I don't have an independent recollection
10 whether they're there or not. I don't remember looking at
11 them.

12 Q: And if they're not in the medical records of the
13 hospital, it's fair to say that they were not sent; right?

14 MR. DAVIS: Objection to the form of the question.

15 BY MR. GOINGS:

16 A: Maybe.

17 Q: Who gives instructions about what to send to the hospital
18 from Midlands Orthopedics?

19 A: Usually, they request -- have a request sheet of what
20 they -- what they want.

21 Q: What is on the request sheet for this type of surgery?

22 A: It would be -- it would be -- they would request what
23 they would need.

24 Q: So you would only send the records that would be
25 requested?

1 A: Sometimes we send -- we send them anyway. I can't -- I
2 can't remember if they requested them or if we sent some or
3 whether or not they got the office records from this case.
4 I'm not sure.

5 Q: The request sheet, is that a document from the hospital?

6 A: I don't know if they had a specific request sheet or not.

7 Q: Does Midlands just send the records that are requested or
8 does Midlands send the entire chart, the entire record of a
9 patient before surgery?

10 A: Well, they might send what's requested or they might send
11 what they thought was pertinent.

12 Q: Do you really know the answer to the question or are you
13 just speculating?

14 A: For this particular case as to what was actually sent, I
15 don't know. I don't remember exactly what was sent for this.
16 I mean, you could look in the hospital chart and see.

17 Q: Okay. So the best answer as to what was sent in this
18 particular case, you would direct me to the hospital's medical
19 chart?

20 A: It would be easy to determine if -- if it was in their
21 chart or not.

22 Q: What's the purpose of neuromonitoring during a spinal
23 surgery?

24 A: To monitor the nervous system.

25 Q: Is neuromonitoring important?

1 A: It can be.

2 Q: Why can neuromonitoring be important?

3 A: Why what?

4 Q: Why can neuromonitoring be important during a spinal
5 surgery?

6 A: To assess the status of the nervous system.

7 Q: Is neuromonitoring designed to promote patient safety and
8 limit bad outcomes in spinal procedures?

9 A: We use it to try to improve the safety of the surgery.

10 Q: And you would agree that one of the primary objectives of
11 neuromonitoring is to promote patient safety and to limit poor
12 outcomes or unintended outcomes in spinal procedures?

13 A: We use it to order -- in order to try and help achieve a
14 good outcome.

15 Q: Okay. Is the purpose of neuromonitoring to detect and
16 limit possible injury to a patient's nervous system during a
17 surgery?

18 A: We do use it for that.

19 Q: And intraoperative neuromonitoring can provide valuable
20 information to you as a surgeon who performs complex spinal
21 procedures; is that correct?

22 A: It can.

23 Q: And the information that you obtain through
24 intraoperative neuromonitoring is used to prevent and to
25 lessen the degree of injury to a patient during this type of

1 procedure?

2 A: It can be used for that.

3 Q: And why would the nervous system need to be monitored
4 during a procedure like the one that Crystal Goodwin had?

5 A: We're operating near the nervous system.

6 Q: Is the purpose of intraoperative neuromonitoring to
7 promote safety for a patient?

8 A: Yes.

9 Q: Does the use of intraoperative neuromonitoring assist
10 physicians, such as yourself, in averting neurological
11 complications and other sensory defects that may arise as a
12 result of spinal surgery?

13 A: It can.

14 Q: And neuromonitoring technology allows the intraoperative
15 assessment of spinal cord function through real-time feedback
16 from sensory tracts, motor tracts, and individual nerve roots;
17 is that right?

18 A: It can.

19 Q: What would intraoperative neuromonitoring be used for in
20 the type of procedure that Crystal Goodwin had?

21 A: We use it primarily to monitor function of the spinal
22 cord.

23 Q: Is it important to monitor the function of the spinal
24 cord during this procedure?

25 A: I don't think it's required, but it's something I chose

1 to do.

2 Q: And why did you choose to use intraoperative
3 neuromonitoring?

4 A: I thought it was an additional level of safety.

5 Q: And it's an additional level of safety that the patient
6 pays for; right?

7 A: The patient pays for the neuromonitoring? I don't know
8 who got billed for that. That's the -- that's a separate
9 company from the hospital.

10 Q: Okay. Neuromonitoring is not free though, is it?

11 A: No.

12 Q: And neuromonitoring is not used in all spinal cases, is
13 it?

14 A: No.

15 Q: With you as a neurosurgeon, how often did you use
16 neuromonitoring in discectomies or laminectomies?

17 A: Discectomies and laminectomies, usually not.

18 Q: What about laminectomies?

19 A: Usually not.

20 Q: Why would you choose to use neuromonitoring for Crystal
21 Goodwin's surgery?

22 A: It was in the thoracic level.

23 Q: Is the thoracic level susceptible to injury of the spinal
24 cord when you perform this type of procedure?

25 A: Could it be injured? That's possible.

1 Q: Can you explain to me why neuromonitoring was
2 particularly used for Crystal Goodwin's thoracic laminectomy?
3 A: I thought it would give an additional level of safety.
4 Q: Safety from what?
5 A: Injury.
6 Q: Did any event occur, incident, or anything occur during
7 the procedure that would have affected SSEP readings?
8 A: Yes. We lost the SSEP readings at about 10:03.
9 Q: Okay. Is there anything that would have caused that to
10 be lost that you know of?
11 A: Yes.
12 Q: What was that?
13 A: Stroke in the spinal cord.
14 Q: Okay. Ischemia?
15 A: Yes.
16 Q: Okay. And can you tell us all of the potential causes of
17 a stroke in the spinal cord?
18 A: Well, there are a number of different things that could
19 cause a stroke.
20 Q: What are those?
21 A: It could be bleeding, infection, inflammation, a vascular
22 reason. Those are some of the things that might cause it.
23 Q: In a vascular etiology, that would be an ischemic event?
24 A: Circulation. Yes, an ischemic could cause an ischemic
25 event. All of those things could cause an ischemic event.

1 Q: When you say circulation, are you also including
2 perfusion?

3 A: It could be.

4 Q: Okay. So we have bleeding, infection, a vascular event?

5 A: Right.

6 Q: What else?

7 A: Pressure on the spinal cord could cause that.

8 Q: Was there an issue with bleeding during this procedure?

9 A: No.

10 Q: Was there an issue with infection during this procedure?

11 A: No.

12 Q: Was there an issue with inadequate pressure on the spinal
13 cord during the procedure?

14 A: No.

15 Q: Of these main ones, which does Midland's Orthopedic
16 believed to be the most probable cause of Crystal Goodwin's
17 condition?

18 MR. DAVIS: Object to form in question. Go ahead and
19 answer.

20 BY MR. GOINGS:

21 A: No definite cause was ever determined.

22 Q: T9 level. What vascular components are found in the T9
23 level?

24 A: Blood vessels that supply the spinal cord.

25 Q: Do those blood vessels have any particular name to them?

1 A: Most of them don't. There's one that comes in at that
2 level called Adamkiewicz is the one that sometimes comes in at
3 that level.

4 Q: Was it --

5 A: Most of them are not named.

6 Q: All right. The one that comes in that level is called a
7 what?

8 A: Adamkiewicz, sometimes.

9 Q: What are the causes of ischemic events in that area?

10 A: I think I just went over all of those.

11 Q: Could lack of blood supply through that area cause the
12 ischemic event?

13 A: It could.

14 Q: You can't rule that out?

15 A: No. Any one of those things that I named could cause
16 that.

17 Q: And you had no opinion as to which of those four that you
18 named could be the most probable cause?

19 MR. DAVIS: Object to the form of the question.

20 BY MR. GOINGS:

21 A: In the end -- in the end, all strokes are vascular in
22 nature, but I can't tell you exactly what the cause of this
23 was. No cause was ever demonstrated, even on the very
24 sensitive MRI scan did not demonstrate a cause for why this
25 stroke occurred.

DR. THOMAS HOLBROOK - 30(b)(6) DEPOSITION

1 (WHEREUPON, the videotaped deposition was stopped.)

2 THE COURT: Okay.

3 MR. GOINGS: That's the end of the testimony --

4 THE COURT: Okay.

5 MR. GOINGS: -- for this deposition that we've designated
6 by agreement.

7 THE COURT: Yes, sir.

8 Ladies and gentlemen, we're going to take a short break
9 this afternoon. Please return to your jury room. Don't
10 discuss the case.

11 (WHEREUPON, the jury exited the courtroom at 4:06 p.m.)

12 THE COURT: All right. Let's take 15 minutes, folks.

13 (WHEREUPON, there was a break in the proceedings, after
14 which the proceedings resumed as follows.)

15 (WHEREUPON, the depositions of Dr. Holbrook were marked
16 as Court's Exhibits Number 8 and 9.)

17 THE COURT: Bring the jury, please.

18 (WHEREUPON, the jury entered the courtroom at 4:25 p.m.)

19 THE BAILIFF: All jurors are seated, Your Honor.

20 THE COURT: Thank you.

21 Welcome back, folks. Plaintiff is going to call the next
22 witness.

23 MR. GOINGS: Your Honor, the next witness is Dr. Thomas
24 Jefferson Holbrook in his sworn deposition a year before the
25 one we just heard in his individual capacity on May 11th,

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 2020. And we have provided the court reporter, for the
2 record, certified copies of both depositions.

3 THE COURT: Wonderful.

4 So, ladies and gentlemen, this is another video
5 deposition.

6 MR. GOINGS: Yes, Your Honor.

7 THE COURT: Yes. Okay. This is Dr. Holbrook, not as a
8 representative of Midlands Orthopedics and Neurology, but on
9 his own behalf. But, I mean, the procedure is the same.

10 So you may proceed.

11 MR. GOINGS: Thank you, Your Honor.

12 (WHEREUPON, the videotaped deposition of Dr. Holbrook was
13 played. Transcribed as follows.)

14 DISCOVERY DEPOSITION

15 BY MR. HINSON:

16 Q: In your review of the records, did you come across
17 anything that you believe had been recorded incorrectly?

18 A: I believe I think there were some transcription errors.

19 Q: Transcription errors with regard to -- to what document
20 or documents?

21 A: I think there was one in the -- in the last -- one of the
22 last op notes, and there may have been another one. I can't
23 -- I can't remember.

24 Q: Okay. And when you say transcriptions errors, you mean
25 something that you had said that was then transcribed

1 incorrectly?

2 A: Well, I don't know if -- I don't know where the error
3 occurred.

4 Q: Okay. But is that -- you're speaking of something in the
5 -- the notes you made in the chart?

6 A: In the operative record.

7 Q: Okay. And when you say the operative record, you're
8 speaking to the operative report?

9 A: Yes.

10 Q: And speaking of operative reports that you made?

11 A: That I dictated.

12 Q: And after dictating those records, you would have then
13 reviewed them; correct?

14 A: In a manner. Yes, sir.

15 Q: What do you mean by in a manner?

16 A: I may not have read every word in every report.

17 Q: But then after reviewing them, as you put it in a manner,
18 you would electronically sign and verify those operative
19 reports; correct?

20 A: Yes.

21 Q: So if there was a transcription error in one of those
22 operative reports, you would have had an opportunity to review
23 and correct that transcription error; is that fair?

24 A: If I had picked it up, yes.

25 Q: With the exception of potentially a transcription error

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 in the operative report you dictated, did you come across
2 anything else that you believe may have been incorrect in
3 Crystal Goodwin's medical records?

4 A: I haven't read every word in the entire medical record.

5 Q: But sitting here today, is there any other thing you
6 could point to that you believe may be incorrect in the
7 medical record?

8 A: I can't think of anything right offhand.

9 Q: Do you agree there are dangers associated with a patient
10 becoming hypotensive during a surgery?

11 MR. DAVIS: Objection to the form of the question.

12 BY MR. HINSON:

13 A: There could be, but Crystal Goodwin did not have any
14 hypotension.

15 Q: Do you agree that there are dangers associated with a
16 patient becoming hypotensive during surgery?

17 MR. DAVIS: Same objection.

18 BY MR. HINSON:

19 A: It's possible.

20 Q: What are some of the dangers associated with a patient
21 becoming hypotensive during -- hypotensive during surgery?

22 A: A lack of perfusion.

23 Q: Is that lack of perfusion including lack of perfusion to
24 the spinal cord?

25 A: To various body parts, including the spinal cord.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: So if a patient becomes hypotensive during a surgery,
2 there could be a lack of perfusion to the spinal cord?

3 MR. TODD: Objection.

4 MR. ROBINSON: Object to the form.

5 MR. DAVIS: The same objection.

6 BY MR. HINSON:

7 A: So is that possible? That's possible.

8 Q: And when we talk about perfusion, you're speaking of
9 perfusion of blood; correct?

10 A: Correct.

11 Q: And if there is a lack of perfusion of blood to the
12 spinal cord, what could result?

13 A: Well, you would think if it affected the spinal cord, it
14 would also affect multiple other organs, which is -- is more
15 common. It could cause -- if it affected the spinal cord, it
16 could injure the spinal cord.

17 Q: The question I was asking, Dr. Holbrook, is if a patient
18 becomes hypotensive, if their blood pressure becomes too low,
19 does that increase their risk of suffering an infarction?

20 MR. TODD: Objection.

21 MR. ROBINSON: Object to the form.

22 MR. DAVIS: The same objection.

23 BY MR. HINSON:

24 A: If they had significant hypotension, it would be much
25 more common for them to affect other organs than an isolated

1 injury just to the spinal cord. That would be very uncommon.

2 Q: Do you agree that during a spine surgery under
3 anesthesia, a patient's intraoperative blood pressure should
4 be kept within a certain range of his or her baseline blood
5 pressure?

6 A: It should be kept at a reasonable level.

7 Q: And what's a reasonable level for one patient may differ
8 to another patient; is that fair?

9 A: No. The point at which they may have symptoms from an
10 abnormality may be different in different patients.

11 Q: One should consider the patient's baseline blood pressure
12 when determining what blood pressure to keep the patient
13 during a surgery?

14 A: We look at the baseline blood pressure.

15 Q: So a patient who has been historically hypertensive might
16 need a higher blood pressure maintained during surgery than
17 another patient who had normal blood pressure historically?

18 MR. ROBINSON: Object to the form.

19 BY MR. HINSON:

20 A: Do you mean is that ever possible --

21 Q: Well --

22 A: -- on any situation? Could it ever happen? Yes, it's
23 possible.

24 Q: Do you agree that when determining where to keep a
25 patient's blood pressure during anesthesia, the patient's

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 historical baseline blood pressure should be considered?

2 A: It is considered, and it should be considered.

3 MR. ROBINSON: Object to the form.

4 BY MR. HINSON:

5 A: It is considered.

6 Q: And it should be considered?

7 A: It is considered. I mean, that's just a normal part of
8 the process. Every patient's baseline blood pressure is
9 observed before the surgery.

10 Q: How far would one go back to look at baseline blood
11 pressure?

12 A: I don't know.

13 Q: Whose job is that?

14 A: Is to look at the blood pressure?

15 Q: To determine the baseline blood pressure.

16 A: To determine the baseline blood pressure? I think that's
17 something that everybody -- everybody knows what the baseline
18 blood pressure is.

19 Q: Is that something you consider prior to the surgery?

20 A: Yes.

21 Q: As a surgeon preparing to perform a spine surgery, what
22 would you look at to determine the patient's preoperative
23 blood pressure?

24 A: The numbers of the blood pressure.

25 Q: You would look at the patient's chart; correct?

1 A: Yes.

2 Q: And you would look at the recordings of blood pressure in
3 previous appointments and visits; correct?

4 A: We record the blood pressure at our visits, yes.

5 Q: And you would look at that prior to performing the
6 surgery?

7 A: Yes, we look at blood pressure before the surgery.

8 Q: And you would look at the patient's blood pressure in
9 prior visits before performing the surgery?

10 A: I wouldn't look at every blood pressure with every visit
11 that you take with every doctor. No. No, that's not
12 customary.

13 Q: So how far back would you go?

14 A: I would look at her existing blood pressure, her history
15 of hypertension and, based on her history, try to determine if
16 there were any issues with that that needed to be dealt with
17 preoperatively.

18 Q: How might a history of hypertension need to be dealt with
19 preoperatively?

20 A: That would be up to her primary care physician or whoever
21 was treating her blood pressure.

22 Q: If you reviewed a patient's chart and found that they had
23 a history of elevated blood pressures, you would take that
24 into consideration going into the operating room; is that
25 fair?

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 A: I would consider that.

2 Q: Would a patient having a history of high blood pressures
3 potentially need to have their blood pressures maintained at a
4 higher level during the operation as opposed to patients who
5 have blood pressures in the normal range?

6 A: Not necessarily.

7 Q: Why not?

8 A: It may not be necessary.

9 Q: For some is it necessary?

10 A: Is it possible it could be? I mean, it's possible.

11 Q: Have you in your career had the occasion where a patient
12 -- where you operated on a patient who had a history of high
13 blood pressure?

14 A: Yes.

15 Q: And in your career, have you operated on a history -- a
16 patient with a history of high blood pressure and, as a
17 result, determined that it would be safest for the patient to
18 keep their blood pressure elevated more than what one might
19 keep the average patient?

20 A: Well, what's your question?

21 Q: Sure. Dr. Holbrook, in your career as a neurosurgeon,
22 you said you had the occasion to operate on patients with high
23 blood pressure; correct?

24 A: Yes.

25 Q: And in operating on patients with high blood pressure,

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 have you had the occasion where in going into the surgery, you
2 made the determination that the patient's intraoperative blood
3 pressure should be maintained slightly higher than that of
4 someone who had a normal blood pressure?

5 A: It's possible that you would maintain their blood
6 pressure based on their history rather than basing everybody's
7 treatment off of what a normal blood pressure would be. So
8 that's where the baseline blood pressure might be used.

9 Q: So for the intraoperative blood pressure, it's not a one-
10 size-fits-all type thing, is it?

11 A: No.

12 Q: One has to consider the patient's history and history of
13 blood pressure?

14 A: I consider their blood pressure history.

15 Q: Because what's safe for one patient -- blood pressure --
16 intraoperative blood pressure for one patient may not be a
17 safe intraoperative blood pressure for another patient?

18 A: Do you have an example of that?

19 Q: Sure. Well, my question is, do you agree that if you
20 have a patient with a chronically high blood pressure, what
21 would be a safe intraoperative blood pressure for that patient
22 would likely be different than a patient with a historically
23 healthy normal blood pressure?

24 A: Not necessarily.

25 Q: But it could be; correct?

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 A: Could it possibly ever be? Maybe. It's possible.

2 Q: Have you in your career, Dr. Holbrook, had the occasion
3 where you were performing surgery on a patient with
4 chronically high blood pressure and the understanding during
5 the operation was that the patient's blood pressure should be
6 maintained at a rate or a level higher than the average
7 patient's?

8 MR. TOOD: Objection.

9 BY MR. HINSON:

10 A: It depends on what you're doing surgically.

11 Q: I'm not asking about what you're doing. Have you had the
12 occasion that that occurred?

13 A: It's -- in the spine? No.

14 Q: So in your -- in your career, you've never had the
15 occasion where you're performing a spine surgery and you made
16 a determination that the patient's blood pressure, because of
17 their -- because of chronic high blood pressure, should be
18 maintained slightly higher than the average person?

19 A: Well, I would say that it should be maintained in
20 accordance with that particular patient. We wouldn't maintain
21 their blood pressure based off what's normal for some other
22 patient. That's -- that's not how we do that.

23 Q: You maintain blood pressure based off the patient?

24 A: We use the patient's history. Yes, sir.

25 Q: And what do you try to maintain? Is there a range you

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1 try to maintain from the historical blood pressure?

2 A: A range? Well, if you'd give me an example.

3 Q: Well, do you look at their mean arterial pressures or do
4 you look at just their systolic and diastolic alone?

5 A: Both.

6 Q: If you -- do you calculate the patient's average mean
7 arterial pressure prior to surgery?

8 A: I think it's -- that's part of the record, I think.

9 Q: Is that something you would look at prior to surgery?

10 A: Prior to surgery, the mean? I probably would look at the
11 systolic and the diastolic would be the main numbers we would
12 use.

13 Q: Okay. And when you look at the systolic and diastolic,
14 do you make a determination based off the patient's history of
15 a range of the systolic and diastolic that you would like it
16 to be maintained during the course of the surgery?

17 A: Yeah. Usually the monitoring of the blood pressure and
18 the range is -- is something that anesthesia monitors.

19 Q: Okay. A little different than my question though, Dr.
20 Holbrook. Do you make a determination prior to the surgery as
21 to where a patient's blood pressure should be maintained or a
22 range of where it should be maintained?

23 A: I don't come up with an exact number of where I think it
24 should be.

25 Q: Do you --

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 A: I don't think that's necessary.

2 Q: Do you come up with a general concept?

3 A: I don't come up with a range of numbers for the
4 particular patient prior to surgery, no.

5 Q: Okay. Do you in any way make a determination about
6 intraoperative blood pressure prior to surgery?

7 A: I'll see what it is at the start. Anesthesia monitors
8 it, monitors it during the case, and if there's an issue with
9 the blood pressure, then they let me know.

10 Q: Do you expect anesthesia to have a range where they would
11 like to keep the patient's blood pressure?

12 A: I think it's an individual thing.

13 Q: Individual to the patient or individual to the anesthesia
14 team?

15 A: To the patient.

16 Q: So for each patient there may be a different range for
17 where the blood pressure should be maintained by the
18 anesthesia team?

19 A: Could there be? Yes.

20 Q: Is that something you typically discuss with the
21 anesthesia team prior to surgery?

22 A: What? What their blood pressure is? If there's an issue
23 with it.

24 Q: Do you recall if you ever discussed Crystal Goodwin's
25 baseline and historical blood pressure prior to the surgery

1 performed on July 28th, 2016?

2 A: I don't believe that was necessary with this case.

3 Q: Do you recall if you ever discussed Crystal Goodwin's
4 blood pressure prior to the surgery performed on July 28th,
5 2016?

6 A: I believe her blood pressure, by history, was well
7 controlled, and I did not discuss it preoperatively with
8 anesthesia.

9 Q: And because one can't know with certainty the exact
10 blood pressure figures or measurements where one would have a
11 vascular problem, do you agree it's important to maintain
12 blood pressure in a way that is consistent with the patient's
13 historical blood pressure --

14 MR. ROBINSON: Object to the form.

15 BY MR. HINSON:

16 Q: -- preoperatively?

17 A: I think the blood pressure should be managed in a
18 reasonable manner.

19 Q: And that management is done by the anesthesia team?

20 A: They manage the blood pressure. Yes, sir.

21 Q: Not you as the surgeon?

22 A: Anesthesia monitors the blood pressure during the
23 surgery.

24 Q: And manages the blood pressure during the surgery?

25 A: Yes.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: Is it anesthesia's job to make a determination of the
2 safe range to maintain the patient's blood pressure during
3 surgery?

4 A: Is it what now?

5 Q: Is it the job of the anesthesia team to make a
6 determination as to the safe range to maintain the patient's
7 blood pressure during surgery?

8 MR. DAVIS: Objection to the use of the word safe. You
9 can answer the question.

10 BY MR. HINSON:

11 A: I think they monitor the blood pressure, and they may do
12 some treatments, modify their anesthesia based on a blood
13 pressure reading.

14 Q: If a patient's blood pressure needs to be elevated, what
15 medications can be given during surgery to bring the patient's
16 blood pressure up?

17 A: That would be a determination of anesthesia as to what
18 they would use for that.

19 Q: You are unaware of what medicines can be given?

20 A: Well, it might be an epinephrine-based medicine could
21 make it go up.

22 Q: There are means and mechanisms by which to control the
23 patient's blood pressure during surgery; is that a fair
24 statement?

25 A: Yes.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: If Crystal Goodwin's pre-surgery, preoperative blood
2 pressures were 152 over 112, 129 over 81, 156 over 99, and 160
3 over 99, where would you -- as the surgeon, what range would
4 you like to keep her blood pressure during the surgery?

5 MR. ROBINSON: Object to the form.

6 BY MR. HINSON:

7 A: I mean, is that a -- I mean, a one or two time individual
8 readings? Over what period of time is that? I think that
9 would be -- as determining her blood pressure and what it
10 needed to be on a long-term basis would be up to her treating
11 physician for her blood pressure.

12 Q: I'm not asking about her blood pressure over a long-term
13 basis, Dr. Holbrook. I'm asking about during surgery
14 performed in the morning of July 28th, 2016.

15 A: I don't think you can give a specific number as to what
16 it needs to be.

17 Q: Could you not give a range?

18 A: For?

19 Q: Where you would like to maintain her blood pressure
20 during the surgery?

21 A: I would leave that up to anesthesia.

22 Q: Okay. So --

23 A: I would not tell them where to keep the blood pressure
24 unless it was related to something specifically to what I was
25 doing.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: So if one looks at Crystal Goodwin's blood pressure
2 readings preoperatively, you would leave it up to the
3 anesthesia team to make a determination of a range of where to
4 keep her blood pressure during the surgery; is that fair?

5 A: For this particular type of surgery, yes.

6 Q: Okay. So for Crystal Goodwin, with regard to the surgery
7 performed on July 28th, 2016, you would defer to the
8 anesthesia team as to the range with which to attempt to keep
9 her blood pressure?

10 A: During the surgery? Yes.

11 Q: All right. So just so we're clear, with regard to
12 Crystal Goodwin's surgery on July 28th, 2016, you deferred to
13 the anesthesia team as to the range to keep her intraoperative
14 blood pressure?

15 MR. DAVIS: Objection. Asked and answered. He's already
16 answered that question. Let's move on, Mr. Hinson.

17 BY MR. HINSON:

18 A: I would defer to them to monitor the blood pressure and
19 treat it as they saw fit.

20 Q: And you would --

21 A: That pretty much answers that.

22 Q: There was neuromonitoring being done during the surgery;
23 is that correct?

24 A: Yes.

25 Q: What's the purpose of the neuromonitoring?

1 A: To monitor the nervous system.

2 Q: What type of neuromonitoring was being done?

3 A: Evoked potentials.

4 Q: In layman's terms, what does that mean?

5 A: Checking -- checking the electrical conductance through
6 the nervous system.

7 Q: And there were two types being done; right? SSEPs and
8 MEPS?

9 A: Correct.

10 Q: How do those differ? What's the difference between an
11 SSEP and an MEP?

12 A: One monitors a sensory system. One monitors a motor
13 system.

14 Q: And neuromonitoring is being done intraoperatively in an
15 effort to timely identify any injury or potential injury to
16 the spinal cord; is that fair?

17 A: We're doing it to monitor the nervous system to see if
18 there are abnormalities, significant abnormalities from the
19 baseline.

