

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 III

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

1 that tourniquet effect, and you let the tourniquet out, you
2 take the pressure off, you let the tourniquet out, blood flows
3 in and it creates that swelling, and it's that swelling that
4 -- that creates that fluid.

5 And so with a reperfusion injury, it's kind of hard to
6 explain on an MRI, but MRIs image hydrogen. That's what
7 they're looking at. They're looking at hydrogen. Anything
8 with high hydrogen is bright white. What has high hydrogen?
9 H₂O. Right? Two hydrogens in water, and so anything with
10 edema or water in it images bright white, and so that hallmark
11 of a reperfusion injury is seeing that bright white cord right
12 afterwards. Almost can't be anything else.

13 And so that's a -- maybe getting off the subject a little
14 bit, but a big part of my opinion is that Dr. Holbrook scanned
15 her right -- right post-op, and she was whited out there, and
16 that white out has to be reperfusion. I don't know if it has
17 to be, but it most likely is a reperfusion.

18 MR. DAVIS: If we could show the animation?

19 BY MR. DAVIS:

20 Q: Excuse me, Doctor. I'm going to show you something here
21 and then ask you to comment on it.

22 (WHEREUPON, an animation was shown.)

23 BY MR. DAVIS:

24 Q: Okay. Are these drawings consistent with the
25 preoperative MRIs?

1 A: That's right. The spinal canal should be a circle, and
2 that bone spur on the right is -- is digging into the right
3 part of the cord. And that shows how the cord looks when it's
4 been decompressed.

5 Q: And is that the -- the tourniquet effect that you were
6 talking about?

7 A: Right.

8 Q: It expands?

9 A: Right. Again, that's what I call it. I think
10 reperfusion is the medical term. I just, you know, can't get
11 away from that tourniquet effect where it's just how I see it.
12 It just swells up.

13 MR. DAVIS: Thank you, Andrew.

14 BY MR. DAVIS:

15 Q: Doctor, in your opinion, can a reasonably competent,
16 prudent spine surgeon predict when or what patient is going to
17 suffer a reperfusion injury before the surgery begins?

18 A: No. No, you can't tell. It's a risk in these sensitive
19 areas of the spinal cord. The end of your spinal cord in the
20 lower thoracic region is probably the highest risk.

21 Q: And is that that swelling or edema I think the
22 radiologist calls it in his report on that MR after the
23 surgery? Is that what -- what causes the damage to the cord,
24 or is it the blood coming back in?

25 A: Right. You just don't get the signals through the cord

1 because the nerves swell up and the signal doesn't get
2 through. That's at least how I look at it.

3 Q: And does the swelling of the spinal cord in a situation
4 from a reperfusion event, like in this case, have the
5 potential to cause permanent neurologic injuries, similar to
6 that which Ms. Goodwin has suffered?

7 A: It did. And again, I apologize again for talking about
8 Ms. Goodwin while she's sitting here, but when she -- when she
9 woke up from the surgery, at least according to the records,
10 she had complete paraparesis, couldn't move her legs at all.

11 I think Dr. Lustgarten in his deposition categorizes it.
12 There's categorization. He called it A, ASIA A, a neurologic
13 deficit, which means that she can't move anything, but
14 reperfusion injuries are swelling injuries, and so they have
15 the ability to improve, maybe not be cured, in fact, probably
16 not cured, but improve. And that's why over that first 30-day
17 period, she went from not moving anything to moving something,
18 from not being able to get out of bed, ultimately to being
19 able to use a rolling walker or assistive devices.

20 And so one of the hallmarks of a reperfusion injury is
21 that statistical chance that it could improve. If this was --
22 again, these are complicated medical terms, but if it was an
23 ischemic injury, meaning if she stroked out her cord, that'd
24 be it. It wouldn't come back and -- and she'd be, you know,
25 that way and not better. It just couldn't come back.

1 So, again, the basis of my opinion of a reperfusion
2 injury is you see that white out right after the surgery, and
3 she gets a little bit -- you know, I don't want to make it
4 sound like it's a home run or anything because it's tragic,
5 but -- but she gets a little better. She goes from complete
6 paralysis to having some -- some movement. That improvement
7 in that immediate white out is -- is what's involved in a
8 reperfusion injury.

9 And again, you know, I'm not a hundred percent sure. You
10 know, I heard that one of the doctors said he was a hundred
11 percent sure. I'm not a hundred percent sure about anything
12 in spine surgery, but -- but -- but I think that's probably
13 what happened. That's probably how it went down.

14 MR. DAVIS: Pull up the -- the board with the -- it shows
15 the surgery, the 4 or 5. Yes.

16 BY MR. DAVIS:

17 Q: And looking at this illustration, this drawing, assuming
18 this is the operative field, where's the spinal cord?

19 A: Well, I guess I cannot have a pointer, but the spinal
20 cord is the inside part in between the -- the bones called the
21 lamina. And so the lamina are the bones over the spinal cord,
22 and that's why removing the lamina is called a laminectomy.

23 Q: Okay. Can the operating surgeon see the spinal cord in
24 this kind of an operation?

25 A: Right. That's -- that's the whole operation, if you

DR. STEVEN POLETTI - DIRECT BY MR. DAVIS

1 will. It's to see the spinal cord, and so the surgery is make
2 your incision. Again, this is a tough surgery in a redo
3 setting. And then you usually have to use a high-speed drill
4 to drill down that bone. And then you have special little
5 devices called rongeurs that sort of bite that last bit of
6 bone off of the cord and -- and free it up to get a good look
7 at it.

8 MR. DAVIS: Can you pull that up?

9 MR. HEITMAN: Yeah.

10 MR. DAVIS: That's why I let somebody else do it.

11 THE WITNESS: I do it the same way.

12 MR. DAVIS: There we go.

13 BY MR. DAVIS:

14 Q: Talking about rongeurs, is that that big word there?

15 A: Right. Yeah. That big rongeur to take the big bones out
16 is called a Leksell rongeur, but you don't want to use that
17 right on the cord.

18 (WHEREUPON, defense counsel conferred off the record.)

19 MR. DAVIS: Okay. That's fine. Okay. I know it
20 disappeared, but that's okay. It's just technical stuff. Can
21 you pull it up again?

22 MR. HEITMAN: I will try to.

23 MR. DAVIS: There we go. Let's see how long we can keep
24 going.

25 BY MR. DAVIS:

1 Q: If a reperfusion injury happens at some point in the
2 operation, would it be most likely at the point in time where
3 you're removing the pressure, you're decompressing the spine?

4 A: That's right. After it opens up, it's, you know, kind of
5 hard to say if it would happen. To me, it's sort of like
6 Jenga, you know, when you're slowly taking the pressure off of
7 the -- the cord and then -- then -- then it all falls down.
8 That's sort of how it happens, I think.

9 Q: Can you, as the operating surgeon, see reperfusion
10 happening inside the cord?

11 A: Not really, no. I mean, sometimes you can see the
12 vessels and the cord beating, but -- but not so much there.

13 Q: Once a reperfusion injury happens, as the operating
14 surgeon, if you assume, just for the sake of this
15 hypothetical, that you -- oh, yeah, this must be reperfusion
16 and your field is open, is there anything you can do to
17 reverse it to get it back to where it used to be?

18 A: Well, I don't know how you could guess a reperfusion
19 injury is happening any -- any other way but Monday morning
20 quarterbacking it. You know, again, there's been a lot of
21 talk about the signal -- signals going out. You know, the
22 signal going out is -- is like your DirecTV going out, and the
23 first thing you do is check to make sure it's plugged in. And
24 then usually if you reboot your DirecTV, it'll come back on
25 its own.

1 You never think when the DirecTV goes out that the --
2 that the dish was hit by lightning, you know, but that's sort
3 of what a reperfusion injury is. It's -- it's a rare event.
4 It's just a catastrophic thing in many situations, but -- but
5 when the signal goes out, you usually don't think it's a, you
6 know, catastrophic event because it usually isn't.

7 Q: When a reperfusion injury happens, can that -- when that
8 happens, can -- can that result in a very sudden change to the
9 patient as far as her nerves, the signal?

10 A: Right. I think that the signal -- we've talked about how
11 the signal goes out. And again, I think that the reperfusion
12 happens gradually and then reaches a point where it's just
13 overwhelming, sort of like the Jenga puzzle following a boom.
14 It happens, at least those are the way that I've, you know,
15 seen it.

16 So I think a lot of people talk about this latency, and
17 -- and I don't hold myself out as an expert on -- on
18 neuromonitoring, but I use neuromonitoring on every spine
19 case. I know that some people have said they just use it on
20 important spine cases. I don't know what that means. I use
21 it on every spine case.

22 And -- and, yeah, I've seen the signals go out a number
23 of times when it turns out that nothing is wrong. You have a
24 very unsettled 15 or 20 minutes or sometimes an hour, and then
25 -- then the patient wakes up and they're neurologically

1 intact. So neuromonitoring is a hard thing to -- to gauge.

2 People talk about this latency is how long after the
3 insult happens does it take for the signal to go out, and I'm
4 not sure that anybody knows for a reperfusion injury. I think
5 that they were asking, is it 2 minutes? Is it 5 minutes? Is
6 it 30 minutes? I don't know.

7 I do know if you cut the nerve, it would be right away,
8 but the reperfusion injury, how long it takes to -- to be
9 noticeable on the SSEP, I don't know that anybody knows. I
10 sure don't know.

11 Q: Okay. And in looking at this case, what do you
12 understand Dr. Holbrook did when he was notified that the SSEP
13 signal, the only signal they had at that time, just suddenly
14 went out and he was notified about it? What do you understand
15 he did?

16 A: Right. So, you know, I think I said this in my
17 deposition. That's like being in the cockpit, and the check
18 engine light comes on. And as a -- as a surgeon, you've got
19 to keep cool in that situation. You've just got to go through
20 your checklist.

21 First, you go to the monitoring techs and make sure that
22 everything is right with the monitoring, because you'd be
23 surprised that sometimes it's not right and sometimes they
24 have to check the wires. You know, with this you actually put
25 needles into their arms and legs, and sometimes that can be a

1 problem. So you go through that and make sure the monitoring
2 is okay.

3 And then you look at the field. And so the -- the thing
4 that you worry about that maybe you could correct if the
5 signals go out is that something is sticking in the cord, and
6 what it could -- what it could be is more bone spurring. It
7 sometimes is, is when you take the pressure off the cord, it
8 starts expanding up, and it's still digging into that bone
9 spur that you haven't completely gotten out. So you want to
10 look at that.

11 And then the other thing is that the blood vessels on the
12 cord under the cord are called epidural blood vessels. That's
13 the term for it. And sometimes they can bleed, and when they
14 bleed, they can create a hematoma, and that hematoma can choke
15 the cord. And so I'm sure that Dr. Holbrook scanned the field
16 to make sure there's no bone spurs on the cord, make sure
17 there's no epidural hematoma. Go through that signal check
18 with the tech there.

19 And if that's it, usually you feel pretty good about it.
20 I mean, at least, you know the times that it's happened to me,
21 I feel pretty good about it. Well, you know, it likely is not
22 a catastrophic injury because everything looks good here and
23 there's nothing wrong, but, obviously, in this case, it wasn't
24 that way.

25 Q: In your opinion, Dr. Poletti, did the standard of care

1 require Dr. Holbrook -- when the signal was announced that it
2 went out and was confirmed, no, the machine is working
3 appropriately and the signal is still out, did the standard of
4 care require him, in your opinion, to ask the M.D. anesthesia
5 to come to the O.R.?

6 A: Well, you know, the M.D. anesthesia is in the O.R.,
7 meaning that if you've ever been in an operating room, there's
8 often a CRNA or a nurse anesthetist in the room the whole
9 time, and the anesthesiologist sort of circles through, and I
10 don't know that it's as, like, paramilitary as is maybe Dr.
11 Lustgarten made it sound, like call the anesthesiologist now.

12 You know, I just think there's a little bit of shared
13 decision making. You probably will ask the anesthetist
14 everything okay up there, but, you know, I think if the
15 signals stayed out, you might -- might, you know, mention it
16 to her. Maybe you want to let the anesthesiologist know, but
17 I wouldn't have some insistence that they come into the room
18 immediately because -- because they can't fix it.

19 Q: Did the standard of care, in your opinion, require Dr.
20 Holbrook to tell the anesthesia -- anesthesia person, CRNA in
21 the room, increase the blood pressure?

22 A: Well, this blood pressure issue -- and I get it. It's --
23 it's the other opinion in this situation where -- where the
24 contention is that -- that somehow hypotension is what -- what
25 caused -- caused this.

1 And I think I mentioned this in my direct deposition, but
2 I've been doing that for 32 years. I'm sure I've done 15,000
3 spine operations. And Dr. Lustgarten had been doing it for 40
4 years, and -- and he said he'd done 8- or 10,000 spine
5 operations. So between us, it's 75 years of experience in
6 25,000 cases, and neither of us have ever seen it.

7 Q: Seen what?

8 A: Seen an ischemic event from hypotension cause cord
9 infarct. Never. Not once. And so why here? Why this case?
10 Why this one? Why are -- why are you a hundred percent sure?
11 I think that's what he said, a hundred percent sure that
12 that's what happened, and something that you've never seen,
13 that I've never seen.

14 And again, it's possible. It's possible, but I think
15 it's unlikely. And so I don't -- her blood pressure just
16 didn't bounce that dramatically. I'm not a blood pressure
17 expert. You don't want an orthopedic surgeon dealing with
18 your blood pressure, but it just didn't bounce that much, I
19 didn't think and -- and, you know, especially here. Shoot, in
20 South Carolina, I bet you half the patients I operate on have
21 hypertension, and I've never seen it.

22 And I figure -- and again, this isn't to brag or anything
23 like that, but I've done so many of these that I figured if
24 anybody would see it, it would be me. And -- and so that's --
25 that's why I didn't think that he had some need to increase

1 the blood pressure. It would have never occurred to me.

2 Q: What's a -- what's a wake-up test?

3 A: Well, you know, wake-up test, I think I kind of
4 facetiously said that wake-up test is 1975. But a wake-up
5 test is a test that we used to do on kids with scoliosis,
6 where you put the rods in, and in the old days -- and I'm old
7 enough for the old days.

8 We used to put hooks into the spinal canal and then
9 almost put it on a rack and pull their spine up. Now you put
10 screws in and de-rotate it. It's different now. It's safer
11 now, but in the old days we would just really distract that
12 spinal cord. And this is before monitoring was -- was really
13 popular.

14 And so then what we do -- and they did this a little bit
15 at Duke in the '80s, but lighten up the anesthesia and have
16 the child wiggle their toes. But I haven't seen it done
17 since. I think I saw it done once at the Med U, the Medical
18 University of South Carolina, in like '92, but -- but I
19 haven't seen it since. I don't know anybody that's doing it.

20 Q: In your opinion, did the standard of care require Dr.
21 Holbrook to perform a wake-up test in the operation?

22 A: Right. Yeah. In 1985, it would have, but -- but not in
23 2016.

24 Q: There's been a lot of talk about low urine output. I
25 want to ask you your opinion about urine output in this

1 surgery and then just urine output generally. In your
2 opinion, was there low urine output in this case?

3 A: It might been a little low. I mean, again, I think that
4 they said they thought urine output should be 60cc an hour.
5 I've often looked at 30 of being the urine output, but it's
6 not dramatic loss of urine output. I think that Dr. Sampson
7 spoke to that earlier. About 80, you know, for a four-hour
8 prone case, it -- it just doesn't, like, send off any alarms
9 in my head.

10 Q: Have you ever had an experience with a sudden loss of
11 signal, similar to what happened in this operation on July
12 28th, 2016?

13 A: Right. Yes. Yes, I sure have.

14 Q: Explain what you do and what you did when that happened?

15 A: Well, again --

16 Q: It was like 50 times in your experience?

17 A: Right. I bet you it's happened 50 times. Shoot, it has
18 happened during a posterior cervical last week, that -- you
19 know, in that situation, I was in there with one of my
20 partners doing a posterior cervical laminectomy.

21 And the way sometimes you do it in the -- in the neck is
22 to what they call eggshell it out, meaning that you cut around
23 the cord and you drill that bone off, and then you try to lift
24 it up in one piece so that you don't tug on the cord at all.
25 And in the process where we're lifting up that lamina, the

1 signals go out.

2 Now, that'll get your attention. Looked at it, went
3 through the checklist with the -- the monitoring tech. Again,
4 I think they spoke to this, but the monitoring tech -- they
5 must all be in Tennessee because our -- our monitoring tech is
6 in Tennessee. Checked with the neurologist.

7 Checked to make sure that they haven't gotten a paralytic
8 from the anesthesiologist. It's something that if they give
9 you a paralytic, something that paralyzes your nerve function
10 during the surgery, it'll make the signals go out, and -- and
11 then you just make sure there's nothing pressing on the cord
12 and close it up.

13 But we had kind of a, you know, heart-wrenching 45
14 minutes there, but -- but, you know, it happens sometimes.
15 And fortunately, there was nothing. The patient woke up and
16 -- and like I said, I liken it to that DirecTV signal going
17 out, and usually you can just reboot it and usually it's not
18 anything drastic. Catastrophic loss of signal in the absence
19 of direct spinal cord injury is -- is just, you know, unheard
20 of, but it -- but it's described.

21 Q: Doctor, regarding the theory that Crystal Goodwin had low
22 blood pressure that caused her injury, do you have an opinion
23 whether or not low blood pressure caused the injury to Crystal
24 Goodwin on July 28th, 2016?

25 A: Right. I think I said this before that when we're asked

1 to say what our opinion is to a reasonable degree of medical
2 certainty, it means what do you think most likely happened,
3 how do you think all this really happened, and -- and it's
4 possible that hypotension could cause this. It's within the
5 realm of possibility, but it's something that, like I said,
6 I've never seen. Dr. Sampson said he'd never seen it. Dr.
7 Lustgarten said he'd never seen it. I don't know anybody
8 who's ever seen it.

9 We have seen reperfusion injuries, injuries where the
10 cord whites out when you image it right afterwards, where
11 someone has a neurologic deficit that gradually recovers. And
12 so, you know, we're Monday morning quarterbacking this thing.
13 What do you think likely happened in retrospect?

14 And yeah, her cord whited out in the MRI an hour post-op,
15 and she regained function. Not complete function, don't get
16 me wrong, but she regained function over the course of 30
17 days. And there's that old saying in medicine, common things
18 are common. What's the most common thing that could happen?
19 It would be a reperfusion injury. Is -- is hypotension a
20 possibility? It's a possibility, but it's not very high on my
21 list.

22 Q: In your operating room or in any operating room where
23 spine surgery is being performed, whose responsibility within
24 their area of expertise is it to monitor -- monitor vital
25 signs?

1 A: Right. I think that everybody would say, well, sure,
2 that's -- that's the anesthesiologist's responsibility.

3 Q: And vital signs would include things like pulse rate?

4 A: Right. Pulse rate, blood pressure. I mean, as you
5 probably know, they can measure the percentage of carbon
6 dioxide you exhale with every breath. So all those things are
7 anesthesia.

8 Q: Okay. In your opinion, did anything that Dr. Holbrook do
9 or anything he failed to do, do any -- either one of any of
10 those categories, in your opinion, cause or contribute to this
11 injury suffered by this patient?

12 A: Right. Again, I don't think that there's anything that
13 Dr. Holbrook could have done differently. To begin, operating
14 on her, it was a big risk. She had a catastrophic problem.
15 She had two prior thoracic surgeries, had congenital stenosis,
16 is diabetic, has on top of that severe degenerative changes.
17 I think Dr. Sampson described them as the knuckles. I'm going
18 to start using that.

19 And so her surgery, like I said, it was tough, and -- and
20 I think he did a good job with the operation. It's just
21 catastrophic that -- that this happened. I don't think it was
22 something that he could have done differently though.

23 MR. DAVIS: Thank you, Dr. Poletti.

24 THE WITNESS: Thank you.

25 THE COURT: Ms. Gooding?

DR. STEVEN POLETTI - CROSS BY MS. GOODING

1 MS. GOODING: Thank you, Your Honor. May it please the
2 Court.

3 CROSS-EXAMINATION

4 BY MS. GOODING:

5 Q: Good afternoon, Dr. Poletti.

6 A: Good afternoon.

7 Q: It's good to see you.

8 A: Thank you.

9 Q: Just as a point of clarity, Doctor, I believe you said
10 this earlier, but you're not a neurosurgeon; correct?

11 A: That's right. I'm an orthopedic surgeon.

12 Q: Okay. And, therefore, you would not be board certified
13 in neurosurgery or neurology either?

14 A: Right.

15 Q: That follows.

16 A: Sure.

17 Q: And in layman's terms, we might call an orthopedic
18 surgeon a bone doctor? Is that kind of how it's known?

19 A: Right. Right.

20 Q: I don't mean any insult, just to make it easy for
21 everybody.

22 A: No. I think that at least with spine surgery, again, you
23 know, in the '80s, there was more of a delineation of
24 neurosurgeons did the nerve work and orthopedic surgeons did
25 the bone work. And I think all that sort of was that way in

1 the '80s and -- and kind of came together with -- frankly,
2 with my generation. I think I was one of the first orthopedic
3 surgeons to do a fellowship where they call it post-surgical
4 training with neurosurgeons. I operate with a neurosurgeon
5 now. Right? You know, my partner is a neurosurgeon.

6 And so -- but you're right. I'm not a board-certified
7 neurosurgeon. I've never done a brain operation. But by the
8 same token, I've never treated a broken bone except in the
9 spine.

10 Q: So you've chosen to focus your practice on spinal
11 surgery; is that right?

12 A: Right, right. That was, like I said before, kind of that
13 unique part of our practice.

14 Q: And Mr. Davis asked you about occasions that you've had
15 to work with my firm; correct?

16 A: That's right.

17 Q: And in those instances, were -- were you the doctor who
18 was treating the injury that perhaps one of our clients had
19 suffered?

20 A: That's right. Like I said, this is, you know, maybe the
21 third time I've ever, I guess, even in a deposition or in
22 court, testified about somebody who wasn't my patient.

23 Q: I understand, Doctor. And you -- the jury has heard
24 about this several times already, but as an expert witness,
25 you're being paid for your time here; correct?

1 A: That's right.

2 Q: And what is your rate for appearing at trial?

3 A: You know, I don't know. I know that sounds horrible. I
4 agreed to do this, but never really set a fee. I presented a
5 fee schedule at the -- at the deposition that our practice
6 had, but -- but I don't know what it is.

7 Q: Okay. Well, I'll help you out with that a little bit.
8 I've got a copy of your fee schedule. It actually does not
9 have trial appearance on here, so you might have to add that.

10 A: Right. Because, like I said, I haven't done it, but --
11 but three times.

12 Q: According to your fee schedule, it indicates that your
13 deposition rate is \$1,500 an hour. Does that sound right to
14 you?

15 A: That is right.

16 Q: Okay. And for an attorney conference, it charges per 15
17 minutes, and that rate is 300. So per hour, it would be a
18 \$1,200 an hour rate; is that right?

19 A: Yes.

20 Q: But you're charging in increments of 15 minutes?

21 A: That's right.

22 Q: Okay. And then for review of medical records, the rate
23 indicates \$500 an hour; is that right?

24 A: Right, right. I -- honestly, I haven't reviewed it
25 itself, but it's something that -- that I think Dr. Johnson

1 and I put out a few years ago and just --

2 Q: Would you like to see it, Doctor? I'm happy to hand it
3 to you.

4 A: No. I mean, I know I turned it -- I turned it over, I
5 think, in the deposition, so I'm sure it's accurate.

6 Q: You did. And I'll just -- I don't want you to think I'm
7 tricking you.

8 A: No, no. Thank you.

9 Q: So we've got 1,500 an hour for deposition, \$1,200 an hour
10 for attorney conference, and \$500 an hour as listed on the
11 rate sheet. It says it's effective 2018. Do you think this
12 is the same rate sheet that's still -- y'all are still using?

13 A: Right. I haven't changed it. So --

14 Q: Okay. Great. Now, I did not have an opportunity to see
15 you at your deposition in this case, but thankfully, I have
16 been able to read the transcript, and I think that there's
17 actually quite a lot that we can agree on. So I just would
18 kind of like to walk through some of those things and just
19 make sure that I'm understanding your opinion.

20 A: All right.

21 Q: And I want to start by talking again about what surgery
22 was done and what we were kind of trying to -- to remedy with
23 the surgery. And so if we can pull up the image, and these
24 are some of the images similar to what you were looking at
25 with Mr. Davis just a minute ago. They put these together.

1 We thought they were so good that we thought we would look at
2 them as well.

3 And so Dr. Holbrook did a decompressive laminectomy on
4 Ms. Goodwin in 2016; correct?

5 A: That's right.

6 Q: And we -- he was treating her for spinal stenosis or that
7 narrowing that you've been telling us about; right?

8 A: Right.

9 Q: And then there was also this osteophyte. Can we call
10 that a bone spur? Is that kind of a fair --

11 A: Right. That's what osteophyte is, yeah.

12 Q: Okay. And so this osteophyte is putting pressure on the
13 cord at this area; right?

14 A: Right. Kind of moving it to the right.

15 Q: Okay. And this is -- this blue part here is labeled as
16 the T8-9 disc. So I take it that that's this blue area
17 between T8 and T9?

18 A: Right.

19 Q: And then the -- the bone underneath it or the vertebra
20 underneath it would be T9; correct?

21 A: Correct. Below it.

22 Q: Below it? Right. And so that -- that's the level we
23 were looking at that osteophyte?

24 A: Right.

25 Q: And that's one of the -- was one of the primary things

1 that Dr. Holbrook would have been doing in this decompression
2 would be to remove that bone spur?

3 A: Right. Like I said, you kind of drill it down, and then
4 when it's thin enough, bite it out. Well, one of those little
5 biters.

6 Q: I'm thankful you have a tool for that.

7 A: Yeah, there's a special tool for it. Yes. It's called a
8 Lex -- a Kerrison rongeur. Yeah.

9 Q: It sounds a little scary when you say bite it out.

10 A: Yeah, I know. It is a little scary.

11 Q: And, Doctor, you agreed in your deposition that using
12 neuromonitoring for a laminectomy in the thoracic spine, like
13 what Crystal Goodwin had, was the standard of care in 2016;
14 correct?

15 A: Oh, absolutely. Yes. Like I said, I personally use
16 neuromonitoring on every surgery I do.

17 Q: And when a patient is under anesthesia, you, as the
18 doctor, want to know everything that you can about what's
19 going on with that patient; right?

20 A: Sure.

21 Q: And you told us that the neurologic part is really the
22 part that you're most interested in, in terms of what
23 neuromonitoring can tell you?

24 A: Right.

25 Q: And one of the reasons to use neuromonitoring in the

1 spine surgery, like what Ms. Goodwin had, is that if the
2 monitoring does indicate some sort of injury or dysfunction to
3 the nerve signals, that the surgery team can be aware of that
4 dysfunction right away and try to take steps to address that;
5 right?

6 A: That's right.

7 Q: And so it gives the surgical team an opportunity to do
8 what it can --

9 A: Right.

10 Q: -- to try to address it?

11 A: That's right.

12 Q: Okay. And I think you also told us that you have seen an
13 indication that neuromonitoring signals are lost pretty
14 frequently. At your deposition, I think you said you actually
15 saw it about once a week. Does that sound right?

16 A: Right. In some capacity. I mean, again, losing the
17 neuromonitoring like, bam, it's all gone, is -- is a little
18 bit harrowing. That -- that doesn't happen every week, but
19 often what the monitoring tech will say is something like
20 we're seeing decreased signals or we're losing signals in the
21 right leg. Right? Or -- or the -- the -- we're getting some
22 changes on the left compared to the right.

23 Again, I read -- I want to say his name was Griffith, Dr.
24 Griffith. You know, he said her signals were a little
25 thready. Ms. Goodwin's signals were a little thready or not

1 -- not as -- not full, complete signals like they were in the
2 upper extremities when -- when they were monitoring her. And
3 so sometimes they'll say -- will say -- see that. They'll say
4 we're kind of not getting great signals in the right leg or
5 the left leg.

6 It's -- it's not a common thing for them to go completely
7 out like -- but they do sometimes. Like I said, last week,
8 they did, but -- but more often when I say they go out, that
9 means that there's some change that -- that we want to
10 address.

11 And to me -- you know, I heard where Dr. Sampson said,
12 well, I don't use the monitoring because if it goes out,
13 there's nothing you can do. I don't really look at it that
14 way. Usually when the monitoring changes, you see gradual
15 changes, maybe on the right leg or the left leg, or it's more
16 unusual for it to just -- just go completely black, so to
17 speak.

18 Q: Okay. So when you say that it's something that kind of
19 happens all the time, there's some issue that the
20 neuromonitoring signal is picking up about once a week; is
21 that --

22 A: Right. There's something that -- maybe the lead will
23 come loose or the needle won't be right in the leg or -- or
24 sometimes when you're doing, for example, anterior based
25 surgery in the spine when you go through the front of the

1 spine and you actually have to put a retractor on the aorta or
2 vena cava and it shuts off your blood flow, it will cause a
3 change in the neuromonitoring too.

4 Q: I'm not going to ask you to get into what aorta and vena
5 cava mean.

6 A: Yeah.

7 Q: It sounds like more than we want to bite off.

8 A: Right, right.

9 Q: I think you said probably only about 10 to 12 times a
10 year does there end up being, like, an actual equipment
11 failure with neuromonitoring; is that right?

12 A: Right, right. Very rare. Usually, it's just some minor
13 glitch in it, but, you know, very often the monitoring will go
14 out, like I said, probably once a month, something like that.

15 Q: And you would agree with me, Doctor, that when there's a
16 loss of signal in neuromonitoring -- I think you referenced
17 this earlier -- that there's sort of a checklist that the
18 surgical team can go through when that signal goes out?

19 A: Right.

20 Q: And if there is a loss of neuromonitoring signal, the
21 first thing that you do is check the equipment; right?

22 A: Right. First thing.

23 Q: And you also have a conversation with the
24 anesthesiologist or the -- the member of the anesthesia team
25 who's in the room to assess for anesthetic changes; right?

1 A: That's right.

2 Q: And as far as anesthetic changes may go, you would defer
3 to the -- the member of the anesthesia team who is in the room
4 on whether there's anything that can be done?

5 A: That's right.

6 Q: And part of that conversation with the anesthesia team
7 would be checking the urine output and vitals, that kind of
8 thing?

9 A: Kind of. I mean, again, the -- if it happens, you're --
10 like Dr. Sampson said, you're looking at the field and you
11 might just say everything all right up there? You know, you
12 know, everything good? I don't know that -- that we often
13 will say, you know, give me the urine output and what's the
14 blood pressure? I'm not sure it's quite that -- that formal.

15 Q: But you agreed in your deposition that when you see the
16 neuromonitoring go out, you want somebody to be checking the
17 patient's vitals; right?

18 A: That's for sure, yes.

19 Q: Okay. And looking at the urine output is also an
20 appropriate thing to do at that time?

21 A: Yeah, I would say --

22 Q: Not that you're going to do it personally necessarily?

23 A: Right, right.

24 Q: And another thing to do would be to improve perfusion;
25 correct?

1 A: Well, you could. I mean, again, I -- I think I have
2 heard them say that, but I've never really thought of saying,
3 well, increase the blood pressure when the monitoring goes
4 out. It just never occurred to me.

5 Q: But you did agree with us in the deposition that an
6 appropriate thing to do when the neuromonitoring goes out is
7 to improve perfusion; correct?

8 A: Sure. I think that's reasonable, yes.

9 Q: Okay. And on this chart that we've shown, it has step
10 one, check equipment. Step two, anesthetic changes? And step
11 three, improve perfusion. Did I read that correctly?

12 A: Yes.

13 Q: Okay.

14 A: And I agree with all those things except, like I said,
15 step five. I just don't think anybody is doing step five. If
16 they are, I don't know who they are.

17 Q: And that's the wake-up test that you talked about
18 earlier?

19 A: That's right.

20 Q: I won't ask you to explain that again. Thank you,
21 Doctor. And I think you also said that you are happy to have
22 that initial conversation with the CRNA, if that's who's in
23 the room when the signals go out; right?

24 A: Right.

25 Q: But if the signals remain out, that you would expect at

1 some point that the M.D. anesthesiologist would be notified of
2 that; is that fair?

3 A: I think that's fair, yes.

4 Q: And you agree that, at this point, we know that the loss
5 of signal in Ms. Goodwin's surgery was not due to an equipment
6 failure; right?

7 A: Right. That's for sure.

8 Q: Okay. And you would agree it kind of follows that Ms.
9 Goodwin's neurologic deficit that we now know she has was
10 marked by that loss of neuromonitoring signal at about 10 a.m.
11 that we've been able to see; is that right?

12 A: Right. Right at 10, 10:02 or something.

13 Q: And you also agreed that low blood pressure can cause
14 ischemia to any bodily structure, including the spinal cord;
15 correct?

16 A: Yes. No question.

17 Q: And those areas where we have the smallest blood vessels
18 are often the most affected by blood pressure issues; right?

19 A: They are.

20 Q: And the area of the spine that is most susceptible to
21 developing neurological deficits is this lower thoracic
22 region, kind of the bottom of the blue or I think you called
23 it the thoracolumbar junction; is that true?

24 A: Right. Right at that T10 to L1 level.

25 Q: Okay. So this -- this says T10, T11, T12, L1?

1 A: Right there.

2 Q: Okay. And that area of the spine is also referred to as
3 the watershed region; is that right?

4 A: That's right. Well, I mean there's -- watershed is --
5 again, you know, I'm not sure that most doctors know what a
6 watershed is. It's commonly referred -- I view it like the
7 Mississippi Delta. Right? It's an area where the water can
8 be diverted into any of the rivers. It can go into the Ohio,
9 the Missouri, but the Delta is -- is the beginning point of
10 where it goes off.

11 Q: But you've heard of it being called the watershed region;
12 correct?

13 A: Right, right.

14 Q: And that's -- that's in the same lower thoracic region
15 that we were just talking about?

16 A: Right.

17 Q: About T11 I think you said?

18 A: Yeah. Right there and then -- and then, of course, in
19 the brain there are the two big ones.

20 Q: Okay. And you told us during your deposition that there
21 should be a preoperative timeout before every surgery;
22 correct?

23 A: Right. That's required. Right, for sure.

24 Q: Do you always do one?

25 A: I have to.

1 Q: Yeah. And that you should also have a conversation with
2 the anesthesiologist or anesthesiology team, and I think in
3 your deposition you called it kind of a curbside consult prior
4 to every surgery; correct?

5 A: Right. Right. Pretty much. You know, we -- you know,
6 again, I don't know that if a 25-year-old is having a
7 discectomy in his low back, we have much of a conversation
8 with the anesthesia.

9 Q: It might be very short?

10 A: Right. It would be very short, but -- but for one like
11 this, I'm sure you would.

12 Q: And in that preoperative curbside consult, let's call it,
13 you would discuss any comorbidities or pre-existing conditions
14 that might have an impact on the surgery; right?

15 A: Right.

16 Q: Surgical history would be included?

17 A: Right.

18 Q: And any conditions that the patient may have that should
19 be considered during surgery by the whole surgery team,
20 something that you want everybody to know would be part of
21 that?

22 A: That's right.

23 Q: And you told me -- told -- I'm sorry -- Mr. Hinson in
24 your deposition that the standard of care actually requires
25 that you have that kind of a conversation, even if it's very

1 minimal?

2 A: Right. I mean, I think that the right thing to do,
3 especially if you're operating around a high-risk patient, is
4 just -- I mean, again, it's not as formal as Dr. Lustgarten
5 made it sound, but I just think, you know, you just say to the
6 anesthesiologist, boy, we got our hands full here. This is a
7 third-time redo, and a lady with diabetes, you know. So we
8 might be in here for a little while, like that.

9 Q: It can be somewhat conversational; right?

10 A: Right, right.

11 Q: Understood, Doctor. And you would agree also that a
12 patient who has chronic and relatively high hypertension might
13 need to have their intraoperative blood pressures kept
14 somewhat higher than someone who -- who does not have
15 longstanding chronic hypertension; right?

16 A: I think that's fair, yes.

17 Q: Okay. And, Doctor, I understand that this is not the
18 opinion that you came here to give today, but in general, you
19 acknowledge that low urine output during surgery can be the
20 result of low perfusion to the kidneys; correct?

21 A: Yes, it could. Again, I don't know that I'm a kidney
22 expert by any stretch of the imagination. I'm, like I said,
23 more of a, you know, carpenter than a scientist, I suppose,
24 but the -- the -- I imagine that's true, yes.

25 Q: And -- and I heard you say on the stand earlier that you

1 feel like Ms. Goodwin's output was a little low in this case?
2 A: Right, a little low. I mean, I guess, you know, I don't
3 know what the right number would be, but -- but 25 or 30 an
4 hour wouldn't really surprise me. So if it was, you know, 100
5 or 120, that might be it. But like I said before, it doesn't
6 send some sort of shock wave or alarm to me that her urine
7 output was 80. It just doesn't.

8 Q: And you agree that the fact that the neuromonitoring
9 signal was lost is something that should be included in the
10 operating report; correct?

11 A: Probably. Again, like I said before, that monitoring
12 going out is not as uncommon as you might think and, for
13 example, you know, it often doesn't cause a high degree of --
14 of angst or worry amongst you if you think that the case went
15 smooth and everything looks good. You're just not expecting
16 this.

17 Q: Even if you're not expecting this type of outcome though,
18 would you agree that the fact that the signal went out would
19 be appropriately included in the operative report?

20 A: Probably. I mean, again, you know, we dictate these
21 operative notes like we're auctioneers right after the
22 surgery, you know, patient placed in prone position, prepped,
23 etc., and again, you know, you're dictating it into a Dragon
24 dictation now and then. It's, you know, creating the
25 operative report, but it's a quick process and -- and

1 sometimes things get left out. Sometimes I leave things out,
2 but that's the nature of it. You're trying to finish it
3 quickly.

4 Q: In a situation where there is a poor outcome, doesn't
5 that make it particularly important to make sure that
6 everything is properly noted?

7 A: Right. I think that -- that at least from -- we talked
8 about this in that deposition a little bit. Dr. Holbrook
9 dictated the note before he knew there was a poor outcome.
10 Right? He dictated it when they were closing.

11 Q: But he didn't sign it before he knew there was a poor
12 outcome; right?

13 A: Well, right. I think that we talked about that a little
14 bit too. I mean, yesterday when I finished in surgery, I
15 finished surgery yesterday at 5 o'clock. And when I went to
16 the medical record to sign out, it said that in the ensuing,
17 you know, seven hours that I was in the O.R., I had 236 things
18 to sign, 236, and there's an electronic button that you push
19 that says sign all. Right? You know, that's mostly how --
20 how you do it, at least in private practice it is. And -- and
21 so I get how, you know, a report could be signed that you
22 dictated that -- that you didn't completely read over.

23 Q: Did you have any patients wake up paralyzed this week,
24 Dr. Poletti?

25 A: No, no. I mean, again, you're right about that. It's no

1 denying that Ms. Goodwin had a catastrophic complication, but
2 at the point where he dictated the note, he didn't know that.

3 Q: And, Doctor, you referenced Dr. Lustgarten's deposition
4 -- I'm sorry -- trial testimony a few times earlier today.

5 Were you here when Dr. Lustgarten testified?

6 A: No, I think -- I mean, if I said trial testimony, I meant
7 deposition.

8 Q: Okay. You were referring to his deposition testimony
9 then?

10 A: Right.

11 Q: Right. Is it your recollection, then, that Dr.
12 Lustgarten testified when he said that -- was talking about
13 whether he had seen this type of injury, this ischemic type of
14 injury, that, thankfully, none of his patients had ever
15 suffered an infarct, but that he had seen cases of infarct.
16 Does that sound right?

17 A: Right. I don't know if he said that in court, then --
18 then he said it, but -- but I didn't read that in his
19 deposition.

20 Q: And, Doctor, you testified in your deposition that the
21 cervical spine and the lower thoracic spine are the two areas
22 that are most susceptible to perfusion injury; right?

23 A: Well, they're the ones that have the biggest
24 consequences. And so, you know, if you see a reperfusion
25 injury in the lumbar spine and you get that whiteout in your

1 low back, it's below your spinal cord. You're not going to
2 have that dramatic paraparesis or partial paralysis that you
3 could get if it happens in the neck or the mid-back, and so
4 particularly in the lower part of the thoracic spine and in
5 the neck, if you have that, the consequences are going to be
6 high. I think that's what he meant by that.

7 Q: So you -- you don't think that the cervical spine is
8 particularly susceptible to lack of perfusion injury?

9 A: Well, I mean, again that's where you can have -- your
10 cervical spine can get really tight. And when you do that
11 posterior or anterior decompression and you get a reperfusion
12 type of injury, the kind of consequence that you have can be
13 catastrophic. So --

14 Q: Sure.

15 A: -- you can get a reperfusion injury anywhere -- right? --
16 that's tight that you open up, but -- but the consequences are
17 catastrophic in the cervical and lower thoracic spine.

18 Q: And, Doctor, I'm sorry, I mean, to -- to ask you about a
19 a lack of perfusion injury or an ischemic injury. So --

20 A: Right.

21 Q: Is the cervical spine particularly susceptible to a lack
22 of perfusion injury? You just said reperfusion, I think. So
23 I'm not sure --

24 A: Right.

25 Q: -- if I've already qualified that.

1 A: I think I was talking about a reperfusion injury.

2 Q: Are you aware, Doctor, that there was also an issue in
3 this case with the SSEP signals in the cervical spine?

4 A: I think I had read that and then heard about it today
5 because I heard Dr. Sampson's testimony.

6 Q: Okay. Prior to today when you heard it when Dr. Sampson
7 was on the stand, had Mr. Davis or Mr. Heitman pointed that
8 out to you?

9 A: I can't remember. I do remember -- I want to say it's
10 the expert for -- for Ms. Goodwin talked about how the signals
11 were kind of thready in the legs pre-op. That was Dr. -- one
12 of -- was it Griffith or Garrett? I don't know, but I hadn't
13 -- they hadn't pointed it out to me. And then the first I
14 heard about it was when they were talking with Dr. Sampson
15 about it today.

16 Q: Thank you, Doctor. And the -- the bone spur that we
17 looked at, you said it was at T9; right?

18 A: I think so.

19 Q: Okay. So we -- assuming that the -- the image that we're
20 looking at on the screen is correct, you've got T9 here. That
21 shows compression on the cord there with that bone spur;
22 right?

23 A: Right.

24 Q: And these are images that are taken from Ms. Goodwin's
25 MRI, and then they've just been kind of colored to make it

1 easier for us to understand?

2 A: Right.

3 Q: And we don't see that compression at T10-T11; right?

4 A: Right.

5 Q: And we know we don't see it at T11-T12 either?

6 A: Right. She developed that eventually, you know, and had
7 to have that fourth surgery, but --

8 Q: You're correct.

9 A: -- that's that domino effect I think we were talking
10 about.

11 Q: Understood.

12 MS. GOODING: Thank you, Doctor. No further questions.

13 THE WITNESS: Thank you.

14 THE COURT: Any redirect?

15 MR. DAVIS: No, ma'am.

16 THE WITNESS: Oh. Thank you. You may step down.

17 THE WITNESS: Thank you.

18 MR. DAVIS: We ask that he be excused.

19 THE COURT: Any objection, Ms. Gooding?

20 MS. GOODING: Oh, no, Your Honor.

21 THE COURT: Okay.

22 MS. GOODING: I'm sorry.

23 THE COURT: You are free to go. Thank you, sir.

24 THE WITNESS: Thank you.

25 THE COURT: Do we have another witness that we can do?

JAMES GOODWIN - DIRECT BY MR. HINSON

1 MR. HINSON: Yes, Your Honor.

2 THE COURT: Okay. Call your next witness.

3 MR. HINSON: Plaintiffs would call James Goodwin to the
4 stand.

5 THE COURT: I'm sorry. Yes. We're switching back to the
6 plaintiffs' case. We only went to the defense for those two
7 witnesses. We're back on the plaintiffs' case.

8 THE CLERK: Do you solemnly swear or affirm that the
9 testimony you are about to give in this case will be the
10 truth, the whole truth, and nothing but the truth, so help you
11 God?

12 THE PLAINTIFF MR. GOODWIN: Yes.

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

14 THE PLAINTIFF MR. GOODWIN: James D. Goodwin, Jr.

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

16 JAMES GOODWIN, being first duly
17 sworn, testified as follows:

18 DIRECT EXAMINATION

19 BY MR. HINSON:

20 Q: Good afternoon, James.

21 A: Good afternoon.

22 Q: Would you please introduce yourself to the jury?

23 A: My name is James Goodwin, Jr. I'm a resident of
24 Columbia, South Carolina. I have three daughters, Jasmine,
25 Jamila, Jamarla, and a grandbaby named Jalaya [ph].

JAMES GOODWIN - DIRECT BY MR. HINSON

1 Q: James, how old are you today?

2 A: Forty-five.

3 Q: And where'd you grow up at?

4 A: I grew up in Godsell's Garden [ph].

5 Q: Who is this lady right here to you?

6 A: Huh?

7 Q: What is -- who is she to you?

8 A: That's my wife there.

9 Q: How did you and Crystal meet?

10 A: Well, y'all might not believe it, but this is how it went

11 down. The apartment we moved in, they moved out. So when we

12 go check the mailbox, they have mail. So I was taking mail

13 around to their house, and that's how we met at eight years

14 old.

15 Q: James, how have I known you for three years now and you

16 just now told me that story?

17 A: Yeah, that's how I met her.

18 Q: How did y'all come to start dating?

19 A: My cousin and her oldest brother --

20 THE COURT REPORTER: I can't hear him.

21 MR. HINSON: Is the microphone on there? Yep.

22 THE COURT: Oh, no. You.

23 MR. HINSON: Oh, me. Can the Court take notice that

24 somebody told me to speak up?

25 THE COURT: Absolutely.

1 BY MR. HINSON:

2 A: My cousin and her oldest brother started dating, and I
3 seen her with my cousin. I told my cousin, hey, tell her I
4 want to holler at her.

5 Q: Okay.

6 A: And she did. And we took a trade class at Lynn Haven
7 together. So we started exchanging phone numbers and talking
8 then, and it was -- it was heaven ever since that.

9 Q: And what year was that?

10 A: That was in '94.

11 Q: And what year did y'all get married?

12 A: We got married July 19th of 2008.

13 Q: Any other marriages for either of y'all?

14 A: No. We ain't never been separated.

15 Q: James, I want to just kind of fast forward now to the
16 events of 2016.

17 A: Uh-huh.

18 Q: Particularly July 28th, 2016. Do you remember that day?

19 A: Sure. Yeah.

20 Q: And how did your wife get to the hospital that morning?

21 A: Well, we got up, and we thought we was late. We thought
22 we was late, so we rushed. We rushed to get there. So when
23 we got there, we parked in the parking garage, and we ran
24 across the crosswalk.

25 Q: You literally ran?

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1 A: Yeah, we ran because we thought we was late. But once we
2 got there, we was 45 minutes early.

3 Q: Okay. And did she -- did Crystal run as well?

4 A: Yes, yes.

5 Q: Okay. And just generally, what happened next?

6 A: Well, she signed in, and then we went and sat down for a
7 little bit. And then somebody out the back came and got her
8 and took her downstairs and got her ready for surgery.
9 Somebody came and got me and let me talk to her before. I
10 guess they do what they have to do, and I went back upstairs
11 and I waited on them.

12 Q: All right. Where'd you wait? You may not know the room
13 number or anything --

14 A: Yeah.

15 Q: -- but where did you wait?

16 A: It was a waiting room where me and other -- well, not my
17 family members, but other people's family members in there
18 waiting on them too.

19 Q: All right. Did somebody from y'all's family come join
20 eventually during that day?

21 A: Yeah.

22 Q: Who was that?

23 A: My mother-in-law.

24 Q: Ms. Edna?

25 A: Yeah. Ms. Edna Delbridge.

1 Q: What's her nickname?

2 A: Fruity. Fruity in the booty.

3 Q: I meant to ask her that. And so we saw earlier the
4 surgery was about four-and-a-half hours. Did somebody come
5 eventually talk to y'all at the end of it?

6 A: Yes.

7 Q: Who was that?

8 A: It was Mr. Holbrook.

9 Q: And what did Dr. Holbrook tell you when he came out?
10 Y'all were in the waiting room. He comes out. What did he
11 tell you?

12 A: He came up to me, said, Mr. Goodwin, everything went
13 fine. She's in the recovery room. I guess y'all can go home
14 and get you some rest or some lunch, and I'll talk to y'all
15 later.

16 Q: Did he tell you he had any concerns about how the surgery
17 went?

18 A: No.

19 Q: Did he tell you the neuromonitoring went out?

20 A: No.

21 Q: Did he tell you there had been any complication?

22 A: No.

23 Q: He told you to go get lunch?

24 A: Yeah.

25 Q: All right. So what happened next?

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1 A: I left from -- me and my two -- well, my middle -- my
2 baby girl and my middle girl, we left from the hospital. Had
3 to go by the job, sign some paperwork.

4 Q: Let me stop you. I should have asked this before. What
5 do you do for a living?

6 A: I'm a lead operator at the City of Columbia, Solid Waste
7 Division.

8 Q: And what does that mean, exactly?

9 A: I operate the recycling truck. So --

10 Q: How long have you worked there?

11 A: Twenty-one years.

12 Q: Do you still work there?

13 A: Yes.

14 Q: Okay. All right. I'm sorry. I didn't mean to
15 interrupt, James. I just meant to ask you that earlier. I
16 didn't want to forget. So you go in to -- to your job to
17 check. I'm sorry. You were saying?

18 A: I left from Baptist.

19 Q: Uh-huh.

20 A: Right there from Baptist to Harden Street. Before you
21 make that right on Colonial Way, the old SCAG building was, I
22 got a phone call, and I can't say if it was for sure Mr.
23 Holbrook or one of his -- well, people that's working up under
24 him, but somebody called and asked to speak to me. So I said,
25 yeah, this is him.

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1 Mr. Goodwin, can we get your permission to take Ms.
2 Goodwin back to surgery? I said, well, what's the problem?
3 She's paralyzed. Well, she can't feel her lower extremities.
4 So the first thing I did, I started screaming and hollering,
5 and I -- I want to be -- I want to be kind of accurate.
6 I stopped. I told my middle girl to call my mother-in-
7 law. So I'm screaming. Well, screaming and hollering. So I
8 done whipped the truck around. So we're headed back up there.
9 So my middle girl called my mother-in-law and told her. I
10 couldn't talk. I couldn't talk on the phone.
11 Q: Well, why couldn't you talk?
12 A: I was -- I was distraught. I -- I couldn't get myself
13 together. So my mother-in-law -- I can hear her screaming and
14 hollering. And then after that, the only thing I knew, I was
15 back at the hospital, pacing the floor. From that point to
16 back to there, I couldn't tell you how I got there.
17 Q: Do you remember the next time you saw your wife, Crystal?
18 A: Yeah.
19 Q: Tell us about that?
20 A: By that time, some more family members had came to the
21 hospital because we done started calming down and calling
22 everybody and letting them know what's happening. So they
23 took us down to the recovery room or the basement or whatever
24 it was, and she wakes up and she see family members
25 surrounding her crying. And I'm laying on her chest crying,

1 and she's just looking around because she's still heavily
2 medicated. And then she said what's wrong? I said you're
3 paralyzed, and then she started crying and that just made
4 people cry more.

5 Q: And it was about how long would you all spend in the
6 hospital before she would go on to rehab and other things
7 afterwards?

8 A: Two weeks in the hospital.

9 Q: What were those two weeks like for you and for Crystal
10 and for your family?

11 A: It was rough because my baby girl -- well, my middle
12 girl, Jamila, she -- she stayed up there for the whole 14, 15
13 days. She stayed there with her, and the baby girl was back
14 and forth with me.

15 Q: How old was y'all's youngest then?

16 A: She was 11.

17 Q: What grade does that put her in? Sixth grade? Fifth
18 grade?

19 A: I couldn't even tell you these days.

20 Q: Did you go through a lot of different emotions that --
21 those two weeks?

22 A: Yeah. Especially being at home without your wife that
23 you -- y'all done been together almost over -- I would say at
24 that time, 10, 12 years, same place every day together.

25 That's hard.

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1 Q: Yeah. To be home with your 11-year-old.

2 A: Yeah, I got -- I got to be the mama now. I can't do no

3 hair. You know, I can get them up and get them ready and make

4 them take their baths, get them ready for school, but there

5 wasn't no school. That was a good thing. But I couldn't do

6 no hair and -- and do the -- the errands and wash clothes and

7 cook dinner.

8 Q: Were you there every day?

9 A: Every day.

10 Q: At the hospital?

11 A: Every day.

12 Q: And then after Crystal finally gets discharged from the

13 hospital, where did she go next?

14 A: To HealthSouth.

15 Q: And what's HealthSouth, just generally?

16 A: I guess it's really -- I can't pronounce that word, but

17 they help you get you back on your feet.

18 Q: And about how long was she there?

19 A: I would say another 14 or 15 days, another two weeks.

20 Q: Did your family go see her every day?

21 A: Well, I did, I did. I went to see her every day, me and

22 -- me and the kids, but you know.

23 Q: Yeah, that's what I mean. The immediate family.

24 A: Yes, sir.

25 Q: There's a lot of cousins and all that?

1 A: Yeah.

2 Q: So eventually -- well, what happened after HealthSouth?
3 Did she come home?

4 A: Yes.

5 Q: James, what was -- what was that like bringing your wife
6 back into the house for the first time after about a month or
7 so? She left the house walking, and she's coming back to the
8 house in a wheelchair. Tell us -- tell us that experience in
9 your own words?

10 A: It's -- it's hard to explain when you got to bring your
11 wife home and she have to sleep in your living room for almost
12 a year.

13 Q: Why did she have to sleep in the living room for a year?

14 A: She wasn't able to function because she was a new injury
15 and, you know, it takes time with therapy and everything. And
16 we couldn't get in our bed. So we had to get a hospital bed.
17 So we slept -- she slept in the hospital bed for a whole year
18 in our living room. Imagine that.

19 Q: Did she have to go -- continue to go -- even after she
20 left the rehab center, did Crystal have to go to rehab?

21 A: They had people come to the house.

22 Q: Okay. First people came to the house? People came to
23 your house?

24 A: Yeah, they was coming to the house, and we was getting
25 her back and forth to rehab the days that she was scheduled to

1 go.

2 Q: You watched at times your wife go through these rehab
3 visits with them?

4 A: I was doing it every day.

5 Q: Tell us about some of those. What -- what kind of things
6 did they do -- have to do to her or would try to help her?

7 A: First, they had to get her balance together because she
8 was -- she was like a newborn calf. She couldn't -- couldn't
9 sit up. She couldn't -- she couldn't do nothing. She would
10 fall over. She had to balance herself, get her balance
11 together, but once you got that together, it moves slowly but
12 surely.

13 Q: And since this happened, has she continued to go to rehab
14 at -- and can she by herself take -- take herself to rehab?

15 A: No.

16 Q: Can she get in the car and all that?

17 A: She'd have to have somebody with her at all times to put
18 a wheelchair in the trunk and load it and unload it for her.

19 Q: You've been to therapy visits with your wife?

20 A: Yes, sir.

21 Q: I know you're not a therapist, but what kind of patient
22 is she? Is she a --

23 A: She's a good patient. She'll help you laugh.

24 Q: She's got a good attitude about it?

25 A: Yeah. And I'm -- I'm her motivator.

1 Q: Yeah.

2 A: Keep her motivated.

3 Q: Has she needed some motivation at times?

4 A: Yes.

5 Q: Has it been tough?

6 A: It's very tough. It's very tough.

7 Q: Being together with Crystal for as long as you have --

8 A: Twenty-nine years.

9 Q: Twenty-nine years. Have there been times since July
10 28th, 2016, when you've seen her low?

11 A: I still see it. I still see it.

12 Q: At the same time, has she kept her head up, too?

13 A: Yes. Because we ain't going to let her get too far down.
14 That could cause real problems. So we try to be there for her
15 anytime she has a moment, an episode.

16 Q: James, I don't want to -- I've got to, I'm afraid, ask
17 you about some things that may be a little uncomfortable.
18 We've taken lunch breaks through this week. Where have you
19 and Crystal gone?

20 A: We had to go back to the house for her to use the
21 restroom and stuff.

22 Q: And when you say use the restroom, what do you mean?

23 A: She go back and cath herself and just make sure she ain't
24 went in her clothes or nothing like that. Because we tried to
25 get into the woman's bathroom, but the stall wasn't big

1 enough, and from --

2 Q: You mean here at the courthouse?

3 A: Yeah. So -- and I didn't see another one for handicapped
4 people. So -- and that's from -- like, that's from here to
5 the lower Richland area. So we was doing that for the last
6 week.

7 Q: And do you have to help your wife and have you helped
8 your wife over these years with her bowel movements to have a
9 bowel movement?

10 A: Yes. Yes.

11 Q: And I'm not going to ask you, but is it similar or is it
12 the same as what you hear when Cathy Gragg-Smith, the nurse --

13 A: Uh-huh.

14 Q: -- rehabilitation nurse talked about it? Is that what
15 you have to do for her?

16 A: Uh-huh.

17 Q: And, James, I've got to ask you has -- since July 28th,
18 2016, has your physical intimacy with your wife been impacted?

19 A: Yes, yes, yes, yes, yes, yes.

20 Q: Have you -- and stop me if you want me to. Say that's
21 enough and we'll move on to the next question. Have y'all
22 tried before to have marital relations since July 16th?

23 A: We tried numerous times, but it didn't -- it didn't turn
24 out well. It didn't. It didn't. She -- she -- she went to
25 the bathroom on herself. And once that happened, she got

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1 really depressed. Now, she thinks she's letting me down, but
2 I told her it's not about me. It's about you. I'm going to
3 be all right. I ain't going nowhere.

4 Q: James, since y'all got home from the hospital and the
5 rehab center, have you and Crystal cried together about this?

6 A: All the time. All the time. And her line is, why me
7 that's sick. Ain't no question, man, what we're going to do.
8 We're going to try to move on. Get a little stronger. We got
9 a grandbaby now to raise, and we're going to be all right.
10 We'll be all right.

11 Q: And I understand that, but have you had times too where
12 you were by yourself, you would weep?

13 A: I weep in front of her. She know that. She's --
14 sometimes she'll rub my back. What's wrong with you? I'm all
15 right. You know, it's been a long road. It's been a long
16 road from the time she came home, laid in that front room for
17 almost a year, to where we're at now. I think -- I think
18 we're doing pretty good.

19 Q: James, I'm going to hand you a group of -- I'm going to
20 hand you several photos.

21 A: Do I have to take these home?

22 Q: I got an extra copy. You can. Just tell us just what
23 are we looking at with that first picture?

24 A: That was a -- that was a couple of weeks before the
25 surgery.

1 Q: This one right here?

2 A: Yes. I was in my best friend's wedding.

3 Q: Can I kind of go to that one?

4 A: Uh-huh.

5 Q: Is that the same time?

6 A: Yes.

7 Q: Did y'all ever take a picture together standing after

8 this one?

9 A: That was the last one.

10 Q: How about this one --

11 A: Oh, that was --

12 Q: -- right here?

13 A: That was way before the last one.

14 Q: Okay.

15 A: Yeah.

16 Q: That's a younger -- a younger you and a younger Crystal?

17 A: You can tell by the dreads and my hairline.

18 Q: Are you kind of like a tree, instead of the --

19 A: Yeah.

20 Q: -- the rings on the tree, we just judge your age by how

21 long the dreads are?

22 A: Yeah. I was young then.

23 Q: And we got one more in here, James. I think this one

24 speaks for itself. Tell me about it?

25 A: Yeah, that was our -- when we got married in '08.

1 Q: All right.

2 A: Yeah.

3 MR. HINSON: Your Honor, we'd move this group of photos
4 in as Plaintiffs' Exhibit 25.

5 THE COURT: Any objection?

6 MR. DAVIS: No, ma'am.

7 THE COURT: Plaintiffs' 25 is admitted without objection.
8 Have you given those to the court reporter to be marked?

9 MR. HINSON: Thank you, Your Honor.

10 THE COURT: And are they stapled? I don't want an errant
11 photo.

12 MR. HINSON: They are. They're stapled.

13 (WHEREUPON, Plaintiffs' Exhibit Number 25, photographs,
14 was admitted into evidence.)

15 BY MR. HINSON:

16 Q: James, I'm going to hand you a few more.

17 A: Uh-huh.

18 Q: Tell us what we're looking at in that first photo? There
19 we go.

20 A: That's -- that's Ms. Jenny and my wife.

21 Q: Is that Christmas, this past most recent Christmas?

22 A: Yes. We -- we rode up to -- to North Carolina. She had
23 wanted to get out of the house. I told her, well, let's go.
24 Let's ride. We went up there just to -- to walk around and
25 get something to eat. And matter of fact, it was all of us.

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1 Me and my three daughters, all of us went up there.
2 Q: And the grandbaby?
3 A: Yeah. We just got a family outing.
4 Q: And this next one? Generally, when was that?
5 A: That was --
6 Q: If you have to use your hair, I understand.
7 A: Well, that was -- that was this year.
8 Q: Okay.
9 A: That would have probably been a couple of months ago.
10 Uh-huh.
11 Q: And let's go to the last one real quick. Well, let's go
12 to the -- let's go to the next one.
13 A: And that --
14 Q: There we go. All right.
15 A: That's --
16 Q: James, how about this one? Where's this one?
17 A: We was at the beach at a cousin trip.
18 Q: And, James, the -- is that a vacation trip?
19 A: Yes, with all my cousins and the children.
20 Q: All right.
21 MR. HINSON: The last one, if you would, Robert.
22 BY MR. HINSON:
23 A: And that was -- that was in therapy.
24 Q: And there's a big smile on your wife's face?
25 A: Yeah.

1 Q: Did she get a milestone that day?

2 A: Yeah. She said she was -- she -- she got a little
3 taller. That was what she was telling us, but, yeah, she --
4 she did good in therapy that day.

5 MR. HINSON: Your Honor, we would move these photos in as
6 Plaintiffs' Exhibit 26.

7 THE COURT: Any objection?

8 MR. DAVIS: No, ma'am.

9 THE COURT: Plaintiffs' 26 submitted without objection.

10 (WHEREUPON, Plaintiffs' Exhibit Number 26, photographs,
11 was admitted into evidence.)

12 BY MR. HINSON:

13 Q: And, James, this beach trip right here --

14 A: Uh-huh.

15 Q: Is there anything about that beach trip that would help
16 us understand -- help the jury to understand the types of
17 things that your wife can't do and the way this injury has
18 impacted your family and you and her and the whole Goodwin --
19 the whole Goodwin family?

20 A: Yeah. Well, that particular day, we had -- we -- I think
21 we just got back from bowling with the family, and we decided
22 to go out and take a picture, and we went back to the room.
23 We got ourselves together. She went to the restroom. It was
24 getting dark and, you know, at the beach once it gets dark,
25 you know, family members and lovers or whatever you want to

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1 call it like to walk on the beach and talk. So we was all
2 posed up on the little -- I'm going to say, little picnic area
3 before you walk to the beach.

4 Q: The boardwalk kind of thing?

5 A: Yeah. Once you go up and, you know, then you can walk
6 down the stairs and walk out. So we was there and we was
7 doing good. All the family was there. Then one of my cousins
8 say, well, we fixing to walk on the beach. So I said, okay,
9 we're going to go, we're going to go. So once my last cousin
10 hit the bottom step, she bust in tears.

11 Q: Who bust in tears?

12 A: My wife.

13 Q: Okay.

14 A: I really wasn't comprehending it, but about 2 or 3
15 minutes later, it sunk in. They're gone, and we're still
16 right here.

17 Q: You couldn't take the wheelchair on the beach?

18 A: I tried to, but with the sand, that's the farthest I can
19 get was off the little wood to the sand. That was it. Yeah.
20 So she -- she -- she cried. We calmed her down. Me and her
21 sat right there in the sand. We laughed a little bit, joked.
22 She took about 30 minutes, but she calmed down. She calmed
23 down.

24 Q: James, it sounds like you spend a lot of time taking care
25 of Crystal?

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1 A: I don't call it taking care. That's my job. That's my
2 wife.

3 Q: Have there been other occasions where you witnessed her
4 or you not being able to do something that you knew she
5 wanted? You told us about walking on the beach and not being
6 able to walk on the beach with the rest of the family. Have
7 there been other occasions where no matter what you had, she
8 still couldn't do what everybody else was doing?

9 A: Yeah. Just this summer, we was at my mother-in-law's
10 house, had a big family cookout. All the cousins and you
11 know, they done -- they from out at Eastover, Hopkins, and all
12 over, but we had a big family cookout and we was out there
13 having a good time. Then it started raining. My mother-in-
14 law's house kind of sit up a little high. It's like six or
15 seven steps on her patio. It's about the same in the front.

16 So we were having a good time, and everybody went in the
17 house. We had to get in the car and leave because it wasn't
18 -- it was a way, but she didn't trust nobody to lift her up
19 that many stairs to get her in the house. And if she do get
20 in there, she just designated to one room because the doors
21 don't open up or the door frame is not wide enough for her to
22 go through because it's an older house.

23 So we got in the car. By the time we got -- our house is
24 like 5 to 10 minutes away, depending on traffic. She cried,
25 she cried, she cried. My mother-in-law called. Hey, where

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1 y'all at? I said it started raining. We had to go. And then
2 that threw down the mother-in-law's plans because she ain't
3 seen her daughter in a while. And that was -- that was --
4 that was a real sad night for both parties.

5 Q: James, what are some of the things that Crystal enjoyed
6 doing? Tell us about -- was she a -- well, I'll just leave it
7 at that. What did she like to do before this injury that she
8 can no longer do?

9 A: It's -- it's so much. It's so much she'd like to do. I
10 know she liked to bowl. One thing, you know, if the Tootsie
11 Roll come on, she -- she's going to do the Tootsie Roll.

12 Q: You mean, like, at a wedding or a family reunion?

13 A: Any way. If it come on right now and -- and she was
14 walking, she'd turn this courtroom out. She loves to dance.
15 She loves to -- she loves to have a good time, really do, and
16 that and it's just so much. So much I just can't -- one thing
17 just don't come to my mind, but it's so much, so much she like
18 to do.

19 Q: James, I'm going to shift gears for just a second. How
20 often do you work for the City of Columbia?

21 A: I'm usually about 55 hours a week.

22 Q: Fifty-five hours a week?

23 A: Yeah.

24 Q: Are you the sole breadwinner of the family?

25 A: Yes. Yes.

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1 Q: Before this injury, was Crystal able to make -- well,
2 what -- what did Crystal do to make money for the family
3 before the injury?

4 A: Oh, she's a baker. She bakes for the people at the
5 church, friends, family. Anytime it's a birthday party or --
6 or a cookout or baby shower or wedding, and they need somebody
7 reasonable, putting some good product that they --

8 Q: She can make some good cake?

9 A: Oh, man. She makes a lovely cake, any kind you want, and
10 she's cheap.

11 Q: And before this injury, would she sometimes deliver the
12 cakes?

13 A: Oh, yeah. Yeah, she used to -- matter of fact, we'd just
14 leave the truck at home and she'll come pick me up from work
15 because she be ripping and running all day. There wasn't no
16 need for me to take the truck for her to sit in the parking
17 lot at the -- at the job. So she delivered, delivered.

18 Q: And has this injury decreased the amount of baking she
19 can do to bring home some income for the family?

20 A: Yes, because at one time she can do, like, three cakes at
21 a time because she was on her feet. She can -- she can move.

22 Q: Yeah.

23 A: But now she's rolling, and it takes time. She got stuff
24 set up over here and stuff set up over here, and that way she
25 can get it, but back then she can just go.

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1 Q: Can't do quite the volume she used to?

2 A: No, no.

3 Q: Okay. James, you said you're 45 years old today?

4 A: Uh-huh.

5 Q: And you pick your wife up and put her in the truck and
6 put her -- help her wherever she may need to be set?

7 A: No problem.

8 Q: Do you have worries about the future? I hate to tell you
9 not to worry at 45.

10 A: Yeah, because I ain't going to be able to go to the gym
11 like I did the other day. I ain't. You know what they say.
12 The older you get, the more you know.

13 Q: Yeah.

14 A: So I'm going to try to stay healthy as long as I can, not
15 only for myself, but for her.

16 Q: How much do you love this lady?

17 A: How much? You can't imagine. It's out there. It's way
18 out there.

19 Q: You're going to stick with her?

20 A: I ain't going nowhere. Like, they say, till death do us
21 part.

22 MR. HINSON: Thank you, James.

23 No more questions at this time, Your Honor.

24 THE COURT: Any cross-examination?

25 MR. DAVIS: No questions.

1 THE COURT: All right. Thank you, sir. You may step
2 down.

3 All right. I think this is a good time to break for the
4 day, for the week. So please return Monday morning at 9:30.
5 Okay? Right, 9:30 Monday morning.

6 Don't discuss the case amongst yourselves or with anyone
7 else. Don't do any research about the case. Don't talk about
8 the case at all. Just go. Have a good weekend, and I'll see
9 you at 9:30 Monday morning. Thank you.

10 (WHEREUPON, the jury exited the courtroom at 4:40 p.m.)

11 THE COURT: Counsel, before we leave, can we talk about
12 this bifurcation of the trial and what that looks like to
13 y'all, what you envision? Is there a verdict on liability and
14 then separate testimony or not, Mr. Davis?

15 MR. DAVIS: I'm sorry. I don't understand your question.

16 THE COURT: Well, bifurcating liability and punitive
17 damages. Are you seeking just to have two separate verdicts?
18 So have them deliberate about liability and then deliberate --
19 or then be charged and deliberate again on punitive damages or
20 will there need to be additional testimony before the punitive
21 damages phase?

22 MR. DAVIS: Well, my --

23 THE COURT: And you probably need to step from behind
24 that monitor. Yes. Perfect.

25 MR. DAVIS: Can you hear me better now?

1 THE COURT: Yes.

2 MR. DAVIS: Okay.

3 THE COURT: Yes.

4 MR. DAVIS: My understanding is that a verdict form would
5 be prepared, and both sides would have some input into that,
6 and it would include a bifurcation of the issue of liability.
7 Did the doctor fall below the standard of care? Yes or no?
8 If -- if so, was it -- did it proximately cause the resulting
9 injury? Yes or no?