20 Q: And the reason you'd like to know if there are
21 abnormalities or significant abnormalities from the baseline
22 is so that you can take action during the surgery to address
23 anything that may have occurred to cause those abnormalities?

24 A: Well, we would consider what we were doing during the
25 surgery at the time there was a change or a significant change

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 and decide whether we needed to modify what we were doing.

2 Q: Was there a significant abnormality signaled during the
3 surgery performed on Crystal Goodwin on July 28th, 2016?

4 A: Yes.

5 Q: What type of signal abnormality occurred?

6 A: They lost the signal.

7 Q: What do you mean by they lost the signal?

8 A: There was a normal signal, and then suddenly there was no
9 signal.

10 Q: What time did the signal stop?

11 A: I think it was around 10 o'clock.

12 Q: What's the Stagnara wake-up test?

13 A: I'm not familiar with that.

14 Q: Are you familiar with different wake-up tests that can be
15 done?

16 A: I've heard of waking people up to test them.

17 Q: Have you ever performed that?

18 A: Not for this particular type of procedure.

19 Q: Have you ever performed it in other procedures?

20 A: Yes.

21 Q: What were some of the occasions where you had to do that?

22 A{ These were spinal cord stimulator cases to determine
23 where the stimulators were affecting the patient.

24 Q: Was that part of the plan anyway to wake them up?

25 A: Yes.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: Have you ever woken a patient up during a surgery in an
2 unplanned manner where you thought there may have been an
3 injury?

4 A: You mean to wake them up during surgery with the plan of
5 continuing surgery after that? No.

6 Q: When the SSEP signal was lost, did you inquire with the
7 anesthesia team about Crystal's blood pressures?

8 A: We looked at her vital signs.

9 Q: Including the blood pressure?

10 A: Yes.

11 Q: Did you make any changes to the blood pressure following
12 that review?

13 A: I don't -- I don't recall whether they made any blood
14 pressure changes. As I recall, there was not an issue with
15 the blood pressure that needed to be changed.

16 Q: Dr. Holbrook, can you identify what we've marked as
17 Exhibit 2?

18 A: Operative report, 7/28/2016.

19 Q: And then there's two operative reports on this document;
20 correct?

21 A: Yes.

22 Q: All right. And these are your two operative reports from
23 the surgery performed on Crystal Goodwin -- surgeries
24 performed on Crystal Goodwin on July 28th, 2016; correct?

25 Q: Yes.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: And you dictated these reports; correct?

2 A: Yes.

3 Q: And then after dictating them, you signed and verified
4 them; correct?

5 A: I signed them, yes.

6 Q: You signed and verified them; correct?

7 A: Well, I signed them. I did not read every word in both
8 of these reports.

9 Q: So the verified part is incorrect? You did not, in fact,
10 verify this?

11 A: I verified that I dictated the report, yes.

12 Q: But you did not read it for completeness and accuracy?

13 A: I didn't read every word in it. No, sir.

14 Q: Okay. There's a couple of blanks on this report. Do you
15 see those?

16 A: Yes.

17 Q: Why would there be blanks on it?

18 A: Maybe the transcriptionist couldn't make out what was --
19 what was said or there was some technical issue with it.

20 Q: And part of the reason for electronically -- well,
21 reviewing and electronically signing operative reports is to
22 have the opportunity to correct or fill in places where the
23 transcriptionist had difficulty; is that fair?

24 A: Yes.

25 Q: All right. And you did not fill in these two places

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 where the transcriptionist was unsure of what was said?

2 A: No, I did not.

3 Q: All right. Can you, sitting here today, fill in what
4 those two blanks are?

5 A: The first blank would be the sensory-evoked potentials.
6 And the second blank --

7 MR. ROBINSON: I'm sorry. Could you repeat it?

8 MR. HINSON: Sensory-evoked potentials.

9 MR. ROBINSON: Thank you.

10 THE WITNESS: Or evoked potentials.

11 BY MR. HINSON:

12 A: And the second one would be lamina and brought out.

13 Q: Dr. Holbrook, in this operative report, you don't
14 describe what took place in response to the SSEPs stopping
15 signal, do you?

16 A: Let's see here. What was your question now?

17 Q: Do you describe what -- what you did in response to what
18 -- what you did in response to the SSEPs losing signal?

19 A: I just told you what I did.

20 Q: It's not included. What you just told me is not included
21 in this report, is it?

22 A: Well, no specific cause -- surgical cause was identified,
23 and there was -- so there was nothing -- nothing else that we
24 did other than to inspect the wound.

25 Q: The second operative report, Dr. Holbrook, there's some

1 blanks in that as well. Do you see that?

2 A: Yes.

3 Q: What's the first blank? What should be there?

4 A: I believe that would be at the T9-10 level.

5 Q: Same for the second blank?

6 A: Yes.

7 Q: What about the third blank?

8 A: Where is that?

9 Q: It's here in the Description of Procedure, the sentence
10 that reads: On inspection of the superior portion of the
11 laminectomy site showed partially calcified scar tissue was
12 encountered on the left, and then there's a blank.

13 A: That's T9-10. I thought that was the only two I saw.
14 Where's the other one?

15 Q: Up at the top.

16 A: Oh, sorry. Probably thoracic. In the one at the top,
17 thoracic.

18 Q: Okay. So, just to be clear then, so I'm looking at the
19 -- at the very bottom of Bates stamped Prisma Health Baptist
20 715. I'm looking down here. There's a blank.

21 A: Which page is that?

22 Q: Well, it's Bates stamped 715, which is this little number
23 right here at the bottom right-hand corner.

24 A: Okay. Thoracic.

25 Q: Okay. And then flip the page. There's another blank.

1 That should be?

2 A: We did that one.

3 Q: Okay. That's the thoracic as well.

4 A: Yes, sir.

5 Q: All right. And about two-thirds down the page, that's
6 the -- what goes in that blank?

7 A: T9-10 level.

8 Q: Okay. That's what goes in between left and the canal?

9 A: Encountered on the left at the T9-10 level. Probably
10 don't need the canal on the left side. I think they maybe
11 transcribed that twice.

12 Q: Then it says further dissection was done in this area,
13 blank, the scar tissue. What goes in that blank?

14 A: Well, further dissection was done in this area. That
15 area would be the T9-10 level, and the scar tissue was
16 dissected free from the thecal sac.

17 Q: It's difficult to determine what belongs in that blank,
18 isn't it?

19 A: No.

20 Q: And so what belongs in that blank?

21 A: I believe a description of the T9-10 level is what it's
22 referring to.

23 Q: You didn't correct this at the time you signed and
24 verified this document, did you?

25 A: No.

1 Q: Why not, Dr. Holbrook?

2 A: I didn't read the entire report.

3 Q: Should these blanks have been filled in before signing
4 it?

5 A: Theoretically, they should be, yes.

6 Q: In your --

7 A: I didn't catch -- I didn't catch them at the time.

8 Q: The SSEPs losing signal in the first surgery would
9 indicate that something happened to her spinal cord around 10
10 a.m., would it not?

11 A: Well, in this particular case, as it turned out, yes.
12 Initially, we thought it may have been a problem with the
13 equipment, but as it turned out, it was an injury to the
14 spinal cord.

15 Q: Your initial belief was that it was something wrong with
16 the equipment; correct?

17 A: Correct.

18 Q: What led you to determine it was, in fact, not an
19 equipment issue, but something that occurred in the spinal
20 cord?

21 A: Well, when we examined her in the recovery room, she had
22 significant weakness in her legs. We performed an MRI scan,
23 which showed this area of increased signal intensity within
24 the cord.

25 Q: When the SSEPs stopped giving signal around 10 a.m., how

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 long would you anticipate you looked to determine the cause
2 before continuing on with the surgery?

3 A: Well, we immediately looked to see if we could find a
4 cause, but first of all we looked at the equipment and then
5 checked the equipment. At the same time, I was inspecting the
6 wound.

7 Q: So how long did that take?

8 A: It didn't take very long.

9 Q: All right. Help me with the time?

10 A: I don't know. Maybe a minute or two.

11 Q: And after that, you continued on with the surgery?

12 A: We finished the -- we finished the surgery, closed, made
13 a determination as to what we thought was best at that time
14 and proceeded.

15 Q: Did the neuromonitoring folks ever tell you that they
16 thought it might be an equipment error?

17 A: They checked their equipment, and they said they could
18 not find an error in their equipment.

19 Q: Who made the determination that it may be an equipment
20 error that was causing the SSEPs to lose signal?

21 A: Well, I -- I initially thought that that was the cause
22 because there was nothing being done during the surgery which
23 I felt would be -- would have caused that.

24 Q: So, as I understand, what made you believe it was likely
25 an equipment error was because at the time signal was lost,

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 you didn't believe you were doing anything that would have
2 caused an injury to the spinal cord?

3 A: No.

4 Q: Is that a fair summary?

5 A: I was not doing anything that I felt would be injurious
6 to the spinal cord. There was no hematoma, no other issue
7 that we could identify on direct visual inspection which would
8 have caused that.

9 Q: Did you consider it might be a vascular issue?

10 A: Yes.

11 Q: What did you do to determine it wasn't a vascular issue?

12 A: Well, at that time, when we finished what we were doing,
13 we took her to the recovery room, made the MRI scan in order
14 to try and determine what the cause was.

15 Q: So in determining whether or not it was a vascular issue,
16 that was done after the surgery taking her to MRI?

17 A: Well, we didn't have a cause -- okay? -- when we took her
18 to the recovery room. That's why we made the MRI scan was to
19 try and determine what the cause was.

20 Q: Sitting here today, what do you believe the cause of the
21 injury to Crystal Goodwin's spinal cord to have been?

22 A: Well, none of the -- none of the things that we did, even
23 the direct inspection of the wound, demonstrated a cause.

24 Even the very sensitive MRI scanning did not demonstrate a
25 cause. It demonstrated a probable ischemic area in the cord,

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 but it did not demonstrate a cause.

2 Q: That's a little different than my question, Doctor. What
3 -- sitting here today, what do you believe -- what do you
4 believe was the most likely cause of the injury to Crystal
5 Goodwin's spinal cord?

6 A: Despite direct inspection and the sensitive MRI scan, we
7 were not able to determine a cause.

8 Q: Do you believe it was something during the course of the
9 surgery that irritated one of the blood vessels?

10 A: I believe it was something that occurred during the
11 surgery, but I can't tell you exactly what it was. I don't
12 know. No exact cause was ever determined.

13 Q: Dr. Holbrook, do you agree that Crystal Goodwin suffered
14 a neurologic injury during the surgery performed on the
15 morning of July 28th, 2016?

16 A: Yes.

17 Q: How would you describe the injury that she suffered?

18 A: The MRI showed what is consistent with an ischemic
19 injury.

20 Q: And in layman's terms, what do you mean, ischemic injury,
21 when you're speaking of the spinal cord?

22 A: Stroke.

23 Q: And at what level did the ischemic injury occur?

24 A: It's at about the T9 level.

25 Q: Is the T9 level -- is that within the watershed region of

1 the spine?

2 A: What do you mean by that?

3 Q: Are you familiar with the term watershed region?

4 A: Somewhat. Why don't you tell me exactly what you're
5 referring to?

6 Q: Well, are there -- is there an area of the spine that in
7 medicine is sometimes referred to as the watershed region?

8 A: As far as what?

9 Q: As far as --

10 A: Water?

11 Q: Well, as far as blood flow.

12 A: As far as blood flow? Yes, sir.

13 Q: So there's an area of the spine that in medicine is
14 sometimes referred to as the watershed region, which is for
15 speaking to blood flow, not water, of course; is that correct?

16 A: Yes, sir. What's your question?

17 Q: Is the T9 level -- is that within the watershed region?

18 A: That's an area where there is usually good blood flow,
19 good blood supply.

20 Q: T9 is?

21 A: Yes.

22 Q: But is that within the watershed region?

23 A: That's not an area that I would think would be more
24 susceptible. I think that area would be less susceptible to
25 ischemia than other areas.

1 Q: T9?

2 A: Yes.

3 Q: What about the watershed region? What -- where is the
4 watershed region?

5 A: Well, the watershed region would be an area where there
6 was relatively less blood supply.

7 Q: And what areas of the spinal cord are considered to be in
8 the watershed region?

9 A: Well, I don't really -- I don't really use that term.

10 Q: Okay. What term do you use?

11 A: For what?

12 Q: For areas of the spinal cord that have less blood flow.

13 A: Well, I think all the areas are well perfused.

14 Q: Okay. Are there areas of the spinal cord that are
15 susceptible -- that are more susceptible than other areas of
16 the spinal cord to a vascular incident?

17 A: I guess it would depend on the circumstance.

18 Q: Are there areas of the spinal cord that are more
19 susceptible to others to having poor perfusion?

20 A: I think the T9 level has a good perfusion.

21 Q: Are there areas of the spinal cord that are more
22 susceptible to others to having poor perfusion?

23 A: Could be.

24 Q: What areas are those?

25 A: Further away from a major supply.

1 Q: Where would that be?

2 A: I would say probably in the upper -- upper thoracic would
3 be one of the areas.

4 Q: And you do not believe the T9 level to be an area that
5 would be susceptible -- more susceptible to lesser perfusion?

6 A: That's an area that typically has a more robust blood
7 supply.

8 Q: So I want to understand what -- what types of things
9 could cause this ischemic injury. One would be a blood clot;
10 is that fair?

11 A: Yes.

12 Q: What other possibilities would there be, if any?

13 A: Bleeding, infection, inflammation, ischemia, an ischemic
14 change from a blood vascular issue.

15 Q: That ischemic change, could it be a drop in blood
16 pressure or a failure to perfuse the area?

17 A: It could be. I've reviewed the anesthetic note, and I
18 didn't see any issues with blood pressure recorded on the
19 anesthesia note. If you have some specific blood pressure
20 that you're concerned about, we could discuss that.

21 Q: Sitting here today, do you believe the most likely cause
22 was a clot?

23 A: No. I don't know what it was.

24 Q: You had no --

25 A: There was no clot demonstrated on the MRI scan.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 Q: So does that leave open the possibility of a perfusion-
2 related injury?

3 A: It was an ischemic injury from some cause. I don't know
4 what the cause was. Despite all the testing we did, we could
5 not demonstrate an exact cause for it.

6 Q: Do you agree that blood pressure getting too low below
7 one's baseline can have the potential to cause a spinal cord
8 injury?

9 A: In this case or in any case?

10 Q: Generally speaking. Is that a physiological possibility?

11 A: Generally, is it ever possible? Yes.

12 Q: So you do not believe that happened in this case though?

13 A: In this specific case, I have reviewed the anesthesia
14 record and the timeline of the blood pressure. I don't see
15 any issues there with the blood pressure that I think would
16 have contributed to this. If you have one, I'd be glad to
17 look at it.

18 Q: How low would the blood pressure have to get before you
19 would believe it could potentially cause an injury such as
20 this?

21 A: I can't give you a specific number, and that would vary
22 from patient to patient.

23 Q: For this patient, how long?

24 A: For this patient, I would have expected much more serious
25 injuries to other organs before the spinal cord. Normally, if

1 it was a hypotensive problem that caused the injury to a
2 patient, it would be very unusual to have an isolated injury
3 to the spinal cord.

4 Q: What organs would you expect to see injured?

5 A: Liver, kidneys. I think all the organs would be affected
6 to some degree, but it would be extremely unusual to have an
7 isolated injury to the spinal cord.

8 Q: Did Crystal Goodman have risk factors for spinal cord
9 ischemia and infarction?

10 A: She had spinal stenosis.

11 Q: Would that put her at greater risk for spinal cord
12 ischemia and infarction?

13 A: Having spinal stenosis? Yes.

14 Q: If her diastolic blood pressure was typically running in
15 the 90s, would a diastolic blood pressure of 70 during the
16 surgery be a significant change?

17 MR. ROBINSON: Object to the form.

18 BY MR. HINSON:

19 A: Well, it's a change. I don't think it has any
20 relationship to the complication that she had.

21 Q: Does it have the potential to cause injury?

22 A: Well, if you look at the rest of the anesthesia record,
23 there are several other areas where it was -- her diastolic
24 pressure was also 70. She didn't have any problem there. So
25 you'd think if that was going to cause a problem, it would

1 have caused it back at 8:30.

2 Q: Does it --

3 A: It didn't.

4 Q: Does it have the potential to cause injury was my
5 question, Doctor.

6 A: At 9:30?

7 Q: Does -- if a person has --

8 A: Well, if we're looking at it with the time the injury
9 occurred and her blood pressure diastolic was 70 and she had
10 an injury, if you're saying it was because of that, then why
11 didn't it happen earlier in the case when it was 70 at those
12 times too? So I think it's very unlikely that a diastolic of
13 70 at 10 o'clock is all of a sudden now going to be
14 symptomatic. I don't think that's related to the
15 complication.

16 Q: Doctor, if the patient's blood pressure was typically --
17 diastolic blood pressure was typically in the 90s, would a
18 intraoperative blood pressure in the 70s have the potential to
19 cause injury?

20 MR. ROBINSON: Object to the form.

21 MR. TODD: Objection.

22 MR. DAVIS: The same objection.

23 BY MR. HINSON:

24 A: I've already answered that. I don't think in this case
25 it had the potential to because if it was, it would have

1 caused it earlier in the case when it was 70.

2 Q: Doctor, I'm not asking you about this specific surgery on
3 July 28th. I'm just asking you generally speaking, Doctor, if
4 a patient typically has a blood pressure -- diastolic blood
5 pressure in the 90s, would an intraoperative blood pressure
6 diastolic pressure in the 70s -- of 70 have the potential to
7 cause injury?

8 MR. TODD: Objection.

9 MR. ROBINSON: Object to the form.

10 MR. DAVIS: Same objection.

11 BY MR. HINSON:

12 A: Could it ever possibly happen in any situation that you
13 could ever think of? Yes. But in this case, apparently not
14 or it would have caused a problem earlier in the case when it
15 was also 70.

16 Q: Crystal Goodwin came out of this surgery paralyzed from
17 the waist down, did she not, Doctor?

18 A: She was not completely paralyzed.

19 Q: Crystal Goodwin came out of the surgery nearly paralyzed
20 from the waist down, did she not?

21 A: She had significant weakness, yes.

22 Q: And by 10 o'clock, she had had a period -- multiple
23 periods of time during the surgery where her blood pressure
24 had been well below its normal? Do you agree with that?

25 MR. ROBINSON: Object to form.

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 MR. TODD: Objection.

2 MR. DAVIS: The same objection.

3 BY MR. HINSON:

4 A: It had been below what it started at.

5 Q: Do you not agree with the statement by 10 o'clock a.m. on
6 July 28th, 2016, her intraoperative blood pressures had been
7 below her normal?

8 MR. ROBINSON: Object to form.

9 BY MR. HINSON:

10 A: What is her normal?

11 Q: Doctor --

12 A: What are you saying her normal is?

13 Q: You tell me, Doctor. You said you reviewed her medical
14 record.

15 A: I don't have all --

16 Q: What do you believe her --

17 A: I don't have all the records of her blood pressure.

18 Q: Okay. Presume with me that her normal would show to have
19 been somewhere in the 90s for her diastolic. Do you agree
20 with me that by 10 o'clock her intraoperative blood pressures
21 had been below her normal?

22 A: They were below the normal, but I don't believe that was
23 significant or related to this complication.

24 Q: And what's your basis for that belief?

25 A: Because earlier in the case several times it was also at

DR. THOMAS HOLBROOK - DISCOVERY DEPOSITION

1 70. She never had a problem then. Can you explain that?

2 Q: So because she didn't suffer an injury earlier,
3 therefore, it's your testimony that it wouldn't have caused
4 injury later?

5 A: Well, it would seem if the circumstances of the blood
6 pressure were the same -- okay? -- that it would be unlikely
7 that that would be the cause.

8 Q: So it's your testimony that because she didn't have a
9 problem when it was 70 at around -- well, around -- let's see.
10 It looks like around 9 -- excuse me. 8:25 her diastolic drops
11 to around 70. Do you see that?

12 A: Yes.

13 Q: All right. And so it's your testimony that because it
14 didn't cause her injury at 9:25, therefore, diastolic blood
15 pressures around 70 wouldn't cause her injury around 10?

16 A: I think it makes that much less likely.

17 Q: And it's your testimony that this wouldn't be a
18 cumulative effect; is that fair?

19 A: I don't believe -- I don't see anything on this blood
20 pressure record that I think caused this complication in
21 Crystal Goodwin.

22 Q: Would low blood pressure during the course of the surgery
23 not have some cumulative effect?

24 A: It would have to be a significant -- a significant
25 decline, I think, to cause an effect. I don't think she had a

1 significant decline.

2 Q: But the cumulative nature would be something to consider?

3 A: I mean, you could consider anything you want, but in
4 considering her blood pressure, I don't think that's related
5 to the complication.

6 Q: You've -- you've made that clear, but that's not my
7 question, Doctor. When one looks at a blood pressure
8 intraoperatively and whether or not it may cause injury to a
9 patient, would one not look at the cumulative data?

10 A: I think if it was at a significant -- a level to be
11 significant enough over a longer period of time would have
12 been more significant than a shorter period of time. However,
13 I don't see anything in this record that I think is a
14 significant decline in her blood pressure to the point where
15 it had anything to do with this complication.

16 Q: What would you consider significant for this patient?

17 A: Something that would have been symptomatic.

18 Q: Doctor, you don't believe blood pressure played any part
19 in Crystal Goodwin's injury?

20 A: If you -- can you show me an area that you think caused
21 it? I don't see one. I don't think hypotension caused her
22 injury.

23 Q: Do you believe hypotension played any part in her injury?

24 A: No.

25 Q: If blood pressure didn't cause or play part in the

1 injury, do you have a belief as to what did?

2 A: Despite all of the testing that we did, including the
3 very sensitive MRI scanning, we were never able to come up
4 with a specific reason for this.

5 Q: And sitting here today, you don't have a belief?

6 A: No. Despite all the testing capabilities that we have in
7 modern medicine, we don't always find a cause for every
8 condition.

9 Q: Okay. And that holds true for this that, sitting here
10 today, you don't have a belief as to what caused the injury?

11 A: I don't know.

12 Q: What's your understanding of Crystal Goodwin's condition
13 today?

14 A: At this time, she is -- she has improved to the point
15 where she can stand and walking up in her kitchen to -- to
16 cook and bake.

17 Q: Have you conducted any research related to Crystal
18 Goodwin's surgery and injury?

19 A: No.

20 Q: Following her surgery on July 28th, 2016, did you
21 undertake any research about the issues involved in her
22 surgery?

23 A: Did I research her issues? No.

24 (WHEREUPON, the video was stopped.)

25 MR. GOINGS: That's it, Your Honor.

1 THE COURT: All right, ladies and gentlemen. We will
2 call it a day for today. Please be back in your jury room
3 tomorrow morning at 9:30. Do not discuss the case. Have a
4 good night.

5 (WHEREUPON, the jury exited the courtroom at 5:20 p.m.)

6 THE COURT: Is there anything we need to discuss before
7 we break for the evening? Okay. I'll see you all at 9:30
8 tomorrow morning.

9 (WHEREUPON, the proceedings adjourned for the day.)

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11 --- CONTINUED IN VOLUME V ---

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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 5 OF 9 - VOLUME V
	)	April 14, 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 14, 2023

2 (WHEREUPON, the proceedings resumed at 9:50 a.m.)

3 (WHEREUPON, a jury note regarding scheduling was marked
4 as Court's Exhibit Number 10.)

5 MR. HINSON: And, Your Honor?

6 THE COURT: Yes?

7 MR. HINSON: We would move to sequester Dr. --

8 THE COURT: Hold on. We're not actually on the record.

9 MR. HINSON: Okay.

10 THE COURT: But I was just chatting with y'all, but if we
11 need to go on the record, let's do that. Yeah, let's. Now,
12 what did you want to say?

13 MR. HINSON: Thank you. May it please the Court.

14 The plaintiff would move to sequester Dr. Poletti. Dr.
15 Poletti and Dr. Sampson have similar testimony, as we
16 understand, and he was one -- obviously, if a radiologist is
17 listening to a standard of care expert, that's one thing, but
18 literally, they're both kind of the same. They're both fine
19 surgeons for the defense, and we'd ask that Dr. Poletti be
20 sequestered during Dr. Sampson's testimony.

21 THE COURT: Any objection?

22 MR. DAVIS: Yes, ma'am. There's never been a motion to
23 sequester through all of their case at this point. I didn't
24 make one.

25 MR. HINSON: I just made one.

1 MR. DAVIS: I would object at this point.

2 THE COURT: Have those two witnesses been deposed?

3 MR. DAVIS: Yes, ma'am.

4 MR. GOINGS: Well, we just made a motion to sequester.
5 That's what we did.

6 THE COURT: Well, right. But, I mean, at the start of
7 trial.

8 MR. GOINGS: That's not what the rule says that you make
9 a motion.

10 THE COURT: I know, I know. I'm just interpreting, you
11 know.

12 MR. HINSON: Okay.

13 THE COURT: That was a ruling.

14 MR. HINSON: And, Your Honor, again, I'm just
15 differentiating between. It's one thing if a radiologist is
16 listening to standard of care testimony, but these are both,
17 as I understand, nearly identical witnesses. We earlier had a
18 motion to exclude the redundancy. And we understand your
19 ruling. We respect your ruling, but we would ask, since it's
20 almost the same testimony, that the second -- second witness
21 be sequestered.

22 THE COURT: Right. I just don't know the necessity of it
23 when they've been deposed. You can certainly impeach them.
24 You know, I don't -- I don't have any strong feelings on that.
25 I'm going to deny the motion to sequester.

1 I mean, certainly, it's fodder for cross-examination.
2 When did you form those opinions and, you know, why did you
3 never testify to this before or whatever. I don't know how it
4 -- how it's going to happen, how it's going to come up, but,
5 you know, I'm more prone to do it with all witnesses in a
6 trial, which is why I hinted at the motion being made earlier,
7 or in criminal cases where, you know, you don't have prior
8 recorded testimony necessarily or sworn testimony, and you're
9 talking about eyewitnesses --

10 MR. GOINGS: Yes, Your Honor.

11 THE COURT: -- and you don't want to copy testimony.

12 MR. HINSON: And, your Honor, I -- we respect your
13 ruling, but I would just say this is the only -- these are the
14 only two witnesses we would move to sequester because they are
15 the same, the same issue, and for that reason, these are the
16 ones we want. We won't -- we won't move to sequester any
17 other, just these two. We would just -- I'd respectfully
18 request you reconsider, since it's this -- and we understand
19 you denied the motion on redundancy, but we'd ask that you at
20 least sequester the second witness during the first witness's
21 testimony.

22 THE COURT: Okay. Let me think about that. I'll let you
23 all know in a minute. I've got a SLED agent back there
24 waiting on me.

25 MR. HINSON: Thank you, Your Honor.

1 THE COURT: Okay. So Wednesday at the latest. Are y'all
2 all set up and ready otherwise?

3 MR. DAVIS: Your Honor, law clerk mentioned that we tried
4 to put the TV where it was yesterday, and she said you may
5 object to it. If -- let me know and we'll move it.

6 THE COURT: What are you using it -- for exhibits?

7 MR. DAVIS: Yes, ma'am. We're going to. We'll use our
8 trial pad like they did for certain exhibits. Would you like
9 me to move it?

10 THE COURT: I think it's okay. Oh, you've got a podium
11 back here. I think we're fine.

12 MR. DAVIS: Okay.

13 THE COURT: Yes.

14 MR. DAVIS: Thank you.

15 THE COURT: Particularly with the podium here, because I
16 can see everybody. We'll just seat the jurors, as we did
17 yesterday, try to keep them out of that corner.

18 MR. DAVIS: If I -- if I move it more this way, would
19 that help you? Is that better?

20 THE COURT: That's better. Yes. Perfect. Let's leave
21 it there. Yeah. That way I can see all the jurors. I can
22 see counsel. I can see the witness. We're good.

23 MR. DAVIS: Thank you.

24 THE COURT: Good, good. All right. We'll be at recess
25 for just a few minutes.

1 Oh, Mr. Goings, yes?

2 MR. GOINGS: Yes, sir. Yes, Your Honor. First thing, so
3 not to cause distraction in the examination of Dr. Sampson,
4 he's calling Dr. Sampson subject to our objections and our
5 motions *in limine*. And just for the record, Mr. Davis and I
6 agree for a running objection on that based on what we put in
7 our -- in our motions *in limine*, and we understand your --
8 your ruling on that is now final as it relates to Sampson
9 being called.

10 THE COURT: Yes.

11 MR. GOINGS: I just wanted to put that on the record for
12 preservation purposes.

13 THE COURT: Yes, sir.

14 MR. GOINGS: And then we're on agreement; right?

15 MR. DAVIS: Yes.

16 MR. GOINGS: Okay. And then before Sampson is called as
17 a witness, we do have one very short witness that may take
18 five minutes. It's Crystal's mom, and the reason we need to
19 call her now is because there's a childcare issue that her mom
20 is handling, and -- and she has to get called now so she can
21 go take care of the child issues. So we're good with that.

22 MR. DAVIS: That's fine.

23 MR. GOINGS: So just letting you know.

24 THE COURT: Okay.

25 MR. GOINGS: So out of turn after grandma.

1 THE COURT: Right.

2 MR. GOINGS: Okay.

3 THE COURT: Grandma first and then we're jumping to the
4 defense.

5 MR. DAVIS: And because we're doing it out of turn out of
6 necessity, would -- would the Court be inclined to give some
7 sort of instruction?

8 THE COURT: Yeah, I will let them know what's going on.

9 MR. DAVIS: Okay. Thank you, Your Honor.

10 THE COURT: Okay.

11 MR. GOINGS: Thank you.

12 THE COURT: All right. We'll be at recess just a few
13 minutes.

14 (WHEREUPON, there was a break in the proceedings, after
15 which the proceedings resumed as follows.)

16 THE COURT: Bring the jury, please.

17 (WHEREUPON, the jury entered the courtroom at 10:01 a.m.)

18 THE BAILIFF: All jurors are seated, Your Honor.

19 THE COURT: Thank you.

20 Good morning, folks.

21 THE JURORS: Good morning.

22 THE COURT: I love your jacket, by the way, and during a
23 break, I'm going to need to know where you got it from.

24 UNIDENTIFIED FEMALE: Okay.

25 THE COURT: We'll talk about that later.

1 All right. Okay. So we're still on the plaintiffs'
2 case. The plaintiff is going to call the next witness.

3 I did receive the note. I am told that we will be here
4 till Wednesday. Wednesday at the latest is what I'm told.
5 Of course, you know, that all depends on how the examination
6 of witnesses goes. I know that for certain witnesses, they've
7 been on the witness stand a little longer than the attorney --
8 that the -- than the attorneys anticipated, and so sometimes
9 that happens, but the best guess is Wednesday.

10 So I hope that answers your questions, and y'all make
11 sufficient plans to be here next week, but with that, we're
12 going to turn back to Mr. Goings? Ms. Gooding? Mr. Hinson?
13 Mr. Hinson. I never know which one's going to stand up. The
14 plaintiff is going to call their next witness.

15 MR. HINSON: The plaintiff calls Ms. Edna Delbridge to
16 the stand.

17 THE BAILIFF: Place your left hand here and raise your
18 right.

19 THE CLERK: Do you solemnly swear or affirm that the
20 testimony you're about to give in this case will be the truth,
21 the whole truth, and nothing but the truth, so help you God?

22 THE WITNESS: I do.

23 THE CLERK: Please state your full name for the record.

24 THE WITNESS: Edna Delbridge.

25 THE CLERK: You may have a seat, please.

EDNA DELBRIDGE - DIRECT BY MR. HINSON

1 THE WITNESS: All right.

2 THE BAILIFF: You need to speak right into the mic.

3 THE WITNESS: Okay.

4 EDNA DELBRIDGE, being first duly
5 sworn, testified as follows:

6 DIRECT EXAMINATION

7 BY MR. HINSON:

8 Q: Good morning, Ms. Delbridge.

9 A: Good morning.

10 Q: Would you please introduce yourself to our jury?

11 A: My name is Edna Delbridge.

12 Q: And, Ms. Delbridge, where are you from?

13 A: Columbia, South Carolina.

14 Q: Your whole life?

15 A: My whole life.

16 Q: Ms. Delbridge, what's your relationship -- what's your
17 relation to Crystal and James Goodwin?

18 A: I am Crystal's mother and James' mother-in-law.

19 Q: And, Ms. Delbridge, were you -- now, did you accompany or
20 come to the hospital on July 28th, 2016, with regard to your
21 daughter's surgery performed by Dr. Holbrook?

22 A: Yes.

23 Q: Were you present in the waiting room when Dr. Holbrook
24 came out?

25 A: Yes.

EDNA DELBRIDGE - DIRECT BY MR. HINSON

1 Q: Did you speak to Dr. Holbrook? Did he speak to you?

2 A: Yes.

3 Q: After the surgery was over and Dr. Holbrook came to the
4 waiting room, what did he tell you?

5 A: He told us everything was fine, and Crystal was in
6 recovery, and we could go on and get lunch because she was
7 going to be there a little while.

8 Q: Did he ever tell you that the neuromonitoring signal was
9 lost at 10 o'clock?

10 A: No.

11 Q: Did he ever tell you that he had any concern about the
12 surgery?

13 A: No.

14 Q: Did he tell you that there was anything, any complication
15 that occurred during the surgery?

16 A: No.

17 Q: Did he give you reassurance that it had gone well?

18 A: We thought so.

19 MR. HINSON: No further questions, Ms. Delbridge.

20 MR. HEITMAN: We don't have anything, Your Honor.

21 THE COURT: All right. Thank you, Ms. Delbridge. You
22 may step down.

23 Okay. So, ladies and gentlemen, before we began the
24 trial, I told you the way it typically goes is that you hear
25 from the plaintiff. The plaintiff presents their witnesses,

1 followed by the defendant presenting their witnesses. Because
2 this trial has lasted longer than any of us really
3 anticipated, there are some witnesses who have some scheduling
4 concerns and -- and two that I'm told are unavailable next
5 week, two of the defendants' witnesses.

6 So right now we are going to put time out on the
7 plaintiffs' case. We're going to switch over to the
8 defendants' case. This is not typical, but we're trying to
9 accommodate schedules. And so the next two witnesses you are
10 going to hear from are defendants' witnesses, not the
11 plaintiffs' witnesses. So I just want to make that clear and
12 explain why we're doing that.

13 And I neglected when I stepped back in before bringing
14 the jury in to rule on the motion made by plaintiff or the
15 reconsideration of my ruling. The motion is -- it remains
16 denied, and so we will proceed as anticipated.

17 I'll now call on Mr. Davis to call his first witness out
18 of order.

19 MR. DAVIS: Thank you, Your Honor. Your Honor, we would
20 like to call Dr. John Sampson.

21 THE BAILIFF: Place your left hand on the Bible and raise
22 your right.

23 THE CLERK: Do you solemnly swear or affirm that the
24 testimony you are about to give in this case will be the
25 truth, the whole truth, and nothing but the truth, so help you

1 God?

2 THE WITNESS: I do.

3 THE CLERK: Please state your full name for the record.

4 THE WITNESS: John Howard Sampson.

5 THE CLERK: You may have a seat, please.

6 THE WITNESS: Thank you.

7 THE BAILIFF: Be sure to speak into the mic.

8 DR. JOHN SAMPSON, being first
9 duly sworn, testified as follows:

10 DIRECT EXAMINATION

11 BY MR. DAVIS:

12 Q: Good morning, Dr. Sampson.

13 A: Good morning.

14 Q: Can you hear me okay?

15 A: I can.

16 Q: All right. Dr. Sampson, introduce yourself to the jury
17 and then, if you would, walk us through your education, your
18 training, and experience up to this point in time as a
19 physician.

20 A: Sure. So my name is John Sampson. I'm a neurosurgeon at
21 Duke University. I came to Duke in 1990, lived here in the
22 South most of my life now. I started at Duke as a resident.
23 I was a 7-year -- 6- or 7-year residency for most. For me, it
24 was a little longer, not because I was slow or disadvantaged,
25 but because I took some extra training.

1 So during that time, I also did -- in addition to the
2 neurosurgical training, which is about six years, I did
3 additional training in two particular areas. One is a Ph.D.,
4 so a second doctoral degree in neuropathology, understanding
5 how the nervous system is affected by -- affected by various
6 injuries or other things like that, and particularly how the
7 immune system might affect that.

8 I also did a fellowship in the intensive care unit. So
9 learning about how blood pressure is managed, how ventilators
10 are managed, how to manage the sickest patients with
11 neurosurgical problems either in the brain or in the spine.

12 After that, I also went on to get a degree at Duke called
13 a Master's in Health Sciences, which is really a way of
14 teaching people how to better understand the medical
15 literature. So there might be a difference, for example, of
16 what's on Google and what's actually in the medical
17 literature, and how do we weigh the importance or the accuracy
18 of some of that information. And so I took that training as
19 well.

20 I've been at Duke as a neurosurgeon ever since then in
21 active clinical practice. I've had a number of roles there.
22 They advance you, sort of a promotion in universities, in
23 assistant professor, associate professor, full professor. And
24 then, in addition, some people get a particular accolade where
25 it's a named professorship, which is the top level that you

1 can get to in an academic center.

2 Over the past ten years or so, I've taken on leadership
3 roles as well. So I became the chair of the department.
4 That's the leader of the department, where I'm responsible for
5 guiding other faculty, hiring those faculty, training our
6 residents, educating medical students, and so on.

7 Throughout that time, I also did research and have been
8 currently -- I still am the number one funded researcher at
9 the NIH in the neurosurgery field. So I use those monies to
10 study different areas, particularly in brain tumors, for my
11 research, but my clinical practice is broad. And then
12 ultimately, I now lead the entire physician practice at Duke
13 as well.

14 During that time, I've had a number of really special
15 honors, but the most important one to me is to become a member
16 of the National Academy of Medicine. That's a group that was
17 really started -- the National Academy was started by
18 President Lincoln a long time ago, and it really nominates
19 just a handful of individuals to be represented among the top
20 physicians in their field, and so I'm now one of probably a
21 handful or less of neurosurgeons in that -- in that group.

22 Q: Are you published, sir?

23 A: Yes.

24 Q: And what sort of articles or journal -- peer-review
25 journal articles have you published in?

1 A: So we have -- our resumes are called curriculum vitae or
2 CVs. I'm not sure why they use that fancy name, but that's
3 what they're called. And I don't remember. We publish quite
4 frequently on different things, but I probably have well over
5 200 publications now.

6 I've also served in an editorial position on many of
7 those journals. In particular, the top journal in our field
8 is the Journal of Neurosurgery, and I was one of the editors
9 of that journal, meaning that I evaluated what would be
10 published and what wouldn't be published for, I think, about
11 seven years.

12 It's a pretty thankless job. I think I read about four
13 papers a day on average during that period of time. It was
14 not particularly pleasant, but it is something that's
15 important for our field to have people in top positions review
16 those articles and make sure that what's published is the
17 highest quality it can possibly be.

18 Q: You mentioned residency, resident. Explain to the jury
19 what that is?

20 A: Yeah, I should have been more clear. So, you know, in a
21 good way, while medical students go to a university and they
22 get a degree, the way you train in -- in specialties in
23 medicine is called a residency, and it's really like an
24 apprenticeship. So it's no different than becoming an
25 electrician or a plumber. We have to sort of work with

1 younger people usually, or at least younger in their training.
2 They round with us, they meet patients with us, they operate
3 with us just like they would in an apprenticeship. So it's
4 really just an apprenticeship in neurosurgery.

5 Q: The type of surgery that is subject to this case I think
6 is called a decompressive laminectomy; is that right?

7 A: Yes, sir.

8 Q: Have you ever performed those kind of surgeries before?

9 A: Hundreds, if not thousands.

10 Q: Could you tell the jury some of the things that you
11 recall reviewing in this case that, in addition to your
12 training, your education, and your experience, helps you to
13 form opinions that you're going to tell them?

14 A: Sure. I mean, principally, when I look at a case like
15 this, it would be similar to me evaluating a patient who
16 wanted to come see me in clinic. We get records from doctor's
17 offices, so records like from Dr. Holbrook's office. We would
18 get records that weren't just about the particular hospital
19 admission that we've talked about, but prior records as well,
20 prior surgeries.

21 And so we look through all of that material, and then
22 there's these things called depositions, which are sort of
23 recorded or written out, when people like me get asked
24 questions and then the -- by the attorneys, and then we give
25 answers. So I reviewed those as well.

1 Q: Did you also review certain imaging?

2 A: Yes.

3 Q: Did that include the MRs, if I can call them MR? MRI?

4 A: Yeah.

5 Q: Both from 2009, 2011, and 2016?

6 A: Right. I mean, the pictures -- I mean, you see them on
7 TV all the time; right? They're very helpful. So I think
8 part of reviewing material like this is to look at those
9 images. So I looked at all of them that I was provided.

10 MR. DAVIS: Your Honor, we would offer Dr. Sampson as an
11 expert in neurosurgery.

12 THE COURT: Any objection?

13 MR. HINSON: Your Honor, if Dr. Sampson is going to offer
14 standard of care opinions, we would object. As he told me in
15 his deposition, he did not intend to offer standard of care
16 opinions. If he is not offering standard of care opinions,
17 similar to what he told me previously, then we have no
18 objection.

19 THE COURT: Do you have any objection as to his
20 expertise, him being qualified as an expert in neurosurgery?

21 MR. HINSON: I have no objection to that, Your Honor.

22 THE COURT: All right. Ladies and gentlemen of the jury,
23 as I've told you about expert witnesses, they are, unlike
24 other witnesses, permitted to offer opinion testimony within
25 their field of expertise. You give their opinions the weight

1 and credibility you think they deserve.

2 Dr. Sampson is an expert in neurosurgery. He'll be
3 permitted to give his opinions within his field of expertise,
4 but otherwise, you treat him like any other witness.

5 Mr. Davis, you may continue.

6 MR. DAVIS: Thank you, Your Honor.

7 BY MR. DAVIS:

8 Q: Dr. Sampson, let me start with something that's called
9 standard of care. I want you to assume, for the sake of my
10 question, that in the state of South Carolina, the standard of
11 care is that which the reasonably prudent, in this case,
12 neurosurgeon would do or would not do in a same or similar
13 circumstance. When you're asked questions about the standard
14 of care, I want you to assume that that's the definition of
15 it.

16 A: Sure.

17 Q: Is that fair to you?

18 A: Yes, of course.

19 Q: And would you agree that any opinions that you give to
20 this jury today will be within a reasonable degree of medical
21 certainty, unless you tell me otherwise?

22 A: Yes, sir.

23 Q: All right, sir. Do you have an opinion on whether or not
24 the surgery that Dr. Holbrook performed on Ms. Goodwin on July
25 28th, 2016, was indicated?

1 A: It was indicated. Ms. Goodwin, unfortunately, had had a
2 couple of surgeries before that and had a lot of what we call
3 degenerative disease or arthritis. Many of the jurors may
4 have it in their knees or their knuckles, and they swell.

5 In this particular case, that swelling, those knuckles of
6 bone, push in on your spinal cord. And unfortunately, despite
7 prior surgeries, this keep -- kept happening to her, as it
8 does, unfortunately, with arthritis. And so the surgery was
9 necessary to remove what we call osteophytes or pieces of bone
10 that were pushing on the spinal cord.

11 Q: Now, I want to talk just a moment about neuromonitoring.
12 You're aware that neuromonitoring was ordered and is present
13 in her surgery on this day; correct?

14 A: Yes. Yes, sir.

15 Q: In your opinion, do you use neuromonitoring for
16 decompressive laminectomies in the spinal cord?

17 A: Sometimes.

18 Q: Okay. In your opinion, is there any evidence that
19 neuromonitoring in any way improves the outcome of your
20 patients or anybody's patient?

21 A: So neuromonitoring is stimulating on one end of the
22 nervous system and recording on another. So I used to do a
23 lot of work around the home, electrical work and other work
24 with my dad, so I'll use electricians' analogies. It's kind
25 of looking for continuity -- right? -- between one wire to

1 another wire.

2 And so you can -- you can do that in neurosurgical cases.
3 They put electrodes on your head or on your toes, and then
4 they look at -- shoot signals down and look at whether they
5 come through, and sometimes in very difficult and challenging
6 cases, like the one performed in 2016 by Dr. Holbrook on Ms.
7 Goodwin, because those knuckles are pushing in on the spinal
8 cord, you want to know that those circuits are moving when you
9 start. In many cases, you wouldn't use it because it wouldn't
10 be as challenging of a case, but more importantly, it's never
11 really shown to make any real difference.

12 So it makes me feel comfortable if those signals are
13 still going as I'm operating, but the truth is, if it goes
14 out, I oftentimes don't know what that means, and so that just
15 makes me uncomfortable, but it doesn't tell me very much. And
16 more importantly, there's almost nothing I can do about it in
17 a case like this.

18 There's other types of cases, ones where we call it --
19 called scoliosis, where the spine is twisted or crooked, and
20 when we straighten out that spine or jack it up, we actually
21 pull or stretch on the spinal cord. In those cases, that's
22 really helpful because if I stretch and that signal goes away,
23 then I can let the stretch go -- go down again and hope that
24 those signals come back.

25 But in a decompression, we're taking bone away. And so

1 if the signals go out, that's a done deal. It's kind of like
2 you've got a flat tire; right? You can't go back and run back
3 over the nail and have the tire reinflate. Like, it doesn't
4 work like that.

5 And we wouldn't want to put the bone back. You know, we
6 can remove the distraction and make the spine crooked again,
7 if we desire, but we can't take it back. So the truth of the
8 matter is that despite us using it and it helps us feel
9 comfortable, it doesn't actually change the outcome in a
10 patient. And in all the literature, all those papers that I
11 reviewed, there's never been a paper that shows that it does.

12 And so that's why when you asked, I said I use it
13 sometimes because the truth is, once I've got that flat tire,
14 I can't just back up over the nail and have the tire
15 reinflate. It's done. So it tells me it's happened, but
16 there's nothing I can do to fix it.

17 Q: The records in this case, particularly of the
18 neuromonitoring tech, Ms. Adkins, who testified earlier this
19 week, and her records documents that just minutes before the
20 signal, as he characterized them, was suddenly lost, the
21 signals were stable, and it was verified by the off-site
22 neurologist, you know, in the --

23 A: Correct.

24 Q: Dr. Gregg. When -- have you seen in surgeries that
25 you've performed where the SSEPs -- and assume that's all you

1 have, that's all they had at the time -- when they just --
2 just suddenly go from stable to out?

3 A: I have, unfortunately.

4 Q: What do you do in that situation?

5 A: Well, most of all, you sweat because you know something's
6 happened; right? And again, there's not much you can really
7 do about it, but you check. Right? First of all, you stop
8 what you're doing. Let's say that you're doing something.
9 You want to stop doing that and see if those signals come back
10 for some reason. They usually don't because what you've done
11 is already done. Right?

12 If you're driving down the road and your tire goes flat,
13 you don't keep driving on it. You stop. Right? So the first
14 thing you do is you stop.

15 The second thing you do is you look in the field. Right?
16 Is there a blood clot or is there something pushing on the
17 spinal cord that I can simply remove? Again, there's a few
18 things you can think about doing. So you do that.

19 You know, maybe I should have mentioned this first, but
20 the first thing you do is you ask your colleagues in the room,
21 your anesthesiologist and the monitoring people, like, did the
22 wire fall off. Right? Because if it suddenly went away and
23 the wire fell off, then that's going to make me feel a lot
24 better about things. Right?

25 So you'd say is the wire off, did you change the

1 anesthetic at all? Sometimes when you change the anesthesia,
2 you give more of the anesthetic drugs, you can -- those things
3 can change. Has anything else changed? You ask them those
4 questions.

5 From the surgeon's perspective, that's about all you can
6 do. Except in this case that I told you about with scoliosis,
7 where the spine is curved and if I sort of jacked it up, I can
8 unjack it, but other than looking around and making sure that
9 the monitoring is happening and that there's nothing else that
10 I can stop doing, that's the bind we get into because there is
11 nothing else to do at that point.

12 So when that happens, I do those things, and then you
13 have to make a decision. Are we going to continue doing the
14 surgery or are we going to stop? And that's a tough one
15 because if you continue doing the surgery, then you really
16 don't know what's going on. And if you stop, then you haven't
17 done the surgery, so you've done the patient a disservice. So
18 if you talk about between a rock and a hard place, that's a
19 tough decision, and it's really hard to know what to do in
20 those cases.

21 Q: Doctor, do you have an opinion whether or not the
22 standard of care required Dr. Holbrook at that time when he
23 was notified of the signals, in addition to whatever else he
24 may have done, but did the standard care require him to
25 request the M.D. anesthesia to come to the O.R.?

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 A: Well, no, it doesn't. You know, when we're in -- when
2 we're in surgery, I told you all the things that Dr. Holbrook
3 would have to do. You would hope as a patient that Dr.
4 Holbrook is doing his part and the anesthesia team is doing
5 their part.

6 It's my understanding that a CRNA was present. In -- in
7 many cases, they operate very independently. And so it would
8 be up to them or the rest of the anesthesia team to decide if
9 there's anything in particular that they would do, and I think
10 that would be up to, you know, Dr. Root, who was the
11 anesthesiologist. Would Dr. Root have wanted to be called?
12 Would she have done anything if she had been called?

13 And that -- that's up to them, but the neurosurgeon has
14 to keep both eyes on the field. Right? You wouldn't want a
15 one-eyed neurosurgeon, so you don't want one eye on the field
16 and one eye over here on the monitoring and another eye over
17 here on the anesthesia. I guess a three-eyed neurosurgeon
18 would be odd, but, you know, you have -- you have only two
19 eyes, and -- and they need to be on the field on the patient,
20 and that's the -- that's the neurosurgeon's job. So they do
21 the things I mentioned, and then the other things are the
22 responsibility of somebody else.

23 Q: Doctor, in your opinion, did the standard of care at that
24 time when the signals were announced to be lost and it was
25 confirmed that the neuromonitoring machine was operating,

1 functioning appropriately, but it wasn't broken or wasn't not
2 working --

3 Q: Right.

4 Q: Did the standard of care at any point along those lines
5 at that time require Dr. Holbrook to order an increase in
6 blood pressure?

7 A: Well, no. In fact, an increase in blood pressure at that
8 time could have been dangerous to the patient for a couple of
9 reasons. Blood pressure isn't always a good thing. In fact,
10 many of you know that you can have hypertension and it can be
11 a bad thing.

12 But in a case like this, what happens is there's, like, a
13 napkin ring around the spinal cord. Now, it's not an even
14 napkin ring, and you may have seen pictures, but there's these
15 knuckles of bone that are sort of squeezing the spinal cord in
16 different locations. And just like when you take a sponge
17 that you've had in your garage or something and it's dry and
18 it's small and you open it up or you add water to it, the
19 spinal cord gets bigger at that point in time.

20 What's happening there is just like when you add water to
21 a sponge, blood rushes in. Because part of the reason that
22 this patient, Ms. Goodwin, has had problems with this is
23 because her spinal cord has been clamped down on. So you open
24 it up and you let the blood come in. A little bit of blood is
25 good. That's what we're trying to achieve.

1 If you jack the blood pressure up and a lot of blood
2 comes in, that can be a problem because it starts to leak out
3 and it starts to actually damage the spinal cord, and you get
4 swelling or edema. The spinal cord starts to swell up, and
5 now you've got a bigger problem, because that then makes it
6 difficult for the cells to get the blood and the oxygen that
7 they need.

8 So it wasn't his responsibility, but moreover, there's no
9 way he could know whether that should be done, what the blood
10 pressures had been, how to manage those. That's why there is
11 an entire anesthesia team monitoring this.

12 In many cases, for instance in my operating room, I can't
13 even see those monitors. Right? And that's a good thing
14 because I have -- I have a person who's directly responsible
15 to do that. So it's their job to do that. It's my job to
16 keep two eyes on the field.

17 Q: There's been some discussion that has -- I think you were
18 aware of the watershed region in the spinal cord. Can you --
19 can you address that? And first of all, does everybody have a
20 watershed region?

21 A: So not everybody has a watershed region. I'm trying to
22 think of how best -- excuse me -- of how best to describe what
23 a watershed is. A watershed is, like, if you have those old
24 sprinklers. Excuse me for a second. If you had those old
25 sprinklers that kind of went around in a circle and you put

1 them on your front lawn, it never fails. There's that part
2 between the two of them that doesn't get water, and your grass
3 gets brown there. That's what a watershed is.

4 So a watershed is where there's blood supply coming from
5 one side and blood supply coming from another side. And the
6 spine, it could be from one side or the other or from above
7 and below, and there's an area that's kind of tenuous. So if
8 you turn your sprinklers up, now they come together. If you
9 turn them down, they don't come together, and there's that
10 part of your grass that doesn't get watered. That's a
11 watershed.

12 Now, for your lawn, it depends on what sprinkler you
13 have. Right? Just like in every human, it depends on what
14 blood flow you have. So some people have blood flow that may
15 be very far apart, and so the sprinklers aren't going to
16 touch. They touch barely. Otherwise, we'd have deficits to
17 begin with, but in the normal state, they're barely touching.
18 In other people, they're really close together, and so they
19 always touch, and even if you lost a little bit of blood flow,
20 it would still be fine.