10 Then the third question, it seems to me, would be, do you
11 find that Dr. Holbrook or Midlands Orthopedics -- well, I
12 guess it was Dr. Holbrook, because this is a vicarious type of
13 a case. Was Dr. Holbrook -- did -- did -- was his negligence
14 gross negligence, and I'm not -- I'm not proposing that that's
15 the wordage. I hope we can do a whole lot better than that,
16 but that sort of was my thinking.

17 And if the jury then deliberates, they first have to
18 check the boxes that if they say no liability, you know, sign
19 a defense verdict. The second one, if yes, it was negligence,
20 yes, it proximately caused -- resulted in injury, yes, yes,
21 and then the third one, you know, was his -- was it
22 negligence? Was it gross negligence, as the Court would
23 instruct. If they say yes to that, I think at that point they
24 -- they sign the verdict form without coming up with a number.

25 And then they have to -- I think they can have testimony

1 and the plaintiff can put testimony up if they wish, in the
2 bifurcated part, because now they have to determine the
3 damages. So -- and then the verdict form would be something
4 like for each cause of action, you know, economic/non-economic
5 damage, punitive damages. I believe that would kind of be all
6 to it.

7 So yeah, that's kind of how I envision it, and the devil
8 is in the details of how we word it in working with the Court
9 and with plaintiffs' counsel.

10 THE COURT: Okay. And I mean, that's my question. Is
11 there additional testimony necessary because we're talking
12 about wrapping up on Wednesday, but I don't -- I don't really
13 know what that means.

14 MR. GOINGS: Right.

15 THE COURT: And, you know, I mean, you need to do what
16 you need to do, but I'm also trying to balance my assigned
17 term of court next week and let Horry County know am I coming
18 at all? I mean, are we getting to liability and an initial
19 deliberation on Wednesday? Will there be then additional
20 testimony and might come back Thursday? I don't know.

21 MR. GOINGS: I can help you answer that.

22 THE COURT: Please.

23 MR. GOINGS: So -- and I'm not going to get into the
24 verdict form. I think there's some -- some disagreement on
25 that.

1 So there may be additional testimony on punitive damages,
2 and that goes to the elements of the *Gamble* factors now that
3 are statutorily adopted factors. One of those is the ability
4 to pay. Okay? And if that's one of them, you know, somebody
5 from Midlands Orthopedics is going to have to come testify
6 about the ability to pay. Okay?

7 You know, we asked that in discovery, and it was no, and
8 when the Court thinks that somebody needs to come talk about
9 the ability to pay, we'll make that person available. So
10 there is a likelihood that maybe one or two witnesses may
11 testify. I don't see that to be long or involved.

12 But in the meantime, how about this, Your Honor? On
13 Monday morning, we will submit -- email you a proposed verdict
14 form from the plaintiffs' standpoint, as we think the verdict
15 form needs to be if you look at the bifurcation statute,
16 because the statute is pretty clear about what needs to be
17 included and what doesn't.

18 Stage one of the verdict form is actual damages. And if
19 -- you know, then stage two after potential additional
20 testimony would be a punitive damages verdict form. So there
21 would be two verdict forms. In the middle of those would be
22 very short testimony.

23 THE COURT: That's -- that was my question.

24 MR. GOINGS: Yes.

25 THE COURT: You phrased it properly. That was my

1 question.

2 MR. GOINGS: Yeah.

3 THE COURT: Okay.

4 MR. GOINGS: But I don't think that testimony, honestly,
5 quite frankly, would be more than an hour of testimony. I
6 don't know who Midlands Orthopedics is going to have to come
7 testify about -- about their finances. You know, that's
8 something that you really see on a balance sheet; right?
9 Maybe they can go ahead and produce that over the weekend. We
10 can see if we need to actually have a witness for that or not.
11 Produce it confidentially. That's what I'm getting at because
12 there may not actually be a witness. We can stipulate as to
13 the net worth.

14 That's, I mean, one way. I'm just throwing out
15 suggestions.

16 THE COURT: Oh, sure. And I'm happy for that to happen
17 if --

18 MR. GOINGS: So --

19 THE COURT: -- everyone's on the same page about that.
20 That's fine. That gives me some guidance.

21 Over the weekend, I would also ask that counsel submit
22 any proposed jury charges, just between now and Monday
23 morning. In Word format would be the preference, via email to
24 my law clerk at JNewmanLC -- for law clerk -- @sccourts --
25 plural -- .org.

1 MR. HINSON: Okay. Your Honor, a quick question about
2 that. Do you want the entire proposed jury instructions or
3 just the med mal portion? You got your -- I presume you got
4 your other stuff you typically have already decided long ago
5 you wanted to use. Just the med mal part?

6 THE COURT: Just the med mal part and -- and really --

7 MR. HINSON: What damages we're seeking, you know, med
8 mal?

9 THE COURT: Right. I mean, it -- really, it's only
10 anything that's sort of unique that you're requesting those
11 things that y'all like to pull from case law and say please
12 charge the jury on this, that, or the other.

13 But standard charges I've got. I don't need a charge on
14 direct and circumstantial evidence. I don't need a charge on
15 expert witnesses unless there is some special language, some
16 specific sentence that you think needs to be added. I mean,
17 you've all tried cases before, so, you know, you don't maybe
18 have the standard charges in front of you, but you can -- you
19 have a pretty good idea, you know, based on memory, and a lot
20 of ours come from Ralph King Anderson's book. I mean, that --
21 that's sort of no secret. So I don't need a whole beginning
22 to end packet of jury charges, just those special requests.

23 MR. GOINGS: Do you have any verdict forms that you use
24 in similar cases that -- that Your Honor prefers that we --
25 you want us to look at when we put together the verdict form?

1 THE COURT: Maybe. I've got my charges organized and the
2 verdict forms organized by case name and not necessarily
3 topic. So I --

4 MR. GOINGS: Okay.

5 THE COURT: -- need to do better about that. I need to
6 remember which case was a med mal.

7 MR. GOINGS: Well, I mean if -- if something like that
8 comes up, Your Honor, and you know what it is, then we're
9 happy to consider whatever you want to use too.

10 THE COURT: Yeah. And I'm -- and I'm happy to accept
11 suggestions. I -- you know, I think the verdict form is sort
12 of the easier part of it.

13 MR. GOINGS: Okay.

14 THE COURT: So if you want to submit a proposed verdict
15 form, each of you, I'm happy to review those as well.

16 Anything else before we break for the week? Yes, Mr.
17 Davis?

18 MR. DAVIS: Just -- just inquiring about logistics when
19 we start back Monday morning. The plaintiffs are still in
20 their case, as I understand, and I prefer letting them finish
21 whatever they've got in their case before I start the rest of
22 our witnesses.

23 THE COURT: Absolutely.

24 MR. GOINGS: Hold on now. First off, I thought Root was
25 only available Monday morning.

1 MR. DAVIS: I think she's moved around.

2 MR. GOINGS: Put her Monday so she can go on Tuesday.

3 MR. DAVIS: No, y'all need to finish your case, and we'll
4 work around that.

5 MR. GOINGS: Oh, so she's coming? I thought we had to
6 take it out of turn for her.

7 MR. DAVIS: I'm still working on that. Still -- still
8 waiting to hear back from her attorney. I just --

9 MR. GOINGS: That's fine. We're just trying to
10 accommodate you.

11 MR. DAVIS: No. And I appreciate that too, and that
12 still may be the case. I just can't tell you right now. I
13 don't know.

14 MR. GOINGS: So you --

15 MR. DAVIS: I would prefer to let y'all go ahead and
16 finish your case. Y'all just take Monday morning and go
17 through it, and then we'll go ahead and have our case. We'll
18 wait to start our case, if you'd like.

19 MR. GOINGS: Okay. So if we can be done by a late lunch
20 on Monday, who would -- do you know who y'all -- was it -- is
21 it y'all's anesthesiologist? Was it Balistrieri? How do you
22 say it?

23 MR. DAVIS: No. We probably would go ahead and put up
24 Dr. Root and Erich Starn.

25 MR. GOINGS: All right. Okay.

1 MR. DAVIS: And then we get to Balistrieri, and then I'll
2 see. So --

3 MR. GOINGS: Okay.

4 MR. DAVIS: And Dr. Holbrook.

5 MR. GOINGS: So that would be cool if we do --

6 THE COURT: Okay. I'm sorry to interrupt, but do y'all
7 need me anymore today?

8 MR. GOINGS: No, Your Honor.

9 THE COURT: Because I wasn't really talking.

10 MR. GOINGS: You have a good weekend.

11 MR. DAVIS: Thank you.

12 THE COURT: Okey-dokey. Thank you. So we are adjourned
13 until 9:30 Monday morning.

14 Ms. Goodwin, if you'll hang out?

15 My clerk is going to step down and -- and talk to your
16 client just about her chair and logistics. We're trying to
17 figure out if we can be of any assistance so that she doesn't
18 have to run home at lunch every time, but Bailey's going to
19 try to figure that out. So don't leave just yet.

20 All right. Thank you, folks. See you on Monday.

21 MR. GOINGS: Thank you, Your Honor. Have a great
22 weekend.

23 (WHEREUPON, the proceedings adjourned for the day.)

24

25 --- CONTINUED IN VOLUME VI ---

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 6 OF 9 - VOLUME VI
	)	April 17, 2023
Midlands Orthopedics and	)	
Neurosurgery and Dr. Thomas	)	
J. Holbrook, M.D.,	)	
	)	
Defendants.	)	
	)	

April 10-20, 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 17, 2023

2 (WHEREUPON, the proceedings resumed.)

3 THE COURT: All right. Ready? Ready? Ready? Anything
4 come up over the weekend, Mr. Davis?

5 MR. DAVIS: Yes, ma'am. There has been something come
6 up, I imagine, I think late Saturday night. Let her know and
7 Mr. Goings, too. But we're -- the defense is withdrawing
8 their request for bifurcation.

9 THE COURT: Yes, sir.

10 MR. DAVIS: And to follow up with that, Mr. Goings, would
11 you like to go ahead -- this morning we received the subpoena.
12 I agree to accept it. This is going to happen. There was
13 already -- there was a subpoena to the current chief executive
14 officer or administrative officer, Evans. Mr. Goings alerted
15 me. Was it yesterday? It was sometime over the weekend that
16 he wanted certain financial information from Midlands. So he
17 sent -- he sent me a subpoena. I agreed to accept it. I have
18 forwarded it on to Mr. Chorzewski, if I'm pronouncing that
19 right, the CEO of Midlands Orthopedics and Neurosurgery.

20 Mr. Goings handed me the papers today, so I've already
21 seen it and sent it to him. So I had a brief conversation
22 with Mr. Chorzewski this morning, since I didn't receive any
23 response to my emails from yesterday or this morning. And
24 without divulging any client -- attorney-client privilege, I
25 want the Court to be aware that I did advise him that there is

1 a subpoena in the email, please check it, requesting certain
2 financial information, and he needs to respond in some way to
3 that subpoena.

4 And that's all I know. That's -- that's everything as
5 late as I can. I would respectfully object to anything
6 requested in the subpoena. I'm happy to hand you a copy of
7 it.

8 THE COURT: Yes, sir.

9 MR. GOINGS: Here's an extra copy.

10 MR. DAVIS: You got one? Okay. Thank you. Thank you.

11 MR. GOINGS: May I approach?

12 THE COURT: Yes, sir.

13 MR. GOINGS: See, I asked.

14 THE COURT: I appreciate that.

15 Go ahead, Mr. Davis. What are you objecting to?

16 MR. DAVIS: Your Honor, I'm respectfully objecting to any
17 information contained in the exhibit to the subpoena beyond
18 the net worth of Midlands Orthopedics. And I would by history
19 point out that on July 31st, 2020, a long time ago, I
20 responded to Mr. Hinson and Mr. Goings' earlier request for
21 certain information and a net worth statement from and about
22 Midlands Orthopedics. I'm happy to hand the Court the email.

23 But in that email -- and I've shared this with Mr. Goings
24 last night or this morning, I can't remember which. The --
25 the statement from me, as reported by Midlands Orthopedics at

1 that time was, quote, the approximate net worth of Midlands
2 Orthopedics is \$100,000. That's what was told to me and
3 that's what I related to plaintiffs' counsel back in July of
4 2020. I'm happy to hand that email to you if you need to see
5 it.

6 THE COURT: No, that's not necessary.

7 MR. DAVIS: Okay. So, Your Honor, anything, any
8 information they're requesting, I respectfully would object to
9 being disclosed or either brought forward. We've already
10 disclosed the net worth in respect to their request back in
11 2020, and there was never any objection or request for
12 depositions or financial documents.

13 That was almost three years ago, and now we have a
14 subpoena on Monday of the second week of trial for the
15 business administrator or chief executive officer to come and
16 bring up a lot of financial data about Midlands, and I just
17 think it's untimely, burdensome, and we would object. Thank
18 you, Your Honor.

19 THE COURT: How do you know it's burdensome? Well, let's
20 start with untimely. Untimely why?

21 MR. DAVIS: This case has been going on since 2019, In
22 2020, they asked for the --

23 THE COURT: Yes, sir.

24 MR. DAVIS: They asked for the net worth of Midlands.
25 I disclosed that to them.

1 THE COURT: Yes, sir.

2 MR. DAVIS: If they requested or needed any further
3 documentation of that, they -- they've been seeking punitive
4 damages the whole time. That's not news. We would have
5 addressed it at that time. So I think it's untimely.

6 This is the second week of trial. I'm out of my office
7 in Greenville. I've done everything I can to communicate to
8 Midlands. They've gotten a subpoena, and we respectfully
9 object to the untimely nature of the request. They could have
10 requested this two months ago.

11 THE COURT: They could have, but they determined they
12 didn't need it then or -- or -- or it may have been an
13 oversight, I don't know, or somewhere in between, but can
14 discovery not be conducted really at any time?

15 MR. DAVIS: Your Honor, we're in the second week of
16 trial. I think it's untimely. I think that's a -- that's a
17 burden it puts on us. We're trying to defend this case, and
18 now I've got to go chase this issue down instead of focusing
19 my time and attention on the witnesses at trial. I think it's
20 untimely.

21 THE COURT: Well, it's a subpoena directed to Midlands
22 Orthopedics. So, I mean, if it were a -- which happens to be
23 your client. If it were a subpoena directed to Jane Doe, I
24 guess we wouldn't have a problem. That puts it on the
25 recipient of the subpoena, the target of the subpoena, which

1 is Ron C-h-o-r-z-e-w-s-k-i, the CEO, Ron Chorzewski?

2 MR. DAVIS: I think it's Chorzewski.

3 THE COURT: Chorzewski?

4 MR. DAVIS: I'm not sure. I've never met him, just
5 spoken to him.

6 THE COURT: I was comparing it to Mike Krzyzewski for
7 some reason. It ends with the same?

8 MR. DAVIS: I don't know. Anyway, Your Honor, I just --
9 I just need to just make my position as clear as I can on the
10 record --

11 THE COURT: Yes, sir.

12 MR. DAVIS: -- and submit it to the Court. I've done
13 everything I can do.

14 THE COURT: Yes, sir.

15 MR. GOINGS: Thank you, Your Honor. There's two issues.
16 I'll address the second one about the subpoena first, Your
17 Honor.

18 So remember when we departed on Friday, I said that Mr.
19 Davis and I would try to get together and see if we could come
20 to an agreement on net worth. And then on Sunday, he emailed
21 me and said that the net worth of Midlands is \$100,000. And I
22 don't know how the -- the largest orthopedic and neurosurgery
23 practice in the Midlands with 30 physicians in multiple
24 locations has a net worth of \$100,000. I mean, that's -- I
25 told -- I told Mr. Davis that I'll put in an offer to purchase

1 Midlands Orthopedics if it's only \$100,000.

2 THE COURT: Right.

3 MR. GOINGS: So --

4 THE COURT: I would too actually.

5 MR. GOINGS: Yeah. So -- so maybe you and I can run up
6 the bid a little bit on them.

7 So I thought he was kidding at first, but he's not, so
8 it's fine. So then I said -- and I talked to Mr. Davis, and
9 we get along fine. I just want you to understand that I said,
10 well, I'm going to -- I'm going to issue a subpoena for these
11 documents. He said, fine, I'll accept service. We'll take it
12 up with the judge in the morning, and then we want to take
13 this up early so his witness would have the ability to gather
14 what we needed.

15 We've only narrowly tailored it to the last two years.
16 Okay? And I don't know how they get \$100,000. You know, in
17 order to determine that, you've got to look at total revenue,
18 and so we would like to have that so we could have the day to
19 digest it, this evening to digest it.

20 One of the things on there they did provide, by the way,
21 Dr. Holbrook's buyout agreement when they bought out the
22 shares and they valued the worth of his shares, but they
23 redacted the price of the shares or the amount of the shares.
24 So we need an unredacted copy of that. We would obviously say
25 this would be under a confidentiality order, not disclose it

1 to -- to anyone. We'll hand it back to him at the end of the
2 trial, but we have to have something to determine net worth.

3 Now, I will say we -- our 30(b)(6) deposition notice to
4 Midlands included all this net worth stuff. Mr. Davis
5 objected to it. And he said after the deposition I'll just
6 provide you what we say the net worth is and going forward,
7 get to trial, if there's an issue, we can take it up then.
8 Try not to make an issue out of something that may not be an
9 issue, and then here we are and they're saying it's 100,000.

10 We need to look into that for obvious reasons. It's an
11 issue. There shouldn't be any burdensome component of this
12 because these are readily available materials, you know, the
13 balance sheet or profit-loss sheet, a pro forma prospectus.
14 These are things that, of all people, a CEO would have,
15 especially right now here in tax season when you know what
16 your dollars and cents are.

17 So, I mean, it really is a click of a button to get it,
18 and I don't want to belabor that point anymore, but if -- if
19 we could get it produced today, then we can have it this
20 evening to look at.

21 I can address the bifurcation if you want me to now or
22 later.

23 THE COURT: Well, they've withdrawn their motion, so --

24 MR. GOINGS: Well --

25 THE COURT: -- unless you're willing to make a separate

1 motion.

2 MR. GOINGS: So we -- we object to --

3 THE COURT: Them withdrawing it?

4 MR. GOINGS: -- their withdrawing bifurcation, and the
5 reason is, is because the bifurcation has already been granted
6 and we're now a week and a day into a trial. We would have
7 tried this case a lot different if this wasn't a bifurcated
8 case. Like, for example, there are things we would be going
9 into in opening that we didn't go into because it was
10 bifurcated. Honestly, the order of our witnesses would have
11 changed dramatically.

12 And now just to throw in net worth and punitive damages
13 at the end is bizarre when we're talking about compensatory,
14 and we've been doing compensatory in opening and now, and I
15 don't think -- in fact, I looked at the statute. The statute
16 doesn't give a provision to bifurcate, bifurcation granted,
17 then say changed my mind, withdraw bifurcation. It's either a
18 bifurcated case or it's a non-bifurcated case.

19 They moved for bifurcation. The statute doesn't give us
20 the ability to oppose it. So it was bifurcated. And now to
21 undo and unring a bifurcation would be improper because we've
22 been at this trial for a while, presented a lot of evidence,
23 and it really tactically changes the game plan for us.

24 I think we should stay with the bifurcated trial. I
25 think that makes more sense. It's not going to add much more

1 time at all to this -- this case. And the longer I argue
2 about it, the longer it's going to take. So I will sit down.
3 I don't think it's proper at all to unbifurcate a bifurcated
4 case. It's -- it comes with significant prejudice to us to do
5 so, Your Honor. Thank you.

6 MR. HINSON: And just to Mr. Goings's point, I had slides
7 in opening I was going to talk about with regard to punitive
8 damages and that issue. Mr. Davis said he wanted bifurcated.
9 I deleted those slides based off of the -- obviously, the fact
10 that it wasn't coming in. So the opening statement went
11 different, Your Honor.

12 THE COURT: Yes, sir. Mr. Davis?

13 MR. DAVIS: Thank you, Your Honor.

14 Your Honor, I've got the statute before me, and I'm
15 reading it. There's -- there is nothing in the statute that
16 says the defense cannot withdraw while the plaintiff is still
17 in their case. There's no prejudice. They have a closing
18 argument. I'm going to ask them to open in full.

19 If they want to now -- they're still on their case. They
20 sent me a subpoena this morning for the CEO to provide a bunch
21 of financial data. We're in the process of trying to get that
22 done. When it's here, I'm happy to turn it over to them under
23 that protective order we already have established three years
24 ago and let them look at the data, and they can introduce
25 whatever the Court allows them to introduce.

1 There's no prejudice to them. It's still their case, and
2 there's nothing in the statute that says we can't withdraw.

3 THE COURT: Well --

4 MR. DAVIS: But for the purposes of court efficiency and
5 -- and all the rest.

6 THE COURT: I mean, to be fair, I'm sure there are very
7 few, if any, statutes out there that provide for the
8 withdrawal of a motion. That's just sort of my practice. And
9 so because there are no guidelines for that or anything really
10 probably many other statutes or similar motions, then I've got
11 to determine what is fair and equitable.

12 And if it has changed the presentation of evidence, then
13 that puts plaintiffs at a disadvantage. So the trial will
14 remain bifurcated because I think that's the most equitable
15 remedy in this situation.

16 As to the subpoena, any objection or I guess sort of an
17 impromptu motion to quash is denied. Objection to the extent
18 that it's an objection is overruled.

19 You know, I understand the need for this information. I
20 don't think that the ability to request it is waived by
21 delaying the request in some manner. Again, the onus is on
22 Midlands Orthopedics and Neurology, and I don't know if
23 there's a representative here today, but I've not seen one all
24 week. Even at the 30(b)(6) deposition, it was Dr. Holbrook,
25 who's now retired and no longer works there. So I would guess

1 that most of these documents are not in his possession.
2 They're in the possession of people who have not been in this
3 courtroom and should be in their office, their practice
4 working on these things, particularly around tax time for the
5 2022 tax return. I would hope that that's complete because
6 it's due today to the IRS.

7 And so all of these other things really go with that.
8 2021 is not so long ago. It's not something that's got to be
9 requested from the IRS or dugged out of the archives. So I
10 don't see the burden in producing those things. I've not been
11 given any extrinsic evidence of the subpoena response being
12 unduly burdensome, just a representation by counsel that it's
13 burdensome, but, you know, even that representation lacks any
14 foundation that's been demonstrated to the Court.

15 So for all of those reasons, the objection is overruled
16 or the -- the motion to quash, as it were, is denied.

17 Are we ready for the jury?

18 MR. GOINGS: Can we just kind of get an understanding of
19 when they get it to us today? Just so -- we're not going to
20 present it today. Okay? Just so you know.

21 THE COURT: Yes, sir.

22 MR. GOINGS: Perhaps, maybe if we can get it by, you
23 know, the close of business, just so we can have it this
24 evening to -- to look through.

25 THE COURT: Can we sort of revisit that? Because they

1 came in here ready to object. That might need to be revisited
2 at lunchtime.

3 MR. GOINGS: That's fine.

4 THE COURT: Because I'm sure Mr. Davis, Mr. Heitmann,
5 someone's going to need the opportunity to make a phone call,
6 which is not right now.

7 Mr. Davis, did you have a witness that needed to testify
8 today out of turn?

9 MR. DAVIS: No. I'm going to wait until they finish their
10 case.

11 THE COURT: Okay.

12 Okay. All right. Bring the jury, please.

13 (WHEREUPON, the jury entered the courtroom at 10:05 a.m.)

14 THE BAILIFF: All jurors are seated, Your Honor.

15 THE COURT: Thank you.

16 Welcome back, folks. I hope you had a good weekend.

17 Thank you, Madam Juror, for the note about the jacket.

18 That yellow jacket that juror had on last week.

19 Gorgeous. I had to stop her in the hallway and ask where she
20 got it, and she gave me the information.

21 UNIDENTIFIED FEMALE: Are you sharing, Judge?

22 THE COURT: I don't know. We have a Julie Walker.

23 UNIDENTIFIED FEMALE: They come in different colors.

24 THE COURT: But I will share it with you at the end of
25 the trial.

JAZINE GOODWIN - DIRECT BY MS. GOODING

1 We're still on the plaintiffs' case, so please give them
2 your attention. They're going to call their next witness.

3 Ms. Gooding?

4 MS. GOODING: Thank you, Your Honor. May it please the
5 Court. The plaintiff calls Ms. Jazmine Goodwin to the stand.

6 THE BAILIFF: Ms. Goodwin, if you'll stand here. Put
7 your left hand and raise your right.

8 THE CLERK: Do you solemnly swear or affirm that the
9 testimony you're about to give in this case will be the truth,
10 the whole truth, and nothing but the truth, so help you God?

11 THE WITNESS: Yes, ma'am.

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

13 THE WITNESS: Jazmine Demetria Goodwin.

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

15 THE BAILIFF: And please speak into the microphone so
16 everybody can hear you.

17 THE WITNESS: Okay.

18 MS. GOODING: Jazmine, you can adjust that microphone so
19 that it's easy for you to talk into. It's hard for the jury
20 to hear behind that glass. So we want to make sure they can
21 hear you.

22 THE WITNESS: Can you hear me?

23 MS. GOODING: Talk a little louder for me.

24 JAZMINE GOODWIN, being first
25 duly sworn, testified as follows:

DIRECT EXAMINATION

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BY MS. GOODING:

Q: Please introduce yourself to the jury?

A: My name is Jazmine Goodwin. I am James and Crystal's oldest daughter, and I have two younger siblings. They are -- they are 9 -- I'm sorry. They are --

THE BAILIFF: Keep that microphone up right there. Okay? And talk into that mic. Okay?

THE WITNESS: Okay. Can you hear me?

THE BAILIFF: Yes.

MS. GOODING: Yes.

THE WITNESS: Okay.

BY MS. GOODING:

A: They are 20 and 18.

Q: Okay. And are you a little nervous today, Jazmine?

A: I am.

Q: That's okay. We'll go as quick as we can. Okay? Now, I understand that you no longer live at home; is that right?

A: Yes, ma'am.

Q: How close do you live to your mom and dad?

A: I live two minutes away.

Q: Excellent. Do you get to see them often?

A: Every day.

Q: Good. And in July of 2016, how old were you?

A: I was 19 years old.

1 Q: And that would have made your sisters 15 and 11; is that
2 right?

3 A: Yes, it is.

4 Q: Okay. And were you in school at the time?

5 A: Yes. And I was also working at Walmart.

6 Q: Great. Now, do you recall your mom having surgery back
7 in July of 2016?

8 A: Yes, I do.

9 Q: Did you know very much about why she was having that
10 surgery?

11 A: Not at all. I just know Dr. Holbrook recommended it.

12 Q: Okay. What do you recall about the day of that surgery?

13 A: My mother came in and kissed me very early and told me
14 she would see me later, and my father came back and got my
15 sisters around lunchtime to take them to the hospital. Later
16 that day, my grandmother called me and told me that we needed
17 to go to the hospital because something happened, and they
18 wasn't sure what happened.

19 Q: Take your time. Do you need some water, Jazmine, or do
20 you have some?

21 A: My grandmother called me and told me that we needed to go
22 to the hospital, and they weren't sure what happened to my mom
23 in surgery. I didn't know how to feel, and I just was praying
24 that my mom was okay because I didn't hear from her that day.

25 Q: Now, you mentioned that your grandma was the one who

1 called to tell you that they weren't sure what was going on
2 with your mom at that time?

3 A: Yes, ma'am.

4 Q: Now, was that your grandma who's here in the courtroom
5 with us today?

6 A: No, ma'am. It's my grandmother's older sister, but she's
7 a grandma speaker.

8 Q: You call her Grandma Tiny; is that right?

9 A: Yes, ma'am.

10 Q: Okay. And when you got -- did Grandma Tiny come and get
11 you?

12 A: Yes, ma'am. Because she was going to be my ride to work,
13 but, of course, the phone call changed. So she was my ride to
14 the hospital instead.

15 Q: When you got to the hospital, who did you see there?

16 A: I seen my sisters, my father, my grandmother, and -- and
17 my cousin, Christian.

18 Q: There were a number of family members already there?

19 A: Yes, ma'am.

20 Q: When did you get to see your mom for the first time after
21 getting that call from your Grandma Tiny?

22 A: I seen my mother hours after, and she was in recovery.

23 Q: Okay. Tell us what you remember about being with your
24 mom in recovery that night?

25 A: She was just crying. She really didn't want to talk.

1 She shut down, and she was in disbelief what she had just been
2 told. It was very hard to digest.

3 Q: And what she has just -- had just been told was that --
4 the news about her not being able to move her legs?

5 A: Yes, it was.

6 Q: And tell me who was there when you all had that
7 conversation with your mom?

8 A: It was me, my sisters, my father, and my grandmother,
9 Edna.

10 Q: Did you go home that night?

11 A: Yes, I did, because I had to go to school the next day.

12 Q: Who stayed with your mom?

13 A: My middle sister, Jamila.

14 Q: And the littlest one came home?

15 A: Yes, ma'am. She came home.

16 Q: Did you and your sisters and your dad continue to visit
17 your mom during that hospital stay?

18 A: We visited my mom daily.

19 Q: And did you have an opportunity to speak with Dr.
20 Holbrook at some point during that time?

21 A: He came and spoke to the whole family.

22 Q: And -- and in one of those times that he came and spoke
23 to the whole family, did you hear from him on what happened
24 during the surgery?

25 A: Yes, I did.

1 Q: And did you record one of those conversations on your
2 phone?

3 A: Yes, I did.

4 Q: Why did you decide to do that?

5 A: Because my mother was heavily medicated and she wasn't
6 understanding anything anyone was saying to her, so she asked
7 me to use it as a reference so she could understand.

8 Q: So you wanted to be able to play it back to understand it
9 later?

10 A: Yes.

11 Q: Okay. And was that within a few days after the surgery?

12 A: Yes, it was.

13 Q: Do you remember who was in the room with you when you
14 took that video?

15 A: It was my father, my sisters, me, my grandmother, Edna,
16 and my uncle, Mario, and of course, my mother.

17 Q: And did you provide us with a copy of that video?

18 A: Yes, I did.

19 Q: Did you alter it in any way?

20 A: No, ma'am.

21 Q: Okay.

22 MS. GOODING: We'd like to play the video that Ms.
23 Goodwin took on August 1st, 2016.

24 THE COURT: Any objection?

25 MR. DAVIS: No, Your Honor. We've seen this video.

JAZINE GOODWIN - DIRECT BY MS. GOODING

1 THE COURT: You may proceed, Ms. Gooding.

2 MS. GOODING: Thank you. We'll get it pulled up here.

3 (WHEREUPON, the video was played with questioning during
4 as follows. Video not transcribed herein.)

5 BY MS. GOODING:

6 Q: Is that your daddy in the background?

7 A: Yes, it is.

8 (WHEREUPON, the video continued playing and was then
9 stopped, after which the proceedings resumed as follows.)

10 BY MS. GOODING:

11 Q: Ms. Goodwin, is this the video you took on August 1st,
12 2016?

13 A: Yes, it is.

14 Q: Is it the whole video you took?

15 A: Yes, it is.

16 Q: Does it accurately capture what was said in the room at
17 that time?

18 A: Yes, it does.

19 Q: Did you hear Dr. Holbrook say that something restricted
20 the blood flow to that area of your mom's spinal cord?

21 A: Yes, I did.

22 Q: Did you hear him say that something irritated one of the
23 blood vessels and caused it to occlude?

24 A: Yes, I did.

25 Q: Did you hear it say -- hear him say that your mom had a

1 stroke in her spinal cord?

2 A: Yes, I did.

3 MS. GOODING: Your Honor, I would move to admit this
4 video into evidence. I believe we're on Exhibit Number 27.

5 THE COURT: Any objection, Mr. Davis?

6 MR. DAVIS: Excuse me. Yes, Your Honor. It's -- it's
7 not a complete video of the entire discussion. It starts
8 after he was in the room. We don't know what he said before.
9 We don't know what he said after. We don't know what other
10 conversations he's had on other days. So I'd object.

11 THE COURT: Plaintiffs' 27 will be admitted over the
12 defendants' objection.

13 (WHEREUPON, Plaintiffs' Exhibit Number 27, video, was
14 admitted into evidence.)

15 MS. GOODING: Thank you, Your Honor. And we'll mark that
16 in just a few minutes, if that's okay.

17 THE COURT: Thank you.

18 BY MS. GOODING:

19 Q: Jazmine, let's talk about your mom a little bit before
20 this surgery now. Okay? So we're talking about before July
21 28th of 2016. What kinds of things did you see your mom doing
22 on a regular basis before this surgery?

23 A: Well, my mom was a stay-at-home mom. So she cooked all
24 the meals. She ran errands. She took us to school, after
25 school to work. Just being a stay-at-home mom.

1 Q: Did whatever needed to be done?

2 A: Yes.

3 Q: Okay. And did -- do you have any memory of your mom
4 being unable to do any of those things, unable to drive or
5 pick you up or cook or any of the things that you just
6 mentioned because of back pain prior to this collision [sic]?

7 A: Not at all.

8 Q: Tell me about the kinds of things that you and your mom
9 did together before this surgery?

10 A: We would go get our hair done every two weeks. We would
11 run errands. We would go bowling sometimes as a family. We
12 no longer get our hair done because of the steps. She can't
13 get up the steps. So the hairdresser comes to the house. I
14 no longer can go to the grocery store with my mother. It's
15 difficult getting in and out of the car. It takes so long.
16 So she gets groceries delivered. I help her put up the
17 groceries.

18 Just last month, my mother fell out of her wheelchair
19 head first trying to put up groceries because they're so
20 heavy. So I help out with housework as much as I can. For
21 example, say -- excuse me. Vacuuming is very hard. So I
22 vacuum for my mother. Sometimes I'll transfer some laundry
23 from the washer to the dryer for her. Just make sure she's
24 set up for the day.

25 Q: Those are things you try to do even now that you're not

1 living at home?

2 A: Even though I'm not living at home, yes.

3 Q: We heard -- the jury heard from your dad on Friday, and
4 he said that your mom was baking again; is that right?

5 A: Yes. It's something she's passionate about.

6 Q: Are you happy to see her doing that again?

7 A: I am, but because it's something she loves and it keeps
8 her mind off of things.

9 Q: Is it -- is she able to do it in the same way that she
10 did before this surgery?

11 A: No. It's kind of hard. She has to help -- have
12 assistance with having stuff at her level, but she makes it
13 work.

14 Q: How old is your mom again?

15 A: My mother is 45 years old.

16 Q: Did you ever think before 2016 that you would be taking
17 care of your mom the way you are at 45 years old?

18 A: Of course not, not in this way at all, but I would do it
19 a million times over because it's my mom. She's my best
20 friend. The same way she took care of us, I want to return
21 that favor. I want to always be there for my mother for her
22 life and after.

23 MS. GOODING: Thank you, Jazmine. I don't have any other
24 questions.

25 THE COURT: Mr. Davis?

JAZINE GOODWIN - CROSS BY MR. DAVIS

1 MR. DAVIS: Thank you, Your Honor.

2 Will you take that down, please? Thank you.

3 CROSS-EXAMINATION

4 BY MR. DAVIS:

5 Q: Just a few questions. Can you hear me okay?

6 A: Yes.

7 Q: Okay. Could you tell us what time of day of that video
8 that you showed to the jury? What time of day was that?

9 A: I don't remember the time, but I know it was in the
10 evening.

11 Q: In the evening?

12 A: Yes.

13 Q: Okay. Were you there that morning when Dr. Holbrook made
14 rounds and saw your mom?

15 A: No, I was at school.

16 Q: Okay. Do you remember what date in relation to her
17 surgery that that video that you made was?

18 A: It was the Monday after her surgery.

19 Q: So her surgery was the 28th of July. That would have
20 been July 29th?

21 A: The Monday after the surgery. I'm not sure of the date.

22 Q: Well, the Monday after surgery?

23 A: Yes.

24 Q: Okay. Were you present every time that Dr. Holbrook
25 spoke to and explained things to your mom after her surgery?

1 A: No.

2 Q: No?

3 A: It was just that time.

4 Q: Just that time? Do you know how long Dr. Holbrook had
5 been there before you started doing the video?

6 A: About a minute.

7 Q: About a minute? Can you tell us what you recall him
8 saying before he started the video?

9 A: He came in and introduced himself to everyone.

10 Q: Uh-huh.

11 A: And that's it.

12 Q: Okay. Do you recall what he said after you turned the
13 video off? Because it looked like he was still talking.

14 A: No, I don't remember.

15 Q: Did you record any other conversations while your mom was
16 in the hospital when Dr. Holbrook came to see her, check on
17 her, talk to her?

18 A: I was in school.

19 Q: All right. Do you know how long your mom is in the
20 hospital? How many days?

21 A: I don't recall.

22 MR. DAVIS: Nothing further. Thank you.

23 THE COURT: Any redirect?

24 MS. GOODING: No, Your Honor.

25 THE COURT: All right. Thank you. You may step down.

1 MS. GOODING: Your Honor, Jazmine is under subpoena. May
2 she be excused?

3 MR. DAVIS: Certainly.

4 THE COURT: Okay. You're free to go, Ms. Jazmine.
5 Let's pause now to mark that exhibit so that we don't
6 forget.

7 MS. GOODING: Your Honor, our next witness is actually by
8 video.

9 If you want to go ahead and get that set up --

10 MR. GOINGS: Sure.

11 MS. GOODING: -- while I'm grabbing this.

12 THE COURT: Absolutely. Who is your next witness?

13 MS. GOODING: Dr. Fred Jones.

14 THE COURT: Okay.

15 MS. GOODING: He's an anesthesiologist.

16 MR. HINSON: And, Your Honor, could -- we just ask for a
17 -- we took this deposition in -- which was -- Dr. Jones
18 couldn't make it. Just some brief instruction as to how a *de*
19 *bene esse* deposition works when a witness is unable to come to
20 trial.

21 THE COURT: I feel like I've sort of given that
22 explanation already. Right? I've told the jury about
23 depositions, out of court procedures when a person, I think --
24 right.

25 MR. HINSON: Yeah. This --

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 THE COURT: The first time, I don't know exactly why the
2 portions of the depositions were taken. That's the attorney's
3 prerogative because that was Dr. Holbrook, who is sitting
4 right in the courtroom, but that procedure is typically done
5 when a witness, for whatever reason, cannot appear live in
6 trial.

7 And so you are to accept that deposition testimony sworn
8 under oath with attorneys there, the same as if the witness
9 were live in court sitting on the witness stand. Dr. Jones
10 apparently could not be here. That's not uncommon with
11 physicians or people who are from out of state or something
12 like that, but this is how this next witness will be presented
13 to you.

14 MR. HINSON: Thank you, Your Honor.

15 THE COURT: Yes, sir.

16 (WHEREUPON, the deposition of Dr. Jones was played as
17 follows.)

18 DR. FREDERICK JONES, being first
19 duly sworn, testified as follows via video deposition:

20 THE VIDEOGRAPHER: We are now on the record. Today is
21 March the 30th, 2023, and the time is --

22 DIRECT EXAMINATION

23 BY MR. HINSON:

24 A: -- off to come to trial.

25 Q: Dr. Jones, what do you do for a living?

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 A: I'm an anesthesiologist.

2 Q: And why is it today that we're taking your testimony by
3 video instead of having you come to Columbia, South Carolina,
4 in a few weeks?

5 A: Serious personnel shortages in my department, and I was
6 unable to get the time off to -- to come to trial.

7 Q: And, Dr. Jones, if you would, tell us just a little bit
8 about yourself. Are you married? Do you have kids?

9 A: I am married. Married 32 years come July 28th. I have
10 two children, two sons, one 30, one 25. Born in Meridian,
11 Mississippi. Raised on the East Coast. My father was in the
12 Navy, so we moved a little bit.

13 And graduated from college, Wake Forest University in
14 Winston-Salem, North Carolina. Medical school at Howard
15 University right after. I attended college on a four-year
16 Army ROTC scholarship. Then after medical school, I did my
17 internship in Pennsylvania.

18 Then I served four years as a medical officer in the U.S.
19 Army, a year in Korea, Second Infantry Division, and then
20 three years at Aberdeen Proving Ground, and then I did
21 another, for a total of 23 years Army, 4 active duty, 19
22 reserve.

23 Q: And when you say medical officer, what is -- generally
24 what does that mean for us lay folks?

25 A: That's an Army term meaning doctor. General medical

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 officer, meaning basically a family practitioner for the four
2 years I was active duty. And then at the end of my active-
3 duty term, I did my anesthesiology residency, but the term is
4 still medical officer. That's just a military term for any
5 physician.

6 Q: And so you have done a residency, you say, in
7 anesthesiology?

8 A: Right. A three-year residency in anesthesiology,
9 followed by a one-year fellowship in critical care medicine.
10 At the completion of that training, I was appointed a clinical
11 instructor in anesthesiology and director of the Transplant
12 Anesthesiology Program at the University of Maryland in
13 Baltimore, where I had done my residency and fellowship.

14 And then moved to Oxford, Mississippi, in 1999. A former
15 medical school classmate told me of a good opportunity down
16 there, and the family and I visited and liked it. So we moved
17 down in 1999 to Oxford, Mississippi.

18 I was at the practice at Baptist Memorial Hospital in
19 North Mississippi for five years and then got an offer at the
20 Baptist Memorial Hospital-DeSoto in Southaven and came up here
21 in 2004 and have been here. I was there almost 18 years, and
22 then last year was asked to take the leadership at the
23 flagship hospital of our health system, the Baptist Memorial
24 Hospital in Memphis, which is where I am now.

25 Q: And so in your new role here in Memphis, do you still

1 practice clinical medicine?

2 A: Every day. Oh, yeah. I have the administrative title of
3 site chief. Also assistant professor of anesthesia at the
4 University of Tennessee Anesthesiology Residency clinical
5 faculty. I don't give lectures or anything like that. But
6 yeah, I do clinical anesthesia every day, in addition to my
7 administrative duties, which is basically in-between cases or
8 after hours.

9 Q: And so have you been involved in teaching medical
10 students?

11 A: Only in the operating room. I don't give lectures or
12 prepare lectures or anything of that type. But certainly, we
13 teach them in the operating room, medical students and
14 residents and student anesthesiologists. We have several CRNAs in
15 our hospital. So we teach all three classes of students: the
16 residents, the student anesthesiologists, and medical students.

17 Q: A minute ago, you mentioned a residency you did in
18 anesthesia. What year did you complete that residency?

19 A: 1996, I completed the residency. In 1997, I completed
20 the fellowship.

21 Q: And for us non-doctors, just generally, what is a
22 residency and what is a fellowship? Terms we often hear, but
23 --

24 A: Right.

25 Q: -- maybe not know what they are.

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 A: After a doctor completes medical school, you still -- you
2 know the books, but you don't know medicine. So you do an
3 internship. You can't really get a license until you finish
4 your internship. Then after an internship, you are a general
5 practitioner. You could hang a shingle, but you're a general
6 practitioner.

7 A fellowship -- I'm sorry. A residency is what allows
8 you to become a specialist. In my case, my specialty is
9 anesthesiology. And a fellowship allows you to be a
10 subspecialist if you choose to practice in that subspecialty
11 area. My subspecialty would be critical care medicine, which
12 I don't practice. I've stayed strictly with anesthesiology,
13 but that's the difference between residency and fellowship.

14 Q: And do you hold any board certifications?

15 A: Yes. I'm board certified by the American Board of
16 Anesthesiology.

17 Q: And how long have you held that board certification?

18 A: Since September of 1997.

19 Q: And, Doc, this may be a hard thing to estimate, but in
20 your career as a physician, how many separate surgical
21 procedures have you had some involvement in in the field of
22 anesthesia?

23 A: It would be in the thousands.

24 MR. HINSON: At this time, plaintiffs would offer Dr.
25 Frederick Jones as an expert in the field of anesthesiology.

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 MR. HEITMAN: No objection.

2 BY MR. HINSON:

3 Q: All right. Dr. Jones, this work we're here for today in
4 a medical legal context, have you ever done that before?

5 A: Yes, I have.

6 Q: And have you ever worked with me or my law firm before?

7 A: Not before this case, no.

8 Q: And we have my colleague, Mr. Robert Goings, and Jess
9 Gooding is with him in his firm as well. Have you ever worked
10 with either of them before?

11 A: No, I have not.

12 Q: How many times -- how many different cases would you
13 estimate you have given deposition or trial testimony in?

14 A: In between deposition and trial, probably 50 to 60.

15 Q: And of those approximately 50 to 60, how many would you
16 estimate were on behalf of the patient/plaintiff and how many
17 would you estimate were on behalf of the healthcare
18 provider/defendant?

19 A: Maybe 10 to 15 percent for the patient/plaintiff, and the
20 rest would be for the health care provider.

21 Q: And so then typically when you're in this setting, you're
22 essentially on the other side of the courtroom testifying on
23 behalf of the defendant?

24 A: That's correct.

25 Q: This type of work, medical legal expert work, tell us --

1 tell the jury why you -- why you do it?

2 A: I became involved in it initially in my residency when it
3 was my first encounter, one of my attending anesthesiologists.
4 In other words, when I was still in training, we went through
5 the process, and I was deposed at that point. An attorney
6 mentioned to me, he said, well, you -- you handle yourself
7 pretty well under questioning. You ever considered looking at
8 a case for me? And that was in 1997, ninety -- yeah, probably
9 '97.

10 Anyway, it caught my attention, but over the years, I
11 enjoy the fact that I can learn vicariously from these cases.
12 It makes me look at things I might not necessarily have looked
13 at before. I think it's made me a better physician, and also
14 it's important that, yeah, if a case is presented to me, there
15 are cases in which I think healthcare providers make mistakes.
16 And in a lot of cases, I think that they deserve good defense,
17 and I try to help out as best I can.

18 Q: Have you turned down cases?

19 A: Yes.

20 Q: Have you turned down cases for the plaintiff?

21 A: Yes.

22 Q: Have you turned down cases for the defense?

23 A: Absolutely.

24 Q: Doc, I want to shift gears a little bit back to your
25 clinical experience. In your work as an anesthesiologist, of

1 all the surgeries you've been involved with as an
2 anesthesiologist, approximately how many would you estimate
3 were some sort of spine surgery?

4 A: A few hundred, and that would include practice now, but
5 also as a resident. The University of Maryland Medical Center
6 at one point had a spine fellowship, one of the best
7 supposedly in the country. And so even since 1993, when I
8 started residency, I've been working in providing anesthesia
9 for spine surgery. So I would say in the hundreds.

10 Q: What percentage of all your surgeries would you estimate?

11 A: Probably anywhere 5, 10 percent.

12 Q: And of those spine surgeries you've been involved with as
13 an anesthesiologist, have you had the occasion where
14 neuromonitoring was used?

15 A: Most required neuromonitoring, yes.

16 Q: And while you yourself are not a neuromonitoring
17 technician, are you familiar with that process?

18 A: Very.

19 Q: Doctor, just generally speaking, as an anesthesiologist,
20 do you have an understanding as to how a patient's blood
21 pressure should be managed during a surgery intraoperatively?

22 A: Yes, I do.

23 Q: If a patient's blood pressure is not adequately
24 maintained during surgery, are there repercussions or
25 consequences that can befall the patient that can happen?

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 A: Certainly. There are many that can befall the patient if
2 the blood pressure is not properly maintained.

3 Q: And so if they are allowed to fall too low for too long
4 of a period of time, what -- what sort of things can -- could
5 happen to the patient?

6 A: A number of organ systems can be affected by the pressure
7 falling too low. You can have cerebral infarction, in other
8 words a stroke. You can have heart attack. You can have
9 renal failure. And you can have poor perfusion really of all
10 the organs, but the ones that stand out most are usually going
11 to be the central nervous system and spinal cord. The kidneys
12 certainly are one, and the heart is a very obvious one too,
13 but all of the organs can suffer. You can even have muscle
14 damage due to low blood pressure for too long.

15 Q: And, Doc, I should have mentioned this earlier. As we go
16 through today and we talk about different -- different things
17 with medical concepts, as we talk about Crystal Goodwin
18 specifically, would you agree that, unless you state
19 otherwise, all the testimony that you offer, you will only
20 offer if you hold it to a reasonable degree of medical
21 certainty?

22 A: I would agree with that, yes.

23 Q: If a patient's -- well, Doc, let me ask you this. If --
24 let's talk about what you've reviewed in your work in this
25 case. Tell me what -- tell the jury what materials you have

1 been provided and what you've reviewed?

2 A: I've reviewed the records from the Midland Orthopedic
3 Surgery Clinic. I reviewed the records from the
4 hospitalization during the surgery that we're talking about.
5 I've also reviewed the neuromonitoring records and, certainly,
6 the depositions that were taken in this case, several of the
7 depositions, and affidavits.

8 Q: And when you say in this case, these are records
9 involving what patient?

10 A: Yes, Ms. Crystal Goodwin.

11 Q: Earlier -- sorry to jump around just a second, but I
12 realized I forgot to make mention of this. I asked you if a
13 patient's blood pressure was not adequately maintained during
14 surgery, the consequences that could -- could occur.

15 A: Certainly.

16 Q: And one of the things you mentioned was -- you used the
17 term poor perfusion?

18 A: Yes.

19 Q: And I'm not sure what -- at what point in the -- in the
20 trial your -- your testimony may be played, but in the event
21 that hasn't been discussed with the jury --

22 A: Right.

23 Q: Could you just tell us in layman's terms what we're
24 talking about when you use the term perfusion or poor
25 perfusion?

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 A: Perfusion in layman's terms is just a driving pressure of
2 the fluid through a pipe line, if you will. You know, if you
3 can turn on your faucet and it's just dripping instead of
4 flowing, you've got this poor perfusion through that pipe.
5 Same in the human body. The perfusion is the -- the driving
6 pressure of blood through the blood vascular system, through
7 your blood vessels.

8 Q: And so do we have perfusion in our lungs?

9 A: Yes. You have perfusion in every organ of your body that
10 requires blood flow, and that's every organ of your body. So,
11 yes, you've got perfusion everywhere.

12 Q: Would it include your spinal cord?

13 A: Absolutely.

14 Q: Would it include your kidneys?

15 A: Yes.

16 Q: Your liver?

17 A: Yes.

18 Q: Heart, lungs, et cetera?

19 A: Correct. And I think the important thing to remember
20 about perfusion is perfusion itself is not just the issue.
21 You've got to have perfusion, but it also has to be at the
22 proper pressure. If the pressure -- the perfusion pressure is
23 what we call it. If that perfusion pressure is too low, that
24 in itself is a problem. In other words, it's not just -- it's
25 not enough just to have blood flowing through it. It needs to

1 be flowing through it at a specific pressure. You don't want
2 it too high, but you also cannot have it too low.

3 Q: Okay. Doc, I want to talk about that concept in a
4 minute, but first I want to jump back to the materials that
5 you've reviewed. The hospital that Crystal Goodwin had her
6 surgery on July 28th, 2016, was -- now it's called Prisma
7 Health, but it actually used to be called Palmetto Health
8 Baptist. Like a lot of them, it has changed names. Have you
9 undertaken to kind of get a general idea of the hospital, its
10 size, its capabilities?

11 A: I have, not long really after the -- I became involved
12 in this case. It's about the same size and it seems like the
13 same services offered as a hospital where I was chief of
14 anesthesia for about 17 years, which is Baptist Memorial
15 Hospital-DeSoto, right down in Southaven. About 300 beds,
16 tertiary care hospital with a wide variety of surgical
17 services. So, yes, I'm familiar with -- with hospitals of
18 that type, and I know it's situated in Columbia. It's the
19 state capital of South Carolina.

20 Q: And the -- you used the term tertiary care. For --
21 again, for us lay folks, what -- just generally, what does
22 that term mean?

23 A: Tertiary care, meaning that you have a hospital that can
24 provide, you know, not just emergency room or primary care,
25 but tertiary care, inpatient hospital care, usually involving

1 also surgery and major surgeries, such as spine surgery and
2 those types of surgeries.

3 Q: And, Dr. Jones, we can get into the -- the specifics and
4 the details later on in just a little bit here, but kind of
5 the overarching 30,000-foot question, from your review of
6 these materials that you mentioned a minute ago, did Crystal
7 Goodwin suffer an injury during the surgery Dr. Holbrook
8 performed on July 28th, 2016?

9 A: Absolutely.

10 Q: And can you just in general terms describe what that
11 injury was?

12 A: Sure. She suffered a severe damage to the spinal cord
13 that has left her basically a functional paraplegic.

14 Q: And again, we can get into the details in a few minutes,
15 but from your review of the materials, have you reached any
16 conclusions as to this neurologic injury that you just
17 described?

18 A: Yes, I have.

19 Q: As to the cause of it?

20 A: Yes, I have.

21 Q: And what is that?

22 A: That there was inadequate perfusion to her spinal cord
23 during a critical portion of the surgery, and that's caused
24 the neurologic injury that I just mentioned.

25 Q: And so when you say inadequate perfusion to the spinal

1 cord, what are we talking about?

2 A: The blood pressure was too low for too long.

3 Q: Doc, in general terms, what does it mean to be the
4 attending anesthesiologist in a spine surgery?

5 A: Attending anesthesiologist is the same -- really, the --
6 the broader term is attending physician. As I was mentioning
7 earlier, in my training, you have interns, you have residents,
8 you have fellows, and you have attendings. Attending is the
9 highest level of being a physician, and in the anesthesia
10 arena specifically, you have CRNAs or certified registered
11 nurse anesthetists, and you have the attending
12 anesthesiologist. The attending anesthesiologist is the
13 anesthesiologist who oversees the CRNA.

14 Q: And for the surgery that Dr. Holbrook performed on the
15 morning of July 28th, 2016, who did you understand to be the
16 attending anesthesiologist?

17 A: My understanding is it was Dr. Jennifer Root.

18 Q: And how does -- how, if at all, does -- does that
19 relationship work between the anesthesiologist and the
20 surgeon? Just in general terms, how does that work?

21 A: The anesthesiologists and the surgeons are parts of the
22 team. The surgeon certainly brings the patients to the
23 hospital and posts the cases, but the anesthesiologist works
24 with the surgeon and the other members of the team. In this
25 case, you have the CRNA and the neuromonitoring tech.

1 But there's a collaborative understanding, but also we
2 focus on our individual areas of specialty. He's operating on
3 the -- he's functioning and looking at the actual surgical
4 opening and closure and those concerns. We're focusing on
5 managing the patient, keeping them alive and properly
6 perfused, properly oxygenated, properly ventilated throughout
7 the surgery, but we are in communication, and we have to have
8 an understanding of how we're going to manage the patient.
9 That's probably the most important thing.

10 Q: As the anesthesiologist working a spine case, do you rely
11 on the surgeon to provide you certain information?

12 A: Absolutely. I rely on the surgeon to provide me
13 information, and typically that surgeon is going to rely on me
14 to provide certain information to him or her.

15 Q: Two-way street?

16 A: Correct.

17 Q: And, Doc, I want to talk about the assessment of a
18 patient prior to surgery.

19 A: Uh-huh.

20 Q: So before surgery begins, do physicians evaluate the
21 patient?

22 A: Yes.

23 Q: And just generally speaking, what's the purpose of that
24 evaluation?

25 A: The purpose of that evaluation is to determine the

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1 patient's baseline status, to -- and we do that with an eye
2 toward how to best provide an anesthetic that is safe, that is
3 effective, and that also accomplishes the surgical objectives.
4 We want to optimize operating conditions, while at the same
5 time, we have to take into consideration that patient's unique
6 physical -- literal anatomical physical status because we're
7 managing airways. We're looking at body habitus. We're
8 looking at positioning, those types of things, but also the
9 patient's physiologic status. We're looking at the major
10 organ systems. What is their neurologic status? What is
11 their cardiac status? What is their pulmonary status? What
12 is their renal status? All of those things are taken into
13 consideration.

14 People often don't really realize that, but we are having
15 to look at all of those things, and those need to be tailored.
16 People often think that I think an anesthetic is one size fits
17 all. It's not. And one of the things I impress upon those
18 who I teach, residents, medical students, or CRNA students, an
19 anesthetic should be like a suit of clothes. You tailor that
20 anesthetic to that patient. One size does not fit all.

21 If we did the same anesthetic on everybody who comes
22 under our care, there'd be a lot of dead people in the
23 operating room. So, no, it has to be tailored in that we
24 learn what size to cut that suit in a pre-anesthetic
25 evaluation.

1 Q: And so the things that a physician looks at in a pre-
2 anesthesia evaluation -- evaluation, does that include blood
3 pressure?

4 A: Absolutely. Blood pressure and -- and as many blood
5 pressures that we have access to, in addition to lab work and
6 other things. But yes, blood pressure certainly plays a big
7 role in that.

8 Q: And is there a kind of a rule of thumb or a standard
9 range where someone's blood pressure should be typically
10 maintained during a surgery?

11 A: We typically want to maintain it within 20 percent of
12 their baseline blood pressure.

13 Q: And so does that go both directions, 20 percent up and 20
14 percent down?

15 A: That's correct.

16 Q: And when you say baseline blood pressure, just generally,
17 what do you mean by that term?

18 A: As best we can determine it, the -- the average of their
19 blood pressures over time. In -- you know, in many cases,
20 patients don't take their own blood pressures at home, and if
21 they do, they may write them down, they may not, but whatever
22 blood pressures we have access to, as many of those as we
23 have, we try to determine from that some average about where
24 they are and where they're trending. But that's the best that
25 we can typically do with determining their baseline blood

1 pressures.

2 Q: And is that sometimes simply just the morning of and the
3 pre-anesthesia evaluation.

4 A: Sadly, a lot of times that's all we have to work with.

5 Q: The -- the concept you mentioned of 20 percent above and
6 20 percent below, as we go through today's testimony, can we
7 use the term 20 percent rule to describe that concept?

8 A: Sure. That's fair.

9 Q: The -- the 20 percent rule. If -- if a patient during a
10 surgery goes outside of that range of 20 percent above or 20
11 percent below for a prolonged period of time, can that cause
12 injury to a patient?

13 A: Certainly.

14 Q: What types of injury can occur if a patient's blood
15 pressure were allowed to go prolonged -- for a prolonged
16 period of time during surgery below 20 percent of their
17 baseline?

18 A: Because using the understanding that I gave earlier of
19 perfusion, if your pressure is too low for too long, then you
20 will not deliver oxygen and nutrients to the organs in
21 adequate quantity for those organs to function properly. So
22 you'll start to see what we call end organ dysfunction. In
23 other words, the organs are not going to be doing their job
24 because they don't have the building blocks that they require,
25 number one, oxygen, and also carrying away waste products.

1 It's not just enough to deliver oxygen and nutrients to our
2 tissues. We also have to carry away waste products, one of
3 those waste products being carbon dioxide, another being
4 lactic acid. And adequate perfusion is necessary to achieve
5 all those functions.

6 So low blood pressure for too long is going to compromise
7 that function, and the organs will start to show, first off,
8 dysfunction. And ultimately, they may stop functioning
9 altogether.

10 Q: And would those organs include the spinal cord?

11 A: Yeah, absolutely.

12 Q: The -- when you're determining the baseline blood
13 pressure, a term that I believe we'll have heard in this case
14 -- well, what is the term -- let me ask it this way. What
15 does the term MAP or mean arterial pressure mean?

16 A: Mean arterial pressure is -- if you were to use a
17 calculation, everyone knows the systolic blood pressure. If
18 you take a blood pressure and, say, 120 over 80, systolic
19 would be the 120, diastolic would be the 80.

20 Q: And let me stop you for a second. Now, those two
21 numbers, the systolic, what does that reflect?

22 A: When your heart contracts, the -- the blood that jets out
23 of the left ventricle of your heart, which is the main driving
24 ventricle, the main driving pump of your heart, that's your
25 systolic blood pressure. When the heart contracts --

1 Q: How much pressure is at that moment?

2 A: Correct. At that instant. If we were to take your
3 pulse, what you're feeling is your systolic blood pressure.
4 All right? That's your systolic.

5 Now, when the heart relaxes in order to draw blood in
6 before it contracts again, that's going to be your diastolic.
7 The difference between the two, the 120 and the 180 -- and the
8 80, let's say in a 120 over 80, which, you know, people
9 consider textbook, but it's textbook if you're young and
10 healthy, that's known as the pulse pressure, the difference
11 between those two.

12 Now, one-third of that amount plus the diastolic gives
13 you your mean arterial pressure. So if you were to write it
14 out for the mathematically-inclined people, it would be one
15 third of your pulse pressure plus your diastolic blood
16 pressure. That's your mean arterial pressure.

17 The reason that's of value to us in medicine is because
18 it allows us to -- instead of trying to follow two different
19 pressures all along, it allows us to follow one. It really
20 tells the tale of how much perfusion pressure, how much flow
21 you've got going through your blood vessels at any given time.

22 Q: All right. And that concept is called what? That term?

23 A: The mean arterial pressure? Yes.

24 Q: And is it sometimes just called MAP?

25 A: MAP is our abbreviation for it, yes.

1 Q: And so I want to make sure I understand. With that, of
2 the two numbers, systolic and diastolic, is one weighted
3 heavier, given more emphasis in that calculation?

4 A: Well, the systolic is higher. Certainly, that's the one
5 that concerns us most if pressures are high or low. The
6 diastolic, if it's elevated -- looking on the high end of
7 that, above that 20 percent, the diastolic can be particularly
8 damaging to the heart. Diastolic blood pressures over 100 we
9 get very concerned about.

10 On the low end, we tend to focus more on the systolic.
11 And so that systolic falling below a certain level concerns us
12 a little more than the diastolic on the low side of that 20
13 percent rule.

14 Q: Now, as you are working with a patient in the operating
15 room setting, somebody who's under anesthesia, does an
16 anesthesiologist and surgical team undertake to monitor and
17 evaluate the patient's blood pressure?

18 A: Consistently. That's a requirement. That's a standard
19 of care. The blood pressure must be monitored continuously
20 throughout the surgery and even before the surgery itself
21 begins. A lot of times in surgery, we're actually in the
22 operating room for several minutes before the actual surgery
23 begins. The monitoring begins immediately upon entry into the
24 operating room.

25 Q: Okay. And as part of this monitoring, are there -- well,

1 just generally, what tools do you use to monitor a patient's
2 blood pressure?

3 A: Basic monitoring during general anesthesia is going to be
4 EKG, blood pressure, and pulse oximeter, as well as -- and
5 then there are -- depending on the type of surgery, monitoring
6 of the urine output. We may need to do invasive monitoring,
7 and that's going to depend on the types of surgery that the
8 patient is going to undergo and their physical status.

9 So in some cases, you'll need an arterial line instead of
10 just a blood pressure cuff. In some cases, you may need a
11 pulmonary artery catheter just because of the type of surgery,
12 for instance, open heart surgery and that type of thing. And
13 then, as I said, a urine output in small, brief cases, you may
14 not measure urine output. In bigger cases, you do.

15 And then in this case, that neuromonitoring is not an
16 anesthesia monitoring, but it is a type of monitoring that's
17 needed for this type of case. There's also cerebral oximetry
18 monitoring that's used in some cases.

19 Q: And as far as blood pressure, what tool is used to
20 monitor blood pressure? I know that's kind of an elementary
21 question, but what do we do? How do we determine the
22 patient's blood pressure intraoperatively?

23 A: The most common is a non-invasive blood pressure cuff.
24 We put a cuff on the arm and it's connected to our monitor,
25 and it inflates every few minutes and gives the blood pressure

1 reading.

2 Q: Is it similar to what somebody might have at home?

3 A: Very similar. Uh-huh.

4 Q: The things you mentioned that are monitored during
5 surgery, did that include urine output as well?

6 A: Yes. In certain types of cases, yes. In cases such as
7 this, which is considered a bigger surgery, yes, urine output
8 needs to be monitored.

9 Q: Approximately how long did the surgery last?

10 A: This surgery was a little over four hours. So, yeah,
11 you'd want to monitor urine in a surgery of that type. Also,
12 a surgery where you expect there to be significant fluid
13 shifts where you should be giving large volumes of fluid,
14 you'd want to monitor urine output. And also, you don't want
15 the bladder to become distended. So you want to put in a
16 Foley catheter, which is a flexible plastic catheter connected
17 to a bag to collect the urine in.

18 Q: Okay. And a minute ago, you just described how blood
19 pressure could be monitored or would be monitored simply with
20 the blood pressure cuff.

21 A: Sure.

22 Q: How was the urine output monitored?

23 A: As I just said, the -- the Foley catheter is placed
24 inside the bladder and it's draining into a bag or what we
25 call a urimeter, which is nothing more than usually a plastic

1 bag with markations on there to let you know how much fluid is
2 in there.

3 Q: So the bag has -- has lines with measurements?

4 A: Yes. Uh-huh.

5 Q: Doc, I want to talk about a concept -- a medical concept
6 that I -- called arterial remodeling. Just generally
7 speaking, what is arterial remodeling?

8 A: Arterial -- first of all, people need to understand the
9 difference between a vein and an artery. A vein is almost
10 like a bag in that it will collapse. If it's not -- if
11 there's nothing in it, it's flat.

12 An artery, on the other hand, is muscular. An artery
13 literally has muscles in its wall, and for that reason it is
14 thicker in diameter. Its walls are thicker in diameter.
15 However, because it has muscle in its walls, the muscles in an
16 artery are just like the muscles in your arm or your legs.
17 The more stress they're placed under, the thicker they get,
18 the stronger they get.

19 So in the case of a person who has hypertension, for
20 instance, where the pressure, that perfusion pressure I talked
21 about, that driving pressure is high, the walls of the
22 arteries and arterioles, which are even smaller than arteries
23 that go to the organs, will become thicker. They also, as
24 they become thicker, become less flexible. There's no give to
25 them, and the -- that thickening of the wall is remodeling.

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1 Now, the side effect of that remodeling is that you now
2 have a situation where the blood -- the amount of -- the
3 diameter of the vessels becomes smaller typically, and the
4 blood flow becomes very dependent on the heart contracting,
5 but there's no autoregulation, there's no give to the system.
6 If -- if the -- before remodeling if pressure falls, there may
7 be some residual effect where the blood vessels will dilate to
8 allow more blood to flow. After the remodel, they no longer
9 have that type of response.

10 And I know I'm working with the -- the -- Dr. Shipley,
11 who is a medical animator, and we put together, I think, a
12 pretty good demonstrative demonstration of remodeling and how
13 it affects the blood flow.

14 Q: All right. Great. And that's something I want to --
15 want to move to now. So have you worked with a graphic artist
16 who also happens to be an M.D.? Have you worked with somebody
17 to prepare a graphic animation describing this concept of
18 arterial remodeling?

19 A: I have. I let them know what I needed and what we needed
20 to show, and he did a pretty good job of doing that, I think.

21 Q: And does the -- the animation that was prepared between
22 your collaboration with Dr. Shipley, the graphic artist, does
23 it accurately display this medical concept of arterial
24 remodeling as a result of -- of hypertension or high blood
25 pressure?

1 A: Yes, it does.

2 MR. HINSON: At this point, plaintiff would move the
3 video of arterial remodeling into evidence as Jones Exhibit 1.

4 MR. HEITMAN: We're going to object to that.

5 MR. HINSON: All right. And so I presume for the
6 purposes of today, we will --

7 MR. HEITMAN: Yes.

8 MR. HINSON: -- move forward and address that at a later
9 time.

10 MR. HEITMAN: Sure.

11 BY MR. HINSON:

12 Q: So, Doc, I'm going to hand you the laptop there, and I'm
13 going to hand you the steering wheel, so to speak. And so if
14 you need to pause it at any point.

15 A: Okay.

16 MR. HEITMAN: And just for the record, I'm objecting
17 because it's demonstrative evidence. So I'm objecting to that
18 going into evidence.

19 MR. HINSON: Okay. So I just want to -- want to make
20 clear. Is -- do you object to it being shown or you just
21 object to it going into evidence?

22 MR. HEITMAN: I object to it going into evidence.

23 MR. HINSON: Okay. But you don't have an objection to it
24 being shown?

25 MR. HEITMAN: No.

1 MR. HINSON: Okay. All right.

2 BY MR. HINSON:

3 A: Okay. So what we're looking at here is just a nice
4 diagram of the vertebrae and at the level, you know, this
5 being armpits obviously here and that being the vertebrae.

6 Spinal cord with some of the nerves going out of the
7 cord. This one is just showing an overlay of the aorta,
8 which, as you know, is the largest blood vessel -- largest
9 artery in the body. And this is a detail, assuming the aorta
10 has been cut away now. You're looking at how the blood flows
11 to the spinal cord.

12 What you're looking at here is the anterior spinal
13 artery. The way the anterior spinal artery lies on the spinal
14 cord is, if you would imagine, a stack of spools of thread
15 with a line running down right in the middle of them, right
16 down the middle of them on the front side of them, and that
17 would be the anterior spinal artery. And coming off of the
18 anterior spinal artery are smaller blood vessels that supply
19 the individual levels of the spinal cord.

20 This is just a cross-section of the -- of the artery, and
21 this could be on any artery, but this is specifically looking
22 at the anterior spinal artery. But the walls -- this is meant
23 to show that the walls are muscular. They're not just flat
24 single layers of wall. They actually are muscular. And
25 that's the animated flow of blood.

1 Q: Are artery walls thicker than vein walls?

2 A: Much, much thicker. In fact, when we're doing ultrasound
3 looking at blood vessels, whether we're doing nerve blocks or
4 putting in central lines, you can compress a vein to the point
5 where you can't even see it. An artery can't be compressed.
6 If it can, then the pressure inside of it is too low.

7 So this is an animation of the normal situation.

8 Q: So it says MAP there. Is that the -- the medical concept
9 we were talking about earlier?

10 A: Correct. The mean arterial pressure is normal in this --
11 this part of the animation.

12 And this is just showing that in the normal vessel, when
13 the mean arterial pressure falls, the artery can dilate to --
14 to maintain flow, and that's called autoregulation. That
15 happens throughout the body, and it's very necessary because
16 during the course of even a regular day in a nonsurgical
17 situation, there are times when your -- your blood pressure
18 may fall. You may get too hot on a summer day and haven't
19 consumed enough fluids. Well, your organs don't necessarily
20 shut down because you've got blood vessels that allow flow to
21 regulate because their walls are expansible.

22 However, if the main arterial pressure is high for too
23 long and the arterial wall becomes thickened, then you lose
24 that autoregulatory effect. The wall becomes very thick and
25 very inflexible, and that's where when pressure drops or your

1 perfusion drops, it will not autoregulate. It will not adjust
2 to allow greater flow.