21 There's no way of knowing because these arteries are
22 tiny, the size of one of your hairs. There's no way of
23 knowing in Ms. Goodwin's case whether she had a so-called
24 watershed or not. Right? Was her blood supply like the
25 sprinklers that are close together or far apart? There's just

1 no way of knowing.

2 And certainly, not everybody does have a watershed. So
3 many, many people, probably most people, are perfectly fine.
4 The vast majority would not have that issue. They have
5 sprinklers that work really well.

6 Q: Is there any evidence that you could see in this case,
7 MRs, imaging that you reviewed, any other medical records that
8 would help the jury to be able to conclude, oh, yeah, she had
9 a watershed?

10 A: No. You couldn't possibly tell unless you had a
11 microscopic -- like, looked under the microscope and looked at
12 the blood vessels.

13 Q: Doctor, in your opinion, if a patient was suffering from
14 severe hypertension, high blood pressure, severe, and had a
15 watershed region in her spinal cord, would that be a potential
16 area to suffer injury from the severe hypotension?

17 A: I guess if you did have a watershed and you had severe
18 hypotension, so you turned the sprinklers way down, I guess
19 that could be an area that is put at risk, yes.

20 Q: And how would you characterize severe hypotension?

21 A: Well, if you think about -- excuse me. If you think
22 about how we're put together, we don't naturally have
23 watersheds. Right? Because that would be a really bad
24 design, and when we're made, we have sprinklers that overlap.
25 Otherwise, we'd have a stroke from day one. Right? So

1 they're pretty well overlapping.

2 In addition, even though we may have -- at times have
3 changes in our blood flow -- right? -- our blood pressure can
4 go up or down. Sometimes if you've -- I mean, maybe you drank
5 a little bit too much last night, and you get up and you get a
6 little bit lightheaded. Right? That doesn't cause a spinal
7 cord stroke. Right? Because our bodies adjust to those
8 things.

9 So there's multiple mechanisms that allow our blood
10 vessels to adjust to make sure we don't have those kind of --
11 of watershed infarcts. So when you get up and you get
12 lightheaded, you may even pass out. Right? That's a pretty
13 significant change in blood pressure, but it's not, as you
14 would describe, as a severe one that would cause an infarct.

15 So where we see infarcts, true infarcts in the spinal
16 cord, in our practice is during cardiac bypass. So during
17 cardiac bypass -- hopefully, no one in the jury has
18 experienced this, but during cardiac bypass, your blood
19 pressure is zero. Right? They take -- they stop your heart.
20 It's zero. Sometimes in those cases you can have a watershed
21 infarct. That's where that concept really comes from.

22 So when we say severe drop in blood pressure, we're not
23 talking about a couple points or 10 or 20 percent. We're
24 talking about, like, zero. Right? Like, really low. In
25 those cases, yeah, I mean, many of us would still not have a

1 watershed. Right? I mean, people who have cardiac bypass
2 don't all have spinal cord strokes. Very few do, but even
3 under those circumstances, while few do, some do.

4 Q: If there was severe hypotension intraoperatively in a
5 patient having decompressive laminectomy in the thoracic spine
6 and the hypertension with a drop in blood pressure was very,
7 very low, severe, would that impact the kidney function?

8 A: It would have to go pretty low to impact the kidney
9 function. So, in general, the kidneys have the same sort of
10 approach. Right? They can push out more fluid or push out
11 less. Right?

12 Not to go too far down this pathway, but if you drink a
13 lot of beer, you urinate a lot, but the next morning, because
14 you've passed all that water, your kidneys reduce it to almost
15 zero. Right? So the kidneys also sort of go up and down.

16 And it's sort of like I think of the kidneys sort of like
17 a bathtub. Right? You have water coming in through the tap,
18 and then you have the drain going out, and the kidneys are the
19 drain, and they plug that drain or open that drain depending
20 on what's going on. So when you're putting in a lot of beer,
21 the drain opens up and the urine comes out. But now that
22 there's so much coming out and the bathtub starts to go down
23 and you stop drinking, that gets clotted off or turned off,
24 because now you need some -- you need a certain amount of
25 fluid.

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 So your body regulates that, and we do see this in
2 surgery. Right? When you're in surgery, you evaporate a
3 tremendous amount of your water. And if you've ever seen a
4 breathing tube on TV, one of the ways they fake you into
5 believing that it's really someone who's got a tube in their
6 throat is they show the mist in the tube going in and out.
7 Well, that water is all coming out of your body -- right? --
8 during surgery.

9 Plus, if you open up the tissues, our skin's main role, I
10 mean, we use moisturizer because our skin's main goal is to
11 keep moisture in the body. When you make a big incision in
12 someone's back, a lot of fluid comes out there.

13 Plus, if you've ever seen surgery with someone who's in
14 the prone or face down position, when you see them after
15 surgery, their faces are very puffy. All of that water
16 actually sinks to the bottom of the body. You may see that
17 when you've walked around all day. If you go for a long hike,
18 your legs get bigger. Take your socks off and there's that
19 band around there.

20 It's not terribly serious. It just means that the
21 fluid's gone somewhere else. So the kidneys now are going to
22 clamp down because that fluid is not coming in. It's actually
23 going somewhere else now. Right? So the kidneys do a pretty
24 good job, and you'd have to really have a very low blood
25 pressure for that to make a major impact.

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 MR. DAVIS: Andrew, can we pull up the slide with the
2 2011 -- excuse me -- 2009, 2011, and 2016 MAPs in a graph?

3 MR. HEITMAN: Is it labeled?

4 MR. DAVIS: Yeah.

5 BY MR. DAVIS:

6 Q: The laser pointer won't work on a TV screen. So I've got
7 a good old-fashioned kind here, too. Can you see that all
8 right, Doctor?

9 A: Yes, sir.

10 Q: I want you to assume, for the sake of my question, that
11 the -- the yellow line is a graph of the mean arterial
12 pressures as recorded by the anesthesiologist through the
13 surgery of July 28th, 2016, the subject of this case, and the
14 white line is the 2009 surgery, and the grey line, a little
15 harder to see, is the 2011 surgery, as recorded by the
16 anesthesiologist every five minutes as a -- as a recorded
17 blood pressure.

18 I want you to also assume, for the sake of the question,
19 there's been testimony that between 9:20 and 9:55 in the 2016
20 operation that one of the experts for the plaintiff, Dr.
21 Lustgarten, opined that that was a, quote, critical 35
22 minutes, and we've kind of drawn a bar there. And over here,
23 we've said 10:03 loss of SSEPs reported.

24 Doctor, there's a -- what we have labeled ideal MAP range
25 -- and we'll have anesthesiologists later talk about that --

1 from 70 to 100. Do you have an opinion as a neurosurgeon
2 whether any of these blood pressures, let's say from 2009,
3 were lower than the 2016?

4 A: It does look like there's some from the white line, which
5 I guess is 2009, that are -- actually, most of the time, it
6 actually is lower than the yellow line from 2016.

7 Q: Thank you, sir.

8 MR. HINSON: Your Honor?

9 THE COURT: Yes, sir.

10 MR. HINSON: I would object to this demonstrative. This
11 data that he's using is not in evidence in this case. The
12 basis of the data has not been demonstrated. He's just put up
13 a chart without any supporting evidence.

14 THE COURT: Foundation.

15 MR. HINSON: Thank you.

16 THE COURT: Mr. Davis, your response? I can't see what
17 you've got there, so I don't know how to rule on it, but --

18 MR. DAVIS: It's -- it's a graph, and I -- thank you, Mr.
19 Hinson. I'll offer this into evidence at this time.

20 MR. HINSON: We would object. This is just a chart that
21 he's put together for his interpretation of some -- what some
22 little check marks mean in the medical record.

23 THE COURT: Well, let me see it.

24 MR. HINSON: Your Honor, no one has confirmed these
25 numbers to be what -- what's on anesthesia records.

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 THE COURT: I understand. You need to lay a foundation
2 with the witness first, Mr. Davis.

3 MR. DAVIS: May we have this marked for identification?

4 THE COURT REPORTER: Defendants' 1 for ID.

5 MR. GOINGS: Your Honor, the demonstrative needs to come
6 down until he properly lays a foundation.

7 THE COURT: Absolutely. Would you turn the monitor off?

8 BY MR. DAVIS:

9 Q: I'm going to hand you what's been marked Defense Exhibit
10 1 for identification and ask you to look at that, please, sir.
11 I'm going to ask you some questions about it.

12 A: Okay.

13 Q: What do you understand that exhibit to contain, sir?

14 A: So it's about five pages, and on the first page is the
15 blood pressures, including the MAP or the mean arterial
16 pressure from the 2009 surgery, followed by two similar pages
17 from 2011 and then two pages from 2016.

18 Q: Okay. I'm going to hand you anesthesia records from
19 2009. Let me mark this as an exhibit and just provide it to
20 you.

21 THE COURT REPORTER: Defendants' 2 for ID.

22 BY MR. DAVIS:

23 Q: Doctor, I'm going to hand you Defense Exhibit 2 for
24 identification, and would you tell me what that document is?

25 A: So this is from 2009. Looks like it's all from 2009.

1 Q: Right.

2 A: And what it includes are the -- the way they mark blood
3 pressure is upside down or right side up Vs along the time --
4 timeline.

5 Q: Okay. We'll mark this next one for subsequent
6 identification.

7 THE COURT REPORTER: Defense 3 for ID.

8 MR. DAVIS: Thank you.

9 BY MR. DAVIS:

10 Q: I'm handing you Defense 3 for identification. Would you
11 tell the jury what you understand that document to reflect?

12 A: I'm just making sure that I have the right date here.

13 This -- this also looks like 2009.

14 Q: All right.

15 A: Yeah. Same thing. Sort of check marks.

16 Q: And one more set.

17 THE COURT REPORTER: Defense 4 for ID.

18 BY MR. DAVIS:

19 Q: And this document, Number 4, is dated 8/11/11. Could you
20 look through those and tell me what you understand those to
21 be?

22 A: So it's the same check marks for blood pressure charted
23 here from the 2011 surgery.

24 Q: Thank you, sir.

25 MR. DAVIS: Your Honor, I believe those records are

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 already in evidence, but we'll just offer them as defense
2 exhibits into evidence at this time.

3 THE COURT: Any objection?

4 MR. HINSON: No objection, Your Honor.

5 MR. DAVIS: Thank you.

6 THE COURT: Plaintiffs' 1, 2, 3 -- I'm sorry.
7 Defendants' 1, 2, 3, and 4 are admitted without objection.

8 (WHEREUPON, Defendants' Exhibits 1, 2, 3, and 4, blood
9 pressure records, were admitted into evidence.)

10 MR. DAVIS: Thank you, Your Honor.

11 BY MR. DAVIS:

12 Q: When you look at those --

13 MR. DAVIS: Let's pull up the anesthesia record from
14 2016, please.

15 BY MR. DAVIS:

16 Q: Doctor, when -- I know this is not a neurosurgery record.
17 It's an anesthesia record; right?

18 A: Yes, sir.

19 Q: Okay. You were saying these check marks. Are these --
20 how do you call those? Carets? I'm not sure.

21 A: Upside down V's.

22 Q: Upside down V's. Fair enough. That's -- that works.
23 For example, I'll just use one. This check mark here, upside
24 down V here, what did -- what do they represent?

25 A: So the top one represents the systolic blood pressure or

1 the high component, and the bottom one represents the
2 diastolic pressure or the lower component of the blood
3 pressure.

4 Q: Okay. For example -- excuse me. If this line -- if this
5 little check mark is on this line right here, we would go over
6 and it's between 100 and 120. That would be 110?

7 A: Yes.

8 Q: Over -- let's use this line. 80?

9 A: Yes.

10 Q: Okay. So when you do all that and write them out on a
11 piece of paper, it would look like that exhibit I gave you;
12 right?

13 A: Yeah. This one. This one with the numbers here.

14 Q: Right.

15 A: Yeah.

16 Q: And then to calculate the mean arterial -- arterial
17 pressure, that's just a calculation. You can do it on the
18 phone?

19 A: Yeah. Or in your head.

20 Q: Well --

21 A: Either way.

22 Q: I couldn't do it my head.

23 A: Yeah.

24 Q: I use my phone. Are the numbers on those sheets of paper
25 from the three surgeries supportive and reflective of the

1 anesthesia records that we have in evidence before you?

2 A: Yes, I believe they are.

3 MR. DAVIS: Your Honor, I'd like to now go ahead and use
4 that graph.

5 MR. HINSON: Your Honor, the same objection. There's a
6 tremendous amount of interpretation into what is meant by
7 these carets and check marks. The person who made those
8 carets and check marks has not come to trial to testify as to
9 what is intended by them.

10 As to the 2016 anesthesia record, we had a request to
11 admit to the CRNA confirming what he meant by them.

12 THE COURT: Let me pause you. This is -- what exhibit
13 number is this?

14 MR. HINSON: Well, it was Defendants' -- I believe --

15 MR. DAVIS: I marked them.

16 THE COURT: But it's marked -- it's been entered as an
17 exhibit, though?

18 MR. HINSON: It's been entered as an exhibit, yes.

19 THE COURT: Without objection? Right. You didn't object
20 to it. It's in.

21 MR. HINSON: We objected to the demonstrative though is
22 what it is. We're not objecting to the anesthesia record.
23 We're objecting to the demonstrative interpreting it, which
24 has not been established. If I can show --

25 THE COURT: This is not the same as the exhibit? This is

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 why it's bad that I can't ever see the monitor. Hold on.

2 Let's pause.

3 MR. HINSON: If I could approach, Your Honor?

4 THE COURT: I'm going to step down here there.

5 MR. DAVIS: Yes, ma'am.

6 THE COURT: I'd like to see what the exhibits are and
7 what we're objecting to so that I can make an intelligent --

8 MR. HINSON: Sure.

9 THE COURT: -- ruling.

10 MR. HINSON: So this has been admitted. And what -- as I
11 understand, Mr. Davis is taking his interpretation of what
12 these little check marks mean and converting them into
13 numbers, but the person who -- there's -- as you can see, it's
14 very difficult to tell whether it's --

15 THE COURT: Is this the demonstrative?

16 MR. HINSON: This is the demonstrative. I have no
17 objection to this coming into evidence.

18 THE COURT: I gotcha.

19 MR. DAVIS: Well, we're not putting this into evidence.

20 MR. HINSON: Well, it's being used.

21 MR. DAVIS: It's just a demonstrative.

22 THE COURT: That comes from here?

23 MR. HINSON: That's -- that's my objection, Your Honor.

24 MR. DAVIS: It's -- it's a lot bigger than that, but it's
25 part of the reasons that this is so analogous. This is an

1 analogous chart that they used as a demonstrative in their
2 case.

3 THE COURT: I see.

4 MR. HINSON: The difference being, Your Honor, in our
5 case, what these little check marks were, were confirmed by
6 the CRNA. And here what those check marks were meant to
7 indicate have not been confirmed by anybody.

8 THE COURT: I understand. I will allow it over
9 Plaintiffs' objection.

10 MR. HINSON: Thank you, Your Honor.

11 MR. DAVIS: Thank you. So let's see if I can pick up
12 where -- where I left off. Pardon me.

13 BY MR. DAVIS:

14 Q: So we were looking at this exhibit, and this is --
15 according to the plaintiffs' expert, from here to here is the
16 anesthesia recorded MAPs. Do you see in either of the other
17 two prior surgeries where the MAPs are lower than that?

18 A: Quite a few times for just as long or longer.

19 Q: To your knowledge, was there any cord stroke or ischemic
20 cord stroke during the 2009 or 2011 surgery?

21 A: No evidence. So, in other words, the blood pressures
22 were lower during those two surgeries and didn't cause any
23 problems than they were in the 2016 surgery.

24 Q: Dr. Sampson, in your experience as an operating
25 neurosurgeon doing decompressive laminectomies, have you ever

1 seen blood pressure between the MAP of 70 and 100 in your
2 surgeries result in a cord stroke in the thoracic region, sir?

3 A: No. I mean, that's the generally accepted range.

4 Q: Well, I want to -- I'm going to go back and revisit just
5 a moment.

6 MR. DAVIS: You can take that down. Thank you.

7 BY MR. DAVIS:

8 Q: -- the fluid imbalances.

9 A: Okay.

10 Q: And this is something the plaintiff has prepared and
11 shown to the jury. 80 milliliters, that's the recorded urine
12 on the anesthesia record, and 480 milliliters is what they
13 have offered as what it should be during a four-hour surgery.
14 And this -- and I probably -- I've got a bad shoulder, and I
15 probably can't lift it. I'm not going to try that. There's a
16 great big container here of blue water. It has 2,700
17 milliliters, which is what the anesthesia records you've seen
18 fluid going in during --

19 A: Sure.

20 Q: -- this four-hour surgery. Doctor, how can you explain,
21 if you can, why you've got 2,700 cc going out, and that's all
22 you got coming -- coming out? Going in, and that's all you've
23 got coming out in the surgery like this?

24 A: Well, first of all, I don't know how they get to the 480
25 because urine output isn't the same all the time. Right?

1 I mean, maybe not everybody's had a beer, but if you have, you
2 know that your urine goes up and down depending on, you know,
3 what you're drinking, all kinds of other things.

4 The difference here is that the effects of this surgery
5 are massive on the body. Right? All your fluid when you're
6 laying flat goes down. Right? Just like when you go for a
7 hike when it goes down into your feet. Imagine if you went on
8 a hike, like, laying flat. It would all go down there.

9 So all that fluid is no longer in the bloodstream. So
10 it's like you've turned the tap down. So to keep the level of
11 the bathtub the same, you've got to turn the -- the plug down.
12 Right? If the plug keeps putting this 480 out, then you'll
13 have problems because you've got to keep your balance in the
14 tub or in the body the same.

15 But there's a couple of other reasons here as well. The
16 way they measure this is in a Foley bag. It's -- I mean, many
17 of you have probably seen one, but it's like a baggy. It's
18 really hard to estimate what that is. Right? It's kind of a
19 guess.

20 But in addition to that, the way the bladder works, if
21 this is the bladder of someone, the Foley catheter is at the
22 top of the bladder when they're prone. And so if you turn
23 them around, there's no way that all the urine that could
24 still be in the bladder is actually drained out from the
25 Foley. Right? Because it's at the top. And so when you turn

1 someone around like that, you -- you're not going to -- you're
2 going to miss that as well.

3 But the bottom line is, is that 80 cc of urine during
4 this period of time is perfectly fine, and we always expect
5 the urine output to drop during surgery because we're third
6 spacing. That's all the fluid that goes into your ankles or
7 into the front of the body. You're measuring it in a
8 different way. Right? You're measuring it by a Foley, and
9 the evaporation that's taking place from the mist in the
10 breathing tube, and, I mean, you have a big incision. Right?

11 I mean, you've probably seen again on TV when they cut
12 into the body, there's this mist that comes up. Right? It's
13 kind of there for dramatic effect, but you evaporate. You
14 don't have skin there anymore, so your muscles are completely
15 exposed. You're losing blood. So all that fluid is sort of a
16 way of reducing the amount of water flowing into the tub. So
17 I would expect the amount of water flowing out of the plug to
18 be less as well.

19 If it was zero, then I think, you know, the anesthesia
20 team should have done something about that, but it wasn't. It
21 was 80. Right? And that's within a perfectly reasonable and
22 not unexpected range.

23 Q: You know, Dr. Sampson, there has been a lot of talk about
24 blood pressure in this case.

25 A: Right.

1 Q: A lot of talk about blood flow. As a neurosurgeon, are
2 those the same thing?

3 A: No, they're not. And many places in this case, that
4 becomes important, but it's probably analogous to a garden
5 hose. Right? I mean, depending on how much you turn the tap,
6 you can have more or less flow, but if you constrict it or if
7 there's a plug in the tap or a leak in the tap or a leak in
8 the hose, then the actual amount of water that comes out the
9 other end is very different. Right?

10 So the pressure going in from your tap can be exactly the
11 same, but if I put a clamp on that hose or a kink maybe --
12 everybody's had a kink in their hose and you have to walk back
13 and unkink it. Right? So you have a kink in your hose or
14 there's a leak, the amount of water coming out is different.
15 That's flow.

16 So the body works the same way. Right? Any -- actually,
17 any fluid system works the same way, and so pressure doesn't
18 equal flow at all. In fact, high pressure can lead to low
19 flow. Low pressure can lead to high flow. I mean, it can go
20 up and down depending on whether you got a kink in your hose
21 or not.

22 Q: There's been some mention of hardened arteries in the
23 spinal cord from chronic hypotension?

24 A: Yep.

25 Q: Excuse me. Hypertension. Hyper?

1 A: Hyper, yeah.

2 Q: Can that happen?

3 A: I guess it can. I mean, people have probably heard about
4 that. There's no evidence for that in this case at all in the
5 spinal cord or anywhere else, actually. So there's no
6 evidence, but -- but I guess it could.

7 Q: Okay. Well, if -- if that happens, is that going to
8 affect the blood flow to tissues?

9 A: Well, it can, and I think it did in this case. One of
10 the things like a kink that reduces the amount of blood flow
11 to the spinal cord are these osteophytes, these pieces of bone
12 that are pushing on it. Right? The blood pressure coming in
13 is counterbalanced by the pressure in the spine. Right? So
14 if there's really a pressure here on the spine and the blood
15 pressure coming in, you're not going to get as much flow.
16 Right? It's like there's a kink in the -- in the hose. What
17 happens then is that that probably is okay. Right?
18 There's a kink and it's not as much, but it's probably okay.

19 In this case, what happens is you take off those
20 osteophytes, that's like getting rid of the kink, and blood
21 flow now can come in better. Right? The kink is gone. So
22 the blood flow comes in better.

23 The problem in this case, if you do have hardening of
24 your arteries, is that the body is -- one of the body's
25 abilities to change that blood flow is out of whack. Right?

1 So what generally would happen is the body would say, oh, this
2 is great. No more kink. I'm going to reduce the pressure.
3 I'm not going to spray someone with the hose. Right? I'm
4 going to reduce the pressure.

5 But if your arteries are completely hard, you can't do
6 that. So now we've taken out the kink, and we've put a lot of
7 blood into the spinal cord, and what happens, what's clear on
8 the postop MRI, is all of that blood comes in and it starts to
9 leak out because it's just too much. And those blood vessels
10 can't change their diameter, can't adjust to that coming in.
11 So you get all of this fluid coming in. And where does that
12 fluid go? Because it's -- the spinal cord is not used to it.
13 It goes out.

14 It causes what we call T2 change or a white signal in the
15 cord, and the cord gets swollen and white. And that now
16 becomes a problem because now the cord is starting to get
17 swollen, and the very tiny blood vessels, because of that
18 swelling, now start to get constricted, and that can lead to a
19 stroke.

20 So remember I said earlier that not always is higher
21 blood pressure good? I mean, of course we all know that.
22 Right? We know we need to get treated for our hypertension.
23 So, in general, you're healthier with low blood pressure than
24 high blood pressure, but in this particular case, if you have
25 hardening of the arteries and you can't adjust that, it could

1 be really bad. And if you raise the blood pressure even more,
2 it just gets worse.

3 If you look at the post-op MRI, there's two segments --
4 well, maybe three, 8, 9, and 10, which are totally whited out
5 immediately after the surgery as a result of too much of that
6 blood getting in there and an inability of the arteries to
7 adjust. I mean, I'm exaggerating, but two segments is
8 probably this much.

9 That's a small part of your spinal cord, I know, but if
10 your entire spinal cord -- if I cut that out of your spinal
11 cord, you would not do well. You would lose all function.
12 Right? And that's what this rushing in of blood is doing
13 here, and that's what happened to Ms. Goodwin is that blood
14 rushed in, her arteries couldn't fix it. They were not used
15 to it, and even at the blood pressures here, which, again, are
16 in an ideal, normal, and expected range, was too much for her
17 to handle.

18 Q: What is a reperfusion -- perfusion injury?

19 A: Well, it's kind of what I just described, but reperfusion
20 injury happens all the time. If someone has a cardiac arrest
21 and they have no blood flow, then when you restart their
22 heart, they get a reperfusion injury, and the heart actually
23 gets damaged from that because it was used to having low blood
24 flow, and now it's got a lot more.

25 The other time it can happen is when someone has a

1 stroke. The stroke, because there's a clot in there, has
2 reduced the blood supply. If you take that stroke out or it
3 goes away by TPA or some of the blood thinners, then all of a
4 sudden there's more blood flow than is expected, and
5 oftentimes that can lead to a hemorrhage.

6 So these anti-stroke drugs that we talk about are great
7 for removing the clot, but the big risk is because of this
8 reperfusion, they come and they cause a bleed. So it's -- I
9 mean, unfortunately, medicine has always these
10 counterbalances. Right? It's not that one thing one way is
11 always good and one thing the other way is always bad.

12 In a case like this, balancing that is really difficult,
13 and so what happened here is we flooded essentially Ms.
14 Goodwin's spinal cord. Now, I don't believe that was
15 anybody's fault. What's happened here is you've had someone
16 with high blood pressure. You've decompressed the spine,
17 which she needed to have, and these were massive knuckles of
18 bone pushing on her spinal cord.

19 But when you do that, in some cases, I've had some, that
20 blood sort of floods into the spinal cord, and that causes
21 what you see on the MRI. It's a big segment. Right? And
22 that can cause some -- some damage. And a lot of that gets
23 better with time. Right? Not -- not like a typical stroke
24 where you have a deficit that's there. This gets better with
25 time because some of that swelling will go away. But the

1 spinal cord actually swells up. On the MRI it looks white
2 because it's swollen.

3 Q: Do you have an opinion whether or not low blood pressure
4 caused the injury that Mrs. Goodwin suffered and suffers from
5 today?

6 A: So I don't think it could have, I guess I would say for a
7 couple of reasons. First of all, I don't believe her blood
8 pressure was low. Okay? We saw that on the chart.

9 Second of all, when you give anesthetics, they actually
10 protect your body against low blood pressure. So it's very
11 unusual to have an injury like this under anesthesia. In
12 fact, all anesthetics lower the blood pressure, and we know
13 they do and so we -- we build into those medicines protectants
14 so they protect the body, the heart, the lungs, the brain,
15 everything, the spinal cord.

16 The MRI picture shows, as I said, three segments that are
17 affected. If I stroked out three segments of your spinal
18 cord, you would have no neurologic function, period. Right?
19 So if you look at the MRI immediately after, there's this
20 swelling. Right? That's reperfusion injury. Too much blood,
21 not too little.

22 Q: Uh-huh.

23 A: If it was too little, you would expect the cord to get,
24 you know, smaller. You'd expect it to have an area of
25 infarct, which would be quite small because Ms. Goodwin,

1 although has some neurologic deficits certainly, it's not
2 complete. She has some motor function. She has some sensory
3 function. If you infarcted that much of your spinal cord,
4 there's just no way you could do that.