3 Q: Now, is that something that would happen in just a matter
4 of a few days of -- of hypertension or high blood pressure?

5 A: No, that's not something that happens quick. That's
6 going to come after years, typically, of hypertension.

7 Q: And hypertension is synonymous with?

8 A: High blood pressure.

9 Q: And what do we -- what are you showing there with this?

10 A: What we're looking at here is the fact that you now have
11 a thickened arterial wall, and the arterial wall is thickened
12 to create a permanently narrow channel that will not
13 accommodate falls in blood pressure. So it is very dependent
14 on the driving pressure out of the heart. There is no give.
15 There is no fluctuation.

16 If perfusion falls, the artery can no longer adjust its
17 own flow to allow better blood flow. It will -- the blood
18 flow -- the pressure downstream from the -- from the aorta or
19 from the heart is going to fall, and it's a permanent change.
20 It's not something that -- that goes away really ever. I
21 mean, you can -- you can take blood pressure medicine and so
22 forth that may drop your blood pressure over time, but this
23 effect, this -- this remodeling doesn't -- doesn't reverse.

24 That -- and as I said, this is the concept of remodeling.
25 And this happens in anywhere there's arteries, not just in the

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1 spinal cord, but also the heart, the blood vascular system,
2 everywhere. And as I said, once remodeling is occurring, if
3 the current mean arterial pressure drops, for instance, during
4 surgery, it will not autoregulate. The -- the -- the effect
5 is much more dramatic than a person who does not have
6 longstanding hypertension or in whom remodeling has not
7 occurred.

8 Q: And so I want to make sure I understand the concept that
9 you're discussing here. So if a person has had chronic high
10 blood pressure or long-standing high blood pressure, what is
11 it that occurs in the arteries throughout their body, just in
12 summary?

13 A: Remodeling. In summary, remodeling will occur.

14 Q: Which is?

15 A: Which is this. In other words, their pressure is no
16 longer going to be -- it will be in a -- in a state of -- of
17 hypertension. In the face of low blood pressure, their
18 likelihood of having organ damage is increased because the
19 blood vessels supplying blood to the organs cannot maintain
20 any ability to increase blood flow as needed.

21 Q: And what is it that lessens a person's with chronic
22 hypertension, chronic high blood pressure, ability to adjust
23 or autoregulate?

24 A: This remodeling of the -- of the arteries. Arterial
25 remodeling or vascular remodeling.

1 Q: Is the artery less pliable or flexible?

2 A: That's it exactly. Yeah, as I said, pliability,
3 flexibility. Correct. So there's no autoregulation in it.
4 It's just like a -- it's like a pipe, just like a PVC pipe
5 now.

6 Q: Okay. And so what are you showing right there, Dr.
7 Jones?

8 A: Just what we were just talking about. In other words,
9 the artery can no longer expand and adjust its flow. And so
10 if the -- if the -- the general -- if blood pressure falls
11 throughout the body, the individual vessels can no longer make
12 the adjustments that they do in a normal person. The -- the
13 effect is going to be more -- the end -- the end organ is
14 going to suffer more than in a person who does not have
15 remodeling.

16 Without remodeling, as I said, blood flow at the level of
17 the individual vessels can autoregulate. Once remodeling has
18 occurred, you've lost that.

19 Q: And so with what's being shown there on the screen, an
20 artery that has undergone this remodeling that is now having a
21 period of low blood pressure --

22 A: Uh-huh.

23 Q: What would be the result to the nearby organs?

24 A: Oh, the nearby organs are not going to get the oxygen or
25 the nutrients they would normally receive. And also, you're

1 not going to have enough pressure to ensure that the products
2 of metabolism are carried away. So you're going to end up
3 with organ damage.

4 Q: When you say products of metabolism, waste products?

5 A: Waste products of metabolism: carbon dioxide, lactic
6 acid, so forth. And this is occurring at a cellular level
7 and, obviously, cells is what makes up all of our organs. So
8 as you destroy cells or compromise cells' ability to
9 metabolize normally, then you're going to have organ damage.

10 Q: And is -- this concept that you've described here, how
11 does it relate to essentially the 20 percent rule we discussed
12 earlier?

13 A: Well, once you fall below that 20 percent, you're going
14 to start to see perfusion dropping in anyone. Once you fall
15 below that 20 percent rule in a person who has not had
16 vascular remodeling, they may be able to -- to -- to rebound
17 somewhat because autoregulation will allow blood flow to
18 resume or to maintain a fairly normal flow.

19 Now, that's part of the problem or part of the -- the
20 curse of the 20 percent rule is within that 20 percent, we
21 know that autoregulation occurs. Outside of that 20 percent,
22 that's part of the problem. You lose that autoregulatory
23 component, and that's why it's important on both sides.
24 On the high side, if the pressure gets too high, then the
25 system also can regulate to try to keep things within a normal

1 range, but outside that 20 percent, that's why we want to keep
2 them within that, because outside of that, you start to lose
3 that. And in people who have had remodeling, it's even more
4 dramatic.

5 Q: Is that part of the reason why you look at a person's
6 baseline blood pressure?

7 A: Yes, very much so, because it helps us to determine
8 intraoperatively where to keep that patient. I don't want to
9 keep, you know, that -- that high school or that college
10 athlete who has the 120 over 80 all the time -- well, I can
11 keep them at 120 over 80 in the operating room. However,
12 someone whose pressure is typically higher, 120 over 80 is not
13 enough.

14 Q: And you just used the term keep a person's blood
15 pressure.

16 A: Uh-huh.

17 Q: What tools do you have as a physician working in the
18 operating room to keep a person's blood pressure somewhere?

19 A: We have medications, we have fluids, and there are a
20 couple of techniques. And I mean, to a great extent, we can
21 put a blood pressure anywhere it needs to be. We have fluids
22 at our disposal in the operating room.

23 Certainly, in a tertiary care hospital such as this,
24 you're going to have lactated Ringer's crystalloid solution,
25 normal saline crystalloid solution, albumin, blood, if

1 necessary. And then you have pressor agents. You have
2 phenylephrine, ephedrine, vasopressin. These are all --
3 Levophed, which is norepinephrine, epinephrine itself. All of
4 these are available.

5 And then you also have the ability as an anesthesiologist
6 to adjust the level of anesthesia. In this situation, Ms.
7 Goodwin was on two anesthetic agents during this case. The
8 anesthetic level can also be adjusted, and these are all
9 things that are done every day in operating rooms all over the
10 place. I do it. I was doing it till 1 o'clock this morning.
11 You're adjusting that constantly. It's part of the art and
12 the science of anesthesia is making those adjustments.

13 Q: And so if you find a patient has gotten too high, there's
14 things you can do to bring it down?

15 A: Certainly.

16 Q: And if you find somebody's too low?

17 A: You can bring it up. Absolutely. We can -- you can put
18 a pressure wherever you need it.

19 Q: Okay.

20 A: Basically.

21 Q: Doc, I'll take that computer back and not be distracted.
22 Thank you.

23 A: Certainly.

24 Q: Let's -- Dr. Jones, let's shift gears for a minute now
25 and talk specifically about Crystal Goodwin.

1 A: Okay.

2 Q: In the materials you reviewed, did they reflect that
3 Crystal had longstanding or chronic high blood pressure?

4 A: They did. From my review of the record, she had been
5 diagnosed with hypertension back in 2007, which had been --
6 would have been nine years before this event, before this
7 surgery.

8 Q: And what did the pre-anesthesia evaluation show Crystal
9 Goodwin's blood pressure to be at that time?

10 A: She had had a blood pressure -- and I jotted down a
11 couple of them -- a few days before, I think. Her surgery was
12 on July 28th. She had a blood pressure on July 22nd. She had
13 another recorded on July 18th, and one, of course, on June
14 20th.

15 And on the 28th, her mean arterial pressure was 119. On
16 the 22nd, which is the week before, it was 113. She had one
17 on July 18th that was 97, and she had one on June 20th that
18 was 125. So those are the -- the four blood pressures that we
19 had. And at the time of the pre-anesthetic evaluation or
20 going into surgery, that's the information that would have
21 been available to the anesthesia team.

22 Q: Okay. Would that information have been available to the
23 surgeon as well?

24 A: Certainly. Certainly. In fact, the ones that were taken
25 in the office would have been available to the surgeon before

1 they were available to the anesthesia team.

2 Q: Okay. The -- did you undertake to determine what would
3 be a reasonable preoperative baseline blood pressure to
4 consider for Ms. Goodwin?

5 A: Sure. Looking at the -- the average of her mean arterial
6 pressures going into surgery, her mean should have been about
7 116. And the -- the term we're using, 116, refers to
8 millimeters of mercury pressure.

9 Q: Okay. But -- but the 116 is the MAP?

10 A: Mean arterial pressure.

11 Q: Okay.

12 A: That's the mean arterial pressure.

13 Q: That concept we talked about earlier?

14 A: Correct. Using the calculation I talked about earlier.

15 Q: Okay. And, Doc, let me show you what we -- you talked
16 earlier about evaluating a patient before a surgery. Was
17 Crystal Goodwin evaluated prior to undergoing surgery on July
18 28th, 2016?

19 A: Yes, she was.

20 Q: And just when did that evaluation take place?

21 A: On the 22nd, a week before.

22 Q: Okay. And what -- at that evaluation, what was her mean
23 arterial pressure determined to be at that point?

24 A: 113 millimeters of mercury.

25 Q: Okay. Doc, I'm going to show you a document.

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1 MR. HINSON: One second here. That's the pre -- pre-
2 anesthesia.

3 MR. HEITMAN: You can -- you can -- you can give that one
4 if you want. I just want to see it.

5 BY MR. HINSON:

6 Q: Doc, I'm going to show you --

7 THE VIDEOGRAPHER: Counselor, your microphone just fell
8 off.

9 MR. HINSON: Oh, I'm sorry.

10 BY MR. HINSON:

11 Q: I'll show you a document. If you can, identify what
12 we're looking at there?

13 A: Okay. This is from the Prisma Health Baptist Hospital,
14 and this is the preoperative assessment for Ms. Goodwin on the
15 22nd of July of 2016, which would have been six days before
16 her surgery.

17 Q: And was that part of the materials you reviewed?

18 A: Yes, it was.

19 Q: And does that document reflect a blood pressure being
20 taken during the preoperative assessment?

21 A: It does.

22 Q: All right.

23 MR. HINSON: The plaintiffs would move the preoperative
24 assessment as Jones Exhibit 2.

25 MR. HEITMAN: Is that a -- is that a clean copy, Brink?

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1 MR. HINSON: I have a clean copy of that, if that's all
2 right.

3 MR. HEITMAN: Yeah. No objection then.

4 MR. HINSON: Here it is right here. I found my clean
5 copy. I'll swap you.

6 THE WITNESS: Okay.

7 MR. HINSON: I'll swap you out. Sorry about that.

8 THE WITNESS: Oh, that's okay.

9 BY MR. HINSON:

10 Q: And so tell us, Doctor, on that exhibit, where will we
11 find the blood pressures that were recorded during that pre-
12 operative assessment?

13 A: Well, in the pre-operative assessment, on the first page
14 under vital signs, it has her temperature, her pulse rate, and
15 a few other items. Pulse oximetry, which is her oxygen
16 saturation, but it has her blood pressure, 156 over 92. Used
17 -- a blood pressure cuff was on her right arm. That's how the
18 pressure was taken. And that comes with a mean arterial of
19 113, as I said.

20 Q: And could you hold that document up and just show us
21 where on the document you'll find the -- the -- the blood
22 pressure?

23 A: Right there.

24 Q: Okay. So that's on -- on Exhibit 2?

25 A: Correct.

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1 Q: Thank you. And, Doc, were there -- was there another
2 blood pressure taken prior to the -- the surgery commencing,
3 the surgery beginning --

4 A: Yes.

5 Q: -- on July 28th?

6 A: Yes. We call that the pre-induction pressure, and that's
7 something that anesthesiologists and anesthesia providers
8 typically do. And that is to basically establish the baseline
9 for that case, in addition to, you know, the understanding of
10 what was available on preoperative evaluation, in this case
11 the week before. But yes, her pre-induction blood pressure
12 mean was 119 millimeters of mercury.

13 Q: All right. And so let me hand you another document. Can
14 you identify what we're looking at there?

15 A: What we're looking at here is known as the intraoperative
16 anesthesia record, and this is from July 28th, 2016. And this
17 is a -- how we anesthesia providers, anesthesiologists and
18 CRNAs, record what we do during the surgery.

19 Q: And does this record contain a preoperative blood
20 pressure as well?

21 A: It does. On the left column here, it has 160 over 99 and
22 a pulse of 100.

23 Q: And, Doc, is -- in your work as an anesthesiologist, do
24 you use similar anesthesia records as what we're looking at?

25 A: We do. This -- nowadays, a lot of it is electronic, but

1 this system obviously had not gone to electronic health
2 records at that point. But yes, in places that don't have
3 electronic health records, this is the same type of form we've
4 been using for many years.

5 MR. HINSON: And plaintiffs would move the anesthesia
6 record -- two-page anesthesia record in as Jones Exhibit 3.

7 MR. HEITMAN: No objection.

8 BY MR. HINSON:

9 Q: Dr. Jones, taking the two -- taking the two blood
10 pressures we've talked about, the preoperative blood pressure
11 -- the preoperative assessment blood pressure and the pre-op
12 blood pressure on the day of surgery, what was the baseline
13 MAP for Crystal?

14 A: That would be 116 millimeters of mercury, and we reached
15 that by simply adding 113 plus 119 and dividing it by two.

16 Q: Okay. That's math even I can do, I believe. And so then
17 if you take the 116 to be her baseline, what would be the --
18 applying the 20 percent rule, what would be the low end of
19 where you'd want to keep Crystal's blood pressure?

20 A: The low end should be low 90s, mid -- mid to low 90s.

21 Q: Doc, I want to look at that anesthesia record we've
22 marked as Exhibit 2. Can you tell us what it is exactly we're
23 looking at here, this -- this grid?

24 A: Sure. On the grid, what you're looking at --

25 Q: Well, let me do this. I have a bigger demonstrative.

1 A: Right.

2 Q: It's just a blow up of Exhibit -- I said Exhibit 2. It's
3 Exhibit 3 -- of Exhibit 3. Can you take us through what we're
4 looking at on that grid?

5 A: Okay. So this is the -- this is your -- this is what we
6 call the intraoperative record. Just to give you a quick
7 little sketch, you've got the continuous start time, the time
8 that we typically roll into the operating room and the time
9 out of the operating room. ASA is -- we're talking about the
10 patient's American Society of Anesthesiologists physical
11 status classification. The type of anesthetic, whether it's
12 going to be general or spinal or epidural or monitored
13 anesthesia care, local, so forth. The surgeon's name, the
14 anesthesiologist's name, the CRNA's name, the diagnosis.

15 Q: Tell us what this little grid is right there?

16 A: The grid is -- okay. Let's look at it. The grid allows
17 us to document the blood pressures. We put time across the
18 top, and the grid is broken down going this way in five-minute
19 increments. And the little arrows or carets or whatever you
20 want to call them, to us anesthesia providers tells us the
21 blood pressure.

22 For instance, here where the check mark is, like,
23 downward is the systolic, upward is the diastolic. And then
24 the dot, those are the pulse rates. And this is -- the grid
25 is basically telling you or showing you graphically the blood

1 pressures and the pulse rates across time.

2 Q: And so, Doc, on that blow-up demonstrative there, could
3 -- would you take this orange highlighter and just kind of
4 highlight where the systolic blood pressure carets are at?
5 Do you -- I guess a line-up of those?

6 A: Sure.

7 Q: And so, again, what is the increment between each little
8 arrow or caret?

9 A: That's five minutes.

10 Q: And then if you'd also do -- do the same for the
11 diastolic?

12 A: Okay. Okay.

13 Q: And, Doc, have you reviewed the -- well, who would have
14 charted these -- these -- these arrows or carets there?

15 A: From my understanding, this would have been Erich Starn,
16 who was the CRNA on the case.

17 Q: Okay. And have you reviewed his testimony to glean or
18 understand exactly the numbers he intended by those arrows and
19 carets, to the degree there's a little bit of subjectivity,
20 whether it's 100 and whether one is a 96 or 97?

21 A: Yes.

22 Q: Have you reviewed his testimony to confirm that?

23 A: I have read the deposition testimony and also have looked
24 at -- he generated a -- a table of those blood pressures. So
25 we can see them here. You know, sometimes there can be a

1 discrepancy. Was it a -- was it really 140, was it 139 or was
2 it 141, but he went back and looked at them and actually
3 generated a table of what those blood pressures were, which
4 was very helpful.

5 Q: And have you reviewed a demonstrative chart that puts
6 together those figures or those blood pressures graphically in
7 a way that's easier to -- to view and understand?

8 A: Yes, I have.

9 Q: All right. Doc, I'm going to hand you this and just ask
10 you to identify this foam board.

11 A: Okay.

12 Q: Tell us just generally what are we looking at?

13 A: This is somewhat similar to what we were just looking at
14 on the -- on that grid. It's different in appearance but the
15 same breakdown in terms of time going this way and the blood
16 pressure is going up and down. And the times are across here
17 at the bottom, and the blood pressures are here in millimeters
18 of mercury. And that's what we're looking at.

19 Q: And do the -- does the data included on that foam board
20 that you're holding in your hand -- is it taken from --

21 A: It's taken from the blood pressures that Mr. Starn
22 verified from the anesthesia record.

23 Q: And have you undertaken to confirm its accuracy?

24 A: I have looked at every single one of these, and they're
25 all exactly what he recorded in his testimony and on the

1 tabular chart that he generated.

2 Q: And is -- is this document or this -- this foam board
3 that you're holding, is it a graphical representation of data
4 that is in Crystal Goodwin's medical chart?

5 A: Yes, it is.

6 Q: All right.

7 MR. HINSON: Plaintiffs would move this demonstrative
8 graph as Exhibit 4.

9 MR. HEITMAN: Objection.

10 MR. HINSON: And is -- is your objection just to entering
11 it into evidence?

12 MR. HEITMAN: Yes.

13 MR. HINSON: Okay. But you don't have an objection to us
14 using the demonstrative?

15 MR. HEITMAN: No.

16 MR. HINSON: Okay. We would seek to move it into
17 evidence, and we can argue that.

18 MR. HEITMAN: Sure.

19 MR. HINSON: Is that fair?

20 MR. HEITMAN: All right.

21 BY MR. HINSON:

22 Q: So, Doctor, what is the -- there's red, obviously, on
23 that chart. Tell us what that red represents?

24 A: The red represents the zone below that 20 percent window
25 that we want to see based on a mean arterial pressure of 116.

1 So everything that -- that is depicted in red -- into red
2 would be an area that we want to stay out of. The mean
3 arterial pressures we need to see to keep her within 20
4 percent would need to be above the red or pink area.

5 Q: Okay. And so tell us what you see on this -- on this --
6 well, let me ask you is this a summary -- I'm kind of shifting
7 gears on you, Doc. I apologize. Is this -- is what you're
8 holding in your hand -- is it a summary of the data taken from
9 Crystal's medical chart?

10 A: Yes, it is. This is -- this -- to the -- to the lay
11 person would be what I look at when I see the chart that I was
12 holding up a minute ago, that grid, and it shows me also where
13 in the nicest way how long she was in the danger zone, i.e.
14 how long or all the -- the incidents when she fell below that
15 20 percent baseline that we want to see or within that 20
16 percent of her mean arterial pressure. So, yeah, this is a
17 graphic description or graphic presentation not only of the
18 blood pressures, but for me, it helps me see how long and how
19 often she was under -- outside the range that we would want to
20 consider a safe range.

21 Q: And right there about two-thirds through that summary of
22 the -- of the data taken from the anesthesia record, there's
23 this yellow line. Now, tell us what -- what that is there?

24 A: This corresponds with the time period when the signal was
25 lost in the -- on the anesthesia record. There is no record,

1 by the way. It's never mentioned that the signal was lost,
2 but we know from looking at the neuromuscular --
3 neuromonitoring technician's note and also the -- the
4 deposition testimony is that around 9:57, the signal -- the
5 SSEP signal, which stands for somatosensory evoked potential,
6 signal was lost, and that's what the yellow line there
7 corresponds to. And you can see right down here 9:55 and then
8 a minute later, roughly 9:56 is where we see the signal lost.

9 Q: Doctor, what do you equate and believe that signal loss
10 to have been the result of?

11 A: I believe that signal loss right there is due to all of
12 this time spent below that pink line, especially this time
13 leading right up to it. You're looking at -- at 9:56. The
14 signals are -- or 9:57, the signal was lost. Well, for the
15 better part of an hour leading up to that, you had mean
16 arterial pressures well below the lower end of that 20 percent
17 window that we want to keep the patient at. That, in my mind
18 without a doubt, is what's the cause of the signal loss.

19 Q: And, Doctor, what we're looking at there with the blood
20 pressures taken from the anesthesia chart and the signal loss
21 -- well, let me ask this. Where'd you get the signal loss
22 information from?

23 A: The signal loss information came primarily from the
24 neuromuscular -- monitoring technician.

25 Q: Okay. And does what you're holding in your hand -- is

1 that a summary of evidence taken from the medical chart?

2 A: This was taken from the medical chart, but there was an
3 additional blood pressure reading that the neuro -- the
4 neuromonitoring technician included that was not included on
5 the anesthesia record.

6 This was all verified by Mr. Starn, which is fine, but he
7 made one omission that caught my attention, and that's the one
8 that I think is graphically displayed on the -- on another
9 one. That is right after this, there was a reading of 77
10 millimeters of mercury, which ends up, by the way, being the
11 lowest reading, the lowest mean arterial pressure reading on
12 the entire chart, and that was the last one before the loss of
13 the signal.

14 Q: All right. And I will show you that in just a second.
15 Before we move on, I want to make sure I understand that what
16 you're holding in your hand there, is that a summary of data
17 taken from the medical record?

18 A: It is.

19 MR. HINSON: And again, I would move the foam board there
20 in Dr. Jones's hands into evidence as Plaintiff's Exhibit 4.

21 MR. HEITMAN: Objection.

22 MR. HINSON: Same as before?

23 MR. HEITMAN: Same as before.

24 MR. HINSON: All right.

25 BY MR. HINSON:

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1 Q: Doc, I'm going to take that back from you. Now, I'm
2 going to hand you -- I'm going to hand you another document,
3 Dr. Jones.

4 A: Uh-huh.

5 Q: And just generally, can you identify what it is we're
6 looking at there?

7 A: This is the neuromonitoring record that Teresa Adkins
8 generated during the case.

9 Q: And have you reviewed this material in preparation for
10 your testimony today?

11 A: Yes, I have.

12 Q: And this was part of the overarching -- was this part of
13 Crystal Goodwin's overarching medical record?

14 A: Yes, it was.

15 MR. HINSON: Plaintiffs would move the neuromonitoring
16 record in as Exhibit 5, Jones Exhibit 5.

17 MR. HEITMAN: No objection.

18 BY MR. HINSON:

19 Q: All right. Doc, you made a reference a minute ago to
20 another blood pressure reading during the course of this
21 surgery. Tell -- tell us what you were talking about there.
22 Tell the jury what you meant?

23 A: What I'm talking about is on page 36 of the
24 neuromonitoring record. There is an entry at the top of the
25 page, 9:56:18, where Ms. Adkins recorded a blood pressure of

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1 103 over 64. That corresponds to a mean arterial pressure of
2 77. That was the lowest mean arterial pressure on the entire
3 anesthesia record, and that also is the last mean arterial
4 pressure before we lose the signal.

5 (WHEREUPON, the video was stopped.)

6 THE COURT: All right. Ladies and gentlemen, I
7 understand there's a good bit left on this deposition. So I
8 think now is a good time to take a break. Please return to
9 your jury room for just a few minutes. Don't discuss the
10 case.

11 (WHEREUPON, the jury exited the courtroom at 11:29 a.m.)

12 THE COURET: All right. Let's take 15 minutes.

13 MR. HINSON: Your Honor, before we -- just very briefly.
14 We'd ask just the identification that these gentlemen have
15 come into the room recently. Just if they're somebody we need
16 to sequester. I just -- I don't know who they are, and we
17 just would like to know who the -- who these individuals are.

18 THE COURT: Okay. You have a witness list. Is there
19 anyone on the witness list that you need to sequester? Why
20 don't y'all think about that while we take a few-minute break?

21 MR. HINSON: Okay.

22 THE COURT: See if you can find the identity of these
23 folks.

24 MR. HINSON: All right.

25 THE COURT: All right. Fifteen minutes.

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

3 THE COURT: All right. Did we figure out who folks are
4 and do we have a --

5 MR. DAVIS: We did.

6 THE COURT: -- sequestration request? No?

7 MR. HINSON: No, Your Honor.

8 THE COURT: Okay. Mr. Davis?

9 MR. DAVIS: Your Honor, this is Dr. Balestrieri. He's an
10 expert witness for us. We don't know when we're going to be
11 able to put him up.

12 And the gentlemen behind him I have not met in person,
13 but have just met him during the break.

14 Mr. Ron, please pronounce your last name?

15 MR. CHORZEWSKI: Chorzewski.

16 MR. DAVIS: Chorzewski. Is it -- your position?

17 MR. CHORZEWSKI: Chief executive officer.

18 MR. DAVIS: Chief executive officer with Midlands
19 Orthopedics.

20 THE COURT: So that was closer than you with my Mike
21 Krzyzewski parallel. You know, Duke basketball.

22 MR. DAVIS: He brought me copies of the subpoena sent to
23 him early this morning and the documents that we believe were
24 maintained in his possession. He did inform me during the
25 break that the 2022 taxes -- they filed an extension. They

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1 don't have those. I don't have mine either. But anyway, I'm
2 happy to turn this over to him, as Mr. Goings said, pursuant
3 to our previously negotiated, agreed-upon protective order.

4 THE COURT: All right. And I'm sure I'll hear about it
5 at the next break if there's an issue with what has been
6 produced. And -- yeah. Yeah. So look through that while
7 we're listening to this -- the remainder of this deposition.

8 MR. DAVIS: Okay. May Mr. Chorzewski leave at this time
9 or do you require him to stay here?

10 THE COURT: I don't suppose he needs to stay. We just
11 need to be able to contact him and get him back, if necessary.
12 Because, you know, of course, Mr. Goings has just received
13 those documents. I don't know if anything's missing or if
14 he'll have some complaint, objection, something.

15 So as long as you are reachable by phone or are in your
16 office and Mr. Davis can find you in the event there's an
17 issue.

18 MR. GOINGS: That works. Thank, Your Honor.

19 MR. DAVIS: Thank you, Your Honor.

20 THE COURT: Thank you. So you're free to go. Thank you,
21 sir.

22 All right. Bring the jury back, please.

23 (WHEREUPON, the jury entered the courtroom at 11:49 a.m.)

24 THE BAILIFF: All jurors are seated, Your Honor

25 THE COURT: Thank you.

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1 Welcome back, folks. We'll now continue the deposition
2 of Dr. Jones.

3 (WHEREUPON, the video deposition of Dr. Frederick Jones
4 resumed playing as follows.)

5 BY MR. HINSON:

6 Q: Was this part of Crystal Goodwin's overarching medical
7 record?

8 A: Yes, it was.

9 MR. HINSON: Plaintiffs would move the neuromonitoring
10 record in as Exhibit 5, Jones Exhibit 5.

11 MR. HEITMAN: No objection.

12 MR. HINSON: All right.

13 BY MR. HINSON:

14 Q: Doc, you made a reference a minute ago to another blood
15 pressure reading during the course of this surgery. Tell --
16 tell us what you were talking about there. Tell the jury what
17 you meant?

18 A: What I'm talking about is on page 36 of the
19 neuromonitoring record. There is an entry at the top of the
20 page, 9:56:18, where Ms. Adkins recorded a blood pressure of
21 103 over 64. That corresponds to a mean arterial pressure of
22 77. That was the lowest mean arterial pressure on the entire
23 anesthesia record, and that also was the last mean arterial
24 pressure before we lose the signal.

25 So, obviously, it stood out in Ms. Adkins' mind because

1 it's also the only entry of its type, I believe, in the entire
2 neuromonitoring record where she actually makes a note of
3 putting that in there. She also notes, by the way, the level
4 of anesthetic that was being provided at the time.

5 So in my mind, having done enough of these cases and
6 worked with enough neuromonitoring techs, that's something
7 that's significant. They don't typically record in that
8 fashion unless it strikes them as -- as being significant.

9 Q: And have -- is there a summary of that evidence available
10 to include that 77?

11 A: Yes, there is.

12 Q: That low -- that blood pressure?

13 A: Oh, yeah, there is.

14 Q: Okay. So that blood pressure of 103 over 64, what does
15 that turn into as far as the mean --

16 A: 77 mean arterial pressure, yeah. I'm sorry.

17 Q: And I'm going to hand you another foam board.

18 A: Okay.

19 Q: Doc, what are we -- what do you -- what do you hold in
20 your hands there?

21 A: What I'm holding here is the same data as before, but
22 with the inclusion of the blood pressure that Ms. Adkins
23 recorded, which is not recorded on the intraoperative
24 anesthesia record that Mr. Starn generated, which causes me a
25 little bit of concern why he did not record that as the lowest

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1 pressure of the case. That's the last blood pressure before
2 loss of signal. You know, I don't know why that's not there,
3 but it's not. And it is here. It's on her record. She's
4 documented it on the neuromonitoring record.

5 Q: Her being Ms. Adkins?

6 A: Her being Ms. Adkins, right.

7 Q: And so there is a blood pressure recorded -- what is the
8 lowest blood pressure recording during the surgery from all
9 the evidence available to you?

10 A: That one right there.

11 Q: And was that -- was that -- and what time was that?

12 A: That's at 9:56:18.

13 Q: All right. And did that information make it into the
14 anesthesia chart?

15 A: No, it didn't.

16 Q: Okay. And so, Doc, what you're holding in your hand
17 there, that foam board, is that -- is that a summary of the
18 evidence that was available to you?

19 A: Yes, it is.

20 Q: And does it accurately reflect the blood pressures both
21 in the anesthesia chart and as you could glean from the
22 neuromonitoring report?

23 A: Yes. That includes both.

24 Q: All right.

25 MR. HINSON: Plaintiff would move that chart as Exhibit

1 5.

2 MR. HEITMAN: I'm going to object to it being used as
3 demonstrative evidence, as well as going into evidence in the
4 case.

5 MR. HINSON: All right. What's the -- what's the
6 objection on the demonstrative?

7 MR. HEITMAN: Well, the issue is Dr. Jones giving his
8 opinion on the 77 blood pressure reading. In his deposition,
9 he never testified at all to the 77 blood pressure reading.
10 And he -- he said in his deposition that he would let counsel
11 know -- let his counsel know if he had a change or addition in
12 opinions, and we've never been notified of this new opinion.

13 MR. HINSON: Okay.

14 BY MR. HINSON:

15 Q: Doctor, does this 77 mean arterial pressure -- does it
16 change your opinions in any way?

17 A: No, not at all.

18 Q: Is it still your opinion -- well, even considering the 77
19 mean arterial pressure at 9:56, what is your opinion as to
20 what the cause of the neuromonitoring signal loss was?

21 A: That single pressure at 9:56 is significant. However, it
22 doesn't change my opinion because that single incident is not
23 what caused it. It was the time, the -- the pressure being so
24 low for so long, not a single point in time. So it wouldn't
25 change my opinions at all.

1 Q: Does it further support your opinions?

2 A: It further supports it, but it doesn't change my opinion.

3 Q: So, Doc, you said earlier that Crystal Goodwin suffered a
4 neurologic injury during the July 28th surgery. Can you kind
5 of summarize for us how these blood pressures during the
6 surgery played a part in what you believe caused that
7 neurologic injury?

8 A: Sure. And as I said just a second ago, her blood
9 pressures, her mean arterial pressure, that perfusion
10 pressure, that driving pressure I was describing earlier, was
11 too low for too long and, as a result, she -- her spinal cord
12 did not receive adequate oxygen or nutrients, and the tissue
13 was compromised. And that's what caused her spinal injury.

14 Q: Did neuromonitoring reflect this spinal -- spinal cord
15 injury?

16 A: Yes, it did. That loss of signal, that is where the
17 neuromonitoring -- and that's why neuromonitoring is there is
18 to document and, first of all, to detect those type of
19 injuries. And in the cases that I do myself, spine cases,
20 that's -- we're relying on the neuromonitoring tech to tell us
21 those types of things so that we can make adjustments. And
22 that's a common practice. In many cases, you're going to have
23 to make adjustments throughout the surgery based on the
24 information the neuromonitoring tech gives.

25 Q: And if the neuromonitoring tech isn't giving that

1 information to the anesthesiologist, is there somebody else
2 who should ensure that information gets relayed?

3 A: Oh, sure. The surgeon. The neuromonitoring tech should
4 be conveying to everyone in the room. And in fact, in many
5 cases I've been in, we actually will turn the monitor so the
6 neuromonitoring tech can see the same thing we're seeing, and
7 some surgeons want to see it, too.

8 And so the whole team is tuned in to what's going on with
9 the -- with the vital signs. Now, we can't all see what the
10 neuromonitoring tech sees because they have a screen typically
11 off only they're looking at, but everyone can see the vitals.
12 And yes, the neuromonitoring tech is following, and we are
13 following what they tell us.

14 And they usually let us know if there's anything. In
15 this situation, for instance, not only will these what they
16 call somatosensory evoked potentials be monitored, but also
17 the motor potentials. So the, you know --

18 Q: Is there an acronym for those two things that are --

19 A: Well, motor evoked potentials or MEPs versus SSEPs,
20 somatosensory evoked potentials.

21 Now, because there had been an issue during the case with
22 the airway and they had to paralyze the patient, they could no
23 longer monitor the motor potentials because once you're
24 paralyzed, you can't monitor that.

25 Q: And when you say paralyzed, you're not speaking of her

1 legs, are you?

2 A: No, I'm talking about chemical paralysis. I'm sorry.
3 We anesthesiologists -- when I talk about it, I'm really
4 talking about a chemical paralysis. She was given a
5 medication called rocuronium. Its job is to -- to stop the
6 muscles throughout the body from responding. Not like a
7 spinal paralysis, no.

8 Q: But that wouldn't -- would that -- would the -- would
9 administering the rocuronium -- would that affect the MEPs?

10 A: The MEPs --

11 Q: I'm sorry. The SSEPs.

12 A: It would not affect the SSEPs, correct. And that's one
13 of the reasons why you want both.

14 Q: Okay. And what time again did the signal loss take place
15 approximately?

16 A: Around 9:56.

17 Q: And did you see anything in the record that would
18 demonstrate that the CRNA or the surgeon ever alerted the
19 anesthesiologist of this loss of neuromonitoring signal?

20 A: No. And in fact, the CRNA acknowledged in his deposition
21 he didn't notify her. The surgeon, I believe in his
22 deposition, said he didn't see the need for her to be notified
23 by the CRNA. But no, she was never notified. And Dr. Root in
24 her deposition said that she was never notified.

25 Q: If a patient has lost signal to her lower extremities

1 during a spine surgery, is that something that an
2 anesthesiologist would want to be notified of?

3 A: That's a major event. If a CRNA of mine is doing a case
4 and this happens and they don't notify me, we're going to have
5 some talk, a serious talk. And I know when I was a resident
6 and a fellow in a case such as this, the attending would be
7 livid if you didn't because it's a very significant change.

8 Q: Would you also be upset with the surgeon if they didn't
9 take effort to inform you of this change?

10 A: Oh, certainly.

11 MR. HEITMAN: Objection.

12 THE WITNESS: The team in general. I'm sorry.

13 MR. HEITMAN: Well, he's -- he's not a surgeon.

14 MR. HINSON: Well, I asked if he would be upset with the
15 surgeon.

16 BY MR. HINSON:

17 Q: If -- in a situation -- if a situation were such where
18 nobody from the operating room, not the CRNA nor the surgeon,
19 told you of a loss of neuromonitoring signal to the patient's
20 lower extremities, would you be upset with both -- both
21 individuals?

22 A: Well, sure. I'd want to know that this had occurred
23 because this patient is not just the surgeon's patient. It's
24 my patient, too. It's the CRNA's patient, too. And that's
25 one of the most dramatic events that can occur -- that can

1 occur during a spine surgery is loss of signal. So, yeah, I
2 would want to know, and I'd expect anybody in the room -- if
3 the tech needed to call me, they could call me. The surgeon
4 could let us know.

5 I've been notified in many cases by a surgeon, hey, Fred,
6 you need to get in here, you know, something's wrong. What
7 can you fix? Can you adjust something? Spin a dial?
8 Something. But I'd expect to be informed, yes.

9 Q: That brings up my next question, Dr. Jones. If the
10 standard of -- if -- if the anesthesiologist had been
11 informed, which I think you've established she was not, or had
12 the anesthesiologist been informed of this loss of signal,
13 what would the standard of care require the anesthesiologist
14 to do in response to loss of signal to the patient's lower
15 extremities in this clinical situation?

16 A: First thing she would do would get the pressure up by
17 whatever means necessary, whether it's fluid bolus,
18 administration of pressors, or lightening up the anesthetic
19 agents, but that's what she would do to keep -- to be within
20 standard of care.

21 Q: And had those things been done in a timely fashion, do
22 you have an opinion to a reasonable degree of medical
23 certainty what the likely outcome would have been for Crystal?

24 A: I think that she would have maintained proper perfusion
25 to her spine. She wouldn't be paralyzed today.

1 Q: Doc, besides the blood pressures that we've talked about,
2 is there anything else in the chart that demonstrates
3 inadequate perfusion for Crystal during the course of this
4 July 28th surgery?

5 A: Certainly, the urine output.

6 Q: Okay. And tell us about that?

7 A: Urine output. People have to understand your kidneys are
8 one of the most vascular organs or two of the most vascular
9 organs in your whole body. Every time your heart contracts,
10 25 percent of your cardiac output goes to your kidneys.
11 That's how important and how dependent on blood flow the
12 kidneys are.

13 Urine output is one of our best ways of assessing the
14 adequacy of a patient's organ perfusion because, like I was
15 saying earlier in the demonstration that I showed, that
16 animation, what's going on there is not just going on in the
17 spinal cord. It's going on throughout the body. Perfusion is
18 critical. If perfusion drops to the kidneys, you're not going
19 to produce urine. If perfusion is adequate to the kidneys,
20 you're going to produce urine unless you are in end-stage
21 renal failure, and there's no indication here that Ms. Goodwin
22 was in any way in any type of renal failure.

23 So her urine output is going to be almost entirely
24 dependent on perfusion, and probably one of the best
25 indicators of her perfusion status. And her urine output was

1 dismal for this case.

2 Q: All right. And let's talk about that. How much urine
3 output -- well, let me ask you this way, Doctor. Is there a
4 rule of thumb of how much urine output a physician expects to
5 see a patient produce during a surgery?

6 A: Sure. During general surgery or during under general
7 anesthesia, an adult patient should usually produce between 1
8 to 2 milliliters per kilogram per hour --

9 Q: Okay.

10 A: -- of urine.

11 Q: And, Doc, I have some -- some different measuring --
12 liquid measuring devices here that I've brought. We have some
13 water we've dyed blue. And you said how much? What would be
14 the rule of thumb for urine?

15 A: One to 2 milliliters per kilogram per hour. And Ms.
16 Goodwin weighed about 120 kilograms on the day of surgery.

17 Q: Okay. And so then taking what's -- giving the benefit of
18 the doubt, let's take the lower number there of 1 milliliter
19 of urine per kilogram --

20 A: Per hour.

21 Q: -- per hour.

22 A: Uh-huh.

23 Q: Can you show us how much urine you would expect on the
24 low end for Ms. Goodwin to be producing in the course of an
25 hour during this surgery?

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1 A: So in the course of an hour at 120cc for 120 kilograms,
2 on the low end, she should produce 120 milliliters, which is
3 -- per hour.

4 Q: And so --

5 A: That's --

6 Q: Can you hold that up and show us and just tell us --

7 A: Sure. Per hour, that's what I would expect to see,
8 120cc, because that will be one cc per kilogram in that one
9 hour.

10 Q: All right. And so then over the course of a little bit
11 over a four-hour surgery, how much -- can you show us how much
12 urine --

13 A: Sure.

14 Q: -- you would expect on the low end for a properly
15 perfused patient to be --

16 A: So that was probably --

17 Q: -- producing?

18 A: Okay. That was at the end of, let's say, hour one. That
19 would be the end of hour two. End of hour three. End of hour
20 four. And she was actually in there for a little over four
21 hours, but that would be at the end of four hours.

22 Q: Okay. And can you show us graphically with the tools in
23 front of you there how much urine was recorded as Crystal
24 having produced during the surgery?

25 A: During the whole surgery, she produced that much. So

1 you're looking at -- and this is on the low end. I would
2 expect, like I said, 1 to 2. So really on the upper end,
3 twice this much, but this is how much -- I would expect this
4 is how much she produced, 80cc according to the record.

5 Q: And what does that tell you as a -- as a physician?

6 A: That she's -- her kidneys are not perfused either. So in
7 other words, throughout her body, her -- her perfusion was not
8 adequate. She was hypotensive. Her blood pressure was too
9 low throughout her whole body throughout the case.

10 And the best evidence we have objectively was with the
11 urine output, but then the neuromonitoring also, in my mind,
12 verified that by showing a loss of signal. She was not
13 adequately perfused. Her pressure was low too long. She
14 should have produced far more urine. Like I said, this was on
15 the low end. I would expect it to be much higher.

16 Q: Can you show us what the high end would look like?

17 A: Sure. Double that amount. So that was 120 per hour.
18 Okay, 2cc per kilo per hour, that's how much. Actually, I
19 expected more than that because, like I said, her surgery
20 actually went a little over four hours, but this is at 2
21 milliliters per kilogram per hour versus, again, what she
22 actually produced.

23 Q: In your mind, is there any way a patient producing only
24 four milliliters of urine over the course of a four-plus hour
25 surgery was adequately perfused?

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1 A: No, no. If she had a history of renal failure, if she
2 was on dialysis, yeah, you might only expect 80cc. Ms.
3 Goodwin was not in that situation. She had normally
4 functioning kidneys. The only reason she would produce such a
5 small amount of urine is she was inadequately perfusing her
6 kidneys, and she was inadequately perfusing her kidneys
7 because her blood pressure was too low.

8 Q: Doctor, does the chart tell us how much fluid she was
9 getting during the surgery?

10 A: According to the records, she received 2700 milliliters
11 or 2,700 milliliters of crystalloid during the case. Yes.

12 Q: Can you show us what 2700 milliliters of crystalloid
13 would look like?

14 A: Okay. Well, this is 1,000 in here. That's 2,000. And
15 700. So that's how much crystalloid she received. And again
16 --

17 Q: And I'm sorry, Doc. What is -- for us lay folks, what is
18 --

19 A: Oh, crystal -- I'm sorry. For us anesthesiologists or
20 physicians, crystalloid is a salt water IV solution. That's
21 all it is.

22 Q: Saline? Is that --

23 A: Saline. Like, it's not blood. It's not albumin. It's
24 not platelets. It's not plasma. It's crystalloid. It's
25 basically salt water.

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1 Q: And so what are we looking at there in the jar?

2 A: We're looking at 2,700 milliliters of fluid, and --

3 Q: And that represents what?

4 A: That represents how much she received during the course
5 of the surgery.

6 Q: Okay. And how much output did she have?

7 A: 80 milliliters. That's it.

8 Q: Is that a fluid imbalance there?

9 A: Huge.

10 Q: Doctor, someone producing that little urine over the
11 course of four hours, would they even stand the risk of -- of
12 suffering renal injury?

13 A: Oh, yeah. Acute renal insufficiency would be a very
14 definite possibility in having the type of fluid imbalance.
15 She was a -- she was not anuric, which means no urine, but she
16 was oliguric, meaning she was, you know, very little urine.

17 Q: What -- so what about other organs, like liver and
18 pancreas and spleen? Are there -- is there a way we can
19 measure whether or not they were suffering during this
20 surgery?

21 A: You could draw a liver function test immediately
22 afterwards. It might tell you that, but I don't think that
23 was done. That's -- you know, if you had a cerebral oximetry
24 monitor on her, sometimes that might also be of assistance,
25 but that wasn't used in this case, nor did the standard of

1 care require it to be. But there are tests that you can take
2 to see if hypoperfusion, you know, was occurring at the real
3 -- in real time. But after the -- the -- after the case, that
4 would be hard to -- to find.

5 Q: And so, in other words, do we have any way of measuring
6 whether or not other organs besides the spine and the kidneys
7 were suffering from lack of perfusion during the surgery?

8 A: Not that was in place at that time, no.

9 Q: Okay. All right, Doctor. I'm going to show you one
10 other graph here. Can you tell us -- can you hold that up and
11 tell us -- well, first of all, just tell us what we're looking
12 at before you hold it up.

13 A: Okay. What you're looking at here is her urine output
14 over time, starting at 7:30 that morning and running until
15 11:30 that morning. And we're seeing on the lower line,
16 green, what her actual urine production was based on the
17 anesthesia record, with that first 40 being at 9:30, which is
18 annotated in the record on the anesthesia record.

19 And then the -- the blue line is showing what ideally it
20 should be at that same point in time. So you can see the very
21 -- the very large discrepancy, 480 milliliters of urine versus
22 80 milliliters.

23 Q: And is that the high end or the low end of that range?

24 A: That's the low end. That's the low end. The high end
25 would be twice that high.

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1 Q: And does the graph you're holding -- is that -- is the
2 information in the green line there taken from the chart?

3 A: Yes.

4 Q: Is that from the evidence in this case?

5 A: Yes, it is.

6 MR. HINSON: Plaintiffs would move the graphic
7 description of the evidence in as Exhibit 6.

8 MR. HEITMAN: We would object to it going into evidence.

9 MR. HINSON: Again, just so I'm clear, the objection
10 isn't against it being used, just it being entered; is that
11 fair?

12 MR. HEITMAN: Correct.

13 BY MR. HINSON:

14 Q: Okay, Doc. So that we can later figure out where this
15 information is, can you show us on the anesthesia record --

16 A: Uh-huh.

17 Q: -- where we will see the urine output?

18 A: Sure. Right here. You see the 40 under urine
19 interval/total.

20 Q: Would you circle that?

21 A: Sure.

22 Q: Just make a big circle on it. And what time is that 40
23 recorded?

24 A: That's at around 9:30.

25 Q: Okay.

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1 A: Which corresponds with what's on the graph. And then you
2 have another 40 here between 10:15 and 10:45 right there, and
3 that's it, for a total of 80.

4 Q: And where will we find how much crystalloid or saline she
5 was given?

6 A: Right here. LR being given by 18-gauge IV in the right
7 hand.

8 Q: And is it summarized there at the end of the --

9 A: Correct.

10 Q: -- surgery?

11 A: Right. That's what it says 2700.

12 Q: All right. Doctor, do you have a belief to a reasonable
13 degree of medical certainty as to whether sustained low blood
14 pressure during the surgery on July 28th, 2016, caused Crystal
15 Goodwin's neurologic injury?

16 A: Yes, I do.

17 Q: And what is that belief?

18 A: It did. That's -- her blood pressure was too low for too
19 long, and that's what caused the injury.

20 Q: And if it had been -- if her blood pressure had timely
21 been raised in the face -- or in response to this
22 neuromonitoring signal loss to her lower extremities, do you
23 have a belief as to whether her permanent neurologic injury
24 could have been avoided?

25 A: Yes, I do. And I think it could have been avoided.

1 Q: And, Doctor, what is a reperfusion injury?

2 A: A reperfusion injury is really an inflammatory response
3 that occurs when tissue that has not had adequate blood flow
4 and oxygenation is suddenly reperfused. In other words, the
5 perfusion that we talked about earlier. The pressure is low.
6 Now it's high again. And it's the body's response -- they've
7 studied it now, and it seems that the same mechanisms that we
8 see almost like in a -- in a traumatic injury occurs in
9 organs. So that's basically it in a nutshell.

10 Q: Does the clinical picture and the evidence in this case
11 fit with a reperfusion injury?

12 MR. HEITMAN: Objection. He was never asked about that
13 at his deposition. Never gave an opinion. He's also not a
14 neurosurgeon.

15 BY MR. HINSON:

16 Q: You believe that; correct? You can answer that, Doc.

17 A: Okay. Reperfusion though is not just a neurosurgical
18 concept. It's a concept throughout medicine. But I say that
19 no for a couple of reasons. One, if perfusion is adequate up
20 to that point, then there is no reperfusion injury. In other
21 words, reperfusion injury occurs in tissue that has not been
22 perfused and you suddenly restore perfusion.

23 Looking at this record, the perfusion wasn't adequate --
24 was -- if it had been adequate to begin with, there would not
25 have been any occurrence of reperfusion injury. Also,

1 reperfusion injury does not occur at an instant in time. Even
2 Dr. Holcomb [sic] in his deposition said the signal drop off
3 was dramatic. It was, like, almost instantaneous, like
4 flipping a switch.

5 That's not the way reperfusion injury typically occurs.
6 It manifests over a period of time. So, no, I don't think
7 reperfusion injury occurred here.

8 Q: And if there weren't -- if it were -- I understand your
9 position is you don't believe it was a reperfusion injury, but
10 if it were a reperfusion injury, would doing the things you
11 mentioned earlier in response, giving fluids, lowering the
12 anesthetic levels, raising blood pressure, would they help to
13 lessen or alleviate a reperfusion --

14 MR. HEITMAN: Same objection.

15 BY MR. HINSON:

16 Q: You can answer.

17 A: Okay. With reperfusion, yes. You'd be doing the same
18 thing. You'd want to restore pressure, provide supportive
19 therapy, keep the pressure up, keep the patient well
20 oxygenated and ventilated. And that's about all you would --
21 would do. So if the same things had been done that should
22 have been done as soon as the signal was lost, then if this
23 was due to a reperfusion injury, it should have resolved.

24 Q: And -- but in order to do that, those things that you
25 just described, the anesthesiologist would have to what?

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1 A: They would have to have been notified.

2 MR. HINSON: Thank you. Dr. Jones., I've got no further
3 questions for you at this time. Please answer any questions
4 opposing counsel may have.

5 THE WITNESS: Certainly.

6 MR. HEITMAN: Can y'all take a quick break?

7 MR. HINSON: Sure. That'd be fine.

8 THE VIDEOGRAPHER: This ends Media Number 1. Going off
9 the record at 5 -- at 4 p.m. Wait, 5 p.m.

10 MR. HINSON: And, Doc, we can't talk just like we
11 couldn't in court. So --

12 THE WITNESS: I understand.

13 THE VIDEOGRAPHER: This begins Media Number 2. Going
14 back on the record at 5:07 p.m.

15 THE WITNESS: I don't see my face there.

16 MR. HEITMAN: Yeah. He -- we just turned it off.

17 MR. HINSON: I turned it off because of the other
18 attorney.

19 THE WITNESS: Oh, okay. Gotcha. All right.

20 CROSS-EXAMINATION

21 BY MR. HEITMAN:

22 Q: Dr. Jones, my name is Andrew Heitman. I met you off the
23 record.

24 A: Yes.

25 Q: I represent Dr. Holbrook and Midlands Orthopedics and

1 Neurosurgery.

2 A: Understood.

3 Q: You're an anesthesiologist; correct?

4 A: Yes.

5 Q: Okay. And you're not a neurosurgeon like Dr. Holbrook
6 is; right?

7 A: Correct.

8 Q: Okay. How long have you been working as an
9 anesthesiologist?

10 A: I finished my residency in September -- I'm sorry, July
11 of 1996. Board certification on first pass, 1997. And so
12 I've been a board-certified anesthesiologist since September
13 1997.

14 Q: Okay. And you might have -- you might have already
15 answered this. I'll try not to repeat too much of what Mr.
16 Hinson did, but how long have you been an expert for?

17 A: I started doing expert witness work in around 1999. '98,
18 '99. Yeah, probably '99.

19 Q: And how much do you get paid for reviewing a case?

20 A: \$400 an hour.

21 Q: And what about for your deposition?

22 A: That's -- I do 500 an hour with a three-hour minimum.

23 Q: And then what about for trial?

24 A: Same price, but for a four-hour minimum.

25 Q: About how many hours do you think you've spent on this

1 case?

2 A: Total, probably 20 hours, but that's over the three
3 years. And I've already been paid for about half of that
4 amount. I haven't billed for the other half yet.

5 Q: At this point in your career, you said you -- you've
6 treated thousands of patients; is that correct?

7 A: Yes. Yeah.

8 Q: And in all of these cases that you've done, do you do a
9 pre-anesthesia evaluation?

10 A: Yes.

11 Q: And oftentimes the first time you see a patient is on the
12 day of surgery; correct?

13 A: Frequently.

14 Q: So when the pre -- when is the pre-anesthesia evaluation
15 performed?

16 A: Most of the time it's immediately before surgery. You
17 rarely have the -- the luxury of seeing them beforehand more
18 than the day of surgery. But sometimes you do, but many times
19 you don't. Sometimes it depends also if they're inpatient or
20 outpatient, but most of the pre-anesthetic evaluations are
21 right before surgery.

22 Q: And it's at the pre-anesthesia evaluation that the
23 baseline blood pressure is determined; is that correct?

24 A: You have the -- not only just the pre-op evaluation.
25 You usually want to look at any kind of blood pressure that

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1 you have available to you that's in the record, and then also
2 in your immediate pre-induction blood pressure. That tells us
3 quite a bit as well. And that's the one that you take once
4 you're actually in the operating room before you induce.

5 Q: Who all is involved in the pre-anesthesia evaluation?

6 A: The anesthesiologist who is going to perform the
7 anesthetic in the operating room sometime, but not always.
8 One of the things that we often have now are pre-anesthesia
9 evaluation clinics, where you will have an anesthesiologist
10 and non-anesthesia nurses doing assessments of patients,
11 sometimes days in advance of a surgery. So it depends on
12 where you are and the facility and their processes.

13 Q: So it would be the -- but it would be the
14 anesthesiologist or the -- and/or the nurse anesthetist who
15 would determine the baseline blood pressure?

16 A: Usually -- correct, one of the two.

17 Q: Is it usually one more than another?

18 A: The anesthesiologist usually takes precedence. We're the
19 ones who call the shots. We're kind of the captain of the
20 ship. So usually we're the ones who determine that.

21 Q: And why is it important to determine the baseline blood
22 pressure?

23 A: Because that will help guide your intraoperative
24 management of the blood pressure.

25 Q: Help guide the anesthesiologist intraoperative

1 management?

2 A: Correct.

3 Q: It's your opinion that more likely than not Mrs.

4 Goodwin's blood pressure fell so low during her surgery on

5 July 28th, 2016, that it caused her to have permanent leg

6 weakness due to lack of blood flow to her spine; is that

7 correct?

8 A: Correct.

9 Q: And it's your opinion that more likely than not, if Mrs.

10 Goodwin's blood pressure was maintained in an adequate range,

11 that she would have maintained adequate perfusion to her

12 spinal cord; is that correct?

13 A: Correct.

14 Q: And in your opinion more likely than not, if Mrs.

15 Goodwin's spinal cord was adequately perfused, she would have

16 avoided her neurological injury or the injury would not have

17 been as severe; correct?

18 A: Correct.

19 Q: The MAP calculations directly correlate to the blood

20 pressure; is that correct?

21 A: Correct.

22 Q: How is it calculated?

23 A: Typically, mean arterial pressure is calculated by taking

24 one-third of the pulse pressure and adding it to the diastolic

25 blood pressure. And your pulse pressure is the difference

1 between your systolic and diastolic.

2 Q: In your opinion, Mrs. Goodwin's MAP should have been
3 maintained between 100 and 110; right?

4 A: Roughly that because I'm taking her mean arterial
5 pressure baseline to be 116. So within 20 percent of that on
6 either side.

7 Q: The lower the MAP, the lower the blood pressure is; is
8 that correct?

9 A: Correct.

10 Q: Mrs. Goodwin's lowest MAP, according to what Erich Starn
11 recorded leading up to her event on July 28th, 2016, was 86.6;
12 is that correct?

13 A: I need to look at it and see.

14 Q: Sure. I've got a copy of it.

15 A: Okay. Thank you. The -- the problem with this one, it
16 doesn't have the means on there. I'd have to -- if you want
17 for me to calculate it or we could use that graph that had the
18 -- he gave a tabular listing that -- from his deposition that
19 showed those blood pressures.

20 Q: I can -- I'll show you a copy of your deposition just to
21 help refresh your memory.

22 A: Okay.

23 Q: And if you will, Doctor -- let's see -- turn to page 80.

24 A: Okay. All right.

25 Q: And on line 19, 19 through 22, it says: Looking at your

1 sheet, it looks like the lowest mean arterial pressure on the
2 sheet was 82, and that was at 10:45. But that was after the
3 event. Leading up to the event, her lowest pressure was 86.6;
4 is that correct?

5 A: Correct. That's true.

6 Q: You agree that Erich Starn, the CRNA during the surgery,
7 was keeping the blood pressures in real time; is that right?

8 A: That's my understanding, yes.

9 Q: And you agree that he'd be sitting there looking at the
10 blood pressure monitor right in front of him?

11 A: Correct. That would be my understanding.

12 Q: In your review, the MAP at 9:45 was 86; is that right?
13 You can look on page 78, line 12.

14 A: Okay. That's what I see. MAP of 86. That's fine.

15 Q: Okay. And at 9:55, it was 85; is that right?

16 A: Yes.

17 Q: And at 10 o'clock, it was 108?

18 A: Uh-huh.

19 Q: And at 10:05, it was 96; is that right?

20 A: Right. Sounds right.

21 Q: And the -- and the signal was lost and announced in the
22 operating room at 10:04?

23 A: Well, it began at 9:57. It was lost completely at 10:04.

24 Q: All right. You would reasonably expect a patient's blood
25 pressure to be elevated on the day of surgery; is that right?

1 A: Within limits, certainly.

2 Q: And you agree that white coat syndrome is real?

3 A: It's real, not always to that extent. And also what
4 gives me reason to question that being white coat syndrome is
5 because her pressure is elevated in situations when she was
6 not in the hospital. But white coat syndrome, is it real?
7 Sure, it's real.

8 Q: And white coat syndrome is an episodic anxiety about just
9 being in the health care environment, particularly a surgical
10 environment; is that right?

11 A: That's correct.

12 Q: And just being in a doctor's office can cause it as well;
13 is that right?

14 A: It can, certainly. Again, I wouldn't expect it to be at
15 that extent. In my experience, you don't usually see it that
16 high.

17 Q: Your opinion as the baseline blood pressure for Mrs.
18 Goodwin on July 28th, 2016, is a systolic in the 150s and a
19 diastolic in the 90s; is that right?

20 A: Okay. Just a sec. Which one was that now?

21 Q: Your opinion on her baseline blood pressure?

22 A: Uh-huh.

23 Q: On the day of surgery?

24 A: You're saying -- okay. 160 over 99 pre-induction or
25 another one?

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1 Q: No. I'm asking your opinion of -- of what Mrs. Goodwin's
2 baseline blood pressure was on the day of her surgery.

3 A: Uh-huh.

4 Q: And -- and in your opinion, was the systolic in the 150s
5 and the diastolic in the 90s?

6 A: As I said, her baseline on the day of surgery in my mind
7 is her pre-induction and the one that she had the week before.

8 Q: So --

9 A: Which gives me a mean of 116.

10 Q: Okay. Would that -- would that work out to a systolic in
11 the 150s and a diastolic in the 90s?

12 A: I'd have to calculate it out, but I don't doubt what
13 you're saying. If you've already calculated it, that's fine.

14 Q: You can calculate it if you'd like to.

15 A: Okay. Which one did you say now?

16 A: A systolic in the 150s and a diastolic in the 90s.

17 A: I think it's going to give you a mean -- you're saying
18 systolic in the 150s -- systolic in the 150s, diastolic in the
19 90s?

20 Q: Correct.

21 A: Okay. Okay. That's going to give you around 110.

22 Q: Okay. Is that your opinion that that's what her baseline
23 blood pressure was?

24 A: Well, like I said, her baseline blood pressure was 116.

25 Q: Okay. Doctor, can you please turn to page 58 of your

1 deposition?

2 A: Okay. All right.

3 Q: Are you there?

4 A: I am.

5 Q: All right. Would you please look at line 15 through 21?

6 Question: Okay. So did you come up with a baseline blood
7 pressure for Mrs. Goodwin?

8 Answer: I would say that her baseline systolic is going
9 to be in the 150s, and her baseline diastolic is going to be
10 in the 190s.

11 A: Okay.

12 Q: Question: And that's based on those four blood pressures?

13 Answer: Correct.

14 Did I read that correctly?

15 A: You did.

16 Q: Doctor, so your opinion of her baseline blood pressure in
17 that range is based on only four blood pressures?

18 A: Correct.

19 Q: Correct?

20 A: Correct.

21 Q: And that would be -- would that be the blood pressure
22 taken on June 20th, which was 152 over 112?

23 A: Uh-huh.

24 Q: July 18th, which was 129 over 81?

25 A: Uh-huh.

1 Q: And July 22nd, which was 156 over 92?

2 A: And then the one pre-induction.

3 Q: July 28th, which is 160 over 99?

4 A: Right.

5 Q: Is that correct?

6 A: Correct.

7 Q: Is -- is that why, Doctor, that you're saying her MAP
8 should have been maintained from 100 to 110?

9 A: Correct. Her mean should have been, you know, within 20
10 percent of the 110. So roughly -- correct. The mean should
11 have been no less than probably 85 if you're just going with
12 the 20 percent off of 110. If you're going off 116, it would
13 be higher than that.

14 Q: Okay. And what should the MAP be maintained at in a
15 normal, healthy patient with normal blood pressure?

16 A: In normal blood pressure, first of all, you have to
17 define what that is, because a normal blood pressure for a
18 person in their teens or a young adult with 120 over 80 is
19 going to be different than a person who's older, also a person
20 with chronic hypertension.

21 But in a 120 over 80, you want to keep it within -- you
22 know, 120 over 80, so your pulse pressure being 40 plus 80, a
23 third of that. You want to be at around 80 or 80 to 90 to
24 keep within range.

25 Q: And you've never seen any studies or reports where

1 someone undergoing spine surgery had permanent nerve injury
2 where the MAP stayed above 80; is that correct?

3 A: Restate your question?

4 Q: You've never seen any studies or reports where someone
5 undergoing spine surgery had a permanent nerve injury where
6 the MAP stayed above 80; is that right?

7 A: I've never seen any study of that, no. I can only go
8 with my experience, what I've seen in the operating room.

9 Q: Doctor, I want to show you a copy of a Plaintiffs' Second
10 -- sorry. The Second Amended Answer to Plaintiffs' Third Set
11 of Requests for Admission. This is a copy of the table of
12 blood pressures that Erich Starn gave.

13 A: Right. Uh-huh.

14 Q: Do you mind just looking that over and tell me if you
15 would generally agree with those, or do any of those that you
16 disagree with?

17 A: No. I've looked at this before. This is fine. It's
18 verified. I have no objection to this at all.

19 Q: Okay.

20 MR. HEITMAN: I'd like to admit that as Defense Exhibit
21 Number 1.

22 MR. HINSON: I would object. I think RTAs get published,
23 not admitted.

24 MR. HEITMAN: Okay. We can take that up --

25 MR. HINSON: Yeah.

1 MR. HEITMAN: -- sometime.

2 MR. HINSON: Yeah.

3 BY MR. HEITMAN:

4 Q: Doctor, in your opinion, what's the likelihood that Mrs.
5 Goodwin's spine would become poorly perfused if her MAP
6 dropped down to 86.6?

7 A: Because her pressure is normally higher than that, I -- I
8 believe it would be at risk. And looking at her pressures,
9 several of those were close to that -- to that value. I still
10 think because of her hypertension history that she would be at
11 risk for hypoperfusion.

12 Q: You agree for the most part that Mrs. Goodwin's MAP was
13 maintained in the high 80s to 90s range; is that right?

14 A: Sure. And that's what the -- that's what the record
15 reflects.

16 Q: Okay. And in your opinion, is it predictable and
17 foreseeable that Mrs. Goodwin's spine would become poorly
18 perfused if her MAP were maintained in the high 80s to 90s?

19 A: Again, restate your question there?

20 Q: Yeah. Is it -- is it predictable and foreseeable to you
21 that Mrs. Goodwin's spine would become poorly perfused if her
22 MAPs were maintained in the high 80s to 90s range?

23 A: If they're perfused throughout that, it would be still a
24 possibility because of her history of hypertension. Her
25 pressure or mean should have maintained -- been maintained

1 higher than that, certainly to ensure adequate perfusion. So
2 I'd have to say no.

3 Q: No, it's not predictable and foreseeable or -- or, yes,
4 it is predictable and foreseeable?

5 A: Predictable and foreseeable that her pressures would --
6 that her spine would be perfused or would not be?

7 Q: Would be poorly perfused?

8 A: Would be poorly perfused, correct.

9 Q: Okay. So in your opinion, it is predictable and
10 foreseeable that Mrs. Goodwin's spine would become poorly
11 perfused if her MAPs were maintained in the -- in the high 80s
12 to 90s range?

13 A: And I guess my problem there is, as a physician, 90s
14 range. I mean, you're saying low 90s, but you -- high 80s to
15 low 90s. High 80s to low 90s is kind of a paper or if you
16 prefer gray area where I would expect to have been some
17 perfusion, yes. Would it be adequate? Probably not, no. But
18 would it -- would she be perfusing her spine? Yes.

19 Q: I can ask it a different way, Doctor --

20 A: Okay.

21 Q: -- if -- if that would help.

22 A: Sure.

23 Q: In your opinion, is it predictable and foreseeable that
24 Mrs. Goodwin's spine would become poorly perfused if her MAPs
25 were maintained in the range that they were during this

1 surgery on July 28th --

2 A: Yes.

3 Q: -- 2016?

4 A: Yes.

5 Q: Is that to a reasonable degree of medical certainty, more
6 likely than not?

7 A: Yes.

8 Q: In your opinion, if Mrs. Goodwin's spine is poorly
9 perfused, is it predictable and foreseeable that it would
10 cause these neurologic damages that we see in her today?

11 A: Yes.

12 Q: Is that opinion to a reasonable degree of medical
13 certainty, more likely than not?

14 A: Yes.

15 Q: If you were the anesthesiologist for Mrs. Goodwin's case,
16 you would have raised her blood pressure to try to get the
17 signal back as soon as it was lost; is that correct?

18 A: Absolutely.

19 Q: And if low blood pressure caused Mrs. Goodwin's injuries,
20 then it would be important to raise the blood pressure after
21 the signal is lost because if the surgeon is telling you that
22 it's not mechanical and the technician is telling you that
23 it's not her equipment, then you, as the anesthesiologist,
24 need to do what you can to raise the blood pressure to ensure
25 adequate perfusion; is that correct?

1 A: That's absolutely right.

2 Q: And the same thing would be sure with the CRNA. The CRNA
3 would need to raise that blood pressure; is that correct?

4 A: Correct. And there's an inherent -- there's another
5 obligation upon the CRNA. In addition to doing the very same
6 things that the anesthesiologist would do, administer
7 pressors, give fluid, lighten the anesthetic, he also needs to
8 notify the surgeon and the anesthesiologist.

9 Q: Have you yourself ever been involved in a case where the
10 signal was temporarily lost but then returned?

11 A: Yes.

12 Q: How many -- how many cases?

13 A: Over a period of 20-some year career, I wouldn't say
14 probably more than about 10 or 15 that I've had to deal with
15 that, but yeah, that's a reality of -- of spine surgery.

16 Q: And in those situations, was the signal lost due to poor
17 perfusion?

18 A: Well, let's see. We go through the diagnostic. In some
19 cases, it was perfusion issues, in which case you raise the
20 pressure. In others, it was mechanical, and surgeons had to
21 make adjustments.

22 I don't recall if I've been anywhere where the signal was
23 -- was thrown off due to -- from the monitor error, but I know
24 some stand out in my mind of perfusion issues and the -- the
25 surgeon manipulating instrumentation.

1 Q: About how many would you say were due to poor perfusion?

2 A: Maybe as many as a half.

3 Q: And in those situations, did you raise the patient's
4 blood pressure?

5 A: Yes. That's how -- that's largely how we determined that
6 it was a perfusion issue. You run into a differential
7 diagnosis when you lose the signal. Okay? First of all, you
8 have to assume is it, you know, the monitor, but the
9 monitoring tech is usually going to be working on that.

10 On our side, we're looking at the pressures. And
11 sometimes those pressures on the screen may appear what we
12 would consider textbook normal. Okay. It's 120 over 80. Why
13 are we having this? But you raise the pressure because if it
14 turns out that raising the pressure doesn't do it, then you
15 rule that out as a cause of it. In which case then you say,
16 you know, surgeon, hey, I brought the pressure up. I've got a
17 mean now, you know, well over, you know, the 20 percent range.
18 And we still don't have return of signal. We know it's not a
19 perfusion issue. Check again.

20 In some cases, the surgeon will check and say, oh -- in
21 many cases, it is something. It is compression. If they're
22 applying screws or whatever, they let off on it, all of a
23 sudden the signal comes back.

24 But it's a differential thing, and that's where the
25 communication is crucial because we don't always know, but

1 you've got to try everything until you get that signal back.
2 If the -- if the equipment's working, we know it's not the
3 equipment. The surgeon says, hey, I haven't touched it, fine.
4 It's not you. It must be at the head of the table, as we say,
5 which is anesthesia. Lighten the anesthetic, give a fluid,
6 give pressors, see if you get the signal back. Thank God I've
7 never had one that didn't get back. So that's how we roll
8 through that.

9 Q: So in those cases that you mentioned, when you raise the
10 blood pressure, the signal returned?

11 A: Correct. In those cases where it was a matter of
12 perfusion. In some cases, we raised the blood pressure and it
13 didn't. The surgeons in those cases typically would make a
14 manipulation and would get return of signal.

15 Q: And in your experience in thousands of cases, you've
16 never been involved in a -- in a case where the signal was
17 lost or remained lost; is that correct?

18 A: Correct.

19 Q: The signals always come back in your experience with low
20 perfusion cases because you raise the blood pressure?

21 A: On the cases that I myself have performed, yes, that's
22 correct. I have heard of cases in partners and in practice
23 where that did not happen, but I've just been lucky enough
24 where we got these signals back. Like I said, some are due to
25 low perfusion, some are due to surgeons. In my cases when it

1 was perfusion, we got the pressure up, the signals came back.