5 Q: Can you see that?

6 A: Yeah.

7 Q: It's the post-operative MR?

8 A: Yeah, you can see the --

9 Q: Is it axial? Axial image?

10 A: You can see the area of white, right sort of to the
11 right of the T9.

12 Q: Okay. These are axial images back in June, prior to
13 surgery, but what is -- what do you see here?

14 A: Well, that's one of those -- that's one of those big
15 knuckles. But I do want to make another point because, I
16 think to me, this is sort of subtle detective work.

17 Your spinal cord, like your brain, has different
18 functions. Right? So part of it affects your motor function.
19 Part of it affects your sensory function, the way you feel.
20 But the spinal cord is really unique in that way, in that
21 light touch and pinprick or temperature sensation are actually
22 different parts of the spinal cord.

23 So if we want to do some detective work, we can say,
24 well, what part is missing? And in Ms. Goodwin's exams, she
25 can feel a pin prick on the right side, but not light touch,

1 and she can feel light touch on the left side, but not pin
2 prick.

3 So when I saw that, I thought, well, that's interesting.
4 Right? That tells me that there's only different parts of the
5 spinal cord which were affected. And so does that help me?
6 If you drop all of your blood pressure, why would the whole
7 cord not be affected? Why would not all of it be affected?
8 She would lose pinprick on both sides, she'd lose light touch
9 on both sides, but she didn't. So that tells you something.
10 That tells you that only certain areas were affected.

11 Now, you might say, well, why did the blood rush in and
12 not affect all the spinal cord? Why only some areas and not
13 other areas? Because that big piece of bone he showed you
14 there was constricting and pushing on one part of the spinal
15 cord and not the other. Right? So we actually take that bone
16 out. It increases the blood flow. She's got more blood flow
17 there than she did before we did the laminectomy, but certain
18 parts of that area are re-expanding more than others.

19 And I think what we call a dissociated sensory neurologic
20 exam, pinprick on one side, light touch on the other, things
21 like that tell us that this wasn't a global phenomenon. This
22 wasn't all of her blood vessels losing pressure. There was
23 certain blood vessels that were now decompressed and blood
24 rushed in in certain areas, and that's why it caused these
25 differences.

1 Q: In your opinion, Dr. Sampson, is a reperfusion injury
2 predictable as you go into a decompressive laminectomy? Can
3 you predict it?

4 A: You know, I've had patients who have had this
5 complication, so I wish it were, but it's not. I mean, these
6 are subtle changes at the microscopic level, and there's just
7 no way that you can predict that.

8 Q: Well, I mean, it didn't happen in 2009 with Ms. Goodwin,
9 it didn't happen in 2011, but it happened here?

10 A: Right.

11 Q: (Coughs.) Excuse me. Excuse me. We saw earlier this
12 morning a video to help explain or demonstrate reperfusion
13 injury. Let's look at that, and I want you to kind of tell us
14 when you need to pause and we'll just -- let's go through it
15 one time.

16 A: Okay.

17 Q: And then if you need to go back and still frame and
18 explain things, let's do that.

19 A: Okay.

20 (WHEREUPON, the video was played.)

21 A: You can see the osteophyte here, how it's affecting only
22 part of the cord. Right? It's on one side and not the other,
23 and I think that's why I came to believe this wasn't blood
24 pressure but was, in fact, reperfusion.

25 You can see that the blood vessels on the right side are

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 gray, whereas the left side there's still blood. So that's
2 the area where when we release that, blood is going to rush in
3 and it's going to cause this dissociated neurologic exam.

4 THE COURT: Let's pause momentarily.

5 THE COURT REPORTER: It's just a backup. It's fine.

6 THE COURT: Is it dying, though? Do you need to --

7 THE COURT REPORTER: No, it's fine. I've got plenty.

8 THE COURT: Okay.

9 THE COURT REPORTER: Yeah.

10 THE COURT: Okay. So it's one of the court reporter's
11 audio recorders. I guess the battery is probably dying.
12 That's what the beeping is, but we're okay to go forward.

13 Okay. You may proceed, Mr. Davis.

14 MR. DAVIS: Thank you, Your Honor.

15 BY MR. DAVIS:

16 Q: Can you pick up where we left off?

17 A: Yeah. So here you can start to see now that the cord is
18 going to reperfuse, and what you'll see is where the arrow is
19 on the right-hand side, you'll see that it starts to reperfuse
20 and gets -- it changes color more on that side than on the
21 other side. And as you go along, that's where you're going
22 to, again, get this dissociated neurologic exam. I mean, this
23 is a picture, a cartoon --

24 Q: Sure.

25 A: -- of what was happening.

1 Q: Right.

2 A: But that osteophyte and then the reperfusion in that
3 area, you saw there was no blood vessels and now there were.
4 that's why she's got this dissociated neurological exam. If
5 the blood -- if the cord is open and there's equal blood
6 vessels everywhere and the blood pressure drops -- excuse me.
7 A little bit too dramatic, I guess. You'd expect it all over,
8 and you don't see that.

9 So just looking at the evidence -- right? And when I say
10 evidence, I don't mean legally. I mean just like looking at
11 the evidence of what's in the neurologic exams. This wasn't a
12 uniform change. This had to be a focal change because of
13 looking at what symptoms and signs she has today.

14 Q: And when you say focal, what does that mean?

15 A: Part of the cord, not another part of the cord.

16 Q: Okay. You mentioned that in the post-operative MRI that
17 Dr. Holbrook ordered after he examined her in the recovery
18 room after she got awake, you noted -- I think you said
19 swelling. Cord swelling?

20 A: Yes.

21 Q: Is that consistent with a reperfusion injury?

22 A: Yes. I mean, when the -- when the blood rushes in, it's
23 like -- it's like adding water to your sponge. Right? It
24 gets -- it gets bigger. On an MRI, it looks white just
25 because of the sequence that we use. Water is white. So you

1 see the water get in and it turns white, and it turns white
2 over a fairly significant area.

3 Q: The cord swelling that you saw on the post-operative MR
4 that Dr. Holbrook ordered, in your opinion, is that consistent
5 with spinal cord injury from low blood pressure?

6 A: Well, it's -- it can't -- well, it can't be in my
7 opinion, because first of all, it involves a big area. Right?
8 And so it involves a big area on the MRI, meaning that it's
9 not just an area that was infarcted that was small. And if
10 you had that big of an area that was infarcted, all of your
11 spinal function would be gone.

12 But second of all, because the blood pressure would
13 affect everywhere equally, because it's the whole blood
14 pressure coming down, again, you'd expect all of those things
15 to be the same on both sides, and you just don't see that.

16 So the only way I can put it together is a reperfusion
17 injury, which differentially affected the areas that were
18 compressed versus not compressed or less compressed, and
19 that's consistent with the current neurologic function. So it
20 actually makes perfect sense.

21 Q: It's been testified to earlier that reperfusion injury is
22 a diagnosis of exclusion. Can you explain to the jury what
23 that means?

24 A: So a diagnosis of exclusion is something where they say
25 you have to rule out everything else. To some degree, that's

1 true for everything. Right? I mean, if you're going to say
2 that you have a bump that's cancer, you want to make sure that
3 you ruled out that it wasn't something benign. Right?

4 So I usually look at these things in both ways. Right?
5 When we're thinking about someone who has a new neurologic
6 injury, we ask ourselves, well, is this a blood clot? No. So
7 we exclude that. The MRI excluded that. Is this an
8 infection? Well, there's no reason for her to have -- for her
9 to have an infection. Right? So we've excluded that.

10 And you get down to the bottom of the list and you say,
11 well, okay, so could it be something like reperfusion injury
12 or could it be a blood pressure drop? You say, well, I guess
13 it could be either, but if you put all the evidence together
14 and fortunately or unfortunately now looking back -- what? --
15 6 or 7 years later, we actually have a lot more data. So now
16 looking back, we can say, well, the neurologic exam, the MRI,
17 everything fits with a reperfusion injury and not with an
18 infarct.

19 So it is a diagnosis of exclusion. You want to exclude a
20 few other things, but then you also want to say, well, just
21 because I excluded the other things, I don't want to drop to
22 that and assume that. I want to say does it fit with the
23 evidence? Is there anything else that fits better? And in
24 this case, I don't think there is anything that fits better
25 and, in fact, it fits pretty well, particularly, again

1 fortunately or unfortunately, with the benefit of hindsight
2 over the last 6 or 7 years and all the records in toto.

3 Q: Dr. Sampson, if Dr. Holbrook or anybody had -- at the
4 time signal loss was determined at 10:03, 10:05, in that time
5 frame, if the blood pressure had been increased, would that
6 have prevented injury to Ms. Goodwin?

7 A: I think it would have made it worse.

8 Q: Why?

9 A: Well, as I've explained, you have too much blood coming
10 in. If you turn the faucet on the tap even more, you're going
11 to have even more blood coming in. And instead of being from
12 T8 to T10, it could have been from T7 to T11. It could have
13 affected more areas of the spinal cord. The motor function
14 may have even been more dramatically affected.

15 That might have been reasonable if the blood pressure
16 wasn't in that normal range and, in fact, when the -- when the
17 -- when the actual signals are dropped, the blood pressure is
18 actually pretty high. Moreover, by decompressing her, we've
19 allowed more blood to come in. That was the intent. So why
20 would we add insult to injury? We've done the decompression
21 to add more blood. It's now causing her a problem. If we're
22 adding insult to the injury, we would add more blood pressure,
23 and it would cause even more of a problem.

24 Q: Once a reperfusion injury happens, as you are of the
25 opinion that it happened in the surgery, is there anything

1 you, as a neurosurgeon -- if at that moment you think, wow, I
2 bet this is a reperfusion injury, can you do anything to -- to
3 undo it? Treat it right then?

4 A: Unfortunately, not. It's -- you can -- you know, you can
5 manage the blood pressure and not let it get too high, but
6 this is fluid, and you can see the fluid on the MRI. Well,
7 technically, you don't see the fluid. You see the MRI signal
8 of the fluid, but there's no real way of pulling that out.
9 It's microscopic. It's basically squishing the cells sort of
10 at a microscopic level. And so microscopically, there's no
11 real way of pulling that out, unfortunately.

12 Q: I'm kind of skipping through my outline. I think we
13 covered a lot of this. So bear with me.

14 Do you have an opinion as a neurosurgeon, Dr. Sampson,
15 whether the standard of care required Dr. Holbrook to tell the
16 anesthesiologist be sure you don't let the MAP in this case
17 drop below 100 to 105? Did it require that?

18 A: Well, I talked about my six plus a couple additional
19 years of training. Anesthesiologists go through the same
20 training, and they're experts on keeping the blood pressure
21 where it needs to be. From the records that I saw, Dr. Root
22 saw Ms. Goodwin that morning, knew what her blood pressure
23 was, came into that operation knowing what her blood pressure
24 was, and had had four-plus years of experience while -- years
25 of training and then all that experience to keep the blood

1 pressure where it needed to be to prevent it being too high
2 and to prevent it being too low.

3 I don't think that's Dr. Holbrook's area of expertise.
4 Right? The way I kind of think about it is it's like the
5 brake guy walking over to the muffler guy and saying, oh, I
6 think you should do the muffler this way. Why would you do
7 that? Right?

8 So I think that in situations like this, again, the
9 surgeon has to have two eyes on the operation. The
10 anesthesiologist, God bless them, they have multiple eyes
11 because they have multiple monitors, but that's their job.
12 Right? I mean, we literally have a drape up there so that
13 they're looking at one thing and we're looking at another.

14 So that would be a little bit inappropriate actually,
15 given the training differences between the two people. Right?
16 And I -- in my neuro intensive care training, I worked with a
17 lot of anesthesiologists. So, I mean, I learned some of what
18 they know, but even after that, even after a fellowship and
19 being an attending in the ICU for many years, they still know
20 much more about that than I would as a neurosurgeon. Right?
21 I mean, I learn how to take bone off and things like that, and
22 they learn how to control blood pressure.

23 Q: Dr. Sampson, in your opinion, would mean arterial
24 pressures during a surgery like this between 70 and 100 be
25 adequate to prevent ischemic injury to the spinal cord?

1 A: Yes. In general, that's true.

2 Q: In your opinion, did her blood pressures as recorded by
3 anesthesiology -- and I will add this. The neuromonitoring
4 tech at -- I think it was 9:56 or 9:58 documented a blood
5 pressure. I think it was 103 over 64 that she got off the
6 monitor in between the five minutes anesthesia records?

7 A: Yeah, I saw that.

8 Q: You saw that? Which I'll ask you to assume for the sake
9 of the question the MAP is 77.

10 A: Okay.

11 Q: But the signals were stable at that time, as the
12 neuromonitoring tech documents. Adding the 77 to all the --
13 all the rest of the anesthesiologist recordings, does that
14 change your opinion that low blood pressure caused this
15 injury?

16 A: It doesn't change my opinion. I mean, 77 isn't that far
17 out of the range of the other numbers that we saw, but more
18 importantly, you just said the monitoring was actually stable
19 at that time.

20 Q: Yes, sir,

21 A: And in fact, when the monitoring goes out, the blood
22 pressure is actually higher. So there can be a small lapse of
23 a couple of minutes between the monitoring and the blood
24 pressures, but when that blood pressure is recorded and the
25 subsequent blood pressures, if you look at it, that blood

1 pressure had nothing to do with the change in the monitoring.

2 Q: Excuse me.

3 MR. HINSON: Can we help you, Mr. Davis?

4 MR. DAVIS: I'm looking for [inaudible].

5 MR. HINSON: Here it is.

6 MR. DAVIS: Thank you. Thank you, Mr. Hinson.

7 BY MR. DAVIS:

8 Q: I want to show this to you. Do you recognize this
9 algorithm?

10 A: I do.

11 Q: And the article that you were asked about at your
12 deposition?

13 A: I do.

14 Q: In your opinion, does the standard of care require the
15 neurosurgeons to do all these things in every situation where
16 the signal is lost, sir?

17 A: Well, it -- it doesn't, first of all. Second of all,
18 this article actually is all about scoliosis surgery. So it's
19 the one with the bending. It's not really about this type of
20 surgery.

21 And in particular, the wake-up test. I mean, I may have
22 stated this in my deposition. It would almost be malpractice
23 to do that. Cruel at least to do that in this case because
24 you'd be waking somebody up and, as I said before, there's
25 nothing you can do about it. Right? So you're going to wake

1 them up with this massive incision in their back. Can you
2 imagine how much pain that would be in?

3 And frankly, people do remember surgeries like this and
4 can have psychological trauma after that. So it would be,
5 first of all, mean, but you do that and then you do what? You
6 can't change the bend because we didn't bend anything here.
7 You wouldn't put the bone back. Right? That wouldn't make
8 sense. So what would you do? Right? So you'd just be being
9 cruel.

10 But keep in mind the reason why the patient is under
11 anesthesia and the reason why they got an additional dose of
12 anesthesia was because they were biting on their breathing
13 tube. They sort of -- they were too awake, so they started
14 biting on their breathing tube. So they gave them an
15 additional drug which took out the motor-evoked potentials or
16 the MEPs. That was required, because if you bite on your
17 tube, you don't get to breathe during your surgery, and that's
18 bad. Right? Airway, breathing, circulation. Right? That's
19 what we're taught. It's ABCs. Airway is number one.

20 If Ms. Goodwin had been woken up, it's highly predictable
21 because she did it already, even under a significant amount of
22 anesthesia, if we wake her up completely and she was biting at
23 this level of anesthesia, she's going to bite at this level.
24 God forbid she bit it in half. We'd have no way of breathing
25 her. She's on her stomach. You can't put an endotracheal

1 tube in someone on their stomach, at least without an
2 incredible amount of difficulty.

3 She would have had no way to breathe. So waking her up
4 would have been cruel. It would have told you nothing because
5 there's nothing you could have done. It clearly wouldn't have
6 helped in this case, and it probably would have caused her
7 death because she couldn't have breathed through the tube.

8 So these things are -- are an interesting algorithm from
9 a paper that is not particularly -- what I would say, not
10 particularly well done. It's just somebody's opinion, but
11 it's focusing on scoliosis surgery, and many of these things
12 just would not have been done. I mean, number 4 is, you know,
13 reverse manipulation. Well, there's no manipulation here to
14 reverse. So to hold Dr. Holbrook to doing all these things
15 doesn't make sense at all.

16 Q: Dr. Sampson, in your opinion, was it appropriate for Dr.
17 Holbrook -- when he checked with the neuromonitoring tech, is
18 your equipment working, he looks in the surgical field,
19 doesn't see anything, asks anesthesia are there any issues,
20 assume for the sake of the question he did all those things?

21 A: Okay.

22 Q: And the neuromonitoring tech says the equipment is not
23 malfunctioning. We've lost the signal. In your opinion,
24 would it have been appropriate for Dr. Holbrook to continue
25 his surgery --

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 MR. DAVIS: let's go the next one, please.

2 BY MR. DAVIS:

3 Q: -- and close up and get her to the recovery room?

4 A: Well, I mean, you don't really have any choice at that
5 point. Right? I mean, it's not -- it's not what anybody
6 hopes to happen. Certainly, the patient, but also the
7 surgeon. But you don't have any choice. So you have to
8 finish up and get the patient to an MRI so we can exclude some
9 of these other things, like a blood clot or something like
10 that.

11 And so Dr. Holbrook actually looks in the field. Right?
12 He looks and sees. One of the things there is, you know,
13 increase the decompression. He looks. The decompression is
14 good. He doesn't see a blood clot. You know, he looks in the
15 field, but after that, again, this is the point I've been
16 trying to make is that when these things go out, that's why
17 they're sort of -- they're nice when they're there, but when
18 they go out, they don't help me. And so you have to just
19 finish up, close up, and take her immediately, which Dr.
20 Holbrook did, to the MRI. Right?

21 I saw evidence in multiple cases here, multiple places
22 that Dr. Holbrook was attentive. Right? Within minutes of
23 her arriving in the recovery room, he's at her side, examining
24 her. Within minutes, he's ordering an MRI. MRIs take a
25 while, but within minutes of the MRI being done, he's back at

DR. JOHN SAMPSON - DIRECT BY MR. DAVIS

1 her bedside. So he tried to be attentive in every way. Took
2 her back to surgery, again very quickly, even though it was
3 not clear that there was anything that could be done. He
4 wanted to do everything he could. Right?

5 So I think he was attentive both in the operation room
6 and after. Why would he be so attentive after if he wasn't
7 attentive during the surgery? I think it was pretty
8 consistent he was attentive throughout that whole time. And
9 unfortunately, with a reperfusion injury like this, it catches
10 you off guard. It's unpredictable, and it's irreversible most
11 of the time.

12 Q: And I believe you said earlier that you have had patients
13 suffer reperfusion injuries yourself; true?

14 A: Unfortunately, yes.

15 Q: Doctor, in your opinion, as you look back over this case,
16 things you've reviewed, based on your training, your
17 knowledge, experience -- excuse me -- as a neurosurgeon, do
18 you have an opinion whether or not Dr. Holbrook was reasonable
19 and appropriate when he cared for Ms. Goodwin from the time
20 the signal went out and on?

21 A: Reasonable and appropriate and attentive, I would say.
22 He did everything that he could.

23 MR. DAVIS: Thank you, sir. I'll take that now. Thank
24 you. Answer any questions that counsel may have for you, sir.
25 Thank you.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 THE WITNESS: Okay. Thanks.

2 THE COURT: All right. Let's take a break before cross-
3 examination. Please return to your jury room and do not
4 discuss the case.

5 (WHEREUPON, the jury exited the courtroom at 11:28 a.m.)

6 THE COURT: We'll be at recess for 15 minutes.

7 MR. DAVIS: Thank you, Your Honor.

8 (WHEREUPON, there was a break in the proceedings, after
9 which the proceedings resumed as follows.)

10 THE COURT: All right. Let's get the witness back on the
11 stand, and let's bring the jury, please.

12 THE BAILIFF: Yes, ma'am.

13 (WHEREUPON, the jury entered the courtroom at 11:50 a.m.)

14 THE BAILIFF: All jurors are seated, Your Honor.

15 THE COURT: Thank you.

16 We're ready for cross-examination.

17 MR. HINSON: Yes, Your Honor. May it please the Court.

18 THE COURT: Yes, sir.

19 CROSS-EXAMINATION

20 BY MR. HINSON:

21 Q: Good morning, Dr. Sampson.

22 A: Good morning, almost afternoon.

23 Q: It's almost afternoon. A minute ago, you made an analogy
24 of you don't necessarily need the muffler guy talking to the
25 brake guy; right?

1 A: I did.

2 Q: I'm going to ask you a question. If you brought your car
3 in to have the muffler fixed, and the muffler guy noticed
4 there was something wrong with the brakes, would you want the
5 muffler guy talking to the brake guy?

6 A: Well, you'd want the brake guy addressing the brakes, not
7 the muffler guy addressing the brakes.

8 Q: But would you want the muffler guy talking to the brake
9 guy?

10 A: Well, I'm not against communication. What I was really
11 getting at is whose responsibility it is, and I don't want the
12 muffler guy fixing my brakes.

13 Q: Dr. Sampson, would you want the muffler guy communicating
14 with the brake guy if the muffler guy thought there was
15 something wrong with your brakes?

16 A: Only in that very, very short window.

17 Q: So is that -- is that a yes to my question?

18 A: I don't think I would answer that with a yes. I want to
19 reiterate, I don't want the muffler guy fixing my brakes.

20 Q: Okay. So you can't answer the question if the muffler
21 guy noticed something wrong with your brakes, whether you
22 would want him to tell the brake guy. You can't answer that
23 question yes?

24 A: I think I've been clear.

25 Q: Well, I'm not clear.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 A: I would like him to say, hey, you know, look at the
2 brakes. The brake guy might say, you know what? There's
3 nothing wrong with the brakes. That's the point. Right? The
4 brake guy is the expert on the brakes. The anesthesiologist
5 is the expert on the blood pressure. So, yeah, I mean, I'm
6 not against communication, but what we're asking really here
7 is who's responsible. The brake guy is responsible, not the
8 muffler guy.

9 Q: Okay. I'm not asking about who's responsible. My
10 question, Dr. Sampson, is, do you acknowledge that if you
11 bring your car in to have the muffler worked on and the
12 muffler guy thought there might be something wrong with the
13 brakes, that you would like him to bring this to the attention
14 of the brake guy? That's my question.

15 A: If he knows anything about brakes. He might not.

16 Q: That's not my question, Dr. Sampson. My question is, do
17 you, Dr. Sampson, if you brought your car in to have the
18 muffler worked on and the muffler guy thought there might be
19 something wrong with the brakes, would you like the muffler
20 guy to bring that to the attention of the brake guy? That's
21 the only question I'm asking you right now.

22 A: Only within the very limited caveats that I've discussed.

23 Q: So yes?

24 A: Within the limited caveats that I've discussed. Yes --

25 Q: Thank you.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 A: -- within the limited caveats that I've discussed.

2 Q: Thank you, Doctor. Doctor, you mentioned earlier that a
3 mist comes up when you cut into the body?

4 A: True.

5 Q: A mist?

6 A: Yeah, it's -- it's basically the heat. Right? I mean,
7 our bodies are at 98 degrees, and the room temperature is
8 generally 70 degrees. So what happens is there's heat that
9 comes up and, of course, we don't see heat. What we see is
10 the water that's carried up at the same time, but that's why
11 it happens. Because, again, our body temperatures are 30
12 degrees warmer than room temperature.

13 Q: And so, Doctor, I unfortunately have had the occasion in
14 my life to cut myself pretty badly. I didn't see a mist come
15 up. Did I just get lucky then?

16 A: Well, your cut, I hope, was nowhere near the type of
17 incisions that we make during surgery, nor was it anywhere
18 near as deep. If you had cut yourself down to the spinal
19 bones, yeah, you would have seen a mist.

20 Q: And, Doctor, you believe that there were hundreds of cc
21 of evaporation during this surgery; correct?

22 A: Yeah.

23 Q: Hundreds?

24 A: Oh, at least.

25 Q: At least? 200? 300?

1 A: Could be up to five.

2 Q: Up to five? Okay. During a four-and-a-half hour

3 surgery, you believe there were hundreds of cc of evaporation?

4 A: Well, if you left a piece of meat out on the counter for

5 4 or 5 hours, it would turn color. Right? It would dry out.

6 Right? So why wouldn't you expect a living or breathing human

7 to have that same amount of evaporation? I mean, this is a

8 pretty big incision. So absolutely. That's well known in the

9 medical field.

10 Q: The incision isn't any bigger than that, is it, Doctor?

11 A: Well, it's probably longer than that, yeah.

12 Q: It's longer than this?

13 A: Uh-huh.

14 Q: What about the total -- the total distance, the total

15 surface area? It wouldn't be bigger -- she doesn't have a

16 hole bigger than this in her back, does she?

17 A: Well, it's hard to compare because incisions are linear,

18 not circular.

19 Q: But the amount of -- you know what surface area means,

20 don't you?

21 A: I do.

22 Q: Okay. Would you think there's more surface area at that

23 incision than in this bowl?

24 A: I do, actually.

25 Q: Okay. Doctor, you said hundreds of cc of fluid; right?

1 A: Yes.

2 Q: All right. Just a second. All right. So how many cc of
3 fluid or milliliters of -- cc and milliliters is the same
4 thing, aren't they, Doctor?

5 A: Yeah. About 300.

6 Q: And cc and milliliters are the same thing; right?

7 A: Yes.

8 Q: All right. I'm going to put this 300cc of fluid right
9 here in this bowl. I'm just going to watch it over the course
10 of the day and see if it evaporates over the course of the
11 next four-and-a-half hours.

12 A: You might --

13 Q: Doctor, are you comfortable --

14 A: Sir? If you are going to do that, you might want to heat
15 it up to 98 degrees where it'll nearly boil, and then you will
16 actually see it evaporate. That's -- that's not a fair
17 comparison.

18 Q: Doctor, you're comfortable -- well, let me ask this. You
19 said earlier that the Foley bags are -- and I believe your
20 words were notoriously inaccurate; is that right?

21 A: Yes.

22 Q: Okay. What am I looking at here?

23 A: Well, that could be a Foley bag. I have no idea whether
24 that is or was the one that was used at surgery.

25 Q: Well, I'll represent -- it was not the one used in

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 surgery, but I represent to you this is the Foley bag that
2 Prisma Health uses. This is -- this is a Foley bag; right?

3 MR. DAVIS: Your Honor --

4 A: Well, it could be. I have no idea.

5 MR. DAVIS: There's no -- there's no testimony to support
6 what he --

7 MR. HINSON: I'll retract that statement. I'll retract
8 that, Your Honor.

9 BY MR. HINSON:

10 Q: This is a Foley bag, isn't it?

11 A: It could be.

12 Q: It could be a Foley bag?

13 A: Well --

14 Q: You don't recognize what this device is?

15 A: It could be a drainage bag. It could be all kinds of
16 other things.

17 Q: All right. Well, let's just presume it's a Foley bag,
18 Doctor.

19 A: Fair enough.

20 Q: All right. Actually, I've got a brand new one right
21 here.

22 A: Is this the one that was used in her surgery?

23 Q: This is a brand new one, Doctor. It's not the one used
24 in her surgery.

25 A: Okay.

1 Q: Just what does the packaging say?

2 A: 35 -- 350ml urine meter.

3 Q: Okay. So it's a device meant to capture urine; right?

4 A: Yes.

5 Q: I'll set that back just so there's no question I'm being
6 honest and truthful with you. This urine meter that we just
7 opened up, urine meter, same as what we're looking at here;
8 right? I've just, because this is kind of cumbersome, cut the
9 --

10 A: Yes.

11 Q: Cut the top off. And you say these are notoriously
12 inaccurate; right?

13 A: Well, I think that's probably different than the one used
14 in her surgery.

15 Q: Why do you think that? What's your basis?

16 A: Well, my basis is that in 2016, that hard plastic part on
17 the outside of it generally didn't exist, and so what you were
18 left with was the lines on the bag. And that's what I meant
19 when I said inaccurate. Right? So what you're going to
20 demonstrate may not reflect what happened in her surgery. If
21 you just put it in the bag and not the hard plastic part.
22 You'll see how when you move the bag around, the numbers
23 actually change.

24 Q: Okay. Doctor, would you -- how much -- how much fluid do
25 we have in here?

1 A: 40ml.

2 Q: All right. Would you pour this into the funnel for me?

3 A: I can, but with the caveat that that's not how the urine
4 would have come out of Ms. Goodwin's surgery.

5 Q: All right. Doc, what do we have there? Just a little
6 less than four -- and I'm dripping out the bottom. That's my
7 fault. I didn't close it. What do we got there?

8 A: Oh, less than 40.

9 Q: A little less than 40? Of course, I spilled a little.
10 Pretty darn close, though, wasn't it?

11 A: Well, again, probably not the same bag that they had used
12 in 2016, which would have been the softer part, and you can
13 imagine trying to measure in a volume on, like, a baggy. It
14 doesn't work as well. That's actually why they started to add
15 the hard plastic parts more recently, because although they
16 are more expensive, they are more accurate. So that's what I
17 was referring to.

18 Q: So they were so inaccurate, they just were worthless?

19 A: Well, I didn't say they were worthless, but they were so
20 inaccurate that we now spend considerably more money to have
21 more advanced measures to monitor the urine output.

22 Q: Doctor, did you look at what her urine output was in the
23 2009 surgery?

24 A: I don't recall.

25 MR. HINSON: Mr. Goings, can you put that up there?

1 BY MR. HINSON:

2 Q: How long was the 2009 surgery?

3 A: It looks like it was about four hours.

4 Q: So it was actually a shorter surgery than the 2016
5 surgery; right?

6 A: I'll take that at face value.

7 Q: Well, do you know how long the 2016 surgery was?

8 A: About four-and-a-half hours.

9 Q: Okay. And you agree that four hours is less than four-
10 and-a-half hours?

11 A: I do.

12 Q: Okay. Thank you. All right. So a four-hour surgery,
13 half an hour less than the 2016 surgery.

14 MR. HINSON: Mr. Goings, can you go a little bit further
15 down here?

16 BY MR. HINSON:

17 Q: How much urine did she produce in the 2009 surgery that
18 was shorter than the 2016 surgery?

19 A: Well, the number says 300, but remember that it depends
20 on so many other things. Right? Like the -- to keep the
21 number in the tub, the amount in the tub the same, you adjust
22 the amount flowing out of the -- of the hole in the tub, and
23 that depends on how much is coming in.

24 So this surgery would have been a different surgery with
25 different fluid dynamics and so on. So I don't think

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 comparing urines from one surgery to another is really a
2 legitimate comparison.

3 Q: But yet comparing blood surgery or blood pressures from
4 one surgery to another is?

5 A: Not exactly. That's not what I was doing. What I was
6 doing is I was saying that if someone was susceptible to a
7 stroke from the blood pressure, we would look at blood
8 pressures at all the different times. And if the blood
9 pressures were the same and she never had a stroke, then we
10 would not expect a stroke during the 2016 surgery either.

11 Q: And, Doc, I'm sorry. My co-counsel just brought
12 something to my attention. The 2009 surgery -- the 2009
13 surgery --

14 MR. HINSON: Mr. Goings, would you go to the top of that
15 2009 surgery? A little -- a little higher, Mr. Goings?

16 BY MR. HINSON:

17 Q: It began at what time?

18 A: Well, the anesthesia start time is 7:21.

19 Q: And the end time is what time?

20 A: 9:40.

21 Q: So that is 2 hours and 19 minutes; correct?

22 A: It appears to be so.

23 Q: All right. And so in 2 hours, 19 minutes, a solid 2
24 hours less than the 2016 surgery, she produced 300cc of urine,
25 according to the record. Do you agree?

1 A: According to the record, that's true. But you must
2 remember that, just like when we go out at night and have
3 three or four beer, in two hours we could produce 300cc. The
4 next morning, having already produced a lot of urine, we would
5 produce more like 80cc over four-and-a-half hours because
6 we're dry. So you just -- you're comparing two things across
7 many, many years that don't really count because there's more
8 factors that are involved in the urine output than you're
9 recognizing.

10 Q: Because she's not the same patient in 2009 as she is in
11 2016; isn't that right, Doctor? She's --

12 A: No, she's pretty close. I saw no evidence in the record
13 that her kidney function changed or that her blood pressure
14 changed. They were all pretty much the same.

15 Q: So it's your testimony to this jury that her -- her
16 baseline blood pressure in 2009 was about the same as her
17 baseline blood pressure in 2016?

18 A: Well, there were several. When I looked at the baseline
19 blood pressure for the 2011 surgery, it was actually slightly
20 higher than the baseline blood pressure at the anesthesia
21 check just before the surgery than in 2016.

22 So I actually used that to say, well, the surgery, again
23 2011 being closer to 2016, if her starting blood pressure was
24 even a little higher in 2011, and her blood pressures during
25 the surgery were even lower in 2011, then I wouldn't have

1 expected that the difference from a starting lower pressure to
2 an ending higher pressure in 2016 would have caused a stroke.

3 Q: What was her baseline blood pressure in 2009, Doctor?

4 A: I'd have to go back through the records. There were
5 multiple recordings.

6 Q: You didn't make a calculation of that, did you?

7 A: Well, I thought it was most relevant. First of all, it's
8 not a memory test, so I don't happen to have it on top of my
9 head, but I did look back at 2011 thinking that that was
10 closer to 2016 and would be more relevant. And again there,
11 her blood pressure was higher and the intraoperative pressures
12 were lower. So there was more of a change in 2011, and yet
13 that didn't lead to a stroke.

14 Q: Doctor, you don't know what her baseline blood pressure
15 was in 2009; correct?

16 A: Well, I think you just flashed it up at 139 over
17 something. So --

18 Q: That was her pre-operative blood pressure. My question
19 is, Doctor, what was her baseline blood pressure in 2009?

20 A: I guess I don't know the difference then between what
21 you're asking, baseline or preoperative.

22 Q: So you don't know the difference between a baseline blood
23 pressure and a preoperative blood pressure?

24 A: Well, the blood pressures that I looked at for 2011 and
25 2016 were the ones taken by the anesthesia team immediately

1 prior to the surgery. So I thought those were the most
2 relevant to the anesthesia team who would be monitoring her
3 blood pressure during the surgery.

4 Q: Dr. Sampson, what is the difference between a baseline
5 blood pressure and a preoperative blood pressure? That's my
6 question.

7 A: In the medical field, we wouldn't differentiate between
8 the two.

9 Q: You don't differentiate? I want to understand your
10 testimony. You don't differentiate in the medical field
11 between a baseline blood pressure and a preoperative blood
12 pressure? That's your testimony to this jury?

13 A: I guess it just depends on the context. You'd have to
14 define the terms for me before I could answer.

15 Q: You're the one that went to medical school, Doctor. I'm
16 asking you, what does the term baseline blood pressure mean?

17 A: In reference to this case, I would define the baseline
18 blood pressure as the one immediately before surgery taken by
19 the anesthesia team.

20 Q: Baseline blood pressure is the one immediately before
21 surgery? That's your testimony?

22 A: No, that's not what I said.

23 Q: Okay.

24 A: What I said --

25 Q: Sorry.

1 A: -- was you have to -- you're asking the question. You'd
2 have to define the terms. I would consider before a surgery
3 the baseline blood pressure the one before the surgery.

4 Q: Okay. How -- how is that different than what I just
5 wrote? You consider the baseline blood pressure to be the one
6 immediately before surgery. Isn't that what I just wrote?

7 A: Well, except that it depends on the context of your
8 question, sir.

9 Q: Okay. So the context of my question is in 2009, what
10 would you consider her baseline blood pressure to be right
11 prior to the beginning of surgery? What would -- what should
12 the physicians consider this patient's baseline blood pressure
13 to be?

14 A: Probably the one the morning of the anesthesia
15 evaluation, which is the one I considered in 2011, which again
16 was higher than the one in 2016.

17 Q: So now you'd say they would consider the one -- one blood
18 -- you would consider one blood pressure to determine the
19 preoperative baseline blood pressure?

20 A: Well, again, sir, that depends on how you're defining
21 your terms. Right? I mean, I'm not sure why we're arguing
22 about this. I mean, you can define baseline however you want,
23 and then I'll tell you what I think about it. But to me, the
24 most relevant blood pressure was the one immediately before
25 the surgery. Why would we look back a day? Two days? Three

1 days? Five days? Wouldn't we be better off to know the one
2 just before she goes into the surgery?

3 Q: So you don't think it matters what her typical blood
4 pressure is? That's not really relevant to you as a surgeon?

5 A: It could be. I mean, again, when I'm in surgery, I'm
6 looking at the field. I'm depending on the anesthesiologist
7 to look at the blood pressure. So I would defer to them to
8 assess that and manage it.

9 Q: Have you looked at Prisma Health's policies and
10 procedures in this case?

11 A: I probably did. I don't recall.

12 Q: All right. Have you looked at how many blood pressures
13 they look at to consider a baseline blood pressure?

14 A: Maybe I should look at it so that I'm sure.

15 Q: Well, Doctor, Goodwin 579 from Prisma Health Policies and
16 Procedures, and I'm just going to ask you, Doctor, to read
17 line 5. Can you read line 5, Doctor? I'm happy to let you
18 look at the document, but right now I'm asking you to read
19 line 5.

20 A: Well, just like any document, I want to look at what I'm
21 reading.

22 Q: I understand. You're welcome to read it, but I'd like
23 you to read line 5 out loud.

24 A: Okay. So in this document, which does appear to be
25 related to ambulatory outpatient surgery and, therefore, would

1 not apply in this case, although, again, not having had time
2 to look at it completely, that's one thing that I'm just
3 noting.

4 Line 5 says the inpatient should have at least three
5 blood pressure recordings prior to surgery in order to provide
6 baseline measurement. So --

7 Q: And then --

8 A: -- in this case, if you wanted to find baseline that way,
9 that's fine. I would still say that that's a policy baseline
10 and not the most relevant blood pressure to the surgery.

11 Q: Well, let's -- let's read that one more time. I'll read
12 it out loud, Doctor.

13 The patient should have at least three blood pressure
14 readings prior to surgery in order to provide baseline
15 measurement.

16 Is that what it says?

17 A: On a policy that appears to be related to outpatient
18 ambulatory surgery, yes.

19 Q: Doctor, in this case, you put together a list or your
20 counsel put together a list of everything you'd reviewed;
21 right?

22 A: Yes. It's quite extensive.

23 Q: And that included the policies and procedures, didn't it?

24 A: It could have. I may have ignored that one because it
25 was, again, outpatient and ambulatory, which clearly was not

1 the case here.

2 Q: So outpatient surgeons -- or excuse me, outpatient
3 surgery patients, for them it's important to look at three
4 baseline blood or three blood pressures, but for inpatient
5 surgeries, it isn't?

6 A: Well, again, it depends on what you're using the baseline
7 blood pressure for. To me, the blood pressure immediately
8 before surgery as assessed by the anesthesiologist and the
9 closest surgery to the 2016 surgery is the most relevant.

10 Q: I think that was different than my question, Doctor. Why
11 would it be different for outpatient -- for patients
12 undergoing an outpatient surgical procedure to have three
13 blood pressure readings and it wouldn't be important for a
14 patient undergoing an inpatient surgical procedure to have
15 three baseline or three blood pressure readings?

16 A: Well, I'm not sure it's important. You're just showing
17 me a policy from an ambulatory surgery document.

18 Q: So you're not sure it's important to establish a baseline
19 blood pressure?

20 A: I do. I think that it's -- the anesthesiologist is going
21 to look at the blood pressure. They're going to determine
22 what the blood pressure is. They're going to measure it the
23 way they measure it, because they're going to continue to
24 measure it that way during surgery. So, again, I defer to the
25 anesthesiologist to look at the blood pressure and to manage

1 it. And in both of those cases in 2011 and 2016, the
2 anesthesiologist looked at the blood pressure just before the
3 surgery.

4 MR. HINSON: Thank you, Mr. Goings.

5 BY MR. HINSON:

6 Q: Doctor, what's the -- I'm just going to go up to the
7 title of this document. This is called *Preoperative*
8 *Preparation of the Patient*, isn't it?

9 A: Right. But if you look just below that, it says
10 *Ambulatory Outpatient Surgery Preoperative Clinical Care*.

11 Q: Well, it says name of associated -- it just says -- let's
12 get this straight what we're looking at. The policy is simply
13 preoperative preparation of the patient; right?

14 A: Right.

15 Q: Can you --

16 A: But again, if it's referring to an ambulatory outpatient
17 document, I don't know that this isn't just for ambulatory
18 patients. It says so much about ambulatory there, I'd have to
19 assume that.

20 Q: Okay. So that's your assumption.

21 A: Well, I mean it says ambulatory.

22 MR. HINSON: Mr. Goings, let's get -- let's go back up.

23 BY MR. HINSON:

24 Q: Let's go back up to the top of this document before we
25 move on. Almost done, Dr. Sampson. So the PGR, what does PGR

1 stand for?

2 A: I have no idea.

3 Q: I'll represent to you it stands for policies, guidelines,
4 and rules.

5 A: Okay.

6 Q: PGRs.

7 A: Okay.

8 Q: And you didn't determine that when you reviewed these
9 materials what a PGR is in this, Doctor?

10 A: I assumed it was policy.

11 Q: Okay. And it just says this is the name of the policy;
12 right? This is pre-operative preparation of the patient,
13 policies, guidelines, and rules, and then it says name of
14 associated policies. That doesn't mean -- well, what do you
15 interpret that to mean, Doctor?

16 A: Well, those are associated, but the ones I was referring
17 to are the ones below.

18 Q: Okay. Anywhere in this document -- it's four pages.
19 Besides where it says associated PGRs, does it ever say this
20 only applies to outpatients? Look at it.

21 A: It doesn't, but it seemed to me that it probably does.
22 And you keep circling inpatient, but of course, once they get
23 admitted for their outpatient surgery, they're now an
24 inpatient. So that doesn't dissuade me in my opinion.

25 Q: Doctor, you would be comfortable with any amount of urine

1 output during surgery so long as there is some; isn't that
2 correct?

3 A: Well, I guess what I said earlier in my testimony when
4 Mr. Davis was asking me questions, I said if it was zero, I
5 would be concerned. So I think that's probably an accurate
6 statement, but again, the point is that your kidneys adjust
7 depending on how much evaporation there is, how much blood
8 loss there is, how much fluid there is, all those kind of
9 things. So as long as urine is being put out, we know the
10 kidneys are working.

11 Q: Doctor, you would be comfortable as long as there was any
12 amount of urine output; isn't that correct?

13 A: Well, again, it would depend on the circumstances, but in
14 general, yes.

15 Q: Okay. Good. All right. So in general, yes. So you
16 would have no concern as long as the amount of urine output
17 wasn't zero, generally speaking?

18 A: Well, you're generalizing, and we're talking about a
19 specific patient. So --

20 Q: I'm talking about in general. In general under surgery,
21 as long as the patient is putting out any urine, you're okay
22 with it?

23 A: Over a four-and-a-half period, yes.

24 Q: Okay.

25 A: I mean, many of the jurors probably haven't put out any

1 urine this morning or maybe they've put out one time. That's
2 not meaning that they have a problem.

3 Q: They don't have a catheter in, do they?

4 A: Well, but they're obtaining some -- oh, I hope not, but
5 they're obtaining some, you know, fluid in their bladder and
6 they're emptying it, and it might only be a little bit.

7 Q: You would have no concern about the urine output during
8 surgery as long as it wasn't zero?

9 A: Correct.

10 Q: All right. Let's -- let's save this, this right here.
11 All right, Doctor. Doctor, you testified earlier about what
12 the standard of care -- about what the standard of care is;
13 right?

14 A: Yes.

15 Q: Earlier did you -- you and I have met before today;
16 right?

17 A: Yes.

18 Q: At that time, you didn't know what the standard of care
19 meant, did you?

20 A: Well, I don't think that's a fair characterization of my
21 testimony. When in depositions, people will ask you the
22 standard of care and, many times, that's a legal definition.
23 So I'm always hesitant to sort of become a lawyer, just like
24 I'd be hesitant to be a brake guy or a muffler guy. Having
25 said that, the standard of care is generally what another

1 neurosurgeon would do -- right? -- who was reasonable and
2 prudent.

3 So that's a reasonable definition of the standard of
4 care, but I'm always hesitant in a deposition to answer that
5 question because I'm worried that someone's going to trip me
6 up with some words of a legal definition that I'm not
7 interested in getting involved in. It's a -- it's a theme to
8 me, or a -- a general gestalt that another neurosurgeon did
9 what I would do as a reasonable neurosurgeon.

10 Q: Doctor, when you and I met previously, you told me you
11 didn't know what the standard of care was, and it really
12 wasn't your area of expertise?

13 A: If you're quoting me, I'd like to see where you're
14 quoting me from.

15 Q: Sure. I'll be happy to. You gave a deposition; right?

16 A: I did.

17 Q: You gave a deposition on May 17th, 2022; correct?

18 A: I don't remember it, but --

19 Q: You were under oath at that time; right?

20 A: Yes.

21 Q: All right. Doctor, turn to page 54 of that deposition.

22 A: Okay.

23 Q: I asked you on page -- excuse me -- page 54, line 20, I
24 asked, do you agree that if a physician who's providing
25 medical care and treatment to a patient does so in a manner

1 that is different from what a reasonable and prudent physician
2 would do under like or similar circumstances, even without
3 intending harm, that physician can fall below the standard of
4 care? What was your answer?

5 A: Similar to what I just gave here, it says, I guess, if
6 that's the definition of standard of care. I mean, to me
7 you're asking me a legal question, not a medical question. So
8 it's not really my area of expertise, meaning the law. Fair
9 answer, kind of just what I said without seeing my deposition.
10 It seems pretty similar to me.

11 Q: You said -- when we met before, you told me you weren't
12 going to give standard of care opinions, didn't you? And then
13 you came into this courtroom today and did.

14 A: Well, hold on one second, sir. As a doctor, I'm here to
15 give honest answers to questions that Mr. Davis or you asked
16 me. Whether that's standard of care or whether that's
17 causation or whatever that is, I don't know. Right? I'm just
18 here to answer your questions as honestly and accurately as I
19 can. So to say that I'm doing something beyond that, I don't
20 think it's fair. That, again, may be a legal subtlety. I
21 didn't study law.

22 Q: Doctor, I asked you before -- well, you've been in
23 depositions before this case; right?

24 A: Yes.

25 Q: And part of the purpose of that deposition is so I can

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 understand what your testimony is going to be; right?

2 A: I gather that's your purpose. Again, my purpose is to
3 give you answers to questions that you ask. If you don't ask
4 me a question, I can't answer it. Right? And I don't think
5 at the deposition I'm supposed to volunteer stuff for you to
6 ask me. So if you don't ask me a question, I can't answer it.

7 Q: Okay. Well, that's -- that's right. It's -- you're
8 supposed to answer my questions truthfully and honestly at
9 deposition, just like you are today; correct?

10 A: To the best of my ability, yes.

11 Q: All right. And in this case, I asked you if you intended
12 to give standard of care opinions, and you told me you weren't
13 going to, didn't you?

14 A: May I see it?

15 Q: Sure.

16 MR. HINSON: Can you find that, Ms. Gooding?

17 BY MR. HINSON:

18 Q: All right. Doctor, if you would turn to page 47 of your
19 deposition?

20 A: Okay.

21 Q: All right. 47, I asked you, line 8, do you agree that
22 Dr. Root -- okay. So you are going to testify as to what the
23 standard of care is for an anesthesiologist? Your answer was
24 no; correct?

25 A: Correct.

1 Q: And then I asked you, are you going to testify as to what
2 the standard --

3 A: I'm sorry.

4 Q: I asked you, are you going to testify as to what the
5 standard of care is for a neurosurgeon, and your answer was, I
6 don't believe I've been hired to testify on behalf of Dr.
7 Holbrook either. Isn't that what you said?

8 A: Right. So at that time, I wasn't hired to do that. So I
9 wasn't testifying in that area because I can't testify on
10 standard of care for an anesthesiologist, but I came here
11 today, and if I was asked questions that you perceive being
12 legally nuanced, I feel I'm supposed to answer those
13 questions.

14 Q: Okay. My question is, at the time I took your
15 deposition, you told me you weren't giving standard of care
16 opinions, you weren't hired by Dr. Holbrook; correct?

17 A: Correct. But that doesn't mean I couldn't have been
18 asked questions about Dr. Holbrook, as I was today.

19 Q: Doctor, you were first hired in this case by Dr. Jennifer
20 Root and her counsel, the anesthesiologist and her lawyers;
21 right?

22 MR. DAVIS: Objection, Your Honor.

23 THE COURT: Overruled.

24 BY MR. HINSON:

25 A: Yes.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 Q: Yeah. So you were not -- originally, you weren't hired
2 by these folks. Originally, you were hired by the fellow in
3 the back of the room who represents Dr. Root, weren't you?

4 A: That's what I recall.

5 Q: Okay. Then Dr. Root's now gotten out of the case, and
6 now you're working for these folks; right?

7 A: Yeah. I didn't -- I didn't know that, but thank you.

8 Q: You didn't know you'd swapped teams?

9 A: Well, what often happens in these cases is they'll use
10 experts under multiple attorneys. So I assume that's what was
11 happening.

12 Q: All right. And you're being paid \$700 an hour for your
13 review of the record?

14 A: I believe that's correct.

15 Q: And being paid \$1,000 an hour for deposition testimony?

16 A: Yes.

17 Q: And \$1,000 an hour for trial testimony billed portal to
18 portal, meaning from the moment you leave your house to the
19 moment you come back, you're billing \$1,000 an hour?

20 A: Well, I don't include in that sleep time and dinner time
21 and those kind of things.

22 Q: Isn't that what portal to portal means, typically?

23 A: Not -- not to me.

24 Q: Not to you? So you have a different definition of portal
25 to portal than -- than most folks, you think?

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 A: Well, I think it's -- I mean, just so the jury knows, our
2 practice has numbers that they put out to bill for this, and
3 mine are within the range of that. In fact, they've usually
4 been less, but I don't think it's fair to bill while I'm
5 sleeping, so I don't. If I'm here in the courtroom, I'll
6 bill. If I'm traveling and working on those records, I'll
7 bill. I thought that was fair, but I don't bill for sleeping
8 time.

9 Q: Just so we understand, so you were first disclosed to me
10 in Dr. Root's -- when she was still in this case, you were
11 first disclosed to me that you were going to come testify that
12 Dr. Root met the standard of care. You were going to testify
13 that the anesthesiologist met the standard of care.

14 A: Well, you just read from my deposition where I said I
15 wasn't going to do that.

16 Q: I know. I'm trying to figure out what in the world is
17 going on, Doc, because I don't know what test -- I didn't know
18 until today what testimony you were really going to give,
19 because I was told first you were talking about the
20 anesthesiologist, then I was told you were talking about
21 neurosurgeons. Then I took your deposition, and you told me
22 you weren't going to talk about standard of care, and now you
23 come to trial and say you are.

24 A: But to be clear, I didn't make the answers in my
25 deposition. The legal nuances of what I'm used for and who

1 I'm hired by are not of my concern. I'm here to answer
2 questions, I guess, from Mr. Davis and also from you.

3 Q: Okay.

4 A: I'm happy to do that, but what legal documents said I was
5 going to do or not going to do, I can only be responsible for
6 the questions that I answered.

7 Q: I understand. My question right now is simply you were
8 first hired by Dr. Root's attorney. Now she's no longer in
9 the case. She's -- we've resolved that issue.

10 A: Okay.

11 Q: Now you're working for Dr. Holbrook's counsel; right?

12 A: I guess that's true.

13 Q: Okay. Thank you. And, Doctor, 75 to 80 percent of all
14 your work as an expert is on behalf of the defense; right?

15 A: That's true for firms that contact me, but I have
16 testified in cases similar to this on behalf of patients, both
17 in deposition and in trial. And so I try to support patients
18 equally when I can.

19 Q: Okay. But my question is 75 to 80 percent of your work
20 as an expert is on that side of the courtroom for the doctor;
21 correct?

22 A: Well, just to be clear, I don't choose that. That's who
23 calls me.

24 Q: Doctor, 75 to 80 percent of your work is on behalf of the
25 doctor?

1 A: Well, I don't think that I've not answered that, but what
2 I want to be clear on is that in the people who contact me, 75
3 percent are on behalf of the doctor, but I have testified for
4 patients in multiple occasions in situations just like this.

5 Q: Okay. I want you to answer my question yes or no, and
6 then you're welcome to explain it, Doctor, but my question,
7 yes or no, and then you can explain it. Yes or no, 75 to 80
8 percent of your testimony as an expert is on that side of the
9 courtroom for the doctors; correct?

10 A: Yes. With the definition of work being those who contact
11 me, which I don't really have any control over.

12 Q: Doctor, you believe the purpose of neuromonitoring is to
13 make the surgeon more comfortable; correct?

14 A: Yeah, I kind of articulated that earlier because if the
15 monitoring remains intact, we can feel more comfortable with
16 the surgery that we haven't caused harm to the patient. So
17 that does make you more comfortable. I think it makes --
18 makes you a better surgeon, but I limit it to that
19 specifically because when it goes out, unless you're doing a
20 scoliosis surgery, there's not much you can do about it.