2 Q: In this case involving Mrs. Goodwin, her blood pressure
3 was raised to a MAP of 108 after the signal was lost; is that
4 right?

5 A: For a very, very brief period of time, correct.

6 Q: And 108, in your opinion, would have been an adequate
7 MAP; is that correct?

8 A: For that brief period of time. The problem with that --
9 and I looked at that on the record. The spike that occurred,
10 number one, there was a -- yeah. The spike that occurred was
11 -- was isolated. And I don't know. It doesn't make good
12 sense to me as an anesthesiologist. You went from a mean of
13 86 to basically a mean after the signal loss was reported to
14 110 without administering anything. I don't know, and I
15 didn't see in his deposition testimony where Mr. Starn said he
16 gave anything or adjusted anything, but then it goes right
17 back down.

18 And that's also one of the reasons for my criticism is
19 that going in, we had low MAPs. You had that one spike that
20 was good, but I don't know why it's there. And then it drops
21 back down. It's allowed to remain down. That gives me some
22 cause for concern too, because, you know, we -- the
23 hypotension is what led to the signal loss, and that was due
24 to the poor perfusion.

25 Then even after that, you know, something occurred. I

1 don't know what it was. It got it up, but then it was allowed
2 to drift down again. For all I know, she may have been
3 salvageable. The cord may have been salvageable at that point
4 if the right things had been done, but they weren't.

5 Pressors, fluids, lightening the anesthetic, any of those
6 things could have been done. And yet, after that one episode,
7 it goes down as low as it was before, in some cases even
8 lower. That was -- that gave me serious reasons for concern.
9 And that, combined with the low urine output, it was a
10 perfusion issue without a doubt in my mind.

11 Q: So, Doctor, your answer to my question was, yes, with
12 your explanation that 108 was an adequate MAP; is that right?

13 A: Right. For that one episodic blood pressure, 108 was
14 good. If it had been maintained before that, I think we would
15 have had a different outcome. But go ahead.

16 Q: Yeah. Her SSEP signal never came back; is that right?

17 A: Correct.

18 Q: It's your opinion that by 10 o'clock the damage to Mrs.
19 Goodwin's spine had already been done; is that right?

20 A: It certainly was not work -- functioning at that point.
21 Her spine was not, according to the SSEPs. Now, had adequate
22 perfusion been provided over a period of time, other than just
23 one blood pressure measurement, then she may have been
24 salvageable. The spine, I should say, could have been
25 salvaged.

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1 Q: But by 10 o'clock, the damage had already been done to
2 Mrs. Goodwin's spine; is that right?

3 A: It had been hypoperfused to the point where it was not
4 functioning properly. Correct. But what I'm saying is damage
5 had been done, but the damage may not have been irreparable at
6 10 o'clock.

7 Q: The way you determine if you're getting adequate
8 perfusion is by looking at in-organ function; is that right?

9 A: Correct.

10 Q: And you can look at the spine, the brain, the kidneys.
11 and the heart; is that right?

12 A: You can look at those and other organs, yes, if you have
13 the monitors to do so. The spine, brain, kidneys, heart,
14 those are the ones that are easily measurable.

15 Q: Who all is present in the room during a laminectomy?

16 A: It depends on the operating room, but the base is going
17 to be, of course, your anesthesia provider, your surgeon, your
18 neuromonitoring technician. And some surgeons don't use
19 neuromonitoring technicians. Most of them do. And usually,
20 the surgeon is going to have a scrub tech and a first assist
21 is often in there also, and a circulating nurse. Those are
22 pretty much minimal number of people that you're going to have
23 in a case of this type.

24 Q: A scrub tech? Is that the same as a surgical tech?

25 A: Uh-huh.

1 Q: And each person in the room has different roles; is that
2 correct?

3 A: Correct.

4 Q: What is a -- what is a scrub tech? What is their role?

5 A: The scrub tech or surgical technologist is the person who
6 hands the instruments to the surgeon, maintains the sterile
7 field. In movies when the surgeon says scalpel, it's a
8 surgical tech that hands him the scalpel. But they also
9 maintain the surgical field. And in some cases, depending on
10 the hospital, if it's a kind of a no-frills operating room,
11 the surgical tech may often sometimes even hold retractors
12 while the surgeon operates.

13 Q: And what's the neuromonitoring operator's role?

14 A: The neuromonitoring operator's role is to monitor the --
15 whatever parameter they have been requested to monitor. And I
16 say that because neuromonitoring techs typically aren't --
17 they don't just show up for every case. Usually, the surgeon
18 will say I need neuromonitoring for this.

19 And for spinal cases, most surgeons will say that. There
20 have been some who don't, but most will say I need
21 neuromonitoring for this and that tech comes in to set up
22 their machine and they put their electrodes on the body,
23 depending on the part of the body they're going to be
24 monitoring. And during the case, they will sit at their
25 station, which is usually not far from the anesthesia station

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1 because they're watching the vital signs monitor, and that's
2 all they do. They sit there for the entire case, watching
3 those wave forms like you see on the neuromonitoring record.

4 Q: Okay. And who is part of the anesthesia care team?

5 A: The anesthesia care team consisted of the
6 anesthesiologist, Dr. Jennifer Root, and the nurse
7 anesthetist, Mr. Starn. And I believe someone gave him a
8 break at one point, but he was there for the majority of the
9 case.

10 Q: During the procedure such as laminectomy that Crystal
11 Goodwin underwent on July 28th, 2016, it is the anesthesia
12 care team's responsibility to appropriately monitor the -- the
13 patient's blood pressure; is that right?

14 A: Certainly, yes. Not just blood pressure, but all the
15 vital signs.

16 Q: And it's the anesthesiologist and the CRNA's job to
17 monitor urine output; is that right?

18 A: Correct. Correct. Now, I will say this. It's not in
19 isolation. I say that to say this, it is their job to monitor
20 it because the surgeon can't. The surgeon is scrubbed in.
21 But the communication has to be going on, and we often will in
22 the operating room say, you know, urine output is down or
23 we're looking over into the operative field. It's not
24 everyone operating in isolation in a marginalized area.

25 But, you know, the anesthesiologist or the CRNA, whoever

1 the anesthesia provider is, we are the primary people
2 monitoring urine output, blood pressure, pulse rate, pulse
3 oximetry, which is a measure of oxygenation. You know,
4 ventilatory parameters in a patient who is being ventilated.
5 Positioning, because in a case such as this, the patient is
6 prone. Patients in the prone position are at high risk of
7 nerve damage and pressure injuries.

8 So all of that, the anesthesia provider is the person
9 primarily responsible for watching it. But as we always say
10 in the operating room, we're all a team. So everyone -- we
11 would communicate what's going on.

12 Q: And it is also the anesthesiologist's and the CRNA's
13 responsibility to administer medication or fluids to lower or
14 raise the patient's blood pressure to keep it in a safe range;
15 is that correct?

16 A: That's correct. We're the only ones really who can. The
17 surgeon can't do it. The -- you know, the monitoring tech
18 can't do it. Only anesthesia can really do the medications
19 and the fluids.

20 Q: And performing a Stagnara wake-up test, would that be the
21 anesthesiologist and the CRNA's responsibility too?

22 A: Well, that definitely has to be coordinated with the
23 surgeon because when you wake that patient up, they might
24 move. And when that patient has a microscope or something in
25 that spine, that has to be very, very carefully titrated. You

1 don't want to wake them up too much. You want to wake them up
2 enough where they can comply, but it is something that needs
3 to be finessed.

4 And there has to be constant communication between the
5 surgeon and the anesthesia provider, but anesthesia is the one
6 that lightens the anesthetic. We're also the ones that
7 reverse the paralytic if the patient is paralyzed, but the
8 surgeon is the one who often will let us know, okay, we're
9 ready to do that Stagnara wake-up test.

10 Q: It would be the anesthesiologist and the CRNA who would
11 be primarily responsible for the Stagnara wake-up test?

12 A: Yes, as far as titrating medications. Right. But as far
13 as saying when to do it, that's the surgeon.

14 Q: As far as actually waking the patient up though?

15 A: Oh, yeah. Yeah. Because we're the ones that are keeping
16 them asleep. Your baseline is always to wake up. So, yeah,
17 we'd be the ones to adjust that.

18 Q: And I believe you said it's the -- the surgeon's role to
19 focus on operating on the patient; is that right?

20 A: Sure. Operate on the patient and, you know, let us know
21 what he's seeing in his field also. He may be seeing things
22 that we need to be aware of.

23 Q: You agree that in this case Dr. Holbrook did not
24 determine what the cause of the injury was; correct?

25 A: Correct. According to the deposition, he said he did not

1 know.

2 Q: But you did see that he indicated it was not anything
3 mechanical or something that he did during the surgery?

4 A: Correct. Which is also what gave me further reason to --
5 to believe, as I do, that it was a matter of perfusion.

6 Q: And you saw that Dr. Holbrook said he was not near the
7 cord when the signal went out; is that right?

8 A: Correct. That's what I saw in the deposition.

9 Q: And you as an anesthesiologist really cannot comment on
10 the standard of care of the neurosurgeon, Dr. Holbrook, in
11 this case; is that correct?

12 A: As it regards anesthesia and interaction with anesthesia
13 and the other members of the operative team, I can. As far as
14 his technical performance of his duties, no, I can't speak to
15 that. But how he communicates with the anesthesia care team,
16 I can definitely respond to that. And how he communicates
17 with the neuromonitoring technician, I can respond to that as
18 well.

19 Q: You mentioned earlier that you've participated in
20 thousands of surgeries; right?

21 A: Correct.

22 Q: And so you're very experienced with knowing and
23 recognizing the level of communication required between a
24 surgeon and the anesthesia care team; is that right?

25 A: Yes. Very much so.

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1 Q: And I understand that you're not a neurosurgeon and
2 cannot testify to surgical aspects of this case. However, as
3 to the communication between Dr. Holbrook and the anesthesia
4 care team, you don't have any criticisms of Dr. Holbrook;
5 true?

6 A: I've not seen anything where he failed to communicate
7 anything he saw. It seems to me during the critical portions
8 of the case where the signal was lost, which is what stands
9 out most in my mind, he and the anesthesia care team were
10 informed at the same time. So I don't think there was a
11 breakdown in communication between them, other than the fact
12 that, you know, if he had been more adamant about get your
13 attending in here, in other words, Dr. Root, or exploring or,
14 you know, mentioning to the CRNA, perhaps, what is the
15 pressure? These are all things that in spine cases I've been
16 in that have started to have problems with the signal, that
17 has occurred.

18 And so, yeah, I would have a criticism of that. I don't
19 think he communicated with them enough once he was told that
20 the signal dropped off. Bells and whistles should go off when
21 that occurs.

22 Q: Can you turn to page 126 of your deposition? Look at
23 line 11.

24 A: I think I handed it back to you.

25 Q: Oh, 11 through 20.

1 A: What page was that again, sir?

2 Q: Page 126, please.

3 A: 1-2-6.

4 Q: Let me know when you're there.

5 A: Oh, I'm there.

6 Q: Okay. Line 11.

7 Question: If I understand what you said earlier, you said
8 that in your point of view, there was no deviation under the
9 standard of care by Dr. Holbrook; is that correct?

10 Answer: Not that I could determine. I said, you know,
11 the relationship between he and the anesthesiologist and
12 communication between them I can address, but I didn't see
13 where there was a problem, no.

14 Question: So nothing you can testify to?

15 Answer: Correct.

16 Did I read that correctly, Doctor?

17 A: You did.

18 Q: So from an anesthesia standpoint, you can't see where Dr.
19 Holbrook did anything inappropriate in this case; is that
20 correct?

21 A: Correct. And I would still have to say though,
22 regardless of that, that, you know, communicating -- again, if
23 he had felt strongly enough about it to tell the CRNA to get
24 the anesthesiologist in there. That's the only criticism I
25 would have, but that would be it. As far as his technical

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1 neurosurgery skill, I have no way of criticizing that.

2 Q: And the CRNA is capable of raising blood pressures?

3 A: Absolutely. I mean, that is part of their core training,
4 privileges, and so forth. Yes.

5 Q: They're qualified to do that?

6 A: Yes. They better do that.

7 MR. HEITMAN: I don't have any other questions, Doctor.
8 Thank you.

9 THE WITNESS: Okay.

10 REDIRECT EXAMINATION

11 BY MR. HINSON:

12 Q: Very brief redirect, Dr. Jones. The Stagnara wake-up
13 test was mentioned earlier. Just generally speaking, what is
14 that test?

15 A: The Stagnara wake-up test is where the patient is still
16 prone. Their operating field is still open, meaning in this
17 case the spine will still be exposed, but the surgeon would
18 say, okay, Fred, we're going to do a wake-up test.

19 So at that point, I start to dial down the anesthetic.
20 In this case, it would have been the sevoflurane. Cut back on
21 the propofol infusion. Make sure the muscle relaxant was
22 reversed, in this case the rocuronium. I would give a
23 reversal agent, and we would let -- following vital signs and
24 so forth, we would start to continuously talk to the patient
25 and -- until the patient started to respond.

1 And typically, at that point, the neurosurgeon would say,
2 okay, you know, Brink, move your right foot, and you'd move
3 your right foot. Move your left foot. Move your left foot.
4 That's basically it. And once they've done that, they say,
5 okay, we're good, and I'd put them right back down. Spin the
6 volatile anesthetic agent back up, give them the propofol, and
7 go right back to sleep.

8 Q: And in your experience and work as a physician, have you
9 had occasions where you've seen and been a part of the
10 Stagnara wake-up test being done?

11 A: Yes. Yeah. It's pretty dramatic to see someone with
12 their spine open who is wiggling their feet and their toes and
13 responding to your questions.

14 Q: It is not an archaic thing that's never done anymore; is
15 that fair?

16 A: No. You don't see it done as much now as you used to,
17 but it's still done.

18 Q: And in this situation, Crystal's situation, I understand
19 it's your testimony that had there been anesthetic changes,
20 meaning lowering the anesthetic, had the blood pressure been
21 increased and had the perfusion been increased -- excuse me --
22 the -- the fluid had been increased, the things you talked
23 about earlier, that you believe her signal would have
24 returned. Had it not returned in the face of those things,
25 would the Stagnara wake-up test be something that the entire

1 surgical team might consider?

2 A: Certainly. I could do something that could be considered
3 -- while the surgical team may consider that, that is
4 definitely something that the surgeon would have to order. We
5 can't just do it without him saying so because that could be
6 detrimental.

7 Q: And as Mr. Heitman mentioned to you a minute ago, you
8 yourself are not a neurosurgeon?

9 A: Correct.

10 Q: But you -- do you work with neurosurgeons?

11 A: Every day.

12 Q: And I want to make sure I understood your testimony and
13 the jury understands your testimony. Both at deposition and
14 today, you're not criticizing -- you don't have the education,
15 training, and background to criticize a neurosurgeon's
16 particular skill with their instruments; fair?

17 A: No. Correct. I do not.

18 Q: But from your experience and as you testified at
19 deposition and today, do you have criticism of Dr. Holbrook
20 regarding what he did and did not bring to the attention of
21 the attending anesthesiologist, Dr. Root?

22 A: Correct. When the -- when the signal was lost, that
23 would -- I would expect him to have said, hey, get Dr. Root in
24 here. Something as simple as that.

25 Q: And earlier in the cross-exam, Mr. Heitman looked at some

1 -- some blood pressures. Regardless of whether you look at
2 one blood pressure or two blood pressures or four blood
3 pressures, whether you look at just the -- the one the morning
4 of surgery, the one the week before surgery, and the -- the
5 two that were done in Dr. Holbrook's office, do you have an
6 opinion as to whether there was an adequate consideration in
7 this surgery for her -- for Crystal Goodwin's chronic
8 hypertension?

9 Q: They would have to have appreciated it, you know, by
10 merely looking at the blood pressures. You know, Mr. Starn,
11 and to a certain extent Dr. Root, taking that information and
12 dealing with it appropriately, I would have to say no, because
13 if they had, they would have kept the pressure higher.

14 Q: And in the face of that, with the signal going out, what
15 should have occurred with the whole surgical team? What
16 should -- just generally speaking, what should have been done?

17 A: An emphasis should have been placed right away on getting
18 the pressure back up, getting the pressure higher, and if they
19 thought it was in normal range, then you get it even higher
20 than that because sometimes that's what it takes.

21 Q: And you've -- have you in your career had occasion where
22 signal went out because, unfortunately, inadequate perfusion?

23 A: Yes. Oh, yes.

24 Q: And in your experience, what was done in the face of
25 inadequate perfusion?

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 A: The very things I mentioned. Lighten the anesthesia if
2 you can. Sometimes lightening the anesthetic is not an option
3 because you don't want the patient to wake up. But fluids is
4 a big one, particularly in a patient who really is running dry
5 based on how much she was getting versus how much she was --
6 urine output she had.

7 And then pressor agents. Pressor agents are probably the
8 most common. And like I said, vasopressin, phenylephrine,
9 ephedrine, all of those medications we regularly give in these
10 cases.

11 They're fairly high-volume cases. Patients have lots of
12 insensible fluid loss. We know that going in. They can be
13 bloody cases. This one was not particularly bloody. 200
14 milliliters for this type of case is not bad. But yeah, we do
15 all of those things.

16 Q: And in every occasion where you had that occur, where
17 there was a signal loss and there was a reaction with
18 pressors, fluids, and lightening anesthetic, was the patient's
19 neurologic function able to be salvaged in return?

20 A: Yes. Thank God they were.

21 Q: And you believe that could have happened in this case?

22 A: I do.

23 Q: Do you believe it would have happened in this case had
24 the standard of care been followed?

25 A: I do.

DR. FREDERICK JONES - VIA VIDEO DEPOSITION

1 MR. HINSON: No further question, Dr. Jones.

2 MR. HEITMAN: I don't have anything on recross.

3 (WHEREUPON, the video deposition ended, and the
4 proceedings resumed as follows.)

5 THE COURT: All right. Ladies and gentlemen, that
6 concludes that portion of testimony. It's now time to take a
7 lunch break. As you know, we have ordered lunch for you. I'm
8 still going to give you an hour for lunch. So you can sit in
9 the jury room and eat your lunch, if you choose to. If not,
10 you can take it to your car, take it home, go to the park,
11 whatever you would like to do with your lunch.

12 Just be back in your jury room at 2 o'clock. Don't
13 discuss the case. I'll see you then.

14 (WHEREUPON, the jury exited the courtroom at 12:58 p.m.)

15 THE COURT: Ready for a lunch break? See you at 2
16 o'clock.

17 MR. GOINGS: The exhibits? We will put them on the
18 record when we come back.

19 THE COURT: That's fine.

20 MR. GOINGS: Okay.

21 THE COURT: Okay.

22 MR. GOINGS: Thank you.

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

25 THE COURT: All right. Do we need to discuss anything

1 before we bring the jury?

2 MR. GOINGS: Yes, Your Honor, we do.

3 THE COURT: Yes?

4 MR. GOINGS: So the exhibits for Dr. Jones's deposition,
5 I'll say the Exhibit 2 and 3 that were used, Plaintiffs' 2 and
6 3, it's already in evidence and been marked as other -- as
7 other exhibit numbers. Exhibit 1 is an animation about blood
8 flow.

9 THE COURT: Uh-huh.

10 MR. GOINGS: And we would move that Exhibit 1, the
11 animation about blood flow, be admitted.

12 I will call the Court's attention to the case of *Clark v.*
13 *Cantrell*. As you know, it's a South Carolina Supreme Court
14 case, and it deals with computer-generated video animation.
15 And it says demonstrative evidence often is admitted only for
16 use in the courtroom to explain and illustrate a witness's
17 testimony, but it may also be admissible as an exhibit for the
18 jury to examine or consider during deliberations.

19 So, throughout this case, there's been an idea that
20 demonstrative evidence is not -- you shouldn't put a sticker
21 on demonstrative exhibits because they're not an exhibit, but
22 that's not what *Clark v. Cantrell* says. And we would -- we
23 would move that the -- the video about blood flow and
24 autoregulation, which is Exhibit 1, into evidence at this
25 time.

1 MR. HEITMAN: Your Honor, as far as Exhibit Number 1,
2 there is no support in the medical records at all in this case
3 that Mrs. Goodwin had this autoregulation. So we don't
4 believe that this demonstrative exhibit in this case is
5 supported by the medical records and should not be submitted.

6 THE COURT: Is it not supported by Dr. Jones's testimony?

7 MR. HEITMAN: Dr. Jones was testifying that -- as to what
8 autoregulation is, but I don't believe there is any testimony
9 that Mrs. Goodwin actually had this issue, and there's nothing
10 else in the medical records that would -- that would point to
11 that.

12 THE COURT: I mean, I understand that. I'm not asking
13 about that. I'm asking about the witness's testimony.

14 Mr. Goings?

15 MR. GOINGS: Yeah, that's what he testified about, and
16 that was the basis of his testimony. The animation explained
17 it and illustrated her autoregulation issues.

18 THE COURT: All right. So -- and we've been referring to
19 it as Exhibit 1. That was for Dr. Jones's *de bene esse*
20 deposition. In this trial, I believe it would be Plaintiffs'
21 28. That will be admitted over the defendants' objection.

22 (WHEREUPON, Plaintiffs' Exhibit Number 28, animation, was
23 admitted into evidence.)

24 MR. GOINGS: And, Your Honor, I have a copy of a thumb
25 drive of Dr. Jones's deposition, along with the certified

1 copy, that I can hand Madam Court Reporter, for her purposes.

2 THE COURT: We'll mark those as Court's Exhibits.

3 THE COURT REPORTER: 11 and 12.

4 THE COURT: Thank you.

5 (WHEREUPON, the thumb drive and transcript were marked as

6 Court's Exhibits Number 11 and 12.)

7 MR. HINSON: Your Honor, during Dr. Jones's cross exam,

8 defendant sought to introduce our RTA, request to admit. And

9 Your Honor, the case of *Scott v. Greenville Housing Authority*

10 says in our state requests to admit are not submitted to the

11 jury. Rather, the proper course of action is to publish the

12 admissions to the jury.

13 We have no objection to them being published. But they --

14 I mean, *Scott v. Greenville Housing Authority* flatly says they

15 don't become exhibits into evidence.

16 MR. HEITMAN: Your Honor, we don't -- we don't have any

17 issue with that.

18 THE COURT: So they're not being offered into evidence at

19 this trial?

20 MR. HEITMAN: Yes, Your Honor.

21 THE COURT: Yes, I am correct?

22 MR. HEITMAN: Yes, Your Honor. We're -- we're not

23 offering them into evidence.

24 THE COURT: Right.

25 MR. HEITMAN: Just -- just to be clear.

1 THE COURT: Okay. Understood.

2 MR. HEITMAN: Thank you.

3 THE COURT: Any additional deposition exhibits?

4 MR. GOINGS: Yes, Your Honor. Number 5 and 6. Number 5
5 is a chart of blood pressure, mean arterial pressures during
6 the 2016 surgery. Exhibit 6 is a graph of urine output.

7 I recall your ruling earlier this week when we tried to
8 move in a -- a chart, and it was not allowed in. And I think
9 the argument was by the defense that it's demonstrative, and
10 demonstrative evidence don't come in.

11 Again, *Clark v. Cantrell* says what -- the opposite. I
12 will say this. That the defense has charts too, and to the
13 extent that they're going to offer their charts then, they
14 shouldn't come in or our chart should come in and theirs
15 should come in too.

16 So the point I'm making -- I can't really see it because
17 of the glare on the screen. The point I'm making is what's
18 good for the goose needs to be good for the gander. We would
19 move those in and request Your Honor admit those only in the
20 extent that if the defense does that. Otherwise, Your Honor,
21 we will respect your previous ruling.

22 THE COURT: Well, my previous rulings have been dependent
23 on the chart. I believe one or more was admitted over the
24 defendants' objection. I can't recall why the one that was
25 not admitted was not. I'm not sure. That was several days

1 ago.

2 Any objection to Plaintiffs' 5 and 6 from the *de bene*
3 *esse* deposition?

4 MR. HEITMAN: Yes, Your Honor. Exhibit 5, I believe, is
5 this chart that has the danger -- it says danger zone across
6 the bottom of it. You know, the data points themselves we
7 believe are reflective of what is in the medical records and
8 the anesthesia chart.

9 However, this danger zone, we believe that's prejudicial.
10 It's not reflective of the medical records, and so we would --
11 we would object to this coming into evidence based -- based on
12 that.

13 And then as far as Exhibit Number 6, I believe, those
14 were the urine output, and it has -- it has on there Crystal's
15 measuring output, as well as the lowest normal output.

16 And we -- we would object to that coming in. We agreed
17 that that would be -- that Crystal's measured output is
18 reflective of the medical records. However, there is nothing
19 about the lowest normal output in the medical records in this
20 case. And so for those reasons, we would object to that
21 coming in as well.

22 THE COURT: Again, did Dr. Jones testify about this
23 lowest normal output? I believe he did.

24 MR. GOINGS: He used the -- he was pouring -- pouring
25 blue water and talking about that.

1 THE COURT: And let me see the other one that was 5 to
2 the deposition.

3 MR. GOINGS: Which is -- I think it's this one, Your
4 Honor. And I will say, everybody talked about the danger
5 zone. This is the 20 percent zone because you need to
6 understand the 20 percent, and I can juxtapose this one with
7 the defense one. And they -- instead of calling it danger
8 zone, they call it ideal MAP range. Okay? So it's even --
9 they just have different terminology that their witness is
10 using and our witness is using.

11 My point is, is that we would move ours into evidence
12 because under *Clark v. Cantrell*, especially a case that's
13 complicated with mean arterial pressure, calculate 20 percent
14 up, 20 percent down, where's the right range? Where's the
15 wrong range? These charts just sum it very well and distill
16 some pretty complicated medical testimony into something that
17 is visual.

18 And we've both done it. So I was just saying I think
19 ours should be admitted. And -- and, Your Honor, when -- when
20 the defense lays the foundation for theirs, I would assume
21 that it would be admitted as well, keeping in line with *Clark*
22 *v. Cantrell*.

23 THE COURT: Mr. Heitman, you were going to say something?

24 MR. HEITMAN: Oh, I was just going to say I don't think
25 we -- I don't think we've admitted ours into evidence yet. So

1 --

2 THE COURT: Yet?

3 MR. HEITMAN: Well --

4 THE COURT: Do you intend to offer it?

5 MR. HEITMAN: Well, if -- if the plaintiffs are going to
6 offer theirs, we will offer ours, but I still don't believe
7 that it's reflective of the medical records. If -- if you're
8 trying to get it in as a summary of -- of what the data points
9 are in the medical records, the danger zone is -- is more of
10 what I have a problem with.

11 THE COURT: Right. I understand that. And I keep trying
12 to pull you from the medical records. It doesn't have to be
13 photocopied or plucked directly from the medical records. The
14 witness testified that the data as it relates to Ms. Goodwin
15 is the data from the medical records, but, you know, part of
16 that is his knowledge, training, expertise, and opinion as an
17 expert, you know, to which your expert may disagree, but I
18 still think it's admissible.

19 So those will be Plaintiff's 29 and 30, admitted over the
20 defendants' objections.

21 (WHEREUPON, Plaintiffs' Exhibit Number 29, MAPs
22 demonstrative, and Plaintiffs' Exhibit Number 30, urine
23 output demonstrative, were admitted into evidence.)

24 MR. GOINGS: Your Honor, our next witness is Crystal
25 Goodwin. Is this mic working so she can sit next to the

1 witness stand? Or do you have a place where you want her to
2 go? Just --

3 MR. HINSON: Robert, I think Ms. Harris had talked about
4 putting her right here.

5 Would this work, Ms. Harris? That's where you want her?

6 MR. GOINGS: Okay. He says this is working. Testing?
7 Just leave it right there?

8 THE COURT REPORTER: Leave it right there.

9 MR. GOINGS: Okay. You got it.

10 THE COURT: So we'll -- yeah. We'll leave it there and
11 put her closer to the witness stand because there are other
12 recording devices --

13 MR. GOINGS: Okay.

14 THE COURT: -- around the courtroom.

15 MR. GOINGS: The only reason I say that is because I know
16 with the witnesses I've been trying to get them to talk in --
17 if her head is here, it's not going to be picked up on this
18 mic, but it may be for the court reporter's sake, and she'll
19 be loud enough.

20 Madam Court Reporter, if you have a problem with it, will
21 you just let me know and we can reconfigure?

22 THE COURT REPORTER: Yes.

23 MR. GOINGS: Okay.

24 THE COURT: So really, these microphones are to amplify
25 -- amplify things for us in the courtroom. And to some

1 extent, they help the court reporter, but she's also got her
2 own recording devices that she's listening to. And I think
3 she -- at least she thinks that it will be okay.

4 MR. GOINGS: One final thing. The financial records that
5 they gave us omitted a lot of information. I've talked to Mr.
6 Davis, and he is communicating or being communicated to -- to
7 his representative at Midlands to obtain the information. So
8 I don't think we have anything at this time to address with
9 it. We're working it out.

10 THE COURT: Okay. Sounds good.

11 Okay. Please bring the jury.

12 (WHEREUPON, the jury entered the courtroom at 2:26 p.m.)

13 THE BAILIFF: All jurors are seated, Your Honor.

14 THE COURT: All right. Thank you.

15 Welcome back, folks. We're still on the plaintiffs'
16 case. They're going to call their next witness.

17 MR. GOINGS: Thank you, Your Honor. May it please the
18 Court. The plaintiff calls Ms. Crystal Goodwin.

19 THE COURT: All right. Get Ms. Goodwin up towards the
20 witness stand to be sworn.

21 THE BAILIFF: She's facing the jurors when she's
22 testifying?

23 THE COURT: Yes. Have you accounted for that, Elizabeth?

24 THE COURT REPORTER: Yes.

25 THE COURT: Okay. So yeah. Let's have her facing the

1 jury.

2 THE BAILIFF: She wasn't already sworn in, was she?

3 THE COURT: Well, let's have her sworn, please. I'm
4 sorry. It's getting complicated.

5 THE BAILIFF: All right. Place your left hand and raise
6 your right.

7 THE CLERK: Do you solemnly swear or affirm that the
8 testimony you're about to give in this case will be the truth,
9 the whole truth, and nothing but the truth, so help you God?

10 THE PLAINTIFF MS. GOODWIN: I do.

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

12 THE PLAINTIFF MS. GOODWIN: Crystal Goodwin.

13 THE CLERK: Okay. Thank you.

14 CRYSTAL GOODWIN, being first
15 duly sworn, testified as follows:

16 DIRECT EXAMINATION

17 BY MR. GOINGS:

18 Q: Crystal, we're friends, aren't we?

19 A: You're more like my brother from another mother.

20 Q: I know this is going to be hard for both of us. Okay?
21 We have to go through this.

22 Dr. Holbrook has said that your injuries are not
23 permanent. Dr. Holbrook has also said that you're not
24 paralyzed, and I need to ask you why you think you're
25 paralyzed. Will you tell the jury why you believe you're

1 paralyzed?

2 A: I can't move the way I want. My brain can't tell my legs
3 to do what my brain is thinking. I can't just get up and walk
4 and do what I got to do. I got to rely on this chair.

5 Q: Have you been able to walk since July 28th, 2016?

6 A: No.

7 Q: When is the last day you walked in your life?

8 A: July 28th, 2016. I ran. It was the last day I was on my
9 feet.

10 Q: How'd you do that, Crystal?

11 A: I was running to get into the hospital because I thought
12 I was late for surgery.

13 Q: Were you late?

14 A: No, I was actually early.

15 Q: How'd you come out of the hospital?

16 A: On a stretcher.

17 Q: How many days after your surgery?

18 A: Two weeks.

19 Q: Now, going into the hospital, what was the plan about how
20 long you would have been in the hospital?

21 A: It was an outpatient surgery. I was supposed to go home
22 the same day.

23 Q: Did you pack your bags?

24 A: No.

25 Q: But you were in the hospital for two weeks; right?

1 A: Yes. Correct.

2 Q: Where did you go after the hospital?

3 A: They put me in an ambulance and took me over to

4 HealthSouth.

5 Q: How long were you at HealthSouth?

6 A: Another two weeks.

7 Q: How did you leave HealthSouth?

8 A: In a wheelchair.

9 Q: The same wheelchair you're in here today?

10 A: No.

11 Q: How many wheelchairs have you had in the last seven

12 years?

13 A: This is the second one.

14 Q: So the jury has heard what's happened to you nearly seven

15 years ago, but I want them to know the person you are and the

16 person you were and the person you are today. So let's back

17 up. Tell the jury where you grew up.

18 A: I grew up here in Columbia.

19 Q: Where were you born?

20 A: Here.

21 Q: Okay. Where'd you go to school?

22 A: Elementary school was Line Street. Went to Creighton

23 Middle School. Then I went to Dreher High School.

24 Q: Did you graduate high school?

25 A: I did.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 Q: What year did you graduate?
2 A: 1996.
3 Q: Are your parents still alive?
4 A: Yes.
5 Q: Is your mom still alive?
6 A: That's my mom right there.
7 Q: What's her name?
8 A: Edna Delbridge.
9 MR. GOINGS: I need to bring my voice up? Okay.
10 BY MR. GOINGS:
11 Q: When did you first meet James?
12 A: We grew up together in the same neighborhood, and we
13 attended elementary school together. So, like, second grade.
14 Q: So you've known him since second grade?
15 A: Yes.
16 Q: Now, was -- was James like the -- the elementary school
17 kid that, like, picked on you?
18 A: No, no. He was a sweet kid. And he's still just as
19 sweet as he was today as he was back then.
20 Q: All right. Mild mannered?
21 A: Yes.
22 Q: Respectful?
23 A: Very.
24 Q: Hard working?
25 A: Very. Seven days a week.

1 Q: He works seven days a week?

2 A: Yes.

3 Q: Where?

4 A: At the City of Columbia.

5 Q: Doing what?

6 A: Monday through Friday, he drives the recycle truck. He

7 picks up people's recycle cans. And then every Saturday

8 night, he goes in about 12 o'clock at night, and he has to

9 clean up the Vista, Five Points, and Main Street. And he gets

10 home around 9 o'clock on Sunday mornings.

11 Q: Just in time for church?

12 A: Yes, but he goes to sleep. I go to church.

13 Q: Okay. So, Crystal, how does he take care of you if he's

14 working seven days a week?

15 A: It's hard, but he's a great provider. He -- he -- he and

16 my daughter, they make sure I have everything that -- that I

17 need to reach. You know, everything is in place for me to be

18 able to be home by myself.

19 Q: So just yesterday, Saturday, did he go to work?

20 A: Yes, he did.

21 Q: So at midnight on Saturday, in the morning hours of

22 Sunday, he was cleaning up Five Points and the Vista?

23 A: And Main Street, yes.

24 Q: Okay. Is he the sole provider of your family?

25 A: He is.

1 Q: And y'all have three kids; right?

2 A: Yes. Three daughters.

3 Q: And your oldest daughter testified earlier today; right?

4 A: Uh-huh. Yes.

5 Q: Now, do you have any grandchildren?

6 A: Yes, I do. I have one grandbaby. That's my first

7 grandbaby.

8 Q: And what's her name?

9 A: Her name is Jalaya [ph], but we call her Jelly.

10 Q: Y'all seem to have names for everybody in your family.

11 Is that Jelly?

12 A: That's Miss Jelly.

13 Q: You ever call her Jelly Roll?

14 A: We do.

15 Q: All right. She's kind of a chunky baby?

16 A: She is. Very.

17 Q: How old is Jelly Roll?

18 A: Jelly Roll is eight months old.

19 Q: Now, is Jelly Roll walking?

20 A: No.

21 Q: Is she crawling?

22 A: No.

23 Q: Is she crying?

24 A: Yes.

25 Q: Now, what is your role with your granddaughter?

1 A: I am her primary caretaker.

2 Q: Why is that?

3 A: Because my daughter works for FedEx about 14 hours,
4 Monday through Friday. So I have the baby Monday through
5 Friday, 14 hours a day.

6 Q: And you take care of her in your wheelchair?

7 A: I do.

8 Q: Have you thought about what's going to happen when she
9 starts crawling or walking?

10 A: I have, and I'm not sure. We may have to put her in
11 daycare if I'm not able to keep up with her.

12 Q: Tell the jury what it's like for you to keep your
13 grandbaby?

14 A: That's the light of my life. I depend on that baby every
15 day to keep me from falling into depression and going back to
16 a dark place. That -- that baby is everything to me.

17 Q: You told me once, Crystal, that you were put on this
18 earth to be a mama; right?

19 A: I was.

20 Q: That's your first priority?

21 A: Yes.

22 Q: That includes being a grandma?

23 A: Yes, it is.

24 Q: When Jelly is with you, she gets everything, doesn't she?

25 A: Yes, she does.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 Q: How far is she away from walking or crawling?

2 A: It's -- it's going to be soon, very soon.

3 Q: Is that going to be a difficult transition?

4 A: That would be, because that means she -- she will be away

5 from me.

6 Q: If she gets to the door and gets near the door and tries

7 to go out, will you be able to get her?

8 A: Probably not.

9 Q: Crystal, tell the jury about, you know, your employment

10 history, you know, over the years and what you've done for a

11 living?

12 A: My first job was at a Winn-Dixie grocery store and then

13 in the bakery. That was my 12th grade year. And then I went

14 on to be a telemarketer. And then I also worked at a

15 Hardee's. And then my husband said it's time to be a stay-at-

16 home mom. So that's when I decided to be a stay-at-home mom.

17 Q: It's been mentioned about you being a baker and loving to

18 bake, and you actually started in a -- in a grocery store;

19 right?

20 A: Well, no, I actually started in middle school.

21 Q: All right. Tell us about that?

22 A: I was in home economics class. My mom first taught me

23 how to bake at home, and then when I got into home economics,

24 the teacher introduced it to me, and I just fell in love with

25 it and I stayed with it ever since.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 Q: So my grandmother was a home economics teacher in Union,
2 and she came -- became very close with all of her students and
3 she told me --

4 MR. DAVIS: Your Honor, I'm going to object to this kind
5 of comments.

6 MR. GOINGS: Okay. I'm sorry. I'll continue on.

7 BY MR. GOINGS:

8 Q: Did you become close with your home economics teacher?

9 A: I did.

10 Q: Tell the jury about that?

11 A: Oh, she -- she was like a second mother to me. She
12 taught me how to sew. She taught me how to cook, how to bake.
13 We were very close.

14 Q: She inspired you to be a baker?

15 A: Yes.

16 Q: Tell the jury about what type of dreams or aspirations
17 you had when it comes to baking?

18 A: I wanted to open a bakery. Once I got my girls up and
19 out of school, I wanted to own a bakery.

20 Q: Before this surgery in 2016, can you tell the jury
21 approximately how many cakes you were baking?

22 A: A day? About six cakes per day.

23 Q: Five days a week?

24 A: Six days a week. I only took Sundays off.

25 Q: Okay. You baked on Saturday, too?

1 A: Yes.

2 Q: So roughly six cakes or baked items, you would say?

3 A: Uh-huh.

4 Q: A day?

5 A: Yes.

6 Q: Six days a week?

7 A: Yes.

8 Q: 36? 40?

9 A: Yes. Correct.

10 Q: Okay. Wow. What -- what was your -- like, your average

11 price? I mean, I know bigger cakes were probably worth more.

12 Little cakes started where?

13 A: They started -- the average cake would just start at

14 around \$40.

15 Q: Okay.

16 A: But then it went up in price. As it went, like, to your

17 big wedding cakes, it -- price went up.

18 Q: Now, did you have your own recipe or do you do, like, out

19 of the box?

20 A: My own recipe.

21 Q: So it tastes good too?

22 A: Very. And I'm not the type to brag on myself. I let

23 everybody else do that.

24 Q: Okay. You were proud of them, weren't you?

25 A: Yes.

1 Q: Let me show you something.

2 A: Oh, that's the cake I made your daughter.

3 Q: That one right there?

4 A: Yes.

5 Q: For her birthday?

6 A: Uh-huh.

7 Q: Thumb through these. Are these the cakes that you made?

8 A: Oh, yeah. That's my work. Yep.

9 Q: These were all after your surgery in your wheelchair;
10 right?

11 A: Yes.

12 Q: You made all these in the wheelchair?

13 A: Uh-huh.

14 Q: Okay.

15 MR. GOINGS: Your Honor, I'd like to move into evidence
16 Exhibit 31, which is pictures of her cakes.

17 THE COURT: Any objection?

18 MR. DAVIS: I'm just seeing it for the first time. I
19 can't count the number you have. I mean, there was -- I don't
20 -- how many are in there?

21 MR. GOINGS: She makes a lot of cakes.

22 MR. DAVIS: Well, because I can't -- I haven't had time
23 to count. So let me just respectfully make an objection as to
24 the volume. I mean, I think we can pick five or six. I'll
25 have an objection as representative.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 THE COURT: Plaintiffs' 31 will be admitted over the
2 defendants' objection.

3 (WHEREUPON, Plaintiffs' Exhibit Number 31, photographs,
4 was admitted into evidence.)

5 BY MR. GOINGS:

6 Q: The cakes that you have in your hand in the photo, I'm
7 going to just show the jury, kind of scroll through them.
8 Cocomelon cake?

9 A: Uh-huh.

10 Q: For somebody's first birthday?

11 A: Yes.

12 Q: And you did all of these in a wheelchair?

13 A: Yes.

14 Q: Is that in your kitchen?

15 A: Uh-huh. Yes.

16 Q: Where did you bake these cakes?

17 A: Where do I bake them?

18 Q: Yeah.

19 A: In my kitchen.

20 Q: Okay. After -- what's that?

21 A: I made that for Brink. That was a Reese's cheesecake,
22 Reese's peanut butter cup cheesecake.

23 Q: Okay. What about that one?

24 A: That's strawberry cheesecake.

25 Q: The TikTok birthday cake?

1 A: Yeah, I do a lot of those.

2 Q: What's that?

3 A: That's just a cookies and cream cake.

4 Q: You don't have a Gamecock cake? I see a Clemson cake.

5 A: Because that was for my nephew. That's his favorite

6 team.

7 Q: Okay. Paw Patrol cake. Was this for some twins?

8 A: I -- I'm not sure if they were twins. The lady just

9 ordered one pink and one blue.

10 Q: Okay. That's got feathers coming off the top of it.

11 A: That was for the movie Harlem Nights. That -- it was a

12 Harlem Nights theme.

13 Q: Okay. What's your favorite cake to bake?

14 A: My favorite cake to bake would be the butter pecan,

15 because that's my husband's favorite.

16 Q: Do you do that often for him?

17 A: I do.

18 Q: All right. Could that be contributing to high blood

19 pressure?

20 A: It could be.

21 Q: All right. So before your injury, you said you baked

22 about six cakes a day?

23 A: Yes.

24 Q: Okay. In your kitchen at --

25 A: Yes.

1 Q: -- your house?

2 A: Yes.

3 Q: Now, we know you still bake cakes. How much and often
4 are you baking cakes now?

5 A: Now, it may be one -- one to two a day.

6 Q: How many days a week?

7 A: It's not every day. Maybe three, three or four days a
8 week.

9 Q: Now you're keeping your grandbaby. Do you -- do you have
10 to do it while she's sleeping or in the -- in the kitchen with
11 you?

12 A: Yeah. Yeah, I got a little set up. Like, I got a swing
13 here. You know, I got things that -- a walker, you know,
14 things to keep her busy while I'm baking.

15 Q: Will you tell the jury -- well, did you bake anything
16 this weekend?

17 A: Yeah, I had to make some cupcakes for a little girl's
18 birthday.

19 Q: Tell the jury what your general health was like before
20 this surgery?

21 A: Overall, I would say my health was pretty good.

22 Q: Explain that?

23 A: I just had hypertension, high blood pressure.

24 Q: Did all your doctors know that?

25 A: Yes.

1 Q: Any other health concerns?

2 A: No.

3 Q: What was your activity level like?

4 A: Oh, on the run, every day on the go. Kids, got to take
5 the kids to school. Got to take my husband to work. Got to
6 come back. Got to get these cakes made. Got to get them
7 delivered. Go back. Pick everybody up. Go to the grocery
8 store. And then at the end of the day, me and my husband was
9 going to Planet Fitness every day, five days a week. We went
10 to Planet Fitness to work out.

11 Q: How far is Planet Fitness from your house?

12 A: Maybe 2 or 3 minutes.

13 Q: Okay. That's the one over there on Garner's Ferry;
14 right?

15 A: Yes.

16 Q: Okay. Is that something y'all would always do together?

17 A: Yes. Every day.

18 Q: Okay. Now, we've heard that you had some -- some back
19 problems. You had surgery on your back; correct?

20 A: Yes.

21 Q: How have you done after every one of those surgeries?

22 A: I did very well after the first two surgeries.

23 Q: Were you able to -- to walk normally?

24 A: Yes.

25 Q: Were you able to run and exercise?

1 A: Yes.

2 Q: Did you have any problems with bending or kneeling or
3 squatting?

4 A: No.

5 Q: Were there any issues with having numb legs or not being
6 able to walk?

7 A: No.

8 Q: Okay. And you've testified -- well. I have heard that
9 you've had high blood pressure, and you said you had
10 hypertension; right?

11 A: Yes.

12 Q: Okay. Did you know what your blood pressure generally
13 ran?

14 A: Now?

15 Q: So good question. Did your blood pressure change over
16 time?

17 A: It did.

18 Q: Okay. So let's go back to -- so your first surgery was
19 in 2009; right?

20 A: Uh-huh. Yes.

21 Q: Okay. Do you recall generally what your blood pressure
22 ran back in 2009?

23 A: In 2009, it probably ran around 125 over 65.

24 Q: Okay. And how do you -- I mean, how do you know that?

25 A: Because I'm always checking my blood pressure in the

1 machine at Walmart.

2 Q: That's where you check your blood pressure?

3 A: Yes.

4 Q: Did you go to Walmart a lot?

5 A: Almost every day.

6 Q: How far is the Walmart from your house?

7 A: Walmart is probably about two minutes from my house.

8 Q: Is that where you bought your baking stuff?

9 A: Yes.

10 Q: So your flour, sugar?

11 A: Butter.

12 Q: Icing?

13 A: Not icing. I don't buy icing. I make icing.

14 Q: You got the ingredients to make your icing?

15 A: Yes.

16 Q: All right. And you would check your blood pressure

17 regularly there?

18 A: Yes, I would.

19 Q: Okay. So in 2009, your blood pressure ran around 125

20 over 65?

21 A: Yes.

22 Q: Okay. What about, let's say, 2011-2012 timeframe?

23 A: It started to go up a little bit. So probably 130 -- 135

24 over 75.

25 Q: Okay. Would you ever be, like, 125 over 70?

1 A: Around that time, it started going up.

2 Q: Okay. What about -- what was your blood pressure running

3 back in 2016 when you had this surgery?

4 A: Oh, it was like 150 over 90.

5 Q: Okay. Is that what it was generally all the time?

6 A: Yeah.

7 Q: How would you know?

8 A: From going to doctor visits.

9 Q: Okay. What about Walmart?

10 A: Yeah. Still Walmart.

11 Q: Would it be the same at Walmart as it was in the doctor

12 visits?

13 A: It was.

14 Q: Okay. Did you tell Dr. Holbrook in 2016 that you had

15 high blood pressure?

16 A: I did.

17 Q: Did you take your blood pressure medicine regularly in

18 2016?

19 A: Every day.

20 Q: Okay. Did you take your blood pressure regularly in

21 2016? July 2016?

22 A: I did.

23 Q: Did Dr. Holbrook's office there at Midlands test your

24 blood pressure at the appointments?

25 A: Yes.

1 Q: Okay. Before this surgery, when was the last time your
2 blood pressure was checked?

3 A: Before the surgery? I think the week -- the week before
4 at pre-op.

5 Q: Okay. So you had your blood pressure done pre-op --

6 A: Uh-huh.

7 Q: -- a week before; right?

8 A: Yes.

9 Q: What about the morning of?

10 A: Yes. The morning of, yes, they checked it.

11 Q: Did you tell them the morning of your surgery anything
12 about your blood pressure?

13 A: No.

14 Q: Did you say anything about hypertension?

15 A: No. I thought they already knew that because it was in
16 my charts.

17 Q: Okay. It was in your chart; right?

18 A: Yes.

19 Q: Okay. Did they ask you about hypertension or they just
20 took your blood pressure?

21 A: They just took my blood pressure.

22 Q: In the last ten years, has anybody ever told you that you
23 had low blood pressure?

24 A: No.

25 Q: In the last ten years, has anybody ever told you you had

1 normal blood pressure?

2 A: No.

3 Q: Let's talk about the morning of the surgery. Okay?

4 Crystal, what do you recall about that morning? I think you
5 kind of first mentioned it, that you thought you were late,
6 but go into more detail about the morning, what you remember.
7 Tell the jury.

8 Q: I got there. Me and my husband sat in the surgery
9 waiting area for them to call us down. We went down, and I
10 had to put on, like, the hospital gown and everything to get
11 ready for surgery. They came in, took my blood pressure and
12 told me they was going to put something in my IV to make me a
13 little sleepy.

14 And I know my mom and my sister and my nephew -- they
15 came in to see me before they put the stuff in my IV. And
16 that's -- that's about all I remember after that because they
17 started giving me the medication.

18 Q: Okay. Now, before coming in that morning, what had Dr.
19 Holbrook told you about this surgery?

20 A: He said that he saw a little scar tissue built up in the
21 spot where I had the previous surgeries, and that he needed to
22 go in and remove the scar tissue.

23 Q: Okay. Did he tell you anything about the surgery, what
24 to expect or anything like that?

25 A: No, because I had already had it two times before, so I

1 guess I didn't need an explanation.

2 Q: Okay. Did he go over any risks of the surgery?

3 A: No.

4 Q: Okay. Did you think that you were going to be spending
5 the night for this surgery?

6 A: No. It was supposed to be outpatient.

7 Q: Okay. Come home that day?

8 A: Yes.

9 Q: Do you recall receiving medication after you had the gown
10 on laying on the table?

11 A: I was in a room still in the bed.

12 Q: Okay. Do you recall them taking you into the surgery
13 room?

14 A: No.

15 Q: Okay. Tell the jury the first thing you remember or
16 recall next?

17 A: I remember Dr. Holbrook waking me up, but I was still,
18 like, under anesthesia. So I remember him saying, Ms.
19 Goodwin, move your legs. I tried, I couldn't, and he said,
20 move your legs, and I could not move my legs. And I went back
21 out. When I came to again, I was inside the MRI machine, and
22 that's all I remember.

23 Q: What do you recall next?

24 A: I woke up again and I just looked around the room and I
25 saw my whole family in there just crying. Everybody was just

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 standing there crying and I'm, like, what's going on? And my
2 husband just came to me and he just fell on my chest and he
3 said you're paralyzed, and I lost it.

4 Q: You remember that?

5 A: Yes.

6 Q: Crystal, do you recall what your husband said to you in
7 the recovery room?

8 A: He just -- he said that the doctor said something
9 happened in surgery, and I couldn't feel my legs.

10 Q: Do you recall if you responded?

11 A: I started screaming and crying, and I just -- I just
12 didn't want to talk to anybody.

13 Q: Could you feel your legs?

14 A: I couldn't.

15 Q: Could you move your legs?

16 A: I couldn't.

17 Q: What happened next, Crystal?

18 A: I think it was Mario. I can't remember his last name.
19 He and Dr. Holbrook came in, and they said I had to be
20 admitted. I couldn't go home.

21 Q: How long were you admitted for?

22 A: Two weeks.

23 Q: Were you able to feel your legs any in those two weeks?

24 A: No.

25 Q: Were you able to move your legs any those two weeks?

1 A: Not at all.

2 Q: Was there anything going through your mind these two
3 weeks in the hospital?

4 A: It was.

5 Q: What?

6 A: I was trying to figure out how was I going to be the
7 mother that I was, how -- how was I going to take care of my
8 children and my husband the way that I did?

9 Q: Were you scared?

10 A: I was.

11 Q: Are you still scared?

12 A: I am.

13 Q: You'd give anything to be able to do what I'm doing right
14 now, wouldn't you?

15 A: I would.

16 Q: You heard testimony in this case that you were able to
17 walk and sending videos to your family of you walking. Do you
18 remember that?

19 A: Yes.

20 Q: Is that the extent of your ability to ever walk?

21 A: That's it.

22 Q: Are you able to do that now?

23 A: No.

24 Q: Like, when was the last time in physical therapy you were
25 able to do that?

- 1 A: A couple of weeks ago in therapy.
- 2 Q: Were you able to do that last week?
- 3 A: I wasn't in therapy last week. I was here.
- 4 Q: How about the week before --
- 5 A: Yes.
- 6 Q: -- the trial started?
- 7 A: Yes.
- 8 Q: You were?
- 9 A: Yes.
- 10 Q: And have you undergone treatment and therapy and medical
- 11 expenses since the date of this surgery?
- 12 A: Yes.
- 13 Q: I'm going to hand you a document that's been marked as
- 14 Exhibit 32 that's already been agreed upon as its admission
- 15 into evidence. Does this calculate your past medical
- 16 expenses?
- 17 A: It does.
- 18 Q: From what date? The 28th until now?
- 19 A: Yes.
- 20 Q: And is that the calculation of your expenses that you
- 21 know of?
- 22 A: Yes.
- 23 Q: And how much is that?
- 24 A: That's \$389,752.84.
- 25 Q: Nearly \$400,000 in medical expenses?

1 A: Yes.

2 MR. GOINGS: Exhibit 32, Your Honor.

3 THE COURT: Is that by stipulation?

4 MR. GOINGS: It is. We didn't have a number yet for it
5 though.

6 THE COURT: Is that correct, Mr. Davis?

7 MR. DAVIS: Yes, ma'am.

8 THE COURT: All right. Plaintiffs' 32 without objection.

9 (WHEREUPON, Plaintiffs' Exhibit Number 32, medical
10 expenses, was admitted into evidence.)

11 BY MR. GOINGS:

12 Q: Now, on that itemization of nearly \$400,000, does it
13 anywhere say mileage?

14 A: No.

15 Q: That didn't include your mileage; right?

16 A: No.

17 Q: Do you know how far it is from your house to physical
18 therapy?

19 A: I don't know in miles, but it takes me about 20 minutes
20 to get from my house to physical therapy.

21 Q: So 40 minutes each way?

22 A: Yes.

23 Q: What's your address?

24 A: 903 Green Lawn.

25 Q: And physical therapy is over on Two Notch?

1 A: Two Notch.

2 Q: How many days a week do you go there?

3 A: Three.

4 Q: Okay. You going next week?

5 A: Yes, I am.

6 Q: All right. If this trial is over?

7 A: Yeah. If it's over, I will be there.

8 Q: All right. If it's over earlier this week, you're going

9 to be going?

10 A: I'm going back, yeah.

11 Q: Okay. Do you need physical therapy?

12 A: I do.

13 Q: Tell the jury what physical therapy does for you,

14 Crystal?

15 A: It's keeping me where I am. It's keeping me from getting

16 weaker and going back to not being able to do anything. It's

17 -- it's helped me a lot with strength and everything.

18 Q: How do you get to physical therapy?

19 A: I drive.

20 Q: Does somebody have to go with you?

21 A: Every time.

22 Q: Okay. Have you been able to -- to drive more these days?

23 A: I have.

24 Q: Okay. Can you tell the jury how you do that?

25 A: With -- I have hand control. It's a metal bar, and you

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 screw it down to the gas and the brake, and you operate it
2 with your hands.

3 Q: Now, I want to show you something. Is that you, Crystal?

4 A: Yes, that's me.

5 Q: Who is the girl in the very back?

6 A: That's my baby girl.

7 Q: All right. Is that the hand control?

8 A: It is.

9 Q: And that operates the gas and the brake?

10 A: Uh-huh.

11 Q: Who's that?

12 A: That's my little nephew. That's little Robert. That's
13 your baby.

14 Q: So you came by my house to show me your hand controls?

15 A: I did.

16 Q: You wouldn't leave until you got to hold baby Robert?

17 A: Until you put that baby in my arms.

18 Q: Crystal, I want you to tell the jury -- because this is
19 the only time you'll be able to talk to them, I want you to
20 tell the jury what life is like now every day for you and what
21 you go through. And I know these are all strangers and they
22 don't know you, but you have to tell them what you go through.

23 Q: Well, to start my day, either my husband or my daughters
24 -- they go and set up a kiddie pool in my den because I can't
25 get into my bathrooms. So I use a bedside commode over in a

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 kiddie pool with gallons of water to take a bath. I have to
2 brush my teeth at my kitchen sink.

3 Then I have to go back. I'll get in my bed so I can get
4 my clothes on, which is a hassle, because my legs -- they get
5 really stiff, and it's like you got to fold them up and try to
6 get your pants on. And if they spazz, they stick straight
7 out. So you have to just wait until they relax, and it's a
8 hassle just getting clothes on. And then it probably takes me
9 about 20 minutes just to get clothes on now.

10 As to when I was walking, I could jump into clothes in
11 less than five minutes and I'm out the door. Now, after I'm
12 dressed, if I have to go somewhere, I'm -- my daughter -- one
13 of my daughters or my husband is always with me because I
14 can't lift the wheelchair and put it in the car. And I use a
15 sliding board to transfer because I can't get up and get into
16 the car. So I use a board to transfer to get in and out of
17 the car. Like I said, one of -- one of them will put the
18 chair in the car and then we go about our day.

19 Q: Crystal, how do you use the bathroom?

20 A: I have a bedside commode set up in my formal living room.
21 And I use catheters to urinate, and I have to digitally stim
22 myself as far as a bowel movement.

23 Q: Let's talk about the catheters. The doctor said you do
24 it five to six times a day. Is that wrong or right?

25 A: That's right.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 Q: When was the last time you cathetered [*sic*] yourself?

2 A: When we left here on break, I had to go back home because
3 the bathrooms are not accessible here. So every day on break,
4 we leave here. We go all the way back home.

5 Q: In Hopkins?

6 A: Yeah.

7 Q: Describe for us how this digital stimulation works for
8 you to use the restroom?

9 A: You have to have gloves. I use Vaseline. You have to
10 put your hand in your rectum and move it around to pull the
11 stool out.

12 Q: How often do you have to do that?

13 A: I do it every day.

14 Q: Crystal, James said, for the first year, year and a half,
15 you didn't leave the house; is that right?

16 A: I didn't.

17 Q: Why not?

18 A: It was like people just look at you. People point. I've
19 had people to just walk up and ask me, like, crazy stuff. My
20 mom took me to physical therapy one day, and a lady just
21 walked up to me and said I guess domestic violence put you in
22 this wheelchair. I was, like, what? Like, I didn't want to
23 leave my house --

24 Q: Tell the jury --

25 A: -- for people pointing and staring and just insinuating.

1 Q: Tell the jury about the effects of your emotional and
2 mental health in the last seven years?

3 A: It was good. I was suicidal. I didn't want to be here.
4 I was -- I was asking God to take me because I didn't want to
5 live like this. I didn't think I would be any good to my
6 husband or my children like this, but I have a strong support
7 system, my -- my husband, my children, my mother. They
8 wouldn't allow me to -- to stay like that. They pushed,
9 pushed, and pushed to -- to get me strong and to -- to get out
10 of that depressive state.

11 Q: Before July 28th, 2016, did you cry a lot?

12 A: No.

13 Q: Do you cry a lot now?

14 A: I do.

15 Q: Crystal, what brings you depression and anxiety?

16 A: If -- like, if we go somewhere, it's hard. It's not
17 accessible. Like, all of my family, I don't visit unless I
18 sit out in their yard. My mom's house is not accessible. My
19 brother, my sister, nobody's house is accessible, you know.
20 So if I go visit, I either sit in my car and they talk to me,
21 or we'll sit out in the yard.

22 My daughter had a photo shoot over at the State House for
23 her prom. We couldn't find a park anywhere because, you know,
24 we can't park on a curb because my wheelchair needs to be flat
25 for me to be able to slide over. We rode around that State

1 House an hour trying to find a park that day. We couldn't. I
2 missed the whole thing.

3 You know, it's just things like that when I can't be
4 included. Family trips, I can't be included because it's not
5 accessible.

6 Q: Has your spinal cord injury affected your intimacy?

7 A: It has.

8 Q: Crystal, was that important to you?

9 A: It was.

10 Q: You said you find your husband working a lot?

11 A: Seven days a week.

12 Q: Besides your cakes now, he provides?

13 A: Very well.

14 Q: Working for the solid waste and sanitation of the City of
15 Columbia?

16 A: Yes.

17 Q: Twenty-one years?

18 A: Twenty-one years.

19 Q: On Saturdays you say he cleans Five Points and cleans the
20 Vista?

21 A: And here, down here.

22 Q: First of all, we took a video of a day at your house and
23 a day at physical therapy, didn't we?

24 A: Yes.

25 Q: We'll play that video.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 (WHEREUPON, the video was played. Not transcribed
2 herein.)

3 BY MR. GOINGS:

4 Q: Is that your house?

5 A: Yes.

6 Q: What is this? Your bedroom?

7 A: Yes.

8 Q: You didn't know all those people were going to see in
9 your garage, did you?

10 A: I didn't.

11 (WHEREUPON, the video was stopped.)

12 BY MR. GOINGS:

13 Q: Crystal, the video shows you bathing in a kiddie pool?

14 A: Yes.

15 Q: Since July 28th, 2016, how many times have you bathed in
16 your bathtub?

17 A: Once. Once. We tried with me sidestepping, but I have
18 to have on my brace to be able to sidestep. They put that
19 commode over into the bathtub and I sat on it to shower.
20 Well, when we tried to get back out, my legs buckled. My
21 husband had to carry me out of that bathroom and put me back
22 in my wheelchair.

23 Q: So this week you've bathed in the kiddie pool?

24 A: Yes.

25 (WHEREUPON, the video resumed playing.)

1 BY MR. GOINGS:

2 Q: Crystal, are you moving your legs there?

3 A: With help.

4 (WHEREUPON, the video was stopped.)

5 BY MR. GOINGS:

6 Q: Crystal, talk to us about the spasms that we've
7 witnessed?

8 A: It's uncontrollable. I can't do anything about it. It
9 just happens out of nowhere. They'll just start shaking. I
10 just -- I have to just let it shake.

11 Q: Do you feel any pain?

12 A: It's -- it's painful. It burns.

13 Q: How often are you in pain, Crystal?

14 A: Constant.

15 Q: Does it affect your sleep?

16 A: It does.

17 Q: How many hours would you say you get of sleep each night?

18 A: Maybe five.

19 Q: Five at least or five at most?

20 A: Five at most.

21 Q: Do you wake up in pain?

22 A: I do.

23 Q: Do you take opioids every day?

24 A: I do.

25 Q: Are you on opioids right now?

1 A: I am.

2 Q: What opioids are you on?

3 A: Hydrocodone.

4 Q: How much?

5 A: Five -- five milligrams.

6 Q: Have you ever tried to wean off of it?

7 A: I'm in pain constantly, so I have to take them.

8 Q: Have you been told that opioids are dangerous?

9 A: Yes, I have.

10 (WHEREUPON, the video resumed playing.)

11 BY MR. GOINGS:

12 Q: Where are you now? Where are you now? Where are you
13 going?

14 A: My physical therapy place.

15 (WHEREUPON, the video was stopped.)

16 BY MR. GOINGS:

17 Q: Now, Crystal, it looks like you're getting back in the
18 car; right?

19 A: Uh-huh.

20 Q: Before you went to therapy, I heard you say I don't drive
21 anymore. Do you remember that?

22 A: Yes.

23 Q: Was that before you got the hand controls?

24 A: That's before I got the hand controls and learned to
25 drive with them.

CRYSTAL GOODWIN - DIRECT BY MR. GOINGS

1 Q: Okay. Does the hand controls -- are they easy to use or
2 -- tell us about that?

3 A: So the first time we hooked them up, I was so afraid, and
4 my husband said, oh, you going to do it today. And he took me
5 on a back road, and I was just -- I was driving so fast, and
6 then I was braking so hard, and it was crazy. It was funny,
7 but eventually I got it.

8 Q: It's your preference for somebody to drive for you
9 though?

10 A: Yeah. Yeah.

11 Q: I mean, if you and James were -- who's been taking you
12 back and forth to -- to -- to trial this week? Last week?

13 A: My husband.

14 Q: Okay. You haven't been driving, have you?

15 A: No.

16 Q: Okay. So if it's y'all together, he always drives?

17 A: I'm not driving.

18 Q: But if you've got to, you can?

19 A: Yes.

20 Q: Okay.

21 (WHEREUPON, the video resumed playing and was then
22 stopped.)

23 BY MR. GOINGS:

24 Q: Crystal, does that video answer the question that Dr.
25 Holbrook asked me that I should ask you, why you believe

1 you're paralyzed?

2 A: I hope it does answer the question.

3 Q: Crystal, did Dr. Holbrook ever call you after this
4 surgery once you got home from rehab?

5 A: No.

6 Q: Did anybody from Midlands call you?

7 A: Nancy.

8 Q: Who's Nancy?

9 A: That was his nurse.

10 Q: What did Nancy tell you?

11 A: Nancy said that --

12 MR. DAVIS: Your Honor, objection to the hearsay.

13 MR. GOINGS: It's not hearsay because she's saying what
14 an employee of Midlands said to her. So --

15 MR. DAVIS: Objection to the hearsay.

16 MR. GOINGS: -- by a party opponent.

17 THE COURT: Overruled.

18 BY MR. GOINGS:

19 Q: Continue on.

20 A: Nancy said that Dr. Holbrook was sorry for what happened
21 and was there anything that Midlands could do for me? Could
22 they send me a nurse? Did I need anything? And I declined.

23 Q: Okay. Did Dr. Holbrook call you ever?

24 A: No.

25 Q: Okay.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 MR. GOINGS: Crystal, please answer any questions that
2 opposing counsel might have for you.

3 THE COURT: Let's take a short break before the cross-
4 examination. Please return to your jury room and don't
5 discuss the case.

6 (WHEREUPON, the jury exited the courtroom at 3:32 p.m.)

7 THE COURT: All right. We'll take a 15-minute break.

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

10 THE COURT: Okay. Everybody is back. Let's bring the
11 jury, please.

12 (WHEREUPON, the jury entered the courtroom at 3:48 p.m.)

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

14 THE COURT: Thank you.

15 Now it's time for cross-examination. Mr. Davis?

16 MR. DAVIS: Thank you, Your Honor.

17 CROSS-EXAMINATION

18 BY MR. DAVIS:

19 Q: Good afternoon.

20 A: Good afternoon.

21 Q: Can you hear me okay?

22 A: Yes.

23 Q: All right. Thank you. If you need me to speak up, I'll
24 do the very best I can with this cold. All right?

25 A: Okay.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 Q: Thank you, ma'am. Back in -- I'm sorry. Back in
2 September of 2008 -- I know that was a long time ago. All
3 right. You think that's when you started having some back
4 pain? Would that be -- does that sound about right to you?

5 A: Yes.

6 Q: All right. And at that -- at that time, remind us how
7 old you were? I know I can't do math, so --

8 A: Thirty.

9 Q: About 30?

10 A: Yes.

11 Q: Thank you, ma'am. In March of 2009, a few months later,
12 you were taken to the hospital because you had problems with
13 your legs not working and you had some back pain?

14 A: Yes.

15 Q: And if -- I may have missed -- may not remember this
16 correctly, all the things that we read about you in the case,
17 but you were taken to the hospital because you couldn't get up
18 or something, you had fallen?

19 A: Yeah. I fell.

20 Q: Okay. And they took you to what hospital?

21 A: Baptist.

22 Q: All right. And were you admitted to the emergency room?

23 A: Yes.

24 Q: And got to the floor?

25 A: Yes.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 Q: And is that when somebody requested Dr. Holbrook to come
2 and -- and see you?

3 A: Yes.

4 Q: All right. And do you recall him coming to see you in
5 the hospital?

6 A: Yes.

7 Q: All right. And that was that first time you met him?

8 A: Yes.

9 Q: And did they do some X-rays and -- what is it? A CAT
10 scan or MRI?

11 A: MRI.

12 Q: MRI?

13 A: Uh-huh.

14 Q: You know what an MRI is?

15 A: Yes.

16 Q: Is that -- it's that terrible tube you get in and it
17 bangs?

18 A: Yes.

19 Q: Those of us who have them don't forget.

20 A: Right.

21 Q: Yes, ma'am. And did he then offer -- after the MRI and
22 looking at it and examining you, did he offer surgery for you?

23 A: Yes.

24 Q: Okay. And was that the first -- call it a decompressive
25 laminectomy? You probably know these terms better than most

1 of us.

2 A: Yes, that was the first one.

3 Q: Yes, ma'am. And do you recall Dr. Holbrook told you that
4 if that surgery were not done back in 2009, that it could
5 result in your being paralyzed?

6 A: Yes.

7 Q: All right. And following that 2009 surgery, you -- you
8 were able to get some improvement with some physical therapy
9 and --

10 A: Yes.

11 Q: And we -- we've seen a lot of your physical therapy. You
12 work really, really hard.

13 A: I try my best.

14 Q: Yes, ma'am. I'm sure you work hard. You also recall Dr.
15 Holbrook explaining to you back in 2009 that another back
16 surgery might be in your future down the line?

17 A: Yes.

18 Q: All right. Kind of fast forward with me to 2011. You
19 came back to see Dr. Holbrook?

20 A: I did.

21 Q: All right. And you had started having -- feeling pain in
22 your legs and your legs became weak?

23 A: Yes.

24 Q: Is that -- that's what you were experiencing?

25 A: Yes.

1 Q: And you told them that?

2 A: Uh-huh. Yes.

3 Q: And you'd been experiencing that -- that leg pain for
4 about two months before getting back to him, hoping maybe it
5 would go away? You know, I don't know.

6 A: Yes.

7 Q: And it did?

8 A: It did.

9 Q: And when you went back to him, did he also -- did -- they
10 did another MRI?

11 A: They did.

12 Q: And did he offer you another surgery, the second surgery?

13 A: He did.

14 Q: After that surgery, I think you told us a long time ago
15 in your deposition, which was years ago, you did great?

16 A: I did.

17 Q: It improved?

18 A: I did.

19 Q: Your hard work, good physical therapist. We've heard
20 from her?

21 A: Yes.

22 Q: Was that the same physical therapist you've had
23 throughout?

24 A: No.

25 Q: Okay. You had another one?

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 A: I had at home therapy after both surgeries.