21 So to me, when I say comfortable, I don't mean just in an
22 emotional sense. What I mean is that as a comfortable
23 surgeon, you can be as aggressive as possible. So if you're
24 decompressing a spine, you want to be as aggressive as
25 possible to limit the need for another surgery. If you're

1 taking a tumor out, you want to be as aggressive as possible
2 so you get it all out.

3 The monitoring helps me be as aggressive as possible. It
4 makes me feel comfortable doing what I think I need to do, but
5 when I lose it, there's usually nothing I can do. That's what
6 I meant by that.

7 Q: You don't believe neuromonitoring is in any way about
8 patient safety, do you? And if you want to refer to your
9 deposition, you're welcome to.

10 A: Yeah, I'm happy to refer to my deposition. Again, I
11 articulated earlier that I have a degree in evaluating the
12 medical literature, served as an editor for the top journal in
13 our field for seven years, and saw many articles on this
14 topic. The truth of the matter is that there's never been a
15 study that convincingly showed that it really improved patient
16 outcomes.

17 Q: Okay. Doctor, my question is, you don't believe
18 neuromonitoring is about patient safety? Can you please
19 answer that question?

20 A: Well, in the context of the answer that I've given, I
21 would believe that's true, yes.

22 Q: Okay. So we agree that it's your testimony that you
23 believe -- sorry. You need some water?

24 A: It would be nice to have some water.

25 MR. HINSON: Yeah, let's get it.

1 THE COURT: Here, Mr. Hinson.

2 MR. HINSON: Yes. Oh, thank you.

3 BY MR. HINSON:

4 Q: All right. So I want to make sure we're in agreement.

5 The purpose of neuro -- neuromonitoring is not about patient
6 safety. That's your testimony at deposition. That's your
7 testimony today?

8 A: No, I wouldn't characterize it like that. What I would
9 say is that in a case like this where you can't re --
10 remanipulate or take the manipulation off, it doesn't enhance
11 patient safety --

12 Q: Okay.

13 A: -- because there's nothing you can do about it.

14 Q: You believe neuromonitoring is unreliable, don't you?

15 A: It's a fact it's unreliable, yes.

16 Q: Okay. All right. Neuromonitoring is unreliable. Dr.
17 Sampson says neuromonitoring is unreliable. That's your
18 testimony; right?

19 A: That's fine.

20 Q: All right. Look at that right there. And you believe
21 there's no evidence that neuromonitoring improves patient
22 outcomes; correct?

23 A: I do believe that. I'm sure you can find a study that
24 says that, just like you can find a study that says you should
25 do five things in a case and apply it here when it doesn't

1 apply, because they all reference scoliosis cases. But if you
2 look at the sum of the literature and you examine it in a way
3 that my seven-year degree on examining the literature taught
4 me, there's no evidence to support that it improves outcomes.

5 Q: Okay. The purpose generally is to make the patient -- or
6 to make the physician more comfortable?

7 A: Well, in fairness, you're taking some of those things out
8 of context, and I think when you reshow them, anybody who's
9 looking at that should remember the context that I put them
10 in.

11 Q: Okay. With that --

12 A: Because it's a little bit unfair to --

13 Q: Okay.

14 A: -- take a quote out of context.

15 Q: Well, this is -- with that context, this is still your
16 testimony; right?

17 A: Yeah. Maybe you should write context on the bottom
18 there.

19 Q: Write context? I'm happy to. I'm not a very good
20 speller. Context. Did I spell that right?

21 A: I'm not a very good speller either. So --

22 Q: All right. Well, you and I share that affliction. All
23 right. Not a very good speller. Much to my kindergarten
24 teacher mother's dismay, I was never a very good speller.

25 Doctor, you yourself use neuromonitoring in thoracic

1 spine surgeries; right?

2 A: I do. Again, you know, oftentimes, as in this case,
3 there's big knuckles of bone pushing on the spine, and I want
4 to be as aggressive as I can be. And I mean, in a sense, I
5 don't want to chicken out. Right? So that tells me that I
6 can keep going and try to do the very best job that I can for
7 the patient. Having said that, when it goes out, I'm in the
8 same situation that Dr. Holbrook is. There's nothing I can do
9 about it.

10 Q: Okay. Doctor, in this case, the surgery was being done
11 because of stenosis and an osteophyte, a bone spur; right?

12 A: Yes.

13 Q: You would agree those were some sort of -- some form of a
14 spinal deformity in Ms. -- Ms. Goodwin's spine?

15 A: Well, we typically wouldn't use the word deformity.
16 Deformity -- I mean, like it or not, scoliosis is a deformity.
17 It means that there's a bend. There was no bend here. This
18 was just an osteophyte.

19 Q: Okay.

20 A: So I would not use that word. I think that's incorrect.

21 Q: Okay. Do you think other physicians might consider it
22 some sort of deformity developing in a spine if there's an
23 osteophyte or a stenosis?

24 A: It's a pretty loaded term in our field. I mean, there's,
25 you know, scoliosis and deformity. That's sort of an area.

1 So they might, and they might have used it, you know, within a
2 certain context or maybe in a more layperson way, but
3 deformity surgery is very different than what Ms. Goodwin had.

4 Q: Doctor, earlier, you and Mr. Davis talked about --

5 MR. HINSON: Let's pull up number 7.

6 BY MR. HINSON:

7 Q: -- this article the plaintiffs have looked at that has an
8 algorithm for the management of neuromonitoring signal down
9 here, and the title of this article, Doctor, is -- what is the
10 title of the article?

11 A: *Management of Intraoperative Neuromonitoring Signal Loss.*

12 Q: Okay. It doesn't say management of intraoperative
13 neuromonitoring signal loss in scoliosis patients? It just
14 says management of intraoperative neuromonitoring signal loss?
15 Is that --

16 A: Well, the title doesn't say that. Fair. But again, I
17 spent seven years learning how to look at papers like this and
18 dissect them and better understand them. And if you look at
19 this, you will quickly find that the references all reference
20 scoliosis.

21 Q: Okay.

22 A: Moreover, in the actual algorithm down there under number
23 4, it talks about manipulation. Well, there's no manipulation
24 that occurred in Ms. Goodwin's surgery. So it would have been
25 impossible for anyone to follow all those steps.

1 Q: Well, to be fair, it doesn't just say manipulation. It
2 says reverse manipulation or widen the decompression. They
3 were doing a decompression in Ms. -- in Ms. Goodwin's surgery,
4 weren't they?

5 A: Well, it doesn't say or. It says --

6 Q: It doesn't say or.

7 A: It says both. Right? And I mean, again, there's a
8 couple of things you have to understand here. First of all,
9 it wouldn't say reverse manipulation unless it was a
10 manipulation. So immediately you have to think that this
11 might not apply to surgeries like Ms. Goodwin had. But if you
12 look at the references, you'll see if you look them up that
13 they're all related to scoliosis and, you know, for scoliosis,
14 this is a reasonable approach. Right?

15 It also doesn't say that the equipment should be checked
16 by the neurosurgeon. That's absurd. Would you want your
17 neurosurgeon when you've just lost the signal to scrub out and
18 go over and check with the neuromonitoring people to make sure
19 the electrodes are in place? Of course not. Would you want
20 them to scrub out, walk around the drapes, and check what the
21 blood pressure is with the anesthesiologist? Of course not.

22 Would you want them to wake you up in the middle of the
23 surgery when you have an incision that's that big, as you
24 indicated, with no anesthetic, no painkillers? Would that be
25 the right thing to do when there's nothing you can do about it

1 anyway because you can't reverse the manipulation? Would that
2 be the right thing to do?

3 And would it be the right thing to do when, you know, in
4 this patient in this case that without anesthetic, she bites
5 her tube and can't breathe, is it the right thing to do harm
6 in that situation by waking someone up, having them bite their
7 tube and stop breathing? I think not. So this does not apply
8 in this case.

9 Q: Doctor, do you remember what my question was?

10 A: I think I answered your question.

11 Q: But do you remember what my question was?

12 A: You were asking me about this -- this paper.

13 Q: I was. And do you remember what the question was?

14 A: No.

15 Q: Thank you. It might be -- okay. Do you agree that
16 during the surgery done on July 28th, 2016, they were doing a
17 decompression?

18 A: Yes.

19 Q: Thank you. Do you agree that if you got back a lab value
20 that was way off the charts -- let's see if we can agree,
21 because I know you like definitions here. Would you agree
22 that a white blood cell count of 21,000 would be off the
23 charts? That's really high, isn't it?

24 A: Well, we -- unfortunately, we probably won't agree on
25 this either.

1 Q: Okay. Well, you tell me.

2 A: There's a normal range, and that would be outside the
3 normal range. Is it off the charts? Well, that depends.
4 Does someone have an infection? Are they taking steroids?
5 Are they anxious? If you get excited, your -- your white
6 blood cells demarginate and they'll be higher.

7 So is it off the charts or abnormal for people under
8 those situations? No, it's not. Right? It's outside of the
9 normal reference range, meaning that if you take twelve people
10 and you draw their blood all in a controlled condition, yeah,
11 it would be. It would be abnormal from a lab perspective. Is
12 it abnormal from a patient care perspective?

13 Q: Okay.

14 A: That requires additional information.

15 Q: All right. Doctor, let's see if we can -- we can work
16 through this. All right. You're taking care of a patient
17 post-surgery. No reason to think there's an infection. You
18 do a CBC, a complete blood count; right?

19 A: Yes.

20 Q: Okay. Are you with me with this hypothetical?

21 A: I am.

22 Q: All right. You don't think there's an infection. The
23 CBC comes back, and let's say the white blood count is 25,000.
24 That would be a pretty alarming finding for a patient who you
25 didn't think had an infection, wouldn't it?

1 A: No.

2 Q: Okay. That --

3 A: Because that patient's been under a dramatic amount of
4 stress, and I just said stress can increase the white count.
5 And if we happened to be talking about Ms. Goodwin here, she
6 was also placed on steroids, I believe, which dramatically
7 increased her white blood count. So -- and a lot of patients
8 are. So post-op patient, big stress, lots of steroids, a high
9 white blood count, perfectly -- perfectly expected.

10 Q: So it's your testimony to this jury a patient undergoing
11 surgery comes back, no reason to think there's an infection, a
12 white blood count of 21,000 wouldn't cause you any alarm?
13 That's your testimony to these folks?

14 A: Correct.

15 Q: Okay. Doctor, what if you're seeing a patient, how about
16 -- how about a white blood count of 32,000? Would that give
17 you a concern?

18 A: I think in a post-op patient who is otherwise normal, I
19 would expect that 32,000 is probably the same thing. I will
20 admit that when the blood counts get up into the 30s and 40s,
21 you'd have to think of someone having a leukemia. For someone
22 to have had a spine surgery and suddenly have leukemia, it
23 seems unusual, particularly if their pre-op counts weren't
24 that high. But yeah, I guess that in the 30s and 40s, I'd
25 say, boy, maybe we missed the boat here and this patient has

1 leukemia, but that's seems pretty odd to me.

2 Q: Let's give some context to the jury. What is a normal
3 white blood cell range?

4 A: It varies from place to place, but 8 to 12, something
5 like that.

6 Q: Eight to 12? And so a post-op patient, is there any
7 range on the high end where you would have concern?

8 A: Well, I just said when it gets in the 30s, 40s, and 50s,
9 I would worry about leukemia, but again, that would be an odd
10 circumstance. Right? So the first thing I'd probably do is
11 just repeat it, because to have someone suddenly develop
12 leukemia having just gone through a surgery seems really
13 unlikely to me.

14 Q: Okay. But you would not presume it was a lab malfunction
15 and just ignore it, would you?

16 A: Oh, I might, yeah. As I just said, I would just repeat
17 it, which meant that I would repeat it because I would assume
18 it was a lab malfunction.

19 Q: Okay. But you wouldn't ignore it, would you?

20 A: Well, if by ignore, you mean that I wouldn't repeat it, I
21 guess it depends. I mean, a blood count of 30 that's out of
22 the blue and I know I'm getting another count, probably
23 tomorrow, I might ignore it. I mean, it seems really unlikely
24 that this poor patient just had a big spine surgery and now
25 has leukemia. I guess it's possible. The truth is, if I

1 diagnose leukemia today or tomorrow, it's not going to make
2 any difference.

3 Q: All right. So it's your testimony to this jury you do a
4 -- do a surgery on a patient who's not believed to have an
5 infection, not believed to have cancer, and afterwards, the
6 complete blood count shows a markedly high white blood count,
7 and you might just ignore it? That's -- I just want to make
8 -- I want to make sure I understand your testimony.

9 A: Well, my testimony was a little bit more than that. When
10 you say markedly high in that question, I would -- I would
11 define that as in the 30s, 40s, and 50s, as I said.

12 Q: Okay.

13 A: And I was going to get another blood count tomorrow and I
14 had no reason to believe she has leukemia, yeah, I think
15 ignoring it would be perfectly fine.

16 Q: Okay. Just say must be a lab malfunction, we'll just get
17 another one later?

18 A: Well, given that it's highly unlikely, and it wouldn't
19 matter if I knew that or not, yeah.

20 Q: Okay.

21 A: I mean, to be clear, when you're looking at lab values
22 and ordering lab values, you have to also take those into
23 context. You kind of have to think to yourself, what does
24 this -- what is this telling me and how real is this? So we
25 do that every day.

1 Q: You ignore labs every day?

2 A: Yeah. I mean, if you say ignore labs, meaning that
3 they're abnormal, outside of the normal reference range,
4 absolutely. My cholesterol happens to be outside of the
5 normal reference range. Unfortunately, many of you probably
6 are outside of the normal reference range. Many people are
7 high. Mine tends to be low. No big deal. Right? So we
8 ignore blood values that are outside of the reference range,
9 because there are some physiologic conditions where we expect
10 them to be outside of the normal range. Right?

11 I was put on a statin. My cholesterol was pretty normal.
12 It's actually LDL, but fat in your blood, and it dropped below
13 the normal value. Should I rush back to the lab and check
14 that again and keep checking it? Heck, no. I was given a
15 statin. The statin is supposed to lower your blood count of
16 cholesterol or lipids. It did that. I'm fine with that.
17 Right?

18 Similarly, if I went to McDonald's and had a cheeseburger
19 and went and got my blood work and it was higher, I'd ignore
20 that too, because I know it was the cheeseburger. Right? So
21 you have to understand when and why and how to interpret those
22 blood levels. That's why medical school is four years and the
23 residency is eight years in my case.

24 Q: I ignore abnormal lab values every day. I believe that's
25 what you just said at the beginning of that, Doctor.

1 A: Again, you might want to write context on that one --

2 Q: Okay.

3 A: -- because that's really important.

4 Q: I'll be happy to. Context. I'm pretty sure I'm spelling
5 it right.

6 Doctor, you didn't undertake -- well, let me ask this.
7 One of the bases of your opinion in this case is that if it
8 were a perfusion injury, if the cause of Crystal Goodwin being
9 in a wheelchair today was a perfusion injury, you would expect
10 there to have been other parts of the spinal cord that were
11 affected during the surgery; right? Maybe the cervical?

12 A: If by perfusion, you're saying the blood pressure;
13 correct?

14 Q: Right.

15 A: Yeah. That's correct.

16 Q: If it were a perfusion injury, you would expect other
17 parts of the spine such as the cervical spine to be affected;
18 correct?

19 A: No. I'm sorry if I wasn't clear on that. What I -- I
20 didn't mean that the lumbar spine and the cervical spine would
21 be affected. What I meant was the spinal cord is divided into
22 segments. You can say left, right, front, back, and those
23 have different functions. Right?

24 So if we're saying that there's not enough blood supply
25 to this part of the spine, I would expect the front and the

1 back and both sides to have the same effects. However, if
2 that spinal cord was previously compressed by an osteophyte
3 such that this part of the spine was more impacted, and then I
4 rushed blood into that, yeah, then I would expect that to be
5 different.

6 So to me, that was, I guess, you know, kind of cool
7 detective work to say, huh, it's interesting. She can feel
8 pinprick on the right, can't on the left. She can feel light
9 touch on the left, not on the right. That tells me that only
10 part of that was affected. Why would a global drop in blood
11 pressure from the heart only affect part of that? It
12 wouldn't.

13 Q: You wouldn't expect it to have some impact up here in the
14 cervical spine, would you? Because that osteophyte was way
15 down here; right?

16 A: Well, it would depend a little bit on the -- if there's
17 osteophytes in her cervical spine, but yeah, I mean, I wasn't
18 referring to the cervical spine.

19 Q: Well, they weren't removing osteophytes from the -- from
20 the cervical spine, were they?

21 A: No.

22 Q: Okay. So let's make -- let's make sure we're talking --
23 so they're operating down here; right?

24 A: Yes.

25 Q: And the cervical spine is up here; right?

1 A: Yes.

2 Q: Okay. And the main area of injury shown on the
3 neuromonitoring is in this area right here; correct? This
4 lower part of the thoracic spine?

5 A: Well, neuromonitoring actually doesn't dictate that.

6 Q: I'm sorry. Neuroradiology. The neuroradiology shows
7 that?

8 A: Correct.

9 Q: All right. And so if the spine was getting perfused --
10 if it were a perfusion problem, do you agree with me if there
11 were other parts of the spine that were impacted that were
12 affected, that would at least lend some credence to it might
13 be a perfusion injury; right?

14 A: Well, no, not necessarily because you're saying that at a
15 certain time point there may be other injuries. Right? Well,
16 that can happen from everything that's occurring in this case.
17 Right? What you really have to focus on is where is the
18 biggest injury, and you yourself just said it was in the
19 thoracic spine. So you really want to focus on the biggest
20 injury.

21 If there's other things going on, that may be true, but
22 that's not causing Ms. Goodwin's problems right now. So if
23 we're going to focus on sort of a red herring over here,
24 that's fine, but then I'm not willing to agree that that's the
25 cause of her problems, because the cause of her problems, as

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 you just said, is the major injury in the thoracic spine.

2 Q: Well, Doctor, the reperfusion injury you believe it
3 happened that -- your theory that there was a reperfusion
4 injury, it occurred right down here in the lower thoracic
5 spine; right?

6 A: Yes.

7 Q: Okay. I think we agree on one thing. It's your
8 testimony a reperfusion injury happened right around here?

9 A: Yes, and her deficits correlate exactly with that.

10 Q: Okay. All right.

11 MR. HINSON: Mr. Goings, would you please go to that
12 neuromonitoring record? All right. Are you on 53? It
13 switched. Yeah.

14 BY MR. HINSON:

15 Q: All right. So this is in central time because we're in
16 Tennessee. I think I said Memphis early, but I should have
17 said -- I should have said Nashville, the volunteer state. I
18 apparently don't know my geography very well.

19 So this is 10:17; right? It's really 10:17, which is
20 after the signal has gone out; right, Doctor?

21 A: Yes.

22 Q: We agree on that. And what does Dr. Herb Gregg say at --

23 MR. HINSON: Mr. Goings, we're not looking at this right
24 now. We'll get to that in a second.

25 BY MR. HINSON:

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 Q: What does -- what does Dr. Herb Gregg say at 10:17?

2 A: He says left upper is interesting. Looks like cervical

3 also affected but not much change in -- I don't know what that

4 is. E-R-Bs?

5 Q: Erb's? You don't know Erb's?

6 A: I don't know what it means.

7 Q: You know what Erb's palsy is, don't you, Doc?

8 A: I do.

9 Q: What is Erb's palsy?

10 A: Well, it's a palsy in the brachial plexus.

11 Q: Brachial plexus is up here; right?

12 A: Yes.

13 Q: Coming down?

14 A: Yes.

15 Q: Down your neck? The brachial plexus lets you --

16 A: Yeah.

17 Q: -- move your arm so you -- Erb's, don't you agree it

18 could be referring to the brachial plexus nerves?

19 A: It's kind of odd to talk about a palsy when you're doing

20 the monitoring, but if that's what he's referring to, you'd

21 have to ask him.

22 Q: You'd not heard the brachial plexus nerves called the

23 Erb's nerves sometimes?

24 A: I've never heard that, no.

25 Q: All right. Okay. But Dr. Herb -- Dr. Gregg Herb [sic],

1 the neuromonitoring physician, saw the cervical being affected
2 as well, didn't he?

3 A: Right. Well, the way neuromonitoring works is you're
4 looking at the signals going up and down the spinal cord. So
5 if you have a traffic jam at one end of the spinal cord, it's
6 not unexpected that you wouldn't find an effect of that at the
7 other end. Right? If you have a traffic jam on the highway
8 near your neighborhood, your neighborhood is also going to see
9 some of that traffic. So that could be one explanation. And
10 again, you'd have to ask Dr. Gregg. That could be one
11 explanation of this.

12 Q: He literally --

13 A: The other explanation could be is why would you suddenly
14 expect that the effect of a change would be all the way up in
15 the cervical spine, as opposed -- and yet not affect the
16 entire thoracic spine? Right? So if it's perfusion, why
17 aren't we affecting it here, but we're affecting it here?

18 Q: Doctor, couldn't it be the reason that we're getting some
19 effect here and a lot of effect here is because there's blood
20 vessels coming into the spine along the way and so you're
21 getting an area of low perfusion here and an area of extremely
22 low perfusion right here? Isn't that -- isn't that possible?

23 A: Except that the blood supply to those two areas is
24 entirely different.

25 Q: But if the blood pressure goes lower than the patient is

1 used to, all the blood supply could be impacted, couldn't it,
2 Doctor?

3 A: No.

4 Q: No?

5 A: Because the blood supply is entirely different.

6 Q: That's not how blood supply works?

7 A: In the spine, it's not. No.

8 Q: Doctor, you believe that she suffered a reperfusion
9 injury, not some sort of ischemic injury; right?

10 A: Well, to be clear, a reperfusion injury by flooding the
11 cord with blood and causing the swelling actually does lead to
12 an ischemic injury. It's just more focal, and that's why I
13 was sort of making the point about her exam, which she doesn't
14 have deficits in her arms. She has deficits about the lower
15 thoracic level. So it perfectly fits with that.

16 Q: Doctor, there is latency in neuromonitoring, isn't there?

17 A: Yeah. As I testified in my deposition, it can be at --
18 probably at most a couple of minutes.

19 Q: Is that what you said in your deposition, Doc, or do we
20 need to pull it out? Didn't you tell me --

21 A: We can -- we can pull it out. We -- I mean, I read it
22 this morning. I know what I said.

23 Q: And did you say 1 to 5 minutes back when I took your
24 deposition before?

25 A: I probably did start with 1 to 5, and then if we go on

1 and keep reading, I say something about a few minutes, but --

2 Q: Okay.

3 A: -- you know, 1 to 5. I mean, it depends on the system.

4 Q: All right. So we can agree 1 to 5 minutes of latency?

5 A: Well, if you look later in my deposition, you're trying
6 to push me to say 30, which is absurd, and then I say it's a
7 few minutes. I probably can find it here if you want me to
8 look.

9 Q: I'm just asking. Well, what do you -- what is your
10 testimony today, Doctor? How much latency is there?

11 A: A few minutes.

12 Q: A few minutes? And what do you mean by a few minutes
13 today?

14 A: A couple of minutes.

15 Q: Okay. So now we're down to a couple of minutes instead
16 of five. Okay.

17 A: Well, no, no, hang on a second. I said initially in my
18 deposition 1 to 5. When you asked for a clarification, I said
19 a few minutes. To me, a few is three.

20 Q: All right. Doctor, turn to page 30. I ask you there,
21 beginning on line 15 -- and I admittedly stammered a little
22 bit. That's kind of embarrassing.

23 I said, Doctor, but can you give me some sort of range of
24 what the latency can be? Can it be -- are we talking 1 to 5
25 minutes. Are we talking 7 to 30 minutes? What is the range

1 of what the latent -- what that latency ranges from?

2 That's what I asked you; right?

3 A: Yes.

4 Q: And then you gave me a long answer, and it ended with --
5 let's start on page 31, line 9.

6 You said, so, you know, again, it depends on the
7 particular technician and the machine, but it's certainly in
8 the range of 1 to 5 minutes, not in the range of 30.

9 Isn't that what you told me back in May?

10 A: Yes.

11 Q: Okay. And -- but now I want to just -- I want to know
12 where we're playing with the playing field today. Today the
13 playing field is 1 to 2 minutes?

14 A: No. That's -- I mean, sir, that's not what I said,
15 either in my deposition or here today. What I said was a few
16 minutes. There's other parts of this deposition where we go
17 through, and a few minutes in my definition is three minutes.

18 Q: Okay.

19 A: And again, it depends a lot on the machine. It's not 30.

20 Q: Okay.

21 A: Right? So if you have an old machine or a bad
22 technician, it might be five. If you have a reasonably good
23 one, it might be one, it might be 30 seconds. Right? So not
24 knowing the exact technique of the machine, which you could
25 ask somebody -- right? -- I'm giving you my global experience.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 Q: All right. So, Doctor, I don't think I misread it
2 though. You told me in May 1 to 5 minutes. That's -- that's
3 literally what you said; right?

4 A: Right. But I go on to clarify that.

5 Q: You go on to change your testimony and change it down to
6 --

7 A: I don't think that clarifying it to a few minutes is
8 changing my testimony. Sir, I don't think that's fair at all.

9 Q: So you didn't mean 1 to 5 minutes when you said it?

10 A: No. Sir, in the deposition, you were pushing me to 30,
11 and I said, that's absurd. It's somewhere between 1 and 5,
12 and then we went on to have a discussion, as we have today,
13 where I said it depends on the machine and it depends on the
14 technician. And I said it's a few minutes.

15 Q: All right. So by me asking you, are we talking about 1
16 to 5 minutes, are we talking about 7 to 30 minutes, that's me
17 pushing you to say 30 in your mind?

18 A: Well, you're the one who came up with 30, not me.

19 Q: Doctor, I just couldn't get a straight answer from you.
20 I was trying to learn what your testimony was.

21 A: It's a few minutes, depending on the machine and the
22 technician. I'm not wavering from that in my deposition to
23 here.

24 Q: All right. All right. Can we agree that at about 10:03
25 the signal is lost?

1 A: Yes.

2 Q: Do you agree on that?

3 A: I do.

4 Q: All right. And if there's a -- what do you mean by
5 latency? We're talking about a delay from the time of injury
6 to the time of its showing up on monitoring; right?

7 A: Not exactly. So let's just be clear on this.

8 Q: Okay. Please tell us.

9 A: The way these things work is they take an average. So as
10 soon as the injury occurs, it changes immediately. Right?
11 And this was a very quick injury. So it changes.