2 Q: Okay. So were -- the physical therapist would come to
3 you?

4 A: To my house, yes.

5 Q: And work with you and do exercises and -- and different
6 things?

7 A: Yes.

8 Q: I'm sure you worked very hard with -- with him as well?

9 A: Exactly.

10 Q: And you -- and you improved?

11 A: I did.

12 Q: And as you move into 2016, about a month before you saw
13 Dr. Holbrook in his office again, I think you told us that
14 you'd suffered a fall when you were in your bathtub?

15 A: Yes. I slipped and fell in the bathtub.

16 Q: All right. And when you fell, did you -- did you notice
17 some -- some pain and leg weakness after you fell?

18 A: I did.

19 Q: And I believe you told us earlier that the pain and
20 weakness that you felt when you suffered that fall in the
21 bathtub in 2016 was similar to the pain you had experienced in
22 the past?

23 A: It was.

24 Q: What did you think when you felt that familiar pain
25 again?

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 A: I thought, oh, my God, I might need another surgery.

2 Q: Yeah. Okay. And you went back to Dr. Holbrook?

3 A: I did.

4 Q: Let him check you out?

5 A: I did.

6 Q: And we all know he did another MRI?

7 A: Yes.

8 Q: All right. And after the MRI that he looked at it and
9 told you or tried to explain perhaps to you what he was
10 finding there and offered another surgery?

11 A: Yes.

12 Q: Having your -- facing the third back surgery, Ms.

13 Goodwin, did that cause you a great deal of apprehension,
14 fear, concern about how is this going to come out?

15 A: It did because the leg pain went away. I didn't have any
16 weakness. So when I went to see him, he told me that I needed
17 surgery. My question was to him do I really need it right
18 now?

19 Q: Uh-huh.

20 A: And he said, well, let's do it before anything gets
21 worse.

22 Q: Okay. There's been a lot of medical testimony -- and I'm
23 not going to make you a medical doctor, I'm not one either --
24 about -- I think the doctors called it a progressive spinal
25 stenosis, where you're -- the narrowing of your spinal canal

1 gets progressively worse as you get older. And you can
2 remember some of the doctors talking about that --

3 A: Yes.

4 Q: -- in this trial?

5 A: Yes.

6 Q: Is that what you understood? Is that -- was that what
7 you understood was happening to you?

8 A: Well, I thought it was just scar tissue from the previous
9 surgeries.

10 Q: All right. Did Dr. Holbrook in 2016 explain to you that
11 your condition could get worse without surgery?

12 A: That's what he said.

13 Q: And would it be fair to say that you honestly don't
14 recall any conversations that Dr. Holbrook may have had with
15 you when he explained the risks to the surgery in 2019 -- or
16 2016?

17 A: I don't recall any conversation.

18 Q: Okay. Thank you. You know, you're a veteran of
19 operations for all the wrong reasons, and I'm not -- you know,
20 I hate it for you, but let me ask you this. In every
21 operation you've ever had for -- for anything, even other
22 operations, every time you had to sign a consent for your
23 surgeon to operate on you?

24 A: Yes.

25 Q: And did you do that in this case, too?

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 A: I don't recall. I may have.

2 Q: Okay. In the medical records that are in evidence, I
3 have a piece of paper that says I've been explained the risks
4 and the benefits and alternatives by my surgeon. I consent to
5 have Dr. Holbrook perform the surgery on me. And then you
6 signed and dated it. If that's in the medical record, you
7 would have no dispute with that, would you?

8 A: I wouldn't.

9 Q: Okay. The morning of July 28th, 2016, I hate it that you
10 guys are running across that crosswalk to get there because
11 you thought you were late, you were early. That -- that
12 probably doesn't happen very often, and I'm sure it's never
13 happened to you before.

14 A: No.

15 Q: But that morning, things kind of settled down. Would it
16 be fair to say, as you told us sometime earlier in this case,
17 that you remember being scared before that surgery?

18 A: I was, yeah.

19 Q: And who wouldn't be? I mean, I'm not critical of that.
20 The only medicine I believe you said that you took that
21 morning was your -- and I never can pronounce it. You
22 probably can.

23 A: Hydrochlorothiazide.

24 Q: That's easy for you to say. Can you spell it?

25 A: No.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 Q: Okay. All right. I can't either. And can we call it
2 HTHZ or something?

3 A: HCTZ.

4 Q: Thank you. And did you understand that that's kind of
5 like a diuretic?

6 A: Yes.

7 Q: Okay. But it's given by doctors or your doctor who
8 prescribed it to help control your blood pressure?

9 A: Yes.

10 Q: And you've been taking that medicine since 2007?

11 A: Yes.

12 Q: And you took -- and you took it faithfully every day?

13 A: I did.

14 Q: And was it -- how many milligrams? Was it 50?

15 A: 50.

16 Q: Right. Did you ever experience any problems or side
17 effects with that blood pressure medicine?

18 A: No.

19 Q: After the surgery, maybe that night after your surgery,
20 maybe the next morning, do you recall Dr. Holbrook speaking
21 with you? And your mom was there and your husband; right?

22 A: Yes.

23 Q: Okay. And as you recall, you wanted to know --
24 understandably, you wanted to know what happened.

25 A: I did.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 Q: What -- why can't I move my legs? Why can't I feel my
2 legs; right?

3 A: Right.

4 Q: And as you recall, Dr. Holbrook said it was something
5 that happened in surgery. We're not sure what it was. Did he
6 say something like that to you?

7 A: He said it was something we did in surgery. I'm not
8 sure.

9 Q: Yeah. But we're not sure what it was?

10 A: Uh-huh.

11 Q: We're not sure? I'm not sure?

12 A: Yes.

13 Q: All right. Has Dr. Holbrook ever told you what he
14 thought was the cause of -- of your injury?

15 A: I never really got a -- I never really did understand,
16 you know, what he was saying.

17 Q: Okay. All right. So the video that we've seen that was
18 taken by your daughter with Dr. Holbrook coming in and talking
19 to you and other family members there, we looked at that. I
20 mean, you were there. You've seen the video?

21 A: Yes.

22 Q: But that wasn't the first time Dr. Holbrook talked to
23 you; correct?

24 A: No.

25 Q: It wasn't the last time he talked to you; correct?

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 A: I'm not sure, because his other colleagues were coming in
2 to talk to me.

3 Q: Other partners, other neurosurgeons?

4 A: Yes.

5 Q: Okay. So if he was not there, somebody else from his --

6 A: Yes.

7 Q: -- office would come? Did any of those folks ever offer
8 you an opinion of, well, we think this is what caused it?

9 A: They didn't.

10 Q: Okay. Do you have any idea about how many times -- just
11 a guess, your best guess -- that Dr. Holbrook came to see you
12 apart from partners that might have been covering for him when
13 he was not there? Do you remember about how many times he
14 would see you in that hospital?

15 A: I don't remember.

16 Q: And you were there, ma'am, for -- was it two weeks --

17 A: Two weeks.

18 Q: -- after your surgery?

19 A: Yes.

20 Q: Okay. And then you went to a rehab facility?

21 A: HealthSouth.

22 Q: For two weeks?

23 A: Yes.

24 Q: All right. We talked to your -- your physical therapist.
25 We looked at her records for you. We've seen the hard work

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 that you've done in physical therapy. It's -- it appears that
2 you did make some improvement. Would that be fair?

3 A: That's fair.

4 Q: All right. But then sometime in early 2021, you had more
5 weakness and back pain again; is that right?

6 A: I did.

7 Q: And Dr. Deholl, an orthopedic surgeon, saw you, did an
8 MRI, and recommended another back surgery?

9 A: Yes.

10 Q: And that operation was in April of 2021?

11 A: Yes.

12 Q: And that was more on the lower part of your back?

13 A: Yes.

14 Q: So in the lumbar area?

15 A: It was still in the thoracic.

16 Q: It was thoracic?

17 A: Yes.

18 Q: Down -- a little bit further down to?

19 A: Maybe L1.

20 Q: L1? So L1 would be lumbar 1. That's lumbar 1, 2, 3, 4,
21 5, I think?

22 A: Yeah. It was like T --

23 Q: You know that better than me.

24 A: T12, yeah, to L1.

25 Q: Okay. And in that operation, Dr. Deholl actually put in

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 some screws and plates and fused that lower part of your back?

2 Is that what he did?

3 A: Yes.

4 Q: All right. Okay. And you were satisfied with Dr.

5 Holbrook's care of you following the first two surgeries;

6 correct?

7 A: Yes.

8 Q: And did you continue to see him or somebody in his office

9 through some time in 2019, about three -- almost three years

10 after the surgery?

11 A: I saw him June of 2017.

12 Q: Okay.

13 A: I think that was the last time.

14 Q: All right. And would you call the office from time to

15 time and ask for help with different supplies and things?

16 Physical therapy, things that you needed?

17 A: I -- maybe they would have to get a prescription from him

18 at the time to -- to continue physical -- physical therapy.

19 Q: Okay. And whenever you needed that, you would call the

20 office, and they would --

21 A: I would call Nancy.

22 Q: Okay. Nancy?

23 A: Yes.

24 Q: His nurse?

25 A: Yes.

CRYSTAL GOODWIN - CROSS BY MR. DAVIS

1 Q: And I assume he would have to approve that?

2 A: I guess so.

3 Q: And he always did that, as far as you know?

4 A: As far as I know.

5 Q: Okay. So that was through sometime in 2019 you stopped
6 calling him again?

7 A: No. 2017.

8 Q: If the medical records -- if the medical records indicate
9 and show that you were continuing to call Dr. Holbrook's
10 office and requesting --

11 A: It could have been my physical therapist that was calling
12 to get those prescriptions.

13 Q: Okay. All right. Well, we'll look at the records later.
14 That's fine. Did Dr. Holbrook's office help you to get
15 equipment and supplies that you needed from time to time?

16 A: No.

17 Q: Who would help to do that?

18 A: I had, like, a caseworker at the hospital and from rehab,
19 and they called to get all the medical equipment.

20 Q: Would it be fair to say, as you told us some time ago,
21 Ms. Goodwin, you do not have any personal criticisms of Dr.
22 Holbrook?

23 A: I don't.

24 MR. DAVIS: Thank you for your patience with me, Crystal.
25 I really appreciate you. Thank you.

CRYSTAL GOODWIN - REDIRECT BY MR. GOINGS

1 THE PLAINTIFF MS. GOODWIN: Thank you.

2 REDIRECT EXAMINATION

3 BY MR. GOINGS:

4 Q: Crystal, I'm looking at a consent form that was signed in
5 the early morning before the surgery, and it says I understand
6 that all surgery involves general risks, such as severe loss
7 of blood or infection. Are you here today because of loss of
8 blood?

9 A: No.

10 Q: Are you here today because of infection?

11 A: No.

12 Q: Now, did you sign any form that said that you were okay
13 with them not taking your high blood pressure into
14 consideration when they put you under anesthesia?

15 A: No.

16 Q: Did you sign any form that said that they didn't have to
17 establish your baseline blood pressure?

18 A: No.

19 Q: Did you have -- did you sign a little form that said that
20 they could ignore alarms that went off in the operating room?

21 A: No.

22 Q: Did you sign a little form that said that they could
23 violate hospital policy while they were doing your surgery?

24 A: No.

25 Q: Did you sign a little form that said when the signal goes

1 out, they can ignore the steps that you learned and taught in
2 med school?

3 A: No.

4 Q: Would you have consented to this surgery if you knew all
5 the things would happen that you learned about here in this
6 trial?

7 A: No.

8 Q: You didn't sign up for all that, did you?

9 A: I did not.

10 MR. GOINGS: Thank you, Your Honor.

11 THE COURT: Anything further from this witness?

12 MR. DAVIS: No, Your Honor.

13 THE COURT: All right. Thank you, ma'am.

14 Mr. Goodwin, you can come get her or she can roll
15 yourself, whichever.

16 THE PLAINTIFF MS. GOODWIN: Yes, ma'am.

17 THE COURT: Call your next witness.

18 MR. GOINGS: Your Honor, I know we spent Friday with two
19 of the defense witnesses, and I just want you to know that
20 that is our last witness for the plaintiffs' case in chief.

21 THE COURT: Okay.

22 MR. GOINGS: Thank you.

23 THE COURT: So the plaintiffs rest?

24 MR. GOINGS: Yes, Your Honor.

25 THE COURT: All right.

1 All right, ladies and gentlemen. There's certain matters
2 of law that I need to discuss with the attorneys outside of
3 your presence. Please return to the jury room and do not
4 discuss the case.

5 (WHEREUPON, the jury exited the courtroom at 4:08 p.m.)

6 THE COURT: Any motions, Mr. Davis? Mr. Heitman?

7 MR. DAVIS: Your Honor, I think I got it. He can
8 probably do a better job, but I'll go and I'll take a run at
9 it.

10 Your Honor, the defense would ask for a directed verdict
11 on the issue of liability. There's been no evidence offered
12 by the plaintiff or by any expert that the surgery -- excuse
13 me -- that the injury sustained was reasonably foreseeable and
14 predictable, based on the plaintiffs' theory of the mechanism
15 of injury, foreseeable being touched on proximate cause, an
16 essential element of the plaintiffs' case.

17 I don't recall any standard of care expert, particularly
18 Dr. Lustgarten, who was the standard of care expert in this
19 case, offering a testimony that cord stroke from
20 hypoperfusion, which is the plaintiffs' theory of injury, was
21 reasonably predictable and foreseeable. That's a -- that's
22 our motion for directed verdict on the case in chief.

23 This may be untimely, but I think I probably need to make
24 my motion regardless of punitive damages and gross negligence.
25 That there has been no expert testimony by Dr. Lustgarten or

1 any other expert in this case about Dr. Holbrook being
2 reckless, willful, careless, having a conscious disregard for
3 the plaintiff or others, or malice, key elements that are
4 essential to having this case submitted at any stage on the
5 issue of gross negligence or punitive damages.

6 There's been no evidence or any expert testimony that
7 characterized in any way, by implication, directly or
8 indirectly, in testimony of particularly Dr. Lustgarten, who
9 was the standard of care expert for the plaintiff, that Dr.
10 Holbrook's alleged negligence was in any way grossly
11 negligent.

12 And so we'd ask for consideration of directed verdict on
13 both those issues.

14 THE COURT: Mr. Goings?

15 MR. GOINGS: Your Honor, first as to causation, the --
16 the record, the evidence is -- has developed significantly
17 with multiple witnesses, multiple expert witnesses that
18 discuss causation. We had one today, Dr. Fred Jones. Dr.
19 Lustgarten. Dr. Mancuso. And they all say that clearly the
20 cause of this was that the blood pressure got too low. Not
21 only did it get too low, but it got too low for too long.

22 And if the standard of care would have been followed,
23 first the blood pressure wouldn't have gotten low. Number
24 two, if the standard of care was followed, then through
25 increasing her blood pressure would have -- would have been a

1 perfusion change increase, and that perfusion change increase
2 would have brought her spinal cord back. It was not infarcted
3 at that point. It was just ischemic, and ischemic tissue
4 comes back.

5 It's kind of like putting grass on -- putting water on
6 grass that is -- that is browning, but not dead. So all
7 you've got to do is just add perfusion, and they did not do
8 that.

9 Your Honor, we have -- we've established liability
10 through breach and liability through causation based on expert
11 testimony of multiple experts and the cumulative effect of all
12 the experts combined and through the cross-examination of the
13 30(b)(6) and the deposition of Dr. Holbrook.

14 And I will say that Dr. Poletti, the defense's expert --
15 well, I guess I can't consider him because he was taken out of
16 turn, but the cross-examination of Dr. Holbrook established
17 the standard of care that we've been saying all along in this
18 case. If we ever have this case again, I'm going to hire him
19 because he sets forth the standard of care.

20 So I do believe, Your Honor, we have shown evidence for a
21 -- any evidence is the standard for a jury to properly
22 consider whether or not Dr. Holbrook breached the standard of
23 care and whether or not his breach proximately caused -- or
24 one of the multiple breaches that we found proximately caused
25 the harm that we're claiming in this case.

1 As it relates to recklessness, just like the standard for
2 negligence, if there is any evidence of -- of conscious
3 indifference or the culpability, whether it's negligent or
4 gross negligent, that is a factor that goes to the jury. I
5 will recall that Mr. Hinson asked Dr. Lustgarten do you
6 believe this is recklessness, and the defense lawyer stood up
7 and objected on the grounds that it called for a legal
8 conclusion, and now he's saying that there's no evidence
9 because that is a legal conclusion, and that's for the jury to
10 conclude recklessness.

11 And, you know, when the alarms are going off in the
12 emergency -- in the operating room and you consciously decide
13 to do nothing and you consciously decide not to follow the
14 steps, that is evidence for a jury to consider of gross
15 negligence. When you know the hospital policy is to do an
16 operative -- preoperative timeout, that's the policy of the
17 hospital, and you consciously decide not to do it, that's
18 gross negligence.

19 When you know that she's hypertensive and you know that
20 you're doing surgery on the thoracic area and you know that
21 the thoracic area is most susceptible to injury based on
22 perfusion level issues, and you consciously don't tell the
23 anesthesiologist that she's hypertensive and there's four
24 blood pressures that we have that show her up in the range of
25 113 to 116, depending on how you calculate it, that's evidence

1 of -- of gross negligence, at least evidence that a jury can
2 properly consider.

3 Now, I know that this jury is not considering gross
4 negligence at this moment because it's a bifurcated trial, but
5 we have submitted on our verdict form one question. Do you
6 believe gross negligence or recklessness? Because that could
7 trigger the stage two of the bifurcated procedure. So I do
8 want to point that out. We have submitted the verdict form to
9 Your Honor.

10 But respectfully, we would urge that these motions be --
11 be denied. Thank you, Your Honor.

12 THE COURT: Yes, sir?

13 MR. DAVIS: Your Honor, just briefly in response to my
14 friend that my motion about causation was not causation in
15 fact, but was it legal cause. There is no foreseeability
16 that's been or predictability that's been testified to by any
17 expert, particularly Dr. Lustgarten, who was the standard of
18 care expert in this case, that this was a foreseeable event or
19 a predictable event.

20 That it happened does not prove legal cause and,
21 therefore, we respectfully renew our motion.

22 THE COURT: Your motion for a directed verdict in both
23 regards is respectfully denied.

24 MR. DAVIS: Thank you, Your Honor.

25 THE COURT: Does the defense have a witness ready? Do

1 y'all need a break?

2 MR. GOINGS: Can I just use the restroom? I'm sorry,
3 Your Honor.

4 THE COURT: Yeah, I was just going to ask you do we need
5 a break. Let's take a break for 5, 10 minutes.

6 How long do we anticipate the witness will last?

7 MR. DAVIS: I don't have any idea.

8 THE COURT: You don't have any idea?

9 MR. HEITMAN: Not -- not terribly long, Your Honor. How
10 do you define that?

11 THE COURT: Yeah. That's objective.

12 MR. HEITMAN: I mean, it depends on, I think, how long
13 the cross will go.

14 MS. GOODING: Only about two hours, Your Honor.

15 MR. HEITMAN: So we should be in the range of 30 minutes?
16 An hour? Half a day? You know?

17 MR. HEITMAN: Maybe with direct and cross, maybe about an
18 hour. I don't -- that's about right.

19 THE COURT: Okay.

20 MR. HEITMAN: That's fine.

21 THE COURT: That's fine. I just wanted to know.

22 MR. GOINGS: And the famous Monty Todd is in the back of
23 the courtroom.

24 THE COURT: I've seen him in and out.

25 MR. GOINGS: There is no scorn there.

1 THE COURT: All right. We'll take 10 minutes.

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

3 which the proceedings resumed as follows.)

4 THE COURT: You can bring the jury, please.

5 (WHEREUPON, the jury entered the courtroom at 4:33 p.m.)

6 THE BAILIFF: All jurors are seated, Your Honor,

7 THE COURT: Thank you.

8 Ladies and gentlemen, as you heard before you stepped out

9 of the courtroom, the plaintiff has rested their case in

10 chief. It's now time to move on to the defendants' case.

11 You'll recall that we did hear two defense witnesses sort

12 of out of turn just because they were not available this week,

13 but we're going to move on to the remainder of the defendants'

14 witnesses.

15 So, Mr. Heitman? Yes, call your first witness.

16 MR. HEITMAN: Your Honor --

17 THE COURT: Or third witness.

18 MR. HEITMAN: The defense calls Erich Starn.

19 THE COURT: Yes, sir.

20 THE BAILIFF: Mr. Erich, please put your left hand on the

21 Bible and face her and raise your right hand.

22 THE WITNESS: Left hand?

23 THE CLERK: Do you solemnly swear or affirm that the

24 testimony you're about to give in this case will be the truth,

25 the whole truth, and nothing but the truth, so help you God?

ERICH STARN - DIRECT BY MR. HEITMAN

1 THE WITNESS: I do.

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

3 THE WITNESS: Erich Reed Starn.

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

5 THE BAILIFF: Speak into the mic, sir. Thank you.

6 THE WITNESS: Uh-huh.

7 THE BAILIFF: Thank you.

8 ERICH STARN, being first duly
9 sworn, testified as follows:

10 DIRECT EXAMINATION

11 BY MR. HEITMAN:

12 Q: Mr. Starn, can you please introduce yourself to the jury?

13 A: My name is Erich Starn. I'm a nurse anesthetist. I
14 worked at Baptist for the last -- almost 15 years now. Before
15 that, I worked in University of South Alabama surgical trauma
16 intensive care unit. Before that, I was a commissioned
17 officer in the Coast Guard for 12 years. I did all kinds of
18 things in the Coast Guard. I don't know if you want to hear
19 about that. So, I mean, is that good enough or --

20 Q: That's good. Yes, sir. Where are you from?

21 A: I grew up in Fair Lawn, New Jersey, right outside of New
22 York City.

23 Q: And how long have you lived in Columbia for?

24 A: Almost 15 years.

25 Q: And you work at Prisma currently?

1 A: Yeah, I'm at Prisma Health Baptist as a nurse
2 anesthetist.

3 Q: Is that the same thing as a CRNA?

4 A: Yes, it is.

5 Q: As a CRNA, what are some of your duties?

6 A: I work in conjunction with anesthesiologists and
7 surgeons, and we -- you know, we give anesthesia. We take
8 patients back to the O.R., we intubate them, or we give
9 anesthesia with them breathing oxygen. Put in IVs. We're,
10 you know, masters or doctorate prepared nurses.

11 Q: Where did you go to school?

12 A: I went to nursing school at the University of South
13 Alabama in Mobile. I've got a couple of other degrees that
14 are not related to nursing. I went to Woford College in
15 Naples, got a master of science in anesthesia, and then I took
16 the boards for nurse anesthesia.

17 Q: What type of training or certifications do you have for
18 anesthesia?

19 A: I'm board certified through the state and nationally
20 board certified.

21 Q: And what -- what board would that be?

22 A: They've -- you know, the NBCRNA, I believe, is the
23 initials.

24 Q: And how long was your training for?

25 A: As a nurse, it's a four-year degree. I trained for five

1 years in that ICU, and then I did 28 months, master's degree
2 full time, and then went over to Baptist Hospital.

3 Q: And you possess the correct licenses to practice as a
4 CRNA?

5 A: Yes, I do.

6 Q: Are you able and qualified to administer anesthesia?

7 A: Yes.

8 MR. HEITMAN: Your Honor, at this time, I present Erich
9 Starn as an expert in the field of anesthesia as a certified
10 registered nurse anesthetist.

11 MS. GOODING: As a CRNA, Your Honor, no objection.

12 THE COURT: Okay. Ladies and gentlemen, as I've told you
13 before, when a person is qualified by virtue of their
14 education and training and experience to be an expert in some
15 field, they are permitted to give you their opinion testimony
16 within their field of expertise.

17 This witness is a -- an expert certified registered nurse
18 anesthetist and will be permitted to give you his opinions
19 within his field of expertise. Give his testimony the weight
20 and credibility you think it deserves, as you would with any
21 other witness.

22 You may proceed, Mr. Heitmann.

23 MR. HEITMAN: Thank you, Your Honor.

24 BY MR. HEITMAN:

25 Q: Mr. Starn, do you agree with me that any opinions you

1 state today are made to a reasonable degree of medical
2 certainty unless you tell me otherwise?

3 A: Yes.

4 Q: Can you please explain your role to the jury in caring
5 for patients, both before surgery begins and then your role
6 once the patient has been anesthetized?

7 A: Well, we -- you know, we assess the patient. We look
8 over records in conjunction with the anesthesiologist. We're
9 supervised by an anesthesiologist at Baptist Hospital. So we
10 come up with a plan for anesthesia, and that all depends on
11 the coexisting diseases and all the -- all the variabilities
12 of that individual patient.

13 No two patients are the same. They all have various
14 things wrong with them in this hospital. You know, some may
15 have, you know, obesity, hypertension, diabetes. They may
16 have -- those -- those are three we see a lot. They may be on
17 various medications for them, and we just tailor our
18 anesthesia to suit the individual patients.

19 Q: Is a CRNA different than an anesthesiologist?

20 A: An anesthesiologist is a medical doctor, and a CRNA is a
21 nurse who's had specialty training through either a master's
22 or now doctorate, clinical doctorate. The medical doctor has
23 done specialty training in anesthesia.

24 Q: When the anesthesiologist -- well, let me back up. Is
25 the anesthesiologist always in the room with you?

1 A: They are not. They're not always in the room there.
2 Generally, they're at induction of anesthesia. They're pre-
3 opping the patient. They may be -- they're -- they're
4 interviewing the patient before anesthesia, and I do that as
5 well. They are frequently in the room during the emergence of
6 anesthesia. They're in the recovery room during the emergence
7 of anesthesia as well.

8 Q: When the anesthesiologist is not in the room, are you in
9 control of monitoring and administering the anesthesia?

10 A: Yes.

11 Q: And as a CRNA, are you part of the anesthesia care team?

12 A: Yes.

13 Q: Who makes up the anesthesia care team?

14 A: The anesthesiologist, myself. You know, it's just --
15 it's the two of us. There's -- it's basically just the two of
16 us.

17 Q: Okay. Is part of the anesthesia care team's role to
18 establish the baseline blood pressure?

19 A: Well, that -- you know, if we have the information
20 available, we can do that.

21 Q: Can -- can nervousness at office visits or on the day of
22 surgery affect a -- a patient's baseline blood pressure?

23 A: There's a lot of things. Nervousness can. Pain can.
24 There are -- there's all kinds of things. Anxiety will affect
25 their blood pressure.

1 Q: And -- and in what way does it affect the blood pressure?

2 A: It'll go up. It'll -- it can go up significantly.

3 Q: Do you see that frequently?

4 A: I see it every day.

5 Q: Is that called white coat syndrome?

6 A: White coat hypertension. White coat syndrome.

7 Q: If a patient is experiencing pain, can that also lead to
8 a blood pressure that appears higher than normal?

9 A: Yes. It can be considerably higher when they're in pain.

10 Q: Do you know whether or not Mrs. Goodwin was experiencing
11 any pain leading up to her surgery in 2016?

12 A: I'd have to assume she was. It's on your third back
13 surgery. You're going -- you're going to have pain. I
14 believe this was her third surgery. So you're going to have
15 pain.

16 Q: There's been a lot of discussion in this case regarding
17 the intraoperative blood pressures. In this case involving
18 Mrs. Goodwin, were you the CRNA that was monitoring her blood
19 pressures during that surgery that Dr. Holbrook performed on
20 July 28th, 2016?

21 A: Yes.

22 Q: What do you recall about Mrs. Goodwin in her surgery?

23 A: She had blood pressures that were -- you know, I looked
24 at all the blood pressures on the chart, and they had mean
25 arterial pressures in the 80s. She also did bite her

1 endotracheal tube during the surgery because we had not
2 relaxed her. They were doing monitoring, and we had to fix
3 that. And you know, what I saw on the chart, the blood
4 pressures were all in the -- they were good blood pressures.
5 They -- you know, they all had MAPs that were consistent with
6 perfusion.

7 Q: Do you recall when the SSEP signals were lost?

8 A: I can't give you an exact time. It was towards the end
9 of the case.

10 Q: Do you remember that event though happening?

11 A: Yeah, I remember the event happening.

12 Q: Do you recall anything that Dr. Holbrook said once Mrs.
13 Goodwin lost her SSEP signals?

14 A: I thought he said something like I wasn't anywhere near
15 the spine at that time. For some reason, I remember that.

16 Q: It was --

17 A: Yeah.

18 Q: I know it was a long time ago.

19 A: Yeah, it was about seven years ago. I do -- I do think I
20 remember that.

21 Q: Do you recall what, if anything, you did once her signal
22 was lost?

23 A: I did write a note on it. I know that. You know, her
24 blood pressures were still good. I wasn't given any -- any
25 tasks to perform. You know, that's about -- that's about all

1 I can tell you.

2 Q: Did you review her blood pressures when the signal was
3 lost?

4 A: Well, I was looking. I was looking at her current blood
5 pressure. It was fine. I can tell you that. I didn't -- you
6 know, I don't know if I went back and looked at the chart
7 then, but they were all written down in real time. So --

8 Q: Who was the anesthesiologist on this case?

9 A: That was Dr. Root.

10 Q: Is part of your job as -- as part of the anesthesia care
11 team to raise or lower a patient's blood pressure to keep it
12 within a safe range?

13 A: Yes, I -- you know, we do that all the time.

14 Q: And as a CRNA, you're qualified to raise or lower the
15 patient's blood pressure on your own without an
16 anesthesiologist telling you to do so?

17 A: Yes.

18 Q: In your experience as a CRNA, are there different roles
19 that people play in the operating room?

20 A: We have -- we have people with various jobs. We have,
21 you know, circulating nurses, and we have techs, scrub techs
22 or certain, you know, people who hold -- who set up the -- set
23 up the instruments in a sterile manner, and they hold
24 retractors and things like that. And we have -- you know,
25 sometimes they have specialty -- specialty people come in.

1 Q: And the surgeon's role is to perform the surgery?

2 A: Yes.

3 Q: And I believe you talked about the -- the anesthesia care
4 team monitors the blood pressure, but what else? What else do
5 you do?

6 A: We monitor all vital signs. We monitor the level of
7 anesthetic on board through various means. We're monitoring
8 their end tidal carbon dioxide output through an endotracheal
9 tube. You know, we're monitoring their blood loss. We're
10 monitoring how much fluid we give them. We're monitoring how
11 much fluid comes out if they have a catheter. We're
12 monitoring any -- any type of fluid loss. You can have other
13 fluid losses in surgery, but predominantly the vital signs.

14 Q: At any time during the surgery, if you felt like Mrs.
15 Goodwin's blood pressure was too low or too high, could you
16 have given medication or fluids to help raise or lower her
17 blood pressure?

18 A: Yes. I mean, she was getting fluids the whole time.

19 Q: What would -- what would be the lowest MAP that you'd
20 want to see for Mrs. Goodwin?

21 A: We generally like to keep them above 70, and I believe
22 they all were above 70.

23 Q: I'd like to go over this record right here. Do you
24 recognize this? It's a -- it's a blown-up version.

25 A: Yeah. It looks like -- looks like a lot of my sloppy

1 handwriting right there.

2 Q: Can you see that okay?

3 A: Yeah, I think I can see that.

4 Q: Did you record Mrs. Goodwin's blood pressures during her
5 surgery on this chart?

6 A: Yes.

7 Q: Where on the chart do you record the blood pressures?

8 A: You've got a square full of boxes, and you have what look
9 like check marks and what look like inverted check marks, and
10 those are the blood pressures. And the little dots are heart
11 rate. And there are various other numbers and symbols that
12 correspond to other -- other things on the chart.

13 Q: I'm going to give you a laser pointer, if that makes it a
14 little bit easier for you to point.

15 A: These are the blood pressure. That's the upper number.
16 This is the diastolic, the lower number.

17 Q: Explain to the jury how that works. Are you recording
18 those in real time?

19 A: I am recording them in real time. They come up on a -- a
20 screen. We have a blood pressure monitor with a cuff. In
21 this case, the cuff is placed around the arm. Every three
22 minutes, we're recording blood pressures. And it's a kind of
23 a blood pressure cuff that senses the oscillation of blood
24 through the artery and it gives us a number, or it gives us a
25 systolic and diastolic and a mean -- mean arterial pressure.

1 Q: And you said that the -- the blood pressure cuff reads
2 every three minutes?

3 A: It's reading every three minutes.

4 Q: Okay.

5 A: I'm sure -- I'm sure that's what I had it set on.

6 Q: If -- if you recorded the blood pressures every five
7 minutes, is that -- are you just recording it two minutes
8 after it's read it?

9 A: No. A lot of times I'll hit another one. They're --
10 they're recorded in real time.

11 Q: Okay. And you physically write those on that chart?

12 A: Yeah, I physically wrote those.

13 Q: I'm going to read you the blood pressures, and these were
14 -- I believe you gave these during your deposition. I'm just
15 going to read off each one.

16 MR. HEITMAN: And, Your Honor, is it okay if he steps
17 down to take a closer look at that chart?

18 THE COURT: Yes, sir.

19 BY MR. HEITMAN:

20 Q: If you'll just take a look at the chart and -- and tell
21 me if what I'm reading to you looks like what's on the chart.
22 So at 7:25, I have 140 over 90?

23 A: Yeah, that looks right.

24 Q: 7:30, I have 140 over 82?

25 A: That looks right.

1 Q: 7:35, 130 over 100?

2 A: That looks right.

3 Q: 7:40, 130 over 100?

4 A: Well, these are little -- these are a little higher, but,

5 you know, for all essential purposes, that's -- that's right.

6 You know, it looks like I didn't quite hit the line there.

7 I don't know how exact you want to be, but I -- that's fine.

8 Q: Seven -- did I just say 7:40 or 7:45?

9 A: I think you're on 7:45 now.

10 Q: Okay. 7:45, 130 over 100?

11 A: Yes.

12 Q: 7:50, 120 over 85?

13 A: Yes.

14 Q: 7:55, 120 over 75?

15 A: 7:55? Yeah, that's right.

16 Q: 8 o'clock, 110 over 75?

17 A: That looks good.

18 Q: 8:05, 120 over 75?

19 A: Yes.

20 Q: 8:10, 120 over 78?

21 A: You're saying 8:20?

22 Q: Yeah. Or 8 -- yeah.

23 A: All right. That -- that looks -- that looks good.

24 Q: 8:25, 120 over 78?

25 A: Yes.

1 Q: 8:30, 120 over 70?
2 A: Yes.
3 Q: 8:35, 110 over 80?
4 A: Yes.
5 Q: 8:40, 118 over 90?
6 A: Yes.
7 Q: 8:45, 118 over 70?
8 A: Yes.
9 Q: 8:50, 110 over 87?
10 A: Yes.
11 Q: 8:55, 110 over 80?
12 A: Yes.
13 Q: 9 o'clock, 120 over 90?
14 A: Yes.
15 Q: 9:05, 120 over 80?
16 A: Yeah.
17 Q: 9:10, 110 over 80?
18 A: Yes.
19 Q: 9:15, 110 over 80?
20 A: Yes.
21 Q: 9:20, 115 over 75?
22 A: Yes.
23 Q: 9:25, 110 over 75?
24 A: Yes.
25 Q: 9:30, 115 over 70?

1 A: Yes.

2 Q: 9:35, 115 over 70?

3 A: Yeah.

4 Q: 9:40, 120 over 75?

5 A: Yeah.

6 Q: 9:50, 120 over 70?

7 A: Yes.

8 Q: 9:55, 118 over 70?

9 A: Yes.

10 Q: 10 o'clock, 130 over 100?

11 A: Yes.

12 Q: 10:05, 120 over 90?

13 A: Yes.

14 Q: 10:10, 118 over 80?

15 A: Yes.

16 Q: 10:15, 120 over 80?

17 A: Yes.

18 Q: 10:20, 115 over 80?

19 A: Where are we? Is that the -- you got a page 2 or do we

20 need a page 2? Yep.

21 Q: Yeah.

22 A: So what -- what was your last time?

23 Q: Oh, it was 10:20.

24 A: All right.

25 Q: 115 Over 80?

1 A: That's right.
2 Q: 10:25, 113 over 75?
3 A: Yeah, that's right.
4 Q: 10:30, 110 over 78?
5 A: Correct.
6 Q: 10:35, 108 over 80?
7 A: Yes.
8 Q: 10:40, 108 over 70?
9 A: Yes.
10 Q: 10:45, 110 over 68?
11 A: Yes.
12 Q: 10:50, 108 over 70?
13 A: Yes.
14 Q: 10:55, 108 over 72?
15 A: Yes.
16 Q: 11 o'clock, 110 over 70?
17 A: Yes.
18 Q: 11:05, 115 over 70?
19 A: Yes.
20 Q: 11:10, 110 over 72?
21 A: Yes.
22 Q: 11:15, 110 over 78?
23 A: Yes.
24 Q: 11:20, 105 over 70?
25 A: Yes.

1 Q: 11:25, 110 over 70?

2 A: Yes.

3 Q: 11:30, 115 over 70?

4 A: Yes.

5 Q: 11:35, 118 over 80?

6 A: Yes.

7 Q: And 11:40, 116 over 80?

8 A: Yes, that's correct.

9 Q: Were all those blood pressures appropriate for Mrs.

10 Goodwin?

11 A: Yes, they were.

12 Q: You can have a seat back up there.

13 A: All right.

14 Q: Mr. Starn, we've charted all of those blood pressures

15 during her surgeries, the yellow line right here.

16 A: Uh-huh.

17 Q: You can take a look at that. Were any of her blood

18 pressures below a MAP of 70?

19 A: The yellow line?

20 Q: Yes.

21 A: They don't look like they're at all below. I mean, 70 is

22 at the bottom of that green rectangle. Right?

23 Q: Correct.

24 A: So they should be good.

25 Q: They're nowhere near 70, are they?

1 A: They're all above 70. Some of them are -- you know,
2 they're all above 80.

3 Q: So you discussed that the anesthesia care team monitors
4 the blood pressure. I believe you pointed out the pulse to
5 us. Does it also monitor the oxygen saturation?

6 A: Yes. We have a -- we have a pulse oximeter attached to a
7 finger.

8 Q: Is that reported on that chart?

9 A: Yes. Let me see. So the SC02 all along here, it's a
10 100, 100, 100, 100, 99, 99, 100, 100, 100, 100, and 100 on
11 there. And 99, 99, 99. That looks like a 99.

12 Q: What does the oxygen saturation tell you?

13 A: It's the -- it tells -- well, the hemoglobin. It's the
14 percentage of oxygen attached to the red blood cells
15 basically. It's -- you know, you're moving -- you're moving
16 oxygen through the lungs, and it's exchanging in the lungs
17 with red blood cells, and it's going out. This is on an
18 extremity. I usually put it on this finger and it's on an
19 extremity.

20 And this finger has to be perfused. You have two
21 different wavelengths of light in a pulse oximeter, and the --
22 the wavelengths are reflected and come back through a wire and
23 they're run through -- they're run through a machine, and it
24 gives you a number based on a fast Fournier formula or a fast
25 Fournier equation is what it used to be called, but it

1 basically tells you how well oxygenated the patient is.

2 It'll also tell you a heartbeat because it has something
3 called -- uses something called plethysmography. It senses
4 the oscillations of the small blood vessels in your finger,
5 and so it gives you two things. It gives you a number and it
6 gives you a heart rate. And it's all the way on the end of
7 the finger.

8 Q: So oxygen saturation can be a good indicator of
9 perfusion?

10 A: It's always a good indicator of perfusion.

11 Q: But what do you want to see those oxygen saturation
12 numbers at?

13 A: A hundred is always good. Anything above -- you know,
14 anything above 95 is good because some patients will never
15 make it to 100. But 100 is always good. 99 is great. You
16 know, I'm happy with -- I'm always happy when I get people
17 that saturate that way.

18 Q: What level of oxygen saturation would raise a red flag
19 and tell you that a patient is not getting good perfusion?

20 A: You know, I -- I'd start -- I start getting concerned
21 below 92. Some people would say below 90. It really depends
22 on the patient, but, you know, if you're running a fair amount
23 of oxygen -- let me see what I had dialed in. I was running
24 60 percent oxygen, so 40 percent air, 60 percent oxygen.

25 You know, if they were going down to 94, 92, I'd start

1 wondering why they were going down and, you know, I'd start
2 investigating. But she's -- you know, she's a hundred.

3 Q: What -- what did Mrs. Goodwin's oxygen saturation numbers
4 indicate to you about Mrs. Goodwin's perfusion in this case?

5 A: She has good perfusion. It's reaching her fingertips.

6 Q: Does the patient's heart rate also tell you whether or
7 not you're getting good perfusion?

8 A: Yeah. If you're not getting good perfusion, that heart
9 rate is generally going to go up, and you'll get tachycardia
10 because it's trying to deliver oxygenated blood to your vital
11 organs. And if your organs aren't getting the -- the blood
12 they need or not exchanging, it's going to keep trying harder
13 and harder. So your heart's going to beat faster.

14 Q: I believe you said earlier that you recorded her heart --
15 her heart rate on that chart?

16 A: That she was 110 to begin with. And it went down and,
17 all along, you know, 90s, 80s. That's 90s and 80s right
18 there. They give medicines that will affect a patient's heart
19 rate ahead of time. A lot of times they'll give a medicine
20 called Robinul that will -- it will increase your heart rate,
21 and it will also dry out your secretions because secretions
22 can get in the way of -- of intubation. They can make it more
23 difficult to intubate a patient. But the Robinul will -- will
24 make your heart rate go up. And, you know, there are other
25 things that will make your heart rate go up. Stimulation.

1 Q: What does Mrs. Goodwin's heart rate during her surgery
2 tell you about perfusion in this case?

3 A: She's well perfused.

4 Q: She --

5 A: That's a good heart rate. It's not tachycardic, and it's
6 not bradycardic, which means it's not too low. It's not too
7 high. It's -- she's moving -- she's moving blood through her
8 body.

9 Q: There were no issues with the anesthesia in this case,
10 were there?

11 A: We had that --

12 MS. GOODING: Objection, Your Honor. Leading.

13 THE COURT: Sustained.

14 BY MR. HEITMAN:

15 Q: Do you have any -- do you have an opinion whether or not
16 there were issues with the anesthesia in this case?

17 A: The only thing I said is when she bit her tube and we
18 fixed that, and that's -- you know, that can happen. I've had
19 other patients do that.

20 Q: If there is a significant issue with the anesthesia
21 during a surgery and the anesthesiologist is not aware, is it
22 the CRNA's job to -- to inform the anesthesiologist?

23 A: Yes.

24 Q: Do you have any criticisms of Dr. Holbrook in this case?

25 A: No.

ERICH STARN - CROSS BY MS. GOODING

1 MR. HEITMAN: Thank you, Mr. Starn. That's all I have.

2 THE COURT: Ms. Gooding?

3 MS. GOODING: Thank you, Your Honor. May it please the
4 Court.

5 CROSS-EXAMINATION

6 BY MS. GOODING:

7 Q: Good evening, Mr. Starn. I'm making a mess of this. Mr.
8 Starn, you have a lawyer in this case; right?

9 A: Yes.

10 Q: The claims against you have been resolved; right?

11 A: Yes.

12 Q: But your lawyer has been here today, and the defense
13 counsel has called you today to testify on behalf of Dr.
14 Holbrook; correct?

15 A: Correct.

16 Q: And you've already told us that you are a CRNA?

17 A: Yes.

18 Q: And I understand that that means that you work with or
19 under an anesthesiologist for every operation that you take
20 part in; is that right?

21 A: At the Baptist Hospital, yes.

22 Q: Okay. Which is where you've been for the last --

23 A: Yes.

24 Q: Remind me how many years?

25 A: Fourteen, going on 15.

1 Q: And my understanding is that typically you're assigned to
2 one case or operation at a time, and the anesthesiologist that
3 you're working with that day may be assigned to four or five
4 cases, and they kind of move around; correct?

5 A: Probably no more than four.

6 Q: Okay.

7 A: Sometimes less. That -- that all depends on the time of
8 day and, you know, what they have scheduled, but it'll be four
9 to one, four CRNAs to one anesthesiologist. That's a --
10 that's the most you're going to see.

11 Q: Okay. But it's true that -- that you, as a CRNA, would
12 be in the room the whole time?

13 A: Yes.

14 Q: And you would not expect the anesthesiologist to be in
15 your room the entire time?

16 A: Not the entire time.

17 Q: Okay. And in this case, you worked with Dr. Root; right?

18 A: Yes.

19 Q: And -- but you don't always work with Dr. Root when
20 you're at Baptist?

21 A: I work with whoever they assign me. And, you know,
22 there's -- I don't know how many exactly -- I don't have an
23 exact number because that varies, but there's usually five or
24 six anesthesiologists there during the day. And, you know, I
25 work with -- some days I'll work with all of them.

1 Q: Same five or six anesthesiologists over the last 14 years
2 or how many over that period?

3 A: No. It varies. It varies. Some come. Some go. They
4 also staff other hospitals. It's whoever the -- their
5 anesthesia group assigns to the hospital that day.

6 Q: Okay. So you just happened to be working with Dr. Root
7 on this case; is that correct?

8 A: Yes.

9 Q: Okay. And you told us earlier about your schooling and
10 some of the things that are your responsibilities as a CRNA,
11 and I think you indicated that you're taught in school to
12 calculate and monitor a patient's mean arterial pressure; is
13 that right?

14 A: Yes.

15 Q: And that's during a surgery, I mean?

16 A: Yeah. Well, the -- the MAP comes up right on the screen.
17 So, you know, the machine is calculating it in real time.

18 Q: Sure. So when you're actually recording those, you're
19 able to see on the digital screen?

20 A: Yeah.

21 Q: It has a line for mean arterial pressure?

22 A: Yes.

23 Q: So I assume at some point you've also been taught how to
24 calculate a mean arterial pressure?

25 A: Yes.

1 Q: Okay. And if you are recording -- you showed us with
2 your laser pointer here that this is where you're recording
3 the blood pressures, and you said you're doing that every five
4 minutes; correct?

5 A: Uh-huh.

6 Q: Is that a yes? I'm sorry.

7 A: Yes.

8 Q: Okay. But you indicated that the blood pressure cuff is
9 actually getting a reading every three minutes; right?

10 A: Yes.

11 Q: So fair to say that you don't write down every single
12 blood pressure that's recorded during the surgery?

13 A: Yeah, that's true.

14 Q: Okay. And when you're managing a patient's anesthesia,
15 it's important to understand the patient's baseline blood
16 pressure prior to the surgery; correct?

17 A: It's nice to know. It's -- it's nice to know a baseline
18 blood pressure. You may not always. You may not always get
19 good information.

20 Q: Sure. But if a patient has a history of hypertension,
21 that's a factor that you want to consider when determining
22 where to keep that patient's blood pressure during the
23 surgery; right?

24 A: Yes.

25 Q: And taking that into consideration, you told us in your

1 deposition it's actually required by the standard of care. Do
2 you agree with that?

3 A: Yes.

4 Q: And I believe you indicated that you would keep the blood
5 pressure for a patient with a history of hypertension a little
6 bit higher than a patient that didn't have a history of
7 hypertension, because you want to make sure that they are
8 properly perfused; is that right?

9 A: Correct.

10 Q: And you said you like to keep a patient within 10 to 15
11 percent of their baseline blood pressure; right?

12 A: You could go lower than that. It really depends on, you
13 know, how high is their blood pressure. It depends on how
14 high their blood pressure is. And really, anything with an
15 MAP over 70 is going to be good.

16 Q: But you told us in your deposition that you like to keep
17 a patient within 10 to 15 percent of that baseline blood
18 pressure; is that right? Would you like to see it?

19 A: I might have said that. I -- I guess I said that. You
20 can probably show me in the deposition if -- if it says that
21 there, I'll -- I'll take your word on it, you know.

22 Q: I'll show it to you.

23 A: Sure.

24 Q: I won't make you take my word for it. There's a copy of
25 your original --

1 A: All right.

2 Q: -- deposition transcript there. If you'll look at page
3 32 for me. Have you found that?

4 And at line 8, the question is: Is there a certain
5 percentage or a range that you try to keep a patient's blood
6 pressure during anesthesia when compared to their baseline
7 blood pressure?

8 Answer: Well, I'd want it -- I guess you can go with 10
9 to 15 percent of their baseline.

10 Did I read that correctly?

11 A: Yeah, it looks like it.

12 Q: Okay. And you went on to explain that that's because if
13 a patient is not adequately -- adequately perfused, that that
14 can result in injury; correct? And -- and that is actually on
15 -- on line 42. But if you agree with me, you don't have to go
16 and find that.

17 A: Line 42?

18 Q: Page 42.

19 A: Oh, page 42. Okay.

20 Q: Page 42, line 8. The question is: If a patient is not
21 adequately perfused during a surgery, do you agree that injury
22 can result?

23 A: All right.

24 Q: The answer is: If they're not adequately perfused, yes.

25 Is that correct?

1 A: Correct.

2 Q: Okay. Have you had a chance to finish reading?

3 A: Oh, yeah.

4 Q: Okay. And I know you've indicated that you don't

5 remember all the details of this case, but this case does

6 stick out to you; right? You remember some things about it?

7 A: There's always some things you're going to remember about

8 cases.

9 Q: And you told us in your deposition that you remember

10 speak -- excuse me -- speaking with Ms. Goodwin during pre-op;

11 is that right?

12 A: I think she was already sedated during the pre-op. I

13 probably did. You know, I'm going to speak to them. I speak

14 to every patient during the pre-op, so I spoke to her. I can

15 guarantee you that.

16 Q: Okay. No one gave you any specific instructions or

17 information regarding her blood pressure; correct?

18 A: Correct.

19 Q: And prior to the start of that July 28th, 2016, surgery,

20 not counting anything that you've done as a part of this case,

21 you did not review any recorded blood pressures from Ms.

22 Goodwin other than the blood pressure taken that morning;

23 correct?

24 A: I don't think -- I don't think I saw anything other than

25 that, what was taken that morning.

1 Q: Okay. And the pre-anesthesia blood pressure for Ms.
2 Goodwin on July 28th, 2016, is recorded right over here on
3 your chart. I believe it says 160 over 99, and I believe you
4 told us that that would be a mean arterial pressure of 119; is
5 that right? I can grab you a calculator if you want.

6 A: That sounds right. It's going to be -- it's going to be
7 high.

8 Q: And you also testified earlier that you reviewed the
9 charts and that you saw MAPs in the 80s. When you said that
10 earlier, were you referring to these blood pressures where --
11 where she's already under anesthesia as far as mean arterial
12 pressure is in the 80s?

13 A: That must have been what I was talking about. A lot of
14 times they'll have -- they'll have a paper chart. At that
15 time in the hospital, they would have paper charts, and we've
16 looked -- we've looked them over. But, you know, it really
17 depends on what was in the paper chart. I think I was talking
18 about that, what you're seeing there.

19 Q: Okay. And you told us that you had the blood pressure
20 taken that morning and we just looked at that, mean arterial
21 pressure of 119, but you thought it might be artificially high
22 because surgical patients are often nervous.

23 A: 99 percent nervous, if not 100 percent. They're always
24 nervous.

25 Q: And you remember also about this case that Ms. Goodwin

1 was biting down on her endotracheal tube at one point in the
2 surgery?

3 A: At one point --

4 Q: Right?

5 A: -- she did.

6 Q: She wasn't biting through it; right? It just --

7 A: No, no. She -- she bit down on it, and it kinked.

8 Q: And you remember that shortly after that, the SSEPs or
9 the neuromonitoring signal were lost; right?

10 A: That was -- let's see. I don't have a time on there. Is
11 there a -- is there a timeline on when -- when there was --
12 that airway problem and then when the SSEPs were lost?

13 Q: I believe you told us in your deposition that at about
14 9:30, you had the airway problem, and at about ten, SSEPs were
15 lost.

16 A: All right. So that's --

17 Q: Does that sound right?

18 A: That sounds about right.

19 Q: Okay. And you told us that you remembered that the
20 neuromonitoring technician announced to the room that the
21 neuromonitoring signals were out; correct?

22 A: Yes.

23 Q: And that there had been a loss of signal to the lower
24 extremities; correct?

25 A: Yes.

ERICH STARN - CROSS BY MS. GOODING

1 Q: And you remember Dr. Holbrook telling the neuromonitoring
2 technician to check her equipment; right?

3 A: I think so. I'm sure he did say that. I mean, that
4 sounds like something he'd say. If it's in that deposition,
5 then -- then I said that. So --

6 Q: And you remember that she did, in fact, check her
7 equipment; is that right?

8 A: I'm sure she did.

9 Q: And if you -- if you'd like to look, that's on page 17 of
10 your deposition beginning at line 10.

11 Do you recall if Ms. Adkins checked her equipment?

12 A: Uh-huh.

13 Q: Answer: Yes, I do recall that. I think she did.

14 A: Uh-huh.

15 Q: Question: And did she inform Dr. Holbrook that she could
16 not identify that anything was wrong with her equipment?

17 And the answer is: Yes.

18 Is that correct?

19 A: Uh-huh. Yes.

20 Q: So you recall that she checked her equipment and that she
21 informed Dr. Holbrook that nothing was wrong with the
22 equipment; correct?

23 A: Correct.

24 Q: And then you testified to this earlier. You remember Dr.
25 Holbrook saying something to the effect of that he wasn't

1 working around the spine at that time; correct?

2 A: I remember that.

3 Q: And then you remember him continuing with the surgery?

4 A: Yes. Yeah, he did continue with the surgery.

5 Q: But you do not remember him asking you any questions
6 about her anesthesia, her vital signs, or anything else at
7 that time; correct?

8 A: I don't think he did.

9 Q: And he did not ask you to call Dr. Root; correct?

10 A: No, not as far as I know.

11 Q: If he would have asked you to call Dr. Root, would you
12 have done that?

13 A: Well, yes, I would have. I would have done that.

14 Q: Because when you're in the O.R., the surgeon is the
15 leader of the surgical team; correct?

16 A: Yes.

17 Q: And you testified earlier that you weren't given any
18 tasks to perform when that neuromonitoring went out; right?

19 A: As far as I can remember, yes.

20 Q: And your notes do not indicate anywhere that Dr. Root was
21 notified of the loss of signal; right?

22 A: I didn't write a note on that, so that's true.

23 Q: Okay. But you agree that she should have been notified?

24 A: Yes.

25 Q: Okay. And you did not make any changes to Ms. Goodwin's

1 anesthesia at that time; correct?

2 A: No.

3 Q: And in fact, Ms. Goodwin did not receive any medications
4 to raise her blood pressure at any point during this surgery;
5 correct?

6 A: I don't -- I don't see anything on there. She didn't --
7 she probably didn't require that. You can do it with just
8 fluid, and you can titrate anesthesia, and that will -- that
9 will raise and lower blood pressures as well.

10 Q: And you also have medications that you can use to raise
11 and lower blood pressure?

12 A: There are -- there are medications.

13 Q: Okay. You did not give her any medications intended to
14 raise her blood pressure?

15 A: No, I don't see any listed there.

16 Q: But the record does show that she was given three
17 medications that tend to lower your blood pressure; correct?

18 A: Anesthesia will lower your blood pressure. So she's
19 given anesthesia.

20 Q: Which would tend to lower her blood pressure; correct?

21 A: It will. It will.

22 Q: And as you testified in your deposition, given the
23 records from July 28th, which is on this board right here,
24 showing the recorded mean arterial pressure of 119 and from
25 July 22nd showing a recorded mean arterial pressure of 113,

1 you agreed that if those blood pressures were accurate, Ms.
2 Goodwin's intraoperative blood pressure on July 28th, 2016,
3 should have been kept higher than it was; isn't that correct?

4 MR. HEITMAN: Objection, Your Honor. He's already
5 testified as to this.

6 THE COURT: Overruled.

7 BY MS. GOODING:

8 A: Well, you know, I don't -- tell me that question again,
9 because it's just --

10 Q: Given this record from July 28th of 2016 showing the mean
11 arterial pressure of 119 --

12 A: Uh-huh.

13 Q: -- and the July 22nd record showing a mean arterial
14 pressure of 113 --

15 A: Uh-huh.

16 Q: -- you agreed in your deposition that if those blood
17 pressures were accurate, Ms. Goodwin's intraoperative blood
18 pressure on July 28th, 2016, should have been kept higher than
19 it was; correct?

20 A: Did I -- I said that?

21 Q: You did, sir.

22 A: All right.

23 Q: On page 95 of your deposition beginning on line 18.

24 The question is: Looking at the preoperative assessment
25 today, that she had a mean arterial pressure of 113 on 7/22 or

ERICH STARN - CROSS BY MS. GOODING

1 July 22nd, would you agree that Ms. Goodwin's intraoperative
2 blood pressure on the morning of 7/28 should have been kept
3 higher than it was?

4 Answer: Well, if that's accurate, yes.

5 Did I read that correctly?

6 A: Yes, you did.

7 MS. GOODING: Thank you. No further questions.

8 THE COURT: Any redirect?

9 MR. HEITMAN: Yes, Your Honor, briefly.

10 REDIRECT EXAMINATION

11 BY MR. HEITMAN:

12 Q: Mr. Starn, you were asked to read from page 42 of your
13 deposition, and I wanted to give you a chance to look further
14 down that page.

15 Page 42, line 21 says: Do you believe these blood
16 pressures we just went through during Crystal Goodwin's
17 surgery on the morning of July 28th, 2016, demonstrate
18 adequate perfusion for someone with chronic hypertension?

19 And you said: Yes, I do.

20 Is that still your opinion today?

21 A: Yes.

22 Q: And you were asked about this blood pressure 160 over 99.
23 In your opinion, is that consistent with white coat
24 hypertension?

25 A: A high starting blood pressure like that, yes. I've seen

1 it many times.

2 MR. HEITMAN: One moment. I don't have any other
3 questions. Thank you.

4 THE COURT: Anything further from this witness?

5 MS. GOODING: No, Your Honor.

6 THE COURT: All right. Thank you. You may step down.

7 MR. HEITMAN: Your Honor, may the witness be excused,
8 please?

9 MS. GOODING: No objection, Your Honor.

10 THE WITNESS: All right. Thanks.

11 THE COURT: All right, sir. You are free to go. Thank
12 you.

13 THE WITNESS: All right.

14 THE COURT: All right. Ladies and gentlemen, we're going
15 to call it a day at this point. I'm going to have you return
16 tomorrow morning at 10 o'clock.

17 Do not discuss the case amongst yourselves or with anyone
18 else. Don't do any research about the case. Have a good
19 night and be back at 10 o'clock tomorrow. Thank you.

20 (WHEREUPON, the jury exited the courtroom at 5:23 p.m.)

21 THE COURT: All right. Counsel, I want you all back at
22 9:30 tomorrow. I don't have anything particular in mind, but
23 somehow you all seem to fill about 30 minutes of time before I
24 can bring the jury out. So if it doesn't happen in the
25 morning, then we'll just be early, but I hate to keep the jury

1 waiting any longer than necessary.

2 So I'll see you all at 9:30. Have a good night.

3 MR. GOINGS: You, too. Thank you, Your Honor.

4 (WHEREUPON, the proceedings adjourned for the day.)

5

6 --- CONTINUED IN VOLUME VII ---

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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 7 OF 9 - VOLUME VII
	)	April 18, 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 18, 2023

2 (WHEREUPON, the proceedings resumed at 9:33 a.m.)

3 THE COURT: Good morning, folks. Is there anything that
4 we need to handle before the jury arrives from the plaintiffs?

5 MR. GOINGS: No, Your Honor. The only thing I could
6 possibly think of is that Midlands is supposed to provide some
7 additional financial information today. They couldn't get it
8 here yesterday. So we believe we'll get that today, hopefully
9 soon.

10 THE COURT: Okay.

11 MR. GOINGS: Nothing from the plaintiff, though. Thank
12 you, Your Honor.

13 THE COURT: From the defense?

14 MR. DAVIS: I can't think of anything.

15 THE COURT: The one time I have the jury come later.

16 MR. DAVIS: I know.

17 THE COURT: That's fine.

18 MR. DAVIS: I wish I could.

19 THE COURT: No, no, no, no. I don't want you to create
20 anything.

21 MR. DAVIS: As Your Honor can see, I was here with a
22 packet.

23 THE COURT: Okay. Let's handle that.

24 MR. DAVIS: We can do that.

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

1 which the proceedings resumed as follows.)

2 THE COURT: All right. I would like to start discussing
3 proposed jury charges. Okay. I'm going to begin with the
4 defendants' requested charges, just because I think that will
5 be easier. So let's just sort of go through them one by one,
6 and I guess what I need to know is whether plaintiffs object
7 to any of those.

8 Do you also have that box of Kleenex with you where you
9 can come up here to the exhibit table? Those Kleenex?

10 MR. GOINGS: I've confined my mess to this area. We're
11 good, Judge. We can keep going.

12 THE COURT: Okay.

13 MR. GOINGS: So the question is, which questions -- which
14 requests to admit we have an objection to or what charges?

15 THE COURT: Jury charges.

16 MR. GOINGS: Yes.

17 THE COURT: Yeah. Let's go through them because -- and
18 there's a -- well, yours are number two, but let's go through
19 by number.

20 MR. GOINGS: Okay. So the first one, hindsight, we
21 object to that. You -- in the standard medical malpractice
22 charge, there is a reference to something similar to this, and
23 I think it's more appropriately worded. So I think it's just
24 redundant and it doesn't need to be called. It doesn't need
25 to be read twice. And I say that to say I don't know what

1 your standard charges are, but I know what the standard
2 charges generally are.

3 THE COURT: Right. And so -- and like I said, I don't
4 want to keep the jury waiting too long. So I kind of want to
5 go through and get your ideas.

6 MR. GOINGS: Got it.

7 THE COURT: Then during testimony, I can be sort of
8 comparing notes and -- and so if the objection is that it's
9 redundant, but in substance you're okay with it, then --

10 MR. GOINGS: Okay.

11 THE COURT: -- I can correct for that.

12 MR. GOINGS: Got it. So we object to Number 1. We think
13 the standard medical malpractice charge is more appropriate.

14 Number 2 is not an incorrect statement of the law, but I
15 think your standard medical malpractice charge may read a
16 little more simply. Same for Request to Charge Number 3.
17 Same with Request to Charge Number 4 and 5, 6.

18 I don't -- Request to Charge Number 7, expert testimony
19 necessary, I'll say this. I know you've told the jury they
20 can consider expert testimony or not consider expert
21 testimony, they can give it no weight or a little weight, and
22 this just contradicts what you previously told them.

23 I think, as a matter of law, expert testimony is
24 necessary to, you know, reach that evidentiary hurdle, but to
25 tell them they have to consider expert testimony I think is

1 incorrect.

2 THE COURT: I agree with that. Let's -- let's pause
3 there, and let me hear from Mr. Davis and Mr. Heitman before I
4 do that one, specifically Request Number 7 about expert
5 testimony.

6 I tend to agree with Mr. Goings that certainly as a
7 matter of law, that's necessary. In fact, had there been no
8 expert testimony, I would have directed a verdict in
9 defendants' favor, but now that we've gotten beyond that
10 threshold, is this a jury question? Because I will tell the
11 jury that they can believe all, some, or none of the experts.
12 And if they don't believe plaintiffs' experts, then that's a
13 defense verdict. Right?

14 Go ahead.

15 MR. HEITMAN: Your Honor, I believe that you're right,
16 that it is up to the jury to give whatever weight they want to
17 to whichever expert. However, it is a necessary part of a
18 medical malpractice case to have the plaintiff to have expert
19 testimony to prove certain elements of -- of standard of care.

20 THE COURT: Right. So I'm not going to charge Request --
21 Defendants' Request 7 because -- because, as I said, that's --

22 MR. HEITMAN: Okay.

23 THE COURT: That would be a directed verdict, a summary
24 judgment, a legal dispositive issue if there were no expert
25 testimony. If they -- they being the jury -- doesn't believe

1 the plaintiffs' expert, then they just return a defense
2 verdict. So -- okay.

3 Moving on, Mr. Goings?

4 MR. GOINGS: Foreseeability. That's not an incorrect --

5 THE COURT: Okay. Would you give me --

6 MR. GOINGS: Excuse me. 9, Request to Charge 9.

7 THE COURT: Do you object to 8, though?

8 MR. GOINGS: 8 is expert testimony.

9 THE COURT: Yes. So --

10 MR. GOINGS: So 7 and 8 are the same thing.

11 THE COURT: They are.

12 MR. GOINGS: Okay.

13 THE COURT: Okay. Go ahead.

14 MR. GOINGS: Number 9, foreseeability. That's not an
15 incorrect statement of law, but you charge foreseeability
16 anyway, I understand. So --

17 THE COURT: Yeah, but it's --

18 MR. GOINGS: It's subsumed in your proximate charge,
19 proximate cause charge.

20 Opinions regarding treatment, Number 10. This is out-of-
21 state precedent from Pennsylvania in the Sixth Circuit. This
22 is not South Carolina law. I think the standard medical
23 malpractice charge is most appropriate, and we shouldn't be
24 giving them law from other states. So Number 10, we would
25 object to.

1 Number 11. Number 11 is -- you're kind of commenting on
2 facts in this one, like saying medicine is an inexact science.
3 You know, I -- some jurors may think science is not inexact
4 and you've got to believe the science. Right? So I think
5 that, you know, dicta in Court of Appeals opinions -- and this
6 is not straight out of it, but dicta in Court of Appeals
7 opinions is not jury charges. So Number 11, we have an
8 objection to. Again, I think your standard medical
9 malpractice charge is more appropriate.

10 Number 13 -- Number 12, not an insurer. That is included
11 in the standard medical malpractice charge, and I don't think
12 it needs to be charged again separately.

13 Number 13, sympathy charge. You have that as your
14 beginning general charges.

15 Number 14, bad result charge. This is -- we would object
16 to bad result as a standalone charge. Again, this is a part
17 of the standard medical malpractice charge.

18 Negligence not presumed. Well, I don't think you need to
19 call it out that negligence on the part of the physician is
20 not presumed. I mean, you talk about the burden of proof, and
21 I don't think the burden of proof has to be called out in
22 particular as it relates to a physician. I mean, this is
23 basically a burden of proof charge, and it just sounds like
24 you're giving extra emphasis or credit to a doctor instead of
25 a party.

1 Number 16, failure to cure or development of
2 complications, no evidence of malpractice, malpractice per se.
3 I don't know anything about this. I mean, this is not even a
4 case that I'm aware of, something Am Jur. Again, I think that
5 this kind of runs afoul of South Carolina law, and your
6 standard medical malpractice charge is more appropriate. And
7 it -- it -- it would include, you know, language that -- that
8 is the most appropriate.

9 THE COURT: I do have a charge and a -- if we haven't put
10 it in here yet, we will, but a charge that the mere fact of
11 injury is not sufficient to prove negligence. Each and every
12 element must be proven by the preponderance or greater weight
13 of the evidence.

14 MR. GOINGS: And that's the same as a car wreck to a
15 medical malpractice.

16 THE COURT: Exactly.

17 MR. GOINGS: Expert testimony, most probable test.
18 Again, you are commenting on -- on the standard or the weight
19 of testimony. You know, this most probably is a threshold for
20 purposes as a matter of law, not telling them, you know, the
21 weight of the testimony, they need to consider the weight of
22 the testimony, and also we're talking about burden of proof
23 too. So I think the expert most probable test is not an
24 appropriate charge for the jury.

25 Punitive damages I don't think you're charging in this

1 phase anyway.

2 THE COURT: Right.

3 MR. GOINGS: The gross negligence charge. I think our
4 gross negligence and reckless charge is more appropriate than
5 theirs. And perhaps you can look at theirs and look at ours
6 and look at yours. You know, this is a legal definition. So
7 --

8 Damages. Your Honor, you -- you have the damages charge
9 that you use you're probably the most comfortable with.

10 Those are our suggestions and thoughts, Your Honor.

11 THE COURT: Okay. Thank you, sir.

12 Mr. Heitman, do you want to run back through any of
13 these? Are there any that you're married to that -- that Mr.
14 Goings has objected to?

15 MR. HEITMAN: Well, Your Honor, I think all of them are
16 reflective of -- of some common law. All of them would be
17 appropriate to charge in this case. As far as --

18 THE COURT: Well, they're not all reflective of South
19 Carolina law. There's at least one that's from another state.

20 MR. HEITMAN: Yeah.

21 THE COURT: But I get your point.

22 MR. HEITMAN: Yes, Your Honor.

23 THE COURT: And so when I asked about language that
24 you're married to, for example, the plaintiffs object to
25 Request Number 1 in that the Court's standard charge includes

1 some version of this, and this would be redundant.

2 So is this particular language what you're married to,
3 this phrasing of it, or would you be okay to see what the
4 Court has?

5 MR. HEITMAN: Your Honor, I'll review what the Court has
6 and just go through ours.

7 THE COURT: Sure.

8 MR. HEITMAN: And compare them.

9 THE COURT: Sure.

10 MR. HEITMAN: Thank you.

11 THE COURT: Okay. And that's the same sort of 2, 3, 4,
12 5, 6. We've already discussed 7 and 8. What about 9 with
13 foreseeability? What's the defense position?

14 MR. HEITMAN: Your Honor, that's a direct quote taken
15 from that case, and we believe that the language in it is
16 appropriate.

17 THE COURT: So I know you don't have a copy of it yet,
18 but what I will charge the jury on -- my goodness. I need to
19 look through this. I mean, foreseeability is really sort of
20 an element of a negligence case. That's part of causation.
21 That the injuries must be foreseeable, not the particular
22 injury that occurred, but some injury from the act must be
23 foreseeable.

24 So I guess, again, the question is whether this
25 particular language. I don't disagree that foreseeability is

1 appropriate to be charged to the jury, but is this language
2 the language that I would need?

3 MR. HEITMAN: Yes, Your Honor. I believe that it is.
4 And I'm not sure exactly what you have, but I think, you know,
5 describing it as a natural and probable consequence of the
6 complained-of acts I felt really breaks it down for the jury
7 and helps them to understand foreseeability.