12 But let's say we're looking at something and we're
13 saying, well, it's a ten, it's a ten, it's a ten, now it's a
14 zero. Well, the average of what I just gave you is ten, ten,
15 ten, zero. That's 30 divided by four. Right? It's not ten
16 anymore, but it's like an eight or a nine. Then if it stays
17 at zero, that average keeps coming down. Right? And it
18 depends on how you're looking at it, how quickly the machine
19 is running these averages. Right? So if it's getting a ten
20 every five minutes. then it's going to take a long time when
21 it goes to zero for that average to change. But if it's
22 getting a ten every 10 seconds, it won't take long because
23 it's 10 seconds, 10 seconds, 10 seconds, boom. Right?

24 That's the latency. Right? It's not from the time of
25 injury because there's actually an immediate change at the

1 time of injury. It's just that the average changes over time.
2 Right? It's sort of like when the sun goes down, it gets
3 colder, but it won't get to freezing until the middle of the
4 night. But it's not like you didn't notice that it didn't get
5 colder. Right? That's what we mean by latency.

6 Q: Whatever happened to make the signal go -- go away at
7 around 10:03 was somewhere a few minutes earlier; right?

8 A: At the most.

9 Q: At the most? Somewhere -- somewhere earlier; right?

10 A: I can't see your --

11 Q: I'm just asking you somewhere a few minutes earlier?

12 A: At the most.

13 Q: Okay. Maybe like two minutes earlier?

14 A: Well, if you're circling the 77 --

15 Q: I am.

16 A: It's important to recognize again that the blood pressure
17 was higher in her prior surgeries and there was no change.
18 It's also important to recognize that where the yellow signal
19 loss is, her blood pressure is actually quite high.

20 Q: I actually have a copy of this chart, which y'all looked
21 at. I'll be happy to turn it around. And this blue line --
22 well, let's look at this. This little line here is the 2009
23 surgery; right?

24 A: I believe that's correct.

25 Q: All right. It was a whole lot shorter surgery; right?

1 It was only two hours and 19 minutes long; right?

2 A: Right. But if you look at the blood pressures that are
3 actually even below the 77 and you draw similar lines around
4 that, as I guess I think it says Dr. Lustgarten did, you'll
5 see that the time it was lower in that surgery, despite it
6 being a shorter surgery, is actually longer. So it's not only
7 a longer time that it was lower, it's a longer percentage of
8 the time that it was lower.

9 So when I looked at that, I said, well, why would more
10 low time in one surgery not produce a stroke and then a
11 shorter low time in another surgery, not produce -- or do
12 produce a stroke when they're both within the normal range?

13 Q: Doctor, my question was just it's a shorter time; right?
14 That's all my question was.

15 A: The surgery is shorter, but the hypotension is not
16 shorter.

17 Q: Okay. Two hours and 19 minutes is less than four hours
18 and a half; right, Doctor?

19 A: The surgery is shorter.

20 Q: Okay.

21 A: The period of hypotension is not shorter --

22 Q: Okay.

23 A: -- and represents a higher percentage of the shorter
24 surgery time.

25 Q: All right. And, Doctor, in 2019 -- or excuse me -- 2009

1 when this surgery was done, you don't know what her typical
2 average blood pressure was day to day at that time, do you?

3 A: You'd have to define that for me. I don't know how you
4 would assess that. To me, what was important was the
5 preoperative blood pressures immediately before the 2011
6 surgery because that was closer to 2016. So that's the one I
7 looked at, and it was higher.

8 Q: My question was, you don't know what her typical day-to-
9 day blood pressure was in 2009? Can you answer that question,
10 please, Doctor? It's a yes or no question.

11 A: I don't, but I thought that was less relevant than the
12 blood pressure immediately before surgery at the time of the
13 surgery that was closer to 2016.

14 Q: All right. So you're saying what her typical blood
15 pressure is isn't particularly relevant to your testimony?

16 A: That's not what I said. And I wish you wouldn't do that,
17 because it's not fair to me to restate something that's not
18 what I said.

19 Q: Well, that's why I'm -- to be fair, Doctor, I'm giving
20 you -- I'm trying to make sure we're on the same playing
21 field. I think I understand what you're saying, and then I
22 restate it and you tell me I'm wrong.

23 A: Well, you only restate part of it.

24 Q: Doctor, is -- is it relevant to your opinions what
25 Crystal Goodwin's blood pressure ran on a day-to-day basis

1 back in 2009?

2 A: It could be, but less relevant than the preoperative
3 blood pressure at a more proximal surgery in 2011.

4 Q: Okay. And, Doctor, in the 2011 surgery, which was about
5 the same length of time, the overall surgery; right?

6 A: Yes.

7 Q: The second half of that surgery, her blood pressure was
8 way higher than what Dr. Holbrook and his team kept it at in
9 2016, wasn't it?

10 A: Right. And in the first half, it was way lower,
11 actually.

12 Q: All right. But at this point, by the time the
13 neuromonitoring signal goes out right here, it was higher,
14 wasn't it? The neuromonitoring signal goes out right here,
15 and by that point in 2000 -- as far as length of time into the
16 surgery, it was way -- her blood pressure was way higher,
17 wasn't it?

18 A: Well, you actually didn't circle the area where the
19 monitoring went out. And if you do, you'll include that high
20 yellow bar, which is where her blood pressure was in 2016. So
21 if you really want to include what I guess your expert put as
22 the time the signal went out, the blood pressure is actually
23 really high.

24 Q: Well, there's the latency; right?

25 A: Of a couple of minutes, yeah.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 Q: Okay. Doctor, it's your testimony that a patient could
2 have a blood pressure with a mean arterial pressure in the 10s
3 before it would impact the kidneys; isn't that right?

4 A: Well, I remember that statement exactly, because it was
5 an example where you tried to restate something. What I said
6 was in the 10s, and you responded, you mean 10? And I said,
7 no, 10s, meaning like 50. That's exactly what I said in my
8 deposition.

9 So you took that sort of out of context and tried to
10 twist it. Obviously, 10, no, but in the 50s or the 10s, yeah.
11 I mean, the blood pressure has to be pretty low before your
12 kidneys stop. Your kidneys are pretty good at continuing to
13 work into very low blood pressures.

14 Q: Okay. So when you told me 10s, what you meant was 50s?

15 A: I think that's what it says on my deposition, literally.

16 Q: Okay. So 10s means 50s.

17 A: Well --

18 Q: Does 10s mean 20s and 30s, too?

19 A: Well, sir, to be clear, I mean, if you want to show me
20 the page, I'm sure I could find it or we can look, but I
21 literally said 50s. So for you to try to say that I meant
22 anything different when it's right here what I told you before
23 and you knew that coming in here seems odd to me.

24 Q: Well, Doctor, I think I've given you every opportunity
25 every time to explain what you meant, and if you ever think I

1 haven't, please let me know.

2 You have never required an anesthesiologist to
3 participate in a preoperative timeout, have you?

4 A: We also discussed this in my deposition.

5 Q: Can you answer my question yes or no, and then you can
6 explain it?

7 A: For a timeout, I have not.

8 Q: Okay. So the answer -- the question is never required an
9 anesthesiologist ever to participate in a pre-operative
10 timeout, and the answer is yes?

11 A: So let me be clear. For a timeout, yes, they always
12 participate. Well, let me -- let me -- let me make sure that
13 I'm clear. So a timeout is where we say, is this the right
14 patient, is this the right thing, and an anesthesia team
15 member does have to be there. So be it the CRNA or even the
16 resident, they have to be there. We check the patient's name
17 band, that kind of thing. So in that context, if that's what
18 you're asking, then yes, we do.

19 Q: Okay. My question is this, Doctor. You have never
20 required an anesthesiologist to participate in a preoperative
21 timeout?

22 A: Let me see where you're reading from, sir.

23 Q: I'd like you first to answer the question, and then you
24 can see if you kept it consistent with what you told me
25 before.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 A: Well, it is consistent because it's the facts of what we
2 do. So in our timeouts, which we say is this the right
3 patient, check their name band, the rules where I practice are
4 that an anesthesia team member has to participate in that,
5 just like a nursing team member. It can be the resident. It
6 can be the attending.

7 But in this case, just so that the jury knows, the
8 timeout has been construed to mean a pre-operative meeting,
9 and so in my deposition, I may not have been clear when that
10 question was first asked, which is why I'd like to see the
11 context. I'm not sure why I can't.

12 Q: Doctor, first, I want you to answer the question, and
13 then we can look at your testimony, I promise you. Is it true
14 that you have never demanded the anesthesiologist to be in the
15 room for the timeout? Yes or no?

16 A: I don't recall ever demanding the anesthesiologist to be
17 there.

18 Q: Okay. So I think you're consistent. So your testimony
19 is you have never demanded the anesthesiologist participate in
20 the timeout?

21 A: Right. Because that's not our policy.

22 Q: All right.

23 THE COURT: All right. Mr. Hinson?

24 MR. HINSON: Yes, ma'am?

25 THE COURT: I absolutely hate to interrupt anyone's

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 examination. Do you think you'll wrap up soon or can we take
2 a lunch break? It's after 1 o'clock.

3 MR. HINSON: I'd like a little more time. If I could
4 have one more question and then we'll take a lunch break?

5 MR. DAVIS: Your Honor, may I approach?

6 THE COURT: Yes.

7 MR. HINSON: Literally, one more question, then we can.

8 THE COURT: He may have some redirect though.

9 MR. HINSON: Well, I just meant one more question before
10 we break.

11 THE COURT: Oh, before? Yeah.

12 MR. DAVIS: Can we approach?

13 THE COURT: Yeah. I know you're on a roll, but --

14 MR. HINSON: Okay.

15 (WHEREUPON, a bench conference was held off the record,
16 after which the proceedings resumed as follows.)

17 THE COURT: Go ahead, Mr. Hinson.

18 MR. HINSON: Yep.

19 BY MR. HINSON:

20 Q: So, Doctor, I've never required that the anesthesiologist
21 participate in a preoperative timeout is a truthful statement;
22 correct?

23 A: Within the context that I gave you.

24 Q: What context is it? What context do we need to add to
25 this?

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 A: Well, defining when it says anesthesiologist, that that
2 doesn't mean anybody from the anesthesia team. And
3 preoperative timeout as I define it as we use it at Duke,
4 which is really looking at whether a patient is the right
5 patient and so on. So maybe we put context on that one as
6 well.

7 Q: I'll write context. Okay. I mean, I don't really think
8 there's much -- I mean anesthesiologist doesn't mean CRNA,
9 does it? Anesthesiologist means medical doctor; right?

10 A: Yes.

11 Q: Okay.

12 MR. HINSON: If you'd like to break, Your Honor, we can
13 take a break right now.

14 THE COURT: Yes, sir.

15 Ladies and gentlemen, we're going to break for lunch. I
16 typically wouldn't do that while a witness is on -- well,
17 during an attorney's examination, but I think Mr. Hinson plans
18 on going a little -- a good bit longer, and it's 1:07, 1:08
19 right now.

20 So let's take a lunch break until 2:30. Be back in the
21 jury room at 2:30. Don't discuss the case. Thank you.

22 (WHEREUPON, the jury exited the courtroom at 1:07 p.m.)

23 THE COURT: All right, folks. We're going to break for
24 lunch until 2:30.

25 I'm sorry, Mr. Hinson, for interrupting your examination.

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 It just didn't seem like you were coming to a close yet.

2 MR. HINSON: Your Honor, I totally understand, I do.

3 THE COURT: Okay.

4 MR. HINSON: I'm sorry I'm being so -- so long winded.

5 THE COURT: No, it is what it is. I just -- you know, I
6 -- had I sensed that you were coming to a close, then, you
7 know, I would have held out.

8 Dr. Sampson, I understand that means you are going to
9 miss a flight.

10 THE WITNESS: Yes.

11 THE COURT: But that just is the circumstance.

12 THE WITNESS: That's fine.

13 THE COURT: And, you know, hopefully you can push it to
14 later today without any real cost or -- or inconvenience, but
15 we are going to break for lunch until 2:30.

16 I'll see you all then. Thank you.

17 MR. GOINGS: Thank you, Your Honor.

18 MR. DAVIS: Your Honor, would you instruct the witness?

19 THE COURT: Oh, please do not discuss your testimony with
20 anyone. Not please. You are not permitted to discuss your
21 testimony with anyone during the lunch break. You can talk
22 about the weather, college basketball, whatever you want to
23 talk about, but not your testimony.

24 THE WITNESS: Thank you.

25 (WHEREUPON, there was a break in the proceedings, after

DR. JOHN SAMPSON - CROSS BY MR. HINSON

1 which the proceedings resumed as follows.)

2 THE COURT: Let's get Dr. Sampson back on the stand, and
3 please bring the jury. You can bring the jury first.

4 THE BAILIFF: Okay.

5 (WHEREUPON, the jury entered the courtroom at 2:50 p.m.)

6 THE BAILIFF: All jurors are now seated, Your Honor.

7 THE COURT: Thank you.

8 Still on cross-examination of Dr. Sampson?

9 MR. HINSON: Yes.

10 THE COURT: Go ahead, sir.

11 MR. HINSON: May it please the Court.

12 THE COURT: Yes, sir.

13 BY MR. HINSON:

14 Q: Dr. Sampson, this isn't the first time you've testified
15 in the courtroom on behalf of a doctor who was being sued;
16 correct?

17 A: That's correct. Nor would it be the first time that I
18 testified on behalf of a patient.

19 Q: And you have given testimony in 50 to 60 different cases,
20 haven't you?

21 A: Over a 20- to 30-year period, by deposition, but not in
22 trial, yes.

23 Q: Fifty to 60 times under oath you've given testimony?

24 A: By deposition over a period of 20 to 30 years, yes.

25 MR. HINSON: No further questions.

1 THE COURT: Any redirect?

2 MR. DAVIS: Yes.

3 REDIRECT EXAMINATION

4 BY MR. DAVIS:

5 Q: Dr. Sampson --

6 MR. DAVIS: Would you take this down, please? Take that
7 down, please. Thank you.

8 BY MR. DAVIS:

9 Q: Okay. Mr. Hinson asked you about the first deposition in
10 May of 2022.

11 A: My deposition in this case?

12 Q: Yes, sir.

13 A: Yes.

14 Q: Had you and I ever met before that deposition?

15 A: I don't believe so.

16 Q: Sometime after your deposition, late summer or early
17 fall, did I contact you and ask you would you be willing to
18 look at this case and give opinions to this jury about the
19 standard of care of Dr. Holbrook? Did I do that?

20 A: That's my recollection.

21 Q: What was your response to me?

22 A: I am reaching back and I don't pay all that much
23 attention, but my recollection is I said I can't because I'm
24 dealing with another lawyer in the -- in the case.

25 Q: And subsequently -- subsequently, did you agree to let me

1 retain you to be here today to give your opinions about Dr.
2 Holbrook?

3 A: Yes.

4 Q: Are you aware of the fact that I disclosed you as an
5 expert witness for Dr. Holbrook way back in sometime in 2022?
6 Were you aware of that?

7 A: I think so, yes.

8 Q: Okay. Any time after you said, yes, I'm willing to give
9 standard of care opinions for Dr. Holbrook, did you ever get a
10 contact by anybody that, hey, we want to take your deposition
11 and find out what you're going to say about Dr. Holbrook?

12 A: Not that I recall.

13 MR. DAVIS: Nothing further. Thank you.

14 THE COURT: Anything further from this witness?

15 MR. HINSON: One question, Your Honor.

16 RE CROSS-EXAMINATION

17 BY MR. HINSON:

18 Q: That other lawyer Mr. Davis was referencing had been Dr.
19 Root the anesthesiologist's lawyer; right?

20 A: I believe so.

21 MR. HINSON: Nothing further, Your Honor.

22 THE COURT: All right. Thank you, sir. You may step
23 down.

24 MR. DAVIS: May he be excused?

25 THE COURT: Any objection?

DR. STEVEN POLETTI - DIRECT BY MR. DAVIS

1 MR. HINSON: No objection.

2 THE COURT: All right, sir. You're free to go.

3 THE WITNESS: Thank you.

4 THE COURT: Mr. Davis, call your next witness.

5 MR. DAVIS: Thank you. I'd like to call Dr. Steven
6 Poletti.

7 THE BAILIFF: If you'll just --

8 THE WITNESS: Put this down?

9 THE BAILIFF: Yes, you can. And put your left hand and
10 raise your right.

11 THE WITNESS: Right here?

12 THE BAILIFF: Uh-huh.

13 THE CLERK: Do you solemnly swear or affirm that the
14 testimony you are about to give in this case will be the
15 truth, the whole truth, and nothing but the truth, so help you
16 God?

17 THE WITNESS: I do.

18 THE CLERK: Please state your full name for the record.

19 THE WITNESS: Steven Charles Poletti.

20 THE CLERK: You may have a seat, please.

21 THE WITNESS: Thank you.

22 DR. STEVEN POLETTI, being first
23 duly sworn, testified as follows:

24 DIRECT EXAMINATION

25 BY MR. DAVIS:

1 Q: Sir, would you introduce yourself to the jury?

2 A: Well, as I said, it's Steve Poletti. I'm a medical
3 doctor. I practice in Charleston, South Carolina. I went to
4 college and medical school in California. I graduated from
5 medical school from the University of California in 1985 and
6 then did an internship and residency at Duke University
7 Medical Center, where -- where John Sampson was -- when I was
8 chief resident was an intern in our Grey's Anatomy days, I
9 suppose.

10 And after that, I came to Charleston, and I co-founded
11 the Southeastern Spine Institute, where I've been practicing
12 for the past 31 years. So I'm an orthopedic surgeon, not a
13 neurosurgeon, and I think what makes my practice or our
14 practice a little bit different than a lot is -- is that
15 orthopedic surgeons classically will do broken bones and maybe
16 some fractures and then may have a specialty. Neurosurgeons
17 might do a brain surgery and spinal surgery, but I've never
18 done another operation than a spine operation, and -- and I
19 think that's what the insight I think I might have is, is
20 that, for whatever reason, when I -- when I started in -- in
21 Charleston, there was nobody doing spine surgery. Nobody.
22 Nobody was putting screws and rods in or treating scoliosis.
23 This was, you know, 1991, in a different time.

24 And as a consequence, I just did a lot of spine surgery,
25 a high volume. I'm not an academician, like -- like Dr.

1 Sampson or the other doctor that was the expert, I want to say
2 Dr. Lustgarten. I'm -- I'm just in the office seeing patients
3 and operating. And so, as a consequence, I've done a high,
4 high volume of spine surgery over -- over the past 31 years
5 there. And I don't say it to get a pat on the back, but --
6 but -- but -- but maybe there's 64-year-old doctors that have
7 done more spine surgery than me, but -- but I don't know who
8 they are.

9 And so what I often tell patients is that that may not
10 make me better at spine surgery, but I've got a unique insight
11 into how it turns out, and I feel like I've seen it all, and
12 that's why I believe they asked me to review this case and
13 talk about it with -- with you today.

14 Q: Are you board certified then in orthopedic surgery?

15 A: I am. I'm board certified in orthopedic surgery. Board
16 certification is an onerous process where you pass a written
17 exam and then go through an oral exam and then go through a
18 recertification process every ten years. So I've been board-
19 certified for 32 years and been through that recertification
20 process three times. So yes.

21 Q: Dr. Poletti, have you had occasion as part of your
22 professional experience as an orthopedic spine surgeon to
23 perform decompressive laminectomies in the thoracic spine?

24 A: Yes. I think I said that in the deposition. I've done
25 that -- that surgery many, many, many times.

1 Q: How many?

2 A: Gosh. In the thoracic spine, more than a thousand.

3 Q: Okay. How many total decompressive laminectomies do you
4 estimate that you have performed it so far in your career?

5 A: Probably 10,000.

6 MR. DAVIS: Your Honor, we'd like to offer Dr. Poletti as
7 an expert in orthopedic spine surgery.

8 MS. GOODING: No objection, Your Honor.

9 THE COURT: You may proceed.

10 BY MR. DAVIS:

11 Q: Doctor, any time I ask you an opinion about something,
12 will you agree with me ahead of time that you give those
13 opinions within a reasonable degree of medical certainty
14 unless you tell me otherwise?

15 A: Yes. That's fair, yes.

16 Q: All right. You have testified in plaintiffs' cases
17 before, have you not?

18 A: Yes. This is -- you know, my voice probably sounds kind
19 of nervous because this is only the -- the third time I think
20 I've testified in front of a jury and haven't done it for,
21 gosh, 10 or 15 years.

22 But in the course of seeing people that are injured with
23 their back, we see people that are injured in accidents or
24 injured at work, and often we're asked to do depositions,
25 which I guess are shown in court, but it's not like this. And

1 so I've done that. I've done depositions as an expert in --
2 gosh, you know, well over a thousand times. Those are
3 typically on patients that I've seen and treated though.

4 So this is a little bit of a nerve-wracking experience.
5 You're talking about a patient that is here that I haven't
6 seen, that I don't have a doctor-patient relationship with.
7 It's very humbling.

8 Q: The plaintiff attorneys that have asked you to do work
9 for them includes Mr. Goings?

10 A: Yes.

11 Q: More than -- more than once?

12 A: That's correct.

13 Q: Doctor, have you -- tell the jury basically what you've
14 had occasion to review in this case that helps to form the
15 basis of your opinions, in addition to your training and
16 experience and knowledge in orthopedic spine surgery?

17 A: Well, I have reviewed Ms. Goodwin's medical records, as I
18 think all the experts have. I've looked at her MRI scans,
19 which is especially important, and I've reviewed the
20 testimony, the depositions from Dr. Lustgarten, Dr. Sampson,
21 and then the anesthesia expert and radiology experts, two
22 radiology experts.

23 Q: All right. Did it also include the review of certain MR
24 images?

25 A: That's right. The MRI or magnetic resonance imaging. I

1 think -- I couldn't tell if they were showing those earlier,
2 but -- but I looked at those films directly, yes.

3 Q: Yes, sir. Dr. Poletti, have you formed an opinion
4 concerning the care provided by Dr. Holbrook to Crystal
5 Goodwin in the surgery performed on July 28th, 2016, as to
6 whether or not it met or was within the standard of care?

7 A: Yes. Again, Ms. Goodwin had to do this surgery. This
8 operation is done in a critical area of the spinal canal.
9 It's at the tip of the spinal canal, the -- the lower part of
10 the thoracic spine.

11 It's kind of hard to verbalize it, but the spinal cord
12 ends in your -- in the upper part of your low back, and then
13 it's just a collection of nerves, but as you get down to the
14 bottom of it in this T9, T10, T11 region of the thoracic
15 spine, that is an area where if you have compression and
16 you're losing feeling in your legs and having difficulty
17 getting around and you have that compression or stenosis,
18 that's what they call the narrowing or stenosis, if you don't
19 get it fixed, it's going to get worse and -- and be
20 catastrophic.

21 And so Ms. Goodwin had no choice but to do the surgery,
22 and I think everybody agrees with that. I read Dr.
23 Lustgarten's deposition and Dr. Sampson's. I mean, there
24 would be universal consensus among neurosurgeons and spine
25 surgeons that it was -- it was go time. She didn't have a

1 choice.

2 Q: Do you have an opinion on whether or not Dr. Holbrook in
3 performing that surgery met or was within the standard of
4 care?

5 A: Yes. So Dr. Holbrook did the surgery from a technically
6 successful satisfaction rate. Again, if we have trouble when
7 we're operating around the spinal cord, if we get in the wrong
8 place or have a complication, very often we see something
9 called a cerebrospinal fluid leak.

10 So the spinal cord is held in by something that looks
11 very much like a water balloon, and this surgery is -- it's --
12 it's tricky. It's almost like peeling sticky bubblegum off a
13 water balloon. It's hard to explain, but you're under a
14 microscope. And if you have a problem, if you have a
15 technical error, not always, but almost always you'll see a
16 leak of spinal fluid. It will come out dramatically.

17 And so no CSF leak. The surgery was performed in a
18 technically good fashion, and you could see on the post-op MRI
19 that -- that it was well what we call decompressed. That's
20 when we take the pressure off of the spinal cord. It looked
21 well decompressed.

22 Q: Is that the goal of that surgery to decompress it?

23 A: That's right. It's, you know, circular and you kind of
24 open it up so that it's U-shaped. You give that back end of
25 the cord more room.

1 Q: Doctor, in your opinion, if this operation had not been
2 performed, if for whatever reason the patient decides, you
3 know, like, I don't want to, I don't want to do the surgery,
4 if -- if that had happened, hypothetically, do you have an
5 opinion what -- what most likely would have happened to Ms.
6 Goodwin?

7 A: Right. It would have led to a progressive what we call
8 paresis or weakness. If, you know, she was stranded somewhere
9 and didn't have the surgery, any patient, was they'd develop
10 progressive what they call paraparesis, not be able to use
11 their legs.

12 Q: Doctor, do you have an opinion on whether or not Ms.
13 Goodwin would have needed additional surgeries after Dr.
14 Holbrook's surgery on July 28th, 2016, even in light of the
15 complications she suffered?

16 A: Well, this is the tough thing about spine surgery in this
17 -- this region. Again, Ms. Goodwin had stenosis, and I think
18 that Dr. Sampson talked about some of it was from arthritis,
19 but some of it was from birth. And -- and so when you have a
20 spinal canal that's normal size, that's one thing, but when
21 it's narrow to begin with, that's another.

22 So she had a spinal canal that was narrow to begin with,
23 and what happens with spine surgery is that you can sometimes
24 get what we call a domino effect, meaning that you operate on
25 one level, and it leads to the next level having more pressure

1 against it and it goes bad. I think that almost everybody has
2 heard of somebody that said, oh, don't ever have back surgery
3 because you have one and then you have another and then you
4 have another. And -- and -- and that's true for some people,
5 especially people with congenital stenosis.

6 And so when you're born with a narrow spinal canal, you
7 can almost count on -- on having another operation. And
8 again, that's why Ms. Goodwin, even after this operation in
9 2016, had that second -- or I'm going to call it fourth
10 surgery, then by Dr. DeHoll, who's a spine surgeon here in
11 Columbia. So although you can't say for sure, it won't
12 surprise me if she has another.

13 Q: Doctor, do you know what a reperfusion injury is?

14 A: I do. You know, I call reperfusion injuries a tourniquet
15 effect injury. And, you know, I was a boy scout, and when you
16 put a tourniquet on an injury, they tell you that to release
17 the tourniquet every 30 minutes. Right? If you've ever been
18 through Boy Scout training, they tell you that. And the idea
19 is, is that if you leave a tourniquet on for a long period of
20 time and then let it off, your arm will fill up with
21 reperfusion or blood, and then it will start to swell. I
22 thought that analogy that Dr. Sampson gave was a pretty good
23 one, like water going into a sponge. When water comes into
24 the sponge, it's going to get bigger.

25 And so reperfusion injury is when an area is tight, like