8 THE COURT: All right. What I would charge -- and we'll
9 just sort of compare that now.

10 The plaintiff must also prove legal cause. Legal cause
11 is proven by showing that the injury was foreseeable. This
12 means that the injury occurred as a natural and probable
13 consequence of the defendants' negligence. The plaintiff must
14 prove that some injury from the defendants' negligence was
15 foreseeable, but does not have to prove that the particular
16 injury that occurred was foreseeable. However, the defendants
17 cannot be held responsible for something which could not be
18 expected to happen, which is essentially --

19 MR. HEITMAN: I guess pretty close.

20 THE COURT: Yeah, pretty close. Okay.

21 All right. Number 10. That's the one that is not South
22 Carolina law. Opinions regarding treatment.

23 MR. HEITMAN: Your Honor, I think the concept of that is
24 -- is accurate in South Carolina law. We would request that
25 it be charged.

1 THE COURT: It's not South Carolina law, and I think this
2 is more argument, not a jury charge. So I will not charge
3 defendants' Request Number 10.

4 Number 11. I feel the same way, but I'm happy to hear
5 from you, Mr. Heitmann.

6 MR. HEITMAN: I'm sorry, Your Honor? The same way as
7 which one?

8 THE COURT: Same way as the last one. This is argument
9 but not necessarily a jury charge.

10 MR. HEITMAN: Your Honor, I wouldn't describe it as an
11 argument. I mean, it was taken also directly from that case,
12 although I don't believe it was a direct quote, but I believe
13 it's appropriate law to charge.

14 I think it's -- it's -- it's not really commenting as to
15 the weight, like -- like we said earlier with the expert
16 testimony. I believe it's commenting on the weight, but it's
17 commenting on the fact that there's different methods to treat
18 a patient. And just because -- just because someone doesn't
19 use the exact same method doesn't mean that they're negligent.

20 And medicine is an inexact science, Your Honor. If you
21 want to strike that science from it because you don't like it,
22 I don't have an objection to that, but I think the rest of it
23 is -- is definitely law that stands.

24 THE COURT: Okay. I'll review that one. Thank you.

25 Number 12, I believe, probably is included in the charge

1 in some fashion. Probably not as windy as this, but certainly
2 that a doctor is not an insurer of any particular outcome.

3 Thank you. Page 9. A doctor is not an insurer of a
4 cure, a perfect result, or even of a positive result. The
5 mere fact that treatment does not benefit the patient or that
6 it even harms the patient does not, in and of itself, mean
7 that the defendants were negligent. A bad result, injury, or
8 failure to cure is not by itself enough to show that the
9 defendants were negligent. Again, top of page 10. And
10 negligence may not be inferred by a poor result.

11 Is that sufficient, Mr. Heitman?

12 MR. HEITMAN: Your Honor, I believe that it's pretty
13 close to what we have.

14 THE COURT: I think that one, there's actually more to
15 it.

16 MR. HEITMAN: Okay.

17 THE COURT: And so we'll wait until you've seen a copy of
18 what I've got.

19 MR. HEITMAN: I appreciate it. Thank you.

20 THE COURT: Okay. The same for 13, 14. 15 I think is
21 already included. I mean, I would repetitively say that --
22 that the plaintiff must prove things by the preponderance or
23 greater weight of the evidence. The fact of injury does not
24 show negligence. I don't know. We can return to that one to
25 the extent that you may want it there once you've seen my

1 charge.

2 In fact, let's do that with the rest of them. 16, 17,
3 18 we'll come back to with punitive damages. Yes. I'll just
4 -- I'll get to work on what I've got. And then during a
5 break, I'll get y'all copies of what I have. Okay?

6 MR. HEITMAN: Thank you.

7 THE COURT: And then at some point later, we'll go for
8 the plaintiffs' requested charges, but not now. We don't have
9 time. So we're going to take five minutes or so.

10 Are we going to be using this monitor -- sorry -- this
11 morning?

12 MS. GOODING: Yes.

13 THE COURT: Okay. Just checking. We'll take a few
14 minutes until all the jurors are here, if they're not already,
15 and then I'll be back with you.

16 MR. HEITMAN: Thank you, Judge.

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

19 THE COURT: Bring the jury, please.

20 (WHEREUPON, the jury entered the courtroom at 10:11 a.m.)

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

22 THE COURT: Good morning, ladies and gentlemen. We're
23 still on the defendants' case. I hope you're ready for a
24 riveting day. I'm sorry. There are moments that are
25 riveting. Listen, I told you at the outset that trials --

1 trials are -- people think that trials are full of high drama,
2 intense action, and riveting circumstances. While all those
3 things may be true at times, this trial is not for
4 entertainment. It is a fundamental part of our democracy, an
5 effort to make sure that justice is done between the parties
6 before the Court.

7 I have it all up here. That's what they give us, but I
8 remember it. Anyway, so yeah, there were moments of
9 excitement and -- and others not, but all of it's necessary.
10 So, yes, please give the defense counsel your undivided
11 attention.

12 Mr. Davis, call your next witness.

13 MR. DAVIS: Your Honor, let me call Dr. Holbrook to the
14 stand.

15 THE BAILIFF: All right. Place your left hand and raise
16 your right, sir.

17 THE CLERK: Do you solemnly swear or affirm that the
18 testimony you're about to give in this case will be the truth,
19 the whole truth, and nothing but the truth, so help you God?

20 THE DEFENDANT: Yes, I do.

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

22 THE DEFENDANT: Thomas J. Holbrook.

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

24 THE COURT: And, Dr. Holbrook, I think you're going to
25 have to speak directly into that microphone. You seem to be a

1 bit soft-spoken.

2 THE DEFENDANT: Yes, ma'am.

3 THE BAILIFF: All right.

4 MR. DAVIS: Let's try this out.

5 DR. THOMAS J. HOLBROOK, being
6 first duly sworn, testified as follows:

7 DIRECT EXAMINATION

8 BY MR. DAVIS:

9 Q: Would you introduce yourself to the jury?

10 A: Good morning. My name is Thomas Holbrook.

11 Q: Thank you. I can -- I can hear you pretty well. I think
12 that's going to work. Can you hear me okay?

13 A: Yes, sir.

14 Q: All right. Yeah. Keep kind of speaking close to it.

15 A: Yes, sir.

16 Q: All right.

17 A: Thank you.

18 Q: Dr. Holbrook, would you give the jury some -- kind of a
19 thumbnail sketch of your training, your education, and
20 experience as a neurosurgeon? Let's start with college and
21 kind of walk us through.

22 A: I went to college at the University of Kentucky, and then
23 I went to medical school at West Virginia University, which is
24 my original home state, and then I went to Vanderbilt
25 University in Nashville to do my neurosurgical training. And

1 I've been here in Columbia ever since.

2 Q: Doctor, when you finished medical school, did you explore
3 a residency training program somewhere?

4 A: In Nashville at Vanderbilt.

5 Q: And what was that in?

6 A: Neurosurgery.

7 Q: How long was that residency?

8 A: Six years.

9 Q: At the end of that six years, did you become at some
10 point board certified in neurosurgery?

11 A: Yes, sir.

12 Q: What do you have to do to become board certified, Doctor?

13 A: You take an oral exam, and you take a written exam.

14 Q: You've got to pass them both?

15 A: Yes, sir.

16 Q: Did you pass them both the first time?

17 A: Yes, sir.

18 Q: Okay. When did you begin practice as a neurosurgeon?

19 A: In 1987.

20 Q: Was that here in Columbia?

21 A: Yes, sir.

22 Q: And what was the name of that group?

23 A: It turned into Columbia Neurosurgical Associates.

24 Q: All right. And then at some point, did that merge with
25 Midlands Orthopedics?

1 A: Yes, sir.

2 Q: Okay. About when was that?

3 A: I think it was about 2015.

4 Q: All right, sir. Now you're retired?

5 A: Yes, sir.

6 Q: What year did you retire from your practice?

7 A: 2020.

8 Q: Why did you retire?

9 A: Well, you can't do it forever. Okay? So you have to

10 retire at some point, and I always thought that age 65 would

11 be a good time.

12 Q: Okay. What do you find yourself doing these days in your

13 retirement other than being in court?

14 A: Well, I read some and do some volunteer work and that

15 sort of thing. Nothing really very exciting.

16 Q: Are you married?

17 A: Yes.

18 Q: And where do you all live, you and your wife?

19 A: Hopkins.

20 Q: I'm sorry?

21 A: In Hopkins.

22 Q: How long have you lived there?

23 A: I've probably been in Hopkins about maybe ten years.

24 Q: Okay. Do y'all have children?

25 A: We have three grown children.

1 Q: And tell us about your children?

2 A: Well, I have an oldest daughter who's a veterinarian.
3 She has a family down in Florida. My oldest son is in the Air
4 Guard out at McIntyre. He's a pilot and flies out there, and
5 he's also training to be an emergency room physician. And
6 then my youngest son is a pilot and flies for a service that
7 flies transplant organs around and transplant teams around to
8 various hospitals to harvest and implant organs.

9 Q: Doctor, give the jury some estimate of the number of
10 decompressive laminectomies you've performed in your career?

11 A: Probably a few thousand.

12 Q: A few thousand?

13 A: Probably. I mean, there are many different types of
14 spine surgery, and decompressive laminectomy is only one type
15 of spine surgery.

16 Q: How many spine surgeries, including decompressive
17 laminectomies and other spine surgeries, do you estimate
18 you've performed in your career?

19 A: You know, I don't know. I'd guess maybe 5,000. I don't
20 know.

21 Q: How many times did you operate on Crystal Goodwin in your
22 career?

23 A: Four.

24 Q: Do you remember Crystal Goodwin as your patient, Dr.
25 Holbrook?

1 A: Yes, sir.

2 Q: Back in 2009, explain to the jury from your perspective
3 -- Crystal has already testified some about this yesterday. I
4 think it was yesterday. When you were asked to come to her
5 bedside in a hospital on a consulting basis to examine her and
6 -- and do whatever you needed to offer her at that time, tell
7 the jury about that?

8 A: Well, I can give you sort of a brief timeline of my, you
9 know, experience with Crystal. It started back in 2009.
10 About six months before I met her, she started having weakness
11 and numbness in her legs, which got worse and worse and worse.

12 And on the day that I met her, she had been in to see a
13 medical neurologist to sort of look and see if they could find
14 out what the problem was. And when she came out of that
15 office, her legs became so weak that she collapsed on the
16 sidewalk, couldn't stand, couldn't walk, and was taken to the
17 Baptist Hospital, where I subsequently saw her at that time,
18 examined her, and made an MRI scan of her spine, which showed
19 the stenosis.

20 And that -- you've had several people talk to you about
21 the stenosis or the narrowing of the spinal canal. Her spinal
22 canal had become so narrow that the bones inside the canal
23 were compressing her spinal cord, and that's what caused this
24 to happen. Now, this is a progressive disease which over time
25 slowly gets worse and worse. There's really no other

1 treatment for it other than surgery. Okay? There's no
2 medicine, no therapy that will affect it. And if you don't do
3 surgery, it will just continue to get worse and worse until
4 you've lost all function.

5 So we operated on her at that time and did the
6 decompressive laminectomy to decompress her spine, and over
7 time, after several months of physical therapy, she recovered
8 function back to the point where she could walk and go about
9 her normal activities without much difficulty. It didn't come
10 100 percent back to normal, but close enough that she could go
11 about her normal activities without any difficulty.

12 And she did very well for probably two years, and then
13 she came back again, having symptoms of weakness and numbness
14 in her legs. It got bad enough, I think, at that time, to
15 where she had to use a walker at times and had some difficulty
16 with controlling her bladder. We made another MRI scan at
17 that time, and it again showed recurrence or progression of
18 the spinal stenosis, again with pressure on her spinal cord.

19 So we knew the history of this disease in this patient
20 and its progression that if we didn't do something, it was
21 going to just continue to get worse and worse. The only
22 treatment was another decompressive laminectomy, which we did.
23 She did well from that surgery and after, you know, some
24 physical therapy and that sort of thing, her function returned
25 again to the point where she could go about her normal

1 activities without any particular problem.

2 She did pretty well after that for about five years and
3 had a fall, and after that fall again began starting to have
4 some weakness and numbness in her legs. She came back to see
5 me again. We examined her. We made another MRI scan, which
6 again showed progression of this same spinal stenosis. Okay?

7 At that time, we did her third surgery, which was the
8 surgery that she had this complication. After -- after this
9 complication, I continued to see her in the office for
10 probably about three more years, getting her therapy,
11 medicine, assistive devices, and that sort of thing to try and
12 minimize the effects of this complication as much as we could.

13 After about three years, she stops coming to see me about
14 the same time that this lawsuit was filed, but she continued
15 working with therapy and making some slow progress, you know,
16 with the -- with this therapy. And then again, maybe three
17 years or so after she left my care, she again started to have
18 progressive weakness and numbness in her legs, which is the
19 history of this disease, necessitating that she have the
20 fourth surgery with a different surgeon.

21 But the nature of this disease is that it is progressive.
22 I think she will continue to have problems with this for the
23 rest of her life and will likely need some further surgeries,
24 and that sort of brings us up to present time.

25 Q: Thank you, sir. Doctor, before each of your three

1 surgeries with Ms. Goodwin, did you have the opportunity to
2 explain the risks, the benefits, the alternatives to the
3 surgery you were offering to her?

4 A: Yes, sir.

5 Q: Explain to the jury basically what -- what you tell a
6 patient like Ms. Goodwin facing a decompressive laminectomy
7 like she faced in 2009, again in 2011, and again in 2016?

8 A: Well, generally, we've already gone over things like, you
9 know, the disease process, what the problem is and what the
10 treatment is and the surgery, what we plan to do and that sort
11 of thing. I also discuss with them the risk of the surgery.
12 And for any surgery, I would generally discuss the risks that
13 are pertinent or really apply to that particular type of
14 surgery, like in this case, bleeding or infection. Okay? I
15 explain to them that any complications like that around the
16 nerves of the spinal cord could damage and make it worse than
17 it already is.

18 At the end of the discussion, I will tell -- no matter
19 what kind of surgery it is, I will always tell the patient
20 that, you know, in the end, really anything bad that you can
21 think of, could it ever possibly happen, yes, including in
22 this case, paralysis and death.

23 Q: Was she a compliant patient? A good patient of yours?

24 A: Yes, sir. She was.

25 Q: A good communicator?

1 A: Yes.

2 Q: Did she seem to understand things that you explained to
3 her as your -- as her physician?

4 A: Yes, sir.

5 Q: All right. Let's focus on July 28th, 2016, the surgery.
6 When we look at your operative note -- and there's been some
7 testimony about that already -- there's some blanks on that
8 operative note. I want you to explain to the jury that when
9 you finished the surgery back in 2016, July of 2016, and you
10 go to prepare your operative note, explain to the jury the
11 technology or mechanism of how you do that?

12 A: Well, the operating note is sort of a summary of what the
13 surgery -- what happened during the surgery, what you did
14 during the surgery. It doesn't explain every last detail, but
15 it's a summary of that. And you dictate it. You dictate it
16 on a telephone and then it's transcribed by a
17 transcriptionist, and then it comes back to the chart, and at
18 some point you read it and sign it.

19 Q: This is a -- just a picture where we've got the whole
20 thing in front of us of your operative note from the first
21 surgery on the 28th, before you took her back a second time.
22 I want to read this sentence, and I'll ask you to fill in the
23 blanks for me that you dictated that you didn't fill in when
24 you signed it. Okay?

25 A: Correct.

1 Q: Examination with the Midas rex and a small Kerrison -- is
2 it rongeur?

3 A: Rongeur. Yes, sir.

4 Q: Rongeur? Okay. Blank remains stable up to this point
5 and then abruptly stopped. What -- what did you dictate
6 there?

7 A: That was evoked potentials, the neuromonitoring that we
8 were doing, the evoked potentials, the somatosensory evoked
9 potentials.

10 Q: By not filling in that blank when you signed this, were
11 you trying to hide anything?

12 A: No. And ideally, yes, you should read, you know, every
13 word of every op note and sign it, but I didn't in this case.
14 I commonly don't read every word of every note.

15 Q: Okay. You're trying to cover anything up?

16 A: No.

17 Q: I want to go to the next blank. A small Hemovac drain.
18 What's a Hemovac drain, Doctor?

19 A: It's a small tube that's placed into the wound at the end
20 of the surgery, and it comes out to the outside of the skin.
21 It's connected to a little bag so that if there's any bleeding
22 that accumulates during in the wound, it will drain out
23 through that little tube into the bag instead of forming a
24 hematoma or a blood clot in the wound.

25 Q: Doctor, we're going to see a picture of that, a drawing

1 of that in just a minute, but it says a small Hemovac drain
2 was left in the epidural space. What's the epidural space?

3 A: Well, in the surgery, there's a tissue called the dura,
4 which covers and surrounds the spinal cord. It's what holds
5 the spinal fluid in around the spinal cord. It's sort of a
6 gray tissue. You can't see through it, so you can't see the
7 spinal cord, but if you made an incision or an opening in that
8 dural covering, then spinal fluid would leak out. That's what
9 that is.

10 Q: All right. A small Hemovac drain was left in the
11 epidural space at the level of the blank to a separate stab
12 incision. What -- what did you dictate in that blank?

13 A: That blank would have been lamina, which is a part of the
14 back part of the bone of the spine, and it just lets you know
15 how deep in the wound that that was placed.

16 Q: Okay.

17 MR. DAVIS: Can we make that just a little bigger? My
18 eyes aren't that good. Just a little bit bigger. There you
19 go. Thank you. And go to the next page, please, Andrew.
20 That's not the next page.

21 MR. HEITMAN: Yes, it is.

22 MR. DAVIS: It is the next page? Okay. It is. All
23 right. Thank you.

24 BY MR. DAVIS:

25 A: Well, the other thing, too, with the operative note,

1 that's something that's dictated after the surgery is all over
2 and transcribed after the surgery is over. So having happened
3 all after the surgery is over, it could not have had anything
4 to do with causing this complication.

5 Q: All right, sir. When you dictated that operative note,
6 did you know that she could not move her legs?

7 A: No, not at that time.

8 Q: What is your understanding of the purpose of an operative
9 note?

10 A: It's a summary of what was done during the surgery.

11 MR. DAVIS: Yeah, a little bit. Yeah. Andrew, can you
12 pull this out?

13 BY MR. DAVIS:

14 Q: The identifiable cause within the wound was demonstrated.
15 Do you see that?

16 A: Yes, sir.

17 Q: Okay. Thank you. Is that what you dictated? The
18 identifiable cause within the wound was demonstrated? Is that
19 what you dictated?

20 A: It should be no identifiable cause was identified. Now,
21 if -- if that was the correct statement and said that there
22 was an identifiable cause, then the next sentence would have
23 gone on to describe what that cause was. So it should have
24 read no identifiable cause was demonstrated.

25 Q: All right. Well, apart from this note, was an

1 identifiable cause demonstrated for the signals going out?

2 A: No, sir.

3 Q: All right. At the time you dictated this, you didn't
4 even know that there was any inability of Ms. Goodwin to move
5 her legs?

6 A: No, I don't think so. I can't remember exactly what time
7 it was dictated, but as I recall, no.

8 Q: Okay. All right, sir. In your opinion, was -- was that
9 a clerical error?

10 A: I think it was a transcription error.

11 Q: A transcription error? Okay. You're not blaming anybody
12 for that?

13 A: No, sir.

14 Q: That happens from time to time?

15 A: Yes, sir.

16 Q: What is a timeout?

17 A: A timeout is something that's done right before you start
18 the surgery. Okay? It's a hospital procedure, sort of a
19 standard of the care. Any operation that's done in the
20 hospital, it's required that you have a -- what's called a
21 timeout procedure before the surgery is started, and it occurs
22 right before the surgery starts. The patient's already asleep
23 on the table and the timeout occurs.

24 And in this case, it would be the nurse anesthetist would
25 go over the pertinent things related to this patient. One

1 would be that this is the correct patient. Go over the name,
2 the surgical procedure. Make sure you have the right patient,
3 the right procedure. They would also go over any medicines
4 that she was taking, and they would also go over any other
5 health issues that she had, like in this case would be high
6 blood pressure and diabetes.

7 They would also go over the type of anesthesia. They
8 would be using a different type of anesthesia than normal for
9 this particular surgery, because we were going to use the
10 evoked potential monitoring, and it would make it more -- you
11 know, easier for us to -- and more accurate than the evoked
12 potentials with this particular type of IV anesthetic that we
13 were using, rather than the normal type, which involves
14 inhaled gases.

15 And we would go over all those sorts of things. And then
16 at the end, everybody in the operating room has stopped
17 whatever they're doing to listen to this. And then each
18 person says, I agree, so that everybody makes sure that they
19 agree with everything that was said and everything that was
20 done. At that time, the surgery proceeds.

21 Q: Were you present during the timeout in this case?

22 A: Yes, sir. Everybody is present. All the -- the whole
23 surgical anesthesia team is present.

24 Q: Thank you. Explain what neuromonitoring is. We've heard
25 a lot about it, but from your perspective, you ordered it in

1 this case. What is it and why did you elect to have it
2 employed in this case?

3 A: We all have heard a little bit about what this is
4 already, but just sort of briefly to -- to recap that we're
5 doing motor monitoring, which monitors muscle function, and
6 we're motoring -- monitoring sensory function as well. And
7 there are electrodes on the extremities, the arms and legs,
8 and there are electrodes on the scalp.

9 And for the sensory -- okay? -- they will stimulate, say,
10 down in the leg and measure the strength and the speed of the
11 transmission of those nerve action potentials as they go to
12 the brain, and then they're recorded over the skull.

13 The motor ones are done the opposite of that. A signal
14 is -- a stimulus is given to the scalp, to the surface of the
15 brain, which sends a signal down through the spinal cord, the
16 nerves to the muscles. And we also monitor the strength of
17 that signal and monitor the speed of that signal to determine
18 if there's any changes or abnormalities during the surgery.

19 Q: Shortly after the surgery began -- and that may be a
20 mischaracterization, but at some point prior to those signals
21 -- the SSEP signals going out, something happened in the
22 operating room of Crystal's bite block. Explain what that is
23 and what you remember happening?

24 A: She -- you know, during the surgery, while she's asleep,
25 she has a breathing tube, you know, that goes in the mouth,

1 you know, down into the trachea to -- to breathe for her
2 during the surgery. Okay? And at some point during the
3 surgery, you know, she bit down on that tube and partially
4 occluded it. Okay? Making it harder to ventilate her, to get
5 air into the lungs.

6 And so we had to stop and let the anesthesiologist, you
7 know, take care of that so that that wouldn't happen again.
8 One of the things that they wanted to do in order to make that
9 safer was to use muscle relaxant drugs -- okay? -- to try and
10 prevent that from happening again, but those drugs interfere
11 with the motor-evoked potentials. Okay?

12 And it was our decision at the time that the -- the --
13 the best course of action was to go ahead and use these muscle
14 relaxants, which would keep us from using the motor-evoked
15 potentials in order to help protect her airway, but then we
16 still had the sensory potentials.

17 Now, the sensory potentials are continuously monitored
18 throughout the entire case. We all do that. They're
19 continuously monitored. The motor potentials, whenever you
20 send a stimulus to the muscles, it causes all the muscles to
21 contract. Okay? So that that leg or arm moves, the whole
22 body moves. So you can't do those continuously throughout the
23 case. If you decide you want to check the motor potentials,
24 you have to stop the surgery and pause because you can't
25 operate, you know, around the spinal cord, you know, if the

1 body is moving.

2 Q: Just tell that to the jury, if the jury wishes to when
3 they examine the records in this case, when they look at the
4 anesthesia record, there's a little -- there's a lot of
5 information on that little piece of paper, but every now and
6 then there's a -- or the neuromonitoring report as well. The
7 TOF, train of four, twitch. What's that?

8 A: So they're -- they're monitoring, you know, the level of
9 the -- of the motor function. I believe that's what they're
10 doing with that to determine the strength of that signal.

11 Q: And that's -- is that when -- when they do a train of
12 four or to see if there's a twitch in the muscles, that's when
13 they do something to -- to stimulate the motor?

14 A: Yeah. They have to -- they have to stimulate, you know,
15 those nerve cells that send action potentials to the muscles,
16 and they will record, you know, when they -- when they do
17 that, when they send that signal to check the muscle function.

18 Q: Okay. Now, when the -- when the rocuronium, which is a
19 paralytic muscle relaxer, I guess is a better word to call it,
20 it -- the -- the motor signals are not going to work. They
21 can't send a signal to the -- to the motor stimulus and try to
22 make the muscles twitch because the muscles have been knocked
23 out with the -- with the medicine; right?

24 A: Right. Once you use that medicine, which was used to
25 help protect her airway, you can't -- you can't run the motor

1 potentials because the muscles don't contract, because they
2 have this muscle relaxant in the system. And we felt that it
3 was safer to do that than to -- than to not do that and have
4 the -- be able to use the motor potentials but still have the
5 risk of her biting and obstructing her airway.

6 Q: Okay. So after that was all adjusted and the rocuronium
7 was given by the anesthesia with -- with your consent,
8 permission, you knew you only had sensory signals?

9 A: Correct.

10 Q: Did you continue your surgery?

11 A: Yes.

12 Q: Explain to the jury what -- how you did your surgery?

13 A: Well, generally, the -- the spinal canal is surrounded by
14 bones. And what you do with a decompressive laminectomy is
15 from the back of the spine, you remove some -- some bone from
16 the back of the spine to open it up -- okay? -- or decompress
17 it, and then you can see inside the spinal canal.

18 And you can also see these bone spurs, which have grown
19 inside the spinal canal and are compressing the spinal cord.
20 And you remove those bone spurs as well, so that the spinal
21 cord is completely free from where it had been compressed.

22 Q: Can you see that okay?

23 A: Yes, sir. Yes, sir.

24 Q: Does that -- is that illustration representative of the
25 kind of surgery you were performing?

1 A: Yes, sir. I mean, do you want me to show them what that
2 is?

3 Q: Oh, yes, sir. Come on down if you --

4 MR. DAVIS: Your Honor, can he do that? Okay?

5 THE COURT: Yes.

6 MR. DAVIS: Thank you.

7 THE COURT: Sorry.

8 MR. DAVIS: That's okay. Thank you.

9 BY MR. DAVIS:

10 A: I mean, it's a little hard to see sometimes if you -- you
11 know, you're not familiar with that, but this one shows a
12 better picture of it. Okay? This is the spine here. These
13 retractors are holding back the skin, this fatty tissue, and
14 the muscle. They're opening that up so that we can see the
15 back of the spine.

16 This is -- this is the back of the spine here. There's
17 not really a side view, but these little bones right here in
18 the back are the ones you can feel those in the middle of your
19 back. Okay? So this is the back of the spine.

20 And at this level, those have been removed. Okay? And
21 this bone here in the back of the spine called the lamina has
22 also been removed so that we can see this, which is the thecal
23 sac, the dura I was talking to you about that covers the
24 spinal cord, the nerves, and holds the spinal fluid in. So we
25 can see that.

1 And you can see this little drill instrument which is
2 removing bone from the back of the spine, and also bone spurs,
3 which would be coming in here from the side, so that this
4 looks nice and free here.

5 Q: Okay. That's good.

6 MR. DAVIS: Next, please?

7 BY MR. DAVIS:

8 Q: Explain to the jury what we're seeing on these
9 illustrations, sir?

10 A: Yeah. This one is -- it shows mainly this bone spur
11 that's growing on the side of the spinal canal and it's
12 growing into the spinal canal, and you can see where it's
13 compressing the spinal cord, the thecal sac that holds in the
14 spinal fluid, and compressing the spinal cord at that level.
15 And that main bone spur right there at the T9-10 level was the
16 main thing that was causing Crystal's weakness and numbness in
17 her legs.

18 Q: And did you remove that bone spur?

19 A: Yes, sir. That's removed. And this is just a picture
20 where it shows the decompression done. All the bone spurs
21 have been removed. Okay? And you can see the thecal sac here
22 and each nerve. These are nerves that are coming out at each
23 level on each side. And that's nice and open and well
24 decompressed. No more pressure on the nerves or the spinal
25 cord.

1 Q: Yes, sir. Thank you. Have a seat.

2 Now, the jury is aware and evidence has been presented
3 that at approximately 10:03, whatever the time actually was in
4 real time, in that time frame, it was announced by Ms. Adkins,
5 the neuromonitoring tech, that the SSEP signals had gone out?

6 A: Right.

7 Q: Tell the jury when you heard that what you thought, what
8 you said, what you did?

9 A: Well, usually when there's an abnormality with the
10 signal, it's something that you were doing during the surgery.
11 And it's pretty obvious that that's -- you know, you were
12 doing some sort of manipulation or something that that caused
13 that. In this case, it was kind of a surprise because I was
14 doing nothing during the surgery that should have interfered
15 with that or caused any problem.

16 And it's like, you know, where -- you know, where did
17 this come from? Now, most of the time when we get an abnormal
18 signal -- okay? -- and we don't see any obvious cause for it,
19 it's usually a false reading or something that's not true.

20 Now, the evoked potentials are -- they're a pretty good
21 way of monitoring the spinal cord and the nerves, but they're
22 not a hundred percent reliable. Sometimes they will tell you
23 that something is wrong when there's nothing wrong, and
24 sometimes they will tell you that everything's fine when
25 actually there has been a problem. So it's sort of -- it's

1 the best way that we have to monitor the nervous system, but
2 it's not perfect.

3 Q: All right. So what was your first thought when that was
4 announced to you, knowing what you were doing or not doing?

5 A: Well, originally, you know, I thought that probably this
6 was a false reading because we weren't doing anything that
7 that -- you know, that would cause this. Looking in the
8 wound, I couldn't see anything, any pressure on the spinal
9 cord, any bleeding, hematoma. Nothing to explain that.

10 So the next step was to ask Teresa, who's the monitoring
11 tech -- okay? -- to look at her equipment and see if there was
12 some issue. Sometimes there is something that they can see
13 that they can correct and get the monitoring back. Okay? But
14 there was no -- you know, she said everything is fine.

15 But even if she says everything is fine, there can still
16 be, you know, an abnormal reading. Okay? It doesn't
17 necessarily mean that -- you know, that everything is back a
18 hundred percent, but it's -- you know, that's all you can do
19 to check that.

20 The next thing, you know, probably looked at -- after
21 looking in the wound was looked at the anesthesia monitoring
22 to look at the blood pressure, the pulse, oxygen level, all
23 those sorts of things. All those sorts of things, they all
24 looked good to me.

25 I asked the nurse anesthetist, Erich that you all met

1 yesterday, I said are there any anesthesia issues, and he
2 said, no, everything is stable. So at that point, my decision
3 was to go back, re-inspect the wound again, see if we saw
4 anything else. Okay? At that point, the only way to really
5 find out, you know, is there a problem, that sort of thing,
6 and where is the problem and what is the problem would be to
7 monitor her to do an MRI scan.

8 So, at that point, I finished up with the surgery, made
9 sure that all the decompression was wide enough to completely
10 decompress the spinal canal, closed the wound, took her to the
11 recovery room. In the recovery room when she awakened --
12 okay? -- she couldn't move her legs. So we knew at that point
13 -- that's the first time we knew for sure that this was --
14 that there was a problem.

15 So we took her down to the MRI scan to scan the spinal
16 canal, the spinal cord, to look and see, you know, what the
17 issue was, and it showed an area of what's called increased
18 signal intensity in the spinal cord at the T9 level, which
19 means there's fluid, extra fluid in the -- in the spinal cord,
20 which is a sign of injury to the spinal cord.

21 Q: Dr. Holbrook, do you recall where -- what level of her
22 thoracic spine you were actually operating on when you were
23 told the -- the signal has just been lost?

24 A: Well, we were down at the bottom, probably down at the
25 T11, T12 area. We were almost finishing up what we were

1 doing, and we were down at that level.

2 This injury to the spinal cord occurred at the top of the
3 surgical site, the T9 level, but there's no way for us to know
4 that while I was doing the surgery. The only -- we had to
5 have the MRI scan to find out, you know, what the problem was
6 and where it was.

7 Q: How would -- how would you characterize in your
8 experience the -- the loss of this signal from -- I mean, was
9 it kind of gradually sliding off a hill or did it just drop
10 off a cliff or what happened?

11 A: Well, it was -- it was completely normal. And a lot of
12 times if there's some issue with the surgery, something that's
13 actually that you can identify that's causing the problem, it
14 will come on gradually, and the evoked potentials will
15 gradually deteriorate, sort of giving you a heads up or a
16 warning that there's a potential problem so that you can look
17 at it and take -- take care of it before it becomes, you know,
18 a more serious problem.

19 Q: All right.

20 MR. DAVIS: Will you pull up the image of the pre-op?
21 Pre-op MRI? The illustration? Yep.

22 BY MR. DAVIS:

23 Q: We've pulled up on the screen, sir, some images from the
24 preoperative MRI done about a month before the surgery, and
25 the jury has seen this before, but at the T9-10, is that the

1 osteophyte that's --

2 A: Yeah. Let me show that.

3 Q: Yeah. Come on down and show us.

4 A: So these are MRI scans of her thoracic spine. This is
5 the front. This is the vertebral body here, and this is the
6 front. This is the belly, the chest, and the lungs out here.
7 And this is the back back here. Okay? This is the vertebral
8 body, the bony body.

9 This little gray area here in the middle is the spinal
10 cord, and this white is the spinal fluid. Okay? And you can
11 see this bony spur, this osteophyte, that is growing on the
12 edge of the spinal canal that's pressing into the spinal canal
13 and pressing on the spinal cord.

14 Q: Do you know or have an opinion about how long that
15 osteophyte had been pushing into and against the spinal cord,
16 displacing it?

17 A: When she had been decompressed about five years earlier,
18 so it wasn't there then, and it slowly grew from that point so
19 that it took five -- five years to get to that size.

20 Q: Okay.

21 A: And it would continue to grow and get bigger and bigger
22 and cause more and more pressure if something wasn't done for
23 it.

24 Q: We've superimposed an artist's illustration on those same
25 images, and we've labeled those. Are those labels accurate?

1 A: Yes, sir. These are just pictures of what we just looked
2 at. The bony vertebral body. This is the front, the belly,
3 the chest up here, and the back back here. And this is the
4 osteophyte, the spur that's pressing on the spinal cord.

5 Okay?

6 You can see the spinal cord here is more of a sort of an
7 oval shape. Okay? Which looks symmetrical. And here you can
8 see where it's kind of pushed over to the other side and being
9 flattened by this bone spur.

10 Q: Do you have an opinion whether or whether or not that
11 bone spur has the potential to cause ischemia to the spinal
12 cord, sir?

13 A: Yes, it does. That's part of how it injures the spinal
14 cord. Some of it is because of direct pressure from the bone
15 spur on it. The bone spur also presses on the small blood
16 vessels in the -- in the spinal cord, so that -- that that
17 area of the spinal cord can't get enough blood supply and
18 causes further damage to it, as well as just the pressure of
19 the bone spur.

20 Q: Is that one of the reasons why it's very important to try
21 to surgically remove that bone spur, sir?

22 A: Correct. If you don't, the bone spur is just going to
23 continue to grow and get bigger and bigger and cause more
24 damage.

25 Q: Thank you.

1 (WHEREUPON, the defendant returned to the witness chair.)

2 BY MR. DAVIS:

3 Q: So you've explained to the jury just a moment ago your
4 recollection of what you did from your perspective when Ms.
5 Adkins said, hey, the signals just went out. We've covered
6 that. Did you ever consider waking her up, sir?

7 A: Well, there's a -- there's a test called a wake-up test
8 where if you have a question during the surgery, you know, is
9 there a problem with the spinal cord, that sort of thing, that
10 you can wake up the patient during surgery to the point where
11 they can actually hear and cooperate when you say, you know,
12 move your hands, your arms, move your legs, that sort of
13 thing.

14 The evoked potentials -- since the evoked potentials have
15 come into use, hardly anybody uses that test anymore because
16 it takes -- you know, in this case, maybe would have taken 1
17 to 3 hours to wake them up enough to do this test. And, you
18 know, what are you doing during those 1 to 3 hours? Really,
19 you're just sitting there waiting. You're really just
20 delaying what you really need to do, which is get the MRI
21 scan, which will show you definitely what's going on.

22 And even, you know, in some of the literature that's been
23 submitted in this case where they're describing this test,
24 it's -- they call it the Stagnara test. It's also called just
25 the wake-up test. Some people call it the Miami wake-up test.

1 At Vanderbilt, we were taught it was just the wake-up test.

2 But in doing this test, let's say you do the test, you
3 take 1 to 3 hours, you wake the patient up, and they can't
4 move their legs. So you know there's a problem, but it didn't
5 tell you what the problem was or where the problem was. You
6 need an MRI scan. So if you've done that test, you're still
7 going to have to put her back to sleep, close the wound, take
8 them to the recovery room, wake them back up, and then take
9 them to the MRI scan.

10 So, really, all it would accomplish is a delay in making
11 the desired -- the final diagnosis. It won't help you any.
12 That's, you know, the exact opposite of what you want to do.

13 I think now with the evoked potentials, that wake-up test
14 I think is still done in some places where they don't have
15 evoked potentials, but even the people who are writing about
16 this test say that since the advent of evoked potentials, it
17 sort of obviates the need for doing this test.

18 And there's some risk to doing the test. Some people
19 wake up and they're combative, pull out their breathing tubes,
20 their IVs, and that sort of thing. So there's some risk to
21 it, and you don't really get any information out of it in this
22 case, which would help us to treat this -- this complication.

23 Q: Yes, sir. Is that why you continued to finish your
24 surgery to get her to the recovery room?

25 A: Well, we finished. We wanted to go ahead and complete

1 the decompression to make sure that there was no other areas
2 of pressure on the spinal cord. Okay? And then get her to
3 the recovery room and see, you know, is this a -- is this a
4 problem or is this just a false reading?

5 Q: Did you ask anybody to get Dr. Root, the M.D. anesthesia,
6 into the operating room when the signals were lost?

7 A: No. After I looked at the monitor, myself and the nurse
8 anesthetist said that there were no issues with the
9 anesthesia, everything was stable. Then I'm going back to --
10 to the surgery, re-examining the wound, see if there's another
11 issue.

12 If there's no anesthesia issues, there's nothing else for
13 the anesthesiologist to do. And even looking back on it
14 today, even if she'd been in the room the whole time, there's
15 nothing different that she would have done.

16 Q: Dr. Holbrook, let's talk just a little bit about the
17 anesthesia care team, Erich Starn, who testified yesterday.
18 Dr. Root, who will testify later in this trial, the M.D.
19 anesthesia. You're familiar with both of those people prior
20 to July 28th?

21 A: Yes, I worked with both of them on a regular basis over
22 the years.

23 Q: All right. At the time of surgery and this surgery, any
24 spinal surgery that you perform, is the M.D. anesthesia always
25 in the room the whole time?

1 A: No. Most of the time they're not in the room.

2 Q: But Mr. Starn, the certified registered nurse
3 anesthetist, was?

4 A: Yeah, an anesthetist was there the whole time.

5 Q: All right. Explain as a neurosurgeon your understanding
6 of the anesthesia team's role in a surgery like was performed
7 on Ms. Goodwin on July 28th, 2016?

8 A: Well, they're responsible for putting the patient to
9 sleep and monitoring the patient while they're asleep and then
10 waking them up at the end of the procedure.

11 Q: Do you rely on the anesthesia team to monitor vital signs
12 from minute to minute?

13 A: Yes. That's part of their job.

14 Q: And what would be included in those vital signs that they
15 are to monitor?

16 A: Well, it would be the blood pressure, the pulse, oxygen
17 level. Those sorts of things are what they -- what they
18 monitor and focus on.

19 Q: And do they have machines surrounding them at the head of
20 the bed that they can look at to monitor all these various
21 different things?

22 A: Yeah. They have a monitor so that they can look at what
23 the values are of those various parameters that they're
24 measuring.

25 Q: All right. And if there's an abnormality in the vital

1 signs, would you rely upon and expect the anesthesia care
2 person in the operating room to let you know?

3 A: If it was significant, they would let me know. A lot of
4 times, if it's just some minor issue, they'll go ahead and
5 take care of them themselves. But if they think it's a
6 significant issue, then they'll let me know.

7 Q: Okay.

8 A: Like with the breathing tube. They had an issue with the
9 breathing tube, and they said, hey, we got an issue with this
10 breathing tube. We need to stop the surgery, take care of
11 this. So -- okay. So they let me know that.

12 Q: Did they let you know anything else during the surgery,
13 sir?

14 A: No. Everything else was stable during the surgery.

15 Q: All right. So at any point in time during the surgery
16 did any member of the anesthesia care team, either Erich Starn
17 or Dr. Root, who was in and out of the operating room at
18 various times during the surgery, did any -- any member of the
19 anesthesia care team say, Dr. Holbrook, we've got a problem
20 with low blood pressure?

21 A: No. There was never a -- there was never a problem with
22 low blood pressure. The blood pressure was maintained in a
23 safe range the entire time.

24 Q: Is low blood pressure the same as low blood flow?

25 A: No, not -- not -- not exactly. Pressure -- just mainly

1 the pressure and flow is the volume.

2 Q: Okay. Have you reviewed the blood pressures from the
3 anesthesia in this case?

4 A: Yes.

5 Q: As a neurosurgeon, do you see an issue with low blood
6 pressure during your surgery with Crystal Goodwin?

7 A: No, sir. And really, looking at the blood pressure,
8 that's not something that I monitor or treat during the
9 surgery. My total attention is devoted to doing the surgery,
10 and anesthesia monitors and treats this, you know, and treats
11 any blood pressure issues as they -- as they think it's
12 indicated.

13 Q: Okay. Doctor, as a neurosurgeon, do you have an opinion
14 whether or not there are risks to the patient if the patient
15 becomes hypertensive, high blood pressure during the surgery?

16 A: Yes.

17 Q: What would the -- what would be those risks?

18 A: It can cause bleeding. If it's high enough, it can cause
19 a stroke, that sort of thing. Damage to -- damage to organ
20 systems. The brain is particularly susceptible.

21 Q: Well, if a patient indeed has hypo -- low blood pressure,
22 hypotension, low blood pressure during a surgery like this, if
23 it's low enough for long enough, can that cause problems for
24 the patient?

25 A: It can. If the blood pressure is low enough, the -- you

1 -- the heart -- the heart would stop. So it's possible.

2 Okay? But the blood pressure in this case was not low. If we
3 look at some of the evidence that's been submitted by some of
4 the anesthesiologists and, in this case, I think one of the
5 studies that they presented said that --

6 MR. GOINGS: Your Honor, this witness is talking about
7 what other witnesses testified, experts. He's not been
8 qualified as an expert in this case, and he -- this is
9 actually pitting -- pitting a witness. So I would object to
10 the line of questioning.

11 THE COURT: Mr. Davis?

12 MR. DAVIS: Thank you, Your Honor.

13 And I probably missed this, but we would ask the Court to
14 take judicial notice of the fact that Dr. Holbrook is a board-
15 certified and experienced neurosurgeon and able to offer
16 opinions. We would also submit, if I could lay a foundation,
17 that as an expert, he should be able to testify about material
18 he has reviewed that forms the basis of any of his opinions.

19 THE COURT: Well, I don't know that that's an appropriate
20 thing for the Court to take judicial notice of.

21 MR. DAVIS: All right.

22 THE COURT: And you may offer him -- tender him as an
23 expert.

24 MR. DAVIS: I'd be happy to do that.

25 THE COURT: But that has not yet been done.

DR. THOMAS J. HOLBROOK - DIRECT BY MR. DAVIS

1 MR. DAVIS: I'll be happy to do that, Your Honor.

2 Your Honor, we'd offer Dr. Holbrook to the Court as an
3 expert in neurosurgery.

4 MR. GOINGS: Your Honor, he has not been designated ever
5 in this case as an expert that would be called to testify as
6 an expert. He's hired doctors to be experts, and he's
7 testified that he doesn't even know the cause. So he can't
8 now testify about the cause, and I would object to this line
9 of questioning. Thank you.

10 THE COURT: Mr. Davis, has he ever been designated as an
11 expert during the preparation for the trial of this case?

12 MR. DAVIS: Not that I'm aware of, Your Honor, but he's
13 the defendant neurosurgeon and should be able to give his
14 opinions on his care.

15 THE COURT: On the care that he's rendered, but not
16 generally, as an expert would, about other experts' opinions.
17 So he will not be admitted as an expert in the trial of this
18 case. He can testify about his experiences, his treatment, et
19 cetera, but not about the opinions of other experts, whether
20 someone's right or wrong in their expertise, simply what he
21 would do or did do, et cetera. Understood?

22 MR. DAVIS: Yes, ma'am.

23 THE COURT: Okay.

24 MR. DAVIS: Thank you.

25 THE COURT: I just want to make sure I'm being clear.

1 MR. DAVIS: I got you.

2 THE COURT: Okay. Okay.

3 MR. DAVIS: Good. Thank you.

4 THE COURT: You may continue.

5 MR. DAVIS: Thank you.

6 THE DEFENDANT: So can I talk about a research article
7 that was presented?

8 MR. DAVIS: Who was presenting it?

9 THE DEFENDANT: I believe that was Dr. Rose.

10 MR. GOINGS: No, Your Honor. That's what he's -- that's
11 my objection, and I would -- I would move to strike his -- his
12 testimony on this.

13 THE DEFENDANT: I mean, it's in -- it's in his
14 deposition.

15 MR. DAVIS: Did you read it?

16 THE DEFENDANT: Yes, sir. I read the deposition.

17 THE COURT: Yeah. That objection is sustained.

18 MR. DAVIS: Okay. No, we can't talk about that.

19 THE DEFENDANT: Okay.

20 BY MR. DAVIS:

21 Q: Doctor, in all of your decompressive laminectomies,
22 thousands of them, sir, including this one, have you ever seen
23 or known of blood pressure in the ranges that were recorded in
24 this surgery on July 28th cause or result in a stroke of the
25 spinal cord?

1 A: No. And there's -- there's -- really there's no evidence
2 that a low blood pressure has ever caused an isolated stroke
3 or infarct in the spinal cord without causing a problem with
4 some other issue. Okay? There's no evidence that that has
5 ever happened.

6 Q: Have you ever operated on patients with hypertension
7 similar to the levels of Ms. Goodwin?

8 A: Yes.

9 Q: Any of those spine patients ever suffered cord stroke as
10 a result of low blood pressure during any of your operations?

11 A: No. I've never seen that happen. I've never heard that
12 happen. And there are probably ten medical doctors that have
13 testified in this trial, and --

14 MR. GOINGS: Your Honor, again --

15 A: -- none of them have ever seen that happen.

16 MR. GOINGS: -- he can't testify --

17 THE COURT: Hold on, Dr. Holbrook.

18 MR. GOINGS: Objection.

19 THE COURT: That objection is sustained. So his lifetime
20 career experience is one thing, but he cannot comment on what
21 medical journals say, what the evidence is, what he heard from
22 anyone else. This is only his experiences because he is not
23 qualified or has -- well, I don't want to say he's not
24 qualified. He is not admitted as an expert in the trial of
25 this case.

1 MR. DAVIS: Thank you, Your Honor.

2 BY MR. DAVIS:

3 Q: Dr. Holbrook, in your opinion, would hypoperfusion, low
4 blood perfusion or lack of perfusion of blood to other areas
5 of the body affect any other organs in addition to the spinal
6 cord, if it's causing some issue with the spinal cord?

7 A: What was that now? Say that again?

8 Q: Assume for the sake of the question that hypoperfusion,
9 low blood perfusion, causes some injury to the spinal cord.

10 A: Right.

11 Q: Do you have an opinion whether or not that would also
12 affect other organs in the body?

13 A: Yes.

14 Q: What other organs would be affected?

15 A: I think probably the brain would be the most susceptible.

16 Q: Is there any evidence of any injury to Ms. Goodwin's
17 brain?

18 A: No. There was no evidence of any injury to any other
19 body system.

20 Q: Well, what about the kidneys?

21 A: Yeah, I don't -- there was no evidence of any injury to
22 the kidneys.

23 Q: But she only had 80cc of urine in a four-hour surgery.

24 A: I mean, anesthesia monitors and deals with any issues
25 with urine output, but as far as I can tell, there was no

1 issue with the urine output in this case. And if you look at
2 her last surgery, her last spine surgery, the urine output was
3 even lower in that case than it was in the one where she had a
4 complication.

5 Q: I'm just kind of going through some questions that I
6 think you've already answered. So bear with me just a moment.

7 Who is responsible in the operating room, sir, for giving
8 fluids or medications to either raise or lower blood pressure,
9 if -- if that is indicated?

10 A: That's something that anesthesia does.

11 Q: It's not something you do?

12 A: No, I'm -- my total time and focus is on the surgery.

13 Q: Did you ever tell the anesthesia team increase her blood
14 pressure?

15 A: There was never any reason to do that. And I think
16 increasing the blood pressure in this particular case would
17 have made it worse instead of better.

18 Q: Why is that?

19 A: Well, if you look at what -- what the most likely cause
20 for this was, this -- you know, a -- it's a vascular injury to
21 the --

22 MR. GOINGS: Your Honor, I would object to this witness
23 now telling the jury what the cause of this was when he
24 previously testified that he does not know the cause, and now
25 he's --

1 THE COURT: Oh.

2 MR. GOINGS: -- giving his opinion.

3 THE DEFENDANT: Well, the most likely cause.

4 THE COURT: Overruled.

5 BY MR. DAVIS:

6 Q: Go ahead. Go ahead, sir.

7 A: There's -- there's no test that we could do in this case
8 that would tell us definitely a hundred percent this is what
9 caused this issue. Okay? So we're sort of going by what we
10 think, looking at all the evidence, what is the most likely
11 cause of this?

12 Now, when I first -- you know, during the surgery, while
13 I was still doing the surgery, I'm thinking of what -- what
14 possibly could this be? And I want to try to look mainly at
15 what could this be that I could do something about to reverse
16 the effects of it. The main thing that could come on so
17 quickly like that that I could do something about would be a
18 hematoma or a blood clot within the spinal cord. Now, if that
19 happened to be the case, raising the blood pressure would
20 cause more bleeding and make it worse. Okay?

21 So once we got the MRI scan, we could tell that that was
22 not the case. There was no evidence of any abnormal bleeding
23 or blood clot. So we're left with what other causes could it
24 be, and any other cause would be a vascular cause, something
25 related to the blood system. Okay?

1 You know, so there's really three different vascular
2 scenarios that have been talked about in this case. Okay?
3 One is the low blood pressure that -- that Brink and Robert
4 have talked about. The other thing would be a typical stroke,
5 a common stroke like you see, you know, in the brain where
6 there's some sort of an embolus or a blood clot or a
7 cholesterol plaque that has broken off and plugged up one of
8 the blood vessels, sort of your typical classic stroke. And
9 then there's the reperfusion injury, which is also vascular
10 related.

11 Now, if we look at the total of all the different things
12 that it could be and all the evidence that we have back during
13 the surgery, it looked like the most common -- the most likely
14 thing that this would be would be a stroke, a common stroke
15 where there was some blockage of one of the feeding blood
16 vessels.

17 We didn't have any evidence of that, and there was no
18 test that was done that would definitely show us that that's
19 what it was, but based on all the evidence we have, we thought
20 that was the most likely cause. Okay? Since the surgery --
21 okay? -- there's been new articles and research that have been
22 written --

23 MR. GOINGS: Your Honor, it's this --

24 A: -- about this, which makes it more likely --

25 MR. GOINGS: And --

1 THE COURT: Stop.

2 A: -- that it was a perfusion injury.

3 THE COURT: Okay. Stop. Dr. Holbrook, when you hear the
4 word objection, you have to stop talking.

5 THE DEFENDANT: Yes, ma'am.

6 THE COURT: So that I can rule on the objection, even if
7 you're in the middle of a sentence.

8 Mr. Goings, your objection is?

9 MR. GOINGS: Same objection. He's now talking about
10 research articles, opinions, new evidence has come out. And
11 again, I would object and move to strike the testimony.

12 THE COURT: Yes, sir. That objection is sustained.

13 Ladies and gentlemen, disregard that last answer, at
14 least the last part of that answer given by Dr. Holbrook where
15 he starts to talk about newer articles. From that point on,
16 you must disregard that testimony.

17 THE DEFENDANT: And that's sort of -- that's sort of the
18 heart of what this is about.

19 MR. GOINGS: Now the witness is arguing with your ruling,
20 Judge.

21 THE WITNESS: Yes, ma'am.

22 BY MR. DAVIS:

23 Q: Dr. Holbrook, just answer my questions.

24 A: Okay. Sorry.

25 Q: That's all right. Dr. Holbrook, what is a reperfusion

1 injury?

2 A: Well, a reperfusion injury is a type of vascular injury.
3 You can see where this bone spur, this osteophyte was pressing
4 on the spinal cord. So not only did it injure the spinal cord
5 by just the compressive force -- okay? -- that's on the spinal
6 cord, but it's also compressing some of the small blood
7 vessels in the spinal cord -- okay? -- and causing further
8 injury to them.

9 Now, the central nervous system, the brain and the spinal
10 cord, have the ability to sort of autoregulate their own blood
11 supply, more so than other tissues, to a degree. Okay? Not
12 totally, but to a degree, so that when the tissue senses that
13 we need more blood -- okay? -- the tissues, the brain, spinal
14 cord needs more blood, then it can dilate the blood vessels
15 that supply it and cause an increase in the blood flow. Or if
16 the tissue senses, hey, we're getting too much blood flow, we
17 don't need this much, it can cause a constriction of the -- of
18 those blood vessels to limit the flow.

19 Now, in a case like this, where there's been pressure on
20 those blood vessels, they -- that tissue is not getting enough
21 blood. So it has maximally dilated those blood vessels.
22 They're trying to get as much blood to that area as they can.
23 And after they have been compressed for a long period of time,
24 they lose the ability to autoregulate so that when that bone
25 spur is removed -- okay? -- and that allows a normal blood

1 pressure to resume into those tissues, that normal blood
2 pressure is too high. Okay? The tissues cannot handle that
3 much blood flow.

4 And so that causes blood products, plasma, fluid to leak
5 out of those blood vessels into the tissue. Okay? And that
6 causes pressure in the tissue, almost like you would take a
7 needle and syringe with some water and inject it into the
8 spinal cord, causing fluid and tension within the cord, which
9 would damage those cells not only from pressure on them, but
10 from further restricting blood flow.

11 So the problem is too much blood flow. The blood
12 pressure is too high. Okay? So if you then elevate the blood
13 pressure on top of that, you're going to cause more fluid to
14 leak out and cause more damage to the area.

15 Q: In the 2009 surgery, there was no osteophyte like this;
16 correct?

17 A: In 2009?

18 Q: Right.

19 A: She did have some osteophyte formation, but not as
20 prominent as this.

21 Q: How about 2011? Anything like that?

22 A: She had pressure on it, but not -- not as much. There's
23 really -- with the reperfusion injury, there's -- there is no
24 way to predict that that'll happen. There's no tests. Okay?
25 There's no way to -- there's nothing else that you can do to

1 prevent something like that from happening. And once it's
2 happened, there's really nothing else that you can do to
3 minimize the effects of it, other than what we did in this
4 case.

5 Q: Which was?

6 A: Which was to minimize the effects afterwards.

7 Q: Right.

8 A: We gave her some steroids and the therapy and those sorts
9 of things.

10 Q: Okay. When Crystal was moved from the operating room to
11 the recovery room, who was tending to her getting awakened
12 from anesthesia?

13 A: It would be the nurses in the recovery room would be
14 tending to her at her bedside.

15 Q: Does M.D. anesthesia come in at the -- sort of the end of
16 the surgery in the operating room and is she involved at that
17 point --

18 A: Yeah.

19 Q: -- in helping the patient wake up?

20 A: Yeah, usually they do.

21 Q: And do they then take the patient to the recovery room?

22 A: Yes. The nurse anesthetist and the circulating nurse
23 usually are the ones that take the patient to the recovery
24 room.

25 Q: Okay. At some point when they got her awake, did they

1 ask you to come to the bedside?

2 A: Well, I was -- I was already there.

3 Q: All right. What happened?

4 A: When she waked up enough, I examined her and could tell
5 that she could not move her legs. And at that point, we
6 ordered an emergency MRI scan of the area to look and see why.

7 Q: What did the MRI scan tell you, if anything?

8 A: The MRI scan showed an area of what's called increased
9 signal intensity. I've heard some of the other people --
10 experts testify about that, which means the spinal cord is
11 normally gray, but in this case with the fluid leaking out,
12 the fluid -- it looks white, and so it has the appearance of
13 white in the spinal cord and swelling of the spinal cord is a
14 little bit bigger diameter because of the swelling, and this
15 white fluid that's inside the spinal -- the spinal cord is a
16 sign of damage.

17 Q: What was your goal to take her -- for taking her back to
18 the operating room?

19 A: In looking at the MRI scan, it looked like there may be
20 another area of scar tissue that may be causing some further
21 issue, and it was my judgment that, you know, maybe this was
22 causing a problem, maybe it wasn't, but just to be on the safe
23 side and make sure that the spinal cord was completely free,
24 to give it the best chance to heal.

25 Q: Doctor, as a neurosurgeon, do you have an opinion about

1 the relative blood supply to the -- at the level of the T9,
2 the thoracic level? Do you have an opinion about that level
3 of the spine?

4 A: Well, if you look at the blood supply of the thoracic
5 spinal cord, it has a very good blood supply overall. You
6 rarely see any issues with the spinal cord having a problem
7 with blood supply. And you see that in the thoracic spinal
8 cord there are 12 vertebrae stacked, each one on top of each
9 other, and between each one of those there is a small blood
10 vessel that comes from around the front, the aorta in the --
11 in the belly and the chest, that comes around and goes into
12 the spinal canal, one on each side.

13 So at each level there are two blood vessels, one coming
14 in from each side to supply blood supply to the spinal cord.
15 Okay? And those blood vessels will interconnect. Okay? So
16 that if you maybe took one or blocked one of those little
17 blood vessels off, the others, the adjacent ones, would have
18 enough blood supply to compensate for that. So it sort of has
19 a -- an overlap of blood supply.

20 Now, there are two areas in the spinal cord that have
21 overall a better blood supply than the rest. One at the top,
22 the T1 level, there's a larger artery there. And at the T9
23 level is the largest artery and the best blood supply in the
24 whole spinal thoracic spinal cord. It's called the Adam, the
25 artery of Adamkiewicz. It's such a big artery that it has its

1 own name. So the best blood supply and the area of the spinal
2 cord that has the best blood supply is T9, which is where the
3 injury occurred.

4 Q: All right. After Crystal was admitted to the hospital
5 following her recovery from the second surgery performed on
6 her, did you have a number of conversations with her and/or
7 her family members?

8 A: Yes, I did.

9 Q: All right. The jury has seen and you've seen the cell
10 phone video that was taken at some day -- on some day after
11 the operation by her daughter. It shows part of what you were
12 saying at that -- wherever that day was.

13 A: Well, one thing I can say to you about talking to the
14 family on the day of the surgery --

15 Q: I meant to ask you about that.

16 A: Yeah. When -- when this first occurred. So --

17 MR. GOINGS: Your Honor, I object to hearsay. What he
18 said to the family is hearsay because that's not a party, the
19 family. So I would object to that.

20 THE COURT: Sustained.

21 BY MR. DAVIS:

22 Q: Did you have occasion -- if I could lay a foundation --
23 to talk to the family immediately after the first surgery?

24 A: Yes.

25 Q: What do you recall saying to them? Not what they said to

1 you.

2 A: Right.

3 MR. GOINGS: It's still an out-of-court statement.

4 THE COURT: It's still hearsay. Sustained.

5 BY MR. DAVIS:

6 Q: You heard testimony earlier in this case from -- I think
7 it was Crystal's mom, maybe others, that you said that surgery
8 was just fine. No complications, no problems. And you
9 remember that?

10 A: I remember that, and I remember exactly what I said to
11 them.

12 Q: Did you say that?

13 MR. GOINGS: Your Honor, same objection. And move to
14 strike the answer because it's hearsay.

15 THE COURT: Sustained.

16 Ladies and gentlemen, disregard that last series of
17 questions and attempted answers.

18 BY MR. DAVIS:

19 Q: But you did have a conversation with them; correct?

20 A: Yes, I did. More than -- more than one on that same day.

21 Q: Sure. Thank you.

22 A: Can I tell you what I told them?

23 MR. GOINGS: Object.

24 MR. DAVIS: Apparently not. The Court's ruled. So we're
25 going to abide by the rule.

1 THE DEFENDANT: Okay.

2 THE COURT: Well, the rules of evidence dictate that he
3 cannot. That it's an out-of-court statement offered for the
4 truth of the matter asserted, which is the exact definition of
5 hearsay.

6 BY MR. DAVIS:

7 Q: Okay. That cell phone video, was that the only time you
8 talked to Crystal and/or her family about her condition?

9 A: No. I had several discussions with them when they were
10 in the hospital and even later when they were in the office
11 after this.

12 Q: Well, why did you say in that video that day -- I think
13 if I got it quoted right, it was something that we did during
14 surgery. What did you mean by that?

15 A: Well, obviously it was something that happened during the
16 surgery. Okay? If we hadn't done the surgery, it wouldn't
17 have happened. Okay? And I went over with them a number of
18 different things that it could be. Okay? But still, we
19 didn't have any test or any definite evidence to say that any
20 one particular thing was what caused this. Okay?

21 But looking back now, I think the act of removing this
22 bone spur and the pressure on the spinal cord is what allowed
23 this flow of normal blood pressure to come into the spinal
24 cord that the spinal cord could not handle because it had lost
25 its ability to regulate that or autoregulate that blood

1 pressure and allowed that fluid to leak out into the spinal
2 cord, which is what did the damage.

3 Q: All right, sir. Well, when you said something we did,
4 were you saying and intending that it's something you did
5 wrong?

6 A: No, it's nothing that we did wrong, but it's removing the
7 bone spur was the part of the surgery. That's what the
8 purpose of the surgery was. There was no way to know that
9 doing that would cause this reperfusion injury. It's a very
10 uncommon type of injury. Right? But with all of the evidence
11 that we have in this case and all of the data --

12 MR. GOINGS: Your Honor, again --

13 A: -- I think that's most likely.

14 MR. GOINGS: -- his testimony is -- is objectionable. I
15 mean, he's doing this again, and I move to strike his -- his
16 -- his testimony on this.

17 THE COURT: Yeah. The objection is sustained.

18 Again, you can't backdoor your way into telling what you
19 told the family. You cannot testify that way.

20 THE DEFENDANT: Well, this -- no.

21 MR. DAVIS: Dr. Holbrook --

22 THE COURT: I'm completely with you, sir. That's my
23 ruling.

24 MR. DAVIS: Don't address the Court.

25 THE DEFENDANT: I'm sorry.

1 MR. DAVIS: I'm here. Okay? We address the jury.

2 Answer my questions.

3 THE DEFENDANT: Yes, sir.

4 BY MR. DAVIS:

5 Q: Well, Doctor, why did you put in your records and why
6 have you spoken about, well, I think this was an ischemic
7 injury? Why did you keep saying that?

8 A: Well, it is a type of ischemic injury. Okay? There's
9 different types. Okay? And I talked to you about the three
10 different types that you've heard about in this. You know,
11 the low blood pressure. You've heard about an embolic stroke,
12 something that would block off one of the blood vessels, such
13 as typically you see in the brain, and also a reperfusion
14 injury. Those are all types of vascular injuries.

15 Q: Thank you.

16 A: Do you want me to tell you about the one in the video?

17 Q: Sir?

18 A: Is that what you want me to do? Tell you about the one
19 we talked about in the video that her daughter took?

20 Q: All right. I think that's what I was asking you about.

21 A: Yeah, well, in that I was describing to her, you know,
22 things that possibly could have caused this. Okay?

23 Q: Okay. Thank you.

24 THE COURT: Let's pause here, ladies and gentlemen.

25 MR. DAVIS: Sure.

1 THE COURT: Let's take a break. Please return to your
2 jury room. Do not discuss the case.

3 Everyone else remain in the courtroom.

4 (WHEREUPON, the jury exited the courtroom at 11:27 a.m.)

5 THE COURT: All right, folks. It's very much my
6 intention to allow trials to progress as they will and allow
7 lawyers to ask the questions they want to ask and the
8 witnesses to give the answers that are appropriate to the
9 questions.

10 However, when there is an objection, the witness must
11 stop speaking and -- and that's whether you hear the word
12 objection. I know that's the first way I phrased it, but when
13 opposing counsel stands up during the midst of your -- in the
14 midst of your sentence, that is him lodging an objection. You
15 have to stop talking immediately, number one, so that I can
16 hear his objection. Number two, so that I can rule on the
17 objection and determine whether what you're about to say is
18 appropriate for the jury to hear. Number three, because the
19 court reporter cannot transcribe everybody talking at the same
20 time.

21 In addition, once an objection has been sustained
22 multiple times, once -- and in this case, I've given the
23 reasoning for my ruling. You cannot just decide that you're
24 going to give the testimony anyway. I don't know, but you
25 tried ten different ways to tell the jury what you told the

1 family on that day, and I have specifically instructed the
2 witness that that is not appropriate testimony in this case.

3 So govern yourselves accordingly. We're going to take a
4 15-minute break. I'll see you then.

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

7 THE COURT: Let's get Dr. Holbrook back up on the stand.
8 You can bring the jury.

9 (WHEREUPON, the jury entered the courtroom at 11:50 a.m.)

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

11 THE COURT: Thank you.

12 All right. Yes, Mr. Davis. You may resume.

13 MR. DAVIS: Thank you, Your Honor. May it please the
14 Court.

15 BY MR. DAVIS:

16 Q: Dr. Holbrook, do you have an opinion whether or not
17 spinal stenosis that Crystal had going into your surgery of
18 July 28th, 2016, put her at any increased or greater risk for
19 spinal cord injury?

20 A: Yes, it does.

21 Q: Doctor, do you have an opinion whether or not this was a
22 reperfusion injury?

23 A: I think the most likely cause for this complication was a
24 reperfusion injury.

25 MR. DAVIS: Answer any questions that counsel may have

1 for you. Thank you, sir.

2 THE COURT: Mr. Goings? Mr. Goings, do you need this
3 monitor?

4 MR. GOINGS: I do, Your Honor.

5 THE COURT: Okay.

6 MR. GOINGS: I was just -- may it please the Court? I
7 was just --

8 THE COURT: Yes, sir.

9 MR. GOINGS: Thank you, Your Honor.

10 CROSS-EXAMINATION

11 BY MR. GOINGS:

12 Q: Dr. Holbrook, can you explain to me and the members of
13 this jury why you felt the need to perform a criminal
14 background check on Crystal Goodwin?

15 A: I didn't know that. I was not aware of that.

16 MR. DAVIS: Your Honor, this -- this has never been
17 disclosed in any kind of discovery.

18 MR. GOINGS: It's his criminal background check that he
19 produced to me that they did on this lady in a wheelchair.

20 THE COURT: The objection is overruled.

21 BY MR. GOINGS:

22 Q: I'll show you that you produced it, Doctor. Crystal
23 Goodwin, SLED Report. Name. Date of birth. Social security
24 number. South Carolina Law Enforcement Division. No arrest
25 data found. Did it surprise you to know that she's never been

1 arrested?

2 A: I didn't know anything about any of that.

3 Q: Well, let me show you your discovery responses in
4 discovery, Doctor. Defendant Holbrook's and Midlands
5 Orthopedics Answers to Discovery Request.

6 You are requested to set forth a list of photographs,
7 plats, videos, sketches, and other prepared documents in your
8 possession or Midlands' possession that relate to any claim or
9 defense in this case.

10 Do you see that?

11 A: I see that.

12 Q: Do you see what I highlighted, Doctor?

13 A: I see that.

14 Q: Did you think Crystal Goodwin was a bad person?

15 A: This is the first time I've heard anything about that.

16 Q: Doctor, these were provided in 2019. This is the first
17 time you've heard about this?

18 A: It's the first time I've heard about any criminal checks.
19 Yes, sir.

20 Q: Doctor, the article regarding what to do when the signal
21 goes out, you've seen this document before, haven't you?

22 A: Yes, sir.

23 MR. DAVIS: Your Honor, I'm going to object. This is an
24 article. He's not an expert, and I object.

25 THE COURT: The objection is sustained.

1 MR. DAVIS: Thank you.

2 BY MR. GOINGS:

3 Q: Doctor, you're familiar with the steps that you as a
4 neurosurgeon should take for neuromonitoring signal loss,
5 aren't you?

6 A: Well, those are the steps from your article I've seen.

7 Q: I'm not asking about the article. You know about these
8 steps; right?

9 A: Well, that's the first time I'd seen that listing of
10 steps was when you gave me this article.

11 Q: And, Your Honor, that -- Judge -- I mean, Dr. Holbrook,
12 that article is in a published, peer-reviewed medical journal,
13 isn't it?

14 MR. DAVIS: Your Honor, that's --

15 A: I'm not sure that that's --

16 MR. GOINGS: He opened the door. He opened the door,
17 Your Honor.

18 MR. DAVIS: I'm trying to get my objection on the record,
19 Mr. Goings.

20 Your Honor, he continues to ask about an article. We
21 couldn't talk about it. I respect your ruling, but I think
22 it's not appropriate.

23 MR. GOINGS: I asked about the steps.

24 THE COURT: But now you're asking about the article?

25 MR. GOINGS: No. I asked about the steps of what to do

1 when the signal runs, and then he talks about the article.

2 And I didn't ask him about the article, but he's bringing the
3 article into it. So now I need to continue on, but brief,
4 Your Honor.

5 THE COURT: Well, no, that objection is sustained. We're
6 not going to talk about the article. You can ask him about
7 whatever steps you want, but not the article.

8 BY MR. GOINGS:

9 Q: And you're familiar that the steps of what to do in
10 neuromonitoring signal loss is to first check the equipment;
11 correct?

12 A: That's what I did.

13 Q: And to assess any anesthesia changes and improve
14 perfusion?

15 A: I assessed anesthesia changes. I looked at the monitor
16 myself, and I asked the nurse anesthetist if there were any
17 anesthesia issues. He said they were all stable.

18 Q: Now, Doctor, when Crystal Goodwin came in to the hospital
19 that morning before surgery, you did nothing to determine
20 Crystal's baseline blood pressure, did you?

21 A: That's something that anesthesia does.

22 Q: It's something that you do as well? Everybody determines
23 the baseline blood pressure; isn't that true?

24 A: Well, there are different ways to determine it, depending
25 on what your objective is.

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 Q: Doctor, when we took your deposition -- and I can give
2 you a certified copy of your deposition. The court reporter
3 has it. So you can read along. When I asked you that
4 question, did you determine Crystal Goodwin's baseline blood
5 pressure?

6 MR. GOINGS: Let the record reflect that I'm -- I'm
7 opening Court's Exhibit 9, which is the certified copy of the
8 deposition of Dr. Thomas Holbrook, taken on May 11th, 2020.

9 THE COURT: Yes, sir.

10 BY MR. GOINGS:

11 Q: So that's just what anesthesia does, but this is what you
12 said, Doctor, when we took your deposition. I want you to
13 look at line -- page 28, line 15. I'm going to read the
14 question. I want you to read your answer.

15 A: I didn't get there yet. Hold on. I'm on page 28. Where
16 now?

17 Q: Line 15.

18 A: Okay.

19 Q: The question was: Do you agree that when determining
20 where to keep a patient's blood pressure during anesthesia,
21 the patient's historical blood pressure should be considered.

22 And what was your answer?

23 MR. DAVIS: Your Honor, with all due respect, I really
24 hate to interrupt his question, but that is exactly what was
25 played to the jury when this portion of his deposition was

1 played in this plaintiffs' case.

2 THE COURT: Yes, sir. He may still use it for
3 impeachment.

4 You may proceed. The objection is overruled.

5 MR. DAVIS: Thank you.

6 BY MR. GOINGS:

7 Q: I will read it again, Doctor, since there was an --

8 A: Okay.

9 Q: -- interruption there, and I want you to read your
10 answer.

11 The question is: Do you agree that when determining where
12 to keep a patient's blood pressure during anesthesia, the
13 patient's historical baseline blood pressure should be
14 considered?

15 And what was your answer under oath then?

16 A: It is considered. It's considered by anesthesia.

17 Q: No. Hold on a second. It said -- no. It says it is
18 considered; right?

19 A: Yeah. By anesthesia.

20 Q: I want you to read literally what's on the paper. So if
21 it's black and a letter, read it. Don't add anything. So it
22 says: It is considered. Right?

23 A: Yes, that's what it says.

24 Q: Okay. Then the next question was: And it should be
25 considered? And read what you said, Doctor?

1 A: It is considered. I mean, that's just a normal part of
2 the process. Every patient's baseline blood pressure is
3 observed before surgery, but that's -- anesthesia considers
4 it.

5 Q: We're getting there, Doctor.

6 A: Okay.

7 Q: Now, the next question was: How far would one go back to
8 look at baseline blood pressure? And what was your answer?

9 A: I don't know. That's -- anesthesia does that.

10 MR. GOINGS: Your Honor, we'd instruct the witness to
11 read what is on the paper and not add language outside of the
12 transcript. That's what he's doing, which is highly improper.

13 THE COURT: Dr. Holbrook, you need to respond exactly to
14 the question that is asked, and what he's asking you to do
15 right now is to read. He's not asking --

16 THE DEFENDANT: Yes, ma'am.

17 THE COURT: -- of your current knowledge. He may get to
18 that or maybe your attorney will get to that at some point,
19 but at the moment, he's asking you to read something.

20 THE DEFENDANT: Yes, ma'am.

21 THE COURT: If you'll do that.

22 THE DEFENDANT: Can I -- can I explain my answers?

23 MR. DAVIS: See, I just have -- it's just a logistical
24 question. What page and line number are you now?

25 MR. GOINGS: We're just now flipped to the next page.

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 MR. DAVIS: Okay. Well, I didn't catch the transition,
2 so I need to know.

3 MR. GOINGS: Oh, we're just reading the transcript. Now,
4 we're reading the transcript.

5 MR. DAVIS: Okay. I just need to know the reference,
6 sir.

7 MR. GOINGS: Oh, all right. So when we started at page
8 28 and when we turned to the next page, that's on page 29.

9 MR. DAVIS: Okay. Thank you. On what line?

10 MR. GOINGS: Top of the line. Line 1.

11 MR. DAVIS: Line 1 that says blood pressure?

12 MR. GOINGS: Well, yes, sir.

13 MR. DADVIS: Okay. Thank you.

14 MR. GOINGS: Well, because it says on page 28, how far
15 would one go back to look at blood pressure? Page 29, line 1.

16 MR. DAVIS: Thank you.

17 BY MR. GOINGS:

18 Q: And what is your answer, Doctor?

19 A: I don't know.

20 Q: Okay. And then the next question was: Whose job is
21 that? What was your answer under oath?

22 A: Well, I just asked you, is it to look at the blood
23 pressure?

24 Q: The next question was to determine baseline blood
25 pressure, and what was your answer?

1 A: To determine the baseline blood pressure, that's a
2 question. I think that's something that everybody --
3 everybody knows what the baseline blood pressure is.

4 Q: And you said this is something that everyone does; right?
5 In your deposition under oath?

6 A: Where is that?

7 Q: Line 6.

8 A: Says?

9 Q: I think that's something that everybody -- everybody
10 knows what the baseline blood pressure is. Do you see that?

11 A: I see that.

12 Q: Okay. And then the next question: Is that something you
13 -- referring to you, Dr. Holbrook, the neurosurgeon. Is that
14 something you consider prior to a surgery? And what was your
15 answer?

16 A: Yes.

17 Q: Okay. And, Doctor, you're familiar with the hospital
18 policy that says that the patient should have at least three
19 blood pressure readings prior to surgery in order to provide
20 baseline measurement?

21 A: Well, what's the question?

22 Q: You're aware of the hospital that you were operating at,
23 its policy was to have at least three blood pressure readings
24 prior to surgery in order to provide baseline management?

25 A: No, I was not aware of that. That's anesthesia's

1 department.

2 Q: Now, anesthesia doesn't have the luxury of tracking a
3 patient for weeks and months and years before the surgery, do
4 they?

5 A: Well, they're allowed to check on whatever information
6 they think they need. You know, there's no time limit on what
7 they can check on.

8 Q: And if your records at Midlands Orthopedics with the
9 blood pressure readings were not sent to the hospital, then
10 anesthesiology would have never seen the blood pressure
11 readings that you took in your office at Midlands Orthopedics;
12 correct?

13 A: All the blood pressure readings that we had at the time
14 of surgery were adequate to safely proceed with the surgery.
15 I mean, your own anesthesiologist said that.

16 Q: Yeah. Well, so, Doctor, I'm not asking if you think they
17 were safe to proceed with the surgery. My question is this.

18 A: Well, the anesthesiologist said that.

19 Q: I want you to understand my question so you can answer it
20 for the ladies and gentlemen of this jury. Here's my
21 question. If Midlands Orthopedics records that have the
22 baseline blood pressures every time Crystal Goodwin comes into
23 the hospital -- excuse me -- every time Crystal Goodwin comes
24 into Midlands Orthopedics, if those are not sent to the
25 hospital, the anesthesiologist and the anesthesiology team is

1 not going to know what her blood pressure readings were at
2 your office; correct?

3 A: They had enough blood pressures to make their decision.

4 Q: I want you to answer my question. I'm going to ask it
5 now the third time because I want you to answer this question.
6 It's important. The anesthesiologist, the anesthesiology
7 team, if -- will not have Crystal Goodwin's blood pressure
8 from Midlands Orthopedics in June of 2016, in July of 2016, if
9 those records are not given to the hospital before the
10 surgery; correct?

11 A: Well, anesthesia can -- can request them if they'd like
12 them.

13 Q: But the anesthesia team is not going to know Midlands
14 Orthopedics' blood pressure readings unless they get it from
15 Midlands Orthopedics and Midlands Orthopedics sends them;
16 correct?

17 A: Well, they can ask for it if they want it, and we'd be
18 happy to send them whatever information they need.

19 Q: Well, knowing that you have to have at least three blood
20 pressure readings prior to surgery and those blood pressure
21 readings are done at Midlands Orthopedics, couldn't it be a
22 good idea for Midlands Orthopedics to tell the hospital what
23 Crystal Goodwin's baseline blood pressure is?

24 A: Well, I didn't know that anesthesia was required to have
25 three. I didn't know that exact number.

1 Q: Now, you keep saying anesthesia; right? Right?

2 A: Yes, sir.

3 Q: Anesthesia can't know what you know if you don't tell
4 anesthesia; right?

5 A: Well, they know that we have office records, and they
6 know that they can request them if they need them.

7 Q: And you know you have office records and you know you
8 have blood pressure readings, and you can send them to
9 anesthesia yourself as well; right?

10 A: Well, they didn't need any more. They would have asked
11 for more.

12 Q: Doctor, did anything prevent you from giving anesthesia
13 the blood pressure readings that you took in your office of
14 Crystal Goodwin?

15 A: Well, we give them whatever they request, and they
16 request what they think they need.

17 Q: Well, let me ask you, Doctor --

18 A: They felt that they had enough blood pressure readings to
19 safely proceed with the surgery.

20 Q: Let me ask you this, Doctor. Nothing prevented you;
21 correct? Yes or no?

22 A: I could have.

23 Q: Okay. Nothing prevented Midlands Orthopedics either, did
24 it?

25 A: Who would that -- who would that have been?

1 Q: Whoever at Midlands Orthopedics who hasn't come to court
2 yet in this case. Nobody prevented those people from your
3 office from sending it to the hospital either; correct?

4 A: Well, they didn't need it. We're not going to send them
5 information that they don't need unless they requested it.

6 Q: Now, Doctor, isn't it true that Midlands Orthopedics did,
7 in fact, send documents to the hospital for Crystal Goodwin to
8 schedule the surgery to get the surgery scheduled?

9 A: I'll be glad to look at them if you want me to.

10 Q: I'm going to hand them to you. Midlands Orthopedics
11 provided these six documents that were sent to -- that were
12 sent to the hospital for purposes of scheduling the surgery.
13 I want you to look through these records, and if you dispute
14 that these are -- these are the records Midlands sent, I can
15 show you the discovery response, Doctor, where Midlands said
16 these are the only six pages that we sent to Palmetto Health
17 Baptist for this surgery. Look through them.

18 A: Okay. So what's your question?

19 Q: I'm going to put it on the board. Doctor, do these
20 appear to be true and accurate copies of Midlands Orthopedic
21 records?

22 A: Best I can tell.

23 MR. GOINGS: Your Honor, I'd like to move these documents
24 into evidence as Plaintiffs' next.

25 MR. DAVIS: Can I see a copy of it, please?

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 THE COURT: Do you have a copy that can be marked?

2 MR. GOINGS: The witness has that.

3 THE DEFENDANT: Do you want that?

4 MR. DAVIS: Does he have a copy?

5 MR. GOINGS: He's got your same copy.

6 MR. DAVIS: Okay. Your Honor, I would object to these.

7 I don't know if that was provided in the original documents
8 provided.

9 MR. GOINGS: That's how I was provided the original
10 documents that you sent. That is not our copy. That is the
11 original documents you sent us.

12 MR. DAVIS: Okay. That's fine. I'm just -- just asking,
13 Mr. Goings.

14 MR. GOINGS: He said this is exactly what he sent us,
15 Judge.

16 MR. DAVIS: We sent a lot of things over three years.

17 THE COURT: I understand. Any objection?

18 MR. DAVIS: No.

19 MR. GOINGS: Thank you.

20 MR. DAVIS: Plaintiffs' -- that'll be Plaintiffs' 33. If
21 you, Mr. Goings, would allow the court reporter to go ahead
22 and mark --

23 MR. GOINGS: Yes, ma'am.

24 THE COURT: -- that and then you can hand it back to the
25 witness. So admitted without objection.

1 MR. GOINGS: May I have the document?

2 And, Your Honor, this is Exhibit 33, for the record.

3 THE COURT: Yes, sir.

4 (WHEREUPON, Plaintiffs' Exhibit Number 33, medical
5 records from Midlands Orthopedics, was admitted into
6 evidence.)

7 BY MR. GOINGS:

8 Q: Okay. Doctor, the second page of this document I have
9 up, and it shows that you're the surgeon and what was sent was
10 a summary of care record and send with order. Do you see
11 that?

12 A: Yes.

13 Q: And it was sent to Prisma Health, to Prisma Health
14 Baptist. Do you see that?

15 A: Yes.

16 Q: Okay. And if you look at, Doctor, the order that was
17 sent, it's in your hand. Is this the order, the surgery order
18 that was sent to the hospital, Doctor?

19 A: Looks like it.

20 Q: Okay. And on this surgery order, does it have any
21 reference to blood pressure?

22 A: Well, to my knowledge, you don't put blood pressure on
23 the surgery order. It's just an order for the surgery. It's
24 not a blood pressure document.

25 Q: Okay. Is there any reference to blood pressure on the

1 surgery order? Yes or no?

2 A: I mean, if there was one, where do I need to look?

3 Q: I'm asking you, is there any reference to blood pressure
4 on the surgery order? Yes or no?

5 A: Okay. I'm looking. I don't see any reference to blood
6 pressure, but there wouldn't be one on a surgery order.
7 That's not where it would be.

8 Q: Okay. Is there any reference on the surgery order to
9 hypertension?

10 A: I don't see any. That's not where you would find that.

11 Q: Okay. Now, Doctor, you know that this -- that the cover
12 page that was sent to the hospital says summary of care
13 record, send with order. We've reviewed the order. Do you
14 agree with me?

15 A: We reviewed the front page of the surgery order. Yes,
16 sir.

17 Q: Okay. And on the surgery order, there's no reference to
18 blood pressure or hypertension; correct?

19 A: I don't think there's supposed to be.

20 Q: But there's not reference to hypertension or blood
21 pressure on the surgery order; correct?

22 A: Well, that's not where you look for the surgical history.
23 That's just a surgery order.

24 Q: Okay. So let's look at the summary of care record. This
25 is page 1 of the summary of care record. Do you see that,

1 Doctor?

2 A: Is that the second page that you gave me?

3 Q: It looks like this. It says summary of care records for
4 Crystal Goodwin, signed Thomas J. Holbrook, Jr.

5 A: Okay.

6 Q: Do you see that?

7 A: I see that.

8 Q: I'm going to blow it up so the jury can see it. It says
9 most recent encounter was on 7/18/2016 at one of your offices
10 at Gateway Corporate Boulevard. Do you see that?

11 A: I see that.

12 Q: And do you see there's a table of contents?

13 A: I see that.

14 Q: Okay. And in the table of contents, it says reason for
15 referral, problems, allergies, current medication, vaccine
16 list, vitals, tobacco smoking status, functional status, past
17 encounters, procedures, medical equipment, results, mental
18 status assessment, plan of care goals, health concerns,
19 demographics. Did I leave any out, Doctor?

20 A: I see that.

21 Q: Okay. So that's the first page. Let's go to the second
22 page. Second page, reason for referral. Do you see that?

23 A: Yes, sir.

24 Q: All right. Then you see allergies. Do you see that?

25 A: Allergies? I see allergies. Yes, sir.

1 Q: Do you see current medications?
2 A: Yes, sir.
3 Q: Do you see vaccine list?
4 A: I see that.
5 Q: Do you see vitals?
6 A: Yes.
7 Q: Do you see tobacco smoking status?
8 A: Yes.
9 Q: Never smoker. Do you see that?
10 A: Yes.
11 Q: Do you see functional status?
12 A: Yes.
13 Q: Now, on page 2, is there any reference to hypertension or
14 blood pressure?
15 A: Backing up a page or two pages?
16 Q: On this page that we're looking at that lists allergies,
17 medications, vaccine lists, vitals, smoking status, functional
18 status, any reference to blood pressure or hypertension?
19 A: I don't see anything on that page.
20 Q: Okay. Let's go to the -- to the third page of the
21 summary of care status report. Do you see it says past
22 encounters?
23 A: I see that.
24 Q: Do you see it says procedures?
25 A: I see that.

1 Q: Do you see it says medical equipment?

2 A: I see that.

3 Q: Do you see it says results, lab results?

4 A: I see that.

5 Q: What is listed under lab results, Doctor?

6 A: None recorded.

7 Q: Do you see mental status?

8 A: Yes.

9 Q: What is listed under mental status?

10 A: Unknown.

11 Q: What's listed under assessment?

12 A: None recorded.

13 Q: So on this page, is there any reference to hypertension
14 or blood pressure?

15 A: The -- the surgery order is not where you would look for
16 that.

17 Q: I'm not looking at the surgery order. I'm looking at the
18 summary of patient care that was actually sent to the hospital
19 that anesthesia would have had. What does it say for lab
20 results?

21 A: None.

22 Q: Okay. Does it say --

23 A: Those are already at the hospital. They have those on
24 their pre-surgical assessment, I'm pretty sure.

25 Q: Does it show that her blood pressure readings from the

1 three to four times she was in your office before the surgery
2 were listed under her lab results or vitals?

3 A: Well, you don't list blood pressure on your lab results.

4 Q: Would you list it under vitals?

5 A: You could.

6 Q: Well, let's go back. What's listed under vitals?

7 A: None recorded.

8 Q: Okay.

9 A: Now, there's a -- there's a different set of office notes
10 which has the blood pressures.

11 Q: They're -- you're right, isn't it? There's a different
12 set of office notes that have the blood pressures; right?

13 A: Yes.

14 Q: And look at the six pages that were sent to -- to the
15 hospital for purposes of this surgery. Not one of those pages
16 has anything about blood pressure, has anything about
17 hypertension, and those pages at your office with Crystal
18 Goodwin's baseline blood pressure was never once sent to
19 anesthesia or the hospital. Now, isn't that true?

20 A: They didn't need them. They had enough information that
21 they had already at the hospital to make a decision regarding
22 safely proceeding with surgery. They -- at some point, you
23 get enough information to make your decision.

24 Q: They didn't need them, Doctor?

25 A: No, that's -- they said they didn't need them, and your

1 anesthesiologist said --

2 Q: No. You can't tell me --

3 A: -- they didn't need them.

4 Q: You can't tell me what an expert says.

5 A: This is your expert.

6 Q: Well, Doctor, look at this. You said that the hospital
7 didn't need them, but the hospital policy says, again, the
8 patient should have at least three blood pressure readings
9 prior to surgery in order to provide baseline measurement;
10 isn't that true?

11 A: Well, that's up to anesthesia.

12 Q: And it's also up to Midlands Orthopedics and you, sir,
13 sending them to the hospital so anesthesia can have them to
14 assess them, to read them, to set the blood pressure
15 appropriately; isn't that true?

16 A: Well, if they already have enough blood pressure to
17 safely proceed, they wouldn't ask for anymore, but if they
18 needed some more, we'd be happy to send it to them. They
19 didn't think they needed any more.

20 Q: Doctor, Exhibit 33, the only documents that Midlands
21 Orthopedic sent to the hospital in front of you today. tell
22 this jury if any of those documents have Crystal's baseline
23 blood pressure, prior blood pressure readings, or what you
24 believed to be hypertension as a problem that she has?

25 A: I wouldn't expect a surgery order to have that

1 information on it.

2 Q: Well, you also have not only the sum -- you don't -- I'm
3 not talking about the summary order -- I mean, the -- the
4 surgery order, Doctor. I'm talking about the summary of care
5 record that was sent that's multiple pages that has no mention
6 whatsoever about hypertension or blood pressure.

7 A: Well, that's not -- that's not where it's kept.

8 Q: It's kept at Midlands Orthopedics, not the hospital;
9 right?

10 A: Well, our office notes are kept at the office. Yes, sir.

11 Q: Okay. And the hospital can't -- the hospital can't have
12 your office notes without your office sending the office
13 notes; right?

14 A: Well, if they request them, we'd be glad to send it to
15 them.

16 Q: Well, and you're the -- you're the surgeon. You're doing
17 the procedure. You know the history of the patient; right?

18 A: Yes.

19 Q: Of all the doctors that treated Crystal Goodwin on the
20 28th of July, you were the doctor that knew her history;
21 right?

22 A: Anesthesia also knew her history.

23 Q: Anesthesia ain't never met her a day in this world until
24 she -- she walked into the hospital on July 28th; isn't that
25 right?

1 A: No, that's not true.

2 Q: So Dr. Jennifer Root previously did anesthesia -- she
3 previously knew Crystal Goodwin before the 28th of July?

4 A: It might not have been Dr. Root, but she had a pre-op
5 visit like about a week or so before that where anesthesia
6 interviewed her, went over all her history and labs and blood
7 pressures.

8 Q: Doctor, how many -- how many physicians were responsible
9 for Crystal Goodwin's care team during the surgery?

10 A: How many physicians were there?

11 Q: Yes, sir.

12 A: It would be me and Dr. Root would be the only physicians.

13 Q: You and Dr. Root. You were the only physician out of you
14 and Dr. Root that knew Crystal's history; isn't that true?

15 A: No.

16 Q: Okay. You were the only doctor out of you and Dr. Root
17 that has actually seen or treated Crystal Goodwin; isn't that
18 true?

19 A: No, that's not true.

20 Q: Well, what evidence do you have that -- that Dr. Root has
21 treated Crystal Goodwin before the day of this surgery?

22 A: Well, it might not have been Dr. Root, but --

23 Q: I'm asking you Dr. Root though.

24 A: I'm explaining. She had a pre-operative evaluation about
25 a week before where she was evaluated by anesthesia. It might

1 not have been Dr. Root. It might have been one of the other
2 anesthesia personnel, but they did a pre-op anesthesia
3 evaluation about a week before the surgery, I believe.

4 Q: Doctor, can you agree with me that you -- we've
5 established that Midlands Orthopedics nor you ever sent the
6 office notes with her blood pressure to the hospital before
7 the surgery?

8 A: They were not needed for the surgery.

9 Q: So is the answer they were not sent?

10 A: Well, I didn't see them.

11 Q: Okay. Is the answer they were not sent? Yes or no?

12 A: Well, I don't -- I don't see that they were sent, and I
13 didn't send them.

14 Q: Okay. So they were not sent to the hospital?

15 A: Well, as far as I know.

16 Q: Okay. Thank you. Now, you've heard of the 20 percent
17 rule, haven't you, Doctor?

18 A: I've heard of the 20 percent guideline. I've also heard
19 of the 30 percent guideline.

20 Q: You've heard of the 20 percent guideline?

21 A: The 20 percent and 30 percent.

22 Q: And in your deposition, Doctor, you told us that you knew
23 clearly about the 20 percent rule; isn't that right?

24 A: I've heard of it. I think it's more -- it's not so much
25 a rule, but a guideline.

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 (WHEREUPON, a portion of Dr. Holbrook's video deposition
2 was played as follows.)

3 Q: You testified that Ms. Goodwin's blood pressure was
4 normal?

5 A: I think it was within normal limits during the
6 entire surgery. Yes, sir.

7 Q: Okay. Were they within normal limits for Ms.
8 Goodwin or were they in normal limits for purposes of
9 someone who does not have hypertension?

10 A: I believe they were in normal limits for Ms.
11 Goodwin.

12 Q: Are you aware of what's referred to in medicine that
13 the intraoperative blood pressure should be maintained
14 within 20 percent of a patient's baseline?

15 A: I've heard that.

16 (WHEREUPON, the video deposition was stopped and the
17 proceedings resumed as follows.)

18 BY MR. GOINGS:

19 Q: A blood pressure reading of 152 over 1112 [sic], Doctor,
20 is that a normal blood pressure or a hypertensive blood
21 pressure?

22 A: You say 152 over what?

23 Q: 112.

24 A: I think that's high.

25 Q: Is a blood pressure of 156 over 92 a normal blood

1 pressure or a hypertensive blood pressure?

2 A: I think that's high.

3 Q: Is a blood pressure of 160 over 99 a normal blood
4 pressure or a hypertensive blood pressure?

5 A: I think that's high.

6 Q: And you know that Crystal Goodwin had all three of these
7 blood pressure readings that you had available to you in the
8 weeks and month before this surgery; isn't that true?

9 A: Are those from my office notes?

10 Q: Do you want to see your office notes?

11 A: I'm just asking. Is that where you're getting them from?

12 Q: Yes, sir.

13 A: Okay.

14 Q: And the average MAP, mean arterial pressure, for those is
15 -- is in the range of 113 and higher; isn't that true?

16 A: Well, I'll take your word for it.

17 Q: And you have access to these blood pressures; correct?

18 A: Yes.

19 Q: You had access to the blood pressure from 6/20/16, a
20 month from -- just one month before the surgery; correct?

21 A: Yes.

22 Q: And you never told Dr. Root anything about the blood
23 pressure reading on 6/20/16 that was hypertensive, did you?

24 A: Well, they had their own blood pressure readings, and
25 they didn't need any more.

1 Q: Let me ask you this. I know you want to say that.

2 A: Well, it's true.

3 Q: You've been saying that, but I want you to answer my
4 question. I'm going to say this. Answer it yes or no, so I
5 can -- I can know that you've answered.

6 A: Okay.

7 Q: Yes or no?

8 MR. DAVIS: Excuse me.

9 Q: The blood pressure from --

10 MR. DAVIS: He needs to see those notes. I need to
11 object. I'm fine with him giving answers to these questions,
12 but I believe he has an opportunity and obligation and right
13 to explain his answers.

14 THE COURT: He does, but he must first answer the
15 question.

16 MR. DAVIS: Sure.

17 THE COURT: And if it's a yes or no question, I would
18 expect the words yes or no to be the first things out of the
19 witness's mouth.

20 MR. DAVIS: Sure. Thank you.

21 THE COURT: You may proceed, Mr. Goings.

22 MR. GOINGS: Thank you.

23 BY MR. GOINGS:

24 Q: Yes or no? The blood pressure that was taken by you at
25 Midlands Orthopedics over a month before the surgery on

1 6/20/2016, that blood pressure, which is hypertensive you just
2 said, was not provided to Dr. Root; correct?

3 A: That's correct, but she didn't need it.

4 Q: Okay. The blood pressure from 7/18/2016, which was taken
5 at your office, was not provided to Dr. Root; isn't that true?

6 A: That's true. But she also didn't need that one either.
7 She made that determination.

8 Q: And you never spoke with Dr. Root at any point in time
9 before this surgery; isn't that true?

10 A: On the day of surgery, I probably saw her before we
11 started.

12 Q: Okay. Let me show you, Doctor, what you said when we
13 asked you this question the first time.

14 MR. DAVIS: What page was that? Your Honor --

15 MR. GOINGS: I'll tell you.

16 MR. DAVIS: Okay. Thank you.

17 MR. GOINGS: This is in his first deposition.

18 MR. DAVIS: Okay. What page, sir?

19 MR. GOINGS: He said it multiple places. I'm going to
20 find the exact ones.

21 Your Honor, these are designations that we -- that we
22 have agreed to. He's welcome to come and look at the screen
23 where it actually has the -- the testimony, but I may not be
24 able to quickly find the exact page for him. So if he wants
25 to see the line number, it's -- it's on the monitor. I'm just

1 trying to speed things along here.

2 THE COURT: Yes sir.

3 MR. DAVIS: I need to know the page. That's all. I just
4 need to know the reference.

5 THE COURT: But the --

6 MR. DAVIS: I'm not objecting to it. I just need to know
7 where he is.

8 MR. GOINGS: It's in the transcript.

9 THE COURT: It's there on the screen? I can't see it.

10 MR. GOINGS: Yes. I'm sorry. His video is on the screen
11 with him saying it, and then below it has the -- the text.

12 MR. DAVIS: But it doesn't show the page number.

13 MR. GOINGS: I don't know if the page number really
14 matters right now.

15 MR. DAVIS: Well, it does to me, sir. I want to know
16 where this is so it's not out of context.

17 THE COURT: Yes, sir. You're welcome to watch the
18 screen. Your transcript should have a key word index, and
19 that may be beneficial to you.

20 MR. DAVIS: Judge, that index is multiple pages long, the
21 key word index.

22 THE COURT: Well, I understand, but it's a key word
23 index. So, yes, it's -- the full index is multiple pages
24 long, but if you're looking for a specific word, it gives you
25 page and line numbers.

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 MR. GOINGS: Yes, it's 37, Your Honor, I'm pretty sure.

2 MR. DAVIS: Page 37, Robert?

3 MR. GOINGS: 37, yep.

4 MR. DAVIS: Thanks so much.

5 BY MR. GOINGS:

6 Q: All right. Let's play it, Doctor.

7 (WHEREUPON, the video deposition of Dr. Holbrook was
8 played as follows.)

9 Q: Is that something you typically discuss with the
10 anesthesia team prior to surgery -- surgery?

11 A: What their blood pressure is? If there's an issue
12 with it.

13 Q: Do you recall if you ever discussed Crystal
14 Goodwin's baseline and historical blood pressure prior to
15 the surgery performed on July 28th, 2016?

16 A: I don't believe that's necessary for this case.

17 Q: Okay. Do you recall if you ever discussed Crystal
18 Goodwin's blood pressure prior to the surgery performed
19 on July 28th, 2016?

20 A: I believe there's a blood pressure that history was
21 well controlled, and I did not discuss it preoperatively
22 with anesthesia.

23 Q: Concerning performance of the morning of July 28th
24 of 2016, you did not have a discussion with anesthesia
25 regarding Crystal Goodman's historical blood pressure;

1 correct?

2 A: I don't recall any discussion with them at that
3 time.

4 Q: You see nothing in the record to reflect a
5 discussion with anesthesia regarding her blood pressure
6 prior to the surgery performed on the morning of July
7 28th, 2016?

8 A: Not that I can recall right offhand. I recall that
9 her blood pressure was well controlled, and that there
10 was no ongoing issue with it at that time.

11 Q: Did anyone with Midlands Orthopedics discuss Ms.
12 Goodwin's blood pressure to Dr. Root or anyone with the
13 anesthesiology team prior to starting the procedure?

14 A: I don't recall right offhand.

15 (WHEREUPON, the video deposition was stopped, and the
16 proceedings resumed as follows.)

17 MR. DAVIS: You know, Judge, we obviously have moved now
18 from the May 2020 deposition to the 30(b)(6) deposition. I
19 just want to -- I just need to know, you know, the page
20 reference. I don't think that's unreasonable.

21 THE COURT: All right. Pause right here. Mr. Goings, I
22 can't see you.

23 MR. GOINGS: I'm sorry.

24 THE COURT: But can we stop here for a lunch break?

25 MR. GOINGS: Absolutely. That's fine.

1 THE COURT: Perfect.

2 Ladies and gentlemen, let's break for lunch until 2:15.

3 I've got a need to talk to the attorneys for a little bit

4 outside of your presence, and I want court staff to have an

5 adequate lunch time, too.

6 So be back in your jury room at 2:15. Don't discuss the
7 case.

8 (WHEREUPON, the jury exited the courtroom at 12:33 p.m.)

9 THE COURT: All right. Now, let's duke it out right now.
10 Mr. Davis, talk to me. Let's not do this in front of the
11 jury. Let's -- let's talk right now.

12 MR. GOINGS: So, Your Honor, we'll use this break to find
13 the line and page numbers of these and --

14 THE COURT: Okay.

15 MR. GOINGS: -- provide them to -- to Mr. Davis. I just
16 didn't think he needed to know this right now, but I'm going
17 to give them to him over lunch. He's going to have them.
18 We're not going to have a distraction doing this in front of
19 the jury.

20 MR. DAVIS: Your Honor, just for the record, I -- I've
21 never been in a trial where depositions have been used for
22 impeachment or to refresh the recollection of any witness
23 where the counsel, including myself, has to cite the page and
24 line number so opposing counsel can know where it's coming
25 from, to see if it's in context, and if they want to redirect

1 on -- on that, they can refer back to that.

2 I mean, it's -- it's -- this is not something unique I'm
3 asking for. This is -- this should be routine. I'm happy to
4 do that for them, and I appreciate Mr. Goings saying that --
5 that he'll accommodate my request.

6 MR. GOINGS: I will accommodate his request.

7 MR. DAVIS: Thank you. Thank you, sir.

8 THE COURT: All right. Anything else?

9 MR. GOINGS: No, Your Honor.

10 THE COURT: I'll see y'all at 2 o'clock, 2 o'clock,
11 folks.

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

14 MR. DAVIS: Your Honor, I don't know where my client is.
15 I'm going to go outside and see if I can find him.

16 THE COURT: Well, we don't have all the jurors yet. I
17 just wanted to make sure that there's nothing we need to
18 discuss before the jury comes back in.

19 Anything, Mr. Davis?

20 MR. DAVIS: No, ma'am.

21 THE COURT: Mr. Goings?

22 MR. GOINGS: No, ma'am. And if I reference any of the
23 prior depositions, I will call out the page and line number
24 for the edification of the defense.

25 THE COURT: Yeah, just turning back to that, I -- I

1 believe that that's a courtesy. And certainly, if you have
2 the designations in front of you, absolutely communicate them
3 to opposing counsel, but the rule regarding a prior statement
4 of a witness requires upon counsel's request that the
5 statement be shown to counsel, but you have it. You were
6 there or if you weren't there, you have the transcript.

7 So I would not require Mr. Goings to point out page and
8 line number each and every time, and he may or may not know
9 what page and line numbers he's going to use. I don't know,
10 but I don't think that the rules require that. I think that
11 that is a courtesy.

12 And so I'm -- I'm happy for you to do it, Mr. Goings. I
13 suggest that it be done to the extent possible, but -- but not
14 to the point, I guess -- I don't think it's an appropriate
15 objection that he doesn't do it or if he doesn't have it for
16 you, he doesn't have it. But --

17 MR. GOINGS: I spent the lunch hour looking over the
18 questions that may be subject to a line and a page
19 designation, and I'll -- as a courtesy, I'll provide that to
20 Mr. Davis.

21 THE COURT: Absolutely.

22 MR. GOINGS: Thank you, Your Honor.

23 THE COURT: All right. Anything else before the jury
24 comes in?

25 MS. GOODING: No.

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 THE COURT: Okay. We'll be at recess while we wait for
2 the last couple jurors, and you can find Dr. Holbrook.

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

5 THE COURT: All right. Let's get Dr. Holbrook back on
6 the stand, and you can bring the jury, please.

7 THE BAILIFF: Yes, ma'am.

8 (WHEREUPON, the jury entered the courtroom at 2:19 p.m.)

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

10 THE COURT: Thank you.

11 Before the lunch break, I interrupted Mr. Goings' cross-
12 examination.

13 So, Mr. Goings, you may proceed to finish that.

14 MR. GOINGS: Thank you, Your Honor. May it please the
15 Court.

16 THE COURT: Yes, sir.

17 BY MR. GOINGS:

18 Q: Dr. Holbrook, when your lawyer was asking you questions
19 on direct examination, you said that you had a discussion with
20 anesthesia -- the anesthesia care team before the surgery.
21 Before we took a break, I showed you two clips of your
22 deposition, the first deposition you gave, where you said you
23 didn't recall or have any discussion with anesthesia.

24 Now, you've now given a second deposition in this case;
25 isn't that right? In 2021?

1 A: Correct. Right.

2 Q: Okay. I'm going to play what you said in that deposition
3 in 2021.

4 MR. GOINGS: And, counsel, page 26, starting at line 12.

5 MR. DAVIS: Thank you.

6 (WHEREUPON, the video deposition of Dr. Holbrook was
7 played as follows.)

8 Q: Did anyone with Midlands Orthopedics discuss Ms.
9 Goodwin's blood pressure to Dr. Root or anyone with the
10 anesthesiology team prior to starting the procedure?

11 A: I don't recall right offhand.

12 (WHEREUPON, the video deposition was stopped, and the
13 proceedings resumed as follows.)

14 BY MR. GOINGS:

15 Q: All right. Now, if you go to line 72, in the same
16 deposition starting at -- excuse me, page 72, line 25.

17 (WHEREUPON, the video deposition of Dr. Holbrook was
18 played as follows.)

19 Q: You did not have any communications with Dr. Root or
20 anyone on the anesthesia staff about what the blood
21 pressure should be set at during this procedure; is that
22 fair?

23 A: That is not necessary.

24 Q: So you didn't have any of those communications with
25 anesthesia?

1 MR. TODD: Object to form.

2 A: That was not necessary in this case.

3 Q: Why was that not necessary?

4 A: I think this was a standard -- this case was managed
5 in a standard manner.

6 (WHEREUPON, the video deposition was stopped, and the
7 proceedings resumed as follows.)

8 BY MR. GOINGS:

9 Q: All right. I want to show you what you said a fifth
10 time, page 50, line 4.

11 (WHEREUPON, the video deposition of Dr. Holbrook was
12 played as follows.)

13 Q: But you didn't go to Dr. Root and say, Dr. Root,
14 this patient has got a history of hypertension and blood
15 pressure readings are in our chart, and it looks like she
16 had a 160 over -- over 99 a year before we -- before we
17 started. You need to keep the blood pressure higher than
18 you would normally keep it for someone who does not have
19 hypertension.

20 A: I didn't think she needed to keep it higher than
21 normal.

22 Q: Okay. So you didn't tell her how she needed to keep
23 it, did you?

24 A: I didn't think she needed to keep it higher.

25 Q: Okay.

1 (WHEREUPON, the video deposition was stopped, and the
2 proceedings resumed as follows.)

3 BY MR. GOINGS:

4 Q: Doctor, how much trouble would it have been for you to
5 just simply tell anesthesia before the surgery that Crystal
6 had hypertension?

7 A: They already knew she had hypertension. They didn't need
8 me to tell them again.

9 Q: How much trouble would it have been for you to tell
10 anesthesia that she had been hypertensive for a period of 6 to
11 7 weeks before the surgery?

12 A: Do what now?

13 Q: How much trouble or effort would it have been for you to
14 simply tell anesthesia that for the -- for the 6 or 7 weeks
15 before the surgery, she was hypertensive in your office?

16 A: I think it was more than 6 or 7 weeks. She had that for
17 years, I think.

18 Q: But it wasn't more than 6 or 7 weeks; right?

19 A: I think she had it for several years.

20 Q: And to determine a baseline blood pressure, you can just
21 look at blood pressures over the course of several weeks;
22 isn't that right?

23 A: You could.

24 Q: And you had blood pressure readings for just a -- for --
25 for a series of weeks; isn't that right?

DR. THOMAS J. HOLBROOK - CROSS BY MR. GOINGS

1 A: You mean the ones that we took in our office?

2 Q: Yeah. Those were over a course of weeks; right?

3 A: We had, and she had them over the course of years with
4 her -- I guess her blood pressure treating doctor.

5 Q: And baseline blood pressure can be determined by the
6 blood pressure established over a course of weeks; right?

7 A: Well, it can be.

8 Q: Okay. And that's what you told us when we --

9 (WHEREUPON, the video deposition of Dr. Holbrook was
10 played as follows.)

11 A: Baseline blood pressure I think would be determined
12 over a longer length of time, maybe weeks or longer, and
13 we don't have that information. That was not necessary.

14 (WHEREUPON, the video deposition was stopped, and the
15 proceedings resumed as follows.)

16 BY MR. GOINGS:

17 Q: So you said you didn't have that information?

18 A: Yes.

19 Q: But isn't it true, Doctor, you actually did have that
20 information in your medical file at Midlands Orthopedics?

21 A: Well, we're talking about two different types of baseline
22 blood pressure.

23 MR. DAVIS: I'm sorry. I knew you couldn't see me stand
24 up, and it's probably hard to hear me, but -- and I didn't
25 mean to interrupt you. Yeah, that -- that was not appropriate

1 impeachment, that video clip you played objectively. That's
2 an improper use of the deposition.

3 THE COURT: Mr. Goings?

4 MR. GOINGS: He said that he did not have the baseline
5 blood pressures at the office. That's what he said, and now
6 he's saying he did have the baseline blood pressures.

7 THE COURT: The objection is overruled.

8 MR. DAVIS: Thank you, Your Honor.

9 BY MR. GOINGS:

10 Q: So what is it, Doctor? Did you have the baseline blood
11 pressures or did you not have the baseline blood pressures for
12 Crystal Goodwin?

13 A: We had the pressures that we took in the office. Is that
14 the ones you're referring to?

15 Q: That established baseline blood pressure; right?

16 A: Well, the baseline blood pressure doesn't need the ones
17 at the office to establish that for the day of surgery, but
18 you're talking --

19 Q: And --

20 A: -- about two different kinds of baseline.

21 Q: And the procedures, guidelines, and references of the
22 hospital says that three blood pressure readings prior to
23 surgery need to be sent in order to provide a baseline
24 measurement; isn't that right?

25 MR. DAVIS: Your Honor, that's been asked and answered at

1 least two or three times already.

2 THE DEFENDANT: That's not what that says.

3 THE COURT: Well, you've got to wait for me to rule on
4 the motion.

5 THE DEFENDANT: Oh, sorry.

6 THE COURT: I'm going to sustain the objection. Move on
7 to your next question, Mr. Goings.

8 BY MR. GOINGS:

9 Q: Doctor, you told this jury that you now know the cause of
10 Crystal Goodwin's injury; isn't that right?

11 A: Well, I think if you look at all of the evidence --

12 Q: Did you --

13 A: -- that we have in this case --

14 Q: Did you tell the jury?

15 A: I'm telling -- I'm telling them right now.

16 MR. DAVIS: I think the witness needs to be allowed to
17 answer the question.

18 THE COURT: Right. The witness was asked a yes or no
19 question, and I've yet to hear a yes or no. Answer the
20 question and then explain the answer.

21 THE DEFENDANT: Okay.

22 BY MR. GOINGS:

23 A: What was your question?

24 Q: You told this jury today that you now know the cause of
25 Crystal Goodwin's injury? Yes or no?

1 A: Well, no. And here's the explanation for that. I didn't
2 tell them that I knew the cause. I told them what I thought
3 the most likely cause was based on all the information that we
4 have.

5 Q: Okay.

6 A: There's no specific test that you can do for a
7 reperfusion injury, and there's no test that we did to tell
8 whether or not this was definitely an embolic type of stroke,
9 like you see in the brain, where a blood clot blocks off a
10 vessel. But if you look at the totality of all of the
11 information that we have, the most likely diagnosis is a
12 reperfusion injury.

13 Q: Doctor, you have one of your depositions in front of you,
14 don't you?

15 A: Yes.

16 Q: And it's thick; right? Because you gave a lot of
17 testimony, didn't you?

18 A: You asked a lot of questions.

19 Q: And there's also the other deposition that's in front of
20 me, and I'm going to open it up for you. This is the
21 deposition that actually I took. I didn't take the one in
22 front of you. The one -- the one that I took --

23 MR. GOINGS: And let the record reflect I'm opening the
24 certified transcript of your 30(b)(6) deposition.

25 BY MR. GOINGS:

1 Q: Will you hold both of those deposition transcripts up so
2 you can see what we have? Isn't it true, Doctor, in both of
3 these documents, you never once said the word perfusion --
4 reperfusion injury; isn't that true? You never said this was
5 a reperfusion injury?

6 A: I thought Mr. Hinson asked me about it at some point. I
7 thought he did. Maybe he didn't.

8 Q: You never uttered out of your mouth in 2020 or 2021 that
9 this was a reperfusion injury; isn't that true, Doctor?

10 A: Well, we have more information at this time that makes
11 that more likely.

12 Q: I'm asking you now, sitting here when you were deposed in
13 2020 and 2021, the words reperfusion injury never came out of
14 your mouth, did it?

15 A: Well, at that time --

16 Q: Yes or no?

17 A: -- they weren't asking me. Okay.

18 Q: Yes or no?

19 A: Well, I haven't read it all.

20 Q: There's a --

21 A: But I'll just say it was a no.

22 Q: Okay.

23 A: And then I'll explain my answer. He asked me what I
24 thought was the most likely cause back then, and at that time
25 I thought it was probably an embolic type stroke. But now

1 with the additional information that we have that was not
2 available at that time, I think the most likely diagnosis is a
3 reperfusion injury.

4 Q: Doctor, there has not been another MRI done on Crystal
5 Goodwin that gives you that new opinion now; isn't that right?

6 A: It's not based on an MRI.

7 Q: There's not been any additional studies, additional
8 tests, or anything that now wants you to say there was a
9 reperfusion injury; isn't that right?

10 A: Yeah, there are additional studies. That's what I'm
11 referring to.

12 Q: No. There was not an additional study done on Crystal
13 Goodwin; correct?

14 A: We didn't need any additional studies --

15 Q: Okay.

16 A: -- on Crystal.

17 Q: So you have not gotten any new evidence, medical
18 evidence, diagnostics, tests, scans for you to now change your
19 answer to say it's a reperfusion injury?

20 A: We do have additional research which points to the fact
21 that --

22 Q: You can't --

23 A: -- it's part of the theory --

24 MR. GOINGS: He -- he continues to do this, and you've
25 already told him.

1 THE DEFENDANT: It's true.

2 MR. GOINGS: And I will move to strike his answer because
3 he knows he shouldn't go into this.

4 THE COURT: That's overruled. You asked him about it.
5 We're not going to get into details about studies or anything
6 like that, but if that forms the basis of his answer as we sit
7 here today, so be it, without going into detail.

8 MR. GOINGS: Okay.

9 BY MR. GOINGS:

10 Q: Doctor, pull the deposition in front of you, your first
11 one in 2020, and -- and turn to page 64.

12 A: Okay.

13 Q: I'm going to read the question and where it says A,
14 that's your answer. Just read your answer without adding any
15 -- any words or context. This is my question.

16 A: Wait a minute. Which -- which question is it?

17 Q: 9, line 9.

18 A: Okay. I got it.

19 Q: Question: Sitting here today, what do you believe the
20 cause of the injury to Crystal Goodwin's spinal cord to have
21 been?

22 And tell us your answer?

23 A: Well, none of the things that we did, either the direct
24 inspection of the wound demonstrated a cause, even the very
25 sensitive MRI scan did not demonstrate a cause. It

1 demonstrated a probable ischemic area in the cord, but it did
2 not demonstrate a cause.

3 Q: The next question --

4 A: Do I get to explain that?

5 Q: Then I said that's a little -- well, the question was:
6 That's a little bit different than my question, Doctor.
7 Sitting here today, what do you believe was the most likely
8 cause of the injury to Crystal Goodwin's spinal cord?

9 And what was your answer on line 21?

10 A: Despite direct inspection and sensitive MRI scanning, we
11 were not able to determine a cause.

12 Q: Okay. And then the question was: Do you believe it was
13 something during the course of the surgery that irritated one
14 of the blood vessels?

15 Do you see that?

16 A: Yes, I see that.

17 Q: And then the next page, page 65, you say: I believe it
18 was something that occurred during the surgery. I can't tell
19 you exactly what it was. I don't know. No exact cause was
20 determined.

21 Isn't it true you said in 2020 you don't know, no exact
22 cause was determined?

23 A: I'm saying I didn't. It says no exact cause was ever
24 determined.

25 Q: Okay.

1 A: That's true.

2 Q: And then turn to page 71, Doctor.

3 A: Okay.

4 Q: You mentioned earlier about a potential clot. And on
5 line 13, the question was: Sitting here today, do you believe
6 the most likely cause was a clot?

7 And what was your answer?

8 A: No, I don't know what it was.

9 Q: I don't know what it was.

10 A: It could have been a clot, but I didn't have any evidence
11 that that's what it was.

12 Q: Okay. Now, when you were deposed in 2021, you know,
13 we're kind of going up the years now, 2021. Pull -- pull that
14 deposition in front of you, Doctor, and turn to page 105. Do
15 you have page 105 in front of you, Doctor?

16 A: Okay. I got it now.

17 Q: Okay. Doctor, if you'll go to line 21?

18 A: Okay.

19 Q: You gave -- you remember you said there were -- there
20 were four potential issues: inflammation, vascular, ischemic.
21 You remember you -- you went through the four broad categories
22 of what it could be. Do you remember that?

23 A: Yeah. There's probably more than four, too.

24 Q: And then I can show you what you said in your deposition,
25 but you only gave four. Bleeding was another one in four --

1 of the four. And then look at line 21.

2 A: Okay.

3 Q: And the question was: Of these main ones, which does
4 Midlands Orthopedic believe to be the most probable cause of
5 Crystal Goodwin's injury?

6 Then the next page, read your answer on line 1 and 2.

7 A: Line 1 and 2. No definite cause was ever determined.
8 That's with the information we had at that time.

9 Q: Okay. Then if you go to page 108, line 9, the question:
10 And you have no opinion as to which of those four that you
11 named could be most -- the most probable cause.

12 I'm going to stop there. Of the four that you named as
13 the most probable cause, isn't it true, Doctor, you never once
14 used the words reperfusion injury? That was never one of your
15 four potential causes; isn't that true?

16 A: Well, that wasn't a complete list.

17 Q: But you only gave us four in your deposition. You would
18 agree with that?

19 A: Well, I gave you an example of some things that it could
20 be. I mean, it's not a complete list.

21 Q: Did you give an example of a pre -- a reperfusion injury
22 as one of the potential causes?

23 A: Well, a vascular cause is reperfusion. So that's sort of
24 the category of a --

25 Q: Okay.

1 A: -- vascular event.

2 Q: So I'm going to read that question. I want you to read
3 your answer starting at line 12. Question --

4 A: What page are you on?

5 Q: You have no opinion as to which of these four -- those
6 four that you named could be the most probable cause?

7 A: Which page are we on now?

8 Q: Page 108.

9 A: Which line?

10 Q: Line 12.

11 A: Okay.

12 Q: Would you like for me to read for you?

13 A: What's your question?

14 Q: Read line 12 down to the period at line 16.

15 A: Okay. Let's see.

16 So the question was: You have no opinion as to which of
17 these four that you named could be the most probable cause?

18 And the answer is: In the end, all strokes are vascular
19 in nature, which is true, but I can't tell you exactly what
20 the cause of this was. No cause was ever determined. Even on
21 the very sensitive MRI scan did not demonstrate a cause for
22 why this stroke occurred.

23 Q: And, Doctor, is it --

24 A: You don't get a reason with a reperfusion injury. It's
25 not going to show you the answer to that on the MRI scan.

1 Q: But today, now 2023, you tell this jury that I know I
2 said it under oath one time, I know I said it under oath two
3 times in two different years, but now I think it's a
4 reperfusion injury. Is that your testimony here today?

5 A: We have information that didn't come to us until 2021 to
6 --

7 Q: Okay.

8 A: -- help form that opinion. And based on that and looking
9 at that and all of the evidence that we have, I think the most
10 likely diagnosis is a reperfusion injury.

11 Q: And you said in your deposition that -- multiple times
12 that low blood pressure can lead to low perfusion, and low
13 perfusion over an extended period of time can lead to ischemic
14 changes, which result in an infarction that puts you in a --
15 in a paralyzed state in a wheelchair; isn't that true?

16 A: Well, the evidence that we have says that that's not
17 true.

18 Q: Okay.

19 A: You want me to explain that?

20 Q: I want to show you, Doctor, when we asked you just to
21 admit something very simple in a request to admit, we sent
22 over a question to -- to you and your attorneys to answer, and
23 this is what the question was: Admit that you told Crystal
24 Goodwin that her 2016 spinal cord injury was caused by, quote,
25 something during the course of the surgery that irritated one

1 of those blood vessels or that sort of thing, causing it to
2 occlude and restrict the blood flow to that area of the spinal
3 cord. That was the question that we asked.

4 And when you answered it under oath, your answer was:
5 Denied.

6 Now, that was provided to you after we had produced the
7 video that -- that -- that Crystal's daughter took in the
8 hospital, and I want to play it. And you tell me if what you
9 denied under oath you told Crystal is exactly what you said in
10 this video.

11 MR. DAVIS: Your Honor, we've played this video.

12 (WHEREUPON, the video was played briefly and then
13 stopped.)

14 MR. DAVIS: I was objecting.

15 MR. GOINGS: I was trying to stop it.

16 MR. DAVIS: I know. I saw you trying to do that. I
17 appreciate that.

18 Your Honor, we -- the jury has seen this video. We don't
19 contest what it says. I've asked him about it on direct, and
20 it's -- it's really redundant, and I'm asking that it would be
21 not allowed at this point. We can move on.

22 THE COURT: The objection is overruled.

23 BY MR. GOINGS:

24 Q: So I showed you what you denied, that you contested what
25 it said. Now I want you to play it. I'm going to play it,

1 and I want you to tell me if you said what we put in quotes
2 that you did say. Okay, Doctor?

3 (WHEREUPON, the video was played and then stopped.)

4 BY MR. GOINGS:

5 A: What -- let me see it in writing again. So what was the
6 question?

7 Q: You did not say this under oath in the case, but that
8 audio that I just played is your voice; right?

9 A: Well, what that was explaining is that could be one of
10 the causes that possibly could cause something like this. The
11 circulation of the blood vessels that supply the spinal cord
12 come in from the front of the spine. We were operating on the
13 back of the spine. So we didn't expose any of those blood
14 vessels or see any of those blood vessels. That's not part of
15 this surgery to operate on those blood vessels.

16 Q: Doctor, the question was admit that you told Crystal this
17 statement. You admit you told her that now; right?

18 A: I told her that that's one of the things that could
19 possibly cause a of stroke.

20 Q: Did you tell her there was a possible reperfusion injury
21 at the hospital?

22 A: Well, I don't -- I don't have that whole thing, and I
23 don't recall specifically saying -- I recall telling her that
24 it could be of vascular origin, but I don't -- I don't recall
25 using the exact word reperfusion injury, because at that time

1 we thought it was more likely an embolic type stroke.

2 Q: Now, Doctor, when you -- when you do a preoperative
3 timeout -- when you do a preoperative timeout, all team
4 members, including the anesthesiologist, should be involved;
5 isn't that true?

6 A: I think the anesthesiologist is there. I know the nurse
7 anesthetist is there, but I'm not sure if the anesthesiologist
8 is there for all of them. You'd have to ask anesthesia that,
9 if they're required to be there. I'm not sure.

10 Q: Is the anesthesiologist part of the -- the -- the team?

11 A: Yes.

12 Q: Okay. Here's the policy from Prisma Health. We have it
13 on the board, the policies about the timeout policy, and it
14 says the communication process will be active, not passive,
15 and include all team members involved. Do you see that?

16 A: Yes, sir.

17 Q: Okay. And you previously said you didn't talk to
18 anesthesiology about the blood pressure, but the timeout
19 policy requires that the anesthesiologist be a part of it
20 because they're part of the team; right, Doctor?

21 A: Well, blood pressure and hypertension is part of the
22 timeout that we discussed.

23 Q: Okay. But in 2020, you were asked under oath and you
24 said you didn't do that. In --

25 A: Didn't do what?

1 Q: You didn't -- you did not talk to anesthesiology about
2 this blood pressure.

3 A: That's not the same thing. You're talking about
4 something different.

5 Q: So did you or did you not talk to anesthesiology about
6 hypertension and blood pressure of Crystal Goodwin before this
7 surgery occurred?

8 MR. DAVIS: Your Honor, that's also been asked and
9 answered this afternoon.

10 THE COURT: Overruled.

11 BY MR. GOINGS:

12 A: Okay. So the timeout that's done, when we do that --

13 Q: No. No. That elicited a yes or no answer. Did you or
14 did you not? That means yes, I did, or no, I didn't. I
15 didn't ask you about timeout. I said did you discuss with
16 anesthesiology before this surgery started about -- about
17 issues of Crystal Goodwin's high blood pressure and
18 hypertension, and I want a yes or no answer.

19 A: Well, are you including the timeout as part of that?

20 Q: Any time before the surgery began, did you talk to
21 anesthesiology about Crystal Goodwin's high blood pressure or
22 hypertensive? Yes or no?

23 A: We did not have a special meeting other than the timeout
24 where it was discussed.

25 Q: Did you hear Sunny Jumper, the surg -- your surgical tech

1 for this procedure say that there was no timeout?

2 A: Yes, I did hear that.

3 Q: Okay.

4 A: That's not true.

5 Q: Now --

6 A: That's not true.

7 Q: Does your operative note say that you did a timeout?

8 A: It's documented in the hospital record.

9 Q: Does your operative note say you did a timeout?

10 A: That's not something that's commonly put into the
11 operative note.

12 Q: You're aware that most surgeons put in the operative note
13 at the very beginning that they did perform the required
14 timeout with anesthesia?

15 A: That's not necessary.

16 Q: But a lot of surgeons put that in there, don't they?

17 A: No. I wouldn't have any way of knowing that.

18 Q: Doctor, when the signals went out and there was no
19 feeling in Crystal Goodwin's lower extremities, you could have
20 made the recommendation to anesthesiology to increase
21 perfusion, couldn't you?

22 A: I think that would have most likely have made that worse,
23 considering what we know about it at this time.

24 Q: Doctor, I'm going to ask -- I hate asking you the same
25 question over and over again because I'm just needing an

1 answer. Here's my question again. I want you to answer the
2 question.

3 When the signals went out, Teresa Adkins says there are
4 no lower signals, and you said, well, check the equipment,
5 equipment's fine, Doctor, could you have told anesthesiology
6 or ordered anesthesiology to increase the blood pressure,
7 meaning increase perfusion?

8 A: That would be the wrong thing to do in this case.

9 Q: I didn't ask you that, Doctor. In your scope, you're --
10 you're the surgeon in the room; right?

11 A: Correct.

12 Q: There's nobody above you in that surgical suite; correct?

13 A: Well, I don't really look at it that way.

14 Q: Well, you -- you're -- it's your surgery suite and you
15 tell people what to do, and you can give orders because
16 there's actually a chain of command in the -- in the surgery
17 suite; right?

18 MR. DAVIS: Excuse me just a minute, Mr. Goings.

19 I object. This is getting into a topic that we have
20 discussed some time ago about captain of the ship.

21 THE COURT: Overruled.

22 MR. DAVIS: Okay.

23 BY MR. GOINGS:

24 Q: As the surgeon, you can tell anesthesiology or any other
25 member in that surgery suite things that they need to do for

1 the benefit of the patient; isn't that true?

2 A: I can, but as part of the timeout, any member of the team
3 is allowed to speak up at any time during the surgery if they
4 think there's some issue that we need to be aware of.

5 Q: In the surgery, surgery is going on and the signals go
6 out and you know it's not an equipment issue --

7 A: Not necessarily.

8 Q: And the signals go out and you know it's not an equipment
9 issue because --

10 A: We don't know that.

11 Q: Let me finish my question. You're in the surgery suite
12 and the signals go out, and you know it's not an equipment
13 issue because the equipment tech tells you three or four times
14 that it's not an equipment problem.

15 A: That still doesn't mean it's not.

16 Q: I'm not finished.

17 A: It's not an equipment issue.

18 Q: I'm trying to be patient. I just want to finish my
19 question.

20 A: Yes, sir. Go ahead.

21 Q: Okay. You're in the surgery suite. The signal goes out.
22 It's told to you that -- multiple times that there's nothing
23 wrong with the equipment. Okay? It is you, Doctor, the
24 surgeon, that makes the recommendation to check anesthesia and
25 check perfusion and, if necessary, increase perfusion; isn't

1 that right?

2 A: If there's an issue with that, I can make that
3 recommendation, or anesthesia could also say something if they
4 see a problem with -- with the blood pressure.

5 Q: So you're the surgeon in the room, and if you think her
6 blood pressure needs to be increased, you can make that
7 recommendation and they're supposed to follow your
8 recommendation; isn't that right?

9 A: Well, we would discuss it, but I would not make that
10 recommendation for this case. I think that's the opposite of
11 what should have been done.

12 Q: I'm not asking you for this case. I'm saying you can
13 tell the anesthesiology team to increase perfusion. That is
14 in your purview, in your responsibility, isn't it?

15 A: Well, I can't really tell them to do something that they
16 think is not reasonable.

17 Q: And if they don't think it's reasonable and you're
18 telling them to do something, you can say, well, you need to
19 go get the anesthesiologist here so I can talk to her about
20 that? You could have done that; right?

21 A: No. I'm talking about talking to the anesthesiologist.
22 If I told them to do something that they thought was not
23 reasonable, then they wouldn't do it.

24 Q: All right. I'm going to show you, Doctor, what you said
25 in your deposition when we asked you this question as to

1 whether or not you can make the recommendation to -- to order
2 perfusion changes. In your deposition, your second one, on
3 page 25, line 25. We'll play it for you, Doctor.

4 (WHEREUPON, the video deposition of Dr. Holbrook was
5 played as follows.)

6 Q: Whose responsibility is it to increase perfusion
7 levels during surgery?

8 A: To actually do that? Anesthesia.

9 Q: Okay. Do you -- as the neurosurgeon, can you make
10 that recommendation to anesthesia?

11 (WHEREUPON, the video deposition was stopped, and the
12 proceedings resumed as follows.)

13 BY MR. GOINGS:

14 Q: What's your answer, Doctor?

15 A: Yes. And I could make that recommendation, but they
16 still wouldn't do it if they didn't think it was reasonable.

17 Q: I didn't --

18 A: We'd have a discussion about it.

19 Q: But it's hard to have a discussion about it when the
20 anesthesiologist is not in the room, and you don't even tell
21 her to come to the room; right?

22 A: Well, then how could she make that recommendation or how
23 could I recommend that to her?

24 Q: All right. I'll play it for you.

25 (WHEREUPON, the video deposition of Dr. Holbrook was

1 played as follows.)

2 Q: As the neurosurgeon, can you make that
3 recommendation to anesthesia?

4 A: Yes.

5 Q: Okay. And how is perfusion levels decreased during
6 surgery?

7 A: Drugs usually.

8 Q: And you, as the neurosurgeon in the room, can make
9 that recommendation to anesthesia?

10 A: Yes. I have done that in cases from time to time.
11 (WHEREUPON, the video deposition was stopped, and the
12 proceedings resumed as follows.)

13 BY MR. GOINGS:

14 Q: You've made that recommendation in cases from time to
15 time, haven't you?

16 A: To lower the blood pressure.

17 Q: You've also made the recommendations to increase the
18 blood pressure too, haven't you?

19 A: Never in a spine surgery.

20 Q: And --

21 A: Always in brain surgery.

22 Q: You keep talking about bleeding. Oh, I don't want to
23 increase bleeding. Isn't it true that bleeding was never a
24 problem in this case? You had no problems with excess blood
25 in this surgery; right?

1 A: Well, we -- we couldn't tell if there was a problem with
2 bleeding with the spinal cord without making the MRI scan. We
3 didn't know that, and that was one of the things that we
4 thought it could be before we made the scan.

5 Q: But there was never a bleeding concern during the
6 surgery. You didn't say, oh, my gosh, she's bleeding too
7 much, did you?

8 A: Well, there's always a concern.

9 Q: Yes or no?

10 A: You always keep that in mind.

11 Q: Yes or no? Did you -- did you make a -- was there a
12 concern of bleeding of the patient like she's bleeding too
13 much during this procedure?

14 A: We did not experience any abnormal bleeding during the
15 surgery.

16 Q: And if you did experience abnormal bleeding, that would
17 be in your operative note, wouldn't it?

18 A: Depends on, you know, how serious it was.

19 Q: And your operative note said there were no problems with
20 bleeding during the surgery; right?

21 A: Well, you can show it to me.

22 Q: Is that one of the blanks in your report?

23 A: You'd have to show it to me.

24 Q: Now, Doctor, after she woke up, she couldn't move her
25 legs. Did you order a complete or comprehensive metabolic

1 panel?

2 A: We needed to get an MRI at that time, but we didn't need
3 to spend time doing blood work at that time. We needed the
4 MRI.

5 Q: Let me ask it again. Did you order just basic lab work,
6 which is called a complete or a comprehensive metabolic panel?
7 Yes or no?

8 A: That was not needed at that time. No, we did not order
9 that.

10 Q: Okay. And you didn't perform any urinalysis to test her
11 urine, did you?

12 A: Absolutely, we did not do any lab tests, urine tests.
13 The main thing we needed was the MRI scan at that time. We
14 didn't need any lab tests or urine tests. We needed the MRI.
15 And to spend time having the lab come up and draw labs and
16 that sort of thing would only have delayed us getting the MRI.
17 So that was not indicated.

18 Q: And, Doctor, a lab test, a urinalysis test could have
19 shown if there were any enzyme changes to the liver, the
20 kidneys, or the spleen that could have been a lack of
21 perfusion oriented result; isn't that right?

22 A: We absolutely did not need any of that information at
23 that time. We needed the MRI scan.

24 Q: But, Doctor, your defense in this case is, well, there
25 was nothing wrong with her liver or her kidneys or her spleen,

1 but isn't it true that you didn't do any lab work that could
2 tell this jury if there was something wrong in those other
3 organs?

4 A: Well, if we had any indication that there was a problem
5 with any other organ, we could have looked into that later.
6 Okay? But the main thing we needed to do at that time was
7 find out what the MRI scan showed to see mainly is there
8 something in the spinal cord that we can do something about to
9 minimize or correct this complication. Spending time getting
10 labs and that sort of thing would not be something that you
11 would do at that time. It would only delay getting the MRI
12 scan. And if there was a concern about some other organ
13 system, then we could do that after the MRI.

14 Q: And you told the jury you ordered the MRI on an emergency
15 basis?

16 A: Yes.

17 Q: And is that -- does that show up in the records that it's
18 stat? Is that what it's called?

19 A: I'm not sure how it showed up in the records.

20 Q: I mean, not -- not in the records, but I mean, is that
21 called a stat order?

22 A: It can be sometimes.

23 Q: What does that mean?

24 A: It means it needs to be done now.

25 Q: Okay. Or would it say emergency on the order?

1 A: I'm not sure.

2 Q: Okay. But you wanted to order it right away; correct?

3 A: Correct. We needed it right away.

4 Q: Right away?

5 A: That's correct. As soon as possible.

6 Q: Okay. I'm going to hand you a document, Doctor. I'm
7 going to represent to you it's from the hospital, and it is
8 your order for an MRI in the medical records. Do you dispute
9 that what I showed you is the order, Doctor?

10 A: Well, if you say so. I mean, I don't -- that's -- let me
11 see what it says. It looks like a request for an MRI.

12 Q: Okay.

13 MR. GOINGS: Your Honor, at this time, I'd like to move
14 this into evidence as Plaintiffs' Exhibit 34.

15 MR. DAVIS: No objection.

16 THE COURT: Plaintiffs' 34 is admitted without objection.

17 (WHEREUPON, Plaintiffs' Exhibit Number 34, MRI order, was
18 admitted into evidence.)

19 BY MR. GOINGS:

20 Q: Doctor, under Crystal Goodwin's name, it says --

21 MR. GOINGS: Yes, ma'am.

22 THE COURT: I'm sorry.

23 MR. GOINGS: Just keeping them straight.

24 THE COURT: I know.

25 BY MR. GOINGS:

1 Q: Doctor, will you put that sticker on that order, please,
2 sir. 34.

3 A: Uh-huh.

4 Q: All right. Needed to do it emergency. Needed to do it
5 stat. Needed to do it now. Doctor, the priority that you put
6 on this MRI was just a routine MRI; isn't that true?

7 A: Well, I'm not sure how it got to be routine. This may
8 have been the order that was sent down in the computer, but
9 when we needed that, the MRI technician was directly called
10 and said, hey, we need -- we have this issue, we need to get
11 this scan right away. So it would be a phone call and not
12 just putting in a routine order in the computer. I'm not sure
13 exactly. I don't have an explanation for why that says
14 routine, but --

15 Q: And it --

16 A: -- it was not done as a routine. A routine would be
17 sometime in the next day or two.

18 Q: Doctor, the request time that this order for an MRI was
19 requested was at 12:54, nearly 1 o'clock p.m.; isn't that
20 true?

21 A: It says 12:54.

22 Q: And that's nearly 1 o'clock; right?

23 A: Yes.

24 Q: So at nearly 1 o'clock, you put in an order or an order
25 was put in for this emergency MRI; correct?

1 A: The order looks like appointment time is 12:54. I'm not
2 sure exactly what appointment means.

3 Q: Do you see it says requested exam time?

4 A: Okay. I see that.

5 Q: Time requested?

6 A: Yeah, I see that.

7 Q: Okay. And, Doctor, when you look at the surgery timeline
8 that we've talked about, we have that the blood pressure was
9 too low in the hours before 10:03. The signals to the legs
10 went out at 10:03. We say that the blood pressure remained
11 too low until the surgery -- until she was actually put in the
12 recovery room at noon, and it was an hour after she was put in
13 the recovery room that an MRI was ordered, and this MRI that
14 needed to be so emergent, so now, so stat, actually occurred
15 at 2:30 p.m., which is four-and-a-half hours after she lost
16 signal to her legs; isn't that true?

17 A: From what you have there, that's what it looks like. It
18 takes some time for her to wake up in the recovery room before
19 we can even order the MRI scan.

20 Q: Doctor, you said that we don't want to waste time drawing
21 blood, and then you also said we don't want to waste time
22 doing a wake-up test because that could take 1 to 3 hours to
23 do a wake-up test. This MRI took four-and-a-half hours; isn't
24 that true?

25 A: No.

1 Q: Okay. Now --

2 A: We can't do -- we can't take her down while she's still
3 asleep. She has to wake up first, and that takes some time.
4 I'm not sure exactly how long that took.

5 Q: Doctor, it wouldn't take hours, one hour, two hours,
6 three hours, four hours, or four-and-a-half hours to increase
7 perfusion. You can increase perfusion in a matter of seconds
8 and in the matter of minutes in the operating room; isn't that
9 true?

10 A: I think that would have made it worse.

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

13 THE COURT: Redirect?

14 MR. DAVIS: Yes, ma'am, very briefly.

15 REDIRECT EXAMINATION

16 BY MR. DAVIS:

17 Q: Let me start where they left off.

18 A: Yes, sir.

19 Q: All right. I think it's their Exhibit number 23, this
20 thing right here. Did you generate that document, Doctor?

21 A: No, sir.

22 Q: You didn't do that, did you?

23 A: No.

24 Q: All right. Doctor, did you order an MRI to be done as
25 soon as you knew she could not move her legs?

1 A: Yes.

2 Q: Did you have to wait until the anesthesia team in the
3 recovery room woke her up before you knew that?

4 A: Yes.

5 Q: Once you ordered the -- you said you called or there was
6 a phone call made?

7 A: I believe one of the nurses called the -- the MRI tech to
8 tell him that we needed a scan right away.

9 Q: Then you've just got to wait until they do what they do?

10 A: Correct.

11 Q: All right, sir.

12 A: It takes some time to get the MRI scan.

13 Q: Could you have gotten her to the MRI scan any sooner than
14 you did? Could you have done anything to make that happen
15 quicker?

16 A: No.

17 Q: In eight hours of deposition testimony that you have
18 given under oath in this case at their request, one three
19 hours, another five hours, in any of those when both these
20 lawyers -- one of them deposed you the first time, the other
21 one deposed you the second time. In eight hours of their
22 questions that you were under oath to answer, did they ever
23 ask you about what a reperfusion injury was?

24 A: Not that I can recall.

25 Q: They never brought it up?

1 A: No, sir. I was going to go back to the MRI scan and how
2 long it took and that sort of thing. We didn't know it at the
3 time, but what it demonstrated is -- you know, it didn't --
4 it didn't show us anything that we could immediately do
5 something about, like a blood clot. Okay? So even if it took
6 a little longer, it didn't -- you know, it didn't matter as
7 far as what we did for her treatment. We didn't know that
8 before the MRI scan. That's why we wanted to get it right
9 away.

10 But as it turns out, with this vascular injury,
11 reperfusion injury, that sort of thing, or even if we thought
12 it was a stroke, there's no other -- no other treatments that
13 we could have done in the meantime. We were looking mainly
14 for something like a hematoma that we could do something
15 about, and we didn't know that before we got the MRI scan.

16 Q: Dr. Holbrook, what is a diagnosis of exclusion, sir?

17 A: Well, that's if you have a diagnosis of some type of
18 condition for which there's no specific test that you can do
19 that will tell you that that's what it is, and so you look at
20 all of the other possibilities that it could be. Okay? And
21 you can rule those out with certain tests and determine that
22 it wasn't -- you know, it wasn't this, it wasn't that. And
23 then you're left with your last one, which you can't do a
24 specific test for and which you've excluded all the other
25 things that it could be. And so you think most likely that's

1 what it was.

2 Q: All right.

3 A: The one that you could not do a specific test for.

4 Q: Is it -- is a reperfusion injury, in your opinion, a
5 diagnosis of exclusion?

6 A: Yes.

7 Q: Thank you. Before I show you Exhibit 4 to your
8 deposition -- I think it was your first one. It's a pre-
9 anesthesia evaluation.

10 MR. DAVIS: Gentlemen, it's on Palmetto Health Baptist
11 page 000754. Permission to read.

12 MR. GOINGS: Okay.

13 MR. DAVIS: Thank you.

14 BY MR. DAVIS:

15 Q: Let me hand this to you, if I might, and ask you to look
16 at it. I know this is not your document, but what is the
17 title of that document?

18 A: Palmetto Baptist Pre-anesthesia Evaluation.

19 Q: What's the date and time of that document? Is there a
20 handwritten time?

21 A: I mean, I'm looking.

22 Q: I think it's at the top.

23 A: I don't know. Handwritten at the top?

24 Q: Let me see. Let me see if I can find it.

25 A: Oh, here's one date.

1 Q: Okay.

2 A: 7/28/2016. Time is 6:45.

3 Q: Is that 6:45 in the morning?

4 A: I'm assuming that's what it would be, yes.

5 Q: What sort of things are checked or indicated about vital
6 signs or prior health history, including blood pressure or
7 hypertension?

8 A: Just the ones that have to do with -- with blood
9 pressure?

10 Q: Yeah. Tell the jury what's on that document. What's
11 checked?

12 A: The ones in yellow? Well, there's -- there's several
13 different things with -- with the vital signs. It has her
14 age, temperature, pulse, blood pressure.

15 Q: What's the blood pressure?

16 A: It's 160 over 99.

17 Q: Okay. Is there anything in there noted by the
18 anesthesiologist or the person who created that document prior
19 to her surgery that indicates that she had hypertension?

20 A: Yeah. They checked the box yes for high blood pressure.

21 Q: So whoever wrote -- whoever generated this document, part
22 of the anesthesia team, knew before the surgery she had
23 hypertension?

24 A: Correct.

25 Q: And they documented it?

1 A: Yes.

2 Q: Is that why you felt like it wasn't necessary for you to
3 tell them what they already knew?

4 A: Well, they already had enough blood pressures to come up
5 with a safe surgical plan. If they felt they needed more
6 blood pressures, they could have gotten them either from our
7 office or from her treating doctor who treats her blood
8 pressures. They didn't feel they needed them. They felt that
9 it was safe to proceed with the surgery with the information
10 they had that morning.

11 Q: Did you concur with that?

12 A: Yes.

13 MR. DAVIS: Nothing further. Thank you.

14 THE COURT: Anything further from this witness, Mr.
15 Goings?

16 RECROSS-EXAMINATION

17 BY MR. GOINGS:

18 Q: The document that your lawyer showed you doesn't say how
19 high her blood pressure has been over the last four, five,
20 six, seven weeks that you were treating her; isn't that true?

21 A: That's a one-time reading on that document the morning of
22 surgery.

23 Q: Okay.

24 MR. GOINGS: Thank you, Your Honor.

25 THE COURT: All right. Thank you. You may step down.

DR. FRANCIS BALESTRIERI - DIRECT BY MR. DAVIS

1 THE DEFENDANT: Thank you, ma'am.

2 THE COURT: Just leave all those exhibits up there.

3 Whatever you have, leave it all there.

4 THE DEFENDANT: Okay.

5 MR. DAVIS: Thank you, Your Honor. So may we call our
6 next witness?

7 THE COURT: Yes, sir.

8 MR. DAVIS: Your Honor, we would like to call Frank
9 Balestrieri.

10 THE WITNESS: Good afternoon.

11 THE BAILIFF: If you will, stand by me. Put your left
12 hand on the Bible and raise your right.

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: Francis Joseph Balestrieri.

20 THE CLERK: You can have a seat, please.

21 THE WITNESS: Thank you.

22 THE BAILIFF: Speak directly into the mic, sir.

23 THE WITNESS: Thank you.

24 DR. FRANCIS BALESTRIERI, being
25 first duly sworn, testified as follows:

DIRECT EXAMINATION

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BY MR. DAVIS:

Q: How do you spell your last name?

A: Let me check my ID.

Q: For the court reporter.

A: B-a-l-e-s-t-r-i-e-r-i.

Q: Is that French?

A: It's Italian.

Q: Italian?

A: Sicily.

Q: All right. Very good. Dr. Balestrieri, would you introduce yourself to the jury and give them sort of a thumbnail sketch of your education, training, and experience as a medical doctor, sir?

A: Well, I went to -- my -- my dad was a -- in the military, so I grew up kind of all over the place. I was about 7 or 8 when I was in Tripoli, Libya. It was when he -- when the United States had an Air Force base there. We then went to Germany and Italy and a couple of other places, ended up in San Francisco for a couple of years, and then ended up in Washington, D.C. So I graduated from high school in D.C., a block up from the Capitol before we had all the guards.

And -- and then I went to Georgetown College. At the end of college, I met my wife, who I'm still married to after 55 years, and then I went to dental school. Did -- I did my

1 dental degree. Went in the Air Force because about halfway
2 through dental school, I ran out of money. The Air Force
3 helped with that. I then did an internship at Wright-
4 Patterson, and then had the actually great honor of being the
5 dentist for the guys who flew President Nixon around for two
6 years.

7 At that point, against reasonably strenuous objection
8 from my wife, I went back to medical school. I wanted to be a
9 really good head and neck surgeon. So I went back to medical
10 school with the Navy support at this time. Got out of medical
11 school and -- and was obligated to go in the Navy. Did a year
12 internship in the Navy, did my residency in the Navy. Then I
13 did a fellowship in critical care medicine with the Navy, and
14 then I did another three years with the Navy until 1983, when
15 the Navy sent me to Beirut.

16 And if you recall, that was when there was a rather
17 disastrous bombing. It changed my view of the risk of being
18 in the military, and so within a year, I got out and went to
19 Bowman Gray. I was one of the anesthesiologists at Bowman
20 Gray for about three years, and then my family is in
21 Washington, D.C., and I got a great job offer there. So I
22 went to Washington, D.C., for the next 19 years or so.

23 Q: What did you do in Washington for those 19 years?

24 A: It was at a place called Inova Fairfax Hospital. It's a
25 -- it's probably one of the largest hospitals in -- in

1 Virginia, about 800 beds when I got there, about a thousand
2 when I left. And -- and during that time, I was a staff
3 anesthesiologist. From 1990 to 2000, I was the medical
4 director for ambulatory surgery. From 2000 to '03, I was the
5 chairman.

6 And about a year later, I left for Colorado. We had had
7 enough of the traffic, and we liked hiking. And I was working
8 110 -- 20 hours a week when I was at Fairfax, and it was
9 either get divorced or go to Colorado. So we went to
10 Colorado.

11 I was there for about 14 years. After the second year, I
12 became the medical director for surgical services. The
13 hospital in Colorado was a relatively small 150, 200-bed
14 hospital. It was part of a larger Banner Health System that
15 has about 15 hospitals.

16 And then my grandkids came along, and we figured out a
17 way to come back to Raleigh, where my grandkids are, and
18 that's why we're at Raleigh now. Since then, I've been
19 working for a group called American Anesthesiology of North
20 Carolina, and I'm one of the staff anesthesiologists. I went
21 from a full-time position to a -- to a retired position from
22 working like 4 or 5 days a week to working 5 or 6 days a month
23 about a year ago October. And that's how I got to where I am.

24 Q: Are you board certified in anesthesiology?

25 A: I am.

1 Q: And about how long have you been board certified?

2 A: I think that was 1983. So for probably -- what am I
3 going to -- 40 years.

4 Q: Okay. And you're still providing anesthesia services and
5 you're still working as an anesthesiologist?

6 A: Yes, sir. Got to get to work tomorrow morning.

7 Q: Yes, sir. About how often would you serve as a primary
8 attending anesthesiologist, M.D. anesthesiologist, in
9 operative procedures that include decompressive laminectomies?

10 A: Now it's probably about a third of my -- of what I do.
11 So I'm working roughly five -- so just say five days a month.
12 So probably, I frequently get the -- the major orthopedic
13 cases because I have an interest in -- in that kind of
14 surgery, and the surgeons are really pretty incredible people.
15 And so I probably do -- we usually do two or three of those a
16 day. So I'm probably doing 15 a month now. And before
17 October of 2021, I was probably doing 30.

18 Q: Doctor, have you testified as an expert for plaintiffs in
19 the past?

20 A: Yes, sir.

21 Q: As well as defendants like in this case?

22 A: Yes, sir.

23 MR. DAVIS: Your Honor, I'd like to offer Dr. Balestrieri
24 as an expert in anesthesiology.

25 MR. HINSON: Your Honor, we have no objection to the

1 proffer of Dr. Balestrieri as an expert in anesthesiology. We
2 do have one quick matter of law to take up.

3 THE COURT: Okay. Ladies and gentlemen, please return to
4 your jury room. Do not discuss the case.

5 (WHEREUPON, the jury exited the courtroom at 3:16 p.m.)

6 THE COURT: Gentlemen?

7 MR. HINSON: Your Honor, for purposes of this matter of
8 law, we would respectfully request that the witness just step
9 outside the courtroom so our positions that we put on don't
10 educate the witness improperly. Thank you.

11 THE COURT: Absolutely.

12 Dr. Balestrieri, would you step down from the witness
13 stand but also step out of the courtroom?

14 THE WITNESS: Yes, Your Honor.

15 THE COURT: There is a vestibule outside the doors. Go
16 beyond that to the main hallway, if you will.

17 THE WITNESS: Yes, ma'am.

18 THE COURT: Thank you.

19 (WHEREUPON, there was a pause in the proceedings until
20 the witness exited the courtroom.)

21 THE COURT: Yes, sir.

22 MR. HINSON: Thank you, Your Honor.

23 This is a similar motion to before, only it's a little,
24 quite frankly, for lack of a better word, cleaner. This is
25 another expert that Defendant Holbrook and Midlands are

1 piggybacking. He was originally named by Prisma. Then later
2 -- well, at his deposition on August 25th, 2021, I asked him:

3 Question: And you don't intend to come to trial and
4 testify as to what -- excuse me -- what future medical needs
5 she may or may not have?

6 He says: I will not testify to that.

7 And I said: Okay. You do not intend to come to trial and
8 testify as to what caused her injury. Are you going to give a
9 causation opinion?

10 His answer: No, sir.

11 I went on to say: And so your testimony will be limited
12 to the standard of care, opinions, and anesthesia?

13 His answer: Yes, sir.

14 A couple of pages later, I asked: And I understand if you
15 -- if you don't intend to come to trial and offer an expert
16 opinion on the cause of Ms. Goodwin's injury, but I
17 nonetheless want to ask, do you have an opinion or a belief as
18 to what caused her paralysis?

19 His answer: I do not know what caused her spinal cord
20 injury.

21 And, Your Honor, when -- then Defendant Holbrook
22 piggybacked this expert. They disclosed him and they said Dr.
23 Balestrieri is a board-certified anesthesiologist and will
24 testify consistent with his sworn deposition testimony taken
25 by plaintiffs' counsel on August 25th, 2021.

1 Your Honor, I just -- he's welcome to come and talk about
2 what anesthesiology should or shouldn't do, but he twice told
3 me at deposition he wasn't giving causation opinions.

4 MR. GOINGS: May I approach to see how they designated
5 him, Your Honor?

6 THE COURT: Yes, sir. That's exactly what I was about to
7 ask for.

8 MR. GOINGS: Because I think that was germane to your
9 prior ruling, which I understand why you ruled and what you
10 did.

11 THE COURT: Yes, sir.

12 MR. HINSON: And if I could show you the transcript?

13 THE COURT: Yes.

14 MR. HINSON: Let me get my mark up. It's right here,
15 Your Honor, and then down there.

16 THE COURT: Yes, sir. Thank you.

17 Mr. Davis?

18 MR. DAVIS: I haven't asked him a single question yet.

19 MR. HINSON: And I just want to make sure we don't -- we
20 don't get into it in the presence of the jury.

21 MR. DAVIS: Yeah, and I appreciate that. Okay.

22 THE COURT: All right. Where are we going with it,
23 generally speaking?

24 MR. DAVIS: Well, Your Honor, I'm going to ask him does
25 he have an opinion based on his review of this case and the

1 blood pressures and the anesthesia record and everything that
2 he's looked at in this case as an expert and as an
3 anesthesiologist, whether or not he has an opinion whether
4 it's low blood pressure caused this injury. That's it.

5 MR. HINSON: But, Your Honor, he specifically said he
6 wasn't testifying about that.

7 MR. DAVIS: He testified about that in his deposition.
8 He was unequivocal about it.

9 THE COURT: Tell me again, Mr. Davis, what he is going to
10 testify to today?

11 MR. DAVIS: He's going to talk about the amount being the
12 problem in this case, the level of the urine output is not
13 consistent with the -- with a low blood pressure problem.

14 MR. HINSON: No -- no -- no problem with that testimony,
15 Your Honor.

16 MR. DAVIS: Okay. Your Honor, it's a bad -- I have to
17 dig out everything in his deposition, but let me see if I can
18 do that.

19 THE COURT: Well, as long as it's confined to what he
20 said in his deposition, then I don't think there's a problem.

21 MR. DAVIS: Okay.

22 THE COURT: But if he is going to talk about something
23 other than standard of care opinions in anesthesia or if he is
24 going to express an opinion or belief as to what caused her
25 paralysis --

1 MR. DAVIS: No, he's not going to -- we're not -- we're
2 not asking him about that.

3 MR. HINSON: Then -- then we're good. I just wanted to
4 address this.

5 THE COURT: Okay.

6 MR. DAVIS: But we do intend to ask him, in his opinion,
7 based on his review of the medical records, whether or not low
8 blood pressure was a cause of her injury from an
9 anesthesiology standpoint.

10 MR. HINSON: That's what he said. That's what he said in
11 his deposition.

12 MR. DAVIS: Brink --

13 THE COURT: Show me where he said that in his deposition.

14 MR. DAVIS: Well, let me -- if I might hand you an
15 exhibit that he produced that we intend to go into at trial,
16 this document he prepared prior to his deposition that was
17 marked as an exhibit.

18 THE COURT: Sure. I want to see in his deposition where
19 he talks about that.

20 MR. HINSON: Your Honor, I will -- I will acknowledge I
21 did ask him some questions about it. I mean, I ask people
22 questions about all kinds of stuff. I ask them, you know,
23 where did you go to med school? I ask them, you know, have
24 you ever worked with Mr. Davis before? All kinds of things.

25 But I did not explore it fully because he told me he

1 wasn't testifying about it. I mean, why take a six-hour
2 deposition if you can take a two-hour deposition when
3 somebody's testified they don't intend to go into causation?

4 MR. DAVIS: Your Honor, several places in this
5 deposition, he is asked about it, and he testified about what
6 a baseline blood pressure is. That's been asked forever in
7 this case, and he's going to comment about that. That's what
8 he testified at length about that. He also testified at
9 length about what he considered to be a safe and appropriate
10 -- appropriate MAP level for this surgery for this patient.

11 THE COURT: I keep asking you --

12 MR. DAVIS: Okay.

13 THE COURT: -- to show me, and if that part is not
14 objectionable, then you need not show me. Tell me what is
15 objectionable, Mr. Hinson.

16 MR. HINSON: Your Honor, if he says what caused her
17 injury, what caused that, that's the problem I have. If he
18 says is this a safe MAP, I've got no problem with it. That is
19 anesthesia standard of care questions.

20 But if he says did this MAP cause the injury, then we've
21 gone too far. That's -- that's the line I'd like to draw.

22 THE COURT: Any problem with that, Mr. Davis?

23 MR. DAVIS: I don't -- I don't really think so, but he
24 was also asked about the wake-up test. I'm going to ask him
25 about that from an anesthesia perspective.

1 MR. HINSON: No problem with that.

2 MR. DAVIS: Okay. Well, let me -- let me -- let me look
3 at my outline real quick because I think I might be able to
4 short circuit this for everybody.

5 MR. HINSON: And, Your Honor, should this -- in the event
6 this comes up again, I didn't want to give you my -- my
7 outline because I'm going to use that, but --

8 THE COURT: I understand.

9 MR. HINSON: -- those are the two relevant portions right
10 there.

11 THE COURT: Thank you.

12 MR. DAVIS: I intend to ask him what sort of MAP number
13 in Mrs. Goodwin's case would he believe would be within the
14 standard of care? If he gives some sort of range or number,
15 that is page 79 -- excuse me -- 75 through 80 and also page 39
16 and 40. I'm going to ask him the basis of that opinion, about
17 the risks of keeping the blood pressure too high or the risk
18 of keeping the blood pressure too low. These are anesthetic
19 questions.

20 MR. HINSON: No -- no objection to --

21 MR. DAVIS: Okay.

22 MR. HINSON: -- those questions, Your Honor.

23 MR. DAVIS: I think -- I think we're going to be okay.

24 MR. HINSON: Okay. Good enough. The word "cause" will
25 result in --

1 MR. DAVIS: Then we can copy that.

2 MR. HINSON: I don't want to say yes, Mr. Davis, but I
3 would, yeah. Thank you.

4 THE COURT: Yeah. I think the issue would be making the
5 -- the causal connection between MAP, blood pressure, et
6 cetera, and why Ms. Goodwin is in a wheelchair today. I think
7 that's what was apparently missing in the deposition, and they
8 don't want that to happen today.

9 MR. DAVIS: That's fair. I would ask him about baseline
10 blood pressures, urine output, mean arterial pressures, the
11 goal of maintaining a mean arterial pressure above 80, which
12 he's going to opine, as he said in his deposition. He was
13 asked, well, what mean arterial pressure would you keep Ms.
14 Goodwin in this case? Is it probably in the 80s? Why? You
15 know, those kind of things.

16 THE COURT: Okay.

17 MR. HINSON: Perfectly fine.

18 MR. DAVIS: Okay.

19 THE COURT: Okay.

20 MR. DAVIS: I think -- I think we're good.

21 THE COURT: Okay.

22 MR. HINSON: And if the witness starts to kind of delve
23 into that, we may alert Your Honor so you can advise him of
24 such.

25 MR. DAVIS: Okay. Can I -- can I --

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1 MR. HINSON: Yes. Go tell him.

2 MR. DAVIS: I -- can I talk to him?

3 THE COURT: Yes.

4 MR. DAVIS: Just make sure. I don't think -- I mean, I'm
5 looking at my outline. I don't see where I --

6 MR. HINSON: Or maybe call him in here and you tell him .

7 THE COURT: I'm happy for Mr. Davis to tell him.

8 MR. DAVIS: Okay.

9 THE COURT: Because we're going to take a short break
10 since the jury's out already anyway.

11 MR. DAVIS: Right.

12 THE COURT: This was your exhibit, Mr. Davis.

13 MR. DAVIS: Yes, ma'am. Thank you.

14 THE COURT: It was up here for you. Let's just take ten
15 minutes.

16 MR. DAVIS: So I have permission to just give him an
17 instruction?

18 THE COURT: Yes, sir.

19 MR. DAVIS: Thank you.

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

22 THE COURT: All right. Dr. Balestrieri? Dr. B?

23 MR. DAVIS: You did that really well.

24 THE COURT: I'll answer to anything, Your Honor.

25 THE COURT: All right. Bring the jury, please.

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1 (WHEREUPON, the jury entered the courtroom at 3:40 p.m.)
2 THE BAILIFF: The jurors are seated, Your Honor.
3 THE COURT: Thank you.
4 Where were we? Direct examination, Mr. Davis?
5 MR. DAVIS: Thank you, Your Honor.
6 Your Honor, we offer Dr. Balestrieri as an expert in
7 anesthesiology.
8 THE COURT: Yes. Ladies and gentlemen --
9 MR. DAVIS: Brink, do you have --
10 MR. HINSON: Without objection.
11 MR. DAVIS: Okay. Thank you.
12 THE COURT: Right. As I've told you with other expert
13 witnesses, they can testify about opinions. Give their
14 testimony the weight and credibility you think it deserves.
15 Dr. Balestrieri is an expert anesthesiologist and will
16 give opinion testimony within that field of expertise.
17 You may proceed, Mr. Davis.
18 MR. DAVIS: Thank you, Your Honor.
19 BY MR. DAVIS:
20 Q: Doctor, in your practice as an M.D. anesthesiologist, do
21 you have occasion to work with CRNAs like Mr. Starn in this
22 case?
23 A: Yes, sir.
24 Q: Is that on a pretty regular basis?
25 A: Pretty regular. I occasionally provide anesthesia as a

1 loan person at one of the electroconvulsive therapy locations
2 in Raleigh, but that may be terminating soon. But that's the
3 only other -- other venue. Otherwise, I work with CRNAs and
4 anesthesiologist assistants.

5 Q: Okay. Dr. Balestrieri, I asked you a moment ago about
6 your testimony history. Could you give the jury a breakdown
7 of percentage wise between plaintiffs' work and defendants'
8 work as an expert?

9 A: I would say currently I'm probably 60 percent defendants
10 and about 40 percent plaintiffs. A lot of it just has to do
11 with -- I don't advertise. I just -- people ask me, call me
12 up and ask me. And it used to be I was probably doing 60
13 percent plaintiffs and 40 percent defendants, but -- but over
14 the -- since I've been in Raleigh, I met an attorney who asked
15 me to help and -- and he's a defense -- he predominantly does
16 defense work. So I've had more cases to review from him.

17 Q: Have you and I ever worked together before?

18 A: I don't believe so.

19 Q: Okay. I don't think so. About how many times have you
20 reviewed a case for a plaintiff and found that the standard of
21 care is of an anesthesiology case was not met and then been
22 willing to testify for the plaintiff?

23 A: Probably about 25 or 30 times.

24 Q: So, Doctor, tell the jury what you had occasion to review
25 in this particular case?

1 A: Well, there was a -- there was a lot of material. I've
2 been getting this stuff over the last many years. And so I'll
3 just read from my latest bill, which tends to be the most
4 accurate recollection of what I did.

5 I reviewed the complaint. I reviewed plaintiffs' answers
6 to defendant Prisma Health. I reviewed the supplemental
7 answers to plaintiffs' first interrogatories. I reviewed
8 Columbia Colonial FP note. I reviewed the chronology file. I
9 reviewed Dr. -- Dr. Lustgarten, his notes. The affidavit of
10 merit of F. Jones. The affidavit of merit of G. Lustgarten,
11 deposition of -- of D. Blair Cereny [ph]. That was the relief
12 nurse anesthetist who came in to relieve Mr. Starn.

13 I reviewed the deposition of Mr. Starn, the deposition of
14 -- of Dr. Holbrook, the deposition of C. Goodwin, Ms. Goodwin,
15 the deposition of -- of F. Jones, the anesthesiologist for the
16 -- for the plaintiff, and I also reviewed his video that you
17 all saw yesterday.

18 I reviewed the exhibits of deposition of -- of -- of Dr.
19 Jones, the anesthesiologist, and the Specialty Care
20 neuromonitoring document, which was done during the surgery of
21 June -- of July 28th. I reviewed the five -- 593-page Prisma
22 Health Baptist Hospital in Columbia document. I reviewed the
23 deposition of Dr. Root. I reviewed the deposition -- the
24 records, 30 pages, of Midlands Orthopedics.

25 And then I also sat for a deposition with -- with the --

1 with the plaintiffs. And most recently, I looked over the --
2 the videos and the -- and the -- and the items that were meant
3 to illustrate what was going on, which I reviewed again. And
4 finally, I reviewed the deposition of -- this was the latest.
5 It was last October '22 of Anthony Mancuso, John Sampson, Dr.
6 Sampson, and I believe, Dr. Michael Rose. And I think that
7 was it.

8 Q: All right, sir. Doctor, what's the -- what is the -- I'm
9 going to call it a 20 percent rule that we've heard about from
10 anesthesia. What is that?

11 A: Well, it -- it -- we call it kind of the 20 percent rule
12 or 20 percent guideline. There -- you know, as you -- as you
13 -- as you do this longer and longer, you find there are some
14 incredibly simple questions to which we don't have really good
15 answers. So -- so a simple question is this is the patient's
16 blood pressure, where should we keep it. So the 20 percent
17 rule -- so let's -- let's assume that I decide that your blood
18 pressure is 140 over 90. Now, with current definitions,
19 that's high blood pressure, but ten years ago, 140 over 90 was
20 acceptable. But if I take 140 over 90, the mean pressure
21 there is going to be about -- let's just say 120 or 110.

22 The 20 percent rule says if you're -- if you think that's
23 where the patient normally lives, what's frequently referred
24 to as baseline blood pressure, I mean, just think about it.
25 What -- what -- what's going on most of the time with my

1 heart. It's actually a difficult number to come up with, but
2 if I pick it and I decide that it's 100, then I say in order
3 to keep this patient safe, I need to keep it below 120, the 20
4 percent rule, 20 percent up and 20 percent down. So 100 minus
5 20, 80. 100 plus 20, 120. So I keep it in that range, and
6 I'm hopefully going to be safe.

7 Q: Do you personally try to keep the patient's blood
8 pressure intraoperatively within that 20 percent guideline of
9 his or her baseline blood pressure?

10 A: So it depends upon the surgery, and it depends upon the
11 patient. On the other hand, it is -- that's a good rule, I
12 think, to start with, but let's say that I have a patient with
13 very low blood pressure. Some people are just naturally low.
14 They may have some system malfunction in their autonomic
15 nervous system that makes their blood pressure low, but let's
16 just say you're a runner or you're just a health nut and your
17 blood pressure is 90 over 50.

18 So -- so that's a pretty good blood pressure. On the
19 other hand, so -- so the mean arterial pressure would be one
20 of the ways of doing it. I usually just go to the computer
21 and use a calculator, but let's say it's 90 over 40 or let's
22 make it easier, let's make 90 over 50. So -- so I would take
23 the 50 and I'd take the difference, the pulse pressure. So 50
24 over 90. So that's going to be 40, and I take a third of
25 that. So roughly 12 or 13. So my lowest blood pressure

1 should be, like, 60.

2 Well, you know, the -- so where -- so this -- I mean,
3 this is such a simple question, you'd think I'd know the
4 answer, and I've been doing this for a while. I don't, but I
5 do know what makes the most sense. If you spend hours every
6 week reading through stuff and trying to find out answers to
7 these simple questions, you'll realize that there's one
8 reasonably good rule to follow. You should never let the
9 blood pressure fall below 65 millimeters of mercury. So a
10 mean arterial pressure of 65 or above is usually safe.

11 Now, if a patient has hypertension -- and I can tell you
12 that is not an uncommon thing. I would say that a third of my
13 patients have -- have -- have hypertension and diabetes and
14 they're significantly overweight. So that's kind of who I
15 take care of regularly. Matter of fact, Cary is a major
16 center for obesity surgery. So you're constantly dealing with
17 -- with diabetes and hypertension.

18 Now, what I know is, is that if I keep most patients'
19 blood pressure between 70 and 100, I'm probably going to be
20 safe, and that's kind of the background assumptions that most
21 of us take when we're going to the operating room. So -- so
22 the answer is, is that I take into consideration the patient's
23 history, where their blood pressure is.

24 For example, what you're dealing with, I believe the
25 morning of surgery, the patient's blood pressure, Ms.

1 Goodwin's blood pressure was like 160 over 90. Now, in the
2 record, I remember seeing that that was recorded at 6:45, but
3 it was also recorded at 6:07. I'd have to -- but it was
4 recorded before surgery, and I can tell you that if I saw
5 that, that would alarm me. I would be -- I would be very
6 interested in discussing with the patient what -- what's
7 really going on.

8 Another thing to remember is that the current medical
9 record -- so I just listed a lot of medical records. There's
10 probably 5,000 pages of those records that I was showing you.
11 Probably 4,500 of them are meaningless accounting
12 documentation.

13 And what -- what -- what you're forced to do is know
14 where to go in the electronic record to find the data you
15 want, and what I need to find out most mornings for doing most
16 orthopedic back surgery is -- the patient comes into the
17 hospital. They're frequently there a week or so before. I
18 check what their vital signs are then. I look at what their
19 vital signs are the morning of surgery. I then look at what
20 their vital signs are when they're in the pre-op area, and
21 that may or may not get recorded, but I definitely check what
22 their blood pressure is when they're in the operating room,
23 when they're maybe a little bit relaxed just before I give
24 them anesthesia, and that's the pre-op, that's the immediate
25 preoperative blood pressure.

1 That's kind of a requirement. If you don't do that and
2 something bad happens, you've probably done a bad thing. So
3 that's what I would have tried to do with -- with Ms. Goodwin.

4 Q: Okay. Doctor, as an anesthesiologist and given your
5 experience, are you aware of any substantial evidence that
6 blood pressures much above 70 or 80 mean arterial pressure are
7 of any benefit in perfusing the organs, including the spine?

8 A: The -- the -- so the basic answer to that is the spinal
9 cord and the brain do something called autoregulating. It's a
10 really nice concept that makes us all feel really good about
11 taking care of our patients.

12 So here I am. You know, I've got a mean arterial
13 pressure here of -- of -- of 60. And depending upon where you
14 read it in a textbook or in an article, it may be 50 or 60,
15 frequently 60. So from a mean arterial pressure of 60 up to a
16 mean arterial pressure of as much as 140, that's where we say
17 the blood vessels to the brain will contract or constrict to
18 make sure that the blood flow to the brain, as determined by
19 the brain or by the spinal cord, is adequate.

20 So that's -- that's what you've got to deal with. So as
21 a general rule, If I keep the blood pressure above 70 and
22 below 140, the brain's going to take care of itself.

23 Now, the only caveat to that -- and this is something
24 that we started doing probably -- well, probably ten years
25 into Fairfax. So 30 -- 25, 30 years ago, we started treating

1 patients with stroke, and the question with stroke is we need
2 the blood pressure as high as we can get it, but it needs to
3 be -- but where do we -- where do we lose -- where do we get
4 more -- more risk than benefit from keeping the pressure up
5 high?

6 So, normally, when we take care of a patient who's having
7 a stroke -- and where I work, Cary -- in Cary, Wake Med in
8 Cary, we -- we have been a stroke center for about four years
9 now. So our goal -- we put -- we put a catheter in their
10 artery so we can measure it, and our goal is to keep their
11 mean arterial pressure around 90, and that's as high as we go.

12 Now the problem is -- so say 80 to 90 because -- because
13 these -- these numbers -- it's not like -- you can't -- you
14 cannot dial in a blood pressure. You can try to, but -- but
15 you have a variety of techniques to do that with. And as you
16 all have heard, you can use -- you can use drugs like
17 epinephrine, adrenaline. You can use volume. You can use a
18 variety of different kinds of volumes, but the trouble with
19 the chemicals that we use, like adrenaline, that may raise my
20 blood pressure, but this whole idea of what's happening at the
21 brain is really we don't know whether the epinephrine that I'm
22 giving them to raise my blood pressure in my arm is causing --
23 excuse me. I'm a Balestrieri. I talk with my hands.

24 I don't know whether the -- the blood pressure is --
25 whether that drug, that adrenaline, is going -- is making the

1 -- the blood flow to the spinal cord or the brain worse. It's
2 definitely raising the blood pressure, but it's not pressure,
3 it's flow. And so I try to use volume first if I can, but I
4 try to keep the pressure below 100 when I'm taking care of
5 stroke patients.

6 Q: A lot of talk about baseline blood pressure and,
7 obviously, we're going to ask you as an anesthesiologist
8 expert about that. So let me -- let me dive in. How, in your
9 opinion, is a baseline blood pressure determined in the
10 setting of a spine surgery like was performed on this Goodwin
11 on July 28th, 2016? How's that done?

12 A: Well, first of all, if -- if it's -- if we limit it to
13 spine surgeries like Ms. Goodwin, we're really -- we're
14 talking about a patient who's had two spine surgeries before,
15 and she's having a third spine surgery. There is very little
16 data on the complications as a result of spine surgery,
17 somewhere between 1 and 1,000 bad outcomes to 1 in 100 for the
18 first time, but it's double that the second time. Still very
19 low, and I don't know what it is for the third time. At
20 least, I haven't come across anything that would -- would --
21 would lead me to think -- it surely is not going to be a lower
22 risk.

23 But the -- so determining a baseline surgery blood
24 pressure is not something that is absolutely required. It's
25 not something that you have to do. It's something that for

1 major spine surgeries like Ms. Goodwin, I always do that in a
2 discussion with the surgeon.

3 Now, there's -- there's two surgeons that I've worked
4 with for the last six years at -- at Cary -- at Wake Med,
5 Cary, and I know them very well. We've probably done -- I
6 don't know -- 500 backs, big backs on -- on -- on -- on older
7 people. I did a -- did a multi-level back surgery on an 82-
8 year-old. And Ms. Goodwin is young. She's a young vibrant
9 woman.

10 And -- and -- and so this -- we decided that her blood
11 pressure -- and she was hypertensive, and I discussed that
12 with the surgeon. Matter of fact, I put a catheter in her
13 artery so I could watch her blood pressure continuously. So
14 again, continuous means I do it, like, every chance that I
15 get.

16 So, like, with a -- with a -- with an arterial line, I
17 see her blood pressure, if her heart rate is 60, every second.
18 Okay? But what's required is that you take the blood pressure
19 continually, which just means that you take it regularly, but
20 relatively frequently. And that's what Ms. Goodwin got.

21 So what do we do? I would say that a third of the time,
22 all that I have -- and for most patients having spine surgery,
23 they've seen the preoperative evaluation clinic, which I think
24 was the case with Ms. Goodwin. And I look at the blood
25 pressures there, and then I look at the blood pressures that

1 they get. Invariably, a patient coming for surgery on Monday
2 morning is going to be checked in, and they will get a blood
3 pressure when they first check in. If there's a blood
4 pressure like 160 over 99 like Ms. Goodwin had, I would have
5 been immediately called. They would have said, Frank, get
6 over here and have a -- have a discussion.

7 Now, the other thing that I found over the years is that
8 the literature supports 80 percent of what I do, but at least
9 a third, 20 percent to 30 percent, it's just this is the way
10 we've been practicing things, like the 20 percent rule.

11 Well, if I -- but what I do know is if I go and I talk to
12 the patient and they tell me how they're doing, I can get a
13 pretty good idea of how bad their hypertension is. Now, if
14 her blood pressure had been 160 over 99 immediately before
15 they put her to sleep, that would have frightened me because
16 that is a very high, very possibly dangerous blood pressure.
17 If -- if -- if she were 160 over -- over 110, I would send her
18 to the emergency room or else I would begin -- I would begin
19 very -- I would have a real discussion. Do we need to do
20 this? We got to get this under control. But her blood
21 pressure just prior to going to sleep was in the reasonable
22 range. So I would use that, and I would have to make a
23 judgment. The judgment is what is this? Okay?

24 Now, we've talked about white coat syndrome. I'm not
25 sure I've -- I've seen that. I see a lot of patients who have

1 high blood pressure. Okay? But I'm not sure what white coat
2 syndrome is. I'm not sure exactly the mechanisms by which
3 it's mediated, but it's something that we observe.

4 Now -- but I have seen it, and what it is is very
5 different than just somebody with high blood pressure. It is
6 somebody who comes in with a blood pressure that is not 150 or
7 160, but 180 over 110. So the discussion is -- and I've had
8 this happen twice in the last year -- should we send you to
9 the emergency room? And this one woman said, Dr. B, this
10 happens to me every time. And I said, well, I just can't let
11 you go back to the operating room without treating your blood
12 pressure now. So we treated her blood pressure. We got her
13 through her hernia operation.

14 And -- and then I had given her blood pressure medicine,
15 and I had to give her extra fluids and keep her in the
16 hospital for an extra two hours because I had treated her
17 white coat syndrome, and her pressure was too low to let her
18 go home. So that's white coat syndrome.

19 People that we care for on a daily basis are
20 hypertensive. So the question then becomes, what do I use to
21 come up with my best guess as to what the baseline blood
22 pressure should be?

23 The major message that I get from my colleagues in
24 orthopedics and neurosurgery is I need the blood pressure
25 lower because of bleeding is usually the case. So we're

1 having that discussion. And my goal is to keep the blood
2 pressure as low as possible, but high enough so that I don't
3 put the patient at risk.

4 Now, with -- with Ms. Goodwin, I would have had to make a
5 judgment as to where to keep it. And I think -- as it turns
6 out, I'm not sure I couldn't glean from the records, all these
7 records, what Mr. Starn and -- and Dr. Root decided on or --
8 or Dr. Holbrook, but I do know where she ended up with was a
9 great place for her to be, in my opinion, and if she had been
10 --

11 Q: What do you mean by that? What place are you talking
12 about?

13 A: So -- so -- so one of the things that -- that -- one of
14 the things that was -- that I used -- so -- so -- so the issue
15 in this matter is what is the baseline blood pressure? I
16 mean, what should it be? I can tell you that it is not
17 something that -- you know, you've seen a lot of anesthesia
18 records. You've seen blood pressure, heart rate. You've
19 seen, you know, 27 different boxes for every kind of billing
20 thing, but have you ever seen baseline blood pressure? No.

21 We address it. It's something that's kind of in the
22 background. We assume we're going to maintain somebody's
23 blood pressure between a mean pressure of 60 and 100. That's
24 good care.

25 So I don't have the ability to get a good set of data to

1 come up with a really decent baseline blood pressure on most
2 patients. I use what -- what data is available, and some of
3 the data that's 2 or 3 months old can be misleading. For
4 example, it's not clear. It's clear to me that Ms. Goodwin
5 was on hydrochlorothiazide, HCTZ. That is a diuretic. It
6 makes you -- makes you urinate, but it also causes your veins
7 to dilate, and it lowers your blood pressure. It can also
8 mess with your potassium. But -- but -- and from Dr. Root's
9 evaluation, there was a question about lisinopril, which is
10 another blood pressure.

11 So the question that came into my mind is, is, okay, so I
12 take blood pressure medicine. Sometimes I don't take it. So
13 a real effect is that if you skip 1 or 2 days of your blood
14 pressure medicine, your blood pressure can be really high,
15 rebound hypo -- hypertension. So I don't know whether that's
16 coming into play.

17 So I'm usually trying to do what -- what most people do
18 with this kind of -- of an operation is you look at the
19 pressures that you have available, you throw out the ones that
20 you think are just due to the patient being frightened, and
21 you try to get an idea. And in this case, the best one that I
22 found was the immediate preoperative before you go to sleep
23 blood pressure.

24 Q: What was that?

25 A: That was intraoperative, 140 over 90. So that's a mean

1 of 107 and a -- and a 20 percent. So --

2 Q: Is that reflected on this anesthetic record?

3 A: Yes, sir.

4 Q: 140?

5 A: That's the first one.

6 Q: Over 90?

7 A: 90, 92. Yes, sir. Somewhere around there.

8 Q: Okay.

9 A: So that -- that -- that gives you a mean arterial
10 pressure of 107. Now, you know, 107 is very different than --
11 than, you know, 120. And so that's -- that's not a bad place
12 to aim for, but the lowest that I want it to be is 20 percent
13 less than that, which gives us a number of about 86.

14 Now, in my view, the question -- and this is -- this is
15 -- this is something that I ask myself. I say what -- this is
16 a little different. I don't know if any of you have high
17 blood pressure, but when I -- when I followed my blood
18 pressure, it was -- and I'm a doctor. I'm taking my blood
19 pressure four times a day. It was a pain. I frequently was
20 not compliant. And my wife, too.

21 So we had an opportunity with Ms. Goodwin to basically
22 say what was her blood pressure? What really is her -- where
23 does she live most of the time? And we had that, and it's
24 part of the record that I gave during my deposition.

25 So if you look at her health record here, I had a patient

1 who for -- for -- for a catastrophic reason was in the
2 hospital for -- for ten -- more than ten days. It -- it -- it
3 -- dealing with the suffering that she was going through and
4 dealing with the pain of having had surgery.

5 So I took every blood pressure I could find in the
6 record, and I put it down and -- and I looked at the -- I
7 looked it over from -- from August from -- from the 29th, the
8 day after her surgery, through August the 8th. I took a look
9 at 31 blood pressure recordings over 11 days, and the mean
10 arterial pressure there for those 31 recordings, which I just
11 don't have on the average patient, it just -- we could, if we
12 had made a decision 20 years ago that we wanted baseline blood
13 pressure data to come to patients in the operating room, we
14 could. We didn't. We do have a system that does very good at
15 billing.

16 So what was her blood pressure of all those days? And it
17 was -- it was 94, 94, 20 percent of 94 for the 20 percent rule
18 turns out to be 75. So that was -- and then you looked --
19 then -- then -- then let's -- let's look. I looked from the
20 28th that afternoon. Okay? And I got 85. Okay? As a lower
21 blood pressure.

22 And then so the bottom line is that I got between -- I
23 got 84, 84, and -- and then -- so I came to the conclusion
24 that a blood pressure above 85 would be a good place to keep
25 Ms. Goodwin and that that would adequately give me a pressure

1 head to adequately perfuse her brain, her spinal cord, and the
2 rest of her organs.

3 Q: Well, Dr. Balestrieri, in the medical records, you have a
4 chart with blood pressures during surgery numbers. Let me
5 pull this up. Just a minute. There we go. No. This
6 surgery. There we go. These are the MAPs from the blood
7 pressures from the anesthesia record.

8 A: Right.

9 Q: 86.7 on the board to below 86. 88.3. 86.7. 85. 85.
10 86.6. 86.6. 86. There's -- there's an 82.7 and an 82.

11 I want you to assume, for the sake of the question, that
12 at 9:58, between the 9:55 and the 10 o'clock, there was a
13 blood pressure recorded by the neuromonitoring tech, and I
14 think you've seen this. You -- you brought it to our
15 attention. Is it 103 over -- 104 over 63? I can't remember.

16 A: 103 over 64.

17 Q: 64. And that's an MAP of -- you calculated it at 77?

18 A: Yes, sir.

19 Q: Well, that's -- that's below that 80 range you're talking
20 about. Is that going to cause a problem for your patient?

21 A: Well --

22 Q: The perfusion, I guess, is what --

23 A: You know, I've been -- I've been doing this for a while.
24 As a matter of fact, when I was at -- at Bowman Gray after
25 getting out of the Navy, the -- the neurosurgery component at

1 Bowman Gray was -- was pretty impressive. And the -- we were
2 beginning from -- that was from, like, '83 to, like, '86, '87.
3 I was there about four years, and we were beginning to do
4 neuromonitoring. So Bowman Gray was a little bit ahead of the
5 curve, and that was being done by the anesthesiologist.

6 So we had this -- this -- this -- imagine this medical
7 instrument that sold for a lot of money that we could put on
8 the patients and -- but it allowed us to monitor their spine.
9 Most of the surgery that was being done in the '80s and '90s
10 was usually done for scoliosis surgery when you have a bad
11 stretched back, and when you straighten that out, you stretch
12 the spinal cord. And that's when we did actually Stagnara
13 tests, things like that, but I haven't done that for a long
14 time.

15 But the neuromonitoring normally doesn't record blood
16 pressure. So I am -- I mean, to be truthful, I just -- I
17 don't know what to make of that blood pressure. Number one,
18 if that is real, which I don't think it was. Number one,
19 that's not the job of the neuromonitoring tech. If the
20 neuromonitoring tech did note that -- and they didn't. I read
21 through their deposition. They really didn't have -- I don't
22 know how it got there, and they didn't have a good
23 explanation.

24 So in my opinion, it is -- it's really not very
25 meaningful. The other problem is with -- with saying, whoops,

1 that was hypotension. Well, first of all, a mean arterial
2 pressure of 77 is not hypotension, period. If it's -- if it's
3 57, maybe hypotension, even in a patient with hypertension.

4 And if you look at Ms. Goodwin, if you're in -- I'm
5 trying to understand what happened to this lovely woman, and I
6 don't think it does us any good just to make up something and
7 then try to apply the record to what our story is. What
8 really did happen?

9 So my conclusion is from -- from having the ability --

10 MR. HINSON: Objection. Your Honor. This is -- this is
11 moving into causation, which the expert said he wouldn't
12 testify about.

13 THE WITNESS: I have no idea about causation.

14 THE COURT: Okay. Overruled. Keep going.

15 THE WITNESS: Thank you, Your Honor.

16 MR. HINSON: That's my objection.

17 BY MR. DAVIS:

18 A: So what I'm saying is this -- is this. I'm just looking
19 at the blood pressures. We have the benefit in Ms. Goodwin's
20 case of having a pretty good idea of what her baseline blood
21 pressure was, and if anything, we're overestimating it. So --
22 so -- so her baseline blood pressure -- this is below that,
23 but I would argue, first of all, that I don't think it's a
24 reliable number. I don't know its source. I can't get it
25 verified even with the deposition of the -- of the tech.

1 And it's not hypotension. It's a little lower than I
2 would like it to be. If I aim for 85 as my mean arterial
3 pressure, and I've agreed to that with the surgeon, if it goes
4 down to 80, I'm addressing it and I'm going to change it, but
5 I just don't think that's -- that's a reliable number.

6 Q: Okay.

7 A: Now, the other thing to remember is -- and this is
8 extremely important. Somatosensory evoked potentials, where
9 we're looking at the sensory part of the connection in the
10 spinal cord, that's something that we constantly stimulate,
11 but we don't know when the insult that occurred occurred. It
12 can be off by a minute. It can be off by 5 minutes. It can
13 be off by up to 30 minutes. So it is less reliable to say,
14 oh, you know, the blood pressure was 103. That's when she was
15 hypotensive. That's when we lost the SSEP.

16 That's possible. 103 over -- over 64 though, I would
17 argue would not cause her -- again, that would not cause there
18 to be low blood. That is not low blood pressure. That is
19 lower blood pressure, but adequate to supply the body. And so
20 that would be my judgment on that one.

21 Q: So if I heard you correctly -- and correct me if I'm not
22 getting this summation correct, but you've testified that for
23 Ms. Goodwin for this surgery on this day, that your goal would
24 be to keep her in the 80s, 80 and above for MAP?

25 A: Yes, sir.

1 Q: All right. Were they?

2 A: Yes, they were all above. They were all above, I
3 believe, 84. I've got to look at what I ==

4 Q: I think we saw an 82 in there somewhere.

5 A: Right. They were all above 80. That's for sure.

6 Q: Okay. Let's talk about urine output. Okay?

7 A: Yes, sir.

8 Q: Do you, as an anesthesiologist in the operating room,
9 monitor a number of vital signs and other things, including
10 urine output?

11 A: Yes, sir.

12 Q: How do you do that?

13 A: Basic anesthesia monitoring includes the -- the
14 electrocardiogram, the pulse oximeter. The electrocardiogram
15 you monitor continuously. The pulse oximeter you monitor
16 continuously. The blood pressure you monitor continually and
17 regularly, usually at least every five minutes. I'm looking
18 at the pulse oximetry, which I monitor continuously. That
19 just means you're monitoring it all the time.

20 And then I monitor entitled CO2, which is the sign that
21 you're in the right place, and it can give you -- it can give
22 you a -- a -- an indicator that something might be going
23 wrong.

24 And then I also am usually giving muscle relaxants. So I
25 use a neuromuscular stimulator to get a feeling, get a -- get

1 a measurement of how relaxed the patient's muscles are. I'm
2 usually using that in conjunction with putting a tube in the
3 windpipe.

4 Q: She had a total urine output --

5 A: And I measure urine output. I'm sorry.

6 Q: All right. Let me get back to urine output. Plaintiffs'
7 counsel has prepared these things. I can't vouch for the
8 numbers. This is what they represent as 80 milliliters.
9 Okay? Assume that to be the case.

10 A: True.

11 Q: See -- she was -- in her bag, measured at the end of the
12 surgery, 40 and another 40 for a total of 80 milliliters of
13 urine in four hours?

14 A: Right. She must have gotten methylene blue in that IV to
15 get that color urine.

16 Q: No. That's water.

17 A: Oh, okay. Good. I didn't know how real you wanted it to
18 be.

19 Q: No, no. That's their exhibit, not mine. I'm pretty sure
20 it's water. In your opinion, is 80 milliliters of urine
21 output in a surgery like this, with these blood pressures,
22 with these MAPs that are recorded on the records, an
23 indication of damage to the kidney?

24 A: No.

25 Q: Is it, in your opinion, an indication of damage, even

1 transient damage to the kidney from lack of blood perfusion to
2 the kidney?

3 A: No. No evidence for that.

4 Q: Why would you say that?

5 A: Well, we've been having discussions about how to measure
6 perfusion of the body for as long as I've been doing this, and
7 I still don't have a really good answer. We used to think
8 that -- that 1 to 2 milliliters per kilogram was pretty good,
9 but then we realized that that really doesn't apply if you're
10 -- if you have a normal -- if you have the -- the -- the --
11 what's called not obese body habitus, then it works. 70 -- if
12 you're 70 kilograms, you know, 150 pounds, then -- then making
13 7cc an hour normally is to be expected and -- but when you're
14 150 kilograms or 3- or 400 pounds and you're five foot ten,
15 you're not going to have the same. You're -- you're going to
16 -- your urine output normally is not going to be dependent
17 upon your body weight. So you have to -- you have to decide
18 whether you're going to use -- use the patient's ideal body
19 weight.

20 Now, I take care of a lot of people over 300 pounds. If
21 I were giving them one -- if I were aiming for a urine output
22 and they all get Foley catheters because they're all having
23 major laparoscopic surgery, if I were aiming for a urine
24 output of 1 to 2 milliliters per kilogram, I would be
25 overhydrating all the patients.

1 And if you -- so if I give a patient, whatever this is,
2 500 milliliters of fluid in their IV, within 35 to 45 minutes,
3 a third of that is still in their blood vessels. Two-thirds
4 of it is -- is in their tissues. So you see somebody after
5 surgery and they look like they gained 10 pounds because their
6 face is puffy, that's all that fluid that they got.

7 If I give them albumin, it takes it about a day to get
8 there, but a lot of it ends up in their interstitial tissue.
9 So -- and that's overhydrating, and that can be -- that can be
10 harmful. And mainly because you're doing surgery, and the
11 surgery needs to heal. The more swelling there is in the
12 surgical area, the worse it is for the healing and the
13 recovery. And that's true for the whole body.

14 So at this point -- and -- and this really doesn't apply
15 here, but I take care of children sometimes for bigger
16 operations. And -- and we're down to, like, 0.2, not 2, 0.2
17 milliliters per kilogram. Now, kids are usually not very
18 chubby, but occasionally they are. But we're finding that
19 lower urine output is compatible with better outcomes.

20 Now, the real key though is in the perioperative, and
21 that's one of the -- one of the --

22 Q: What does perioperative mean?

23 A: Well, perioperative would be the period of time from the
24 time the patient comes into the operating room area and goes
25 back to the operating room until they recover from anesthesia

1 and have been released from the care of the anesthesia care
2 team to the recovery room nurse. That's the immediate
3 perioperative period.

4 Then the global perioperative period is going to be from
5 the time that they get admitted to the hospital to the time
6 that they go home. That would be a broad definition.

7 Q: Dr. Balestrieri, in your opinion, does the standard of
8 care require a preoperative meeting with a CRNA, the M.D.
9 anesthesia, and the surgeon?

10 A: No.

11 Q: I'm sorry. What?

12 A: No, sir.

13 Q: Why not?

14 A: Well, the -- the origin of -- of the timeout came in --
15 in good part because of wrong side surgery. Okay? So it's
16 hard to imagine that -- that I expected to have my -- my right
17 trigger finger fixed, and I woke up and my left trigger
18 finger, which really didn't bother me much, has been fixed,
19 but my right is still bad.

20 So that -- and it was led by actually orthopedic surgeons
21 and neurosurgeons to have us all stop, and before we -- before
22 the surgeon starts the surgery, the critical members of the
23 team, the surgical team -- now, it varies from -- from -- from
24 place to place, and I do not know what it is at Prisma, but I
25 can tell you what it is at -- at virtually every hospital I've

1 worked at in the last 40 years. It requires a member of the
2 anesthesia team to be there, the anesthesiologist or the CRNA
3 or the anesthesiology assistant.

4 It requires a surgeon to be there or it can be the
5 surgeon's PA. It can be the -- it can be the -- the -- the --
6 frequently with these kinds of operations, I have two
7 surgeons, the primary surgeon and the secondary surgeon, or it
8 could be in -- like, when I'm down at Big Wake, the big
9 hospital in the center of town, we have residents. So it can
10 be the resident who is assisting the surgeon. Then it is the
11 circulating nurse. Okay?

12 And it is critical that everyone stop, and everyone stops
13 because everybody's doing all kinds of things when you're
14 getting ready for surgery. Everyone has to stop and focus on
15 the patient and what we are doing here to prevent wrong-sided
16 surgery. So that -- that -- that -- that requirement is going
17 to vary from place to place.

18 And if indeed there's a requirement that the
19 anesthesiologist and the nurse anesthetist be there for the
20 timeout, then if that were the policy of the hospital, that
21 would be a violation.

22 Q: Okay, Doctor. Doctor, this urine output, let me just see
23 if I can wrap it with this. In your opinion, do you think
24 that Ms. Goodwin had adequate urine output during this surgery
25 on July 28th, 2016?

1 A: Yes, sir. And if I might just read the reason for that?

2 Q: Yes, sir.

3 A: Okay. A lot of times, you know, I can tell you that --
4 that the 20 percent rule is really a guideline. It's a --
5 it's a common practice. There is very little data or -- or
6 literature on that, but there is literature on urine output,
7 and there was a review article. And the bottom line is,
8 several studies have examined the relationship between fluid
9 administration and intraoperative urine output and its
10 correlation with postoperative acute kidney injury.

11 One such randomized prospective study examined 102
12 patients undergoing bariatric surgery who received either high
13 or low volume amounts of lactated ringers. That's that saline
14 solution stuff. The editors failed to find a correlation
15 between low urine output in the intraoperative period and
16 postoperative acute kidney injury.

17 So it is very common. It's more -- more common than not
18 to have a half a cc to a cc per kilogram ideal body weight per
19 hour. So 20 to 40 milliliters per hour. She had in the 20
20 per hour range, which was a little bit lower, but many of our
21 surgeons are requesting -- requesting that we limit our fluid
22 crystalloid administration to when they're particularly
23 concerned about edema and swelling post-operatively.

24 So there is no good science that says -- as a matter of
25 fact, the science is that it's not that good to give 2 to 4

1 milliliters per kilogram per hour to avoid kidney damage.

2 That just isn't the case.

3 Q: You talked a little while ago, Dr. Balestrieri, about the
4 things that you as an anesthesiologist will -- will monitor.
5 I want to ask you about three or four other things. What is
6 entitled CO2?

7 A: So --

8 Q: ET CO2, what is that?

9 A: ET CO2. So, normally, we have very little carbon dioxide
10 in [*inaudible due to coughing*], but it's getting bigger, 450
11 to 500 parts per million. So we have to be a little worried
12 about that, parts per million.

13 So normally when you breathe in, there's no carbon
14 dioxide registered in the gas that you're breathing in, but
15 when you breathe out, you have carbon dioxide because you're
16 -- you guys -- we're all burning fluid and we're burning fuel
17 and we're producing carbon dioxide. And where is it? Where
18 does it get rid of it? It -- we get rid of it through the
19 lungs.

20 So carbon dioxide is a critical measure of adequacy of
21 ventilation. So if I stop breathing for her or if I lower my
22 breathing rate, then my carbon dioxide will come up. So it's
23 a good indication as to whether I'm breathing well for a
24 patient.

25 Now, if I breathe too much for them, I can cause their

1 blood to become basic. If I breathe too little, I can be --
2 it can become acidotic. And basic or acidotic can affect
3 blood flow. So we try to keep it kind of in the middle.

4 Now, with the brain specifically, as I raise the CO₂, I
5 get more blood flow to the brain, and as I lower CO₂, I get
6 less blood flow. So that's one of the ways that we have of
7 managing edema in the brain.

8 Q: Looking at this chart we put up here as demonstration,
9 I'll ask you to assume that it's from the anesthesia record.
10 I'm happy to show that to you. That these are times during
11 the operation, and these are entitled CO₂ and SAO₂, and I'll
12 ask you to explain what that is in just a second. Just the
13 entitled CO₂ is --

14 MR. DAVIS: And, Andrew, can we just go ahead and show
15 all the numbers? Thank you.

16 BY MR. DAVIS:

17 Q: Can you see that okay?

18 A: Yes, sir.

19 Q: Do you have an opinion whether those are in a normal
20 range, the entitled CO₂?

21 A: Yes. Probably, I would say between 30 and 45 or 50 is a
22 normal range.

23 Q: All right.

24 A: And as you can see, it varies.

25 Q: Yeah.

1 A: It -- it can vary from breath to breath, how big a
2 breath.

3 Q: Okay. And that's being measured as the patient is
4 exhaling?

5 A: Yes. That's one of the measures that is -- that should
6 be measured continuously.

7 Q: Uh-huh.

8 A: So every time I breathe in and I breathe out, I get -- if
9 I suddenly lose my CO2 --

10 Q: Uh-huh.

11 A: -- that could be due to some bad things. And I'm -- and
12 I'm -- that's a real-time immediate monitor for trouble, and
13 you want to keep it in the range there.

14 Q: You want to keep it in the range?

15 A: 30 to 40.

16 Q: Okay.

17 A: 40, 45 to 50, even 50. You can allow it depending upon
18 what's happening. Frequently, and especially when I'm -- when
19 I'm doing obesity surgery, it can be a challenge to ventilate
20 the patient adequately while the surgeon is -- is insufflating
21 the abdomen so that they can do the surgery.

22 Q: That's a big word, insufflate?

23 A: Yeah.

24 Q: What's that mean?

25 A: I have no clue what that means. I'm sorry. No.

1 Insufflate -- so, you know, when you have laparoscopic surgery
2 to get out your gallbladder or a hernia fixed, the surgeon
3 goes through the abdominal wall, doesn't go into the stomach,
4 goes into the peritoneum, which is a sac that -- that -- that
5 the abdomen -- that the abdominal contents, the liver, the
6 spleen, the kidneys -- actually, the kidneys are
7 retroperitoneal, but -- and the bowel is in. So --

8 Q: But that's not what this case was about?

9 A: No, sir.

10 Q: Okay. Let's move on.

11 A: Right.

12 Q: SAO2. What is that?

13 A: That is -- that is a -- a measure of -- it actually uses
14 -- some -- some -- some monitors use two wavelengths. The
15 more -- more recent ones use three or four wavelengths. And
16 with an algorithm, they look through your finger, through your
17 lip, through your -- through your gums. You can put it on the
18 nose. It -- it -- you -- you shine these lights, different
19 wavelength lights, through the tissue, and different --
20 different wavelengths are absorbed differently, and you can
21 use an algorithm to calculate the saturation of oxygen in the
22 blood, the amount of hemoglobin that has oxygen on it.

23 Q: Oxygen needs to be carried to the tissues through the
24 blood?

25 A: Yes, sir.

1 Q: For the tissues to thrive? Is 100 as high as you can
2 get? 100 percent?

3 A: Yes.

4 Q: And these are her oxygen saturations through her surgery
5 recorded on the anesthesia record. Are those all within
6 normal limits?

7 A: Yes. Anything above, like, 93, 94.

8 Q: Okay. The lowest one is 99?

9 A: Yeah, yeah. Her oxygen sats were -- were -- her end
10 tidal CO2 and her O2 sats were -- were not an issue. I'm not
11 sure exactly where that was. Frequently, it's on a hand or a
12 finger, and that just says at that particular place, but if
13 I'm perfusing my -- my -- my -- my finger, I'm probably
14 perfusing the rest of my body.

15 Q: Including your spinal cord?

16 A: Especially in my spinal cord.

17 Q: The brain? Your heart?

18 A: Even more so the brain.

19 Q: Your kidneys? Your liver?

20 A: Yes. Well -- yes.

21 Q: All right. But -- but, Doctor, can looking at the end
22 tidal CO2s and the oxygen saturations on your monitors in real
23 time as you're at the head of the table doing the anesthesia
24 job for the patient in the surgery like this, can these
25 numbers give you some direct or indirect indication of blood

1 flow, sir?

2 A: They are an indirect indication of adequate blood flow.

3 The end tidal CO2 --

4 Q: Okay.

5 A: -- I'm not aware of as being an indicator of good blood

6 flow, but end tidal CO2 sudden loss is an indicator of

7 something potentially catastrophic. So that's one of the

8 reasons -- one of the many reasons we -- we -- we look at end

9 tidal CO2.

10 Q: Doctor, is blood flow of a patient the same as blood

11 pressure?

12 A: No.

13 Q: What's the difference?

14 A: Well, the pressure is what's my blood pressure? The flow

15 is going to be measured by looking at if there is adequate

16 perfusion to the tissues. You're going to look at urine

17 output. You're going to look at pulse oximetry.

18 Unfortunately, one of the -- the best ways to know about

19 flow we actually have, which is esophageal stethoscopes, which

20 we use now routinely on all heart patients who are having open

21 heart surgery. But the question is, how much -- is there

22 enough fluid in the blood vessels so that it can squeeze -- so

23 the heart can squeeze enough to get flow.

24 So pressure is a prerequisite for flow, but it doesn't

25 guarantee flow. And the dilemma is, is that at low pressure,

1 it makes good sense. If you don't have any pressure, you're
2 not going to have any flow. The similar conclusion, that if I
3 really raise the pressure high, I'm going to get much better
4 flow, is not true. When the blood pressure gets much over a
5 mean arterial pressure -- and in the brain we're pretty sure
6 it's about 140 -- then blood flow is not dependent upon need.
7 It's just going to push its way through.

8 The dilemma with that, at that point, what we've got is a
9 greater chance for aneurysms, for any abnormality in the
10 brain, for hemorrhage. And more troublesome, and especially
11 in patients who are having major back surgery, is that
12 hypertension can result. The heart will fail. If there's too
13 high a pressure, it will fail. The patient will have
14 congestive heart failure. The heart can't pump enough blood
15 because it's working too hard.

16 And even worse is the more the pressure, the more oxygen,
17 the more fuel the heart needs, and if the blood pressure is
18 really high, like much -- much over 100, 110 mean arterial
19 pressure, you put the patient at risk for having a major heart
20 attack.

21 Q: Dr. Balestrieri, did, in your opinion, the standard of
22 care require that the mean arterial pressure in this surgery
23 be maintained between 100 and 105 throughout her surgery, sir?

24 A: I think -- well, her mean arterial pressure was --

25 Q: Wait a minute. That's a yes or no, and then you can

1 explain it.

2 A: Would you please repeat the question?

3 Q: I'll be glad to. In your opinion, did the standard of
4 care require the mean arterial pressure range to be maintained
5 between 100 as a low and 105 as a high during this surgery.

6 A: No, sir.

7 Q: Why not?

8 A: It would have put her at risk for what I just described.

9 Q: What is that?

10 A: A heart attack, congestive heart failure, and more likely
11 than not, increasing -- increasing edema and swelling at the
12 site, at any site in her body that might be subject to
13 inflammatory changes, specifically the area of her surgery.

14 Q: The spike?

15 A: Yes, sir.

16 Q: All right. There's been talk -- you mentioned it a
17 little while ago about this wake-up test. Let me ask you
18 this. The jury has heard about it. I don't think we need to
19 go over that again, but let me ask you this. As an
20 anesthesiologist who does numerous cases of decompressive
21 laminectomies, like that which was done on July 28th, 2016,
22 with Ms. Goodwin, when is the last time you've had occasion to
23 see that happen in a surgery like that?

24 A: Probably the last time was when I was in Colorado about
25 10 or 15 years ago. The -- there were seven orthopedic. They

1 did a lot of back surgery in Colorado, and most of them didn't
2 use evoked potentials, but -- but there was one occasion where
3 I was actually doing the anesthesia when I was in Colorado.
4 One day a week, I did -- I did the anesthesia myself, and the
5 other four days, I supervised a nurse anesthetist.

6 And so this was a case where the neuromonitoring noted a
7 loss of somatosensory evoked potentials, and the surgeon had
8 just been putting in a bunch of hardware and distracting the
9 -- the spinal column, and he readjusted that and -- and then
10 the signal actually came back. It doesn't happen very often.

11 Q: That's not the kind of surgery this -- in this case, was
12 it?

13 A: No, sir.

14 Q: Doctor, I probably should have asked you this. My friend
15 just reminded me. Every opinion that you've given to me today
16 in response to my questions, were they within a reasonable
17 degree of medical certainty, sir?

18 A: Yes, sir.

19 Q: Okay. Doctor --

20 MR. DAVIS: Let's pull up the anesthesia record again,
21 please.

22 Excuse me. I'm almost done. I mean, I'm running out of
23 voice. So carry me.

24 But, Andrew, let's call that out a little bit. Thank
25 you. Let me see if I can -- here we go.

1 BY MR. DAVIS:

2 Q: This is the -- the legend. It's got a black round dot
3 for pulse?

4 A: Yes, sir.

5 Q: Would that be these -- these --

6 A: Yes, sir.

7 Q: -- things right here?

8 A: Pulse. Pulse rate.

9 Q: Okay.

10 MR. DAVIS: And can we go to the second page, Andrew?
11 This is kind of a two page. Okay. And call that out, please.
12 Thank you.

13 BY MR. DAVIS:

14 Q: And again, the pulse rate continuing on -- on the second
15 page, these black dots here?

16 A: Yes, sir.

17 Q: Do you have an opinion whether or not the pulse rate was
18 within a normal range?

19 A: It appears to me to be within a normal range.

20 Q: Does that tell you anything about blood pressure? Does
21 that tell you anything about hypoperfusion or high -- hyper --
22 hyperperfusion or hypoperfusion? Does it tell you anything
23 about that?

24 A: Well, the only issue with heart rate and perfusion is --
25 is really related to the -- to the heart.

1 Q: Okay.

2 A: The heart's going to do its best to get perfusion to the
3 brain, the body, the kidneys, the rest. The problem is, is
4 that at a heart rate of -- of 80 to 100, the heart has time in
5 between contracting to have blood flow to the heart. So my
6 concern with heart rate and perfusion is really related to the
7 perfusion of the heart.

8 So if I double the heart rate to 120, then I've basically
9 decreased the time for blood flow to the heart itself, maybe
10 by as much as a half, and one of the major determinants
11 besides stress from hypertension on heart oxygen and -- and
12 fuel supply is the heart rate. So it's a double -- it -- if
13 your -- if your heart rate is very high and your blood
14 pressure is very high, you've got a demand that's -- that's
15 really significantly increasing the heart's need for fuel and
16 for oxygen, both from two different sources.

17 Q: As you look at the anesthesia records, as you look at the
18 500 pages of care after the surgery, all the work that you've
19 done looking at and analyzing this case, do you have an
20 opinion within a reasonable degree of medical certainty
21 whether or not the blood pressures and the perfusion, the flow
22 of blood, were maintained at an adequate level, a safe level
23 in this case?

24 A: As it turned out, from looking at the record, the full
25 record, it appears to me that -- that this level of

1 maintenance of blood pressure was very good.

2 MR. DAVIS: Thank you, Doctor. Answer any questions that
3 counsel may have for you, sir.

4 THE WITNESS: Yes, sir.

5 CROSS-EXAMINATION

6 BY MR. HINSON:

7 Q: Good afternoon, Doc.

8 A: Hello.

9 Q: You were originally named as an expert in this case for
10 the hospital; correct?

11 A: I don't believe so. I thought I was representing Mr.
12 Starn.

13 Q: Well, Mr. Starn was an employee of the hospital.

14 A: Oh.

15 Q: Okay. So, originally, a different lawyer other than this
16 team right here called you; right?

17 A: Yes, sir.

18 Q: All right. And so you were working with Mr. Starn's
19 lawyer, the hospital's lawyer, and now that those claims have
20 been resolved, you've entered the -- the transport --
21 transport -- transfer portal, if we're talking about college
22 football, and you're transferred over there; right? You
23 changed teams?

24 A: Yes. It wasn't really a change of teams. It was just a
25 different team. I mean, it's not like -- it's not like -- I'm

1 not -- I don't -- I don't look upon -- I look upon this as my
2 effort to try to find out the truth.

3 Q: Okay.

4 A: And I don't -- I don't -- don't view it as a -- as a --
5 even a college football team.

6 Q: Just trying to make a fun analogy here --

7 A: Yes, sir.

8 Q: -- towards the end of the afternoon, and I think the
9 transfer portal is the most amazing thing and kind of weird.
10 So --

11 A: And I kind of liked it too.

12 Q: So, Doctor, you've -- you've been in the operating room
13 while people were performing surgeries; right?

14 A: Yes, sir.

15 Q: Fair enough. And you have had the occasion where you
16 spoke with surgeons, you being the anesthesiologist and the
17 surgeon doing the surgery. You spoke with the surgeon; right?

18 A: Talk to surgeons all the time.

19 Q: All right. While they're doing the surgery?

20 A: Oh, yeah.

21 Q: So surgeons are operating on the back. He can talk to
22 you while he's doing that surgery, can't he?

23 A: Most surgeons are pretty focused on what they're doing.
24 They aren't interested in chatting about football or anything
25 else.